



Musculo-contractural Ehlers-Danlos syndrome (former EDS type VIB) and adducted thumb clubfoot syndrome (ATCS) represent a single clinical entity caused by mutations in the dermatan-4-sulfotransferase 1 encoding CHST14 gene.

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Musculo-contractural Ehlers-Danlos syndrome (former EDS type VIB) and adducted thumb clubfoot syndrome (ATCS) represent a single clinical entity caused by mutations in the dermatan-4-sulfotransferase 1 encoding *CHST14* gene.

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Abstract

We present clinical and molecular findings of three patients with an EDS VIB phenotype from two consanguineous families. The clinical findings of EDS kyphoscoliotic type (EDS type VI A&B) comprise kyphoscoliosis, muscular hypotonia, hyperextensible, thin and bruisable skin, atrophic scarring, joint hypermobility and variable ocular involvement. Distinct craniofacial abnormalities, joint contractures, wrinkled palms, and normal urinary pyridinoline ratios distinguish EDS VIB from EDS VIA. A genome-wide SNP scan and sequence analyses identified a homozygous frameshift mutation ([NM_130468.2:c.145delG, NP_569735.1:p.Val49*](#)) in *CHST14*, encoding dermatan-4-sulfotransferase 1 (D4ST-1), in two Turkish siblings. Subsequent sequence analysis of *CHST14* identified a homozygous 20-bp duplication ([NM_130468.2:c.981_1000dup, NP_569735.1:p.Glu334Glyfs*107](#)) in an Indian patient. Loss-of-function mutations in *CHST14* were recently reported in adducted thumb-clubfoot syndrome (ATCS). Patients with ATCS present similar craniofacial and musculoskeletal features as the EDS VIB patients reported here, but lack the severe skin manifestations. By identifying an identical mutation in patients with EDS VIB and ATCS, we show that both conditions form a phenotypic continuum. Our findings confirm that the EDS-variant associated with *CHST14* mutations (Miyake, et al., 2010) forms a clinical spectrum, which we propose to coin as “musculo-contractural EDS” and which results from a defect in dermatan sulfate biosynthesis, perturbing collagen assembly.

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Keywords: Ehlers-Danlos syndrome type VI, collagen, *CHST14*, dermatan-4-sulfotransferase 1, adducted thumb clubfoot syndrome

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Introduction

The Ehlers-Danlos syndrome (EDS) comprises a heterogeneous group of connective tissue diseases of which the major clinical features are skin hyperextensibility, joint hypermobility and generalized connective tissue fragility. (Steinmann et al., 2002) The current classification recognizes six subtypes which differ in clinical symptoms, inheritance pattern and the nature of the underlying biochemical and molecular defect(s). In several of these subtypes mutations have been identified in genes encoding the polypeptide (α)-chains of fibrillar collagen type I (arthrochalasia type), collagen type III (vascular type) and collagen type V (classic type), or in genes encoding enzymes involved in the posttranslational modification of type I collagen (kyphoscoliotic and dermatosparaxis type). (Beighton et al., 1998) Recently, several new EDS-variants have been characterized, which include the progeroid form of EDS (*β4GALT7*, OMIM 604327) (Quentin et al., 1990); a Tenascin-X deficient form of EDS (*TNXB*, OMIM 600985) (Schalkwijk et al., 2001); a cardiac-valvular EDS-form (*COL1A2*, OMIM 120160) (Schwarze et al., 2004; Malfait et al., 2006); and an EDS-like spondylocheirodysplastic form (*SLC39A13* OMIM 608735). (Giunta et al., 2008)

EDS kyphoscoliotic type or EDS type VI is an autosomal recessive (AR) disorder which is characterized by early-onset progressive kyphoscoliosis, severe neonatal muscle hypotonia with delayed gross motor development, generalized joint hyperlaxity, marfanoid habitus, osteopenia, and a fragile, hyperextensible and bruisable skin with widened atrophic scars. In some patients, scleral fragility with risk for rupture of the globe, and life-threatening rupture of medium-sized arteries have occasionally been reported. (Yeowell and Steinmann, 2000) One form of EDS kyphoscoliotic type, EDS type VIA, is caused by deficient activity of the enzyme procollagen-lysine, 2-oxoglutarate 5-dioxygenase 1 (PLOD1 or lysyl hydroxylase-1 (LH-1)) (Pinnell et al.,

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1972). This enzyme hydroxylates lysyl residues in Xaa-Lys-Gly- triplets of the helical region of collagens and collagen-like sequences of non-collagenous proteins (Kivirikko and Pihlajaniemi, 1998). The resulting hydroxyllysyl residues are essential for the formation of stable intermolecular crosslinks that provide tensile strength and mechanical stability to the collagen fibrils, and they serve as attachment sites for carbohydrate units. These carbohydrate units have been shown to influence the lateral packing of collagen molecules into fibrils. The diagnosis of EDS type VIA can be confirmed by the demonstration of an increased ratio of lysylpyridinoline (LP) to hydroxyllysylpyridinoline (HP) crosslinks in the urine, (Steinmann et al., 1995), a reduction of > 75% of LH-1 enzyme activity in skin (Yeowell and Walker, 2000), and mutation analysis of the *PLOD1* gene (OMIM 153454).

A subset of EDS type VI patients have been reported with normal LH-1 activity and normal urinary LP/HP ratios. They are usually referred to as “EDS type VIB” and the underlying molecular defect is hitherto unknown (Steinmann et al., 1975; Ogur et al., 1994; Steinmann et al., 2002; Walker et al., 2004; Kosho et al., 2005; Kosho et al., 2010). A small proportion of these present with predominant corneal fragility and fit into the Brittle Cornea Syndrome (BCS), for which *ZNF469* was recently identified as the causal gene. (Al-Hussain et al., 2004; Abu et al., 2008).

Here we report the clinical, biochemical and ultrastructural features of three patients with EDS type VIB from two consanguineous families and provide evidence that this phenotype is caused by mutations in *CHST14* (OMIM 608429), encoding dermatan-4-sulfotransferase 1.

Material and Methods

Subjects

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The patients and parents participated in this study following informed consent. This study has been approved by the Ethics Committee of the Ghent University Hospital, Ghent, Belgium. In all patients, a skin biopsy was taken for ultrastructural and/or biochemical studies. Blood samples were collected from the patients, their parents, and from unaffected siblings.

Biochemical analysis

A dermal fibroblast culture of patient 1 and 2 was established from a skin biopsy, and grown under standard conditions. At confluence the cells were labeled with ¹⁴C proline as described previously (Nuytinck et al., 1996) and collagen proteins were separated on SDS-polyacrylamide gels. The gels were processed for fluorography, dried and exposed to an X-ray film. Urinary lysylpyridinoline and hydroxyllysylpyridinoline excretion was evaluated with HPLC in all patients as described previously. (Steinmann et al., 1995).

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Ultrastructural analyses

For ultrastructural studies, a skin biopsy from the upper arms of patient 2 was fixed with 4% glutaraldehyde in phosphate buffer at pH 4.7 and prepared for transmission microscopy.

Homozygosity mapping

Genomic DNA was isolated from venous blood using the Puregene® DNA purification kit (Gentra Systems, Minneapolis, MN, USA) according to the manufacturer's instructions. Genotyping was performed for individuals II.1-3 of family 1 using the Mapping 250K Nsp array from Affymetrix containing 262264 SNPs (analysis performed by DNA Vision, Gosselies, Belgium). Genomic regions harbouring 25 consecutive homozygous SNPs (approximately 250

kb) or more were marked. To overcome SNP miscalls, regions spanning maximum 50 kb between two marked regions were considered homozygous. Eventually, regions that contained at least 100 consecutive homozygous SNPs were assigned as a candidate region if they were homozygous for the same allele in both affected patients and had a different genotype in the non-affected individual.

Mutation screening

PCR amplification was performed with 50ng genomic DNA. Reaction conditions, oligonucleotide primer pairs and thermal cycling conditions are listed in [Suppl. Table S1](#). PCR products were bidirectionally sequenced using the BigDye® Terminator Cycle Sequencing kit protocol (Applied Biosystems, Foster City, CA, USA), followed by separation on the ABI 3730XL Genetic Analyzer (Applied Biosystems).

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Results

Clinical findings

The clinical findings are summarized in [Suppl. Table S2](#) and illustrated in Fig 1.

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Family 1 (patient 1 & 2)

Patient 1 was born by normal vaginal delivery at 42 weeks of gestation as the second child to first-cousin Turkish parents. Birth weight was 3100g (-0.67 SD) and birth length 51cm (mean). Occipitofrontal circumference (OFC) was not recorded. She presented a large fontanel, flexion-adduction contractures of the thumb, which disappeared during the first year of life, camptodactyly of the 3rd, 4th and 5th finger and clubfeet, which were surgically corrected at age 2,5 yrs. She had a slender build with low muscle and fat mass leading to severe decubitus

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2 wounds on the buttocks during school age. Motor development was delayed, and she was not
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4 able to walk before age 4 yrs. During childhood she developed a kyphoscoliosis, which
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6 worsened rapidly at time of puberty and required surgery at age of 14 yrs. Her tissues were noted
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8 to be very thin and fragile upon surgical procedures. Skin fragility, delayed wound healing, easy
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10 bruising and bleeding from the gums were prominent. An umbilical hernia was corrected at age 5
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12 yrs. Hiatal hernia with gastro-esophageal reflux and frequent bouts of abdominal cramping pain
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14 were reported. Abdominal ultrasonography revealed nephrolithiasis at a very young age. Early-
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16 onset high myopia and glaucoma required several surgical treatments, but evolved to phtysis in
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18 the right eye and were complicated by retinal detachment in the left eye.
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20 Examination at age 22 yrs revealed a height of 155cm (-2.0 SD) with an armspan of 149 cm and
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22 OFC of 55 cm (mean). She presented a slender build with low muscle mass and marked
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24 muscular hypotonia, a corrected kyphoscoliosis and a narrow, flattened anterior thorax with no
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26 breast development. She had no light perception, and presented mild bilateral hearing loss.
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28 Craniofacial abnormalities included brachycephaly, asymmetric face with deep-set eyes,
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30 downslanting palpebral fissures, low-set and posteriorly rotated ears, malar hypoplasia, a short
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32 nose with hypoplastic columella, small mouth with thin upper lip, dental crowding, high and
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34 narrow palate and a protruding jaw with pointed chin. Her skin was very thin, transparent and
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36 hyperextensible, showed several cigarette paperscars and felt doughy and soft upon palpation
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38 with a very puffy aspect on lower limbs and feet. She had tapering fingers, severe wrinkling of
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40 the palms, flexion contractures of fingers (Fig 1D) and toes, and dislocation of the radio-ulnar
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42 joints. Joint hyperlaxity was limited to the metacarpophalangeal joints. She presented talipes
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44 valgus and planus. Echocardiography at age 21 yrs, was normal, with an aortic root of 17 mm.

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Patient 2, the younger sister of patient 1, was born at 42 weeks of gestation after a normal pregnancy and vaginal delivery. At birth, her fontanel was large and she had clubfeet which were corrected at 12 months. Muscular hypotonia caused delayed gross motor development and inability to walk independently before age 2 yrs. During childhood, she suffered a spontaneous rupture of the abdominal muscles and diastasis recti, repetitive painful dislocations of the patellae, requiring surgical fixation, and repeated dislocations of temporomandibular, shoulder and ankle joints. At the age of 14 yrs she developed a rapidly progressive lumbar scoliosis. Skin fragility, delayed wound healing, easy bruising and formation of widened atrophic scars were comparable to her sister's. She suffered from early onset nephrolithiasis and abdominal ultrasonography disclosed hydronephrosis due to renal ptosis and ureteral stenosis for which an ureteral stent was placed. The laparoscopic procedure was complicated by severe hemorrhage due to excessive tissue fragility. Early-onset high myopia and glaucoma were complicated by retinal detachment of the left eye. Clinical examination at the age of 14 yrs showed a similar, though milder phenotype as her older sister, with low muscle mass, muscular hypotonia and a narrow, flat thorax. She was 168 cm tall (0.68 SD) with an armspan of 157 cm and an OFC of 58 cm (> 2.0 SD). Facial appearance was characterized by brachycephaly, malar hypoplasia, bushy eyebrows and synophrys, downslanting palpebral fissures, blue sclerae, microcornea, thin upperlip and a high, narrow palate (Fig1A). Her skin had the same doughy, hyperextensible and thin aspect as her sister's, with atrophic cigarette paperscars on both knees (Fig 1 J&K) and marked generalized hirsutism. She had tapering fingers, clinodactyly, small joint hypermobility, wrinkled palms (Fig 1E) and dislocation of the radio-ulnar joints (Fig 1I). Her feet were small and broad with short toes, and markedly soft and puffy subcutaneous tissues (Fig 1G). Follow-up examination at age 21 yrs (Fig 1B) revealed moderate thoracolumbar scoliosis with high

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vertebral bodies on X-rays, absence of breast development and a mild hearing impairment.

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Echocardiography at the age of 14 yrs was normal with an aortic root of 18 mm.

Family 2 (patient 3)

Patient 3 is a 12-year old girl and first child of a consanguineous couple of Indian origin. She was born at term after an uneventful pregnancy and delivery with a birth weight of 2800 g (-1.88 SD). Birth length and OFC were not recorded. She presented clubfeet at birth, which were corrected at the age of 18 months. Her fingers and toes were tapering with flexion contractures of all fingers (Fig 1F) and toes (Fig 1H) and flexion-adduction contractures of the thumbs (Fig 1F). She had prominent wrinkles on the palms, but absence of deep palmar creases. At the age of 5 months she developed a kyphoscoliosis which worsened progressively during childhood. Gross motor development was delayed, she had a slender build with low muscle mass and a history of dislocation of the left elbow and tendon injury of the right knee following a fall. Her skin was soft and hyperextensible, especially over elbows and neck. Wound healing was delayed with large gaping wounds and severe atrophic cigarette paperscars (Fig 1L), which needed multiple surgical suturing over knees. She presented easy bruisability and chronic ulcers. Her facial appearance was characterized by blue sclerae, microcornea, prominent bulging eyes, myopia and low-set ears (Fig 1C). At the age of 8 yrs she had a subacute duodenal obstruction due to malrotation, which was treated surgically.

Morphological and ultrastructural studies

The majority of the collagen bundles were small-sized. Some bundles were composed of variable diameter collagen fibrils separated by irregular interfibrillar spaces. Flower-like collagen fibrils were present. Granulo-filamentous material was found throughout the dermis, within the

collagen bundles and in the interstitial area, which in addition contained large stellate globules of hyaluronic acid (not shown). The elastic fibers presented normal ultrastructural features in papillary and reticular dermis (not shown). Fibroblasts exhibited an elongated and/or dilated endoplasmic reticulum (ER) (Fig 2).

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Biochemical studies

SDS-PAGE analysis of procollagens and pepsin-digested collagens from the medium and the cell layer fraction showed a normal electrophoretic pattern for type I, III and V (pro)collagen proteins (data not shown).

In all three patients, normal LP/HP ratios were observed, excluding the diagnosis of EDS type VIA.

Molecular studies

After excluding the presence of disease-causing mutations in the *PLOD1* gene by means of direct sequencing at gDNA level, homozygosity mapping for individuals II.1-3 from family 1 identified four candidate regions which were homozygous among the two affected patients, but not in the non-affected sib and which contained in total 217 known or predicted genes, excluding pseudogenes (NCBI MapViewer, Build 36.3) (detailed description of the regions in Table 1).

Within the disease interval no genes previously associated with EDS were found. Sixteen positional and functional candidate genes, including *TGFBR3*, *RSPO3*, *ZNF596*, *SRP14*, *CHST14*, *DNAJC17*, *PPP1R14D*, *SPINT1*, *VPS18*, *VPS39*, *SNAP23*, *LRRC57*, *PDIA3*, *MFAP1*, *GALK2* and *AP4E1* were selected for sequencing using the Sanger method, and this resulted in the identification of a homozygous deletion of a single nucleotide in the *CHST14* gene in the two

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affected patients of family 1 ([NM_130468.2:c.145delG, NP_569735.1:p.Val49*](#)) (Fig 3A).
Subsequent sequencing analysis of *CHST14* identified a homozygous 20-bp duplication in
patient 3 ([NM_130468.2:c.981_1000dup, NP_569735.1:p.Glu334Glyfs*107](#)) (Fig 3B). The
mutations were found in homozygous state only in the affected patients, and were present in the
heterozygous state in their parents. The unaffected sister from family 1 has two wild-type alleles.
The mutations were not detected in 109 control individuals (218 alleles). Nucleotide numbering
reflects cDNA numbering with +1 corresponding to the A of the ATG translation initiation
codon in the reference sequence (GenBank reference sequence [NM_130468.3](#)), according to the
journal guidelines. The initiation codon is codon 1.

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Discussion

We report homozygous frameshift mutations in *CHST14*, encoding dermatan-4-sulfotransferase 1 (D4ST-1), in two unrelated inbred families from Turkish and Indian origin respectively, presenting a form of EDS, which, up till now, has been, referred to as EDS VIB. The clinical phenotype in these patients is characterized by distinct craniofacial, musculoskeletal, cutaneous and ophthalmological abnormalities (Suppl. Table S2). Our patients closely resemble the Pakistani siblings reported by Steinmann and co-workers (Steinmann et al., 1975), with a phenotype of EDS kyphoscoliotic type (EDS VI) but normal LH-1 activity, a condition subsequently referred to as EDS VIB. (Steinmann et al., 2002). Loss-of-function mutations in *CHST14* were recently shown to cause a rare autosomal recessive condition called “adducted thumb clubfoot syndrome” (ATCS). (Dundar et al., 2009). The EDS patients reported here show many features of ATCS including the craniofacial abnormalities, congenital contractures of thumbs and fingers, clubfeet, joint hyperlaxity, wasted build, thin skin and easy bruising. However, they differ from ATCS in the severity of the cutaneous manifestations, especially in the presence of atrophic scars, and also in the more severe kyphoscoliosis and ocular involvement (Suppl. Table S2). With the identification of a homozygous NM_130468.2:c.145delG (NP_569735.1:p.Val49*) mutation in patient 1 and 2 of this study, which is identical to the mutation reported earlier in two ATCS-sibs (Dundar et al., 2009), we provide evidence that ATCS and EDS VIB form a continuum within the same clinical spectrum. Furthermore our findings show that the new EDS-variant, recently reported by Kosho et al (Kosho et al., 2010), and also shown to be associated with loss-of-function mutations in *CHST14* (Miyake et al., 2010), is situated within the EDS VIB-ATCS spectrum.

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Hitherto reported *CHST14* mutations comprise six missense mutations, one frameshift mutation and one nonsense mutation (Dundar et al., 2009). We expand the range of mutations in *CHST14* with a novel homozygous 20-bp duplication in the Indian patient (patient 3).

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The *CHST14*- related EDS VIB phenotype is distinguished from EDS VIA by the presence of distinct craniofacial abnormalities, contractures of fingers and toes, tapering fingers, severe wrinkling of the palms, and gastro-intestinal and genito-urinary manifestations (Suppl. Table S2). On the other hand, arterial rupture and rupture of the eye globe, sometimes observed in EDS VIA, have not been observed in patients with *CHST14* mutations so far. In order to clearly distinguish the *CHST14*-related phenotype and its associated risks from the kyphoscoliotic type of EDS, we propose to coin the *CHST14*-related condition “musculo-contractural Ehlers-Danlos syndrome”.

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Musculo-contractural EDS shows phenotypic resemblance to the spondylocheiroadysplastic form of EDS (SCD-EDS) (Suppl. Table S2), caused by mutations in the *SLC39A13*, encoding a membrane-bound zinc transporter and in which moderately increased urinary LP/HP ratios

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(intermediate values between EDS VIA & VIB) have been reported (Giunta et al., 2008).

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CHST14 encodes the enzyme D4ST-1, which is involved in the biosynthesis of the glycosaminoglycan (GAG) dermatan sulfate (DS), where it catalyzes 4-O-sulfation of N-acetyl-galactosamine (GalNAc) (Penc et al., 1998). GAGs, such as DS and chondroitin sulfate (CS) are long unbranched polymers, whose synthesis starts with the formation of a tetrasaccharide linker region that attaches the GAG chains to a serine residue within the conserved attachment sites of core proteins (Suppl. Fig S1). CS/DS chains are composed of alternating glucuronic acid (GlcA) and GalNAc disaccharide units. (Trowbridge and Gallo, 2002), In DS, GlcA is epimerized to iduronic acid (IdoA) (Maccarana et al., 2006; Pacheco et al., 2009). Subsequent addition of

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sulfate to the C-4 hydroxyl group of GalNAC prevents further epimerization of the adjacent GlcA or IdoA. (Malmstrom, 1984) GalNac can be sulfated in the 4-O-position by the three major sulfotransferases C4ST-1 and -2 (chondroitin-4-sulfotransferase 1 & 2) and D4ST-1, which have different substrate specificities. (Evers et al., 2001; Hiraoka et al., 2001; Mikami et al., 2003)

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The epimerisation and sulfation reactions are not random, but reflect a tightly controlled system which produces structural variability into the CS/DS chain, thereby determining functional interactions with potential protein partners. (Trowbridge and Gallo, 2002). Both Dundar et al and Miyake et al showed that the *CHST14* mutations result in loss of D4ST-1 activity. Although patients' fibroblasts are able to epimerize GlcA-GalNac to IdoA-GalNac, they cannot add sulfate to the C-4 hydroxyl group of IdoA-GalNac, thereby allowing back-epimerisation from IdoA to GlcA to form CS. (Dundar et al., 2009; Miyake et al., 2010) This suggests that D4ST-1 is the key enzyme for 4-O-sulfation of DS in skin, which cannot be compensated for by the chondroitin 4-O-sulfotransferases.

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DS is covalently attached via an O-xylose linkage to serine residues of core proteins to form DS proteoglycans (DSPG), such as thrombomodulin, versican, and the small leucine-rich proteoglycans (SLRP) decorin and biglycan. These DSPG have widespread tissue distribution in blood vessel walls, cornea, skin, tendon, cartilage, bone and undifferentiated mesenchymal tissue. (Trowbridge and Gallo, 2002) They are involved in organization of the extracellular matrix, wound repair, anti-coagulant processes, cell adhesion, migration and proliferation.

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Miyake et al showed that DS of decorin is completely lost and replaced by CS in the patients' fibroblasts. (Miyake et al., 2010) Decorin is essential in maintaining skin integrity and collagen structure. The protein core of decorin binds to collagen fibrils, and its single DS chain binds to Tenascin-X, another extracellular matrix (ECM) protein which co-localizes with collagen fibrils.

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Patients deficient in tenascin-X and mice deficient in decorin both have increased skin fragility and altered skin collagen fibril architecture (Danielson et al., 1997; Schalkwijk et al., 2001).

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Miyake et al argue that loss of the decorin hybrid CS/DS chain and replacement by CS decreases the flexibility of the GAG chain. This hybrid CS/DS regulates the space between collagen fibrils, and its replacement by CS results in disturbed collagen bundle organisation, as observed on ultrastructural examination of the skin from D4ST-1 deficient patients (Miyake et al., 2010) and this study).

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DSPG bind to a diverse range of extracellular matrix proteins either through their core protein or through their GAG chains. Besides structural molecules such as collagens and tenascin-X, these include growth factors, cytokines, chemokines and protease inhibitors, including proteins involved in the coagulation cascade (Trowbridge and Gallo, 2002). The broad array of physiological events in which DS and DSPG play a role, and the essential role of D4ST-1 in the biosynthesis of these DS, indicate that altered interaction of these proteoglycans, and disturbed ECM homeostasis underly the pathogenesis of both musculo-contractural EDS and ATCS, and explains the observed multisystemic clinical manifestations which result from disturbances in diverse physiological processes, including development, extracellular matrix maintenance and wound repair.

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Acknowledgments:

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Table 1: Candidate regions for family 1 following homozygosity mapping.¶

Figure Legends

Figure 1: Clinical characteristics.

A-C: Clinical pictures of patient 2 at age 14 yrs (A) and age 21 yrs (B), showing craniofacial dysmorphism with flattened profile, malar hypoplasia, bushy eyebrows and synophrys, downslanting palpebral fissures, blue sclerae, microcornea, long philtrum with thin upperlip, and protruding jaw with pointed chin. Clinical picture of patient 3 at age 12 yrs (C).

D-I: Hands and feet with characteristic features. Patient 1 at age 22 yrs (D), patient 2 at age 14 (I) and age 21 yrs (E, G) and patient 3 at age 12 yrs (F, H): tapering fingers with flexion contractures and excessive wrinkling of the palms (D-F), foot deformities with short broad feet

and toes in patient 2 (G) and long tapering toes with contractures, pseudotumor and cigarette paper scarring in patient 3 (H); dislocation of radio-ulnar joint in patient 2 (I).
J-L: Thin and hyperextensible skin (J) and cigarette paperscars in patient 2 (K) and 3 (L).

Figure 2: electron microscopic findings in skin of patient 2.

Fibroblasts show dilatation of endoplasmic reticulum.

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Figure 3: *CHST14* mutations in the patients.

A: Pedigree of family 1. Sequence analysis reveals a homozygous G deletion at cDNA position 145 of the *CHST14* gene in both affected siblings. The deleted nucleotides are *boxed* in the WT sequence (upper panel), while the *arrow* indicates the position of the deleted nucleotide in the mutant sequence (lower panel).

B: Pedigree of family 2. Sequence analysis reveals a homozygous 20-bp duplication at cDNA position c.981-1000 of the *CHST14* gene in the affected patient. The duplicated nucleotides are *boxed* in upper and lower panel.

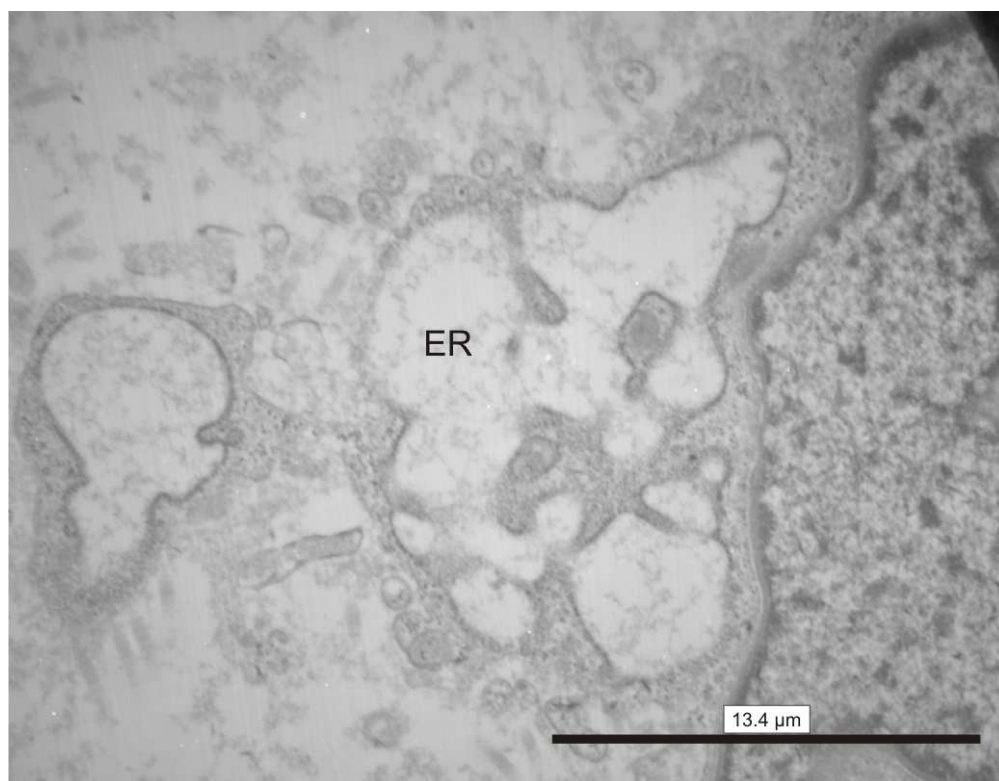
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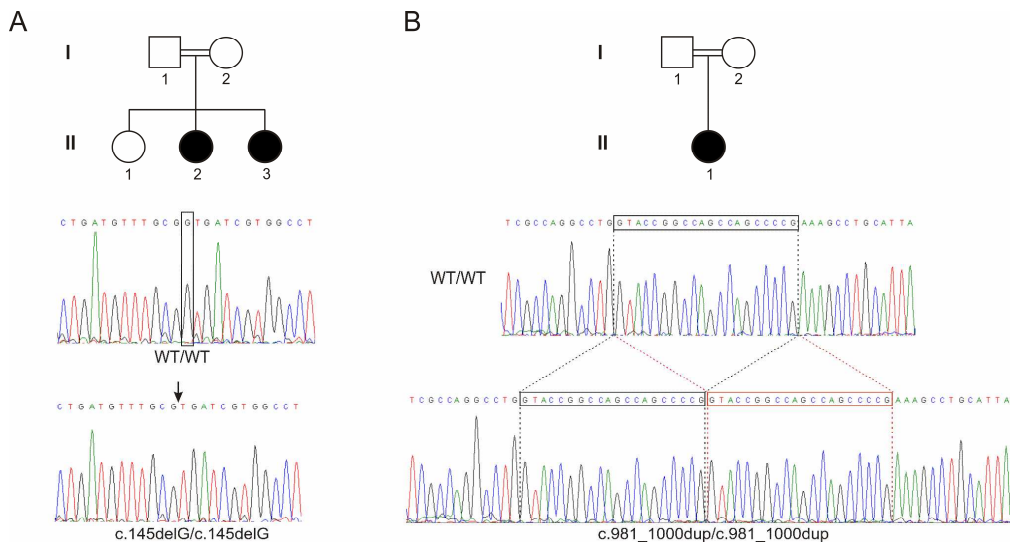
Clinical characteristics.

A-C: Clinical pictures of patient 2 at age 14 yrs (A) and age 21 yrs (B), showing craniofacial dysmorphism with flattened profile, malar hypoplasia, bushy eyebrows and synophrys, downslanting palpebral fissures, blue sclerae, microcornea, long philtrum with thin upperlip, and protruding jaw with pointed chin. Clinical picture of patient 3 at age 12 yrs (C).
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J-L: Thin and hyperextensible skin (J) and cigarette paperscars in patient 2 (K) and 3 (L).

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electron microscopic findings in skin of patient 2. Fibroblasts show dilatation of endoplasmic reticulum.
43x34mm (600 x 600 DPI)



CHST14 mutations in the patients.

A: Pedigree of family 1. Sequence analysis reveals a homozygous G deletion at cDNA position 145 of the *CHST14* gene in both affected siblings. The deleted nucleotides are boxed in the WT sequence (upper panel), while the arrow indicates the position of the deleted nucleotide in the mutant sequence (lower panel).

B: Pedigree of family 2. Sequence analysis reveals a homozygous 20-bp duplication at cDNA position c.981-1000 of the *CHST14* gene in the affected patient. The duplicated nucleotides are boxed in upper and lower panel.

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Table Legend

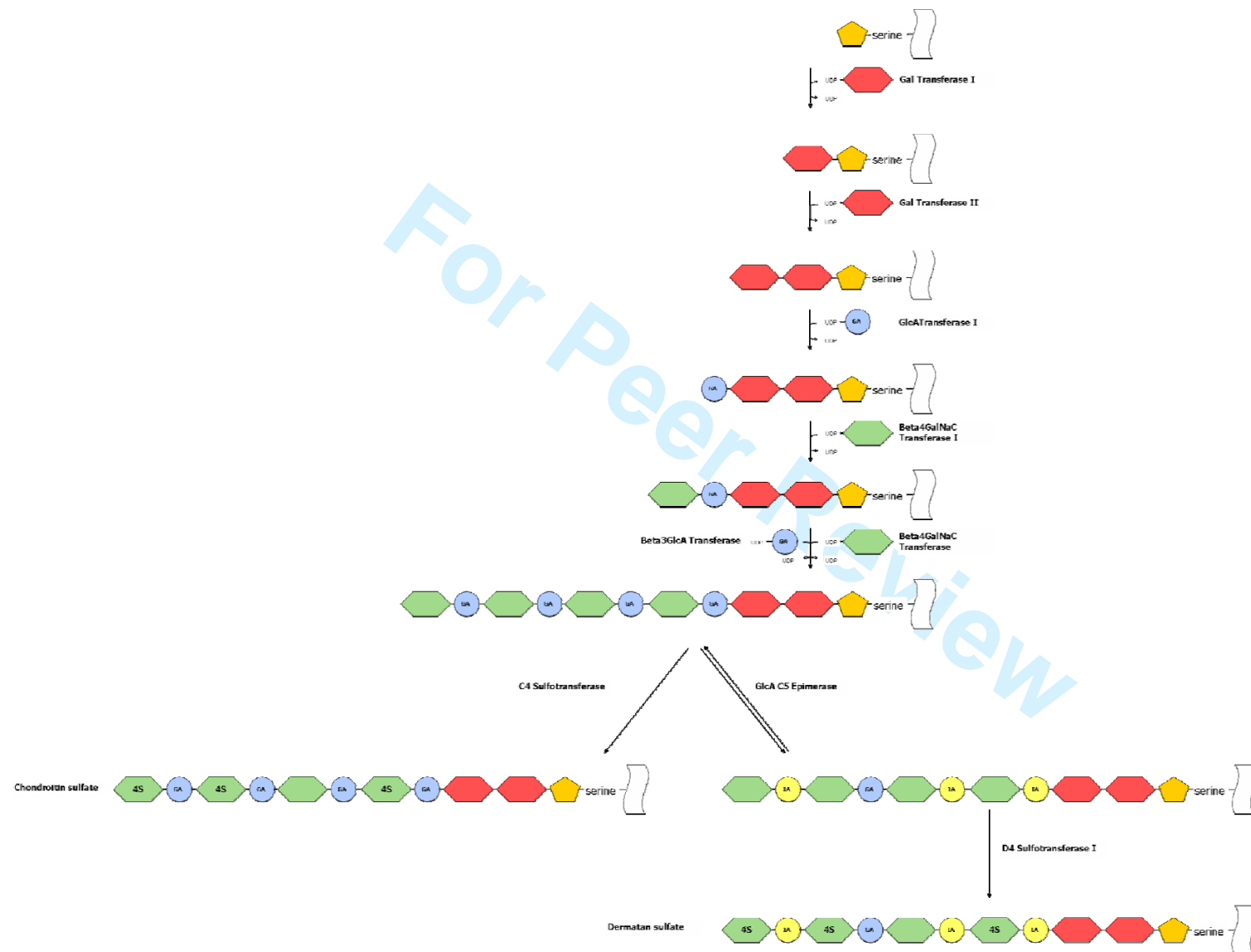
Table 1: Candidate regions for family 1 following homozygosity mapping.

Chr	SNP delineation	#Mb	# genes	# microRNAs
1	rs284180-rs1325433	0.65	10	0
6	rs2875742-rs4371861	2.31	16	1
8	rs10488368-rs1822243	3.01	18	1
15	rs2412456-rs7176579	11.17	173	3
Total		17.14 Mb	217	5

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Suppl. Figure S1: Biosynthesis of Chondroitin and Dermatan Sulfate.

Synthesis of CS and DS starts with the formation of a tetrasaccharide linker region that attaches the GAG chains to a serine residue within the conserved attachment sites of core proteins. The activity of Beta4 GalNac Transferase I, that transfers the first GalNac residue onto the tetrasaccharide linker, starts a growing CS/DS chain, composed of alternating GlcA and GalNac disaccharide units. (Trowbridge and Gallo, 2002). In DS, GlcA is epimerised to IdoA, followed by sulfate addition to C-4 hydroxylgroup of the adjacent GalNac residue by D4ST-1, thereby generating DS from CS. Loss of D4ST-1 activity will result in loss of this 4-O-sulfation lock, and will allow back epimerisation of IdoA to GlcA, replacing DS by CS.



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Suppl. Table S1:

CHST14 sequencing oligonucleotide primer pairs. Fragments 1 to 4 amplify the coding region whereas fragments 5 and 6 amplify the 3'UTR of the gene.

Amplicon	F primer sequence	R primer sequence	PCR mix	Annealing temperature
Fr1	GCCTGTGTCACCTGCGAG	CCGCTCGATCATGAGCA	A	TD62-50
Fr2	CTGCCGTCCATGCTGAT	CTGCGGTGGTCCATCTT	A	TD62-50
Fr3	GAAGCGGGTGATGAAGGT	TCCAGCACCTGATTTGCAT	B	AT60
Fr4	CTTGTGCCGTGCACTATG	CTGTCCTCTGAGTCACTGT	B	TD62-50
Fr5	GGATCCTGGATGGCAGAG	TGGCAGGTGTAGGAAATTTTGA	B	TD62-50
Fr6	CAGGACTAGAGTGAGCAATC	ACATCGAGGAGATCTGCTG	B	TD62-50

For mix A, PCR amplification was performed with 50ng genomic DNA, 0.6 μ M of each primer (oligonucleotide primer pairs (Invitrogen, Carlsbad, CA, USA) are listed in Supplementary Table 1), 0.12 mM dNTP mix (Invitrogen), and 1 unit of KAPA2G Robust HotStart DNA polymerase in 1 x KAPA2G Robust HotStart GC Buffer (Kapa Biosystems, Woburn, MA, USA).

For mix B, PCR amplification was performed with 50ng genomic DNA, 0.6 μ M of each primer (oligonucleotide primer pairs (Invitrogen) are listed in Supplementary Table 1), 1 mM MgCl₂, 0.12 mM dNTP mix (Invitrogen), and 0.5 units of KAPATaq HotStart DNA polymerase in 1 x KAPATaq HotStart Buffer (Kapa Biosystems, Woburn, MA, USA).

For TD62-50 thermal cycling conditions consisted of an initial denaturation step of 94°C for 4 minutes, 12 cycles of 94°C for 20s, 62°C for 15s, and 72°C for 60s with a decrease in annealing temperature of 1°C each cycle, followed by 24 cycles of 94°C for 40s, 50°C for 40s, and 72°C for 30s, and a final extension at 72°C for 10 minutes.

For AT60 thermal cycling conditions consisted of an initial denaturation step of 94°C for 4 minutes, 32 cycles of 94°C for 20s, 60°C for 20s, and 72°C for 40s followed by a final extension at 72°C for 10 minutes.

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Suppl. Table 2:

Summary of the clinical findings in the currently reported patients, and comparison with patients reported by Steinmann et al (Steinmann, et al., 1975; Steinmann, et al., 2002), Kosho et al (Kosho, et al., 2010), patients with typical EDS VIA, patients with ATCS (Dundar, et al., 2009) and patients with spondylocheiroadysplastic (SCD) EDS (Giunta, et al., 2008).

Abbreviations: AR: autosomal recessive; n.r.: not reported

Symbols: +: present; -: absent; †: deceased

	P1	P2	P3	(Steinmann, et al., 1975)	(Kosho, et al., 2010)	ATCS	EDS VIA	SCD-EDS
Inheritance pattern	AR	AR	AR	AR	AR	AR	AR	AR
CRANIOFACIAL								
Large fontanel	+	+	n.r.	n.r.	+ (5/5)	+ (7/7)	-	-
Brachycephaly	+	+	-	-	-	+ (7/7)	-	-
Flat face	+	+	-	-	+	+ (6/7)	-	-
low-set ears	+	+	+	-	+ (5/5)	+	-	-
Downslanting palpebral fissures	+	+	-	+	+ (6/6)	+ (7/7)	-	+ (3/6)
Telecanthus/hypertelorism	-	-	-	+	+ (6/6)	+ (7/7)	-	+ (1/6)
Short nose, hypoplastic columella	+	+	-	+ (1/2)	+ (6/6)	n.r.	-	-
Long philtrum, thin upper lip	+	+	-	-	+ (5/5)	+ (1/7)	-	-

Small mouth	+	+	-	+	+ (4/4)	-	-	-
High palate	+	+	+	+ (1/2)	+ (6/6)	+ (3/7)	+	-
Dental crowding	+	+	-	-	-	-	-	-
Protruding jaw, pointed chin	+	+	-	-	+ (5/5)	-	-	-
CUTANEOUS								
Skin fragility/atrophic scars	+	+	+	+	+ (5/6)	-	+	+ (5/6)
Hyperextensibility	+	+	+	+	+ (6/6)	-	+	+ (6/6)
Thin, transparent	+	+	+	n.r.	+ (6/6)	+	+	+ (6/6)
Doughy, velvety	+	+	+	+	n.r.	n.r.	+	+ (4/6)
Easy bruising	+	+	+	+	+ (6/6)	+	+	+ (4/6)
Palmar wrinkling	+	+	+	+ (1/2)	+ (6/6)	n.r.	-	+ (6/6)
Hyperalgesia to pressure	-	-	n.r.	+	+ (5/6)	-	-	n.r.
MUSCULOSKELETAL								
Kyphoscoliosis	+	+	+	+	+ (6/6)	+ (1/7)	+	-
Joint hyperlaxity	+	+	+	+	+ (6/6)	+ (5/7)	+	+ (4/6)
Dislocations	-	+	+	+ (1/2) (hip)	+ (4/6)	+ (1/7)	+	+ (3/6)
Tapered fingers	+	+	+	+ (1/2)	+ (6/6)	+ (7/7)	-	+ (6/6)
Joint contractures	+	+	+	-	+	+ (7/7)	-	+ (5/6)
Adducted thumbs	+	-	+	-	+ (5/6)	+ (7/7)	-	-
Clubfeet	+	+	+	+	+ (6/6)	+ (7/7)	+	+ (1/6)
Pectus deformity	+ flat	+ flat	-	+ flat	+ (6/6)	+ (2/7)	+	-
Muscle hypotonia	+	+	+	+	+	+ (mild 4/7)	+	-
CARDIOVASCULAR								

Valve abnormalities	-	-	-	-	+ (3/5)	+ (2/7)	-	-
OPTALMOLOGICAL								
Microcornea	-	+	-	+	+ (1/6)	-	+	+ (3/3)
Blue sclerae	-	+	+	+ (1/2)	+ (4/6)	+ (4/7)	+	+ (6/6)
Myopia	blind	+ (-14.5 diopters at 14 yrs)	+	+	+	-	+	+ (2/6)
Scleral/corneal fragility	-	-	-	-	-	-	+	-
Glaucoma	+	+	-	-	+ (3/6)	↑ IO pressure 2/7	+	-
Retinal detachment	+	+	-	-	+ (1/6)	-	+	-
OTHER								
Hearing impairment	+	+	-	-	+ (4/6)	+	-	-
Intestinal	Abdominal cramping	Abdominal cramping	malrotation with duodenal obstruction	-	Constipation (5/6) Diverticula perforation (1/6)	Absence of gastrocolic omentum, spontaneous volvulus of small intestine (1/7)	-	-
Genito-urinary	nephrolithiasis	Nephrolithiasis is- renal ptosis with ureteral obstruction	-	Nephrolithiasis and hydronephrosis (1/2)	Nephrolithiasis (1/6) Urinary retention Cryptorchidism (1/2M)	Hydronephrosis (2/7) Nephrolithiasis (1/7) Horseshoekidney (1/7) Crytorchidism (4/4 M)	-	-
Other	-	Rupture abdominal	-	† (1/2)	Diastasis recti (1/6)	Cleft lip/ palate (2/7)	-	Platyspondyly Metaphyseal

		muscles				Diassasis recti		broadening
		diastasis recti				(1/7)		Thenar
						Contractures		hypotrophy
						elbows/knees		
						(1/7)		
						Coarctatio aortae		
						(1/7)		
						† (5/11)		

Or Peer Review