Nephronophthisis-a genetic cause of ciliopathy

**Keywords:** nephronophthisis, ciliopathies, nephrocystin-1, etiologies, oligogenicity, polyuria, polydipsia, nocturia

**Abbreviations:** NPHP, nephronophthisis; BBS, alström and bardet-biedl syndrome; LCA, leber congenital amaurosis

**Introduction**

In the last-stage kidney defect the most expected Genetic cause is Nephronophthisis (NPHP) in kids and young ages. It is a recessive cystic kidney disease. Functional assuming and Nine genes positional cloning (NPHP) through 9 of the proteins that are encoded have confers towards a consolidate hypothesis that assign diseases related to cyst of kidney as “ciliopathies.” It refers a congregation of overlapping syndromes and disorders whose etiologies lie in ciliary function and structure which are imperfect. The Cilia can be non-motile or non-motile (primary) on the basis of their function and structure. Both the types has a basal body which lies below the surface of cell and structure which stretch to a distance from the cell. Ciliopathies are fast growing type of human physical condition in which there is disturbance of normal function by malfunction of non-motile cilia, or these conditions recently describe. The part of all non-motile cilia have a basic common pattern which consist a rounded array of nine microtubule doublets forming the axoneme, which is supported in the basal body, a transmogrify centriole. The NPHP incidence varies worldwide from 1 in 50,000 to 1 in 90,000 children. The last stage kidney disease among pediatric patients in the USA reported 5% prevalence. NPHP and cysitic kidney of medulla which is autosomal dominant disease often are characterized commonly because of similar morphological features. The age of onset is major difference between NPHP and MCKD. Due to NPHP the median age is 13years of ESRD, while in adulthood the MCKD usually progresses to ESRD. NPHP is a genetic based heterogeneous disease along with 13 identified genetic mutations calculating for 30% of all influenced patients. The protein compounds of maximum mutated genes localize to the non-motile cilium in conformance with the conception of ciliopathies. Infantile NPHP has been associated with NPHP2 mutations, while the more normal juvenile type has mutations in various genes including NPHP 1, 4, 5 and 6. Mutation in Nephrocystin-1 (NPHP1) accounts for majority of isolated incidence of NPHP.7,8

Ciliopathies have share clinical aspects like as cysts in kidney, retinal defects, obesity and diabetes and mental retardation. Alström and Bardet-Biedl syndrome (BBS) are ciliopathies that include multi organ systems and share similar clinical aspects of blindness because of defect in retina, diabetes and before the expected time of onset obesity. Both syndromes are confirmed by genetic testing. The clinical findings of Nephronophthisis (NPHP) are kidney cysts, retinal dystrophy, and the gene associated in NPHP are XPNPEP3/ NPHP1, TMEM67/NPHP11, SDCCAG8/NPHP10, NEK8/NPHP9, RPGRIP1L/NPHP8, GLIS2/NPHP7, CEP290/NPHP6, ICB1/NPHP5, NPHP4, NPHP3, INV/NPHP2. An assortment of additional renal manifestation can happen with NPHP including retinitis pigmentosa, oculo motor apraxia, cerebellar vermis hypoplasia, occipital encephalocele, coloboma of the optic nerve, Leber congenital amaurosis (LCA), hepatic fibrosis and situs in versus demonstrate the multitude of downstream outcome of ciliopathies.

**Genetic basis, clinical features and syndromes associated with nephronophthisis (NPHP)**

A short account of the syndromes aligned with NPHP and added renal features common in those syndromes is explained below. Oligogenicity, in which allelic version at different locations can present to the disease, and epistasis in which modifier genes can alter phenotype, have been identified with NPHP. Oligogenicity and epistasis describe the broad range of clinical dissimilarity that can be related with any variant gene in NPHP (Table 1).

**Table 1 Genetic basis, clinical features and syndromes associated with nephronophthisis (NPHP)**

<table>
<thead>
<tr>
<th>Syndromes &amp; deformity</th>
<th>Gene</th>
<th>Clinical aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joubert syndrome (JBS)</td>
<td>Nephrocystin1 (NPHP1), Abelson Helper Integration Site 1, Inositol poly phosphate 5-phosphate E, Transmembrane protein 157, Transmembrane protein 1, Tetratricopeptide repeat domain 23 B, KIF7, Tectonic family member 1, Transmembrane protein 237, Centrosomal protein 41, Transmembrane protein 38, CSOrf42, Tectonic family member 3, Zinc finger protein 423, Transmembrane protein 213, Tectonic family member 2, Meckel syndrome type 1, B9D1.</td>
<td>Hypotonia and ataxia, delayed motor development.</td>
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Table continued...

<table>
<thead>
<tr>
<th>Syndromes &amp; deformity</th>
<th>Gene</th>
<th>Clinical aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meckel Gruber syndrome (MKS)</td>
<td>Meckel syndrome type1, Transmembrane protein 216/ Meckel syndrome type2, Transmembrane protein 67/MKS3, Centrosomal protein290, Regulator interacting protein-1, CCZDA, Nephrocystin3, Tectonic family member2, B9D1, B9D2, Transmembrane protein 231, Transmembrane protein 138, Transmembrane protein 237, EVC ciliary complex subunit2 and C5orf42.</td>
<td>Cystic renal displasia, occultal encephalolipom, polydactyly, hepatic ductal displasia, congenital heart defects, cleft palate and cleft lip.</td>
</tr>
<tr>
<td>Asphyxiating Thoracic Dystrophy (ATD) or Jeune syndrome (JATD)</td>
<td>Intraflagellar transport80, Intraflagellar transport 139/ Tetraricopeptide repeat domain21B, Dynein cytoplasmic 2 heavy chain 1, WD Repeat domain19/ Intraflagellar transport 144, WD repeat domain60, WD repeat domain 34.</td>
<td>Narrow thorax, short ribs and skeletal abnormalities.</td>
</tr>
<tr>
<td>Cogan syndrome</td>
<td>Nephrocystin 1</td>
<td>Oculomotor recessive, nystagmus</td>
</tr>
<tr>
<td>Boichis syndrome</td>
<td>Nephrocystin 1</td>
<td>Congenital hepatic fibrosis, skeletal dysplasia, pituitary deficiency.</td>
</tr>
</tbody>
</table>

Treatment

There is no conclusive cure for NPHP and other affiliated ciliopathies at present. We could expect some definitive therapy in slowing renal cyst formation and progression in the future with better understanding of ciliopathies and ongoing trial in animal models. Drugs of interest include but not limited to vasopressin receptor antagonist, mTOR inhibitors and cyclin dependent kinase inhibitors16–19 in animal models of NPHP and ADPKD which have been tried with success.

Ciliotherapy

Other than renal replacement therapy and hemodialysis remains the only effectual cure in the intensive evolution of new treatment or therapy recourse, of the last-stage disease. However, currently there has been a significant progression in comprehension the molecular pathogenesis of the defect, in including the finding of the duty of the primary cilium. Current findings have unequivocally affirmed that the alteration in the length of the non motile cilium is an dominant stimulator of pathological processes that outcome in the evolution and progression of NPHP. The recommencement of the non-motile cilium length by pharmacological regulation can prevent fibrosis, stop cystic growth, and upgrade renal function. There has been a significant progress in recent year about the area that activate rigorous growth of targeted therapy. These results have choices a new era in the development of targeted drugs which is known as Ciliotherapy.20

Evaluation plannings

To impaired concentrating ability of the kidneys early presenting features in NPHP are usually subtle and are secondary. Early findings often include polyuria, nocturia, polydipsia and secondary enuresis. Anemia and lethargy presents early in the disease. Early morning urine will be inappropriately dilute due to the inability to concentrate in the setting of water restriction.21 Slow declination of kidney function occurs with progression to ESRD by adolescence in juvenile NPHP. Children may reach renal failure by 3 years of age in the infantile form. Diagnosis of NPHP based on a clinical presentation of the disease. Cystic kidney diseases will be included in the differential diagnosis in children having findings of polyuria, polydipsia, enuresis and low urine concentrating ability.

Conclusion

Our perception has upgrade tremendously on the molecular basis of NPHP over the past decade. The actuality that ciliopathies have a extensive spectrum of clinical exposition, the task of cystoproteins in pathogenesis and non motile or primary cilia, has been find out or learnt. To know the biological work of nephrocystins and the molecular mechanism behind cyst formation, the difficulties still remains. Ongoing or Further investigation is important to facilitate the evolution of novel therapy and understanding of the biology of cyst formation at a cellular level to reverse the disease process or delayed it.
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Acknowledgements

None.

Conflict of interest

Author declares that there is no conflict of interest.

References