Analysis of immune-related loci identifies 48 new susceptibility variants for multiple sclerosis

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Abstract

Using the ImmunoChip custom genotyping array, we analysed 14,498 multiple sclerosis subjects and 24,091 healthy controls for 161,311 autosomal variants and identified 135 potentially associated regions (p-value < 1.0 × 10^{-8}). In a replication phase, we combined these data with previous genome-wide association study (GWAS) data from an independent 14,802 multiple sclerosis subjects and 26,703 healthy controls. In these 80,094 individuals of European ancestry we identified 48 new susceptibility variants (p-value < 5.0 × 10^{-8}); three found after conditioning with case ascertainment and phenotyping.
on previously identified variants. Thus, there are now 110 established multiple sclerosis risk
variants in 103 discrete loci outside of the Major Histocompatibility Complex. With high
resolution Bayesian fine-mapping, we identified five regions where one variant accounted for
more than 50% of the posterior probability of association. This study enhances the catalogue of
multiple sclerosis risk variants and illustrates the value of fine-mapping in the resolution of
GWAS signals.

Multiple sclerosis (OMIM 126200) is an inflammatory demyelinating disorder of the central
nervous system that is a common cause of chronic neurological disability.¹ ² It has its
greatest prevalence amongst individuals of Northern European ancestry³ and is moderately
heritable,⁴ with a sibling relative recurrence risk (λₛ) of ⁶.³⁵ Aside from the early success in
demonstrating the important effects exerted by variants in the Human Leukocyte Antigen
(HLA) genes from the Major Histocompatibility Complex (MHC),⁶ there was little progress in
unravelling the genetic architecture underlying multiple sclerosis susceptibility prior to
the advent of genome-wide association studies (GWAS). Over the last decade, our
Consortium has performed several GWAS and meta-analyses in large cohorts,⁷⁻¹⁰
cumulatively identifying more than 50 non-MHC susceptibility alleles. As in other complex
diseases, available data suggest that many additional susceptibility alleles remain to be
identified.¹¹

The striking overlap in the genetic architecture underlying susceptibility to autoimmune
diseases⁹⁻¹³ prompted the collaborative construction of the “ImmunoChip” (see
Supplementary Note and Supplementary Figs. 1 and 2 for details of IMSGC nominated
content), an efficient genotyping platform designed to deeply interrogate 184 non-MHC loci
with genome-wide significant associations to at least one autoimmune disease and provide
lighter coverage of other genomic regions with suggestive evidence of association.¹⁴ Here,
we report a large-scale effort that leverages the ImmunoChip to detect association with
multiple sclerosis susceptibility and refine these associations via Bayesian fine-mapping.

After stringent quality control (QC), we report genotypes on 28,487 individuals of European
ancestry (14,498 multiple sclerosis subjects, 13,989 healthy controls) that are independent of
previous GWAS efforts. We supplemented these data with 10,102 independent control
subjects provided by the International Inflammatory Bowel Disease Genetics Consortium
(IIBDGC),¹⁵ bringing the total to 38,589 individuals (14,498 multiple sclerosis subjects and
24,091 healthy controls). We performed variant level QC, population outlier identification,
and subsequent case-control analysis in 11 country-organized strata. To account for within-
stratum population stratification we used the first five principal components as covariates in
the association analysis. Per stratum odds ratios (OR) and respective standard errors (SE)
were then combined with an inverse variance meta-analysis under a fixed effects model. In
total we tested 161,311 autosomal variants that passed QC in at least two of the 11 strata
(Online Methods). A circos plot¹⁶ summarising the results from this discovery phase
analysis is shown in Figure 1.

We defined an a priori discovery threshold of p-value <1 × 10⁻⁴ and identified 135 primary
statistically independent association signals; 67 in the designated fine-mapping regions and
68 in less densely covered regions selected for deep replication of earlier GWAS. Another
13 secondary and 2 tertiary statistically independent signals were identified by forward stepwise logistic regression. A total of 48 of the 150 statistically independent association signals (Supplementary Table 1) reached a genome-wide significance p-value $<5 \times 10^{-8}$ at the discovery phase alone. Next, we replicated our findings in 14,802 multiple sclerosis subjects and 26,703 healthy controls with available GWAS data imputed to the 1000 Genomes European phase I (a) panel (Online Methods). Finally, we performed a joint analysis of the discovery and replication phases.

We identified 97 statistically independent SNPs meeting replication criteria ($p_{\text{replication}} < 0.05$, $p_{\text{joint}} < 5 \times 10^{-8}$, and $p_{\text{joint}} < p_{\text{discovery}}$); 93 primary signals (Supplementary Figs. 3-95) and four secondary signals. Of these, 48 are novel to multiple sclerosis (Table 1) and 49 correspond to previously identified multiple sclerosis effects (Table 2). An additional 11 independent SNPs showed suggestive evidence of association ($p_{\text{joint}} < 1 \times 10^{-6}$) (Supplementary Table 2).

The strongest novel association, rs12087340 ($p_{\text{joint}} = 1.1 \times 10^{-20}$, OR = 1.21), lies between BCL10 (B-cell CLL / lymphoma 10) and DDAH1 (dimethylarginine dimethylaminohylaminohydrolase 1). The protein encoded by BCL10 contains a caspase recruitment domain (CARD) and has been shown to activate NF-kappaB. The latter is a signalling molecule that plays an important role in controlling gene expression in inflammation, immunity, cell proliferation, and apoptosis. It has been pursued as a potential therapeutic target for multiple sclerosis. BCL10 is also reported to interact with other CARD domain containing proteins including CARD11. We have also identified a novel association of rs1843938 ($p_{\text{joint}} = 1.2 \times 10^{-10}$, OR = 1.08), which is only 30 kb from CARD11.

One novel SNP was found within an exon, rs2288904 ($p_{\text{joint}} = 1.6 \times 10^{-11}$, OR = 1.10); a missense variant in SLC44A2 (solute carrier family 44, member 2). Notably, this variant is also reported as a monocyte-specific cis-acting eQTL for the antisense transcript of the nearby ILF3 (interleukin enhancer binding factor 3). This protein was first discovered to be a subunit of a nuclear factor found in activated T-cells, which is required for T-cell expression of IL2, an important molecule regulating many aspects of inflammation.

Of the 49 previously identified effects, 9,10,21 37 are in designated fine-mapping regions, and 23 of these 37 signals were localized to a single gene based on genomic position (Supplementary Table 3). Recognizing that proximity does not necessarily indicate functional importance, this emphasizes the utility of dense mapping in localizing signals from a genome-wide screen. The ImmunoChip analysis furthered the understanding of previously proposed secondary signals at three loci (Supplementary Note and Supplementary Tables 4-6); in particular we showed that the effects of two previously proposed independent associations at the IL2RA locus are driven by a single variant, rs2104286.7,22.

In an effort to define the functionally relevant variants underlying these associations, we further studied the regions surrounding the 97 associated SNPs using both a Bayesian and frequentist approach in 6,356 multiple sclerosis subjects and 9,617 healthy controls from the
Based on imputation quality, fine-mapping was possible in 68 regions (Supplementary Table 7): 66 of 93 primary (Fig. 2A) and two of four secondary. Eight of the 68 regions were fine-mapped to high resolution (Table 3, Fig. 2B and Supplementary Fig. 96). One third of the variants identified in these eight regions were imputed, indicating reliance on imputation even with dense genotyping coverage.

To assess whether functional annotation provides clues about the molecular mechanisms associated with genetic risk, we considered the relationship of variants to described coding and regulatory features in these eight regions. Although we found no variants with missense or nonsense effects, there was a notable enrichment for variants with functional effects: one known to affect splicing, three known to correlate with RNA or serum protein levels and several in transcription-factor binding and DNase I hypersensitive sites. Four of the 18 variants in the fine-mapped regions are within conserved regions (GERP > 2). This lack of functional annotation likely reflects the limited repertoire of reference expression and epigenomic profiles and suggests that the function of the variants may be cell-type or cell-state specific, as has been reported for many eQTLs in immune cell types.

To determine the Gene Ontology (GO) processes of the 97 associated variants, we used MetaCore from Thomson Reuters (Online Methods). We found the majority of the 97 variants lie within 50 kb of genes having immunological function. Of the 86 unique genes represented, 35 are linked to the GO immune system process (Table 1 and Table 2). We do not see a substantial over- or under-representation of certain GO processes when comparing the novel and previously identified loci, but this may be a limitation of ImmunoChip targeting genomic loci enriched for immunologically active genes, with more subtle distinctions between them not adequately captured by broad annotations such as GO.

Finally, we explored the overlap between our findings and those in autoimmune diseases with reported ImmunoChip analyses. We calculated the percentage of multiple sclerosis signals (110 non-MHC) overlapping those of other autoimmune diseases by requiring an \( r^2 \geq 0.8 \) between the best variants reported in each study using SNAP. In total we find that ~22% of our signals overlap at least one other autoimmune disease. More specifically, ~9.1% overlap with inflammatory bowel disease (IBD) - ~7.3% with ulcerative colitis (UC), ~9.1% with Crohn’s disease (CD), ~9.1% with primary biliary cirrhosis (PBC), ~4.5% with celiac disease (CeD), ~4.5% with rheumatoid arthritis (RhA), ~0.9% with psoriasis (PS), and ~2.7% with autoimmune thyroid disease (AITD). We report the same top variant seen in PBC for 7 loci. We also note that our best TYK2 variant (rs34536443) is also the most associated variant for PBC, PS and RhA. Lastly, AITD, CeD, PBC, and RhA report variants with pairwise \( r^2 \geq 0.8 \) to the multiple sclerosis variant near MMEL1 (Supplementary Table 8).

In summary, we have identified 48 new multiple sclerosis susceptibility variants. These novel loci expand our understanding of the immune system processes implicated in multiple sclerosis. We estimate that the 110 non-MHC established risk variants explain 20% of the sibling recurrence risk; 28% including the already identified MHC effects (Supplementary Note). Additionally, we have identified five regions where consistent high resolution fine-
mapping implicated one variant which accounted for more than 50% of the posterior in previously identified regions of TNFSF14, IL2RA, TNFRSF1A, IL12A, and STAT4. Our study further implicates NF-kappaB in multiple sclerosis pathobiology\(^\text{18}\), emphasizes the value of dense fine-mapping in large follow-up data sets, and exposes the urgent need for functional annotation in relevant tissues. Understanding the implicated networks and their relation to environmental risk factors will promote the development of rational therapies and may enable the development of preventive strategies.

**Online Methods**

**ImmunoChip data (discovery set)**

Details of case ascertainment, processing and genotyping for the discovery phase are provided in the Supplementary Note (Supplementary Table 9). Genotype calling for all samples was performed using Opticall.\(^\text{40}\) Samples that performed poorly or were determined to be related were removed (Supplementary Table 10). The data were organized in 11 country level strata: ANZ (Australia + New Zealand), Belgium, Denmark, Finland, France, Germany, Italy, Norway, Sweden, United Kingdom (UK), and the United States of America (USA). SNP level quality control (Supplementary Table 11) and population outlier identification using principal components analysis (Supplementary Fig. 97) were done in each stratum separately.

**Discovery set analysis**

We applied logistic regression, assuming a per-allelic genetic model per data set, including the first five principal components as covariates to correct for population stratification (Supplementary Table 12 lists the per data set genomic inflation factors, \(\lambda\)). We then performed an inverse-variance meta-analysis of the 11 strata, under a fixed effects model, as implemented in PLINK.\(^\text{41}\) To be more conservative and account for any residual inflation in the test statistic, we applied the genomic control equivalent to the per-SNP standard error in each stratum. Specifically, we corrected the SNP standard errors by multiplying them with the square root of the raw genomic inflation factor \(\lambda\), per data set, if the \(\lambda\) was >1.

Within the designated fine-mapping intervals, we applied a forward stepwise logistic regression to identify statistically independent effects. The primary SNP in each interval was included as a covariate, and the association analysis was repeated for the remaining SNPs. This process was repeated until no SNPs reached the minimum level of significance (p-value <1 \(\times\) 10\(^{-4}\)). Outside of the designated fine-mapping intervals, all SNPs having a p-value <1 \(\times\) 10\(^{-4}\) were identified and grouped into sets based on a physical distance of less than 2Mb and a similar stepwise regression model was applied. Any SNPs to enter the model with p-value <1 \(\times\) 10\(^{-4}\) after conditioning were considered statistically independent primary signals.

In addition, because of the close physical proximity between some fine-mapping intervals and SNP sets, independence was tested for all identified signals within 2Mb of one another. The and cluster plots (Supplementary Fig. 98) of all independent SNPs were examined, and the SNP was excluded if unsatisfactory. If any SNP was excluded, the forward stepwise logistic regression within that fine-mapping interval or SNP set was repeated after removal
of the SNP. During this process, 17 additional SNPs were excluded based on cluster or forest plot review.

**Replication Set**

The replication phase included GWAS data organized into 15 strata. Within each stratum, poorly performing samples (call rate < 95%, gender discordance, excess heterozygosity) and poorly performing SNPs (Hardy-Weinberg equilibrium (HWE) p-value <1 × 10^{-6}, minor allele frequency (MAF) < 1%, call rate < 95%) were removed. Principal components analysis was performed to identify population outliers per stratum, and the genomic control inflation factor was < 1.1 for each. The data included in the final discovery and replication analyses are summarized in Supplementary Table 13 and Supplementary Table 14. All the samples used in the replication set were unrelated to those in the discovery set; verified by identity-by-descent analysis.

We attempted replication of all non-MHC independent signals that reached a discovery p-value of <1 × 10^{-4} in a meta-analysis set of GWAS. Each data set was imputed to the 1000 Genomes European phase I (a) panel using BEAGLE^42 to maximize the overlap between the Immunochip SNP content and the GWAS data. Post-imputation genotypic probabilities were used in a logistic regression model, per stratum, to estimate SNP effect sizes and p-values. By using the post-imputation genotypic probabilities, we penalized SNPs that didn’t have good imputation quality, thus ensuring a conservative analysis. Furthermore, we accounted for population stratification in each data set by including the first five principal components in the logistic model. We then meta-analysed the effect size and respective standard errors of the 15 strata using a fixed effects model inverse-variance method. We applied the genomic control equivalent to the per-SNP standard error in each stratum, controlling for the respective genomic inflation factor \( \lambda \) (Supplementary Table 14).

To replicate the primary SNPs per identified signal in the discovery phase, we used the replication effect size and respective standard error. For the secondary and tertiary SNPs, we fitted the same exact models as in the discovery phase, per data set. We then performed fixed effects meta-analysis to estimate an effect size that corresponds to the same logistic model. In the case that a SNP was not present in the replication set, we replaced it with a perfectly tagging SNP, i.e. a SNP that had \( r^2 \) and D’ equal to 1. If a perfectly tagging SNP was not available, we selected a SNP that had equivalent MAF and the highest possible \( r^2 \) and D’. Estimation of \( r^2 \) and D’ for this objective were based on the ImmunoChip control samples.

**Joint analysis (discovery and replication sets)**

The discovery and replication phase effect sizes and respective standards errors were meta-analysed under a fixed effects model. A SNP was considered replicated when all three of the following criteria were met: 1) replication p-value <5.0 × 10^{-2}, 2) joint p-value <5 × 10^{-8}, and 3) the joint p-value was more statistically significant than the discovery p-value. SNPs that reached a p-value of <1 × 10^{-6} but did not pass the genome-wide threshold, were coined suggested if the above criteria 1) and 3) were met.
**Fine-mapping of association signals**

To fine-map signals of association we used a combination of imputation and Bayesian methodology.\(^\text{23}\) Around each of the 97 associated SNPs, 2Mb were isolated in the discovery and replication phase UK data as well as the European samples from the Phase 1 1000G.\(^\text{28}\) Forming the single largest cohort, only UK samples were considered to minimize the effects of differential imputation quality between populations of different ancestry. In addition to the previous quality control, SNPs with failed alignment or a difference in MAF > 10% between the typed cohorts and the 1000G samples, MAF < 1%, or HWE p-value < 1.0 × 10\(^{-4}\) were removed.

Imputation was performed separately for the UK discovery and replication cohorts on each 2Mb region using the default settings of IMPUTEv2.\(^\text{43,44}\) Missing genotypes in the genotyped SNPs were not imputed, and any imputed SNP that failed the HWE and MAF threshold was subsequently removed. We carried out frequentist and Bayesian association tests on all SNPs in each cohort separately, assuming additivity, using the default settings of SNPTESTv2.\(^\text{45}\) Frequentist fixed-effect meta-analysis was carried out using the software META.\(^\text{46}\) Bayesian meta-analysis was carried out using an independence prior (near-identical results were obtained using a fixed-effect Bayesian meta-analysis).

To identify regions where reliable fine-mapping could be achieved, we used the information score (INFO, obtained from IMPUTEv2) as identified from the 1000G samples. Specifically, we measured the fraction of variants with both \(r^2 > 0.5\) and \(r^2 > 0.8\) to the primary associated variant, having greater than 50% and 80% INFO scores respectively. Regions where any SNP with \(r^2 > 0.5\) had INFO < 50% were excluded. We also excluded regions where the top hit from imputation had an INFO score less than 80%. Regions were considered to be fine-mapped with high quality when all variants with \(r^2 > 0.8\) had at least 80% INFO. Within these regions, we excluded variants where the inferred direction of association was opposite in the UK discovery and replication cohorts.

To measure the posterior probability that any single variant drives association, we calculated the Bayes Factor. Under the assumption that there is a single causal variant in the region, this is proportional to the probability that the variant drives the association.\(^\text{23}\) We identified the smallest set of variants that contained 90% and 50% of the posterior probability. We called a region successfully and consistently fine-mapped if there were at most five variants in the 50% confidence interval and the top SNP from the frequentist analysis lived in the 90% confidence interval. For these regions, we annotated variants with information about evolutionary conservation, predicted coding consequence, regulation, published associations to expression or DNase I hypersensitive sites using ANNOVAR,\(^\text{47}\) VEP,\(^\text{24}\) and the eQTL browser, a recent immune cell expression study\(^\text{20}\), and other literature.

**Gene Ontology**

To determine the GO processes for which our associated variants were involved, we used MetaCore from Thomson Reuters. We annotated the processes for the unique genes within 50Kb of the variants.
Cross disease comparison

In order to explore the potential overlap with variants identified across other autoimmune diseases, we calculated the percentage overlap of reported variants found in other ImmunoChip reports to our ImmunoChip results. The top variants reported as either novel or previously known in other ImmunoChip reports were compared with the 110 variants representing both our novel and previous discoveries in multiple sclerosis. In order for a signal to be considered as overlapping, we required an $r^2 \geq 0.8$ using the Pairwise LD function of the SNAP tool in European samples.31

Secondary analyses

We performed a severity based analysis of MSSS in cases only from the discovery phase (Supplementary Fig. 99). In addition, a transmission disequilibrium test was done in 633 trios to test for transmission of the 97 identified risk alleles (Supplementary Fig. 100). Details are given in the Supplementary Note.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Center, Montreal, Canada 87 Service de Neurologie, Hôpital Pasteur, CHRU Nice, France 88 Department of Neurology, Ospedale Maggiore, Novara, Italy 90 Department of Medical Genetics, Oslo University Hospital, Ullevål, Oslo, Norway 91 Department of Vertebrate Genomics, Neuropsychiatric Genetics Group, Max Planck Institute for Molecular Genetics, Berlin, Germany 92 Department of Clinical Neurosciences and Rehabilitation, Institute of Neuroscience and Physiology, Sahlgrenska Academy, Göteborgs Universitet, Göteborg, Sweden 93 Department of Psychiatry and Human Behavior, School of Medicine, University of California, Irvine, California, USA 94 Department of Pharmacological and Biomolecular Sciences, University of Milan, Milan, Italy 95 Department of Chronic Disease Prevention, National Institute for Health and Welfare, Helsinki, Finland 96 Canterbury District Health Board, Christchurch, New Zealand 97 Department of Neurology, Queen Elizabeth Medical Centre, Edgbaston, Birmingham, UK 98 Department of Neurology, The Norwegian Multiple Sclerosis Registry and Biobank, Haukeland University Hospital, Bergen, Norway 99 National Multiple Sclerosis Center Melsbroek, Melsbroek, Belgium 100 Neurology Department, Charing Cross Hospital, London, UK 101 Department of Clinical Sciences, Lund University, Lund, Sweden 102 Department of Neurology, Royal Hallamshire Hospital, Sheffield, UK 103 Department of Neurology, University of Oulu, Oulu, Finland 104 Department of Neurology, University Hospital of Oulu, Oulu, Finland 105 Laboratory of Neurobiology, Vesalius Research Center, Leuven, Belgium 106 Experimental Neurology, Leuven Research Institute for Neurodegenerative Diseases (LIND), University of Leuven (KU Leuven), Leuven, Belgium 107 Department of Neurology, University Hospitals Leuven, Leuven, Belgium 108 Institute of Psychological Medicine and Clinical Neuroscience, Cardiff University, University Hospital of Wales, Cardiff, UK 109 Department of Neurology, Greater Manchester Neurosciences Centre, Salford Royal NHS Foundation Trust, Salford, UK 110 Department of Neuroscience, Centre for Experimental Neurological Therapies, Mental Health and Sensory Organs, Sapienza Università di Roma, Rome, Italy 111 Department of Neurology, Royal Preston Hospital, Preston, UK 112 Department of Neurology, Norfolk and Norwich Hospital, Norwich, UK 113 Department of Neurology, Flinders University, Adelaide, South Australia, Australia 114 Institute of Basic Medical Sciences, University of Oslo, Oslo, Norway 115 Department of Neurology, Peterborough City Hospital, Peterborough, UK 116 Neurology and Stroke Unit, San Francisco Hospital, Nuoro, Italy 117 Department of Neurology, Helsinki University Central Hospital and Molecular Neurology Programme, Biomedicum, University of Helsinki, Helsinki, Finland 118 Department of Epidemiology, Erasmus MC, Rotterdam, The Netherlands 119 Division of Applied Health Sciences, University of Aberdeen, Foresterhill, Aberdeen, UK 120 Institute of Clinical Neurosciences, University of Bristol, Frenchay Hospital, Bristol, UK 121 Centre for Population Health Sciences, University of Edinburgh, Edinburgh, UK 122 Institut für Humangenetik, Technische Universität München, Munich, Germany 123 Institut für Humangenetik, Helmholtz Zentrum München, Munich, Germany 124 Harvard NeuroDiscovery Center, Harvard Medical School, Boston,
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References


Figure 1. Discovery phase results
Primary association analysis of 161,311 autosomal variants in the discovery phase (based on 14,498 cases and 24,091 healthy controls). The outer most track shows the numbered autosomal chromosomes. The second track indicates the gene closest to the most associated SNP meeting all replication criteria. Previously identified associations are indicated in grey. The third track indicates the physical position of the 184 fine-mapping intervals (green). The inner most track indicates $-\log(p)$ (two-sided) for each SNP (scaled from 0-12 which truncates the signal in several regions, see Supplementary Table 1). Additionally, contour lines are given at the a priori discovery ($-\log(p) = 4$) and genome-wide significance ($-\log(p) = 7.3$) thresholds. Orange indicates $-\log(p) \geq 4$ and $< 7.3$, while red indicates $-\log(p) \geq 7.3$. Details of the full discovery phase results can be found in ImmunoBase.
Figure 2. Bayesian fine-mapping within primary regions of association
a) Summary of the extent of fine-mapping across 66 regions in 9,617 healthy controls from the UK, showing the physical extent of, the number of variants, and the number of genes spanned by the posterior 90% and 50% credible sets. b) Detail of fine-mapping in region of TNFSF14. Above the x-axis indicates the Bayes Factor summarizing evidence for association for the SNPs prior to conditioning (blue markers) while below the x-axis indicates the Bayes Factor after conditioning on the lead SNP (rs1077667). Mb=Megabases.
Table 1

48 Novel non-MHC susceptibility loci associated with multiple sclerosis at a genome-wide significance level

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**Secondary**

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All listed signals had a discovery P-value \(\leq 1.0 \times 10^{-4}\), a replication P-value \(\leq 5.0 \times 10^{-2}\), and a joint P-value \(\leq 5.0 \times 10^{-8}\). All P-values are two-sided.

RA = Risk Allele, RAF = Risk Allele Frequency

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Nat Genet. Author manuscript available in PMC 2014 May 01.
a Position is based on human genome 19 and dbSNP 137.
b Nearest gene listed if within 50Kb. Bold indicates Gene Ontology Immune System Process.
c A proxy SNP (rs1036207, r^2 = 0.99) and
d (rs716719, r^2=1.00) was used in replication.
e The P-value and OR values provided are after conditioning on rs67297943 (Known – see Table 2),
f rs9736016, and
g rs12927355 (Known – see Table 2).

* Note primary was rs11865086 (P-value = 1.77 × 10^{-8}) in Discovery but not available in Replication so the best proxy was used.
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</table>

All listed signals had a discovery P-value ≤1.0 $\times 10^{-4}$, a replication P-value ≤5.0 $\times 10^{-2}$, and a joint P-value ≤5.0 $\times 10^{-8}$

All P-values are two-sided

RA = Risk Allele, RAF = Risk Allele Frequency
Position is based on human genome 19 and dbSNP 137.


A proxy SNP (rs10431552, $r^2 = 0.99$) was used in replication.

The P-value and OR values provided are after conditioning on rs9736016 and rs533646 (both Novel – see Table 1).

These three SNPs were not primary in the 2011 GWAS, two were secondary and the third was tertiary in that study.
Table 3

The 18 variants from the 8 regions with consistent high resolution fine-mapping

<table>
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<tr>
<th>Gene</th>
<th>SNP</th>
<th>Chr</th>
<th>Position</th>
<th>Posterior</th>
<th>GERP</th>
<th>Functional Annotation</th>
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<td>-3.89</td>
<td>intronic, TFBS / DNase1 peak, correlates with serum levels of TNFSF14</td>
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<td>6099045</td>
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<td>-0.47</td>
<td>intronic, correlates with soluble IL-2RA levels</td>
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<td>rs1800693</td>
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<td>6440009</td>
<td>0.69</td>
<td>2.53</td>
<td>intronic, causes splicing defect and truncated soluble TNFRSF1A</td>
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All listed variants have posterior ≥ 0.1 in regions where ≤ 5 variants explain the top 50% of the posterior and the top SNP from the frequentist analysis lives in the 90% confidence interval, ordered by maximum posterior.

Posterior denotes the posterior probability of any variant driving association. GERP denotes Genomic Evolutionary Rate Profiling.

\(^a\) Position is based on human genome 19 and dbSNP 137.

\(^b\) Functional data from VEP, eQTL browser, Fairfax et al. (2012), pubmed searches, 1000G. Dash indicates intergenic with no additional annotation. Variants without annotation are intergenic and have no reported regulatory consequence.

\(^c\) Imputed variant.