Association of Genetic Polymorphisms in \( \text{GSTP1}, \text{GSTM1}, \) and \( \text{GSTT1} \) Genes with Vesicoureteral Reflux Susceptibility in the Children of Southeast Iran

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**Abstract**

**Background:** Vesicoureteral reflux (VUR) disease is the most common type of urinary tract anomalies in children. Genetic risk factors may be associated with the etiology of VUR. The role of the Glutathione S-transferases (GSTs) as multifunctional enzymes is cellular oxidative stress handling. This is the first study aimed at evaluating the relative risk of \( \text{GSTP1}, \text{GSTM1}, \) and \( \text{GSTT1} \) polymorphisms in VUR susceptibility in children and provides new important insights into the genetics of affected children.

**Methods:** The study was done in 2013 in Sistan and Baluchestan University, eastern Iran. Genotyping of three \( \text{GSTP1}, \text{GSTM1}, \) and \( \text{GSTT1} \) genes were determined using the multiplex polymerase chain reaction assay in 216 reactions for 72 VUR children and 312 reactions for 104 healthy controls.

**Results:** The presence of \( \text{GSTT1} \) deletion was associated with high risk of VUR in children, whereas \( \text{GSTP1} \) and \( \text{GSTM1} \) genotypes did not show the same effect. Furthermore, the combination of \( \text{GSTT1/GSTM1} \) and \( \text{GSTT1/GSTP1} \) genotypes showed a significant influence on lower risk of VUR in children.

**Conclusion:** Deletion of \( \text{GSTT1} \) functional gene is a genetic risk factor causing VUR in children. Interestingly, the combination of \( \text{GSTM1} \) and \( \text{GSTP1} \) null genotypes with \( \text{GSTT1} \) has shown a protective role against risk of \( \text{GSTT1} \) deletion.

**Keywords:** Vesicoureteral reflux; Genetic susceptibility; Glutathione S-transferase; Genetic polymorphisms

**Introduction**

*Vesicoureteral reflux (VUR)* disease is an abnormal condition in which urine retrogrades from the bladder into the ureters and kidneys\(^1\),(1). It is the most common congenital urological anomaly in children and may be observed in two forms like primary and secondary \( (1) \). The primary VUR disease has been reported in 1%-2% of the pediatric population and 30%-40% of children with urinary tract infections \( (1-5) \). The secondary condition is due to high blood pressure factors in the bladder, such as neurogenic bladder and obstructive factors \( (1) \). The outbreak of VUR in 27%-
51% of siblings and 66% of offsprings of known VUR patients suggests that VUR is often hereditary (6-9). VUR is considered to be a complex disease with different patterns of inheritance such as autosomal dominant with incomplete penetrance (10, 11), autosomal recessive (12) X-linked (13), and polygenic (14). In the pathogenesis of VUR, several genes play a pivotal role (15). Here, we will focus our attention on GSTs gene polymorphisms. GSTs are members of a multigene family of metabolic enzymes divided into four major subfamilies designated as GSTα (GSTA1), GSTμ (GSTM1), GSTθ (GSTT1) and GST π (GSTP1). These enzymes as cell housekeepers protect cells against electrophiles and oxidative stressors in the environment by detoxifying a wide variety of potentially toxic and carcinogenic electrophiles (16,17). GSTP1, GSTM1 and GSTT1 genes are located on chromosomes 11q13, 1p13.3 and 22q11.2 respectively (18). In the GSTP1, exon 5 is rs1695 polymorphism with an A→G transition at nucleotide 313, leads to replacement of valine for isoleucine (19). The GSTM1 and GSTT1 null genotypes are referred to as deletions in the sequence of these genes that caused by homologous recombination of a number of repeats spanning around them (20). It was identified that detoxification effects modified by GSTs polymorphism possibly can aggravate the susceptibility to diseases (18,21). The magnitude of the influences of GST genes polymorphism distribution on various diseases has been extensively studied (22-24).

Our goal was to assess the influence of GST genes polymorphism on VUR susceptibility in the Iranian children.

Material and Methods

Subjects
In February, 2013, a case control study was conducted on 176 samples, including 72 children with VUR disease diagnosed at different stages of disease progression and 104 healthy children as a control group. Three GSTP1, GSTM1, and GSTT1 polymorphisms were evaluated in patients and healthy subjects. 216 reactions were done for patients and 312 for healthy subjects. The group of control were children who did not have any history of VUR and urinary tract diseases.

The current study was a student thesis. The parents of the children entered the study with informed consent and voluntary participation of the children. The study was approved by the Ethics Committee of the University of Sistan and Baluchestan as per proposal and protocol of study code 2011.7170.

Genomic DNA Extraction and PCR Mix Preparation
DNA from the whole blood was extracted by the salting-out method described by Miller et al (25). Concentration and purity of DNA were determined by DNA electrophoresis and spectrophotometer. Primers used in reactions of PCR were selected according to the previous study (26) then verified using database of single nucleotide polymorphisms (SNPs) (dbSNP 129; https://www.ncbi.nlm.nih.gov/projects/SNP/) and BLAST website (http://blast.ncbi.nlm.nih.gov/Blast.cgi).

The PCR mixtures of GSTM1, GSTT1 and, GSTP1 genes were prepared in volumes of 20 µl containing 10 µl master mix PCR (Parstous 1x.Iran), 100 ng genomic DNA, and 1 µl (10 pM) of each forward and reverse primers.

GSTP1 Polymorphism
Tetra primer amplification refractory mutation system– polymerase chain reaction (T-ARMS-PCR) used for amplifying the region that comprises of 467bp fragment of the GSTP1 gene polymorphism with two non-allele-specific primers as the outer primers (Table 1). Two bands of 233 bp and 290 bp were observed with two allele-specific primers as the inner primers (Table 1). PCR was performed in a total volume of 20 µl containing 10 µl master mix PCR (Parstous 1x.Iran), 100 ng genomic DNA, 1 µl (10 pM) of each primers (inner and outer primers). PCR program started at 94 °C initial denaturation temperature for 5 min followed by 40 cycles at 95
°C denaturation temperature for 40 sec, 60 °C annealing temperature for 30 sec, 72 °C extension temperature for 30 sec, and 72 °C as final extension temperature for 10 min. Finally, amplification products separated by loading in 2% agarose gel electrophoresis stained by green viewer.

Table 1: The Features of Primers used to Amplify the GSTP1, GSTT1, and GSTM1 Genes Polymorphism

<table>
<thead>
<tr>
<th>Genes</th>
<th>Sequence</th>
<th>Fragment length (bp)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTP1 - exF</td>
<td>5'-CAGGTGTCAAGGTGAGCTCTGAGGCAC -3'</td>
<td>467</td>
</tr>
<tr>
<td>GSTP1 - exR</td>
<td>5'-ATAAGGGTGCAAGTTGCTCTTGTCCCTCCA -3'</td>
<td></td>
</tr>
<tr>
<td>GSTP1 - inF</td>
<td>5'-GTGGAGGACCTCCGCTGCAAATCTCA -3'</td>
<td>233 A allele</td>
</tr>
<tr>
<td>GSTP1 - inR</td>
<td>5'-CAGCATAGTGTAGTGAGGATAC -3'</td>
<td>290 G allele</td>
</tr>
<tr>
<td>GSTT1-F</td>
<td>5'-TTCTGCTTTATGGGGTCTTC-3'</td>
<td>542</td>
</tr>
<tr>
<td>GSTT1-R</td>
<td>3'-GTTGATGTTCTGCTGCTTCTC-3'</td>
<td></td>
</tr>
<tr>
<td>GSTM1-F</td>
<td>5'-GCTGCCCTACTTGATTGATG-3'</td>
<td>325</td>
</tr>
<tr>
<td>GSTM1-R</td>
<td>3'-GGTGGCCATCCAACTCTGTC-3'</td>
<td></td>
</tr>
</tbody>
</table>

GSTP1 Gene Polymorphism and VUR Patient Risk in Children

To analyze the GSTP1, the AA genotype was considered as reference. When the other two genotypes AG and GG were compared with the reference genotype, it appeared that there was not a significant difference for GSTP1 gene between A and G allele frequencies in the children with VUR and healthy controls.
Table 2: GSTP1 Gene Genotypes Frequency in Children with VUR Disease (72) and Control Group (104)

<table>
<thead>
<tr>
<th>GSTP1</th>
<th>Cases, n(%)</th>
<th>Controls, n(%)</th>
<th>OR</th>
<th>CI(95%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA genotype</td>
<td>26(36.11)</td>
<td>37(35.57)</td>
<td>-</td>
<td>-</td>
<td>Ref</td>
</tr>
<tr>
<td>AG genotype</td>
<td>41(56.94)</td>
<td>60(57.69)</td>
<td>0.97</td>
<td>0.49 – 1.94</td>
<td>1.00</td>
</tr>
<tr>
<td>GG genotype</td>
<td>5(6.94)</td>
<td>7(6.73)</td>
<td>1.02</td>
<td>0.23 – 4.20</td>
<td>1.00</td>
</tr>
<tr>
<td>AG+GG genotypes</td>
<td>46(63.88)</td>
<td>67(64.42)</td>
<td>0.98</td>
<td>0.50 – 1.92</td>
<td>1.00</td>
</tr>
<tr>
<td>A Allele</td>
<td>93(0.65)</td>
<td>134(0.64)</td>
<td>-</td>
<td>-</td>
<td>Ref</td>
</tr>
<tr>
<td>G Allele</td>
<td>51(0.35)</td>
<td>74(0.36)</td>
<td>1.02</td>
<td>0.64-1.57</td>
<td>1.00</td>
</tr>
</tbody>
</table>

GSTT1 Gene Polymorphism and VUR disease risk in children

As seen in Table 3, a statistically significant difference was found between the deletion of GSTT1 gene polymorphism in children affected by VUR disease and healthy children group (P-value=0.004). With odds ratio higher than one, a correlation was found between the GSTT1 Null genotype and increased risk of VUR disease occurrence in children (OR 3.14, CI 1.4387 – 6.8745) (Table 3).

Table 3: Frequency of GSTT1 and GSTM1 Genes Genotypes in Children with VUR Disease and Control Group

<table>
<thead>
<tr>
<th>GENES</th>
<th>Alleles</th>
<th>Case, n(%)</th>
<th>Controls, n(%)</th>
<th>OR (CI(95%))</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTT1</td>
<td>Present</td>
<td>62(86.11)</td>
<td>69(66.35)</td>
<td>-</td>
<td>Ref</td>
</tr>
<tr>
<td></td>
<td>Null</td>
<td>10(13.89)</td>
<td>35(33.65)</td>
<td>3.14(1.43-6.87)</td>
<td>0.004</td>
</tr>
<tr>
<td>GSTM1</td>
<td>Present</td>
<td>35(48.61)</td>
<td>53(50.96)</td>
<td>-</td>
<td>Ref</td>
</tr>
<tr>
<td></td>
<td>Null</td>
<td>37(51.39)</td>
<td>51(49.4)</td>
<td>1.09(0.60-2.00)</td>
<td>0.887</td>
</tr>
</tbody>
</table>

Present=Non Deletion, Null=Deletion/ Homozygous Null Genotypes

GSTM1 Gene Polymorphism and VUR Risk in Children

No statistically significant correlation was found in children affected by VUR compared to controls, when null allele genotype was considered as reference (Table 3).

GSTM1 and GSTT1 Combined Genotypes in Children with VUR Disease

The combination of GSTM1 and GSTT1 genotypes showed a significant correlation with lower risk of VUR when it compared to GSTM1 present/GSTT1 present genotype (P-value=0.023, OR= 0.25, CI 0.06–0.89) (Table 4).

GSTM1 and GSTP1 Combined Genotypes and VUR Disease in Children

GSTP1 AG/GSTT1 null combined genotypes compared to GSTP1 AA/GSTT1 present genotypes showed a significant correlation with lower risk of VUR in children (P-value=0.048, OR 0.00, CI 0.00–2.72) (Table 4).

Discussion

In this study, the GSTT1 gene deletion in children with the VUR disease is significantly higher than those in control group. Therefore, there is an increased risk of VUR disease in children with GSTT1 null genotype. Other studies have shown the deletion of GSTT1 gene does have a close association with the Brazilian acute promyelocytic leukemia and psoriasis in North India.
In addition, the GSTM1/GSTT1 null genotypes are related to increased susceptibility to acute promyelocytic leukemia (27,28). In this study, the GSTP1 and GSTM1 genotypes do not indicate a significant risk of increased susceptibility to VUR disease. But there is a significant correlation between reduced risk of the VUR disease and a combination of GSTM1 present and GSTT1 null polymorphism. Furthermore, combination of GSTP1 AG/GSTT1 null significantly reduces the risk of VUR disease in children. GSTM1 present and GSTP1 AG genotypes have a very strong compensating effect on the deletion of GSTT1 gene.

There are other researches on GST genes. For example, in one study, GSTM1-null and GSTP1 Val allele genotypes, were found to increase the risk of nonalcoholic fatty liver in the Iranian population (26). A significant association was found between GSTM1 null genotype and GSTT1 gene polymorphism in inflammatory bowel diseases (29). Another study discovered GSTM1 and GSTT1 null genotype are associated with male infertility (30). A research result reported a significant relationship between GSTT1 null polymorphism and chronic myeloid leukemia (31). By contrast, GSTP1 Val is associated with the decreased risk of premalignant lesions in another study (32). A combination of GSTM1 present and GSTT1 null genotypes have a protective role against susceptibility to chronic myeloid leukemia (31). GSTP1Val allele reduces the risk for premalignant and endoscopic gastric lesions, whereas GSTM1 and GSTT1 null genotypes increases it. (32). GSTM1 and GSTT1 null polymorphisms are associated with risk factors causing the Asian breast cancer and also GSTP1 Val105Ile (rs1695) polymorphism is a risk factor for Caucasians breast cancer (33).

Carriers of GSTP1, GSTM1 and GSTT1 polymorphisms tend to show a supportive effect for detoxification activity of GST. Thus, these polymorphisms activate a defense response against toxic metabolites. Deleting genes of GST could decrease detoxification of harmful electrophiles associated with GST activity and DNA stability, which results in susceptibility to various diseases (22-24). There are contradictory results in the

Table 4: Combination of Genotypes of GSTP1 and GSTM1/GSTT1 Polymorphisms and Vescicoureteral Reflux Susceptibility in Children with VUR Disease and Control Group

<table>
<thead>
<tr>
<th>GSTs genotypes</th>
<th>Cases, n(%)</th>
<th>Controls, n(%)</th>
<th>OR</th>
<th>CI(95%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GSTT1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present / Null</td>
<td>31(43.06)</td>
<td>34(32.69)</td>
<td>1.03</td>
<td>0.49 – 2.16</td>
<td>1.00</td>
</tr>
<tr>
<td>Null / Present</td>
<td>4(5.55)</td>
<td>18(17.31)</td>
<td>0.25</td>
<td>0.06 – 0.89</td>
<td>0.023</td>
</tr>
<tr>
<td><strong>GSTM1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present / Null</td>
<td>6(8.33)</td>
<td>17(16.35)</td>
<td>0.40</td>
<td>0.12 – 1.24</td>
<td>0.092</td>
</tr>
</tbody>
</table>

Present=Non Deletion, Null=Deletion/ Homozygous Null Genotype
studies on the effect of $GST\alpha$ polymorphism on Atherosclerosis due to demographic diversity of the studied population (34). $GST\alpha$ cellular detoxification activities involve in inflammatory processes, cellular differentiation and signaling pathways (35-37). Studies performed in past years have revealed that oxidative stress worsens diseases caused by inflammatory response (38,39). Studies demonstrated $GST\alpha$ enzyme activities always depend on their genotype. Therefore, a specific genotype of $GST$ genes can lead to reduced enzymatic activity (40,41).

The goal of VUR treatment is to reduce urinary tract infection, inflammation, kidney scars control and other complications caused by this abnormality in children. Combination of various deletions lead to pharmacology, toxicology and hereditary differences which theoretically increases the risk of various diseases (42,43). Thus, $GST\alpha$ genes may prove effective in managing VUR infection and scar prevention.

**Conclusion**

This study suggests a correlation between deletion of $GSTT1$ gene and increased risk of VUR disease in children. However, $GSTP1$ Ile/Val and $GSTM1$ act in a preventative role against susceptibility to VUR disease, given deletion of $GSTT1$ gene.

**Ethical considerations**

Ethical issues (Including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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**Conflicts of interest**

No competing financial interests exist.

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