Merosin-Deficient CMD Type 1C (MDC1C): FKRP Gene Sequencing

Test Code: SFKRP
Turnaround time: 4 weeks
CPT Codes: 81404 x1

Condition Description

The congenital muscular dystrophies are a group of genetically and clinically heterogeneous hereditary myopathies characterized by congenital hypotonia and muscle weakness, contractures, and delayed motor development. Muscle biopsy usually reveals a nonspecific dystrophic pattern. The clinical course is broadly variable and can involve the brain and eyes. Initial testing often includes clinical evaluation, muscle imaging, electromyography, and muscle biopsy, followed by targeted genetic testing.

Mutations in the FKRP gene (fukutin-related protein; 19q13.3) can cause a milder form of congenital muscular dystrophy (CMD) called limb-girdle muscular dystrophy type 2I (LGMD2I) or a more severe form of CMD called merosin-deficient CMD type 1C (MDC1C). Both conditions are autosomal recessive in inheritance.

Limb-Girdle Muscular Dystrophy Type 2I (LGMD2I)

LGMD2I tends to be milder in presentation than MCD1C but has a variable phenotype depending on age of onset. The phenotype ranges from severe (similar to Duchenne muscular dystrophy) to mild with no clinically apparent skeletal involvement. Onset within the first few years of life predicts a Duchenne-like progression with muscle hypertrophy in the thigh and tongue, and lost independent walking during second decade of life. The milder end of the spectrum resembles Becker muscular dystrophy with later onset; some patients remain ambulatory into the fifth decade of life, have less hypertrophy of the calf, thigh, and tongue, and have muscle cramps following exercise. Cardiac involvement occurs in 10-55% of affected individuals and respiratory involvement in about 50%. Cardiomyopathy without skeletal muscle involvement has been reported.

Merosin-Deficient CMD Type 1C (MDC1C)

Individuals with MDC1C have severe hypotonia and contractures of the elbows, knees, and fingers; onset is usually between birth to six months and affected individuals do not usually achieve independent ambulation. Other clinical features include a normal MRI; a normal IQ (in most cases); hypertrophy of the calves and quadriceps; a myopathic EMG; and macroglossia. Some individuals have dilated cardiomyopathy or impaired left ventricular function. Respiratory failure often occurs in the second decade of life.

MDC1C can be distinguished from other nonsyndromic forms of CMD by the presence of calf pseudohypertrophy, dilated cardiomyopathy involving the left ventricle, and absence of white matter changes on MRI. A few affected individuals have had mental retardation, suggesting a syndromic form of the condition.

Serum creatine kinase (CK) concentration in individuals with LGMD2I and MDC1C is usually markedly increased. Immunostaining of muscle tissue reveals significantly reduced amounts of glycosylated alpha dystroglycan and deficiency of fukutin-related protein. Partial deficiency of merosin (laminin alpha 2) and alpha sarcoglycan can also be seen. FKRP mutations differ in LGMD2I and MDC1C. Individuals who are homozygous or compound heterozygous for missense mutations in FKRP have the LGMD2I phenotype. Individuals who are homozygous or compound heterozygous for nonsense mutations have the MDC1C phenotype. Two common mutations have been identified in LGMD2I. Asymptomatic individuals homozygous for either common mutation or compound heterozygous for both mutations have been reported.

For patients with suspected MDC1C or LGMD2I, sequence analysis is recommended as the first step in mutation identification. For patients in whom mutations are not identified by full gene sequencing, deletion/duplication analysis is appropriate.

References


Genes

FKRP

Indications

This test is indicated for:

- Confirmation of a clinical diagnosis of MDC1C or LGMD2I
- Carrier testing in adults with a family history of MDC1C or LGMD2I

Methodology

PCR amplification of 1 exon contained in the FKRP gene is performed on the patient's genomic DNA. Direct sequencing of amplification products is performed in both forward and reverse directions, using automated fluorescence dideoxy sequencing methods. The patient's gene sequences are then
Sequence analysis is required before deletion/duplication analysis by targeted CGH array. If sequencing is performed outside of Emory Genetics Laboratory, please submit a copy of the sequencing report with the test requisition.