Original article

Heterogeneous Phenotype of Long QT Syndrome Caused by the KCNH2-H562R Mutation: Importance of Familial Genetic Testing

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Keywords:
KCNH2 gene
Long QT syndrome
Sudden death

ABSTRACT

Introduction and objectives: Long QT syndrome is an inherited ion channelopathy that leads to syncope and sudden death. Because of the heterogeneous phenotype of this disease, genetic testing is fundamental to detect individuals with concealed long QT syndrome. In this study, we determined the features of a family with 13 carriers of the KCNH2-H562R missense mutation, which affects the pore region of the HERG channel.

Methods: We identified the KCNH2-H562R mutation in a 65-year-old man with a prolonged QTc interval who had experienced an episode of torsade de points. Subsequently, a total of 13 mutation carriers were identified in the family. Carriers (age 48 [26] years; 46% males) underwent clinical evaluation, electrocardiography and echocardiography.

Results: The mean (standard deviation) QTc in carriers was 493 (42) ms (3 [23%] showed normal QTc); 6 (46%) had symptoms (4, syncope; 1, sudden death; 1, aborted sudden death [proband]). While under treatment with beta-blockers, 11 of 12 carriers (92%) remained asymptomatic at 5 years of follow-up (1 patient required left cardiac sympathectomy). The QTc shortening with beta-blockers was 50 (37) ms. There was 1 sudden death in a patient who refused treatment.

Conclusions: Family study is essential in the interpretation of a genetic testing result. This article describes the heterogeneous and variable phenotype of a large family with the KCNH2-H562R mutation and highlights the role of genetic study for the appropriate identification of at-risk individuals who would benefit from treatment.

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Fenotipo heterogéneo del síndrome de QT largo causado por la mutación KCNH2-H562R: importancia del estudio genético familiar

RESUMEN

Introducción y objetivos: El síndrome de QT largo es una canalopatía hereditaria que se asocia a sincope y muerte súbita. La heterogeneidad fenotípica de esta enfermedad hace que el estudio genético sea fundamental para detectar a los sujetos con síndrome de QT largo oculto. En este trabajo se exponen las características de una familia con 13 portadores de la mutación missense KCNH2-H562R que afecta a la región del poro del canal HERG.

Métodos: Se describió la mutación KCNH2-H562R en un varón de 65 años con intervalo QTc prolongado que presentó un episodio de torsade de points. Posteriormente, se identificaron 13 portadores de la mutación en la familia. Se realizó evaluación clínica, electrocardiograma y ecoardiograma a los portadores (edad, 48 ± 26 años; el 46% varones).

Resultados: El QTc medio en los portadores fue de 493 ± 42 ms (3 [23%] mostraron QTc normal); 6 (46%) tuvieron síntomas (4, sincope; 1, muerte súbita; 1, muerte súbita resucitada [probando]). Durante el tratamiento con bloqueadores beta, 11 (92%) de los 12 portadores permanecieron asintomáticos a los 5 años de seguimiento (1 paciente requirió simpatectomía cardíaca izquierda). El acortamiento del QTc con bloqueadores beta fue de 50 ± 37 ms. Hubo 1 muerte súbita en un paciente que rechazó tratamiento con bloqueadores beta.

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http://dx.doi.org/10.1016/j.rec.2014.10.022
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CONCLUSIONS: El estudio familiar es fundamental en la interpretación de los resultados de los tests genéticos en la actualidad. Este artículo describe el fenotipo variable y heterogéneo de una amplia familia portadora de la mutación KCNH2-H562R y destaca el papel del estudio genético en la identificación de los individuos en riesgo que se beneficiarían del tratamiento con bloqueadores beta.

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(the patient refused an implantable cardioverter defibrillator) to increase the heart rate and the dose of beta-blockers, with the purpose of reducing the QTc interval and controlling the sinus bradycardia symptoms. After atrial pacing and maximum dose of bisoprolol, QT was reduced to 470 ms. Subsequently, he has remained asymptomatic and had no arrhythmic events in the 24-h Holter ECG or the exercise test at annual follow-up visits during a 5-year follow-up period.

The patient's pedigree was taken and his first degree relatives were screened (Figure 2). Genetic analysis of cardiac ion channel genes was performed in the proband. This analysis revealed that the index case was heterozygous for the KCNH2-H562R missense mutation, being diagnosed with LQT2.

**Family Events**

Twenty-four family members (Figure 2) were screened for the mutation previously found in the proband, and 12 relatives (50%) were carriers of the KCNH2-H562R mutation. Demographic characteristics, QTc intervals, and events in mutation carriers are shown in Table 1.

The family history revealed 3 unexplained deaths among children aged less than 1 year (III.6, III.8, III.9) (ECGs were not available and genetic study was not performed). Among the 13 carriers of the mutation, 6 patients (46%, including the index case) had cardiac symptoms (Table 2). Patient IV.4 had been diagnosed with epilepsy due to several nocturnal convulsive episodes. She showed a wide variation of the QTc interval in previous ECGs (QTc from 430 ms to 480 ms) and her cardiologist prescribed beta-blocker therapy, but she refused treatment. One night the phone rang while she was sleeping and she lost consciousness shortly after the conversation started; 6 years later, she died suddenly during sleep. Her father (III.2), who had to be an obligate carrier of the mutation, had died suddenly at home 15 years before at the age of 35 (no autopsy was performed). The daughter of patient IV.4 (patient V.1), had several episodes of syncope at rest despite treatment with propanolol (QTc 480 ms; Figure 3A), requiring a left cardiac sympathetic denervation at the age of 6 years because she was considered too young for an implantable cardioverter defibrillator.

![Figure 1](image1.png)  
**Figure 1.** Twelve-lead electrocardiogram of the proband. A: post-cardioversion, showing a prolonged QTc interval of 560 ms. B: after treatment with 5 mg of bisoprolol/day, QTc interval of 490 ms.

Under treatment with a medium dose of bisoprolol, the QTc was reduced to 490 ms (Figure 1B). However, the patient had symptomatic sinus bradycardia and multiple orthostatic presyncopal episodes. Thus, we decided to implant a DDD-R pacemaker.
Currently, all living carriers (n = 12) are under treatment with beta-blockers, and only the aforementioned patient V.1 has shown cardiac symptoms during a 5-year follow-up period.

**Electrocardiographic Study of Mutation Carriers**

The typical notched T waves on the ECG were observed in 3 (23%) patients (Figure 3B), with broad T waves being the predominant morphology in the other patients. The QTc interval was longer in mutation carriers than in non-carrier relatives QTc, 493 [46] ms vs 442 [19] ms; P = .002. QTc was prolonged in symptomatic rather than in asymptomatic carriers, although the difference was not statistically significant (QTc, 517 [57] ms vs 477 [33] ms; P = .28) (Figure 4). QTc interval was normal in 23% of carriers (n = 3), with all of them being asymptomatic. Females had a higher QTc than males but this difference was not statistically significant (QTc, 508 [57] ms vs 481 [21] ms; P = .23).

While the results of the genetic study were available, stress testing was done in those family members with a normal QTc to identify probable carriers. In the 3 individuals with normal QTc who were later found to be carriers of the mutation, the QTc interval showed similar behavior with exercise: during the first minute the QTc increased in 25 (5) ms, then progressively shortened during the rest of the exercise, and finally in the third minute of the recovery phase the QTc increased by 25 (10) ms. This pathological behavior allowed an early initiation of beta-blockers in these patients.

All carriers received beta-blockers (except IV.4, as noted above). Of these, 5 (42%) were initiated on bisoprolol, 4 (33%) on metoprolol, and 3 (25%) on propranolol (1 patient was excluded from the analysis due to ventricular pacing). The mean QTc shortening with beta-blockers was 50 (37) ms (n = 11; QTc, 493 [46] ms vs 442 [19] ms; P = .002). The QTc shortening was 44 (25) ms with bisoprolol, 47 (23) ms with metoprolol and 63 (73) ms with propranolol (P = .9).

**Genetic Analysis**

The c.1685A>G, p.H562R (rs199472922) heterozygous variant was detected in exon 7 of the KCNH2 gene. This variant causes an amino acid change from histidine 562 to arginine, with this replacement taking place in the S5 transmembrane region of the protein (Figure 5). The amino acid involved is located in a highly conserved region between the species and parologue genes. A bioinformatic study of the mutation was performed using “Mutation Taster”, resulting in a pathogenic variant with P = .99 (P indicates the prediction value; values close to 1 indicate high reliability of the prediction made).

**DISCUSSION**

In the present study, we describe for the first time the phenotype of the KCNH2-H562R missense mutation in a large family with LQTS. Our clinical data show a proband with a history of syncope that suffered a resuscitated sudden death in the setting of hypokalemia and clarithromycin therapy.

**Implications of HERG Mutations Located in the Pore Region**

In humans, KCNH2 is located on chromosome 7q35-36, and the coding region comprises 16 exons.2 The full length HERG1 subunit is composed of 1159 amino acids and has 6 transmembrane domains (S1–S6). The K+ selective pore is found between transmembrane domain S5 and S6 (amino acid residues 550 through to 650). The mutation that we found in the family studied is located in the S5 domain, being part of the channel pore. In 2002, Moss et al.11 published the follow-up which extended over a period of 40 years analyzing 44 different HERG mutations, in which subjects with pore mutations had more severe clinical manifestations and a higher frequency of arrhythmia-related events (74% vs 35%; P < .001). Later, Shimizu et al.12 proposed that the S5-loop-S6 region was also associated with the greatest risk in a study including 858 LQT2 patients with 162 different KCNH2 mutations. The reason for this is that pore mutations have a greater negative effect on cardiac delayed rectifier K+ current. However, only a small percentage of KCNH2 mutations have been characterized by a functional in vitro electrophysiological analysis.2,4

The KCNH2-H562R mutation was reported in 2 isolated patients in a study that examined the spectrum of mutations found in 2500 unrelated cases,9 but the authors did not describe the phenotype-genotype relationships of the genetic variants found. In addition, Sharma et al.10 showed that the functional analysis of another mutation in the same amino acid (H562P) resulted in a marked reduction of the K+ current in a patient with several

**Table 1**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Carriers (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at diagnosis, mean (SD), y</td>
<td>48 (26)</td>
</tr>
<tr>
<td>Men</td>
<td>6 (46)</td>
</tr>
<tr>
<td>QTc interval, mean (SD), ms</td>
<td>493 (42)</td>
</tr>
<tr>
<td>Prolonged QTc interval</td>
<td>10 (77)</td>
</tr>
<tr>
<td>Presence of symptoms</td>
<td>6 (46)</td>
</tr>
<tr>
<td>Syncope</td>
<td>4 (31)</td>
</tr>
<tr>
<td>Sudden death</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Resuscitated sudden death</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>7 (54)</td>
</tr>
<tr>
<td>Prolonged QTc interval</td>
<td>4 (31)</td>
</tr>
<tr>
<td>Normal QTc interval</td>
<td>3 (23)</td>
</tr>
<tr>
<td>Schwartz score, mean (SD)</td>
<td>3.7 (1.2)</td>
</tr>
</tbody>
</table>

SD, standard deviation.

Data are expressed as mean (standard deviation) or No. (%).

**Table 2**

Events in Family Members Carrying the KCNH2-H562R Mutation

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age at first evaluation, years</th>
<th>QTc at first evaluation, ms</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.4</td>
<td>83</td>
<td>508</td>
<td>Syncope at rest</td>
</tr>
<tr>
<td>III.4</td>
<td>53</td>
<td>490</td>
<td>Syncope at rest</td>
</tr>
<tr>
<td>IV.4</td>
<td>23</td>
<td>455</td>
<td>Convulsive episodes (diagnosed with epilepsy); syncope triggered by an acoustic stimulus; sudden death</td>
</tr>
<tr>
<td>IV.12</td>
<td>20</td>
<td>600</td>
<td>Syncope at rest</td>
</tr>
<tr>
<td>V.1</td>
<td>3</td>
<td>488</td>
<td>Syncope at rest</td>
</tr>
</tbody>
</table>
syncopal events. All these findings support the pathogenicity of the mutation found in the family described here.

However, assessment of the pathogenicity of an identified genetic variant is sometimes controversial, and is currently more common after the introduction of new genotyping technologies of next-generation sequencing. With these genotyping techniques, a large number of genes can be analyzed, thereby increasing the problems for interpretation. Thus, recent genome studies have questioned the pathogenicity of up to 17% of suggested diseases causing genetic variants in cardiomyopathies. In this article, we show how the clinical information and the analysis of cosegregation of the mutation with the disease allowed us to establish the diagnosis.

Genotype-phenotype Correlation

The ECG study showed a lower frequency of typical notched T waves, with only 23% of carriers showing this pattern. In

Figure 3. Twelve-lead electrocardiogram of some KCNH2-H562R carriers. A: patient V.1 (QTc 480 ms). B: patient IV.12 (QTc, 600 ms). Both reported several episodes of syncope at rest.
addition, we observed a large variance in phenotype and QTc interval duration in family members sharing the same mutation. This variable penetrance could be partially explained by the coexistence of a single polymorphism on LQT-causing genes and/or unknown genes and/or multiple gene mutations.14

We observed no differences in the duration of the QTc in carriers with and without symptoms. Thus, we could not identify a priori by using the QTc interval value, those subjects who would develop symptoms during the follow-up. In addition, there were 3 asymptomatic carriers that showed a normal QTc. In this regard, it is known that there is an important overlap in the distribution of QTc between otherwise healthy subjects and patients with genetically confirmed LQTS. According to the published literature, 40% of the genotyped LQTS population exhibit QTc values < 460 ms.15

Multiple studies have shown the usefulness of QTc response to exercise in patients with LQTS. Long QT syndrome type 1 patients usually have a marked prolongation of QTc during exercise, whereas LQT2 patients have a discreetly prolonged or not prolonged QT interval.16 Later, it was described that the QT interval is prolonged at 2–3 min of the recovery phase in patients with LQT2,17,18 a finding also observed in carriers of this family.

Sex has been identified as an important independent factor affecting event risk in LQT2, wherein women display a significantly higher risk of cardiac events than men after the onset of adolescence.5 This is corroborated in our study, in which women had a higher QTc and 4 of the 6 symptomatic carriers (66%) were females.

In patients with LQT2, most cardiac events are associated with an increased sympathetic tone, emotional stress, and/or sudden auditory stimulation, which are the most common triggers for arrhythmia, 19 such as in patient IV.4. A study published in 201020 showed that the most important risk factors for arousal-triggered cardiac events were female sex and pore-loop mutations, while those for exercise-triggered events were the presence of nonpore-loop mutations. However, other carriers of the mutation studied showed symptoms at rest. In this context, several studies have reported that about 30% of the cardiac events in LQT2 patients occurred at rest.21 Thus, REM sleep is associated with deep sympathetic activation, which could play an important role in triggering cardiac events in LQT2 patients.

**Epilepsy**

It is not uncommon for LQTS patients to be diagnosed with epilepsy. Accordingly, the KCNH2 gene was initially discovered in the hippocampus, and its expression was later demonstrated in many regions of the central nervous system. In a study that included 343 LQTS probands, a personal history of seizures was more common in LQT2 than all other subtypes of LQTS combined.22 In the family studied, patient IV.4 had a previous history of pharmacologically treated epilepsy. Some antiepileptic drugs such as phenytoin and other antiepileptic drugs have arrhythmogenic potential because of their cardiac delayed rectifier K+ current blocker potential in vitro. Therefore, an ECG should be performed in all patients with syncope and seizures to rule out LQTS,2 since treatment with antiepileptic drugs may be inadequate and deleterious.

**Other Triggers**

There are multiple causes of abnormal QT interval prolongation such as myocardial ischemia, cardiomyopathies, hypothermia,
hypokalemia, hypocalcemia, hypomagnesemia, autonomic influences, the effects of drugs, and the recently described decrease in epicardial temperature. Hypokalemia and clarithromycin may have been the triggering factors in the index patient. Some studies have recently demonstrated a reduction in QTc interval in LQT2 patients with a combination of potassium supplementation and aldosterone-inhibition. We recommended treatment with potassium supplements in the proband and other carriers with hypokalemia or potassium levels toward the lower limit of normality. Furthermore, there is a wide array of drugs that prolong the QT interval and/or induce polymorphic ventricular tachycardia. In this context, prolonged QT interval and ventricular arrhythmias have been reported in patients treated with erythromycin because this drug produces an inhibition of the cardiac delayed rectifier K+ current channel. Similar to our index patient, several cases of QT prolongation and torsades de pointes after clarithromycin administration have been published. Since the structure of clarithromycin is similar to that of erythromycin, the arrhythmogenic properties should be similar in both. Other macrolides such as roxithromycin and azithromycin appear to be less arrhythmogenic in comparative in vitro studies.

Treatment

Therapy for LQTS is directed toward reducing the incidence of syncope and sudden death. The standard treatment includes beta-blockers, sometimes used in combination with an implantable cardioverter defibrillator. The effectiveness of beta-blockers was documented in a large study that included 869 LQTS patients, where cardiac events were reduced in probands from 0.97 to 0.31 and in affected family members from 0.26 to 0.15 events per year. In our cohort, with the exception of the girl V.1, we observed no events after the initiation of beta-blockers, observing a significant reduction in the mean QT interval.

The protective effect of beta-blockers in the LQTS population is not uniform because its mechanism of action is probably related to the attenuation of adrenergic-mediated triggers. Prior data suggest that there is a high rate of cardiac events among patients with LQT2 and LQTS type 3 treated with beta-blockers. A later study published in 2011 suggests that within the LQT2 population there is a trigger-specific response to beta-blocker therapy, so that LQT2 patients experience a very low rate of exercise-triggered events during beta-blocker therapy, but have a high rate of arousal (more abrupt changes in heart rate than exercise) and nonexercise/nonarousal (not associated with sympathetic activation) triggered cardiac events despite recommended therapy. However, 13% and 17% of the patients who experienced a first arousal- and nonexercise/nonarousal-triggered event, respectively, experienced a subsequent exercise-triggered event. Migišalovich et al. reported that medical therapy with beta-blockers was associated with a 61% reduction in the risk of sudden death in a population of 1166 LQT2 patients. A recent study comparing the efficacy of commonly used beta-blockers showed that propranolol had a higher QTc shortening effect than metoprolol and nadolol. The only patient that remained symptomatic underwent left cardiac sympathetic denervation. In a study involving 147 LQTS patients, left cardiac sympathetic denervation reduced cardiac events by approximately 90%.

Risk Stratification

The most widely accepted risk stratification of LQTS is based on published mortality rates, and classifies patients in high (history of aborted and/or ECG-documented episodes of polymorphic ventricular tachycardia), intermediate (prior syncope and/or QTc > 500 ms), and low (no prior syncope and QTc ≤ 500 ms) risk.

However, a recent study showed a different association between mutation characteristics and time-dependent differences in the clinical course of LQT2 patients. Therefore, after the onset of adolescence, women with and without high-risk mutations show increased risk for life-threatening cardiac events, whereas the risk in men only increased among carriers of the higher-risk pore-loop mutations. Therefore, the current trend is toward a combined assessment of clinical and mutation-specific data to improve risk stratification for life-threatening cardiac events in LQT2.

CONCLUSIONS

This article describes the clinical manifestations and QTc interval values of the KCNH2-H562R missense mutation for the first time in a large family of carriers. We corroborate previous data about the high risk associated with pore mutation and focus on the clinical and electrocardiographic heterogeneity of this channelopathy. Within this framework, our study highlights the fundamental role that genetic testing has acquired in deciding which individuals are appropriate for treatment. Finally, we emphasize the current importance of cosegregation analysis of the mutation with the disease in the family, particularly in an era of technological development when the techniques of next-generation sequencing are acquiring an increasing role.

CONFLICTS OF INTEREST

None declared.

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