Welcome Families and Professionals

We have come a long way in understanding what it means to have Kabuki syndrome since it was first described in 1981. Studies and their resulting published articles have given us objective data, helping to decipher what is typical for the syndrome and what is simply typical for that individual. Equally important has been the observations and sharing of information between parents and professionals.

The Medical Management Package has been a joint effort between Margot Schmiedge, founder and director of Kabuki Syndrome Network (KSN) and Peta Colton, founder and director of Supporting Aussie Kids with Kabuki Syndrome (SAKKS). It was developed to provide users with an easy to read and print alternative. This package is designed for educational purposes only. It is not intended for diagnosis or advice on medical conditions. It is not meant to endorse particular therapies, treatments and/or medicines. It is paramount that families seek care from the professionals. In addition, this package will only be updated occasionally. The best place for current, up-to-date information is at the respective websites: www.kabukisyndrome.com and http://www.sakks.org.

The articles may use medical terminology. It is difficult to avoid since one medical word often requires ten layman’s words. There are many online dictionaries available or, if you prefer, you can use the one at www.kabukisyndrome.com.

The language used to describe varying disability has evolved as society has gained increased knowledge. Some terms have acquired shameful implications because of misuse. We will always refer to a child with Kabuki as just that – not a Kabuki child. The terms cognitive disability and intellectual disability are used interchangeably. ‘Developmental delay’ is a term often used by professionals. It usually means there are global delays present, including either or both physical and intellectual. It’s a ‘safe’ term because ‘delay’ infers that the individual will eventually catch-up. After all, a delayed flight does eventually arrive! We are not suggesting that we get hung-up on the terms we use, just that they are respectful and accurate for the situation.

Many families find it helpful to keep their child’s medical records and notes in a binder, which they bring with them to appointments for handy reference.

We would like to throw a word of caution, especially to new parents of children with Kabuki. In the coming years you will be inundated with research, advice, and medical procedures. Each family will find it necessary to weed out what is important and what is not for their individual child. Sometimes, though, we need a reminder that it be kept in perspective, that we don’t become wholly obsessed with caloric counts, medical procedures and therapies, and in the process, forget to enjoy our children!
More common ocular conditions can include:
- blue sclerae
- strabismus
- coloboma
- ptosis
- microphthalmia

Less common conditions can include:
- nystagmus
- Peters’ anomaly
- Marcus Gunn phenomenon
- optic nerve hypoplasia
- obstructed nasolacrimal ducts
- refractive anomalies
Dental

Teeth are often wide spaced, irregularly shaped and/or misaligned. Hypodontia is common, in particular missing upper incisors.

Sensitivity to oral stimulus frequently interferes with proper oral hygiene.
Important Dental and Orthodontic Issues for Children with Kabuki Syndrome

By Bryan J. Williams DDS, MSD, MEd
Pediatric Dentistry and Orthodontics

Oral health is important for all children but is especially important for children with special medical and/or developmental challenges. Children with Kabuki Syndrome have a complex array of special features and functional challenges. Good oral health and proper dental follow up is an important element in the overall care pathway for these children. This paper outlines important issues in dental development, oral health care, facial growth and development and orthodontic care.

Facial Growth Patterns

Children with Kabuki Syndrome have characteristic facial features that have been well documented and described in the literature and this paper will not describe these in detail. As we well know, there is classically some flatness in the cheek areas below the eyes and lack of forward projection of the cheek bones. The lower portion of the face is often disproportionately long compared to typically developing children. This pattern of facial features is rooted in the growth patterns of the jaw structures and the neuromuscular environment. In this paper we will focus on the underlying facial development which has implications for facial pattern, jaw alignment, dental development, and oral health.

Overall jaw growth and bite relationships are classified into three patterns (Class I, II and III). These patterns result from the relative growth of the two jaws and can be seen in Figure 1. If the upper and lower jaws are in balance this is called a Class I pattern. The bite will be ideal in the molars and the front teeth with the lower front teeth biting slightly behind the upper front teeth. The facial profile will be ideal as well. A Class II pattern occurs when the lower jaw is shorter than the upper which alters the bite on the molars and front teeth. In these children the lower front teeth fit well behind the upper front teeth and commonly these children are said to have an “overbite”. These children have a profile where the chin seems receded and/or the upper front teeth appear to protrude. A Class III pattern occurs when either the upper jaw is too short or the lower jaw is too long or both. In children with a Class III pattern the lower front teeth are in front of the upper front teeth and this is called a crossbite. The facial profile will seem like the chin is protrusive. Jay Leno is a good example of a person with a Class III jaw growth pattern.

In the Caucasian population Class III patterns are seen in between 1 and 3% of the population. For children with Kabuki Syndrome this is much more common and is the most frequent jaw development pattern. In many children with Kabuki Syndrome this is due to underdevelopment of the upper jaw relative to the lower. Children who have this pattern of jaw growth have less projection in the cheek bone area and the face may appear flatter than ideal in this area. Due to the jaw growth pattern it is also more common to see a crossbite of the front teeth with the lower front teeth in front of the upper. Figures 2 and 3 show a lateral jaw x ray and tracing of a 12 year old male with Kabuki Syndrome. His Class III pattern shows the upper jaw

![Figure 1: Common Patterns of Facial and Jaw Development](image1)

![Figure 2: Lateral Jaw Xray of 12 Year Old Male with Kabuki Syndrome](image2)
behind the lower and lower front teeth which are ahead of the upper front teeth. Children with Kabuki Syndrome also often have a tendency to a long lower facial proportion. This relates to a lower jaw which is canted downwards more steeply than ideal. The feeling is that this relates to the neuromuscular pattern where the jaw muscles are more lax allowing the lower jaw to develop at a steeper angle.

Figure 4 shows a jaw x ray tracing of a 7 year old girl with Kabuki Syndrome. The lower jaw angle is steep when compared to a tracing of a typically developing child (Figure 5).

The tendencies to have length and angular imbalances in jaw development have significant implications for facial growth, the bite and for potential orthodontic treatment. From the parents perspective it can cause a disconcerting change in the bite as the child matures. Often when the baby teeth are present the bite may look fine to the parent but as the jaw development progresses the bite may become more noticeably irregular. This usually becomes more obvious when the permanent teeth are beginning to erupt. Often this is when the child will be taken for a consultation with an orthodontist. For children with Kabuki syndrome, it is especially important that the orthodontist do a thorough evaluation of the underlying jaw development pattern in advance of initiating any orthodontic treatment. The biting pattern of the teeth is most often a result of the growth pattern of the jaws and not just malposition of the teeth. Treatment options must be carefully assessed in order to optimize outcome. Given the pattern of the neuromuscular environment, children with Kabuki Syndrome may not have the same options for orthodontic treatment as typically developing children where sometimes during growth muscle forces can be harnessed to improve the bite and jaw positions. In children with Kabuki Syndrome with significant jaw length abnormality or vertical jaw imbalance ideal correction may necessitate integrating jaw repositioning surgery into the orthodontic management plan. Obviously careful evaluation of the child’s overall medical and developmental status is important prior to considering significant treatment like jaw repositioning surgery.

Other Important Oral Findings

Once there is an understanding of the overall jaw development pattern there are other important oral and dental development issues.

First it is important to realize that over 50% of children with Kabuki Syndrome have some significant cardiac anomaly. For certain dental procedures and with certain types of cardiac issues it will be necessary to provide prophylactic antibiotic coverage in advance of many dental appointments. The American Heart Association has recently revised the guidelines for antibiotic premedication for children with cardiac irregularities (April 2007). It is important that your dentist be familiar with the new guidelines.

The literature shows that high arched palate is common in children with Kabuki syndrome. Cleft Palate occurs in excess of 50% of the children. Cleft Palate has significant implications for breathing, feeding, speech, jaw development and dental development. Optimum management for children with cleft palate requires a coordinated management plan from the time of birth. The management plan should involve a team of specialists who
will provide well coordinated care for all of these significant issues.

In addition to some degree of laxity of the muscles that position the lower jaw, children with Kabuki Syndrome also have a higher risk of laxity in the ligament and muscular structures that position the temporomandibular joint (TMJ) which is the hinge between the base of the skull and the lower jaw. Although the literature doesn’t indicate that a high proportion of the children have problems with dysfunction of the TMJ it is important for the child’s dental professional to monitor the function of the joint during routine checkup visits.

Children with Kabuki Syndrome commonly have dental anomalies that can affect the shape, size and number of teeth. The two upper front teeth (central incisors) often have a characteristic shovel shape where the lower edge of the tooth is narrower than the mid portion. This is opposite to the normal shape of this tooth where the lower edge is the widest part of the tooth. This is a dental anomaly that is very rarely found in other children and the presence of shovel shaped central incisors is one diagnostic sign that is helpful in formulation of a diagnosis of Kabuki Syndrome. The dentist can improve the shape of the central incisors with simple cosmetic bonding materials. Children with Kabuki Syndrome often have agenesis or lack of formation of one or more permanent teeth resulting in missing permanent teeth. This most commonly involves the upper lateral incisors which are the teeth next to the big front ones (central incisors). When permanent teeth are missing there are a number of management options that your dentist can consider and discuss with you.

Preventing cavities and gingivitis is therefore relatively straightforward with three key actions by parents and children being important. One is to disrupt the bacteria and food that is left around the teeth by at least twice daily tooth brushing. Also in a child who is cooperative, flossing is of great value in cleaning the areas between the teeth that can’t be reached by the toothbrush. Second, teeth can be strengthened by the use of fluoride which hardens the tooth enamel and makes it more resistant to decay. The fluoride can come in many forms including community water fluoridation, fluoride in toothpaste, fluoride supplements by prescription if you live in an area where the water is not fluoridated, or professionally applied fluoride treatments. The third factor in preventing dental disease relates to control of the diet. Sugar containing foods provide food for the bacteria and also if a child snacks frequently (or constantly) there are some natural cavity healing mechanisms in the mouth that don’t have a chance to work. Many of the dietary habits that increase a child’s risk for cavities also are unhealthy for other concerns like childhood obesity.

Regular ongoing dental care is an important part of good medical care for a child with Kabuki syndrome. The American Academy of Pediatric Dentistry recommends the first dental visit be around one year of age. This provides an opportunity to have a base line evaluation, have your questions addressed and with the dentist develop a long term plan to assure the child will grow with good dental health. In a child with complex long term health and developmental needs it is even more important to get a very solid and early start on good oral health.

**Maintaining Basic Dental Health**

For any children with special health needs the maintenance of good dental health is very important. Children with Kabuki Syndrome can have intellectual and behavioral parameters which make dental treatment difficult. For these children it is extremely important to prevent dental disease in order to avoid the need for treatment which could be difficult to accomplish.

In simple terms there are two dental diseases that should concern any parent. One is dental caries or what is commonly referred to as decay or cavities. The second is inflammation or infection of the gum tissue which is periodontal disease. Usually in children severe periodontal disease is uncommon but gingivitis which is an early stage of the disease is much more common. Both cavities and gingivitis have a common cause in that certain types of bacteria in the mouth digest sugar containing foods and secrete acids and toxins which attack the teeth and the gum tissue.
Virtually all children are more susceptible to recurrent ear infections in their early childhood years. It is unclear whether the infections are secondary to underlying immune deficiencies. Craniofacial abnormalities, including cleft palates, may also be a contributing factor. It is significant to point out that the typical toddler has approximately 11 upper respiratory infections a year.

Recurring renal tract infections have been reported. Other disorders can include Idiopathic Thrombocytopenic Purpura (ITP), autoimmune hemolytic anemia, polycythemia, hypogammaglobulinemia, and selective IgA deficiency.
Hypoglycemia, or the presence of low blood sugar, usually measured as glucose, is most often reported as a short-lived problem in newborns with Kabuki syndrome. Glucose is the primary fuel source for the brain. If the glucose levels remain low, below an accepted “safe” level of about 60 mg/dl, it may expose a child to the risk of brain injury. Some individuals with Kabuki syndrome, however have persistent hypoglycemia throughout infancy and childhood. The underlying cause has not been found in most cases—most likely because it has not been studied well and reported in the medical literature. There are case reports suggesting some may release too much insulin—a hormone made in the pancreas that helps to lower and regulate blood sugar levels. There have also been cases reported of other hormone deficiencies that to some degree regulate blood sugar levels. These include growth hormone, adrenocorticotropic hormone (ACTH) and cortisol. There may also be other undescribed biochemical or metabolic reasons for some children with Kabuki syndrome to have hypoglycemia.

The behavioral symptoms of hypoglycemia, which overlap with nonspecific normal behaviors, can be easily overlooked. Most children experience some of the following symptoms. Infants with low blood glucose may have, low tone or floppiness (hypotonia), poor feeding, seizures, and pauses in breathing (apnea). In older children, symptoms may include sudden irritability, hunger, nervousness, shakiness, perspiration, dizziness, light-headedness, sleepiness, confusion, difficulty speaking, or feeling anxious or weak. Suggestions that low blood sugar may occur at night, while sleeping, include crying out or having nightmares, or finding pyjamas or sheets that are damp from sweating. Children may be tired, irritable, or confused when they wake up. As you can see, these symptoms are common childhood behaviors, so there is some intuition required to feel that your child “just isn’t right” and request that your physician begin to explore if low blood sugar is a possible cause. A simple test parents can do to confirm their suspicions is to see if the symptom is relieved by providing a source of simple sugars, such as a half cup of fruit juice, sugar candies (~eight lifesavers), a quarter cup of raisins, etc. The symptoms should resolve within ten to twenty minutes after eating if it is due to low blood glucose.

What is done for hypoglycemia? In most cases, a pediatric endocrinologist should help with diagnosis and management. First—how often does it occur? The amount of time that the patient’s blood sugar is low is determined—often while a child is hospitalized, but it may be initiated with home blood glucose testing. At home, blood sugar may be monitored with a blood glucose meter identical to the device that an individual with diabetes mellitus would use. Treatment is tailored to the severity of hypoglycemia and its cause. Specific recommendations are impossible to recommend at this time, because no one common cause has been found for hypoglycemia in Kabuki syndrome. Minimally, simultaneous measurement of blood glucose and insulin levels should be performed. Usually, if a person has low blood glucose, insulin secretion is suppressed and measures very low. Measurement of the amount of glucose needed to keep blood sugars in the normal range should be done (determined by milligrams of glucose needed per kilogram of patient per minute). Additional testing to assist in the diagnosis of a cause of hypoglycemia may include measuring free fatty acids, lactic acid and ketone bodies in the blood as well as ketone bodies in the urine during an episode of hypoglycemia. Beyond these tests, evaluation and interpretation of results becomes much more complex, with measurement of other hormones, organic acids or acylcarnitines. A glucagon stimulation test may be necessary. For unusual cases, the best evaluation is probably achieved by an endocrinologist working in conjunction with a biochemical genetics specialist.

Treatment is directed at making sure sufficient food is provided to prevent low blood glucose. Frequent feedings and avoidance of prolonged fasting may be necessary, but some individuals have required continuous drip feeds through a feeding tube or modified formulas and supplements. Stressful situations, such as illnesses, even minor viral infections, may make management of...
hypoglycemia difficult. In the case of prolonged inability to take food or to keep food down because of vomiting, other methods of maintaining blood sugar levels are necessary. An intravenous (IV) line, placed in a vein, can be provide glucose with IV fluid. The amount of glucose and rate of fluid provided will need to be individualized for each patient depending on the assessment of their clinical condition.

There are few reports of treatment of hypoglycemia in patients with Kabuki syndrome beyond the need for frequent feedings. Perhaps some have been treated with medications that are used for some other causes of hypoglycemia, such as producing too much insulin. One such drug, Diazoxide (trade name Hyperstat or Proglycem in the USA), may be used in combination with other drugs to keep the blood sugar in a safe range. Clearly, further reports of management of hypoglycemia in Kabuki syndrome are needed. Since it is a rare complication of a not-so-rare genetic syndrome, no one physician will have much experience. The Kabuki Syndrome Network can serve as a clearinghouse to connect family and physicians so that there is increased awareness of the potential for hypoglycemia.

I would be interested to hear about the experience of families, because this is clearly an area of management that requires more study.

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We all get exposed every day to many things that can cause infections, and we all know how easy it is to catch a cold if a family member or co-worker is sick. The body relies on the immune system to fight infections from germs such as viruses, bacteria, or fungi. But if the body’s immune system is not working well, a person can get infections more often and have a harder time getting better.

Many children with Kabuki syndrome get an increased number of infections. Although not all of these children have a problem with the immune system, some children with KS do have an immune system that is not working completely properly. For example, an immune problem, or immunodeficiency, can be a cause of more frequent and/or more serious infections. The extent and severity of the infections depends on the degree to which the immune system is affected. There are medications that can be given if a child is found to have an immunodeficiency.

A number of doctors have seen that there can be immune problems in children with KS, and in children that we have evaluated at The Children’s Hospital of Philadelphia, many have decreased antibody levels. Antibodies (also called immunoglobulins) are made by immune cells and are found in the blood. Antibodies are critical for the body to handle infections effectively. If the antibody levels fall very low, there is a much greater chance that a person will get an infection, and it will be harder for the body to fight off the infection. There are several different types, or classes, of antibodies. The major classes are IgG, IgM, IgA, and IgE. When the antibody levels are low, usually only some, not all, of the antibody classes are decreased. The severity of infections will depend on which of these classes are low, and how low the levels are. The levels of each class of antibody can be easily measured with a blood test. We do not know exactly why the immune problems happen in KS, although it is probably due to a change in a gene that is different in individuals with KS.

We also know that autoimmune conditions seem to occur more often in children with KS. However, most children with KS do not develop an autoimmune condition. An autoimmune condition is a disease in which the body’s immune system causes damage to its own cells and tissues. Autoimmune conditions that have been seen in children with KS include those that affect the thyroid, the skin (vitiligo, a localized decrease in skin pigment), and blood cells (anemia, low platelets). The fact that autoimmune problems occur more often in people with KS is probably related to the fact that immune problems may also be seen in children with KS, although a person does not have to have a known immune problem to have an autoimmune disease.

In order for the immune system to work properly, it has to be able to detect an infection and send the right cells into action to fight off that particular infection. That is, the immune system is regulated in a very precise way. The immune system is also regulated so that it does not attack the body. So, problems with regulation of the immune system can cause the immune system to not function properly, either by not responding well to infections or by failing to ensure that the immune system does not attack the body. Therefore, it is likely that suboptimal regulation of the immune system underlies the immune and autoimmune issues that can be seen in children with KS.

Checking of antibody levels should be considered for children with KS who are more than one year old or if there are symptoms of an immunodeficiency. If there are any deficiencies, the child should be seen by a pediatric immunologist. Also, if a child seems to be having more infections or more serious infections than most children, the immune system should be checked. It should be remembered that if the antibody levels are only mildly low, there may not be any problems with fighting infections. However, this is still good information to know because it will be important to have an immunologist follow the antibody levels over time in case the antibody levels get lower. Also, the immunologist will be alert about infections so that the proper treatment and immune diagnosis can be given quickly.
Cardiac

Approximately half the children diagnosed with Kabuki syndrome will have a cardiovascular malformation. Diverse conditions are reported, but the most common are juxtaductal coarctation of the aorta, ventricular septal defect and atrial septal defect. Often there is a combination of these defects in an infant.

Since the cardiac conditions are congenital, during the formation of the heart, no further defects should occur. Diagnosis of the cardiac conditions often occurs prior to diagnosis of Kabuki syndrome.
Cardiac Defects in Patients with Kabuki Syndrome

By Grace C. Kung, MD, FASE, FACC

Kabuki syndrome, also known as Kabuki make-up syndrome and Niikawa-Kuroki syndrome, was initially described in 1981 by Niikawa and Kuroki [8]. Most patients have five cardinal features: distinct facial features, postnatal growth retardation, developmental delay or mental retardation, skeletal abnormalities and dermatoglyphic abnormalities which are referred to as a persistence of fetal fingerpads. At present, the diagnosis is made clinically. A prior review by the original investigators Niikawa and Kuroki reported a population of 62 patients with Kabuki syndrome and associated cardiac defects in up to 31% of patients [8]. Since then, there has been a series reported with 35 patients with an incidence of associated congenital heart disease as high as 58% [3]. Overall, associated cardiac defects have been well documented [4,6,7,9,11].

As a brief review of the anatomy of the heart and circulation, the heart consists of four chambers (Figure 1).

There are two right sided chambers which receive the blood from the body after it has delivered the oxygen to the tissues and then pumps it to the lungs to receive more oxygen. Then the blood with oxygen returns to the left sided chambers to be pumped to the body to deliver the oxygen to the tissues again. In a fetus, there is a communication between the right and left upper chambers and it usually closes after birth. Otherwise in a normal heart, there is no communication between the right and left sides. A fetus also has an extra blood vessel called a patent ductus arteriosus (PDA) that it uses in the womb to divert blood away from the lungs since it is not breathing and this vessel also usually closes after birth.

The majority of the cardiac defects have been what are called ‘shunt lesions’, such as atrial and ventricular septal defects and patent ductus arteriosus, also known as ASD, VSD and PDA respectively [13] (Figures 2, 3 and 4). VSDs and PDA can be detected by listening to the patient’s heart and hearing a certain type of murmur. The finding is confirmed by performing and ultrasound of the heart, also known as an echocardiogram. These are called shunt lesions because there is a communication between right and left sides of the heart and allows extra ‘shunting’ of blood flow to the lungs. This results in excess blood flow to the lungs and depending on how much there is, may result in extra fluid in the lungs and dilation of the heart. These lesions, if they occur in isolation, are

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treatable either by cardiac catheterization device closure or with more traditional surgical closure. Device closure involves placing a catheter in the patient’s leg and using that catheter to enter the heart and place a device to close the hole for an ASD or to close off an open blood vessel in the case of a PDA. Surgery involves an incision on the chest and placement on a cardiac bypass machine for the surgery.

They have also been finding problems with the left sided heart structures in up to 29% of cases. One specific lesion that is found is called Coarctation of the aorta (CoA) and is a narrowing of the aorta, or the large vessel that exits the heart to deliver blood to the body (Figure 5). This can result in diminished blood flow to the body and stress on the heart. This can be detected clinically if the patient has poor pulses or lower blood pressures in the lower body as compared to the upper body. This can also be diagnosed by echocardiography. Depending on the patient’s age and severity of the narrowing, this can be addressed either by a balloon or stent in the catheterization lab or, if needed, by surgical widening of the narrowed area. The balloon or stent procedure consists of introducing a catheter from the blood vessel in the patient’s leg to the area of narrowing and then inflating a balloon to dilate the narrowed area or using the balloon to place a stent to open up the narrowed area. The balloon and catheter are then removed. Surgical correction requires an incision in the chest and placement on cardiac bypass for the surgery.

Coarctation of the aorta is also a common finding in patients with Turner’s syndrome leading some to hypothesize an overlap between Kabuki syndrome and Turner syndrome [1,5].

There are also more severe types of heart defects that can be found in patients with Kabuki syndrome including Tetralogy of Fallot (TOF) and Transposition of the Great Arteries (TGA). The most significant type of defect is referred to as a ‘single ventricle physiology’ meaning that there is only one functioning ventricle instead of two. We did a case report of such a finding in three patients specifically with what is called Hypoplastic Left Heart Syndrome (HLHS) where the left side of the heart is significantly smaller and cannot function properly [14]. These patients cannot simply have a hole closed or a narrowing made bigger, they need multiple surgeries to eventually separate out the unoxygenated blood from the oxygenated blood. Fortunately, this finding is very rare, as only 5 such cases have been reported in the literature.

These are all considered congenital heart defects and occur when there is a problem with how the heart is formed very early on at about 6-8 weeks gestational age. Most of these defects can even be detected pre-natally by a specialized ultrasound focusing on the baby’s heart called a fetal echocardiogram after 20 weeks gestation age. Some lesions such as an ASD, PDA and CoA are harder to see pre-natally but can be diagnosed after the baby is born by ultrasound as well. Once the heart has finished forming, it is unlikely that further defect will occur. After the baby is born, another echocardiogram ram is performed to confirm any abnormal finding on the fetal echocardiogram. Since these are abnormalities of formation of the heart, no further defects should occur. How the baby does will depend on the specific cardiac
defect and how they respond to any intervention that may be needed.

The main difficulty with Kabuki syndrome is that it can be hard to diagnose as an infant whereas most of these cardiac defects are diagnosed either pre-natally or within the first month or so of life, often in the neonatal period. In fact, the features typical of Kabuki syndrome may be under-recognized and underappreciated in the neonatal period, only to become more pronounced with time and patient growth [12]. The cardiac disease often occurs before the diagnosis of the syndrome, thus we also propose that patients with left-sided heart defects, including HLHS, who have normal chromosomes, developmental delay and growth failure may benefit from periodic genetic evaluations during the first few years of life to assess for Kabuki syndrome and to assist parents in counselling and prognosis.

References:

Most individuals with Kabuki Syndrome have mild to moderate intellectual disability, with a small percentage falling in the severe range. Hypotonia is characteristic of Kabuki, hampering motor development and feeding.

To date, there is very limited information available on the developmental outcome of individuals with Kabuki Syndrome. One such study dedicated specifically to intellectual and adaptive behaviors, identified a clear pattern of weakness in visuospatial construction and relative strength in verbal and non-verbal reasoning. One published article, describing the long-term follow-up of three individuals, found that although they were able to achieve independent daily living skills and hold part-time jobs, they required sheltered living environments. Appropriate long-term planning will be essential.

Hypotonia is a very common characteristic, although studies show an improvement with age. Other neurological abnormalities include microcephaly and seizures. There does not appear to be any one type of seizure associated with KS, although the majority have localization-related epilepsy. The age of onset can range from infancy to middle childhood.
Hypoglycemia is usually a short-lived problem in infants, but it has also been reported in older children. Vigilant monitoring during fasting periods for surgeries is essential.

Renal tract infections can occur, sometimes due to structural abnormalities and/or immune dysfunction. Common renal anomalies include renal dysplasia, renal agenesis, horseshoe kidney, and ectopic kidney. Ureter abnormalities include obstruction, reflux, and duplication.

Undescended testes, hypospadias, and small penis have all been reported. A significant amount of girls have premature breast development and, rarely, premature onset of puberty. Growth hormone deficiency, congenital hypothyroidism, and insulin-dependent diabetes mellitus are all rare findings in KS.
Kidney Anomalies in a Person with Kabuki Syndrome

By Doctor Paul Henning, Pediatric Nephrologist

Note: Not all persons with Kabuki Syndrome are affected by kidney anomalies

Approximately 25% of persons with Kabuki Syndrome can present with renal anomalies. They represent anatomical abnormalities in foetal development and may cause clinical problems over a wide range of severity. Anomalies that have been reported include hydronephrosis (associated with obstruction of the urinary tract or vesico-ureteric reflux), ectopic kidneys, horseshoe kidney (fusion abnormalities), renal dysplasia (and probably renal agenesis) and ureteric duplication.

Many of these anomalies may be asymptomatic but they do carry an increased risk for urinary tract infection and less frequently renal calculi. Kidney damage may arise from these problems and occasionally surgery is indicated. Renal tract ultrasound to detect anomalies is justified and appropriate screening for urine infection should be undertaken if anomalies are identified. Referral to a urologist or nephrologist may be needed where severe or complex abnormalities are present.

Significant loss of renal function is uncommon in Kabuki Syndrome patients but when present has usually been associated with congenital renal dysplasia (sometimes in a single kidney). A very small number of individuals have been reported to reach end-stage kidney failure. Dialysis and kidney transplantation have been successfully performed.
Gastroesophageal reflux is prevalent in young children with Kabuki Syndrome, hindering the child's health, appetite and growth. Undiagnosed diarrhea and/or constipation is commonly reported. It is suspected that hypotonia may be a contributing factor.

Although less common, structural and functional abnormalities of the abdominal organs can be serious. These may include diaphragm hernias or eventration, malrotation of the intestines, and abnormalities with the anus or rectum in the form of anal atresia, anovestibular fistula or anteriorly placed anus.
Individuals with Kabuki syndrome can have hyperelastic skin, suggestive of a connective tissue disorder. The hands feel soft and are short with short fingers, in particular the fifth fingers. Persistent fetal fingertip pads is highly characteristic of Kabuki syndrome. Mild cutaneous syndactyly is common, usually between fingers II/III or III/IV.

Individuals can have abnormalities with the nails, hair and skin. Nails can be absent, incompletely formed and fragile. Brittle hair, irregular diameter and twisting of shafts, and increased body hair have been rarely reported. Many parents report a rosy, dry appearance to their children’s cheeks for no apparent reason. A significant number of individuals have a sacral sinus or dimple.
Hypoglycemia is usually a short-lived problem in infants, but it has also been reported in older children. Vigilant monitoring during fasting periods for surgeries is essential.

Certain physical (structural) features associated with Kabuki syndrome could complicate the effects of anesthesia. These may include:

- Micrognathia
- Obstructive sleep apnea
- Stenosis of central airways
- Renal abnormalities
- Diaphragmatic eventration
- Cleft or high arched palate
- Hypotonia
- Cardiac anomalies
- Seizures
- Scoliosis