Velocardiofacial (Shprintzen) syndrome: an important syndrome for the dysmorphologist to recognise

A H Lipson, D Yuille, M Angel, P G Thompson, J G Vandervoord, E J Beckenham

Abstract
We report the dysmorphological, genetic, and speech therapy aspects of 38 cases of velocardiofacial syndrome presenting to a craniofacial clinic and a specialised children's hospital, to indicate a relatively low incidence of clefting, good response to pharyngoplasty, considerable variability of the syndrome, and two further familial cases. We emphasise the low index of suspicion by paediatricians and paediatric subspecialists which resulted in delayed diagnosis and delayed treatment for the hypernasal speech and velopharyngeal insufficiency for periods of four months to seven years.

Velocardiofacial syndrome (VCFS) was first delineated in 12 children by Shprintzen et al., though Strong had described a familial case previously. The features of the syndrome include overt and submucous clefting of the palate, cardiac anomalies, particularly of the conotruncal type, hypotonia, myopathic and dysmorphic facies, developmental delay and learning difficulties, small stature, velopharyngeal insufficiency, and a variety of other anomalies. Patients may manifest overt or subclinical features of the Di George anomaly. Although familial cases have been described indicating dominant inheritance, a consistent aetiology is not apparent, indicating that the condition may be heterogeneous in aetiology. The great majority of patients have been described from one centre where it has been reported to be the most common cause of clefting.

Patients
Of our 38 patients, 19 were male and 19 female. A representative sample of facial features is shown in figs 1 to 8. The average age of referral was 6 years.

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Figure 1 Case 1 aged 5. Referred at the age of 4 with speech problems from a developmental paediatrician. Hypotonia, undescended testes, mild intellectual impairment, and hypernasal speech. Height 10th centile. Note myopathic facies, almond shaped palpebral fissures, deficient nasal alae, long narrow nose and prominent nasal bridge, and apparent micrognathia.
Dysmorphology

CLEFT PALATE (TABLES 1 AND 2)
Seven patients had overt and 15 submucous clefts of the palate. Two children had associated cleft of the lip with overt cleft of the palate.

CONGENITAL HEART DISEASE (TABLES 2 AND 3)
Sixteen patients had congenital heart disease, the most common lesions being tetralogy of Fallot and ventricular septal defect. Unusual defects such as various hypoplasias of pulmonary arteries, hemitruncus, and interrupted aortic arch were seen. Only one child had a right sided aortic arch, the case with double aortic arch and vascular ring (case 28).

ASSOCIATED ANOMALIES (TABLE 4)
Nineteen patients had anomalies other than clefting and congenital heart disease.

TYPICAL FACIES
All patients had the typical face consisting of a long nose with a broad, squared root and deficient alae, narrow alveolar base, flattened malar eminences and (range 9 months to 30 years). Ethnic distribution reflected the general population, with the majority being white Caucasians with origins from the United Kingdom and Europe. Two were from Chinese, three Italian, two Yugoslav, one Greek, and one Lebanese backgrounds.

Each patient was evaluated dysmorphologically and genetically by AHL with a three generation family history, a standard questionnaire concerning medications and other influences during pregnancy, and examination of other family members if appropriate. All patients with hypernasal speech had cinefluoroscopy to evaluate palatal length and movement. The patients were evaluated over a period of 10 years, 1980 to 1990.

Speech therapy assessments were performed when possible before and after pharyngoplasty. Assessment of the response was made six months after surgery and graded as excellent (normal speech, normal tone, no nasal airway escape, normal articulation), good (inconsistent nasal airway escape, mild tone discrepancy), fair (no considerable improvement in tone but improved intelligibility/articulation), poor (only marginal improvement in tone, articulation/intelligibility), and no response (no change from preoperative status).
small mandible, myopathic facies often associated with almond shaped palpebral fissures, and minor malformations and prominence of the auricles. The mouth was often small and open resulting in a misdiagnosis of 'adenoid' facies. A notable feature in some children was small nasal openings. Older patients had an appearance of a broad bulbar tip to the nose.

OTHER FEATURES (TABLE 2)
Other features included hypotonia, particularly in the first years of life, learning difficulties, mild to severe retardation, small stature, and tapering fingers. Ureteric reflux, hypocalcaemia, T cell anomalies, and abdominal hernias were seen.

VELOPHARYNGEAL INCOMPETENCE
All but one child had velopharyngeal incompetence as assessed by a speech pathologist or videofluoroscopy or both. The exception was one of sibs (case 24) who was recognised because of the presentation of his sib with velopharyngeal incompetence. Hypernasal speech coupled with delayed expressive speech, learning difficulties, retardation, small stature, and secondary psychological overlay caused by
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Figure 7  Case 32 aged 8. Interrupted aortic arch, ventricular septal defect, atrial septal defect. Hypocalcaemia fit aged 3 months. Nasal regurgitation of feeds in first year of life. Submucous cleft of palate diagnosed at the age of 4. Hypotonia. Aged 8, calcium normal, T cell studies borderline abnormal result. Normal intelligence. Diagnosis of VCFS aged 8 and definitive treatment of hypernasal speech offered after 4 years of speech therapy. Note almond shaped palpebral fissures, long narrow nose, deficient nasal alae, apparent maxillary and mandibular hypoplasia, and prominent deficient ears.

Figure 8  Case 38 aged 4½. Referred from speech therapist at the age of 4. Hypernasal speech. Submucous cleft palate. Velopharyngeal insufficiency. Note myopathic facies, almond shaped palpebral fissures, deficient nasal alae, maxillary and mandibular hypoplasia. Normal height and development. Very small nasal and external auditory openings.

decreased intelligibility combined to make the speech very poor in many children. A history of nasal regurgitation of feeds in the first year of life was very prominent in the children who did not have an overt cleft; at least 15 gave such a history. It was often misdiagnosed as oesophageal reflux. This settled after the first year of life in all cases. Two children had started sign language as a method of communication. Both had a good response to pharyngoplasty. The children and their families were frustrated by the lack of intelligibility and this often resulted in social withdrawal. The patients were uniformly unresponsive to speech therapy, often continuing for some years with no success.

RESPONSE TO PHARYNGOPLASTY
Twenty-four had a detailed speech therapy assessment at least six months after pharyngoplasty. Of these, 15 had an excellent response, four had a good response, four a fair response, and one a poor response. Improvement occurred up to four years after operation. No postoperative obstructive sleep apnoea was seen. Many children have not been assessed for this long, so that improvement could still occur. The oldest patient operated on was 15·2 years when he had the procedure and had a poor response. One who was operated on at 14·4 years had a fair response. A strong clinical impression was that operation in infancy produced a quicker and better response. In addition, a marked improvement in confidence, vocabulary, and general ability was noted in many children who appeared to be socially withdrawn because of their lack of intelligibility. Two children who were using sign language before operation had a good response, with rejection of

| Table 1  Major features (n = 38). |
|---------|-------|-----|
|         | No    | %   |
| Overt cleft palate | 7     | 18  |
| Associated with cleft lip | 2     | 5   |
| Submucous cleft palate | 15    | 39  |
| Congenital heart disease | 16    | 42  |
| Other defects | 21    | 55  |
| Hypotonia | 29    | 76  |
| Learning deficiencies/retardation | 31    | 82  |
| Small stature (<3rd centile) | 24    | 63  |
| Dysmorphic face | 38    | 100 |
| Pharyngoplasty | 34    | 89  |


**Table 3** Congenital heart disease (n = 16).

<table>
<thead>
<tr>
<th>No</th>
<th>Case No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary atresia with ventricular septal defect, both left sided aortic arch</td>
<td>2 19, 34</td>
</tr>
<tr>
<td>Ventricular septal defect only</td>
<td>6 2, 14, 17, 18, 26, 30</td>
</tr>
<tr>
<td>Ventricular septal defect and hypoplastic pulmonary arteries</td>
<td>1 9</td>
</tr>
<tr>
<td>Tetralogy of Fallot (one with hemihypertrophy, all left sided aortic arch)</td>
<td>3 8, 10, 15</td>
</tr>
<tr>
<td>Vascular ring/double aortic arch</td>
<td>1 28</td>
</tr>
<tr>
<td>Pulmonary stenosis, atrial septal defect</td>
<td>1 29</td>
</tr>
<tr>
<td>Interrupted aortic arch (associated with VSD, ASD 1)</td>
<td>2 32, 33</td>
</tr>
</tbody>
</table>

**Table 4** Associated anomalies.

<table>
<thead>
<tr>
<th>No</th>
<th>Case No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ureteric reflux</td>
<td>4 7, 19, 21, 23</td>
</tr>
<tr>
<td>Umbilical hernia</td>
<td>2 22, 25</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>3 22, 33, 35</td>
</tr>
<tr>
<td>Undescended testes</td>
<td>3 1, 7, 33</td>
</tr>
<tr>
<td>Talipes</td>
<td>4 14, 20, 26, 33</td>
</tr>
<tr>
<td>Hypocalcaemia 1st year</td>
<td>5 5, 30, 32, 33, 34</td>
</tr>
<tr>
<td>Proven hypoparathyroidism</td>
<td>3 5, 33, 34</td>
</tr>
<tr>
<td>Proven T cell deficiency</td>
<td>2 10, 33</td>
</tr>
<tr>
<td>Vertical talus</td>
<td>1 34</td>
</tr>
<tr>
<td>Hypospadias</td>
<td>1 6</td>
</tr>
<tr>
<td>Sprengel's shoulder</td>
<td>1 4</td>
</tr>
<tr>
<td>Hypermetropia</td>
<td>1 38</td>
</tr>
<tr>
<td>Myopia</td>
<td>1 16</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>1 26</td>
</tr>
<tr>
<td>Laryngeal web</td>
<td>1 29</td>
</tr>
<tr>
<td>Bilateral coloboma of iris</td>
<td>1 30</td>
</tr>
<tr>
<td>Bilateral preauricular sinus</td>
<td>1 4</td>
</tr>
</tbody>
</table>

signing after operation. Of the remaining cases who had velopharyngeal incompetence but had not been operated on, one was mild and refused operation aged 34 (case 26). One was too retarded and had very little speech (case 31), two still had to have the procedure (cases 30 and 36), and one still had to be formally assessed (case 34). The nine remaining who had pharyngoplasty with some response but no formal assessment have either been lost to follow up after reporting initial improvement, or have not had a formal assessment at the time of writing.

**Family history**

Two sibs and a probable twin brother and affected mother of one patient were seen. The sibs had normal parents and normal twin first cousins with clefts of the palate. The second sib was ascertained because of the diagnosis in his sister and response to palatal surgery. He had learning difficulties and
retardation, hypotonia, myopathic facies, small stature, and typical facies. He did not have velopharyngeal incompetence. The second familial case was a mild to moderately retarded 30 year old man with minimal hypernasal speech, typical facies, and congenital heart disease, whose twin brother and mother had died of congenital heart disease (cause unknown). These two latter persons were not examined and there are no photographs available. This familial case is therefore provisional.

PREVIOUS ASSESSMENTS AND TREATMENT
Eight patients were assessed by developmental paediatricians, three by geneticists, and four by paediatric neurologists for developmental, speech, and dysmorphic features during infancy and after speech had started without a specific dysmorphological or speech diagnosis. Treatment of the hypernasal speech was delayed for periods of one to seven years. Most had been treated during this time by speech therapists on a medical referral with no response. Most had been seen by a paediatrician, or a cardiologist, if a cardiac lesion was present, a general practitioner, or ENT surgeon in the first years of life and before and after speech had started. Two children had had adenoidectomy because of the confusion between hypernasal and hyponasal speech and the myopathic facies, exacerbating the hypernasal speech. Two children had had extensive therapy for hypotonic cerebral palsy. Three children had had a provisional diagnosis of VCFS made before speech started, one by a paediatrician at 3 months and two by the dysmorphologist member of the cleft palate team at 9 months and 2 years.

REFERRALS
Other than referrals by the clinic team, nine children were referred by speech therapists, eight by general paediatricians, two by developmental paediatricians, four by ENT surgeons, two by general practitioners, one by a general paediatrician, and one by a school. Two referred by developmental paediatricians and one by a general paediatrician had the diagnosis of VCFS already made. Others were referred to clinic team members because of palatal, speech, or dysmorphological problems. Treatment of an overt cleft at the cleft palate clinic facilitated the diagnosis. In the latter part of the study period, clinical presentations by clinic members caused confident referrals from speech therapists and developmental paediatricians.

Discussion
Although the velocardiofacial syndrome (VCFS) has now been delineated for over a decade there is still a relative paucity of reports from centres not associated with the original reporting institution. Shprintzen et al. have now reported 60 cases from New York City, Meinecke et al. eight cases from Germany, Mackenzie-Stepner et al. three from Canada, Stevens et al. two cases from Salt Lake City, and Wraight et al. one case from Great Britain. In Shprintzen's clinic at the Montefiore Medical Centre, New York City, 8.1% of children with palatal clefts have VCFS. In our clinic, VCFS accounts for 5% of the palatal cleft population. The number of children has justified the establishment of a VCFS parent support group over the last 12 months. The ethnic background of our population is generally the same as North America, with a predominant white Caucasian population from the United Kingdom and Europe. Clearly the syndrome is either not recognised or not being reported. Our experience supports the former contention. The craniofacial and cleft palate clinic where this study was undertaken serves a statewide population of 5 million with 80,000 births per year seeing approximately 90% of craniofacial and clefting disorders. VCFS appears to be very variable with incomplete forms being recognised. Twenty-two (57%) have either overt or submucous clefts in contradistinction to the original reports of Shprintzen et al. which cite up to 100% as having cleft palate. This may be associated with the definition of submucous cleft at operation, which has generally been conservative in our clinic. The fact that cardiac disease was uncommon, the presence of hypotonia and learning problems inconstant, and a family history rare may have hindered the diagnosis. Shprintzen et al. described the syndrome in 1978, three years before the first case was recognised at our clinic.

Diagnostic evaluation included exclusion of other chromosomal, teratogenic, and genetic aetiologies. Differential diagnosis includes trichorhinophalangeal syndrome, Stickler syndrome, the fetal alcohol syndrome, FG syndrome, and myotonic dystrophy. The face has many features of a hypotonic or myopathic face and shares characteristics with other syndromes with hypotonia, such as the almond shaped palpebral fissures in Prader-Willi syndrome, the FG syndrome, and even congenital facial paralysis as seen in Möbius syndrome. No patient was seen with the Pierre-Robin syndrome though this has been noted by Shprintzen et al.

Shprintzen et al. noted four unaffected mothers who had been given progestational agents during the early first trimester and one mother was an operating room nurse who had been exposed to anaesthetic gases during pregnancy. No cases in this series have reported a mother exposed to progestogens or anaesthetic gases during pregnancy.

Five cases of hypocalcaemia were seen and this has been reported before. Three had proven
hypoparathyroidism and, of these, two had proven T cell dysfunction. Certainly the Di George sequence is in the differential diagnosis of this syndrome; in particular the association of complex cardiac defects of neural crest origin with some of the dysmorphic and developmental associations may mean that many reported cases of Di George sequence may actually have the VCF syndrome. Stevens et al\textsuperscript{7} reported two families with Di George sequence and VCFS. Shimizu et al\textsuperscript{20} and Radford et al\textsuperscript{21} studied children with conotruncal congenital heart disease and a dysmorphic face and found T cell abnormalities in the majority of those tested. Goldberg et al\textsuperscript{1} and Shprintzen et al\textsuperscript{12} reported, among 60 patients with the VCFS, a high incidence of infections, diminished lymphoid tissue, transient hypocalcaemia in the first year of life, and T cell abnormalities. Williams et al\textsuperscript{16} subsequently reported a higher incidence of adenoidal hypoplasia in VCFS, which would further accentuate velopharyngeal insufficiency. The association of dysmorphic facies, palatal clefts, conotruncal cardiac anomalies, and other anomalies suggestive of VCFS have been reported by Shimizu et al\textsuperscript{20} Rohn et al\textsuperscript{22} Kepper et al\textsuperscript{23} and Radford.\textsuperscript{24} Wyse et al\textsuperscript{25} noted the association of conotruncal congenital heart disease with clefts of the lip and palate. Kepper et al\textsuperscript{23} and Rohn et al\textsuperscript{22} described autosomal dominant transmission and Shimizu et al\textsuperscript{20} recognised an affected parent in six of 36 patients with the conotruncal anomaly face syndrome, which they recognised as probably analogous to VCFS.

Recent animal experimental work involving ablation of premigratory cranial neural crest has shown that conotruncal\textsuperscript{26-27} and thymic abnormalities\textsuperscript{28} may result. The cranial neural crest that participates directly in heart development has been mapped using quail to chick neural crest transfer in vivo.\textsuperscript{26-27} The region called the cardiac neural crest extends from the level of the midotic placode to the caudal limit of somite 3 and migrates into pharyngeal arches 3, 4, and 6. These contribute to the development of the aortic arch and outflow tracts where they form the aorticopulmonary septum and populate the truncal folds. The thymus develops from pharyngeal arches 3 and 4 and ablation of the premigratory neural crest has been shown to result in reduction or absence of the thymus in the experimental animal.\textsuperscript{28} Abnormalities of neural crest migration are also involved in the development of the face and palate, including the muscles of the face.\textsuperscript{29} It is clear that there is an embryological basis for the VCFS. Stevens et al\textsuperscript{4} reported the association of Di George sequence and VCFS in two families, indicating dominant inheritance, and presented data to indicate that the familial cases of Di George syndrome reported by Kepper et al\textsuperscript{23} and Rohn et al\textsuperscript{22} may represent VCFS transmitted as a dominant trait. This tends to support dominant inheritance, at least when overt or subtle T cell changes are present.

The type of congenital heart disease in our cases was consistent with a conotruncal classification: vascular ring, interrupted aortic arch, hypoplastic pulmonary arteries, hemi-truncus, tetralogy of Fallot, and ventricular septal defect. One child had a muscular ventricular septal defect, the others were membranous or supravalvular. Young et al\textsuperscript{5} from Shprintzen's clinic, reported 23 cardiac anomalies in their first 27 cases, including ventricular septal defect, tetralogy of Fallot, and right sided aortic arch. No case with a cardiac lesion had a right sided aortic arch except the child with vascular ring (case 16). Truncus arteriosus was seen in case 1 of Stevens et al\textsuperscript{7} and the illustrations in the articles of Radford\textsuperscript{24} and Shimizu et al\textsuperscript{20} of facial anomalies with conotruncal congenital heart disease are very suggestive of VCFS. The survival of children with severe conotruncal anomalies has improved dramatically in the last 10 years owing to advances in cardiac surgery. The paucity of cases of truncus arteriosus and interrupted aortic arch in the original series of Young et al\textsuperscript{5} may be because their cases were reported at least 10 years ago, before good survival of this group was recorded.

The family histories in cases 23 and 24 (sibs) and case 26 (twin brother and mother) are of interest. Unfortunately, no further information is available on the facial appearance or type of cardiac lesions in the family of case 26. Dominant inheritance is likely. In the family with sib recurrence (cases 23 and 24), case 24 is an incomplete case only ascertained because of the typical features in his sister. The parents are normal and there are no other affected family members. This could either indicate germinal mosaicism in a normal parent or recessive inheritance. The twin cousins of this case have cleft palate and are reported to be of normal height and intelligence and without dysmorphic features or other anomalies. Several other familial cases have been reported indicating dominant inheritance with transmission from parent to child, including male to male transmission by Williams et al\textsuperscript{1} four families by Shprintzen et al,\textsuperscript{3} two families by Meinecke et al,\textsuperscript{6} six by Shimizu et al,\textsuperscript{20} and two by Stevens et al.\textsuperscript{4} Wraith et al\textsuperscript{20} reported a mother with tetralogy of Fallot and velocardiofacial syndrome having offspring with tetralogy of Fallot and holoprosencephaly. This case must be considered as doubtful as the mother's features, especially the absence or presence of velopharyngeal incompetence, are not well documented. No chromosomal anomalies have been shown to be associated. No common environmental agent or teratogen has been noted. It is likely that there is heterogeneity in the causes of VCFS and non-genetic phenocopies to account for at least some...
of the other patients, and counselling should take
this into account.

The cause of the severely hypernasal speech is
probably multifactorial, including pharyngeal hypo-
tonia readily seen on videofluoroscopy, increased
pharyngeal width associated with platybasia, in-
creased distance between the pterygoid plates,9
and adenoidal hypoplasia.10 A standard repair of an
overt or submucous cleft was never adequate to
prevent velopharyngeal insufficiency.

The study of Arvystas and Shprintzen11 reported
cephalometric evidence of platybasia indicating that
the facial features of retrogнатhia, malar deficiency,
and prominence of the nasal root may be not pri-
mary but secondary to this feature. They wondered
whether landmarks at the cranial base could be
altered by abnormally weak muscular forces in the
nasopharynx, and posed a hypothesis that the cranial
and facial findings of the syndrome could merely be
secondary to neurogenic muscular weakness of a
pre- and postnatal time course. Almond shaped eyes
are seen in other muscular hypotonic syndromes
affecting the face, such as the Prader-Willi and FG
syndromes and myotonic dystrophy. The associ-
ation of inguinal and umbilical hernias, and perhaps
even vesicoureteric reflux, may be further indication
for a secondary effect of muscular deficiency.

Talipes was seen in four patients, but none required
operative reduction. This may result from in-stra-
tine deformation secondary to hypotonia, which is
self-corrective after birth. Hypotonia of the mand-
ible and tongue could cause retrogнатhia and pro-
lapse of the tongue into the posterior pharynx,
obstructing palate closure and resulting in a U
shaped posterior cleft palate. Hypotonia of the palat-
haryngeal structures in utero may give rise to
submucous clefts of the palate and incomplete inser-
tion of muscular fibres.

Studies of the cleft palate population have shown
that children with clefts tend to be smaller than
those without,32 suggesting nutritional depriva-
tion as infants. These studies all assume that such a
population was homogeneous when it has now been
shown to be highly heterogeneous by studies such as
that by Shprintzen et al.8 However, it is now likely
that these children, in fact, have syndromes such as
the velocardiofacial syndrome.

The relative commonness of this syndrome in the
population of children with clefts and speech prob-
lems seems at variance with an apparent failure to
diagnose this dysmorphological syndrome. Under-
diagnosis by therapists and paediatric subspecialists
often resulted in prolonged and fruitless speech
therapy and the inadvertent withholding of a quite
effective treatment of the hypernasal speech by
pharyngeal surgery. There was no response to
speech therapy in any child until after pharyngop-
asty. Although the cause and definitive treatment
of VCFS may elude us in the majority of cases,
surgery, speech therapy, developmental treatment,
and genetic counselling provide a good quality of life
for these children and their families. Diagnosis
should be considered in any child with a conotruncal
cardiac anomaly, particularly if associated with cleft-
ing, Di George sequence, or hypoparathyroidism.

Nasal regurgitation of feeds in the first year of life,
poor growth, hypotonia, and later developmental
problems, as well as facial dysmorphism, should give
a high index of suspicion of a diagnosis of VCFS.
The children in whom the diagnosis is suspected
should be followed carefully until speech starts as it
is then that a functional palatal problem may first be
evident, even if a cleft palate has been repaired
previously. Expressive speech delay was common
and tended to delay the diagnosis. Facial dysmor-
phism may also not be obvious in the first years of
life. There are subtle changes in the facial appear-
ance with age, with the teenage and adult patients
developing a bulbar and broad tip to the nose. Other
reports of adults have a similar bulbar nasal tip, such
as in case 7 of Meinecke et al.6 The absence of
cardiac disease should not deter the clinician from a
diagnosis of VCFS. Only 42% of our cases had
genital heart disease. Differences in this series from
those previously published11 included absence of
the Pierre Robin sequence and the association of
cleft lip in two cases and ureteric reflux in
four cases. All those with ureteric reflux required
antireflux surgery, though there was no associated
renal malformation or damage. We did see cases of
laryngeal web, scoliosis, abdominal hernias, and
undescended testes which have all been described
before. Genetic counselling should be approached
on a patient by patient basis and should include
examination of other family members and studies of
T cell function. Abnormalities in T cell subsets and
hypoparathyroidism may indicate a dominant inher-
itance pattern, though this was not recognised in
families of such children in this series. Many
patients with the Di George sequence may have the
VCFS. Confident counselling of dominant inher-
ance in every case would presuppose an exception-
ally high spontaneous mutation rate, which is unlik-
ely. The known association of Di George sequence
with chromosomal anomalies, such as deletion of the
long arm of chromosome 22,33–35 and teratogenic
insults, such as ethanol36 and retinoic acid,37–39 may
mean that monogenic VCFS probably accounts for
only a proportion of the total cases. However, at
present no chromosomal or teratogenic association
with VCFS has been described, although the over-
lap with the fetal alcohol syndrome has been noted
before.40

We wish to thank Miss Michelle Giaquinto and
Anne Lyon for secretarial assistance, Lyndal Le Bas
for case finding, our colleagues for referring their cases, and the families and children with VCFS for their cooperation.


37 Thayer JM, Adams EA, Effman EL, Sulik KK. Critical period for 13 cis retinoic acid induced aortic arch malformations precedes initial formation of the 4th visceral arch vessel. Teratology 1987;35:32A.


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