
Characterization of alpha thalassemic genotypes by multiplex ligation-dependent probe amplification in the Brazilian population

Abstract

Alpha-thalassemia is the most common inherited disorder of hemoglobin synthesis. Genomic deletions involving the alpha-globin gene cluster on chromosome 16p13.3 are the most frequent molecular causes of the disease. Although common deletions can be detected by a single multiplex gap-PCR, the rare and novel deletions depend on more laborious techniques for their identification. The multiplex ligation-dependent probe amplification (MLPA) technique has recently been used for this purpose and was successfully used in the present study to detect the molecular alterations responsible for the alpha-thalassemic phenotypes in 8 unrelated individuals (3 males and 5 females; age, 4 months to 30 years) in whom the molecular basis of the disease could not be determined by conventional methods. A total of 44 probe pairs were used for MLPA, covering approximately 800 kb from the telomere to the MSLN gene in the 16p13.3 region. Eight deletions were detected. Four of these varied in size from 240 to 720 kb and affected a large region including the entire alpha-globin gene cluster and its upstream regulatory element (alpha-MRE), while the other four varied in size from 0.4 to 100 kb and were limited to a region containing this element. This study is the first in Brazil to use the MLPA method to determine the molecular basis of alpha-thalassemia. The variety of rearrangements identified highlights the need to investigate all cases presenting microcytosis and hypochromia, but without iron deficiency or elevated hemoglobin A2 levels and suggests that these rearrangements may be more frequent in our population than previously estimated.

Key words: Alpha-thalassemia; Hb H disease; Multiplex ligation-dependent probe amplification; Genetic polymorphisms; Brazilian population

Introduction

The human alpha (α)-globin gene cluster is located on the distal portion (p13.3-pter) of the short arm of chromosome 16 and includes three functional α-like protein coding genes (ζ, α2, and α1), two expressed genes with unknown function (µ and θ1), and three pseudogenes (ψζ, ψα1, ψρ) arranged in the order 5'-ζ-ψζ-µ-α1-ψρ-α2-α1-ψρ-θ1-3' (1,2). The α-globin regulatory elements lie upstream of the start of the α-globin gene (10 to 50 kb) and consist of four conserved Dnasel hypersensitive sites (HS-48, HS-40, HS-33, and HS-10) that bind erythroid-specific transcription factors (3,4). Of these four sites, HS-40 is the only capable of directing high-level expression of the α-globin chains and is thus the major regulatory element (α-MRE) (5).

Molecular lesions affecting the α-globin genes or their regulatory element (α-MRE) lead to α-thalassemia, an inherited hemoglobin (Hb) disorder characterized by a reduction in or absence of α-globin chain synthesis. Deletions are the major molecular cause of the disease and may affect one or both α-genes in the chromosome (the α+ and α0 forms, respectively) (1,6). The clinical phenotype of carriers varies according to the number of genes affected. Carriers of three functioning globin genes (α+/αα) do not present detectable red blood cell abnormalities or globin-chain imbalance, while carriers of two functioning
α-genes (-α/-α, --/α) have mild microcytic, hypochromic anemia with normal hemoglobin A2 levels. Carriers of only one functioning α-gene (−/−α) present moderate to severe anemia with markedly unbalanced globin-chain synthesis ratios. Failure to inherit any functional α-globin genes (−−) is usually incompatible with life and leads to Hb Bart’s (γ4 tetramers) hydrops fetalis (1,7).

Although α-thalassemia is present throughout the world, its distribution varies greatly among different populations. In Brazil, most of the recognized α-thalassemia mutations involve deletions of one α-globin gene (α+−thalassemias), although several cases of α0-thalassemias have been reported in the literature (8-12). It has been shown that the α3.7 deletion is the most frequent mutation in the Brazilian population, occurring in 20-25% of the black population in the Southeastern region of the country (13).

The most common α-thalassemia deletions can be detected by a single multiplex gap-PCR [i.e., -α3.7, -α4.2, -α20.5, -MED, -SEA, -FIL, -THF] (14). However, there are many cases whose iron profile, Hb A2 and Hb F levels are normal but whose red blood cells have reduced mean corpuscular volume (MCV) and mean corpuscular hemoglobin (MCH), hematological alterations that are characteristic of defects in hemoglobin synthesis and whose causes remain unidentified. Southern blot and/or FISH have been employed to determine the cause of these abnormalities; however, both techniques are time consuming and labor intensive (15).

Multiplex ligation-dependent probe amplification (MLPA) is a simple technique that is suitable for rapid quantitative analysis and allows the detection of any deletions or duplications in the screened regions. More recently, it has been used to study large alterations in globin genes (15). In the present study, we used this technique to determine the molecular basis of α-thalassemic phenotypes in 8 unrelated individuals, 5 of whom had Hb H disease.

### Patients and Methods

#### Patients

Eight patients of different ethnic backgrounds suspected of having hemoglobinopathies were referred to the UNICAMP Hospital, Campinas, in Southeastern Brazil, for hematological and DNA analysis. Three of them were selected because, although their iron status was normal, they had a thalassemia phenotype (MCV < 70 fl, MCH < 25 pg) and structurally intact α-globin genes. The other patients had Hb H disease, for which it had not been possible to determine the molecular basis as analysis revealed only one mutation (−α3.7 deletion). Family analysis was only possible for some patients because samples were not available for all family members. Demographic, hematological and molecular data of patients and relatives are summarized in Table 1.

Red blood cell indices were obtained with an electronic cell counter (Sysmex XE2100, Sysmex, Japan). Hemoglobin evaluation was carried out by electrophoresis on cellulose acetate at alkaline and neutral pHs, and the levels of Hb A2, Hb F, Hb H, and Hb Bart’s, when these were present, were quantified using cation exchange-high performance liquid chromatography (16) (Variant™, Bio-Rad Laboratories, USA). Preparations for the detection of Hb H inclusions were processed by incubating an aliquot of whole blood for 1 h at 37°C with 1% brilliant cresyl blue in buffered saline (16).

### Table 1. Demographic, hematological and molecular data for the patients and their families.

<table>
<thead>
<tr>
<th>Cases</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>PM3</th>
<th>PB3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>PF7</th>
<th>P8</th>
<th>PM8</th>
<th>PF8</th>
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<tbody>
<tr>
<td>Age/Gender</td>
<td>16/F</td>
<td>14/M</td>
<td>26/F</td>
<td>44/F</td>
<td>24/M</td>
<td>14/F</td>
<td>30/M</td>
<td>23/F</td>
<td>4m/F</td>
<td>29/M</td>
<td>3/M</td>
<td>27/M</td>
<td>30/M</td>
</tr>
<tr>
<td>RBC (10⁶/mm³) (RF: M: 4-5.6, F: 4.2-5.4)</td>
<td>5.02</td>
<td>4.66</td>
<td>6.66</td>
<td>5.05</td>
<td>5.38</td>
<td>5.03</td>
<td>5.97</td>
<td>5.64</td>
<td>5.35</td>
<td>6.15</td>
<td>6.09</td>
<td>4.55</td>
<td>6.37</td>
</tr>
<tr>
<td>Hb (g/L) (RF: M: 14-18, F: 12-16)</td>
<td>9.4</td>
<td>9.2</td>
<td>7.7</td>
<td>11.3</td>
<td>14.5</td>
<td>9.0</td>
<td>10.6</td>
<td>11.5</td>
<td>10.3</td>
<td>13.3</td>
<td>11.3</td>
<td>13.3</td>
<td>13.9</td>
</tr>
<tr>
<td>MCV (fl) (RF: M: 81-99, F: 80-96)</td>
<td>62</td>
<td>66.5</td>
<td>68.2</td>
<td>68.0</td>
<td>89.2</td>
<td>66.2</td>
<td>59.4</td>
<td>61.7</td>
<td>60.4</td>
<td>67.6</td>
<td>58.3</td>
<td>89.5</td>
<td>67.8</td>
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<tr>
<td>MCH (pg) (RF: 27-32)</td>
<td>18.6</td>
<td>18.6</td>
<td>16.5</td>
<td>22.4</td>
<td>27</td>
<td>17.9</td>
<td>18.1</td>
<td>20.4</td>
<td>19.3</td>
<td>21.6</td>
<td>18.6</td>
<td>29.2</td>
<td>21.8</td>
</tr>
<tr>
<td>HbF (%) (RF: &lt;1)</td>
<td>1.0</td>
<td>0.6</td>
<td>0.8</td>
<td>0.2</td>
<td>-</td>
<td>1.7</td>
<td>0.2</td>
<td>0.3</td>
<td>-</td>
<td>0.8</td>
<td>0.1</td>
<td>0.4</td>
<td>0.1</td>
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<tr>
<td>Hb A2 (%) (RF: 1.5-3.5)</td>
<td>1.3</td>
<td>1.2</td>
<td>1.5</td>
<td>2.7</td>
<td>-</td>
<td>1.6</td>
<td>1.5</td>
<td>2.6</td>
<td>-</td>
<td>3.1</td>
<td>3.0</td>
<td>3.4</td>
<td>3.0</td>
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<tr>
<td>Hb H (%)</td>
<td>4.5</td>
<td>13.4</td>
<td>9.5</td>
<td>-</td>
<td>-</td>
<td>6.9</td>
<td>10.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Molecular analysis*</td>
<td>-α3.7</td>
<td>-α3.7</td>
<td>-α3.7</td>
<td>-α3.7</td>
<td>-α3.7</td>
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<td>-α3.7</td>
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<tr>
<td>Sequencing of α-MRE</td>
<td>Hapl A</td>
<td>Hapl D</td>
<td>Hapl A</td>
<td>Hapl A</td>
<td>Hapl D</td>
<td>Hapl D</td>
<td>Hapl D</td>
<td>Hapl D</td>
<td>Hapl D</td>
<td>Hapl A</td>
<td>Hapl A</td>
<td>Hapl A</td>
<td>Hapl A</td>
</tr>
</tbody>
</table>

P = patients; PM = patient’s mother; PB = patient’s brother; PF = patient’s father; RBC = red blood cells; Hb = hemoglobin; MCV = mean corpuscular volume; MCH = mean corpuscular hemoglobin; * by multiplex gap-PCR and/or specific PCR; Homo = homozygous; Hetero = heterozygous; Hapl = haplotype; RF = reference values; M = males; F = females; m = months.
Genomic DNA was extracted from peripheral blood samples collected in EDTA using a commercial kit (Blood GenomicPrep Mini-Spin, GE Healthcare, Amersham, UK). Patients in whom no abnormalities were found by multiplex gap-PCR for the common deletions [-α^3.7, -α^4.2, -(α)^20.5, -MED, -SEA, -FIL, and -THAI] (14) were screened for common non-deletional mutations (HphI, NcoI and Tsaudi), after selective PCR amplification and restriction analysis (17). Direct nucleotide sequencing of the α-MRE was performed using primers described elsewhere (18) and an ABI 377 DNA Analysis System (ABI PRISM™ 377 DNA Automated Sequencer, Applied BioSystems, USA).

The study was approved by the Ethics Committee (Opinion No. 918/2007, 18/02/2007) of the Universidade Estadual de Campinas and all subjects gave written informed consent to participate.

**MLPA reaction**

A commercially available kit was used to screen for copy number variations involving the α-globin cluster on chromosome 16p13.3 (SALSA MLPA kit P140B2 HBA, MRC-Holland, The Netherlands). First, 26 probes included in the commercial kit were used, spanning a 130-kb region of the α-globin gene cluster from gene POLR3K (next to the tip of the short arm of chromosome 16) to the 3’ region of the α°-globin gene. HS-40 and all the coding genes (ζ, α2, and α1) were targeted (represented as darker arrows in Figure 1A). The probe mix included 12 reference probes targeting chromosomal sites other than those in the 16p13.3 region, which were used as internal controls to normalize the results for each sample. Eighteen additional synthetic probes described elsewhere (15) were then synthesized to enlarge and refine map deletions and duplications distributed along an 800-kb genomic region from the POLR3K gene that can cause α-thalassemias. These oligonucleotides, synthesized in a salt-free environment (25-nmol scale), were from Invitrogen (USA) and were used without further purification. The MLPA reactions using these probes were carried out in two steps (represented as dotted and narrow arrows in Figure 1A).

A 200- to 250-ng aliquot of DNA sample was used for each subject. Tests were performed with a standard thermocycler (Eppendorf, Germany) according to manufacturer instructions. Amplification products were separated by capillary electrophoresis on a MegaBACE™ sequencer (GE Healthcare Life Sciences, Sweden) and the results were analyzed with Fragment Profiler® (MegaBACE™, GE Healthcare Life Science). At least three normal control samples were analyzed with each group of patient samples. Deletions previously confirmed by gap-PCR (-α^3.7, -(α)^20.5, -MED, -SEA, -FIL) were used as positive controls for the MLPA of the α-globin gene cluster.

**MLPA data analysis**

Data from Fragment Profiler® were exported to Microsoft Excel for analysis. The relative probe signals were determined by dividing the peak height of each amplification product by the total peak height of the reference probes in the probe mix. Each normalized peak was then divided by the average height of the normalized peaks for normal control subjects. The upper threshold for deletions was set at 0.75, and the lower threshold for duplications at 1.25. Normal values were defined as being between 0.8 and 1.2. All samples were tested at least twice, and in some cases the same tests were carried out with samples from other members of the families.

**Results**

In most diagnostic laboratories, a subset of thalassemia phenotypes for which no molecular defect has been identified by conventional techniques remains uncharacterized. However, thalassemia is still a possibility in these cases since the patients present persisting hematological alterations such as hypochromia and microcytosis. We used MLPA to test DNA samples from eight patients whose hematological alterations could not be explained by conventional analysis of the globin genes.

Five cases with Hb H (P1 to P5) were found to have a combination of the α° deletion with the common α^[3,7] deletion, and 3 other patients were simple α° heterozygous carriers (P6 to P8). Patient 1 (P1) showed a deletion limited to a region containing the upstream regulatory element HS-40 (probes 2 and 3). Hence, although the α-globin genes were intact, they were not expressed in this patient. Three individuals (P2, P7, and P8) showed the same type of deletion, in which the region from the telomere to the 5’ region of gene ζ encompassing probes 1 to 9 H (P2 and P7) and 1 to 4 (P8) is absent. Large deletions involving the entire α-globin gene locus, including the α-MRE, were found in 4 other cases (P3, P4, P5, and P6). These encompassed probes 1 to 22 H, 1 to 30 H (except 28 H), 1 to 30 H, and 1 to 35 H, respectively. A schematic overview of all the deletions is shown in Figure 1A.

In the family analyses, the MLPA assay revealed that the mother and brother of patient 3 were homozygous and heterozygous, respectively, for the common -α^[3,7] deletion (probe 14α2 to 13α1), a result that is in agreement with the multiplex-PCR findings. Patients 7 and 8 had the same deletions as those detected in their parents (Figure 1B).

**Discussion**

α-Thalassemias are caused by a wide variety of molecular alterations, ranging from small deletions and/or insertions to very large deletions. This diversity of alterations is associated with the presence of several homologous regions, such as the Alu family of repeats, subsegments X, Y, and Z (between α-globin genes) and the GAGG motif, that are distributed along the α-locus and facilitate homologous and
Characterization of alpha-thalassemic genotypes by MLPA


Figure 1. Schematic representation of the short arm of chromosome 16 (16p13.3). A, An 800-kb region containing the α-globin gene cluster and HS-40 (adapted from Ref. 15). The oval shape denotes the telomeric repeat region, and the solid boxes denote the genes throughout the regions. The vertical arrows indicate the locations of the probe pairs; the different forms of arrows correspond to each group of probes: darker arrows represent probes included in the kit and dotted and narrow arrows correspond to synthetic probes. The bars below the figure indicate deletions found by multiplex ligation-dependent probe amplification (MLPA) in 8 patients (P). The vertical lines mark the first and last probes deleted. The open boxes indicate the region where deletion breakpoints are expected to be located. M = mother; B = brother; F = father.

B
non-homologous recombination events (19,20). Our results illustrate this diversity. The deletions found in this study are probably different from each other, and the breakpoints are probably unique because the deletions are rare and the patients were unrelated. As the MLPA method has been adapted for high-resolution mapping of deletions, we were able to investigate cases whose molecular alterations could not be identified by conventional techniques (multiplex gap-PCR, specific PCR and DNA sequencing).

Four of our patients (P1, P2, P7, and P8) had deletions limited to a region containing the upstream regulatory element; hence, the α-globin genes, although intact, were not expressed. These deletions span a region of at least 0.4 kb in 1 case and from 95 to 100 kb in the others [positions 163464-163904, 97000-193847, 97000-202417, and 97000-202417 of the UCSC Genome Browser (21), February 2009, respectively]. Since the first description of a deletion of this type, which removes 62 kb including the HS-40 element (22), deletions involving this region have been described in more than 20 patients (10,15,23-31). The regulatory element α-MRE behaves as a classic enhancer: its main function in the normal chromosomal environment is to activate and enhance expression from the ζ-globin and α-globin promoters (32). Impairment of this element affects important binding sites for several transcriptional factors (GATA 1, NF-E2 and CACC box) and suppresses α-globin gene expression. Like the deletions that remove the α-globin genes, at least some of the α-MRE deletions seem to be the result of recombination events between partially homologous Alu repeats and subtelomeric rearrangements (2,20).

Four other patients (P3, P4, P5, and P6) had large deletions spanning genomic regions of at least 240, 470, 500, and 720 kb [positions 97000-334571, 97000-570532, 97000-602492, and 97000-816477 of the UCSC Genome Browser (21), February 2009, respectively] that affect the entire α-globin gene cluster and its upstream regulatory element. In these cases, the deletions affected a considerable number of genes and could result in other clinical implications (e.g., mental retardation), as observed in ATR-16 syndromes (33,34). However, no other abnormalities concomitant with α-thalassemia were reported in our patients.

Although the exact breakpoint positions and deletion lengths could not be determined at the time of the study, the deletions found in 6 patients (P1, P2, P3, P6, P7, and P8) are close in terms of size and genome position to previously described alterations (10,24,26,27,31). Two deletions, found in patients 4 and 5, showed no resemblance to previously described deletions and are possibly novel. Different from other cases, the α0 deletion found in patient 4 may be the result of a breakage in the segment defined by probes 28 and 30 H, followed by inversion and deletion of the same segment. The binding site of probe 28 H appears to be preserved since we obtained a normal peak signal for this probe, whereas for the other probes located in cis (27, 29, and 30 H) there was a reduction in peak signal (Figure 1A).

In the family analysis, MLPA assays for the mother and brother of patient 3 revealed an -α3.7 deletion in a homozygous and heterozygous state, respectively. Since a sample from the patient’s father was not available, it was not possible to conclude whether the α0 deletion was inherited from the father or arose in the mother’s germ line. The same types of deletions found in patients 7 and 8 were found in their respective fathers, confirming the paternal origin of these mutations (Figures 1B and 2).

Figure 2. Pedigrees of the three families. A, The propositus (P3) had Hb H disease (α0 and -α3.7 deletions), while her mother (P3M) and brother (P3B) were homozygous and heterozygous for the -α3.7 deletion, respectively. A sample from the father (P3F) was not available. B, The propositus (P7) and her father (P7F) were heterozygous for an α0 deletion. A sample from the mother (P7M) was not available. C, The propositus (P8) and his father (P8F) were heterozygous for an α0 deletion, while his mother (P8M) was normal.
This study is the first in Brazil to use the MLPA method to investigate the molecular basis of α-thalassemias. We identified different α0 deletions in 8 patients, demonstrating that MLPA is a suitable method for detecting unknown uncommon deletions and is particularly suited to characterizing cases that remain unsolved after standard diagnostic tests. The variety of rearrangements identified in the present study highlights the need to investigate all cases presenting microcytosis and hypochromia but without iron deficiency and elevated Hb A2 levels, since these hematological alterations are often interpreted as indicators of iron deficiency and may be the result of patients being inappropriately treated with oral iron therapy.

Carrier diagnosis and molecular characterization of unknown and uncommon α0 thalassemia deletions are very important for genetic counseling because they allow couples who request prenatal diagnosis and who are at risk for having a severely affected child to make an informed reproductive choice.

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References


