

Multiple endocrinopathies in β thalassemia major child – A case report

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Abstract

Beta thalassemia is a chronic blood disorder characterised by decreased production of beta globin chains and excess accumulation of the other globin chains. Multiple endocrinopathies in β thalassemia major patients are common. Because of iron overload, multiple endocrinopathies are still prevalent despite extensive chelation therapy. Usually life expectancy may be increased by regular blood transfusions, but there might be growth problems, thyroid dysfunctions, hypoparathyroidism and hypocalcaemia. Here we are presenting an unusual case of various endocrinological dysfunctions in a chronic case of β thalassemia major.

Keywords: Hypoparathyroidism, Hypocalcaemia, β -Thalassemia major.

Introduction

Survival of thalassaemic patients can be increased by repeated blood transfusions and extensive chelation therapy, still endocrinopathies like growth disturbances, diabetes mellitus, thyroid dysfunctions and unusually hypoparathyroidism in β thalassemia major patients can be seen.¹ Severe Hypoparathyroidism is usually associated with hypocalcaemia and presents with other symptoms like tetany, carpopedal spasm, paresthesia.² So, there is a need of regular hormonal profile assays in thalassaemic patients.

Case Report

A 16 years aged girl, who is a known case of β -thalassemia major, brought to the emergency department of S.Nijalingappa Medical College & HSK Hospital, Bagalkot with dyspnoea, dysphagia, carpopedal spasm. At 3 months of age based on clinical features and investigations like High-performance liquid chromatography of Haemoglobin she was diagnosed as β -thalassemia major. From the age of 3 months, she is receiving repeated blood transfusions until today. On general examination, the girl was of mild to moderately built with moderate pallor and icterus, stunted growth (<3rd centile). She had typical haemolytic facies with frontal bossing, mal-occluded teeth, prominent malar prominences and high arched palate. On systemic examination she had splenohepatomegaly. The girl belongs to Tanner stage 2 and had not attained menarche. She was supplemented with oxygen and intravenous calcium gluconate infusion for her presenting symptoms like difficulty in breathing and carpopedal spasm. The blood investigations showed Haemoglobin level of 7.1 g/dl, RBC count of 2.23 million/cmm, 85000/cu.mm of platelets and slightly elevated reticulocyte count of 3%. The serum electrolyte levels are Mg²⁺-1.5mg/dl, Na-133 meq/L, K-3.1 mg/dl and PO₄³⁻—4.2 mg/dl. The peripheral blood smear picture showed normocytic hypochromic anemia with pancytopenia and anisocytosis. The free calcium level was 5.2mg/dl and ionised calcium level was 1.4mg/dl, both were found to be less than the normal value. The serum vitamin D3 level was 11.265 nmol/l (recommended

reference level 36- 144nmol/l) and parathyroid hormone (iPT) level was of 4pg/ml (the recommended reference level 10- 65pg/ml) and concluded that both values were lowered compare to the normal values. In liver function tests, Liver enzymes were slightly elevated. The renal function tests like urea and creatinine etc were within normal ranges, but the urinary calcium excretion was increased from 77.2mg/dl to 209 mg/dl and serum calcium was also increased to 8.0mg/dl after treating with calcium gluconate. Which was suggestive of severe hypoparathyroidism. Serum ferritin was 2873 ng/ml which was very highly elevated than the normal threshold value, suggestive of iron overload. She is on deferasirox 40 mg/kg/day since 9-10 yrs.



Fig. 1: Growth retardation



Fig. 2: carpopedal spasm

Discussion

In our case, the patient's serum ferritin status showed that she was suffering from iron-overload because of frequent blood transfusions. It has been already proved that the iron overload is the main culprit of various endocrinopathies in transfusion dependent patients.³ The accumulation of iron in various organs may result in known complications, including diabetes, hypogonadism, hypothyroidism, low bone mass and hypoparathyroidism⁴ In this case, we observed that growth hormone-insulin like growth factor axis dysfunction was the main cause of the growth retardation. As we all knew that different hormonal factors like GH, IGF-I, sex hormone and their receptors influence the bone metabolism and skeletal consolidation.⁵ Adding to that, chelation therapy may also be one of the important cause of growth retardation, in transfusion dependent thalassemia major patients, like our case. Deferasirox– a iron chelating agent, though it decreases iron overload, it may also causes bony lesions like genu-valgum and spinal growth retardation.⁶ Hypogonadism, bone marrow expansion, increased iron stores and Deferasirox toxicity may also lead to osteoporosis and osteopenia in transfusion dependent thalassemia patients.⁷ Vitamin D deficiency and Hypocalcaemia may also causes the osteopenia in such patients. The elevated iron overload results in elevation of serum ferritin and deposition of iron in parathyroid glands, which may be a

cause of reduced parathyroid function and leading to Vitamin D deficiency.

Conclusion

From the above discussion, it is obvious that multiple endocrinopathies like hypoparathyroidism and hypocalcaemia are still important causes of morbidity even though the newer emergence of chelation therapy, hence we reported this case. This case report may be useful for practitioners for understanding and effective management of beta thalassemia patients by growth monitoring, periodic assessment of hormones and correction of any deficiencies.

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