BRIEF COMMUNICATION

Familial cortical dysplasia type IIA caused by a germline mutation in DEPDC5


1Bioinformatics Division, The Walter and Eliza Hall Institute of Medical Research, 1G Royal Parade, Parkville, Victoria, Australia
2Bruce Lefroy Centre for Genetic Health Research, Murdoch Childrens Research Institute, Parkville, Victoria, Australia
3The Florey Institute of Neuroscience and Mental Health, Melbourne, Australia
4Epilepsy Research Centre, University of Melbourne, Austin Health, Melbourne, Australia
5Department of Radiology, Royal Children’s Hospital, Melbourne, Australia
6Department of Radiology, University of Melbourne, Melbourne, Australia
7Epilepsy Research Program, School of Pharmacy and Medical Sciences, University of South Australia, Adelaide, Australia
8Sansom Institute for Health Research, University of South Australia, Adelaide, Australia
9Department of Pediatrics, University of Melbourne, Melbourne, Australia
10Department of Anatomical Pathology, Royal Children’s Hospital, Melbourne, Australia
11Department of Neurosurgery, Royal Children’s Hospital, Melbourne, Australia
12Murdoch Childrens Research Institute, Melbourne, Australia
13Department of Neurology, Royal Children’s Hospital, Melbourne, Australia
14Clinical Genetics, Austin Health, Melbourne, Australia
15Shriners Hospital Pediatric Research Center, Temple University, Philadelphia, Pennsylvania

Correspondence
Richard J. Leventer, Department of Neurology, Royal Children’s Hospital, Flemington Road, Parkville, Victoria 3052, Australia. Tel: +61393455661; Fax: +61393455977; E-mail: richard.leventer@rch.org.au

Abstract
Whole-exome sequencing of two brothers with drug-resistant, early-onset, focal epilepsy secondary to extensive type IIA focal cortical dysplasia identified a paternally inherited, nonsense variant of DEPDC5 (c.C1663T, p.Arg555*). This variant has previously been reported to cause familial focal epilepsy with variable foci in patients with normal brain imaging. Immunostaining of resected brain tissue from both brothers demonstrated mammalian target of rapamycin (mTOR) activation. This report shows the histopathological features of cortical dysplasia associated with a DEPDC5 mutation, confirms mTOR dysregulation in the malformed tissue and expands the spectrum of neurological manifestations of DEPDC5 mutations to include severe phenotypes with large areas of cortical malformation.

© 2015 The Authors. Annals of Clinical and Translational Neurology published by Wiley Periodicals, Inc on behalf of American Neurological Association. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
Introduction

Focal cortical dysplasia (FCD) encompasses a spectrum of lesions from highly localized bottom of the sulcus dysplasias (BOSD) to extensive multifocal, quadrantic or hemispheric malformations. Although the magnetic resonance imaging (MRI) appearance can lead to the suspicion of FCD, definitive diagnosis and classification requires histological analysis. FCD is characterized by cortical dyslamination either in isolation (FCD type I) or with dysmorphic neurons (FCD type IIA) or dysmorphic neurons and balloon cells (FCD type IIB). Most cases of FCD are sporadic; however, rare familial cases are described.2,3 Deleterious mutations affecting the gene encoding Dishevelled, Egl-10 and Pleckstrin (DEP) domain-containing protein 5 gene (DEPDC5) cause familial focal epilepsies without obvious cortical malformations with variable penetrance and expressivity.4–6 DEPDC5 is a component of the GATOR1 complex, a critical negative regulator of the mammalian target of rapamycin (mTOR) pathway.7 Germline heterozygous mutations in DEPDC5 have been associated with lesional epilepsies including BOSD type FCD.3 Notably, there was considerable intrafamilial variability in the presence or absence of cortical abnormalities, with only one pedigree showing more than one individual with FCD. Surgery was not required for seizure control, therefore the pathological correlates of these lesions remain unknown. Recently, two studies showed mutations in DEPDC5 associated with a range of FCD subtypes and hemimegalencephaly,8,9 yet no variants of interest were validated in the siblings and genotyped in extended family members by Sanger sequencing. The DEPDC5 reference sequences NM_001242896.1 and NP_001229825.1 were utilized.

Results

Detailed clinical summaries for the two affected siblings are published as Family 1.2 The extended pedigree is shown in Figure 1. Both brothers (III:6 and III:7) had intractable neonatal-onset focal epilepsy, successfully treated by surgery in infancy; a right hemispherectomy in III:6 and a right temporo-parietal-occipital resection in III:7. There was no relevant family history on the maternal side, and mother had a normal brain MRI. The father (II:3) had four nocturnal tonic clonic seizures and one daytime seizure beginning at 24 years managed successfully with carbamazepine. Right leg jerking was witnessed at onset on one occasion and post-ictal EEG showed focal slowing over the left hemisphere. 3 T brain MRI at age 49 years was normal. The paternal uncle (II:2) had nocturnal tonic clonic seizures followed by left-sided weakness beginning at 38 years treated successfully with carbamazepine. 3 T brain MRI at age 53 years showed mild ventriculomegaly. Results of EEG were not available. A parental first cousin (III:2) had a history of febrile seizures. A grand paternal uncle (I:3) had epilepsy with...
onset at age 12 years. A paternal second cousin once removed (II:5) died during a seizure at 18 years. Further clinical and imaging details and DNA samples were not available on these three individuals.

Brain MRI, histopathology and phospho S-6 immunostaining are shown in Figure 2A–F. Both brothers had extensive imaging abnormalities of their right hemisphere suggestive of FCD. Histopathology showed cortical dyslamination and dysmorphic neurons but no balloon cells consistent with FCDIIA. Phospho S6 labeling was positive in both.

Analysis of the SNP-chip genotypes for the two siblings confirmed sibling relatedness and excluded consanguinity. Linkage analysis identified 69.4% of the siblings’ genomes was shared (IBD = 1 or 2), in broad agreement with the expectation for two siblings (25% IBD = 0, 75% IBD = 1/2). Bioinformatic analysis of WES data identified a total (union) of 441,161 variants, of which three had normal brain MRI. It is possible that additional variants in other genes encoding components of the mTOR pathway could contribute to the phenotypic variability associated with DEPDC5, which encompasses both lesional and nonlesional epilepsies. We demonstrate for the first time mTOR dysregulation in brain tissue of individuals with DEPDC5 mutations.

These siblings represent the severe end of the spectrum of clinical and imaging phenotypes thus far reported in DEPDC5 mutations. Both brothers had drug-resistant, early-onset focal epilepsy and imaging showed extensive FCD, being multifocal hemispheric in one and posterior quadrianc in the other. The Dutch family reported to have focal epilepsy and an identical mutation in DEPDC5, albeit without the imaging correlate of FCD. These data support the notion that DEPDC5 mutations are associated with early-onset focal epilepsy and imaging abnormalities of the right hemisphere.

Discussion

Disruption of the mTOR signaling pathway is increasingly recognized in the etiology of malformations of cortical development, with both germline and somatic mutations in mTOR pathway genes contributing to a range of phenotypes. Mutations in DEPDC5, a negative regulator of mTOR activity, cause focal epilepsy with or without a cortical malformation visible on MRI. Here, we show a DEPDC5 mutation in two brothers with extensive FCD type IIA, and a paternal family history of nonlesional epilepsy.

WES identified three predicted damaging variants affecting DEPDC5, NF1, and DEPTOR, which encode components of the mTOR pathway. DEPDC5 encodes a subunit of the GATOR1 complex which suppresses mTORC1 activity in response to amino acid deprivation. A key step in the activation of mTORC1 is its recruitment to the lysosomal surface. shRNA-mediated downregulation of DEPDC5 in vitro was associated with constitutive localization of mTOR to the lysosomal surface and dysregulated activity. Consistent with these in vitro studies, we demonstrate for the first time mTOR dysregulation in brain tissue of individuals with DEPDC5 mutations.

Figure 1. Pedigree structure and genotyping. Pedigree showing the epilepsy phenotypes and the genotypes for the variants identified in DEPDC5, DEPTOR, and NF1.
includes the suppression of v-maf avian musculoaponeurotic fibrosarcoma oncogene homolog (MAF). Neither brother nor their mother had clinical or imaging features of neurofibromatosis making the NF1 variant of questionable significance.

These data expand the understanding of DEPDC5-associated epilepsies by showing pathologically proven cortical dysplasia with associated mTOR activation. It remains unclear whether the germline mutation in DEPDC5 is sufficient in isolation to cause cortical dysplasia or whether additional germline or somatic variants of mTOR pathway genes may also contribute to the severe cortical dysplasia seen in these siblings. Additional studies of mTOR pathway genes in germline DNA and DNA from resected brain tissue from sporadic FCD cases will be required to explore this hypothesis.

Acknowledgments

We thank the family for participating in this study. We are grateful for the generous support of the Lefroy and Handbury families. This work has been supported by the Victorian Government’s Operational Infrastructure Support Program and Australian Government NHMRC.
Author Contributions

Dr. Scerri performed bioinformatic analysis, interpreted the data, and wrote the manuscript. Ms. Riseley performed molecular analysis and read/contributed to the manuscript. Ms. Gillies performed sample acquisition, molecular analysis, and read/contributed to the manuscript. Ms. Pope performed patient recruitment, sample acquisition, and read/contributed to the manuscript. Dr. Burgess performed patient recruitment, sample acquisition, and read/contributed to the manuscript. Dr. Mandelstam interpreted brain imaging and read/contributed to the manuscript. Dr. Dibbens performed molecular analysis and read/contributed to the manuscript. Dr. Chow interpreted pathological data, provided histopathological images, and read/contributed to the manuscript. Dr. Maixner provided tissue samples and read/contributed to the manuscript. Dr. Harvey provided clinical data and tissue samples and read/contributed to the manuscript. Dr. Jackson interpreted brain imaging and read/contributed to the manuscript. Dr. Delatycki contributed to the design of the study and read/contributed to the manuscript. Dr. Amor contributed to the design of the study and read/contributed to the manuscript. Dr. Crino performed immunohistochemical analysis and read/contributed to the manuscript. Dr. Berkovic contributed to the conceptualization/design of the study, provided and interpreted the clinical data, and read/contributed to the manuscript. Dr. Scheffer contributed to the conceptualization/design of the study, provided and interpreted the clinical data, and read/contributed to the manuscript. Dr. Bahlo performed bioinformatic analysis, interpreted the data, and read/contributed to the manuscript. Dr. Lockhart contributed to the conceptualization/design of the study, performed molecular and bioinformatic analysis, interpreted the data, and co-wrote the manuscript. Dr. Leventer conceptualized and designed the study, provided and interpreted clinical and imaging data, and co-wrote the manuscript.

Conflict of Interest

Dr. Bahlo reports grants from National Health and Medical Research Council of Australia Program Grant, other from Australian Research Council Fellowship, during the conduct of the study. Dr. Berkovic reports grants from National Health and Medical Research Council, grants from NINDS, during the conduct of the study; grants from UCB Pharma, Novartis Pharmaceuticals, Sanofi-Aventis Jansen Cilag, outside the submitted work. In addition, Dr. Berkovic has a patent for SCN1A testing held by Bionomics Inc and licensed to various diagnostic companies. No financial return. Dr. Berkovic was a consultant to Bionomics and Athena diagnostics over 4 years ago issued, and a patent submitted by University of Melbourne for DEPDC5 testing pending. Dr. Lockhart reports grants from National Health and Medical Research Council, during the conduct of the study. Dr. Scheffer reports grants from NHMRC, grants from NIH, during the conduct of the study; other from Annals of Neurology, other from Epileptic Disorders, other from Neurology, personal fees from UCB, personal fees from Athena Diagnostics, personal fees from Transgenomics, personal fees from GlaxoSmithKline, personal fees from Biocodex, outside the submitted work. In addition, Dr. Scheffer has a patent Diagnostic and Therapeutic Methods for EFM (Epilepsy and Mental Retardation Limited to Females) with royalties paid. All other authors declare no conflicts of interest.

References

8. D’Gama AM, Geng Y, Couto JA, et al. mTOR pathway mutations cause hemimegalencephaly and focal cortical...

Supporting Information

Additional Supporting Information may be found in the online version of this article:

Table S1. List of genes causative or potentially associated with brain malformations derived from extensive literature searches, including key search terms such as “brain malformation,” “cortical dysplasia,” and “cortical malformations.” It includes all currently known genes associated with brain malformations with potential interacting partners and associated pathway genes identified by STRING analysis.
Author/s:
Scerri, T; Riseley, JR; Gillies, G; Pope, K; Burgess, R; Mandelstam, SA; Dibbens, L; Chow, CW; Maixner, W; Harvey, AS; Jackson, GD; Amor, DJ; Delatycki, MB; Crino, PB; Berkovic, SF; Scheffer, IE; Bahlo, M; Lockhart, PJ; Leventer, RJ

Title:
Familial cortical dysplasia type IIA caused by a germline mutation in DEPDC5

Date:
2015-05-01

Citation:

Persistent Link:
http://hdl.handle.net/11343/55017

License:
CC BY-NC-ND