Porphyria Cutanea Tarda

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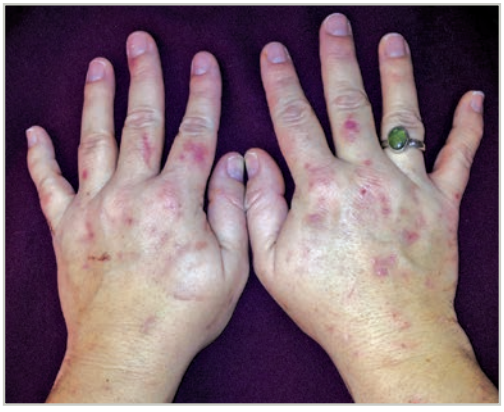
A 39-year-old woman presented to the clinic with recurring blistering lesions on the dorsum of both hands. Over the course of 6 months, the patient's skin became fragile and bumps that arose during everyday activities resolved to form pigmented scars (image). She took no regular medications and consumed alcohol socially. Results of a complete blood cell count and comprehensive metabolic panel were normal, except for mild elevation of alanine aminotransferase and aspartate aminotransferase. Additional laboratory test results revealed elevated urine uroporphyrin and heptacarboxyl porphyrin levels, which led to the diagnosis of porphyria cutanea tarda. The patient was prescribed low-dose hydroxychloroquine and the lesions resolved. She continues to have regular follow-up appointments.

Porphyria cutanea tarda is caused by an inherited or acquired deficiency of uroporphyrin decarboxylase and may be a harbinger of underlying disease. Predisposing factors include exposure to estrogen and alcohol, as well as underlying hepatitis C virus infection, hemochromatosis,[1] or diabetes mellitus.[2] Accordingly, physicians must maintain a high index of suspicion for comorbidities. Treatment options include removal of offending agents, repeated phlebotomy, and chloroquine administration.[3] (doi:10.7556/jaoa.2016.138)



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