Multiple endocrine neoplasia type 2 (Sipple's syndrome): clinical and cytogenetic analysis of a kindred

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SUMMARY  This report describes the clinical and cytogenetic analysis of a kindred with multiple endocrine neoplasia type 2 (MEN-2 or Sipple's syndrome) in two generations. Medullary thyroid carcinoma was present in five members either as a large or as an occult tumour. Phaeochromocytoma was demonstrated in one severely hypertensive relative and urine vanillylmandelic acid (VMA) was increased in one normotensive member. Serum parathormone (PTH) was normal in all but one normocalcaemic patient of this family who did not have a history of nephrolithiasis. Prometaphase banding failed to detect a 20p12·2 deletion or chromosome instability as observed in some MEN-2 families.

The group of hereditary diseases characterised by multiple endocrine neoplasia (MEN) is composed of three types known as MEN-1, MEN-2 (or 2a), and MEN-3 (or 2b). The main distinguishing features of MEN-2 are the presence of medullary thyroid carcinoma or phaeochromocytoma or both in some cases.

MEN-2 locus mapping has been attempted through linkage studies with HLA and the P blood group. Jackson et al. suggested a possible linear order of genes for MEN-2, P red cell antigen, and HLA on chromosome 6. Linkage between the loci for MEN-2 and HLA was recently excluded. Al-Saadi and Lieberman reported a high incidence of aneuploidy in leucocyte preparations from three patients with MEN-2. The finding was not confirmed by other cytogenetic investigations. Van Dyke et al. reported a minor deletion of chromosome 20 in some MEN-2 families and Hsu et al. showed chromosomal instability in patients with MEN-2.

We report clinical and cytogenetic studies in patients in a family with MEN-2.

Case reports

We studied six cases of MEN-2 in two generations. The pedigree of this family (fig 1) is consistent with

![Pedigree of the family](http://jmg.bmj.com/)
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TABLE Clinical and biochemical data.

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age (yr) and sex</th>
<th>Clinical diagnosis</th>
<th>Main symptom</th>
<th>Enlarged thyroid gland</th>
<th>Hypertension</th>
<th>Serum CT (ng/ml) on pentagastrin (0-5 μg/kg bw)</th>
<th>CEA (ng/ml)</th>
<th>Serum PTH (ng/ml)</th>
<th>Urinary VMA (mg/24 h)</th>
<th>Surgical diagnosis</th>
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<td>1</td>
<td>50/F</td>
<td>MTC</td>
<td>None</td>
<td>+</td>
<td>-</td>
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<td>110</td>
<td>0.5</td>
<td>4</td>
<td>MTC</td>
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<td>Flush</td>
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<td>-</td>
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<td>0.5</td>
<td>2.5</td>
<td>MTC</td>
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<tr>
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<td>-</td>
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<td>0.8</td>
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<tr>
<td>4</td>
<td>24/M</td>
<td>MTC</td>
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<td>-</td>
<td>-</td>
<td>0.5 2.5 1.2 1.5</td>
<td>60</td>
<td>1.9</td>
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<td>5</td>
<td>41/F</td>
<td>MTC</td>
<td>Abdominal pain</td>
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<td>3.5</td>
<td>500</td>
<td>6.3</td>
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<td>MTC</td>
</tr>
<tr>
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<td>46/M</td>
<td>PH</td>
<td>Headache</td>
<td>-</td>
<td>+</td>
<td></td>
<td>34.5</td>
<td></td>
<td></td>
<td>PH</td>
</tr>
</tbody>
</table>

MTC = medullary thyroid carcinoma, PH = phaeochromocytoma, CT = calcitonin, CEA = carcinoembryonic antigen, PTH = parathormone, VMA = vanillylmandelic acid.

FIG 2 Solid tumour with amyloid deposits (case 1). (Haematoxylin and eosin. Original magnification × 106).

autosomal dominant inheritance with high penetrance and variable expressivity with regard to age of onset and involvement of endocrine glands.

CASE 1 (II.3)
A 50 year old female, married with three children, was seen in December 1979 because a large, symptomless, slow growing, left sided thyroid nodule had been noted since she was 20. Fine needle aspiration cytology displayed the typical amyloid dispersed cell pattern. High basal and pentagastrin stimulated serum calcitonin (CT) was found as well as high carcinoembryonic antigen (CEA) levels. Serum PTH and urine VMA were normal (table). Total thyroidectomy and midline lymph node dissection were performed. Histology showed a medullary thyroid carcinoma (fig 2) with lymph node involvement. The excised right inferior parathyroid was 10 mm in diameter with normal histology. After operation, CT and CEA were still raised and in the following 2 years metastases developed in the lymph nodes of the neck and the lumbar spine. The patient died in February 1982.

CASE 2 (III.2)
This was an 18 year old girl with a small multinodular goitre. Her only complaint was a recurrent and persistent cyanotic flush of the face and neck associated with even the most minor emotional reactions. Borderline basal CT serum levels, but high values after pentagastrin, were found. CEA levels were increased and PTH and urine VMA were normal (table). Total thyroidectomy was performed in February 1981 and histology showed a medullary carcinoma with normal lymph nodes. The excised left parathyroid was normal. Serum basal and stimulated CT, as well as CEA levels, were normal 2 months after the operation. She is now well and on thyroxine replacement.

CASE 3 (III.3)
This was a 16 year old boy with no symptoms. Thyroid examination revealed a nodule ½ cm in diameter on the upper pole of the left thyroid lobe. Borderline basal serum CT but high pentagastrin response were found, as well as a definite increase in CEA levels. The serum PTH and urine VMA were normal. He refused total thyroidectomy.

CASE 4 (III.1)
This was a 24 year old man with no symptoms. Thyroid examination revealed a nodule 1 cm in diameter in the upper pole of the left thyroid lobe. Borderline serum CT but high pentagastrin response were found together with increased CEA serum levels. Serum PTH was nearly twice the upper limit of normal with normal blood calcium. Urine VMA was also increased but with no hypertension. He refused operation.

CASE 5 (II.9)
This was a 41 year old female, married with one daughter (who was not investigated). She was operated on in 1973 for medullary thyroid carcinoma and received local radiotherapy because of positive lymph node involvement. Admitted in 1977 because
of abdominal pain, she was found to have disseminated metastases (liver, lymphatics, and lumbar spine). Very high CT and CEA serum levels were found and normal urine VMA excretion (table). She received a complete course of Adriablastine with partial remission. She died in August 1978.

**CASE 6 (II.10)**

This was a 45 year old male, married with one son. When he was 40 he started to suffer from undiagnosed hypertension. He was admitted to hospital in 1977 with very severe hypertension and loss of consciousness and died 2 days later. Necropsy showed a right adrenal, 5 cm in diameter, with phaeochromocytoma and a large area of infarction.

**Hormonal methods**

Serum CT was assayed by radioimmunoassay (RIA)8 (Byk Gulden reagents). In normal controls CT basal value was less than 0·2 ng/ml and penta-gastrin stimulated peak (Peptavlon, ICI, 0·5 μg/kg bw) was found to be less than 0·6 ng/ml.

Serum PTH was assayed by RIA9 (Byk Gulden reagents), with an antiserum recognising the carboxy terminal fragment as well as the entire hormone. Upper normal PTH limit was 1·1 ng/ml.

Serum CEA assayed by RIA10 (CIS-SORIN reagents) was less than 10 ng/ml in normal non-smokers.

Urine VMA, determined according to Pisano et al11 was found to be less than 6·5 mg/24 hours in normal controls.

**Cytogenetics**

Three members of this family (III.1, III.2, and III.3) were available for cytogenetic studies. Chromosome preparations from peripheral blood lymphocytes were analysed (about 50 mitoses for each subject). R banding of prometaphase chromosomes, obtained after 15 minutes’ incubation with cocolmid,12 failed to detect a 20p deletion or any other chromosome aberrations.

**Linkage studies**

We attempted linkage studies for red cell antigens ABO, Rh, MNSs, P, K, FY, Le, Lu, and Jk in III.1, III.2, III.3, and their father. The results were not informative.

**Discussion**

The association between thyroid carcinoma and phaeochromocytoma was emphasised by Sipple.13 This familial association was defined as part of a syndrome of multiple endocrine neoplasia type 2 (MEN-2),14 including medullary thyroid and adrenal tumours, described by Sipple, and primary hyperparathyroidism. Later these patients were identified as having MEN-2a if suffering from medullary thyroid carcinoma (100% of cases), phaeochromocytoma (50%), and hyperparathyroidism (50%), or as having MEN-2b1 if suffering from medullary thyroid carcinoma (100%), phaeochromocytoma (50%), hyperparathyroidism (rare), marfanoid habitus (100%), intestinal ganglioneuromatosis (100%), and mucosal neuromas (100%).

In the family studied by us, medullary thyroid carcinoma was present in all but one member. There was a manifest phaeochromocytoma in case 6 and in case 4 there was probable adrenal medullary hyperplasia because of the high urine VMA excretion. No history of hyperparathyroidism or nephro lithiasis was recorded in this family. A moderate increase of serum PTH was documented on several occasions in case 4. In cases 1 and 2 the excised parathyroids showed no evidence of hyperplasia. Parathyroid hyperplasia in this syndrome is mostly diagnosed on the basis of high PTH levels with normal serum calcium.5 Microscopical observation may give rise to differing opinions which can be solved by electron microscopy. Mucosal neuromas or intestinal ganglioneuromatosis were not present in this family. A slight appearance of marfanoid habitus was noted in some members.

Concerning the cytogenetic aspects of the syndrome, Hsu et al7 studied some patients with MEN-2 and observed chromosomal instability with a preponderance of aberrations such as dicentrics, acentric fragments, and marker chromosomes. Van Dyke et al8 studied six families with MEN-2, in which 10 patients in five families showed a minor deletion of the short arm of chromosome 20 (20p12·2). In the sixth family the only patient showed a normal karyotype.

These findings are not surprising. Wilms’s tumour and retinoblastoma are known examples of hereditary neoplastic diseases sometimes associated with chromosomal aberrations, 11p deletion16 and 13q interstitial deletion17 respectively. Furthermore, chromosomal instability has been found in various Mendelian diseases with neoplastic diathesis, such as Fanconi’s anaemia, Bloom’s disease, Louis-Barr syndrome, etc.

The finding of a typical deletion or chromosomal instability in MEN-2 could be of value in preclinical and antenatal diagnosis of the syndrome. Today, a growing body of evidence suggests that the locus for MEN-2 is probably on the short arm of chromosome...
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20. Our negative results as regards the 20p deletion and chromosomal instability do not contradict previous cytogenetic evidence, as the deletion could be so small that even high resolution banding might have failed to detect it.

Another hypothesis is that the gene could be present but abnormal and functionally equivalent to a deleted one. In Wilms' tumour and retinoblastoma the typical deletion is not always present.

References


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