**Case reports**


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**Postgraduate Medical Journal (August 1976) 52, 535-538.**

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**Contraceptive pill-induced porphyria cutanea tarda presenting with onycholysis of the finger nails**

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**Summary**

A case of porphyria cutanea tarda induced by oral contraceptive pill therapy is reported, and its unusual presenting sign of onycholysis of the finger nails is noted. Reference is made to the rarity of nail changes in porphyria and the regression of the onycholysis in the patient following therapy is outlined.

**Introduction**

The porphyrias encompass a group of metabolic disorders, genetic and acquired, characterized by the excess production of porphyrins or their precursors. With the exception of acute intermittent porphyria, cutaneous manifestations, resulting from exposure to light, are prominent in these disorders and include oedema, vesicle and bulla formation, increased skin fragility, pigmentation, scarring and atrophy of the light-exposed surfaces of the body, namely the face, neck and dorsa of the hands.

Nail changes may occur in porphyria especially in the acute phase (Dean, 1975, personal communication) but the rarity of nail dystrophy is attested to by the absence of any reference to nail lesions occurring in porphyria in two major dermatological textbooks (Samman, 1972; Cairns, 1972).

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Among the nail changes that may be seen in porphyria are opaqueness, brown and bluish-grey discolours, and loss of the lunule, but such changes are exceptionally rare in porphyria cutanea tarda compared with erythropoietic porphyria (Degos, 1970). Onycholysis, i.e. separation of the distal nail plate from its bed, has been observed in symptomatic porphyria (Tsuduy, Magnus and Kalivas, 1971).

A case is reported of porphyria cutanea tarda in a young woman who had been taking an oral contraceptive agent, Norinyl-1, for 18 months, and who presented initially to her general practitioner with discoloration of her finger nails due to onycholysis.

**Case report**

The patient was a 21-year-old married policewoman, with no previous history of a skin disorder either in herself or her family. In January, 1974, she noted brownish discoloration of the distal parts of some of her finger nails and thumbs. She was referred to the dermatology clinic by her general practitioner where the nail discoloration was diagnosed as onycholysis. In addition, numerous vesicles, erosions and pitted scars were noted on the dorsa of the hands and face, together with hypertrichosis of the face. Associated with these signs was a feeling of soreness in these regions on exposure to light. There were no symptoms referable to the abdominal or
neurological systems. A provisional diagnosis of porphyria, either cutanea tarda or variegata, was made and the patient was admitted for further investigations.

Up to this time, the patient had been on no medication other than Norinyl-1, an oral contraceptive pill containing norethisterone BP 1 mg and mestranol BP 50 μg in each tablet.

No member of her family ever had a similar condition. The patient admitted to a modest intake of alcohol. Detailed examination revealed a fit but anxious young woman. On the hands were numerous erosions, vesicles and small pitted scars. There was onycholysis of both thumb nails, right index and middle finger nails (Figs 1 and 2). On the face there was a fine vellus growth of hair on both cheeks, together with scars and ruptured vesicles. There was no other detectable physical abnormality, especially no hepatomegaly.

Investigations revealed a haemoglobin of 14·9 g/100 ml, a serum iron of 225 μg/100 ml, and total iron binding capacity of 300 μg/100 ml. The prothrombin index was 87% and partial thromboplastin time 46·0 sec (control = 38·5 sec).

A biochemical screen revealed a serum glutamic oxaloacetic transminase of 118 mu/ml (normal 7–40 mu/ml) and alkaline phosphatase 130 mu/ml (normal 30–85 mu/ml). The serum bilirubin, total proteins and albumin were within normal limits. A plasma BSP dye test showed 28% retention at 45 min after injection of the dye.

Urine and blister fluid gave a pink fluorescence under a Woods Lamp. Porphobilinogen was not detected in the urine. The red cells did not fluoresce. There was a weak positive anti-smooth muscle antibody titre, but tests for LE cells and anti-nuclear factor were negative. A liver biopsy revealed a vast
excess of iron in the hepatocytes and Kupffer cells but no other abnormality was seen. Biopsy of a vesicle on the hand revealed a rim of PAS-positive diastase resistant material around a blood vessel.

Detailed stool and urine porphyrin analyses are given in Table 1.

Consequently a diagnosis of porphyria cutanea tarda was made in view of the clinical features and laboratory findings of raised urinary and faecal uroporphyrins and coproporphyrins, negative testing for porphobilinogen, raised serum iron level, abnormal liver function tests and hepatic siderosis on histology.

Therapy using ordinary sodium bicarbonate to alkalinize the urine and thereby increase porphyrin excretion (Copeman, 1970) was unsuccessful. Consequently venesection therapy was introduced, and 4 l of blood were removed in all over a period of 4 months, 500 ml being removed fortnightly. As a result of this treatment, together with abstention from the 'pill', there was a dramatic improvement in the patient’s symptoms and signs, namely no further vesiculation, scarring or undue skin fragility. Fortunately too, the patient’s nails rapidly regained their normal appearance, the new nail growth leading to extrusion of the onycholytic nails (Fig. 3).

TABLE 1. Results of porphyrin analyses.

<table>
<thead>
<tr>
<th>Urine porphyrins/24 hr</th>
<th>Normal range (µg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coproporphyrin</td>
<td>63·6 µg</td>
</tr>
<tr>
<td>Uroporphyrin</td>
<td>14·79 µg</td>
</tr>
<tr>
<td>Faecal porphyrins/g dry weight</td>
<td></td>
</tr>
<tr>
<td>Coproporphyrin</td>
<td>135 µg</td>
</tr>
<tr>
<td>Protoporphyrin</td>
<td>40·3 µg</td>
</tr>
<tr>
<td>'X' porphyrin</td>
<td>105 µg</td>
</tr>
<tr>
<td>'X' porphyrin consisted predominantly of uroporphyrin.</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

Porphyria cutanea tarda is one of the commoner types of porphyria, and in the United Kingdom is probably second only in frequency to erythropoietic protoporphyria (Magnus, 1974). Whilst typically occurring in middle-aged males with a history of alcohol abuse (Cairns, 1972; Tschudy, Magnus and Kalivas, 1971; Walsh et al., 1970), there are an increasing number of reports recording the onset of porphyria cutanea tarda following oestrogen therapy (Walsh, 1963; Roenigk and Gottlob, 1970; Behm and Unger, 1974). It is felt that the above case, in view of her age, history of oestrogen therapy and lack of heavy alcoholic intake, is a further example of contraceptive pill-induced porphyria cutanea tarda.

Whilst it is possible that the patient’s signs and symptoms may have regressed merely by stopping therapy, her improvement, still apparent 9 months following venesection, is considered to be due to phlebotomy. Numerous authors have recorded the efficacy of phlebotomy in porphyria cutanea tarda (Ippen, 1960; Epstein and Redeker, 1968; Baker and Turnbull, 1969).

Venesections aid PCT by removing hepatic cellular iron which is aggravating an underlying biochemical anomaly (Turnbull, 1974). Especially gratifying to the patient was the return to normal of her finger nails, as the onycholysis was a considerable embarrassment in view of her occupation. The porphyrins, known photosensitizing agents, are found in the skin and in the presence of light, are responsible for a reaction which leads to oedema, and
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doi: 10.1136/pgmj.52.610.535