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The first case of protease-sensitive prionopathy (PSPr) in The Netherlands: a patient with an unusual GSS-like clinical phenotype

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ABSTRACT
An atypical case of prion disease is described in a 54-year-old Dutch man, homozygous for valine at codon 129 of the prion protein gene (PRNP). The clinical phenotype was characterised by progressive dementia, spastic paraplegia and sensorimotor polyneuropathy. The disease duration was 20 months. Genetic analysis of PRNP did not reveal any abnormalities. Neuropathologically, only mild spongiform change and a coarse granular immunohistochemical staining for the abnormal prion protein, PrPSc, was observed, with poorly formed plaques in the molecular layer of the cerebellar cortex. However, Western blotting showed low but detectable levels of proteinase K (PK)-resistant PrPSc occurring in an unusual ladder-like profile. These features define a phenotype that corresponds to the recently described protease-sensitive prionopathy (PSPr). Our report on the first Dutch patient with PSPr further expands the spectrum of prionopathies and exemplifies the need to re-evaluate cases of atypical prion disease.

Prion diseases are unique neurodegenerative disorders that occur in sporadic, genetic and acquired forms.1 According to the prion hypothesis, the causative agent consists of an abnormally folded isoform of a host-encoded prion protein (PrP C ) termed PrPSc.2 In contrast to PrPSc, the pathological isoform PrPSc has a higher content of β-sheet and is partially resistant to degradation by proteinase K (PK).3 Based on the size of the protease-resistant core fragment, several isoforms of PrPSc can be recognised by immunoblotting,4 most commonly a type 1 (21 kDa) or a type 2 isoform (19 kDa). The currently accepted classification for sporadic Creutzfeldt-Jakob disease (sCJD) combines the PrPSc isotype with the presence of either methionine or valine at codon 129 of the prion protein to define six molecular subtypes that correspond to distinct clinical and neuropathological phenotypes.5 A smaller fragment of protease-resistant PrPSc (7–8 kDa) is found in patients with Gerstmann-Sträussler-Scheinker disease (GSS), a genetic form of prion disease.6

Recently, Gambetti et al reported 11 patients with a prionopathy characterised by the presence of an abnormal PrP species that was largely sensitive to protease digestion.7

The PrPSc present in these patients occurred in an unusual immunohistochemical staining pattern and generated a ladder-like profile that was hard to detect by conventional Western blotting. Since the relative PK sensitivity of the PrPSc present was considered to be a defining feature, the authors referred to this condition as protease-sensitive prionopathy (PSPr).

We report the first Dutch patient with a neuropathological and biochemical phenotype consistent with PSPr.

CLINICAL HISTORY
The patient presented with walking difficulties at the age of 54 years. He had stiffness and slowness of voluntary movements. His medical history was otherwise unremarkable. There was no known history of prion exposure. He had a family history of neurodegenerative disease: his mother was reported to have a neurodegenerative disorder with amyotrophic lateral sclerosis (ALS)-like phenotype, although no medical records from that time period could be retrieved.

On examination, 1 year after the first symptoms, he was slightly dysarthric and showed reduced facial expression. He had word-finding difficulties. Atrophy and fasciculations were noted in the extremities. He had increased tone of the leg musculature and demonstrated dysdiadochokinesia. The plantar responses were extensor.

MRI of the brain showed cerebral cortical atrophy with normal basal ganglia. Western blot assay for the 14-3-3 protein in cerebrospinal fluid was weakly positive. An EEG did not show characteristic abnormalities suggestive of CJD. Genetic analysis showed no abnormalities of the Huntingtin gene or of the genes causing spinocerebellar ataxia and hereditary spastic paraplegia. An electromyogram revealed sensorimotor polyneuropathy of the axonal type. On the basis of dementia, spastic paraplegia and sensorimotor polyneuropathy, a clinical diagnosis of atypical Alzheimer’s disease or GSS was considered. The patient died at the age of 57 years, 20 months after the onset of symptoms.

MATERIALS AND METHODS
PRNP analysis
DNA was extracted from frozen brain tissue, and the codon 129 (methionine/valine) polymorphism of the prion protein gene (PRNP) was determined by restriction fragment length polymorphism analysis, with full sequence analysis of PRNP using established methods.

Histopathology and immunohistochemistry
Neuropathological examination was performed on 5-micrometer-thick sections of formalin-fixed and
paraffin-embedded brain tissue blocks. Sections were stained with H&E and a combined Luxol—periodic acid-Schiff stain. Monoclonal antibody (mAb) 3F4 (1:400; Signet Laboratories, Dedham, Massachusetts, USA) was used for immunohistochemical detection of PrPSc following pretreatment with PK according to standard procedures. Other immunohistochemical stains included mAb Ubiquitin (1/1000; Dako, Glostrup, Denmark) and mAb 2E2-D3 against TARD-BP (1/1600; Abnova, Walnut, California, USA).

Western blotting
Frozen CJD brain tissue was stored at −80°C and investigated for the presence of PrPSc by immunoblotting. Frozen tissues from the occipital and temporal cortices were homogenised, and Western blot analysis of PrPSc was performed using an established method with minor modifications. Homogenates, both with and without PK digestion, were analysed. The homogenates were immunoblotted with mAb 3F4 (1:1000; Dako) and with mAb 1E4 (1.022 μg/ml) to human PrP residues 109–112 and 97–102, respectively.
**DISCUSSION**

Gambetti et al recently described a new prion disease phenotype in 11 patients, based on clinical, pathological and biochemical findings. First, a typical clinical disease course, characterised by slow cognitive decline, gait impairment and incontinence. Second, valine homozygosity at codon 129 of PRNP was largely comparable to the cases described by Gambetti et al, and a sensitive and optimised immunoblotting technique did indeed reveal the presence of fragments of PK-resistant PrPSc in a ladder-like profile.

Although, in general, PrPSc can be distinguished from PrPC by its resistance to treatment with PK, a protease-sensitive but disease-associated form has been described before. Furthermore, accumulation of PrPSc that is relatively protease sensitive has been described in patients affected by GSS. Interestingly, immunoblotting of these cases also show multiple smaller fragments of PK-resistant PrPSc, sometimes in combination with conventional...
PrPSc but differing from the profile seen in patients with PSPr. Gambetti et al. considered the preferential staining of these fragments with mAb 1E4 and not with 3F4, an additional argument against GSS. In our hands, however, these fragments were detectable by *both* antibodies, and the mechanism by which two antibodies with such closely adjacent epitopes might produce different results remains speculative.

PSPr is probably not an extremely rare disease entity, occurring in approximately 3% of sCJD patients in the North American cohort reported by Gambetti et al., although we were only able to find one patient in our database of 135 sCJD patients. This, however, corresponds to 9% of all VV homozygotes in our patient population, which is comparable with the number mentioned by Gambetti et al. In the past, PSPr patients probably escaped postmortem examination because clinical diagnoses other than prion disease were made. Clinical recognition of the possibility of atypical prion disease in these patients seems to be the key to a diagnosis of PSPr, and this will, in part, depend on familiarity with these admittedly rare diseases.

Our patient’s case indicates that PSPr is not associated with exclusively North American risk factors and exemplifies the benefits of re-evaluating cases of “atypical dementia”. It also underlines the importance of considering PSPr in patients with a GSS-like phenotype but no mutations in *PRNP*.

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**REFERENCES**