The Association of Rothmund Thomson Syndrome and Cystic Fibrosis: Case Report

Rothmund Thomson Syndrome, a rare recessive autosomal genetic skin disease, is characterized by poikiloderma, growth retardation, congenital bone defects, and premature aging of the skin. Cystic fibrosis (CF), on the other hand, is a common genetic disease that causes respiratory problems, digestive issues, and other health complications.

This case report describes a four-year-old boy with Rothmund Thomson Syndrome (RTS) and Cystic Fibrosis (CF). The boy presented with symptoms of both conditions, including poikiloderma, growth retardation, and respiratory issues.

Key Words: Rothmund-Thomson syndrome; cystic fibrosis
pulation which is resulted in premature respiratory failure. It is characterized chiefly by obstruction and infection of airway and by maligestion and its consequences. CF is the major cause of severe chronic lung disease in children and is responsible for most exocrine pancreatic insufficiency during early life. The other features of CF are failure to thrive, abnormal stools, intestinal obstruction, electrolyte and acid-base abnormality, vitamin deficiency states, acrodermatitis-like rash, edema and the existence of family history. The association of CF with albinism and eczema has also been reported. Airway abnormalities may be found in patients with RTS. To the best of our knowledge, the association of CF and RTS has been initially described by Lewis in 1972. Herein, we report a four-year-old boy with RTS and CF.

A 2-year-old boy presented with generalized discolorations and erythema. The clinical onset of lesions was about 6 months of age. He had a history of recurrent respiratory tract infections beginning early in infancy. He was delivered at full term with no complication throughout the pregnancy. He was the third child of the family and his siblings had normal physical and dermatological examination.

Physical examination revealed hepatomegaly and expiratory rhoncus. The patient was well be-
low the 25th percentile for weight and length and at the 50th percentile for head circumference. On laryngeal examination, laryngeal adhesions were detected. He had normal intelligence. Other physical findings were unremarkable. Dermatological examination revealed erythema on the cheeks (Figure 1) and dorsal aspects of the hands. In addition to hyperpigmentation, erythematous papules and atrophy on extensor aspects of arms, forearms, trunk and the legs, subungual hyperkeratosis was found on the both first toe nails. Hematological and biochemical tests were normal except elevated ESR (65 mm/hr) and an abnormal sweat test (Na+ 104 mmol/L). Immunoglobulin (IgG, IgM, IgA, IgE) and hormone (FT3, FT4, TSH) levels were within normal limits. Direct mycological examination and mycological cultures of first toe nails were negative. Radiological examination showed widespread infiltration at the right lung and normal appearance of bones. Histopathological examination of skin lesions on the distal limb showed lamellar hyperkeratosis, epidermal atrophy, hydropic degeneration of the basal cell layer, telangiectatic vascular proliferation in superficial and deep dermis, increase and homogenization of collagen fibers (Figure 2). Chromosomal analysis could not be performed in our case due to technical insufficiencies. RTS and CF were diagnosed based on clinical, laboratory and histopathological findings. Sunscreen cream was suggested for UV-protection. After 2 years-follow up period, characteristic appearance of poikiloderma on the affected areas especially on the cheeks and hyperkeratotic papules particularly on the extensor surfaces of the extremities and cuticle fingers have been detected (Figure 3, 4).

**DISCUSSION**

Chromosomal anomalies, ultraviolet-A (UVA) induced DNA damage and abnormal repair processes, lymphocyte and fibroblast radio sensitivity, growth hormone deficiency, a defect in connective tissue metabolism are suggested from the mechanism which is responsible for the increase of carcinogenesis and photosensitivity in RTS. As in our case the location of lesions especially on photo-exposed areas supports the role of UV in the etiology of RTS.

The diagnosis of RTS is made currently on clinical findings since diagnostic laboratory test for RTS is unavailable. Skin biopsy may show poikiloderma. Molecular tests may be useful in confirming the diagnosis. Mutational heterogeneity and environmental factors appear to be responsible for highly variable involvement of the lung, pancreas and other organs in CF. In our case, there was poikilodermic appearance on predominantly photo-exposed areas in addition to recurrent respiratory tract infections from his early infancy and laryngeal adhesions that may be developed due to both RTS and CF presence. Histological examination of a skin biopsy showed poikilodermatous skin reaction pattern. He had no clinical and laboratory findings of other congenital poikiloderma such as ataxia telangiectasie, Fanconi’s anaemia and Bloom’s syndrome.

RTS is an autosomal recessive skin disorder and genetic defect is mutations in the RECQL4 gene (human DNA helicase gene) of chromosome 8. Hallman and Patiala also described autosomal dominant inheritance in a patient. Sex linked inheritance was not reported and spontaneous mutation was accused for RTS. It has been reported patients with RTS who have abnormalities including trisomy 7 and trisomy 8.  

CF is inherited as an autosomal recessive trait. Skin symptoms in CF are rare. But, the association of CF with albinism, eczema and acrodermatitis enteropatica-like eruption has also been reported. All of the more than 700 gene mutations that contribute to the cystic fibrosis syndrome occur at a single locus on the long arm of chromosome 7.  

There was not family history of RTS and CF in our case. 

Lewis reported the association of RTS and CF that was the first case in 1972. CF was called as a fibrocystic disease of the pancreas in this literature.

In our case which is the second report in the literature, although chromosome analyses were not able to perform due to technical insufficiencies, we think that this association might be either due to a mutation in both chromosome 7 and 8 or due to coincidence.
REFERENCES