Early-Onset Cerebral Amyloid Angiopathy and Alzheimer Disease Related to an APP Locus Triplication

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Abstract

Background and Objective
To report a triplication of the amyloid-β precursor protein (APP) locus along with relative messenger RNA (mRNA) expression in a family with autosomal dominant early-onset cerebral amyloid angiopathy (CAA) and Alzheimer disease (AD).

Methods
Four copies of the APP gene were identified by quantitative multiplex PCR of short fluorescent fragments, fluorescent in situ hybridization (FISH), and array comparative genomic hybridization. APP mRNA levels were assessed using reverse-transcription–digital droplet PCR in the proband’s whole blood and compared with 10 controls and 9 APP duplication carriers.

Results
Beginning at age 39 years, the proband developed severe episodic memory deficits with a CSF biomarker profile typical of AD and multiple lobar microbleeds in the posterior regions on brain MRI. His father had seizures and recurrent cerebral hemorrhage since the age of 37 years. His cerebral biopsy showed abundant perivascular amyloid deposits, leading to a diagnosis of CAA.

In the proband, we identified 4 copies of a 506-kb region located on chromosome 21q21.3 and encompassing the whole APP gene without any other gene. FISH suggested that the genotype of the proband was 3 copies/1 copy corresponding to an APP locus triplication, which was consistent with the presence of 2 APP copies in the healthy mother and with the paternal medical history. Analysis of the APP mRNA level showed a 2-fold increase in the proband and a 1.8 fold increase in APP duplication carriers compared with controls.

Discussion
Increased copy number of APP is sufficient to cause AD and CAA, with likely earlier onset in case of triplication compared with duplication.
Amyloid-β precursor protein (APP) is the main gene known to be involved in autosomal dominantly inherited cerebral amyloid angiopathy (CAA). After the description of point mutations, APP locus duplications were identified in 2006 as a cause of early-onset CAA and/or early onset Alzheimer disease (EOAD, onset before 65 years). Such copy number variations encompass at least the APP gene, with or without surrounding genes on chromosome 21, and are associated with ~1.5-fold increased messenger RNA (mRNA) levels in blood compared with healthy controls, in similar ranges to patients with trisomy 21. The size of the duplication and the gene content—beyond the critical APP gene—do not appear to influence phenotypic presentation in cases. Patients with trisomy 21 usually show cognitive impairment similar to Alzheimer disease (AD), although they less frequently exhibit cerebral hematoma, suggesting the presence of protective mechanisms in patients with Down syndrome. Indeed, a recent histopathologic study showed more severe CAA but less parenchymal amyloid plaque formation in APP duplication than in trisomy 21 patients. Given this diversity in amyloid distribution according to the underlying genetic background, CAA pathogenesis remains to be understood. We here report an APP locus triplication, along with relative mRNA expression in the proband’s blood.

**Case Presentation**

A 41-year-old man without medical history was referred to a memory care center for the evaluation of progressive cognitive decline. From age 39 years, he presented with an aggressive course of episodic memory loss making him unable to maintain his professional activity as well as attention deficit and executive dysfunction. The Mini Mental State Examination (MMSE) scored 18/30 and Frontal Assessment Battery 15/18. There was neither language impairment nor praxis or visuoconstructive dysfunction. The patient did not present any episode suggestive of stroke or seizures. Brain MRI showed multiple lobar microbleeds in the posterior fossa and occipital region and posterior periventricular leukoencephalopathy (Figure 1A) with hippocampal atrophy (bilateral Scheltens scale rating of 2). He underwent lumbar puncture for quantification of CSF AD biomarkers Aβ42, tau, and phosphorylated-tau. The Aβ42 level was decreased (404 ng/L, N > 550), with increased tau (491 ng/L, N < 400) and phospho-tau protein levels (95 ng/L, N < 60). The Aβ40 level was 8,546 ng/L (4,540 < N < 8,480). Overall, he fulfilled the diagnostic criteria of probable AD with evidence of the AD pathophysiologic process, in association with probable CAA following the modified Boston criteria, except the age criterion.

His father had had recurrent migraine with visual aura and presented at age 37 years with transient loss of consciousness (Figure 1B). Focal epilepsy was diagnosed after recurrent episodes of contact loss and electroencephalography showing slow bilateral temporal waves and then treated by carbamazepine. Subsequent cerebral MRI showed hyperintensities in

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**Glossary**

aCGH = array comparative genomic hybridization; AD = Alzheimer disease; APP = amyloid-β precursor protein; CAA = cerebral amyloid angiopathy; EOAD = early-onset Alzheimer disease; MMSE = Mini Mental State Examination; mRNA = messenger RNA; QMPSF = quantitative multiplex PCR of short fluorescent fragments.
centrum semiovale on T2-weighted sequences. CSF was acellular and showed a moderately high protein level (0.61 g/L), but AD biomarkers were not available at this time.

Progressive behavioral disorders and severe cognitive impairment occurred 4 years later and worsened over time with an MMSE of 24/30. Neuropsychological testing showed...
episodic memory loss associated with praxis and visuocentric moderate dysfunction. He thus fulfilled the diagnostic criteria of probable AD and probable CAA. Tc99m-HMPAO cerebral single photon emission computerized tomography was considered normal. At age 44 years, his condition was extremely severe with repeated loss of consciousness episodes and major upper cerebral dysfunction. Cerebral MRI showed acute bilateral temporal hematomas and posterior leukoencephalopathy. Cerebral angiography did not display any sign of cerebral vasculitis. Cerebral biopsy revealed abundant perivascular amyloid deposits enabling the final diagnosis of probable CAA with supporting pathological evidence (Figure 1C). He died at age 48 years after a second hemorrhagic event with left temporal lateral temporal hematomas and posterior leukoencephalopathy. There was no history of dementia or stroke in his family, although a censoring effect was noticed: the paternal grandfather of the proband indeed died at age 50 years from lymphoma (Figure 1B).

**Genetic Assessment**

We obtained informed written consent for genetic analyses by the patient and by the father’s legal representative. This study was approved by the Institutional Review Board of Rouen University Hospital (CERDE #2019-55 notification).

Quantitative multiplex PCR of short fluorescent fragment (QMPSF) analyses performed from DNA isolated from fresh whole blood revealed 4 copies of the APP gene in the proband (Figure 2A). His APOE genotype was 33, and Sanger sequencing did not detect any point mutation in exons 16–17 of APP. The 68-year-old unaffected mother carried 2 copies of APP, suggesting a 3 + 1 genotype in the proband, but no DNA sample was available from his father. Fluorescent in situ hybridization using APP locus specific probes (RP11-410J1; Empire Genomics, Williamsville, NY) on cultured lymphocytes metaphase cells showed an asymmetric positive hybridization signal on chromosome 21 long arm without other signal hybridization anywhere else (Figure 2C), further suggesting a 3 + 1 genotype and hence autosomal dominant transmission of a triplication.

We further mapped the triplication using array comparative genomic hybridization (aCGH, Agilent SurePrint 4 × 180k; Agilent Technologies, Santa Clara, CA). The 506-kb 21q21.3 duplication (chr21:27,156,233-27,662,338;hg19) was restricted to the whole APP gene without any flanking gene coding sequence (Figure 2, B and D).

Finally, mRNA APP levels were assessed using reverse-transcription–digital droplet PCR in the proband whole blood comparatively to 10 normal controls (including the proband’s mother) and 9 patients carrying APP duplications (see eMethods, links.lww.com/NXG/A465). The patient showed a 2-fold increase of relative APP mRNA levels compared with controls (Figure 3 and eFigure 1, links.lww.com/NXG/A470). Patients with APP duplication showed a median of 1.8 fold increase compared with controls, but no comparison could be directly made with our proband, considering this single APP triplication case.

**Discussion**

To our knowledge, this is the first report of an APP locus triplication, causing a two-fold upregulation of APP mRNA levels, in a family presenting with autosomal dominant EOAD with severe CAA. Although duplications of a given gene are now a classical cause of several autosomal dominant disorders, there are few examples of mendelian diseases caused by a gene triplication. In the field of neurodegenerative diseases, SNCA triplications on chromosome 4 have been reported in patients with Parkinson or Lewy body disease along with duplications in other patients. As for the APP gene, alpha-synuclein–encoding SNCA increased gene copies encompassed at least the SNCA gene, with or without surrounding genes (1 to 50), and displayed high diversity in clinical phenotype. Similarly, since its first description, some diversity of phenotypes associated with APP duplications has been described, mostly related to the predominance of AD or CAA-related symptoms at presentation. In this report, triplication was associated with diverse presentation, including severe cognitive disorder in the proband and recurrent ICH and seizures in his father.
The higher copy number seemed to be associated with earlier symptomatic phase in our report (37 and 39 years of age at onset) compared with APP duplications carriers showing ages at onset ranging from 39 to 65 years. However, we can expect some degree of diversity in ages of onset in other APP triplication families.

In a recent French series of EOAD, APP duplication carriers were more likely to present with seizures, possibly explained by $\beta$-overproduction related to increased APP expression. Early seizures may be a shared clinical feature with APP triplication as observed in the father of the proband.

Different mechanisms can be involved in autosomal dominant CAA and AD pathogenesis. In contrast with APP point mutations, which can result in increased beta cleavage of APP, change in $\beta$42/38 ratio, or in $\beta$-aggregation propensity, APP duplications lead to APP overproduction, with severe $\beta$ deposits in the brain parenchyma and within vessel walls. Here, cerebral biopsy of the proband’s father confirmed severe amyloid perivascular deposits consecutive to APP overproduction. Indeed, we found a 2-fold upregulation of APP mRNA levels in blood. Unfortunately, no comparison could be made with APP duplication carriers given the availability of RNA in the proband only so that we cannot be sure that triplications result in significantly increased mRNA levels than in duplication.

Here, we showed by aCGH that the triplication encompassed the APP gene only. To our knowledge, there is a single case report of an APP duplication encompassing the APP gene solely, highlighting that increased APP expression is sufficient to cause EOAD and CAA. However, the resolution of the techniques did not allow us to assess whether the breakpoints were the same in our case and in this 290–750 kb duplication. The mechanisms underlying genomic instability of the APP region remain elusive, and further reports are needed to refine shared or novel breakpoints.

Overall, our report provides further evidence that increased APP expression is sufficient to lead to $\beta$ aggregation and subsequent EOAD and CAA. Although ages at clinical onset were among the earliest ones in our APP triplication carriers compared with duplication carriers, further cases would be required to conclude.

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Disclosure
The authors report no disclosures relevant to the manuscript. Go to Neurology.org/NG for full disclosures.

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References


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