

Association of Alcohol Use Disorder Risk With *ADH1B*, *DRD2*, *FAAH*, *SLC39A8*, *GCKR*, and *PDYN* Genetic Polymorphisms

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Abstract. *Background/Aim:* Alcohol use disorder (AUD) is a chronic, multifactorial psychiatric condition with an enormous impact on public health and social cost. Genetic studies suggest a heritability, and genome-wide association studies (GWAS) have revealed genetic polymorphisms influencing AUD development. Our study aimed to investigate known variants located in *ADH1B*, *DRD2*, *FAAH*, *SLC39A8*, *GCKR*, and *PDYN* genes (*rs1229984*, *rs7121986*, *rs324420*, *rs13107325*, *rs1260326*, *rs2281285* respectively) in an AUD Greek cohort in order to shed more light on the genetic predisposition to AUD. *Materials and Methods:* Alcohol-dependent individuals (*n*=251) meeting both the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the ICD-10 guidelines for alcohol abuse and dependence, and control individuals (*n*=280) were recruited. DNA was extracted from whole blood and PCR-restriction

fragment length polymorphism (RFLP-PCR) or allele-specific PCR method was used for genotyping. *Results:* Individuals carrying the *FAAH* *rs324420* A allele were significantly associated with increased risk of AUD (*p*<0.0001). *SLC39A8* *rs13107325* T allele and *ADH1B* *rs1229984* T allele are overrepresented in control subjects (*p*<0.0001 and *p*<0.0001, respectively). The associations are maintained following an adjustment for age and sex and Bonferroni correction. *GCKR* *rs13107325*, *DRD2* *rs7121986*, and *PDYN* *rs2281285* polymorphisms did not show a significant association with AUD in the studied population after Bonferroni correction. *Conclusion:* Susceptibility to AUD is related to variations in *FAAH*, *ADH1B*, and *SLC39A8* genes. These polymorphisms could serve as potential biomarkers for AUD risk.

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Alcohol use disorders (AUDs) are characterized by uncontrolled alcohol consumption, compulsive drinking, and negative feelings during alcohol withdrawal that can lead to a chronic and relapsing course (1). AUD is described as a single spectrum of problematic use and clinically significant impairment based on endorsement of at least two of the 11 criteria that assess behavioral and physical manifestations of heavy alcohol consumption by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (2). Current estimates suggest that 5.6% of individuals met the AUD criteria during the previous year, leading to important socioeconomical issues and public health losses (3, 4). Recently, data showed that the total quantity of lifetime alcohol consumption and the combination of drinking frequency combined with the amount consumed per incident augment the risk of alcohol-related harm, in a dose-

dependent manner (5). For instance, a causal and dose-related link between AUD and various types of cancer has been proposed mostly in the gastrointestinal system, breast, and larynx (6).

The prevalence of AUD is increased among high/upper middle-income countries in both sexes. Approximately 3 million deaths annually (5.3% of all deaths) are due to alcohol abuse, along with more than 5% of the disease burden globally as WHO data suggests (1). Nevertheless, alcohol use and its effects vary remarkably across countries. The European Union (EU) represents the region with the most increased alcohol consumption globally; 87% of the adolescent's drink at least once in their life. This percentage is higher than that of the American adolescents which is 70% (7). According to WHO, in 2016, the prevalence of alcohol abuse in the Greek population was 9.4% for males and 2.9% for females, while alcohol dependence was 4.2% and 1.3%, respectively (8), indicating that AUDs in Greece are not as common as in North Europe. During the past two decades, nationwide trends present a decline in alcohol use; however, the frequency of alcohol intake by Greek teenagers remains one of the highest in Europe (9). Although AUDs present a warning prevalence and an economic burden (that affects the individuals, their families, and the society) no more than 20% of individuals seek or receive any treatment (10). Even worse, only a small fraction of the affected individuals is prescribed medication with demonstrated efficacy in heavy drinking reduction or abstinence promotion (11).

The pathophysiology of AUDs, as other chronic multifactorial diseases, is attributed to the combination of genetic risk and environmental factors (12). Strong predictors of AUD initiation could be the endophenotypes that are to an extent heritable and include an individual's response to alcohol and neurobiological susceptibilities (13). A key for developing an effective treatment for AUD could be the deep understanding of its pathophysiological mechanisms (14). The substantial genetic component of alcohol consumption guides the efforts to recognize specific variants across the genome related to AUD, since the heritability of the disease is estimated as high as 50% (2). A plethora of variants have been identified by genome-wide association studies (GWAS) (15-19), with most studies using alcohol consumption (*e.g.*, drinks/week), since it represents an easily assessable measurement.

A twin study found a single-nucleotide polymorphism (SNP)-based heritability of AUD in more than a third of patients (15). Accumulated data from GWAS showed various chromosomal loci to be associated with a greater AUD risk, with some of them presenting significant reproducibility among studies. The most profound connections found in GWAS were the functional polymorphisms in two enzymes affecting alcohol metabolism: alcohol dehydrogenase (*ADH*) and aldehyde dehydrogenase (*ALDH*) (19-24).

Among variants, *ADH1B* (rs1229984) has been unequivocally linked to the etiology of alcohol addiction (17, 25, 26). A significant conclusion was that missense polymorphisms in *ADH1B* were associated with AUD in two independent populations (15). An additional implicated gene is the glucokinase receptor gene (*GCKR*) that regulates cellular trafficking in liver cells. The SNP rs1260326 in *GCKR* was robustly correlated to alcohol intake (*i.e.*, drinks/week) in large-scale GWAS; this coding missense SNP has been linked with over 25 metabolic traits including type II diabetes. (15, 17-19, 26). To date, another gene locus, (rs7121986) in *DRD2* gene has been linked to AUD and other addiction phenotypes, but not to alcohol consumption (17). *DRD2* represents a biologically plausible candidate for alcohol dependence susceptibility as shown by *in vivo* and *in vitro* experiments (27); since affected *DRD2* expression results in heterogeneous responses to substances (28) bearing a high addiction risk (26). A few GWAS have linked the rs13107325 polymorphism, located in the Zn transporter gene *SLC39A8*, to AUD in European populations (17, 26). *SLC39A8*, one of the most pleiotropic genes, is involved in several biological processes [blood pressure (29), BMI (30), Crohn's disease (31), serum levels of Mn (32), HDL-cholesterol (33), and schizophrenia (34)]; however, its role in AUD is not sufficiently studied. The *FAAH* rs324420 variant has been linked to substance use disorders, such as cannabis dependence and evidence suggests that altered *FAAH* activity could influence alcohol use (35, 36), even though the findings are heterogeneous and complex (37-40). The above-mentioned variant has ancestry-specific effects, suggesting variable results between different populations (36). Likewise, various polymorphisms in *PDYN* are implicated in the risk for alcohol (41) opioid and cocaine dependence (42, 43). *PDYN* could be a biologically plausible candidate for substance use disorders, as this gene encodes dynorphins (DYNs), which belong to the opioid peptide family and are crucial regulators in a plethora of brain pathways. Specifically, *PDYN* rs2281825 has been correlated with depression symptoms in heroin addicted (44) and alcohol negative craving (45) but the findings remain inconsistent (46).

Most of the aforementioned gene polymorphisms have been linked to AUD susceptibility *via* the available GWAS. Although some of these SNPs have been already studied in multiple genetic studies, the results are inconsistent in different populations and therefore, their role remains to be elucidated. In an attempt to validate previous genetic associations with AUD, our study aimed to investigate known gene polymorphisms located in *ADH1B*, *DRD2*, *FAAH*, *SLC39A8* and *GCKR* genes (rs1229984, rs7121986, rs324420, rs13107325, rs1260326, respectively) in an AUD Greek cohort in order to shed more light on AUD genetic risk.

Materials and Methods

Study population. This case-control study included a total of 531 participants of Greek origin, 251 were alcohol-dependent individuals (cases) and 280 healthy individuals (controls), recruited from the Psychiatric Hospital of Attica (PHA). Cases attended a treatment inpatient program for alcohol dependence during the current study. Diagnostic assessments were determined using the Greek version of the International Neuropsychiatric Interview (M.I.N.I.) clinical inventory (47). Eligible participants met the DSM-IV as well as the ICD-10 criteria for alcohol abuse and dependence, whereas cases with comorbid major mental disorders, such as major depression, bipolar disorder, and schizophrenia were excluded. Furthermore, a family history of alcoholism was recorded. Alcohol dependence severity was estimated through the co-assessment of factors such as the total duration of alcohol use in years, as well as the amount of daily use/abuse of alcohol in years. The non-alcoholic control group was recruited from local communities. All healthy controls were exposed to alcohol but did not report any harmful use or alcohol dependence. A history of drug abuse (except nicotine) and major psychiatric disorders were excluded following the completion of self-report questionnaires. All participants provided written informed consent. The study was conformed to the Declaration of Helsinki.

Genotyping. Genomic DNA was extracted from peripheral whole blood using the NucleoSpin Blood Kit (Macherey-Nagel, Düren, Germany) according to the manufacturer's instructions. The quality and concentration of purified DNA was estimated using the NanoDrop 8000 Spectrophotometer (Thermo Fisher Scientific Inc., Waltham, MA, USA).

Genotypes for the rs324420 (*FAAH* gene), rs1260326 (*GCKR* gene) rs1229984 (*ADH1B*), and rs2281285 (*PDYN*) were determined using the PCR-restriction fragment length polymorphism (RFLP-PCR) method. The primer sequences for rs324420 were forward primer: 5'-GGA AGT GAA CAA AGG GAC CA-3' and reverse primer: 5'-AAT GAC CCA AGA TGC AGA GC-3 (size 204 bp). The PCR products were digested by the restriction enzyme *StyI* (New England BioLabs, Ipswich, MA, USA) resulting in two fragments of 133 and 71 bp in CC genotype, whereas in the presence of the A allele, products remained uncut as a single fragment of 204 bp (48).

For the rs1260326, PCR was conducted using the forward primer: 5'-TGC AGA CTA TAG TGG AGC CG-3' and reverse: 5'-CAT CAC ATG GCC ACT GCT TT-3' followed by digestion with *HpaII* restriction enzyme (Fermentas, Burlington, ON, Canada). When the C allele was present, digestion resulted in 18, 63, and 150 bp fragments; whereas the TT genotype gave two fragments of 18 and 213 bp (49).

Primers used for the rs1229984 genotypes were forward: 5' ACA ATC TTT TCT GAA TCT GAA CAG CTT CTC and reverse: 5' TTG CCA CTA ACC ACG TGG TCA TCT GCG. The PCR product (97 bp) was digested by *Hin6I* restriction enzyme (Fermentas International Inc.). The PCR product was cut in 70 bp and 27 bp restriction fragments where the common C allele was present. The rs2281285 was genotyped as described previously by Hashemi et al. (46).

Genotyping of the rs13107325 (*SLC39A8*) and rs7121986 (*DRD2*) was performed by allele specific PCR. The sequences of the primers were as follows: Common: 5' ACTTTGTGATCCTACT 3', C allele:

Table I. Characteristics of alcohol-dependent individuals and nondependent controls.

Characteristics	Alcohol-dependent individuals (n=251)	Non-alcohol dependent controls (n=280)	p-Value
Sex, N (%)			
Males	191 (76.1)	188 (67.14)	0.39
Females	60 (23.9)	92 (32.86)	0.11
Age, years			
Mean±SD	43.5±11.5	42.8±14.3	0.54
Range	26-62	21-68	
Familial history (n)	88 (35.06%)		
Alcohol consumable, years (mean±SD)	20.46±8.1		
Alcohol abuse, years (mean±SD)	11.93±6.67		
Drug use history (n)	15		

5' TATAATATTTGGAGC 3', T allele: 5' TATAATATTTGGAGC 3' for the rs13107325 and common 5' GTAGAAGAAAACATGAATGC 3' allele-specific C: 5' TGGCCTGCCTTCTCCAC 3', T: 5' GGCCTGCCTTCTCCAT 3' for the rs7121986.

Briefly, PCR for all SNPs was carried out in a total volume of 25 µl, containing 100 ng of genomic DNA, 2.5 µl of 10×PCR buffer, 0.5 µmol/l of each primer, 0.15 mmol/l of dNTP, 1.5 mmol/l of MgCl₂, and 1 U of Taq DNA polymerase (Kappa Biosystems, Cape Town, South Africa).

Statistical analysis. The association between SNP genotypes and alcoholic status was evaluated using the SNPStats tool applying a chi-squared test (50). A Bonferroni corrected p-value was applied to the multifactorial analysis p-values to account for the multiple testing of six different SNPs in the same samples (corrected $\alpha=0.05/6=0.008$). Hardy-Weinberg equilibrium was tested separately in patients and healthy controls using the Fischer's exact test. $p \leq 0.05$ (two-sided) was considered significant.

Results

Two hundred fifty-one (251) alcohol-dependent individuals, 191 males (76%) and 60 females (24%) with a mean age of 43.5±11.5 years (range=26-62 years) were recruited. The healthy control group consisted of two hundred eighty (280) non-alcohol dependent subjects with an average age of 42.8±14.3 years (range=21-68 years), 188 males (67%) and 92 females (33%). A positive family history of alcoholism in first degree relatives was reported by 88 cases (35%). Within cases, the average duration of alcohol use was 20.46±8.1 years, while the average daily alcohol use and abuse was 11.93±6.67 years. The demographic and clinical characteristics of participants are presented in Table I. The allele frequencies were in Hardy-Weinberg equilibrium in both patients and control groups ($p > 0.05$). Table II depicts genotype distributions for each SNP in alcohol-dependent

Table II. Genotype frequencies and allele distribution between alcohol-dependent individuals and controls.

Gene, SNP	Alcohol-dependent individuals (%)	Non-alcohol dependent Controls (%)	OR (95%CI)	p-Value*
<i>FAAH</i> , rs324420				
CC	128 (50.99)	189 (67.5)	1	
AC	108 (43.03)	86 (30.71)	0.54 (0.37 - 0.77)	0.001*
AA	15 (5.98)	5 (1.79)	0.23 (0.08-0.64)	0.004*
C allele	364 (72.51)	464 (82.86)	1	
A allele (effect allele)	138 (27.49)	96 (17.14)	0.55 (0.41-0.73)	<0.0001*
<i>GCKR</i> , rs1260326				
CC	60 (23.90)	84 (30)	1	
CT	113 (45.01)	130 (46.43)	0.82 (0.54-1.25)	0.39
TT	78 (31.07)	66 (23.57)	0.60 (0.38-0.96)	0.04
C allele	233 (46.41)	298 (53.21)	1	
T allele (effect allele)	269 (53.59)	262 (46.79)	0.76 (0.59-0.97)	0.03
<i>SLC39A8</i> , rs13107325				
CC	185 (73.70)	135 (48.21)	1	
CT	61 (24.30)	123 (43.93)	2.76 (1.89-4.04)	<0.0001*
TT	5 (1.99)	22 (7.86)	6.03 (2.23-16.33)	<0.0001*
C allele (effect allele)	431 (85.86)	393 (70.18)	1	
T allele	71 (14.14)	167 (29.82)	2.58 (1.89-3.52)	<0.0001*
<i>ADH1B</i> , rs1229984				
CC	165 (65.74)	143 (51.07)	1	
CT	73 (29.08)	105 (37.50)	1.66 (1.14-2.41)	0.008
TT	13 (5.18)	32 (11.43)	2.84 (1.43-5.62)	0.002*
C allele (effect allele)	403 (80.28)	391 (69.82)	1	
T allele	99 (19.72)	169 (30.18)	1.76 (1.32-2.34)	<0.0001*
<i>DRD2</i> , rs7121986				
CC	141 (56.17)	167 (59.64)	1	
CT	89 (35.46)	102 (36.43)	0.97 (0.67-1.39)	0.93
TT	21 (8.37)	11 (3.93)	0.44 (0.21-0.95)	0.04
C allele	371 (73.90)	436 (77.86)	1	
T allele (effect allele)	131 (26.10)	124 (22.14)	0.80 (0.61-1.07)	0.15
<i>DPYN</i> , rs2281285				
AA	150 (59.76)	192 (68.57)	1	
AG	96 (38.25)	85 (30.36)	0.69 (0.48-0.99)	0.05
GG	5 (1.99)	3 (1.07)	0.47 (0.11-1.99)	0.47
A allele	396 (78.88)	469 (83.75)	1	
G allele (effect allele)	106 (21.12)	91 (16.25)	0.72 (0.53-0.99)	0.04

*Significant after Bonferroni correction ($p < 0.008$).

and non-dependent healthy individuals. *FAAH* rs324420 A allele was found to be significantly associated with increased risk of AUD ($p < 0.0001$). This association remained significant and after Bonferroni correction. A marginal association was observed between *GCKR*, rs1260326 TT genotype and AUD ($p = 0.04$); however, this association did not remain significant after Bonferroni correction. *SLC39A8* rs13107325 T allele, and *ADH1B* rs1229984 T allele were over-represented in non-alcohol dependent controls ($p < 0.0001$, and $p < 0.0001$ respectively), and remained significant after Bonferroni correction, suggesting that *SLC39A8* rs13107325 C allele and *ADH1B* rs1229984 C allele are risk alleles for AUD. Regarding *DRD2* rs7121986 polymorphism, even if there is a marginal association before Bonferroni correction of TT genotype and AUD ($p = 0.04$),

the presence of the T allele was not found to be associated with AUD risk. For *DPYN* rs2281285, there is a marginal association before Bonferroni correction of the G allele and AUD ($p = 0.04$); however, this association was not significant after Bonferroni correction.

It is important to note that, the same trends were maintained following an adjustment for age and sex (Table III) and after Bonferroni correction.

Discussion

Alcohol use disorder is a chronic, complex, multifactorial psychiatric condition with an enormous impact on public health and social cost. The likelihood of AUD is possibly attributed to environmental and genetic risk factors (12), yet

Table III. Genotype distribution between alcohol-dependent individuals and controls adjusted for sex and age.

Model	Genotype	Alcohol-dependent individuals (n=251)	Non-alcohol dependent controls (n=280)	OR (95%CI)	p-Value*
	<i>FAAH</i> , rs324420				
Codominant	C/C	128	189	1.00	
	A/C	108	86	0.55 (0.38-0.79)	3×10 ⁻⁴ *
	A/A	15	5	0.24 (0.08-0.68)	
Dominant	C/C	128	189	1.00	
	A/C – A/A	123	91	0.51 (0.36-0.73)	2×10 ⁻⁴ *
Recessive	C/C – A/C	236	275	1.00	
	A/A	15	5	0.30 (0.10-0.85)	0.015
Overdominant	C/C – A/A	143	194	1.00	
	A/C	108	86	0.60 (0.41-0.86)	0.005*
	<i>GCKR</i> , rs1260326				
Codominant	C/C	60	84	1.00	
	C/T	113	130	0.91 (0.59-1.39)	0.091
	T/T	78	66	0.61 (0.38-0.99)	
Dominant	C/C	60	84	1.00	
	C/T – T/T	191	196	0.78 (0.53-1.16)	0.22
Recessive	C/C – C/T	173	214	1.00	
	T/T	78	66	0.65 (0.44-0.97)	0.032
Overdominant	C/C – T/T	138	150	1.00	
	C/T	113	130	1.16 (0.82-1.65)	0.4
	<i>SLC39A8</i> , rs13107325				
Codominant	C/C	185	135	1.00	
	C/T	61	123	2.58 (1.76-3.80)	<0.0001*
	T/T	5	22	5.46 (1.99-14.96)	
Dominant	C/C	185	135	1.00	
	C/T – T/T	66	145	2.80 (1.93-4.07)	<0.0001*
Recessive	C/C – C/T	246	258	1.00	
	T/T	5	22	3.87 (1.42-10.53)	0.003*
Overdominant	C/C – T/T	190	157	1.00	
	C/T	161	123	2.29 (1.57-3.35)	<0.0001*
	<i>ADH1B</i> , rs1229984				
Codominant	C/C	165	143	1.00	
	C/T	73	105	1.60 (1.09-2.34)	0.0016*
	T/T	13	32	2.88 (1.43-5.77)	
Dominant	C/C	165	143	1.00	
	C/T – T/T	86	137	1.79 (1.25-2.56)	0.0014*
Recessive	C/C – C/T	238	248	1.00	
	T/T	13	32	2.43 (1.23-4.82)	0.008
Overdominant	C/C – T/T	178	175	1.00	
	C/T	73	105	1.41 (0.97-2.04)	0.071
	<i>DRD2</i> , rs7121986				
Codominant	C/C	141	167	1.00	
	C/T	89	102	0.90 (0.62-1.30)	0.048
	T/T	21	11	0.39 (0.18-0.84)	
Dominant	C/C	141	167	1.00	
	C/T – T/T	110	113	0.80 (0.56-1.14)	0.21
Recessive	C/C – C/T	230	269	1.00	
	T/T	21	11	0.40 (0.19-0.87)	0.017
Overdominant	C/C – T/T	162	178	1.00	
	C/T	89	102	0.98 (0.68-1.41)	0.92
	<i>DPYN</i> , rs2281285				
Codominant	A/A	150	192	1.00	
	A/G	96	85	0.72 (0.50-1.04)	0.13
	G/G	5	3	0.43 (0.10-1.85)	
Dominant	A/A	150	192	1.00	
	A/G – G/G	101	88	0.70 (0.49-1.01)	0.058
Recessive	A/A – A/G	246	277	1.00	
	G/G	5	3	0.48 (0.11-2.05)	0.31
Overdominant	A/A – G/G	155	195	1.00	
	A/G	96	85	0.73 (0.51-1.06)	0.098

*Significant after Bonferroni correction ($p < 0.008$).

the underlying pathophysiology of AUD remains poorly understood. Genetic components seem to be crucial in AUD pathogenesis with heritability estimated to be approximately 50% (51, 52). However, identifying genetic risk variants remains a challenge, mostly because of the large genetic and clinical heterogeneity, and the vast number of the implicated variants, which are only partially responsible for the total disease risk (53).

Linkage studies failed to identify specific risk alleles associated with AUD due to its complex, polygenetic pathobiology; thus, GWAS represent the most efficient approach to reveal associated SNPs (52). GWAS of AUD or excessive drinking using various assessment methods have successfully uncovered contingent risk genes (52). Recent large-scale GWAS and meta-analyses including many thousands of participants have revealed associations between AUD susceptibility and common genetic variants in *GCKR* (15-19, 26), *ADH1B* (15-19, 26), *DRD2* (16, 18, 26), and *SLC39A8* (16-19) gene loci.

In the current study, we aimed to clarify the associations between known DNA polymorphisms located in *ADH1B*, *DRD2*, *FAAH*, *SLC39A8*, *GCKR*, and *PDYN* genes and disease risk in a Greek cohort of AUD cases. The findings showed a robust association between *FAAH* rs324420, *SLC39A8* rs13107325 and *ADH1B* rs1229984 polymorphisms and AUD. A recent systematic review concluded that *FAAH* protein product (fatty acid amide hydrolase) contributes to the biology and clinical features of AUD; the pharmaceutical targeting of this molecule could be effective for alcohol withdrawal as it may reduce anxiety and alcohol intake reinstatement (54). Fatty acid amide hydrolase metabolizes the endogenous cannabinoid anandamide (AEA), which regulates the brain reward signaling, thus possibly leading to increased addiction susceptibility (55). *FAAH* variant Pro129Thr (rs324420), reduces *FAAH* catalytic activity and influences the addictive properties of several substances (36). The association of rs324420 with substance use disorders (56) is in accordance with earlier studies reporting genetic associations with the use of methamphetamine (48), marijuana (57), cannabis (35), and cocaine (58). Regarding alcohol dependence, similarly with our results, Sloan *et al.* concluded that American European adults (mean age: 39 years) carrying the A allele had a significantly increased frequency of compulsive drinking episodes and increased AUDIT scores as opposed to individuals with the CC genotype (36). Similarly, Best *et al.* suggested that both AC and AA genotypes of the *FAAH* rs324420 polymorphism are responsible for abnormal drinking behaviors and increased AUDIT scores in youths (59). Animals carrying the polymorphism have displayed higher alcohol intake and alcohol dependence severity (60), while pharmacological inhibition of *FAAH* increased anandamide levels and ethanol intake (61).

Regarding, *GCKR* rs1260326 polymorphism even if this locus has consistently been linked to AUD through GWAS, in contrast to previous studies, in our population, *GCKR* rs1260326 T allele was found to be slightly over-presented in AUD cases compared to controls; however, this association was not significant (15, 17, 18). This discrepancy, maybe due to the differences between different ethnic groups or/and, the limitation of our study regarding the number of participants. *GCKR* regulates cellular trafficking in liver cells. Its polymorphism rs1260326 has also been implicated in diverse metabolic diseases (62, 63). Since alcohol intake is connected to metabolic and lipid profiles alike, it remains to be elucidated whether *GCKR* rs1260326 may have a functional impact on metabolic diseases or alcohol influences glucose and lipid metabolism depending on *GCKR* genotype.

SLC39A8, one of the most pleiotropic genes, is implicated in various pathophysiological pathways and has been linked to schizophrenia (64, 65), inflammatory bowel disease (31), cardiovascular (29, 66), and metabolic phenotypes (30). A functional study by Evangelou *et al.* indicated the pivotal role of *SLC39A8* in alcohol consumption in *Drosophila*. Furthermore, the same group suggested a significant association of SNP rs13107325 in the *SLC39A8* gene and putamen volume differences (16). Interestingly, evidence from animal studies has linked putamen with alcohol consumption (67). In accordance with our results, Thompson *et al.* (26) reported the SNP rs13107325 C allele as risk allele for alcohol consumption in European ancestry populations. Other member of the *SLC39* family have also been associated to mental disorders, as in the case of *SLC39A3* that is associated with bipolar disorder and *SLC39A11* with depressive disorder, implying that disrupted transport of metal ions could disturb brain homeostasis (65).

Another genetic locus widely studied in conjunction with alcohol addiction is *DRD2*, coding for dopamine D2 receptor. The central dopaminergic system is believed to have a vital role in the development of addiction to a plethora of psychoactive substances such as opiates, cocaine, nicotine, and alcohol. *DRD2* encodes a receptor of the post-synaptic dopaminergic neurons; its down-regulation has been implicated with alcohol craving stimulating the medial prefrontal cortex (27). Earlier studies of the dopamine receptors have indicated that common *DRD2* polymorphisms (-141C Ins/Del, TaqI B, and TaqI A) are associated with alcohol dependence risk (68-73). Subsequent meta-analyses have robustly showed a link between polymorphisms near *DRD2* and alcohol dependence (18, 74); however, this gene only exhibits a mild effect that could be partially explained *via* publication bias influenced by racial ancestry (74). A recent GWAS meta-analysis suggested another intronic variant, the rs7121986, located in *DRD2*, to be associated with alcohol intake (16). Our study did not find an association with AUD risk in the Greek population. To the best of our

knowledge, no other genetic association study has been performed to investigate rs7121986 in alcohol dependence.

The most extensively investigated and well-replicated risk alleles for AUD are located in the *ADH* gene locus. There are several isoforms of *ADH* involved in liver alcohol metabolism (*ADH1A*, *ADH1B*, *ADH1C*, and *ADH4-7*). Alcohol dehydrogenase isoform 1B (*ADH1B*) is an important ethanol-oxidizing enzyme but is also involved in multiple molecular mechanisms and metabolic processes of several molecules such as fatty acids, acetone, epinephrine, glucose, and neurotransmitters (for instance serotonin and noradrenaline) (75, 76). The *ADH1B* rs1229984 is associated with alcohol-flush reaction; individuals with the rs1229984 X-allele present a higher ADH activity leading to an increased rate of alcohol metabolism (77). Consistent with previous studies that characterize the T allele as protective (21, 23, 78), our results confirm the decreased risk of developing AUD among those carrying the minor rs1229984 T-allele. Of note, this association is also obvious across different populations (17), such as individuals of European (15, 16, 26), European American (24), African American (23), and Asian origin (78-80).

The last gene examined in our study was *PDYN*. Either animal experimental studies or postmortem brain human studies have indicated that the dynorphin system has a noteworthy contribution in alcohol and substance addiction. DYNs are enriched in brain circuits affecting mood, motivation, and stimulus-response (habit) and have been associated to drug-seeking behavior (81, 82). The dynorphin (DYN)/k-opioid receptor (KOR) system could be responsible for unpleasant feelings and emotions and affect the motivational parameters of stress by inducing anhedonia, dysphoria, pain, and aversion in humans and animals (45, 83). Various polymorphisms in *PDYN* have been studied for their correlation to substance addiction (41, 84), but most recently, the rs2281285 has been further discussed for its role in alcohol dependence and negative craving (45, 83, 85). Our results showed no statistical association between this SNP and AUD and are in accordance with the results of Xuei *et al*. Although Karpyak *et al*. detected an association between alcohol dependence and rs2281285 (85), results could not reach statistical significance after correction. However, the role of this SNP in negative craving is well established (45) and may present a sex-specific effect (83). Of note, haplotypes including rs2281285 SNP are linked to both alcohol dependence and negative craving, suggesting its involvement with these disorders (85); thus, further studies are needed to elucidate the exact role of this SNP.

In conclusion, our study demonstrated that rs324420 in *FAAH*, rs13107325 in *SLC39A8*, and rs1229984 in *ADH1B* are linked with AUD susceptibility in a Greek population. These polymorphisms could serve as potential biomarkers for AUD risk; however, taking into consideration the

complexity of AUD pathogenesis and the variety of the genetic and environmental factors involved, further case-control studies including increased population size and of different origin are needed to confirm these findings.

Conflicts of Interest

The Authors have no conflicts of interest to declare in relation to this study.

Authors' Contributions

EL, AH, MG analyzed the data and wrote the paper. DT, ES, MP, GM, VM, LL collected the samples and clinical data. DT, MG, NS designed the study. MG, AH and NS reviewed and revised the paper. All Authors contributed to the article and approved the submitted version.

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