Successful Hemodialysis and Renal Transplantation in Combined Factors of V and VIII Deficiencies

Ali Naderi1, Mohmmadreza Ebadzadeh2, Jalal Azmandyan3, Razieh Fayazfar4, Elham Ahmadi5, Ali Rikhtehgaran Tehrani6

1Pediatric Hematology- Oncology Department, Kerman University of Medical Sciences, Kerman, Iran
2Urology Department, Kerman University of Medical Sciences, Kerman, Iran
3Nephrology, Kerman University of Medical Sciences, Kerman, Iran
4Hemophilia center of Afzalipour Hospital, Kerman University of Medical Sciences, Kerman, Iran
5Pediatric Ward, Kerman University of Medical Sciences, Kerman, Iran
6Researcher, Kerman University of Medical Sciences, Kerman, Iran

Corresponding Author: Dr. Ali Naderi, MD, Assistant Professor of Pediatric Hematology- Oncology
Department of Pediatric, Kerman Medical Sciences University
Kerman, Iran
Tel.: E-mail: dnaderihn@yahoo.com

Abstract:
Introduction: The prevalence of rare bleeding disorders, including combined factor V+VIII deficiency are higher in Iran than in developed countries. There are only a few reports which have been written concerning kidney transplantation in the patients suffering from these disorders.
Case report: A 22-year old girl, with a known case of combined factor V+VIII deficiency, a history of bladder stone surgery, postoperative bleeding and a need for hemodialysis due to renal failure was admitted for allograft kidney transplantation. The patient received fresh-frozen plasma and factor VIII, according to individualized protocol before, during and after the course of the transplantation. The function of the grafted kidney was very good nine months post-transplantation.
Discussion: Only heparin was used during hemodialysis. It has been shown that allograft kidney transplantation can be performed in rare bleeding disorders with good replacement therapy without any complications.

Key words: Rare Bleeding Disorders, Combined Factor V+VIII Deficiency, Kidney Transplantation

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Introduction
There are limited researchs and guidelines in hemophilic patients, concerning optimal factor/heparin infusions during hemodialysis. Since bleeding disorders are considered to be a relative contra-indication, there are only a few reports which have been written on renal transplantation in patients with this kind of disease.
Heavy surgical interventions are possible in hemophilic patients, but depend on good replacement therapy during the peri and post operative period.(1,2,3)
In the following report, we discuss a successful hemodialysis and renal transplantation in a patient with combined factor V and VIII deficiency, which is an AR (Autosomal Recessive) bleeding disorder with an incidence of about 1 in 1 million. It
nose bleeding (77%), the bleeding of the uterus (58%), oral cavity bleeding (51%), bleeding of the joints (25%), cord bleeding (22%), GI tract bleeding (7%), bleeding of the muscles (7%) and CNS bleeding (4%).(5,4)

Case Report
A 22-year old girl was admitted to the renal transplantation Ward of the Afzalipoor Medical Center (at Kerman university of Medical Sciences) with renal failure. This renal failure was due to multiple renal and bladder stones as well as a history of bladder surgery 7 years before with prolonged, heavy bleeding.

After surgery for bladder stones, tests of the coagulation system revealed activity of factor VIII 13%, and factor V 10%.

Prothromin time (PT) was prolonged to 16.5 seconds (the normal range is 11"-13"). Partial thromboplastin time (PTT) was prolonged to 58 seconds (the normal 35"- 40"). Other coagulation parameters were within normal limits.

On admission, the patient’s vital signs were normal. Urine analysis showed many white blood cells within a high-power field, many bacteria, one- plus proteinuria, one- plus blood, a specific gravity of 1.-030 and positive culture (>10^5 cfu/ml) for hemolytic streptococci.

Serum chemistry analysis showed elevated creatinine (4.5 mg/dl), triglyceride and cholestrol with other normal parameters.

Ultrasonography revealed small sized kidneys with increased echogenicity and bilateral hydronephrosis. Other organs in the abdomen were normal.

The patient had been hemodialysed via an internal arteriovenous fistula without any replacement therapy (factor VIII or fresh- frozen plasma) 5 months before this admission.

She received a matched allogenic kidney graft from a live, unrelated donor. Before transplantation, the level of F V was 10% and F VIII was 13% without any inhibitors.

The level of FV (with fresh– frozen plasma) and factor VIII (with plasma derived factor VIII) maintained 100% on the day of surgery and 3 days after, then, gradually, replacement therapy was tapered and eventually stopped three weeks after transplantation (Table- 1).

We transfused 5 units of isogroup platelets a few hours before transplantation.

The patient was discharged 7 days postoperatively with good renal graft function. The immunosuppressive medications (Prednisolone, Mycophenolate Mofetil and Cyclosporine) prescribed for her.

The function of the graft was very good without any episode of rejection or bleeding and without replacement therapy nine months post-transplantation.

Discussion
Limited research exists to identify the “optimal factor/heparin” infusions for dialysis in hemophilic patients. Most centers in severe form of factor deficiencies use a combination of heparin and factor replacement before and after dialysis to prevent clot formation in the extracorporeal circulation as well as to minimize bleeding.(7)

Because our patient had a mild factor deficiency, we used heparin only during hemodialysis without any episode of bleeding or clot complication.

We transfuse platelet before transplantation because the addition of platelets may aid in hemostasis by providing another source of factor V that localizes at the site of bleeding(4) and improves platelet function in an uremic patient. The patient’s bleeding time was normal, but this test is notoriously difficult to interpret because of non-standard operator techniques and inter patient variability. We decided to transfuse platelets despite the risk of alloimmunisation.(8,9)

We conclude that hemodialysis and heavy surgical interventions are possible without any compilations in patients with rare bleeding disorders, but with good replacement therapy during the peri and post operative period.

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