

Identification of genetic variants associated with Huntington's disease progression: a genome-wide association study

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Identification of genetic variants associated with Huntington's disease

progression: a genome-wide association study

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ABSTRACT

Background Huntington's disease (HD) is a fatal inherited neurodegenerative disease, caused by a CAG repeat expansion in *HTT*. Age at onset (AAO) has been used as a quantitative phenotype in genetic analysis looking for HD modifiers, but is hard to define and not always available. Therefore here we aimed to generate a novel measure of disease progression, and identify genetic markers associated with this progression measure.

Methods We generated a progression score based on principal component analysis of prospectively acquired longitudinal changes in motor, behavioural, cognitive and imaging measures in the TRACK-HD cohort of HD gene mutation carriers (data collected 2008 – 2011). We generated a parallel progression score using 1773 previously genotyped subjects from the REGISTRY study of HD mutation carriers (data collected 2003 – 2013). 216 subjects from TRACK-HD were genotyped. Association analyses was performed using GCTA, gene-wide analysis using MAGMA and metaanalysis using METAL.

Findings Longitudinal motor, cognitive and imaging scores were correlated with each other in TRACK-HD subjects, justifying a single, cross-domain measure as a unified progression measure in both studies. The TRACK-HD and REGISTRY progression measures were correlated with each other ($r=0.674$), and with AAO ($r=0.315$, $r=0.234$ respectively). A meta-analysis of progression in TRACK-HD and REGISTRY gave a genome-wide significant signal $(p=1.12x10^{-10})$ on chromosome 5 spanning 3 genes, *MSH3, DHFR* and *MTRNR2L2*. The lead SNP in TRACK-HD (rs557874766) is genome-wide significant in the meta-analysis ($p=1.58\times10^{-8}$), and encodes an amino acid change (Pro67Ala) in MSH3. In TRACK-HD, each copy of the minor allele at this SNP is associated with a 0.4 (95% CI=0.16,0.66) units per year reduction in the rate of change of the Unified Huntington's Disease Rating Scale (UHDRS) Total Motor Score, and 0.12 (95% CI=0.06,0.18) units per year in the rate of change of UHDRS Total Functional Capacity. The associations remained significant after adjusting for AAO.

Interpretation The multi-domain progression measure in TRACK-HD is associated with a functional variant that is genome-wide significant in a meta-analysis. The strong association in only 216 subjects implies that the progression measure is a sensitive reflection of disease burden, that the effect size at this locus is large, or both. As knock out of Msh3 reduces somatic expansion in HD mouse models, this highlights somatic expansion as a potential pathogenic modulator, informing therapeutic development in this untreatable disease.

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Research in context

Evidence before this study

Huntington's disease (HD) is universally caused by a tract of 36 or more CAG in exon 1 of *HTT*. Genetic modifiers of age at motor onset have recently been identified in HD that highlight pathways, which if modulated in people, might delay disease onset. Onset of disease is preceded by a long prodromal phase accompanied by substantial brain cell death and age at motor onset is difficult to assess accurately and is not available in disease free at risk subjects. We searched all of PubMed up to Oct 31st 2016 for articles published in English containing "Huntington* disease" AND "genetic modifier" AND "onset" which identified 13 studies, then "Huntington* disease" AND "genetic modifier" AND "progression" which identified one review article. Amongst the 13 studies of genetic modification of HD onset most were small candidate gene studies; these were superseded by the one large genome wide genetic modifiers of HD study which identified three genome-wide significant loci, and implicated DNA handling in HD disease modification

Added value of this study

We examined the prospective data from TRACK-HD and developed a measure of disease progression that reflected correlated progression in the brain imaging, motor and cognitive symptom domains: there is substantial correlation among these variables. We used the disease progression measure as a quantitative variable in a genome-wide association study and in only 216 people from TRACK-HD detected a locus on chromosome 5 containing three significant genes, *MTRNR2L2*, *MSH3* and *DHFR*. The index variant encodes an amino acid change in MSH3. We replicated this finding by generating a parallel progression measure in the less intensively phenotyped REGISTRY study and detected a similar signal on chromosome 5, likely attributable to the same variants. A meta-analysis of the two studies strengthened the associations. There was some correlation between the progression measures and AAO of disease but this was not responsible for the association with disease progression. We also detected a signal on chromosome 15 in the REGISTRY study at the same locus as that previously associated with AAO.

Implications of all the available evidence

The progression measures used in this study can be generated in asymptomatic and symptomatic subjects using a subset of the clinically relevant parameters gathered in TRACK-HD. We use these measures to identify genetic modifiers of disease progression in HD. We saw a signal in only 216 subjects, which replicates in a larger sample, becoming genome-wide significant, thus reducing the chance of it being a false positive. This argues for the power of better phenotypic measures in genetic studies and implies that this locus has a large effect size on disease progression. The index associated genetic variant in TRACK-HD encodes a Pro67Ala change in MSH3, which implicates *MSH3* as the associated gene on chromosome 5. Notably, altering levels of Msh3 in HD mice reduces somatic instability and crossing *Msh3* null mice with HD mouse models prevents somatic instability of the *HTT* CAG repeat and reduces pathological phenotypes. Polymorphism in *MSH3* has been linked to somatic instability in myotonic dystrophy type 1 patients. MSH3 is a non-essential neuronally expressed member of the DNA mismatch repair pathway and these data reinforce its candidacy as a therapeutic target in HD and potentially in other neurodegenerative expanded repeat disorders.

INTRODUCTION

Huntington's disease (HD) is a autosomal dominant fatal neurodegenerative condition caused by a CAG repeat expansion in *HTT* (1). It is a movement, cognitive and psychiatric disorder, but symptoms, age of disease onset (AAO) and disease progression vary (2). AAO (1, 3) reflects the trajectory of disease pathology up to the point of motor onset. However, the transition from premanifest to manifest HD is gradual (4, 5), making clinical definition challenging, furthermore psychiatric and cognitive changes may not be concurrent with motor onset (6). Despite this imprecision in defining onset, the inverse correlation of *HTT* CAG repeat length and age at motor onset accounts for 50-70% of the observed variance in onset (7). Part of the remaining difference in onset age was recently shown to be genetically encoded, identifying genes of the DNA damage response as likely to modify onset of HD (8).

The need for clinical trials close to disease onset has motivated a raft of observational studies (5, 9, 10). This provides the opportunity to investigate the relationship between onset and progression, whether they are influenced by the same biology, and permits the study of subjects before clinical onset.

TRACK-HD represents the most deeply phenotyped cohort of premanifest and symptomatic disease with annual visits involving clinical, cognitive and motor testing alongside detailed brain imaging $(5, 1)$ 6). We used TRACK-HD (5, 6) data to generate a novel unified Huntington's disease progression measure for use in a genetic association analysis. We developed a similar measure in subjects from the REGISTRY study to replicate our findings (9).

MATERIALS AND METHODS

Study design and participants

All experiments were performed in accordance with the Declaration of Helsinki and approved by the University College London (UCL)/UCL Hospitals Joint Research Ethics Committee; ethical approval for the REGISTRY analysis is outlined in (8). Peripheral blood samples were donated by genetically-confirmed HD gene carriers, and all subjects provided informed written consent.

TRACK-HD was a prospective observational biomarker study collecting deep phenotypic data including imaging, quantitative motor and cognitive assessments on adult subjects with early HD, premanifest HD gene carriers and controls (5, 6). It provides annually collected high quality longitudinal prospective multivariate data over three years (2008-2011) with 243 subjects at baseline (6) (**Figure 1**). Demographic details of these individuals are shown in **Supplementary Information**.

REGISTRY(9) was a multisite prospective observational study which collected phenotypic data between 2003 – 2013 on over 13,000 subjects, mostly manifest HD gene carriers. The aim is for annual assessments $+/- 3$ months, though this is variable. The core data include: age, CAG repeat length, UHDRS Total Motor Score (TMS) and Total Functional Capacity (TFC); some patients have further assessments such as a cognitive battery (9). 1835 adult subjects from REGISTRY were included in this study on the basis of available genotype data (8). We obtained: TMS, symbol digit modality (SDMT), verbal fluency, Stroop colour reading, word reading and interference measures, functional assessment score, and TFC.

Procedures

For both studies, atypical severity scores were derived with a combination of principal component analysis (PCA) and regression of the predictable effects of the primary gene *HTT* CAG repeat length. Details differed however, due to differences in nature of the two data sets. In TRACK-HD, 24 variables were used to stratify the cohort in terms of disease progression (**Supplementary Information)**. They were divided *a priori* into 3 broad domains: (1) brain volume measures, (2) cognitive variables, and (3) quantitative-motor variables. For each variable the input for analysis was the subject's random longitudinal slope from a mixed effects regression model with correlated random intercepts and slopes for each subject. This model regressed the observed values on clinical probability of onset statistic (CPO) derived from CAG repeat length and age, and its interaction with follow-up length. The subjects' random slope estimates thus provided a measure of atypical longitudinal change not predicted by age and CAG length. Principal Component Analyses (PCA) of the random slopes was then used to study the dimensionality of these age and CAG-length corrected longitudinal changes. Further methodological detail, including control for potential demographic confounders, is given in Supplementary Methods and a flow chart is given in **Figure 1**.

For REGISTRY, in contrast to TRACK-HD, follow-up length and frequency was variable and missing data were substantial, making longitudinal progression analysis problematic. We therefore examined cross-sectional status at last visit, using a single unified motor-cognitive dimension of severity. We performed multiple imputation to fill in missing data, derived PCA severity scores and regressed off the predictive effect of age, CAG length, and gender on the PCA severity scores derived from this data to obtain the measure of atypical severity at the last visit. This gives a single point "severity" score based on how advanced a subject is compared with expectations based on their CAG repeat and age. 1773 subjects had adequate phenotypic data to score; further detail is given in Supplementary Methods and a flow chart is given in **Figure 1.**

Statistical and genetic analysis

Data analyses were performed using SAS/STAT 14.0 and 14.1 primarily via the MIXED, FACTOR and GML procedures (11). We occasionally used a log or inverse transform of a measure, with the goal of better approximate normality of the distribution and the avoidance of inappropriate influence of extreme scores.

218 TRACK-HD study participants with complete serial phenotype data were genotyped on Illumina Omni2.5v1·1 arrays, and quality control performed as described in Supplementary Methods. Imputation was carried out using the 1000 Genomes phase 3 data as a reference (Supplementary Methods). This yielded 9·65 million biallelic markers of 216 individuals. Genotypes for the REGISTRY subjects were obtained from the GeM-HD Consortium (8), where details of their genotyping, quality control, curation and imputation are provided.

Association analyses were performed with the mixed linear model (MLM) functions included in GCTA v1·26(12). Conditional analyses were carried out using the COJO procedure included in GCTA. Because of the relatively small sample sizes, analyses were restricted to SNPs with minor allele frequency >1%. A meta-analysis of the TRACK-HD and REGISTRY association results was performed using METAL(13). To test whether the association signals in TRACK-HD and REGISTRY could have arisen from the same causal SNPs, and whether these also influenced expression co-localisation analysis was carried out using GWAS-pw v0·21 (14). Gene-wide p-values were calculated using MAGMA v1.05, a powerful alternative to SNP-based analyses which aggregates the association signal inside genes while taking linkage disequilibrium (LD) between SNPs into account (15), using a window of 35kb upstream and 10kb downstream of genes (16). Such an analysis can increase power over single-SNP analysis when there are multiple causal SNPs in a gene, or when the causal SNP is not typed and its signal is partially captured by multiple typed SNPs in LD with it. To maximise comparability with the GeM GWAS, our primary pathway analyses used Setscreen (17), which sums the log p-values of all SNPs in a pathway, also correcting for LD between SNPs.

All of the methods and analyses mentioned in this section are described in more detail in Supplementary Information.

RESULTS

We performed individual PCA of each domain and found that first PC scores were highly correlated between the domains $(P < 0.0001$ in all cases, **Supplementary Information**.) No phenotypic subtypes of symptom clusters in motor, cognitive or imaging domains were observed; rather, longitudinal change in TRACK-HD not predictable by CAG-age was distributed on a correlated continuum (**Figure 2**). We therefore repeated PCA of the measures combined across all domains. The first PC of this combined analysis accounted for 23.4% of the joint variance, and was at least moderately correlated $(r>0.4)$ with most of the variables that contributed heavily to each domainspecific first PC (**Supplementary Tables 3 and 4**). The first psychiatric PC has notably lower correlation with motor and cognitive domains and CPO variables, so was excluded from our progression measures.

The cross-domain first principal component was used as a unified Huntington's disease progression measure in the TRACK-HD cohort (**Figure 1 and 2B**). To confirm that our progression measure correlated with commonly recognised measures of Huntington's disease severity not included in the progression analysis, we examined the residual change relationships between the progression score and UHDRS TMS change and TFC change after controlling for the CPO. We found a correlation of r=0.448 (p <0.0001) for the residual motor slope and r=-0.421 (p <0.0001) for the residual TFC slope. One unit increase in unified Huntington's disease progression measure corresponded to an increase of 0.71 (95% CI=0.34,1.08) units per year in the rate of change of TMS, and an increase of approximately 0.2 (95% CI=0.12,0.30) units per year in the rate of change of TFC. The 15 fastest progressing subjects in TRACK-HD showed a mean annual rate of decline in the UHDRS TMS of 2·52 more points per year than would be expected (Standard deviation =2.47, Standard Error of Mean =0.64); the 15 slowest progressing subjects had an annual TMS decline of 0·45 points less per year than predicted by age and CAG length (Standard deviation =1.85, Standard Error of the Mean $=0.48$).

Huntington's disease subjects in the early stages of the disease were significantly faster progressors on the unified HD progression measure than those still in the premanifest phase ($p < 0.0001$). Amongst the 96 subjects who had experienced onset, the rater AAO showed the expected relation with predicted AAO based on CAG length (**Supplementary Information**), and earlier than predicted AAO was correlated with faster progression on our unified HD progression measure $(r=0.315; p = 0.002)$.

The unified HD progression measure developed in TRACK-HD could not be transferred directly to REGISTRY subjects with more limited data. Individual clinical measures in REGISTRY showed correlations across the motor, cognitive, and functional domains, consistent with our finding in TRACK-HD (**Supplementary Information**). PC1 accounted for 75·6% of the variance in severity; no other principal components explained any substantial amount of the common variance within the measures used (**Supplementary Information**). Therefore this first principal component was chosen as a measure of severity in the REGISTRY cohort (**Figure 2C**). Higher values of this measure mean greater severity than expected at a given time: we infer that this is the result of faster progression (**Figure 2A**) and we used this as the unified Registry progression measure. The unified REGISTRY progression measure and earlier than predicted AAO were modestly, but significantly, correlated $(r =$ 0·2338; p<0·0001) (**Supplementary Information**). Atypically rapidly or slowly progressing subjects tend to become more atypical over time: correlation between time since disease onset and REGISTRY progression $(-0.3074; p<0.0001)$ is greater than that between AAO and REGISTRY progression.

In TRACK-HD, the last-visit severity scores had a correlation of 0.674 with the previously calculated longitudinal unified progression measure, indicating that our progression measures for TRACK-HD and REGISTRY reflected strongly, although not perfectly, related elements of clinical

phenotype. Further support for this conclusion was given by the correlation of 0·631 between the TRACK-HD and REGISTRY progression measures in the 14 subjects present in both studies.

We then performed a genome-wide association analysis using the unified TRACK-HD progression measure as a quantitative trait, which yielded a significantly associated locus on chromosome 5 spanning *DHFR*, *MSH3* and *MTRNR2L2*. The index SNP rs557874766 is a coding missense variant in *MSH3* ($p = 5.8x10^{-8}$; G=0.2179/1091 (1000 Genomes); **Figure 3A and D and Supplementary Information**). Analyses conditioning on this SNP failed to show evidence for a second independent signal in this region in TRACK-HD **(Supplementary Information).** The genes in this locus were the only ones to reach genome-wide genic significance ((15, 18) $(MTRNR2L2 \text{ p=2} \cdot 15 \text{x} 10^{-9})$; *MSH3* p=2·94x10-8; *DHFR* p=8·37x10-7 , **http://hdresearch.ucl.ac.uk/data-resources/**).

Performing a genome-wide association analysis in REGISTRY using the unified progression measure replicated the signal identified in TRACK-HD (lead SNP rs420522, $p = 1.39 \times 10^{-5}$) on a narrower locus (chr5:79902336-79950781), but still tagging the same three genes (**Figure 3B and D**). No genes reach genome-wide significance, though there is evidence of association (**http://hdresearch.ucl.ac.uk/data-resources/)** at *DHFR* (p=8·45x10-4), *MSH3* (p=9·36x10-4), and $MTRNR2L2$ (p= $1.20x10^{-3}$).

The meta-analysis of TRACK-HD and REGISTRY strengthened the signal of both individual SNPs in this region, encompassing the first three exons of *MSH3* along with *DHFR* and *MTRNR2L2* (**Figure 4C and D, Supplementary Information**), and also genic associations over *MSH3*, *DHFR*, and *MTRNR2L2* (**http://hdresearch.ucl.ac.uk/data-resources/**). The most significant SNP in the meta-analysis is rs1232027, which is genome-wide significant ($p=1.12x10^{-10}$), with the p-value of $rs557874766$ being $1.58x10^{-8}$. No other regions attained genome-wide significance **(http://hdresearch.ucl.ac.uk/data-resources/).** Rs557874766 is nominally significant in REGISTRY (p=0.010), with a direction of effect consistent with that in TRACK-HD. Analyses conditional on rs1232027 largely remove the association in this region **(Supplementary**

Information), suggesting that there is only one signal. Conditioning on rs557874766 has a similar effect **(Supplementary Information)**, so this SNP remains a plausible causal variant.

As suggested by the meta-analysis, co-localisation analyses between TRACK-HD and REGISTRY showed this locus was likely influenced by the same SNPs in both studies (posterior probability 74.33%), although conditioning REGISTRY on rs55787466 did not remove the association signal entirely **(Supplementary Information)**. Co-localisation analyses with the GTeX expression data (19) showed strong evidence (posterior probability 96-99%) that SNPs influencing progression in TRACK-HD were also eQTLs for DHFR in brain and peripheral tissues (**Supplementary Information**). Conversely, there was strong evidence (posterior probability=97·8%) that progression SNPs in REGISTRY were eQTLs for MSH3 in blood and fibroblasts (**Supplementary Information**). Despite the lack of co-localisation between the TRACK GWAS and MSH3 expression signal, several of the most significant GWAS SNPs were associated with decreased MSH3 expression and slower progression (**Supplementary Information**). Thus, the signal on chromosome 5 could be due to the coding change in *MSH3*, or to expression changes in MSH3, DHFR or both, and both effects may operate in disease.

The second most significant association region in REGISTRY (**Supplementary Information**) tags a locus on chromosome 15 which has been previously associated to HD AAO (8). Five genes were highlighted, two of which reached genome-wide genic significance (*MTMR10* p=2·51x10⁻⁷; *FAN1* p=2·35x10⁻⁶, **http://hdresearch.ucl.ac.uk/data-resources/**). Notably, *MLH1* on chr3 contains SNPs approaching genome-wide significance ($p = 2.2 \times 10^{-7}$) in GeM-HD (8), and also shows association in the REGISTRY progression gene-wide analysis ($p = 3.97 \times 10^{-4}$).

As noted earlier, both progression measures are correlated with AAO. Thus, to test whether there is an association with progression independent of AAO, we repeated the REGISTRY progression GWAS conditioning for the AAO measure previously associated with this locus in GeM in the individuals (N=1,314) for whom we had measures of both progression and AAO. Both *MTMR10* $(p=1.33x10^{-5})$ and *FAN1* $(p=1.68x10^{-4})$ remained significant (**http://hdresearch.ucl.ac.uk/dataresources**). Furthermore, the most significant SNP ($rs10611148$, $p=2.84x10^{-7}$) was still significant after conditioning on AAO ($p=2.40x10^{-5}$). Notably, the genic associations at the *MSH3* locus in the TRACK-HD sample also remain significant after correcting for AAO (**http://hdresearch.ucl.ac.uk/data-resources/),** as does the association with rs557874766 $(p=6.30x10^{-6})$. A similar pattern is observed at the *MSH3* locus in the meta-analysis. Thus, the associations reported here are mainly due to disease progression, rather than AAO.

Gene set analysis of the 14 pathways highlighted by the GeM-HD paper (8) show that the four most significant pathways in the TRACK-HD progression GWAS are related to mismatch repair, and all show significant enrichment of signal in REGISTRY (**Table 1**). This enrichment is strengthened in the meta-analysis (**Table 1**). Notably, the top two pathways in TRACK-HD are also significant in the MAGMA competitive gene-set analysis (GO:32300 p=0·010, KEGG:3430 p=0·00697). *MSH3* $(2.94x10^{-8})$ and *POLD2* $(7.21x10^{-4})$ show association in TRACK, with *MSH3* $(9.52x10^{-4})$ and *MLH1* (3.97×10^{-4}) showing association in REGISTRY (**Supplementary Information**). These findings are supported by analysis of DNA damage response pathways derived from Pearl *et al*. (20) (**Figure 4A, Supplementary Information)** where two mismatch repair pathways are significantly associated with the unified TRACK-HD progression measure after correction for multiple testing of pathways. Again, the meta-analysis strengthens the enrichment **(Figure 4B, Supplementary Information**). Genes from the two significant pathways in TRACK-HD are shown in the **Supplementary** Information, with the significant genes being very similar to those from the GeM pathways (**Supplementary Information).** A complete list of genes in the Pearl et al. (20) pathways is given in **http://hdresearch.ucl.ac.uk/data-resources/.**

DISCUSSION

The evidence from our study suggests that *MSH3* is likely to be a modifier of disease progression in Huntington's disease. We undertook an unbiased genetic screen using a novel disease progression measure in the TRACK-HD study, and identified a significant locus on chromosome 5, which encompasses three genes: *MTRNR2L2, MSH3* and *DHFR*. This locus replicated in an independent group of subjects from the European HD REGISTRY study using a parallel disease progression measure, and was genome-wide significant in a meta-analysis of the two studies. The lead SNP in TRACK-HD, rs557874766, is a coding variant in MSH3; it is classed of moderate impact, making it genome-wide significant given its annotation (21). This SNP becomes clearly genome-wide significant at the more widely used threshold of $p=5x10^{-8}$ in a meta-analysis of TRACK-HD and REGISTRY. Furthermore, eQTL analyses show association of lower MSH3 expression with slower disease progression.

Genetic modifiers of disease in people highlight pathways for therapeutic development; any pathway containing genetic variation that ameliorates or exacerbates disease forms a pre-validated relevant target. However, while the classical case-control design in complex disease has yielded multiple genetic associations highlighting relevant biology for novel treatment design (22), studies of potential genetic modifiers in genetically simple Mendelian diseases have been difficult to conduct. The diseases are rare and show gene and locus heterogeneity, thus finding genuine modifying associations in such a noisy background is inherently difficult. However, variants that modify disease in the context of a Mendelian causative gene may not be under negative selection pressure in the general population. Recent successful identifications of modifiers have been made in specific genetic subtypes of disease (23) or in relatively large samples with consistent clinical data (8, 24).

One way to increase the power of genetic studies is to obtain a more accurate measure of phenotype. Prospective multivariate longitudinal measures such as those collected in TRACK-HD are ideal (25). Our analysis of Huntington's disease progression showed that motor, cognitive and brain imaging variables typically progress in parallel and that patterns of loss are not sufficiently distinct to be considered sub-phenotypes for genetic analysis. As psychiatric symptoms showed a different trajectory, we developed a single progression measure excluding the psychiatric data (**Figure 2A and B**). AAO was correlated with the unified progression measure but did not explain the genetic associations observed with progression. Thus, progression seems to be measuring a different aspect of disease to AAO, or a similar aspect of disease, but with greater precision. The data available in REGISTRY are less comprehensive; therefore we used a different approach by comparing crosssectional severity at the most recent visit with that expected based on age and CAG. The unified progression measures in TRACK-HD and REGISTRY are correlated and again, the genetic associations in REGISTRY are not completely driven by AAO, demonstrating the utility of retrospective composite progression scores in genetic analysis. Prognostic indices for motor onset have been developed (26), and the development of progression scores for prospective use, for example to empower drug trials by stratifying patients by predicted rate of progression warrants further attention

However, our study has a number of limitations. TRACK-HD has the same standardised detailed phenotypic information on nearly all participants, but in only 243 HD gene mutation carrying subjects. The REGISTRY study is much larger but the phenotypic data are less complete (**Supplementary Information**), often not collected at regular intervals and not on everyone in the study, and in multiple centres which will inevitably lead to intrinsic variation. Nevertheless, the progression measures show the expected relationship with change in TMS and TFC in both TRACK-HD and REGISTRY indicating their clinical relevance. However, future development of the progression statistic and confirmation of the genetic association in subjects from ongoing large studies such as ENROLL (27), with data collected more systematically than in REGISTRY but in less detail than TRACK-HD, would be ideal.

The genetic locus identified by the unified TRACK-HD progression measure association includes three genes, but *MSH3* is the likeliest candidate. Firstly, the lead SNP is a coding variant in exon 1 of *MSH3*, MSH3 Pro67Ala, with the potential to affect function (SNiPA(28) accessed 10/11/2016). Clinically, each copy of the minor allele (G) at this SNP corresponds to a decrease of approximately 0.4 (95% CI=0.16,0.66) units per year in the rate of change of TMS, and a reduction of approximately 0.12 (95% CI=0.06,0.18) units per year in the rate of change of TFC (see Supplementary Information). Secondly, *MSH3* has been extensively implicated in the pathogenesis of HD in both mouse and cell studies, though this is the first human study to link *MSH3* to HD. MSH3 is a neuronally expressed member of a family of DNA mismatch repair proteins (29); it forms a heteromeric complex with MSH2 to form MutSβ, which recognises insertion-deletion loops of up to 13 nucleotides (30) **(Figure 4D)**. There is, however, a high level of interconnectedness between pathways involved in the DNA damage response, and MutSβ is implicated in other processes (20). Changes in CAG repeat size occur in terminally differentiated neurons in several HD mouse models and in human patient striatum, the brain area most affected in HD, and notably, somatic expansion of the CAG repeat in HD patient brain predicts onset (31). *Msh3* is required for both somatic expansion of *HTT* CAG repeats and for enhancing an early disease phenotype in mouse striatum (32), *Msh3* expression level is associated with repeat instability in mouse brain, (whereas DHFR is not) (30) and expansion of CAG and CTG repeats is prevented by msh3Δ in *Saccharomyces cerevisiae (33)*. This gives a plausible mechanism through which variation in *MSH3* could operate in HD **(Figure 4C and D)**. In patients with myotonic dystrophy type 1 (DM), somatic instability of the CTG repeat (CAG on the non-coding strand), is associated with age of onset and an *MSH3* variant was recently associated with somatic instability in blood DNA of patients (34). Variants in DNA repair pathways including those in *MSH3* contribute to age of onset modification of multiple CAG repeat expansion diseases (35) implicating the CAG repeat itself as the source of modification in these diseases.

This is the first study to use a measure of progression to look for modifiers of a neurodegenerative Mendelian disorder. We detected association with a coding variant on chromosome 5, reaching genome-wide significance given its annotation (21) in just 216 subjects, which replicated in a larger

independent sample and strengthened on meta-analysis. This indicates that either our progression measure developed in TRACK-HD is an excellent reflection of disease pathophysiological progression or that this is a locus with a very large effect size, or, most likely, both. While there are three genes at the locus, the most significant variant gives a coding change in MSH3, which together with the prior biological evidence makes it the most likely candidate. Somatic expansion of the CAG repeat through alterations in *MSH3* is a plausible mechanism for pathogenesis in HD which can be followed up in functional experiments in HD models. These data provide additional support for the therapeutic targeting of Huntingtin and the stability of its CAG repeat. Loss of or variation in mismatch repair complexes can cause malignancy and thus they are not regarded as ideal drug targets, but MSH3 is not essential as it can tolerate loss of function variation (36) and could provide a therapeutic target in HD. We note that if it does operate to alter repeat expansion it may also be a drug target in other repeat expansion disorders.

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Author contributions and declarations

DJHM collected data, undertook analysis, and wrote the first draft of the ms. AFP undertook the genetic analysis, co-wrote the ms. DL undertook the statistical analysis of phenotype, co-wrote the ms. KL undertook genetic analysis. BRL collected data. RR collected data. AD collected data. SM co-supervised the genetic analysis. PH co-supervised data analyses, undertook genetic analysis, and co-wrote the ms. LJ helped secure funding, supervised data analyses, co-wrote the ms. SJT conceived the study, secured funding, recruited subjects, supervised data analyses and co-wrote the ms.

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Figure & Table legends

Figure 1: Study Design. After establishing that brain imaging, quantitative motor and cognitive variables are correlated and follow a similar trajectory, we scored the TRACK-HD subjects using principal component 1 as a Unified progression measure, and used this measure to look for genomewide associations with HD progression. We replicated our findings in the EHDN Registry subjects by looking at how far their disease had progressed compared with expectations based on CAG/Age, and used this progression measure to look for genome-wide associations in REGISTRY. 1835 Registry subjects had genotype data (8). UHDRS TMS: Unified Huntington's Disease Rating Scale Total Motor Score. SDMT: symbol digit modality test. TFC: Total Functional Capacity.

Figure 2: Assessing progression in Huntington's disease (A) Graphical illustration of the trajectory of HD symptoms and signs over time, annotated to show what time period the different measures of onset and progression discussed in this paper cover. The TRACK-HD progression score uses longitudinal data over 3 years. Given limited longitudinal data in REGISTRY, cross-sectional severity at last visit compared to predicted severity was used as a proxy for progression. Age at onset occurs when a subject has unequivocal motor signs of Huntington's disease. (B) Distribution of progression measure in 218 members of TRACK-HD cohort. (C) Distribution of atypical severity (compared to predicted severity at final visit) in in 1835 members of the REGISTRY cohort. The curves in (B) and (C) are the normal distribution approximations of the severity score distributions.

Figure 3: Genome-wide Association Analysis of Progression Score. Green line in A-C: $5x10^{-8}$. (A) Manhattan plot of TRACK-HD GWA analysis yielding a locus on chromosome 5. Significance of SNPs (y axis) is plotted against genomic location (x axis). (B) Manhattan plot of REGISTRY GWA analysis showing suggestive trails on chromosome 15 in the same area as the GeM GWAS significant locus (8), and chromosome 5 in the same area as the TRACK progression GWAS. (C) Manhattan plot of Meta-analysis of TRACK and REGISTRY progression analysis. (D) Locus zoom plot of the TRACK-HD (top), REGISTRY (middle) and meta-analysis (bottom) data showing the structure of linkage disequilibrium (LD) and $-\log^{10}(p-value)$ of the significant locus on chromosome. The top image shows the chromosome; the red square shows the region which is zoomed in on in the other panels. The colours of the circles are based on r^2 with the lead SNP in TRACK-HD as shown in the bottom of the plot; intensity of colour reflects multiple overlying SNPs. Dashed lines: $5x10^{-8}$

Figure 4: Significant genes are functionally linked and may cause somatic expansion of the *HTT* CAG repeat tract. STRING diagram showing all proteins from the Pearl *et al* (20) dataset with genewide p-values for association with Huntington's disease progression < 0.02 in **A**: the TRACK-HD dataset and **B**, the meta-analysis of TRACK-HD and REGISTRY

(**http://hdresearch.ucl.ac.uk/data-resources/**). Genes with p<0.02 coloured; 10 further interactors in grey, confidence of interaction is shown in the 'Edge confidence' box, homo sapiens protein data used: http://string-db.org/cgi/ accessed October 2016 and January 2017 (37). **C** Schematic diagram showing how DNA mismatch repair proteins may be involved in somatic expansion of the CAG tract. Proteins with p<0.01 in the meta-analysed progression GWAS are coloured red. (i) The CAG repeat DNA is partly unwound by lesions, constraints of the CAG tract structure (middle image) or by transcription. (ii) This unwound DNA is recognised by MutSbeta (MSH2/MSH3) which recruits the endonuclease MutLalpha (PMS2/MLH1) and cleaves the DNA. (iii) Repair of the strand break leads to expansion of the CAG repeat. In neurones of the striatum somatic expansion is an ongoing process that occurs throughout life and variants in MSH3 may promote or inhibit repeat recognition, binding or repair. **D** Potential link between degree of somatic expansion over a patient's lifespan and rate of Huntington's disease progression.

Table 1: Setscreen enrichment p-values for the 14 pathways highlighted in GeM-HD (8).

The GO and KEGG terms in the first column refer to pathways of biologically related genes in the Gene Ontology Consortium(1) and Kyoto Encyclopedia of Genes and Genomes (2) databases respectively. The p-values in columns $2 - 4$ refer to the association between the pathway indicated and rate of progression described in this paper (TRACK- TRACK-HD study; REGISTRY-REGISTRY study; META- meta-analysis). P(GeM) refers to the association between the indicated pathway and age at motor onset in the GeM-HD study (8).

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Hensman Moss *et al* Manuscript Table

Table 1: Setscreen enrichment p-values for the 14 pathways highlighted in GeM-HD (8). The GO and KEGG terms in the first column refer to pathways of biologically related genes in the Gene Ontology Consortium(1) and Kyoto Encyclopedia of Genes and Genomes (2) databases respectively. The p-values in columns 2 – 4 refer to the association between the pathway indicated and rate of progression described in this paper (TRACK- TRACK-HD study; REGISTRY- REGISTRY study; META- meta-analysis). P(GeM) refers to the association between the indicated pathway and age at motor onset in the GeM-HD study (8).

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Identification of genetic variants associated with Huntington's disease progression: a genome-wide association study

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Supplementary Material: Table of Contents

Supplementary text information *Methods*

Defining progression in TRACK-HD

Among the wide variety of potential cognitive and quantitative-motor variables, we analysed a subset of those that were previously used in a 36-month predefined primary analysis(1). A small number of quantitative-motor variables that were substantively redundant were eliminated and those with more tractable metric properties were chosen (**Supplementary Table 2**).

For the Track HD study, 10 subjects were excluded because they had no follow-up data. 15 other subjects were excluded because of missing brain MRI data there was no missing data for the other variables used in the analysis.

Our models controlled for study site, gender, education, and their interactions with follow-up time, consistent with the models used in the TRACK-HD standard analyses which are described elsewhere(1-4). The dominance of the first principal component is shown in the Scree plot in **Supplementary Figure 9**.

Progression analysis in REGISTRY

We used a square-root transform of TMS to improve approximate multivariate normality of the data. Missing data were considerable as documented **Supplementary Table 15**.

To deal with the missing data for clinical items, multiple imputation with 25 imputations was performed. Age, gender, and CAG expansion length were auxiliary variables for the imputations. Proper methods to account for imputation variation were used for all statistical inferences. Final parameter estimates and statistical significance were estimated by Rubin's method(5). We performed the above using the MI and MIANALYZE procedures of SAS/STAT 13.1(6).

In order to generate atypical severity scores, we needed to undertake three sequential procedures: (i) Multiple imputation of missing data (ii) Principal Component Analysis (PCA) and severity scoring of the combined imputed data replications (iii) Regression of the predictive effect of age, CAG length, and gender on the PCA-derived severity scores so that we are left with a measure of atypical (or "unexplained") severity. The steps were taken in the order above; given that these steps could be done in different orders we also confirmed that there were only minimal differences due to the order (*data not shown*). We also noted some evidence of study site effects in the eventual regressions. Thus we used a random effect for site in models adjusting for age and CAG. Atypical severity was defined as the residual between each subject's observed and marginal predicted value. The dominance of the first principal component is shown in **Supplementary Figure 10**.

The final averaged multiple imputation model used a 2 degree of freedom restricted cubic spline(7) of cumulative probability of onset (CPO), plus main effects of gender and CAG length and a random effect for site. Marginal effects from this model, which represent the estimated effects after accounting for site fluctuations, were used for all predictions. The knot placement for the clinical probability of onset spline was defined a priori using a conventional standard at the 10^{th} , 50^{th} , and 90^{th} percentiles of its observed distribution. The corresponding values were (0.131, 0.395, 0.885). Atypical severity was defined as the residual between each subject's observed and marginal predicted value. Final parameter estimates, along with estimates of statistical significance adjusted for the multiple imputation procedure are shown in the **Supplementary Table 16**.

We inspected the potential biasing influence of the CAG repeats, by classifying the individual in short (CAG \leq 41) and long (CAG $>$ 55) repeats. We found an overrepresentation of people with larger atypical severity scores among those with short CAG, which implies that those with a small number of repeats are more likely to be in the study if atypically severely affected. This is likely to be due to the disease only being partially penetrant in those with short CAG repeats, resulting in bias (8). This prompted us to exclude subjects with short CAG from the creation of the severity scores, while retaining those with long CAG. However, we confirmed that the age-CAG severity function predicted using CAG > 41 gave sensible estimates for both the short and long ranges, enabling even those subjects with short CAG to be used in the final analysis (**Supplementary Figure 11)**.

Comparing TRACK-HD and REGISTRY progression measures

There are four common measures between TRACK-HD and REGISTRY: TMS, symbol digit score, Stroop word reading score and TFC. We took the first principal component score from an analysis of these four measures at the last TRACK-HD visit: this accounted for 79.4% of the variance in the PCA and correlated approximately equally with each of the four observed variables (**Supplementary Table 21**). To calculate the measure of severity unaccounted for by age and CAG length in TRACK, we regressed these principal component scores on the same predictors used for the unified REGISTRY progression measure, to give TRACK-HD severity scores.

As explained in the manuscript page 13, within the TRACK-HD data, the last-visit severity scores had a Pearson correlation of 0·674 with the previously calculated longitudinal progression measure. It can be shown that the predicted values obtained from the TRACK-HD and REGISTRY formulas are nearly linear, hence that Pearson correlation should be an adequate descriptive statistic for the relationship (**Supplementary Figure 12**).

Genotyping and quality control

DNA was obtained from blood samples of the 218 TRACK-HD study participants who had complete serial phenotype data, using standard methods (2). Genotyping was performed in Illumina Omni2.5 v1.1 arrays at UCL Genomics, in accordance with the Infinium LCG Assay (15023141 A, June 2010) protocol (Illumina Inc, San Diego, USA). Standard QC procedures (9) were performed using PLINK v1.9 (10), including controlling for coverage and call rates (5% of missing data allowed per SNP and individual), inbreeding ($F <$ 0.2 required) and Hardy-Weinberg equilibrium (SNPs with $p \lt 10^{-6}$ in an exact test were removed). With these criteria, and after removing one individual of a twin pair, a total of 216 gene positive TRACK-HD subjects were left in the sample, genotyped for 2.34 million genome-wide markers (**Figure 1**).

Identity-by-descent analysis showed 9 pairs of individuals with a relatedness coefficient $(\hat{\pi})$ higher than 0.15, which included 6 putative first degree relatives, 2 putative second degree relatives and 1 putative pair of third degree relatives. Additionally, an ADMIXTURE analysis with a subset of the 1000 Genomes (11) populations revealed 6 individuals with more than 25% of non-European ancestry. All these individuals were retained in the TRACK-HD sample, as their relatedness and admixture can be accommodated well by using association methods based on mixed linear models (12, 13).

TRACK-HD was imputed in the Cardiff University high-performance computing cluster RAVEN(14), using the SHAPEIT/IMPUTE2 algorithms(15, 16) and a standardised pipeline(17). The 1000 Genomes phase 3 panel provided by the IMPUTE2 authors (release October 2014), was used as the reference imputation panel. Imputation probabilities ("dosages") were converted to best-guess genotypes in fcGENE v1.07(18) using a minimum probability threshold of 80% and a per-SNP missingness threshold of 5% of the sample. After this process an INFO score cutoff of 0.8 was applied in order to select well-imputed variants, and all monomorphic and singleton markers were excluded. With these filters 9.65 million biallelic markers remained in the dataset.

Genotypes for the REGISTRY subjects were obtained from the GeM-HD Consortium (19), where details of their genotyping, curation and imputation are provided. This dataset harboured 8.94 million biallelic markers of 1,773 individuals (**Figure 1**).

Mixed linear model GWAS

Association analyses were performed with the mixed linear model (MLM) functions included in GCTA v1.26(20), specifically the leave-one-chromosome-out (LOCO) procedure(21). As the genetic relationship matrix used by MLMs can accurately account for cryptic relatedness and ancestry, and phenotypic variables already controlled for relevant clinical covariates, no covariates were added to the analyses. In order to transform the results into independent GWAS signals, PLINK was again used to perform linkage disequilibrium (LD) clumping ($r^2 = 0.1$, $p < 1x10^{-4}$; window size < 3 Mb). Due to the relatively small size of the TRACK-HD and REGISTRY samples, calculation of SNP-based heritability (h^{2}_{SNP}) for our tested phenotypes was not possible using either genotyped or imputed markers(22, 23). Because of the small sample sizes, analyses were restricted to SNPs with minor allele frequency $>1\%$.
Meta-analysis of the GWAS summary statistics from the TRACK-HD and REGISTRY studies was carried out using the fixed effects method with inverse-variance weights as implemented in METAL (24). The meta-analysis of TRACK-HD and REGISTRY studies was carried out using the fixed effects method with inverse-variance weights as implemented in METAL(24). To control for spurious results due to scale differences between the TRACK-HD and REGISTRY progression phenotypes, effect sizes from both summary statistics were standardised to have equal variances before meta-analysis.

QQ plots of observed log p-values (sorted by value) for each SNP versus their expected values in the absence of association are shown for TRACK-HD, REGISTRY and the meta-analysis in **Supplementary Figure 13**. If there is no association, and no systematic inflation in the test statistics (for example, from population stratification), the observed log p-values would follow their expected values (the red line in **Supplementary Figure 13**) exactly. Indeed, this is what is observed for the majority of data points, which do not show association. The extent to which such systematic inflation exists is measured by the genomic

95% confidence interval for log p-values in the absence of association is shaded grey, and the points lying above this in the top right corner indicate genuine associations.

Conditional analyses of GWAS summary statistics were carried out using the COJO procedure included in GCTA v1.26(26).

Co-localisation analyses

In order to discern if our top GWAS signals were mediated by the same SNPs in both TRACK-HD and REGISTRY, we used the co-localisation method of Giambartolomei *et al*.(27), as implemented in GWASpw v0.21 (28). In summary, the GWAS summary statistics of our two samples were first divided into approximately independent LD blocks(29), and each block was then scanned to estimate the probability (in a hierarchical Bayesian framework) of harbouring an association common to the two samples. In contrast to the original algorithm, the model priors do not need to be pre-specified in GWAS-pw, as they are estimated directly from the summary statistics. This implementation has been thoroughly tested by simulation and applied to real data from heterogeneous sources (28). By testing the entire genome instead of a small number of candidate regions arising from the GWAS clumps, we follow a conservative approach towards estimating co-localisation, which also has the desirable property of allowing us to compare our candidates (to the resolution of single SNPs) with every other region in the genome.

A similar procedure was used to test for co-localisation between the region on chromosome 5 containing GWAS signal in TRACK-HD and REGISTRY and SNPs influencing expression (eQTLs), since this may indicate which gene in an association region is causal. Given that eQTLs close to the gene (cis-eQTLs) tend to replicate more reliably than those from other parts of the genome (30), these analyses were restricted to

the regions of GWAS signal and genes within 1Mb of these regions. These analyses used expression data from 53 tissues, accessed through GTeX (31). To minimise multiple testing, the two tissues showing the most significant eQTLs for each gene were used for the co-localisation analysis. Additionally, for DHFR and MSH3, analyses were performed using three brain tissues (caudate, cerebellum and cortex), since these are the most biologically relevant to HD a priori. Co-localisation results are shown for the TRACK-HD GWAS in **Supplementary Table 8**, and the REGISTRY GWAS in **Supplementary Table 9**. Plots of GWAS and eQTL signals with significant co-localisation are shown in in **Supplementary Figures 7 and 8.**

Gene-based and gene-set analyses

Gene-wide p-values were calculated using MAGMA v1.05 (32) on the TRACK-HD and REGISTRY summary statistics, by summing the p-values of all SNPs inside each gene. MAGMA aggregates the association evidence across all SNPs in a gene, while correcting for LD between SNPs (using the European data from Phase 3 of the 1000 Genomes Project as reference). This analysis increases power when a gene contains multiple causal SNPs (e.g. as a result of allelic heterogeneity), or when the causal SNP is not typed and its signal is partially captured by multiple genotyped SNPs in LD with it. We set a window of 35 kb upstream and 10 kb downstream of each gene in order to capture the signal of proximal regulatory SNPs(33, 34).

To maximise comparability with the GeM GWAS, our primary gene-set analyses used Setscreen (Moskvina et al. 2011). Setscreen sums the (log-) p-values of all SNPs in the gene set, similar to Fisher's method, but adjusts the distribution to allow for non-independence of SNPs due to linkage disequilibrium (Brown 1975). Significant enrichments from the Setscreen analyses were confirmed using the competitive gene-set analysis procedure implemented in MAGMA. This more conservative approach tests whether genes in a gene set have more significant gene-wide p-values than other genes, correcting for gene size, SNP density and intergenic linkage disequilibrium (de Leeuw et al. 2015), but may be less powerful than the Setscreen analysis for small gene sets.

Initially, we performed gene set analyses on the 14 pathways found to be significantly enriched for association signal in the GeM GWAS. Many of these pathways relate to DNA repair, so we investigated the biological specificity of this signal further by analysing 78 gene-sets taken from a recent review of DNA repair (Pearl et al 2015).

As a secondary analysis, to potentially uncover areas of novel disease-related biology, we tested the same gene sets used by GeM-HD Consortium (2015). This comprises a collection of 14,706 pathways containing between 3 and 500 genes from the Gene Ontology (GO)(35), Kyoto Encyclopedia of Genes and Genomes (KEGG)(36), Mouse Genome Informatics (MGI)(37), National Cancer Institute (NCI)(38), Protein ANalysis THrough Evolutionary Relationships (PANTHER)(39), BioCarta(40) and Reactome(41). Multiple testing correction was carried out for this analysis by calculating q-values (Storey and Tibshirani, 2003).

Linking genetic variation to clinical measures

To explain how our TRACK-HD lead variant (rs557874766) affected commonly used clinical measures of HD severity we first correlated TRACK-HD progression score with UHDRS Total Motor Score (TMS) and UHDRS Total Functional Capacity (TFC). We defined "raw" TMS rate as TMS change divided by followup years and "adjusted" TMS rate as the residual of raw TMS rate after regressing off effects of initial TMS, age, sex, CAG. We followed the same procedure for TFC.

Regressing these measures on progression gives the following estimates of the amount of change for one unit increase in progression (standard errors in brackets):

Raw TMS rate: 0.71(0.19) Adjusted TMS rate: 0.57 (0.18) Raw TFC rate: 0.21 (0.047) Adjusted TFC rate: 0.20 (0.044)

The effect size at the top MSH3 SNP in TRACK (rs557874766) is -0.58 (s.e. =0.087) units of progression per copy of the minor allele G (see **Supplementary Table 21**) this corresponds to a change of -0.33 (95% $CI = 0.10, 0.56$ to -0.41 (0.16,0.66) units in TMS rate compared to the major allele C, which can be interpreted as a reduction in the rate of TMS increase by 0.33-0.41 units per year for each copy of the G allele. Similarly, this corresponds to a reduction in the rate of TFC change of 0.12 (0.06,0.18) units per year per G allele.

Results

Since *MSH3* is a member of all the most significantly enriched pathways, we tested whether *MSH3* was individually responsible for the pathway enrichments by removing it and repeating the analyses. GO:32300 and KEGG:3430 are still nominally significant in TRACK (p=0.0413, p=0.0452 respectively) but not in REGISTRY. Neither of the two Pearl pathways is significant in TRACK or REGISTRY. The only pathways nominally significant both in TRACK and REGISTRY are GO:32389 (MutLalpha complex) and Pearl pathway "Repair_pathway/SSR/MMR/MutL_homologs", neither of which contain *MSH3*. Thus, it appears that the mismatch repair pathway enrichments are mainly driven by *MSH3*. However, in the TRACK-REGISTRY meta-analysis, the Pearl et al. MMR pathway ($p=1.27 \times 10^{-4}$), GO:32300 ($p=1.02 \times 10^{-3}$), KEGG 3430 (1.07×10^{-4}) and GO:30983 are at least nominally significant without *MSH3*. Pathway enrichments without *MSH3* are shown in **Supplementary Table 18** for the 14 GeM pathways and **Supplementary Table 19** for the Pearl et al. pathways.

Setscreen gene set analysis of the large set of pathways analysed by the GeM-HD Consortium (2015) is shown in **Supplementary Table 24.** There were 26 pathways showing significant (q<0.05) enrichment in 22. Yang J, Benyamin B, McEvoy BP, Gordon S, Henders AK, Nyholt DR, et al. Common SNPs explain a large proportion of the heritability for human height. Nat Genet. 2010;42(7):565-9.

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TRACK after correction for multiple testing of pathways. These pathways mainly relate to DNA repair and binding, and none is more significant than GO:32300 (mismatch repair complex). The genes in these 26 pathways are shown in **Supplementary Table 25,** and are similar to those in Tables 2 and 3, with the exception of DHFR (however, the pathways containing DHFR tend to be less strongly associated than the mismatch repair pathways in both TRACK and REGISTRY). Thus, analysis of the large set of pathways does not appear to throw up any novel areas of biology outside those indicated by the GeM paper.

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Supplementary Figure 1: Observed versus Expected Age of Onset Among Those Who Have Experienced Onset in the TRACK-HD analysis: amongst these 96 subjects who had experienced onset, the rater AAO showed the expected relation with predicted AAO based on CAG length. Earlier than predicted onset age was correlated with faster progression (using the unified HD progression measure) ($r=0.315$; $p = 0.002$)

Rater AOO

Supplementary Figure 2: REGISTRY progression measure and atypical onset age are modestly correlated in REGISTRY. Note bias for very late expected onset for those with low CAG repeats. SD = Standard deviation.

Supplementary Figure 3: Regional plot of TRACK-HD GWAS signal in the MSH3-DHFR region before(top) and after (bottom) conditioning on the most significant SNP in TRACK-HD (rs557874766). The lack of significant association after conditioning on this SNP is consistent with here being only one association signal in the region.

Supplementary Figure 4: Regional plot of TRACK-HD and REGISTRY meta-analysis GWAS signal in the MSH3-DHFR region before(top) and after (bottom) conditioning on the most significant SNP in the metaanalysis (rs1232027). The lack of significant association after conditioning on this SNP is consistent with here being only one association signal in the region.

Supplementary Figure 5: Regional plot of TRACK-HD and REGISTRY meta-analysis GWAS signal in the MSH3-DHFR region before(top) and after (bottom) conditioning on the most significant SNP in TRACK-HD (rs557874766). The lack of significant association after conditioning on this SNP is consistent with here being only one association signal in the region.

Supplementary Figure 6: Regional plot of REGISTRY GWAS signal in the MSH3-DHFR region before(top) and after (bottom) conditioning on the most significant SNP in TRACK-HD (rs557874766). The significance of association is largely unaffected by conditioning on this SNP. This indicates that rs557874766 does not explain the REGISTRY association signal in this region.

Supplementary Figure 7: Regional plot of TRACK-HD GWAS signal in the MSH3-DHFR region (top, red), along with GTeX eQTL associations with DHFR expression in (top-bottom) whole blood, skeletal muscle, cerebellum, cortex.

Supplementary Figure 8: Regional plot of REGISTRY GWAS signal in the MSH3-DHFR region (top, blue), along with GTeX eQTL associations with MSH3 expression in (top-bottom) whole blood, transformed fibroblasts.

Supplementary Figure 9: (A) Scree Plot and (B) Plot showing proportion of variance explained in the TRACK-HD progression principal component analysis: the dominance of the first PC is illustrated.

Supplementary Figure 10: (A) Scree Plot and (B) Plot showing proportion of variance explained in the REGISTRY progression principal component analysis: the dominance of the first PC is illustrated.

Supplementary Figure 11: Age-CAG severity function against clinical probability of onset (CPO) in REGISTRY. A: plot showing predicted values for all subjects. B: plot of predicted values using only subjects in the CAG 41–55 range. C: Plot based on extrapolating the severity model to subjects with CAG in the 36-40 range (the appearance of two rather distinct lines are due to the gender effect, with women having lower predicted scores than men).

Supplementary Figure 12: Linear relationship between the longitudinal atypical severity scores used for the TRACK-HD analysis and cross-sectional atypical severity scores at the last TRACK visit when calculated using the method employed for the REGISTRY data (r = .674).

Supplementary Figure 13:

there is no systematic inflation of test statistics.

Expected $-log_{10}(p)$

Supplementary tables:

Supplementary Table 2: List of Variables to be used in TRACK-HD progression analyses. Further detail regarding these measures can be found in Tabrizi *et al* 2009, 2011, 2012, 2013.

Supplementary Table 3: Correlations among Domain-Specific Residual Principal Components in the TRACK-HD analysis, showing that the first principle components of each domain are significantly correlated.

The prefaces "brain", "cog", and "mot" indicate the domain. The suffix f1, f2, etc, numbers the principal components within each domain. Having approximated the residual longitudinal variability within each of the three domains via principal components, we then examined cross-domain relationships among these components. For example, after accounting for CAG-age-risk, testing whether residual longitudinal change in the brain measures correlated with the Q-motor measures.

Supplementary Table 4: PCA of Residual Longitudinal Change Among Variables form All 3 Domains in the TRACK-HD analysis showing that the variables that correlated with the domain specific analyses also correlated with the common principal component analysis.

Supplementary Table 5: Factor pattern of the first two principal component analysis of the REGISTRY severity score which was used as a progression score for the Registry data. Factor 1 = 1st PC; Factor 2 = 2nd PC.

Supplementary Table 9: Co-localisation between REGISTRY GWAS signal on chromosome 5 and GTeX eQTLs for MSH3, DHFR

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Supplementary Table 14: Gene-wide p-values for the most significant genes in the two Pearl et al. pathways showing significant enrichment in TRACK

Supplementary Table 16: Parameter estimates of variables in the model used to generate the REGISTRY cross sectional severity score. Multiple imputation adjusted estimates of statistical significance are given. CPO_1: clinical probability of onset; CPO_2: single transformation of clinical probability of onset. DF: degrees of freedom.

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FIGURES

Identification of genetic variants associated with Huntington's disease progression: a genomewide association study

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Time (years): the letters A, B, C, D indicate points in time

