and the human CASK protein isoform 1 are NM_003688.3 and NP_003679.2, respectively.

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Hypoperfusion in caudate nuclei in patients with brain–lung–thyroid syndrome

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ABSTRACT

Mutations in *NKX2-1* cause neurological, pulmonary, and thyroid hormone impairment. Recently, the disease was named brain–lung–thyroid syndrome. Here, we report three patients with brain–lung–thyroid syndrome. All patients were unable to walk until 24 months of age, and still have a staggering gait, without mental retardation. They have also had choreoathetosis since early infancy. Genetic analysis of *NKX2-1* revealed a novel missense mutation (p.Val205Phe) in two patients who were cousins and their maternal families, and a novel 2.6-Mb deletion including *NKX2-1* on chromosome 14 in the other patient. Congenital hypothyroidism was not detected on neonatal screening in the patient with the missense mutation, and frequent respiratory infections were observed in the patient with the deletion in *NKX2-1*. Oral levodopa did not improve the gait disturbance or involuntary movement. The results of ^{99m}Tc-ECD single-photon emission computed tomography (ECD-SPECT) analyzed using the easy Z-score imaging system showed decreased cerebral blood flow in the bilateral basal ganglia, especially in the caudate nuclei, in all three patients, but no brain magnetic resonance imaging (MRI) abnormalities. These brain nuclear image findings indicate that *NKX2-1* haploinsufficiency causes dysfunction of the basal ganglia, especially the caudate nuclei, resulting in choreoathetosis and gait disturbance in this disease.

1. Introduction

NK2 homeobox 1 (*NKX2-1* or *TITF-1*; MIM #600635), which maps on chromosome 14q13, is a member of the *NK-2* gene family of highly conserved homeodomain-containing transcription factors [1,2]. The gene is expressed in the thyroid, bronchial epithelium, and specific areas of the forebrain during development in the mouse [3–5]. Mice homozygous for the disrupted gene are born dead and lack a thyroid gland, lung parenchyma, and pituitary gland, while heterozygous mice develop normally [4]. An abnormality of the gene in humans was first reported in patients with congenital hypothyroidism [6]. Subsequently, heterozygous point mutations in *NKX2-1* were identified in affected members of a family with benign hereditary chorea [7]. Recently, *NKX2-1* was reported as the gene responsible for brain–lung–thyroid syndrome (MIM #610978), which involves symptoms of neurological impairment, pulmonary disorders, and hypothyroidism [8–13]. Respiratory distress during the neonatal period, recurrent respiratory tract infection, and hypothyroidism are common clinical findings. The neurological impairment is characterized by gait disturbance with delayed first walking and choreoathetosis, in the absence of mental retardation or brain magnetic resonance imaging (MRI) abnormalities [13]. However, some affected individuals have had low-average intelligence, learning problems, psychosis and seizures [14–16].

The pathological mechanism of *NKX2-1* haploinsufficiency has been clarified for the hypothyroidism [17] and pulmonary impairment [18,19], but it is still unclear for the neurological symptoms. Most of the neurological deficits, i.e., the gait disturbance and involuntary movements sometimes accompanied with dystonia, dysarthria, action tremor and saccadic abnormalities [20], reflect dysfunction of the control of movement. Therefore, the basal ganglia were considered to be the most important causal lesion [8,14]. The *NKX2-1* null mouse showed severe morphological changes in the basal ganglia, including absence of the globus pallidus and enlargement of the striatum [4]. *NKX2-1* gene expression has been identified as the origin of the pallidum in the mammalian and avian embryonic archistriatum. These studies indicated that *NKX2*-1 is essential for development of the striatum, especially the pallidum rather than the caudate nuclei [5,21,22].

Brain MRI of patients with brain–lung–thyroid syndrome showed no notable abnormalities, except one case report of reduced size and intensity in the pallidum [8]. Previous brain nuclear imaging studies described various findings regarding the basal ganglia, including reduced blood flow in the striatum and thalamus [23], and hypometabolism in the basal ganglia, more prominent in the caudate nuclei [15].

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Here, we report three patients with brain–lung–thyroid syndrome in whom the diagnosis was confirmed by genetic examinations. We performed brain nuclear image analysis to investigate the causal lesion for the neurological symptoms.

2. Method

2.1. Clinical findings

We studied three patients (5, 6, and 7 years old; one male and two females) with gait disturbance who visited Tohoku University Hospital between 2008 and 2009 (Table 1).

Patient 1 was the second female child of healthy non-consanguineous parents (Fig. 1). She was born at term without neonatal respiratory problems. Congenital hypothyroidism was noted on neonatal screening and she has been given thyroxin replacement therapy since then. After the age of 1.6 years, she developed recurrent respiratory infections and was admitted to hospital five times in one year. She had normal mental development, but delayed gross motor development. She could sit alone at the age of 12 months and first walked at 38 months. A staggering gait persists. Her trunk and extremes were mildly hypotonic and continuous choreoathetosis was observed during wakefulness and exacerbated by stress.

Patients 2 and 3 were cousins via their maternal families (Fig. 1). Patient 2 was the third female and Patient 3 was an only male child. Both sets of non-consanguineous parents were healthy fathers and affected mothers with mild involuntary movement and a history of delayed first walking. Both patients were born at term without any perinatal complications. Congenital hypothyroidism was diagnosed in the neonatal period by screening in Patient 2, but at the age of 5 years in Patient 3, despite a neonatal screening test. Unlike Patient 1, they had no severe respiratory infections during infancy. Similar to Patient 1, first walking was observed at 30 months in Patient 2 and at 24 months in Patient 3. They also have persistent gait disturbance and choreoathetosis without mental retardation. The neurological examinations in all three patients did not detect any abnormalities, such as muscle weakness, abnormal deep tendon reflexes, or cerebellar manifestations.

Brain MRI in all three patients showed normal brain size, form, and intensity, including the basal ganglia. Oral levodopa (20 mg/kg/day) was given to all three patients, but no obvious improvement in the neurological symptoms was observed.

2.2. Brain nuclear image analysis

All three patients underwent single photon emission computed tomography (SPECT) to evaluate brain function at Tohoku University Hospital using technetium-99 m ethyl cysteinate dimer (ECD, approximately 12 MBq/kg of body weight) as the radiotracer. Twenty minutes after the injection, SPECT images were acquired using a PRISM IRIX (Shimadzu, Kyoto, Japan), with a low-energy, high-resolution, fan-beam collimator. In total, 120 projection datum points in a 128 × 128 matrix were obtained in 20 min. Using an ODYSSEY computer (Shimadzu), tomograms two pixels thick (5.8 mm) were reconstructed after a high-frequency cutoff with a Butterworth filter.

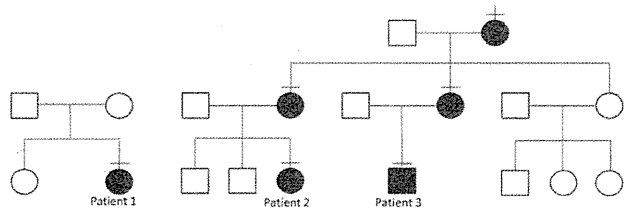

Fig. 1. Family pedigrees of three patients. Affected members are indicated by black squares and circles; unaffected members, white squares and circles. Patient 2 and 3 are cousins on mother's side.

The easy Z-Score Imaging System (eZIS; Fuji Film RI Pharma), used for the statistical analysis of SPECT images, standardizes brain images using Statistical Parametric Mapping (SPM99) [24]. Each SPECT image of the subjects after anatomical standardization followed by isotropic 12-mm smoothing was compared with the mean and SD of SPECT images of the age-matched healthy controls already incorporated in the eZIS program as a normal database using voxel-by-voxel Z-score analysis after voxel normalization to global mean values: Z score = (control mean − individual value)/control SD. These Z-score maps were overlain on tomographic sections and projection with an averaged Z-score of 14-mm thickness to surface rendering of the anatomically standardized MRI template.

Positron emission tomography (PET) was performed in Patients 2 and 3, 1 h after administering [^{18}F]-fluorodeoxyglucose (^{18}FDG) (approximately 3 MBq/kg of body weight) using a Biograph Duo, ECAT EXACT HR^{+} (Siemens, Hoffman Estates, IL) or SET-2400 W (Shimadzu) after fasting for at least 4 h. Emission scans were performed for 10 min for the entire brain. Attenuation was corrected. Fourteen 6-mm-thick slices parallel to the orbitomeatal line, encompassing virtually the entire brain, were analyzed visually by two investigators independently. When the interpretation was inconsistent, a third investigator was called to make a decision.

2.3. Gene analysis

Gene analyses were performed with the informed consent of the patients' parents. Genomic DNA was extracted from peripheral blood lymphocytes using a Sepa Gene kit (Sanko Junyaku, Tokyo, Japan). All coding exons and flanking introns in *NKX2-1* were amplified by PCR. All primers were based on the NCBI reference sequence (accession number NG_013365; the primer sequences are available upon request). The PCR products were separated on 3% agarose gels and purified with a QIAquick Gel Extraction kit (QIAGEN, Chatsworth, CA, USA). The PCR products were sequenced directly using a Big Dye Primer Cycle Sequencing kit and ABI 310 Genetic Analyzer (PE Applied Biosystems, Foster City, CA, USA).

Subsequent array-based comparative genomic hybridization (CGH) analysis was performed using an Agilent 244 K oligonucleotide array (Agilent, Santa Clara, CA; www.agilent.com) with a resolution of approximately 15 kb following the protocols provided by Agilent. The array was analyzed with the Agilent scanner and the Feature Extraction software (v. 9.1.3).

Table 1
Clinical characteristics in three patients.

	Patient 1	Patient 2	Patient 3
Age/sex	7 years/female	5 years/female	6 years/male
Recurrence of respiratory infection	Yes	No	No
Neonatal respiratory problems	No	No	No
Hypothyroidism	Yes (neonatal screening)	Yes (neonatal screening)	Yes (diagnosed at 5 years)
Initiation of walking	3 years and 2 months	2 years and 6 months	2 years
Mental retardation	No	No	No
Choreoathetosis	Yes	Yes	Yes
Response to L-dopa	No	No	No
Brain MRI	Normal	Normal	Normal
NKX2-1 analysis	del 14q12–13	p.V205P	p.V205P

3. Results

From the raw nuclear image ECD-SPECT findings in all three patients (Fig. 2, lower figures) and FDG-PET in Patients 2 and 3

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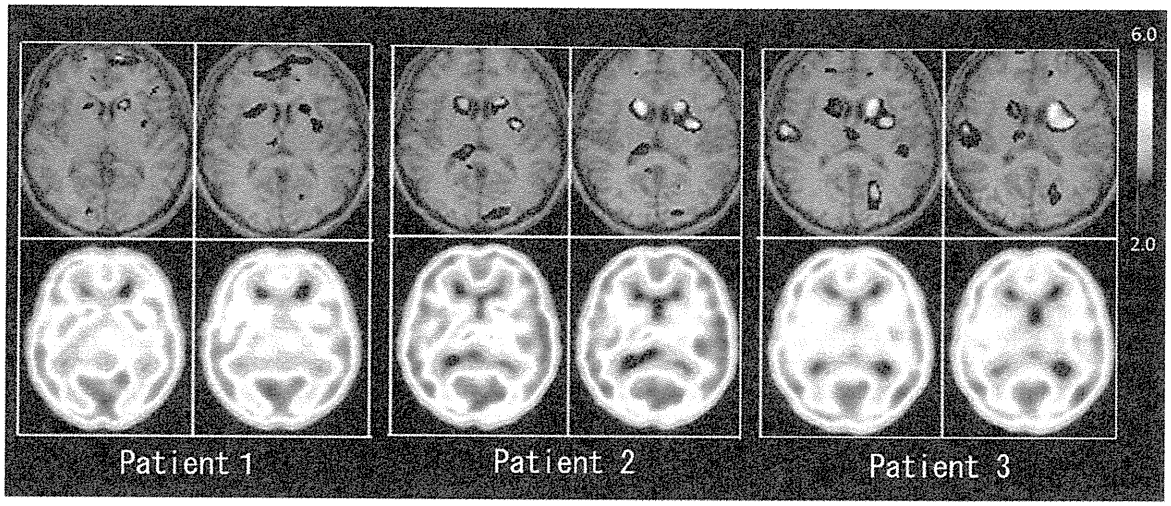

Fig. 2. ECD-SPECT and eZIS results.Usual color images of ECD-SPECT in three patients were shown on the lower figures in each patient. Analyzed images using eZIS were shown on the upper figures. The converted images indicate regions of decreased cerebral blood flow by colors from blue (2.0 standard deviation) to red (6.0 standard deviation). Reduction in cerebral blood flow was shown most common and prominent in the bilateral caudate nuclei in all three patients.

(data not shown), we could not discriminate visible areas of abnormal cerebral perfusion or glucose metabolism. However, the statistical analysis of the ECD-SPECT data using eZIS demonstrated significant declines in cerebral blood flow in the basal ganglia, especially in the caudate nuclei (Fig. 2, upper figure). Although several other brain regions were shown to have decreased blood flow, these were not shared in the three patients.

Array CGH analysis revealed that Patient 1 had an approximately 2.6-Mb hemizygous deletion including *NKX2-1* in 14q12–13 (Fig. 3, top). Direct sequencing analysis revealed a novel hemizygous mutation in the coding exons in Patients 2 and 3 (Fig. 3, bottom), but no mutation in Patient 1. A hemizygous G-to-T substitution at nucleotide position 613 (c.613G>T) in Patients 2 and 3 created an amino acid substitution at amino acid position 205 (p.Val205Phe) within exon 3, which is localized within the *NKX2-1* homeodomain. The mothers and grandmother of Patients 2 and 3 had the same missense mutation.

4. Discussion

In this study, we diagnosed three children with brain–lung–thyroid syndrome based on clinical findings of delayed walking, unsteady gait, choreoathetosis, and hypothyroidism. The diagnosis was confirmed by genetic analysis detecting a novel hemizygous deletion and missense mutations in *NKX2-1*. In addition, we performed nuclear image examinations and analyzed the results using statistical image analysis with eZIS. We found a significant reduction in the blood flow in the caudate nuclei in all three patients.

Recurrent respiratory infection was observed only in the patient with the deletion in *NKX2-1*, but not in the two patients with missense mutations. These phenotype-genotype correlations support previous reports [8,10–13] that large deletions and truncation mutations are related to the severe phenotype with the symptom triad, while missense mutations have a milder phenotype [13]. The existence of respiratory symptoms is very important for management because no deaths have been reported in patients without lung disease [12]. In one case with a missense mutation, hypothyroidism was not detected until the age of 5 years, while it was detected in his cousin with the same mutation at neonatal screening. This interfamilial heterogeneity, as described previously [25], indicates that simple haploinsufficiency cannot fully explain the spectrum of clinical presentations. Other modifying genes might contribute to the phenotype heterogeneity [9,12].

Central nervous impairment is the most common and essential symptom in brain–lung–thyroid syndrome [12,13]. Typically, mental retardation and brain MRI abnormalities are not associated with this disease. The characteristic presentation involves delayed walking, a staggering gait, and choreoathetosis. Since no obvious nervous system abnormalities were detected on neurological examinations, we speculate that the choreoathetosis in the lower limbs caused the delay in walking and unsteady gait.

To identify the brain region responsible for the neurological impairment, we examined brain ECD-SPECT and FDG-PET, but no obvious pathological abnormalities were detected on visual inspection of the raw images. Further statistical analysis of the ECD-SPECT data was performed using eZIS, while the FDG-PET was not analyzed because we did not have an appropriate analysis method. The eZIS method can detect a significant difference of regional cerebral blood flow by comparison with age-matched normal controls, and shows the result as color images. Previous reports described significant superiority of this program over visual inspection of raw SPECT images in several diseases [26–28]. We analyzed our patients and found a common, significant reduction in cerebral blood flow in the caudate nuclei. Although most reports describe expression of the *NKX2-1* gene in the pallidum [8,21,22], a recent study showed *NKX2-1* expression in the postnatal mouse striatum, including the caudate nuclei, in addition to the pallidum [29]. In humans, nuclear image studies indicated a reduction in blood flow [23] and glucose metabolism [15] in the basal ganglia. Hypoperfusion in the caudate nuclei was described in a patient with Huntington's disease [30,31], which usually involves chorea. From these reports and our ECD-SPECT findings using eZIS, we believe that the region responsible for the neurological symptoms in brain–lung–thyroid syndrome, pathologically, is the caudate nuclei. We speculate the possible mechanism that the mutation may impair developmental differentiation and organization of the striatum. Huntington's disease, which also involves the caudate nuclei, partially mimics brain–lung–thyroid syndrome clinically, although the latter is easily differentiated by the history of delayed walking.

In our cases, oral L-dopa [32], a dopamine agonist, and clonazepam failed to improve their neurological impairment. Only a few effective treatment for involuntary movement has been reported [13]. Although some reports described the choreatic movements tend to decrease over time [7,23], the movement disability causes severe trouble with daily life, especially writing difficulty resulting in a leaning impairment in

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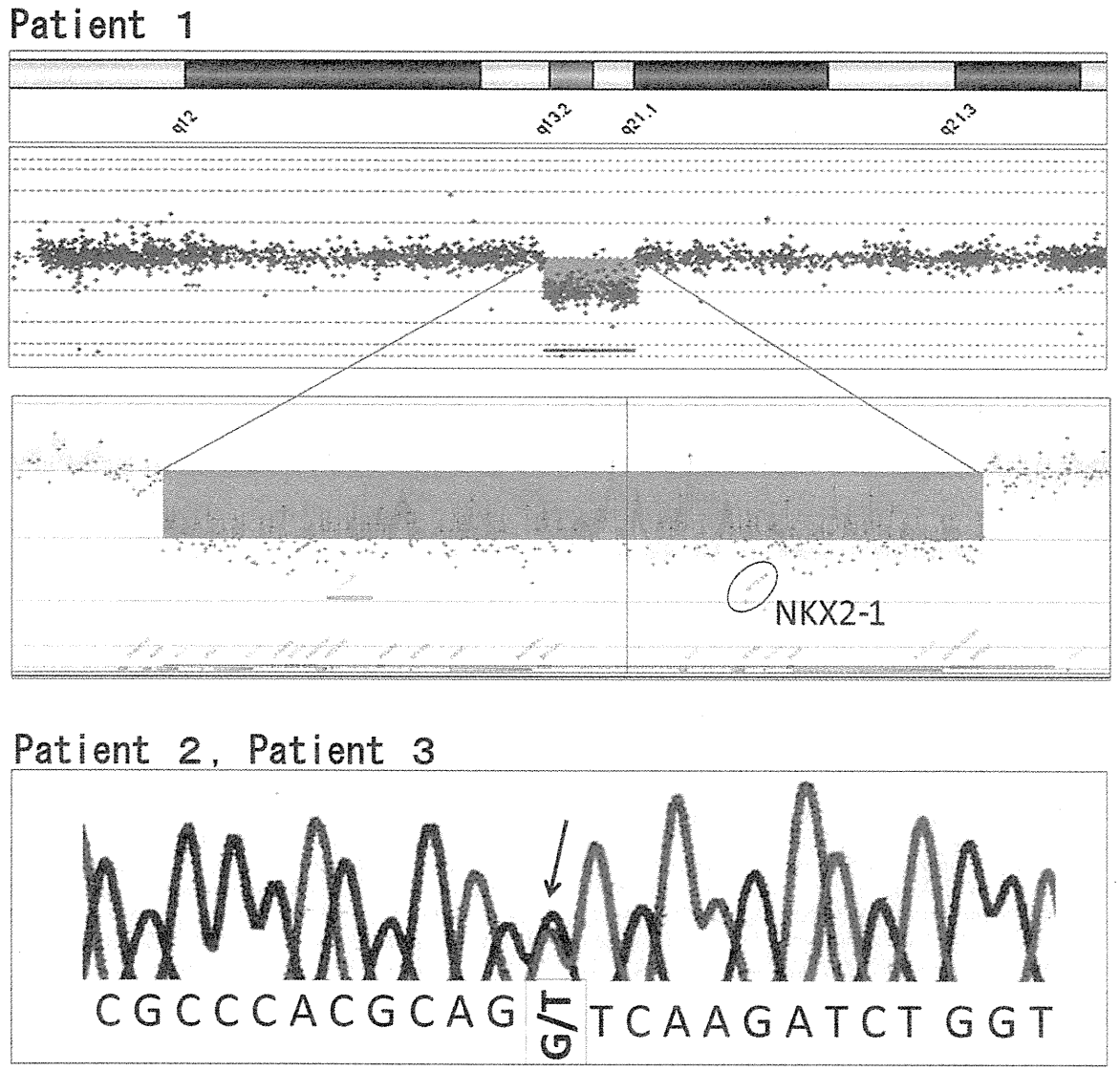

Fig. 3. Deletion and missense mutation in *NKX2-1*. Chromosome 14 profile and detail of 14q12–13 region generated by Cytogenomics (version 1.5, Agilent Technologies) showed a hemizygous 2.6-Mb deletion including *NKX2-1* in Patient 1. Sequencing analysis showed hemizygous missense mutations (c.613G>T) in *NKX2-1* in Patients 2 and 3. (For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article.)

childhood. We postulate that deep brain stimulation might treat involuntary movement, such as in Huntington's disease [33]. The pathophysiology of this disease should be clarified to develop an effective treatment.

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Mutations in genes encoding the glycine cleavage system predispose to neural tube defects in mice and humans

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Neural tube defects (NTDs), including spina bifida and anencephaly, are common birth defects of the central nervous system. The complex multigenic causation of human NTDs, together with the large number of possible candidate genes, has hampered efforts to delineate their molecular basis. Function of folate one-carbon metabolism (FOCM) has been implicated as a key determinant of susceptibility to NTDs. The glycine cleavage system (GCS) is a multi-enzyme component of mitochondrial folate metabolism, and GCS-encoding genes therefore represent candidates for involvement in NTDs. To investigate this possibility, we sequenced the coding regions of the GCS genes: *AMT*, *GCSH* and *GLDC* in NTD patients and controls. Two unique non-synonymous changes were identified in the *AMT* gene that were absent from controls. We also identified a splice acceptor site mutation and five different non-synonymous variants in *GLDC*, which were found to significantly impair enzymatic activity and represent putative causative mutations. In order to functionally test the requirement for GCS activity in neural tube closure, we generated mice that lack GCS activity, through mutation of *AMT*. Homozygous $Amt^{-/-}$ mice developed NTDs at high frequency. Although these NTDs were not preventable by supplemental folic acid, there was a partial rescue by methionine. Overall, our findings suggest that loss-of-function mutations in GCS genes predispose to NTDs in mice and humans. These data highlight the importance of adequate function of mitochondrial folate metabolism in neural tube closure.

INTRODUCTION

Neural tube defects (NTDs), such as spina bifida and anencephaly, are severe birth defects that result from failure of closure of the neural folds during embryonic development (1). Although NTDs are among the commonest birth defects in humans, the causes are still not well understood. This is most likely due to their complex, multifactorial causation

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which is thought to involve contributions from both genetic and environmental factors (2–4). The potential complexity of NTD genetics is illustrated by the fact that more than 200 different genes give rise to NTDs when mutated in mice (5,6). Moreover, inheritance patterns in humans suggest a multigenic model in which an affected individual may carry two or more risk alleles, which by themselves may be insufficient to cause NTDs (2).

Folate one-carbon metabolism (FOCM) is strongly implicated as a determinant of susceptibility to NTDs since suboptimal maternal folate status and/or elevated homocysteine are established risk factors, whereas periconceptional maternal folic acid supplementation can reduce the occurrence and recurrence of NTDs (7,8). Nevertheless, the precise mechanism by which folate status influences NTD risk remains elusive (7,9). FOCM comprises a network of enzymatic reactions required for synthesis of purines and thymidylate for DNA synthesis, and methionine, which is required for methylation of biomolecules (Fig. 1A) (9). In addition to the cytosol, FOCM also operates in mitochondria, supplying extra one-carbon units to the cytosolic FOCM as formate (Fig. 1A) (10).

Genes that are functionally related to folate metabolism have been subjected to intensive genetic analysis in relation to NTD causation, principally through association studies (reviewed in 3,4,11). In the most extensively studied gene, *MTHFR*, the c.677C>T SNP is associated with NTDs in some, but not all, populations. However, other FOCM-related genes have largely shown non-significant or only mild associations. Given the apparently complex inheritance of the majority of human NTDs, many association studies have been hampered by limitations on sample size. Moreover, although positive associations have been noted for other genes including *DHFR*, *MTHFD1*, *MTRR* and *TYMS* (12,13), these have not been replicated in all populations, and additional studies are required. The hypothesis that genetically determined abnormalities of folate metabolism may contribute to NTD susceptibility is supported by the observation of defects of thymidylate biosynthesis in a proportion of primary cell lines derived from NTDs (14). However, these defects do not correspond with known polymorphisms in FOCM-related genes. Overall, it appears likely that genetic influences on folate metabolism remain to be identified in many NTDs.

A potential link between mitochondrial FOCM and NTDs was suggested by the finding of an association of increased NTD risk with an intronic polymorphism in *MTHFD1L* (15). Another component of mitochondrial FOCM, the glycine cleavage system (GCS), acts to break down glycine to donate one-carbon units to tetrahydrofolate (THF), generating 5,10-methylenetetrahydrofolate (methylene-THF; Fig. 1B) (16,17). The GCS consists of four enzyme components, each of which is required for the glycine cleavage reaction (18,19). The components—glycine dehydrogenase (decarboxylating) (GLDC; P-protein), aminomethlyltransferase (AMT; T-protein), glycine cleavage system protein H (GCSH; H-protein) and dihydrolipoamide dehydrogenase (DLD; L-protein)—are encoded by distinct genes: *GLDC*, *AMT*, *GCSH* and *DLD*, respectively. The functions of *GLDC*, *AMT* and *GCSH* are specific to the GCS, whereas *DLD* encodes a housekeeping enzyme. GCS components have been found to be abundantly expressed in the neuroepithelium during embryogenesis in the rat (20).

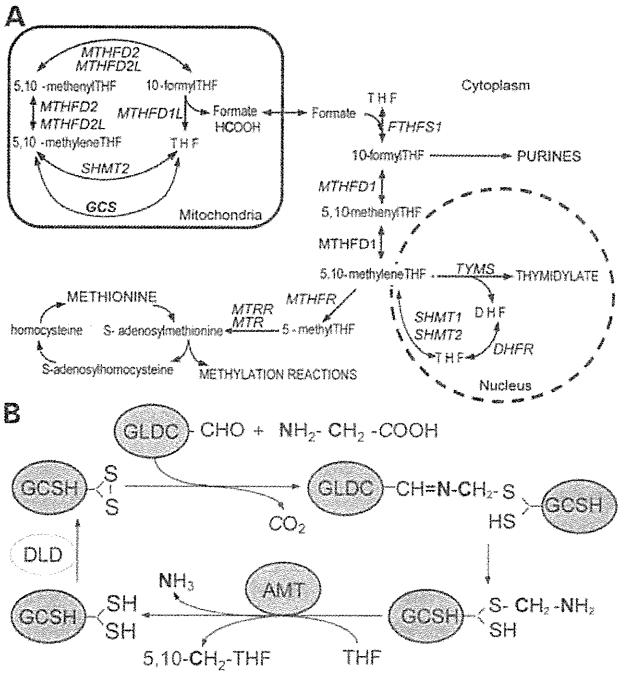

Figure 1. Schematic diagrams summarizing the key reactions of folate-mediated one-carbon metabolism and the GCS. (**A**) Folates donate and accept one-carbon units in the synthesis of purines, thymidylate and methionine. Mitochondrial FOCM supplies one-carbon units to the cytoplasm via formate. The GCS is a key component of mitochondrial FOCM that breaks down glycine and generates 5,10-methylene-THF from THF. Genes encoding enzymes for each reaction are indicated in italics. DHF, dihydrofolate; THF, tetrahydrofolate. (**B**) Summary of the GCS. The glycine cleavage reaction is catalysed by the sequential action of four individual enzymes: GLDC, GCSH, AMT and DLD. The first three of these (shaded grey) are specific to the GCS. Glycine is broken down into CO_2 and NH_3, and donates a one-carbon unit (indicated in bold) to THF, generating 5,10-methylene-THF. The other carbon in glycine (indicated in italics) enters CO_2.

We hypothesized that modulation of GCS activity has the potential to influence efficacy of cellular FOCM during the period of neural tube closure and, hence, susceptibility to NTDs. Therefore, in the current study, we screened genes encoding GCS components for possible mutations in NTD patients and controls. We tested variant proteins for loss of function by enzymatic assay and mice lacking GCS function were generated, to test the effect on embryonic development.

RESULTS

The hypothesis that genes of the GCS represent candidates for involvement in NTDs prompted us to screen for potential mutations in patient samples. Coding exons of *AMT* (9 exons), *GCSH* (5 exons) and *GLDC* (25 exons) were sequenced in a total of 258 NTD patients comprising cohorts from Japan, the UK and Sweden. Each of the major categories of NTDs was represented among study samples, including anencephaly ($n = 38$), spina bifida ($n = 198$) and craniorachischisis ($n = 22$).

Table 1. Nucleotide changes in NTD patients and controls identified by exon sequencing of AMT, GLDC and GCSH

Location	Nucleotide change	Effect	Number of mutation carriers in UK cohorts		Number of mutation carriers in the Japanese cohort		Number of mutation carriers in the Swedish cohort		Variant GLDC enzyme activity[a]
			NTD group (type[b]) ($n = 166$)[c]	Control group ($n = 189$)[c]	NTD group (type[b]) ($n = 14$)[c]	Control group ($n = 36$)[c]	NTD group (type[b]) ($n = 76$)[c]	Control group ($n = 145$)[c]	
AMT									
Exon 2	c.103A>C	p.R35R	0	1	0	0	0	—	
	c.214A>G	p.T72A	0	0	0	1	0	—	
Exon 6	c.623C>A	p.A208D	0	2	0	0	0	—	
	c.631G>A	p.E211K[d]	2 (SBA)	0	0	0	1	—	
	c.589G>C	p.D197H	0	0	1 (An)	0	0	—	
Exon 7	c.825T>A	p.N275K	0	1	0	0	0	—	
	c.850G>C	p.V284L	1 (SBA)	0	0	0	0	—	
GLDC									
Exon 1	c.52G>T	p.G18C	2 (SBO/SBA)	2	0	0	2 (SBA)	2	84%
Exon 5	c.668C>G	p.P223R	0	0	0	1	0	—	92%
Exon 12	c.1508A>C	p.E503A	1 (SBA)	0	0	0	0	0	—
	c.1512G>C	p.E504D	1 (SBA)	0	0	0	0	0	99%
	c.1519G>C	p.G507R	1 (An)	0	0	0	0	0	17%
	c.1525C>G	p.P509A[e]	1 (An)	0	0	0	0	0	41%
	c.1550G>C	p.S517T	0	0	0	0	1 (SBA)	0	—
	c.1570G>C	p.V524L	1 (SBA)	0	0	0	0	0	34%
Exon 14	c.1705G>A	p.A569T[f]	3 (SBA/SBO/SBO)	1	0	0	1 (SBA)	0	40%
Exon 17	c.1953T>C	p.H651H	0	1	0	0	0	—	—
Exon 19	c.2203G>T	p.V735L	0	2	0	0	0	—	81%
Intron 19	c.2316-1G>A	splice	1 (SBA)	0	0	0	0	—	
Exon 20	c.2380G>A	p.A794T	2 (SBASBA)	0	0	0	2 (SBA)	2	88%
	c.2406G>A	p.A802A	1 (An)	0	0	0	0	0	—
Exon 21	c.2474G>A	p.G825D	0	0	1 (An)	0	0	—	24%
	c.2487C>T	p.A829A	0	1	0	0	0	—	—
	c.2565A>C	p.A855A	1 (An)	0	0	0	0	—	—
Exon 23	c.2746C>T	p.L916L	1 (Crn)	0	0	0	0	—	—
Exon 25	c.2964G>A	p.R988R	0	0	0	0	1 (SBA)	0	—
	c.2965A>G	p.I989V	0	1	0	0	0	0	130%
GCSH									
Exon 1	c.53C>T	p.A18V	1 (An)	1	0	0	—	—	

All nucleotide changes were found in heterozygous form. One individual carried c.52G>T and c.1705G>A in *GLDC*, whereas no other individuals carried more than one of the nucleotide changes listed here. Eight silent polymorphisms and four missense variants present in dbSNP (http://www.ncbi.nlm.nih.gov/projects/SNP/) are not listed in this table and include: *AMT*: c.954G>A (p.R318R, rs11715915); *GLDC*: c.249G>A (p.G83G, rs12341698), c.438G>A (p.T146T, rs13289273), c.501G>A (p.E167E, rs13289273), c.660C>T (p.L220L, rs2228095), c.666T>C (p.D222D, rs12004164), c.671G>A (p.R224H, rs28617412) and c.1384C>G (p.L462V, rs73400312); and for *GCSH*: c.62T>C (p.S21L, rs8052579), c.90C>G (p.P30P, rs8177847), c.159C>T (p.F53F, rs177876), c.218A>G (N73S, rs8177876), c.252T>C (Y84Y, rs8177907) and c.261C>G (L87L, rs8177908). Grey shading indicates loss-of-function mutations, based on enzymatic activity in the *in vitro* expression study or splicing defect.

[a]Residual enzymatic activity of GLDC mutant protein is expressed as %activity of the wild-type enzyme (Fig. 2).

[b]SBA, spina bifida aperta; SBO, spina bifida occulta; An, anencephaly; Crn, craniorachischisis.

[c]Total number of UK, Japanese or Swedish NTD patients.

[d]This variant was previously established as likely to be a non-functional polymorphism by segregation in an NKH family (21).

[e]A biochemical test of folate metabolism, the dU suppression test, was previously performed on primary fibroblasts derived from this patient and showed a defect of thymidylate biosynthesis to be present (14).

[f]p.A569T has previously been reported as a pathogenic mutation in a patient with typical NKH (21).

In *AMT*, we identified two novel sequence variants predicted to result in non-synonymous missense changes, c.589G>C (D197H) and c.850G>C (V284L), in anencephaly and spina bifida patients, respectively, from the UK cohort (Table 1). Neither variant was present in 526 UK or 36 Japanese control subjects or in the SNP databases dbSNP and 1000 Genomes. An additional missense variant, E211K, was also identified in three spina bifida patients, two from the UK and one from Sweden. Causative mutations in *AMT* have been found previously in an autosomal recessive inborn error of metabolism, non-ketotic hyperglycaemia (NKH) (17). The E211K variant had previously been identified in an NKH family but was established as likely to be a non-functional polymorphism by segregation (21). Therefore, this variant is considered unlikely to be causally related to NTDs.

Exon sequencing of *GCSH* revealed eight single-base substitutions, one of which (c.53C>T, p.A18V) was a novel change found in both an NTD and a single control (Table 1). The others all corresponded to known SNPs, which did not suggest a role for *GCSH* in NTDs.

Next we turned our attention to *GLDC*, in which we identified 27 single-base substitutions (Table 1), including 11 silent nucleotide changes, 15 non-synonymous changes and a splicing acceptor variant of intron 19 (c.2316-1G>A). The

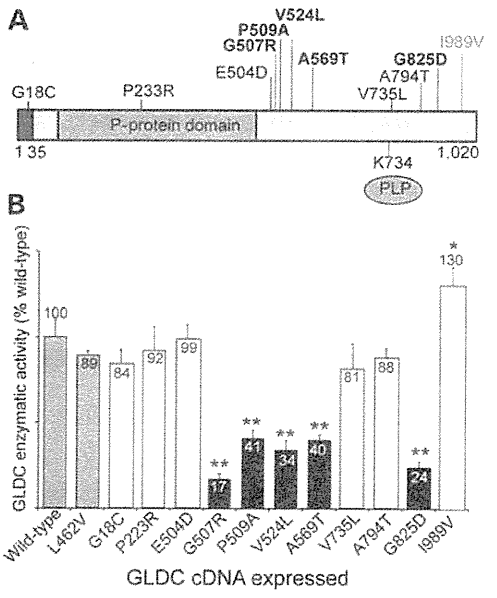

Figure 2. Characterization of *GLDC* missense mutations identified through DNA sequence analysis. (**A**) The schematic represents the 1020 amino acid residue GLDC polypeptide with the positions of the identified missense variants indicated. Mutations conferring significantly reduced activity (**B**) are indicated in bold. The leader peptide for mitochondrial import (shaded black) and the lysine 754-binding site for the co-factor pyridoxal phosphate (PLP) are indicated (49). (B) Enzymatic activity of GLDC missense variants. Expression vectors with wild-type and mutant *GLDC* cDNAs were transfected into COS7 cells for the evaluation of GLDC activity, which is expressed as relative activity (%) of cells expressing wild-type cDNA (shaded grey). The L462V GLDC enzyme (shaded grey) was tested as an example of a normally occurring variant (rs73400312). Variant proteins whose activities were significantly diminished compared with wild-type are indicated by black shading. The I989V variant, identified in a control parent, showed significantly elevated activity. Values are given as mean ± SD of triplicate experiments ($^{*}P < 0.05$; $^{**}P < 0.01$, compared with wild-type).

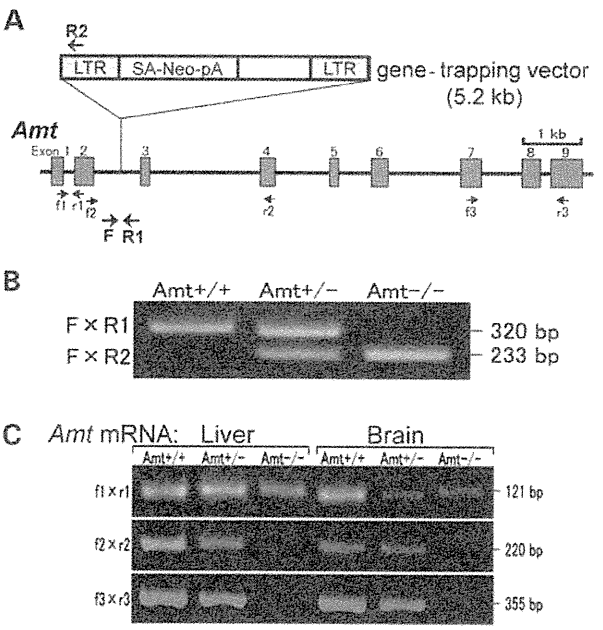

Figure 3. Generation of *Amt* knockout mouse by gene trapping. (**A**) The location of the gene-trap vector in *Amt* intron 2 in the ES cell line OST181110 was determined by inverse PCR. Mice carrying this mutation were generated using standard methods of blastocyst microinjection with OST181110 ES cells to generate chimeras, and germ-line transmission. LTR, long terminal repeats; SA, splicing acceptor site; Neo, neomycin phosphotransferase gene; pA, polyadenylation sequence. (**B**) For genotyping, mouse genomic DNA was subjected to allele-specific amplification with F, R1 and R2 primers (Supplementary Material, Table S1). A genomic fragment of 320 bp was amplified from the wild-type allele, whereas a 233 bp fragment was amplified from the *Amt*-mutant allele. (**C**) RT-PCR analysis of *Amt* mRNA expressed in the brain and liver of *Amt*-mutant mice. Primers in exon 1–2 generated a 121 bp band irrespective of mouse genotypes. RT-PCR in which either one (f2-r2) or both (f3-r3) primers were located in exons 3′ to the insertion site produced 220 and 355 bp cDNA fragments, respectively, in $Amt^{+/+}$ and $Amt^{+/-}$ mice, but not in $Amt^{-/-}$. The *Amt* mRNA in mice carrying the trap vector was, therefore, aberrantly spliced at the end of exon 2, resulting in truncation of *Amt* mRNA in $Amt^{-/-}$ mice.

latter is deduced to abolish normal splicing of the *GLDC* mRNA, with predicted skipping of exon 19 resulting in loss of the reading frame. Among the 15 missense variants identified in *GLDC*, 5 were unique to the NTD group, being absent from all 562 control individuals as well as from the SNP databases. A further three novel variants were found only in controls, whereas the remainder were found in both NTDs and controls, and included previously reported SNPs.

We investigated the possible functional effects of *GLDC* missense variants by expressing wild-type and mutant cDNA constructs in COS7 cells, followed by enzymatic assay of GLDC activity involving a decarboxylation reaction using [1-^{14}C]glycine (22). Twelve GLDC variants were tested, including those that were unique to NTD patients and, therefore, hypothesized to be potentially pathogenic (Fig. 2). The L462V variant, which corresponds to a known SNP (rs73400312), was included as an example of a known normally occurring form. Five of the missense changes, G507R, P509A, V524L, A569T and G825D, resulted in a significant reduction in GLDC activity compared with the wild-type protein ($P < 0.001$). Notably, all five of these deleterious variants were present solely in NTD cases, whereas none of the variants that were unique to controls (P223R, V735L and I989V) showed loss of enzymatic function. In the case of G18C and A794T, which occurred in both NTDs and controls, there was no significant loss of enzymatic activity, suggesting that these are unlikely to be causative mutations.

Having identified putative mutations in *AMT* and *GLDC* in NTD patients, we hypothesized that loss of GCS function could predispose to development of NTDs. In order to directly test the functional requirement for GCS activity in neural tube closure, we generated mice that lacked GCS activity, using a gene trap (OmniBank, OST181110) of the *Amt* gene. The vector was located in intron 2, resulting in a truncated transcript that lacked exons 3–9 (Fig. 3). The efficacy of the gene-trap vector in trapping expression of *Amt* (Amt^{-}) was confirmed by RT-PCR analysis (Fig. 3). Heterozygous $Amt^{+/-}$ mice were viable and fertile and exhibited no obvious malformations. Homozygous $Amt^{-/-}$ mice were not observed among post-natal litters from heterozygote intercrosses, and so fetuses were examined at embryonic day (E) 17.5. Strikingly, 87% of $Amt^{-/-}$ fetuses (34 out of 39) exhibited NTDs, whereas no malformations were observed in $Amt^{+/+}$ ($n = 33$) or $Amt^{+/-}$

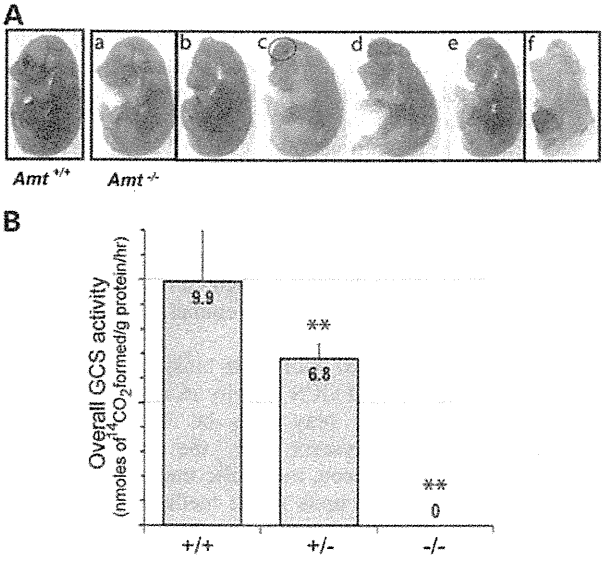

Figure 4. Mice lacking GCS activity exhibit NTDs. (**A**) Phenotypes of *Amt* mutant mice. NTDs were evident in the majority (88%) of $Amt^{-/-}$ fetuses (examples shown are at E17.5). Various types of NTDs were observed in $Amt^{-/-}$ fetuses, which principally affected the cranial region; a, no NTDs; b, small exencephaly (dotted circle); c–e, large exencephaly; f, craniorachischisis. (**B**) Enzymatic activity of the GCS in *Amt* knockout mice. $Amt^{+/-}$ and $Amt^{-/-}$ fetuses had significantly lower GCS activity in the liver than $Amt^{+/+}$ fetuses, with activity in $Amt^{-/-}$ samples below the level of detection ($^{**}P < 0.01$ compared with $Amt^{+/+}$).

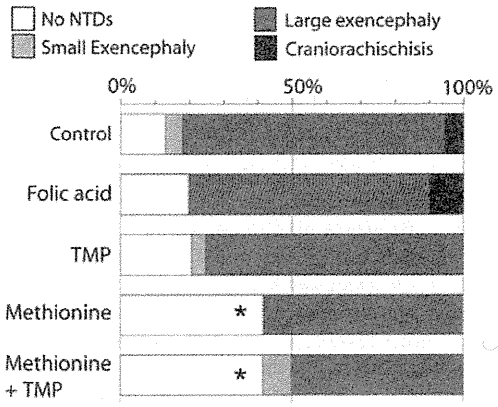

Figure 5. Maternal supplementation of *Amt* mutant embryos with folic acid, TMP or methionine. Maternal treatment with folic acid ($n = 10$ homozygous mutant fetuses) or TMP ($n = 12$) had no significant effect on NTD frequency, whereas the frequency of unaffected embryos was significantly increased following treatment with methionine ($n = 12$) or methionine plus TMP group ($n = 12$). The asterisk indicates significant difference compared with non-treated group ($P < 0.05$).

($n = 66$) fetuses. Defects mainly comprised exencephaly (82%), in which the cranial neural folds persistently failed to close (Fig. 4). There was also a low frequency of the more severe condition, craniorachischisis (5%), in which the neural tube remains open from the mid- and hindbrain, and throughout the spinal region (Fig. 4). Fetal liver samples were subjected to enzyme assay to determine overall activity of the GCS. In $Amt^{-/-}$ mice, overall GCS activity was effectively ablated being below the detection level of the assay (0.01 nmoles of $^{14}CO_2$ formed/gram protein/h), consistent with the Amt^{-} allele being a functional null (22) (Fig. 4). These findings confirm that AMT function is essential for GCS activity, and that the latter is necessary for successful neural tube closure.

Given that GCS is a component of FOCM (Fig. 1), we evaluated the possible prevention of NTDs by folate-related metabolites. Maternal supplementation was performed with folic acid, thymidine monophosphate (TMP), methionine or methionine plus TMP (23). Neither folic acid nor TMP significantly affected the frequency of NTDs among the homozygous $Amt^{-/-}$ offspring. However, we observed a significant protective effect of maternal supplementation with methionine or methionine plus TMP, compared with the non-treated group ($P < 0.05$; Fig. 5).

DISCUSSION

NTDs remain among the commonest human birth defects and understanding their genetic basis presents a considerable challenge owing to their multigenic inheritance and the potential influence of environmental factors, either predisposing or ameliorating. Several lines of evidence indicate a requirement for FOCM in neural tube closure and, therefore, GCS-encoding genes provide excellent candidates for possible involvement in NTD susceptibility. We identified putative mutations in *AMT* and *GLDC* which include a splice acceptor mutation and a number of non-synonymous variants that were absent from a large group of population-matched controls, as well as from public SNP databases. In the case of *GLDC*, enzymatic assay confirmed that several mutations resulted in significant loss of enzyme activity. Finally, *in vivo* functional evidence of a requirement for GCS function in neural tube closure was provided by the occurrence of NTDs in $Amt^{-/-}$ mice lacking GCS activity. Together these findings indicate that mutations in *GLDC* and *AMT* predispose to NTDs in both mice and humans.

Where parental samples were available (6 of the 11 NTD cases that involved putative mutations in *GLDC*), we demonstrated parent-to-child transmission (Supplementary Material, Table S2). Six were instances of maternal transmission and one involved paternal transmission. We hypothesize that absence of an overt NTD phenotype in parents who carry a deficient *GLDC* allele may result from incomplete penetrance, or lack of additional genetic or environmental factors which are predicted to be necessary for NTDs owing to their multifactorial aetiology. We also note that partial penetrance is a feature of numerous mouse models of NTDs (5,8).

Inherited GCS deficiency, owing to mutation of *AMT* and/or *GLDC*, has been shown to cause NKH in humans (17). NKH is a rare, autosomal recessive, inborn error of metabolism, characterized by accumulation of glycine and encephalopathy-like neurological signs, including coma and convulsive seizures in neonates. GCS activity is greatly diminished in NKH patients and they would, therefore, be predicted to be at increased risk of NTDs. It is possible that NTDs may occur in combination with NKH but as anencephaly is a lethal condition, co-existing

NKH would go undetected. Lack of NTDs in NKH patients may also reflect the multigenic nature of NTDs, which require the presence of additional risk alleles in non-GCS genes. NKH is a relatively rare condition, with a prevalence of 1/63 000 births in British Columbia (24) and 1/250 000 in the USA (25). It is therefore possible that an increased risk of NTDs among carriers of GCS mutations in NKH families may not have been noted and this possibility is worthy of investigation. Based on estimated carrier frequency and the incidence of mutations among NTD patients, we predict that NTDs might be expected among 1/150 of the siblings of NKH patients (see Supplementary Material, Table S3 for estimate calculation). One case report of an NKH patient with a *GLDC* mutation describes the additional presence of spinal cord hydromyelia (19). This condition is often associated with low spinal defects (involving secondary neurulation), but it is also possible that the expanded spinal canal was also present at a higher level and might indicate a limited defect in primary neurulation.

The mutations described in the current study were all present in heterozygous form and, therefore, are hypothesized to be insufficient to cause NKH while predisposing to NTDs. For example, in the current study we found four NTD patients and one control individual to be heterozygous for the A569T mutation, which is shown to result in reduced enzyme activity. This mutation was previously identified in a Caucasian patient with typical NKH, in combination with a second mutation, P765S (26), confirming that it is deleterious *in vivo*. Hence, we predict that, depending on the co-existing genetic milieu, the A569T variant may cause NKH, predispose to NTDs or be compatible with normal development.

The high incidence of NTDs in *AMT* mutant mice is particularly notable as NTDs have not previously been found to be a common feature of mouse models deficient for folate-metabolizing enzymes. This includes null mutants that have been reported for eight other genes that encode enzymes in FOCM (Fig. 1A) (27). Four have normal morphology at birth (*Cbs*, *Mthfd1*, *Mthfr* and *Shmt1*) (28–31), *Mthfd2* null embryos die by E15.5 but neural tube closure is complete (32) and null mutants for *Mtr*, *Mtrr* and *Mthfs* die before E9.5, prior to neural tube closure (33–35). Although analysis of mouse mutants has not supported a role for single-gene mutations in FOCM as major causes of NTDs, a requirement for cellular uptake of folate for neural tube closure has been demonstrated in *Folr1* null embryos, in which NTDs occur when rescued from early lethality by folic acid supplementation (36). There is also considerable evidence for possible involvement of gene–environment and/or gene–gene interactions in NTDs. For example, in *Pax3* mutant (*splotch*) embryos, which exhibit a defect of thymidylate biosynthesis, dietary folate-deficiency increases the frequency of cranial NTDs (23,37). Similarly, a diet deficient in folate and choline causes NTDs in *Shmt1* mutant embryos, whereas *Shmt1* and *Pax3* mutations exhibit genetic interaction (38).

Regarding the mechanisms by which GCS mutations affect neural tube closure, a key question is whether NTDs are caused by impairment of FOCM or by another cause such as glycine accumulation. Modelling of hepatic FOCM, based on biochemical properties of folate-metabolizing enzymes (39), predicts that loss of the mitochondrial GCS reaction would reduce the efflux rate of formate to the cytosol by ~50%. This results in reduced synthesis of purines and thymidylate, which are essential for the rapid cell division in the closing neural folds. Interestingly, a UK patient with anencephaly who was found to carry the *GLDC* loss-of-function mutation P509A in the current study (Table 1) was previously found to have impaired thymidylate biosynthesis, assayed in cultured fibroblasts (14). These findings support the hypothetical link between diminished GLDC function, reduced thymidylate biosynthesis and development of NTDs. Reduced thymidylate biosynthesis and diminished cellular proliferation are proposed to underlie folate-related cranial NTDs in *splotch* (*Pax3*) mouse mutants (37,38).

As well as impairment of nucleotide biosynthesis, the predicted effect of diminished GCS activity in reducing production of methionine (39) may also be of relevance as methionine is the precursor for the methyl donor *S*-adenosylmethionine. Indeed, metabolic tracing experiments suggest that ~80% of 1C units in the methylation cycle are generated within mitochondrial FOCM (40). Impairment of the methylation cycle and/or DNA methylation is known to cause NTDs in mice (41) and is proposed as a possible cause of human NTDs (7,42). It was therefore notable that we found a preventive effect of methionine supplementation in $Amt^{-/-}$ mice. Together, these findings suggest that FOCM, required for both thymidylate biosynthesis and methylation reactions that are essential for neural tube closure, may be functionally deficient in individuals who have mutations in *GLDC* or *AMT*.

MATERIALS AND METHODS

Patient cohorts and sequencing

Mutation analysis by DNA sequencing was performed on all exons of *AMT*, *GCSH* and *GLDC* as described (26). Cases comprised Japanese patients with anencephaly ($n = 14$) and two separate cohorts of UK patients with a diagnosis of anencephaly (combined $n = 24$), spina bifida ($n = 122$) or craniorachischisis ($n = 22$). In addition, the exons of *AMT*, *GCSH* and *GLDC* were sequenced in 76 Swedish patients with spina bifida. Unaffected controls, completely sequenced for these genes, comprised 36 Japanese and 189 unrelated UK subjects. Exons found to contain missense mutations were also sequenced in a further cohort of 192 well-characterized UK controls (43) and in 145 Swedish controls. This study was approved by the Ethical Committees of Tohoku University School of Medicine, UCL Institute of Child Health, Newcastle University and the Karolinska Institute.

Enzymatic assay of GCS activity and GLDC activity

GCS activity was measured in mouse liver samples by a decarboxylation reaction using [1-^{14}C]glycine as described (22). For analysis of GLDC activity, wild-type and mutant *GLDC* cDNAs were cloned into pCAG expression vector, kindly provided by Professor Jun-ichi Miyazaki (Osaka University, Japan) (44). Constructs were transfected into COS7 cells, which were harvested as described previously and cell pellets stored at −80°C prior to analysis (45). GLDC

enzymatic activity was determined, in triplicate, by exchange reaction between carbon dioxide and glycine using $NaH^{14}CO_3$ in the presence of excess recombinant bovine GCSH protein as described (22). An expression system of lipoylated bovine GCSH protein in *Escherichia coli* was kindly provided by Dr Kazuko Fujiwara (Tokushima University, Japan) (46). Statistical analysis was performed using SPSS software version 11.0 (SPSS, Inc., Chicago, IL, USA).

Knockout of Amt by insertion of a gene-trap vector

Mice carrying a gene-trap allele of *Amt* (here denoted Amt^{-}) were generated at Lexicon Genetics, Inc. (Houston, TX, USA) using the OST181110 ES cell line. The genomic insertion site of the gene-trap vector was determined by inverse PCR and localized to intron 2 (Supplementary Material, Fig. S1). Total RNA was prepared from the mouse liver and brain at E18 for RT-PCR analysis (Supplementary Material, Fig. S1 and Table S1). $Amt^{+/-}$ mice were backcrossed with wild-type C57BL/6 mice for nine generations to generate a congenic line of mice on the C57BL/6 background, for use in biochemical and histological analyses. This study was approved by the Animal Experiment Committee of Tohoku University.

Maternal supplementation with folic acid and related metabolites

Dams were treated with folic acid (25 mg/kg), thymidine-1-phosphate (TMP; 30 mg/kg) or L-methionine (70 mg/kg) by intra-peritoneal injection, 2 h prior to mating and daily from E7.5–10.5. Doses were based on previous studies (23,47,48).

SUPPLEMENTARY MATERIAL

Supplementary Material is available at *HMG* online.

Conflict of Interest statement. None declared.

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Case report

Epilepsy in RAS/MAPK syndrome: Two cases of cardio-facio-cutaneous syndrome with epileptic encephalopathy and a literature review

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ABSTRACT

We report two individual cases of cardio-facio-cutaneous (CFC) syndrome with severe neurological impairment consisting of infantile spasms with hypsarrhythmia and refractory epilepsy with multifocal epileptic paroxysms such as modified hypsarrhythmia. Both cases shared diffuse brain atrophy and severely delayed myelination on neuroimaging. Genetic analysis revealed individual heterozygous mutations in the KRAS (phenotype of CFC/Noonan syndrome) and BRAF genes (phenotype of CFC syndrome). Neurological impairment in cases with mutations in the RAS/MAPK (mitogen activated protein kinase) signal pathway may be more severe, and could be linked to some forms of refractory epilepsy, especially epileptic encephalopathy that includes infantile spasms.

1. Introduction

Cardio-facio-cutaneous (CFC) syndrome is a very rare and sporadic disease that includes the characteristics of dysmorphic facial appearance, ectodermal abnormalities, cardiac abnormalities, growth retardation and neuro-developmental delay. This syndrome is categorized as one of the RAS/MAPK syndromes, which cause altered signal transduction of the RAS/MAPK (mitogen activated protein kinase) pathway, including BRAF, MEK1/2, and KRAS.[1–3] Compared with other RAS/MAPK syndromes, such as Costello syndrome and Noonan syndrome, CFC syndrome exhibits a more severe phenotype including severe neurological impairment, seizures, and developmental delay. We describe the clinical details of neurological findings in two cases of genetically determined CFC syndrome which displayed refractory epilepsies diagnosed as infantile spasms and other epileptic encephalopathy, and we then compare our results with those of similar literature findings.

2. Case reports

2.1. Case 1: six-year-old boy

A large-for-date boy was delivered as the first child to healthy and non-consanguineous Japanese parents (mother 42 years old and father 31 years old) at 32 weeks of gestational age with a birth weight of 3758 g and with moderate neonatal asphyxia (an Apgar score of 6 at 5 min after birth) following a normal pregnancy. The patient was intensively treated in the neonatal intensive care unit (NICU) in our hospital. Postnatal screening showed fetal hydrops with heart failure due to severe pulmonary valve stenosis which was treated with diuretics and beta blockers. Peculiar craniofacial features included "coarse face," curly hair, prominent forehead, downslanting palpebral fissures, short nose and broad nasal tip with anteverted nares, low-set dysmorphic and posteriorly angulated ears, abnormal skin (loose and pigmented skin with deep furrows and multiple lentigo, wrinkled palms with deep palmar and plantar creases), webbed neck, chest deformity, and micromelic dwarfism (Fig. 1A).

At three days postnatal, myoclonic seizures of the extremities occurred which were controlled by administration of bolus midazolam (MDL). At the age of 11 months, he developed repetitive series-formed tonic spasms, and the interictal electroencephalogram (EEG) showed hypsarrhythmia (Fig. 1C). Valproic acid (VPA), clonazepam (CZP), and zonisamide (ZNS) were ineffective in reducing seizure frequency and improving EEG findings, and complete remission was only obtained by one course of low dose (0.025 mg/kg) adrenocorticotropic hormone (ACTH). Since undergoing ACTH therapy, he has had no episodes of epileptic seizures while undergoing VPA monotherapy until the present age of six years, but his most recent (interictal) EEG showed asynchronous, high-voltage slow waves with irregular spike-waves, or polyspikes with/without waves dominantly in the right temporal-occipital region (Fig. 1D). Magnetic resonance imaging (MRI) at three years of age revealed agenesis of the corpus callosum, ventricular dilatation, diffuse cortical atrophy and severely delayed myelination (Fig. 1B). Tracheotomy was performed and persistent mechanical ventilation

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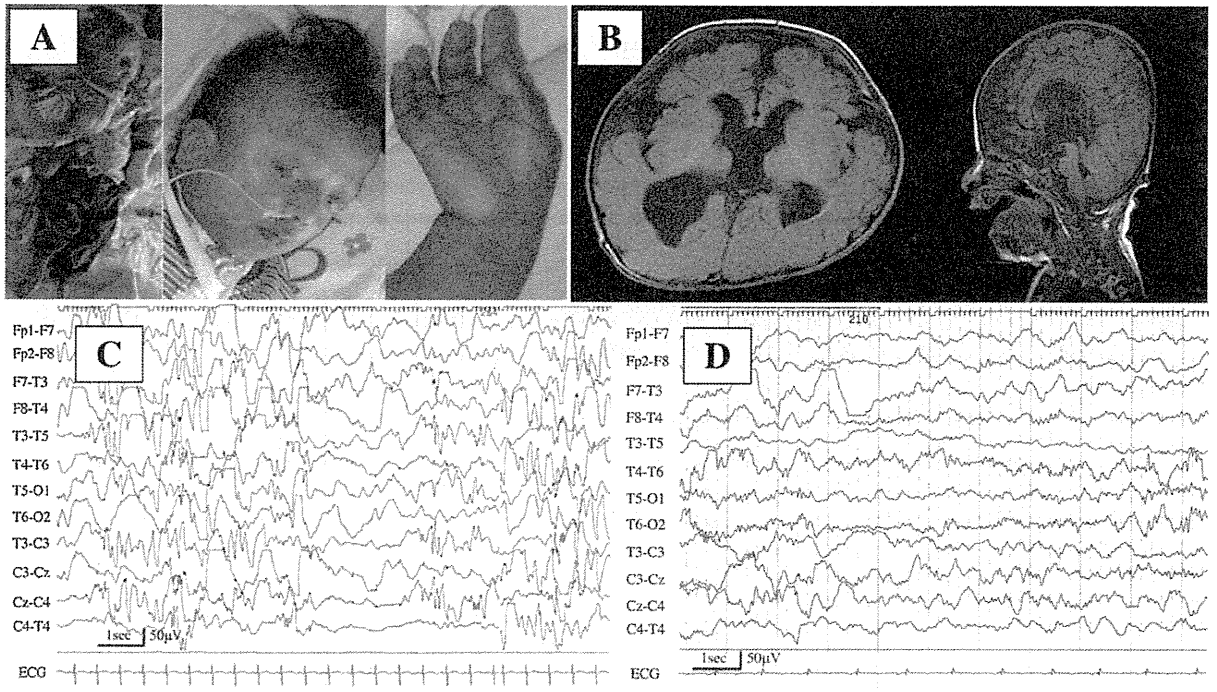

Fig. 1. Case 1. "Coarse face," curly hair, prominent forehead, dysmorphic ears, abnormal loose and pigmented skin, webbed neck, chest deformity, and micromelic dwarfism at six years (A), agenesis of the corpus callosum, ventricular dilatation, diffuse cortical atrophy and severely delayed myelination on MRI images at three years (B), hypsarrhythmia at 11 months (C), asynchronous, high-voltage slow waves with irregular spike-wave or polyspikes with/without waves dominantly in the right temporal-occipital region at six years of age (D) on EEG.

was initiated for severe dyspnea with laryngo/tracheomalacia. Percutaneous endoscopic gastrostomy (PEG) was performed for repetitive aspiration pneumonia caused by dysphagia. He has been diagnosed as mentally retarded and had not developed any expressive language. Additionally, he suffers from truncal hypotonia with increased muscle tone and joint contractures in his extremities. He has been profoundly delayed in terms of physical and mental development due to his severe motor and intellectual disabilities.

His karyotype was 46,XY and genetic screening confirmed a heterozygous nucleotide change within exon 5 of the KRAS gene (c.458A > T), causing the amino acid substitution D153V, whose phenotype was CFC/Noonan syndrome.

2.2. Case 2: four-year-old girl

An appropriate-for-date girl (35 weeks of gestational age with a birth weight of 2624 g) without asphxial episodes was born to healthy and non-consanguineous parents (mother 30 years old and father 35 years old) who had previously given birth to three healthy baby girls. Following delivery, several surface anomalies were noted, such as an odd-looking "coarse" face (prominent forehead, short nose and broad nasal bridge with anteverted nares, downslanting palpebral fissures, and low-set dysmorphic ears), curly and sparse hair, abnormal skin manifestations (loose, pigmented skin with multiple lentigo, wrinkled palms with deep palmar and plantar creases), narrow chest, and hypotonic micromelic dwarfism (Fig. 2A). Postnatal screening revealed cardiac failure due to severe hypertrophic cardiomyopathy, resulting in chronic heart failure, which necessitated the administration of diuretics and beta blockers.

On admission to our NICU, a subtle seizure occurred and was only controlled following the infusion of phenobarbital (PB) and MDL. After this episode, seizures have been severely refractory and uncontrolled despite the use of a majority of antiepileptic drugs, including PB, VPA, CZP, ZNS, carbamazepine, phenytoin, primidone, nitrazepam, clobazam, topiramate, lamotirigine, gabapentin, levetiracetam. Seizures are composed of repetitive brief tonic spasms, tonic-clonic (sometimes developing to status epileptics), myoclonic, and complex partial seizures (sometimes evolving to generalized tonic-clonic seizure [GTCS]), all occurring daily and frequently. Interictal EEG revealed modified hypsarrhythmia at one year of age (Fig. 2C), and her most recent (interictal) EEG showed continuous high-voltage spike or polyspikes with/without slow waves mainly in the left centro-temporal-parietal region at four years of age (Fig. 2D). ACTH therapy has not been introduced because of moderate cortical atrophy with delayed myelination and hypoplastic corpus callosum on cranial MRI images noted at two years of age (Fig. 2B). In addition to seizures, she has exhibited frequent involuntary movement, consisting of dystonia, athetosis, and myoclonus, all resistant to various muscle-relaxant drugs.

She had frequently developed episodes of dyspnea due to congenital laryngo/tracheomalacia, which resulted in tracheotomy and persistent mechanical ventilation during night sleep before two years of age, but recurrent aspiration pneumonia caused by dysphagia finally required PEG. She has been profoundly mentally retarded and unable to speak any words. She has been unable to sit unassisted because of general hypotonia and joint contractures in her extremities. Overall, she has exhibited severe motor and intellectual disabilities.

Her karyotype was 46,XX and advanced genetic screening confirmed a heterozygous nucleotide change within exon 12 of the BRAF gene (c.1454T > C), causing the amino acid substitution L485S, whose clinical phenotype was CFC syndrome.

3. Discussion

The different types of RAS/MAPK syndrome have many overlapping characteristics, including craniofacial manifestations, cardiac malformations, cutaneous, musculoskeletal, gastrointestinal, ocular abnormalities, and neuro-cognitive impairment,

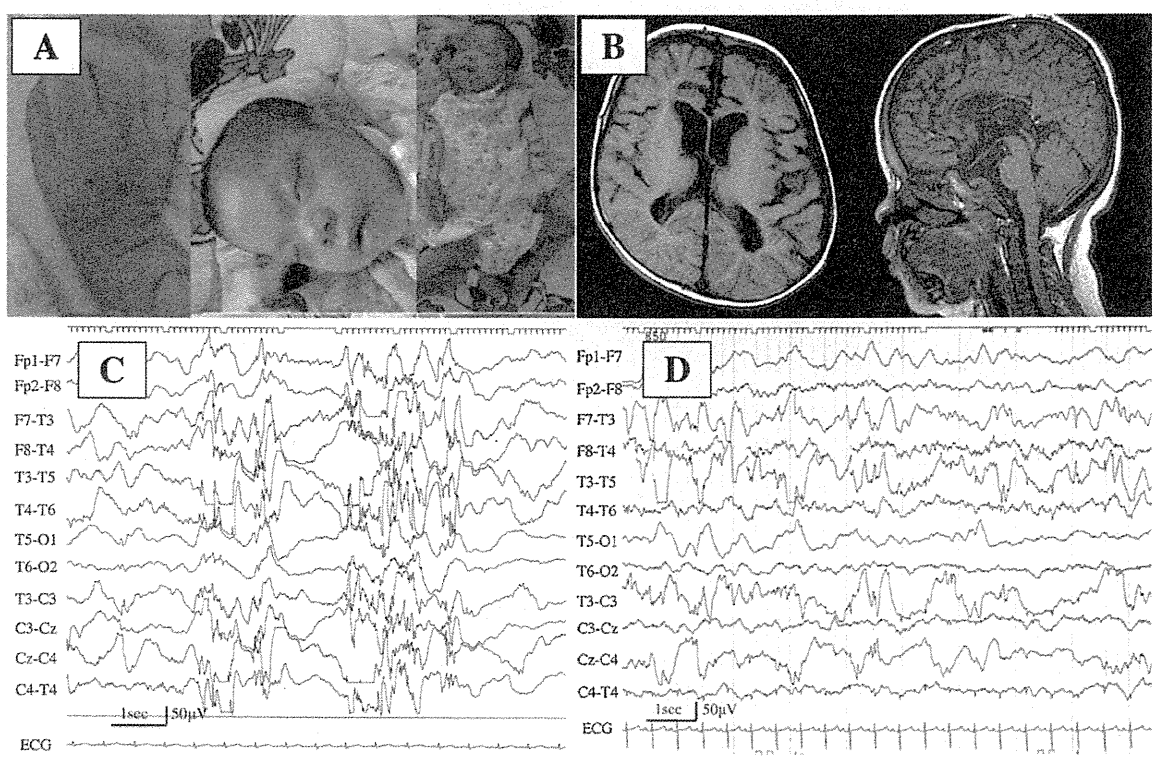

Fig. 2. Case 2. Odd looking "coarse" face (prominent forehead, short nose, and low-set dysmorphic ears, curly sparse hair), abnormal loose, pigmented skin with multiple lentigo, narrow chest, and hypotonic micromelic dwarfism at four years (A), diffuse brain atrophy with delayed myelination and hypoplastic corpus callosum on MRI images at two years (B), modified hypsarrhythmia at one year (C), and continous high-voltage spike or polyspikes with/without slow waves mainly in the left centrotemporalparietal region at four years of age (D) on EEG.

including hypotonia and seizures, caused by dysregulation of signaling in the RAS/MAPK pathway due to mutations mainly in BRAF, MEK1, or MEK2.[1–3] Correlation between confirmed mutations and non-neurological, cardiovascular, cutaneous, and musculoskeletal abnormalities in CFC patients have been discussed,[1–3] but detailed analyses of their associated neurological impairments, especially epileptic conditions, have been sorely lacking.

Only a few previous reports[4–10] of CFC syndrome mentioned associated neurological impairment, especially seizures and EEG findings, but were lacking in terms of their detailed clinical features and courses. Gross-Tsur et al. described the neurological status of 16 patients with CFC syndrome (genetically undetermined cases) in their report with a literature review,[4] including six EEG findings (generalized dysrhythmia [grade, and ungraded], low voltage, focal activity, and episodes of spike and slow 2 Hz with slow background activity). Recently, Yoon et al. mentioned the seizure types and EEG findings in 12 of 15 cases, including four cases of infantile spasms with hypsarrhythmia on EEG.[7] Moreover, Aizaki et al. reported a case of CFC syndrome with infantile spasms, suggesting that seizures with CFC syndrome were refractory despite the administration of various types of anticonvulsants and that the neuro-developmental delay caused by CFC syndrome is severe.[10]

Both cases in the present report exhibited infantile spasms with severely abnormal EEG (modified hypsarrhythmia). Case 1 has been remitted with ACTH therapy and Case 2 remains uncontrolled despite the administration of various types of anticonvulsants. Upon reviewing previous literature[4–10] describing the epileptic conditions and neuroimages in patients with cardio-facio-cutaneous syndrome (Table 1), 62 cases were discovered which mentioned their epileptic condition which included 12 cases (19.3%) with infantile spasms or brief tonic spasms, each of which were accompanied by hypsarrhythmia or modified hypsarrhythmia on EEG. Other cases also develop various types of seizures, GTCS (sometimes evolving to status epileptics), and complex partial seizure, with severe abnormal EEG, consisting of generalized or partial epileptiform activities. Most of the seizures in these patients still remain uncontrolled despite the use of various types of anticonvulsants. Based on the two present cases and the literature review, the high complication rate of infantile spasms in CFC syndrome suggests that there may be specific factors relating to refractory epilepsy, especially epileptic encephalopathy, in the RAS/MAPK signaling pathway.

As for correlations between genotype and epileptic phenotype, D153V mutation in the KRAS gene (as seen in Case 1) was previously reported[11–13] in six cases (two of CFC syndrome, three of Noonan syndrome, and one of CFC/Noonan syndrome), but in none of these cases did the patient develop seizures. Accordingly, this mutation may be unrelated to epileptic severity. On the other hand, it is noteworthy that the mutation L485S in the BRAF gene (as seen in Case 2) has been recently reported to be detected in a patient of CFC syndrome with infantile spasms following a refractory therapeutic course.[10] This point mutation may be related to the severity of epileptic conditions in RAS/MAPK syndrome. In addition, this report[10] described the efficacy of a ketogenic diet (KD) to reduce seizure frequency, but in the present Case 2 patient with the same mutation in the BRAF gene, KD has not been introduced because of severe thinness despite adequate tube nutrition.

In a recent report of CFC patients, neuroimaging played an important role in the diagnosis of this syndrome.[14] Most of the 62 patients with CFC syndrome in the present review shared severe abnormal neuroimaging, including hydrocephalus, agenesis/hypoplasia of the corpus callosum, ventricular dilatation, cortical

Table 1
Epileptic conditions and neuroimages in patients with cardio-facio-cutaneous syndrome: present cases and those from a literature review.

Ref.	Gene	Mutation	Sex	Age of seizure onset	Seizure type	Interictal EEG findings	Anticonvulsant therpay	Seizure prognosis	Neurodevelopmental delay	Neuroimaging (brain MRI)
Gross-Tsur et al.[4] ($n=1$)	N.A.	N.A.	M	1 y 9 mo	Lennox–Gastaut syndrome	Multiple episodes of spike and slow wave activity, 2 Hz. The background activity was abnormally slow.	VPA, CZP	Decrease in seizures	Hypotonia, ataxia, lack of language skill, extreme hyperactivity	Normal
Raymond and Holmes[5] ($n=2$)	N.A.	N.A.	F	–	No seizure	Decrease in anterior voltages, no epileptiform activity (postnatal screening)	–	–	No motor delay, marked language delay	External hydrocephalus with widened subarachnoid space, cortical atrophy in the frontal and temporal lobes (CT)
	N.A.	N.A.	M	–	No seizure	N.A.	–	–	No motor delay, marked language delay	Marked cortical atrophy (CT)
Sabatino et al.[6] ($n=2$)	N.A.	N.A.	M	1 y 3 mo	Tonic-clonic (SE)	Focal activity in the bilateral posterior areas	N.A.	N.A.	Moderate to severe	Cortical atrophy, ventriculomegaly
	N.A.	N.A.	F	6 y	GTCS	Irritative waves and generalized disorganization, frequent focal spikes in the right regions, sometimes in contralateral areas.	PB	Controlled	Moderate to severe	Diffuse cortical atrophy
Yoon et al.[7] ($n=15$)	MEK1	F53S	F	15 y 10 mo	GTCS, Abs, CPS	Generalized spikes/slow waves ($n=5$), hypsarrhythmia ($n=4$), focal epileptiform discharges ($n=3$)	ZNS, LEV	Not described in detail. Polytherapy required in 9 of 15 cases, suggesting that seizure control is often difficult.	Severe	Ventriculomegaly and hydrocephalus (66%), prominent Vircho- Robin spaces (20%), cortical atrophy, prominence of CFS spaces wih macrocephaly, benign extraventricular obstructive hydrocephalus. (some cases)
	BRAF	L485F	M	2 wk	CPS, sGTCS, Abs		OXC, DZP,		Severe	
	BRAF	F468S	F	11 y	GTCS		CBZ, PB		Profound	
	BRAF	Q257R	M	2 y 6 mo	Abs, focal		VPA		Mild	
	BRAF	del E11	F	1 y 6 mo	IS		TPM, CZP, VPA, PSL		Severe	
	BRAF	Q257R	M	3 y	Not specified		CBZ		Severe	
	BRAF	F595L	F	6 mo	IS, vocal motor, CPS		Felbamate, ZNS, CZP		Profound	
	BRAF	T599R	F	3 y	Not specified		OXC		Profound	
	BRAF	G534R	M	5 y	GTCS, Abs		OXC		Profound	
	BRAF	L485S	M	4 mo	GTCS, CPS, IS		TPM, CZP, VPA, DZP		N.A.	
	MEK1	Y130C	F	2y	Not specified		LEV		N.A.	
	BRAF	D638E	F	1 y 6 mo	GTCS, Abs		LEV, PHT		Profound	
	BRAF	K499N	F	7 mo	GTCS, Abs		LTG, CBZ, CZP		Severe	
	MEK1	Y130N	F	1 y	CPS		OXC		Profound	
	MEK1	G128V	F	5 mo	IS		PB, LTG, VPA, CZP		N.A.	

Table 1 (*Continued*)

Ref.	Gene	Mutation	Sex	Age of seizure onset	Seizure type	Interictal EEG findings	Anticonvulsant therpay	Seizure prognosis	Neurodevelopmental delay	Neuroimaging (brain MRI)
Armour and Allanson[8] ($n=38$)	BRAF (15/32 cases) MEK1(2/4 cases) MEK2(1/2 cases)	N.A.	N.A.	IS ($n=5$), Abs ($n=4$), GTCS ($n=4$), CPS ($n=4$)	N.A.	N.A.	Respondents 49%	All significant delay (available in 27cases)	Hydrocephaly (2), ventriculomegaly (9), reduced white matter (6), thin corpus callosum (3), cerebral atrophy (3), delayed myelination (3), Chiari 1 malformation (1), pachygyria (1), nodulat heterotopia (1), abnormal migration (1), cerebellar calcification (1) available on 23 cases)	
Demir et al.[9] ($n=1$)	BRAF	F468S	F	N.A.	Recurrent clonic seizures	Epileptiform discharges in the right front central temporal region	VPA, CBZ, TPM	Controlled	Mental/motor/ language delay	Mild frontoparietal cortical atrophy, mildly dilated ventricles, thinning of the posterior part of the corpus callosum
Aizaki et al.[10] ($n=1$)	BRAF	L485S	F	2 mo	Brief tonic spasms (repetitive)	Asynchronous, high-voltage slow waves with multifocal sharp waes appeared with bilateral pariet-occipital predominance	VPA, VitB6, ZNS, CLB, PB, ACTH, KD, Clorazepate dipotassium	Uncontrolled	Profound	Hypoplastic corpus callosum, moderate brain atrophy, delayed myelination, ambiguous coorticomedullary boundary in the right posterior temporal lobe
Present cases ($n=2$)	KRAS	D153V	M (Case 1)	3 mo/11 mo	Myo/IS	Hypsarrhythmia (at 11 mos), asynchronous, high-voltage slow waves with irregular spike-wave, or polyspikes with/without waves dominantly in the right temporal-occipital region (at 6 yrs)	MDL/VPA, CZP, ZNS, ACTH	Controlled	Profound	Diffuse cortical atriphy, ventricular dulatation, agenesis of the corpus callosum, delayed myelination
	BRAF	L485S	F (Case 2)	Day 0	Subtle, brief tonic spasms, CPS, GTCS	Modified hypsarrhythmia (at 1 yr), Continous high-voltage spike or polyspikes with/without slow waves in the left centro-temporalparietal region (at 4 yrs)	MDL, VPA, CZP, NZP, PB, CBZ, ZNS, CLB, PHT, PRM, GAP, TPM, LTG, LEV, TRH, ST	Uncontrolled	Profound	Diffuse cortical atrophy, ventricular dulatation, hypoplastic corpus callosum, delayed myelination

GTCS: generalized tonic-clonic seizure, sGTCS: secondarily generalized tonic-clonic seizure, CPS: complex partial seizure, Abs: absence seizure, Myo: myoclonic seizure, IS: infantile spasms, SE: status epileptics, Subtle: subtle seizure.

PB: phenobarbital, VPA: valproic acid, CBZ: carbamazepine, ZNS: zonisamide, PHT:pheytoin, PRM: primidon, CZP: clonazepam, CLB: clobazam, NZP: nitrazepam, DZP: diazepam, MDL: midazolam, ST: sultiame, VitB6: vitamin B6, GAP: gabapentin, TPM: topiramate, LTG: lamotrigine, LEV: levetiracetam, OXC: oxcarbazepine, ACTH: adrenocorticotropic hormone, PSL: prednisone, KD: ketogenic diet, CSF: cerebrospinal fluid, MRI: magnetic resonance image, CT: computed tomography, SE: status epilepticus, N.A.: not applicable.

atrophy, and delayed myeliation, resulting in neuro-developmental delay ranging from 'moderate to severe' to 'profound', all of which distinguish CFC syndrome from the other types of RAS/MAPK syndrome (Noonan and Costello syndromes).

More cases will need to be studied in order to clarify the genotype–phenotype correlations of several genes in the RAS/MAPK signaling pathway associated with refractory epilepsy.

Conflict of interest

The authors report no conflict of interest.

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