Diagnostic and Genetical Aspects of Tuberous Sclerosis

N. C. NEVIN* and W. G. PEARCE

From the Medical Research Council, Population Genetics Research Unit, Old Road, Headington, Oxford

There have been many reviews of tuberous sclerosis (Critchley and Earl, 1932; Ross and Dickerson, 1943; Dawson, 1954; Reed, Nickel, and Campion, 1963; Paulson and Lyle, 1966; Lagos and Gomez, 1967). The classical features, epilepsy, mental retardation, and adenoma sebaceum, are found in most patients with tuberous sclerosis, while retinal tumours (phakomas), visceral tumours, skeletal lesions, and other cutaneous manifestations are noted less frequently. The complete syndrome is easily recognized in the older child and the adult, but in infancy and childhood the diagnosis may be difficult before the appearance of adenoma sebaceum. Convulsions, the most frequent presenting symptom, often begin in infancy and childhood, and may take the form of infantile spasms. Apart from adenoma sebaceum, a variety of skin manifestations occurs, shagreen plaques, subcutaneous fibromata, café-au-lait spots, periungual and subungual fibromata, cervical polypi or tags, and areas of depigmentation. Recently, Chao (1959) has called attention to depigmented areas of skin as the earliest skin lesion in tuberous sclerosis. In the course of treating 39 children with infantile spasms over a two-year period, Gold and Freeman (1965) found that of the children with areas of depigmented skin, 6 subsequently developed other manifestations of tuberous sclerosis. Crichton (1966) examined 174 children with infantile spasms, and of 11 with tuberous sclerosis, all had areas of depigmentation.

Early diagnosis of tuberous sclerosis would enable the paediatrician to provide a more realistic prognosis for the patient and would also greatly assist genetic counselling. In the course of a survey of tuberous sclerosis in the area of the Oxford Regional Hospital Board, we were able to examine 18 patients with tuberous sclerosis.

This paper describes the clinical features and genetic data of these patients, with particular emphasis on the diagnostic criteria in infancy. A further 14 patients who were reported at necropsy to have died from tuberous sclerosis of the brain are also included in the study.

Criteria for Clinical Diagnosis

Typical cases exhibiting the complete syndrome present no difficulty in diagnosis, but where one or more of the major features are absent (formes frustes) or have not yet appeared, recognition is less easy.

Cases were therefore only included as suffering from tuberous sclerosis if they showed either: (a) adenoma sebaceum, or (b) retinal phakoma (astrocytic hamartoma).

Present Investigation

Persons with tuberous sclerosis living in the area of the Oxford Regional Hospital Board were ascertained from superintendents of mental institutions, consultant paediatricians, dermatologists, neurologists, neurosurgeons, pathologists, ophthalmologists, and from hospital records. Data for clinical and genetical analysis were obtained from the patients and relatives of 16 families. The relatives of only one index patient refused to take part in the investigation.

The ocular fundi were examined with full pupillary dilatation (1% homatropine or 1% cyclopentolate hydrochloride). In children and uncooperative mentally retarded adults, the examination was made under sedation, using for children, trimepazine syrup 4–6 mg. per kg. body weight, and for adults tabs. quinalbarbitone or pentobarbitone sodium gr. 3–6. Where possible, a fundus photograph was taken using a Kowa fundus camera with Kodachrome-X film.

Results

Clinical Features. The clinical findings in the 18 patients with tuberous sclerosis are shown in Table 1.

Skin and Mucosal Lesions. Adenoma sebaceum was present in the naso-labial folds of 15 (83%)
patients; 13 patients older than 12 years had multiple lesions, while the 2 youngest patients aged 4 and 5 had at least one identifiable adenoma sebaceum. The 3 patients lacking adenoma sebaceum were aged 1 year, 2 years, and 3 years.

Shagreen patches were also found in 15 (83%) patients. These lesions were located in the lumbar region. All affected individuals over 12 years of age, and 2 children aged 3 years and 5 years, had shagreen lesions, while the 3 without shagreen patches were aged 1 year, 2 years, and 4 years.

Areas of skin depigmentation were present in 11 (61%) patients, including the 5 children in the series. Unlike the shagreen patches, no predilection for a particular region was observed. In several patients, these white areas had been noted at birth, but in others recognition was delayed until they were emphasized by their inability to tan.

Periangular and subungual fibromata were observed in 7 (39%) patients, cervical polypi or tags in 7 (39%), café-au-lait spots in 5 (27%), gingival tumours in 4 (22%), subcutaneous fibromata in 3 (16%), and a scalp tumour in one patient.

**Convulsions and Mental Retardation.** Fifteen (83%) patients presented with convulsions. Ten with grand mal, petit mal, or both, were over the age of 12, whereas the convulsions in the remainder, who were aged 1 to 5 years, took the form of infantile spasms. In only 3 patients was there no history of convulsions.

Mental retardation was present in 11 (61%) patients, and all had associated convulsions. Among the 7 patients with normal intelligence, 6 were in regular employment and one was resident in an epileptic colony.

**Ocular Lesions.** Retinal tumours (phakomas) were found in 13 (76%) of 17 patients. The remaining patient had had a bilateral enucleation in infancy for suspected retinoblastoma.

A total of 30 phakomas was observed in these 13 patients. Their frequency in one or both eyes is included in Table I. The majority of phakomas (20) were white in colour, well demarcated, and projected from the retina with an irregular nodular surface. The minority (10) were greyish-white in colour, less well outlined, and tended to fade into the surrounding retina. They had a smooth regular surface and did not project forward from the retina. In the 5 children, the projecting variety of tumour appeared virtually colourless, with a translucent veil-like sheen through which the retina was indistinctly visualized. A fine retinal vessel was noted to pass over the surface of 3 tumours, but the remainder appeared totally avascular.

Associated ocular findings may be considered in 3 groups.

1. As part of the clinical picture of tuberous sclerosis. These included areas of depigmented retina observed in 2 patients and a small retinal plaque found in a further patient. This latter
lesion was similar to what François and Deweer (1952) called an atypical coloboma of choroid. These lesions alone were not sufficient for a diagnosis of tuberous sclerosis.

(2) As complications of tuberous sclerosis. The optic atrophy found in 2 patients was probably secondary to phakomas in the optic nerves. In one patient, small tumours were visible within the physiological optic cup.

(3) Coincidental to tuberous sclerosis. One patient had a typical coloboma of the choroid and iris, and one had a divergent squint.

Community Status. The 18 patients form 3 quite distinct groups with regard to their social position in the community. Group I—adults of normal intelligence in regular employment (6); Group II—adults requiring continuous institutional care (7); Group III—children with mental retardation living at home but requiring intermittent hospitalization (5). The frequency of the cutaneous, cerebral, and ocular manifestations in each group is shown in Table II.

**Necropsy Cases.** A survey of necropsy records from 1941 to 1966 inclusive revealed 14 cases of tuberous sclerosis (Table III). The mean age at death was 23·80 years (SD 21·74). All these cases presented with convulsions save one infant, where the onset was characterized by attacks of cyanosis, the necropsy revealing a rhabdomyoma of the heart, as well as tuberous sclerosis of the brain. The latter finding was present in the remaining 13 patients, though in the majority tuberous sclerosis had not been diagnosed or suspected, as the characteristic skin lesions were either absent or so minimal that they were not detected. These families were traced and all first degree relatives were visited and examined. Six cases (A5, 6, 8, 9, 10, and 12) were born outside the area and 2 cases (A4 and A8) were from family NN1. Therefore within the area of the Oxford Regional Hospital Board there were 6 deceased sporadic cases.

Genetical Findings Among Living Cases. From all sources, 20 subjects were ascertained as

### TABLE II

**FREQUENCY OF MAJOR FEATURES OF TUBEROUS SCLEROSIS ACCORDING TO STATUS IN COMMUNITY**

<table>
<thead>
<tr>
<th>Type of Convulsions</th>
<th>No.</th>
<th>Adenoma Sebaceum</th>
<th>Depigmented Areas</th>
<th>Convulsions</th>
<th>Mental Retardation</th>
<th>Retinal Tumours</th>
</tr>
</thead>
<tbody>
<tr>
<td>GM + PM</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>GM</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>5*</td>
</tr>
<tr>
<td>IS</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>GM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GM + PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Excludes patient with bilateral enucleation.
affected and the diagnosis was confirmed in 16. Investigation of the living relatives yielded a further 2 affected subjects. In 4 families (Fig. and Appendix) the pattern of inheritance was characteristic of a dominant trait, while in the remaining 12 families only one member in each was affected, and these were considered to represent 'sporadic' cases. There were 4 female and 8 male sporadic cases whose ages ranged from 3 to 34 years (mean 16·83 SD 3·16). The patients with a family history of tuberous sclerosis consisted of 3 males and 3 females whose ages ranged from 1 to 59 years (mean 23·83 SD 21·81 years).

**Parental Age and Birth Order of Sporadic Cases.** Parental age and birth order were obtained in 11 of the 12 living sporadic cases. The parents of the remaining case refused to co-operate in the investigation. The mean birth rank was 2·36 (SD 1·56). The maternal age at the birth of the sporadic case was 28·27 years (SD 5·16). The mean maternal age for the general population was 27·65 (SD 5·84) years (Blank, 1960). The paternal age at the birth of the sporadic case was 32·91 years (SD 5·01), compared with the mean paternal age of 31·04 years (SD 6·79) for the general population (Blank, 1960). The difference between the mean parental ages was +4·64 years.

**Prevalence of Ascertained Living Cases in a Population.** Eighteen living affected individuals were ascertained in the area of the Oxford Regional Hospital Board which has a population of about 1,800,000. The crude prevalence of ascertained cases was therefore about 10 x 10^-6. Of these 18 living cases, 12 were sporadic so that the prevalence of ascertained sporadic living cases was about 7 x 10^-6. This must be regarded as a minimal estimate of the true prevalence.

**Frequency of Sporadic Cases in a Series of Births.** Considering together the sporadic living cases and those ascertained via necropsy records, as will be seen from Tables I and III, 18 were born between 1882 and 1964. Ignoring the two earliest born, there were 16 births of sporadic cases between 1938 and 1964. Between 1938 and 1966 there were about 756,000 live births in the area, so that the frequency of sporadic cases in live births was about 21 x 10^-6.

Many children with tuberous sclerosis must have been born and died since 1938 without being ascertained either as living or from necropsy records, so that again this is the lower limit for an estimate of birth frequency.

It will be noted that the estimated prevalence of living sporadic cases (7 x 10^-6) is only one-third of the estimate (which is minimal) of the frequency at birth (21 x 10^-6). This is what would be expected by reason of high childhood mortality from tuberous sclerosis; but in view of the inexact nature of both estimates, no quantitative conclusions can be drawn.

**Mutation Rate.** It seems reasonable to suppose that a high proportion of all sporadic cases are mutants having received a fresh mutation that arose in the germ cells of a parent. Certainly this is so in respect of the cases mentioned where relatives have been examined. On such an assumption a minimal direct estimate of the mutation rate is 4 x (21 x 10^-6) = 10·5 x 10^-6 per gene per generation.

### TABLE III

**NECROPSY FINDINGS IN 14 PATIENTS**

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex</th>
<th>Year of Birth</th>
<th>Age at Death (yr.)</th>
<th>Symptoms and Signs</th>
<th>Necropsy Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>F</td>
<td>1955</td>
<td>3 wk.</td>
<td>Talipes and spasticity</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A2</td>
<td>F</td>
<td>1959</td>
<td>2 mth.</td>
<td>Pseudoclerema neonatorum; calcinosis</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A3</td>
<td>M</td>
<td>1958</td>
<td>18 mth.</td>
<td>Enlarged penis and testes; pubic hair; acne</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A4</td>
<td>F</td>
<td>1956</td>
<td>Stillborn</td>
<td></td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A5</td>
<td>M</td>
<td>1921</td>
<td>27</td>
<td>Adenoma sebaceum; mental retardation; shagreen patches; phakoma retina</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A6</td>
<td>F</td>
<td>1930</td>
<td>33</td>
<td>Adenoma sebaceum; mental retardation</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A7</td>
<td>M</td>
<td>1938</td>
<td>24</td>
<td>Adenoma sebaceum; mental retardation</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A8</td>
<td>P</td>
<td>1920</td>
<td>38</td>
<td>Status epilepticus</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A9</td>
<td>M</td>
<td>1921</td>
<td>44</td>
<td>Signs of brain tumour</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A10</td>
<td>F</td>
<td>1908</td>
<td>54</td>
<td>Signs of brain tumour</td>
<td>Paraventricular tumours of tuberous sclerosis</td>
</tr>
<tr>
<td>A11</td>
<td>M</td>
<td>1938</td>
<td>19</td>
<td>Immature personality</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A12</td>
<td>F</td>
<td>1949</td>
<td>14</td>
<td>Infantile hemiplegia (L); optic atrophy</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A13</td>
<td>F</td>
<td>1956</td>
<td>10</td>
<td>Mental retardation</td>
<td>Tuberous sclerosis, brain</td>
</tr>
<tr>
<td>A14</td>
<td>F</td>
<td>1982</td>
<td>69</td>
<td>Road accident; low intelligence</td>
<td>Tuberous sclerosis, brain</td>
</tr>
</tbody>
</table>
Diagnostic and Genetical Aspects of Tuberous Sclerosis

Discussion

Adenoma sebaceum and shagreen plaques were the most frequent cutaneous manifestations of tuberous sclerosis, being present in all affected subjects over 5 years of age. Their absence in infants and young children has always made diagnosis difficult. The present investigation emphasizes that other cutaneous lesions may be present from an early age, in particular areas of skin depigmentation. This observation confirms that of Chao (1959), Gold and Freeman (1965), and Crichton (1966).

Surprisingly, the next most frequent manifestation of tuberous sclerosis has been the high percentage (76%) of patients with retinal tumours (phakomas). One additional patient (NN13) had a bilateral enucleation in infancy for suspected retinoblastoma which could not be confirmed.
mentally (phakomas), very high sclerosis had to infantile 3 (Table II). The suggestion of a correlation between the degree of mental impairment and the presence of retinal tumours (Lagos and Gomez, 1967) was not confirmed statistically using the exact probability test (p = 0.1181).

Tuberous sclerosis is inherited as an autosomal dominant trait (Gunter and Penrose, 1935; Borberg, 1951). In the present study, the disorder was observed in 2 generations in 4 families. Examination of the relatives in 12 families failed to reveal further cases of tuberous sclerosis and these affected patients were considered to be sporadic. The true incidence of tuberous sclerosis is difficult to estimate because of the varying manifestations and the difficulty of ascertaining *formes frustes*. We have estimated a minimal frequency of the trait for the population of the area of the Oxford Regional Hospital Board to be 1 in 100,000. Dawson (1954) estimated an incidence of 1 in 300,000 for England. Patients with incomplete forms of the disease are probably as frequent as the complete triad, and thus Dawson (1954) suggested that the frequency of tuberous sclerosis is probably about 1 in 150,000 persons. Gunter and Penrose (1935) found the incidence of tuberous sclerosis in hospitals for mental defectives at 1 in 300, and as the incidence of mental deficiency in the population is 1%, estimated the incidence of severe cases in the population to be at 1 in 30,000. In Northern Ireland the incidence of tuberous sclerosis was estimated at 1 in 150,000 (Stevenson and Fisher, 1956).

As most severely affected patients with tuberous sclerosis do not reproduce, the mutation rate must be adequate to maintain a constant proportion of tuberous sclerosis in the community if the condition is not to be eradicated. The assumption, therefore, that most sporadic cases are due to mutation is not unreasonable. We have calculated a minimal mutation rate of 10.5 per million genes per generation. Gunter and Penrose (1935) estimated it to be 8 per million genes per generation.

Advanced parental age has been known to be a feature of parental syndromes such as achondroplasia (Stevenson, 1957), Marfan's syndrome (Lynas, 1958), and acrocephalosyndactyly (Blank, 1960). In sporadic cases of tuberous sclerosis, neurofibromatosis, and retinoblastoma, parental ages are slightly raised above the population average but the difference is barely significant statistically when all groups are pooled (Table 6, Penrose, 1961). In the Northern Ireland survey (Stevenson and Fisher, 1956) the parental ages of the sporadic cases seemed high. The number of cases in the present study is not sufficient to form any conclusions.
Diagnostic and Genetical Aspects of Tuberous Sclerosis

Summary

An attempt has been made to ascertain all cases of tuberous sclerosis in the area of the Oxford Regional Hospital Board. A total of 32 patients was found, and of these 18 were alive at the time of the study.

Tuberous sclerosis was inherited as a regular autosomal dominant trait affecting 6 living and 5 dead members of 4 families over 2 generations. Twelve living patients were the only affected subject in the remaining 12 families and were considered to be 'sporadic' cases. Necropsy records revealed a further 14 patients, of whom 6 were both sporadic and born within the region. The minimal incidence of tuberous sclerosis in the area was 1 in 100,000 persons. The rate of mutation at the tuberous sclerosis locus was estimated to be at least 10⁻⁵ × 10⁻⁶ per gene per generation.

Clinical examination of affected subjects revealed a wide range of cutaneous manifestations. Adenoma sebaceum was present in 15 (83%) patients, shagreen plaques in 15 (83%), depigmented areas in 11 (61%), cerebral tags or polypi in 7 (39%), periungual and subungual fibromata in 7 (39%), café-au-lait spots in 5 (28%), and gingival fibromata in 4 (22%). Mental retardation was a feature in 11 (61%) patients and convulsions in 15 (83%). Retinal tumours (phakomas) were observed in 13 out of 17 patients (76%).

Five children with infantile spasms had multiple depigmented patches and retinal tumours (phakomas). The suspicion that infantile spasms with multiple depigmented patches is often an early manifestation of tuberous sclerosis has been confirmed, and the finding of retinal tumours (phakomas) in all of these cases has enabled a definitive diagnosis to be made. It is suggested that a fundus examination should be a routine procedure in all cases of infantile spasms associated with skin depigmentation.

We are particularly indebted to Dr. H. O. Phillipson of Manor House Hospital, Aylesbury, Bucks, and Dr. B. D. Bower of the Radcliffe Infirmary, Oxford, who provided us with the facilities for examining the children under their care, and without whose active assistance and co-operation this work would have been incomplete. We are also grateful to the superintendents of the hospitals for mentally retarded patients and to the consultant paediatricians, dermatologists, neurologists, neurosurgeons, and pathologists of the Oxford Regional Hospital Board for referring their patients and allowing access to their records. We would finally like to thank Dr. A. C. Stevenson, Director of the Population Genetics Research Unit, for initiating the study, and for his advice and criticism in the preparation of this paper.

References


Appendix

Clinical Details of Familial Cases of Tuberous Sclerosis

The pedigrees of the following families are displayed in the Figure.

(a) Family NN17. The propositus (III.2), a man aged 34 years, was 10 years old before his speech was intelligible. The first grand mal attack occurred when he was 2 and adenoma sebaceum when he was 15. There were periungual fibromata of the fingers, shagreen plaques in the lumbar region, cutaneous skin tags, and several café-au-lait spots. The ocular fundi showed well-demarcated depigmented areas but no phakomas.

We are particularly indebted to Dr. H. O. Phillipson of Manor House Hospital, Aylesbury, Bucks, and Dr. B. D. Bower of the Radcliffe Infirmary, Oxford, who provided us with the facilities for examining the children under their care, and without whose active assistance and co-operation this work would have been incomplete. We are also grateful to the superintendents of the hospitals for mentally retarded patients and to the consultant paediatricians, dermatologists, neurologists, neurosurgeons, and pathologists of the Oxford Regional Hospital Board for referring their patients and allowing access to their records. We would finally like to thank Dr. A. C. Stevenson, Director of the Population Genetics Research Unit, for initiating the study, and for his advice and criticism in the preparation of this paper.
Radiographs of the skull showed intracranial calcification. Intravenous pyelogram was normal.

The mother (II.1) and a half-sister (III.1) were normal. A brother (III.3) died aged 14 months with scarlet fever and a sister (III.4) with jaundice at 1 week. The father's (II.2) only manifestation of tuberous sclerosis was adenoma sebaceum, but neither he nor his brothers and sisters were available for examination.

(b) Family NN2. The propositus (III.4), a youth of 19 years, was severely mentally retarded. He had his first grand mal attack when 15 months old, and had adenoma sebaceum, shagreen plaques, and gingival fibromata. There was a coloboma of the choroid and iris and a retinal phakoma in the right eye.

A sister (III.5 and Table III, A4) was stillborn. Necropsy, however, revealed a rhabdomyoma of the heart, tuberous sclerosis of the brain with 'candle guttering' on the thalamus and the caudate nucleus. The mother's (II.4 and Table III, A8) first grand mal convulsion occurred at 2 years of age, and adenoma sebaceum at 14. She died at 38 years in status asthmaticus, and at necropsy there was tuberous sclerosis of the brain, bilateral renal leiomyomata, and a phakoma of the right eye. All living relatives were examined, but in none was there any evidence of tuberous sclerosis.

(c) Family NN22. The propositus (III.14), a girl of 2 years, had infantile spasms from 4 months. There were no adenoma sebaceum, but on the lower limbs there were multiple depigmented spots. A phakoma was present in the right fundus. The electroencephalogram was abnormal, with extensive multifocal spike and wave abnormalities. Chest and skull x-rays and an electrocardiogram showed no abnormality.

A sister (III.15), aged 1 year, also had infantile spasms from 4 months. Her only cutaneous lesion was also multiple depigmented spots on the lower limbs and on the trunk. There were 2 phakomas in the left retina and 2 depigmented patches in the right. The electroencephalogram was abnormal, with varied extensive multifocal spike and slow wave abnormalities. Skull and chest x-rays were normal.

The father (II.7), aged 23 years, first noted adenoma sebaceum at 14 years. There was no history of convulsions. He also had shagreen plaques, cervical skin tags, and depigmented spots. Five phakomas were present in the left fundus and 2 depigmented plaques in the right.

The mother (II.8) and all living relatives on the maternal side had no manifestations of tuberous sclerosis.

(d) Family NN9. The propositus (III.1), a woman aged 59 years, had adenoma sebaceum from the age of 5. She also had shagreen plaques and periungual fibromata of fingers and toes. The fundi were normal. There was no history of convulsions.

A brother (III.6) died at 7 years in a road accident, but according to the propositus he had had epilepsy, adenoma sebaceum, and periungual fibromata of fingers. Another brother (III.7) died aged 28 years with a brain tumour which at necropsy was considered to be an astrocytoma. However, Dr. Oppenheimer of the Neuropathology Department, Radcliffe Infirmary, Oxford, kindly re-examined the cerebral histology, and considered the appearance to be characteristic of the paraventricular tumours of tuberous sclerosis. The necropsy report had also described 'some reddish papules around the mouth'.

The father (II.9) died aged 73 years with emphysema and chronic bronchitis. He had had adenoma sebaceum but no history of epilepsy. A paternal uncle (II.4) had an enucleation of the right eye for a malignant melanoma of the choroid. The remaining living relatives were normal.
Diagnostic and genetical aspects of tuberous sclerosis.

N C Nevin and W G Pearce

doi: 10.1136/jmg.5.4.273

Updated information and services can be found at:
http://jmg.bmj.com/content/5/4/273.citation

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/