Incidence of Inborn Errors of Metabolism by Expanded Newborn Screening in a Mexican Hospital

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Abstract

Newborn screening for the detection of inborn errors of metabolism (IEM), endocrinopathies, hemoglobinopathies, and other disorders is a public health initiative aimed at identifying specific diseases in a timely manner. Mexico initiated newborn screening in 1973, but the national incidence of this group of diseases is unknown or uncertain due to the lack of large sample sizes of expanded newborn screening (ENS) programs and lack of related publications. The incidence of a specific group of IEM, endocrinopathies, hemoglobinopathies, and other disorders in newborns was obtained from a Mexican hospital. These newborns were part of a comprehensive ENS program at Ginequito (a private hospital in Mexico), from January 2012 to August 2014. The retrospective study included the examination of 10 000 newborns’ results obtained from the ENS program (comprising the possible detection of more than 50 screened disorders). The findings were the following: 34 newborns were confirmed with an IEM, endocrinopathies, hemoglobinopathies, or other disorders and 68 were identified as carriers. Consequently, the estimated global incidence for those disorders was 3.4 in 1000 newborns; and the carrier prevalence was 6.8 in 1000. Moreover, a 0.04% false-positive rate was unveiled as soon as diagnostic testing revealed negative results. The most frequent diagnosis was glucose-6-phosphate dehydrogenase deficiency; and in the case of carriers, it was hemoglobinopathies. The benefit of the ENS is clear as it offers prompt treatment on the basis of an early diagnosis including proper genetic counseling. Furthermore, these results provide a good estimation of the frequencies of different forms of newborn IEM, endocrinopathies, hemoglobinopathies, and other disorders at Ginequito.

Keywords

incidence, expanded newborn screening, inborn errors of metabolism, inherited disorders, retrospective study

Introduction

Newborn screening for the detection of inborn errors of metabolism (IEM), endocrinopathies, hemoglobinopathies, and other disorders is a public health initiative that aims to identify these diseases in a timely manner, avoiding related complications that may arise if not detected on time. Early intervention is an important step in the management of these diseases, which are directly associated with affected patients’ final outcomes. Newborn screening uses dried blood spots (DBSs) as samples, which should be obtained after the first 24 hours of life following previously established and standardized procedures.1,2 The different screened disorders and the nomenclature used in this article, as suggested by Sweetman et al.,3 are provided in Table 1.
Thanks to the benefits of tandem mass spectrometry (MS/MS), nearly 40 diseases can be diagnosed. Detection programs, such as the one described in this report, began in the 1960s using DBSs for phenylketonuria (PKU) detection. A few years later, maple syrup urine disease (MSUD), homocystinuria (HCY), tyrosinemia, galactosemia, and congenital hypothyroidism (CH) were added.

Nowadays, the diseases included in newborn screening programs, detected by MS/MS, vary widely among countries. In the United States, the implementation of MS/MS is covered in almost all states, each state being in charge of the program management. Similarly, it occurs in Canada, where each province or territory is responsible for its own program. Until July 2008, all Canadian provinces and territories carried out a screening for PKU by MS/MS; however, heterogeneity is still present for the detection of other IEM.

In the case of Europe, the newborn screening for CH and PKU constitutes an obligatory requirement for all programs, and in recent years there has been an increased interest for expanding the number of screened diseases. For example, in Spain, the only IEM detected in all communities is PKU. Since 2001, the MS/MS is being used in Galicia to identify nearly 30 IEM. This technique is spread across the country; and in 2007,

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**Table 1.** The IEM, Endocrinopathies, Hemoglobinopathies, and Other Disorders Detected in the Ginequito’s ENS Program.

| Detection Method | Condition | Nomenclature |
|------------------|-----------|--------------|
| MS/MS Fatty acid oxidation disorder conditions | Carnitine acylcarnitine translocase deficiency | CACT |
| MS/MS | Carnitine palmitoyltransferase type I deficiency | CPT IA |
| MS/MS | Long chain l-3-hydroxyacyl CoA dehydrogenase deficiency | LCHAD |
| MS/MS | 2,4-Dienoyl-CoA reductase deficiency | DE RED |
| MS/MS Medium-chain acyl-CoA dehydrogenase deficiency | MCAD |
| MS/MS Glutaric acidemia type II | GA2 |
| MS/MS Carnitine palmitoyltransferase type II deficiency | CPT II |
| MS/MS Short-chain acyl-CoA dehydrogenase deficiency | SCAD |
| MS/MS Short-chain l-3-hydroxyacyl-CoA dehydrogenase deficiency | SCHAD |
| MS/MS Trifunctional protein deficiency | TFP |
| MS/MS Very long-chain acyl-CoA dehydrogenase deficiency | VLCAD |
| Organic acid disorder conditions 3-Hydroxy-3-methylglutaricaciduria | HMG |
| Organic acid disorder conditions Glutaric acidemia type I | GA |
| Organic acid disorder conditions Isobutyrylglycinuria | IBG |
| Organic acid disorder conditions Acute isovaleric acidemia | Acute IVA |
| Organic acid disorder conditions Chronic isovaleric acidemia | Chronic IVA |
| Organic acid disorder conditions 2-Methylbutyrylglycinuria | 2MBG |
| Organic acid disorder conditions 3-Methylcrotonyl-CoA carboxylase deficiency | 3-MCC |
| Organic acid disorder conditions 3-Methylglutaconicaciduria | 3MGA |
| Organic acid disorder conditions Methylmalonyl-CoA mutase deficiency (MUT 0 type) | MUT |
| Organic acid disorder conditions Methylmalonyl-CoA mutase deficiency (MUT type) | MUT |
| Organic acid disorder conditions Cobalamin disorders | Cbl A, B, C, D |
| Organic acid disorder conditions β-ketothiolase deficiency | β KT |
| Organic acid disorder conditions Acute propionic acidemia | Acute PROP |
| Organic acid disorder conditions Chronic propionic acidemia | Chronic PROP |
| Organic acid disorder conditions Holocarboxylase synthase deficiency | MCD |
| Organic acid disorder conditions Malonic acidemia | MAL |
| Organic acid disorder conditions Arginemia | ARG |
| Organic acid disorder conditions Acute argininosuccinic aciduria | Acute ASA |
| Organic acid disorder conditions Chronic argininosuccinic aciduria | Chronic ASA |
| Organic acid disorder conditions 5-Oxoprolinuria | 5OXOPRO |
| Organic acid disorder conditions Citrullinemia type I | CIT |
| Organic acid disorder conditions Citrullinemia type II | CIT II |
| Organic acid disorder conditions Homocystinuria | HCY |
| Organic acid disorder conditions Hypermethioninemia | MET |
| Organic acid disorder conditions Hyperornithinemia–hyperammonemia–homocitrullinuria | HHH |
| Organic acid disorder conditions Classic maple syrup urine disease | MSUD |
| Organic acid disorder conditions Intermediate maple syrup urine disease | MSUD |
| Organic acid disorder conditions Classic phenylketonuria | PKU |

(continued)
Other countries, such as Mexico, have recently incorporated MS/MS in their newborn screening programs; while China, South Korea, India, Japan, Malaysia, and Thailand are in the implementation phase.\(^4\)

The situation in Latin America is also diverse; some countries (Chile, Costa Rica, Cuba, and Uruguay) have well-established programs supervised by their own health authorities, with a coverage of over 98% in the diagnosis, treatment as well as follow-up regarding positive cases.\(^5\) Other countries, such as Mexico, Brazil, and Argentina, are expanding their coverage; some others are in the implementation stage (Colombia, Paraguay, Venezuela, Nicaragua, Peru); others such as Guatemala, Panama, and Ecuador have isolated activities concerning this matter; and others are not carrying out at all newborn screening activities (El Salvador, Honduras, and Haiti).\(^6\)

Mexico initiated a newborn screening program in 1973 that was aimed at detecting PKU, galactosemia, MSUD, homocystinuria, and tyrosinemia. Unfortunately, the program ended in 1977; nevertheless, it was in 1986 that another program was initiated for the detection of PKU and CH.\(^6\) By 1988, the Health Department published the Official Mexican Technical Norm, which stated that screening for CH was mandatory within all health institutions providing services for newborns. This official norm was obligatory in nature until 1995.\(^7\)

A few years later, in October 2003, the Official Mexican Standard for the prevention and control of birth defects was established (NOM-034.SSA2-2002), which subsequently modified (NOM-034.SSA2-2010 and NOM-034.SSA2-2013) to include more IEM, endocrinopathies, hemoglobinopathies, and other disorders.\(^8-11\) The differences between the type and number of diseases screened in newborns vary considerably worldwide and even within each country. This has been a huge problem and has represented a global concern, given that each nation has different regulations, economic resources, and disease frequencies.\(^8,12\)

With the aim of standardizing and establishing an expanded newborn screening (ENS) guidelines among states, the Department of Health and Human Services of the United States commissioned the elaboration of these recommendations to the American College of Medical Genetics (ACMG). As main proposal, the ACMG determined a 29-condition core panel and other 25 secondary targets, suggesting the employment of the MS/MS with mixed technologies as detection methods.

The diseases considered in the core panel had basic principles to be met, such as: a clinical diagnosis cannot be made within the neonates’ first 24 to 48 hours of life; tests featuring enough sensitivity and specificity; moreover, there should be proof that early detection offers beneficial outcomes and that early diagnosis leads to a specific treatment with a more favorable outcome.

On the other hand, the secondary targets included diseases that can be detected collaterally as part of the differential diagnosis of the core panel conditions and are clinically relevant in spite of the lack of an effective treatment.

The incidence of different IEM in Mexico is unknown or uncertain due to the lack of nationwide ENS programs.\(^13\) The Instituto Nacional de Pediatría and the Universidad Autónoma de Nuevo León have undertaken studies pertaining to ENS, which clarify the incidence within the Mexican population. Although limited data are available from these investigations, Mexican health providers and researchers still use this information and records from different countries to establish their cutoffs for a positive diagnosis.\(^2,12,14-16\)

Out of all diseases detected via the newborn screening program in Mexico, the most frequent one, according to the results of previous studies, is CH, with an incidence of 1/2000 newborns. Moreover, cystic fibrosis (CF) has a reported incidence of 1/3721, and the incidence of sickle cell disease ranges from 1/3721 to 1/5000.\(^2,13\) Significant variations arise depending on the region and studied population.\(^12,13\)

The retrospective study presented in this work was carried out at the Hospital de Ginecología y Obstetricia SA de CV (Ginequito), which was founded in 1976 and was initially dedicated to address women’s needs throughout their lives and to provide newborn care. It is a general hospital that offers medical care for the whole family, mainly for individuals from Nuevo Leon, Mexico; women and their newborns account for 85% of this hospital’s patients. Moreover, Ginequito launched an ENS program in July 2011, which included the detection of over 50 IEM, endocrinopathies, hemoglobinopathies, and other disorders, applying mixed technologies.

**Aim**

The purpose of this article is to present the local incidence of IEM, endocrinopathies, hemoglobinopathies, and other disorders in Nuevo Leon based on the first 10 000 newborns screened at Ginequito starting from January 1, 2012, to August 9, 2014. This new information will broaden the knowledge of the incidence of diseases detected by ENS in this northern Mexican population.

**Methods**

Ginequito, in collaboration with Genomi-k SAPI de CV, implemented an ENS program for the early detection and intervention of more than 50 IEM, endocrinopathies, hemoglobinopathies, and other disorders (Table 1). This is a retrospective study that included the evaluation of medical records and ENS results from all 10 000 screened newborns, starting January 1, 2012, at the hospital. Blood samples were taken by venipuncture between the neonates’ first 24 and 48 hours of life; the samples were then placed on filter paper.\(^17\) The DBSs were processed by PerkinElmer Genetics Laboratories in Bridgeville, Pennsylvania.

The technologies applied in the screened disorders detection were MS/MS, biochemical assays, isoelectric focusing,
and molecular studies. The first technology was used for studying the amino acid and acylcarnitine profiles; biochemical assays were performed in order to detect the principal biomarker related to congenital adrenal hyperplasia (CAH), CH, galactosemia, biotinidase deficiency (BIOT), and CF. Moreover, hemoglobinopathies were detected by isoelectrofocusing, and glucose-6-phosphate dehydrogenase deficiency (G6PD) was diagnosed by a molecular study.

The protocol put into practice during this ENS program consisted of a first sample, in which the technologies mentioned were performed; however, if the biomarker was reported out of the reference value, a second-tier analysis was carried out, or in the absence of a second step, a second sample was requested. The disease, its marker, the test, and the tier analysis are shown in Table 2.

In addition, a newborn screening result is considered false positive when a negative result in a diagnostic test is obtained.

Results

From January 2012 to August 2014, a total of 10 000 newborns were screened, of which 9812 were normal and 188 were abnormal. The summary of the results concerning the first sample are shown in Table 3. The newborns diagnosed directly from molecular studies done within the ENS included 26 having G6PD (26 [A-] phenotype) and 1 having a homozygous delta-F508 mutation. Furthermore, 1 newborn female was identified having heterozygous G1388A mutation for G6PD and 4 having delta-F508 mutation carriers for CF. Moreover, 64 newborn carriers with hemoglobin (Hb) disorders were detected: 7 Bart Hb, 38 Hb S, 3 Hb E, 1 Hb D Los Angeles, and 15 others with unidentified variants. On the other hand, for the 96 newborns presumed to be positive, the medical protocol was carried out.

In 6 of those 96 cases, a diagnostic test was requested due to the high analyte concentration and/or the biomarker encountered. Of that, 1 newborn was diagnosed with CAH due to 21-hydroxylase deficiency, 1 was ruled out for CH following a normal thyroid function test, and 1 was analyzed for further mutations after detecting 1 delta-F508 copy mutation, having a positive identification of (TG)12-5T/(TG)10-9 T. For the other 3 heterozygous for delta-F508 mutation, an additional molecular study could not be performed.

For the remaining 90 newborns presumed to be positive, a second DBS sample was requested. Of those, only 84 samples were processed (Table 4); 5 samples were not obtained due to a change of address or the provision of incorrect contact information, and 1 newborn had died due to a factor VII deficiency before his screening was concluded.

Of the 84 newborns who had a second sample taken, 76 had normal results and 8 remained abnormal (Table 4). Of the 8 abnormal cases, 2 had fatty acid oxidation defects that were confirmed with organic acid analysis of urine; 1 was a female with 3-methylcrotonyl-CoA carboxylase deficiency (3-MCC) that did not have the common 518insT mutation but had substantially elevated 3-OH-isovaleric acid levels in her urine. The second case featured a female with methylmalonic acidemia that did not show the 2 common mutations (N219Y or G717); nevertheless, methylmalonic acid was markedly elevated in her urine. Additionally, 2 other newborns showed positive elevated tyrosine; 1 patient was diagnosed with TYR I by plasma amino acid quantification, urine organic acid analysis, and positive succinylacetone, while the other case was ruled out by a normal plasma amino acid quantification. Another newborn was suggestive of MSUD; although the second-tier testing did not show a positive mutation (Y438 N), it was considered positive by plasma amino acid and organic acid analysis. Two other newborns showed a significantly elevated IRT (immunoreactive trypsinogen) value suggestive of CF; both were ruled out—1 by a negative sweat test and the other by a significant drop in the IRT values between her first and second samples. Finally, a newborn with presumptive positive BIOT was confirmed by the detection of a homozygous D444H mutation. However, even with the presence of a homozygous genotype, it was not enough to classify this case as a partial deficiency since the enzymatic activity in the newborn’s serum was 82%.

It should be noted that 29/84 newborns had a positive amino acid profile on their first sample, while 14 were diagnosed with transient neonatal tyrosinemia (TNT) when their tyrosine levels returned to normal in the second sample; 9 of those cases (64%) consisted of premature infants (24-36.6 weeks).

In summary, during the ENS program, the estimated global incidence for IEM, endocrinopathies, hemoglobinopathies, and other disorders was 34 newborns diagnosed of the total 10 000 screened. There were 26 diagnosed with G6PD, 2 with CF, 1 newborn with a 3-MCC, 1 case of methylmalonic acidemia, 1 newborn with CAH, 1 case of MSUD, 1 newborn with TYR I, and 1 newborn with BIOT (Table 5). Sixty-four newborns were identified with a hemoglobinopathy heterozygous mutation, 3 with CFTR heterozygous mutations, 14 with TNT, and 1 female carrier of G6PD.

In this study, the results of the ENS were obtained by applying mixed technologies that established a presumptive positive rate of 1.88% after analysis of the first sample. According to the adopted protocol, it was necessary to request a second sample for 90 cases, of which only 84 samples were obtained.

Furthermore, this study suggested that there was a false-positive rate of 0.04%; this value is related to the healthy newborns in whom no disease was detected after the diagnostic tests performed. On the other hand, the false-negative rate was assumed to be close to 0%. Therefore, the positive predicted value for detecting IEM, endocrinopathies, hemoglobinopathies, and other disorders is close to 89.5% among the screened newborns.

Discussion and Conclusions

The ENS program has the advantage of detecting over 50 IEM, endocrinopathies, hemoglobinopathies, and other disorders, presenting an estimated incidence of 3.4:1000 and a carrier
detection of 6.8:1000. This proves the importance of establishing a nationwide screening program for every newborn in Mexico. This finding is higher than expected, considering other previous reports.

A study undertaken in Nuevo Leon, Mexico, showed an IEM incidence of 1 in 5000, considering only 30 diseases screened by MS/MS in a sample size of 42,264 newborns, while our comparative results showed an incidence of 1 in 2500. Other countries, such as the United States, have published an incidence rate as high as 1 in 500, as compared to the rate of 1 in 295 in this study; over 50 IEM, endocrinopathies, hemoglobinopathies, and other disorders were included in that study as well. However, when specifically examining Table 2.

| IEM, Endocrinopathies, Hemoglobinopathies, and Other Disorders | First Tier | Second Tier |
|---------------------------------------------------------------|------------|-------------|
| **marker** | **test** | **marker** | **test** |
| CF | IRT | Fluoroimmunoassay | 39 common CFTR gene mutations and 4 polymorphisms | AS-PCR (Allele-specific Polymerase Chain Reaction) |
| CH | TSH | Fluoroimmunoassay | NA | NA |
| Hemoglobinopathy | Hemoglobin | Isoelectric focusing | Most common mutations associated with those types | AS-PCR |
| β (S, C, E, and D variants) | | | | |
| α (Bart trait) | Hemoglobin | Isoelectric focusing | NA | Organic extraction of 17-OHP |
| CAH | Total 17-OHP (17-hydroxyprogesterone) | Fluoroimmunoassay | NA | Quantification |
| BIOT | Biotin | Colorimetric assay | BTD gene mutations: G98: d7i3, D444H, RS38C, Q456H, A171T, D252G, R157H, and F403V | AS-PCR |
| G6PD | G202A, A376G, C563T, G1376T, and G1388A | AS-PCR | NA | NA |
| GALT | Total galactose (galactose plus galactose-1-phosphate) quantification GALT enzyme activity | Fluorometry assay | If total galactose is over the limit, free galactose is quantified. If GALT activity is under the limit, GALT mutations are tested: N314D, Q188R, S135L, K285N, and L195P | AS-PCR |
| Amino acid profile | Valine, leucine, isoleucine | MS/MS | Y438N mutation | AS-PCR |
| MSUD | Amino acids | MS/MS | If the Tyr is out of range, succinylacetone is quantified | Quantification |
| Other amino acid-related diseases (eg. tyrosinemia) | | | | |
| Acylcarnitine profile | C6, C8, C10, C10:1; C8/C2 and C8/C10 ratios | MS/MS | 985A>G, 199T>C | AS-PCR |
| MCAD | C16-OH, C16:1-OH, C18-OH, C18:1-OH, and C16-OH/C16 ratio | MS/MS | 1528G>C | AS-PCR |
| LCHAD | Glutaric acid bound covalently to carnitine, C5DC/C5-OH, C5DC/C8, and C5DC/C16 ratios | MS/MS | A421V, R402W | AS-PCR |
| Acylcarnitine profile | C3-acylcarnitine, C3/C2 and C3/C16 ratios | MS/MS | E168K, 1218del14/ins12, 1170insT | AS-PCR |
| Propionic acidemia | C3-acylcarnitine, C3/C2 and C3/C16 ratios | MS/MS | N219Y, G717V | AS-PCR |
| Methylmalonic acidemia | C5-acylcarnitine, C5/C0, C5/C2 and C5/C3 ratios | MS/MS | 932C>T (A282V) | AS-PCR |
| Isovaleric acidemia | C5-OH acylcarnitine, C5-OH/C8 and C5-OH/C0 ratios | MS/MS | 517insT | AS-PCR |

Abbreviations: BIOT, biotinidase deficiency; CAH, congenital adrenal hyperplasia; CH, congenital hypothyroidism; CF, cystic fibrosis; ENS, expanded newborn screening; G6PD, glucose-6-phosphate dehydrogenase deficiency; GALT, galactosemia; IEM, inborn errors of metabolism; IRT, immunoreactive trypsinogen; LCHAD, long chain 3-hydroxyacyl-CoA dehydrogenase deficiency; 3-MCC, 3-methylcrotonyl-CoA carboxylase deficiency; MS/MS, tandem mass spectrometry; MCAD, medium-chain acyl-CoA dehydrogenase deficiency; MSUD, maple syrup urine disease; NA, not applicable; TSH, thyroid stimulating hormone.
G6PD, the incidence obtained was nearly 1 in 400, less than that found by Lin et al who reported an incidence rate of 1 in 90.\textsuperscript{19}

The prevalence of IEM, endocrinopathies, hemoglobinopathies, and other disorders may vary depending on the number of diseases screened and the technology used for their detection. The higher detection rate reported in this study could be attributed to the inclusion of DNA testing at the first- and second-tier protocol as well as to the combination of technologies used for the screening process. Other variables that should be considered are the following: genotypic differences among populations and races, consanguinity, cutoff value differences among laboratories, and different sample sizes.

A Mexican group of researchers reported vast heterogeneity between medical institutions when exploring the diseases that were screened and the methodologies used.\textsuperscript{12} A comparison of the results is difficult, and establishing the actual disease incidence is merely a matter of speculation. The ENS carried out at the Ginequito Hospital used MS/MS as well as biochemical and molecular methods to detect more than 50 diseases related to IEM, endocrinopathies, hemoglobinopathies, and other disorders during first-tier testing, while additional mutation detection was performed during the second-tier testing for CF, BIOT, as well as amino acid and acylcarnitine profiles. This protocol enables the detection of more diseases than other newborn screening programs, offering a closer estimation of the real incidence of these diseases in the Mexican hospital.

The G6PD was the most frequently detected disease, which is in alignment with previously established worldwide incidence reports.\textsuperscript{19} Furthermore, this study detected carriers, mainly for hemoglobinopathies,\textsuperscript{20,21} and this is beneficial for the families as they received genetic counseling. Moreover, the important detection of TNT was also discovered, accounting for 14 additional cases. Although a benign condition in the short-term, there is evidence that in the long-term it may cause specific learning disabilities.\textsuperscript{22} Once again, the importance of early detection and the correct gathering of all data related to the newborn’s condition is highlighted, as they enable one to precisely diagnose patients to provide adequate care for these infants.

Table 3. Positive Results Obtained From the First Sample of 10 000 Newborns Screened.

| IEM, Endocrinopathies, Hemoglobinopathies, and Other Disorders Detection | First Tier | Second Tier |
|---|---|---|
| | Positive or PP | Carriers | Positive or PP | Carriers | First Sample Detection |
| G6PD | 26* | 1* | NA | 27 |
| CF | 11 | — | 1* | 4 | 11 |
| Hemoglobinopathies | | | | |
| Bart trait | — | 7* | NA | 7 |
| S, C, D, E variants | — | 57 | — | 57 |
| BIOT | 7 | — | NA | 7 |
| CH | 15 | — | NA | 15 |
| Acylcarnitine profile | 30 | — | 0 | 30 |
| Amino acid profile | 30 | — | 1 | 30 |
| CAH | 4 | — | 4 | 4 |
| Total | 188 |

Abbreviations: BIOT, biotinidase deficiency; CAH, congenital adrenal hyperplasia; CH, congenital hypothyroidism; CF, cystic fibrosis; G6PD, glucose-6-phosphate dehydrogenase deficiency; IEM, inborn errors of metabolism; NA, not applicable (no second-tier protocol available for these diseases); PP, presumptive positive.

*Newborns confirmed by the identification of a specific mutation, or the exempting of a diagnostic test.

Table 4. Positive Results Obtained From the Second Sample of 10 000 Newborns Screened.

| IEM, Endocrinopathies, Hemoglobinopathies, and Other Disorders Detection | Second Sample Analyzed | First Tier | Second Tier | Second Sample Detection |
|---|---|---|---|---|
| | | Positive or PP | Carriers | Positive or PP | Carriers | |
| Acylcarnitine profile | 27 | 2 | — | NA | 2 |
| Amino acid profile | 29 | 3 | — | 1 | 3 |
| CF | 5 | 2 | — | NA | 2 |
| BIOT | 7 | 1 | — | 1 | 1 |
| CAH | 2 | 0 | — | NA | 0 |
| CH | 14 | 0 | — | NA | 0 |
| Total | 84 | | | 8 |

Abbreviations: CAH, congenital adrenal hyperplasia; CH, congenital hypothyroidism; CF, cystic fibrosis; IEM, inborn errors of metabolism; NA, not applicable (no second-tier protocol available for these diseases); PP, presumptive positive.
There are still inaccuracies in the sample collection that need immediate attention and improvement, such as its technique, shipping, and storage as well as the correct reporting of an infant’s age, diet, drugs, transfusions, ethnicity, and so on. However, it is well known that the purpose of screening is to significantly reduce the false-negative rate, leading to a rise in false-positive results.

Concerning follow-up, once a positive result is detected, parent education becomes a priority; so an adequate diet and treatment options can be initiated to avoid additional stress and to prevent permanent damage or even death. More ENS programs should be undertaken in countries where the incidence of IEM, endocrinopathies, hemoglobinopathies, and other disorders is not yet clear in order to establish the frequency of these diseases. This will also allow affected patients to be treated promptly. In the cases presented, preventive measures were undertaken in a timely manner for all G6PD cases. In the same way, treatment was initiated for patients diagnosed with MSUD, tyrosinemia type 1, CAH, 3-MCC, and methylmalonic acidemia. Genetic counseling was provided to all families with diagnosed newborns.

The ENS Program carried out at Ginequito bolsters our comprehension of the real frequency of IEM, endocrinopathies, hemoglobinopathies, and other disorders in the northern Mexican hospital, which can be used to further our understanding of these diseases. Developing the ENS program for all newborns born at this hospital is an ongoing task; however, it is still critical to raise awareness of the importance of a unified nationwide ENS program to obtain the real incidence rates of diseases screened in all of Mexico.

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