Hereditary haemorrhagic telangiectasia (HHT) affects one in 5–8000, and no longer can be viewed as solely causing anaemia (due to nasal and gastrointestinal bleeding) and characteristic mucocutaneous telangiectasia. Arteriovenous malformations commonly occur, and in the pulmonary and cerebral circulations demand knowledge of risks and benefits of asymptomatic screening and treatment. HHT is inherited as an autosomal dominant trait and there is no age cut off when apparently unaffected offspring of an individual with HHT can be told they are unaffected. This review focuses on the evolving evidence base for HHT management, issues regarding pregnancy and prothrombotic treatments, and discusses the molecular and cellular changes that underlie this disease.

Hereditary haemorrhagic telangiectasia (HHT, Osler-Weber-Rendu syndrome) has been subject to under-reporting for many years. Recent careful epidemiological studies in France, Denmark, and Japan, however, reveal an incidence of one in 5–8000. Individuals with HHT present to a wide range of specialties spanning medical, surgical, and general practice disciplines. Advances in medical practice mean that an expectant approach to management is no longer appropriate, and patients are increasingly aware of this through patient self help websites (see end of article). However, many specialists lack appreciation of the full range of consequences of diagnosis for patients and their families, and still view HHT as a "rare" disease, compounded by the generally poor recognition of cases.

In this article we highlight the modern view of HHT. We also cover the scientific background of a disease which features prominently in postgraduate medical examinations due to the ready availability of outpatient with classical stigmata (a recent survey indicated that HHT occurred in approximately one in 20 short case examinations for MRCP). Later descriptions by Osler, Weber, and Hanes brought the disorder to the attention of the general medical community. These resulted in the eponym Osler-Weber-Rendu syndrome, though Hanes' suggestion of hereditary haemorrhagic telangiectasia is often preferred. The combination of nose bleeds, gastrointestinal bleeding, and iron deficiency anaemia associated with characteristic telangiectasia on the lips, oral mucosa, and fingertips (fig 1) has become firmly established as a medical entity. Yet this constitutes only "19th century HHT" (fig 2), and may not be evident in HHT patients who still have life threatening manifestations of disease.

Modern view of HHT

By the 1940s, additional abnormal vessels were being described in HHT, particularly arteriovenous malformations (AVMs) of the pulmonary, hepatic, and cerebral circulations. Initially it was suspected that such involvement was rare, but this was based on the frequency of symptomatic presentation to an astute practitioner. With the onset of asymptomatic screening programmes for clinical or research purposes, a much higher frequency of involvement was seen. We now estimate that at least 30% of HHT patients have pulmonary involvement, 30% hepatic involvement, and 10%–20% cerebral involvement. Faced with such high figures, there is a reasoned debate regarding the extent to which these studies have overestimated risk based on screening of preselected "severe" HHT populations (that is, relatives of patients with a pulmonary AVM) or screening tests with high false positive rates. However, the figures in fig 2 provide a fair reflection of data currently available.

It is recognised that the manifestations of HHT are not present generally at birth, but develop with increasing age such that nose bleeds are usually the earliest sign of disease, often occurring in childhood, pulmonary AVMs becoming apparent from puberty, with mucocutaneous and gastrointestinal telangiectasia developing progressively with age (fig 3). Data suggest that by the age of 16 years, 71% of individuals will have developed some sign of HHT, rising to over 90% by

Abbreviations: AVM, arteriovenous malformation; HHT, hereditary haemorrhagic telangiectasia; MRI, magnetic resonance imaging; TGF-β, transforming growth factor-beta
the age of 40 years. However these data mean that during their childbearing years, an apparently unaffected child of an HHT patient still has a 5%–20% chance of actually carrying the HHT disease gene.

**DIAGNOSIS OF HHT**

Not every individual with recurrent nose bleeds, even familial nose bleeds, will have HHT yet as indicated below, it is important that the diagnosis of HHT is considered in such cases. To permit a high level of clinical suspicion without leading to overdiagnosis, recent international consensus diagnostic criteria were developed based on the four criteria of spontaneous recurrent nosebleeds, mucocutaneous telangiectasia, visceral involvement, and an affected first degree relative. These define “definite HHT” where three criteria are present, “possible HHT” or “suspected” if two criteria are present, or “unlikely” if fewer than two criteria are present.

**Criteria**

1. Epistaxis: spontaneous, recurrent nose bleeds.
2. Telangiectases multiple, at characteristic sites:
   - Lips
   - Oral cavity
   - Fingers
   - Nose
3. Visceral lesions such as:
   - Gastrointestinal telangiectasia (with or without bleeding).
   - Pulmonary AVM.
   - Hepatic AVM.
   - Cerebral AVM.
   - Spinal AVM.
4. Family history a first degree relative with HHT according to these criteria.

All offspring of an individual with HHT are at risk of having the disease since HHT may not manifest until late in life. If there is any concern regarding the presence of physical signs, an experienced physician should be consulted. Coagulation disorders should be excluded. The presence of visceral abnormalities in children should prompt a particularly careful check of other family members. These criteria are likely to be further refined as molecular diagnostic tests become available in the next few years.

**Clinical Features of HHT**

**Nose bleeds**

Spontaneous recurrent nose bleeds from telangiectasia of the nasal mucosa are the most common clinical manifestation of HHT. While some patients will have only occasional nose bleeds, others will experience significant bleeds on a daily basis. Many patients require no treatment other than iron supplementation by diet and oral supplements, whereas others may require transfusions and emergency nasal packing. A number of topical, systemic, and surgical treatments are available (table 1), and in expert hands there are uncontrolled data that each appears to reduce bleeding, though responses are variable. Cauterisation is best avoided due to damage of nasal mucosa prompting vascular regrowth. The adage “to do as little as possible for as long as possible” is taking hold in HHT circles, and treatments are generally directed to patients either experiencing massive haemorrhages, or experiencing daily nose bleeds. Systemic treatments have also been introduced, and are discussed with gastrointestinal haemorrhage below.

**Figure 1** Classical HHT: (A) sparse telangiectasia on lips and (B) more extensive on conjunctiva.

**Figure 2** The changing face of HHT. The familial basis of HHT was recognised in both settings.

**Figure 3** Age of onset of HHT features. Symptomatic HHT data points (circled) derived from references 20–22. PAVM (pulmonary AVM) and CAVM (cerebral AVM) figures highly approximated.
Gastrointestinal haemorrhage

This probably contributes less frequently to iron deficiency than under-recognised nose bleeds: in many patients, improvement in nasal haemorrhage is able to significantly reduce iron and transfusion requirements. However recurrent gastrointestinal tract haemorrhage occurs in a substantial minority (up to a third) of HHT affected individuals, particularly in later years. 20 It often presents as an iron deficiency anaemia but occasionally as an acute gastrointestinal haemorrhage. The onset is usually from the fifth or sixth decade. Telangiectasia occur throughout the gastrointestinal tract, and are more common in the stomach or duodenum, than in the colon. They are visualised by endoscopy and are similar in size and appearance to mucocutaneous telangiectases but may be surrounded by an anaemic halo. Less commonly AVMs and aneurysms may occur, depicted by gastrointestinal angiography.

Most patients are satisfactorily managed conservatively with oral iron therapy and, if necessary, blood transfusions. Repeated laser therapy may also be used to control bleeding in the short term, though results are not as good as in the non-HHT population. 21 Surgery has limited success due to recurrent disease, but may be useful for emergency control of haemorrhage from discrete lesions, as may embolisation. Antihaemorrhagic medical treatments have been sought. The only therapy supported by evidence from randomised controlled trials is the use of female hormones (50 µg ethinylestradiol and 1 mg norethisterone) in heavily transfusion-dependent patients. Additional manoeuvres are discussed below in the “Current debates” section.

Mucocutaneous telangiectasia

Telangiectases of the skin and buccal mucosa occur in about 75% of individuals, typically presenting later in life than epistaxis from about the third decade of life, and increasing in size and number with age. 22 They mostly occur on the face, lips, tongue and buccal mucosa, and fingertips, but can occur elsewhere. They may bleed but this is rarely clinically important and the main concern is cosmetic, when short term benefits of laser or other ablation therapies may be obtained.

Pulmonary AVMs

Pulmonary AVMs are thin walled abnormal vessels that replace normal capillaries between the pulmonary arterial and venous circulations, often resulting in bulbous sac-like structures (fig 4A). They provide a direct capillary-free communication between the pulmonary and systemic circulations with three main clinical consequences:

- Pulmonary arterial blood passing through these right-to-left shunts cannot be oxygenated, leading to hypoxaemia.
- The absence of a filtering capillary bed allows particulate matter to reach the systemic circulation where it impacts in other capillary beds, causing clinical sequelae particularly in the cerebral circulation.
- The fragile vessels may haemorrhage into a bronchus or the pleural cavity.

Patients with clinically silent pulmonary AVMs are still at risk of haemorrhage, and more commonly neurological sequelae due to paradoxical embolism. Catastrophic embolic cerebral events (cerebral abscess and embolic stroke), and transient ischaemic attacks occur in patients regardless of the degree of respiratory symptoms and still carry significant morbidity and mortality. Indeed, in published series of approximately 400 patients the majority of pulmonary AVM patients had no respiratory symptoms, and, only a third of affected individuals exhibited physical signs indicating a massive right-to-left shunt (cyanosis, clubbing, and polycythaemia; see table 2). 23

Pulmonary AVM complications can be limited if the condition is recognised and treated, with transcatheter embolotherapy offering the safest methods of treatment. In experienced centres, there are proved long term physiological benefits of embolisation, with excellent safety profiles, and this has supported the trend towards earlier treatment of the asymptomatic patient, accompanied by clinical screening of high risk groups. In addition, prophylactic antibiotics are recommended at the time of dental and surgical procedures to reduce the risk of brain abscess (fig 4B). Screening methods vary between centres, but are based on non-invasive methods to image the pulmonary AVMs (thoracic radiography and computed tomography), or detection of the right-to-left shunt (hypoxaemia on room air and 100% fractional inspiratory oxygen, radionuclide perfusion scans or contrast echocardiography).

Table 1  Treatment options for epistaxis

<table>
<thead>
<tr>
<th>Modality</th>
<th>Data from RCTs</th>
<th>Data from case reports/uncontrolled series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local ablation</td>
<td></td>
<td>Short term success in expert hands 25 26</td>
</tr>
<tr>
<td>Laser: argon, Nd:YAG</td>
<td>None</td>
<td>May be beneficial 27</td>
</tr>
<tr>
<td>Cauterisation</td>
<td>Not recommended due to local tissue damage</td>
<td>Beneficial if tolerated 29</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>Case reports only, long term effects unknown</td>
</tr>
<tr>
<td>Septal dermatoplasty</td>
<td>None</td>
<td>Anecdotal only - short term benefits (7±1 year)</td>
</tr>
<tr>
<td>Septal closure</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Arterial ligation</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Embolisation</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Systemic therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oestrogen-progesterone</td>
<td>Beneficial in heavily transfusion-dependent patients</td>
<td></td>
</tr>
<tr>
<td>Tranexamic acid and antifibrinolytics</td>
<td>None</td>
<td>Short term benefit and risks unknown (see debate)</td>
</tr>
<tr>
<td>Topical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal sprays and creams</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

RCTs, randomised controlled trials.

Table 2  Complications of untreated pulmonary AVMs

<table>
<thead>
<tr>
<th>Feature</th>
<th>Mean (%)</th>
<th>Range (%)</th>
<th>No of cases*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>49</td>
<td>25–58</td>
<td>260</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>49</td>
<td>27–71</td>
<td>483</td>
</tr>
<tr>
<td>Chest pain</td>
<td>14</td>
<td>6–18</td>
<td>198</td>
</tr>
<tr>
<td>Haemoptysis</td>
<td>11</td>
<td>4–18</td>
<td>479</td>
</tr>
<tr>
<td>Haemorrhax</td>
<td>&lt;1</td>
<td>0–2</td>
<td>192</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>30</td>
<td>9–73</td>
<td>275</td>
</tr>
<tr>
<td>Clubbing</td>
<td>32</td>
<td>6–68</td>
<td>267</td>
</tr>
<tr>
<td>Bruit</td>
<td>49</td>
<td>25–58</td>
<td>263</td>
</tr>
<tr>
<td>Embolic phenomena</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral abscess</td>
<td>9</td>
<td>0–25</td>
<td>368</td>
</tr>
<tr>
<td>CVA or TIA</td>
<td>27</td>
<td>11–55</td>
<td>401</td>
</tr>
</tbody>
</table>

*Number of published cases in which frequency of feature assessed. CVA, cerebrovascular accident; TIA, transient ischaemic attack.

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Significant clinical concerns remain however. First, many patients with pulmonary AVMs remain under regular follow up in respiratory units without consideration of intervention. Second, published and anecdotal data suggests higher rates of complications in inexperienced hands. These include perioperative events and long term development of systemic arterial feeders to the sac resulting in catastrophic haemorrhage, though this is not widely recognised. Finally, modern detection methods reveal more disease than is treatable with today’s technologies and much of current management lies in the long term prevention of cerebral embolic events in patients with residual disease following maximal embolotherapy.

Cerebral AVMs
HHT patients may have cerebral involvement with telangiectases, cerebral AVMs, aneurysms, or cavernous angiomas. Most complications arise from cerebral AVMs that are thought to affect more than 10% of HHT patients. They can lead to headache, seizures, ischaemia of the surrounding tissue due to a steal effect, or haemorrhage. Haemorrhage usually has devastating effects (significant long term morbidity after cerebral AVM rupture in the non-HHT population is quoted as 53%–81%[14][15]), and patients with symptoms suggestive of cerebral AVMs deserve further assessment as in the non-HHT population, including non-invasive imaging and ultimately assessment by experienced neurointerventional centres. Cerebral magnetic resonance imaging (MRI) is currently the most sensitive non-invasive test, though will fail to identify a significant proportion of AVMs, and generally should not be performed in patients with pulmonary AVMs embolised with non-MRI compatible coils (the majority until the late 1990s). The question of whether asymptomatic HHT patients should be screened for cerebral AVM remains hotly debated and is discussed below.

Hepatic involvement
Silent hepatic involvement occurs in up to 30% of patients, although symptomatic involvement is much less frequent, with fewer than 100 patients reported in worldwide series. When patients do present it is usually with high output heart failure, portal hypertension, or biliary disease, reflecting different patterns of vascular involvement. Hyperdynamic circulations, and less commonly high output cardiac failure and steal syndromes caused by angina result from large AVMs between the hepatic artery and vein, causing a substantial left to right shunt. Portal hypertension and hepatic encephalopathy particularly after gastrointestinal tract bleeding may result from shunts between the hepatic portal vein and portal vein, and more commonly appear to result from increased sinusoidal blood flow (that may in turn lead to increased deposition of fibrous tissue and pseudocirrhosis of the liver). Hepatic AVMs, suspected by hepatomegaly, a liver bruit, or abnormal liver function tests can be diagnosed by angiography, computed tomography, MRI, or Doppler sonography.

The treatment of hepatic AVMs has changed in the last two to three years. Embolisation of feeding vessels used to be performed but after several cases of fatal hepatic necrosis, HHT physicians in the United States have placed a moratorium on this treatment unless supported by a liver transplantation programme. In the rare cases when acute hepatic failure develops, liver transplantation may be life saving.

HOW TO MANAGE THE HHT PATIENT
The majority of patients with HHT will still effectively have “19th century” HHT, experiencing only nose bleeds, mucocutaneous telangiectasia, and a tendency to iron deficiency anaemia. For HHT patients who do not present spontaneously to medical practitioners before the age of 60 years, there is no excess mortality. However, there is significant morbidity and mortality in younger patients, predominantly attributed to the consequences of visceral involvement, particularly pulmonary and cerebral involvement leading to early onset strokes and brain abscesses.

General principles of HHT management are illustrated in box 2 overleaf.

Special circumstances and debated topics in HHT
The pregnant HHT patient
Pregnancy poses a risk to a small proportion of women with HHT, and individual patients may need to be cautioned against pregnancy on a case-by-case basis. However, for the majority of patients, pregnancy is uneventful. The patient should be aware that any offspring will have a 50% risk of inheriting HHT, that there may be complications due to enlargement of pulmonary AVMs, and that as spinal AVMs affect perhaps as many as 1%–2% of HHT patients, many anaesthetists will not perform epidural analgesia for HHT mothers unless MRI scans have excluded this possibility. Otherwise, anecdotal data suggests nose bleeds may get worse, and skin telangiectasia become more prominent, with no firm data regarding effects on hepatic and cerebral AVMs.

Medical practitioners should be aware that any pulmonary AVMs will enlarge during pregnancy, and fatal haemorrhage from maternal pulmonary AVMs has been described. Women with HHT should be screened for pulmonary AVMs and treated maximally before pregnancy, though treatment may...
be safely undertaken in late pregnancy if required. Any hae-
moptysis should be seen as a medical emergency and prompt
immediate admission.

**Should asymptomatic patients be screened for cerebral
AVMs?**

The question of whether asymptomatic HHT patients should be
screened for cerebral AVMs remains hotly debated since
diagnostic and interventional modalities carry significant
risks, and many believe cerebral AVMs identified in an asym-
ptomatic HHT population by screening to have a lower rate of
haemorrhage than those in other populations. The North
American and European management approaches to indi-
viduals with HHT differ markedly. Many centres in North
America advocate and practice screening of HHT neonates,
whereas screening is not performed in the majority of
European centres. This is a difficult issue in patient
management as many patients will access US based websites.
However, all patients should be aware that the risk-benefit of
asymptomatic screening is by no means clear cut and remains
the subject of intense scrutiny on both sides of the Atlantic.

**How safe is it to use hormones and antifibrinolytics to
modify the haemorrhagic phenotype?**

In a double blind randomised controlled trial, 50 µg
ethinyloestradiol and 1 mg norethisterone resulted in a
significant reduction in transfusion requirements in 10
patients with a mean transfusion requirement of 19.4 packed
cells units per year. These data have been extrapolated in
clinical practice to patients with lesser degrees of haemor-
rhage not necessarily associated with regular transfusion
requirements. The use of higher dose conjugated oestrogens in
the “hormone replacement” range of over 625 µg ethinyl-
oestradiol equivalent, or prothrombotic agents such as
tranexamic acid and aminocaproic acid are also widespread
in management of HHT related bleeding, though not supported by data from randomised controlled trials. How-
ever, it should be remembered that HHT patients are at risk of
thromboembolic disease, and in our experience there is con-
cern that these practices may increase the risk of thrombotic
events in HHT patients.

**How safe is it to ascribe unusual presentations to rare
complications of HHT?**

As potential complications of HHT become better appreciated,
there is the genuine concern that HHT patients may not under-
go the full range of diagnostic investigations for particu-
lar clinical presentations. It is crucial that assessments
are based on an appreciation of the likely frequency of HHT
complications, and possible HHT pathologies also considered. This is particularly true when a possible
ever really rare complication of HHT such as severe chest pain,
pulmonary hypertension, or hepatic failure is under consid-
eration. Even for lower gastrointestinal bleeding, at least one
colonoscopy to exclude a malignant aetiology is usually
warranted.

**MOLECULAR AND CELLULAR BASIS OF HHT**

HHT is inherited as an autosomal dominant trait with varying
penetrance and expressivity. Mutations in two genes, endoglin
and ALK-1, have been shown to be responsible for HHT, with
the disease subtypes designated HHT1 and HHT2, respectively.
The search for a third disease locus in families shown to map
to neither of these loci is ongoing.48 The search for a third disease locus in families shown to map
and
ALK-1
mutations are causative is available from experiments in
transgenic mice. Some mice carrying one normal and one
mutated copy of the endoglin gene (that is, endoglin+/− heterozy-
gotes) display features of HHT.

Endoglin and ALK-1 encode proteins expressed on vascular
endothelial cells. Most gene products resulting from HHT-
causing mutations in these genes are unstable at the level of
mRNA or protein, and it has been shown that endothelial cells
derived from HHT1 or HHT2 patients express approximately
one half of the normal endoglin or ALK-1 levels, respectively.
Therefore it is believed that in most if not all cases, HHT results from endoglin or ALK-1
haploinsufficiency—that is, lack of sufficient protein for
normal function. As endothelial cells derived directly from
arteriovenous malformations also express half the normal
levels of endoglin, these malformations do not appear to be
due to an additional local loss of endoglin expression due to
a “second hit”.51

**How do mutations in endoglin and ALK-1 result in HHT?**

These genes encode proteins that are involved with signalling
by the transforming growth factor-beta (TGF-β) superfamily.
This group of peptide growth factors includes TGF-βs, activins,
and the bone morphogenetic proteins, which affect
cellular growth and differentiation through signal transduc-
tion cascades from transmembrane receptor complexes (for
review, see Heldin et al52). Generally, type II TGF-β receptors
bind the ligand directly, recruit and activate type I receptors
that activate downstream cytoplasmic signalling molecules
including SMADs. SMADs then bind into complexes and
translocate to the nucleus, where they modulate the expres-
sion of target genes through direct binding to DNA.

As ALK-1 is a TGF-β superfamily type I receptor, and endog-
lin associates with different signalling receptors and can
modify TGF-β1 signalling, it is expected that the abnormal
vessels in HHT develop because of aberrant TGF-β signalling
at some stage during vascular development and homeostasis.
Endoglin and ALK-1 work together to play specific parts in
governing cellular responses such as proliferation and
adhesion induced by members of the TGF-β superfamily. As
other HHT disease genes are identified, these will also likely
play a part in this signalling pathway possibly either as
ligands, receptors, or downstream transducers of TGF-β fam-
ily member signals.

**Box 2: Key points**

<table>
<thead>
<tr>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HHT is one of the commonest monogenic diseases with an incidence of one in 5,000.</td>
</tr>
<tr>
<td>• Due to late onset penetrance, no child of an HHT affected parent should be told they do not have HHT, unless there is a molecular diagnosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The 19th century view of HHT as a condition of nose bleeds and gastrointestinal bleeding is no longer appropriate.</td>
</tr>
<tr>
<td>• Catastrophic strokes occur in the HHT population due to usually silent pulmonary and cerebral AVMs.</td>
</tr>
<tr>
<td>• Pulmonary AVMs can be safely detected and treated—all HHT patients should be screened for pulmonary AVMs and treated with prophylactic antibiotics and embolisation.</td>
</tr>
<tr>
<td>• Asymptomatic screening for cerebral AVMs remains the subject of debate because of the risks of diagnostic and treatment modalities, and unclear natural history.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Should asymptomatic patients be screened for cerebral AVMs?</td>
</tr>
<tr>
<td>• How safe is it to use hormones and antifibrinolytics to modify the haemorrhagic phenotype?</td>
</tr>
<tr>
<td>• How safe is it to ascribe unusual presentations to rare complications of HHT?</td>
</tr>
<tr>
<td>• How do mutations in endoglin and ALK-1 result in HHT?</td>
</tr>
</tbody>
</table>

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However, understanding whether patients have endoglin or ALK-1 mutations does not allow a strong prediction of the likely course of HHT since all features of HHT can be seen in both HHT1 and HHT2. The different pattern of disease in different members of the same families in man (and in the mouse models) suggest that other genetic and environmental influences modify the HHT phenotype. Understanding these modifications will be critical to furthering our understanding of the development of the vascular lesions in HHT, and may help our understanding of the pathways by which normal vascular integrity is maintained.

ACKNOWLEDGEMENTS
We thank Dr James Jackson FRCS, MRCP for performing the pulmonary angiogram illustrated in fig 4A, and Mr William Grant FRCS, for helpful comments on the manuscript.

MULTIPLE CHOICE QUESTIONS (TRUE (T)/FALSE (F); ANSWERS AT END OF REFERENCES)
Q1. Hereditary haemorrhagic telangiectasia (HHT), Osler-Weber-Rendu syndrome:
(A) Affects approximately one in 100 000 individuals
(B) Can be safely ignored in the patient who just has nose bleeds
(C) Is only life threatening with a patient with nose bleeds and facial telangiectasia
(D) Does not influence mortality in epidemiological studies of the over 60s
(E) Frequently causes early onset strokes

Q2. A child of an individual with HHT:
(A) Can be told they do not have HHT if they show no manifestation of the disease by the age of 30
(B) Has a one in two chance of developing HHT
(C) If develops HHT, is likely to have the same type of HHT as their parent
(D) Has definite HHT if they develop nose bleeds
(E) Does not require medical review if they do not have nose bleeds

Q3. An individual with HHT complains of feeling generally unwell. Possible diagnoses to consider are:
(A) Anaemia
(B) Hypoxaemia
(C) Recent onset stroke
(D) Liver disease
(E) Transient ischaemic attacks

Q4. Patients who are fit and well with HHT should be screened for:
(A) Gastrointestinal telangiectasia
(B) Pulmonary AVMs
(C) Cerebral AVMs
(D) Hepatic AVMs
(E) Spinal AVMs

Q5. The science of HHT:
(A) HHT develops in the presence of only a single abnormal mutated gene
(B) The genes mutated in HHT are implicated in signalling by fibroblast growth factor
(C) The genes mutated in HHT allow prediction of the pattern of HHT in the individual
(D) No environmental modifiers of HHT have been found to date
(E) The disease genes in HHT are likely to be the only genetic factors influencing the HHT phenotype

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Wallace GMP. Shovlin CL. A hereditary hemorrhagic telangiectasia family with pulmonary involvement is linked to the known HHT genes, endoglin and AXK-1. Thorax 2000;55:685–90.


ANSWERS

Q1. (A) F (one in 8000), (B) F (needs pulmonary AVM screening), (C) F, (D) T, (E) T. Q2. (A) F, (B) T, (C) F, (D) F (only suspected HHT), (E) F, Q3. (A) T, (B) T, (C) T, (D) T, (E) T. Q4. (A) F, (B) T, (C) do not know; subject remains topic for debate, (D) F, (E) F; though there may be special circumstances, such as epidural analgesia when this might be considered. Q5. (A) T, (B) F, (C) F, (D) F (pregnancy precipitates pulmonary AVM development), (E) F.

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Hereditary haemorrhagic telangiectasia (Osler-Weber-Rendu syndrome): a view from the 21st century
M E Begbie, G M F Wallace and C L Shovlin

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