Germline mutations in the MAP2K1 gene have been reported to be associated with two distinct syndromes: Noonan syndrome and cardiofaciocutaneous (CFC) syndrome. These syndromes share a common pattern of congenital anomalies, including typical heart defects, overlapping craniofacial dysmorphisms, short stature, and a variable degree of intellectual disability.

Noonan syndrome

Noonan syndrome (NS) is an autosomal dominant dysmorphology syndrome characterized by short stature, congenital heart defect, and developmental delay of variable degree. Other findings can include broad or webbed neck, unusual chest shape with superior pectus carinatum and inferior pectus excavatum, cryptorchidism, varied coagulation defects, lymphatic dysplasias, ocular abnormalities, and deafness. Characteristic facies include hypertelorism (74%), downward sloping palpebral apertures (38%), epicantal folds (39%), ptosis (48%), and low-set posteriorly rotated ears. Early feeding difficulties such as poor suck or gastrointestinal dysfunction are also common. Although birth length is usually normal, final adult height approaches the lower limit of normal. Up to one-third of affected individuals have mild intellectual disability.

Congenital heart disease occurs in 50%-80% of individuals with NS. Pulmonary valve stenosis, often with dysplasia, is the most common heart defect and is found in 20%-50% of individuals. Hypertrophic cardiomyopathy is found in 20%-30% of individuals, and may be congenital or develop in infancy or childhood. Other structural defects include atrial and ventricular septal defects, branch pulmonary artery stenosis, and tetralogy of Fallot.

NS is clinically diagnosed. Affected individuals have normal chromosome studies. Molecular genetic testing identifies mutations in PTPN11 in over 50% of affected individuals. Other genes known to be involved include KRAS in fewer than 5% of affected individuals, SOS1 in approximately 13%, and RAF1 in 3%-17%. Mutations in the NRAS, BRAF, and MAP2K1 (15q21) genes have been reported in less than 1% of cases.

Many affected individuals have de novo mutations; however, an affected parent is recognized in 30%-75% of families. When the parents are clinically unaffected, the risk to the sibs of a proband appears to be low (<1%). Noonan syndrome has an estimated incidence of 1 in 1,000 to 2,500 live births.

CFC Syndrome

Cardiofaciocutaneous (CFC) syndrome is characterized by features in three primary systems: cardiac, craniofacial, and ectodermal; however, other systems may be involved as well. Cardiac abnormalities can include pulmonic stenosis and other valve dysplasias, septal defects, hypertrophic cardiomyopathy, and rhythm disturbances. Individuals with CFC syndrome have a distinctive craniofacial appearance. Ectodermal features include skin findings, such as xerosis, hyperkeratosis, ichthyosis, keratosis pilaris, urerythema oophorogenes, eczema, pigmented moles, palmoplantar hyperkeratosis; hair findings such as sparse, curly, fine or thick, woolly, or brittle hair, and possible absent eyelashes and eyebrows; and the nails may be dystrophic or fast growing. Cognitive delay (ranging from mild to severe) is seen in all affected individuals. Neoplasias have been reported in some individuals with CFC.

There are four genes known to be associated with CFC. Mutations in the BRAF gene account for ~75% of cases, MAP2K1 and MAP2K2 account for ~25% of cases, and KRAS accounts for <2% of cases. CFC syndrome is inherited in an autosomal dominant manner; however, most cases of CFC syndrome arise de novo.

Please note this is for the MAP2K1 gene only.

For patients with suspected MAP2K1-related disorders, 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:

- GeneReviews
- OMIM #176872: MAP2K1 gene
- OMIM #610733: NS
- OMIM #115150: CFC

**Genes**

MAP2K1

**Indications**

This test is indicated for:

- Confirmation of a clinical diagnosis of MAP2K1-related disorders in an individual in whom sequence analysis was negative.
- Carrier testing in adults with a family history of MAP2K1-related disorders in whom sequence analysis was negative.

**Methodology**

DNA isolated from peripheral blood is hybridized to a CGH array to detect deletions and duplications. The targeted CGH array has overlapping probes which cover the entire genomic region.
Detection

Detection is limited to duplications and deletions. The CGH array will not detect point or intronic mutations. Results of molecular analysis must be interpreted in the context of the patient's clinical and/or biochemical phenotype.

Specimen Requirements

Submit only 1 of the following specimen types

Type: Whole Blood (EDTA)

Specimen Requirements:
EDTA (Purple Top)
Infants and Young Children (2 years of age to 10 years old): 3-5 ml
Older Children & Adults: 5-10 ml
Autopsy: 2-3 ml unclotted cord or cardiac blood

Specimen Collection and Shipping:
Ship sample at room temperature for receipt at EGL within 72 hours of collection. Do not freeze.

Type: DNA, Isolated

Specimen Requirements:
Microtainer
3µg
Isolation using the Perkin Elmer™Chemagen™ Automated Extraction method or Qiagen™ Puregene kit for DNA extraction is recommended.

Specimen Collection and Shipping:
Refrigerate until time of shipment in 100 ng/µL in TE buffer. Ship sample at room temperature with overnight delivery.

Special Instructions

Sequence analysis is required before deletion/duplication analysis by targeted CGH array. If sequencing is performed outside of EGL Genetics, please submit a copy of the sequencing report with the test requisition.

Related Tests

- Sequence analysis of the MAP2K1 gene is available and is required before deletion/duplication analysis.
- Sequence and deletion/duplication analysis are also available for the MAP2K2, KRAS, NRAS, PTPN11, RAF1 and SOS1 genes.
- Custom diagnostic mutation analysis (KM) is available to family members if mutations are identified by targeted mutation testing or sequencing analysis.
- Prenatal testing is available only for known familial mutations to individuals who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.