Familial adenomatous polyposis associated with multiple adrenal adenomas in a patient with a rare 3' APC mutation

Alex Kartheuser, Corinne Walon, Sarah West, Cor Breukel, Roger Detry, Anne-Catherine Gribomont, Tayebeh Hamzehloei, Pierre Hoang, Dominique Maiter, Jacques Pringot, Jacques Rahier, P Meera Khan, Ann Curtis, John Burn, Riccardo Fodde, Christine Verellen-Dumoulin

Abstract
Familial adenomatous polyposis (FAP) is characterised by hundreds of colorectal adenomas. Endocrine neoplasms have occasionally been reported, as have gastric polyps, which are usually hamartomatous in the fundus of the stomach and adenomatous in the antrum. A 57 year old man with colorectal, gastric, and periampullary adenomatous polyposis, in association with three bilateral adrenocortical adenomas, is presented. Mutation screening showed a 5960delA germline mutation in the adenomatous polyposis coli (APC) gene predicted to lead to a premature stop codon. This mutation was found in three of the four children of the patient. Western blot analysis of a lymphoblastoid cell line derived from the patient failed to detect any truncated APC polypeptide. This rare 3' mutation is responsible for an unusually complex and late onset phenotype of FAP.

Keywords: familial adenomatous polyposis; APC mutation; adrenal adenoma

Familial adenomatous polyposis (FAP) is a dominantly inherited disease characterised by the development of hundreds of colorectal adenomas in young adults.1 Upper gastrointestinal polyps in FAP include non-adenomatous gastric fundic gland polyps, distal gastric adenomas, and duodenal adenomas.1,2 Gastric fundic polyps are usually hamartomas, which are not at risk of becoming malignant, whereas antral and duodenal polyps are adenomas and often display signs of dysplasia with a risk of subsequent carcinoma.1 2 Among rare extracolonic manifestations of FAP, endocrine neoplasms of the pituitary gland, pancreatic islets, and adrenal cortex have occasionally been reported.1

Case report
Here we report a case of a 57 year old man from southern Italy who was referred for surgical treatment of complex FAP disease. His mother had died previously of colon cancer at the age of 66. This patient has three sisters and four children, who are all asymptomatic (fig 1).

Figure 1 Family pedigree and mutation segregation. E+, presence or absence of the mutation; ?, not tested; arrow, proband; grey symbols represent asymptomatic carriers of the mutation.

Figure 2 Pathology of adrenal masses. (A) Macroscopic appearance. The cortex of this left adrenal gland appeared slightly nodular and contained a well delimitated yellowish nodule of 19 mm. (B) Microscopic appearance. The cells had an alveolar or cord-like arrangement. The tumoral nests were surrounded by fine fibrous tissue septa. Most of the cells had a clear cytoplasm rich in lipid. Their size was remarkably uniform, as were the nuclei. Signs of malignancy were absent.
Discussion

The mutation identified in our patient is a rare one, located at the 3′ end of exon 15 of the APC gene and leading to an unusually complex and late onset phenotype. This mutation was previously reported by Scott et al6 in a pedigree from Switzerland, which could possibly share a common ancestor with our Italian patient. In the report of Scott et al,6 the patients were not assessed for adrenal tumours, although gastric polyposis were found in three patients and an adenocarcinoma of the stomach in one. The location of this mutation, 5960delA (codon 1981), seems to lead to a less severe phenotype (only a few rectal polyps and late onset) but a more complex disease, involving the colon, stomach, duodenum, and both adrenal glands. Since our patient is the only member of his family who was available for investigation, further conclusions cannot be drawn about the precise phenotype associated with the present mutation.

Recently, this and other 3′ mutations have been reported to lead to variable, but in general attenuated, FAP phenotypes. As is true for the vast majority of the APC mutations, this is a frameshift mutation predicted to result in a truncated protein product. However, as previously reported,7 Western blot analysis failed to show a truncated APC polypeptide of the expected length. Previous authors have postu-
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Our patient bearing a mutation at codon 1982 of the APC gene has an unusually complex, late onset FAP phenotype. A better genotype-phenotype correlation would be very helpful in the search for extracolonic manifestations of FAP, which become increasingly important because of their influence on the survival of patients after prophylactic colectomy. In the light of this case, we recommend systematic biopsies of gastric polyps during upper gastrointestinal endoscopy. Furthermore, to evaluate the effect of 3' APC mutations on the adrenal glands, an abdominal ultrasound examination should be performed in FAP patients carrying this type of mutation.

In conclusion, we report a patient with a rare APC mutation leading to an unstable truncated polypeptide which was responsible for an unusually complex, late onset FAP phenotype. Without any evidence of CHRPE on ophthalmological examination.


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