Osteoporosis-pseudoglioma syndrome: clinical, morphological, and biochemical studies

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Summary We report a sibship of a sister and brother with osteoporosis-pseudoglioma syndrome. Several other family members became blind or showed signs of bone involvement. There was considerable consanguinity in the pedigree. The proband was small in size and had prominent skeletal deformities and clinical muscle weakness. These features were not present in her brother, suggesting clinical variability. Mental function was normal in both. Bone histology showed osteopenia. Several biochemical events of procollagen biosynthesis were analysed in fibroblast cultures, but no significant abnormalities compared to control fibroblast cultures were detected.

Osteoporosis-pseudoglioma syndrome is a rare genetic disorder with autosomal recessive transmission. Characteristic findings are generalised osteoporosis and blindness, which is usually due to retinal detachment. Other manifestations, such as muscular hypotonia, hyperextensible joints, and mental retardation, are present to a variable extent. Frontali et al. reviewed the published reports and found 21 cases, mainly from the Mediterranean area. Seven other cases published separately are likely to represent the same entity.

The disorder is presumed to be an inherited connective tissue disease although very little is known of the underlying pathology. We present two further cases and the results of morphological and biochemical studies.

Case reports

Case 1

The proband (V.2) and her brother (V.5) are products of a highly consanguineous marriage (fig 1). Their ancestors can be traced back for more than two centuries and they all come from a small rural village. At least five consanguineous marriages are detectable. Several family members became blind at varying ages and many members are reported to have suffered from some kind of bone involvement, but only members of the last generation have been studied with adequate methods.

The proband was born preterm, slightly asphyxiated because the umbilical cord was around the neck. She recovered immediately, however, and neonatal development was normal. She sat at the age of one year and spoke words at 18 months. Motor development was delayed. She learned to get up from the floor and to stand with support between the ages of five and eight, but she never learned to walk unsupported and has been using a wheelchair for two decades. At the age of five vision gradually started to deteriorate in the left eye and the eye was removed; the diagnosis was retrolental fibroplasia. At the age of eight the vision also started to deteriorate in the right eye. Physical examination revealed clouding of the cornea and the lens, as well as nystagmus. There was generalised muscle weakness and hypotonia. She was unable to raise her head from bed and could stand with support for short periods only. She had a prominent scoliosis in the thoracic and lumbar spine. X rays showed generalised osteoporosis. Vision deteriorated gradually and at the age of 10 she was completely blind. She was treated at home and was admitted to a school for the blind when she was 29 years old. There she was a good student, and she is at the moment continuing her studies at university. She had one bone fracture at the age of 32.

Further examinations were carried out at the age of 36. Physical examination showed a blind woman

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with abnormal craniofacial features (fig 2a and b). She had a broad face with a short philtrum and a prominent mouth region. The ears were located somewhat lower than usual and were tilted posteriorly. The posterior side of the skull was flattened. She also had micrognathia and a depressed bridge of the nose. OFC was 53.5 cm.

She was of short stature (147 cm). The upper segment/lower segment ratio was 0.81. Her neck was short. The thoracic spine showed a prominent kyphosis and scoliosis. The extremities were disproportionately long with a span of 164 cm in the upper extremities. The fingers were long and their joints were hyperextensible, whereas the feet were short. The knees were fixed in a valgus position and the feet in an equinovarus position. She had no contractures.

Intellectual function was normal. She had a generalised, predominantly proximal muscle weakness and hypotonia, which had remained relatively unchanged since the age of eight. Tendon reflexes were normal except for brisk patella reflexes. Ophthalmological examination showed laterally sparse eyebrows. The left eye had been replaced with a prosthesis and the right eye showed microphthalmia and corneal clouding. She was entirely blind with no response either on ERG or VEP.

Bone x rays showed generalised osteoporosis and there were some osteoporotic cysts in the metatarsal bones (fig 3a). The thoracic and lumbar spine showed a prominent scoliosis (fig 4a). The cervical spine contained some slight anomalies and osteoporosis, but no sign of medullary compression. Computerised tomography of the brain showed mild, predominantly central brain atrophy. Computerised tomography of the orbits showed atrophy of the bulbi with some calcification in the frontal region.

EEG showed mild, non-specific changes with no spikes or sharp waves and EMG showed increased amounts of polyphasic potentials of short duration, especially in the proximal muscles of the upper extremities. ECG and echocardiography were normal.

CASE 2
The second patient, the proband’s younger brother (V.5), was born at term after an uneventful pregnancy. His left eye was apparently blind from birth. The right eye had some vision but became blind in the space of one day at the age of eight. Developmental milestones were otherwise normal. He entered a school for blind children and subsequently, with special arrangements, studied mathematics at university. His intellectual capacity appeared to be excellent and he has collaborated in the development of a special device for the blind. At
the age of 28 he had an epileptic seizure after substantial consumption of alcohol on the previous evening. On recovering consciousness he complained of back pain. X rays of the spine showed compression fractures in four thoracic vertebrae and generalised osteoporosis.

An extensive medical examination was carried out at the age of 30. The facial appearance was abnormal. The forehead and the eyebrows were prominent and the philtrum was short. The nose was broad with hypoplastic alae (fig 2c and d). He was of normal size (169 cm), but the extremities were disproportionately long with a span of 192 cm in the upper extremities and an upper/lower segment ratio of 0.94. His OFC was 57 cm and weight was 80 kg.

Both eyes were completely blind. Band keratopathy was present in the cornea in both eyes. The eye bulbs were of reduced size and showed calcification on computerised tomography of the orbits (fig 5). Bone x rays showed generalised osteoporosis (fig 3b), old compression fractures in the thoracic vertebrae, and a mild scoliosis (fig 4b). His muscle strength and muscle bulk were both normal. EEG and EMG gave normal results.

LABORATORY INVESTIGATIONS
Routine blood and urinary analyses were normal in both patients. Other laboratory examinations included serum concentrations and daily urinary excretion of calcium and phosphorus, serum alkaline phosphatase, serum parathyroid hormone and calcitonin measurements, serum concentration and
FIG 3  X rays of the metatarsal bones of the proband (a) and her brother (b) showing osteoporotic cysts and generalised osteoporosis.

FIG 4  X rays of the spine showing profound scoliosis and osteoporosis in the proband (a) and osteoporosis and old compression fractures in her brother (b).
Tissue culture studies on collagen metabolism

Skin fibroblast cultures were established from skin biopsies and grown by routine methods as described previously. Prolyl 4-hydroxylase (PH), lysyl hydroxylase (LH), hydroxyllysyl galactosyl transferase (HGT), galactosylhydroxyllysyl glucosyltransferase (GGT), and lysyl oxidase (LO) activities were analysed from cultured skin fibroblasts as described previously. To quantify the secreted collagenous protein, the fibroblast cultures were labelled with 14C-proline for 24 hours and the 14C-hydroxyproline content was analysed from the medium by the method of Juva and Prockop, as described in Peltonen et al. The labelling of procollagen chains with 14C-proline was performed essentially as described by Deak et al. To prevent the post-translational modifications, occasionally 1 mmol/l α,α′-dipyridyl was added. The procollagen chains were separated on 4 to 8% gradient SDS-polyacrylamide gel electrophoresis and visualised by fluorography.

Results

Muscle biopsy

Histological examination of the biopsy obtained from the proband (V.2) showed generalised muscle fibre atrophy, but no sign of myopathy or denervation. The microscopic picture was compatible with disuse atrophy. The muscle biopsy obtained from the second patient (V.5) was normal.

Bone biopsy

The amount of cancellous bone was decreased in both patients. The proband had a slightly increased amount of osteoid. The amount of resorption surfaces was within normal limits in both patients.

Table 1 Enzyme activities of procollagen biosynthesis.

<table>
<thead>
<tr>
<th>Enzyme Activity</th>
<th>Patients</th>
<th>Controls</th>
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<tbody>
<tr>
<td>Prolyl-4-hydroxylase (PH)</td>
<td>127±10^3 cpm/10^6 cells</td>
<td>190±10^3 cpm/10^6 cells</td>
</tr>
<tr>
<td>Procollagen lysylhydroxylase (LH)</td>
<td>43±7±10^3 cpm/10^6 cells</td>
<td>48±2±10^3 cpm/10^6 cells</td>
</tr>
<tr>
<td>Hydroxyllysyl galactosyl transferase (HGT)</td>
<td>85±7±10^3 cpm/10^6 cells</td>
<td>111±10^3 cpm/10^6 cells</td>
</tr>
<tr>
<td>Galactosyl hydroxyllysyl glucosyl transferase (GGT)</td>
<td>24±2±10^3 cpm/10^6 cells</td>
<td>37±10^3 cpm/10^6 cells</td>
</tr>
<tr>
<td>Lysyl oxidase (LO)</td>
<td>2790±10^3 cpm/10^6 cells</td>
<td>2200±10^3 cpm/10^6 cells</td>
</tr>
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</table>
values (table 1). Excretion of $^{14}$C-hydroxyproline was also normal (table 2).

No major differences could be detected in the electrophoretic mobility of the intracellular type I procollagen chains (two hour labelling, data not shown) and, also, the secreted $^{14}$C-proline labelled $\alpha_1$(I) and $\alpha_2$(I) (24 hour labelling) migrated the same way in both the patients' and the control culture media (data not shown).

**Discussion**

The combination of juvenile osteoporosis and vitreoretinal dysplasia or phthisis bulbi is typical of the osteoporosis-pseudoglioma syndrome. The syndrome is thought to be inherited in an autosomal recessive fashion. Some findings in this pedigree may look exceptional, although they are not actually contrary to this mode of inheritance. Several family members became blind at various stages of their lives, but unfortunately it is not possible to diagnose the cause of their blindness in retrospect. Some of them may have had the same syndrome, as they became blind suddenly at a young age and occasionally had simultaneous skeletal involvement. The pedigree data are not incompatible with autosomal recessive inheritance because of the exceptionally high consanguinity rate present in the pedigree.

Although both patients showed the cardinal features of the syndrome, the manifestations differed to some extent. The proband was small in size and had pronounced skeletal deformities and clinical muscle weakness, whereas her brother was of normal size and had normal muscle strength. His juvenile osteoporosis became clinically apparent only when he had a compression fracture of the thoracic vertebrae because of an epileptic seizure. The sibs thus illustrate the variability of clinical features. In some cases the skeletal abnormalities may apparently remain unnoticed for a long period of time.

Mental retardation was considered to be a common feature in the syndrome for some time, but in a recent review only seven out of the 20 cases were found to be retarded. Since our two cases were exceptionally bright students, and none of the seven other cases published separately was retarded, it seems fair to conclude that mental retardation is actually rare in the osteoporosis-pseudoglioma syndrome.

Various authors have suggested that osteoporosis-pseudoglioma syndrome should be included among the inherited connective tissue disorders, but little is known about the underlying abnormality. Bone pathology has been described in one paper and in one recent abstract only. Bone histology appears to distinguish the syndrome from osteogenesis imperfecta, but apart from this offers few clues to the basic abnormality. In our two patients the main finding was osteopenia with no disease specific features.

One possibility for the basic defect behind the osteoporosis-pseudoglioma syndrome is an alteration in the biosynthetic events of type I collagen. In this study neither sensitive protein chemical techniques nor well established assays of the collagen biosynthetic enzymes were able to show any major abnormalities in cultured skin fibroblasts. However, these negative findings do not exclude the possibility of an underlying defect in collagen metabolism. The situation is somewhat analogous to osteogenesis imperfecta, where the primary defect is likely to be in type I collagen, but it has often been hard to prove this with protein chemical techniques. Now that linkage studies using polymorphic markers of the $\alpha_1$(I) and $\alpha_2$(I) genes have become available, it has been possible to show that a mutation in these type I collagen coding genes seems to be responsible for the primary defect in almost all families suffering from osteogenesis imperfecta. Linkage studies using polymorphic markers of the structural genes coding connective tissue components might be informative in searching for the mutated gene causing the osteoporosis-pseudoglioma syndrome.

**References**

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