The anatomy and embryology of the hypothalamus in relation to hypothalamic hamartomas

Jeremy L. Freeman

Children’s Epilepsy Program, Department of Neurology and Murdoch Childrens Research Institute, Royal Children’s Hospital, Parkville, Victoria, Australia; Department of Paediatrics, University of Melbourne, Victoria, Australia; and Epilepsy Research Institute, Austin and Repatriation Medical Centre, Heidelberg, Victoria, Australia

ABSTRACT – The hypothalamus is involved in a variety of autonomic, endocrine, neurological and behavioural functions including temperature, osmotic and autonomic nervous system regulation, pituitary, thyroid, adrenal and gonadal control, thirst, appetite and weight control, memory and emotional behaviour including aggression and laughter, and biological (circadian) rhythms. The functional anatomy of the hypothalamus and its major afferent and efferent neurological connections are described, with particular reference to hypothalamic hamartomas (HH), gelastic seizures, MRI of the hypothalamus, and potential effects of surgery for HH. Normal development of the hypothalamus is reviewed in relation to models of forebrain development, descriptive hypothalamic embryology and the importance of known transcription factors. Potential environmental antecedents to HH development are discussed, and the significance for sporadic, isolated HH of several syndromes associated with HH is explored.

KEY WORDS: embryology, hypothalamic hamartoma, hypothalamus, neuroanatomy, neuroradiology

Hypothalamic hamartomas (HH) are developmental malformations associated with a range of neurological and endocrine problems including intractable seizures, cognitive impairment, pervasive developmental disorders, behavioural disturbances and psychiatric disorders, and central precocious puberty [1-5]. This review will firstly present an outline of the structure and function of the hypothalamus in relation to HH, in consideration of the clinical features of the syndrome, and of the potential complications arising from its surgical treatment. Discussion of the endocrine hypothalamus, central nervous system control of appetite and weight, and endocrine aspects of surgery for HH is presented elsewhere in this issue (Freeman JL et al.). The cause of sporadic HH is unknown; clues to the aetiology may be found in literature concerning the normal embryology of the hypothalamus, environmental causes of brain malformation and multiple congenital anomaly syndromes associated with HH. These subjects will also be reviewed briefly and avenues for further investigation discussed.
Freeman termed the which presents to the subarachnoid space below and is passes the floor of the third ventricle, the inferior surface of thalamic sulcus. Ventrally, the hypothalamus encom-

drawn between the posterior commissure and the caudal limit of the mammillary body, and superiorly by the hypo-

thalamic sulcus (grey swelling). The lateral boundaries include the internal capsule, cerebral pe-
duncle and subthalamus on each side. Far from being sharply delimited however, the hypothalamus is broadly continuous with surrounding grey matter, the transition between structures often gradual, and in some places arbitrarily defined [6].

Based on the comparative hypothalamic anatomy of sub-
mammalian vertebrates, the hypothalamus can be divided into two longitudinal zones. In such animals, there is a cell-rich, medial zone flanked by an almost acellular lateral zone [6]. Although the cellularity of the lateral hypothalamic zone in higher vertebrates is greatly in-

creased, the medial zone in humans contains the majority of named hypothalamic nuclei and can be roughly separated from the lateral zone by a sagittal plane passing through the anterior pillar of the fornix [7]. Some would further divide the medial zone into a thin periventricular zone and the adjacent medial zone, however the distinction in humans is not clear [6].

The hypothalamus is also commonly divided into regions along its anterioposterior axis (figure 1). Rostral to the optic chiasm and extending dorsally to the anterior com-

missure and its bed nucleus is the preoptic region [8]. The supraoptic region lies above the optic chiasm. The tuberal region lies above and includes the tuber cinereum. The mamillary region includes the mammillary bodies and the posterior hypothalamic nuclei. One accepted defini-
tion of the boundary between the tuberal and mamillary regions is a plane extending along the caudal border of the column of the fornix [6]. The supraoptic and tuberal regions contain many nuclei embedded in myelin-poor hypothalamic grey matter, in sharp contrast to the mammillary region which is rich in myelin [9].

**Hypothalamic nuclei and fibre connections**

The hypothalamic nuclei were traditionally defined ac-
cording to a combination of embryological, comparative anatomical and cytoarchitectonic criteria [9, 10]. Their organisation and connections have been studied more recently in laboratory animals using a combination of retrograde tracing experiments and immunohistochemical techniques [11]. These studies have shed new light on the variety of specific functions that have been attributed to hypothalamic nuclei and cell types [12, 13]. A summary of the major nuclei, their location with respect to the described zones and regions, and their known or suspected functions is presented in table 1.

The hypothalamus receives inputs from a widely distrib-
uted network of fibres arising in the forebrain, brainstem and spinal cord. These connections usually have recipro-
cal efferent components and multiple intrahypothalamic destinations. For a more detailed account than can be given here, the reader is referred to Nauta and Haymaker [6], and to Saper [13]. The medial forebrain bundle traverses the lateral hypothalamus, is continuous with the septal area rostrally and with the brainstem tegmentum caudally, and has interstitial nuclei along its length. The dorsal longitudinal fasciculus connects nuclei of the periventricular medial zone with the periaqueductal grey. The amygdala has two main projections to the hypothal-

amus, the stria terminalis and the ventral amydalofugal pathway. Input from the hippocampal formation is prima-
arily through the fornix, the large postcommissural myeli-
nated columns of which traverse the tuberal region, giving considerable input to nuclei of the medial zone before terminating in the mammillary body [6]. Other notable inputs include those from the retina, the circumventricular organs, basal frontal cortex and insula. The outputs of the mammillary body are among the most conspicuous efferent hypothalamic pathways, and are abundantly myeli-
nated. The mammillary output divides close to its origin into the ascending mammillothalamic tract and the de-
scending mammillo-tegmental tract. The mammillo-thalamic tract projects to the anterior nucleus of the thalamus, which in turn projects to the cingulate gyrus. The major endocrine outputs of the hypothalamus and their role in controlling pituitary function are discussed elsewhere in this issue (Freeman JL et al.).

**Functional aspects**

A large body of literature on hypothalamic function has collected over the last century, with data derived predominantly from animal experimentation and rarely from clinical observations. Studies initially involved either destructive lesioning or stimulation (chemical or electrical) of hypothalamic regions. The accuracy of spatial localisation was limited by the available technology. Despite these limitations, evidence accumulated that the hypothalamus is concerned with a broad range of endocrine, autonomic and neurological functions, integrated by virtue of the extensive network of reciprocal connections as described above. Apart from structures crossing the midline in the floor of the third ventricle, each of the hypothalamic nuclei and fibre connections are paired entities and, with the possible exception of the fornix (see below), no left-right differences or dominances have been noted in humans, although in animals, functionally significant lateral asymmetries are suspected [14].

The suprachiasmatic nucleus receives input from the retina directly as well as from the lateral geniculate nucleus, and exerts influence over pineal melatonin production. It is considered to be a biological clock with intrinsic pacemaker-like properties controlling circadian rhythms of hormonal and behavioural function, entrained to the day-night cycle by its afferent connections [15].

The tuberomammillary nucleus extends through the posterior tuberal and anterior mammillary regions, in close association with the fornix and the mammillary body, and surrounding the distinctive lateral tuberal nuclei [9]. It contains the only histaminergic neurones in the brain. These project widely to the cerebral cortex bilaterally and to the spinal cord, and are important in maintaining a wakeful state, exemplified by the sedating effect of centrally acting antihistamines [13].

Sympathetic and parasympathetic outflow are regulated at the hypothalamic level. Although the areas involved overlap considerably, those associated with parasympathetic responses tend to be located rostrally, and those associated with sympathetic responses tend to be located caudally [16]. Temperature regulation is one example of the complementary roles played by the rostral and caudal hypothalamus in homeostasis. Stimulation of the rostral hypothalamus results in hypothermia, whereas destruction of this area causes an inability to dissipate heat in a warm environment; therefore, the rostral hypothalamus is regarded as a “heat loss” centre. In contrast, the caudal hypothalamus produces shivering, peripheral vasoconstriction and piloerection resulting in heat retention. Ther-

---

**Table 1. Major hypothalamic nuclei, their location and function**

<table>
<thead>
<tr>
<th>Region</th>
<th>Zone</th>
<th>Nucleus (n.)</th>
<th>Functional characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoptic</td>
<td>Medial</td>
<td>OVLT</td>
<td>Osmoreception and chemoreception</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subforniceal organ</td>
<td>Sensitive to circulating angiotensin, thirst centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medial preoptic n.</td>
<td>Heat dissipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intermediate n.</td>
<td>Sexually dimorphic nucleus</td>
</tr>
<tr>
<td>Supraoptic</td>
<td>Medial</td>
<td>Anterior n.</td>
<td>Heat dissipation; parasympathetic excitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suprachiasmatic n.</td>
<td>Biological clock, circadian rhythms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraventricular n.</td>
<td>Antidiuretic hormone (ADH), oxytocin secretion</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>Supraoptic n.</td>
<td>ADH, oxytocin secretion; osmoreception</td>
</tr>
<tr>
<td>Tuberal</td>
<td>Medial</td>
<td>Ventromedial n.</td>
<td>Satiety centre; aggression produced if destroyed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dorsomedial n.</td>
<td>Not well defined (structurally or functionally)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Periventricular zone</td>
<td>Anterior pituitary (AP) control</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>Infundibular (arcuate) n.</td>
<td>AP control; weight and appetite regulation</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td>Tuberomammillary n.</td>
<td>Arousal, wakefulness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lateral tuberal nuclei</td>
<td>Striking appearance, but unknown function</td>
</tr>
<tr>
<td>Mamillary</td>
<td>Medial</td>
<td>Mammillary body</td>
<td>Short-term memory; emotional experience?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Posterior n.</td>
<td>Heat conservation; sympathetic excitation</td>
</tr>
<tr>
<td>All 3</td>
<td>Lateral</td>
<td>Lateral hypothalamic area</td>
<td>Interstitial nuclei of the medial forebrain bundle</td>
</tr>
</tbody>
</table>

OVLT = organum vasculosum of the lamina terminalis.
mosensitive neurons providing regulatory feedback are located in the preoptic region, whereas the caudal hypothalamus is said to be "temperature-blind". Chemoreceptors of the rostral hypothalamus also influence body temperature, as demonstrated by the febrile response to infiltrated endotoxin [17].

The ability of electrical and chemical stimulation or destruction of areas within the hypothalamus of laboratory animals to produce or inhibit combinations of visceral and somatic motor responses, led to the notion that the hypothalamus is central to the expression of emotional behavioural responses [18]. The well-known 'sham rage' phenomenon observed in response to minimal provocation in decorticate cats, for example, relies on integrity of the posterior hypothalamus and its caudal connections [19].

The hypothalamus is implicated in laughter, the behavioural manifestation of mirth. Foerster and Gagel described discrete bursts of laughter accompanied by whistling, joking and swearing produced repeatedly by the swabbing of blood from the floor of the third ventricle in a patient, after removal of an intraventricular cyst [20]. Lesions in the vicinity of the third ventricular floor producing 'sham mirth' were described by Martin [21], including the case of a young man who laughed uncontrollably at his mother's funeral, and who died from subarachnoid hemorrhage while under investigation for his inappropriate behaviour. He was found to have a ruptured aneurysm at the bifurcation of the basilar artery that compressed the mammillary bodies and elevated the floor of the third ventricle [21]. As discussed by Arroyo et al., a role for the hypothalamus in laughter is strengthened by virtue of the association between HH and gelastic seizures [22]. It has since been shown that the HH itself is the site of origin of gelastic seizures [23] and that the ictal symptoms, including laughter, could be reproduced by electrical stimulation of the HH [24]. However, the role of the hypothalamus proper in the laughter-like vocalisations produced by HH remains uncertain.

Integration of emotional behavioural responses with cognitive processes into an emotional experience was postulated by Papez to be the function of a loop connecting the hippocampus to the mammillary body via the fornix, then via the mammillothalamic tract to the anterior thalamic nucleus, in turn to the cingulate gyrus and then back to the hippocampus [25]. As pointed out by Saper however, each of these structures contains multiple subdivisions with complex connectivity, and credible evidence for the circuitous transfer of information between them is lacking [13]. Nevertheless, the idea has proven extremely influential and has given impetus to research into the structure and function of the limbic system [16].

The fornix and mammillary body are undoubtedly important with respect to memory, but are only two structures among the many interconnected components implicated, many of which are located in the vicinity of the third ventricle [26]. Evidence for the role of the mammillary body comes predominantly from study of the pathological correlates of amnesia in chronic alcoholism, where bilateral destruction of the mammillary bodies is the most consistent finding. However, in patients with Korsakoff psychosis, mammillary body damage is invariably accompanied by involvement of the medial dorsal and posteriorthalamic nuclei, the involvement of which is often lacking in alcoholic patients without amnesia [27]. The fornix provides the major efferent pathway from the hippocampal formation (and in particular the subiculum). Disconnection between the hippocampus and mammillary body could therefore be expected to produce memory deficits. Despite conflicting reports concerning the effects of fornical injury in humans and suggestions that memory impairment need not result from isolated injury even when bilateral [28], a respected review of this literature (and critique of such suggestions) by Gaffan and Gaffan [29] concluded that fornix transection does produce amnesia. In monkeys, lesions of the fornix or mammillary nuclei produce memory impairment that is short-lived when compared to that caused by destruction of the hippocampus [30]; this finding could support an expectation of similarly mild or transient effects of isolated fornix injury in humans. Modality-specific deficits may be produced by unilateral injury according to observations that selective verbal memory impairment follows section of the fornix in the dominant hemisphere [31].

Hypothalamic hamartomas in relation to normal neuroanatomy

Hypothalamic hamartomas have been classified radio logically on the basis of the breadth of attachment to the tuber cinereum (sessile versus pedunculated) [32], the presence of more than minimal distortion of the outline of the third ventricle (intrahypothalamic versus parahypothalamic) [33], or using a combination of size, breadth of attachment, distortion of the hypothalamus and location of attachment (types Ia, Ib, Ia and Iib) [34]. These classifications have attempted to correlate the clinical features observed with the physical properties of the hamartoma. Of interest in relation to these physical properties is the question of what distinguishes a hamartoma associated with seizures, from one without epileptogenic potential. With respect to the surgical treatment of hypothalamic hamartomas causing intractable seizures however, a more important issue may be the determination of that part or attachment of the lesion that is necessary for seizure production or propagation.

The myelinated white matter tracts and nuclei of the hypothalamus (fornices, mammillary bodies and mammillothalamic tracts) are readily visualized with magnetic resonance imaging (MRI) in cadaver brains [35], in normal subjects and in patients with tumours involving these.
structures [36]. None of the currently employed classification methods however, consider the attachment of the hamartoma in relation to these intrahypothalamic structures, nor in relation to the above described regions and zones of the hypothalamus. Our observations from a series of more than 50 patients with gelastic seizures (unpublished data) suggest that intraventricular, intrahypothalamic extension of the hamartoma displaces the column of the fornix anterolaterally on the side of predominant attachment. The lateral extent of the intrahypothalamic portion of the lesion is situated between the fornix anteriorly, the mammillary body inferiorly and the mammillotemporal tract posteriorly, and therefore lies predominantly within the mammillary region of the hypothalamus. This detail is often only appreciated with high-resolution, thin-slice T2-weighted images in three planes through the hypothalamus and HH (figure 2). The importance of the intrahypothalamic connections of HH associated with seizures is a subject of great interest, having potential implications for mechanisms of epileptogenesis (how partial and secondary generalised seizures develop), and requires consideration when devising surgical strategies for the management of intractable epilepsy in these patients.

![Figure 2. Anatomy of a small hypothalamic hamartoma.](image)

(A) Parasagittal T2-weighted magnetic resonance image (TE 6200, TR 100.5, 3 mm thickness) at the level of the right fornix and mammillotemporal tract, with a magnified view of the same image in the right-hand panel (B), and magnified T2-weighted axial (C) and coronal (D) images below.

The images clearly show the myelinated anterior commissure (white arrowhead); fornices (black arrows), mammillotemporal tracts (white arrows) and mammillary bodies (black arrowheads) in relation to the HH, with displacement of the right fornix anterolaterally (C) and the right mammillary body inferiorly (D).

### Embryology of the hypothalamus and hamartomas

#### Forebrain development

Early models of forebrain development were based on the appearance and transformation of sulci and ridges along the ventricular and pial surfaces of the developing brain [37], and the hypothalamus was regarded as the ventral-most derivative of ‘longitudinally’ arranged histogenic columns in the diencephalon (along with the thalamus and epithalamus dorsally) [38, 39]. However, fate-mapping studies of the neural plate showed that the hypothalamus is derived from the anterior-most parts of the neuraxis [40, 41]. In addition, assimilation of information concerning the expression of transcription factors in the developing brain suggested a segmental organisation of the forebrain comparable to that found in the hindbrain and spinal cord [42, 43]. In the segmental ‘prosomic’ model, the basal and alar plates extend to the anterior-most part of the brain [44] and the hypothalamus is not derived from the diencephalon, but from ventral aspects of the two or three rostral segments of the neural tube (secondary prosencephalon), the dorsal derivatives of which form the telencephalon. According to the current formulation of the model, an alar ‘prethalamic’ region of the secondary prosencephalon contains the preoptic, supraopticus-paraventricular, suprachiasmatic, anterior, perifornicidal and dorsal parts of the hypothalamus, while the retrochiasmatic, median eminence, ventral, infundibular and mammillary regions of the hypothalamus are derived from the basal and floor plate parts of the same prosomeres [45]. A comparison of the pervasive columnar model and the increasingly refined prosomeric model is shown in figure 3. For greater detail, the reader is referred to a review by one of the proponents of the prosomeric model [43].

#### Descriptive embryology of the human hypothalamus

Despite reservations about the significance of ventricular sulci and ridges, direct knowledge of human brain development is largely confined to descriptions of these, together with some information regarding the anlagen of nuclei and fibre tracts. In the absence of a known sequence and timing of cellular mechanisms, these morphological data might assist in roughly pinpointing abnormal development. The authors of the first descriptions of the Pallister-Hall syndrome, for example, used the descriptive embryology and the presence or absence of other hypothalamic and pituitary anomalies to suggest that the large HH associated with the neonatally lethal form of this disease develop in the fifth week of gestation [46, 47]. A summary of descriptive embryological milestones for the hypothalamus is presented in table 2, based on Muller and O’Rahilly’s studies of the Carnegie collection of human embryos [37, 48-53], in which described stages depend
on morphological criteria corresponding to a range of post-fertilization ages [54].

Developmental biology of the hypothalamus

The relationship between the pituitary gland and hypothalamus in development has been clarified by laboratory animal evidence showing that the whole of the pituitary (including the anterior pituitary precursor Rathke’s pouch, formerly thought of as an epithelial structure) is derived from the anterior neural ridge [55], and that the adjacent neural plate gives rise to the hypothalamus [40]. Some cells of the hypothalamus proper arise in structures of anterior neural ridge origin but take an extracerebral route to their final destination [56]; luteinising-hormone-releasing hormone – (LHRH) producing cells, for example, originate in the olfactory placode and then migrate to the septal region, anterior hypothalamus and median eminence [57].

Genetic mechanisms that underlie hypothalamic development are beginning to be unravelled. As reviewed by Michaud, the program of development progresses from induction and patterning of the hypothalamus by the axial mesendoderm, to the differentiation of specific hypothalamic nuclei [58]. At present, considerably more is known about development of the hypothalamic-pituitary axis than about other hypothalamic structures, just as knowledge of the function of the hypothalamus is more advanced in relation to neurendocrine aspects.

Sonic hedgehog protein (SHH) is a concentration-dependent morphogen that is produced by the axial mesendoderm and plays a crucial role in dorso-ventral patterning of the neuraxis along its length, by regulating the expression of a large number of homeodomain proteins [59]. It is the major known factor in centralisation of the developing forebrain and its expression by the underlying prechordal plate is a requirement for appearance of the hypothalamic anlage, and splitting of the eye field into two [60]. SHH-dependent Nkx-2.1 expression [61] demarcates the primordial hypothalamus as early as the threesomite stage in mice (equivalent Carnegie stage IX) [44], and is required for the normal development of the anterior pituitary as well as many hypothalamic nuclei, including those in the mammillary region [62]. In addition, SHH appears to influence both proliferation and cell-type determination in the developing pituitary gland [63].

In the hypothalamic-pituitary axis, differentiation of specific cell types progresses in an orderly fashion, controlled by a hierarchy of transcription factors expressed in a spatially and temporally restricted sequence. Factors involved in pituitary specification include Rpx (Rathke’s pouch homeobox), Six3, Pax6, Lhx3, Ptx1, Pit-1 and SF-1. Development of cell phenotype in the supraoptic, paraventricular, periventricular and arcuate nuclei is regulated by factors including Sim1, Amt2, Otp, Brn2, and Gsh1. Treier and Rosenfeld reviewed the topic of hypothalamic-pituitary co-development in detail [64]; more recent information concerning neurendocrine hypothalamic differentiation was summarised by Acampora et al. [65].

Although the precise mechanisms of hypothalamic nuclear specification are unknown, the number of transcription factors implicated continues to increase. These include: FhX5, essential for mammillary body development [66]; Pax6, required for mammillothalamic tract

---

Table 2. Descriptive embryology of the human hypothalamus

<table>
<thead>
<tr>
<th>CS</th>
<th>DPC</th>
<th>Morphological milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>IX</td>
<td>25</td>
<td>Three primary brain divisions visible in open neural folds</td>
</tr>
<tr>
<td>X</td>
<td>28</td>
<td>Optic sulcus visible; neural tube begins to fuse</td>
</tr>
<tr>
<td>XI</td>
<td>29</td>
<td>Closure of rostral neuropore is complete</td>
</tr>
<tr>
<td>XII</td>
<td>30</td>
<td>Infundibular hypothalamus indicated by relation to Rathke’s pouch</td>
</tr>
<tr>
<td>XIII</td>
<td>32</td>
<td>Mammillary recess identified</td>
</tr>
<tr>
<td>XIV</td>
<td>33</td>
<td>Hypothalamic cell cord identified</td>
</tr>
<tr>
<td>XV</td>
<td>36</td>
<td>Appearance of mammillary nuclei and MTT fibres</td>
</tr>
<tr>
<td>XVII</td>
<td>41</td>
<td>Supra- and inframammillary recesses define the mammillary area</td>
</tr>
</tbody>
</table>

CS = Carnegie stage of development; DPC = approximate days post-conception; MTT = mammillothalamic tract.
development and axon path finding [67]; Wnt8b, expressed in the mammillary region of human embryos [68]; and SF-1, necessary for normal development of the ventromedial nucleus [69]. Further study of these and other factors may answer questions about normal and abnormal hypothalamic development.

**Development of hypothalamic hamartomas**

The embryological origin of HH has not been determined. Histological examination of hamartoma biopsy material from patients with epilepsy has shown a mixture of mature neuronal and glial cells [70], with some myelinated fibres present [71] and an overall resemblance to normal hypothalamic grey matter [32]. Hamartomas associated with precocious puberty have been shown to contain neurosecretory granules and immunoreactive staining with antibodies to LHRH [72], including one child with the combination of gelastic seizures and precocious puberty [73]. In other two cases with precocious puberty alone, LHRH was not found, but transforming growth factor alpha and its receptor were present [74]. A detailed study of HH cell characteristics with respect to normal hypothalamic nuclear cytoarchitecture and immunohistochemistry in a large series is awaited.

A relatively small number of potentially harmful prenatal exposures have been accepted as causing brain malformation, with some known to produce specific malformations of cortical development (MCD). Examples of the latter include viral infections such as cytomegalovirus, ionising radiation, medications such as isotretinoin, alcohol, illicit drugs such as cocaine, and toxins such as methylmercury [75-78]. Only two case-control studies of MCD are reported in the literature. The first involved mainly adult epilepsy surgery patients, comparing those with and without MRI evidence of MCD, and found that mothers of patients with MCD were more likely to have been exposed to injury, medication, infection, or irradiation during pregnancy than were mothers of patients without MCD [79]. The second study found a higher rate of antenatal maternal exposure to medication, alcohol and potential toxins among paediatric epilepsy surgery patients with histological evidence of MCD, as compared to age-matched, neurologically normal controls [80]. Together, these provide some evidence for the importance of environmental factors in the pathogenesis of MCD, although neither study included patients with HH. Potential environmental antecedents to the development of HH deserve some attention and, given the rarity of the malformation, a case-control study would be appropriate.

There are a number of multiple congenital anomaly syndromes in which HH have been described, but in only one of these – Pallister-Hall syndrome (PHS) – is the HH a characteristic feature and required for the diagnosis of an index case [81]. Along with central polydactyly, associated malformations in PHS include dysplastic nails, pituitary hypoplasia or dysfunction, bifid epiglottis and imperforate anus [82]. Autosomal-dominant transmission of PHS is described [83], and in some families a mutation in the Gli3 gene on chromosome 7p13 is present [84]. Gli proteins are zinc-finger transcription factors that act downstream of SHH-signalling to regulate target-gene expression [85]. As discussed by Michaud, the mechanism by which Gli3 frameshift mutation leads to HH formation is currently unknown, but may be related to either gain or loss of normal Gli3 function as an inhibitor of SHH-signalling [58].

One case report of the cytogenetic evaluation of an HH in a patient with PHS, cited by Biesecker and Graham [82], showed the absence of chromosome 17 in two of 43 cells, but no similar studies on HH tissue are described. One patient with HH and microphthalmia, but not polydactyly, was found to have an unbalanced chromosome 7 translocation that did not involve the Gli3 locus [86]. Other entities, probably distinct from PHS, in which HH have been reported include the McKusick-Kaufman syndrome [87], Bardet-Biedl syndrome [88], oral-facial-digital syndrome type 6 [89] and Waardenburg syndrome [90]; of interest in relation to the first two conditions is that one form of Bardet-Biedl syndrome has a mutation in the gene associated with McKusick-Kaufman syndrome (MKKS) on chromosome 20p12 [91]. It is quite possible that genetic factors in the development of syndrome-associated HH could play a part in the development of sporadic, non-syndrome-associated HH, however no clinical or molecular genetic studies of such patients have been reported. Cytogenetic and molecular genetic evaluation of biopsied HH material might also prove rewarding in this respect.

It is likely that both the anatomical position and the intrinsic epileptogenicity of HH associated with seizures together contribute to the various neurological disorders associated with HH [92]. Appreciation of the normal functional anatomy of the hypothalamus, the structural relationship and connectivity between HH and adjacent hypothalamic nuclei and fibre pathways, and visualisation of this with high-quality MRI is necessary for understanding the clinical manifestations of HH and in predicting potential complications that may result from HH surgery. The anatomical-clinical correlation may contribute to questions about the mechanisms of epileptogenesis, reasons for cognitive deficits and the nature of behavioural and psychiatric disturbance.

While the cause of sporadic HH development is not known, there is considerable effort currently invested in understanding normal development of the human hypothalamus, and this will undoubtedly contribute to a better appreciation of abnormal development. The most promising avenue for further investigation in this respect is the exploration of the mechanisms of HH development in genetically determined, syndrome-associated HH.
Acknowledgements

I wish to acknowledge Dr A. Simon Harvey who encouraged this work, facilitated its presentation at the symposium, and reviewed the manuscript.

This work was supported by a Postgraduate Research Scholarship from the National Health and Medical Research Council of Australia and by a Faculty Research Scholarship from the University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences.

References


