Late-Onset Nephropathic Cystinosis: Clinical Presentation, Outcome, and Genotyping

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Background and objectives: Cystinosis is an autosomal recessive disease characterized by the intralysosomal accumulation of cystine, as a result of a defect in cystine transport across the lysosomal membrane. Three clinical forms have been described on the basis of severity of symptoms and age of onset: infantile cystinosis, characterized by renal proximal tubulopathy and progression to end-stage renal disease before 12 yr of age; juvenile form, with a markedly slower rate of progression; and adult form, with only ocular abnormalities.

Design, setting, participants, & measurements: Fourteen patients in nine unrelated families with noninfantile cystinosis were studied. Information about clinical outcome, biochemical data, renal histopathologic data, and genotyping was collected.

Results: Eight patients had Fanconi syndrome. Proteinuria was present in all patients. Serum creatinine at last follow-up, without specific treatment, ranged between 69 and 450 μmol/L, at an age of 12 to 56 yr. Four patients reached end-stage renal disease by 12 to 28 yr. Renal biopsies, available in four cases, disclosed focal segmental glomerulosclerosis in three and crystals in three. Genetic screening showed that patients were compound heterozygous for mutations in the CTNS gene in four families and homozygous in two families. Patients had at least one “mild” mutation. A single heterozygous mutation was identified in one family and none in two families (only 72% mutations found).

Conclusion: Renal involvement is heterogeneous in patients with noninfantile cystinosis even within families, and renal disease should be assessed even in families of patients with seemingly isolated ocular forms.


Cystinosis is an autosomal recessive lysosomal storage disease caused by a defect in the carrier-mediated system that normally transports cystine out of lysosomes. This defect results in intralysosomal cystine accumulation, crystal formation, and progressive organ damage (1).

Infantile cystinosis, also known as nephropathic infantile cystinosis, is the most common form. Affected children develop renal proximal tubulopathy (or Fanconi syndrome) at 6 to 12 mo of age. In the absence of treatment, renal failure occurs, with progression to ESRD at approximately 9 yr of age (2). Renal histopathologic changes in infantile nephropathic cystinosis include severe lesions of proximal tubules; typical alterations to the glomerular podocytes, which become multinucleated giant cells; and the presence of cystine crystals, mostly in interstitial cells and podocytes (3). The proximal tubule is the first clinical target of the disease, but cystine crystals are rarely found in the tubular cells of patients with cystinosis. Cystine crystal deposition in the cornea leads to photophobia. Continuous widespread cystine accumulation eventually leads to rickets and retinal, endocrinologic (hypothyroidism and impaired glucose tolerance), hepatic, gastrointestinal, muscular, and neurologic abnormalities. Cysteamine is the only cystine-depleting drug available; it helps to eliminate cystine from lysosomes and slows renal deterioration and other organ dysfunctions (4). Cysteamine hydrochloride eye drops dissolve corneal crystals and improve ocular discomfort (5). CTNS, the gene that is mutated in cystinosis, maps to chromosome 17p13 and encodes a lysosomal membrane protein—cystinosin—that has been shown to act as a cystine transporter (6,7). CTNS mutations have been detected in almost all children with infantile nephropathic cystinosis. More than 50 different CTNS mutations have been described, but approximately 75% of those of European descent carry a homozygous approximately 57-kb deletion encompassing CTNS exons 1 through 10 (6,8–10).

Forms with a later onset also have been identified, accounting for approximately 5% of all cases of cystinosis (1). These forms have been divided in two basic phenotypes: Nephropathic and nonnephropathic (11). Nephropathic forms can be further classified, on the basis of age at presentation, into child-, adolescent-, and adult-onset forms. These nonnephritile forms are associated with glomerular impairment but not necessarily Fanconi syndrome. Patients may progress to ESRD. In contrast, renal disease does not develop in the nonnephropathic (or ocular) form of cystinosis, in which deposits are limited to the
cornea and conjunctiva. Point mutations in the CTNS gene that do not disrupt the open reading frame of cystinosin are more commonly associated with the late-onset phenotype and generally affect the intertransmembrane loops or the N-terminal region (10,12–15). Affected individuals are usually homozygous for “mild” mutations of this type or compound heterozygous for a mild mutation and a “severe” mutation (i.e., a mutation that completely prevents cystine transport). We studied nine unrelated families with late-onset nephropathic cystinosis, collecting information about clinical outcome, biochemical data, renal histopathologic data, and genotyping.

**Concise Methods**

All patients included in this study had late-onset nephropathic cystinosis; patients with infantile cystinosis were excluded. None of the patients included presented ESRD before the age of 12 yr. We included 11 patients who had late-onset nephropathic cystinosis and were referred for DNA studies to the Department of Genetics at Necker-Enfants Malades Hospital in Paris between 1999 and 2006. Clinical data were collected with the help of the physicians in charge of these patients in France, Belgium, and Spain. Two patients (8a and 9a) were directly referred to the Adult Nephrology Department of this hospital for diagnostic confirmation and medical care. Family investigation revealed one additional affected individual (8b; Table 1). Thus, this study reflects the experience of the Department of Genetics and of the Adult Nephrology Department at Necker-Enfants Malades Hospital in Paris.

Estimated GFR was calculated in adult patients, using the abbreviated Modification of Diet in Renal Disease (MDRD) formula (16,17).

Renal failure was defined by GFR < 60 ml/min per 1.73 m². Means ± SD are presented.

**Diagnosis**

All patients had typical cystine crystal deposits in the cornea, as observed on slit-lamp examination (Figure 1). All had high granulocyte-free cystine content, determined by cystine-binding protein assay, as previously reported (18), expressed as nanomoles of half-cystine per milligram of protein (normal < 0.15). The diagnosis of renal proximal tubulopathy (or renal Fanconi syndrome), often incomplete, was based on the usual criteria: Hyperaminoaciduria, glycosuria, tubular proteinuria with the presence of β2-microglobulin, renal loss of potassium, decreased reabsorption of phosphate and hypophosphoremia, reduction in bicarbonate reabsorption producing plasma acidosis, and/or hypouricemia.

**Renal Biopsies**

Biopsy specimens for light microscopy were fixed in Bouin’s solution, embedded in paraffin, and sectioned at 2 μm. Sections were stained with Masson trichrome, hematoxylin and eosin, periodic acid-Schiff, and silver methenamine. For the detection of cystine crystals, unstained sections or sections briefly stained with methylene blue in absolute alcohol were examined by polarization or phase contrast microscopy. Immunofluorescence studies were carried out as described previously (19). Specimens for electron microscopy were fixed in glutaraldehyde and embedded in Epon resin.

**Table 1. Clinical presentation and outcome of patients**

<table>
<thead>
<tr>
<th>Family</th>
<th>Patient</th>
<th>Gender</th>
<th>Age at Onset of Symptoms (yr)</th>
<th>Age at Diagnosis (yr)</th>
<th>Proximal Tubulopathy</th>
<th>SCr at Diagnosis (μmol/L)</th>
<th>Proteinuria</th>
<th>SCr at Last Follow-up (μmol/L)</th>
<th>Granulocyte Cystine Content (nmol half-cystine/mg protein)</th>
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<tbody>
<tr>
<td>1</td>
<td>a</td>
<td>F</td>
<td>7</td>
<td>10</td>
<td>+</td>
<td>63</td>
<td>+</td>
<td>160 (16 yr)</td>
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</tr>
<tr>
<td>2</td>
<td>a</td>
<td>F</td>
<td>5</td>
<td>13</td>
<td>+</td>
<td>88</td>
<td>+</td>
<td>104 (15 yr)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>F</td>
<td>4</td>
<td>16</td>
<td>+</td>
<td>88</td>
<td>+</td>
<td>202 (19 yr)</td>
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<tr>
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<td>7</td>
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<td>Unknown</td>
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<td>ESRD (12 yr), KT (17 yr)</td>
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<tr>
<td>5</td>
<td>a</td>
<td>M</td>
<td>7</td>
<td>7</td>
<td>+</td>
<td>73</td>
<td>+</td>
<td>400 (21 yr)</td>
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<tr>
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<td>F</td>
<td>4</td>
<td>6</td>
<td>+</td>
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<td>+</td>
<td>450 (35 yr)</td>
<td>0.91 (1978), 1.96 (1988) Increasedb</td>
</tr>
<tr>
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<tr>
<td>7</td>
<td>a</td>
<td>M</td>
<td>14</td>
<td>14</td>
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<td>240 (48 yr)</td>
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<tr>
<td></td>
<td>b</td>
<td>M</td>
<td>13</td>
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<td>−</td>
<td>Unknown</td>
<td>+</td>
<td>ESRD (27 yr), KT (29 yr)</td>
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<tr>
<td>8</td>
<td>a</td>
<td>F</td>
<td>12</td>
<td>12</td>
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<td>+</td>
<td>69 (29 yr)</td>
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<td>b</td>
<td>M</td>
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<td>−</td>
<td>Unknown</td>
<td>+</td>
<td>ESRD (21 yr) Increasedb</td>
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<tr>
<td>9</td>
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<td></td>
<td>b</td>
<td>M</td>
<td>19</td>
<td>26</td>
<td>−</td>
<td>N</td>
<td>+</td>
<td>ESRD (28 yr), KT (29 yr)</td>
<td>1.02</td>
</tr>
<tr>
<td>c</td>
<td>F</td>
<td>23</td>
<td>24</td>
<td>−</td>
<td>N</td>
<td>+</td>
<td>N (35 yr)</td>
<td>1.08</td>
<td></td>
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</table>

*KT, kidney transplantation; N, normal; SCr, serum creatinine concentration.

bIncreased according to medical charts; no values were transmitted to us. However family history, clinical presentation, and genetic studies were typical.
Eight patients (from seven families) presented renal Fanconi syndrome, which was often incomplete. In family 7, patient 7a had Fanconi syndrome, whereas patient 7b did not. β2-Microglobulinuria was determined and found to be high, at 11,706 µg/L (normal 0 to 350 µg/L), in patient 5a, and normal in patients 8a (130 µg/L) and 9a (30 µg/L). Patients without Fanconi syndrome received the diagnosis significantly later than those with Fanconi syndrome (mean 10.4 ± 3.9 years versus 29.4 ± 14.1 yr; P < 0.01). All patients but one (9a) had proteinuria (approximately 1 g/d). At last follow-up, 12 patients displayed renal failure, which led to ESRD in four (patients 4a, 7b, 8b, and 9b) at the ages of 12, 27, 21, and 28 yr, respectively. GFR at last follow-up in patients 2b, 5a, 6a, 7a, 8a, and 9a was calculated and ranged from 10 to 93 ml/min per 1.73 m². These patients were aged between 19 and 56 yr.

Patients 2a and 2b presented with growth retardation, blond hair, a fair complexion, and poor tanning on exposure to the sun (like many patients with infantile nephropathic cystinosis). Hair color and skin tanning were normal in the 12 other patients. Patients 2a and 2b were sisters and had two brothers and one sister, who died during infancy with rickets. Hypothyroidism was observed in patient 3a. None of the other patients showed hypothyroidism, impaired glucose tolerance, or any other extrarenal involvement. Patient 4 was included in this series because she developed ESRD only at 12 yr of age, unlike patients with infantile form, who reach ESRD earlier. Hair color and skin tanning were normal, and she had no rickets. Seven patients were treated by oral cysteamine. In patient 8a, oral cysteamine treatment was initiated at the age of 29 yr, in association with lisinopril, according to the results of a renal biopsy (see the Renal Biopsy Data section).

Of interest, renal disease progression was highly heterogeneous within families. In family 7, one patient (without Fanconi syndrome) presented ESRD at the age of 27 yr, whereas his brother (with Fanconi syndrome) showed severe renal failure (GFR of 27 ml/min per 1.73 m²) significantly later in life (48 yr of age). In family 8, one patient presented ESRD at the age of 21 yr (8b), whereas his sister (8a) had normal renal function at the age of 29 yr (GFR 93 ml/min per 1.73 m²). The situation was similar in family 9: Patient 9b presented ESRD at the age of 28 yr, whereas his affected older sister had no proteinuria and a GFR of 59 ml/min per 1.73 m² at the age of 56 yr.

Granulocyte Cystine Content
Granulocyte cystine content ranged from 0.76 to 4.80 nmol half-cystine/mg protein (mean 1.63 ± 1.34) in all 12 patients for whom data were available (normal <0.3). It is interesting that patient 4 had the highest levels of cystine in the granulocytes and also displayed the most rapid progression to ESRD. In patient 8a, granulocyte cystine content decreased from 2.5 to 0.12 nmol half-cystine/mg protein after the introduction of oral cysteamine therapy (daily dosage 1200 mg).

Renal Biopsy Data
Renal biopsies were available in four cases. In patient 1a, light microscopy of a renal biopsy specimen obtained at 10 yr of age disclosed intact glomeruli, dilated tubules, and intratubular...
alleles tested). No patient carried the approximately 57-kb de-
72% mutations were found (13 mutations detected among 18
first two noncoding exons or in the promoter. On the whole,
identified mild mutations (21). No mutation was found in the
affects an amino acid in a transmembrane loop, like most of the
This mutation is thought to be a mild mutation, because it
of asparagine for threonine and has never been reported before.
The newly identified p.T334N missense mutation is located in
ilies 3 and 5. Most patients had at least one "mild" mutation.
in two families (4 and 8). Only one heterozygous mutation was
four families (1, 6, 7, and 9) and homozygous for one mutation
in any of the biopsy samples.

Genotyping
Genetic screening (Table 2) showed that patients were com-
pound heterozygous for two mutations in the CTNS gene in
four families (1, 6, 7, and 9) and homozygous for one mutation
in two families (4 and 8). Only one heterozygous mutation was
identified in family 2, and no mutations were detected in fam-
ilies 3 and 5. Most patients had at least one "mild" mutation.
The newly identified p.T334N missense mutation is located in
the sixth intertransmembrane loop. It results in the substitution
of asparagine for threonine and has never been reported before.
This mutation is thought to be a mild mutation, because it
affects an amino acid in a transmembrane loop, like most of the
identified mild mutations (21). No mutation was found in the
first two noncoding exons or in the promoter. On the whole,
72% mutations were found (13 mutations detected among 18
alleles tested). No patient carried the approximately 57-kb de-
letion in the homozygous state.

Discussion
Cystinosis provides a good example of a "pediatric" disease
with a spectrum extending into adult medicine. Early oral
cysteamine therapy slows the deterioration of renal function.
Patients with infantile cystinosis would therefore be expected
to go on to develop renal failure later in life, during adulthood.
Kidney transplantation makes it possible for patients with in-
fantile cystinosis to reach adulthood. These patients are likely
to be followed up in adult units and to experience serious
extrarenal complications of the disease (1,22). Patients with
late-onset cystinosis are particularly likely to be followed by
adult nephrologists.

Late-onset nephropathic cystinosis is rare; therefore, no large
series of patients has yet been reported (13). We studied 14
patients from nine families with noninfantile cystinosis. Early
detection was associated with a higher probability of Fanconi
syndrome but was not necessarily associated with a poor prog-
nosis. The rate of renal progression was heterogeneous: Age at
last follow-up and age at ESRD (in four patients) ranged from
12 to 56 and from 12 to 28 yr, respectively. CTNS mutations
were found in only 72% of the alleles tested, and at least one
mild mutation was found in most cases in which two CTNS
mutations were identified.

Our findings show that nephropathic cystinosis may be dif-
ficult to diagnose and that patients may receive the diagnosis
late in life, even after kidney transplantation. Some patients
may have been unnecessarily treated with immunosuppression
for proteinuria before arriving at the diagnosis of nephropathic
cystinosis, thus emphasizing the importance to screen for cysti-
nosis. Indeed, clinical presentation may be nonspecific in ado-
lescents or adults. Renal Fanconi syndrome was lacking in six
of 14 patients. Proteinuria was often the only abnormality. The
detection of typical cystine corneal deposits could be diagnost-
ic, but some adult patients did not complain of ocular discom-
fort. Renal biopsy showed in three of the four cases nonspecific
FSGS, with no crystal deposits in one case. Granulocyte cystine
content was higher than normal, but this increase was less
marked than that in children with infantile nephropathic cysti-
nosis: Approximately 8 nmol in the study by Gahl et al. (23) and
4 nmol half-cystine/mg protein in the study by Cochat et al.
(24). In our patients with noninfantile forms, it generally did
not exceed 2.5 nmol half-cystine/mg protein, as previously
reported (23).

The renal changes observed in late-onset nephropathic cysti-
nosis have been less extensively described than in the infantile
form. Renal biopsy data are available for approximately 15
patients from published studies (13,25–33). Crystals were seen
in only three of the four biopsies carried out in our series. Our results
are concordant with other reports in which cystine crystals
were found in only one third of the patients who underwent
renal biopsy (26,28,30); however, cystine crystals are water
soluble and may be missed if certain precautions are not taken.
The most striking lesion was FSGS, found in most biopsy
specimens in published studies and in three of our four biop-
sies. The patients concerned had proteinuria, probably unre-
lated to proximal tubular dysfunction. FSGS may thus play a
role in renal progression in late-onset cystinosis. Multinucle-
ated podocytes have been reported in some patients (3) but
were not observed in our patients. Multinucleation may lead to
podocyte death, glomerular basement membrane denudation,
and subsequent events that trigger the development of FSGS.

The spectrum of mutations found in these late-onset cystino-
sis cases differs from that found in infantile-type cystinosis.
Mutations are found in all families with infantile cystinosis.
Individuals have "severe" mutations in both alleles, leading to
the complete loss of cystinosin function. The most common mutation is an approximately 57-kb deletion, found in the homozygous state in approximately 75% of patients of European descent. In contrast, we found point mutations that do not disrupt the open reading frame of cystinosin in our late-onset cystinosis cases. No patient was found to carry the homozygous approximately 57-kb deletion. Patients were usually homozygous for a mild mutation of this type or compound het-

Figure 2. Patient 8a. (A) Light microscopy. Trichrome light green. Focal tubulointerstitial lesions with mild interstitial fibrosis, tubular atrophy, and focal arteriolar thickening. (B) Light microscopy. Trichrome light green. FSGS on one glomerulus. Magnifications: ×100 in A; ×200 in B.
erozygous for a mild mutation and a severe mutation (12). Mild mutations impair but do not completely abolish cystine transport (21). Moreover, the level of transport inhibition often correlates with the severity of symptoms. The new missense mutation p.T334N is located in the sixth intertransmembrane loop. We believe this mutation to be mild because it affects a loop (21). As in patient 4a, some of the tissue-sparing seen in benign cystinosis may result from tissue-specific splicing factors, mitigating the effect of splice-site mutations in renal tissue by favoring the expression of residual normal message (14,15,21). Mutations in the promoter region have also been described in patients with ocular cystinosis (20), but we did not detect such mutation in our population. In addition, contrary to what is found in infantile cystinosis, in which virtually all mutations

Figure 3. Patient 8a. (A) Electron microscopy. Alterations in distal tubules without cystine crystals. Dilation and atrophy of distal tubules. (B) Electron microscopy. Effacement of foot processes along the glomerular basement membrane. Magnification, ×5000.
renal disease progression was reported by Thoene (families 7, 8, and 9; Table 2). Similar interfamily variability in between the affected siblings of three kindreds reported here may be involved.

such as genes encoding proteins that interact with cystinosin, \textit{CTNS}, such as the regulatory regions, not tested here, may be detected, \textit{CTNS} are detected, \textit{CTNS} mutations were found in only 72% of the alleles tested here. Mutations in the noncoding regions of \textit{CTNS}, such as the regulatory regions, not tested here, may be involved in these late-onset forms. Alternatively, other genes, such as genes encoding proteins that interact with cystinosin, may be involved.

The rate of renal disease progression differed considerably between the affected siblings of three kindreds reported here (families 7, 8, and 9; Table 2). Similar interfamily variability in renal disease progression was reported by Thoene et al. (13) in a family with intermediate cystinosis, whereas renal progression was remarkably similar in two other patients from another kindred. Thus, renal progression cannot be accurately predicted from late-onset nephropathic cystinosis (14). Our findings challenge this distinction. Indeed, patient 9a, at the age of 59 yr, had typical corneal deposits and high free cystine granulocyte content, with little or no renal involvement (no proteinuria, borderline GFR of 59 ml/min per 1.73 m²; no renal biopsy carried out), whereas her brother had reached ESRD at the age of 28 yr. These observations suggest that environmental and/or modifier genes may influence renal progression in patients with late-onset cystinosis.

There are several possible reasons for the slow progression of renal disease in patients with late-onset nephropathic cystinosis. Mild mutations are usually found, preserving often some transport activity of cystine out of lysosomes. The renal toxicity of cystine depends on events downstream from the lysosomes. These pathophysiologic steps may modulate the severity of the phenotype. Some polymorphisms in the genes that control these steps may modify clinical expression of the disease.

The possibilities for treating late-onset cystinosis depend on the putative mechanisms responsible for renal progression. Oral cysteamine can be considered to deplete cystine from lysosomes. Its efficacy against renal damage in late-onset forms is unknown. In patient 8b, oral cysteamine normalized granulocyte cystine content. Cysteamine may also be useful for preventing or reversing cystine deposition in other organs. Inhibitors of the renin-angiotensin system should be administered to reduce proteinuria and to prevent FSGS. Progress in the treatment of cystinosis depends on the design of new compounds to prevent the accumulation of cystine in lysosomes and on improvements in our understanding of the successive steps that lead from the primary lysosomal event to cell damage.

Conclusions

The clinical presentation of late-onset nephropathic cystinosis may be confusing with mild renal insufficiency and proteinuria without extrarenal signs. Progression is heterogeneous, even within families, but may be severe, leading to ESRD; however, severity is not correlated with the presence of Fanconi syndrome. Family investigations are requested in this field. Further investigations might provide deeper insight into the molecular or cellular mechanisms that modulate disease severity and reveal unsuspected aspects of the pathogenic cascade.

Table 2. Mutation analysis in patients with juvenile and adult cystinosis

<table>
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<th>Patient</th>
<th>Position</th>
<th>Nucleotide Change</th>
<th>Amino Acid Change</th>
<th>Transport Activity</th>
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<td>Exon 10</td>
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<td>NF</td>
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<td>p.G110V&lt;sup&gt;d&lt;/sup&gt;</td>
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<th>Transport Activity</th>
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</thead>
<tbody>
<tr>
<td>1a</td>
<td>Exon 5</td>
<td>537–557 del21bp</td>
<td>ITILELp67–73del</td>
<td>19 ± 6.1</td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>Exon 6</td>
<td>c.6668G&gt;T</td>
<td>p.G110V&lt;sup&gt;d&lt;/sup&gt;</td>
<td>120 ± 27</td>
<td></td>
</tr>
<tr>
<td>5a</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td>NF</td>
<td></td>
</tr>
<tr>
<td>7a</td>
<td>Exon 9</td>
<td>c.938C&gt;T</td>
<td>p.P200L</td>
<td>15.0 ± 4.5</td>
<td></td>
</tr>
<tr>
<td>7b</td>
<td>Exon 9</td>
<td>c.938C&gt;T</td>
<td>p.P200L</td>
<td>15.0 ± 4.5</td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>Exon 7</td>
<td>c.755C&gt;T</td>
<td>p.S139F</td>
<td>−2.9 ± 1.0</td>
<td></td>
</tr>
<tr>
<td>8b</td>
<td>Exon 7</td>
<td>c.755C&gt;T</td>
<td>p.S139F</td>
<td>−2.9 ± 1.0</td>
<td></td>
</tr>
<tr>
<td>9a</td>
<td>Exon 12</td>
<td>c.1340C&gt;A</td>
<td>T334N</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>9b</td>
<td>Exon 12</td>
<td>c.1340C&gt;A</td>
<td>T334N</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>Exon 12</td>
<td>c.1340C&gt;A</td>
<td>T334N</td>
<td>ND</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Mutations in patients 4a and 7a were described by Kalatzis et al. (21) and in patient 6a by Attard et al. (case P41) (12). ND, not determined; NF, not found.

<sup>b</sup>The first nucleotide of the cDNA sequence is considered as +1; the ATG start codon is situated at +340. The nucleotide changes indicated here are those proposed in the original publications, although they do not follow the recommendations that the A of the ATG start codon should be considered as +1.

<sup>c</sup>Effect on transport activity (expressed as a percentage of wt cystinosin activity ± SEM) reported by Kalatzis et al. (21).

<sup>d</sup>The G110V missense mutation in this patient does not affect cystine transport (21); it is the splicing defect that generates the associated phenotype (15).
Acknowledgments
This work was supported by the Cystinosis Research Foundation, Vaincre les Maladies Lysosomales and the Cystinosis Research Network.

This work was presented as an abstract at the 39th annual meeting of the American Society of Nephrology; November 14 through 19, 2006; San Diego, CA.

We thank the following physicians who took care of the patients and provided medical information: Dr. Broyer, CHU Necker, France; Dr. Fischbach, CHU Strasbourg, France; Dr. Legrand, CHR Annonay, France; Dr. McGregor, CHU Lyon, France; Dr. Anglicheau, CHU Necker, France; Dr. Bedet, France; Dr. Dehenaert, CHU Lille, France; Dr. Lombaerts, University Hospital Leuven, Belgium; Dr. Vilaseca, Hospital Sant Joan de deu, Barcelona, Spain; Dr. Godefroid, Cliniques universitaires St Luc et Hôpital des enfants Reine Fabiola, Brussels, Belgium; Dr. Souami, CHU Ibn Rochd, Casablanca, Morocco. We thank Dr. Touchard, N. Quellard, and B. Fernandez in the ultrastructural and experimental pathology unit in Poitiers. We are very grateful to Dr. Marie-Claire Gubler for critical reading of this article and advice.

Disclosures
None.

References


