Domain-specific mutations in sequestosome 1 (SQSTM1) cause familial and sporadic Paget’s disease

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Paget’s disease of bone (PDB) is a common disorder characterized by focal abnormalities of increased and disorganized bone turnover. Genetic factors are important in the pathogenesis of PDB, and in previous studies, we and others identified a locus for familial PDB by genome-wide search on 5q35-qter (PDB3). The gene encoding sequestosome 1 (SQSTM1/p62) maps to within the PDB3 critical region, and recent studies have identified a proline–leucine amino acid change at codon 392 of SQSTM1 (P392L) in French-Canadian patients with PDB. We conducted mutation screening of positional candidate genes in the PDB3 locus in patients with PDB, and also identified mutations in the gene encoding SQSTM1 as a common cause of familial and sporadic PDB. Three different mutations were found, all affecting the highly conserved ubiquitin-binding domain. The most common mutation was the P392L change in exon 8, which was found in 13 of 68 families (19.1%). Another mutation—a T insertion that introduces a stop codon at position 396 in exon 8—was found in four (5.8%) families. A third mutation affecting the splice donor site in intron 7 was found in one (1.5%) family. The P392L mutation was also found in 15 of 168 (8.9%) of patients with sporadic PDB and 0 of 160 of age- and sex-matched controls (P < 0.0001). These studies confirm that mutations affecting the ubiquitin-binding domain of SQSTM1 are a common cause of familial and sporadic Paget’s disease of bone.

INTRODUCTION

Paget’s disease of bone (MIM 167250, 602080; see http://www.ncbi.nlm.nih.gov/OMIM) is a common disorder, affecting up to 3% of individuals above the age of 55 years in the UK and other Caucasian populations (1,2). The disease is characterized by focal areas of increased osteoclastic bone resorption, coupled to increased and disorganized new bone formation. Whilst many patients are asymptomatic, up to 30% have symptoms related to the disease, such as bone pain, bone deformity, pathological fracture and deafness (3,4). Accumulating evidence suggests that PDB is largely determined by genetic influences. Familial clustering is common in PDB, and between 15% and 40% of individuals have an affected first-degree relative (5–7). Many families have been described where PDB is inherited in an autosomal dominant manner (5,8,9), as is the rare bone dysplasia familial expansile osteolysis (FEO) (MIM 174810), which shares many clinical features with PDB (10). The gene responsible for FEO was mapped to a locus on chromosome 18q21–22 by Hughes and colleagues (11) in 1994, and some PDB kindreds were subsequently found to be linked to the same region (8,9). It is now clear that FEO, expansile skeletal hyperphosphatasia and some cases of familial Paget’s disease that present below the age of 20 years are allelic disorders caused by different activating mutations affecting the signal peptide region of the receptor activator of NFκB (RANK) (12,13). Whilst this demonstrates that abnormalities in the NFκB signaling pathway can cause a PDB-like phenotype, mutations of the osteoprotegerin and RANK genes have been excluded as a common cause of familial and sporadic PDB (14,15).

Several other susceptibility loci for familial PDB have been identified by genome-wide search on chromosomes 5q35 (PDB3) (16,17), 5q31 (PDB4) (16), 2q36 (PDB5) (17),

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RESULTS

Mutation analysis of the positional candidate genes FLT4, ADAMTS12, retinoid X activating protein, MSX2 and calnexin in affected individuals from 10 families with a high probability (>70%) of linkage to the PDB3 locus on chromosome 5q35, and recently Laurin et al. (19) identified a recurrent mutation of SQSTM1 in a population of French-Canadian patients with PDB. In this study, we also report the identification of mutations in the ubiquitin-binding domain of SQSTM1 as a common cause of familial and sporadic PDB.

DISCUSSION

PDB is a common bone disease of ageing that is characterized by foci of increased and disorganized bone remodeling predominantly affecting the axial skeleton (2). Whilst many patients are asymptomatic, others present with bone pain, deformity, pathological fracture, deafness, nerve compression syndromes and osteoarthritis (4). Osteosarcoma is a rare complication of PDB (4), but almost all osteosarcomas occurring in adults do so in patients with PDB (21). Genetic factors are important in the pathogenesis of PDB, and many families have been described where the disease segregates as an autosomal dominant trait with incomplete penetrance (5,9,22,23). It has been estimated that between 15% and 40% of pagetic individuals have an affected first-degree relative (5–7), but the true prevalence of familial PDB is difficult to ascertain, because the condition is often asymptomatic or presents with non-specific symptoms that are attributed to other causes. Several potential susceptibility loci for familial PDB have been identified on chromosomes 6p21, (PDB1) (24), 18q21–22 (PDB2) (8,9,11), 5q35 (PDB3) (16,17), 5q31 (PDB4) (16), 2q36 (PDB5) (17), 10p13 (PDB6) (17) and 18q23 (PDB7) (18). Involvement of the PDB2 locus seems to be restricted to early-onset PDB-like syndromes, and recent work has indicated that FEO, expansile skeletal hyperphosphatasia and some cases of early-onset familial PDB are allelic disorders, caused by different activating mutations in the signal peptide region of the RANK molecule (12,13). Involvement of the PDB2 locus and RANK is rare in late-onset familial Paget’s disease (16,23,25). In contrast, the PDB3 locus on 5q35 has been found to be linked to late-onset PDB in families of both French-Canadian (16) and British descent (17), consistent with the presence of a major susceptibility gene in this chromosomal region.
Recently Laurin et al. (19) were able to narrow the PDB3 critical region to a 300 kb interval between D5S2073 and D5S408 in French-Canadian families. This resulted in the identification of a recurrent P392L mutation of SQSTM1 as the cause of PDB in 46% of French-Canadian families and 16% of individuals who apparently had sporadic PDB (19). The findings reported here confirm the importance of SQSTM1 as an important susceptibility gene for familial and sporadic PDB. We found the same P392L mutation as reported by Laurin et al. in 13 of 68 (19.1%) of the families studied and 8.9% of British patients with sporadic Paget’s disease. A novel mutation that introduces a premature stop codon at position 396 was also found in a further 4 families (5.8%). A mutation affecting the splice donor site at the start of intron 7 was found in 1 (1.5%) family. Whilst further studies will be required to determine whether this mutation affects splicing, the site of the mutation and its predicted consequences, coupled with the fact that it segregated with the disease in family members, and was absent from non-pagetic controls, suggests that this was a disease-causing mutation, rather than a benign polymorphism. Thus, SQSTM1 mutations occurred in 26.5% of cases of familial PDB in this series of Caucasian patients from different geographical regions. We found no evidence to suggest that affected individuals shared an ancestral common haplotype, which is consistent with the view put forward by Laurin et al. (19) that this region of the SQSTM1 gene may be a mutational hotspot.

In all families, the mutations co-segregated with the disease, and were not found in spouses or a large series of non-pagetic controls, which lends support to the hypothesis that the mutations were causal. In one family, however, mutations were found in only 2 of 4 of the affected individuals. This is in keeping with the known genetic heterogeneity of PDB, and presumably reflects the fact that the other affected family

**Figure 1.** Sequestosome 1 mutations in Paget’s disease of bone. (A) Wild-type sequence at the start of exon 8. (B) Heterozygous C/T mutation giving rise to the P392L amino acid substitution. (C) and (D) Heterozygous T insertion mutation at position 1224 sequenced in forward and reverse orientations in the same individual. Note the double tracking of the sequence immediately after the mutation. (E) Wild-type splice donor sequence (GC) at the start of intron 7. (F) Heterozygous G/A mutation at position +1 of intron 7 that disrupts the splice donor site, potentially resulting in the production of a truncated protein, terminated by the stop codon at IVS7+6–8 (underlined). The positions of the mutations are indicated by arrows in each panel.
members may have had mutations in a different susceptibility gene. In families carrying SQSTM1 mutations, disease-associated mutations were also present in younger individuals (age <50 years) who were not thought to have PDB on the basis of biochemical screening. We did not routinely carry out bone scan examinations in these subjects unless they had elevated alkaline phosphatase values, and therefore we cannot exclude the possibility that they may have had localized Paget’s disease which was not detected by biochemical screening. Another possibility is that they may not yet have developed the disease, since PDB rarely presents clinically before the age of 55 years.

The mechanisms by which these domain-specific mutations in SQSTM1 cause PDB remain to be elucidated, but the fact that all the mutations described so far affect the ubiquitin-binding region is likely to be significant. Ubiquitination plays a crucial role in the regulation of signal transduction, by targeting key cellular proteins for degradation through the proteasome (26). Deletion of residues 361–440 completely abolishes the ability of sequestosome 1 to bind to ubiquitin, whereas deletion of residues 392–440 significantly inhibits ubiquitin binding (20). The PDB-causing mutations described in this paper and by Laurin et al. (19) all affect this region of the molecule. The functional consequences of the P392L mutation remain to be established, but the intron 7 splice site mutation would be impaired degradation of sequestosome 1 to bind to ubiquitin (20), a possible consequence would be impaired degradation of sequestosome 1 and its accumulation within the cytoplasm. Previous studies have shown that sequestosome 1 facilitates tumour necrosis factor (TNF)-induced NFκB activation by linking the adaptor protein RIP to members of the atypical protein kinase C family (aPKC) (27), and also facilitates interleukin-1 (IL-1)-induced signalling by linking TRAF6 to aPKC (28). Moreover, inhibition of sequestosome 1 expression by antisense RNA has been shown to inhibit NFκB signalling in vitro (27,28). It is tempting to speculate that the mutations that have been observed in PDB cause activation of NFκB signalling by increasing levels of sequestosome 1, although further studies will be required to investigate this hypothesis.

Irrespective of the underlying mechanisms, the data presented here show that sequestosome mutations are a common cause of PDB, and provide evidence in support of the hypothesis that PDB (19) and related syndromes such as FEO and expansile skeletal hyperphosphatasia (12,13) may occur as the result of mutational events in different components of the RANK–NFκB signalling pathway.

**MATERIALS AND METHODS**

**Family recruitment and disease ascertainment**

The families described in this paper comprised 62 of those included in the genome-wide search reported previously (17), plus an additional 6 families with autosomal dominant PDB. Pedigree diagrams are available at the Bone Research Group’s website at the University of Aberdeen (http://www.abdn.ac.uk/medicine_therapeutics/bone/paget%20pedigrees.hti). We screened for the presence of PDB in family members by measurement of serum total alkaline phosphate (AP). Individuals above the age of 55 years in whom AP values were <65 u/l (reference range 40–105 u/l) were considered as unaffected, whereas those with AP levels above this were considered as diagnosis unclear and were investigated further where possible. These individuals were scored as affected if evidence of PDB was found on radionuclide bone scan examinations and/or skeletal radiographs. Unless PDB had been confirmed radiologically or scintigraphically, individuals under the age of 55 years were considered as ‘diagnosis unclear’ even in the presence of normal AP levels to take account of fact that PDB does not usually present clinically until the fifth or sixth decade. The patients with sporadic PDB were recruited from UK clinic referrals and had been diagnosed on the basis of typical radiographic and scintigraphic findings. As controls, we used a combination of clinic referrals undergoing investigation of suspected osteoporosis and normal healthy individuals taking part in population-based surveys of osteoporosis risk. All subjects gave informed consent to being included in the studies, which were approved by the Grampian Research Ethics Committee and the Research Ethics Committees of the other contributing centres.

**Mutation analysis of positional candidate genes**

We conducted mutation screening of the proximal promoter, coding exons and intron–exon boundaries of candidate genes within the PDB3 locus between D5S2034 and the telomere using automated DNA sequencing. In affected individuals from 10 families where analysis with the HOMOG program (29) had shown a high probability (>70%) of linkage to chromosome 5q35. Primers used in mutation analysis of the sequestosome 1 gene are shown in Table 2. We used 35 cycles of amplification with annealing temperatures as shown in Table 2 using Qiagen Taq polymerase according to the manufacturer’s instructions. The PCR products were treated with ExoSAP-IT (Amersham).

<table>
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<tr>
<th>Exon</th>
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<th>Annealing temp (°C)</th>
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<td>60</td>
</tr>
<tr>
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<td>AGAAGGAGGAGGCGAACGCAC</td>
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</tr>
<tr>
<td>2F</td>
<td>CCTACGCCCATTCCAGCAGC</td>
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<tr>
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<td>CTCGCCCCTCTGAGCTCAAG</td>
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<tr>
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</tr>
<tr>
<td>4F</td>
<td>ACAGGCCACAGTGACGACAGA</td>
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<tr>
<td>4R</td>
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</tr>
<tr>
<td>5F</td>
<td>GCCCTGCGCGGAAATAGC</td>
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Table 2. Primers for amplification of sequestosome 1
and sequenced in forward and reverse directions using DYEnamic ET terminator chemistry on a MegaBACE 1000 automated DNA sequencer. Primers used in the mutation screening of FLT4, ADAMTS12, retinoid X activating protein, MSX2 and calxinexin are available from the authors on request.

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