Partial duplication of the long arm of chromosome 6: a clinically recognisable syndrome

Enikő K Pivnick, Mazin B Qumsiyeh, Avirachen T Tharapel, John B Summitt, R Sid Wilroy

Abstract
Reciprocal translocations involving the short arm of acrocentric chromosomes can segregate to produce partial duplications without associated deletions. We present a case of an infant with a 46,XY,−15, +der(15),t(6;15)(q23;p12)pat chromosome complement. The infant had multiple congenital abnormalities including cranial anomalies, facial dysmorphism, anterior webbing of the neck, cardiac anomalies, and joint contractures. From a comparison of the infant's phenotype with 20 other patients with a similar duplication, it is evident that partial duplication of the long arm of chromosome 6 is a clinically diagnosable syndrome.

During meiosis the translocated chromosomes of a balanced translocation carrier can segregate to produce gametes with duplications, deletions, or a combination of both. If such gametes are involved in fertilisation, the resulting zygotes may exhibit duplication, deletion, or both duplication and deletion. Patients with tandem duplications, insertions, or derivative chromosomes resulting from translocations involving the short arm of acrocentric chromosomes often show pure duplication for chromosomal segments. The short arms of acrocentric chromosomes contain terminal satellites attached to the centromere by a stalk. The stalk represents the nucleolar organising region (NOR). The NOR carries genes for ribosomal RNA 18s and 28s. The loss of the short arms of a few acrocentric chromosomes appears to be insignificant, as indicated by the normal phenotype seen in balanced Robertsonian translocation carriers.1

Duplication or partial trisomy of the distal long arm of chromosome 6 has characteristic clinical manifestations. Since the publication of the initial case by de Grouchy et al2 3 at least 19 additional cases have been published. While having common characteristics, these patients also have inconsistent phenotypic features. These inconsistent features may be attributed to the length of the duplicated segment of chromosome 6 or to the deleted segment of the second chromosome involved in the translocation.

Three of the previously reported patients had duplication for the distal long arm of chromosome 6 owing to translocation with the short arms of acrocentric chromosomes.3-5 Essentially these patients show pure duplication of the distal long arm of chromosome 6. A fourth case with duplication 6q23–qter derived from a paternal t(6;15)(q23;p12) is presented along with a phenotype-karyotype correlation of such patients.

Case report
The proband was the product of the second pregnancy of a non-consanguineous, 24 year old mother and a 22 year old father. Their first pregnancy ended in spontaneous abortion during the fifth month of gestation. Necropsy or other studies were not

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Figure 1 The proband showing the characteristic anterior webbing of the neck.
performed on the abortus. Both parents were in good health at the time of the proband's conception. The mother denied taking medications, drinking alcohol, or exposure to environmental toxins, rubella, or other known teratogens during pregnancy. However, she smoked one to two packets of cigarettes a day.

Delivery was at term. Cry and respiration were delayed. The patient was intubated for a brief period after delivery and received oxygen. Birth weight (1900 g), head circumference (29 cm), and crown-heel length (46 cm) were at or below the 5th centile. Multiple congenital anomalies noted at birth included acrocephaly, microcephaly, downward slanting palpebral fissures, telecanthus, micrognathia, short neck with anterior webbing, carp shaped mouth, joint contractures, and club feet (fig 1). Examination of the heart indicated a grade III/VI systolic murmur with a loud click heard best at the left sternal border. Echocardiogram showed severe valvular pulmonary stenosis. Ultrasound of the head and kidneys showed no abnormalities. Hyperglycaemia developed neonatally and required insulin therapy. Serum glucose levels fluctuated between 440 and 1137 mg/dl. Corrective cardiac surgery was performed. The patient died of fulminant sepsis at 2 months of age. Permission for necropsy was denied.

**CYTOGENETICS**

Chromosome analysis of peripheral blood lymphocytes and skin fibroblasts showed 46 chromosomes. However, each cell showed one chromosome 15 with an unusually large short arm. Chromosome analyses of the father's lymphocytes showed a balanced reciprocal translocation between a chromosome 6 and a 15 involving bands 6q23 and 15p12, respectively. Extended family studies showed other members who were carriers of this balanced translocation. GTG and QFQ banding clearly showed the satellite (15p13) translocated to 6q23 (fig 2a and b). NOR staining confirmed the breakpoint on chromosome 15 to be distal to the nucleolar organising region (fig 2c). Thus, the infant's karyotype was interpreted as 46,XY,−15,+der(15),t(6;15)(q23;p12)pat.

**Discussion**

The known clinical and cytogenetic data on 21 patients with duplication of the distal long arm of chromosome 6 are summarised in the table. In four patients the duplication resulted from inherited insertions or inversions.5-8 The case reported by Schroer et al9 represents both duplication and deletion, while the other three represent pure trisomies for 6q15→q27 or 6q13→q21. In 13 cases the duplications resulted from a derivative chromosome inherited from a parent with a reciprocal translocation. Therefore, these patients have a 'double syndrome' involving both duplication 6q and deletion of a segment of a second chromosome.

In the remaining three cases3-5 and in the present case, the partial duplication resulted from the inheritance of the derivative acrocentric chromosome with the 6q region translocated to its short arm. Since the deletion of the satellites or their stalk has no contri-
**Phenotypic characteristics associated with duplication of the distal long arm of chromosome 6 in 21 patients.**

<table>
<thead>
<tr>
<th>Case No</th>
<th>1 (Present case)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5, 6</th>
<th>7</th>
<th>8-21&lt;sup&gt;18-20&lt;/sup&gt;</th>
<th>Total patients with reported characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presumed deleted segment</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>19</td>
</tr>
<tr>
<td>Microcephaly</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Acrocephaly</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20</td>
</tr>
<tr>
<td>Downward slanting palpebral fissures</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20</td>
</tr>
<tr>
<td>Telecanthus</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20</td>
</tr>
<tr>
<td>Micrognathia</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20</td>
</tr>
<tr>
<td>Carp shaped mouth</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Anteriorly webbed neck</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20</td>
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<tr>
<td>Joint contractures</td>
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<tr>
<td>Club foot</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Heart defects or murmur</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Genitourinary abnormalities</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>13/13&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Psychomotor retardation (in older patients)</td>
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<td>NA</td>
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<td>+</td>
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<tr>
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<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>10/12</td>
</tr>
</tbody>
</table>

<sup>a</sup>Patients with condition present/patients examined. NA=not applicable.

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