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Clinical vignette

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Black and white: alkaptonuria and gout

A 49-year-old man was admitted to our hospital with an acute exacerbation of oligoarticular gouty arthritis. His medical history included alkaptonuria, SLE complicated with nephrotic syndrome, treated with bumetanide, metabolic syndrome and recently diagnosed crystal-proven tophaceous gout treated with urate-lowering therapy. A remarkable finding on physical examination was grey–black darkening of his auricular cartilage related to the alkaptonuria and also tophaceous gout deposits in the antihelix of his ear (Fig. 1). Aspiration of the ear tophi was omitted because of the clear clinical picture and recent crystal-proven tophaceous gout. His serum uric acid level was 0.68 mmol/l. The arthritis responded well to a higher dose of prednisolone, and subsequently urate-lowering therapy was re-initiated. Bumetanide was probably a contributing factor for induction of hyperuricaemia and gout as a result. Unfortunately, diuretic treatment could not be stopped because of the nephrotic syndrome. As far as we could determine, there is no association between the use of diuretics and the development of alkaptonuria. Tophaceous gout and alkaptonuria are both chronic disorders that can cause specific clinical features like subcutaneous depositions [1, 2]. Simultaneous occurrence of both diseases is very rare, and only a few cases have been reported. As our patient demonstrates, both diagnoses can be suspected based on specific findings following careful physical examination.

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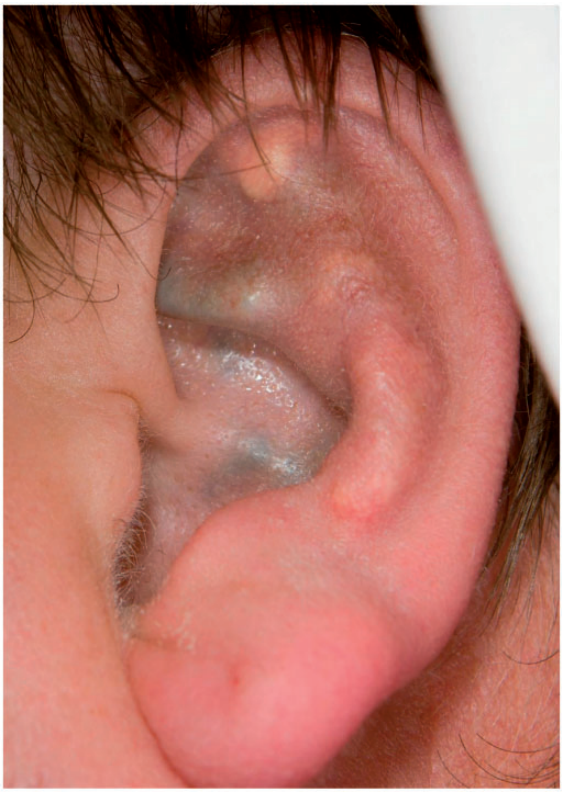
Fig. 1 Left ear showing grey–black darkening and tophaceous gout deposits.



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