Case Report

Zinc Monotherapy as an Alternative Treatment Option for Decompensated Liver Disease due to Wilson Disease?

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1. Background

Wilson disease (WD) is a rare autosomal recessive genetic disorder of copper metabolism, which is a defective biliary excretion of copper, resulting in the accumulation of copper in the liver, brain, kidney, and cornea. The disease affects one in 100,000 individuals [1, 2]. Patients with WD have varying clinical presentations ranging from an asymptomatic state to acute life-threatening liver involvement (acute liver failure), which can cause high mortality reaching 95% without liver transplantation [1, 3, 4]. Other patients may present with chronic liver disease mimicking other etiologies and neuropsychiatric manifestations. Though acute liver failure (ALF) presentation is rare in pediatric age groups (only 3% of all ALF case series in children), it is dramatic and may result in suddenness [3]. Although Wilson disease is rarely diagnosed and reported in African children, it must be considered differential in any patient with liver disease. There are few reports regarding zinc monotherapy in patients with decompensated liver disease. Our case report documents the role of zinc monotherapy in clinical resolution and normalization of laboratory liver synthetic dysfunction in patients with the severe hepatic presentation of Wilson disease.
1.1. Case Presentation. A 15-year-old male child, from nonconsanguineous marriage, was referred to our hospital from a private clinic with a possible diagnosis of renal disease in December 2015. His main complaint was generalized body swelling of 3 months in duration. In the private clinic, he was given Lasix for the diagnosis of renal disease, but the symptoms got worse and he discontinued the medication. He had easy fatigability and shortness of breath at rest and loss of appetite associated with yellowish discoloration of the eye for two weeks. He was a grade seven student. He had no change in school performance, no difficulty in playing and writing, and no behavioral change or abnormal body movement. He had no history of vomiting, change in bowel habit, abdominal pain, drug, or herbal medication use, alcohol intake, previous history of jaundice or contact with a jaundiced person, and family history of similar illness. He also had no history of bleeding from any site. His developmental history was optimal. The physical examination showed that he was conscious and oriented to time, person, and place. He had icteric sclera, a well-formed Kayser–Fleischer ring visible with the naked eye (Figure 1), which was confirmed by slit-lamp examination, grossly distended abdomen with shifting dullness and fluid thrill, pitting pedal, and pretibial edema. Initial investigations showed deranged liver function (Table 1). His serum creatinine and blood urea nitrogen, serum electrolytes, lipid profile, and urine analysis were normal. A serologic test for the human immunodeficiency virus (HIV), hepatitis B virus surface antigen (HBsAg), antinuclear antibody (ANA), and antibodies to the hepatitis C virus (HCV) were negative. Serum ceruloplasmin was very low, less than 8 mg/dl (normal 20–60 mg/dl), and the 24-hr urinary copper excretion was high (150 mcg/dl). Abdominal ultrasound showed that the liver size was normal, but it was coarse and nodular with ascites. For our patient, Wilson disease was diagnosed according to the scoring system proposed by the local language of what food to avoid). Our patient is still screened with serum ceruloplasmin, and his mother had a low level of ceruloplasmin, but she is asymptomatic.

2. Discussion and Conclusion

WD is rarely diagnosed and reported in African countries except in North African countries. In North African countries where consanguinity is common, autosomal recessive disease, including Wilson disease, is relatively common and reported. There are also reports from Senegal and Nigeria (two case reports). But the exact epidemiology of WD in Africa is not known because it is rare to diagnose and report. In those patients with signs and symptoms of liver disease which is not due to viral infections, WD must be considered and investigated because hepatic manifestations are common in children [4–7]. The diagnosis of WD relies on clinical manifestations like the pigmentation of the iris (Kayser–Fleischer rings, suggestive signs and symptoms of liver disease, and neuropsychiatric problems) with some laboratory pieces of evidence (low ceruloplasmin, elevated urine, and hepatic copper level) [5, 6]. However, the presence of Kayser–Fleischer rings and a low level of ceruloplasmin is sufficient to diagnose WD, especially in developing countries with limited resources [7]. Hepatic manifestation is more common in children with the symptoms ranging from an asymptomatic elevation of liver enzymes to a fulminant course [1, 8, 9]. So, in any patient with an unexplained liver disease, the disease must be investigated for possible WD and relatives of WD patients must also be screened for any asymptomatic WD with ceruloplasmin or urine copper, so that they will start early management [7].

Our patient had signs and symptoms of liver disease (jaundice, peripheral edema, and ascites) with elevated liver enzymes, hypoalbuminemia, hyperbilirubinemia, and coagulation abnormality. He had Kayser–Fleischer ring in both clinical (Figure 1) and slit-lamp examination. In addition to the K–F ring, our patient had laboratory evidence (high urinary copper and low ceruloplasmin) for WD. Laboratory tests, including alkaline phosphatase, bilirubin, and serum aminotransferases, were elevated. Medical therapy is effective, but WD is not yet curable, and it is progressive and fatal if not diagnosed and treated early [1, 10]. The American Association for the Study of Liver Diseases (AASLD) and the European Association for the Study of the Liver (EASL) recommend the use of a copper chelating agent, such as D-penicillamine or trientine, in the initial treatment of symptomatic patients. Zinc therapy can be initiated in those presymptomatic patients or for maintenance after chelators in symptomatic patients [10–13]. Till now, different guidelines, including the standard Nelson Textbook of Pediatrics, recommend that all symptomatic patients with Wilson disease receive a chelating agent [11, 13–15]. But chelators have many side effects with limited access, and most patients with neurologic WD symptoms may exacerbate as high as 50% and some may be intolerant [11, 15]. Although zinc is less effective than chelators in established Wilson disease treatment, data are limited and uncontrolled. While zinc treatment is effective in neurologic WD and in
asymptomatic patients, caution is needed in hepatic WD as there are reports of hepatic deterioration. This may be related to less efficient decoppering and any adverse effects of zinc with most common gastrointestinal irritations [14].

Thus, exclusive monotherapy with zinc in those with symptomatic WD is controversial [14, 15]. In cases of hepatic presentation, treatment is usually initiated with potentially toxic copper chelators (D-penicillamine or trientine). Although multiple studies have introduced zinc as less toxic, available in low cost for WD treatment, its use has been limited to adjunctive or single-agent maintenance options for asymptomatic patients [10]. From most observational studies, it has been found that zinc therapy is the best choice in presymptomatic patients as it is effective and has fewer adverse effects. Especially acutely ill hepatic patients might do better on D-penicillamine, as zinc acts too slowly in these patients [12]. The use of zinc monotherapy in patients suffering from decompensated liver disease has not been well documented with the controversial results, but there are few cases reported with successful treatment [10].

Milanino et al. used a 2-year course of zinc sulfate in the pediatric case and noted normalization of the liver function, negative copper balance, and reduction of inflammatory infiltration, necrosis, and fat deposition in the liver histology [16, 17]. Brewer et al. briefly commented on a patient presenting with hepatic failure who experienced marked improvement in hypoalbuminemia and resolution of ascites after 8 months of zinc acetate therapy after the initial 4 weeks of Trenton therapy. In the same study, the investigators reported on the histologic evaluation of consecutive liver biopsy examination in 7 patients undergoing zinc monotherapy. The pathologic review showed no progression of cirrhosis and in two cases showed a complete resolution of cirrhosis [18]. There was one case of a 58-year-old male patient reported in Virginia, admitted with acute liver failure caused by WD, who was initiated with zinc monotherapy while awaiting liver transplantation. Over a 1-year period with zinc monotherapy, the patient experienced normalization of hepatic synthetic function and resolution of hypoalbuminemia and coagulopathy. Clinical stabilization of variceal bleeding, ascites and lower-extremity edema was also observed. The patient was not a candidate for transplantation because of the improvement in symptoms and the stage of the disease which is assessed by the Child—Turcotte—Pugh score [10]. This was supported by a study done in Italy, which showed that zinc

<table>
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<tr>
<th>Laboratory parameters</th>
<th>At presentation</th>
<th>Subsequent laboratory measurement on follow-up</th>
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<tr>
<td></td>
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<td>2nd week</td>
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<tr>
<td>WBC (4.0–10.5 x 10^3/L)</td>
<td>8.4</td>
<td>97</td>
</tr>
<tr>
<td>Hemoglobin (12.5–16.1)</td>
<td>12</td>
<td>160</td>
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<tr>
<td>Platelet (150–4500 x 10^9)</td>
<td>247</td>
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<tr>
<td>AST (5–45 IU/L)</td>
<td>130</td>
<td>32.4</td>
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<tr>
<td>ALT (5–45 IU/L)</td>
<td>581</td>
<td>36.8</td>
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<tr>
<td>ALP (115 IU/L)</td>
<td>300</td>
<td>2.88</td>
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<tr>
<td>Serum albumin (3.2–5.1 gm/L)</td>
<td>1.7</td>
<td>9.3</td>
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<tr>
<td>Total protein</td>
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<tr>
<td>PT (11–14 sec)</td>
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<td>32.4</td>
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<tr>
<td>APTT (25–35 sec)</td>
<td>38.5</td>
<td>36.8</td>
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<tr>
<td>INR (0.8–1.2)</td>
<td>2.62</td>
<td>2.88</td>
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<tr>
<td>Total bilirubin (mg/dl)</td>
<td>5</td>
<td>5.3</td>
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<tr>
<td>Serum ceruloplasmin (20–60 mg/dl)</td>
<td>&lt;8</td>
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<td>24 hr urine copper (mcg/dl)</td>
<td>150</td>
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<td>Slit lamp examination</td>
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monotherapy is effective in controlling WD-related liver disease, both as first-line and as maintenance treatment in patients with milder liver disease diagnosed in childhood [18]. There was also a case report from Nigeria, an 8-year-old male patient, with decompensated liver disease with neurologic manifestations managed with zinc monotherapy because of the unavailability of copper chelator drugs, and the patient showed significant improvement in the clinical manifestations and laboratory abnormalities [6]. There are a few examples (Table 2) that summarize the improvement of decompensated liver on zinc treatment. In our current case report, there is documentation of clinical resolution and normalization of laboratory liver synthetic dysfunction with zinc treatment. There were no documented adverse effects on the time frame. So, zinc is less toxic, accessible, and inexpensive. This may give hope for countries with limited resources. And this example and other case reports hopefully will encourage future investigations on the monotherapeutic administration of zinc for symptomatic hepatic Wilson disease. This is especially important for developing countries which have no access to copper chelator drugs and liver transplantation options.

3. Strengths and Limitations
The strengths of this case report are that the patient fulfills the diagnostic criteria, there was no doubt about the diagnosis and the synthetic functions done, and the severity of liver dysfunction was also assessed. The patient is followed up until now in clinics, and the clinical and laboratory resolution of symptoms was assessed fully. Lack of diagnostic modality for liver biopsy and the genetic analysis might be considered as a limitation in this case report.

Abbreviations
WD: Wilson disease
ALF: Acute liver failure
K-F ring: Keyser-Fleisher ring
AST: Aspartate aminotransferase
ALT: Alanine aminotransferase
ALP: Alkaline phosphatase.

Consent
Written informed consent was obtained from the patient’s legal guardian (his mother) for publication of this case report and any accompanying images.

Conflicts of Interest
The authors declare that they have no conflicts of interest.

Authors’ Contributions
HHL conceived and drafted the case report. MM and TGG reviewed the data. They were also involved in preparation
and critical revision of the manuscript. All authors read and approved the final report.

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References


