Clinical and Genetic Study of the First Japanese FTDP-17 Patient with a Mutation of +3 in Intron 10 in the MAPT Gene

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Abstract:
Frontotemporal dementia with parkinsonism linked to chromosome 17 (FTDP-17) with mutations in the MAPT gene is a hereditary neurodegenerative tauopathy with various clinical phenotypes. We herein report the first Japanese patient with FTDP-17 caused by an IVS10+3G>A mutation in the MAPT gene, which is linked to an H1M haplotype. The present study suggests that the IVS10+3G>A mutation in the MAPT gene can have originated from a non-Caucasian population. In the disease course, myoclonus and respiratory failure can be observed. This study may expand on the clinical and genetic findings for FTDP-17 with mutations in the MAPT gene.

Key words: FTDP-17, MAPT, IVS10+3G>A mutation, non-Caucasian, H1M haplotype

Introduction
Frontotemporal dementia with parkinsonism linked to chromosome 17 (FTDP-17) comprises a group of heterogeneous neurodegenerative tauopathies characterized by behavioral and personality disturbances, cognitive impairment and motor dysfunction as cardinal symptoms (1). The majority of FTDP-17 families have mutations in the MAPT gene (2), which is inherited in an autosomal-dominant manner (3). The MAPT gene encodes the microtubule-associated protein tau, which is involved in microtubule assembly and stabilization, neuronal polarity and axonal transport in the brain (4). MAPT consists of 16 exons and encodes 6 human brain isoforms of tau protein with 3 or 4 microtubule-binding repeat domains (3R and 4R) (5). By 2015, 53 pathogenic MAPT mutations had been reported in approximately 150 families from Asia, Australia, Europe and both North and South America (1). Among them, 16 MAPT pathogenic mutations in 29 Japanese FTDP-17 families have been reported (6). Multiple system tauopathy with presenile dementia (MSTD), which has previously been found in one American kindred of European ancestry, is an inherited disease caused by a G to A transition at position +3 in intron 10 of MAPT (7, 8). The IVS10+3G>A mutation in the MAPT gene results in the overproduction of tau isoforms with 4 microtubule-binding repeats (5). The first reported MSTD family is the most well-studied kindred with this mutation (9). However, while the IVS10+3G>A mutation in the MAPT gene has been reported in four Caucasian families, it has never been found in a non-Caucasian population.

We herein report the first Japanese patient with a heterozygous IVS10+3G>A mutation in the MAPT gene.

Case Report
The pedigree consists of 22 Japanese family members across 4 generations, with 4 affected individuals. The proband (Figure A, III-1) is a 50-year-old woman who was the elder sister in her family. She presented with marked deterioration in her memory function at 48 years of age. At 49 years of age, the patient exhibited gait disturbance, limb...
bradykinesia and postural instability with frequent falling. Later, she developed vertical supranuclear gaze palsy and neck rigidity. She gradually lost facial animation, and bulbar syndrome appeared.

She presented with difficulty eating, speaking and breathing. A neurological examination revealed upward gaze palsy, dysarthria and dysphagia. She showed increased muscle tone in all four limbs as well as the neck and muscles of mastication. As a consequence, she had difficulty opening her mouth. She also showed myoclonus in the right upper limb and neck. The tendon reflexes were exaggerated in the upper limbs, and positive Babinski signs were noted. No muscle weakness or cerebellar, sensory or autonomic dysfunction was detected. She exhibited decreased fluency and agrammatism of speech at 48 years of age. At that time, the patient’s Mini-Mental State Examination (MMSE) score was 23/30. On an examination two years later, she showed total loss of speech output. As a result, no detailed testing of the cognitive function was possible. She became bedridden, and feeding via a percutaneous gastrostomy tube was begun six months previously. Hypercapnic respiratory failure appeared at night, and non-invasive positive pressure ventilation (NIPPV) was conducted. There were no significant abnormalities in laboratory serologic tests. Brain magnetic resonance imaging (MRI) showed mild cerebral atrophy in the left frontal and temporal lobes (FigureB). Brain 99mTc-ethyl cysteinate dimer-single-photon emission computed tomography showed a perfusion decrease in the bilateral frontal lobes (FigureC).

The proband’s father (FigureA, II-3) had been employed as a house painter until 44 years of age, when he was laid off due to frequent mistakes. At the same time, changes in his behavior and personality were noted. Subsequently, he developed memory deficits, bradykinesia and gait disturbance. At that time, he was diagnosed with ‘early-onset Alzheimer’s disease’. The patient’s condition gradually deteriorated, and he developed dysarthria, dysphagia and marked muscular hypertonia. At 49 years of age, he was bedridden and required gastrostomy. He died of pneumonia at 50 years of age.

The proband’s grandmother (FigureA, I-2) suffered from a similar illness that remained undiagnosed until her death at 50 years of age. She presented with memory deficits and gait disturbance, similar to the proband. She was bedridden for several years before death. The age of onset was not clear.

Only limited information was available on the proband’s uncle (FigureA, II-1), who moved to another town early in life. One of the relatives recalled he had worked normally until 50 years of age, when he developed a rare illness like ‘dementia’. Soon after, he burned to death in an accident.

No other family members were known to be affected in this pedigree. While the proband’s aunt (FigureA, II-2) died of cholangiocarcinoma at 50 years of age, the proband’s...
we identified a G to A transition at position +3 in intron 10 (FTLD), Parkinson’s disease (PD) and amyotrophic lateral sclerosis (SALS). We then examined exon 10 and its flanking intronic sequence in the causative genes. We then examined exon 10 and its flanking intronic sequence in the MAPT gene, which was in a heterozygous state in the proband via polymerase chain reaction (PCR). On Sanger sequencing, we reconfirmed this IVS10+3G>A mutation in intron 10 of the MAPT gene, which was in a heterozygous state in the proband (FigureD). The haplotype associated with the mutation was identified by the presence or absence of the 238-bp deletion in intron 9 (del-In9) and by genotyping 5 single-nucleotide polymorphisms (SNPs) (rs1467967, rs242557, rs3785883, rs2471738, del-in9, rs7521) (10). The insertion of the del-In9 tags the H1 haplotype, and its deletion tags the H2 haplotype. The five haplotypes tagging SNPs allow further division of the H1 haplotype into subtypes. Polymerase chain reaction primer pairs (available on request) were designed and used to amplify each SNP of interest. On Sanger sequencing, we identified the MAPT diplotype of the proband as H1M/H1M (Table).

In addition to the American MSTD family, three other sets of kindred have been identified in British, Italian and Italian-Polish families with the identical IVS10+3G>A mutation in the MAPT gene (11-15). The clinical signs and symptoms reported in these cases show some phenotypic heterogeneity. The major symptoms presented in the American MSTD family were disinhibition, early short-term memory loss and superior gaze palsy. The predominant feature in the British family was generalized deterioration in the cognitive function with choreiform-like movements. The predominant clinical signs in the Italian kindred were changes in speech, behavioral and social conduct and cognitive decline. The predominant clinical signs in the Italian-Polish family were behavioral abnormalities, bulbar syndrome, aphasia and damage to the cardiovascular system. Parkinsonian symptoms were a consistent clinical feature in members of all four families. Although there were a few subtle differences in the pathological findings among the four sets of kindred with the IVS10+3G>A mutation, clinical imaging or post-mortem assessment of the four families consistently revealed marked neurodegeneration in the medial temporal and frontal regions (9).

In this paper, we describe the clinical, neuroimaging and genetic features of a woman from a Japanese family with the IVS10+3G>A mutation in the MAPT gene. At least the proband’s mother and grandmother had suffered a similar illness in this family. They all presented with predominant clinical signs of cognitive decline, bradykinesia and gait disturbance, and all were bedridden for several years before their death. In the proband, the first signs of disease were observed at 48 years of age, and her deterioration was very rapid, progressing to respiratory failure within only 2 years. In contrast, the proband’s father showed symptoms at 44 years of age, and the disease duration was 6 years, which is consistent with the age of onset and disease duration for the first reported MSTD kindred (mean age of onset: 49 years; mean duration: 11 years) (6). Furthermore, the proband also presented with rather complicated symptoms, such as myoclonus and respiratory failure, that were absent in her father. Neither of these two symptoms was reported in the four sets of Caucasian kindred mentioned above. However, clinical variability can be seen in individuals with the same MAPT mutation, even within the same family (16). The predominant clinical signs of the proband are changes in speech, cognitive decline, generalized bradykinesia and rigidity and

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**Table. Mutation Analysis of the MAPT gene of the Proband–ideoGram.**

<table>
<thead>
<tr>
<th>Mutation</th>
<th>Rs1467967</th>
<th>Rs242557</th>
<th>Rs3785883</th>
<th>Rs2471738</th>
<th>Del-in9</th>
<th>IVS10+3</th>
<th>Rs7521</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proband</td>
<td>G/G</td>
<td>A/A</td>
<td>G/G</td>
<td>C/C</td>
<td>H1H1</td>
<td>G/A</td>
<td>G/G</td>
</tr>
</tbody>
</table>

Haplotype nomenclature is assigned as previously reported (10). Alleles for the SNPs defining the haplotypes are given in the 5’ to 3’ order as follows: rs1467967, rs242557, rs3785883, rs2471738, Del-in9, rs7521. The order of “GAGCH1G” indicates H1M haplotype.
superior gaze palsy, which most closely resemble those of the first MSTD family and have therefore contributed to the main clinical picture of atypical PSP.

The diverse clinical presentations in families with this mutation suggest that additional genetic factors may influence the phenotypic expression of the disease (11). There are two main haplotypes in MAPT: H1 and H2. Several SNPs throughout the MAPT gene are in complete linkage disequilibrium (LD) and largely tag the H1 and H2 haplotypes (17). The H1-specific SNPs in the MAPT genomic region allow for further division of the H1 haplotype into subtypes (18). The analysis of diplotype associated with the mutation in the proband showed that the IVS10+3G>A mutation was in the haplotype H1M background. The different haplotypes around the mutation might account for the different phenotypes. The synergistic effects of the H1M haplotype and the IVS10+3G>A mutation in the proband might have played a role in the clinical presentation of rapid deterioration, with respiratory failure and myoclonus.

Interestingly, the H2 haplotype is absent in the Japanese population (19) and is thought to be exclusively Caucasian in origin (20). To date, the IVS10+3G>A mutation in the MAPT gene has only been reported in Caucasian populations. Our findings show that, unlike the H2 haplotype, the IVS10+3G>A mutation in the MAPT gene can develop independently in different parts of the world. In the disease course, myoclonus and respiratory failure can be observed. This study may expand on the clinical and genetic findings for FTDP-17.

The authors state that they have no Conflict of Interest (COI).

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Ethical standards

The present clinical and genetic study was approved by the institutional review board of Yamanashi University, and written informed consent was obtained from the patient.

References


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