Usher syndrome (USH) is an autosomal recessive disorder comprising of bilateral sensorineural hearing loss, progressive loss of vision due to retinitis pigmentosa (RP), and variable vestibular dysfunction. It is the most frequent cause of deafness and concurrent blindness in schools for the deaf-blind,1 with a prevalence of 1/16 000 to 1/50 000 in various populations.2 The majority of Usher syndrome cases can be clinically classified into three subtypes.3–4 USH type I (USH1; OMIM 276900, 276903, 276904, 601067, 602097, 602083 and 606943) is characterised by profound prelingual sensorineural hearing loss, vestibular areflexia, and prepubertal onset of RP. USH type II (USH2; OMIM 276901, 276905 and 605472) is characterised by moderate to severe hearing impairment, no vestibular impairment, and onset of RP in the first or second decade of life. USH type III (USH3; OMIM 276902) is characterised by progressive, post-lingual hearing loss, variable onset and severity of RP, with or without vestibular dysfunction. Atypical forms of Usher syndrome associated with mutations in USH1B and USH1D have also been reported.5–7 There is progression of hearing loss in some of these atypical cases, making them potentially difficult to clinically distinguish from USH3.

USH3 was originally thought to be very rare, accounting for at most a few percent of the total USH population, until Pakarinen and coworkers found that up to 40% of the USH cases in Finland were consistent with USH3.8 Difficulty in accurately detecting the progression of hearing loss may account for the lower frequency of reported USH3 cases outside of Finland. In the Finnish USH3 cohort, hearing loss was diagnosed before the age of 10 years in most patients, but up to the age of 40 years in some patients, with moderate to severe hearing threshold elevations at the time of detection. The mean hearing threshold (80 dB HL) in the USH3 cohort was lower than that in USH1 but higher than in USH2. The rate of progression varied greatly, with 42% of patients having final hearing thresholds greater than 90 dB HL (profound), and the time interval since onset of hearing loss significantly correlated with the final hearing level.9 Vestibular function was abnormal in 50% of the patients.10 Average age of diagnosis of RP in the Finnish cohort ranged from 3 to 51 years (mean 17 years) with both visual fields and visual acuity reaching minimal levels by 40 years of age and progression of visual acuity loss not significantly differing from the other USH types.10 Similarly, visual findings are not useful for differentiating between USH1 and USH2.11 It thus appears that progression of hearing loss is the key discriminatory feature between USH3 and USH1 or USH2.

One USH3 locus, USH3A on chromosome 3q25, has been identified.12 USH3A expression has been detected in the cochlea and retina, although its function is unknown.11,12 Nine mutations causing disease have so far been identified in USH3A.12–14 Y176X (also referred to as Finmajor) is a nonsense mutation responsible for most of the USH3 cases among Ashkenazi Jews with USH3.10,14–16 The rate of progression of hearing loss in some of these atypical cases, making them potentially difficult to clinically distinguish from USH3.

Sixteen (40%) of a cohort of 40 Ashkenazi Jewish subjects with Usher syndrome were clinically classified as USH3, all of whom were homozygous for the N48K mutation of USH3A.15 The carrier frequency of N48K was 0.7% (95% CI 0 to 1.6%) among Ashkenazi Jews from the New York area, with a predicted USH3 prevalence of 1.2 per 100 000.16 N48K homozygotes displayed a wide range of phenotypic severities.

Genetic testing for N48K in Ashkenazi Jews will prove helpful in diagnosing USH3 in infants and young children and in distinguishing it from other forms of Usher syndrome.

Key points

- Usher syndrome type III (USH3) is an autosomal recessive disorder characterised by progressive hearing loss, retinitis pigmentosa, and variable peripheral vestibular dysfunction.
- Sixteen (40%) of a cohort of 40 Ashkenazi Jewish subjects with Usher syndrome were clinically classified as USH3, all of whom were homozygous for the N48K mutation of USH3A.
- The carrier frequency of N48K was 0.7% (95% CI 0 to 1.6%) among Ashkenazi Jews from the New York area, with a predicted USH3 prevalence of 1.2 per 100 000.
- N48K homozygotes displayed a wide range of phenotypic severities.
- Genetic testing for N48K in Ashkenazi Jews will prove helpful in diagnosing USH3 in infants and young children and in distinguishing it from other forms of Usher syndrome.

Abbreviations: RP, retinitis pigmentosa; USH, Usher syndrome.

LETTER TO JMG

Genetic homogeneity and phenotypic variability among Ashkenazi Jews with Usher syndrome type III


LETTER TO JMG

Genetic homogeneity and phenotypic variability among Ashkenazi Jews with Usher syndrome type III

endonuclease digestion, based upon the observation that Control DNA samples were screened for N48K by restriction affected subjects by direct sequencing of PCR products.

Individuals from three unrelated families.\textsuperscript{b}ers tested were either heterozygous or homozygous for the mutation tested.\textsuperscript{b}ers tested were either heterozygous or homozygous for the mutation tested.\textsuperscript{b}

Genomic DNA was extracted from antecubital venous blood samples (PUREGENE reagents, Gentra Systems, Inc, Minneapolis, MN, USA) or buccal mucosal cells obtained by a swab.\textsuperscript{14} Normal controls were anonymised DNA samples that had been previously prepared from 419 Ashkenazi Jewish individuals presenting for Tay-Sachs disease carrier screening in the New York city area. Family histories of hearing loss or RP were not available from these individuals, who had provided consent for the use of their DNA samples in additional genetic studies.

\textbf{Mutation analysis}

The first exon (nt 129–545, GenBank accession NM\_174879) of \textit{USH3A} was PCR amplified from genomic DNA as previously described.\textsuperscript{11} \textit{143T\rightarrow G} (N48K) was detected in affected subjects by direct sequencing of PCR products. Control DNA samples were screened for N48K by restriction endonuclease digestion, based upon the observation that \textit{143T\rightarrow G} creates a \textit{Stu}I digestion site.\textsuperscript{11}

\textbf{RESULTS}

\textbf{USH3A genotype}

Sixteen (40\%) of 40 USH subjects, from 11 of 30 unrelated Ashkenazi Jewish families, were classified as USH3 (fig 1). Subjects with USH3 ranged in age from 26 to 70 years old. DNA samples were obtained from 14 of these individuals, as well as from 17 unaffected family members. Two affected individuals (LMG 198/II-3 and LMG214/II-1) were interviewed but no DNA was obtained. These two individuals were assumed to have the same genotype as their affected siblings (fig 1), who were found to be homozygous for N48K. Eleven of the USH3 subjects were female and three were male. An initial screening for the N48K mutation of \textit{USH3A}\textsuperscript{11–12} demonstrated that all 14 affected subjects were homozygous for this mutation. All unaffected family members tested were either heterozygous or homozygous for the wild type allele. N48K was not detected in five USH2 individuals from three unrelated families.

We found an N48K carrier frequency of 3/419 (0.7\%; 95\% CI 0–1.6\%) among Ashkenazi Jews from the New York area. The corresponding allele frequency (3/838 chromosomes; 0.35\%) is not significantly different (p = 0.608) from that CI 0–1.6\%) among Ashkenazi Jews from the New York area. The corresponding allele frequency (3/838 chromosomes; 0.35\%) is not significantly different (p = 0.608) from that among our USH3 cohort. For example, subjects III-1 and II-3 in LMG181 are first cousins once removed (fig 1): II-3 had a moderate to profound hearing loss at 25 years of age, while II-2 had a moderate to profound hearing loss at 29 years (fig 2). Subjects II-2 and II-3 in LMG195 are siblings (fig 1): II-2 had a moderate to profound hearing loss at 25 years of age, while II-3 had a moderate to profound hearing loss for only the mid to high frequencies at the same age (fig 2). Furthermore, II-2 has a visual field of less than 5\˚ at 41 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 44 years of age. Two subjects without vestibular complaints also had ENG/caloric tests, which were both normal. Additional evaluations (rotary chair testing) with potentially increased sensitivity for detecting subtle vestibular dysfunction were not performed.

\textbf{Intrafamilial variation}

Five study families had more than one affected USH3 individual. In most of these cases, the intrafamilial visual and auditory phenotypic variability was significant and approximated the interfamilial variability we observed among our USH3 cohort. For example, subjects III-1 and II-3 in LMG181 are first cousins once removed (fig 1): II-3 had a mild to moderate hearing loss at 38 years of age, while III-1 already had a moderate to profound loss at 29 years (fig 2). Subjects II-2 and II-3 in LMG195 are siblings (fig 1): II-2 had a moderate to profound hearing loss at 25 years of age, while II-3 had mild to moderate loss for only the mid to high frequencies at the same age (fig 2). Furthermore, II-2 has a visual field of 15\˚ at 44 years of age, while II-3 has a visual field of less than 5\˚ at 41 years of age (table 1).

\textbf{DISCUSSION}

We previously reported a founder mutation in the \textit{GJB2} gene (167delT) that is carried by 4\% of Ashkenazi Jews and is a major cause of autosomal recessive nonsyndromic hearing loss in this population.\textsuperscript{14} We also recently described a founder mutation in \textit{PCDH15} (R245X) that is the major cause of USH1 in the same population.\textsuperscript{20} Our current results are consistent with those of other studies, and indicate that the N48K mutation of \textit{USH3A} accounts for a large proportion of USH3

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in Ashkenazi Jews, and is thus another prevalent founder mutation causing hearing loss in this population.

It is of interest that sixteen (40%) of our 40 USH subjects had USH3. USH3 has previously been considered to be a rare type of Usher syndrome, comprising only a few percent of the total cases, although no systematic studies are available to support this claim. The high proportion of USH3 in the Finnish and Ashkenazi Jewish populations suggests that only populations with a genetic history permitting the wide spread of a founder mutation will display an increased frequency of USH3. A similar situation, in which mutational events at a locus are uncommon, also exists for DFNB1 deafness caused by GJB2 mutations in Ashkenazi Jews.

We classified 44% of the subjects in our larger cohort as USH1, consistent with the results of other studies, whereas 11% were classified as USH2, which is a much lower proportion than previously reported for the general population. The comparatively increased proportion of USH3 and decreased proportion of USH2 in our cohort may be due to ascertainment bias, as our subjects were recruited primarily through deaf-blind centres and organisations, and through the internet. Larger cohorts will be needed to determine if our findings accurately reflect the epidemiology of Usher syndrome in the Ashkenazi Jewish population.

We identified an N48K carrier frequency of 0.7% in Ashkenazi Jewish control DNA samples. Assuming Hardy-Weinberg equilibrium, the predicted prevalence of USH3 due to N48K is 1.2 per 100 000. If USH3 accounts for 40% of all types of Usher syndrome among Ashkenazi Jews, the predicted overall prevalence of Usher syndrome is 3 in 100 000 in this population. This is within the published estimates of the prevalence of Usher syndrome in the general population (1/16 000 to 1/50 000). These results indicate that there is not necessarily a greater prevalence of Usher syndrome among Ashkenazi Jews, in whom N48K and the R245X mutation of PCDH15 account for approximately 67% of cases.

None of the 17 unaffected USH3 family members we tested were homozygous for N48K, suggesting that this mutation is likely to be fully penetrant in homozygotes. Although N48K mutation testing will be an excellent diagnostic tool for USH3 in Ashkenazi Jews, it will be less useful for predicting clinical prognosis due to the highly variable expressivity that we observed. Our findings and those of Pakarinen and co-workers indicate that genetic, environmental, or stochastic factors may modify the USH3 phenotype.

Progression of hearing loss is a consistent finding in USH3 patients. Indeed, our clinical classification based upon reported or audiometric evidence of hearing loss progression was 100% concordant with the molecular diagnosis of USH3 in our Usher syndrome cohort. The wide range of severity and age of onset of visual impairment in our subjects and in the Finnish cohort indicates that the ocular phenotype will not be useful in differentiating USH3 from other types of Usher syndrome. Thus, progression of hearing loss is a key clinical criterion for distinguishing USH3 from USH1 and USH2. Reports of hearing loss progression in USH2 are unconvincing due to either the absence of genetic confirmation of the

Figure 1 Pedigrees for the USH3 study families. All affected subjects who underwent molecular testing were homozygous for the N48K mutation.
Table 1  Demographic and phenotypic data for N48K homozygotes

<table>
<thead>
<tr>
<th>Family</th>
<th>Subject</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Age at onset (years)</th>
<th>Most recent HL severity</th>
<th>Communication; rehabilitation</th>
<th>Auditory phenotype</th>
<th>Ocular phenotype</th>
<th>Vestibular symptoms</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II-3</td>
<td>M</td>
<td>52</td>
<td>5-6</td>
<td>Mild to moderate</td>
<td>Oral; HA</td>
<td>9-10</td>
<td>Light perception, gross objects; minimal VF</td>
<td>None</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td>LMG187</td>
<td>III-3</td>
<td>M</td>
<td>48</td>
<td>7-8</td>
<td>Profound</td>
<td>Oral; CI</td>
<td>4</td>
<td>NA</td>
<td>None</td>
<td>1. Mumps encephalitis at 4 years</td>
</tr>
<tr>
<td>LMG191</td>
<td>II-1</td>
<td>M</td>
<td>50</td>
<td>Late teens</td>
<td>Moderate to profound</td>
<td>Oral; HA</td>
<td>5</td>
<td>Totally blind since 38 years</td>
<td>None (normal)</td>
<td>1. Asymmetric hearing loss</td>
</tr>
<tr>
<td>LMG195</td>
<td>III-3</td>
<td>F</td>
<td>41</td>
<td>9-10</td>
<td>Mild to severe</td>
<td>Oral; HA</td>
<td>10</td>
<td>20/60; good CV; &lt;-3° VF</td>
<td>None (normal)</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>II-2</td>
<td>F</td>
<td>44</td>
<td>3</td>
<td>Severe to profound</td>
<td>Oral; HA</td>
<td>12</td>
<td>20/70; good CV; 15°VF</td>
<td>Mild (normal at 1.4 years)</td>
<td>2. Otospongiosis at 20-30 years</td>
</tr>
<tr>
<td>LMG198</td>
<td>III-3</td>
<td>F</td>
<td>40</td>
<td>9-10</td>
<td>Severe</td>
<td>Oral; HA</td>
<td>Late teens</td>
<td>Good CV, limited VF</td>
<td>None</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>II-1</td>
<td>F</td>
<td>46</td>
<td>7</td>
<td>Severe to profound</td>
<td>Oral; HA</td>
<td>18</td>
<td>Good CV, limited VF</td>
<td>Mild</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td>LMG199</td>
<td>II-1</td>
<td>M</td>
<td>49</td>
<td>Teens</td>
<td>Mild to severe</td>
<td>Oral; HA</td>
<td>Teens</td>
<td>20/40; can read, VF 5° OS, 15° OD</td>
<td>None</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>II-2</td>
<td>M</td>
<td>56</td>
<td>Teens</td>
<td>Moderate</td>
<td>Oral; HA</td>
<td>11</td>
<td>Can’t read; VF &lt;5°</td>
<td>None</td>
<td>1. MD and glaucoma OD</td>
</tr>
<tr>
<td>LMG201</td>
<td>II-2</td>
<td>F</td>
<td>26</td>
<td>18</td>
<td>Moderate to severe</td>
<td>Oral; HA</td>
<td>15</td>
<td>Good CV; 20° VF</td>
<td>None</td>
<td>2. Cataract surgery</td>
</tr>
<tr>
<td>LMG202</td>
<td>II-2</td>
<td>F</td>
<td>56</td>
<td>1-2</td>
<td>Moderate to severe</td>
<td>Oral; HA</td>
<td>Early childhood</td>
<td>No useful vision</td>
<td>None</td>
<td>1. Ichthyosis; affected brother has USH and ichthyosis</td>
</tr>
<tr>
<td>LMG203</td>
<td>IV-2</td>
<td>F</td>
<td>56</td>
<td>&gt;35</td>
<td>Moderate to severe</td>
<td>Oral; HA</td>
<td>Early childhood</td>
<td>No useful vision</td>
<td>None</td>
<td>1. Ichthyosis; affected brother has USH and ichthyosis</td>
</tr>
<tr>
<td>LMG206</td>
<td>II-2</td>
<td>F</td>
<td>54</td>
<td>6</td>
<td>Severe to profound</td>
<td>Sign + oral; HA</td>
<td>Early childhood</td>
<td>Can read large print; very limited VF</td>
<td>None</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td>LGG214</td>
<td>II-3</td>
<td>F</td>
<td>60</td>
<td>5</td>
<td>Profound</td>
<td>Sign + oral; CI</td>
<td>9</td>
<td>20/200; can read large print; VF &lt;5°</td>
<td>None (normal)</td>
<td>1. Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>II-1</td>
<td>F</td>
<td>70</td>
<td>Infancy</td>
<td>Profound</td>
<td>Sign + oral; no HA or CI</td>
<td>17</td>
<td>Light perception, gross objects</td>
<td>None</td>
<td>1. Cataract surgery</td>
</tr>
</tbody>
</table>

HL, hearing loss; HA, hearing aids; VF, visual field; CV, central vision; CI, cochlear implant; NA, not available; MD, macular degeneration; OD, right eye; OS, left eye.
USH2 diagnosis or a lack of longitudinal documentation of progression. However, there are atypical forms of USH1 with documented progression of hearing loss due to mutations in USH1B and USH1D. Because of these rare cases and to confirm the diagnosis, it is important to perform molecular testing in all cases of USH3 in Ashkenazi Jews to distinguish it from atypical USH1. The rate of progression may also eventually be a useful criterion to distinguish between the two. However, this study cannot address that question because too few of our subjects had serial audiometric data with enough residual hearing over a sufficiently long time interval to derive quantitative conclusions about rates of hearing loss progression associated with N48K.

Little is known about the initial hearing status and onset of hearing loss in USH3, although the development of normal speech indicates that the onset of functionally significant loss is post-lingual. This is consistent with the late detection of hearing loss in many USH3 patients. Although the congenital hearing status of USH3 patients has not been reported, it is possible that many of these individuals will pass universal newborn hearing screening or even subsequent childhood screens. This information could potentially be used to distinguish USH3 clinically from USH1 and USH2.

USH3 presents differently from USH1 and USH2, and the onset of visual symptoms may precede the onset of auditory symptoms. Atypical forms of USH caused by some mutations in MYO7A or CDH23 may also have a delayed onset of symptoms. The perception of USH as a childhood disease may lead to diagnostic errors in populations where USH3 or atypical phenotypes are more prevalent. Ashkenazi Jewish and Finnish patients presenting with progressive sensorineural hearing loss should undergo ophthalmological evaluation, and those presenting with RP should undergo an audiological evaluation. Molecular testing can be helpful in both situations, especially in Ashkenazi Jews where a high proportion of USH3 is due to a single mutation. Genetic testing of infants at risk for Usher syndrome could prove especially helpful in cases where sedation would otherwise be required for an electroretinogram to detect RP. The applicability of this paradigm to other ethnic groups will depend upon the prevalence and genetic basis of USH3 in those populations.

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