CASE REPORT

Metatropic Dysplasia - Description of a Newborn with Suspected Epiphyseal Dysplasia

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Abstract
The paper presents a female neonate with a suspected skeletal defect that was eventually diagnosed as metatropic dysplasia. This is the first case of this disease in our Clinic. Clinical course of the disease was discussed as well as findings of additional examinations and the differentiation from other diseases with a similar clinical picture. Newborns have a narrow and elongated chest with extremely short limbs, with bones resembling dumbbells. Other problems associated with dysplasia involve the spine - the vertebrae are excessively flattened, and any excessive movement of the cervical spine may lead to spinal cord damage. The chest may be sunken or excessively bowed which may lead to disable full lung expansion that constrains breathing, also joint deformities occur such as contractures limiting movements in the largest joints. In the collected genetic material no TRPV4 mutation was discovered. There are slightly more than 80 cases of this disease described worldwide.

Keywords
Metatropic dysplasia, Neonate, Bone metabolic, Skeletal deformations

Introduction
Metatropic dysplasia is a rare skeletal system defect which is characterised by dwarfism and skeletal system lesions. There are slightly more than 80 cases of this disease described worldwide [1]. Newborns have a narrow and elongated chest with extremely short limbs, with bones resembling dumbbells [2]. There are also reports of children born with a remaining coccyx, the structure of which corresponds to cartilage and shrinks over time [3]. Other problems associated with dysplasia involve the spine - the vertebrae are excessively flattened, and any excessive movement of the cervical spine may lead to spinal cord damage. The chest may be sunken or excessively bowed, also joint deformities occur such as contractures limiting movements in the largest joints: Shoulder, elbow, hip and knee. Individuals suffering from this disease may develop arthritis already at the early stage of life. Dysplasia may involve a wide range of relatively mild to life-threatening symptoms. In the most severe cases, narrow thorax and spine abnormalities disable full lung expansion that constrains breathing. At present, there are several distinct forms of metatropic dysplasia identified based on disease's severity. These are non-lethal type with autosomal recessive transmission, non-lethal dominant type and lethal type causing death before or soon after birth, probably inherited in an autosomal recessive pattern. However, all these forms are now considered as part of one single condition with a wide spectrum of overlapping symptoms [1].

The presentation of the below child description is to draw the attention of physicians of different specialities to the importance of a multi-disciplinary approach and close cooperation between several fields of medicine, as well to the severity of problems that parents of children with such a burden have to face.

Case Report
Female newborn child on day 4 of life with a suspected skeletal system deficit was admitted to the Clinic of Paediatrics, Neonate Pathology and Bone Metabolic Disorders.

Accepted: October 19, 2019; Published: October 21, 2019
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Metabolic Diseases for further diagnostics and treatment. Medical history and records indicate that the child was born spontaneously from 1st pregnancy, 1st delivery, in week 38 of pregnancy with body weight of 2780 g and Apgar score of 2/5/8/8. Immediately after birth the girl required respiratory support. The obstetrics history with a burden of anaemia and colonisation of the birth canal with GBS. The mother was hospitalised in week 25 of pregnancy due to a suspected fetal chondrodysplasia. After birth, multiple developmental defects of the skeletal system were observed in the child and metaphyseal dysplasia was suspected. The disease occurred in the family for the first time. On admission to the Clinic the girl was in a general fair and stable condition. The physical examination revealed the yellowing of the skin, white tongue, excessive hair in the lumbar area, hemangioma on the lids, greyness around the lips, multiple crackles over the lung fields. Moreover, multiple musculoskeletal system defects were present: Disproportion between the cerebrocranium and faciocranium, depressed nasal bridge, overlapping skull bones, narrow disproportional thorax, broadened rib endings, deformed spine, protruding spinous processes, additional vertebrae as coccygeal segment, broadened long bone metaphyses, contractures in joints, long fingers and toes. On the first days of her stay at the Clinic antibiotic treatment was used due to clinical and radiological symptoms of infection. Temporary saturation falls were also observed in the child that decreased after the cervical spine was stabilised with a cervical collar. The girl was fed through a feeding tube, attempts were made to feed her with a soother however she was only able to eat small amounts by herself. Due to an increasing hypercapnic respiratory failure of up to 166 mmHg the child was transferred to the ICU for further treatment. The girl was intubated and Synchronized Intermittent Mechanical Ventilation (SIMV) was initiated.

During hospitalisation imaging examinations of bones of both lower limbs and skull were made. The performed lateral roentgenogram of lower limbs revealed: Short lower limb and thigh bones with significant metaphyseal flaring, significantly broadened proximal tibial metaphyses with emphasis of the anterior outline, especially the right one, altered shape and structure of uneven outlines of ossification centres for ankle and heel bones (Figure 1). The picture seemed to support tanatophoric or spondylometaphyseal dysplasia. X-ray of the skull revealed a skull deformity with a large biparietal diameter and a reduced anterio-posterior diameter, flattened upper part of the skullcap, especially on the left, thin parietal bones, mildly calcified, prominent frontal bone, moreover low-set ears and saddle nose deformity. No pathological intracranial calcifications were observed. Also atypical placement of dens axis was observed, with a possible subluxation, therefore transfontanelle ultrasound was performed, followed by a computed tomography of the head. In the ultrasound, a smaller posterior cranial fossa was observed, and dilated frontal horns, rounded. Comput-
ed tomography of the head revealed the atlantodental interval of approx. 3 mm, narrow AP dimension of the spinal canal at the level of C1-C2 of approx. 4.5 mm - depending on the shortening of the posterior C1 arch, the height of cervical and thoracic vertebral bodies significantly decreased - platyspondylyia (Figure 2) only partially ossified; arches and vertebrae well formed, quite massive, ossified. Spinal canal in the cervical segment C3-C7 of approx. 8 mm, in the thoracic segment it is narrow again (4-6 mm), especially in the transverse dimension - shortened and too closely located epiphyses of the arches, 12 ribs visible on each side - shortened, especially in the posterior segments which reduces the volume of the thoracic cage (Figure 3). Lung fields with impaired aeration in dorsal segments of lower lobes bilaterally, and of the left upper lobe; small, shallow fields of atelectasis visible also in the right middle and upper lobes. Due to ambiguous diagnosis of atlantoaxial instability, it was decided to put stabilising collar and nurse with caution.

During the stay at the Clinic the child had multiple consultations: Orthopaedic, rehabilitative and radiologic with a hypothesis of spondylometaphyseal dysplasia. Moreover, cardiological, neurological and genetic consultations were held. During the genetic consultation anthropometric examination and analysis of the family history as well as of the available medical records took place. It was determined that the disease occurred in the family for the first time so the inheritance is unknown. Antley-Bixler syndrome was suspected and the analysis of the performed x-rays and CT of the skull for craniostenosis of lambdoid and coronal suture was proposed. In the tested genetic material no gene TRPV4 mutation was discovered. The results of laboratory tests

![Figure 3: Lower and upper limbs - extremely short long bones, resembling dumbells, metaphyseal flaring, hypoplasia of ilium shafts.](image)

<table>
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<th>Parameter/date</th>
<th>Ca (mg/dl)</th>
<th>P (mg/dl)</th>
<th>Vit. D3 25 (OH) (ng/ml)</th>
<th>Vit. D3 1,25 (OH)2 (pg/ml)</th>
<th>PTH (pg/ml)</th>
<th>Alkaline phosphatase (U/l)</th>
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<td>4.65-8.06</td>
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<td>25.00-86.50</td>
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<th>P/crea.</th>
<th>Mg/crea.</th>
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<td>0.362</td>
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<td>&lt; 1 yoa 0.3-1.2</td>
<td>0.11-0.31</td>
<td>Before pubescence 13.4-60.4</td>
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assessing calcium-phosphate metabolism demonstrated a significantly lowered vitamin D3 metabolite level in liver and an increased vitamin D3 metabolite level in kidneys which is presented in Table 1. Additionally urine markers were included in Table 2. The child was given one drop of vitamin D3, approx. 500 UI, but after the analysis of the results the dose was increased to three drops, approx. 1500 UI.

Following the admission to the ICU the child was in a critical condition, with efficient circulation was intubated, ventilated mechanically (SIMV), quite conscious. The radiological examination revealed atelectatic - infectious lesions, analgosedation was used and then antibiotic treatment was modified based on antibiogram; parenteral feeding was withdrawn and because of the features of anaemia, haematopoietic treatment was initiated. Effort of extubated was taken and non-invasive ventilation was used along with caffeine supply. On day 11 of the treatment, due to repeat features of respiratory failure, the girl was intubated again and SIMV was started. On day 15 of the treatment, as there were no signs of infection, antibiotic treatment was stopped and NMR of the spine was performed that revealed similar lesions concerning the cervical and thoracic spine. Moreover, angular kyphosis of the spine on the thoracic and lumbar border was stated. In the lumbar spine, narrowing of the spinal canal at the level of epiphyses of the arches (like in the thoracic segment) up to 4 mm transverse -ly, and 8 mm in AP measurement. The spinal canal modelled on the dorsal side at the level of C1-C2 narrowing, in the cervical spine, the spinal cord with no signs of compression, with normal signal, without focal lesions. In the thoracic segment and on the thoracic-lumbar border - modelled cord, especially in the transverse section. Low-lying medullary cone - visible at the level of L3. During the hospitalisation the patient had neurosurgical consultation with no recommendations for the surgical procedure. On day 19 of the treatment, antibiotic treatment was implemented again due to clinical features of infection, and was continued for the following 10 days. A paediatric radiology specialist was asked to consult bone x-ray finding, with the following report obtained after the analysis of the collected material: Short ribs with broadened rib endings, thin, rounded vertebral bodies, significant narrowing in the dorsal part, hypoplasia of ilium shafts and significant shortening of tubular bones with broadened “mushroom-like” endings. The radiologist made a clear diagnosis of lethal type of metatropic dysplasia also defined as hypochondro- genesis with autosomal recessive inheritance. It is a disorder belonging to the group of lethal dysplasias with platyspondyly.

The 2-month infant in a general fair condition, conscious, intubated, with SIMV of average parameters, with efficient circulation, with gastrostomy tube used for feeding (Table 3), with maintained orthopaedic collar was discharged for further treatment at the place of residence, at the Department of Intensive Treatment of the Hospital Polanki in Gdańsk. An attempt to contact child’s parents was unsuccessful.

Discussion

The paper presents a rare case of skeletal system defect - metatropic dysplasia; it is the first case of this disease in our clinical practice. It seems to be important that making a diagnosis based on the clinical picture, phenotypical features and findings of additional examinations, including x-ray, CT and MRI is difficult and requires a cooperation between the experts of many medicine specialities, like in the case of the described infant.

The differential diagnostics of metatropic dysplasia should consider Antley-Bixler syndrome, spondylo-metaphysseal dysplasia or tanatophoric dysplasia.

Antley-Bixler syndrome (ABS) is a rare type of craniosynostosis, characterised by typical clinical features including: Underdeveloped midfacial regions with flat nose, trapezoid face, prominent frontal bossing, proptosis, underdeveloped ears, defects of the musculoskeletal system, such as radiohumeral or radioulnar synostosis, multiple contractures of joints and urinary and genital deficits. ABS is a heterogeneous disorder, so far two types of this syndrome have been described: Type 1 involves mutations in FGFR2 (10q26) gene without steroidogenesis disorders, type 2 involves mutations in cytochrome P450 oxidoreductase (POR) coding gene that plays a direct role in steroidogenesis. Type 2 ABS is an autosomal recessive disorder and is associated with abnormal genitalia in both sexes due to impaired steroidogenesis. Occasionally, a diverse range of cardiac, renal, gastrointestinal and vertebral malformations may occur [4,5]. Our infant has not developed multiple craniofacial malformations, as those described for ABS, nor urogenital defects, no FGFR2 and cytochrome P450 P50 mutation testing was performed which excluded this syndrome as a diagnosis.

Tanatophoric dysplasia (TD) is a type of neonate dwarfism which is extremely lethal in the perinatal period. It is characterised by short limbs, narrow bell-shaped thorax, macrocephaly with prominent fore-

<table>
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<th>Body weight (kg)</th>
<th>Body length (cm)</th>
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Tanatophoric dysplasia (TD) is a type of neonate dwarfism which is extremely lethal in the perinatal period. It is characterised by short limbs, narrow bell-shaped thorax, macrocephaly with prominent fore-
head and flattened vertebral bodies. These defects are the result of autosomal dominant mutations in Fibroblast Growth Factor Receptor 3 (FGFR3) gene. TD may be divided into two types: Type I characterized by micromelia with flattened femurs and by the presence of cloverleaf skull deformity, and type II characterized by micromelia with straight femurs and a moderate to severe cloverleaf skull deformity. The common feature of both types is the presence of narrow thorax which causes respiratory failure soon after birth [6, 7]. Our infant had no flattened femurs described for type I tanatophoric dysplasia, nor flat femurs present in type II tanatophoric dysplasia, no cloverleaf skull deformity was stated, so this syndrome was excluded as a diagnosis.

Spondylometaphyseal dysplasia, Kozlowski type, is a relatively common autosomal dominant disease in a heterogeneous group of approximately 30 different disorders with vertebral and tabular bone metaphyses abnormalities. It is one of the best clinically defined spondylometaphyseal dysplasias with molecular basis explained. TRPV4 mutations identified in patients with this disorder affect calcium-permeable ion channels. These mutations of bone dysplasias are characterised by dwarfism, kyphoscoliosis, distortion and bowing of the extremities, and contractures of the large joints. This disease is characterised by a combination of decreased bone density, bowing of the long bones, platyspondyly and irregularities of endochondral ossification with areas of calcification and streaking in epiphyses, metaphyses and apophyses [8, 9]. The observed neonate had no TRPV4 gene mutation, long bones had “mushroom-like” epiphyses, however without bowing, moreover no streaking in the epiphyses was described, therefore this syndrome was also excluded as a diagnosis.

In the described case the respiration was maintained using SIMV, which enabled to discharge the child to continue treatment at the hospital at her place of residence. Also monitoring of biochemical and calcium-phosphorus metabolism assessing parameters is important to supply adequate doses of vitamin D3 or possibly calcium. A significant issue that we wish to emphasize is the possibility to perform corrective surgeries to stop malformation progression, however it depends on the moment of such an intervention as well as on the careful selection of patients, especially the assessment of pulmonary function. It seems that in the case presented in the paper there will not be such an opportunity, and bone deformities will progress, and probably increase respiratory disorders. The understanding of the clinical spectrum of metatropic dysplasia, and adequate intervention at an early disease stage, mainly through rehabilitation and normal nutrition, may improve patients’ functionality, enabling at the same time their independent social life in difficult cases [1].

Conclusions

1) Due to a non-specific clinical picture, the diagnostics of metatropic dysplasia is very complicated, sometimes long-lasting, and the diagnosis based on the clinical, phenotypic traits and findings of additional examinations, including x-rays, CT, MRI, requires a close cooperation between doctors of many specialities.

2) Patients require the monitoring of biochemical parameters and vital signs, due to respiratory disorders and progression of bone deformities.

3) An important element is the selection of adequate treatment, including surgical or neurosurgical treatment, to improve the functioning and independent living in the society, as well as providing children’s parents with suitable psychological care.

Acknowledgements

We would like to thank parents of the girl described for allowing us to share her details and thank PhD MD Tadeuszowi Biegańskiemu for radiological consultation and laboratory in Warsaw for genetic testing.

Conflict of Interest

None.

Funding

This work was supported by Medical University of Lodz, Poland (503/1-090-02/503-11-001).

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