Dysmorphology report

Fetal brain disruption sequence: a milder variant

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Abstract
We report on a female infant with severe microcephaly, scalp rugae, overlapping sutures, and telencephalic damage with relatively satisfactory early motor development. This case represents a milder form of the 'fetal brain disruption sequence', which is thought to be the result of an exogenous insult to the developing brain during the second half of gestation.

Clinical examination
Birth weight 1670 g (10th centile), length 42 cm (10th centile). Severe microcephaly with head circumference of 24 cm (–6 SD), striking scalp rugae (fig 1), and overlapping coronal sutures palpable. Slight micrognathia and large appearing, well formed ears, but otherwise normal face. Apart from minor muscular hypotonia, rest of examination normal.

Investigations
Radiographs of the skull as newborn (fig 2a). Severe microcephaly, parietal bone overlapping frontal bone, other sutures abnormally narrow. No intracranial calcifications.

Computed tomography of the head as newborn (fig 2b). Grossly enlarged lateral ventricles (especially temporal horns and cellae mediae), cortical mantle thinned with rarefaction of gyral pattern. Subarachnoid space particularly marked in the frontotemporal regions. Caudal structures considered to be normal.

TORCH titres were negative.

Clinical course
General development was satisfactory, otherwise the clinical course was complicated by intermittent bradycardia, making continuous monitoring necessary. Discharge at 40 weeks’ gestational age. Motor development at this age was considered to be normal by an experienced examiner. The child was seen at 1 year by the family paediatrician who was surprised by the good progress the child had made. He considered the motor development to be equivalent to a 4 month level. Unfortunately, re-examination of the child by one of us was not possible.

Discussion
The observed pattern is consistent with the 'fetal brain disruption sequence' described by Russell et al. Severe microcephaly, scalp rugae resembling cutis verticis gyrata, and overlapping sutures indicating
collapse of the fetal skull owing to severe brain destruction with diminution of intracranial hydrostatic pressure are thought to be diagnostic of this type of microcephaly, distinguishing it from other, often heritable, types of severe congenital microcephaly. With regard to aetiology, a vascular insult or a prenatal infection (for example, herpes simplex), disrupting normal brain development around the second to third trimester, are thought to be causally related to this sequence. Since TORCH titres were negative in our patient, a vascular insult could be assumed here. Our case is noteworthy in that it represents a milder variant than that described by Russell et al. Such variation in severity is consistent with the presumably diverse consequences of a vascular or infectious insult affecting the brain during late pregnancy.

In spite of the severe brain destruction proved by the CT scan, the early motor development in our patient appeared to be adequate. Thus, it is conceivable that the disruption, possibly of vascular aetiology, was essentially limited to the telencephalon. These structures are considered to be of minor importance in early motor development, which might explain the better prognosis for early motor development than seen in more generalised conditions, such as metabolic disorders or disturbed cytoarchitecture of the brain.

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