Polymorphisms in the Estrogen Receptor Beta Gene and the Risk of Unexplained Recurrent Spontaneous Abortion

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Abstract

Background: Recurrent Spontaneous Abortion (RSA) is caused by multiple genetic and non-genetic factors. Around 50% of the RSA cases have no known etiology and are considered as Unexplained RSA (URSA). Estrogens, via binding to their receptors, play an important role in female reproduction. This study aimed to investigate whether single nucleotide polymorphisms (SNPs; +1082G/A, +1730G/A and rs1256030 C/T) in the estrogen receptor beta (ESR2) gene are associated with susceptibility to URSA in a population of Iranian women.

Methods: In this case-control study, the study groups consisted of 240 subjects with a history of URSA and 102 fertile women as controls. Serum levels of follicle stimulating hormone (FSH), luteinizing hormone (LH), and estradiol (E2) were measured on day 2-3 of menstrual cycle. Two functional SNPs, +1082G/A (a silent mutation in exon 5) and +1730G/A (3' untranslated region of the exon 8), and one intron, rs1256030C/T, in the ESR2 gene were genotyped, using polymerase chain reaction-restriction fragment length polymorphism (PCR-RFLP) analysis.

Results: Serum levels of LH were significantly increased in URSA women. No significant differences in distribution of +1082G/A, +1730G/A and rs1256030C/T between URSA and control groups were observed.

Conclusion: Our findings suggest that the studied SNPs on ESR2 gene may not be associated with URSA.

Keywords: Estrogen receptor, Habitual abortion, Polymerase chain reaction, Restriction fragment length polymorphism, Single-nucleotide polymorphism

Introduction

Recurrent Spontaneous Abortion (RSA) is a multifactorial disorder and in most cases, a single cause for repeated abortions cannot be identified. RSA is defined as repeated occurrence of 3 or more miscarriages before 20th week of gestation which affects about 0.5-1% of total pregnancies 1. Diverse factors, including uterine anomalies, chromosomal abnormalities, endocrine and immune defects, thrombophilia and infections could be associated with increased risk of RSA 2. In addition, at least half of the cases with RSA have no anomaly in any applied diagnostic test and are considered as cases with Unexplained RSA (URSA). With increase in the number of abortions, maternal factors that affect embryo-endometrial interactions may become more and more involved in pregnancy failures 3.

The role of hormones in reproductive events has been extensively investigated, and alterations in the Hypothalamus-Pituitary-Ovarian (HPO) axis factors are shown to negatively affect fertility and pregnancy. Recent studies revealed that genetic polymorphisms affecting the function of genes involved in regulating HPO, could be associated with RSA 4.

Estrogens are steroid hormones that affect reproductive system in both female and male. Estrogens are mainly produced in ovaries and influence female reproduction in several aspects, including progesterone induction, endometrial proliferation and maintenance, fetoplacental function and maturation, as well as uteroplacental circulation 5.

Estrogen action is mediated by Estrogen Receptors (ERs). The ERs are ligand activated transcription factors and belong to the steroid/retinoid receptor gene super family that also includes receptors for androgens, progesterone, glucocorticoids, mineralocorticoids, as
well as thyroid hormone, retinoic acid and vitamin D. Two nuclear receptors for estrogen have been identified in humans: Estrogen Receptor α (ERα) and Estrogen Receptor β (ERβ), coded by ESR1 (located on chromosome 6q25.1) and ESR2 (on chromosome 14q22-24) genes, respectively, each consisting of 8 exons. Although these two receptors have high homologies, they are expressed in a preferable but sometimes over-lapping modes and display functional similarities as well as differences, sometimes even opposite actions.

The essential roles of ERβ in normal ovulation efficiency and in regulation of follicular growth and oocyte development are well documented, while ERα has a key role in fertilization. The genetic variants of ESR1 and ESR2 genes and their associations with ovulatory dysfunction especially those with unknown causes and pregnancy outcomes have been investigated. The aim of this study was to examine the role of three Single Nucleotide Polymorphisms (SNPs) in the ESR2 gene, including +1082G/A (a silent transition in exon 5), +1730G/A (3' untranslated region of the exon 8) and one intron (rs1256030 C/T in intron2) in URSA among Iranian population.

Materials and Methods

Subjects

In this case-control study, 240 women (mean age; 33.3 ±0.4 years, BMI; 26.6 ±0.3) were included as the case group, who suffered from at least three consecutive abortions before 20th week of gestation, and were referred to Avicenna Fertility Center, Tehran, Iran, for treatment of RSA. Standard diagnostic procedures including a detailed history, chromosomal analyses of peripheral blood lymphocytes, ultrasonography and hysterosalpingography to detect uterine anomalies, hormone profiles on day 2-3 of the menstrual cycles, measurement of Follicle Stimulating Hormone (FSH), Luteinizing Hormone (LH), and Estradiol (E2) as well as investigation of thrombophilia, infections and immune factors were performed for all patients. Patients with anatomical, chromosomal, infectious, endocrine, thrombophilia and autoimmune causes including anti-phospholipid syndrome were excluded from the study.

The control group consisted of 102 healthy ethnically matched women (mean age; 39.2 ±0.6 years, BMI; 27.5 ±0.4) with two or more successful pregnancies and live birth and no history of complicated pregnancies, miscarriages, still births, small gestational age fetuses, pre-eclampsia, ectopic pregnancy or preterm delivery.

The study was approved by Avicenna Research Institute’s (ARI) local ethics committee for medical research, and written consents were obtained from participating subjects before entry into the study.

Biochemical assays

Serum level of E2 was measured by Enzyme Immunoassay (ELISA) (Axis Shield, Dundee, UK). LH and FSH were measured by Chemiluminescent Immuno Assays (CLIA) (Diasorin; Saluggia, Italy).

Single nucleotide polymorphism genotyping

Peripheral blood samples were obtained from all subjects and analyzed for ESR2 gene polymorphisms; +1082G/A, +1730G/A and rs1256030C/T. Genomic DNA was extracted from anti-coagulated peripheral blood, using a standard salting out procedure. Genotyping of the ESR2 polymorphisms was determined by Polymerase Chain Reaction-Restriction Fragment Length Polymorphism (PCR-RFLP), using specific primers as shown in table1. PCR reaction mixtures contained 200 ng of DNA, 1xPCR Master Mix (Taq DNA Polymerase Master Mix Red, Amplicon, Herlev, Denmark) and 10p moles of each specific primer. Annealing temperatures of 55.0°C for +1082G/A, 59.0°C for +1730G/A and 56.0°C for rs1256030C/T were used. The amplification cycles included 95°C for 5 min, followed by 35 cycles of 95°C for 30 s, 30 s for annealing and 72°C for 30 s and a final elongation time of 72°C for 5 min. PCR products were then digested by restriction endonucleases RsaI (+1082G/A, AluI for +1730G/A and rs1256030C/T (Fermentas, Vilnius, Lithuania) for 3 hr at 37°C (Table1). Restriction endonuclease fragments were blended with gel red (Biotium, CA, USA) and then applied on to a 2-2.5% agarose gel and electrophoresed. Detection was made by visualization on an ultraviolet light transilluminator.

Statistical analysis

All statistical analyses were carried out with SPSS software package 16.0 (SPSS Inc., USA). The distributions of polymorphisms were compared between groups using Mann– Whitney U test. T-test was used to compare...
Table 2. The hormone profiles of control and URSA women on day 2-3 of the menstrual cycles

| Characteristics | Controls | URSA | p-value | +
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<tbody>
<tr>
<td>Estradiol (pg/ml)</td>
<td>44.5±6.0</td>
<td>37.4±3.6</td>
<td>NS</td>
<td>0.519</td>
</tr>
<tr>
<td>FSH (IU/ml)</td>
<td>7.0±0.4</td>
<td>7.5±0.3</td>
<td>NS</td>
<td>0.936</td>
</tr>
<tr>
<td>LH (IU/ml)</td>
<td>3.0±1.4</td>
<td>4.5±0.2</td>
<td>p&lt;0.001</td>
<td>0.082</td>
</tr>
</tbody>
</table>

Table 3. The hormone profiles of control and URSA women on day 2-3 of the menstrual cycles

| Characteristics | Controls | URSA | p-value | +
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Table 3. Genotype frequencies of ESR2 gene polymorphisms in URSA and control groups

| Polymorphism | URSA, no (%) | Control, no (%) | p-value | +
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<tbody>
<tr>
<td>+1082G/A(Ars1256049)</td>
<td>n=237</td>
<td>n=102</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>GG</td>
<td>218(92%)</td>
<td>99(97.1%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>GA</td>
<td>19(8%)</td>
<td>3(2.9%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>AA</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>+1730 G/A(Ars4986938)</td>
<td>n=235</td>
<td>n=102</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>GG</td>
<td>104(44.2%)</td>
<td>48(47%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>GA</td>
<td>108(46%)</td>
<td>32(31.4%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>AA</td>
<td>23(9.8%)</td>
<td>22(21.6%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>rs1256030 C/T</td>
<td>n=238</td>
<td>n=99</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>CC</td>
<td>56(23.5%)</td>
<td>27(27.3%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>CT</td>
<td>110(46.2%)</td>
<td>38(38.4%)</td>
<td>-</td>
<td>0.082</td>
</tr>
<tr>
<td>TT</td>
<td>72(30.3%)</td>
<td>34(34.3%)</td>
<td>-</td>
<td>0.082</td>
</tr>
</tbody>
</table>

Table 4. The hormone profiles of wild type, heterozygotic and homozygotic genotypes of ESR2 polymorphisms

| Polymorphism | Wild type | Heterozygous | Homozygous | p-value | +
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estradiol (pg/ml)</td>
<td>+1082G/A</td>
<td>40.1±3.1</td>
<td>27.3±11.4</td>
<td>-</td>
<td>0.321</td>
</tr>
<tr>
<td>+1730 G/A</td>
<td>33.1±3.1</td>
<td>42.9±4.9</td>
<td>55.0±16.5</td>
<td>-</td>
<td>0.079</td>
</tr>
<tr>
<td>rs1256030 C/T</td>
<td>47.0±7.2</td>
<td>38.1±4.1</td>
<td>35.2±5.7</td>
<td>-</td>
<td>0.346</td>
</tr>
<tr>
<td>FSH (IU/ml)</td>
<td>+1082G/A</td>
<td>7.3±0.2</td>
<td>8.4±0.8</td>
<td>-</td>
<td>0.301</td>
</tr>
<tr>
<td>+1730 G/A</td>
<td>7.8±0.3</td>
<td>7.3±0.4</td>
<td>6.0±0.5</td>
<td>-</td>
<td>0.063</td>
</tr>
<tr>
<td>rs1256030 C/T</td>
<td>7.3±0.4</td>
<td>7.7±0.4</td>
<td>6.8±0.3</td>
<td>-</td>
<td>0.296</td>
</tr>
<tr>
<td>LH (IU/ml)</td>
<td>+1082G/A</td>
<td>4.1±0.2</td>
<td>5.5±0.8</td>
<td>-</td>
<td>0.099</td>
</tr>
<tr>
<td>+1730 G/A</td>
<td>4.1±0.4</td>
<td>4.3±0.2</td>
<td>3.7±0.6</td>
<td>-</td>
<td>0.722</td>
</tr>
<tr>
<td>rs1256030 C/T</td>
<td>3.9±0.4</td>
<td>4.2±0.3</td>
<td>4.2±0.4</td>
<td>-</td>
<td>0.790</td>
</tr>
</tbody>
</table>

Data presented as mean±SEM. *Determined by one way ANOVA.

Discussion

RSA is recognized as a syndrome with a multifactorial etiology. At least, 50% of RSA cases were defined as RSA with unexplained origin. Investigating genes and biological mechanisms that can affect miscarriage may have beneficial effects on increasing live birth rates in cases suffering from RSA. Through investigating polymorphic genetic markers, a number of candidate genes for this syndrome have been identified. Genetic variation concerning thrombophilic and vascular genes is reported as a significant contributor to pregnancy complications. Polymorphisms in the estrogen receptor genes could affect different estrogen dependent pathways which may influence vascular tone and flow, leading to disruption of pregnancy maintenance. Role of ESR gene polymorphisms in increasing the risk of RSA has been investigated and most of the studies considered the involvement of G/A was only found in the URSA group (r=-0.155, p=0.017).
expression or function 24. Alternatively, some studies regulatory sequence variations that may influence gene phisms are in linkage disequilibrium with different in the ER such polymorphisms do not lead to amino acid changes

In conclusion, our data suggest that $ESR2$ gene in +1082G/A, +1730G/A and rs1256030C/T polymorphisms may not be involved with the risk of URSA, although further investigations regarding +1082G/A and +1730G/A genotypes are required to establish a role for URSA.

Acknowledgement

We are grateful to the women who entered this study. We greatly appreciate the assistance of the personnel of Avicenna Fertility Center in sample collection. This work was supported by grants from Avicenna Research Institute (Grant no: 90-16), Tehran, Iran.

Conflict of Interest

The authors declare that they have no conflict of interests.

References

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