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Title page:

Title:

Antenatal finding of 16q24.1 duplication including *FOXF1*, revealing an autosomal dominant familial pathology with congenital short bowel, malrotation and renal abnormalities

Short title

16q24.1 duplication and congenital short bowel syndrome

Authors

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28 Data Availability Statement :
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31 The 16q24.1 duplication and the associated phenotype have been submitted to the
32 DECIPHER database at <https://decipher.sanger.ac.uk/>, (ID LDC367088). Further
33 data supporting the findings of this study are available from the corresponding
34 author upon reasonable request.
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1 Patients with congenital short-bowel syndrome (CSBS) are born with a substantial shortening
2 of the small intestine, and malrotation of the small bowel is always present. Patients with
3
4 CSBS develop intestinal failure and malabsorption, requiring long term home parenteral
5
6 nutrition (PN). CSBS was first described by Hamilton *et al* and it is thought to have a genetic
7
8 cause[1]. Mutations in *CLMP* and *FLNA* cause recessive and X-linked forms of CSBS,
9
10 respectively[2]. We describe the antenatal finding of a 16q24.1 duplication including *FOXF1*,
11
12 revealing an autosomal dominant familial pathology with CSBS, malrotation and renal
13
14 abnormalities.
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20 Family tree is described in figure 1. The proband (III-2) is the second male child of a non-
21
22 consanguineous couple. He was antenatally diagnosed with 16q24.1 duplication and has
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24 intestinal malrotation, CSBS, unilateral kidney duplicity with cysts.
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28 His mother (II-2) presented with volvulus at three weeks of age, and CSBS (65cm) with a
29
30 complete intestinal malrotation diagnosed during the laparotomy. She had fifteen months of
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32 PN. She also had kidney abnormalities, with unilateral renal duplication, kidney cysts, several
33
34 episodes of pyelonephritis and renal lithiasis in childhood and adulthood. During the
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36 pregnancy, antenatal ultrasound examinations in the second trimester showed high suspicion
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38 of intestinal malrotation and kidney duplication. The possibility of an autosomal dominant
39
40 pathology inherited from the mother (II-2) was explained to the parents, who accepted an
41
42 amniocentesis. Array-CGH analysis performed on DNA obtained from amniotic liquid
43
44 revealed heterozygous 16q24.1 duplication (768 kb) including *FOXF1*. The variant
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46 nomenclature, according to ISCN 2016 [3], was 46,XY.arr[GRCh37]
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48 16q24.1(86220144_86988149)x3. This duplication, considered pathogenic, was inherited
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51 from the mother.
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1 The child was born at 39 weeks' gestation with normal birth parameters: weight 3075g (25th
2 percentile), length 50cm (52th p), head circumference 35,3cm (66th p). The meconium passed
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4 within 24 hours after birth. He was exclusively breastfed. Abdominal ultrasonography at day
5
6 five suspected an intestinal malrotation as mesenteric artery was on the right of mesenteric
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8 vein without any sign of volvulus, and found left kidney nephromegaly with pyelic
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10 duplication and multiple bilateral cysts. CSBS was suspected because of diarrhea, familial
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12 history and genetic findings. At two months old, height was 57cm, weight 4kg, and
13
14 laparotomy confirmed incomplete 180° rotation and CSBS with normal ileocecal valve. A
15
16 Ladd band was resected. Repositioning of the intestine and mesentery, and an appendectomy
17
18 were performed. Small bowel length (SBL) was 85 cm, 41% of the mean estimated SBL for
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20 height and age, as a length superior to 165cm was expected (mean estimated SBL: 207 cm;
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22 95% CI: [165 – 250])[4]. Prolonged PN was provided via central venous catheter. At two
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24 years old, height and weight development were normal with partial home PN maintained.
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His older brother (III-1) has no digestive symptoms and was not tested. A maternal uncle (II-3) without digestive or renal symptoms was found to be negative for the duplication. The younger brother III-3 was tested after birth, he doesn't carry the familial duplication, he has no digestive symptoms at six months old. The maternal uncle (II-4) had diarrhea and malabsorption with long term PN during his first year and chronic abdominal pain afterwards. He had a unilateral nephrectomy due to kidney damage associated with recurrent pyelonephritis and renal dysplasia. Unfortunately he could not be informed of the genetic disease to be tested.

The familial duplication was also confirmed in the symptomatic maternal grandmother (I-4); she was diagnosed with intestinal malrotation at age 62, during a pancreatitis surgery. She

1 probably had CSBS, as she suffered from chronic diarrhea with malabsorption and failure to
2 thrive in infancy. She had multiple episodes of pyelonephritis and developed chronic
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4 interstitial nephropathy by renal dysplasia, and had undergone a renal transplantation at the
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6 age of 31. After the age of 50, she had recurrent episodes of acute pancreatitis, with six
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8 hospitalisations and no etiology was found even though extensive tests were performed.
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12 The dorsal mesentery is important in generating the left–right asymmetry that allows rotation
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14 of the midgut during embryological development to take place[5]. Point mutations and
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16 genomic deletions of *FOXF1*, a key gene in the establishment of the dorsal mesentery, are
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18 associated with intestinal malrotation and CSBS has been reported in one case[6]. These
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20 patients have a severe developmental lung abnormality, alveolar capillary dysplasia with
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22 misalignment of pulmonary veins (ACD/MPV) causing early death.
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28 16q24.1 duplications of different sizes encompassing *FOXF1* have been described in four
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30 unrelated families[7] without pulmonary problems. Interestingly in one family, with
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32 duplication similar in size and genomic location to the one we have identified, the daughter,
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34 mother and maternal grandfather presented with malrotation; the daughter also had short
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36 bowel. In the other families with larger duplications, the patients had developmental delay but
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38 no significant gastrointestinal problems or malrotation are specified. A 1.5 Mb de novo
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40 duplication on 16q24 involving *FOXF1* has been described more recently in one patient
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42 presenting with intestinal malrotation, mild intellectual disability, short stature and pulmonary
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44 artery stenosis[8].
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51 Pathogenicity of genomic duplications is often not explained by changes in gene dosage, but
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53 can be linked to the formation of new chromatin domains[9] with changes in the structure and
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55 function of topologically associated domains (TADs). TADs are chromosomal regions with
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57 an elevated frequency of internal chromatin interactions, such as interactions between genes
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1 and their distal regulatory elements. For example, duplications within TADs can increase
2 interactions between (duplicated) regulatory elements and their target genes, which can cause
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4 changes in gene expression and consequently disease.
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7 Reinterpretation of the familial history combined with the genetic findings during the
8 pregnancy led to close surveillance of the proband after birth. It also allowed for the parents to
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10 be informed of the increased risk of volvulus and CSBS in their child. Parenteral nutrition was
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12 started before the laparoscopic CSBS confirmation, so it permitted early care and avoided
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14 diagnostic delay of this rare condition. The mother also agreed to resume medical nutrition
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16 follow-up, her digestive symptoms improved and she had no renal lithiasis since
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These findings allowed for appropriate genetic counseling to be provided to the family; as
prior to the diagnosis during the second pregnancy, the parents were not aware of the 50%
risk of recurrence of the 16q24.1 duplication and CSBS transmission. The parents did not ask
for prenatal diagnosis for the third pregnancy, but the child (III-3) was tested shortly after
birth, he doesn't carry the familial duplication and has no digestive symptoms.

Array-CGH could be recommended for all patients with CSBS, as the prevalence of this
condition is unknown.

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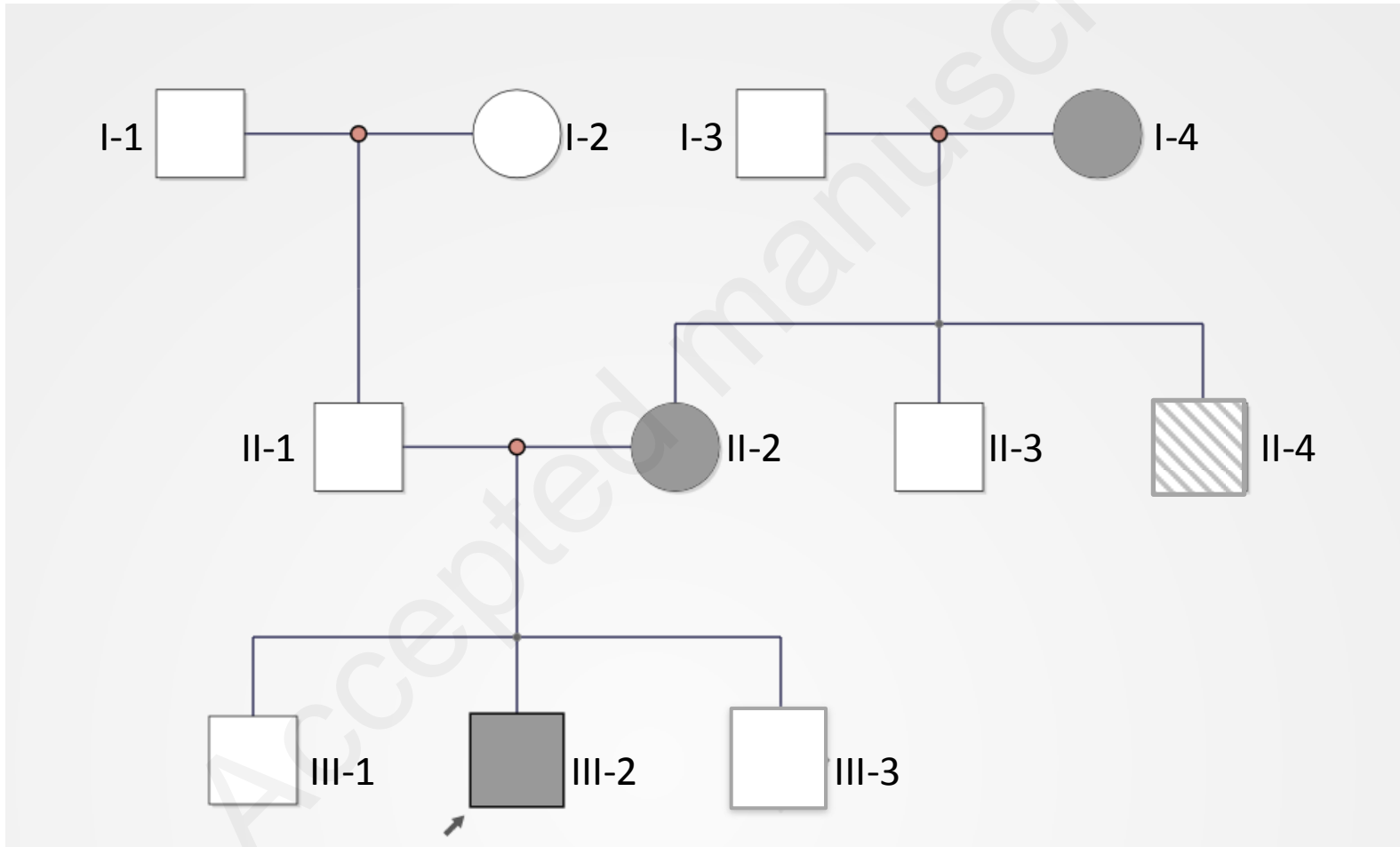
Legend

Figure 1: Family tree

Autosomal dominant familial pathology with congenital short bowel, malrotation and renal abnormalities, affected patients (I-4, II-2, III-2) with CSBS and 16q24.1 duplication. II-3 and III-3 are asymptomatic and tested negative for the duplication. II-4 had malabsorption with long term PN, he refused to be tested. III-1 has no digestive symptoms and was not tested.

Figure 1

-  Symptomatic patient with unknown genetic status
-  Symptomatic patients who have the 16q24.1 duplication



Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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