Alagille syndrome: clinical perspectives

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Abstract: Alagille syndrome is an autosomal dominant, complex multisystem disorder characterized by the presence of three out of five major clinical criteria: cholestasis with bile duct paucity on liver biopsy, congenital cardiac defects (with particular involvement of the pulmonary arteries), posterior embryotoxon in the eye, characteristic facial features, and butterfly vertebrae. Renal and vascular abnormalities can also occur. Inter- and intrafamilial variabilities in the clinical manifestations are common. We reviewed the clinical features and management as well as the molecular basis of Alagille syndrome.

Keywords: Alagille syndrome, ALGS, genetics, liver

Introduction

Alagille syndrome (ALGS; MIM118450) is a highly variable, autosomal dominant multisystem condition with an estimated frequency of one in 30,000.1 ALGS is caused by mutations in one of two genes: JAG1 and NOTCH2. It was initially described as a hepatic disease, but molecular testing has shown that individuals with ALGS and JAG1 or NOTCH2 mutations may present without overt liver disease.2,3

ALGS has been defined by a paucity of intrahepatic bile ducts, in association with at least three of five main clinical abnormalities: cholestasis, cardiac disease, skeletal abnormalities, ocular abnormalities, and characteristic facial features.2 The cholestasis is a consequence of the paucity of bile ducts.

The prevalence of ALGS was originally estimated at 1:70,000 live births; however, this is most likely an underestimation, as cases were ascertained exclusively on the basis of presence of neonatal liver disease2 and childhood and adult cases without overt liver disease were not included in this frequency.

Clinical diagnosis and diagnostic criteria

Traditionally, the clinical diagnostic criteria for ALGS included liver histology showing bile duct paucity (an increased portal tract-to-bile duct ratio) and three of five major clinical features: cholestasis; ophthalmologic abnormalities (commonly posterior embryotoxon); characteristic facial features (prominent forehead, deep-set eyes with moderate hypertelorism, pointed chin, and straight nose with a bulbous tip); cardiac defect (commonly stenosis of the peripheral/pulmonary arteries); and skeletal abnormalities (commonly butterfly vertebrae).

In addition, abnormalities of the kidneys and vasculature (often in the head and neck) are important manifestations of ALGS.1,3 These recent observations have led to
an expansion of the phenotypic criteria of ALGS such that three of seven characteristic clinical criteria are sufficient for a clinical diagnosis. Two classic criteria with confirmed ALGS in a first-degree relative may also be sufficient for a diagnosis of ALGS. Finally, a liver biopsy is no longer considered mandatory to make a diagnosis of ALGS, and the presence of cholestasis is acceptable to fulfill this criterion.

**Systemic manifestations and clinical description**

**Disease history and presentation**

ALGS is a multisystem disorder with a wide spectrum of clinical variability ranging from life-threatening liver or cardiac disease to only subclinical manifestations, such as mildly abnormal liver enzymes, a heart murmur, butterfly vertebrae, posterior embryotoxon, or characteristic facial features. The diagnosis may be difficult because of the variable expressivity of the clinical manifestations. This variability is present even among individuals from the same family sharing the same mutation. In a study of 53 mutation-positive relatives of affected individuals, 25 (47%) did not meet classic clinical diagnostic criteria. Thus, without a molecular diagnosis, those individuals would have likely been missed altogether.7

Disease prognosis and risk of mortality depend on the severity of organ involvement. Early mortality is typically caused by cardiac disease or severe liver disease and later mortality is often caused by vascular accidents.8,9

A few case reports have documented the prenatal findings in ALGS using a detailed ultrasound scan, including fetal hemi vertebrae in the lower thoracic region, cardiac changes, and absent gallbladder, in a fetus with JAG1 mutation10 (Figure 1A–C).

Two studies, one by Emerick et al8 and another by Subramaniam et al,11 discuss the frequency of clinical manifestations in individuals with ALGS (Table 1).

**Hepatic manifestations**

In the majority of cases, individuals with ALGS present in infancy with cholestasis (conjugated hyperbilirubinemia with high GGT, increased serum bile acids, and elevated cholesterol and triglycerides), which manifest as jaundice, intense pruritus, xanthomas (fatty deposits on the extensor surfaces), and failure to thrive due to fat malabsorption.7,12,13

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**Figure 1** Prenatal diagnosis of Alagille syndrome.

**Notes:** (A) A prenatal anatomy scan revealing kyphosis with underlying thoracic vertebral anomaly (blue arrow). (B) A transverse image shows thoracic hemivertebrae (arrows). (C) A three-dimensional sonogram in the posterior–anterior plane demonstrates classic butterfly and hemivertebrae (arrow).
A liver biopsy typically shows paucity of the intrahepatic bile ducts. In newborns with ALGS, bile duct paucity is not always present and the liver biopsy may demonstrate ductal proliferation, resulting in the possible misdiagnosis of ALGS as biliary atresia.

Unremitting cholestasis and progressive liver disease necessitating liver transplantation occur in ∼15% of individuals with ALGS. To date, it has been difficult to predict which infants will progress to end-stage liver disease. There are no genotypic, histologic, or radiologic predictors of liver disease severity. However, a recent study by Mouzaki et al demonstrated that a high serum total bilirubin between the ages of 12–24 months combined with fibrosis on liver biopsy and the presence of xanthomata on physical examination can predict poor long-term hepatic outcomes in patients with ALGS (Figure 2).

<table>
<thead>
<tr>
<th>Cardiac manifestations</th>
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<tbody>
<tr>
<td>Cardiac findings ranging from benign heart murmurs to significant structural defects occur in 90%–97% of individuals with ALGS. The pulmonary vasculature is most commonly involved. Pulmonic stenosis (peripheral and branch) is the most common cardiac finding (67%). The most common complex cardiac defect is tetralogy of Fallot, which is seen in 7%–16% of individuals. Other cardiac malformations include ventricular septal defect, atrial septal defect, aortic stenosis, and coarctation of the aorta (in order of decreasing frequency).</td>
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<table>
<thead>
<tr>
<th>Ocular manifestations</th>
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<tr>
<td>The most common ocular finding in individuals with ALGS is posterior embryotoxon, diagnosed by a slit-lamp examination. Posterior embryotoxon (a prominent Schwalbe’s ring) is a defect in the anterior chamber of the eye and has been reported in 78%–89% of individuals with ALGS. Posterior embryotoxon does not affect visual acuity and has an incidence of 8%–15% in the general population.</td>
</tr>
<tr>
<td>Ocular ultrasonographic examination in 20 children with ALGS found optic disk drusen in 90%. Retinal pigmentary changes are also common (32% in one study). Although</td>
</tr>
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**Figure 2** Xanthomas present on the extensor surface of the buttocks and thighs.

<table>
<thead>
<tr>
<th>Table 1 A summary of the clinical features and the frequency reported among individuals with ALGS</th>
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<tbody>
<tr>
<td><strong>Common system involved in ALGS</strong></td>
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<tr>
<td>Hepatic</td>
</tr>
<tr>
<td>Cardiac</td>
</tr>
<tr>
<td>Facial features</td>
</tr>
<tr>
<td>Eye</td>
</tr>
<tr>
<td>Skeletal</td>
</tr>
<tr>
<td>Renal</td>
</tr>
<tr>
<td>Abbreviation: ALGS, Alagille syndrome.</td>
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</table>
Skeletal manifestations
The most common radiographic finding is butterfly shaped thoracic vertebrae, secondary to clefting abnormality of the vertebral bodies. The reported frequency of butterfly vertebrae ranges from 33% to 93%.9,16,17 Additional skeletal features include a square shape of the proximal part of the fingers with tapering distal phalanges and extra digital flexion creases.18 There also appears to be an increase in pathological long bone fractures in ALGS, which may be due to cholestasis and/or an intrinsic defect of the bones.19

Facial features
The pattern of facial features observed in children with ALGS includes a high forehead with frontal bossing or flattening, deep-set eyes with moderate hypertelorism, pointed chin, and saddle or straight nose with a bulbous tip (Figure 3). These features give the face the appearance of an inverted triangle. The typical facial features are almost universally present in ALGS due to JAG1 mutations.1,20 The typical facial features do not seem to be as prevalent in individuals with ALGS carrying a NOTCH2 mutation.

Renal abnormalities
Structural renal anomalies, such as small hyperechoic kidney and renal cysts, as well as functional abnormalities, such as renal tubular acidosis, have been reported in up to 39% of individuals with ALGS.5 Hypertension and renal artery stenosis have also been noted in adults with ALGS.21

Vascular abnormalities
Neurovascular accidents (intracranial bleeding) have been reported in 15% of ALGS8 and accounted for 34% of mortality in one large study.7 These are potentially devastating complications, and there are reports of adults with ALGS with sudden subarachnoid hemorrhage following the rupture of intracranial aneurysms.22 Renovascular anomalies, middle aortic syndrome, and other intra-abdominal vascular anomalies have also been reported.21

Additional features
The following additional features have been observed: short stature: this may be due to poor growth associated with cholestasis, a severe cardiac defect, and/or intrinsic bone defects (50%–90%);9,23 and immunodeficiency and recurrent infections.24

Pregnancy and ALGS
A few cases of successful pregnancy in AGS have been described by different groups (Table 2), and stemming from these cases, several issues should be considered before attempting embarking on a pregnancy:

- the severity of liver disease and the degree of portal hypertension, which could further worsen during pregnancy;
- the degree of cardiac dysfunction and, in particular, the severity of pulmonary hypertension; and
- the 50% chance for the fetus to inherit the maternal or paternal ALGS mutation, although the severity of the clinical manifestations cannot be predicted in view of the observed intrafamilial variability.
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Thus, genetic counseling is crucial before conception.\(^{25}\) This includes the discussion of preimplantation and prenatal diagnosis as well as the use of surrogate mother if the pregnancy can be associated with maternal risk for deterioration.

### Genetics of ALGS

ALGS is caused by mutations in one of two genes: \(JAG1\) and \(NOTCH2\). Up to 98% are caused by mutations in \(JAG1\) and 2% are caused by mutations in \(NOTCH2\) (Table 3).

\[ \text{JAG1 (chromosome 20p12.2)} \]

\(JAG1\) is a cell surface protein that functions as a ligand for one of four Notch transmembrane receptors, which are key signaling molecules in the Notch signaling pathway, an evolutionarily conserved pathway that is crucial in development.

More than 500 pathogenic mutations have been identified so far in individuals with ALGS. In all, 69% are protein-truncating variants (frameshift and nonsense).\(^{26,27}\)

\[ \text{NOTCH2 (chromosome 1p12-p11)} \]

\(NOTCH2\) encodes a member of the Notch family of transmembrane receptors. The Notch receptors (\(NOTCH1, NOTCH2, NOTCH3, \)and \(NOTCH4\) in humans) share structural characteristics, including an extracellular domain consisting of multiple epidermal growth factor-like repeats and an intracellular domain consisting of multiple, different domain types. The Notch family members play a role in a variety of developmental processes by controlling cell fate decisions.

Twelve different pathogenic variants have been identified in eleven unrelated families with clinical features of ALGS, including one splice site alteration, one frameshift variant, one nonsense variant, and seven missense variants.\(^{28,29}\)

### 20p12.2 microdeletion

The presence of developmental delay and/or hearing loss in addition to the features commonly seen in ALGS may increase the suspicion of chromosome 20p12.2 interstitial microdeletion, which encompasses the \(JAG1\) gene (the ALGS critical region). Kamath et al studied 21 patients with deletions of the short arm of chromosome 20. Eleven patients who had normal development with no anomalies outside of those associated with ALGS had deletions between 95 kb and 4 Mb. The proximal and distal boundaries of these eleven deletions constitute a 5.4 Mb region that defines the \(JAG1\)-

<table>
<thead>
<tr>
<th>Study</th>
<th>LT before pregnancy</th>
<th>Maternal age (years)</th>
<th>Prenatal counseling</th>
<th>Chorionic villous sampling</th>
<th>Delivery (gestational week)</th>
<th>Delivery (technique)</th>
<th>ALGS in the newborn</th>
<th>Newborn outcome at 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witt et al(^{44})</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Albayram et al(^{45})</td>
<td>No</td>
<td>21</td>
<td>No</td>
<td>No</td>
<td>35</td>
<td>Spontaneous vaginal delivery</td>
<td>Yes</td>
<td>NA</td>
</tr>
<tr>
<td>Herr et al(^{46})</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>36</td>
<td>Cesarean section</td>
<td>Yes</td>
<td>NA</td>
</tr>
<tr>
<td>Rahmoune et al(^{47})</td>
<td>No</td>
<td>34</td>
<td>Yes</td>
<td>No</td>
<td>34</td>
<td>Cesarean section</td>
<td>Yes</td>
<td>NA</td>
</tr>
<tr>
<td>Maisonneuve et al(^{48})</td>
<td>Yes</td>
<td>22</td>
<td>No</td>
<td>Yes</td>
<td>37</td>
<td>Elective forceps delivery</td>
<td>Yes</td>
<td>NA</td>
</tr>
<tr>
<td>Jung et al(^{49}) (case series of four pregnancies)</td>
<td>One out of four moms</td>
<td>NA</td>
<td>Yes</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
<td>One out of four newborns</td>
<td></td>
</tr>
</tbody>
</table>

**Table 2** Case reports of successful pregnancies in mothers with ALGS

**Table 3** Summary of molecular genetic testing used in ALGS (GeneReviews)

<table>
<thead>
<tr>
<th>Gene</th>
<th>Proportion of ALGS attributed to mutation of this gene</th>
<th>Test method</th>
<th>Mutations detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>(JAG1)</td>
<td>89%</td>
<td>Sequence analysis/mutation scanning</td>
<td>Sequence variants</td>
</tr>
<tr>
<td></td>
<td>-5%–7%</td>
<td>Deletion/duplication analysis (including FISH and MLPA)</td>
<td>Deletion and duplication of exon(s) and entire gene deletion</td>
</tr>
<tr>
<td>(NOTCH2)</td>
<td>1%–2%</td>
<td>Sequence analysis</td>
<td>Sequence variants</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>Deletion/duplication analysis</td>
<td>Unknown, none reported</td>
</tr>
</tbody>
</table>

**Abbreviations:** ALGS, Alagille syndrome; NA, not applicable; LT, liver transplantation.
associated critical region. The other ten patients had bigger deletions between 3.28 Mb and 14.62 Mb, which extended outside the critical region, and, notably, all of these patients had developmental delay and other associated features.

Genotype–phenotype correlations
No genotype–phenotype correlations exist between the clinical manifestations of ALGS and the specific JAG1 pathogenic variant types or the location of the mutation within the gene. However, two families with JAG1 pathogenic missense variants had cardiac disease without liver involvement.

Patients with disease-causing variants in NOTCH2 may have an increased incidence of kidney disease. However, the number of individuals identified with ALGS caused by mutations of NOTCH2 is still too small to draw conclusions.

In general, understanding the genetic basis of ALGS has assisted the molecular diagnosis and broadened our understanding of the phenotype associated with JAG1 and NOTCH2 mutations. However, a lack of genotype–phenotype correlations has limited the use of these genetic data to impact clinical management.

Treatment of manifestations
Given the multisystem involvement of ALGS, patients with ALGS require evaluation by a multidisciplinary team, including specialists in hepatology, medical genetics, cardiology, nephrology, nutrition, and ophthalmology; liver transplantation team; neurologists; neurosurgeons; and specialists in child development depending on the findings.

Here, we will concentrate on the hepatic and neurovascular complications of ALGS.

Hepatic manifestations
The liver disease of ALGS typically manifests with severe debilitating pruritus and disfiguring xanthomas. The management is largely supportive with choleretic agents (ursodeoxycholic acid) and other medications (cholestyramine, rifampin, naltrexone) for the itch. Surgical biliary diversion procedures (partial internal biliary diversion and ileal exclusion) have also been used in ALGS to ameliorate itch and xanthomas. A Kasai procedure (hepatic portoenterostomy), as used in biliary atresia, seems to worsen the outcome in ALGS and is therefore not recommended.

Liver transplantation for ALGS has an 80% 5-year survival rate, and results in some catch-up growth in 90% of affected individuals. Kamath et al showed that the 1-year survival rate for individuals with ALGS was 87%, compared to a 96% 1-year survival rate for individuals with biliary atresia. This reduction in survival was attributed to the vascular and systemic involvement in ALGS.

Neurovascular manifestations
Neurovascular manifestations are treated in a standard manner. For ALGS individuals with symptomatic moyamoya disease, revascularization can prevent ischemic events and neurologic disability. A recent study by Baird et al on a group of five children with ALGS and symptomatic moyamoya revealed good postsurgical outcomes. These patients remained clinically and radiologically stroke free during long-term follow-up despite progression of moyamoya arteriopathy on angiographic studies.

No cerebrovascular screening guidelines exist for ALGS. Given this good outcome, it was suggested by Kamath et al that the same standards of care applied to children with moyamoya in the absence of ALGS should be applied to children with ALGS.

Genetic counseling
ALGS is inherited in an autosomal dominant manner. Therefore, offspring of an individual with ALGS have a 50% chance of inheriting the causative gene mutation in the JAG1 or NOTCH2 gene.

In ~50%–70% of affected individuals, the mutation is de novo, while up to 50% of individuals with ALGS have an affected parent.

If the proband has an identifiable JAG1 or NOTCH2 pathogenic variant, molecular genetic testing of the parents is recommended. If the proband shows a microdeletion of 20p12 on fluorescence in situ hybridization (FISH) testing, FISH testing of both parents is indicated.

If one of the parents is affected, their risk for having an affected child in their future pregnancies is 50%. However, when the parents are clinically unaffected, the risk to the siblings of a proband appears to be low, but multiple instances of a child inheriting ALGS from an apparently unaffected, phenotypically normal parent with mosaicism for a 20p microdeletion have been reported. If the JAG1 or NOTCH2 pathogenic variant or deletion present in the proband cannot be found in either parent, the risk to the siblings is low, but higher than that of the general population because of the possibility of germline mosaicism.

Conclusion
ALGS is a multisystem disorder associated with liver, cardiac, eyes, face, renal, central nervous, and skeletal abnormalities.
The condition has an autosomal dominant mode of inheritance, and thus, the recurrence risk for an affected person is 50% in each subsequent pregnancy. The mortality is ~10%, with vascular accidents, cardiac disease, and liver disease being the most frequent cause of death. The two causative genes associated with ALGS are JAG1 and NOTCH2. The management of an affected patient should be conducted by a multidisciplinary team, which includes specialists in medical genetics, gastroenterology, hepatology, nutrition, cardiology, ophthalmology, nephrology, liver transplantation, and when necessary, neurosurgery.

Disclosure
The authors report no conflicts of interest in this work.

References


