Genetic Heterogeneity for Recessively Inherited Congenital Cataract Microcornea with Corneal Opacity

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PURPOSE. To investigate whether three consanguineous families from the Punjab province of Pakistan, with affected members with recessively inherited congenital cataract microcornea with corneal opacity, are genetically homogeneous.

METHODS. An ophthalmic examination was performed on each family member to establish the diagnosis. The two largest families were analyzed by homozygosity mapping using SNaPshot arrays. Linkage was confirmed using polymorphic microsatellite markers, and logarithm of odds (LOD) scores were calculated. Candidate genes were prioritized using the ENDEavour program.

RESULTS. Autosomal recessive congenital cataract-microcornea with corneal opacity mapped to chromosome 10cen for family MEP57 and to either chromosomes 2pter or 20p for family MEP60. For MEP57, the refined interval was 6.7 Mb from the telomere of chromosome 2 to marker D2S281 or 3.8 Mb interval containing the mutation was either 6.7 Mb from the telomere of chromosome 2 to marker D2S281 or 3.8 Mb flanked by D20S906 (1.5 Mb) and D20S835 (5.3 Mb). Maximum multipoint LOD scores of 3.09, 1.94, and 3.09 were calculated at D10S567, D2S281, and D20S473 for families MEP57 and MEP60. Linkage to these loci was excluded for family MEP68. SLC4A11 was excluded as a candidate gene for the observed phenotype in MEP60.

CONCLUSIONS. The authors have identified two new loci, one on chromosome 10cen and the other on 2pter or 20p, that are associated with recessively inherited congenital cataract-microcornea with corneal opacity. This phenotype is genetically heterogeneous in the Pakistani population. Further genetic studies of this kind, combined with a detailed phenotypic description, will contribute to more precise classification criteria for anterior segment disease. (Invest Ophthalmol Vis Sci. 2011;52:4294–4299) DOI:10.1167/iovs.10-6776

Congenital cataracts are a major cause of childhood blindness in the developing world. 1,2 There are many causes, and approximately one-third have a genetic basis. Most of the inherited forms that have been described are inherited in an autosomal dominant manner, though autosomal recessive and X-linked cases have also been reported. 3 To date, 39 genetic loci have been mapped and 26 genes have been identified. 4 The severity and morphology of congenital cataracts can vary between families even with the same mutation, reflecting differences due to genetic background and environmental factors. Cataracts can exist in isolation, alongside other ocular anomalies, or as part of a syndrome with systemic features. Microcornea is one of the ocular abnormalities that can occur with congenital cataract, highlighting the close interrelationship between the lens and the cornea during development. 5 Corneal opacification is also another feature that can sometimes accompany this developmental abnormality. 6 Genetic heterogeneity of the microcornea-cataract phenotype with dominant inheritance (CCMS; Mendelian Inheritance in Man [MIM] #116150) has already been documented. 7 However, this combination of phenotype with corneal opacity and recessive inheritance has not been reported before. Reports on cataracts have tended to overlook corneal diameters and have instead focused on the sight-threatening cataract. For recessively inherited nonsyndromic congenital cataracts, mutations in seven genes have been implicated, and five other loci have been mapped. These are CRYAA (MIM +123580), 8 CRYBB1 (MIM +600929), 9 10 CRYBB3 (MIM *125630), 11 HSFX (MIM *602438), 12, 13 GAJ1 (MIM +600897), 14 GCNT2 (MIM *600429) 15 and GJA2 (MIM +154045) 16 together with loci at 1p34 (MIM %612958), 17 3p22 (MIM %610019), 18 7q4, 19 9q13 (MIM %605749) 20 and 19q13 (MIM %609376). 21 Congenital corneal opacifications can either be primary, affecting the cornea alone, or they can be secondary, associated with anterior segment abnormalities. 8 Secondary corneal opacities without nonocular manifestations are often diagnosed as Peters’ anomaly and represent kerato-irido-lenticular dysgenesis as well as developmental anomalies of the iridotrabecular system. Some of these cases can be caused by mechanical damage or infectious agents, whereas others have a genetic origin.
basis. For example, dominant mutations in FOXE3 (MIM *601094) have been described in patients with Peters’ anomaly who have corneal opacity associated with cataract.22,23 Note that recessive FOXE3 gene mutations give rise to a severe ocular phenotype, with patients having primary congenital aphakia and total sclerocornea.24,25 Other examples of the genetic basis of Peters’ anomaly include recessive mutations in CYP1B1 (MIM *601771), known to cause primary congenital glaucoma,26,27 and dominant mutations in PAX6 (MIM *607108), known to be a cause of aniridia.28,29

Here we present three consanguineous families from the Punjab province of Pakistan who have affected members with a general diagnosis of nonsyndromic congenital microcornea with corneal opacity, which we have abbreviated to CCMCO. These are shown to be genetically heterogeneous, implicating two novel loci for this condition and proving the existence of yet further loci.

**Patients and Methods**

**Patients**

The study was performed using a process approved by the Pakistan Medical Foundation in Lahore and the Leeds Research Ethics Committee. Participants gave their informed consent, in accordance with the tenets of the Declaration of Helsinki. Three multigenerational consanguineous pedigrees with a family history of poor vision were examined (Fig. 1, Table 1). All affected members had variable corneal opacities present from birth or very early in life, and each family history suggested that these changes were not progressive. They also had horizontal corneal diameters of <11 mm. Where a clinical view was possible, it showed cataract of the lens and a normal fundus appearance. The patients did not have any systemic problems or neurologic abnormalities. These patients fit broadly into a diagnosis of CCMCO. A
blood sample was taken from both affected and unaffected family members, and genomic DNA was extracted according to standard procedures.

**Homozygosity Mapping**

DNA from affected persons in the two largest families, MEP57 and MEP60, were genotyped using single nucleotide polymorphism array (SNP; Affymetrix 6.0; AROS Applied Biotechnologies, Aarhus, Denmark). Regions of homozygosity were highlighted using identification software.30

**Linkage Analysis**

Linkage was confirmed by analysis with fluorescence-labeled polymorphic microsatellite markers on a genetic analyzer (3130xl Genetic Analyzer; Applied Biosystems, Warrington, UK) using genotyping software (GeneMapper version 4.0; Applied Biosystems). LOD scores were calculated using multipoint analysis with the program SUPERLINK (http://Bioinfo.cs.technion.ac.il/superlink-online/) assuming equal allele frequencies, a mutant allele frequency of 0.001, and 100% penetrance. As a group, however, the anterior chambers were of near normal depth with no central keratolenticular touch or any obvious anterior capsular abnormality. These findings were consistent with a diagnosis of CCMCO, this being a description of the predominant features.

The absence of any obvious anterior segment abnormalities in the parents of the affected patients, the evident consanguinity, and the presence of multiple affected siblings within a family suggested a recessive pattern of inheritance. Therefore, we carried out whole genome SNP genotyping on genomic DNA from affected members of the two largest pedigrees, MEP57 and MEP60, to highlight regions of homozygosity. In MEP57, a single region of homozygosity was identified, but for MEP60, two regions were found. These regions were confirmed by linkage analysis using microsatellite markers.

For family MEP57, a shared homozygous region at chromosome 10 was identified in patients that segregated with the disease phenotype, as expected, in a recessive manner (Fig. 2). A maximum LOD score of 3.09 was established for the marker D10S567. The refined locus extends from D10S1208 (35.3 Mb) to D10S676 (72.1 Mb) and encompasses a 36.8-Mb (26.7-cM) interval that includes the centromere and contains 160 genes (Supplementary Fig. S1, http://www.iovs.orglookup/suppl/doi:10.1167/iovs.10-6776/-/DCSupplemental).

These genes were prioritized using ENDEAVOUR (Supplementary Table S1, http://www.iovs.orglookup/suppl/doi:10.1167/iovs.10-6776/-/DCSupplemental). The three top-ranked genes were EGR2 (MIM *129010), RET (MIM +164761), and NEUROG3 (MIM *604882). EGR2 is a zinc finger transcription factor from the early growth response family important for the induction of cell differentiation, cell proliferation, and cell death in response to environmental stimuli. EGR2 has been shown to be expressed in neural crest–derived Schwann cells that accompany peripheral nerves, and the presence of these cells has been demonstrated at the corneal limbus.34 Defects in this gene are associated with various neuropathies.35 RET is a member of the cadherin superfamily that encodes a receptor tyrosine kinase for transducing signals for cell growth and differentiation. RET plays a crucial role in neural crest development, and mutations in this gene are associated with multiple endocrine neoplasia type II that can have a corneal phenotype.36 NEUROG3 is a basic helix-loop-helix transcription factor that is expressed in the central and peripheral nervous system. NEUROG3 has been shown to regulate retinal neurogenesis by inducing genes for early-born neurons while repressing those for later-born neurons.37 Defects in this gene are a cause of congenital malabsorptive diarrhea.38

For family MEP60, shared homozygous regions were identified on chromosomes 2pter and 20p in the affected persons (Fig. 3). Maximum LOD scores of 1.94 and 3.09 were established for markers D2S281 and D20S835 (5.3 Mb) and containing 55 genes (Supplementary Fig. S2B, http://www.iovs.orglookup/suppl/doi:10.1167/iovs.10-6776/-/DCSupplemental), including the SLCA411 gene (MIM *610206) at 3.2 Mb. SLCA411 mutations have been described in patients with the anterior segment abnormality CHERD2 (corneal hereditary endothelial dystrophy 2) (MIM *217700), which affects the cornea alone.39 DNA analysis of the coding sequence of the SLCA411 gene in affected members of the MEP60 pedigree failed to identify a pathogenic mutation, suggesting that another gene is likely to harbor the defect seen in this family.

These candidate genes from both regions were combined and prioritized using ENDEAVOUR (Supplementary Table S2, http://www.iovs.orglookup/suppl/doi:10.1167/iovs.10-6776/-/DCSupplemental). The three top-ranked genes were...
SOX11 (MIM *600898), MYT1L (MIM *613084), and PRNP (MIM *176640). SOX11 is an SRY-related HMG-box transcription factor that is abundantly expressed in the embryonic central and peripheral nervous system. Other Sox family members are important in lens development.39 MYT1L encodes a neural-specific, zinc finger-containing transcription factor that plays a role in embryonic stem cell differentiation into functional neurons.40 PRNP encodes the prion protein, a membrane glycosylphosphatidylinositol-anchored glycoprotein that tends to aggregate into rodlike structures. Mutations in this gene have been associated with Creutzfeldt-Jakob disease, fatal familial insomnia, Gerstmann-Straussler disease, Huntington disease, and kuru. No specific ocular expression has been described, making this less likely to be involved in anterior segment embryogenesis.

The recessively inherited CCMCO phenotype observed in a third Pakistani family, MEP68, was excluded from the loci on chromosomes 1cen, 2ptel, and 20p, with significant negative LOD scores across all the regions, suggesting that there is at least one other locus to be identified for this condition (Fig. 4).

DISCUSSION

We studied consanguineous families from the Punjab province of Pakistan segregating a recessive form of kerato-irido-lenticular dysgenesis, which we have called congenital cataract microcornea with corneal opacification, or CCMCO. We expected that these families, having the same condition and being of the same ethnic and geographic origins, might have a mutation or mutations in the same gene, but instead we found considerable genetic heterogeneity associated with this phenotype. We describe new genetic loci implicated in this phenotype on chromosomes 1cen and either 2ptel or 20p. Candidate gene screening is underway to try to identify the pathogenic mutations. We also excluded linkage at these loci in a third family, suggesting further locus heterogeneity. As a consequence of this study, we can now offer accurate genetic counseling to the MEP57 family. Given that the detection of carriers is now possible and that consanguineous marriages are the cultural norm in these communities, we could, if the family
desired, provide guidance on reducing the risk for more blind offspring in subsequent generations.

In terms of providing a clinical diagnosis, corneal opacification can sometimes prevent an accurate assessment of the underlying anterior segment structures (e.g., MEP57). This can usually be circumvented with the use of ultrasound biomicroscopy or optical coherence tomography. However, such techniques were not available in the rural setting in which these families lived, therefore considerable care was taken in describing the visible abnormalities as accurately as possible while accepting that some clinical details could not be commented on. An accurate clinical diagnosis is important for any subsequent genotype-phenotype correlations but may also have clinical implications. For instance, congenital cataracts associated with other forms of anterior segment dysgenesis may also have clinical implications. For instance, congenital cataracts associated with other forms of anterior segment dysgenesis carry an increased risk for glaucoma.34

By studying recessively inherited CCMCO, we hope to identify important proteins essential for normal function or structural development of the eye. It is not surprising that mutations in genes that lead to cataract formation can also lead to abnormalities of the anterior segment, since the development of the lens and the anterior segment structures are closely independent. The lens forms from surface ectoderm that invaginates to produce the lens vesicle, whereas the anterior segment structures are produced primarily from neural crest–derived cells, with the mesoderm and neuroectoderm also involved.11,12 However, lens transplantation studies have suggested that factors secreted by the anterior lens induce differentiation of the cornea and iris.13,14 Corneal opacity in the patients described in this article either could be secondary to a cataractous, but otherwise normally sized and shaped, lens or it could represent a primary phenotype independent of the lens cataract given that many severe cataracts are not associated with corneal abnormalities. Further studies of this condition will not only expand our knowledge of ocular disease pathogenesis but will also contribute to a more accurate classification of anterior segment conditions based on genotype-phenotype correlations.

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References


