Letter to the Editor

Cysteine-Sparing CADASIL Mutations in NOTCH3 Show Proaggregatory Properties In Vitro

To the Editor:

We read with great interest the article by Wollenweber et al.,1 proposing the use of scanning for intensely fluorescent targets to determine the pathogenicity of rare NOTCH3 variants in the context of cerebral autosomal-dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL). CADASIL-causing mutations characteristically lead to an uneven number of cysteine residues in the NOTCH3 ectodomain.2 In the vast majority of patients (>95%), a clinical diagnosis of CADASIL can be readily confirmed by the detection of a cysteine altering missense mutation in one of exons 2 to 24 of NOTCH3. Other CADASIL-causing NOTCH3 mutations, such as small deletions, also induce numeric cysteine changes, supporting a fundamental role for unpaired cysteines in NOTCH3 pathogenesis.3 Therefore, in the absence of such a cysteine-altering mutation, CADASIL is considered unlikely. When non–cysteine-altering variants in NOTCH3 are detected, these are generally considered polymorphisms. There are, however, rare non–cysteine-altering variants with evidence for pathogenicity. These variants do not have characteristics distinguishing them from NOTCH3 polymorphisms. Confirming their pathogenicity, therefore, is not straightforward and requires an indiscernible clinical diagnosis of CADASIL. Because CADASIL signs and symptoms are not specific, patients with a non–cysteine-altering variant need to have a skin biopsy to confirm the diagnosis. Electron microscopy shows distinct granular osmiophilic material (GOM) in the media of skin arterioles, and immunohistochemistry shows a typical granular NOTCH3 staining.3 Because a skin biopsy is not always feasible, a reliable functional assay to determine the pathogenicity of non–cysteine-altering variants would be of significant value, not only for diagnostic purposes but also for novel insights into CADASIL pathophysiology. Wollenweber et al1 describe such a potential assay, namely scanning for intensely fluorescent targets to analyze aggregation properties of NOTCH3 fragments harboring non–cysteine-altering variants. They conclude that this assay can reliably distinguish NOTCH3 pathogenic variants from polymorphisms.

As a possible missed diagnosis or misdiagnosis of CADASIL has potential far-reaching consequences, a correct classification of NOTCH3 variants is essential. However, we have some concerns about the suggestion that scanning for intensely fluorescent targets could replace skin biopsy as a more reliable diagnostic tool. We would argue that, based on the presented data, this proposition is too premature. The critical question is whether the patients described in the article truly have CADASIL. The presence of GOM in 1 patient is certainly suggestive, but not sufficient for a conclusive CADASIL diagnosis because GOM were not found in 2 other family members with the variant. Furthermore, although GOM is considered pathognomonic for CADASIL, it is probably not 100% specific. We have seen GOM in patients with cerebral small-vessel disease, in whom CADASIL was excluded by incompatible clinical signs, the lack of a NOTCH3 mutation and negative NOTCH3 staining (unpublished). In our experience, a 2-test skin biopsy, namely NOTCH3 staining in addition to the more widely used electron microscopy, is more reliable than electron microscopy analysis alone. Clearly, if the clinical diagnosis of CADASIL is disputable, a reliable classification of a NOTCH3 variant is impossible. To establish a clinical diagnosis of CADASIL in patients with a NOTCH3 variant, we recommend assessment of brain MRI and patient and family history by an experienced CADASIL team, and confirmation of the diagnosis by performing a 2-test skin biopsy. Only if the biopsy shows GOM and positive NOTCH3 staining, then the diagnosis can be considered confirmed and the variant probably pathogenic.

The comments above do not detract from the fact that scanning for intensely fluorescent targets analysis may prove to be a valuable tool in the classification of NOTCH3 variants. However, in our opinion, sensitivity and specificity should be more firmly established, before the test can be used as a diagnostic assay in CADASIL.

Disclosures

None.

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