Carney triad, SDH-deficient tumors, and Sdhb<sup>+/−</sup> mice share abnormal mitochondria

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Abstract

Carney triad (CTr) describes the association of paragangliomas (PGL), pulmonary chondromas, and gastrointestinal (GI) stromal tumors (GISTs) with a variety of other lesions, including pheochromocytomas and adrenocortical tumors. The gene(s) that cause CTr remain(s) unknown. PGL and GISTs may be caused by loss-of-function mutations in succinate dehydrogenase (SDH) (a condition known as Carney–Stratakis syndrome (CSS)). Mitochondrial structure and function are abnormal in tissues that carry SDH defects, but they have not been studied in CTr. For the present study, we examined mitochondrial structure in human tumors and GI tissue (GIT) of mice with SDH deficiency. Tissues from 16 CTr tumors (n = 12), those with isolated GIST (n = 1), and those with CSS caused by SDHC (n = 1) and SDHD (n = 2) mutations were studied by electron microscopy (EM). Samples of GIT from mice with a heterozygous deletion in Sdhb (Sdhb<sup>+/−</sup>, n = 4) were also studied by EM. CTr patients presented with mostly epithelioid GISTs that were characterized by plump cells containing a centrally located, round nucleus and prominent nucleoli; these changes were almost identical to those seen in the GISTs of patients with SDH. In tumor cells from patients, regardless of diagnosis or tumor type, cytoplasm contained an increased number of mitochondria with a ‘hypoxic’ phenotype: mitochondria were devoid of cristae, exhibited structural abnormalities, and were of variable size. Occasionally, mitochondria were small and round; rarely, they were thin and elongated with tubular cristae. Many mitochondria exhibited amorphous fluffy material with membranous whorls or cystic structures. A similar mitochondrial hypoxic phenotype was seen in Sdhb<sup>+/−</sup> mice. We concluded that tissues from SDH-deficient tumors, those from mouse GIT, and those from CTr tumors shared identical

Key Words

- GIST
- mitochondria
- Carney triad
- succinate dehydrogenase
abnormalities in mitochondrial structure and other features. Thus, the still-elusive CTr defect(s) is(are) likely to affect mitochondrial function, just like germline SDH-deficiency does.

Introduction

Carney triad (CTr) is a syndrome that describes the association of paragangliomas (PGLs) with gastrointestinal (GI) stromal tumors (GISTs) and pulmonary chondromas; other lesions, including pheochromocytomas, esophageal leiomyomas, and adrenocortical adenomas, have also been described (Carney 1999, 2009, Stratakis & Carney 2009). CTr is a novel form of MEN that predominantly affects females; it is caused by a still-unknown genetic defect (Matyakhina et al. 2009). CTr is a novel form of MEN that predominantly affects females; it is caused by a still-unknown genetic defect (Matyakhina et al. 2009). CTr is a novel form of MEN that predominantly affects females; it is caused by a still-unknown genetic defect (Matyakhina et al. 2009). CTr is a novel form of MEN that predominantly affects females; it is caused by a still-unknown genetic defect (Matyakhina et al. 2009). 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Sdhb also showed mitochondrial structural abnormalities, and this last point has, to our knowledge, never before been demonstrated.

Materials and methods

Patient case evaluations

Sixteen cases were identified, including six from the Mayo Clinic, nine from the National Institutes of Health, and one from La Timone University Hospital, Marseille, France (Taieb et al. 2012).

Tumors from a total of 16 patients were studied; the patient’s clinical data are presented in Table 1. There were three male and 13 female patients (but only one male patient had CTr). A total of 19 tumors were investigated: CTr-associated GISTs (n=13), PGL (n=1), and chondroma (n=1); a tumor from a patient with an isolated GIST (n=1); and tumors from patients with the dyad (CSS), including a GIST caused by SDHC (n=1) and a GIST (n=1) and a PGL (n=1) caused by an SDHD mutation, each of which were from a sibling with CSS from the same family. Their mutations and pathology (with regard to SDHB immunohistochemistry) have been described by our group previously (Janeway et al. 2011, Matayakhina et al. 2007); all of the tumors demonstrated negative SDHB immunohistochemistry (data not shown but previously published (Janeway et al. 2011, Matayakhina et al. 2007)).

Electron microscopy

For nine cases specimens were obtained from fresh tissue samples and were diced into 1 mm³ cubes, fixed in 2.5% glutaraldehyde, post-fixed in osmium, embedded in Epon epoxy resin, and routinely processed for transmission electron microscopy (EM). Specimens for another seven cases were retrieved from formalin-fixed paraffin-embedded tissue; although these showed suboptimal preservation, we were able to make observations pertaining to mitochondrial ultrastructure. A total of five to 15 sections were analyzed for each patient sample.

Mouse studies

Sdhb+/- mice (obtained from Dr Maher) (Maher et al. 2011) were maintained on a C57BL/6 genetic background.

Table 1 Clinical and molecular findings in the patients that were included in the present investigation

<table>
<thead>
<tr>
<th>Patient/ case no.</th>
<th>Age at diagnosis (years)</th>
<th>Sex</th>
<th>Clinical presentation</th>
<th>Dyad/triad</th>
<th>SDHx mutation</th>
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<tbody>
<tr>
<td>1</td>
<td>29</td>
<td>F</td>
<td>PGL</td>
<td>Triad</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>F</td>
<td>Stomach GIST</td>
<td>Triad</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
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<td>F</td>
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</tr>
<tr>
<td>4</td>
<td>15</td>
<td>M</td>
<td>Stomach GIST</td>
<td>Triad</td>
<td>None</td>
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<tr>
<td>5</td>
<td>17</td>
<td>M</td>
<td>Stomach GIST</td>
<td>Triad</td>
<td>None</td>
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<tr>
<td>6</td>
<td>52</td>
<td>F</td>
<td>Stomach GIST</td>
<td>Triad</td>
<td>None</td>
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<tr>
<td>7</td>
<td>15</td>
<td>F</td>
<td>Lung chondoma</td>
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<tr>
<td>8</td>
<td>20</td>
<td>F</td>
<td>Stomach + duodenum GIST</td>
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</tr>
<tr>
<td>9</td>
<td>14</td>
<td>F</td>
<td>GIST m, met + PGL m</td>
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<tr>
<td>10</td>
<td>34</td>
<td>F</td>
<td>GIST m, met</td>
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<tr>
<td>11</td>
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<td>F</td>
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</tr>
<tr>
<td>12</td>
<td>25</td>
<td>F</td>
<td>GIST met + PGL + adrenocortical tumor</td>
<td>Triad</td>
<td>None</td>
</tr>
<tr>
<td>13</td>
<td>18</td>
<td>M</td>
<td>Stomach GIST</td>
<td>Dyada</td>
<td>None</td>
</tr>
<tr>
<td>14</td>
<td>9</td>
<td>M</td>
<td>GSS m + PGL nf</td>
<td>Dyada</td>
<td>SDHC c.405 + 1G &gt; A (IVSS + 1G &gt; C/p.Met136Leufs*3</td>
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<tr>
<td>15</td>
<td>20</td>
<td>F</td>
<td>PGL m, nf</td>
<td>Isolated PGL</td>
<td>SDHC c.388InsG/p.Ala130Glyfs*61b</td>
</tr>
<tr>
<td>16</td>
<td>16</td>
<td>M</td>
<td>GSS multibulobulated + PGL m, nf + pigmented penile spots</td>
<td>Dyada</td>
<td>SDHC c.388InsG/p.Ala130Glyfs*61b</td>
</tr>
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</table>

m, multiple; nf, nonfunctioning; f, functioning; met, metastatic; PGL, paraganglioma; GIST, gastrointestinal stromal tumor; GSS, gastric stromal sarcoma; IVSS, intervening sequence intron5. 

Dyad, the dyad of PGLs and GISTs or Carney–Stratakis syndrome (CSS).

These two patients also have a co-segregating variation in SDHB c.423 + 20T > A.
Mice were killed (by CO2 inhalation) at 12 months of age (n=4, all female), and their GI tissue (GIT) was dissected. Small intestines (duodena) were isolated and fixed in 2.5% glutaraldehyde, post-fixed in osmium, embedded in EPON, and routinely processed for transmission EM (Laboratory of Pathology, National Cancer Institute (NCI), NIH, Bethesda, MD, USA). All of the animal experiments were approved by the National Institute of Health Animal Ethics Committee (06-033).

Results

Ultrastructural findings in human tumors with SDH deficiency

The abnormalities of the tumor cells are described in comparison with normal control tissues. The descriptions highlight the salient abnormal features of the various sets of our tumor specimens. The two patients with GISTs that harbored SDHB or SDHC mutations had a similar mitochondrial morphology to that observed in the CTr samples. A summary of the mitochondrial ultrastructural features is presented in the following sections.

Gastrointestinal stromal tumors

GISTs were characterized by plump, epithelioid cells that contained a centrally located, large, round nucleus with a prominent nucleolus and diffuse chromatin (Fig. 1A) as well as an increased number of morphologically abnormal mitochondria (Fig. 1A, B and C). Most of the mitochondria contained remnants of cristae and hyaline aqueous solution. Throughout the cytoplasm, glycogen granules were evident, which is a sign of hypoxic conditions and is simultaneously present in cases of dysfunctional mitochondria. Cytoplasmic membranes were well defined and had frequent microvillus-like filopodia (Fig. 1A, B and D). Some oval and spindle cells with indented nuclei,

Figure 1

(A, B, C and D) Gastric stromal sarcoma (case no. 1). Luxuriant filopodal cell borders (F), numerous glycogen granules (arrow), and prominent nucleoli (B). Mitochondria showed abnormal cristae structure (*) (B). Moderately increased numbers of mitochondria (C and D), all showing abnormal morphology; no cristae (*). (E and F) Gastric stromal sarcoma (case no. 2, specimen 6). There were fewer numbers of oval and spindle cells with heavily lobulated nuclei (E, arrows), intracytoplasmic filamentous aggregates, and slender-surface filopodia (F). A few short intercellular attachments were also present. Polygonal and spindle cells were packed with cystic-looking mitochondria (*) without cristae and with intra-mitochondrial membranous inclusions (H, *). (G, H and I) CTr gastrointestinal stromal tumors (case no. 2, specimen 6). Oval and spindle cells were in close apposition. Slender filopodia (F) were evident with few short intercellular attachments. The cytoplasm contained strands of rough endoplasmic reticulum (RER), branching ER, intermediate filaments, and increased numbers of mitochondria (*). Mitochondria exhibited variable sizes and structural abnormalities – some were small and round, whereas others were thin and elongated with tubular cristae. Many mitochondria had partial to complete loss of cristae and exhibited amorphous material that contained membranous whorls or cystic structures.
intracytoplasmic filamentous aggregates, slender-surface filopodia, and a few short, intercellular attachments were present as well (Fig. 1E and F). These polygonal and spindle cells were packed with abnormal cystic-looking mitochondria that were devoid of cristae and had intra-mitochondrial membranous inclusions. Some of the mitochondria were small and round or thin and elongated, but many were enlarged and exhibited partial or complete loss of cristae and amorphous fluffy material with membranous whorls or cystic structures (Fig. 1G, H and I). No autophagy or mitophagy processing was seen. In general, the morphology of the mitochondria in the GIST cells can be described as being very close to those of a primitive neoplasm.

Paragangliomas

PGLs were characterized by scant cytoplasm, diffuse chromatin, the presence of intracytoplasmic dense core secretory granules (Fig. 2A and B), and a large number of morphologically abnormal mitochondria. This last feature was similar to the GISTs. However, unlike the GISTs, the mitochondria in the PGLs appeared more numerous and occupied most of the cytoplasm; they were also larger in size than those of the GISTs (Fig. 3A, B, C and D). The cell membranes were occasionally degenerated, and the cells appeared as if they were multinucleated; the nuclei had various shapes, ranging from round to lobulated (Fig. 3A). Again, no autophagy or mitophagy processing was seen. Adjacent endothelial cells did not have any of these mitochondrial abnormalities (images not shown).

CTr lung chondroma

The only evaluated case of lung chondroma showed fibroblastic-looking cells with dilated endoplasmic reticulum. The mitochondria were morphologically abnormal, with degenerated inner membranes and absent cristae, or only their remnants were present (Fig. 3E and F). Interestingly, we also detected the presence of leaky extranuclear chromatin (Fig. 3F).
Ultrastructural findings in mice with SDH deficiency (Sdhb<sup>−/−</sup> mice)

In mouse GIT, in the duodenum in particular, Cajal cell morphology had similar characteristics to those of patients with epithelioid GISTs; cytoplasm contained numerous mitochondria that displayed highly abnormal morphology, including disintegration of the inner membrane and a lack of cristae, budding of mitophagic vesicles, and variability of sizes, with some swelling that gave a few a round shape; the swelling seemed to be the result of the accumulation of an aqueous substance (Fig. 4A and B). Chromatin appeared pycnotic, and the nuclear membrane was separated from the aqueous substance (Fig. 4A and B). Additionally, some short, rough endoplasmic membrane strands were present (Fig. 4A and B), and lysosomes were visible (Fig. 4B).

Discussion

GISTs are the most frequent spindle cell tumor of the GI tract, and they are thought to arise from the interstitial cells of Cajal (Min & Leabu 2006). GISTs occur most frequently in the stomach (Durham et al. 2004). To a lesser extent (in approximately 30% of patients), GISTs can be found in the small bowel, and in 10% or fewer cases, they are found in the esophagus and rectum. GISTs exhibit heterogeneous ultrastructural features (Matsumoto et al. 1997, Kindblom et al. 1998, Yantiss et al. 2002, Park et al. 2004). In clinical studies to date the histopathology, immunohistochemical, and genetic characteristics of GISTs have been examined (Hirota & Isozaki 2006, Miettinen & Lasota 2006a,b, Paral et al. 2010); however, there have been no reported studies in which the ultrastructure of the mitochondria in GISTs and their morphology in CTr have been examined.

In the present study, we provide insight into the mitochondrial ultrastructure in CTr and in GISTs and PGLs caused by SDH deficiency. We determined that in all of the clinical cases examined, mitochondria had a strikingly similar morphology—a hypoxic phenotype, a general lack of cristae, vacuoles, and varied sizes. The prominence of the features reflected the severity/aggressiveness of the tumor. Patients with the dyad of PGLs and GISTs (CSS) without other tumors harbor loss-of-function mutations in SDHx subunit genes. The results of the present study indicate that the mitochondrial ultrastructure in the tumors of these patients is almost identical to that in tumors from patients with CTr. Interestingly, we recently found high succinate levels, as assessed by 1H high-resolution magic angle spinning nuclear magnetic resonance spectroscopy, in two CTr-associated PGLs (Imperiale et al. 2015). The CTr-related PGL’s metabolomic profile was indeed consistent with SDH deficiency.

We also utilized a mouse model with an Sdhb heterozygous deletion (Maher et al. 2011). Unlike in humans (where there is a high penetrance of PGLs in individuals with SDHB mutations), no PGLs, GISTs, or any other tumors have been detected in Sdhb<sup>+/−</sup> mice (Maher et al. 2011), except for the recent description by our laboratory of modest pituitary gland hyperplasia and increased growth hormone and prolactin secretion (Xekouki et al. 2015). However, as seen in the present study, there are mitochondrial defects in the GI cells of these mice. It is unclear how these defects influence disease progression; mitochondria play a central role in orchestrating many apoptotic processes (Newmeyer & Ferguson-Miller 2003), but it is possible that mice require more genetic hits in order for GISTs and PGLs to develop. SDH deficiency is apparently enough to produce a phenotype in the mouse pituitary gland, although tumors also fail to develop there, which is unlike the situation in humans (Xekouki & Stratakis 2012, Xekouki et al. 2015).

The results of the present ultrastructural study indicate that mitochondria from both SDH-mutant tumors and those associated with CTr have considerable similarity, particularly with respect to their increase in number, size, and loss or complete absence of cristae. Tumor cells have the ability to successfully escape hypoxia-mediated death as a result of the reduced expression or mutation of p53 (Moll & Schramm 1998). Under hypoxic conditions, mitochondria are unable to provide enough ATP for cell survival; therefore, tumor cells must up-regulate the glycolytic pathway. This up-regulation is facilitated by the induction of hypoxia-inducible factor-1 (HIF-1) (Wang & Semenza 1993). Tumors from patients with SDHx mutations indeed have higher levels of HIF-1 (Hagg & Wennstrom 2005). It has been previously proposed that
enlarged mitochondria arise from HIF-1-induced fusion and that these enlarged mitochondria confer resistance to apoptosis (Chiche et al. 2010). We have seen a similar phenotype in human mutant SDHx-associated pituitary tumors (Xekouki & Stratakis 2012, Xekouki et al. 2012).

Although further studies on live cells are needed to identify the contribution of the abnormal mitochondria to CTr pathogenesis, the present study constitutes yet another observation in the endeavor to better describe the molecular etiology of CTr. It is now tempting to speculate that the still-elusive gene(s) may be involved somehow in mitochondrial function along with the down-regulation of SDHB (Gaal et al. 2011, Janeway et al. 2011) and SDHC (Haller et al. 2014).

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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