Twin sisters, monozigotic with the fragile X mutation, but with a different phenotype

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Abstract
The absence of the fragile X mental retardation protein (FMRP) results in fragile X syndrome. All males with a full mutation in the FMR1 gene and an inactive FMR1 gene are mentally retarded while 60% of the females with a full mutation are affected. Here we describe monozigotic twin sisters who both have a full mutation in their FMR1 gene, one of whom is normal while the other is affected. Using molecular and protein studies it was shown that owing to preferential X inactivation in the affected female a minority of the cells expressed the normal FMR1 gene, while in her sister most cells expressed the normal FMR1 gene. This shows that X inactivation took place in the female twins after separation of the embryos and that for a normal phenotype FMR1 expression is necessary in the majority of cells.

Keywords: fragile X syndrome; mental retardation; monozigotic twins; Lyonisation

Fragile X syndrome is the most common form of X linked inherited mental retardation in humans with a prevalence of 1:4000 males and 1:6000 females. The basic genetic defect is an increase in length of a stretch of CGG triplet repeats (>200 repeats, full mutation) within the FMR1 gene. The large number of CGG repeats leads to silencing of the FMR1 gene and consequently the absence of the encoded FMR1 protein (FMRP). The absence of FMRP in the brain is responsible for the observed mental retardation. Males carrying the full mutation are always affected, whereas females carrying a full mutation show mental impairment in only approximately 60% of cases. Females carrying a full mutation are characterised by cells with and without FMRP expression, which can be explained by inactivation of the X chromosome (Lyonisation). Thus, in cells without FMRP expression the normal FMR1 allele is inactivated, whereas in cells with FMRP expression the mutant FMR1 allele is inactivated. It has been suggested that an insufficient number of FMRP expressing neurones in the brain in affected females causes the mental retardation as a result of the proportion of mutant FMR1 alleles on the active X chromosome.

Monozigotic twins are genetically identical and concordance for cognitive function between monozigotic twins carrying a full mutation would be expected. At least three cases of live born male monozigotic twins with the fragile X syndrome have been published and three pairs of brothers were concordant for the mental retardation. One of the male twins had a different size of the full mutation. No information about the time of twinning was available. Of the four sister pairs with retardation, one pair was concordant for mental retardation. Of the other three, only one sister was mentally retarded. Two of the three pairs had significant differences in X inactivation pattern showing that in the normal girl the X chromosome with the full mutation was preferentially inactivated. For an overview of twin studies in fragile X syndrome see Helmerman et al.

Here we describe the unexpected observation of different phenotypes in monozigotic twin sisters with the full mutation. One sister is affected and is living in an institute for the mentally handicapped without having typical features of fragile X syndrome, but this is often seen in affected females. The other sister is intellectually normal and has finished secondary school. Unfortunately their IQ values are not available.

Molecular studies on DNA isolated from blood showed that both had a full mutation (fig 1), but in the normal sister in almost all blood cells the normal X chromosome was active (“N active”), while in the affected sister the normal X chromosome is inactive in approximately 50% of her blood cells (“N active + N inactive”). However, it should be noted that in DNA studies performed so far, only a weak correlation has been found between the X inactivation pattern and cognitive function. However, this weak correlation is not strong enough to be a prognostic indicator.

Recently, we described a non-invasive antibody test for fragile X syndrome using hair root analysis. This test offers an affordable and alternative tool for identifying fragile X patients. We have hypothesised that this new test might be of value for predicting the mental capacities of females carrying a full mutation because hair roots originate, like brain tissue, from the ectoderm during embryonic development.

The affected sister shows FMRP expression in 35% of 20 hair roots, whereas her mentally normal sister shows it in 79% of 18 hair roots (fig 1). In controls (>130 persons), FMRP expression in hair roots was found to be between 77 and 100%, whereas affected females carrying a full mutation showed FMRP expression in only some of their hair roots (<55%).
In conclusion, we were able to show in this case a correlation between FMRP expression in hair roots and cognitive function in these monozygotic twin sisters, who are discordant for the fragile X syndrome. We can explain the discordance of mental capacity between the twin sisters by the fact that the number of FMRP expressing neurones in the brain of the affected sister is insufficient to prevent mental retardation. In contrast, her normal sister has a sufficient number of FMRP expressing neurones in the brain to develop normal cognitive function in adult life. The results look promising for the development of a diagnostic test to predict the mental status of females carrying the full mutation. In addition, these results also show that the Lyonisation and inactivation pattern took place in the female twins after separation of the embryos.