2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) poisoning in Victor Yushchenko: identification and measurement of TCDD metabolites

O Sorg, M Zennegg, P Schmid, R Fedosyuk, R Valikhnovskyi, O Gaide, V Kniazevych, J-H Saurat

Summary

Background 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) has a long half-life of 5–10 years in human beings as a result of its high lipophilicity, and little or no metabolism. We monitored TCDD, its form, distribution, and elimination in Victor Yushchenko after he presented with severe poisoning.

Methods In late December, 2004, a patient presented with TCDD poisoning; the levels in his blood serum (108 000 pg/g lipid weight) were more than 50 000-fold greater than those in the general population. We identified TCDD and its metabolites, and monitored their levels for 3 years using gas chromatography and high-resolution mass spectrometry in samples of blood serum, adipose tissue, faeces, skin, urine, and sweat, after they were extracted and cleaned with different organic solvents.

Findings The amount of unmodified TCDD in the samples that were analysed accounted for about 60% of TCDD eliminated from the body during the same period. Two TCDD metabolites—2,3,7-trichloro-8-hydroxydibenzo-p-dioxin and 1,3,7,8-tetrachloro-2-hydroxydibenzo-p-dioxin—were identified in the faeces, blood serum, and urine. The faeces contained the highest concentration of TCDD metabolites, and were the main route of elimination. Altogether, the different routes of elimination of TCDD and its metabolites accounted for 98% of the loss of the toxin from the body. The half-life of TCDD in our patient was 15·4 months.

Interpretation This case of poisoning with TCDD suggests that the design of methods for routine assessment of TCDD metabolites in human beings should be a main aim of TCDD research in the metabolomic era.

Funding University of Geneva Dermatology Fund, and Swiss Centre for Applied Human Toxicology.

Introduction “If there is no poison, there cannot be poisoning, and there was no trace of it whatsoever”1 This statement shows the prevailing geopolitical and juridical context that had impaired the scientific investigation to find out whether Victor Yushchenko, a candidate for the presidential election in Ukraine (figure 1), had been poisoned in 2004. While he was campaigning for the election, he suddenly became severely ill (figure 2) as a result of being poisoned during a dinner in Kiev on Sept 5, 2004.2,3 However, identification of the poison—pure dioxin (2,3,7,8-tetrachlorodibenzo-p-dioxin [TCDD])—was delayed from Sept 5, 2004, until late December, 2004, because the presence of TCDD is not routinely investigated in medical practice in a patient with signs of acute poisoning. Therefore whether forensic investigators would have detected the poison in Victor Yushchenko had he died soon after the intoxication is unknown.

TCDD is the most potent member of a group of polyhalogenated aromatic hydrocarbons that includes polychlorinated dibenzo-p-dioxins (PCDDs), polychlorinated dibenzofurans (PCDFs), and polychlorinated biphenyls.4 These lipophilic compounds diffuse freely across cell membranes, and exert their pleiotropic biological effects by binding to the intracellular aromatic hydrocarbon receptor.5 Their toxic effects, particularly those of TCDD, are caused by their high affinity for this receptor, and by their long elimination half-lifes. Because polyhalogenated aromatic hydrocarbons are lipophilic, they accumulate in the lipids in tissues on a physical basis by simple partitioning; this process accounts for their slow elimination in the faeces. Only 17 (including TCDD) of 210 possible PCDDs and PCDFs have chlorine substituents at the lateral positions—ie, carbons 2, 3, 7, and 8, therefore preventing or greatly slowing their bioconversion to polar metabolites during oxidation by the phase I and phase II enzymes. An efficient bioconversion by enzymatic oxidation can take place when two adjacent hydrogen atoms are available, which is not the case when the lateral positions have chlorine substituents.6,7 Although the metabolism of PCDFs can be induced by TCDD or by themselves,8,9 TCDD has not been shown to induce its own metabolism.10 The cytochrome P450 (CYP) monooxygenases CYP1A1, CYP1A2, and CYP1B1 have been shown to be substantially induced in human beings,11,12 but metabolites of TCDD have not been clearly shown so far. The expected half-life of TCDD ranges from less than 5 years in individuals exposed to high levels—ie, more than 10 000 pg/g lipid weight of TCDD in the blood serum—to more than 10 years in those exposed to less than 50 pg/g lipid weight.13
In late December, 2004, we were presented with a patient who was severely affected with probable TCDD poisoning. Without an established specific treatment protocol for such a severe and painful disease, the two possible treatment strategies were to continuously monitor the poison, its form, distribution, and elimination, and to search for medical molecular-based solutions for the organs that were affected by the toxin. We report here the first strategy because the specific wish of the patient was that his case contributed to increasing scientific knowledge about TCDD toxicity.

Methods
We obtained written approval from the patient to release peer-reviewed scientific information about his case. In early January, 2005, we identified TCDD (108 000 pg/g lipid weight) in our 50-year-old patient’s blood serum, drawn under controlled conditions at the Geneva University Hospital, Switzerland (table 1), which was more than 50 000 times the average levels of TCDD in the general population.17 Similar levels were identified by an independent laboratory in a sample taken from the same patient in mid-December, 2004.18

The patient’s faeces were first lyophilised after homogenisation, whereas solid tissue samples (adipose tissue and skin) were frozen in liquid nitrogen and then homogenised by grinding with a pestle and mortar. Blood, urine, and sweat were frozen. We extracted and cleaned all the samples with different organic solvents, and then analysed the solvent extracts separately for the presence of TCDD metabolites. We mixed the samples with 17 standard 13C12-labelled 2,3,7,8-chlorosubstituted PCDDs and PCDFs before we measured the concentrations of TCDD and its metabolites. Because only the levels of TCDD, and not the other 16 chlorinated congeners, were higher in the patient than the levels in the general population, we only measured concentrations of TCDD in subsequent analyses. We used gas chromatography and high-resolution mass spectrometry to identify and quantify TCDD and its possible metabolites. Because reference standards for hydroxylated dibenzo-p-dioxins were not commercially available, we used 13C12-labelled 3,3’,4,5’-tetrachloro-4’-hydroxybiphenyl (Cambridge Isotope Laboratories, Andover, MA, USA) for quantification of the possible metabolites in the samples. The presence of possible TCDD metabolites was investigated on the basis of those predicted by Van den Berg and colleagues,5 and identified by the analysis of the four most abundant signals of the chlorine isotope patterns within the expected molecular ion clusters in the selected ion monitoring mode during gas chromatography and high-resolution mass spectrometry. Because reference standards for hydroxylated dibenzo-p-dioxins were not commercially available, we used 13C12-labelled 3,3’,4,5’-tetrachloro-4’-hydroxybiphenyl (Cambridge Isotope Laboratories, Andover, MA, USA) for quantification of the possible metabolites. This compound was chosen because it was structurally similar to hydroxylated TCDD metabolites and had a similar fragmentation pattern during electron ionisation mass spectroscopy.19 Trichloromethoxydibenzo-
p-dioxin and tetrachloromethoxydibenzo-p-dioxin, used as reference compounds for TCDD metabolites, were prepared in situ, whereas five of six possible mono-hydroxy tetrachlorodibenzo-p-dioxins were provided. The lipid content of all samples was measured gravimetrically after evaporation of the solvent.

Equation 1 was used to calculate the decay of TCDD:

\[
TCDD_{\text{concentration}}(t) = 110\,000 \ (\text{pg/g serum lipids}) \cdot e^{-0.045 \cdot t}
\]

In this equation, \( t \) was time expressed in months, TCDD concentration was expressed as pg/g lipid weight, \( e \) was 2.71828, and \( t_0 \) was the date of poisoning. The half-life was calculated from equation 1—ie, \( \ln(2)/0.045 = 15.4 \) months. We used a period of 1 year, starting 11 months after the poisoning to try to correlate the TCDD decay curves with the TCDD eliminated or recovered from different routes. The concentrations of TCDD in the lipids at the start and end of this period were calculated with equation 1. The patient’s body fat was calculated with a formula reported by Gallagher and colleagues, and corroborated with CT imaging analysis.

The amount of TCDD eliminated in faeces, urine, and sweat during the 12 months of analysis was calculated with equation 2 as follows:

\[
\Delta m = \int m \cdot e^{-K \cdot t} \cdot dt = \frac{m}{K} (1-e^{-12K})
\]

In this equation, \( dt \) was the differential of time, \( m \) was the estimated mass of TCDD eliminated in the faeces, urine, or sweat during the first month—ie, the product of TCDD concentration at \( t_0 \) and the amount eliminated in 1 month, and \( K \) was the decay (or rate) constant.

The frequent surgical interventions during which many skin biopsies were taken and cutaneous lesions were removed also represented routes of TCDD elimination. Equation 3 was used for the calculation of...
the two-phase kinetics (scripts refer to the phases) shown by these skin biopsies and removed lesions

\[ \Delta m = \frac{m_1}{K_1} \left( e^{-K_1 \cdot t} - e^{-K_2 \cdot t} \right) + \frac{m_2}{K_2} \left( e^{-K_2 \cdot t} - e^{-K_3 \cdot t} \right) \]

The two-phase kinetics can be explained by an accumulation phase from the blood and fat in the first stage, which lasted several months, followed by an exponential decay. About 200 samples of materials extracted from the skin were removed for analysis each month during 12 months. These materials contained skin (epidermis and dermis), blood, fat, and dermal cysts (webappendix).

**Role of the funding source**

The sponsor of the study had no role in study design, data gathering, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

**Results**

We measured the concentrations of TCDD in serum lipids and subcutaneous fat samples from Victor Yushchenko over 3 years. The decay curves of TCDD in serum lipids and subcutaneous fat samples, calculated with first-order kinetics (figure 3), were similar, providing confirmation that TCDD was in equilibrium between serum lipids and subcutaneous fat.

The concentrations of TCDD in the lipids at the start and at end of the period of analysis were 66 000 pg/g and 38 000 pg/g, respectively. TCDD burden at the start and at end of the period of analysis was 990 μg and 740 μg, respectively. The amount of TCDD eliminated from the body during this time was 250 μg.

Table 2 shows the fitted values (ie, to the analytic curves) for the estimated TCDD eliminated per month (m_1) and the decay constant (K_1). The amount of TCDD eliminated, using equations 2 and 3, in the faeces, urine, and sweat, and during the surgical procedures that were done during 1 year was about 150 μg, representing 60% of total (250 μg) eliminated by the body.
body during the same time (table 1). A substantial amount of TCDD eliminated had thus to be accounted for by its metabolism.

Two metabolites—2,3,7-trichloro-8-hydroxydibenzo-p-dioxin (OH-TriCDD) and 1,3,7,8-tetrachloro-2-hydroxydibenzo-p-dioxin (OH-TCDD)—were detected in faeces, serum, and urine, whereas none were detected in fat and skin (table 3; figure 4). The decay constants for TCDD, determined from the concentrations of OH-TriCDD and OH-TCDD in faeces and urine on different dates, were 0·0736 per month for faeces and 0·0684 per month for urine. The amounts of the two metabolites eliminated in the faeces and urine were 90 μg and 5 μg, respectively, giving a total of 95 μg, when we used equation 2 with m equal to 11·3 μg per month for faeces and 560 ng per month for urine, and the respective decay constants. The average molecular mass of the two metabolites (321 g/mol) was almost the same as that of TCDD (322 g/mol), as were the average concentrations of the metabolites in faeces and urine, which meant that the total amount of the two metabolites was equivalent to 95 μg of TCDD, or 38% of 250 μg eliminated from the body.

### Discussion

Of 17 PCDDs and PCDFs analysed in Victor Yushchenko’s blood, only TCDD levels were higher than those in the general population, indicating an acute intoxication with pure TCDD. Victor Yushchenko is one of two people reported to be exposed to high levels of TCDD. The other person, a young woman with acute centrofacial inflammatory dermatosis, which had begun in autumn 1997 after she developed non-specific mild gastrointestinal symptoms, came to the University of Vienna Medical School, Austria, in March, 1998; this woman had a blood serum TCDD concentration of 144 000 pg/g lipid weight.21 This patient was exposed to pure TCDD in her food, and developed an acute gastrointestinal syndrome during a known period, whereas victims of Agent Orange during the Vietnam war,22 industrial accidents, such as the Icmesa factory in Seveso, Italy,23,24 or environmental disasters, such as in Yusho, Japan,25 were exposed to a mixture of chemicals. The biological half-life of TCDD seemed to depend mainly on its tissue concentration. Even if 30% of 38% of TCDD eliminated by the body might have been related to repeated surgical procedures, we calculated a half-life that was much shorter than the generally predicted 36–120 months in moderately exposed individuals. The shorter half-lifes in other individuals exposed to high TCDD levels in Vienna, Austria,26 and Italy,23,24 also support the inverse association of the half-life with tissue concentration. The analysis of the effects of treatments given specifically to increase the excretion of TCDD in the faeces by manipulation of the lipid excretion (with olestra and orlistat) on the shorter half-life is difficult, and studies

### Table 2: Equations for the calculation of concentrations of 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) eliminated from the body and in tissue samples as a function of time

<table>
<thead>
<tr>
<th>Sample</th>
<th>OH-TriCDD (pg/g wet weight)</th>
<th>OH-TCDD (pg/g wet weight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 00</td>
<td>Faeces</td>
<td>810.0</td>
</tr>
<tr>
<td>23 00</td>
<td>Faeces</td>
<td>610.0</td>
</tr>
<tr>
<td>28 50</td>
<td>Faeces</td>
<td>110.0</td>
</tr>
<tr>
<td>39 25</td>
<td>Faeces</td>
<td>33.0</td>
</tr>
<tr>
<td>9 75</td>
<td>Subcutaneous fat</td>
<td>≤15.0</td>
</tr>
<tr>
<td>17 50</td>
<td>Subcutaneous fat</td>
<td>≤9.3</td>
</tr>
<tr>
<td>15 52</td>
<td>Skin</td>
<td>≤5.9</td>
</tr>
<tr>
<td>34 12</td>
<td>Skin</td>
<td>≤3.2</td>
</tr>
<tr>
<td>39 25</td>
<td>Skin</td>
<td>≤36.0</td>
</tr>
<tr>
<td>4 00</td>
<td>Blood serum</td>
<td>12.0</td>
</tr>
<tr>
<td>6 50</td>
<td>Blood serum</td>
<td>5.6</td>
</tr>
<tr>
<td>15 50</td>
<td>Blood serum</td>
<td>≤2.1</td>
</tr>
<tr>
<td>23 00</td>
<td>Blood serum</td>
<td>≤1.7</td>
</tr>
<tr>
<td>23 75</td>
<td>Blood serum</td>
<td>≤2.9</td>
</tr>
<tr>
<td>28 50</td>
<td>Blood serum</td>
<td>≤0.81</td>
</tr>
<tr>
<td>4 00</td>
<td>Urine</td>
<td>5.4</td>
</tr>
<tr>
<td>23 00</td>
<td>Urine</td>
<td>1.4</td>
</tr>
<tr>
<td>28 50</td>
<td>Urine</td>
<td>1.5</td>
</tr>
</tbody>
</table>

OH-TriCDD=2,3,7-trichloro-8-hydroxydibenzo-p-dioxin. OH-TCDD=1,3,7,8-tetrachloro-2-hydroxydibenzo-p-dioxin.
TCDD, and that TCDD is slowly metabolised, probably by the liver and skin. In the skin, the genes encoding TCDD—ie, 2,3,7,8-tetrabromodibenzo-p-dioxin—have been identified in rat bile.

Although not done previously, levels of TCDD and its metabolites in tissue, faeces, and body fluids should be monitored in a patient with severe dioxin poisoning because they are indicators of what the follow-up period and treatment strategy should be. The poisoning of Victor Yushchenko with TCDD has changed from a story reported in the news to a medical model. This model of TCDD poisoning indicates that methods need to be designed for the routine analysis of TCDD metabolites in human beings, and the main aims of research into TCDD poisoning in the metabolomic era should be the analysis of factors that are involved in the metabolism of this toxin.34

Contributors
OS contributed to the study design, literature search, data analysis and interpretation, writing the report, and drawing figures. MZ and PS contributed to literature search, data analysis and interpretation, and writing the report. OG, RF, RV, and VK participated in gathering samples and patient care. All authors have seen the final version of this report.

Conflicts of interest
We declare that we have no conflicts of interest.

Acknowledgments
This study was supported by the University of Geneva, Dermatology Foundation, and Swiss Centre for Applied Human Toxicology; Geneva, Switzerland; the authors had the freedom to use the funds for their research on dioxin poisoning. We thank the patient for his ability to cope with this disease and his willingness to contribute to increasing scientific knowledge about TCDD toxicity; Norbert Heeb, Andreas C Gercke, and Hans-Rudolf Buser for helpful discussions; Helder Hak and Janice K Huwe from the US Department of Agriculture, Fargo, ND, USA, for providing reference compounds of hydroxylated TCDD; and Richard W James for his careful reading of the report and helpful comments.

References
5 Van den Berg M, De Jongh J, Poiger H, Olson JR. The toxicokinetics and metabolism of polychlorinated dibenzodioxins (PCDDs) and dibenzofurans (PCDFs) and their relevance for toxicity. Crit Rev Toxicol 1994; 24: 1–74.
8 Rifkind AB. CYP1A in TCDD toxicity and in physiology-with particular reference to CYP dependent arachidonic acid metabolism and other endogenous substrates. Drug Metab Rev 2006; 38: 291–335.


