Corticosteroid pharmacogenetics: association of sequence variants in CRHR1 with improved lung function in asthmatics treated with inhaled corticosteroids

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Received March 5, 2004; Revised and Accepted April 19, 2004

Corticosteroids mediate a variety of immunological actions and are commonly utilized in the treatment of a wide range of diseases. Unfortunately, therapy with this class of medications is associated with a large proportion of non-responders and significant side effects. Inhaled corticosteroids are the most commonly used asthma controller therapy. However, asthmatic response to corticosteroids also varies widely between individuals. We investigated the genetic contribution to the variation in response to inhaled corticosteroid therapy in asthma. The association of longitudinal change in lung function and single nucleotide polymorphisms from candidate genes crucial to the biologic actions of corticosteroids were evaluated in three independent asthmatic clinical trial populations utilizing inhaled corticosteroids as the primary therapy in at least one treatment arm. Variation in one gene, corticotropin-releasing hormone receptor 1 (CRHR1) was consistently associated with enhanced response to therapy in each of our three populations. Individuals homozygous for the variants of interest manifested a doubling to quadrupling of the lung function response to corticosteroids compared with lack of the variants (P-values ranging from 0.006 to 0.025 for our three asthmatic populations). As the primary receptor mediating the release of adrenocorticotropic hormone, which regulates endogenous cortisol levels, CRHR1 plays a pivotal, pleiotropic role in steroid biology. These data indicate that genetic variants in CRHR1 have pharmacogenetic effects influencing asthmatic response to corticosteroids, provide a rationale for predicting therapeutic response in asthma and other corticosteroid-treated diseases, and suggests this gene pathway as a potential novel therapeutic target.

INTRODUCTION

Corticosteroids mediate a variety of immunological actions and are commonly utilized in the treatment of a diverse number of diseases. However, focused evaluation of the literature surrounding therapy with corticosteroids demonstrates a variable response, with a substantial number of individuals that fail to respond to this class of medication. For example,
approximately one-third of patients in recent studies of Crohn’s disease (1) and nephrotic syndrome (2) failed to respond to initial therapy with corticosteroids. Moreover, corticosteroid treatment in these studies was associated with a significant incidence of adverse side effects (1,2). In asthma, corticosteroids taken by the inhalational route are the most effective and commonly used drugs for the treatment of asthma but may also be associated with serious adverse effects (3–5). Large inter-individual variation, including a significant incidence of adverse side effects (1,2), and the known physiologic role of this gene would be expected to alter basal levels of endogenous corticosteroid secretion providing for the opportunity for an enhanced response to exogenous corticosteroid administration. Here we show that variation in one gene, corticotropin-releasing hormone receptor 1 (CRHR1) was associated consistently with enhanced response to therapy in each of our three populations, as manifested by a doubling to quadrupling of the longitudinal FEV1 response to corticosteroids, compared with lack of the variation. These findings are consistent with the known physiologic role of CRHR1 in that variations of this gene would be expected to alter basal levels of endogenous corticosteroid secretion providing for the opportunity for an enhanced response to exogenous corticosteroid administration.

RESULTS

Populations

We studied three different clinical trial populations: 470 adult asthmatics (termed Adult Study), 311 childhood asthmatics (termed CAMP for Childhood Asthma Management Program) and 336 adult asthmatics (termed ACRN for Asthma Clinical Research Network). Clinical characteristics of the three populations are shown in Table 1. Our analyses were confined to Caucasians, owing to concerns about possible population stratification and the small numbers of subjects in other racial groups. In addition to age, gender distribution and type of inhaled corticosteroid used, the baseline severity of the populations (as denoted by mean FEV1 at enrollment) differed, with the two adult populations composed of milder to moderate asthmatics and the pediatric population, of mild to moderate asthmatics.

The primary outcome measure of the association analyses was percent change in FEV1 over time in response to inhaled corticosteroids, defined as the FEV1 difference from baseline to 8 weeks for the Adult Study and CAMP, and to 6 weeks in ACRN, divided by the baseline value. The mean FEV1 percent change was 7.0 ± 19.3% in the Adult Study, 6.8 ± 13.8% in CAMP and 6.7 ± 19.7% in ACRN. Although each of these changes represented significant improvements in lung function from baseline (P < 0.05), there was wide inter-individual variability in these responses (Fig. 1).

Table 1. Population characteristics

<table>
<thead>
<tr>
<th></th>
<th>Adult Study (primary)</th>
<th>CAMP (replicate)</th>
<th>ACRN (second replicate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>470</td>
<td>311</td>
<td>336</td>
</tr>
<tr>
<td>Inhaled corticosteroid used</td>
<td>Flunisolide</td>
<td>Budesonide</td>
<td>Triamcinolone</td>
</tr>
<tr>
<td>Age</td>
<td>39.4 ± 13.4</td>
<td>9.0 ± 2.1</td>
<td>33.2 ± 11.6</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td>195 (41.5)</td>
<td>181 (58.2)</td>
<td>139 (41.4)</td>
</tr>
<tr>
<td>Male</td>
<td>275 (58.5)</td>
<td>130 (41.8)</td>
<td>197 (58.6)</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td>415 (88.5)</td>
<td>201 (64.6)</td>
<td>224 (66.7)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>34 (7.0)</td>
<td>44 (14.1)</td>
<td>63 (18.8)</td>
</tr>
<tr>
<td>African American</td>
<td>12 (2.6)</td>
<td>32 (10.3)</td>
<td>25 (7.4)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9 (1.9)</td>
<td>34 (10.9)</td>
<td>24 (7.1)</td>
</tr>
<tr>
<td>Mean baseline FEV1 (%)</td>
<td>72.2 ± 16.2</td>
<td>93.6 ± 14.4</td>
<td>77.8 ± 15.9</td>
</tr>
<tr>
<td>Mean change in FEV1 (%)</td>
<td>7.0 ± 19.3</td>
<td>8.3 ± 14.1</td>
<td>6.7 ± 19.7</td>
</tr>
</tbody>
</table>

*As plus-minus values are means ± standard deviations.

Owing to concerns over possible population stratification and small numbers of subjects in other racial groups, only genotypic information from Caucasians were analyzed.

As a percent of predicted.

Change in FEV1 while on inhaled corticosteroids evaluated at 8 weeks in the Adult Study and CAMP and 6 weeks in ACRN.
from across the gene by testing multi-SNP haplotypes in the CRHR1 gene. Owing to linkage disequilibrium (LD) and/or limited haplotype diversity, haplotypes may be distinguished using a subset of SNPs, termed ‘haplotype-tag SNPs’ (htSNPs) (9). We found that the htSNPs rs1876828, rs242939 and rs242941 distinguished all four haplotypes imputed with at least 2.5% frequency in both the Adult Study and CAMP populations. Genotypes for these SNPs were in Hardy–Weinberg equilibrium in all study cohorts. Utilizing the htSNPs, the average haplotype frequencies for the four haplotypes analyzed in the two populations were 0.46, 0.27, 0.21 and 0.05, respectively. One common haplotype (frequency 27%), termed GAT, was associated with a significantly enhanced response to inhaled corticosteroids in both the Adult Study and CAMP (P = 0.02 and 0.01, respectively). The estimated 8 week improvement in FEV1 for those subjects imputed to have the homozygous GAT/GAT haplotype was more than twice that for those homozygous for non-GAT haplotypes in the Adult Study (13.73 ± 3.80 versus 5.54 ± 1.29%, respectively), and nearly three times that in CAMP (21.83 ± 8.07 versus 7.35 ± 1.41%, respectively) (Fig. 3). Improvement in those heterozygous for the GAT haplotype was intermediate between the two groups, suggesting an additive effect.

Screening of first population and initial replication

In the Adult Study, we screened 131 SNPs in 14 genes (Supplementary Material). Utilizing a cutoff value of P < 0.05, we identified four SNPs (rs242941, rs1990975, rs889182 and rs6191) from three genes, CRHR1 (NM_002002), FCER2 (NM_000176), associated with the 8 week response to inhaled corticosteroids. We recognized that false positive results could occur in these analyses because the significance threshold was not corrected for multiple comparisons, but viewed these screening results as providing an initial list of candidates for further replication testing.

To validate our findings, we then studied the three genes (and only these genes) in the second independent population, CAMP. CRHR1 showed positive association with significantly improved lung function after 8 weeks of inhaled corticosteroid therapy in this study as well. Specifically, rs242941 (minor allele frequency ~30%) was associated with positive treatment response in both the Adult Study and CAMP (P = 0.025 and 0.006, respectively) (Fig. 2A). In the Adult Study, the mean percent change in FEV1 for those homozygous for the minor allele was 13.28 ± 3.11, compared with 5.49 ± 1.40 for those homozygous for the wild-type allele. Similarly, in CAMP, the percent change was 17.80 ± 6.77 versus 7.57 ± 1.50 for the variant and wild-type homozygotes, respectively. In CAMP, evaluation of the placebo arm revealed no association of rs242941 or any of the other genotyped SNPs with change in lung function. Moreover, while inhaled corticosteroid usage was associated with improved FEV1 at 8 weeks (P < 0.001), variation in rs242941 significantly enhanced the improvement in lung function associated with this form of therapy (interaction P = 0.02).

Haplotypic associations

Since rs242941 is intronic and unlikely to affect function of CRHR1, we sought to capture more of the information present across the gene by testing multi-SNP haplotypes in the CRHR1 gene. Owing to linkage disequilibrium (LD) and/or limited haplotype diversity, haplotypes may be distinguished using a subset of SNPs, termed ‘haplotype-tag SNPs’ (htSNPs) (9). We found that the htSNPs rs1876828, rs242939 and rs242941 distinguished all four haplotypes imputed with at least 2.5% frequency in both the Adult Study and CAMP populations. Genotypes for these SNPs were in Hardy–Weinberg equilibrium in all study cohorts. Utilizing the htSNPs, the average haplotype frequencies for the four haplotypes analyzed in the two populations were 0.46, 0.27, 0.21 and 0.05, respectively. One common haplotype (frequency 27%), termed GAT, was associated with a significantly enhanced response to inhaled corticosteroids in both the Adult Study and CAMP (P = 0.02 and 0.01, respectively). The estimated 8 week improvement in FEV1 for those subjects imputed to have the homozygous GAT/GAT haplotype was more than twice that for those homozygous for non-GAT haplotypes in the Adult Study (13.73 ± 3.80 versus 5.54 ± 1.29%, respectively), and nearly three times that in CAMP (21.83 ± 8.07 versus 7.35 ± 1.41%, respectively) (Fig. 3). Improvement in those heterozygous for the GAT haplotype was intermediate between the two groups, suggesting an additive effect.

Secondary replication

To further verify our findings, subsequently we evaluated the CRHR1 gene in the third clinical trial population, ACRN, by genotyping only the three htSNPs (rs1876828, rs242939 and rs242941). Although neither the rs242941 SNP (P = 0.29) nor the GAT haplotype (P = 0.59) was significantly associated with lung function response in this population, the second of the three SNPs, rs1876828, was strongly associated with improved FEV1 over the 6 week study period (P = 0.006) (Fig. 2B). Homozygotes for the minor allele had an average increase in their FEV1 of 23.72 ± 9.75 compared with 5.14 ± 1.31% for homozygotes for the common allele. We did not observe any haplotype association stronger than this SNP in ACRN.

DISCUSSION

Our results identify genetic variants associated with the therapeutic response to corticosteroids. Specifically, we have demonstrated that genetic variation in CRHR1 is associated with an enhanced pulmonary function response to inhaled corticosteroids in all three of our asthmatic populations. Our data suggest that this pharmacogenetic effect related to the use of inhaled corticosteroids is robust. In the evaluation of three CRHR1 htSNPs, one SNP and one specific haplotype were associated with a salutary therapeutic response at 8 weeks in both an adult and a pediatric population. The strong association of a second htSNP with response to inhaled corticosteroids in a third population and the significant interaction of CRHR1 variation with inhaled steroid usage, resulting in enhanced improvement in lung function in the pediatric population, lend additional credence to the pharmacogenetic role of this gene.

While the association with a different SNP distinguishes the third study from the first two, the finding of associations in...
all three populations is nonetheless significant. Given the variability among the three populations studied, the varying sample sizes and the fact that the three SNPs are all non-coding, the likely explanation for the difference is that the actual causal variant in CRHR1 remains to be discovered and that the three SNPs studied are imperfectly correlated markers in LD with that variant. Systematic analysis of the haplotype structure and sequence variation of the CRHR1 gene will be required to identify the actual causal variants, which might lie in the structural gene or in regulatory sequences controlling alternative splicing, transcription or translation (10–14).

Corticotropin-releasing hormone (CRH) is a well-recognized neuroendocrine mediator of the immune system response to stress. A relationship of CRH to the pathogenesis of asthma (15) has been postulated. CRHR1 is the predominant CRH receptor in the pituitary gland, mediating the release of adrenocorticotropic hormone (ACTH) (16,17) and the catecholaminergic response to CRH (18,19). Peripherally, CRH may bind to mast cells via CRHR1 (20). Alterations of any of these CRH effects, as mediated by the CRHR1 gene, have the potential to influence the pathogenesis of asthma. For example, decreased expression or function of CRHR1, imposed by genetic variation, would be expected to diminish the capacity to secrete cortisol in response to inflammation, owing to decreased ACTH release. Therefore, asthmatic patients with alterations in this gene would be more likely to respond following the administration of an exogenous corticosteroid. Our data support this hypothesis—improvement in lung function was associated consistently with the variant allele in the associations found in each of our three populations.

Potential limitations of this study included lack of complete sequence information prior to genotyping. Our sequencing efforts focused on the exons of candidate genes, limiting our knowledge of the full LD pattern of the gene. Therefore, we cannot fully exclude a gene if no association was noted in our initial analyses. Candidate genes of great interest, such as CRH and the glucocorticoid receptor, may fall into this category. A second potential limitation is multiple comparisons. To compensate for spurious statistical associations owing to multiple comparisons, we carefully designated a limited number of corticosteroid response measures, all related to a single phenotype, longitudinal change in FEV1. Moreover, our study relies on the replication of effects in a second and a third, very different, populations prior to relevance being attributed to a gene.

In summary, our findings of an association of CRHR1 genetic variants with the enhanced response to inhaled corticosteroids in asthmatics, adjusted for age, sex, height and baseline FEV1, are consistent with our prior studies in non-asthmatic populations. Utilizing the htSNPs rs1876828, rs242939 and rs242941, the mean FEV1 improvement in those adults imputed with the GAT/GAT homozygous haplotype was 13.7%, while in those homozygous for non-GAT haplotypes it was 5.5%. In CAMP, those imputed for the GAT/GAT haplotype demonstrated a 21.8% improvement in FEV1 versus 7.4% for those with no GAT haplotype. Improvement in those heterozygous for the GAT haplotype was intermediate between the two groups, suggesting an additive effect. Mean values ± SEM are shown.
corticosteroids in three diverse asthmatic populations provide novel insights into the therapy of asthma. Animal model studies of this pathway support our findings by implicating CRH in the inflammatory response in asthma (E.S. Silverman, personal communication). Genetic association with a therapeutic response to this class of commonly used medications is an important step in the development of individualized therapy for asthma, providing a potential mechanism to decrease both morbidity and cost. Moreover, since the proportion of non-responders to treatment with corticosteroids is similar between asthma and other diseases, these findings may be relevant to the myriad of other diseases whose therapeutic approaches include the utilization of corticosteroids.

MATERIALS AND METHODS

A graphical summary of the approach utilized for genotyping and analyzing candidate genes for the pharmacogenetic response to inhaled corticosteroids is shown in Figure 4.

Study populations

We utilized DNA samples from three clinical trials. All patients or their legal guardians consented to the study protocol and ancillary genetic testing. The Adult Study was a multicenter 8 week randomized clinical trial comparing the effect of once-daily high-dose inhaled flunisolide versus standard inhaled corticosteroid therapy; 470 moderate to severe adult asthmatics participated. Since the change in the FEV1 in both treatment groups was the same ($P = 0.30$), we utilized the combined study cohort in our analyses. Inclusion criteria were a history of asthma, ≥12% improvement in FEV1 with albuterol and using inhaled steroids at randomization. Exclusion criteria were non-asthma pulmonary disease, smoking (>10 pack-years) and recent asthma exacerbations requiring systemic steroids. Subjects were phoned weekly and had spirometry at 4 and 8 weeks.

CAMP is a multicenter, randomized, double-blinded clinical trial testing the safety and efficacy of inhaled budesonide versus nedocromil versus placebo over a mean of 4.3 years. Trial design and methodology have been published (21,22). CAMP enrolled 1041 children aged 5–12 years with mild to moderate asthma. Entry criteria included asthma symptoms and/or medication use for ≥6 months in the previous year and airway responsiveness with provocative concentration of methacholine causing a 20% reduction in FEV1 ($PC_{20}$) ≤ 12.5 mg/ml. Follow-up visits with spirometry occurred at 2 and 4 months and every 4 months thereafter. The replication sample subjects were the 311 Caucasian CAMP children randomized to the corticosteroid group, evaluated at their 2 month follow-up visit.

Two completed trials conducted by the ACRN, the salmeterol or corticosteroids (23) and salmeterol + inhaled corticosteroids (24) trials, had a common initial 6 week run-in period utilizing four inhalations twice-daily of triamcinolone prior to separate randomization to one of the two trials. Details regarding the entry criteria, run-in period and randomization have been published with the primary trial results (23,24). All patients met the American Thoracic Society definition of asthma and criteria for treatment with inhaled corticosteroids. Of the 339 subjects eligible for randomization, 336 had DNA available, forming the basis of our second replication sample.
Genotyping

In 14 candidate genes involved in innate glucocorticoid synthesis and metabolism, cellular receptors, and transcriptional regulators 131 SNPs were genotyped (Supplementary Material). The genes were selected carefully by experts in the fields of endocrinology and steroid biology as being those biological candidates most likely influencing drug-treatment response. SNPs were selected utilizing two sources, public databases and cDNA sequencing performed at the Whitehead Institute. We over-sampled exonic regions and attempted coverage of at least one SNP every 10 kb. Replicate genotyping was performed in CAMP on the three candidate genes with a measurable effect in the Adult Study and ACRN on the three htsSNPs of the single gene with associations in both the Adult Study and CAMP.

SNPs were genotyped via a SEQUENOM MassARRAY MALDI-TOF mass spectrometer (Sequenom, San Diego, CA, USA) for analysis of unlabeled single-base extension minisequencing reactions with a semiautomated primer design program (SpectroDESIGNER, Sequenom). Our protocol implemented the very short extension method (25), whereby sequencing products are extended by only one base for three of the four nucleotides and by several additional bases for the fourth nucleotide (representing one of the alleles for a given SNP), permitting clearly delineated mass separation of the two allelic variants at a given locus.

Statistical methodology

The FEV\textsubscript{1} phenotypic measures in our populations reflect similar outcomes over similar time frames. The percent change in FEV\textsubscript{1} was defined as the FEV\textsubscript{1} at the end of the period minus the FEV\textsubscript{1} at the beginning of the trial divided by the FEV\textsubscript{1} at the beginning of the trial multiplied by 100. In the Adult Study, we tested associations between individual SNPs and asthma phenotypes using generalized linear models under the assumption of an additive model. Genes with significant associations (\(P < 0.05\)) were genotyped in CAMP and tested for associations. In CAMP an additional analysis, incorporating in interaction term testing for additive genotype with inhaled steroid usage, was performed for the SNP that replicated in both populations. Single SNP analyses were performed using SAS, version 8 (Cary, NC, USA).

For the 14 SNPs spanning \(\sim 27\) kb of the \textit{CRHRI} gene, which were successfully genotyped in both the Adult Study and CAMP, we inferred haplotypes using the program \textit{Phase} (26). Four common haplotypes comprised 90 and 94\% of the total haplotypic substructure for the Adult and CAMP Caucasians, respectively. Subsequently, we used our haplotype-tag approach (27) to identify htSNPs for haplotypes with \(\geq 5\%\) frequency. We chose a minimal subset of htSNPs that was identical for both Adult Study and CAMP, noting that the common haplotypes, although differing in frequency, were represented in both populations, allowing us to compare haplotype-specific effects across the two populations. These SNPs were tested for haplotype association using the \textit{Haplo.score} program (28), where score tests, derived from generalized linear models, are used for global tests of association, as well as haplotype-specific tests. Linkage phase ambiguity (inherent in methods that infer haplotypes from unphased marker data) is addressed by computing the weighted conditional distribution of haplotypes given the observed genetic data for all study subjects. We modified the method to include data from individuals with partially missing marker information. \textit{Haplo.score} permits analysis of continuous and categorical phenotypes, with and without covariate adjustment. Given replication in two asthmatic populations, the htSNPs were tested in the ACRN population. Multivariable individual SNP and haplotypic analyses adjusting for age, sex and baseline FEV\textsubscript{1} were performed for any significant, unadjusted association and are reported throughout the text and figures. Height was also incorporated into the multivariable models involving the CAMP and ACRN populations. In a separate analysis of a random panel of 59 SNPs across the genome in each of our three populations, we found no evidence of population stratification (\(P > 0.05\) for dichotomizations of each study into highest and lowest quartiles).

SUPPLEMENTARY MATERIAL

Supplementary Material is available at HMG Online.

ACKNOWLEDGEMENTS

We wish to acknowledge the ACRN investigators, R.F. Lemanske, Jr, C.A. Sorkness, H.A. Boushey, J. Fahy, S. Lazarus, R.J. Martin, S.J. Szeffer, M. Kraft, J.E. Fish, J.G. Ford, J.K. Fagan, V.M. Chinchilli, S. Peters, T. Craig, E. Mauger, S. Nachman and J. Spahn for their contribution to this work. We would also like to acknowledge the technical staff, J. Senter Sylvia, K. Weiland and M.A. Faggart for their contribution as well as N. Beattie for her assistance with preparation of this manuscript. This work was supported by U01 HL65899: The Pharmacogenetics of Asthma Treatment from the NHLBI. We acknowledge the CAMP investigators and research team for collection of CAMP Genetic Ancillary Study data. CAMP was supported by contracts N01 RR00079 and M01 RR03186 from the NHLBI. The ACRN is supported by U01 HL51510, U01 HL51834, U01 HL51843, M01 RR00079 and M01 RR03186 from the NHLBI.

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