LETTERS TO THE EDITOR

Multiple pterygium syndrome: a relatively common disorder among Arabs

Multiple pterygium syndrome (MPS), also referred to as Escolbar syndrome1 or pterygioarthromyodysplasia syndrome,2 is a rare, autosomal recessive disorder characterized by multiple congenital joint contractures, multiple skin webs, camptodactyly with or without syndactyly, distinct facial appearance with ptosis and antimongoloid eye slant, short stature, kyphoscoliosis, and vertebral segmentation anomalies. Approximately 60 cases have been reported from several countries in English language publications.3-5

In Kuwait, during a community genetic survey at Farwania district hospital, serving a mixed Arab population of 400,000, we have ascertained 13 cases of MPS in six sibships in four Arab families. There were five males and eight females. Their ages ranged from soon after birth to 19 years. Family 1. The parents are normal, first cousin Kuwaitis whose first child (female) had congenital joint contractures, pterygia, and the typical facial appearance, as noted at the age of 7 months.

Our cases of MPS, briefly reported here, represent the largest series reported so far from one centre. It is noteworthy that they are not the only cases detected in Kuwait (population 2 million) where there is a well established community genetic service in three districts. The estimated minimum prevalence in the general population of Farwania district is approximately 1 in 31,000 (13,400 00) and, if the specific age group is considered, the prevalence would be much higher. This prevalence is high for a monogenic malformation syndrome and is similar to that of Bardet-Biedl syndrome in the Arabs of Kuwait.6 The finding of Thompson et al7 of a high proportion of Asian and Middle Eastern cases (including a case from Jordan) among 11 cases studied in UK is highly significant and is not a chance occurrence. Data from other centres in the Middle East may show that MPS is relatively common among Arabs in particular or even among other communities in the Middle East.

AHMAD S TEEBI, AZHAR S DAOUDE
Kuwait Medical Genetics Centre
and Farwania Satellite Genetic Clinic,
and Pediatric Department, Farwania
Hospital, PO Box 36660,
Ras-24757, Kuwait.


Features of Turner's and DiGeorge's syndromes with X;22 translocation

We read with interest the paper entitled 'Features of Turner's and DiGeorge's syndromes in a child with an X;22 translocation' by Pinto et al (J Med Genet 1989;26:778-80) and would like to comment on it. We agree that in this case the DiGeorge's syndrome (DGS) is the result of a 22q11 deletion. However, the hypothesis that a paternal meiotic accident plus adrenal hypoplasia (AHC) in one of the mother's X chromosomes was a coincidence is not convincing. The AHC gene is rare and no other case is mentioned in this family. Furthermore, as the authors quoted, "it is tempting to assume that the breakpoint in this t(X;22) is located at the region to which the AHC gene was assigned". This does not imply that the patient's mother is a carrier of the AHC gene. The authors concluded that only the abnormal X was inactivated.

If the replication study was mainly carried out on peripheral blood cells, available surviving lymphocyte cell lines necessarily come from clones with the abnormal X inactivated. This selective effect has been seen in females with X linked immunodeficiency diseases. In the other tissues, inactivation of the normal X, which usually occurs in unbalanced t(X;A), would be sufficient to explain the association of DGS and AHC in this child.

SIMONE GILGENKRANTZ
MICHEL TEBOUL
Laboratoire de Génétique,
CRTS Nancy-Brabois,
Avenue de Bourgogne,
54511 Vandoeuvre les Nancy Cedex,
France.

Marfan syndrome

Dr de Groote et al (J Med Genet 1990;27:82-5) present linkage data for Marfan syndrome using markers on
chromosomes 1 and 11 in six kindreds. We are concerned about the possibility of over diagnosis of Marfan syndrome within the kindreds presented. In the six families, one would expect 37 out of the 74 offspring who are at a 1 in 2 risk of inheriting the gene to be affected. Fifty-seven were in fact diagnosed as having Marfan syndrome; this is significant ($\chi^2=5.3$, $p<0.05$). The disparity is even more marked when families are sampled selectively. In family 4 a lod score of 0.92 was obtained using one of the probes, D1S7. However, out of 13 subjects at a 1 in 2 risk, only two were diagnosed unaffected.

Such methodological problems, we believe, may lead to false conclusions regarding exclusion of loci which may possibly be involved in Marfan syndrome.

RICHARD S HOUlstON, PAULINE PARRY
Department of Clinical Genetics,
The Royal Free Hospital,
Pond Street,
London NW3 2QG.

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BOOK REVIEW


This volume contains papers presented at the Third International Conference on Osteogenesis Imperfecta (Pavia, Italy, 1987). Contributions on clinical, genetic, biochemical, and molecular aspects are presented, and aim to give a broad overview of current knowledge about this heterogeneous and complex group of connective tissue disorders.

Part I on nosology and genetics contains four papers discussing clinical classification and correlation of phenotype with biochemical and molecular pathology. The first paper by Sillence outlines his generally used clinical classification and contains useful radiographs. This is followed by a different and somewhat conflicting classification by Maroteaux et al based on antenatal or postnatal presentation, while Beighton et al report linkage data on families categorised according to the Sillence classification. It is clear from these papers that the biochemical and molecular heterogeneity within each defined clinical phenotype is considerable and not yet well understood.

Part II contains eight papers on biochemical defects detected in type I collagen, ranging from reports of abnormalities documented in single families to studies of substantial numbers of patients with all clinical types of osteogenesis imperfecta. No summary of collagen biochemistry is given, and a basic knowledge in this area is required in order to interpret the findings presented.

Part III contains three very good papers on the structure of the type I collagen genes, including an excellent review by Byers et al on the molecular basis of clinical heterogeneity. As in the biochemical papers, it is assumed that the reader will be familiar with molecular terminology.

Part IV on genetic counselling incorporates only two papers. The first by Sykes and Ogilvie concentrates on the potential application to prenatal diagnosis of linkage with either COL1A1 or COL1A2 loci in dominantly inherited OI. The paper by Thompson et al gives excellent practical guidelines for counselling in cases of perinatally lethal and progressively deforming osteogenesis imperfecta.

Part V on management contains four papers, three of which report experience with orthopaedic treatment from units with a special interest in osteogenesis imperfecta.

As is inevitable in a book of this format, the style and quality of the papers varies considerably, and there is a certain amount of repetition between various chapters. The fact that English is not the first language of some authors detracts from a few of the chapters. It is difficult to define the readership for this book. Scientific investigators working in this field will inevitably find certain areas already out of date, and clinicians involved with osteogenesis imperfecta will find limited new information that is not already available to them. The lack of general introductory chapters on collagen biochemistry and molecular studies detracts from the value of the book for readers who are not already conversant with these aspects. Paediatricians who are occasionally faced with the task of clarifying the diagnosis and prognosis in affected neonates would find the clinical classification useful, despite the limitations imposed by the unresolved problem of heterogeneity in this group of disorders. Despite these reservations, this book would be a useful addition to postgraduate libraries, even if few clinicians or scientists wish to purchase personal copies.

HELEN M KINGSTON
Marfan syndrome.

R S Houlston and P Parry

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Updated information and services can be found at:
http://jmg.bmj.com/content/27/12/791.3.citation

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