Autosomal Dominant Progressive Sensorineural Hearing Loss Due to a Novel Mutation in the KCNQ4 Gene

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**Objective:** To identify the genetic etiology in a family with autosomal dominant progressive sensorineural hearing loss.

**Design:** Prospective molecular genetic research study.

**Setting:** Academic genetic research laboratory.

**Participants:** Seventeen members of a family with dominant progressive nonsyndromic sensorineural hearing loss: 9 affected, 6 unaffected, and 2 spouses.

**Interventions:** Clinical data from questionnaires, interviews, serial audiograms, and medical records; genetic data from genome-wide linkage analysis and candidate gene mutation analysis.

**Main Outcome Measures:** Symptoms, age at onset, serial audiometric data, and the presence or absence of a deafness-associated mutation.

**Results:** Affected individuals in this family presented with autosomal dominant nonsyndromic high-frequency progressive sensorineural hearing loss, with age at onset ranging from 1 to 21 years. Genome-wide linkage analysis of single-nucleotide polymorphisms yielded evidence of linkage to an 18.9-Mb region on chromosome 1p34-p36, with a multipoint logarithm of odds score of 3.6. This interval contains a known deafness gene, KCNQ4, which underlies DFNA2 deafness. Sequencing of the 14 coding exons and intron-exon junctions of KCNQ4 revealed a novel heterozygous missense mutation, c.859G>C, p.Gly287Arg. The mutation disrupts the highly conserved GYG motif (glycine-tyrosine-glycine) of the phosphate-binding loop, hypothesized to be critical in maintaining pore structure and function. All 274 controls were negative for the mutation.

**Conclusions:** Autosomal dominant high-frequency hearing loss is genetically heterogeneous, and linkage analysis is an efficient means of identifying the etiology in larger families. Deafness in this family is caused by a novel mutation in KCNQ4.


In recent years, more than 50 genes responsible for hearing impairment have been identified. Whereas GJB2 mutations are the most common cause of recessive nonsyndromic deafness in the US population, dominant nonsyndromic deafness may result from mutations in a variety of genes, none of which predominate in the population. Although various clinical algorithms have been proposed, developing an efficient and cost-effective means to diagnose the genetic etiology of dominant deafness remains a challenge.

The DFNA2 (deafness, nonsyndromic, autosomal dominant 2) locus was originally mapped to chromosome 1p in 2 families with progressive high-frequency sensorineural hearing loss (SNHL). Ultimately, a potassium channel gene, KCNQ4 (OMIM NM_0047000), was identified as the responsible gene. We used genetic linkage analysis and candidate gene screening to identify the genetic cause of deafness in a family with dominant progressive high-frequency SNHL.

**METHODS**

This research was approved by the University of Michigan and the Baylor College of Medicine and Affiliated Hospitals institutional review boards, and informed consent was obtained from all the participants. A family (family 63) of European descent segregating high-frequency SNHL was ascertained through contact with the principal investigator (M.M.L.) (Figure 1). Participants completed...
Figure 1. Pedigree of family 63 segregating progressive high-frequency sensorineural hearing loss. Single-nucleotide polymorphisms are listed to the left of the individual's genotype. The haplotype segregating with deafness is highlighted with a gray box. The interval is defined by recombination events at rs1502856 (centromeric) and rs926979 (telomeric). KCNQ4 maps between rs209598 and rs883062.
questionnaires, underwent audiologic testing, and provided saliva or peripheral venous blood samples. Historical clinical and audiometric data were obtained as available. DNA was isolated from blood using the Gentra Puregene Cell Kit (Qiagen, Valencia, California) and from saliva using the Oragene DNA Collection Kit (DNA Genotek, Kanata, Ontario, Canada) according to the manufacturers’ instructions.

GENOTYPING AND LINKAGE ANALYSIS

A whole-genome scan was performed at the Center for Inherited Disease Research using the Illumina HumanLinkage-12 panel (Illumina Inc, San Diego, California), which contains 6090 single-nucleotide polymorphism (SNP) marker loci, for all 16 pedigree members from whom a DNA sample was available. Genotype data were screened for mendelian incompatibilities using PedCheck,15 and MERLIN (Multipoint Engine for Rapid Likelihood Inference)16 was used to assess the data for the occurrence of double recombination events over short genetic distances, which are most likely due to genotyping error. MLINK of the FASTLINK software package7 was used to perform 2-point linkage analysis, genetic map distances were based on the Build 16 Rutgers map, the sequence-based physical map (Build 36) was used as a reference to determine the physical positions of SNP marker loci, and then interpolation was used to determine the genetic map distance. Haplotype reconstruction was performed using SimWalk2.11,12

SEQUENCING OF VARIANTS

Candidate genes mapping to the linkage region were screened by sequencing of all exons and intron-exon boundaries. Primer sets for polymerase chain reaction were designed using Primer3 (Table 1). Polymerase chain reaction was performed using the FailSafe PCR Kit according to the manufacturer’s instructions (Epicentre Biotechnologies, Madison, Wisconsin) with a 50-µL reaction volume, 200-ng template DNA, and 0.2-µM primer, with 32 cycles at 58°C annealing temperature and 1 minute 30 seconds of extension time. The polymerase chain reaction product was purified using Qiaquick columns (Qiagen) and was sequenced by the University of Michigan DNA Sequencing Core.

ANALYSIS OF VARIANTS

Sequence data were compared with the reference sequence (NM_004700) for KCNQ2, and variations were recorded. Novel variants were assayed in a panel of 275 controls (550 control chromosomes), of which 185 were from the Caucasian-American Panel and 90 were from the Polymorphism Discovery Resource (Coriell Cell Repositories, Camden, New Jersey), containing 24 European Americans, 24 African Americans, 24 Asian Americans, 12 Mexican Americans, and 6 Native Americans, according to the same protocols listed previously herein.

To assess the affect of amino acid substitutions, wild-type amino acid sequence was compared with mutant sequence using the SIFT (Sorting Intolerant from Tolerant) program.17 A SIFT score of 0.05 or lower is predicted to be deleterious, and a score higher than 0.05 predicts a tolerated substitution.

Table 1. Polymerase Chain Reaction Primers Used for Amplification of KCNQ4 Exons

<table>
<thead>
<tr>
<th>Primer Name</th>
<th>5' -3' Sequence</th>
<th>Type</th>
<th>Exon</th>
<th>Targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCNQ4x1f</td>
<td>GGAAGAGGACAGCCCATCGAGT</td>
<td>Forward</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x1r</td>
<td>GATTGAGAAACGCGCTAGG</td>
<td>Reverse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x2f</td>
<td>CCAGGAAATCCATCTTGA</td>
<td>Forward</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x2r</td>
<td>TTGCTAGAGGCCAGTAGGTGA</td>
<td>Reverse</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x3f</td>
<td>CCTGACCGAGGGACTCTTTG</td>
<td>Forward</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x3r</td>
<td>GATTGAGAAACGCGCTAGG</td>
<td>Reverse</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x4f</td>
<td>GAGAAGGCCAGACATCTAGC</td>
<td>Forward</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x4r</td>
<td>AGACGGCCTCTAGCCTTA</td>
<td>Reverse</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x5f</td>
<td>CTCTTACCCTTTCCTGTG</td>
<td>Forward</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x5r</td>
<td>GATGAGGAGCTAGCTAGTG</td>
<td>Reverse</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x6f</td>
<td>CGAGTCTGCCATCTTCTGG</td>
<td>Forward</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x6r</td>
<td>AGACGGCCTCTAGCCTTA</td>
<td>Reverse</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x7f</td>
<td>GCTGACCGAGGGACTCTTTG</td>
<td>Forward</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>KCNQ4x7r</td>
<td>CCAAGGACTGGTCTTCTCA</td>
<td>Reverse</td>
<td>7</td>
<td></td>
</tr>
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</table>

Table 2. Audiologic Findings for Affected Members of Family 63

<table>
<thead>
<tr>
<th>Individual</th>
<th>Age When Tested, y</th>
<th>Audiometric Pattern of Hearing Lossa</th>
</tr>
</thead>
<tbody>
<tr>
<td>III-1</td>
<td>7</td>
<td>Mild sloping to moderately severe SNHL</td>
</tr>
<tr>
<td>II-2</td>
<td>4</td>
<td>Mild SNHL</td>
</tr>
<tr>
<td>IV-1</td>
<td>4</td>
<td>4000-Hz sloping to profound SNHL</td>
</tr>
<tr>
<td>III-2</td>
<td>5</td>
<td>Moderate to profound SNHL</td>
</tr>
<tr>
<td>III-3</td>
<td>10</td>
<td>Moderate to severe SNHL</td>
</tr>
<tr>
<td>IV-2</td>
<td>18</td>
<td>Moderate to severe SNHL</td>
</tr>
<tr>
<td>IV-3</td>
<td>7</td>
<td>Moderate to severe SNHL</td>
</tr>
<tr>
<td>IV-4</td>
<td>24</td>
<td>Moderate to severe SNHL</td>
</tr>
<tr>
<td>IV-5</td>
<td>3</td>
<td>Moderate SNHL</td>
</tr>
</tbody>
</table>

Abbreviation: SNHL, Sensorineural hearing loss.

aHearing loss is bilateral unless otherwise specified.
Table 3. LOD Scores for the DFNA2 Locus Region

<table>
<thead>
<tr>
<th>Marker Name</th>
<th>Physical Positions</th>
<th>Genetic Positions</th>
<th>MPT LOD</th>
<th>2-Point LOD, Recombination Fraction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td>0.01</td>
</tr>
<tr>
<td>rs213006</td>
<td>21,551,187</td>
<td>46,050</td>
<td>1.25</td>
<td>0.34</td>
</tr>
<tr>
<td>rs6426746</td>
<td>22,501,644</td>
<td>47,280</td>
<td>−∞</td>
<td>−∞</td>
</tr>
<tr>
<td>rs742230</td>
<td>25,124,011</td>
<td>51,220</td>
<td>−∞</td>
<td>−∞</td>
</tr>
<tr>
<td>rs6564</td>
<td>28,085,562</td>
<td>54,000</td>
<td>0.05</td>
<td>1.60</td>
</tr>
<tr>
<td>rs1886651f</td>
<td>29,579,999</td>
<td>55,000</td>
<td>−∞</td>
<td>−∞</td>
</tr>
<tr>
<td>rs555920</td>
<td>30,832,451</td>
<td>57,011</td>
<td>2.91</td>
<td>−0.09</td>
</tr>
<tr>
<td>rs12409103</td>
<td>31,747,269</td>
<td>59,610</td>
<td>3.27</td>
<td>0.35</td>
</tr>
<tr>
<td>rs760594</td>
<td>33,231,390</td>
<td>60,510</td>
<td>3.34</td>
<td>0.47</td>
</tr>
<tr>
<td>rs899378</td>
<td>34,287,917</td>
<td>61,420</td>
<td>3.41</td>
<td>0.45</td>
</tr>
<tr>
<td>rs491603</td>
<td>36,304,903</td>
<td>64,310</td>
<td>3.57</td>
<td>1.88</td>
</tr>
<tr>
<td>rs6619</td>
<td>37,803,283</td>
<td>66,140</td>
<td>3.56</td>
<td>0.45</td>
</tr>
<tr>
<td>rs649593</td>
<td>37,980,150</td>
<td>66,770</td>
<td>3.55</td>
<td>0.95</td>
</tr>
<tr>
<td>rs661316</td>
<td>39,403,884</td>
<td>69,700</td>
<td>3.54</td>
<td>1.47</td>
</tr>
<tr>
<td>rs209598g</td>
<td>40,635,418</td>
<td>71,570</td>
<td>3.52</td>
<td>1.51</td>
</tr>
<tr>
<td>rs883062b</td>
<td>42,382,454</td>
<td>72,840</td>
<td>3.48</td>
<td>−0.07</td>
</tr>
<tr>
<td>rs2782642</td>
<td>43,658,908</td>
<td>74,310</td>
<td>3.43</td>
<td>−0.04</td>
</tr>
<tr>
<td>rs1707302</td>
<td>46,373,504</td>
<td>75,400</td>
<td>3.40</td>
<td>0.48</td>
</tr>
<tr>
<td>rs926979f</td>
<td>48,458,022</td>
<td>77,800</td>
<td>1.68</td>
<td>−0.12</td>
</tr>
<tr>
<td>rs1502856f</td>
<td>50,644,434</td>
<td>78,260</td>
<td>1.52</td>
<td>0.30</td>
</tr>
<tr>
<td>rs1242339f</td>
<td>53,169,430</td>
<td>79,250</td>
<td>13.11</td>
<td>−∞</td>
</tr>
</tbody>
</table>

Abbreviations: LOD, logarithm of odds; MPT, multipoint.

a All the data are given for theta values of 0.0 to 0.4.
b Physical map positions from Build 36 of the human reference sequence.
c Genetic map positions from the Rutgers combined linkage-physical map of the human genome, Build 36.
d Scores obtained using Allegro1.2c.
e These markers delimit the 3-unit support interval.
f These markers flank the haplotype.
g The gene KCNQ4 is located between the marker loci rs209598 and rs883062.

RESULTS

CLINICAL DATA

Of 17 participants, 9 were affected with hearing loss, 6 were unaffected, and 2 were spouses. Age at onset ranged from 1 to 21 years. Affected family members had sloping SNHL, with low-frequency thresholds less affected than high-frequency thresholds. In general, hearing was symmetrical. Hearing loss was noted to typically progress with age, with mild to moderate hearing loss identified early in life progressing to severe-profound loss by the seventh decade of life (Table 2). Several family members successfully used hearing aids; none were cochlear implant recipients. The phenotype in the family members affected with hearing loss was consistent with DFNA2 deafness.15

GENETIC ANALYSIS

Results of the genome-wide SNP genotyping analysis showed significant evidence of linkage to chromosome 1p34-p36. The maximum 2-point logarithm of odds (LOD) score of 1.8 and the maximum multipoint LOD score of 3.6 both occurred at marker rs491603 (chromosome 1; 36.3 Mb) (Table 3). Haplotype analysis revealed recombination events that define an 18.9-Mb interval between rs1886651 (chromosome 1; 29.6 Mb) and rs926979 (chromosome 1; 48.5 Mb), containing the KCNQ4 gene (Figure 1). This region corresponds closely to the 3-unit support interval, which is slightly larger and extends from rs491603 to rs1242330 (chromosome 1; 53.2 Mb).

A heterozygous point mutation in exon 6 of KCNQ4, c.859G>C, was detected by sequencing DNA in affected family members (Figure 2). The c.859G>C nucleotide substitution results in a p.Gly287Arg amino acid substitution in the phosphate-binding loop region of KCNQ4. This mutation was not found in 275 controls (550 control chromosomes). SIFT analysis of the Gly287Arg amino acid substitution predicted a deleterious effect on protein function, with a score of 0.00.

COMMENT

The KCNQ4 gene encodes a tetrameric voltage-gated potassium protein with 6 transmembrane domains; the N and C termini of the protein are on the intracellular side of the membrane, and the fourth transmembrane domain is the voltage sensor portion of the protein. The fifth and sixth transmembrane domains of the
mutations. Most mutations occur in the channel pore previously reported in association with.

Chips may be expensive, and genes such as GJB3 also includes another reported hearing loss gene, DFNA2. The linkage region identified in family 63 detected linkage with a significant multipoint LOD power to detect linkage for a dominant trait, we have mild low-frequency and moderate high-frequency SNHL, mutations may occur in any of possible genes. Affected individuals in family 63 have mild low-frequency and moderate high-frequency SNHL early in life, progressing to moderate low-frequency and severe-profound high-frequency SNHL later in life, consistent with the phenotype of SNHL early in life, progressing to moderate low-frequency and severe-profound high-frequency SNHL later in life, consistent with the phenotype of KCNQ4 deafness associated with KCNQ4 mutations.

For families with dominant nonsyndromic SNHL following this pattern, clinical genetic testing for KCNQ4 is reasonable to consider (for laboratory listings, see http://www.genetests.org).

High-throughput technologies, such as resequencing microarrays, have been developed to analyze multiple genes mutated in SNHL. However, these “gene chips” may be expensive, and genes such as KCNQ4 may be excluded. In addition, without a priori evidence of linkage to a particular chromosome, it is difficult to classify variants of unknown significance.

For families that are large enough to provide sufficient statistical power, genetic linkage analysis remains an efficient means of identifying deafness genes. New methods using SNP markers have greatly decreased the cost and time of whole-genome genotyping analyses. For dominant high-frequency hearing loss, phenocopies, such as individuals with hearing loss due to aging or noise exposure, are common, which may reduce the power to detect linkage. Although family 63 (with 9 affected individuals) may be at the borderline level of power to detect linkage for a dominant trait, we detected linkage with a significant multipoint LOD score of 3.6. The linkage region identified in family 63 also includes another reported hearing loss gene, GJB3. However, because the evidence implicating GJB3 mutations as a cause of dominant nonsyndromic deafness is unclear, GJB3 was not examined for mutations in this family.

In conclusion, we describe a novel mutation in KCNQ4 segregating in a family with autosomal dominant high-frequency SNHL. Linkage analysis may still have a role to play in facilitating identification of the molecular etiology of deafness in patients in the future.

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Author Contributions: All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Lee, Leal, and Lesperance.

Acquisition of data: Arnett, Emery, Kim, Boerst, Leal, and Lesperance.

Analysis and interpretation of data: Arnett, Emery, Lee, Leal, and Lesperance.

Drafting of the manuscript: Arnett, Emery, Boerst, Lee, Leal, and Lesperance.

Critical revision of the manuscript for important intellectual content: Arnett, Kim, Lee, Leal, and Lesperance.


Study supervision: Lesperance.

Financial Disclosure: None reported.

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Previous Presentation: This study was presented at the 25th Annual Meeting of the American Society of Pediatric Otolaryngology; May 1, 2010; Las Vegas, Nevada.

Additional Contributions: We thank the family for their participation.
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dominant progressive inner ear deafness. Acta Otolaryngol. 1983;95(5-6):
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a rare cause of failed parathyroidectomy that should be considered before reoperation. Patients with persistent hyperparathyroidism who have negative findings on sestamibi scans may benefit from widening or customization of scanned fields as directed by selective venous sampling.

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Author Contributions: Mr Nguyen and Dr Yeh had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Abemayor and Yeh. Analysis and interpretation of data: Nguyen, Lau, Abemayor, and Yeh. Drafting of the manuscript: Nguyen, Abemayor, and Yeh. Critical revision of the manuscript for important intellectual content: Lau, Abemayor, and Yeh. Administrative, technical, and material support: Nguyen. Study supervision: Lau, Abemayor, and Yeh.

Financial Disclosure: None reported.

REFERENCES


Correction

Omission of Grant Number. In the article titled “Autosomal Dominant Progressive Sensorineural Hearing Loss Due to a Novel Mutation in the KCNQ4 Gene,” by Arnett et al, published in the January issue of the Archives (2011; 137[1]:54-59), a funding source was omitted. The acknowledgment on page 58 should have read as follows:

Funding/Support: This work was supported by grants R21 DC010074 and R01 D007380 (Dr Lesperance), and R01 DC03594 (Dr Leal) from the National Institute on Deafness and Other Communication Disorders and by the Biomedical Research Council of the University of Michigan (Dr Lesperance). Genotyping services were provided by the Center for Inherited Disease Research through a fully funded federal contract (N01-HG-65403) from the National Institutes of Health to The Johns Hopkins University. The article was corrected online.