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ABSTRACT

Background Mutations in TRPV4, a gene that encodes a Ca\(^{2+}\) permeable non-selective cation channel, have recently been found in a spectrum of skeletal dysplasias that includes brachyoilmia, spondyloметaphyseal dysplasia, Kozlowski type (SMDK) and metatrophic dysplasia (MD). Only a total of seven missense mutations were detected, however. The full spectrum of TRPV4 mutations and their phenotypes remained unclear.

Objectives and methods To examine TRPV4 mutation spectrum and phenotype-genotype association, we searched for TRPV4 mutations by PCR-direct sequencing from genomic DNA in 22 MD and 20 SMDK probands.

Results TRPV4 mutations were found in all but one MD subject. In total, 19 different heterozygous mutations were identified in 41 subjects; two were recurrent and 17 were novel. In MD, a recurrent P799L mutation was identified in nine subjects, as well as 10 novel mutations including F471del, the first deletion mutation of TRPV4. In SMDK, a recurrent R594H mutation was identified in 12 subjects and seven novel mutations. An association between the position of mutations and the disease phenotype was also observed. Thus, P799 in exon 15 is a hot codon for MD mutations, as four different amino acid substitutions have been observed at this codon; while R594 in exon 11 is a hotspot for SMDK mutations.

Conclusion The TRPV4 mutation spectrum in MD and SMDK, which showed genotype—phenotype correlation and potential functional significance of mutations that are non-randomly distributed over the gene, was presented in this study. The results would help diagnostic laboratories establish efficient screening strategies for genetic diagnosis of the TRPV4 dysplasia family diseases.

Metatropic dysplasia (MD; OMIM 156530) is a severe skeletal dysplasia. “Metatropic” is derived from the Greek and refers to the age-dependent evolution of body proportion in MD, changing from short trunk at birth to short trunk in childhood as a result of progressive kyphoscoliosis.1 Affected individuals present with narrow thorax, prominent joints and occasionally tail-like coccygeal appendage (caudal tail). The radiological hallmarks of MD include narrow thoracic cage with short ribs, severe platyspondyly with elongated vertebral bodies, flared ilia with horizontal acetabula and occasionally supra-acetabular notches and marked metaphyseal enlargement of the long bones, leading to a dumbbell appearance (figure 1).2 MD has so far been considered to be genetically heterogeneous. While the majority was felt to be autosomal dominant, a subset of patients with severe phenotypes was presumed to be inherited as autosomal recessive.3

Spondyloметaphyseal dysplasia, Kozlowski type (SMDK; OMIM 1842522), is an autosomal dominant skeletal dysplasia characterised by short trunk with platyspondyly and metaphyseal dysplasia (metaphyseal irregularity and flaring) of the long bones (figure 2).4 5 Progressive kyphoscoliosis is common, and the ilium is broad and occasionally flared. A diagnostic skeletal alteration of SMDK is overfaced pedicles that refer to broadened vertebral bodies extending beyond pedicles on antero-posterior radiograph of the spine (figure 2A).

Brachyoilmia (BO) is a heterogeneous group of skeletal dysplasias characterised by short trunk and general platyspondyly without significant epiphysial, metaphyseal and diaphyseal changes in the long bones. Based on the mode of inheritance and radiographic features, three types have been described.6 The autosomal dominant form of BO (OMIM 113500) shows platyspondyly that is particularly severe in the cervical spine, overfaced pedicles and broad ilia. These features resemble those of SMDK. Autosomal dominant MD, SMDK and autosomal dominant BO are caused by heterozygous mutations in the gene encoding TRPV4 (transient receptor potential cation channel, subfamily V, member 4). TRPV4 is a calcium permeable non-selective cation channel.7 Human TRPV4 is a protein of 871 amino-acids composed by a proline-rich region, six ankyrin (ANK) repeats, six transmembrane (TM) domains and a calmodulin-binding domain (figure 3). A putative cation-permeable pore is located between the fifth and sixth TM domains.8 TRPV4 is activated by a variety of physical and chemical stimuli, including heat, mechano-stimuli, endogenous substances such as arachidonic acid and synthetic alpha-phorbol derivatives. TRPV4 is involved in many different cellular functions; it has an important role in differentiation of chondrocytes and terminal differentiation of osteoclasts via calcium influx.9 10

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Through linkage analysis followed by a candidate gene approach, Rock et al identified two TRPV4 mutations in autosomal dominant BO.11 Because of radiological similarities between BO and SMDK, Krakow et al subsequently tested TRPV4 in patients with SMDK and found three different heterozygous mutations. Then, because of radiographic similarities between MD and SMDK, they further examined TRPV4 and found two mutations in autosomal dominant MD.12 Thus, TRPV4 is the causative gene of a spectrum of disorders that constitute a bone dysplasia family including autosomal dominant BO, SMDK and autosomal dominant MD. However, because only seven distinct mutations have been reported so far (three in SMDK and two in BO and MD, respectively)11 12 (figure 3), the spectrum of TRPV4 mutation remains unclear, as well as the range of phenotypes caused by TRPV4 mutations.

To further evaluate these questions, we searched for TRPV4 mutations in a total of 42 families with MD and SMDK. We detected 19 kinds of heterozygous mutations in 41 patients and found two mutational hotspots in TRPV4. We also found an association between location of mutations and disease phenotype.

SUBJECTS AND METHODS

Patients
MD and SMDK patients were enrolled from the participating institutions. The study was approved by the ethical committee of RIKEN and participating institutions and informed consent was obtained from all subjects. Clinical assessments for the patients were performed by their clinicians (Supplementary Table 1). The radiological features were reviewed by two pediatric radiologists (O.K. and G.N.) and by a pediatrician and a geneticist (A.S.-F. and S.U.) separately, and then discussed to consensus conclusion (supplementary Table 2).

The radiographic criteria for MD included wafer-like thin or diamond-shaped vertebral bodies in infancy and marked platyspondyly with progressive spinal deformities (scoliosis and/or kyphosis) in childhood (figure 1). The criteria also included flared iliac wings, flared acetabula with/without flared iliac wings and supra-acetabular notches, flared metaphyses of the long bones without dumbbell shape, metaphyseal irregularities with almost normal epiphyses and almost normal short tubular bones (figure 2). Metaphyseal irregularities were assessable only in pre-pubertal patients. Carpal age was evaluated because delayed bone age has been emphasised as an essential finding of SMDK. BO was defined as the condition...
that showed platyspondyly with overfaced pedicles and broad ilia, but no overt metaphyseal changes (flaring and irregularity).

**Mutation search**

Genomic DNA was extracted by standard procedures from peripheral blood or by Isohair kit (NIPPON GENE, Wako, Japan) from nail and hair. Exon sequence of TRPV4 with its flanking intron sequence was amplified by PCR from genomic DNA. PCR products were sequenced directly by using an ABI Prism 3700 automated sequencer (PE Biosystems, Foster City, CA, USA). PCR primer sequence is available on request, and the same primer was used for sequencing. For confirmation of novel
mutations in sporadic cases, genomic DNA from the unaffected parents was sequenced for the corresponding regions when parents’ samples were available. The molecular analysis was performed independently in the two laboratories in Tokyo and in Freiburg.

**Restriction fragment length polymorphism**

PCR-restriction fragment length polymorphism (RFLP) method was used to confirm mutations in two hotspot codons, R594 and P799. c.1721G→A creates the NciI (TAKARA BIO, Dalian, China) restriction site, and c.2595C→T/G and c.2596C→T/G abolishes SmaI (TAKARA BIO) restriction site, respectively. PCRs were the same as those for sequencing. We prepared the reaction mixture according to the manufactures of the two enzymes and incubated it at 37°C overnight. Digested PCR products were electrophoresed in 4% agarose gel (3% NuSieve GTG Agarose (Lonza, Rockland, Maine, USA) and 1% SeaKem LE Aagarose (BMA, Rockland, Maine, USA)).

**RESULTS**

A total of 42 probands were included in the study. There were 14 Koreans, 14 Europeans, 10 Japanese, two Turks and one Indian. All MD cases were sporadic and four SMDK cases were familial. All were from non-consanguineous marriages. The clinical and radiological findings of the patients are summarised in supplementary tables 1 and 2. The phenotypes comprised 22 MD and 20 SMDK. In general, a radiological diagnosis of bone dysplasias rests on the overall pattern of skeletal changes rather than a single radiological sign; after all, however, presence/absence of dumbbell- or halberd-shaped femora ascertained than a single radiological sign; after all, however, presence/absence of dumbbell- or halberd-shaped femora ascertained.

Distinction between MD and SMDK (supplementary table 2).

Subjects had 

**DISCUSSION**

We found that TRPV4 mutations in the MD and SMDK-disease spectrum include two mutational hotspots. We have observed the recurrent mutation c.1781G→A, which had been found in four SMDK patients in the previous study and in 12 SMDK subjects in our cohort (supplementary table 3). The mutation was identified in various ethnic backgrounds. c.1781G→A is at present the most prevalent TRPV4 mutation; 16/51 known cases carry this mutation. We also found that c.2596C→T is a recurrent mutation in MD (supplementary table 3). This mutation, found in one MD patient in the previous study, was found in nine MD subjects with various ethnicities in our study. Knowledge of the mutation hot spots will enable the construction of an efficient screening system for TRPV4 mutations and facilitate the molecular diagnosis of these diseases. The two RFLPs established in this study are useful tools for the screening of TRPV4 mutations as they can capture ~60% (30/51) of TRPV4 mutations.

MD and SMDK mutations are clustered in specific exons. Exon 11 is a hot exon for SMDK mutations. 15 mutations were identified in this exon in our patient population and taken together with results of previous studies, ~70% (18/26) of SMDK mutations were found in this exon. Only one exon-11 mutation has been identified in a MD patient. In contrast, exon 15 is a hot exon for MD mutations; ~60% (14/23) of MD mutations were found in this exon. There is only one exon-15 mutation in SMDK. All but one exon-15 mutation occurred at the same P799 codon; interestingly, four different mutations, leading to four different amino acid substitutions, were found at this “hot codon”.

In practice, these observations mean that we can prioritise specific TRPV4 exons for MD and SMDK when searching for mutations. The locations of the mutations relative to the domains of the molecule (ANK, TM, cytoplasmic, etc.) did not show any consistent relation with phenotypes (figure S).
Despite genetic homogeneity of SMDK, its phenotypic range was broad, particularly in the severity of metaphyseal dysplasia and in appearances of ilia. The variable phenotypes, even due to the same mutation, are in part attributable to age-related differences. Sequential radiological follow-up would address this issue. MD patients who had mutations in exon 15 showed milder radiographic changes in terms of rib shortening, platyspondyly and dumbbell deformity than those with mutations in other exons (figure 1 and supplementary figure 3). However, accurate delineation of the total phenotypic spectrum even among individuals with the common mutation would require further accumulation of cases with radiographs taken at standard ages.

Genetic heterogeneity of MD has long been in debate. Most investigators have believed that MD comprises lethal autosomal recessive and non-lethal autosomal dominant phenotypes.\(^3\) On the other hand, other investigators have suggested that all cases represent a dominant form with phenotypic variability.\(^2\)\(^4\)\(^5\)\(^6\) Our series of patients included individuals with a relatively mild SMDK/BO phenotype and individuals with quite severe, though non-lethal, MD; thus, the concept that all forms of MD may be the result of dominant mutations seems quite likely. We studied one MD patient (M22) who did not have a TRPV4 mutation. The girl, unlike other affected children, has not shown epiphysial dysplasia until now (supplementary figure 4).

One MD patient had a 3-bp deletion in TRPV4. All other mutations in this study, as well as the seven mutations previously reported, are missense mutations.\(^11\)\(^12\) The deletion mutation caused the loss of an evolutionally conserved amino-acid residue. From a previous functional study,\(^11\) the molecular pathogenetic basis of TRPV4-pathies has been suggested to be a gain-of-function characterised by increased constitutive activity and elevated channel activation by a variety of mechanisms. It remains to be examined whether the deletion mutation would also cause a gain of TRPV4 function.

In summary, we found TRPV4 mutations in 41 of 42 patients with MD and SMDK, indicating genetic homogeneity for these disorders. We identified 17 different novel mutations, including the first deletion mutation of TRPV4. We confirmed that R594H is a common and recurrent mutation in SMDK and found that P799L is a common and recurrent mutation in MD. There were mutational hot spots for TRPV4: R594 in exon 11 is a hot spot exclusive for SMDK mutations, while P799 in exon 15 is a hot spot for MD mutations. Our study presented an initial picture for the TRPV4 mutation spectrum in MD and SMDK. Further studies are necessary to determine its complete picture and phenotypic extension of the TRPV4 mutation.

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**Competing interests**

None.

**Patient consent**

Obtained.

**Ethics approval**

This study was conducted with the approval of the Ethical Committee of RIKEN, Japan.

**Contributors**

Jin Dai, Ok-Hwa Kim, and Tae-Joon Cho, these authors are contributed equally to the work.
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