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van Maldegem, B.T.

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Clinical aspects of short-chain acyl-CoA dehydrogenase deficiency

Bianca T. van Maldegem1, Ronald J.A. Wanders2, and Frits A. Wijburg1

1Department of Pediatrics, 2Laboratory Genetic Metabolic Diseases, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands.

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Abstract

Short-chain acyl-CoA dehydrogenase deficiency (SCADD) is an autosomal recessive inborn error of mitochondrial fatty acid oxidation. SCADD is biochemically characterized by increased C4-carnitine in plasma and ethylmalonic acid in urine. The diagnosis of SCADD is confirmed by DNA analysis showing SCAD gene mutations and/or variants. SCAD gene variants are present in homozygous form in approximately 6% of the general population and considered to confer susceptibility to development of clinical disease.

Clinically, SCADD generally appears to present early in life and to be most frequently associated with developmental delay, hypotonia, epilepsy, behavioral disorders, and hypoglycemia. However, these symptoms often ameliorate and even disappear spontaneously during follow-up and were found to be unrelated to the SCAD genotype. In addition, in some cases, symptoms initially attributed to SCADD could later be explained by other causes. Finally, SCADD relatives of SCADD patients as well as almost all SCADD individuals diagnosed by neonatal screening, remained asymptomatic during follow-up.

This potential lack of clinical consequences of SCADD has several implications. First, the diagnosis SCADD should never preclude extension of the diagnostic workup for other potential causes of the observed symptoms. Second, patients and parents should be clearly informed about the potential lack of relevance of the disorder, in order to avoid unfounded anxiety. Furthermore, to date, SCADD is not an optimal candidate for inclusion in newborn screening programs. More studies are needed to fully establish the relevance of SCADD and solve the question whether SCADD is involved in a multifactorial disease or represents a non-disease.
Introduction

Short-chain acyl-CoA dehydrogenase (SCAD, EC 1.3.99.2) deficiency (SCADD, OMIM 201470) is an autosomal recessive inborn error of mitochondrial fatty acid oxidation (FAO). SCAD catalyzes the dehydrogenation of butyryl-CoA (C4-CoA) during the first step of the short-chain fatty acid β-oxidation spiral. Impaired SCAD activity results in accumulation of its substrate (C4-CoA) and the subsequent production of alternative metabolites including the following: 1) the corresponding carnitine-ester, i.e. butyrylcarnitine (C4-C), 2) the corresponding glycine-ester (butyrylglycine), 3) butyrate and 4) ethylmalonic acid (EMA). C4-C, measured in blood and EMA, measured in urine, are generally used as biochemical markers for SCADD.

The diagnosis of SCADD is usually confirmed by DNA analysis. The majority of SCADD patients are homozygous or compound heterozygous for 2 common variants of the SCAD-encoding gene (ACADS), or for ACADS variants in combination with an inactivating mutation.1-4 Up to 70 different inactivating ACADS mutations have been reported so far.3;5-12 There is a remarkably high prevalence of homozygosity for ACADS variants in the general population, with frequencies of approximately 0.3% for the p.R171W (c.511C>T) and 5.5% for the p.G209S (c.625G>A) variant.13;14 Homozygosity for these variants is considered to confer susceptibility to clinical disease.7;8;15

Most SCADD patients have been diagnosed as a result of investigations for neurological symptoms and/or hypoglycemia.1-4 There is, however, debate on the clinical relevance of SCADD.3;16 Nevertheless, newborns are screened for SCADD in the USA.17

In this manuscript, we will summarize the clinical aspects of SCADD and discuss the clinical relevance of this inborn error of metabolism.

Clinical symptoms in SCADD

Symptoms in clinically identified patients

The first SCADD patient was originally reported by Amendt and co-workers18 and subsequently genetically confirmed by Naito in 1990.5 The patient was reported to suffer from lethargy, hypertonia, and circulatory problems with metabolic acidosis during her first week of life. Although she was reported to show normal growth and development and without recurrence of metabolic acidosis up to the age of 2 years, Bhala et al. later reported that this patient had died, without reporting clinical details.19 As this publication included another SCADD patient who died, after initial presentation with severe skeletal muscle hypotonia, a devastating clinical course of SCADD was suggested. However, the same publication included another 2 cases, initially presenting with “possible hyperactivity” and “probable seizure activity”, but with a normal follow-up. Initially, a few other patients with SCADD had been reported,18-20 however in these patients the
diagnosis was, to our knowledge, not genetically confirmed. As the definitive diagnosis
of SCADD requires molecular testing, these patients are excluded from this review.

Subsequently a large cohort of SCADD patients was presented by Corydon et al. and
several case reports were published. Based on these publications, SCADD appeared
to be associated with a wide spectrum of clinical signs and symptoms, including
developmental delay, hypotonia, epilepsy, and hypoglycemia, and in solitary cases
dysmorphic features, vomiting, failure to thrive, hepatic dysfunction after premature
delivery, and bilateral optic atrophy. One case report suggested the association between
SCADD and acute fatty liver of pregnancy in the mother. Again a striking spectrum was
observed in patient outcome. Outcome was reported for 7 patients, of whom 5 fully
recovered, 1 slowly progressed, and 1 died.

In 2006, we reported data on 31 Dutch SCADD patients. The most frequently
reported symptom in this cohort was developmental delay, followed by epilepsy,
behavioral disorders, and hypoglycemia. Behavioral disorders, observed in 8 out of the 31
patients, had not been previously reported in SCADD patients. Remarkably, most of the
clinically severely affected patients belonged to the group of patients homozygous for
the c.625G>A variant. In 4 patients, additional diagnoses, that were highly likely causing
the clinical symptoms, were made after the initial diagnosis of SCADD.

In 2008, Tein and co-workers published a study on 10 SCADD patients. In this study
developmental delay was again the most common symptom, but this time hypotonia
was also as frequent. In addition this study reported for the first time a relatively high
prevalence of lethargy (5 patients), myopathy (4 patients), and facial weakness (3 patients).
All patients in this study were of Ashkenazi Jewish descent, carried the c.319C>T mutation
and were either homozygous for this mutation or had the c.625G>A variant on the other
allele. In 2 patients with myopathy, a muscle biopsy revealed multiminicore disease, a rare
congenital myopathic disorder. However, other genetic causes for multiminicore disease,
in particular mutations in SEPN1 and RYR1, which are present in about 50% of cases, had not been excluded.

In the same year, Pedersen and co-workers published a study on a very large cohort of
114 SCADD patients from Europe, New Zealand and Canada. Again developmental delay
was the most frequently reported clinical sign, in combination with hypotonia, seizures,
and failure to thrive. In addition, several patients were reported to have failure to
thrive and hypotonia without developmental delay and a smaller group had dysmorphic
features.

A third study, also published this same year, by Waisbren and co-workers, reported
on another 6 clinically identified patients. In 3 of them newborn screening had failed
to detect SCADD and in the other 3 no screening for SCADD was performed. The most
significant symptoms in these 6 patients were developmental delay, hypotonia, feeding
problems, and failure to thrive and epilepsy.
Age of presentation, symptom transience and genotype-phenotype relation in clinically identified patients

It appears that clinical signs and symptoms in SCADD patients generally present early in life, with almost all patients presenting under the age of 5 years.1-4 Symptoms were transient in 9 out of the 31 patients in the van Maldegem study, and 2 out of 6 patients in the Waisbren study. Furthermore, no association could be made between genotype and clinical phenotype in the patients from the Pedersen and the van Maldegem study.

Clinical symptoms in SCADD individuals identified by newborns screening

With the implementation of newborn screening for SCADD in the U.S.A and Australia, the clinical spectrum of SCADD has expanded. Several follow-up studies of SCADD newborns diagnosed through newborn screening were published within the last few years. The first one reported 17 SCADD newborns who all remained symptom-free at follow-up during their first 2 years of life.28 Of the 3 patients reported by Koeberl et al., 1 developed seizures and a cerebral infarction at the age of 10 weeks, while the other 2 patients remained symptom-free during their first 3 years of life.9 One out of the 8 children reported by Waisbren and co-workers did show developmental delay consisting of a language delay at the age of 2 years.1 Jethva and Ficicioglu reported a group of 14 children with SCADD of whom 11 were identified by newborn screening and 3 diagnosed by screening of sibs diagnosed through newborn screening. During a follow-up of 1 to 7 years, in 2 of them (siblings) speech delay was diagnosed. A causative relation between this speech delay and SCADD was considered unlikely, as both parents had learning disabilities, suggesting other causes.29 All 4 Australian SCADD children diagnosed by newborn screening and studied during 6 years remained symptom-free. SCADD has meanwhile been excluded from the Australian screening panel because of supposed lack of clinical significance.30

![Figure](image-url)
An interesting finding by Waisbren and co-workers is a relatively high prevalence of pregnancy complications in the mothers of children diagnosed with SCADD by newborn screening as well as in mothers of the group of SCADD patients diagnosed because of clinical symptoms.\(^1\) In 5 out of 14 patients, hypertension, maternal bradycardia, pre-eclampsia, and mild HELLP syndrome were reported in the mothers. This suggests that fetal SCADD, like other FAO disorders such as LCHAD deficiency, might be associated with pregnancy complications as previously suggested.\(^2\)\(^5\) However, in almost 30% of all pregnancies in the Dutch population mild to moderate pregnancy complications are reported, including hypertensive disorders and pre-eclampsia.\(^3\)\(^1\) Furthermore, the association between SCADD and maternal pregnancy complications was not detected in the Dutch cohort of SCADD patients\(^3\) as maternal disease during pregnancy was only reported in 4 out of 24 patients (17%) on whom pregnancy details were known (unpublished data).

**Family studies**

Thirty-seven relatives (20 parents and 17 sibs) of the SCADD patients from the Dutch cohort were investigated for their \(ACADS\) genotype and 9 of them were found to have the same \(ACADS\) genotype as the proband.\(^3\) Except for 1 father with an \(ACADS\) genotype homozygous for the c.625G>A variant, all relatives with an \(ACADS\) genotype identical to the proband were found to have increased C4-C and/or EMA. Eight relatives had always been healthy, while 1 had a history of transient food refusal during her first year of life.

**Clinical significance**

The clinical studies discussed above show that symptoms in SCADD generally present early in life and most frequently concern developmental delay, hypotonia, epilepsy, behavioral disorders, and hypoglycemia. Signs and symptoms often ameliorate and disappear completely during follow-up. In addition, they can sometimes be explained by other causes and are not related to the \(ACADS\) genotype. Finally, almost all relatives diagnosed with SCADD, as well as almost all individuals detected by newborn screening, remain fully asymptomatic. Based on these observations, one may question the clinical relevance of SCADD. Indeed, we hypothesize that the association between the reported signs and symptoms and the diagnosis of mutations or gene variants in the \(ACADS\) gene could be co-incidental.

As a first step to study this, we searched the database of the laboratory for metabolic diseases in our centre for the most frequently reported symptoms of patients for whom metabolic studies were requested between November 2007 and November 2008. Developmental delay was by far the most frequently reported, followed by behavioral disorders, epilepsy, hypotonia, and hypoglycemia. The incidence of these symptoms is comparable to that in the SCADD patients group (Figure), suggesting at least that there is no specific cluster of clinical signs and symptoms in SCADD, and that the association might indeed be coincidental.
Implications with respect to policy towards SCADD patients and families

The probable lack of clinical significance of SCADD has important implications for the clinical management and counselling of SCADD patients and families. First, the diagnosis of SCADD should never preclude a full diagnostic workup for other potential causes of the symptoms. Any delay in doing so might postpone the diagnosis of other potentially treatable causes. Second, patients and parents as well as their physicians should be clearly informed about the potential lack of clinical relevance of the detected biochemical and genetic abnormalities concerning SCADD, once the diagnosis of SCADD has been made. Furthermore, without a clear clinical phenotype of SCADD to date, SCADD is not an optimal candidate for inclusion in newborn screening programs. Meanwhile, further studies are needed to fully unravel the implications of SCADD in order to answer the question whether SCADD is involved in a multifactorial disease or represents a non-disease.
References


8. Gregersen N, Winter VS, Corydon MJ et al. Identification of four new mutations in the short-chain acyl-CoA dehydrogenase (SCAD) gene in two patients: one of the variant alleles, 511C→T, is present at an unexpectedly high frequency in the general population, as was the case for 625G→A, together conferring susceptibility to ethylmalonic aciduria. Hum Mol Genet 1998;7:619-627.


