No evidence for uniparental disomy as a common cause of Sotos syndrome

Martin Smith, Paul Fullwood, Yu Qi, Sheila Palmer, Meena Upadhyaya, Trevor Cole

Abstract
A number of rare diseases (including Sotos syndrome) of unknown aetiology, which occur mainly sporadically and with features of growth disorder and developmental delay, may be caused by imprinted genes and therefore be associated with UPD. Using 112 dinucleotide repeat DNA polymorphisms, we have examined parental inheritance of all autosome pairs, except chromosome 15, in 29 patients with Sotos syndrome. All informative cases showed biparental inheritance and no cases of UPD were found. We conclude that Sotos syndrome is either not caused by an imprinted gene or that UPD is rare or of a segmental form in its aetiology.
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Keywords: imprinting; growth disorder; developmental delay.

Uniparental disomy (UPD) is the presence of two homologous chromosomes/chromosome segments from a single parent with no corresponding chromosome from the other. It may be classified as heterodisomy if both uniparental homologues are present, or isodisomy if both are copies of a single uniparental homologue. If the contribution of maternal and paternal alleles were equivalent, UPD would be of no phenotypic consequence except when recessive alleles are present on an isodisomic segment. For some chromosomes, however, both isodisomy and heterodisomy cause distinct syndromes, owing to the presence of genes that are differentially expressed according to their parental origin. This is the phenomenon of genetic imprinting and subjects are functionally hemizygous at such loci.

Observation of the offspring of pairs of mice carrying identical balanced Robertsonian translocations, from which a proportion of UPD would be expected, have shown a range of phenotypes including both normal and abnormal development with early fetal death, disordered growth, and behavioural alterations, depending on the chromosome segment involved. A number of human diseases manifesting some of these features are associated with genetic imprinting and UPD: Prader–Willi syndrome with maternal chromosome 15 UPD or paternal deletions of chromosome 15q11-q13; Angelman syndrome with paternal chromosome 15 UPD or maternal 15q11-q13 deletion; Beckwith–Weidemann syndrome with paternal chromosome 11 UPD; and Silver-Russell syndrome with maternal chromosome 7 UPD.

Sotos syndrome is a rare growth disorder first delineated in five children in 1964. Clinical features include large body size, characteristic facial appearance, advanced bone age, and developmental delay. Cole and Hughes conducted a clinical study of 40 “classical” cases with follow up data for two to five years. This allowed the refinement of the diagnostic criteria and these, together with the clinical details of the cases, were reported in 1994.

Despite published reports of almost 300 cases, the aetiology of Sotos syndrome remains unknown. Most cases are sporadic but there are several reports of pedigrees compatible with autosomal dominant inheritance. None of the available pedigrees is large enough individually or collectively to produce a significant lod score with linked DNA markers. Various karyotypic anomalies have been reported, but there is no consistent breakpoint and very few of these cases would satisfy the strict diagnostic criteria delineated in table 1. The exception is the apparently balanced de novo translocation, t(3;6)(p21;p21), described by Schrander-Stumpel et al. Cole et al suggested that p21 could be a candidate locus after the identification of small cell carcinoma of the lung in a 23 year old non-smoker with Sotos syndrome. However, no further karyotypic abnormalities of this region have been reported and molecular studies have not identified evidence of allelic loss or altered fragments (unpublished data).

Beemer et al reported two cases diagnosed as Sotos syndrome who, on subsequent investigation, were shown to have fragile X syndrome. Several papers have since suggested that this may be a common cause of the “Sotos phenotype”. To exclude fragile X syndrome as a cause of our patients’ phenotype, we have investigated them cytogenetically for the presence of fragile sites on the X chromosome. We have also used molecular genetic techniques to exclude the presence of the fragile X-A trinucleotide repeat expansion mutation.

The clinical features of Sotos syndrome (growth disorder with few structural abnormalities, behavioural anomalies, develop-

Table 1 Diagnostic criteria for Sotos syndrome

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<th>Characteristic facial gestalt, plus at least three of the following</th>
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<td>(1) Height &gt;97th centile on 2 consecutive measurements at least 1 year apart</td>
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<td>(2) Head circumference &gt;97th centile</td>
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<td>(3) Bone age &gt;97th centile</td>
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<td>(4) Developmental delay</td>
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mental delay, and mainly sporadic occurrence) show similarities to Prader–Willi, Angelman, Beckwith–Weidemann, and Silver–Russell syndromes. This has led to speculation that Sotos syndrome and other disorders with broadly similar features may be caused by UPD for other chromosomes. We have therefore investigated UPD as a mechanism in the aetiology of Sotos syndrome. In order to find cases of UPD, we have attempted to determine the parental origin of all autosomal pairs (except chromosome 15) in each patient using 112 chromosome specific dinucleotide repeat DNA polymorphisms. Chromosome 15 was excluded because the maternal and paternal UPD phenotypes are known. Chromosomes 7 and 11 were included, as the paternal UPD7 and maternal UPD11 phenotypes have not been described.

Methods

Twenty cases from a previous study plus nine cases assessed by one of us (TC) and satisfying the stringent criteria proposed by Cole and Hughes (table 1) were included in the study. Genomic DNA from the 29 patients and their parents was extracted and purified from peripheral venous blood by the phenol/chloroform method. Genotyping was performed using the polymerase chain reaction (PCR) at Genethon (Paris) and at our own Birmingham and Cardiff laboratories. One hundred and twelve primer pairs which amplified dinucleotide repeat polymorphisms on all human chromosomes (except 15 and X) were selected from published reports. To test for fragile X syndrome, primers amplifying the fragile X-A dinucleotide repeat expansion were used, in addition to routine cytogenetic examination. All primer sequences used, and references to them, are available on request. Parent and paternal DNA was amplified using the Genethon protocol or by a standard PCR protocol modified by the use of \(^\gamma\)A TP as the isotopic label.

Results

Cytogenetic and molecular genetic examination did not show changes typical of fragile X-A syndrome in any of the patients.

All autosomal pairs except chromosome 15 were studied in 29 patients with Sotos syndrome. Biparental inheritance of these was confirmed by the observation of at least one fully informative marker on the relevant autosome, or by the observation of maternal and paternal alleles at different loci on the same autosome with semi-informative markers. Biparental inheritance of every autosomal pair was observed in 21 patients. Reference to tables of exact confidence gives the incidence of uniparental disomy in this population as 0.0–16.1%. In addition, biparental inheritance of all informative markers was observed in the remaining one or two chromosomes were uninformative (table 2).

Discussion

We have found no evidence for the presence of UPD in 29 patients with Sotos syndrome. From our data, if UPD is a cause of Sotos syndrome, the incidence is less than 16.1% (p<0.05). Considering that the frequency of UPD in Angelman syndrome is 3–5%, we cannot exclude UPD as a cause of Sotos syndrome.

Partial UPD for a chromosome arm or segment owing to somatic recombination, resulting in a mosaic pattern of UPD, has not been excluded. This may be difficult to show if the proportion of cells involved were low. Postzygotic exchange of chromosomal material, because of mitotic recombination, is documented in Beckwith–Weidemann syndrome in which only the 11p15.5 region appeared to be paternally disomic. To exclude this, informative markers mapping to the distal portions of each chromosome (and indeed the
whole chromosome length, if double re-
combinations are to be accounted for) would
need to be typed. However, the low (<1%)
frequency of asymmetry in Sotos syndrome (T
Cole, unpublished data) is at variance with
Beckwith-Weidemann syndrome (14% asym-
metry) and this phenomenon may represent a
manifestation of mosaic UPD. Therefore, mitotic
recombination in Sotos syndrome may be less likely.

If paternal UPD were a cause of Sotos syn-
drome, it may only be observed at a low inci-
dence. Paternal UPD accounts for only 3–5% of
Angelman syndrome cases, whereas about 28% of Prader–Willi syndrome cases are caused by
maternal UPD.21 The difference in the rate
of UPD for the same chromosome shown by
these two disorders may reflect the different
rates of aneuploidy observed in female and
male meiosis. Aneuploidy may be present in
18–19% of human ova, compared to 3–4% of
human sperm.22 If UPD is caused by corrective
chromosome loss in a trisomic conception,23
then one may expect to find more cases in-
volving maternally rather than paternally
derived chromosomes.

Cytogenetic and molecular investigations have
excluded fragile X syndrome in all our
Sotos syndrome cases. We would suggest the
two conditions are separate entities and that
strict application of the diagnostic criteria
will make errors unlikely.

The current study has not excluded UPD as
a causative mechanism in Sotos syndrome, but
indicates that it is unlikely to account for any
more than 16% of cases, if present at all. Fur-
ther clues to the possible aetiology of this
condition are now required if molecular in-
vestigation is to be fruitful.

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