A synopsis of current care of thalassaemia major patients in Hong Kong

Objective To provide a synopsis of current thalassaemia major patient care in Hong Kong.

Design Retrospective study.

Setting All haematology units of the Hospital Authority in Hong Kong.

Patients All patients with thalassaemia major with regular transfusion.

Results To date, there were 363 thalassaemia major patients under the care of the Hospital Authority. Prenatal diagnosis has helped to reduce the number of indigenous new cases, but in recent years immigrant cases are appearing. The patients have a mean age of 23 (range, 1-52) years, and 78% of them are adults. In 2009, they received 18,782 units of blood. This accounted for 9.5% of all blood consumption from the Hong Kong Red Cross. In the past, cardiac iron overload was the major cause of death (65%) and few patients survived beyond the age of 45 years. The availability of cardiac iron assessment by magnetic resonance imaging (T2* MRI) to direct the use of oral deferoxamine chelation has reduced the prevalence of heart failure and cardiac haemosiderosis, which should reduce mortality and improve life expectancy.

Conclusion The future for thalassaemia care in Hong Kong is bright. With better transfusion and chelation, it should be possible to avoid growth and endocrine deficiencies in younger patients.
from HSCT. There is a rapid dropoff in patient number beyond the age of 40 years, mainly due to premature cardiac deaths. However, with better iron assessment and chelation, future life expectancy of TM patients is expected to approach that of the background population. Presently, 78% of thalassaemia patients are already adults, while only 22% are below the age of 18 years. Hence, it is hoped that thalassaemia care will gradually shift from paediatric to adult (and later geriatric) medicine.

**Transfusion**

Safe and free red cell transfusion is available for all patients in Hong Kong. Due to their transfusion habits however, the pre-transfusion haemoglobin level of these patients ranges from 55 to 111 g/L with a median of 92 g/L. A total of 132 (36%) of the patients had undergone splenectomy (age range, 5-56; median, 30 years). In 2009, the total blood consumption was 18,782 units, which accounts for 9.5% of all red cells collected in Hong Kong during that period. Pre-storage filtered, phenotype-matched blood units are pre-arranged for all patients ahead of their scheduled transfusions. The prevalence of allo-antibody carriage in Hong Kong TM cases is low. However, lifelong regular transfusion (and cross-matching beforehand) imposes a huge burden on the social life of these patients.

**Iron overload**

With free transfusions, iron overload and organ failure (particularly cardiac iron overload and heart
failure) become the leading cause of death. Parenteral
deferoxamine was available in Hong Kong in 1970s
and significantly reduced patient mortality.1 To gauge
c Hathogenesis adequacy and as a surrogv for heart hiron,
serum ferritin is the cheapest and most convenient
means of monitoring. It is checked quarterly in the
clinics, and the current median ferritin level among
all TM cases in Hong Kong is 3664 (range, 225-
51 789; normal range, 52-738) pmol/L. Unfortunately,
serum ferritin level fluctuates with inflammation,
hepatitis and the time of the day. It also correlates
better with liver rather than cardiac iron.6 In the 1990s,
liver iron was commonly adopted as surrogate marker
of cardiac iron and chelation adequacy. In Hong
Kong, it was only assessed by liver biopsies, which
were invasive, and require complex biochemical
analysis with limited reproducibility.7 Liver biopsies
are now obsolete in TM cases, except for histological
assessments of viral hepatitis.7 Neither ferritin nor
liver iron show significant correlations with cardiac
iron as measured by magnetic resonance imaging
(MRI).8 The latter is the only independent predictor
of heart failure and cardiac death.9

The development of a standardised T2*
MRI assessment of cardiac iron was a landmark in
thalassaemia management. A lower MRI reading
in milliseconds (ms) indicates more cardiac iron
(normal, >20 ms; high risk of death, <10 ms).8 As
part of an international effort, the MRI scanner in
Prince of Wales Hospital was calibrated against the
international standard in 2006.10 Later, all TM cases in
Hong Kong were offered scanning under the auspices
of the Children's Thalassaemia Foundation (HKCTF).
Among 180 adult patients scanned and reported, the
median T2* MRI level of the heart was 19.3 (range,
3.3-63.5) ms and that of liver was 3.1 (range, 1.0-31.8;
normal, <6.3) ms. Inadequate chelation was therefore
common, with only half of patients having a normal
cardiac T2*; and 26% and 14% of cases had severely
abnormal MRI cardiac T2* (<10 ms) and liver (<1.6
ms) T2* levels, respectively.9 Considerable iron
accumulation was also demonstrated in endocrine
organs. Both heart and endocrine haemosiderosis
 correlated with organ dysfunction.10,11 Clearly,
subcutaneous deferoxamine-based chelation did not
completely prevent cardiac haemosiderosis and
premature mortality. Nonetheless, in young patients
and for historical reasons it was still the first-line
chelation therapy.

Oral deferasirox can reduce cardiac iron,
leading to prevention and reversal of heart failure.12
In Hong Kong, the drug was licensed in 2005.7 The
use of oral deferasirox (either as monotherapy
or in combination with nocturnal subcutaneous
deferoxamine)13 resulted in a dramatic reduction
in cardiac haemosiderosis and ferritin levels. With
the advent of combination therapy, 13% of Hong
Kong TM cases now have ferritin levels within
normal range. Epidemiological experience from
Italy, England, and Cyprus suggests that MRI-
directed deferasirox therapy could reduce cardiac
iron and TM mortality.14-18 This was supported by
our local data.19 A 3-year reassessment MRI (HKCTF
scheme) showed improvement among all 84 of the
90 previously poorly chelated adult patients (2 died
of heart failure, 4 refused re-scan). The percentage
of very poor T2* MRIs (<10 ms) fell by half. However,
agranulocytosis is a life-threatening side-effect of
deferasirox, for which reason seven TM patients had
to stop treatment. A third chelator, oral deferasirox
was introduced in 2008 after extensive safety and
efficacy testing.15,16 Deferasirox monotherapy showed
promise in reducing ferritin levels as well as liver and
heart iron after prolonged treatment.20 However,
the cost (up to 10 times that of deferasirox or
deferoxamine) remains prohibitive, and it is contra-
indicated in patients with renal impairment. Survival
benefit data are also pending. It is currently used in
Hong Kong in very young patients (age <6 years),
poorly chelated patients with contra-indication to
deferasirox, as well as those who self-finance the
treatment or enter clinical trials. At present chelation
for TM cases in Hong Kong involves subcutaneous
deferoxamine (30%), oral deferasirox (17%),
combination deferasirox and deferoxamine therapy
(48%), and oral deferasirox (n=5%).

Organ damage
Since iron deposit and organ damage is cumulative,
in TM population the prevalence of some organ
failures increases with age. Cardiac failure is the most
important cause of death in TM. A low cardiac T2*
MRI is the only predictor for future heart failure and
cardiac deaths.21 Among the 180 patients surveyed
in 2006, the prevalence of low ejection fraction (EF)
[55%] was 19%, while 34% of the cases also had a
history of heart failure.12 Among the 90 patients with
abnormal T2*MRIs (<20 ms), the median EF was only
59%. With aggressive chelation, this improved to 66%
(P<0.001). Only eight patients still had EFs below 55%,
seven of whom showed an improving trend. Two
patients died of heart failure (cardiac T2*MRIs being
3.5 ms and 4.3 ms) shortly after their first assessment.

The prevalence of endocrine failure was also
high in this population. Diabetes mellitus occurs in
up to 25% of adults with TM and is rapidly emerging
as the most important cause of morbidity.11 Such a
high prevalence may reflect inadequate chelation at
younger ages, since established pancreatic damage
is less reversible than cardiac damage, even with
aggressive chelation. Hypogonadism is prevalent
among older patients and half of all adult male and
female patients are on hormone replacements.
Younger patients, however, had normal gonadal
function, weight and stature, and were physically
indistinguishable from the normal population. Recently, two Hong Kong women with TM successfully gave birth. Other endocrinopathies such as hypothyroidism (20%) and hypoparathyroidism (16%) were less common.11

Osteoporosis is highly prevalent in these patients. In a dual-energy X-ray absorptiometry scan screening of 62 adult TM cases, the median vertebral Z score was -1.93 (range, -0.13 to -3.84), while the median hip Z score was -1.79 (range, -0.32 to -3.87).23 All Z scores fell with age indicating ongoing bone loss. Osteoporosis and osteopenia were diagnosed in 29% and 37% of all Queen Mary Hospital TM cases, respectively; similar findings were also reported from Tuen Mun and Prince of Wales hospitals.21 Among multiple risk factors, reduced vitamin D levels and hypogonadism are correctable causes of bone loss.24 Supplements of calcium and vitamin D are recommended. For patients with osteoporosis, additional treatments with standard weekly or monthly bisphosphonates are useful.25 Strontium has not been used to treat local TM patients.

Infection
With the implementation of nucleic acid testing for viral DNA, the risk of transfusion-related infection for blood products in Hong Kong has been reduced to 1 in 5 million for hepatitis C virus (HCV), 1 in 1 million for human immunodeficiency virus (HIV), and 1 in 11 000 for hepatitis B virus (HBV) [written communication, CK Lee, Hong Kong Red Cross Blood Transfusion Service]. A total of 59 TM patients tested positive for HCV antibody carriage (age range, 13-49 years). It is known that up to 30% of HCV antibody carriers may be non-viraemic,26 and have had no evidence of hepatitis on biopsy.27 For non-viraemic TM patients, HCV antiviral treatment is not necessary, but monitoring for HCV recrudescence and liver cancer is advisable.28 In young Hong Kong TM patients with HCV viraemia and active hepatitis, the response to a combination treatment of ribavirin and pegylated interferon was good.29 Since 1999, no more transfusion-related HCV has been reported among TM patients in Hong Kong. Only six patients (age range, 22-49 years) were HBV surface antigen

*Secular years from 1995 to 2009
†HSCT denotes haematopoietic stem cell transplantation

TABLE. Numbers of thalassaemia major patients in Hong Kong succumbing to various causes

<table>
<thead>
<tr>
<th>Year</th>
<th>Heart failure</th>
<th>HSCT†</th>
<th>Infection</th>
<th>Renal failure</th>
<th>Cancer</th>
<th>Suicide</th>
<th>Stroke</th>
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<tr>
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<td>0</td>
<td>1</td>
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</tr>
<tr>
<td>Total</td>
<td>29 (61%)</td>
<td>7 (15%)</td>
<td>5 (10%)</td>
<td>3 (6%)</td>
<td>2 (4%)</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td>48</td>
</tr>
</tbody>
</table>

*Secular years from 1995 to 2009
†HSCT denotes haematopoietic stem cell transplantation

FIG 2. Deaths in thalassaemia major patients in Hong Kong: 1996 to 2009
(HBsAg) carriers. No new TM HBV carriers were reported since the advent of universal vaccination in Hong Kong lifebirths in 1988. The HBsAg carriage rate was 2.7% in TM cases aged older than 22 years. This was consistent with the background prevalence rate, and unlikely to be related to local blood transfusions. There was one reported TM case of transfusion-related HIV. This occurred prior to the era of screening blood products by nucleic acid testing.30

There was a considerable frequency of Klebsiella sepsis in deferoxamine-treated TM patients in Hong Kong.31 Campylobacter infection has also been reported. Both are ferrophilic organisms and can cause life-threatening infections and abscesses. In TM patients, there is also an increased prevalence of haemolytic anaemia-related gallstones, acute cholecystitis, cholangitis, and even liver abscesses.32 Yersinia infection was commonly reported in Italian and Greek TM cases, but is seldom encountered locally.

Mortality
A survey in 1999 showed that heart failure, HSCT, and sepsis were the three leading causes of mortality in TM patients.5 An updated survey of mortality from 1996 to 2009 revealed that heart failure (61%), HSCT (15%), and sepsis (10%) remained the main causes of death (Table). The risk-benefit ratio of HSCT in young thalassaemia patients is debatable, and depends on donor availability, age, iron load, organ damage, and HSCT expertise.33 Encouragingly, in TM patients there has been a steady decline in the crude incidence of death (Fig 2). There is also suggestion that better chelation, HSCT, and infection control has reduced the traditional causes of death. With increasing age, other causes of mortality (eg renal failure secondary to diabetes mellitus) may begin to emerge.

Social challenges and conclusions
Reduced life expectancy, the need for regular blood-taking follow-ups, and daily medications (including injections), as well as retardation in growth and sexual developments (particularly in earlier cohorts) impose huge personal challenges to TM patients and their families. With improved treatment, the external appearance of younger TM cases can be indistinguishable from normal children and adults. Historically, disruption to schooling and employment could be prohibitive. Such difficulties can be alleviated by increasing weekend and evening cross-matching and transfusions. Today, many TM patients in Hong Kong are able to enjoy a full education, career, marriage and family life. This is a tribute to the 0.2 million annual blood donors in Hong Kong, our safe blood supply, the efficiency of our public hospital care system, and the dedication of the numerous medical and nursing colleagues who provide lifelong care for affected patients. With increasing age, more TM patients are transferred to adult units. A redistribution of resources, plus a readjustment of patient and parent expectations, has to follow. Novel approaches such as the establishment of special transfusion centres need to be explored. Medical professionals will continue to work closely with the patient and parent groups to achieve a continuously improving quality of life for these individuals.

Acknowledgements
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References