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Severe Acute Hyponatremia as an Initial Presentation of Acute Intermittent Porphyria Triggered by a Subdermal Etonogestrel Implant

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Abstract

Objective
We present a case of acute intermittent porphyria with accompanying euvolemic hyponatremia from elevated ADH triggered by an implanted hormonal contraceptive device.

Case description
A 19-year-old African-American female with history of childbirth two months prior presented to the emergency department of Grady Memorial Hospital with vague but severe back pain and found with marked hyponatremia of 125mEq/L. Serum sodium level decreased to 113mEq/L after volume resuscitation with 0.9% sodium chloride. The patient experienced progressive decline in mental status and a single generalized tonic clonic seizure. Patient was admitted to intensive care unit and improved with administration of 3% sodium chloride. Extensive evaluation for etiology of euvolemic hyponatremia was initially unremarkable, and patient was managed with free water restriction, hypertonic sodium chloride, vasopressin receptor antagonists, and antihypertensive medications. Empiric removal of a recently inserted etonogestrel implant was performed with resolution of patient’s symptoms. Approximately 2 weeks following hospital discharge, the send-out lab for urine porphobilinogen was found to be notably elevated.

Conclusion
We stress the importance of considering the diagnosis of AIP in patients presenting with back or abdominal pain, hyponatremia and altered mental status who are reproductive age females and using implanted hormonal contraceptive devices. Appropriate supportive treatment and removal of the implant is required to prevent morbidity and life-threatening consequences.

Keywords: Acute intermittent porphyria; Etonogestrel implant; Hyponatremia; Postpartum; Seizure; SIADH

Introduction
Acute Intermittent Porphyria (AIP) is one of several disorders that arise from enzymatic derangements in the biosynthetic pathway of the heme molecule. AIP is the most common of the acute porphyrias worldwide, with an estimated prevalence of approximately 5 per 100,000 people [1]. Specifically, AIP results from a defective copy in one of the two genes for Porphobilinogen (PBG) deaminase, leading to the inadequate synthesis of the normal enzyme. Typically, patients will be symptom-free until a precipitating factor causes increased transit through the porphyrin metabolic pathway, resulting in accumulation in Aminolevulinic Acid (ALA) and Porphobilinogen (PBG) (Figure 1) [2-4]. AIP is the second most common porphyria but can have variable expression making diagnosis difficult [5]. We describe a case of acute intermittent porphyria that presented with non-specific lower back pain and progressive acute hyponatremia complicated by seizure, acute encephalopathy, tachycardia, and hypertension.

Case Description
A 19 year old African-American recently post-partum female with no known past medical history presented to the emergency department of Grady Memorial Hospital for a 3 day history of worsening mid-back pain and fatigue. Two months prior to admission, the primigravida delivered a pre-term infant at 27 weeks gestational age following spontaneous rupture of membranes. At admission, the primigravida delivered a pre-term infant at 27 weeks gestational age following spontaneous rupture of membranes. At that time, she received antenatal steroids, tocolysis, empiric group B Streptococcus prophylaxis, and had an uneventful vaginal delivery. She was discharged two days after delivery. There is no mention of eclampsia or preeclampsia during review of outside records.

She recovered well and elected to have an etonogestrel 68 mg implant (Implanon®, Merck & Co., Inc., Whitehouse Station, NJ, USA) placed in her left arm for contraception, which was performed two weeks prior to this presentation. The patient continued to produce and pump breast milk throughout this time. The day prior to admission, she presented to an Emergency Department (ED) at another hospital for mid-back pain and fatigue, was diagnosed with a viral syndrome,
and discharged home. Notable laboratory studies from that visit revealed sodium of 131mEq/L and creatinine of 1.26mg/dL (baseline 0.7-0.8). The following morning the patient continued to experience severe back pain. The patient’s parents noticed worsened fatigue, prompting presentation to our ED for further evaluation. On the day of admission, the patient also described three days of decreased appetite and nausea.

Initial physical examination was unremarkable; the patient’s back was not tender to palpation, nor could pain be elicited by musculoskeletal or costovertebral angle maneuvers. Laboratory evaluation revealed a sodium level of 125mEq/L and a creatinine of 1.1mg/dL. Initial imaging, including CT renal stone protocol and CT Head without contrast, was unrevealing. The ED physicians assessed the patient as having hypovolemic hyponatremia, and administered a two liter bolus of 0.9% sodium chloride (NaCl). Following this, the patient’s mental status deteriorated and repeats sodium was decreased to 116mEq/L, prompting consultation to the Medical Intensive Care Unit (MICU) service for progressively symptomatic and worsening acute hyponatremia. On MICU evaluation, repeat physical examination suggested patient was currently at or near euvoeulia. On neurological exam, she was now obtunded and unresponsive to verbal or painful stimuli with a disconjugate gaze and absent patellar reflexes. Sinus tachycardia to 120s and marked hypertension with systolic blood pressures in the 200s were noted. She was admitted to the MICU for intensive monitoring of sodium and acute treatment of hyponatremia and hypertension. While en route to ICU, she suffered a witnessed general tonic clonic seizure of two minutes duration prompting emergent intubation for airway protection.

Immediate laboratory data post-seizure revealed sodium level of 113mEq/L. Urine sodium of 174mEq/L, urine osmolality of 473mOsm/kg, and serum osmolality of 245mOsm/kg again suggesting euvoeulia hyponatremia and consistent with elevated ADH state. Fluid restriction and infusion of 3% NaCl at 30mL/hr were started. As malignant hypertension (possibly from post-partum eclampsia) leading to hypertensive encephalopathy and seizure could not be immediately excluded, a nicardipine infusion was initiated for acute blood pressure control. Over the next 24 hours, sodium level increased to 124mEq/L, and infusion of 3% hypertonic saline was decreased to 15mL/hr. No further seizure activity occurred and acute encephalopathy and focal neurologic symptoms improved steadily, facilitating liberation from mechanical ventilation within 24 hours. Table 1 demonstrates further diagnostic evaluation undertaken to determine etiology of apparent SIADH state on admission [6,7].

Table 1: Relevant differential diagnosis of SIADH and corresponding diagnostic work-up for our patient’s presentation.

<table>
<thead>
<tr>
<th>Etiologies of SIADH</th>
<th>Patient findings/results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other causes of excessive ADH</td>
<td>Normal TSH and cosyntropin stimulation test</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>Adrenal insufficiency</td>
<td></td>
</tr>
<tr>
<td>Malignancy</td>
<td>Negative chest, abdomen, and pelvis CT scans, negative transvaginal ultrasound</td>
</tr>
<tr>
<td>Lung</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
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<tr>
<td>Lymphoma</td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>Negative chest CT, absence of clinical symptoms consistent with infection</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>Negative HIV testing during pregnancy per OSH records and Negative HIV testing during current hospitalization</td>
</tr>
<tr>
<td>Intracranial processes</td>
<td></td>
</tr>
<tr>
<td>Brain tumors</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td></td>
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<tr>
<td>Encephalitis</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Sheehan’s syndrome</td>
<td></td>
</tr>
<tr>
<td>Medications/Ingestions</td>
<td>Was not on any of these medications at presentation</td>
</tr>
<tr>
<td>SSRI’s</td>
<td></td>
</tr>
<tr>
<td>Narcotics</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Drug/volatile screen negative, with exception of elevated acetone level from starvation ketosis</td>
</tr>
<tr>
<td>NSAIDs</td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>Acute Intermittent Porphyria (AIP)</td>
<td>Elevated urine porphobilinogen - result available after hospital discharge</td>
</tr>
<tr>
<td>Acute psychosis</td>
<td>Psychiatric consultation did not suggest postpartum psychosis</td>
</tr>
</tbody>
</table>

Approximately 5 days after hospital discharge, the physician was notified of an elevated urine porphobilinogen (a send-out lab that normally takes 2-3 weeks to result) of 56.80mg/g creatinine (Reference Range < 2.0mg/g creatinine). Patient was informed of this finding and follow up with Benign Hematology Clinic was arranged and encouraged for further evaluation including genetic analysis. Despite repeated contact with patient via telephone and encouragement to return for outpatient evaluation, patient refused further assistance and has since been lost to follow-up.

Discussion

Acute intermittent porphyria can be a diagnostic challenge, as it presents with a constellation of nonspecific but oftentimes severe symptoms such as abdominal or back pain, autonomic dysfunction manifested as hypertension and tachycardia, and progressive muscle weakness and neuropathy [8,9]. Severe AIP crises can rapidly progress to encephalopathy often secondary to hyponatremia from an elevated ADH state, respiratory failure from diaphragm paralysis, and psychosis with marked agitation [10,11]. It should be noted that, in the acute presentation, it can be difficult to clinically distinguish...
appropriate ADH release from volume depletion from inappropri-
ate ADH release (SIADH) in these cases as many patients have acute
volume depletion at presentation, and it is known that patients with
porphyria have a lower blood volume at baseline [12]. On the basis
of the MICU team physical exam suggesting euveolic state and
2L fluid bolus with 0.9% NaCl by the ED, our team interpreted the
urinary studies to be consistent with an SIADH state while admitting
that this may not be entirely the case. In addition to enccephalopathy,
other important diagnostic clues for AIP include dark reddish-brown
urine on physiologic and elevated spot urinary porphyrin,
porphobilinogen, usually indicative of an acute symptomatic attack. Low
porphobilinogen deaminase activity can be detected during times of
disease remission [13]. The mainstay of AIP management involves
the avoidance of suspected precipitants [14]. Well-known precipitants
include sulfonamide antibiotics, anti-epileptics, Oral Contraceptive
Pills (OCPs), alcohol, decreased caloric intake, stress, and smoking
[15]. In addition to symptomatic management, glucose or intravenous
heme (heme arginate in Europe or panhematin in the USA) can be
administered to reduce starvation ketosis and ALA synthesis,
respectively, in those patients with known or highly suspected cases of
AIP [8,9,14].

Six weeks after a recent childbirth, our patient elected to have an
tonogestrel implant inserted into her arm as a contraceptive method.
Two weeks later, the patient experienced symptoms and laboratory
findings consistent with AIP. In review of porphyrinogenic medications
listed on the Porphyria Foundation’s drug database, progestins are listed as unsafe due to their ability to induce
accumulation of porphyrins [16]. We believe that the progestin-only
contraception in addition to her recent decreased caloric intake
triggered this AIP crisis and, ultimately, established the patient as
suffering from porphyria. Following removal of etonogestrel implant
and discontinuation of other porphyrinogenic medications (such as nicardipine), the patient’s clinical status, including symptomatic
hyponatremia, dramatically improved. Despite studies demonstrating
the association of AIP attacks with oral contraception [17,18],
importantly and to our knowledge, none have reported the role of
an implanted contraceptive in precipitating overt AIP. Adding to the
unusual nature of our patient’s case is the rarity of AIP among African
and African American populations. A review published in 2000 noted
that only 38 patients have been reported with AIP and African
ancestry, and this is thought to be due to a different spectrum of
mutations in the Porphobilinogen Deaminase gene (PBGD) in the
African population compared to the Caucasian population [19,20].

Sex hormones such as estrogen and progesterone have been
previously implicated in the precipitation of acute AIP crises
[15,21-23]. Approximately 10-30% of women with porphyria
experience cyclical AIP attacks, an association thought to be
secondary to progestogen’s induction of ALA synthase, one of the
major rate-limiting steps in heme synthesis [18]. This relationship
of AIP with progesterone is further established by improved clinical
symptoms with the use of Gonadotropin-Releasing Hormone (GnRH)
agonists in patients with recurrent cyclical AIP attacks [21]. GnRH
agonists decrease the number of pituitary GnRH receptors, leading to
suppressed hypothalamic-pituitary-ovarian axis and decreased
progesterone release [18]. Furthermore, in a Swedish population
based-study, questionnaires administered to 166 women with clinical or latent AIP demonstrated that 24% of participants
experienced an AIP attack with concurrent OCP use, and 18% of
respondents stated that OCPs actually precipitated their first AIP
attack [17]. AIP attacks can also occur during pregnancy but first
presentations of AIP are rare during this time. A single case series,
by Keung et al., described women with latent or undiagnosed AIP
presenting with overt clinical symptoms during pregnancy or
postpartum period. However, it is unclear whether the hormonal
changes occurring during pregnancy alone are sufficient to exacerbate
AIP, as most women described in this case series also experienced the
use of a potential aggravating medication, comorbid infections, or
decreased caloric intake [24].

Once the precipitating medications were removed, our patient
required symptomatic treatment alone without the use of heme.
Interestingly, our patient’s family did note an uncharacteristic
high-carbohydrate diet. These cravings could illustrate the role of
carbohydrate loading in the suppression of ALA synthase and
subsequent decreased production of intermediate porphyrins.
Although high carbohydrate diets have previously been advocated as
integral to preventing future AIP attacks, and were commonly used
in the treatment of AIP prior to heme availability, the benefit of high
carbohydrate diets has not been scientifically proven [25].

Once the diagnosis of AIP is suspected and/or confirmed in a
patient, it is advisable to refer the patient to one of the participating
clinical centers in the Porphyrias Consortium of the Rare Disease
Clinical Research Network. There are nine such clinical centers
located in the USA. In addition, patients should be informed of the
availability of genetic testing through the Department of Genetics
& Genomics at the Icahn School of Medicine at Mount Sinai in
New York, New York [26].

Conclusion

Acute intermittent porphyria requires high clinical suspicion, especially in young females with abdominal pain out of proportion
to physical exam, SIADH, and new-onset hypertension. Because of the low prevalence of this disease in the United States, AIP was,
admittedly, not high on our initial differential diagnosis for our
patient’s presenting signs and symptoms. However, a negative history
and laboratory work-up for eclampsia, Sheehan’s syndrome,
toxication, and adrenal insufficiency prompted reconsideration
of more rare diagnoses. An elevated spot urine porphobilinogen,
review of the patient’s recent medications, and the collection of clinical
symptoms in a relatively healthy 19 year old female suggested an
acute exacerbation of undiagnosed latent AIP. Our particular case
demonstrated newly diagnosed AIP with acute attack likely prompted
by recent etonogestrel implant insertion and complicated by decreased
nutritional intake. The importance of recognition and diagnosis is
paramount to preventing morbidity and life-threatening consequenc-
es of AIP, and AIP should be considered as a rare cause of euvolemic
hyponatremia in critically ill patients.

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