Duplication of chromosome 15 in the region 15q11–13 in a patient with developmental delay and ataxia with similarities to Angelman syndrome

J Clayton-Smith, T Webb, X J Cheng, M E Pembrey, S Malcolm

Abstract

Duplications of the proximal long arm of chromosome 15 have been seen in the Prader-Willi syndrome (PWS), and in subjects without the Prader-Willi phenotype but with other clinical features including short stature, diabetes, anal and jejunal atresia, and acanthosis nigricans. The non-PWS subjects all had different phenotypes despite the identical findings on cytogenetic analysis. A normal phenotype has also been observed in patients with similar duplications. We report a further patient with a duplication of 15q11–13 which was detected cytogenetically and confirmed on molecular genetic analysis. She has developmental delay, particularly concerning the acquisition of speech, and an ataxic gait. These are interesting clinical features in view of the association of Angelman syndrome with abnormalities of 15q11–13.

(J Med Genet 1993;30:529–31)

Case report

The proband is the first born child of unrelated, healthy parents and weighed 3630 g at term. She has a normal younger sister. The pregnancy and neonatal period were uneventful and she smiled at 12 weeks of age, sat unsupported at 9 months, and walked independently when she was 19 months old.

At 2 years of age she came to medical attention because of delay in language development with poor vocalisation and no recognisable words. On examination she was a tall, muscular girl with an ataxic ‘bobbing’ gait and a tendency to fall frequently. She was lax jointed and had difficulty with gross motor coordination. When reviewed at the age of 4 years (fig 1) she continued to have a wide based, ataxic gait. Her height and weight were on the 87th centile and her OFC on the 50th centile. She had two small café au lait patches on her skin but did not appear dysmorphic. She was now able to say some single words. An EEG and CT scan were both normal. She had ginger hair and blue eyes but was not significantly hypopigmented compared to the other family members. At 6 years of age she is globally developmentally delayed, functioning at a 3 year level.

Deletions, duplications, and other chromosomal rearrangements of chromosome 15q11.2 have been reported frequently in the Prader-Willi syndrome.12 Cytogenetic deletions, inversions, and translocations involving this area of proximal 15q have also been reported in subjects with Angelman syndrome (AS).5 6 To date, Angelman syndrome has not been found in association with a duplication of 15q11–13. Cytogenetic examination of this region may be difficult as there is considerable normal variation in appearances, particularly of the pale band 15q11.2.7 A long 15q11.2 band may therefore occasionally be interpreted as abnormal if this is not taken into account. Comparison of the appearance with the chromosomes 15 of the parents may safeguard against this error. We report a patient who has a de novo duplication of the 15q11–13 region, initially detected on cytogenetic examination and confirmed by DNA analysis, and shown to involve the locus D15S10 which is associated with the critical region in AS. It is of interest that she has significant developmental delay, particularly in the area of language, and was noted from 2 years of age to have a wide based, ataxic gait. These clinical features are seen to a more severe degree in Angelman syndrome.7

Figure 1 The proband aged 4½ years.
Molecular genetic studies
METHODS
The CA repeat at the D15S10 (pTD3–21) locus on chromosome 15q was analysed in the proband, both parents, and controls using the polymerase chain reaction technique. The reported polymorphism consists of two amplified bands of 179 and 181 base pairs. We have also observed a third allele of 183 bp at a frequency of 2% and a fourth allele of 161 bp once in 256 chromosomes. DNA amplification was carried out in a 50 μl volume containing 25 to 100 ng of genomic DNA template extracted from peripheral blood lymphocytes. The reaction solution contained 25 pmol of each oligodeoxynucleotide primer, 200 μmol/l dATP, TTP, and dGTP, 20 μmol/l dCTP (Pharmacia UK), 1 μCi α32P-dCTP (3000 Ci/ mmol), 50 mmol/l KCl, 10 mmol/l Tris (pH 8.8), 1.5 mmol/l MgCl2, 0.1% Triton X-100, and 0 to 10 units of Tag Polymerase (Promega). Samples were overlaid with mineral oil and after initial denaturations at 94°C for 10 minutes were processed through 30 temperature cycles at 94°C (30 seconds), 56°C (20 seconds), and 72°C (30 seconds) in a PTC-2 thermocycler (Techne). The reaction mix was diluted 5 to 10 fold and 2 μl mixed with 2 μl sequencing stop solution. The PCR products were run on a 6% sequencing gel for two hours at 55 W.

RESULTS
Fig 3 shows an autoradiograph of amplified DNA from the proband, her mother, and several controls. The father was homozygous lower and, therefore, uninformative. Although a slight shadow is seen below each band, probably from the GT strand, comparison of the proband’s track with controls shows that no other subject shows this increased density of signal in a heterozygote, indicating increased copy number of sequences in the D15S10 region.

Discussion
The de novo duplication of 15q11–13 was detected by both cytogenetic and molecular genetic techniques, and as extensive tests have failed to show another cause for the proband’s developmental delay, it seems reasonable to assume that this abnormality is the cause of her developmental problems and ataxia. Shohat et al. described a case with an obesity syndrome who also had a de novo duplication of 15q11–13 and reviewed 10 other patients. Rauch and Nevin10 reported a further five patients. The clinical features of all 16 patients are documented in the table along with those of our patient. None was phenotypically similar to our patient. Rauch and Nevin11 also commented that they had seen similar cytogenetic abnormalities in two normal subjects. It is possible that in some of these patients the apparent extra material on chromosome 15 was in fact because of normal variation in the length of 15q11.2 without necessarily having any material duplicated. The clinical problems...
Duplication of chromosome 15 in the region 15q11-13 in a patient with developmental delay and ataxia

Previously reported cases of 15q11-13 duplication.

<table>
<thead>
<tr>
<th>Author</th>
<th>Age</th>
<th>Phenotype</th>
<th>Duplication</th>
</tr>
</thead>
<tbody>
<tr>
<td>De France et al</td>
<td>6y</td>
<td>Typical PWS</td>
<td>q12-q15</td>
</tr>
<tr>
<td>Fuhrmann-Rieger et al</td>
<td>12y</td>
<td>Short stature, diabetes, large incisors, Cohen</td>
<td>q11-q13</td>
</tr>
<tr>
<td>Stallard and Van Dyke</td>
<td>Fetus</td>
<td>Apparently normal</td>
<td>q11.2-q13.3</td>
</tr>
<tr>
<td>Stallard and Van Dyke</td>
<td>Stillborn</td>
<td>Anal atresia, renal and skeletal abnormalities</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Pattigrew et al</td>
<td>9y</td>
<td>Typical PWS</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Pattigrew et al</td>
<td>13y</td>
<td>Cleft palate, mild mental retardation</td>
<td>q12-q13</td>
</tr>
<tr>
<td>Brookwell and Veleba</td>
<td>10y</td>
<td>Short stature, clinodactyly, mild mental retardation</td>
<td>q11-q13</td>
</tr>
<tr>
<td>Brookwell and Veleba</td>
<td>4 mth</td>
<td>Jejunal atresia, brain malformations</td>
<td>q11-q13</td>
</tr>
<tr>
<td>Barron et al</td>
<td>34y</td>
<td>Normal phenotype</td>
<td>q11-q13</td>
</tr>
<tr>
<td>Shohat et al</td>
<td>13y</td>
<td>Typical PWS</td>
<td>q11.2-q13.3</td>
</tr>
<tr>
<td></td>
<td>26y</td>
<td>Obesity, hypothyroidism, acanthosis nigricans, mental retardation</td>
<td>q12-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>Neonate</td>
<td>Encephalocoele, cystic brain lesion</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>?</td>
<td>Similar to PWS</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>?</td>
<td>Primary amenorrhea</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>?</td>
<td>Infantile dependent diabetes, epilepsy</td>
<td>q12-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>?</td>
<td>Personality disorder</td>
<td>q11.2-q13</td>
</tr>
<tr>
<td>Rauch and Nevin</td>
<td>?</td>
<td>Normal phenotype, infertility</td>
<td>q12-q13</td>
</tr>
<tr>
<td>Clayton-Smith et al (this paper)</td>
<td>6y</td>
<td>Ataxia, mild mental retardation, speech delay</td>
<td>q11.2-q13</td>
</tr>
</tbody>
</table>

would therefore have another cause. Alternatively the extra material may not have been derived from chromosome 15. This would be difficult to prove without molecular genetic studies. Most deletion cases of AS (and PWS) involve large deletions including DNA probes D15S9, D15S10, D15S11, D15S12, and D15S13. However, a report of three cases within one family found a much smaller deletion involving D15S10 inherited from the grandfather to the mother without phenotypic effect, and passed on by the mother to three affected children. D15S10 may, therefore, be regarded as close to a 'critical' region in AS. In this case we have shown that D15S10 is duplicated.

It is now well established that Prader-Willi syndrome can result from a deletion of the paternally derived chromosome 15 whereas in Angelman syndrome the deletion is maternally derived. A reasonable hypothesis, therefore, is that the parental origin of a chromosome 15q11-13 duplication influences the resulting phenotype. Berry et al reported a patient with classical PWS who inherited a 15q duplication from his normal father. Given that our patient has some clinical features in common with Angelman syndrome we might therefore expect that the duplication would be of the other parental origin, that is, maternal. The cytogenetic studies suggest this is the case. Molecular studies do not so far provide any information on the parental origin of the proband's duplication but prove that the extra material is derived from 15q. A lymphoblastoid cell line is available from the proband.

JC-S is an Action Research Training Fellow and XJC is funded by a fellowship from the World Health Organization.

Duplication of chromosome 15 in the region 15q11-13 in a patient with developmental delay and ataxia with similarities to Angelman syndrome.

J Clayton-Smith, T Webb, X J Cheng, M E Pembrey and S Malcolm

*J Med Genet* 1993 30: 529-531
doi: 10.1136/jmg.30.6.529