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A Genome-Wide Association Study of Type 2 Diabetes in Finns Detects Multiple Susceptibility Variants

Laura J. Scott, Karen L. Mohlke, Lori L. Bonnycastle, Cristen J. Willer, Yun Li, William L. Duren, Michael R. Erdos, Heather M. Stringham, Peter S. Chines, Laura J. Scott, Karen L. Mohlke, Lori L. Bonnycastle, Cristen J. Willer, Yun Li, William L. Duren, Michael R. Erdos, Heather M. Stringham, Peter S. Chines,1

Identifying the genetic variants that increase the risk of type 2 diabetes (T2D) in humans has been a formidable challenge. Adopting a genome-wide association strategy, we genotyped 1161 T2D cases and 1258 Finnish NGT controls for 8SNJ, UK. 5Clinical Genetics Department, Royal Devon and Exeter Hospital (Heavitree), Gladstone Road, Exeter, EX1 2ED, UK. 6Department of Clinical Genetics, St. George’s Hospital Medical School, Jenner Wing, Cranmer Terrace, London, SW17 0RE, UK. 7Department of Medical Genetics, St. Mary’s Hospital, Hashtead Road, Manchester, M3 9JH, UK. 8South East of Scotland Clinical Genetics Service, Western General Hospital, Crewe Road, Edinburgh, EH12 9XU, UK. 9Department of Medical Genetics, The Princess Anne Hospital, Cufford Road, Southampton, SO16 5YA, UK. 10Clinical Genetics Unit, Birmingham Women’s Hospital, Metcshley Park Road, Edgbaston, Birmingham, B15 2TG, UK. 11Yorkshire Regional Genetic Service, Department of Clinical Genetics, Cancer Genetics Building, St. James University Hospital, Beckett Street, Leeds, LS9 7TF, UK. 12Department of Clinical Genetics, Leicester Royal Infirmary, Leicester, LE1 5WW, UK. 13Department of Clinical Genetics, St. Michael’s Hospital, Southwest Street, Bristol, BS2 8EG, UK. 14Institute of Human Genetics, International Centre for Life, Central Parkway, Newcastle upon Tyne, NE1 3BZ, UK. 15Institute of Medical Genetics, University Hospital of Wales, Heath Park, Cardiff, CF14 4XW, UK. 16Department of Clinical Genetics, Alder Hey Children’s Hospital, Eaton Road, Liverpool L12 2AP, UK. 17Clinical Genetics Centre, Argyll House, Foresthill, Aberdeen, AB25 2ZR, UK. 18Clinical Genetics, 7th Floor New Guy’s House, Guy’s Hospital, St. Thomas Street, London, SE1 9RT, UK. 19Clinical Genetics Service, Belfast City Hospital Trust, Belfast City Hospital, Lisburn Road, Belfast, BT9 7AB, UK. 20Clinical and Medical Genetics Unit, Institute of Child Health, 3D Guildford Street, London, WC1N 3EB, UK. 21Department of Clinical Genetics, Addenbrooke’s NHS Trust, Box 134, Hills Road, Cambridge, CB2 2QK, UK. 22Department of Clinical Genetics, Moston Lodge, Countess of Chester Hospital, Liverpool Road, Chester, CH2 1UL, UK. 23Department of Clinical Genetics, Churchill Hospital, Old Road, Headington, Oxford OX3 7JL, UK.

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A Genome-Wide Association Study of Type 2 Diabetes in Finns Detects Multiple Susceptibility Variants


Identifying the genetic variants that increase the risk of type 2 diabetes (T2D) in humans has been a formidable challenge. Adopting a genome-wide association strategy, we genotyped 1161 Finnish T2D cases and 1174 Finnish normal glucose-tolerant (NGT) controls with >315,000 single-nucleotide polymorphisms (SNPs) and imputed genotypes for an additional >2 million autosomal SNPs. We carried out association analysis with these SNPs to identify genetic variants that predispose to T2D, compared our T2D association results with the results of two similar studies, and genotyped 80 SNPs in an additional 1215 Finnish T2D cases and 1258 Finnish NGT controls. We identify T2D-associated variants in an intergenic region of chromosome 11p12, contribute to the identification of T2D-associated variants near the genes IGF2BP2 and CDKAL1 and the region of CSDK2A and CSDK2B, and confirm that variants near TCF7L2, SLC30A8, HHEX, FTO, PPARG, and KCNJ11 are associated with T2D risk. This brings the number of T2D loci now confidently identified to at least 10.

Type 2 diabetes (T2D) is a disease characterized by insulin resistance and impaired pancreatic beta-cell function that affects >170 million people worldwide (1). With first-degree relatives having ~3.5 times as much risk as compared to individuals in the general middle-aged population (2), hereditary factors, together with lifestyle and behavioral factors, play an important role in determining T2D risk (3). To date, intense efforts to identify genetic risk factors in T2D have met with only limited success. This study, reports from our collaborators (4–6), and the recently published work of Sladek et al. (7) describe results of genome-wide association (GWA) studies that further define the genetic architecture of T2D and identify biological pathways involved in T2D pathogenesis.

We genotyped 1161 Finnish T2D cases and 1174 Finnish NGT controls on 317,503 SNPs on the Illumina HumanHap300 BeadChip in stage 1 of a two-stage GWA study of T2D (8). These samples are from the Finland–United States Investigation of Non–Insulin-Dependent Diabetes Mellitus Genetics (FUSION) (9, 10) and Finnrisk 2002 (11) studies (tables S1 and S2A). Among the 317,503 GWA SNPs, 315,635 had >10 copies of the less common allele [minor allele frequency (MAF) > 0.002] and passed quality-control crite-
### Table 1. Confirmed T2D susceptibility loci based on all available data from the FUSION, DGI, and WTCCC/UKT2D samples.

<table>
<thead>
<tr>
<th>FUSION</th>
<th>Chr (bp)</th>
<th>Genes</th>
<th>Risk allele / nonrisk allele</th>
<th>FUSION Stage 1 + 2 control risk allele freq.</th>
<th>FUSION stage 1</th>
<th>FUSION stage 2</th>
<th>FUSION stage 1 + 2</th>
<th>DGI All Data</th>
<th>WTCCC/UKT2D All Data</th>
<th>FUSION-DGI-WTCCC/UKT2D All Data</th>
<th>Total sample size for 80% power **</th>
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<td>1.28</td>
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<td>1.17</td>
<td>1.11</td>
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<td>1.22</td>
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<td>1.18</td>
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<td>1.17</td>
<td>1.14</td>
<td>0.17 ) 6.7×10^{-11}</td>
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Total sample size 2,335 2,473 4,808 13,781 13,965 32,544

Number of cases/controls 1,161/1,174 1,215/1,258 2,376/2,432 6,529/7,252 5,681/8,284 14,586/17,968

* rs10946398 WTCCC/UKT2D $\chi^2 = 1$. **Multispecies tag for rs9300039 DGI and rs1534823 WTCCC/UKT2D $\chi^2 = 0.965)$. § DGI GWA samples. **Approximate total sample size for 80% power to detect T2D SNP association at significance level 0.05 is based on the FUSION control risk allele frequency and the risk ratio calculated from FUSION-DGI-WTCCC/UKT2D all-data analyses, assuming 0.10 T2D prevalence. The sample sizes vary slightly from those of (4) because study-specific allele frequencies were used in the calculations.
western Europe) (CEU) samples to predict genotypes of autosomal SNPs not genotyped in our subjects. A total of 2.09 million HapMap CEU SNPs (14) had imputed MAF >1% in FUSION and passed our imputation quality-control criteria. In the HapMap CEU sample, imputed SNPs passing these criteria increased coverage of SNPs with MAF >1% from 71.9 to 89.1% at an $r^2$ threshold of 0.8.

To increase the statistical power to detect T2D predisposing variants, we compared our stage 1 results to GWA results from the Diabetes Genetics Initiative (DGI) and the Wellcome Trust Case Control Consortium (WTCCC). We selected 82 SNPs for FUSION stage 2 follow-up genotyping based on evidence from: (i) FUSION-genotyped and FUSION-imputed SNPs; (ii) a combined analysis of GWA results from FUSION, DGI, and WTCCC; and (iii) previous T2D association results. For (i) and (ii), we used a prioritization algorithm that advantaged SNPs based on genome annotation (8) (table S7) and gave preference to genotyped SNPs over nearby imputed SNPs. We successfully genotyped 80 of the 82 SNPs in our stage 2 sample of 1215 Finnish T2D cases and 1258 Finnish NGT controls (8) (table S2B) and carried out joint analysis of the combined FUSION stage 1 + 2 sample (table S5). DGI (4) and United Kingdom T2D Genetics Consortium (UKT2D) (5) investigators also followed up DGI and WTCCC GWAs by genotyping replication samples.

We confirmed well-established T2D associations with TCF7L2, PPARG, and KCNJ11 (Table 1) (15–18). SNPs in TCF7L2 reached genome-wide significance in the FUSION stage 1 + 2 sample [odds ratio (OR) = 1.34, $P = 1.3 \times 10^{-8}$] and in the FUSION-DGI-WTCCC/UKT2D “all-data” (i.e., all GWA and follow-up samples) meta-analysis (OR = 1.37, $P = 1.0 \times 10^{-8}$) (Table 1 and table S5). PPARG Pro$^{12}$→Ala$^{12}$ (rs1801282) and KCNJ11 Glu$^{23}$→Lys$^{23}$ (rs5219) were not genotyped in the FUSION GWA, but nearby SNPs showed some evidence for T2D association, as did the imputed genotypes for the coding variants. All-data meta-analysis resulted in genome-wide significant T2D association with KCNJ11 Glu$^{23}$→Lys$^{23}$ (OR = 1.14, $P = 6.7 \times 10^{-11}$) and strong evidence for PPARG Pro$^{12}$→Ala$^{12}$ (OR = 1.14, $P = 1.7 \times 10^{-6}$). The PPARG and KCNJ11 results emphasize the value of combining data across studies and suggest that other T2D-associated loci remain to be found.

The combined samples from the three studies provide evidence for seven additional T2D loci. For the first three of these loci, we had strong evidence in the FUSION stage 1 GWA data and, for the latter four, our FUSION stage 1 evidence was more modest.

A cluster of variants in the IGF2BP2 (insulin-like growth factor 2 mRNA binding protein 2) region was associated with T2D in our stage 1 sample (e.g., rs1470579 with OR = 1.27, $P = 1.6 \times 10^{-8}$) (Fig. 1A). The all-data meta-analysis for rs4402960 resulted in genome-wide significance (OR = 1.14, $P = 8.9 \times 10^{-16}$). Including the rs4402960 genotype as a covariate essentially eliminates evidence for T2D association for other variants in the cluster (Fig. 1A), which is consistent with all SNPs representing the same T2D-predisposing variant(s). IGF2BP2 is a paralog of IGF2BP1, which binds to the 5′ untranslated region of the insulin-like growth factor 2 (IGF2) mRNA and regulates IGF2 translation (19). IGF2 is a member of the insulin family of polypeptide growth factors involved in the development, growth, and stimulation of

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Fig. 1. Plots of T2D association and LD in FUSION stage 1 samples for regions surrounding IGF2BP2 (A) and rs9300039 (B). (A) and (B) each contain six panels. The top panels display RefSeq genes; there are none in the rs9300039 region. The second panels (i.e., directly below the top panels) show the T2D association in log$_{10} P$ values in FUSION stage 1 samples for SNPs genotyped in the GWA panel (closed blue circles) or imputed (open blue circles). The third panels show T2D association in log$_{10} P$ values for each SNP in a logistic regression model correcting for the reference SNP [indicated by the red circle for rs4402960 in (A) and for rs9300039 in (B)]. SNP rs74800010, reported by Sladek et al. (7), is also labeled in the rs9300039 plot (B) (green circle). A decrease in the $-\log_{10} P$ value from the second to the third panels indicates that the association signal of the tested SNPs can be explained, at least in part, by the reference SNP. In both regions, the reference SNP was chosen for convenience; the choice of another strongly associated SNP nearby would have resulted in a similar picture. The fourth panels show recombination rate in centimorgans per megabase for the HapMap CEU sample (14). The fifth and sixth panels show LD $r^2$ and $D'$ based on FUSION stage 1–genotyped and FUSION stage 1–imputed data.
SLC30A8 transports zinc from the cytoplasm into insulin granules, affecting insulin stability, storage, or secretion. In high-glucose conditions, overexpression of SLC30A8 in insulinoma (INS-1E) cells enhanced glucose-induced insulin secretion.

SNP rs13266634, a nonsynonymous Arg125→Trp125 variant in the pancreatic beta-cell–specific zinc transporter SLC30A8 (20), showed (through our annotation-based algorithm) evidence for T2D association in stage 1 (Table 1 and fig. S2). Modest evidence in stage 2 resulted in stronger evidence in our stage 1 + 2 sample (OR = 1.18, \( P = 7.0 \times 10^{-5} \)) (Table 1 and table S5). Subsequent DGI and UKT2D genotyping resulted in strong evidence in the combined samples (OR = 1.12, \( P = 5.3 \times 10^{-8} \)). Sladek et al. (7) recently reported independent T2D association evidence with the same allele in two French samples (\( P = 1.8 \times 10^{-5} \) and \( P = 5.0 \times 10^{-5} \)). SLC30A8 transports zinc from the cytoplasm into insulin secretory vesicles (20, 21), where insulin is stored as a hexamer bound with two \( \text{Zn}^{2+} \) ions before secretion (22). Variation in SLC30A8 may affect zinc accumulation in insulin granules, affecting insulin stability, storage, or secretion. In high-glucose conditions, overexpression of SLC30A8 in insulinoma (INS-1E) cells enhanced glucose-induced insulin secretion.

SNP rs9300039 in an intergenic region on chromosome 11 showed evidence for T2D association in stage 1 (Table 1 and Fig. 1B); genotyping our stage 2 sample resulted in near genome-wide significance in our stage 1 + 2 sample (OR = 1.48, \( P = 5.7 \times 10^{-8} \)) (Table 1 and tables S3 and S5). In the WTCCC and DGI scans, the nearby SNP rs1514823 (\( r^2 = 0.97 \) with rs9300039) provided weak evidence for T2D association with the appropriate allele; combining results across all three studies gave OR = 1.25 and \( P = 4.3 \times 10^{-7} \). Fifty-six imputed SNPs and two more genotyped SNPs spanning 219 kb are in LD with rs9300039 and show substantial evidence for T2D association (\( P < 10^{-8} \)) in our stage 1 sample (table S3 and Fig. 1B). Including the genotype for rs9300039 as a covariate essentially eliminates evidence for T2D association with the remaining SNPs (Fig. 1B). This region includes three sets of spliced Expresssed Sequence Tags but no annotated genes. The identification of a T2D-associated variant >1 Mb from the nearest annotated gene highlights the value of a genome-wide approach. Sladek et al. (7) reported strongly associated SNPs in two nearby regions on chromosome 11. SNP rs7480010 near hypothetical gene LOC387761 is 331 kb centromeric to rs9300039. LD between rs9300039 and rs7480010 is essentially zero (\( r^2 = 0.00063 \) and \( D' = 0.036 \)), and rs7480010 showed little evidence for association in our stage 1 + 2 sample (OR = 1.03, \( P = 0.54 \)). Sladek et al. (7) also reported T2D association with three intronic variants of EXT2, located -2.4 Mb centromeric of rs9300039; we found no evidence for association with EXT2 SNPs.

SNP rs4712523, located within intron 5 of CDKAL1, showed modest evidence for T2D association in our FUSION stage 1 sample, which strengthened slightly in our combined stage 1 + 2 sample (OR = 1.12, \( P = 0.0073 \)) (table S5). Nearby SNPs in strong LD with rs4712523 including rs7754840 showed modest evidence for T2D association in the DGI scan and considerably stronger evidence in the WTCCC scan. Including strong DGI and UKT2D replication data resulted in genome-wide significance (OR = 1.12, \( P = 4.1 \times 10^{-11} \)) for rs7754840 in the all-data meta-analysis (Table 1). CDKAL1 (cyclin-dependent kinase 5 (CDK5) regulatory subunit associated protein–like 1) shares protein domain similarity with CDK5 regulatory subunit–associated protein 1 (CDK5RAP1), which specifically inhibits activation of CDK5 by CDK5 regulatory subunit 1 (CDK5R1) (23). Using quantitative reverse transcription polymerase chain reaction analysis of a panel of RNA samples from human tissues and cells, we detected the highest expression of CDKAL1 in skeletal muscle and brain cells, as well as in 293T and HepG2 cells (fig. S3A). The associated SNPs within intron 5, or SNPs in LD with them, may regulate expression of CDKAL1 and so affect the expression of CDK5. CDK5 and CDK5R1 activity is influenced by glucose and may influence beta-cell processes (24, 25); overactivity of CDK5 in the pancreas may lead to beta-cell degeneration, especially under glucotoxic conditions (26).

SNP rs10811661 near cyclin-dependent kinase inhibitors CDKN2A and CDKN2B showed modest evidence for T2D association in our stage 1 + 2 sample (OR = 1.20, \( P = 0.0022 \)) (Table 1 and table S5) and showed genome-wide significance in the all-data meta-analysis (OR = 1.20, \( P = 7.8 \times 10^{-15} \)). SNP rs10811661 is located upstream of CDKN2A and CDKN2B, may have a long-range effect on one of these genes, or may influence a gene not yet annotated. CDKN2A and CDKN2B inhibit the activity of CDK4 and CDK6. In mice, Cd4 activity has been shown to influence beta-cell proliferation and mass, with loss of Cd4 leading to diabetes (27, 28). We find CDKN2A to be expressed at high levels in islets, adipocytes, brain, and pancreas and at even higher levels in 293T, HeLa, and HepG2 cells (fig. S3B); CDKN2B is expressed in islets and adipocytes and, to a lesser degree, in small intestine, colon, 293T, and HepG2 cells (fig. S3C). CDKN2A and CDKN2B are also tumor suppressor genes and may play a role in aging (29).

SNPs rs1111875 and rs7923837 showed modest evidence of T2D association in the FUSION and DGI scans, much stronger evidence in the WTCCC scan, and genome-wide significant evidence (OR = 1.13, \( P = 5.7 \times 10^{-10} \)) for rs1111875 in the all-data meta-analysis. These SNPs are in LD (\( r^2 = 0.70 \)) in a region that includes HHEX (hematopoietically expressed homeobox), which is critical for development of the ventral pancreas (30), the insulin-degrading enzyme gene IDE, and the kinesin-interacting factor 11 gene KIF11. Sladek et al. (7) recently reported independent genome-wide significant evidence for T2D association with these SNPs.

The WTCCC/UKT2D groups identified evidence for T2D and body mass index (BMI) associations with a set of SNPs including rs8050136 in the FTO region; the T2D association appears to be mediated through a primary effect on adiposity (5, 6, 31). We observed modest evidence for association with T2D in the combined FUSION stage 1 + 2 sample (OR = 1.11, \( P = 0.016 \)) (Table 1 and table S5). T2D can be a component of a larger syndrome of metabolic abnormalities, and we were interested to assess the effects of T2D-related traits on our association results. We repeated our T2D association analysis for the 10 SNPs in Table 1 with one of several variables included as an additional covariate. Adjustment for BMI strengthened T2D association with TCF7L2 and SLC5A8, weakened association with rs9300039 and FTO, and had little effect on the other loci. The effect of waist circumference was similar to that of BMI; blood pressure variables had essentially no effect.

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**Fig. 2.** Prediction of T2D risk in the FUSION sample with the use of 10 T2D susceptibility variants. T2D cases and NGT controls with complete genotype data were included in the analysis. To obtain a sample with a T2D prevalence of ~10%, we included nine copies of each of 2176 NGT controls and one copy of each of 2102 T2D cases. The predicted risk for each individual was estimated from a logistic regression model containing the 10 risk variants listed in Table 1. The proportion of T2D cases is shown as a horizontal line. The proportion of T2D cases increases from ~5% in the lowest to 20% in the highest predicted risk categories.
Complex I Binding by a Virally Encoded RNA Regulates Mitochondria-Induced Cell Death

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Human cytomegalovirus infection perturbs multiple cellular processes that could promote the release of proapoptotic stimuli. Consequently, it encodes mechanisms to prevent cell death during infection. Using rotenone, a potent inhibitor of the mitochondrial enzyme complex I (reduced nicotinamide adenine dinucleotide–ubiquinone oxido-reductase), we found that human cytomegalovirus infection protected cells from rotenone-induced apoptosis, a protection mediated by a 2.7-kilobase virally encoded RNA (β2.7). During infection, β2.7 RNA interacted with complex I and prevented the relocation of the essential subunit genes associated with retinoid/interferon–induced mortality–19, in response to apoptotic stimuli. This interaction, which is important for stabilizing the mitochondrial membrane potential, resulted in continued adenosine triphosphate production, which is critical for the successful completion of the virus’ life cycle. Complex I targeting by a viral RNA represents a refined strategy to modulate the metabolic viability of the infected host cell.

D uring primary infection or reactivation of human cytomegalovirus (HCMV), especially in the immunocompromised, the virus is able to replicate in a number of cell types, often resulting in life-threatening disease (1). HCMV exhibits a relatively protracted life cycle (upwards of 5 days) and at early times of infection (12 to 24 hours) encodes a highly abundant 2.7-kb RNA transcript (β2.7), accounting for >20% of total viral gene transcription (2, 3) of unknown function. The RNA may be associated with mitochondria (4), and no protein product of this RNA has ever been detected in infected cells (3), suggesting that it functions as a noncoding RNA (5).

We investigated the possibility that β2.7 could function as a noncoding RNA. A

References and Notes
8. Materials and methods are available as supporting material on Science Online.
13. L. F. Scheet, J. Ding, G. R. Abecasis, submitted for publication; manuscript available from G.R.A. (e-mail: gonzalo@umich.edu).
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Supporting Online Material
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Author Contributions
Materials and Methods
Figs. S1 to S3
Tables S1 to S7
References
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