



Mapping a *simple* genetic trait relative to genetic markers in a population





Can we map diseases without controlled crosses/ pedigrees?



- Not socially acceptable to force people to mate with others, especially ones who have diseases...
- Can't always find enough subjects who happened to breed in an informative way.
- Another route?

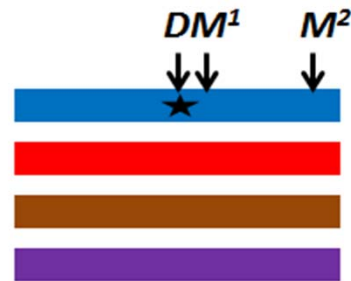
Use “population data” over time



- Human generation time historical average ~20 years
- When looking at very close genes, we saw low probability of exchange in ONE generation
 - BUT, over the thousands of years of history, there has been A LOT of recombination
 - Even 0.1% exchange in 1 generation has 99.3% probability of exchange in 5000 generations
 - Most neighboring genes shuffled, and even areas within genes are sometimes shuffled

Start “population” with 4 chromosomes

We'll focus on D and M¹ in the blue chromosome



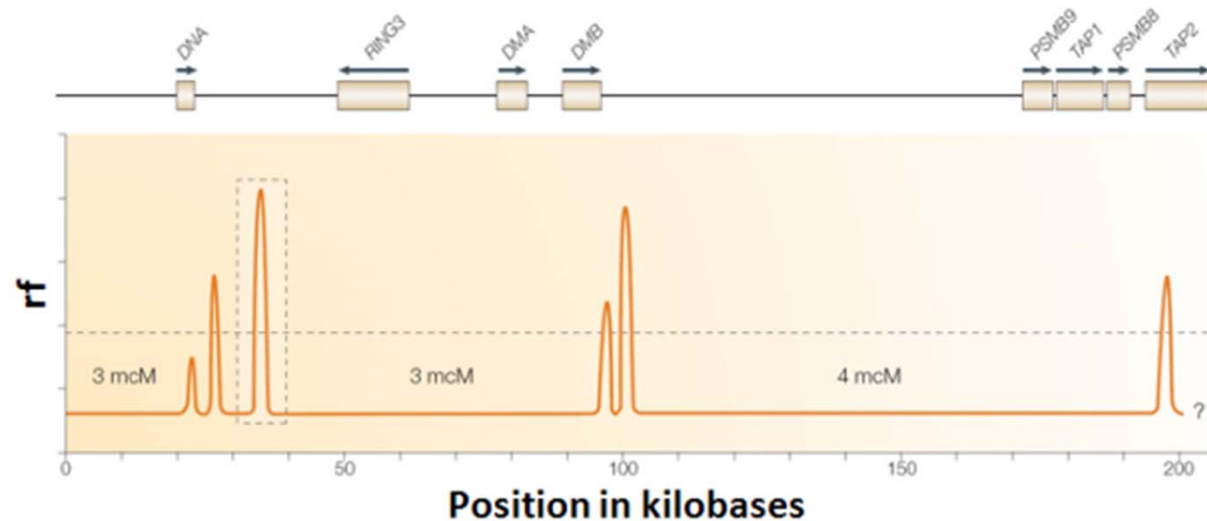
D and M¹ allele stay associated
D and M² allele shuffled

After many generations



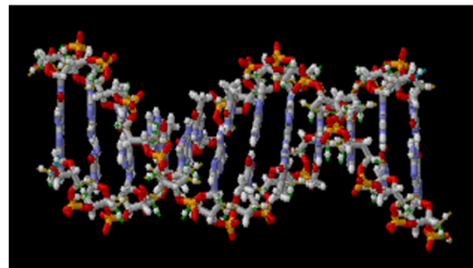
**... AND, recombination is not homogeneous
when look at a very fine scale**

- Tends to occur in “hotspots” every few thousand bases; rest of genome is ~ 0 rf

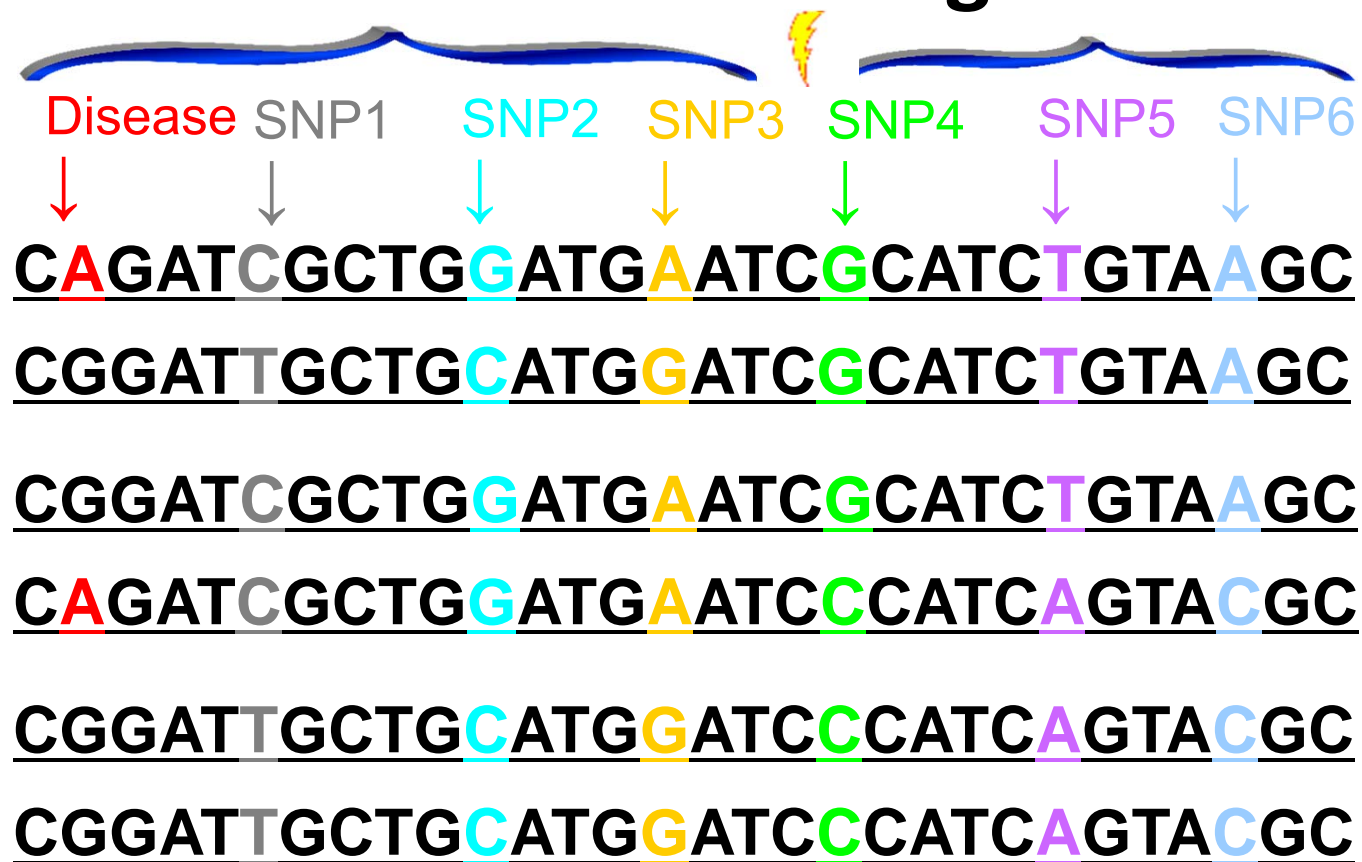


What are the implications?

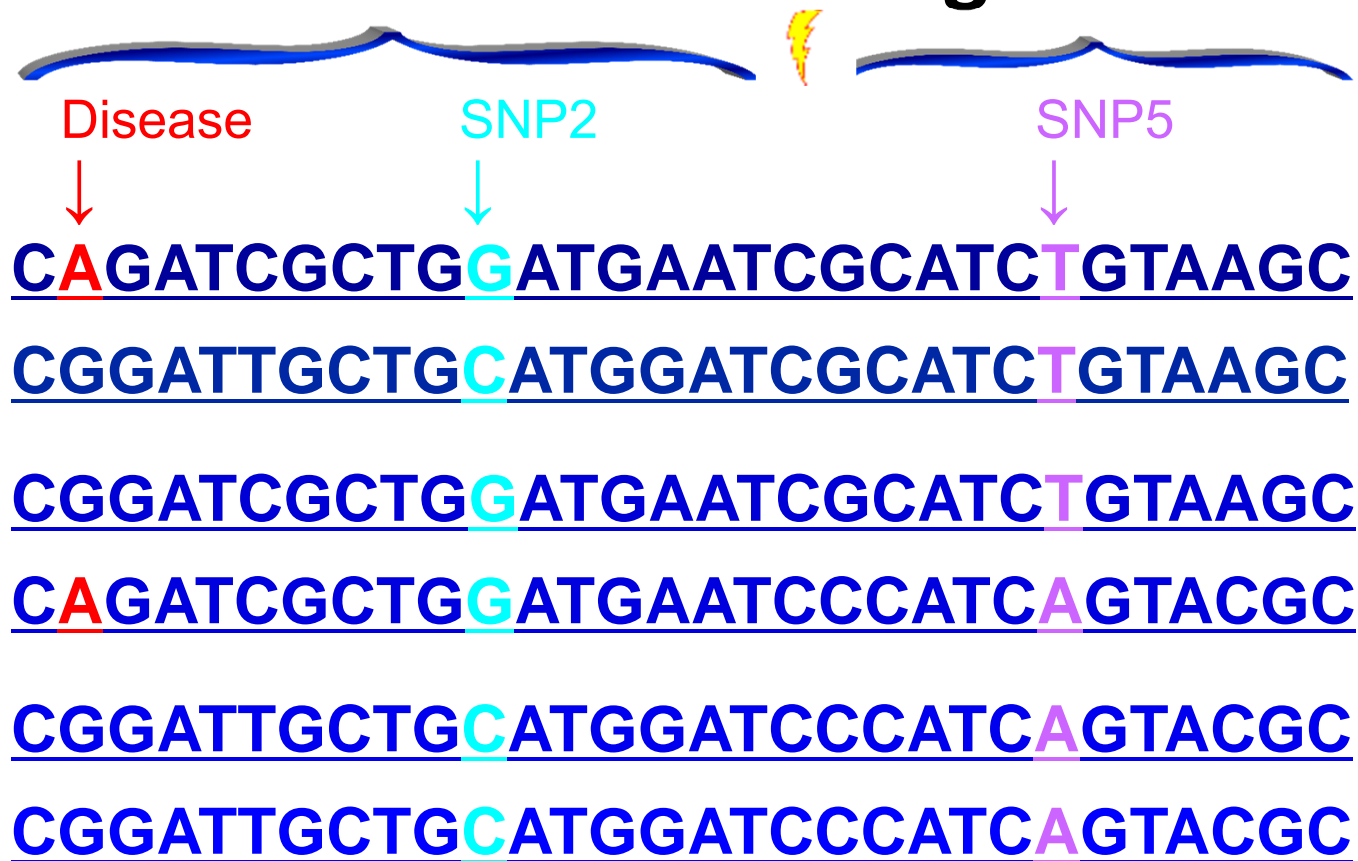
- Shuffling occurs between the “windows” every few thousand bp
- Virtually no shuffling occurs WITHIN windows
 - Said to be in “linkage disequilibrium” (LD)
- Some windows contain “disease genes”
- We can leverage these features to find disease genes!



One Marker May Rarely Recombine From Its Close Neighbors



One Marker May Rarely Recombine From Its Close Neighbors

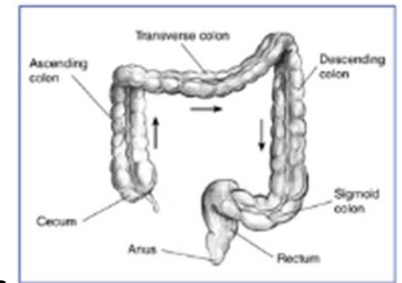




PREDICTION:

- Disease gene mapping is associating a “genotype” (marker allele at one location) with a “phenotype” (disease)
- **If a marker is very close to the disease-causing gene, individuals having one allele will be more likely to have the disease than individuals having the other allele**
 - The marker is in “LD” with the disease gene
- Does this mean the marker gene or SNP causes the disease?

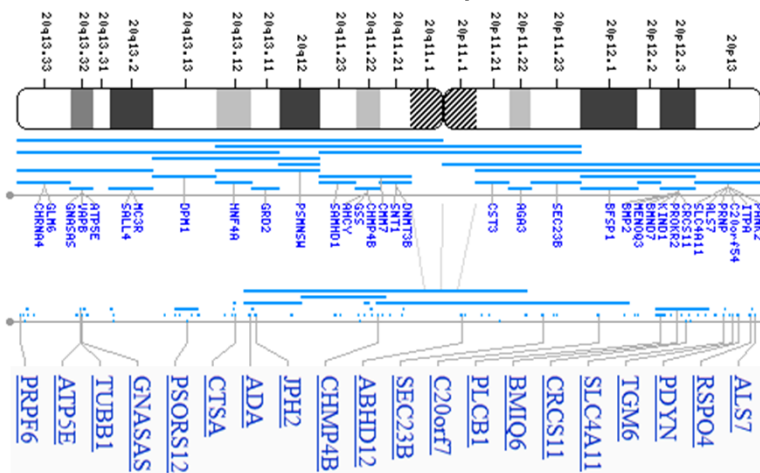
Example



- Sample the population for alleles at 2 markers and for incidence of irritable bowel syndrome (IBS)
 - For simplicity, let's ignore heterozygotes
- SNP 1:
 - AA- 100 individuals, 20 w/ IBS
 - aa- 200 individuals, 40 w/ IBS
- SNP 2:
 - BB- 50 individuals, 45 w/ IBS
 - bb- 250 individuals, 15 w/ IBS

but the genome is so big...

- ~3 billion bases in the genome
- If there's a hotspot every ~3000bp, how many markers would you need to study to find disease genes?
 - About how many “windows” are there?



Technology helps!

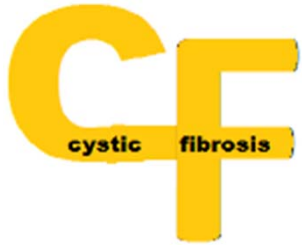
- Not a problem! We have “microarray chips” that can tell us genotypes at >1 million markers at once from spit!
- Companies will do this for you at low cost, and tell you susceptibility to many mapped diseases!





Example for you to try

- Sampled 1000 people: 950 healthy; 50 w/ CF
- Marker1: **AA**- 600 people, 28 w/ CF
 aa- 400 people, 22 w/ CF
- Marker2: **BB**- 750 people, 39 w/ CF
 bb- 250 people, 11 w/ CF
- Marker3: **CC**- 100 people, 45 w/ CF
 cc- 900 people, 5 w/ CF
- Marker4: **DD**- 800 people, 42 w/ CF
 dd- 200 people, 8 w/ CF



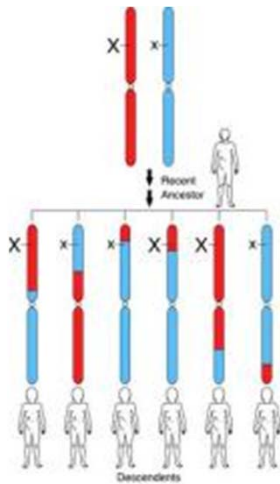
So...

- CC genotype at Marker 3 causes CF, right?
- Why do some people with “cc” still have CF?
 - **MANY answers** (remember title of italicized word in video title)

Distinctions between association mapping and cross/ pedigree mapping

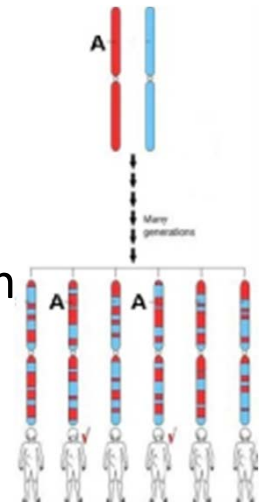
Cross

Maps in known families
Resolution ~2 million bp
1 gen of recombination
Works even if mutation rare



Population

Maps across population
Resolution ~3000bp
MANY gen of recombination
Fails when mutation rare



For reference, two sides of hotspot probably are <0.01cM apart.

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