Genetic Variation Associated with Longer Telomere Length Increases Risk of Chronic Lymphocytic Leukemia

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Abstract

Background: Chronic lymphocytic leukemia (CLL) is the most common leukemia in the Western world. Shorter mean telomere length in leukemic cells has been associated with more aggressive disease. Germline polymorphisms in telomere maintenance genes affect telomere length and may contribute to CLL susceptibility.

Methods: We collected genome-wide data from two groups of patients with CLL (N = 273) and two control populations (N = 5,725). In ancestry-adjusted case-control comparisons, we analyzed eight SNPs in genes definitively associated with inter-individual variation in leukocyte telomere length (LTL) in prior genome-wide association studies: ACYP2, TERC, NAF1, TERT, OBFC1, CTC1, ZNF208, and RET1L.

Results: Three of the eight LTL-associated SNPs were associated with CLL risk at P < 0.05, including those near: TERC (OR, 1.46; 95% CI, 1.15–1.86; P = 1.8 × 10^-3), TERT (OR = 1.23; 95% CI, 1.02–1.48; P = 0.030), and OBFC1 (OR, 1.36; 95% CI, 1.08–1.71; P = 9.6 × 10^-3). Using a weighted linear combination of the eight LTL-associated SNPs, we observed that CLL patients were predisposed to longer LTL than controls in both case-control sets (P = 9.4 × 10^-4 and 0.032, respectively). CLL risk increased monotonically with increasing quintiles of the weighted linear combination.

Conclusions: Genetic variants in TERC, TERT, and OBFC1 are associated with both longer LTL and increased CLL risk. Because the human CST complex competes with shelterin for telomeric DNA, future work should explore the role of OBFC1 and other CST complex genes in leukemogenesis.

Impact: A genetic predisposition to longer telomere length is associated with an increased risk of CLL, suggesting that the role of telomere length in CLL etiology may be distinct from its role in disease progression. Cancer Epidemiol Biomarkers Prev; 25(7): 1-7. ©2016 AACR.

Introduction

Chronic lymphocytic leukemia (CLL) is a highly heterogeneous disease with clinical course ranging from indolent to highly progressive (1). Currently, several prognostic markers including somatic hypermutation in the immunoglobulin heavy-chain variable region, ZAP70 and CD38 expression, and TP53/SF3B1/NOTCH1 mutation status are used in combination to estimate disease prognosis (2). Telomere length is also associated with CLL progression, where shorter telomere length is correlated with advanced disease stages, Richter transformation (3), and poor patient prognosis (4).

Telomeres are repetitive DNA sequences that cap and protect chromosomes. Telomeric repeats are lost with each somatic cellular division and, when depleted, future mitoses result in the loss of integral genomic DNA. This induces replicative senescence and apoptosis, limiting the replicative potential of somatic cells (5). If adequate oncogenic mutations are acquired before reaching replicative senescence, unlimited proliferation may follow and cancer may result. Thus, long telomeres may increase the risk of cancer by allowing additional time in which a cell can accumulate mutations before reaching this apoptotic checkpoint (6). Following malignant transformation, leukemic cells that proliferate in the absence of an active mechanism of telomere maintenance (e.g., telomerase reactivation) will continue to experience telomere depletion (7, 8). In such tumors, short telomere length would be expected to associate with more advanced and/or highly proliferative leukemia (9, 10).
Telomere length decreases with age, but can be significantly different between individuals of the same age due to genetic and environmental influences (11). Heritable differences in leukocyte telomere length (LTL) are associated with SNPs in eight genes involved in telomere maintenance, including ACYP2, TERC, NAF1, TERT, OBFC1, CTC1, ZNF208, and RTESL1 (12, 13). Genome-wide association studies (GWAS) indicate that inherited SNPs near the telomerase-component genes TERC and TERT are also associated with increased risk of CLL and implicate telomere biology in leukemia predisposition (14, 15). We therefore hypothesized that inherited variation affecting telomere length may be associated with risk of developing CLL, with the heritable and somatic genetic influences having a net effect on telomere length in tumors.

To determine whether common genetic variants associated with inter-individual variation in telomere length confer risk for CLL, we analyzed eight independent SNPs in 273 patients with CLL and 5,725 controls. These SNPs have previously been definitively associated with inter-individual variation in LTL in a GWAS of 37,684 individuals of European ancestry conducted by the ENGAGE Consortium Telomere Group (12). In addition to single variant analyses, we also constructed a weighted linear combination of subject genotype at the eight SNPs to create a summary score that quantifies genotypic contributions to differences in LTL across patients and controls. Although direct measurement of LTL (e.g., by qPCR) is frequently influenced by differing distributions of potential confounders across patients and controls (e.g., age, sex, chemotherapy), SNP genotypes are present since birth and are not confounded by the effect that these variables may have on both telomere length and cancer risk. In addition, although the effect of individual alleles in telomere maintenance genes may be small, the combined effect of numerous such polymorphisms could potentially be quite large and could help identify the "missing heritability" of cancer (16). This Mendelian randomization approach for examining the relationship between telomere length and cancer risk has been previously applied to glioma, melanoma, and lung adenocarcinoma, but not to hematologic malignancies (17–19).

Materials and Methods

Ethics statement

The genome-wide meta-analysis of mean LTL obtained approval by local ethics committees, as previously outlined (12). CLL patients and associated genotype and phenotype data in the discovery analyses were collected by the Mayo Clinic as part of the Eastern Cooperative Oncology Group (ECOG) 2997 trial and accessed through dbGaP Study Accession phs000621.v1.p1 after review and approval by the NCI Data Access Committee (2). CLL patients and associated genotype and phenotype data in the replication analyses were collected by The Dana-Farber Cancer Institute (DFCI) and accessed through dbGaP Study Accession phs000435.v2.p1 after review and approval by the National Human Genome Research Institute (NHGRI) Data Access Committee (1).

Case–control populations

We assessed genetic variants in telomere-associated genes in two independent CLL case–control study groups. The first group included 215 CLL patients from the ECOG 2997 trial (2) and 3,390 Illumina iControls. ECOG patients had symptom-atic, untreated CLL as defined by NCI 1996 guidelines (20). The second group included 101 nonoverlapping CLL patients from DFCI and 2,603 controls from the Wellcome Trust Case-Control Consortium (WTCCC; refs. 1, 21). The majority (67%) of DFCI cases were chemotherapy-naïve. Additional case and control data appear in Supplementary Table S1.

Case–control genotyping and quality control

For ECOG patients, DNA was isolated from peripheral blood, obtained before treatment, and shipped overnight at ambient temperature to a central processing laboratory. Mononuclear cells were isolated using Ficoll density-gradient centrifugation and then processed for DNA. All case and control DNA specimens in discovery analyses were genotyped using either the Illumina HumanCNV370-Duo BeadChip or the Illumina HumanHap550 platform. Samples with call rates <95% were excluded from analysis, as were samples with mismatched reported versus genotyped sex. Although all subjects were of self-reported European ancestry, this was validated using principal components analysis in Eigenstrat (22). Analyzed SNPs had call rates >98% and Hardy–Weinberg equilibrium P values >0.001 among controls.

For DFCI patients, DNA samples were obtained from normal tissue via either 5 mm skin punch biopsies or collection of 2 ml of saliva as a source of normal epithelial cells. DNA specimens were genotyped using the Affymetrix 6.0 genotyping array. Genotype data for 2,603 European-ancestry control samples genotyped using the Affymetrix 6.0 genotyping array were downloaded from the WTCCC (21). Subjects showing evidence of non-European ancestry, as well as duplicate samples and related subjects (IBD > 0.125) were excluded from analyses. Genome-wide SNP data were used to ensure there was no overlap between ECOG patients and DFCI patients. SNPs with call rates <98% or HWE P value <0.001 (among controls) were excluded.

To ensure that infiltrating tumor DNA from ECOG patients did not bias allele frequencies in SNP analyses of blood-derived specimens, genome-wide allele frequencies from ECOG patients (blood-derived specimens) were compared with those in DFCI patients (skin biopsy or saliva-derived specimens). With the exception of SNPs on 13q, allele frequencies differed by no more than 5% across patient sets, reflecting the relatively low burden of copy-number alterations in CLL and the comparability of the two CLL case populations (23, 24). Importantly, there was no evidence of copy-number alterations or copy-neutral LOH within 250 kb of the eight LTL-associated SNPs, as the most common LTL-associated copy-number alterations are located on chromosomes 11, 13, 17 (loss), and 12 (gain; ref. 25), whereas the LTL-associated SNPs are located on chromosomes 2, 3, 4, 5, 10, 17, 19, and 20. As further evidence, allele frequencies in flow-sorted CLL tumor DNA were nearly identical to those in skin biopsy DNA in the eight LTL-associated gene regions among DFCI subjects (Supplementary Fig. S1).

SNP imputation

Within the two CLL case–control datasets, we imputed 250 kb regions centered on eight SNPs previously associated with LTL in GWAS (12, 13): rs11125529 (ACYP2), rs10936599 (TERC), rs7675998 (NAFI), rs2736100 (TERT), rs9420907 (OBFC1), rs3027234 (CTC1), rs8105767 (ZNF208), and rs755017 (RTESL1). The top LTL SNP was directly genotyped on-array for TERC, TERT, and OBFC1 among ECOG cases and the iControls, and was imputed for the other five genes. The top
LTL SNP was directly genotyped on-array for ACYP2, TERT, OBF1, CTC1, and ZNF208 among the DFCI cases and Wellcome Trust controls, and was imputed for the other three genes. Imputation was performed using the Impute2 v2.1.2 software and its standard Markov chain Monte Carlo algorithm and default settings for targeted imputation (28). All 1,000 Genomes Phase 1 haplotypes were provided as the imputation reference panel (27). All SNPs had imputation quality (info) scores $>0.80$ and posterior probabilities $>0.90$. Individuals with imputed genotype probabilities $<0.70$ were excluded to prevent allele misclassification. Imputation was performed separately for the ECOG/iControl case–control set (Illumina array data) and the DFCI/WTCCC dataset (Affymetrix array data).

Statistical analyses

For single locus SNP associations, allele frequencies in all CLL patients were compared with those in the pooled control dataset using logistic regression in SNPTESTv2 under an allelic additive model (28), adjusting for the first five ancestry-informative principal components from Eigenstrat and for genotyping array (Illumina vs. Affymetrix). To account for potential errors in imputation, a missing-data likelihood score test was applied to produce standard errors which account for the additional uncertainty inherent in the analysis of imputed genotypes. $P$ values $<0.05$ were considered nominally significant. Sensitivity analyses were conducted wherein cases were compared only with controls genotyped on the same genotyping platform to account for potential differences in genotyping or imputation across arrays.

To investigate the combined effect of the eight LTL-associated SNPs, we created a weighted linear combination by summing the number of "long LTL" alleles that an individual possesses and increasing quintiles of LTL (Fig. 3). Individuals in the highest quintile had a 2.3-fold increased risk of CLL compared with those in the lowest LTL quintile (OR $= 3.58; 95\%\ CI, 1.12–10.83; \text{P} = 0.030$). To determine if the association between a genetic predisposition to longer telomeres and increased LTL risk was entirely attributable to the previously reported associations between CLL risk and SNPs in TERT and TERC, we recalculated the weighted linear combination of the 8 LTL-associated SNPs in patients and controls using only the six SNPs located near genes not previously associated with CLL risk ($\text{ACYP2, NAF1, OBF1, CTC1, ZNF208, and RETL1}$). Using this reduced 6-SNP estimate of LTL, CLL patients still had a genetic predisposition to significantly longer LTL than controls ($P = 0.039$; Supplementary Fig. S3).

Discussion

We identify inherited genetic variants in TERC, TERT, and OBF1 that are associated with an increased risk of CLL in case–control analyses. SNPs in these genes have previously been
associated with inter-individual variation in LTL (12). By integrating CLL case–control data with data from our previous GWAS of LTL, we observed that CLL risk alleles in TERC, TERT, and OBFC1 are associated with longer LTL. Although it has previously been reported that inherited SNPs in TERC and TERT are associated with CLL risk (14, 15), our analyses identify a potential mechanism through which these SNPs may affect leukemia risk: by increasing an individual’s LTL. This is supported by our observation that a genetic predisposition to longer LTL is associated with increased CLL risk, even after removing the contributions of TERC and TERT SNPs from the model. Although each of the LTL-associated variants explains only a small proportion of the total variance in telomere length across individuals (12), the summary variable made by combining the eight SNPs accounted for a 893-bp difference in LTL. Assuming an annual telomere attrition rate of approximately 30 bp/year in leukocytes, this translates to approximately 30 years of age-related telomere attrition.

Telomere length helps cells to regulate the precipitous balance between mitotic competence and cellular senescence and is influenced by both inherited genetic variants and acquired somatic mutations. In studies where telomere length was measured in CLL tumor cells, shorter telomere length was correlated with more aggressive disease (4, 29, 30). Telomere length in cancer tissue can also be affected by patient age, therapeutic regimen, and the rate of tumor proliferation (31). Our analyses use a Mendelian randomization approach to estimate genotypically determined telomere length in healthy leukocytes, free from the confounding effects of age, sex, therapy, subclinical tumor, or disease aggressiveness. Our results complement a recent case–control study, nested within the EPIC cohort, that directly measured LTL in prediagnostic blood specimens from patients with B-cell lymphoma. Similar to our results, they observed that longer LTL was associated with increased cancer risk (32).

Table 1. Results for each telomere length–associated SNP, including effect on telomere length in the ENGAGE Consortium genome-wide meta-analysis and on CLL risk in the pooled CLL case–control dataset

<table>
<thead>
<tr>
<th>SNP</th>
<th>Chromosome</th>
<th>Gene</th>
<th>Effect allele</th>
<th>EAFa</th>
<th>Beta</th>
<th>BPc</th>
<th>P</th>
<th>ORf</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs1125529 (ACYP2)</td>
<td>2</td>
<td>ACYP2</td>
<td>A</td>
<td>14%</td>
<td>0.056</td>
<td>66.9</td>
<td>4.5 x 10^-6</td>
<td>13%</td>
<td>1.26</td>
<td>0.98–1.63</td>
</tr>
<tr>
<td>rs10936599 (TERC)</td>
<td>3</td>
<td>TERC</td>
<td>C</td>
<td>75%</td>
<td>0.097</td>
<td>117.3</td>
<td>2.5 x 10^-1</td>
<td>76%</td>
<td>1.46</td>
<td>1.15–1.86</td>
</tr>
<tr>
<td>rs7675998 (NAFI)</td>
<td>4</td>
<td>NAFI</td>
<td>G</td>
<td>78%</td>
<td>0.074</td>
<td>89.7</td>
<td>4.3 x 10^-1</td>
<td>77%</td>
<td>1.01</td>
<td>0.83–1.24</td>
</tr>
<tr>
<td>rs2736100 (TERT)</td>
<td>5</td>
<td>TERT</td>
<td>C</td>
<td>49%</td>
<td>0.078</td>
<td>94.2</td>
<td>4.4 x 10^-1</td>
<td>51%</td>
<td>1.23</td>
<td>1.02–1.48</td>
</tr>
<tr>
<td>rs9420907 (OBFC1)</td>
<td>10</td>
<td>OBFC1</td>
<td>C</td>
<td>14%</td>
<td>0.069</td>
<td>82.8</td>
<td>6.9 x 10^-1</td>
<td>14%</td>
<td>1.36</td>
<td>1.08–1.71</td>
</tr>
<tr>
<td>rs3027234 (CTC1)</td>
<td>17</td>
<td>CTC1</td>
<td>C</td>
<td>79%</td>
<td>0.021</td>
<td>25.3</td>
<td>0.020</td>
<td>78%</td>
<td>0.97</td>
<td>0.77–1.20</td>
</tr>
<tr>
<td>rs8105767 (ZNFX208)</td>
<td>19</td>
<td>ZNFX208</td>
<td>G</td>
<td>29%</td>
<td>0.048</td>
<td>57.6</td>
<td>1.1 x 10^-9</td>
<td>29%</td>
<td>1.12</td>
<td>0.92–1.36</td>
</tr>
<tr>
<td>rs755017 (RTEL1)</td>
<td>20</td>
<td>RTEL1</td>
<td>G</td>
<td>13%</td>
<td>0.062</td>
<td>74.1</td>
<td>6.7 x 10^-9</td>
<td>12%</td>
<td>1.01</td>
<td>0.76–1.34</td>
</tr>
</tbody>
</table>

aAll SNPs were associated with LTL in a previous GWAS and replicated at P < 0.05 in the ENGAGE Consortium genome-wide meta-analysis (12).

bThe effect allele is the allele associated with increased leukocyte telomere length.

cEffect allele frequency (EAF) calculated in all ENGAGE Consortium subjects (N = 37,684).

dBase pair (BP) estimates of the per-allele effect on LTL in base pairs calculated from the equivalent age-related attrition in telomere repeat length ratio, as previously described (12).

eEffect allele frequency calculated in CLL control subjects.

fORs are for each additional copy of the allele associated with longer LTL, calculated in 273 CLL patients and 5,725 controls. ORs >1.0 indicate that the “long” allele is more common in CLL patients, and the “short” allele is more common in controls.
Mendelian randomization is an epidemiologic technique that can elucidate the causality of associations (33). As genotypes of individuals are randomized at birth, such studies can eliminate both exogenous confounding factors and the phenomenon of reverse causation. However, factors like linkage disequilibrium, population stratification, and pleiotropy can affect interpretations of Mendelian randomization studies (34). As we analyzed unlinked SNPs that are located on separate autosomes, it is unlikely that linkage disequilibrium would influence the results. Similarly, biases due to population stratification were likely eliminated by carefully excluding individuals with non-European ancestry and adjusting for principal components in all analyses. As genetic variation near TERC and TERT may influence cancer risk independent of its effect on telomere length (35), there remains a possibility that pleiotropy could partially underlie the association between LTL and CLL risk observed in our data. Although our sample size was limited to fewer than 300 cases, we observe statistically significant and extremely concordant effects in both the discovery and replication datasets. Future studies in larger and more ethnically diverse populations appear warranted.

Although an association between CLL risk and both shelterin component genes (POT1) and telomerase-component genes (TERC and TERT) has been previously reported, this is the first report of a significant association between CLL risk and a CST complex gene (OBFC1). The human CST complex is encoded by three genes: CTCl, OBFC1, and TEN1. The CST complex competes with shelterin for telomeric DNA and inhibits telomerase-based telomere extension through primer sequestration and physical interaction with the POT1–TPP1 telomerase processivity factor (36). Through binding of the telomerase-extended telomere, CST limits telomerase activity and restricts telomere extension to approximately one event per cell cycle (36).

An association between longer LTL and increased cancer risk was recently observed in glioma, melanoma, and lung adenocarcinoma, where a genetic predisposition to longer telomere length was associated with increased risk of malignancy (17–19). Interestingly, patients diagnosed with CLL are at 2-fold to 4-fold increased risk of developing melanoma (37, 38). Although this increased risk has been primarily attributed to the immunosuppressive effect of CLL, a common genetic etiology involving telomere lengthening may also contribute. Indeed, a common genetic etiology for melanoma and glioma has already been reported, mediated by shared heritable risk variants in TERC, TERT, and POT1 (39).

Several studies have focused on identifying the underlying cause of shorter telomere length in leukemic cells. Although a
predisposition to longer telomeres at baseline might provide precancerous cells with additional opportunities to acquire mutations and undergo malignant transformation (6, 40, 41), subsequent telomere attrition in aggressive and highly proliferative tumors could cause leukemic cells to have shorter telomere length than healthy cells (42). This is supported by studies revealing that early-stage CLL (i.e., Binet stage A and Rai stage 0) shows no significant difference between telomere length measured in tumor cells and in healthy cells (7, 29), whereas telomere length is significantly shorter in tumor cells than healthy cells taken from patients with advanced disease (9, 10). Thus, shorter telomere length in tumor cells may be a marker of high-risk CLL in association with increased tumor burden, perhaps due to an increased rate of telomere attrition in highly proliferative tumors (30).

We observe a strong and consistent association between a genetic predisposition to longer LTI and increased risk of CLL, similar to previous reports for lung adenocarcinoma, melanoma, and glioma (17–19). Future work is needed to understand the cellular mechanisms underlying this association and to explore the role of OBFC1 and other CST complex genes in leukemogenesis. These studies of CLL initiation will complement existing knowledge about disease progression and can move the field toward better understanding the breadth of factors involved in CLL biology.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

Authors’ Contributions

Conception and design: M.R. Wrensch, J.L. Wiemels, K.M. Walsh

Development of methodology: M.R. Wrensch, K.M. Walsh

Acquisition of data (provided animals, acquired and managed patients, provided facilities, etc.): V. Codd, N.I. Samani, H.M. Hansen, J.K. Wienecke, M.R. Wrensch, K.M. Walsh

Analysis and interpretation of data (e.g., statistical analysis, biostatistics, computational analysis): J. Ojha, V. Codd, C.P. Nelson, I.V. Smirnov, M.R. Wrensch, K.M. Walsh

References


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