X;Y translocation in a girl with short stature and some features of Turner’s syndrome: cytogenetic and molecular studies

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Abstract
A 13 year old girl referred for chromosome analysis because of disproportionate short stature (short neck, curved legs, pectus excavatum) with an initial clinical diagnosis of Turner’s syndrome was found to have the karyotype 46,X,+der(X) in 100% of her blood lymphocytes. By means of conventional differential staining (QFH/AcD, FPG, and RBA banding) supplemented with distamycin A treatment, the karyotype of the proband was interpreted as 46,X,t(X;Y)(p22.3;q11). The rearranged marker X chromosome was found to be active in 91% of lymphocytes studied. PCR analysis with Y chromosome specific oligonucleotides showed the presence of some Y chromosome long arm DNA in both lymphocyte and gonadal tissue biopsy cells. At laparoscopy the patient was found to have small gonads with a rudimentary uterus and fallopian tubes. Histological examination of gonadal tissue showed primary follicles with dystrophic changes of the germ cells and numerous follicular cysts (polycystic ovaries). The proband’s phenotype and its correlation with the genetic imbalance of the rearranged X chromosomes, as well as with non-random t(X;Y) chromosome inactivation, are briefly discussed.

DNA studies
DNA samples extracted from peripheral blood lymphocytes or from ovarian tissue by means of conventional proteinase K methods were used in PCR with specific oligonucleotide sets corresponding to Yp11.2 (SRY) for the short arm, to Yp11.1 (DYZ3) for the centromere, and to Yq12 (DYZ1) corresponding roughly to the middle part of the Yq heterochromatin, and to the extreme tip of Yq12 (DYZ2). Physical mapping of Y chromosome and relevant primer sequences were as reported elsewhere.

Results
Cytogenetic studies
All metaphase spreads of PHA stimulated lymphocytes showed 46 chromosomes with only one normal X chromosome and one metacentric marker (46,X,Y). With QFH banding

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(Hoechst 33258/AcD staining) the marker chromosome appeared to be a metacentric X chromosome with the brightly fluorescing heterochromatin block attached to its short arm (fig 1A). DA treatment of the lymphocyte cultures for the last 24 hours prevented condensation of the translocated fragment (fig 1B), thus favouring its heterochromatin nature.

With FPG and RBA banding there was a faint differentiation along the marker with relevant breakpoints located within Xp22.3 and Yq11 (fig 1C,D). Chromosome replication analysis after 5-BrdU treatment showed early replication of the rearranged X chromosome in 91 (fig C,D) and late replication in nine of the total 100 cells scored.

DNA ANALYSIS
PCR with DNA samples from lymphocytes and ovarian cells gave positive signals for both Yq heterochromatin segment (DYZ1 and DYZ2) probes but were negative for Yp (SRY) and centromeric heterochromatin (DYZ3) probes (fig 2). All Y chromosome probes were negative when tested on control samples from the proband’s mother.

Discussion
The results of the present study show a 46(X;Y)(p22.3;q11) translocation. Differential staining (RBA, FPG, QFH) and identification of DYZ1 and DYZ2 by PCR suggest recombination between Xp22 and Yq11 in our proband. Microscopically detectable X;Y translocations are quite rare. The majority of reported translocations of this kind have their breakpoints in Xp22 and Yq11. Extensive DNA sequence homology of these chromosomal segments predisposing to illegitimate recombinations in meiosis has been suggested and in some cases proved.

Some of the reported X;Y translocations are known to be sporadic events, while others are inherited. We were unable to trace the origin of the translocation in our proband as her parents were not available for karyotyping. However, the absence of DNA sequences corresponding to Y specific DNA by PCR in the maternal DNA samples indicates a paternal origin of the rearranged chromosome, perhaps as a result of an abnormal recombination event in male meiosis. With some minor exceptions most of the females with Xp22;Yq11 translocations are reported as phenotypically normal and even fertile. Although short stature is often a feature of such females our patient had hypogonadism, a short neck, a wide chest, disproportionate short stature (curved joints, short limbs), and reduced progesterone levels. These findings suggested the initial diagnosis of Turner’s syndrome. Thus the clinical manifestations of the X;Y translocation in our proband seemed to be more severe than those in other

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**Figure 1** The proband’s normal X and marker Y chromosomes (arrowed) after QFH/AcD banding (A), distamycin A/Giemsa staining (B), RBA banding (C), and FPG banding (D).

**Figure 2** Electrophoregram of PCR amplified products of (A) locus SRY, (B) DYZ3 (Yp11.1, centromere region), (C) DYZ1 (Yq12 middle), and (D) DYZ2 (Yq12, extreme tips) from the control male XY (3), from the proband’s blood samples (2), and from the proband’s gonadal tissue (1). Molecular weights are shown.
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