The clinical features of patients with type 2 Stickler syndrome with confirmed mutations in the gene encoding the \( \alpha_1 \) chain of type XI collagen (COL11A1) are described.

Six pedigrees, all exhibiting the beaded or type 2 vitreous phenotype, were identified. Ophthalmic, oro-facial, skeletal, and audiologial features were assessed in addition to echocardiography. Linkage analysis was carried out with markers for the candidate genes COL2A1, COL11A1, and COL11A2. Amplification and sequencing of COL11A1 cDNA was achieved using RNA from cultured dermal fibroblasts.

Thirty one affected members from the six pedigrees were identified. Of these 87% were myopic and 38% had paraxial lattice retinopathy, 64% had a cataract and five exhibited the wedge-shaped cortical opacities typical of Stickler syndrome. Forty two per cent had suffered retinal detachment, 19% bilaterally. The average age at which retinal detachment occurred was 34 years (range 9–55). Thirty seven per cent showed evidence of midline clefting and 80% were found to have mild (asymptomatic) or moderate high tone sensorineural hearing loss. No patient had evidence of mitral valve prolapse.

Type 2 Stickler pedigrees with confirmed mutations in COL11A1 have a high risk of retinal detachment. The facial phenotype is highly variable. The diagnosis, which can be determined by observation of the vitreous phenotype, can be helped by audiologial evidence of sensorineural deafness.

4. Audiometric confirmation of sensorineural hearing defect.
5. Midline clefting (bifid uvula, submucous cleft, high arch palate, cleft repair, Pierre Robin sequence).

Ophthalmic, oro-facial, skeletal, and audiologial features were assessed using the methods reported previously in addition to echocardiography. A general ophthalmic history was recorded with particular attention to the age of onset, degree and progression of myopia, cataract, and vitreoretinal disease. A full ophthalmic examination was carried out. In some of the younger patients applanation tonometry and gonioscopy were not possible. Anterior and posterior segment photographs were taken where appropriate.

Orofacial features were assessed according to standard protocols. Antero-posterior and lateral facial photographs at a standardised scale of 1:8 using a Nikon FM2 camera with Micro Nikon 105 mm medical lens and Kodachrome 64 film.
at F16. A 1 cm grid was printed and then photographed at a scale of 1:8 to match and clinical measurements of outer canthal distance, inner canthal distance, philtrum length, and middle finger length were also recorded. These measurements were used as controls for the photographic calibration. Control measurements of inner and outer canthal distance, interpupillary distance, and philtrum length from 20 unaffected siblings and 60 age matched controls (recruited from the general ophthalmic clinic) were also recorded.

Joint hypermobility was assessed objectively using the Brighton scoring system. A score of 1 or 0 is given for a series of joint manoeuvres and the total sum allocated up to a possible maximum score of 9/9.

A total of 38% had pigmented paravascular lattice. Thirteen patients (42%) suffered retinal detachment. Six had bilateral retinal detachment, one with bilateral giant retinal tears. The average age at which retinal detachment had occurred was 34 years with a range of 9–55 years. Two patients had retinal detachment under the age of 16.

Orofacial

One third of patients were found to have variable manifestations of mid-line clefting including bifid uvula, high arched palate, and cleft palate. Facial features were in general more subtle than those seen in type 1 Stickler syndrome with mild mid-facial and nasal hypoplasia. In some affected individuals the facial phenotype did not vary significantly from age/sex matched controls (fig 4).

Seven patients had lateral skull X rays. Four were normal (normal calvaria and frontal sinuses). Of the three abnormal cases, in one the frontal sinus was absent; in another it was small and, in contrast, large in the third.

No patient had any abnormalities of skin, hair, or sweating as reported in Marshall syndrome.

Skeletal

One third of patients exhibited or reported previous joint laxity (fig 5) with almost half experiencing symptoms of arthritis (most frequently knees, ankles, back, and wrists).

Audiological

A total of 45% of patients reported symptomatic hearing loss but, of those tested, 20/25 (80%) had some degree of high frequency sensorineural hearing loss ranging from mild (30 dB) to moderate (30–60 dB) loss. No patient reported profound deafness in either ear. Three patients had mild or moderate conductive hearing loss in addition to sensorineural loss.

Mitral valve prolapse

None of the 12 patients who underwent echocardiography had mitral valve prolapse.

DISCUSSION

This is the first report describing the clinical features of type 2 Stickler syndrome. All patients have a proven mutation in COL11A1 and exhibited the “beaded” type 2 vitreous phenotype. The range of clinical features is similar to those in type 1 Stickler syndrome, with variability between and within families, but with a particularly high prevalence of sensorineural hearing loss which is often mild enough to go unnoticed by the patient. In contrast to the study by Ananthan et al., this study confirms that individuals are indeed at high risk of retinal detachment, 42% of this group having suffered a retinal detachment in at least one eye at the time of study.

There has been some confusion in the literature regarding the vitreous phenotypes of type 1 and type 2 Stickler syndrome. It is important to recognise that the type 1 anomaly is a congenital and not a degenerative manifestation. Following a case report by Parentin et al., McLeod et al. have suggested that observation of the vitreous phenotype is not reliable in distinguishing between type 1 and type 2 Stickler syndromes. The pedigree reported by Parentin et al. was classified as type 1 Stickler syndrome but linkage analysis was thought to favour COL11A1 rather than COL2A1, although no mutation analysis was performed. The description in the manuscript of the vitreous phenotype suggested type 1 Stickler syndrome, but the photographs included in the paper did not demonstrate the type 1 vitreous anomaly. All three patients, in whom the vitreous had been commented upon, had bilateral retinal detachment. An alternative explanation is that the type 1 vitreous anomaly was confused with the detached posterior hyaloid membrane. In addition, the implication of COL11A1 was only weakly
Figure 1  Type 2 Stickler syndrome pedigrees. The sixth pedigree consists of one member MS67 I:1.
supported by the linkage analysis, whilst the markers used for the linkage analysis did not adequately exclude a mutation in COL2A1 as they did not flank both sides of the gene.

McLeod et al.39 also describe two affected members of a type 2 Stickler syndrome pedigree (with a COL11A1 mutation confirmed) and report that the vitreous phenotype appeared to change from a type 2 anomaly to a type 1 anomaly with the development of a posterior vitreous detachment. In contrast to the congenital type 1 vitreous anomaly, the posterior hyaloid membrane is visible only after posterior vitreous detachment and is clearly a separate entity.40 Both membranes can be demonstrated in the same eye when a patient with type 1 Stickler syndrome develops a posterior vitreous detachment.

Figure 2 "Beaded" vitreous phenotype: (A, B) MS42 III:2; (C) MS42 II:2.

Table 1 COL11A1 mutations

<table>
<thead>
<tr>
<th>ID</th>
<th>cDNA mutation</th>
<th>Genomic DNA mutation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS1</td>
<td>G-T G97V</td>
<td>G-T G97V</td>
<td>Richards et al, 1996&lt;sup&gt;28&lt;/sup&gt;</td>
</tr>
<tr>
<td>MS40</td>
<td>774 bp deletion</td>
<td>Exon 31–42 deletion</td>
<td>Martin et al, 1999&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td>MS42</td>
<td>Exon 15 skip (54 bp)</td>
<td>I VS 14 A-2 del</td>
<td>This report</td>
</tr>
<tr>
<td>MS67</td>
<td>Exon 52 skip (54 bp)</td>
<td>I VS 14 A-2 del</td>
<td>This report</td>
</tr>
<tr>
<td>MS71</td>
<td>Exon 61 skip (36 bp)</td>
<td>I VS 60 A-2 – G-2</td>
<td>This report</td>
</tr>
</tbody>
</table>

Table 2 Clinical features of patients with type 2 Stickler syndrome

<table>
<thead>
<tr>
<th>Pedigree number</th>
<th>Age</th>
<th>Ocular phenotype</th>
<th>Articular phenotype</th>
<th>Aural phenotype</th>
<th>Oro-facial phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Myopia&lt;sup&gt;*&lt;/sup&gt;</td>
<td>RD†</td>
<td>Joint hypermobility</td>
<td>Radiological abnormality</td>
</tr>
<tr>
<td>JH1 I:3</td>
<td>21</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 I:2</td>
<td>10</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 II:3</td>
<td>49</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 III:5</td>
<td>34</td>
<td>+</td>
<td>Cryo</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 II:2</td>
<td>42</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 III:2</td>
<td>84</td>
<td>+</td>
<td>Laser</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JH1 IV:4</td>
<td>18</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS1 I:4</td>
<td>32</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>MS1 II:3</td>
<td>34</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS1 II:2</td>
<td>28</td>
<td>+</td>
<td>Cryo</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>MS1 III:5</td>
<td>31</td>
<td>+</td>
<td>++</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS1 II:2</td>
<td>59</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS1 I:2</td>
<td>55</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS40 I:3</td>
<td>63</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>MS40 II:2</td>
<td>68</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>MS40 IV:12</td>
<td>43</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS40 IV:11</td>
<td>47</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS40 I:4</td>
<td>57</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS40 III:1</td>
<td>65</td>
<td>+</td>
<td>++</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>MS40 IV:2</td>
<td>36</td>
<td>+</td>
<td>0</td>
<td>++</td>
<td>0</td>
</tr>
<tr>
<td>MS40 IV:6</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS40 IV:8</td>
<td>32</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS42 I:2</td>
<td>73</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS42 II:3</td>
<td>41</td>
<td>+</td>
<td>++</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS42 II:4</td>
<td>12</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS42 II:4</td>
<td>22</td>
<td>+</td>
<td>Laser</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MS67 I:1</td>
<td>19</td>
<td>+</td>
<td>++</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>MS71 I:1</td>
<td>47</td>
<td>+</td>
<td>0</td>
<td>++</td>
<td>0</td>
</tr>
<tr>
<td>MS71 I:2</td>
<td>17</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>++</td>
</tr>
<tr>
<td>MS71 II:2</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>++</td>
</tr>
</tbody>
</table>

0: absent; +: mild; ++: moderate; +++: severe.
*0: not myopic; +: mild (< –5); ++: moderate (–5 to –10); +++: high (>–10); †Retinal detachment (RD): 0: no RD; +: RD in one eye; ++: RD in both eyes; cryo/laser: prophylactic cryo or laser retinopexy; 10: none; +: mild 30 dB; ++: moderate 30–60 dB; +++: severe >60 dB; 10: none; +: bifid uvula; ++: high arched; +++: cleft palate.

All patients exhibited the "beaded" vitreous phenotype and had confirmed mutations in the a1 chain of type XI collagen (COL11A1).
detachment. The posterior hyaloid membrane differs in its position, its movement, and the degree of surface crinkling. We believe the suggestion that the type 2 phenotype can convert to the type 1 phenotype is misleading.

The “beaded” type 2 vitreous anomaly is less easy to distinguish but, as our study demonstrates, is sufficiently characteristic to be a useful clinical hallmark differentiating type 2 from type 1 Stickler syndrome.

In contrast to the findings of Liberfarb and Goldblatt41 who found that over 45% of their patients had mitral valve prolapse, Ahmad et al42 looked at 78 patients who included both type 1 and the type 2 Stickler syndrome patients included in this study and found that none had mitral valve prolapse.

Other disorders have been reported to share some of the features of Stickler syndrome. Wagner43 reported a large Swiss family with an autosomal dominant vitreoretinal disorder resembling Stickler syndrome but without retinal detachment. Analysis of the original Wagner pedigree has shown linkage to 5q13–q14,44 confirming that it is genetically distinct from Stickler syndrome. The original Weissenbacher-Zweymuller syndrome patient45 was found to be heterozygous for a mutation in \(\text{COL11A2}\).46 Although, in cartilage, the \(\alpha2(\text{XI})\) collagen forms heterotrimers with \(\alpha1(\text{XI})\) collagen, it is not expressed in the eye and thus there are no associated eye changes. The term non-ocular Stickler syndrome (McKusick no. 184840) encompassing \(\text{COL11A2}\) disorders has been suggested.

There is continuing debate over the clinical overlap and differential diagnosis of Stickler and Marshall syndromes.29 47–49 Marshall36 described seven members in a three generation pedigree who were affected with a hereditary “ectodermal dysplasia” with ocular abnormalities and hearing defect. The pedigree showed autosomal dominant inheritance, normal stature but diminished sweating, and abnormal teeth. Hair and nails were normal. All patients were myopic (moderate to high) with fluid vitreous, although the vitreous phenotype was not described in detail. Several affected individuals had congenital or juvenile cataract which underwent sudden maturation, some with lens subluxation and secondary glaucoma. At the age of 43, one patient suffered a retinal detachment, 9 months following traumatic lens dislocation. Otherwise, there were no localised retinal lesions. In contrast to the series of patients described here, all the patients reported by Marshall had a short, depressed nose and an underdeveloped maxilla. x Rays showed a thickening of the outer table of the skull and absent frontal sinus in two siblings. Midline clefting and arthropathy were not reported although one patient had mild postural scoliosis. Shanske et al50 argue that photographs published in Marshall’s original paper also show that several of the patients have striking ocular hypertelorism, and confirm that Marshall syndrome is a rare condition, with only eight additional reports since 1958. In two of these reports cited by Shanske et al, the authors did not consider their patients to have Marshall syndrome.51 52 The distinction between the Stickler and Marshall syndromes is complicated by further reports describing Marshall syndrome but with features that were
not described in the original Marshall kindred, and yet are known features in cases of Stickler syndrome confirmed by molecular genetic analysis. Annunen et al described a series of patients with mutations in COL11A1 and COL2A1 and found similar clinical findings in patients with mutations in either gene. The notable differences were that those with COL11A1 mutations more commonly had severe hearing impairment and seldom had vitreoretinal degeneration or retinal detachment. Those with COL11A1 mutations were classified as having Marshall syndrome, whereas those with COL2A1 mutations more commonly had severe hearing loss and a high prevalence of vitreoretinal degeneration and retinal detachment. Those with COL2A1 mutations were considered to have Stickler syndrome. The controversy will continue until the molecular genetic basis of the original Marshall pedigree is resolved.

In the continuing search for a clinical distinction between Stickler syndrome and Marshall syndrome, concentration on subtle facial differences may detract from recognizing the serious risk of retinal detachment. This study demonstrates the importance of the vitreous phenotype in the diagnosis of Stickler syndrome, even in those individuals who appear clinically normal in other aspects of the disorder. Recognising the risk to the individual and to members of the family allows appropriate steps to be taken to educate, offer genetic counselling, consider prophylaxis, and offer prompt remedial treatment.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the help of the Stickler Syndrome Support Group, Gillian Whitmore and Katherine Haslam.

 Authors’ affiliations

A Y Poulson, R Murthy, J D Scott, M P Snead, Vitréoretinal Service, Addenbrooke’s NHS Trust, Cambridge, UK
J M M Hooymans, Department of Ophthalmology, University Hospital of Groningen, Groningen, Netherlands
A J Richards, Department of Pathology, University of Cambridge, Cambridge, UK
P Bearcroft, Department of Radiology, Addenbrooke’s NHS Trust, Cambridge, UK
D M Baguley, Department of Audiology, Addenbrooke’s NHS Trust, Cambridge, UK

This research is funded by grants from The Guide Dogs for the Blind Association, The Isaac Newton Trust, The Stanley Thomas Johnson Foundation, Action Medical Research and The University of Cambridge Retinal Research Fund.

Conflict of interest: none declared.

Correspondence to: M P Snead, Vitréoretinal Service, Box 41, Addenbrooke’s NHS Trust, Hills Road, Cambridge, CB2 2QO, UK; mps34@cam.ac.uk

Revised version received 29 February 2004 Accepted for publication 1 March 2004

REFERENCES

36 Parentin F, Sangalli A, Mootes M, Parissotti P. Stickler syndrome and vitreoretinal degeneration: correlation between locus mutation and vitreous


