SMAD4 mutation and the combined syndrome of juvenile polyposis syndrome and hereditary haemorrhagic telangiectasia

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ABSTRACT

Juvenile polyposis syndrome (JPS) and hereditary haemorrhagic telangiectasia (HHT) are autosomal dominant disorders with characteristic clinical phenotypes. Recently, reports of the combined syndrome of JPS and HHT have been described in individuals with mutations in the SMAD4 gene, whose product—SMAD4—is a critical intracellular effector in the signalling pathway of transforming growth factor β (TGFβ). This report describes a 24-year-old man who presented to the Respiratory Institute after identifying the presence of a deletion mutation in the SMAD4 gene. The patient was identified in his mother, two brothers and one sister.

A 24-year-old man, who never smoked tobacco, was seen in the Respiratory Institute after identifying the presence of a deletion mutation in the SMAD4 gene.

His history began 8 months previously, when juvenile polyposis syndrome (JPS) was diagnosed after he underwent colonoscopy for an episode of haematochezia. Colonoscopy revealed multiple polyps distributed diffusely throughout the colon; biopsy of several random polyps showed hamartomatic features without evidence of dysplasia consistent with juvenile polyposis. Due to the disease burden, total colectomy with ileo-rectal anastomosis was recommended. On the day of the operation, he was premedicated with 2 mg of midazolam in the preanaesthesia holding area, following which he developed atrial fibrillation (AF). The procedure was cancelled and bedside echocardiogram was performed along with Cardiology consultation. The echo showed no evidence of structural heart disease, with normal left and right ventricular size and function, normal atrial chambers, normal valvular apparatus and no suggestions of pulmonary hypertension. Following the intravenous injection of agitated saline there was late appearance of bubbles in the left atrium suggestive of an intrapulmonary shunt. With the use of supplemental oxygen and 25 mg of oral metoprolol, the episode of AF spontaneously terminated within 6 h and he was sent home with an event monitor. On follow-up with Cardiology a month later, he was asymptomatic and no further episodes of AF were documented on event monitoring. He was diagnosed with lone AF that was triggered by sedation, proceeded to surgery uneventfully and was discharged home in 4 days.

Due to the diagnosis of JPS, molecular genetic tests were conducted to identify mutations in the BMPR1A and SMAD4 genes. Mutation analysis with PCR identified a deletion mutation, 1228-1229delCA, located within the MH2 domain of the SMAD4 gene. His parents and five other siblings underwent screening genetic testing and the same mutation was identified in his mother, two brothers and one sister.

He was subsequently referred to the Respiratory Institute for further evaluations. On taking his history, besides the single episode of haematochezia, he reported recurrent spontaneous episodes of epistaxis since childhood, but denied haemoptysis, melena or haematemesis. He denied history of iron deficiency anaemia, or symptoms suggestive of stroke or seizures. Physical examination was remarkable for the presence of telangiectasias on the lips and nasal cavity. He had normal heart and lung sounds on auscultation, there was no evidence of cyanosis or digital clubbing, and a detailed neurological examination was normal.

Contrast-enhanced helical CT of the chest with maximum intensity projection reconstructions identified an arteriovenous malformation (AVM) in the right middle lobe with a 1.3 mm feeding vessel (figure 1) and a smaller AVM in the right lower lobe with a 1.5 mm feeding vessel. MRI of the brain showed a supratentorial dural arteriovenous fistula that was confirmed by cerebral angiography (figure 2). Doppler ultrasonography of the liver did not identify any telangiectasias or vascular masses. With this constellation of findings he met the Curação criteria for a diagnosis of definite haemorrhagic telangiectasia (HHT).1 Given the history of JPS and the presence of a SMAD4 mutation, diagnosis of the combined syndrome of JPS—HHT was established. Due to the risks of serious neurological events with pulmonary AVMs supplied by a feeding artery at least 5 mm in diameter or larger, he underwent prophylactic coil embolotherapy of the right middle lobe AVM.

On follow-up in 6 months, he felt well and denied any respiratory or gastrointestinal symptoms. He continued, however, to have mild infrequent episodes of epistaxis with normal haemoglobin levels and no requirements for blood transfusions.

DISCUSSION

The combined syndrome of JPS—HHT is a rare disorder caused by SMAD4 mutations that tend to cluster in the MH2 domain of the protein.2 3 Since 1980 case reports of patients with phenotypic features of both JPS and HHT began to be published and this prompted questions about a single genetic mutation.
involvement most commonly manifests as pulmonary AVMs, although hepatic and cerebral AVMs have also been infrequently noted. The mean age of AVM detection is 26 years (range: 4 months to 60 years). Thus far, there has been no identification of patients with SMAD4-positive JPS—HHT with pulmonary arterial hypertension.

SMAD4 is a critical intracellular effector in transforming growth factor β (TGFβ) signalling which controls a plethora of cellular responses. Despite the pleiotropy of TGFβ, its downstream messenger elements remain relatively constant, including cell membrane-based type II, type I and accessory receptors, and intracellular receptor-regulated SMADs (R-SMADs) and the Co-SMAD, SMAD2,12 TGFβ is essential for vascular integrity, as ENG (accessory receptor) and ALK1 (type II receptor) mutations lead to the failure to form cord-like vascular structures which leads to the fragility of small vessels with bleeding characteristic of HHT, or to disrupted and abnormal angiogenesis after injuries, and may explain the clinical symptoms associated with this disease. In the gastrointestinal system, TGFβ signalling is thought to exert a landscaping effect from within the microenvironment as SMAD4 and BMPR1A (type I receptor) mutations lead to mucosal hyperplasia and polyph formation.14

Greater awareness of this rare syndrome and its implications is needed among respiratory physicians caring for these patients. Patients with JPS and SMAD4 mutations should be screened for the vascular lesions associated with HHT, especially occult AVMs in visceral organs that may otherwise present suddenly with serious medical consequences. Similarly, in patients with HHT with neither ENG nor ALK1 mutations, molecular testing for SMAD4 mutations should be included as their presence suggests an elevated risk of gastrointestinal polyposis, and screening for colonic and gastric polyps associated with JPS needs to be conducted.

Competing interests None.

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