**RYR2 and CASQ2 Mutations in Patients Suffering From Catecholaminergic Polymorphic Ventricular Tachycardia**

*To the Editor:*

Catecholamine-induced polymorphic ventricular tachycardia (CPVT) is characterized by episodes of syncope, seizures, or sudden death in response to physical activity or emotional stress. The two modes of inheritance that have been described are autosomal dominant1 and autosomal recessive.2 Mutations in the ryanodine receptor 2 gene (RYR2), which encodes a cardiac sarcoplasmic reticulum Ca2+ release channel, were shown to cause the autosomal dominant form of the disease.3

Recently, Priori et al4 reported on clinical and molecular character-
ization of 30 probands with catecholaminergic polymorphic ventricular tachycardia and their 118 family members. A mutation screening of the RYR2 gene identified mutations in only 14 of 30 probands and in 9 family members.

Our group has recently described a missense mutation in a highly conserved region of the calsequestrin 2 gene (CASQ2) as the potential cause of the autosomal recessive form of CPVT.5 The CASQ2 protein serves as the major Ca2+ reservoir within the sarcoplasmic reticulum of cardiac myocytes and is part of a protein complex that contains the ryanodine receptor. The mutation converts a negatively charged aspartic acid into a positively charged histidine in a highly negatively charged domain and is likely to exert its deleterious effect by disrupting Ca2+ binding.

It is possible that at least some of the nongenotyped CPVT probands described by Priori et al4 may carry mutations in the CASQ2 gene.

Lack of family history in part of the probands’ affected families may suggest a recessive inheritance, increasing the likelihood that some of them harbor mutations in a common gene.

We suggest that a full genetic evaluation of CPVT patients should include mutation screening for both known genes, RYR2 and CASQ2.

**Response**

We agree with Drs Lahat and Eldar that homozygous CASQ2 mutations may be the cause of catecholaminergic polymorphic ventricular tachycardia (CPVT) in our patients.1 We have screened the coding region of the CASQ2 gene in all of the probands and failed to identify a CASQ2 homozygous mutation in any of them. This observation suggests that CASQ2-related CPVT, so far described only in the consanguineous kindred reported by Lahat et al,5 may be an uncommon variant of CPVT.

We also agree that in patients with CPVT, genetic analysis should include assessment of the RyR2 and CASQ2 genes.

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