Clinical features of patients with ring chromosome 3 or partial monosomy 3p are compared in the table. There is some resemblance in facies as shown by the microcephaly, ptosis, epicanthal folds, dysplastic ears, broad nasal root, and down-turned corners of the mouth in the patient’s photographs. Three patients had intrauterine growth retardation while four had severe failure to thrive. None had evidence of heart disease, while various digital, genitourinary, and anal anomalies were noted. Mental impairment ranged from mild to severe and three patients developed hypertonicity. The concordant features and the similar facies seen in photographs offers a preliminary view of a ring 3 deletion 3p chromosome syndrome. Further delineation of this phenotype will require additional cases of ring 3 deletion 3p and, if such an anomaly exists in liveborns, reports of distal monosomy 3q.^

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References


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Cat-like cry and mental retardation owing to 7q interstitial deletion (7q22→7q32)

**SUMMARY** A patient with mental retardation and mild facial dysmorphism had a karyotype which was considered to be normal before the availability of chromosomal banding techniques. She had a history of a cat-like cry and severe feeding problems during infancy. At the age of 9, she was still found to have initial aphonia on trying to initiate sounds. Repeat chromosome analysis with G banding showed an interstitial deletion of the long arm of chromosome 7.

Several patients have been reported with interstitial deletions of the midpoint of the long arm of
chromosome 7. Although the affected patients have had several abnormalities in common, their facial features and general appearance are not sufficiently distinctive to constitute an easily recognisable clinical syndrome. It is of interest, however, that several of these patients have been described as having an abnormal cry, which may facilitate recognition of this particular chromosomal deletion.

Case report

This family requested referral for genetic counselling because of a 9-year-old daughter with mental retardation. An older sib was considering marriage and was concerned about the risks to his future offspring. The proband was born on 1.8.72 to a G5, P4, A0 mother after a 42-week pregnancy which was uneventful except for treatment with thyroid hormone for symptoms of hypothyroidism. Delivery occurred precipitously. The mother recalls that spontaneous breathing did not occur for 2 to 3 minutes and that the infant required some resuscitation, although Apgar scores were listed as 10 at 1 and 5 minutes. Birth weight was 3570 g, head circumference 35 cm, and chest circumference 35 cm. In the newborn nursery record, it was noted that she was "unable to cry well, does go through motions of crying, but a very feeble cry results".

Laryngoscopy was done at 3 days of life because the cry, also described at that time as 'cat-like', was associated with episodes of cyanosis. The vocal cords were noted to be flaccid and either oedematous or thickened. Also described was a bowing deformity with escape of air through the midportion of the vibrating edge of the vocal cords. The infant was sent home and was noted to feed poorly and have difficulty in sucking. The cat-like cry persisted for at least her first year of life, during which there were several admissions to a local hospital for choking spells and possible asphyxiation. At 1 year of age she was evaluated at the Rhode Island Hospital. A pneumoencephalogram showed dilation of the ventricles suggesting cerebral atrophy. Laryngoscopy was done but no unusual findings were noted. Chromosome analysis done in 1973 on peripheral blood and skin fibroblasts without banding showed no abnormality. Because of occasional febrile seizures, she was given anticonvulsant medication until she was aged 6. Psychomotor development has been slow. She did not walk until the age of 5, no speech has developed, and she is only partially toilet trained. There is no family history of similarly affected subjects and both parents and the five older sibs are all normal.

Physical examination revealed a severely retarded, mildly dysmorphic, but friendly and co-operative child (fig 1). The height was 114 cm (50th centile for a 5\f{1}/2-year-old), weight was 25.8 kg (10th centile), and head circumference was 50.75 cm (low normal). The body was rather stocky with a relatively large thorax. The cranial vault was somewhat unusual in shape, with a bony protuberance over the area of the anterior fontanelle and mild underdevelopment of the frontal areas. The pinnae were normally
<table>
<thead>
<tr>
<th>Reference</th>
<th>Deleted segment</th>
<th>Sex</th>
<th>Birth weight/ gestational age</th>
<th>Head</th>
<th>Ears</th>
<th>Mouth</th>
<th>CNS</th>
<th>Cry</th>
<th>Other</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>21–31</td>
<td>F</td>
<td>1740 g 36 wk</td>
<td>Microcephaly</td>
<td>Low-set, pointed</td>
<td>Large lips</td>
<td>L brain hypoplastic, arhinencephaly</td>
<td>Not mentioned</td>
<td>Hyperplasia of islets of Langerhans</td>
<td>Died 2nd mth</td>
</tr>
<tr>
<td>1</td>
<td>21–32</td>
<td>F</td>
<td>2320 g 40 wk</td>
<td>Low normal</td>
<td>Low-set, dysplastic</td>
<td>Large with turned-down corners</td>
<td>Hypertonia, seizures</td>
<td>Feeble until 3 mth</td>
<td>Early feeding difficulty, developmental delay</td>
<td></td>
</tr>
<tr>
<td>4 (case 1)</td>
<td>21–32</td>
<td>F</td>
<td>1500 g Term</td>
<td>3rd centile at birth; 25th centile at 6 yr</td>
<td>Large, prominent anihelix</td>
<td>Large</td>
<td>Poor suck, hypotonia with hypertonia of lower limbs</td>
<td>Not noted</td>
<td>Severe MR, no speech, recurrent respiratory and urinary infections</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>22–32</td>
<td>F</td>
<td>2300 g Term</td>
<td>Malformed, low-set</td>
<td>Seizures, congenital glaucoma</td>
<td>Not noted</td>
<td>Small palpebral fissures with upward slant, contractures of fingers</td>
<td>Poor suck, gavage feeding, died of CHF at 39 d (AS and VSD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>22–31</td>
<td>F</td>
<td>3200 g 40 wk</td>
<td>Normal at birth and 17 mth</td>
<td>Thin outer ear cartilage</td>
<td>Normal</td>
<td>Broad-based gait, clumsy movements</td>
<td>Aphonie, unusual</td>
<td>Short distal phalanges of 3rd–5th fingers, clitoral hypertrophy</td>
<td>Swallowing difficulty, moderate MR</td>
</tr>
<tr>
<td>6</td>
<td>31–34</td>
<td>F</td>
<td>Less than 5th centile at 10 wk</td>
<td>Low-set, prominent antotragus</td>
<td>Turned-down thin upper lip</td>
<td>Moderate hypertonia</td>
<td>Weak, cat-like</td>
<td>Reflux, digitised R thumb, extra vaginal mucous membrane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present case</td>
<td>22–32</td>
<td>F</td>
<td>4000 g 42 wk</td>
<td>Low normal at 9 yr</td>
<td>Protuberant R preauricular sinus</td>
<td>Large</td>
<td>Hypertonia lower extremities, broad-based-gait</td>
<td>Weak, cat-like, aphonie</td>
<td>Early feeding difficulty, severe MR</td>
<td></td>
</tr>
</tbody>
</table>
shaped, but slightly protuberant, and there was a left preauricular sinus. The mouth appeared large. The hands had mild bilateral 5th finger clinodactyly. There was moderate hypertonia of the lower extremities and a slow broad-based gait. Her cry was quite unusual, with initial aphony and difficulty with initiation of sound, followed by a fairly normal cry of slightly diminished volume but normal pitch.

Another chromosomal analysis with banding was requested. An abnormality was found consisting of interstitial deletion of the long arm of chromosome 7 (fig 2). The deleted portion appeared to be the segment lying between band 7q22 and 7q32. Both parental karyotypes were normal.

Discussion

In attempting to obtain a specific diagnosis for this patient, we requested that the karyotype preparation be specifically examined for a possible small deletion of the midportion of the 5p15 band, which is considered to be the phenotypically relevant segment in the cri-du-chat syndrome.7 The discovery of the 7q deletion prompted us to review previously published cases in an attempt to determine whether or not this is a clinically recognisable syndrome.

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References


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