Guidelines in classification, diagnosis, and treatment of the photodermatoses

7. Endogenous: The (cutaneous) porphyrias

1 - Definition

The porphyrias are a group of infrequent metabolic diseases caused by partial deficiencies of the activity of 7 sequentially acting enzymes in the biosynthesis pathway of haem. They are inherited diseases with the exception of sporadic Porphyria cutanea tarda. (PCT Type I) the most frequent form of porphyria. PCT type is the result of inactivation of hepatic Uroporphyrinogen-decarboxylase (URO-D) enzyme.

2 - Pathogenesis

The result of these enzyme deficiencies or inactivation is the accumulation of intermediate metabolites in the pathway, the porphyrin precursors or porphyrins in tissues and their excess excretion in urine or stool.

The haem biosynthesis pathway includes 8 enzymes. Each enzyme deficiency correlates with one form of Porphyria except for the first one – (α-amino levulinic acid synthase - ALA-S) causing X-linked sideroblastic anemia. The deficiency of second and third enzymes – ALA dehydratase and PBG deaminase – are related with two clinical pictures – ALA dehydrase porphyria (ADP) and Acute Intermitent Porphyria (AIP) – the acute porphryias with neurovisceral manifestations and no photosensitivity. These two forms of porphyria are out of the scope of these guidelines. From the fourth enzyme onwards photosensitivity manifestations are the main manifestations of the so called cutaneous and mixed porphyrias – associated to neurovisceral symptoms - which include: Congenital erythropoietic porphyria (CEP), Porphyria Cutanea Tarda / Hepatoerythropoietic Porphyria (PCT / HEP), Variegate Porphyria (VP), Hereditary Coproporphyria (HCP) and Erythropoietic Protoporphyria (EPP). (Table1)

The presence of genetic defects does not correlate with clinical expression of the disease because the many different genetic mutations that can be found cause different levels of enzyme deficiency. On the other hand clinical expression depends on the action of secondary acquired and environmental factors. (Table2)
Clinical features

Classification

Porphyrias are classified in different ways:

1 – By location of the excess porphyrin production: erythropoietic or hepatic

2 – By clinical manifestations: acute (neurovisceral manifestations and no cutaneous photosensitivity), cutaneous (photosensitivity) or mixed (photosensitivity + neurovisceral manifestations)

Considering the scope of this guideline of photodermatoses the following clinical forms will be considered

1. - Erythropoietic porphyrias. Congenial erythropoietic porphyria (CEP) and Erythropoietic Protoporphyria (EPP)

2. - Hepatic porphyrias: Porphyria cutanea tarda (PCT type 1 sporadic, PCT type 2 familial), Hepatoerythropoietic porphyria HEP, Variegate Porphyria (VP) and Hereditary Coproporphyria (HCP)

Epidemiology – Incidence / Prevalence

Porphyria appears in individuals in all human races. The prevalence has been evaluated in a variable percentage of 0.5 – 10 per 100,000 in different populations.

Clinical penetrance of genetic defects is very low so that about 80 % of individual carriers of mutations will never present biochemical alterations or develop clinical symptoms. Only irrelevant enzyme activity reduction may be present.

Nevertheless high prevalence gives the possibility of appearance homozygous inheritance of defects without consanguinity and the appearance of rare “dual” porphyria forms with inheritance of two different defects in the same individual.
**Photoinduced cutaneous Clinical manifestations**

Specific clinical cutaneous photoinduced manifestations of the different forms are grouped in:

**Chronic photosensitivity:**

- CEP
- PCT / HEP
- VP / HCP (mixed porphyrias)

**Acute photosensitivity**

- EPP

Chronic symptoms are manifested by skin fragility with erosions appearing with minimal trauma and bullous photo-induced lesions. These lesions evolve to scarring and slowly progressing sclerodermiform skin transformation with mutilating lesions specially on acral areas as fingers, nose and ears. Scalp alopecia may appear.

Acute photosensitivity is manifested with erythema, oedema and petechiae associated to skin tingling, burning and pain upon light exposures evolving to peculiar skin thickening characteristic in EPP.

Ocular lesions may be present (scleromalacia) or even oral mucosal lesions. In CEP teeth discoloration is a specific clinical sign – erythrodontia – which appears as bright red flourescence under Wood’s light illumination.

On the other hand in some cutaneous porphyrias one has to consider the association with exogenous factors or other disorders that may influence the clinical evolution of the disease. Specially in the most frequent form of cutaneous porphyria, sporadic acquired PCT type I, clinical manifestations are due to the action of drugs (e.g. oestrogens), chemical substances (Hexachlorobenzene), alcohol, iron overload, and viral infections (Hepatitis C HCV, or Human immunodeficiency virus, HIV).

An evident relationship has been established with the inheritance of Hemochromatosis genetic defects.

Hepatobilliary alterations may be frequently associated with PCT and EPP and patients PCT especially associated with HCV may be prone to develop hepatocarcinoma.

Also haematological disease can be associated together with haematological malignancies especially in late onset porphyria.

Treatment procedures as hemodialysis may initiate PCT manifestations.
Pregnancy may influence the evolution of PCT and EPP. There have been a number of reports of coincidence of propyria with Lupus erythematosus or Dermatomyositis in the same patient. 

Pathogenesis of photoinduced lesions in porphyria is complex. Porphyrins are phototoxic reactive molecules. accumulation of uroporphyrin and protoporphyrin in tissues allows phototoxic reaction production upon light exposure. This phototoxicity is the basis of cutaneous lesions through the generation of oxygen reactive species, lipid peroxidation leads to lesions of membrane structures and degranulation of mastocytes, liberation of inflammation mediators, complement activation and increased collagen synthesis.

**Diagnostic procedures**

After a **clinical assessment**, this diagnosis should be confirmed by laboratory work-up.

Laboratory study should include (1) **Biochemical investigation** (2) **Enzyme activity determination** and (3) **Genetic studies** in order to trace family carriers of the defect, risk of those carriers of presenting disease and establishment of associated genetic defects and risk factors.

**1 Biochemical studies**

Biochemical investigation includes the study of porphyrin (uroporphyrin, coproporphyrin and protoporphyrin) and porphyrin precursors (aminolevulinic acid, porphobilinogen) in urine, faeces and blood-plasma and RBC (See Diagnostic algorithm (Fig 1). and plasma specific fluorescence peaks demonstration (PCT, VP).

**2 Enzyme activity determination.** This determination is usually performed in erythrocytes or leucocytes.

**3 Genetic studies**

The search for the mutation responsible is advisable specially in severe clinical forms (CEP, HEP) or mixed porphyrinas (VP, HCP) to trace carriers for genetic counselling and prevention of acute manifestations. Prenatal diagnosis has already been performed in cases of CEP.

It is also advisable to look for associated gene mutations in

**PCT - Investigation of haemochromatosis (HEFE) Mutations**
EPP - Investigation of Single-Nucleotide Polymorphisms of IVS3-48C alleles.

**Treatment**

Management of cutaneous lesions

1. **Photoprotection** (cutaneous and ocular) (For all cutaneous and mixed forms)

High protection broad band Sunscreens (up to 600 nm)

- Adequate clothing and exposure behaviour
- Organic glasses mounted in spectacles with upper, lower and lateral protection
- Window glass protection with filtering films (yellow acrylate)
- Attention to operating theatres illumination.

2. **Avoidance of skin trauma**

Management of metabolic alterations

**PCT**

- **Phlebotomy** – 400-500 ml / every 14 days – 2 – 6 months to keep Hb levels between 100 –110 g/L. Treatment of choice in patients with HFE mutations. Not suitable for patients with tendency to anaemia or with cardio-vascular disease. Also not suitable for patients with cirrhosis due to the demand of augmented hepatic albumin synthesis. Not suitable for children in case of physical or emotional stress.

May be used during pregnancy. In this case iron supplementation should be avoided.

Monitoring includes determination of Hemoglobin concentration, Ferritin levels and serum iron binding capacity.
- Low-dose Chloroquine - 125 mg twice a week 6 – 12 months.

This approach is not advisable in case of HEFE mutations.

- Desferrioxamine -1,5 gr- 8-10 h. infusion – 5 days/week – weekly to halving the uroporphyrin excretion level, 2-3 weeks monthly to normalisation of uroporphyrin level, 1 week every 2-3 months as maintenance. Or 200mg/Kg in 500 ml saline once a week to halving uroporphyrin excretion and twice monthly up to normalisation and once every 2-3 months as maintenance.

- Other approaches - High-dose chloroquine (this could lead to liver failure in some patients) , IFN if associated to Hepatitis Virus C, HAART if associated to HIV infection, Alkalinisation, Vitamin E, Cimetidine(120).

In haemodialysis patients:

- Desferrioxamine 1,5 – 4 g with haemodialysis

- Erythropoietin 20-50 U/Kg after haemodialysis or low-volume phlebotomies 50-10 mL/once or twice weekly.

- Plasmapheresis

- Plasma exchange

HEP

No specific treatment available but treatment as in CEP may be indicated.

VP / HCP

No specific treatment available but Phlebotomy as in PCT regimen may be applied

EPP

Photosensitivity

- Oral Betacarotene - 30 – 90 mg / day Infants 120-180 mg / day adults to keep plasma levels at 6-8 mg/L

- Other approaches - Oral Cysteine, Vitamin C, Cimetidine, NBUVB Phototherapy (only NBUV is evidence based)

**Liver protoporphyrin deposition and hepatic disfunction**

- Cholestyramine, RBC transfusions, Exchange transfusions, Intravenous hematin, Iron supplementation.
CEP

- High level transfusions (attention to iron overload)
- Oral activated charcoal – 60 gr three times daily
- Cholestyramine
- Hydroxyurea
- Splenectomy
- Hematin (late onset CEP) 3 mg./Kg. Daily for 4 consecutive days.

Transplantation

Severe forms of CEP and EPP Bone-marrow transplantation or Bone-marrow + Hepatic Transplantation. Liver transplantation is successful in the liver failure which is rarely associated with EPP, symptoms of EPP slowly recur. Liver failure in VP may also be treated by transplantation.

Other management recommendations

- Ocular protection in all forms is advisable

- Avoidance of triggering factors

Specially in the case of sporadic acquired PCT it is important to avoid triggering or aggravating factors as:

- Drug, Alcohol, Hormones/Oestrogens, Nutritional status - Starvation, Tobacco
- Infections (HVC, HIV), Haemodialysis, Iron overload (HFE Mutations)
- Chlorinated hydrocarbons

Follow up

Patients with prophyria should remain under control life-long clinically and biochemically. Levels of porphyrin excess excretion should be controlled periodically. Clinical evolution of lesions should be surveyed. In patients with PCT
Serology for hepatitis virus – HVC / HIV – should be periodically checked. Abdominal ultrasound for early detection of hepatic cirrhosis development in HVC + patients for appearance of hepatocarcinoma.

EPP

Hepatic function and porphyrin profile changes for early detection of liver failure should be performed. (Decline of fecal protoporphyrin excretion and increase in urine coproporphyrin I > III ratio).

Gallstones formation

CEP and HEP

Follow-up of haemolytic anaemia
# Tables

## Table 1

### The Porphyrias

<table>
<thead>
<tr>
<th>Porphyria</th>
<th>Deficient enzyme – Heme biosynthesis</th>
<th>Porphyrin overproduction</th>
<th>Clinical manifestations</th>
<th>Inheritance</th>
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<tbody>
<tr>
<td>ALA-synthase</td>
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<tr>
<td>ALA dehydratase deficiency prophyria (ADP))</td>
<td>ALA-Dehydratase</td>
<td>Hepatic</td>
<td>Acute neuro-visceral symptoms</td>
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<td>Acute intermittent Porphyria (AIP)</td>
<td>PBG Deaminase</td>
<td>Hepatic</td>
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<td>Autosomal dominant</td>
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<td>Congenital erythropoietic porphyria (CEP)</td>
<td>UROgen III Cosynthetase</td>
<td>Erythropoietic</td>
<td>Cutaneous Chronic Photosensitivity</td>
<td>Autosomal recessive</td>
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<td>Porphyria cutanea tarda (PCt)</td>
<td>UROgen</td>
<td>Hepatic</td>
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<td>Autosomal dominant</td>
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<tr>
<td>Hepatoeritropoietic prophyria (HEP)</td>
<td>Decarboxylase</td>
<td>Hepatic Erythropoietic</td>
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<td>Hereditary coproporphyria (HCP)</td>
<td>COPROgen Oxidase</td>
<td>Hepatic</td>
<td>Acute neuro-visceral symptoms + Cutaneous Chronic Photosensitivity</td>
<td>Autosomal dominant</td>
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<td>Variegate porphyria (VP)</td>
<td>PPgen Oxidase</td>
<td>Hepatic</td>
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<td>Erythropoietic protoporphyria (EPP)</td>
<td>Ferrochelatase</td>
<td>Erythropoietic</td>
<td>Cutaneous Acute Photosensitivity</td>
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</table>
### Table 2

**Cutaneous and mixed Porphyria – Genetic Background**

<table>
<thead>
<tr>
<th>Porphyria</th>
<th>Enzyme Ref. Nr.</th>
<th>Chromosomal location</th>
<th>Structure</th>
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<tr>
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<td></td>
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<td>Hsk, 1+2B-10</td>
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<td></td>
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<td></td>
<td>Ery. 2A^a+2B-10</td>
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<td>Porphyria cutanea tarda (Pct)</td>
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<td>Hepatoerithropoietic prophyria (HEP)</td>
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<td>Hereditary coproporphyria (HCP)</td>
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<td>Variegate porphyria (VP)</td>
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<td>Erythropoietic protoporphyrria (EPP)</td>
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<td>18q21.3</td>
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Evidence support of treatment options in Cutaneous prophyrias


<table>
<thead>
<tr>
<th>Porphyria</th>
<th>Treatment options</th>
<th>Level of recommendation (Class)</th>
<th>Level of evidence</th>
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<tbody>
<tr>
<td>PCT</td>
<td>Phlebotomies</td>
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<td>Low-dose Chloroquine</td>
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<td>IFN(+Hepatitis C infection)</td>
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<tr>
<td></td>
<td>Deferoxamine(Hemodialysis)</td>
<td>B</td>
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<tr>
<td></td>
<td>Erythropoietin(Hemodialysis)</td>
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<tr>
<td>HEP</td>
<td>Treatment may be considered as in CEP</td>
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<td>VP/HCP</td>
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<tr>
<td>EPP</td>
<td>Iron supplementation</td>
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<tr>
<td></td>
<td>Oral Betacarotene</td>
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<td>Oral Cysteine</td>
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<td>Vitamin C</td>
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<td>Cholestyramine</td>
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<td>RBC transfusions</td>
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<td>Hematin</td>
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<td>Bone marrow transplantation</td>
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<td>Liver transplantation</td>
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<td>High Level transfusions</td>
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<td>Bone marrow transplantation</td>
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References Guideline Photodermatosis – Porphyria

Total references reviewed 3412

Selection general references

(Cutaneous pophrinia 1960 -2007 – 564 items reviewed)


Other references

Dual porphyrias

(1960-2007 - 23 items reviewed)


Congenital erythropoietic porphyria

(1960-2007 - 348 items reviewed)


- Murphy GM. Diagnosis and management of the erythropoietic porphyrias. Dermatol Ther. 2003;16(1):57-64


**Erythropoietic protoporphyria**

(1960-2007 - 664 items reviewed)


• Murphy GM, Hawk JL. Erythropoietic protoporphyria advances today, with a special tribute to the late Professor Ian Magnus. Br J Dermatol. 2006 Sep;155(3):501-3.


Porphyria cutanea tarda

(1960-2007 - 1813 items reviewed)


Website

European Porphyria Initiative (EPI) [http://www.porphyria-europe.com](http://www.porphyria-europe.com)


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