A case of 18p deletion syndrome after blepharoplasty

Li-juan Xu1
Lv-xian Wu2
Qing Yuan3
Zhi-gang Lv1
Xue-yan Jiang2
1Department of Ophthalmology,
2Department of Pediatrics,
3Department of Clinical Laboratory,
Jinhua Central Hospital, Jinhua,
Zhejiang, People’s Republic of China

Objective: The deletion of the short arm of chromosome 18 is thought to be one of the rare chromosomal aberrations. Here, we report a case to review this disease.

Case report: The proband is a five-and-a-half-year-old girl who has had phenotypes manifested mainly by ptosis, broad face, broad neck with low posterior hairline, mental retardation, short stature, and other malformations. Chromosomal analysis for her mother showed a normal karyotype. Her father and younger brother were phenotypically normal.

Result: Phenotypical features were quite similar throughout other cases and in accordance with the usual phenotype of del(18p) suggested within the same cases and among the del(18p) cases described. She underwent blepharoplasty, which improved her appearance.

Conclusion: 18p deletion syndrome is diagnosed by gene analysis. Plastic surgeries for improving the appearance might be an option for these patients.

Keywords: chromosome, deletion, blepharoplasty

Introduction

The deletion of part or the entire short arm of chromosome 18 is a rare chromosomal aberration, which is estimated to affect ~1 in 50,000 live births, with a female to male ratio of 3:2.1–4 Since its first description by Jean de Grouchy in 1963,5 >150 cases have been reported.

The clinical features of this syndrome vary from one patient to another, depending on the deletion size and specific breakpoints. The larger the deletion and the closer to the centromeric region of the chromosome, the more severe the anomalies.3 The clinical abnormalities include growth deficiency, mental retardation, facial deformity (eg, ptosis, epicanthal folds, low nasal bridge, and large protruding ears), microcephaly, holoprosencephaly, and clinodactyly of the fifth finger. Besides, the discrepancy between verbal and nonverbal performance, as well as dystonias, has also been reported.6,7 Though there are diverse phenotypic manifestations, the diagnosis depends mostly on cytogenetic findings.4

Two-thirds of del(18p) cases were supposed to originate from de novo pure terminal deletion, while one-third of cases were caused by a de novo unbalanced translocation, malsegregation of a parental translocation or inversion, and a ring chromosome or isochromosome 18q.8–11 Here, we report a girl with del(18p) with variable clinical features, whose facial appearance improved after blepharoplasty.
**Case report**

This study complied with the tenets of the Declaration of Helsinki. The consent form for the publication of this report and the accompanying images has been signed by the parents of the child.

The proband was born with a birth weight of 2,200 g, following a normal gestation and delivery without complications, the first child of a healthy couple (mother: 37 years, 152 cm; father: 39 years, 170 cm). Developmental milestones were retarded; she can sit at 7 months, walk at 18 months, and speak at 27 months. At the age of five-and-a-half years, she was brought to medical attention because of ptosis. At that time, she could only count numbers within 10 and her height was 98 cm (less than third centile), weight was 13.5 kg (less than third centile), and head circumference was 46 cm (less than third centile). The width of palpebral fissure was 7–8 mm in the right eye and 2–3 mm in the left eye when raising her eyebrows. The axial length was 19.89 mm in the right eye and 19.74 mm in the left eye. She was not cooperative when examining visual acuity, eye movement, anterior segment, and fundus of the eyes. But both eyes had pupil size and light reaction were normal. Other phenotypic manifestations were as follows (Figure 1A): rectangle face, epicanthal folds, low nasal bridge, broad neck with a low posterior hairline, and mental retardation (intelligence functioning level). Maranda et al.13 reported about a mother and her two daughters who had mild-to-moderate mental retardation, and all of them had the same chromosomal deletion: 46, XX, del (18) (p11.2). Peng et al.14 studied a girl with mosaic 46, XX, del (18) (p11.2)/46, XX, i (18q), and mild mental retardation and communication disorders were observed.

Epilepsy, together with mental retardation, commonly occurs in chromosomal aberrations.15 However, this girl has no history of epilepsy. Grosso et al.16 reported that the short arm of chromosome was less likely to be associated with epilepsy. Hasi-Zogaj et al.17 reviewed 106 18p deletions and found that seizures were not particularly common.

Short stature is another feature of this patient. There were reports suggesting that growth hormone (GH) deficiency occurs with deletions of the distal region of 18p and is involved in the main clinical features of the syndrome.18 The growth delay of our patient could be the result of the region of deletion involved. Though several cases of 18p monosomy with GH deficiency reported that the patients showed excellent catch-up growth after GH treatment;19,20 however, there is no indication of GH treatment according to the guideline of US Food and Drug Administration and Growth Hormone Research Society.21,22 Additionally, there is controversy regarding GH treatment of patients with gene defects;23 thus, after fully understanding the possible consequences of the GH application, the parents of our case are cautious and taking a “wait-and-see” approach.

Other phenotypic features were quite similar with other cases of del(18p). It commonly includes a microcephaly, ptosis, a broad, flat nose, a “carp-shaped” mouth, large,
A case of 18p deletion syndrome

protruding ears, widely-spaced eyes, and/or other abnormalities. Other neurologic findings and/or extremely variable midline facial defects include the presence of maxillary incisor, hypotelorism, an abnormal groove in the upper lip, cleft palate, and/or in severe cases, absence of the nose and/or cyclopia. For some of the abnormal appearances, plastic surgery might be an option. In our case, the girl’s facial appearance greatly improved after blepharoplasty.

Detailed breakpoints location and deleted genes identification help to pick up the del(18p). There are 19 genes related to this syndrome, contributing to the variable clinical pictures. USP 14 gene encodes a member of proteases, and mice with a mutation were retarded for growth. Gripp et al reported that TGIF1 links to NODAL signal pathway to the bifurcation of the human forebrain and the establishment of ventral midline structures. However, the information about breakpoints or genotype–phenotype correlations is limited. This report presents a case deletion of part of the p-arm (18p11.2). It is usually caused by spontaneous (de novo) errors very early in the development of the embryo that appear to occur randomly for unknown reasons. Thus, further study is needed to clarify the etiology and the correlation between genes and symptoms. Besides, the patient should be followed up for a long term.

Conclusion
This report sheds new lights on the del(18p) syndrome. Plastic surgery may be an option for some of the abnormalities to improve the appearance, as well as the life quality. Genetic counseling for these patients should be taken into account.

Acknowledgment
This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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

References


