Supplementary Information B

Intermarker linkage disequilibrium

Figure B1 Three blocks of LD in the *CD28-CTLA4-ICOS* region. Pair-wise LD values of $D' > 0.8$ are shaded. The physical distance between the genes is not to scale. Breaks in LD, or hot spots of recombination, are denoted by arrows, and the marker loci indicated at these breakpoints (CTAF305 and CTBC053).

D' values were calculated for 108 SNPs in all two-SNP combinations using the 652 controls. In contrast to the very strong LD (average $D' = 0.84$, indicating low levels of historical recombination) between markers in the *CTLA4* block LD was much lower across the hot spots (average $D' = 0.29$). Alleles of SNPs are more likely to be in LD with alleles of other SNPs if they are close to each other on the chromosome, in the order of 100 kb or less, and the base changes occurred at a similar time in history. Association of alleles on particular chromosomes or haplotypes is eroded by homologous recombination at meiosis between chromosomes carrying different alleles. The pattern of recombination is not uniform along chromosomes and tends to be concentrated in hot spots such that two SNPs flanking a hot spot, one a causal variant, could be next to each other but show very little LD. These recombination hot

spots can create breaks in the pattern of LD. It is, therefore, informative in a systematic approach to association mapping of a causal variant, to analyse the pattern of intermarker LD across the region under analysis.

Detailed description of logistic regression analyses.

1. Graves' disease

The 108 SNPs genotyped in 384 GD cases and 652 controls were analysed using logistic regression¹ (Table B7). CT60 was the most associated marker $P = 1.6 \times 10^{-6}$ (Table B1). The plot of marker disease association, taken as the *P* value of the odds ratio, against sequence position (Fig. B2) showed there were three main peaks of association. Markers were first tested using a model that assumed no particular mode of inheritance then, using a multiplicative model. The adequacy of the model was assessed with a likelihood ratio test. For all loci except the $(AT)_n$ -3'UTR the multiplicative model could be used.

The next step was to try to distinguish between the three disease association peaks in terms of which one might harbour the causal variant. Therefore, we chose the most disease-associated SNP from each peak to see if it could explain the association at the other two peaks. This was done with logistic regression in the following way². Consider two loci A and B. To distinguish the effects of A and B we address the question: does locus B add to a model with locus A, or are the effects of locus B explained by locus A? The null hypothesis is, locus A is sufficient to model the data. No specific mode of inheritance is assumed for locus A, so genotype risks of a/A and A/A are modelled relative to the a/a genotype. A one degree-of-freedom trend test is used for locus B, which assumes a multiplicative model for the effects of the individual alleles at locus B.

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Table B1: Association of key *CTLA4* SNPs in 384 Graves' disease cases and 672 controls. Odds ratios are calculated from the coefficients of the regression equation¹, and *P*-values are for the null hypothesis of no association of the marker. The typing of the CT60 SNP in 210 GD families helped confirm the validity of the disease association: the G allele was transmitted at 59.4% to affected offspring $(P = 0.023)$ and 45.7% to unaffected offspring $(P = 0.35)$.

MH30 was put in the regression model as the best marker for the 5' *CTLA4* peak, and all other markers added to see if a second locus could improve the model. Thirteen SNPs of the 107 tested improved the model (CTAF343, CTAF450_1, CT41, CT57, CT60, JO31, JO30, JO27_1, JO23, JO6_2, JO6_1, JC068sFa, JC068sRb with *P* = 0.049, 0.024, 0.034, 0.025, 0.012, 0.036, 0.040, 0.022, 0.047, 0.016, 0.042, 0.024, 0.042 respectively). A model using CT60, the best marker from the second peak, was

improved by adding any one of eight markers (MH18, CT41, CT57, $(AT)_n$ -3'UTR, JO23, JO10, JO6_2, JC068sFa with *P* = 0.038, 0.006, 0.010, 0.004, 0.039, 0.040, 0.010 and 0.033 respectively, see Fig. B3). Ten markers improved a model with CTBC217_1, the best marker from the third peak (CTAF343, rs1863800, MH30, CT57, CT60, JO31, JO30, JO27_1, JO6_1, JC068sFa with *P* = 0.008, 0.021, 0.036, 0.018, 0.001, 0.002, 0.004, 0.006, 0.035 and 0.022 respectively). All improvements to the models were at modest levels of significance given that 107 markers were tested, although the *P*-values were smaller for the CTBC217_1 peak analysis suggesting that it was unlikely to contain the disease variant.

Next, we tested a regression model taking each one of 107 loci in turn and adding the test locus to it. There were thirteen markers that MH30 did not improve (CTAF343, rs1863800, CTAF439_2, MH26, CT60, JO31, JO30, JO27_1, JO8_2, CTBC190, CTBC182_1, CTBC165_3, CTBC165_2). Marker CT60 added significantly to all markers except JO30, JO31 and JO27 1 (Fig. B4). In contrast, CTBC217 1 did not improve a model with any one of 31 markers in it (CTAF322, CTAF343, CTAF371_1, rs1863800, CTAF422, CTAF434_2, CTAF439_1, CTAF439_2, CTAF450_1, CTAF450_4, MH30, MH26, MH18, CT60, JO37_2, JO35, JO34, JO31, JO30, JO27_1, JO18, JO13, JO8_2, JO6_1, JO3, CTBC190, CTBC182_2, CTBC182_1, CTBC165_3, CTBC165_2, CTBC165_1). Therefore, taking the first stage regression results together with these results, the CTBC217_1 peak is unlikely to harbour the causal variant, and the association is probably due to LD with the causal variant residing in either of the other two peaks of association.

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Analysis of the MH30:CT60:CTBC217_1 haplotype also showed that CTBC217_1, and its neighbouring markers in the third peak, are not having an additional effect. Three loci haplotypes were generated for cases and controls, imputing phase from the *a posteriori* distribution using a stochastic version of the EM algorithm. Estimates of odds ratios with confidence intervals were calculated by the multiple imputation method³. The three most common MH30:CT60:CTBC217_1 haplotypes were G:G:T, 53% in cases and 44% controls, C:A:C, 35% in cases and 44% in controls and G:G:C, 10% in cases and 8% in controls. Using C:A:C as reference, the G:G:T haplotype has OR = 1.53 with 95% CI [1.26-1.87]. Similarly the G:G:C haplotype has OR = 1.48 with 95% CI [1.06-2.07]. The G:G:C and G:G:T haplotypes have very similar odds ratios and 95% CIs despite the change of allele at CTBC217_1, thus implying neither CTBC217 1 nor any of the markers from peak 3 in strong LD with it, are a primary disease determinant.

Statistical results for the region's previously known markers, –319C>T/CT44, $+49G>A/CT42$, $+1,822T>C/CT55$ and $(AT)_n-3$ ['] UTR are given in Table B2. Despite +49G>A/CT42 and +1,822T>C/CT55 having significant *P*-values in a single locus analysis, the two loci analyses with MH30, CT60 or BC217_1 excluded all three SNPs. None of the markers added to a model with MH30 in, whereas MH30 improved a model with any one of these three SNPs in. Similar results were seen with the best markers from the other two peaks, CT60 and BC217_1. Coding the $(AT)_{n}$ -3' UTR as a biallelic marker with the most common allele, allele 1, versus the remaining alleles, the $(AT)_n - 3' UTR$ was analysed as a single locus and within a two locus model. A model assuming no particular mode of inheritance was required. The $(AT)_{n}$ -3' UTR did not improve a model with MH30 in whereas MH30 did improve a model

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with $(AT)_{n-3}$ ² UTR in, $P = 0.0078$. However the $(AT)_{n-3}$ ² UTR was one of the loci that improved a model with CT60 included, $P = 0.004$. However the $(AT)_{n-3}$ [']UTR had a very modest single locus association, $P=0.01$, and, CT60 improved a model with the $(AT)_{n-3}$ [']UTR included ($P=0.0001$). Hence, the microsatellite is unlikely to be disease causing in a major way.

After our study was completed we located a report⁴ on the association of CTLA4 with IgE production, which reported that a SNP 5' of *CTLA4* was associated with bronchial hyperreponsiveness and asthma, -1,147C $>$ T. In the same study +49G>A was associated with total serum IgE levels. We believe that these authors' – 1,147C>T SNP corresponds to a SNP we assigned as CT54. In our current study we do not report the genotyping results for CT54 (–1,478G>A) because the results for the locus in the GD case control study showed some evidence of irregular LD patterns and also the SNP is the centre of a the common LINE repeat. This marker was therefore removed from the study. Nevertheless, with the data we have (not shown) CT54 was not associated with GD ($P = 0.51$, odds ratio = 1.09). Also, CT54 was in strong LD with CT61 (r^2 = 0.9) and CT61 is not associated with GD either (Table B7).

Table B2: Exclusion of the four previously known markers in Graves' disease. The $(AT)_n$ -3' UTR has been coded as a biallelic marker, the most common allele, allele 1 versus the remaining 25. The most common allele of $(AT)_n$ -3'UTR was the lowest size allele. Odds ratios are from the coefficients of the regression equation 1 and *P*values are for the null hypothesis of no association. Two-locus *P*-values are for the null hypothesis of the second locus not having an additional effect to the first.

The eight SNPs typed in the larger GD dataset, 672 cases and 844 controls, were analysed with logistic regression (Table B3). Two loci from the 5' *CTLA4* peak, MH30 and $rs1863800$ had $P \sim 10^{-6}$, whereas four loci, CT60, JO31, JO30, JO27_1 from the second peak all had $P \sim 10^{-7}$ (Table B1). The two-locus approach described above, was used to try to distinguish these two peaks. Choosing MH30 as the best locus from the 5' peak, four markers improved the model, CT60, JO31, JO30, JO27_1 with $P = 0.006, 0.003, 0.008$ and 0.006 respectively. CT60 was chosen as the best locus from the second peak and no additional loci were required to model the data. Equally, each of JO30, JO31 or JO27_1 was sufficient to model the data without additional loci and explain the association of the region in this sample. Finally, we added the test locus to each of the remaining seven loci. MH30 did not improve a model with any one of rs1863800, CT60, JO31, JO30 or JO27_1 included.

Conversely, CT60 did not improve a model with JO31, JO30 or JO27_1 included. We can conclude that +49G>A, rs1863800, MH30 and CTAF343 are less likely to be the casual variants in GD than the markers under the CT60 peak. Note however our data is limited by sample size. Rejection of MH30 is due to the lower and higher risks associated with two *rare* haplotypes, G:A:A and G:A:C (Table B4).

Table B3: Association of *CTLA4* SNPs in Graves' disease (672 cases and 844 controls). Odds ratios were calculated from the coefficients of the regression equation¹, and *P*-values are for the null hypothesis of no association of the marker.

Marker/	Case	Control	Odds	95%	P value
allele	chromosomes	chromosomes	ratio	confidence	
	(%)	(%)		interval	
CTAF343/C	80.5	74.3	1.44	$1.20 - 1.72$	0.00007
rs1863800/C	64.9	56.0	1.45	$1.24 - 1.68$ 1.19 x 10 ⁻⁶	
MH30/G	64.9	56.0	1.45	$1.25 - 1.68$ 1.02×10^{-6}	
$+49/G$	44.0	37.1	1.34	$1.16 - 1.56$	0.0001
CT60/G	63.4	53.2	1.51	1.31 - 1.75 2.72 x 10^{-8}	
JO31/G	61.0	50.9	1.49	1.29 - 1.73 8.35 x 10^{-8}	
JO30/G	61.2	51.2	1.49	1.29 - 1.73 7.26 x 10^{-8}	
$JO27$ 1/T	58.7	49.6	1.46	$1.25 - 1.69$ 9.47 x 10^{-7}	

Previously, authors speculated that $+49G>A$ or the $(AT)_n-3'$ UTR might be the GD etiological variant, but our regression analyses indicated that they are not. This is illustrated by analysis of haplotypes across the LD block. The distribution of the MH30:+49G>A:CT60 haplotype in cases and controls, shows there are only three common haplotypes, C:A:A, G:G:G and G:A:G (Table B4). The C:G:G and C:A:G haplotypes differ at $+49G>A$, yet they have the same positive risk compared to the protective T:A:A haplotype thus indicating +49G>A is not having an additional

effect. MH30 and CT60 were then assessed for haplotype specific effects using logistic regression. A model that included both CT60 and MH30 genotypes was compared to a model in which CT60 and MH30 had phased genotypes, to see if phase information improved the model. No haplotype specific effects were found.

Table B4: Odds ratios of MH30:+49G>A:CT60 3-marker haplotypes in Graves' disease (672 cases and 844 controls).

Finally the mode of inheritance of CT60 was evaluated with a logistic regression approach. For a full dominance effect to be observed, the risk of the A/G genotype would be approximately equal to the G/G genotype risk. (These risks would have a value greater than one when A/A is taken as reference.) The dominance hypothesis was formally tested with a χ^2 test. In both the initial GD dataset of 652 controls $(P=0.0024)$ and, the extended GD dataset of 844 controls $(P=0.0013)$ the mode of inheritance of CT60 did not fit a full dominant or recessive model, and was not inconsistent with a multiplicative model.

2. Type 1 diabetes

The ten SNPs typed in 3,671 T1D families were analysed using the same general strategy as for the GD data sets. However, since these studies are family-based, we generated "pseudo-controls" by conditioning upon parental genotype and considering the possible genotypes that could have been passed to offspring. This facilitated the use of conditional logistic regression but robust variance estimates were necessary to allow for non-independence of sibs. These methods are described in detail elsewhere². Single locus results are given in Table 1 of the main text, *P* values and percentage transmissions under the TDT are also given for comparison. Again there were two peaks of association. MH30 was the best marker from the 5' *CTLA4* peak and JO30 the best marker from the second peak both with $P \sim 10^{-6}$. The *ICOS* SNP, CTIC154_1, was not associated. Neither was another SNP, JC068sFa, 11.8 kb 3' of *ICOS* in 1,999 T1D families (*P* = 0.97).

Again two-locus regression analysis clearly rejected +49G>A as the causal SNP and suggested that CTAF343 and JO31 were also unlikely to be involved. A model with +49G>A was improved by MH30 and CT60, $P = 0.0002$ and 0.0002 respectively, but +49G>A did not improve models with either MH30 or CT60 included. Choosing MH30 as the best SNP from the 5' *CTLA4* peak, each of the other loci were added to see if they improved the model. No loci improved the model. Similarly no loci improve a model with CT60 included. Conversely, adding MH30 to each locus in turn, improves models with CTAF343, +49G>A and JO31 included, *P*=0.0101, 0.0018 and 0.0112, respectively. CT60 also improves models with CTAF343, +49G>A and JO31 included, *P*=0.0052, 0.0016 and 0.0126, respectively.

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The JO31 result was unexpected because JO31 was not excluded in the GD study. A case pseudo-control analysis of the T1D family data, by individual population provided an explanation. A rare CT60:JO31 haplotype, G:T, at about 2% frequency in the UK population showed no association with disease in UK T1D families, or in the UK GD case-control dataset. However, in all the non-UK populations, from Finland, Norway, Romania and the USA, there was an increased frequency of this haplotype in cases compared to pseudo-controls (Table B5). Since the T allele of JO31 is associated with low disease risk, the positive disease association of the CT60*G:JO31*T haplotype in the non-UK sets would have led to its exclusion in the regression analysis. Nevertheless, this result requires replication. Very large samples are needed because evidence for or against a marker being the causal variant comes from rare haplotypes. An additional informative approach may be to search for populations with different frequencies of these haplotypes.

Table B6: Association of *CTLA4* SNPs by population in T1D families. The relative risks (RR) are calculated from the coefficients of the regression equation¹, and the Pvalues are for the null hypothesis of no association of the SNP.

By considering the appropriate "interaction" terms in the regression, we found that genotype associations were consistent over populations. Table B6 gives the genotype associations by population. Like in the combined dataset neither +49G>A or CTIC154_1 are associated in any individual population. MH30 is associated in all populations except the UK, while CT60 is associated in just the Finnish and USA populations. However all 95% confidence intervals of the relative risks overlap for each locus across populations including the combined dataset.

Finally, the MH30:CT60 haplotype was analysed for haplotype-specific effects in addition to the MH30 and CT60 genotypes. There was evidence for haplotypespecific effects $(P = 0.003)$ but this was based on two rare haplotypes. The two largest populations in the study, the UK and the Finnish datasets, were analysed separately for haplotype specific effects. Phase was only important in the UK dataset $(P=0.001)$ and not the Finnish, *P*=0.5499. The fact that this haplotype-specific effect was only seen in the UK dataset and arises from two rare haplotypes requires verification in

even larger data sets. Rare haplotypes may possibly exist with different functional CTLA-4 gene variants.

A single causative common disease SNP is the most likely explanation for the association of the region with GD. However, the T1D CTLA-4 gene effect was significantly weaker ($OR \sim 1.2$) than in GD ($OR \sim 1.5$). Thus, to detect the effect at least four times more subjects would be required in T1D than in GD. This is one possible reason why the 5' and 3' peaks of association flanking *CTLA4* could not be distinguished in T1D. Alternatively, there could be more than one SNP involved in T1D, or the T1D causal SNP is in the 5' *CTLA4* peak and not in the 3' *CTLA4* CT60 peak. However, the results of the expression analyses presented, do not support a major functional role for the 5' SNPs in modulating CTLA-4 gene transcription.

For reference we provide allele frequencies, odds ratios with 95% confidence intervals, and *P* values for all 108 SNPs typed in the Graves' case-control study (Table B7).

Table B7: Association of 108 SNPs and the $(AT)_{n}$ -3'UTR in 384 Graves' disease cases and 652 controls. Their positions in our database are also given. Odds ratios are calculated from the coefficients of the regression equation 1 , and *P*-values are for the null hypothesis of no association of the marker.

3 rs1181390 *P***=0.70**

6 rs1863800 *P***=0.72**

Position: 91798

7 rs1181425V *P***=0.36**

8 rs1181426V *P***=0.24**

10 CTAF212 *P***=0.27**

11 CTAF305 *P***=0.21**

12 CTAF322 *P***=0.0020**

13 CTAF343 *P***=2.5e-05**

14 CTAF371_1 *P***=0.00019**

15 rs1863800 *P***=4.5e-05**

16 CTAF422 *P***=0.00072**

17 CTAF434_2 *P***=0.00030**

18 CTAF439_1 *P***=0.00030**

Position: 177655 **Alleles Case % Control % Odds ratio 95%CI** C | 311 \mid 40.9 629 49.1 1.40 | 1.16 | 1.68 T | 449 59.1 651 50.9

19 CTAF439_2 *P***=0.00023**

20 CTAF450_1 *P***=0.00027**

Position: 178883

21 CTAF450_2 *P***=0.043**

22 CTAF450_3 *P***=0.42**

Position: 178987 **Alleles Case % Control % Odds ratio 95%CI** A 627 84.5 1092 85.8 1.11 0.86 1.42 G $|$ 115 15.5 180 14.2

23 CTAF450_4 *P***=0.00010**

24 MH30 *P***=2.5e-05**

28 MH18 *P***=0.00028 Position:** 191345 **Alleles Case % Control % Odds ratio 95%CI** T 488 64.0 699 55.9 1.41 1.17 1.71

29 MH17 *P***=0.0058**

31 MH14 *P***=0.45**

32 MH13_2 *P***=0.0083**

34 MH3 *P***=0.023**

35 MH2 *P***=0.012**

36 MH1 *P***=0.011**

37 CT50 (-1765T>C) *P***=0.0083**

Position: 201114

38 CT51 (-1722T>C) *P***=0.50**

39 CT52 (-1661A>G) *P***=0.085**

Position: 201218

40 CT53 (-1577G>A) *P***=0.0037**

Position: 201302

41 CT41 (-658C>T) *P***=0.48**

Position: 202221

42 CT44 (-319C>T) *P***=0.27**

43 +49G>A *P***=0.0021**

44 CT43 (923C>T) *P***=0.16**

45 CT55 (1822T>C) *P***=0.00063**

46 CT57 *P***=0.081 Position:** 207073 **Alleles Case % Control % Odds ratio 95%CI** C | 763 99.3 1281 98.5 2.28 0.85 6.16 A $5 = 0.7$ 19 1.5

48 (AT)n-3' UTR *P***=0.25 (1df)**

Position: 208256 - 208295

49 CT60 (6230G>A) *P***=1.6e-06**

50 CT61 (6249G>A) *P***=0.14**

51 JO37_3 *P***=0.00097**

52 JO37_2 *P***=0.00074**

56 JO34 *P***=0.00012**

58 JO30 *P***=1.9e-06**

59 JO27_2 *P***=0.22**

61 JO26_2 *P***=0.34**

62 JO26_1 *P***=0.22**

63 JO23 *P***=0.76**

65 JO18 *P***=0.00072**

68 JO9 *P***=0.74**

69 JO8_2 *P***=0.00029**

70 JO8_1 *P***=0.55**

72 JO6_1 *P***=0.00016**

- **74 CTBC358** *P***=0.0017 Position:** 243864 **Alleles Case % Control % Odds ratio 95%CI** T 167 22.3 370 28.5 1.40 1.13 1.73 G 583 77.7 926 71.5
	- **75 CTBC313** *P***=0.32**

76 CTBC305 *P***=0.010**

77 CTBC217_2 *P***=0.0021**

78 CTBC217_1 *P***=0.00023**

79 CTBC190 *P***=0.00043**

80 CTBC182_2 *P***=0.00042**

81 CTBC182_1 *P***=0.00023**

82 CTBC165_3 *P***=0.00050**

83 CTBC165_2 *P***=0.00027**

84 CTBC165_1 *P***=0.00033**

86 CTBC099 *P***=0.0085**

87 CTBC078 *P***=0.21**

89 CTBC053 *P***=0.0012**

90 CTIC065 *P***=0.27**

91 IC082R *P***=0.50**

93 CTIC114_1 *P***=0.098**

94 CTIC114_2 *P***=0.55**

95 CTIC114_3 *P***=0.93**

96 CTIC142_1 *P***=0.71**

Position: 294465

97 CTIC142_2 *P***=0.72**

98 CTIC142_3 *P***=0.096**

100 CTIC154_1 *P***=0.12**

101 CTIC154_2 *P***=0.26**

102 CTIC154_3 *P***=0.73**

103 CTIC159 *P***=0.49**

105 JC058sR *P***=0.30**

107 JC068sRb *P***=0.042**

A | 475 62.0 762 60.6

Names in parentheses of SNPs used by Johnson *et al*. (*Nature Genet* **29,** 233-237 (2001))

References

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