Accepted Manuscript

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PII: S0960-8966(16)30082-7
DOI: http://dx.doi.org/doi: 10.1016/j.nmd.2016.05.006
Reference: NMD 3185

To appear in: Neuromuscular Disorders

Received date: 3-3-2016
Accepted date: 9-5-2016

Please cite this article as: Renata Siciliani Scalco, Alice R. Gardiner, Robert D.S. Pitceathly, David Hilton-Jones, Anthony H Schapira, Chris Turner, Matt Parton, Mahalekshmi Desikan, Rita Barresi, Julie Marsh, Adnan Y Manzur, Anne-Marie Childs, Lucy Feng, Elaine Murphy, Phillipa J Lamont, Gianina Ravenscroft, William Wallefeld, Mark R Davis, Nigel G Laing, Janice L. Holton, Doreen Fialho, Kate Bushby, Michael G Hanna, Rahul Phadke, Heinz Jungbluth, Henry Houlden, Ros Quinlivan, CAV3 mutations causing exercise intolerance, myalgia and rhabdomyolysis: expanding the phenotypic spectrum of caveolinopathies, Neuromuscular Disorders (2016), http://dx.doi.org/doi: 10.1016/j.nmd.2016.05.006.

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CAV3 mutations causing exercise intolerance, myalgia and rhabdomyolysis: expanding the phenotypic spectrum of caveolinopathies

Renata Siciliani Scalco1,2, Alice R. Gardiner1,*, Robert D. S. Pitceathly1,3, David Hilton-Jones4, Anthony H Schapira1, Chris Turner1, Matt Parton5, Mahalekshmi Desikan1, Rita Barresi5,6, Julie Marsh7, Adnan Y Manzur5, Anne-Marie Childs8, Lucy Feng7, Elaine Murphy9, Phillipa J Lamont10, Gianina Ravenscroft11, William Wallefeld12, Mark R Davis12, Nigel G Laing11,12, Janice L. Holton1, Doreen Fialho1, Kate Bushby6, Michael G Hanna1, Rahul Phadke1,7, Heinz Jungbluth1,13,14, Henry Houlden1, Ros Quinlivan1,7

* Both authors contributed equally for this publication

1 MRC Centre for Neuromuscular Diseases and Department of Molecular Neuroscience, University College London Institute of Neurology and National Hospital for Neurology and Neurosurgery, Queen Square, London WC1N 3BG, United Kingdom
2 CAPES Foundation, Ministry of Education of Brazil, Brasilia DF, Brazil
3 Department of Basic and Clinical Neuroscience, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London SE5 8AF, United Kingdom
4 Department of Clinical Neurology, West Wing, John Radcliffe Hospital, Oxford OX3 9DU, United Kingdom
5 NHS England HSS for Rare Neuromuscular Diseases, Muscle Immunooanalysis Unit, Dental Hospital Richardson Road, Newcastle upon Tyne NE2 4AZ, United Kingdom
6 The John Walton Muscular Dystrophy Research Centre and MRC Centre for Neuromuscular Diseases, Institute of Genetic Medicine, Newcastle University, Newcastle upon Tyne NE1 3BZ, United Kingdom
7 Dubowitz Neuromuscular Centre, UCL Institute of Child Health, Great Ormond Street Hospital, London WC1N 3JH, United Kingdom
8 Leeds Teaching Hospitals, Leeds LS1 3EX, United Kingdom
Correspondence:
Dr Renata S. Scalco
r.scalco@ucl.ac.uk
Fax: 0203 448 4725
Institute of Neurology, First Floor, Department of Neuropathology
Queen Square, WC1N 3BG, London, United Kingdom
Highlights

- Here we present a series of eight patients from seven families presenting with exercise intolerance, myalgia and rhabdomyolysis caused by mutations in \( CAV3 \)
- This case series broadens the phenotypic spectrum of caveolinopathies.
- Exercise intolerance, myalgia and rhabdomyolysis may be caused by \( CAV3 \) mutations.
- Rippling muscle contractions and percussion-induced rapid muscle contractions (PIRCs) are important clinical clues indicative of caveolinopathies.
- Immunoblotting may be a more sensitive method to detect reduced caveolin-3 levels than immunohistochemistry.

Abstract:

Rhabdomyolysis is often due to a combination of environmental trigger(s) and genetic predisposition; however, the underlying genetic cause remains elusive in many cases. Mutations in \( CAV3 \) lead to various neuromuscular phenotypes with partial overlap, including limb girdle muscular dystrophy type 1C (LGMD1C), rippling muscle disease, distal myopathy and isolated hyperCKemia. Here we present a series of eight patients from seven families presenting with exercise intolerance and rhabdomyolysis caused by mutations in \( CAV3 \) diagnosed by next generation sequencing (NGS) (n=6). Symptoms included myalgia (n=7), exercise intolerance (n=6) and episodes of rhabdomyolysis (n=2). Percussion-induced rapid muscle contractions (PIRCs) were seen in five out of six patients examined. A previously reported heterozygous mutation in \( CAV3 \) (p.T78M) and three novel variants (p.V14I, p.F41S, p.F54V) were identified. Caveolin-3 immunolabeling in muscle was normal in 3/4 patients however, immunoblotting showed more than 50% reduction of caveolin-3 in five patients compared with controls. This case series demonstrates that
exercise intolerance, myalgia and rhabdomyolysis may be caused by CAV3 mutations and broadens the phenotypic spectrum of caveolinopathies. In our series immunoblotting was a more sensitive method to detect reduced caveolin-3 levels than immunohistochemistry in skeletal muscle. Patients presenting with muscle pain, exercise intolerance and rhabdomyolysis should be routinely tested for PIRCs as this may be an important clinical clue for caveolinopathies, even in the absence of other “typical” features. The use of NGS may expand current knowledge concerning inherited diseases, and unexpected/atypical phenotypes may be attributed to well-known human disease genes.

**Key Words:** CAV3; Rhabdomyolysis; Myoglobinuria; Caveolinopathy; Exercise Intolerance; Myalgia

**Abbreviations:**

ATPase: Adenosine triphosphatase
CAV3: Caveolin-3 (M-caveolin) – OMIM # 601253
CK: creatine kinase
COX: cytochrome oxidase
CPT2: Carnitine Palmitoyl Transferase 2
CRP: C-reactive protein
ECC: Excitation-contraction coupling
EM: Electron microscope
ESR: Erythrocyte sedimentation rate
H&E: Hematoxylin and eosin
LGMD1C: limb girdle muscular dystrophy type 1C
MHC: Myosin heavy chain
MRI: Magnetic resonance imaging
NADH-TR: Nicotinamide adenine dinucleotide-tetrazolium reductase
NGS: Next-generation sequencing
nNOS: Neuronal nitric oxidase synthase
PIRCs: percussion-induced rapid muscle contractions
PFK: phosphofructokinase
RM: Acute Rhabdomyolysis
SDH: Succinic dehydrogenase
SR: Sarcoplasmic reticulum
WB: Western blotting
WES: Whole exome sequencing
1 Introduction

Acute rhabdomyolysis (RM) is a serious event often requiring critical care management. Precipitating causes include a range of environmental trigger(s) with and without a known genetic predisposition [1]. In many cases no cause is found. Here we report eight patients who on next-generation sequencing (NGS) were found to carry four heterozygous missense CAV3 mutations after extensive earlier investigations had been negative. Our findings expand the CAV3-related phenotypical spectrum, so far comprising limb girdle muscular dystrophy type 1C (LGMD1C), rippling muscle disease, distal myopathy, isolated hyperCKemia and familial hypertrophic cardiomyopathy [2].

2 Materials and methods:

Eight patients presenting with exercise intolerance, myalgia and/or recurrent RM who remained genetically unresolved despite extensive previous investigations are reported. Six patients (patients 1-5 and 8) were identified from a larger cohort of 225 patients with exercise intolerance, myalgia and/or recurrent RM. DNA from patient 6 (the father of patient 5) was assessed following a genetic diagnosis in his son. Patient 7 was genetically investigated following muscle biopsy analysis. Approval was obtained from the regional ethics committee, and informed consent was obtained from all subjects for genetic studies. Medical notes were reviewed retrospectively and patients were reassessed following the genetic diagnosis, except patients 1,3 and 4 who failed to attend follow up visits, and patient 6, who is deceased. Clinical findings are summarized in Table 1, including: age of onset, age at assessment, presenting symptom, recurrent RM and its triggers, reported rippling muscle contraction, percussion-induced rapid muscle contractions (PIRCs) assessed during physical exam (by a reflex hammer (percussion of a muscle)), muscle pain, muscle weakness assessed
during physical exam, reported exercise intolerance (defined as pain and/or a cramp-like sensation during exercise), fatigue and baseline serum creatine kinase (CK) levels. Histopathological studies were performed as described in Supplementary Material. Polyacrylamide gel electrophoresis and western blotting were performed as previously described [3]. Blots were incubated with 43DAG/8D5 (β-dystroglycan, Leica Biosystems, NCL-b-DG, dil. 1/350) and caveolin-3 (BD Biosciences BD610421, dil. 1/350). Myosin heavy chain staining with Coomassie blue on the post-blotted gel was used as a control for protein loading and quality of the transfer. Bands were visualised with SuperSignal West Pico Chemiluminescent Substrate detection (Life Technology) using Alphalnnootech FluorChemR Q platform and AlphaViewR software v3.0. Densitometric analysis was undertaken using ImageJ v1.47 software with data normalised to the density of the myosin heavy chain band on the Coomassie blue stained post-blotted gel and expressed as a percentage of the control sample.

DNA from six patients was sequenced by a NGS Illumina ‘Trusight One’ enrichment panel; designed to screen for 50 relevant genes, previously associated or putatively linked with RM (for review [1]). Mutations identified on NGS were confirmed by Sanger sequencing. Patient 7 was evaluated by bi-directional sequence analysis for mutations in CAV3 and patient 8 by whole exome sequencing (SOLiD™). Whole exome sequencing was performed as outlined previously [4]. Three μg of DNA was fragmented by sonication and ligated to SOLiD™ system sequencing adaptors. The resulting library was enriched for exomic sequences using the SeqCap EZ Human Exome Library v2.0 exome capture system (Nimblegen, Roche Diagnostics) and sequenced using a 5500XL Genetic Analyser (Life Technologies). After sequencing and alignment, average coverage was 56-fold with 73% of the exome covered to 20-fold or greater. Variant calling was performed using LifeScopeTM 2.5 (Life Technologies) and the resulting variants were filtered using ANNOVAR. The CAV3
mutations were confirmation by bi-directional Sanger sequencing. Mutations were described using the single letter nomenclature to describe non-synonymous variants.

3 Results:

The clinical history from each patient is outlined below and key findings are summarized in Table 1. Patient 1 presented with fatigue, muscle pain, and recurrent episodes of myoglobinuria (highest CK: 28,000 IU/L) without apparent trigger. Inflammatory markers (CRP and ESR), HIV testing and auto-antibodies for auto-immune myositis were negative. Plasma acylcarnitine profile, urine organic acids, fatty acid oxidation flux and CPT2 activity in skin fibroblasts were all normal. Patient 2 presented with a longstanding history of muscle pain and tenderness exacerbated by mild physical activities and exercise that interfered with normal daily activities. Examination was unremarkable except for muscle pain evoked by muscle palpation. Routine biochemistry was normal, apart from raised CK. Inflammatory markers (CRP and ESR) and autoantibodies including ANA, GAD, Anti-DNA, Rheumatoid Factor, Anti-Hu, Anti-Yo, Anti-Ri, were negative. Patient 3 had exercise intolerance throughout adult life. RM occurred at age 37 following a few hours of moderate intensity swimming. At the time he was also taking antibiotics for an infection. Severe pain and acute muscle weakness were accompanied by myoglobinuria. A second episode was associated with exercise (swimming) in conjunction with fever. A third episode occurred spontaneously with no apparent precipitant. Patient 4 presented with exercise-related muscle cramps and stiffness since childhood. Examination was unremarkable. He had hypoglycaemic seizures in the neonatal period. Genetic testing for GLUT1, HADH and LPIN1 were normal. Patient 5 had muscle symptoms from childhood. He had mild muscle weakness, and could not perform endurance activities. Paroxysmal weakness lasting 2-3 hours occurred after strenuous exercise. Post exercise muscle pain was also a feature. Hypertrophic cardiomyopathy was
diagnosed in his 40s during a routine health check. Extensive genetic investigations were negative (including full mutation screening of \textit{VCP}, \textit{DES}, \textit{MYOT}, \textit{CRYAB}, \textit{ZASP}, \textit{TTN}, targeted sequencing of \textit{POLG1} and \textit{PEO1}, plus testing for large scale rearrangements and full sequencing of muscle-extracted mtDNA). Muscle biopsy slides were not available for review. Patient 6, the father of patient 5, presented with progressive muscle weakness from the fourth decade and died aged 85. Muscle weakness initially involved the anterior thighs with progression to the distal upper limbs later in life. He became wheelchair-dependent in his late 60s. He had no swallowing or respiratory difficulties and no facial or axial weakness, no ptosis and a full range of eye movements. A muscle biopsy performed at 67 years was reported as showing dystrophic features (muscle biopsy slides not available for review). Genetic investigations for \textit{FKRP}, \textit{VCP} and dystrophin gene mutations and FSHD testing were all negative. Patient 7 presented with exercise intolerance and muscle pain relieved by rest. He occasionally experienced muscle cramps post exertion with muscle rippling. He had mild proximal weakness (MRC 4+/5) with a modified Gowers’ manoeuvre. He walked with a mild wide-based gait with everted flat feet and had mild tightness of the tendon achilles (-5 degrees bilaterally) and a mild lumbar lordosis. Serum lactate, acylcarnitine profile and routine biochemistry were normal. Patient 8 was an elite athlete, but her high level training was complicated by severe exercise-induced myalgia. On examination she had muscle hypertrophy especially marked in the lower limbs without muscle weakness.

Four heterozygous \textit{CAV3} mutations were found: a previously described p.T78M substitution (exon 2, c.233C>T) (Patients 3-6) located in the central hydrophobic transmembrane domain of the protein, and three novel substitutions: p.V14I (exon 1, c.40G>A) (Patients 1 and 2) located in the N-terminal domain of the protein, p.F41S (exon 2, c.122C>T) (Patient 7) and p.F54V (exon 2, c.160T>G) (Patient 8), both within the oligomerization domain.
Muscle biopsies (n=5) showed non-specific changes as seen in Fig 1 (Supplementary Table 1). To investigate the effect of the mutation, caveolin-3 protein expression was assessed by WB in five patients (Patients 1,2,4,7,8). Levels in four patients (Patients 1,2,4,8) were reduced by more than 50% compared to controls (Fig 2). β-dystroglycan, used as a loading control, also had reduced levels in three of the samples (Patients 1,2,4). Caveolin-3 was markedly reduced on muscle tissue sections from Patient 7 and absent on WB on the same tissue (Supplementary Fig 1).

4 Discussion

We present eight patients with myalgia (n=7), exercise intolerance (n=6) and recurrent RM (n=2) who were found to carry mutations in CAV3; a few of them had been screened for selected metabolic myopathies before NGS was performed. The use of NGS is rapidly expanding the phenotypic spectrum of many neuromuscular disease genes, as sequencing of disease genes is done in an unbiased approach, influencing future classification of disease phenotypes and inherited disorders. This case series illustrates that a “metabolic phenotype”, so far more frequently recognized in association with disorders of muscle metabolism (e.g.: glycogen storage disorders and disorders of fatty acid metabolism), may also be part of the phenotypic spectrum of proteins without immediately apparent primary metabolic link such as caveolin-3. As opposed to disorders of muscle metabolism, there was no clear provoking trigger for RM episodes in the reported cases. Patient 1 had no clear trigger for several episodes of RM. It is unclear if exercise, infection or the combination of both contributed to the RM episodes in patient 3, who also developed a third episode with no apparent trigger.

CAV3 encodes caveolin-3, a muscle specific plasma membrane protein involved in several processes related to the formation of caveolae, invaginations of the plasma membrane. Autosomal dominant – and, less frequently, recessive – CAV3 mutations have
been implicated in hyperCKaemia, rippling muscle disease and LGMD1C [2]. Recurrent RM has been previously described in only one patient with a CAV3 mutation, in whom NGS had not been performed to exclude other genetic causes of RM [5]. Our findings suggest that CAV3 mutations are a more frequent cause of myalgia, exertion intolerance and RM than previously thought, and ought to be considered in patients presenting with such features. The pathogenicity of the CAV3 variants identified and emerging genotype-phenotype correlations are supported on several levels: 1) Exclusion of other genetic conditions predisposing to similar symptoms by NGS; 2) the apparent association of CAV3-related symptoms with the recurrent p.V14I and p.T78M substitutions; 3) and reduced caveolin-3 protein levels on WB.

Although myalgia, exercise intolerance and/or recurrent RM were the most prominent features leading to referral for further assessment, other features – hyperCKaemia, reported muscle rippling, PIRCs, muscle weakness and hypertrophic cardiomyopathy – were either noted at presentation or evolved over time, emphasizing the previously observed wide and overlapping phenotypical spectrum associated with CAV3 mutations. Along similar lines, there was also marked intrafamilial variabilty, with one affected son (Patient 5) having a different clinical picture to his father (Patient 6). PIRCs, a clinical hallmark of caveolinopathies, were seen in five out of six patients examined, but were only assessed after the genetic diagnosis had been established in 2 patients (patient 1 and 2). Four out of six patients reported rippling muscle contraction. We believe PIRCs and rippling muscle contraction are important clinical clues for caveolinopathies and should be assessed for in patients presenting with exercise intolerance, myalgia and RM, even if other features suggestive of a caveolinopathy are absent. Additional features in our series, which may or may not be related, included a history of neonatal hypoglycaemic seizures, previously reported in one patient with CAV3 mutations [5], and paroxysmal muscle weakness, a novel association.
Primary protein defects and absence of caveolin-3 staining on immunohistochemistry is well documented in patients with caveolinopathies [2]. The key histopathological finding in patient 7 was marked reduction of immunostaining for caveolin-3; in combination with an absent band on WB, supporting the pathogenicity of the novel p.F41S substitution. Almost complete absence of caveolin-3 on immunoblotting of patient 8 (p.F54V) supported pathogenicity. These variants were absent from or expressed at a low frequency (0.0008%) in ExAC, respectively. The three muscle biopsies from patients harbouring the p.V14I and p.T78M substitutions showed only minor non-specific histochemical findings and normal caveolin-3 immunostaining. However, reduced caveolin-3 levels on WB, supported the pathogenicity of these mutations and suggested that WB may be the more sensitive method to detect caveolin-3 deficiency. Reijneveld et al. also identified normal caveolin-3 immunostaining in two patients with hyperCKaemia, one with the p.T78M substitution [6]. Although these and our own observations indicate sufficient caveolin-3 expression to generate a normal immunostaining pattern, it is currently uncertain if the p.V14I and p.T78M substitutions exert their pathogenic effect through relative reduction or abnormal protein function, or both.

Bioinformatics analysis (Table 2) predicts that p.T78M is damaging and it has been described in association with long QT syndrome and sudden death [7, 8], isolated hyperCKaemia [6], and rippling muscle disease with proximal myopathy in a patient carrying a D4Z4 FSHD-sized allele [9]. Bioinformatic programs also predicted the p.F41S and p.F54V substitutions to be pathogenic, while the p.V14I substitution was predicted to be benign by all programs.

The interaction between caveolin-3 and the skeletal muscle ryanodine receptor (RyR1), involved in excitation-contraction coupling (ECC) and also implicated in virally- and exercise induced myalgia and rhabdomyolysis [10-12], could be of potential relevance to the
phenotype observed in our patients. Both caveolin-3 and RyR1 co-localize at the T-tubule and sarcoplasmic reticulum (SR), and a critical role for caveolin-3 has been suggested in the correct localization of RyR1 to the SR and as a modifier of ECC [13, 14].

The significance of β-dystroglycan reduction in three WB samples is uncertain, even though β-dystroglycan, is a known interactor of caveolins [15, 16]. Myosin heavy chain was also used as a protein loading control, ensuring that this observation is not due to uneven loading of skeletal muscle protein.

A limitation of this study was the inability to perform co-segregation studies in other family members to strengthen the pathogenicity of the CAV3 variants and to evaluate their penetrance. In addition, future more detailed functional characterization may clarify the precise pathogenic effect of the new CAV3 variants and their role in genetic counselling, and additional genetic modifiers with potential synergistic effects may be identified.

5 Conclusions

In summary, myalgia, exertion intolerance and recurrent RM are features associated with CAV3 mutations, highlighting the broad and expanding spectrum of caveolinopathies. Rippling muscle contraction and PIRCs may be important clinical clues indicative of caveolinopathies and should be assessed in patients who present with exertion related symptoms. Non-specific changes in muscle biopsy do not exclude CAV3 mutations, and WB and/or specific genetic testing should be performed if a caveolinopathy is strongly suspected on clinical grounds.

Acknowledgement: We would like to thank NHS England highly specialized services, the Department of Health's NIHR Biomedical Research Centres' funding scheme, the National Health and Medical Research Council of Australia (Early Career Researcher
Fellowship APP1035955 to GR, Research Fellowship APP1002147 to NGL and Project Grant APP1080587) and the Raine Medical Research Foundation for funding and the AGSD(UK) for their support.

References:


Legends:

**Figure 1:** Quadriceps muscle biopsies were available from four patients; patients 1 (I) & 2 (II) were biopsied as adults, while 4 (III) and 7 (IV) were biopsied at 14 years. The adults (Ia, IIa; HE) and one child (IIIa; HE) showed minimal non-specific changes including occasional small fibres. The second child (IVa; HE) showed mild myopathic changes with increased fibre size variation, few small granular basophilic fibres, mild internal nucleation and focal perimysial fatty infiltrate. Fibre typing was preserved in all cases with mild oxidative abnormalities ranging from slight unevenness of stain to presence of a few mini-cores (Ib, IIB, IIB; NADH-TR). Occasional fibres expressed fetal myosin (IIId). Protein immunoanalysis revealed normal sarcolemmal/basal lamina expression of the DAG complex including caveolin-3 (Ic, IIc, IIIc) and beta-dystroglycan (Id, IId) except in patient 7 (IV), where a marked reduction was identifiable in sections (IVc). Caveolin-3 labeling in a non-disease control (IVd). The bar in the bottom right represents 100 microns in length.

**Figure 2:** Western blots showed reduced levels of caveolin-3 and β-dystroglycan (β-DG) in patients with CAV3 mutations (A,B,C). P1: patient 1; P2: patient 2; P4: patient 4; P8: patient 8. Levels of caveolin-3 in patient 8 were calculated to be 0.12 of controls (using the longer exposure blot). Myosin heavy chain (MHC) was used as a protein loading control.
Table 1: Key findings in patients with CAV3 mutations. NA: not applicable; ND: no data; Rippling (reported): rippling muscle contraction reported by the patient; PIRCs: percussion-induced rapid muscle contractions; LL: lower limbs; UL: upper limbs; CK: creatine kinase; ECG: electrocardiogram; NCS-EMG: neurophysiology evaluation; CTS: carpal tunnel syndrome; MRI: magnetic resonance imaging; Family history: Family history for neuromuscular symptoms.

<table>
<thead>
<tr>
<th>Patient 1</th>
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<th>Patient 3</th>
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<th>Patient 5</th>
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<td>V14I</td>
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<td>T78M</td>
<td>T78M</td>
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Family history for neuromuscular symptoms:
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<td>ND</td>
<td>Mild fatty infiltration (rectus femoris, sartorius, biceps femoris, gastrocnemius and semitendinosus muscles)</td>
<td>ND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Affected father (patient 6), mother (enlarged heart), sister (fatigue), son (exercise related myalgia)</td>
<td>Affected son (Patient 5)</td>
<td>Father (difficulty with mobility)</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
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<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>-------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
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<td></td>
</tr>
</tbody>
</table>


Table 2: Frequency of the CAV3 mutations in ExAC and the *in silico* predictions for each substitution.

<table>
<thead>
<tr>
<th>Substitution</th>
<th>Novel</th>
<th>ExAC (%)</th>
<th>MutationTaster</th>
<th>PolyPhen-2</th>
<th>SIFT</th>
<th>Provean</th>
<th>MutationAssessor (Fx impact)</th>
<th>cDNA change</th>
<th>Genomic coordinates</th>
</tr>
</thead>
<tbody>
<tr>
<td>p.V14I</td>
<td>yes</td>
<td>0.0519</td>
<td>Polymorphism</td>
<td>Benign</td>
<td>Tolerated</td>
<td>Neutral</td>
<td>Neutral</td>
<td>c.40G&gt;A</td>
<td>3:8775602 G/A (rs121909281)</td>
</tr>
<tr>
<td>p.F41S</td>
<td>yes</td>
<td>not present</td>
<td>Disease-causing</td>
<td>Probably damaging</td>
<td>Damaging</td>
<td>Medium</td>
<td>Medium</td>
<td>c.122T&gt;C</td>
<td>3:8787215 T/C</td>
</tr>
<tr>
<td>p.F54V</td>
<td>yes</td>
<td>0.0008</td>
<td>Disease-causing</td>
<td>Benign</td>
<td>Tolerated</td>
<td>Deleterious</td>
<td>Medium</td>
<td>c.160T&gt;G</td>
<td>3:8787257 T/G</td>
</tr>
<tr>
<td>p.T78M</td>
<td>no</td>
<td>0.3038</td>
<td>Disease-causing</td>
<td>Probably damaging</td>
<td>Tolerated</td>
<td>Neutral</td>
<td>Low</td>
<td>c.233C&gt;T</td>
<td>3:8787330 C/T (rs172546668)</td>
</tr>
</tbody>
</table>