Atlas of the clinical genetics of human dilated cardiomyopathy

Jan Haas1,2, Karen S. Frese1,2, Barbara Peil3, Wanda Kloos1, Andreas Keller4, Rouven Nietsch1,2, Zhu Feng1, Sabine Müller4, Elham Kayvanpour1,2, Britta Vogel1, Farbod Sedaghat-Hamedani1,2, Wei-Keat Lim6, Xiaohong Zhao6, Dmitriy Fradkin6, Doreen Köhler1, Simon Fischer1, Jennifer Franke1, Sabine Marquart1,2, Ioana Barb1,2, Daniel Tian Li1,2, Ali Amr1,2, Philipp Ehlermann1, Derlis Mereles1,2, Tanja Weis1,2, Sarah Hassel1,2, Andreas Kremer7, Vanessa King6, Emil Wirsz6,5, Richard Isnard11, Michel Komajda11, Alessandra Serio8, Maurizia Grasso8, Petros Syrris9, Eleanor Wicks9, Vincent Plagnol9, Luis Lopes9, Tenna Gadgaard13, Hans Eiskjær13, Mads Jørgensen19, Diego Garcia-Giustiniani16, Martin Ortiz-Genga16, Maria G. Crespo-Leiro17, Rondal Lekanne D. Deprez10, Imke Christiaans10, Ingrid A. van Rijsingen10, Arthur A. Wilde10, Anders Waldenstrom18, Martino Bolognesi15, Riccardo Bellazzi14, Stellan Mörner18, Justo Lorenzo Bermejo3, Lorenzo Monserrat16,17, Eric Villard11, Jens Mogensen12, Yigal M. Pinto10, Philippe Chartron11, Perry Elliott9, Eloisa Arbustini8, Hugo A. Katus1,2,20, and Benjamin Meder1,2,20

1Department of Internal Medicine III, University of Heidelberg, Germany; 2DZHK (German Centre for Cardiovascular Research), Germany; 3Institute of Medical Biometry and Informatics (IMBI), University Hospital Heidelberg, Germany; 4Department of Human Genetics, Saarland University, Germany; 5Siemens AG, Erlangen, Germany; 6Siemens Corporate Technology, Princeton, USA; 7Siemens AG, Österreich; 8Fondazione IRCCS Policlinico San Matteo, Pavia, Italy; 9University College London, Great Britain; 10Academisch Medisch Centrum (AMC), Amsterdam, Netherlands; 11INSERM UMR956, UPMC Univ Paris 6, AP-HP, Hôpital Pitié-Salpêtrière, Paris, France; 12Department of Cardiology, Odense University Hospital and Institute of Clinical Research, University of Southern Denmark; 13Department of Cardiology, Aarhus University Hospital and Institute of Clinical Research, University of Southern Denmark; 14Biomedical Informatics Laboratory, University of Pavia, Italy; 15Department of BioSciences, University of Milano, Italy; 16Health-in-code, La Coruña, Spain; 17Cardiology Department, Biomedical Research Institute INIBIC, A Coruna, Spain; 18Department of Public Health and Clinical Medicine, Umeå University, Umeå, Sweden; 19Department of Clinical Genetics, Vejle Hospital, 7100 Vejle, Denmark; 20Klaus Tschira Institute for Computational Cardiology, University of Heidelberg, Germany

Online publish-ahead-of-print 27 August 2014

See page 1074 for the editorial comment on this article (doi:10.1093/eurheartj/ehu402)

Aim
Numerous genes are known to cause dilated cardiomyopathy (DCM). However, until now technological limitations have hindered elucidation of the contribution of all clinically relevant disease genes to DCM phenotypes in larger cohorts. We now utilized next-generation sequencing to overcome these limitations and screened all DCM disease genes in a large cohort.

Methods and results
In this multi-centre, multi-national study, we have enrolled 639 patients with sporadic or familial DCM. To all samples, we applied a standardized protocol for ultra-high coverage next-generation sequencing of 84 genes, leading to 99.1% coverage of the target region with at least 50-fold and a mean read depth of 2415. In this well characterized cohort, we find the highest number of known cardiomyopathy mutations in plakophilin-2, myosin-binding protein C-3, and desmoplakin. When we include yet unknown but predicted disease variants, we find titin, plakophilin-2, myosin-binding protein C-3, desmoplakin, ryanodine receptor 2, desmocollin-2, desmoglein-2, and SCN5A variants among the most commonly mutated genes. The overlap between DCM, hypertrophic cardiomyopathy (HCM), and channelopathy causing mutations is considerably high. Of note, we find that >38% of patients have compound or combined mutations and 12.8% have three or even more mutations. When comparing patients recruited in the eight participating European countries we find remarkably little differences in mutation frequencies and affected genes.

* Corresponding author: Benjamin Meder, University Hospital of Heidelberg, Department of Internal Medicine III, Im Neuenheimer Feld 669, 69120 Heidelberg, Germany, Tel.: +49 6221 5646835, Fax: +49 6221 5646465, Email: benjamin.meder@med.uni-heidelberg.de

Published on behalf of the European Society of Cardiology. All rights reserved. © The Author 2014. For permissions please email: journals.permissions@oup.com.
Introduction
Dilated cardiomyopathy (DCM) accounts for 30–40% of all heart failure cases in large clinical trials and is the leading cause of heart transplantation. There is ample data on the familial aggregation of DCM and in recent registers familial forms of DCM account for 30–50% of all DCM cases. With an autosomal-dominant inheritance being the predominant pattern of transmission, some familial cases also present by an autosomal recessive or X-linked recessive trait. Particularly in western countries, the small size of contemporary families may obscure the genetic nature of the disease and it is important to consider that also sporadic DCM cases can be due to genetic mutations.

Tremendous advances have been made in understanding the genetic basis of DCM. Linkage analyses in families and candidate gene sequencing as well as genome-wide association studies (GWAS) in large cohorts have contributed to the identification of risk variants and disease causing mutations in >30 disease genes, many of which encode for structural components of the heart muscle, such as the sarcomere or the cardiac z-disc. Recently, we and others have used Next-Generation Sequencing (NGS) approaches to dissect the genetic causes of DCM and established a comprehensive methodology for the clinical genetic testing of all currently known disease genes. However, the existing studies are either limited by the small number of investigated patients or the restriction to only a subset of disease genes, prohibiting a more detailed dissection of the role of DNA-alterations in DCM.

We are here presenting the results of the gene sequencing study of the European INHERITANCE project including 639 patients with sporadic or proven familial DCM enrolled in eight different clinical centres (Denmark, Sweden, France, Italy, Germany, UK, Netherlands, and Spain). We aimed to systematically investigate not only the clinically relevant DCM genes but also genes causative for other inherited cardiomyopathies and to systematically benchmark the analytical performance of NGS as a novel technology being introduced into broad clinical application.

Methods
Patients and study design
This multi-centre study was conducted in accordance with the principles of the Declaration of Helsinki. All participants from all centres have given written informed consent and the study was approved by the ethic committees of the participating study centres.

Conclusion
This is to our knowledge, the first study that comprehensively investigated the genetics of DCM in a large-scale cohort and across a broad gene panel of the known DCM genes. Our results underline the high analytical quality and feasibility of Next-Generation Sequencing in clinical genetic diagnostics and provide a sound database of the genetic causes of DCM.

Keywords
Cardiomyopathy • Genetics • Patients • Diagnosis

Translational Perspective
We were able to show that targeted Next-Generation Sequencing is well suited to be applied in clinical routine diagnostics, substantiating the ongoing paradigm shift from low- to high-throughput genomics in medicine. By means of our atlas of the genetics of human DCM, we aspire to soon be able to apply our findings to the individual patient with cardiomyopathy in daily clinical practice.

Target enrichment, next-generation sequencing, and data analysis
SureSelectXT Target Enrichment System (Agilent; Waldbronn, Germany) was used for capturing of the desired regions. Design of the capture baits was done using eArray (Agilent Technologies, Santa Clara, CA, USA). Raw data analysis was performed with an in-house pipeline based on variant calling of the Genome Analysis Toolkit (GATK). Annotation of the variants was mainly done using ANNOVAR. Genotype–phenotype association tests were done with the SAS software. For a detailed description of the data analysis, please refer to the Supplemental Material online.

Variant classification
In this study, we relied on distinct, well-defined categories for the classification of variants. Variants were classified as benign when present in
‘dbSNP137common’ (http://hgdownload.soe.ucsc.edu/goldenPath/hg19/database/snp137Common.sql) and flagged as validated-by-frequency, which means that those variants have been found with an allele-frequency of ≥1% in populations. For further determination of the likelihood to being disease relevant mutations, we defined distinct categories (see also Figure 1C): category Ia consists of coding human genome mutation database (HGMD) disease mutations (heart muscle diseases and channelopathies) and either are non-synonymous, frameshift insertions or deletions, splice or start/stop mutations. The same definition was applied for category Ib, where we additionally removed variants present in the 4300 individuals of the European-Americans cohort of the NHLBI GO Exome Sequencing Project (ESP) database (http://evs.gs.washington.edu/EVS/). As category II, we defined all not common, truncating variants that are either frameshift insertions/deletions, splice, or start/stop variants. Finally, all not common non-synonymous variants with prediction ‘disease’ were classified as category III. The predictions were based on SNPs&GO (February/March 2013; http://snps.biofold.org/snps-and-go/snps-and-go.html).}

Genotype–phenotype association analysis

Association analyses were carried out using the SAS software version 9.2 (SAS Institute, Inc., Cary, NC, USA). Patients were characterized by gender, country, family history of DCM, LVEF, LVEDD, NYHA classification, age at diagnosis, heart transplantation, and implantation of ICD according to available information. Based on the above-described variant classification, the number of variants, the number of patients carrying at least one variant, the number of patients carrying at least two variants in a single investigated gene, and the number of patients carrying at least two variants in any investigated gene were calculated for each group. Probability values and effect sizes with 95% confidence intervals were estimated based on logistic and Poisson regression assuming a dominant penetrance model. To identify the most relevant DCM variants according to their function, a stepwise forward model selection was carried out. The list of explanatory variables included the variant carrier status in genes grouped by function (ion flux, nucleus, cell membrane, sarcomeric, cytoskeleton, and intercalated disc). Significant explanatory variables at the 5% level (score test) entered the models and they were not removed if they remained significant at the 10% level. Because of the exploratory
nature of the genotype–phenotype association analysis, no correction for multiple testing has been applied.

**Results**

**Ultra-high coverage next-generation sequencing enables comprehensive diagnostics of dilated cardiomyopathy**

For the purpose of this study, we designed and optimized a custom target-enrichment assay based on in-solution hybridization, targeting relevant genes involved in human DCM being summarized in Supplementary material online, Table S1. The custom target region encompasses all known coding exons of each gene. In total, we analysed 639 patients with known DCM diagnosed according to current ESC guidelines. Importantly, all 639 samples from the eight countries analysed in this study were processed according to the same standard operating procedures (SOPs) and quality control measures, allowing detailed inter-sample comparisons. Figure 1 details the origin of patients and the workflow applied. As shown in Table 1, the proportional number of patients with familial DCM was 49%. Left ventricular ejection fraction, indicating disease severity, was 31.2% (± 12.1), while the NYHA functional class, being a measure of the individual clinical status, was mainly in I–III. Heart transplantation was performed in 113 patients and another 130 received ICD implantation. Gender distribution was as expected with more male patients being affected. For detailed patient characteristics, please refer to Table 1.

As a pre-requisite for clinically applicable tests, we reached a very high 50-fold target coverage of 99.1% over all genes by iteratively improving the enrichment assay in a preceding establishment phase, being relevant to conclude positive as well as negative test results in individual patients. The mean coverage over all DCM genes was as high as 2526-fold (Figure 2A). To determine the accuracy, specificity, and sensitivity of the proposed diagnostic tool, we followed-up 25 randomly selected amplicons containing at least one variant by Sanger sequencing. From 5909 readable bases in the Sanger sequencing, we observed 5879 true-negative calls (TN) and 26 true-positive (TP) calls. Only three false-positive (FP) calls and one false-negative (FN) call were found, together resulting in a sensitivity [TP/(TP + FN)] of 96.3% and specificity [TN/(TN + FP)] of 100% and accuracy [(TP + TN)/(TP + FP + FN + TN)] of 99.9%. To further increase the depth of variants for benchmarking, we enriched and sequenced the well-genotyped HapMap sample NA12878 using the same methodology. When testing the standard GATK cut-off values, we find a sensitivity of 100% and an accuracy of 85.4%. Using our filter off-sets described in materials and methods, we achieved a much higher accuracy of 91.3% by maintaining a sensitivity of 99.0%. After manual inspection of the false-positives that could not be validated by Sanger, we postulated that at least some of these must be true variants. Hence, we exemplarily subcloned genomic DNA of patients with a variant call in the NGS data set and negative Sanger sequencing and sequenced individual clones. As shown in Supplementary material online, Figure S2, wild-type as well as mutant clones from one individual can be found, which is not obvious in the Sanger sequence, indicating that the actual accuracy of NGS is even higher than the estimated and that Sanger sequencing may miss at least some of the variants.

**Distribution of mutations in dilated cardiomyopathy patients**

In total, we identified 8269 unique genetic variants, adding up to 359669 variants in the 639 patients across the investigated target region. On average, each patient carries 563 variants in this region. To gain information on the relevance of each variant, we performed a stepped filtering approach, first by eliminating known common variants. We thereafter annotated the remaining variants using ANNOVAR, snpEff, Genometrax (Biobase), and SNPs&GO.

We then applied the classification presented in Figure 1C. A known cardiomyopathy mutation (category Ia; reported in HGMD as cardiomyopathy or channelopathy variant) was found in 309 patients (48% of all patients). When we additionally excluded variants observed in a large non-DCM control cohort (ESP whole exome sequencing project2) (=category Ib), we still find in 294 patients (46%) a known mutation previously reported as disease causing. Figure 2B gives an overview over the distribution of mutations across the screened DCM genes. When considering only DCM-causing mutations by excluding mutations of other cardiomyopathies, a known mutation is found in 101 patients (16% of all patients).

Since many cardiomyopathy cases will be caused by rare or private mutations, which are not yet annotated in databases such as HGMD, we next searched in all patients for ‘likely’ disease mutations (category II). ‘The likely’ mutations include frameshift insertions/deletions, stop-gain/-loss variants, and splice-site mutations within the target genes. In addition to the category Ia variants, our analysis yielded insertions with resulting frameshifts in three different genes across 13 patients and...
frameshift deletions in 10 DCM genes covering a total of 37 patients. We also identified 11 individual splicing variants in 8 DCM genes in a total of 37 patients and 60 stop-gain/-loss variants in 17 genes in another 67 patients. Altogether, we find 117 previously not annotated highly ‘likely’ pathogenic variants in 26 genes for 147 patients (23%).

To search for ‘potential’ disease mutations (category III), we selected all non-common, non-synonymous variants, and applied bioinformatics methods to predict a detrimental effect of each variant on the protein function. By using SNPs&GO, we classified as many as 939 variants as neutral and 141 unique variants as potentially disease causing. These
141 variants were detected in 221 patients and are rare judged by their frequency. Figures 3 and 4 exemplify the distribution of variants for representative disease genes (Nexlin, Titin, Lamin A/C). See also Supplementary material online, Figure S1 for the whole list of genes. To investigate whether the variants from category II–III indeed represent rare mutations, we calculated the percentage of Singletons, which means variants found uniquely in only one patient. Here, the rate was 21.8% in the categories II–III, compared with 1.6% in the removed variants, underlining the stringency of the classification approach.

Looking at the total number of variants within the DCM genes, the majority of variants (13%) can be found in the Titin gene (TTN) (Figure 5A). This is not surprising since TTN is the largest human gene and accounts for >20% of the total target region. When normalizing, the number of variants to the size of each gene.
Figure 4  Variant classification in TTN and LMNA. Diagrams are showing the number of individual variants of different types for (A) titin and (B) lamin. Numbers in brackets are the total sum of variants found in the cohort. HGMD disease variants (category Ia) were annotated using the Biobase Human Genome Mutation Database, regardless of their appearance in dbSNP137 common. All subcategories (non-synonymous, frameshift, stop/start, predicted disease, predicted benign, splicing, synonymous) were annotated after removing those common variants. For prediction of non-synonymous variants, SNPs&Go was used. Colours of the boxes indicate a potential benign (green) or deleterious (red) effect. Variant categorization is indicated below the deleterious variant types. Sketch below the diagram is showing the target region of the gene (black) and the distribution of common (green) and known and likely/potential pathogenic variants (red).
Figure 5B: A rather even distribution can be found, disproving the existence of instability hotspots in DCM genes. A detailed view on the distribution of all likely and potentially pathogenic variants is given in Figure 5C showing the total number of variants per dilated cardiomyopathy gene (A) and after normalization to the gene size (B). (C) Bar graphs are showing the total number of variants overall patients by predicted effect type for each gene (splice, frameshift, stop, non-synonymous, and predicted disease). Curly brackets grouping the likely truncating variants (category II) and indicating the potential disease causing variants (category III).
Distribution of the functional effects of dilated cardiomyopathy mutations

Numerous studies suggest different phenotypic manifestations or severities depending on the gene affected, type and number of mutations. Hence, we tested if DCM patients in our cohort might carry multiple disease mutations, e.g. compound mutations (category Ib–III). Strikingly, such compound heterozygous states were found in 49 (7%) patients and combined heterozygous mutations were found in 243 patients (38%). Remarkably, we detected in 82 patients (12.8%) at least 3 mutations (Table 2). Considering only the very stringent category Ib variants of annotated disease mutations after exclusion of variants detected in additional control cohorts, still 82 patients (12.8%) carry at least 2 known disease mutations. As expected, using logistic regression, we find a significant association of patients having a disease mutation and familial DCM ($P = 0.03$, category Ib–III) (Table 3). To test if those results are driven by an effect of the large ttn gene, we repeated the analysis after exclusion of any ttn variant and still find 79 patients (12.4%) with at least two category Ib variants (Supplementary material online, Table S5).

When looking more closely at the variants annotated using the HGMD database (CatIb), a large portion of disease causing mutations are known to cause arrhythmogenic right ventricular cardiomyopathy (ARVC) (31%), HCM (16%), or channelopathies (6%) (Figure 6A), indicating a marked overlap not only related to disease genes, but also to specific mutations in cardiomyopathies. Hence, based on current literature, all genes investigated in this study were classified according to the different cell components or functions they contribute to (Supplementary material online, Table S1).

Next, we summed up the number of patients carrying a category Ib mutation in the different groups. Figure 6B details the groups and the identified number of patients. Based on this classification, the sarcomere group shows the highest number of patients having a mutation (14%), followed by ion flux (13%), z-disc/cytoskeleton (12%), and intercalated disc (11%).

We next asked whether we might identify specific genotype–phenotype associations in this large cohort. This would have direct clinical implications, since a genotype-guided risk assessment could improve patient selection for intensified monitoring or directed therapies. First, we investigated the gene groups introduced above and the available phenotypes. In an exploratory association analysis by using a stepwise forward selection, we could identify a logistic regression model for the group ‘nucleus’ being a significant predictor for ICD-carrier status in DCM (unadjusted $P = 0.02$). The odds ratio (OR) for patients carrying such variants was 2.44 [95% confidence interval (95% CI): 1.13–5.28]. This association was mainly driven by the nuclear gene RBM20, having an OR of 5.65 (1.89–16.86; $P = 0.002$). For the age at diagnosis, which might be relevant for establishing genetic testing in relatives, we find a significant association between MITH6 and ADRB3 mutations (Tables 4 and 5). Other clinically relevant associations were found for SMYD1, which we here suggest as novel disease gene for DCM, as well as for alpha-crystalin B (CRYAB) mutations, both were associated with LVEF. Alterations in left-ventricular diameter (LVEDD) could be seen in association with TBX20 (OR: 0.45, 0.22–0.94; $P = 0.03$). Since a significant number of patients also received heart transplantation (HTX) due to end-stage heart failure (20% of the cohort), we investigated associations with HTX. Here, we found a significant association with MYPN having an OR of 4.23 (1.04–17.18).

### Differences of dilated cardiomyopathy mutations across Europe

This study includes a total of 639 patients from eight countries, enabling us to investigate the geographical distribution of cardiomyopathy relevant variants. When considering genetic variants from category Ib–III (Supplementary material online, Table S6), we observe small yet statistically significant differences between countries regarding the rate of mutations (variants per patient), with Germany showing the lowest rate of 0.98 and Great Britain showing the highest rate of 1.51 (global $P = 0.04$, Poisson regression). The rate of mutation positive patients for single genes and across countries is depicted in Figure 7. For example, the rate of patients carrying a TTN variant ranged from 0.56 in Dutch patients to 0.20 in German patients.

---

**Table 2** Multiple mutations affecting single patients

<table>
<thead>
<tr>
<th>Number of mutations</th>
<th>HGMD* variant pos patients (%)</th>
<th>Category Ib–IIIb variant pos patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>345 (54.0)</td>
<td>171 (26.7)</td>
</tr>
<tr>
<td>$\geq 1$</td>
<td>294 (46.0)</td>
<td>468 (73.2)</td>
</tr>
<tr>
<td>$\geq 2$</td>
<td>82 (12.8)</td>
<td>243 (38.0)</td>
</tr>
<tr>
<td>$\geq 3$</td>
<td>14 (2.2)</td>
<td>82 (12.8)</td>
</tr>
<tr>
<td>$\geq 4$</td>
<td>2 (0.3)</td>
<td>16 (2.5)</td>
</tr>
</tbody>
</table>

*aCategory Ib.

*bEither category Ib or category II or category III.

---

**Table 3** Association of familial and sporadic dilated cardiomyopathy with number of mutation positive results

<table>
<thead>
<tr>
<th></th>
<th>No. of patients</th>
<th>No. of patients having category Ib–III* variant</th>
<th>$P$-value from logistic regression</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sporadic DCM</td>
<td>271</td>
<td>185</td>
<td>0.03</td>
<td>Reference</td>
</tr>
<tr>
<td>Familial DCM</td>
<td>265</td>
<td>203</td>
<td></td>
<td>1.52 (1.04–2.23)</td>
</tr>
</tbody>
</table>

*aEither category Ib or category II or category III.

OR, odds ratio; CI, confidence interval.
However, mutation frequencies of DCM genes are clearly more homogeneous than previously reported in smaller studies, suggesting that genetic testing for DCM can be applied in a uniform setting across Europe.

**Discussion**

To our knowledge, this is the most comprehensive study on the contribution of DCM-causing genes to date. The data reported shed light...
bioinformatics analyses must include a filter step, e.g. excluding described here. nearly complete coverage and high accuracy of the approach has now become feasible and technically validated as shown by the testing of disease genes for DCM, HCM and other cardiomyopathies target enrichment followed by NGS, for high-throughput genetic sensitivity and detection failure of clinically relevant mutations. The use of representation and coverage of exons, bearing the risk of limited sen-
teristics for the comprehensive exploration of genetic mechanisms.10 However, NGS retains some weaknesses, such as the incomplete distribution of genes, the number of mutations and mutational burden of patients with DCM.

Next-generation sequencing technologies (NGS) have emerged as a fast alternative to Sanger-sequencing, providing the analytical charac-
tries. This effect may be due to a higher number of patients in Denmark, as well as for the Netherlands, where we observed the lowest number of variants in the German cohort when compared with the other countries. We observed the highest number of pathogenic alleles.11 On the other hand, disease mutation databases contain potentially benign variants, previously classified as disease causing. Therefore, to substantiate the disease causing nature of a variant, further investigations must include a screening of well-phenotyped control cohorts from diverse populations and a detailed follow-up on the clinical circumstances in each patient and family, for example, by co-segregation analyses. But since families are often small and many patients are classified as sporadic, the ultimate solution of this intricate problem seems illusive. Mestroni and Taylor12 recently reviewed how the progress in genetic research already changed the view on the genetic basis of DCM. It is hence obvious that bioinformatics strategies must grow together with the enormous amount of data from adequately sized and high-quality NGS studies. With regard to a functional prediction, Thusberg et al.13 observed signifi-
cant differences between algorithms, but found that algorithms such as the here applied SNPS&GO perform already surprisingly well. However, at least by now, proving new variants or genes as disease causing requires further efforts to validate them through functional and familial studies and large-scale population-based control cohorts sequenced by NGS.

Previous publications have given rise to the notion that disease-causing gene mutations may underlie geographical disparities.14 In our study, we enrolled patients from eight countries to create a Euro-

<p>| Table 4 Association between genotypes and dilated cardiomyopathy |
|---------------------|---------------------|---------------------|---------------------|---------------------|</p>
<table>
<thead>
<tr>
<th>Gene</th>
<th>Phenotype</th>
<th>No. of patients</th>
<th>Patients with category Ib-III* variants</th>
<th>P-value from logistic regression</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR1AB</td>
<td>LVEF</td>
<td>582</td>
<td>2</td>
<td>0.04</td>
<td>0.05 (0.00–0.81)</td>
</tr>
<tr>
<td>MYPN</td>
<td>Received HTX</td>
<td>No</td>
<td>465</td>
<td>4</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>113</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>RBM20</td>
<td>Received ICD</td>
<td>No</td>
<td>344</td>
<td>5</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>130</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>SMYD1</td>
<td>LVEF</td>
<td>582</td>
<td>2</td>
<td>0.03</td>
<td>4.42 (1.14–17.10)</td>
</tr>
<tr>
<td>TBX20</td>
<td>LVEDD</td>
<td>538</td>
<td>7</td>
<td>0.03</td>
<td>0.45 (0.22–0.94)</td>
</tr>
<tr>
<td>MYH6</td>
<td>Age at diagnosis</td>
<td>439</td>
<td>8</td>
<td>0.03</td>
<td>0.63 (0.41–0.96)</td>
</tr>
<tr>
<td>ADRB3</td>
<td></td>
<td>2</td>
<td>0.04</td>
<td></td>
<td>0.36 (0.14–0.94)</td>
</tr>
</tbody>
</table>

Only significant associations are shown (unadjusted α = 5%, two-sided).
*Either category Ib or category II or category III.
OR, odds ratio; CI, confidence interval. For LVEF OR are calculated per 10% step. For LVEDD OR are calculated per 10 mm step. For age at diagnosis, OR are calculated per 10 years step.

<p>| Table 5 Mutation counts by country |
|---------------------|---------------------|---------------------|---------------------|</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>No. of patients</th>
<th>No. of category Ib-III* variants</th>
<th>P-value from poisson regression</th>
<th>RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>100</td>
<td>130</td>
<td>0.04</td>
<td>Reference</td>
</tr>
<tr>
<td>England</td>
<td>70</td>
<td>106</td>
<td>1.16 (0.90–1.51)</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>92</td>
<td>111</td>
<td>0.93 (0.72–1.20)</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>98</td>
<td>93</td>
<td>0.73 (0.56–0.95)</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>78</td>
<td>97</td>
<td>0.96 (0.74–1.24)</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>70</td>
<td>99</td>
<td>1.09 (0.84–1.41)</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>82</td>
<td>107</td>
<td>1.00 (0.78–1.30)</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>49</td>
<td>71</td>
<td>1.11 (0.83–1.49)</td>
<td></td>
</tr>
</tbody>
</table>

*Either category Ib or category II or category III.
RR, relative risk; CI, confidence interval.
previously mentioned mutation frequencies might express a very local phenomenon rather than a common cause of DCM. The overall distribution of mutations in DCM disease genes all over the participating countries appeared to be more homogeneous than expected.

In clinical routine, only detailed workup of cases and their families allows to uncover familial aggregation. Often this is impeded by small family structures, unavailable family members or incomplete penetrance, which classifies many cases as sporadic or idiopathic. However, this does not exclude a genetic cause of DCM in this individual patient. By introducing familial and sporadic DCM cases in our study, we were able to compare both groups in a comprehensive and well-controlled manner. By doing so, we observed significantly higher mutation rates in familial cases than in the sporadic ones (OR: 1.52). However, as shown, we find also in many cases of idiopathic DCM a known and well-characterized disease mutation. Hence, the current work underlines that even if a definite familial DCM may not be proven, a genetic aetiology cannot be ruled out. The decision to genetically test sporadic cases should be taken carefully to avoid unnecessary costs and inconclusive results. By limiting testing to familial DCM and risk groups of idiopathic DCM, e.g. with documented arrhythmias, would be an apparent conclusion.

Genotype–phenotype correlations will be of increasing importance to predict the clinical manifestations of genetically diagnosed patients. However, there are few existing studies on genotype–phenotype correlations in selected cohorts. Convincing data exist for the clinical impact of LMNA. Here, several studies have repeatedly shown a poor prognosis for LMNA mutation carriers due to the occurrence of ventricular arrhythmias and sudden cardiac death. In our study, the often-maligned stop or frameshift mutations in LMNA ranked within the top three genes of our tested gene panel and we find LMNA to having together with RBM20 the most category Ib–III mutations for genes with a comparable size. While we observed a significant association of ICD-carriers with the functional gene group ‘nucleus’ to which LMNA belongs, a statistically significant effect could only be seen for RBM20, where we find an association with the ICD-carrier status. It should be kept in mind that present results rely on a small number of observations for some strata and that probability values are not corrected for multiplicity. When using an exact test, the probability value for MYPN and HTX (P = 0.04) decreases to P = 0.0051, while the probability value for CRYAB (P = 0.04) decreases to P = 0.02 and RBM20 (P = 0.002) remains unchanged. While for RBM20 our results may be seen as validation of previous findings and hence underline the importance for testing this gene now routinely, the newly found associations require additional replication in independent cohorts of DCM patients.

Remarkably, we find in our DCM cohort a high percentage of mutations previously described for HCM, ARVC, or channelopathies, which questions the hypothesis of the allelic nature of cardiomyopathies. For instance, we found plakophilin-2 to be a frequent cause of ARVC, which is characterized by the degeneration of cardiomyocytes and resulting arrhythmias. A similar finding was recently provided by Pugh et al., underlining that our findings are not spurious. While they hypothesized that misdiagnosis in their broad referral population of an ordering provider could be one potential explanation, we nearly can exclude this due to the controlled setting of our study. To avoid phenotypic misclassification, we relied on experienced clinicians for recruiting to our
best knowledge only DCM patients and performed additional phenotyping by coronary angiography, cMRI, or myocardial biopsy where appropriate. We rather hypothesize a pathophysiological link between conductance defects and resulting cardiac mechanical disparities. However, even then a certain overlap of phenotypes will explain at least a part of these findings.

We were to our knowledge first to introduce genetic testing of cardiomyopathy patients for the large TTN gene using NGS. According to recent findings by Herman et al. reporting TTN truncating mutations to be the cause of DCM in ~25% of familial and in 18% of sporadic cases, we were able to identify such mutations in 19% of familial and 11% of sporadic cases. Interestingly, 44% of all patients with a truncating TTN variant also had additional known disease-causing variants in at least one other gene, suggesting that in these cases, the TTN variant may not be the sole cause of DCM, underlining the importance to investigate a broad gene panel rather than selected genes. In this regard, this study sheds for the first time light on the role of truncating mutations to be the cause of DCM in at least a part of these findings.

This work was also supported by grants from the European Union (FP7 INHERITANCE and BestAgeing), the ‘Bundesministerium für Bildung und Forschung’ (BMBF), German Center for Cardiovascular Research (DZHK), NGFN II, NGFN-plus and NGFN-transfer, the medical faculty of the University of Heidelberg (B.M.), and INSIGHT DCM (BMBF and Agence nationale pour la recherche).

**Supplementary material**

Supplementary material is available at European Heart Journal online.

**Acknowledgements**

This work was supported by grants from Assistance Publique - Hôpitaux de Paris (PHRC AOM04141), the ‘Fondation Leducq’ (Eurogene Heart Failure network), the Société Française de Cardiologie/ Fédération Française de cardiologie, the CONNY-MAEVA charitable foundation.


**References**


