Case reports

Journal of Medical Genetics, 1985, 22, 140–153

De novo paracentric inversion in an X chromosome

HELEN M HERR, SUSAN J HORTON, AND CHARLES I SCOTT JR

Department of Genetics, Alfred I duPont Institute of the Nemours Foundation, PO Box 269, Wilmington, Delaware 19899, USA.

SUMMARY  A 10½ year old female with skeletal abnormalities was referred for genetic consultation because of learning disabilities and a suggestion of 'Turner-like' stigmata. Cytogenetic analysis revealed a paracentric inversion of an X(q13·1q26·1) chromosome.

Before the advent of chromosome banding techniques paracentric inversions were virtually undetectable. Although high resolution banding is now being used regularly to detect small structural rearrangements, paracentric inversions apparently remain relatively rare. We have been able to find fewer than 25 published cases since the first report of Del Solar and Uchida in 19741 and none of them involved an X chromosome. In 1981 Ridler and Sutton2 cited 15 unpublished cases of paracentric inversions, one of which was reportedly an Xq. One other Xq case, by Shabtai et al.,3 was cited in the Abstracts of the European Society of Human Genetics Symposium on X-linked Diseases in 1982. We report here a paracentric inversion in an X(q13·1q26·1) of a prepubertal female with learning disabilities and skeletal anomalies.

Case report

The patient (fig 1), a 10½ year old white female, was the product of the only pregnancy of a 24 year old woman and her 29 year old non-consanguineous husband. The pregnancy was complicated by cholestasis requiring cholecystectomy eight weeks after delivery. The gallbladder disease contributed to persistent nausea which was treated with either Bendectine or Compazine throughout the pregnancy. There also was a vaginal infection early in gestation which was treated topically. Failure of cervical dilation beyond three fingers following a 30 hour labour necessitated delivery by caesarean section. Birth weight was 3·68 kg and length was 50·8 cm.

No abnormalities were noted at birth, and early developmental milestones were considered to be within normal limits. Learning difficulty, however, became apparent at school age, and the patient has always been in special schools for the neurologically impaired. She has minimal brain dysfunction with gross and fine motor incoordination as well as visual perceptive defects. At the age of 9 an abnormal gait was detected and she was referred for orthopaedic evaluation. The left femoral head was consistent with osteonecrosis and acetabular dysplasia, and mild thoracic scoliosis was noted. An arthrogram showed a voluminous joint capsule with mild lateral displacement of the left femur. Diagnostic studies, including T3, T4, and TSH, were within normal limits. A CT scan confirmed an enlarged thymus...
Case reports

considered to be due to benign hyperplasia. Because somewhat 'Turner-like' facies and habitus were noted, a genetics consultation was requested while the patient was in hospital for orthopaedic procedures.

On physical examination at the age of 10½ years, her height (140·2 cm) was at the 50th centile for age, but her weight (42·5 kg) was at the 50th centile for 12 years. Her head circumference was greatly increased (55·2 cm), representing the 50th centile for 18 years. The face was large with heavy jowls, the neck was very short, and the nuchal hairline quite low. The broad chest was symmetrical. The breasts were prepubertal, as were the external genitalia. There were no cardiac thrills or murmurs and the lungs were clear. Obesity was marked, but no abdominal organomegaly was present. Numerous dark brown pigmented macular moles were scattered over most of her body. Bilateral brachydactyly of the fifth fingers was noted. The feet were short and broad and the patient walked with a Trendelenberg gait to the left.

CYTOGENETIC STUDIES

Chromosome analysis, using high resolution banding techniques, revealed a modal number of 46 with a paracentric inversion of one of the X chromosomes in all cells examined. Replication studies determined that the inverted X was active 50% of the time. The karyotype was 46,XX,inv(X) (q13-1q26·1) (figs 2a and b). A buccal smear showed 9% Barr bodies. Dermatoglyphic analysis was essentially unremarkable, except for an accessory interdigital triradius on the right hand and thenar patterns bilaterally. The total finger ridge count was not raised. High resolution banded chromosomes from both parents revealed normal 46,XX and 46,XY karyotypes.

Discussion

With so few cases of paracentric inversions having been reported, none of which involved an X chromosome, the phenotypic effect of such a rearrangement cannot be clearly defined. It is possible, however, that there is a relationship
between the structural abnormality of the X chromosome and the physical findings in this case. Although the banding studies indicated a rearrangement of chromosome material, no visible deletion could be detected. The 'critical region' hypothesis of Sarto et al. proposed that breaks from Xq21 to Xq25 result in gonadal dysgenesis. However, Summitt et al. extended this region proximally to include Xq13 and the upper breakpoint in our patient is at band Xq13-1. Since the patient was prepubescent and surgery was imminent, a complete endocrine evaluation was declined by the family. It will be important to follow her progress over the next few years, and if puberty does not ensue, efforts will be made to obtain the endocrine studies. Should she achieve spontaneous sexual maturation and menarche, we could not predict with certainty the phenotype of any offspring, but it would seem reasonable to assume that fertility might be reduced. Unequal crossovers within the loop of the inverted chromosome could result in unstable derivative chromosomes. In addition, liveborn children with multiple anomalies due to rearrangements of duplication or deletion might result, for which antenatal diagnosis could be performed.

The authors gratefully acknowledge the expert technical assistance of Susan Ross, Teresa Stalcup, and Alice Wooldridge in the preparation of the cultures and karyotypes.

References

Correspondence and requests for reprints to Ms H M Herr, Department of Genetics, Alfred I duPont Institute of the Nemours Foundation, PO Box 269, Wilmington, Delaware 19899, USA.

Monosomy 13q32-3→qter: report of two cases

H RIVERA, S A GONZÁLEZ-FLORES, F RIVAS, J SÁNCHEZ-CORONA, M MOLLER, AND J M CANTÚ

División de Genética, Subjefatura de Investigación Científica, Unidad de Investigación Biomédica, Centro Médico de Occidente, Instituto Mexicano del Seguro Social, Guadalajara, Jalisco, Mexico.

SUMMARY Two unrelated patients with monosomy 13q32-3→qter are reported. Comparison with six similar cases previously published indicates that the craniofacial dysmorphism of the 13qter monosomy syndrome is related to band 13q34, the thumb hypoplasia to band 13q32, and an apparently different phenotype to band 13q33. Coagulation deficiency appears to be non-specific in monosomy 13qter.

The purpose of this report is to describe two cases of monosomy 13q32-3→qter and to review the karyotype-phenotype correlation.

Received for publication 19 June 1984.
Accepted for publication 20 July 1984.
De novo paracentric inversion in an X chromosome.

H M Herr, S J Horton and C I Scott, Jr

doi: 10.1136/jmg.22.2.140

Updated information and services can be found at:
http://jmg.bmj.com/content/22/2/140

**Email alerting service**

*These include:*

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/