Unexpected \(\alpha-\alpha\) Interactions With \(\text{Na}_\text{v}1.5\) Genetic Variants in Brugada Syndrome

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If you do not expect the unexpected, you will not find it, for it is not to be reached by search or trail

—Heraclitus of Ephesus, c.535–c.475 BC

In human genetics, autosomal dominant disorders are characterized by the fact that only 1 mutated copy of a given gene is sufficient to lead to a pathological phenotype. Sophisticated molecular mechanisms underlying dominant disorders have been described and among them, the case of negative dominance is an interesting phenomenon. Dominant-negative mutations have been defined by Herskowitz as mutations encoding mutant polypeptides that when overexpressed disrupt the activity of the wild-type (WT) gene. In its classical description, an inhibitory polypeptide (poison protein) negatively affects the function of a multimeric protein, thus leading to a dominant-negative effect that is in general, more severe than simple haploinsufficiency, where a copy of an allele is not expressed.

Several classes of membrane ion channels are formed by multimers of \(\alpha\)-subunits to constitute the pore protein and allow for the flux of ions across the membrane. The concept of negative dominance has been convincingly demonstrated with mutants of potassium channel subunits, formed by tetramers of \(\alpha\)-subunits, in cases of cardiac genetic channelopathies, such as congenital long-QT syndrome. Previous clinical studies have demonstrated that patients carrying missense mutations (which exert a dominant-negative effect) had more severe phenotypes when compared with ones carrying nonsense mutations.

The cardiac voltage-gated sodium channel \(\text{Na}_\text{v}1.5\), encoded by the gene \(\text{SCN}5\text{A}\), plays an important role in cardiac channelopathies because genetic variants in its gene were found to be linked, to date, to 9 distinct pathological phenotypes. Among the cardiac genetic disorders that are associated with \(\text{SCN}5\text{A}\) variants, Brugada syndrome (BrS) is one of the most prevalent. Briefly, BrS is characterized by malignant arrhythmias and sudden cardiac death and occurs predominantly in adult male individuals. A characteristic coved-type right-precordial ST-segment-elevation of the ECG is observed in patients with BrS. Three main aspects of the pathophysiological mechanisms underlying BrS are still the subject of intense investigations: (1) although rare \(\text{SCN}5\text{A}\) variants have been found in \(\approx20\%\) of patients with BrS, the causality link between these variants and the phenotype has been disputed; (2) a recent genome-wide analysis study demonstrated that \(\geq3\) loci contribute to the genetic background of the syndrome, and (3) the origin of the ECG alterations and the arrhythmogenic mechanisms may be explained by \(\geq3\) different working models that involve either depolarization or repolarization (or a combination of both) phases of cardiac electric activity. Many of the \(\text{SCN}5\text{A}\) genetic variants have been functionally characterized for the past years.

Some of these involve either premature stop codons or frame shifts that cause a lack of expression of the mutant allele, demonstrating that \(\text{SCN}5\text{A}\) haploinsufficiency can cause BrS. However, about two thirds of the \(\text{SCN}5\text{A}\) variants are missense mutations for which the pathogenic mechanisms are different.

A few years ago, our group investigated the BrS \(\text{SCN}5\text{A}\) missense p.L325R mutation. To recapitulate the heterozygous state of the patients, we coexpressed the WT and the p.L325R variants in HEK293 (human embryonic kidney) cells and observed that the sodium current was disproportionately reduced after the expression of the mutant variant (Figure, negative dominance–classical mutants). This phenomenon was not observed with a BrS nonsense mutation. This finding was the first demonstration that a mutant \(\text{Na}_\text{v}1.5\) protein may have a dominant-negative effect, raising the obvious question about the molecular mechanism underlying this unexpected observation because sodium channel multimerization had not been suspected. More recently, 2 other studies confirmed a dominant-negative phenomenon with other BrS mutations and further demonstrated that, in HEK293 cells, \(\alpha\)-subunits could coimmunoprecipitated. These were the first convincing biochemical evidence for an interaction between \(\alpha\) subunits of \(\text{Na}_\text{v}1.5\). It is also interesting that a similar negative dominance phenomenon was observed with genetic variants in the gene coding for \(\text{Ca}_{\text{2.1}}\) (which has a similar structure to \(\text{Na}_\text{v}1.5\)) in patients with episodic ataxia and epilepsy.

In this issue of Circulation: Cardiovascular Genetics, Hoshi et al., from the Deschénes group, present another unexpected twist. The initial motivation for their studies was the observation that several BrS \(\text{SCN}5\text{A}\) variants, for which the pathogenic potential was not demonstrated, presented only minor, if any, biophysical defects when studied in cellular expression systems. The authors named these variants atypical because classical BrS variants are either less expressed at the cell membrane (Figure) or showed loss-of-function biophysical alterations.
They observed that the atypical variants, when coexpressed with the WT channels, showed a surprisingly strong negative effect on the sodium current, ranging from 30% to 70% when compared with variants expressed alone. One variant, p.L567Q, was chosen to demonstrate that the results seen in HEK293 cells were not only a peculiarity of the expression system but also a phenomenon observed in neonatal ventricular myocytes and in human-induced pluripotent stem cell-derived cardiomyocytes. Hoshi et al. were also able to demonstrate with biotinylation experiments that the sodium current decrease, induced by the dominant-negative effect of p.L567Q channels on WT channels, was the result of reduced surface membrane protein expression of both WT and mutant channels (Figure). In addition, coimmunoprecipitation experiments were performed to show that the interaction between WT and atypical p.L567Q α-subunits was maintained. Finally, they performed functional experiments with MTSET ([2-(Trimethylammonium)ethyl] methanethiosulfonate) inhibitor on HEK293 cells, coexpressed with WT-p.C373Y (resistant to MTSET) and p.L567Q channels, to demonstrate that both channels were not only functional but also expressed at the cellular surface at similar levels (Figure).

These unexpected and intriguing findings by Hoshi et al. expand the range of possible molecular and pathological mechanisms underlying BrS and demonstrate the surprising fact that atypical, supposedly benign, mutant proteins may have a dominant-negative effect on WT channel proteins. Moreover, this work shows that the same level of mutated proteins and WT proteins are found at the membrane for the condition of negative dominance with atypical Na\textsubscript{v}1.5 variants. No other previous work had investigated the density of mutated and WT channels in the condition of negative dominance with classical Na\textsubscript{v}1.5 mutants. The mechanisms underlying this unusual dominant effect are not yet understood, as mentioned in the thoughtful discussion of Hoshi et al. Elucidation of these mechanisms is a clear objective for future studies because one can postulate that this knowledge will help us to understand the astonishing diversity in the pathological cardiac phenotypes linked to SCN5A variants.6

In conclusion, we raise a few open questions related to these new findings: What is the stoichiometry of sodium channel α-subunit multimerization? What are the molecular determinants of these α–α interactions? Could other voltage-gated sodium channel isoforms expressed in cardiac cells also interact with Na\textsubscript{v}1.5 and induce a dominant-negative effect?19

Finally, the question of the clinical relevance of these findings is also obvious. Meregalli et al. observed a few years ago that there is a positive correlation between BrS expressivity (in particular the occurrence of syncope) and the Na\textsubscript{v}1.5 variant-induced
reduction of sodium current. Could it be that dominant-negative variants in Na\textsubscript{1.5} with either typical or atypical mechanisms lead to varying degrees of severity of the BrS phenotypes?

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**Disclosures**

None.

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