Out-of-Frame Mutations in ACTN2 Last Exon Cause a Dominant Distal Myopathy With Facial Weakness

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Abstract

Background and Objectives
To clinically, genetically, and histopathologically characterize patients presenting with an unusual combination of distal myopathy and facial weakness, without involvement of upper limb or shoulder girdle muscles.

Methods
Two families with a novel form of actininopathy were identified. Patients had been followed up over 10 years. Their molecular genetic diagnosis was not clear after extensive investigations, including analysis of candidate genes and FSHD1-related D4Z4 repeats.

Results
Patients shared a similar clinical phenotype and a common pattern of muscle involvement. They presented with a very slowly progressive myopathy involving anterior lower leg and facial muscles. Muscle MRI finding showed complete fat replacement of anterolateral compartment muscles of the lower legs with variable involvement of soleus and gastrocnemius but sparing thigh muscles. Muscle biopsy showed internalized nuclei, myofibrillar disorganization, and rimmed vacuoles. High-throughput sequencing identified in each proband a heterozygous single nucleotide deletion (c.2558del and c.2567del) in the last exon of the ACTN2 gene. The deletions are predicted to lead to a novel but unstructured slightly extended C-terminal amino acid sequence.

Discussion
Our findings indicate an unusual form of actininopathy with specific molecular and clinical features. Actininopathy should be considered in the differential diagnosis of distal myopathy combined with facial weakness.
Distal myopathies are genetic muscle diseases, presenting at the onset with weakness of foot and lower leg and/or hand and forearm muscles, which cause progressive loss of muscle tissue. Prominent anterior lower leg weakness, facial weakness, and scapular winging are the hallmarks of facioscapulohumeral muscular dystrophy. Facial weakness has also been reported in patients with distal myopathies due to mutations in \textit{ADSSL1}, \textit{RYRI}, \textit{MYH7}, \textit{NEB}, and \textit{DNM2}.\(^1\)

We have been following up for many years 2 unrelated patients with an unusual combination of distal lower limb myopathy and facial weakness without involvement of upper limbs or shoulder girdles. Proband 1 (F1,II:4) is a Finnish woman in her 60s (eFigure1, links.lww.com/NXG/A442). The proband’s first neurologic examination in 2005 revealed weakness of ankle dorsiflexion and mild atrophy of anterior lower leg muscles. Mild facial weakness, noticeable since her late childhood, was also observed (Table). Weakness slowly progressed over the years. At age 59 years, she displayed severe distal lower limb weakness and atrophy, mild proximal lower limb weakness; moderate facial weakness, and pes cavus. The second proband (F2,II:2) is a 58-year-old Italian man (eFigure1). He had presented with tachyarrhythmia and lower limb distal weakness since his early adulthood (Table). The disease later progressed to proximal lower limb and facial muscles (eFigure2, links.lww.com/NXG/A443) without scapular and upper limbs involvement. He also developed dilated cardiomyopathy.

Lower leg muscle MRI finding showed a similar pattern with complete fatty replacement of anterolateral compartment muscles of the lower legs but largely sparing thigh muscles (Figure 1).

The probands did not have any FSHD-1–causing mutation. High-throughput sequencing analysis (for F1,II:4, Nimblegen SeqcapEZ Human Exome Library v2.0; Roche, Basel, Switzerland, and for F2,II:1, ClearSeq Inherited DiseaseXT; Agilent Technologies, Santa Clara, CA) identified single nucleotide deletions in the \textit{ACTN2} last exon and did not detect causative mutations in \textit{SMCHD1} or other myopathy-causing genes. The variant NM001103:c.2567del in the Italian patient, \textit{ADSSL1} in the Finnish patient, \textit{MYH7}, and \textit{DNM2} were conserved in other unaffected relatives tested. The \textit{ACTN2} deletion, NM001103:c.2558del, identified in the Italian patient, replaces the 45 final amino acids (p.Glu853Glyfs*48) and results in a C-terminal amino acid sequence similar to the one

### Table Clinical Data of the Reported Patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex/age at last examination/origin</th>
<th>Symptoms at onset (age at onset)</th>
<th>Muscle weakness (last assessment)</th>
<th>MRI findings</th>
<th>CK</th>
<th>Muscle biopsy</th>
<th>EMG</th>
<th>Cardiac function</th>
<th>Causative variant (NM_001103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1 II:4</td>
<td>M/58/Italy</td>
<td>Foot drop and atrial fibrillation (young adult)</td>
<td>Severe distal LL weakness and atrophy, mild proximal LL weakness; moderate facial weakness, and pes cavus</td>
<td>1–1.5× Internalized nuclei</td>
<td>Myopathic</td>
<td>DCM, AF, tachyarrhythmia</td>
<td>c.2558del; p.Glu853Glyfs*48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F1 III:2</td>
<td>F/39/Finland</td>
<td>Scoliosis (teen)</td>
<td>Mild bilateral foot drop, lower facial weakness</td>
<td>n.a.</td>
<td>n.a.</td>
<td>Core-like structures and internalized nuclei; myofibrillar aggregates and rimmed vacuoles</td>
<td>Myopathic</td>
<td>Normal cardiac echo at age 60 years</td>
<td>c.2567del; p.(Pro856Argfs*45)</td>
</tr>
<tr>
<td>F2 II:1</td>
<td>M/58/Italy</td>
<td>Foot drop and ankle amputation (young adult)</td>
<td>Distal anterior LL weakness and atrophy, moderate facial weakness</td>
<td>Anterior and peroneal compartments, gastrocnemius medialis, and soleus</td>
<td>Normal</td>
<td>Core-like structures and internalized nuclei; myofibrillar aggregates and rimmed vacuoles</td>
<td>Myopathic</td>
<td>Normal cardiac echo at age 60 years</td>
<td>c.2567del; p.(Pro856Argfs*45)</td>
</tr>
</tbody>
</table>

Abbreviations: AF = atrial fibrillation; CK = creatine kinase; DCM = dilated cardiomyopathy; LL = lower limb; n.a. = not available.
resulting from the c.2567del variant (eFigure3). The variant was not present in the proband’s healthy mother and brother.

The identified variants are not listed in gnomADv2.1.1 and are not anticipated to result in nonsense-mediated decay. The variants replace the entire second EF (EF3-4) domain that is needed for alpha-actinin 2 dimerization and for its binding to titin\(^3\) (eFigure3).

Muscle biopsies showed internalized nuclei and fiber size variation. Immunohistochemical analysis was performed on the Finnish patients using monoclonal antibodies against desmin (Biogenex, Fremont, CA; clone D33), myotilin (Leica Biosystems, Wetzlar, Germany; clone RSO34), alpha-B-crystallin (Novus Biologicals, Littleton, CO; clone 1D11C6E6), and alpha-actinin (Sigma-Aldrich, St. Louis, MO; clone EA-53). In the Finnish patients’ biopsies, there were rimmed vacuoles and myofibrillar aggregates, strongly positive for alpha-crystallin and myotilin and weakly positive for desmin (Figure 2). Nicotinamide adenine dinucleotide stain showed core-like pathology.

In the Finnish proband’s muscle biopsy, immunochemistry showed minor irregular staining of alpha-actinin pinpointing the areas of myofibrillar disarray (Figure 2), which, however, could simply reflect disorganization of the underlying myofibrils. No clear accumulation of alpha-actinin was observed (the antibody recognizes both alpha-actinin 2 and 3, but the patient has no expression of alpha-actinin 3, being homozygous for the \(\text{ACTN3}\) p.R577X variant\(^4\)). A transcriptome analysis (library prepared using the NEBNext Ultra II Directional RNA library Prep for Illumina, New England Biolabs) on the same sample confirms that the variant c.2567del results in a normal, biallelic expression of \(\text{ACTN2}\) transcripts.

In 2019, we described a distal myopathy, without facial weakness, caused by \(\text{ACTN2}\) missense variants in 4 families.\(^5\) De novo \(\text{ACTN2}\) variants were identified in 2 patients with congenital myopathy with structured cores, showing mild facial weakness.\(^6\) Missense variants have also been associated with cardiomyopathies\(^7\) (eFigure3c, links.lww.com/NXG/A444).

In this study, we describe a novel form of dominant distal actininopathy to be considered in the differential diagnosis of patients having lower leg predominant distal myopathy with facial weakness.

**Standard Protocol Approvals and Patient Consents**

Patients provided informed consent. Ethical approval falls under HUS:195/13/03/00/11.

**Data Availability**

Deidentified data are available on request.
Acknowledgment
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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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### Appendix (continued)

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### References

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