Is genotype clinically useful in predicting prognosis in hypertrophic cardiomyopathy?

Mutation Type Is Not Clinically Useful in Predicting Prognosis in Hypertrophic Cardiomyopathy

Andrew P. Landstrom, BS; Michael J. Ackerman, MD, PhD

Hypertrophic cardiomyopathy (HCM), or clinically unexplained hypertrophy of the heart, is a common genetic cardiovascular disorder marked by genetic and phenotypic heterogeneity. As the genetic mutations underlying the pathogenesis of this disease have been identified, investigators have attempted to link mutations to clearly defined alterations in survival in hopes of identifying prognostically relevant biomarkers of disease. While initial studies labeling particular MYH7-encoded beta myosin heavy chain and TNNT2-encoded cardiac troponin T mutations as “malignant” or “benign” raised hopes for mutation-specific risk stratification in HCM, a series of subsequent investigations identified mutations in families with contradictory disease phenotypes. Furthermore, subsequent proband-based cohort studies indicated that the clinical prognostic relevance of individual mutations labeled as “malignant” or “benign” in large referral centers is negligible. Herein, we seek to summarize the controversy and dispute the notion that mutation-specific risk stratification in HCM is possible at the present time. We provide evidence for clinicians and basic scientists alike to move beyond simple mutation descriptors to a more nuanced understanding of HCM mutations which fully captures the multi-factorial nature of HCM disease expression.

Response by Ho on p 2450

Over the last 2 decades, the genetic underpinnings of heritable cardiovascular disease have begun to be unveiled, starting with the discovery of rare pathogenic mutations that cause cardiomyopathies and cardiac channelopathies. The simple paradigm of Mendelian inheritance, while helpful in certain monogenic disease processes, is fundamentally incapable of explaining the entirety of how complex diseases express in the context of complex human physiology under the influence of a myriad of intrinsic and extrinsic variables. Our understanding of the intricate interplay between such intrinsic variable, the genome, and the manifestation of disease was advanced significantly in the decoding of a handful of human’s genomes in February of 2001.1,2 Despite the decade of research these discoveries have initiated, clinicians and scientists alike are only beginning to appreciate the impact of this revolution on our understanding of health and disease. One disease, hypertrophic cardiomyopathy (HCM), typifies this struggle, as we seek to integrate the role of genetic alterations into the variation we see in this sudden-death-predisposing disease.

Defined by clinically unexplained hypertrophy of the ventricular walls and/or septum, HCM affects approximately 1 in 500 persons and is the most common inherited cardiovascular disease.3 HCM is the most common cause of sudden cardiac death (SCD) in young athletes and a significant cause of sudden death in the young in general.4,5 A heterogeneous disease, HCM demonstrates phenotypic variation in the degree of hypertrophy (none to extreme), fibrosis and myocyte disarray (none to extreme), left ventricular (LV) outflow tract obstruction (none to severe), morphological subtype (reverse curve, sigmoid, and apical-HCM, for example), associated symptoms (none to debilitating symptoms refrac-
tory to pharmacotherapy), and sudden death susceptibility (normal longevity to premature sudden death). The clinical progression is variable as well, with some patients remaining asymptomatic over their lifetime while others present during infancy with profound cardiac hypertrophy.

**Genetic Basis of Hypertrophic Cardiomyopathy**

The sentinel discovery of a genetic locus responsible for familial HCM was identified in 1989 by Jarcho and colleagues.9 Jarcho used linkage analysis of a large, multigenerational family to identify a portion of the long arm of chromosome 14, which cosegregated with incidence of disease. The following year, Geisterfer-Lowrance and investigators identified the first HCM-causative mutation in the MYH7-encoded beta myosin heavy chain.7 Over the past 20 years, HCM has been appreciated as principally an autosomal dominant disease with variable expressivity and penetrance, and hundreds of mutations found in dozens of genes encoding various sarcomeric/myofilament, Z-disc, and calcium (Ca²⁺)-handling proteins have been identified. These HCM-susceptibility genes are summarized in Table 1. In addition, the genetic basis of myocardial disease, so-called HCM phenocopies, which can masquerade as HCM, have also been elucidated (Table 2).

The majority of HCM is due to mutations in genes encoding the components of the cardiac sarcomere responsible for generating the molecular force of myocyte contraction. This sarcomeric basis of HCM is comprised of proteins of the thick myofilament (MYH7, MYL2-encoded regulatory myosin light chain, and MYL3-encoded essential myosin light chain8,9), the intermediate myofilament (MYBPC3-encoded cardiac myosin binding protein C10), and the thin myofilament (ACTC-encoded actin11, TPM1-encoded α-tropomyosin,12 TNN12-encoded cardiac troponin T13, TNNI3-encoded cardiac troponin I13, and TNNC1-encoded cardiac troponin C14). Finally, while a complete coding region interrogation through a large cohort of HCM probands has yet to be performed, a small number of mutations have been identified in the giant filament TTN-encoded titin. In this exceptionally large protein, which extends throughout half of the cardiac sarcomere, TTN-R740L has been identified in a single individual.15 In an independent study, Arimura and colleagues identified 2 additional mutations, TTN-R8500H and R8604Q, in a cohort of 384 HCM probands.16

Based on the replication and wide-spread acceptance of the role of these genes in the pathogenesis of HCM, this panel of genes, with the exception of TTN, has moved from the realm of research investigation to commercially/clinically available genetic tests for HCM. Depending on the cohort analyzed, the overall yield of HCM genetic testing, or its research equivalent, varies from 24% to 63% (24% Swedish,17 34% German/Turkish,18 38% United States,19 and 63% European20 cohorts, respectively, among others). In comparison, the yield for the commercially available genetic test is purported to be 50% to 70% depending on the company. Although the frequency of mutations in these 9 genes depends on the cohort studied, mutations in MYBPC3 and MYH7 comprise the majority of mutations among myofilament genes. Depending on the cohort, the prevalence of MYBPC3- and MYH7-HCM mutations varies among mutation-positive HCM probands, yet these 2 genes represent the most common genetic subtypes of HCM.17,18,20

Although the clinically available genetic test represents a significant advance in the understanding of HCM pathogenesis, a significant proportion of the HCM population remains genotype-negative with no biomarker for, or mechanistic explanation of, their disease process. One possible explanation for the incomplete yield of mutation-positive HCM may

### Table 1. Summary of Hypertrophic Cardiomyopathy-Associated Genes

<table>
<thead>
<tr>
<th>Gene</th>
<th>Locus</th>
<th>Protein</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYBP3C</td>
<td>11p11.2</td>
<td>Cardiac myosin-binding protein C</td>
<td>25–40%</td>
</tr>
<tr>
<td>TTN</td>
<td>2q31</td>
<td>Titin</td>
<td>Rare</td>
</tr>
<tr>
<td>MYH7</td>
<td>14q11.2-q12</td>
<td>β-Myosin heavy chain</td>
<td>25–40%</td>
</tr>
<tr>
<td>MYH6</td>
<td>14q11.2-q12</td>
<td>α-Myosin heavy chain</td>
<td>Rare</td>
</tr>
<tr>
<td>MYL2</td>
<td>12q23-q24.3</td>
<td>Regulatory myosin light chain</td>
<td>Rare</td>
</tr>
<tr>
<td>MYL3</td>
<td>3p21.2-p21.3</td>
<td>Essential myosin light chain</td>
<td>Rare</td>
</tr>
<tr>
<td>Z-disc HCM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACTN2</td>
<td>1q42-q43</td>
<td>α-Actinin 2</td>
<td>Rare</td>
</tr>
<tr>
<td>ANKR1D1</td>
<td>10q23.31</td>
<td>Cardiac ankyrin repeat protein</td>
<td>Rare</td>
</tr>
<tr>
<td>CSRPS3</td>
<td>11p15.1</td>
<td>Muscle LIM protein</td>
<td>Rare</td>
</tr>
<tr>
<td>LBD3</td>
<td>10q22.2-q23.3</td>
<td>LIM binding domain 3</td>
<td>Rare</td>
</tr>
<tr>
<td>MYOZ2</td>
<td>4q26-q27</td>
<td>Myozin 2</td>
<td>Rare</td>
</tr>
<tr>
<td>TCAP</td>
<td>17q12-q21.1</td>
<td>Telethonin</td>
<td>Rare</td>
</tr>
<tr>
<td>VCL</td>
<td>10q22.1-q23.3</td>
<td>Vinculin/metavinculin</td>
<td>Rare</td>
</tr>
<tr>
<td>Calcium-Handling HCM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALR3</td>
<td>19p13.11</td>
<td>Calreticulin 3</td>
<td>Rare</td>
</tr>
<tr>
<td>CASQ2</td>
<td>1p13.3-p11</td>
<td>Calsequestrin 2</td>
<td>Rare</td>
</tr>
<tr>
<td>JPH2</td>
<td>20q13.12</td>
<td>Junctophilin 2</td>
<td>Rare</td>
</tr>
<tr>
<td>PLN</td>
<td>6q22.1</td>
<td>Phospholamban</td>
<td>Rare</td>
</tr>
<tr>
<td>RYR2</td>
<td>1q42.1-q43</td>
<td>Ryanodine receptor 2</td>
<td>Rare</td>
</tr>
</tbody>
</table>

**MYH7** comprise the majority of mutations among myofilament genes. Depending on the cohort, the prevalence of MYBPC3- and MYH7-HCM mutations varies among mutation-positive HCM probands, yet these 2 genes represent the most common genetic subtypes of HCM.17,18,20
be due to limitations in the mutation detection methodology. As most genetic analyses utilize direct DNA sequencing of coding exons, possibly including a denaturing high-performance liquid chromatography intermediate platform, large genetic deletions or duplications as well as intronic or promoter variations are missed.21 Another potential explanation, which is certainly not mutually exclusive with the first, is that the disease causative pathogenic substrate lies elsewhere in the genome, thereby fostering the possibility for subsequent investigation into the causes of genotype-negative HCM to identify not only disease biomarkers but also novel cardiac physiology and disease pathophysiology.

The search for novel HCM genes moved away from principle myofilaments of the cardiac sarcomere to the genes that encode proteins comprising the adjacent cardiac Z-disc. Serving as mechanical integration site of the myofilaments, the network of Z-disc proteins anchor the thin filaments from the principle myofilaments of the cardiac sarcomere to the genes that encode proteins comprising the adjacent cardiac Z-disc.22 The first Z-disc mutations associated with HCM were described in CSRP3 (17q25.2-q25.3) encoding CSRP-encoded muscle LIM protein23 and TCAP-encoded telethonin.24,25 Subsequently, LDB3-encoded LIM domain binding 3, ACTN2-encoded alpha actinin 2,26 VCL-encoded vinculin/metavinculin,27,28 MYOZ2-encoded myozin 2,29 and ANLRD1-encoded cardiac ankyrin repeat protein16 have been identified as rare causes of HCM.

Apart from sarcomeric- and Z-disc-HCM, independent studies have identified rare genetic mutations in genes encoding Ca2+-handling or Ca2+-regulatory proteins, including JPH2-encoded junctophilin 2,30 CALR3-encoded calreticulin,31 and the previously mentioned Ca2+-sensitive TNNC1,14 in individuals with myofilament negative-HCM. All told, mutations in these genes explain only a small percentage of HCM, yet may expand understanding of the role of Ca2+ in the pathogenesis of HCM.

### Genesis of “Benign” and “Malignant” Mutations

The first studies exploring the possibility of mutations holding prognostic importance came on the heels of the identification of the first HCM mutation. Just 2 years after the first mutation was discovered, Watkins and investigators identified 4 families with mutations in MYH7 associated with a marked reduction in survival on Kaplan-Meier analysis.32 Family members hosting either the MYH7-R403Q or R453C missense mutation had increased disease-related deaths and sudden deaths compared to those hosting a V606M mutation. The R403Q and R453C were designated “malignant” mutations, while the V606M was considered “benign.” At the time, it was postulated that these initial malignant MYH7 mutations might cluster around a “hot spot” on myosin, a loop that forms part of the binding cleft for actin, imparting a more dramatic functional impact on the protein than mutations seen elsewhere.33 Anan et al identified a MYH7-F513C “benign” mutation as well as “malignant” MYH7-G716R and R719W.34 In particular, the R719W mutation was associated with decreased survival when compared to a family hosting the “benign” F513C mutation.

Watkins and colleagues went on to identify mutations in additional genes, including 4 in TNNT2 in 7 families which were associated with decreased life expectancy and a high incidence of SCD despite minimal cardiac hypertrophy.35 Specifically, TNNT2-I79N, R92Q, a deletion of Q160 (delQ160), and a G to A transition in the 5’ splice donor site of intron 15 (intervening sequence, IVS15+1G>A) were found to have reduced survival compared with the “benign” MYH7-V606M yet similar to the previously described “malignant” MYH7-R403Q. Moolman and colleagues identified a TNNT2-R92W by linkage analysis in 2 pedigrees of familial HCM.36 Among the 18 clinically examined individuals hosting this mutation, only 6 demonstrated LV wall
thickness ≥13 mm by echocardiographic evaluation. Despite this mild HCM phenotype, the authors showed increased mortality, particularly in young males, with TNNT2-R92W positive individuals.

Together, these initial studies nucleated an archetype whereby an individual mutation type could, by itself, be considered a poor prognostic biomarker associated with increased risk of sudden death (MYH7-R403Q, R453C, G716R, and R719W; TNNT2-I79N, R92Q, R92W, delQ160, and IVS15+1 G>A) or a reassuring indicator of reduced mortality risk (MYH7-F513C, V606M).\(^{37}\) Investigators quickly extended these studies beyond individual mutations and attempted to link the entire gene, independent of the specific type of mutation, to a particular genotype-specific clinical HCM manifestation. The following genotype-specific pronouncements emerged: MYH7-HCM and early onset with increased hypertrophy and susceptibility to SCD, MYBPC3-HCM and later onset of diagnosis with lower risk, TNNT2-HCM and youthful disease presentation, particularly among males, SCD-predisposition, and minimal hypertrophy, and ACTC-HCM and benign prognosis and apical LV hypertrophy morphology.\(^{38-40}\)

**Nonreplication, Contradictions, and Confusion**

Just as quickly as the field of prognostically relevant mutations expanded, a series of studies directly contradicted, or at least failed to replicate, many of these initial observations. In a family with the "malignant" MYH7-R403Q mutation, Fananapazir and Epstein found no SCD or disease-related deaths among 6 MYH7-R403Q-positive/HCM phenotype-positive individuals, yielding a 100% survival at 50 years of age\(^{41}\) compared with 9/44 SCD and 21/44 disease-related deaths among 6 MYH7-R403Q-positive/HCM phenotype-positive individuals, yielding a 100% survival at 50 years of age\(^{41}\) compared with 9/44 SCD and 21/44 disease-related deaths previously observed.\(^{32}\) In addition to contradicting the "malignant" label of this mutation, investigators went on to contradict the "benign" nature of the MYH7-V606M mutation in a multigenerational family with HCM and prevalent SCD. Among 8 MYH7-V606M-positive/HCM phenotype-positive individuals, 4 succumbed to SCD between the ages of 15 and 27 years, yielding a 71% cumulative cardiac event rate at 50 years of age. In this way, Fananapazir and Epstein began to challenge the notion that clinical analysis of a single large pedigree was sufficient to designate a discrete mutation as intrinsically "malignant" or "benign."\(^{32}\)

A second independent group led by Havrrapu et al, also noted the "benign" MYH7-V606M in a family with HCM and a high incidence of SCD.\(^{42}\) In this multigenerational family demonstrating complete disease penetrance, 3 individuals, including a son of the index case, suffered youthful SCD with pronounced septal hypertrophy. Among the surviving 4 MYH7-V606M-positive/HCM phenotype-positive individuals, all were diagnosed before 18 years of age and 3 demonstrated either nonsustained ventricular tachycardia or atrial fibrillation.

These contradictions were not limited to MYH7-HCM. The "malignant" TNNT2-I79N mutation, which was first associated with the SCD of 4/9 mutation-positive individuals in the sentinel pedigree,\(^{35}\) was identified by Menon et al in a family with a mixed cardiomyopathic phenotype.\(^{43}\) The mutation was identified in each of the 9 affected family members who held diagnoses of restrictive cardiomyopathy (N=2), dilated cardiomyopathy (N=2), HCM (N=4), and a mixed cardiomyopathy (N=1). Furthermore, although there was a high incidence of atrial tachyarrhythmias, there was no incidence of SCD. Taken together with previous studies, these results began to call into question the associations between individual mutations and patient survival. In addition to survival, contradictory reports began to emerge about the role of specific mutations influencing other aspects of HCM disease manifestation, such as the septal hypertrophy morphology.

In the sentinel study implicating TNNT3 as an HMC-associated gene, Kimura et al identified a proband hosting a deletion of lysine 183 (TNNT3-delK183), which demonstrated apical-type HCM while his son, hosting the same mutation, had "typical" HCM.\(^{13}\) A later study by Kokado et al identified an identical finding in a seemingly independent group of 25 individuals from 7 families associated with a highly variable clinical expression of the deletion.\(^{44}\) Indeed, among the 15 individuals demonstrating hypertrophy, only 1 had apical disease while 7 did not exhibit the apical morphology. Similarly, Brito and investigators identified 2 independent families with an identical novel MYH7-I263T mutation.\(^{45}\) Despite hosting an identical mutation, family A (N=20 members) had increased LV hypertrophy when compared with family B (N=18 members, mean 23.4 mm versus 16 mm, respectively). Conversely, family B demonstrated reduced disease penetrance (100% versus 33%, respectively) with an increased propensity for SCD (0/20 versus 2/18, respectively) when compared with family A.

Taken together, these kindred studies illustrated the multifactorial nature of HCM in that the distinct mutation cannot be the sole factor that dictates clinical phenotype. Accordingly, one must be extremely cautious in assigning prognostic value to a specific mutation. Indeed, even in families carrying so-called "malignant" mutations, such as TNNT2-I79N and R92Q, there was significantly reduced disease penetrance with 3/9 (33%) and 7/32 (22%) mutation-positive individuals failing to show any clinical signs of HCM, respectively.\(^{46}\) A major limitation of each of these studies is the small number of individuals available for analysis in even the largest, multigenational family. Furthermore, confounding inherited factors that would be retained within a family, independent of the specific HCM-causative mutation, might greatly influence the ultimate expression of disease. What was not appreciated at the time, and may not be fully appreciated now, is the role of genomic and epigenetic influences on disease expression. Approaching the pathogenesis of HCM as a classical monogenic disease process, such as cystic fibrosis, does not fully capture the influence of other disease-modifying genetic variation outside the "gene of interest," or biologically relevant factors inherited apart from the genome in an epigenetic fashion. These confounding factors might be 1 explanation for contradictory findings in families hosting
identical disease-associated mutations. Lastly, these studies do little to capture the epidemiological relevance of these “malignant” or “benign” mutations, and one is left wondering what the overall clinical impact of these mutations might be, if any, among the HCM population.

A Proband-Based Cohort Approach to Validation

In an attempt to move beyond kindred-based investigations of HCM mutation prognostic relevance and to identify “benign” and “malignant” mutations outside of the confounding influences of the genetic milieu of the family, a proband-based cohort approach was undertaken. Van Driest and colleagues identified 5 probands (1.7%), out of a cohort of nearly 300 consecutive index HCM cases, which hosted 1 of 2 “benign” HCM mutations: MYH7-R719Q or L908V. Initial investigations by Consevage et al described the R719Q mutation in a large Hispanic family with no history of arrhythmia or SCD among 64 “at risk” family members. Furthermore, Epstein et al initially identified the L908V mutation in a family with mild HCM with only 2 (4%) of 46 individuals <55 years of age experiencing SCD and only 5 (26%) of 19 individuals ≤30 years of age with a maximal LV thickness >12 mm. In contrast, each of the “benign” mutation probands identified by Van Driest et al demonstrated significant clinical disease with an average age at diagnosis <30 years and LV outflow tract obstruction requiring surgical myectomy, with 4 necessitating β- and Ca2+ channel-blockade post myectomy. Three of the individuals had a positive family history of SCD, although 1 required cardiac transplant in the second decade of life because of end-stage HCM. In each of these cases, genetic counseling pertaining to the identification of each patient’s “benign” mutation would have been sorely amiss.

A follow-up study by Ackerman et al sought to determine the prevalence of purported “malignant” mutations in this cohort of clinically robust HCM probands. Despite the large size of the cohort, only 3 probands (1%) of the 293 hosted the “malignant” MYH7-R453C, G716R, and TNNT2-R92W mutations, leaving 98% of the 95 patients within the cohort with a positive family history of HCM, 99% of the 69 patients with family history of SCD, 92% of the 25 patients treated with an implantable cardioverter-defibrillator (ICD), and 89% of the patients with severe HCM phenotype and were part of families with SCD-predisposition (Figure 1).

One newly identified host of the “benign” MYH7-V606M mutation was diagnosed with HCM after an aborted SCD attempt and was found to be in ventricular fibrillation prior to resuscitation. A second proband hosting MYH7-V606M suffered the loss of his father from an HCM-related SCD at the age of 40 years as well as the SCD of a first cousin at the age of 10 years.

Figure 1. Pie chart of the proportion of our 1064-proband HCM cohort that hosted literature-described “malignant” (black fill) and “benign” (gray fill) HCM mutations. Clinical characteristics of these patients, such as whether the proband underwent myectomy, are noted. FH indicates family history; SCD, sudden cardiac death; ICD, implantable cardioverter-defibrillator.
Table 3. Summary of Contradictory Follow Up Studies

<table>
<thead>
<tr>
<th>Mutation</th>
<th>Family/ Cohort</th>
<th>Phenotype</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYH7</td>
<td>...</td>
<td>No sudden death in 6/6 individuals</td>
<td>...</td>
</tr>
<tr>
<td>R403Q</td>
<td>Family</td>
<td>Young adult SCD in three individuals</td>
<td>41</td>
</tr>
<tr>
<td>TNNT2</td>
<td>...</td>
<td>Aborted SCD, family hx of SCD Mayo</td>
<td>...</td>
</tr>
<tr>
<td>I79N</td>
<td>Family</td>
<td>No sudden death in 9/9 individuals</td>
<td>43</td>
</tr>
<tr>
<td>R92W</td>
<td>Cohort</td>
<td>Family hx of SCD Mayo</td>
<td>50</td>
</tr>
<tr>
<td>“Benign”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MYH7</td>
<td>Family</td>
<td>SCD &lt;30 years of age in 4/8 individuals</td>
<td>41</td>
</tr>
<tr>
<td>V606M</td>
<td>Family</td>
<td>Youthful SCD in three individuals</td>
<td>42</td>
</tr>
<tr>
<td>V606M</td>
<td>Cohort</td>
<td>Aborted SCD, family hx of SCD Mayo</td>
<td>...</td>
</tr>
<tr>
<td>R663H</td>
<td>Cohort</td>
<td>Aborted SCD, family hx of SCD Mayo</td>
<td>...</td>
</tr>
<tr>
<td>R719Q</td>
<td>Family</td>
<td>Family hx of SCD, transplant Mayo</td>
<td>47</td>
</tr>
<tr>
<td>R719Q</td>
<td>Cohort</td>
<td>Family hx of SCD, transplant Mayo</td>
<td>47</td>
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<tr>
<td>L908V</td>
<td>Cohort</td>
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<td>L908V</td>
<td>Cohort</td>
<td>Family hx of SCD, Mayo</td>
<td>47</td>
</tr>
</tbody>
</table>

Family/cohort indicates the type of follow-up study conducted; phenotype, pertinent clinical characteristics of kindred within the family or probands within the cohort studied; hx, history; SCD, sudden cardiac death/arrest; Mayo, results from analysis of the unpublished 1064 Mayo Clinic HCM probands.

Among unrelated patients with thick filament (MYH7, MYL2, and MYL3), intermediate filament (MYBPC3), and thin filament (ACTC, TPM1, TNNT2, and TNNT3) HCM mutations. Indeed, among these 3 myofilament-based subtypes, there were no statistical differences in age at diagnosis, the number presenting with cardiac symptoms, family history of HCM or SCD, LV wall thickness, proportion with severe hypertrophy ≥30 mm, LV outflow tract gradient, and the proportion receiving myectomy, pacemaker, or ICD implantation.

For example, although MYBPC-HCM has been correlated with benign disease diagnosed late in life compared with MYH7-HCM, which was associated with extensive hypertrophy, Van Driest identified no statistical difference in age at diagnosis (MYH7, 33.0±17 years versus MYBPC, 37.6±15) or LV wall thickness (23.5±7 mm versus 22.5±5 mm, respectively, Figure 2). In addition to being unable to replicate many of the genotype-phenotype correlations that had been identified from multigenerational families, this study also highlighted that the 2 most common genetic subtypes of HCM, MYBPC-, and MYH7-HCM, were clinically similar.

A Rose by Any Other Name

Although it seems clear that a particular HCM-causative mutation is not inherently “malignant” or “benign,” there is still a clear diagnostic role for HCM genetic testing in identifying occult disease. Identification of a disease-associated mutation in a proband with HCM provides the genetic biomarker for the systematic genetic evaluation of his/her offspring, siblings, parents, and more distant relatives that do not demonstrate clinically apparent disease. Furthermore, a positive genetic test, independent of prognostic value of the discrete mutation, allows for risk stratification of family members based on the presence of this biomarker including: 1) close surveillance of the genotype-positive, preclinical individual and 2) casual observation or dismissal of the genotype-negative/phenotype-negative relative and his/her future progeny. In this way, identification of a “benign” mutation in a family with HCM should not exclude close follow up of all mutation-positive individuals, nor should identification of a “benign” mutation solely dictate clinical management of a patient with HCM. Indeed, just as Juliet pondered “What’s in a name? That which we call a rose by any other name would smell as sweet,” in William Shakespeare’s Romeo and Juliet, HCM mutations should be regarded as such without consideration for old descriptors.

Recent Advances in the Prognostic Role of Genotyping

Although significant controversy surrounds the notion of mutation-specific and genotype-specific risk stratification, recent evidence has emerged revealing that unrelated patients with a positive HCM genetic test have a distinctively more severe phenotype than patients with a negative HCM genetic test. In the Mayo Clinic study, compared with patients with a negative genetic test, patients with a positive genetic test were younger at diagnosis, demonstrated greater hypertrophy, were more likely to have a positive family history of HCM, and were more likely to receive an ICD from their HCM specialist even though the cardiologists were blinded to the patient’s genetic status. Furthermore, a positive genetic test conferred a hazard ratio of 4.3 (1.5% to 12.5%, 95% confidence interval which was greater than that of age, degree of outflow tract obstruction, and presence of atrial fibrillation. Subsequently, these same distinguishing features between patients with a positive genetic test and those with a negative genetic test were seen in an independent cohort of patients with HCM from Italy. In this study, Olivotto and colleagues demonstrated a marked difference in outcome among those with a positive myofilament genetic test (Figure 3). In this collection of 203 index cases, the 126 patients (62%) with a positive HCM genetic test had an increased combined risk of cardiovascular death, nonfatal stroke, or progression to New York Heart Association class III or IV symptoms compared with those with a negative genetic test. Furthermore, myofilament-positive individuals demonstrated a greater probability of severe LV systolic (ejection fraction <50%) and diastolic (restrictive filling pattern) dysfunction. These studies represent the first time a “positive genetic test” might be associated with adverse outcome in patients with HCM.
Thus, although mutation-specific risk stratification is not possible, genetic test-based risk stratification seems clinically informative. Still, the translation of this observation into a clinically meaningful and “actionable” biomarker for the patient with already clinically manifest HCM is unclear. Knowing the difference in natural history and the increased likelihood toward disease progression, should patients with a positive genetic test be seen more frequently, intervened on sooner, and if so, with what interventions? Perhaps, the greatest contribution of the HCM genetic test for the phenotypically positive host will be for the clinician to “relax” somewhat for the patient with a negative HCM genetic test knowing that collectively, such HCM gene test negative-individuals exhibit a milder disease phenotype and are far less likely to progress. Perhaps HCM patients with a negative HCM genetic test will ultimately require less frequent evaluations and cardiac tests.

**Conclusion**

It is clear that HCM is a truly complex disease that can present at any age with variable hypertrophy and outflow tract obstruction, and it can progress in an innocuous fashion, or predispose

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**Figure 2.** Drawing of the proteins that comprise the cardiac myofilaments include MYBP3-encoded myosin binding protein C and MYH7 encoded β-myosin heavy chain. Clinical characteristics for patients hosting MYBP3 and MYH7 mutations are given. Drawing adapted from Spirito et al.³⁷ Dx indicates age at diagnosis in years; LVWT, left ventricular wall thickness; FH, family history; SCD, sudden cardiac death.

**Figure 3.** A) Top, table of the associations between clinical characteristics and a positive and negative HCM genetic test. Variance measured as standard deviation. Dx indicates diagnosis; MLVWT, maximal left ventricular wall thickness; FH, family history; ICD, implantable cardioverter-defibrillator. Bottom, table of the hazard ratio and 95% confidence interval of a positive HCM genetic test compared with age, left ventricular outflow tract obstruction, and atrial fibrillation. Adapted from Van Driest et al.¹⁹ B) Kaplan-Meier analysis of the probability of cardiovascular (CV) death, nonfatal ischemic stroke, or progression to heart failure with a negative and positive HCM genetic test.

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![Figure 2](image1.png)

![Figure 3A](image2.png)

![Figure 3B](image3.png)
individuals to arrhythmia and SCD. This clinical heterogeneity is matched by the genotypic heterogeneity associated with the pathogenesis of this disease. While the mutated genes that serve as the molecular substrate for this disease are becoming increasingly understood, the mechanistic link between a HCM-susceptibility mutation and disease pathogenesis and expressivity remains a significant challenge to elucidate. In large part, this is due to the multiplicity of factors that can modulate disease phenotype beyond the discrete HCM-causative pathogenic substrate. These additional patient-specific factors, whether intrinsic or extrinsic to the myocardium, can cause the same genetic misspelling to ultimately lead to dramatically different phenotypic variations of HCM in different individuals. Until these factors are more clearly understood, and the explanation for the contradiction and nonreplication of many of the studies trying to link specific HCM mutations to a particular phenotype is understood, there is no prognostic utility of a specific mutation in isolation.

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**Disclosures**

Michael J. Ackerman is a consultant for Medtronic, St. Jude Medical, Inc., Boston Scientific, and PGxHealth, and he serves on the Scientific Advisory Board for PGxHealth.

**References**


Response to Landstrom and Ackerman

Carolyn Y. Ho, MD

The crux of this debate is not the prognostic value of specific mutations, but rather the true purpose of genetic testing in HCM. Although their use of a small number of exceptions to invalidate potentially informative genotype-phenotype trends should be considered cautiously, I agree with the authors that prognosis cannot be determined solely on the basis of mutation identity with the current knowledge base. Indeed, genetic heterogeneity and inconsistent clinical expression hinder precise risk stratification in all inherited cardiovascular disorders. However, genetic testing has much more to offer beyond this narrow interpretation. The real utility of genetics is that it provides the best opportunity to understand disease and change medicine. Rather than categorizing all patients as having unexplained LVH, NOS, genotyping can tell you who has disease and what that disease is. This is crucial because prognosis is intimately tied to accurate diagnosis. As the authors acknowledge, patients without sarcomere mutations may have a more favorable outcome than those with mutations. In families with HCM, genotyping is the only way to identify susceptible relatives before disease is entrenched; those without mutations bear no risk.

Moreover, knowledge is evolving. Genotype-phenotype correlations may seem inconsistent now because traditional phenotypes (LVH, heart failure, sudden death) are late manifestations of disease. With better understanding of early manifestations, stronger correlations will emerge, mechanistic pathways will be identified, and disease-modifying treatments can be developed. I look forward to the day when we tell parents that although their child has a mutation, we can change their destiny.
Mutation Type Is Not Clinically Useful in Predicting Prognosis in Hypertrophic Cardiomyopathy
Andrew P. Landstrom, Carolyn Y. Ho and Michael J. Ackerman

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