The Hereditary Spastic Paraplegias

Nine Genes and Counting

John K. Fink, MD

Heredity is a progressive neurologic disorder in which the primary symptom is insidiously progressive difficulty walking due to lower extremity weakness and spasticity. There have been great strides in our knowledge of this group of disabling disorders; 20 HSP loci and 9 HSP genes have been discovered. Insights into the molecular causes of HSPs are beginning to emerge. This review summarizes these advances in HSPs' genetics.

Heredity spastic paraplegia (HSP) is a syndromic designation encompassing more than 30 disorders in which the predominant feature is spastic gait.1 The HSP syndromes are classified clinically as uncomplicated (also known as pure or non-syndromic) if symptoms are limited to progressive spastic weakness in the legs, often accompanied by urinary urgency and subtle dorsal column impairment. The HSP syndromes are classified as complicated or syndromic if the inherited disorder includes other neurologic abnormalities (eg, neuropathy, amyotrophy, ataxia, mental retardation, or thin corpus callosum) or systemic disturbances (eg, cataracts) for which alternate disorders have been excluded. Postmortem studies of uncomplicated HSP have shown axonal degeneration that is most marked in the distal terminals of corticospinal tracts and fasciculus gracilis fibers.2

Symptoms of HSP may begin at any age, from infancy to older than 60 years. If symptoms begin during the teenage years or later, then spastic gait disturbance usually progresses insidiously over many years. Canes, walkers, and wheelchairs may eventually be required. If symptoms begin in late infancy or early childhood, however, then there may be relatively little functional worsening, even over many years. Individuals with early-onset, apparently nonprogressive HSP may be distinguishable from those with spastic diplegic cerebral palsy only by family history (which may be absent in recessive, X-linked, or dominantly inherited HSP with variable age of symptom onset).

Autosomal dominant, autosomal recessive, and X-linked HSP are each genetically heterogeneous. Genetic mapping has identified 20 different HSP loci (Table) designated SPG (SPastic paraplegia) 1 through 21 in order of their discovery (SPG18 has been identified but not published). Thus far, 10 loci for autosomal dominant HSP, 7 loci for autosomal recessive HSP, and 3 loci for X-linked HSP have been published. The occurrence of HSP in families for which known HSP loci are excluded indicates the existence of additional loci (J.K.F. and S. Rainier, PhD, unpublished observations, 2003).

Different genetic types of uncomplicated HSP usually cannot be distinguished by clinical and neuroimaging parameters alone. This reflects both the clinical similarity between different types of HSP and the phenotypic variability within a given genetic type of HSP. There may be significant clinical variability both within a given family in which all subjects have the same HSP gene mutation; between families with the same genetic type of HSP; and between families with different genetic types of HSP. For example, some families with SPG4 HSP (due to spastin gene mutations described in the next section) include individuals with childhood-onset symptoms and individuals whose symptoms begin after age 30 years.

From the Department of Neurology, University of Michigan, and the Geriatric Research Education and Clinical Center, Ann Arbor Veterans Affairs Medical Center, Ann Arbor.
Mutations in the SPG4 gene (spastin protein) are responsible for approximately 40% of autosomal dominant HSP cases. Hereditary spastic paraplegia due to SPG4 gene mutation is the single most common form of autosomal dominant HSP, and possibly the single most common form of any type of HSP. At this stage, we know very little about the function of spastin, the encoded protein of SPG4, and the mechanisms by which spastin abnormalities lead to axonal degeneration in HSP. It is widely held that most, if not all, SPG4 mutations are pathogenic because of haploinsufficiency (ie, decreased abundance of functionally normal spastin) rather than a dominant negative mechanism. This conclusion is based on (1) the fact that many mutations reduce the abundance of full-length, sequence-normal spastin, such as mutations that cause premature translation termination, insertions, or deletions that lead to nonsense transcripts and mutations that cause aberrant messenger RNA splicing, and (2) recent studies in which expression of SPG4 bearing nonsense or frameshift mutations resulted in the absence of immunologically detectable spastin.

SPG4 is expressed widely and undergoes alternate splicing variable inclusion of exon 4. Thus far, none of the more than 80 reported HSP-specific SPG4 mutations have occurred in exon 4. In addition to variable splicing, there is also evidence that tissue-specific posttranslational modifi-
participates in the intracellular movement of organelles,
impaired mitochondrial distribution.

Emerging evidence suggests that spastin may interact
with microtubules. Azim et al. showed that antitu-
bulin antibodies could precipitate spastin in vitro. More
recently, Errico et al. showed that a spastin fusion pro-
colonized with microtubules in Cos-7 and HeLa
cells transfected with wild-type and mutant SPG4
expression vectors. Findings that spastin may interact
directly with microtubules support the hypothesis that
disruptions in axonal cytoskeleton or transport underlie
some forms of HSP.

Atlastin

Autosomal dominant HSP linked to the chromosome 14q
SPG3A locus represents approximately 10% of domi-
nantly inherited HSP cases and is particularly preva-
 lent among those autosomal dominant HSP kindreds in
which each affected subject developed symptoms in child-
hood. Zhao et al. identified mutations in a novel gene
(SPGL3A) as the cause of this form of HSP. At this stage,
insight into the possible function of SPG3A comes only
from analysis of the sequence of its encoded protein,
atlastin. Atlastin does not contain an AAA motif and is not
homologous to spastin or other proteins implicated in
HSP. In contrast, atlastin contains conserved motifs for
GTPase binding and hydrolysis and is structurally ho-
monologous to guanylate binding protein 1. The func-
tional importance of atlastin’s GTPase motif is indicated
by a recently identified HSP mutation that disrupted a
conserved GTPase domain.

Guanylate binding protein 1, to which atlastin shows
homology, is a member of the dynamin family of large
GTPases. Dynamins play essential roles in a wide variety
of vesicle trafficking events. Dynamins play essential
roles in the action of many neurotrophic factors and are
critical elements in the rapid and efficient process of re-
cycling of synaptic vesicles. Dynamins are also involved
in the maintenance and distribution of microtubules and
microtubule binding. Recently, Azim et al. identified a
mutation in heat shock protein 60 in affected sub-
jects from an SPG13-linked HSP kindred. The mecha-
ism by which heat shock protein 60 mutations cause
HSP are not yet known. It is intriguing however, that 2
HSP genes, heat shot protein 60 or chaperonin 60 and
SPG7 or paraplegin, encode mitochondrial proteins.

NIPA1

NIPA1 gene mutations cause autosomal dominant HSP
linked to chromosome 15q (SPG6 HSP). SPG6 HSP is a
prototypical example of adolescent or adult-onset, slowly
progressive, uncomplicated HSP. SPG6 and SPG8 are per-
haps the most severe forms of dominantly inherited, un-
complicated HSP. Recently, Azim et al. identified a disease-
specific mutation in a novel gene (NIPA1) in an SPG6-
linked HSP kindred and in an unrelated kindred that was
too small for linkage analysis. Precisely the same NIPA1
gene mutation (T45R) was discovered in 2 unrelated kin-
dreds. The function of NIPA1 is unknown. It is widely
expressed, particularly in the central nervous system.
The presence of 9 alternating hydrophobic-hydrophilic
domains suggests that NIPA1 encodes a membrane pro-
tein. This feature makes NIPA1 unique among HSP pro-
teins. The NIPA1 mutation T45R appears to act through a
dominant negative gain of function. This prediction is
based on the observation that subjects who are missing
one NIPA1 gene entirely (eg, subjects with Prader-Willi
and Angelman syndromes who have deletions involving
this region of chromosome 15q) do not develop HSP.

TWO AUTOSOMAL RECESSIVE HSP GENES

Paraplegin

SPG7 encodes a mitochondrial protein (paraplegin). De
Michele et al. discovered disease-specific mutations in
SPG7 as the cause of chromosome 16q–linked autosomal
recessive HSP. This is a rare form of autosomal recessive
HSP.
HSP with only a few reported families affected.33,34 Within these families, some individuals had pure HSP, and others had HSP complicated by dysarthria, dysphagia, optic disc pallor, axonal neuropathy, and evidence of vascular lesions, cerebellar atrophy, or cerebral atrophy on cranial magnetic resonance imaging. Paraplegin is highly homologous to the yeast mitochondrial ATPases AFG3, RCA1, and YME1, which have both proteolytic and chaperone-like activities at the inner mitochondrial membrane. Parapleghia and paraplegin are mitochondrial proteins, it does not appear that all types of HSP are due to mitochondrial dysfunction. Biochemical and histological evidence of mitochondrial abnormalities has been sought but has not been observed in SPG4 (spastin), SPG3A (atlastin), SPG8, and SPG6 autosomal dominant HSP.3,36-38

Spartin

Spartin mutations cause HSP associated with distal muscle wasting (SPG20 Troyer syndrome).39 This gene is designated “spartin” (spastin-related autosomal recessive Troyer protein) because its amino-terminal region is similar to that of spastin, mutations in which cause SPG4 HSP. Spartin is also homologous to proteins involved in endosome morphology and membrane trafficking.

TWO X-LINKED HSP GENES

Proteolipid Protein

Proteolipid protein (PLP) is an intrinsic myelin protein. PLP gene duplications and point mutations cause Pelizaeus-Merzbacher disease, an infantile-onset, progressive leukodystrophy, and are responsible for dysmyelination in jinpy mice.40,41 In addition, some individuals with X-linked HSP linked to the SPG2 locus on Xq22 also have PLP mutations.42,43 Although some of these patients have clinical features consistent with uncomplicated HSP, others have abnormal-appearing white matter on brain magnetic resonance imaging scans or evidence of peripheral neuropathy. Leukodystrophy is not a feature of other forms of uncomplicated HSP. Some of the phenotypic variation of PLP mutation syndromes (infantile-onset leukodystrophy vs childhood-onset slowly progressive spastic paraparesis) can be attributed to different mutations in the PLP gene. However, both syndromes have occurred in the same family in individuals who share the same PLP gene mutation (F. Cambi, MD, PhD, J.K.F., unpublished observation, 2001). This observation indicates that, in some cases, the neurologic consequences of PLP gene mutation are influenced by modifying factors that presumably include additional genes and possibly environmental factors.

L1 Cell Adhesion Molecule

Neuronal cell adhesion molecule L1 (L1CAM) gene mutations cause a variety of X-linked neurologic disorders, including complicated spastic paraplegia, hydrocephalus, and mental retardation aphasia, shuffling gait, and adducted thumbs (MASA syndrome.44 Although there is correlation between some of these syndromes and specific L1CAM mutations,45 X-linked hydrocephalus, MASA syndrome, and X-linked spastic paraplegia have occurred in kindreds in which affected individuals had the same L1CAM mutation.46 L1CAM is an integral membrane glycoprotein and a member of the immunoglobulin superfamily of cell adhesion molecules that mediate cell-to-cell attachment. L1CAM is found primarily in the nervous system, and its functions include guidance of neurite outgrowth during development, neuronal cell migration, and neuronal cell survival.47,48 Dahme et al49 used gene targeting to create transgenic mice in which the L1CAM gene was disrupted. These animals exhibited weak hind limbs and reduced size of corticospinal tracts.

CONCLUSIONS

The very recent discovery of many HSP genes is rapidly shaping new concepts of the pathophysiologic mechanisms of HSP. Whereas the uniform clinical appearance of uncomplicated HSPs initially suggested that a common biochemical disturbance underlies most types of HSP, this appears to not be the case. Rather, it appears that very long central nervous system axons (ie, corticospinal tracts and dorsal column fibers) are particularly vulnerable to a number of distinct biochemical disturbances and that the highly similar clinical features of genetically diverse types of uncomplicated HSP reflect the limited repertoire of symptoms from corticospinal tract and, to a lesser extent, dorsal column fiber disturbance.

Based on the diversity of the HSP genes discovered, a biochemical classification of HSP is emerging. For example, one can consider (1) HSP due to mitochondrial abnormality (including SPG13 due to chaperonin 60 mutation and SPG7 due to paraplegin mutation); (2) HSP due to axonal transport abnormality (including SPG10 due to kinesin heavy chain mutation and possibly SPG3A due to atlastin mutation and SPG4 due to spastin mutation; (3) HSP due to primary myelin disturbance (SPG2 due to PLP mutation); and (4) HSP due to embryonic development of corticospinal tract neurons (SPG1 due to L1CAM mutation). Whether these disparate primary biochemical disturbances converge into one or more common pathways remains to be determined. Each HSP gene discovery permits direct exploration of the molecular mechanisms that underlie HSP, insights that bring us one step closer to developing real treatment.
Accepted for publication March 25, 2003.

This study was supported by grants RO1NS33645, RO1NS36177 and RO1NS38713 from the National Institute of Neurological Disorders and Stroke, National Institutes of Health, Bethesda, Md, and grants from the Veterans AffairsMerit Review, Washington, DC, and the National Organization for Rare Disorders, Danbury, Conn.

I gratefully acknowledge the expert secretarial assistance of Lynnette Girbach and the participation of subjects with HSP and their families, without whom our investigations of HSP would not be possible.

Corresponding author and reprints: John K. Fink, MD, 5214 Cancer Genetics Center Bldg, Box 0940, 1500 E Medical Center Dr, Ann Arbor, MI 48109 (e-mail: jkfink@umich.edu).

REFERENCES


