

GENETICS OF CHILDHOOD-ONSET DIABETES

Molecular Diagnostics Symposium 2021

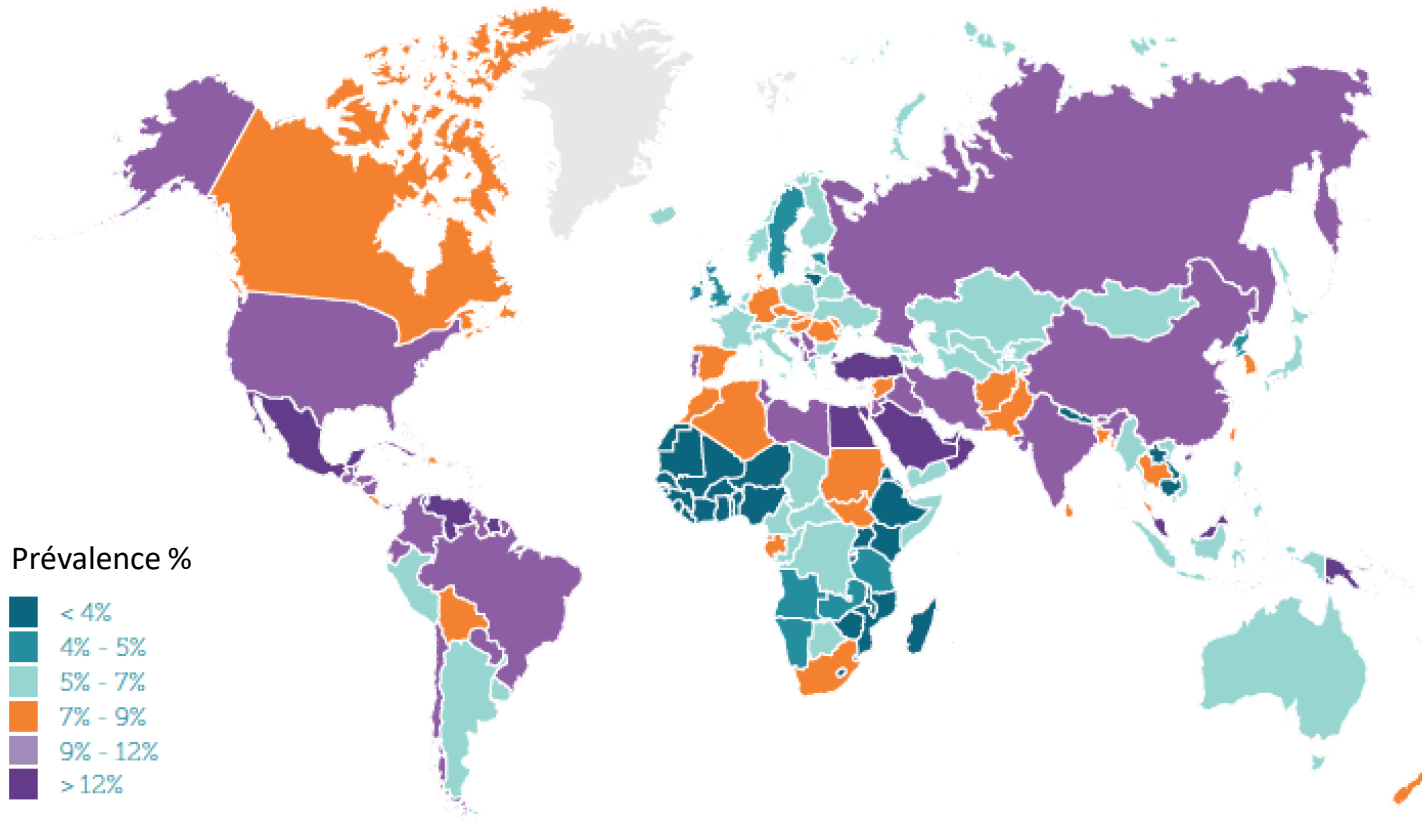
University of Zurich
May 31st, 2021

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DIABETES

DEFINITIONS - PREVALENCE

Not a rare disease !
425 Millions of people worldwide with diabetes in 2017
625 Millions in 2045



Définitions

Diabetes

Glycemia ≥ 7 mmol/l fasting

Glycémie 2h after meal ≥ 11.1 mmol/l

HbA1c (glycated haemoglobin=[glucose]blood) $\geq 6.5\%$

Pre-Diabetes

Glycemia fasting ≥ 5.6 - 6.9 mmol/l,

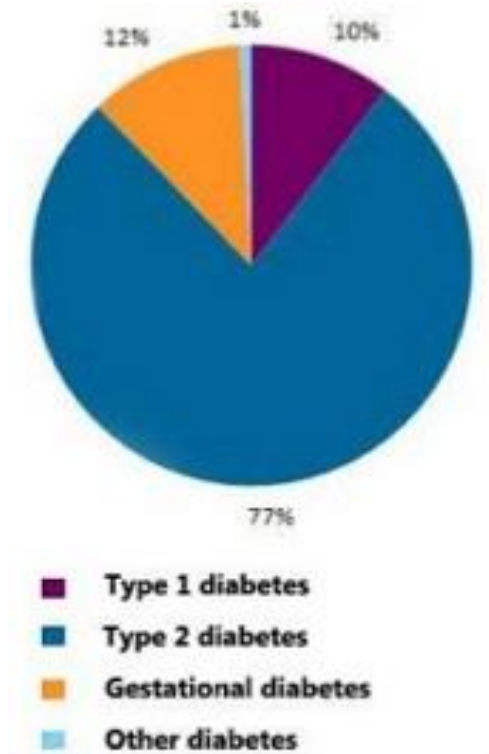
Glycémie 2h after meal at 7.8-11 mmol/l

HbA1c = 5.7-6.4%,

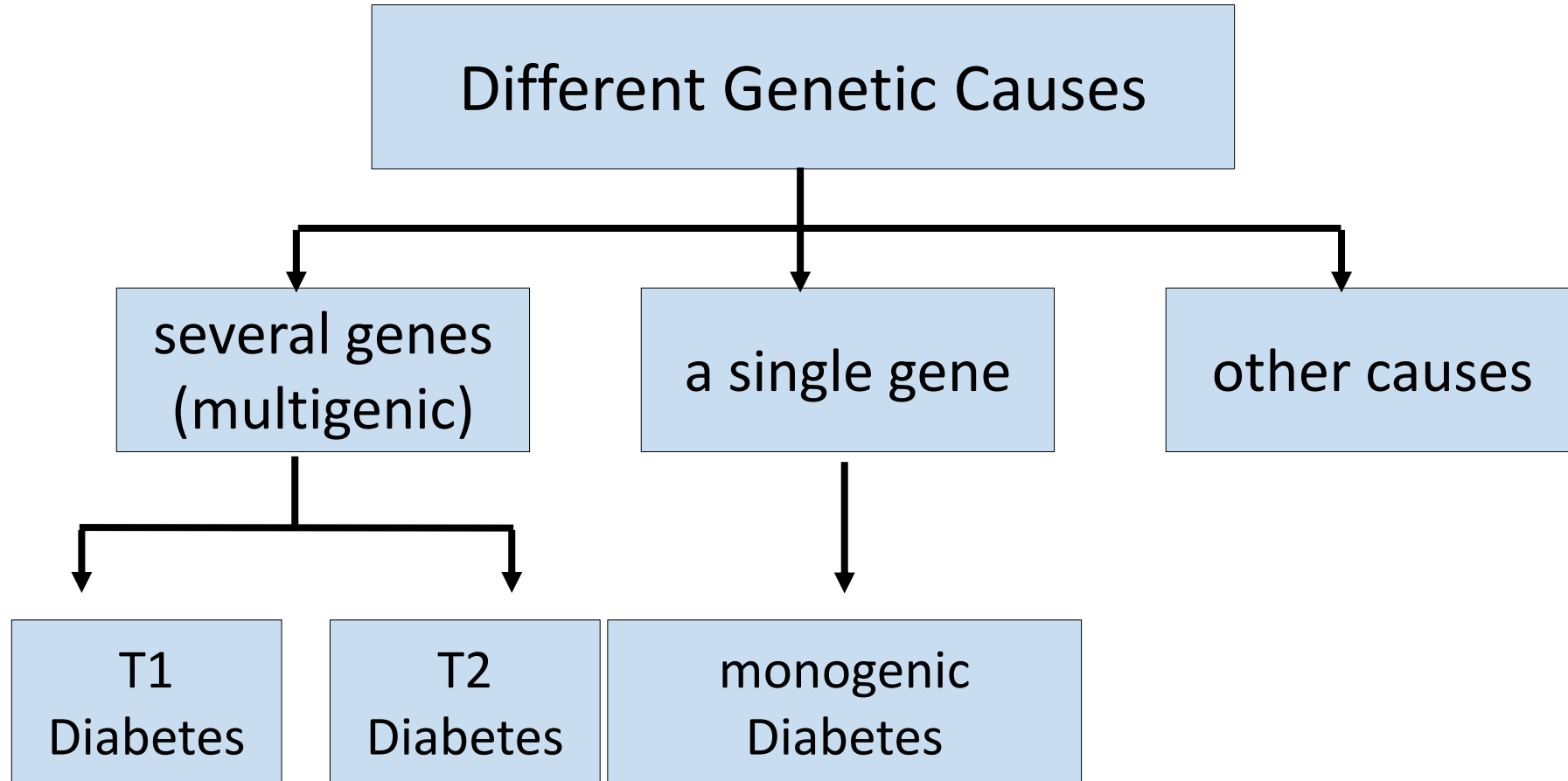
DIABETES TYPES

In general, a disease showing an abnormal elevated rate of glucose in blood.

1	Type 1 (T1D) <i>(insulin-dependent)</i>	<ul style="list-style-type: none"> • Destruction of beta cells • Absolute insulin deficiency
2	Type 2 (T2D) <i>(insulin-resistant)</i>	<ul style="list-style-type: none"> • Progressive deficit of adequate insulin secretion • Insulin resistance
3	Gestational <i>(2^{ème} ou 3^{ème} trimestre)</i>	<ul style="list-style-type: none"> • Miscellaneous causes
4	Specific diabetes of other origins	<ul style="list-style-type: none"> • Monogenic diabetes syndromes (eg, neonatal diabetes, maturity onset diabetes of the young, MODY) • Diseases of the exocrine pancreas (e.g. Cystic Fibrosis) • Toxins or drugs (e.g. cyclosporine, glucocorticoids, HIV/AIDS, transplantation)



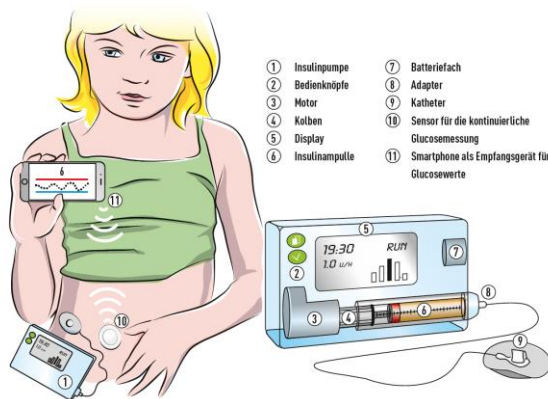
DIABETES AETIOLOGY



GENE DICTATES TREATMENT

«the right treatment in the right patient»

Type 1



Monogenic

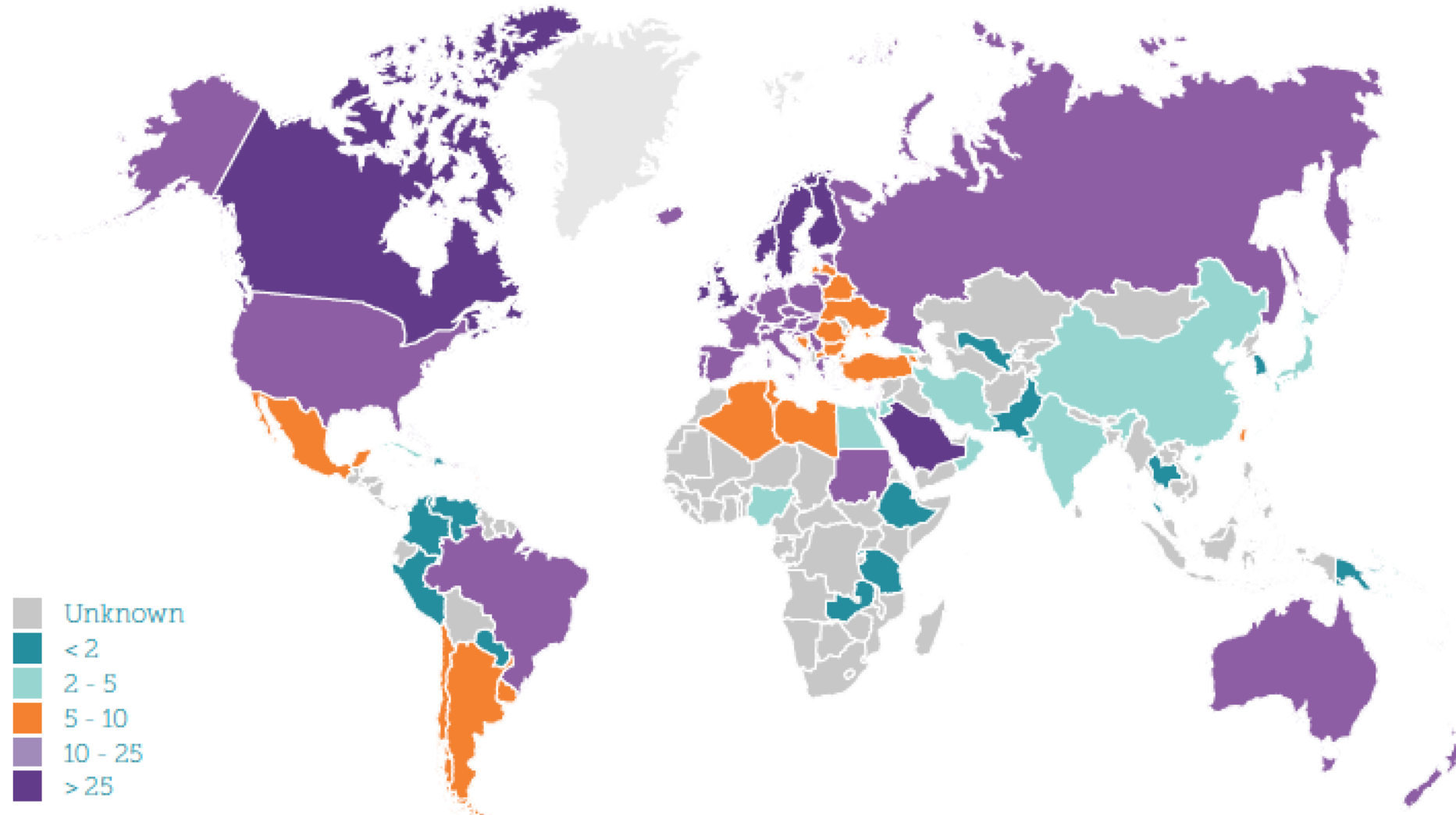


- No therapy required
- or
- Tablets
- or
- Sometimes insulin

Type 2



WORLDWIDE INCIDENCE OF TYPE 1 DIABETES

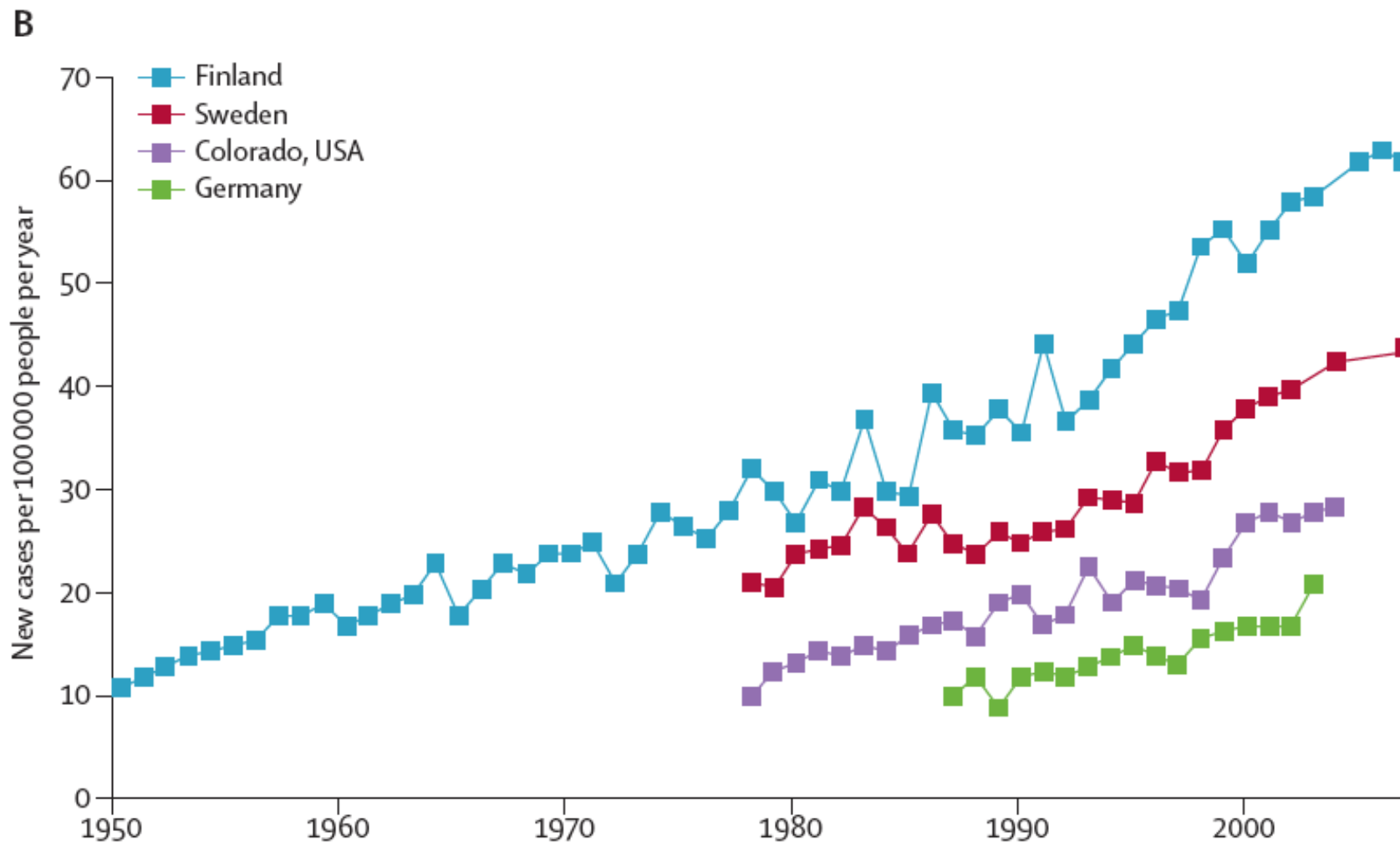


Incidence per 100'000 children/year

IDF 2015

EVOLUTION OF INCIDENCE OF TYPE 1 DIABETES

Constant increase of T1D
(since 1950)



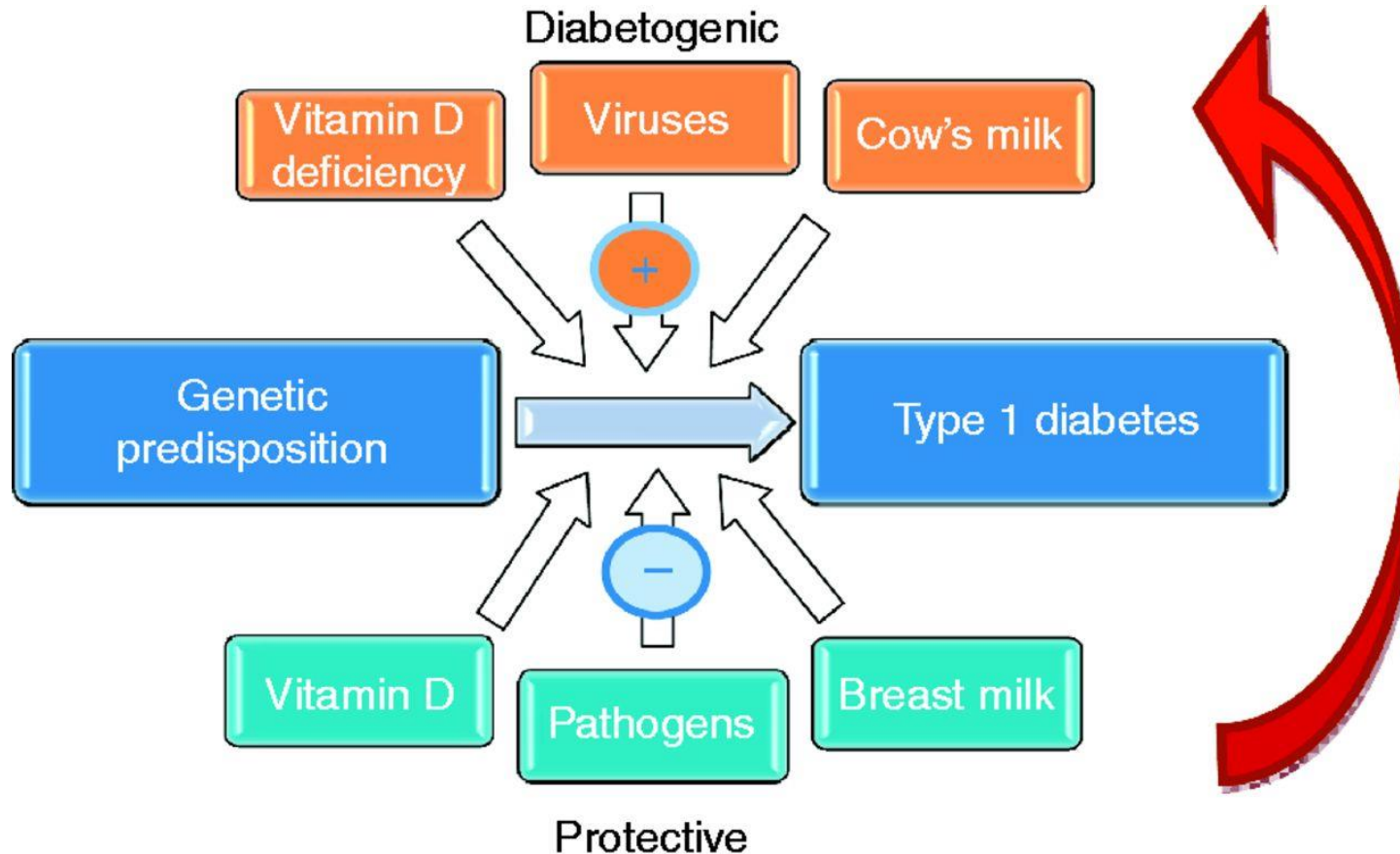
CAUSES OF TYPE 1 DIABETES

Increased incidence: Thought to be due to environmental factors ?

-hygiene, perhaps less exposure to infectious agents during childhood

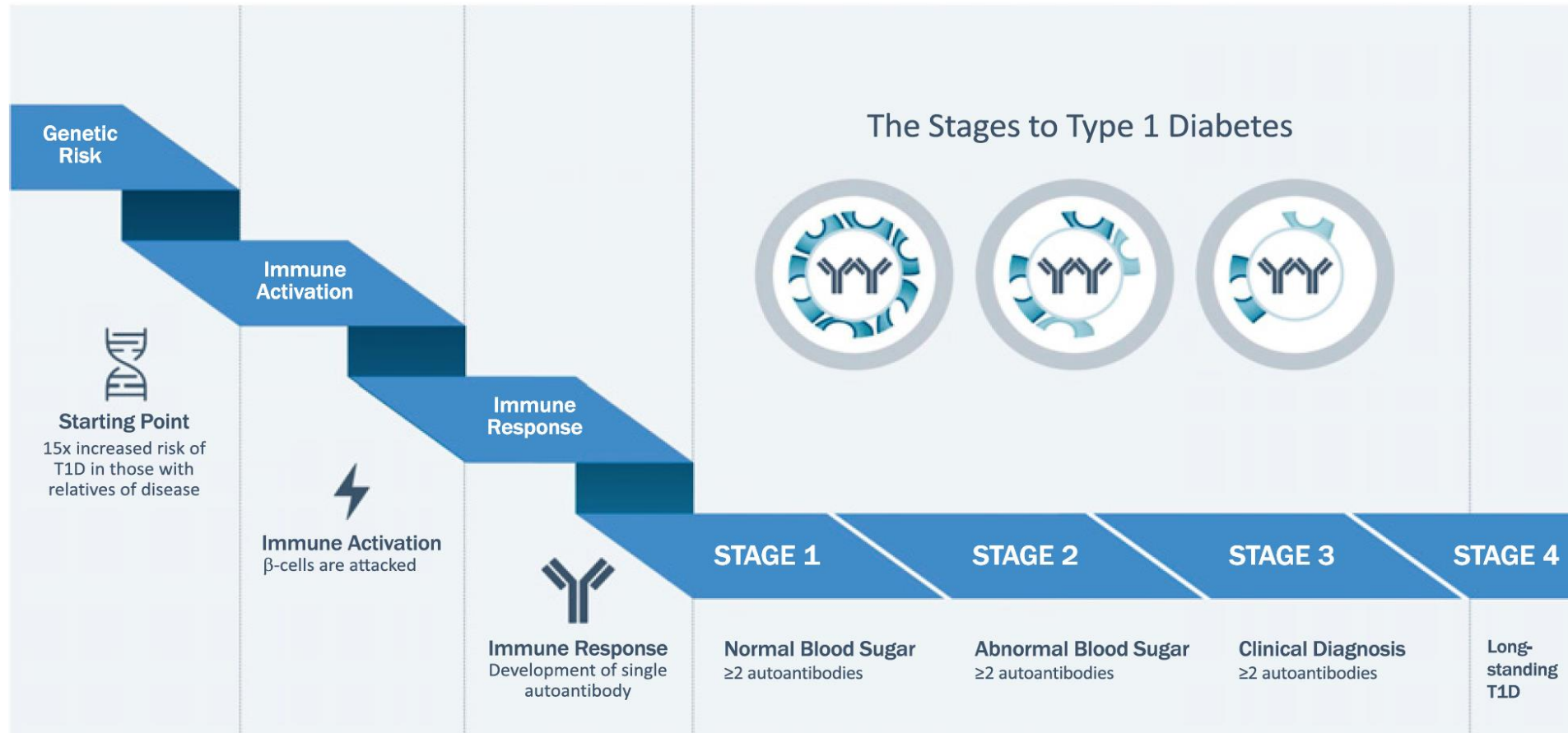
-cow's milk: decrease breast feeding

-...

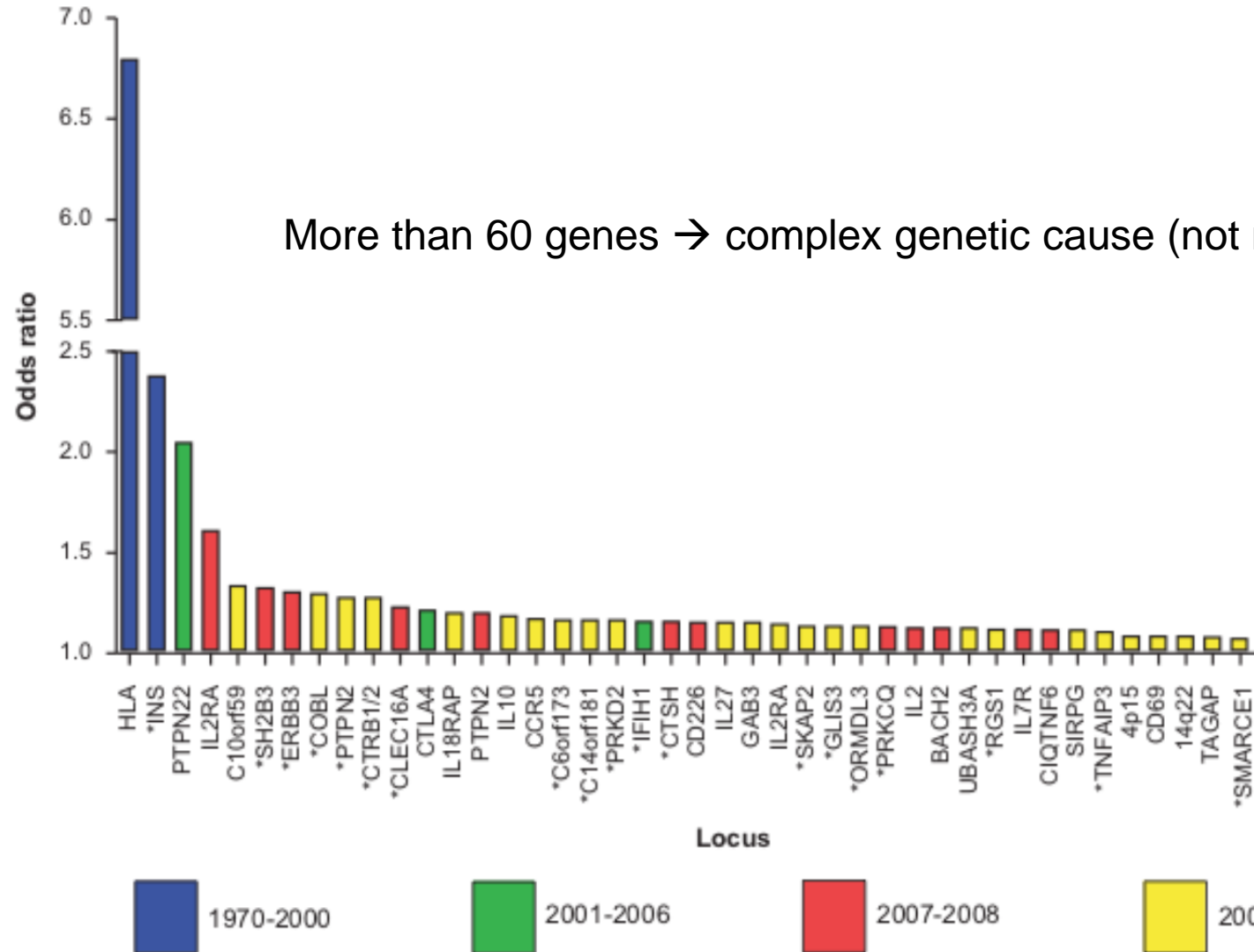


STAGES OF TYPE 1 DIABETES

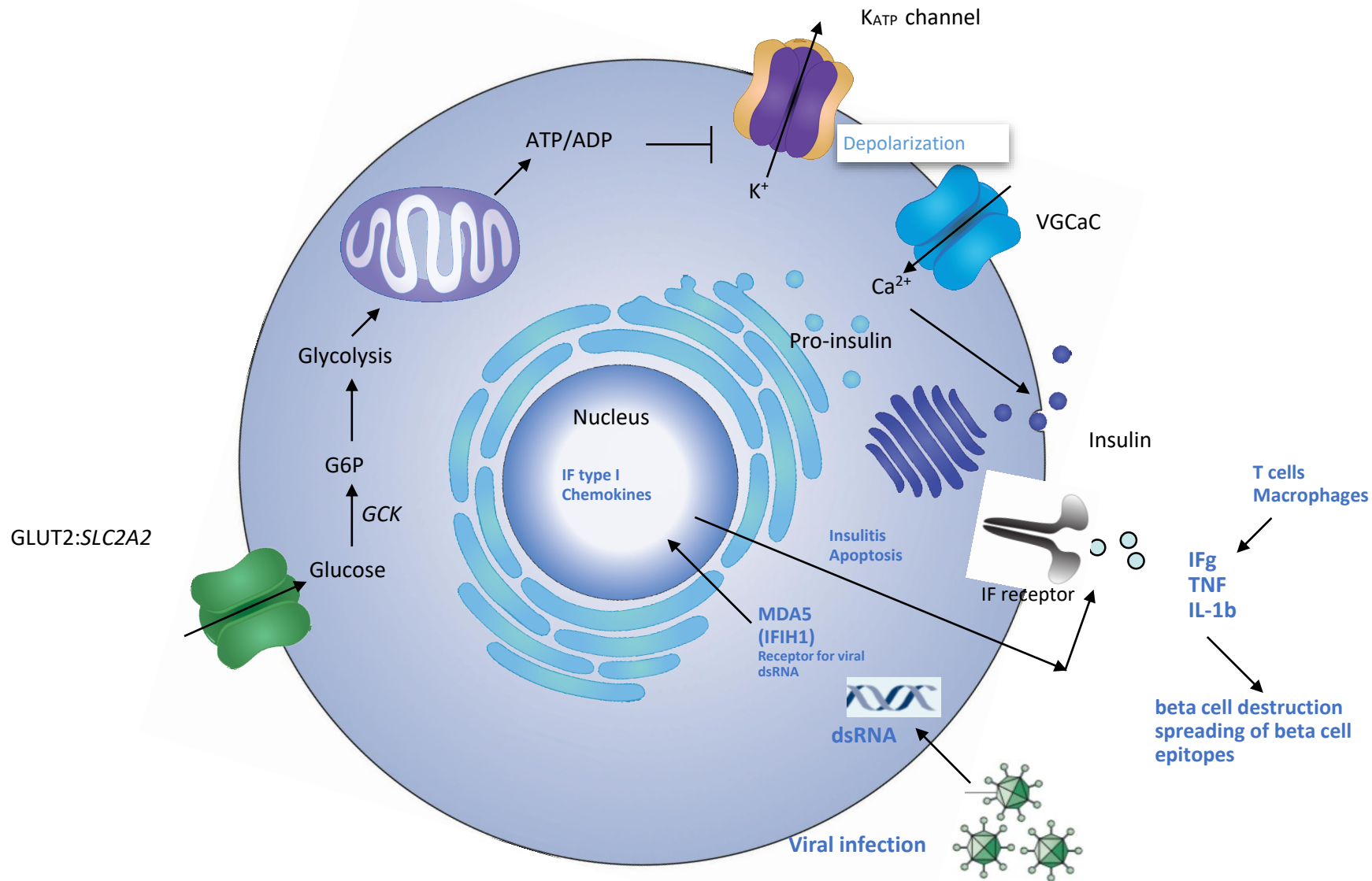
- Study with people at high risk for diabetes (stage 2)



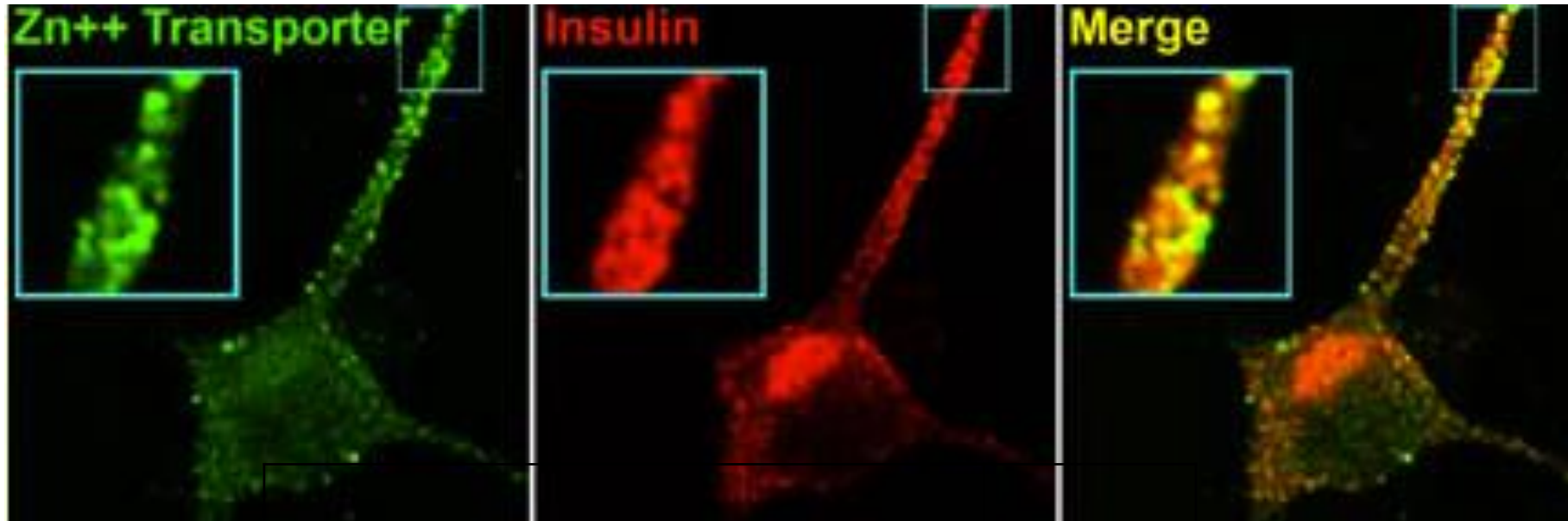
T1D PREDISPOSING GENES



VIRAL INFECTION HYPOTHESIS



AUTOIMMUNE ANTIBODIES: MARKERS LOSS



Anti-glutamate decarboxylase 65	GAD
Anti-IA2 (tyrosine phosphatase)	IA-2
Anti-insuline	IAA
Anti-îlots	ICA
Transporteur de Zinc	ZnT8

Achenbach et al., Diabetologia 2009

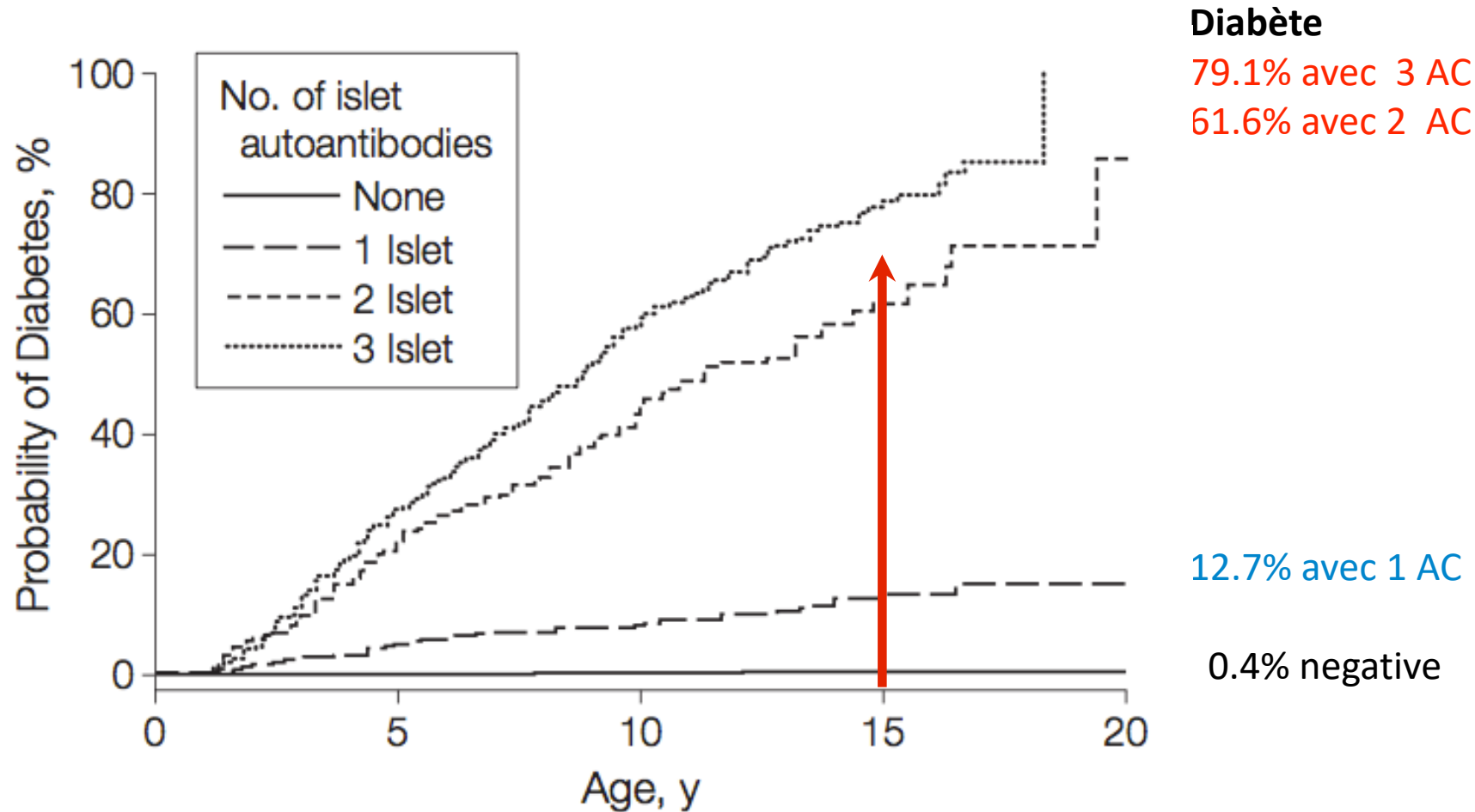
Tsirogianni et al., Autoimmunity Reviews 2009

Solimena et al, EMBO 1996

Wenzlau et al., PNAS 2007

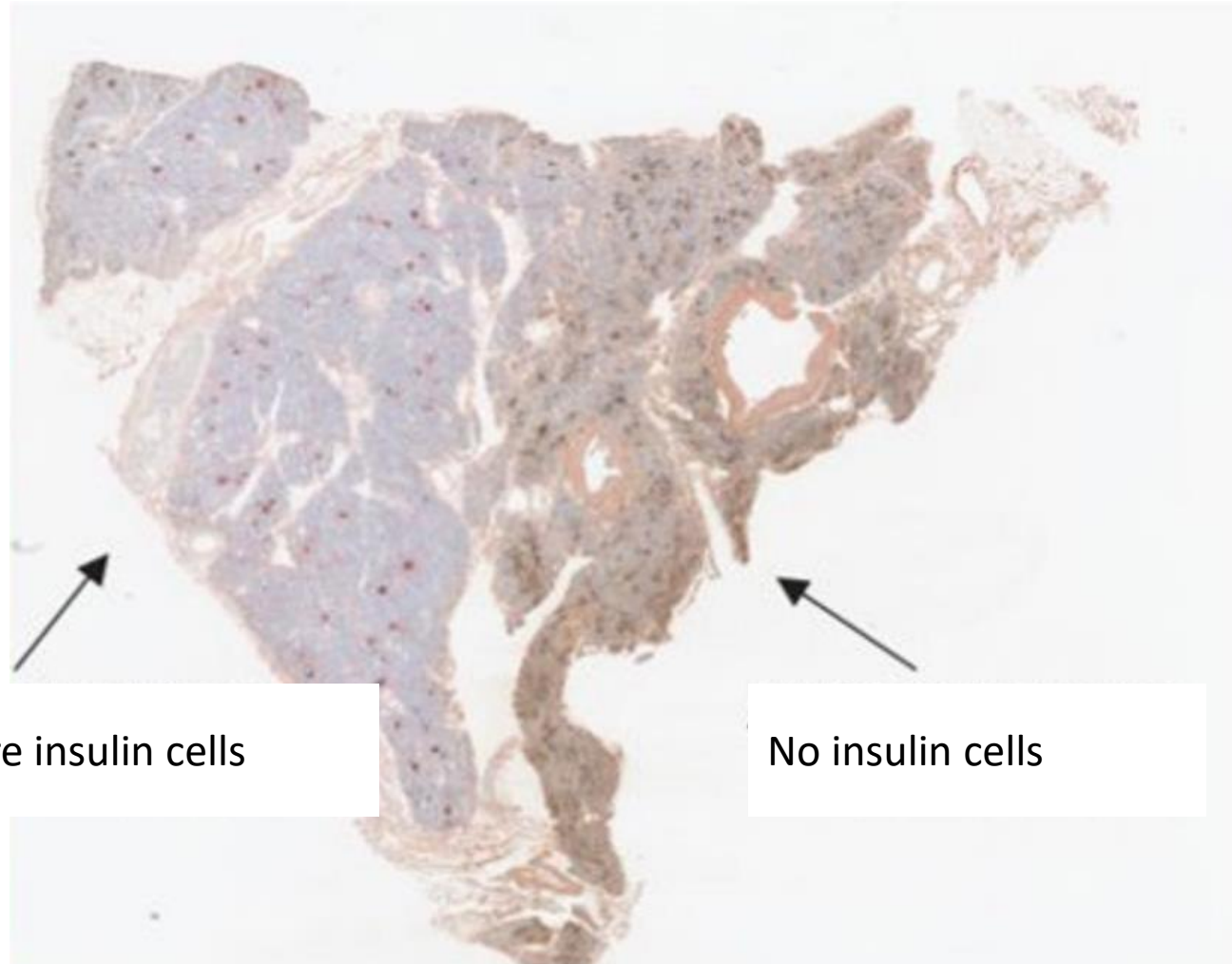
Courtesy of Antonio R. Lara-Lemus, M.D., Ph.D. and Peter Arvan, M.D., Ph.D., Department of Internal Medicine-Metabolism, Endocrinology & Diabetes, University of Michigan

RISK OF DIABETES - ANTIBODIES



**A total of 13,377 children included, 92.1% neg, 7.9% pos
4% multiple antibodies
Among 1059 children pos, 428 children had diabetes.**

HISTOLOGICAL SECTION IN TYPE 1

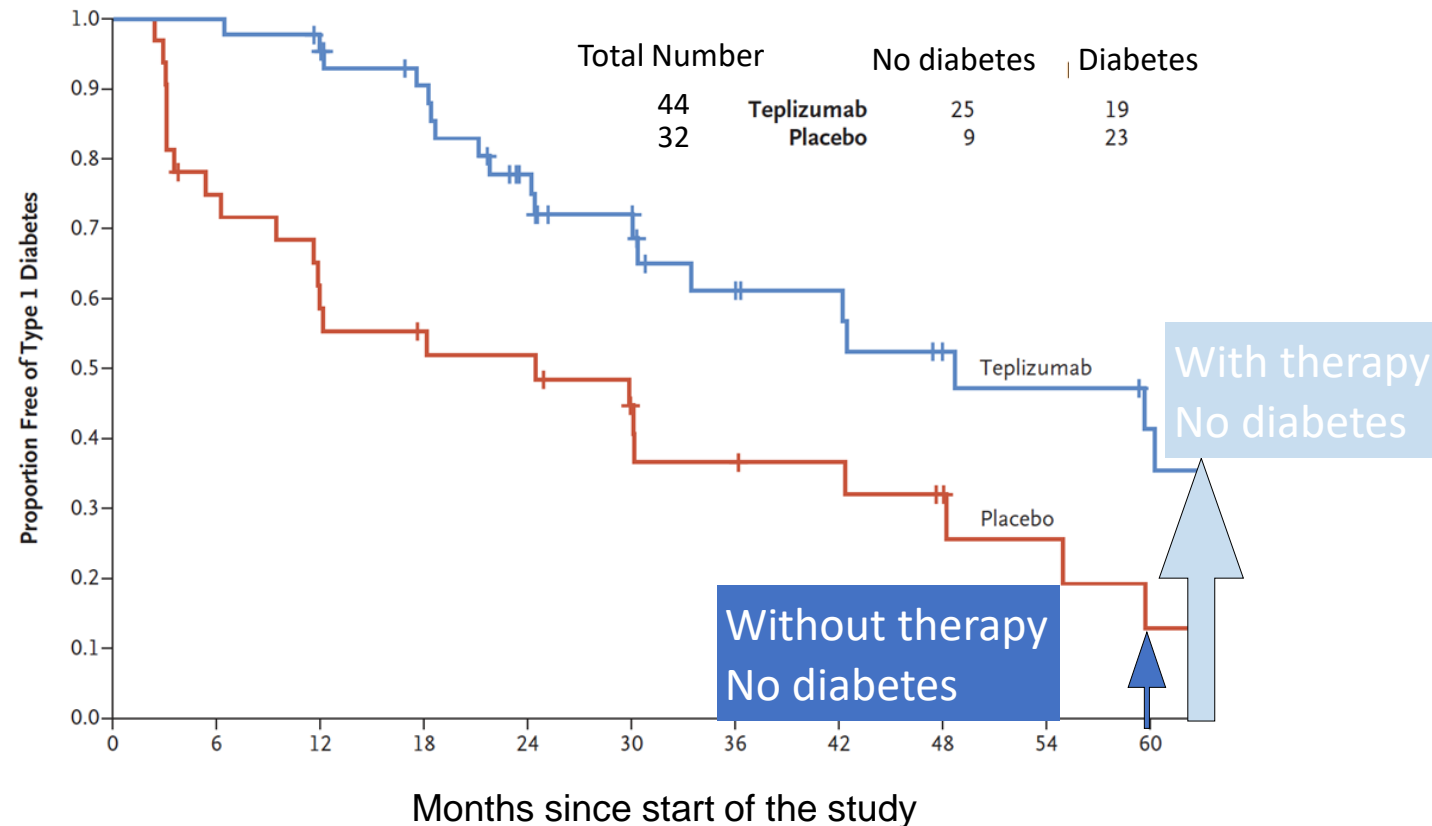


Everywhere insulin cells


No insulin cells

CAN TYPE 1 DIABETES BE PREVENTED?

- Study with people at high risk for diabetes (stage 2)
- 14-day therapy with teplizumab (AC anti-CD3 monoclonal)
- Immunomodulator: acts on inflammatory cells (CD8+ lymphocytes), which probably kill insulin-producing beta cells.



STUDY SUMMARY

- 14-day therapy with teplizumab (AC anti-CD3 monoclonal)
 - slows the onset of diabetes in high-risk individuals
- 2-year slowdown
- 43% of treated and 72% of untreated people developed diabetes.
- Treatment can be done in children and adults.
- One sub-group responds better than others
-  Precision medicine
- First study showing a slowing down of diabetes by immunotherapy

CONCLUSIONS

- Accurate diagnosis leads to accurate treatment
- Diagnosis with autoimmune antibodies
- Diagnosis by genetic analysis
- Measuring risk in family members of people with diabetes becomes possible
- Measuring the risk for all children will be possible in the future

MONOGENIC DIABETES (MD)

- A heterogeneous group of disorders
- **Results from a defect in a single gene**
- Originally MD were classified in two groups depending on the age of diagnosis

Neonatal Diabetes Mellitus
(NDM)

Maturity Onset Diabetes of the Young
(MODY)

- Remains undiagnosed in probably more than 90% of patients
- Diagnosis often missed ← children diagnosed with T1D or T2D
- Switzerland: 350'000 diabetic individuals of whom 2% (≈ 7'000) are supposed to have MD
- **Definitive diagnosis by genetic analysis**
- **Genetic defect dictates the treatment = precision medicine**

NEONATAL DIABETES MELLITUS (NDM)

Diagnosed within the first 6 months of life

- Prevalence is 1/90 000 to 1/160 000 live births
- Permanent (PNDM) and transient (TNDM) forms

22 Known NDM genes

- >50% of patients harbor activating mutations of
 - ✓ *KCNJ11*
 - ✓ *ABCC8* genes
(coding for the K-ATP channel)
- 90% of patients respond to high doses of Sulfonylurea
- ✓ syndromic features
 - pancreas agenesis
 - delayed development
 - epilepsy
 - hearing loss
 - cardiopathy

22 NDM Genes	
<i>PLAGL1</i>	<i>KCNJ11</i>
<i>ZPF57</i>	<i>ABCC8</i>
<i>PDX1</i>	<i>GCK</i>
<i>PTF1A</i>	<i>SLC2A2</i>
<i>HNF1B</i>	<i>SLC19A2</i>
<i>RFX6</i>	<i>INS</i>
<i>GATA6</i>	<i>FOXP3</i>
<i>GLIS3</i>	<i>EIF2AK3</i>
<i>NEUROG3</i>	<i>IER3IP1</i>
<i>NEUROD1</i>	<i>WFS1</i>
<i>PAX6</i>	<i>STAT3</i>

Rubio Cabezas O. Horm Res Paediatr 2013
Pearson E.R. NEJM 2006

MATURITY ONSET DIABETES OF THE YOUNG (MODY)

MODY are diabetes **diagnosed before 25 years**

- Autosomal dominant inheritance
- Insulin independence
(although insulin may be required for optimal control)

Usually absence of

- features of insulin resistance
- β cell autoimmunity
($< 1\%$ positive GAD or IA2 Auto Ab)

Patients with *HNF1A* or *HNF4A* mutations

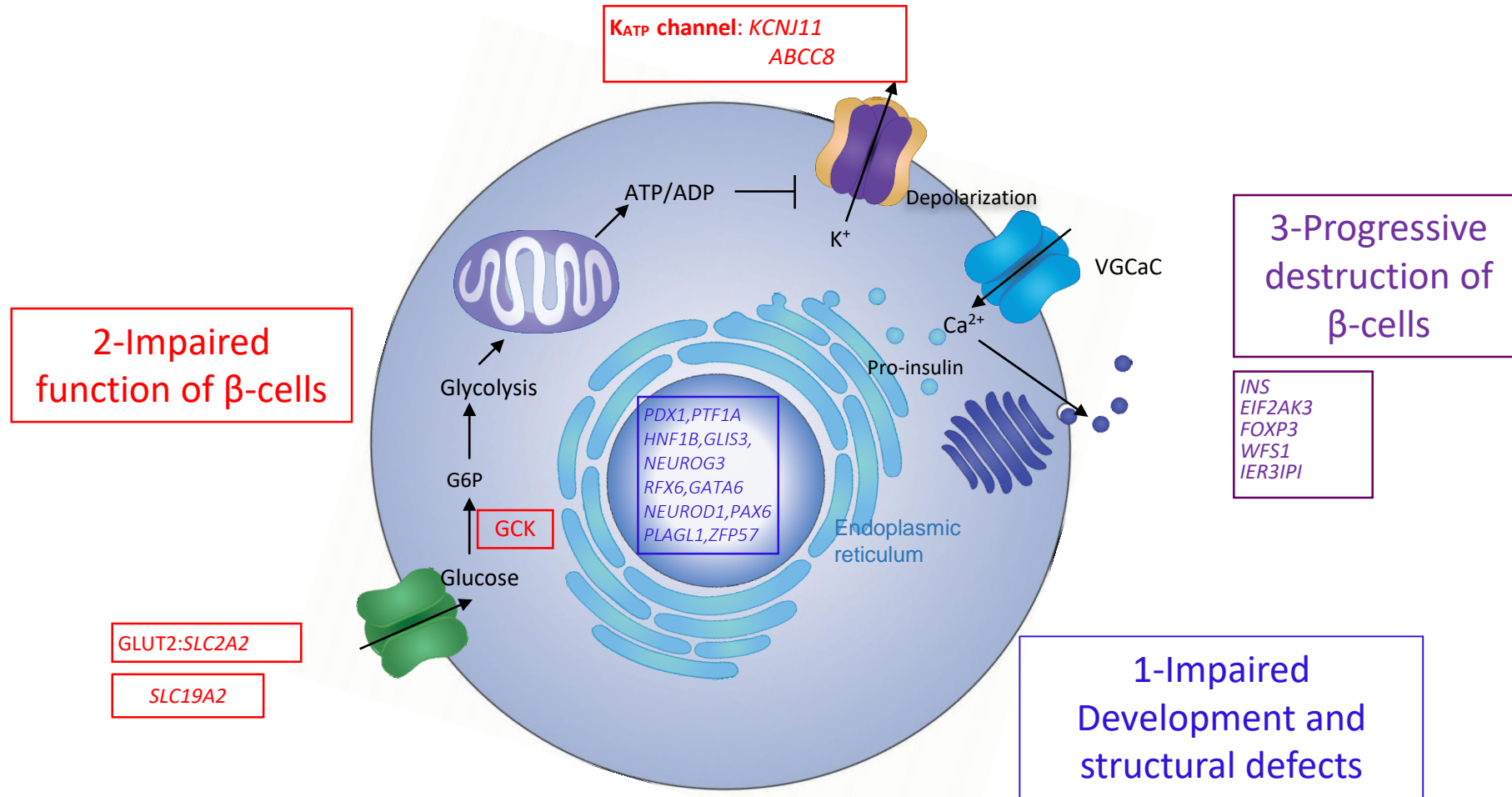
→ sensitive to low doses of Sulfonylurea

Patients with *GCK* mutations

→ do not require pharmacological treatment

13 MODY Genes	
<i>HNF4A</i>	MODY 1
<i>GCK</i>	MODY 2
<i>HNF1A</i>	MODY 3
<i>PDX1</i>	MODY 4
<i>HNF1B</i>	MODY 5
<i>NEUROD1</i>	MODY 6
<i>KLF11</i>	MODY 7
<i>CEL</i>	MODY 8
<i>PAX4</i>	MODY 9
<i>INS</i>	MODY 10
<i>BLK</i>	MODY 11
<i>ABCC8</i>	MODY 12
<i>KCNJ11</i>	MODY 13

PANCREATIC BETA CELL



GENETIC ANALYSIS IN PATIENTS WITH MONOGENIC DIABETES

- ✓ Probably more than 90% of patients with suspicion of MD remains **undiagnosed**
- ✓ Traditional testing for MD focuses only on one or a few genes depending on the clinical picture and the patient's phenotype

Aim

- Determining the respective prevalence of known MD genes
- Identify potential novel genes causing MD

Method

- Identify gene variants causing MD using next-generation sequencing (NGS)
- Selection of 323 potential diabetes genes
- Design of a capture assay for coding and splicing regions of these genes (HaloPlex technology)

PATIENT INCLUSION CRITERIA

Neonatal
Diabetes

Suspicion
of MODY

Presumed T1DM
No AB

Presumed T2DM
Diagnosis <45 yrs
Without metabolic
features

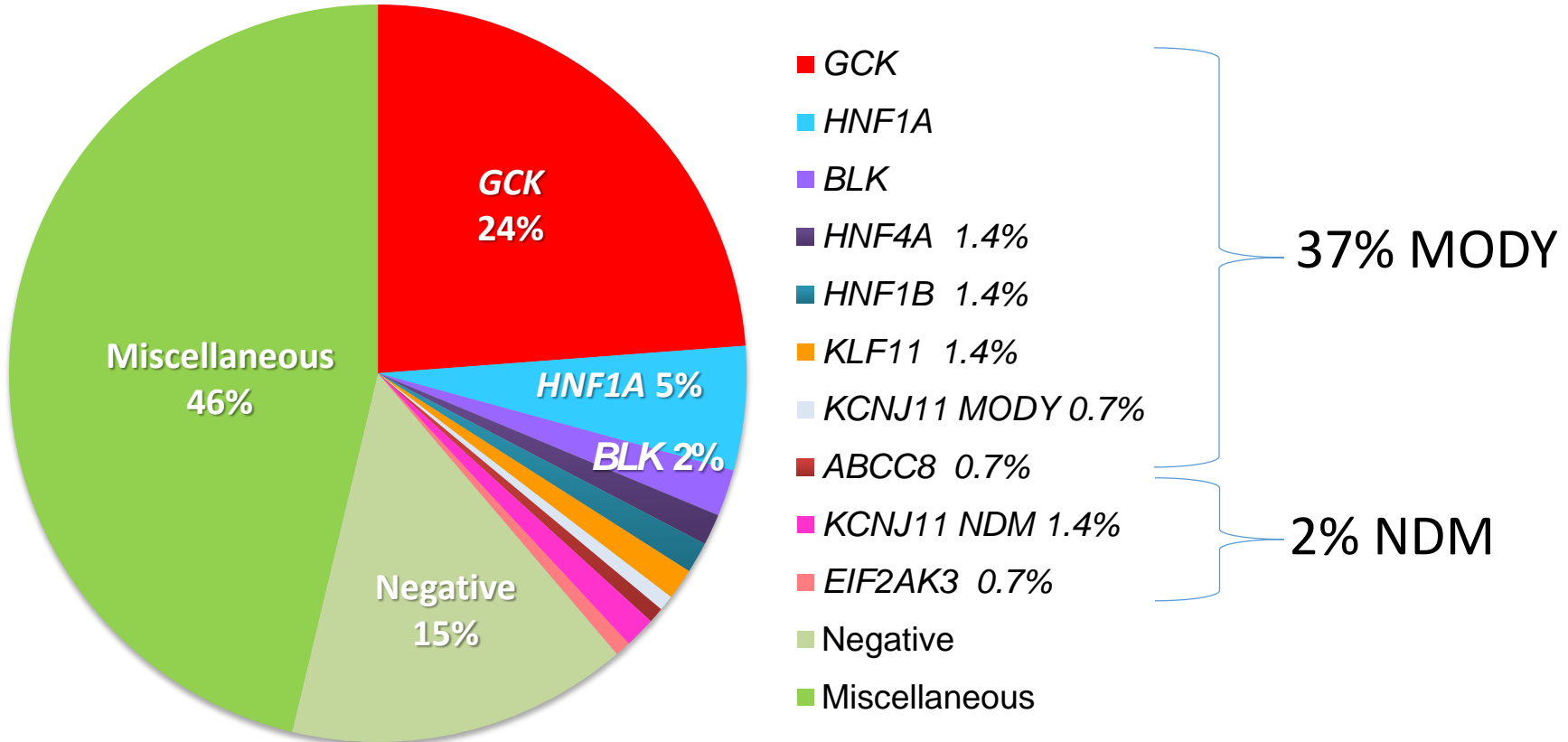
Syndromic diabetes
with extra-pancreatic
features such as:
Hearing loss
Developmental delay
Epilepsy
Cardiopathy

147 diabetic patients

Age at diagnosis	Diabetes < 6 months	Diabetes ≥ 6m - 18 y	Diabetes ≥ 18 years
Number of patients	4	44	99
Mean age at diagnosis	1.5 month	130 months (10.8 years)	423 months (35.3 years)
Sexe	25% female	59% female	59% female
Mean HbA1c at diagnosis	3.4%	8.9%	8.1%
Mean Glycemia at diagnosis	37.8 mmol/l	14.3 mmol/l	10.2 mmol/l

MONOGENIC KNOWN DIABETES GENE PREVALENCE IN CH

147 CH patients



8 novel GCK mutations, 2 novel HNF1A mutations, 1 novel KLF11 mutation

NEONATAL RESULTS

4 patients with Neonatal diabetes

Age at diagnosis	Diabetes < 6 months
Number of patients	4
Mean age at diagnosis	1.5 months
Genes	<i>KCNJ11/HNF4A, EIF2AK3, IL18RAP</i>

1 patient with *KCNJ11* PNDM

1 patient with a digenic
KCNJ11/HNF4A TNDM

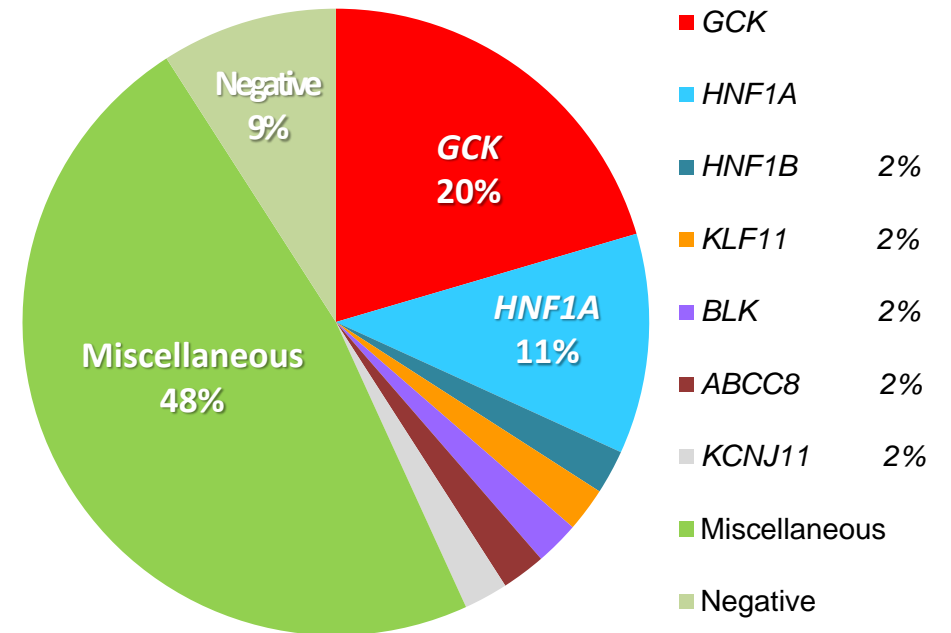
1 patient with a Wolcott Rallison
syndrome

1 patient with an neonatal T1DM

PEDIATRIC RESULTS

44 paediatric patients with clinical suspicion of monogenic diabetes

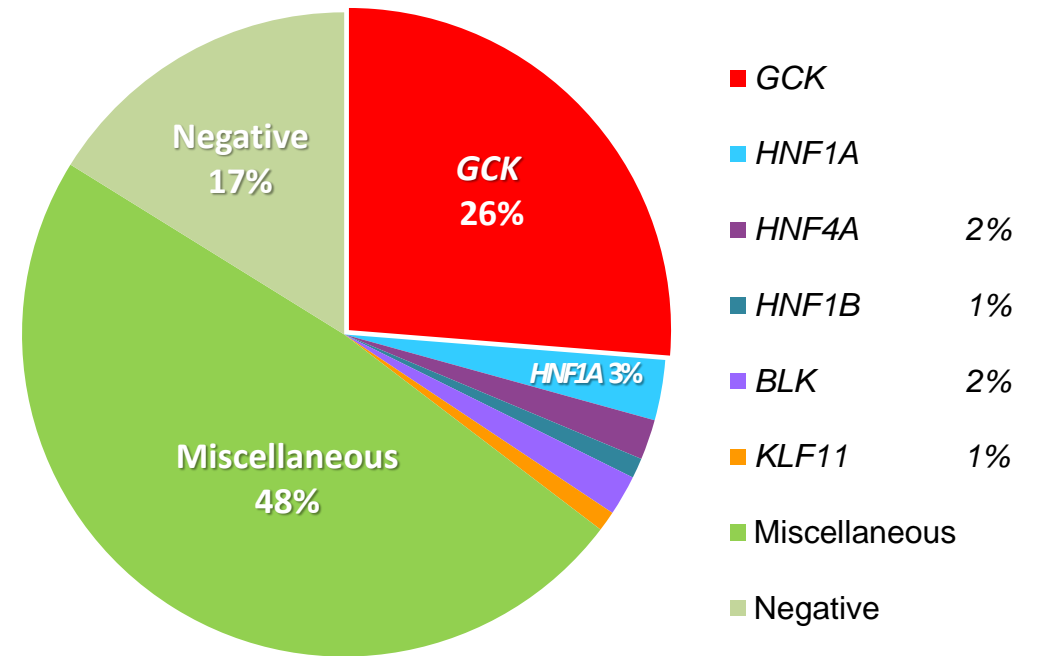
Age at diagnosis	Diabetes ≥ 6-months to 18 years
Number of patients	44
Mean age at diagnosis	130 months (10.8 years)
Genes	<i>GCK</i> <i>HNF1A</i> <i>HNF1B</i> <i>KLF11</i> <i>BLK</i> <i>ABCC8</i> <i>KCNJ11</i>



ADULT RESULTS

99 adult patients with clinical suspicion of monogenic diabetes

Age at diagnosis	Diabetes ≥ 18 years
Number of patients	99
Mean age at diagnosis	423 months (35.3 years)
Genes	<i>GCK</i> <i>HNF1A</i> <i>HNF4A</i> <i>HNF1B</i> <i>KLF11</i> <i>BLK</i>



DEVELOPMENT OF A GENETIC DIAGNOSTIC TOOL

Following this study we launched a **diagnostic tool for monogenic diabetes** genes

- **Gene targeted NGS Based**

- Advantages:

- ✓ **More comprehensive:** allows the analysis of several/many genes in one step
(instead of the traditional « one-by-one » successive serial test)

- ✓ **Cheaper**
(compared to more than one gene analysis by traditional methods)

- ✓ **Very suitable for pathologies with high genetic heterogeneity** (several to many genes involved)

- ✓ **Flexibility in choice of genes at the bioinformatic analysis stage**
(all sequenced genes, or a subpanel of few genes analyzed)

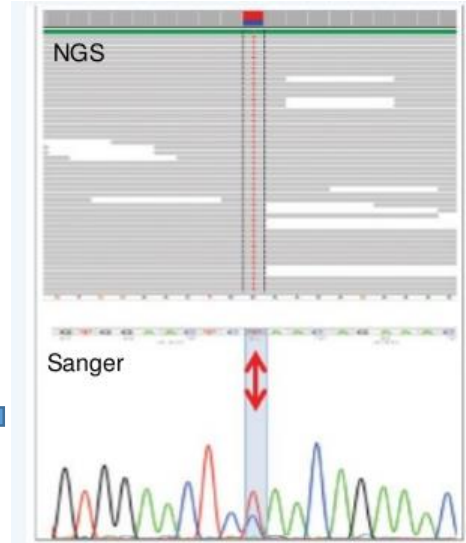
- Disadvantages:

- TAT are longer than for a single gene analysis by classical Sanger method

- Some types of variants (still) not yet detected (complex deletions/duplications, repeats, ...)

DNA SEQUENCING SCALE

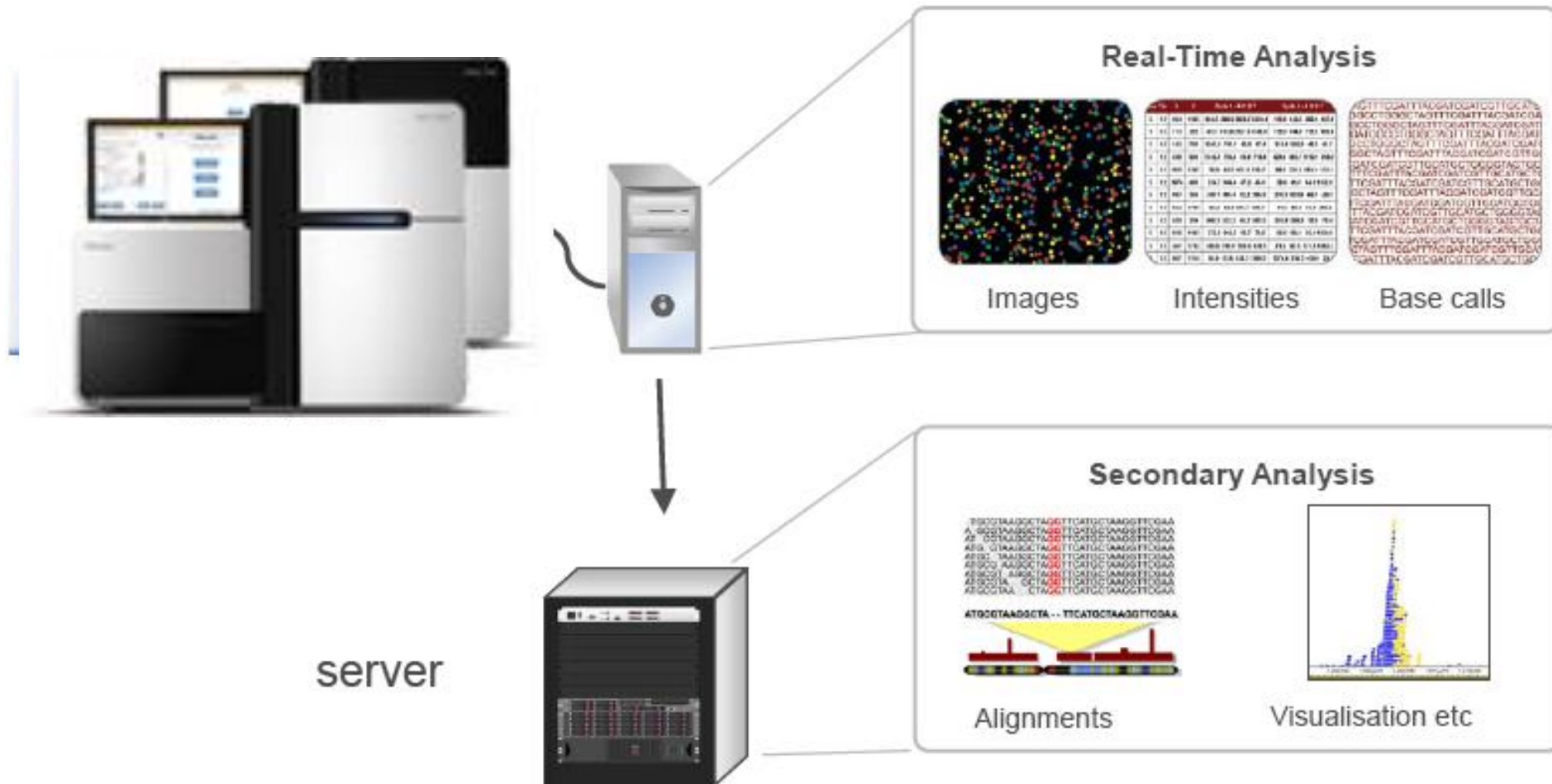
Years 1990-2000
Sequencing few parts of genes
(1 individual at a time)



from year 2005
Sequencing of dozen to thousands genes
(in several individuals at a time)

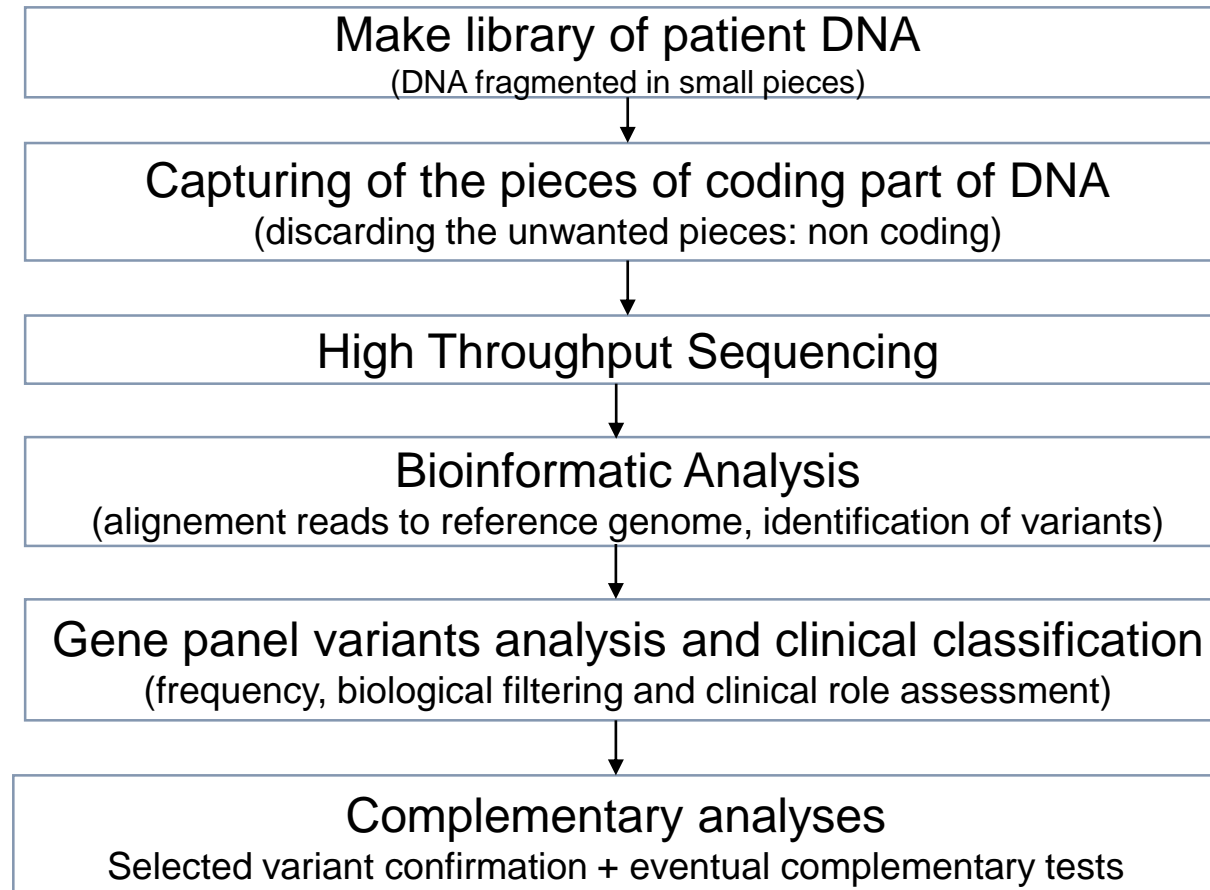
	1st	2nd	3rd
	Sanger Sequencing	“Next Generation” Sequencing	« Single molecule sequencing »
Information Capacity:	100's of reads per experiment	10,000,000's of reads per experiment	1,000,000,000's of reads per experiment
Cost per Human Genome:	\$1,000,000's	1'000-10'000	1'000s

NGS DATA WORKFLOW



NGS ON GENE PANEL

It is required to **trap the coding portions of patient DNA to be analyzed**,.....
.....if one do not want to sequence entire genome (~more than 98% of the data to discard).
→ Need a way to **capture the portions of DNA of interest**



NGS DIAGNOSTIC TOOL GENE PANEL

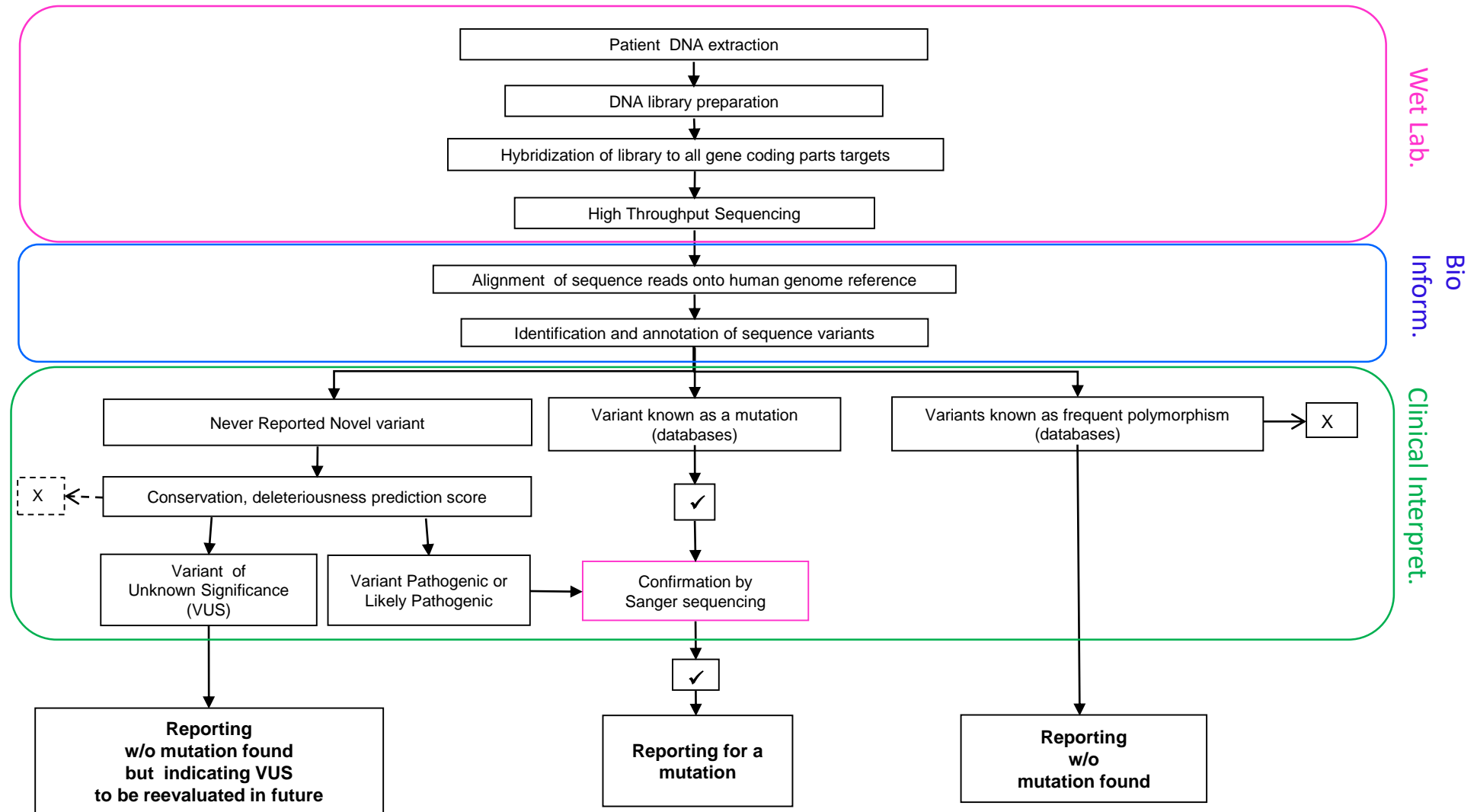
v.1.0 DESIGN

- **43 genes + non coding regions chosen from**
 - Monogenic diabetes genes: MODYs (1-13)
 - other neonatal, early or late onset monogenic Diabetes (14-43)

Gene name	RefSeq accession number (Genbank)	Chromos. Location	Theoretical coverage (%)	Missing nucleotides (n)	non covered (%)
<i>HNF4A</i>	NM_000457	Chr.20	100	-	-
<i>GCK</i>	NM_000162	Chr.7	100	-	-
<i>HNF1A</i>	NM_000545	Chr.12	100	-	-
<i>PDX1</i>	NM_000209	Chr.13	100	-	-
<i>HNF1B</i>	NM_000458	Chr.17	100	-	-
<i>NEUROD1</i>	NM_002500	Chr.2	100	-	-
<i>KLF11</i>	NM_003597	Chr.2	100	-	-
<i>CEL</i>	NM_001807	Chr.9	100	-	-
<i>PAX4</i>	NM_006193	Chr.7	100	-	-
<i>INS</i>	NM_000207	Chr.11	100	-	-
<i>BLK</i>	NM_001715	Chr.8	100	-	-
<i>ABCC8</i>	NM_000352	Chr.11	100	-	-
<i>KCNJ11</i>	NM_000525	Chr.11	100	-	-
<i>SLC19A2</i>	NM_006996	Chr.1	100	-	-
<i>DNAJC3</i>	NM_006260	Chr.13	100	-	-
<i>PLAGL1</i>	NM_001080954	Chr.6	100	-	-
<i>GATA6</i>	NM_005257	Chr.18	100	-	-
<i>GATA4</i>	NM_002052	Chr.8	100	-	-
<i>SLC2A2</i>	NM_000340	Chr.3	100	-	-
<i>NKX2-2</i>	NM_002509	Chr.20	100	-	-
<i>NEUROG3</i>	NM_020999	Chr.10	100	-	-
<i>GLIS3</i>	NM_152629	Chr.9	99.7	9	0.30%

Gene name	RefSeq accession number (Genbank)	Chromos. Location	Theoretical coverage (%)	Missing nucleotides (n)	non covered (%)
<i>RFX6</i>	NM_173560	Chr.6	100	-	-
<i>MXN1</i>	NM_005515	Chr.7	100	-	-
<i>EIF2AK3</i>	NM_004836	Chr.2	100	-	-
<i>WFS1</i>	NM_006005	Chr.4	100	-	-
<i>IERSIP1</i>	NM_016097	Chr.18	100	-	-
<i>PAX6</i>	NM_000280	Chr.11	100	-	-
<i>FOXP3</i>	NM_014009	Chr.X	100	-	-
<i>STAT3</i>	NM_139276	Chr.17	100	-	-
<i>PCBD1</i>	NM_000281	Chr.10	100	-	-
<i>SIRT1</i>	NM_012238	Chr.10	100	-	-
<i>LRBA</i>	NM_001199282	Chr.4	99.98	2	0.02%
<i>ZPF57</i>	NM_001109809	Chr.6	100	-	-
<i>PTF1A enhancer</i>	hg19	Chr.10	96.6	25	3.40%
<i>INS intron</i>	hg19	Chr.11	100	-	-
<i>PPP1R15B</i>	NM_032833	Chr.1	100	-	-
<i>TMRT10A</i>	NM_152292	Chr.4	100	-	-
<i>KMT2D</i>	NM_003482	Chr.12	98.87	~200	1.13%
<i>KDM6A</i>	NM_021140	Chr.X	100	-	-
<i>RAP1A</i>	NM_001010935	Chr.1	100	-	-
<i>RAP1B</i>	NM_015646	Chr.12	100	-	-
<i>CISD2</i>	NM_001008388	Chr.4	100	-	-
<i>PTF1A</i>	NM_178161	Chr.10	100	-	-

NGS FLOWCHART



NGS SEQUENCE READ TILING

ALIGNMENT OF SEQUENCE TO GENOME REFERENCE : DETECTION OF NUCLEOTIDE VARIANTS

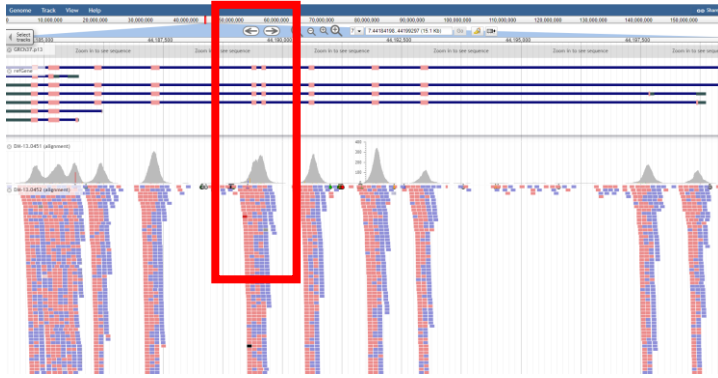


Fig. A

Example of gene *GCK*

Fig.A: sequencing coverage in short-reads for entire gene.

- Pink color boxes (on the blue bars) show respective location of the exons (each of the blue bars show distinct transcripts of the gene)
- Each «grey peaks» depicts distribution of coverage depth in exon and close vicinity

Fig.B: zoom of the red squared section of fig.A
Below the grey area (enlarge grey peaks) are the distribution of forward (red) and reward (blue) reads of sequences



Fig. B

HIGH THROUGHPUT SEQUENCING

Identify thousands of variant (exome) / millions of variants (genome) per individual

That is necessary to class, filter, then to interpret in order to sort out the causative variant

Fig.A: example of files of sequence reads
Each line is a read followed by sequence quality

Fig.B: example of aligned sequence reads

Each line is a read

Each letter A,C,G,T or N depicts a variant or a non assigned call

Here, only the « G » and « A » are true calls (not errors)

All the other dispersed letters are sequencing errors

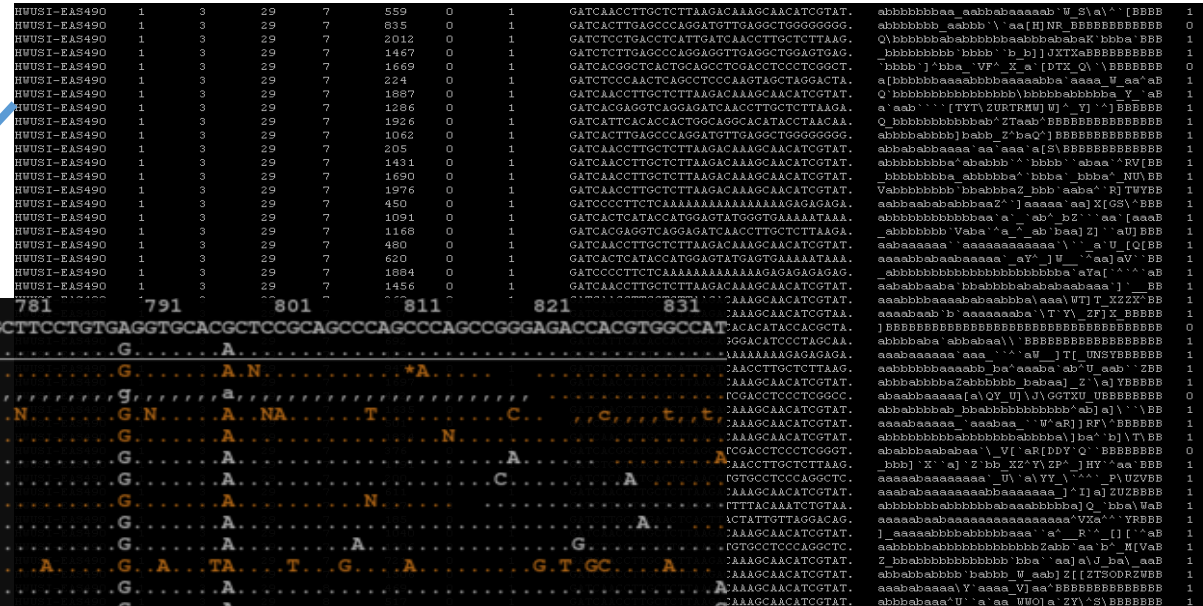


Fig.A

Fig.C: Table of selected variants

Each line show a variant with informations regarding its position in gene, gene name, type, annotation, prediction, and genome localisation

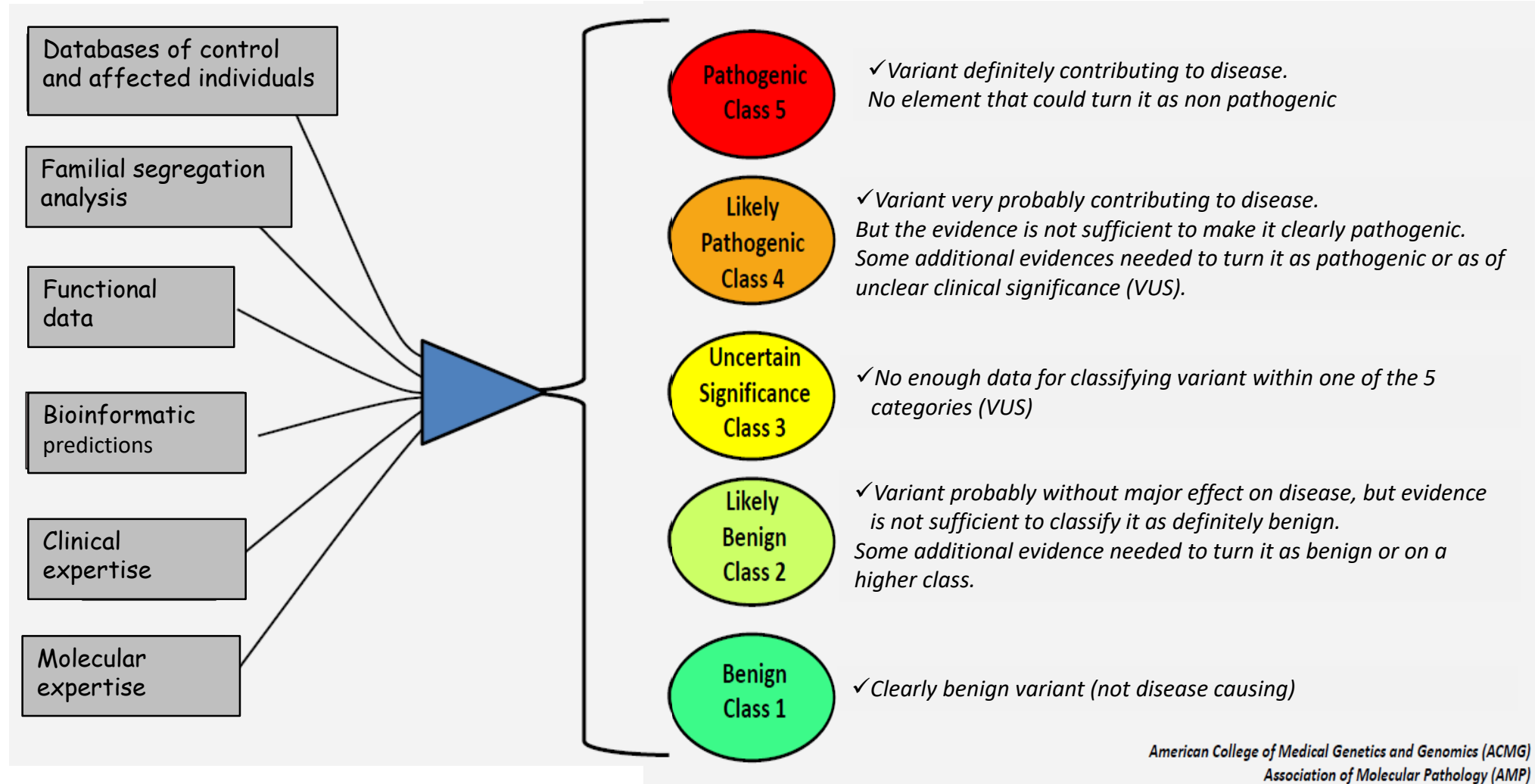
Func	Gene	ExonicFunc	AAChange	SIFT	PolyPhen	Chr	Start	End	Ref	Obs	Het/Hom	Qscore	Reads
exonic	GATA6	nonsynonymous SNV	p.R456H		0.999	chr18	19761478	19761478	G	A	het	225	151
exonic	C5orf22	nonsynonymous SNV	p.D155Y	0.12	0.503	chr5	31538452	31538452	G	T	het	225	42

Fig.B

Fig.C

CLINICAL CLASSIFICATION OF VARIANTS

An important task in variant interpretation is to classify variants according to 5 levels of clinical significance (from pathogenic to benign).



GENE PREVALENCE FROM DIAGNOSTICS

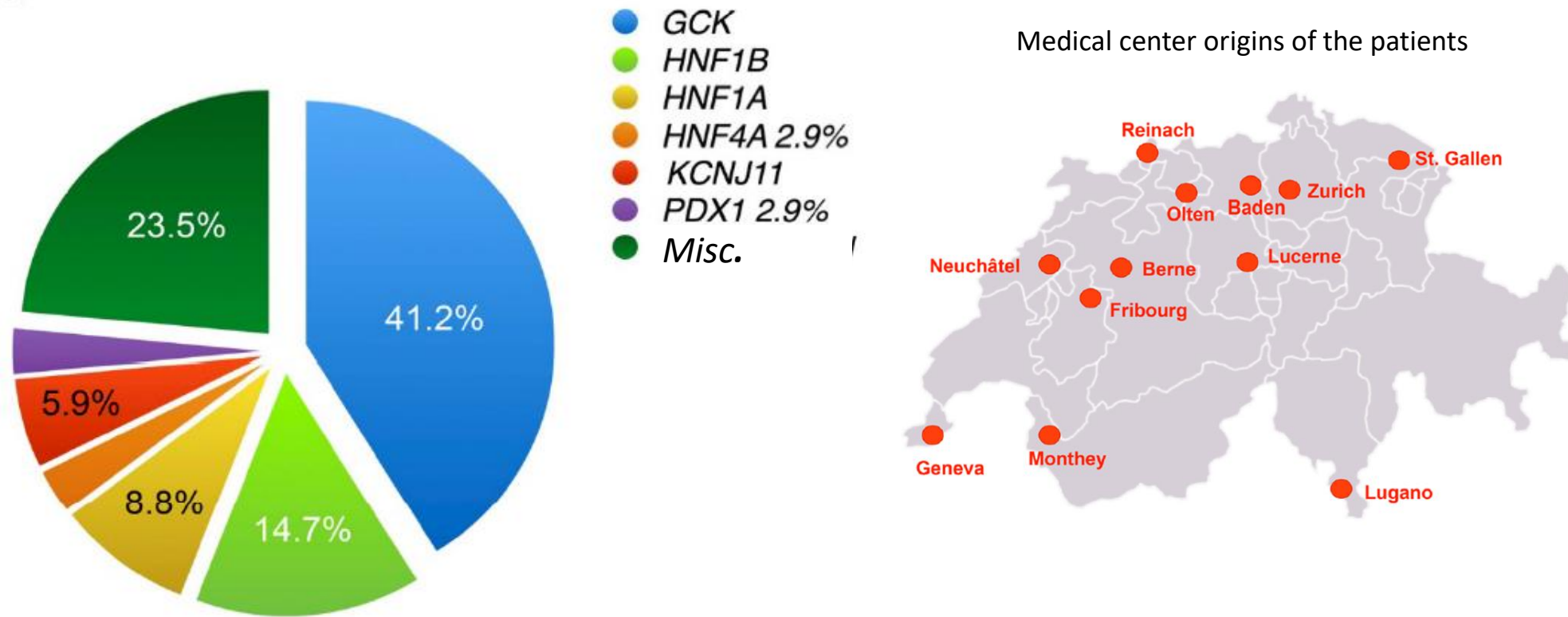


Figure 1: Types and proportions of mutations in surveyed patients with a genetically confirmed diagnosis of monogenic diabetes. n=74 patients (44 females/30 males)
For 34 patients, genetic analysis was performed by Sanger sequencing (not by NGS)

CONCLUSIONS

- Childhood onset diabetes are diagnosed in **3 main types** (T1D, Monogenic, other non-genetic causes)
- T1D has complex aetiology including **complex genetic** cause
 - Genetic causes are currently not investigated in routine diagnostics
- Monogenic diabetes is caused by **one gene**, but is genetically **highly heterogeneous**
 - >40 genes can cause the disease: diagnostic **sensitivity is about 50%** today
 - Still unknown genes or genetic causes to date that remain to be identified through research efforts
 - **Genetic diagnostic is available**, and performed routinely in specialized centers
 - Ideally molecular genetic diagnostics should be investigated using next-generation-sequencing (NGS)
 - At least 13 genes for MODY, 22 genes for NIDDM, should be analysed for all coding part
 - Clinical classification of variant is a key step (causative variant, or VUS, or benign)
 - Only the **Pathogenic and Likely Pathogenic** variants should be reported
 - Variant of unknown Clinical Significance (VUS) or Likely benign/benign should not be reported
 - Knowing the gene dictates the treatment: **personalized medicine** (specific drug administration)
- Perspectives
 - It is expected that T1D and T2D will also be genetically investigated in clinical setting in future
 - **Polygenic Risk Score**: some studies investigating this way allow risk estimation of developing Diabetes
 - Help in life-style choice / decision (specific medical surveillance, food, sport, preventive drug ?, ...)



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Monica Albarca

Michel Guipponi

Members SGED/SSED

Members SGPED/SSEDP

