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Case Report

Stomorrhagia Revealing Hemophilia in an Infant: About a Case Treated at CHUOwendo

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Abstract: ***Introduction***: Persistent oral bleeding in a child may be a sign of a bleeding disorder. The objective of this work is to describe the diagnostic and therapeutic aspects of hemophilia. ***Observation*:** We report the case of an 11-month-old male infant who had been admitted to the maxillofacial surgery department for persistent post-traumatic gingivorrhagia in a patient with no particular history. The clinical examination noted a wound with a layer of gingival bleeding, hematomas in the two upper limbs. Biological exploration revealed normochromic microcytic anemia at 6.5 g/dl; 97% prothrombin rate. The treatment consisted of gingival suture with tranexamic acid compression dressing, vitamin k injection and transfusion of 2 iso-group, iso-rhesus blood bags. The persistence of bleeding led to a search for coagulation factors, with factor VIII returning to less than 1%, concluding with the diagnosis of hemophilia A. Transfusion of an iso-group iso-rhesus blood bag to stop the bleeding. Transfer of the patient to the hematology department for specialized care. ***Discussion*:** Any unusual bleeding from the cephalic and bucco-facial sphere in an infant should raise the question of hemophilia. ***Conclusion***: Stomatorrhagia is the evocative sign and the suture accompanied by blood transfusion a means of treatment.

Keywords: Hemophilia, factor VIII deficiency, gingival bleeding, infant.

INTRODUCTION

Hemophilia is a rare genetic disorder that results from mutations in genes that code for proteins needed for normal blood clotting of factor VIII (hemophilia A) and factor IX (hemophilia B). It is a ubiquitous condition with an incidence of one case per 10,000 births. [1, 2]

About 30% of hemophilia cases occur sporadically at birth and a few cases occur later in life (acquired hemophilia), with hemophilia A being four times more common than hemophilia B [1].

Clinical manifestations are rare at the oral level but usually appear and result early in characteristic hemarthrosis (knees, ankles) or hematomas. At the craniofacial level, the manifestations are essentially cerebral hemorrhages. Treatment focuses on local and parenteral means of hemostasis [3, 4]. The purpose of this work is to describe the signs of hemophilia, determine diagnosis and treatment.

OBSERVATION

MMA infant, male, 11 months of age, with correct immunization status for the expanded programme of immunization and for age, and unknown electrophoretic status had been hospitalized for persistent post-traumatic stomatorrhagia that had been progressing for 48 hours. The clinical examination found asthenia, conjunctival pallor, a gingival wound in relation to the 51 measuring 1cm of major axis with abundant bleeding, erosion of the labial mucosa upper with edema, bruising on the upper limbs. The biological assessment carried out was at NFS Hb 6.5g / dl normochromic microcytic; wafers: 277,000/mm³. TP 97%, GS-Rh: O positive, coagulation factors had also been

The local treatment consisted of a suture of the gum wound, with a compression buffering with tranexamic acid, associated with a parenteral treatment which was made of tranexemic acid IV: 250mg / 8h, Vitamin K1: 10mg in IV, amoxicillin clavulanic acid: 80mg / kg divided into 3 doses, paracetamol 60mg / mg divided into 3 doses and a transfusion of an iso-rhesus

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globular pellet. The evolution had been marked by a cessation of bleeding for a few hours, with resumption of a bleeding in a tablecloth. The flashy examination done on Day 3 of hospitalization highlighted a reappearance of conjunctival pallor and integuments. A control NFS noted normochrome microcytic anemia at 7.1g/dl. A transfusion of an iso-rhesus red blood cell was administered on Day 3 and Day 5, there was a decrease in bleeding and on Day 8 of hospitalization, Bleeding was permanently stopped. The biological results of the Coagulation Factors indicated a deficiency of factor VIII (level less than 1%, diagnosis of hemophilia A major). The patient was referred to hematology for specialized management and was seen again in consultation two weeks after his discharge where the stomatological examination was normal.

DISCUSSION

Hemophilia, which is a late hemorrhagic disease, is essentially characterized at the craniofacial level by the occurrence of a cerebral hemorrhage, which is demonstrated by the work of Abdelhalim et al in Morocco where hemophilia B had been revealed in an infant following a cerebral hemorrhage. This cerebral manifestation is also noted in studies by Peltier et al in France which reveal hemophilia A in 3 infants [3, 5]. At the oral level Bah et al in Guinea Conakry diagnose hemophilia after a dental avulsion in a 12-year-old child. This oral localization in infants is rare.

In the event of unexpected bleeding in children, the search for coagulation factors should be required. In hemophilic disease, hemophilia A are the most found as confirmed by the work of Mouffok et al in Algeria where hemophilia A is found at 80% including 50% of hemophilia major [4]. Thus, the search for factor VIII must be systematic because its deficiency makes it possible to make the diagnosis of hemophilia A.

The symptomatic treatment of hemophilia is mainly based on the administration of vitamin K, tranexamic acid, blood transfusion and especially hemostasis surgery [4-6]. However, the administration of coagulation factors remains the basic treatment for any hemophiliac.

CONCLUSION

Hemophilia is a disease related to an inherited deficiency or dysfunction of clotting factor. Its diagnosis is based on the demonstration of hemorrhage and a dosage of coagulation factors that will be deficient. Treatment is based on effective means of hemostasis and administration of coagulation factors. This care must be multidisciplinary.

No Conflict of Interest

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