

# SDHC gene

## Associated Syndrome Name: Hereditary pheochromocytoma-paranganglioma syndrome (hereditary PPGL syndrome)

### SDHC Summary Cancer Risk Table

CANCER	GENETIC CANCER RISK
Endocrine	High Risk
Other	Elevated Risk
Renal	Elevated Risk

### SDHC gene Overview

Hereditary pheochromocytoma-paranganglioma syndrome (hereditary PPGL syndrome) <sup>1, 2, 3, 4, 5, 6</sup>

- Individuals with mutations in *SDHC* have hereditary pheochromocytoma-paranganglioma syndrome (hereditary PPGL syndrome).
- Individuals with hereditary PPGL syndrome due to mutations in *SDHC* have a high risk for cancers of the nervous system (parangangliomas), which can be in the head, neck, upper body or abdomen. There is also a high risk for parangangliomas of the adrenal gland (pheochromocytomas). Parangangliomas and pheochromocytomas can develop at young ages.
- Parangangliomas and pheochromocytomas in individuals with hereditary PPGL syndrome often secrete hormones that can cause symptoms such as high blood pressure, rapid and/or abnormal heartbeat, headaches, sweating, nausea, fatigue and anxiety.
- Individuals with hereditary PPGL syndrome due to mutations in *SDHC* have an elevated risk for renal cancer and for gastrointestinal stromal tumors (GIST), mostly in the stomach. The exact level of these risks is not known.
- Some studies have shown that hereditary PPGL syndrome also includes an increased risk for pituitary adenomas and neuroblastoma. However, the data are not conclusive at this time and there are currently no specific medical management guidelines related to these other tumors.
- It is appropriate to offer genetic counseling to individuals with hereditary PPGL syndrome who are of reproductive age to discuss reproductive risks and options. There are additional considerations before and during pregnancy for women with hereditary PPGL syndrome.
- Although there are high risks for cancers and other medical conditions in individuals with hereditary PPGL syndrome, it may be possible to reduce these risks with appropriate medical management. Guidelines for the medical management of patients with hereditary PPGL syndrome have been developed by the National Comprehensive Cancer Network (NCCN) and international consensus. These are summarized below. Since hereditary PPGL syndrome is a complex condition, and management recommendations are likely to change over time, patients with *SDHC* mutations and a diagnosis of hereditary PPGL syndrome should be managed by a multidisciplinary team with expertise in medical genetics and the prevention and treatment of the complications associated with this condition.

### SDHC gene Cancer Risk Table

CANCER TYPE	AGE RANGE	CANCER RISK	RISK FOR GENERAL POPULATION
Paranganglioma/Pheochromocytoma	To age 60 <sup>1, 6, 7, 8</sup>	Up to 25%	<0.1%
Renal	To age 80 <sup>2, 4, 8</sup>	Elevated risk	1.4%
Gastrointestinal Stromal Tumors (GIST)	To age 80 <sup>1, 6, 8</sup>	Elevated risk	<0.1%

### SDHC Cancer Risk Management Table

The overview of medical management options provided is a summary of professional society guidelines. The most recent version of each guideline should be consulted for more detailed and up-to-date information before developing a treatment plan for a particular patient.

This overview is provided for informational purposes only and does not constitute a recommendation. While the medical society guidelines summarized herein provide important and useful information, medical management decisions for any particular patient should be made in consultation between that patient and his or her healthcare provider and may differ from society guidelines based on

a complete understanding of the patient's personal medical history, surgeries and other treatments.

CANCER TYPE	PROCEDURE	AGE TO BEGIN	FREQUENCY (UNLESS OTHERWISE INDICATED BY FINDINGS)
Paraganglioma/Pheochromocytoma	Clinical monitoring, including blood pressure measurement <sup>3,9</sup>	10 to 15 years	Annually
	Biochemical screening of blood and urine <sup>3,9</sup>	10 to 15 years	Every 1 to 3 years, depending on symptoms and findings, or prior to any surgical procedure
	Whole-body MRI. If not available, consider chest CT and MRI of abdomen, pelvis, skull base, and neck. <sup>3,9,10</sup>	10 to 15 years	Every 2 to 3 years
Renal	Abdominal MRI (preferred) or CT, with and without IV contrast. <sup>4</sup>	12 years	Every 2 years
Gastrointestinal Stromal Tumors (GIST)	Complete blood count and attention to symptoms such as gastric bleeding, obstruction, abdominal pain, nausea, etc. <sup>5</sup>	6 to 8 years	Annually

## Information for Family Members

The following information for Family Members will appear as part of the MMT for a patient found to have a mutation in the *SDHC* gene.

This patient's relatives are at risk for carrying the same mutation(s) and associated cancer risks as this patient. Cancer risks for females and males who have this/these mutation(s) are provided below.

Family members should talk to a healthcare provider about genetic testing. Close relatives such as parents, children, brothers and sisters have the highest chance of having the same mutation(s) as this patient. Other more distant relatives such as cousins, aunts, uncles, and grandparents also have a chance of carrying the same mutation(s). Testing of at-risk relatives can identify those family members with the same mutation(s) who may benefit from surveillance and early intervention.

It is appropriate to offer genetic counseling to individuals with hereditary PPGL syndrome who are of reproductive age to discuss reproductive risks and options. There are additional considerations before and during pregnancy for women with hereditary PPGL syndrome.<sup>6</sup>

Since *SDHC* mutations carry a risk for complications in children and some screenings are recommended to begin as early as age 6 years, consideration should be given to mutation testing in childhood.<sup>5</sup>

## References

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