Short communication

Novel GCH1 variant in Dopa-responsive dystonia and Parkinson's disease

A.J. Lewthwaite a,b,c,1, T.D. Lambert a,1, E.B. Rolfe d, S. Olgiati e, M. Quadri e, E.J. Simons e, K.E. Morrison a,c, V. Bonifati e, D.J. Nicholl a,d,f,*

a Department of Neurology, Queen Elizabeth Hospital, Birmingham, UK
b Department of Neurology, The Dudley Group NHS Foundation Trust, Dudley, UK
c School of Clinical and Experimental Medicine, College of Medicine and Dentistry, University of Birmingham, Birmingham, UK
d Department of Radiology, Queen Elizabeth Hospital, Birmingham, UK
e Department of Clinical Genetics, Erasmus MC, Rotterdam, The Netherlands
f Department of Neurology, Sandwell & West Birmingham Hospitals NHS Trust, Birmingham, UK

ABSTRACT

Background: GTP cyclohydrolase I (GCH1) mutations are the commonest cause of Dopa-responsive dystonia (DRD). Clinical phenotypes can be broad, even within a single family.

Methods: We present clinical, genetic and functional imaging data on a British kindred in which affected subjects display phenotypes ranging from DRD to Parkinson’s disease (PD). Twelve family members were studied. Clinical examination, dopamine transporter (DAT) imaging, and molecular genetic analysis of GCH1 and the commonest known familial PD-related genes were performed.

Results: We have identified a novel missense variant, c.5A>G, p.(Glu2Gly), within the GCH1 gene in affected family members displaying a range of phenotypes. Two affected subjects carrying this variant had abnormal DAT imaging. These two with abnormal DAT imaging had a PD phenotype, while the remaining three subjects with the novel GCH1 variant had normal DAT imaging and a DRD phenotype.

Conclusions: We propose that this GCH1 variant is pathogenic in this family and these findings suggest that similar mechanisms involving abnormal GTP cyclohydrolase I may underlie both PD and DRD. GCH1 genetic testing should be considered in patients with PD and a family history of DRD.

© 2015 Published by Elsevier Ltd.

ARTICLE INFO

Article history:
Received 22 October 2014
Received in revised form 22 December 2014
Accepted 6 January 2015

Keywords:
Parkinson's disease
Dopa responsive dystonia
GCH1
SPECT DAT imaging

1. Introduction

Dopa-responsive dystonia (DRD) is an autosomal dominant dystonia, now classified as DYT5, with an estimated incidence of between 0.5 and 1 per million [1]. DRD typically manifests as lower limb dystonia in childhood, although the spectrum of symptoms can be broad, even within the same family. Patients typically have an excellent and sustained response to low dose levodopa. Women are more commonly affected with a lower penetrance of mutations in men [2,3].

Mutations in the GTP cyclohydrolase I gene (GCH1) are the most common cause of DRD. GCH1 is located on chromosome 14 (14q22.1-q22.2) and encodes the 32-kDa guanosine 5'-triphosphate cyclohydrolase 1 (GTPCH1) protein. GCH1 contains six exons, and more than 200 different mutations have been identified [1,2].

Single positron emission computerized tomography (SPECT) Dopamine Transporter (DAT) imaging is a demonstration of in vivo striatal dopamine activity. The DAT ligands for SPECT, including [123I]FP-CIT (DaTSCAN) have all shown significantly reduced striatal uptake in PD [4], whilst uptake has usually been normal in DRD [5].

We have studied a family with an inherited movement disorder, with phenotypes ranging from DRD to slowly progressive PD. We report results from clinical, genetic and imaging studies of this kindred.

2. Methods

Twelve members of the kindred were studied. A diagnosis of PD was made according to United Kingdom Parkinson’s Disease Society (UKPDS) Brain Bank clinical
diagnostic criteria. The Hoehn and Yahr PD rating scale and a Folstein MMSE (Mini Mental State Examination) were performed on each subject. Olfactory function was assessed by use of the University of Pennsylvania Smell Identification Test (UPST-40) (Sensometrics, Haddon Heights, NJ) and data compared to normative values. Seven subjects (II:1-II:5, III:1 and III:11) underwent dopamine transporter SPECT scanning (DaTSCAN, Amersham Health) and images reviewed by ER, who was blinded to demographic and clinical data.

Molecular genetic screening of the six affected family members was performed by polymerase chain reaction (PCR) and sequencing of the entire coding sequence, and intron-exon boundaries, of the genes SNCA, Parkin, PINK1, DRD2 and GCH1, using primers and PCR conditions available on request. Multiple ligation-dependent probe amplification (MLPA) was used to detect the presence or absence of copy number variation, using MLPA kits P051 and P052 (MRC Holland), details available on request. Subsequently, six unaffected family members (II:2 and III:4,5,7,9,11) and 150 UK control DNA samples from the PD GEN DNA databank were screened for the novel GCH1 variant.

All subjects gave informed written consent to take part in the study. The study had appropriate ethical approval from South Birmingham LREC and Sandwell and West Birmingham LREC.

3. Results

Twelve individuals in the pedigree (Fig. 1, those annotated with an age) were examined in detail. We noted features consistent with slowly progressive PD in individuals II:1 and II:4 (Supplementary video), with additional levodopa-induced dyskinesias and dementia in subject II:1. Disease onset was at 58 and 50 years in II:1 and II:4 respectively. Subject II:3 had an isolated rest tremor (asymmetrical, right upper limb), with an older age of onset of 75 years, had not progressed over six years and did not meet diagnostic criteria for PD. Subjects II:5, III:1 and III:11 had features consistent with DRD, with median age of disease onset 17 years and median disease duration of 22 years. The remaining members of the family were unaffected. All the studied subjects are Caucasian and clinical details of affected individuals are summarized in Table 1 (more clinical details in Supplementary data).

Supplementary video related to this article can be found at http://dx.doi.org/10.1016/j.parkreldis.2015.01.004.

The findings from DaTSCAN images on six affected subjects (II:1, II:3-II:5, III:1 and III:11) and one unaffected subject (II:2) are summarized in Table 1 (Supplementary data). Subjects II:3 and II:4 had a second DaTSCAN performed 18 months after the first scan due to atypical disease progression (ie only very slowly progressing which would be unexpected in idiopathic PD).

No novel or previously documented mutations were identified in the coding sequences of SNCA, Parkin, PINK1, DJ-1 and LRRK2. However, a novel heterozygous substitution was identified in the first exon of GCH1 affecting the fifth nucleotide of the open reading frame (c.5A>G (Supplementary data). This change is predicted to replace a glutamic acid residue with glycine (p.(Glu2Gly)). This mutation (GenBank accession NM_000161.2, NP_000152.1.) is not listed as a known mutation or polymorphism in standard databases (dbSNP138 (http://www.ncbi.nlm.nih.gov/SNP/); 1000 genomes (release October 2013, http://browser.1000genomes.org/); Exome Variant Server (HLBI-EP56500, http://evs.gs.washington.edu/EVS/database accessed Sept, 2014). The novel GCH1 variant was identified in five of the affected members of the family, but not in subject II:3 or unaffected subjects II:2 and III:4,5,7,9,13, nor in 300 UK control chromosomes. MLPA did not reveal any copy number variation in SNCA, Parkin, PINK1, DJ-1 and LRRK2 or GCH1.

4. Discussion

We have identified a novel heterozygous missense variant within GCH1 (c.5A>G) in five family members affected by PD or DRD. Several arguments support the contention that this variant is pathogenic. The variant cosegregates with disease state in the family; it is absent from 300 UK control chromosomes tested here, and from all the large public databases; furthermore, it is almost completely conserved among species (Supplementary Fig. 2), and it is predicted to replace one of the larger hydrophilic amino acids with a small hydrophobic glycine within the N-terminal region of the protein. It is well known that in-silico prediction tools possess limited accuracy [6]. This mutation is predicted as pathogenic by SIFT and SNP&GO, but not by PolyPhen-2 and Mutation Taster. The clinical symptoms and signs observed in subjects II:1 and II:4 met diagnostic criteria for PD. In both cases the disease was more slowly progressive than is usual in idiopathic PD. Subject II:3 had an isolated rest tremor and subjects II:5, III:1 and III:11 were diagnosed...
with DRD. The symptoms in subjects III:1 and III:11 started at a young age and in the case of subject III:11 were more severe than those seen in subject II:5, illustrating the extreme phenotypic heterogeneity in this kindred and possibly reflecting the increased penetrance of GCH1 mutations in females.

DaTSCAN data supported the clinical diagnoses in most cases. The clinical phenotypes of DRD and PD and correspondingly penetrance of GCH1 mutations in females. Indeed DAT imaging has been proposed as a diagnostic tool to help differentiate between DRD and early onset PD [5]. There have been case reports of individuals with adult onset dystonia-parkinsonism [7] or PD without any dystonia [8] carrying a GCH1 mutation and an abnormal DaTSCAN.

Recently, Mencacci and colleagues reported 4 unrelated individuals with adult onset parkinsonism, presumed pathogenic GCH1 mutations and abnormal DaTSCANs [9].

These cases, and the two in our family (subjects III:1 and III:4), raise the question as to whether PD, in patients with presumed pathogenic GCH1 mutations, is in fact a rare phenotype of DRD. Certainly the phenotype of DRD is suggested to be broad, as illustrated by a recently reported family with classical DRD, adult onset PD and an MSA-like phenotype associated with a GCH1 two exon deletion [3]. As recently speculated by Mencacci and colleagues [9], chronic dopamine deficiency resulting from GCH1 deficiency could directly predispose to nigral cell death (rather than classical Lewy body associated neurodegeneration as typically seen in PD). Although earlier studies screening for a GCH1 mutations in PD cohorts did not identify a significant role for genetic variation in GCH1, recent studies have implicated GCH1 as a risk locus for PD [9,10].

An alternative, but less plausible, explanation in our family is the decreased expression of 5-hydroxytryptophan decarboxylase (5-HTDC) caused by GCH1 deficiency, which may lead to decreased synthesis of dopamine and 5-HT. This phenomenon has been observed in animal models and in human tissues [9]. However, the significance of this potential mechanism remains to be determined.

In further studies we will screen for GCH1 variants in subjects with familial PD, and in subjects with parkinsonism who have normal DaTSCANs, as well as pursuing further studies into the functional effects of the novel variant described here. We anticipate that future post-mortem histological data on affected individuals, particularly those with the PD phenotype will shed more light on disease mechanisms in this interesting family.

### Author roles

The study was designed by AJL, with support and advice by DJN, VB, and KEM. AJL and TDL carried out the clinical assessments and the LRRK2 sequencing work. SO, MQ, EJS, and VB carried out the further genetic analyses (sequencing and MLPA). EBR assessed the DaT Scans. AJL and TDL drafted the manuscript. All the co-Author contributed to revising the manuscript for intellectual content and approved the final version for publication.

### Conflict of interest

None of the authors has any conflict of interest to disclose.

### Acknowledgments

Funding agencies: The Parkinson’s Disease Society of the UK, Sandwell and West Birmingham Hospital NHS Trust and the Midland Neuroscience Teaching and Research Fund. Stichting ParkinsonFonds, The Netherlands (research grant to VB).

---

**Table 1**

<table>
<thead>
<tr>
<th>Subject &amp; gender</th>
<th>Age at eval.</th>
<th>Age at sympt. onset</th>
<th>Clinical diagnosis</th>
<th>L-dopa response</th>
<th>H&amp;Y stage</th>
<th>MMSE</th>
<th>UPSIT score (percentile)</th>
<th>DaT scan</th>
<th>GCH1 mut. p.E2G</th>
</tr>
</thead>
<tbody>
<tr>
<td>II:1 M</td>
<td>82</td>
<td>58</td>
<td>PD</td>
<td>Y</td>
<td>3</td>
<td>27</td>
<td>21 (40th)</td>
<td>A</td>
<td>Y</td>
</tr>
<tr>
<td>II:2 M</td>
<td>80</td>
<td>N/A</td>
<td>Unaffected</td>
<td>N/A</td>
<td>27</td>
<td>31</td>
<td>71st</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>II:3 M</td>
<td>78</td>
<td>75</td>
<td>Isolated rest tremor</td>
<td>No Rx</td>
<td>1</td>
<td>30</td>
<td>23rd</td>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>II:4 M</td>
<td>68</td>
<td>50</td>
<td>PD</td>
<td>Y</td>
<td>2</td>
<td>29</td>
<td>31st</td>
<td>2</td>
<td>A</td>
</tr>
<tr>
<td>II:5 M</td>
<td>66</td>
<td>44</td>
<td>DRD</td>
<td>Y</td>
<td>N/A</td>
<td>28</td>
<td>24th</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>III:1 F</td>
<td>56</td>
<td>17</td>
<td>DRD</td>
<td>Y</td>
<td>N/A</td>
<td>30</td>
<td>35th</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>III:11 F</td>
<td>26</td>
<td>6</td>
<td>DRD</td>
<td>Y</td>
<td>N/A</td>
<td>29</td>
<td>40th</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Summary of the clinical, functional neuro-imaging and molecular genetic data on subjects from the study family.** PD denotes Parkinson’s disease; DRD Dopa-responsive dystonia; N/A not done or not appropriate; MMSE mini mental state examination score; UPSIT University of Pennsylvania Smell Identification Test; DaTSCAN dopamine transporter imaging; Mod. moderate. Age and sex corrected percentile values for UPSIT scores are presented in brackets.
We thank the participating family for all their cooperation with this work. A subset of DNA samples from subjects with PD, and controls, was supplied from the PD GEN DNA databank (Prof C.E. Clarke, Prof K.E. Morrison & Prof K. Wheatley, funded by the Medical Research Council of the UK). We gratefully acknowledge our funding sources The Parkinson’s Disease Society of the UK, Sandwell and West Birmingham Hospital NHS Trust and the Midland Neuroscience Teaching and Research Fund, and the Stichting ParkinsonFonds, The Netherlands (research grant to VB).

Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.parkreldis.2015.01.004.

References


