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1 **ORAI1 mutations with distinct channel gating defects in tubular**
2 **aggregate myopathy**

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19 **ABSTRACT**

1 Calcium (Ca^{2+}) is a physiological key factor, and the precise modulation of free cytosolic Ca^{2+}
2 levels regulates multiple cellular functions. Store-operated Ca^{2+} entry (SOCE) is a major
3 mechanism controlling Ca^{2+} homeostasis, and is mediated by the concerted activity of the
4 Ca^{2+} sensor STIM1 and the Ca^{2+} channel ORAI1. Dominant gain-of-function mutations in
5 *STIM1* or *ORAI1* cause tubular aggregate myopathy (TAM) or Stormorken syndrome, while
6 recessive loss-of-function mutations are associated with immunodeficiency. Here we report
7 the identification and functional characterization of novel *ORAI1* mutations in TAM patients.
8 We assess basal activity and SOCE of the mutant ORAI1 channels, and we demonstrate that
9 the G98S and V107M mutations generate constitutively permeable ORAI channels, while
10 T184M alters the channel permeability only in the presence of STIM1. These data indicate a
11 mutation-dependent pathomechanism and a genotype/phenotype correlation, as the *ORAI1*
12 mutations associated with the most severe symptoms induce the strongest functional cellular
13 effect. Examination of the non-muscle features of our patients strongly suggest that TAM and
14 Stormorken syndrome are spectra of the same disease. Overall, our results emphasize the
15 importance of SOCE in skeletal muscle physiology, and provide new insights in the
16 pathomechanisms involving aberrant Ca^{2+} homeostasis and leading to muscle dysfunction.

17

18 **KEYWORDS**

19 Tubular aggregate myopathy, Stormorken syndrome, ORAI1, calcium, SOCE, STIM1

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24 **INTRODUCTION**

1 Skeletal muscle physiology directly depends on changes in free cytosolic calcium (Ca^{2+})
2 levels, and small disturbances in Ca^{2+} homeostasis can severely impact on muscle contraction,
3 differentiation, or gene transcription. A major mechanism controlling Ca^{2+} homeostasis is
4 store-operated Ca^{2+} entry (SOCE), which is triggered by Ca^{2+} store depletion of the
5 endoplasmic/sarcoplasmic reticulum (ER/SR), and results in extracellular Ca^{2+} influx through
6 Ca^{2+} release-activated Ca^{2+} (CRAC) channels as ORAI1 (MIM# 610277). This highly Ca^{2+} -
7 selective plasma membrane channel is composed of tetramers or hexamers forming three
8 concentric rings around the central pore (Hou, et al. 2012; Thompson and Shuttleworth 2013;
9 Cai, et al. 2016). Each ORAI1 subunit is composed of 4 alpha-helical transmembrane
10 domains (M1 to M4) linked by two external (I and III) and one internal (II) loop, with the N-
11 and C-termini facing the cytosol. The M1 transmembrane domain constitutes the ~55 Å long
12 channel pore with an acidic glutamate ring at position E106 forming the selectivity filter and,
13 together with negative residues in the first external loop, conferring high selectivity for Ca^{2+}
14 ions (Vig, et al. 2006; Zhou, et al. 2010; McNally, et al. 2012; Frischauf, et al. 2015). The
15 central segment of the pore contains a rigid hydrophobic section responsible for the low
16 channel conductance, a gating hinge controlling pore opening, and a basal component
17 potentially avoiding backward Ca^{2+} efflux from the cytoplasm (Zhang, et al. 2011).

18 Channel opening is mediated through the interaction of the cytoplasmic N- and C-termini of
19 the ORAI1 subunits with STIM1 (MIM# 605921), a transmembrane protein in the ER/SR
20 able to sense luminal Ca^{2+} (Muik, et al. 2008; Navarro-Borelly, et al. 2008; Zheng, et al.
21 2013). Ca^{2+} store depletion induces a conformational change resulting in oligomerization and
22 cytosolic extension of the STIM1 molecules. The exposure of lipid-binding and channel
23 activating domains (CAD) promotes the accumulation of the STIM1 oligomers at junctional
24 ER/SR structures near the plasma membrane, where they trap and gate the ORAI channels
25 (Luik, et al. 2006; Stathopoulos, et al. 2006; Park, et al. 2009).

1 We previously identified *STIM1* gain-of-function mutations as genetic cause of autosomal
2 dominant tubular aggregate myopathy (TAM, MIM# 160565) (Bohm, et al. 2013). TAM
3 mostly involves elevated creatine kinase (CK) levels and slowly progressive muscle weakness
4 predominantly affecting the proximal muscles of the lower limbs, but also myalgia, cramps,
5 and asymptomatic CK elevation have been described (Bohm, et al. 2013; Bohm, et al. 2014;
6 Hedberg, et al. 2014; Walter, et al. 2015). Muscle biopsies from patients with TAM typically
7 show regular arrays of 70-200 nm long membrane tubules as the main histopathological
8 hallmark (Chevessier, et al. 2005). Tubular aggregates can also arise as secondary features in
9 various inherited and acquired muscle disorders, and accumulate in normal muscle with age
10 (Boncompagni, et al. 2012). All TAM mutations affect highly conserved amino acids in the
11 Ca^{2+} -sensing EF hand domains of STIM1. The only cytosolic STIM1 mutation R304W has
12 been associated with Stormorken syndrome (MIM# 185070), a multisystemic disorder
13 involving tubular aggregate, elevated CK levels, miosis, thrombocytopenia, ichthyosis,
14 asplenia, dyslexia, and short stature (Misceo, et al. 2014; Morin, et al. 2014; Nesin, et al.
15 2014). Mutations in *STIM1* causing either TAM or Stormorken syndrome were both shown to
16 induce constitutive STIM1 oligomerization, CRAC channel activation and Ca^{2+} influx in the
17 absence of store depletion (Bohm, et al. 2013; Bohm, et al. 2014; Misceo, et al. 2014; Nesin,
18 et al. 2014). Recently, three gain-of-function mutations causing TAM or a Stormorken-like
19 syndrome were also described in *ORAI1* (Nesin, et al. 2014; Endo, et al. 2015). These
20 mutations did not alter *ORAI1* localization at the plasma membrane, but resulted in increased
21 SOCE and diminished Ca^{2+} -dependent channel inactivation (CDI).

22 This study reports the identification of three *ORAI1* gain-of-function mutations (two in the
23 channel pore and one in M3) in patients with TAM with or without isolated characteristics of
24 Stormorken syndrome. Based on clinical, histological, genetic, and functional data, we
25 establish a genotype/phenotype correlation and conclude that TAM and Stormorken syndrome

1 clinically overlap, and have to be considered as spectra of the same disease. We provide the
2 functional evidence that mutations in the first transmembrane domain induce a STIM1-
3 independent permeable Ca²⁺ channel resulting in a more severe phenotype, while the mutation
4 in the third transmembrane domain requires activation through STIM1 to generate an
5 excessive Ca²⁺ influx and causes a milder phenotype, suggesting that the *ORAI1* mutations
6 involve different pathological mechanisms.

7

8 **MATERIALS AND METHODS**

9 **Patients**

10 Sample collection was performed with informed consent from the patients according to the
11 declaration of Helsinki and experimentation was performed following institutional IRB-
12 accepted protocols and the Comité de Protection des Personnes Est IV (DC-2012-1693).
13 Patients were from Honduras (Family 1), the United Kingdom (Family 2), and Italy (Family
14 3).

15 **Sequencing and segregation analysis**

16 Genomic DNA was prepared from peripheral blood by routine procedures and *STIM1*
17 mutations were excluded by Sanger sequencing. Whole exome sequencing was carried out for
18 patient 11200 from Family 1, and for patients II.1, II.3, and IV.1 from Family 2 using the
19 SureSelect Human All Exon Kit v4 (Agilent, Santa Clara, USA) and the Illumina HiSeq 2000
20 or 2500 systems (San Diego, USA). Sequence data were aligned to the GRCh37/hg19
21 reference genome using the Burrows-Wheeler aligner software ([http://bio-
22 bwa.sourceforge.net](http://bio-bwa.sourceforge.net)), and variant calling was performed with SAMtools (Li, et al. 2009) or
23 the UnifiedGenotyper (<https://www.broadinstitute.org/gatk>). Following databases were used
24 for SNP annotation and filtering: Exome Variant Server (<http://evs.gs.washington.edu/EVS/>),

1 ExAC Browser (<http://exac.broadinstitute.org/>), dbSNP
2 (<http://www.ncbi.nlm.nih.gov/projects/SNP/>), 1000 genomes
3 (<http://www.1000genomes.org/>), as well as the in-house exome databases in Illkirch and
4 Manchester. Impacts of variations were predicted using Alamut v.2.5 ([http://www.interactive-](http://www.interactive-biosoftware.com)
5 [biosoftware.com](http://www.interactive-biosoftware.com)).

6 For patient 5510 from Family 3, direct Sanger-sequenced for both coding exons of *ORAI1* and
7 the adjacent splice-relevant regions was performed. Segregation analyses for Families 1 and 2
8 were also performed by Sanger sequencing. The *ORAI1* mutations were numbered according
9 to GenBank NM_032790.3 and NP_116179.2. Nucleotide position reflects cDNA numbering
10 with +1 corresponding to the A of the ATG translation initiation codon. All identified
11 mutations have been submitted to the LOVD database (<http://www.lovd.nl/ORAI1>).

12 **Histology and electron microscopy**

13 For histology, transverse sections (10 μ m) of the muscle biopsies were stained with modified
14 Gomori Trichrome, NADH tetrazolium reductase (NADH-TR) and Succinic dehydrogenase
15 (SDH) and assessed for fiber morphology, fiber type distribution, and
16 accumulations/infiltrations.

17 For electron microscopy, muscle sections were fixed in 2.5% paraformaldehyde, 2.5%
18 glutaraldehyde, and 50 mM CaCl₂ in 0.1 M cacodylate buffer (pH 7.4). Samples were
19 postfixed with 2% OsO₄, 0.8% K₃Fe(CN)₆ in 0.1 M cacodylate buffer (pH 7.4) for 2 h at 4 °C
20 and incubated with 5% uranyl acetate for 2 h at 4 °C. Muscles were dehydrated in a graded
21 series of ethanol and embedded in epon resin. Thin sections were examined with an electron
22 microscope (Philips CM120, FEI Company, Hillsboro, USA).

23 **Protein studies**

1 Immunofluorescence was performed with routine protocols using following antibodies: rabbit
2 anti-Orai1 (Abcam, Paris, France), mouse anti-GOK/Stim1 (BD Biosciences, Franklin Lakes,
3 USA), mouse Anti-Ryanodine receptor Clone 34C Product R-12 (Sigma-Aldrich, Saint Louis,
4 USA), NCL-SERCA2 mouse monoclonal antibody, clone IID8 (Novocastra, Newcastle, UK).
5 Sections were mounted with antifade reagent (Invitrogen, Carlsbad, USA) and viewed using a
6 laser scanning confocal microscope (TCS SP2; Leica Microsystems, Wetzlar, Germany).

7 **Constructs**

8 The human ORAI-eGFP and mCherry-STIM1 constructs were kind gifts from Liangyi Chen
9 (Beijing University, China) and Richard S. Lewis (Stanford University, USA). The *ORAI1*
10 point mutations (c.292G>A, c.319G>A, c.551C>T) were introduced by site-directed
11 mutagenesis using the *Pfu* DNA polymerase (Stratagene, La Jolla, USA), and the plasmid
12 carrying an untagged STIM1 was purchased from OriGene (NM_003156; OriGene
13 Technologies, Rockville, USA).

14

15 **Cells and transfections**

16 *Stim1*^{-/-}/*Stim2*^{-/-} mouse embryonic fibroblasts (MEF-DKO), generated by targeted gene
17 disruption, were a kind gift from Masatsugu Oh-Hora (Tokyo Medical and Dental University,
18 Japan), and HEK-293T cells were purchased from ATCC (CRL-11268; Manassas, USA).
19 MEF-DKO and HEK-293T cells were respectively cultured in DMEM 15140-122 and 31966-
20 021 (Gibco Life Technologies, Carlsbad, USA) supplemented with 10% fetal bovine serum
21 (10270-106, Gibco Life Technologies), 5 µg/ml streptomycin and 5 units/ml penicillin
22 (15140-122, Gibco Life Technologies), and were maintained at 37 °C in 5 % CO₂. Cells were
23 seeded on poly-L-lysine (P4832; Sigma-Aldrich) coated glass coverslips, and transfected at
24 50% confluency with Lipofectamine® 2000 (11668-019; Invitrogen). For co-expression

1 experiments, mCherry-STIM1 and ORAI1-eGFP constructs were transfected in a 3:1 ratio by
2 mass. For cells transfected with the ORAI1-eGFP G98S mutant and the respective controls,
3 low Ca^{2+} containing medium (0.2 mM CaCl_2) was used to prevent Ca^{2+} toxicity. All
4 subsequent experiments were performed within 24h post transfection.

5 **TIRF microscopy**

6 To assess the impact of the *ORAI1* mutations on the channel distribution at the plasma
7 membrane (PM), HEK-293T cells were co-transfected with wild type (WT) or mutated
8 ORAI1-eGFP and an untagged STIM1 construct, and cultured overnight in low Ca^{2+}
9 containing medium complemented with 5 μM lanthanum. The TIRF plane was determined
10 according to the PM GFP fluorescence at resting state, and images were collected by a Nikon
11 Eclipse Ti microscope (Tokyo, Japan) equipped with a Perfect Focus System, a 100x 1.49 Oil
12 CFI Apochromat TIRF objective and a cooling EMCCD iXon camera (DU-897E-CS0-#BV-
13 500; Andor Technology Ltd, Belfast, Northern Ireland). Cells were excited with a 488 nm 50
14 mW laser and light was collected through the TIRF Quad dichroic beamsplitter
15 405/488/561/640 and the emission filter FITC 525/50 from Nikon. The experiment was
16 performed at room temperature. Cells were treated with 1 μM Thapsigargin (Sigma-Aldrich)
17 to follow the kinetics of ORAI1 clustering at the PM. Live images were acquired with the
18 NIS-Elements AR software V4.30.02 (Nikon), and ORAI1 clusters were quantified and
19 characterized with a granularity detection journal on Metamorph software 7.8.12.0 (Molecular
20 Devices, Sunnyvale, USA) after background subtraction. Regions containing clusters were
21 identified at the end of each experiment and their increasing intensities were plotted over
22 time. The results were normalized as follows: $F_{c(t=n)} = (F_{cr(t=n)} - F_{rr(t=n)})$; $F/F_{0(t=n)} = (\sum$
23 $F_{c(t=n)}/\text{nb. clusters} + F_{rr(t=0)})/F_{rr(t=0)}$, where $F_{c(t=n)}$ is the fluorescence intensity of a cluster at a
24 given time, $F_{cr(t=n)}$ the intensity measured in a region that will contain a cluster following
25 store depletion, and $F_{rr(t=n)}$ the intensity of a reference region devoid of clusters throughout the

1 experiment. The average fluorescence intensity of cumulated clusters at the cellular level
2 ($F_{(t=n)}$) was normalized to the fluorescence of the empty region at the beginning of the
3 experiment ($F_0=F_{rr(t=0)}$). The percentage of the PM covered by clusters (density) was
4 determined as the summed area of clusters divided by the total surface of the PM visible in the
5 TIRF plane.

6 **Ca²⁺ measurements**

7 To assess cytosolic Ca²⁺ levels, cells were loaded at room temperature with 4 μ M of the Ca²⁺
8 sensor Fura-2 AM and 1 μ M Pluronic acid F-127 (F-1201 and P-3000MP; Invitrogen) in 2 or
9 0.2 mM CaCl₂ recording solution. After 30 minutes in the dark, cells were washed and
10 allowed for de-esterification for at least 15 min. Fura-2 ratiometric fluorescence emission was
11 recorded with an Axio Observer microscope (Zeiss, Jena, Germany) equipped with a Lambda
12 DG4 175 watts xenon arc lamp (Sutter Instrument Company, Novato, USA) and a rapidly
13 changing filter wheel (Ludl Electronic Products, München, Germany). Excitation filters
14 340AF15 and 380AF15 were purchased from Omega Optical (Brattleboro, USA). Exposure
15 time was 500 ms every 3 seconds for each wavelength. Emission was collected through the
16 dichroic/filter couple 415DCLP/510WB40 (Omega Optical), by a 12-bit CCD cooling camera
17 (CoolSnap HQ, Roper Scientific, Trenton, USA) with a 2x gain and a binning of 4. To
18 measure store-operated Ca²⁺ entry, 1 μ M Thapsigargin was used to passively deplete the Ca²⁺
19 stores. For Mn²⁺ quenching experiments, 500 μ M Mn²⁺ were added while cells were excited
20 at 360 nm (360BP10, Omega Optical). Recording solutions contained 140 mM NaCl, 5 mM
21 KCl, 1 mM MgCl₂, 10 mM Hepes, 10 mM D-(+)-glucose and the indicated amounts of CaCl₂.
22 The Ca²⁺-free solution contained 1 mM EGTA instead of CaCl₂. The pH was adjusted to 7.4
23 at 37 °C with NaOH. All experiments were achieved at 37 °C with pre-heated solutions. Ca²⁺
24 recordings were acquired and analyzed with the Metafluor 6.3 software (Universal Imaging,
25 West Chester, USA) after background subtraction. For cells co-expressing mCherry-STIM1

1 and ORAI1-eGFP constructs, only cells with a mCherry/eGFP fluorescence ratio above 1
2 were analyzed.

3 **Statistics**

4 GraphPad Prism 6.05 was used for statistical evaluation of the data. Statistical significance
5 was determined by the two-tailed unpaired Student's test with systematic Welch correction for
6 variance.

7

8 **RESULTS**

9 **Clinical reports**

10 The patients characterized in this study belong to three unrelated families with a broad range
11 of symptoms and signs with different ages of onset and disease severity, but sharing
12 prominent tubular aggregates on muscle biopsies as the main histopathological hallmark.
13 Patient 11200 (Family 1) is a singleton, Family 2 has an ancestral history of a muscle
14 phenotype segregating as a dominant disease over at least four generations, and Family 3
15 displays a mother to son disease inheritance (clinical features summarized in Table 1).

16 Patient 11200 from Family 1 is now 12 years old. Pregnancy, birth and neonatal history were
17 uneventful, although motor milestones were slightly delayed. The patient achieved sitting at
18 the age of 8 months, and independent walking at 24 months. Tip-toe-walking and frequent
19 falls were noticed since age 2, and contractures of elbows and Achilles tendons were
20 diagnosed in the following years. Clinical examination at the age of 10 revealed ichthyosis,
21 stiffness, proximal muscle weakness and reduced tendon reflexes of the lower limbs. The
22 patient was unable to jump, and had a waddling gait. He reported cramps and myalgia, both at
23 rest and after exercise, headaches, and frequent episodes of bleeding from mouth, nose, and

1 bowel. He had anemia but not thrombocytopenia, and blood Ca^{2+} levels were repeatedly
2 normal or only mildly reduced. Eye examination showed miosis, heart and lung functions
3 were normal, and cognitive assessment showed results within the normal range. CK levels
4 were repeatedly elevated, with values up to 2052 U/l. Motor nerve conduction velocities were
5 normal and EMG showed chronic neurogenic abnormalities and mild myopathic changes in
6 the proximal lower limbs. Muscle MRI revealed fibro-fatty replacements in the posterior and
7 medial compartments of the thigh and of the posterior compartment of the calf (Supp. Figure
8 S1). Abdominal ultrasound excluded asplenia/hyposplenia. The parents and the younger sister
9 are healthy.

10 For Family 2, five affected members underwent regular clinical examinations. They are now
11 between 6 and 47 years old, and pregnancy, birth, and early childhood was normal for all.
12 Slightly delayed motor milestones as well as slight dyslexia were reported for patients IV.1,
13 and IV.2, and might have been overlooked for the older generations. All showed tip-toe
14 walking associated to Achilles tendon contractures by the age of 8 years. Only the youngest
15 patient, now 6 years old, does not show tip-toe walking. The proximal muscle of the lower
16 limbs were predominantly affected, and involved weakness (II.1, III.1, III.2), stiffness (II.1,
17 III.2), cramps (II.1, III.2), and myalgia (II.1, III.1, IV.1, IV.2). All had difficulties running and
18 climbing stairs. Calf hypertrophy was noted for patients III.1 and IV.1. CK levels were
19 elevated for all and ranged between 484 and 1538 U/l. Motor nerve conduction velocity,
20 assessed for patient III.1 was normal, and EMG showed myopathic changes.

21 Patient 5510 from Family 3 was diagnosed with asymptomatic hyperCKemia through routine
22 blood tests at the age of 56. Medical examination at age 60 revealed mild general muscle
23 weakness, and the patient reported myalgia of the lower limbs and cramps, but motor nerve
24 conduction velocity and EMG did not reveal any abnormalities. The patient also presented
25 with hypereosinophilia resulting from allergic diathesis, pectus excavatum, and arched palate.

1 CK levels were repeatedly elevated and ranged between 400 and 600 U/I, and his mother was
2 also reported to have asymptomatic hyperCKemia.

3 **Histology and ultrastructural analyses reveal tubular aggregates**

4 Muscle biopsies from all patients described in this study displayed tubular aggregates
5 appearing on Gomori trichrome and on NADH-TR staining (Figure 1). In agreement with
6 previously described TAM cases, the aggregates are less detectable with SDH, suggesting a
7 reticulum and not a mitochondrial origin (Chevessier, et al. 2005; Bohm, et al. 2013).
8 Aggregates were observed in both fiber types in all analyzed biopsies. Additional
9 observations comprise fiber size variability and internalized nuclei.

10 Ultrastructural analyses demonstrated that the tubular aggregates are of variable size and
11 consist of single or double-walled membranes of different diameter (Figure 1). Overall, the
12 histological and ultrastructural features of the biopsies were strikingly similar and strongly
13 suggestive of tubular aggregate myopathy.

14 **Exome sequencing identifies mutations in *ORAI1***

15 Sanger sequencing of the known TAM gene *STIM1* did not reveal any putative pathogenic
16 variant in the families described here. We performed exome sequencing for Families 1 and 2,
17 and identified heterozygous missense mutations in *ORAI1*. Patient 11200 from Family 1
18 carries the *ORAI1* c.292G>A (p.Gly98Ser) *de novo* mutation in exon 1, and the affected
19 members of Family 2 harbor the *ORAI1* c.319G>A (p.Val107Met) mutation in exon 2 (Figure
20 2A). Another missense mutation (c.551C>T; p.Thr184Met) in exon 2 was found by direct
21 *ORAI1* Sanger sequencing of patient 5510 from Family 3. None of the three mutations was
22 found in the available healthy family members and none was listed in the public or internal
23 SNP databases. However, the p.Gly98Ser mutation was previously described in an unrelated

1 Japanese family with TAM involving diffuse muscle weakness, joint contractures, a rigid
2 spine and hypocalcaemia (Endo, et al. 2015).

3 All three missense mutations affect highly conserved amino acids in ORAI1 (Figure 2B) The
4 mutations p.Gly98Ser and p.Val107Met affect amino acids in M1, and p.Thr184Met affects
5 an amino acid in M3 (Figure 2C). M1 forms the ion conduction pathway, while M2 and M3
6 encircle the pore and are surrounded by the M4 outer ring (Hou, et al. 2012; Frischauf, et al.
7 2015). The residue G98 is located in the rigid section of the channel responsible for ion
8 conduction, and the residue V107 neighbors E106, involved in Ca²⁺ selectivity.

9 **Tubular aggregates contain STIM1**

10 To characterize the structure and composition of the tubular aggregates associated with
11 *ORAI1* mutations, we performed immunolocalization experiments on muscle biopsies from
12 patient 11200 (Family 1) and II.1 (Family 2) (Figure 1). We previously showed that tubular
13 aggregates in TAM patients with *STIM1* mutations contain various SR proteins as STIM1, the
14 Ca²⁺ channel RYR1 (MIM# 180901), the RYR1-effector triadin (MIM# 603283), or the Ca²⁺
15 pump SERCA (MIM# 108730), and that RYR1 and STIM1 are exclusively found in the
16 aggregate periphery (Bohm, et al. 2013). In agreement with our previous observations, the
17 aggregates in the TAM patients with *ORAI1* mutations also contain SERCA, and RYR1 is
18 mainly found in the periphery of the aggregates (Figure 1). The aggregates display strong
19 STIM1 signals, thereby linking *STIM1* and *ORAI1*-related TAM. Of note, STIM1 signals are
20 not restricted to the aggregate periphery; this is in contrast to the immunolocalization
21 experiments in *STIM1* patients, and might reflect different ways of tubular aggregate
22 formation in patients with *STIM1* or *ORAI1* mutation. Aggregated ORAI1 is barely or not
23 detectable on the biopsies of the analyzed patients, supporting the idea that tubular aggregates
24 essentially consist of sarcoplasmic reticulum membrane and proteins.

1 **ORAI1 mutants traffic normally to plasma membrane clusters**

2 In order to assess the impact of the three *ORAI1* mutations on channel localization and
3 trafficking, we generated wild type (WT) and ORAI1-eGFP G98S, V107M, and T184M
4 constructs, exogenously co-expressed them with human STIM1 in HEK-293T cells, and
5 imaged the formation of ORAI1 clusters at the PM by total internal reflection fluorescence
6 (TIRF) microscopy. WT and mutant ORAI1 were homogenously distributed in the TIRF
7 plane in resting cells, and accumulated in clusters following depletion of ER Ca²⁺ stores with
8 the SERCA inhibitor Thapsigargin (Tg) (Figure 3A). The intensity of the clusters and the
9 extent of cell membrane covered by clusters was comparable in cells expressing WT or
10 mutant ORAI1 at resting or activated state (Figure 3B and 3C). We therefore conclude that
11 the mutations do not significantly alter the ORAI1 localization at the plasma membrane, nor
12 its clustering upon SOCE activation.

13 ***ORAI1* mutations produce constitutively active channels**

14 To evaluate the impact of the *ORAI1* mutations on the basal channel activity, we measured the
15 cytosolic Ca²⁺ levels ([Ca²⁺]_{cyt}) in HEK-293T cells transfected with the ORAI1-eGFP
16 constructs, and loaded with the ratiometric Ca²⁺ sensor Fura-2, AM. Cells were sequentially
17 exposed to Ca²⁺-rich and Ca²⁺-poor media to assess the extent of Ca²⁺ entry across the
18 channel in cells with replete stores (Figures 4A-C, Fura-2 calibration curves in Supp. Figure
19 S2). Mean basal Fura-2 ratio values were elevated in cells expressing ORAI1 V107M (0.52,
20 SD ± 0.14) or T184M (0.48, SD ± 0.10) compared to cells expressing WT ORAI1 (0.39, SD ±
21 0.08), and decreased significantly upon Ca²⁺ removal. HEK-293T cells expressing the ORAI1
22 G98S construct displayed extremely high [Ca²⁺]_{cyt} in Ca²⁺-rich conditions and were cultured
23 in 0.2 mM CaCl₂ to minimize cytotoxicity. Under these conditions, mean basal Fura-2 ratio
24 was significantly elevated (0.68, SD ± 0.19, compared to WT 0.35, SD ± 0.03), decreased
25 upon Ca²⁺ removal, and markedly increased upon addition of 2 mM Ca²⁺ (1.28, SD ± 0.20,

1 compared to WT 0.36, SD \pm 0.04, Figures 4B and 4C). These results suggest that the mutated
2 ORAI1 channels are Ca²⁺ permeable even in the absence of store depletion, with a more
3 pronounced degree of permeability for G98S compared to V107M or T184M ORAI1.

4 **G98S and V107M alter ORAI1 activity independently of STIM1**

5 In order to assess the STIM-dependence of the constitutive activation of mutant ORAI1
6 channels, we next transfected mouse embryonic fibroblasts bearing a targeted disruption in
7 the *Stim1* and *Stim2* genes (MEF-DKO). Since steady-state [Ca²⁺]_{cyt} reflects the combined
8 activity of Ca²⁺ pumps, channels and exchangers, we used the Mn²⁺ quench assay (Figures
9 4D-F). Mn²⁺ permeates through Ca²⁺ channels and quenches the Fura-2 fluorescence, thereby
10 allowing the individual quantification of the influx component. In these experiments, we
11 observed a massive Mn²⁺ influx in MEF-DKO cells expressing ORAI1-eGFP V107M or
12 G98S, while only a small Mn²⁺ influx was detectable in cells expressing ORAI1-eGFP
13 T184M or WT with no significant difference among these two conditions (Figure 4D-F).
14 Similar results were obtained by measuring the amplitude of the Ca²⁺ elevation evoked by the
15 readmission of 2 mM Ca²⁺ to MEF-DKO cells treated with Tg (Supp. Figure S3), where Fura-
16 2 ratio increase was observed only in cells expressing G98S or V107M ORAI1. In conclusion,
17 G98S and V107, but not T184M ORAI1 channels appear constitutively active in the absence
18 of STIM proteins. Accordingly, Mn²⁺ quench experiments in HEK-293T cells endogenously
19 expressing STIM1 and STIM2 demonstrated that cells transfected with any of mutant
20 channels including ORAI1-T184M displayed significant cation entry (Supp. Figure S4).

21 **The ORAI1 mutants mediate excessive Ca²⁺ entry when gated by STIM1**

22 To test whether the *ORAI1* mutations also impact on the STIM1-gated maximal channel
23 activity, we co-transfected HEK-293T cells with mCherry-STIM1 and WT or mutated
24 ORAI1-eGFP constructs. We induced passive reticular Ca²⁺ depletion through Tg treatment in

1 Ca²⁺-free medium, and measured SOCE upon readmission of 0.5 mM Ca²⁺ to the medium.
2 Cells expressing any of the ORAI1 mutants displayed significantly increased SOCE with 2-3
3 fold steeper slope of Fura-2 ratio increase compared to cells expressing WT ORAI1 (Figures
4 5A and 5B). Analysis of the response kinetics 60 s after Ca²⁺ admission demonstrated a 30 %
5 Fura-2 ratio decrease for cells transfected with WT or T184M ORAI1, while the ratio
6 remained at near maximal levels in cells expressing G98S or V107M ORAI1 (Figure 5C).

7 To specifically assign ORAI1 channel activation to STIM1, we repeated the co-expression
8 experiments in MEF-DKO cells (Figures 5D-F). Following Tg treatment and readmission of
9 Ca²⁺, cells co-expressing STIM1 and V107M or T184M ORAI1 mutants displayed a strongly
10 increased SOCE slope compared to cells co-expressing STIM1 and WT ORAI1. Expression
11 of a control vector did not affect the Ca²⁺ response of the recipient cells, and expression of
12 STIM1 alone fully restored SOCE in the MEF-DKO cells (Supp. Figure 3) Unexpectedly,
13 MEF-DKO expressing STIM1 and WT or G98S ORAI1 and cultured in low Ca²⁺ exhibited a
14 high SOCE slope (Figures 5D-E) , potentially reflecting a specific adaptation of these cells to
15 Ca²⁺ deprivation, and resulting in a more efficient activation of the SOCE pathway. However,
16 and in agreement with the results obtained in transfected HEK-293T cells, the Fura-2 ratio
17 remained elevated 60 s post Ca²⁺ readmission in cells expressing the G98S and V107M
18 mutants while [Ca²⁺]_{cyt} decreased in cells expressing T184M ORAI1 (Figure 5F).

19 Overall and in accordance with the Mn²⁺ quenching data, these results strongly indicate a
20 mutation-dependent pathomechanism . All three ORAI1 mutations G98S, V107M, and
21 T184M involve maximal SOCE in presence of active STIM1, but only G98S and V107M
22 generate a constant Ca²⁺ influx independently of STIM1 activation.

23

24 **DISCUSSION**

1 Here we report three *ORAI1* mutations causing tubular aggregate myopathy, and we support
2 our findings by clinical, histological, genetic and functional data. Our patients presented with
3 different age of onset, disease severity, and additional non-muscular features, suggesting that
4 TAM and Stormorken syndrome are spectra of the same disease. We functionally demonstrate
5 for the first time that the mutations in different *ORAI1* transmembrane domains appear to
6 involve different pathomechanisms, and thereby uncover a genotype-phenotype correlation.

7 **Tubular aggregates in *ORAI1* patients contain STIM1**

8 As both *STIM1* and *ORAI1* mutations lead to TAM, we compared the structure and
9 composition of the tubular aggregates in our *ORAI1* patients with the published *STIM1*
10 patients (Bohm, et al. 2013). The tubular aggregates in *STIM1* patients were shown to contain
11 diverse sarcoplasmic reticulum proteins as RYR1, triadin, SERCA, and STIM1, and STIM1
12 was mainly found in the periphery of the aggregates (Bohm, et al. 2013).
13 Immunohistofluorescence on muscle sections from *ORAI1* patients also demonstrated the
14 presence of STIM1 and other sarcoplasmic reticulum proteins in the aggregates. This
15 observation provides a link between *STIM1* and *ORAI1*-related TAM at the histopathological
16 level, and suggests that secondary STIM1 aggregation plays a role in the pathogenesis of
17 *ORAI1* mutations. Of note, the STIM1 signals were detectable in the periphery as well as in
18 the center of the aggregates, potentially reflecting a difference in tubular aggregate formation
19 in patients with *STIM1* and *ORAI1* mutation. Even if mutated, the plasma membrane Ca^{2+}
20 channel *ORAI1* is barely or not detectable in the aggregates, confirming that the tubular
21 aggregates are primarily of sarcoplasmic reticulum origin. Considering the increased Ca^{2+}
22 entry resulting from *STIM1* or *ORAI1* mutations, we might speculate that the excessive
23 cellular Ca^{2+} is in large parts stored in the reticulum, provoking reticular overload and
24 dilatation, and resulting in cisternal pinching off to form the primary stage of the tubular

1 aggregates. This is line with the observation that tubular aggregates contain large amounts of
2 Ca^{2+} (Salviati, et al. 1985; Chevessier, et al. 2005).

3 ***ORAI1* mutations involve different pathomechanisms**

4 To mechanistically investigate the impact of the *ORAI1* G98S, V107M, and T184M
5 mutations, we analyzed the channel activity in presence or absence of STIM1. Expression of
6 any of the mutant *ORAI1*-eGFP constructs in HEK-293T cells resulted in elevated basal Ca^{2+}
7 levels, but in mouse fibroblasts devoid of STIM (*Stim1*^{-/-}/*Stim2*^{-/-}), only G98S and V107M
8 induced significant cation influx in the Mn^{2+} quench assay. This demonstrates that both G98S
9 and V107M *ORAI1* channels are constantly permeable for Ca^{2+} , while the overactivity of the
10 T184M *ORAI1* channel is conditioned by the presence of STIM. Accordingly, and in
11 consideration of constantly fluctuating Ca^{2+} levels within cellular compartments resulting in a
12 varying sub-pool of activated STIM1/STIM2 proteins in the reticulum, the endogenous STIM
13 proteins in HEK-293T cells are sufficient to partially activate the T184M *ORAI1* channel.
14 Especially STIM2 with its lower Ca^{2+} affinity and higher lipid-binding avidity has been shown
15 to be pre-recruited to the cortical ER at basal ER Ca^{2+} concentrations (Parvez, et al. 2008). It
16 is possible that the T184M mutation increases the binding sensitivity of the channel to STIM1
17 and STIM2 or to the transient receptor potential canonical (TRPC) channels to form a ternary
18 complex with STIM1 at the plasma membrane (Lu, et al. 2010), which might explain the
19 higher basal Ca^{2+} level in cells expressing the T184M mutant even in the absence of store
20 depletion. The extensive characterization of the T184M mutation might reveal a residue or
21 domain regulating STIM-mediated channel gating. Excessive Ca^{2+} entry was also reported for
22 other *ORAI1* mutations (Nesin, et al. 2014; Endo, et al. 2015), but the STIM-dependence of
23 the channel activation was not investigated in these studies.

24 Further evidence for a different pathomechanism of the *ORAI1* mutations comes from the co-
25 expression experiments. HEK-293T or MEF-DKO cells co-expressing mCherry-STIM1 and

1 any of the ORAI1-eGFP mutants induced excessive Ca^{2+} influx following SOCE activation,
2 but only G98S and V107M generated a continuous and long lasting Ca^{2+} influx. In contrast,
3 Ca^{2+} influx significantly decreased over time in HEK-293T or MEF-DKO cells co-expressing
4 STIM1 and T184M ORAI1. This discrepancy potentially reflects a difference in Ca^{2+} -
5 dependent inactivation (CDI) of the mutant channels and/or their dissociation kinetics from
6 STIM1. Alternatively, the higher basal Ca^{2+} levels in cells expressing ORAI1 G98S or
7 V107M might increase the threshold triggering CDI or Ca^{2+} extrusion. It is also possible that
8 the G98S and V107M mutations directly impact on the Ca^{2+} extrusion systems.

9 In summary, our results suggest a mutation-specific pathomechanism. G98S and V107M
10 induce constitutive channel opening independently of STIM, while T184M overactivation is
11 conditioned by the presence of STIM. In accordance, the amino acid G98 resides in the
12 hydrophobic gating hinge, and V107 locates near the Ca^{2+} selectivity filter of the M1
13 transmembrane domain (Zhou, et al. 2010; Hou, et al. 2012). Disturbance of these key
14 functions is expected to impact on ion flow, which is confirmed by our functional data
15 demonstrating constitutive Ca^{2+} permeability independently of STIM. This conclusion is also
16 sustained by similar findings based on the functional characterization of artificial M1
17 mutations (Zhang, et al. 2011). Conversely, T184 is not located in the channel pore, and the
18 STIM-dependent overactivation of the mutant channel strongly suggests that transmembrane
19 domain M3 is directly or indirectly implicated in STIM-mediated ORAI1 gating.

20 ***ORAI1* mutations in M1 induce a more severe phenotype**

21 Considering the clinical presentation of our and all previously published patients with
22 activating *ORAI1* mutations (Nesin, et al. 2014; Endo, et al. 2015), the most severe muscle
23 phenotypes result from mutations in M1, a moderate muscle phenotype from a mutation in
24 M2, and milder muscle phenotypes from mutations in M3 and M4. This correlates well with
25 our functional data, demonstrating a stronger impact of M1 mutations on channel function.

1 Our patients were diagnosed with tubular aggregate myopathy based on biochemical blood
2 tests and histological findings. All displayed repeatedly elevated serum CK levels in
3 combination with prominent tubular aggregates as the major structural aberration on muscle
4 biopsies. The clinical presentation was however variable, ranging from severe early-onset
5 muscle weakness and contractures (patient 11200 from Family 1) to mild late-onset muscle
6 weakness (patient 5510 from Family 3). A similar interfamilial variability was recently
7 described for other families with *ORAI1* mutations. G98S was described in two Japanese
8 family presenting childhood-onset TAM, joint contractures, hypocalcaemia, rigid spine, and
9 elevated CK levels (Endo, et al. 2015). We identified the same mutation in our unrelated
10 Family 1, and the clinical manifestations were comparable. The same study reported a third
11 Japanese family harboring the *ORAI1* L138F mutation, and presenting with weaker clinical
12 features involving adolescence-onset TAM, minor joint contractures, and slightly elevated CK
13 levels. In addition, a family carrying the *ORAI1* P245L mutation was described with late-
14 onset TAM and increased CK levels (Nesin, et al. 2014).

15 Taking into account the clinical manifestation of all TAM patients with *ORAI1* mutation, our
16 functional data, and the published *ORAI1* protein structure, we conclude that mutations
17 affecting the pore lead to constitutive channel permeability, and result in early-onset muscle
18 weakness often associated with contractures. In contrast, mutations affecting the concentric
19 channel rings involve a STIM-dependent overactivity of *ORAI1*, and result in less severe
20 symptoms with minor muscle weakness.

21 ***ORAI1* patients present discrete signs of Stormorken syndrome**

22 Tubular aggregate myopathy in combination with miosis, thrombocytopenia, asplenia,
23 ichthyosis, dyslexia/intellectual disability, and short stature defines Stormorken syndrome.
24 Both TAM and Stormorken syndrome are caused by gain-of-function mutations in *STIM1* and
25 *ORAI1* (Bohm, et al. 2013; Misceo, et al. 2014; Morin, et al. 2014; Nesin, et al. 2014; Endo, et

1 al. 2015). To explore the possibilities that TAM and Stormorken syndrome are either different
2 nosological entities or spectra of the same disease, we examined our patients for non-muscle
3 phenotypes and reviewed the published *ORAI1* cases. We noticed miosis (patient 11200,
4 Family 1, and (Nesin, et al. 2014)), frequent episodes of bleeding (patient 11200, Family 1),
5 ichthyosis, (patient 11200, Family 1), and dyslexia/intellectual disability (patients IV.1, and
6 IV.2, Family 2, Family A (Endo, et al. 2015)). These data show that signs of Stormorken
7 syndrome are found in many patients with activating *ORAI1* mutations, and we conclude that
8 TAM and Stormorken syndrome are spectra of the same disease. This is of high importance
9 for genetic diagnosis and counseling, as *ORAI1* mutations should be considered in patients
10 with elevated CK levels and prominent tubular aggregates on muscle biopsies, especially if
11 they present signs of Stormorken syndrome.

12 **Overactive SOCE versus underactive SOCE in Mendelian disorders**

13 *STIM1* and *ORAI1* act within the same SOCE pathway regulating Ca^{2+} homeostasis in
14 various tissues. The identification of gain-of-function mutations in *STIM1* and *ORAI1*
15 represents a strong proof for the implication of aberrant SOCE in the development of
16 TAM/Stormorken syndrome. This is sustained by our functional and immunolocalization
17 studies demonstrating a pathomechanistic link between both proteins.

18 While heterozygous gain-of-function mutations in *STIM1* or *ORAI1* generate excessive Ca^{2+}
19 influx and result in the development of TAM/Stormorken syndrome (Bohm, et al. 2013;
20 Bohm, et al. 2014; Hedberg, et al. 2014; Misceo, et al. 2014; Morin, et al. 2014; Nesin, et al.
21 2014; Endo, et al. 2015; Markello, et al. 2015), homozygous loss-of-function mutations in
22 either of the genes suppress Ca^{2+} influx and are associated with severe immunodeficiency
23 (Feske, et al. 2006; McCarl, et al. 2009; Picard, et al. 2009; Byun, et al. 2010; Fuchs, et al.
24 2012; Lacruz and Feske 2015) (MIM# 612782, # 612783). We conclude that strict regulation
25 of Ca^{2+} homeostasis ensures normal physiology of muscle, leucocytes, platelets, skin, and

1 other cells and tissues, and that overactive SOCE causes tubular aggregate
2 myopathy/Stormorken syndrome, while underactive SOCE causes immunodeficiency.

3 **Conclusions**

4 Our work indicates for the first time a mutation-specific pathomechanism for *ORAI1* gain-of-
5 function mutations, thereby uncovers a clear genotype-phenotype correlation, and improves
6 the understanding of the pathology of TAM/Stormorken syndrome and store-operated Ca²⁺
7 entry, altered in rare and common diseases.

8

9

10 **CONFLICT OF INTEREST**

11 None of the authors reports conflict of interest.

12

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1

2

3 **AUTHOR CONTRIBUTIONS**

4 JB, WGN, ND, and JL designed and coordinated the study. JB, MB, JU, EM, SGW, JO, AS,
5 CK, and WGN performed the experiments. GB, MM, WGN, MR, RV, MM, HK, TD, CGD,
6 JN, and NBR contributed clinical samples, histological and patient data. JB, MB, ND and JL
7 wrote the manuscript.

8

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17

18 **FIGURE LEGENDS**

19 **Figure 1 - Histological, ultrastructural, and immunohistochemical characterization of** 20 **the biopsies**

21 (A) Muscle biopsies from patients from all three families display tubular aggregates
22 appearing in red on Gomori trichrome and in dark blue on NADH-TR staining in both fiber
23 types. The aggregates are barely detectable with SDH. Minor fiber size variability and
24 internalized nuclei are also noted. Ultrastructural analyses demonstrate that the tubular
25 aggregates are of variable size and consist of single or double-walled membranes of different

1 diameter. EM pictures were not available for Family 2. (B) Immunolocalization studies on
2 biopsies from Family 1 and Family 2 show that the tubular aggregates contain STIM1, RYR1,
3 SERCA, whereas ORAI1 is barely or not trapped. Note that STIM1 signals are found in the
4 periphery and in the center of the aggregates, while RYR1 is mainly found in the periphery
5 (arrows). * indicate identical fibers of serial sections.

6 **Figure 2 - Identification of *ORAI1* mutations**

7 (A) Heterozygous *ORAI1* missense mutations were identified in all three families, and
8 segregated with the disease. (B) The mutations affect highly conserved amino acids in
9 *ORAI1*. (C) Schematic representation of *ORAI1*. Mutations found in our patients are depicted
10 in blue, published mutations appear in red. G98S and V107M affect amino acids in
11 transmembrane domain 1 (M1), and T84M affects an amino acid in M3. Residue G98 is
12 located in the rigid section of the channel, and V107 neighbors the Ca²⁺ selectivity filter
13 E106.

14 **Figure 3 - Effect of *ORAI1* mutations on channel localization and clustering at the PM**

15 (A) TIRF images of HEK-293T co-expressing STIM1 and wild-type (WT) or mutated
16 (V107M, T184M, G98S) *ORAI1*-eGFP taken before and 10 min after addition of 1 μM
17 Thapsigargin (Tg). Insets show cluster morphology at higher magnification. (B) Changes in
18 intensity of eGFP clusters and in cluster density (% PM covered by clusters) in the TIRF
19 plane following Tg addition in cells co-expressing STIM1 and WT or mutated *ORAI1*-eGFP.
20 (C) Statistical evaluation of eGFP cluster intensity and density before and after Tg treatment.
21 Data are mean ± SEM of 33, 24, 25, and 14 cells for WT, V107M, T184M and G98S,
22 respectively. No statistically significant differences were observed between WT and mutated
23 channels in resting and store-depleted conditions.

24 **Figure 4 - Effect of *ORAI1* mutations on basal Ca²⁺ level**

1 (A) Representative Fura-2 recordings of HEK-293T cells expressing wild-type (WT) or
2 mutated (V107M, T184M) ORAI1-eGFP during Ca^{2+} removal (2 mM Ca^{2+} replaced by 1 mM
3 EGTA). (B) Recordings of cells expressing WT or G98S ORAI1-eGFP during Ca^{2+} removal
4 and readmission. Cells were cultured in a Ca^{2+} -poor medium (0.2 mM) to mitigate the toxicity
5 associated with the G98S mutation. (C) Statistical evaluation of the responses illustrated in
6 (A) and (B), measured between the time points indicated with # (n = 79, 39, 49 for WT,
7 V107M, T184M respectively, and n = 38, 20 for WT and G98S cultured in low Ca^{2+}). (D), (E)
8 Representative Mn^{2+} quench recordings of MEF-DKO cells (*Stim1*^{-/-}/*Stim2*^{-/-}) expressing WT
9 or mutated ORAI1-eGFP. Fura-2 fluorescence was recorded at 360 nm in the presence of 2
10 mM Ca^{2+} . Traces are offset to facilitate comparison. (F) Statistical evaluation of Mn^{2+} quench
11 rates in (D) and (E), measured between the time points indicated with # (n = 17, 20, 21 and
12 23, 32 for WT, V107M, T184M, and WT, G98S cultured in low Ca^{2+} , respectively). Data are
13 mean \pm SEM, statistically significant differences versus respective WT conditions are
14 indicated by **** p < 0.0001.

15 **Figure 5 - Effect of *ORAI1* mutations on maximal SOCE**

16 (A), (D) Fura-2 responses evoked by the readmission of 0.5 mM Ca^{2+} (HEK-293T) or 2 mM
17 Ca^{2+} (MEF-DKO) to cells co-expressing mCherry-STIM1 and ORAI1-eGFP (WT, V107M,
18 T184M or G98S) treated with Tg. (B), (E) Statistical evaluation of influx rate evoked by Ca^{2+}
19 readmission in (A) and (D), measured as Fura-2 increase slope between the time points
20 indicated with #. (C), (F) Statistical evaluation of the Ca^{2+} level 60 seconds after the peak of
21 the response in (A) and (D), illustrated by the dotted line, and expressed as percentage of the
22 peak. Data are mean \pm SEM of 24-51 cells for (B), (C) and of 17-29 cells for (E), (F).
23 Statistically significant differences versus respective WT conditions are indicated by ** p <
24 0.01, *** p < 0.001, and **** p < 0.0001.

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