Xq– Turner’s Syndrome: Reconsideration of Hypothesis that Xp– Causes Somatic Features in Turner’s Syndrome

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Jacobs et al. (1961) suggested that a study of individuals with deletions of the X chromosome, ‘may help to determine whether genes which influence height are on the short arm of the X chromosome’. Ferguson-Smith (1965) advanced the hypothesis, based on further karyotype-phenotype correlations, that ‘deletion of the long arm of the X chromosome . . . is not sufficient by itself to cause the extreme short stature and the multiple stigmata . . .’, and that ‘monosomy of the short arm of the X chromosome is the decisive factor in the causation of short stature and congenital malformations in Turner’s syndrome’. This idea has been generally accepted (Lancet, 1965; Jacobs, 1969). To our knowledge, it has not hitherto been substantially challenged.

We wish, therefore, to describe a patient with partial deletion of the long arm of the X chromosome (Xq–), to compare her phenotypically to other patients with Xq– and to patients with XO(45,X), and then reconsider the hypothesis that the genes that affect height and somatic features are on the short arm of the X(Xp).

Case Report

This girl presented at 15 years of age because of short stature, primary amenorrhoea, and lack of secondary sexual development. She had not had peripheral lymphoedema, otitis media, gastro-intestinal bleeding, or renal disease. She had had asthma from age 3 to 8 years. She was of normal intelligence and was doing well in school.

Family. The patient’s father was 24 and her mother 23 years of age at her birth. Her father was 175 cm. and her mother 155 cm. tall. Her three sisters experienced normal sexual development with menarche at age 11 years.

Physical examination. At age 15 years the patient was 145.4 cm. tall (Fig. 1). Blood pressure was within normal limits. There was no puffiness over the dorsum of the hands or feet. The fifth fingers were normal in length and shape. The finger-nails were small, hyperconvex, and deep-set at the base. Cubitus valgus was present. Her facial appearance was unremarkable; she did not have epicanthal folds, ptosis of the eyelids, . . .

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narrow maxilla, acutely arched palate, or a small mandible. Her ears were prominent. The posterior hairline was lower than normal. Her neck was neither short nor webbed. The nipples were widely spaced and inverted and there was no breast development. The chest was rather broad. Heart sounds were normal and no murmur was heard. Femoral pulses were normal. There was little pubic hair development and the labia and clitoris were infantile. She showed more pigmented naevi than her sisters. The distal palmar axial triradii were located more than 35% of the distance up the palms.

**X-rays.** The fourth metacarpals were hypoplastic, such that a line drawn tangential to the fifth and fourth metacarpal heads passed through the head of the third metacarpal. The fourth metacarpals were also shorter than the combined length of the proximal and distal phalanges by 0.45 cm. on the right and 0.4 cm. on the left. There was no deformity of the medial tibial condyle. The bone age at age 15 years was retarded to the 10 to 11 year level in the wrist and hand and to the 13 to 14 year level in the elbow and pelvis.

**Cytogenetic studies.** Buccal smears showed a small sex chromatin body in a normal number (25%) of nuclei.

Peripheral blood lymphocyte cultures yielded a total of 386 well-spread metaphases. The modal number of chromosomes per cell was 46. Karyotypes of 24 cells showed a missing chromosome in the C (6–12 +X) group and an extra submentacentric chromosome indistinguishable from chromosome 16 (Fig. 2). No cells consistent with 45,X were observed. The other non-modal cells were karyotypically inconsistent. Neither bone-marrow nor a skin biopsy could be obtained.

Lymphocytes were prepared for autoradiography after continuous late-labelling with tritiated thymidine for 6 hours before harvest. One of the 3 chromosomes...
in the No. 16 group was found to be uniformly and heavily labelled (Fig. 3), suggestive of its being the partially deleted X chromosome.

Chromosome studies of the patient's parents and sisters gave normal results.

Extensive blood grouping was consistent with the presumed paternity. The patient and her parents were Xg(a +) and had normal colour vision.

**Discussion**

**Chromosomal diagnosis of Xq−.** The patient's karyotype (with a missing C chromosome and an extra chromosome No. 16) is consistent with deletion of one-half to two-thirds of the long arm of the X chromosome. The uniformly late DNA replication of the extra chromosome in the No. 16 position is in keeping with its being Xq−.

There was no evidence of a second line of cells. Though mosaicism can never be excluded in any person, extensive lymphocyte studies gave evidence only for Xq−.

**Phenotypic findings.** We have found reports of 5 other patients with Xq− without evidence of mosaicism. The Table lists their findings and those of the present patient.

It should be noted that our patient and 2 other patients with Xq− had 'short stature', being less than 152.4 cm. tall (Table), and that at least one of the remaining 3 patients was also somewhat short, being only 155 cm. in height as an adult (Court Brown et al., 1964). It is also noteworthy that individuals with Xq− may have the other somatic stigmata of Turner's syndrome such as short fourth metacarpals, increased numbers of pigmented naevis, and hypoplastic nails.

**Comparison between 46,XXp− and 45,X.** The Table lists the phenotypic findings in Xp− and 45,X together with the findings in Xq−. Only cases of Xp− and Xq− without known mosaicism have been included, since mosaic cases could confuse such a comparison. Similarly, cases with isochromosomes for the X long arm (Xq1) chromosomes have been omitted, since they are not only monosomic for one arm of the X, but trisomic for the other as well.

The paucity of data on Xp− and Xq− is apparent in the Table. More cases with Xp− or Xq− need to be described, preferably from chromosome surveys of newborns, to provide a fuller picture of the phenotypes associated with Xp− and Xq−.

**Hypothesis reconsidered.** Ferguson-Smith (1965) pointed out that individuals with Xq− show fewer somatic stigmata of Turner's syndrome than individuals with 45,X or Xp−. If this is correct, what could be the basis for it? Ferguson-Smith (1965) suggested one possibility, namely, that Xp− is responsible for the somatic features of Turner's syndrome. Another possibility is biased ascertainment. The X chromosome is one of the longest, most metacentric chromosomes in the C group. Penrose (1964), pooling data from various laboratories, concluded the 'discrimination between X and No. 6 by metrical means is not possible'. Turpin and Lejeune (1965), using cells prepared without

<table>
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<tr>
<th>TABLE</th>
<th>COMPARISON OF PHENOTYPIC FINDINGS</th>
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<tr>
<td>Findings</td>
<td>This Case*</td>
</tr>
<tr>
<td>Short stature‡</td>
<td>+ 2/5 3/6 (50%)</td>
</tr>
<tr>
<td>Shield chest</td>
<td>+ 0/2 1/3 (33%)</td>
</tr>
<tr>
<td>Webbed neck</td>
<td>− 0/5 0/6 (0%)</td>
</tr>
<tr>
<td>Lymphoedema</td>
<td>− 0/3 0/4 (0%)</td>
</tr>
<tr>
<td>Short fourth metacarpal</td>
<td>+ 0/5 1/6 (17%)</td>
</tr>
<tr>
<td>Hypoplastic nails</td>
<td>+ 0/5 1/6 (17%)</td>
</tr>
<tr>
<td>Pigmented naevi</td>
<td>+ 2/4 3/5 (60%)</td>
</tr>
<tr>
<td>Congenital heart disease</td>
<td>− 0/5 0/6 (0%)</td>
</tr>
<tr>
<td>Menstruation</td>
<td>− 1/5 1/6 (17%)</td>
</tr>
<tr>
<td>Streak gonads</td>
<td>O 3/3 3/3 (100%)</td>
</tr>
<tr>
<td>Severe mental defect</td>
<td>− 0/5 0/6 (0%)</td>
</tr>
<tr>
<td>References</td>
<td>§</td>
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* + = present; – = Absent; O = no data.
† Becker, Paris, and Albert (1963) and Becker (1964, personal communication to Ferguson-Smith (1965), Court Brown et al. (1964) and D. J. Mantle (1964, personal communication to Ferguson-Smith (1965); Ferguson-Smith (1965); Grouchy et al. (1961); and Grouchy (1964, personal communication to Ferguson-Smith (1965)); Polani (1963; 1964, personal communication to Ferguson-Smith (1965), and P. E. Polani, personal communication to the authors, 1967).
‡ Short stature = less than 152.4 cm.
§ Atkins, Santesson, and Voss (1965); Jacobs et al. (1961); Lejeune et al. (1966); Steinberger et al. (1966); Tvetendra (1965).
¶ Ferguson-Smith (1965).
colchicine, ranked the X between chromosomes Nos. 5 and 6, whereas Bender and Kastenbaum (1969) placed it between chromosomes Nos. 7 and 8. Xp – may be more difficult to detect cytologically than Xq –. An individual with Xp – and a mild somatic phenotype might be more easily missed than an individual with a comparable phenotype and Xq –. Xq – might make that chromosome more metacentric than other chromosomes in the C group and thus allow its detection with relative ease. Comparable deletions of the short arm might serve only to hide that chromosome (Xp –) among the smaller, less metacentric C chromosomes. Thus, there may be a tendency to investigate only cases with Xp – with relatively flagrant somatic stigmata of Turner’s syndrome.

**Evolution and the X chromosome.** The hypothesis that Xp – is responsible for the somatic stigmata of Turner’s syndrome implies that genes influential in the development of stature and other somatic features are clustered on Xp (Ferguson-Smith, 1965; Jacobs, 1969). The limitation of somatic information to Xp is not in keeping with the view that the X chromosome evolved from an autosome and that the former autosomal loci on it were conserved virtually without loss during evolution (Ohno, 1967). As we have suggested, biased ascertainment and small numbers of cases may be responsible for the apparent differences between the phenotypes associated with Xp – and Xq –.

The idea that either Xp – or Xq – may give rise to short stature and the other somatic stigmata of Turner’s syndrome would thus fit better with current concepts with the evolution of the X chromosome. If correct, it would suggest that X-linked genes of an ‘autosomal nature’ (such as haemophilia A and B, Duchenne muscular dystrophy, colour-blindness, and glucose-6-phosphate dehydrogenase) might be on either the short or the long arm of the X chromosome.

**Summary**

A patient is described with partial deletion of the long arm of the X chromosome (Xq –). She presented with primary amenorrhoea, lack of secondary sexual development, short stature, and other somatic abnormalities associated with Turner’s syndrome.

Comparison of her phenotype with that of other Xq – patients indicates that deletions affecting the long arm of the X chromosome may produce short stature and other somatic stigmata of Turner’s syndrome, though not so frequently as with 45,X.

The question is raised: Does the Xq – phenotype differ from that with Xp –? Small numbers and possibly biased ascertainment of cases presently preclude answering this question. Restriction of most loci affecting somatic development to the short arm of the X is in conflict with the view that the X chromosome was once a primitive autosome and that former autosomal loci on the X have been retained essentially intact during evolution (Ohno, 1967). The location of ‘autosomal’ segments on the X chromosome has important implications for the map of the X chromosome.

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**References**


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