Serum enzyme changes after intramuscular bleeding in patients with haemophilia and Christmas disease

CHARLES D. FORBES,1 JOHN KING, COLIN R. M. PRENTICE, AND GEORGE P. McNICOL2

From the Departments of Medicine and Biochemistry, Royal Infirmary, Glasgow, Scotland

SYNOPSIS Serum creatine kinase, lactate dehydrogenase, aspartate and alanine transaminases, and aldolase were determined in 41 hospital inpatients with haemophilia or Christmas disease and no significant differences from the normal ranges were found. Levels of these enzymes in a further 10 such patients who had sustained muscle haematoma were determined: in all of these there was a consistent rise in the level of creatine kinase, the peak occurring between 36 and 96 hours.

In bleeding disorders a rise in serum creatine kinase levels may be useful as a diagnostic test for intramuscular haemorrhage.

Elevation of serum creatine kinase (CK) is known to be the most sensitive enzyme test of skeletal and cardiac muscle damage and has been widely used in diagnosis (Ebashi, Toyokura, Momoi, and Sugita, 1959; Dreyfus, Schapira, Scebat, Renaix, and Lenègre, 1960; Okinaka, Kumagai, Ebashi, Sugita, Momoi, Toyokura, and Fujie, 1961; Wright, Clarkson, Brown, and Fuster, 1971). Transient rises in levels of CK have also been reported after strenuous muscular exercise (Graig and Ross, 1963; Schneider and Heise, 1963), after epileptic seizures (Wilson, 1971, personal communication), and after extensive injuries in road or industrial accidents (King, 1970). Similarly, elevation of lactate dehydrogenase (LD) and aldolase (ALS) has been reported after prolonged muscular exercise (Baumann, Escher, and Richterich, 1962; Remmers and Kaljot, 1963).

We report here the changes in serum levels of creatine kinase, lactate dehydrogenase, aldolase, and aspartate and alanine transaminases (AST, ALT) in patients with haemophilia and Christmas disease who had suffered haemorrhage into muscles either spontaneously or as a result of trauma.

Received for publication 10 October 1972.

1 Reprint requests: Dr C. D. Forbes, Department of Medicine, Royal Infirmary, 86 Castle Street, Glasgow, C4
2 New address: Department of Medicine, University of Leeds, Leeds General Infirmary, Leeds

Methods and Materials

All enzymes were assayed by initial reaction rate procedures at 37°C. The transaminases and lactate dehydrogenase assays were carried out on the LKB 8600 reaction rate analyser using Boehringer test combination reagents. Boehringer kits were also employed for estimating aldolase and creatine kinase activities initially on a Unicam SP800 and latterly on a Unicam SP1800 recording spectrophotometer with temperature control by a circulating Heto water bath. Enzyme activities are expressed in International Units at 37°C. (International Union of Biochemistry, 1961, 1965).

Normal ranges of activities were established in a hospital patient population by truncated probit analysis (Neumann, 1968) as follows: AST 9-34 IU/litre, ALT 5-26 IU/litre, LD 115-465 IU/litre, ALS 0-6 IU/litre, and CK 0-100 IU/litre at a reaction temperature of 37°C (McQueen, Garland, and Morgan, 1972).

Electrophoretic separation of lactate dehydrogenase isoenzymes was performed as previously described (Forbes, King, and McNicol, 1971). Assays of antihemophilic factor (AHF) or Christmas factor (CF) were performed by the method as described by Breckenridge and Ratnoff.
Serum enzyme changes in patients with haemophilia and Christmas disease

(1962) and clinical grading of the severity of the defect was as described by Biggs and Macfarlane (1962).

Estimation of the serum levels of enzymes was undertaken in a series of 41 control patients with haemophilia or Christmas disease. They were all inpatients in hospital and had been rested in bed for at least 24 hours. All had some clinical bleeding problem, eg, haematuria, haemoptysis, haemarthrosis, haematemesis and melaena, or epistaxis. None had clinical evidence of muscle bleeding.

Ten patients with haemophilia or Christmas disease with obvious or suspected muscle haematoma were investigated; clinical details are shown in Table I. Serial blood samples were taken from the time of admission until the enzyme levels had returned to baseline values.

Results

NORMAL LEVELS OF SERUM ENZYMES IN HAEMOPHILIAC PATIENTS WITHOUT MUSCLE HAEATOMATA

The results are shown in Table II. There are no significant differences in CK, LD, AST, or ALT levels in the haemophilic population from the normal values found in the hospital population.

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Age (yr)</th>
<th>Grade of Defect</th>
<th>AHF or CF Level (units per 100 ml)</th>
<th>Site of Haematoma</th>
<th>Clinical Size</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15</td>
<td>Severe</td>
<td>0</td>
<td>Bilateral, thigh</td>
<td>Massive</td>
<td>Automobile accident</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>Severe</td>
<td>0</td>
<td>Thigh</td>
<td>Massive</td>
<td>Intramuscular injection</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>Severe¹</td>
<td>0</td>
<td>Thigh</td>
<td>Massive</td>
<td>Traumatic</td>
</tr>
<tr>
<td>4</td>
<td>46</td>
<td>Moderate</td>
<td>3</td>
<td>Buttock</td>
<td>Moderate</td>
<td>Traumatic</td>
</tr>
<tr>
<td>5</td>
<td>21</td>
<td>Severe</td>
<td>0</td>
<td>Thigh</td>
<td>Small</td>
<td>Traumatic</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
<td>Severe</td>
<td>0</td>
<td>Thigh</td>
<td>Small</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>7</td>
<td>34</td>
<td>Severe</td>
<td>0</td>
<td>Deltoids¹</td>
<td>Small</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>8</td>
<td>24</td>
<td>Severe</td>
<td>0</td>
<td>Buttock</td>
<td>Small</td>
<td>Intramuscular injection</td>
</tr>
<tr>
<td>9</td>
<td>13</td>
<td>Severe</td>
<td>0</td>
<td>Diagnostic problem</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>Severe¹</td>
<td>0</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Table I Clinical details of the 10 patients with haemophilia or Christmas disease with intramuscular haematoma from various causes

¹Patient had Christmas disease.
²Associated with a cute haemarthrosis of joint.

<table>
<thead>
<tr>
<th>Control haemophilic group (mean) (range)</th>
<th>Lactate Dehydrogenase</th>
<th>Aspartate Transaminase</th>
<th>Alanine Transaminase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatine Kinase</td>
<td>32-7</td>
<td>271</td>
<td>18-6</td>
</tr>
<tr>
<td>Control (range)</td>
<td>0-75</td>
<td>165-465</td>
<td>10-35</td>
</tr>
<tr>
<td>Normal values for hospital population</td>
<td>0-100</td>
<td>115-465</td>
<td>9-35</td>
</tr>
</tbody>
</table>

Table II Normal levels of creatine kinase, lactate hydrogenase, aspartate and alanine transferases in a control group of inpatients with haemophilia and Christmas disease

No patient had clinical evidence of muscle bleeding. There is no significant difference between these groups.
Table III  Peak levels of enzymes in nine patients with intramuscular bleeding and one patient with suspected bleeding into the sacro-spinalis muscle

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Creatine Kinase</th>
<th>Lactate Dehydrogenase</th>
<th>Aspartate Transaminase</th>
<th>Alanine Transaminase</th>
<th>Aldolase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17400</td>
<td>2100</td>
<td>348</td>
<td>88</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>575</td>
<td>1020&lt;sup&gt;1&lt;/sup&gt;</td>
<td>26</td>
<td>15</td>
<td>4.0</td>
</tr>
<tr>
<td>3</td>
<td>330</td>
<td>474&lt;sup&gt;1&lt;/sup&gt;</td>
<td>27</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>4</td>
<td>568</td>
<td>420&lt;sup&gt;1&lt;/sup&gt;</td>
<td>12</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>196</td>
<td>380&lt;sup&gt;1&lt;/sup&gt;</td>
<td>18</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>167</td>
<td>410&lt;sup&gt;1&lt;/sup&gt;</td>
<td>14</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>7</td>
<td>112</td>
<td>335&lt;sup&gt;1&lt;/sup&gt;</td>
<td>15</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>102</td>
<td>250</td>
<td>13</td>
<td>13</td>
<td>4.85</td>
</tr>
<tr>
<td>9</td>
<td>125</td>
<td>415</td>
<td>23</td>
<td>39</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>177</td>
<td>320&lt;sup&gt;1&lt;/sup&gt;</td>
<td>11</td>
<td>10</td>
<td>-</td>
</tr>
</tbody>
</table>

*Electrophoresis of LD 1>2>3>5>4.

is creatine kinase. The 'normal' activity of CK in serum is probably derived from muscle and in a healthy population the levels are influenced by the degree of muscular activity (Griffiths, 1966).

Within 24 hours of the occurrence of muscle bleeding, there is a rise in level of creatine kinase which may persist for a further 48 hours before falling to normal values by the fourth day after injury. The extent of haematoma formation in muscle is difficult to assess clinically but there would appear to be a crude positive correlation between the size of haematoma and the peak level of CK activity. Lactate dehydrogenase, AST, ALT, and ALS showed no consistent rise after muscle bleeding.

Determination of the isoenzymes of LD by electrophoresis was generally unhelpful. One patient (patient 1) had duplication of LD<sub>1</sub> which was probably due to the large amount of plasma concentrate (cryoglobulin precipitate) infused during and immediately after surgery to repair a ruptured ureter (Forbes et al, 1971). The other five patients in whom isoenzymes were estimated showed a pattern 1>2>3>5>4. This probably represents release of LD from red cells in the haematoma; however, the pattern 5>4 may possibly represent leakage of muscle lactate dehydrogenase.

The cause of the rise in CK levels after exercise and in disease states of muscle is not known. It has been suggested that it is due to leakage of the enzyme through the sarcolemma and it has been further suggested (Aebi, Richterich, Colombo, and Rossi, 1961) that CK is more likely to pass to the extracellular compartment than the other muscle enzymes, because of its high concentration and low molecular weight (Schmidt and Schmidt, 1967).

The majority of patients in this series had muscle haematomas which were clinically obvious and presented no diagnostic problems. Estimation of CK, however, shows such a consistent elevation following muscle bleeding that it may be of value in the haemophiliac who presents with abdominal pain of obscure aetiology. Case 10 illustrates the potential usefulness of CK estimation as a diagnostic test. This patient presented with severe loin pain which was initially diagnosed as being due to pyelonephritis. However the urine was sterile and both an isotope renogram and an intravenous pyelogram were normal. After infusion of plasma, pain stopped and the patient was sent home. Similar symptoms recurred two weeks later and a pattern of enzyme change similar to that seen in association with muscle haematoma formation was found. The diagnosis would seem to have been bleeding into the sacro-spinalis muscle.

It is suggested that estimation of creatine kinase may be of value in the diagnosis of occult muscle haemorrhage in patients with bleeding disorders and it is possible that it may be of value in the differentiation of acute appendicitis from haemorrhage into the ilio-psaos muscle, a recurrent clinical problem in haemophilia.

References


Serum enzyme changes in patients with haemophilia and Christmas disease


Serum enzyme changes after intramuscular bleeding in patients with haemophilia and Christmas disease

Charles D. Forbes, John King, Colin R. M. Prentice and George P. McNicol

doi: 10.1136/jcp.25.12.1034

Updated information and services can be found at:
http://jcp.bmj.com/content/25/12/1034

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/