Featured Article

A 22-single nucleotide polymorphism Alzheimer’s disease risk score correlates with family history, onset age, and cerebrospinal fluid Aβ42

Kristel Sleegers a,b,*,1, Karolien Bettens a,b,1, Arne De Roeck a,b, Caroline Van Cauwenberghe a,b, Elise Cuyvers a,b, Jan Verheijen a,b, Hanne Struyfs b, Jasper Van Dongen a,b, Steven Vermeulen a,b, Sebastiaan Engelborghs b,c, Mathieu Vandenbulcke d, Rik Vandenberghe e, Peter Paul De Deyn b,c,f, Christine Van Broeckhoven a,b,*, on behalf of the BELNEU consortium

aNeurodegenerative Brain Diseases Group, Department of Molecular Genetics, VIB, Antwerp, Belgium
bInstitute Born-Bunge, University of Antwerp, Antwerp, Belgium
cDepartment of Neurology and Memory Clinic, Hospital Network Antwerp Middelheim and Hoge Beuken, Antwerp, Belgium
dDepartment of Old Age Psychiatry and Memory Clinic, University of Leuven and University Hospitals Leuven Gasthuisberg, Leuven, Belgium
eLaboratory for Cognitive Neurology, Department of Neurology, University of Leuven and University Hospitals Leuven Gasthuisberg, Leuven, Belgium
fDepartment of Neurology and Alzheimer Research Center, University of Groningen, University Medical Center Groningen, Groningen, The Netherlands

Abstract

Introduction: The ability to identify individuals at increased genetic risk for Alzheimer’s disease (AD) may streamline biomarker and drug trials and aid clinical and personal decision making. Methods: We evaluated the discriminative ability of a genetic risk score (GRS) covering 22 published genetic risk loci for AD in 1162 Flanders-Belgian AD patients and 1019 controls and assessed correlations with family history, onset age, and cerebrospinal fluid (CSF) biomarkers (Aβ1–42, T-tau, P-tau181P). Results: A GRS including all single nucleotide polymorphisms (SNPs) and age-specific APOE ε4 weights reached area under the curve (AUC) 0.70, which increased to AUC 0.78 for patients with familial predisposition. Risk of AD increased with GRS (odds ratio, 2.32 (95% confidence interval 2.08–2.58 per unit; \( P = 1.0 \times 10^{-15} \)). Onset age and CSF Aβ1–42 decreased with increasing GRS (\( P_{\text{onset age}} = 9.0 \times 10^{-11} \); \( P_{\text{Aβ}} = 8.9 \times 10^{-7} \)). Discussion: The discriminative ability of this 22-SNP GRS is still limited, but these data illustrate that incorporation of age-specific weights improves discriminative ability. GRS-phenotype correlations highlight the feasibility of identifying individuals at highest susceptibility.

Keywords: Alzheimer’s disease; Genetic risk profile; Genotype-phenotype correlation; CSF Aβ1–42; Onset age; Family history

1. Introduction

Alzheimer’s disease (AD) is an incapacitating, incurable disease characterized by a progressive loss of cognitive functions. It has a long disease course and ultimately requires fulltime medical care. Aside from drugs that temporarily relieve symptoms, no treatment exists for AD. With the growing proportion of people >65 years, and the high costs associated with care for AD patients, the future impact of AD on society and public health is of great concern. Projection models demonstrate that even therapies with a modest effect could decrease the number of AD patients by millions [1]. AD has a long prodromal phase [2], necessitating preclinical therapeutic intervention to successfully avert the pathologic process before widespread neurodegeneration. However, knowledge of the pathophysiological processes during this prodromal phase, and hence the ability to accurately recognize or detect it, is still limited. Owing to technological progress and global collaborative research in the field of AD...
genetics (e.g. the International Genomics of Alzheimer’s Project [IGAP]), our understanding of the genetic foundations of AD is rapidly expanding. Genome-wide association studies (GWAS) have resulted in the identification of 20 novel genetic risk loci in addition to AP0E ε4 [3–8], which have been associated with a range of biological processes including lipid metabolism, immune response, and synaptic processes. The clinical utility of these findings for today’s patients, e.g. in risk prediction, is still limited. Most of these risk factors exert only minor effects on susceptibility to AD. Combination of single single nucleotide polymorphisms (SNPs) into a genetic risk score (GRS) has been proposed to improve predictive ability, but in the absence of therapeutic consequences, the clinical application of such a score will be restricted. Nevertheless, there may already be a significant purpose for genetic risk profiling. AD is a multifactorial and heterogeneous condition. Genetic risk profiling can be used for individual molecular subclassification, by determining the pathways enriched for risk alleles within an individual. This may increase the efficiency and outcome of clinical trials and biomarker studies. In the long run, genetic risk profiling could enable tailored treatment of each individual with clinical AD. In addition, if genetic risk profiles are predictive of specific clinical characteristics such as onset age or speed of progression, this may aid decision making at the clinical and personal level. For example, a high score on an 8-SNP weighted genetic risk score (wGRSs) has been associated with a two times more rapid progression from mild cognitive impairment to AD [9].

We investigated the predictive ability of a GRS combining AP0E ε2/ε3/ε4 with the 20 most significant SNPs (CLU, PICALM, CR1, ABCA7, MS4A6A, BIN1, CD2AP, CD33, EPHA1, HLA-DRB5, PTK2B, SORL1, SC24A4-RIN3, INPP5D, MEF2C, NME8, ZCWPW1, CELF1, FERMT2, and CASS4 loci) identified in recent GWAS and IGAP as well as a rare variant in TREM2 (p.R47H), which increases risk of AD nearly fourfold [10–12] on a large, well-characterized Flanders-Belgian AD study population, part of which was previously included in the replication phase of GWAS [3–6]. Our aim was twofold. First, we aimed to determine the best discriminating model. Second, we investigated to which extent this model can define subgroups with shared phenotypic characteristics (familial disease history, age at onset, and three cerebrospinal fluid [CSF] biomarkers amyloid-β [Aβ1–42], total tau (T-tau), and tau phosphorylated at threonine 181 [P-tau181P]), which may have additional value in clinical practice or drug or biomarker development.

2. Methods

2.1. Study population

The Flanders-Belgian patient group consisted of 1328 AD patients (mean age of onset 74.4 ± 8.9 years, % female = 63.0), of which the majority was ascertained at the Memory Clinic of the ZNA Middelheim and Hoge Beuken, Antwerp, Belgium (S.E. and P.P.D.D.) in the frame of a prospective study of neurodegenerative and vascular dementia in Flanders, the Dutch-speaking region of Belgium [13,14]. Another subset of patients was collected at the Memory Clinic of the University Hospitals of Leuven (UHL), Gashuisberg, Leuven, Belgium (M.V. and R.V.) as part of a prospective study on the molecular genetics of cognitive impairment which was initiated in October 2006 using the same clinical assessments and biosampling schemes. Each patient underwent a neuropsychological examination and structural and/or functional neuroimaging [15].

For a subset of patients (n = 338; mean age at onset 76.2 ± 8.5 years, 63% = women), CSF levels of Aβ1–42, T-tau, and P-tau181P were available as part of the diagnostic work-up, determined with commercially available single parameter ELISA kits (Fujirebio Europe, Ghent, Belgium).

The control group (n = 1123, mean age at inclusion 64.9 ± 13.7 years, 56% = women) consisted of healthy unrelated individuals, without neurologic or psychiatric antecedents or neurologic complaints or without organic disease involving the central nervous system. Control individuals were examined at the Memory Clinic of ZNA Middelheim and Hoge Beuken, Antwerpen, Belgium and at the memory clinic at the University Hospitals of Leuven, Gashuisberg, Leuven, Belgium. Additional community control individuals were included after interview concerning medical and family history. Memory impairment was assessed in all AD patients and control individuals by mini mental state examination (MMSE) (control cohort MMSE > 26; Folstein et al.). Patients and control individuals originated from the same geographical area (Flanders-Belgium). There is no evidence of population substructure (Supplementary Fig. 1). Part of the Flanders-Belgian Alzheimer (n = 878) and control (n = 661) population was included in the replication phase of the IGAP [6].

2.2. Ethical assurances

All participants and/or their legal guardian gave written informed consent for participation in clinical and genetic studies. Clinical study protocol and the informed consent forms were approved by the Ethics Committee of the respective hospitals at the cohort sampling sites in Flanders-Belgium. The genetic study protocols and informed consent forms were approved by the Ethics Committees of the University of Antwerp and the University Hospital of Antwerp, Belgium and the University Hospitals of Leuven, Belgium. After informed consent, blood samples of patients and control individuals were collected for genetic studies.

2.3. Genotyping

We selected 22 polymorphisms to construct a GRS. This included AP0E ε2/ε3/ε4, TREM2 p.R47H, and 20 SNPs at the AD risk loci identified in recent GWAS. At each locus,
we selected the most significant SNP from the GWAS in which each locus was first reported. Genotype data were available from previous studies for APOE ε2/ε3/ε4, TREM2 p.R47H [10], CLU rs11136000 [16], CR1 rs3818361 [17,18], and BIN1 rs744373 [19] on the full cohort, and for PICALM rs3851179, CD33 rs3865444, CD2AP rs9349407, ABCA7 rs3764650, MS4A6A rs610932, EPHA1 rs11767557, HLA-DRB5 rs9271192, PTK2B rs28834970, SORL1 rs11218343, SLCA4A4-RIN3 rs10498633, INPP5D rs35349669, MEF2C rs190982, NME8 rs2718058, ZCWPW1 rs1476679, CELF1 rs10837825, FERMT2 rs17125944, and CASS4 rs7274581 on part of the cohort (n = 878 patients, n = 661 control individuals) [6]. Additional genotyping to generate genotype data for the full cohort was for most SNPs performed by MassARRAY using iPLEX Gold chemistry (Sequenom, Hamburg, Germany), followed by MALDI-TOF mass spectrometry. Polymerase chain reaction and extension primers were designed using MassARRAY AssayDesign software v3.0.2.0. Genotypes were called automatically using MassARRAY Typer software v4.0 and were visually inspected by two researchers blinded for disease outcome. SNPs in PICALM, EPHA1, HLA-DRB5, SORL1, ZCWPW1, and CELF1 were genotyped by Sanger sequencing. Primers for these SNPs were designed with Primer-BLAST, and sequences were analyzed by two independent researchers using SeqMan or novoSNP [20]. Interplate controls showed 100% concordance for all SNPs. All selected SNPs had a minor allele frequency >5% and were in Hardy-Weinberg equilibrium in the control population (P > .001). Inhouse genotyping and IGAP data showed 99.5% concordance. An average genotyping success rate of 93.1% was obtained over the 22 susceptibility genes.

2.4. Statistical analyses

2.4.1. Single SNP analyses

Allele frequencies of AD patients and control individuals were compared using χ² statistics. Odds ratios (OR) (calculated relative to the common genotype) and 95% confidence intervals (CIs) were corrected for gender, APOE ε4 genotype (presence of one or two APOE ε4 alleles vs. the absence of any APOE ε4 allele), and age at onset (age at inclusion for control individuals) using a logistic regression model. Single SNP analyses were performed using SPSS 20.0 version for Windows (IBM SPSS Inc, Chicago, IL).

2.4.2. Genetic risk scores

Different GRSs were composed (Table 1). A counted genetic risk score (cGRS) was derived by taking the sum of risk alleles per individual (ModelALL-C). To account for the strength of the genetic association of each allele, wGRSs were derived by multiplying the number of risk alleles for each SNP with the natural logarithm of their respective OR (lnOR; based on discovery ORs [4,6,7,11] [Table 2]) and taking the sum of these products per sample. Two wGRSs were created, differing in how information about APOE ε4 was incorporated. In the first scenario, the contribution of APOE to the GRS was weighted by the simple effect estimate of APOE ε4 on an independent AD GWAS cohort of European ancestry (ModelALL-WS) [3]. In the second scenario, weighting of APOE ε4 was based on age-specific ORs for different APOE ε4/3/4 genotypes as described by Genin et al. [21] to approximate the known association between APOE ε4 and onset age (ModelALL-WA).

Table 1

<table>
<thead>
<tr>
<th>Model</th>
<th>Algorithm</th>
<th>Number of SNPs</th>
<th>APOE included</th>
<th>APOE weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOE-S</td>
<td>wGRS</td>
<td>1</td>
<td>+</td>
<td>Standard</td>
</tr>
<tr>
<td>APOE-A</td>
<td>wGRS</td>
<td>1</td>
<td>+</td>
<td>Age-related</td>
</tr>
<tr>
<td>ALL-C</td>
<td>cGRS</td>
<td>22</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>ALL-WS</td>
<td>wGRS</td>
<td>22</td>
<td>+</td>
<td>Standard</td>
</tr>
<tr>
<td>ALL-WA</td>
<td>wGRS</td>
<td>22</td>
<td>+</td>
<td>Age-related</td>
</tr>
<tr>
<td>OTH-W</td>
<td>wGRS</td>
<td>21</td>
<td>-</td>
<td>NA</td>
</tr>
</tbody>
</table>

Abbreviations: GRS, genetic risk score; SNPs, single nucleotide polymorphisms; wGRS, weighted genetic risk score; NA, not applicable.

After removing individuals with five or more missing genotypes (166 patients and 104 control individuals), a SNP score for missing genotypes was imputed by the product of lnOR and the expected probability of having a risk allele (briefly: 0 × (1−q)² + 1 × 2 (1−q) q + 2 × q² = 2q, where q equals the risk allele frequency). The final data set available for GRS analyses comprised 1162 patients and 1019 control individuals. To predict the discriminative ability of the cGRS and wGRS for AD, receiver operating characteristic (ROC) curves were generated with pROC in R [22] by plotting the true positive rate against the false positive rate and calculating the area under the curve (AUC). Statistical comparison of ROC curves for different models was performed with bootstrap analysis in a paired or nonpaired approach, depending on the comparison of GRS within or between groups. Stratification analyses were performed for APOE and for familial history. For APOE stratification, GRSs without APOE ε4 (ModelOTH-W) were compared between APOE ε4 noncarriers and individuals carrying one or two APOE ε4 alleles. For familial history stratification, GRSs were compared between familial (FAD) and sporadic AD (SAD) patients (ModelALL-WA and ModelOTH-W). Known pathogenic mutation carriers in APP, C9orf72, PSEN1, PSEN2, and GRN were excluded (n = 16).

The relationship between the best GRS model (ModelALL-WA) and risk of AD, FAD, and SAD was modeled using logistic regression in R, using GRS as a continuous predictor. In addition, individuals were partitioned into five quantiles (quintiles) based on ModelALL-WA (with cutoffs...
<table>
<thead>
<tr>
<th>Gene</th>
<th>SNP</th>
<th>Published OR</th>
<th>Minor allele</th>
<th>Risk allele</th>
<th>Controls</th>
<th>Patients</th>
<th>P value</th>
<th>OR (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOE [3]</td>
<td>rs7412, rs429358</td>
<td>2.53</td>
<td>ε4</td>
<td>ε4</td>
<td>0.14</td>
<td>0.32</td>
<td>1.06⁻⁷</td>
<td>3.23 (2.74–3.82)</td>
<td>1.06⁻⁷</td>
</tr>
<tr>
<td>CR1 [4]</td>
<td>rs3818361</td>
<td>1.21</td>
<td>A</td>
<td>A</td>
<td>0.19</td>
<td>0.22</td>
<td>.007</td>
<td>1.15 (0.97–1.36)</td>
<td>.1</td>
</tr>
<tr>
<td>BIN1 [4]</td>
<td>rs744373</td>
<td>1.17</td>
<td>G</td>
<td>G</td>
<td>0.30</td>
<td>0.31</td>
<td>.5</td>
<td>1.24 (1.07–1.45)</td>
<td>.005</td>
</tr>
<tr>
<td>CD2AP [7]</td>
<td>rs9349407</td>
<td>1.14</td>
<td>C</td>
<td>C</td>
<td>0.28</td>
<td>0.30</td>
<td>.2</td>
<td>1.10 (0.95–1.28)</td>
<td>.2</td>
</tr>
<tr>
<td>ABCA7 [4]</td>
<td>rs3764650</td>
<td>1.22</td>
<td>G</td>
<td>G</td>
<td>0.09</td>
<td>0.11</td>
<td>.005</td>
<td>1.37 (1.09–1.72)</td>
<td>.007</td>
</tr>
<tr>
<td>HLA-DRB5 [6]</td>
<td>rs2971192</td>
<td>1.11</td>
<td>C</td>
<td>C</td>
<td>0.26</td>
<td>0.30</td>
<td>.02</td>
<td>1.13 (0.96–1.33)</td>
<td>.1</td>
</tr>
<tr>
<td>PTK2B [6]</td>
<td>rs28834970</td>
<td>1.10</td>
<td>C</td>
<td>C</td>
<td>0.36</td>
<td>0.39</td>
<td>.07</td>
<td>1.08 (0.93–1.26)</td>
<td>.3</td>
</tr>
<tr>
<td>INPP5D [6]</td>
<td>rs2718058</td>
<td>1.07</td>
<td>T</td>
<td>T</td>
<td>0.47</td>
<td>0.48</td>
<td>.4</td>
<td>1.05 (0.89–1.18)</td>
<td>.7</td>
</tr>
<tr>
<td>CASS4 [6]</td>
<td>rs1476679</td>
<td>0.92</td>
<td>C</td>
<td>T</td>
<td>0.66</td>
<td>0.71</td>
<td>.001</td>
<td>0.80 (0.69–0.94)</td>
<td>.005</td>
</tr>
<tr>
<td>ZCWPW1</td>
<td>rs2745851</td>
<td>0.87</td>
<td>C</td>
<td>T</td>
<td>0.91</td>
<td>0.92</td>
<td>.2</td>
<td>0.84 (0.64–1.09)</td>
<td>.2</td>
</tr>
</tbody>
</table>

Abbreviations: SNPs, single nucleotide polymorphisms; OR, odds ratio; CI, confidence interval.

NOTE. Selected SNPs are presented with their published discovery odds ratios (OR), given for the minor allele. For APOE, OR was calculated within the Flanders-Belgian population. Frequency of the risk alleles, which are included in GRS models, is presented for Flanders-Belgian patients and controls, along with a nominal P value based on χ² statistics. The OR and 95% confidence interval (95% CI) obtained in the Flanders-Belgian cohort are given for the minor allele and are adjusted for APOE ε4 status (for all SNPs except APOE genotype itself), age at onset or inclusion, and gender.

3. Results

3.1. Single SNP associations in the Flanders-Belgian AD cohort

We included 22 polymorphisms in this study, which were previously implicated in AD risk (Table 2; Table S1). Seven polymorphisms (at APOE, CR1, ABCA7, SORLI, ZCWPW1, HLA-DRB5, and CLU) showed nominal evidence of association with AD in the full Flanders-Belgian study cohort and eight polymorphisms remained (APOE, ABCA7, SORLI, ZCWPW1, and CLU) or became (BIN1, TREM2, and PIC-ALM) nominally significantly associated after adjusting for age, gender, and APOE ε4 status. Only APOE ε4 would be considered significant after Bonferroni correction for 22 tests.

3.2. GRS model comparisons

We composed four different GRS models (Table 1) and compared them against each other as well as with the discriminative ability of two models based on APOE genotype alone (Fig. 1A). The AUC based on the weighted alleles of APOE ε4 only (ModelAPOE-A) was 0.65. The discriminative ability of APOE improved when taking into account age-specific weights for the different APOE genotypes (ModelAPOE-A; AUC = 0.67, P = 5.2e⁻⁵). ModelALL-C, which was derived by the sum of risk alleles at the 22 polymorphisms, had less discriminative ability toward disease outcome in the...
3.3. GRS and family history of AD

The discriminative ability of GRS Model₁ALL-WA toward disease outcome was significantly higher in AD patients with a positive family history (\(AUC_{\text{FAD vs Con}} = 0.78\); \(AUC_{\text{SAD vs Con}} = 0.68\) [\(P = 1.7e^{-5}\); Fig. 2A]). Although much of the discriminative ability was attributable to \(APOE\) (Model₁APOE-A; \(AUC_{\text{FAD vs Con}} = 0.76\); \(AUC_{\text{SAD vs Con}} = 0.65\) [\(P = 5.6e^{-7}\)] and the AUCs for FAD and SAD were not significantly different for Model₁OTH-W, the 21 genes had a significant added value when combined with \(APOE\) in FAD patients (\(P = .01\)) as well as in SAD patients (\(P = 5.5e^{-8}\)) in contrast to \(APOE\) only (Fig. 2A).

Risk of AD increased with increasing GRS for both FAD and SAD but the risk increased more strongly for FAD (OR, 3.01 [95% CI, 2.55–3.58] per unit increase on Model₁ALL-WA; Z-statistic, 12.7; \(P < 1.0e^{-15}\)) than for SAD (OR, 2.14 [95% CI, 1.92–2.40]; Z-statistic, 13.3; \(P < 1.0e^{-15}\)). The proportion of familial and sporadic Alzheimer patients was the highest in the highest risk quantiles of Model₁ALL-WA (Fig. 2B). In total, 41% of all patients with a positive family history had a \(wGRS > 4.31\), as opposed to only 8% of all control subjects (Fig. 2B). Patients in the upper quantile had an OR, 2.03 (95% CI, 1.27–3.27) of having a familial history of AD compared with patients in the center quantile.

3.4. GRS—endophenotype correlations

The GRS was negatively correlated with onset age (Pearson \(r = -0.20\), \(P = 9.0e^{-11}\); Fig. 3). Onset age decreased with 2.39 years (standard error [SE], 0.36; \(P < 1.0e^{-7}\)) per unit increase in risk score. Patients in the lower quantile had a median onset age of 80 years compared with 74 years in the upper quantile (\(P 1.3e^{-7}\)). To evaluate the influence of \(APOE\), additional analysis was performed based on Model₁OTH-W. The combined score of the 21 genes remained significantly correlated with a decreasing age at onset (Pearson \(r = -0.12\), \(P = .0001\)) after exclusion of \(APOE\).
We observed a significant correlation between the GRS (Model\textsubscript{ALL-WA}) and CSF $\beta_1$-42 levels in patients but not T-tau or P-tau\textsubscript{181P} (Fig. 4A–C). The GRS was negatively correlated with $\beta_1$-42 concentrations in CSF ($r = -0.28$, $P = 8.9e^{-7}$). $\beta_1$-42 decreased with 49.9 pg/mL (SE 10.6) per unit increase on the GRS ($P = 4.0e^{-6}$) and had a median value of 531 pg/mL in the lower quantile and 399.5 pg/mL in the upper quantile ($P = .001$). After exclusion of APOE from the GRS, however, this correlation was no longer significant ($r = -0.071$, $P = .1$). In contrast, the 21-SNP GRS excluding APOE (Model\textsubscript{OTH-W}) appeared correlated with log\textsubscript{10} T-tau (Pearson $r = 0.11$, $P = .03$) and log\textsubscript{10} P-tau\textsubscript{181P} (Pearson $r = 0.11$, $P = .04$).

### 4. Discussion

In this study, 22 AD susceptibility loci were combined to explore the potential of GRSs in AD. Except for APOE, these individual variants only have a marginal contribution toward disease prediction, but when combined, they result in a better risk profile than based on APOE alone. When combining genotype data on all 22 variants, best discrimination between patients and control individuals was achieved by a wGRS with age-related weighting of APOE genotypes (Model\textsubscript{ALL-WA}). As expected, wGRS outperformed the cGRS, given that the latter model does not take into account the stronger risks conveyed by APOE\textsubscript{ε4} and TREM2 p.R47H [24,25]. There were no notable differences in genetic risk profile in the presence or absence of APOE\textsubscript{ε4} in our study population.

Parsimony analysis demonstrated the potential of reduced models to have equal predictive value of disease outcome. This can be especially interesting in a clinical context where the aim is to capture as much information as possible, while limiting the cost and labor of genotyping.

It should be noted that determination of parsimonious models may be population-specific, because of differences in allele frequencies, patterns of linkage disequilibrium, and interactions. In addition, in the context of personalized medicine and given the diversity of pathophysiological pathways contributing to AD susceptibility, parsimonious profiles might omit relevant information. The findings of the parsimony analysis are not fully unexpected, given the diminishing effect sizes of loci detected due to increasingly large study cohorts and suggest that there may be limited gain in future performance of the GRS by inclusion of new indirectly associated SNPs with small ORs.
The best model had an AUC of 0.70 in our study population, with sensitivity of 55% and specificity of 78% at its point of balanced accuracy [26] and maximum potential effectiveness (Youden index [27]). In comparison, a CSF biomarker panel comprising Aβ1–42 and T-tau and P-tau181P can discriminate autopsy-confirmed AD from cognitively healthy elderly with a sensitivity of 86% and a specificity of 89% [28]. Particularly in light of the current lack of preventive or therapeutic consequences, these GRSs have limited utility in risk prediction. Nevertheless, the marked increase in risk of AD with increasing GRS, as well as the GRS-endophenotype correlations, identify a potential toward application at the shorter term. Individuals with the 20% highest scores (score >4.31) were at a substantial, fivefold, increased risk to develop AD compared with individuals with the 20% average scores. Moreover, this group had a significantly lower onset age, even when excluding the known effect of APOE ε4 on onset age. The ability to genetically determine this high risk profile may be of value to expedite drug and biomarker trials, which are shifting their focus toward prodromal phases of AD.

CSF Aβ1–42 decreased with increasing GRS, but this appeared to be driven by APOE ε4. This suggests that there may be added benefit from a combined genetic and CSF risk profile, as the GWAS loci appear to capture pathophysiological processes other than Aβ pathology. The value of more complex risk profiling incorporating additional nongenetic information is demonstrated by the fact that the model including age-specific effects for APOE performed better than a model ignoring this information.

Interestingly, the discriminative ability of the GRS was stronger when limiting the analysis to patients with a positive family history. As expected, much of the predictive power came from APOE. Nonetheless, adding the 21 susceptibility genes to the risk model significantly improved its discriminative ability. The risk of FAD increased even more strongly with increasing GRS than risk of SAD. This suggests that part of the familial aggregation of AD can be explained by a high combined SNP risk score. We cannot exclude that de novo mutations or recessive causes of disease exist in the SAD cohort which may have diluted the discriminative ability of the GRS in SAD; however, we do not expect this to have a large effect given the most likely rare events of de novo mutation and recessive AD. Future studies are warranted to address the ability of the GRS to predict—in individuals with a positive family history of AD—who eventually becomes affected.

Although not ready for clinical application, GRSs are a promising method to identify individuals at high risk which may facilitate therapeutic or biomarker trials. Future directions include improvement of GRSs with novel functional variants and comparing and combining genetic profiles with CSF or plasma-based biomarkers.

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Fig. 4. GRS-CSF biomarker correlations. Scatterplots of GRS ModelALL-WA with patient CSF concentrations of (A) Aβ1–42, (B) T-tau, and (C) P-tau181P. Regression lines are presented with 95% CI. Abbreviations: GRS, genetic risk score; CSF, cerebrospinal fluid; CI, confidence interval.
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BELNEU consortium: Patrick Cras (Institute Born-Bunge, University of Antwerp, Antwerp, Belgium; Antwerp University Hospital, Edegem, Belgium); Dirk Nuytten (Hospital Network Antwerp Stuivenberg, Antwerp, Belgium); Patrick Santens, Jan De Bleecker, Anne Sieben, Bart Dermaut (University Hospital Ghent, Ghent, Belgium); Jan Versijpt, Alex Michotte (University Hospital Brussels, Brussels, Belgium); Olivier Deryck, Bruno Bergmans (AZ Sint-Jan Brugge, Bruges, Belgium); Christiana Willems (Jessa Hospital, Hasselt, Belgium); Adrian Ivanou (Saint-Luc University Hospital, Université Catholique de Louvain, Louvain-la-Neuve, Belgium); and Eric Salmon (University of Liege and Memory Clinic, CHU Liege, Liege, Belgium).

Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.jalz.2015.02.013.

RESEARCH IN CONTEXT

1. Systematic review: We included all independently replicated genetic risk loci from large-scale genome-wide association studies and next generation sequencing studies on AD identified through systematic search of PubMed.

2. Interpretation: A GRS for AD based on current knowledge has limited utility to predict AD, but this study illustrates that incorporation of nongenetic information, such as age-specific effect estimates for APOE ε4, can improve the discriminative ability. This study highlights the feasibility to identify individuals at highest susceptibility. This enables genetic preselection to streamline biomarker and drug trials and may aid clinical and personal decision making.

3. Future directions: Identification of novel loci and variants will further increase the discriminative ability, but it may be important to combine a GRS with environmental and biomarker data. For biomarker and drug trials, a genetic risk profile ideally should be pathway-based. This will require pinpointing the culprit genes underlying extended genome-wide association signals.

References


