**Hyperargininemic Encephalopathy with Unique Clinical Presentation and Novel Genetic Mutations**

Sundarachary Nagarjunakonda, Rajeswari Daggumati and Sridhar Amalakanti

*Department of Neurology, Guntur Medical College, Guntur, India*

**ABSTRACT**

Hyperargininemia is a urea cycle disorder that has rarely been reported in adults. We present a case of arginase deficiency disorder in a 32-year man with metabolic encephalopathy. He presented with progressive limb spasticity, changes in personality, cognitive decline (impaired judgement, executive and language dysfunction) and pseudo-bulbar affect. He deteriorated to an akinetic mute and rigid state. MRI brain was suggestive of a metabolic disorder. Hyperammonemia was present, blood arginine levels were elevated, and serum arginase levels were reduced. The standard argI gene mutations were absent but rs2781666 (G/T) and rs2608897 (C/T) variations were noted in this patient. Hyperargininemic encephalopathy may present in adults and with atypical features. It should be kept in the differential diagnosis of metabolic encephalopathy in adults.

**Key Words:** Metabolic encephalopathy, Pseudobulbar affect, Arginase deficiency, Hyperammonemia, Urea cycle.


**Urea cycle disorders [UCDs] are a group of inherited diseases.**

Hyperargininemia is a type of UCD caused by deficiency of arginase enzyme. The increased arginine and its metabolites like guanidino compounds and nitric oxide are neurotoxic. The disorder presents typically in a child as slow, onset of growth restriction, spastic paraplegia, intellectual deficiency and epilepsy. Sometimes ataxia and dystonia might be seen. Here, we present a case of hyperargininemia with novel clinical features and genetic variations, in an adult patient.

**CASE REPORT**

A 32-year hypertensive man was brought to our department with spastic quadriparesis, bowel and bladder incontinence, dysphagia, dystonia of right lower limb, apathy, irritability and floccillation, which progressed to akinetic mutism over 7 months. He had a preference for vegetarian and carbohydrate-rich diet and had a tendency to avoid pulses. He was not a smoker but was habituated to alcohol and had started taking high quantities of alcohol in the preceding four months of the illness (90 ml daily).

Complete blood counts, liver function tests, renal function tests, serum electrolytes, cerebrospinal fluid analysis, arterial blood gas analysis and blood sugar were normal. He was negative for viral markers: human immunodeficiency virus (HIV), hepatitis B surface antigen (HBsAg) and hepatitis C virus (HCV). Serum ammonia was elevated to 82 µmol/L.

MRI brain showed hyper-intense signals on T2 and FLAIR sequences in bilateral fronto-parietal periventricular white matter and in the anterior and posterior limb of internal capsules bilaterally. Hyperintensities on T1 were noted in bilateral putamen, suggestive of hepatic encephalopathy (Figure 1). A search for the causes of a chronic mild hyperammonemic state with normal liver function tests and no other evidence of hepatic encephalopathy was made; and the possibility of late-onset UCD was considered. Biochemical analysis revealed high serum arginine 3283.86, µmol/L [normal: 15 – 128] and low serum arginase 18.52 U/g Hb [normal: 50 – 90] (Table I).

**Table 1: Metabolic parameters.**

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Values</th>
<th>Normal range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceruloplasmin</td>
<td>0.38 gm/L</td>
<td>0.2 – 0.6 gm/L</td>
</tr>
<tr>
<td>Copper</td>
<td>76 µg/dl</td>
<td>70 – 140 µg/dl</td>
</tr>
<tr>
<td>Lactate</td>
<td>9.8 mg/dl</td>
<td>4.5 – 20 mg/dl</td>
</tr>
<tr>
<td>Ammonia</td>
<td>82 µmol/L</td>
<td>11 – 32 µmol/L</td>
</tr>
<tr>
<td>Glutamine</td>
<td>17.89 µmol/L</td>
<td>205 – 756 µmol/L</td>
</tr>
<tr>
<td>Ornithine</td>
<td>2.88 µmol/L</td>
<td>48 – 95 µmol/L</td>
</tr>
<tr>
<td>Citruline</td>
<td>0.34 µmol/L</td>
<td>12 – 55 µmol/L</td>
</tr>
<tr>
<td>Arginine</td>
<td>3283.86 µmol/L</td>
<td>15 – 128 µmol/L</td>
</tr>
<tr>
<td>Arginosuccinic acid</td>
<td>0.40 µmol/L</td>
<td>11 – 32 µmol/L</td>
</tr>
<tr>
<td>Arginase</td>
<td>18.52 U/g Hb</td>
<td>50 – 90 U/g Hb</td>
</tr>
</tbody>
</table>

Genotyping of the arginase-1 gene of the patient, his 3 family members and one unrelated person (control) was done. Comparison with published arginase mutations found no match with any specific mutation. Two variations in the promoter regions, rs2781666 (G/T) and rs2608897 (C/T), were observed in the patient and two of his family members. These were not found in the control sample.
In our patient, there was no nausea or vomiting, probably because of self abstinence from ammonemia generating protein-rich food.\textsuperscript{10} Most of the earlier reported patients had persistent vomiting. Adult onset encephalopathy due to arginase deficiency has not been reported widely. Chronic progressive encephalopathy may be due to unmasking of UCD, even in adults. Clinical profile of hyperargininemia due to arginase deficiency in adults may differ from its childhood presentation.

PATIENT’S CONSENT: Written informed consent was obtained from closest relative (as patient’s higher mental functions were not normal) for publication.

CONFLICT OF INTEREST: Authors declared no conflict of interest.

AUTHORS’ CONTRIBUTION: SN, RD, SA: Diagnosed and managed the case, drafted the manuscript, reviewed and finished the work.

REFERENCES