Response to growth hormone in patients with RNPC3 mutations

Martos-Moreno, Gabriel A.

2018-07


http://hdl.handle.net/10138/238269
https://doi.org/10.15252/emmm.201809143

Downloaded from Helda, University of Helsinki institutional repository.
This is an electronic reprint of the original article.
This reprint may differ from the original in pagination and typographic detail.
Please cite the original version.
Response to growth hormone in patients with RNPC3 mutations

Gabriel Á Martos-Moreno1,2,3,4, Lourdes Travieso-Suárez1,2,3, Jesus Pozo-Román1,2,3,4, María T Muñoz-Calvo1,2,3,4, Julie A Chowen1,2,3,4,5, Mikko J Frilander6, Luis A Pérez-Jurado7,8,9, Federico G Hawkins10 & Jesús Argente1,2,3,4,5,*

Background


We describe the effects of rhGH therapy on growth, body composition, bone mineral density (BMD), and bone microarchitecture in the first three patients identified with this condition.

Subjects and methods

Written informed consent was obtained from all subjects and their parents for all studies and their publication. Studies conformed to the principles set out in the WMA Declaration of Helsinki and the Department of Health and Human Services Belmont Report.

Three sisters were born to non-consanguineous average-height [target: 155.6 (−0.99 SDS)] Romanian parents. The father is a heterozygous carrier of a nonsense mutation (c.1504C>T, p.R502X), and the mother and only unaffected daughter are heterozygous for a missense mutation in RNPC3 (c.1320C>A, p.P474T). The three affected girls, compound heterozygous for both mutations, were born at term with normal length and weight, developing severe postnatal growth failure, typical phenotypic features of GHD, and delayed bone age (BA; Table 1 and Fig 1). They were referred to our clinic at 15.5, 8.1, and 6.0 years of age with extremely short stature (Table 1), undetectable serum IGF-1, IGFBP-3 and GH after stimuli (insulin and clonidine), and no clinical or hormonal signs of associated pituitary hormone deficiencies. Anterior pituitary hypoplasia was found in MRI.

Daily subcutaneous rhGH (0.025–0.035 mg/kg/day) was prescribed, with regular clinical, laboratory, and BA (Greulich & Pyle) evaluations.

Lumbar spine BMD (LS-BMD) and body fat percentage were measured using dual-energy X-ray absorptiometry (DXA Discovery Wi, software version 13.3; Hologic, Inc., Waltham, MA, USA) before and 6 months, 1, and 6.5 years after rhGH therapy onset (coefficient of variation 0.70). Data for BMD were adjusted by height-for-age Z-score (Zemel et al, 2010).

Trabecular bone structure (TBS) was calculated from the same DXA acquisition used for LS-BMD (TBS iNsight software, v3.0; Medimaps, France). In children, there is no international consensus of what constitutes a normal or abnormal TBS. In adults, TBS ≥ 1,350 is proposed to be normal, values between 1,200 and 1,350 are consistent with partially degraded bone, and TBS ≤ 1,200 indicates degraded bone (Silva et al, 2014).

Results

Growth, puberty, and biochemical evolution

Patient 1

At age 15.5 years, she was 125.5 cm (−5.9 SDS) with proportional short stature, evident central adiposity, typical facial features of GHD (Fig 1A), no signs of pubertal development (Tanner stage I), and retarded skeletal maturation (3.5 years below chronological age). On rhGH therapy, growth increased drastically, particularly during the first 2 years (growth velocity (GV) 12.8 and

---

1 Department of Endocrinology, Hospital Infantil Universitario Niño Jesús, Madrid, Spain, E-mails: jesuss.argente@uam.es and jesuss.argente@fundacionendo.org
2 Instituto de Investigación La Princesa, Madrid, Spain
3 Department of Pediatrics, Universidad Autónoma de Madrid, Madrid, Spain
4 Instituto de Salud Carlos III, CIBER of Fisiopatología de la Obesidad y Nutrición (CIBEROBN), Madrid, Spain
5 IMDEA Food Institute, CEIUAM+CSIC, Madrid, Spain
6 Institute of Biotechnology, University of Helsinki, Helsinki, Finland
7 Genetics Unit, Universitat Pompeu Fabra, Barcelona, Spain
8 Instituto de Salud Carlos III, Hospital del Mar Research Institute (MIM) and Centro de Investigación Biomédica en Red de Enfermedades Raras (CIBERER), Barcelona, Spain
9 SA Clinical Genetics, Women’s and Children’s Hospital & University of Adelaide, Adelaide, SA, Australia
10 Diabetes and Bone Research Center, Institute i + 12, Complutense University and Hospital 12 de Octubre, Madrid, Spain

DOI 10.15252/emmm.201809143 | EMBO Mol Med (2018) 10: e9143 | Published online 4 June 2018
Table 1. Anthropometric data at baseline and after rhGH therapy onset.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Chronological age (bone age)</th>
<th>Height (SDS)</th>
<th>Growth velocity (SDS)</th>
<th>DXA (baseline)</th>
<th>DXA2</th>
<th>DXA3</th>
<th>DXA4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td></td>
<td></td>
<td></td>
<td>Weight (kg)</td>
<td>BMI (kg/m²)</td>
<td>BMD (g/cm²)</td>
<td>BMD (Z-score)</td>
</tr>
<tr>
<td>Baseline</td>
<td>15.5 (12.0)</td>
<td>125.5 (−5.9)</td>
<td>—</td>
<td>36.7</td>
<td>36.8</td>
<td>35.9</td>
<td>61.3</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; year</td>
<td>16.5 (13.0)</td>
<td>137.8 (−4.2)</td>
<td>12.8 (+31.0)</td>
<td>23.3</td>
<td>20.75</td>
<td>20.91</td>
<td>27.1</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; year</td>
<td>175 (14.0)</td>
<td>143.8 (−31)</td>
<td>6.0 (+21.0)</td>
<td>0.6440</td>
<td>0.733</td>
<td>0.781</td>
<td>1.050</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; year</td>
<td>185 (14.0)</td>
<td>146.4 (−2.6)</td>
<td>2.6 (+14.4)</td>
<td>−3.7</td>
<td>−2.7</td>
<td>−2.2</td>
<td>0.4</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; year</td>
<td>195</td>
<td>148.8 (−2.2)</td>
<td>23 (+12.5)</td>
<td>TBS 1,270</td>
<td>1,280</td>
<td>1,400</td>
<td>N.A.</td>
</tr>
<tr>
<td>Patient 2</td>
<td></td>
<td></td>
<td></td>
<td>Weight (kg)</td>
<td>BMI (kg/m²)</td>
<td>BMD (g/cm²)</td>
<td>BMD (Z-score)</td>
</tr>
<tr>
<td>Baseline</td>
<td>8.1 (6.5)</td>
<td>100.4 (−5.0)</td>
<td>—</td>
<td>175</td>
<td>18.5</td>
<td>20.2</td>
<td>50.4</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; year</td>
<td>9.0 (7.5)</td>
<td>114.0 (−32)</td>
<td>14.2 (+11.4)</td>
<td>17.4</td>
<td>15.75</td>
<td>14.76</td>
<td>20.81</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; year</td>
<td>10.0 (9.0)</td>
<td>125.1 (−2.0)</td>
<td>11.1 (+5.5)</td>
<td>0.478</td>
<td>0.515</td>
<td>0.523</td>
<td>0.825</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; year</td>
<td>11.1 (10.5)</td>
<td>133.2 (−1.5)</td>
<td>8.2 (+1.4)</td>
<td>−1.3</td>
<td>−0.7</td>
<td>−1.0</td>
<td>−1.0</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; year</td>
<td>12.0 (11.3)</td>
<td>138.5 (−1.6)</td>
<td>5.7 (−1.2)</td>
<td>TBS 1,260</td>
<td>1,270</td>
<td>1,360</td>
<td>N.A.</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; year</td>
<td>13.0 (12.5)</td>
<td>146.2 (−1.2)</td>
<td>7.8 (+2.8)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>6 year &amp; 6 month</td>
<td>145 (13.5)</td>
<td>152.9 (−0.7)</td>
<td>5.0 (−1.2)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Patient 3</td>
<td></td>
<td></td>
<td></td>
<td>Weight (kg)</td>
<td>BMI (kg/m²)</td>
<td>BMD (g/cm²)</td>
<td>BMD (Z-score)</td>
</tr>
<tr>
<td>Baseline</td>
<td>6.0 (3.5)</td>
<td>84.5 (−6.7)</td>
<td>—</td>
<td>9.8</td>
<td>11.5</td>
<td>12.7</td>
<td>36</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; year</td>
<td>7.0 (5.0)</td>
<td>98.5 (−4.4)</td>
<td>14.6 (+9.3)</td>
<td>13.7</td>
<td>15.77</td>
<td>14.76</td>
<td>18.90</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; year</td>
<td>8.0 (6.5)</td>
<td>106.9 (−3.6)</td>
<td>8.4 (+3.7)</td>
<td>0.397</td>
<td>0.446</td>
<td>0.470</td>
<td>0.678</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; year</td>
<td>9.0 (7.5)</td>
<td>114.2 (−3.2)</td>
<td>7.4 (+1.1)</td>
<td>−2.2</td>
<td>−1.4</td>
<td>−1.0</td>
<td>−1.1</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; year</td>
<td>10.0 (8.8)</td>
<td>119.3 (−2.9)</td>
<td>5.4 (+0.5)</td>
<td>TBS 1,260</td>
<td>1,270</td>
<td>1,360</td>
<td>N.A.</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; year</td>
<td>10.9 (10.0)</td>
<td>126.4 (−2.5)</td>
<td>7.1 (−1.3)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>6 year &amp; 6 month</td>
<td>123 (11.3)</td>
<td>137.5 (−1.9)</td>
<td>7.4 (+0.5)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

SDS, standard deviation score. Bone mineral density (BMD) and trabecular bone structure (TBS) in DXA (dual-energy absorptiometry analysis) in the three patients before (baseline) and after 6 months (DXA2), 1 year (DXA3), and 6.5 years (DXA4) of rhGH therapy onset (patient 1 received 4.5 years of treatment, and patients 2 and 3 remain on treatment). All of the DXA data refer to lumbar spine (L1−L4) (N.A., not available).
stature and considering that therapy was started after age 15 in the eldest. The improvement in height SDS after 4.5 (for the eldest) to 6.5 years on rhGH was between 4.0 and 4.9 SDS, with the two younger siblings continuing to grow. This change in height SDS is higher than the average response to rhGH in patients with isolated GHD (Darendelier et al., 2011 and Argente et al., 2014), but similar when compared with severe isolated GHD (Ranke & Lindberg, 2010 and Argente et al., 2014). This effect was maximum in patient 3, probably because rhGH was started at a younger age and her baseline height was more severely compromised (Ranke & Lindberg, 2010).

However, the eldest sister increased her height in 24.8 cm despite her advanced chronological (15.5) and bone age (12 years) at therapy onset, with growth progressing even after menarche, achieving a 21.4-cm pubertal growth spurt. However, this late onset of treatment might have compromised her adult height (~0.9 SDS below target height), which is below that expected for her siblings with their height centile close (patient 3) or above (patient 2) their target and still growing on therapy.

The improvements in BMD and TBS during the first year on therapy indicate that the GH-induced rise in IGF-I is fundamental for improving bone development, as we recently reported in patients with PAPP-A2 deficiency (Hawkins-Carranza et al., 2018). Follow-up of the two younger sisters is required to determine whether BMD and TBS completely normalize and to investigate an eventual relationship between RNPC3 mutations and possible impairment of the GnRH axis as suggested by the pubertal and menstrual evolution in patients 1 and 2.

The extremely positive response to exogenous GH treatment suggests that the required receptors and downstream signaling molecules are intact. Indeed, these patients showed almost undetectable GH levels after standard stimuli and basal IGF-I, IGFBP-3, and ALS levels suggesting that the lack of pituitary GH secretion is the underlying cause for their growth failure. Moreover, their lack of antibody production in response to this treatment further indicates an intact GH1 gene. The data and the pituitary hypoplasia observed in these patients highly suggest that the minor spliceosome plays a crucial role in the processing of genes required for somatotroph development and GH synthesis.

The positive family history of hypercholesterolemia and lack of improvement during rhGH replacement (even when the lipolytic effect of rhGH was highly evident) suggest that this finding is most likely independent from GHD.

In summary, despite the fact that the underlying mechanism by which the RNPC3 mutations result in GHD is not completely understood, rhGH dramatically increased growth in three girls with severe isolated GH deficiency due to a defective minor spliceosome mRNA processing, determining a significant improvement in BMD, microarchitecture of the bone, and body composition.

Figure 1. Growth charts of the three sisters after GH therapy. Facial appearance at baseline and growth charts of patients 1 (A), 2 (B), and 3 (C). Blue circles represent height for chronological age, whereas yellow triangles represent height for bone age. BA, bone age; CA, chronological age; GH, start of recombinant growth hormone treatment; TH, target height. Faces of the patients reproduced with permission. (D) Changes in body fat content and distribution showing the lipolytic effect of recombinant human growth hormone treatment in patient 1 after 6 and 12 months of therapy from baseline. Reproduced with permission.
Acknowledgements
JA was funded by the Spanish Ministry of Health (FIS-PI13/02195 & PI16/00485, co-funded by FEDER), Centro de Investigación Biomédica en Red for obesity and nutrition (CIBEROBN) from Instituto de Salud Carlos III, Spain, and the Fundación de Endocrinología y Nutrición. LAPJ was funded by the Spanish Ministry of Health (FIS-PI1302481, co-funded by FEDER), the Generalitat de Catalunya (2014SRG1468), the Institució Catalana de Recerca i Estudis Avançats (ICREA Academia Program), Centro de Investigación Biomédica en Red for rare diseases (CIBERER) from Instituto de Salud Carlos III, Spain, and the Spanish Ministry of Economy and Competiveness “Programa de Excelencia María de Maeztu” (MDM-2014-0370).

Conflict of interest
The authors declare that they have no conflict of interest.

For more information
Publicly available 1,000 genomes (www.1000genomes.org) and 6,503 samples from exome variant server (www.gs.washington.edu/evs); and U12 database (U12DB, http://genome.crg.es/datasets/u12).

References

License: This is an open access article under the terms of the Creative Commons Attribution 4.0 License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.