**MAX Mutations Cause Hereditary and Sporadic Pheochromocytoma and Paraganglioma**

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**Abstract**

**Purpose:** Pheochromocytomas (PCC) and paragangliomas (PGL) are genetically heterogeneous neural crest–derived neoplasms. Recently we identified germline mutations in a new tumor suppressor susceptibility gene, MAX (MYC-associated factor X), which predisposes carriers to PCC. How MAX mutations contribute to PCC/PGL and associated phenotypes remain unclear. This study aimed to examine the prevalence and associated phenotypic features of germline and somatic MAX mutations in PCC/PGL.

**Design:** We sequenced MAX in 1,694 patients with PCC or PGL (without mutations in other major susceptibility genes) from 17 independent referral centers. We screened for large deletions/duplications in 1,694 patients using a multiplex PCR-based method. Somatic mutations were searched for in tumors from an additional 245 patients. The frequency and type of MAX mutation was assessed overall and by clinical characteristics.

**Results:** Sixteen MAX pathogenic mutations were identified in 23 index patients. All had adrenal tumors, including 13 bilateral or multiple PCCs within the same gland (P < 0.001), 15.8% developed additional tumors at thoracoabdominal sites, and 37% had familial antecedents. Age at diagnosis was lower (P = 0.001) in mutation carriers compared with nonmutated cases. Two patients (10.5%) developed metastatic disease. A mutation affecting MAX was found in five tumors, four of them confirmed as somatic (1.65%). MAX tumors were characterized by substantial increases in normetanephrine, associated with normal or minor increases in metanephrine.

**Conclusions:** Germline mutations in MAX are responsible for 1.12% of PCC/PGL in patients without evidence of other known mutations and should be considered in the genetic work-up of these patients.

**Clin Cancer Res; 18(10); 1–10. © 2012 AACR.**
Translational Relevance

MAX has been recently identified as the tenth susceptibility gene for pheochromocytoma (PCC). However, its clinical relevance was not addressed. This international study, based on an outstanding series of 1,694 unrelated patients with PCC or paraganglioma (PGL), has been able to ascertain the prevalence of MAX mutations in PCC patients, extended the spectrum of MAX-related tumors to PGL, uncovered contributions of somatic MAX mutations to sporadic disease, and defined an intermediate catecholamine phenotype, which may guide testing of MAX gene in patients with PCC/PGLs. This study also confirms a preferential paternal mode of transmission with important consequences for genetic counseling. We establish here that MAX germline mutations are responsible for the disease in 1.12% of cases, similarly to the genes recently described, such as TMEM127, SDHA, TMEM127 (8–10) have been identified. Thus, the proportion of hereditary PCC/PGLs may be considered in the genetic work-up of affected patients.

Introduction

Pheochromocytoma (PCC) has been referred to as “the 10 percent” tumor due in part to the belief that 10% are hereditary and usually associated with 3 well-known cancer syndromes: von Hippel–Lindau disease, multiple endocrine neoplasia type 2, and neurofibromatosis type 1 due to syndromes: von Hippel–Lindau disease, multiple endocrine neoplasia type 2, and neurofibromatosis type 1. The 10 percent rule was challenged after identification of VHL neoplasia type 2, and neurofibromatosis type 1 due in part to the belief that 10% are hereditary neuro-endocrine tumors. In Case Control Study (CCS), we showed that up to a quarter of affected patients carried a PCC/PGL susceptibility gene (7). Since then 3 additional susceptibility genes (SDHAF2, SDHA, and TMEM127) (8–10) have been identified. Thus, the proportion of hereditary PCC/PGLs may exceed estimates of 30% to 40% (11, 12), rendering PCC/PGL one of the most inherited tumor entities in existence.

Findings of other patients with a clinical presentation of PCC/PGL that includes a positive family history, early age of presentation, and bilateral adrenal or multiple tumors, but without known mutations, has suggested the presence of further susceptibility genes. With this observation in mind, we recently identified MAX (MYC-associated factor X) as a new PCC tumor suppressor susceptibility gene in 3 independent patients with familial antecedents of the disease (13). Further analysis of 59 patients, selected because they had bilateral PCC and/or an early age of disease presentation, allowed detection of 5 additional cases with MAX mutations (13). Preliminary genotype–phenotype associations suggested MAX mutations were associated with bilateral PCC and an apparent paternal transmission of the disease (13).

Although little is known about genetic alterations in sporadic tumors, it has been proposed that mutations in PCC/PGL susceptibility genes are detrimental for neuronal precursor cells, explaining the apparent rarity of somatic mutations in these genes in apparently sporadic PCC/PGL (14, 15). Guided by transcriptome classification and LOH profiles of a large series of 202 PCC/PGL, we nevertheless recently established that 14% of sporadic tumors harbored somatic mutations in VHL or RET genes (16). Because deregulation of MYC is a prominent hallmark in numerous forms of cancer (17), with activation of MYC genes commonly detected in solid human tumors (18), it is plausible that MAX somatic mutations may also occur in sporadic PCC/PGL.

Establishing the above associations and the prevalence of MAX mutations among patients with PCC/PGL requires analysis of a larger cohort of patients. In a large international collaborative effort, we therefore screened for the presence of germline mutations affecting MAX in 1,694 patients without mutations in major PCC/PGL susceptibility genes. Somatic mutations were searched for in tumors from an additional 245 patients.

Materials and Methods

Patients

The study population consisted of 1,694 apparently unrelated index cases with PCC or PGL, from whom blood-leukocyte DNA samples were available and in whom familial antecedents, presence of metastasis, and number of primary tumors are shown in Table 1. Clinical variables collected for this study were the following: gender, number
of PCC/PGLs, tumor location, age of diagnosis for each tumor (in patients with multiple tumors), the biochemical secretion when available, as well as other malignancies developed by probands. These clinical variables were collected electronically into preformatted forms provided to all contributors, and statistically analyzed in a single center. More detailed assessment of clinical data was further obtained for MAX mutation carriers. Mutations in RET, VHL, SDHB, SDHC, SDHD, and TMEM127 were excluded, and there were no clinical features of neurofibromatosis type 1. Patients were referred from 15 participating centers of the European Network for the Study of Adrenal Tumours (ENS@T) consortium [Madrid, Oviedo, and Seville in Spain (12), Paris, Marseille and Angers in France (19, 20), Leiden, Rotterdam, Nijmegen, and Maastricht in The Netherlands, Padua, Florence, and Brescia in Italy (11), Munich and Dresden in Germany] and 2 centers in the United States (San Antonio and Bethesda). Diagnosis of PCC and/or PGL, including tumors of both sympathetic (thoracic or abdominal) and parasympathetic (head and neck) origin, was established following conventional procedures (including clinical, biochemical, and imaging tests).

Written informed consent to collect phenotypic and genotypic data was obtained from all participants in accordance with institution review board–approved protocols for each center. DNA from 400 unrelated and unaffected individuals was analyzed as controls. 

Tumors

Frozen tumors obtained from a total of 245 apparently unrelated patients without known mutations in the mentioned susceptibility genes were collected through the Spanish National Tumor Bank Network in Madrid (Spain; ref. 21), the Erasmus MC Tissue Bank in Rotterdam (Netherlands), Munich (Germany), the International Familial Pheochromocytoma Consortium of San Antonio and Bethesda (22), Nijmegen Pheochromocytoma Tissue Bank, and the COMETE network in Paris, France (Table 1; refs. 16, 23). From these 245 samples, 106 belonged to patients included in the germline screening. The remaining 139 tumors represented independent cohort. For samples with identified MAX mutations, the corresponding mutation was assessed in constitutive DNA when available to classify them as germline or somatic.

Molecular genetic analyses

Complete genetic characterization of MAX included both point mutation and gross deletion/duplication analyses, the latter done in 1,535 cases with good DNA quality. Primers spanning the 5 exons and intron–exon boundaries of the MAX transcript 2 (ENST00000358664, NM_002382.3) were used as previously described (13). To assess for rearrangements, a semiquantitative multiplex-PCR method using labeled primers was designed as previously described for other genes (24). PCR conditions and primers are available upon request. To assess the pathogenicity of variants we used Alamut mutation interpretation software (http://www.interactive-biosoftware.com/software.html).

LOH was estimated by direct sequencing when tumor DNA was available. Uniparental disomy or chromosomal loss was assessed by microsatellite analysis as previously described (13).

Immunohistochemistry

Immunohistochemical staining was done using 3-μm formalin-fixed paraffin-embedded tumor sections from

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**Table 1. Clinical features of the entire pheochromocytoma and paraganglioma cohort**

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Clinical features</th>
<th>n</th>
<th>Single PCC</th>
<th>Single PGL</th>
<th>mPGL</th>
<th>PCC&amp;PGL</th>
<th>bPCC/mPCC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>H&amp;N/TA</td>
<td>H&amp;N/TA/both</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,694&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1,252</td>
<td>315</td>
<td>29</td>
<td>35</td>
<td>63</td>
</tr>
<tr>
<td>With familial antecedents&lt;sup&gt;b&lt;/sup&gt; (%)</td>
<td>37 (2.18%)</td>
<td>24 (1.91%)</td>
<td>5 (1.58%)</td>
<td>0</td>
<td>2 (5.71%)</td>
<td>6 (9.52%)</td>
<td></td>
</tr>
<tr>
<td>Index cases</td>
<td>Malignant&lt;sup&gt;c&lt;/sup&gt; (%)</td>
<td>129 (7.61%)</td>
<td>79 (6.30%)</td>
<td>27 (8.57%)</td>
<td>2 (6.89%)</td>
<td>15 (42.85%)</td>
<td>6 (9.52%)</td>
</tr>
<tr>
<td>Gender (female/male/unknown)</td>
<td>1,003/682/9</td>
<td>48 (3–88)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median age first tumor (range)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>245&lt;sup&gt;d&lt;/sup&gt;</td>
<td>216</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumors</td>
<td>Gender (female/male)</td>
<td>150/95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median age (range)</td>
<td></td>
<td>52 (11–83)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: PCC, adrenal pheochromocytoma; PGL, paraganglioma; mPGL, multiple paragangliomas; bPCC, bilateral adrenal pheochromocytoma; mPCC, multiple pheochromocytomas within the same gland; H&N, Head and Neck; TA, thoracoabdominal; Both – H&N and TA PGL.

<sup>a</sup>Index cases origin (n): France (664), Italy (428), Spain (245), The Netherlands (166), United States (152), Germany (39).

<sup>b</sup>A hereditary cause of PCC/PGL was considered likely when disease affected at least two family members.

<sup>c</sup>Malignancy was defined as the presence of metastases in which chromaffin cells are normally absent.

<sup>d</sup>Tumor origin (n): France (106), United States (79), The Netherlands (39), Spain (17), Germany (8).
tumors carrying MAX mutations, as previously described (13). Normal adrenal sections and tumors carrying mutations in other PCC susceptibility genes were used as controls. Only cases showing nuclear staining of stromal cells were considered as evaluable.

**Biochemical test results and biologic features**

Biochemical test results available in patients with MAX mutations included urinary fractionated metanephrines in 16 patients measured as part of the routine diagnostic work-up at participating centers, either by liquid chromatography with electrochemical detection (LC-EC) or tandem mass spectrometry. Concentrations of catecholamines (epinephrine, norepinephrine, and dopamine) in tumor tissue available from 7 patients with MAX mutations were quantified in frozen specimens by LC-EC as described elsewhere (25). Results were compared with historical data from 57 patients in one group with mutations of VHL (n = 44), SDHB (n = 10), and SDHD (n = 3) and 36 patients in the other group with RET (n = 31) and NF1 (n = 5) mutations, in all of whom tumor tissue catecholamine results were available (26). Transcriptomic data, involving 2 different microarray platforms (Affymetrix for the French series and Agilent for Spanish series; refs. 27, 28), were further used to determine the expression of mRNA for phenylethanolamine N-methyltransferase (PNMT).

**Statistical analysis**

Statistical analyses were carried out using SPSS software package version 17.0 (SPSS, Inc.). The 4 patients carrying variants of unknown significance (VUS) and a subject in whom it was not possible to establish the germline status were not considered for statistical purposes. Thus, only patients with mutations leading to truncated proteins or affecting conserved amino acids were included in the final analysis. Differences between mutation carriers and non-mutation carriers for gender, adrenal multiple tumors, familial history, and malignancy were assessed using a χ² test or Fisher exact test, where appropriate. Because age, biochemical, and gene expression data could not be established to be normally distributed, nonparametric analysis by Mann–Whitney and Kruskal–Wallis tests were used to assess statistical significance of differences in these variables among the different groups examined.

**Results**

**Germline and somatic MAX variants**

Among the 1,694 patients with PCC and/or PGL and no evident germline mutations in RET, VHL, SDHB, SDHC, SDHD, and TMEM127 genes (Table 1), we identified 16 different heterozygous variants affecting 23 subjects that spanned all 5 exons of the MAX gene (Fig. 1; Table 2). In addition, we analyzed MAX in 245 tumors (Table 1) and...
found 4 cases (1.65%) carrying a mutation that was confirmed as somatic by the finding of no mutation in the germline DNA (Table 2). A fifth tumor with a MAX mutation (case 24, Table 2) was not considered in further analysis because it was not possible to establish its germline status.

None of the variants were found in at least 400 controls, or in public databases (dbSNP132 and 1000 Genomes Project; www.1000genomes.org/).

Table 2. Genetic and clinical features of the 28 MAX positive patients\(^a\) and tumors\(^b\)

<table>
<thead>
<tr>
<th>ID</th>
<th>Gender/age</th>
<th>Fam</th>
<th>PCC</th>
<th>PGL</th>
<th>Mets</th>
<th>Other disease(^d)</th>
<th>cDNA mutation(^b)/Protein alteration(^b)</th>
<th>Predicted Pathogenicity(^c)</th>
<th>LOH</th>
<th>IHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M/27</td>
<td>No</td>
<td>PCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.1-?<del>483</del>?del/p.?</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>2</td>
<td>F/46</td>
<td>No</td>
<td>bPCC</td>
<td>1 TA</td>
<td>No</td>
<td>No</td>
<td>c.2T&gt;A/p.?</td>
<td>n.a.</td>
<td>Yes(^{UPD})</td>
<td>Neg</td>
</tr>
<tr>
<td>3</td>
<td>F/43</td>
<td>No</td>
<td>bPCC</td>
<td>4 TA</td>
<td>Yes</td>
<td>BrC, RO</td>
<td>c.73C&gt;T/p.(Arg25Trp)</td>
<td>Y</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>4</td>
<td>M/23</td>
<td>Yes</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>5</td>
<td>M/27</td>
<td>Yes</td>
<td>bPCC &amp;</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>6</td>
<td>M/34</td>
<td>No(^{dn})</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>7</td>
<td>F/58</td>
<td>Yes</td>
<td>mPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>8</td>
<td>F/26</td>
<td>Yes(^{p})</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>9</td>
<td>M/38</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>SCCT</td>
<td>No</td>
<td>c.2T&gt;A/p.?</td>
<td>n.a.</td>
<td>—</td>
<td>—</td>
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<tr>
<td>10</td>
<td>M/24</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>CCH</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>—</td>
<td>—</td>
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<tr>
<td>11</td>
<td>F/43</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.97C&gt;T/p.(Arg33(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>12</td>
<td>F/18</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.171+1G&gt;A/p.?</td>
<td>n.a.</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>13</td>
<td>F/55</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.178C&gt;T/p.(Arg60Trp)</td>
<td>Y</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14</td>
<td>F/34</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.212T&gt;G/p.(Ile71Ser)</td>
<td>Y</td>
<td>Yes(^{UPD})</td>
<td>Pos</td>
</tr>
<tr>
<td>15</td>
<td>M/57</td>
<td>No</td>
<td>mPCC</td>
<td>No</td>
<td>No</td>
<td>PA</td>
<td>c.220A&gt;G/p.(Met74Val)</td>
<td>Y</td>
<td>Yes</td>
<td>Pos</td>
</tr>
<tr>
<td>16</td>
<td>M/18</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>13HPT</td>
<td>c.223C&gt;T/p.(Arg75(^{+}))</td>
<td>n.a.</td>
<td>—</td>
<td>—</td>
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<tr>
<td>17</td>
<td>F/18</td>
<td>Yes</td>
<td>bPCC</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>c.244C&gt;T/p.(Gln82(^{+}))</td>
<td>n.a.</td>
<td>—</td>
<td>—</td>
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<tr>
<td>18</td>
<td>F/40</td>
<td>No</td>
<td>bPCC</td>
<td>1 TA</td>
<td>Yes</td>
<td>No</td>
<td>c.259+1G&gt;T/p.?</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>19</td>
<td>M/13</td>
<td>Yes(^{p})</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.305T&gt;C/p.(Leu102Pro)</td>
<td>Y</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>20(^{a})</td>
<td>F/48</td>
<td>No</td>
<td>1 H&amp;N</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.18C&gt;T/p.(=)</td>
<td>N</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>21(^{a})</td>
<td>M/13</td>
<td>No</td>
<td>bPCC</td>
<td>1 TA</td>
<td>No</td>
<td>No</td>
<td>c.25G&gt;T/p.(Val9Leu)</td>
<td>N</td>
<td>No</td>
<td>Pos</td>
</tr>
<tr>
<td>22(^{a})</td>
<td>M/22</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.63G&gt;T/p.(=)</td>
<td>N</td>
<td>No</td>
<td>—</td>
</tr>
<tr>
<td>23(^{a})</td>
<td>F/80</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.414G&gt;A/p.(=)</td>
<td>N</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>24(^{a})</td>
<td>F/29</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.269G&gt;C/p.(Arg90Pro)</td>
<td>Y</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>25(^{a})</td>
<td>M/39</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.223C&gt;T/p.(Arg75(^{+}))</td>
<td>n.a.</td>
<td>Yes</td>
<td>Neg</td>
</tr>
<tr>
<td>26(^{a})</td>
<td>F/57</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>RC</td>
<td>c.103C&gt;T/p.(Arg35Cys)</td>
<td>Y</td>
<td>Yes</td>
<td>Pos</td>
</tr>
<tr>
<td>27(^{a})</td>
<td>M/24</td>
<td>No</td>
<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.140_157del/p.(Arg47_Ser52del)</td>
<td>n.a.</td>
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<td>Neg</td>
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<td>F/56</td>
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<td>bPCC</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>c.25del/p.(Val19Trpfs(^{56}))</td>
<td>n.a.</td>
<td>Yes(^{UPD})</td>
<td>Neg</td>
</tr>
</tbody>
</table>

Abbreviations. Gender: F, female; M, male. Fam: familial antecedents; PCC, adrenal pheochromocytoma; bPCC, bilateral adrenal pheochromocytoma; mPCC, multiple pheochromocytomas within the same gland; PGL, paraganglioma; H&N, Head and Neck; TA, thoracoabdominal; Mets, presence of metastases in which chromaffin cells are normally absent; Other disease: BrC, breast Cancer; RO, renal oncocytyoma; SCCT, squamous cell carcinoma of the tongue; CCH, C-cell hyperplasia; PA, pituitary adenoma; 13HPT, primary hyperparathyroidism; RC, renal carcinoma; n.a., not applicable; —, not available; UPD, uniparental disomy; IHC, immunohistochemistry: Pos, positive; Neg, negative.

\(^{a}\)Only data from probands are shown in the table.

\(^{b}\)All cDNA and protein nomenclature is based on reference sequence ENST00000358664. All MAX variants were named following Human Genome Variation Society and checked using Mutalyzer Name Checker (www.mutalyzer.nl).

\(^{c}\)Pathogenicity potential of missense variants was examined by Alamut mutation interpretation software (version 2.5), which provides variant interpretation according to several prediction methods (AlignGVGD, Polyphen, SIFT, ESEfinder, GeneSplicer, RESCUE-ESE).

\(^{d}\)Other tumors in the proband.

\(^{p}\)Paternal familial antecedents.

\(^{dn}\)de novo case.

\(^{UPD}\)VUS, not considered for examination of phenotypic associations.

\(^{s}\)Somatic mutation.

\(^{S}\)This tumor was not considered in further analysis because it was not possible to establish its germline status.
Overall, taking into account the germline and the somatic findings, we identified 18 novel variants affecting MAX and 2 previously reported mutations, c.97C>T and c.223C>T (13). Seven mutations disrupted the MAX protein because they affected the initial methionine (c.27>A), created a premature stop codon (c.25del, c.97C>T, c.223C>T, and c.244C>T) or affected a donor/acceptor splice site (c.171 + 1G>A and c.295 + 1G>T; Fig. 1). In addition, 2 deletions were identified: the first caused an in-frame loss of 6 highly conserved amino acids within the first helix of the protein (c.140_157del), and the second, detected by multiplex-PCR (Supplementary Fig. S1), spanned the whole gene (c.1-?_483 ?del).

Among the 11 nontruncating variants, 7 mutations (c.73C>T, c.103C>T, c.178C>T, c.212T>G, c.220A>G, c.269G>C, and c.305T>C) changed conserved or highly conserved amino acids located within the basic helix-loop-helix leucine zipper (bHLH-Zip) domain of the MAX protein (Fig. 1) and were classified as deleterious by the Alamut software. The remaining 4 nontruncating variants (c.25G>T, c.63G>T, c.414G>A, and c.18C>T) were classified as VUS because these were predicted as benign through bioinformatic tools; it was also not possible to show their pathogenicity with further analyses (Table 2). Positive immunohistochemistry staining was observed in all nontruncating variants assessed (Supplementary Fig. S2).

LOH of the MAX wild-type allele was found in 16 of 18 tumors analyzed (Table 2). MAX wild-type allele was present in 2 tumor associated with the variants c.25G>T/p.(Val9Leu), and c.63G>T/p. (=), both considered as VUS. In summary, we found pathogenic germline MAX variants in the 1.12% of the 1,694 index cases included in this analysis. All mutations, except one gross deletion, consisted of a single nucleotide substitution.

Clinical presentation of MAX carriers

Only those 19 patients who harbored a germline variant defined as pathogenic were considered for examination of phenotypic associations (Table 2). The presence of familial antecedents of disease was found in 7 of the 19 patients (37%) and appeared in the paternal branch in the 3 pedigrees with more than one generation of affected members (Supplementary Fig. S3). These 19 patients developed at least one PCC, with 13 (68.4%) showing either bilateral PCC or multiple PCCs within the same gland, a 48-fold higher rate (P < 0.001) than in MAX-negative cases (4.28%). Age at diagnosis was lower (P < 0.001) in mutation carriers than in cases without mutations (median 34, range 13–58 years vs. 48 range 3–88 years). Three of the 19 patients (15.8%) developed additional tumors at thoracoabdominal sites at a median age of 48 years (range 44–64 years). Importantly, these tumors presented as PGLs, distinct from recurrences of the earlier adrenal tumors. Two patients (10.5%) developed metastatic disease.

Among 4 sporadic cases with MAX somatic mutations, the median age at diagnosis was 47.5 years (range 24–57 years), which was not significantly different from those with MAX-negative sporadic tumors (median 52, range 11–83 years; Table 1).

Biochemical test results and biologic features

All patients with MAX mutations showed increased urinary outputs of normetanephrine that did not differ from patients in the group with VHL and SDHB/D mutations or the other with RET and NF1 mutations (Fig. 2A). In contrast, urinary outputs of metanephrine were either normal or moderately increased in patients with MAX mutations and showed an intermediate distribution, significantly (P < 0.001) higher than in the VHL/SDH group, but lower than in the RET/NF1 group (Fig. 2B). Similarly, tumor tissue concentrations of epinephrine also showed an intermediate distribution, representing 8.4% of total catecholamine contents in MAX tumors, a proportion 5.6-fold higher (P < 0.001) than in VHL/SDH tumors, but a sixth (P = 0.003) that in RET/NF1 tumors (Fig. 2C). Furthermore, levels of PNMT expression in MAX tumors were 14-fold higher (P < 0.001) than in VHL/SDH tumors and a little under a half (P = 0.05) than in RET/NF1/TMEM127 tumors (Fig. 2D).

Discussion

It is widely accepted that MYC deregulation is not restricted to translocations and amplifications at the MYC locus, which suggests that the impact of its deregulation on human cancer incidence is higher than previously thought (18). We recently found MAX germline mutations in patients with PCC (13), suggesting that alterations in this most important regulator of the MYC/MAX/MXD1 network promote hereditary susceptibility to neoplasias. This study followed up on these observations, taking advantage of a large international collaborative network to determine the prevalence and the genotype–phenotype correlations of MAX mutations in 1,694 PCC/PGL patients previously negative for 6 major PCC/PGL susceptibility genes. We establish here that MAX germline mutations are responsible for the disease in 1.12% of cases, a similar contribution to that of the recently reported TMEM127 mutation (29). Furthermore, our findings reveal the presence of MAX somatic mutations in sporadic tumors, extend the spectrum of MAX-related tumors to PGLs, ascertain that MAX tumors are not particularly prone to malignancy, and show that MAX tumors produce predominantly norepinephrine, but with some capacity to also produce epinephrine.

Though it has been reported that somatic mutations in the known PCC susceptibility genes constitute an extremely rare event, we recently found 14% of sporadic PCC/PGL carrying somatic mutations in VHL or RET (16). The presence of somatic MAX mutations in 1.65% of sporadic tumors described here is in agreement with this latter
finding and highlights the importance of the MYC/MAX/MXD1 network in the development of neural crest tumors. It is well known that somatic amplification and overexpression of MYCN is a genetic hallmark in neuroblastoma (30), so ablation of MAX transcriptional repression of MYC in PCC could lead to the same oncogenic MYC dysregulation that occurs in neuroblastoma. Nevertheless, no meaningful trend for a contribution of MAX mutations to other neoplasms, including neuroblastoma, was found in the current series.

The identified variants were distributed along the gene but were especially frequent in exons 3 and 4, matching some of the most important residues within the conserved bHLH-Zip domain of MAX. The majority of mutations lead to truncated proteins, and the expected LOH affecting the remaining wild-type allele of the MAX tumor suppressor gene was further supported by the absence of the protein by immunohistochemistry.

The most frequently found mutation was the previously described c.97C>T variant (13) discovered in 8 unrelated

Figure 2. Dot-box plots illustrating urinary outputs of normetanephrine (A) and metanephrine (B), tumor tissue contents of epinephrine (C), and expression of PNMT mRNA (D) for patients with MAX mutations compared with those with VHL and SDHBD mutations or RET, NF1, and TMEM127 mutations.
patients from 5 nations (Italy, Spain, United States, France, and The Netherlands). This recurrent mutation affects a CpG dinucleotide located contiguous to Gln32, the crucial residue for DNA binding, and represents the first hotspot mutation affecting MAX. In agreement with this, one of the c.297C>T mutation carriers was a de novo case, further suggesting the high mutability of this dinucleotide. The 6 missense variants that altered conserved MAX residues were predicted as deleterious by the Alamut software (Table 2) and have been reported as critical for dimerization and DNA binding of HLH proteins or for interactions within the protein structure (31, 32). Mutations affecting highly conserved amino acids within the bHLH-Zip domain of MAX, involved in protein–protein interactions and DNA binding, can be expected to destroy the ability of MAX to antagonize MYC-dependent cell transformation leading to tumor development.

The absence of familial antecedents in more than 65% of individuals, as well as the paternal transmission identified in 3 pedigrees, further supports previous suggestions of a paternal mode of transmission (13). This mode of inheritance, with its consequence of generation skipping, complicates identification of candidate mutation carriers. In general, the phenotypic characteristics of MAX mutant patients overlap with clinical features observed for other PCC/PGL-related hereditary disorders. For example, the presence of a significant proportion of bilateral/multiple PCC cases among MAX germline mutation carriers, representing 21% (13 of 63) of patients included in this cohort (Table 1), is in agreement with the high percentage (35%–60%) of bilateral tumors found in patients with mutations in VHL, RET, or TMEM127 (7, 29, 33, 34). The age at diagnosis of PCCs in MAX mutation carriers (34 years) was clearly lower than in negative cases (48 years), also lower than the reported on average in patients with TMEM127, RET, and NF1 mutations (38–42 years), but higher to that for VHL and SDHI mutation carriers (27–32 years; refs. 19, 20, 29, 33–35).

Extraadrenal thoracoabdominal PGL are relatively common compared with adrenal tumors in patients with SDHB and SDHD mutations, less common in TMEM127 and VHL mutation carriers, and rarely associated with RET and NF1 germline mutations (12, 33, 36). Interestingly, in all MAX patients with PGL, the extraadrenal tumor was diagnosed after the adrenal tumor. This contrasts with VHL patients with head and neck PGLs, 50% of whom showed no adrenal tumors (34). In this study, only 2 patients developed metastasis, suggesting that unlike SDHB mutations, mutations of MAX are not associated with a high risk of malignancy.

The catecholamine-related information available from patients with MAX mutations indicated a biochemical phenotype intermediate between the established phenotypes of epinephrine producing tumors due to NF1 and RET mutations and the predominantly norepinephrine producing tumors due to VHL or SDHB/D mutations (26). This intermediate diagnostic phenotype, manifested by at least 3-fold larger tumor-associated increases in urinary outputs of normetanephrine than of metanephrine, was explained by a significant but limited capacity to produce epinephrine. This latter finding is supported by the intermediate tissue concentrations of epinephrine and expression of mRNA for PNMT, the enzyme responsible for conversion of norepinephrine to epinephrine. The intermediate biochemical phenotype associated with MAX mutations, together with lack of MAX immunohistochemical staining of tumor tissue, may prove useful for guiding testing of the MAX gene in patients with PCC/PGLs.

In summary, this study involving an unprecedented international effort to genotype and phenotype a substantial number of patients with PCC/PGLs reveals the importance of the MYC/MAX/MXD1 network in the development of both hereditary and sporadic forms of these tumors. MAX is the tenth PCC/PGL susceptibility gene described to date, which now should be considered in the genetic work-up of affected patients.

Disclosure of Potential Conflicts of Interest
The authors have no potential conflicts of interest to declare.

Authors' Contributions

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Conflict of Interest: A.-P. Gimenez-Roqueplo, M. Robledo

Acknowledgments

The authors thank Franco Veglio, MD and Paolo Mulatero, MD, University of Turin, Luigi Bartalea, MD, University of Insibria Varese, Ermanno Rossi, MD, Reggio Emilia Hospital, Pietro Nicolai, MD, and Fabio Facchetti, MD, University of Brescia, who contributed to patient enrollment and evaluation (Dresden); Annabelle Vénisse, Christophe Simian, Céline Loriot and Judith Favier (AP-HP, Hôpital européen Georges Pompidou, Paris, France) for their assistance; Enrico Agabiti Rosei for continued support and encouragement (Dresden). This manuscript was prepared under the aegis of the European Union Sixth Framework Program, Project ‘‘Advanced Genomics in the Diagnosis and Management of Neuroendocrine Tumours’’ (GenetUM). This study was supported by the European Union’s 7th Framework Programme, grants agreement no. 201141 (Degenere et al.). The authors report no potential financial or personal relationships with other people or organizations that could inappropriately influence their work. This study was supported in part by the National Institutes of Health (CA137250, CA105688), the American Cancer Society (PRA-11-149-01-CP), the American Thyroid Association, and the Eckert Foundation. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the American Cancer Society.

Published OnlineFirst March 27, 2012; DOI: 10.1158/1078-0432.CCR-12-0160
MAX Causes Pheochromocytoma and Paraganglioma

Genetics and INSERM U1970, Paris France) for technical assistance and the members of the COMETE (Cortico and Medullar Endocrine Tumors) and PGL.NET networks, of the GTE (Groupe des Tumeurs Endocrines) and of the INCA-COMETE and INCA-RENATEN reference centers. Particularly Frederick Illouz, Delphine Plumet, Marie Claire Prunier-Mirebeau (CHU d’Angers Endocrinology and biochemistry departments), Anne Barlier, Morgane Pertuit (CHU de Marseille, Molecular Biological department), Catherine Genestie, Julie Rigabert, Charlotte Lepourte (APHP-Hôpital de la Pitié Salpêtrière, Endocrinology and nuclear medicine departments). Serge Guyetant (CHU de Tours, Pathological department).; Nathalie Rioux-LeHerlec, Elisabeth Tarasco, Catherine Dugas (CHU de Rennes, Endocrinology and Genetics departments); Jillad Samrani, Philippe Tichetblot, Igor Dauveron (CHU de Clermont-Ferrand, Endocrinology department). Sylvette Helbert-Davidson (APHP Hôpital Henri Mondor, Nuclear Medicine department); Severine Valmary-Degano, Bernadette Kantelip (Tumorothèque Régionale de Franche-Comté); Bruneau Gabriel Viennet, Franck Monmenn, Alfred Penfonds (CHU de Besançon, Surgical, pathological and endocrinology departments); Xavier Bertagna, Rossella Libè, Frédérique Tissier (APHP, Hôpital Cochin, Endocrinology and pathological departments); Annick Rossi, Thierry Frebourg (CHU de Rouen, Genetic department); Michel Krempfi, Anne Moreau, Maille Lebras (CHU de Nantes, Endocrinology department); Cécile Badoual, Claudia de Toma, Plateforme de ressources biologiques de l’HÉGP (APHP, Hôpital européen Georges Pompidou, Pathological department). Sophie Felier, Acinonasiode Biaggi (CHU de Bicêtre, Pathological department) for their helpful assistance in this study (France); Karen Adams who contributed to the patient enrollment and evaluation (NIH, Bethesda): Neelie Arts and Erik Jansen for excellent technical assistance, Nicole Dematteo (CHU de Lille, Pathological department) for the recruitment of patients and/or clinical information: Aude Nardecchia, MD, Domenico Meringolo, MD, Giuseppe Picca, MD, Paola Loli, MD, Erika Grossrubatscher, MD, Maurizio Iacobone, MD, Antonio Toniato, MD, Ambra Fassina, MD, Isabella Negro, MD, GianPaolo Rossi, MD, Massimo Terzolo, MD, Serena Damatic, MD, Maria Vittoria Davi, MD, Giorgio Bertola, MD, Luca Persani, MD, Ulberta Verga, MD, Iacopo Chiodini, MD, Gilberta Giacchetti, MD, Giorgio Arnaldi, MD (Padova); the members of the Familial Pheochromocytoma Consortium for their support and earlier contributions; the following colleagues who contributed to the recruitment of patients and/or clinical information: Elizabeth King, MD, Jan Bruder, MD, Neil Aronin, MD, Kathy Schneider, MPhI, and Stephen Gruber, MD (San Antonio). Finally, the authors thank Sara Cristina Hernández for excellent technical assistance, Cristina Álvarez-Escolá, MD, Carmen Bernal, MD, Amparo Meoro, MD, José Ángel Díaz, MD, María Teresa Calvo, MD, José María de Campos, MD, María García-Barcina, MD, Sharona Azriél, MD, Marcos Lahera, MD, who contributed to the recruitment of patients and clinical information, Maria Jesús Antiga, PhD, and Manuel Movente, MD, for contributing to the recruitment of tumor samples, as well as BioSanbo del Sistema Sanitario Público de Andalucía and the Tumor Bank Network coordinated by CNIO (Spain).

Grant Support

The ENSFT consortium received funding from the European Union Seventh Framework Programme (ENSFT-T-CANCER, HEALTH-F2-2010-259735). The ENSFT registry is supported by a grant of the European Science Foundation (ESF-ENSFT). This work was supported in part by the Fondo de Investigaciones Sanitarias [projects P11/01359, P09/00492, P110/01292, P108/0531 and P108/0883], Mutua Madrileña (AP27/2008), Consejería de Innovación Ciencia y Empresa de la Junta de Andalucía (CTS-2590), Red Temática de Investigación Cooperativa en Cáncer (RD06/0020/0034).

The French COMETE network is supported in part by the Programme Hospitalier de Recherche Clinique grant COMETE 3 (AOM10 0179), by grants from INSERM and Ministère Développement de la Recherche et des Nouvelles Technologies and by the Prostate Cancer Foundation. This work was also funded by grants from the Agence Nationale de la Recherche (ANR 08 GENOP 029 MitOxy) and by the national program "Cartes d’Identité des Tumeurs" funded and developed by the "Ligue Nationale contre le Cancer" (http://www.ligue-cancer.net).

This research was supported, in part, by the Intramural Research Program of the NIH, NICHD.

This work received funding support from the Voelcker Fund to P.L.M. Dahlia.

This work was also supported in part by grants from the Fondazione Comunità Bresciana and the Fondazione Guido Berlucchi.

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Received January 18, 2012; revised March 2, 2012; accepted March 8, 2012; published OnlineFirst March 27, 2012.

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Clinical Cancer Research

MAX Mutations Cause Hereditary and Sporadic Pheochromocytoma and Paraganglioma

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Clin Cancer Res  Published OnlineFirst March 27, 2012.

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