Intrachromosomal triplication of distal 7p

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Abstract
A female infant who died at 2 years of age with growth and psychomotor retardation, wide anterior fontanelle, downward slanting palpebral fissures, large, simple ears, joint dislocation/contractures, recurrent infections, and severe pulmonary hypertension was found to have a de novo 7p+ chromosome. The G banding pattern was suggestive of a triplication of 7p21.3 and 7p22; results of fluorescence in situ hybridisation studies using a chromosome 7 specific library, a subtelomeric 7p repeat (109A6), and yeast artificial chromosome clones 786g1 and 850a1, which are respectively associated with the (CA)n repeat markers D7S517 and D7S513, supported the cytogenetic interpretation and showed that the middle repeat was inverted. The patient’s phenotype was consistent with the 7p duplication syndrome, allowing for the effects of the extra burden introduced by the partial tetrasomy. The present rearrangement may have resulted from several meiotic events occurring at the four chromatid stage, namely an unequal crossover or interhomologue translocation with points of exchange at 7p22 and 7p15 followed by the inverted insertion of 7p21.3→p21.2 at the former breakpoint junction; moreover, a further duplication including D7S517 with the terminal 7p22 band is also required.

Keywords: chromosome 7; intrachromosomal triplication; duplication 7p

Intrachromosomal triplications have so far been described for 15q11-q13,1-3 9p22-pter,4 5p14-p15.3,5 and 2q37.5. We report here on a girl with a 7p duplication phenotype resulting from a 7p distal triplication characterised by banding and fluorescence in situ hybridisation (FISH) studies.

Case report
The proband (fig 1) was the fourth child of unrelated parents; at her birth, the mother was 27 and the father 30 years old. The family history was unremarkable and all three sibs were healthy. The pregnancy was uneventful and vertex delivery occurred at 40 weeks. Birth weight was 2500 g; Apgar scores were 7 and 9 at one and five minutes respectively. The postnatal course was characterised by respiratory infections, delayed milestones, and failure to thrive. At 3 months of age her length was 55 cm, weight 2550 g, and OFC 34.5 cm (all below the 3rd centile). She exhibited hypotonia, no head control, widely open anterior
The patient had a 7p+ chromosome whereas parental karyotypes were normal. The extra segment, which appeared to be beyond 7p22, consisted of two dark and two light G bands and seemingly ended at 7pter. The extra dark bands were considered to be repeats of 7p21; however, the proximal band was thinner than the distal one so that the former was thought to be only 7p21.3. In contrast, both extra light bands were of similar size (fig 2). The FISH results showed that the 7p+ consisted entirely of chromosome 7 sequences, had a single subtelomeric signal (images not shown), and exhibited three distinct signals for each of the previously mentioned YACs. However, there were one proximal and two distal signals for YAC clone 786g1 but one distal and two proximal copies of the DNA segment identified by the YAC clone 850a1 (fig 3). Overall, there appeared to be a complex rearrangement implying triplication of 7p21.3→p21.2 (D7S513), with the middle repeat apparently inverted in orientation, and for D7S517 in 7p22, and duplication of 7p15, 7p21.1, and most of 7p22 (fig 4). Hence, the rearranged chromosome can be described as 7pter→p22::p21.3→p21.2::p15→p22::p22→pter and the patient’s karyotype as 46.XX, trp(7)(p21-p22) de novo.ish trp(7)(p22p21) (wcp7+,'C109A6+, D7S517++, D7S513++, D7Z1+). A cell line is not available.

Discussion

The patient’s clinical features, namely growth and psychomotor retardation, wide anterior fontanelle, downward slanting palpebral fissures, large, misshapen ears, small mandible, joint dislocation and contractures, abnormal palmar creases, and recurrent infections associated with IgA deficiency, are consistent with the 7p duplicaton syndrome.11-14

Although most 7p duplications have resulted from translocations,12-14 intrachromosomal duplications account for 11 of 38 rearrangements.15-17 These intrachromosomal duplications have involved different segments and two of them were mosaic with a normal cell line.11 The observed clinical phe-
notypes in this subgroup of patients fit well with the 7p duplication syndrome and show a good correlation with the extent of the duplication. Thus, the phenotypic abnormalities were more severe in children with large non-mosaic duplications than in patients with smaller non-mosaic duplications. Incidentally, this comparison confirms that the characteristic craniofacial dysmorphism in the 7p duplication syndrome maps at or around 7p21. The clinical picture of our patient is consistent with these correlations and suggests that the extra burden introduced by the tetrasomy resulted in the severe phenotypic consequences, therefore conforming to the principles inferred from other partial trisomy/tetrasomy cases.

Intrachromosomal triplications seem to result from a common mechanism as indicated by the inverted orientation of the middle repeat often found, as well as the constant maternal derivation when the parental origin has been ascertained. In the present case, the signal distribution of YAC clone 850a1 suggested that the middle repeat was also inverted. Although the mechanism accounting for the 7p+ chromosome is unknown, it appears to be a complex one. The combined cytogenetic and FISH data indicate that the 7p+ chromosome resulted from several meiotic events occurring at the four chromatid stage, namely an unequal crossover or interhomologue translocation with points of exchange at 7p22 and 7p15 followed by the inverted insertion of 7p21.3 at the former breakpoint junction; moreover, a "cryptic" duplication including the DNA segment D7S517 within the terminal 7p22 band is also required (fig 4).

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