Familial partial 14 trisomy

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SUMMARY Four children in the same family have 47,+der(14), t(9;14) (p24;q21). Their mothers are sisters with 46,XX,t(9;14) (p24;q21). Clinical features of the children are similar to those of others reported to have partial 14 trisomy.

Partial 14 trisomy is present in children with similar phenotypic abnormalities and subnormal mental and motor development (Reiss et al., 1972; Short et al., 1972; Muldal et al., 1973; Fryns et al., 1974; Raoul et al., 1975; Turleau et al., 1975; Simpson and Zellweger, 1977). In many instances a balanced translocation is present in the mothers. The I. family (Fig. 1) had 5 daughters with normal intelligence and appearance, 4 of whom had a balanced translocation between chromosomes 9 and 14. Three of these women have borne 7 children: a normal boy, two translocation carriers t(9;14) (p24;q21), and 4 abnormal children manifesting features of partial 14 trisomy, 47+der(14),t(9;14) (p24;q21). There had been one spontaneous abortion.

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Case reports

PATIENT JC (IV. 7)
This patient was the first child of healthy parents. He was born in breech presentation at term weighing 2700 g, and had a cleft lip, cleft palate, umbilical hernia, a markedly incurved 5th finger, simple arches on all fingers, an oxycephalic skull narrow towards the front, and distinctive facies. At 16 months, his length, weight, and height were all below the 3rd centile and he was found to have mild spastic quadriaparesis. Motor and mental achievements were severely subnormal. He sat at 12 months and did not speak intelligibly until more than 3 years of age. His general IQ was 23 and he was placed in an institution. He suffered occasional generalised tonic-clonic seizures which were controlled with

Fig. 1 Pedigree of family I.
anticonvulsants. He displayed an ataxic, spastic, broad based, crab-like gait, often causing him to move backwards or sideways.

**PATIENT EC (IV.8)**
This patient was the younger sister of patient JC. Their mother was found to have untreated diabetes mellitus during this pregnancy, and the patient was born after a gestation of 37 weeks weighing 1970 g, with head circumference 31·5 cm and length 36·5 cm (all less than 3rd centile). The baby had a partial midline cleft palate, a congenitally dislocated right hip associated with bilateral spasticity of hip adductor muscles, capillary haemangiomata of the eyelids, distinctive facies, and mild transient hypoglycaemia. She had single palmar creases, incurved 5th fingers, distal digital dysplasia, thin lips, widely flaring nostrils, shortened philtrum, widened nasal bridge, and microcephaly. Her motor and mental achievements were markedly subnormal and she was placed in an institution.

**PATIENT DT (IV.4)**
The patient was born at term, weighing 2540 g, after an uneventful pregnancy. No neonatal problems were encountered, but at 16 months of age she was recognised to be retarded in motor, mental, and physical development. She could not walk or talk but could sit with support and pull to a standing posture. Head circumference was 42·6 cm and weight 7·25 kg (below the 3rd centile). X-rays indicated a widespread skeletal dysmorphism with bilateral posterior dislocation of the radial heads, incurred 5th fingers, 11 sets of ribs, and 4 sternal segments. IVP was normal. She was slightly hypotonic and had no evidence of cardiac abnormality.

At 2 years, she first exhibited generalised tonic-clonic seizures which were fairly well controlled on phenytoin and carbamazepine. At 6 years of age she was small (height 86 cm, weight 14·2 kg, head circumference 47 cm), playful, and severely retarded, using a repetitive set of 8 or 10 phrases for all communication. Her skull was oxycephalic, narrow towards the front, and her face dysmorphic with a wide nasal bridge, short philtrum, prominent nostrils, and flaring alae. There was a thin vermilion border on the upper lip and an arched downturned concave mouth. The palate was high without defect and the ears normally placed with a simple helix. Hypotelorism was present (inner canthal distance 2·3 cm; outer orbital distance 7·4 cm; and interpupillary distance 4·3 cm). She had pectus excavatum, a single palmar crease, distal digital dysplasia and an incurred 5th finger (Fig. 2), 5 arches on the fingertips, and 2 creases on each 5th finger. The electroencephalogram was characterised by bisynchronous 3 to 3½ c/s spike and wave discharges compatible with generalised motor seizures. Amino acid screening was normal.

**PATIENT TC (IV.10)**
The patient was born at term to healthy parents. At 30 months of age his weight, height, and head circumference were 9·2 kg, 78·5 cm, and 45·2 cm, respectively, all less than the 3rd centile. He could crawl and use single words, but could not sit, stand, or say 2 words sequentially. Facial dysplasia was characterised by foreshortened philtrum, downturned concave mouth, epicanthal folds, and hypotelorism (outer orbital distance 7 cm; inner canthal distance 2 cm; and interpupillary distance 3 cm). The ears had a simple helix and the skull was oxycephalic, narrow towards the front. There was an incurred 5th finger, distal digital hypoplasia of fingers 1, 2, and 5, minimal soft tissue syndactyly between the 3rd and 4th fingers, and a shallow sacral dimple.

**Cytogenetic studies**
The karyotypes of the probands and their mothers were determined using quinacrine dihydrochloride (Lin et al., 1971) and acid saline Giemsa (Sumner et al., 1971) stains. The mother of each affected child had a balanced translocation between the long arm
Fig. 3  Karyotype of VC (III.7), 46,XX, t(9p+;14q−). Acid saline Giemsa.

Fig. 4  Karyotype of JC (IV.6), 47,XX, (+14q−). Acid saline Giemsa.
of chromosome 14 and the short arm of chromosome 9 (Fig. 3). This was 46,XX,rcp(9;14) (9pter→9p24::14q21→14pter;14qter→14q21::9p24→9qter). Giemsa 11 (Gagne and Laberge, 1972), done on one of the mothers with the balanced rearrangement, confirmed involvement of chromosome 9 in this translocation. The probands had an extra small acrocentric chromosome (Fig. 4) which, on the basis of banding and maternal karyotypes, was 47, +der (14)rcp(9;14) (p24;q21)mat. The karyotypes of their fathers were normal.

Discussion

The affected children were short and retarded in motor and mental ability. They had microcephaly with oxycephaly, narrow towards the front, and an unusual facial appearance which was dissimilar to their parents and normal sibs (Fig. 5). There was a broad, flat bridge to the nose with prominent alae and a somewhat bulbous tip. The mouth was oval with the lower jaw often hanging slack. The upper lip was slightly arched, downturned, and concave with shortened philtrum. There was an antimongoloid slant and there may have been epicanthi, strabismus, and simple aural helices. The mid-facial and cranial anomalies were subtle without any singular anomaly to aid easy recognition and are best appreciated by comparing pictures of several affected children. Other phenotypic features commonly included an incurved 5th finger and distal digital hypoplasia.

These features are similar to those of other children reported with partial 14 trisomy (Table). They also had multiple anomalies, few of which are lethal. The clinical features of patients with partial 14 trisomy have been summarised recently (Wyandt et al., 1977). At present, there is insufficient data about persons with pter q21, 22, or 23 to justify confident karyotype/phenotype correlation. However, pictures

Fig. 5 Clockwise from top left: patients JC, DT, EC, and TC to illustrate facies. Note broad, flat nose with bulbous tip, antimongoloid slant to eyes, slack jaw, and foreshortened philtrum with arched upper lip, concave downwards.

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<td>Distal digital hypoplasia</td>
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and descriptions indicate that their facial appearance is similar. It is characterised by hypotelorism, short philtrum, and concave mouth. Many have microcephaly and clinodactyly.

In 5 of 7 case reports of partial 14 trisomy, the mother carried a balanced translocation (Short et al., 1972; Fryns et al., 1974; Raoul et al., 1975; Turleau et al., 1975; Simpson and Zellweger, 1977). In one (Muldal et al., 1973), the parents had normal chromosomes, and one patient had a paternal carrier (Reiss et al., 1972). In our family, there was one male carrier (IV.6), who was a child with mild spastic diplegia and mental and developmental retardation. He is at present in the 7th grade and gets along well psychosocially. He has not been tested for IQ. In this family and others in the published reports, there have been no cases of partial 14 monosomy, implying that such a state is nonviable, though partial trisomy for the distal portion of chromosome 14 has been reported (Pfeiffer et al., 1973; Wyandt et al., 1977).

Chromosome 14 is frequently involved in reported translocations. Its long arm fragment has been found translocated onto chromosomes 2, 3, 6, 9, 10, 12, 19, 20, 21, and X (Pfeiffer et al., 1966; Orye and van Nevel, 1968; Alderdice et al., 1971; Reiss et al., 1972; Short et al., 1972; Laurent et al., 1973; Pfeiffer et al., 1973; Fryns et al., 1974; Jacobs et al., 1974; Raoul et al., 1975; Turleau et al., 1975; Simpson and Zellweger, 1977). The probands were not the product of simple segregation of the mother’s chromosomes, but were a tertiary trisomy, the result of 3:1 disjunction during meiosis. Translocated acrocentric segments seem predisposed to 3:1 disjunction as do translocated chromosomes with short interstitial segments (Hamerton, 1971; Lindenbaum and Bobrow, 1975). Chromosome 14 is frequently present in reported reciprocal translocations and in subsequent maternal 3:1 disjunction (Lindenbaum and Bobrow, 1975). However, this may reflect an ascertainment bias due to viability of persons with this cytogenetic defect, since studies involving lymphocyte irradiation find no increased involvement of chromosome 14 (Caspersson et al., 1972; San Roman and Bobrow, 1973). Similarly, the reported frequency with which chromosome 9 is involved in translocations (Jacobs et al., 1974) seems influenced by ascertainment bias.

Partial 14 trisomy is associated with a clinically recognisable syndrome of congenital anomalies and mental defects. It has been found in children who are often offspring of balanced translocation carrier mothers. Some families have contained several carriers. Proper genetic counselling requires thorough chromosome evaluation of probands, parents, and other appropriate members of the family.

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References


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