Neurofibromatous neuropathy in neurofibromatosis 1 (NF1)

R E Ferner, R A C Hughes, S M Hall, M Upadhyaya, M R Johnson

Background: Neurofibromatosis 1 (NF1) is a common, autosomal dominant, neurocutaneous disease that is clinically and genetically distinct from the rare condition neurofibromatosis 2 (NF2). Neurofibromatous neuropathy has been regarded as a common feature of NF2, but is an unusual and unexplained complication of NF1. The clinical and histological features of the NF1 neuropathy are distinct from those encountered in NF2. We describe eight patients with a symmetrical polyneuropathy, which has been called neurofibromatous neuropathy.

Methods: Clinical assessments, laboratory investigations, neuroimaging, and neurophysiology were undertaken in eight individuals with neurofibromatous neuropathy. None were referred because of neuropathic symptoms. Two subjects underwent sural nerve biopsy and three agreed to mutational analysis.

Results: The patients had an indolent symmetrical predominantly sensory axonal neuropathy and unusually early development of large numbers of neurofibromas. The biopsied nerves showed diffuse neurofibromatous change and disruption of the perineurium. Two patients developed a high grade malignant peripheral nerve sheath tumour. Disease causing mutations were detected in two individuals and molecular studies did not reveal any whole gene deletions.

Conclusions: Neurofibromatous neuropathy occurred in 1.3% of 600 patients with NF1. Its cause may be a diffuse neuropathic process arising from inappropriate signalling between Schwann cells, fibroblasts, and perineurial cells.

Neurofibromatosis 1 (NF1) is a common, autosomal dominant, neurocutaneous disease. There is wide variety of disease expression in patients with NF1 and its numerous complications involve many of the body systems. The neurological manifestations may arise from tumours and malformations of the nervous system, deformities of the skull and skeleton, or pressure by neurofibromas on the peripheral nerves, spinal nerve roots, and spinal cord. Neurofibromatous neuropathy has been reported as a rare manifestation and is characterised by a distal sensorimotor neuropathy associated with diffuse neurofibromatous change in thickened peripheral nerves. Until the last decade, the genetic and clinical distinction between NF1 and neurofibromatosis NF2 (NF2) was not always clearly established. In retrospect, the majority of cases of neuropathy and neurofibromatosis reported in the literature have been associated with NF2. NF2 neurofibromatous neuropathy is entirely different clinically and histologically from NF1 associated neurofibromatous neuropathy.

In this paper we describe eight patients with NF1 and neurofibromatous neuropathy, which is the largest group of cases so far reported. The patients all attend our multidisciplinary neurocutaneous clinic comprising 600 NF1 patients, suggesting that this complication of NF1 may not be as rare as previously supposed, although it still only affects 1.3% of patients. We describe the clinical and neurophysiological features in all our patients, the nerve biopsy appearances in two, and the causative NF1 mutation in a further two of the three patients who agreed to mutation testing.

METHODS

The eight patients consist of all those patients with NF1 who also had a symmetrical polyneuropathy and who had been referred to the Guy's Hospital multidisciplinary Neurocutaneous Clinic for general assessment of neurofibromatosis 1, between 1985 and 2003. During this period 600 patients with NF1 were assessed clinically. Ethical approval was obtained for the study. General medical and neurological assessments were performed on all patients and nerve conduction studies were undertaken on all patients with symptoms or signs of a peripheral neuropathy. Magnetic resonance imaging of the spine was performed on seven patients with a 1.5 T superconducting system (Philips Gyroscan S15, Philips Medical Systems). Images were taken in the axial and coronal planes with a slice thickness of 5 mm and an interscan distance of 0.5 mm. Coronal STIR images (TR/TE 2000/25, TI 150) were performed and axial T1 images (TR/TE 700/20) were carried out before and following the administration of gadolinium meglumine triamine pentacetic acid contrast medium at 0.2 ml/kg.

Sural nerve biopsy

Two patients underwent sural nerve biopsy for the purpose of diagnosis. Portions of the nerve were processed into paraffin and also into epon for 1 μm sections stained with thionin and acridine orange and ultrathin sections for electron microscopy as previously described.

Mutational analysis

Three patients agreed to donate blood for mutation analysis. Mutation analysis was performed using a combination of chemical cleavage of mismatch, single strand conformational analysis, and direct sequencing. DNA samples from 70 non-NF1 patients were used as controls. Haploinsufficiency was excluded at the genomic and mRNA level prior to mutation analysis with chemical cleavage of mismatch, by demonstration of heterozygosity at exon 5 (Rsu1 polymorphism) in genomic DNA and cDNA, respectively.

Laboratory investigations

The following investigations were carried out: haemoglobin, erythrocyte sedimentation rate, serum folate, vitamin B12, urea, creatinine and electrolytes, liver function, blood

Abbreviations: GRD, guanosine triphosphatase related domain; MPNST, malignant peripheral nerve sheath tumour; NF1, neurofibromatosis 1; NF2, neurofibromatosis 1
glucose, autoantibodies, serum immunoglobulins, protein electrophoresis, thyroid function, and treponema pallidum microhaemagglutination assay.

RESULTS
The clinical, radiological, and neurophysiological features of all the cases are reported in tables 1–3 and illustrated in figs 1 and 2. The laboratory investigations mentioned for known causes of neuropathy were normal in all patients. The neurophysiological features were those of a predominantly sensory, length dependent axonal neuropathy with abnormally small sural nerve sensory action potentials, relatively normal median nerve sensory action potentials, slightly delayed distal motor conduction and F wave latencies, and slightly slowed motor nerve conduction velocities (table 3).

Nerve biopsy
Patient 1
A sural nerve biopsy showed non-uniform pathological changes. Some fascicles displayed a marked loss of axons of all calibres, whereas in others the axonal drop out was mild and confined to a sub-perineurial zone. There was little evidence of ongoing active degeneration in any fascicle. Regions of focal perineurial disruption, associated with a hypercellular epineurium and disorganised sub-perineurium, were prominent features of fascicles that displayed the most marked axonal loss. At these sites, the sub-perineurial endoneurium was filled with bundles of collagen and numerous process bearing cells, none of which were associated with axons. On morphological criteria, these cells were identified as either chronically denervated Schwann cells11 or perineurial cells, whose long cytoplasmic processes were associated with continuous or patchy basal laminae, and were studded with caveolae, or fibroblasts (fig 3). Schwann cell-ensheathed axons, both myelinated and non-myelinated, were present between the discontinuous perineurial layers, sometimes associated with reduplicated fragments of basal lamina and fibrous long spacing collagen. Perineurial cells and fibroblasts (the latter occasionally surrounding collagen pockets) filled the inter-fascicular epineurium (fig 4). Mast cells were present, often close to a blood vessel, within the epineurium and endoneurium.

Patient 3
A right partial thickness sural nerve biopsy of five fascicles showed a significant reduction of myelinated nerve fibres and an increased number of fibroblast-like cells within the fascicles. Some of the axons were thinly myelinated and associated with unmyelinated axons in structures resembling onion bulbs, and many persisting axons were small and unmyelinated.

Mutation analysis
Molecular studies did not detect a whole-gene deletion in any of the patients tested.
Patient 1
Mutation analysis detected a novel mutation in exon 23.2 of the NF1 gene. This alteration involved the deletion of cytosine at position 4071, which resulted in a premature stop codon. The deletion is predicted to generate a truncated neurofibromin of 1383 amino acids.

Patient 3
Mutation analysis revealed a substitution of leucine to proline at codon 1243 (CTG to CCG). This change results in the introduction of a non-aliphatic amino acid group into the NF1 guanosine triphosphatase related domain (GRD) of the peptide. Such a change is likely to disrupt the structure of the GRD and to be a disease causing mutation.

Patient 4
Mutation analysis failed to detect the mutation in this patient.

DISCUSSION
Of our 600 NF1 patients, eight had neurofibromatous neuropathy. None was initially referred because of symptoms relating to their neuropathy. Consequently, this condition might be under-diagnosed because sensory symptoms might be incorrectly attributed to cutaneous or subcutaneous neurofibromas. The presence of peripheral neuropathy may be revealed by a detailed examination of the nervous system.

There was a variable age of onset of neuropathic symptoms, but we noted a distinctive clinical phenotype, characterised by unusually early development of dermal and subcutaneous neurofibromas, occurring in large numbers and affecting extensive areas of the body. In six of the eight cases we detected neurofibromas arising proximally from multiple nerve roots in the spine. In our experience spinal nerve root neurofibromas are common in NF1 but do not usually cause neuropathic symptoms or signs. In our patients the neuropathic symptoms were predominantly mild and sensory. Only one patient required treatment with a

Table 1
Clinical and neuroimaging features in eight individuals with neurofibromatosis 1 and neurofibromatous neuropathy

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age at last examination (years)</th>
<th>Age of neuropathy onset (years)</th>
<th>Additional clinical problems</th>
<th>Presence of multiple spinal nerve root neurofibromas on MRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>53</td>
<td>42</td>
<td>High grade MPNST left iliac fossa removed in 1986. No recurrence. Benign plexiform neurofibroma left abdominal wall</td>
<td>Yes (fig 1)</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>17</td>
<td>Congenital adrenal 21-hydroxylase deficiency. Cervical intradural neurofibromas removed at age 22. Massive inoperable pelvic neurofibromas</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>Infancy</td>
<td>Complex partial seizures since childhood</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>31</td>
<td>27</td>
<td>Mild cognitive impairment. Brachial plexus neurofibromas</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>48</td>
<td>47</td>
<td>Cognitive impairment</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>19</td>
<td>3</td>
<td>Left sciatic plexiform neurofibroma</td>
<td>No, only lumbar spine scanned</td>
</tr>
<tr>
<td>7</td>
<td>62</td>
<td>55</td>
<td>Bony dysplasia of spine and clavicle. Plexiform neurofibroma involving neck, anterior chest wall, left arm. Died from chronic obstructive airways disease at age 62</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>45</td>
<td>25</td>
<td>Benign neurofibromas removed from right L4 and L5 nerve roots at age 33. High grade MPNST left sciatic nerve removed at age 44. Died from lung metastases at age 45</td>
<td>Yes on myelogram; MRI not performed</td>
</tr>
</tbody>
</table>

MPNST, malignant peripheral nerve sheath tumour.

Table 2
Clinical manifestations of neurofibromatous neuropathy in eight individuals with neurofibromatosis 1

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>First neuropathic symptom</th>
<th>Weakness</th>
<th>Sensory impairment</th>
<th>Reflexes</th>
<th>Diffuse nerve thickening</th>
<th>Disability Rankin Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Numbness and tingling in hands and aching in feet</td>
<td>None</td>
<td>Impairment of light touch and pain up to elbows and to right knee and left mid-calf. Impaired vibration at right hallux and left ankle</td>
<td>Reduced</td>
<td>Present</td>
<td>1**</td>
</tr>
<tr>
<td>2</td>
<td>Pain and weakness in feet</td>
<td>Distally predominant weakness and wasting of upper and lower limbs</td>
<td>Severe impairment of all modalities up to elbows and inguinal ligament</td>
<td>Absent</td>
<td>Present</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Pes cavus</td>
<td>Weakness of toe flexion</td>
<td>Impaired vibration sensation on toes</td>
<td>Absent ankle reflexes</td>
<td>Normal</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>No symptoms</td>
<td>None</td>
<td>Mild impairment of pain on fingers and feet and light touch on toes</td>
<td>Absent</td>
<td>Not recorded</td>
<td>1</td>
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<tr>
<td>5</td>
<td>Numbness and tingling in hands and feet</td>
<td>Weakness of interossei and ankle dorsiflexion</td>
<td>Light touch, vibration, and pinprick sensation reduced to the ankles and vibration sensation on the fingers</td>
<td>Reduced ankle reflexes</td>
<td>Present (fig 2)</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Pes cavus</td>
<td>Mild weakness of dorsal interossei, left ankle dorsiflexion, left toe dorsiflexion, plantar flexion*</td>
<td>Impaired pinprick sensation in glove and stocking distribution up to the mid-foot and mid-shins</td>
<td>Present</td>
<td>Absent</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Tingling and numbness in feet</td>
<td>None</td>
<td>Impaired light touch and pain to mid-palms, the left thigh, and the right foot. Absent vibration in lower limbs</td>
<td>Present</td>
<td>Absent</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Pes cavus, weakness in feet</td>
<td>Wasted anterior compartments bilaterally. Bilateral weakness of hip flexion, knee extension, ankle dorsiflexion, plantar flexion, inversion, eversion</td>
<td>Loss of pain sensation below both knees. Reduced vibration sense at the ankles. Reduced joint position sense at the hallux bilaterally</td>
<td>Absent ankle jerks</td>
<td>Not recorded</td>
<td>4</td>
</tr>
</tbody>
</table>

*Ankle and toe weakness due to left sciatic plexiform neurofibroma.
combination of gabapentin and amitriptyline for neuropathic pain. The patients were followed up for between 1 and 10 years and there was no evidence of significant clinical or neurophysiological deterioration of the neurofibromatous neuropathy. This is in contradistinction to neuropathy in NF2 where there is variable disease progression. Patients 1 and 8 developed a high grade MPNST, which occurs with increased frequency in patients with NF1 and plexiform neurofibromas and often carries a poor prognosis. It remains to be determined whether patients with early development of large numbers of neurofibromas and neurofibromatous neuropathy are at higher risk of malignant change.

We have identified disease causing mutations in patients 1 and 3. Molecular studies did not reveal any whole-gene deletions. A disease causing mutation was not detected in patient 4. All of our eight patients had NF1 as a new mutation and we are unable to assess the effect of familial aggregation of neurofibromatous neuropathy in NF1. In our patients neurofibromatous neuropathy was not associated with any particular genotype, which may be explained by influence from unidentified modifying genes. We (MU) have detected a mutation identical to that in patient 1 in another individual with NF1 who, however, does not have clinical manifestations of a peripheral neuropathy and has normal nerve conduction studies. Undoubtedly, a larger clinical series are not more frequent than we have described, but we cannot exclude the possibility that subclinical peripheral neuropathy is more common. Our findings indicate that patients with peripheral neuropathy should be examined for evidence of peripheral neuropathy. If found, neurophysiological studies should be performed and other possible, often treatable, causes of peripheral neuropathy should be sought. In their absence a diagnosis of neurofibromatous neuropathy can then be made, often without resort to a peripheral nerve biopsy. Further research is needed to confirm that neurofibromatous neuropathy is associated with plexiform neurofibromas and an increased risk of developing MPNSTs. Further research is also needed to elucidate the contribution of the NF1 mutation and individual cell types to the diffuse neurofibromatous change in peripheral nerves which characterises neurofibromatous neuropathy.

**ACKNOWLEDGEMENTS**

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**Table 3 Electrophysiological features in eight individuals with neurofibromatosis 1 and neurofibromatous neuropathy**

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<td></td>
<td>SAP, µV</td>
<td>SCV, m/s</td>
<td>SAP, m/s</td>
<td>SCV, m/s</td>
<td>DMAP, mV</td>
<td>DML, ms</td>
<td>F wave latency, ms</td>
<td>Tibial DMAP, mV</td>
<td>Tibial DML, m/s</td>
<td>Tibial MCV, M/s</td>
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<td>7.6</td>
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<td>4</td>
<td>4.7</td>
<td>ND</td>
<td>36</td>
<td>ND</td>
</tr>
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</table>

DMAP, distally evoked compound muscle action potential; DML, distal motor latency; MCV, maximal motor conduction velocity; NA, not available; ND, not done; SAP, sensory action potential; SCV, sensory conduction velocity.

Abnormal figures are given in bold.
REFERENCES


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