Hydrometrocolpos and polydactyly: a common neonatal presentation of Bardet-Biedl and McKusick-Kaufman syndromes

Albert David, Pierre Bitoun, Didier Lacombe, Jean-Claude Lambert, Annie Nivelon, Jacqueline Vigneron, Alain Verloes

Abstract

McKusick-Kaufman syndrome (MKKS) is a rare, recessively inherited syndrome reported mainly in young children and is characterised by vaginal atresia with hydrometrocolpos, postaxial polydactyly, and congenital heart defect. Bardet-Biedl syndrome (BBS) is the generic name for a genetically heterogeneous group of autosomal recessive disorders characterised by retinal dystrophy or retinitis pigmentosa (appearing usually between 10 and 20 years of age), postaxial polydactyly, obesity, nephropathy, and mental disturbances, or, occasionally, mental retardation. Typically, MKKS is diagnosed (and reported) in very young children, whereas the diagnosis of BBS often is delayed to the teenage years.

We report here a series of nine patients diagnosed in infancy with MKKS because of the presence of vaginal atresia and postaxial polydactyly, who later developed obesity and retinal dystrophy, thus turning out to be instances of BBS.

The overlap of BBS and MKKS is a real diagnostic pitfall and its importance has to be stressed, for genetic counselling, for clinical management and follow up, and for molecular approaches. The diagnosis of MKKS should be considered with caution in all published cases described exclusively in the neonatal period and in those with mental retardation. We strongly recommend all children seen in infancy with a diagnosis of MKKS to be re-evaluated for RP and other signs of BBS.

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Keywords: Bardet-Biedl syndrome; McKusick-Kaufman syndrome; hydrometrocolpos

MKKS was first delineated by McKusick et al in 1964 in two Amish sibships and rapidly confirmed. Over 60 cases have now been reported and autosomal recessive inheritance is clearly established. Cardial features of MKKS are hydrometrocolpos and polydactyly and it is often reported as the “hydrometrocolpos-polydactyly syndrome”. Hydrometrocolpos is present in 80–95% of females and results from either vaginal atresia or imperforate hymen, which leads to the development of an abdonimopelvic mass with regional compression and secondary hydrome-
associated cases polydactyly is mostly confined to the hands. Chromosome 16 associated cases are least inclined to obesity, whereas chromosome 15 associated cases have early onset, morbid obesity.23-25

We report here a collaborative, retrospective study of nine unrelated BBS girls misdiagnosed as MKKS in the neonatal period, in the presence of genital and digital anomalies.

Case reports

Case 1
This girl was born in 1977 to non-consanguineous French parents. Birth weight was 3720 g, length was 50.5 cm, and OFC 34 cm. She was noted to have bilateral postaxial polydactyly of both feet and syndactyly IV-V of the left foot. At the age of 4 months, patent urinary tract infection and oedema of the legs led to the discovery of a hydrometrocolpos with vaginal atresia and severe ureterohydronephrosis. A diagnosis of MKKS was made. At the age of 12 years, obesity, developing progressively since the age of 3, and severe myopia were recorded. At the age of 15 years, she was re-evaluated in a genetic centre. She was 154 cm tall and weighed 83.5 kg. She had myopia (−6 dioptres) and RP with low visual acuity (<1/10 on the other side, with a 5° tubular visual field. Further investigations showed bilateral kidney dysplasia, with enlarged calyces. There was no mental retardation. Family history was unremarkable. BBS was finally diagnosed.

Case 2
This girl was born in 1977 to non-consanguineous French parents. At term, birth weight was 3720 g, length was 50.5 cm, and OFC 34 cm. She was noted to have bilateral postaxial polydactyly of both feet and syndactyly IV-V of the left foot. At the age of 4 months, patent urinary tract infection and oedema of the legs led to the discovery of a hydrometrocolpos with vaginal atresia and severe ureterohydronephrosis. A diagnosis of MKKS was made. At the age of 12 years, obesity, developing progressively since the age of 3, and severe myopia were recorded. At the age of 15 years, she was re-evaluated in a genetic centre. She was 154 cm tall and weighed 83.5 kg. She had myopia (−6 dioptres) and RP with low visual acuity (<1/10 on the other side, with a 5° tubular visual field. Further investigations showed bilateral kidney dysplasia, with enlarged calyces. There was no mental retardation. Family history was unremarkable. BBS was finally diagnosed.

Case 3
An abdominal mass was found in utero in this girl born in 1982 to non-consanguineous French parents. At 38 weeks of gestation, birth weight was 2400 g, length was 44.5 cm, and OFC 32 cm. MKKS was diagnosed in the neonatal period, based on hydrometrocolpos, bilateral ureterohydronephrosis, intercalate polydactyly of the upper limbs, and postaxial polydactyly of the lower limbs. Relative micromelia, hip dislocation, and IUGR were noted. BBS was suggested in infancy because of early obesity, and the ERG, at the age of 1 year, confirmed retinal dysfunction. Mild conductive deafness and scoliosis were noted at ages 4 and 12 years respectively. She menstruated spontaneously at 12 years. At the age of 13½ years, she was 140 cm tall and weighed 60 kg. She had RP with visual acuity <3/10. The family history was unremarkable.

Case 4
This girl was born in 1984 after an uneventful pregnancy to non-consanguineous French parents. She was operated on for hymenal atresia on the second day of life. Postaxial polydactyly was present in the left foot, leading to a diagnosis of MKKS. Impaired renal function was noted at the end of the first week. At the age of 4 months, intestinal occlusion occurred and Hirschsprung disease was found, which required transient ileostomy. Hemeralopia, loss of visual acuity, and progressive reduction of the visual field were noted at the age of 2 years. Visual evoked potentials showed increased latencies and the ERG was flat. A diagnosis of BBS was proposed at that time. Renal insufficiency rapidly worsened and made a renal transplant necessary at the age of 9 years. A rapidly evolving scoliosis was noted in infancy (45° at age 10, 60° at age 12), for which surgical treatment is foreseen. At the age of 12, she was 146 cm tall and weighed 78 kg. She was mildly dysmorphic with a long face, micrognathia, high arched palate, small teeth, short neck, and brachydactyly. She had normal puberty with irregular menses. Basal gonadotrophins and steroid hormones were normal. She was of normal intelligence. The family history was unremarkable.

Case 5
This girl was born in 1985 to first cousin Moroccan parents. Birth weight was 3100 g, length was 44 cm, and OFC 34 cm. Prenatal ultrasonographic investigations showed an abdominal mass, enlarged kidneys, and postaxial polydactyly of all four limbs. These anomalies led the gynaecologist to suggest a diagnosis of MKKS. At birth, vaginal atresia complicated by upper vaginorectal fistula and ureterohydronephrosis seemingly confirmed the diagnosis. A correct diagnosis of BBS was made by the geneticist in the neonatal period, after evaluation of the patient’s brother. In infancy, progressive renal insufficiency appeared, with abnormal corticomedullary differentiation on US scan, but no malformations. Obesity was obvious by the age of 1, and hemeralopia was noted before the age of 3. At the age of 9 years, she had developed atypical RP with pale papillae and gracile retinal vessels. The ERG was flat. Visual acuity was 1/10. At the age of 12, she was 132 cm tall (<3rd centile) and weighed 59 kg. OFC was 52.5 cm. IQ was 56 cm and she required special schooling.

Examination of the older brother of case 5 was prompted by her birth. This boy, aged 5 years at that time, had postaxial polydactyly of all four limbs, obesity (onset at age 3), microepisis, and poor vision. Investigations showed atypical RP with abnormal ERG, allowing a firm diagnosis of BBS, and switching the diagnosis of his newborn sister to BBS. At the age of 17, he was 157 cm tall and weighed
Hydrometrocolpos and polydactyly

With polydactyly

- McKusick-Kaufman syndrome
- Bardet-Biedl syndrome
- Pallister-Hall syndrome
- Ellis-Van Creveld syndrome
- Orofaciodigital syndrome, type IV

Without polydactyly

- Langer-Giedion syndrome

CASE 7

This girl was born in 1989 to non-consanguineous French parents. Postaxial polydactyly of the feet, hydrometrocolpos, bilateral ureterohydronephrosis, urogenital anomalies including ectopia of the urinary meatus, and hypoplastic uterus was noted. Birth weight was 3760 g, with a length of 48 cm. OFC was 54 cm. 35.5 kg. ERG showed photopic and scotopic sensitivity was <1/10 bilaterally. The appearance of his eyes was normal (51 cm). The fundi, at age 7, showed retinal dystrophy with atrophic pigmentary epithelium but without pigment clumps, pale papillae, and gracile retinal vessels, compatible with atypical retinitis pigmentosa. She had mild mental retardation. BBS was highly likely. The family history was unremarkable.

Discussion

Hydrometrocolpos is a rare malformation, which may occur in association with other malformations (table 1). Eight of the nine patients reported here showed a convincing BBS phenotype associated with vaginal atresia, and patient 6 was felt to belong to this spectrum because of RP, renal impairment, and vaginal atresia. Although rare, genital anomalies have been reported in BBS for a long time, but their importance in early infancy has never been stressed. The most common problems are vaginal atresia or transverse septum noted in 12 patients reported before our own series (table 2). Rarely, anomalies involving the Müllerian derivatives have been described: Müllerian duct hypoplasia, and hypoplastic uterus with unilateral ovary. Lower urinary tract anomalies include ectopia of the urinary meatus, urethral atresia, and urogenital sinus.

RP is a hallmark of BBS. In reports of MKKS, RP has been reported twice. In the report of Goecke et al., a sibship with non-consanguineous parents was described, consisting of one girl with postaxial polydactyly and the age of 8 years. She required special schooling. At that time, a diagnosis of BBS seemed appropriate. The family history was unremarkable.
Table 2  Reported cases of vaginal atresia in BBS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Case Details</th>
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<tbody>
<tr>
<td>26</td>
<td>Vaginal septum and uterus duplex in a 30 year old woman</td>
</tr>
<tr>
<td>36, case 3</td>
<td>Vaginal atresia detected at age 13</td>
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<tr>
<td>37</td>
<td>Vaginal atresia + haematocolpos</td>
</tr>
<tr>
<td>38</td>
<td>Vaginal atresia, hydrometrocolpos, and urogenital sinus diagnosed at age 13</td>
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<tr>
<td>39</td>
<td>Absence of vagina</td>
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<tr>
<td>37</td>
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</tr>
<tr>
<td>26</td>
<td>Vaginal septum and uterus duplex in a 30 year old woman</td>
</tr>
<tr>
<td>40</td>
<td>Neonatal hydrometrocolpos + meatal ectopia</td>
</tr>
<tr>
<td>39</td>
<td>Absence of vagina</td>
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Hydrometrocolpos who had a brother with atypical RP. The report of Chitayat et al (family B) describes a 12 year old girl with postaxial polydactyly, hydrometrocolpos, hydrenephrosis, retinal dystrophy, short stature, and normal menarche. Obesity was not mentioned. Recently, Kumar et al46 described a highly inbred Pakistani family in which at least four sibs and two related persons had MKKS. This family showed unusually severe polysyndactyly for MKKS. Males presented with small penis/hypospadias. One of the sibs had Hirschsprung disease (total colonic aganglionosis), bilateral renal cystic dysplasia, and mental delay. From the table in that report, retinal problems are present, although this does not appear in the text of the article. In the light of the present report, we suggest that these three reports deal with BBS instead of the proposed diagnosis, and we have some doubt about the patient reported by Davenport et al,52 who was described as MKKS with Hirschsprung disease.

Heart defect has often been considered as a useful clue to the diagnosis of MKKS in the polydactylyous male, but is of uncertain use in the differential diagnosis of BBS and MKKS. CHD is rarely mentioned in older publications on BBS, 9/330 in the reviews of McLoughlin et al54 and uncommon (9%) in the review by Chitayat et al,55 but it has been noted with high frequency (11/22) in a series of Bedouin BBS patients,56 where the most frequent diagnoses were bicuspid aortic valve, ASD, pulmonary stenosis, and cardiomyopathy. Despite the fact that genital anomalies had already been reported in BBS in 1965, the overlap of BBS with MKKS has not received attention until very recently, and the possible confusion between both disorders is still poorly appreciated. The only clear mention of this overlap was in a letter by Schaap et al57 reporting the erroneous diagnosis of MKKS in their previous case report.58 A reason for this oversight could be that BBS and MKKS have been published in different areas of paediatric and genetic publications, as they are seen (and diagnosed) at different ages by different doctors (neonatologists and paediatric surgeons in infancy, neurologists, endocrinologists, and ophthalmologists later).

Lurie and Wulfsberg in their recent review of MKKS did not discuss BBS at all. They noted that “the frequency of some findings is underestimated [in MKKS]. It is evident, for instance, that not all patients had ophthalmologic examination, and 2 cases of RP may be only ‘the tip of the iceberg’”. Considering our own experience with MKKS, we cannot accept these statements, but we rather think that MKKS is an underdiagnosed condition, perhaps because of the misleading effect of descriptive names in syndromology: our message is that not all children with hydrometrocolpos and polydactyly have the hydrometrocolpos-polydactyly syndrome.

The consequences of this are straightforward. As long as genetic tests for MKKS or BBS are unavailable routinely, genetic counseling for parents of newborns with hydrometrocolpos and polydactyly should be much more cautious, even when congenital heart defect is present, considering the poor visual prognosis of BBS and the risk of mental impairment. A firm diagnosis of MKKS should be deferred to 5 to 10 years and the possibility of delayed complications should be discussed accordingly. Similarly, this clinical overlap in infancy makes it necessary to establish systematic ophthalmological and neurodevelopmental follow up of all newborns presenting as MKKS. It should be stressed that a part of the overestimation of the mental handicap in BBS probably results from their “slow” behaviour and delayed diagnosis of their poor vision. Renal ultrasonography combined with urography should be performed in all cases of MKKS and detection of impaired concentration ability with the DDAVP test should probably be performed in every case.

For the same reasons, retrospective studies of MKKS should be considered with caution if cases are presented in the neonatal period or are mentally retarded, and all MKKS cases should be re-evaluated for RP and other signs of BBS, as some of these children could be affected by BBS, as illustrated by our experience.

The significant overlap of BBS and MKKS could be of importance for teams dealing with MKKS gene mapping in non-Amish populations. The similarities of MKKS and BBS indicate that the MKKS gene products are likely to interact with the proteins involved in the pathogenesis of BBS.

Hydrometrocolpos and polydactyly


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