

# Clinical exome sequencing reveals an important role for clinical diagnosis of intellectual disability with definition of seven novel variants

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## Abstract

Intellectual disability can be defined as a significantly below-average general mental function, accompanied by environmental adaptation and behavioural deterioration. Patient files of 87 children with intellectual disability were evaluated in this study. After clinical exclusion criterias, clinical exome sequencing was performed for 25 of 87 intellectual disability cases with a massively parallel targeted sequencing method. Seventeen variants in the genes *MBOAT7*, *KDM5C*, *TUBB3*, *MAN1B1*, *GFAP*, *CACNA1A*, *BCOR*, *LMNA*, *LBR*, *ALS2*, *ENPP1*, *UBE3A*, *TRAPPC9*, *HSPG2*, *AFF2*, *NLGN4*, and *SOX10* were identified in 14 of 25 patients (56%). Seven of the 17 variants (41.1%) were novel in the genes *KDM5C*, *BCOR*, *UBE3A*, *TRAPPC9*, *AFF2*, *NLGN4*, and *SOX10*. Seven cases (7/25, 28%) had a definite diagnosis of intellectual disability with their pathogenic variants. The high rate of variant detection (56%) in the current study shows that multiple gene analysis plays an essential role in diagnosing the uncertain etiology of intellectual disability. This study also presents seven novel variants, which are first reported.

**Keywords:** Intellectual disability, clinical exome sequencing, novel variant

## INTRODUCTION

Intellectual disability is a below-average intelligence function that occurs in the developmental period and is found with disorders in adaptive behaviour. The frequency of intellectual disability is 1-3%.<sup>1</sup> In diagnostic evaluation, rational use of the laboratory with medical and developmental history, three-generation pedigree, dysmorphic examination, neurological examination, and neuroimaging are employed. Intellectual disability is difficult to diagnose in most children and requires further studies. A specific diagnosis provides social support and information sharing for the family and the physician.<sup>2</sup> The diagnostic evaluation should include detailed patient history and physical examination, standard karyotyping, fragile X molecular analysis, neurological imaging, and/or array comparative genomic hybridization (aCGH) studies with subtelomeric fluorescent in situ hybridization (FISH). With the aCGH method, an increase of 10% in diagnostic rate in cases with

intellectual disability has been reported.<sup>3</sup>

The neuropathology of intellectual disability has a broad spectrum. Neurogenesis, neuronal identity, differentiation, morphogenesis, signal transmission pathways, neurochemical regulation, local energy source deficiencies, metabolic pathways, molecular transport, locally occurring metabolic toxins, gliogenesis, glial identity, differentiation, astrocyte relationships, and systemic and local effects make up this broad spectrum.<sup>2</sup> Intellectual disability may be seen with disorders of some metabolic pathways. The most common deficiencies involve enzymes, transcription regulators, binding proteins, and signal transduction proteins; deficiencies or disorders of these mechanisms are blamed for up to 90% of intellectual disability.<sup>4</sup> Some of these deficiencies include disorders of oxidoreductase, hydrolase, transferase enzymes, transcription regulatory genes, genes encoding transporter and protein binders, signal transduction, and receptor genes, Rho GTPases, which regulate dendritic

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growth and branching, and Rab GTPases, which control synaptic vesicle transport.<sup>5</sup> Dendritic movements become prominent in some diseases, such as Angelman syndrome and Fragile X syndrome. Dendrites are formations located on the axonal structure and show continuous development and activation.<sup>6</sup> Dendritic spurs undergo dynamic changes in both early development and learning, and changes in the morphology of these protrusions can be seen after intense synaptic activity. The morphology and density of these protrusions are abnormal in many types of intellectual disability<sup>7</sup>, they also differ in certain neurological and neuropsychiatric diseases. In Fragile X syndrome and trisomy 13, they appear elongated and sedimentary. In Down syndrome, they are either completely absent or very few and almost invisible.<sup>8</sup>

Fragile X syndrome is the most common cause of intellectual disability after Down syndrome. It has been reported to be seen in 2-4% of cases of intellectual disability, and it has been observed that the incidence is increased in more severe cases.<sup>9</sup> Fragile X syndrome is less common (1%) in those with borderline intelligence.<sup>9</sup> In various notable studies in the literature, it has been reported that aCGH can determine the etiology in 10-20% of cases with intellectual disability and pervasive developmental delay.<sup>9</sup> Although the aetiological classification of intellectual disability has been specified with different percentages in various studies, unknown causes constitute the largest group.<sup>10</sup>

In the current study, a cohort with intellectual disability was evaluated for single-gene etiology using a clinical exome sequencing panel (6699 genes) after excluding chromosomal abnormalities, microdeletion/duplications, and Fragile X syndrome.

## METHODS

This study included cases with unexplained intellectual disability after excluding pathologies for structural and numerical chromosomal abnormalities, microdeletion/duplications, and Fragile X Syndrome. The inclusion criterias were: Age from 5 to 18 years, intelligence quotient (IQ)<70, no history of brain trauma, and no history of infection in the perinatal period. Eighty-seven cases were evaluated firstly in the current study. Considering the inclusion criterias, sixty-two cases with chromosomal abnormalities, microdeletion/duplications, and Fragile X Syndrome were excluded in this study: Thirty-six cases were

diagnosed as Trisomy 21, fourteen cases had a structural chromosomal abnormality, two cases had Fragile X diagnosis, ten cases had a microdeletion/duplication. Twenty-five cases out of eighty-seven were included in our study after all exclusion criterias (Figure 1a,b).

All cases were examined in Child and Adolescent Psychiatry and Medical Genetics Departments from January 2017 to February 2021.

### *Molecular analysis*

After obtaining the written informed consent forms, genomic DNA was extracted from each index patient and his or her parents or other family members from peripheral blood using the EZ1 DNA Investigator Kit (Qiagen, Hilden, Germany) according to the standard procedure.

A clinical exome gene panel including 6699 OMIM genes was analyzed on the Illumina NextSeq550 (Illumina Inc., San Diego, CA, USA) system. Libraries were prepared according to the instructions of the manufacturer's instructions. Quality control of the prepared libraries was done with the Qubit dsDNA BR Assay system (Invitrogen, Carlsbad, CA). Fastq generation was performed on the Illumina NextSeq550 (Illumina Inc., San Diego, CA, ABD) system. Libraries covering the target genes were prepared according to the QIAseq Targeted DNA Panel protocol (Qiagen, Hilden, Germany). Following the target enrichment process, libraries were sequenced on the Illumina NextSeq550 (Illumina Inc., San Diego, CA, ABD) system. QCI analysis (Qiagen, Hilden, Germany) was used for Quality control and ordering Variant Call Format files. Variant analysis was performed with Ingenuity software (Qiagen, Hilden, Germany).

ACMG-2015 (American College of Medical Genetics)<sup>11</sup> guidelines were followed for the classification of all the variants, and recommendations of the Human Genome Variation Society<sup>12</sup> were followed to describe the novel variants. In addition, ClinVar<sup>13</sup>, HGMD-Professional 2020 database, and literature information were considered for collecting the information about known variants. Variants were classified as "pathogenic," "likely pathogenic," "uncertain significance," "likely benign," and "benign" according to the ACMG guidelines.

Sanger sequencing was performed for the index patients and parents to validate the segregation of the variants using a 3500 Genetic Analyzer (Applied Biosystems, USA) capillary electrophoresis system.

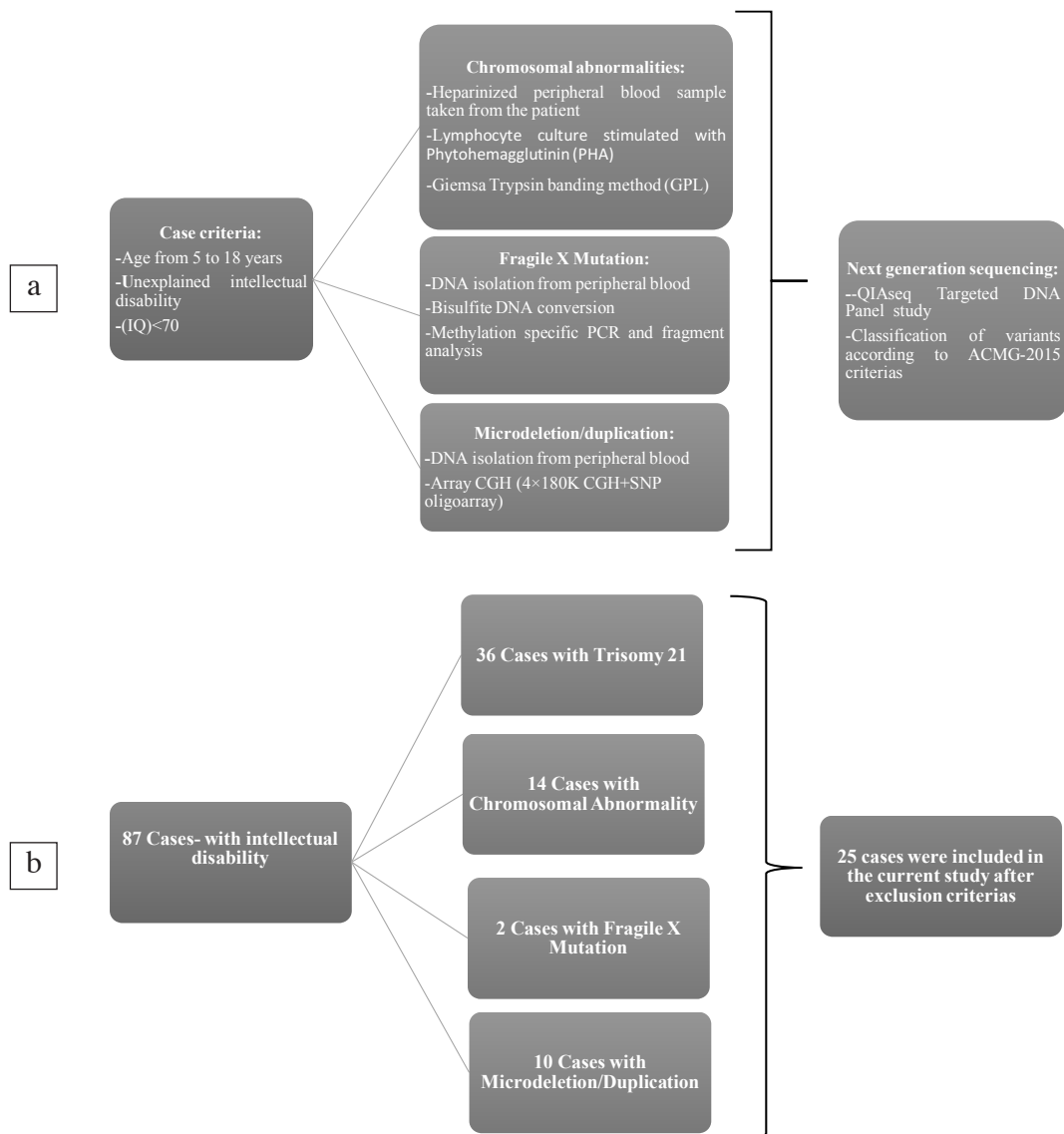


Figure 1. The exclusion chart of our study showing  
 a. Methods used in the current study for each exclusion step  
 b. Case numbers excluded from the study for each criteria

This study is approved by the Ethical Committee of Trakya University Faculty of Medicine with the number 2021/407 and performed in consonance with the principles of the Declaration of Helsinki.

## RESULTS

Twenty-five cases who met the inclusion criteria with intellectual disability were evaluated with clinical exome sequencing in the current study. The mean age of these twenty-five cases was 7.2. Clinical exome sequencing showed fourteen of twenty-five cases (56%) had a clinically related

variant with intellectual disability (Tables 1,2). Seventeen different variants were identified including seven novel variants. Seven cases (7/25, 28%) had a definite diagnosis of intellectual disability with their pathogenic variants (cases 1,2,3,4,5,6, and 10). The consanguinity marriage rate was not high between the parents, only two of 14 parents were consanguineous. Pedigrees of ten cases were shown in Figures 2 and 3. Four pedigrees could not be able to be included, because parents did not know the exact numbers of their sisters or brothers. The dysmorphic features of our five cases were shown in Figure 4.

**Table 1: Pathogenic/likely pathogenic variants detected in the current study and demographic information of the cases**

Case/ Gender/ Age	Clinical findings together with ID	Gene	Coordinate (hg19)	Transcript: Nucleotide change, Protein Change	Zygoty/ Segregation	dbSNP	Clin Var Variation Number	HGMD	ACMG Classification	OMIM phenotypes
1/F/5	Epilepsy, speech delay	<i>MBOAT7</i>	chr19: 54684654	NM_024298.5:c.680_690del p.(Leu227ProfsTer65)	Homozygous	rs1264222654	-	-	Pathogenic (PVS1, PM2, PP3)	Mental retardation, autosomal recessive 57 (AR)
2/M/17	Short stature	<i>KDM5C</i>	chrX: 53246435	NM_004187.5:c.547A>G p.(Asn183Asp)	Hemizygous (maternal)	-	-	-	Likely pathogenic (PS4, PM2, PP2, BP4)	Mental retardation, X-linked, syndromic, Claes-Jensen type (XLR)
3/M/16	Dysmorphic features, epilepsy	<i>TUBB3</i>	chr16: 90001472	NM_006086.4:c.613G>A p.(Glu205Lys)	Heterozygous ( <i>de novo</i> )	rs878853257	30274	CM107130	Pathogenic (PS3, PM2, PM5, PP2, PP3, PP5)	Cortical dysplasia, complex, with other brain malformations 1 (AD), Fibrosis of extraocular muscles, congenital, 3A (AD)
4/M/6	-	<i>MAN1B1</i>	chr9: 139996074	NM_016219.5:c.1204C>T p.(Gln402Ter)	Homozygous	rs865997258	-	-	Pathogenic (PVS1, PM2, PP3)	Rafiq syndrome (AR)
5/F/5	Macrocephaly, developmental delay, synophris	<i>GFAP</i>	chr17: 42987523	NM_001131019.3:c.1276_12 77delACinsGT p.(Thr426Val)	Heterozygous	rs386797323	-	-	Likely pathogenic (PM1, PM2, PP2, PP3)	Alexander disease (AD)
6/M/10	Mild dysmorphic features, epilepsy	<i>CACNA1A</i>	chr19: 13320252	NM_001127222.2:c.6400C>T p.(Arg2134Cys)	Heterozygous	rs121908235	68440	CM041265	Likely pathogenic (PM2, PP2, PP3, PP5)	Developmental and epileptic encephalopathy 42 (AD), Episodic ataxia, type 2 (AD), Migraine, familial hemiplegic, 1 (AD), Migraine, familial hemiplegic, 1, with progressive cerebellar ataxia (AD), Spinocerebellar ataxia 6 (AD)
7/F/5	Motor retardation, blue sclera	<i>LMNA</i>	chr1: 156106048	NM_005572.4:c.1201C>T p.(Arg401Cys)	Heterozygous	rs61094188	48035	CM023951	Likely pathogenic (PM1, PM2, PP2, PP3, PP5)	Cardiomyopathy, dilated, 1A (AD), Charcot-Marie-Tooth disease, type 2B1 (AR), Emery-Dreifuss muscular dystrophy 2, autosomal dominant (AD), Emery-Dreifuss muscular dystrophy 3, autosomal recessive (AR), Heart- hand syndrome, Slovenian type (AD), Hutchinson-Gilford progeria (AD), Lipodystrophy, familial partial, type 2 (AD), Malouf syndrome (AD), Mandibuloacral dysplasia (AR), Muscular dystrophy, congenital (AD), Restrictive dermopathy, lethal (AR)
8/M/7	Atypic autism, mild dysmorphic features	<i>LBR</i>	chr1: 225592154	NM_194442.2:c.1639A>G p.(Asn547Asp)	Heterozygous ( <i>de novo</i> )	rs587777171	100900	CM081321	Pathogenic (PM2, PM5, PP3, PP5)	?Reynolds syndrome (AD), Greenberg skeletal dysplasia (AR), Pelger-Huet anomaly (AD)

9/F/16	Motor retardation, ALS2 cerebral atrophy	chr2: 202626247	NM_020919.4:c.470G>A p.(Cys157Iyr)	Heterozygous	rs121908138	4415	CM061636	Likely pathogenic (PM2, PP2, PP3, PP5)	Amyotrophic lateral sclerosis 2, juvenile (AR), Primary lateral sclerosis, juvenile (AR), Spastic paralysis, infantile onset ascending (AR)
		chr6: 132206103	NM_006208.3:c.2344C>T p.(Arg782Ier)	Heterozygous	-	-	CM062607	Pathogenic (PVS1, PM2, PP3)	{Diabetes mellitus, non-insulin-dependent, susceptibility to} (AD), {Obesity, susceptibility to} (AD, AR), Arterial calcification, generalized, of infancy, 1 (AR), Cole disease (AD), Hypophosphatemic rickets, autosomal recessive, 2 (AR)
10/M/5	-	chr15: 25616056	NM_000462.5:c.1274dupT p.(Asp426GlyfsTer6)	Heterozygous	-	-	-	Pathogenic (PVS1, PM2, PP3)	Angelman syndrome (AD)
14/M/15	Hearing loss, dystopia canorum, motor retardation	chr22: 38374075	NM_006941.4:c.496A>G p.(Lys166Glu)	Heterozygous	-	-	-	Likely pathogenic (PM1, PM2, PP2, PP3)	PCWH syndrome (AD), Waardenburg syndrome, type 2E, with or without neurologic involvement (AD), Waardenburg syndrome, type 4C (AD)

ID: Intellectual disability, dbSNP: The Single Nucleotide Polymorphism Database, HGMD: The Human Gene Mutation Database, ACMG: American College of Medical Genetics, OMIM: Online Mendelian Inheritance in Man, F: Female, M: Male, chr: Chromosome, AR: Autosomal recessive, XLR: X Linked recessive, AD: Autosomal dominant, XLD: X Linked dominant

**Table 2: Variants of unknown clinical significance detected in the current study and demographic information of the cases**

Case/ Gender/ Age	Clinical findings together with ID	Gene	Coordinate (hg19)	Transcript: Nucleotide change, Protein Change	Zygoty/ Segregation	dbSNP	Clin Var Variation Number	HGMD	ACMG Classification	OMIM phenotypes
7/F/5	Motor retardation, blue sclera	BCOR	chrX: 39914668	NM_001123385.2:c.4694C>T p.(Thr1565Ile)	Heterozygous	-	-	-	VUS (PM2, PP2, PP3)	Microphthalmia, syndromic 2 (XLD)
10/M/5	-	TRAPPC9	chr8: 140743401	NM_031466.8:c.3350A>C p.(His117Pro)	Heterozygous	-	-	-	VUS (PM2, PP2, BP4)	Mental retardation, autosomal recessive 13 (AR)
11/M/5	Motor retardation	HSPG2	chr1: 22159838	NM_005529.7:c.11018T>C p.(Phe3673Ser)	Homozygous	rs147707402	587472	-	VUS (PM2, PP2, PP3)	Dyssegmental dysplasia, Silverman-Handmaker type (AR), Schwartz-Jampel syndrome, type 1 (AR)
12/M/10	-	AFF2	chrX: 148049184	NM_002025.4:c.3229C>A p.(Gln1077Lys)	Hemizygous (Maternal)	-	-	-	VUS (PM2, PP2, PP3)	Mental retardation, X-linked, FRAXE type (XLR)
13/M/7	Growth retardation Speech delay	NLGN4	chrX: 5821410	NM_020742.3:c.1309C>T p.(Arg437Trp)	Hemizygous (Maternal)	-	-	-	VUS (PM2, PP2, PP3)	{Asperger syndrome susceptibility, X-linked 2} (XL), {Autism susceptibility, X-linked 2} (IC, Mu, XL), Mental retardation, X-linked (IC, Mu, XL)

ID: Intellectual disability, dbSNP: The Single Nucleotide Polymorphism Database, HGMD: The Human Gene Mutation Database, ACMG: American College of Medical Genetics, OMIM: Online Mendelian Inheritance in Man, F: Female, M: Male, chr: Chromosome, AR: Autosomal recessive, XLR: X Linked recessive, AD: Autosomal dominant, XLD: X Linked dominant

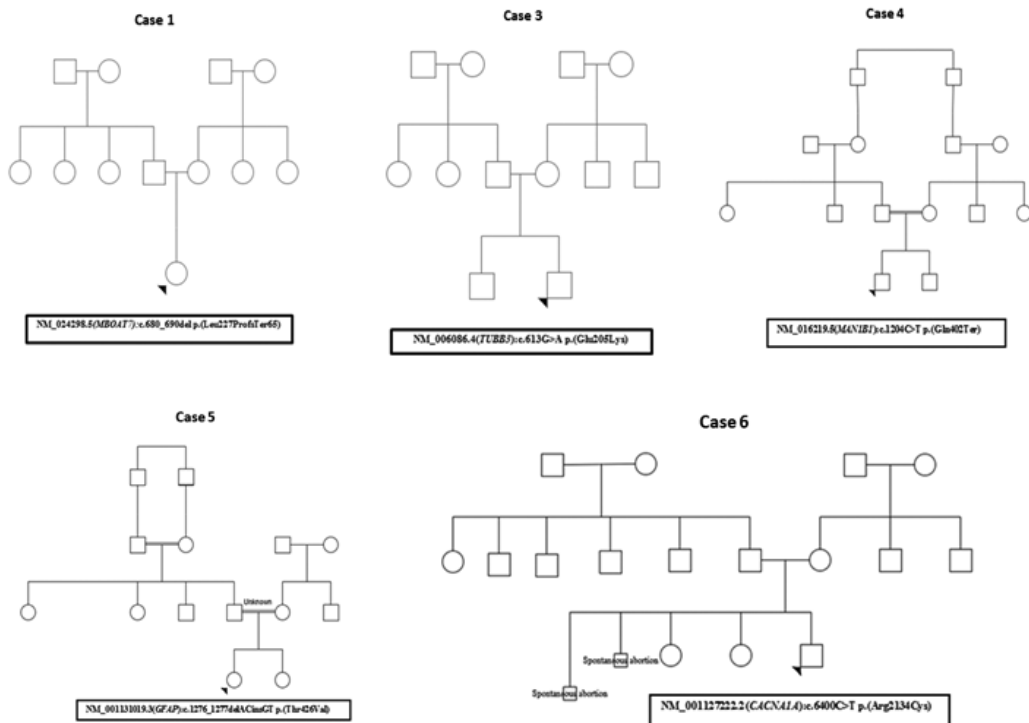


Figure 2. The pedigrees of the cases 1,3,4,5, and 6 in the current study

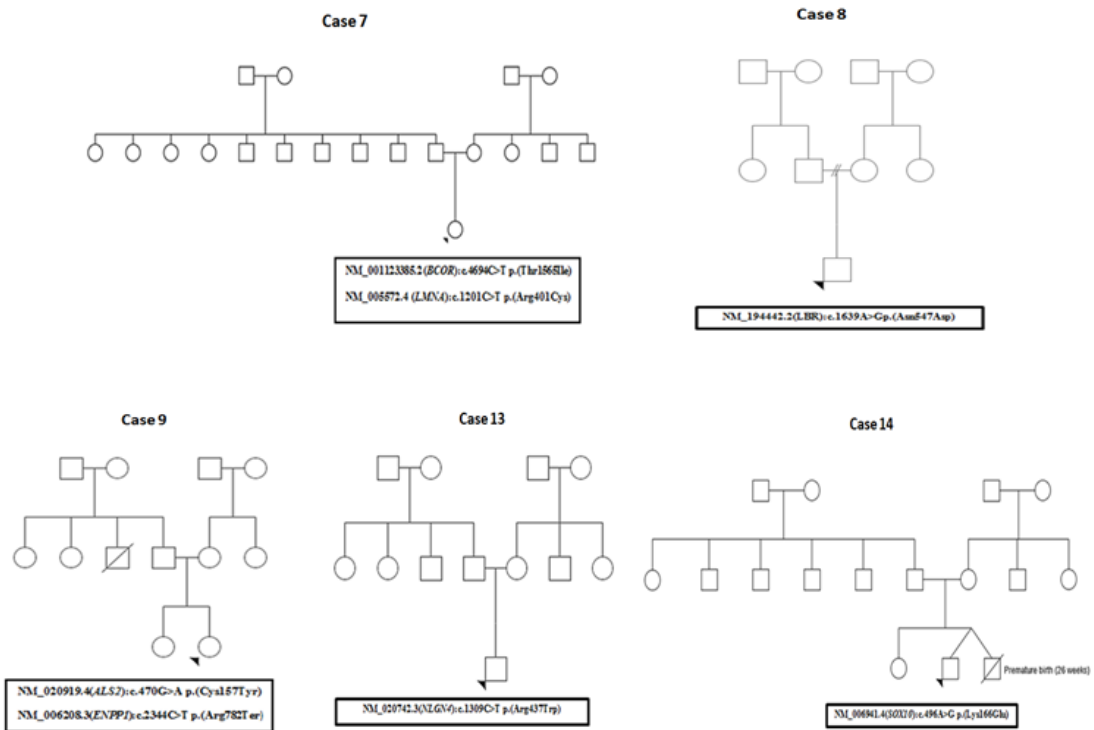


Figure 3. The pedigrees of the cases 7,8,9,13, and 14 in the current study





Figure 4. The clinical dysmorphic features of

- Case 1 with broad forehead, mild synophris, depressed nasal root, smooth philtrum, thin upper lip
- Case 3 with long face, mild narrow temporal region, big ears, retrognathia
- Case 6 with low hairline, depressed nasal root, smooth philtrum, thin upper lip, crowded teeth
- Case 8 with broad forehead, downslanting palpebral fissures, open mouth, low set ears
- Case 14 with mild hypertelorism, broad nose tip, thin upper lip, short neck

#### *X linked variants*

NM\_004187.5:c.547A>G p.(Asn183Asp) hemizygous likely pathogenic novel variant in the *KDM5C* gene was detected in case 2, his 11 years old brother had both intellectual disability and short stature, and the same hemizygous variant. Segregation analysis showed that the asymptomatic mother was heterozygous.

NM\_001123385.2:c.4694C>T p.(Thr156Ile) heterozygous novel variant in the *BCOR* gene was classified as VUS in case 7, who has motor retardation and blue sclera. Parents were non-consanguineous.

NM\_002025.4:c.3229C>A p.(Gln1077Lys) hemizygous novel variant in the *AFF2* gene was detected in case 12 and his brother. His sister and mother were heterozygous for the same variant. However, this variant was classified as VUS. It is related to the patient's clinical findings defining the intellectual disability.

NM\_020742.3:c.1309C>T p.(Arg437Trp) in the *NLGN4* gene was a maternally inherited hemizygous novel VUS variant detected in case 13 who has a speech delay, growth retardation, and absence of seizures. His mouth was open with tongue out, and he had flat feet.

#### *Dominantly inherited variants*

NM\_006086.4:c.613G>A p.(Glu205Lys) heterozygous *de novo* pathogenic variant in the *TUBB3* gene was in case 3 with microcephaly, short philtrum, micrognathia, arachnodactyly, pectus excavatum, broad toe, and epilepsy.

NM\_001131019.3:c.1276\_1277delACinsGT p.(Thr426Val) heterozygous pathogenic variant in the *GFAP* gene was detected in case 5 with intellectual disability, macrocephaly, developmental delay, and synophris.

NM\_001127222.2:c.6400C>T p.(Arg2134Cys) heterozygous likely pathogenic variant in the *CACNA1A* gene was detected in case 6 with mild dysmorphic features (long philtrum, micrognathia, and macroglossia) and epilepsy.

NM\_005572.4:c.1201C>T p.(Arg401Cys) heterozygous likely pathogenic variant in the *LMNA* gene in case 7 who has motor retardation and blue sclera.

NM\_194442.2:c.1639A>G p.(Asn547Asp) heterozygous *de novo* pathogenic variant in the *LBR* gene was detected in case 8, who also shows atypic autism, long philtrum, and dysplastic ears.

NM\_006208.3:c.2344C>T p.(Arg782Ter) heterozygous pathogenic variant in the *ENPP1*

gene was detected in case 9 who has motor retardation together with cerebral atrophy with intellectual disability.

NM\_000462.5:c.1274dupTp.(Asp426GlyfsTer6) heterozygous novel pathogenic variant in the *UBE3A* gene was detected in case 10.

NM\_006941.4:c.496A>G p.(Lys166Glu) heterozygous novel likely pathogenic variant in the *SOX10* gene was detected in case 14 with motor retardation, hearing loss, dystopia cantorum, and strabismus.

#### *Recessively inherited variants*

NM\_024298.5:c.680\_690del p.(Leu227ProfsTer65) homozygous pathogenic variant in the *MBOAT7* gene was detected in case 1, who has epilepsy and speech delay. There was no consanguinity between the parents.

NM\_016219.5:c.1204C>T p.(Gln402Ter) homozygous pathogenic variant in the *MAN1B1* gene was detected in case 4, whose parents had first-degree cousin marriage.

NM\_020919.4:c.470G>A p.(Cys157Tyr) heterozygous likely pathogenic variant in the *ALS2* gene was detected in case 9, who has motor retardation and cerebral atrophy.

NM\_031466.8:c.3350A>C p.(His1117Pro) heterozygous novel VUS in the *TRAPPC9* gene was detected in case 10, who was diagnosed as Angelman Syndrome with the *UBE3A* pathogenic variant.

NM\_005529.7:c.11018T>C p.(Phe3673Ser) homozygous VUS in the *HSPG2* gene was detected in case 11, who has motor retardation and intellectual disability.

## DISCUSSION

The genetic approach of a case with an intellectual disability needs pre-, peri-, and postnatal clinical history; determination of risk factors, noting the pedigree of at least three generations and the parents' socioeconomic status; determination of minor anomalies; and physical measurements, neurological examination, and complete physical examination. The relationship between intellectual disability and congenital malformations is well defined, and detailed dysmorphic examination has a fundamental importance in determining

the etiology of intellectual disability. In many studies investigating the causes of intellectual disability, dysmorphic examination and syndrome identification by an experienced clinician is the primary diagnostic method. The clinical history and dysmorphic examination provide the clinician with information about which tests are necessary. In the first examination, genetic testing for intellectual disability etiology includes chromosome analysis, microdeletion/duplication analysis (aCGH method), and Fragile X mutation analysis. The incidence of chromosomal anomalies in cases with intellectual disability varies between 3% and 34%, and it is seen to be around 15% in studies conducted in various centers.<sup>14</sup> After these routine tests, a detailed molecular analysis should be planned for intellectual disability cases. Proof of diagnosis by molecular genetic testing is essential for atypical cases that suggest a diagnosis but do not have typical findings. Atypical presentations of known clinical syndromes are increasing; therefore, molecular studies come to the fore and are useful in clarifying events.

Clinical exome sequencing, which includes 6699 genes, showed 17 intellectual disability-related variants in 14 of 25 (56%) cases in the current study. This is the first report presenting seven novel variants in the *KDM5C*, *BCOR*, *UBE3A*, *TRAPPC9*, *AFF2*, *NLGN4*, and *SOX10* genes. Four novel variants and 12 pathogenic/likely pathogenic variants were reported in a study presenting whole-genome sequencing results of 45 intellectual disability cases.<sup>15</sup> Another study analyzing 454 genes in 112 intellectual disability/developmental delay cases reported that 14 variants, 13 of these 14 variants, were novel.<sup>16</sup> A similar study from Turkey reported a molecular diagnosis in 29 patients out of 59 with non-syndromic intellectual disability.<sup>17</sup> With a causative variant detection rate of 56% and with seven novel variants, our study presents valuable data for the literature.

Seven novel variants of 14 (50%) were found in the *KDM5C*, *BCOR*, *UBE3A*, *TRAPPC9*, *AFF2*, *NLGN4*, and *SOX10* genes in seven different cases in the current study. The high rate of novel variants determined is remarkable. A study reported a case with a novel *KDM5C* variant (c.3874\_3875del) with intellectual disability and severe short stature.<sup>18</sup> A study presenting 19 females carrying 10 novel heterozygous variants, including five probands with *de novo* variants, reported that all affected individuals presented with learning disabilities or intellectual disability; four also had a language impairment mainly affecting expression,



and four heterozygous females were asymptomatic which is similar to case 2 in the current study.<sup>19</sup> A novel variant of uncertain significance (VUS) was detected in case 7 in the *BCOR* gene in our study. Novel pathogenic variants were reported in the *BCOR* gene with congenital cataract<sup>20</sup> and acute myeloid leukemia.<sup>21</sup> *BCOR* gene pathogenic variants are related to syndromic microphthalmia and craniosynostosis.<sup>22</sup> Case 7 had an *LMNA* pathogenic variant with the *BCOR* VUS in the current study. *UBE3A* pathogenic and *TRAPPC9* novel VUS were detected in case 10 in our study. A novel *UBE3A* sequence variant was previously identified in eight related individuals with neurodevelopmental delay, but the phenotypes did not match the clinical criteria for Angelman syndrome in the literature.<sup>23</sup> It is also reported that functional analysis of the reported variant revealed no significant deficits in the *UBE3A* protein.<sup>23</sup> In our study, case 10 had only intellectual disability. The *TRAPPC9* gene is related to autosomal recessive mental retardation (OMIM #613192), and case 10 had a heterozygous *TRAPPC9* variant, but a functional study could determine the effect for case 10. An *AFF2* novel variant was detected in case 12, a male case inherited maternally, in the current study. It was reported that a heterozygous deletion at Xq27.3q28 including *FMR1*, *AFF2*, and *IDS* causing intellectual disability and characteristic facial features is infrequent in females, with only 10 patients having been reported.<sup>24</sup> Case 12, in the current study, had a VUS in the *AFF2* gene inherited maternally and due to this gene had been related to intellectual disability. The *NLGN4* novel variant was detected in case 13, in which intellectual disability, growth retardation, and speech delay were seen. *NLGN4* has been reported as a possible implication in autism<sup>25</sup> and has been reported to be mutated in many patients with autism and other neurodevelopmental disorders.<sup>26</sup> With molecular analysis results, case 13 was referred to the child psychiatry department to be evaluated for autism. Case 14, who had intellectual disability, hearing loss, dystopia canthorum, and motor retardation, was diagnosed with Waardenburg syndrome with a novel likely pathogenic *SOX10* gene variant. Novel variants on the *SOX10* gene were reported with clinical heterogeneity<sup>27</sup> however, clinical findings may not be typical.

Ten previously reported variants were also detected in our study. An *MBOAT7* homozygous pathogenic frameshift variant was detected in case 1, with intellectual disability, epilepsy,

and speech delay. An *MBOAT7* frameshift variant<sup>28</sup> in-frame deletion variants<sup>29</sup>, and loss of function variants<sup>30</sup> have been reported with intellectual disability, seizures, and autistic features previously. Case 3 in the current study had a *TUBB3* pathogenic variant with intellectual disability, epilepsy, and dysmorphic features. *TUBB3* is related to the malformation of cortical development<sup>31,32</sup>, neuronal migration disorders<sup>33</sup>, and infantile nystagmus.<sup>34</sup> In our study, case 3 had dysmorphic features (microcephaly, short philtrum, micrognathia, arachnodactyly, pectus excavatum, and broad toe) different from those described in the literature. A *MAN1B1* homozygous pathogenic variant was detected in case 4, with isolated intellectual disability. The *MAN1B1* gene is related to congenital disorders of glycosylation, which present with intellectual disability and are thought to be caused by deficient glycosylation of proteins and lipids.<sup>35,36</sup> Case 4 showed a nonsense mutation, (NM\_016219.5:c.1204C>T p.[Gln402Ter]), in the current study; while a case had a homozygous nonsense mutation, (NM\_016219.3: c.1418G>A [p.Trp473\*]), segregated with intellectual disability and additional dysmorphic features in a study.<sup>37</sup> Case 5, who had an intellectual disability, developmental delay, and macrocephaly, was diagnosed with Alexander's disease with a *GFAP* gene mutation. A study evaluating 135 patients diagnosed with Alexander's disease reported that the frequent findings were seizure, macrocephaly, developmental delay, and spasticity.<sup>38</sup> A *CACNA1A* pathogenic variant was detected in case 6, who had an intellectual disability, epilepsy, and dysmorphic features. A study investigating the etiology of undiagnosed neurodevelopmental disorders reported that *CACNA1A* is a promising gene for neurodevelopmental disorders or epileptic encephalopathy.<sup>39</sup> An *LMNA* variant was detected in case 7, with intellectual disability, motor retardation, and blue sclera in our study. A homozygous *LMNA* variant was reported in a family with lipodystrophy.<sup>40</sup> A *de novo* 1q22q23.1 interstitial microdeletion including the *LMNA* gene was reported in a case with short stature, microcephaly, hypoplastic corpus callosum, cleft palate, minor facial anomalies, congenital heart defect, camptodactyly of the fourth to fifth fingers, and intellectual disability.<sup>41</sup> An *LBR* gene *de novo* pathogenic variant was detected in case 8, who had an intellectual disability, atypical autism, and mild dysmorphic features in the current study. *LBR* is associated with Pelger-Huet anomaly, Greenberg dysplasia, and Reynolds syndrome.<sup>42</sup>

To our knowledge, no study has been reported on the relationship between the *LBR* gene and autism. Skeletal dysplasia and dysmorphic features have been reported with the *LBR* gene in two cases reporting a different phenotypic spectrum of *LBR*-associated disorders.<sup>43</sup> *ALS2* and *ENPP1* heterozygous variants were detected in case 9, with intellectual disability, motor retardation, and cerebral atrophy. The *ALS2* gene is recessively inherited, and both *ALS2* and *ENPP1* gene phenotypes were not related to the phenotype of case 9. *ALS2* gene mutations have been reported for juvenile-onset amyotrophic lateral sclerosis and related motor neuron diseases.<sup>44</sup> Due to case 9 being sixteen years old and having cerebral atrophy, *ALS2* may be reported as a candidate gene for cerebral atrophy. An *HSPG2* homozygous VUS was detected in case 11, with intellectual disability and motor retardation in the current study. A case with profound intellectual disability, infantile-onset seizures, chronic respiratory failure, facial dysmorphisms, skeletal abnormalities, and an atrial septal defect was reported with maternally inherited uniparental disomy of chromosome 16 including the *WWOX* gene explains the seizures and intellectual disability.<sup>45</sup> Another pathogenic variant in the *HSPG2* gene was reported as being responsible for the patient's skeletal abnormalities including 1p36 deletion causing developmental delay, intellectual disability, and seizures, which includes the *HSPG2* gene in the region responsible for skeletal dysplasia and congenital heart defects.<sup>46</sup>

The etiology of intellectual disability is heterogeneous and variable. With the development of new diagnostic methods, our knowledge of this subject increases day by day. In a significant proportion of intellectual disability cases, the etiology is unknown. We aimed to focus on these idiopathic intellectual disability cases in this study and to highlight that multiple gene analysis is beneficial to determine the etiology of intellectual disability.

In conclusion, in the current study, 14 cases of 25 (56%) were defined with a variant related to intellectual disability. Seven of fourteen (50%) cases had a definite diagnosis of intellectual disability with the pathogenic variants in *MBOAT7*, *KDM5C*, *TUBB3*, *MAN1B1*, *GFAP*, *CACNA1A*, and *UBE3A* genes. Seven novel variants were determined in the *KDM5C*, *BCOR*, *UBE3A*, *TRAPPC9*, *AFF2*, *NLGN4*, and *SOX10* genes. With a 56% variant detection rate, our study showed that multiple gene analysis for intellectual disability is crucial.

The limitations of this study are: the segregation analysis of all participants could not be applied due to the study was retrospectively planned. The functional studies were not performed on novel variants, they are classified according to the bioinformatical tools.

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## DISCLOSURE

Data availability: The data supporting this study's findings are available from the corresponding author upon reasonable request.

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Conflict of interest: None

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ADNY 1	ADNY 2	ADNY 3	ADNY 4	ADNY 5	ADNY 6	ADNY 7	ADNY 8	ADNY 9	ADNY 10	ADNY 11	ADNY 12	ADNY 13	ADNY 14	ADNY 15	ADNY 16	ADNY 17	ADNY 18	ADNY 19	ADNY 20	ADNY 21	ADNY 22	ADNY 23	ADNY 24	ADNY 25	ADNY 26	ADNY 27	ADNY 28	ADNY 29	ADNY 30	ADNY 31	ADNY 32	ADNY 33	ADNY 34	ADNY 35	ADNY 36	ADNY 37	ADNY 38	ADNY 39	ADNY 40	ADNY 41	ADNY 42	ADNY 43	ADNY 44	ADNY 45	ADNY 46	ADNY 47	ADNY 48	ADNY 49	ADNY 50	ADNY 51	ADNY 52	ADNY 53	ADNY 54	ADNY 55	ADNY 56	ADNY 57	ADNY 58	ADNY 59	ADNY 60	ADNY 61	ADNY 62	ADNY 63	ADNY 64	ADNY 65	ADNY 66	ADNY 67	ADNY 68	ADNY 69	ADNY 70	ADNY 71	ADNY 72	ADNY 73	ADNY 74	ADNY 75	ADNY 76	ADNY 77	ADNY 78	ADNY 79	ADNY 80	ADNY 81	ADNY 82	ADNY 83	ADNY 84	ADNY 85	ADNY 86	ADNY 87	ADNY 88	ADNY 89	ADNY 90	ADNY 91	ADNY 92	ADNY 93	ADNY 94	ADNY 95	ADNY 96	ADNY 97	ADNY 98	ADNY 99	ADNY 100
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AKRI D1	ASAH 2	BMP7 R	CSFC SSC	CUSP 4B	CTZ	DCLK1 IA	DYM AP	FARP 6	FSCB FSCN2	USPA G	HBSA HDI	JLEB B1	KCN V1	LIPH LIPN	MEPE K	MX1 AS	SKX2- 6	OTX PT	PGT PTG	POBP 2	RANG A	SND A	7258 136	SIAE C14	SMAR CC2	STK4 STOM	TH 1	TRPA1 TRPC3	VDR C	ZNF8 13
AKRI A2	ASAH 2	BMP7 R	CSFC SSC	CUSP 4B	CTZ	DCLK1 IA	DYM AP	FARP 6	FSCB FSCN2	USPA G	HBSA HDI	JLEB B1	KCN V1	LIPH LIPN	MEPE K	MX1 AS	SKX2- 6	OTX PT	PGT PTG	POBP 2	RANG A	SND A	7258 136	SIAE C14	SMAR CC2	STK4 STOM	TH 1	TRPA1 TRPC3	VDR C	ZNF8 13