HIF2 and endocrine neoplasia: an evolving story

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Abstract

In this issue of Endocrine-Related Cancer, Toledo et al. report the identification of activating mutations in the HIF2 (EPAS1) transcription factor in a subset of sporadic pheochromocytomas and paragangliomas. These findings add significantly to an evolving and complex story of the role of hypoxic gene response pathways in human endocrine neoplasia.

The heterodimeric HIF transcription factors regulate cellular responses to hypoxia. Each heterodimer consists of a specific α-subunit (HIF1α, HIF2α and HIF3α) which, in hypoxic conditions, complexes with the HIFβ (ARNT) subunit (Kaelin & Ratcliffe 2008). The best characterised factors, HIF1 and HIF2, have overlapping, but differing, roles in the hypoxic gene response. Thus, HIF1 and HIF2 regulate expression of ~200 genes implicated in angiogenesis, energy metabolism, cell proliferation and apoptosis, and while some targets are shared, others are preferentially regulated by HIF1 (BNIP3) or HIF2 (CCND1, VEGF) (Raval et al. 2005). Interestingly, in renal tumours, whereas HIF2 has been demonstrated to drive oncogenesis, loss-of-function mutations have been described in HIF1α (Kaelin & Ratcliffe 2008). The best characterised factors, HIF1 and HIF2, have overlapping, but differing, roles in the hypoxic gene response. 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be demonstrated in only a minority of sporadic cases, suggesting alternative mechanisms for activating hypoxic gene pathways (Eng et al. 1995, Astuti et al. 2004, Yao et al. 2010). Recently, several groups have demonstrated that oncogenic mutations in HIF2A/EPAS1 leading to HIF2 stabilisation can be implicated in the pathogenesis of pheochromocytomas and paragangliomas (Zhuang et al. 2012, Comino-Méndez et al. 2013, Lorenzo et al. 2013, Taïeb et al. 2013, Toledo et al. 2013, Yang et al. 2013).

Initially, Zhuang et al. (2012) reported two unrelated patients who presented with polycythaemia and paragangliomas harbouring gain-of-function HIF2A mutations. Two different HIF2A missense substitutions (p.Ala530Thr and p.Ala530Val) affecting the same exon 12 residue were detected. Previously, germline HIF2A mutations (e.g. p.Pro534Leu, p.Gly537Arg, p.Met535Val, p.Gly537Trp, p.Asp539Glu) had been identified in patients with inherited erythrocytosis (Percy et al. 2008a,b, Furlow et al. 2009), and although the HIF2A mutations were not detected in normal tissues from the two patients described by Zhuang et al. (2012), the presence of polycythaemia and the respective mutations in multiple tumours from each patient (paragangliomas in one patient and a paraganglioma and somatostatinoma in the other) suggested that each of the individuals were likely to be mosaic for a HIF2A mutation that occurred post-zygotically. The p.Ala530 residue is adjacent to one of the two key proline residues (p.Pro531) whose hydroxylation status is critical for pVHL-mediated degradation of HIF2α and Zhuang et al. (2012) demonstrated that both mutations impaired prolyl hydroxylation and promoted HIF2α stabilisation. Subsequently, the same group reported two additional patients with polycythaemia, paragangliomas and somatostatinomas but novel HIF2A missense substitutions (p.Leu529Pro and p.Y532C) in tumour cells (Yang et al. 2013). In addition, Lorenzo et al. (2013) reported a germline activating HIF2A mutation (p.F374Y) (inherited from a apparently unaffected parent) in a patient with polycythaemia and paraganglioma.

Comino-Méndez et al. (2013) extended the clinical phenotype of tumour HIF2A mutations. Of seven patients with HIF2A mutation-positive tumours, three presented with congenital polycythaemia and multiple paragangliomas (p.Ala530Thr, p.Pro531Ser and p.Pro531Leu), one with multiple paragangliomas only (p.Ala530Val) and three with a single pheochromocytoma/paraganglioma (p.Ile533_Pro534del, p.Pro534_Asp536del and p.Asp539Tyr). Following the detection of a somatic HIF2A mutation in six sporadic pheochromocytomas and paragangliomas analysed by exome sequencing, Toledo et al. (2013) found somatic HIF2A mutations in 2.3% (4/167) sporadic tumours but not in inherited cases. Three mutations affected codon 531 (p.Pro531Thr, p.Pro531Ser and p.Pro531Leu) and were shown to be associated with increased HIF2 stability (transcriptional profiles were available for two tumours and these clustered with the pseudohypoxic group that contained tumours associated with VHL and SDHX mutations).

In summary, recent studies of HIF2A mutations in pheochromocytoma and paraganglioma have provided novel insights into the role of hypoxic gene response pathways in the pathogenesis of endocrine neoplasia. To date, a number of common themes are emerging. First, most HIF2A mutations associated with pheochromocytoma and paraganglioma are somatic/mosaic and cluster in or around p.Pro531 resulting in HIF2 stabilisation producing gain-of-function effect. The clinical phenotype is variable, ranging from multiple tumours (paragangliomas or pheochromocytomas or paraganglioma and somatostatinoma) with or without polycythaemia to a single pheochromocytoma/paraganglioma. The role of HIF2 in endocrine neoplasia is now a hot research topic for research and much remains to be defined. From a clinical perspective, further information is required on the range of tumours that might be detected in patients who harbour constitutional or who are mosaic for HIF2A mutations – it would not be surprising if the phenotype expanded. A further key question is whether tumour HIF2A mutations will have implications for prognosis and treatment. Toledo et al. (2013) found evidence that HIF2A mutations at p.Pro531 promoted dedifferentiation of chromaffin cells and reduced the latency of tumour growth in nude mice assays. Malignant paragangliomas are known to be associated with germline SDHB mutations and although malignancy has yet to be reported in HIF2A-mutated tumours, the significance of HIF2A mutations for rate of tumour growth and risk of additional primary tumours in apparently sporadic cases needs to be determined. Although somatic HIF2A mutations may explain a subset of sporadic pheochromocytomas and paragangliomas with a pseudohypoxic gene expression profile, it would appear that additional, as yet uncharacterised, mechanisms must be implicated in other cases. Finally, although surgery is the mainstay of treatment for non-metastatic paragangliomas, much research is ongoing to develop anti-HIF therapies and it will be interesting to see whether, in the future, the finding of a HIF2A mutation in an endocrine tumour will have implications for clinical management.
Declaration of interest
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