Partial Hypoxanthine-Guanine Phosphoribosyltransferase Deficiency as the Unsuspected Cause of Renal Disease Spanning Three Generations: A Cautionary Tale

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ABSTRACT. Hypoxanthine-guanine phosphoribosyltransferase (HPRT) deficiency is an X-linked defect of purine metabolism. Clinical manifestations are usually related to the degree of enzyme deficiency: complete HPRT deficiency (Lesch-Nyhan syndrome) presenting with severe neurologic or renal symptoms, or partial HPRT deficiency (Kelley-Seegmiller syndrome) manifesting as a gout-urolithiasis syndrome. A 3-generation kindred is described in which the recognition of partial HPRT deficiency in 2 adolescent male siblings presenting with uric acid lithiasis led to the diagnosis in 2 maternal uncles already in renal failure of unknown cause. This report highlights the importance of clinical awareness leading to early diagnosis, appropriate diagnostic methodology, and therapy of a treatable inherited disorder of purine metabolism for the prevention of renal failure. Pediatrics 2002;109(1). URL: http://www.pediatrics.org/cgi/content/full/109/1/e17; hypoxanthine-guanine phosphoribosyltransferase deficiency, renal failure.

ABBREVIATIONS. HPRT, hypoxanthine-guanine phosphoribosyltransferase; LND, Lesch-Nyhan disease.

Hypoxanthine-guanine phosphoribosyltransferase (HPRT, EC 2.4.3.8) is an ubiquitous, cytoplasmic, housekeeping enzyme with highest activity in the brain and testes. HPRT catalyzes the transfer of the phosphoribosyl moiety of PP-ribose-P to hypoxanthine and guanine, forming inosine monophosphate and guanosine monophosphate, respectively. Inability to recycle hypoxanthine and guanine produces a lack of feedback control of synthesis accompanied by rapid catabolism of these bases to uric acid (Fig 1).1–3 HPRT deficiency (McKusick #308000) is an X-linked defect (Xq26-q27.2) of purine metabolism with considerable genetic and clinical heterogeneity, the biochemical hallmark being increased levels of uric acid in blood and urine.1–6 Clinical manifestations are related to the degree of enzyme deficiency, complete HPRT deficiency (Lesch-Nyhan disease; LND) presenting with severe neurologic (compulsive self-injury biting, choreoathetosis), gout, and renal symptoms (kidney stones, renal failure).1–4 Partial HPRT deficiency (Kelley-Seegmiller syndrome) has a broad spectrum of presentation ranging from gout and urolithiasis only, to intermediate forms characterized according to the severity of neurologic involvement.1–6 Diagnosis in terms of renal complications in the partial defect depends on early diagnosis. Prenatal diagnosis is possible in LND by direct enzyme assay in a chorionic villous sample, or by molecular analysis where the mutation is well-defined.1–4

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We describe a 3-generation kindred in which the diagnosis of partial HPRT deficiency in 2 adolescent male siblings presenting with urolithiasis led to the diagnosis in a maternal brother and uncle categorized as having familial renal failure of unknown cause. The objective of this report is to stress 1) the importance of clinical awareness and careful family history-taking for early diagnosis of metabolic disease; 2) the use of appropriate diagnostic methodology; and 3) early therapy of partial HPRT deficiency for the prevention of renal failure, an avoidable complication that unrecognized is costly, both to the family and to local health services.

CASE REPORTS

The index patients (IV.1 and IV.2, Fig 2) were 2 adolescent male siblings aged 15 and 14 years, respectively, who were referred to our laboratory because of repeated episodes of renal colic and nephrolithiasis. The referral mentioned that despite the presence of hyperuricemia, urinary uric acid levels were normal to low.

Detailed history-taking revealed a positive family history of nephrolithiasis and renal failure involving a maternal brother (III.1) and uncle (II.1). The mother’s brother, now aged 34 years, had suffered from renal colic and urolithiasis from the age of 20. One kidney is 20% functional. The maternal uncle, aged 65, developed renal failure at an early age, has hyperuricemia, and is now a candidate for dialysis.

Clinical examination in both siblings was normal (no signs of central nervous system involvement), but renal ultrasound revealed the presence of stones in the kidneys of both. Renal echostructure was otherwise normal, and there were no signs of hydronephrosis. Chemical and UV analysis of kidney stones of the siblings revealed uric acid. Measurement of uric acid and creatinine in 24-hour urine (after warming at 56°C) and blood drawn at the completion of the 24-hour collection revealed hyperuricemia and uric acid/creatinine ratio (Table 1), the increased erythrocyte nicotinamide adenine dinucleotide, adenine dinucleotide, and presence of 5-aminooimidazole carboxamide, ribotide triphosphate (indicative of purine overproduction) apparent in the red cell nucleotide profile in Table 2, coupled with the low red cell lysate HPRT activity (Table 1) in the 2 siblings, their uncle, and great uncle, were all consistent with partial HPRT deficiency. This diagnosis was confirmed by the studies of [14C] hypoxanthine incorporation by intact red blood cells of the 4 affected males depicted in Table 1. Importantly, hypoxanthine salvage by the intact red cells was extremely high (range: 66%–97%; control: 90%–100%) indicating functional HPRT activity consistent with the lack of neurologic involvement in the affected members of this kindred. Purine metabolic studies conducted in the remaining 2 siblings of the index patients and their parents were normal.

Therapy of the Index Cases

Elevated uric acid concentrations in HPRT deficiency may be controlled by a high fluid intake, alkali administration, a low purine diet, and allopurinol used with care (5–7.5 mg/kg/day). For this reason, allopurinol (with alkali) was administered to the 2 siblings (IV.1 and IV.2) in incremental doses until plasma uric acid levels had decreased to tolerably high normal levels. Results of monitoring of allopurinol dosage and effect on purine end products are shown in Table 3. Urine purines were monitored at
TABLE 1. Results of Purine Metabolic Studies in HPRT Kindred

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (Years)</th>
<th>Plasma Uric Acid (μmol/L)</th>
<th>Urinary Uric Acid (mmol/24 Hours)</th>
<th>UA/Cr Ratio</th>
<th>Enzymes (nmol/mg/Hb/Hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mg/dL</td>
<td>mg/24 Hours</td>
<td></td>
<td>Lysed RBC HPRT APRT Intact RBC</td>
</tr>
<tr>
<td>IV-1</td>
<td>15</td>
<td>11.7 (695)</td>
<td>2330 (13.86)</td>
<td>0.81</td>
<td>4.6 34 66%</td>
</tr>
<tr>
<td>IV-2</td>
<td>14</td>
<td>8.4 (499)</td>
<td>2068 (12.3)</td>
<td>0.89</td>
<td>4.4 36 73%</td>
</tr>
<tr>
<td>III-1</td>
<td>34</td>
<td>4.0 (236)</td>
<td>1391 (8.28)</td>
<td>0.83</td>
<td>3.7 35 97%</td>
</tr>
<tr>
<td>II-1</td>
<td>65</td>
<td>8.3 (577)</td>
<td>ND</td>
<td>ND</td>
<td>5.3 23 91%</td>
</tr>
<tr>
<td>IV-3</td>
<td>10</td>
<td>4.7 (278)</td>
<td>597 (3.55)</td>
<td>0.66</td>
<td>131 27</td>
</tr>
<tr>
<td>IV-4</td>
<td>3</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>100 28</td>
</tr>
<tr>
<td>III-2</td>
<td>38</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>114 30</td>
</tr>
<tr>
<td>III-3</td>
<td>41</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>117 35</td>
</tr>
</tbody>
</table>

Control range

Females 3.7 ± 0.7 (222 ± 42) 454 ± 84 (2.7 ± 0.5)
Males 4.4 ± 0.7 (261 ± 41) 504 ± 84 (3.0 ± 0.5)

* [14C] hypoxanthine incorporation into intact red blood cells.
UA/Cr indicates uric acid/creatinine; APRT, adenine phosphoribosyltransferase; ND, not done.

TABLE 2. Red Cell Nucleotide Profile in HPRT Kindred

| Patient | Age (Years) | ATP (μmol/L) | ADP | AMP | GTP | GDP | GMP | IMP | NAD | NADP | UDPG | ZTP | OR |
|---------|-------------|--------------|-----|-----|-----|-----|-----|-----|-----|------|------|-----|-----|----|
| IV-1    | 15          | 1530         | 228 | 16  | 38  | 15  | —   | —   | 155 | 58   | 50  | 22  |
| IV-2    | 14          | 1024         | 209 | 28  | 33  | 14  | —   | —   | 97  | 47   | 53  | 16  |
| III-1   | 34          | 1341         | 196 | 21  | 41  | 12  | —   | —   | 121 | 35   | 135 | 16  |
| II-1    | 65          | 1595         | 114 | 15  | 54  | 10  | —   | —   | 123 | 48   | 83  | 176 |
| IV-3    | 10          | 1196         | 244 | 38  | 41  | 15  | —   | —   | 87  | 54   | 25  | —   |
| IV-4    | 3           | 1268         | 268 | 51  | 36  | 14  | —   | —   | 95  | 50   | 48  | —   |
| III-2   | 38          | 993          | 192 | 27  | 34  | 15  | —   | —   | 70  | 49   | 54  | —   |
| III-3   | 41          | 1103         | 233 | 30  | 35  | 14  | —   | —   | 64  | 48   | 60  | —   |
| Mean*   | 1570        | 1373         | 13  | 66  | 17  | —   | —   | —   | 69  | 54   | 35  | —   |

| ±       | 97          | 34           | 4   | 10  | 3   | —   | 15  | 12  | 8   | a    | b   | c   |    |

ATP indicates adenosine triphosphate; ADP, adenosine diphosphate; AMP, adenosine monophosphate; GTP, guanosine triphosphate; GDP, guanosine diphosphate; GMP, guanosine monophosphate; IMP, inosine monophosphate; NAD, nicotinamide adenine dinucleotide; UDPG, uridine diphosphoglucose; ZTP, 5-amino-4-imidazole-carboxamide ribotide triphosphate; OR, orotidine.

* Of control range, (—) normally undetectable, (a,b,c) increased levels of components not normally present.

TABLE 3. Monitoring of Allopurinol Dosage and Effect on Purine Endproducts in Index Patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Dosage (mg)</th>
<th>Urine Creatinine mg/24 h (mmol/24 h)</th>
<th>Endogenous purines mg/24 h (mmol/24 h)</th>
<th>Uric acid mg/24 h (mmol/24 h)</th>
<th>Xanthine mg/24 h (mmol/24 h)</th>
<th>Hypoxanthine mg/24 h (mmol/24 h)</th>
<th>Total mg/24 h (mmol/24 h)</th>
<th>Ratio total oxipurine/creatinine mmol/mmol</th>
<th>Drug metabolites</th>
<th>Total mg/24 h (mmol/24 h)</th>
<th>Dose (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV-1</td>
<td>150</td>
<td>162.5 (14.3)</td>
<td>84.0 (7.4)</td>
<td>1250 (7.45)</td>
<td>359 (2.36)</td>
<td>449 (3.30)</td>
<td>292 (2.15)</td>
<td>54 (1.14)</td>
<td>0.92</td>
<td>113 (0.76)</td>
<td>69% (150 mg/d)</td>
</tr>
<tr>
<td>IV-2</td>
<td>200</td>
<td>187.5 (15.4)</td>
<td>100 (8.4)</td>
<td>1750 (8.75)</td>
<td>185 (2.56)</td>
<td>457 (3.45)</td>
<td>542 (3.21)</td>
<td>72 (1.64)</td>
<td>0.88</td>
<td>140 (0.94)</td>
<td>20% (200 mg/d)</td>
</tr>
</tbody>
</table>

each increment of dosage to ensure the avoidance of xanthine uropathy, because of the fact that xanthine, unlike uric acid, is very insoluble at any pH.2,8,11 The maintenance dose of allopurinol in the older sibling is 150 mg/day. Dosage in the younger sibling (IV.2) was increased to 200 mg/dL because of persistently high uric acid levels in both plasma and urine. Laboratory results after the increase in dosage showed uric acid and xanthine concentrations within reported solubility limits and an acceptable ratio of uric acid to hypoxanthine and xanthine. Renal ultrasound repeated a year after diagnosis was normal in both siblings.

DISCUSSION

The favorable response to therapy, after the recognition of HPRT deficiency as the basis for the uricosuria in 2 male siblings, contrasts sharply with the unfavorable outcome in their 2 uncles already in kidney failure. This underlines the importance of early diagnosis and therapy for the prognosis of partial HPRT deficiency. Lack of awareness of this
disorder in many parts of mainland Europe is attributable to the fact that inherited defects of purine metabolism are relatively new diseases, the majority being discovered during the last 25 years. HPRT deficiency seems to be one of the most common enzyme defects of nucleotide metabolism among the 27 now described. This lack of awareness explains why it took so long for the diagnosis to be made in the uncles. Moreover, the elder, now 65, would have been 32 at the time the partial defect was first described by Kelly et al in 1967, when presumably renal function would already have been compromised. The development of renal disease in his nephew, as in our patients with underexcreting familial gout and renal disease2–3 (familial juvenile hyperuricemic nephropathy), would likewise have been attributed to familial renal disease of unknown cause.

An additional diagnostic problem in the 2 siblings was that the initial measurements of urine uric acid were misleading (and delayed the diagnosis) because falsely low values of urinary uric acid were found. Simply measuring uric acid in urine (as is usual in routine laboratories) without previous warming and thorough mixing of the entire 24-hour collection at 56°C can produce falsely low values because of uric acid precipitation postexcretion—especially if the pH is acidic.2,5–9,11,12 Low urine uric acid results can also be attributable to the presence of acute renal failure, as already indicated. Equally important is the fact that normal uric acid status is age-dependent, and uric acid excretion varies throughout the day, which underlines the need to assess both plasma and 24-hour urine concentrations. The increased fractional clearance in childhood can also lead to normal plasma uric acid levels.2,5,9–11 At the same time, it enhances the risk of renal failure, especially during intermittent periods of dehydration, diarrhea, or infection). Some LND patients have been institutionalized for cerebral palsy of unknown cause because only plasma uric acid was measured.4 Analysis of the urine stones of our patients provided additional clues to diagnosis. Uric acid stones may be the only manifestation in some patients.2 An essential factor in establishing prognosis, as well as diagnosis, is the assay of HPRT activity in intact as well as lysed cells. Because HPRT is undetectable in the majority of deficient patients, whether partial or LND, intact cell studies, in this case erythrocytes, are essential to detect functional residual activity and confirm the milder phenotype.4,7

The lessons from this report are first, that increased levels of uric acid in both plasma and urine characterize all defects of purine metabolism associated with gross purine overproduction and should be followed up by a full metabolic work-up (available in special laboratories). This entails measurement of purine metabolites in body fluids as well as enzyme assays in lysed and intact cells.2–12 In addition, clinicians should be aware of the pitfalls involved when assessing uric acid status and the fact that in acute renal failure attributable to uric acid nephropathy in HPRT deficiency, only the plasma, not the urine uric acid, may be grossly elevated.2,3,11

Second, the family history was particularly relevant in that 2 maternal uncles had a similar history suggesting an X-linked disorder. However, it is also important to be aware that although HPRT deficiency-affected patients are predominantly male (and female carriers are usually asymptomatic), HPRT deficiency has been described in a few females.1,2,13,14 Thus, HPRT deficiency should be included in the differential diagnosis of genetic causes of hyperuricemia in girls together with phosphoribosylpyrophosphate synthase overactivity and familial juvenile hyperuricemic nephropathy.

To our knowledge, these 4 patients are the first diagnosed cases with partial HPRT deficiency in Greece. Their recognition is the direct result of efforts made by clinicians to increase awareness of these disorders in Europe within the structure of the European Council Program of the European Structure for the Research and Diagnosis of Inborn Errors of Purine and Pyrimidine Metabolism.

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