Multiple endocrine neoplasia type 2 (MEN2) syndromes are autosomally dominant clinical associations characterised by a number of tumours, including medullary thyroid carcinoma (MTC), phaeochromocytoma, thyroid C-cell hyperplasia (CCH), parathyroid tumours (MEN2A) and ganglioneuroma of the gastrointestinal tract (MEN2B). The common factor in the MEN2 syndromes is MTC, a poorly differentiated thyroid malignancy that represents 3 - 10% of thyroid tumours1,2 but is hereditary in 20 - 30% of cases.

MTC (and other thyroid tumours) have been shown to be genetically linked to mutations in the \textit{RET} (REarranged during Transfection) proto-oncogene (situated at 10q22 3,4), which plays a pivotal role in at least four clinical syndromes (MEN2A and MEN2B, familial medullary thyroid carcinoma (FMTC) and Hirschsprung’s disease (HSCR)) in a unique ‘switch on, switch off’ manner.5

\textit{RET} gene variations are present in more than 50% of MTC cases as well as a significant number of papillary thyroid carcinomas (chromosomal inversions or translocations (RET/PTC)).6

Inheritance is important, and the risk to family members appears to be particularly high in MEN2. Patients with genetic mutations involving the cysteine radicals of the gene account for 92 - 95% of those who later develop MTC.7,8 Children of families with MTC and the MEN2 syndromes have been reported to...
were subjected to heteroduplex single-strand conformation analysis demonstrating mobility or conformational variants on the PAA gels.

DNA analysis

DNA extraction was performed on colonic tissue samples and whole blood using standard techniques. Polymerase chain reaction (PCR) amplification of the 21 exons of the RET gene in HSCR.17 DNA variation in gene-positive family members. In one 6-year-old, CCH (a premalignant stage23) (Fig. 1) was identified along with a twice-normal serum calcitonin level. In another 2, early occult MTC was detected (serum calcitonin 3 times normal in 1) (Fig. 2). A further 2 are awaiting prophylactic surgery.

A cysteine radical mutation (C620R and C620W) was related to MEN2B category. The remaining 19 were unaffected relatives screened for carrier status, among whom a familial recurrence was observed in 7 (37%). Serum calcitonin levels were raised in 19 of the 21 affected patients. In 2 patients early MTC was not associated with raised calcitonin levels.

Results

Fifty persons were screened (male/female ratio 1:1.5). Their ages ranged from newborn to 54 years, and 7 were children aged <13 years. All ethnic groups were represented (white 12, black 11, coloured 17). There were 9 index MTC cases, 5 phaeochromocytoma, 3 HSCR-MEN associations and 2 miscellaneous (1 neuroblastoma, 1 intestinal neuronal dysplasia); 1 patient fell into the MEN2B category. The remaining 19 were unaffected relatives screened for carrier status, among whom a familial recurrence was observed in 7 (37%). Serum calcitonin levels were raised in 19 of the 21 affected patients. In 2 patients early MTC was not associated with raised calcitonin levels.

On genetic testing, an RET point mutation was identified in 21 of the 40 patients (52.5%) (Table I). The genetic variation occurred at the high-risk 634 cysteine allele in 11 of these (52%). A further cysteine radical mutation at the 620 position was related to MEN2 in 3 families, with proven MTC in recurrent patients in 2 cases; and included the 691 position on codon 11 (11 cases); the 432 position (4 cases, 1 homozygous); intronic mutations on exon 4 (1 case); and an IVS19-37G/C and a D1017N variation in exon 19 in 2 MEN families (Table I). Additional polymorphisms of the gene occurred in both patients and controls (Table II).

Fifteen patients underwent surgical removal of the thyroid gland (total thyroidectomy), including 3 prophylactic thyroidectomies in gene-positive family members. In one 6-year-old, CCH (a premalignant stage23) was detected (serum calcitonin 3 times normal in 1) (Fig. 2). A further 2 are awaiting prophylactic surgery.

A cysteine radical mutation (C620R and C620V) was related to MEN2 in 3 families, with proven MTC in recurrent patients in 2 and suspected in the other. In addition, it was a major factor in a unique family referred from elsewhere in which MEN and HSCR co-existed.20 Other less recognised gene variations were detected throughout the RET gene in 70% of cases and included the 691 position on codon 11 (11 cases); the 432 position (4 cases, 1 homozygous); intronic mutations on exon 4 (1 case); and an IVS19-37G/C and a D1017N variation in exon 19 in 2 MEN families (Table I). Additional polymorphisms of the gene occurred in both patients and controls (Table II).

Discussion

This study confirms the association of RET gene mutation with cancer risk in MEN2 and MTC families in all ethnic groups in the diverse South African population. As MTC is a particularly chemo/radio-resistant tumour, spreading mostly via the lymphatic system and often resulting in death, the major benefit of RET genetic testing lies in the early preclinical identification of carriers of the RET mutation and timely prophylactic thyroidectomy, as carried out in this study.

Activating mutations of RET appear to be of the order of
**TABLE I. POTENTIAL DISEASE-CAUSING MUTATIONS IDENTIFIED IN THE RET Proto-OncoGene in MEN2 Patients**

<table>
<thead>
<tr>
<th>Exon/Intron</th>
<th>Mutation</th>
<th>Nucleotide change</th>
<th>Effect on coding sequence</th>
<th>No. of patients</th>
<th>Gender/ethnic group</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>IVS4-18G/A</td>
<td></td>
<td>Splice acceptor</td>
<td>1</td>
<td>WM</td>
<td>MEN2B</td>
</tr>
<tr>
<td>10</td>
<td>*C620W</td>
<td>TGC→TGG</td>
<td>Missense</td>
<td>2</td>
<td>CM/CF</td>
<td>HSCR-MEN2</td>
</tr>
<tr>
<td>11</td>
<td>*C634S</td>
<td>TGC→AGC</td>
<td>Missense</td>
<td>8</td>
<td>BF/BF/BF</td>
<td>MEN2A</td>
</tr>
<tr>
<td>11</td>
<td>*C634Y</td>
<td>TGC→TAC</td>
<td>Missense</td>
<td>2</td>
<td>WF</td>
<td>MEN2A</td>
</tr>
<tr>
<td>11</td>
<td>*C634R</td>
<td>TGC→CGC</td>
<td>Missense</td>
<td>2</td>
<td>CF/CF</td>
<td>MEN2A</td>
</tr>
<tr>
<td>12</td>
<td>A750P</td>
<td>GCA→CCA</td>
<td>Missense</td>
<td>2</td>
<td>CF/CF</td>
<td>MEN2A</td>
</tr>
<tr>
<td>13</td>
<td>D771N</td>
<td>GAC→AAC</td>
<td>Missense</td>
<td>1</td>
<td>WF</td>
<td>FMTC</td>
</tr>
<tr>
<td>18</td>
<td>M1009V</td>
<td>ATG→GTG</td>
<td>Missense</td>
<td>1</td>
<td>WF</td>
<td>FMTC</td>
</tr>
<tr>
<td>19</td>
<td>D1017N</td>
<td>GAC→AAC</td>
<td>Missense</td>
<td>1</td>
<td>CF</td>
<td>FMTC</td>
</tr>
<tr>
<td>19</td>
<td>V1041G</td>
<td>GTG→GGG</td>
<td>Missense</td>
<td>1</td>
<td>BF</td>
<td>MEN2A</td>
</tr>
<tr>
<td>20</td>
<td>IVS19-37G/C</td>
<td></td>
<td>Splice acceptor</td>
<td>1</td>
<td>CM</td>
<td>MTC carrier</td>
</tr>
</tbody>
</table>

*Related to cysteine radicals on RET gene.

Ethnic grouping: W (M/F) = white; C (M/F) = coloured (mixed ancestry); B (M/F) = black African.

**TABLE II. POLYMORPHISMS IDENTIFIED IN THE RET Proto-OncoGene in MEN2 Patients and Controls**

<table>
<thead>
<tr>
<th>Exon/intron</th>
<th>Codon</th>
<th>Nucleotide change</th>
<th>Allele frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>BC (N=60)</td>
</tr>
<tr>
<td>2</td>
<td>A45</td>
<td>GCG→GCA</td>
<td>0.06</td>
</tr>
<tr>
<td>7</td>
<td>A432</td>
<td>GCG→GCA</td>
<td>0.0</td>
</tr>
<tr>
<td>13</td>
<td>L769</td>
<td>CTT→CTG</td>
<td>0.0</td>
</tr>
<tr>
<td>15</td>
<td>S904</td>
<td>TCC→TCG</td>
<td>0.25</td>
</tr>
</tbody>
</table>

*Allele frequency of polymorphic allele denoted.

BC = black control group; CC = coloured control group; WC = white control group.

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Fig. 1. Calcitonin immunostain of prophylactically excised thyroid gland of a 6-year-old 634 carrier, showing increased calcitonin activity and C-cell hyperplasia (x160).

Fig. 2. Medullary thyroid carcinoma in the 36-year-old mother of a Hirschsprung’s disease patient with a C620 point mutation.
Affecting the tyrosine kinase domain (MEN2B)). MTC in MEN2B (609, 611, 618, 620, 630 and 634 positions) (MEN2A) and those main groups (viz. those affecting one of the six cysteine radicals and 630 positions) (MEN2A) and those affecting the tyrosine kinase domain22 (MEN2B)). MTC in MEN2B is associated with a point mutation (methionine-threonine) in exon 16 (M918T) of the RET proto-oncogene in 95% of cases.23,24 Genetic variants at amino acid positions 634 (MEN2A) and 918 (MEN2B) carry a particularly high-risk profile of MTC in offspring when compared with others.25,26 Other MEN2 tumours (e.g. pheochromocytoma) may also be related to RET but usually occur later in life.27

RET proto-oncogene testing has been shown to be vastly superior to measurement of calcitonin levels in identifying preclinical MTC cases, with a specificity approaching 95 - 100%.28 Genetic screening is extremely sensitive in MEN2 syndromes, and children of MTC families who are carriers of mutant genes are at risk and may be identified by detection of the germline mutation in the RET proto-oncogene. These are particularly related to RET cysteine mutations in exons 10, 11, 13 and 16, but other RET variations also appear to carry risk. In this study, 2 family members with high-risk RET mutations and an early MTC detected at thyroidectomy had normal serum calcitonin levels, demonstrating the value of RET gene screening in diagnosis.

A further interesting phenomenon is the relatively uncommon co-segregation of HSCR and MEN2 in the same patient,29,30 i.e. involving both gain and loss of gene function. This was encountered in 2 families in South Africa and has been reported elsewhere.29

The high frequency with which the C620 RET mutation occurs in HSCR-MEN patients suggests the concept of the so-called 'Janus gene' mutation in this position, which like the Roman god of transition can face in two directions (i.e. activation (MEN/ MTC) and inactivation (HSCR)).30

In 2007 Machens and Dralle stratified MTC risk into three categories according to mutation-related aggressiveness, giving rise to a concept of 'codon-directed' timing of surgery. One long-term follow-up study of 46 RET gene carriers categorised the risk to children and young adults (aged 4 - 21 years) into low-risk (level 1) and intermediate- to high-risk (level 2) mutations.31 Level 1 mutations appeared to be associated with variations in codons 790, 791, 804 and 891 and had a high rate of cure. In contrast, 5 (14%) of the 35 level 2 patients (mutations of codons 618, 620, 630 and 634) had ongoing disease. On long-term follow-up (mean 6.4 years), 2 of those with 634 mutations developed other MEN manifestations (viz. hyperparathyroidism and bilateral pheochromocytoma). This latter risk would probably increase with time, and long-term follow-up is necessary. Level 3 mutations include those at positions 883 and 918.

Patients with phenotypic features resembling MEN2B always require genetic testing even if the family history is negative, because of the high incidence of spontaneous mutations (approximately 50%)33,34 and the early onset of MTC. Offspring of people with MEN2B-related MTC have a particularly high risk of an early aggressive carcinoma, the youngest reported case being at 2 months of age.11

The RET proto-oncogene has been shown to have a significant role in cancer treatment and prevention. Although many of the tumours only occur later in life,6 surgical decision making is required in the childhood years, which then raises a number of points for discussion. The first of these is the question of timing of codon-directed prophylactic thyroid surgery; the second the timing and extent of genetic screening, and the third the nature of patient follow-up and the subsequent risk of other MEN-related tumours, which has to be accompanied by adequate genetic counselling. It is recommended that testing should be carried out before 1 year of age in children (especially in families with 883/918 codon mutations) and before 5 years in MEN2A families (especially with mutations of codons 611, 618, 620 and 634). The high incidence of early aggressive tumours associated with MEN2B35-37 warrants an aggressive surgical approach with early prophylactic thyroidectomy in gene carriers (<1 year).6,11 Total thyroidectomy is recommended, with central lymph node dissection being added in cases of MEN2B.

In addition to its role in MTC, tyrosine kinase activity upregulation has been demonstrated in other thyroid tumours by the RET/PTC fusion gene in papillary thyroid carcinoma.38 After the Chernobyl disaster (ionising radiation), papillary thyroid tumours in children showed a high prevalence of RET fusion gene rearrangements, with at least 11 of these being described (the majority being an RET/PTC3 rearrangement).39

The mechanisms by which the RET proto-oncogene mutation results in gene activation and thus causes thyroid cancer is not yet fully clear. The 'gain of function' variations in the cysteine-rich extracellular domain of RET probably activate RET by inducing aberrant disulphide-linked homodimerisation.24,31 In addition, RET extracellular domain mutations may result in the unfolding of RET. In MEN2B the 918 mutation alters the substrate specificity of RET tyrosine kinase and induces a different set of signalling pathways to those in MEN2A. Y1062 (a critical regulator of RET signalling) appears to be an important location on the gene.39 The downstream effects of RET activation are not fully clear, but RET binds to the glial-derived neurotrophic factor (GDNF) co-receptor which then activates various signalling pathways (e.g. RAS/ extracellular signal-regulated kinase (ERK), phosphatidylinositol 3-kinase (PI3K)/AKT (serine/threonine protein kinase AKT pathway), p38 mitogen-activated protein kinase (MAPK) and c-Jun N-terminal kinase (JNK) pathways) via its GDNF-family co-receptors (GFR alpha (GDNF-family receptor-alpha), etc.).

Approximately 50% of MTC can therefore be genetically related to an RET proto-oncogene mutation,35 with point mutations mostly in high-risk areas of the gene. Prophylactic surgery appears to prevent the cancer if it is in the CCH pre-cancerous phase; it remains the ultimate surgical goal,26,41 and should precede the development of lymph node metastases. Pre-operative serum calcitonin measurement is important for follow-up. Although there is some debate as to the extent of the surgery, it is accepted that total thyroidectomy with bilateral cervico-central lymphadenectomy is adequate 'prophylactic' therapy.42 Revision surgery may entail cervico-lateral lymphadenectomy if the calcitonin levels remain elevated postoperatively, as widespread lymph node involvement may be present.43

In addition to identifying patients at cancer risk, study of the RET proto-oncogene has more recently led to the development of novel molecular approaches to cancer therapy and clinical trials are currently being evaluated in patients with advanced disease.44
Conclusion

RET gene mutation carries a risk of MEN2 and MTC in all ethnic groups in South Africa. Prophylactic surgery may prevent MTC, making genetic screening important in identifying and treating high-risk patients.

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REFERENCES


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