

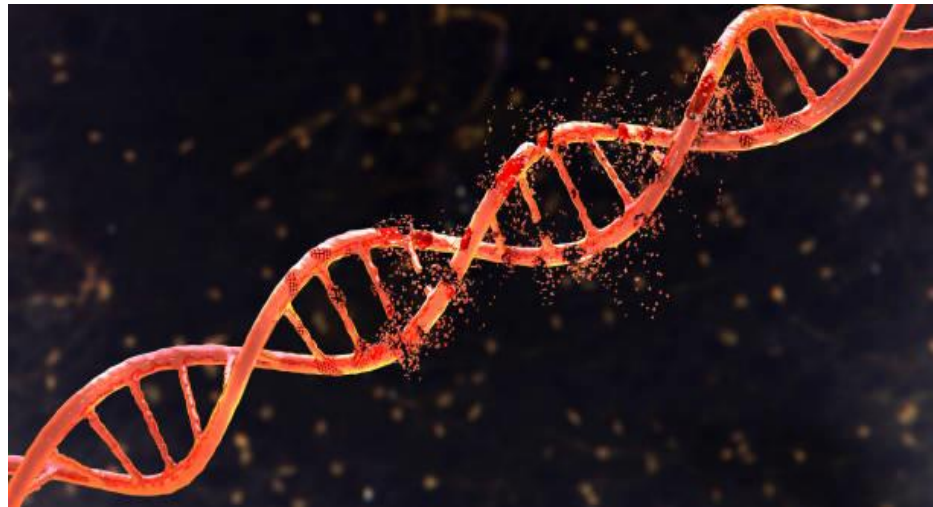
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Prof DR. Waqar Al – Kubaisy

Thalassemia

every year on May 8th



Prof. Dr. WAQAR AL-KUBAISY

6- 4 -2025

every year on May 8



WORLD THALASSEMIA
—●●●— **DAY**

Thalassemia

Thalassemia is a genetic disorder that is due to mutations of the genes that are responsible for the production of hemoglobin in the blood.

*Thalassemia are a heterogeneous grouping of genetic disorders that result from a **decreased** synthesis of **alpha** or **beta** chains of hemoglobin (Hb).

* Hb serves as the oxygen-carrying component of the red blood cells. It consists of **two proteins**, an **alpha**, & a **beta**.

❖ If the body does not manufacture enough of **one or the other** of these two proteins the **red blood cells** do not form correctly and cannot carry sufficient oxygen

❖ this causes **anemia that begins** in early childhood and lasts throughout life.



It is caused by either a genetic **mutation** or a **deletion** of certain key gene fragments.

Thalassemia is an **inherited disease**, meaning that at least **one of the parents** must **be a carrier** for the disease.

As thalassemia is an inherited condition, **individuals with a family history of the condition are more likely to be affected.**

If **both parents** possess **one gene mutation**, any children will have a **25% chance** of **inheriting a gene mutation**, regardless of whether the parents are symptomatic.

If **one or both parents** possess **multiple gene mutations**, the **risk** of gene inheritance **increases**, and the child is more likely to experience symptoms.

Additionally, some particular ethnicities are associated with the



Additionally, some particular **ethnicities** are associated with the condition more often, including people with **Italian, Greek, Middle Eastern, Asian and African** heritage.

The **genetic prevalence** of this condition varies greatly according to the **region** of the world, as well as **the specific ancestry** of an individual.

Thalassemia is caused by **mutations** or **deletions** of the Hb genes, resulting in underproduction or absence of **alpha** or **beta chains**.

Alpha thalassemia is caused by **deletions** of alpha-globin genes, and **beta thalassemia** is caused by a point **mutation** in beta-globin gene on chromosome **11**

Two new terminologies being used more **often in clinical settings** are **transfusion requiring** and **non-transfusion requiring** thalassemia and all the basic classification falls into these two types **depending on the requirement of frequent blood transfusions or not**

Risk factors

Factors that increase the risk of thalassemia include:

- ❖ **Family history of thalassemia.**

Thalassemia is passed from parents to children through mutated hemoglobin genes.

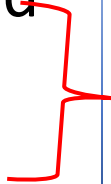
- ❖ **Certain ancestry.**

Thalassemia occurs most often in **African Americans** and in people of **Mediterranean** and **Southeast Asian** descent.

There are two broad types of thalassemia including

1-alpha-thalassemia and

2- beta-thalassemia



Each of which has a different prevalence among certain ethnicities or population groups.

Alpha-Thalassemia

Alpha-thalassemia is caused by alpha-globin gene **deletion** which results in **reduced** or **absent** production of alpha-globin chains.

Alpha-thalassemia arises due to **insufficient synthesis** of **alpha-hemoglobin** chains and an **excess of beta chains**.

There are **four genes** on chromosome **16** that are required to produce the **alpha region** of hemoglobin, **two** of which are **inherited** from **each parent** of an individual.

The **number of gene mutations** corresponds to the **severity** of the condition as follows:



Cont. ... Alpha-Thalassemia

The number of gene mutations corresponds to the severity of the condition as follows:

1- One gene : no signs or symptoms but may pass the disease on to children as a **silent carrier**

2- Two gene: mild signs and symptoms, referred to as alpha-thalassemia minor or **alpha-thalassemia trait**

3- Three gene : moderate to severe symptoms, referred to as alpha-thalassemia **intermedia** or **hemoglobin H disease**

4-Four gene mutations: often fatal before or shortly after childbirth, referred to as alpha-thalassemia **major** or **hydrops fetalis**.

□ up to 20% of world population **are carriers** to the α -thalassemia genes.

Deletion of one ($-\alpha$) thalassemia gene does not result in notable health problem.

However, countries prevalent with **both α -globin genes deletion** (- -) from the same chromosome have more severe forms of thalassemia, **either intermedia or sever**

The **region** of the world and **ethnicity** of the individual is an important factor in the **prevalence** of the gene mutations

❑ **alpha**-thalassemia is more common **in Southeast Asia** than in other areas of the world, although anyone may be affected by the gene mutation that leads to this **condition**

The following list summarizes **which population groups are more likely to be affected by alpha-thalassemia**

	thalassemia trait Prevalence	suspected genetic carriers.
Southeast Asia	1-30%	up to 40%
Sub-Saharan Africa	0%	to 50%
Western Pacific	0%	60%
Eastern Mediterranean	in 0-2%	60%
Americas	0-5%	40%
Europe	1-2%	12%

Beta-Thalassemia

- ❑ Beta-thalassemia occurs **due to insufficient synthesis** of **beta-hemoglobin chains** and an excess of alpha chains.
- ❑ **There are two genes** on **chromosome 11** that are required to produce the beta region of the hemoglobin chain
 - ❖ each of which is inherited from **one parent**.
- ❑ **The number of gene mutations** corresponds to the severity of the condition **as follows:**
 - 1-One gene** mutation: **mild signs or symptoms**, referred to as beta-thalassemia **minor** or thalassemia trait
 - 2-Two gene** mutations: moderate to severe symptoms, referred to as **beta-thalassemia major** or **Cooley's anemia**. Where, **babies born with two mutated beta hemoglobin genes are usually healthy at birth, but disease starts to manifest after 6 months of life when fetal hemoglobin(Hb-gamma) disappears and is replaced by adult Hb.**

CONT. ..Cooley anemia

❑ **Babies born** with two mutated beta hemoglobin genes are usually **healthy ,at birth**, but disease starts to manifest after **6 months** of life when fetal hemoglobin(Hb-gamma) disappears and is replaced by adult Hb.

❑ People with origins in the **Mediterranean**, as well as both

❑ **African** and **South Asian** areas, **are more likely to be affected** by beta-thalassemia

❑ The WHO estimates that Beta-thalassemia affects **2.9%** of the world's population.

The estimated prevalence of those affected by the genetic mutations responsible for beta-thalassemia throughout the world includes

	Prevalence
Eastern Mediterranean	: 2-18%
Europe:	0-19%
Western Pacific	0-13%
Sub-Saharan Africa	0-12%
Southeast Asia	0-11%
Americas:	0-3%

Thalassemia presentation

Thalassemia presentation **varies** widely depending on the **type and severity**.

A **complete history** and **physical examination** can give several clues that are sometimes not obvious to the patient themselves.

The following findings can be noted:

- **Skin; Pallor** due to anemia and jaundice due to hyperbilirubinemia resulting from intravascular hemolysis.
fatigue due to anemia as the first presenting symptom.
- **Extremities examination** can show **ulcerations. bronze skin as a result of** chronic iron deposition due to multiple transfusions
- **Musculoskeletal:** Extra medullary expansion results in **deformed facial and other skeletal bones** and an appearance known as **chipmunk face** وجه السنجاب
- **Cardiac;** Iron deposition can **disrupt the cardiac rhythm**, and the result is various **arrhythmias**.

Due to chronic anemia, overt **heart failure** can also **result**.

Abdomina



Abdominal: Chronic hyperbilirubinemia can lead to precipitation of bilirubin **gall stones** and manifest as typical **colicky pain** of **cholelithiasis**. **Hepatosplenomegaly** can result from chronic iron deposition

Hepatic involvement is a common finding in thalassemia, particularly due to **chronic iron** deposition. **Chronic liver failure** or **cirrhosis** or transfusion-related **viral hepatitis**.

Slow Growth Rates: Particular attention should focus on the child's growth and development according to age.

Anemia can **inhibit** a child's growth rate, and thalassemia can cause a **delay in puberty**.

Endocrinopathies; Deposition of iron in the

- Pancreas can lead to **diabetes mellitus**;
- Thyroid or Parathyroid glands can lead to **hypothyroidism** and **hypoparathyroidism**, respectively.
- **Joints** leads to chronic **arthropathies**.
- **Brain**, iron prefers to accumulate in the substantia nigra and manifests as early-onset **Parkinson's disease** and various other psychiatry problems. (disabilities related to the brain, nerves, bones and muscles)

Screening and diagnosis of thalassemia

Several laboratory tests have been developed to screen and diagnose thalassemia

a) **Complete blood count (CBC):** CBC is often the first investigation in a suspected case of thalassemia

CBC showing **low Hb** and **low MCV** is the first indication of thalassemia, after ruling out iron deficiency as the cause of anemia.

b) The calculation of the **Mentzer index** (mean corpuscular volume divided by red cell count) is useful.

Mentzer index:

- **lower than 13** suggests that the patient has **thalassemia**,
- **more than 13** suggests that the patient has anemia due to **iron deficiency**.

the MCV is usually less than 75 fl with thalassemia and rarely less than 80 fl in iron deficiency until the hematocrit is less than 30 percent. For children, the Mentzer index (MCV/red blood cell count) can help distinguish between iron deficiency and thalassemia
in MCV test measures the size and volume of red blood cells. Normally, MCV is expressed in femtoliters (fL, or 10⁻¹⁵ L) A normal MCV range is roughly 80–100 fl. If someone's MCV level is below 80 fl, they will likely develop or have microcytic anemia. Alternatively, if their MCV levels are greater than 100 fl, they could experience macrocytic anemia.



c) Peripheral blood smear: A blood smear (also called peripheral smear and manual

c) Peripheral blood smear: is next, to assess additional red cell properties. Thalassemia can present with the following findings on the peripheral blood smear :**Microcytic cells** (low MCV), Hypochromic cells, Variation in size and shape (anisocytosis and poikilocytosis) Increased percentage of reticulocytes, Target cells, Heinz bodies

d) Iron studies (*serum iron, ferritin, unsaturated iron-binding capacity (UIBC), total iron-binding capacity (TIBC), and percent saturation of transferrin*) are also done to rule out iron deficiency anemia as the underlying cause.

e) Erythrocyte porphyrin levels may be checked to distinguish an unclear **beta-thalassemia minor** diagnosis from iron deficiency or lead poisoning.

Individuals with beta-thalassemia will have normal porphyrin levels, but those with the latter conditions will have **elevated porphyrin levels**.

f) Hemoglobin electrophoresis: Hemoglobinopathy (Hb) evaluation assesses the type and relative amounts of hemoglobin present in red blood cells.

i-Hemoglobin A (HbA); Composed of both alpha and beta-globin chains, is the type of Hb that typically makes up 95% to 98% of hemoglobin for adults.

ii-Hemoglobin A2 (HbA2) is normally 2% to 3% of Hb while

iii-hemoglobin F usually makes up less than 2% of Hb in adults

❑ **Beta thalassemia:** disturbs the balance of beta and alpha hemoglobin chain formation.

❑ Patients with the **beta-thalassemia major** usually have

❖ **larger percentages of HbF and HbA2 and**

❖ **absent or very low HbA.**

Those with **beta-thalassemia minor** usually have a **mild elevation of HbA2 and mild decrease of HbA.**

❑ **HbH** is a less common form of hemoglobin that may be seen in some cases of **alpha thalassemia.**

❑ Hemoglobinopathy (Hb) assessment is used for prenatal screening when parents are at **high risk for hemoglobin** abnormalities and state-mandated newborn hemoglobin screening.

g) DNA analysis: help to confirm mutations in the alpha and beta globin-producing genes. **DNA testing is not a routine procedure but can be used to help diagnose thalassemia and to determine carrier status if needed.**

* family studies may be necessary to assess carrier status and the types of mutations present in other family members.

h). Genetic testing of amniotic fluid: is useful in those rare instances where a fetus has an increased risk for thalassemia. This is particularly important if both parents likely carry a mutation because that increases the risk that their child may inherit a combination of abnormal genes, causing a more severe form of thalassemia

Prenatal diagnosis with **chorionic villi sampling at 8 to 10 weeks** or by **amniocentesis at 14 to 20 weeks'** gestation can be carried out in high-risk families

I. Multisystem evaluation: Evaluation of all related systems should be done on a regular basis due to their frequent involvement in the disease progression. Biliary tract and gall bladder imaging, abdominal ultrasonography, cardiac MRI, serum hormone measurements are a few examples that can be done or repeated depending on the clinical suspicion and case description.

Treatment / Management

Thalassemia treatment depends on the type and severity of the disease.

Mild thalassemia (Hb: 6 to 10g/dl):

Signs and symptoms are generally mild with thalassemia minor and **little if any, treatment** is needed.

Occasionally, patients may need a **blood transfusion**, particularly **after surgery, following childbirth**, or to help manage thalassemia complications.

Moderate to severe thalassemia (Hb less than 5 to 6g/dl):

Frequent blood transfusions: More severe forms of thalassemia often require **regular blood transfusions**, possibly every few weeks.

The goal is to maintain Hb at around **9-10 mg/dl** to give the patients a sense of **well being** and also to **keep a check on erythropoiesis** and suppress extra medullary hematopoiesis.

To limit

To limit transfusion-related complications, **washed, packed**

To limit transfusion-related complications, washed, packed red blood cells (RBCs) at approximately **8 to 15 mL** cells per kilogram (kg) of body weight **over 1 to 2 hours** are recommended.

❑ **Chelation therapy:** Due to chronic transfusions, iron starts to get deposited in various organs of the body.

❖ **Iron** chelators (deferasirox, deferoxamine, deferiprone) are given concomitantly to remove extra iron from the body.

❑ **Stem cell transplant:** Stem cell transplant, (bone marrow transplant), is a potential option in selected cases, such as **children born with severe thalassemia**.

❖ It can eliminate the need for lifelong blood transfusions.

❖ **However**, this procedure has its own complications, and the clinician must weigh these against the benefits.

❖ **Risks include** including graft vs. host disease, chronic immunosuppressive therapy, graft failure, and transplantation-related mortality.

❑ **Gene therapy:** It is the latest advancement in severe thalassemia management.

❑ Lifestyle modifications

❑ Initially, particularly for mild cases of thalassemia, individuals should make small modifications to their diet and lifestyle to help in the management of the co cases of thalassemia,

❖ It is important to eat a balanced diet with fresh nutritious foods, as this can help patients to feel more energized.

❖ In some instances, supplementation of folic acid may be recommended to encourage red blood cell growth and

❖ Calcium and vitamin D for added bone strength.

❑ Due to the increased risk of individuals with thalassemia experiencing an overload of iron,

❖ it is recommended to avoid excess iron. For this reason, vitamins or supplements that contain iron



Reports exist that **drinking tea** aids in reducing iron absorption from the intestinal tract. So, in thalassemia patients **tea might be a healthy** drink to use routinely.

Vitamin C helps in iron excretion from the gut, especially when used with deferoxamine.

But using vitamin C in large quantities and without concomitant deferoxamine use, there is a higher risk for fatal arrhythmias.

So, the recommendation is to use low quantities of vitamin C along with iron chelators (deferoxamine). and **exercise**

- ❖ **Additionally**, taking measures to **reduce the risk of infections** can be beneficial.
- ❖ This includes **washing hands** frequently and **avoiding contact** with people that are sick.
- ❖ **Immunizations** to protect from **influenza, meningitis, pneumococcal disease and hepatitis B** are also recommended.

Prevention

In most cases, we **can't prevent thalassemia**.

If there is a case of thalassemia, or **carrier of thalassemia gene**, **genetic counselor is recommended for guidance for having children in a future**.

Prenatal diagnosis and genetic counselling

Prenatal diagnosis and **therapeutic abortion** is the **most effective way to prevent severe thalassemia**. In some countries,

Premarital Screening and Genetic Counselling (PMSGC) has been implemented **Cyprus, Greece and Italy** have **demonstrated successful prevention of new cases of thalassemia major**.

However, studies showed that the effect of **mandatory PMSGC** is less satisfactory in the **Middle East countries** PMSGC programme aims to **reduce β -thalassaemia births**

- There is a form of assisted **reproductive technology diagnosis**,
 - **which screens an embryo in its early stages** for genetic mutations combined with in **vitro fertilization**.
- This might help parents who have thalassemia or who are carriers of a defective hemoglobin gene have healthy babies.

Gene Carriers

It is important for individuals who are known to carry gene mutations that may lead to thalassemia to **seek medical advice before** deciding to have children.

- ❖ This is because it is possible for future children to inherit the defective gene, **particularly if both parents are carriers, regardless of the presence of symptoms.**

-Thalassemia in Jordan

β -thalassemia is a common hereditary disorder, especially in the Middle East and is the most common hemoglobinopathy in Jordan with **The carrier prevalence rate of thalassemia in Jordan is currently reported as around 2–4%.**

❖ **in Jordan there were about 1500 thalassaemia patients with a prevalence rate of about 4 to 6% of Beta Thalassemia Major (BTM)** Jordan was among the nations that took special care in preventative measures in the **form of Premarital Screenings and Genetic Counselling (PMSGC).**

- These **screenings helped prevent the marriage of carriers** of the illness which were around **3.5%** of the population.

It was made clear that this measure had **decreased the incidence** of the disease **by 40 %** and that

- ✓ medical professionals hoped the rate **to be halved**, similar to other Mediterranean countries.



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