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TDP-43 accumulation in inclusion body myopathy muscle suggests a common pathogenic mechanism with frontotemporal dementia

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ABSTRACT

TAR DNA binding protein-43 (TDP-43) is one component of the ubiquitinated inclusions (UBIs) in some frontotemporal dementias (FTD-U). One form of FTD-U, due to mutations in the valosin containing protein (VCP) gene, occurs with an inclusion body myopathy (IBMFPD). Since IBMFPD brain has TDP-43 in UBIs, we looked for TDP-43 inclusions in IBMFPD muscle. In normal muscle, TDP-43 is present in nuclei. In IBMFPD muscle, TDP-43 is additionally present as large inclusions within UBIs in muscle cytoplasm. TDP-43 inclusions were also found in 78% of sporadic inclusion body myositis (sIBM) muscles. In IBMFPD and sIBM muscle, TDP-43 migrated with an additional band on immunoblot similar to that reported in FTD-U brains. This study adds sIBM and hereditary inclusion body myopathies to the growing list of TDP-43 positive inclusion diseases.

METHODS

Patients with sIBM had typical patterns of muscle weakness on physical examination, an abnormal EMG with myopathic motor units and spontaneous activity, and a muscle biopsy with myopathic changes, rimmed vacuoles within muscle fibres and endomysial inflammation with focal invasion of muscle fibres. Five patients with IBMFPD and missense mutations in the p97/valom containing protein (VCP) gene (four with R155H and one with N387H) were participants in the IRB approved study. All muscle biopsies were processed and evaluated in the Washington University Neuromuscular Laboratory. Cryostat sections of rapidly frozen muscle were processed for muscle histochemistry and immunocytochemistry in our standard fashion. The presence of vacuoles was evaluated via routine histochemical methods, such as haematoxylin and eosin or modified Gomori-trichrome stains. Immunocytochemistry for each antibody was performed on tissue from patients and compared with normal tissue controls processed simultaneously. Primary antibodies used in this study were directed against CD8 (clone M7103), phosphorylated neurofilaments or other phosphorylated epitopes (SMI-31; Covance, Berkley, California, USA), FK2 antibody to ubiquitinated proteins (PW8810-0500; BioMol, Plymouth Meeting, Pennsylvania, USA), TDP-43 antibodies: rabbit polyclonal antibody (ProteinTech Antibody Group, Chicago, Illinois, USA) and mouse monoclonal antibody 2E2-D3 (Abnova, Taipei, Taiwan). Double labelling immunofluorescence was performed as previously described using Alexa Fluor 488 and 594 conjugated antibodies (Molecular Probes; Eugene, Oregon, USA). Immunoperoxidase was performed as previously described using peroxidase conjugated secondary antibodies (Sigma, St Louis, Missouri, USA). The specificity of TDP-43 immunostaining was confirmed with two different commercial antibodies and incubation with secondary antibody alone (either fluorescent or peroxidase conjugated). ImmunobLOTS were performed as previously described.

RESULTS

In four normal muscle biopsies, TDP-43 was evaluated the localisation of TDP-43 in normal, IBMFPD and sIBM skeletal muscle tissue.
In contrast, all IBMFD muscle tissue had large peripherally based TDP-43 positive sarcoplasmic inclusions that did not localise to myonuclei (fig 1B, 1C). These inclusions consistently colocalised with FK2, an antibody that recognises ubiquitinated proteins (fig 1D) and in some cases with other proteins known to aggregate. SMI-31 binding was less prominent than TDP-43 in IBMFD muscle tissue (fig 1E).

A distinctively different pattern of TDP-43 immunostaining was seen in 21 of 27 sIBM muscle. TDP-43 immunostained multiple small sarcoplasmic aggregates, most commonly in small angular muscle fibres (fig 2A). These inclusions did not colocalise with myonuclei. TDP-43 was also present in debris surrounding some rimmed vacuoles (fig 2A). The TDP-43 inclusions in sIBM were usually ubiquitin negative (fig 2B), but occasionally colocalised with FK2. TDP-43 also colocalised with T cells at sites of inflammatory infiltrates (fig 2C). In contrast with sIBM, TDP-43 positive inclusions were found in only 1 of 12 steroid responsive polymyositis patient biopsies.

ImmunobLOTS of normal, IBMFD and sIBM patient tissue with an antibody to TDP-43 demonstrated an increase in TDP-43 immunoreactivity present at 43 kDa as well as a higher migrating band similar to the phosphorylated form seen in FTD-U patient tissue (fig 2D).

DISCUSSION

Disruptions in the UPS may be associated with the pathogenesis of several degenerative disorders. In particular, IBM muscle and FTD-U brain have UBIs that contain aggregated proteins. However, the principal molecular constituents of the UBIs seen in these diseases have been incompletely defined. Recent studies have identified TDP-43 as a component of the UBIs in FTD-U, including IBMFD, and ALS brain tissue. As IBMFD muscle also has UBIs, we examined the localisation of TDP-43 in normal, sIBM and IBMFD patient skeletal muscle. We found that TDP-43 localised to myonuclei in normal muscle but, in IBMFD and sIBM muscle, TDP-43 was additionally present as sarcoplasmic inclusions. This is associated with an increase in...
TDP-43 protein levels as well as a higher molecular weight band seen in sIBM and IBMPFD patient muscle tissue via immunoblot when compared with normal patient tissue. A similar higher molecular weight band was identified as phosphorylated TDP-43 in patients with FTD-U and ALS. Whether the band seen in IBMPFD and sIBM muscle tissue is the same or another post-translationally modified form (ie, ubiquitinated) is not known.

TDP-43 inclusions were present in 100% of IBMPFD and 78% of sIBM patient muscle biopsies, while 0% of normal muscle and 8% of steroid responsive polymyositis patient muscle biopsies had similar TDP-43 inclusions. This suggests that TDP-43 immunohistochemistry may be helpful in confirming the diagnosis of sIBM. Whether the band seen in IBMPFD and sIBM muscle tissue is the same or another post-translationally modified form (ie, ubiquitinated) is not known.

TDP-43 inclusions were present in 100% of IBMPFD and 78% of sIBM patient muscle biopsies, while 0% of normal muscle and 8% of steroid responsive polymyositis patient muscle biopsies had similar TDP-43 inclusions. This suggests that TDP-43 immunohistochemistry may be helpful in confirming the diagnosis of sIBM. At present, the most reliable antibody marker for the diagnosis of sIBM is SMI-31 (an antibody against phosphorylated tau epitopes) which is not present in all sIBM biopsies and found in other diseased muscle tissue. For example, in our hands, SMI-31 positive aggregates are present in 66% of sIBM patients compared with 17% of steroid responsive polymyositis patients (unpublished observations).

It is notable that the TDP-43 immunostaining pattern was different when comparing sIBM and IBMPFD muscle. sIBM had small punctuate TDP-43 positive inclusions throughout the sarcoplasm that occasionally colocalised with ubiquitin. IBMPFD muscle had large peripherally based TDP-43 positive inclusions that always colocalised with ubiquitin. Both sIBM and IBMPFD patient muscle had evidence of a higher molecular weight TDP-43 species on immunoblot.

Diseases that develop TDP-43 inclusions include FTD-U, ALS, IBMPFD and sIBM, suggesting that similar pathogenic
mechanisms may be present. Additional studies will be needed to further define the role of these proteins and their dysregulation in central nervous system and skeletal muscle tissue.

Competing interests: None.
Ethics approval: Obtained.

REFERENCES