Charcot-Marie-Tooth disease (CMT) is a clinically and genetically heterogeneous group of sensorimotor peripheral neuropathies and represents probably the most frequent cause of inherited pathologies affecting the nervous system [Skre, 1974]. The current classification of these disorders is based on clinical, electrophysiological, genetic and pathological criteria.

Physical examination of patients with CMT reveals symmetric distal amyotrophy in lower limbs and hands, steppage gait, foot deformities (pes cavus, pes planus, pes valgus), distal sensory loss in a stocking/glove distribution and decreased or absent deep tendon reflexes [Harding and Thomas, 1980a, b; Thomas and Harding, 1993]. Patients may have impaired proprioception with balance difficulty. Neuropathic pain may or may not be present [Siskind and Shy, 2011]. Spine deformities are not a constant sign of the disease but are more frequently associated with specific subtypes such as CMT4C [Azzedine et al., 2006]. Onset is classically within the first to second decade of life, with initial symptoms affecting the lower limbs but occasionally also the hands (e.g. GARS and GDAP1 mutations). However, there is a large spectrum of phenotypes, in terms of age of onset, disease progression and severity. Even among affected members of the same
family carrying identical mutations, the phenotype may
vary considerably. Other inherited peripheral neuropathies including hereditary motor neuropathies and hereditary sensory and autonomic neuropathies, which present a partially similar phenotype to CMT, are not covered by this review.

According to electrophysiological criteria including motor nerve conduction velocities (MNCV) and compound muscle action potential amplitudes, CMTs have been divided into 2 major subtypes; demyelinating (CMT1) and axonal (CMT2). In demyelinating forms, the MNCV in the upper extremities (median or ulnar nerve) are below 38 m/s. Conversely, patients with MNCV higher than 38 m/s but with a decrease in compound muscle action potential amplitudes are considered to be affected by axonal CMT. A third, less-defined subtype of the disease called intermediate CMT is characterized by MNCV values between 38 and 45 m/s (some authors report a larger interval: 25–35 to 45 m/s) [Thomas and Calne, 1974; Bouche et al., 1983; Rossi et al., 1985; Verhoeven et al., 2001; Patzko and Shy, 2011).

Earlier studies have shown that approximately two-thirds of CMTs are demyelinating and one-third is of primary axonal defect [Harding and Thomas, 1980a, b]. More recent studies in large cohorts of patients confirmed that most CMTs are demyelinating but lowered its prevalence to approximately half of all cases, while the prevalence of axonal forms was assessed to be less than one-third, i.e. 17.6–27.1% [Foley et al., 2012; Murphy et al., 2012]. The large majority of mutations (~90%) were identified in PMP22, GJB1, MFN2, and MPZ, all genes involved in dominantly inherited CMTs. Concerning demyelinating CMT forms, molecular diagnosis was established in approximately 80% of patients and classical PMP22 duplications alone were responsible for ~70% of all CMT1 cases. In the group of axonal CMT cases, molecular diagnosis was achieved in ~25% of cases, the majority caused by mutations in MFN2 or GJB1.

**Molecular Pathology of CMTs**

Recent identification of a number of genes that were mutated in various forms of CMTs provided unprecedented insights into the biology of both Schwann cells and neurons. Although genes mutated in CMTs encode proteins involved in a relatively wide range of cellular functions, there are some emerging themes that can be identified.

Axonal forms of CMT (see table 2 for the complete list and references) affect both dorsal root ganglion sensory neurons and spinal motor neurons. Both of these neuronal cell types are extremely polarized, axons extending up to 1 m away from their soma to sensory receptors in muscle or skin and to neuromuscular junctions with skeletal muscles [Gentil and Cooper, 2012]. Since the majority of neuronal proteins are synthesized in the cell body, this particular cellular architecture requires intensive transport of proteins between the soma and the axonal extremity. Accordingly, mutations affecting DYNCIHI, which encodes the cytoplasmic dynein heavy chain 1 protein, a critical subunit of dynein1 responsible for axonal retrograde transport, lead to CMT. In addition, NEFL (encoding neurofilament protein) and LMNA (encoding lamin A/C) are both involved in neurofilament homeostasis, which, if disrupted, will affect axonal transport. HSPB1 and HSPB8 (small heat shock proteins acting as ATP-independent chaperones in protein folding) also play a role in the architecture of the cytoskeleton. Among the most dynamic organelles functionally dependent on proper axonal transport are mitochondria. Mutations in
2 different genes implicated in mitochondrial functions (MFN2 and GDAP1) lead to CMT. MFN2 interferes with mitochondrial axonal transport by interacting with the adaptor Miro/Milton complex, by which kinesin attaches mitochondria to microtubules. GDAP1 is a mitochondrial fission factor and is probably directly involved in the adaption of the number and size of mitochondria to the requirements of the cell. In addition, mutations in genes involved in protein synthesis and turnover (GARS, AARS, LRSAM1), endocytosis (RAB7, DNM2), calcium homeostasis (TRPV4), myelin assembly (MPZ) and gene expression regulation (MED25) are also leading to the axonal forms of CMT.

Large axons (with a diameter larger than 1 μm) are wrapped by a myelin sheath, which is a specialized cell membrane with a high lipid-to-protein ratio (lipids account for at least 70% of the dry weight of myelin membranes [Chrst et al., 2011]). The presence of myelin around an axonal segment plays a role as an insulator (by increasing axonal resistance) and participates in the mechanisms leading to the clustering of axonal ion channels at nodes of Ranvier [Barres, 2008]. Myelinating Schwann cells therefore play a critical role in both the architecture and electrical properties of axons, allowing for a substantial increase (up to 100×) in nerve conduction velocity while reducing axonal energy consumption [Hartline and Colman, 2007]. The importance of the appropriate assembly of the myelin membrane is highlighted by the fact that mutations in PMP22, MPZ and PRX, which all participate in the assembly of myelin, lead to CMT (table 2). The observation that changes in myelin protein gene dosage lead to CMT [Suter and Scherer, 2003;...
<table>
<thead>
<tr>
<th>Clinical form of CMT</th>
<th>Type of CMT</th>
<th>Gene</th>
<th>Full name</th>
<th>Molecular function</th>
<th>Cellular function</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axonal CMT</td>
<td>CMT2A1/A2ARCMT2A2</td>
<td>MFN2</td>
<td>mitofusin 2 transmembrane GTPase</td>
<td>mitochondrial dynamics</td>
<td>protein synthesis</td>
<td>Züchner et al., 2004; Detmer et al., 2008; Cartoni et al., 2010; Tschachler et al., 2012</td>
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<tr>
<td></td>
<td>CMT2K/CMT2H</td>
<td>GDAP1</td>
<td>ganglioside induced differentiation associated protein 1</td>
<td>glutathione (GHS) metabolism</td>
<td>protein synthesis</td>
<td>Cuesta et al., 2002; Niemann et al., 2005</td>
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<td></td>
<td>CMT2E</td>
<td>NEFL</td>
<td>neurofilament, light polypeptide intermediate filament protein</td>
<td>neurofilament/mitochondrial dynamics</td>
<td>protein synthesis</td>
<td>Mersiyanova et al., 2000; Gentil et al., 2012; Cartoni et al., 2010; Tschachler et al., 2012</td>
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<td></td>
<td>CMT2B1</td>
<td>LMNA</td>
<td>lamin A/C intermediate filament protein</td>
<td>nuclear lamina/neurofilament assembly</td>
<td>protein synthesis</td>
<td>De Sandre-Giovannoli et al., 2002</td>
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<td>CMT2A1/2</td>
<td>KIF1B</td>
<td>kinesin family member 1B molecular motor</td>
<td>axonal transport</td>
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<td>Zhao et al., 2001</td>
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<td>CMT2C</td>
<td>DYNC1H1</td>
<td>dynein, cytoplasmic 1, heavy chain 1 molecular motor</td>
<td>axonal transport</td>
<td>protein synthesis</td>
<td>Weedon et al., 2011</td>
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<td></td>
<td>CMT2F</td>
<td>2011; d'Ydewalle et al., 2011</td>
<td></td>
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<td></td>
<td>CMT2L</td>
<td>HSP22 (HSPB8)</td>
<td>heat shock 22-kDa protein 8 chaperone</td>
<td>cytoskeletal remodeling</td>
<td>protein synthesis</td>
<td>Tang et al., 2005; Irobi et al., 2010</td>
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<td>CMT2D</td>
<td>GARS</td>
<td>glycyl-tRNA synthetase tRNA synthetase</td>
<td>protein synthesis</td>
<td>protein synthesis</td>
<td>Antonellis et al., 2003; Seburn et al., 2006; Motley et al., 2011</td>
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<td>CMT2P</td>
<td>E3-ubiquitin ligase</td>
<td>protein degradation</td>
<td>E3-ubiquitin ligase</td>
<td>protein degradation</td>
<td>Guernsey et al., 2010; Weterman et al., 2012</td>
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<td>CMT2M</td>
<td>RAS-associated protein RAB7 GTPase</td>
<td>endocytosis</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Verhoeven et al., 2003a; Spinosa et al., 2008</td>
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<td></td>
<td>CMT2C</td>
<td>TRPV4</td>
<td>transient receptor potential cation channel, subfamily V, member 4</td>
<td>calcium homeostasis</td>
<td>protein synthesis</td>
<td>Klein et al., 2011; Landouré et al., 2010</td>
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<td>CMT2I/2J</td>
<td>MPZ</td>
<td>myelin protein zero structural myelin protein</td>
<td>myelin assembly</td>
<td>protein synthesis</td>
<td>Marrosu et al., 1998; Chapon et al., 1999; De Jonghe et al., 1999</td>
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<tr>
<td></td>
<td>CMT1B/CMT4E</td>
<td>MPZ</td>
<td>myelin protein zero structural myelin protein</td>
<td>myelin assembly</td>
<td>protein synthesis</td>
<td>Hayasaka et al., 1993; Kulkens et al., 1993; Martini et al., 1995; Pennuto et al., 2008</td>
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<td>CMT1B/CMT4E</td>
<td>periaxin</td>
<td>signaling</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Gillespie et al., 2000; Guilbot et al., 2001; Court et al., 2004</td>
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<td>CMT4B1</td>
<td>MTMR2</td>
<td>myotubularin-related protein 13 pseudophosphatase</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Azzedine et al., 2003; Senderek et al., 2003a; Tersar et al., 2007</td>
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<td>CMT4B2</td>
<td>MTMR13 (SBF2)</td>
<td>myotubularin-related protein 13 pseudophosphatase</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Azzedine et al., 2003; Senderek et al., 2003a; Tersar et al., 2007</td>
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<td>CMT4J</td>
<td>FIG4</td>
<td>FIG4 homolog, SAC1 lipid phosphatase</td>
<td>lipid phospholipid metabolism</td>
<td>protein synthesis</td>
<td>Chow et al., 2007; Vaccari et al., 2011</td>
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<td>CMT1D/CMT4E</td>
<td>NDRG1</td>
<td>N-myc downstream regulated 1 signaling</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Kalaydjieva et al., 2000; Okuda et al., 2004</td>
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<td>CMT1D/CMT4E</td>
<td>GDAP1</td>
<td>glutathione (GHS) metabolism</td>
<td>mitochondrial dynamics</td>
<td>protein synthesis</td>
<td>Baxter et al., 2002; Niemann et al., 2005</td>
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<td>CMT1F</td>
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<td>neurofilament/mitochondrial dynamics</td>
<td>protein synthesis</td>
<td>Jordanova et al., 2003; Gentil et al., 2012; Cartoni et al., 2010; Tschachler et al., 2012</td>
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<td>CMT4C</td>
<td>SH3TC2</td>
<td>Rab11 effector endosomal recycling</td>
<td>membrane trafficking</td>
<td>protein synthesis</td>
<td>Senderek et al., 2003b; Arnaud et al., 2009; Lupo et al., 2009; Roberts et al., 2010; Stendel et al., 2010</td>
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<td>CMT1C</td>
<td>LITAF</td>
<td>lipopolysaccharide-induced TNF protein sorting</td>
<td>glucose-6-phosphate dehydrogenase</td>
<td>protein synthesis</td>
<td>Street et al., 2003; Somandin et al., 2012</td>
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<td>CMT1D/CMT4E</td>
<td>EGR2</td>
<td>early growth response 2 transcription factor</td>
<td>gene expression regulation</td>
<td>protein synthesis</td>
<td>Warner et al., 1998; Nagarajan et al., 2001</td>
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<td>CMT4G (HMSNR)</td>
<td>HK1</td>
<td>hexokinase 1 converts glucose into glucose-6-phosphate</td>
<td>glucose metabolism</td>
<td>protein synthesis</td>
<td>Hantke et al., 2009</td>
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<td>FGD4/Frabin</td>
<td>FYVE, RhoGEF and PH domain containing 4</td>
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<td>CMT1C</td>
<td>INF2</td>
<td>regulator of actin polymerization/cytoskeletal remodeling</td>
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<td>CMT1D/CMT4E</td>
<td>ARHGEF10</td>
<td>regulator of actin polymerization/cytoskeletal remodeling</td>
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<td>CMT1B/CMT4E</td>
<td>NCKII</td>
<td>Src homology 2 domain containing protein tyrosine kinase 2</td>
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<td>protein synthesis</td>
<td>Warner et al., 1998; Nagarajan et al., 2001</td>
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<td>DI-CMTB</td>
<td>dynamin 2 GTPase</td>
<td>endocytosis/cytoskeletal remodeling</td>
<td>protein synthesis</td>
<td>Züchner et al., 2005; Skripuletz et al., 2012</td>
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<td>CMT1B/CMT4E</td>
<td>I-CMT/CMTX1</td>
<td>gap junction channel component</td>
<td>protein synthesis</td>
<td>protein synthesis</td>
<td>Bergers et al., 1991; Abbas et al., 1993; Wrone et al., 1993; Azim et al., 1997; Manthorpe et al., 2003</td>
</tr>
</tbody>
</table>
|                     | CMT1B/CMT4E | PRPS1 | phosphoribosyl pyrophosphate synthetase 1 | nucleotide synthesis | protein synthesis |警告：所选内容中包含多个错误或不准确的信息。请注意，这些错误可能影响答案的准确性。建议对提供的内容进行校对和验证。
Maeda et al., 2012] is in agreement with the evidence that mutations in EGR2, a transcription factor that regulates myelin gene expression, also lead to a CMT phenotype. The estimated 6,500-fold increase in membrane surface occurring during myelination [Webster, 1971] and the highly polarized structure of Schwann cells suggest that membrane assembly, transport and maintenance are critical for proper Schwann cell function. The identification of mutations in MTMR2, MTMR13/SBF2, FIG4 and NDRG1 genes (encoding proteins involved in membrane trafficking), in SH3TC2 (involved in endosomal recycling), in LITAF (involved in protein sorting) and in FGD4 (involved in cytoskeletal remodeling) supports this hypothesis and provides molecular insight into the various mechanisms involved in myelin membrane homeostasis.

Intermediate forms of CMT are expected to affect both glial and neuronal functions and highlight the close relationship between these 2 cell types. Mutations affecting genes encoding proteins involved in cytoskeletal remodeling (INF2 and DNM2), protein synthesis (YARS), myelin assembly (MPZ and GJB1) and nucleotide synthesis (PRPS1) lead to defects in Schwann cells and in axons.

The diversity of cellular and molecular functions of proteins that are associated with different forms of CMTs demonstrates that the identification of disease genes is a crucial step to obtain insights into both the pathophysiology of the disease and the biology of the peripheral nervous system. In terms of future gene identification efforts, the plethora of genes and gene products involved in CMTs (table 2) precludes simple predictions of additional CMT genes based solely on functional data. This aspect is further highlighted by the ubiquitous expression/function of many CMT genes identified so far (e.g. HSP27, HSP22, GARS, AARS, YARS, MTMR2, MTMR13/SBF2). Therefore, while data obtained through characterization of various CMT forms have generated a list of possible candidate pathways that may be selectively compromised in patients, one cannot exclude that other biological structures or biochemical reactions can be important in the molecular pathology of CMT.

From Positional Cloning to Highly Parallel Genetic Technologies

The majority of CMT genes have been identified by positional cloning, usually involving large families with multiple affected individuals to allow fine-mapping of the culprit mutation to a small region containing only few genes. In more recent times, gene hunting in CMTs (and other heterogeneous conditions) has been forced to adapt to less favorable conditions, classically represented by patients from small families yielding extended or even several regions of potential linkage. Scientists have therefore become more inventive, designing or integrating various techniques to overcome technical limitations. For example, research combining systematic screens with linkage results (e.g. blind mutational screenings of all genes present in a given linkage region) have allowed the discovery of mutations in genes that a priori were not considered as prime candidates (e.g. [Chakarova et al., 2007]). As mentioned above, strategies to prioritize candidate genes based on gene function (if known) and on similarity with or functional relation to genes involved in the same disease [Dryja, 1990, 1997] may not always be successful as structurally and functionally diverse gene products might cause the same or a similar phenotype. Another attractive strategy is to characterize the expression profile of candidate genes in the organ or tissue targeted by the disease. However, for hereditary neuropathies, this approach has been hampered so far by the scarcity of transcriptional data from the affected tissues, i.e. spinal cord and dorsal root ganglion neurons or Schwann cells. Recently, with the availability of high throughput transcriptional analysis techniques, we and others have generated large-scale expression data characterizing peripheral nerve development, degeneration and regeneration, which are now available for gene prioritization [Verheijen et al., 2003; Giambonini-Brugnoli et al., 2005; Verdier et al., 2012].

Regardless of the technique used to pre-select possible culprit sequences, detection of mutations has relied so far on the use of mid- to large-scale systems, i.e. Sanger sequencing [Sanger and Coulson, 1975], sometimes preceded by screening techniques such as single-strand conformation polymorphisms, denaturing high performance liquid chromatography or denaturing gradient gel electrophoresis. More recently, the discovery and the recent commercialization of next-generation sequencing (NGS) instruments have represented a real technological revolution in the field of molecular genetics.

In NGS-driven genomic and exomic approaches, the bulk of the analytical procedures consists in data filtering, since comprehensive sequencing of the human genome (or of its coding sequences) obviously generates much more information than what is required for the identification of the cause of a monogenic disease. In the context of single-gene hunting, only 1 or 2 of the ~4 million variants detected genome-wide (or ~20,000 for a typical exome) represent the ‘signal’, to be distinguished
from the overwhelming noise represented by all other DNA changes.

For recessive Mendelian diseases, one of the most successful approaches for noise reduction is filtering for regions of the genome for which patients carry identical (homozygous or autozygous) alleles inherited from a common ancestor of both parents. In autosomal recessive CMT this is particularly valuable, as in geographic regions and communities with a high prevalence of consanguineous marriages (e.g. Arab countries, Turkey, Iran, Pakistan, Roma populations) autosomal recessive inheritance accounts for 30–50% of all CMT cases [Patzkko and Shy, 2011]. Detection of autozygosity is usually performed by using polymorphic markers (commonly SNPs) and the identification of DNA stretches for which homozygosity of alleles is observed over several kilobases. Using whole-genome SNP homozygosity mapping and subsequent DNA sequencing, Fischer et al. [2012] were able to provide molecular diagnosis to 15 (63%) out of 24 index cases with sporadic or autosomal recessive CMT. Information on SNPs can be obtained prior to exome or genome sequencing, or directly extracted from the genome or exome information. The difference between these 2 approaches relies mostly on costs: in large families, microarray-based genotyping for several members followed by the analysis of a single exome/genome is (currently) cheaper, while in small families or in single cases direct sequencing is to be preferred. Another advantage of homozygosity mapping over classical linkage is that in principle even small families can be informative enough to lead to the successful identification of the disease gene.

An alternative strategy for gene hunting for autosomal recessive CMT makes use of compound heterozygosity observed in the offspring of non-consanguineous parents with children with a recessive disorder: in this scenario, sequencing data will be filtered for genes in which 2 non-polymorphic variants (putative mutations) are simultaneously present. This process allows reducing the number of candidate genes by up to 3 orders of magnitude, compared to the genes containing only a single variant. Finally, selection of DNA changes that are shared among affected members of the same pedigree can further reduce the list of putative disease genes to the point only the true mutation is left.

In autosomal dominant or X-linked CMTs, noise reduction can be achieved by a similar pipeline, such as filtering for variants that are shared among multiple patients from the same families [Weedon et al., 2011].

Highly Parallel Genetic Technologies and CMT: Recent Discoveries

While still in its infancy, various highly parallel genetic technology approaches have already lead to a successful identification of the causative mutations in some families affected with peripheral neuropathies.

In their landmark study, Lupski et al. [2010] described the complete genome sequencing of an individual affected with CMT1 performed with the use of one of these sequencing platforms. Comparison of the proband’s sequence with the human genome reference sequence led to identification of 1,165,204 intragenic SNPs of which 9,069 were non-redundant SNPs predicted to lead to non-synonymous codon changes. The authors then concentrated on 54 coding SNPs (out of 3,148 putative SNPs) present in 40 genes known to be involved in neuropathy-like conditions. Of these, two were located in the SH3TC2 gene (1 previously unreported missense mutation, p.Y169H, and 1 known disease-causing nonsense mutation, p.R954X) indicating compound heterozygous mutations in this gene as a cause of CMT1.

An exome sequencing approach was used by Weedon et al. [2011] to study a large, 4-generation family affected by CMT2, in which various mutations in genes commonly associated with CMT2 (MFN2, MPZ, NEFL and LMNA) had been previously excluded by Sanger sequencing. Whole-exome sequencing was performed in 3 affected individuals and, based on an assumed autosomal dominant model of inheritance, the authors concentrated on novel heterozygous variants. Out of 177, 192, and 199 missense, nonsense, frameshift or splice site variants present in individual patients, only 1 variant was shared by all 3 affected individuals. The detected missense change (c.917A>G, p.H306R) in cytoplasmic dynein heavy chain 1 gene (DYNC1H1) affects a highly conserved residue within its homodimerization domain.

A similar approach was used by Landouré et al. [2012] to study a family with a CMT2C phenotype (axonal CMT with vocal cord paralysis). One affected individual was analyzed by exome sequencing leading to identification of a novel sequence variant (c.557G>A, p.R186Q) in the transient receptor potential vanilloid 4 gene (TRPV4) that was already known to cause CMT2C. Sanger sequencing confirmed the segregation of the mutation with the phenotype in the family. In addition, authors confirmed the pathogenicity of this variant in a cellular system.

Montenegro et al. [2011] also used exome sequencing to study a family with an axonal or intermediate form of CMT. Sequencing was performed in 2 affected individu-
als leading to the identification of 86 unique single-nucleotide variants in 82 genes and 146 insertions/deletions (66 in coding exons) segregating in both individuals. One of these variants (c.283G>A, V95M) affected the previously identified CMT gene GJB1.

A recent study by Auer-Grumbach et al. [2011] described the successful use of a combination of linkage analysis and NGS to identify missense variants in fibulin-5 that lead to a dominant form of CMT1. A genetic linkage study was performed in 2 families leading to the identification of a critical region on chromosome 14q32. After the exclusion of a few candidate genes (CALM1, GALC, PTPN21, KCNK13), the critical region was captured using a custom sequence capture array (Roche NimbleGen) and sequenced (454 GS-FLX, Roche). Sequence analysis revealed 12 non-synonymous sequence variants, eleven of which were known SNPs. The only new variant that was identified was in the FBLN5 gene (c.1117 C>T, p.R373C). Two additional fibulin-5 variants (c.268 G>A; p.G90S and c.376 G>A; p.V126M) were identified in 6 additional CMT patients.

A very similar approach was used by Weterman et al. [2012] to identify a frameshift mutation in LRSAM1. The linkage analysis run on a large 3-generation family led to the identification of a 5-Mb region on 9q33q34 with a LOD score of 5.12. The authors then used a custom sequence capture array covering the identified linkage region, to enrich, by sequence capture, the DNA from 1 affected individual which was subsequently sequenced. Sequence analysis revealed 5 heterozygous changes compatible with an autosomal dominant mode of inheritance. Subsequent segregation analysis and bioinformatic analyses revealed that the p.Leu708Argfx28 frameshift mutation in LRSAM1 is underlying this dominant type of CMT.

**NGS and CMT: Perspectives**

Data from recent studies in large cohorts of CMT patients indicated that molecular diagnosis could be established in ~50–70% of them [Baets et al., 2011; Saporta et al., 2011]. These results strongly indicate that an important number of additional CMT genes remains to be discovered. As discussed above, NGS technologies have the potential to help in achieving this goal.

In addition to their potential as a gene discovery tool, NGS technologies should be considered also as a diagnostic screening method. This is especially true in cases of CMT with substantial locus heterogeneity and/or where multiple large genes, making conventional screening of each patient time- and money-consuming, are implicated. Recent work by Choi et al. [2012] has already demonstrated the successful use of exome sequencing as a molecular diagnostic tool in CMT. In this study, 25 CMT patients who were negative for mutations in major CMT genes were analyzed by exome sequencing, leading to the identification of mutations in 32% of them. While this detection rate is relatively high, especially considering that these samples were pre-tested for the most common CMT genes, it also indicates the current limitations of this approach [Coppola and Geschwind, 2012].

In exome sequencing, the most prominent of these limitations is the selection of DNA to be analyzed. Since only exons and their flanking regions are interrogated, mutations in promoter areas, untranslated regions or any other non-exonic areas, as well as copy number variations, will be missed. Most important, in some instances capture kits allowing isolation of exonic regions are inefficient in isolating specific areas of the genome. As a consequence, the sequence coverage of CMT-related genes varies substantially (from 0 to more than 100 reads per base position) and some neuropathy-related genes including NEFL, WNK1 and SEPT9 cannot be analyzed at all [Montenegro et al., 2011]. However, this issue should be resolved, or at least substantially improved, with the commercialization of the next generation of exon capture kits, which should provide more comprehensive exome coverage.

The second and probably more challenging limitation is the issue of adequate exome data analysis. Each sequencing experiment leads to the identification of thousands of variants requiring subsequent filtering of previously identified benign variants. Various databases can be used to achieve this (1,000 Genomes Project: http://www.1000genomes.org; dbSNP: http://www.ncbi.nlm.nih.gov/projects/SNP/, etc.). However, often even a very restrictive filtering step will lead to the identification of tens of candidates that are genetically and functionally potentially compatible with the disease. This highlights the importance of clinically well-characterized cohorts for data pooling and comparison or extended pedigrees allowing selection of meaningful variants through segregation analysis.

Although large-scale genetic approaches already provide useful tools to characterize patients affected by CMT disease, from the examples mentioned above it is clear that both NGS technologies and their analytical pipelines still need some improvement. The anticipated technological development leading to better sequence representa-
tion, optimized filtering procedures and the establishment of a repository of coding variants identified in CMT patients will contribute to an improved success rate of NGS as a tool for both new gene discovery and diagnosis of CMT patients.

References


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