Musculoskeletal manifestations of alkaptonuria: A case report and literature review

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Abstract

Alkaptonuria (AKU) is a rare autosomal recessive disorder that results from the deficient activity of homogentisate 1,2-dioxygenase and leads to increased levels of homogentisic acid (HGA) and its oxidized product benzoquinone acetic acid (BQA). Both HGA and BQA form polymerized deposits that lead to a bluish-black discoloration of the cartilage as well as degeneration, inflammation, and calcification of the tendons, ligaments, intervertebral discs, and large joints and increased bone resorption. A brittle and fragmented cartilage forms and leads to aberrant loading of the subchondral bone. These fragments then adhere to the synovial membrane and cause fibrosis or chondromatosis, leading to ochronotic arthropathy. Ochronotic tendinopathy most commonly affects the patellar or Achilles tendon and can lead to enthesopathy or spontaneous tendon ruptures. Ochronotic pigments deposited in the bone impair the bone mineralization process and lead to osteopenia or osteoporosis. Here, we report a case of a patient with several musculoskeletal manifestations of AKU and reviewed the literature to summarize the pathophysiology, clinical characteristics, and radiologic findings of the rheumatic features of AKU. Though medical treatment options are limited, early identification of AKU can facilitate prompt surgical intervention.

Keywords: Alkaptonuria, ochronosis, homogentisic acid oxidase deficiency, ochronotic arthropathy, ochronotic tendinopathy

Introduction

Alkaptonuria (AKU) is a rare autosomal recessive disorder that results from a deficiency of the homogentisic acid dioxygenase (HGD) activity, which is the third enzyme in tyrosine degradation. HGD deficiency leads to the accumulation of homogentisic acid (HGA) that can be excreted in the urine (homogentisic aciduria) or can oxidize and polymerize to form an ochronotic pigment that is deposited in the connective tissues (ochronosis) or within the joints (ochronotic arthropathy) (1). Patients are typically asymptomatic in childhood. However, during the second to third decade of life, ochronosis may begin to manifest as a blue or brown pigmentation within the ear cartilage or the sclera; stones (renal, prostatic, gall bladder, and salivary glands); back or peripheral joint pain; rupture of the tendons, muscles, or ligaments; renal failure; osteoporosis; or fractures (2).

AKU is caused by missense mutations in the HGD gene, which maps the human chromosome 3q21-q23, and the prevalence of the mutations is approximately 1:1,000,000-250,000 in most ethnic groups (3). Loss of approximately 99% of the HGD activity is required to cause symptoms of ochronosis.

We report a case of a patient with AKU involving the cervical and lumbar spines, shoulders, and knees who underwent numerous orthopedic surgical procedures prior to his diagnosis of AKU at the age of 61 years. We also review the literature on the common musculoskeletal manifestations of AKU, including arthropathy, tendinopathy, and osteoporosis.

Methods

We searched PubMed for articles published between 1974 and 2017 using the search terms “alkaptonuria”, “ochronosis”, “ochronotic arthropathy”, “ochronotic tendinopathy”, and “alkaptonuria and osteoporosis.” We also checked the references in the retrieved articles.

Case Presentation

A 65-year-old African-American man with a history of hypertension, benign prostatic hypertrophy, nephrolithiasis, aortic stenosis, and osteoarthritis (OA) was initially referred to the rheumatology clinic because of a history of severe degenerative arthritis of the spine and peripheral joints for 20 years and a recent Achilles tendon...
rupture. He underwent multiple orthopedic surgeries through the years. These included open reduction and internal fixation of a right humerus fracture in 1984, cervical fusion of C4-C6 with fibular strut graft in 2000, L2-S1 laminectomy for lumbar spinal stenosis in 2001, discectomy with C3-6 fusion in 2005, fusion of the first metatarsal head with the proximal phalanx in 2009, open reduction and internal fixation of the left distal clavicle fracture in 2010, right knee arthroplasty in 2011, L4-5 microdiscectomy in 2011, repair of the right dorsal distal radial intra-articular fracture in 2014, reconstruction of the left Achilles tendon avulsion in 2014, right total hip replacement in 2015, left total knee arthroplasty in 2016, L4-pelvis posterior internal fixation and fusion for sacral fracture in 2017, and L4-L5 microdecompression in 2017. His medications include calcium and vitamin D supplements, prazosin, and hydrocodone/acetaminophen, as needed. Family history includes a brother who underwent bilateral knee replacement for knee OA at the age of 57 years.

The patient presented to the clinic with complaints of pain in his bilateral shoulders, hips and lower back associated with 10-15 min of morning stiffness with gradual worsening of pain throughout the day with physical activity. On general physical examination, a slight blue-black hyperpigmentation of the bilateral pinna of the ear and a 2/6 systolic murmur best heard along the left sternal border were noted. On musculoskeletal examination, tenderness over the left acromioclavicular joint, right glenohumeral joint, and bilateral knees with no apparent joint effusions was observed. The patient also had limited range of motion in his bilateral shoulders, right wrist, and right hip.

Results of comprehensive metabolic panel, ferritin, and transferrin were normal. He had mild anemia with a hemoglobin level of 12.4 g/dL (normal range: 13.3-17.7 g/dL). Urine qualitative measurement of organic acids was positive for increased level of homogentisic acid. His urine sample turned brown following alkalinization (Figure 1). Thoracic spine radiograph showed calcification of the intervertebral disc spaces at all levels of the thoracic vertebrae with disc space narrowing and anterior and posterior osseous changes (Figure 3). The radiograph of the patient’s lumbar spine showing severe osteopenia with interbody disc space calcification (c)

![Figure 1. a, b. Photographs of the patient’s urine sample before (a) and after alkalinization (b)](image)

![Figure 2. a, b. Radiographs of the patient’s right shoulder (a) and left knee (b) showing severe osteoarthritis; chondrocalcinosis is present in the popliteal bursa](image)

![Figure 3. a-c. Plain X-rays of the patient’s thoracic spine revealing calcification of the intervertebral disc spaces and osteophytes in AP (a) and lateral (b) views; radiograph of the patient’s lumbar spine showing severe osteopenia with interbody disc space calcification (c)](image)

![Figure 4. H&E stained section (10x magnification) of the cartilage and fibrous tissue showing deposition of ochronotic pigment (white arrows) with associated homogenization, rigid appearance, transverse fracture with jagged ends, and fragmentation](image)
oxidation itself produces free radicals that may cause fibrosis or chondromatosis, eventually leading to enthesopathy. The deposition of pigmented cartilaginous matter is characteristic of osteochondral bodies that are characteristic of ochronotic arthropathy due to AKU found that compared with OA, AKU cartilage demonstrates a very low turnover state and has low levels of extractable matrix proteins. In particular, Taylor et al. (7) found that there are few extractable glycosaminoglycan and cartilage oligomeric matrix protein in AKU samples as compared with OA comparators.

The spine is commonly involved earlier than the peripheral joints, and patients typically present with back stiffness, with eventual loss of lordosis and exaggeration of thoracic kyphosis. Ochronotic arthropathy of the spine has been associated with myelopathy and disc prolapse or herniation. Degenerative changes in the spine with osteophytes from the posterior part of the vertebral body or uncinate process may intrude into the neural canal, causing myelopathy. Although disc herniation is less common, several case reports illustrate lumbar disc herniation in patients with ochronosis (8). Typical radiologic findings include intervertebral calcification at multiple levels and vacuum phenomena with radiolucent collections of gas, representing arthrosis of severe degeneration. Kyphosis, apophyseal joint abnormalities, disc space obliteration, and bony bridging may occur with long-standing disease, simulating the spinal changes of ankylosing spondylitis (5). However, in contrast to ankylosing spondylitis, there is relative sparing of the sacroiliac joints and the absence of bamboo spine, annular ossification, syndesmophyte, or erosion in ochronotic spine disease. Although peripheral articular symptoms of ochronotic arthritis may resemble those of rheumatoid arthritis (RA) with chronic painful swollen joints, in contrast to RA, the smaller joints of the hands and feet are often spared. The knee is the most commonly affected peripheral joint and is found in up to 64% of cases; however, degeneration of the knee often occurs many years after the onset of spinal symptoms (5). Knee radiographs reveal joint space narrowing with loose osteochondral bodies that are characteristic of ochronotic arthropathy. Aspiration of the synovial effusion often reveals floating black particles, also called as the “ground pepper sign” (9).

Owing to the rarity of the disease and symptoms mimicking other types of arthritis, the diagnosis of AKU is frequently not made until it is discovered intraoperatively during orthopedic surgery, and the affected joint bears the characteristic bluish-black discoloration. Histopathological findings include macroscopic brown to black coloring of the articular cartilages and synovial tissues, as well as microscopic fibrillation and eburnation (10). Darkening of the urine on oxidation or increased levels of urine HGA confirm the diagnosis. Currently, no available medical treatment options have been shown to prevent the complications of AKU. A low tyrosine and phenylalanine diet, vitamin C or antioxidants, and nitisinone are few of the suggested treatments. A low tyrosine and phenylalanine diet has been proposed because the HGD enzyme is located in the phenylalanine and tyrosine degradation pathway. Therefore, a low-protein diet would theoretically decrease HGA production. However, the long-term effect of such a diet on the symptoms and outcomes of AKU has not been studied (11). Vitamin C and other antioxidants are also proposed as they could theoretically prevent the oxidation of HGA (12). Nitisinone (2-[2-nitro-4-trifluoromethylbenzoyl]-1,3-cyclohexanedione) is a herbicide and potent competitive inhibitor of 4-hydroxyphenylpyruvate dioxygenase, which is the enzyme that produces HGA. In alkaptonuric mice, nitisinone treatment from birth can prevent ochronosis in adult mice, whereas treatment from mid-life stops disease progression (13). A recent international trial demonstrated that nitisinone decreases urinary HGA excretion in a dose-dependent manner and increases tyrosine levels (14). Once significant ochronotic arthropathy develops, surgical intervention through total joint replacement is the best treatment option. Unfortunately, reports of successful surgical intervention for spinal involvement are uncommon. Physical therapy, along with nonsteroidal anti-inflammatory drugs, has been successful in limiting the progression of symptoms but has not been shown to affect the progression of underlying disease (15).

Ochronotic tendinopathy

Tendons are also sites of ochronotic pigment deposition due to their high collagen content, leading to tendinopathy. Among those patients with ochronotic tendinopathy, the prevalence of spontaneous tendon or ligament ruptures is estimated to be approximately 20%-30% (16). The patellar and Achilles tendons are the most commonly affected, often involving the insertion sites of traction tendons, leading to enthesopathy. The deposition of pigmented HGA in collagenous tissues affects the structural...
Osteopenia and osteoporosis

Alkaptonuria is also associated with decreased bone mineral density (BMD) and subsequent increased risk for fragility fractures. It is hypothesized that the newly formed and uncalcified osteoid matrix exposed to the effects of ochronotic pigment could be impaired in the mineralization process. Aliberti et al. characterized the biochemical markers of bone turnover and found that BMD measurements of those treated with alendronate versus those without and found that there is no clinically significant difference in BMD after 2 years of treatment. The effects of HGA deposition render the bone matrix to be unaffected by bisphosphonate therapy (21).

Conclusion

Musculoskeletal manifestations of AKU may be divided into three main categories: early onset arthropathy, tendinopathy, and osteopenia/osteoporosis.

Osteoprotegerin, osteoprotegerin-related factor (OPR), and osteoprotegerin-ligand (OPGL) play important roles in bone turnover. Low levels of OPG and high levels of OPGL have been reported in patients with AKU. These findings suggest that the balance of RANKL/OPG in alkaptonuric patients is altered, which may contribute to the development of osteoporosis in these patients. The role of these molecules in the pathogenesis of osteoporosis in AKU requires further investigation.

Ochronoticpigmentsmayalsodepositinthe ligaments, causing them to become stiff and weakened. A case of patellar ligament rupture during total knee replacement surgery has been reported. Intraoperatively, it was noted that the distal half of the patellar ligament was heavily pigmented and fragile, resulting in rupture during retraction with mild force (19).

Medical treatment to prevent ochronotic involvement of the tendons and ligaments is limited as in the case of the above-mentioned arthropathy. However, improved preoperative preparation and greater care in handling of the tendons and ligaments during operative procedures may help avoid intraoperative complications, including tendon or ligament ruptures (19).

References

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