Syndrome of the month

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The Nance-Horan syndrome

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In 1974 Nance et al.1 and Horan and Billson2 described a type of uncommon X linked congenital cataract, distinctive because of the striking associated dental features. Possible earlier reports of the so-called 'Nance-Horan syndrome' are incomplete and vague, and only a further three families have been described in the past two decades. Van Dorp and Delleman3 were able to confirm and broaden the clinical description of the ophthalmological and facial manifestations and Bixler et al.4 showed that the dental and ophthalmological features in female carriers could be more severe than previously recognised. We report a family (fig 1, table) who further illustrate the Nance-Horan syndrome. The male proband was developmentally delayed and had a dysmorphic facies, features which we believe are integral parts of the syndrome spectrum. Recently it has been suggested that the gene locus is in the Xp21.1–p22.3 region.5

Clinical features
Cataracts in association with the distinctive dental findings and characteristic facial features form the major features necessary to diagnose the Nance-Horan syndrome (table).

Ophthalmological features
X linked cataracts account for a minority of hereditary cataracts. In males with Nance-Horan syndrome the

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**Table: Frequency of features in the Nance-Horan syndrome.**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Previous reports</th>
<th>This family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Ocular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cataract</td>
<td>100%</td>
<td>38%</td>
</tr>
<tr>
<td>Microcornea</td>
<td>65%</td>
<td>NR</td>
</tr>
<tr>
<td>Posterior suture opacity</td>
<td>NR</td>
<td>75%</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mesiodens</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Tapering incisor crown</td>
<td>&gt;50%</td>
<td>100%</td>
</tr>
<tr>
<td>Incisal notching</td>
<td>&gt;65%</td>
<td>NR</td>
</tr>
<tr>
<td>Diastema</td>
<td>&gt;50%</td>
<td>80%</td>
</tr>
<tr>
<td>Facial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prominent ears</td>
<td>94%</td>
<td>8%</td>
</tr>
<tr>
<td>Long face</td>
<td></td>
<td>NR</td>
</tr>
<tr>
<td>Prominent nasal bridge and nose</td>
<td>+</td>
<td>NR</td>
</tr>
<tr>
<td>Intellectual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diminished</td>
<td>18%</td>
<td>NR</td>
</tr>
<tr>
<td>Skeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broad fingers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Approximate rates only because of incomplete reporting. Under-estimation owing to edentulous subjects and probable under-reporting. NR—not reported.
cataracts are severe, bilateral, and congenital. Microcornea (<10 mm diameter), microphthalmia, and nystagmus are usually present; this was true of our proband and the irides were pale and vascular. Younger carrier females most frequently have localised posterior sutural lens opacities and normal vision is usually retained. These lens opacities can be of unequal density and can progress to true cataract formation that affects vision in later life. The adult female in this report (II.1, aged 43 years) had punctate lens opacities affecting the anterior nucleus and not restricted to the sutural area. The degree of eye involvement has been noted to parallel dental manifestations in both sexes and interfamilial variation in expression is likely.

Dental features
It is most often the dental findings that make it possible to distinguish this syndrome from other forms of cataract. Mesiodens, that is, peg shaped, supernumerary teeth, most frequently medial and in the upper jaw, were present in several reported males. The proband’s mother in our family had a single, characteristically placed mesioden as part of her primary dentition, but does not recall its fate. Characteristically, the incisors show tapering of the crown or are peg shaped, with a vertical notch (‘screwdriver’ shaped) and diastema. The close similarity to the incisor shape seen in congenital syphilis was noted by the original authors and described as Hutchinsonian. In our patient this provided us with the diagnostic clue (figs 2 and 3).

Facial features
Nance et al described all affected males as having antverted pinnae which are less frequently observed in females. The ears were long (II.1 and III.5, >97th centile) and prominent in our patients. That there is a characteristic facial appearance in Nance-Horan syndrome is evident in our family (fig 4) and supported by reports that affected subjects have long faces and appear different from unaffected family members. The nasal bridge and nose are prominent, with synophrys in some subjects.

Intellect
Intellect has not been commented upon in the other
published reports, but it is noteworthy that four
subjects, including our proband, that is over 20% of
males reported with the Nance-Horan syndrome, are
intellectually handicapped or have developmental
delay.1 3 4 At the age of 2½ the proband (III.5) has
significant delay in areas of fine/gross motor, social,
language, and self help skills. He has no speech, poor
concentration, is not walking, and has much self-
stimulatory behaviour with vision assessed as ‘ade-
quate’. It is suspected that long term follow up will
indicate mild to moderate intellectual deficit. There
is no report of intellectual deficit in carrier females.

Skeletal features
Broad or short fingers without brachydactyly have
been described in Nance-Horan syndrome, but there
has been no confirmation of short fourth metacarpals
as reported by Nance et al.5 Bixler et al6 commented
that this is probably not a feature of the condition and
it was not evident clinically or radiologically in our
patients. Alkaline phosphatase levels were also normal.

Differential diagnosis
Other syndromes with X linked patterns of inheritance
include congenital cataract with microcornea or
microphthalmos, but none have the associated charac-
teristic dental findings most apparent in males and
evident in female Nance-Horan syndrome carriers
reported so far, often to a minor degree.4-8 The
dental abnormalities may be confused with those seen
in congenital syphilis, so rare in modern times, but
are unlikely to be confused with the pegged teeth of
ectodermal dysplasia. The family described by
Goldberg and McKusick6 featured dental diastema,
possible tapering of incisors, and simple prominent
ears. Only one affected male had cataracts, but all had
colobomatous microphthalmos with marked micro-
cornea and blepharoptosis. Nystagmus, esotropia,
and pupils unresponsive to direct or consensual light
were observed. Other features included microcephaly
with intellectual retardation, short stature, kyphos-
coliosis, and pes cavus. Females examined were
normal.5

Lenz also described an X linked form of micro-
phthalmos with dental anomalies and multiple
congenital malformations which included micro-
cephaly, digital defects, and vertebral, renal, and
heart anomalies.6

Counselling
Those families so far described with Nance-Horan
syndrome most strongly support X linked recessive
inheritance. Firstly, manifestations in the hetero-
zygous female have been less marked than in the
hemizygous male. There has been no example of male
to male transmission. Segregation ratios in 67 persons
from five pedigrees also favour X linked recessive
inheritance. Linkage analysis of Nance-Horan
syndrome segregating in four multigenerational
families using X chromosome RFLP markers DXS143
and DX884 (also DXS43, DXS41, DXS67) obtained
peak lod scores of 3.08 at theta=0.05 and 4.07 at theta=0.05,
respectively. These results place the gene locus
broadly in the Xp21.1 and Xp22.3 region.5

Males with Nance-Horan syndrome generally have
severe visual problems and most will be legally blind.
The risk of mild intellectual handicap in males is
probably about 20%. Bixler et al4 have suggested that
as the syndrome becomes better delineated it may
prove to be a more common condition than currently
recognised.4

The authors would like to thank Mrs Sue Conlan for
her considerable assistance in preparing this manu-
script.

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