Leigh's Syndrome: A Case Report
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Citation

Abstract
Leigh Syndrome (LS) is a rare, progressive neurodegenerative disorder and the case reports in Indian literature are scanty. Nevertheless, it is one of the few neurometabolic disorders where supportive treatment is found to ameliorate clinical symptoms, at least partially. Apt use of neuro-imaging and genetic analysis needs to be emphasized if the disease is to be diagnosed at the earliest presentation. Genetic analysis for mutation detection has significant diagnostic and prognostic implications. We report a two and a half year old Indian child with clinical and laboratory features of Leigh Syndrome suggested by neuro-imaging and genetic analysis.

CASE REPORT
A two and a half year old boy, born full term, out of second degree consanguineous marriage to a fifth gravida mother presented with cough, cold, fever and increased work of breathing for 2 weeks prior admission. He was mechanically ventilated for 9 days for acute bronchopneumonia with respiratory failure at a local hospital before admission into our hospital. The mother has a history of two abortions prior to the birth of this child and unexplained neonatal death on the matriarchal lineage. His birth weight was 3 kg and there was no history suggestive of perinatal asphyxia. He had two sisters who were healthy.

Figure 1
Figure 1: Pedigree Chart

The child was asymptomatic till 9 months of age when he developed fever and seizures and was administered symptomatic treatment. He had attained standing with support, sitting without support and bisyllables by that age. One and a half months later, he was noticed to have difficulty in speaking and subsequent arrest in gaining further developmental milestones in all domains. There has also been a loss of personal-social and language mile stones since then and he has also failed to thrive.

On admission into our hospital, the child was febrile and chest auscultation revealed bilateral crepitations and rhonchi. On neurological examination, he was conscious but not oriented to the surroundings. His right pupil was normal in size and reacting to light but his left pupil was dilated and not reacting (pharmacological mydriasis). There were no other cranial nerve palsies. Motor system examination showed hypertonia (lower limbs more than upper limbs and left side more than right side) and involuntary movements-bilateral choreoathetoid movements and myoclonic jerks. His deep tendon reflexes were exaggerated and plantar reflexes were equivocal. He did not fix his eyes or follow light. Fundus examination and visual evoked potentials were normal. He also had a palpable liver of 2 cm below the costal margin.

In view of the above a clinical possibility of a mitochondrial disorder was considered and he was investigated accordingly.

MR Imaging of the brain revealed diffuse cerebral and brainstem atrophy. There were bilateral symmetric T2 hyper intense lesions involving the pulvinar and dorsal aspects of the thalami and in the parietal, occipital and posterior temporal regions. The involved regions showed restriction of diffusion on diffusion-weighted imaging. The imaging findings were consistent with a progressive
neurodegenerative disorder and suggested the diagnosis of a mitochondrial encephalopathy.

**Figure 2**
Figure 2: Axial Diffusion weighted images reveal restriction of diffusion in the posterior parts of the thalami as well as the cortex of the posterior temporal and occipital lobes on either side.

**Figure 3**
Figure 3: Axial FLAIR images reveal hyperintense lesions involving the thalami on both sides. The grey matter lesions are apparent only as effacement of sulcal spaces in the temporal and occipital regions.
Leigh Syndrome: A Case Report

There was no metabolic acidosis and his arterial lactate estimation was normal. Serum ammonia was not elevated. CSF analysis was normal except for a slightly elevated lactate. 2, 4 DNPH (dinitro-phenylhydrazine) Test was positive on metabolic screening. This observation in the absence of neuro-infection was suggestive of a mitochondrial disorder, - Leigh Syndrome. To investigate the genetic basis, we screened complete ND5 and ATPase6 genes of the child and his mother for known and novel mutations. Genomic DNA was isolated from the leucocytes and both genes were PCR-amplified using specific primers and the purified products were sequenced using Big dye terminator cycle sequencing ready kit (Ver 3.1, Applied Biosystems, Foster City, CA) on ABI 3730 Genetic Analyzer (Applied Biosystems). The sequences were analyzed using Seqscape software by comparing them with Cambridge reference sequence for mitochondrial genome. ATPase-6 gene harboured two mutations C9094T and A8860G, which were homoplasmic and found in his mother too. While A8860G has been identified in normal individuals, the nature of change of amino acid (leucine to phenylalanine) associated with C9094T mutation may be suggestive of its causal nature. Few homoplasmic polymorphisms such as G12372A and G13194A were identified in ND5 gene in both the child and his mother, but were likely to be of no significance as per the literature.

Respiratory infection was managed with intravenous antibiotics (piperacillin-tazobactum and tobramycin), salbutamol and budesonide nebulisations and supplemental oxygen. He was also commenced on antiepileptics (phenytoin and valproate). Phenytoin was gradually tapered off and stopped. Specific supportive therapy for the suspected mitochondrial disorder was begun with intravenous thiamine infusions, oral haloperidol, carnitine and alkali supplementation and oral coenzyme Q (ubiquinone). Enteral feeds were commenced and the feed volumes were gradually increased. In view of the persistent fever and the ear discharge showing gram negative bacilli on Gram stain, the antibiotics were upgraded to ceftazidime and amikacin on the 5th day of admission. Over the next 4 days, his fever defervesced and the choreoathetoid movements showed a significant improvement. Supplemental Oxygen was gradually weaned and stopped. He was discharged home after 12 days. He was also started on oral riboflavin on follow up. Later on he was hospitalized twice for acute bronchopneumonia. Subsequent therapy with intramuscular benzathine penicillin once in every 3 weeks reduced the incidence of respiratory infections significantly.

Developmental assessment after 6 months (at the age of 3 years) revealed a developmental quotient of 46, indicating a moderate developmental delay. Though he was dependent in self-help skills, he was able to comprehend simple 1-2 word phrase instructions and express through differential cry and vocalization. (2-3 word vocabulary) Hypertonia improved and there were no involuntary movements. Attention could be aroused but he got distracted easily. He had a concept of household items. Eye contact was present.

DISCUSSION

Leigh Syndrome, is a rare, inherited neurodegenerative disorder with characteristic pathological features usually presenting in infancy or early childhood.

It was first reported by Denis Leigh, in 1951 in a 7 month old infant. The estimated prevalence of Leigh Syndrome was 2.05 cases per 1,00,000. The preschool incidence of Leigh syndrome was 1 out of 32,000. In India, Bhavsar VM, Kumta NB, described the role of CT Scan of the brain in the diagnosis of Leigh Syndrome in 1991. Ghosh and Pradhan, reported two children with Leigh Syndrome suspected clinically and confirmed by MRI in 1996. The children showed partial response to parenteral thiamine and MRI
lesions showed partial improvement with time over one year of follow up. In one of their patients, medulla and spinal cord were involved which is extremely rare. In 2004, Mannan and Sharma et al., reported autopsy proven Leigh Syndrome in a 15-month-old girl admitted with cough and hyperventilation. In 2005, Hombal and Narvekar, reported Leigh Syndrome in a 3-year-old child with regression of milestones and involuntary movements. The diagnosis in their case was based on neuroimaging.

There are at least four genetically determined causes of Leigh Syndrome, Pyruvate dehydrogenase complex deficiency, complex I deficiency, complex IV deficiency (COX), and complex V (ATPase deficiency). These enzymes, when defective, are known to disturb oxidative phosphorylation and lead to failure of organs with high oxidative metabolic demand such as neuro-muscular system. All the five complexes except complex II are heterogeneous in their origin i.e. components of all the four complexes are encoded by both nuclear and mitochondrial genomes. ND5 and ATPase6, which are mitochondrial component of complex I and complex V respectively, are one of the frequent genetic causes for occurrence of Leigh Syndrome. The activity of these complexes can be detected by histochemical studies of fresh muscle tissues or cultured skin fibroblasts.

The mutations can arise sporadically or be inherited by autosomal recessive transmission (COX deficiency) or X linked transmission (PDHE1 deficiency) or by maternal transmission (complex V deficiency ATPase6 nt 8993 mutation). Maternal inheritance accounts for 20 % of the cases. Mutations in other mitochondrial genes ND4 and ND6 and nuclear genes such as SURF-1 are also reported to be associated with Leigh Syndrome. Yang and Sun et al. reported A8344G, T8993G, T8993C, A3243G, G604C and SURF-1 mutations in a retrospective study of 65 patients with Leigh Syndrome. Yang and Sun et al. reported A8344G, T8993G, T8993C, A3243G, G604C and SURF-1 mutations in a retrospective study of 65 patients with Leigh Syndrome. Neuroimaging, plays an important role in diagnosis as well as follow up of patients with Leigh Syndrome. CT scans may reveal bilateral symmetric areas of low attenuation involving the basal ganglia. On MR imaging, signal changes characterized by low signal on T1 weighted images and high signal on T2 weighted images, have been most commonly reported in the basal ganglia, thalamus and brainstem. Variable involvement of the cerebral and cerebellar cortex, cerebral and cerebellar white matter and the spinal cord has also been reported. The affected regions show restriction of diffusion in the acute phase. MR spectroscopy of the basal ganglia typically demonstrates high lactate levels, decrease in NAA/creatine levels and elevation of choline/creatine ratio. These metabolites are useful indicators of prognosis and response to therapy.

Autopsy findings include focal symmetric areas of necrosis in the thalamus, basal ganglia, tegmental gray matter, periventricular and periaqueductal regions of the brainstem and posterior columns of the spinal cord. These lesions show cystic cavitation with neuronal loss, demyelination and vascular proliferation. Demyelination with relative preservation of neurons and axon differentiates these lesions from those of hypoxic or ischemic origin.

Specific therapy for mitochondrial disorders in children is not available. The results and prognosis are variable. The aim of symptomatic treatment is to improve the ATP production and to lower the lactate levels. High concentrations of lactate can inhibit glycolysis, increase triglyceride turnover or modulate the function of ATP-
sensitive K+ channels. The osmotic effect of accumulated intracellular lactate can cause cell swelling.24 Thiamine, a cofactor of pyruvate dehydrogenase complex has been reported to improve the neurological status in some patients.25 Dichloroacetate has been reported to alter the clinical course of acute deterioration in adult patients with T8993C mutation.24 It is delivered to mitochondria via the transport system for pyruvate; and stimulates the overall activity of the PDH complex in most tissues except for intestine and testes. Dichloroacetate inhibits pyruvate dehydrogenase kinase and thus maintains PDH in a nonphosphorylated, catalytically active form.23 In children, it was shown to produce clinical and biochemical improvement possibly by reducing toxic accumulation of lactate, but could not prevent the natural progression of the syndrome.25 Marked improvement was observed with riboflavin, which nearly normalized the adenosine triphosphate production.26, 27 Rapid clinical and biochemical improvement was observed in patients with acute central respiratory failure with the use of intravenous soya bean oil (ketogenic emulsion).28 Ketogenic diet has been found to improve the outcome in those with a deficiency of pyruvate dehydrogenase.22 Coenzyme Q and carnitine also have been found to be effective. Leung TF, Hui J et al described significant relief of dystonia with intramuscular botulinum toxin.29 Nucleus transplantation into enucleated oocyte is emerging as a new option for prevention of mitochondrial disorders.30

This child presented to us with regression of developmental milestones, seizures and acute exacerbation caused by a trivial respiratory illness. These symptoms pointed towards a neurodegenerative disorder. There was a maternal history of recurrent abortions and unexplained neonatal death on the matriarchal lineage. Earlier studies have shown that mutations causing Leigh Syndrome can be associated with multiple neonatal deaths.31 Examination revealed delayed development, hypertonia, disorientation and bilateral choreathetoid movements all of which are recognized features of Leigh Syndrome. CSF lactate was slightly elevated, but arterial lactate was normal. Though Leigh Syndrome is conventionally associated with elevated serum lactate, earlier studies have shown that serum lactate can be well within normal limits in spite of definite neuroradiological features and spectroscopic evidence of elevated brain lactate.32 MR Imaging of the brain revealed diffuse cerebral and brainstem atrophy. There were bilateral symmetric T2 hyperintense lesions involving the pulvinar and dorsal aspects of the thalami and in the parietal, occipital and posterior temporal regions. The involved regions showed restriction of diffusion on diffusion-weighted imaging. The imaging findings suggested a progressive Neurodegenerative disorder with the possibility of a mitochondrial encephalopathy. This is consistent with neuroradiologic findings in previous reports of Leigh Syndrome,5, 19, 19, 20.

In mutation analysis, we did not find any of the reported mutations such as G13513A, A13084T and T12706C in the ND5 gene. Although few synonymous mutations were observed, they cannot explain the pathogenic role of ND5 gene in this patient. However, two non-synonymous mutations, A8860G replacing threonine with alanine at 112 position (T112A) and C9094T substituting leucine with phenylalanine at 190 position (L190F) were identified in the ATPase6 gene. A8860G is a well-known polymorphism reported in several mitochondrial disorders and part of a haplogroup H in Northeast German and other populations but C9094T is a novel mutation, never reported in any patient with Leigh Syndrome. It was identified in only two normal, healthy individuals (Indians). At 9094 position in the mitochondrial genome, which is a part of ATPase-6 gene, cytosine (C) is present and as a result of transition cytosine is being replaced by thymine (T). This transition results in substitution of leucine (L) by phenylalanine (F), which may affect the function of ATPase6 protein. C9094T could have some functional consequences in view of the nature of change of amino acid and the residue being conserved across the chimpanzee and gorilla. The mutation cannot be classified as a pathogenic or even probably pathogenic according to the scoring system criteria as functional studies (such as PCR) and biopsy of affected tissues have not been performed. Mutation analysis has not been repeated in another laboratory owing to the lack of facilities. Further studies are essential to determine the exact structural effects of the mutation. The positive 2, 4 dinitro phenyl hydrazine test could possibly be attributed to concurrent valproate therapy.

Thus the child has three minor clinical criteria and one minor biochemical criterion according to the modified Walker's criteria for pediatric population namely Symptoms compatible with an RC defect, Metabolic indicator of an RC defect (elevated CSF Lactate), Previous maternal history of recurrent abortions and unexplained neonatal death on the matriarchal lineage and a Movement disorder. These suggest a probable mitochondrial disorder. There was radiological
evidence of a mitochondrial disorder and earlier researchers have reported patients with Leigh Syndrome whose diagnosis was based on neuroimaging alone.  

Enzymology, histology and functional fibroblast ATP synthesis rate were not performed due to the paucity of facilities. Molecular studies revealed a novel mutation but further research is warranted before the pathogenicity of the mutation is established. There was an appreciable improvement with thiamine, carnitine, coenzyme Q and riboflavin. Repeat neuroimaging was not performed as there were financial constraints and the studies done previously to document radiological improvement with supportive therapy were inconclusive. The frequency of respiratory illnesses which can worsen the neurological picture came down noticeably with intramuscular benzathine penicillin prophylaxis. The child is on regular follow up now for the past 2 years and is able to comprehend simple 1-2 word phrase instructions. Hypertonia and involuntary movements improved. He has a concept of household items. Motor development is normal for age. There are no further episodes of stress related neurological deterioration.

CONCLUSION
Mitochondrial disease cannot be cured completely. Efforts for prevention and prenatal diagnosis are still in the nascent stage. With appropriate investigations, accurate diagnosis and prompt institution of adequate supportive therapy, symptomatic amelioration can be achieved, thereby adding life to the limited years of survival of these children. Further research aimed at prenatal identification of the responsible mutations and prevention of the disease is warranted.

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Figure 5
Table 1: Relevant Investigations

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total leukocyte count</td>
<td>12,700 / mm³</td>
</tr>
<tr>
<td>C Reactive Protein (CRP)</td>
<td>8.86 mg/d</td>
</tr>
<tr>
<td>Serum Sodium</td>
<td>129.7 mEq/l</td>
</tr>
<tr>
<td>Serum Calcium</td>
<td>7.3 mg/dl</td>
</tr>
<tr>
<td>Serum Lactate</td>
<td>10.2 mg/dl (Normal: 4.5 - 20 mg/dl)</td>
</tr>
<tr>
<td>Arterial Blood Gas analysis</td>
<td>pH 7.07, PCO2 43.8, PO2 33.2, HCO3 26.7, BE 27</td>
</tr>
<tr>
<td>Prothrombin Time</td>
<td>16.6 seconds</td>
</tr>
<tr>
<td>Control</td>
<td>12.1 seconds</td>
</tr>
<tr>
<td>Partial Thromboplastin Time</td>
<td>140.8 seconds</td>
</tr>
<tr>
<td>Control</td>
<td>35.5 seconds</td>
</tr>
<tr>
<td>Fibre Degradation products</td>
<td>&gt;1000 ng/ml</td>
</tr>
<tr>
<td>Blood for bacterial antigen detection</td>
<td>Positive for influenza B and N meningitidis</td>
</tr>
<tr>
<td>Blood for Culture and sensitivity</td>
<td>Staph</td>
</tr>
<tr>
<td>Serum Bilirubin total</td>
<td>10.32 mg/d</td>
</tr>
<tr>
<td>Indirect</td>
<td>11.44 mg/d</td>
</tr>
<tr>
<td>Blood for metabolic screening</td>
<td>2.4 GNHP test positive</td>
</tr>
<tr>
<td>Urine analysis</td>
<td>8 Tjpus cglycine, Protein &gt; Keto acid bodies</td>
</tr>
<tr>
<td>CSF Cell Count</td>
<td>Nil</td>
</tr>
<tr>
<td>Biochemical Analysis</td>
<td>Normal</td>
</tr>
<tr>
<td>Gram stain smear</td>
<td>Gram negative bacilli seen</td>
</tr>
<tr>
<td>CSF:Brain ratio</td>
<td>0.6 mg/ml (Normal: &lt; 1.2 mg/ml)</td>
</tr>
</tbody>
</table>

References
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