

Identification of Eleven Novel *BRCA* Mutations in Tunisia: Impact on the Clinical Management of *BRCA* Related Cancers

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Research article

Keywords: BRCA cancers, genetic testing, novel BRCA mutations, Clinicopathological signatures, precision Medicine

Posted Date: February 4th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-164986/v1>

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Abstract

Background Breast cancer is the world's most common cancer among women. It is becoming an increasingly urgent problem in low- and middle-income countries (LMICs) where a large fraction of women is diagnosed with advanced-stage disease and have no access to treatment or basic palliative care. About 5-10% of all breast cancers can be attributed to hereditary genetic components and up to 25% of familial cases are due to mutations in *BRCA1/2* genes. Since their discovery in 1994 and 1995, as few as 18 mutations have been identified in *BRCA* genes in the Tunisian population. The aim of this study is to identify additional *BRCA* mutations, to estimate their contribution to the hereditary breast and ovarian cancers in Tunisia and to investigate the clinicopathological signatures associated with *BRCA* mutations.

Methods A total of 354 patients diagnosed with breast and ovarian cancers, including 5 male breast cancer cases, have been investigated for *BRCA1/2* mutations using traditional and/or next generation sequencing technologies. Clinicopathological signatures associated with *BRCA* mutations have been also investigated.

Results 16 distinct mutations were detected: 10 in *BRCA1* and 6 in *BRCA2*, of which 11 are described for the first time in Tunisia including 3 variations that have not been reported previously in public databases namely *BRCA1_c.915T>A*; *BRCA2_c.-227-?_7805+?* and *BRCA2_c.249delG*. Early age at onset, family history of ovarian cancer and high tumor grade were significantly associated with *BRCA* status. *BRCA1* carriers were more likely to be triple negative breast cancer compared to *BRCA2* carriers. A relatively high frequency of contralateral breast cancer and ovarian cancer occurrence was observed among *BRCA* carriers and was more frequent in patients carrying *BRCA1* mutations.

Conclusion Our study provides new insights into breast and ovarian cancer genetic landscape in the under-represented North African populations. The prevalence assessment of novel and recurrent *BRCA1/2* pathogenic mutations will enhance the use of personalized treatment and precise screening strategies by both affected and unaffected North African cancer cases.

Background

Breast cancer is the most common malignancy among women worldwide [1]. Incidence and mortality rates of breast cancer differs between populations [1]. In Tunisia, it remains the most common cancer among females and represents the first leading cause of cancer mortality among women. The mean age at diagnosis of Tunisian breast cancer cases is around 50 years old, a decade younger than Western countries [2, 3].

BRCA1 and *BRCA2* are the most prominent breast cancer susceptibility genes that convey high risk of breast and ovarian cancers [4]. Since their discovery, a wide range of mutational spectrum have been described for both genes. So far, more than 1800 distinct *BRCA1* and 2000 *BRCA2* mutations have been reported in the Breast Cancer Information Core (BIC) database. These mutations explain around 20–30% of breast cancer genetic component and seem to be associated with different other cancers such as prostate, pancreatic, endometrial and melanoma [5]. The identification of novel *BRCA1/2* mutations has important clinical implications. Indeed, unaffected *BRCA* mutation carriers have various preventive options including extensive and regular surveillance, chemoprevention, and risk-reducing surgery [6, 7], while, affected cases carrying *BRCA* mutations could benefit from personalized therapeutic options such as platinum-based chemotherapy and poly (ADP-ribose) polymerase (PARP) inhibitors [8, 9]. However, a full *BRCA1* and *BRCA2* gene screening remains a labor and time-consuming challenge due to the large genes size, diverse mutations or variants of unknown significance (VUS) and complexity of large genomic rearrangements and copy number variations requiring special technical approaches. Recent advances in high throughput sequencing technologies including Target panels and whole exome sequencing allowed rapid, sensitive, and cost-effective screening of the large *BRCA* genes. In addition, the decreased cost of genotyping and sequencing offered affordable targeted testing options.

Sequencing thousands of cancer samples showed that the frequency of germline mutations in *BRCA* genes varies widely among populations. Some mutations are shared between different populations and others are ethnic specific [10, 11]. Indeed, in certain countries and ethnic communities, the *BRCA* mutation spectrum is limited to a few founder mutations [12] [13]. This is mainly observed in geographically, culturally, or religiously isolated populations and in countries with high rates of consanguinity and endogamy that undergo rapid expansion from a limited number of ancestors. Consequently, some alleles become more frequent which explain the high frequency of some founder mutations in these populations. The founder effect may, therefore, influence mutation prevalence and gene penetrance. Since cancer risk is a function of mutation prevalence and penetrance that seems to vary by ethnicity, investigating the prevalence, the frequency, and the penetrance of novel *BRCA* mutation in different populations will bring new insights on cancer risk and etiology.

In Tunisia, previous studies on *BRCA* genes have focused only on breast cancer patients. In some studies, the genetic investigation concerned all the coding regions of *BRCA1* and / or *BRCA2* genes and in others only hotspot exons have been investigated. These reports have revealed a total of only 18 distinct mutations of which 12 are localized within *BRCA1* gene including 2 large rearrangements encompassing exons 5 and 20. Among the identified mutations c.211dupA, c.5266dupC in *BRCA1* and c.1310_1313delAAGA in *BRCA2* were the most recurrent mutations encountered among the hereditary breast cancer cases [10, 14–22]. Despite these efforts, the mutational spectrum of *BRCA1/2* genes is still not well established. The main goal of the present study was to identify additional novel *BRCA* mutations and to investigate the contribution of these mutations to the missing heredity of breast and ovarian cancers. We also aimed to compare breast cancer clinicopathological characteristics in *BRCA* + vs *BRCA*- Tunisian breast cancer cases.

Materials And Methods

Patients

A total of 354 breast and ovarian cancer patients (335 breast cancer patients and 19 ovarian cancer patients) were included in this study referred from different medical oncology departments in Tunisia including those of Abderrahman Mami Hospital, Military Hospital of Tunis, Salah Azaiez Institute of Cancer

and Farhat Hachad University Hospital University of Sousse. Written informed consents were obtained from all participants. The study has been conducted according to the Declaration of Helsinki Principles and ethical approval was obtained from the biomedical ethics committee of Institut Pasteur de Tunis (2017/16/E/Hôpital A-M) was obtained from. Clinico-pathological characteristics and follow-up data were collected from patient's medical records based on the following selection criteria: (1) Presence of at least 3 related first or second-degree cancer cases, (2) Young cancer patients aged less than 35 years, (3) Presence of at least two cases of breast or ovarian cancer, regardless of age, and at least one case of pancreatic cancer or prostate cancer in a related first or second degree patient.

DNA Isolation

Total genomic DNA was isolated from peripheral blood using DNeasy blood DNA extraction Kit (Qiagen) according to the manufacturer's instructions. DNA purity and concentration were measured using a NanoDrop™ spectrophotometer.

Screening for recurrent mutations in *BRCA1* and *BRCA2* genes using Sanger Sequencing

Before performing NGS analysis, the studied cohort was screened for at least one of the recurrent *BRCA1/2* mutations previously reported in the Tunisian population, namely exon5-c.211dupA (rs397508938), exon11-c.798_799delTT (rs80357724), exon11-c.2551delG (rs397508977), exon11-c.3331_3334delCAAG (rs80357701) and exon20-c.5266dupC (rs80357906) of the *BRCA1* gene and exon10-c.1310_1313 delAAGA (rs80359277), exon16-c.7654dupA (rs879255463) in *BRCA2* gene respectively. The reference sequences used were NM_007294.3 for *BRCA1* and NM_000059.3 for *BRCA2*.

PCR reactions were performed on genomic DNA (gDNA), following standard protocols. Sanger sequencing has been performed using an automated sequencer (ABI 3500; Applied Biosystems, Foster City, CA) and a cycle sequencing reaction kit (Bigdye Terminator v3.1 kit, Applied Biosystems). The data were analyzed using BioEdit software version 7.2.5.

Sanger sequencing technique was then used to validate the identified mutations resulting from NGS.

NGS was performed on 75 breast and ovarian cancer cases. Targeted *BRCA1/2* sequencing and whole exome sequencing were performed on 60 and 15 patients respectively.

Targeted *BRCA1/2* genes sequencing (TGS)

Targeted *BRCA1/2* genes sequencing was performed for 60 breast and ovarian cancer patients with strong family history. All targeted coding exons and exon–intron boundaries of *BRCA1/2* genes were amplified with 253 pooled primer pairs. After the targeted amplification and construction of a library through QIAGEN Library Kit v2.0, the libraries were pooled prior to emulsion PCR and bead enrichment steps that were carried out using an automated protocol on the GeneRead QIacube (QIAGEN, Hilden, Germany) using the GeneRead Clonal Amp Q Kit (QIAGEN, Hilden, Germany), according to the manufacturer's protocol. Following bead enrichment, the pooled libraries were sequenced using the GeneReader platform (QIAGEN, Hilden, Germany).

Whole Exome Sequencing (WES)

WES was performed for 16 breast cancer Tunisian patients. Samples were prepared according to Agilent's SureSelect Protocol Version 1.2 and enrichment was carried out according to Agilent SureSelect protocols. Enriched samples were sequenced on the Illumina HiSeq2000 platform using TruSeq v3 chemistry with paired-end (2×100). Exome DNA sequences were mapped to their location in the build of the human genome (hg19/b37) using the Burrows–Wheeler Aligner (BWA) package. The subsequent SAM files were converted to BAM files using Samtools. Duplicate reads were removed using Picard. GATK was then used to recalibrate the base quality scores as well as for SNP and short INDEL calling. Annotation and prioritization of potential disease-causing variants were performed using VarAFT (Variant Annotation and Filtering Tool) (<http://varaf.t.eu>). To annotate variants,

VarAFT uses ANNOVAR, a command line tool. INDELS and SNPs annotated were filtered according to several criteria: (1) considering breast cancer as autosomal dominant disease and removing variants that were found in a homozygous state, (2) variants identified as intronic, intergenic, and none coding or synonymous were discarded, (3) assuming that causal variants are rare, we removed all variants with an allele frequency $> 1\%$ either in Exac [23], 1000 genomes [24] or ESP6500 (<http://evs.gs.washington.edu/EVS/>), (4) benign or tolerated variants, according to the different in silico prediction tools were also removed. Finally, significant candidate variants were obtained after filtering against their phenotypic relevance.

Clinico-pathological features of *BRCA1* and *BRCA2* carriers

Clinical and pathological features of *BRCA+* vs *BRCA-* patients as well as *BRCA1* vs *BRCA2* carriers were compared and evaluated. Statistical analysis was performed using SPSS software (version 23). Quantitative variables with normal distribution were analyzed by Student's t test. Comparison of qualitative data was performed using Chi-square test. Correlation is considered statistically significant between two variables if the *P* value is less than or equal to 0.05.

Results

Epidemiological and clinico-pathological features of investigated breast and ovarian cancer patients

A family history of breast and ovarian cancer was present in 35.24% and 11.14% of patients respectively. In addition, 2.68% of patients presented both breast and ovarian cancers. Consanguineous families represent 35.31% of the studied patients. Mean age at menarche was 12.81 years. Mean age at first pregnancy was 26.62 years. Oral contraception was reported by 47.31% of patients, 25.99% of patients have never breastfed and 31.85% were premenopausal.

The mean age at diagnosis of breast cancer was 43.10 years and 31.94% of patients were ≤ 35 years. 1.49% were male breast cancer cases. Inflammatory breast cancer (T4d) was seen in 8.65% of patients. Invasive ductal carcinoma (IDC) was the most frequent (90.04%) while infiltrating lobular carcinoma (ILC) was observed in only 3.94% of cases. Scarff-Bloom-Richardson (SBR) grade III was the most common (47.71%). Mean Tumor size was 33.62mm. Patients with positive lymph node disease represented 53.37% of our cohort, 88.67% of patients had Ki-67 > 14%. Luminal B tumors were the most common (56.88%) followed by TNBC (23.85%), Her2+ (11.93%) and luminal A (7.34%). 26.34% of patients have developed distant metastases.

For ovarian cancer cases, the mean age at diagnosis was 52.62 years and the majority with serous ovarian carcinoma.

Genetic Analysis

Genetic analysis results showed that 36 out of 354 tested breast and ovarian cancer patients were *BRCA1/2* mutation carriers (31 breast cancer cases and 5 ovarian cancer patients), including 21 patients with *BRCA1* mutation and 15 patients carrying *BRCA2* mutation.

Identified *BRCA1/2* pathogenic mutations in breast cancer cases

Within the studied breast cancer cohort, 13 pathogenic mutations have been identified: 8 in *BRCA1* and 5 in *BRCA2* genes. Among the identified mutations, 9 are described for the first time in Tunisian population (6 in *BRCA1* and 3 in *BRCA2*) (Table 1).

Table 1

Mutations in the *BRCA1/2* genes identified in breast cancer and ovarian cancer patients by Sanger and next generation sequencing technologies

Gene	Exon	Coding change	Protein variation	dbSNP rs ID	Number of families carrying mutations	Number of patients carrying mutations	Screening method
BRCA1	2	c.19_47del	p.Arg7fs*24	rs80359871	1	1 (BC)	NGS
	5	c.211dupA	p.Arg71fs*10	rs397508938	5	6 (BC)	Sanger sequencing
	10	c.668dupA	p.Ala224Glyfs*4	rs80357537	1	1 (BC)	NGS
	11	c.915T > A	Cys305*	-	1	1 (OC)	Sanger Sequencing
	11	c.1612C > T	p.Gln538*	rs80356893	3	4 (2 BC, 2 OC)	NGS
	11	c.2418dupA	p.Ala807Serfs*3	rs886040036	1	1 (BC)	NGS
	11	c.2433delC	p.Lys812fs*3	rs80357524	1	2 (BC)	NGS
	11	c.3049G > T	Glu1017*	rs80357004	1	1 (OC)	NGS
	17	c.5030_5033delCTAA	p.Thr1677fs*2	rs80357580	1	1 (BC)	NGS
	20	c.5266dupC	p.Gln1756Profs*74	rs80357906	2	3 (BC)	Sanger sequencing
BRCA2	3	c.249delG	p.Glu83Aspfs	-	1	1 (OC)	NGS
	8	c.632-1G > A	-	rs81002820	5	6 (BC)	NGS
	10	c.1310_1313delAAGA	p.Lys437fs*22	rs80359277	9	10 (9 BC, 1 MBC)	NGS/Sanger sequencing
	10	c.1389_1390delAG	p.Val464fs*3	rs80359283	1	1 (MBC)	NGS
	16	c.7654dupA	p.Ile2552Asnfs*2	rs879255463	1	2 (BC)	Sanger sequencing
	1-16	c.-227-?_7805+?	-	-	1	1 (BC)	NGS

Abbreviations : BC : breast cancer, MBC: Male Breast Cancer, OC: ovarian cancer, NGS : Next Generation Sequencing.

Considering the *BRCA1* gene, 6 patients belonging to 5 unrelated families were carriers of the recurrent c.211dupA mutation. Three patients belonging to 2 unrelated families were positive for c.5266dupC mutation. The missense c.1612C > T mutation has been identified in 2 related patients. c.19_47del, c.668dupA, c.2418dupA and c.5030_5033delCTAA mutations have been identified each in one patient. c.2433delC has been identified among 2 related patients. Except c.211dupA and c.5266dupC mutations, all remaining *BRCA1* mutations are reported for the first time in the Tunisian population.

In the *BRCA2* gene, 3 frameshift mutations as well as 1 splicing and 1 large rearrangement mutation were detected. Our results revealed 6 patients belonging to 5 unrelated families that are double heterozygous for *BRCA2* gene. Indeed, these families were carrying two mutations classified as pathogenic in the ClinVar database namely c.632-1G > A and c.1310_1313delAAGA. Four additional patients carrying only the c.1310_1313delAAGA mutation have been identified including one male breast cancer. The c.7654dupA mutation was identified in 2 related patients with a strong family history of hereditary breast and ovarian cancer. The c.1389_1390delAG mutation has been identified in 1 additional male breast cancer case. Similarly, a large rearrangement mutation of *BRCA2* gene (Del exons 1–16) has been identified in one patient. Among the identified *BRCA2* mutations, *BRCA2*-Del exons 1–16 mutation is novel and was not described in public databases. c.632-1G > A and c.1389_1390delAG are described for the first time in the Tunisian population.

BRCA1/2 pathogenic mutations identified in ovarian cancer cases

Nineteen ovarian cancer patients were screened for *BRCA* pathogenic mutations using Sanger and/or NGS. Four distinct deleterious mutations were identified: 3 mutations in *BRCA1* gene (c.915T > A, c.1612C > T and c.3049G > T) and one *BRCA2* mutation (c.249delG).

BRCA1-c.915T > A and *BRCA2*-c.249delG mutations are novel and not described in public databases. The other identified mutations are described for the first time in the Tunisian population. c.1612C > T mutation was identified among 2 patients. This same mutation was also identified in 2 related breast cancer patients. Screening for additional carriers of the identified mutations, based on their geographic origin, was performed using Sanger sequencing. Consequently, the geographic origin of the identified *BRCA1/2* mutations has been clearly established (Fig. 1). We have also illustrated the distribution of *BRCA* mutations identified in hereditary breast and ovarian cases on *BRCA1* and *BRCA2* genes (Fig. 2). Breast cancer cluster regions (BCCRs) and ovarian cancer cluster regions (OCCRs) were assigned in Fig. 2 according to the study of Rebbeck et al,2015 [25]. Among *BRCA* mutations identified in breast cancer patients, *BRCA1*_c.211dupA, *BRCA1*_c.5266dupC, *BRCA2*_c.-227-?-7805+?, *BRCA2*_1310_1313delAAGA, *BRCA2*_c.1389_1390delAG and *BRCA2*_c.7654dupA occurred in BCCRs. Considering *BRCA* mutations identified in ovarian cancer patients *BRCA1*_c.1612C > T and *BRCA1*_3049G > T arose in OCCRs.

Polymorphisms and variant of unknown significance identified in *BRCA1* and *BRCA2* genes

In addition to the pathogenic mutations that have been identified in *BRCA* genes, several SNPs and variants of unknown significance (VUS) have been observed (**Supplementary Table 1**). Among the 101 identified variants, 45.54% were coding, 50.49% were intronic and 3.96% were localised within regulatory regions. The majority of variations were classified as benign or likely benign in the ClinVar database (91.08%) and five intronic variations were not reported. One patient carried a VUS rs397507308 in *BRCA2* and 3 other patients carried 2 intronic variations (rs276174878 and rs276174816) that have conflicting interpretations of pathogenicity. Another patient diagnosed with early onset bilateral breast cancer had an inframe variant with conflicting interpretations of pathogenicity rs80358343 (c.5017_5019delCAC) in the *BRCA1* gene.

The Length of mutation indicator reflects the number of observed carriers. The diagrams linearly represent *BRCA1/2* protein domains (x-axis). *BRCA1* domains : Zinc/Ring finger (green); BRCT_assoc : serine-rich domain associated with BRCT (red); Ethylene insensitive 3 (blue); *BRCA1* C terminus domain (yellow). *BRCA2* domains : BRC repeats (green); *BRCA-2*_helical (red); oligonucleotide/oligosaccharide-binding, domain 1 (blue); tower domain (yellow) and oligonucleotide/oligosaccharide-binding, domain 3 (purple). Black mutation indicators depict truncating mutations and purple indicators represent the other types of mutations (splicing, LR). Cluster regions (breast cancer cluster regions (BCCRs) (orange) and ovarian cancer cluster regions (OCCRs) (yellow) were assigned according to the study of Rebbeck et al,2015.

Clinico-pathological features of *BRCA* carriers among breast and ovarian cancer cohort

Clinico-pathological characteristics of *BRCA1* and *BRCA2* carriers are described in Table 2 and Table 3 respectively. We investigated these clinico-pathological features in *BRCA1/2* carriers vs *BRCA* negative patients (Table 4) and between *BRCA1* and *BRCA2* mutation carriers (Table 5), as well.

Table 2
Clinicopathological features of *BRCA1* carriers

Mutation	Carrier ID	Pathology	Age at diagnosis (years)	Family History BC/OC	Family history of other cancers	Histological subtype	SBR grade	ER status	PR status	HER2 status	Ki67-index (%)	I
c.19_47del	BC320-1	BC	35	3 BC	1 gastric, 2 lung, 1 esophageal	IDC	III	ER+	PR-	HER2+	70%	I
c.211dupA	BC9-1	BC/OC/CBC	42	1 BC/OC 1 OC	1 Cervical cancer	IDC	NA	NA	NA	NA	NA	I
	BC49-1	BC/CBC	29	2 BC	Leukemia, Prostate, Colon, Gynecological cancer, Larynx	IDC	III	ER-	PR-	HER2-	NA	I
	BC49-2	BC	37	2 BC		IDC	III	ER +	PR +	HER2-	40	I
	BC199-1	BC	58	1 BC 1 OC	1 Endometrium	IDC	III	ER -	PR -	HER2-	2	I
	BC204	BC/OC	28	2 BC 2 OC	1 Thyroid	IDC	NA	ER -	PR -	HER2-	20	I
	PEC50-1	BC	38	2 BC	2 Lung, 1 Pancreatic	IDC	II	ER -	PR-	HER2-	NA	I
c.668dupA	BC420	BC	64	1 BC	1 Colorectal, 1 tongue cancer	NA	NA	NA	NA	NA	30	I
c.1612C>T	BC276-1	BC	25	4 BC 1 BOC 1 OC	1 Lung, 1 head and neck	IDC	II	ER -	PR-	HER2-	NA	I
	BC276-3	BC/OC	ND	1 BC 1 OC	1 Lung	NA	NA	NA	NA	NA	80	I

Abbreviations: BC : breast cancer, OC: ovarian cancer, CBC: contralateral breast cancer, IDC: intraductal carcinoma, PABC: Pregnancy associated breast cancer
Progesterone receptor, ER : Estrogen receptor

Mutation	Carrier ID	Pathology	Age at diagnosis (years)	Family History BC/OC	Family history of other cancers	Histological subtype	SBR grade	ER status	PR status	HER2 status	Ki67-index (%)	
c.2418dupA	BC93	IBC	34	None	1 Lung, 1 pancreatic	IDC	II	ER -	PR -	HER2-	NA	I
c.2433delC	BC178-1	BC/CBC/ Endometrial cancer	42	2 BC 1 OC	2 Lung, 1 colorectal, 1 bladder	IDC	III	NA	NA	NA	30	I
	BC178-2	BC/CBC	45			IDC	II	ER -	PR -	HER2-	NA	I
c.5030_5033delCTAA	BC70	BC/OC	47	3 BC 1 OC	1 Lung	Polymorphic IDC	III	ER -	PR -	HER2-	65	I
c.5266dupC	BC81-1	BC/(CBC: PABC)	27	4 BC	1 Pancreatic	IDC	III	ER -	PR -	HER2-	NA	I
	BC81-6	BC	36		1 colorectal cancer	IDC	III	ER -	PR -	HER2+	NA	I
	BC314	BC	29	6 BC	1 Prostate	IDC	III	ER +	PR +	HER2-	40	I
Abbreviations: BC : breast cancer, OC: ovarian cancer, CBC: contralateral breast cancer, IDC: intraductal carcinoma, PABC: Pregnancy associated breast cancer Progesterone receptor, ER : Estrogen receptor												

Table 3
Clinico-pathological features of *BRCA2* carriers

Mutation	Carrier ID	Pathology	Age at diagnosis (years)	Family History BC/OC	Family history of other cancers	Histological subtype	SBR grade	ER status	PR status	HER2 status	Nod: stati
DH (c.632-1G>A, c.1310_1313delAAGA)	BC6-1	BC	40	4 BC	1 Throat cancer	IDC	NA	NA	NA	NA	NA
	BC17-1	BBC	36	9 BC	1 Gastric cancer 1 Kidney cancer	IDC	III	ER+	PR+	NA	N+
	BC17-2	BC (PABC)/ CBC	25	9 BC	1 Gastric cancer 1 Kidney cancer	IDC	II	ER +	PR +	HER2-	N+
	BC39	BC	27	None	None	IDC	III	ER +	PR +	HER2-	NA
	BC95	BC	32	None	1 Colorectal cancer	IDC	I	ER+	PR+	HER2-	N-
	BC225-1	BC	50	5 BC	1 cerebral cancer 2 esophageal	IDC	III	ER+	PR+	HER2-	N+
c.1310_1313delAAGA	BC245	IBC (PABC) CBC	36	2 BC	None	IDC	II	ER+	PR+	HER2-	N+
	PEC009	BC	33	1 BC	None	IDC	II	ER+	PR+	HER2-	N+
	PEC0035	MBC	43	2 MBC 1 BC	None	IDC	III	ER+	PR+	HER2-	N+
	BC354-1	BC	37	2 BC 1 IBC 1 MBC	1 pancreatic 1 Lung	ILC	I	ER+	PR+	HER2-	N+
c.1389_1390delAG	PEC0056	MBC	59	1 BC	1 bladder	IDC	III	ER+	PR -	HER2-	N+

Abbreviations : BC : breast cancer, OC: ovarian cancer, CBC: contralateral breast cancer, IDC: intraductal carcinoma, PABC: Pregnancy associated breast cancer, Progesterone receptor, ER : Estrogen receptor

Mutation	Carrier ID	Pathology	Age at diagnosis (years)	Family History BC/OC	Family history of other cancers	Histological subtype	SBR grade	ER status	PR status	HER2 status	Nod: statu
c.7654dupA	BC231-1	BC/OC	47	8 BC	2 Gastric, 1 prostate, 1 hepatic cancers	IDC	III	ER+	PR +	HER2-	N-
	BC231-2	BC	34	1 BOC		IDC	III	ER+	PR +	HER2-	N+
c.-227-?_7805+?	BC287	IBC (PABC)	36	3 BC 1 BBC 1 BOC 1MBC/prostate cancer 1 IBC	1 Larynx	IDC	III	ER+	PR +	HER2-	NA

Abbreviations : BC : breast cancer, OC: ovarian cancer, CBC: contralateral breast cancer, IDC: intraductal carcinoma, PABC: Pregnancy associated breast cancer, PR: Progesterone receptor, ER : Estrogen receptor

Table 4
Epidemiological and clinico-pathological characteristics of patients carrying or not *BRCA1/2* mutations

Variables	<i>BRCA1/2+</i> N = 31	<i>BRCAx</i> N = 52	P value
Mean age at diagnosis (years)	38.37	43.14	0.049
Early age at onset (≤ 35 years)			
Yes	12/30 (40.0%)	11/50 (22%)	0.085
No	18/30 (60.0%)	39/50 (78%)	
Family history of breast cancer			
Yes	28/31 (90.32%)	42/52 (80.77%)	0.247
No	3/31 (9.68%)	10/52 (19.23%)	
Family history of ovarian cancer			
Yes	11/31 (35.48%)	5/51 (9.80%)	0.004
No	20/31 (64.52%)	46/51 (90.20%)	
Personal history of cancers			
Yes	5/31 (16.13%)	4/51 (7.84%)	0.244
No	26/31 (83.87%)	47/51 (92.16%)	
Consanguinity			
Yes	7/30 (23.23%)	13/50 (26%)	0.790
No	23/30 (76.77%)	37/50 (74%)	
Histological type			
IDC	28/29 (96.55%)	26/30 (86.67%)	0.173
Other	1/29 (3.45%)	4/30 (13.33%)	
SBR Grade			
Grade I	2/26 (7.69%)	5/28 (17.86%)	0.025
Grade II	7/26 (26.92%)	15/28 (53.57%)	
Grade III	17/26 (65.38%)	8/28 (28.57%)	
Mean tumor size (mm)	27.15	36.15	0.201
T stage			
T1-T2	9/15 (60.00%)	9/14 (64.29%)	0.670
T3	1/15 (6.67%)	2/14 (14.29%)	
T4	5/15 (33.33%)	3/14 (21.42%)	
Nodes involvement			
N+	15/21 (71.43%)	14/26 (53.85%)	0.218
N-	6/21 (28.57%)	12/26 (46.15%)	
Mean Ki-67 (%)	38.79	34.95	0.598
Ki-67 index status			
Ki-67 $\leq 14\%$	1/19 (5%)	2/21 (9.52%)	0.609
Ki-67 $> 14\%$	18/19 (95%)	19/21 (90.48%)	
Molecular subtypes			
Luminal A	1/23 (4.35%)	2/29 (6.90%)	0.835
Luminal B	12/23 (52.17%)	14/29 (48.28%)	
Her2+	1/23 (4.35%)	3/29 (10.34%)	
TNBC	9/23 (39.13%)	10/29 (34.48%)	

Variables	BRCA1/2+ N = 31	BRCAx N = 52	Pvalue
ER receptor status			
RE+	16/26 (61.54%)	23/37 (62.16%)	0.960
RE-	10/26 (38.46%)	14/37 (37.84%)	
PR receptor status			
PR+	14/26 (53.85%)	22/37 (59.46%)	0.658
PR-	12/26 (46.15%)	15/37 (40.54%)	
HER2 receptor status			
HER2+	2/25 (8.00%)	8/33 (24.24%)	0.105
HER2-	23/25 (92.00%)	25/33 (75.76%)	
TNBC			
TNBC	9/23 (39.13%)	10/29 (34.48%)	0.730
Non-TNBC	14/23 (60.87%)	19/29 (65.52%)	
Metastatic status			
M0	18/24 (75.00%)	22/32 (68.75%)	0.608
M1	6/24 (25.00%)	10/32 (31.25%)	

Table 5
Epidemiological and clinico-pathological characteristics of patients carrying *BRCA1*
and *BRCA2* mutations

Variables	<i>BRCA1+</i> N = 17	<i>BRCA2+</i> N = 14	P value
Mean age at diagnosis (years)	38.50	38.21	0.939
Early age at onset (≤ 35 years)			
Yes	7/16 (43.75%)	5/14 (35.71%)	0.654
No	9/16 (56.25%)	9/14 (64.29%)	
Family history of breast cancer			
Yes	16/17 (94.12%)	12/14 (85.71%)	0.431
No	1/17 (5.88%)	2/14 (14.29%)	
Family history of ovarian cancer			
Yes	8/17 (47.06%)	3/14 (21.43%)	0.138
No	9/17 (52.94%)	11/14 (78.57%)	
Personal history of cancers			
Yes	4/17 (23.53%)	1/14 (5.88%)	0.217
No	13/17 (76.47%)	13/14 (94.12%)	
Consanguinity			
Yes	2/17 (11.76%)	5/13 (38.46%)	0.087
No	15/17 (88.24%)	8/13(61.54%)	
Histological type			
IDC	15/15 (100%)	13/14 (92.86%)	0.292
Other	0/15	1/14 (7.14%)	
SBR grade			
Grade I	0/13	2/13 (15.38%)	0.333
Grade II	4/13 (30.77%)	3/13 (23.08%)	
Grade III	9/13 (69.23%)	8/13 (61.54%)	
Mean tumor size (mm)	25.36	29.33	0.555
T stage			
T1-T2	3/5 (60%)	6/10 (60.00%)	0.056
T3	1/5 (20%)	0/10	
T4	1/5 (20%)	4/10 (40.00%)	
Nodes involvement			
N+	6/10 (60%)	9/11 (81.82%)	0.269
N-	4/10 (40%)	2/11 (18.18%)	
Mean Ki-67 (%)	40.78	37.00	0.727
Ki-67 index status			
Ki-67 $\leq 14\%$	1/9 (11.11%)	0/10	0.279
Ki-67 $> 14\%$	8/9 (88.89%)	10/10 (100%)	
Molecular subtypes			
Luminal A	1/13 (7.69%)	0/10	0.001
Luminal B	2/13 (15.39%)	10/10 (100%)	
Her2+	1/13 (7.69%)	0/10	
TNBC	9/13 (69.23%)	0/10	

Variables	<i>BRCA1+</i> N = 17	<i>BRCA2+</i> N = 14	P value
ER receptor status			
RE+	3/13 (23.08%)	13/13 (100%)	0.000056
RE-	10/13 (76.92%)	0/15	
PR receptor status			
PR+	2/13 (15.38%)	12/13 (92.31%)	0.000084
PR-	11/13 (84.62%)	1/13 (7.69%)	
HER2 receptor status			
HER2+	2/13 (15.38%)	0/12	0.157
HER2-	11/13 (84.62%)	12/12 (100%)	
TNBC			
TNBC	9/13 (69.23%)	0/10	0.001
Non-TNBC	4/13 (30.77%)	10/10 (100%)	
Metastatic status			
M0	8/11 (72.73%)	10/12 (83.33%)	0.538
M1	3/11 (27.27%)	2/12 (16.67%)	

BRCA+* vs *BRCA-

Family history of ovarian cancer was significantly associated with *BRCA* positive status ($p = 0.004$). Regarding the mean age at diagnosis *BRCA* carriers seem to be younger than *BRCA-* patients (38.37 vs 43.14) ($p = 0.049$). However, no significant difference has been observed between both groups regarding family history of breast cancer, personal history of cancer and consanguinity. Similarly, no significant differences have been observed between the 2 groups in histological subtype, nodal involvement, tumor stage, hormonal receptors status, HER2 status, molecular subtypes, Ki-67 index, and metastases (Table 4). Nevertheless, SBR grade III was found in 65.38% of patients with *BRCA1/2* mutations against a frequency of 28.57% among non-carriers, this difference appears to be statistically significant ($p = 0.025$).

BRCA1* vs *BRCA2

Association between clinico-pathological features and *BRCA* status (*BRCA1+*, *BRCA2+* and *BRCAx*) was shown in Fig. 3 and Fig. 4. Our results showed that there were no significant differences between *BRCA1* and *BRCA2* mutated groups regarding the mean age at diagnosis, the family history of personal cancers, of breast cancer and ovarian cancer (Table 5).

Pathology showed that the infiltrating ductal carcinoma was the most common histological type in both groups (100% and 92.86%). HER2 status, lymph node involvement, SBR grade, tumor size, Ki-67 index and metastatic status showed no statistically significant difference between both studied groups. However, *BRCA1* carriers were more likely to have triple negative breast cancer ($p = 0.001$) and *BRCA2* carriers were more likely to have luminal B breast cancer tumors ($p = 0.001$). In addition, positive estrogen receptor (ER) status and positive progesterone receptor (PR) status studied separately were both associated with *BRCA2* mutated tumors ($p = 0.000056$ and $p = 0.000084$), respectively.

Follow up of *BRCA1* and *BRCA2* carriers

Among *BRCA* carriers, contralateral breast cancer and ovarian cancer co-occurrence were observed respectively in 22.58% and 16.12% of cases. One patient diagnosed with early onset breast cancer has undergone a contralateral prophylactic mastectomy and is currently under regular surveillance. Both contralateral breast cancer and ovarian cancer occurrence were more frequent in *BRCA1* than *BRCA2* carriers. Also, 22.58% of the carriers have developed distant metastases and 5 cases died due to disease progression.

Discussion

Detection of mutations in hereditary breast and ovarian cancer related *BRCA1* and *BRCA2* genes is an effective method of cancer prevention, early detection, and treatment. Mutations in the highly penetrant *BRCA* genes explain around a quarter of these cases [26]. The frequency of germline mutations identified on both genes varies depending on the geographic and ethnic distributions. In some populations, a wide spectrum of different mutations is present, whereas in other groups specific recurrent *BRCA* mutations have been reported that may be due to the founder mutation effect [27, 28].

In Tunisia, so far, only 18 deleterious *BRCA* mutations have been reported. In the current study, 16 *BRCA* mutations, including 11 novel variations, have been identified in a cohort of 354 Tunisian breast and ovarian cancer patients. For breast cancer cases, high fractions of young patients (31.94%), cases with family history of breast cancer (35.24%), Triple negative breast cancer (24.31%) and high tumor grade (47.41%) have been observed. As reported in previous studies,

the high fractions of early onset, triple negative cases and also the presence of family history of breast cancer may be associated with germline *BRCA* mutations [29, 30]. Indeed, it is now well documented that breast cancer patients in North Africa are almost 10 years younger than patients from western countries [31]. In Tunisia, around 11% of breast cancer cases are under 35 years old [32]. In fact, at a young age, the human organism usually functions as well as it ever will. However, interactions between some genetic and environmental factors (GxE) may cause a physiological decline of some organism systems leading to early disease presentation. Therefore, the influence of specific genetic background, differences in variant penetrance and frequency between populations along with environmental factors may explain this early onset of the disease. Large cohorts of young breast cancer patients should be studied to elucidate these GxE factors.

For ovarian cancer cases, the mean age at diagnosis was 52.62 years and the majority presented with serous ovarian carcinoma. Previous studies have shown that among all patients diagnosed with serous ovarian carcinoma, which is the most common subtype, over 15% will have germline *BRCA* mutations [33].

Among the 16 distinct deleterious mutations that have been observed c.19_47del, c.668dupA, c.915T > A, c.1612C > T, c.2418dupA, c.2433delC, c.3049G > T and c.5030_5033delCTAA in *BRCA1* and c.-227-?_7805+? (Del exons 1–16), c.249delG, c.632-1G > A, c.1389_1390delAG and in *BRCA2*, are reported for the first time in the Tunisian population. We have also identified an inframe deletion reported to have a conflicting interpretation of pathogenicity effect in early onset bilateral breast cancer patient *BRCA1*_c.5017_5019delCAC. This variation has been described in multiple breast and ovarian cancer cases, with some families showing incomplete co-segregation of the variation [34, 35, 36].

Among *BRCA* mutations identified in breast cancer patients *BRCA1*_c.211dupA, *BRCA1*_c.5266dupC, *BRCA2*_c.-227-?_7805+?, *BRCA2*_1310_1313delAAGA, *BRCA2*_c.1389_1390delAG and *BRCA2*_c.7654dupA occurred in BCCRs that are considered to be associated with an increased likelihood of breast cancer compared to ovarian cancer. Considering *BRCA* mutations identified in ovarian cancer patients *BRCA1*_c.1612C > T and *BRCA1*_3049G > T arose in OCCRs. Other mutations, namely c.19_47del, c.668dupA, c.915T > A, c.2418dupA, c.2433delC, c.5030_5033delCTAA in *BRCA1* and c.249delG, c.632-1G > A in *BRCA2* do not overlap with previously reported breast or ovarian cancer cluster regions. This could be explained by ethnic differences in *BRCA* mutation spectrum or it may indicate shared cluster regions for both breast and ovarian cancer.

In the *BRCA1* gene, the c.19_47del mutation was identified in one breast cancer patient. This mutation was previously described only in the Algerian population [37]. The c.2433delC mutation was described in Korean breast and ovarian patients [38, 39], and in Mexican patients [38, 39]. The pathogenic c.1612C > T mutation was identified in 4 breast and ovarian cancer patients. This mutation has been identified in Brazilian population [42], in ovarian cancer patients from Israeli population [43] and in Macedonian population [44]. We also detected the c.668dupA mutation in one patient. This latter has not been reported in previous studies neither in Tunisia nor in other populations. Nevertheless, it is already listed and classified as pathogenic in ClinVar and predicted to result in the substitution of Alanine to Glycine (p.Ala224Glyfs) which leads to *BRCA1* protein truncation. Another new mutation was identified in *BRCA1* gene, c.2418dupA, that was reported by our group for the first time in the Tunisian population and was not reported previously in other populations [45]. c.3049G > T has been identified in one ovarian cancer patient. This mutation has been reported in Thai patients with non-mucinous epithelial ovarian cancer [46]. The c.5030_5033delCTAA mutation was identified among one patient with breast and ovarian cancers and it is reported in Brazilian population [42]. The c.915T > A mutation is novel and not described in public databases.

In addition to the identification of rare and novel *BRCA1* mutations, other mutations seem to be recurrent and/or were described in previous Tunisian reports. The c.211dupA mutation was shared by 6 patients belonging to the same geographical origin. This mutation has so far been reported only in hereditary breast/ovarian cancer families of Tunisian origin, particularly in the North-East region, suggesting a founder effect. In order to unravel the genetic specificities of this mutation and to trace its origin a haplotype analysis has been conducted by our group on the North Eastern region [45]. Results have determined the founder haplotype segregating with this mutation and have revealed that it arose in the period of colonization approximately 130 years ago.

The c.5266dupC mutation has been identified among two families. This mutation was previously described in 8 Tunisian breast cancer families [10, 15, 16, 19]. It was originally described as an Ashkenazi founder mutation. Haplotype analysis has shown that this mutation arose approximately 1800 years ago in Northern Europe [47]. Then, it has been reported in several other populations such as, Italian, Russian Slovenian and Greek [48].

Interestingly for *BRCA2* gene, 6 breast cancer patients were double heterozygous carrying the two deleterious mutations c.632-1G > A and c.1310_1313delAAGA, and 4 other unrelated patients carried only the c.1310_1313delAAGA mutation including one male breast cancer (MBC). c.632-1G > A mutation appears to be rare in other populations since it was only reported in one patient with prostate cancer in the UK [49]. However, c.1310_1313delAAGA seems to be a founder mutation in Maghreb countries [15, 16, 50, 51]. It has been also identified in patients with Lebanese [50], European [53–56], African [57], Asian [58] and Latino ancestry [59] as well as in Caribbean cohorts [60, 61]. These results show the genetic heterogeneity of breast and ovarian cancers in Tunisian patients and the admixed origins of *BRCA* mutations in Tunisia.

Five male breast cancer cases were investigated in the current study among which 2 carried *BRCA2* mutations (c.1310_1313delAAGA and c.1389_1390delAG). Male breast cancer is a rare disease accounting for less than 1% of all breast cancer cases and it was previously shown that nearly 90% of MBC arising in *BRCA* mutation carriers are found to harbor a *BRCA2* mutation [62]. Unfortunately, being a man with “a women's disease” makes MBC a disease surrounded by social taboo and lack of awareness especially in underdeveloped countries. Indeed, the treatment of MBC has been extrapolated from the knowledge of female breast cancer, despite the multiple differences in the pathogenesis, biology and genetics of these two disease entities. These evidence make MBC a gender issue that requires more attention from the scientific community.

The introduction of the c.1310_1313delAAGA mutation, that have been encountered in diverse populations, in the Tunisian population could be explained by the immigration of Andalusians in Tunisia which has been intensified after the fall of Granada in 1492 and lasted for two centuries before the total expulsion of all Andalusian Moriscos from the Iberian Peninsula in 1610. The diverse geographical distribution of this mutation may further suggest independent origins

as shown for the 4184del4 *BRCA1* mutation reported to have at least three independent origins in the study of Neuhausen et al. [63]. The c.7654dupA *BRCA2* gene mutation which was identified in a unique family with a strong family history of breast and ovarian cancer is reported previously and exclusively in Algerian population [64], and could be therefore specific to North African countries.

Through this report and despite the identification of novel mutations in Tunisian population, it is clear that the genetic susceptibility to breast cancer is explained in a vast majority of cases by recurrent mutations. Indeed, more than 44.44% of carriers harbor *BRCA1*-c.211dupA or *BRCA2*-1310_1313deAAGA mutations which highlights the importance of screening these mutations in the treatment workflow of cases with early onset or strong family history of breast cancer. In fact, identifying germline *BRCA1* and *BRCA2* pathogenic mutations is a crucial component in the medical management of affected patients. Regular surveillance and/or prophylactic mastectomy of the second breast or prophylactic salpingo oophorectomies, which have been shown to reduce the risk of developing cancer, are recommended to these carriers. Moreover, relatives who test positive for a germline *BRCA* pathogenic mutation may take appropriate action to prevent cancer or have cancer diagnosed as early as possible for better treatment options [53].

In addition, mutations in the *BRCA* genes and their associations with clinico-pathological features were reported in several studies [65–67]. However, in Tunisia this aspect was not previously investigated. This point was raised in the present study and our results showed that patients with *BRCA1* and *BRCA2* mutations were similar with regard to several epidemiological and clinico-pathological parameters. Nevertheless, *BRCA1* carriers were more likely to be triple negative breast cancer compared to *BRCA2* carriers ($p = 0.0001$) and *BRCA2* carriers were more likely to be luminal B breast cancer tumors ($p = 0.001$). Consistent with our findings, various previous studies reported that there is a much higher rate of TNBC among *BRCA1* mutation carriers [68, 69] and *BRCA2*-related breast cancer is often luminal [70]. Additionally, positive ER was significantly associated with *BRCA2* + tumors ($p = 0.000056$). PR status was significantly different between *BRCA1* and *BRCA2* mutation carriers; *BRCA2* carriers are more likely to develop progesterone receptor (PR) positive tumors and PR-negative breast cancer are associated with *BRCA1* mutation carriers ($p = 0.000084$). It was reported that the ER positivity was predominantly seen in *BRCA2* mutation carriers, which is consistent with our findings [65, 71]. Furthermore, a previous report has found that *BRCA2*-associated cancers are mainly PR positive [72]. Other studies have raised some pathological differences between *BRCA1/2* mutation carriers and *BRCAx* patients. In our study, *BRCA* carriers seem to be younger than *BRCA-negative* patients ($p = 0.049$). Furthermore, patients with a positive family history of ovarian cancer are more likely to be *BRCA* positive ($p = 0.004$). We also observed a significant predominance of SBR grade III tumors among *BRCA1/2* mutations carriers ($p = 0.025$). These findings are in line with previous literature [29, 73, 74].

Furthermore, we have assessed disease outcomes in *BRCA* carriers, and we have observed a relatively high proportion of contralateral breast cancer and ovarian cancer occurrence that were more frequently observed in *BRCA1* carriers. Previous reports have demonstrated that women carrying a pathogenic mutation in the *BRCA1* or *BRCA2* genes have an increased risk of developing a second primary cancer in the contralateral breast. The cumulative risk 20 years after breast cancer diagnosis was estimated to 40% for *BRCA1* carriers and about 26% for *BRCA2* carriers [75]. In accordance with our findings, it was shown also that the occurrence of both breast and ovarian cancer in a woman is associated with a high likelihood of a germline *BRCA1* mutation [76].

Besides the *BRCA* genetic mutations that have been identified in our study, mutations on other high to moderate breast cancer genes such as *TP53*, *ATM*, *BLM* and *CHEK2* have been also identified for the first time in North Africa populations (data not shown). All these findings reflect the genetic heterogeneity of cancer predisposition in Tunisia and highlights the importance of the use of NGS to identify clinically actionable genetic variants that have a crucial role in disease management. Therefore, technological advances in terms of array and DNA sequencing technologies made the route towards the examination of genetic risk largely clear. However, practical challenges related to marked population-specific differences still exist. In this context, Manolio and colleagues conveniently classified *LRRK2* as a high penetrant gene associated with Parkinson disease [77] with G2019S mutation being the main cause of Parkinson familial cases. Recently the international *LRRK2* consortium reported a worldwide frequency of 1% of *LRRK2* G2019S, 30–40% in Arab patients from North Africa and 10–30% in

Ashkenazi Jews, but is very rare in Asians [78, 79]. As a variant's frequency has a direct impact on its penetrance, this example shows the ethnic-dependent penetrance of some important variants involved in complex diseases and the role of consanguinity and endogamy in shaping the genetic susceptibility to these diseases. Therefore, the same reflection can be applied on high and low penetrant breast cancer variants in order to review their penetrance in underrepresented populations such as North Africans. A disproportionate distribution of the identified mutations is observed between the Northern and Southern regions of Tunisia (Fig. 1), with the vast majority are found in North. This can be explained by a selection bias because most of the recruited participants come from Northern governorates but it can also be explained by the very high consanguinity rates in the South that reaches 98% in some cities and that may have an impact on *BRCA* mutations frequency and prevalence.

Clearly, the prevalence assessment of *BRCA1* and *BRCA2* mutations rely on the quality of both cohort selection criteria and mutation ascertainment methods. The identification of novel *BRCA* mutations and the assessment of their penetrance in a specific population will help to implement more affordable and cost effective targeted genetic testing strategies.

Finally, up until now, most data on *BRCA1/2* mutations associated with high risk for hereditary breast and ovarian cancer do not cover the North African populations. Accordingly, the novel mutations identified in this study will help to improve knowledge on the genetic component of hereditary breast and ovarian cancer in the North African region and will lead to a better clinical management of cancer patients. In addition, we are aiming to share genetic and phenotypic data with larger multi-ethnic Consortia of *BRCA1/2* carriers such as the CIMBA consortium [80]. This will make our findings more broadly useful and will give us a global overview of the similarities and differences that the Tunisian population has compared to other ethnicities.

Conclusion

In conclusion we have identified 16 distinct *BRCA* mutations in breast and ovarian cancer patients including 11 novel mutations in the Tunisian population. The recognition of the *BRCA* mutational spectrum and its geographical distribution in Tunisia is of keen interest for the scientific and medical communities as

it helps to develop precise risk assessment tools, accurate genetic testing, cost-effective approaches for prevention and early detection of the disease as well as personalized treatments of *BRCA* related cancers for both affected and unaffected cancer cases.

Abbreviations

BCCRs: Breast Cancer Cluster Regions

ER: Estrogen receptor

gDNA: Genomic DNA

GxE : Genetic and Environmental factors

IDC: Invasive Ductal Carcinoma

LMICs: Low- and middle-income countries

OCCRs: Ovarian cancer cluster regions

PR: Progesterone receptor

SBR: Scarff-Bloom-Richardson

TGS: Targeted gene sequencing

TNBC: Triple Negative Breast Cancer

VUS: Variants of Unknown Significance

WES: Whole Exome Sequencing

Declarations

Ethics approval and consent to participate:

Written informed consent was obtained from all participants. The study was conducted according to the declaration of Helsinki and with the approval of the biomedical ethics committee of Institut Pasteur de Tunis (2017/16/E/Hôpital A-M).

Consent for publication:

Written informed consent was obtained from participants for the publication of any potentially identifiable images or data included in this article.

Availability of data and materials:

The minimal dataset that would be necessary to interpret, replicate and build upon the findings reported in this study are included in this published article and in its supplementary files. Any additional datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests:

The authors declare that they have no competing interests.

Funding:

This work was supported by the Tunisian Ministry of Higher Education and Scientific Research (LR16IPT05) and the Tunisian Ministry of Public Health (PEC-4-TUN). MB and MBR are recipient of a MOBIDOC fellowship funded by the EU through the EMORI and PASRI programs managed by the ANPR.

Authors' contributions:

YH prepared the study concept and design, supervised the study, did data analysis, data interpretation, drafted and critically revised the manuscript. NMI and MB did the experiments, participated in participant recruitment, and participated in drafting and reviewing the manuscript. NME contributed in clinical data analysis and reviewed the manuscript. SBN contributed in participants recruitment and reviewed the manuscript. MBR and OM contributed in data collection and reviewed the manuscript. HB, YB, HR,OJ, ND, AZ, JA, HEB, SL and JBH contributed to the clinical investigation and recruitment of patients. AH, KR, FB, RM, SBA and HB critically revised the clinico- pathological section and the whole manuscript. SB and SA contributed to the study concept, design and supervision and critically revised the manuscript. All authors read and approved the manuscript.

Acknowledgements:

This manuscript is dedicated to the memory of **Prof Farouk Benna**. We would like to thank Dr. Zied Zidi, Dr Ghazi Jerbi, Dr Samir Khalfallah, Dr Achraf Chaari, Dr Olfa gharbi, Dr Monia Hechiche, Dr Sami Bellil , Dr Ichraf Jbir, Dr Olfa Daldoul Ben Fraj, Dr Bassem Allani /Dr David Khayat, Dr Tarek Bouzid, Dr El Fatmi Rym / Dr Mokrani Amina, Dr Samia Chatti Dey, Dr Hatem Chaaba, Dr Med Ali Ayadi, Dr Lotfi Kochbati, Dr Fethi Messoudi and Dr Chadha Elward Abdelhedi for their contribution in this work. We are also grateful to all participants and their family members for their participation in the study.

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Figures



Figure 1

Geographical distribution of the identified BRCA1 and BRCA2 mutations. Note: The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever on the part of Research Square concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. This map has been provided by the authors.

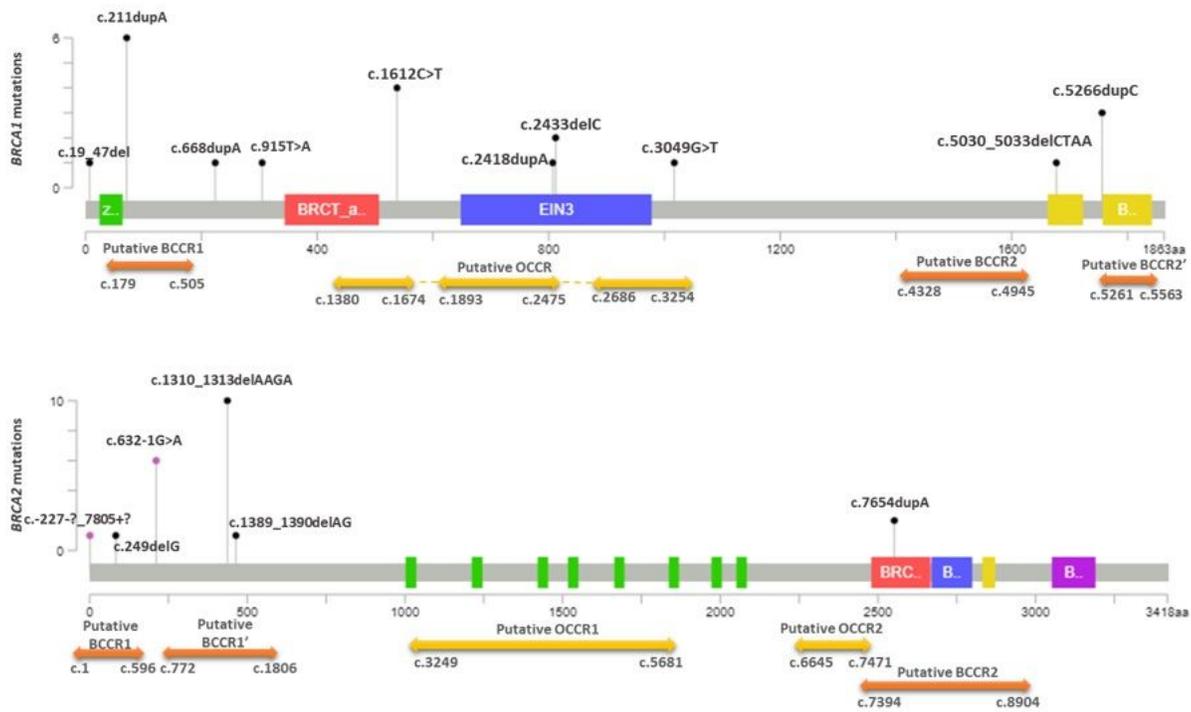


Figure 2
Distribution of BRCA1 and BRCA2 mutations identified in hereditary breast and ovarian cancer cases.

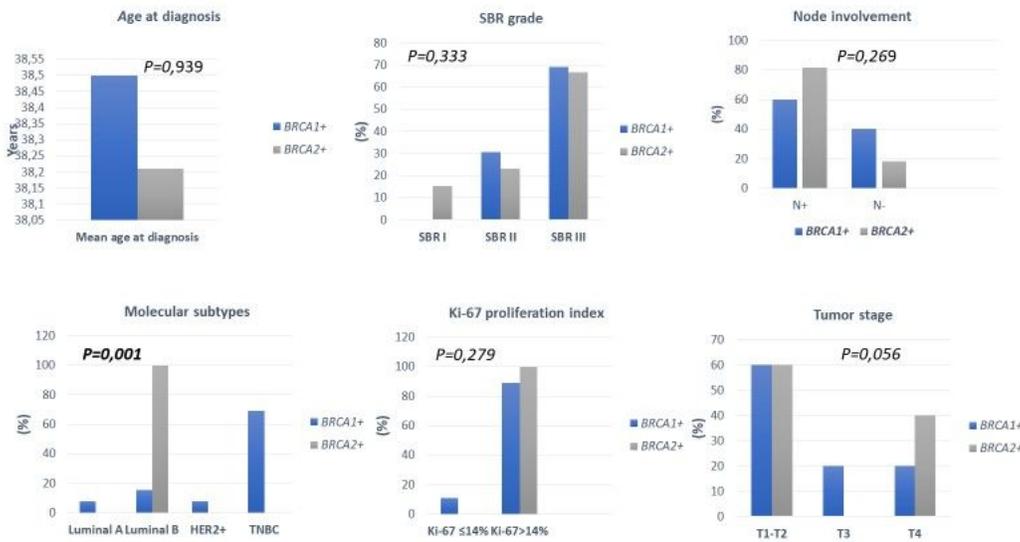


Figure 3
Distribution of clinico-pathological features of breast cancer in BRCA1+ and BRCA2+ patients

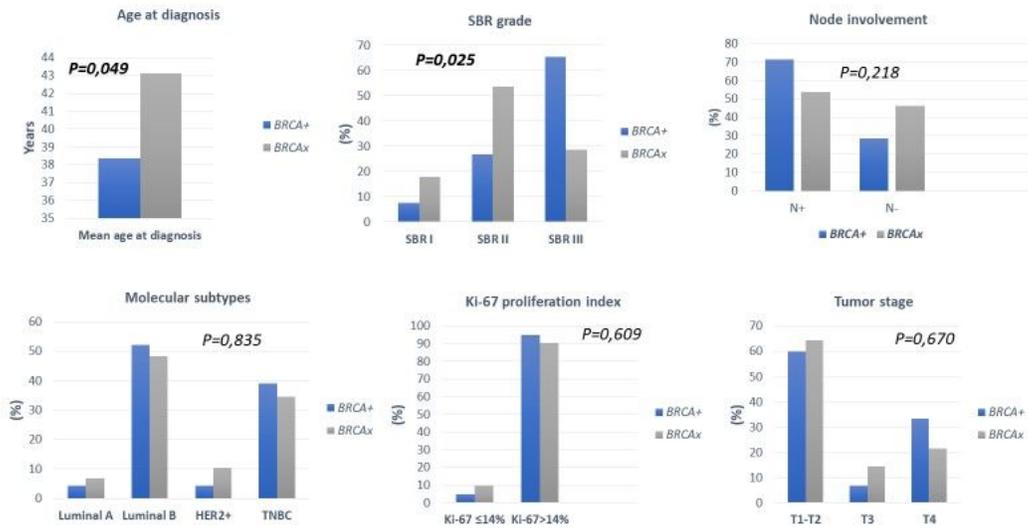


Figure 4

Distribution of clinico-pathological features of breast cancer in BRCA+ and BRCAx patients

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