Anaesthesia and Beckwith - Weideman Syndrome

A Bösenberg, MBChB, DA(SA) FFA (SA)
Department of Anaesthesia, University Cape Town, South Africa

Synopsis of patient: A 15 hour old, 4.2 kg male presents for closure of a large exomphalos. He was delivered by C-section for foetal distress after a prolonged labour at a peripheral hospital. Apgars were recorded as 6 and 8. His mother was an unmarried primigravida who attended antenatal clinic on one occasion. Meconium aspiration was suspected at birth. Preoperative assessment revealed a large term baby with features of Beckwith-Weideman syndrome - a large tongue; a faint naevus on the forehead; and a skin crease on the ear lobe. Assessment of the liver and spleen was difficult in view of the large omphalocele (5x6cm). The exomphalos was stained by the meconium in utero. He was tachypnoeic but the chest was clear. There was a 2/6 ejection systolic murmur at the left sternal border. Chest xray was normal apart from mild cardiomegaly. Blood sugar on admission was 1.2 mmol.l⁻¹; electrolytes were within normal limits. Haemoglobin was 17gm. (Hct 55)

Beckwith-Weideman syndrome

Beckwith-Weideman syndrome (BWS) is an autosomal dominant syndrome with variable expressivity¹ and is characterised by abdominal wall defects, (usually exomphalos), macroglossia, and gigantism often associated with visceromegaly, adrenocortical cytomegaly, and dysplasia of the renal medulla (Table 1). The syndrome was first described by John Bruce Beckwith, a paediatric pathologist in Seattle (but South African born!) in 1963². Hans Rudolf Weidemann, professor in paediatrics at Kiel University (Germany), also described the syndrome at much the same time³. More recently the syndrome has become known as the EMG syndrome: exomphalos - macroglossia - gigantism¹.

Most cases occur sporadically and the incidence is reported to be in the order of 1:14000 births⁴. 23% of 123 exomphalos presenting at King Edward VIII hospital in Durban over a 12 year period had features of BWS,(unpublished data). Family studies indicate linkage of the BWS to the marker 11p15.5 and the IGF-II gene located at that locus. The cellular and tissue overgrowth may be due to an underexpression of a negative regulator protein for cell proliferation (p57 gene) and overexpression of an insulin-like growth factor gene (IGF-II)⁵. Increased levels of IGF-II mRNA have been detected in numerous tumours associated with BWS such as nephroblastomas, neurblastosas, rhabdomyosarcomas, and adrenocortical carcinomas.⁶ Abnormalities of chromosome 11,⁷ including Trisomy 11p15,⁸ have been associated with BWS.

The time dependant nature of many abnormalities in BWS can challenge the anaesthesiologist at various stages in the child’s life⁹,¹⁰. Macroglossia and hypoglycaemic episodes seen in the neonatal period may disappear with growth and time. Gigantism, microcephaly, mental retardation secondary to hypoglycemia in the neonatal period, or cor pulmonale secondary to upper airway obstruction may develop later in childhood.

The typical facial features include macroglossia(Fig 1); a capillary haem-angioma on the central forehead, often described as flame shaped, flammeus naevus; and linear creases on the earlobe(Fig 2). Indentations of the external helix may also be seen. Other less common features described in older children include microcephaly, prognathism, malocclusion and relative exophthalmos.

At laryngoscopy, macroglossia may make visualisation of the cords difficult. Macroglossia, may also cause significant upper airway ob-

Table 1: Spectrum of clinical feature

<table>
<thead>
<tr>
<th>Clinical Characteristic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prematurity</td>
<td>50%</td>
</tr>
<tr>
<td>Macroglossia</td>
<td>92%</td>
</tr>
<tr>
<td>Abdominal wall defect</td>
<td>68%</td>
</tr>
<tr>
<td>High birth weight</td>
<td>53%</td>
</tr>
<tr>
<td>Facial abnormality</td>
<td>52%</td>
</tr>
<tr>
<td>Visceromegaly</td>
<td>50%</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>30-50%</td>
</tr>
<tr>
<td>Persistent hypoglycemia</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Renal anomalies</td>
<td>Up to 59%</td>
</tr>
<tr>
<td>Family history</td>
<td>50%</td>
</tr>
<tr>
<td>Incidence tumours</td>
<td>7.5 - 18% (up to 21%)</td>
</tr>
</tbody>
</table>

Correspondence:
Prof A Bösenberg
email: bossie@cormack.uct.ac.za


11
of these embryonal tumours cancers early. be screened regularly for at least 4-6 years to detect the development of hepatoblastoma, adrenocortical carcinoma, neuoroblastoma, and other malignancies that have been associated with BWS and a strong association with Wilms tumour. Other intra-abdominal malformations have been described. There is increased risk of childhood malignancy associated with nephrocalcinosis and hypercalciuria.13 Infants with persistent nephromegaly are considered to be at risk of developing Wilms tumour.15 Neonatal nephromegaly may regress by four months but structural abnormalities of the renal medulla may be associated with nephrocalcinosis and hypercalciuria.16 Infants with persistent nephromegaly are considered to be at risk of developing Wilms tumour.15

Neonatal hypoglycaemia is common (30-50%)12 and must be treated timeously in the neonatal period to prevent permanent neurological damage. It is secondary to pancreatic cell hyperplasia and the resultant hyperinsulinaemia. Hypoglycaemia may be mild or severe and is usually responsive to corticosteroids. Diazoxide, glucagon, adrenaline and other hyperglycaemic medications may need to be added in various combinations to correct resistant cases. The hypoglycaemia usually resolves spontaneously by the end of the fourth month. Less than 5% will have hypoglycaemia beyond the neonatal period12 but if it persists, or is very severe, nesidioblastosis should be suspected. Continuous glucose infusions may be required to maintain normoglycaemia until a total or partial pancreatectomy can be performed.

The majority of infants with hypoglycaemia are asymptomatic in the neonatal period. Diagnosis can be difficult and all neonates with exomphalos should have a blood glucose checked. Early detection is important and may prevent long term neurological complications. Antenatal diagnosis of BWS is difficult16,17. Indicators that should alert investigators include polyhydramnios, placentomegaly, enlarged kidneys, increased abdominal circumference and rapid growth from 24-36 week gestation.17,18

References