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A new defect of peroxisomal function involving pristanic acid: a case report

B N McLean, J Allen, S Ferdinandusse, R J A Wanders

In general, peroxisomal disorders present either at birth with deficits resulting in severe hypotonia and craniofacial dysmorphism or as later onset psychomotor retardation, seizures, and hepatomegaly. There is, however, a considerable range of clinical problems within a disorder and overlap between disorders, so that some can only be differentiated on biochemical grounds.

We present a case of adult onset neurological disease the features of which were reminiscent of a peroxisomal disorder, but in a novel combination.

The biochemical defect has been recently elucidated, and has been shown to be due to a deficiency of α-methylacyl-CoA racemase (AMACR) making our patient one of the first adults to be described with this condition.

CASE REPORT

A 44 year old man presented with failing vision, having been suspected by his general practitioner of malingering.

He was born of non-consanguineous parents, one of six children, his brother and four sisters being in good health. He had left school at the age of 14. He had been a poor scholar with reading difficulties and after leaving had a succession of unskilled jobs from which he was invariably dismissed. At the age of 18 he presented with an encephalitic illness characterised by 3 days of severe headache, nausea, and photophobia, with a single blackout followed by progressive confusion, irrational behaviour, and resulting in coma.

He developed focal seizures, with eye deviation to the left and jerking of the neck muscles, which on one occasion generalised. He had tonic deviation of his eyes to the right, sometimes with slow deviation, bilateral papilloedema, but no other focal neurological signs. He had a mild pyrexia and a neutrophil leucocytosis (13 ×10³/l). He underwent cerebral angiography and CSF analysis, including protein estimation, both of which were normal. An EEG showed gross disturbances with generalised slowing and loss of α activity. He required ventilation, but then underwent spontaneous recovery, whereupon he was found to be blind. This was initially suspected to be due to occipital lobe infarction, but pigmentary retinal changes were seen extensively in the periphery of both fundi, and a neuroretinitis was proposed. His EEG improved, but did not return to normal, remaining slowed. Vision slowly recovered, initially with perception of light, then colours, and finally acuity of 6/12 bilaterally and a reading acuity of N24 right N18 left. A neuropsychometric assessment showed a premorbid verbal IQ of 86, a reading age of 7.5 years, and a long term problem with vision was suspected.

At the age of 22 he developed generalised seizures, only partially controlled with phenobarbital and phenytoin. An
EEG showed excessive slowing with a right temporal focus and a photoconvulsive response.

At the age of 25 he had an episode of status epilepticus, by which time his vision had declined to 6/36 right and 6/60 left uncorrected.

At the age of 34 he was involved in a road traffic accident and sustained a small right frontal extradural haematoma with confusion, not requiring surgery. After this he developed drop attacks and frequent headaches.

At the age of 41 he became aware of declining vision, and was found to have VA 1/18 L+R, constricted fields, and a generalised “retinopathy”.

When he presented at the age of 44, he was complaining of migrainous headaches daily from his accident, and a recent episode of amnesia with automatic behaviour. He had not been employed since his encephalopathy.

There was a family history of ischaemic heart disease, his father dying aged 67 of a heart attack. He was single without children, and taking only phenytoin and phenobarbital. There was a previous episode of depression with an overdose, and he was thought to have had a viral illness with pyrexia. Minor surgery may precipitate deterioration, so it could be postulated that oxidative stresses triggered decompensation or release of phytic acid from fat stores as a result of catabolic stress. The association with encephalopathy we presume to be genuine, but coincidence cannot be excluded.

A comparison of his clinical features with those found in the other peroxisomal disorders shows a general similarity to those of late onset, particularly Refsum’s disease and in common with the single enzyme deficits, there are mild dysmorphic features, he has a seizure disorder with a peripheral neuropathy, no ataxia, a retinopathy and hypogonadism. His brain MRI did not show white matter abnormalities, as

### RESULTS

Full blood count, differential count, urea, electrolytes, liver and bone profiles, thyroid function, glucose, B12 and folate, VDRL, TPHA, protein electrophoresis, and immunoglobulin concentrations were all normal or negative. Cholesterol was borderline low at 3.4 mmol/l (normal 3.5 – 5.2).

Testosterone was 3.2 nmol/l (normal 9–38), estradiol <30 pmo/l (normal 40–185 ), FSH 34.1 IU/l (normal 1.1–7.8), and LH 10.8 IU/l (1.1–9.4) confirming primary gonadal failure. Prolactin was normal.

Chromosomal analysis showed a normal male karyotype. Mitochondrial DNA analysis was negative for MELAS 3243, 3271, 8344 deletions.

The EEG showed occipital slowing with no seizure activity or photoconvulsive response. Visually evoked potentials were abnormal bilaterally with low amplitude disrupted wave forms. Brain stem auditory evoked potentials were normal with N1-N5 latencies of 3.3 ms left, 3.96 ms right. Brain MRI showed minor cerebral atrophy only with normal white matter.

Table 1 lists the results of fatty acid and bile acid analyses in serum from the patient. The results show normal very long chain fatty acids, a slightly increased phytanic acid concentration, and profoundly increased pristanic acid concentration. Furthermore, both dihydroxycholestanolic acid and trihydroxycholestanolic acid are greatly increased.

These data pointed to a defect in the β-oxidation system which was supported by the finding of a reduced pristanic acid β-oxidation capacity (table 2). Subsequent studies showed that the primary defect in this patient was not at the level of one of the β-oxidation enzymes themselves but rather in one of the auxiliary enzymes involved in β-oxidation called α-methyl-acetyl-CoA racemase.

### DISCUSSION

Our patient had learning difficulties and his psychometric testing as an adult after his encephalopathic illness suggested a longstanding premorbid problem with functional and language skills. Encephalitic illnesses have not been noted as a feature of peroxisomal disorders, although Goldman et al. described a patient with Refsum’s disease who had an acute onset of ataxia after a viral illness—our patient was initially thought to have had a viral illness with pyrexia. Minor surgery may precipitate deterioration, so it could be postulated that oxidative stresses triggered decompensation or release of phytanic acid from fat stores as a result of catabolic stress. The association with encephalopathy we presume to be genuine, but coincidence cannot be excluded.

### Table 1

<table>
<thead>
<tr>
<th>Fatty Acid</th>
<th>Value found</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCLFA profile:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C26 (µmol/l)</td>
<td>0.53</td>
<td>(0.33–1.39)</td>
</tr>
<tr>
<td>C26/C22</td>
<td>0.008</td>
<td>(&lt;0.030)</td>
</tr>
<tr>
<td>C24/C22</td>
<td>0.58</td>
<td>(0.32–0.92)</td>
</tr>
<tr>
<td>Phytanic acid (µmol/l)</td>
<td>20</td>
<td>(&lt;12.8)</td>
</tr>
<tr>
<td>Pristanic acid (µmol/l)</td>
<td>105</td>
<td>(&lt;3.0)</td>
</tr>
<tr>
<td>Pristanic/phytanic</td>
<td>5.25</td>
<td>(0.05–0.40)</td>
</tr>
<tr>
<td>Bile acid profile (µmol/l):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deoxycholic acid</td>
<td>0.02</td>
<td>(&lt;4.0)</td>
</tr>
<tr>
<td>Chenodeoxycholic acid</td>
<td>0.22</td>
<td>(0.20–12.4)</td>
</tr>
<tr>
<td>Cholic acid</td>
<td>0.44</td>
<td>(0.05–6.0)</td>
</tr>
<tr>
<td>Ursodeoxycholic acid</td>
<td>0.00</td>
<td>(&lt;2.1)</td>
</tr>
<tr>
<td>Hyocholic acid</td>
<td>0.00</td>
<td>(&lt;1.0)</td>
</tr>
<tr>
<td>Dihydroxycholestanolic acid</td>
<td>0.11</td>
<td>(not detectable)</td>
</tr>
<tr>
<td>Trihydroxycholestanolic acid</td>
<td>2.90</td>
<td>(not detectable)</td>
</tr>
<tr>
<td>Dihydroxycholic acid</td>
<td>0.00</td>
<td>(not detectable)</td>
</tr>
<tr>
<td>C29 dicarboxylic acid</td>
<td>0.01</td>
<td>(not detectable)</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Patient</th>
<th>De novo plasmalogenge biosynthesis:</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHAPAT activity:</td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td>Pristanic acid β-oxidation activity*</td>
<td>284</td>
<td>ND</td>
</tr>
<tr>
<td>AMACR activity†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>Pristanic acid β-oxidation activity*</td>
<td>1147 [SD 325] (n=30)</td>
</tr>
<tr>
<td>AMACR activity†</td>
<td>92 [SD 30] (n=11)</td>
<td></td>
</tr>
</tbody>
</table>

*pmol/h/mg protein; †pmol/min/mg protein.
ND, Not detectable; AMACR, α-methylacyl-CoA racemase.
For methods see Ferdinandusse17.
seen in adrenomyeloneuropathy, nor neuronal migration deficits as seen in a postmortem of infantile Refsum's disease.

The biochemical defect causing Refsum's disease lies "upstream", yet the clinical phenotype of the disorders differ, although with considerable overlap. Why there should be this distinction is uncertain, but there may be a differential effect on tissues depending on the proportions of product accumulation (phytanic and pristanic acid and bile acid intermediates), or loss of lipid functions "downstream".

In humans, the only peroxisomal disorders of β-oxidation so far identified are those relating to VLCFAs, DHCA/THCA, and pristanic acid. Multiple enzymes are involved (fig 1) and abnormalities of pristanic acid metabolism were first associated with generalised peroxisomal disorders.

This currently described patient showed highly increased pristanic acid concentrations and mildly raised phytanic acid and VLCFA concentrations. Had the pristanic acid concentrations not been measured, the condition would have been considered with generalised peroxisomal disorders.

This currently described patient showed highly increased pristanic acid concentrations and mildly raised phytanic acid and VLCFA concentrations. Had the pristanic acid concentrations not been measured, the condition would have been considered with generalised peroxisomal disorders.

The biochemical defect in this case has only recently been characterised as an absence of the α-methylacyl-CoA racemase. There is stereoselectivity of the α-methyl branched acyl CoA esters and the bile acid intermediates, and these must be converted to their S forms before degradation by peroxisomal β-oxidation. Absence of the racemase has the same consequences as a deficiency of the branched chain acyl-CoA oxidase, although in the second R and S stereoisomers accumulate, and in racemase deficiency only R isomers accumulate. Analysis of both enzymes is required to establish the precise defect.

He therefore has a unique combination of features, distinct from the other peroxisomal disorders, but with many features in common, particularly with Refsum's disease. His disease course has been relatively benign.

Presumably this is autosomal recessive as are most of the other peroxisomal disorders, but his family have refused blood testing and skin biopsy. The presence of hypogonadism does not suggest the possibility of an X linked disorder, but we have been made aware of a woman with the condition (personal communication), so this seems unlikely.

Given that Refsum's disease responds to dietary elimination of phytanic acid, therapy for this disorder was attempted using a pristanic acid and phytanic acid depleted diet, but he would not tolerate the dietary change. His seizures have remained controlled on phenytoin alone, and there has been no significant progression in his visual failure or neuropathy over 2 years.

As biochemical and molecular biological techniques advance, further peroxisomal disorders are likely to emerge. Recently, another novel disorder of peroxisomes has been described, with multiple enzyme deficiencies (reduced lignoceric acid oxidation, cytosol catalase only, reduced di-hydroxyacetone phosphate acyl transferase, and reduced phytic acid oxidation) and normal peroxisomes as in type 2 disorders, but clinically a mixed type 1 and 3 (an adult with dihydroxycetone phosphate acyl transferase deficiency and normal peroxisomes as in type 2 disorders, but clinically a mixed type 1 and 3 (a child with facial deformity, cognitive impairment, retinal pigmentation, seizures, and deafness without liver problems)).

These overlapping clinical syndromes highlight the importance of wider screening of biochemical function using plasma and fibroblasts. We recommend that any patient presenting with retinal pigmentation resulting in visual failure, and neurological disturbances, particularly seizures and a peripheral neuropathy, be screened not only for VLCFA/C26 ratio, but also should have pristanic acid concentrations assayed.

Figure 1 The peroxisomal β-oxidation pathway, showing the steps involved in the oxidation of pristanic acid and THCA/DHCA. The site of activity of AMACR, where the defect occurs in this disorder, is indicated. *

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A new defect of peroxisomal function involving pristanic acid

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