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Reduced cancer incidence in Huntington's disease: analysis in the Registry study

Paul McNulty^{1a}, Richard Pilcher^{1a}, Raviram Ramesh^{1a}, Renata Necuinate¹, Alis Hughes^{3,4} REGISTRY

Investigators of the European Huntington's Disease Network^b, Daniel Farewell², Peter Holmans³ and

Lesley Jones³

1. School of Medicine, Cardiff University CF14 4XN
2. Division of Population Medicine, Cardiff University School of Medicine, Neuadd Meirionnydd, Heath Park, Cardiff CF14 4YS
3. MRC Centre for Neuropsychiatric Genetics and Genomics, School of Medicine, Cardiff University CF24 4HQ
4. Current address for correspondence: Chester Medical School, University of Chester, Bache Hall, Chester. CH2 1BR.
 - a. These authors contributed equally to this report. We dedicate this paper to the memory of Raviram Ramesh.
 - b. Membership of the REGISTRY Investigators of the European Huntington's Disease Network is provided after the references.

Running title: Reduced cancer incidence in HD

Corresponding author: Lesley Jones

MRC Centre for Neuropsychiatric Genetics and Genomics

School of Medicine, Cardiff University

Cardiff CF24 4HQ, UK

Phone: 44(0) 2920 688469

Email: JonesLL1@cf.ac.uk

Abstract

BACKGROUND People with Huntington's disease have been observed to have lower rates of cancers.

OBJECTIVE To investigate the relationship between age of onset of HD, CAG repeat length and cancer diagnosis. **METHODS** Data were obtained from the European Huntington's disease network REGISTRY study for 6540 subjects. Population cancer incidence was ascertained from the GLOBOCAN database to obtain standardised incidence ratios of cancers in the REGISTRY subjects.

RESULTS 173/6528 HD REGISTRY subjects had had a cancer diagnosis. The age-standardised incidence rate of all cancers in the REGISTRY HD population was 0.26 (CI 0.22-0.30). Individual cancers showed a lower age-standardised incidence rate compared with the control population with prostate and colorectal cancers showing the lowest rates. There was no effect of CAG length on the likelihood of cancer, but a cancer diagnosis within the last year was associated with a greatly increased rate of HD onset (Hazard Ratio 18.94, $p < 0.001$).

CONCLUSIONS Cancer is less common than expected in the HD population, confirming previous reports. However, this does not appear to be related to CAG length in HTT. A recent diagnosis of cancer increases the risk of HD onset at any age, likely due to increased investigation following a cancer diagnosis.

Keywords:

Huntington's disease

Trinucleotide repeat

Cancer

Neurodegeneration

Introduction

Huntington's disease (HD) is an inherited neurodegeneration of mid-life onset. It is caused by an expanded CAG repeat at the 5' end of the *HTT* gene, which is translated to give a polyglutamine tract at the N-terminus of the encoded protein, huntingtin (HTT) (1). It is characterised by a movement disorder, cognitive decline and variable psychiatric symptoms with early and continuing cell death in the striatum(1,2). The disease is inexorably progressive and there is no treatment that can prevent the neurodegeneration(2).

Studies in the systematic population registries of the Scandinavian countries show a reduction in the expected age-matched incidence of cancer in subjects with a diagnosis of HD and spinal and bulbar muscular atrophy (SBMA, Kennedy's disease) another disease caused by an expanded CAG tract(3,4). Scandinavian countries have country-wide registers that record whole population health so mining these data can be potentially very productive. Most countries do not have such comprehensive and well maintained registers and thus it is hard to replicate such studies. However, the Oxford Record Linkage Group examined rates of cancers in an all-England population study, the English linked hospital episode statistics (LHES), 1999–2010, and showed a similar effect(5). They examined HD, SBMA, and a larger group of hereditary ataxias (HA), which include the CAG repeat expansion associated spino-cerebellar ataxias (SCAs). The rate ratio cancer diagnosis in 4865 people with HD was 0.53, with no effect seen in subjects with a diagnosis of SBMA or HA. More recently Coarelli et al. (6) questioned a cohort of HD and SCA patients directly about their experience of cancer and found standardised incidence ratios of 0.21 in HD and 0.23 in SCAs.

A reduction in cancer incidence is seen in other neurodegenerative conditions. A systematic examination of records from over 500,000 subjects in observational studies of CNS disorders showed a robust lower cancer co-occurrence in all neurodegenerations, with strikingly significantly lower rates in Alzheimer's disease (ES 0.32)(7). Their HD data was derived from Ji and Sorensen(3,4). By contrast Freedman et al.(8) observed only a modestly reduced risk of Alzheimer's disease in cancer

survivors in a prospective analysis of 1.16 million subjects in a Medicare population (HR = 0.87 (95% CI = 0.84-0.90). To follow up these studies we examined the incidence of cancers in the EHDN REGISTRY study directly. We obtained the data from REGISTRY and the population rates from the Globocan study(9). We also examined the effect of the CAG length and the age of onset of HD on cancer incidence.

Materials and Methods

Participants

Data were provided from 6540 subjects participating in the REGISTRY study of the European Huntington's Disease Network (EHDN) prior to June 2013. 12 subjects originated in South East Asia and were excluded, giving 6528 subjects in the final study. REGISTRY is a large, prospective study observing the natural course, clinical spectrum and management of HD in European countries. More information on the REGISTRY study can be found at (<http://www.euro-hd.net/html/REGISTRY>). All experiments were performed in accordance with the Declaration of Helsinki, full ethical approval for the REGISTRY study was obtained in each of the participating countries, and all participants gave written informed consent. The information includes demographics, HD related CAG repeat length, age at onset of HD, cancer and comorbidity, and medication data. Whilst we obtained data on other aspects of medical history and on alcohol use, smoking, drug abuse and employment we did not use these in analysis as the numbers of cancer patients were relatively low and only 4 subjects were recorded as having a history of lung cancer, for instance. Thus further subdivision of the sample was not deemed useful. Country of clinical site was obtained to adjust for country-specific cancer incidence with the UK, Spain, France, Germany, Italy, Poland given directly and a "Europe" category for all those from countries contributing relatively few subjects. Incidences of cancer were identified by searching for "cancer", "carcinoma" and "malignant neoplasm" in the comorbidity data field and cross-checked using the ICD10 codes given: 171 patients were identified. To provide some confirmation of the cancer diagnosis we looked for subjects taking medication specific for cancers

and 25/171 (14.6%) were confirmed by medication. However, this search also identified two patients taking cancer-specific therapies who did not have cancer listed as a co-morbidity. In the final sample we had 173 subjects with evidence for a diagnosis of cancer.

Comparison of age-standardised cancer incidence

In order to ascertain whether the number of cancer cases is more or less than might be expected we compared these data with age-adjusted cancer incidence from Europe available on the GLOBOCAN website (<http://globocan.iarc.fr>): the data used for the analysis were from 2012 (9) as the REGISTRY data were obtained in June 2013 and thus reflected data captured in the period 2012-13.

The age-standardised incidence rate (SIR) was calculated (equation 1). Person-years were calculated from date of birth until date of diagnosis of cancer or the end of the study period (whichever came first), then the ratio of observed number of cases to expected number of cases was calculated but adjusted for age and sex. This is important in this analysis as the REGISTRY cohort is substantially younger than those at highest risk for cancers in the European population and cancer incidence is age-related.

Equation 1

$$SIR = \frac{\sum_{j=1}^J o_j}{\sum_{j=1}^J n_j \lambda_j} = \frac{O}{E^*}$$

O = observed cancer cases in the study group (173), E^* = sum of stratum-specific person years (n_j) in subjects with HD x stratum-specific standard incidence rates (λ_j^*) obtained from the GLOBOCAN reference group(9). The age stratification is given in Table 1. The weighting was adjusted to reflect the proportions of different countries amongst the 6528 HD subjects.

Relationship of cancer incidence to *HTT* CAG repeat length and age at onset of HD

We analysed time from birth to HD onset using Cox proportional hazards models (10), adjusting for a time-varying covariate defined to be 0 until a person received a cancer diagnosis, and 1 thereafter. The effect of this is to compare, at every age, the rate of HD onset between those with, and without, a previous cancer diagnosis. This corrects for the fact that people with cancer are likely to be older (since they have lived long enough to develop cancer) than those without, and thus to have a later HD onset, since their HD incidence rates are being compared to people of the same age without a cancer diagnosis. A Cox proportional hazard model was used to assess whether CAG repeat length was related to the age of cancer incidence, with adjustment for sex and stratification by country. We also assessed whether a cancer diagnosis influenced the age of onset of HD.

To investigate the possibility that a cancer diagnosis may quickly bring about increased investigation of HD symptoms, and thus an apparent increase in HD incidence rate, we also included a time-varying covariate that was only 1 during the year immediately following a cancer diagnosis, and 0 elsewhere.

Results

There were 6540 patients identified from the EHDN REGISTRY study(11) with appropriate data: details are given in Table 1. Eight subjects were excluded as they were collected outside Europe (Singapore) and four had incomplete records. The 6528 subjects remaining were collected in European clinics, had a clinical diagnosis of HD and 173 (2.65%) of these patients also had information consistent with a cancer diagnosis. In the whole cohort 52.6% of subjects are female and 47.4% male. There is a higher proportion of females amongst those with a diagnosis of cancer than in those without (Table 1): this is attributable to the relative youth of our HD sample as the incidence of breast cancer is higher at relatively young ages compared with many other cancers. The sample size is too small to split by specific cancers to explore this further. The average age of the non-cancer HD subjects at the point of data collection (age at last visit) is over 10 years younger than in those with a cancer diagnosis and the mean CAG repeat length is longer in the non-cancer cohort than in the subjects with cancer (Table 1).

The distribution of the cancer diagnoses in the 173 subjects is given in Table 2. The standardised incidence rate (SIR) of cancers in the HD population was calculated (Table 2) and for all cancers was 0.26 (CI 0.22 – 0.30). All cancers were observed at significantly lower levels than in the European population though there were differences in the rates between the types of cancer. Uterine and skin cancers had age-standardised incidence rates closest to the European levels with colorectal, breast and prostate cancer all recorded at less than half the rates in the European population.

Those with a cancer diagnosis have, on average, over 10 years later age of onset of HD than those without. Testing whether this is significantly different, is, as noted above, complicated by the fact that cancer incidence rises as people age, and those with later ages of onset of HD will, on average, live longer and thus be more likely to develop a cancer(12). Modelling this using a cancer diagnosis at any time in the past as a time-dependent covariate in a Cox proportional hazards model(10) of time to HD onset, shows that those with a cancer diagnosis at any age are very slightly more likely to have HD onset than those without cancer at the same age (HR 1.2773; 95% CI 1.06 to 1.61, $p < 0.001$). A cancer diagnosis during the past year is strongly associated with an increased rate of HD onset (HR 18.95, 95% CI 13.01 to 23.20, $p < 0.001$).

As we noted that the subjects with cancer diagnoses have shorter CAG repeat lengths than those without (Table 1), we investigated whether this is significantly associated with the likelihood of developing cancer. Given that the CAG repeat showed the expected significant inverse correlation with age of HD onset ($p < 2 \times 10^{-16}$), the apparent association of cancer with CAG length could be a result of people with shorter CAG repeats on average living longer (as age at death in HD is inversely correlated with expanded *HTT* allele CAG repeat length), and thus having a greater risk of developing cancer(12). To test whether this bias in lifetime length accounts for the apparent association between CAG length and cancer diagnosis we used a Cox proportional hazards model (10) with time from birth to cancer diagnosis as an outcome (death and HD diagnosis both as censoring) and CAG

length as a covariate. We also adjusted for age and sex and used different baseline hazards for the different countries. There are no discernible effects of CAG repeat length on cancer incidence.

Discussion

The standardised incidence ratio for all cancers detected in the REGISTRY subjects is substantially lower than that in the non-HD population, as reported previously(3–6). Cancer might be underdiagnosed in the HD population in later stages of the illness as potentially relevant signs or symptoms may not be noticed or acted upon, or may be masked by HD symptoms – cachexia for instance, common in cancers, is also common in late stage HD. Our findings in the REGISTRY study show a lower rate of cancers than that reported in previous studies of cancer in HD subjects in population cohorts (3–5) which could indicate under-ascertainment of cancer in our sample. However, the recent study examining French HD and SCA populations and asking directly about cancer show a similar SIR to that which we show in this study(6). However, it is also likely that having a diagnosis of HD, and therefore coming to clinical attention, makes diagnosis of any comorbidities more likely. Turner *et al.*(5), studying hospital admission records in England, found that there was an increased rate of cancer diagnoses in the first year after admission for HD. The overall decrease in the rate of cancers that they observed among HD patients (rate ratio = 0.71) was made more extreme if the first year was excluded (rate ratio = 0.53). This indicates that under-diagnosis is less likely in this population, rather than more likely: we showed a similar effect in the REGISTRY subjects. The only cancer they found to be as common as in the general population was lung cancer, which Turner *et al.*(5) attributed to the higher rate of smoking in the HD subjects(13). We had only four cases of lung cancer in our study, too few to study separately.

The observation that two subjects were taking tamoxifen but had no recorded cancer diagnosis indicates that one of the reasons for the lower rate of all cancers observed here might well be poor recording of comorbidities in the REGISTRY database. This could result from poor recall of the participant, lack of knowledge of their partners and carers in clinic or from subjects dropping out of

the study after a diagnosis of cancer due to treatment or other effects of the cancer itself and issues in the systematic collection of medical history in clinic.

In an attempt to overcome the limitations of these data we investigated the effect of CAG repeat length on the time to a cancer diagnosis with the view that any correlation might implicate the CAG length at the *HTT* locus in promoting or delaying cancer. No such effect was observed. To further investigate any link between the two diseases we also examined whether having a cancer diagnosis was associated with age at onset of HD. This is more difficult as there are competing risks: cancer risk is age-related, and a cancer diagnosis may influence time to death as well as time to HD onset, as may *HTT* CAG length. However, we observe that a diagnosis of cancer at any time slightly increases the likelihood of HD onset: this marginal effect requires replication in further studies. In addition, the study of Turner *et al.*(5) found that cancer incidences were higher in the year around HD onset and we see a similar effect in the REGISTRY data. This latter is likely to be an ascertainment bias: subjects receiving clinical attention are more likely to have any comorbid condition detected and therefore under-diagnosis of cancer is less likely in this population.

What might underlie the later onset of cancer in HD subjects? Defects in the DNA damage response (DDR) cause cancers (14) and the DDR has recently been implicated in altering the age at motor onset of HD and other repeat disorders (15,16). The direction of this effect is unclear and alterations in the operation of the DDR have been shown to be both protective and deleterious in HD and other neurodegenerations. Mismatch repair and base-excision repair have both been implicated as promoting degeneration in the repeat disorders, possibly through somatic expansion of repeats (17,18). Many other neurological diseases are caused by genetic defects in the DDR (19) but conversely, multiple protective effects of the DDR in neurodegenerations have also been observed (20–27).

One consequence of the involvement of the DDR in modifying HD onset might be that although age at onset is later in subjects who have had a cancer diagnosis, if they have cancer in the presence of

lower DDR activity, then that cancer might be more aggressive with a faster course. HTT has been implicated in acceleration of breast cancer development and metastasis in mouse models of HD and to regulate cell division in mammary stem cells (28). In subjects with breast cancer a reduction of ovarian cancer was shown in *BRCA2* mutation carriers also carrying longer *HTT* CAGs(29), along with a paradoxical finding of increased metastasis and younger ages of cancer onset. Direct examination of metastatic breast cancer showed *HTT* mRNA downregulation in primary tumours and that the expression and localisation of the tight junction protein ZO1 was controlled by HTT(30). Lower expression of HTT was correlated with less HTT and ZO1 proteins at tight junctions, poorer differentiation of tumour cells and was predictive of worse cancer prognosis(31).

It is not clear how the effect of increased CAG repeats, which translate to expanded polyglutamine tracts in the cognate proteins, could potentially mediate cancer risk but the underlying biology of HD offers clues. Huntingtin (HTT) is expressed in all cells: cell death is promoted by mutant HTT (32–34) and non-mutant HTT is anti-apoptotic(35). HTT localises to spindle poles at mitosis and has a role in cell fate in neurons(36) that may extend to other cell types: therefore in neuronal cells it has been suggested that HTT regulates the balance between survival and death. Most of the experimental work examining these functions has only looked at long (>40) CAGs compared with a single normal range CAG length thus our knowledge of the downstream effects of small differences in the CAG repeat length below 40 CAGs on HTT biology are limited. If small modulations in CAG length in HTT and potentially other genes containing polymorphic CAG repeats impose a relatively small effect on cell fate decisions over a long period then they could well be one of the multiple factors that influence whether a cell divides or dies, contributing to the risk of uncontrolled cell division. The effect could in part be explained by the RNA generated from the expanded CAG repeat in *HTT*. sCAGs are small CAG repeat RNAs generated from the *HTT* gene (37) which are toxic to neurons (38) and may operate via an RNAi-based mechanism and downregulate trinucleotide repeat-containing survival genes, leading to tumour cell death (39). Similar findings in other neurodegenerative diseases(7) might implicate a broader biological relationship between cell survival and cell death in

the CNS, manifesting as neurodegeneration. Thus determining the relationship between CAG length in *HTT* and other polymorphic CAG repeat loci could well reveal fundamental biological mechanisms underlying both cancer risk and neurodegeneration.

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Author contributions

The REGISTRY Investigators of the European Huntington's Disease Network collected the data. PM, RP, RR, RN and DF analysed the data, AH assisted in interpreting the clinical data, PH and DF supervised the data analysis, LJ conceived the study and wrote the main manuscript text. All authors reviewed the manuscript.

Conflict of Interest

The authors declare no competing financial interests.

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Members of REGISTRY Investigators of the European Huntington's Disease Network

* member of Registry steering committee

** Language coordinator

Raphael M. Bonelli^{4,6*}, Karen Hecht⁴, Brigitte Herranhof⁴, Anna Holl (formerly Hödl)⁴, Hans-Peter Kapfhammer⁴, Michael Koppitz⁴, Sabine Lilek⁴, Markus Magnet⁴, Nicole Müller⁴, Daniela Otti⁴, Annamaria Painold⁴, Karin Reisinger⁴, Monika Scheibl⁴, Helmut Schöggel⁴, Jasmin Ullah⁴, Eva-Maria Braunwarth⁵, Florian Brugger⁵, Lisa Buratti⁵, Eva-Maria Hametner⁵, Caroline Hepperger⁵, Christiane Holas⁵, Anna Hotter⁵, Anna Hussl⁵, Barbara Larcher⁵, Philipp Mahlknecht⁵, Christoph Müller⁵, Bernadette Pinter⁵, Werner Poewe⁵, Eva-Magdalena Reiter⁵, Klaus Seppi⁵, Fabienne Sprenger⁵, Gregor Wenning⁵, Gunther Ladurner⁶, Stefan Lilek⁶, Daniela Sinadinosa⁶, Wolfgang Staffen⁶, Anna Maria Walleczek⁶, Eric Constant⁷, Anne-Françoise Gillardin⁷, Marie-Claude Léonard⁷, Christine Verellen-Dumoulin^{7,8*}, Françoise van de Wyngaerde⁷, Michel Dupuis⁸, Cécile Minet⁸, Pascale Ribai⁸, Dominique Van Paemel⁸, Andrea Boogaerts⁹, Wim Vandenberghe^{9*}, Dimphna van Reijen⁹, Michaela Kaiserova¹⁰, Zuzana Šenkárová¹⁰, Jiří Klempíř^{11,142*}, Veronika Majerová¹¹, Jan Roth¹¹, Louise Hasselstrøm Madsen¹², Anette Torvin Møller¹², Lena Hjermind¹³, Oda Jacobsen¹³, Suzanne Lindquist¹³, Jørgen Nielsen^{13*}, Lisbeth Regeur¹³, Jette Stockholm¹³, Ida Unmack Larsen¹³, Christina Vangsted-Hansen¹³, Tua Vinther-Jensen¹³, Annette Lolk¹⁴, Marianne Lundsgaard¹⁴, Lene Wermuth¹⁴, Christian Andersson¹⁵, Clara Nyberg¹⁵, Jimmy Sundblom¹⁵, Maarit Peippo¹⁶, Marjett Sipponen¹⁶, Paivi Hartikainen¹⁷, Mari Ollokainen¹⁷, Jaana Åman¹⁸, Jaakko Ignatius¹⁸, Mikko Kärppä¹⁸, Aki Mustonen¹⁹, Outi Kajula¹⁹, Outi Jääskäläinen¹⁹, Jukka Moilanen¹⁹, Maire Santala²⁰, Pia Eklund²¹, Heli Hiivola²¹, Hannele Hyppönen²¹, Kirsti Martikainen²¹, Katri Tuuha²¹, Philippe Allain²², Dominique Bonneau²², Marie Bost²², Bénédicte Gohier²², Marie-Anne Guérid²², Audrey Olivier²², Julie Prouzet²², Adriana Prundean²², Clarisse Scherer-Gagou²², Christophe Verny²², Blandine Babiloni²³, Sabrina Debruxelles²³, Charlotte Duché²³, Cyril Goizet²³, Laetitia Jameau²³, Danielle Lafoucrière²³, Umberto Spampinato²³, Julien Couttier²⁴, Bérengère Debilly²⁴, Christine Delaigue²⁴, Franck Durif²⁴, Perrine Legendre²⁴, Sylvie Loiseau²⁴, Miguel Ulla²⁴, Tiphaine Vidal²⁴, Anne-Catherine Bachoud-Lévi^{25*}, Farideh Badei²⁵, Marie-Françoise Boissé²⁵, Lotfi Boudali²⁵, Laurent Cleret de Langavant²⁵, Laurie Lemoine²⁵, Graca Morgado²⁵, Katia Youssouf²⁵, Agnès Annic²⁶, Recka Barthélémy²⁶, Christelle De Bruycker²⁶, Maryline Cabaret²⁶, Anne-Sophie Carette²⁶, Nicolas Carrière²⁶, Eric Decorte²⁶, Luc Defebvre²⁶, Marie Delliaux²⁶, Arnaud Delval²⁶, Alizé Depelchin²⁶, Alain Destee²⁶, Nelly Dewulf-Pasz²⁶, Thibaut Dondaine²⁶, Florence Dugauquier²⁶, Kathy Dujardin²⁶, Lucie Hopes²⁶, Pierre Krystkowiak^{26,27}, Marie-Hélène Lemaire²⁶, Sylvie Manouvrier²⁶, Eugénie Mutez²⁶, Mireille Peter²⁶, Lucie Plomhause²⁶, Bernard Sablonnière²⁶, Clémence Simonin²⁶, Céline Tard²⁶, Stéphanie Thibault-Tanchou²⁶, Isabelle Vuillaume²⁶, Marcellin Bellonet²⁷, Alexandra Benoit²⁷, Hassan Berrisoul²⁷, Stéphanie Blin²⁷, Françoise Courtin²⁷, Cécile Duru²⁷, Véronique Fasquel²⁷, Mélanie Flament²⁷, Olivier Godefroy²⁷, Béatrice Mantaux²⁷, Alicia Playe²⁷, Martine Roussel²⁷, Mélissa Tir²⁷, Béatrice Schüler²⁷, Sandrine Wannepain²⁷, Jean-Philippe Azulay²⁸, Christelle Chabot²⁸, Marie Delfini²⁸, Alexandre Eusebio²⁸, Frédérique Fluchere²⁸, Hélène Grosjean²⁸, Laura Mundler²⁸, Marielle Nowak²⁸, Rolland Rasetta²⁸, Sandra Benaich²⁹, Alexis Brice²⁹, Perrine Charles²⁹, Alexandra Durr²⁹, Claire Ewencyk²⁹, Hélène Francisque²⁹, Céline Jauffret²⁹, Damian Justo²⁹, Abdulrahman Kassar²⁹, Stephan Klebe²⁹, Fabien Lesne²⁹, Paolo Milani²⁹, Marie-Lorraine Monin²⁹, Emmanuel Roze²⁹, Alina Tataru²⁹, Maya Tchikviladzé²⁹, Sandrine Bioux³⁰, Evangeline Blioux³⁰,

Carole Girard³⁰, Lucie Guyant-Maréchal³⁰, Didier Hannequin³⁰, Véronique Hannier³⁰, Séverine Jourdain³⁰, David Maltête³⁰, Dorothée Pouliquen³⁰, Ouhaïd Lagha-Boukbiza³¹, Nadine Longato³¹, Christophe Marcel³¹, Clélie Phillips³¹, Gabrielle Rudolf³¹, Gisèle Steinmetz³¹, Christine Tranchant³¹, Caroline Wagner³¹, Marie-Agathe Zimmermann³¹, Leily Blondeau³², Fabienne Calvas³², Samia Cheriet³², Hélène Delabaere³², Jean-François Demonet³², Jérémie Pariente³², Michèle Pierre³², Sandrine Rolland³², Christoph Michael Kosinski³³, Eva Milkereit³³, Daniela Probst³³, Kathrin Reetz³³, Christian Sass³³, Johannes Schiefer³³, Christiane Schlangen³³, Cornelius J. Werner³³, Markus Beuth³⁴, Harald Gelderblom³⁴, Josef Priller³⁴, Harald Prüß³⁴, Eike Spruth³⁴, Silvia Thiel³⁴, Jürgen Andrich³⁵, Gisa Ellrichmann³⁵, Lennard Herrmann³⁵, Rainer Hoffmann³⁵, Barbara Kaminski³⁵, Peter Kraus³⁵, Carsten Saft^{35*}, Christiane Stamm³⁵, Herwig Lange^{36,45}, Robert Maiwald³⁶, Cecile Bosredon³⁷, Ulrike Hunger³⁷, Matthias Löhle³⁷, Antonia Maass³⁷, Christiana Ossig³⁷, Simone Schmidt³⁷, Alexander Storch³⁷, Annett Wolz³⁷, Martin Wolz³⁷, Zacharias Kohl³⁸, Christina Kozay³⁸, Jasmin Ullah³⁸, Jürgen Winkler³⁸, Ulrike Bergmann³⁹, Regina Böringer³⁹, Philipp Capetian³⁹, Gerit Kammel³⁹, Johann Lambeck³⁹, Miriam Mächtel³⁹, Simone Meier³⁹, Michel Rijntjes³⁹, Birgit Zucker³⁹, Kai Boelmans⁴⁰, Christos Ganos⁴⁰, Ines Goerendt⁴⁰, Walburgis Heinicke⁴⁰, Ute Hidding⁴⁰, Jan Lewerenz^{40,47}, Alexander Münchau⁴⁰, Michael Orth^{40,47}, Jenny Schmalfeld⁴⁰, Lars Stubbe⁴⁰, Simone Zittel⁴⁰, Gabriele Diercks⁴¹, Dirk Dressler⁴¹, Flverly Francis⁴¹, Sabine Gayde-Stephan⁴¹, Heike Gorzolla⁴¹, Bianca Kramer⁴¹, Rebecca Minschke⁴¹, Christoph Schrader⁴¹, Pawel Tacik⁴¹, Michael Ribbat⁴², Bernhard Longinus⁴³, Antje Lüsebrink⁴⁴, Mark Mühlau⁴⁴, Alexander Peinemann⁴⁴, Michael Städtler⁴⁴, Adolf Weindl⁴⁴, Juliane Winkelmann⁴⁴, Cornelia Ziegler⁴⁴, Natalie Bechtel⁴⁵, Heike Beckmann⁴⁵, Stefan Bohlen⁴⁵, Nicole Göpfert⁴⁵, Eva Hölzner⁴⁵, Ralf Reilmann⁴⁵, Stefanie Rohm⁴⁵, Silke Rumpf⁴⁵, Christian Sass⁴⁵, Sigrun Schepers⁴⁵, Nathalia Weber⁴⁵, Michael Bachmeier⁴⁶, Matthias Dose⁴⁶, Nina Hofstetter⁴⁶, Ralf Marquard⁴⁶, Alzbeta Mühlbäck⁴⁶, Katrin Barth^{47,138**}, Andrea Buck⁴⁷, Julia Connemann⁴⁷, Daniel Ecker^{47,138**}, Carolin Geitner⁴⁷, Christine Held^{47,138**}, Andrea Kesse⁴⁷, Bernhard Landwehrmeyer^{47*}, Franziska Lezius⁴⁷, Solveig Nepper⁴⁷, Anke Niess⁴⁷, Ariane Schneider⁴⁷, Daniela Schwenk⁴⁷, Sigurd Süßmuth⁴⁷, Sonja Trautmann⁴⁷, Melanie Vogel⁴⁷, Patrick Weydt⁴⁷, Stephan Klebe⁴⁸, Thomas Musacchio⁴⁸, Christine Leypold⁴⁸, Kerstin Nöth⁴⁸, Claudia Cormio⁴⁹, Olimpia Difruscolo⁴⁹, Giovanni Franco⁴⁹, Vittorio Scirucchio⁴⁹, Claudia Serpino⁴⁹, Marina de Tommaso⁴⁹, Giovanna Calandra-Buonaura⁵⁰, Sabina Capellari⁵⁰, Pietro Cortelli⁵⁰, Roberto Gallassi⁵⁰, Roberto Poda⁵⁰, Cesa Scaglione⁵⁰, Elisabetta Bertini⁵¹, Elena Ghelli⁵¹, Andrea Ginestroni⁵¹, Claudia Mechi⁵¹, Marco Paganini⁵¹, Silvia Piacentini⁵¹, Silvia Pradella⁵¹, Anna Maria Romoli⁵¹, Sandro Sorbi⁵¹, Giovanni Abbruzzese⁵², Monica Bandettini di Poggio⁵², Giovanna Ferrandes⁵², Paola Mandich⁵², Roberta Marchese⁵², Emilio Di Maria⁵², Alberto Albanese⁵³, Simona Castagliuolo⁵³, Anna Castaldo⁵³, Stefano Di Donato⁵³, Daniela Di Bella⁵³, Cinzia Gellera⁵³, Silvia Genitrini⁵³, Caterina Mariotti⁵³, Daniela Monza^{53,138**}, Lorenzo Nanetti⁵³, Marta Panzeri⁵³, Dominga Paridi⁵³, Paola Soliveri⁵³, Francesca Spagnolo⁵³, Franco Taroni⁵³, Chiara Tomasello⁵³, Giuseppe De Michele⁵⁴, Luigi Di Maio⁵⁴, Carlo Rinaldi⁵⁴, Marco Massarelli⁵⁴, Silvio Peluso⁵⁴, Alessandro Roca⁵⁴, Cinzia Valeria Russo⁵⁴, Elena Salvatore⁵⁴, Pierpaolo Sorrentino⁵⁴, Tecla Tucci⁵⁴, Milena Cannella⁵⁵, Valentina Codella⁵⁵, Francesca De Gregorio⁵⁵, Annunziata De Nicola⁵⁵, Francesca Elifani⁵⁵, Tiziana Martino⁵⁵, Irene Mazzante⁵⁵, Martina Petrollini⁵⁵, Maria Simonelli⁵⁵, Maurizio Veza⁵⁵, Ferdinando Squitieri¹⁴⁶, Francesca Lovo¹⁴⁷, Anna Rita Bentivoglio^{56*}, Francesco Bove⁵⁶, Claudio Catalli⁵⁶, Raffaella Di Giacomo⁵⁶, Alfonso Fasano⁵⁶, Marina Frontali^{56,57}, Arianna Guidubaldi⁵⁶, Tamara Ialongo⁵⁶, Gioia Jacopini^{56,57}, Giovanna Loria⁵⁶, Anna Modoni⁵⁶, Martina Petracca⁵⁶, Carla Piano⁵⁶, Chiara Piccinini⁵⁶, Davide Quaranta⁵⁶, Silvia Romano⁵⁶, Francesco Soletti⁵⁶, Marcella Solito⁵⁶, Maria Spadaro⁵⁶, Flavia Torlizzi⁵⁶, Paola Zinzi^{56,57,138**}, Giulia Coarelli⁵⁷, Michela Ferraldeschi⁵⁷, Giovanni Ristori⁵⁷, Silvia Romano⁵⁷, Monique S.E. van Hout⁵⁸, Jeroen P.P. van Vugt⁵⁸, A. Marit de Weert⁵⁸, Marloes

Verhoeven⁵⁸, Meike Dekker⁵⁹, Nico Leenders⁵⁹, Joost van Oostrom⁵⁹, Jesper Klooster⁵⁹, Berry Kremer^{59, 62}, Verena Baake (formerly Rödiger)^{60,138**}, Simon J. A. van den Bogaard⁶⁰, Reineke Bos^{60,138**}, Eve M. Dumas⁶⁰, Ellen P. 't Hart⁶⁰, Anne Kampstra⁶⁰, Raymund A.C. Roos^{60*}, Anne Schoonderbeek⁶⁰, Annelien Duits⁶¹, Mayke Oosterloo⁶¹, Mirella Waber⁶¹, Carla Verstappen⁶², Ellen Økland Blinkenberg⁶³, Erik Hauge⁶³, Hilde Tyvoll⁶³, Olaf Aaserud⁶⁴, Kathrine Bjørge⁶⁴, Nancy Borgeød⁶⁴, Elisabeth Dramstad⁶⁴, Madeleine Fannemel⁶⁴, Jan C. Frich^{64*}, Per F. Gørvell⁶⁴, Arvid Heiberg^{64*}, Lars Retterstøl⁶⁴, Oddveig Røsbjerg⁶⁴, Alma Sikiric⁶⁴, Bodil Stokke⁶⁴, Marleen van Walsem^{64,138**}, Ragnhild Wehus⁶⁴, Inga Bjørnevoll⁶⁵, Sigrid Botne Sando⁶⁵, Marte Gjøl Haug⁶⁵, Hanna Haugan Størseth⁶⁵, Vibeke Arntsen⁶⁵, Artur Dziadkiewicz⁶⁶, Małgorzata Nowak⁶⁶, Piotr Robowski⁶⁶, Emilia Sitek⁶⁶, Jarosław Sławek⁶⁶, Witold Soltan⁶⁶, Michał Szinwelski⁶⁶, Michał Arkuszewski⁶⁷, Magdalena Błaszczuk⁶⁷, Magdalena Boczarska-Jedynak⁶⁷, Ewelina Ciach-Wysocka⁶⁷, Agnieszka Gorzkowska⁶⁷, Barbara Jasińska-Myga⁶⁷, Aleksandra Kaczmarczyk⁶⁷, Gabriela Kłodowska – Duda⁶⁷, Grzegorz Opala⁶⁷, Daniel Stempel⁶⁷, Krzysztof Banaszkiwicz⁶⁸, Dorota Boćwińska⁶⁸, Kamila Bojakowska-Jaremek⁶⁸, Małgorzata Dec⁶⁸, Natalia Grabska⁶⁸, Małgorzata Krawczyk⁶⁸, Ewelina Kubowicz⁶⁸, Michalina Malec-Litwinowicz⁶⁸, Monika Rudzińska⁶⁸, Agata Stenwak⁶⁸, Andrzej Szczudlik⁶⁸, Elżbieta Szczygieł⁶⁸, Magdalena Wójcik⁶⁸, Anna Wasielewska⁶⁸, Jacek Anioła⁶⁹, Anna Bryl⁶⁹, Anna Ciesielska⁶⁹, Aneta Klimberg⁶⁹, Jerzy Marcinkowski⁶⁹, Husam Samara⁶⁹, Justyna Sempołowicz⁶⁹, Bartłomiej Wiśniewski⁶⁹, Daniel Zielonka^{69,138**}, Anna Gogol (formerly Kalbarczyk)⁷⁰, Piotr Janik⁷⁰, Zygmunt Jamrozik⁷⁰, Anna Kaminska⁷⁰, Hubert Kwiecinski⁷⁰, Jakub Antczak⁷¹, Katarzyna Jachinska⁷¹, Wioletta Krysa⁷¹, Maryla Rakowicz⁷¹, Przemysław Richter⁷¹, Rafał Rola⁷¹, Danuta Ryglewicz⁷¹, Halina Sienkiewicz-Jarosz⁷¹, Iwona Stępniaik⁷¹, Anna Sułek⁷¹, Grzegorz Witkowski^{71,138**}, Jacek Zaremba^{71*}, Elżbieta Zdżienicka⁷¹, Karolina Ziara-Jakutowicz⁷¹, Cristina Januário⁷², Filipa Júlio⁷², Manuel Almeida⁷³, Ana Calado⁷³, Margarida Dias⁷³, Joana Morgado⁷³, Cristina Semedo⁷³, Leonor Correia Guedes^{74,138**}, Miguel Coelho⁷⁴, Joaquim J Ferreira^{74*}, Tiago Mestre^{74,138**}, Tiago Mendes^{74,75}, Anabela Valadas⁷⁴, Cristina Costa⁷⁵, Helena Cardoso⁷⁵, Carlos Andrade⁷⁶, Andreia Costa⁷⁶, Carolina Garrett⁷⁶, Miguel Gago⁷⁶, Joana Guimarães⁷⁶, João Massano⁷⁶, Joana Meireles⁷⁶, Ana Monteiro⁷⁶, Carmen Durán Herrera⁷⁷, Patrocinio García Moreno⁷⁷, Jordi Bas⁷⁸, Núria Busquets⁷⁸, Matilde Calopa⁷⁸, Serge Jaumà Classen⁷⁸, Nadia Rodríguez Dedichá⁷⁸, María Teresa Buongiorno⁷⁹, Andrés de la Cerda Santa María⁷⁹, Esteban Muñoz⁷⁹, Pilar Santacruz⁷⁹, Miquel Aguilar Barbera⁸⁰, Ana Rojo Sebastián^{80*}, Sonia Arribas Pardo⁸⁰, Dolors Badenes Guia⁸⁰, Noemi Calzado⁸⁰, Laura Casas Hernanz⁸⁰, Juan Pablo Tartari Díaz-Zorita⁸⁰, Judit López Catena⁸⁰, Pilar Quiléz Ferrer⁸⁰, Gemma Tome Carruesco⁸⁰, Misericordia Floriach Robert⁸¹, Cèlia Mareca Viladrich⁸¹, Elvira Roca⁸¹, Jesús Miguel Ruiz Idiago⁸¹, Antonio Villa Riballo⁸¹, Antonia Campolongo⁸², Ramon Fernandez de Bobadilla⁸², Jaime Kulisevsky Bojarsky⁸², Saul Martinez-Horta^{82,138**}, Javier Pagonabarraga⁸², Jesus Perez Perez⁸², Roser Ribosa⁸², Carolina Villa⁸², Maria Angeles⁸³, Acera Gil⁸³, Koldo Berganzo Corrales⁸³, Juan Carlos Gomez Esteban⁸³, Amaia González⁸³, Beatriz Tijero Merino⁸³, Esther Cubo⁸⁴, Cecilia Gil Polo⁸⁴, Natividad Mariscal⁸⁴, Sandra Gutierrez Romero⁸⁵, José Matías Arbelo⁸⁵, Rocío Malo de Molina⁸⁵, Idaira Martín⁸⁵, Juan Manuel Periañez⁸⁵, Beatriz Udaeta⁸⁵, Fernando Alonso-Frech⁸⁶, María del Valle Loarte⁸⁶, Francisco Barrero⁸⁷, Blas Morales⁸⁷, Belén Frades⁸⁸, Marina Ávila Villanueva⁸⁸, Maria Ascension Zea Sevilla⁸⁸, Fernando Alonso Frech⁸⁹, María del Mar Fenollar⁸⁹, Rocío García-Ramos García⁸⁹, Clara Villanueva⁸⁹, Mónica Bascuñana Garde^{90,138**}, Marta Fatás Ventura⁹⁰, Juan García Caldentey^{90,91,94}, Guillermo García Ribas⁹⁰, Justo García de Yébenes⁹⁰, José Luis López-Sendón Moreno⁹⁰, Verónica Mañanes Barral⁹⁰, Patricia Trigo Cubillo^{90,138**}, Pedro José García Ruíz⁹¹, Ana García⁹¹, Rosa Guerrero López⁹¹, Antonio Herranz Bárcenas⁹¹, Asunción Martínez-Descals^{91,138**}, Veronica Puertas Martín⁹¹, Noelia Rodríguez Martínez⁹¹, María José Sainz Artiga⁹¹, Vicenta Sánchez⁹¹, Angel Martínez Pueyo⁹¹, Moreau María

Dolores Alarcón⁹², Carmen Antúnez Almagro⁹², Esther Diéguez⁹², Lorenza Fortuna⁹², Salvadora Manzanares⁹², Juan Marín Muñoz⁹², María Martirio Antequera Torres⁹², Fuensanta Noguera Perea⁹², Laura Vivancos⁹², Sonia González⁹³, Luis Menéndez Guisasaola⁹³, Marta Para Prieto⁹³, René Ribacoba⁹³, Carlos Salvador⁹³, Pablo Sánchez Lozano⁹³, Inés Legarda Ramirez⁹⁴, Penelope Navas Arques⁹⁴, Monica Rodriguez Lopera⁹⁴, Barbara Vives Pastor⁹⁴, Itziar Gaston⁹⁵, Fermin Garcia-Amigot⁹⁵, Maria Dolores Martinez-Jaurrieta⁹⁵, Maria Antonia Ramos-Arroyo^{95*}, Fátima Carrillo⁹⁶, María Teresa Cáceres Redondo⁹⁶, Pablo Mir⁹⁶, Laura Vargas González⁹⁶, Fátima Damas Hermoso⁹⁷, José Manuel García Moreno⁹⁷, Carolina Mendez Lucena⁹⁷, Eva María Pacheco Cortegana⁹⁷, José Chacón Peña⁹⁷, Luis Redondo⁹⁷, Violeta Sánchez Sánchez⁹⁷, Cristina Melgar Fernandez⁹⁸, María Dolores Romero Lemos⁹⁸, Maite Paredes Mata⁹⁸, Rocío Villagrán Casado⁹⁸, Maria Bosca⁹⁹, Juan Andres Burguera⁹⁹, Francisco Castera Brugada⁹⁹, Carmen Peiró Vilaplana⁹⁹, Pilar Solís⁹⁹, Begoña Jeweinat Figuerola⁹⁹, Paloma Millan Palanca⁹⁹, Jan Wahlström+^{100*}, Ulrika Høsterey-Ugander¹⁰⁰, Gunnel Fredlund¹⁰⁰, Radu Constantinescu¹⁰⁰, Liselotte Neleborn-Lingefjård¹⁰⁰, Maria Berglund¹⁰⁰, Peter Berglund¹⁰⁰, Petra Linnsand¹⁰⁰, Elisabeth Björnsson¹⁰¹, Martin Paucar¹⁰¹, Sven Pålhagen^{101*}, Per Svenningsson¹⁰¹, Tina Wallden¹⁰¹, Ghada Loutfi¹⁰², Carina Olofsson¹⁰², Eva-Lena Stattin¹⁰², Laila Westman¹⁰², Birgitta Wikström¹⁰², Camilla Ekwall¹⁰³, Marie-Lousie Göller¹⁰³, Jimmy Sundblom¹⁰³, Jean-Marc Burgunder^{104*}, Yanik Stebler¹⁰⁴, Alain Kaelin¹⁰⁴, Irene Romero¹⁰⁴, Michael Schüpbach¹⁰⁴, Sabine Weber Zaugg¹⁰⁴, Federica Esposito¹⁰⁵, Jean-Marc Good¹⁰⁵, Karin Paus¹⁰⁵, Francois Vingerhoets¹⁰⁵, Christian Wider+¹⁰⁵, Hans H. Jung¹⁰⁶, Jens A. Petersen¹⁰⁶, Maria Ligon-Auer¹⁰⁶, Violeta Mihaylova¹⁰⁶, Lorna Downie¹⁰⁷, Roisin Jack¹⁰⁷, Kirsty Matheson¹⁰⁷, Zosia Miedzybrodzka¹⁰⁷, Daniela Rae¹⁰⁷, Sheila A Simpson¹⁰⁷, Fiona Summers¹⁰⁷, Alexandra Ure¹⁰⁷, Vivien Vaughan¹⁰⁷, Timothy Harrower¹¹⁵, Nathan Vernon¹⁰⁸, Shahbana Akhtar¹⁰⁹, Jenny Crooks¹⁰⁹, Adrienne Curtis¹⁰⁹, Jenny de Souza (Keylock)¹⁰⁹, Hugh Rickards¹⁰⁹, Jan Wright¹⁰⁹, Elizabeth Coulthard¹¹⁰, Beverley Hayward¹¹⁰, Kasia Sieradzan¹¹⁰, Abigail Wright^{110,138**}, Roger A. Barker¹¹¹, Deidre O’Keefe¹¹¹, Anna Gertz (di Pietro)¹¹¹, Kate Fisher¹¹¹, Anna Goodman¹¹¹, Susan Hill¹¹¹, Sarah Mason¹¹¹, Rachel Swain¹¹¹, Natalie Valle Guzman¹¹¹, Monica Busse¹¹², Cynthia Butcher¹¹², Stephen Dunnett^{112*}, Catherine Clenaghan¹¹², Ruth Fullam^{112,127,138**}, Sarah Hunt¹¹², Una Jones¹¹², Hanan Khalil¹¹², Sara Minster^{112,138**}, Michael Owen¹¹², Kathleen Price¹¹², Jenny Townhill^{112,138**}, Anne Rosser¹¹², David Goudie¹¹³, Lindsay Buchanan¹¹³, Paula McFadyen¹¹³, Alison Tonner¹¹³, Anne-Marie Taylor¹¹³, Maureen Edwards¹¹⁴, Carrie Ho¹¹⁴, Marie McGill¹¹⁴, Mary Porteous¹¹⁴, Pauline Pearson¹¹⁴, Sarah Irvine¹¹⁵, Peter Brockie¹¹⁶, Jillian Foster¹¹⁶, Nicola Johns¹¹⁶, Sue McKenzie¹¹⁶, Jean Rothery¹¹⁶, Gareth Thomas¹¹⁶, Shona Yates¹¹⁶, Catherine Deith¹¹⁷, Jane Ireland¹¹⁷, Stuart Ritchie¹¹⁷, Liz Burrows¹¹⁸, Amy Fletcher¹¹⁸, Alison Harding¹¹⁸, Fiona Laver¹¹⁸, Mark Silva¹¹⁸, Aileen Thomson¹¹⁸, Carol Chu¹¹⁹, Carole Evans¹¹⁹, Deena Gallentree^{119,121}, Stephanie Hamer^{119,121}, Alison Kraus^{119,121}, Ivana Markova¹¹⁹, Ashok Raman¹¹⁹, Alyson Andrew¹²⁰, Julie Frost¹²⁰, Rupert Noad¹²⁰, Emma Hobson¹²¹, Stuart Jamieson¹²¹, Mandy Longthorpe¹²¹, Ivana Markova¹²¹, Hannah Musgrave¹²¹, Caroline Peacy¹²¹, Ashok Raman¹²¹, Liz Rowett¹²¹, Jean Toscano¹²¹, Sue Wild¹²¹, Pam Yardumian¹²¹, Carole Clayton¹²², Heather Dipple¹²², Dawn Freire-Patino¹²², Caroline Hallam¹²², Julia Middleton¹²², Sundus Alusi¹²³, Rhys Davies¹²³, Kevin Foy¹²³, Emily Gerrans¹²³, Louise Pate¹²³, Uruj Anjum¹²⁴, Jan Coebergh¹²⁴, Charlotte Eddy¹²⁴, Nayana Lahiri^{124,126}, Meriel McEntagart¹²⁴, Michael Patton¹²⁴, Maria Peterson¹²⁴, Sarah Rose¹²⁴, Thomasin Andrews^{125,126}, Andrew Dougherty¹²⁵, Charlotte Golding¹²⁵, Fred Kavalier¹²⁵, Hana Laing¹²⁵, Alison Lashwood¹²⁵, Dene Robertson¹²⁵, Deborah Ruddy¹²⁵, Alastair Santhouse¹²⁵, Anna Whaite¹²⁵, Stefania Bruno¹²⁶, Elvina Chu^{126,129}, Karen Doherty¹²⁶, Charlotte Golding¹²⁶, Salman Haider¹²⁶, Davina Hensman¹²⁶, Monica Lewis¹²⁶, Marianne Novak¹²⁶, Aakta Patel¹²⁶, Nicola Robertson¹²⁶, Elisabeth Rosser¹²⁶, Sarah Tabrizi^{126*}, Rachel Taylor¹²⁶, Thomas Warner¹²⁶, Edward Wild¹²⁶, Natalie Arran¹²⁷,

Judith Bek¹²⁷, Jenny Callaghan^{127,138**}, David Craufurd¹²⁷, Ruth Fullam¹²⁷, Marianne Hare¹²⁷, Liz Howard¹²⁷, Susan Huson¹²⁷, Liz Johnson¹²⁷, Mary Jones¹²⁷, Ashok Krishnamoorthy¹²⁷, Helen Murphy¹²⁷, Emma Oughton¹²⁷, Lucy Partington-Jones¹²⁷, Dawn Rogers¹²⁷, Andrea Sollom¹²⁷, Julie Snowden¹²⁷, Cheryl Stopford¹²⁷, Jennifer Thompson¹²⁷, Iris Trender-Gerhard¹²⁷, Nicola Verstraelen (formerly Ritchie)^{127,133}, Leann Westmoreland¹²⁷, Ginette Cass¹²⁸, Lynn Davidson¹²⁸, Jill Davison¹²⁸, Suresh Komati¹²⁸, Sharon McDonnell¹²⁸, Zeid Mohammed¹²⁸, Karen Morgan¹²⁸, Lois Savage¹²⁸, Baldev Singh¹²⁸, Josh Wood¹²⁸, Caroline Knight¹²⁹, Mari O'Neill¹²⁹, Debasish Das Purkayastha¹²⁹, Andrea H Nemeth¹³⁰, Gill Siuda¹³⁰, Ruth Valentine¹³⁰, Richard Armstrong¹³⁰, David Harrison¹³¹, Max Hughes¹³¹, Sandra Large¹³¹, John O Donovan¹³¹, Amy Palmer¹³¹, Andrew Parkinson¹³¹, Beverley Soltysiak¹³¹, Leanne Timings¹³¹, Josh Williams¹³¹, John Burn¹³², Rebecca Weekes¹³², Janet Craven¹³², Wendy Bailey¹³², Caroline Coleman¹³², Diane Haig-Brown¹³², Steve Simpson¹³², Marianne Hare¹³³, Tahir Majeed¹³³, Oliver Bandmann¹³⁴, Alyson Bradbury¹³⁴, Helen Fairtlough¹³⁴, Kay Fillingham¹³⁴, Isabella Foustanos¹³⁴, Paul Gill¹³⁴, Mbombe Kazoka¹³⁴, Kirsty O'Donovan¹³⁴, Louise Nevitt¹³⁴, Nadia Peppa^{134,138**}, Oliver Quarrell^{134*}, Cat Taylor^{134,138**}, Katherine Tidswell¹³⁴, Kirsty O'Donovan¹³⁴, Veena Agarwal¹³⁵, Mary Anderson¹³⁵, Kerry Gunner¹³⁵, Kayla Harris¹³⁵, Elaine Hayward¹³⁵, Melanie Heywood¹³⁵, Liane Keys¹³⁵, Lesley MacKinnon¹³⁵, Christopher Kipps¹³⁵, Sarah Smalley¹³⁵, Pamela Bethwaite¹³⁶, Rachel Edwards¹³⁶, Kathleen Fuller¹³⁶, Lesley Gowers¹³⁶, Michelle Phillips¹³⁶, Kingsley Powell¹³⁶, Ida Biunno^{137*}, Juliana Bronzova^{138*}, Joe Giuliano^{139*}, Olivia J. Handley^{138**,*}, Sergey Illarioshkin^{140*}, Torsten Illmann^{141*}, Jamie Levey^{138*}, Tim McLean^{138*}, Susana Pro Koivisto^{138,143**,*}, Markku Päivärinta^{144*}, Tereza Uhrova^{145*}, Sabrina Betz^{138**}, Adrien Come^{138**}, Selene Capodarca^{138**}, Sébastien Charpentier^{138**}, Wildson Vieira da Silva^{138**}, Martina Di Renzo^{138**}, Ana Maria Finisterra^{138**}, Camille Genoves^{138**}, Mette Gilling^{138**}, Carina Hvalstedt^{138**}, Kerstin Koppers^{138**}, Claudia Lamanna^{138**}, Matilde Laurà^{138**}, Kristina Münkel^{138**}, Lisanne Mütze^{138**}, Martin Oehmen^{138**}, Helene Padieu^{138**}, Laurent Paterski^{138**}, Beate Rindal^{138**}, Niini Røren (formerly Heinonen)^{138**}, Pavla Šašinková^{138**}, Yury Seliverstov^{138**}, Erika Timewell^{138**}, Marie-Noelle Witjes-Ané^{138**}, Elizaveta Yudina^{138**}, Eugeniusz Zielonka^{138**}.

4. Medizinische Universitäts Graz, Psychiatrie, Graz, Austria.
5. Universitätsklinik Innsbruck, Neurologie, Innsbruck, Austria.
6. Christian-Doppler-Klinik Salzburg, Universitätsklinikum der PMU, Universitätsklinik für Neurologie, Salzburg, Austria.
7. St-Luc University Hospital, Bruxelles, Belgium.
8. Institut de Pathologie et de Génétique (IPG), Charleroi, Belgium.
9. Universitair Ziekenhuis Gasthuisberg, Leuven, Belgium.
10. Neurologická klinika, Fakultní nemocnice Olomouc, Olomouc, Czech Republic.
11. Extrapyramidové centrum, Neurologická klinika, 1. LF UK a VFN, Prague, Czech Republic.
12. Aarhus University Hospital, Aarhus, Denmark.
13. Rigshospitalet, Memory clinic, Copenhagen University Hospital, Denmark.
14. Odense University Hospital, Odense, Denmark.
15. Ålands hälso- och sjukvård, Doktorsvägen 1, Mariehamn, Finland.
16. Department of medical genetics, Helsinki-Vaestollitto, Finland.
17. Kuopio University Hospital, Neurology Dept., Finland.
18. Dep. of Neurology, Oulu, Finland.
19. Dep. of Medical Genetics, Oulu, Finland.

20. Terveystalo Healthcare Service Centre, Tampere, Finland.
21. Rehabilitation Centre Suvituuli, Turku-Suvituuli, Finland.
22. Centre de référence des maladies neurogénétique-CHU d'Angers, Angers, France.
23. Hôpital Pellegrin, Bordeaux, France.
24. Hôpital Gabriel Montpied, Clermont-Ferrand, France.
25. Hôpital Henri Mondor, Creteil, France.
26. CHRU Roger Salengro, Lille, France.
27. CHU Sud, Amiens, France.
28. Hôpital La Timone, Marseille, France.
29. Hôpital de la Pitié Salpêtrière, Paris, France.
30. Hôpital Charles Nicolle, Rouen, France.
31. Hôpital Civil, Strasbourg, France.
32. Hôpital Purpan, Toulouse, France.
33. Universitätsklinikum Aachen, Neurologische Klinik, Aachen, Germany.
34. Universitätsmedizin Berlin, Klinik und Poliklinik für Neurologie, Berlin Germany.
35. Huntington-Zentrum (NRW) Bochum im St. Josef-Hospital, Bochum, Germany.
36. Reha Zentrum in Dinslaken im Gesundheitszentrums Lang, Dinslaken, Germany.
37. Universitätsklinikum Carl Gustav Carus an der Technischen Universität Dresden, Klinik und Poliklinik für Neurologie, Dresden, Germany.
38. Universitätsklinikum Erlangen, Molekulare Neurologie und Klinik für Neurologie, Erlangen, Germany.
39. Universitätsklinik Freiburg, Neurologie, Freiburg, Germany.
40. Universitätsklinikum Hamburg-Eppendorf, Klinik und Poliklinik für Neurologie Hamburg, Germany.
41. Neurologische Klinik mit Klinischer Neurophysiologie, Medizinische Hochschule Hannover, Hannover, Germany.
42. Schwerpunktpraxis Huntington, Neurologie und Psychiatrie, Itzehoe, Germany.
43. Klinik für Psychiatrie und Psychotherapie Marburg-Süd, Marburg KPP, Germany.
44. Huntington-Ambulanz im Neuro-Kopfzentrum - Klinikum rechts der Isar der Neurologischen Klinik und Poliklinik der Technischen Universität München, München, Germany.
45. Universitätsklinikum Münster, Klinik und Poliklinik für Neurologie, Münster, Germany.
46. Isar-Amper-Klinikum - Klinik Taufkirchen (Vils), Taufkirchen, Germany.
47. Universitätsklinikum Ulm, Neurologie, Ulm, Germany.
48. Universitätsklinikum Würzburg, Neurologie, Würzburg, Germany.
49. Neurophysiopathology of Pain Unit, Basic Medical, Neuroscience and Sensory System Department, University of Bari, Bari, Italy.
50. DIBINEM - Alma Mater Studiorum - Università di Bologna, IRCCS Istituto delle Scienze Neurologiche di Bologna, Bologna, Italy.
51. Department of Neuroscience, University of Florence & Careggi University Hospital, Florence, Italy.
52. Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics, Maternal and Child Health, University of Genova, Genoa, Italy.
53. SODS Genetica delle Malattie Neurodegenerative e Metaboliche & U.O. Neurologia, Fondazione IRCCS Istituto Neurologico Carlo Besta, Milan, Italy.

54. Naples (Department of Neurosciences and Reproductive and Odontostomatological Sciences, Federico II University of Naples):
55. IRCCS Neuromed, Pozzilli (IS), Italy.
56. Department of Neurology, Università Cattolica del Sacro Cuore; Institute of Translational Pharmacology & Institute of Cognitive Sciences and Technologies, National Research Council of Italy, Rome, Italy.
57. Azienda Ospedaliera Sant'Andrea; Department of Neuroscience, Mental Health and Sensory Organs (NESMOS), Faculty of Medicine and Psychology, Sapienza University of Rome; Institute of Translational Pharmacology & Institute of Cognitive Sciences and Technologies, National Research Council of Italy, Rome, Italy.
58. Medisch Spectrum Twente, Enschede, Netherlands.
59. Polikliniek Neurologie, Groningen, Netherlands.
60. Leiden University Medical Centre, Leiden, Netherlands.
61. Maastricht University Medical Center, Maastricht, Netherlands.
62. Universitair Medisch Centrum St. Radboud, Neurology, Nijmegen, Netherlands.
63. Haukeland University Hospital, Dept of Medical Genetics and Olaviken Psychiatric Hospital, Bergen, Norway.
64. Dept. of Medical Genetics, Dept. of Neurology, Dept. of Neurorehabilitation, Oslo University Hospital, Norway.
65. St. Olavs Hospital, Trondheim, Norway.
66. St. Adalbert Hospital, Gdansk, Medical University of Gdansk, Neurological and Psychiatric Nursing Dpt., Gdansk, Poland.
67. Medical University of Silesia, Katowice, Poland.
68. Krakowska Akademia Neurologii, Krakow, Poland.
69. Poznan University of Medical Sciences, Poznan, Poland.
70. Medical University of Warsaw, Neurology, Warsaw-MU, Warsaw, Poland.
71. Institute of Psychiatry and Neurology Dep. of Genetics, First Dep. of Neurology, Warsaw-IPiN, Warsaw, Poland.
72. Hospital Universitário de Coimbra, Coimbra, Portugal.
73. Hospital dos Capuchos, Centro Hospitalar Lisboa Central, Lisbon, Portugal.
74. Hospital de Santa Maria, Clinical Pharmacology Unit, Instituto de Medicina Molecular, Lisbon, Portugal
75. Hospital Fernando da Fonseca, Lisbon, Portugal.
76. Hospital de São João, Porto, Portugal.
77. Hospital Infanta Cristina, Badajoz, Spain.
78. Hospital Universitari de Bellvitge, Barcelona, Spain.
79. Hospital Clínic i Provincial, Barcelona, Spain.
80. Barcelona-Hospital Mútua de Terrassa, Barcelona, Spain.
81. Hospital Mare de Deu de La Merced, Barcelona, Spain.
82. Hospital de la Santa Creu i Sant Pau, Barcelona-Santa Cruz y San Pablo, Barcelona, Spain.
83. Hospital de Cruces, Bilbao, Spain.
84. Servicio de Neurología Hospital General Yagüe, Burgos, Spain.
85. Hospital Insular de Gran Canaria, Canarias, Spain
86. Hospital Universitario, Fuenlabrada, Spain.
87. Hospital Universitario San Cecilio, Neurología, Granada, Spain

88. Fundación CIEN, Madrid-BTCIEN, Madrid, Spain.
89. Hospital Clínico Universitario San Carlos, Madrid-Clinico, Madrid, Spain.
90. Hospital Ramón y Cajal, Neurología, Madrid RYC, Madrid, Spain.
91. Madrid-Fundación Jiménez Díaz, Madrid FJD, Madrid, Spain.
92. Hospital Universitario Virgen de la Arrixaca, Murcia, Spain.
93. Hospital Central de Asturias, Oviedo, Spain.
94. Hospital Universitario Son Espases, Palma de Mallorca, Spain.
95. Complejo Hospitalario de Navarra, Pamplona, Spain.
96. Hospital Universitario Virgen del Rocío, Sevilla, Spain
97. Hospital Virgen Macarena, Sevilla, Spain
98. Residencia Santa Ana, Sevilla, Spain.
99. Hospital la Fe, Valencia, Spain.
100. Sahlgrenska University Hospital, Göteborg, Sweden.
101. Stockholm Karolinska University Hospital, Stockholm, Sweden.
102. Umeå University Hospital, Umeå, Sweden.
103. Uppsala University Hospital, Uppsala, Sweden.
104. Swiss HD Zentrum and Zentrum für Bewegungsstörungen, Neurologische Klinik und Poliklinik, Universität Bern, Bern, Switzerland.
105. Centre Hospitalier Universitaire Vaudois (CHUV), Lausanne, Switzerland
106. University Hospital and University of Zurich, Zürich, Switzerland.
107. NHS Grampian Clinical Genetics Centre & University of Aberdeen, Aberdeen, UK.
108. North Devon Healthcare NHS Trust, Barnstaple, Devon, UK.
109. The Barberry Centre, Dept of Psychiatry, Birmingham, UK.
110. North Bristol NHS Trust, Southmead Hospital, Bristol, UK.
111. Cambridge Centre for Brain Repair, Forvie Site, Cambridge, UK.
112. Schools of Medicine and Biosciences, Cardiff University, Cardiff, UK.
113. Scottish Huntington's Association, Ninewells Hospital, Dundee, UK.
114. SE Scotland Genetic Service, Western General Hospital, Edinburgh, UK.
115. Department of Neurology Royal Devon and Exeter Foundation Trust Hospital, Exeter, UK.
116. Scottish Huntington's Association Whyteman's Brae Hospital, Fife, UK.
117. Glasgow HD Management Clinic, Southern General Hospital, Glasgow, UK.
118. Department of Neurology Gloucestershire Royal Hospital, Gloucester, UK.
119. Castle Hill Hospital, Hull, UK
120. Millaton Court, Launceston, UK.
121. Chapel Allerton Hospital, Department of Clinical Genetics, Leeds, UK.
122. Leicestershire Partnership Trust, Mill Lodge, Leicester, UK.
123. Walton Centre for Neurology and Neurosurgery, Liverpool, UK.
124. St. Georges Hospital, London, UK.
125. Guy's Hospital, London, UK.
126. The National Hospital for Neurology and Neurosurgery, London, UK.
127. Genetic Medicine, University of Manchester, Manchester Academic Health Sciences Centre and Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK.
128. Centre for Life, Institute of Medical Genetics, Newcastle-upon-Tyne, UK.
129. St Andrew's Healthcare, Northampton, UK.

130. Oxford University Hospitals NHS Trust, Dept. of Neurosciences, University of Oxford, Oxford, UK.
131. Plymouth Huntington Disease Service, Mount Gould Hospital, Plymouth, UK.
132. Brain Injury Service, Poole Hospital, Poole, UK.
133. Neurology Department, Preston Royal Hospital, Preston, UK.
134. The Royal Hallamshire Hospital– Sheffield Children’s Hospital, Sheffield, UK.
135. Southampton General Hospital, Southampton, UK.
136. Victoria Centre, Great Western Hospital, Swindon, UK.
137. Institute for Genetic and Biomedical Research, University of Milan, Italy
138. European Huntington’s Disease Network (EHDN), Ulm, Germany
139. CHDI Foundation, Inc., New York, USA
140. Research Center of Neurology, Moscow, Russia
141. 2mt Software GmbH, Ulm, Germany
142. Clinic of Neurology, Charles University and General Teaching Hospital, Prague, Czech Republic.
143. Center for Rare Disorders, Oslo University Hospital HF, Rikshospitalet, Norway
144. Department of Neurology, Turku University Hospital, Turku, Finland
145. Clinic of Psychiatry, Charles University and General Teaching Hospital, Prague, Czech Republic.
146. IRCCS Casa Sollievo della Sofferenza, San Giovanni Rotondo, Italy
147. LIRH Foundation, Rome, Italy

Table 1 Characteristics of those with and without a cancer diagnosis in the REGISTRY cohort

Age	Non-cancer patients	Cancer patients
	n=6355	n= 173
0 to 10	1 (0.02%)	0 (0%)
11 to 20	14 (0.2%)	0 (0%)
21 to 30	373 (5.9%)	0 (0%)
31 to 40	942 (14.8%)	2 (1.2%)
41 to 50	1588 (25.0%)	14 (8.1%)
51 to 60	1621 (25.5%)	36 (20.8%)
61 to 70	1218 (19.2%)	57 (33.0%)
71 to 80	502 (7.9%)	53 (30.6%)
81 to 90	92 (1.5%)	10 (5.8%)
91 to 100	4 (0.06%)	1 (0.6%)
Average	52.1	66.0
M/F	3009/3346 (47.4%)	62/111 (64.2%)
CAG Repeat Length	44.1 (\pm 4.2) n=5029	42.1 (\pm 2.3) n=173
Age at onset HD	45.7 (\pm 13.9) n=6354	58.0 (\pm 10.7) n=154

Table 2 Standardised incidence rates of cancers in the REGISTRY population

Cancer site	SIR (95% CI)	# Cases
Breast	0.37 (0.26-0.48)*	44
Prostate	0.30 (0.17-0.43)*	20
Skin	0.59 (0.33-0.85)*	20
Uterus	0.66 (0.36-0.96)*	19
Colorectal	0.26 (0.13-0.39)*	16
Kidney	0.40 (0.12-0.68)*	8
Other Sites	0.19 (0.13-0.24)*	46
All	0.26 (0.22-0.30)*	173

SIR = standardised incidence rate. CI = confidence interval. *significantly different from expected. Other sites include ovary (8), lung (4), bladder (4), brain (3), thyroid (3), liver/bile duct (3) and stomach (3).