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Association analysis of Neuregulin 1 candidate regions in schizophrenia and bipolar disorder


Abstract

Schizophrenia (SCZ) and bipolar disorder (BPD) are severe heritable psychiatric disorders involving a complex genetic aetiology. Neuregulin 1 (NRG1) is a leading candidate gene for SCZ, and has recently been implicated in BPD. We previously reported association of two NRG1 haplotypes with SCZ and BPD in a Scottish case–control sample. One haplotype is located at the 5′ end of the gene (region A), and the other is located at the 3′ end (region B). Here, association to haplotypes within regions A and B was assessed in patients with SCZ and BPD and in a second Scottish case–control sample and in the two Scottish combined samples. Association to region B was also assessed in patients with SCZ and BPD in a German case–control sample, and in all three samples combined. No evidence was found for association in the new samples when analysed individually; however, in the joint analysis of the two Scottish samples combined, association to haplotypes within regions A and B was observed in the combined SCZ and BPD case group (p = 0.0017, OR = 1.2, 95% CI: 1.1–1.5), with these associations withstanding multiple testing correction at the single-test level (SCZ: p = 0.044; BPD + SCZ: p = 0.044). This study supports the involvement of NRG1 variants in the less well studied 3′ region in conferring susceptibility to SCZ and BPD in the Scottish population.

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Keywords: Schizophrenia, Bipolar disorder, Neuregulin 1, Association study
motor neuron derived factor isoform, contained a common three-SNP haplotype associated with both SCZ and BPD ($p = 0.000062$).

Here, we sought to replicate our previous findings by assessing the association of regions A and B to SCZ and/or BPD in a second Scottish case–control sample (Scottish 2). Association to region B, the more significant of the two regions, was also assessed in a German case–control sample. In addition, two joint analyses were carried out, first combining the two Scottish samples (Merged Scottish) and then all three samples (Merged All). Approval to conduct this research was obtained from the Scotland A Research Ethics Committee.

The Scottish 1 case–control sample has been described previously [39]. For the Scottish 2 sample, individuals diagnosed with BPD or SCZ (Supplementary Table 1) were recruited from inpatient and outpatient services at psychiatric hospitals in South-East and South-Central Scotland, and from Ravenscraig Hospital, Greenock, Inverclyde. Diagnoses were reached by consensus between two psychiatrists according to the Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM–IV) [2] on the basis of medical and psychiatric histories, case note review, and interview using the Schedule for Affective Disorder and Schizophrenia—Lifetime version (SADS–L) [9].

Control subjects in the Scottish 2 sample were recruited from the same population in South-East and South-Central Scotland and from the Grampian region of Scotland, with the majority (>80%) recruited through the Scottish National Blood Transfusion Service, which only accepts individuals who are not currently taking medication and do not have a chronic illness. The rest were recruited from hospital staff or the general population, and were screened to exclude anyone currently taking medication or with a history of psychiatric illness.

The German case–control sample (Supplementary Table 1) comprised individuals with a lifetime diagnosis of BPD or SCZ, according to DSM-IV criteria, who were recruited from consecutive admissions to the inpatient unit of the Department of Psychiatry and Psychotherapy of the University of Bonn and of the Central Institute of Mental Health in Mannheim. Final diagnoses were reached using a consensus best estimate procedure [21], based on medical records, family history, and information obtained through a structured clinical interview for DSM–III-R (SCID–I) [34].

German control subjects were recruited from the Bonn region of Germany. Both the patient and the control samples were of German ancestry, extending back at least three generations.

Genotyping of the Scottish 1 sample has been described previously [39]. Genotyping of the three region A and three region B SNPs in the Scottish 2 sample was carried out at the Wellcome Trust Clinical Research Facility, Edinburgh, UK, using the Illumina BeadArray platform. The three region B SNPs were genotyped in the German sample using the Illumina BeadArray platform at the University of Bonn, Germany.

For both case–control samples, SNPs with a locus success rate of <90% and samples with a genotyping success rate of <90% were excluded from the analyses. Following these quality control measures, genotype data was available for five SNPs (three region A SNPs and two region B SNPs) in 307 control, 303 SCZ, and 239 BPD subjects in the Scottish 2 sample, and for the three region B SNPs in 397 control, 396 SCZ, and 400 BPD subjects in the German sample (Supplementary Table 1).

All SNPs were assessed for deviation from Hardy–Weinberg equilibrium (HWE) using a $\chi^2$ goodness-of-fit test, with $p \leq 0.05$. None of the SNPs deviated from HWE ($p \geq 0.065$). In order to assess the effect of biases such as population differences prior to combining samples for the merged analyses, the genetic heterogeneity of the three control groups was assessed using the $\chi^2$ test-of-independence. None of the SNPs were found to differ significantly between the three control groups (corrected $p_{H} \geq 0.053$; Supplementary Table 2).

Differences in allele and genotype frequencies between cases and controls were assessed using the $\chi^2$ test-of-independence. Haplotype frequency estimation and comparisons between cases and controls were carried out using Cocaphase 2.404 [8]. Haplotypes were assessed in global and individual tests. Haplotypes with
a frequency of less than 1% in cases and controls were grouped for the 
global test of significance. Odds ratios (ORs) and 95% confidence 
intervals (CIs) were calculated using the most common haplotype 
in the control sample as the reference. When the most common 
haplotype was the haplotype of interest, the second most common 
haplotype was used as the reference.

Associations directly replicating those identified in the analysis 
of the Scottish 1 sample [39] were accepted as significant 
when p ≤ 0.05, due to the a priori evidence for these SNPs. In the 
separate analyses of the Scottish 2 and German samples, novel associ-
ations attaining nominal significance (p ≤ 0.05) were corrected 
by permutation analysis. In the merged analyses, all nominally 
significant associations were corrected by permutation analysis. 
Permutation analysis (1000 permutations) was performed using 
Cocaphase 2.404. Corrections were made at two levels: the single-

In this study, individual analysis of the two new case–control 
samples failed to replicate any of our previously reported associ-
ations [39]. However, on combining the two Scottish samples, a 
two-SNP haplotype in region B (rs6988339 and rs3757930) was sig-
nificantly associated with SCZ and the combined case group, with 
these associations surviving correction for multiple testing at the 
single-test, but not experiment-wise, level of permutation analysis.

One interpretation of these results is that NRG1 risk variants are 

generically heterogeneous amongst cases from different popula-
tions. Heterogeneity amongst different European populations has 
been demonstrated for another SCZ– and BPD-risk gene, DISC1 [18]. 
To investigate this heterogeneity, Hennah et al. [18] used condi-
tional association analysis to detect DISC1 variants that confer risk 
only on certain genetic backgrounds.

Furthermore, SCZ and BPD are likely to be phenotypically het-

erogeneous. The broad diagnostic categories of SCZ and BPD used 
to select cases in this study may have obscured a difference in the 
phenotypic composition of the individual case–control samples. 
Variants in NRG1 may be involved in certain sub-phenotypes of 
SCZ and BPD. Indeed, studies have already demonstrated associa-
tion of NRG1 variants with particular aspects of psychiatric illness, 
including the development of psychotic symptoms, and abnormal 
P300 electroencephalogram activation [4,12,16,31,33].

An important caveat is the issue of sample size and its corollary, 
statistical power. In the larger merged Scottish sample we increase 
power and detect association with a reduced OR, consistent with 
results from genome wide association studies [6]. Estimates of 
effect size in the original study are, therefore, probably inflated, 
following the winner’s curse phenomenon [40]. This suggests that 
the two new samples may have been underpowered to detect a 
variant of small effect size.

Power to detect the two-SNP (rs6988339 and rs3757930) region B 
haplotype in the SCZ and combined case groups in the Scottish 
2 and German samples, assuming the same effect size as identi-

ified in the merged Scottish sample, was assessed using an online 
genetic power calculator [32]. These calculations indicated approx-
imately 90% power (uncorrected p ≤ 0.05) to detect this haplotype 
in all groups (Supplementary Table 4). However, the validity of 
these calculations is limited by the need to assume complete link-
age equilibrium between the genotyped marker(s) and the risk 
allele(s); this is unlikely to be true. Furthermore, following correc-
tion for multiple testing, power to detect differences at adjusted 
p-values will be less than predicted.

In summary, in this study we have found no evidence for asso-
ciation to region A and shown support for the presence of a risk 
variant for SCZ and/or BPD within, or in LD with, region B in an 

enlarged case–control sample. These findings contribute to a sub-
stantial body of genetic and functional evidence supporting the candidacy of NRG1 as a SCZ– and BPD-susceptibility gene. Taking 
into consideration the issues of genetic and phenotypic hetero-
genality, and sample size, it seems that our understanding of NRG1 would be most successfully expanded through association analyses
Table 1

<table>
<thead>
<tr>
<th>Marker (NCBI build 36 position)</th>
<th>Best individual haplotype p-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCZ Single</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Region A</td>
<td></td>
</tr>
<tr>
<td>rs1503491 (chr8:31761648)</td>
<td></td>
</tr>
<tr>
<td>Scottish 1</td>
<td>0.010</td>
</tr>
<tr>
<td>Scottish 2</td>
<td>0.55</td>
</tr>
<tr>
<td>German</td>
<td>0.92</td>
</tr>
<tr>
<td>rs553950 (chr8:31910904)</td>
<td></td>
</tr>
<tr>
<td>Scottish 1</td>
<td>0.028</td>
</tr>
<tr>
<td>Scottish 2</td>
<td>0.093</td>
</tr>
<tr>
<td>Merged Scottish</td>
<td>0.86</td>
</tr>
<tr>
<td>Region B</td>
<td></td>
</tr>
<tr>
<td>rs2919390 (chr8:32646497)</td>
<td></td>
</tr>
<tr>
<td>Scottish 1</td>
<td>0.010</td>
</tr>
<tr>
<td>Scottish 2</td>
<td>0.55</td>
</tr>
<tr>
<td>German</td>
<td>0.92</td>
</tr>
<tr>
<td>rs6988339 (chr8:32665458)</td>
<td></td>
</tr>
<tr>
<td>Scottish 1</td>
<td>0.010</td>
</tr>
<tr>
<td>Scottish 2</td>
<td>0.55</td>
</tr>
<tr>
<td>German</td>
<td>0.92</td>
</tr>
<tr>
<td>Merged Scottish</td>
<td>0.86</td>
</tr>
</tbody>
</table>

Global p-values are shown for each SNP and individual haplotype p-values for two- and three-marker haplotypes for schizophrenia (SCZ), bipolar disorder (BPD), and the combined case group (combined SCZ and BPD). Results from the Scottish 1 sample [39] are shown in italics for comparison. p-Values are shown in line with the first SNP of each multi-marker haplotype. Associations attaining nominal significance (p ≤ 0.05) in the Scottish 1 sample and the threshold level of significance for replication (p ≤ 0.05) are highlighted in bold.

of larger genetically and/or phenotypically homogenous samples, and interaction analyses to determine the effect of NRG1 variants on specific genetic backgrounds.

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Appendix A. Supplementary data


