Mitochondrial Encephalomyopathy Due to a Novel Mutation in ACAD9

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Complex I or NADH:ubiquinone oxidoreductase (Enzyme Commission no. 1.6.5.3) is the largest of the 5 oxidative phosphorylation complexes that catalyze electron transfer from NADH along the respiratory chain, using the lipid-soluble ubiquinone as an electron acceptor.1 Complex I is composed of 45 structural subunits, 14 of which have catalytic functions and 31 of which probably contribute to the assembly, stabilization, and functional regulation of the complex.2 Complex I deficiency is the most common respiratory chain defect associated with early-onset fatal encephalomyopathy. Although many molecular defects have been described both in mitochondrial and nuclear structural subunits and in assembly factors, the molecular diagnosis remains unknown for many patients.3 MitoExome sequencing (deep sequencing of the entire mitochondrial genome and the coding exons of >1000 nuclear genes encoding the mitochondrial proteome) has proven extremely useful in identifying new genetic variants associated with infantile oxidative phosphorylation defects.4 Using MitoExome sequencing, we identified a novel pathogenic ACAD9 gene variant in a patient with infantile-onset and slowly progressive encephalomyopathy, thus enlarging the clinical spectrum of ACAD9-related disorders.

A 13-year-old boy was referred to us because of exercise intolerance, weakness, and mild psychomotor delay. Muscle histochemistry showed mitochondrial proliferation, and biochemical analysis revealed severe complex I deficiency (15% of normal). The level of complex I holoprotein was reduced as determined by use of Western blot both in muscle (54%) and in fibroblasts (57%).

The clinical presentation of complex I deficiency due ACAD9 mutations spans from fatal infantile encephalocardiomyopathy to mild encephalomyopathy. Our data support the notion that ACAD9 functions as a complex I assembly protein. ACAD9 is a flavin adenine dinucleotide–containing flavoprotein, and treatment with riboflavin is advisable.

IMPORTANCE Mendelian forms of complex I deficiency are usually associated with fatal infantile encephalomyopathy. Application of “MitoExome” sequencing (deep sequencing of the entire mitochondrial genome and the coding exons of >1000 nuclear genes encoding the mitochondrial proteome) allowed us to reveal an unusual clinical variant of complex I deficiency due to a novel homozygous mutation in ACAD9. The patient had an infantile-onset but slowly progressive encephalomyopathy and responded favorably to riboflavin therapy.

OBSERVATION A 13-year-old boy had exercise intolereance, weakness, and mild psychomotor delay. Muscle histochemistry showed mitochondrial proliferation, and biochemical analysis revealed severe complex I deficiency (15% of normal). The level of complex I holoprotein was reduced as determined by use of Western blot both in muscle (54%) and in fibroblasts (57%).

CONCLUSIONS AND RELEVANCE The clinical presentation of complex I deficiency due ACAD9 mutations spans from fatal infantile encephalocardiomyopathy to mild encephalomyopathy. Our data support the notion that ACAD9 functions as a complex I assembly protein. ACAD9 is a flavin adenine dinucleotide–containing flavoprotein, and treatment with riboflavin is advisable.

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Report of a Case

A 13-year-old boy was referred to us because of exercise intolerance, weakness, and muscle wasting. He was born after a normal pregnancy and delivery to nonconsanguineous Italian parents. Since the first year of life, he had difficulty eating and showed psychomotor delay. A neuromuscular evaluation revealed severe complex I deficiency (15% of normal). The level of complex I holoprotein was reduced as determined by use of Western blot both in muscle (54%) and in fibroblasts (57%).

His cardiac function was normal, and there were no brain abnormalities detected during magnetic resonance imaging or magnetic resonance spectroscopy.

A metabolic workup showed increased levels of plasma lactate (10mM; normal range, 0.63mM-2.44mM) and alanine (7.90 mg/dL; normal range, 1.84-4.44 mg/dL [to convert to micromoles per liter, multiply by 112.2]), an increased lactate to pyruvate ratio (67; normal range, 10-20), and an increased urinary lactic acid level (53.51 mg/mg creatinine; normal range, <0.28 mg/mg creatinine). He also had hypothyroidism (thy-
rotropin level, 5 mIU/L; normal level, 0.62 mIU/L), which re-
quired treatment with levothyroxine sodium, and an in-
creased plasma free acylcarnitine level. Treatment with high-
dose riboflavin (150 mg/d) improved his muscle strength and
reduced his plasma lactate (2.75 mM) and alanine (5.63 mg/
dL) levels.

Respiratory chain enzyme activities showed severe com-
plex I and moderate complex III deficiencies both in muscle
and in fibroblasts (Table). The severe reduction of complex I
was also documented by Western blot analysis of mitochon-
drial DNA-encoded respiratory chain components in muscle
(54%) and fibroblasts (57%) (Figure, D). The patient’s DNA
was subjected to next-generation exome sequencing using a mi-
tochondrial gene library (“MitoExome”) as previously
described.4-6 We identified a novel homozygous variant
(c.1240C>T) in the ACAD9 gene (Figure, E) affecting a highly
conserved amino acid (p.R414C) and confirmed that both par-
ents were heterozygous. The mutation was predicted to be del-
erious by use of the PolyPhen algorithm (http://genetics.bwh.
harvard.edu/pph/). The patient is now 19 years old and has
nonprogressive exercise intolerance and weakness.

Discussion

Mitochondrial complex I deficiency accounts for 35% of all ox-
dative phosphorylation defects, which are estimated to oc-
cur in 1 in every 5000 newborns.7 Complex I deficiency blocks
the transport of electrons derived from oxidative catabolism
of carbohydrates and fatty acids to coenzyme Q and further

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**Table. Respiratory Chain Activities in Muscle and Fibroblasts**

<table>
<thead>
<tr>
<th>Complex</th>
<th>Muscle</th>
<th>Fibroblasts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient</td>
<td>Controls, Range</td>
</tr>
<tr>
<td>I</td>
<td>0.22</td>
<td>0.67 (0.59)</td>
</tr>
<tr>
<td>I and III</td>
<td>2</td>
<td>13-24</td>
</tr>
<tr>
<td>II and III</td>
<td>26.2</td>
<td>15-28</td>
</tr>
<tr>
<td>III</td>
<td>82</td>
<td>88-167</td>
</tr>
<tr>
<td>IV</td>
<td>332.2</td>
<td>120-220</td>
</tr>
<tr>
<td>V</td>
<td>138.4</td>
<td>120-280</td>
</tr>
<tr>
<td>II</td>
<td>13.4</td>
<td>10.7-17.4</td>
</tr>
<tr>
<td>Citrate synthase</td>
<td>242.3</td>
<td>80-210</td>
</tr>
</tbody>
</table>

* The numbers in bold are abnormal values.
* Normalized to citrate synthase.
* Normalized to milligram of protein.

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The patient at 13 years of age shows scoliosis and truncal obesity (A); Gomori
trichrome (B [original magnification ×20]) and cytochrome c oxidase (C [original
magnification ×20]) histochemical stains show mitochondrial proliferation.
Images of Western blot analysis of oxidative phosphorylation proteins (D) in the
fibroblasts (left) and muscle (right) of the patient (P) and controls (C) are
shown. I indicates complex I, complex II, complex III; IV, complex IV, and V, complex V. The electropherogram of the patient’s DNA shows the variant
(c.1240C>T) and evolutionary conservation of the mutated amino acid (E).
increased by supplementing a patient’s fibroblasts with high-level of complex I holoenzyme in blue-native gel electrophoresis. This reduction was completely reversed by transduction of wild-type ACAD9. Moreover, complex I activity was increased by supplementing a patient’s fibroblasts with high-dose riboflavin, a known catalytic cofactor of ACADs. Recently, Gerards et al. described a milder childhood-onset clinical form with myalgia and premature fatigue in a doubly consanguineous Dutch family. These patients had peculiar episodes of fatigue relieved by vomiting and difficulty with cognitive activities during these events, which lasted hours. Although there was no reduction in the level of complex I holoenzyme, Gerards et al. proposed that ACAD9 might play a role in stabilizing the supercomplexes. Our case adds to the clinical heterogeneity of ACAD9 deficiency, which spans from infantile, rapidly progressive encephalomyopathy and hypertrophic cardiomyopathy to pure myopathy with exercise intolerance and lactic acidosis. Our patient had severe complex I and moderate complex III deficiencies in muscle and fibroblasts. Combined defects of complex I and complex III had been described in patients with mutations in the MTCYB gene, and studies of human and mouse cell lines carrying mutations in MTCYB demonstrated the interdependence of the 2 enzymes. We hypothesize that a reduction in the number of electrons transported downstream to the complexes and a lack of complex I assembly can cause secondary complex III deficiency. However, we did not confirm in our patient the previously described complex IV deficiency.

ACAD9 is a β-oxidation component, and the mechanism by which mutations in this pathway impair oxidative phosphorylation remains poorly understood. Our report confirms that ACAD9 has an important role to play in maintaining complex I activity and protein level, thus bolstering the role of ACAD9 as an assembly factor, although further studies are required to fully understand its function. Because ACAD9 is a flavin adenine dinucleotide–containing flavoprotein, it makes sense that patients would benefit from riboflavin supplementation. This was documented both by in vitro studies showing increased complex I activity in patients’ fibroblasts and by clinical experience in all reported patients. Therefore, ACAD9 deficiency is a potentially treatable mitochondrial disorder, and screening for the ACAD9 gene is indicated for all patient with isolated complex I deficiency.

REFERENCES


