

**Switch in FGFR 3 and 4 expression profile during human renal development may account for transient hypercalcemia in patients with Sotos syndrome due to 5q35 microdeletions.**

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1 **SWITCH IN FGFR 3 AND 4 EXPRESSION PROFILE DURING HUMAN RENAL DEVELOPMENT MAY**  
2 **ACCOUNT FOR TRANSIENT HYPERCALCEMIA IN PATIENTS WITH SOTOS SYNDROME DUE TO 5q35**  
3 **MICRODELETIONS**

4

5 Running title: Ontogeny of FGFR 3 and 4 in human kidney

6

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29 **ABSTRACT**

30 **CONTEXT:** Sotos syndrome is a rare genetic disorder with a distinct phenotypic spectrum including  
31 overgrowth and learning difficulties. Here we describe a new case of Sotos syndrome with a 5q35  
32 microdeletion, affecting the fibroblast growth factor receptor 4 (*FGFR4*) gene, presenting with  
33 infantile hypercalcemia.

34 **OBJECTIVE:** We strived to elucidate the evanescent nature of the observed hypercalcemia by studying  
35 the ontogenesis of *FGFR3* and *FGFR4* – which are both associated with FGF23-mediated mineral  
36 homeostasis – in the developing human kidney.

37 **DESIGN:** RT-qPCR and immunohistochemical analyses were used on archival human kidney samples  
38 to investigate expression of the *FGFR* signaling pathway during renal development.

39 **RESULTS:** We demonstrated that renal gene and protein expression of both *FGFRs* increased during  
40 fetal development between the gestational ages (GA) of 14-40 weeks. Yet, *FGFR4* expression  
41 increased more rapidly as compared to *FGFR3* (slope: 0.047 vs. 0.0075,  $p = 0.0018$ ). Moreover, gene  
42 and protein expression of the essential *FGFR* co-receptor, *Klotho*, also increased with a significant  
43 positive correlation between *FGFR* and *Klotho* mRNA expression during renal development.  
44 Interestingly, we found that perinatal *FGFR4* expression (GA 38-40 weeks) was 7-fold higher as  
45 compared to *FGFR3* ( $p=0.0035$ ), while in adult kidney tissues, *FGFR4* gene expression level was  
46 more than 2-fold lower compared to *FGFR3* ( $p=0.0029$ ), thus identifying a molecular developmental  
47 switch of *FGFR* isoforms.

48 **CONCLUSION:** We propose that the heterozygous *FGFR4* deletion, as observed in the Sotos syndrome  
49 patient, leads to a compromised FGF23 signaling during infancy accounting for transient  
50 hypercalcemia. These findings represent a novel and intriguing view on FGF23-mediated calcium  
51 homeostasis.

52

## 53 INTRODUCTION

54 Sotos syndrome is an autosomal dominant disorder characterized by overgrowth, learning disability  
55 and distinctive facial features such as macrocephaly [1,2]. The syndrome results from mutations and  
56 deletions – mostly *de novo* – of the *NSD1* gene located at chromosome 5, which encodes for the  
57 nuclear receptor-binding SET-domain containing protein 1 (NSD1). Little is known regarding the  
58 function of NSD1 and it remains unclear how *NSD1* gene inactivation or NSD1 dysfunction may  
59 cause the Sotos phenotype [3]. Intragenic mutations are responsible for 80-85% of Sotos syndrome  
60 cases, while 5q35 microdeletions encompassing *NSD1* cause 10-15% of the cases in Europe and the  
61 USA [4]. Of note, 5q35 microdeletions vary in size, from 0.4 to 5 Mb, and may affect genes flanking  
62 *NSD1* [5]. Saugier-veber *et al.* mentioned the occurrence of nephrocalcinosis in three patients with  
63 large deletions and suggested the presence of a predisposing gene in the deleted area [6]. This  
64 phenotype spectrum was confirmed by Kenny *et al.* who reported two unrelated cases of Sotos  
65 syndrome associated with nephrocalcinosis, one of whom had proven infantile hypercalcemia [7]. The  
66 authors suggested that the heterozygous deletion of *SLC34A1* – encoding the main sodium phosphate  
67 cotransporter NPT2a – could explain the temporary hypercalcemia in these patients. However,  
68 hypercalcemia was absent in patients with a loss of function of NTP2a, as described by Magen *et al.*  
69 [8], in contrast to *Npt2<sup>-/-</sup>* mice that exhibited a slight but significant increase in serum calcium  
70 concentration compared to wild type mice [9]. Thus, the transient nature of the hypercalcemia remains  
71 unexplained in Sotos syndrome patients.

72 Another gene mapped to the deletion interval is *FGFR4*, encoding for the fibroblast growth factor  
73 receptor (FGFR) 4. The fibroblast growth factors (FGFs) are a large family of peptides that are  
74 involved in a myriad of biological processes, including development and mineral homeostasis [10].  
75 Currently, seven FGF subfamilies have been identified encompassing 22 different FGFs. The FGF19  
76 subfamily – containing FGF19, FGF21 and FGF23 – plays a key role in regulating energy and mineral  
77 metabolism [10]. Of interest, FGF23 is of the utmost importance in maintaining vitamin D, phosphate  
78 and calcium levels [11]. FGF23 is a ligand for several FGFRs (*e.g.* FGFR1, FGFR3 and FGFR4) and  
79 it has been demonstrated that Klotho forms a complex with these receptors resulting in an increased  
80 affinity selectively to FGF23 [10,12]. FGFR1 is implicated in FGF23 effects on NaPi-2a and NaPi-2c

81 cotransporters [13], whereas FGFR3 and FGFR4 are linked to FGF23 effects on vitamin D and  
82 calcium levels [14]. Thus, there is a clear link between FGFR4-mediated FGF23 signaling and calcium  
83 homeostasis. Here, we describe a new Sotos syndrome case, due to a 5q35 microdeletion, with  
84 infantile hypercalcemia and we hypothesized that a heterozygous mutation in *FGFR4* might be a  
85 possible explanation for the observed elevated calcium levels. To unravel the temporary characteristics  
86 of the perceived hypercalcemia, we studied FGFR3 and FGFR4 ontogenesis in the human developing  
87 kidney that has never reported to date.

88

89 **MATERIALS AND METHODS**

90

91 *Ethics statement*

92 Fetal samples were collected after parental informed and written consent and after declaration to the  
93 French Biomedical Agency (Decree 003812, 09/22/2006). Archival formol-fixed paraffin-embedded  
94 fetal and neonatal kidneys were selected from the collections of several departments of pathology  
95 according to the French legislation. Parental informed and written consents had been obtained at the  
96 time of tissue collection and were conserved in each department. Experimental use of these samples  
97 has been declared to the French Biomedical Agency (Decree 003812, 09/22/2006).

98

99 *Human renal samples*

100 Snap-frozen kidney samples from 18 fetuses, with a gestational age of 14–40 weeks, obtained from the  
101 Fetopathology Department of Robert-Debré University Hospital (Paris, France), were used for qPCR.  
102 For histology, a selection was made from thirty-seven archival tissue sections previously checked for  
103 quality and integrity by immunostaining with vimentin and low molecular weight cytokeratin [15].

104

105 *Quantitative PCR*

106 To study gene expression, total RNA (1 µg) was reverse-transcribed using 50 U MultiScribe Reverse  
107 Transcriptase (Life Technologies, Saint Aubin, France). Subsequently, cDNA was used for  
108 quantitative PCR performed with a StepOnePlus Real-Time PCR system using the TaqMan Universal  
109 PCR Master Mix (Life Technologies). GAPDH was used as housekeeping gene, and relative mRNA  
110 expression levels were calculated using the equation:  $(2^{-\Delta CT}) * 100$ , or as fold change using the  $2^{-\Delta\Delta CT}$   
111 method. The following primer-probe sets were used: FGFR3, Hs00179829\_m1; FGFR4,  
112 Hs01106908\_m1; GAPDH, Hs99999905\_m1; Klotho, Hs00183100\_m1 (all obtained from Life  
113 Technologies).

114

115 *Immunohistochemistry*

116 Five-micrometer-thick tissue sections were deparaffinized and rehydrated in successive baths of  
117 xylene and graded alcohols. Afterwards, the slides were heated in sodium citrate buffer (pH 6) at  
118 100 °C for 15 min. Endogenous peroxidase was blocked with 3 % (v/v) H<sub>2</sub>O<sub>2</sub> for 30 min. Next, non-  
119 specific epitopes were blocked for 30 min at RT with 1% (w/v) bovine serum albumin in PBS  
120 containing 0.1% (v/v) Tween-20. Subsequently, the slides were incubated overnight at 4°C with  
121 rabbit- $\alpha$ -FGFR3 (1:1000; ab137084; Abcam, Cambridge, UK), rabbit- $\alpha$ -FGFR4 (1:500; ab41948;  
122 Abcam) or rabbit monoclonal- $\alpha$ -Klotho antibody (1:100; ab181373; Abcam) in blocking buffer. To  
123 reveal bound Ig, slides were incubated for 30 min at RT with the ImmPRESS anti-rabbit Ig kit  
124 (Vector, Peterborough, UK), and liquid DAB plus chromogene (Dako, Glostrup, Denmark) was used  
125 for visualization. Slides were counterstained with Mayer's hematoxylin and mounted using Glycergel  
126 (Dako). Sections were studied via bright field microscopy (Olympus BX61) and images were taken by  
127 means of a Retiga-2000R Fast 1394 digital camera (QImaging, Surrey, Canada).

128

#### 129 *Statistics*

130 Statistics were performed using GraphPad Prism 6.03 *via* one-way analysis of variance (ANOVA)  
131 followed by Bonferroni's Multiple Comparison Test or an unpaired Student's *t*-test. Differences  
132 between groups were considered to be statistically significant when  $p < 0.05$ . The software was also  
133 used to perform linear regression analyses and correlation analyses (Pearson and Spearman).

134

135 **RESULTS**

136 *Case report of a new Sotos syndrome patient with 5q35 microdeletion and infantile hypercalcemia*

137 G was the fourth child of non-consanguineous parents. His birth weight was 3580 g after 39 weeks of  
138 uncomplicated pregnancy. A short period of artificial ventilation was required after birth due to  
139 respiratory distress. Because of dysmorphic features, Comparative Genomic Hybridization (CGH)  
140 array was performed, which revealed a microdeletion at 5q35, including both *NSDI* and *FGFR4*, as  
141 shown in Fig. 1A. The deletion was absent in both parents, suggesting that it occurred *de novo*. In  
142 addition, hypercalcemia was observed during the first two weeks of life, as presented in Fig. 1B, and  
143 normalized afterwards. In the first weeks following birth from day 8-18, serum phosphate levels were  
144 slightly reduced ranging from 1.22-2.54 mmol/L with a median value of 1.92 (n=8) (reference range:  
145 1.74-2.66 mmol/L) and returned to normal concentrations afterwards. The maximum phosphate  
146 reabsorption rate was decreased, possibly due to the heterozygous deletion of solute carrier family 34  
147 (type II sodium/phosphate cotransporter), member 1 gene (*SLC34A1*) also lost with the deletion (Fig.  
148 1A) [16]. During the first 4 days, the child received intravenous nutrition and was then switched to  
149 breastfeeding. At 4 years of age, he was more extensively investigated and it was demonstrated that  
150 serum calcium and parathyroid hormone (PTH) levels were normal, whereas 1-25  
151 dihydroxycholecalciferol (*i.e.* active vitamin D) was slightly elevated (86 ng/L, normal range: 20-80  
152 ng/L). Nephrocalcinosis was absent on ultrasound scanning. We hypothesized that the heterozygous  
153 deletion in *FGFR4* might be the possible explanation for the observed transient elevated calcium  
154 levels.

155

156 *Expression profile of FGFRs during fetal renal development*

157 To elucidate the impact of the observed *FGFR4* deletion as well as the transient infantile  
158 hypercalcemia, we studied the renal ontogenesis of FGFRs involved in calcium homeostasis. Fig. 2A  
159 demonstrates that the gene expression levels of both *FGFR3* and *FGFR4* in kidney samples  
160 significantly and positively correlate with gestational age (GA) with a calculated Pearson r of 0.63 (p  
161 = 0.0054) and 0.72 (p = 0.0008), respectively. Moreover, the expression level of both receptors  
162 steadily increases during renal development from 14 to 40 gestational weeks; yet there is a strikingly



163 greater increase in *FGFR4* gene expression as compared to *FGFR3* (slope: 0.047 vs. 0.0075,  $p =$   
164 0.0018). An analogous immunochemical pattern was observed with light microscopy, revealing a  
165 similar amount of positively stained tubules at 21 weeks of gestation, while at a GA of 40 weeks,  
166 *FGFR4* protein seems to be more abundantly present as compared to *FGFR3* (Fig. 2B). Furthermore,  
167 in the fetal kidney, *FGFR3* protein expression appears to be limited to the distal tubules, with some  
168 stainings in the glomeruli as well as the medulla (Fig. 2B). In contrast, *FGFR4* was detected in both  
169 the proximal and distal tubules (especially at 40 gestational weeks; Fig. 2B) as well as the medulla  
170 (Fig. 2B), while the receptor was absent in the glomeruli.

171

#### 172 *Correlation between FGFR and Klotho expression*

173 It has been previously reported that Klotho is an essential cofactor for FGF23 signaling [10,17]. As  
174 shown in Fig. 3A and 3B, Klotho mRNA and protein expression increases throughout renal  
175 development, with low mRNA levels in fetal kidneys, consistent with the lack of detectable Klotho  
176 protein in fetal and neonatal kidney samples, at variance with adult kidneys, in which Klotho protein is  
177 readily detected in renal distal tubules. A significant positive correlation was observed between Klotho  
178 mRNA and GA (calculated Pearson  $r = 0.80$ ,  $p < 0.0001$ ). Moreover, the expression profile of Klotho  
179 mRNA significantly correlates with both *FGFR3* ( $r = 0.6$ ,  $p = 0.008$ , Fig. 3C) and *FGFR4* ( $r = 0.77$ ,  $p$   
180  $= 0.0002$ , Fig. 3D) as demonstrated with Spearman correlation analyses, consistent with the key role  
181 of Klotho acting as a renal co-receptor for FGF23.

182

#### 183 *Switch in FGFR expression profile during post-natal development*

184 Next, we compared the *FGFR* expression profile in fetal, neonatal and adult kidney samples. As  
185 illustrated in Fig. 4A, renal *FGFR3* gene expression was extremely low in both the early and late stage  
186 of gestation, with a significant 67-fold and 23-fold lower expression of the receptor as compared to the  
187 adult level ( $p < 0.0001$ ). In contrast, renal *FGFR4* mRNA levels were only 5 times lower during early  
188 gestation as compared to the adult situation ( $p = 0.004$ ), while there was no significant difference in  
189 renal *FGFR4* expression in the late stage of development as compared to adult tissue. Interestingly,  
190 during late gestation, relative *FGFR4* expression is 7-fold higher than that of *FGFR3* ( $p = 0.0035$ , Fig.

191 4B), whereas in adults, renal *FGFR3* expression level was significantly higher than that of *FGFR4* (p  
192 = 0.0029, Fig. 4B). At the protein level, immunohistochemical studies revealed similar trend with  
193 more tubules positively stained for FGFR4 than for FGFR3 at 2 and 9 months of age. Moreover,  
194 FGFR3 and FGFR4 protein localization was similar in the neonatal kidney as compared to fetal  
195 kidney. Conversely, FGFR3 protein expression was markedly increased in the adult kidney (60 years  
196 old), and was detected in proximal and distal tubules as well as glomeruli, whereas there was a strong  
197 decline in the number of FGFR4 positive tubules (Fig. 4C). These findings indicate a major molecular  
198 switch in the respective contribution of both FGFRs in FGF23 signaling during human renal  
199 development.

200 **DISCUSSION**

201 Sotos syndrome is a rare genetic disorder characterized by overgrowth, distinct facial features and  
202 learning disabilities. The clinical features of Sotos syndrome vary between cases and seem to be  
203 independent of genotype [3]. In addition, all features observed in microdeletion cases have also been  
204 reported in individuals with intragenic mutations [3]. Still, the individuals with 5q35 microdeletions  
205 are generally more likely to present with severe learning disabilities and less pronounced overgrowth  
206 as compared to patients with intragenic mutations [18]. Furthermore, there is a nascent amount of  
207 evidence that the phenotypic spectrum also encompasses impaired calcium homeostasis during  
208 infancy.

209 Here, we report a new Sotos syndrome case, due to a 5q35 microdeletion, with evanescent  
210 hypercalcemia. Since the deletion area included *FGFR4*, we hypothesized that dysfunction of this  
211 FGF23 receptor might account for the altered calcium levels. Endocrine calcium homeostasis is an  
212 intricate system involving several regulators and feedback loops. During hypocalcemia, PTH is  
213 stimulated causing active vitamin D levels to rise, which in turn augments intestinal calcium  
214 absorption as well as renal calcium retention [10]. In response to elevated serum calcium, osteocyte-  
215 produced FGF23 is released. Binding of FGF23 to the FGFR-Klotho complex – including either  
216 FGFR3 or FGFR4 – inhibits the synthesis of active 1,25 di(OH)-vitamin D<sub>3</sub>, both directly by reducing  
217 1 $\alpha$ -hydroxylase (CYP27B1) expression and increasing expression of the vitamin D degrading enzyme,  
218 24-25 hydroxylase (CYP24) but also indirectly by decreasing PTH levels, resulting in a negative  
219 calcium balance [10,17]. Thus, changes in FGF23 signaling will directly impact calcium homeostasis.  
220 At present, both FGF23 pathway deficiency and renal FGFR ontogenesis have solely been studied in  
221 animal models and human data is lacking. Therefore, we studied the *FGFR3* and *FGFR4* expression  
222 profile in the developing human kidney.

223 Our results revealed a molecular switch in the FGFR expression profile during human renal  
224 development. These findings provide compelling evidence that heterozygous *FGFR4* inactivation in  
225 humans, as observed in a 5q35 microdeletion Sotos syndrome case, might account for an impaired  
226 FGF23 signaling pathway during early life causing transient infantile hypercalcemia. This notion is  
227 corroborated by previous animal studies. For instance, Shimada *et al.* reported that calcium levels

228 were elevated in *Fgf23*<sup>-/-</sup> mice [19], which is in accordance with the study by Yuan *et al.* [20], and an  
229 analogous discovery was made in *Klotho* deficient mice [21]. Hypercalcemia was also observed in  
230 *Fgf23* and *Klotho* double knockout mice [22]. Moreover, Haenzi *et al.* described that the loss of Memo  
231 – a recently identified FGFR regulator – was associated with increased serum calcium [23]. Of  
232 interest, the only phenotypic feature that has been reported in Sotos syndrome cases with  
233 microdeletions is nephrocalcinosis [18]. Consistent with the transient hypercalcemia observed in the  
234 described case, as well as those previously reported [7,18], it is likely that alterations of calcium  
235 homeostasis might be a distinctive feature in Sotos syndrome associated with microdeletions.  
236 Moreover, Tatton-Brown *et al.* performed a microsatellite analysis in 33 microdeletion cases and  
237 detected a deletion of *FGFR4* in 32 individuals [5], strengthening the hypothesis that a mutation in  
238 *FGFR4*, and subsequent impaired FGF23 signaling, is the culprit in infantile calcium imbalance.

239 Our study is one of the first to provide a detailed description of human renal FGFR ontogeny. Cancilla  
240 *et al.*, demonstrated that *FGFR3* and *FGFR4* gene expression could be detected in the developing rat  
241 kidney and increased during development [24]. Furthermore, at embryonic day 20, FGFR3 protein  
242 expression was present in the distal tubules, whereas immunostaining was absent in the proximal  
243 tubules. In contrast, FGFR4 immunoreactivity was present in both distal and proximal tubules [24].  
244 This expression pattern is similar to our observations. In addition, other studies have also  
245 demonstrated the expression of *FGFR4* during renal development in rat and mice [25,26], and recently  
246 it was reported in a zebrafish study that *fgf23* and *aklotho* were continuously expressed in the  
247 developing kidney [27]. Several decades ago, Partanen *et al.*, reported the expression of both *FGFR3*  
248 and *FGFR4* in human fetal kidney (GA 17-18 weeks) and they described that organ-specific *FGFR4*  
249 expression highly differs from other FGFRs [28]. In a follow-up study, they investigated the  
250 expression of FGFR4 in the developing mouse and, similar to our findings, they demonstrated that  
251 *fgfr4* gene expression in the murine embryo steadily increased during development and was hardly  
252 detectable in newborn and 2 day old mice [29]. Clearly, temporal FGFR expression is conserved  
253 among species and is subjected to change during both early renal development as well as with aging.

254 The present study has some drawbacks; first of all, calcium homeostasis is a complex system  
255 involving a myriad of negative feedback loops and multiple hormones [10], but unfortunately, during

256 the early clinical investigations serum levels of FGF23, soluble Klotho and active vitamin D have not  
257 been determined. Secondly, we could not get access to mRNA from early postnatal kidneys, limiting  
258 the latter part of our study solely to protein expression. Still, this study is the first to concisely describe  
259 postnatal serum calcium levels in an individual with Sotos syndrome, and owing to the availability of  
260 a unique and precious human kidney collection, we have been able to partially dissect and elucidate  
261 the expression profile of FGFRs during human renal development.

262

263 In conclusion, we have demonstrated the presence of transient infantile hypercalcemia in a 5q35  
264 microdeletion case of Sotos syndrome, which included a deletion of *FGFR4*. Furthermore, we found  
265 that *FGFR4* is highly expressed in fetal and neonatal kidney, whereas *FGFR3* expression is highest in  
266 adult tissue. This indicates that there is a developmental switch in the contribution of both FGFRs to  
267 FGF23 signaling during aging, which could explain the fleeting hypercalcemia. These findings  
268 provide a novel and intriguing insight in FGF23-mediated calcium homeostasis.

269

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277 renal samples. The help of Jitske Jansen is also highly appreciated.

278

279 **FIGURE LEGENDS**  
280

281 **Figure 1. New Sotos syndrome case with infantile hypercalcemia.** (A) Extent of 5q35  
282 microdeletion including both *NSD1* and *FGFR4*. (B) Dots represent the calcium level per day during  
283 the first weeks of life. Grey area depicts the normal range of total serum calcium in healthy neonates,  
284 obtained from Robertson's textbook of neonatology (4<sup>th</sup> ed., 2005, Elsevier Churchill Livingstone).

285  
286 **Figure 2. Expression of FGFRs in the human fetal kidney.** (A) *FGFR* gene expression was studied  
287 using RT-qPCR. Relative expression was calculated as  $(2^{-\Delta CT}) * 100$ . Pearson correlation analysis  
288 revealed a significant association between GA and *FGFR3* (●;  $r = 0.63$ ,  $p = 0.0054$ ) and *FGFR4* (■;  $r$   
289  $= 0.72$ ,  $p = 0.0008$ ) gene expression. (B) Immunostaining of FGFRs in the developing kidney. (C)  
290 Secondary antibody control for FGFR staining. Magnification, 20x. Arrows indicate a typical example  
291 of a glomerulus (gl), proximal tubule (pt) and distal tubule (dt).

292  
293 **Figure 3. Klotho expression in the developing kidney.** *Klotho* and *FGFR* gene expression were  
294 studied using RT-qPCR. (A) Relative *Klotho* expression was calculated as  $(2^{-\Delta CT}) * 100$ . Pearson  
295 correlation analysis revealed a significant association between GA (gestational age) and *Klotho* ( $r =$   
296  $0.80$ ,  $p < 0.0001$ ). (B) Immunostaining of *Klotho* in fetal (GA of 40 weeks) and adult kidney tissue (60  
297 years of age). Magnification, 20x. Arrows indicate a typical example of a glomerulus (gl), proximal  
298 tubule (pt) and distal tubule (dt). (C) Positive correlation between *Klotho* and *FGFR3* (Spearman  $r =$   
299  $0.6$ ,  $p = 0.008$ ). (C) Positive correlation between *Klotho* and *FGFR4* (Spearman  $r = 0.77$ ,  $p = 0.0002$ ).

300  
301 **Figure 4. Renal FGFR expression in fetal, neonatal and adult tissue.** *FGFR* gene expression was  
302 studied using RT-qPCR. (A) Expression of *FGFRs* in fetal (early GA of 14-16 weeks; late GA of 38-  
303 40 weeks) and adult renal tissues. Relative expression was calculated with the  $2^{-\Delta \Delta CT}$  method. Data are  
304 expressed as fold change relative to adult values. Statistical analysis was performed *via* one-way  
305 ANOVA followed by Bonferroni's Multiple Comparison Test. (B) *FGFR4* expression in fetal (late,  
306 GA of 38-40 weeks) and adult tissue as compared to *FGFR3*. Relative expression was calculated with

307 the  $2^{-\Delta\Delta CT}$  method. Data are expressed as fold change relative to *FGFR3* levels. Statistical analysis was  
308 performed *via* an unpaired Student's *t*-test. Results are presented as mean  $\pm$  SEM of two independent  
309 determinations performed in duplicate. \*\*\* =  $p < 0.0005$ , \*\* =  $p < 0.008$ , \* =  $p < 0.004$ . (C)  
310 Immunostaining of FGFRs in neonatal and adult kidney tissue (60 years of age). Magnification, 20x.  
311 Arrows indicate a typical example of a glomerulus (gl), proximal tubule (pt) and distal tubule (dt).

312

313 **Supplemental Figure 1. FGFR expression in the renal medulla.** (A) Immunostaining of FGFRs in  
314 fetal kidney tissue (GA of 40 weeks). (B) Secondary antibody control for FGFR staining.  
315 Magnification, 20x.

316



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