

ROLE OF SURGERY IN THALASSEMIA
ESSAY SUBMITTED IN PARTIAL FULFILLMENT OF
MASTER DEGREE IN GENERAL SURGERY

By

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**To my Mother
To my Father
To my Friends who Support
me by all means**

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Abbreviations

Hb	Hemoglobin
Hb.F.	Fetal Hemoglobin
Hb.A.	Adult Hemoglobin
R.B.Cs	Red Blood Corpuscles
W.B.Cs	White Blood Cells
M.C.H.	Mean Corpuscular Hemoglobin
M.C.H.C.	Mean Corpuscular Hemoglobin Concentration
M.C.V.	Mean Corpuscular Volume
B.M.	Bone Marrow
B.M.T.	Bone Marrow Transplantation
P.A.M.S.	Peri-Arterial Macrophage Sheath
P.A.L.S.	Peri-Arterial Lymphatic Sheath
D.F.	Desferrioxamine
Ca DTPA	Calcium Diethylene Triamine Pentacetic Acid

Definitions

M.C.H.	Average weight of Hemoglobin / each cell.
M.C.H.C.	Average amount of hemoglobin in 100 ml R.B.Cs.
M.C.V.	Average volume of one R.B.C.
Heinz Bodies	Denaturated hemoglobin containing ferric iron.
Howell-Jolly Bodies	Abnormal inclusion bodies in R.B.Cs consists of nuclear remnants
Hemosiderin Granules	Aggregated form of ferritin
Anisocytosis	Variation of the size of R.B.Cs than what is present normally (non specific as it is present almost in all blood diseases)
Poikilocytosis	Abnormal variation of the shape of R.B.Cs.

Normal Values

1 milligram	= 1000 microgram (mg)
1 microgram	= 1000 nanogram (ng)
1 nanogram	= 1000 picogram (pg)
M.C.H.	= 27 - 32 pg
M.C.H.C.	= 31 - 35 gm/dL
M.C.V.	= 77 - 93 fL
Hb	= 14 - 16 gm/dL
Number of R.B.Cs.	= 4,500,000 - 5,250,000 /Cmm.
Number of W.B.Cs	= 5,000 - 11,000 /C.m.m.
Number of platelets	= 150,000 - 300,000 / C.m.m.
Hematocrite value	= 42 - 47 %
Reticulocytes	= 0.5 - 2.0% of R.B.Cs.
Fragility of R.B.Cs	= Begins at 0.45% Saline & complete at 0.35% saline.
Packed cell volume	= 40 - 54%
Diameter of R.B.C.	= 6.7 - 7.7 mM
Serum ferritin level	= Male (25 - 250 mg/L) Female (10 - 130 mg/L)

INTRODUCTION

INTRODUCTION

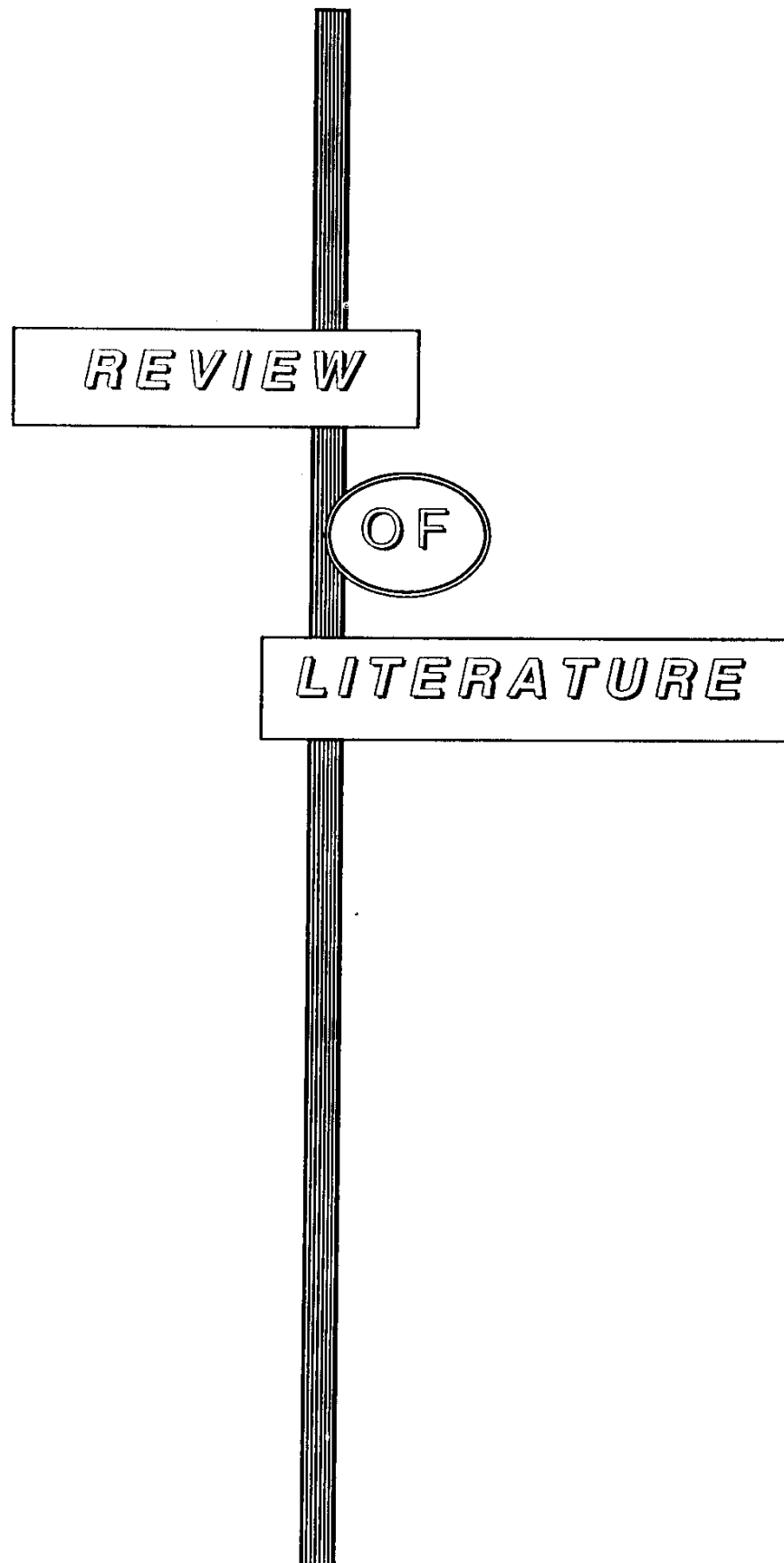
Thalassemia was not recognized as clinical entity until 1925, when Thomas Cooley, a Detroit pediatrician, described a syndrome among children of Italian descent characterized by profound anemia, splenomegaly, and bony deformities (Lukens, 1993).

The thalassemias are hereditary anemias that occur because of mutations that affect the synthesis of hemoglobin. In β -thalassemia there is deficient synthesis of β -globin, whereas in α -thalassemia there is deficient synthesis of α -globin. Reduced synthesis of one of the two globin polypeptides leads to deficient hemoglobin accumulation, resulting in hypochromic, microcytic red cells. These red cell abnormalities are the most constant and characteristic features of the group of disorders (Nienhuis, 1993).

Growth retardation and delayed or absent puberty have been reported to be a common problem in transfusion-dependant thalassemia. (Borgana, et al., 1985). Such retardation includes height, weight and head circumference being more obvious with the height and weight. There is decreased growth velocity after 12 years old with absence of the normal adolescent growth spurt in most of these patients (Behrman & Kliegman, 1992).

Multiple factors share in such retardation of growth such as severe anemia due to hypersplenism, iron overload in the older children and zinc deficiency in most cases of thalassemic children (Alan, 1987).

The different lines of treatment for thalassemia are to support the patients and prevent the side effects of the disease. Also to prevent the decompensating changes of most tissues which usually appear in the second decade threatening the life of the patient. These lines include, early frequent blood transfusion, continuous iron chelation therapy, splenectomy if needed, with the supplementation of zinc, vitamin E and folic acid (Behrman & Kliegman, 1992).



BONE MARROW

Hematopoiesis is, to a large extent, outside the bone marrow (Extramedullary) in the fetus. During the first two months of fetal life, blood cells are formed in yolk sac and thereafter in the liver and spleen until the bone marrow progressively takes over this function during the last three months before birth. Extramedullary hematopoiesis may persist until shortly after birth if there is excessive blood destruction in utero, also extramedullary hematopoiesis may occur in later life if the bone marrow is unable to meet an increased demand as in hemorrhage or hemolysis (Pearson & Benz, 1984).

The marrow cells consist of a "Multiplication Pool" of dividing cells such as pro-erythroblasts, myeloblasts, promyelocytes and early myelocytes, and a "Maturation Pool" of non-dividing cells such as late normoblasts, late myelocytes, band cells and polymorphs. The healthy marrow is able to compensate for a six folds increase in the rate of red cell destruction before significant anemia develops. This is especially so in the case of chronic hemolysis, since an increase in erythroid marrow, at the expense of fatty marrow takes place. This is not possible, however, in infants since the marrow spaces are filled with erythroid marrow. Compensation for hemolysis is then less efficient, being confined largely to extramedullary hematopoiesis (Hann, 1992).

Differential counts of bone marrow (Behrman & Kliegman, 1992)

Age	Blasts (%)	Promyelocytes (%)	Myelocyte & Metamyelocyte (%)	Bands & polymorph-nuclears %	Eosinophils (%)	Lymphocytes (%)	Nucleated R.B.C. (%)	Myeloid/Erythroid ratio
Birth	1	2	5	40	1	10	40	1.2:1
6 months 2 years	0.5	0.5	8	30	1	40	20	2.0:1
6 years	1	2	15	35	1	25	20	2.7:1
12 years	1	2	20	40	1	15	20	3.2:1
Adults	1	2	21	44	2	10	20	3.5:1