Rapidly progressive adenomatous polyposis in a patient with germline mutations in both the APC and MLH1 genes: the worst of two worlds

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CASE REPORT

The two most common inherited forms of colorectal cancer are familial adenomatous polyposis and hereditary non-polyposis colorectal cancer. Simultaneous inheritance of both an APC gene mutation and a mismatch repair gene (for example, MLH1) mutation has never been described. In the present case report, we report rapidly progressive adenomatous polyposis in a 10 year old boy with a germline frame shift mutation in the APC gene and a germline splice site mutation in the MLH1 gene. Immunohistochemical investigations showed abnormal expression of β-catenin in early adenomas with low grade dysplasia, attributed to the APC gene mutation. Subsequent loss of function of the MLH1 gene, as shown by absent immunostaining of its protein in adenomas with high grade dysplasia, may well have caused the rapid progression to high grade dysplasia in many of the adenomas.

The two most common inherited conditions predisposing to colorectal cancer are familial adenomatous polyposis (FAP), caused by germline mutations in the APC (adenomatous polyposis coli) tumour suppressor gene, and hereditary non-polyposis colorectal cancer (HNPCC), caused by germline mutations in one of the DNA mismatch repair (MMR) genes. Together, FAP and HNPCC account for approximately 2% of colorectal cancer cases. In this report, a case is presented of a patient manifesting a severe phenotype who had inherited germline mutations in both the APC gene and the MMR gene MLH1.

CASE REPORT

A 10 year old boy attended the outpatient clinic for evaluation of slimy and bloody stools. His mother had previously been diagnosed with FAP. At the age of 27 years, she underwent prophylactic colectomy. Due to the development of extensive abdominal fibromatosis (desmoid tumour), she died at the age of 32 years. Genetic analysis had revealed a germline de novo β-catenin in early adenomas with low grade dysplasia, attributed to the APC gene mutation. Subsequent loss of function of the MLH1 gene, as shown by absent immunostaining of its protein in adenomas with high grade dysplasia, may well have caused the rapid progression to high grade dysplasia in many of the adenomas.

DISCUSSION

FAP is characterised by the development of multiple colorectal adenomas at a young age, usually before 20 years. Left untreated, one or more of the adenomas will have progressed to cancer before the age of 45 years. Therefore, most patients have a prophylactic colectomy in the second or third decade of life. The APC protein, dysfunctional in FAP, regulates the intracellular level of β-catenin, and controls diverse physiological processes in the colon epithelium including cell growth, adhesion, and apoptosis.

HNPCC is caused by germline mutations in one of the DNA MMR genes, including MLH1, MSH2, and MSH6. MMR deficient cells rapidly accumulate somatic mutations thus explaining the accelerated tumour progression in HNPCC patients. Clinical features of HNPCC include colorectal cancer at an early age (mean 45 years) with a predilection for the proximal colon, an increased frequency of poorly differentiated mucinous tumours, and a high incidence of extracolonic tumours (for example, endometrium, ovary, urinary tract).

To the best of our knowledge, simultaneous inheritance of both types of gene defects in one patient has never been reported previously. The 5 bp deletion at codon 1309 of the APC gene is the most commonly reported change in FAP patients and is typically associated with a severe phenotype with an early onset of disease and the presence of extensive polyposis. The MLH1 mutation we found has previously been described and is not associated with a particular phenotype.

In our patient, the germline APC mutation, followed by somatic loss of the wild-type allele, is likely to have triggered early and multiple adenoma formation. This is illustrated by abnormal expression of β-catenin that was seen in the early adenomas (fig 1). Loss of MMR function, due to the germline MLH1 mutation, and loss of the wild-type allele, may well underlie the rapid progression of dysplasia in our patient. The relevance of MMR dysfunction is supported by the finding that progression from low to high grade dysplasia observed in the adenomas was associated with loss of MLH1 expression (fig 1).

In addition, evidence has emerged from several animal studies of the important role of MMR genes in accelerated intestinal tumorigenesis, especially in an APC deficient adenoma of which many contained areas with high grade dysplasia. Genetic analysis revealed that the patient had inherited both his mother’s APC gene mutation as well as his father’s MLH1 gene defect.

Abbreviations: FAP, familial adenomatous polyposis; APC, adenomatous polyposis coli; HNPCC, hereditary non-polyposis colorectal cancer; MMR, mismatch repair.
background. In mice carrying both APC and MLH1 mutations, the incidence of intestinal adenomas was markedly increased compared with mice carrying only one of these mutations. Alternatively, the severe phenotype in our patient may in fact reflect the marked heterogeneity which is known to exist in both FAP and HNPCC.

Our patient probably has a higher risk of developing cancer at other sites than average FAP or HNPCC mutation carriers. Intensive follow up and surveillance are therefore warranted.

In conclusion, our case represents the first report of a patient with adenomatous polyposis who carried both a pathogenic APC and MLH1 germline mutation. The early adenoma onset and the rapid tumour progression in this patient illustrate that the multistep process of colorectal carcinogenesis in this setting was markedly accelerated.

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Figure 1 Normal colonic mucosa and areas of adenomatous epithelium with low grade dysplasia (A–C) and adenomatous epithelium with high grade dysplasia (D–F). Serial haematoxylin-eosin staining (A, D) and immunohistochemical (brown) staining of β-catenin (B, E) and MLH1 protein (C, F). In the adenomatous areas with low grade dysplasia, β-catenin staining is normal (membranous) in normal mucosa, in contrast with abnormal (cytoplasmic and nuclear) staining in adenomatous areas; MLH1 protein is expressed in both normal mucosa and adenomatous epithelium. In the adenomatous epithelium with high grade dysplasia, β-catenin staining is similar to the adenomatous areas with low grade dysplasia, whereas MLH1 protein expression is seen in normal mucosa but lost in areas with high grade dysplasia (magnification 100×).