GPR56-related bilateral frontoparietal polymicrogyria: further evidence for an overlap with the cobblestone complex


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GPR56-related bilateral frontoparietal polymicrogyria: further evidence for an overlap with the cobblestone complex

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GPR56 mutations cause an autosomal recessive polymicrogyria syndrome that has distinctive radiological features combining bilateral frontoparietal polymicrogyria, white matter abnormalities and cerebellar hypoplasia. Recent investigations of a GPR56 knockout mouse model suggest that bilateral bifrontoparietal polymicrogyria shares some features of the cobblestone brain malformation and demonstrate that loss of GPR56 leads to a dysregulation of the maintenance of the pial basement membrane.
integrity in the forebrain and the rostral cerebellum. In light of these findings and other data in the literature, this study aimed to refine the clinical features with the first description of a foetopathological case and to define the range of cobblestone-like features in GPR56 bilateral bifrontoparietal polymicrogyria in a sample of 14 patients. We identified homozygous GPR56 mutations in 14 patients from eight consanguineous families with typical bilateral bifrontoparietal polymicrogyria and in one foetal case, out of 30 patients with bifrontoparietal polymicrogyria referred for molecular screening. The foetal case, which was terminated at 35 weeks of gestation in view of suspicion of Walker Warburg syndrome, showed a cobblestone-like lissencephaly with a succession of normal, polymicrogyric and ‘cobblestone-like’ cortex with ectopic neuronal overmigration, agenesis of the cerebellar vermis and hypoplastic cerebellar hemispheres with additional neuronal overmigration in thepons and the cerebellar cortex. The 14 patients with GPR56 mutations (median 8.25 years, range 1.5–33 years) were phenotypically homo- geneous with a distinctive clinical course characterized by pseudomyopathic behaviour at onset that subsequently evolved into severe mental and motor retardation. Generalized seizures (12/14) occurred later with onset ranging from 2.5 to 10 years with consistent electroencephalogram findings of predominantly anterior bursts of low amplitude α-like activity. Neuroimaging demonstrated a common phenotype with bilateral frontoparietally predominant polymicrogyria (13/13), cerebellar dysplasia with cysts mainly affecting the superior vermis (11/13) and patchy to diffuse myelination abnormalities (13/13). Additionally, the white matter abnormalities showed a peculiar evolution from severe hypomyelination at 4 months to patchy lesions later in childhood. Taken as a whole, these observations collectively demonstrate that GPR56 bilateral bifrontoparietal polymicrogyria combines all the features of a cobblestone-like lissencephaly and also suggest that GPR56-related defects produce a phenotypic continuum ranging from bilateral bifrontoparietal polymicrogyria to cobblestone-like lissencephaly.

Keywords: polymicrogyria; neuronal migration disorders; cobblestone lissencephaly; GPR56; pial basement membrane; radial glia cells
Abbreviation: BFPP = bilateral bifrontoparietal polymicrogyria

Introduction

Bilateral bifrontoparietal polymicrogyria [BFPP; OMIM® (http://www.ncbi.nlm.nih.gov/omim) 606854] is in most cases a recessively inherited genetic disorder of human cerebral cortical development, characterized by abnormal cortical lamination and gyral organization that is more severe in the frontal and parietal lobes (Piao et al., 2002; Chang et al., 2003). BFPP was initially described by Harbord et al. (1990) as ‘an autosomal recessive neuronal migration defect with non-progressive cerebellar ataxia’. BFPP is a radiological diagnosis that consists of polymicrogyria characterized by multiple and fused small gyri, an irregular limit between white and grey matter, white matter abnormalities and cerebellar hypoplasia. Most of these features are also observed in cobblestone complex brain malformations formerly called type II lissencephaly (Barkovich, 1998), such as Fukuyama congenital muscular dystrophy and muscle-eye-brain disease (Piao et al., 2005; Jissendi-Tchofo et al., 2009), defined as cerebral cortical dysplasia combined with dysmyelination, severe dysplastic cerebellum with cysts and brainstem hypoplasia (Fukuyama et al., 1981; Dobyns et al., 1989; van der Knaap et al., 1997; Barkovich et al., 2005; Jissendi-Tchofo et al., 2009).

A positional cloning approach localized a BFPP locus on chromosome 16q12.2–21 (Piao et al., 2002; Chang et al., 2003) and implicated the GPR56 gene, which encodes an evolutionarily conserved dynamic G-protein-coupled receptor in the BFPP phenotype. Subsequently, Piao et al. (2005) demonstrated that GPR56 mutations account for the majority of patients with typical BFPP. However, mutations in GPR56 were not found in cases of bilateral frontoparietal polymicrogyria that lacked additional white matter or posterior fossa abnormalities nor in those with a more generalized polymicrogyria, indicating that the imaging changes seen in GPR56-related BFPP are specific (Piao et al., 2005).

To date, 13 independent mutations in GPR56 have been identified in 31 patients from 20 families (Piao et al., 2004, 2005; Parrini, 2009). Functional studies of GPR56 mutations that cause BFPP have suggested that they result in a loss of function attributable to aberrant processing and/or trafficking of the protein (Jin et al., 2007; Ke et al., 2007). Interestingly, GPR56 mutations are located in different regions of the protein without any evidence of a relationship between the position of the mutation and phenotypic severity (Piao et al., 2005).

Although GPR56 ligands and downstream signalling pathways remain mostly unknown, studies of a GPR56 knockout mouse model have shed light on the function of GPR56 and the cellular defects underlying BFPP. The GPR56−/− phenotypes in the developing forebrain and rostral cerebellum share significant features, including abnormal neuronal positioning, rupture of the pial basement membrane and disorganization of the glial scaffold (Li et al., 2008). At the forebrain level, loss of GPR56 leads to a dysregulation of the maintenance of the pial basement membrane integrity that results in cortical lamination defects with overmigration through a defective basement membrane into the pial layer (Li et al., 2008). More recently, analysis of the cerebellum of GPR56−/− mice showed that they display a severe malformation of the rostral cerebellum, reminiscent of cerebellar polymicrogyria, including the presence of ectopic granule cells, fusion of adjacent folia, disrupted layering of neurons and fragmentation of the pial membrane. These observations demonstrate that GPR56 is also essential for normal morphogenesis of the rostral cerebellum (Koirala et al., 2009). Altogether, studies of the GPR56 knockout mouse model suggest that BFPP shares some features of the cobblestone brain malformation, but so far no human histopathological data have been documented.

To our knowledge, 31 patients with BFPP, aged from 13 months to 32 years, harbouring GPR56 mutations have been described,
mostly originating from the Middle East or Indian subcontinent (Chang et al., 2003; Piao et al., 2004, 2005; Parrini et al., 2009). Given the rarity of this malformation of cortical development, these patients were reported in three different series (of 12, 6 and 3 patients, respectively), making it difficult to compare phenotypes and to establish a comprehensive clinical spectrum that is representative of the phenotypic variability of GPR56 BFPP. Reported clinical hallmarks consist of global developmental delay, abnormal eye movements with both strabismus and nystagmus, seizures and bilateral pyramidal and cerebellar signs (Piao et al., 2004, 2005; Parrini et al., 2009). Similarly, imaging studies emphasize a common and distinctive phenotype with bilateral symmetrical polymicrogyria most prominent in the frontoparietal regions with a decreasing antero-posterior gradient of severity, white matter signal changes and brainstem and cerebellar hypoplasia with little interindividual variability (Piao et al., 2004, 2005; Parrini et al., 2009). From the seminal description, bilateral patchy white matter signal changes were reported to be non-specific, but they could be considered a distinctive feature, given the lack of white matter changes reported in other polymicrogyria syndromes (Chang et al., 2003). However, reports of the early clinical presentation and natural history, as well as age-related evolution of white matter changes, specifically MRI features at an early age, are scarce.

In light of the recent findings based on GPR56−/− animal model studies and the highlighted unanswered questions, the aim of this study is to provide a comprehensive overview of GPR56-related clinical and imaging phenotypes and their cobblestone-like features using a thorough analysis of a cohort of 14 patients, from eight different families with GPR56 mutations that have not been previously described. Additionally, we report here the first description of a foetopathological case harbouring a GPR56 mutation, further supporting the fact that GPR56 BFPP is a ‘cobblestone-like cerebral dysgenesis’. Finally, we searched for potential genotype–phenotype correlations and indicators that might predict the severity of the disorder.

Patients and methods

Patients

Thirty patients with bifrontoparietal polymicrogyria were referred to one of the two participating laboratories for molecular screening (APHP-Cochin Hospital and APHP Marseille). Of these, 20 were from consanguineous families with more than one family member affected and 10 were born to non-consanguineous families.

Informed consent was obtained from all patients according to national guidelines (Necker Enfants Malades University Hospital or local institutions). Patients were assessed clinically by at least one of the co-authors.

DNA mutation analysis

DNA was extracted from peripheral blood with the use of standard methods. All blood samples were obtained after confirmation of informed consent. DNA samples were screened for mutations in the 14 exons of the GPR56 gene representing a coding region of 2079 bp (GenBank accession number AF 106858) from exon 2 to 14, using polymerase chain reaction amplification and direct sequencing. Primer sequences and polymerase chain reaction conditions are available upon request to the corresponding author. Sequencing reactions were carried out with the BigDye Terminator v1.1 Cycle Sequencing Kit (Applied Biosystems, Courtaboeuf, France) and loaded onto the ABI 3100 genetic analyser (PE Applied Biosystems, Foster City, USA).

Clinical information, brain magnetic resonance imaging analysis and grading of severity

Clinical information and brain MRI features of the 30 patients with BFPP were either collected directly at the Neuropaediatric unit of Necker Enfants Malades Hospital, Paris Descartes University, obtained from the referring physicians or sent by one of the authors and reviewed by N.B.B. and N.B.

MRI scans of the patients with GPR56 mutations were retrospectively reviewed. After reviewing the images, the cases were classified according to the extent of polymicrogyria—predominantly frontoparietal or diffuse with an antero-posterior gradient. The degree of myelination of each patient was reviewed and compared with standards for the patient’s age (Barkovich, 2005). White matter changes were classified according to the type of signal abnormality (i.e. patchy or diffuse) and the maximal location (periventricular or subcortical and anteriorly or posteriorly predominant). Ventriculomegaly was also noted.

The posterior fossa in each case was carefully reviewed with separate attention to the shape and size of the brainstem and pons. Cerebellar abnormalities were also noted, including vermian or hemispheric involvement, overall size, number of fissures and presence of cysts and their location, as previously described (Jissendi-Tchofo et al., 2009). ‘Hypoplasia’ refers to a small vermis showing few or no fissures and no identifiable prepyramidal fissure, and ‘dysplasia’ refers to abnormal foliation or disorientation of fissures. The degree of involvement was further characterized as mild or severe based on consensus by the authors. According to the previous definition (Piao et al., 2005), this analysis allowed us to define BFP1 as typical bifrontoparietal polymicrogyria, with bilateral white matter signal changes, brainstem and cerebellar hypoplasia, and BFP2 when these additional features were absent.

To assess the radiological differences between two possible locations of the mutation (extracellular domain versus transmembrane region), non-parametric statistical tests were used: the Wilcoxon test for continuous variables and the Fisher exact test for categorical variables (R software, http://www.R-project.org.).

Foetal case

A GPR56 mutation was identified in a foetus presenting with an ‘atypical lissencephaly with cerebellar hypoplasia’, diagnosed prenatally at 35 weeks gestation, on ultrasonography and foetal MRI. In this case, the pregnancy was terminated for medical reasons at 35 weeks gestation, in accordance with French laws. Written consent for post-mortem and diagnostic studies was obtained from the parents. Neuropathological analysis was performed after fixation in a 10% formaldehyde solution containing NaCl (9 g/l) and ZnSO₄ (3 g/l) for six weeks. The brain was cut in a coronal plane and sections involving both hemispheres were embedded in paraffin. Paraffin blocks were cut at 8 µm. Sections were stained with haemalum-phloxin and cresyl violet-luxol-fast-blue (Klüver-Barrera). Immunohistochemical
<table>
<thead>
<tr>
<th>Family</th>
<th>Gender/Age</th>
<th>Head circumference</th>
<th>Cognitive delay</th>
<th>Motor delay</th>
<th>Dysconjugate gaze</th>
<th>Oromotor dyspraxia</th>
<th>Pyramidal signs</th>
<th>Cerebellar signs (ataxia)</th>
<th>Age of onset</th>
<th>Type of seizure</th>
<th>Epileptic activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/1</td>
<td>M/31 years</td>
<td>&lt;3rd percentile</td>
<td>Severe</td>
<td>Walking at 4 years</td>
<td>NR</td>
<td>Yes</td>
<td>Yes moderate spasticity</td>
<td>Severe</td>
<td>Yes</td>
<td>10 years</td>
<td>FS</td>
</tr>
<tr>
<td>I/2</td>
<td>M/33 years</td>
<td>&lt;3rd percentile</td>
<td>Severe</td>
<td>Walking at 2 years</td>
<td>NA</td>
<td>NA</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>II/1</td>
<td>F/5 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 2 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>No</td>
<td>No</td>
<td>6 years</td>
</tr>
<tr>
<td>II/2</td>
<td>M/9 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 2 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>No</td>
<td>Severe</td>
<td>No</td>
<td>No</td>
<td>7 years</td>
</tr>
<tr>
<td>III/1</td>
<td>M/5 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 4 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>No</td>
<td>Severe</td>
<td>No</td>
<td>No</td>
<td>2.5 years</td>
</tr>
<tr>
<td>IV/1</td>
<td>M/10 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 18 months</td>
<td>NA</td>
<td>NA</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>No</td>
<td>3.5 years</td>
</tr>
<tr>
<td>IV/2</td>
<td>M/20 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Sitting without support</td>
<td>Convergent strabismus</td>
<td>No</td>
<td>Yes</td>
<td>Severe</td>
<td>No</td>
<td>No</td>
<td>7 years</td>
</tr>
<tr>
<td>IV/3</td>
<td>M/18 months</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 5 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>2.5 years</td>
<td>GTCS Controlled (VPA)</td>
</tr>
<tr>
<td>V/1</td>
<td>F/8.5 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 5 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>5 years</td>
<td>GTCS Controlled (VPA)</td>
</tr>
<tr>
<td>V/2</td>
<td>M/11 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 5 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>5 years</td>
<td>GTCS Controlled (VPA)</td>
</tr>
<tr>
<td>VI/1</td>
<td>F/12 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking acquired but subsequently lost (11 years)</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>8 years</td>
<td>GTCS Controlled (VPA)</td>
</tr>
<tr>
<td>VII/1</td>
<td>F/8 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 3 years</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>4 years</td>
<td>Abs Controlled (VPA)</td>
</tr>
<tr>
<td>VIII/1</td>
<td>F/7 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 18 months</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>Yes</td>
<td>Severe</td>
<td>Yes</td>
<td>4 years</td>
<td>FS/GTS Refractory (VPA)</td>
</tr>
<tr>
<td>VIII/2</td>
<td>F/5 years</td>
<td>Normal</td>
<td>Severe</td>
<td>Walking at 22 months</td>
<td>Yes nystagmus</td>
<td>Yes nystagmus</td>
<td>No</td>
<td>Severe</td>
<td>Yes</td>
<td>4.5 years</td>
<td>FS Controlled (VPA)</td>
</tr>
</tbody>
</table>

a Age at most recent follow-up.
Abs = atypical absence; At = atonic seizures; CBZ = Carbamazepine; F = female; FS = focal seizures; GTCS = generalized tonic clonic seizures; GTS = generalized tonic seizures; LTG = Lamotrigine; M = male; NA = information not available. PHT = Phenytoine; PMG = polymicrogyria; TPM = Topiramate; VPA = Valproate.
procedures were performed in areas selected after conventional histo-
logical study. Paraffin sections were immunostained for glial fibrillary
acidic protein with a polyclonal antibody (1:200–1:400, DAKO,
USA), MAP2 (1:100, HM2, SIGMA) and NeuN (1:500, MAB377,
CHEMICON). The Universal Immunostaining System Streptavidin-
Peroxydase Kit (Coulter) was used to reveal the reaction. Slides were
incubated in citrate buffer at 98°C, placed in a microwave for 30 min,
rinsed in distilled water, incubated in a 3% H2O2 solution for 5 min
and then rinsed again in distilled water. After washing with phosphate
buffered saline, they were treated with protein blocking agent for
5 min (100 μl/slide) at room temperature, without rinsing. The slides
were then incubated with primary antibodies, diluted as specified
above at room temperature for 60 min, and washed with phosphate
buffered saline twice for 5 min each. Subsequently, they were incu-
bated with biotinylated secondary antibody for 30 min at room tem-
perature, washed with phosphate buffered saline twice for 5 min each
and incubated in streptavidin-peroxidase complex for 45 min. After
washing twice for 5 min in phosphate buffered saline, each slide was
entirely covered with a freshly prepared 3,3′-diaminobenzidine-
chromogen solution (100 μl/slide) for 5 min and finally rinsed with dis-
tilled water for 5 min. Haematoxylin was used to counterstain the
brain sections. All sections were examined under a light microscope
(Eclipse 800 NIKON) and some were selected for photographic
documentation.

Results

From the 30 patients with bifrontoparietal polymicrogyria referred
for molecular screening, 14 living patients and one foetal case
were diagnosed as GPR56-related BFPP. There were six females
and eight males, all from eight consanguineous families of
Caucasian (four families), Middle Eastern (one family), Arab
Medierranean (one family), Iraqi (one family) and Turkish (one
family) origin. The eight GPR56 mutations identified in this study
were novel and disrupted the protein at different levels, namely
in the N-terminal domain: a frameshift mutation (p.E56fsX24)
and a missense mutation (p.C91Y), and in the mucin rich
domain: one non-sense (p.Q123X) and one frameshift mutation
(p.D224WfsX99). Additionally, two missense mutations were
found in the transmembrane domain, TM1 (p.C418W) and TM3
(p.S485P), respectively, one frame deletion in TM2 (p.L449del)
and one frameshift in TM2 (p.L406S406fsX41), but no mutation
in the G-protein-coupled receptor proteolytic site cleavage site
was found (Fig. 1).

For the 15 patients in whom no GPR56 mutation was found, 10
were from non-consanguineous families. All were severely
mentally impaired, but none had a pseudomyopathic presentation
at onset. Three had microcephaly. All had spastic tetraplegia with-
out cerebellar signs. All patients had a phenotype consistent with
BFPP2 on MRI, with bilateral polymicrogyria that predominated
in both frontal lobes (n = 7) or a more diffuse picture with an
antero-posterior gradient (n = 3). None of them had white
matter or posterior fossa abnormalities.

Notably, half of the patients were tested for cytomegalovirus
by analysis of urine and serology. The remaining patients were
not tested, either because other siblings were similarly affected
and harboured GPR56 mutations (11/15 in patients with GPR56
mutations, and 4/15 in patients without mutations) or because of
the absence of clinical suspicion of cytomegalovirus, namely
microcephaly (2/15 in patients with GPR56 mutations and 3/15
in patients without mutations) and lack of intracranial calcification
on CT scan.

Family V: from a foetal case with
cobblestone lissencephaly to
bifrontoparietal polymicrogyria

Among the mutations described above, one was identified in
Family V, initially referred for genetic screening for unexplained
cobblestone lissencephaly (Fig. 2A). The foetal case investigated
was the 7th pregnancy (V/3) of a 40-year-old female who already
had a healthy child. The parents were first cousin parents of
Pakistani origin and had two children (V/1 and V/2), both af-
fected by frontoparietal polymicrogyria. The mother had also
had one previous miscarriage in Pakistan and two medical termin-
ations of pregnancy. In two analysed cases, neuropathological
studies showed diffuse cortical lesions associated with brain stem
corebellar lesions characteristic of ‘cobblestone’ lissencephaly.
No biological material was available for further molecular studies
on these three foetuses. In view of the family history and imaging
findings (cortical and cerebellar malformations), the pregnancy
(V/3) was terminated at 35 weeks. Foetopathological examination
showed no gross visceral, skeletal or ophthalmological malforma-
tions and normal brain biometric parameters. Macroscopic analysis
of the brain showed complete agyria with cobblestone-like features
on the cortical surface and vermian hypoplasia. At a
microscopic level, coronal sections further disclosed disorganized
cortical layers with a succession of normal, polymicrogyric and
‘cobblestone-like’ cortex (Fig. 2A–C). In addition to the cortical
disorganization, immunohistochemical staining with NeuN and
MAP2 antibodies showed ectopic neuronal overmigration through
the pial basement membrane into the leptomeningeal space in
unlayered regions (Fig. 2D). The corpus callosum and hippocam-
pus were present and unaffected (Fig. 2E). There was agenesia of
the cerebellar vermis and the cerebellar hemispheres were
hypoplastic (Fig. 2F). Additionally, massive neuronal overmigration
through the pial basement membrane was observed diffusely in
the pons and focally in the cerebellar cortex (Fig. 2G). Muscle
histopathology was normal and included α-dystroglycan analysis
by immunostaining and western blot. In view of the suggestion of
a cobblestone lissencephaly, mutational screening in POMT1 and
POMT2 originally identified in the Walker–Warburg syndrome
phenotype, was performed and was negative (Beltran-Valero
de Bernabe et al., 2002; van Reeuwijk et al., 2005). Additional
genetic testing of POMGnT1, LARGE and Fukutin genes was also
negative.

We subsequently examined the two affected siblings (V/1 and
V/2) with frontoparietal polymicrogyria, who presented with
congenital hypotonia, cerebellar signs, strabismus and late onset
generalized epilepsy. Since their clinical pattern was suggestive of
GPR56 BFPP, GPR56 screening was performed and revealed a
homozygous p.C418W mutation. This pathogenic mutation was
also found in the foetus (V/3), demonstrating an association
with the cobblestone complex (see also the ‘Discussion’ section).
Natural history of bilateral bifrontoparietal polymicrogyria: clinical features and clinical course

Detailed clinical information was available for eight males and six females (Table 1). Most patients presented before one year of age with severe hypotonia, pseudomyopathic behaviour and strabismus. Serum creatine kinase levels were normal in all cases.

Four patients had a muscle biopsy prior to the diagnosis of BFPP and histochemistry was normal. All patients made motor progress. At the last evaluation (age ranging from 1.5 to 33 years, median 8.25 years), all patients except one (an 18-month-old male IV/3) were able to walk unaided but with moderate to severe ataxia. Age of ambulation ranged from 1.5 to 5 years (median 2.5 years).

All patients had severe mental retardation and communication skills limited to eye contact and a few isolated words. Head circumference was normal in 11/14 patients. The two oldest...
patients were microcephalic (I/1 and I/2) and Patient VII/1 had macrocephaly in association with hydrocephalus. All patients had pyramidal signs with brisk deep tendon reflex but without spasticity. Abnormal eye movements were also found in all cases consisting of nystagmus or strabismus but no other ocular abnormalities were detected.

Epilepsy affected 12/14 patients with onset ranging from 2.5 to 10 years of life (median 4.65 years) and mainly consisted of generalized seizures, either tonic clonic or atypical absences. The two unaffected patients were younger, aged 18 months and 5 years at the time of evaluation. Two patients presented with partial status epilepticus. Six patients had a few seizures initially, but were then seizure-free for 2 years following anti-epileptic drug adjustments. Six patients had medically refractory seizures.

None of the patients had normal EEG background activity or normal posterior α-rhythms on eye closure. Only interictal EEG recordings were obtained. The most common EEG pattern consisted either of bursts of fast activity in the frontocentral regions (n = 5) (Fig. 3) or more diffuse notched θ sharp waves and spikes and waves discharges. In four cases, there were subclinical runs of high amplitude sharp and slow wave complexes mixed with high amplitude α-activity. This activity was more prominent over bilateral frontal and temporal areas.

Altogether, this follow-up study indicates that the 14 patients with GPR56 mutations were phenotypically homogeneous with pronounced early central hypotonia and cerebellar signs, later evolving to share common clinical features with some variability in the epilepsy phenotype but similar interictal EEG abnormalities.

**Neuroimaging findings**

Neuroimaging features of the 14 patients with GPR56 mutations were re-examined. In total, 13 MRIs were analysed and consecutive images were obtained for two patients. Magnetic resonance data are detailed in Table 2.

First, we examined the hallmark of BFPP, i.e. bilateral polymicrogyria with anterior to posterior gradient. The characteristic pattern of bilateral and symmetrical polymicrogyria with a slightly thickened cortex with shallow sulci and irregular grey–white matter interface was observed in all cases. We further classified the extent of the symmetrical polymicrogyria into two categories, involving the fronto-parietal lobes (n = 4) or generalized with an anterior to posterior gradient (n = 9) (Fig. 4).

To further assess the presence of cobblestone-like signs (Jissendi-Tchofo et al., 2009), we examined the cerebellum, the brainstem and white matter evolution. Interestingly, all 13 patients showed moderate to severe cerebellar dysplasia with subpial and cortical cysts and vermis disorganization affecting the superior vermis (11/13) or involving the whole vermis (2/13). Additionally, 5/14 patients also demonstrated hemispheric cerebellar dysplasia with surrounding cysts closely located in the peripheral hemispheres (Fig. 5). There was no obvious relationship between the extent and type of cerebral and cerebellar abnormalities. At the brainstem level, hypoplasia with flattening of the ventral portion of the pons at the level of the middle cerebellar peduncle was detected in all patients (Fig. 6). In the most abnormal scans (Table 2, Patients IV/3, V/1, V/2 and VII/1), the brainstem had an unusual posterior concavity to the posterior aspect.
<table>
<thead>
<tr>
<th>Family/case</th>
<th>Gender/age at MRI</th>
<th>Polymicrogyria distribution</th>
<th>Lateral ventricles</th>
<th>White matter abnormalities</th>
<th>Corpus callosum</th>
<th>Cerebellar vermis</th>
<th>Cerebellar hemispheres</th>
<th>Brainstem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I/1</td>
<td>M/28 years</td>
<td>Frontoparietal</td>
<td>Enlarged</td>
<td>Patchy periventricular</td>
<td>Thin and body</td>
<td>Superior and median vermis</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>I/2</td>
<td>M/33 years</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>II/1</td>
<td>F/5 years</td>
<td>Frontoparietal</td>
<td>Slightly enlarged</td>
<td>Patchy</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+ (sup)</td>
<td>-</td>
</tr>
<tr>
<td>II/2</td>
<td>M/8 years</td>
<td>Frontoparietal</td>
<td>Slightly enlarged</td>
<td>Patchy periventricular and frontal predomiance</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+ (sup)</td>
<td>-</td>
</tr>
<tr>
<td>III/1</td>
<td>M/3 years</td>
<td>Frontoparietal</td>
<td>Slightly enlarged</td>
<td>Patchy periventricular and frontal predomiance</td>
<td>Normal</td>
<td>Superior vermis</td>
<td>+ (sup)</td>
<td>-</td>
</tr>
<tr>
<td>IV/1</td>
<td>M/10 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy periventricular</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>IV/2</td>
<td>M/20 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy periventricular and frontal predomiance</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>IV/3</td>
<td>M/4 months</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Diffuse</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>IV/3</td>
<td>M/18 months</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy with subcortical and frontal predomiance</td>
<td>Thin and body arched</td>
<td>Superior vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>V/1</td>
<td>F/4 months</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Diffuse</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>V/1</td>
<td>F/8 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy with subcortical and frontal predomiance</td>
<td>Thin and body arched</td>
<td>Superior vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>V/2</td>
<td>M/2 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy</td>
<td>Thin and body arched</td>
<td>Superior and median vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>V/2</td>
<td>M/11 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy</td>
<td>Thin and body arched</td>
<td>Superior and median vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>VI/1</td>
<td>F/12 years</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy</td>
<td>Thin and body arched</td>
<td>Superior vermis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>VII/1</td>
<td>F/20 months</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy with subcortical predomiance</td>
<td>Thin and body arched</td>
<td>Superior vermis (mild)</td>
<td>+</td>
<td>+ (sup)</td>
</tr>
<tr>
<td>VII/1</td>
<td>F/12 months</td>
<td>Diffuse max frontoparietal</td>
<td>Enlarged</td>
<td>Patchy</td>
<td>Thin and body arched</td>
<td>Superior vermis (mild)</td>
<td>+</td>
<td>+ (sup)</td>
</tr>
<tr>
<td>VIII/1</td>
<td>F/5 years</td>
<td>Diffuse max frontoparietal</td>
<td>Slightly enlarged</td>
<td>Patchy with subcortical and frontal predomiance</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>VIII/2</td>
<td>F/7 years</td>
<td>Diffuse max frontoparietal</td>
<td>Slightly enlarged</td>
<td>Patchy with subcortical and frontal predomiance</td>
<td>Thin</td>
<td>Superior vermis</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

White matter signal changes were determined in T2/fluid attenuation inversion recovery sequence, and classified as patchy when confluent signal changes, or diffuse. + = present; – = absent; NA = not assessed when images were insufficient for reviewing; sup = superior.
Of note, none of these patients had evidence of severe brainstem dysplasia, which is one of the characteristic features of cobblestone complex lissencephaly.

Moreover, all patients with GPR56 mutations exhibited patchy T2 high signal white matter signal abnormalities to a greater or lesser extent, suggestive of dysmyelination and reminiscent of cobblestone-like lissencephalies (Fig. 7). In two patients (IV/3 and V/2), successive MRIs allowed us to follow the progression of myelination. In both, the white matter abnormalities showed a peculiar pattern of evolution with a severe hypomyelination pattern at four months that evolved into patchy white matter signal abnormalities later in childhood (Fig. 8). Strikingly, the evolution of the abnormal white matter signal began in the parieto-occipital subcortical region, which is in contrast to the normal centrifugal pattern of myelination.

Additional significant magnetic resonance changes in patients with GPR56 mutations consisted of a thin corpus callosum with absent rostrum, often with a smoothly arched callosal body and an enlarged subarachnoid space with ventriculomegaly (n = 8).

Taken as a whole, these observations collectively demonstrate that GPR56-related BFPP is a cobblestone-like ‘polymicrogyria’ that combines anteriorly predominant polymicrogyria and cerebellar vermian dysplasia with subpial and cortical cysts, and to a lesser extent cerebellar hemispheric dysplasia with cysts.

**GPR56 mutations: influence of mutation on the severity of GPR56 bilateral bifrontoparietal polymicrogyria**

Based on previous functional studies demonstrating that BFPP-causing mutations impair protein trafficking and cell surface expression to varying degrees according to their location (Jin et al., 2007), and in light of the interindividual variability observed in our study, we analysed the influence of the position of the mutation and type of substitution on the clinical and radiological features (Table 3). Although some discrepancies were observed between patients with mutations in the N-terminal domain (i.e. extracellular domain) and transmembrane spanning domains, notably on the severity of epilepsy (age of seizure onset and drug resistance), as well as the extent of polymicrogyria and white matter abnormalities, no statistical differences were found. The less severely affected patients harboured mutations in the N-terminal domain, which is of interest because biochemical results suggest that these mutations result in more drastic functional consequences on GPR56 function, i.e. reduced intracellular trafficking and poor cell surface expression (Jin et al., 2007).

**Discussion**

The aim of our analysis was to provide new insights into the phenotype of GPR56 BFPP (OMIM® 6066854) in light of recent data from animal studies demonstrating that loss of GPR56 results in cobblestone cortex and leads to rostral cerebellar dysplasia. Combined with the first foetopathological case with a GPR56 mutation, our study examined the clinical and brain MRI

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**Figure 3** Representative interictal electroencephalogram pattern in patients with GPR56 BFPP. (A) Theta activity with medium amplitude and rare and brief spike and wave discharges with predominance in both frontal and temporal areas (Patient II/1 aged 9 years) (Patient V/2 aged 8 years). (B) Runs of fast activity in frontocentral regions resembling α-like activity with high amplitude theta activity maximal in frontal and central regions (Patient II/1 aged 9 years). (C) Diffuse delta waves (2–3 Hz) intermixed with α-like activity and high voltage with paroxysmal discharges of spike and waves, maximal in both frontal and temporal areas (Patient VIII/2 aged 5 years). (D) Unusual α-like activity over both frontal regions (Patient V/1 aged 10 years). No physiological sleep pattern. Amplitude 10 μV/mm. Speed 15 mm/s.
Table 3  Comparison of clinical and radiological features between patients with GPR56 BFPP with mutations in the extracellular domain and mutations in the transmembrane domain

<table>
<thead>
<tr>
<th></th>
<th>Extracellular domain&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Transmembrane domain&lt;sup&gt;a&lt;/sup&gt;</th>
<th>P-value&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients (n)</td>
<td>8</td>
<td>6</td>
<td>0.75</td>
</tr>
<tr>
<td>Median age in years (range)</td>
<td>9.5 (1.5–33)</td>
<td>8.25 (5–12)</td>
<td>0.75</td>
</tr>
<tr>
<td>Severe mental retardation (%)</td>
<td>8/8 (100)</td>
<td>6/6 (100)</td>
<td>1</td>
</tr>
<tr>
<td>Ability to walk (%)</td>
<td>6/7 (85.7)</td>
<td>5/6 (83.3)</td>
<td>1</td>
</tr>
<tr>
<td>Dysconjugate gaze (%)</td>
<td>4/4 (100)</td>
<td>6/6 (100)</td>
<td>1</td>
</tr>
<tr>
<td>Epilepsy (%)</td>
<td>6/8 (75)</td>
<td>6/6 (100)</td>
<td>0.47</td>
</tr>
<tr>
<td>Median age of seizure onset in years (range)</td>
<td>6 (2.5–10)</td>
<td>4.65 (2.5–8)</td>
<td>0.71</td>
</tr>
<tr>
<td>Refractory epilepsy (%)</td>
<td>4/8 (50)</td>
<td>2/5 (40)</td>
<td>1</td>
</tr>
<tr>
<td>MRI (n)</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Diffuse polymicrogyria (%)</td>
<td>3/7 (42.8)</td>
<td>6/6 (100)</td>
<td>0.07</td>
</tr>
<tr>
<td>Enlarged ventricles (%)</td>
<td>4/7 (51.1)</td>
<td>4/6 (66.7)</td>
<td>1</td>
</tr>
<tr>
<td>Patchy white matter abnormalities (%)</td>
<td>3/7 (42.8)</td>
<td>5/6 (83.3)</td>
<td>0.27</td>
</tr>
<tr>
<td>Vermian and hemispheric dysplasia (%)</td>
<td>1/7 (14.3)</td>
<td>4/6 (66.7)</td>
<td>0.10</td>
</tr>
<tr>
<td>Vermian and hemispheric cyst (%)</td>
<td>7/7 (100)</td>
<td>5/6 (83.3)</td>
<td>0.46</td>
</tr>
<tr>
<td>Brainstem hypoplasia (%)</td>
<td>7/7 (100)</td>
<td>6/6 (100)</td>
<td>1</td>
</tr>
</tbody>
</table>

<sup>a</sup> The denominator indicates the number of patients for whom specific information was available.

<sup>b</sup> To assess the differences between defined groups of patients and to evaluate the correlation with the location of the mutation (extracellular domain versus transmembrane mutation) between the severity of cortical dysgenesis and pontocerebellar abnormalities, non-parametric statistical tests were used (Kruskal–Wallis test for multiple group comparison and χ² McNemar test (Statistica version 7.1, StatSoft France, 2005, www.statsoft.fr)). P < 0.05 was considered significant.

Figure 4  Representative brain magnetic resonance images of patients with GPR56 BFPP. T₁-weighted axial section of Patient II/1 (8 years at MRI, A), Patient II/2 (5 years at MRI, B), Patient III/1 (3 years at MRI, C), Patient VIII/1 (7 years at MRI, E), Patient V/1 (8 years at MRI, F), Patient V/2 at 7 years (11 years at MRI, G) and T₁-weighted coronal section of Patient II/2 (5 years at MRI, D) and Patient IV/1 (10 years at MRI, H). These images demonstrate different degrees and extent of polymicrogyria involving the frontoparietal regions bilaterally (A–C), or more generalized polymicrogyria with frontoparietal predominance (E–G). Coronal sections (D and H) at the level of the hippocampus show the parietal predominance of polymicrogyria and the relative preservation of the temporal lobes. Note the ventricular size that is either not (C), moderately (A and B) or severely enlarged (E–H). Note also the right sided lentiform nucleus infarct in Patient IV/1 (H).
Figure 5 Representative T₂-weighted axial sections showing the different features of cerebellar hypoplasia and dysplasia in GPR56 BFPP. These images demonstrate multiple cysts located in dysplastic cerebellar hemispheres (A, C, E and G) and in the cerebellar vermis (B, D, F and H). Different degrees of severity considered as severe cerebellar dysplasia and brainstem hypoplasia in Patient IV/3 (18 months at MRI, A and B) and Patient VII/1 (20 months at MRI, C and D), and milder severity in Patient V/2 (11 years at MRI, E and F) and Patient II/2 (5 years at MRI, G and H). Note the small pons with overmigration (B, Patient IV/3, 18 months at MRI). There is an exaggerated rounded appearance to the high signal myelinated corticospinal tracts (thin black arrows). There are several cerebellar cysts (thick black arrow).

Figure 6 Representative T₁-weighted midline sagittal images in GPR56 BFPP. In the sagittal plane, the pons is thinned with either a flat aspect (A, Patient II/2), (B, Patient III/1), (D, Patient IV/1) (G, Patient VI/1), and in the most severe form, a concave posterior border (C, Patient IV/3), (E, Patient VIII/1) (F, Patient VII/1), (H, Patient V/2), and the midbrain tectum is abnormally large. Note the different aspect of corpus callosum ranging from normal (B) to hypoplasia thin splenium and arched body (C and H).
Figure 7 Representative axial T2 images in GPR56 BFPP. These images demonstrate polymicrogyria in the frontoparietal regions bilaterally, as well as patchy bilateral signal change in the white matter, patchy (A, Patient II/1), (D, Patient IV/3), (E, Patient V/1), (F, Patient VI/1) (G, Patient VII/1) or spotty periventricular and frontal (B, Patient III/1), (C, Patient IV/1) (H, Patient V/2).

Figure 8 Axial T2 images of Patient IV/3 (A, B, E and F) and Patient V/2 (C, D, G and H) showing the appearance of the white matter at 4 months (A–D), highly suggestive of severe hypomyelination and the subsequent evolution to patchy signal changes mostly prominent in subcortical and frontal regions [at the age of 18 months in Patient IV/3 (E and F) and 9 years in Patient V/2 (G and H)].
characteristics of 14 individuals with BFPP from eight families harbouring eight novel mutations in the GPR56 gene. The overall information that can be drawn from this study is that the range of central nervous system involvement is wider than originally described and that cortical, white matter as well as cerebellar involvement occurs in BFPP and is highly reminiscent of cobblestone complex lissencephaly (Barkovich, 1998).

Taken together, the clinical and radiological findings described in our study in combination with previously reported data, suggest that GPR56 defects produce a ‘cobblestone-like cortical dysgenesi’.

**GPR56 bilateral bifrontoparietal polymicrogyria: a peculiar course with a pseudomyopathic presentation that subsequently evolves into severe mental and motor retardation with generalized epilepsy**

The overwhelming majority of patients presented in the first months of life with severe hypotonia and a pseudomyopathic presentation. At first, clinicians suspected congenital muscular dystrophies and performed muscle biopsies that were normal. Subsequently, central hypotonia became more obvious. Later in infancy, patients exhibited clinical features consistent with a developmental brain malformation including severe mental and motor retardation and pyramidal signs, and in addition developed cerebellar signs and eye movement abnormalities. This clinical presentation appears to be specific to GPR56-related BFPP and should lead clinicians who initially suspect congenital muscular dystrophy (Piao et al., 2002, 2005; Chang et al., 2003) to also consider the diagnosis of a GPR56-related disorder.

Epilepsy is a consistent feature in GPR56 BFPP and mainly consists of generalized seizures, either tonic clonic or atypical absences with an EEG pattern highly reminiscent of those with lissencephaly (Piao et al., 2005; Parrini et al., 2009). Notably we provide the first detailed description of the interictal EEG pattern in GPR56 BFPP and highlight the similarity with the pattern seen in diffuse cortical malformations typically described in type I lissencephaly (Gastaut et al., 1987; de Rijk-van Andel et al., 1988; Santanelli, 1991; Mori et al., 1994; Raymond et al., 1995). This consists of unusual α-like activity of low amplitude and is not modified by eye opening or closure. The unusual fast activity often persists as the child gets older and is later associated with high amplitude sharp and slow wave complexes mainly in the frontal and temporal regions bilaterally (Parrini et al., 2009). This pattern is helpful in detecting neuronal migration disorders and, in some cases, may contribute to predicting the timing of seizure onset in the first few years of life. According to Dalla Bernardina and colleagues (1996), the earlier both the high amplitude and fast activity appear, combined with their generalized appearance, the greater the probability of early seizure onset. In our series, EEGs were performed at the age of seizure onset and further studies are therefore needed to evaluate the predictive value of early seizure onset in GPR56 BFPP.

**Further evidence suggesting that GPR56 bilateral bifrontoparietal polymicrogyria is a ‘cobblestone-like cortical dysgenesi’**

Previous studies have highlighted the occurrence of white matter lesions combined with polymicrogyria in GPR56 BFPP. White matter changes are rare in other polymicrogyria syndromes i.e. frontal, perisylvian or generalized polymicrogyria (Jansen and Andermann, 2005; Piao et al., 2005). By contrast, they are common findings in cobblestone complex lissencephalies (Barkovich, 1998). Thus it is not surprising that BFPP had previously been termed ‘cobblestone lissencephaly with normal eyes and muscle’ (Barkovich, 1996).

Cobblestone lissencephaly encompasses a large group of neuronal migration disorders resulting from overmigration of neurons beyond the developing cerebral cortex, passing through defects of the glia limitans into the subarachnoid space. This aberrant migration produces irregular neuronal ‘cobblestones’ (ectopia) on the surface of the brain and is a feature of three distinct human disorders of varying severity: Walker–Warburg syndrome (most severe); muscle-eye-brain disease and Fukuyama congenital muscular dystrophy (least severe) (Brockington et al., 2005; Mercuri et al., 2006, 2009; Godfrey et al., 2007). These three disorders are characterized by cerebral cortical dysplasia that ranges from pachygyria to agyria, combined with dysmyelination, severe dysplastic cerebellum with cysts and brainstem hypoplasia (Fukuyama et al., 1981; Dobyns et al., 1989; van der Knaap et al., 1997; Barkovich et al., 2005; Jissendi-Tchofo et al., 2009).

This is the first study to our knowledge, which provides evidence that GPR56-related BFPP and cobblestone lissencephaly share additional specific features, which consist of cerebellar dysplasia with cysts and severe hypomyelination that subsequently evolves to patchy dysmyelination, and overmigration of neuronal cells in the leptomeningeal space.

First, we show that hind and midbrain abnormalities are consistent key features in GPR56 BFPP. While previous reports described only cerebellar hypoplasia (Piao et al., 2005), we found a high rate of cerebellar dysplasia with microcysts. Vermian dysplasia and cysts strongly predominate in the superior vermis and are observed in >90% of patients in this study, regardless of age. Of note, the dysplasia can be more diffuse involving the whole vermis and the hemisphere. However, no obvious relationship between the extent or type of cerebral and cerebellar abnormalities were found. Hence, cerebellar vermic dysplasia with accompanying cysts is an important finding in BFPP, since it can be recognized more readily than cortical polymicrogyria in a young infant and should prompt a careful search for GPR56 mutations.

Second, combined with previous reports that highlighted the importance of white matter abnormalities in GPR56 BFPP, our observations have allowed us to demonstrate that the myelination process is also impaired in GPR56 BFPP. White matter abnormalities are maximal at a young age and consist of severe and diffuse hypomyelination, but myelination does progress, albeit in an unusual manner proceeding from the peripheral subcortical region.
## Table 4 Characteristics of GPR56 bifrontoparietal polymicrogyria compared with congenital muscular dystrophy

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Role</th>
<th>Clinical presentation</th>
<th>Cerebral cortex</th>
<th>Cerebellar cortex</th>
<th>White matter</th>
<th>Brainstem</th>
<th>Ocular anomalies</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPR56 BFPP</td>
<td><em>GPR56</em> acts as a G-protein-coupled receptor that localizes to radial glial foot processes directly adjacent to the pial basement membrane and is required to maintain structural integrity of this basement membrane</td>
<td>Hypotonia; delayed motor; delayed cognition; variable seizures; normal CK</td>
<td>Frontoparietal polymicrogyria Diffuse PMG with antero-posterior gradient</td>
<td>Polymicrogyria with or without cysts</td>
<td>Delayed myelination in cerebrum</td>
<td>Pontine hypoplasia</td>
<td>Abnormal eye movements</td>
</tr>
<tr>
<td>Fukuyama congenital muscular dystrophy (Fukuyama type and similars)</td>
<td>Mutation in the gene encoding <em>fukutin</em> that probably participates in the biosynthesis pathway of dystroglycan, involved in the binding activity for the ligand laminin</td>
<td>Hypotonia; delayed motor; delayed cognition; variable hydrocephalus; variable seizures; variable CK</td>
<td>Frontal polymicrogyria; temporop-occipital cobblestone cortex with irregular inner surface and smooth outer surface</td>
<td>Polymicrogyria with or without cysts</td>
<td>Delayed myelination in cerebrum; peripheral white matter myelinates first</td>
<td>Variable pontine hypoplasia; variable fused colliculi</td>
<td>Abnormal eye movements; myopia; cataracts; retinal ‘round’ lesions</td>
</tr>
<tr>
<td>Muscle-eye-brain disease</td>
<td>Mutation in O-mannose β1,2-N-acetylgalactosaminyltransferase (<em>POMGnT1</em>) that participates in O-mannosyl-glycan synthesis, results in disorder of radial migration and disruption of the pial barrier</td>
<td>Hypotonia; delayed motor; ocular anomalies; variable hydrocephalus; variable seizures; normal CK</td>
<td>Diffusely dysplastic, same features but intermediate severity between Fukuyama congenital muscular dystrophy and Walker-Warburg syndrome</td>
<td>Polymicrogyria with or without cysts; vermicran hypogenesis</td>
<td>Patchy T₁ and T₂ prolongation; variable callosal hypogenesis</td>
<td>Pontine hypoplasia; fused colliculi</td>
<td>Abnormal eye movements; myopia; cataracts; retinal dystasia; hypoplastic nerve</td>
</tr>
<tr>
<td>Walker–Warburg syndrome</td>
<td>Gene encoding O-mannosyl transferase (<em>POMT1</em>) involved in O-mannosyl-linked glycosylation of proteins important for the formation of glia limitans</td>
<td>Hypotonia; no motor milestones; no cognition; ocular anomalies; hydrocephalus; variable seizures; normal CK</td>
<td>Diffuse cobblestone cortex; hydrocephalus</td>
<td>Polymicrogyria with or without cysts; variable cephalocele</td>
<td>Leucodystrophy; variable callosal hypogenesis</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Congenital Muscular Dystrophy Merosin deficiency</td>
<td>Mutation in the laminin α2 gene (<em>LAMA2</em>), is a permissive substrate for migration of oligodendrocyte precursors</td>
<td>Hypotonia; delayed motor; high CK</td>
<td>Occipital agryia (no cobblestone cortex)</td>
<td>Polymicrogyria with or without cysts</td>
<td>Striking leucodystrophy involving U fibres</td>
<td>Mild pontine hypoplasia</td>
<td>None</td>
</tr>
</tbody>
</table>

CK = serum creatine kinase.
centrally, which is the reverse of normal myelination process. These changes are strikingly similar to those seen in Fukuyama congenital muscular dystrophy (Dobyns et al., 1989; Aihara et al., 1992; Valanne et al., 1994; Barkovich, 1998). Their exact nature is unknown but abnormal production or migration of oligodendrocytes in GPR56 BFPP cannot be excluded. This raises the possibility that delayed myelination and dysmyelination in GPR56 mutations might result in abnormal axonal pathfinding.

Thirdly, foetopathological features reported here, demonstrate that GPR56 mutations lead to a cobblestone-like brain malformation with succession of normal, polymicrogyric and ‘cobblestone-like’ cortex, with focuses of ectopic neuronal overmigration through the pial basement membrane into the leptomeningeal space in unlayered regions, combined with massive neuronal overmigration in the pons and focally in the cerebellar cortex.

In view of these findings and to further investigate whether cobblestone lissencephaly and GPR56 BFPP share additional features, we compared other brain structures (Table 4). At the forebrain level, the main difference is the primary location and the gradient of cortical dysplasia that predominates in the temporoparietal region in Fukuyama congenital muscular dystrophy compared with the frontoparietal gradient seen in GPR56 BFPP. In the midbrain and hindbrain, the cerebellum is more severely hypoplastic in cobblestone lissencephaly than in BFPP, where the cerebellar hemisphere is dysplastic and combined with cysts. In the brainstem, pontine midline cleft and deformity of the mid-hindbrain junction (pontomedullary ‘kink’), which is a hallmark of cobblestone lissencephaly, was not observed in GPR56 BFPP. These features are remarkably predominant in the cobblestone lissencephaly groups, differentiating them from patients with GPR56 BFPP. These differences might reflect the distinctive pathophysiological mechanisms of both conditions.

GPR56 bilateral bifrontoparietal polymicrogyria a ‘cobblestone-like cortical dysgenesis’: pathophysiological similarities with cobblestone lissencephalies

Neuronal migration disorders are related to the impairment of several genetically determined processes that act either at the beginning of migration, during migration and/or towards the end of migration (Gleeson and Walsh, 2000). Of these, classical lissencephaly, also referred to as the agryia-pachygyria spectrum, is caused by a defect during migration that leads to abnormal laminarization and a thickened cortex that is characterized by a more-or-less four-layered cortex. Cobblestone lissencephalies are disorders of migration caused by a defect in the integrity of the pial membrane that leads to the formation of breaches during rapid cortical expansion with a disorganization of radial glia end feet and fibres. This results in a massive overmigration of neuroglial cells in the leptomeningeal spaces surrounding the cerebral cortex and in the cerebellum (Moore et al., 2002; Montanaro and Carbonetto, 2003). On the other hand, polymicrogyria is aetologically and histologically heterogeneous and its pathogenesis remains poorly understood. In polymicrogyria, the normal folding of the cerebral cortex is disrupted, resulting in an irregular surface with numerous smaller and irregular folds (gyri) and shallow, partly fused intervening grooves (sulci). Classically, polymicrogyria is thought to be a disorder of late migration or cortical organization, and supposed to reflect a disruption of normal neuronal migration with subsequent disordered cortical organization (Barkovich et al., 2005).

Interestingly, the foetopathological brain features (i.e. neuronal overmigration, rupture of the pial basement membrane and dysplastic rostral cerebellum) reported in this study are consistent with those described in the developing forebrain and rostral cerebellum of the GPR56-/- mouse model (Li et al., 2008; Koirala et al., 2009). They are also reminiscent of those reported in recent studies on β-tubulin 2B-related polymicrogyria (Jaglin et al., 2009; Jaglin and Chelly, 2009; Jackson, 2009).

Given these findings, we are tempted to propose that the pathophysiological processes underlying GPR56-related BFPP could result from a combined effect of alterations of pial basement membrane integrity, radial glial organization and neuronal overmigration during critical stages of brain development.

At the molecular level, hypotheses based on insights provided by advances in the understanding of the pathogenesis of cobblestone lissencephalies, which are known to be associated with hypoglycosylation and dysfunction of α-dystroglycan (Henry and Campbell, 1998; Hewitt, 2009), should be considered. Indeed, the fact that GPR56 encodes a G-protein-coupled receptor expressed in radial glia endfeet suggests that loss of function of GPR56, or its altered subcellular localization or glycosylation, is likely to have a deleterious effect on the interaction between the pial basement membrane and radial glial endfeet. This results in a disruption of pial membrane basement integrity, radial glia disorganization and subsequently produces abnormalities of cortical organization and folding.

Taken as a whole, the data reported here open new and exciting insights into the pathophysiology of polymicrogyria, and give further evidence of a continuum of cortical dysgenesis from unlayered polymicrogyria at the less severe end of the spectrum to the cobblestone lissencephalies. They suggest that alterations of the regulation of pial basement membrane integrity during development and overmigration of neuronal cells, characteristics reminiscent of cobblestone lissencephaly (Li et al., 2008), should be taken into consideration when attempting to define the pathophysiological mechanisms underlying polymicrogyria.

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foetopathological case. K.P., I.R., L.V. and C.B. performed genetic and molecular investigations. N.B.B. and N.B. re-examined the patient’s MRIs. C.E. performed statistical analysis. N.B.B. and C.S. re-examined patients’ EEG data. N.B.B. drafted the article with the help of K.P., K.L. and J.C. J.C. supervised the design and follow-up of the study and preparation of the article. N.B.B. and K.P. contributed to the writing of the article. The article was finalized by N.B.B., K.P. and J.C. with the assistance of all co-authors.

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References