MUSCLE HEMANGIOMATOSIS PRESENTING AS A SEVERE FEATURE IN A PATIENT WITH THE PTEN MUTATION: EXPANDING THE PHENOTYPE OF VASCULAR MALFORMATIONS IN BANNAYAN-RILEY-RUVALCABA SYNDROME
ABSTRACT

Bannayan-Riley-Ruvalcaba syndrome (BRRS) is a rare autosomal, dominantly-inherited, hamartoma syndrome with distinct phenotypic features. Mutations in the PTEN gene have been identified in PTEN hamartoma tumor syndromes. Our aim was to determine the correlation of phenotype-genotype relationships in a BRRS case. We have evaluated a PTEN mutation in a patient with vascular anomalies and the phenotypic findings of BRRS. We described an 8-year-old girl with the clinical features of BRRS, specifically with vascular anomalies. The mutation in the PTEN gene was identified by DNA sequencing. In our patient, we defined a de novo nonsense R335X (c.1003 C>T) mutation in exon 8, which results in a premature termination codon. Due to vascular anomalies and hemangioma, the patient’s left leg was amputated 1 year after the hemangioma diagnosis. Bannayan - Riley - Ruvalcaba syndrome patients with macrocephaly and vascular anomalies should be considered for PTEN mutation analysis and special medical care.

Keywords: Bannayan - Riley - Ruvalcaba Syndrome (BRRS); Hemangioma; Macrocephaly; PTEN gene; Vascular anomalies.

INTRODUCTION

Bannayan-Riley-Ruvalcaba Syndrome (BRRS; Online Mendelian Inheritance in Man data base, OMIM 153480) is a rare autosomal, dominantly-inherited, congenital disorder characterized by macrocephaly, lipomatosis, hemangiomatosis, hamartomatous growths, central nervous system abnormalities, genital lentiginosis, intestinal polyposis, vascular malformations, and, less commonly, mental retardation [1-3]. Common facial presentations in BRRS patients include frontal bossing, down-slanting palpebral fissures, strabismus hypertelorism, a depressed nasal bridge, long philtrum, epicanthus inversus, a thin upper lip, a broad mouth and relative micrognathia [4,5]. Hypoesthesia, delayed psychomotor development, and seizures are also observed in at least half of BRRS patients [2]. Additionally, ocular abnormalities, lipid storage myopathy, and skeletal system abnormalities such as pectus excavatum, joint hyperextensibility and scoliosis are common manifestations of the syndrome [5]. Bannayan-Riley-Ruvalcaba syndrome and Cowden syndrome (CS; MIM 158350) are two hamartoma syndromes that sometimes show clini-
cal overlap. Thus, at least a subset of BRRS and CS may be allelic. Approximately 60% of patients with BRRS have an identifiable germline mutation in PTEN (OMIM 601728), which is a tumor suppressor gene located on chromosome 10 (10q23) [6,7]. The PTEN gene has nine exons that encode a protein of 403 amino acids, and is also known as MMAC1 (mutated in multiple advanced cancers) or TEP1 (TGFβ-regulated and epithelial cell-enriched phosphatase) [8]. It has been suggested that syndromes characterized by the presence of germline PTEN mutations might be referred to as PTEN hamartoma tumor syndromes (PHTS).

In the present study, we have performed PTEN mutation analysis in a patient with BRRS. We found a de novo nonsense R335X (c.1003C>T) mutation that is rarely reported in the literature for BRRS patients. Furthermore, we attempted to discuss the clinical features of BRRS which should prompt clinicians to test for a PTEN mutation.

MATERIALS AND METHODS

Clinical Report. The proband was an 8-year-old female, referred to the Neurogenetic Division, University of São Paulo-Clínicas Hospital, Ribeirão Preto, São Paulo, Brazil, because of recurrent facial palsy. She was the second child of healthy and non-kins gene parents. Further family history was unremarkable. She was born by vaginal delivery at term; her birth weight, length, and occipitofrontal circumference (OFC) were not recorded at that time. Her growth parameters were normal during childhood. At 2 years of age, she developed recurrent attacks of facial palsy with full recovery days after the episode; there were no other similar cases in her family. Her medical history included one episode of seizures at 3 years of age, but she did not use anticonvulsants. At 7 years of age, she developed gait problems because of pain in her left leg and was evaluated by an orthopedic surgeon who diagnosed hemangiomas. The hemangioma was excised. However, she had another hemangioma in the same leg several months later. At that time her parents noticed that her leg became thinner. New hemangiomas appeared in her right leg, but the parents decided not to operate until they had a definite diagnosis. Her teachers noticed learning disabilities in school. At the age of 8, her weight and height were in the 50th percentile and her OFC was greater than the 97th percentile for her age. Her parents’ OFC were in the normal range. When she was 10, her left leg was amputated because of the hemangioma. On phenotypic inspection, a mild facial dysmorphism consisting of a high forehead, a triangular face, pointed chin, down-slanting palpebral fissures, and a high-arched palate were observed. Several verrucae vulgares on her arms and hands and small café-au-lait spots on her arms and trunk were identified.

Neurological examination identified a mildly asymmetric face, normal eye movements, brisk osteotendinous reflexes, and no signs of cerebellar ataxia. Interestingly, the patient had facial palsy. The weakness in her left leg included a moderate degree of muscle atrophy and aqueous retraction. Her biochemical and serological tests (including thyroid function and karyotype) were all normal. Electroencephalogram (EEG) monitoring recorded as normal. Electromyography (EMG) revealed the presence of myopathic potential units, but nerve conduction velocities were normal. Abdominal ultrasound monitoring recorded as normal. Magnetic resonance imaging (MRI) of the brain showed a small cavitation on the atrium of left lateral ventricle compatible with increased perivascular space. An MRI of the lower limbs showed normal findings in left leg; her right leg displayed the presence of arteriovenous malformation of the right buttock thorough the right lower limbs and severe muscle atrophy. Because of the combination of macrocephaly, angiomyolipomas, and myopathy, we hypothesized that she might have Bannayan-Zonana syndrome, and performed a thyroid ultrasound and colonoscopy. The thyroid ultrasound showed no abnormal findings; colonoscopy showed a few polyps in the sigmoid colon. The results of biopsy on the polyps were compatible with hamartomatous type lesions. In our patient, the existence of hemangiomas, severe vascular malformation leading to amputation of an extremity, macrocephaly, dermatologic and neurologic findings, and facial dysmorphisms in childhood supported a diagnosis of BRRS and an evaluation of PTEN mutation analysis. After we obtained written informed consent from her parents (Ethical Committee for Medical Research document, Brazil).
Characterization of the PTEN Mutation.

We extracted genomic DNA from peripheral blood leukocytes by means of a commercial kit (QIAamp 51104; Qiagen, Hilden, Germany). We then amplified genomic DNA using primers flanking the exons of PTEN. Primer sequences and their Tm values are given in Table 1. Reaction conditions were as follows: after initial denaturation at 98°C for 1 min., three steps were repeated for 35 cycles (denaturation for 8 seconds at 98°C, annealing for 8 seconds at 60°C and extension for 15 seconds at 72°C). The reaction was finished with a final extension for 1 min. at 72°C. The polymerase chain reaction (PCR) products were directly sequenced by a sequencing service company, Iontek (Istanbul, Turkey), to detect mutation. We used the Mutation Surveyor software package (v 3.10, SoftGenetics, LLC, State College, PA, USA) for mutation screening.

RESULTS

A nonsense R335X (c.1003C>T) mutation was identified in exon 8 that resulted in a premature termination codon (Figure 1). The mutation was confirmed with the second sequencing reaction and another round of mutation screening procedures. Sequencing analysis of PTEN exon 8 in the patient’s parents failed to reveal any alteration.

DISCUSSION

The PTEN mutation is related to hamartoma syndromes, displaying partial clinical overlap. The determination of germline mutations in PHTS can allow the identification of new genotype-phenotype correlations, particularly in BRRS. However, it was reported that males are more frequently affected than females but our female patient was in the group of lower penetrance group [9]. We have identified a de novo mutation, R335X, in the PTEN coding sequence in a child with the phenotypic findings of BRRS. Although this truncating PTEN mutation is common in CS, the R335X mutation is rarely reported in BRRS [2]. The R335X mutation at nucleotide 1003 (C>T) in exon 8 results in a truncated protein lacking the C-terminal portion that is needed for phosphatase function [2]. Destabilization of the predicted secondary structure by point mutations on the C-terminal has been shown to result in haploinsufficiency and to affect phosphatase function [10]. Since we did not analyze the DNA of affected tissues, we speculate that a single PTEN hit resulting in PTEN haploinsufficiency may be causative of the patient’s clinical features, such as macrocephaly, verrucae vulgares, café-au-lait spots, seizures and hemangiomas.

Çelebi et al. [2] described for the first time a family with two female members fulfilling the criteria for CS and two male members with the phenotypic findings of BRRS associated with
PTEN R335X mutation. Marsh et al. [11] reported a CS patient with the PTEN gene R335X mutation with malignancy. Parisi et al. [10] reviewed their experience in three families with BRRS and PTEN mutations. Similarly, we encountered common phenotypic features identified in approximately one-third of their patients, who had downward-slanting palpebral fissures, high-arched palates, macrocephaly, frontal bossing, vascular malformations, café-au-lait macules, seizures, and some degree of learning impairment [10]. Fifty-six to 70% of BRRS patients also exhibited high-arched palates [10].

Zhou et al. [12] intended to define whether other syndromes of overgrowth and hamartomas are part of PHTS. They also studied six unrelated individuals who had downward-slanting palpebral fissures, high-arched palates, macrocephaly, frontal bossing, vascular malformations, café-au-lait macules, seizures, and some degree of learning impairment [10]. Fifty-six to 70% of BRRS patients also exhibited high-arched palates [10].

Another small series of Proteus syndrome patients was examined for PTEN mutations [13-15]. Interestingly, R335X was found in two of five Proteus-like individuals and the same mutation has also been found in CS and BRRS patients [15]. Vascular abnormalities, arteriovenous malformations, vascular hamartomas, or hemangiomas, have been reported in some BRRS and CS patients [16-18]. These vascular anomalies are typically multifactorial intramuscular combinations of fast-flow channels and ectopic fat in patients with PTEN mutations [19]. Nevertheless, monitoring for vascular anomalies is not a standard diagnostic procedure for BRRS patients [19]. Erkek et al. [1] reported tender and painful arteriovenous hemangiomas that were misdiagnosed as angiolipomas in their patients. In this report, the patient’s most striking features were the limitation of vascular hamartomas, myopathy, axonal neuropathy and enostosis to the right lower extremity.

Tan et al. [19] identified vascular anomalies in 54% of their patients positively identified as having a PTEN mutation, although none of them had...
hemangiomas or other pure vascular tumors. They found the R335X mutations in two male patients, one with vascular anomalies and one without. They concluded in this research that macrocephalic patients with fast-flow vascular anomalies or multiple intracranial developmental venous anomalies should be tested for PTEN mutation [19]. Although a few cases have been reported with the association of CS, hemangiomas and arteriovenous malformations are reported features of BRRS [20]. Electromyography may reflect the myopathic process [21].

We showed the presence of myopathic potential units in our patient. Bannayan-Riley-Ruvalcaba syndrome is also associated with muscular abnormalities [1]. Our patient had weakness in her left leg with moderate degree of muscle atrophy and aqueous aqulcous retraction. Hamartomatous polyposis occurs in 35-45% of BRRS cases, mainly in the colon and rectum [5,8,22]. The results of our patient’s colonoscopy showed a few polyps in the sigmoid colon; a biopsy showed that the polyps were compatible with a hamartomatous type. Timely identification of PTEN mutations, regardless of clinical presentation, would redefine a diagnosis. Severe arteriovenous malformations/hemangiomas may be a particular presentation of BRRS patients carrying the R335X mutation and can be a debilitating feature of the disease.

We aimed to evaluate genetic features of BRRS, demonstrating clinical correlations in a demonstrated case. Our study has contributed to the knowledge of vascular anomalies in patients with a PTEN mutation. This case report reminds the clinicians to consider a PTEN gene mutation testing for diagnosis of patients with vascular anomalies and other clinical features of CS and BRRS.

Declaration of Interest. The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

REFERENCES


