SNPs Associated with Cerebrospinal Fluid Phospho-Tau Levels Influence Rate of Decline in Alzheimer’s Disease

Carlos Cruchaga1,2,9, John S. K. Kauwe3,*, Kevin Mayo1,2, Noah Spiegel1,2, Sarah Bertelsen1, Petra Nowotny1,2, Aarti R. Shah2,4, Richard Abraham9, Paul Hollingworth5, Denise Harold5, Michael M. Owen5, Julie Williams5, Simon Lovestone6, Elaine R. Peskind7,8, Ge Li7,8, James B. Leverenz7,8,9, Douglas Galasko10, The Alzheimer’s Disease Neuroimaging Initiative1, John C. Morris4,11,6, Anne M. Fagan2,4,13, David M. Holtzman2,4,12,13, Alison M. Goate1,2,4,13

1 Department of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, United States of America, 2 The Hope Center Program on Protein Aggregation and Neurodegeneration (HPAN), Washington University School of Medicine, St. Louis, Missouri, United States of America, 3 Department of Biology, Brigham Young University, Provo, Utah, United States of America, 4 Department of Neurology, Washington University School of Medicine, St. Louis, Missouri, United States of America, 5 Department of Psychological Medicine, Medical Research Council (MRC) Centre for Neuropsychiatric Genetics and Genomics, School of Medicine, Cardiff University, Cardiff, United Kingdom, 6 Kings College, London, United Kingdom, 7 Departments of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, Washington, United States of America, 8 Veterans Affairs Northwest Network Mental Illness Research, Education, and Clinical Center, Seattle, Washington, United States of America, 9 Department of Neurology, University of Washington School of Medicine, Seattle, Washington, United States of America, 10 Department of Neurosciences, University of California San Diego, La Jolla, California, United States of America, 11 Department of Pathology and Immunology, Washington University School of Medicine, St. Louis, Missouri, United States of America, 12 Department of Developmental Biology, Washington University School of Medicine, St. Louis, Missouri, United States of America, 13 Alzheimer’s Disease Research Center, Washington University School of Medicine, St. Louis, Missouri, United States of America.

Abstract

Alzheimer’s Disease (AD) is a complex and multifactorial disease. While large genome-wide association studies have had some success in identifying novel genetic risk factors for AD, case-control studies are less likely to uncover genetic factors that influence progression of disease. An alternative approach to identifying genetic risk for AD is the use of quantitative traits or endophenotypes. The use of endophenotypes has proven to be an effective strategy, implicating genetic risk factors in several diseases, including anemia, osteoporosis and heart disease. In this study we identify a genetic factor associated with the rate of decline in AD patients and present a methodology for identification of other such factors. We have used an established biomarker for AD, cerebrospinal fluid (CSF) tau phosphorylated at threonine 181 (ptau181) levels as an endophenotype for AD, identifying a SNP, rs1868402, in the gene encoding the regulatory sub-unit of protein phosphatase B, associated with CSF ptau181 levels in two independent CSF series (Pcombined = 1.17 x 10^-5). Our analyses suggest that genetic variants associated with CSF ptau181 levels may have a greater impact on rate of progression, while genetic variants such as APOE4, that are associated with CSF Aβ1-42 levels influence risk and onset but not the rate of progression. Our results also suggest that drugs that inhibit or decrease tau phosphorylation may slow cognitive decline in individuals with very mild dementia or delay the appearance of memory problems in elderly individuals with low CSF Aβ1-42 levels. Finally, we believe genome-wide association studies of CSF tau/ptau181 levels should identify novel genetic variants which will likely influence rate of progression of AD.


Editor: Amanda J. Myers, University of Miami, Miller School of Medicine, United States of America

Received April 22, 2010; Accepted July 29, 2010; Published September 16, 2010

Copyright: © 2010 Cruchaga et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Funding: This work was supported by grants from AstraZeneca, National Institutes of Health (AG16208, P01AG03991, P50AG05681, P01AG026276, AG23185, AG05136), the Barnes-Jewish Hospital Foundation, Ford Foundation, the Department of Veterans Affairs, and an anonymous foundation. CC has a fellowship from Fundacion Alfonso Martin Escudero. Data collection and sharing for Alzheimer’s Disease Neuroimaging Initiative (ADNI) (Principal Investigator: Michael Weiner, National Institutes of Health grant U01 AG09461) is funded by the National Institute on Aging, the National Institute of Biomedical Imaging and Bioengineering (NIBIB), and through generous contributions from the following: Pfizer, Inc., Wyeth Research, Bristol-Myers Squibb, Eli Lilly and Company, GlaxoSmithKline, Merck & Co., Inc., AstraZeneca AB, Novartis Pharmaceuticals Corporation, Alzheimer’s Association, Eisai Global Clinical Development, Elan Corporation plc, Forest Laboratories, and the Institute for the Study of Aging, with participation from the United States Food and Drug Administration. Industry partnerships are coordinated through the Foundation for the National Institutes of Health. The grantee organization is the Northern California Institute for Research and Education, and the study is coordinated by the Alzheimer’s Disease Cooperative Study at the University of California, San Diego. ADNI data are disseminated by the Laboratory of Neuro Imaging at the University of California, Los Angeles. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Competing Interests: The work presented in this report is also the subject of a pending patent filed by Washington University in St. Louis, Missouri, United States of America, in which Drs. C. Cruchaga, A. M. Goate, D. M. Holtzman and A. Fagan are named as inventors. The patent is currently under option to AstraZeneca Pharmaceuticals, LP. Drs. Goate and Holtzman have acted as consultants for AstraZeneca Pharmaceuticals, LP, in 2008/2009.

* E-mail: crucchag@psychiatry.wustl.edu

† These authors contributed equally to this work.

‡ A complete listing of the investigators for the Alzheimer’s Disease Neuroimaging Initiative is provided in the Acknowledgments.
Introduction

Genetic studies have helped to further our understanding of the pathogenic mechanism of several diseases, including AD. To date only the ε4 allele of apolipoprotein E (APOEε4) present in 50% of late onset AD (LOAD) cases, has been convincingly demonstrated to influence risk for LOAD. The traditional method for searching for genetic risk factors involves the comparison of genes in AD cases and non-demented elderly controls. AD is a complex and multifactorial disease, and as a result very large datasets have been necessary to identify these genetic risk factors [1–2]. An alternative to the standard case-control study design is to use quantitative traits or endophenotypes. Quantitative traits have been used to successfully identify new genetic factors implicated in anemia [3–6], osteoporosis [7] and heart disease [8–11]. The advantages of quantitative traits are that they provide higher power than regular case-control analyses, a biological model of disease and the possible effects of the associated genetic variation and may decrease the clinical heterogeneity of the samples. This is likely to be true for Alzheimer’s Disease (AD) because up to 30% of individuals in screened elderly non-demented control samples show evidence of AD pathology at autopsy [12], and a similar number have biomarker profiles consistent with preclinical AD [13–15], thus reducing the power of a case-control design.

Both Aβ and tau protein play an important role in AD, are detectable in cerebrospinal fluid (CSF) in all individuals, and have been used as biomarkers for diagnosis [16–18]. Patients with AD show lower CSF Aβ42 levels [19] that inversely correlate with the presence of fibrillar Aβ in the brain (as measured by Pittsburgh Compound B (PET-PIB) retention) in demented individuals [14] and plaque counts in brain samples [20]. Several studies suggest that PET-PIB retention and CSF Aβ42 levels could help to identify individuals with AD pathology before the onset of clinically detectable disease (preclinical AD) [14,21]. The CSF levels of total tau and tau phosphorylated at threonine 181 (ptau181) are detectable in cerebrospinal fluid (CSF) in all individuals, and have been used as biomarkers for diagnosis [16–18]. Patients with AD show evidence of AD pathology at autopsy [12], and a similar number have biomarker profiles consistent with preclinical AD [13–15], thus reducing the power of a case-control design.

Hyperphosphorylation of tau destabilizes the microtubule network, leading to impaired axonal transport and ultimately to neurofibrillary tangle formation and neuronal death (For review see [32]). In the present study we have evaluated 355 single nucleotide polymorphisms (SNPs) in 34 genes involved in tau modification or metabolism for association with CSF levels of ptau181, then determined the effects of those variants on AD risk, onset and rate of progression.

Results

Association with CSF ptau181 levels: Initial screening

Based on bibliographic data we selected 384 SNPs localized in 34 genes related to tau metabolism (tau kinases, phosphatases, tau O-glucosylation or tau degradation (Table S1). 355 SNPs passed quality control (Hardy-Weinberg equilibrium and call rate >95%). Association of SNPs with CSF ptau181 levels was evaluated by ANCOVA in 353 CSF samples from the Washington University Alzheimer Disease Research Center (WU-ADRC-CSF) (Tables 1 and 2). Clinical Dementia Rating (CDR), age and APOE ε4 genotype were included as covariates in the analyses. Eighteen SNPs, located in 7 different genes showed significant association with CSF ptau181 levels in the WU-ADRC-CSF series after multiple test correction (Table 3). The SNP with the most significant p-value, rs1868402, is located in intron 5 of the regulatory subunit of the protein phosphatase B gene, also known as calcineurin B (PPP3R1; MIM#: 601302). The association of rs1868402 with CSF ptau181 levels showed the best fit in the dominant model, with minor alleles carriers showing significantly higher CSF ptau181 levels (P = 5.90 × 10−14, Figure 1A and Figure S1). All subsequent analyses for rs1868402 used the dominant model. Six other SNPs in PPP3R1, which are in high linkage disequilibrium (LD) with rs1868402 (Figure S2, and Table S2), also showed association with CSF ptau181. Based on the linkage disequilibrium (LD) in PPP3R1, we selected rs1868402 and rs6546366 for replication. The remaining eleven SNPs that were significant after multiple test correction were also selected for replication (Table 3).

Association with CSF ptau181 levels: Replication in an independent CSF series and combined analyses

In a replication series of 493 independent CSF samples from ADNI (ADNI-CSF) and University of Washington (UW) (Tables 1 and 2) only the SNP located in calcineurin B, rs1868402, replicated and passed the FDR filter (P = 0.005 ptau181, Table 3, Figure S1). In this series rs1868402 also showed the best fit in the dominant model and minor allele carriers have higher CSF ptau181 levels. In the replication CSF series, rs6546366 (PPP3R1), showed no association with CSF ptau181 levels (Table 3). The lack of association of rs6546366 with CSF ptau181 levels is probably due to a lower level of LD with rs1868402 in the replication series (r² = 0.65) compared with the LD between these two SNPs in the WU-ADRC-CSF series (r² = 0.80). This result indicates that rs1868402, or another unknown variant in LD with rs1868402, is the variant that drives the association with CSF ptau181 levels.

We also performed a combined analysis by combining the residuals for CSF ptau181 after correcting for the covariates (see Materials and Methods). In this analysis we did not included site or platform as a covariate because there were no significant differences between datasets and/or platform for the ptau181 residuals. Inclusion of site/platform as a covariate did not significantly change the p-value. In the combined data, rs1868402 showed the most significant association with CSF ptau181 levels (combined analysis P = 1.71 × 10−95), with a p-value that was significant after Bonferroni correction for the entire study (r: 0.05/384 = 1.30 × 10−94). Minor allele carriers have a 2.4 fold increased risk of being in the highest quartile of the CSF ptau181 distribution compared to the lowest quartile (odds ratio = 2.37, 95% confidence interval 1.59–3.54). None of the other SNPs were significant after Bonferroni correction (Table 5).

Association with CSF ptau181 levels: Context-dependent effects

It has been demonstrated in our longitudinal data and that of others that the increase in CSF tau and ptau181 levels seen in mild AD is preceded by decreases in CSF Aβ42 levels [14,21]. This likely reflects deposition of Aβ in the brain [14]. Individuals with CSF Aβ42 levels less than 500 pg/ml in the WU-ADRC-CSF, and less than 192 pg/ml in the ADNI-CSF series, have evidence of Aβ deposition in the brain, as detected by PET-PIB [14,21]. We used these CSF Aβ42 thresholds to stratify the WU-ADRC-CSF and ADNI-CSF samples into individuals with low or high CSF Aβ42 levels (with and
Author Summary

Alzheimer’s disease (AD) is the most common neurodegenerative disease affecting more than 4.5 million people in the US. Genetic studies of AD have previously identified pathogenic mutations in three genes (APP, PSEN1 and PSEN2) and polymorphisms in APOE as risk factors. These findings have led to a better understanding of the underlying disease mechanisms. However, half of all AD cases have no known genetic risk factors for disease. Most studies are designed to identify variants associated with risk or age at onset, but rarely cover other important facets of AD, such as disease progression or duration. In this study we have used an established AD biomarker (cerebrospinal fluid tau phosphorylated at threonine 181, ptau181) to find genetic variants that influence levels of ptau181 in the cerebrospinal fluid. This novel and powerful approach has allowed us to identify a genetic factor located in the regulatory subunit of the calcineurin that is also strongly associated with rate of progression of AD. This study is important because it defines a strategy to find novel genetic factors influencing different facets of AD pathology including risk, onset and progression.

without likely Aβ deposition in the brain). The difference in CSF Aβ1-42 threshold levels between the WU-ADRC-CSF and ADNI-CSF series is due to different antibodies and procedures used to measure the CSF levels (see Materials and Methods). The data necessary to examine the correlation between the CSF Aβ1-42 levels and PET-PIB signal is not available in the UW CSF series and therefore this dataset could not be included in this analysis. In these analyses we calculated the p-value and the Odds ratios for rs1868402 with CSF ptau181 levels by comparing the frequency of this SNP in the lowest versus the highest quartile of the CSF ptau181 levels after correcting for the covariates. When we stratified the WU-ADRC-CSF and ADNI-CSF series by CSF Aβ1-42 levels, we observed very significant association for rs1868402 with CSF ptau181 in the low Aβ1-42 stratum (combined analysis P = 1.13 × 10^-04; Odds Ratio 3.48; 95% confidence interval 1.8–6.7) and a nominally significant association in the high Aβ1-42 stratum (combined analysis P = 0.023; Odds Ratio 2.54; 95% confidence interval 1.0–6.75, Table 4). Both the high and low Aβ1-42 level strata have sufficient power to detect the association between rs1868402 with CSF ptau181 levels (high Aβ1-42 0.903; low Aβ1-42 0.975; α = 0.05). The nominally significant p-value in the high Aβ stratum may indicate a moderate effect on CSF ptau181 levels in healthy individuals, but it is clear that when AD pathology is present the effect of this SNP is more marked.

Rs1868402 explains 4.62% of the variability in CSF ptau181 levels in individuals with low CSF Aβ1-42 levels in the WU-ADRC-CSF+ADNI-CSF samples, which is similar to the variability explained by other SNPs and endophenotypes [3–11]. It is important to note that in the low CSF Aβ1-42 group there are individuals diagnosed with DAT (CDR > 0, n = 183, 58%) and non-demented individuals (CDR = 0, n = 134, 42%) with possible Aβ deposition in the brain and brain atrophy (presymptomatic AD) [12]. In the high Aβ1-42 stratum 80% of the samples (n = 242) had a CDR = 0.

Implication of SNPs associated with CSF ptau181 levels in AD: Association with rate of progression of AD but not risk for AD or age at onset

The premise of this endophenotype-based approach is that a SNP, such as rs1868402 that shows strong, replicable association with an important AD biomarker should also modulate risk, onset and/or progression of AD. We tested whether rs1868402 influences risk for AD, age at onset and disease progression. We found no association between rs1868402 and risk for AD (P= 0.10, Table 5) or age at onset (P = 0.19 Figure 2) in 1106 cases and 1216 controls of European descent.

To examine disease progression we used two longitudinal datasets: 109 subjects from WU-ADRC-CSF (399 observations) and 150 subjects from ADNI-CSF (620 observations). Association with rate of progression was evaluated by comparing the change in sum of boxes of the CDR (SB-CDR) per year (slope) by genotype including age at the first visit, gender, APOE genotype and initial CDR as covariates. CSF ptau181 and Aβ1-42 levels were also included in the model to correct for the potential association between these

Table 1. Summary of sample characteristics.

<table>
<thead>
<tr>
<th>Sample</th>
<th>n</th>
<th>Age (yrs) Mean ± SD (range)</th>
<th>Male (%)</th>
<th>APOE4 allele (%)</th>
<th>CDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>WU-ADRC-CSF</td>
<td>353</td>
<td>68±11 (45–94)</td>
<td>39</td>
<td>40</td>
<td>0 = 72%: &gt;0.5 = 18%</td>
</tr>
<tr>
<td>ADNI-CSF</td>
<td>236</td>
<td>75±6 (56–91)</td>
<td>56</td>
<td>47</td>
<td>0 = 40%: &gt;0.5 = 60%</td>
</tr>
<tr>
<td>UW</td>
<td>257</td>
<td>69±8 (55–88)</td>
<td>50</td>
<td>50</td>
<td>0 = 52%: &gt;0.5 = 48%</td>
</tr>
<tr>
<td>Brain Samples</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cases</td>
<td>82</td>
<td>86±7 (72–102)</td>
<td>45</td>
<td>41</td>
<td>&gt;0.5 = 100%</td>
</tr>
<tr>
<td>controls</td>
<td>39</td>
<td>85±9 (64–107)</td>
<td>41</td>
<td>23</td>
<td>0 = 100%</td>
</tr>
<tr>
<td>WU-ADRC-CC</td>
<td>340</td>
<td>69±7 (69–101)</td>
<td>35</td>
<td>56</td>
<td>&gt;0.5 = 100%</td>
</tr>
<tr>
<td>cases</td>
<td>281</td>
<td>78±8 (60–102)</td>
<td>39</td>
<td>21</td>
<td>0 = 100%</td>
</tr>
<tr>
<td>control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADNI-CC</td>
<td>100</td>
<td>71±8 (52–91)</td>
<td>55</td>
<td>65</td>
<td>&gt;0.5 = 100%</td>
</tr>
<tr>
<td>control</td>
<td>123</td>
<td>77±5 (61–92)</td>
<td>53</td>
<td>26</td>
<td>0 = 100%</td>
</tr>
<tr>
<td>MRC</td>
<td>666</td>
<td>76±7 (60–97)</td>
<td>27</td>
<td>61</td>
<td>&gt;0.5 = 100%</td>
</tr>
<tr>
<td>control</td>
<td>812</td>
<td>76±6 (61–97)</td>
<td>37</td>
<td>23</td>
<td>0 = 100%</td>
</tr>
</tbody>
</table>

Sample size (n), age, percentage of males, percentage of APOE4 allele carriers, and clinical dementia rating (CDR) for each sample. For the cases at age onset is shown and for controls the age at last assessment.
phenotypes with progression [33]. Because the association of rs1868402 with CSF ptau181 was mainly in individuals with low CSF Aβ42 levels, association with progression was analyzed in individuals with low CSF Aβ42 levels (less than 500 pg/ml in the WU-ADRC-CSF, and less than 192 pg/ml in the ADNI-CSF series), and an initial CDR of 0 or 0.5. Individuals with CDR 0 and 0.5 were selected to maximize the amount of information on progression per individual and to avoid possible ceiling effects from individuals who began the study with advanced levels of dementia.

Carriers of the rs1868402 allele associated with higher CSF ptau181 levels showed an increase of 0.58 SB-CDR per year, which is six-fold faster than the rate seen in individuals homozygous for the allele associated with low CSF ptau181 levels (P = 0.0026; Table 6). The rate of progression (R2 = 0.75) also shows association with PPP3R1 mRNA levels and Braak stage in these samples (P = 0.018; Table 6) and in the same direction in the publicly available GEO GSE8919 [34] dataset (P = 0.015).

We tested whether rs1868402 interacts with rs3785883, a SNP located in MAPT, which is also associated with CSF ptau181 levels [27]. Rs3785883 also showed a p-value for association with CSF ptau181 levels of 0.008 in the combined series of this study. We found significant epistasis between these SNPs. Individuals carrying alleles associated with higher CSF ptau181 for rs1868402 and rs3785883 showed an increase of 1.02 SB-CDR per year on average, whereas those carrying the alleles associated with lower CSF ptau181 at each SNP showed essentially no change in the SB-CDR per year (combined analyses P = 1.43 x 10^-65; Figure 3B; Table 6). The interaction between rs1868402 and rs3785883 also replicated in the ADNI-CSF and ADNI-CC series (Table 6).

### Discussion

In the present study we have used a novel and powerful endophenotype-based approach to identify a novel genetic factor implicated in AD. Most genetic studies in AD have focused on identifying genetic factors that modulate risk or age at onset of Alzheimer's Disease. This study provides evidence for the association of rs1868402 with CSF ptau181 levels and progression in AD. The results suggest that rs1868402 may be a potential biomarker for AD progression.

### Table 2. Summary of biomarker characteristics.

<table>
<thead>
<tr>
<th>ADRC</th>
<th>ADNI</th>
<th>UW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aβ42</td>
<td>564±244 (175–1295)</td>
<td>170±56 (53–300)</td>
</tr>
<tr>
<td>Tau</td>
<td>376±241 (88–1358)</td>
<td>98±56 (28–495)</td>
</tr>
<tr>
<td>ptau181</td>
<td>63±32 (24–241)</td>
<td>18±8 (8–115)</td>
</tr>
</tbody>
</table>

CSF Aβ42, tau and ptau181 levels for the Washington University Alzheimer's Disease Research Center (ADRC), Alzheimer's Disease Neuroimaging Initiative (ADNI) and for the University of Washington, Seattle (UW). For each phenotype the mean in pg/ml with the standard deviation and range is shown.

doi:10.1371/journal.pgen.1001101.t002

### Table 3. SNPs associated with CSF ptau181 levels in the initial series, the replication series and the combined dataset.

<table>
<thead>
<tr>
<th>gene</th>
<th>rs</th>
<th>MAF</th>
<th>WU-ADRC-CSF</th>
<th>Replication series</th>
<th>Combined Series</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>FDR p-value</td>
<td>FDR p-value</td>
<td>effect^2</td>
</tr>
<tr>
<td>PPP3R1</td>
<td>rs1868402^A</td>
<td>0.37</td>
<td>5.90 x 10^-04</td>
<td>0.025</td>
<td>0.005</td>
</tr>
<tr>
<td>PPP3R1</td>
<td>rs6546366^A</td>
<td>0.35</td>
<td>0.004</td>
<td>0.030</td>
<td>0.271</td>
</tr>
<tr>
<td>F2</td>
<td>rs2070852^A</td>
<td>0.32</td>
<td>0.008</td>
<td>0.041</td>
<td>0.690</td>
</tr>
<tr>
<td>FYN</td>
<td>rs927010^B</td>
<td>0.26</td>
<td>5.92 x 10^-04</td>
<td>0.025</td>
<td>0.425</td>
</tr>
<tr>
<td>FYN</td>
<td>rs7768046</td>
<td>0.39</td>
<td>0.004</td>
<td>0.030</td>
<td>0.465</td>
</tr>
<tr>
<td>GSK3β</td>
<td>rs3755575^B</td>
<td>0.12</td>
<td>0.004</td>
<td>0.030</td>
<td>0.442</td>
</tr>
<tr>
<td>GSK3β</td>
<td>rs7431209^A</td>
<td>0.24</td>
<td>0.005</td>
<td>0.030</td>
<td>0.946</td>
</tr>
<tr>
<td>MAPT</td>
<td>rs7210728^A</td>
<td>0.36</td>
<td>0.005</td>
<td>0.041</td>
<td>0.529</td>
</tr>
<tr>
<td>MGEA5</td>
<td>rs2305192^B</td>
<td>0.30</td>
<td>0.008</td>
<td>0.041</td>
<td>0.795</td>
</tr>
<tr>
<td>PRRCA</td>
<td>rs7218425</td>
<td>0.21</td>
<td>0.005</td>
<td>0.030</td>
<td>0.358</td>
</tr>
</tbody>
</table>

SNPs that passed FDR correction in the WU-ADRC-CSF series were followed up in a replication series composed of CSF samples from ADNI-CSF and UW. Both series (WU-ADRC-CSF and Replication) were combined to increase the statistical power. In the WU-ADRC-CSF and replication series; p-values in bold denote values that are significant after FDR correction. In the Combined Series we applied Bonferroni correction. Threshold for Bonferroni correction is 1.3 x 10^-04.

^For each SNP the rs number and P values for association with ptau181 before and after FDR correction are shown.

^Dominant model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.

^Recessive model.
Figure 1. Rs1868402 is associated with CSF ptau181 levels, PPP3R1 mRNA expression levels and tangle counts. A. Association of rs1868402 with CSF ptau181 levels (WU-ADRC-CSF n = 353) was tested by an Analyses of Covariance (ANCOVA) including CDR, age and APOE genotype as covariates. B. Minor allele carriers of rs1868402 have significantly lower PPP3R1 mRNA levels in individuals with AD pathology (n = 82). C. Minor allele carriers of rs1868402 have significantly higher numbers of tangles (n = 82). D: PPP3R1 mRNA expression correlates with tangle counts in individuals with AD pathological changes (n = 82). The p-value is for the correlation between mRNA levels and genotypes.

doi:10.1371/journal.pgen.1001101.g001

Table 4. Rs 1868402 is associated with CSF ptau181 levels in individuals with Aβ deposition.

<table>
<thead>
<tr>
<th>Gene</th>
<th>Rs #</th>
<th>stratum</th>
<th>n</th>
<th>ptau181</th>
<th>Effect</th>
<th>OR (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPP3R1</td>
<td>rs1868402</td>
<td>Total sample</td>
<td>589</td>
<td>2.62 × 10^{-6}</td>
<td>-0.34 (0.08)</td>
<td>2.78 (1.73–4.54)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low Aβ levels</td>
<td>300</td>
<td>1.13 × 10^{-4}</td>
<td>-0.47 (0.12)</td>
<td>3.48 (1.80–6.75)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High Aβ levels</td>
<td>289</td>
<td>0.023</td>
<td>-0.18 (0.10)</td>
<td>2.54 (1.00–5.75)</td>
</tr>
</tbody>
</table>

The p-value and the OR for rs1868402 were calculated by comparing the rs1868402 allele frequency in the lowest quartile vs the highest quartile of CSF ptau181 levels, after correction for covariates in the WU-ADRC-CSF (n = 353) + ADNI-CSF (n = 266) samples. CSF Samples from the UW could not be included in this analysis because there is no study analyzing the correlation between the CSF Aβ42 levels and PET-PIB signal in this dataset, and therefore the threshold of CSF Aβ42 levels for PIB positivity is unknown. OR (95%) = Odds ratio with the 95% confidence interval; Odds ratios were calculated comparing the highest vs lowest quartile of CSF ptau181 levels. Samples were stratified based on CSF Aβ42 levels as an approximation of Aβ deposition. For the ADRC samples individuals with Aβ42 levels less than 500 pg/ml were considered positive for Aβ deposition and for ADNI samples the Aβ42 cutoff value of 192 pg/ml was used. Values in boldface indicate significant p-values.

Dominant model.

Effects and the standard error of the mean are given in units of standard deviation.

doi:10.1371/journal.pgen.1001110.t004
disease [1–2]. The genetic factors influence other important facets of AD, such as rate of progression or disease duration remain poorly understood. Here we report that the minor allele of rs1868402 shows significant, replicable association with higher CSF ptau181 levels and faster rate of progression of AD. We failed to detect evidence for association with risk for disease or age at onset. This is consistent with the known pathobiology of AD, in which Aβ aggregation and deposition is an early preclinical event, followed by increased CSF tau and ptau181 levels and tau pathology during the clinical phase of the disease. Under this model, factors that affect tau phosphorylation and aggregation may be expected to modify disease progression but not risk for disease, while genes that influence Aβ aggregation, such as APOE4 [35], would be expected to influence CSF Aβ12 levels and risk/age at onset of disease but not CSF tau/ptau181 levels or rate of progression of disease. Table 7 illustrates that this is the case in our data. Genetic analyses of CSF Aβ12 and tau variation therefore allow identification of genetic factors that influence different components of the disease process.

Our results suggest that rs1868402, or another variant in LD with it, may reduce calcineurin expression/activity leading to an increase in tau phosphorylation increasing tau pathology and neurodegeneration in individuals with Aβ deposition. The resulting increase in tau-related pathology would then increase the rate of progression of AD. Several studies provide support for a role of calcineurin in AD pathogenesis. Inhibition of calcineurin in mouse brains by cyclosporin A or FK506 or rat brain by antisense oligonucleotides led to enhanced tau phosphorylation [36–38]. In mice the increase in tau phosphorylation was accompanied by impaired spatial memory, a characteristic feature of AD [36]. Finally, in AD patients, calcineurin activity is decreased and correlates with neuropathologic changes [39].

Our analyses suggest that genetic variants associated with CSF Aβ12 levels also influence risk and age at onset (e.g. APOE) but variants associated with CSF ptau181 levels have a greater impact on rate of progression (Table 7). Genome-wide association studies of CSF tau/ptau181 levels should identify novel genetic variants which will likely influence rate of progression of AD. Variants that influence disease progression may have significant clinical benefit. For example, these variants have the potential to predict more accurately the time from diagnosis to functional impairment that may require nursing home placement. Stratification of samples by such SNPs will enable cheaper and more efficient clinical trials by selecting individuals expected to have faster rates of progression. By targeting different facets of AD biology this approach can identify a broader range of potential therapeutic targets than a conventional case-control design. Drugs that inhibit or decrease tau phosphorylation would be expected to decrease cognitive decline in individuals with very mild dementia or delay the appearance of memory problems in elderly individuals with low CSF Aβ12 levels. Finally, we believe that this approach is applicable to other common neurological and psychiatric disorders, where biomarkers of disease have been identified, and underlines the value and importance of finding such markers in other diseases.

### Materials and Methods

**Subjects and endophenotypes**

The cerebrospinal fluid discovery series includes 353 individuals enrolled in longitudinal studies at the WU-ADRC. CSF collection and Aβ12, tau and ptau181 measurements were performed as described previously [14]. Table 1 shows the demographic data for the CSF series and Table 2 shows a description of the CSF biomarker in each dataset. The CSF replication series consists of 236 individuals from the ADNI dataset and 257 individuals from the University of Washington (UW, Seattle). All CSF samples were from individuals of European descent. Written consent was obtained from all participants. While there are differences in the absolute levels of the biomarker measurements between the two studies that likely reflect differences in the methods used for quantification (regular ELISA vs Luminex), ascertainment, and/or

---

### Table 5. Rs1868402 is not associated with risk for AD.

<table>
<thead>
<tr>
<th>Series</th>
<th>Cases</th>
<th>Controls</th>
<th>Minor Allele</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs1868402</td>
<td>MRC</td>
<td>666</td>
<td>C</td>
<td>0.512</td>
<td>0.471</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>WU ADRC-CC</td>
<td>340</td>
<td>C</td>
<td>0.497</td>
<td>0.470</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>ADNI-CC</td>
<td>100</td>
<td>C</td>
<td>0.505</td>
<td>0.446</td>
<td>0.11</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1106</td>
<td>C</td>
<td>0.504</td>
<td>0.467</td>
<td>0.10</td>
</tr>
</tbody>
</table>

rs1868402 was genotyped in the MRC, WU-ADRC-CC and ADNI-CC series. Number of cases and controls, minor allele and minor allele frequency (MAF) for each series and for the combined series are showed. P-value for the dominant (rs1868402) model were calculated by logistic regression including APOE, age, gender and series as covariates.

doi:10.1371/journal.pgen.1001101.t005

---

Figure 2. Survival curves comparing age at onset of LOAD between the different genotypes of rs1868402. Survival fractions were calculated using the Kaplan-Meier method and significant differences were calculated by Log-rank test. Association with age at onset was calculated in a combined series with samples from WU-ADRC-CC, ADNI-CC and MRC.

doi:10.1371/journal.pgen.1001101.g002
in handling of the CSF after collection, CSF ptau181 levels in the WU-ADRC-CSF, ADNI-CSF, and UW samples show similar characteristics. CSF ptau181 levels show a 10–17 fold difference between individuals in each dataset, are normally distributed after log-log transformation, and have similar covariates in each dataset (see statistical analyses).

Risk for disease and age at onset analyses were analyzed in a total of 1106 late-onset AD (LOAD) cases and 1216 age-gender-ethnicity matched non-demented controls (Table 5). These samples were ascertained at the WU-ADRC, MRC genetic resource for late-onset AD (UK, MRC Sample [40]), and ADNI. Cases received a diagnosis of dementia of the Alzheimer’s type (DAT), using criteria equivalent to the National Institute of Neurological and Communication Disorders and Stroke-Alzheimer’s Disease and Related Disorders Association for probable AD [41–42]. All individuals were of European descent and written consent was obtained from all participants.

Association of rate of progression of dementia with genetic variants was tested in two longitudinal series from the WU-ADRC and ADNI. The WU-ADRC-CSF series includes 109 individuals with clinical data from at least two time points starting with a CDR of 0 or 0.5 in the first interview, and a diagnosis of DAT (dementia Alzheimer Type) at the last visit. There are an average of 3.8 observations per individual, which varies from 2 to 14 with an average follow up time of 3.2 years. The second series with longitudinal data is the ADNI series: 459 individuals (236 with CSF data and another 223 with no CSF data) have had a clinical examination at least two time points with an average of 4.1 observations per individual, which varies between two and six observations, however the average follow up time is only 1.9 years. To study the association with progression rate in the CSF samples we analyze only the 150 samples with low (<192pg/ml) CSF Aβ42, as explained in the Statistical Analyses section.

### SNP selection and genotyping

Based on bibliographic data, we selected 384 SNPs in the most relevant tau kinases, phosphatases, and in other genes implicated in other posttranslational modifications of tau, or tau degradation [45–47] (Table S1). Tagging SNPs (r² > 0.8), based on CEU-HapMap data, were selected for each of these genes. We used Pupasuite software [48] to select potentially functional variants in the selected genes and flanking regions. SNPs were genotyped

### Table 6. Association with rate of disease progression.

<table>
<thead>
<tr>
<th>SNP</th>
<th>WU-ADRC-CSF</th>
<th>ADNI-CSF</th>
<th>Combined CSF series</th>
<th>ADNI samples No CSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs1868402</td>
<td>0.0026</td>
<td>0.014</td>
<td>1.71×10⁻⁰⁵</td>
<td>0.0187</td>
</tr>
<tr>
<td>rs1868402*rs3785883</td>
<td>4.00×10⁻⁰⁴</td>
<td>0.010</td>
<td>1.43×10⁻⁰⁵</td>
<td>0.0123</td>
</tr>
</tbody>
</table>

Rs1868402 is associated with progression rate and shows epistasis with rs3785883, which is also associated with CSF tau levels [27].

Rate of progression were analyzed by the change of the Clinical Dementia Rating sum of boxes (CDR-SB) score per year in individuals with low CSF Aβ42 levels (ADRC<500pg/ml; ADNI<192pg/ml) and in samples with no CSF data. Association of SNPs with progression was calculated with mixed linear models (proc mixed) after controlling for age, sex, APOE, CDR and/or CSF ptau181 and Aβ42.

doi:10.1371/journal.pgen.1001101.0006

Figure 3. Genetic variants associated with CSF ptau181 levels are also associated with rate of progression of AD. Rate of progression is defined as the change in the Clinical Dementia Rating sum of boxes (SB-CDR) score per year. Association of SNPs with progression was calculated using a mixed linear model (PROC MIXED) after controlling for age, sex, APOE, initial CDR, CSF ptau181, and Aβ42 levels. A. Minor allele carriers of rs1868402, are associated with higher CSF ptau181 levels, and show a 6 fold faster progression than homozygotes for the major allele (CDR-SB/year: 0.58 vs 0.09; p = 0.0026) in individuals from the WU-ADRC with low CSF Aβ42 levels (<500pg/ml). For this SNP the dominant model was used because it showed the best fit in all the analyses. B. rs3785883 genotypes do not have significantly different progression rates (P = 0.057). The genotype frequency distribution for rs3785883 with disease progression is most likely not significant due to the low statistical power. AA carriers show a CDR-SB of 1.01, AG of 0.47 and GG 0.26 (p = 0.057). The additive model was used because it showed the best fit in all the analyses. B. rs3785883 genotypes do not have significantly different progression rates (P = 0.057). The genotype frequency distribution for rs3785883 with disease progression is most likely not significant due to the low statistical power. AA carriers show a CDR-SB of 1.01, AG of 0.47 and GG 0.26 (p = 0.057). The additive model was used because it showed the best fit in all the analyses. C. Rs1868402 and rs3785883 show an epistatic interaction. Carriers of the alleles associated with higher CSF ptau181 levels (CT+CC for rs1868402 and AA for rs3785883) showed a CDR-SB/year of 1.02 vs ~0.006 for carriers of alleles associated with lowest CSF ptau181 levels. LP indicates lumbar puncture.

doi:10.1371/journal.pgen.1001101.g003
using the Illumina Golden Gate, Sequenom and/or Taqman genotyping technologies. Only SNPs with a genotyping call rate higher than 95% and in Hardy-Weinberg equilibrium were used in the analyses.

Gene expression

Expression studies were carried out using cDNA obtained from the parietal lobe of 82 AD cases and 39 non-demented individuals (CDR = 0) obtained through the WU-ADRC Neuropathology Core (Brain samples; Table 1). AD changes were measured using Braak and Braak staging [43]. All AD cases had a Braak and Braak score of 5 or 6. Among the non-demented individuals 24 brains had a Braak and Braak score ranging from 1–4 indicating the presence of some tangle pathology.

Total RNA was extracted from the parietal lobe of 82 AD cases and 39 non-demented individuals, using the RNeasy mini kit (Qiagen) following the manufacturer’s protocol. cDNAs were prepared from the total RNA, using the High-Capacity cDNA Archive kit (ABI). Gene expression was analyzed by real-time PCR, using an ABI-7500 real-time PCR system. Real-time PCR assays were used to quantify PPP3R1 cDNA levels. Taqman assays for GAPDH (sequences available on request) PPP3R1 (ABI: C_12044272_10) and cyclophilin A (ABI: 4326316E) were used to quantify the gene expression levels. Each real-time PCR run was performed within-plate duplicates and each experiment was performed, at least twice for each sample. Real-time data were analyzed using the comparative Ct method. The Ct values of each sample were normalized with the Ct value for the housekeeping genes, GADPH and cyclophilin, and were corrected for the PCR efficiency of each assay [44], although the efficiency of all reactions was close to 100%.

Only samples with a standard error of <0.15% were analyzed.

Statistical analyses

CSF ptau181 values were measured using different platforms (Innotest plate ELISA vs AlzBia3 bead-based ELISA, respectively) we were not able to combine the raw data, rather we combined the residual values of the CSF ptau181 obtained after correcting for the covariates. No significant differences in the residuals from the different series were found, indicating that the differences in the CSF levels due to the different platforms were corrected by using the residuals.

Multiple test correction: Initial tests for association of SNPs with CSF ptau181 values were evaluated using a False Discovery Rate (FDR) filter of 0.1 to correct for multiple testing [49]. In the initial screening only p-values more significant than 8.1 × 10⁻⁷ passed FDR filter of 0.1. In the replication series p-values more significant than 5.0 × 10⁻⁷ passed FDR filter. To reduce the probability of false positives we also used the more stringent Bonferroni correction to adjust the alpha level in the analysis of association with CSF ptau181 in the combined samples. In this case, the threshold for Bonferroni correction for the combined sample is 1.3 × 10⁻⁸ (α: 0.05/384 = 1.3 × 10⁻⁸). No multiple test correction was applied for association with risk for disease, age at onset or progression because only one or two SNPs with specific hypotheses were tested for association. To calculate the impact of rs1868402 on the CSF ptau181 levels, we calculated the Odds Ratio (OR) of this SNP by comparing its frequency in the highest vs lowest quartile of the residuals for CSF ptau181 levels.

Allelic association with risk for AD was tested using logistic regression including APOE, gender, age and series as covariates. Association with AAO was carried out using the Kaplan-Meier method and tested for significant differences, using a log-rank test. Association with rate of disease progression was evaluated as described previously [33]. Briefly, progression of disease was measured by the change in sum of boxes on the CDR (clinical dementia rate; SB-CDR) per year. CDR is a global measurement of the severity of symptoms of dementia. CDR evaluates cognitive and functional performance in six areas (memory, orientation, judgment and problem solving, community affairs, home and hobbies and, personal care), each of these areas has a possible score of 0, 0.5, 1, 2 or 3. The sum of boxes can vary between 0 and 18. Higher scores indicate more significant memory problems and correlate with neurodegeneration [50]. The change in SB-CDR per year fitted a linear model in both series and therefore we used a mixed linear model (PROC MIXED; SAS Institute Inc) to determine whether there is a relationship between the slope of the SB-CDR score and time as a function of genotype after controlling for initial age, gender, APOE, initial CDR, CSF ptau181 and Aβ42 levels. Because the association between rs1868402 and CSF ptau181 was driven by individuals with low CSF Aβ42 levels, association with progression in the CSF datasets was analyzed only in individuals with low CSF Aβ42 levels (less than 500 pg/ml in the WU-ADRC-CSF series [14] or 192 pg/ml in the ADNI-CSF series [21]). We analyzed whether

| Table 7. Variants that modify CSF Aβ42 levels affect risk for AD, whereas variants associated with CSF ptau181 levels affect rate of progression. |
|----------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Association with Aβ42 | CSF Aβ42 | Risk | age at onset | Progression |
| rs1868402 | 1.17 × 10⁻⁴ | 0.53 | 0.31 | 0.47 | 1.31 × 10⁻⁶ |
| APOE4 | 0.018 | 3.9 × 10⁻⁸ | 3.9 × 10⁻⁸ | 4.0 × 10⁻⁷ | 0.316 |

P-values for the association of rs1868402 (PPPS3R1) and APOE4 with CSF Aβ42 and ptau181 levels, risk for AD, age at onset and disease progression are shown.

Sample size = 846, WU-ADRC-CSF+ADNI-CSF+UW.

Sample size = 2322 MRC+WU ADRC-CC+ADNI-CC.

Sample size = 259; WU-ADRC-CSF+ADNI-CSF with low CSF Aβ42 levels.

Significant p-values are in bold.

doi:10.1371/journal.pgen.1001101.t007
the combination of genotypes of rs1868402 and rs3785883 predicts the rate of progression better than either of these SNPs alone. To do that we included an interaction term rs1868402*rs3785883 in the “proc mixed” SAS program, that combine the genotypes for the two SNPs. We also combined the data from the WU-ADRC-CSF and ADNI-CSF to increase the statistical power. Association between cDNA levels, tau pathology (Braak tangle stage) and genotypes were carried out using ANCOVA. Stepwise discriminant analysis was used to determine the significant covariates (age, gender, post-mortem interval, APOE genotype, and CDR). One-tailed P-values were calculated, because a priori predictions were made based on the associations with CSF ptau181 levels. We also used the GEO dataset GSE8919 [51] to analyze the association between rs12713636, in LD with rs1868402 and the genotype data for rs12713636. Genotypes for rs12713636 were measured in the discovery series (WU-ADRC-CSF) with low CSF Aβ42 levels (<500 pg/ml). B. rs3785883 genotypes do not have significantly different progression rates P = 0.057. The genotype frequency distribution for rs3785883 with disease progression is most likely not significant due to the low statistical power. AA carriers show a CDR-SB of 1.01, AG of 0.47 and GG 0.26 (p = 0.057).

Supporting Information

Figure S1  Minor allele carriers of rs1868402 present significantly higher CSF ptau levels. The mean and the standard error of the mean (SEM) for the raw and residuals CSF ptau levels for the WU-ADRC-CSF, ADNI-CSF and UW series is shown. A. Raw CSF ptau levels for the WU-ADRC-CSF series by rs1868402 genotype. CC:CT: 64.45±2.52. TT: 57.20±2.49 pg/ml. B. Raw CSF ptau levels for the ADNI-CSF series by rs1868402 genotype. CC:CT: 35.95±1.85. TT: 30.22±1.44 pg/ml. C. Raw CSF ptau levels for the UW series by rs1868402 genotype. CC:CT: 67.46±3.53. TT: 61.42±2.71 pg/ml. D. Residuals CSF ptau levels for the WU-ADRC-CSF series by rs1868402 genotype. CC:CT: 0.17±0.07. TT: -0.22±0.08. E. Residuals CSF ptau levels for the ADNI-CSF series by rs1868402 genotype. CC:CT: 0.13±0.09. TT: -0.16±0.08. F. Residuals CSF ptau levels for the UW series by rs1868402 genotype. CC:CT: 0.10±0.08. TT: -0.12±0.09. Found at: doi:10.1371/journal.pgen.1001101.s001 (0.06 MB DOC)

References


Acknowledgments

Some of the data used in the preparation of this article were obtained from the Alzheimer’s Disease Neuroimaging Initiative (ADNI) database (www.loni.ucla.edu/ADNI). As such, the investigators within the ADNI contributed to the design and implementation of ADNI and/or provided data but did not participate in analysis or writing of this report. ADNI investigators: (complete listing available at www.loni.ucla.edu/ADNI/Collaboration/ADNI_Authorship_list.pdf).

The authors thank the Clinical Core of the ADRC for clinical and cognitive assessments of the participants, the Genetics Core of the ADRC for APOE genotypes and the Biomarker Core of the Adult Children Study for the CSF collection and assays.

Author Contributions

Conceived and designed the experiments: CC JSKK AMG. Performed the experiments: CC KM NS ARS. Analyzed the data: CC JSKK SB PN. Contributed reagents/materials/analysis tools: RA PH DH MMO JW SL CMF DMH. Wrote the paper: CC AMG.

Table S1 Genes and SNPs/gene genotyped in this study. The official and the most common alias of the gene, the activity related to tau, chromosomal position, and gene size in Kb are shown. A. Tag SNP. SNPs that capture 80% of the common sequence diversity within the gene. B. Only validated SNP with a minor allele frequency >0.1. C. Number of SNPs that passed quality controls.

Table S2 SNPs in PPP3R1 associated with CSF ptau levels in the discovery series (WU-ADRC-CSF). SNPs associated with CSF ptau levels after FDR correction are shown. MAF = Minor Allele Frequency. A: Dominant model. B: Recessive model.


