FACTOR XIII DEFICIENCY IN PAKISTAN

ABSTRACT

Patients with undiagnosed haemostatic defects seen at The Aga Khan Hospital and Fatimid Blood Transfusion Centre during the period of 7 years (1985-1992) were screened with routine tests including bleeding time (BT), whole blood clotting time (CT), platelet count, activated partial thromboplastin time (APTT), prothrombin time (PT) and 5 molar urea test. Nine patients had a positive 5 molar urea test indicating factor XIII deficiency. Rest of the screening tests were normal in these patients. High incidence of consanguinity was observed in affected families. Clinical features included excessive bleeding from umbilical stump, bruising, post-traumatic bleeding, epistaxis, melaena and intracerebral bleeding. All the patients were treated with fresh frozen plasma and cryoprecipitate (JPMA 43: 67, 1993).

INTRODUCTION

Factor XIII deficiency is a rare disorder. Over 100 cases have been reported in the world literature. Factor XIII, a fibrin stabilizing factor (FSF) also called fibrinologase, is a zymogen with a molecular weight of 320,000. It is composed of four dissociable subunits α2β2. Factor XIII has been purified from both human and bovine plasma by procedures involving differential precipitation and column chromatography. The ‘α’ subunit is synthesized by platelets and megakaryocytes whereas the ‘β’ subunit may be produced by the liver. Factor XIII is present in platelets and placenta but only in the form of active ‘α’ subunits. Factor XIII after activation to XIIIa by thrombin requires calcium as co-factor to form a transamidase. This catalyses the formation of t-glutamyl-E-lysine bonds between adjacent strands of fibrin monomer. The formation of t-glutamyl-E-lysine bond introduces the important properties to fibrin namely, increased stability to mechanical disruption and increased resistance to lysis by proteolytic enzyme. These properties are advantageous in wound healing. Deficiency of factor XIII renders clot unstable. They lack elasticity and are more susceptible than normal to digestion by plasmin. In the laboratory, these are soluble in 5 molar urea in 1% monochloroacetic acid. Failure of fibrin cross linking as a result of factor XIII deficiency leads to the formation of an unstable clot which is susceptible to fibrinolysis and does not support the proper growth of fibroblasts. In an apparently homozygous individual, levels of factor XIII are virtually absent.
when measured biochemically or when assayed by immunological methods\textsuperscript{6,7}. Routine haemostatic screening tests used in Pakistan do not include factor XIII screening test except in a few centres and hence patients with factor XIII deficiency may be missed. First cousin and inter-family marriages are common in Pakistan and autosomal recessive coagulopathies like factor XIII deficiency will have a higher incidence in Pakistan than in the West. This study reports 9 cases of factor XIII deficiency diagnosed at The Aga Khan University Medical Centre and Fatimid Hemophilia Centre during the period 1985-1992.

**PATIENTS AND METHODS**

All patients with undiagnosed haemostatic defects were screened with routine screening tests including platelet count, bleeding time (B.T.), whole blood clotting time (C.T.), activated partial thromboplastin time (A.P.T.T.), prothrombin time (P.T.) and 5 molar urea test for factor XIII deficiency. The techniques utilized standard methodology\textsuperscript{8}.

**RESULTS**

Nine patients (7 males and 2 females) had a positive 5 molar urea test indicating factor XIII deficiency. Their ages ranged from 1 year to 26 years. Six (66.6\%) were in 1-10 years age group, two (22.2\%) in 11-20 years and 1 (11.11\%) in 21-30 years age group. Consanguinity was observed in 4 (45\%) of the affected families and pattern of inheritance favoured an autosomal recessive trait. Excessive bleeding from umbilical stump was reported during the first few days of life in seven (78\%) cases. Other features included haematoma formation, easy bruising, post-traumatic bleeding, delayed wound healing, gastrointestinal bleeding and epistaxis. One child presented with intracerebral bleed. Secondary or acquired causes of factor XIII deficiency were ruled out by history, clinical examination and relevant investigations. The presenting symptoms and haematological parameters are shown in Table.
DISCUSSION

Introduction of factor XIII screening test in routine coagulation tests enabled us to detect 9 cases of factor XIII deficiency hitherto unrecognized in this country. This is to be expected in the arena of inter family marriages. Ratnoff and Steinberg in 1978 suggested a sex linked component to the inheritance pattern, but the development of electrophoretic methods for studying subunit ‘a’ and ‘b’ have clarified the position regarding their inheritance. The studies by Losowsky have confirmed that structural loci for the ‘a’ and ‘b’ sub-units lie on autosomal chromosomes. The consanguinous marriages are fairly common in Pakistan and a high incidence of genetic coagulopathies like factor XIII deficiency are to be expected. The inheritance pattern in our patients appears to be an autosomal recessive trait.

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Sex/age</th>
<th>Signs and symptoms</th>
<th>Investigations</th>
<th>Family history</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient No.1</td>
<td>Male</td>
<td>11 years</td>
<td>Injuries, hematomas, bleeding per rectum, bleeding from umbilical stump</td>
<td>BT 6 min, 20 sec, CT 4 min, 40 sec, PT 13 sec, plt 220,000, 5 MU test positive</td>
<td>No family history of bleeding disorder</td>
</tr>
<tr>
<td>Patient No.2</td>
<td>Male</td>
<td>3 years</td>
<td>Injuries, hematomas skull, gum bleeding, bleeding from umbilical stump, Bleeds on 2nd or 3rd day from wound after injury</td>
<td>BT 3 min, CT 4 min, 5 sec, PT 15 sec, APTT 35 sec, plt 250,000, 5 MU test positive</td>
<td>2 sisters and 1 brother died of bleeding, intracerebral hemorrhage</td>
</tr>
<tr>
<td>Patient No.3</td>
<td>Female</td>
<td>7 years</td>
<td>Bruising, bleeding from umbilical stump on 9th day</td>
<td>BT 3 min, CT 5 min, 50 sec, PT 15 sec, APTT 31 sec, plt 300,000, 5 MU test positive</td>
<td>One younger sister has same problem. Parents first cousins</td>
</tr>
<tr>
<td>Patient No.4</td>
<td>Male</td>
<td>20 years</td>
<td>Hematomas, bleeding from umbilical stump, bruising, epistaxis</td>
<td>Initial workup at Lahore. 5 MU test positive</td>
<td>Parents distantly related. One sister suffering from same disease</td>
</tr>
<tr>
<td>Patient No.5</td>
<td>Female</td>
<td>26 years</td>
<td>Melaena, post-traumatic hematomas and bleeding</td>
<td>Initial workup at Maryland Centre, Lahore. 5 MU test positive</td>
<td>Parents cousins. One sister suffering from same disease</td>
</tr>
<tr>
<td>Patient No.6</td>
<td>Male</td>
<td>10 years</td>
<td>After circumcision, bleeding from umbilical stump on 5th day, bruising, hematomas, gum bleeding</td>
<td>BT 2 min, 50 sec, CT 5 min, 45 sec, PT 15 sec, APTT 43 sec, plt 260,000, 5 MU test positive</td>
<td>No history of bleeding disorder</td>
</tr>
<tr>
<td>Patient No.7</td>
<td>Male</td>
<td>1 year</td>
<td>Circumcisional bleeding</td>
<td>BT 2 min, 50 sec, CT 4 min, 25 sec, PT 15 sec, APTT 38 sec, plt 275,000, 5 MU test positive</td>
<td>No history of bleeding disorder</td>
</tr>
<tr>
<td>Patient No.8</td>
<td>Male</td>
<td>2 years</td>
<td>Circumcisional bleeding, umbilical stump bleeding, gum bleeding</td>
<td>BT 4 min, 50 sec, CT 4 min, PT 14 min, APTT 56 min, plt 304,000, 5 MU test positive</td>
<td>Sister had the same problem</td>
</tr>
<tr>
<td>Patient No.9</td>
<td>Male</td>
<td>4 years</td>
<td>Circumcisional bleeding, umbilical stump bleeding, gum bleeding</td>
<td>BT 5 min, 15 sec, CT 6 min, PT 16 sec, APTT 34 sec, plt 310,000, 5 MU test positive</td>
<td>Parents first cousins</td>
</tr>
</tbody>
</table>

B.T. = Bleeding Time, C.T. = Clotting Time, P.T. = Prothrombin Time, APTT = Activated Partial Thromboplastin Time, plt = Platelet count, 5 MU = 5 molar urea.
Acquired cases of factor XIII deficiency may be seen in liver diseases, disseminated intravascular coagulation, renal insufficiency and in association with anti-tuberculosis therapy. At least nine inhibitors to factor XIII have been described. One developed in a patient with congenital factor XIII deficiency. Four arose in patients on long term treatment with isoniazid. One in a patient with drug induced lupus syndrome. These inhibitors persisted for up to 5 years and eventually disappeared. Study of these inhibitors showed IgG immunoglobulins directed against factor XIII itself, activated factor XIII or both. Existence of patients with non-functional forms of factor XIII was reported by Duckertin 1972. There is a reported high incidence of intracerebral bleed in factor XIII deficiency than in other inherited bleeding disorder. Spontaneous abortions have also been reported in adult female patients, though none of our patients were in this group. Factor XIII is relatively stable in plasma and has a very long post transfusion life in circulation. Half life of transfused factor XIII is 6-10 days and the plasma concentration required for haemostasis is about 5%. Accordingly, haemostasis can easily be achieved by giving transfusion of fresh frozen plasma, cryoprecipitate or concentrated factor XIII. Prophylactic treatment is done by administering fresh plasma, cryoprecipitate or freeze dried concentrate in the dosage of 10-15 units per kilogram body weight every 3-6 weeks. The only freeze dried concentrate at present available is prepared from human placenta. Question remains as to whether placental tissue will produce any long term immunological effect or if the Rivanol which is used in the manufacturing process will prove to be toxic in any way.

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REFERENCES