New X linked spondyloepimeta physeal dysplasia: report on eight affected males in the same family

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Abstract
We report on a probably new form of spondyloepimeta physeal dysplasia (SEMD) with an X linked inheritance pattern. Eight males were affected in the same family. We were able to examine three adult patients and we studied the skeletal radiological aspect of one of these patients at 2 years 6 months and at 9 years of age. The main clinical features are severe short trunked dwarfism, brachydactyly, normal facies, and normal intelligence. Radiologically, the diaphyses of all the long bones are short and broad. The epiphyses of the distal portion of the femora and those of the proximal and distal portions of the tibia are embedded in their metaphyses and there is marked narrowing of the intercondylar groove. There is moderate platyspondyly. Several vertebrae show an anterior tongue in infancy and severe irregularities of the upper and lower surfaces are present in adulthood. The 11th or 12th thoracic vertebra is wedge shaped. The pelvis is narrow. The distal ulnae and fibulae are disproportionately long. The hands show radial deviation and brachydactyly is present in the hands and feet.

This X linked SEMD was not detectable at birth.

The term spondyloepimeta physeal dysplasia (SEMD) is used to refer to a heterogeneous group of disorders marked by a variable, severe ossification disturbance in the spine, epiphyses, and metaphyses. Several syndromes with these clinical features have been reported. We report on eight related male patients, with normal intelligence and life span, affected by an unusual form of dwarfism involving the spine, epiphyses, and metaphyses during the growing period and resulting in moderate osteoarthritic changes. The pedigree is shown in fig 1. The inheritance pattern of the disorder appears to be X linked.

This condition probably represents an as yet undescribed form of bone dysplasia.

Case reports
We were able to examine V.8 at 52 years, V.9 at 49 years, and VI.2 at 25 years of age. At 13½ years, VI.2 was diagnosed by a German orthopaedic surgeon as having pseudoachondroplasia and had grown 21 cm by 15 years of age. At the time of examination, V.8 measured 110 cm, V.9 109 cm, and VI.2 131 cm. The patients had a normal facial appearance, short stature, shortening of the trunk, pectus carinatum, moderate limitation of elbow extension, dorsal projection of the distal end of the ulna, short hands with radial deviation, and short feet (figs 2 and 3). Pregnancy, delivery, birth weight, and birth length was unremarkable in all the patients. They began walking at 15 to 16 months. Disproportionately short limbs were diagnosed at about 2 years of age. All the patients had normal intelligence. No associated extraskeletal anomalies were noted. Routine haematological, biochemical, hormonal, and cytogenetic studies gave normal or negative results. Mucopolysacchariduria and amino acids in plasma and urine were normal. No ocular abnormalities were present. The mothers of V.3 and VI.2 had moderate pectus carinatum and the dead mothers of the other patients had also had this defect.

Radiographical features
We describe the radiological skeleton changes in VI.2 at 2 years 6 months and at 9 years of age, and those present in V.8 and V.9 at 52 years and 49 years of age, respectively. Similar radiographic bone changes were observed in V.8 and V.9.

Skull
This was nearly normal. Mild maxillary hypoplasia was present in all the patients.
Figure 2  V.9 at 49 years. (A,B,C) Patient’s appearance.

Odontoid process
This was slightly hypoplastic in all the patients.

Figure 3  V.9 at 49 years. Prominent distal end of ulna, radial hand deviation, and brachydactyly.

Spine, anterior view
Moderate platyspondyly was present; the interpedicular distance between the first and fifth lumbar vertebrae was normal at all ages. In adulthood, degenerative changes were observed (figs 4 and 5).

Spine, lateral view
At 2 years 6 months, VI.2 showed generalised mild platyspondyly, several vertebrae with an anterior tongue, and a hypoplastic 11th thoracic vertebra (fig 6). At 9 years, a severe kyphosis at the thoracolumbar junction with a wedge shaped 11th vertebral body was present (fig 7). V.8 and V.9 showed severe irregulari-
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hypoplasia of the femoral necks, and mild coxa valga (fig 9). In V.8 and V.9, the iliac bones were short in their craniocaudal dimension, the anterior iliac apophysis was hypertrophic bilaterally, and the femoral necks were very short (fig 10).

Upper limbs and hands
The humeri were short and broad with large metaphyses in all the patients. At 9 years, VI.2 showed short radii with cone shaped epiphyses in their distal portions, moderately long ulnae, and short and broad tubular bones of the hands. Cone shaped defects in ossification of the metaphyses accompanied by cone shaped epiphyses were seen in the metacarpals and proximal phalanges (fig 11). In V.8 and V.9, the distal ends of the radius were flared, the

ties of the upper and lower surfaces of the vertebrae and very hypoplastic wedge shaped 12th thoracic vertebra. The pedicles were short and there was increased angulation at the lumbosacral junction (fig 8).

Thorax and shoulders
The posterior ends of the ribs were moderately cupped. The scapulae were nearly normal and the clavicles were short. The upper humeral metaphyses were irregular.

Pelvis and hip joints
At 9 years, VI.2 showed hypoplastic iliac bones with horizontal acetabular roofs, severe hypoplasia of the femoral necks, and mild coxa valga (fig 9). In V.8 and V.9, the iliac bones were short in their craniocaudal dimension, the anterior iliac apophysis was hypertrophic bilaterally, and the femoral necks were very short (fig 10).

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Pelvis and hip joints
At 9 years, VI.2 showed hypoplastic iliac bones with horizontal acetabular roofs, severe
ulna was dorsally subluxed and disproportionately long with a prominent ulnar styloid process bilaterally, there was radial deviation at the wrist, and the metacarpals and phalanges were short with metaphyseal widening and lack of trabeculation of their proximal and distal extremities (fig 12).

Knees
At 2 years 6 months, VI.2 had flared and irregular metaphyses and small, poorly ossified epiphyses with mildly fragmented margins. At 9 years, he had severe deformation of the condyle and central fusion of both femoral and tibial epiphyses within their metaphyses (fig 13). V.8 and V.9 had very large irregular metaphyses, markedly narrowed intercondylar groove, and mild osteoarthritic changes (fig 14).

Lower limbs
At all ages, the long bones had very short and broad shafts with severe metaphyseal irregularities, the fibulae were disproportionately long distally, and the distal tibial epiphyses
were fused within their metaphyses bilaterally (figs 13 and 14).

Feet
In the patients there was generalised shortening of the tubular bones with severe ossification changes in their extremities (fig 15).

Discussion
In recent years, a large number of distinct skeletal dysplasias have been delineated. Clinical, radiographical, genetic, and histopathological studies have allowed the identification of several types of SEMD. SEMD with joint laxity is characterised by severe dwarfism, oval facies, soft skin, articular hypermobility, and progressive spinal malalignment. This disorder has an autosomal recessive mode of inheritance.1

SEMD, Irapa type, is clinically detectable at birth; the affected children have severe, short trunked dwarfism, platyspondyly with tongue-like appearance of the vertebral bodies, pectus carinatum, increased lumbar lordosis, genu valgum, and shortness of the metacarpals and metatarsals. Autosomal recessive inheritance has been suggested.2,3

Spondylometataphyseal dysplasia (SMED), Strudwick type, is an autosomal dominant disorder characterised by short trunked dwarfism, normal facies, occasionally cleft palate, retarded ossification of the platyspondylotic vertebral bodies, delayed epiphyseal maturation, "dappling" metaphyseal changes, and normally shaped hand and foot bones.4 Clinically and radiologically, this entity is indistinguishable from spondyloepiphyseal dysplasia (SED) congenita during infancy. There have been doubts about the distinction of the SMED Strudwick type from SED congenita.5

SEMD with hypotrichosis is an autosomal dominant syndrome; the patients show congenital hypotrichosis associated with flared metaphyses, delayed epiphyseal ossification, and pear shaped vertebral bodies.6

Vichi et al7 have reported a female patient affected by severe dwarfism with symmetrical metaphyseal and epiphyseal changes, vertebral irregularities, disproportionately long fibulae, marked involvement of the iliac bones, and tarsal bone lesions.

Maloney8 has described two brothers and a third unrelated male with a distinctive type of SMED. The patients showed short stature, hyperextensibility of the joints of the hands, bilateral club foot deformities, kyphoscoliosis with wedged first lumbar vertebra, generalised mild platyspondyly, and minimal epiphyseal and metaphyseal irregularities.

Other bone dysplasias have major alterations in the epiphyses, metaphyses, and the spine, but have not been lumped under the term SEMD. Among them, a well known disorder is pseudoachondrodysplasia. This is usually detectable at 2 to 4 years of age through disproportionate dwarfism with relatively long trunk, short arms and legs, bowed knees, platyspondyly with tongue-like projections of the central portion of the vertebral bodies, delayed epiphyseal ossification, and metaphyseal irregularities.6,11 Almost all cases have an autosomal dominant inheritance pattern or represent new dominant mutations; cases previously reported as autosomal recessive inheritance represented parental mutations.12 However, some rare cases with autosomal recessive inheritance may exist.

Cone shaped epiphyses of the phalanges are common and have been reported in a large number of bone dysplasias,13 while the conical deformation of the epiphyses involving both the femora and the tibiae are very rare. Both in metaphyseal acrocephalodysplasia with severe brachydactyly and in metaphyseal trichoscyphodysplasia with alopecia, severe metaphyseal
several vertebral bodies in infancy; wedge shaped 11th or 12th thoracic vertebrae; irregularities of the upper and lower vertebral surfaces in adulthood; narrow pelvis; short and broad shafts of the long bones with large metaphyses and small, cone shaped epiphyses fused within their metaphyses; disproportionately long distal ulnae and fibulae; radial hand deviation; cone shaped epiphyses in the proximal phalanges of the hand bilaterally; and brachydactyly in the hands and feet. Surprisingly, our patients showed no severe osteoarthritic changes.

The inheritance pattern of the SEMD reported here appears to be X linked and is not clinically detectable at birth. It should be noted that the two living female obligate carriers show moderate pectus carinatum. From the family history it appears that the same feature was present in the other patients’ mothers.

Unfortunately, there were not enough family members available for study to allow linkage analysis. In our opinion, the clinical, radiological, and genetic findings in these patients do not conform to any of the bone dysplasias so far delineated.

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