Research Article

Novel Mutations of COL4A5 Identified in Chinese Families with X-Linked Alport Syndrome and Literature Review

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Received 24 October 2020; Revised 1 February 2021; Accepted 20 February 2021; Published 2 March 2021

Academic Editor: Pasquale Esposito

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Alport syndrome (AS) is an inherited kidney disease caused by defects in type IV collagen, which is characterized by hematuria, progressive nephritis or end-stage renal disease (ESRD), hearing loss, and occasionally ocular lesions. Approximately 80% of AS cases are caused by X-linked mutations in the COL4A5 gene. This study explored novel deletion and missense mutations in COL4A5 responsible for renal disorder in two Han Chinese families. In pedigree 1, the five male patients all had ESRD at a young age, while the affected female members only presented with microscopic hematuria. Whole exome sequencing and Sanger sequencing identified a novel frameshift deletion mutation (c.422_428del, p.Leu142Valfs*11) in exon 7 of COL4A5. In pedigree 2, the 16-year-old male proband had elevated serum creatinine (309 μmol/L) without extrarenal manifestations, while his mother only manifested with hematuria. A missense mutation (c.476G>T, p.Gly159Val) was found in exon 9 of the COL4A5 gene. Neither of these mutations was present in the Exome Variant Server of the NHLBI-ESP database, nor was it found in the ExAC or 1000 Genomes databases. Through the literature review, it was found that male Chinese patients with X-linked AS carried COL4A5 deletion or missense mutations had a more severe phenotype than female patients, particularly in proteinuria and impaired renal function. Compared to male patients with missense mutations, patients in whom deletion mutations were found were more likely to progress to ESRD (15.4% vs. 36.0%, P = 0.041). This study identified two novel COL4A5 mutations in Chinese families with X-linked AS, expanded the mutational spectrum of the COL4A5 gene, and presented findings that are significant for the screening and genetic diagnosis of AS.

1. Introduction

Encoded by the collagen type IV alpha-3 (COL4A3), alpha-4 (COL4A4), and alpha-5 (COL4A5) genes, Alport syndrome (AS) is a rare inherited renal disease caused by abnormalities of the α3, α4, or α5 chains in type IV collagen [1]. These genetic defects lead to inadequate structure and function of basement membranes in glomeruli, the cochlea, ocular lenses, and other organs. The typical clinical features of AS are progressive nephritis, including microscopic hematuria, gross hematuria, proteinuria, impaired renal function or end-stage renal disease (ESRD), neurosensory deafness, and, occasionally, ocular lesions [1, 2].

AS has three genetic forms: X-linked AS, autosomal recessive AS, and autosomal dominant AS. X-linked AS is the most common type, accounts for 80% of cases, and is caused by defective α5 chains in collagen IV. The autosomal recessive inheritance pathway accounts for approximately 15% of cases and is characterized by COL4A3 and/or COL4A4 allele mutations. Autosomal dominant AS is rare (only 5% cases), with the pathological phenotype being caused by heterozygous mutations in COL4A3 or COL4A4 [3–5].

In X-linked AS, hemizygous males show more severe clinical symptoms than heterozygous females, with approximately 60% and 90% of males reaching ESRD before the age of 30 and 40, respectively [6]. Studies have found that,
depending on the type of mutation they carry, males have a full range of clinical symptoms [67], while females with the COL4A5 mutation show a variety of phenotypes even within the same family [8]. At present, a large number of mutations have been found in X-linked AS patients. The most common forms include missense mutations (about 38.0%), followed by deletion mutations (estimated 15.9%) and splicing mutations (about 14.9%) [6]. While the majority of pathogenic variants have been reported, the genotype-phenotype associations have not been studied. To date, the functional consequences of missense and deletion mutations in patients with X-linked AS have not been clarified.

This study reports novel COL4A5 deletion (c.422_428del) and missense mutations (c.476G>T) found in Chinese families with X-linked AS. By reviewing the literature, this study is also aimed at investigating the typical clinical features of deletion and missense mutations in Chinese patients with X-linked AS.

2. Materials and Methods

2.1. Subjects. The proband (III-4) in pedigree 1, a 31-year-old male, was admitted with ESRD to the nephrology outpatient department at the First Affiliated Hospital of Jinan University in March 2019. Several years before admission, he presented with obvious hearing loss. Furthermore, the patient had a positive family history of kidney disease. Clinical information of the patient’s family members was collected during interviews. This included age, gender, symptoms, previous history of disease, and positive test results. Blood samples from the proband and eight other family members were collected for genetic screening (Figure 2).

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2.2. Whole Exome Sequencing (WES). Genomic DNA was extracted from peripheral blood using a QIAamp DNA Blood Mini Kit (Qiagen China Co., Ltd., Shanghai, China) according to the manufacturer’s instructions. The probands in pedigrees 1 and 2 were subjected to exome sequencing. All exon sequences were captured by Agilent SureSelect version 4 (Agilent Technologies, Santa Clara, CA, United States) according to the manufacturer’s protocols. Captured DNA libraries were sequenced on an Illumina HiSeq X Ten platform according to the manufacturer’s instructions for paired-end 150 bp reads.

2.3. Genetic Analysis. Paired-end reads were aligned to the NCBI build37 (hg19) database using BWA, while duplicated reads were marked by Picard [9]. SNVs and indels were detected by SAMtools and an in-house filter pipeline. Anno- var [10] was used for annotation. Common polymorphisms were excluded based on their associated allele frequencies in the 1000 Genomes (ftp://ftp-trace.ncbi. http://nih.gov/1000genomes/ftp/), Exome Aggregation Consortium (ExAC, http://exac.broadinstitute.org/), and National Heart, Lung, and Blood Institute esp6500i (NHBLI, http://evs.gs.washington.edu/EVS/) databases. The assessment of the deleterious effects of the variants was conducted using multiple tools, including MutationTaster (http://www.mutationtaster.org/), SIFT, PolyPhen, and CADD in the annotation. Variants were also annotated with their clinical status of disease on the basis of the Human Gene Mutation database (HGMD, http://www.hgmd.org). Possible AS-associated variants were determined against the following factors: (i) rarity or absence in the three genome databases, (ii) the variation which was expected to have a drastic effect on the protein (nonsense mutation, frameshift mutation, mutations at splice sites, or missense mutations that were highly conserved among species), and (iii) the variation that was predicted to be pathogenic.

2.4. Mutation Validation. For candidate variant validation and pedigree analysis, polymerase chain reaction (PCR) and Sanger sequencing was performed. The PCR primers were designed using regions that were 500 bp up- and downstream from the site of interest and at least 25 bp sequence of each primer. Primers flanking the candidate loci were designed against the Human Genome reference genomic sequences from GenBank in NCBI and synthesized by Invitrogen (Shanghai, China). PCR amplification was carried out in an ABI 9700 Thermal Cycler (Applied Biosystems, Foster City, CA, United States) and the PCR products directly sequenced on an ABI PRISM 3730 automated sequencer (Applied Biosystems). Results were analyzed against COL4A5 sequences (Entrez GeneID: 3508) retrieved from the University of California Santa Cruz Genome Browser (http://genome.ucsc.edu/).

2.5. Literature Comparison. To comprehensively review the pathogenicity of deletion and missense mutations in Chinese patients with X-linked AS, searches for primary studies were conducted on MEDLINE (PubMed) on May 15, 2020. Mesh terms “Alport syndrome or Alport’s syndrome” and “X-linked or X linked or X linkage” were applied for the literature search. All full-text case reports and articles written in English and involving affected Chinese families were included. Thirteen papers describing the COL4A5 deletion or missense mutations in Chinese families with X-linked AS were found [11–23]. Available clinical information and genetic data, including age at symptom onset, gender, urine test, kidney function, extrarenal symptoms, and type of gene mutation, were tabulated and analyzed.

2.6. Statistical Analyses. Continuous variables are presented as the mean ± standard deviation (SD), and categorical variables are expressed as frequency and percentage. Student’s t-test or equivalent nonparametric test was used to compare continuous variables between groups, where appropriate. Differences between categorical variables were analyzed...
using a chi-square test or double-tailed Fisher’s exact test. All values are two-tailed, and $P < 0.05$ was considered statistically significant. Data were analyzed using IBM SPSS Statistics version 25.0 for Windows (IBM, Armonk, NY, USA).

3. Results

3.1. Clinical Features of the AS Families. On admission, the proband (III-4) in pedigree 1 had severely impaired renal function, with serum urea of 49.9 mmol/L, serum creatinine (Scr) of 1793 μmol/L, hemoglobin counts of 48.1 g/L, serum potassium of 4.95 mmol/L, and serum calcium concentrations of 1.16 mmol/L and consequently received emergency hemodialysis. In subsequent investigations, both the proband and his brother (III-3, 33-year-old) had microscopic hematuria, proteinuria (about 1–2 g/d), and typical extrarenal symptoms (binaural sensorineural hearing loss and ocular lesions). His brother had elevated Scr (516 μmol/L), refused to undergo a renal biopsy, and began hemodialysis 1 year later. His father (II-9) was healthy and asymptomatic, while his mother (II-10) had died more than a decade prior of unknown causes. There were three male cousins (III-1, III-2, and III-3) who received hemodialysis, and all died from ESRD between 18 and 25 years of age. The affected female family members (I-2, II-12, and III-6) had microscopic hematuria, proteinuria (about 1–2 g/d), and typical extrarenal symptoms (binaural sensorineural hearing loss and ocular lesions). His brother had elevated Scr (516 μmol/L), refused to undergo a renal biopsy, and began hemodialysis 1 year later. His father (II-9) was healthy and asymptomatic, while his mother (II-10) had died more than a decade prior of unknown causes. There were three male cousins (III-1, III-2, and III-3) who received hemodialysis, and all died from ESRD between 18 and 25 years of age. The affected female family members (I-2, II-12, and III-6) had microscopic hematuria, proteinuria (about 1–2 g/d), and typical extrarenal symptoms (binaural sensorineural hearing loss and ocular lesions).

In pedigree 2, the proband (III-10) had proteinuria at the age of 1 year and presented with hematuria and proteinuria, without impaired renal function, hearing loss, or ocular lesions when he visited our outpatient department for the first time in 2014. Light microscopy by renal biopsy showed mesangial proliferative lesions in the glomerular segment with obvious interstitial foam cell infiltration. Electron microscopy revealed that the basement membrane was of variable thickness (200–600 nm). The segmentary basement membrane was serrated, and the dense layer was thickened, while some regions were torn and the cobweb structure altered. Substantial fusion of cellular processes occurred in podocytes (Figure 3). After 6 years of follow-up, he had elevated Scr levels (309 μmol/L), but lacked extrarenal manifestations. His mother (II-12) presented with only hematuria, while his father (II-11), one aunt (II-8), and one uncle (II-9) were in good health (Table 2, Figure 2). The remaining family members refused to undergo genetic, urine, and blood testing.

3.2. Identification of Novel Mutations in COL4A5 Gene. Through WES and Sanger sequencing, a novel deletion mutation (c.422_428del) was identified in exon 7 of the COL4A5 gene which was located on the X chromosome in pedigree 1. This deletion mutation resulted in the formation of a significantly truncated (p.Leu142Valfs*11) COL4A5 protein, which was shortened from 1686 amino acids to 152 amino acids; 10 of which were aberrant residues. ClinVar database (https://www.ncbi.nlm.gov/clinvar/) analysis showed that this variant was followed by 52 terminating variants, all of which were pathogenic variants (PVS). This mutation was predicted by MutationTaster to cause nonsense-mediated mRNA decay (NMD), resulting in amino acid sequence and splice site changes. Protein features might, therefore, be affected. This
A hemizygous missense mutation in exon 9 of COL4A5, c.476G>T, was found in the proband (III-10) represented in pedigree 2, resulting in the change of the 159th amino acid of the encoded protein from Gly to Val (p.Gly159Val). The heterozygous variant was detected in his mother (II-12), and the variant was not found in the proband’s father (II-11). This mutation was not present in the Exome Variant Server of the NHLBI-ESP database, nor was it found in the ExAC, 1000 Genomes, and HGMD databases. According to the variant interpretation guidelines of the American College of Medical Genetics and Genomics (ACMG) [24], the c.422_428del (p.Leu142Valfs*11) variant was classified as the pathogenic variant in this pedigree when PVS1, PM2, PP1, PP3, and PP4 criteria were included.

A hemizygous missense mutation in exon 9 of COL4A5, c.476G>T, was found in the proband (III-10) represented in pedigree 2, resulting in the change of the 159th amino acid of the encoded protein from Gly to Val (p.Gly159Val). The heterozygous variant was detected in his mother (II-12), and the variant was not found in the proband’s father (II-11).
The variant and renal disorder was cosegregated in the family. According to the MutationTaster prediction, this mutation will cause changes to the amino acid sequence and splice site, thereby affecting protein features. This variant was not found in the Exome Variant Server of the NHLBI-ESP database and ExAC or the 1000 Genomes databases, but is a known disease-causing mutation in the HGMD database (HGMD CD113181). According to the ACMG standards and guidelines for variant interpretation [24], the c.476G>T variant in this pedigree was weighted as "PM2, PP1, PP2, PP3, and PP4" and classed as a variant of "likely pathogenic."

Table 2: Clinical and laboratory features of participants harboring the COL4A5 c.476G>T (p.Gly159Val) variant in pedigree 2.

| Subjects | Gender | Age (years) | Urine test | Renal function | Extrarenal symptoms | Follow-up | Mutation status |
|----------|--------|-------------|------------|----------------|---------------------|-----------|-----------------|
| II-8     | F      | 46          | N          | N              | N                   | NE        | NE              |
| II-9     | M      | 43          | N          | N              | N                   | NE        | NE              |
| II-11    | M      | 42          | N          | N              | N                   | 6.1 75    | 6.1 76          |
| II-12    | F      | 41          | Y          | N              | N                   | 7.1 80    | 7.0 82          |
| III-10   | M      | 16*        | Y          | Y              | Y                   | 7.1 87    | 12.9 309        |

BUN: blood urea nitrogen (mmol/L); ESRD: end-stage renal disease; F: female; GH: gross hematuria; HD: hemodialysis; M: male; MH: microscopic hematuria; N: no; NE: not examined; Scr: serum creatinine (μmol/L), reference value, 46–103 μmol/L; Y: yes. *Age of onset of III-10 was one year old. †Follow-up results of six years after gene detection.

Figure 4: (a) Sequence of the hemizygous c.422_428del variant (III-3, III-4). (b) Sequence of the heterozygous c.422_428del variant (I-2, II-12, and III-6). (c) Sequence of unaffected individuals (II-9, II-14, III-7, and III-8).
those that carried deletion mutations were more likely proteinuric than female patients (18.9%, P = 0.041). About half of the male patients with a deletion mutation had hearing loss and approximately a quarter showed ocular lesions. Comparatively, one-third of the male participants showed ocular lesions (Table 4).

3.3. Literature Review. A comprehensive review on deletion or missense mutations in the COL4A5 gene in the Chinese population with X-linked AS was implemented. Data from this study and 13 published studies were included, thereby representing 141 affected participants among 88 Chinese families [11–23]. Twenty-four deletion mutations were discovered in 24 Chinese families involving 43 affected patients when including data from this study and nine published papers. The mean age of symptom onset was 9.1 ± 6.0 years. All patients had microscopic hematuria, 84.6% had proteinuria, while only 36.9% of males manifested gross hematuria. Sixty-three missense mutations were found in 64 Chinese families involving 98 affected patients from nine published papers. The mean age of symptom onset was 20.6 ± 13.8 years, which was significantly older than that observed with deletion mutations (P < 0.001). Nearly all patients had microscopic hematuria, 81.1% had proteinuria, while only 22.6% had gross hematuria (Table 3).

Male Chinese patients with X-linked AS had more severe phenotypes than female patients, especially regarding proteinuria and impaired renal function. More than half of the male patients had impaired renal function, which was significantly higher than that in female patients (18.9%, P < 0.001). Compared to male patients who carried missense mutations, those that carried deletion mutation were more likely progressed to ESRD (15.4% vs. 36.0%, P = 0.041). About half of the male participants with a deletion mutation had hearing loss and approximately a quarter showed ocular lesions. Comparatively, one-third of the male participants with a missense mutation experienced hearing loss and only 15.8% showed ocular lesions (Table 4).

4. Discussion

In the present study, a novel deletion mutation (c.422_428del) was identified in exon 7 of COL4A5 using WES in a Chinese family with X-linked AS, a finding which was validated by Sanger sequencing. This frameshift deletion mutation produced a significantly truncated (p.Leu142Valfs*11) COL4A5 protein product constituting 10 aberrant residues and only 152 amino acids. After this variant, ClinVar database had recorded 52 pathogenic terminating variants. This mutation was predicted to be “disease causing” by MutationTaster, causing NMD and changes in the amino acid sequence and splice sites and might affect protein features. The c.422_428del variant was cosegregated with phenotype in pedigree 1. In another family, a missense mutation (c.476G>T, p.Gly159Val) resulting in the change of the 159th amino acid of the encoded protein from Gly to Val was found in exon 9 of COL4A5. MutationTaster predicted this mutation to be “disease causing,” resulting in changes to the amino acid sequence and splice sites. Therefore, the protein features might be affected by this mutation. The variant and renal disorder was cosegregated in this family. Neither mutation was present in the Exome Variant Server of the NHLBI-ESP, ExAC, or 1000 Genomes databases. According to the ACMG guidelines [24], the novel c.422_428del (p.Leu142Valfs*11) variant was the pathogenic variant for the disorder, while the c.476G>T (p.Gly159Val) variant was classified as being a variant of “likely pathogenic” for AS. The literature review revealed that, compared to female patients, male Chinese patients with X-linked AS have more severe phenotypes, particularly in proteinuria and impaired renal function. Of the male patients who progressed to ESRD, 36.0% carried deletion mutations. This rate was higher than those that carried missense mutations (15.4%, P = 0.041).

AS is a monogenic nephropathy that results in familial hematuria, progressive renal failure, sensorineural hearing loss, and ocular anomalies. It is caused by defects in type IV collagen, which is the major and necessary structural component of basement membranes in glomeruli, cochlea, and ocular lenses [25]. There are six α chains (α1–α6) encoded by the collagen type IV alpha-1 through alpha-6 genes (COL4A1, COL4A2, COL4A3, COL4A4, COL4A5, and COL4A6). Each of these genes have a common primary structure which includes a 25-residue “7S” domain at the amino terminus, a
As the major form, X-linked AS is caused by mutations in COL4A5 [3–5]. The COL4A5 is located at Xq22, contains 51 exons, and encodes the 1685 amino acid residues that constitute the α5 chain of type IV collagen [12,32]. The α5 chain is composed of a 26-residue signaling peptide, a 1430-residue collagenous domain (exons 2–47) containing the characteristic Gly-X-Y-repeat sequence and 22 short noncollagenous interruptions, and a 229-residue carboxyl-terminal NC1 domain (exons 47–51) [32]. Due to various mutations, patients with X-linked AS have phenotypes that range from benign familial hematuria to ESRD that is occasionally accompanied with neurosensory deafness and ocular lesions [1–12,33]. Hemizygous male patients usually present with

Table 3: Summary of clinical features among affected Chinese families with COL4A5 deletion or missense mutations.

|                          | Deletion mutation | Missense mutation | Total     |
|--------------------------|-------------------|-------------------|-----------|
| **Number of reports**    | 9                 | 6                 | 15        |
| **Pedigree**             | 24                | 64                | 88        |
| **Participants**         | 43                | 98                | 141       |
| **Mutations/variants**   | 24                | 63                | 87        |
| **Number of involving exon** | 26            | 33                | 59        |
| **Gender (male:female)** | 26:17             | 57:41             | 83:58     |
| **Age of onset**         | 9.1 ± 6.0 (n = 19)| 20.6 ± 13.8 (n = 64)
|                          | 18.0 ± 13.3 (n = 83) |
| **Age at study**         | 21.6 ± 18.3 (n = 42)| 25.6 ± 16.1 (n = 97) |
|                          | 24.4 ± 16.8 (n = 139) |
| **Microscopic hematuria**| 100% (39/39)      | 97.9% (94/96)     | 98.5% (133/135) |
| **Gross hematuria**      | 26.9% (7/26)      | 22.6% (12/53)     | 24.1% (19/79) |
| **Proteinuria**          | 84.6% (33/39)     | 81.1% (77/95)     | 82.1% (110/134) |
| **Impaired renal function**| 40.5% (17/42) | 41.8% (38/91)     | 41.4% (55/133) |
| **ESRD**                 | 26.2% (11/42)     | 10.0% (9/90)      | 15.2% (20/132) |
| **Age at ESRD**          | 24.5 ± 7.2        | 30.8 ± 10.9       | 27.4 ± 9.4  |
| **Hearing loss**         | 41.7% (15/36)     | 31.1% (23/74)     | 34.5% (38/110) |
| **Ocular lesions**       | 21.9% (7/32)      | 13.6% (8/59)      | 16.5% (15/91) |

The categorical variable was expressed as % (n/N), where n indicates the number of positive observations and N indicates the total number of indicators observed. ESRD: end-stage renal disease. *Not included in this study. **Compared to the deletion mutation group, P < 0.001. ***Compared to the deletion mutation group, P = 0.016.

Table 4: Summary of clinical features among affected Chinese families, stratified according to gender, with COL4A5 deletion or missense mutations.

|                          | Male Deletion mutation | Missense mutation | Total   | Female Deletion mutation | Missense mutation | Total |
|--------------------------|------------------------|-------------------|---------|--------------------------|-------------------|-------|
| **Microscopic hematuria**| 100% (23/23)           | 98.2% (54/55)     | 98.7% (77/78) | 100% (16/16)           | 97.6% (40/41)     | 98.2% (56/57) |
| **Gross hematuria**      | 42.9% (6/14)           | 25.9% (7/27)      | 31.7% (13/41) | 8.3% (1/12)            | 19.2% (5/26)      | 15.8% (6/38) |
| **Proteinuria**          | 100% (23/23)           | 92.9% (52/56)     | 94.9% (75/79) | 62.5% (10/16)          | 64.1% (25/39)     | 63.6% (35/55) |
| **Impaired renal function**| 52.0% (13/25)       | 57.4% (31/54)     | 55.7% (44/79) | 23.5% (4/17)          | 18.9% (7/37)      | 20.4% (11/54) |
| **ESRD**                 | 36.0% (9/25)           | 15.4% (8/52)      | 22.1% (17/77) | 11.8% (2/17)          | 2.6% (1/38)       | 5.5% (3/55) |
| **Age at ESRD**          | 23.8 ± 6.7            | 27.8 ± 6.5        | 25.6 ± 6.7   | —                        | —                  | —      |
| **Hearing loss**         | 52.4% (11/21)          | 36.0% (18/50)     | 40.8% (29/71) | 26.7% (4/15)          | 20.8% (5/24)      | 23.1% (9/39) |
| **Ocular lesions**       | 23.5% (4/17)           | 15.8% (6/38)      | 18.2% (10/55) | 20.0% (3/15)          | 9.5% (2/21)       | 13.9% (3/23) |

The categorical variable was expressed as % (n/N), where n indicates the number of positive observations and N indicates the total number of indicators observed. ESRD: end-stage renal disease. *Compared to the deletion mutation group, P = 0.041. **Compared to the male group, P < 0.001; P < 0.001, and P = 0.009, respectively. — indicates that the value is not applicable.
more severe phenotypes than heterozygous females and have a higher probability of developing ESRD and/or hearing loss [68]. In our first pedigree, five affected male patients between the ages of 18 and 31 suffered from ESRD, while two presented with hearing loss and ocular lesions. The three affected female patients only presented with microhematuria. Similarly, the male proband in pedigree 2 had progressive glomerulonephritis and renal failure without extrarenal symptom, while his mother manifested only microhematuria. It was furthermore found through the literature review that more than half of the male patients had impaired renal function, a value that is significantly higher than that observed in female patients (18.9%, P < 0.001). Heterozygous females have widely variable disease outcomes, ranging from normal urinalysis and renal function to progression to ESRD and deafness. There was a significant genotype-phenotype correlation in male patients, which was not observed in affected females. Even within the same family, phenotypes differed between females. Thus, genotype might not be the main determinant of phenotypic heterogeneity in X-linked AS females. Phenotypic differences between males and females were considered to be related to allelic heterogeneity and X chromosome inactivation [7]. In recent years, some studies have suggested that the severity of AS in heterozygous females might be affected by skewed X-inactivation patterns. Typically, females would inherit 50% of their active X-chromosomes from each of their parents. X chromosome inactivation was previously considered to be a stable and irreversible phenomenon. However, recent studies had indicated that the X chromosome inactivation rate might be skewed due to chance, X chromosome abnormalities, X-inactivation modifier genes, or selection advantages of mutants [7, 8, 34–36].

By July 2020, more than 1000 mutations had been identified in COL4A5 according to the HGMD. These include large rearrangements and small mutations such as missense, deletion, insertion, nonsense, and splicing mutations [6]. Genotype-phenotype correlations between COL4A5 mutations and X-linked AS have been widely described in a series of case studies and literature reports. According to a 2012 meta-analysis of genotype-phenotype correlation in X-linked AS by Gross et al., typical X-linked AS was suggested to be classified into three types, namely, severe, moderate-severe, and moderate. Severe cases are characterized by juvenile-onset (~20 years of age) ESRD with 80% and 40% of cases involving hearing loss and ocular lesions, respectively. This type is considered to be associated with frameshift, premature stop, large rearrangements, donor splice site, and NC1 domain mutations. Moderate-severe patients are characterized by ESRD at ~26 years of age with a lower probability of extrarenal symptoms. These cases are usually caused by nonglycine missense mutations, glycine substitutions involving exons 21–47, in-frame, and acceptor splice site mutations. Moderately affected individuals are characterized by late-onset ESRD (~30 years of age), with 70% of the cases manifesting hearing loss and less than 30% having ocular lesions. These symptoms are related to glycine substitutions involving exons 1–20 [37–39]. This classification was consistent with our findings. In the first family, while the five male patients who presented with severe phenotypes harbored a novel deletion mutation (c.422_428del) in exon 7, the moderate-severe male proband in pedigree 2 who had elevated Scr (309 μmol/L) without extrarenal manifestations at the age of 22 harbored a missense mutation (c.476G>T) in exon 9.

Currently, although considerable allelic heterogeneity has been reported, a large number of AS families still need to be analyzed in order to determine the genotype-phenotype correlation and characteristics due to the various mutation types. Jais et al. comprehensively reviewed the phenotypes of 401 male patients with X-linked AS from 195 families from the European Community Alport Syndrome Concerted Action [6]. The results showed that all male patients had hematuria and that the rate of progression to ESRD and hearing loss was mutation-dependent. The risk of developing ESRD before the age of 30 years was as high as 90% in male patients with large deletions and nonsense or frameshift mutations, but 70% and 50% in those with splicing or missense mutations, respectively. While roughly 60% of the patients with missense mutations exhibited hearing loss before the age of 30, this condition was observed in approximately 90% of the patients with other mutations. Although there are some literature reports concerning AS in the Chinese population, most of them are case studies. Observational studies that include a large sample size are still lacking. Through the literature review conducted on the clinical manifestations of deletion or missense mutation of COL4A5 in Chinese families with X-linked AS, similar results to those reported in European patients were observed. Observational and follow-up studies with a larger sample size are however necessary for future research.

The present study has several advantages. First, this study identified two novel COL4A5 mutations in Chinese families with X-linked AS and expanded the mutational spectrum of the COL4A5 gene. Second, through a comprehensive literature review, the typical characteristics of COL4A5 deletion and missense mutations in Chinese X-linked AS patients were explored. Third, novel mutations identified by WES may help to identify mutations in different genes that result in similar clinical presentations. This would assist in making the diagnosis of AS more accurate. The limitations of this study include the lack of genetic data of the proband’s mother and renal biopsy data of the proband in pedigree 1 and the lack of clinical data of other family members in pedigree 2. Additionally, the sample size from the literature review was small, and the statistical power of the gender subgroup analysis was low. The c.476G>T (p.Gly159Val) variant was classified as “likely pathogenic” in pedigree 2 according to the ACMG criteria; however, the proband’s kidney biopsy indicated typical pathological manifestations of AS, and WES only found this mutation. Finally, as an observational study, the exact relationship between genotype and phenotype in X-linked AS could not be firmly determined. A study involving a large sample size and follow-ups are thus needed to explore genotype-phenotype correlation.

In conclusion, this study identified novel COL4A5 deletion and missense mutations in Chinese families with X-linked AS. This expands the mutational spectrum of COL4A5 and is significant for the screening and genetic diagnosis of AS. Observational and follow-up studies with
larger sample sizes are however needed to explore genotype-phenotype correlation among Chinese populations with X-linked AS.

**Data Availability**

The data used to support the findings of this study are available from the corresponding author upon request.

**Conflicts of Interest**

The authors declare no conflicts of interest.

**Authors’ Contributions**

WYG participated in the study design, performed the literature review, and aided in writing the manuscript. FNL performed the data collection and statistical analysis. JZ participated in the study design, performed genotyping, and data collection. LHY performed the data collection and statistical analysis. JZ participated in the study design, performed genotyping, and aided in manuscript writing. All of the authors have read and approved the final manuscript.

**Acknowledgments**

The authors would like to acknowledge the patients and their family members for participating in this study. This work was funded by the Guangdong Basic and Applied Basic Research Foundation (No. 2020A1515011287).

**References**

[1] B. G. Hudson, K. Tryggvason, M. Sundaramoorthy, and E. G. Neilson, "Alport’s syndrome, Goodpasture’s syndrome, and type IV collagen," The New England Journal of Medicine, vol. 348, no. 25, pp. 2543–2556, 2003.

[2] D. Cosgrove and S. Liu, "Collagen IV diseases: a focus on the glomerular basement membrane in Alport syndrome," Matrix Biology, vol. 57-58, pp. 45–54, 2017.

[3] O. Gross, C. E. Kashtan, M. N. Rheault et al., "Advances and unmet needs in genetic, basic and clinical science in Alport syndrome: report from the 2015 International Workshop on Alport Syndrome," Nephrology, Dialysis, Transplantation, vol. 32, pp. 916–924, 2017.

[4] K. Nozu, K. Nakanishi, Y. Abe et al., "A review of clinical characteristics and genetic backgrounds in Alport syndrome," Clinical and Experimental Nephrology, vol. 23, no. 2, pp. 158–168, 2019.

[5] V. Morinieré, K. Dahan, P. Hilbert et al., "Improving mutation screening in familial hematuric nephropathies through next generation sequencing," Journal of the American Society of Nephrology, vol. 25, no. 12, pp. 2740–2751, 2014.

[6] J. P. Jais, B. Knebelmann, I. Giatras et al., "X-linked Alport syndrome: natural history in 195 families and genotype-phenotype correlations in males," Journal of the American Society of Nephrology, vol. 11, p. 649, 2000.

[7] M. R. Bekheirnia, B. Reed, M. C. Gregory et al., "Genotype-phenotype correlation in X-linked Alport syndrome," Journal of the American Society of Nephrology, vol. 21, no. 5, pp. 876–883, 2010.

[8] M. N. Rheault, "Women and Alport syndrome," Pediatric Nephrology, vol. 27, no. 1, pp. 41–46, 2012.

[9] H. Li and R. Durbin, "Fast and accurate short read alignment with Burrows-Wheeler transform," Bioinformatics, vol. 25, no. 14, pp. 1754–1760, 2009.

[10] K. Wang, M. Li, and H. Hakonarson, "ANNOVAR: functional annotation of genetic variants from high-throughput sequencing data," Nucleic Acids Research, vol. 38, no. 16, article e164, 2010.

[11] Y. Wu, Y. Guo, J. Yuan et al., "A COL4A5 missense variant in a Han-Chinese family with X-linked Alport syndrome," Current Molecular Medicine, vol. 19, no. 10, pp. 758–765, 2019.

[12] Y. Guo, J. Yuan, H. Liang et al., "Identification of a novel COL4A5 mutation in a Chinese family with X-linked Alport syndrome using exome sequencing," Molecular Biology Reports, vol. 41, no. 6, pp. 3631–3635, 2014.

[13] X. Pan, J. Yan, H. Ren et al., "Detection of COL4A5 gene mutations in Chinese patients with Alport's syndrome," Nephrology Dialysis Transplantation, vol. 19, no. 5, pp. 1123–1128, 2004.

[14] Z. Li, P. Zhu, H. Huang et al., "Identification of a novel COL4A5 mutation in the proband initially diagnosed as IgAN from a Chinese family with X-linked Alport syndrome," Science China Life Sciences, vol. 62, no. 12, pp. 1572–1579, 2019.

[15] X. Tang, Q. Ding, D. Xu, S. Yang, Y. Xiao, and J. Liu, "An overlap of Alport syndrome and rheumatoid arthritis in a patient and literature review," BMC Nephrology, vol. 20, no. 1, p. 277, 2019.

[16] J. Ma, X. Pan, Z. Wang et al., "Twenty-one novel mutations identified in the COL4A5 gene in Chinese patients with X-linked Alport’s syndrome confirmed by skin biopsy," Nephrology Dialysis Transplantation, vol. 26, no. 12, pp. 4003–4010, 2011.

[17] S. Shang, F. Peng, T. Wang et al., "Genotype-phenotype correlation and prognostic impact in Chinese patients with Alport syndrome," Molecular genetics & genomic medicine, vol. 7, article e741, 2019.

[18] J. H. Liu, X. X. Wei, A. Li et al., "Novel mutations in COL4A3, COL4A4, and COL4A5 in Chinese patients with Alport syndrome," PLoS One, vol. 12, article e177685, 2017.

[19] F. Wang, J. Ding, S. Guo, and J. Yang, "Phenotypic and genotypic features of Alport syndrome in Chinese children," Pediatric Nephrology, vol. 17, no. 12, pp. 1013–1020, 2002.

[20] F. Wang, Y. Wang, J. Ding, and J. Yang, "Detection of mutations in the _COL4A5_ gene by analyzing cDNA of skin fibroblasts," Kidney International, vol. 67, no. 4, pp. 1268–1274, 2005.

[21] X. Zhao, C. Chen, Y. Wei et al., "Novel mutations of COL4A3, COL4A4, and COL4A5 genes in Chinese patients with Alport syndrome using next generation sequence technique," Molecular genetics & genomic medicine, vol. 7, article e653, 2019.

[22] X. Xiu, J. Yuan, X. Deng et al., "A NovelCOL4A5 mutation identified in a Chinese Han family using exome sequencing," BioMed Research International, vol. 2014, p. 5 pages, 2014.

[23] Y. Li, Q. He, Y. Wang et al., "Novel deletion mutation in a Chinese family with X-linked Alport syndrome," International Journal of Clinical and Experimental Pathology, vol. 11, no. 9, pp. 4657–4665, 2018.

[24] S. Richards, N. Aziz, S. Bale et al., "Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics
and Genomics and the Association for Molecular Pathology, “Genetics in Medicine,” vol. 17, no. 5, pp. 405–423, 2015.

[25] T. Van Agtmael and L. Bruckner-Tuderman, “Basement membranes and human disease,” Cell and Tissue Research, vol. 339, no. 1, pp. 167–188, 2010.

[26] C. Arrondel, G. Deschênes, Y. Le Meur et al., “A large tandem duplication within the _COL4A5_ gene is responsible for the high prevalence of Alport syndrome in French Polynesia,” Kidney International, vol. 65, no. 6, pp. 2030–2040, 2004.

[27] J. H. Suh and J. H. Miner, “The glomerular basement membrane as a barrier to albumin,” Nature Reviews. Nephrology, vol. 9, no. 8, pp. 470–477, 2013.

[28] Y. Pirson, “Making the diagnosis of Alport’s syndrome,” Kidney International, vol. 56, no. 2, pp. 760–775, 1999.

[29] M. Levy and J. Feingold, “Estimating prevalence in single-gene kidney diseases progressing to renal failure,” Kidney International, vol. 58, no. 3, pp. 925–943, 2000.

[30] C. E. Kashtan, “Alport syndrome: an inherited disorder of renal, ocular, and cochlear basement membranes,” Medicine (Baltimore), vol. 78, no. 5, pp. 338–360, 1999.

[31] J. Zhou, J. M. Hertz, A. Leinonen, and K. Tryggvason, “Complete amino acid sequence of the human alpha 5 (IV) collagen chain and identification of a single-base mutation in exon 23 converting glycine 521 in the collagenous domain to cysteine in an Alport syndrome patient,” The Journal of Biological Chemistry, vol. 267, no. 18, pp. 12475–12481, 1992.

[32] J. Kruegel, D. Rubel, and O. Gross, “Alport syndrome – insights from basic and clinical research,” Nature Reviews. Nephrology, vol. 9, no. 3, pp. 170–178, 2013.

[33] D. Vetrie, F. Flinter, M. Bobrow, and A. Harris, “X inactivation patterns in females with Alport’s syndrome: a means of selecting against a deleterious gene?,” Journal of Medical Genetics, vol. 29, no. 9, pp. 663–666, 1992.

[34] Y. Shimizu, M. Nagata, J. Usui et al., “Tissue-specific distribution of an alternatively spliced COL4A5 isoform and non-random X chromosome inactivation reflect phenotypic variation in heterozygous X-linked Alport syndrome,” Nephrology, Dialysis, Transplantation, vol. 21, no. 6, pp. 1582–1587, 2006.

[35] J. B. Berletch, F. Yang, and C. M. Disteche, “Escape from X inactivation in mice and humans,” Genome Biology, vol. 11, no. 6, p. 213, 2010.

[36] O. Gross, K. O. Netzer, R. Lambrecht, S. Seibold, and M. Weber, “Meta-analysis of genotype-phenotype correlation in X-linked Alport syndrome: impact on clinical counselling,” Nephrology, Dialysis, Transplantation, vol. 17, no. 7, pp. 1218–1227, 2002.

[37] P. Demosthenous, K. Voskarides, K. Stylianou et al., “X-linked Alport syndrome in Hellenic families: phenotypic heterogeneity and mutations near interruptions of the collagen domain in COL4A5,” Clinical Genetics, vol. 81, no. 3, pp. 240–248, 2012.

[38] M. Šlajpah, B. Gorinšek, G. Berginc et al., “Sixteen novel mutations identified in COL4A3, COL4A4, and COL4A5 genes in Slovenian families with Alport syndrome and benign familial hematuria,” Kidney International, vol. 71, no. 12, pp. 1287–1295, 2007.