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Title: NOVEL GRHL3 VARIANTS IN A SOUTH AFRICAN CLEFT LIP AND PALATE COHORT

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Structured Abstract

Objective: The etiology of cleft palate (CP) is poorly understood compared with that of cleft lip with or without palate (CL/P). Recently, variants in Grainyhead like transcription factor 3 (*GRHL3*) were reported to be associated with a risk for CP in European and some African populations including Nigeria, Ghana, and Ethiopia. In order to identify genetic variants that may further explain the etiology of CP, we sequenced *GRHL3* in a South African population to determine if rare variants in *GRHL3* are associated with the presence of syndromic or nonsyndromic CP.

Design: We prospectively sequenced the exons of *GRHL3* in 100 cases and where possible, we also sequenced the parents of the individuals to determine the segregation pattern and presence of *de novo* variants.

Setting: The cleft clinics from two public, tertiary hospitals in Durban, South Africa (SA), namely Inkosi Albert Luthuli Central Hospital (IALCH) and KwaZulu-Natal Children's Hospital (KZNCH).

Patients, participants: 100 patients with CL/P and their parents.

Interventions: Saliva samples were collected.

Main outcome measures: To ascertain the genetic variants in the *GRHL3* gene in patients with CL/P in SA.

Results: Five variants in *GRHL3* were observed; three were novel (two intronic and one missense variant) and two are known variants. The novel variants were intronic variants, c.1062+77A>G and c.627+1G>A and missense variant, p.Asp169Gly.

Conclusions: This study provides further evidence that variants in *GRHL3* contribute to the risk of nonsyndromic CP in African populations, specifically, in the South African population.

Key Words: GRHL3, cleft lip palate, South Africa

Introduction:

Orofacial clefts (OFC) are common craniofacial abnormalities occurring with a worldwide prevalence of 1 in 700 live births ¹. However the prevalence of OFC differs according to ethnicity, race and geographical location. The highest reported prevalence of clefts occur in Asian populations, followed by Europeans, whereas African populations show the lowest prevalence ². The rates range from as high as 1 in 500 births in Asians to as low as 1 in 2000 births in Africans ³.

Although South Africa does not have a current national birth defect registry, studies conducted using the Birth Defects Notification Tool form show that OFC represent one of the top five priority birth defects ⁴. The prevalence of OFCs in South Africa is estimated to be around 1 per 3333 live births ⁵.

There are biological and social effects with OFC and treatment aims should address the appearance, speech and hearing of an affected individual. This condition also places a significant psychological and economic burden on the individual, family and the healthcare service. However, good treatment outcomes are possible, especially in centres where a multidisciplinary OFC team approach is utilised.

The clinical classification of OFC includes cleft lip with or without cleft palate (CL/P) and cleft palate (CP). The etiology of OFC is complex and multifactorial with influences from genetics, genomics, the environment and possible gene-environment interactions ⁶.

The genetic etiology of CP alone is least understood and approximately 50% of all CP patients are nonsyndromic ⁶. To date, very little research has been done on the genetic etiology of OFCs in South Africa. The current study is part of a comprehensive project to identify the genetic and genomic causes of OFC in the South African population through the African Craniofacial Anomalies Network (AfriCRAN) ⁷. In this study, we screened the Grainyhead like transcription factor 3 (*GRHL3*) gene for variants in a cohort from South Africa.

GRHL3 is a transcription factor that plays an important role in primary neurulation and in the differentiation of stratified epithelia of ectodermal or endodermal origin ⁸. *GRHL3* has been previously associated with CP. Mutations were found in a Van Der Woude Syndrome (VWS) family with CP in a linkage and targeted sequencing study ⁹. Leslie et al. 2016 ¹⁰ performed genome wide association studies (GWAS) of nonsyndromic CP and found an association with a missense variant in *GRHL3*. The result was replicated in an independent cohort. They concluded that the p.Thr454Met variant is an etiologic variant for nonsyndromic CP. In a parallel study, Mangold et al 2016 ¹¹ found a significant association between the p.Thr454Met variant in *GRHL3* and nonsyndromic CP.

Recently, variants of *GRHL3* were found to be associated with risk for CP in African populations from Nigeria, Ghana and Ethiopia ¹². The current study identified novel variants in *GRHL3* that are associated with CP.

Participants & Methods

Study population

Patients born with various OFC types and parents of these cases were recruited and assessed at the cleft clinics from two Durban hospitals in South Africa, namely Inkosi Albert Luthuli Central Hospital (IALCH) and KwaZulu-Natal Children's Hospital (KZNCH). The assessment was conducted by the principal investigator, a paediatrician (TN); and findings were verified by plastic surgeons and an orthodontist. This was an observational clinical study to ascertain the genetic causes of cleft lip and palate in the African population in KwaZulu-Natal. Patients were consecutively selected from the cleft clinics. Eligible children must be of African ancestry and have a CL/P.

Informed consent was obtained from all participating families. A case report form was completed and saliva samples were collected with Oragene saliva kits and sponges (DNA Genotek). These samples were sent to the Butali Laboratory at the University of Iowa for processing and analysis. DNA from all samples was extracted, followed by XY genotyping analysis for quality control purposes to ensure that the sex of the sample matched the sex of the actual donor. A combination of 100 case-parent samples (dyads and triads) were collected and included for Sanger sequencing. Biomedical Research Ethics Committee clearance (BE309/18) was obtained from the University of KwaZulu-Natal.

Sanger Sequencing

Methods previously reported by our team were used to sequence DNA from humans¹³. We optimized 13 primers for the amplification of 18 exons in the *GRHL3* gene (NM_198174). We used 1ul of DNA in a 10- μ L reaction for the polymerase chain reaction (PCR). Two Nigerian CEPH samples (NA18855 and NA18856) were added as template controls. The primers used and annealing temperatures are available from the Butali Laboratory upon request. The amplified DNA products were sequenced at Functional Biosciences (<http://functionalbio.com>)

In order to identify novel and rare variants, every variant found in our isolated population were compared to those in the 1000 Genomes database, Exome Variant Server database (<http://snp.gs.washington.edu/EVS/>), and exomes in the Genome Aggregation Database (gnomAD; <http://gnomad.broadinstitute.org>). To predict the functional effects of these variants on the protein, we used bioinformatics tools, such as Combined Annotation Dependent Depletion (CADD; <https://cadd.gs.washington.edu/>;¹⁴, Polymorphism Phenotyping (Polyphen; <http://genetics.bwh.harvard.edu/pph2/>;¹⁵, Sorting Intolerant from Tolerant (SIFT; <http://sift.jcvi.org/>;¹⁶, Have Your Protein Explained (HOPE; <http://www.cmbi.ru.nl/hope>;¹⁷, and Human Splicing Finder (HSF; <http://www.umd.be/HSF/>)¹⁸. To assess the inheritance patterns of these variants, we sequenced parent samples, when available.

Results:

We observed five variants in *GRHL3*, three were novel (two intronic and one missense variant) and two were known variants. The novel variants were missense variant, p.Asp169Gly and intronic variants, c.1062+77A>G and c.627+1G>A (Table 1). These novel variants were absent from all public exome and genome databases including over 8000 individuals from Africa.

Segregation analyses for the novel missense variant, p.Asp169Gly, showed that the father had the variant even though he did not have CP implying that the phenotype was not completely penetrant. The patient's paternal half-sister and first cousin, also had CP (Figures 1 and 2).

The missense mutation (p.Arg298Cys) was found in the 1000 Genomes database and was previously reported twice; in a Non-Finnish European population and a Southeast Asian population. However, this is the first report of the same mutation in an African population with phenotypic data.

The known intronic variant (p.Arg16Gln) with the potential to alter splicing was identified in an individual with a cleft lip and alveolus. This variant was previously reported in East and West African populations. However, this is the first report in a South African population.

According to HOPE (<http://www.cmbi.ru.nl/hope>), the novel missense mutation (p.Asp169Gly) affected the structure and function of the protein for a number of biochemical reasons. There was a difference in charge, size and hydrophobicity between the wild-type and variant amino acid. The charge of the wild-type residue was lost. This could cause loss of interactions with other molecules or residues. The mutant residue was smaller and this may lead to loss of interactions. Lastly, the mutation introduced a more hydrophobic residue in this position which could result in the loss of hydrogen bonds thereby disturbing correct folding of the *GRHL3* protein (Figure 2).

Discussion:

In our variant screen study of *GRHL3* families with OFC from South Africa, we identified a novel missense variant (p.Asp169Gly) in a multiplex family with CP. The variant segregates in the family with the father carrying the variant. However, the father does not have a CP suggesting that there is incomplete penetrance.

This novel missense variant (p.Asp169Gly) was not found in control databases that cumulatively has over 16,000 African alleles. PolyPhen-2 predicts the (p.Asp169Gly) variant is probably damaging while SIFT predicts that it is tolerated. The difference in effect prediction between the two in silico bioinformatics tools may be due to the design of the algorithms used for prediction of variant pathogenicity utilized by each tool. SIFT predicts whether an amino acid substitution is likely to affect protein function based on sequence homology and physico-chemical similarity between the alternate amino acids. The CADD score for this novel missense variant (p.Asp169Gly) is 26 suggesting that this variant is in the top 1% of deleterious variants in the genome. The PROVEAN score of -0.36 predicts that the variant has a neutral effect. The variant was absent from the 1000 Genomes, Exome Variant Server and gnomAD databases.

The novel splice donor variant (c.627+1G>A) was found in intron 4 of a patient with CP. The variant has a high CADD score of 34, placing it in the top 0.1% of deleterious mutations in the genome. It caused alteration to the wild type donor site, which most probably affected splicing. The novel intronic variant (c.1062+77A>G) has a low CADD score of 0.104 and was found in a patient with bilateral cleft lip and palate with the right side having an incomplete cleft lip. This variant may not be associated with phenotype since variants in *GRHL3* have only been previously associated with CP.

The rare known missense variant (p.Arg298Cys) has been reported in the gnomAD database, however it is uncertain if these individuals had isolated CP. It has a CADD score of 26.7 and was predicted to be probably damaging and deleterious. The absence of phenotype in the control database makes it difficult to interpret this finding. Lastly, the known splicing variant (p.Arg16Gln) with a CADD score of 22.7 may contribute to CP as it will potentially affect splicing.

This study provides further evidence that mutations in *GRHL3* contribute to the risk of nonsyndromic CP in African populations, specifically, in the South African population. This is consistent with findings in other studies from Africa¹². More genetics and genomics studies need to be conducted in South Africa to determine additional genetic etiology of orofacial clefts in Sub-Saharan Africa.

Table 1: Sequence Variations for GRHL3 Observed in Individuals from an Isolated South African Population

Nucleotide position	Exon/Intron	HGVS ^c	HGVS ^p	Type of Variant	Novel / Known	1KG	EVS	gAD	PolyPhen	SIFT	Provean	CADD	HSF	Cleft Type of Individual
chr1:24336721	Exon 4/16	c.506A>G	p.Asp169Gly	Missense	Novel	0	0	0	PD	T	-0.36	26.0	n/a	Cleft palate
chr1:24339839	Intron 8/15	c.1062+77A>G		Intronic	Novel	0	0	0	n/a	n/a	n/a	0.104		Bilateral Cleft lip palate. Right side incomplete.
chr1:24336828	Intron 4/15	c.627+1G>A		Splice_Donor_Variant	Novel	0	0	0	n/a	n/a	n/a	34		Cleft palate
chr1:24338043	Exon 7/16	c.892C>T	p.Arg298Cys	Missense	Known	0	0	7.99E-06	PD	D	-5.50	26.7	n/a	Cleft palate
chr1:24331440	Exon 2/16	c.47G>A	p.Arg16Gln	Missense 5 prime UTR Intronic	Known	4.50E-03	2.72E-03	3.26E-03	Benign	T	n/a	22.7	PAS	Right Cleft lip and Alveolus

"c" refers to the coding sequence position within the GRHL3 transcript, NM_198173.3 "p" refers to amino acid substitutions. Amino acid substitution is for the GRHL3 isoform 2 transcript, NP_937816.

1Kg, 1000 Genomes; B, benign; CS, Combined Annotation Dependent Depletion⁸ score; D, deleterious; EVS, Exome Variant Server; gAD, Genome Aggregation Database; HGVS, Human Genome Variation Society; HSF, Human Splicing Finder; P, Polyphen; PAS, potential alteration of splicing; PD, probably damaging; PS, Provean score; S, Sorting Intolerant from Tolerant (SIFT); T, tolerated.

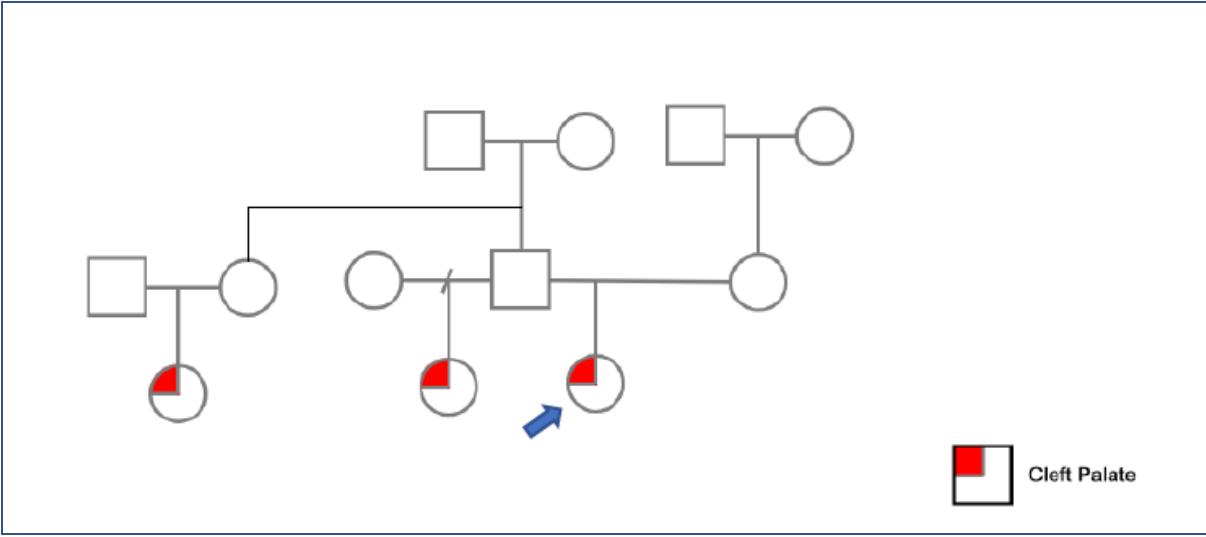


Figure 1. Pedigree of family with novel p.Asp169Gly variant

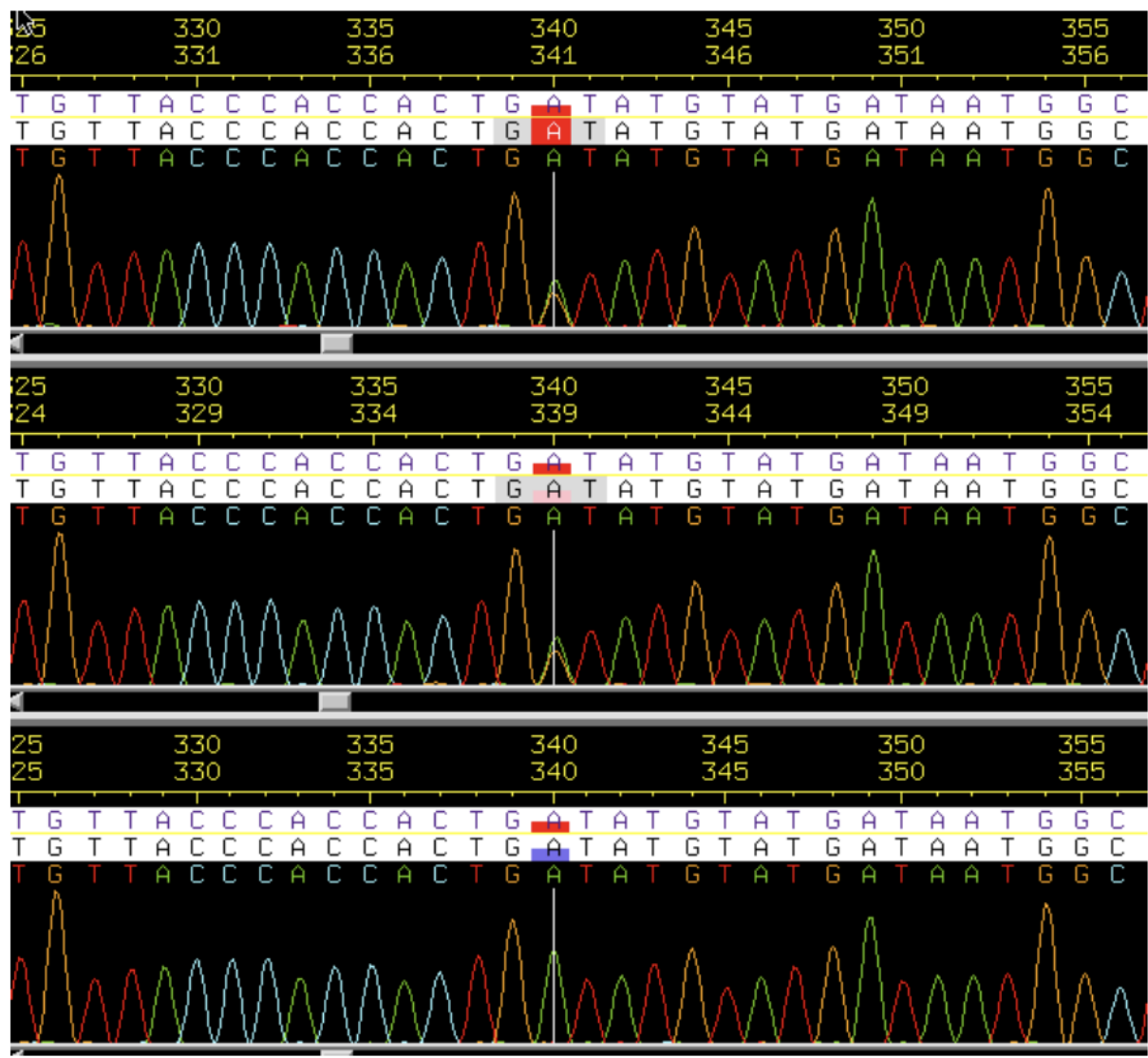


Figure 2: Chromatograph of p.Asp169Gly variant in index patient, father and control showing A>G changes

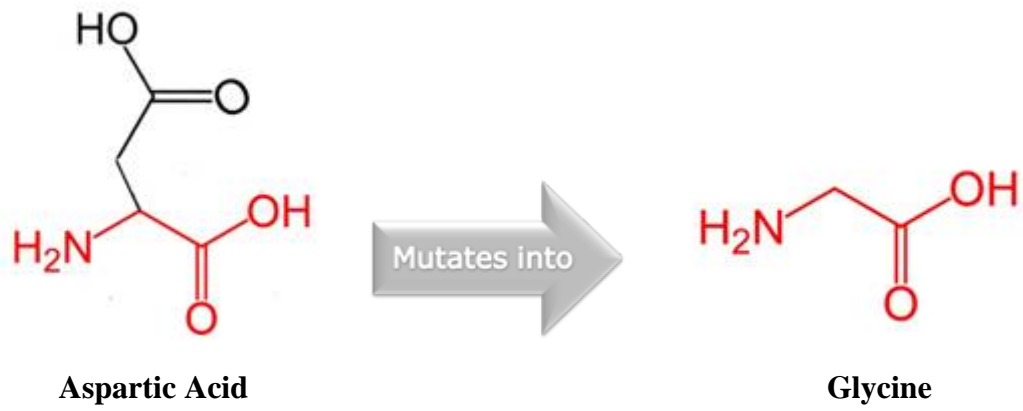


Figure 3. Mutation of Aspartic Acid into Glycine in p.Asp169Gly

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