Copper deficiency myeloneuropathy and pancytopenia secondary to overuse of zinc supplementation

J Rowin, S L Lewis

The haematological complications of acquired copper deficiency have been well documented, but the neurological complications have only recently been reported. An illustrative case of copper deficiency myeloneuropathy with pancytopenia is presented and the potential aetiologies and neurological manifestations of this deficiency state discussed.

CASE REPORT
A 53 year old woman presented with progressive gait imbalance. Four months before presentation she began to develop tingling and numbness in the fingers and feet. One month later she visited an outside emergency room for evaluation of back pain. She was found to have a normocytic anaemia with a haemoglobin concentration of 8.3 g/dl (normal 11.7 to 15.7 g/dl) and a white blood cell count of 3.2×10^3 (normal 3.8 to 10.8×10^3). She received two units of packed red blood cells, bringing her haemoglobin to 11.5 g/dl. Iron supplementation was prescribed for presumed iron deficiency anaemia. Three days after visiting the emergency room she awoke with increased numbness in the extremities and she began using a cane because of unsteadiness.

On presentation her neurological examination showed increased tone and mild weakness in the legs. Muscle stretch reflexes were hyperactive at the knees and normal elsewhere, with absent Babinski signs. Vibratory and proprioceptive sensation was decreased in the feet. She had mild dysmetria with absent Babinski signs. Vibratory and proprioceptive reflexes were hyperactive at the knees and normal elsewhere, and mean corpuscular volume normalised after three months of treatment. There was significant but incomplete improvement in her nerve conduction studies, with the appearance of a normal sural sensory response (latency 4.0 ms (normal <4.2), amplitude 6.5 μV (normal >5.0)). There was no improvement in the motor conduction times.

DISCUSSION
We believe that our patient developed copper deficiency myeloneuropathy and pancytopenia secondary to overuse of zinc supplements, as in a case reported by Kumar et al. Our patient was ingesting approximately 20 times the recommended daily allowance of zinc. Both copper and zinc are absorbed in the stomach and proximal duodenum. Excess...
zinc levels cause an upregulation of metallothionein production in the enterocytes. Copper has a higher affinity for metallothionein than zinc, so it displaces zinc from metallothionein. Copper then remains in the enterocytes and is sloughed off into the intestinal tract and eliminated.

Other aetiologies of copper deficiency myeloneuropathy have been reported, including five cases secondary to gastric resection. Other cases have an unclear aetiology with no known external sources of zinc, but with high plasma zinc concentrations. Copper deficiency with haematological manifestations has been reported in malnutrition, prematurity, and parental or enteral feeding that does not include copper.

There are some features in common between the neurological manifestations of copper deficiency and multiple sclerosis. Interestingly, the copper chelating agent cuprizone is used as a neurotoxicant in a mouse model of CNS demyelination. Although our patient did not show central demyelinating lesions on MRI, Prodan and Holland reported CNS white matter lesions in the brains of their patients with copper deficiency. Also, hyperintensity on T2 weighted MR images can be seen in the dorsal spinal cord of some patients with copper deficiency myelopathy.

Gastric bypass surgery for obesity is associated with neuropathy as well as other neurological complications. It appears that approximately 40% of the cases of post-gastric resection surgery neuropathy are associated with thiamin or vitamin B-12 deficiency, but in the remaining 60% no vitamin deficiency is found. As there are reports of copper deficiency myeloneuropathy after gastric bypass surgery for various indications in the absence of parental or enteral nutrition, copper deficiency should be considered in cases of neuropathy after weight reduction surgery.

As with vitamin B-12 deficiency, the neurological manifestations of copper deficiency may be seen with or without the haematological manifestations, and with or without abnormalities on MRI imaging of the brain and spinal cord. The associated anaemia of copper deficiency may be macrocytic, as in our case, microcytic, or normocytic. Therefore a high index of suspicion is necessary in patients at risk. Copper therapy (2 mg/d) generally leads to an early recovery of the haematological abnormalities, followed by variable recovery of the neurological symptoms.

Copper deficiency should be considered in the differential diagnosis of multiple sclerosis, subacute combined degeneration of the cord, optic myeloneuropathy, post-gastric reduction surgery neuropathy, or in other cases of myelopathy, optic neuropathy, or polyneuropathy where nutritional deficiency or overuse of zinc supplementation is suspected. Prompt recognition and treatment may improve the prognosis for neurological recovery.

Authors’ affiliations
J Rowin, University of Illinois at Chicago, Department of Neurology and Rehabilitation, Section of Neuromuscular Disease, Chicago, Illinois, USA
S L Lewis, Rush University Medical Center, Department of Neurological Sciences, Chicago

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Correspondence to: Dr Julie Rowin, University of Illinois at Chicago, Department of Neurology and Rehabilitation, Section of Neuromuscular Disease, Chicago, IL 60612, USA; rowin@uic.edu

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