Hepatitis C virus infection with peripheral neuropathy is not always associated with cryoglobulinaemia

O Lidove, P Cacoub, T Maisonneuve, J Servan, V Thibault, J-C Piette, J-M Léger

Abstract

Objectives—To describe cases of peripheral neuropathy associated with chronic hepatitis C virus infection without mixed cryoglobulinaemia.

Methods—Four cases of peripheral neuropathy associated with chronic hepatitis C virus infection with persistent negativity of mixed cryoglobulinaemia were found.

Results—All patients had small increases of transaminase levels and a positive viraemia. Liver biopsy showed chronic active hepatitis in all but one case (Knodell 4–9, Metavir A0F0-A3F3). Neuromuscular biopsy showed axonal neuropathy associated with lymphoid infiltrates around small vessels in two cases. Rheumatoid factor was always negative and C4 complement level was always normal. In three patients, neuropathy improved with interferon α, interferon α + ursodesoxycholic acid, or steroids + plasma exchange.

Conclusion—Peripheral neuropathy may be associated with hepatitis C virus infection without mixed cryoglobulinaemia.

Chronic hepatitis C virus (HCV) infection may be associated with numerous extrahepatic manifestations, such as mixed cryoglobulinaemia, membranoproliferative glomerulonephritis, sicca syndrome, or porphyria cutanea tarda. Peripheral neuropathy (PN) may also be associated with HCV infection and it is usually related to mixed cryoglobulinaemia. Before HCV was discovered, PN was known to be associated with numerous extrahepatic manifestations, such as mixed cryoglobulinaemia. Peripheral neuropathy associated with HCV infection is usually a sensory polyneuropathy (n=1) or mononeuropathy multiplex (n=3), associated with motor involvement in two cases, confirmed by electromyography in each case. Neuromuscular biopsy was always performed before treatment, showing an axonal neuropathy, associated with perivascular lymphoid infiltrates in two cases. In these two cases, no necrotising vasculitis “periarteritis nodosum like” aspect was seen, even when the clinical findings were compatible. No granuloma, fibrinoid necrosis, leucocytoclastic, or extravasation of erythrocytes was mentioned on

Table 1 Main characteristics of four patients with chronic hepatitis C virus infection and peripheral neuropathy without mixed cryoglobulinaemia

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Patient No 1</th>
<th>Patient No 2</th>
<th>Patient No 3</th>
<th>Patient No 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/sex</td>
<td>78/M</td>
<td>40/M</td>
<td>62/F</td>
<td>46/M</td>
</tr>
<tr>
<td>Mode of infection</td>
<td>?</td>
<td>Intravenous drug user</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>HCV infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCR*</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Liver biopsy</td>
<td>Knodell 9, Metavir A3F3</td>
<td>Knodell 4, Metavir A0F0</td>
<td>Knodell 6, Metavir A1F1</td>
<td>Knodell 5, Metavir A1F1</td>
</tr>
<tr>
<td>Genotype</td>
<td>2</td>
<td>4</td>
<td>1b</td>
<td>1b</td>
</tr>
<tr>
<td>Extrahepatic manifestations</td>
<td>Sicca syndrome</td>
<td>Arthralgia, myalgia, Raynaud’s phenomenon</td>
<td>Arthralgia</td>
<td>Arthralgia</td>
</tr>
<tr>
<td>Rheumatoid factor</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>C4 level</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
</tbody>
</table>

*PCR = HCV viraemia by polymerase chain reaction.
Table 2  Main characteristics of the peripheral neuropathy in four patients with hepatitis C virus without mixed cryoglobulinaemia

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Patient No 1</th>
<th>Patient No 2</th>
<th>Patient No 3</th>
<th>Patient No 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral neuropathy</td>
<td>Sensory polyneuropathy of legs</td>
<td>Severe motor and sensory multiplex mononeuropathy of three limbs</td>
<td>Mild sensory multiplex mononeuropathy of four limbs</td>
<td>Sensory multiplex mononeuropathy of four limbs</td>
</tr>
<tr>
<td>Initial electromyographic study</td>
<td>Axonal sensory polyneuropathy</td>
<td>Severe neuropathy with low motor and sensory velocities</td>
<td>Axonal sensory neuropathy</td>
<td>Axonal sensory neuropathy</td>
</tr>
<tr>
<td>Neuronal biopsy before treatment</td>
<td>Muscular atrophy with mild denervation; axonal sensory nerve involvement</td>
<td>Normal muscle; axonal sensory nerve loss with perineural, venular, and arteriolar inflammatory infiltrates</td>
<td>Muscular atrophy; inflammatory axonal neuropathy with perivascular and arteriolar lymphoid infiltrates</td>
<td>Normal muscle; axonal sensory neuropathy without inflammatory infiltrate</td>
</tr>
<tr>
<td>Treatment</td>
<td>Interferon α (3 mIU three times a week) + Ursodesoxycholic acid (400 mg/day) for 24 months</td>
<td>Prednisone 1 mg/kg/day during 2 months*</td>
<td>Not treated</td>
<td>Interferon α (3 mIU three times a week) for 10 months†</td>
</tr>
<tr>
<td>Outcome after treatment</td>
<td>Progressive improvement</td>
<td>Improvement</td>
<td>Stable</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

*Interferon was contraindicated because of depressive status.  †Interferon had to be stopped because of severe depressive status.

previous years, if we exclude one case with positive rheumatoid factor. In a series of nine patients with neurological symptoms associated with HCV infection, Temblí et al found two patients without cryoglobulinaemia.12 Symptoms were an anterior optic neuropathy and restless legs syndrome with small fibre neuropathy. The number of cryoglobulinaemia determinations was not mentioned in this study. Moreover, previously undetectable cryoglobulinaemia was noticed after IFNα treatment in the first patient, suggesting that cryoglobulinaemia was positive before treatment. Even if the patient with restless legs syndrome was infected by HCV after transfusion, we do not know whether a search for HIV seropositivity, which may be associated with restless legs syndrome, was made. This condition may also be idiopathic.

The prevalence of mixed cryoglobulinaemia is about 50% in subjects infected by HCV,7 and the association of cryoglobulinaemia with PN might have been coincidental in some cases. Our observations showed that cryoglobulinaemia and indirect markers, such as the presence of rheumatoid factor or a low C4 level, were negative. However, we cannot exclude the possibility that cryoglobulinaemia was positive from time to time, even though the methods we used had a proved sensitivity.11 Recently, Japanese authors have reported the presence of mixed cryoglobulinaemia in up to 90% of patients with HCV using other methods.12 Because age and extensive liver fibrosis are commonly associated with extrahepatic manifestations of HCV infection, patients 2, 3, and 4 may develop mixed cryoglobulinaemia in the future. On the other hand, an eight year follow up of patient 1 has not shown an outbreak of mixed cryoglobulinaemia despite development of cirrhosis.

In a large cohort of patients, PN was found to be associated with skin vasculitis, but not with cryoglobulinaemia.7 Five patients with PN and HCV-type II mixed cryoglobulinaemia have been reported to have high concentrations of anti-HCV antibodies and HCV RNA in the cryoprecipitates. HCV RNA was also found in epineurial cells using reverse transcriptase-polymerase chain reaction (RT-PCR), suggesting a role for HCV itself in type II mixed cryoglobulinaemia-associated neuropathy.13
The high prevalence of PN in HCV patients without other symptoms related to mixed cryoglobulinemia is also compatible with a role for HCV itself in the pathogenesis of damage. Since the study of Feiner published in 1983—before HCV was discovered—it has been known that vasculitic lesions in patients with cryoglobulinemia are not identical in each organ. The first case described in this pathological report is certainly an HCV-mixed cryoglobulinemia (type II mixed cryoglobulinemia with IgMx component) vasculitis with purpura and glomerulonephritis, with identical deposits in normal cutaneous vessels and kidney. In the second case with peripheral neuropathy, the monoclonal component of cryoglobulinemia was IgA and was probably not related to HCV infection. Purpura seems to be a typical type II cryoglobulinemia related lesion with vascular and tissue deposition of HCV-RNA, monoclonal IgM, and complement components. In PN with HCV associated cryoglobulinemic vasculitis, HCV related proteins or RNA have been demonstrated in only a few cases, and immune complexes are found less often.

As reported by Lamprecht et al, different pathogenic mechanisms in different organs are at work in the presence of cryoglobulinemia. Cryoglobulinemic vasculitides are immune complex mediated vasculitides that predominate in small vessels. They should only be diagnosed in the presence of clinical signs of vasculitis and cryoglobulinemia and histological proof of an immune complex mediated vasculitis by immunohistochemistry or electron microscopy.

From the clinical data of our patients, it was not possible to distinguish between neuropathy and polyarteritis nodosa. A pathological study showed that neurological vasculitides were probably mixed in two cases, even if not clearly defined. Unfortunately, immunohistochemistry or electron microscopy was not carried out in our patients. PN in HCV positive patients may be due to another type of vasculitis—namely, polyarteritis nodosa. Occlusion of vasorum nervorum with the “periarteritis nodosa like” aspect has been seen in some cases, but this aspect was not associated with perineural vasculitis in our cases. Finally, it has been reported that IFNα may cause a worsening of PN in patients with HCV-mixed cryoglobulinemia, despite improvement of hepatic parameters. In view of the causative factors that may play a part in patients with HCV infection and PN, treatment has to be considered individually, taking into account the clinical features, neuromuscular biopsy sampling, and liver damage, and it must be regularly monitored.


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