Phenotypic expression in mucopolysaccharidosis VII


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SUMMARY  β-glucuronidase deficiency is an extremely rare disorder which is known to have a considerable phenotypic variation. A survey of the clinical findings in 19 previously reported patients with mucopolysaccharidosis VII is presented together with the results of clinical and biochemical studies in two further patients. Because a similar clinical picture is present in a heterozygotic sister it is doubted whether all signs and symptoms can be attributed to the β-glucuronidase deficiency. The probability of a concomitant disorder is discussed. Diagnosis was made both by demonstration of the deficiency in plasma and leucocytes, and by means of hair root analysis. The phenotypic variation and the fact that increased levels of glycosaminoglycans were not found in the urine of the two patients lead to the suggestion that in certain cases a correct diagnosis may be missed if the β-glucuronidase activity in plasma and leucocytes is not determined and only routine urine investigation is performed as a screening for a mucopolysaccharidosis. Hair root analysis may be a useful method to measure the β-glucuronidase activity.

Since the first description of abnormal mucopolysacchariduria in a girl with Hurler syndrome,1 several types of mucopolysaccharidoses have been recognised.2 Mucopolysaccharidosis type VII (MPS VII: β-glucuronidase deficiency) was first clinically observed by Sly et al3 in a young child; the enzyme defect in this patient's fibroblasts was established by Hall et al.4 Since then, 19 patients have been reported (table 1)3 5–18 with a considerable phenotypic variation. Sewell et al14 discerned three groups of patients on clinical grounds.

We had the opportunity to study two siblings (24 and 39 years old) with MPS VII. They are the oldest patients to be reported with this condition. We present our clinical and biochemical findings together with a survey of the 19 patients so far reported.

Case reports

Case 1

This man, born in 1945, was the first child of healthy non-consanguineous parents. Pregnancy and delivery were uneventful. Psychomotor development was severely retarded. He was able to walk at the age of 4 years and up to now speech is limited to 3-word sentences. At the age of 8, he had to be institutionalised because of behavioural disturbances, especially aggressive outbursts. There is no history of recurrent respiratory infections. Since 1979 he has been suffering from tonic seizures, which are difficult to control. The occurrence of the seizures is associated with moments of stress.

Physical examination showed a severely mentally retarded patient with a height of 1·70 m. He had microcephaly (head circumference <2·5 th percentile) and a coarse facies. The neck was short, the thorax normal. The abdomen showed no abnormalities, and more particularly, there was no evidence of organomegaly or herniae. The vertebral column was normal. The joints were rather stiff. Further general, neurological and ophthalmological examinations revealed no abnormalities.

Case 2

This woman, born in 1960, is a sister of patient 1. Pregnancy and delivery were uneventful. Psychomotor development was mildly retarded. As a child she had been able for a few years to receive school education at a school for learning disabilities. Because of progressive mental deterioration she was institutionalised at the age of 18 years. At the age of 19 she had her first tonic clonic seizure. Later sporadic absences were observed. At the moment the epilepsy is being controlled with medication. Further amnnesia is unremarkable.

Physical examination showed a mentally retarded patient with a height of 1·50 m. Head circumference was between the 2nd and 10th percentiles. Her facial features were not coarse. Thorax and abdomen were, except for a mild
diffuse
voltage fast
frontal
the
normal pattern in the
to
spike
eral
activity
performed.
Electrophysiological
studies
investigations.
Radiological
showed no
microcephaly
medication. Physical examination showed
larities.
epilepsy,
in
are
in
years. Since
she was 15, she
coarse.
mental
retardation or other relevant particulars.
Once the diagnosis was established in the institutionalised
members of the family, the parents refused all further investigations. The healthy family members refused blood
analysis for carrier detection.
Radiological studies
Radiographs of skull, chest, ribs, spine, hands and feet of
case 1 as well as computed tomography scanning were normal. Radiological studies of case 2 and the sister were not performed.
Electrophysiological studies
The EEG of case 1 showed a low-voltage fast background activity with bilateral but predominantly right-sided tempo-
ral sharp theta paroxysms. Later recordings showed diffuse spike to wave complexes. The EEG of case 2 demonstrated a normal pattern in the posterior region but too much diffuse fast activity. Bilateral paroxysmal irritation existed in the frontal regions. The EEG of the sister showed a low
voltage fast pattern.

Table 1 Summary of clinical signs and symptoms of both 19 previously reported cases with mucopolysaccharidosis type VII
and the authors' cases

<table>
<thead>
<tr>
<th>Review of literature</th>
<th>Group I*</th>
<th>Group II†</th>
<th>Group III‡</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Sibling of cases 1 and 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coarse facies</td>
<td>6/6</td>
<td>9/9</td>
<td>2/4</td>
<td>+</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Corneal clouding</td>
<td>2/6</td>
<td>4/9</td>
<td>1/4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Short neck</td>
<td>2/6</td>
<td>3/9</td>
<td>0/4</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>3/6</td>
<td>7/9</td>
<td>0/4</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Sternal protrusion</td>
<td>3/6</td>
<td>6/9</td>
<td>0/4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Recurrent respiratory infections</td>
<td>2/6</td>
<td>7/9</td>
<td>1/4</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Splenomegaly</td>
<td>6/6</td>
<td>6/9</td>
<td>1/4</td>
<td>-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Diastasis recti</td>
<td>1/6</td>
<td>5/9</td>
<td>0/4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Herniae</td>
<td>4/6</td>
<td>5/9</td>
<td>0/4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Metatarsus adductus/taipes equinovarus</td>
<td>4/6</td>
<td>4/9</td>
<td>1/4</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Dysostosis multiplex</td>
<td>5/6</td>
<td>9/9</td>
<td>0/4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Granulations</td>
<td>4/6 (2 NR)</td>
<td>3/9 (6 NR)</td>
<td>4/4</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Mucopolysacchariduria</td>
<td>4/6 (2 NR)</td>
<td>9/9</td>
<td>4/4</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0/6</td>
<td>0/9</td>
<td>0/4</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

*Reference numbers 7, 12, 13, 15-17, †3, 6, 8, 10, 11, 14, 18, ‡5, 7, 9
NR = not reported.

splenomegaly, normal. The thoracolumbar spine showed a scoliosis to the left. A slight hirsutism was present. Further general and neurological examination showed no abnormalities.

Family history
A second sister, born in 1952, turned out to be a carrier of
MPS VII. She had a non-progressive severely retarded psy-
chomotor development and was institutionalised at the age of
17 years. Since she was 15, she has been suffering from sporadic tonic clonic seizures, which are being controlled with medication. Physical examination showed a severely mentally retarded patient with a height of 1-50m and a
microcephaly (head circumference < 2.5th percentile). Her facies was coarse. Further general and neurological examination showed no abnormalities.

All the remaining family members, three siblings included, are in good health and the family history gives no evidence of epilepsy, mental retardation or other relevant particulars.

Once the diagnosis was established in the institutionalised members of the family, the parents refused all further investigations. The healthy family members refused blood analysis for carrier detection.

Routine laboratory studies
The following laboratory tests and data of all three patients were normal: complete blood cell count, urinalysis, renal and hepatic function tests, serum electrolyte levels, serum protein content and creatine kinase. Appropriate studies ruled out endocrinological, immunological, chronic infectious or metabolic diseases, deficiencies, and disorders caused by toxic agents.

Chromosomes of case 1 were normal (G-banding).

Specific laboratory studies
Biochemical methods
β-glucuronidase in leucocytes was assayed on a Cobas cen-
trifugal analyser (Hoffmann-La Roche, Basel, Switzerland) at 37°C using 4-MU-beta-D-glucuronide (Koch-Light, Colnbrook, England, no 4012-00) as a substrate. The sub-
strate concentration during the incubation amounted to
40 mmol/l, 10 μl sample and 125 μl 0-1 mol/l NaAc/HAc buffer pH 4-2 containing the substrate were incubated for 7
minutes. The reaction was stopped with 75 μl of 0-83 mol/l glycine buffer pH 10. Fluorescence was measured using a primary wavelength of 367 nm and a secondary band filter passing light having wavelengths between 445 and 455 nm. Plasma glucuronidase was assayed manually using a similar method. Enzyme analyses were also carried out with the substrate para-toluidine-β-D-glucuronide (Koch-Light, Colnbrook, England, no 4281-H).

Urine analysis
Bound uronic acid was determined according to Di Ferrante et al., while the method of Abeling et al. was used for two-
dimensional electrophoresis of urinary glycosaminoglycans.

Hair root analysis
Enzyme activity in hair roots was expressed as a ratio between β-glucuronidase and acid phosphatase activities. The latter enzyme was determined as described by Vermorken et al. The enzymes were extracted from the hair roots by five cycles of freezing (−20°C) and thawing in 75 μl
Table 2  Lysosomal enzymatic activity in leucocytes (nmol/h/mg protein) and in plasma (nmol/h/ml)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
<th>Sister</th>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein (mg/l)</td>
<td>Leucocytes</td>
<td>Plasma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>238</td>
<td>32</td>
<td>20</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>520</td>
<td>44</td>
<td>55</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>498</td>
<td>362</td>
<td>197</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>345</td>
<td>396</td>
<td>236</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>83</td>
<td>91</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>297</td>
<td>943</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>170–567</td>
<td>400–1450</td>
<td>55–478</td>
<td></td>
</tr>
</tbody>
</table>

ND = not determined.

Results

Biochemical analysis

The deficiency of β-glucuronidase has been established in leucocytes, plasma and hair roots of both patients (table 2, fig 1). Hair root analysis has been carried out in case 1 as well as in four controls. For the latter, essentially similar results were obtained. The enzymatic activity in 14 hair roots of case 1 was in all cases <9% of the mean activity found in the controls. The mean residual activity in his hair roots was 3.5% of the mean activity in controls. There was no overlap in activity between hair roots of case 1 and that of the controls. Table 2 shows the enzymatic activity found in plasma and leucocytes of the family members. Both cases are deficient in enzymatic activity. One sib (the second sister) and her mother seem to have intermediate values indicating a heterozygosity for the defect. β-glucuronidase activity in plasma and leucocytes measured with paranitrophenol-β-D-glucuronide as a substrate, gave essentially similar results (table 2). Other lysosomal enzymes in this family, like N-acetyl-β-glucosaminidase, showed levels within the reference range of leucocytes and plasma (data not shown). Fibroblasts of case 1 have been kept in culture but failed to grow under normal culturing conditions.

Storage products

No elevated uronic acid values could be detected in the urine samples of case 1 and the second sister. A slightly increased value was found in case 2 (8·8 mg uronic acid/mg creatinine; age-matched reference <6·2). The alcian blue spot test was negative in all cases. Two-dimensional electrophoresis of the urine of case 1 showed only small amounts of chondroitin sulphate.

The peripheral granulocytes of cases 1 and 2 showed cytoplasmic vacuoles with the aspect of Alder-Reilly granulation. Those of the sister were

Fig 1  β-glucuronidase activity in hair roots of case 1 and control.
had exhibited only very mild symptoms, often diagnosed at adolescence.

MPS VII is an autosomal recessive hereditary disorder. The variation in clinical picture suggests a genetic heterogeneity. The structural gene of human β-glucuronidase is assigned to chromosome 7. The heterozygous carriers of MPS VII apparently do not develop any of the symptoms of the disease. They have intermediate levels of β-glucuronidase activity in leucocytes and serum. Some authors mention the presence of cytoplasmic granulation in leucocytes of heterozygotes.

Our patients differ in several respects from the others reported to date. They are the oldest patients described in the literature. The more typical signs of MPS VII are absent (table 1). Both patients as well as their heterozygous sister are suffering from epilepsy and severe mental retardation. Epilepsy has not been mentioned before in cases of MPS VII, and severe mental retardation is only seen in combination with other symptoms characteristic of this disorder. These facts and the presence of similar features in the heterozygous sister suggest that epilepsy and mental retardation in our patients are not related to MPS VII but to a concomitant disorder. Since the patients show only mild signs of MPS VII, they should in our opinion be classified under group III.

Our patients have a somewhat higher residual β-glucuronidase activity (3–4%) compared with previously described patients, in whom the specific activities of this enzyme for serum and leucocytes are generally reduced to 0.1–2% of the mean control values. 7,9,16 We had the opportunity to perform a hair root assay in case 1. Such a procedure has not been reported before in cases of MPS VII. It turned out that the deficiency actually can be established in hair roots. A similar level of residual β-glucuronidase activity was found in leucocytes and in hair roots.

The biochemical studies in the patients reported by us are remarkable because no glycosaminoglycans could be detected in their urine by routine procedures; this is in contrast to the findings of all patients with MPS VII described in the literature. The reports mention the excretion of several different glycosaminoglycans. This may be due to variation in the methods of laboratory investigations. The patient reported by Sly et al excreted chondroitin sulphate, which was also reported by other authors as the principal excreted storage product. 5,10,14,16 On the other hand, the patients described by Gehler et al, 6 Beaudet et al, 7 Pfeiffer et al 8 and Teyssier et al 12 excreted predominantly dermatan and heparan sulphates.

Although no elevated amounts of storage products could be found in the urine of our two patients, cellular morphology clearly provided evidence of a storage disease. Light microscopy showed cytoplasmic granu-
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lation in the peripheral granulocytes of both of them. Obvious vacuolation was seen in electron microscopy of the granulocytes, but not in the lymphocytes of case 1. Cytoplasmic granulation in the peripheral granulocytes has been found in almost every patient with MPS VII reported in the literature. They are described as metachromatic granules, prominent granulation, or Alder Reilly anomaly. The clinical findings in cases 1 and 2 emphasize again the phenotypic variation in MPS VII. Because of their nonspecific signs and the absence of glycosaminoglycans in urine they would have escaped diagnosis if determination of lysosomal enzymatic activities had been omitted. Therefore, we consider it advisable to perform enzyme analysis in any patient even if there is a slight suspicion of mucopolysaccharidosis.

We are grateful to Professor S K Wadman and Dr M Duran (Wilhelmina Children’s Hospital, Utrecht) for carrying out the two-dimensional electrophoresis of urinary glycosaminoglycans. The skilful technical assistance of Ms C J M G van den Berg and Mrs R I Hekman-Pheiffer is highly appreciated.

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