



Defining tetrahydrobiopterin responsiveness in phenylketonuria: Survey results from 38 countries



R.A.F. Evers^a, A.M.J. van Wegberg^a, K. Ahring^b, S. Beblo^c, A. Bélanger-Quintana^d, A.M. Bosch^e, A. Burlina^f, J. Campistol^g, T. Coskun^h, F. Feilletⁱ, M. Giżewska^j, S.C.J. Huijbregts^k, S. Kearney^l, M. Langeveld^m, V. Leuzziⁿ, F. Maillot^o, A.C. Muntau^p, J.C. Rocha^{q,r,s}, C. Romani^t, F.K. Trefz^u, A. MacDonald^v, F.J. van Spronsen^{a,*}

^a University of Groningen, University Medical Center Groningen, Beatrix Children's Hospital, Division of Metabolic Diseases, the Netherlands

^b Department of PKU, Copenhagen University Hospital, Denmark

^c Center for Pediatric Research Leipzig, Department of Women and Child Health, Hospital for Children and Adolescents, University Hospitals, Germany

^d Metabolic Diseases Unit, Department of Pediatrics, Hospital Ramon y Cajal, Madrid, Spain

^e Department of Pediatrics, Division of Metabolic Disorders, Amsterdam UMC, University of Amsterdam, Amsterdam, Netherlands

^f Division of Inherited Metabolic Diseases, Department of Integrated Diagnostics, University Hospital of Padova, Padova, Italy

^g Neuropaediatrics Department, Hospital Sant Joan de Déu, University of Barcelona, Barcelona, Spain

^h Hacettepe University Faculty of Medicine, Department of Pediatrics, Division of Pediatric Nutrition & Metabolism, Hacettepe, Ankara, Turkey

ⁱ Inborn Errors of Metabolism, Pediatric unit, University Hospital of Nancy, INSERM UMR_S 1256, Nutrition, Genetics, and Environmental Risk Exposure (NGERE), Nancy, France

^j Department of Pediatrics, Endocrinology, Diabetology, Metabolic Diseases and Cardiology of the Developmental Age, Pomeranian Medical University, Szczecin, Poland

^k Department of Clinical Child and Adolescent Studies-Neurodevelopmental Disorders, Faculty of Social Sciences, Leiden University, Leiden, Netherlands

^l Clinical Psychology Department, Birmingham Children's Hospital, Birmingham, UK

^m Department of Endocrinology and Metabolism, Amsterdam UMC, University of Amsterdam, AZ, Amsterdam, the Netherlands

ⁿ Department of Human Neuroscience, Unit of Child Neurology and Psychiatry, Sapienza University of Rome, Rome, Italy

^o Department of Internal Medicine, CHRU de Tours, Université de Tours, Tours, France

^p University Children's Hospital, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

^q Centro de Referência na área de Doenças Hereditárias do Metabolismo, Centro Hospitalar Universitário do Porto - CHUP, Porto, Portugal

^r Centre for Health Technology and Services Research (CINTESIS), Portugal

^s Nutrition & Metabolism, Nova Medical School, Faculdade de Ciências Médicas, Universidade Nova de Lisboa, Lisboa, Portugal

^t School of Life and Health Sciences, Aston University, Birmingham, UK

^u University Children's Hospital, Dietmar-Hoppe Metabolic Centre, Heidelberg, Germany

^v Dietetic Department, Birmingham Children's Hospital, Birmingham, UK

ARTICLE INFO

Article history:

Received 23 December 2020

Received in revised form 28 January 2021

Accepted 29 January 2021

Available online 4 February 2021

Keywords:

Phenylketonuria

Tetrahydrobiopterin

Survey

International

ABSTRACT

Background: A subset of patients with phenylketonuria benefit from treatment with tetrahydrobiopterin (BH₄), although there is no consensus on the definition of BH₄ responsiveness. The aim of this study therefore was to gain insight into the definitions of long-term BH₄ responsiveness being used around the world.

Methods: We performed a web-based survey targeting healthcare professionals involved in the treatment of PKU patients. Data were analysed according to geographical region (Europe, USA/Canada, other).

Results: We analysed 166 responses. Long-term BH₄ responsiveness was commonly defined using natural protein tolerance (95.6%), improvement of metabolic control (73.5%) and increase in quality of life (48.2%). When a specific value for a reduction in phenylalanine concentrations was reported ($n = 89$), 30% and 20% were most frequently used as cut-off values (76% and 19% of respondents, respectively). When a specific relative increase in natural protein tolerance was used to define long-term BH₄ responsiveness ($n = 71$), respondents most commonly reported cut-off values of 30% and 100% (28% of respondents in both cases). Respondents from USA/Canada ($n = 50$) generally used less strict cut-off values compared to Europe ($n = 96$). Furthermore, respondents working within the same center answered differently.

Conclusion: The results of this study suggest a very heterogeneous situation on the topic of defining long-term BH₄ responsiveness, not only at a worldwide level but also within centers. Developing a strong evidence- and consensus-based definition would improve the quality of BH₄ treatment.

© 2021 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

Abbreviations: BH₄, tetrahydrobiopterin; PAH, phenylalanine hydroxylase; Phe, phenylalanine; PKU, phenylketonuria; USA, United States of America.

* Corresponding author at: University Medical Center Groningen, Hanzeplein 1, 9700 RB Groningen, The Netherlands.

E-mail address: f.j.van.spronsen@umcg.nl (F.J. van Spronsen).

1. Introduction

Phenylketonuria (PKU, MIM 261600) is an inborn error of amino acid metabolism caused by a deficiency of the enzyme phenylalanine (Phe) hydroxylase (PAH) [1]. If left untreated, PKU causes high blood Phe concentrations, leading to severe intellectual disability and behavioural problems. Therefore, limiting dietary Phe intake through a natural protein-restricted diet is essential. Together with the intake of amino acid supplements, this life-long treatment is effective in preventing most complications associated with untreated PKU. However, the treatment for PKU may pose a high burden for patients and caregivers, and can be hard to maintain, especially after childhood [2]. Moreover, outcome in some treated PKU patients is still suboptimal [3].

Besides the dietary treatment, the pharmacological chaperone tetrahydrobiopterin (BH₄) is beneficial for a subset of PKU patients. In BH₄-responsive patients, treatment with BH₄ increases residual PAH activity, which results in a decrease in blood Phe concentrations and/or an increase in natural protein tolerance [4]. Considering not all PKU patients respond to BH₄, it is important to appropriately select patients with PKU who benefit from long-term BH₄ treatment. Evaluating eligibility for treatment with BH₄ is typically done by performing a BH₄ testing period or treatment trial to assess its effects. However, there is on-going debate on how BH₄ responsiveness should be defined, i.e. which effects of BH₄ treatment justify long-term treatment. This debate is also reflected by differences in the recommendations in the two major international PKU guidelines [5,6]. Specifically, the European guidelines define BH₄ responsiveness as an increase of 100% or more in natural protein tolerance or improved biochemical control (>75% of phenylalanine levels in target range), whereas the American guidelines state that clinical judgement is required to determine BH₄ responsiveness.

To harmonize treatment for PKU patients and ensure appropriate use of BH₄, it is important to have a uniform definition of BH₄ responsiveness that can be used by healthcare professionals worldwide. Therefore, it is necessary to have a good overview of the definitions of BH₄ responsiveness that are currently used, and to assess the extent of agreement on this topic. We therefore performed an international survey among healthcare professionals working in the field of PKU.

2. Methods

2.1. General information

We performed a survey using a web-based questionnaire targeting healthcare professionals involved in the care of PKU patients. The medical ethical committee of the University Medical Center Groningen ascertained that our study protocol was not clinical research with test subjects as meant in the Dutch Medical Research act involving human subjects, and therefore did not find it necessary to review the protocol. The CHERRIES checklist for reporting results of internet e-surveys was used to draft this manuscript [7]. Compliance with this checklist is described in Supplementary material 1, where additional methodological information can be found as well.

2.2. Questionnaire development

A first draft of the questionnaire was developed by RAFF, AMJvW and FJvS. All other authors were given the opportunity to comment on this version. With these comments a second version of the questionnaire was developed, which was used for this survey (Supplementary material 2). Adaptive questioning was implemented to present specific follow-up questions depending on previous answers. Consequently, respondents who indicated that their centre did not use BH₄ as a treatment option for PKU patients received no questions concerning their definition of BH₄ responsiveness. The survey contained, depending on the responses, between 4 and 19 closed, semi-closed and open questions. Qualtrics (<https://www.qualtrics.com/>) was used to record survey

responses. The technical functionality was tested by RAFF and AMJvW. The survey was available in English only.

2.3. Questionnaire distribution

The survey was open to everyone with access to the anonymous survey link. This link was distributed per email to healthcare professionals involved with PKU patients via the Metab-L and SSIEM mailing lists. In the invitation email, the goal of the study as well as the approximate time it would take to complete the survey was mentioned. A reminder was sent two weeks after the first invitation. After five more weeks, a second reminder was sent, specifically targeting SSIEM members from countries from which no response had yet been received. All invitees were encouraged to forward the invitation email to colleagues. Data were collected from March 8 to May 23, 2019.

2.4. Data analysis

Only complete questionnaires were analysed. IP addresses, location data (latitude and longitude), survey starting dates and times, and respondent names and main functions were checked to control for multiple entries from the same individual. Multiple responses per center were allowed because entries from different healthcare professionals working in the same center sometimes gave markedly different answers to the questionnaire. Since some answers to open questions covering the same subtopic overlapped, we analysed the overall survey results per subtopic and not per specific question. The following additional measures that were taken to enable analysis of the dataset: [1] if a respondent gave the same answer multiple times in different open questions, redundant answers were removed; [2] if a respondent gave a range for a cut-off value, the lowest number in that range was used; [3] answers regarding dietary intake given as mg Phe were converted into grams natural protein (using a conversion factor of 50 mg Phe for 1 g of natural protein); [4] since we aimed to analyse general healthcare practices, answers that were related to specific cases were not analysed; [5] answers that were unrelated to defining BH₄ responsiveness were removed; [6] responses to open questions were grouped.

Data were analysed using descriptive statistics and grouped according to geographical region (total, Europe, the United States of America (USA)/Canada). Differences between Europe and USA/Canada were assessed using Fisher's exact test, and cut-off values were considered as ordinal variables. IBS SPSS was used for all analyses.

3. Results

3.1. Responses

Three-hundred and forty different visitors clicked on the link in the invitation email, of whom 326 completed the first page of the survey (participation rate of 95.9%). Two-hundred and seventeen participants completed the entire questionnaire (completion rate of 66.6%).

3.2. Participants

Of the 217 respondents who completed the questionnaire, 50 respondents indicated that their center did not use BH₄ treatment. These responses came from Chile, Costa Rica, the Czech Republic, Finland, Ireland, Japan, Lebanon, Moldova, the Netherlands, Philippines, Serbia, Sri Lanka and Sweden (all $n = 1$); Croatia, France, Iran, Pakistan, Poland and Spain (all $n = 2$); Australia, Greece and USA (all $n = 3$); and the United Kingdom ($n = 16$). These responses were not used in further analyses. Additionally, one response was excluded from the analyses since it did not provide clear information.

Of the 166 remaining responses from 38 countries, 96 responses came from Europe (22 countries), 50 responses from USA/Canada (two countries), and 20 responses from other parts of the world (14

countries) (Supplementary material 3). We received more than one response from 26 centres (Supplementary material 3). Almost all respondents were either a physician (67.1%) or a dietician (25.7%). The distribution of physicians and dieticians differed in Europe compared to USA/Canada: in Europe, 81% of respondents were physicians, and 14% were dieticians; in USA/Canada, 40% were physicians, and 52% were dieticians.

3.3. Definitions of long-term BH₄ responsiveness

Table 1 shows the main criteria respondents used for defining long-term BH₄ responsiveness. Almost all respondents indicated using an increase in natural protein tolerance to define long-term BH₄ responsiveness, although improvement of metabolic control and increase in quality of life were also commonly used. The use of other criteria included neurocognitive and neurodevelopmental improvement.

For an increase in natural protein tolerance ($n = 157$, Supplementary materials 4), most respondents (52.2%) used a relative increase in natural protein tolerance to define long-term BH₄ responsiveness. When respondents used a specific cut-off value for this criterion, cut-off values of 30% and 100% were most often used, followed by 50% and 20% (Table 2). When respondents used a specific cut-off value for an absolute increase in natural protein tolerance measured in grams (28.0%), the most common cut-off value was 5 g (range: 0.2 to 20 g). When respondents used a specific cut-off value for an absolute increase in natural protein tolerance per kilograms bodyweight (13.4%), the most common cut-off value was 0.5 g per kilogram (range: 0.05–30 g per kg). Furthermore, most respondents (75.6%) stated that as long as blood Phe concentrations stay within target range, any increase in Phe concentrations is allowed when increasing natural protein intake.

For an improvement in metabolic control ($n = 122$, Supplementary materials 5), most respondents (73.0%) indicated that patients must show a specific reduction in Phe concentrations to be considered as long-term BH₄ responsive. The cut-off value of 30% was most often used, but the use of 20% as cut-off value was not uncommon (Table 3). Alternatively, respondents defined long-term BH₄ responsiveness using the target range of blood Phe concentrations (51.6%), mostly requiring a specific percentage of Phe concentrations to be within the target range. The most common cut-off values for this were 75%, 70% and 80%.

Regarding respondents who used an increase in quality of life to define BH₄ responsiveness ($n = 80$, Supplementary materials 6), only a small proportion measured quality of life using questionnaires (11%). For most respondents, the increase in quality of life was judged by the patients and/or family/parents (91%) and/or by (someone of) the patient's healthcare team (36%).

3.4. Differences between Europe and USA/Canada

Several differences were found between respondents from Europe versus USA/Canada. Improvement of metabolic control and increase in quality of life were significantly more often used in USA/Canada to define long-term BH₄ responsiveness ($p < 0.001$ and $p = 0.02$, respectively). Respondents from USA/Canada more often used stable Phe

Table 2

Cut-off values for an increase in natural protein tolerance that respondents used to define long-term BH₄ responsiveness.

Cut-off value	Total ($n = 71$)	Europe ($n = 45$)	USA/Canada ($n = 18$)	Other ($n = 8$)
10%	6%	4%	11%	0%
15%	1%	0%	6%	0%
20%	11%	7%	6%	50%
25%	3%	0%	11%	0%
30%	28%	20%	61%	0%
40%	4%	4%	0%	13%
50%	15%	18%	6%	25%
70%	1%	2%	0%	0%
100%	28%	42%	0%	13%
150%	1%	2%	0%	0%

Table 3

Cut-off values for a decrease in phenylalanine concentrations that respondents used to define long-term BH₄ responsiveness.

Cut-off value	Total ($n = 89$)	Europe ($n = 42$)	USA/Canada ($n = 39$)	Other ($n = 9$)
20%	19%	10%	26%	33%
25%	2%	5%	0%	0%
30%	76%	86%	71%	56%
50%	2%	0%	3%	11%

concentrations ($p = 0.01$) and tended to more commonly use a specific reduction in Phe concentrations ($p = 0.09$) to define BH₄ responsiveness compared to responders from Europe. The cut-off values for a specific percentage reduction in Phe concentrations differed ($p = 0.04$), with Europe using more strict cut-off values. This was also the case for the cut-off values for a relative increase in natural protein tolerance ($p < 0.001$). Separate analyses for physicians and dieticians, revealed an overall similar picture (Supplementary material 7), although many differences between Europe and USA/Canada were no longer significant in these smaller subgroups.

3.5. Differences within centres

To gain a general impression of the consensus on defining BH₄ responsiveness within the 26 centres from which we received more than one response, we investigated three aspects: [1] the use of general criteria (such as metabolic control, natural protein tolerance, and quality of life); [2] the use of a cut-off value (%) for a decrease in Phe concentrations; and [3] the use of a cut-off value (%) for a relative increase in natural protein tolerance. We found that within 21 of the 26 centres, not all respondents used the same general criteria to assess BH₄ responsiveness. Furthermore, in 11 centres some but not all respondents used a specific percentage decrease in Phe concentrations to define BH₄ responsiveness, and in four centres different cut-off values were used by different healthcare professionals working within the same centre. Similarly, in six centres, some but not all respondents used a specific cut-off value for a relative increase in natural protein tolerance, and in four

Table 1

Main criteria respondents used to define long-term BH₄ responsiveness. Comparisons between Europe and USA/Canada were made using Fisher's exact test.

Main criterion	Total ($n = 166$)	Europe ($n = 96$)	USA/Canada ($n = 50$)	Other ($n = 20$)
Improvement of metabolic control	73.5%	67%	94%***	55%
Increase in natural protein tolerance	94.6%	95%	94%	95%
Increase in quality of life	48.2%	38%	58%*	75%
Other	3.6%	2%	6%	5%

* $p < 0.05$; *** $p < 0.001$.

centres different cut-off values were used by healthcare professionals working within the same centre. Differences within centers were observed both within the same profession (among physicians and among dieticians) and between different professions.

3.6. Confidence and guidelines

Most respondents indicated they felt ‘very confident’ (18.1%) or ‘somewhat confident’ (65.1%) about the definition(s) of BH₄ responsiveness they use, and only 16.9% of respondents felt ‘not so confident’. Nevertheless, the majority of participants responded that they would ‘definitely’ (48.8%) or ‘probably’ (31.9%) be helped by a guideline that gives a better definition. However, 13.9% indicated that they ‘might or might not’ be helped, and 4.2% and 1.2% said they would ‘probably’ or ‘definitely’ not be helped by such a guideline.

4. Discussion

With this study, we aimed to get a better picture of the definitions of long-term BH₄ responsiveness that are used worldwide. Our main finding is the overall lack of consensus regarding this topic among healthcare professionals. This is evident at a worldwide level, but also on a regional level (within Europe and USA/Canada), and even within centres. Despite these large differences, healthcare professionals are remarkably confident about their own definition of long-term BH₄ responsiveness, although, conversely, most stated that they would be helped by a guideline that gives a better definition.

Firstly, we will discuss the strengths and limitations of our study. The main strength is the large number of respondents. As opposed to several recent practice surveys for PKU [8–12], we did not focus on a specific country or region. As a result, we received responses from many different countries around the world, making this the largest practice survey reported about PKU. We especially received many responses from Europe and USA/Canada, enabling us to investigate certain differences between these regions. The limitations of this study are largely related to the general limitations of performing a survey. Firstly, both questions and answers (to open-ended questions) may have been wrongly interpreted. Specifically, some of the reported cut-off values for an absolute increase in natural protein tolerance per kilograms bodyweight seemed extremely unrealistic (e.g. a cut-off value of 30 g per kilogram bodyweight). Furthermore, a selection bias is certainly present, with respect to both the individual respondents and the countries from which we received responses. However, due to the large number of respondents, we estimate that these limitations do not have a large influence on the main conclusions of this study.

It is clear that little agreement exists on the definition of long-term BH₄ responsiveness. Applying the often-used arbitrary cut-off value of 70% to define consensus in the total group of respondents, consensus only exists for the use of metabolic control and natural protein tolerance as criteria for defining long-term BH₄ responsiveness. Specific aspects, such as cut-off values, were all used by less than 70% of the total group of respondents. Moreover, our results show large differences between healthcare professionals who work within the same centre. Illustrative for the lack of consensus was the use of quality of life: around half of the respondents used this criterion to define long-term BH₄ responsiveness. These findings are in contrast with the general feeling of confidence that the respondents had regarding their own definition of BH₄ responsiveness. Ironically, with over 83% of respondents answering that they felt somewhat to very confident, few other questions in our survey were answered with a similarly high level of agreement.

This survey also shows that the definition of BH₄ responsiveness from the 2017 European guidelines for PKU have not yet been implemented in all European countries [13]. These guidelines define BH₄ responsiveness as an increase of 100% or more in natural protein tolerance or improved biochemical control (>75% of phenylalanine levels in target range). Only 20% of the European respondents used

the first part of this definition, and an even smaller proportion (5%) used the second part. As stressed previously [14], more insights into the adherence to the European PKU guidelines is needed, and reasons for lack of adherence (e.g. lack of awareness or disagreement) should be investigated. Moreover, our findings indicate the need of an implementation trajectory to improve the application of guidelines [15].

Comparisons between Europe and USA/Canada showed some significant differences. Perhaps most interesting are the differences regarding cut-off values, indicating that professionals in USA/Canada generally use less strict cut-off values. Although the cause of this is not clear, it may be related to the PKU guidelines from the American College of Medical Genetics and Genomics, which were published in 2014 [5]. These guidelines do not give a specific definition of BH₄ responsiveness, leaving it to the clinician to judge which precise effects are significant and thus define BH₄ responsiveness. This freedom possibly leads to the use of relatively low cut-off values and, more or less by definition, results in a more heterogeneous situation.

Reaching more consensus on this subject would be preferable for multiple reasons. Firstly, this would lead to equality in access to BH₄ treatment regardless of the country or center in which the patient is treated, or the healthcare professional by whom the patient is treated. Secondly, it promotes cost-effective treatment, avoiding unnecessary prescription of this expensive treatment to those who do not benefit. Thirdly, reaching more consensus would facilitate the development of an optimal testing regime for BH₄ responsiveness, since the effectiveness of such a regime depends on the definition [16]. Lastly, reaching consensus on the definition of BH₄ responsiveness may serve as a framework for defining effectiveness of new PKU treatment modalities that could partly or wholly replace dietary treatment. This includes pharmacological treatment with pegvaliase, especially since recently published recommendations on this treatment state that ‘clinically meaningful efficacy benefit should be determined by the treating clinician’ [17], similar to the American recommendations for BH₄ treatment.

Although most respondents answered they felt confident about their definition of BH₄ responsiveness, a majority also indicated that they would be helped with a guideline that gives a better definition of BH₄ responsiveness. Ideally, such a definition of BH₄ responsiveness should be evidence-based. To this end, firstly, the evidence on long-term effects of BH₄ treatment needs to be reviewed. While it is known that BH₄ treatment can decrease Phe concentrations and increase natural protein tolerance [18], it is unclear how changes in these parameters are related to secondary outcomes, such as quality of life, neurocognitive functioning, nutritional status, and anthropomorphic measures. A systematic review on this topic could give valuable insights into the long-term benefits of BH₄ treatment and how these benefits relate to the level of BH₄ responsiveness. While it is likely that the currently available evidence is not sufficient to provide clear-cut answers, such a review would serve as a solid basis to develop an evidence- and consensus-based definition of long-term BH₄ responsiveness. Furthermore, it is also crucial that a new definition of BH₄ responsiveness is useful in daily practice. To that aim, the outcomes of this survey, reporting on a large variety of definitions of BH₄ responsiveness that are currently used, may be of help.

5. Conclusion

The results of this large worldwide practice survey show a very heterogeneous picture regarding the definition of BH₄ responsiveness that healthcare professionals use in daily practice. Considering the implications of the large differences in definitions of BH₄ responsiveness that were observed, even within centres, it is clear that an evidence- and consensus-based definition of long-term BH₄ responsiveness should be developed to improve the quality of BH₄ treatment in PKU patients.

Funding

The authors received no funding for this research.

Contributors' statement

Roeland Evers conceptualized the study, collected the data, carried out the analyses, and was the lead writer of the initial manuscript. Annemiek van Wegberg conceptualized the study, collected the data, and was the second lead writer of the manuscript. Francjan van Spronsen conceptualized the study, and coordinated the project. All authors designed the study, interpreted the data, critically reviewed the manuscript, approved of the final manuscript as submitted, and agree to be accountable for all aspects of the work.

Declaration of Competing Interest

RAFE has received financial support from Biomarin for attending symposia. AMJvW has received a research grant from Nutricia, honoraria from Biomarin as speaker, and travel grants from Nutricia and Vitaflor. AMB has received a speakers fee from Nutricia and has been a member of advisory boards for Biomarin. MG received honoraria and was a consultant for: Nutricia International/Danone, Merck-Serono, Mead Johnson, BioMarin and Vitaflor. JCR has been a member of the European Nutritionist Expert Panel [Biomarin], the Advisory Board for Applied Pharma Research and Nutricia, and received honoraria as a speaker from APR, Merck Serono, Biomarin, Nutricia, Vitaflor, Cambrooke, PIAM and Lifediet. FJvS is a member of scientific advisory boards for PKU and aminoacid defects that are supported by Agios, Applied Pharma Research, Arla Food Int, BioMarin, Eurocept, Homology, Lucane, Nestlé–Codexis Alliance, Nutricia, orphan Europe, Rivium Medical BV, Vivet, has received research grants from Alexion, BioMarin, Beatrix Research Fund, Codexis, ESPKU, NPKUA, NPKUV, Nutricia, Sobi, Tyrosinemia Foundation, Vitaflor, ZONMW, and has received honoraria as a consultant and speaker from Applied Pharma Research, Biomarin, MendeliKABS, Nutricia, Pluvia, SoBi, and Vitaflor. AM is an advisory board member for ELEMENT, Danone–Nutricia, Arla, and Applied Pharma Research, and has received research funding and honoraria from Applied Pharma Research, Nutricia, and Vitaflor International. All other authors reported no conflicts of interest.

Acknowledgements

We sincerely thank all healthcare professionals who participated in this survey, including James B. Gibson, MD, Bert Verhage, Dr. Mary Ann Abacan, Samantha A. Schrier Vergano, J.V. Joergensen, Yilmaz Yildiz, Beth Golden, Jamie Jocis, Marie Lefrancois, Laurie D. Smith PhD MD, Duncan, MPH, RD, Prof. Laurie Bernstein, Sylvia Stockler, Susanne Schweitzer-Krantz, Eman Megdad, Handoom B., Corrie Timmer, MC Nassogne, Annette SJ Feigenbaum, Dr. Avihu Boneh, Anita Inwood, Eiroa Hernan, Zuhair Rahbeeni, Hauro Shintaku, Burcu Kumru, Johannes Häberle, Matthias Baumgartner, Prof. Dr. Peter Witters, Giacomo Biasucci, Esther M. Maier, Patrícia Janeiro, Mikael Oscarson, Dr. Marelli Cecilia, Arnoux Jean-Baptiste, Touati, Corne Christelle, P. Freisinger, H.A.Lemonde, Tomeuoli, Amandine Rubio, Pelin Teke Kisa, Iris Scala, Dr. Nilo Lambruschini, Mays Altai, Patrick Verloo, Stephen Cederbaum, Bozena Didycz, Brett H. Graham, M.D., Ph.D., Kathryn Moseley, PD Dr. D. Haas, Andrea Bordugo, Martin Lindner, Suresh Vijay, Eresha Jasinge, Athanasia Ziagaki, Verónica Cornejo, Fanny Mochel, Hui Bein Chew, Saikat Santra, Kairit Joost, P.J. Moreno Lozano, Nancy Leslie, Anibh Das, A. Cigdem Aktuglu Zeybek, David Dimmock, Imad Dweikat, Eyskens Francois, Wendy E. Smith, MD, Jean-Marc Nuoffer, Ksenija Fumić, Svetlana Lajic, Dr. Alison Cozens, Mahmut Coker, Allan M Lund, Barth, Karit Reinson, D Holmes Morton MD, Martín-Hernández Elena, MAEM Wagenmakers, Sarah Grünert, Danijela Petković Ramadža, Ilse Kern, Charlotte Dawson, Maryam Ziadlou, Stephanie Hacker, Jessica Kopesky,

Natalia Pichkur, Natalia Usurelu, Katrin Ounap, Kathleen Duddy, Martins E, Suzanne Hollander, MS, RD, Siobhan O' Sullivan, Barbara Cochrane, Charlotte Lubout, F-G. Debray, Prof dr. E. Rubio Gozalbo, Liesbeth van der Ploeg, Saadet Mercimek-Andrews, Jessica Burfield, RD, CSP, LDN, Katherine Arduini, María Gabriela Valle, Jessica Myers, Karolina M Stepien, Amy Cunningham, MS, LDN, RD, Gabor Z Racz, Dominique Roland, Gisela Wilcox, Belmatoug Nadia, Benoist JF, Szlago Marina MD, Dr. Ramses Badilla-Porras, MCH Janssen, Dr. Norma Spécola, Dr. Sibtain Ahmed, Aysha Habib Khan, A. Mobarak, Monika Jörg-Streller, Dr. Hani Rao, Heather Allen, Ertugrul Kiykim, Annie Rosen Heath, William Nyhan, Toshihiro Ohura, Linda Christian, BSc, Flavia Piazzon, MD, PhD, Astrinia Skarpalezou BSc, MSc, Peymaneh Sarkhail, Paula Garcia, Alexandra Hörbe-Blindt, Callum Wilson, Jiri Zeman, Sebile Kilavuz, Prof Ina Knerr, C. Hollak, and Maja Djordjevic.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ymgme.2021.01.013>.

References

- [1] N. Blau, F.J. van Spronsen, H.L. Levy, Phenylketonuria, *Lancet* 376 (9750) (2010 Oct 23) 1417–1427.
- [2] E.R. Jurecki, S. Cederbaum, J. Kopesky, K. Perry, F. Rohr, A. Sanchez-Valle, et al., Adherence to clinic recommendations among patients with phenylketonuria in the United States, *Mol. Genet. Metab.* 120 (3) (2017 Mar) 190–197.
- [3] G.M. Enns, R. Koch, V. Brumm, E. Blakely, R. Suter, E. Jurecki, Suboptimal outcomes in patients with PKU treated early with diet alone: revisiting the evidence, *Mol. Genet. Metab.* 101 (2–3) (2010 Oct–Nov) 99–109.
- [4] M.L. Lindegren, S. Krishnaswami, T. Reimschisel, C. Fannesbeck, N.A. Sathe, M.L. McPheeters, A systematic review of BH4 (Sapropterin) for the adjuvant treatment of phenylketonuria, *JIMD Rep.* 8 (2013) 109–119.
- [5] J. Vockley, H.C. Andersson, K.M. Antshel, N.E. Braverman, B.K. Burton, D.M. Frazier, et al., Phenylalanine hydroxylase deficiency: diagnosis and management guideline, *Genet. Med.* 16 (2) (2014) 188–200.
- [6] F.J. van Spronsen, A.M. van Wegberg, K. Ahring, A. Bélanger-Quintana, N. Blau, A.M. Bosch, et al., Key European guidelines for the diagnosis and management of patients with phenylketonuria, *Lancet Diabetes Endocrinol.* 5 (9) (2017 Jan 09) 743–756.
- [7] G. Eysenbach, Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES), *J. Med. Internet Res.* 6 (3) (2004 09 29)e34.
- [8] A. Pinto, S. Adams, K. Ahring, H. Allen, M.F. Almeida, D. Garcia-Arenas, et al., Weaning practices in phenylketonuria vary between health professionals in Europe, *Mol. Genet. Metab. Rep.* 18 (2019 Mar) 39–44.
- [9] N. Yuskiv, B.K. Potter, S. Stockler, K. Ueda, A. Giezen, B. Cheng, et al., Nutritional management of phenylalanine hydroxylase (PAH) deficiency in pediatric patients in Canada: a survey of dietitians' current practices, *Orphanet. J. Rare Dis.* 14 (1) (2019 01 08) 7.
- [10] A. Pinto, S. Adams, K. Ahring, H. Allen, M.F. Almeida, D. Garcia-Arenas, et al., Early feeding practices in infants with phenylketonuria across Europe, *Mol. Genet. Metab. Rep.* 16 (2018 Sep) 82–89.
- [11] M. Gizewska, A. MacDonald, A. Bélanger-Quintana, A. Burlina, M. Cleary, T. Coşkun, et al., Diagnostic and management practices for phenylketonuria in 19 countries of the South and Eastern European Region: survey results, *Eur. J. Pediatr.* 175 (2) (2016 Feb) 261–272.
- [12] M. Zerjav Tansek, U. Grosej, N. Angelkova, D. Anton, I. Baric, M. Djordjevic, et al., Phenylketonuria screening and management in southeastern Europe - survey results from 11 countries, *Orphanet. J. Rare Dis.* 10 (2015 May 30) 68.
- [13] A.M.J. van Wegberg, A. MacDonald, K. Ahring, A. Bélanger-Quintana, N. Blau, A.M. Bosch, et al., The complete European guidelines on phenylketonuria: diagnosis and treatment, *Orphanet. J. Rare Dis.* 12 (2017–10–12).
- [14] C. Sousa, M.F. Almeida, C. Sousa Barbosa, E. Martins, P. Janeiro, I. Tavares de Almeida, et al., The European Phenylketonuria Guidelines and the challenges on management practices in Portugal, *J. Pediatr. Endocrinol. Metab.* 32 (6) (2019 Jun 26) 623–629.
- [15] J. Häberle, M. Huemer, Evaluation of implementation, adaptation and use of the recently proposed urea cycle disorders guidelines, *JIMD Rep.* 21 (2015) 65–70.
- [16] R.A.F. Evers, Annemiek M.J. van Wegberg, K. Anjema, Lubout CMA, E. van Dam, D. van Vliet, et al., The first European guidelines on phenylketonuria: its usefulness and implications for BH4 responsiveness testing, *J. Inher. Metab. Dis.* 43 (2) (2019 Sep 10) 244–250.
- [17] N. Longo, D. Dimmock, H. Levy, K. Vial, H. Bausell, D.A. Bilder, et al., Evidence- and consensus-based recommendations for the use of pegvaliase in adults with phenylketonuria, *Genet. Med.* 21 (8) (2018 Dec 14) 1851–1867.
- [18] U.R. Somaraju, M. Merrin, Sapropterin dihydrochloride for phenylketonuria, *Cochrane Database Syst. Rev.* 3 (2015 Mar 27), CD008005.