Disorders of Sex Development in an Infant (46, XX) - A Case Report and Review of Literature

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Abstract

Background: Disorders of sex development (DSD) are congenital conditions in which there is a disagreement between phenotypic sex and genotypic sex. They involve problems of management and beliefs in developing countries. We report here a ten months old Congolese infant with abnormal external genitalia and make a mini-review on the normal embryonic development of genital tract and report the most common aetiologies’ of DSD.

Patients and Observations: Visualization of internal genitalia was realized by genitography. Genetic sex was determined by karyotyping, fluorescent in situ hybridization (FISH) analysis and polymerase chain reaction of SRY gene.

Results: Genitographic image showed the uterus and the vaginal cavity. Karyotype and FISH visualize two X chromosomes and absence of chromosome Y confirmed by negative SRY PCR amplification.

Conclusion: We concluded that this infant is of ten months old is a 46, XX-DSD male external genitalia with SRY-negative.

Keywords: Disorders of sex development; Sex genes; Embryologic genital development

Introduction

A disorder of sex development (DSD) is a congenital condition where there is a disagreement between chromosomal, gonadal and phenotypic sex [1-3]. Another definition is the discordance between phenotypic sex (macroscopic or somatic) and genotypic sex (chromosome and genetic sequence) [4].

DSD are rare pathologies with an incidence estimated at 1:2,000 to 1:5,500 live births and they are due to various multifactorial etiologies [5-7]. The proposed Chicago nomenclature divides the condition in six groups (Table 1) [7,8], and the terms of intersex disorders and pseudohermaphroditism are abandoned. The current etiologic classification of DSD according to the 2006 Group consensus Lawson Wilkins Paediatric Endocrine Society (LWPES)/European Society for Paediatric Endocrinology (ESPE) [8,9] depends on the adrenal or gonadal involvement and the karyotype analysis [6,8,9]. In congenital adrenal hyperplasia, we note that adrenal androgens excessive biosynthesis masculinizes the genitalia in 46, XX [10,11]. It is a medical emergency that must avoid a loss of NaCl at the risk of exposing to dehydration and to an acute renal failure. In 46, XY DSD (previously called male pseudohermaphroditism), testes are present but the external genitalia are nearly female [12]. In the group with 46, XX DSD (female pseudohermaphroditism), we note the presence of ovaries but external genitalia are incompletely male type with sometimes vaginal obliteration. In the last group, ovotesticular DSD, there is coexistence in the same gonad of both ovarian and testicular tissues [12].

The DSD are new topics in African developing countries, where diagnosis is sometimes delayed with complicated management. Their discovery even in at an early age engenders psychological disorders and problems to chose the gender of rearing [13].

In this work, we present genetic exploration of one Congolese child with abnormal external genitalia and make a review on the normal embryonic genital development and report the most common aetiologies’ of DSD.

Case Presentation

A 10-months-old infant has been declared a boy with external genitalia anomalies detected by the parents. The reason for consultation was ambiguous external genitalia and no palpable testes. The infant was...
born from a normal vaginal delivery of a diinniotic and dichorionic twin pregnancy of normal development. His twin is a boy with normal development. No notion of consanguineous parents was reported.

On clinical examination, the patient does not exhibit facial dysmorphism, nor weight bearing-delay. We noted a median genital tubercle (penoscrotal organ) with external urethral opening male type (Figure 1a), labio-scrotal (or genital) swellings evocative of labia majora and the absence of a labia minora and vaginal orifice (Figure 1b). The testes were not palpable. The anal orifice was normal. The genitographic image showed a uterine and vaginal cavity, but the fallopian tubes were not visible. The abdomino-pelvic ultrasonography was unusable. The patient was classified as Prader IV (Table 2) [12]. Hormonal investigation was not done, due to a lack of financial resources. The karyotype result was 46, XX. Fluorescent in situ hybridization analysis (FISH) (Figures 2a and 2b) was performed from lymphocyte pellets by using cytocell probes (Ref: LPF002; DXZ1 in green, DYZ3 in orange and D18Z1 in blue). It confirmed the absence of Y chromosome and the presence of two X chromosomes. The polymerase chain reaction (PCR) analysis (Figure 2c) has not detected SRY gene. From these results, the etiology of this DSD has not been defined because the patient has been lost to view. We concluded that the infant was a 46, XX male external genitalia stage Prader IV with SRY-negative.

Discussion

It appears that a good understanding of the normal embryonic development of the human genital tract helps to understand the DSD pathogenesis and how to manage the condition. Embryologically, the genital and the urinary system have the same origin. The development of the gonads (testes and ovaries) begins around four weeks of gestation (WG) by the formation of urogenital ridges originated from a part of the third embryonic layer, the intermediate mesoderm [8,14,15]. From urogenital ridge cells, two cellular masses appear and evolve successively towards transitional embryonic kidneys: pronephros and mesonephros and the definitive embryonic kidneys (metanephros). Mesonephros is constituted of the mesonephric (or Wolfian) ducts and the paramesonephric (or Müllerian) ducts (Figure 3) [14,15]. At the six WG, the primordial germ cells derived from ectodermal layer migrate from yolk sac into the urogenital ridges. They join the primary sex cords (originated from mesonephros and the coelomic epithelium) in order to form the bi-potential gonads [14,15]. At this embryonic stage, the gonads are undifferentiated; they are both identical in male and female embryos (Figure 3) [14,15]. However, the embryo genetic sex is already determined during the fertilization by the presence of an X or Y chromosome coming from the paternal spermatozoon [8,15].

The early gonadal differentiation is under the control of various genetic factors (Figure 4) expressed in urogenital ridges and mesonephros [9,12,16,17]. Approximately at the 7 WG, the specific male gene which is the transcription factor SRY (sex-determining region in the Y) mapped on Yp11.2 (with only one exon) is activated by some genes (essentially SF-1, WT1, CRE2, CBX2, GATA4, EMX2) to determine the male gonadal development [15]. SRY also called TDF protein (testis-determining factor) act on primary sex cords to become testes (by developing

| Stages | Description |
|--------|-------------|
| I      | Hypertrophic clitoris with normal others female genitalia |
| II     | Hypertrophic clitoris with urogenital sinus, vaginal and urethral openings covered |
| III    | Hypertrophic clitoris, with posterior and complete fusion of urogenital sinus, high urethro-vaginal confluence |
| IV     | Phallo with small urogenital opening. Detection of vaginal cavity by genitography |
| V      | Male genitalia |

Table 2: Prader classification.

Figure 1: External genitalia anomalies. a) Penoscrotal organ: Median penile clitoris with penile urethra and labio-scrotal folds evocative of labia majora. b) Penoscrotal organ with labia majora but no labia minora (by complete fusion of urogenital folds) and no vaginal orifice.

Figure 2: FISH and PCR analyses. a) FISH on cell interphasic nuclei, b) FISH on metaphasic chromosomes, showing two spots (green) of X chromosome. c) Agarose gel stained with ethidium bromide showing the amplified PCR fragment of SRY gene; PM: DNA ladder (100 pb); H: Male control with amplification of a 486 bp SRY fragment; F: Female control with non-amplification of SRY; PT: Index patient with absence of amplification of SRY gene.

Figure 3: Embryologic genital development, genetic and hormonal factors of sexual development in male gender.

Figure 4: Genetic factors (Figure 4) expressed in urogenital ridges and mesonephros (9,12,16,17).

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In the female gender embryo, gonadal development (ovaries) is induced on the one hand by the absence of the Y chromosome that prevents the expression of the SRY gene, and on the other hand by the presence of the two X chromosomes and the specific feminizing genes. These genes are DAX-1 (also known as NR0B1) mapped on Xp21.2, RPSPO1, WNT4 and FOXL2 (Figure 4) [8,9]. Primary sex cords degenerate and ovaries (containing primordial follicle with oogonia) originate from secondary sex cords [8,15]. The non secretion of androgens induces the regression of the mesonephric ducts at 8-9 WG, while the absence of AMH maintains the paramesonephric ducts from which the female reproductive tract is derived: the fallopian tubes, the uterus (by fusion of Müllerian ducts), and the upper two thirds of the vagina (Figure 4) [8,12,14]. Later, between 10-15 WG, female external genitalia develop under the influence of androgens deficiency on the one hand, and by estrogens stimulation on the other hand. The clitoris is derived from the genital tubercle, labia majora from the labioscrotal swellings, the non-fusion of the urogenital folds forms the labia minora and the lower third of the vagina originated from urogenital sinus [12,14,15].

The differentiation of the mesonephric ducts, the paramesonephric ducts and the external sexual structures allows defining the phenotypic sex. But, note that Y chromosome has a dominant effect, its presence (if no instability) induces male phenotype even in presence of two X chromosomes, except in case of mosaic (47, XXY/46, XX) in which the phenotype depends on the percentage of cells carrying SRY gene [14,19].

The current knowledge on normal embryonic and fetal development as well as the new diagnosis tools allows identifying: (i) fetal phenotypic sex, by the ultrasound monitoring of the pregnancy in the first trimester (starting from 12 WG), period where gonads and external genitalia are already differentiated [20]. The method is efficient in 99% to 100% of cases if no anomalies [20]. (ii) However, the genetic sex may be diagnosed very early at the beginning of the embryonic segmentation stage, and in medical practice during the first trimester of the pregnancy, for example from amniocentesis or choriocentesis.

In summary, in view of literature, normal sex development depends on three elements: the presence of specific male gene SRY on chromosome Y, the development and differentiation of testes and ovaries (depending on gonadal determining genes and hormonal factors), and the control of phenotypic sex by the secretion of specific sex hormones and peripheral androgen and oestrogen receptors [10]. So, imbalance in one of these sex-determining factors could lead to sexual abnormal development.

For example, mutation of the SRY gene or rearrangement in the Y chromosome (microdeletion, isochromosome, ring chromosome) can lead to SRY gene disorders capable of inducing sexual development of the female type to 46, XY male person [21]. In contrast, translocation of SRY on chromosome X, duplication of SOX9 or disorder in ovarian promoting genes can lead to virilisation of 46, XX female person [9,8,18]. Similarly, adrenal androgens excess induces virilisation of external genitalia in female 46, XX while internal genitalia may be intact [8].

According to the literature data, it appears that DSD in 46, XX are more reported and more frequent than in 46, XY [8]. But, a recent large cohort study on DSDS, in South Africa reports that the predominant group found was 46, XY DSD (57.5%), due to deficiency of androgen biosynthesis or action, while 46, XX DSD represent 33% of patients [22]. These results are consistent with those reported in Nigeria, Italy or in Sudan studies. In the latter 32.85% (23/70 patients) have 46, XY DSD with complete androgen insensitivity while 11.4% (8/70) patients show 46, XX DSD [13,16,23].

In order to complete etiologies, we summarize the common genetic causes of DSD reported in the review in (Table 3) [3,2,24,25].

In general, to investigate the various causes of DSD needs complementary para-clinic assessment based on radiological, hormonal, genetic, genetic molecular and histological analyses [2]. Radiological analyses include endoscopy, genitography, abdomino-pelvic ultrasound and magnetic resonance imagery (MRI) [4,19,20].
The consultation of a psychologist and social care are necessary for the parents and for the patient (if he is a teenager or an adult) [11,13]. The announcement must be made with great delicacy, preferably in the parents and for the patient (if he is a teenager or an adult) [11,13].

They allow visualization of the internal genital organs. Exploratory endoscopy allows visualizing the internal genitalia better and also to realize gonadal biopsy which is important for the diagnosis of ovotesticular DSD [19].

Genetic analysis will research genotypic sex based on: cytogenetic analyses (karyotype, FISH and aCGH) to look for sex chromosomes; molecular biology (PCR MLPA, Direct sequencing] for specific analyses (karyotype, FISH and aCGH) to look for sex chromosomes; DNA sequencing will research for genes mutations. Genetic analysis will research genotypic sex based on: cytogenetic analyses (karyotype, FISH and aCGH) to look for sex chromosomes; molecular biology (PCR MLPA, Direct sequencing] for specific analyses (karyotype, FISH and aCGH) to look for sex chromosomes; DNA sequencing will research for genes mutations.

Histological analysis is essential because it allows in case of ovotesticular DSD to specify the coexistence of ovarian tissue (follicles with oogonia or oocytes) and testicular tissue (seminiferous tubules with spermatogonia or spermatozoa) [1].

Table 3: Common etiologies of the DSD.

| Diseases | Clinical manifestations | MI | Gene / Enzyme | Locus/ Karyotype | References |
|----------|-------------------------|----|---------------|------------------|------------|
| Congenital adrenal hyperplasia (CAH) | Female IG, virilization of EG, ambiguous EG, adrenal glands well visible, acute genital failure, EG malformation | AR | -CYP21A2 / 21-OH (6p21.23) (80-95%) -CYP11B1 / 11-OH -3βHSD2 | 46, XX DSD | [5,16] |
| Glucocorticoid receptor mutations | Ambiguous genitalia | F or S | - | - | [8] |
| Aromatase deficiency | Genital ambiguity, tall stature, Virilisation of mother and fetus during pregnancy | CYP19(15p21.1) | 46, XX DSD | [8] |
| 5α-reductase deficiency | Pseudovaginal perineo-scrotal hypospadias, low virilisation, cryptorchidism, small penis, gynecomastia, female EG | AR | SRD5A2 / 5α-reductase type 2 (2p23) | 46, XY DSD | [2,3] ORPHA: 753 |

Chromosomal anomalies

| Klinefelter and variants | EG and IG male phenotype, hypospadias, impulsivity. | S | 47, XXY or mosaic | 46, XX/47, XXX++ | [19,24] |
| Turner and variants | Female phenotype, rare male phenotype, Gonadal dysgenesis, streak gonad | S | 45, X0 or mosaic | 45, X/44, X, XX++ | [21,25] |

Multisystem malformation syndromes

| Denys-Drash | Ambiguous genitalia or female EG, HTA, nephrotic syndrome, Wilms tumor, | AD | WT1 (11p13) | 46, XY DSD | OMIM # 194080 |
| Frasier | Ambiguous genitalia or female EG, Wilms' tumor, renal failure, gonadoblastoma | AD | WT1 (11p13) | 46, XY DSD | OMIM #136680; ORPHA: 347 |
| Fraser | Cryptophthalmia, syndactyly, laryngo-tracheal, ambiguous genitalia, ciliormegaly | AR | FRAS1 (4q21) ++ | FEM2 (13q13) | ORPHA: 2052 |
| Campomelic dysplasia | Gonadal dysgenesis, female appearance, skeletal anomalies, dwarfism | AD | SOX9 (17q24.3-q25.1) | 46, XY sex reversal | ORPHA: 2052 |
| Androgen insensitivity syndrome (AIS) | Gonadal dysgenesis, ambiguous genitalia, female / male phenotype, ectopic testes, gynecomastia, low virilisation, malignant tumors | AR | AR gene (Xq11-12) | 46, XY DSD | [2,3,6] |

DSD in others syndromes

| WAGR; Smith-Lemli-Opitz; Prader-Willi; VACTERL; CHARGE; | | | | | [6,12] |

MI: Mode of Inheritance; EGA: External Genitalia Anomalies; IG: Internal Genitalia; F: Familial; S: Sporadic; OH: Hydrolase; AD: Autosomal Dominant; AR: Autosomal Recessive; An: Abnormal; 3βHSD2:3β-Hydroxysteroid Dehydrogenase 2; AR Gene. Androgen Receptor Gene.

In Congo, the condition involves problems of beliefs, diagnosis, medical and chirurgical care. But collaboration between specialists (Geneticists, anatomopathologists, endocrinologists and pediatric surgeons) is in principle a great asset in the early management of this type of pathology.

It is important to diagnose DSD at new born age or during early childhood to allow an early choice of sex, in order to initiate a medication and a feminizing or masculinizing hormone therapy at the beginning of puberty. Concerning the assignment of sex of rearing, the attribution must be rapid. The choice of sex depends, in each case, on the results of genetic analyses and on the dominant genital organ. Clinicians must inform correctly the patient about the difference between the genetic sex and the phenotypic sex. Note for example that the female sex of rearing is recommended in congenital adrenal hyperplasia 46, XX DSD and in defect in androgen action 46, XY DSD especially if Müllerian derivatives are present [7].
Conclusion

This case report and review of data showed that hormonal, cytogenetic and molecular biology, radiologic and histologic analyses are the best way to allow the correlation of the genotypic sex and the phenotypic sex and to propose the best rearing sex. In case of parental consanguinity (not rare in Congo), parents can also have genetic counseling after positive etiological diagnosis. Finally, an important point from this work is a challenge for us about the urgent need to have a performing genetic platform and to work in a multidisciplinary medical team in order to perform the best diagnosis and management approach in this type of pathology.

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Conflict of Interests

The authors declared that they have no competing interests.

Author’s Contributions

IO, HP and MN established the clinical diagnosis; RN, HP, JPDD and CM performed the genetic analysis; HP drafted the paper. All the authors have read and approved the paper before submission.

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