Partial trisomy 3q causing mild Cornelia de Lange phenotype

S E Holder, L M Grimsley, R W Palmer, L J Butler, M Baraitser

Abstract

A brother and sister are reported with developmental delay and facial features suggestive of the Cornelia de Lange syndrome. Cytogenetic analysis showed them to be trisomic for the region 3q25.1-26.2 because of the inheritance of an unbalanced interchromosomal insertion from their father, who was a balanced insertion carrier.

The clinical phenotype and cytogenetic analysis (including chromosome painting studies) in relation to the possible localisation of the Cornelia de Lange gene are discussed.

(J Med Genet 1994;31:150-152)

The Cornelia de Lange syndrome is a well recognised dysmorphic syndrome first described by Brachmann in 1916 and later by Cornelia de Lange; after whom the condition was named. Typical features include intrauterine growth retardation, short stature, microcephaly, mental retardation, hirsutism, limb anomalies, and distinct facial features. Usually it occurs as a sporadic event and is therefore considered to result from a new dominant mutation or microdeletion. However, occasional families have been reported with recurrence in sibs, suggesting autosomal recessive inheritance, and a milder phenotype has been described occurring in successive generations, consistent with autosomal dominant inheritance.

Occasional chromosomal abnormalities have been reported in association with the Cornelia de Lange syndrome, including a de novo reciprocal translocation with breakpoints at 3q26 and 17q23. A similar facial phenotype has been reported in children with duplication of 3q, although birth weight is usually within normal limits and upper limb reduction defects are rarely a feature. However, in view of the phenotypic overlap and the number of reports involving abnormalities of chromosome 3q, it is considered likely that the gene(s) responsible for the Cornelia de Lange syndrome map to this area. A family reported with duplication of 3q22.1-q24 appears to have a different phenotype, and the precise localisation of a “critical region” on 3q, causing the Cornelia de Lange phenotype, remains to be determined. Current mapping studies are concentrating on the region 3q26-27 (M Ireland, personal communication), trisomy of which is essential in the production of the dup(3q) phenotype, and disruption of which has occurred in the de novo translocation reported by Ireland et al.

Case report

The proband (figs 1 and 2) was the first child of healthy, unrelated parents. She was born at term after a normal pregnancy, birth weight 3300 g. There were no immediate concerns, but her early developmental milestones were delayed; she sat at 8 months, walked at 20 months, and, when seen aged 4 years, was only just starting to form short sentences and become toilet trained. She also had behavioural problems and was being assessed for a special school. On examination, her height was on the 50th centile, and her weight was
Partial trisomy 3q causing mild Cornelia de Lange phenotype

between the 25th and 50th centile. Her head circumference was on the 3rd centile for her age. She had a round face, narrow arched eyebrows, mild synophrys, epicanthic folds, flat nasal bridge, and a small upturned nose. The philtrum was long and prominent, with a thin upper lip and wide mouth. The hands and feet were normal, apart from mild fifth finger clinodactyly.

The younger brother of the proband (fig 3) was born at term, weighing 3700 g. Generally, his development is thought to be better than that of his sister; he sat at 7 months, crawled at 1 year, and has more words than the proband at the same age. However, when seen at 16 months of age, he was not yet walking. On examination, he too had arched eyebrows, epicanthic folds, a flat nasal bridge, a small upturned nose, long philtrum, and thin upper lip. His hands and feet were unremarkable. Height and weight are on the 50th centile for age and his head circumference is on the 25th centile.

CYTOGENETIC STUDIES
Cytogenetic studies were performed on PHA stimulated synchronised lymphocyte cultures prepared for high resolution studies.

Initial analysis of the proband showed the presence of an abnormal chromosome 10. There was an extra dark band in the proximal part of the q arm. All other chromosomes were normal.

High resolution banding studies were carried out on her parents’ chromosomes. Her mother had a normal karyotype, but her father was found to have the same abnormal chromosome 10, and an abnormal chromosome 3, with an interstitial deletion of 3q35.1 to 3q26.2. The father therefore carried a balanced insertion with the karyotype: 46,XY,del(3)(q25.1q26.2), ins(10;3)(q21.2;q25.1q26.2) (fig 4A).

The proband was the result of an unbalanced meiotic segregation of this insertion making her trisomic for the region 3q25.1 to 3q26.2: 46,XX,ins(10;3)(q21.2;q25.1q26.2) (fig 4B).

The proband’s brother was found to have the same unbalanced insertion. Family studies have not identified other relatives who are insertion carriers, although it has not been possible to test both paternal grandparents.

The use of a chromosome 3 paint (CAM-BIO, Cambridge, UK) and fluorescence in situ hybridisation (ONCOR Inc, Gaithersberg, USA) confirmed the presence of chromosome 3 material inserted into a C group chromosome (fig 5).

Discussion
Chromosomal aberrations associated with a distinct phenotype often provide valuable clues to gene localisation, and numerous con-

Figure 3 Brother of the proband aged 16 months.

Figure 4 Chromosome preparation showing (A) the normal chromosome 3 homologues and ins(10) identified in the proband; (B) the balanced insertion identified in the father.
ditions have been mapped following such descriptions. Recent attention has focused on 3q as the localisation of the Cornelia de Lange gene, although it is unclear whether the full phenotype is the result of a submicroscopic chromosomal duplication, deletion of a single gene, or a contiguous gene syndrome. The convincing case reported by Ireland et al. would suggest that disruption of a gene(s) on either 3q or 17q is sufficient to produce the Cornelia de Lange phenotype. The two sibs we have reported have facial features reminiscent of the Cornelia de Lange syndrome and are trisomic for the region 3q25.1-q26.2. They lack the severe mental retardation, growth retardation, and limb abnormalities present in most of the sporadic cases described to date. Their father, who carries a balanced insertion of 3q25.1-3q26.2 into 10q21.2, does not have features of the Cornelia de Lange syndrome, which might be expected if only gene disruption by the insertion breakpoints was the cause of their dysmorphism (the mental retardation being caused by their partial trisomy of 3q).

The fact that, once again, this chromosomal region is associated with the Cornelia de Lange phenotype lends further support to the suggestion that this is the likely localisation of the gene(s) responsible for this important mental retardation syndrome. The breakpoints of the insertions reported here (3q25.1 and 3q26.2), and their proximity to the breakpoint identified in the case reported by Ireland et al. (3q26.3), suggest that the "critical region" for the Cornelia de Lange syndrome is between 3q25.1 and 3q26.3 and further mapping work should concentrate on this region of distal 3q.

A cell line is in preparation: contact Dr M Ireland, Generic Advisory Service, 19 Clarendon Place, Newcastle upon Tyne NE2 4AA.

1 Brachmann E. Ein Fall von symmetrischer Monodaktylie durch Ulnadefekt, mit symmetrischer Flugausbildn in den Ellenbogen sowie anderen Abnormalitäten. Jb Kno-
2 de Lange C. Sur un type nouveau de generation (typus
3 Beratis NG, Hsu LTF, Hirschhorn K. Familial de Lange
4 Naguib KK, Trehi AS, Al-Awadi SA, Marafie MJ. Brach-
  mann-de Lange syndrome in sibs. J Med Genet
  1987;24:627-31.
5 Fryns JP, Dereymaeker AM, Hoefsnaels M, D'Hondt F,
  Mertens G, van den Berge H. The Brachmann-de Lange
  syndrome in two siblings of normal parents. Clin Genet
  1987;31:413-15.
6 Robinson LK, Wolfborg E, Jones KL. Brachmann-de
  Lange syndrome: evidence for autosomal dominant in-
7 Banker A, Haas E, Birrell R. Familial occurrence of
  Brachmann-de Lange syndrome. Am J Med Genet
8 Ireland M, English C, Cross I, Houlbys WT, Burn J. A de
  novo translocation t(3;17)(q26.3;q23.1) in a child with
  40.
9 Wilson GN, Hoiber VG, Schmickel RD. The association
  of chromosome 3 duplication and the Cornelia de Lange
10 Steinbech P, Atkins WW, Caspar H, et al. The dup(3q)
  syndrome: report of eight cases and review of the litera-
  duplication syndrome and assignment of D3S5 to
12 Williamson RA, Donlan MA, Dolan CR, Thuline HC,
  Harrison MT, Hall JG. Familial insertional translocation
  of a portion of region 3q22.1-q24 in different offspring.
13 Gardner RM, Sutherland GR. Chromosomal abnormalities

Note added in proof

Additional work on samples from this family has been carried out (M Ireland,
  personal communication). Using a cosmid probe mapping to 3q26.3, it would
  appear that the breakpoints of the translocated insertion are 3q26.2-3q27, and
  not 3q25.1-3q26.2 as stated in the paper. These results will be published in the
  form of a letter in a future edition of the journal.