LETTER TO THE EDITOR

Neuronal intranuclear (hyaline) inclusion disease and fragile X-associated tremor/ataxia syndrome: a morphological and molecular dilemma

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Sir,

We read with interest the article by Jun Sone and collaborators (Sone et al., 2016) describing clinico-pathological features of adult-onset neuronal intranuclear (hyaline) inclusion disease (NIID). The authors describe in detail the clinical phenotype and define ‘dementia’ and ‘limb-weakness’ dominant groups. They also confirm the usefulness of skin biopsy demonstrating characteristic hyaline, ubiquitin and p62-positive intranuclear inclusions for the ante-mortem diagnosis of NIID.

We have also been confronted with the morphological dilemma of identifying characteristic hyaline intranuclear neuronal and/or astroglial inclusions in 10 post-mortem brains obtained from brain donors who gave their consent to use the brain tissue for research purposes (Table 1): do these findings correspond to NIID, do they represent a mere incidental finding accompanying another neurodegenerative disease or are they related to an adult form of fragile X-associated tremor/ataxia syndrome (FXTAS), a late-onset neurodegenerative disorder presenting with a wide spectrum of motor (tremor, ataxia, parkinsonism), cognitive and psychiatric symptoms in patients carrying a premutation (55–200 CGG repeats) at the fragile X mental retardation 1 gene (FMR1) (Hagerman and Hagerman, 2004).

As the authors state in their article, both diseases share clinical and neuropathological features. Indeed, they are
### Table 1: Characteristics of patients with hyaline intranuclear inclusions at post-mortem neuropathological investigation corresponding to NIHID, FXTAS or as incidental forms

<table>
<thead>
<tr>
<th>Case</th>
<th>Gender</th>
<th>Age at onset (years)</th>
<th>Age at death (years)</th>
<th>Disease duration</th>
<th>Leading clinical syndrome</th>
<th>Family history</th>
<th>Diagnostic category</th>
<th>Brain weight, g</th>
<th>Neuronal nuclear inclusions</th>
<th>Glial nuclear inclusions</th>
<th>Co-existing neuropathology</th>
<th>Skin biopsy</th>
<th>FMR1 premutation</th>
<th>No. of CGG repeats (normal range 6–44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>77 (dementia)</td>
<td>78</td>
<td>Unknown</td>
<td>Parkinsonism, dementia</td>
<td>No</td>
<td>NIHID</td>
<td>860</td>
<td>++ ++ ++</td>
<td>+ + + +</td>
<td>CJD ARTAG, SVD</td>
<td>No</td>
<td>Na</td>
<td>20/31</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>At least 82</td>
<td>84</td>
<td>At least 2 years</td>
<td>Dementia</td>
<td>Yes</td>
<td>NIHID</td>
<td>1045</td>
<td>++ ++ ++</td>
<td>+ + + +</td>
<td>Rosai-Dorfmann</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>49</td>
<td>62</td>
<td>13 years</td>
<td>Ataxia</td>
<td>Yes (cephalic tremor)</td>
<td>Incidental NIHID</td>
<td>1300</td>
<td>++</td>
<td>+ + +</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>47</td>
<td>48</td>
<td>10 months</td>
<td>Rapidly progressive ataxia, parkinsonism</td>
<td>No</td>
<td>Incidental NIHID</td>
<td>1335</td>
<td>++ ++ ++</td>
<td>+ + + +</td>
<td>FFI</td>
<td>No</td>
<td>No</td>
<td>20/31</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>55</td>
<td>59</td>
<td>4 years</td>
<td>Dementia and MND</td>
<td>No</td>
<td>Incidental NIHID</td>
<td>1015</td>
<td>++ + (hippocampus)</td>
<td>+ + ++</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>NA</td>
<td>86</td>
<td>&gt; 2 years</td>
<td>Dementia</td>
<td>No</td>
<td>NIHID</td>
<td>76</td>
<td>+</td>
<td>+ + +</td>
<td>FXTAS</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>73</td>
<td>76</td>
<td>1.5 months</td>
<td>Rapid progressive dementia and gait disorder</td>
<td>No</td>
<td>NIHID</td>
<td>78</td>
<td>+</td>
<td>+ + +</td>
<td>FXTAS</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>95</td>
<td>97</td>
<td>5 years</td>
<td>Dementia, tremor, ataxia</td>
<td>No</td>
<td>NIHID</td>
<td>97</td>
<td>+</td>
<td>+ + +</td>
<td>Premutation carrier</td>
<td>No</td>
<td>No</td>
<td>30</td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>70</td>
<td>-</td>
<td>25 years</td>
<td>Hypoacusia, tremor, ataxia, dementia</td>
<td>Yes</td>
<td>NIHID</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>No</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>Male</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Asymptomatic</td>
<td>Yes</td>
<td>NIHID</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>No</td>
<td>No</td>
<td>-</td>
</tr>
</tbody>
</table>

A, B, C score = A amyloid phase according to Thal, B Braak neurofibrillary stage, C neuritic plaque score according to CERAD (each score ranges from 0 to 3); AD = Alzheimer’s disease neuropathological changes; AgD = argyrophilic grain disease; ARTAG = aging-related tau astrogliopathy; BB = Braak and Braak neurofibrillary stage; CAA = cerebral amyloid angiopathy; CJD = Creutzfeldt-Jakob disease; FFI = fatal familial insomnia; FXTAS = fragile X-associated tremor/ataxia syndrome; MM = methionine homozygosity at codon 129 of the PRNP gene; MND = motor neuron disease; NIH = neuronal intraneuronal hyaline inclusions; NIHID = neuronal intraneuronal hyaline inclusion disease; PART = primary age-related tauopathy; SVD = small vessel disease; VV = valine homozygosity at codon 129 of the PRNP gene; Assessment of inclusions: – absent; + mild amount of inclusions at 100 × magnification; ++ moderate; +++ abundant

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indistinguishable morphologically in haematoxylin and eosin stained tissue sections (Fig. 1). Both disorders affect neurons and glial cells throughout the brain, including cortex, white matter, basal ganglia, hippocampus, brainstem, cerebellum and spinal cord (Fig. 1A–C). The intranuclear inclusions found in both disorders share immunohistochemical features: they are ubiquitinated, ubiquilinated, immunoreactive for p62 (Fig. 1D) and SUMO (Mori et al., 2012), they have several associated components (Pountney et al., 2008), a few show immunoreactivity in intranuclear inclusions found in both disorders share immunohistochemical features: they are ubiquitinated, ubiquilinated, immunoreactive for p62 (Fig. 1D) and SUMO (Mori et al., 2012), they have several associated components (Pountney et al., 2008), a few show immunoreactivity

Figure 1 Morphological overlap of NIID and FXTAS. (A–C) Intranuclear hyaline inclusions in glial cells in cerebellar cortex are observed in FXTAS (A) and NIID (B), and also in neurons (C). (D–I) The immunohistochemical profile of the inclusions is identical in both diseases; inclusions are immunoreactive for p62 (D), rarely for polyQ (E), for FUS (F), and are negative for FMRP (G and H), and TDP43 (I). (J and K) Determination of CGG repeat track in the FMR1 locus in patients with NIID (J) and in a FXTAS patient by means of genomic DNA sequencing.
for polyglutamine chains (Fig. 1E), and they are generally positive for FUS (Fig. 1F), but remain negative for TDP43 protein (Fig. 1I). Although immunostaining of inclusions by LAP2b has been also reported in FXTAS experimental setting (Sellier et al., 2017), we could not detect it in our human FXTAS and NIID cases; we only observed a nuclear membrane pattern (data not shown). This might be due to post-mortem delay, longer formalin fixation, or agonic factors, among others. In contrast to NIID in which intranuclear inclusions can be detected in skin biopsies, in FXTAS no inclusions have been detected in fibroblast cultures (García-Arocena et al., 2010).

In adult forms of NIID presenting with dementia, intranuclear inclusions are more frequently detected in glial cells than in neurons (Muñoz-García and Ludwin, 1986; Takahashi-Fujigasaki, 2003). This is also seen in adult patients with FXTAS. Greco et al. (2006) observed in a post-mortem series of 11 FXTAS patients that the number of inclusions in neurons and astrocytes increases with increasing CGG repeats. The authors suggested that the CGG repeat is a powerful predictor of neurological involvement. Ariza et al. (2016) noted the frequent involvement of Purkinje cells in a study of 66 post-mortem cases and observed that the number of inclusions in the cerebellum increased with age. However, in one of our cases with 77 repeats and long disease duration (90 years old and 25 years of disease duration), we observed a high number of inclusions, suggesting that disease duration might also influence the development of inclusions.

The pathogenic mechanisms inducing neurodegeneration and the development of intranuclear inclusions in FMR1 premutation carriers are largely unknown, as is the case for NIID. A gain-of-function ‘toxicity’ of the abnormal CGG-expanded FMR1 mRNA was first proposed for FXTAS (Hagerman, 2013). It has been shown in vitro and in animal models that the expanded FMR1 mRNA recruits RNA binding proteins with subsequent loss or impairment of their function (Sofola et al., 2007; Sellier et al., 2010; Muslimov et al., 2011). The exact time sequence of protein recruitment and whether these interactions are direct or mediated by other factors are still unknown. It has been shown that there is a repeat-associated non-AUG (RAN) translation of the expanded repeats that leads to expression of the polyglycine- and polyalanine-containing peptides, FMRpolyG and FMRpolyA, respectively (Todd et al., 2013). Specifically, a recent study reports a disease phenotype in transgenic mice expressing FMRpolyG, but not in mice with sole expression of Fmr1 expanded RNA (Sellier et al., 2017). Despite the increasing evidence of the role of RAN translation products in the pathogenesis of FXTAS, the available disease models have limitations and RNA toxicity cannot be totally excluded. Nevertheless, the CGG knock-in mouse model recapitulates much of the pathology seen in patients, including increased expression of FMR1 mRNA, decreased fragile X mental retardation protein (FMRP, encoded by FMR1) ubiquitin-positive intranuclear inclusions and evidence of motor and spatial processing deficits (Willemsen et al., 2003; Hunsaker, 2013). Interestingly, inclusions are not immunoreactive for FMRP in our human cases, either in FXTAS or in NIID (Fig. 1G and H).

Taken together these data raise some questions. First, what is the pathogenic role of the inclusions? In most adult NIID and FXTAS cases, despite the presence of widespread inclusions, there is no prominent neuronal loss. It is likely that neuronal dysfunction predominates and the inclusion may have a protective role in mitigating nuclear toxicity caused by abnormal proteins, as has been suggested for Huntington’s disease or even for Lewy bodies in Parkinson’s disease. Second, what is the relationship between the CGG expansion and the intranuclear inclusion? While some authors observed an increase in the number of inclusions with higher repeats, in two of our FXTAS cases (Cases 8 and 9), a similar number of repeats induced single inclusions in Case 8 and abundant and widespread inclusions in Case 9. This suggests that other factors such as age at death (95 versus 78 in our cases, respectively) or disease duration may influence the development of inclusions. Moreover, trinucleotide repeat expansions have not been found in NIID cases. However, in both NIID and FXTAS some inclusions stain with antibodies directed to polyglutamines (CAG repeats) or even ataxin 3. While this may represent a cross-reaction, it suggests that a long peptide chain may be attached to the inclusion. In any case, FMRP is not an integral part of the nuclear inclusion in either FXTAS or NIID (Fig. 1H). In agreement with this observation, a computational model has shown that FMRP does not have a strong sequestration propensity for the CGG repeat RNA (Cirillo et al., 2013; Botta-Orfila et al., 2016). This may be also related to compartmentalization of proteins and that RNA is transcribed in the cytoplasm and then accumulated in the nucleus.

Undoubtedly, FXTAS markers are needed to therapeutically target the cellular/neuronal dysfunction. What is intriguing to us is the existence of NIID pathogenicity, with a completely unknown molecular substrate. NIID research can certainly benefit from the FXTAS field, although it has to be elucidated whether these represent two completely different entities as suggested by their genotype and whether they share pathogenic mechanisms leading to the same intranuclear hyaline inclusion formation.

In conclusion, NIID and FXTAS may be clinically and morphologically indistinguishable, and even with the possibility of genetic testing for CGG expansion, there is an urgent need for the development of more specific inclusion markers, the elucidation of the role of FMR1 and FMRpolyG or RNA regulating proteins in the development of inclusions and the identification of disease specific biomarkers.

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References


