Table 1.3.3.1
Crystal structures and genetic diseases

Crystal structure	Disease	Reference
Acidic fibroblast growth factor receptor	Familial Pfeiffer syndrome	[1]
Alpha-1-antitrypsin	Alpha-1-antitrypsin deficiency	[2]
Antithrombin III	Hereditary thrombophilia	[3], [4]
Arylsulfatase A	Leukodystrophy	[5]
Aspartylglucosaminidase	Aspartylglusominuria	[6]
Beta-glucuronidase	Sly syndrome	[7]
Branched-chain alpha-keto acid dehydrogenase	Maple syrup urine syndrome, type Ia	[39]
Carbonic anhydrase II	Guibaud–Vainsel syndrome, Marble brain disease	[8]
p53	Cancer	[9], [10]
Ceruloplasmin	Hypoceruloplasminemia	[11]
Complement C3	C3 complement component 3 deficiency	[12]
Cystatin B	Progressive myoclonus epilepsy	[13]
Factor VII	Factor VII deficiency	[14]
Factor VIII	Factor VIII deficiency	[40]
Factor X	Factor X deficiency (Stuart–Prower factor deficiency)	[15]
Factor XIII	Factor XIII deficiency	[16]
Fructose-1,6-bisphosphate aldolase	Fructose intolerance (fructosemia)	[41]
Gelsolin	Amyloidosis V	[17]
Growth hormone	Growth hormone deficiency	[18]
Haemochromatosis protein HFE	Hereditary haemochromatosis	[19]
Haemoglobin	Beta-thalassemia, sickle-cell anaemia	[20]
Tyrosine hydroxylase	Hereditary Parkinsonism	[21]
Hypoxanthine–guanine phosphoribosyltransferase	Lesch–Nyhan syndrome	[22]
Insulin	Hyperproinsulinemia, diabetes	[42]
Isovaleryl–coenzyme A dehydrogenase	Isovaleric acid CoA dehydrogenase deficiency	[23]
Lysosomal protective protein	Galactosialidosis	[24]
Ornithine aminotransferase	Ornithine aminotransferase deficiency	[25]
Ornithine transcarbamoylase	Ornithine transcarbamoylase deficiency	[43]
p16INK4a tumour suppressor	Cancer	[26]
Phenylalanine hydroxylase	Phenylketonuria	[27]
Plasminogen	Plasminogen deficiency	[28], [29], [30]
Protein C	Protein C deficiency	[31]
Purine nucleotide phosphorylase	Purine nucleotide phosphorylase deficiency	[32]
Serum albumin	Dysalbuminemic hyperthyroxinemia	[33]
Superoxide dismutase (Cu, Zn-dependent)	Familial amyotrophical lateral sclerosis	[34]
Thrombin	Hypoprothrombinemia, dysprothrombinemia	[35]
Transthyretrin	Amyloidosis I	[36]
Triosephosphate isomerase	Triosephosphate isomerase deficiency	[37]
Trypsinogen	Hereditary pancreatitis	[38]

References: [1] Blaber *et al.* (1996); [2] Loebermann *et al.* (1984); [3] Carrell *et al.* (1994); [4] Schreuder *et al.* (1994); [5] Lukatela *et al.* (1998); [6] Oinonen *et al.* (1995); [7] Jain *et al.* (1996); [8] Liljas *et al.* (1972); [9] Cho *et al.* (1994); [10] Gorina & Pavletich (1996); [11] Zaitseva *et al.* (1996); [12] Nagar *et al.* (1998); [13] Stubbs *et al.* (1990); [14] Banner *et al.* (1996); [15] Padmanabhan *et al.* (1993); [16] Yee *et al.* (1994); [17] McLaughlin *et al.* (1993); [18] DeVos *et al.* (1992); [19] Lebron *et al.* (1998); [20] Harrington *et al.* (1997); [21] Goodwill *et al.* (1997); [22] Eads *et al.* (1994); [23] Tiffany *et al.* (1997); [24] Rudenko *et al.* (1995); [25] Shah *et al.* (1997); [26] Russo *et al.* (1998); [27] Erlandsen *et al.* (1997); [28] Mulichak *et al.* (1991); [29] Mathews *et al.* (1996); [30] Chang, Mochalkin *et al.* (1998); [31] Mather *et al.* (1996); [32] Ealick *et al.* (1990); [33] He & Carter (1992); [34] Parge *et al.* (1992); [35] Bode *et al.* (1989); [36] Blake *et al.* (1978); [37] Mande *et al.* (1994); [38] Gaboriaud *et al.* (1996); [39] Ævarsson *et al.* (2000); [40] Pratt *et al.* (1999); [41] Gamblin *et al.* (1990); [42] Bentley *et al.* (1976); [43] Shi *et al.* (1998).

major infectious agents will be completed five years hence, if not sooner. This is likely to be followed up by '*selected pathogen structural genomics*', which will provide a wealth of pathogen protein structures for the design of new pharmaceuticals and probably also for vaccines.

This overview, written in late 1999, aims to convey some feel of the current explosion of 'crystallography in medicine'. Ten, perhaps even five, years ago it might have been feasible to make an almost comprehensive list of all protein structures of potentially direct medical relevance. Today, this is virtually impossible. Here we mention only selected examples in the text with apologies to the crystallographers whose projects should also have been mentioned, and to the NMR spectroscopists and electron microscopists whose work falls outside the scope of this review. Tables 1.3.3.1 and 1.3.4.1 to 1.3.4.5 provide more information, yet do not claim to cover comprehensively this exploding field. Also, not all of the structures listed were determined with medical applications in mind, though they might be exploited for drug design one day. These tables show at the same time tremendous achievements as well as great gaps in our structural knowledge of proteins from humans and human pathogens.

1.3.3. Crystallography and genetic diseases

Presently, an immense number of genetic diseases have been characterized at the genetic level and archived in OMIM [On-line Mendelian Inheritance in Man. Center for Medical Genetics, Johns Hopkins University (Baltimore, MD) and the National Center for Biotechnology Information, National Library of Medicine (Bethesda, MD), 1999. URL: http://www.ncbi.nlm.nih.gov/omim/], with many more discoveries to occur in the next decades. Biomolecular crystallography has been very successful in explaining the cause of numerous genetic diseases at the atomic level. The stories of sickle cell anaemia, thalassemias and other deficiencies of haemoglobin set the stage (Dickerson & Geis, 1983), followed by numerous other examples (Table 1.3.3.1). Given the frequent occurrence of mutations in humans, it is likely that for virtually every structure of a human protein, a number of genetic diseases can be rationalized at the atomic level. Two investigations from the authors' laboratory may serve as examples:

(i) The severity of various cases of galactosialidosis – a lysosomal storage disease – could be related to the predicted