Novel Gene Locus for Autosomal Dominant Left Ventricular Noncompaction Maps to Chromosome 11p15

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Background—Left ventricular noncompaction (LVNC) is a congenital unclassified cardiomyopathy with numerous prominent trabeculations and deep intertrabecular recesses in a hypertrophied and hypokinetic myocardium. It has been reported to occur in isolation or in association with congenital heart disease. Mutations in the X-linked G4.5 gene are responsible for cases of isolated LVNC in male infants, but G4.5 mutations were not found in patients with clinical onset of disease in adulthood. In addition, several families with LVNC and an autosomal dominant pattern of inheritance suggest genetic heterogeneity.

Methods and Results—We performed a genome-wide linkage analysis in a family with autosomal dominant LVNC and show that a locus containing the LVNC disease genes maps to chromosome 11p15. A peak 2-point logarithm of odds score of 5.06 was obtained with marker D11S902 at θ=0. Haplotype analysis defined a critical interval of 6.4 centimorgan between D11S1794 and D11S928 corresponding to a physical distance of 6.8 megabases. No disease-causing mutation was identified in 2 prime positional candidate genes, muscle LIM protein (MLP) and SOX6.

Conclusions—We have mapped a locus for autosomal dominant LVNC to a 6.8-megabase region on human chromosome 11p15. Identification of the disease gene will allow genetic screening and provide fundamental insight into the understanding of myocardial morphogenesis. (Circulation. 2004;109:2720-2723.)

Key Words: cardiomyopathy ■ genetics ■ mapping ■ noncompaction

Left ventricular noncompaction (LVNC), also called noncompaction of the left ventricular myocardium, is a rare, unclassified cardiomyopathy.1 It is characterized by numerous prominent trabeculations and deep intertrabecular recesses in hypertrophied and hypokinetic segments of the left ventricle.2-3 An intracardiac arrest of myocardial development with lack of compaction of the loose myocardial meshwork is the assumed mechanistic basis.4 By definition, isolated noncompaction of the left ventricular myocardium occurs in the absence of other structural heart disease.5 Noncompaction of the left ventricular myocardium combined with congenital heart defects is referred to as nonisolated LVNC.6

There is evidence that LVNC is a genetically heterogeneous disorder. A point mutation in the G4.5 gene* has been identified in a family with X-linked isolated LVNC (Online Mendelian Inheritance in Man [OMIM; Johns Hopkins University], No. 300183).7 Mutations in the G4.5 gene were also described to cause Barth syndrome8 and other forms of infantile dilated cardiomyopathies,9 suggesting allelism for these disorders. However, mutations in the G4.5 gene were not responsible in a large series of adult patients with isolated LVNC.10 Recently, mutations in ZASP, a gene encoding for the Z-band alternatively spliced PDZ motif-containing protein, a component of the Z-line in skeletal and cardiac muscle, were described in patients with LVNC and left ventricular dysfunction.11 A mutation in α-dystrobrevin in a family with LVNC and variable forms of complex congenital heart diseases has also been reported (OMIM, No. 606617).5

An autosomal dominant pattern of inheritance (OMIM, No. 604169) has been suggested in a number of families with LVNC.6,10,12 We have previously described kindred LVNC-10510 and now report a locus for autosomal dominant transmission of LVNC on chromosome 11p15 in this family. This genomic locus harbors the candidate genes coding for muscle LIM protein (MLP) and SOX6.

Methods

Clinical Evaluation

The study was carried out with the individuals of pedigree LVNC-105 as shown in the Figure. A repetition of all clinical and
echocardiographic analyses was performed at the University Hospital Zürich before the genetic analyses. Echocardiographic criteria for LVNC were as follows: The noncompacted endocardial layer is at least twice as thick as the compacted epicardial layer (ratio ≥2) and consists of prominent and excessive trabeculations and deep recesses filled with blood from the ventricular cavity as visualized by color Doppler imaging. In partially penetrant cases of LVNC, the ratio of noncompacted to compacted myocardium is ≥2.

Linkage Analysis
A genome-wide linkage analysis was conducted using microsatellite markers spaced at a maximum of 10 centimorgan (cM) apart according to the Marshfield Genetic Map. Two-point logarithm of odds (LOD) score calculations were performed by the LINKAGE 5.20 package, and multipoint LOD scores were calculated with the SIMWALK 2.82 program. Autosomal dominant inheritance was assumed, and LOD score calculations were performed with disease penetrance values between 0.75 and 0.90; for partially penetrant phenotypes, disease penetrance was set at 0.50.

Candidate Gene Analysis
Mutation screening of candidate genes was performed as described previously. Oligonucleotide primers for polymerase chain reaction amplification of MLP, SOX6, and ZASP were designed according to sequences from a public database. Southern blot experiments of MLP exons 1 to 6 were performed according to standard protocols.

Results
Patient Characteristics
Kindred LVNC-105 has previously been described (INVM-105) and was reevaluated for this study (33 subjects; 14 males, 19 females). Nine individuals were diagnosed with LVNC; 3 were found to have a partially penetrant LVNC phenotype (III-7, III-12, and IV-12); and the remaining 21 family members were classified as unaffected (see the Data Supplement for details). Reevaluation resulted in the following changes compared with the original pedigree: Individual IV-7 developed LVNC since she was last seen 3 years ago; individual III-12 was diagnosed with partially penetrant LVNC; and another parent (III-11a) was introduced. On echocardiography, 2 patients (III-7 and III-12) showed mild valvular pulmonary stenosis with mean pressure gradients of 12 and 16 mm Hg, respectively, and another 5 patients had a mild mitral valve prolapse. Patient IV-16 without LVNC had a small secundum atrial septal defect and a mild pulmonary stenosis with a mean pressure gradient of 11 mm Hg.

Linkage Results
In a genome-wide linkage analysis of LVNC in kindred LVNC-105 that used 447 highly polymorphic microsatellite markers, significant 2-point LOD scores were obtained only for markers at chromosome 11p15 (Table). The multipoint LOD score peaked at D11S902 (Z=5.15). LOD scores at chromosome 11p15 were robust for different values of penetrance. Haplotype analysis identified segregation of an affected haplotype in family LVNC-105 (Figure). Individual IV-16, a 14-year-old girl, carries the affected haplotype but...
Currently does not express the phenotype. A recombination
event in affected individual IV-6 defines D11S1794 as the
distal flanking marker. The proximal flanking marker,
D11S928, is defined by 2 recombination events in affected
individuals IV-3 and IV-8. This 6.4-cM critical interval
corresponds physically to 6.8 megabases (Mb).

Haplotype analysis in 2 other kindreds (LVNC-101 and
LVNC-104) with autosomal dominant LVNC revealed no
linkage to the 11p15 locus (data not shown), indicating that
autosomal dominant LVNC is genetically heterogeneous.

Candidate Gene Analysis

Within the 6.8-Mb LVNC disease gene region, 51 putative
genes are contained according to the Ensembl Genome
Browser and 68 genes according to the National Center
for Biotechnology Information (NCBI) human genome as-
semble. The products of most these genes are known. MLP is
an important component of the cytoskeleton of cardiac and
skeletal myocytes, and mutations in MLP cause hypertrophic
or dilated cardiomyopathy. 12,13,15 Sequence analysis and South-
ern blot hybridizations of MLP from individuals of kindred
LVNC-105 (2 affected, 1 unaffected) did not reveal any
alterations. In addition, in another 38 unrelated isolated
LVNC index patients, no mutations in MLP were detected.

Another intriguing candidate gene for LVNC at chromosome
11p15 is SOX6, coding for a member of the SOX DNA
binding protein family. 12,13,15 SOX6 is a candidate gene for p100H
myopathy, heart block, and sudden neonatal death, 12
but no mutations were detected in kindred LVNC-105.

Like in other heart muscle disorders, 12 LVNC shows
 genetic heterogeneity, and mutations in G4.5, ZASP, and
α-dystrobrevin have been reported. 12,13,14,15 Linkage analysis in
LVNC-105 provides a novel locus for LVNC and serves as an
e xample for the autosomal dominant form of LVNC (OMIM,
No. 604169). Most patients presented with isolated LVNC,
meaning the absence of any associated congenital heart
anomalies. However, 2 patients with partially penetrant
LVNC and mild congenital heart disease (pulmonary steno-
sis) were identified to carry the disease locus for autosomal
dominant LVNC (III-7, III-12). These patients did not fulfill
d all the diagnostic criteria established for isolated LVNC
because the ratio of noncompacted to compacted myocardium
was <2. 12,13,15 However, the development of LVNC in these
patients has a genetic cause and cannot be explained by
the impact of a hemodynamic burden in the absence of any left
ventricular inflow and outflow tract abnormalities. The auto-
somal dominant form of LVNC seems to comprise isolated
LVNC and LVNC associated with congenital heart defects and
underscores the clinical heterogeneity of this disease.

In conclusion, we have mapped a locus for autosomal
dominant LVNC to chromosome 11p15 and narrowed the
critical region to 6.4 cM. These findings confirm the genetic
heterogeneity of this disorder. Identification of the disease-
causing gene will allow genetic screening and provide funda-
mental insight to the understanding of myocardial
morphogenesis.

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