Lung squamous cell carcinoma associated with hypoparathyroidism with sensorineural deafness and renal dysplasia syndrome: a case report

Abstract: Hypoparathyroidism with sensorineural deafness and renal dysplasia (HDR) syndrome is an autosomal dominant condition caused by mutations of the gene encoding the dual zinc-finger transcription factor, GATA3. A previous study identified some patients with GATA3 gene variants and breast cancer, suggesting that GATA3 variants may contribute to tumorigenesis in estrogen receptor 1-positive breast tumors; however, these patients did not have HDR syndrome. A 32-year-old nonsmoking Japanese woman was histologically diagnosed with lung squamous cell carcinoma associated with HDR syndrome and a c.C952T>C (p.C318R) germline mutation in GATA3. This is the first report describing cancer in a patient with HDR syndrome. Our data indicates that GATA3 mutations may be a potential therapeutic target for lung cancer.

Keywords: lung cancer, GATA3, missense variant, hypoparathyroidism, sensorineural deafness, renal dysplasia

Introduction

Hypoparathyroidism with sensorineural deafness and renal dysplasia (HDR) syndrome (OMIM: 146255) is an autosomal dominant condition characterized by incomplete penetrance and clinical heterogeneity, and is caused by mutations of GATA3 (OMIM: 131320). GATA3 consists of 6 exons which encode a dual zinc-finger transcription factor. The C-terminal zinc finger of GATA3 is encoded by exon 5 and has a crucial role in DNA binding, whereas the N-terminal zinc finger is encoded by exon 4 and functions in stabilizing DNA binding and interactions with multitype zinc-finger proteins. Many types of GATA3 mutations can cause HDR syndrome, including intragenic deletions, along with nonsense, acceptor splice site, and missense mutations. The missense variants p.C318R and p.N320K are predicted to disrupt the C-terminal zinc finger of GATA3. The detailed structure of GATA3 has been described previously.

Lung squamous cell carcinoma is a major histological subtype of non-small-cell lung cancer and is typically induced by cigarette smoking. Recently, potentially oncogenic mutations have been recognized in approximately 60% of lung adenocarcinoma, and molecular targeting therapies have been shown to improve the clinical outcomes of patients with these mutations. Nevertheless, oncogenic mutations are rare in lung squamous cell carcinoma, and the majority of patients are treated with conventional chemotherapy. Herein, we report a case of a young, nonsmoking woman with HDR syndrome who developed lung squamous cell carcinoma.
A 32-year-old nonsmoking Japanese woman was admitted to Kobe University Hospital in February 2017 to receive chemotherapy under hemodialysis. The patient was congenitally disabled, with hearing difficulties. She underwent hemodialysis in 2012 because of congenital right renal deficiency and left renal hypoplasia. At that time, she had low levels of parathyroid hormone, due to hypoparathyroidism. After obtaining informed consent, she was diagnosed with HDR syndrome by analysis of a whole blood sample via polymerase chain reaction amplification of all GATA3 coding exons and exon–intron boundaries, followed by bidirectional Sanger sequencing. The results indicated that she carried the missense variant, c.C952T>C (p.C318R), in exon 5 of GATA3. According to the standards and guidelines for the interpretation of sequence variants, this variant is classified as “likely pathogenic.”

Intriguingly, she was born to healthy parents and had no family history of a similar disorder (Figure 2).

In November 2016, she attended the hospital complaining of pain in the left back, and chest X-ray revealed left pleural effusion. She underwent a diagnostic bronchoscopy. Histopathological examination of tumor samples revealed dysplasia with coarse chromatin, and specimens stained positive for cytokeratin 5/6, and p63 (markers for squamous cell carcinoma), weakly positive for thyroid transcription factor-1, and negative for Napsin (markers for adenocarcinoma). Consequently, she was histologically diagnosed with lung squamous cell carcinoma (Figure 3). Her clinical stage of cancer progression was cT2aN0M1c, stage IVB, according to the TNM classification of the Union for International Cancer Control. Sequencing analysis of the tumor sample revealed no mutations of EGFR or EML4-ALK. Positron emission tomography–computed tomography revealed multiple bone metastases, including to the cervical, thoracic, and lumbar areas, along with the pelvis, humerus, and right ribs. Intriguingly, this is the only case of a young nonsmoking woman developing lung squamous cell carcinoma that has presented at Kobe University Hospital in the period 2011–2017 (Figure 4).

Upon hospitalization in February 2017, her Eastern Cooperative Oncology Group Performance Status was 2. A physical examination identified anemic palpebral conjunctiva and decreased left breath sounds. Chest X-ray revealed left pleural effusion, pleural thickening, and scoliosis (Figure 5). Chest computed tomography revealed mass-like opacity combined with atelectasis at the left apex, left pleural thickening, and left pleural effusion.
She consented to a combination chemotherapy regimen to treat her non-small-cell lung cancer. On day 1 (non-hemodialysis day), she began treatment with carboplatin (area under the curve 5, estimated glomerular filtration rate 0, 120 mg/body) and paclitaxel (200 mg/m², 310 mg/body). On day 2, her serum AST and ALT levels transiently increased to 364 and 233 U/L, respectively, before falling to Grade 3, according to the Common Terminology Criteria for Adverse Events version 4.0 (US National Cancer Institute, Rockville, MD, USA). From day 7, she experienced appetite loss (Grade 2) and nausea (Grade 2). On day 9, she experienced febrile neutropenia and was treated with 1 g/d (hemodialysis day) or 2 g/d (non-hemodialysis day) cefepime and 75 µg of granulocyte colony-stimulating factor. Fortunately, she recovered from these toxicities and left Kobe University Hospital on day 17; however, the pain in her right upper arm and lower back were exacerbated (Numerical Rating Scale 5/10) from this point.

She was rehospitalized for chemotherapy in March 2017; however, her Eastern Cooperative Oncology Group Performance Status deteriorated to 3 because of pain induced by pathological fractures at sites of bone metastases (Th9, Th11, L2, and L4). Therefore, she was treated with vertebroplasty.
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the second-most significant environmental risk factor for lung cancer in the United States.\(^5\) Other risk factors for lung cancer include exposure to second-hand smoke; family history of lung cancer; air pollution; preexisting disease of the lungs, such as tuberculosis or pneumonia; exposure to a high dose of radiation; and exposure to industrial or chemical carcinogens, such as asbestos, silica, and arsenic.\(^6-9\) However, these risk factors were not applicable to this patient.

Given the above, we feel comfortable concluding that nonsmoking women in their thirties rarely develop cancer, except in response to genetic abnormalities. Indeed, recent studies have reported several genetic abnormalities that cause lung squamous cell carcinoma, including mutations in FGFR, PIL3CA, PTEN, AKT, DDR2, BRAF, PDGFR\(A\), SOX2, EphA2, and IGF-1R.\(^10-12\) However, these genetic abnormalities are relatively rare, and their precise frequencies are unknown.

GATA3 can regulate cell survival or terminal cell differentiation in many nontransformed tissues and also influence tumor differentiation and suppresses tumor dissemination in a luminal breast cancer model.\(^13\) In addition, GATA3 interacts with and stabilizes HIF-1\(\alpha\), which is important in the pathogenesis of various human cancers, and can enhance cancer cell invasiveness.\(^14\) These data support the hypothesis that the GATA3 mutation identified in the present case is associated with her development of lung squamous cell carcinoma.

Nakamura et al\(^1\) described another GATA3 missense variant in the same position (p.C318S; this patient carries p.C318R) without clinical history of cancer. Further investigations are needed to clarify the different effects of these changes on oncogenesis.

We analyzed a whole blood sample from the patient using polymerase chain reaction-direct sequencing and found that she was carrying the missense variant, p.C318R, in exon 5; however, we were unable to perform further analyses of genetic abnormalities, including of GATA3 in the lung tumor, because the patient refused to give consent.

**Conclusion**

This is the first report describing the co-occurrence of cancer in a patient with HDR syndrome. Our study may provide valuable information regarding the pathogenesis of lung squamous cell carcinoma and indicate that GATA3 mutations may be a potential therapeutic target for lung cancer.

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**Author contributions**

MK, TN, and MT drafted the manuscript. KN, NK, and HK were involved in the clinical care of the patient. MY, KK, and YN interpreted clinical and laboratory data. SH provided histopathology results. TU coordinated genetic diagnosis, interpreted data, and critically revised the manuscript. All authors contributed toward data analysis, drafting and critically revising the paper and agree to be accountable for all aspects of the work. All authors read and approved the final manuscript.

**Disclosure**

The authors report no conflicts of interest in this work.

**References**


