



PP1-229. GROWTH AND SYNDROMES (TO INCLUDE TURNER SYNDROME) 2
“Endocrine evaluation of 29 Cornelia de Lange Syndrome patients (CdLS)”

Ascaso A, Romero de Ávila M, Llorente M, Trujillano L, Ramos F, Pie J, Bueno G.
Servicio de Pediatría, Hospital Clínico Universitario “Lozano Blesa”, Zaragoza, España

INTRODUCTION AND OBJECTIVES

Cornelia de Lange (CdLS) syndrome (OMIM #122470) is a complex disease, characterized by distinctive facial features, failure to thrive, microcephaly, intrauterine growth retardation and anomalies in multiple organ systems. The complexity and severity of the endocrine commitment is variable. *NIPBL*, *SMC1A*, *SMC3*, *RAD21* and *HDAC8* genes, all involved in the cohesin pathway, have been identified to cause CdLS. There are few published studies on the endocrine evaluation in these patients; so our study is aimed at expanding our knowledge in this broad field of research.

METHODS

A descriptive study of 29 Spanish patients diagnosed with CdLS was performed. We have analyzed the different metabolic, anthropometric variables. A complete study was carried out, genetic testing and analyzing different endocrine axes including thyroid, adrenal, growth, gonadal, lipid, phosphocalcic and metabolic study.

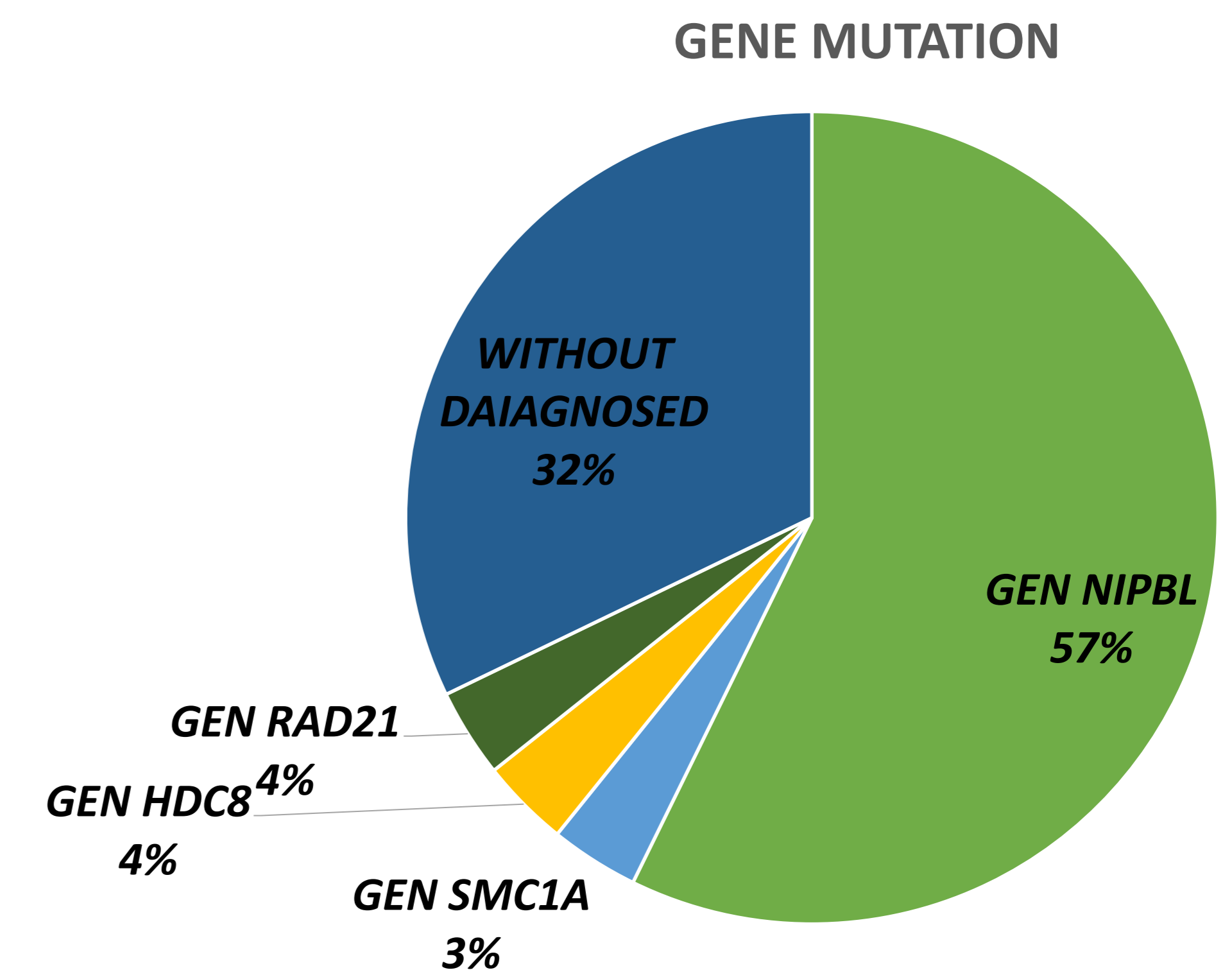
RESULTS

BACKGROUND	TOTAL(n=29)	
Gestational		
- Pregnancy control	n (%)	29 (100)
- Gestational diabetes	n (%)	2 (7,7)
- IUGR*	n (%)	10 (38,5)
- Caesarean	n (%)	9 (33,3)
- Hypoglycemia	n (%)	6 (20,7)
- Admission neonatology	n (%)	17 (63)
- Breastfeeding	n (%)	8 (29,6)
Family		
- Delayed or early puberty	n (%)	6 (22,2)
- Obesity	n (%)	7 (25,9)
- Autoimmune disease	n (%)	15 (55,6)

Table 1. Family and gestational background
*IUGR: Intrauterine growth restriction

PERINATAL HISTORY	TOTAL (n=29)	
- Male	n (%)	10 (34,5)
- Premature < 37 SG	n (%)	15 (51,7)
- Birth weight (g)	$\bar{x} \pm DE$	2371,1 \pm 528
- Birth weight W < -2 DE	n (%)	9 (31)
- Birth length (cm)	$\bar{x} \pm DT$	44,4 \pm 3,69
- Birth length < -2 DE	n (%)	13 (44,8)
- Cranial perimeter (cm)	$\bar{x} \pm DT$	30,4 \pm 1,9

Table 2. Perinatal history of CdLS patients



Gráphe 1. Gene mutations of CdLS patientes

ANTHROPOMETRY	TOTAL (n=29)	
Weight(Kg)	$\bar{x} \pm DE$	34,70 \pm 23,90
Weight (SDS)	$\bar{x} \pm DE$	-1,30 \pm 1,80
Height (cm)	$\bar{x} \pm DE$	123,5 \pm 26,40
Height(SDS)	$\bar{x} \pm DE$	-3,3 \pm 1,90
BMI (Kg/m2)	$\bar{x} \pm DE$	19,99 \pm 8,31
BMI (sds)	$\bar{x} \pm DE$	0,11 \pm 2,40
Head circumference (cm)	$\bar{x} \pm DE$	49,50 \pm 4,70
Head circumference (SDS)	$\bar{x} \pm DE$	-2,92 \pm 2,60
Waist circumference (cm)	$\bar{x} \pm DE$	64,30 \pm 15,60
Waist circumference (SDS)	$\bar{x} \pm DE$	-0,40 \pm 1,70

Table 3. Current anthropometry of CdLS patientes

BIOCHEMISTRY	TOTAL (n=24)	
Glycemia (mg/dl)	$\bar{x} \pm DE$	88,5 \pm 10,30
Triglycerides (mg/dl)	$\bar{x} \pm DE$	123 \pm 74,70
Total cholesterol (mg/dl)	$\bar{x} \pm DE$	164,2 \pm 38,7
HDL cholesterol (mg/dl)	$\bar{x} \pm DE$	45,8 \pm 9,20
LDL cholesterol (mg/dl)	$\bar{x} \pm DE$	93,7 \pm 33,60
Insulin (microU/ml)	$\bar{x} \pm DE$	15,60 \pm 9,90
HOMA IR	$\bar{x} \pm DE$	4,09\pm4,30
Calcium (mg/dl)	$\bar{x} \pm DE$	9,62 (0,55)
Phosfores (mg/dl)	$\bar{x} \pm DE$	3,81 (0,97)
25-0h-vitamin D (ng/ml)	$\bar{x} \pm DE$	24,30 (5,26)

Table 4. Biochemistry variables of the sample

HORMONAL	TOTAL (n=24)	
ACTH (pg/ml)	$\bar{x} \pm DE$	30,73 (37,37)
Cortisol (mcg/dl)	$\bar{x} \pm DE$	10,21 (4,47)
Androstendiona (ng/ml)	$\bar{x} \pm DE$	1,55 (1,00)
17-OH-PG (ng/ml)	$\bar{x} \pm DE$	0,77 (0,44)
Prolactin (ng/ml)	$\bar{x} \pm DE$	26,03 (19,80)
TSH (mU/mL)	$\bar{x} \pm DE$	1,78 (1,12)
T4 Free (ng/dL)	$\bar{x} \pm DE$	1,22 (0,18)
IGF1 (ng/mL)	$\bar{x} \pm DE$	173,68 (83,69)
IGFBP3 (mcg/mL)	$\bar{x} \pm DE$	4,36 (1,46)
PTH (pg/ml)	$\bar{x} \pm DE$	40,11 (18,21)
LH (mU/ml)	$\bar{x} \pm DE$	6,66 (4,64)
FSH (mU/ml)	$\bar{x} \pm DE$	4,35 (2,95)
Testosterone	$\bar{x} \pm DE$	0,6 (1,00)

Table 5. Descriptive study hormonal variables

CONCLUSIONS

Our patients have growth retardation, most of them with prenatal onset, according to the clinical criteria of CdLS. Only few reports have commented on endocrine abnormalities in CdLS. In our sample of 29 CdLS patients serious alterations are not observed; however, it is important to carry out an endocrine evaluation, for each individual patient, in order to understand and be able to assess their metabolism adequately.

REFERENCES

Schwartz et al. Endocrinopathies in Cornelia de Lange syndrome. J Pediatr. 1990 Dec;117(6):920-3. EXPERT CONSENSUS DOCUMENT. Antonie D. Kline. Joanna F. Moss. Angelo Selicorni. Diagnosis and management of Cornelia de Lange syndrome: first international consensus statement. NATURE REVIEWS | GENETICS. Lynette A. Gillis, Jennifer McCallum. NIPBL Mutational Analysis in 120 Individuals with Cornelia de Lange Syndrome and Evaluation of Genotype-Phenotype Correlations. Am. J. Hum. Genet. 75:610-623, 2004.. Mora-Bautistaa et al.. Contreras-García,c. Cornelia de Lange Syndrome and multiple hormonal deficiency, an unusual association. Clinical case. Arch Argent Pediatr 2017;115(3):e170-e174. Michael de Graaf et al. Successful Growth Hormone Therapy in Cornelia de Lange Syndrome. J Clin Res Pediatr Endocrinol 2017;9(4):366-370