

## PROTOCOL FOR NEWBORN SCREENING RESULT

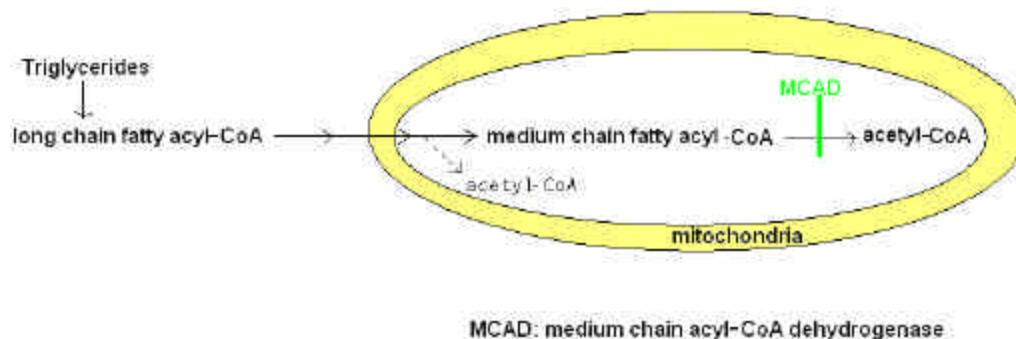
### Elevated C4 acylcarnitine, (butyrylcarnitine); Short Chain Acyl-CoA Dehydrogenase Deficiency (SCADD)

#### First Newborn screening result

**C4 elevated, > 1.3  $\mu\text{mol/L}$ , possibly SCADD**

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Short Chain Acyl-CoA Dehydrogenase Deficiency (SCADD) is a defect of short chain fatty acid utilization for energy. Consequently there is little or no tolerance for fasting or hypoglycemic states. Sudden death or permanent neurologic damage during a metabolic crises can rapidly ensue.



#### History and examination

The infant and parent(s) must be seen within the next day or two following notification from the newborn screening lab. A metabolic physician must be consulted.

The infant is most likely to have a normal history. On occasion however, there is a history of neonatal lethargy, vomiting, seizures, or coma in conjunction with metabolic acidosis. Since SCADD is an autosomal recessive genetic disorder, there is a 25% chance that sibs of the identified infant may also have SCADD. A family history of SIDS is very significant. There may also be a history of other children in the family becoming seriously ill or dying suddenly in childhood.

#### Examination

The infant will most likely appear entirely healthy and well. Neonatal symptoms, while rare, do occur. The sick infant may be lethargic and have hepatomegaly. Laboratory findings during neonatal illness will probably include hypoglycemia, metabolic acidosis, hyperammonemia and abnormal liver function test results, particularly of coagulation factors (PT, PTT). **ANY signs of illness must be treated as a medical emergency and treated immediately. Go to Acute illness protocol, SCADD.**

If the child appears well it is still essential to refer to the metabolic center to ensure that the child and family receive the necessary treatment and guidance to prevent any morbidity. **Contact the metabolic physician for elevated C4**

ENSURE THAT THE REPEAT NEWBORN SCREENING SAMPLE IS SENT TO THE NEWBORN SCREENING LABORATORY AND THE RESULT OBTAINED ASAP

(Go to **NNSGRC** for the state labs)

**Discussion with parents for elevated C4**

Response to a reported newborn screening result must be undertaken in two parts;

1. Initial contact with the family, often by phone, to inform them of the newborn screening result.
2. Meeting with the family at the office.

### **Initial communication**

Many parents want to know what the result is testing positive for and are reassured if their doctor has knowledge of Short Chain Acyl-CoA Dehydrogenase deficiency (SCADD), or has taken the time to find out about the condition when informing the family (see **commonly asked questions**).

An acylcarnitine C4 level between 1.3 and 2  $\mu\text{mol/L}$  may have had only a transient elevation (false positive). However, it could indicate the presence of SCADD. Until this is determined the metabolic physician may recommend frequent scheduled feeds to be safe.

SCADD is a disease of fat energy utilization. It is TREATABLE and if managed appropriately should not affect the child's well being. However, if not treated preventatively, children can become seriously ill very rapidly as they run out of usable energy. As the mainstay of treatment is prevention, it is essential that they arrange to see a metabolic doctor as soon as possible.

### **In the office**

Many parents do not understand newborn screening or the need to treat their apparently healthy baby.

Parental anxiety will be high and it is important to reassure them that

- Their child is healthy and if treated will remain so.
- But note that failure to treat a baby with SCADD may result in life threatening illness, which could produce mental retardation or sudden death.

Treatment for SCADD is based on ensuring that hypoglycemia through fasting or the increased energy requirements of the body when sick is avoided. Therefore, when well the baby should initially be fed every 4 hours around the clock with NO exceptions. If the infant becomes ill, supplemental glucose as 10% dextrose given intravenously is often required to maintain energy levels and avoid life threatening energy deficit. When this happens, the metabolic doctor will want to be involved to ensure that all the necessary metabolic tests and measures are carried out in order to ensure their child's well being.

**Further counseling, treatment and a more detailed assessment and testing of the infant is required; therefore [contact metabolic physician](#)**

### Commonly asked questions

#### **1. What is SCADD?**

SCADD, also known as Short Chain Acyl-CoA Dehydrogenase Deficiency, is a fatty acid oxidation disorder (FAOD). It is a defect in one of the enzymes responsible for converting fats to fuel that can be used by the body. It becomes very important when the body is low on glucose or needs additional fuel such as when the child has not eaten for a period of time, during infections and other illnesses, during operations, or when exercising vigorously.

#### **2. How and when will we know if my baby has SCADD?**

If your baby's newborn screening result showed a C4 level  $>2 \mu\text{mol/L}$ , he or she probably has SCADD. If the result was  $>1.3 \mu\text{mol/L}$  your baby either could still have SCADD or it may have been a false positive result. The newborn screening test will be repeated and additional tests will be undertaken to help determine if your baby has SCADD or not. Typically the results of these tests take up to 4 days to come back. Depending on the test results, additional testing can take a variable amount of time to confirm the diagnosis. In a very small minority of cases, it can be difficult to determine whether a child is affected or not.

#### **3. How did my baby get this?**

SCADD is an autosomal recessive disorder. This means that your baby has two mutated SCAD genes, one from the mother and one from the father. Having only one mutated SCAD gene (a carrier) does not affect a person at all.

#### **4. What does it mean for my child?**

If your baby has SCADD, he or she will have to be fed regularly on a relatively low fat diet and cannot be allowed to miss a meal. Some children also take carnitine, a mild supplemental medicine, but your metabolic physician will be able to let you know if this is appropriate for your child. If he or she becomes ill, it may be necessary early in the illness (i.e. when it might be considered mild), to provide extra energy in the form of glucose through addition to food or, if necessary, by intravenous drip.

#### **5. What is the treatment? Does it work? Is the diet difficult to do/expensive?**

SCADD is primarily treated by a high carbohydrate and low fat diet that is given at regular defined intervals around the clock. As the diet is essentially normal it should not be an added financial burden. However, ensuring that you and the baby wake up, initially every 4 hours, can be physically exhausting over time. If possible you should anticipate this and try and ensure that you have support from your spouse or other close contacts to assist you so that you may enjoy your time with your baby.

#### **6. What about my other children/future children?**

As SCADD is an inherited condition it is essential to have your other children tested. Children from the same father and mother as the affected infant have a 1 in 4 (25%) chance of having SCADD. Your other children can appear healthy and still have SCADD. If they have SCADD, successfully having weathered illnesses in the past is no guarantee that an illness in the future will not have serious consequences.

Since there is a risk for having a future child with SCADD it is important to let your obstetrician and pediatrician know that you have a child with SCADD if you are planning future pregnancies so that they may discuss the options with you and prepare accordingly.

### Definitive Investigations

#### **1. Quantitative urine organic acids**

In symptomatic patients, short-chain organic acids are elevated with a characteristic pattern of large quantities of ethylmalonic acid as well as methylsuccinate. Ketones may be present unlike the other fatty acid oxidation defects. Nevertheless, standard urine organic acid profiles may be uninformative when those with SCADD are stable and are not fasting.

#### **2. Plasma acylcarnitines**

The profile of patients with SCADD is characterized by accumulation of C4 species, with C4 (octanoylcarnitine) as the most prominent abnormality. A potential pitfall of acylcarnitine analysis in the diagnosis of SCADD is the possibility that patients with secondary carnitine deficiency may not show a significant elevation of acylcarnitines.

#### **3. Urinary acylglycines**

Quantitative determination of urinary butyrylglycine requires only a random urine sample from asymptomatic subjects and can be informative immediately after birth on the basis of increases in one or more of these acylglycines. However, in asymptomatic infants who are not fasting, the urinary excretion of these acylglycines may be  $<5 \mu\text{mol/mol}$  creatinine, levels not detectable by this analysis.

#### **4. Acute illness labs**

As can be seen from above, many of the lab tests can be not informative when the infant is well, therefore these tests are most valuable at times of acute illness. Labs ideally obtained for diagnostic purposes during acute illness in order of priority include plasma glucose, urinalysis, plasma acylcarnitines, plasma amino acids, and urine for organic acids and acylglycines. However, treatment should **NEVER** be delayed to obtain these labs and acute management labs should take priority (see [Acute illness protocol, SCADD.](#) )

#### **5. Enzyme assay**

SCAD enzymatic activity can be measured in cultured cells. A frequently employed assay involves acylcarnitine analysis of the short in cultured fibroblasts in the presence of anti-MCAD antibodies. The accumulation of C4 acylcarnitine usually confirms the diagnosis. Patients with SCADD usually exhibit less than 10% of normal SCAD activity.

#### **6. Molecular testing**

Mutation testing of the gene can help to confirm the diagnosis and for prenatal testing for future pregnancies. The most common pathological mutations are G625A and C511T

[Go to genetests.](#)

## Treatment

### Diet

The mainstay in the treatment of SCADD is avoidance of fasting. Infants require frequent feedings, initially every 4 hours. A relatively high carbohydrate, low-fat diet (*e.g.*, <30% of total energy from fat) could be beneficial.

### Carnitine

Oral supplementation with 100 mg/kg/day of carnitine is used in some cases to correct secondary carnitine deficiency though efficacy has not been proven as yet.

### Acute illness treatment

Any time the child is sick an evaluation should be made and the child's metabolic physician contacted. Prophylactic intravenous 10% glucose should be given if the child is unable to eat, vomiting or physiologically stressed, even mildly. The threshold for aggressive treatment should be very low.

All patients should be provided with an up to date personalized "emergency" letter to give to ER, or other doctors, who are probably not familiar with SCADD. This letter should include management issues and emphasize the importance of preventive measures (*e.g.*, IV 10% glucose regardless of "normal" laboratory results and the telephone numbers of the patient's metabolic specialist who needs to be contacted to discuss management). See [Acute illness protocol](#).

## Discussion with parents for elevated C4

### Contact metabolic physician for elevated C4

Your local metabolic physician can be found via [metabolic physicians and specialists](#)

The metabolic physician's role

- Discusses, in further detail, the meaning of the test result with the family, particularly why a mildly elevated C4 level should still be taken seriously.
- Provides you with information on SCADD
- If considered appropriate, starts [treatment](#)
- Provides supportive counseling and reassurance for the family
- Undertakes [definitive investigations](#)
- Provides genetic / antenatal counseling
- Hospitalizes, if necessary, in a metabolic unit for acute illnesses. These children can not be managed conservatively when they become ill or have the common childhood infections. The threshold should be very low for intravenous 10% dextrose and very close metabolic monitoring by a metabolic physician.

Return to [discussion with parents for elevated C4](#)