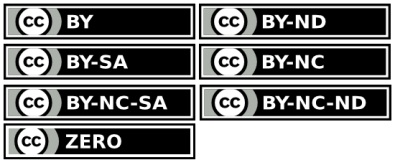
Guidelines for the management of haemophilia in Australia

*© Australian Haemophilia Centre Directors’ Organisation, 201X.* ****

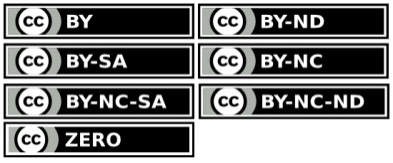
With the exception of any logos and registered trademarks, and where otherwise noted, all material presented in this document is provided under a Creative Commons Attribution-NonCommercial-ShareAlike 3.0 Australia (<http://creativecommons.org/licenses/by-nc-sa/3.0/au/>) licence.

You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute the authors and distribute any derivative work (i.e. new work based on this work) only under this licence.

If you adapt this work in any way or include it in a collection, and publish, distribute or otherwise disseminate that adaptation or collection to the public, it should be attributed in the following way:

   
This work is based on/includes theAustralian Haemophilia Centre Directors’ Organisation’s *Guidelines for the management of haemophilia in Australia*, which is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 Australia licence.

Where this work is not modified or changed, it should be attributed in the following way:

  
© Australian Haemophilia Centre Directors’ Organisation, 201X.  
ISBN XXX (hard copy ISBN)

**For more information and to request permission to reproduce material:**

Australian Haemophilia Centre Directors’ Organisation

7 Dene Avenue

Malvern East VIC 3145

Telephone: +61 3 9885 1777

Website: [www.ahcdo.org.au](http://www.ahcdo.org.au/)

Disclaimer

This document is a general guide to appropriate practice, to be followed subject to the circumstances, clinician’s judgement and patient’s preferences in each individual case. It is designed to provide information to assist decision making. The relevance and appropriateness of the information and recommendations in this document depend on the individual circumstances. Moreover, the recommendations and guidelines are subject to change over time.

Each of the parties involved in developing this document expressly disclaims and accepts no responsibility for any undesirable consequences arising from relying on the information or recommendations contained herein.

**Guidelines for the management of haemophilia in Australia**

Acknowledgements

The Australian Haemophilia Centre Directors’ Organisation (AHCDO) wishes to acknowledge and thank the World Federation of Hemophila (WFH) for allowing AHCDO to review and adapt the *Guidelines for the management of hemophilia (2nd edition)* for the Australian setting.

The following clinical experts reviewed the WFH’s *Guidelines for the management of hemophilia (2nd edition)* and adapted the content for the Australian setting.

Alfred Health

Australasian College of Phlebology

Australasian Society of Infectious Diseases

Australasian Society of Thrombosis and Haemostasis

Australia & New Zealand College of Anaesthetists

Australian & New Zealand Social Workers & Counsellors’ Group

Australian & New Zealand Society of Nephrology

Australian Haemophilia Nurses Group

Australian Physiotherapy Association

Haematology Society of Australia & New Zealand – Nurses Group

Haemophilia Foundation Australia

Human Genetics Society of Australasia

New South Wales Haemophilia Advisory Committee

Royal Australasian College of Dental Surgeons

Royal Australasian College of Physicians

Royal Australasian College of Surgeons

Royal Australian & New Zealand College of Obstetricians & Gynaecologists

Royal Australian & New Zealand College of Ophthalmologists

Royal College of Pathologists of Australasia

Royal Prince Alfred Hospital

World Federation of Hemophilia

The development of the *Guidelines for the management of haemophilia in Australia* was a joint project between AHCDO and the National Blood Authority, Australia (NBA). The NBA provided project management oversight and managed the procurement of all goods and services associated with the development of guideline.

# Contents

[Contents 4](#_Toc431484297)

[Summary of key practice points 6](#_Toc431484298)

[Introduction 10](#_Toc431484299)

[1 GENERAL CARE AND MANAGEMENT OF HAEMOPHILIA 11](#_Toc431484300)

[1.1 What is haemophilia? 13](#_Toc431484301)

[1.2 Principles of care 14](#_Toc431484302)

[1.3 Comprehensive care 16](#_Toc431484303)

[1.4 Fitness and physical activity 19](#_Toc431484304)

[1.5 Adjunctive management 20](#_Toc431484305)

[1.6 Prophylactic factor replacement therapy 21](#_Toc431484306)

[1.7 Home therapy 22](#_Toc431484307)

[1.8 Monitoring health status and outcome 23](#_Toc431484308)

[1.9 Pain management 25](#_Toc431484309)

[1.10 Surgery and invasive procedures 27](#_Toc431484310)

[1.11 Dental care and management 29](#_Toc431484311)

[2 SPECIAL MANAGEMENT ISSUES 35](#_Toc431484312)

[2.1 Carriers 36](#_Toc431484313)

[2.2 Genetic testing/counselling and prenatal diagnosis 37](#_Toc431484314)

[2.3 Delivery of infants with known or suspected haemophilia 38](#_Toc431484315)

[2.4 Vaccinations 38](#_Toc431484316)

[2.5 Psychosocial issues 39](#_Toc431484317)

[2.6 Sexuality 40](#_Toc431484318)

[2.7 Ageing haemophilia patients 40](#_Toc431484319)

[2.8 von Willebrand disease and rare bleeding disorders 43](#_Toc431484320)

[3 LABORATORY DIAGNOSIS 47](#_Toc431484321)

[4 HAEMOSTATIC AGENTS 49](#_Toc431484322)

[4.1 Clotting factor concentrates 50](#_Toc431484323)

[4.2 Other plasma products 54](#_Toc431484324)

[4.3 Other pharmacological options 55](#_Toc431484325)

[5 TREATMENT OF SPECIFIC HAEMORRHAGES 62](#_Toc431484326)

[5.1 Joint haemorrhage (haemarthrosis) 63](#_Toc431484327)

[5.2Muscle haemorrhage 66](#_Toc431484328)

[5.3Central nervous system haemorrhage/head trauma 68](#_Toc431484329)

[5.4 Throat and neck haemorrhage 68](#_Toc431484330)

[5.5 Acute gastrointestinal (GI) haemorrhage 69](#_Toc431484331)

[5.6Acute abdominal haemorrhage 69](#_Toc431484332)

[5.7Ophthalmic haemorrhage 69](#_Toc431484333)

[5.8 Renal haemorrhage 69](#_Toc431484334)

[5.9 Oral haemorrhage 70](#_Toc431484335)

[5.10 Epistaxis 70](#_Toc431484336)

[5.11 Soft tissue haemorrhage 71](#_Toc431484337)

[5.12 Lacerations and abrasions 71](#_Toc431484338)

[6 COMPLICATIONS OF HAEMOPHILIA 74](#_Toc431484339)

[6.1 Musculoskeletal complications 75](#_Toc431484340)

[6.2 Inhibitors 82](#_Toc431484341)

[6.3 Transfusion-transmitted and other infection-related complications 86](#_Toc431484342)

[7 PLASMA FACTOR LEVEL AND DURATION OF ADMINISTRATION 95](#_Toc431484343)

[7.1 Choice of factor replacement therapy protocols 96](#_Toc431484344)

[8 THE FRAMEWORK FOR MANAGEMENT OF BLEEDING DISORDERS IN AUSTRALIA 99](#_Toc431484345)

[Introduction 99](#_Toc431484346)

[Comprehensive Care 100](#_Toc431484347)

[Supply of clotting factor products 101](#_Toc431484348)

[Stakeholder partnership and collaboration 103](#_Toc431484349)

[Information systems and data 104](#_Toc431484350)

[Knowledge development and practice improvement 105](#_Toc431484351)

[Appendix A - Acronyms and abbreviations 107](#_Toc431484352)

[Appendix B - Development process 109](#_Toc431484353)

[Appendix C - Systematic review methodology 111](#_Toc431484354)

[Appendix D - Areas for further research 113](#_Toc431484355)

[Appendix E - Patient information 114](#_Toc431484356)

[Appendix F - Implementation and review of the Australian haemophilia guidelines 115](#_Toc431484357)

[Appendix G - Oxford Centre for Evidence-Based Medicine - 2011 levels of evidence 116](#_Toc431484358)

# Summary of key practice points

**GENERAL CARE AND MANAGEMENT OF HAEMOPHILIA**

|  |  |
| --- | --- |
| No. | **Key Practice Point** |
| **PP 1.1** | Haemophilia is an X-linked inherited bleeding disorder that should be suspected in individuals presenting with joint or muscle bleeding. |
| **PP 1.2** | Laboratory testing is required to confirm the diagnosis of haemophilia. |
| **PP 1.3** | Prompt treatment of bleeding complications is required in patients with haemophilia. |
| **PP 1.4** | Patients should carry details of their diagnosis and treatment with them to expedite prompt appropriate therapy. |
| **PP 1.5** | A comprehensive care model improves outcomes in patients with haemophilia. |
| **PP 1.6** | Essential members of a comprehensive care team include a medical director, a dedicated haemophilia nursing position, musculoskeletal experts including physiotherapy, a specialised coagulation laboratory scientist and psychosocial worker. |
| **PP 1.7** | Use of the Australian Bleeding Disorder Registry is a key tool for communication between team members and documenting care plans. |
| **PP 1.8** | Haemophilia treatment centres (HTCs) should offer advice regarding physical activity to patients with bleeding disorders. |
| **PP 1.9** | Prophylaxis is the standard of care in all children with severe haemophilia. Decisions regarding the timing of commencement, dosing regimen, and continuation of prophylaxis into adulthood will be influenced by the bleeding phenotype of the individual patient. |
| **PP 1.10** | Home therapy should be made available to all patients in whom the bleed frequency makes this desirable. |
| **PP 1.11** | Regular review of patients with haemophilia and documentation of key clinical outcomes is essential. The frequency of review will be determined by the age of the patient and the severity of haemophilia. |
| **PP 1.12** | Chronic pain is a common feature in patients with haemophilia and may require the input of a specialist pain service. |
| **PP 1.13** | COX-2 inhibitors are the preferred agent (in preference to non-selective non-steroidal anti-inflammatory drugs (NSAIDs)) if second line analgesia is required in patients with haemophilia. |
| **PP 1.14** | Clotting factor replacement is required to minimise the risk of peri-operative bleeding. Dosing, particularly for major surgery, should be determined and co-ordinated by a HTC. |
| **PP 1.15** | Regular dental assessment is an important component of care of patients with haemophilia. |

**SPECIAL MANAGEMENT ISSUES**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 2.1** | Women who are carriers of the haemophilia gene may have reduced clotting factor levels and an increased risk of bleeding. Such women should have their clotting factor level documented. |
| **PP 2.2** | Active intervention may be required to reduce bleeding risk in haemophilia carriers with reduced clotting factor levels, particularly around invasive procedures. |
| **PP 2.3** | Genetic counselling should be offered to all individuals with haemophilia, carriers and their partners as part of routine care. |
| **PP 2.4** | Genetic testing may also help with assessing individual risk of inhibitor development. |
| **PP 2.5** | Delivery of infants with known or suspected haemophilia should be atraumatic and forceps delivery or vacuum extraction should be avoided. Ideally delivery should occur in hospitals with a “high risk” obstetric service, in close liaison with a haemophilia treatment centre. |
| **PP 2.6** | Social work review is a central component of haemophilia management. |
| **PP 2.7** | Individuals with haemophilia are at risk of common age related diseases. Monitoring and appropriate treatment of these conditions in liaison with the patients general practitioner is an important component of clinical care. |

**LABORATORY DIAGNOSIS**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 3.1** | A correct diagnosis is essential in all patients with bleeding disorders to ensure appropriate treatment, as different bleeding disorders may have similar symptoms. |
| **PP 3.2** | Accurate diagnosis can only be made with the support of a comprehensive and accurate laboratory service. This is dependent on the laboratory following strict protocols and procedures, which require:  • knowledge and expertise in coagulation laboratory testing  • use of the correct equipment and reagents  • quality assurance |
| **PP 3.3** | Laboratories are strongly advised to participate in an external quality assessment scheme (EQAS) to audit the effectiveness of the internal quality control (IQC) systems in place. The minimum National Association of Testing Authorities (NATA) requirement is 1 EQAS. |
| **PP 3.4** | The Royal College of Pathologists of Australia (RCPA) runs a comprehensive program for haemophilia, Von Willebrands disease and other haemostatic disorders in which all laboratories involved in the diagnosis of bleeding disorders should participate. |
| **PP 3.5** | Other national and international quality assess­ment schemes are also available.eg. External quality Control of diagnostic Assays and Tests Foundation (ECAT), the National External Quality Assessment Service (NEQAS). Most laboratories associated with HTCs should participate in an international EQAS. |
| **PP 3.6** | It is suggested that a chromogenic FVIII assay be performed on diagnostic samples where a diagnosis of mild haemophilia is suspected. |
| **PP 3.7** | The Nijmegen modification of the FVIII inhib­itor assay offers improved specificity and sensitivity over the original Bethesda assay. |
| **PP 3.8** | Detailed information on technical aspects and specific instructions on screening tests and factor assays, please consult the WFH’s Diagnosis of Hemophilia and Other Bleeding Disorders: A Laboratory Manual, Second edition [1] and other reference documents. [2,3] |

**HAEMOSTATIC AGENTS**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 4.1** | Recombinant clotting factor concentrates where available should be used in preference to plasma derived products. |
| **PP 4.2** | In Australia recombinant clotting factor concentrates are available for the treatment of haemophilia A and haemophilia B. Plasma derived products should only be used in these patient groups for urgent treatment where recombinant products are not available. Plasma derived FVIII may be occasionally indicated for use in patients with factor VIII inhibitors undergoing tolerisation – the management of such patients should be discussed with the tolerisation advisory committee (TAC). |
| **PP 4.3** | The use of adjuvant therapy such as DDAVP and tranexamic acid should always be considered in responsive patients. DDAVP should be considered as first line therapy in patients with mild haemophilia provided the individual response has been demonstrated to be adequate to cover the haemostatic challenge being treated. |

**TREATMENT OF SPECIFIC HAEMORRHAGES**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 5.1** | Bleeding in patients with haemophilia can occur at different sites each of which require specific management. |
| **PP 5.2** | It is important that individuals with bleeding disorders and their families be educated about the symptoms and signs of bleeding disorders and understand the benefit of prompt treatment. |
| **PP 5.3** | All patients with bleeding disorders should have a management plan documented to be followed in the event of bleeding. This should ideally be documented on a treatment card generated from the ABDR (see ‘’Principles of Care’, Section 1.2). |
| **PP 5.4** | As a general principle in case of large internal haemorrhage or repeated intermittent bleeding, haemoglobin should be checked and corrected while other measures are being planned. Measures of haemodynamic stability, such as pulse and blood pressure, should be moni­tored as indicated. |
| **PP 5.5** | Appropriate rehabilitation is an important component of care following joint and muscle haemorrhage and ideally should be guided by a physiotherapist familiar with the management of bleeding disorder patients. |

**COMPLICATIONS OF HAEMOPHILIA**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 6.1** | Musculoskeletal complications are common in patients with haemophilia, and are best managed through a multidisciplinary approach that includes input from physiotherapy and musculoskeletal experts (including rheumatology and/or orthopaedics specialists). |
| **PP 6.2** | Acute synovitis should be managed aggressively to reduce the risk of the development of chronic complication. Adequate factor replacement, pain control and physiotherapy input are important. Other interventions require further investigation. |
| **PP 6.3** | Chronic arthropathy management requires a multi-modal approach. Strategies to delay the time to joint replacement are important. |
| **PP 6.4** | Inhibitor management is often complex. Management of new patients with inhibitors, including tolerisation, should be referred to the AHCDO Tolerisation Advisory Committee (TAC) for discussion. |
| **PP 6.5** | Transfusion related infection with HIV and the hepatitis viruses has been an important cause of morbidity and mortality in the haemophilia community. The ongoing treatment and monitoring for complications of these conditions in liaison with other speciality teams (including infectious disease and hepatology) is an important role of HTCs. |

**PLASMA FACTOR LEVEL AND DURATION OF ADMINISTRATION**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 7.1** | Factor replacement may be episodic for the management of acute bleeding or surgery, or prophylactic to limit or prevent haemophilic arthropathy. |
| **PP 7.2** | Standard doses for prophylaxis in the Australian setting range from 25 to 40 IU/kg three weekly or alternate daily. |
| **PP 7.3** | Further research is required to define the optimal prophylaxis regimen and the long-term effectiveness of current dosing regimens. |
| **PP 7.4** | The duration and dosing of episodic therapy will depend on the severity of the haemophilia and the nature of the bleed or surgical procedure being managed. |
| **PP 7.5** | Dosing according to individual pharmacokinetic profile should be considered, particularly in patients undergoing major surgery. |
| **PP 7.6** | The presence of an inhibitor should be excluded in patients undergoing surgery. Follow up inhibitor testing is also recommended 6 to 8 weeks following intense factor VIII exposure in patients with mild or moderate haemophilia A. |

# Introduction

Haemophilia is a sex-linked inherited bleeding disorder that is characterised by a deficiency of either factor VIII (haemophilia A) or factor IX (haemophilia B). While predominantly affecting males, women carrying a haemophilia mutation can also have a clinically significant bleeding disorder. Recent data suggests that there are approximately 2200 individuals with haemophilia living in Australia of who approximately 25% have severe disease with residual clotting factor activity of < 1% of normal.

It is recognised that the best outcomes for patients with haemophilia are achieved via a comprehensive care model, within which a dedicated team manage not only the direct bleeding complications of haemophilia but also other aspects of care including complications that may have arisen from treatment. Collaboration among all clinical team members, the patient population, and the funders of haemophilia care is central to good clinical management and efficient use of resources. Guidelines offer an important framework to guide both clinical decision making and also policy regarding resource allocation.

Guidance for the management of haemophilia in Australia has been developed for the following reasons:

* Guidelines that provide multidisciplinary guidance on the management of the patients with haemophilia relevant to the Australian setting are not currently available
* To help standardise management of haemophilia in treatment centres throughout Australia
* The Australian Evidence-based clinical practice guidelines for the use of recombinant and plasma-derived FVIII and FIX products are due for revision
* The World Federation of Hemophilia’s (WFH) Guidelines for the management of hemophilia (2nd edition) provide a good basis upon which to develop Australian guidance
* The National Safety and Quality Health Service Standards requires that blood product policies, procedures and/or protocols are consistent with national evidence based guidelines for pre-transfusion practices, prescribing and clinical use

This guideline is based on the WFH’s *Guidelines for the management of hemophilia (2nd edition)* but has been adapted for the Australian setting. All significant changes are listed at the beginning of each chapter. Further details describing the adaptation of the WFH guidelines for the Australian setting can be found at Appendix B (Development process). An additional chapter has been included in the guideline to describe the supply of clotting factor products and the management of information systems and data in Australia (Chapter 8 *Framework for the management of bleeding disorders in Australia*)*.*

In line with the WFH guidelines, the Australian guideline contains several practice statements regarding the clinical management of people with haemophilia. All statements highlighted in bold font are evidence-based. For further details on the systematic review methodology, please refer to Appendix C (Systematic review methodology). Where possible, references for recommendations that fell outside the selection for practice statements were also included. These refer­ences have not been graded.

This guideline is intended to offer practical advice on the diagnosis and general management of haemophilia, as well as the management of complications including musculoskeletal issues, inhibitors, and transfusion-transmitted infections. By adapting the WFH guidelines for the Australian setting, AHCDO aims to assist healthcare providers seeking to initiate and/or maintain haemophilia care programs, encourage practice harmonisation and, where recommendations lack adequate evidence, stimulate appropriate studies.

## 1 GENERAL CARE AND MANAGEMENT OF HAEMOPHILIA

**Key practice points**

|  |  |
| --- | --- |
| No. | **Key Practice Point** |
| **PP 1.1** | Haemophilia is an X-linked inherited bleeding disorder that should be suspected in individuals presenting with joint or muscle bleeding. |
| **PP 1.2** | Laboratory testing is required to confirm the diagnosis of haemophilia. |
| **PP 1.3** | Prompt treatment of bleeding complications is required in patients with haemophilia. |
| **PP 1.4** | Patients should carry details of their diagnosis and treatment with them to expedite prompt appropriate therapy. |
| **PP 1.5** | A comprehensive care model improves outcomes in patients with haemophilia. |
| **PP 1.6** | Essential members of a comprehensive care team include a medical director, a dedicated haemophilia nursing position, musculoskeletal experts including physiotherapy, a specialised coagulation laboratory scientist and psychosocial worker. |
| **PP 1.7** | Use of the Australian Bleeding Disorder Registry is a key tool for communication between team members and documenting care plans. |
| **PP 1.8** | Haemophilia treatment centres (HTCs) should offer advice regarding physical activity to patients with bleeding disorders. |
| **PP 1.9** | Prophylaxis is the standard of care in all children with severe haemophilia. Decisions regarding the timing of commencement, dosing regimen, and continuation of prophylaxis into adulthood will be influenced by the bleeding phenotype of the individual patient. |
| **PP 1.10** | Home therapy should be made available to all patients in whom the bleed frequency makes this desirable. |
| **PP 1.11** | Regular review of patients with haemophilia and documentation of key clinical outcomes is essential. The frequency of review will be determined by the age of the patient and the severity of haemophilia. |
| **PP 1.12** | Chronic pain is a common feature in patients with haemophilia and may require the input of a specialist pain service. |
| **PP 1.13** | COX-2 inhibitors are the preferred agent (in preference to non-selective non-steroidal anti-inflammatory drugs (NSAIDs)) if second line analgesia is required in patients with haemophilia. |
| **PP 1.14** | Clotting factor replacement is required to minimise the risk of peri-operative bleeding. Dosing, particularly for major surgery, should be determined and co-ordinated by a HTC. |
| **PP 1.15** | Regular dental assessment is an important component of care of patients with haemophilia. |

**Significant changes from the original WFH Guidelines**

1. The Australian Bleeding Disorder Registry (ABDR) is highlighted as the central point for the recording of treatment administered, outcome measures, and the documenting of treatment plans. Essential and desirable data to be recorded in the ABDR are documented.
2. Primary prophylaxis is the standard of care in patients with severe haemophilia in Australia.
3. It is recognised that long-acting clotting factor concentrates appear to be as efficacious as shorter half-life concentrates.
4. The results of a systematic review regarding the efficacy and safety of selective and non-selective non-steroidal anti-inflammatory drugs are summarised
5. Changes are made to recommendations regarding analgesia selection based on local guidelines.
6. The important role of mutation testing in assessing inhibitor risk in patients with mild and moderate haemophilia A is emphasised.

### 1.1 What is haemophilia?

1.1.1 Haemophilia is an X-linked congenital bleeding disorder caused by a deficiency of coagulation factor VIII (FVIII) (in haemophilia A) or factor IX (FIX) (in haemophilia B). The deficiency is the result of mutations of the respective clotting factor genes.

1.1.2 The reported incidence of haemophilia A ranges from 6.6 to 12.8 per 100,000 males, and for haemophilia B ranges from 1.2 to 2.7 per 100,000 males. The reported incidence is higher in developed countries.

1.1.3 Estimations based on the WFH’s annual global surveys indicate that the number of people with haemophilia in the world is approximately 400,000. [1] The prevalence of haemophilia A and B combined in Australia is approximately 13 per 100,000 individuals. [65]

1.1.4 Haemophilia A is more common than haemophilia B, representing 80-85% of the total haemophilia population.

1.1.5 Haemophilia generally affects males on the maternal side, however women who carry a F8 gene mutation may also have reduced FVIII levels and may therefore be classified as having haemophilia. Both F8 and F9 genes are prone to new mutations, and as many as 1/3 of all cases are the result of spontaneous muta­tion where there is no prior family history.

1.1.6 Accurate diagnosis of haemophilia is essential to inform appropriate management. Haemophilia should be suspected in patients presenting with a history of:

* easy bruising in early childhood
* “spontaneous” bleeding (bleeding for no apparent/known reason or to minor trauma not identified by the patient), particularly into the joints, muscles, and soft tissues.
* excessive bleeding following trauma or surgery.
* in affected females primary menorrhagia and post-partum bleeding

1.1.7 A family history of bleeding is present in about two-thirds of all patients.

1.1.8 A definitive diagnosis depends on factor assay to demonstrate deficiency of FVIII or FIX.

#### Bleeding manifestations

1.1.9 The characteristic phenotype in haemophilia is the bleeding tendency.

1.1.10 While the history of bleeding is usually life-long, some children with severe haemophilia may not have bleeding symptoms until later when they begin walking or running.

1.1.11 Patients with mild haemophilia may not bleed excessively until they experience trauma or surgery.

1.1.12 The severity of bleeding in haemophilia is gener­ally correlated with the clotting factor level, as shown in Table 1-1.

1.1.13 Most bleeding occurs internally, into the joints or muscles (see Table 1-2 and Table 1-3).

1.1.14 Some bleeds can be life-threatening and require immediate treatment (see Section 5).

**TABLE 1-1: RELATIONSHIP OF BLEEDING SEVERITY TO CLOTTING FACTOR LEVEL [62]**

|  |  |  |
| --- | --- | --- |
| SEVERITY | CLOTTING FACTOR LEVEL | BLEEDING EPISODES |
| Severe | < 1 IU/dl (< 0.01 IU/ml) or  < 1 % of normal | Spontaneous bleeding into joints or muscles, predominantly in the absence of identifiable haemostatic challenge |
| Moderate | 1-5 IU/dl (0.01-0.05 IU/ml) or  1-5% of normal | Occasional spontaneous bleeding; prolonged bleeding with minor trauma or surgery |
| Mild | 5-40 IU/dl (0.05-0.40 IU/ml) or  5-<40% of normal | Severe bleeding with major trauma or surgery. Spontaneous bleeding is rare. |

**TABLE 1-2: TABLE 1-3:**

**SITES OF BLEEDING IN HAEMOPHILIA [63] APPROXIMATE FREQUENCY IN BLEEDING AT DIFFERENT SITES**

|  |  |
| --- | --- |
| SITE OF BLEEDING | APPROXIMATE  FREQUENCY |
| Haemarthrosis  ■ more common into hinged joints:  ankles, knees, and elbows  ■ less common into multi-axial joints:  shoulders, wrists, hips | 70%-80% |
| Muscle | 10%–20% |
| Other major bleeds | 5%–10% |
| Central nervous system (CNS) | 5% |

|  |  |
| --- | --- |
| Serious | Joints (haemarthrosis)  10%–20% |
| Muscles, especially deep compartments (iliopsoas, calf, and forearm) |
| Mucous membranes in the mouth, gums, nose, and genitourinary tract |
| Life-  Threatening | Intracranial |
| Neck/throat |
| Gastrointestinal |

### 1.2 Principles of care

1.2.1 The primary aim of care is to prevent and treat bleeding with the deficient clotting factor.

1.2.2 Whenever possible, specific factor deficiency should be treated with specific factor concentrate.

1.2.3 People with haemophilia are best managed in a comprehensive care setting (see ‘Comprehensive care’, section 1.3 and chapter 8).

1.2.4 **Acute bleeds should be treated as quickly as possible, either at home or in the hospital, preferably within two hours, and should be not delayed by the performance of diagnostic investigations. If in doubt, treat. [2]**

1.2.5 Patients usually recognise early symptoms of bleeding even before the manifestation of phys­ical signs. This is often described as a tingling sensation or “aura”.

1.2.6 During an episode of acute bleeding, an assess­ment should be performed to identify the site of bleeding (if not clinically obvious) and appro­priate clotting factor should be administered.

1.2.7 In severe bleeding episodes that are potentially life-threatening, especially in the head, neck, chest, and gastrointestinal tract, treatment with factor should be initiated immediately, even before diagnostic assessment is completed.

1.2.8  **To facilitate appropriate management in emer­gency situations, all patients should carry easily accessible identification indicating the diagnosis, severity of the bleeding disorder, inhibitor status, type of treatment product used, initial dosage for treatment of both severe traumatic or spontaneous bleeds and minor bleeding events, and contact information of the treating physician/clinic. [3] Hard plastic Emergency Treatment Cards (also known as Patient Cards) which contain this information are available to all patients registered on the Australian Bleeding Disorders Registry (ABDR).**

1.2.9  **Administration of desmopressin (DDAVP) can raise FVIII level adequately (three to six times baseline levels) to control bleeding in patients with mild, and possibly moderate, haemophilia A. Testing for DDAVP response in individual patients is appropriate. [4-6]**

1.2.10 Veins must be treated with care. They are the lifelines for a person with haemophilia.

* 23- or 25-gauge butterfly needles are recommended
* Never cut down into a vein, except in an emergency
* Apply pressure for three to five minutes after venipuncture
* Venous access devices should be avoided whenever possible but may be required in some children.

1.2.11 Adjunctive therapies can be used to control bleeding, particularly in the absence of clotting factor concentrates, and may decrease the need for them (see ‘Adjunctive management’, section 1.5).

1.2.12 If bleeding does not resolve despite adequate treatment, clotting factor levels should be measured. Inhibitor testing should be performed if the factor level is unexpectedly low or if the clinical response to replacement therapy is inadequate (see ‘Inhibitors’, section 6.2).

1.2.13 Prevention of bleeding can be achieved by prophylactic factor replacement (see ‘Prophylactic factor replacement therapy’, section 1.6).

1.2.14 Home therapy can be used to manage mild/moderate bleeding episodes (see ‘Home therapy’, section 1.7).

1.2.15 Regular exercise and other measures to stimulate normal psychomotor development should be encouraged to promote strong muscles, develop balance and coordination, and improve fitness (see ‘Fitness and physical activity’, section 1.4).

1.2.16 Patients should avoid activities likely to cause trauma (see ‘Fitness and physical activity’, section 1.4).

1.2.17 Regular monitoring of health status and assessment of outcomes are key components of care (see ‘Monitoring health status and outcome’, section 1.8).

1.2.18 Drugs that affect platelet function, particularly acetylsalicylic acid (ASA) and non-steroidal anti-inflammatory drugs (NSAIDs), except certain COX-2 inhibitors, should be avoided. Paracetamol/acetaminophen is a safe alternative for analgesia (see ‘Pain management’, section 1.9).

1.2.19 Factor levels should be raised to appropriate levels prior to any invasive procedure (see ‘Surgery and invasive procedures’, section 1.10).

1.2.20 Good oral hygiene is essential to prevent periodontal disease and dental caries, which predispose to gum bleeding (see ‘Dental care and management’, section 1.11).

### 1.3 Comprehensive care

1.3.1 **Comprehensive care promotes physical and psychosocial health and quality of life while decreasing morbidity and mortality. [7-9]**

1.3.2 Haemophilia is a rare disorder that is complex to diagnose and to manage. Optimal care of these patients, especially those with severe forms of the disease, requires more than the treatment of acute bleeding.

1.3.3 Priorities in the improvement of health and quality of life of people with haemophilia include:

* prevention of bleeding and joint damage
* prompt management of bleeding
* management of complications including:
* joint and muscle damage and other sequelae of bleeding
* inhibitor development
* viral infection(s) transmitted through blood products
* attention to psychosocial health

1.3.4 Benchmarking of practice and available resources across HTCs is an important tool to help standardise and improve care (see Chapter 8).

#### Comprehensive care team

1.3.5 **The wide-ranging needs of people with haemophilia and their families are best met through the coordinated delivery of comprehensive care by a multidisciplinary team of health­care professionals, in accordance with accepted protocols that are practical and national treat­ment guidelines, if available. [10-12]**

1.3.6 The comprehensive care team should be multidis­ciplinary in nature, with expertise and experience to attend to the physical and psychosocial health of patients and their families.

1.3.7 The core team should consist of the following essential members:

* a medical director (preferably a paediatric and/ or adult haematologist, or a physician with interest and expertise in haemostasis)
* a nurse coordinator who
* coordinates the provision of care
* educates patients and their families
* acts as the first contact for patients with an acute problem or who require follow-up
* is able to assess patients and institute initial care where appropriate
* musculoskeletal experts (including physiotherapist, orthopaedic specialist or rheumatologist) who can address prevention as well as treatment
* a specialist coagulation medical scientist
* a psychosocial expert (preferably a social worker, or a psychologist) familiar with available community resources

1.3.8 The roles assumed by core team members may differ, depending on the availability and expertise of trained staff and the organisation of services within the centre.

1.3.9 All members of the core team should have exper­tise and experience in treating bleeding disorders and should be accessible to patients in a timely and convenient manner. Adequate emergency care should be available at all times.

1.3.10 The following support resources are necessary:

* access to a coagulation laboratory capable of performing accurate and precise clotting factor assays and inhibitor testing
* provision of appropriate clotting factor concentrates, either plasma-derived or recombinant, as well as other adjunct haemostatic agents such as desmopressin (DDAVP) and tranexamic acid where possible
* access to casting and/or splinting for immobilization and mobility/support aids, as needed

1.3.11 The comprehensive care team should also include or have access to, among others:

* a pain specialist with expertise in the management of both acute and chronic pain
* dentist
* geneticist / genetic counsellor
* hepatologist
* infectious disease specialist
* immunologist
* gynaecologist/obstetrician
* vocational counsellor

1.3.12 Written management protocols are required to ensure continuity of care despite changes in clinic personnel.

1.3.13 The comprehensive care team should have the resources to support family members. This may include identifying resources and strategies to help cope with:

* risks and problems of everyday living, particularly with management of bleeding
* changes associated with different stages of the patient’s growth and development (especially adolescence and aging)
* issues regarding schooling and employment
* risk of having another affected child and the options available.

1.3.14 Establishing a long-term relationship between patients/families and members of the comprehensive care team promotes compliance.

#### Functions of a comprehensive care program

1.3.15 To provide or coordinate inpatient (i.e. during hospital stays) and outpatient (clinic and other visits) care and services to patients and their family.

**Patients should be seen by all core team members at least yearly (children, and patients with severe bleeding disorders every six months) for clinical review, and to develop, audit, and refine an individual’s comprehensive management plan. It is suggested that a comprehensive musculoskeletal and psychosocial assessment be performed annually. Referrals for other services can also be given during these visits. [13,14]**

1.3.16 The management plan should be developed with the patient and communicated to all treaters and care facilities. All changes in treatment plan should be recorded on the ABDR.

1.3.17 Smaller centres and personal physicians can provide primary care and management of some complications, in frequent consultation with the comprehensive care centre (particularly for patients who live a long distance from the nearest HTC).

1.3.18 To initiate, provide training for, and supervise home therapy with clotting factor concentrates where available.

1.3.19 To educate patients, family members and other caregivers to ensure that the needs of the patient are met.

1.3.20 To collect data on sites of bleeds, types and doses of treatment given, assessment of long-term outcomes (particularly with reference to musculo­skeletal function), complications from treatment, and surgical procedures. This information is best recorded on the ABDR and should be updated regularly by an ABDR data manager or other designated person and maintained in accordance with confidentiality laws and other national regulations. Particular emphasis should be placed on recording of all bleeding events (both by HTC staff and by patients through ABDR and MyABDR), clotting factor administration (again both through the ABDR and MyABDR), joint outcome using the Haemophilia Joint Health Score, and an appropriate quality of life measure.

Systematic data collection will:

* facilitate the auditing of services provided by the HTC and support improvements to care delivery
* help inform allocation of resources
* promote collaboration between centres in sharing and publishing data.

1.3.21 Where possible, to conduct basic and clinical research. Since the number of patients in each centre may be limited, clinical research is best conducted in collaboration with other haemophilia centres.

### 1.4 Fitness and physical activity

1.4.1 **Physical activity should be encouraged to promote physical fitness and normal neuro­muscular development, with attention paid to muscle strengthening, coordination, general fitness, physical functioning, healthy body weight, and self-esteem. [15]**

1.4.2 Bone density may be decreased in people with haemophilia. [16, 17]

1.4.3 **For patients with significant musculoskeletal dysfunction, weight-bearing activities that promote development and maintenance of good bone density should be encouraged, to the extent their joint health permits. [16]**

1.4.4 The choice of activities should reflect an indi­vidual’s preference/interests, ability, physical condition, local customs, and resources.

1.4.5 Non-contact sports such as swimming, walking, golf, badminton, archery, cycling, rowing, sailing, and table tennis should be encouraged.

1.4.6 Decisions to participation in high contact and collision sports such as soccer, AFL, hockey, rugby, boxing, and wrestling, as well as high-velocity activities such as motocross racing and skiing, are best made after discussion with the HTC team and should take in to consideration the age of the individual, and the severity and type of their bleeding disorder. Because of the potential for life-threatening injuries any individual who decides to participate in such activities should have adequate prophylaxis cover.

1.4.7 Organised sports programs should be encour­aged as opposed to unstructured activities, where protective equipment and supervision may be lacking.

1.4.8 The patient should consult with a musculoskeletal professional before engaging in physical activi­ties to discuss their appropriateness, protective gear, prophylaxis (factor and other measures), and physical skills required prior to beginning the activity. This is particularly important if the patient has any problem/target joints. [18]

1.4.9 **Target joints can be protected with braces or splints during activity. [19,20]**

1.4.10 Activities should be re-initiated gradually after a bleed to minimise the chance of a re-bleed.

### 1.5 Adjunctive management

1.5.1 Adjunctive therapies are important, particularly where clotting factor concentrates are limited or not available, and may lessen the amount of treat­ment product required.

1.5.2 First aid measures: In addition to increasing factor level with clotting factor concentrates (or desmo­pressin in mild haemophilia A), protection (splint), rest, ice, compression, and elevation (PRICE) may be used as adjunctive management for bleeding in muscles and joints.

1.5.3 Physiotherapy/rehabilitation is particularly important for functional improvement and recovery after musculoskeletal bleeds and for those with established haemophilic arthropathy (see ‘Principles of physiotherapy/Physical medicine in haemophilia’, see section 6.1).

1.5.4 Antifibrinolytic drugs (e.g. tranexamic acid) are effective as adjunctive treatment for mucosal bleeds and dental extractions (see ‘Tranexamic acid’, section 4.3 and ‘‘Epsilon aminocaproic acid’, section 4.3).

1.5.5 Certain COX-2 inhibitors may be used judiciously for joint inflammation after an acute bleed and in chronic arthritis (see ‘Pain management’, section 1.9).

### 1.6 Prophylactic factor replacement therapy

1.6.1 Prophylaxis is the treatment by intravenous injec­tion of factor concentrate in order to prevent anticipated bleeding (see Table 1-4).

1.6.2 Prophylaxis was conceived from the observation that moderate haemophilia patients with clotting factor level >1 IU/dl seldom experience sponta­neous bleeding and have much better preservation of joint function. [21-24]

1.6.3 **Prophylaxis prevents bleeding and joint destruction and should be the goal of therapy to preserve normal musculoskeletal function. [24-29]**

1.6.4 Prophylactic replacement of clotting factor has been shown to be useful even when factor levels are not maintained above 1 IU/dl at all times. [26,29,30]

1.6.5 It is unclear whether all patients should remain on prophylaxis indefinitely as they transition into adulthood. Although some data suggest that a proportion of young adults can do well off prophylaxis [31] more studies are needed before a clear recommendation can be made. [32]

1.6.6 **In patients with repeated bleeding, particu­larly into target joints, short-term prophylaxis for four to eight weeks can be used to inter­rupt the bleeding cycle. This may be combined with intensive physiotherapy or synoviorthesis. [33,34]**

1.6.7 Prophylaxis does not reverse established joint damage; however, it decreases frequency of bleeding and may slow progression of joint disease and improve quality of life.

1.6.8 Cost-efficacy studies designed to identify minimum dosage are necessary to allow access to prophylaxis in more areas of the world.

**TABLE 1-4: DEFINITIONS OF FACTOR REPLACEMENT THERAPY PROTOCOLS [64]**

|  |  |
| --- | --- |
| PROTOCOL | DEFINITION |
| Episodic (“on demand”) treatment | Treatment given at the time of clinically evident bleeding |
| Continuous prophylaxis  Primary prophylaxis | Regular continuous\* treatment initiated in the absence of documented osteochondral joint disease, determined by physical examination and/or imaging studies, and started before the second clinically evident large joint bleed and age 3 years\*\* |
| Secondary prophylaxis | Regular continuous\* treatment started after 2 or more bleeds into large joints\*\* and before the onset of joint disease documented by physical examination and imaging studies |
| Tertiary prophylaxis | Regular continuous\* treatment started after the onset of joint disease documented by physical examination and plain radiographs of the affected joints |
| Intermittent (“periodic”) prophylaxis | Treatment given to prevent bleeding for periods not exceeding 45 weeks in a year |

\* continuous is defined as the intent of treating for 52 weeks/year and receiving a minimum of an a priori defined frequency of infusions for at least 45 weeks (85%) of the year under consideration.

\*\*large joints = ankles, knees, hips, elbows and shoulders

#### Administration and dosing schedules

1.6.9 There are two prophylaxis protocols currently in use for which there is long-term data:

* The Malmö protocol: 25-40 IU/kg per dose administered three times a week for those with haemophilia A, and twice a week for those with haemophilia B.
* The Utrecht protocol: 15-30 IU/kg per dose administered three times a week for those with haemophilia A, and twice a week for those with haemophilia B.

1.6.10 However, many different protocols are followed for prophylaxis, even within the same country, and the optimal regimen remains to be defined.

1.6.11 New long acting factor concentrates are likely to become available during the lifetime of this guideline. Available data suggest that prophylactic treatment with these agents, using a reduced frequency of administration, results in a similar reduction in annual bleeding rates as conventional prophylactic regimens with normal half-life factor concentrates.

1.6.12 The protocol should be individualised as much as possible, based on age, venous access, bleeding phenotype, pharmacokinetics, activity, and availability of clotting factor concentrates.

1.6.13 One alternative option for the treatment of very young children is to start prophylaxis once a week and escalate depending on bleeding and venous access.

1.6.14 Prophylaxis is best given in the morning to cover periods of activity.

1.6.15 **Prophylactic administration of clotting factor concentrates is advisable prior to engaging in activities with higher risk of injury. [18,34,35]**

### 1.7 Home therapy

1.7.1 Where appropriate and possible, persons with haemophilia should be managed in a home therapy setting. The decision to provide product for home therapy should take into account the likely frequency of administration of clotting factor and the likelihood of product expiry.

1.7.2 **Home therapy allows immediate access to clot­ting factor and hence optimal early treatment, resulting in decreased pain, dysfunction, and long-term disability and significantly decreased hospital admissions for complications. [36,37]**

1.7.3 Further improvements in quality of life include greater freedom to travel and participate in physical activities, less absenteeism, and greater employment stability. [38]

1.7.4 Home therapy is ideally achieved with clotting factor concentrates or other lyophilized products that are safe, can be stored in a domestic fridge, and are reconstituted easily.

1.7.5 **Home treatment must be supervised closely by the comprehensive care team and should only be initiated after adequate education and training. [36,37]**

1.7.6 Teaching should focus on general knowledge of haemophilia; recognition of bleeds and common complications; first aid measures; dosage calcula­tion; preparation, storage, and administration of clotting factor concentrates; aseptic techniques; performing venipuncture (or access of central venous catheter); record keeping; proper storage and disposal of needles/sharps; and handling of blood spills. A certification program is helpful.

1.7.7 Patients or parents should keep bleed records using MyABDR that include date and site of bleeding, dosage and lot number of product used, and adverse effects.

1.7.8 Infusion technique and bleed records should be reviewed and monitored at follow-up visits.

1.7.9 Home care can be started with young children with adequate venous access and motivated family members who have undergone adequate training. Older children and teenagers can learn self-infu­sion with family support.

1.7.10 **An implanted venous access device (Port-A-Cath) can make injections much easier and may be required for administering prophylaxis in younger children. [39,40]**

1.7.11 **However, the risks of surgery, local infection, and thrombosis associated with such devices need to be weighed against the advantages of starting intensive prophylaxis early. [41,42]**

1.7.12 The venous access device must be kept scrupu­lously clean and be adequately flushed after each administration to prevent clot formation. [41]

### 1.8 Monitoring health status and outcome

1.8.1 **Regular standardised evaluation at least every 12 months allows longitudinal assessment for individual patients and can identify new or potential problems in their early stages so that treatment plans can be modified. [14,26,43]**

1.8.2 Patients should be seen by the multidisciplinary care team after every severe bleeding episode.

1.8.3 The following should be evaluated and education should be reviewed and reinforced:

* issues related to venous access
* issues related to haemostasis (bleed record)
* use of products for replacement therapy and the response to them
* musculoskeletal status: impairment and function through clinical assessment of joints and muscles, and radiological evaluation annually or as indicated (see ‘Musculoskeletal complications’, section 6.1)
* transfusion-transmitted infections: commonly HIV, HCV, and HBV, and others if indicated (see ‘Transfusion-transmitted and other infection-related complications’, section 6.3)
* development of inhibitors (see ‘Inhibitors’, section 6.2)
* overall psychosocial status
* dental/oral health

1.8.4 Several haemophilia-specific scores are available to measure joint impairment and function, including activities and participation. These include:

* Impairment:
* Clinical: WFH Physical Examination Score (aka Gilbert score), Haemophilia Joint Health Score (HJHS)
* Radiological: Pettersson score, MRI, and ultrasound scores
* Activity: Haemophilia Activities List (HAL), Paediatric Haemophilia Activities List (PedHAL), Functional Independence Score in Haemophilia (FISH)
* Health-related quality of life: (HemoQol, Canadian Hemophilia Outcomes: Kids’ Life Assessment Tool [CHO-KLAT])

**TABLE 1-5: OUTCOME MEASURES TO BE RECORDED IN THE ABDR**

|  |  |
| --- | --- |
| ESSENTIAL | DESIRABLE |
| Annualised bleeding rate | Pharmacokinetic measures |
| Haemophilia Joint Health Score | Adverse events other than bleeds |
| All administered clotting factor concentrate – combined with weight this will allow the benchmarking parameter of usage summarised as (U/kg/year) to be calculated. | Details of immune tolerance treatment other than factor administration |
| Weight (recorded at least every 6 months for paediatric patients and at least every 2 years for adult patients) | Radiological measures |
|  | Quality of life measures (Haem-A-QOL for adults and CHO-KLAT for paediatric patients) |

### 1.9 Pain management

1.9.1 Acute and chronic pain are common in patients with haemophilia. Adequate assessment of the cause of pain is essential to guide proper management.

#### Pain caused by venous access

1.9.2 In general, no pain medication is given.

1.9.3 In some children, application of a local anaes­thetic spray or cream at the site of venous access, or use of nitrous oxide gas may be helpful.

#### Pain caused by joint or muscle bleeding

1.9.4 While clotting factor concentrates should be administered as quickly as possible to stop bleeding, additional drugs are often needed for pain control (see Table 1-6: Strategies for pain management in patients with haemophilia).

1.9.5 Other measures include cold packs, immobili­zation, splints, compression bandages and crutches. [44]

#### Post-operative pain

1.9.6 Intramuscular injection of analgesia should be avoided.

1.9.7 Post-operative pain should be managed in coor­dination with specialist acute pain services.

1.9.8 If intravenous opioids are required fentanyl, morphine and other opioids may be used. Oxycodone and tramadol should be used when pain is less severe and oral intake is possible. Codeine should be used with caution there is significant individual variation in its rate of metabolism to morphine.

1.9.9 Regular early use of paracetamol is recommended as part of all analgesic regimens.

#### Pain due to chronic haemophilic arthropathy

1.9.10 Chronic haemophilic arthropathy develops in patients who have not been adequately treated with clotting factor concentrates for joint bleeding.

1.9.11 **Treatment includes functional training, adap­tations, and adequate analgesia as suggested in Table 1-6. [15,45]**

1.9.12 **COX-2 inhibitors have a greater role in this situation. [46,47]**

A systematic review was performed to evaluate the efficacy and safety of COX-2 inhibitors in patients with haemophilia with and without pre-existing haemophilic arthropathy. (Appendix C) The following conclusions were made after available evidence was assessed using the GRADE criteria;

1. In patients with haemophilia and haemophilic arthropathy, COX-2 inhibitors probably lead to little or no difference in bleeding episodes compared with no COX-2 inhibitors.
2. In patients with haemophilia and haemophilic arthropathy, COX-2 inhibition probably improves pain compared with no use of COX-2 inhibitors.
3. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the impact of COX-2 inhibitors on recurrent haemarthrosis.
4. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the impact of COX-2 inhibitors on development of a target joint.
5. In patients with haemophilia, no studies were found that evaluated the impact of COX-2 inhibitors on cardiovascular events.
6. In patients with haemophilia, no studies were found that evaluated the impact of COX-2 inhibitors on the presence and severity of arthropathy.

1.9.13 **Other NSAIDs should be avoided. [48]**

A systematic review was performed to evaluate the efficacy and safety of non-selective NSAIDs in patients with haemophilia with and without pre-existing haemophilic arthropathy. (Appendix C) The following conclusions were made after available evidence was assessed using the GRADE criteria;

1. In patients with mild or moderate haemophilia, medium term[[1]](#footnote-1) ibuprofen may lead to little or no difference in the occurrence of bleeding episodes compared with no ibuprofen.
2. In patients with haemophilia, the use of NSAIDs probably leads to little or no difference in the occurrence of upper gastrointestinal (UGI) bleeding compared with no NSAIDs.
3. In patients with moderate or severe haemophilia and arthropathy, it is uncertain whether ibuprofen improves arthropathy symptoms because the certainty of the evidence is very low.
4. In patients with haemophilia, no studies were found that evaluated the impact of NSAIDs on cardiovascular events.
5. In patients with haemophilia, with or without arthropathy, ibuprofen may lead to little or no difference in bleeding time compared with no ibuprofen.
6. In patients with haemophilia, ibuprofen may improve pain compared with no ibuprofen.
7. In patients with haemophilia, ibuprofen may lead to little or no difference in joint restriction.
8. In patients with haemophilia and arthropathy, ibuprofen probably decreases the duration of morning stiffness compared with no ibuprofen.

As the level of evidence for the benefit of NSAIDs is low, and there are theoretical evidence that COX-2 inhibitors may be associated with less bleeding risk than non-selective NSAID use, COX-2 inhibitors are the preferred agents in patients with haemophilia.

1.9.14 **When pain is disabling, orthopedic surgery may be indicated. [49]**

1.9.15 Patients with persisting pain should be referred to a specialised pain management team.

**TABLE 1-6: STRATEGIES FOR PAIN MANAGEMENT IN PATIENTS WITH HAEMOPHILIA**

|  |  |
| --- | --- |
| 1 | Paracetamol/acetaminophen  *If not effective* |
| 2 | COX-2 inhibitor (e.g. celecoxib, meloxicam, and others)  OR  Paracetamol/acetaminophen plus tramadol (3-4 times/day) |
| 3 | Opiate analgesia: use a slow release product such as controlled-release oxycodone, tramadol SR, tapentadol SR or controlled release morphine. |

Notes:

* If for any reason medications have been stopped for a period of time, patients who have been taking and tolerating high-dose narcotic drugs should re-start the drug at a lower dose, or use a less powerful painkiller, under the supervision of a physician.
* COX-2 inhibitors should be used with caution in patients with hypertension and renal dysfunction.
* It is recommended that patients with chronic pain requiring long-term narcotic analgesia should be managed in liaison with a specialist pain service with clear communication with their primary care provider.

### 1.10 Surgery and invasive procedures

1.10.1 Surgery may be required for haemophilia-related complications or unrelated diseases. The following issues are of prime importance when performing surgery on persons with haemophilia.

1.10.2 Surgery for patients with haemophilia will require additional planning and interaction with the healthcare team than what is required for other patients. Appropriate surgical intervention should be available for all patients with haemophilia regardless of the underlying severity of their bleeding disorder.

1.10.3 **A haemophilia patient requiring surgery is best managed at or in consultation with a comprehensive haemophilia treatment centre. [50,51] Emergency surgical procedures may be required to be conducted in non-haemophilia treatment centres, but should be performed in close consultation with the staff of haemophilia treatment centres.**

1.10.4 The anaesthetist should have experience treating patients with bleeding disorders.

1.10.5 Adequate laboratory support is required for reliable monitoring of clotting factor level and inhibitor testing.

1.10.6 **Pre-operative assessment should include inhib­itor screening and inhibitor assay, and possibly PK assessment, particularly if the recovery of the replaced factor is signif­icantly less than expected. [52,53]**

1.10.7 Surgery should be scheduled early in the week and early in the day for optimal laboratory and blood bank support, if needed.

1.10.8 Adequate quantities of clotting factor concen­trates should be available for the surgery itself and to maintain adequate coverage post-opera­tively for the length of time required for healing and/or rehabilitation.

1.10.9 In exceptional circumstances, if clotting factor concentrates are not available, blood bank support for the provision of alternative plasma compo­nents may be needed.

1.10.10 The dosage and duration of clotting factor concentrate coverage depends on the type of surgery performed (see Table 7-1).

1.10.11 Effectiveness of haemostasis for surgical proce­dures may be judged as per criteria defined by the Scientific and Standardization Committee of the International Society on Thrombosis and Haemostasis (see Table 1-7) [64].

1.10.12 **Patients with mild or moderate haemophilia A, as well as patients receiving intensive factor replacement for the first time, are at particular risk of inhib­itor development and should be re-screened 4–12 weeks post-operatively. [54]**

1.10.13 **Mutation testing may be used to further assess the risk of inhibitor formation in the post-operative period in patients with mild to moderate haemophilia. Mutation analysis should ideally be performed prior to major invasive procedures.**

1.10.14 Careful monitoring for inhibitors is also advis­able in patients with non-severe haemophilia A receiving continuous infusion after surgery, particularly in individuals with high risk mutations. [55]

1.10.15 Infusion of factor concentrates/haemostatic agents is necessary before invasive diagnostic proce­dures such as lumbar puncture, arterial blood gas determination, or any endoscopy with biopsy.

**TABLE 1-7: DEFINITION OF ADEQUACY OF HAEMOSTASIS FOR SURGICAL PROCEDURES [64]**

|  |  |
| --- | --- |
| Excellent | Intra-operative and post-operative blood loss similar (within 10%) to the non-haemophilic patient.  ■ No extra (unplanned) doses of FVIII/FIX/bypassing agents needed AND  ■ Blood component transfusions required are similar to non-haemophilic patient |
| Good | Intra-operative and/or post-operative blood loss slightly increased over expectation for the non-haemophilic patient (between 10-25% of expected), but the difference is judged by the involved surgeon/anaesthetist to be clinically insignificant.  ■ No extra (unplanned) doses of FVIII/FIX/bypassing agents needed AND  ■ Blood component transfusions required are similar to the non-haemophilic patient |
| Fair | Intra-operative and/or post-operative blood loss increased over expectation (25-50%) for the non-haemophilic patient and additional treatment is needed.  ■ Extra (unplanned) dose of FVIII/FIX/bypassing agents needed OR  ■ Increased blood component (within 2 fold) of the anticipated transfusion requirement |
| Poor/none | Significant intra-operative and/or post-operative blood loss that is substantially increased over expectation (>50%) for the non-haemophilic patient, requires intervention, and is not explained by a surgical/medical issue other than haemophilia  ■ Unexpected hypotension or unexpected transfer to ICU due to bleeding OR  ■ Substantially increased blood component (> 2 fold) of the anticipated transfusion requirement |

Notes:

* Apart from estimates of blood loss during surgery, data on pre- and post-operative haemoglobin levels and the number of packed red blood cell units transfused may also be used, if relevant, to estimate surgical blood loss
* Surgical haemostasis should be assessed by an involved surgeon and/or anaesthetist and records should be completed within 72 hours following surgery
* Surgical procedures may be classified as major or minor. A major surgical procedure is defined as one that requires haemostatic support for periods exceeding 5 consecutive days.

### 1.11 Dental care and management

1.11.1 For persons with haemophilia, good oral hygiene is essential to prevent periodontal disease and dental caries, which predispose to gum bleeding. [56]

1.11.2 Dental examinations should be conducted regu­larly, starting at the time the baby teeth start to erupt.

1.11.3 Teeth should be brushed twice a day with a medium texture brush to remove plaque deposits.

1.11.4 Dental floss or interdental brushes should be used wherever possible.

1.11.5 Toothpaste containing fluoride should be used in areas where natural fluoride is not present in the water supply. Fluoride supplements may also be prescribed if appropriate.

1.11.6 An orthodontic assessment should be recommended for all patients between the ages of 10–14 in order to determine if there are any problems associated with overcrowding, which can result in periodontal disease if left untreated.

1.11.7 Close liaison between the dental surgeon and the haemophilia team is essential to provide good comprehensive dental care.

1.11.8 **Treatment can be safely carried out under local anaesthesia using the full range of techniques available to dental surgeons. Infiltration, intra-papillary, and intra-ligamentary injections are often done under factor cover (20-40%) though it may be possible for those with adequate expe­rience to administer these injections without it.  [57,58]**

1.11.9 Treatment from the haemophilia unit may be required before an inferior alveolar nerve block or lingual infiltration.

1.11.10 **Dental extraction or surgical procedures carried out within the oral cavity should be done with a plan for haemostasis management, in consul­tation with the haematologist. [51]**

1.11.11 **Tranexamic acid is often used to cover dental procedures to reduce the need for replacement therapy. [59,60]**

1.11.12 Oral antibiotics should only be prescribed if clin­ically necessary.

1.11.13 Local haemostatic measures may also be used whenever possible following a dental extraction. Typical products include oxidized cellulose and fibrin glue.

1.11.14 Following a tooth extraction, the patient should be advised to avoid hot food and drinks until normal feeling has returned. Smoking should be avoided as this can cause problems with healing. Regular warm salt water mouthwashes (a teaspoon of salt in a glass of warm water) should begin the day after treatment and continue for five to seven days or until the mouth has healed.

1.11.15 Prolonged bleeding and/or difficulty in speaking, swallowing, or breathing following dental manip­ulation should be reported to the haematologist/dental surgeon immediately.

1.11.16 Non-steroidal anti-inflammatory drugs (NSAIDs) and aspirin must be avoided.

1.11.17 An appropriate dose of paracetamol every six hours for two to three days will help prevent pain following an extraction.

1.11.18 The presence of blood-borne infections should not affect the availability of dental treatment.

1.11.19 Prevention of bleeding at the time of dental proce­dures in patients with inhibitors to FVIII or FIX requires careful planning. [61]

**References**

1. Stonebraker JS, Bolton-Maggs PH, Soucie JM, Walker I, Brooker M. A study of variations in the reported haemophilia A prevalence around the world. *Haemophilia* 2010;16(1):20-32.
2. Ingram GI, Dykes SR, Creese AL, Mellor P, Swan AV, Kaufert JK, Rizza CR, Spooner RJ, Biggs R. Home treatment in hemophilia: clinical, social and economic advantages. *Clin Lab Haematol* 1979;1(1):13-27.
3. Singleton T, Kruse-Jarres R, Leissinger C. Emergency department care for patients with hemophilia and von Willebrand disease. *J Emerg Med* 2010;39(2):158-65.
4. Castaman G, Mancuso ME, Giacomelli SH, et al. Molecular and phenotypic determinants of the response to desmopressin in adult patients with mild hemophilia A. *J Thromb Hemost* 2009;7(11):1824-31.
5. Franchini M, Zaffanello M, Lippi G. The use of desmopressin in mild hemophilia A. *Blood Coagul Fibrinolysis* 2010;21(7):615-9.
6. Mannucci PM. Desmopressin (DDAVP) in the treatment of bleeding disorders: the first twenty years. *Haemophilia* 2000;6(Suppl 1):60-67.
7. Berntorp E, Boulyzenkov V, Brettler D, et al. Modern treatment of hemophilia. *Bull WHO* 1995;73:691-701.
8. Kasper CK, Mannucci PM, Boulyzenkov V, et al. Hemophilia in the 1990s: Principles of treatment and improved access to care. *Semin Thrombosis Hemostas* 1992;18:1-10.
9. Soucie JM, Nuss R, Evatt B, Abdelhak A, Cowan L, Hill H, Kolakoski M, Wilber N; Hemophilia Surveillance System Project Investigators. Mortality among males with hemophilia: relations with source of medical care. *Blood* 2000;96:437–42.
10. Colvin BT, Astermark J, Fischer K, Gringeri A, Lassila R, Schramm W, Thomas A, Ingerslev J; Inter Disciplinary Working Group. European principles of hemophilia care. *Hemophilia* 2008;14(2):361-74.
11. Evatt BL. The natural evolution of hemophilia care: developing and sustaining comprehensive care globally. *Hemophilia* 2006;12(Suppl 3):13-21.
12. Evatt BL, Black C, Batorova A, Street A, Srivastava A. Comprehensive care for hemophilia around the world. *Hemophilia* 2004;10(Suppl 4):9-13.
13. Canadian Hemophilia Standards Group. Canadian Comprehensive Care Standards for Hemophilia and Other Inherited Bleeding Disorders, First Edition, June 2007. http://www.ahcdc.ca/documents/ CanadianHemophiliaStandardsFirstEdition070612\_1.pdf (Accessed September 4, 2011).
14. de Moerloose P, Fischer K, Lambert T, Windyga J, Batorova A, Lavigne-Lissalde G, Rocino A, Astermark J, Hermans C. Recommendations for assessment, monitoring and follow-up of patients with hemophilia. *Hemophilia* 2012 May;18(3):319-25.
15. Gomis M, Querol F, Gallach JE, Gonzalez LM, Aznar JA. Exercise and sport in the treatment of hemophilic patients: a systematic review. *Hemophilia* 2009;15(1):43-54.
16. Iorio A, Fabbriciani G, Marcucci M, Brozzetti M, Filipponi P. Bone mineral density in hemophilia patients: a meta-analysis. *Thromb Hemost* 2010;103(3):596-603.
17. Wallny TA, Scholz DT, Oldenburg J, et al. Osteoporosis in hemophilia - an underestimated comorbidity? *Hemophilia* 2007;13(1):79-84.
18. Seuser A, Boehm P, Kurme A, Schumpe G, Kurnik K. Orthopaedic issues in sports for persons with hemophilia. *Hemophilia* 2007;13(Suppl 2):47–52.
19. Philpott J, Houghton K, Luke A. Physical activity recommendations for children with specific chronic health conditions: Juvenile idiopathic arthritis, hemophilia, asthma and cystic fibrosis. *Paediatr Child Health* 2010;15(4):213-25.
20. Querol F, Aznar JA, Haya S, Cid A. Orthoses in hemophilia. *Hemophilia* 2002;8(3):407-12.
21. Fischer K, Van der Bom JG, Mauser-Bunschoten EP, et al. Changes in treatment strategies for severe hemophilia over the last 3 decades: effects on clotting factor consumption and arthropathy. *Hemophilia* 2001; 7: 446-52.
22. Löfqvist T, Nilsson IM, Berntorp E, Pettersson H. Hemophilia prophylaxis in young patients: a long-term follow-up. *J Intern Med* 1997;241:395-400.
23. Nilsson IM, Berntorp E, Löfqvist T, Pettersson H. Twenty-five years’ experience of prophylactic treatment in severe hemophilia A and B. *J Intern Med* 1992;232(1):25-32.
24. Aronstam A, Arblaster PG, Rainsford SG, Turk P, Slattery M, Alderson MR, et al. Prophylaxis in hemophilia: a double-blind controlled trial. *Br J Haematol* 1976;33(1):81-90.
25. Astermark J, Petrini P, Tengborn L, et al. Primary prophylaxis in severe hemophilia should be started at an early age but can be individualized. *Br J Haematol* 1999;105:1109-13.
26. Feldman BM, Pai M, Rivard GE, et al. Tailored prophylaxis in severe hemophilia A: interim results from the first 5 years of the Canadian Hemophilia Primary Prophylaxis Study. *J Thromb Hemost* 2006; 4(6):1228-36.
27. Fischer K, Van der Bom JG, Mauser-Bunschoten EP, et al. Effects of postponing prophylactic treatment on long-term outcome in patients with severe hemophilia. *Blood* 2002;99:2337-41.
28. Gringeri A, Lundin B, Mackensen SV, et al; ESPRIT Study Group. A randomized clinical trial of prophylaxis in children with hemophilia A (the ESPRIT Study*). J Thromb Hemost* 2011;9(4):700-10.
29. Manco-Johnson MJ, Abshire TC, Shapiro AD, et al. Prophylaxis versus episodic treatment to prevent joint disease in boys with severe hemophilia. *NEJM* 2007;357(6):535-44.
30. Petrini P. What factors should influence the dosage and interval of prophylactic treatment in patients with severe hemophilia A and B? *Hemophilia* 2001;7(1):99-102.
31. Fischer K, Van Der Bom JG, Prejs R, et al. Discontinuation of prophylactic therapy in severe hemophilia: incidence and effects on outcome. *Hemophilia* 2001;7(6):544-50.
32. Hay CR. Prophylaxis in adults with hemophilia. *Hemophilia* 2007;13(Suppl 2):10-5.
33. Kavakli K, Aydogdu S, Taner M, et al. Radioisotope synovectomy with rhenium186 in hemophilic synovitis for elbows, ankles and shoulders. *Hemophilia* 2008;14(3):518-23.
34. Luchtman-Jones L, Valentino LA, Manno C; Recombinant Therapy Workshop Participants. Considerations in the evaluation of hemophilia patients for short-term prophylactic therapy: a paediatric and adult case study. *Hemophilia* 2006;12(1):82-6.
35. Petrini P, Seuser A. Hemophilia care in adolescents—compliance and lifestyle issues. *Hemophilia* 2009; 15 Suppl 1:15-9.
36. Soucie JM, Symons J, Evatt B, Brettler D, Huszti H, Linden J; Hemophilia Surveillance System Project Investigators. Home-based factor infusion therapy and hospitalization for bleeding complications among males with hemophilia. *Hemophilia* 2001;7:198-206.
37. Teitel JM, Barnard D, Israels S, Lillicrap D, Poon MC, Sek J. Home management of hemophilia. *Hemophilia* 2004;10(2):118-33.
38. Szucs TD, Offner A, Kroner B, et al; European socioeconomic study group. Resource utilization in hemophiliacs treated in Europe: results from the European study on socioeconomic aspects of hemophilia care. *Hemophilia* 1998;4(4):498-501.
39. Neunert CE, Miller KL, Journeycake JM, et al. Implantable central venous access device procedures in hemophilia patients without an inhibitor: systematic review of the literature and institutional experience. *Hemophilia* 2008;14(2):260-70.
40. Valentino LA, Ewenstein B, Navickis RJ, Wilkes MM. Central venous access devices in hemophilia. *Hemophilia* 2004;10(2):134-46.
41. Ljung R.The risk associated with indwelling catheters in children with hemophilia. *Br J Haematol* 2007;138(5):580-6.
42. Ragni MV, Journeycake JM, Brambilla DJ. Tissue plasminogen activator to prevent central venous access device infections: a systematic review of central venous access catheter thrombosis, infection and thromboprophylaxis. *Hemophilia* 2008;14(1):30-8.
43. Su Y, Wong WY, Lail A, Donfield SM, Konzal S, Gomperts E; Hemophilia Growth And Development Study. Long-term major joint outcomes in young adults with hemophilia: interim data from the HGDS. *Hemophilia* 2007;13(4):387-90.
44. Hermans C, de Moerloose P, Fischer K, Holstein K, Klamroth R, Lambert T, et al; European Hemophilia Therapy Standardisation Board. Management of acute haemarthrosis in hemophilia A without inhibitors: literature review, European survey and recommendations. *Hemophilia* 2011;17(3):383-92.
45. Vallejo L, Pardo A, Gomis M, et al. Influence of aquatic training on the motor performance of patients with hemophilic arthropathy. *Hemophilia* 2010;16(1):155-61.
46. Rattray B, Nugent DJ, Young G. Celecoxib in the treatment of hemophilic synovitis, target joints, and pain in adults and children with hemophilia. *Hemophilia* 2006;12(5):514-7.
47. Tsoukas C, Eyster ME, Shingo S, et al. Evaluation of the efficacy and safety of etoricoxib in the treatment of hemophilic arthropathy. *Blood* 2006;107(5):1785-90.
48. Eyster ME, Asaad SM, Gold BD, Cohn SE, Goedert JJ; Second Multicenter Hemophilia Study Group. Upper gastrointestinal bleeding in hemophiliacs: incidence and relation to use of non-steroidal anti-inflammatory drugs. *Hemophilia* 2007;13(3):279-86.
49. Rodriguez-Merchan EC. Musculoskeletal complications of hemophilia. *HSSJ* 2010;6:37-42.
50. Batorova A, Martinowitz U. Intermittent injections vs. continuous infusion of factor VIII in hemophilia patients undergoing major surgery. *Br J Haematol* 2000;110(3):715-20.
51. Hermans C, Altisent C, Batorova A, et al.; European Hemophilia Therapy Standardisation Board. Replacement therapy for invasive procedures in patients with hemophilia: literature review, European survey and recommendations. *Hemophilia* 2009;15(3):639-58.
52. Mathews V, Viswabandya A, Baidya S, George B, Nair S, Chandy M, Srivastava A. Surgery for hemophilia in developing countries. *Semin Thromb Hemost* 2005;31(5):538-43.
53. Teitel JM, Carcao M, Lillicrap D, et al. Orthopaedic surgery in hemophilia patients with inhibitors: a practical guide to hemostatic, surgical and rehabilitative care. *Hemophilia* 2009;15(1):227-39.
54. Kempton CL, Soucie JM, Miller CH, et al. In non-severe hemophilia A the risk of inhibitor after intensive factor treatment is greater in older patients: a case-control study. *J Thromb Hemost* 2010;8(10):2224-31.
55. Eckhardt CL, Van der Bom JG, Van der Naald M, Peters M, Kamphuisen PW and Fijnvandraat K. Surgery and inhibitor development in hemophilia A: a systematic review. *J Thromb Hemost* 2011;9:1948–1958.
56. Friedman M, White B, Dougall AJ. An audit of the protocol for the management of patients with hereditary bleeding disorders undergoing dental treatment. *J Disab Oral Health* 2009;10(4):151-55.
57. Frachon X, Pommereuil M, Berthier AM, et al. Management options for dental extraction in hemophiliacs: a study of 55 extractions (2000-2002). *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2005;99(3):270-5.
58. Hewson I, Makhmalbaf P, Street A, et al. Dental surgery with minimal factor support in the inherited bleeding disorder population at the Alfred Hospital. *Hemophilia* 2011;17(1):e185-8.
59. Coetzee MJ. The use of topical crushed tranexamic acid tablets to control bleeding after dental surgery and from skin ulcers in hemophilia. *Hemophilia* 2007;13(4):443-4.
60. Franchini M, Rossetti G, Tagliaferri A, et al. Dental procedures in adult patients with hereditary bleeding disorders: 10 years experience in three Italian Hemophilia Centers. *Hemophilia* 2005;11:504–9.
61. Brewer A. *Dental Management of Patients with Inhibitors to Factor VIII or Factor IX*. Treatment of Hemophilia monograph no 45. Montreal: World Federation of Hemophilia, 2008.
62. White GC 2nd, Rosendaal F, Aledort LM, Lusher JM, Rothschild C, Ingerslev J. Definitions in hemophilia. Recommendation of the scientific subcommittee on factor VIII and factor IX of the scientific and standardization committee of the International Society on Thrombosis and Hemostasis. *Thromb Hemost* 2001;85(3):560.
63. Aronstam A, Rainsford SG, Painter MJ. Patterns of bleeding in adolescents with severe hemophilia A. *Br Med J* 1979;1(6161):469-70.
64. Definitions in hemophilia. Recommendations of the scientific subcommittee on factor VIII and factor IX of the scientific and standardization committee of the International Society on Thrombosis and Hemostasis. *JTH* 2012 (in press).
65. ABDR Annual Report 2012-13

## 2 SPECIAL MANAGEMENT ISSUES

**Key practice points**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 2.1** | Women who are carriers of the haemophilia gene may have reduced clotting factor levels and an increased risk of bleeding. Such women should have their clotting factor level documented. |
| **PP 2.2** | Active intervention may be required to reduce bleeding risk in haemophilia carriers with reduced clotting factor levels, particularly around invasive procedures. |
| **PP 2.3** | Genetic counselling should be offered to all individuals with haemophilia, carriers and their partners as part of routine care. |
| **PP 2.4** | Genetic testing may also help with assessing individual risk of inhibitor development. |
| **PP 2.5** | Delivery of infants with known or suspected haemophilia should be atraumatic and forceps delivery or vacuum extraction should be avoided. Ideally delivery should occur in hospitals with a “high risk” obstetric service, in close liaison with a haemophilia treatment centre. |
| **PP 2.6** | Social work review is a central component of haemophilia management. |
| **PP 2.7** | Individuals with haemophilia are at risk of common age related diseases. Monitoring and appropriate treatment of these conditions in liaison with the patients general practitioner is an important component of clinical care. |

**Significant changes from the original WFH Guidelines**

1. It is emphasised that genetic testing should be offered to all at risk female family members to facilitate genetic counselling.
2. The likely future role of non-invasive methods to determine fetal gender are highlighted.
3. The recommended age for CVS is altered to be consistent with local guidelines.
4. Delivery of haemophilia carriers should ideally occur in hospitals with a “high risk” obstetric service, a paediatric unit, and a HTC. This is particularly the case if it is likely the offspring may have a severe bleeding disorder.
5. It is recommended that dosing of obese patients should be based on ideal body weight.

### 2.1 Carriers

2.1.1 Haemophilia is an X-linked disorder that typically affects males, while females are normally classified as carriers. It is important to note than affected males will pass on the haemophilia gene to their daughters, and that women carrying a factor F8 or F9 gene mutation may have reduced factor levels and as such should be classified as having haemophilia.

2.1.2 Obligate carriers are:

* daughters of a male with haemophilia
* mothers of one son with haemophilia and who have at least one other family member with haemophilia
* mothers of one son with haemophilia and who have a family member who is a known carrier of the haemophilia gene
* mothers of two or more sons with haemophilia.

2.1.3 The expected mean clotting factor level in carriers of haemophilia is 50% of the levels found in the healthy population. [1,2]

2.1.4 Most carriers are asymptomatic.

2.1.5 Carriers with clotting factor levels of 40-60% of normal may have an increased bleeding tendency, although this may not correlate well with factor level. [3]

2.1.6 Some carriers may have clotting factor levels in the range seen in males with haemophilia — mostly in the mild cate­gory (5-40%) —but in rare instances, carriers can be in the moderate or severe range due to extreme lyoniza­tion.

2.1.7 Carriers with clotting factor levels in the haemo­philia range may be symptomatic with bleeding manifestations commensurate with their degree of clotting factor deficiency, particularly during trauma and surgery. [3]

2.1.8 Menorrhagia and bleeding after medical interven­tions are the most common manifestations among women with significantly low factor levels. [3]

2.1.9 **Carriers with low clotting factor levels should be categorised as having haemophilia of appropriate severity and managed accordingly.**

2.1.10 Use of the oral contraceptive pill and tranexamic acid may be useful in controlling symptoms of menorrhagia. In women with persistent menorrhagia despite these measures consideration should be given to use of Mirena intrauterine device. Use of desmopressin may also be beneficial in some women.

2.1.11 Levels of factor VIII increase significantly in preg­nancy. Levels of factor IX, however, do not usually change significantly. [4]

2.1.12 **Immediate female relatives (mother, sisters, and daughters) of a person with haemophilia should have their clotting factor level checked, especially prior to any invasive intervention, childbirth, or if bleeding symptoms occur. [3,5]**

### 2.2 Genetic testing/counselling and prenatal diagnosis

2.2.1 **Genetic testing for carrier status should be offered to at-risk female family members of people with haemophilia to facilitate genetic counselling, and if desired by the family, for prenatal diagnosis. [6]****Mutation analysis is best performed on an affected male in the first instance. Cascade carrier testing ought to be offered to female first-degree relatives. If the female is a carrier, then clotting studies including FVIII ought to be undertaken. Ideally management advice and genetic counselling in carriers ought to be provided through a centre with experience in managing haemophilia A.**

2.2.2 DNA-based mutation analysis to identify the specific mutation responsible for haemophilia in a particular family is becoming technically easier and more widely available. This facilitates iden­tification of women carrying a F8 or F9 gene mutation and prenatal diagnosis for male fetuses.

2.2.3 Genetic counselling is key to helping people with haemophilia, carriers, and their families make more informed choices.

2.2.4 Genetic testing may be helpful to determine risk of inhibitor formation in individuals with haemophilia, particularly in individuals with mild or moderate disease.

2.2.5 Prenatal diagnosis is usually offered when termi­nation of the pregnancy would be considered if an affected fetus was identified. However, it may also be done to help the family prepare and to plan delivery. Assisted delivery is best avoided in an affected fetus.

2.2.6 Fetal gender can be determined using Y chromo­some-specific PCR in maternal plasma/serum after 7-9 weeks of gestation [7,8] or by ultraso­nography beginning week 11 of gestation. [9] Non-invasive prenatal techniques utilising maternal blood sampling to determine gender are likely to replace the above methods in the near future.

2.2.7 **Chorionic villus sampling (CVS), or biopsy, is the main method of prenatal diagnosis and is best done between 11-14 weeks of gestation. Biopsy carried out earlier may be associated with increased complications including fetal limb abnormalities. [10-13]**

2.2.8 Amniocentesis can be done at 15-17 weeks of gestation. [11]

2.2.9 The above procedures should be performed by an appropriately medically registered practitioner.

2.2.10 For women with low clotting factor levels haemostatic support may be required to prevent maternal bleeding during prenatal diagnosis procedures.

2.2.11 **All invasive methods used for prenatal diag­nosis may cause feto-maternal haemorrhage. Anti-D immunoglobulin should be given if the mother is RhD negative.[14]**

2.2.12 IVF with pre-implantation genetic diagnosis allows selection of embryos without a specific known mutation to be transferred into the uterus. [15]

### 2.3 Delivery of infants with known or suspected haemophilia

2.3.1 **FVIII levels usually rise into the normal range during the second and third trimesters and should therefore be measured in carriers during the early third trimester of pregnancy to inform decisions for factor coverage during delivery. [4]**

2.3.2 **In women with significantly low factor levels (< 50 IU/dl), clotting factor replacement is necessary for surgical or invasive procedures including delivery.[4]**

2.3.3 The need for clotting factor replacement should be planned in the prenatal period.

2.3.4 Ideally delivery should occur in hospitals with a “high risk” obstetric service, a paediatric unit, and a HTC. This is particularly the case if it is likely the offspring may have a severe bleeding disorder.

2.3.5 Route of delivery in carriers with a normal fetus should be as per obstetric indications.

2.3.6 **Delivery of infants with known or suspected haemophilia should be atraumatic, regardless of whether it is vaginal or caesarean, to decrease the risk of bleeding. [4]**

2.3.7 Forceps and vacuum extraction **should be avoided** in vaginal delivery, as well as invasive procedures to the fetus such as fetal scalp blood sampling and internal fetal scalp electrodes. [16]

### 2.4 Vaccinations

2.4.1 **Persons with bleeding disorders should be vaccinated, but should preferably receive the vaccine subcutaneously rather than intra­muscularly or intradermally, unless covered by infusion of clotting factor concentrates. [17]**

2.4.2 If intramuscular injection is to be given: It is best done soon after a dose of factor replacement therapy.

* An ice pack can be applied to the injection area for five minutes before injection
* The smallest gauge needle available (usually 25-27 gauge) should be used
* Pressure should be applied to the injection site for at least five minutes. [18]

2.4.3 Live virus vaccines (such as oral polio vaccine, MMR) may be contraindicated in those with HIV infection.

2.4.4 People with haemophilia who have HIV should be given pneumococcal and annual influenza vaccines.

2.4.5 **Immunisation to hepatitis A and B is important for all persons with haemophilia. These immu­nisations may not be as effective in those with HIV infection. [19,20]**

### 2.5 Psychosocial issues

2.5.1 Patients and their families should be provided with psychological and social support. [21,22]

2.5.2 Haemophilia is also a financial burden that places restrictions on several aspects of normal living. [23]

2.5.3 The social worker and/or other members of the comprehensive care team should:

* provide as much information as possible about the physical, psychological, emotional, and economic dimensions of haemophilia, in terms the patient/parents can understand
* be open and honest about all aspects of care
* allow the patient/parents to work through their emotions and ask questions.
* Provide care and support patiently
* talk to affected children, not just their parents. Children can often understand a good deal about their illness and can work with the physi­cian if properly informed and educated
* remind parents not to ignore siblings that are healthy
* be able to recognise warning signs of burnout and depression, which are common with chronic illness, and provide suggestions for coping
* recognise that cultural background may affect patients’ views of illness
* encourage patients to engage in productive and leisure activities at home and in the workplace
* work in partnership with the patient organi­sation to advocate for haemophilia care and to provide education to families and members of the community
* enlist the assistance of local groups and orga­nisations where social workers are unavailable
* involve the school in the care of the patient –to avoid discrimination or bullying of individuals with bleeding disorders
* promote participation in HFA sponsored programs including MyABDR.

### 2.6 Sexuality

2.6.1 Patients with haemophilia can have normal sexual intercourse. [24]

2.6.2 Muscle bleedings (for e.g. iliopsoas) may some­times be the result of sexual activity.

2.6.3 Complications of haemophilia can be accompa­nied by sexual dysfunction, which may include lack of libido or impotence.

2.6.4 Pain or fear of pain may affect sexual desire, and haemophilic arthropathy may place limitations on sexual intercourse.

2.6.5 Sexuality is also affected by chronic HCV and HIV infection, age-related diseases like hyper­tension and diabetes mellitus, and certain medications.

2.6.6 In some cases, oral phosphodiesterase-5 inhib­itors (sildenafil, tadalafil) may be helpful. These medications mildly inhibit platelet aggregation in vitro, and may cause epistaxis due to nasal congestion.

### 2.7 Ageing haemophilia patients

2.7.1 Ageing patients with haemophilia will inevitably suffer from age-related diseases. [24,25]

2.7.2 Comorbidities in ageing haemophilia patients should be managed appropriately as they may accentuate problems associated with haemophilia and impact the patient’s physical and psychoso­cial health, and thus their quality of life.

#### Osteoporosis

2.7.3 Bone mineral density (BMD) is decreased in people with haemophilia. [26,27]

2.7.4 An increased number of arthropathic joints, loss of joint movement, and muscle atrophy leading to inactivity are associated with a lower BMD. [27] It is recommended that BMD should be routinely checked in individuals with these additional risk factors for reduced bone density.

2.7.5 Weight-bearing activities (suitable sports) that promote development and maintenance of good bone density should be encouraged if joint health permits.

2.7.6 Calcium and vitamin D supplementation are also important and bisphosphonate therapy may be required. A dental evaluation is advis­able before initiating long-term bisphosphonate therapy. [28,29]

#### Obesity

2.7.7 The prevalence of overweight (BMI 25-30 kg/m2) and obesity (BMI > 30kg/m2) is increasing. [30]

2.7.8 Lack of activity may contribute to an increase in BMI and increased body weight.

2.7.9 A high BMI has been associated with: a significant limitation in range of motion (ROM) [31]

* increased arthropathic pain
* increased risk of developing target joints [32]
* increased risk of diabetes mellitus, atheroscle­rosis, and cardiovascular disease, which may further damage arthropathic joints.

2.7.10 Regular physical activity should be advised.

2.7.11 If functional limitations restrict daily activities, a physiotherapist familiar with haemophilia may be able to suggest appropriate alternatives.

2.7.12 In some cases referral to a dietician may be indicated.

2.7.13 Dosing of FVIII in obese patients should be based on Ideal body weight. [33]

#### Hypertension

2.7.14 Haemophilia patients have a higher mean blood pressure, are twice as likely to have hyperten­sion, and use more anti-hypertensive medication compared to the general population. [34,35]

2.7.15 In view of increased risk of bleeding, hyperten­sive patients with haemophilia should be treated adequately and have their blood pressure checked as part of routine clinical review.

2.7.16 In the absence of other cardiovascular risk factors, a systolic blood pressure ≤140 mmHg and a diastolic pressure ≤90 mmHg should be maintained.

#### Diabetes mellitus (DM)

2.7.17 The prevalence of DM in haemophilia is not well documented, but was observed to be higher in a cohort of mild haemophilia. [36]

2.7.18 In ageing haemophilia patients, especially among those who are overweight, glucose levels should be checked annually.

2.7.19 **If treatment with insulin is indicated, subcuta­neous injections can be administered without bleeding complications. [24]**

#### Hypercholesterolemia

2.7.20 Mean cholesterol levels in patients with haemo­philia have been reported to be lower than in the general population. [37]

2.7.21 Cholesterol levels (total cholesterol, HDL, and LDL fraction) should be measured in ageing haemophilia patients at risk of cardiovascular disease as part of annual review.

2.7.22 Treatment is indicated if cholesterol levels are high as per current Australian Guidelines. [38]

#### Cardiovascular disease

2.7.23 Haemophilia patients appear to have a reduced risk of mortality from ischemic cardiovascular disease, but the number of deaths from this cause is increasing. [35,39,40]

2.7.24 A possible association between the occurrence of myocardial infarction and previous adminis­tration of clotting factor concentrates has been described. [41,42]

2.7.25 Haemophilia patients with cardiovascular disease should receive routine care adapted to the individual situation, in discussion with a cardiologist. [43,44]

2.7.26 For acute coronary syndromes requiring percutaneous cardiac intervention (PCI):

* **Adequate correction with clotting factor concentrates before PCI and until 48 hours after PCI is required. [42,43,45]**
* High factor levels should be avoided in order to prevent occlusive thrombi. During complete correction: Heparin can be administered according to standard cardiologic treatment protocols.
* Glycoprotein IIb/IIIa inhibitors (abcix­imab, tirofiban) used in PCI with stenting can be administered.
* **Radial artery access site, if technically possible, is preferred over femoral, in order to minimise retroperitoneal or groin bleeds. [42,43,45]**
* Factor concentrates should be given for the duration of dual antiplatelet therapy, about two weeks, aiming at trough levels of 30 IU/dl. [43]
* Prolonged use of aspirin is not recommended in severe haemophilia. Its use in patients on regular intensive prophylaxis is possible, though the data available is inadequate. [43] It is generally accepted that antiplatelet therapy is acceptable in patients with mild bleeding disorders, however such patients should be closely observed for changes in bleeding phenotype.

#### Psychosocial impact

2.7.27 In the ageing patient, the presence of crippling, painful arthropathy can affect quality of life and may lead to loss of independence. [46]

2.7.28 Patients may be confronted with unexpected emotional problems due to memories of nega­tive experiences related to haemophilia (such as hospitalisation) during their youth.

2.7.29 Adaptations at home or at work and an adequate pain schedule are indicated to improve quality of life and preserve independence.

2.7.30 Active psychosocial support should be provided by a social worker, haemophilia nurse, physician and/or psychologist.

### 2.8 von Willebrand disease and rare bleeding disorders

2.8.1 These guidelines are intended for the treatment of haemophilia. Recent publications that address the principles of diagnosis and treatment of von Willebrand disease (VWD) and rare bleeding disorders include:

* Management of von Willebrand disease: a guideline from the UK Haemophilia Centre Doctors’ Organization. *Haemophilia* 2004;10(3):218.231.
* The Diagnosis, Evaluation and Management of von Willebrand Disease. US Dept Health and Human Services, National Heart, Lung and Blood Institute NIH Publication no. 08-5832, December 2007. www.nhlbi.nih.gov
* Von Willebrand Disease: An Introduc­tion for the Primary Care Physician. David Lillicrap and Paula James, World Federation of Hemophilia Treatment of Hemophilia mono­graph No 47, January 2009. www.wfh.org
* Rare Bleeding Disorders. Peyvandi F, Kaufman R, Selighson U et al. *Haemophilia* 2006 Jul; 12 Suppl: 137-42.
* The Rare Coagulation Disorders. Paula Bolton- Maggs, World Federation of Hemophilia Treatment of Hemophilia No 39, April 2006. www.wfh.org

**References**

1. Lee CA, Chi C, Pavord SR, Bolton-Maggs PH, Pollard D, Hinchcliffe-Wood A, Kadir RA; UK Haemophilia Centre Doctors’ Organization. The obstetric and gynaecological management of women with inherited bleeding disorders--review with guidelines produced by a taskforce of UK Haemophilia Centre Doctors’ Organization. *Haemophilia* 2006 Jul;12(4):301-36.
2. Rizza CR, Rhymes IL, Austen DE, Kernoff PB, Aroni SA. Detection of carriers of haemophilia: a ‘blind’ study. *Br J Haematol* 1975;30(4):447-56.
3. Plug I, Mauser-Bunschoten EP, Brocker-Vriends AH, et al. Bleeding in carriers of hemophilia. *Blood* 2006;108(1):52-6.
4. Chi C, Lee CA, Shiltagh N, Khan A, Pollard D, Kadir RA. Pregnancy in carriers of hemophilia. *Haemophilia* 2008;14(1):56-64.
5. Ljung R, Tedgård U. Genetic counseling of hemophilia carriers. *Semin Thromb Hemost* 2003;29(1):31-6.
6. Dunn NF, Miller R, Griffioen A, Lee CA. Carrier testing in haemophilia A and B: adult carriers’ and their partners’ experiences and their views on the testing of young females. *Haemophilia* 2008;14(3):584-92.
7. Mortarino M, Garagiola I, Lotta LA, Siboni SM, Semprini AE, Peyvandi F. Non-invasive tool for foetal sex determination in early gestational age. *Haemophilia* 2011 Nov;17(6):952-6**.**
8. Rijnders RJ, van der Luijt RB, Peters ED, Goeree JK, Van Der Schoot CE, Ploos Van Amstel JK, Christiaens GC. Earliest gestational age for fetal sexing in cell-free maternal plasma. *Prenat Diagn* 2003;23(13):1042-4.
9. Chi C, Hyett JA, Finning KM, Lee CA, Kadir RA. Non-invasive first trimester determination of fetal gender: a new approach of prenatal diagnosis of haemophilia. *BJOG* 2006;113(2):239-42.
10. Evans MI, Andriole S. Chorionic villus sampling and amniocentesis in 2008. *Curr Opin Obstet Gynecol* 2008;20(2):164-8.
11. Jauniaux E, Pahal GS, Rodeck CH. What invasive procedure to use in early pregnancy? *Baillieres Best Pract Res Clin Obstet Gynaecol* 2000;14(4):651-62.
12. Tabor A, Alfirevic Z. Update on procedure-related risks for prenatal diagnosis techniques. *Fetal Diagn Ther* 2010;27(1):1-7.
13. Wapner RJ.Invasive prenatal diagnostic techniques. *Semin Perinatol* 2005;29(6):401-4.
14. Katiyar R, Kriplani A, Agarwal N, Bhatla N, Kabra M. Detection of fetomaternal hemorrhage following chorionic villus sampling by Kleihauer Betke test and rise in maternal serum alpha feto protein. *Prenat Diagn* 2007;27(2):139-42.
15. Lavery S. Preimplantation genetic diagnosis of haemophilia. *Br J Haematol* 2009;144:303-307.
16. Kletzel M, Miller CH, Becton DL, Chadduck WM, Elser JM. Postdelivery head bleeding in hemophilic neonates: Causes and management. *Am J Dis Child* 1989;143:1107-10.
17. Kulkarni R, Lusher J. Perinatal management of newborns with haemophilia. *Br J Haematol* 2001 Feb;112(2):264-74.
18. Evans DI, Shaw A. Safety of intramuscular injection of hepatitis B vaccine in haemophiliacs. *BMJ* 1990;300:1694–95.
19. Miller EJ, Lee CA, Karayiannis P, Holmes S, Thomas HC, Kernoff PB. Immune response of patients with congenital coagulation disorders to hepatitis B vaccine: suboptimal response and human immunodeficiency virus infection. *J Med Virol* 1989;28:96–100.
20. Steele M, Cochrane A, Wakefield C, et al. Hepatitis A and B immunization for individuals with inherited bleeding disorders. *Haemophilia* 2009;15(2):437-47.
21. Cassis F. Psychosocial care for people with hemophilia. Treatment of Hemophilia monograph no 44. Montreal: World Federation of Hemophilia, 2007.
22. Miller R. Counselling about diagnosis and inheritance of genetic bleeding disorders: haemophilia A and B. *Haemophilia* 1999;5(2):77-83.
23. Bullinger M, von Mackensen S. Psychosocial determinants of quality of life in children and adolescents with haemophilia: a cross-cultural approach. *Clin Psychol Psychother* 2008;15(3):164-72.
24. Mauser-Bunschoten EP, Fransen Van De Putte DE, Schutgens RE. Co-morbidity in the ageing haemophilia patient: the down side of increased life expectancy. *Haemophilia* 2009 Jul;15(4):853-63.
25. Siboni SM, Mannucci PM, Gringeri A, et al. Health status and quality of life of elderly persons with severe haemophilia born before the advent of modern replacement therapy. *J Thromb Haemost* 2009;7(5):780-6.
26. Iorio A, Fabbriciani G, Marcucci M, Brozzetti M, Filipponi P. Bone mineral density in haemophilia patients: A meta-analysis. *Thromb Haemost* 2010 Mar;103(3):596-603.
27. Wallny TA, Scholz DT, Oldenburg J, et al. Osteoporosis in haemophilia - an underestimated comorbidity? *Haemophilia* 2007;13(1):79-84.
28. Kovacs CS. Hemophilia, low bone mass, and osteopenia/osteoporosis. *Transfus Apher Sci* 2008;38(1):33-40.
29. Scottish Dental Clinical Effectiveness Programme, Oral Health Management of Patients Prescribed Bisphosphonates: Dental Clinical Guidance. Dundee: Scottish Dental Clinical Effectiveness Programme, April 2011.
30. Hofstede FG, Fijnvandraat K, Plug I, Kamphuisen PW, Rosendaal FR, Peters M. Obesity: a new disaster for haemophilic patients? A nationwide survey. *Haemophilia* 2008;14(5):1035-38.
31. Soucie JM, Cianfrini C, Janco RL, et al. Joint range-of-motion limitations among young males with hemophilia: prevalence and risk factors. *Blood* 2004;103(7):2467-73.
32. Carpenter SL, Chrisco M, Johnson E. The effect of overweight and obesity on joint damage in patients with moderate to severe hemophilia. *Blood* 2006;108:ASH Annual Meeting Abstracts 4064.
33. Pharmacokinetic analysis of anti-hemophilic factor in the obese patient.[Graham A](http://www.ncbi.nlm.nih.gov/pubmed?term=Graham%20A%5BAuthor%5D&cauthor=true&cauthor_uid=24252161)1, [Jaworski K](http://www.ncbi.nlm.nih.gov/pubmed?term=Jaworski%20K%5BAuthor%5D&cauthor=true&cauthor_uid=24252161). Haemophilia. 2014 Mar;20(2):226-9
34. Biere-Rafi S, Baarslag MA, Peters M, Kruip MJ, Kraaijenhagen RA, Den Heijer M, Büller HR, Kamphuisen PW. Cardiovascular risk assessment in haemophilia patients. *Thromb Haemost* 2011 Feb 1;105(2):274-8.
35. Lim MY, Pruthi RK. Cardiovascular disease risk factors: prevalence and management in adult hemophilia patients. *Blood Coagul Fibrinolysis* 2011 Jul;22(5):402-6.
36. Walsh M, Macgregor D, Stuckless S, Barrett B, Kawaja M, Scully MF. Health-related quality of life in a cohort of adult patients with mild hemophilia A. *J Thromb Haemost* 2008;6(5):755-61.
37. Rosendaal FR, Briet E, Stibbe J, van Herpen G, Leuven JA, Hofman A, Vandenbroucke JP. Haemophilia protects against ischaemic heart disease: a study of risk factors. *Br J Haematol* 1990;75(4):525-30.
38. Sullivan DR, Watts GF, Nicholls SJ, Barter P, Grenfell R, Chow CK, Tonkin A, Keech A. Clinical guidelines on hyperlipidaemia: recent developments, future challenges and the need for an Australian review. Heart Lung Circ. 2015 May;24(5):495-502.
39. Kulkarni R, Soucie JM, Evatt BL; Hemophilia Surveillance System Project Investigators. Prevalence and risk factors for heart disease among males with hemophilia. *Am J Hematol* 2005;79(1):36-42.
40. Ragni MV, Moore CG. Atherosclerotic heart disease: prevalence and risk factors in hospitalized men with haemophilia A. *Haemophilia* 2011 Nov;17(6):867-71.
41. Girolami A, Ruzzon E, Fabris F, Varvarikis C, Sartori R, Girolami B. Myocardial infarction and other arterial occlusions in hemophilia A patients: a cardiological evaluation of all 42 cases reported in the literature. *Acta Haematol* 2006;116(2):120-5.
42. Schutgens RE, Tuinenburg A, Roosendaal G, Guyomi SH, Mauser-Bunschoten EP. Treatment of ischaemic heart disease in haemophilia patients: an institutional guideline. *Haemophilia* 2009;15(4):952-58.
43. Mannucci PM, Schutgens RE, Santagostino E, Mauser-Bunschoten EP. How I treat age-related morbidities in elderly patients with hemophilia. *Blood* 2009;114 (26):5256-63.
44. Tuinenburg A, Mauser-Bunschoten EP, Verhaar MC, Biesma DH, Schutgens RE. Cardiovascular disease in patients with hemophilia. *J Thromb Haemost* 2009;7(2):247-54.
45. Coppola A, Tagliaferri A, Franchini M. The management of cardiovascular diseases in patients with hemophilia. *Semin Thromb Hemost* 2010;36(1):91-102.
46. Street A, Hill K, Sussex B, Warner M, Scully MF. Haemophilia and ageing. *Haemophilia* 2006;12(Suppl 3): 8-12.

## 3 LABORATORY DIAGNOSIS

**Key practice points**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 3.1** | A correct diagnosis is essential in all patients with bleeding disorders to ensure appropriate treatment, as different bleeding disorders may have similar symptoms. |
| **PP 3.2** | Accurate diagnosis can only be made with the support of a comprehensive and accurate laboratory service. This is dependent on the laboratory following strict protocols and procedures, which require:  • knowledge and expertise in coagulation laboratory testing  • use of the correct equipment and reagents  • quality assurance |
| **PP 3.3** | Laboratories are strongly advised to participate in an external quality assessment scheme (EQAS) to audit the effectiveness of the internal quality control (IQC) systems in place. The minimum National Association of Testing Authorities (NATA) requirement is 1 EQAS. |
| **PP 3.4** | The Royal College of Pathologists of Australia (RCPA) runs a comprehensive program for haemophilia, Von Willebrands disease and other haemostatic disorders in which all laboratories involved in the diagnosis of bleeding disorders should participate. |
| **PP 3.5** | Other national and international quality assess­ment schemes are also available.eg. External quality Control of diagnostic Assays and Tests Foundation (ECAT), the National External Quality Assessment Service (NEQAS). Most laboratories associated with HTCs should participate in an international EQAS. |
| **PP 3.6** | It is suggested that a chromogenic FVIII assay be performed on diagnostic samples where a diagnosis of mild haemophilia is suspected. |
| **PP 3.7** | The Nijmegen modification of the FVIII inhib­itor assay offers improved specificity and sensitivity over the original Bethesda assay. |
| **PP 3.8** | Detailed information on technical aspects and specific instructions on screening tests and factor assays, please consult the WFH’s Diagnosis of Hemophilia and Other Bleeding Disorders: A Laboratory Manual, Second edition [1] and other reference documents. [2,3] |

**Significant changes from the original WFH Guidelines**

Extensive governance structures overseen by the RCPA are in place regarding the quality of diagnostic services in Australia. It was felt that extensive guidance regarding pre-analytical and analytical aspects of the diagnosis were not required as part of these guidelines. A separate collaborative document in conjunction with the RCPA is however seen as a future priority.

**References**

1. Kitchen S, McCraw A, Echenagucia M. Diagnosis of Hemophilia and Other Bleeding Disorders: A Laboratory Manual, 2nd edition. Montreal: World Federation of Hemophilia, 2010.
2. Clinical and Laboratory Standards Institute. Collection, Transport, and Processing of Blood Specimens for Testing Plasma-Based Coagulation Assays and Molecular Hemostasis Assays: Approved Guideline– Fifth edition. CLSI H21-A5, Wayne PA, Clinical and Laboratory Standards Institute 2008.
3. Collins PW, Chalmers E, Hart DP et al. Diagnosis and treatment of FVIII and IX inhibitors in congenital haemophilia: (4th Edition). Br J Haematol, 2013 (160); 153-170.

## 4 HAEMOSTATIC AGENTS

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 4.1** | Recombinant clotting factor concentrates where available should be used in preference to plasma derived products. |
| **PP 4.2** | In Australia recombinant clotting factor concentrates are available for the treatment of haemophilia A and haemophilia B. Plasma derived products should only be used in these patient groups for urgent treatment where recombinant products are not available. Plasma derived FVIII may be occasionally indicated for use in patients with factor VIII inhibitors undergoing tolerisation – the management of such patients should be discussed with the tolerisation advisory committee (TAC). |
| **PP 4.3** | The use of adjuvant therapy such as DDAVP and tranexamic acid should always be considered in responsive patients. DDAVP should be considered as first line therapy in patients with mild haemophilia provided the individual response has been demonstrated to be adequate to cover the haemostatic challenge being treated. |

**Significant changes from the original WFH Guidelines**

1. Recombinant clotting factor concentrates are the treatment of choice for haemophilia A and haemophilia B in Australia.
2. Where recombinant or specific plasma derived factor concentrates are available cryoprecipate or fresh frozen plasma should not be used.
3. Intranasal desmopressin is not available for the treatment of bleeding disorders in Australia.

### 4.1 Clotting factor concentrates

4.1.1 **The WFH strongly recommends the use of viral-inactivated plasma-derived or recombinant concentrates in preference to cryoprecipitate or fresh frozen plasma for the treatment of haemo­philia and other inherited bleeding disorders. [1,2]**

4.1.2 The comprehensive WFH *Guide for the Assess­ment of Clotting Factor Concentrates* reviews factors affecting the quality, safety, licensing, and assessment of plasma-derived products and the important principles involved in selecting suit­able products for the treatment of haemophilia. [2]

4.1.3 The WFH also publishes and regularly updates a *Registry of Clotting Factor Concentrates*, which lists all currently available products and their manufacturing details. [3]

4.1.4 Currently manufactured plasma-derived concen­trates produced to Good Manufacturing Practice (GMP) standards have an exemplary safety record with respect to lipid-coated viruses, such as HIV and HCV.

4.1.5 Product safety is the result of efforts in several areas:

* improved donor selection (exclusion of at-risk donors)
* improved screening tests of donations, including nucleic acid testing (NAT)
* type and number of in-process viral inactiva­tion and/or removal steps.

4.1.6 The risk of prion-mediated disease through plasma-derived products exists. In the absence of a reliable screening test for variant Creutzfeldt- Jakob disease (vCJD), and with no established manufacturing steps to inactivate the vCJD prion, this problem is currently being handled by excluding plasma from all donors perceived to be at risk. As new information evolves in this field, constant awareness of current scientific recommendations is needed for those involved in making decisions regarding choice of clotting factor concentrate for people with haemophilia.

4.1.7 While it recognised that the use of current commercially available plasma derived products are associated with a very low risk of transmission of infection due to the above measures, where suitable products are available it is recommended that Australian patients with bleeding disorders receive recombinant factor concentrates.

#### Product selection

When selecting plasma-derived concentrates, consid­eration needs to be given to both the plasma quality and the manufacturing process. Two issues deserve special consideration:

* Purity of product
* Viral inactivation/elimination

#### Purity

4.1.8 Purity of concentrates refers to the percentage of the desired ingredient (e.g. FVIII), relative to other ingredients present.

4.1.9 There is no universally agreed classification of products based on purity.

4.1.10 Concentrates on the market vary widely in their purity.

4.1.11 Some products have high or very high purity at one stage of the production process but are subsequently stabilised by albumin, which lowers their final purity. Generally speaking, products with higher purity tend to be associated with low manufacturing yields. These concentrates are, therefore, costlier.

4.1.12 Concentrates of lower purity may give rise to allergic reactions. [4,5] Patients who experience these repeatedly with a particular product may benefit from the administration of an antihista­mine immediately prior to infusion or from use of a higher purity concentrate.

4.1.13 Plasma-derived FVIII concentrates may contain variable amounts of von Willebrand factor (VWF). It is therefore important to ascertain a product’s VWF content (as measured by ristocetin cofactor activity) if it is used for the treatment of VWD. [6]

4.1.14 **For treatment of FIX deficiency, a product containing only FIX is more appropriate than prothrombin complex concentrates, which also contain other clotting factors such as factors II, VII, and X, some of which may become acti­vated during manufacture. Products containing activated clotting factors may predispose to thromboembolism. Recombinant FIX is available in Australia for the management of FIX deficiency and is the preferred product to be used in this patient population. Prothrombin complex concentrates should only be used in emergency situations where recombinant product is not available. [7,8]**

4.1.15 The viral safety of products is not related to purity, as long as adequate viral elimination measures are in place.

#### Viral inactivation/elimination

4.1.16In-process viral inactivation is the single largest contributor to the safety of plasma-derived concentrates. [9]

4.1.17 There is a growing tendency to incorporate two specific viral-reducing steps in the manufacturing process of concentrates.

* Heat treatment is generally effective against a broad range of viruses, both with and without a lipid envelope, including HIV, HAV, HBV, and HCV.
* Solvent/detergent treatment is effective against HBV, HCV, and HIV but does not inactivate non-enveloped viruses such as HAV.

4.1.18 Some viruses (such as human parvovirus B19) are relatively resistant to both types of process. None of the current methods can inactivate prions.

4.1.19 Nano (ultra) filtration can be used to remove small viruses such as parvovirus but filtration techniques currently in use do not eliminate the risk of transmission. [10]

4.1.20 A product created by a process that incorporates two viral reduction steps should not automatically be considered better than one that only has one specific viral inactivation step.

4.1.21 If only one step is used, this step should pref­erably inactivate viruses with and without lipid envelopes.

#### FVIII concentrates

4.1.22 **Recombinant FVIII concentrates are the treatment of choice for haemophilia A in the Australian setting.**

4.1.23 All plasma-derived products currently in the market are listed in the WFH *Registry of Clotting Factor Concentrates.* [3] Consult the product insert for specific details.

#### Dosage/administration

4.1.24 Vials of factor concentrates are available in dosages ranging from approximately 250 to 3000 units each.

4.1.25 **In the absence of an inhibitor, each unit of FVIII per kilogram of body weight infused intravenously will raise the plasma FVIII level approximately 2 IU/dl. [11]**

4.1.26 The half-life of FVIII is approximately 8-12 hours.

4.1.27 **Where clinically indicated the patient’s factor level should be measured approximately 15 minutes after the infusion to verify the calculated dose. [11]**

4.1.28The dose is calculated by multiplying the patient’s weight in kilograms by the factor level in IU/dl desired, multiplied by 0.5.

***Example:*** *50 kg × 40 (IU/dl level desired) × 0.5 = 1,000 units of FVIII. Refer to Table 7-1 for suggested factor level and duration of replace­ment required based on type of haemorrhage.*

4.1.29 **FVIII should be infused by slow IV injection at a rate not to exceed 3 ml per minute in adults or as specified in the product information leaflet. [12]**

4.1.30 Subsequent doses should ideally be based on the half-life of FVIII and on the recovery in an individual patient for a particular product.

4.1.31 It is best to use the entire vial of FVIII once recon­stituted by rounding up the dose to the nearest vial size, though many products have been shown to have extended stability after reconstitution.

4.1.32 **Continuous infusion avoids peaks and troughs and is considered by some to be advantageous and more convenient. However, patients must be monitored frequently for pump failure. [13,14]**

4.1.33 Continuous infusion may lead to a reduction in the total quantity of clotting factor concentrates used and can be more cost-effective in patients with severe haemophilia. [15] However, this cost-effectiveness comparison can depend on the doses used for continuous and intermittent bolus infu­sions. [16]

4.1.34 Dose for continuous infusion is adjusted based on frequent factor assays and calculation of clearance. Since FVIII concentrates of very high purity are stable in IV solutions for at least 24-48 hours at room temperature with less than 10% loss of potency, continuous infusion for a similar number of hours is possible.

#### FIX concentrates

4.1.35 **Recombinant FIX concentrates are the treatment of choice for haemophilia B.**

4.1.36 All plasma-derived products currently in the market are listed in the WFH *Registry of Clotting Factor Concentrates.* [3] Consult the product information guide for specific details.

4.1.37 FIX concentrates fall into two classes:

* Pure FIX concentrates, which may be plasma-derived or recombinant.
* FIX concentrates that also contain factors II, VII, IX, and X, also known as prothrombin complex concentrates (PCCs).

4.1.38 **The use of a pure FIX concentrates is preferable for the treatment of haemophilia B as opposed to PCC. [7,8]** Prothrombinex HT, the only currently available PCC in Australia, should only be used for the treatment of haemophilia B where emergency replacement of FIX is required and a pure FIX concentrate is not available.

4.1.39 Pure FIX products are free of the risks of throm­bosis or disseminated intravascular coagulation (DIC), which may occur with large doses of PCCs.

#### Dosage/administration

4.1.40 Vials of FIX concentrates are available in doses ranging from approximately 250 to 3000 units each.

4.1.41 **In absence of an inhibitor, each unit of FIX per kilogram of body weight infused intravenously will raise the plasma FIX level approximately 1 IU/dl. [11]**

4.1.42 The half-life is approximately 18–24 hours.

4.1.43 **Where clinically indicated the patient’s FIX level should be measured approximately 15 minutes after infusion to verify calculated doses. [11]**

4.1.44 Recombinant FIX (rFIX) has a lower recovery than plasma-derived products, such that each unit of FIX per kg body weight infused will raise the FIX activity by approximately 0.8 IU/dl in adults and 0.7 IU/dl in children under 15 years of age. The reason for the lower recovery of rFIX is not entirely clear. [17]

4.1.45 To calculate dosage, multiply the patient’s weight in kilograms by the factor level desired.

***Example:*** *50 kg × 40 (IU/dl level desired) = 2000 units of plasma-derived FIX. For rFIX, the dosage will be 2000 ÷ 0.8 (or 2000 × 1.25) = 2500 units for adults, and 2000 ÷ 0.7 (or 2000 × 1.43) = 2860 units for children. Refer to Table 7-1 for suggested factor level and duration of replacement therapy based on type of haemorrhage.*

4.1.46 **FIX concentrates should be infused by slow IV injection at a rate not to exceed a volume of 3 ml per minute in adults or as recommended in the product information leaflet. [12]**

4.1.47 **If used, PCCs should generally be infused at half this rate. Consult the product information leaflet for instructions. [18]**

4.1.48 Purified FIX concentrates may also be admin­istered by continuous infusion (as with FVIII concentrates).

4.1.49 Allergic reactions may occur with infusions of FIX concentrates in patients with anti-FIX inhib­itors. In such patients, infusions may need to be covered with hydrocortisone. [19] Changing the brand of clotting factor concentrate sometimes reduces symptoms.

### 4.2 Other plasma products

**4.2.1 The WFH supports the use of coagulation factor concentrates in preference to cryoprecipitate or fresh frozen plasma (FFP) due to concerns about their quality and safety. Where recombinant or specific plasma derived factor concentrates are available cryoprecipate or FFP should not be used. [1,2]**

4.2.2 Cryoprecipitate and FFP are not subjected to viral inactivation procedures (such as heat or solvent/detergent treatment), leading to an increased risk of transmission of viral pathogens, which is significant with repeated infusions. [1]

4.2.3 Certain steps have been taken to minimise the risk of transmission of viral pathogens. These include:

* Nucleic acid testing (NAT) to detect viruses—a technology that has a potentially much greater relevance for the production of cryoprecipi­tate than for factor concentrates, as the latter are subjected to viral inactivation steps. [20]

4.2.4 Allergic reactions are more common following infusion of cryoprecipitate than concentrate. [21]

#### Fresh frozen plasma (FFP)

4.2.5 As FFP contains all the coagulation factors, it is sometimes used to treat coagulation factor deficiencies.

4.2.6 **Cryoprecipitate is preferable to FFP for the treatment of haemophilia A. [22]**

4.2.7 **Due to concerns about the safety and quality of FFP, its use is not recommended, if avoidable. [23]** However, as FFP and cryo-poor plasma contain FIX, they can be used for the treatment of haemophilia B.

4.2.8 In Australia, it is possible to apply some forms of virucidal treatment to packs of FFP (including solvent/detergent treatment) and the use of treated packs is recommended. However, virucidal treatment may have some impact on coagulation factors. The large scale preparation of pooled solvent/detergent-treated plasma has also been shown to reduce the proportion of the largest multimers of VWF. [24,25]

#### Dosage/administration

4.2.9 One ml of fresh frozen plasma (FFP) contains 1 unit of factor activity.

4.2.10 It is generally difficult to achieve FVIII levels higher than 30 IU/dl with FFP alone.

4.2.11 FIX levels above 25 IU/dl are difficult to achieve. **An acceptable starting dose is 15−20 ml/kg.  [22]**

#### Cryoprecipitate

4.2.12 Cryoprecipitate is prepared by slow thawing of fresh frozen plasma (FFP) at 4°C for 10-24 hours. It appears as an insoluble precipitate and is sepa­rated by centrifugation.

4.2.13 Cryoprecipitate contains significant quantities of FVIII (about 3-5 IU/ml), VWF, fibrinogen, and FXIII *but not FIX or FXI*. The resultant super­natant is called cryo-poor plasma and contains other coagulation factors such as factors VII, IX, X, and XI.

4.2.14 **Due to concerns about the safety and quality of cryoprecipitate, its use in the treatment of congenital bleeding disorders is not recom­mended and can only be justified in situations where clotting factor concentrates are not avail­able. [1,22,26]**

#### Dosage/administration

4.2.15A bag of cryoprecipitate made from one unit of FFP (200-250ml) may contain 70–80 units of FVIII in a volume of 30–40 ml.

### 4.3 Other pharmacological options

4.3.1 In addition to conventional coagulation factor concentrates, other agents can be of great value in a significant proportion of cases. These include:

* desmopressin
* tranexamic acid

#### Desmopressin (DDAVP)

4.3.2 Desmopressin (1-deamino-8-D-arginine vaso­pressin, also known as DDAVP) is a synthetic analogue of vasopressin that boosts plasma levels of FVIII and VWF. [28]

4.3.3 **DDAVP may be the treatment of choice for patients with mild or moderate haemophilia A when FVIII can be raised to an appropriate therapeutic level because it avoids the expense and potential hazards of using a clotting factor concentrate. [28,29]**

4.3.4 Desmopressin *does not affect FIX levels* and is of no value in haemophilia B.

4.3.5 **Each patient’s response should be tested prior to therapeutic use, as there are significant differences between individuals. The response to intranasal desmopressin is more variable and therefore less predictable. [28,29]**

4.3.6 **DDAVP is particularly useful in the treatment or prevention of bleeding in carriers of haemophilia. [30]**

4.3.7 **Although DDAVP is not licensed for use in pregnancy, there is evidence that it can be safely used during delivery and in the post-partum period in an otherwise normal pregnancy. Its use should be avoided in pre-eclampsia and eclampsia because of the already high levels of VWF. [31,32]**

4.3.8 Obvious advantages of DDAVP over plasma prod­ucts are the much lower cost and the absence of any risk of transmission of viral infections.

4.3.9 DDAVP may also be useful to control bleeding and reduce the prolongation of bleeding time associated with disorders of haemostasis, including some congenital platelet disorders.

4.3.10 The decision to use DDAVP must be based on both the baseline concentration of FVIII, the increment achieved, and the duration of treat­ment required.

#### Dosage/administration

4.3.11 Though desmopressin is given subcutaneously in most patients, it can also be administered by intravenous infusion or by nasal spray. It is important to choose the correct preparation of desmopressin because some lower-dose prepara­tions are used for other medical purposes.

4.3.12 Appropriate preparations available in Australia include

* 4 μg/ml for intravenous use
* 15 μg /ml for intravenous and subcutaneous use

4.3.13 **A single dose of 0.3 μg /kg body weight, either by intravenous or subcutaneous route, can be expected to boost the level of FVIII three- to six-fold. [28,33]**

4.3.14 For intravenous use, DDAVP is usually diluted in at least 50–100 ml of physiological saline and given by slow intravenous infusion over 20–30 minutes.

4.3.15 The peak response is seen approximately 60 minutes after administration either intravenously or subcutaneously.

4.3.16 **Closely spaced repetitive use of DDAVP over several days may result in decreased response (tachyphylaxis). Factor concentrates may be needed when higher factor levels are required for a prolonged period. [34]**

4.3.17 Rapid infusion may result in tachycardia, flushing, tremor, and abdominal discomfort.

4.3.18 **As a result of its antidiuretic activity, water retention and hyponatremia can be a problem. When repeated doses are given, the plasma osmolality or sodium concentration should be measured. [28,37]**

4.3.19 Although uncommon in most adults, careful, regular assessment is needed in the post operative setting to avoid potentially life threatening hyponatraemia.

4.3.20 **Due to water retention, DDVAP should be used with caution in young children and is contraindicated in children under two years of age who are at particular risk of seizures secondary to cerebral edema due to water retention. [38,39]**

4.3.21 **There are case reports of thrombosis (including myocardial infarction) after infusion of DDAVP. It should be used with caution in patients with a history, or who are at risk, of cardiovascular disease, particularly the elderly**.  **[33]**

#### Tranexamic acid

4.3.22 Tranexamic acid is an antifibrinolytic agent that competitively inhibits the activation of plasminogen to plasmin.

4.3.23 It promotes clot stability and is useful as adjunc­tive therapy in haemophilia and some other bleeding disorders. [40]

4.3.24 **Regular treatment with tranexamic acid alone is of no value in the prevention of haemarthroses in haemophilia. [40]**

4.3.25 **It is valuable, however, in controlling bleeding from skin and mucosal surfaces (e.g. oral bleeding, epistaxis, menorrhagia). [41-43]**

4.3.26 **Tranexamic acid is particularly valuable in the setting of dental surgery and may be used to control oral bleeding associated with eruption or shedding of teeth. [42,44]**

#### Dosage/administration

4.3.27 Tranexamic acid is usually given as an oral tablet, 25mg/kg or up to 1.5 gms in adults, three to four times daily. It can also be given by intravenous infusion two to three times daily, and is also available as a mouthwash.

4.3.28Gastrointestinal upset (nausea, vomiting, or diarrhoea) may rarely occur as a side effect, but these symptoms usually resolve if the dosage is reduced. When administered intravenously, it must be infused slowly as rapid injection may result in dizziness and hypotension.

4.3.29Tranexamic acid can be constituted as a suspension for topical use on bleeding mucosal lesions particularly in the oral cavity.

4.3.30Tranexamic acid is commonly prescribed for seven days following dental extractions to prevent post-operative bleeding.

4.3.31Tranexamic acid is excreted by the kidneys and the dose must be reduced if there is renal impairment in order to avoid toxic accumulation.

4.3.32*The use of tranexamic acid is contraindicated for the treatment of haematuria* as its use may prevent dissolution of clots in the ureters, leading to serious obstructive uropathy and potential perma­nent loss of renal function.

4.3.33Similarly, the drug is contraindicated in the setting of thoracic surgery, where it may result in the development of insoluble haematomas.

4.3.34 **Tranexamic acid may be given alone or together with standard doses of coagulation factor concentrates. [45]**

4.3.35 **Tranexamic acid should *not* be given to patients with FIX deficiency receiving prothrombin complex concentrates, as this will exacerbate the risk of thromboembolism. [46]**

4.3.36 **If treatment with both agents is deemed neces­sary, it is recommended that at least 12 hours elapse between the last dose of APCC and the administration of tranexamic acid. [46]**

4.3.37 **In contrast, thromboembolism is less likely when tranexamic acid is used in combination with rFVIIa to enhance haemostasis. [47]**

**References**

1. Evatt BL, Austin H, Leon G, Ruiz-Sáez A, de Bosch N. Haemophilia therapy: assessing the cumulative risk of HIV exposure by cryoprecipitate. *Haemophilia* 1999;5(5):295-300.
2. Farrugia A. Guide for the assessment of clotting factor concentrates, 2nd ed. Montreal: World Federation of Hemophilia, 2008.
3. Brooker M. Registry of Clotting Factor Concentrates, 9th edition. Facts and Figures monograph no 6. Montreal: World Federation of Hemophilia, 2012.
4. Brettler DB, Forsberg AD, Levine PH, Petillo J, Lamon K, Sullivan JL. Factor VIII:C concentrate purified from plasma using monoclonal antibodies: human studies. *Blood* 1989 May 15;73(7):1859-63.
5. Recht M, Pollmann H, Tagliaferri A, Musso R, Janco R, Neuman WR. A retrospective study to describe the incidence of moderate to severe allergic reactions to factor IX in subjects with haemophilia B. *Haemophilia* 2011 May;17(3):494-9.
6. Federici AB, Mannucci PM. Management of inherited von Willebrand disease in 2007. *Ann Med* 2007;39(5):346-58.
7. Kim HC, McMillan CW, White GC, et al. Purified factor IX using monoclonal immunoaffinity technique: clinical trials in hemophilia B and comparison to prothrombin complex concentrates. *Blood* 1992;79(3):568-75.
8. Lippi G, Franchini M. Pathogenesis of venous thromboembolism: when the cup runneth over. *Semin Thromb Hemost* 2008;34(8):747-61.
9. Giangrande PL. Blood products for hemophilia: past, present and future. *BioDrugs* 2004;18(4):225-34.
10. Burnouf T, Radosevich M. Nanofiltration of plasma-derived biopharmaceutical products. *Haemophilia* 2003 Jan;9(1):24-37.
11. Björkman S, Berntorp E. Pharmacokinetics of coagulation factors: clinical relevance for patients with haemophilia. *Clin Pharmacokinet* 2001;40(11):815-32.
12. Hemophilia of Georgia. Protocols for the treatment of hemophilia and von willebrand disease. Hemophilia of Georgia, 2012. http://www.hog.org/publications/page/ protocols-for-the-treatment-of-hemophilia-and-von-willebrand-disease-2 (Accessed June 6 2012).
13. Batorova A, Martinowitz U. Intermittent injections vs. continuous infusion of factor VIII in haemophilia patients undergoing major surgery. *Br J Haematol* 2000;110(3):715–20.
14. Martinowitz U, Luboshitz J, Bashari D, et al. Stability, efficacy, and safety of continuously infused sucrose-formulated recombinant factor VIII (rFVIII-FS) during surgery in patients with severe haemophilia. *Haemophilia* 2009;15(3):676-85.
15. Martinowitz U, Schulman S, Gitel S, et al. Adjusted dose continuous infusion of factor VIII in patients with haemophilia A. *Br J Haematol* 1992;82(4):729-34.
16. Mathews V, Viswabandya A, Baidya S, George B, Nair S, Chandy M, Srivastava A. Surgery for hemophilia in developing countries. *Semin Thromb Hemost* 2005 Nov;31(5):538-43.
17. Poon MC, Lillicrap D, Hensman C, Card R, Scully MF. Recombinant FIX recovery and inhibitor safety: A Canadian post-licensure surveillance study. *Thromb Hemost* 2002;87:431-5.
18. Ruiz-Sáez A, Hong A, Arguello A, Echenagucia M, Boadas A, Fabbrizzi F, Minichilli F, Bosch NB. Pharmacokinetics, thrombogenicity and safety of a double viral inactivated factor IX concentrate compared with a prothrombin complex concentrate. *Haemophilia* 2005;11(6):583-8.
19. Shibata M, Shima M, Misu H, et al. Management of haemophilia B inhibitor patients with anaphylactic reactions to FIX concentrates. *Haemophilia* 2003;9(3):269-71.
20. Chamberland ME. Surveillance for transfusion-transmitted viral infections in the United States. *Biologicals* 1998 Jun;26(2):85-8.
21. O’Shaughnesy DF, Atterbury C, Bolton Maggs P, et al. Guideline for the use of fresh frozen plasma, cryoprecipitate and cryosupernatant. *Br J Haematol* 2004;126(1):11-28.
22. Stanworth SJ. The evidence-based use of FFP and cryoprecipitate for abnormalities of coagulation tests and clinical coagulopathy. *Hematology Am Soc Hematol Educ Program* 2007:179-86.
23. Kasper CK. Products for clotting factor replacement in developing countries. *Semin Thromb Hemost* 2005 Nov;31(5):507-12.
24. Budde U, Drewke E. Von Willebrand factor multimers in virus-inactivated plasmas and F VIII concentrates. *Beitr Infusionsther Transfusionsmed* 1994;32:408-14.
25. Chin S, Williams B, Gottlieb P, Margolis-Nunno H, Ben-Hur E, Hamman J, Jin R, Dubovi E, Horowitz B. Virucidal short wavelength ultraviolet light treatment of plasma and factor VIII concentrate: protection of proteins by antioxidants. *Blood* 1995 Dec 1;86(11):4331-6.
26. Chuansumrit A, Isarangkura P, Chantanakajornfung A, et al. The efficacy and safety of lyophilized cryoprecipitate in hemophilia A. *J Med Assoc Thai* 1999;82(Suppl 1):S69-73.
27. El-Ekiaby M, Sayed MA, Caron C, et al. Solvent-detergent filtered (S/D-F) fresh frozen plasma and cryoprecipitate minipools prepared in a newly designed integral disposable processing bag system. *Transfus Med* 2010;20:48-61.
28. Mannucci PM. Desmopressin (DDAVP) in the treatment of bleeding disorders: the first 20 years. *Blood* 1997;90(7):2515-21.
29. Franchini M, Rossetti G, Tagliaferri A, et al. Dental procedures in adult patients with hereditary bleeding disorders: 10 years experience in three Italian Hemophilia Centers. *Haemophilia* 2005;11:504–9.
30. Leissinger C, Becton D, Cornell C Jr, Cox Gill J. High-dose DDAVP intranasal spray (Stimate) for the prevention and treatment of bleeding in patients with mild haemophilia A, mild or moderate type 1 von Willebrand disease and symptomatic carriers of haemophilia A. *Haemophilia* 2001;7(3):258-66.
31. Mannucci PM. Use of desmopressin (DDAVP) during early pregnancy in factor VIII-deficient women. *Blood* 2005;105(8):3382.
32. Trigg DE, Stergiotou I, Peitsidis P, Kadir RA. A Systematic Review: The use of desmopressin for treatment and prophylaxis of bleeding disorders in pregnancy. *Haemophilia* 2012;18(1):25-33.
33. Castaman G. Desmopressin for the treatment of haemophilia. *Haemophilia* 2008;14(Suppl 1):15-20.
34. Mannucci PM, Bettega D, Cattaneo M. Patterns of development of tachyphylaxis in patients with haemophilia and von Willebrand disease after repeated doses of desmopressin (DDAVP). *Br J Haematol* 1992;82(1):87-93.
35. Khair K, Baker K, Mathias M, et al. Intranasal desmopressin (Octim): a safe and efficacious treatment option for children with bleeding disorders. *Haemophilia* 2007;13(5):548-51.
36. Rose EH, Aledort LM. Nasal spray desmopressin (DDAVP) for mild hemophilia A and von Willebrand disease. *Ann Intern Med* 1991;114(7):563-8.
37. Sica DA, Gehr TWG. Desmopressin: safety considerations in patients with chronic renal disease. *Drug Safety* 2006;29:553–556.
38. Das P, Carcao M, Hitzler J. DDAVP-induced hyponatremia in young children. *J Pediatr Hematol Oncol* 2005;27(6):330-2.
39. Smith TJ, Gill JC, Ambruso DR, Hathaway WE. Hyponatremia and seizures in young children given DDAVP. *Am J Hematol* 1989;31(3):199-202.
40. Mannucci PM. Hemostatic drugs. *N Engl J Med* 1998 Jul 23;339(4):245-53.
41. Coetzee MJ. The use of topical crushed tranexamic acid tablets to control bleeding after dental surgery and from skin ulcers in haemophilia. *Haemophilia* 2007;13(4):443-4.
42. Frachon X, Pommereuil M, Berthier AM, et al. Management options for dental extraction in hemophiliacs: a study of 55 extractions (2000-2002). *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2005;99(3):270-5.
43. Kouides PA, Byams VR, Philipp CS, et al. Multisite management study of menorrhagia with abnormal laboratory haemostasis: a prospective crossover study of intranasal desmopressin and oral tranexamic acid. *Br J Haematol* 2009;145(2):212-20.
44. Franchini M, Zaffanello M, Lippi G. The use of desmopressin in mild hemophilia A. *Blood Coagul Fibrinolysis* 2010;21(7):615-9.
45. Hvas AM, Sorensen HT, Norengaard L, et al. Tranexamic acid combined with recombinant factor VIII increases clot resistance to accelerated fibrinolysis in severe hemophilia A*. J Thromb Haemost* 2007;5(12):2408-14.
46. Luu H, Ewenstein B. FEIBA safety profile in multiple modes of clinical and home-therapy application. *Haemophilia* 2004 Sep;10 (Suppl 2):10-6.
47. Giangrande PL, Wilde JT, Madan B, et al. Consensus protocol for the use of recombinant activated factor VII in elective orthopaedic surgery in haemophilic patients with inhibitors. *Haemophilia* 2009;15(2):501-8

## 5 TREATMENT OF SPECIFIC HAEMORRHAGES

**Key practice points**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 5.1** | Bleeding in patients with haemophilia can occur at different sites each of which require specific management. |
| **PP 5.2** | It is important that individuals with bleeding disorders and their families be educated about the symptoms and signs of bleeding disorders and understand the benefit of prompt treatment. |
| **PP 5.3** | All patients with bleeding disorders should have a management plan documented to be followed in the event of bleeding. This should ideally be documented on a treatment card generated from the ABDR (see ‘’Principles of Care’, Section 1.2). |
| **PP 5.4** | As a general principle in case of large internal haemorrhage or repeated intermittent bleeding, haemoglobin should be checked and corrected while other measures are being planned. Measures of haemodynamic stability, such as pulse and blood pressure, should be moni­tored as indicated. |
| **PP 5.5** | Appropriate rehabilitation is an important component of care following joint and muscle haemorrhage and ideally should be guided by a physiotherapist familiar with the management of bleeding disorder patients. |

**Significant changes from the original WFH Guidelines**

1. A summary of the findings of a systematic review evaluating the efficacy and safety of selective and non-selective non-steroidal anti-inflammatory medications, and joint aspiration in acute joint haemorrhage are incorporated.

### 5.1 Joint haemorrhage (haemarthrosis)

5.1.1 A joint bleed is defined as an episode of bleeding that is typically associated with loss of range of motion, pain, or unusual sensation in the joint, swelling and warmth of the overlying skin.

5.1.2 The onset of bleeding in joints is frequently described by patients as a tingling sensation and tightness within the joint. This “aura” precedes the appearance of clinical signs. In infants and babies the onset can be non-verbal, for example “favouring a limb”, refusing to weight bear, and irritability and crying.

5.1.3The earliest clinical signs of a joint bleed are increased warmth over the area and discomfort with movement, particularly at the ends of range.

5.1.4Later symptoms and signs include pain at rest, swelling, tenderness, and extreme loss of motion.

5.1.5A re-bleed is defined as worsening of the condi­tion either on treatment or within 72 hours after stopping treatment. [1]

5.1.6A target joint is a joint in which 3 or more sponta­neous bleeds have occurred within a consecutive 6-month period.

5.1.7Following a joint bleed, flexion is usually the most comfortable position, and any attempt to change this position causes more pain.

5.1.8 Secondary muscle spasm follows as the patient tries to prevent motion and the joint appears “frozen”.

5.1.9The goal of treatment of acute haemarthrosis is to stop the bleeding as soon as possible. This should ideally occur as soon as the patient recognises the “aura” or it is recognised the child is not moving the joint or the limb, rather than after the onset of overt swelling and pain.

5.1.10 Evaluate the patient clinically. Usually, X-rays and ultrasound are not indicated unless a history suggests significant trauma.

5.1.11 **Administer the appropriate dose of factor concentrate to raise the patient’s factor level suitably (refer to Table 7-1). [2-5]**

5.1.12The definitions listed in Table 5-1 are recom­mended for the assessment of response to treatment of an acute haemarthrosis. [1]

5.1.13 **Instruct the patient to avoid weight-bearing, apply compression, and elevate the affected joint. [4]**

5.1.14 **Appropriate analgesia may also be prescribed. Paracetamol containing medications are recommended as first line therapy with rapid escalation of analgesia if required (see section 1.9). Non-selective NSAIDs should be avoided (see ‘Other NSAIDs should be avoided’, section 1.9.13).**

5.1.15Consider immobilising the joint with a splint until pain resolves.

5.1.16 Ice/cold packs may be applied around the joint for 15-20 minutes every four to six hours for pain relief, if found beneficial. Do not apply ice in direct contact with skin. [39]

5.1.17 **If bleeding does not stop, a second infusion may be required. If so, repeat half the initial loading dose in 12 hours (haemophilia A) or 24 hours (haemophilia B). [4]**

5.1.18 Further evaluation is necessary if the patient’s symptoms continue despite appropriate factor therapy. The presence of inhibitors, septic arthritis, or fracture should be considered if symptoms and findings persist.

5.1.19 **Rehabilitation must be stressed as an active part of the management of acute joint bleeding episodes.[4,6,7]**

* As soon as the pain and swelling begin to subside, the patient should be encouraged to change the position of the affected joint from a position of comfort to a position of function, gradually decreasing the flexion of the joint and striving for complete extension.
* This should be done as much as possible with active muscle contractions. Gentle passive assistance may be used initially and with caution if muscle inhibition is present.
* Early active muscle control must be encour­aged to minimise muscle atrophy and prevent chronic loss of joint motion.
* Active exercises and proprioceptive training must be continued until complete pre-bleed joint range of motion and functioning are restored and signs of acute synovitis have dissi­pated. [8]
* If exercises are progressed judiciously, factor replacement is not necessarily required before exercising.

**TABLE 5-1: DEFINITION OF RESPONSE TO TREATMENT OF ACUTE HAEMARTHROSIS [1]**

|  |  |
| --- | --- |
| Excellent | Complete pain relief within 8 hours and/or complete resolution of signs of bleeding after the initial injection and not requiring any further replacement therapy within 72 hours. |
| Good | Significant pain relief and/or improvement in signs of bleeding within approximately 8 hours after a single injection, but requiring more than one dose of replacement therapy within 72 hours for complete resolution. |
| Moderate | Modest pain relief and/or improvement in signs of bleeding within approximately 8 hours after the initial injection and requiring more than one injection within 72 hours but without complete resolution. |
| None | No or minimal improvement, or condition worsens, within approximately 8 hours after the initial injection. |

Note: The above definitions of response to treatment of an acute haemarthrosis relate to inhibitor negative individuals with haemophilia. These definitions may require modification for inhibitor positive patients receiving bypassing agents as haemostatic cover or patients who receive factor concentrates with extended half-lives.

#### Arthrocentesis

5.1.20 **Arthrocentesis (removal of blood from a joint) may be considered in the following situations:**

* **a bleeding, tense, and painful joint which shows no improvement 24 hours after conservative treatment**
* **joint pain that cannot be alleviated**
* **evidence of neurovascular compromise of the limb**
* **unusual increase in local or systemic temper­ature and other evidence of infection (septic arthritis) [4,9,10]**

5.1.21 Inhibitors should be considered as a reason for persistent bleeding despite adequate factor replacement. The presence of inhibitors must be ruled out before arthrocentesis is attempted.

5.1.22 The early removal of blood should theoretically reduce its damaging effects on the articular cartilage. [10] If there is a large accumulation of blood, it will also decrease pain.

5.1.23 Arthrocentesis is best done soon after a bleed under strictly aseptic conditions.

5.1.24 **When necessary, arthrocentesis should be performed under factor levels of at least 30–50 IU/dl for 48–72 hours. Arthrocentesis should not be done in circumstances where such factor replacement is not available. In the presence of inhibitors, other appropriate haemostatic agents should be used for the procedure, as needed. [4]**

5.1.25 A large bore needle, at least 16-gauge, should be used.

5.1.26 The joint should be immobilised with mild compression.

5.1.27 Weight-bearing should be avoided for 24–48 hours.

5.1.28 Physiotherapy should be initiated as described above.

The routine use of joint aspiration with or without administration of intra-articular steroids in patients with acute haemarthrosis to limit active synovitis and reduce the risk of recurrent bleeding is unclear. A systematic review was performed to evaluate the efficacy of joint aspiration and intra-articular steroid injection in patients with haemophilia with and without pre-existing haemophilic arthropathy or synovitis. (Appendix C) The following conclusions were made after available evidence was assessed using the GRADE criteria;

1. In patients with haemophilia A and haemarthrosis of the knee, it is uncertain whether joint aspiration leads to bleeding episodes compared with no joint aspiration because the certainty of the evidence is very low.
2. In patients with haemophilia A and acute, tense knee haemarthrosis, it is uncertain whether early joint aspiration (performed in the first 24 hours after the onset of symptoms) leads to better resolution of acute knee haemarthroses compared with no joint aspiration because the certainty of the evidence is very low.
3. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of joint aspiration on recurrent haemarthrosis.
4. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of joint aspiration on development of a target joint.
5. In patients with haemophilia A and haemarthrosis of the knee, it is uncertain whether joint aspiration (performed in the first 48 hours after the onset of symptoms) improves range of movement compared with no joint aspiration because the certainty of the evidence is very low.
6. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on recurrent haemarthrosis.
7. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on development of a target joint.
8. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on bleeding rates/events.
9. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on development of or change in arthropathy.

Further research is therefore required to evaluate the routine use of joint aspiration +/- the administration of intra-articular steroid in the management of acute haemarthrosis.

### 5.2Muscle haemorrhage

5.2.1 Muscle bleeds can occur in any muscle of the body, usually from a direct blow or a sudden stretch.

5.2.2 A muscle bleed is defined as an episode of bleeding into a muscle, determined clinically and/or by imaging studies, generally associated with pain and/or swelling and functional impair­ment e.g. a limp associated with a calf bleed. [1]

5.2.3 Early identification and proper management of muscle bleeds are important to prevent permanent contracture, re-bleeding, and formation of pseudotumours.

5.2.4 Sites of muscle bleeding that are associated with neurovascular compromise, such as the deep flexor muscle groups of the limbs, require imme­diate management to prevent permanent damage and loss of function. These groups include:

* the iliopsoas muscle (risk of femorocutaneous, crural, and femoral nerve palsy)
* the superior-posterior and deep posterior compartments of the lower leg (risk of poste­rior tibial and deep peroneal nerve injury)
* the flexor group of forearm muscles (risk of Volkmann’s ischemic contracture)

5.2.5 Bleeding can also occur in more superficial muscles such as the biceps brachii, hamstrings (triceps surae), gastrocnemius, quadriceps, and the gluteal muscles.

5.2.6 Symptoms of muscle bleeds are:

* aching in the muscle
* maintenance of the limb in a position of comfort
* severe pain if the muscle is stretched
* pain if the muscle is made to actively contract
* tension and tenderness upon palpation and possible swelling

5.2.7 **Raise the patient’s factor level as soon as possible, ideally when the patient recognises the first signs of discomfort or after trauma. If there is neurovascular compromise, main­tain the levels for five to seven days or longer, as symptoms indicate (refer to Table 7-1). [11-13]**

5.2.8 Rest the injured part and elevate the limb.

5.2.9 Splint the muscle in a position of comfort and adjust to a position of function as pain allows.

5.2.10 Ice/cold packs may be applied around the muscle for 15-20 minutes every four to six hours for pain relief if found beneficial. Do not apply ice in direct contact with skin.

5.2.11 **Repeat infusions are often required for two to three days or much longer in case of bleeds at critical sites causing compartment syndromes and if extensive rehabilitation is required. [14,15]**

5.2.12 **The patient should be monitored continuously for neurovascular compromise; fasciotomy may be required in some such cases. [16,17]**

5.2.13Haemoglobin level should be checked and corrected if needed as muscle bleeds can result in significant blood loss.

5.2.14 **Physiotherapy should begin as soon as pain subsides and should be progressed gradually to restore full muscle length, strength, and func­tion. [12,18]**

5.2.15Factor coverage during this process is prudent, unless the physiotherapist is experienced with haemophilia management. Serial casting or splinting may be required. Supportive bracing will be required if there has been nerve damage.

5.2.16 Increasing pain during physical therapy can suggest re-bleeding and should be regularly evaluated. [19]

#### Iliopsoas haemorrhage

5.2.17 This type of muscle haemorrhage has a unique presentation. Signs may include pain in the lower abdomen, groin, and/or lower back and pain on extension, but not on rotation, of the hip joint. There may be parasthesia in the medial aspect of the thigh or other signs of femoral nerve compres­sion such as loss of patellar reflex and quadriceps weakness. The symptoms may mimic acute appendicitis, including a positive Blumberg’s sign.

5.2.18 **Immediately raise the patient’s factor level. Maintain the levels for five to seven days or longer, as symptoms indicate (refer to Table 7-1).  [20-22]**

5.2.19 **Consider hospitalisation for observation and control of pain. Maintain *strict* bed rest. Ambulation with crutches is *not* permitted, as ambulation requires contraction of the muscle. [20-22]**

5.2.20 **It is useful to confirm the diagnosis by medical imaging (ultrasonography, CT scan or MRI). If clinically indicated imaging may be required to monitor recovery**. **[20-22]**

5.2.21 **Limit the patient’s activity until pain resolves and hip extension improves. A carefully supervised program of physiotherapy is key to restoring full activity and function and preventing re-bleeding. Restoration of complete hip extension before returning to full activity is recommended. [20-22]**

5.2.22 If residual neuromuscular deficits persist, further orthotic support may be necessary.

### 5.3Central nervous system haemorrhage/head trauma

5.3.1 **This** **is a medical emergency. Treat first then investigate with relevant scans and blood tests** *.*

5.3.2 All post-traumatic head injuries, confirmed or suspected, and significant headaches, with or without vomiting, must be treated as intracranial bleeds. Sudden severe pain in the back may be associated with bleeding around the spinal cord. Do not wait for further symptoms to develop or for laboratory or radio­logic evaluation.

5.3.3 ***Immediately* raise the patient’s factor level when significant trauma or early symptoms occur. Further doses will depend on imaging results. Maintain factor level until aetiology is defined. If a bleed is confirmed, maintain the appropriate factor level for 10-14 days (refer to Table 7-1). [23,24]**

5.3.4 **Intracranial haemorrhage may be an indication for prolonged secondary prophylaxis (three to six months), especially where a relatively high risk of recurrence has been observed (e.g. in the presence of HIV infection). [23,25,26]**

5.3.5 **Immediate medical evaluation and hospitalisa­tion is required. A CT scan or MRI of the brain should be performed. Neurosurgical consulta­tion should be sought as soon as possible. [27,28]**

5.3.6 Severe headache may also be a manifestation of meningitis in immunocompromised patients.

### 5.4 Throat and neck haemorrhage

5.4.1 **This is a medical emergency because it can lead to airway obstruction. Treat first before evaluating***.*

5.4.2 ***Immediately* raise the patient’s factor level when significant trauma or symptoms occur. Maintain the factor levels until symptoms resolve (refer to Table 7-1). [15,29,30]**

5.4.3 **Hospitalisation and evaluation by a specialist is essential. [15]**

5.4.4 To prevent haemorrhage in patients with severe tonsillitis, treatment with factor may be indicated, in addition to bacterial culture and treatment with appropriate antibiotics.

### 5.5 Acute gastrointestinal (GI) haemorrhage

5.5.1 ***Immediately* raise the patient’s factor levels. Maintain the factor level until haemorrhage has stopped and the aetiology is defined (refer to Table 7-1). [31,32]**

5.5.2 Acute gastrointestinal haemorrhage may present as haematemesis, haematochezia, or malena.

5.5.3 For signs of GI bleeding and/or acute haemor­rhage in the abdomen, medical evaluation and possibly hospitalisation are required.

5.5.4 Haemoglobin levels should be regularly moni­tored. Treat anaemia or shock, as needed.

5.5.5 Initiate investigation to identify and treat the origin of haemorrhage as indicated.

5.5.6 Tranexamic acid may be used as adjunc­tive therapy.

### 5.6Acute abdominal haemorrhage

5.6.1 An acute abdominal (including retroperitoneal) haemorrhage can present with abdominal pain and distension and can be mistaken for a number of infectious or surgical conditions. It may also present as a paralytic ileus. Appropriate radio­logic studies may be necessary.

5.6.2 ***Immediately* raise the patient’s factor levels. Maintain the factor levels (refer to Table 7-1) until the etiology can be defined, then treat appropriately in consultation with a specialist. [15,29,30]**

### 5.7Ophthalmic haemorrhage

5.7.1 This is uncommon unless associated with trauma or infection.

5.7.2 ***Immediately* raise the patient’s factor level. Maintain the factor level as indicated (refer to Table 7-1). [15,29,30]**

5.7.3 Have the patient evaluated by an ophthalmolo­gist as soon as possible.

### 5.8 Renal haemorrhage

5.8.1 **Treat painless haematuria with complete bed rest and vigorous hydration (3 litres/m2 body surface area) for 48 hours. Avoid DDAVP when hydrating intensively. [33]**

5.8.2 **Raise the patient’s factor levels (refer to Table 7-1) if there is pain or persistent gross haematuria and watch for clots and urinary obstruction. [33,34]**

5.8.3 **Do not use antifibrinolytic agents. [33]**

5.8.4 Evaluation by an urologist is essential for eval­uation of a local cause if haematuria (gross or microscopic) persists or if there are repeated episodes. A child with haematuria should be seen by a paediatrician and an ultrasound of the kidneys and a urine microscopy and culture performed.

### 5.9 Oral haemorrhage

5.9.1 Early consultation with a dentist or an appropriate surgical specialist is recommended with significant bleeding to determine the source of bleeding. The most common causes are:

* dental extraction
* gingival bleeding often due to poor oral hygiene
* trauma

5.9.2 Local treatments must be considered to treat the haemorrhage. These may include:

* direct pressure on the area using a damp gauze swab, maintained for at least 15 minutes
* sutures to close the wound
* application of local haemostatic agents
* antibiotics, especially in gingival bleeding due to poor oral hygiene
* use of tranexamic acid (an adult dose of 1 gm three to four times per day and a paediatric dose of 25mg/kg three to four times per day are recommended). A standard mouthwash solution of 500mg crushed and dissolved in 10mls of saline may also be used.
* Young children may be offered ice to suck (e.g. an icy pole)

5.9.3 An appropriate dose of regular paracetamol will help control the pain.

5.9.4 Antifibrinolytic agents should not be used systemically in patients with Factor VIII inhibitors receiving activated prothrombin complex concentrates (eg “FEIBA”). [35,36]

5.9.5 Factor replacement may be required as directed by the haemophilia centre.

5.9.6 Advise the patient to eat a soft diet for a few days.

5.9.7 If significant bleeding, evaluate and treat for anaemia as indicated.

### 5.10 Epistaxis

5.10.1 Place the patient’s head in a forward position to avoid swallowing blood. Firm pressure with gauze soaked in ice water should be applied to the ante­rior softer part of the nose for 10-20 minutes.

5.10.2 Factor replacement therapy is often not neces­sary unless there is ongoing evidence of continued bleeding or recurrent bleeding occurs. [15,29]

5.10.3 Antihistamines and decongestant drugs are useful for bleeds specifically related to allergies, upper respiratory infections, or seasonal changes. Topical steroids can also be helpful.

5.10.4 If bleeding is prolonged or occurs frequently, eval­uate for anaemia and treat appropriately.

5.10.5 Tranexamic acid applied locally in a soaked gauze may be helpful.

5.10.6 Consult with an ear, nose and throat surgeon if the bleed is persistent or recurrent. Anterior or posterior nasal packing may be needed to control bleeding.

5.10.6 Epistaxis can often be prevented by increasing the humidity of the environment, applying gels (e.g. vaseline or saline drops/gel) to the nasal mucosa to preserve moisture, or adminis­tering saline spray).

### 5.11 Soft tissue haemorrhage

5.11.1 Symptoms will depend on the site of haemorrhage.

5.11.2 Factor replacement therapy is not necessary for most superficial soft tissue bleeding. The application of firm pressure and ice may be helpful. [15,29]

5.11.3 Evaluate the patient for severity of haemor­rhage and possible muscular or neurovascular involvement. Rule out possible trauma to spaces containing vital organs, such as the head or abdomen.

5.11.4 Open compartmental haemorrhage, such as in the retroperitoneal space, scrotum, buttocks, or thighs, can result in extensive blood loss. Treat with factor immediately if this situation is suspected.

5.11.5 Haemoglobin levels and vital signs should be regu­larly monitored if bleeding is in an open compartment.

### 5.12 Lacerations and abrasions

5.12.1 Treat superficial lacerations by cleaning the wound, then applying pressure and steri-strips.

5.12.2 **For deep lacerations, raise the factor level (refer to Table 7-1), and then suture. [15,29,30]**

5.12.3 Sutures may be removed under cover of factor concentrate.

**References**

1. Definitions in hemophilia. Recommendations of the scientific subcommittee on factor VIII and factor IX of the scientific and standardization committee of the International Society on Thrombosis and Haemostasis. *JTH* 2012 (in press).
2. Aronstam A, Wassef M, Choudhury DP, Turk PM, McLellan DS. Double-blind controlled trial of three dosage regimens in treatment of haemarthroses in haemophilia A. *Lancet* 1980 Jan 26;1(8161):169-71.
3. Aronstam A, Wassef M, Hamad Z, Cartlidge J, McLellan D. A double-blind controlled trial of two dose levels of factor VIII in the treatment of high risk haemarthroses in haemophilia A. *Clin Lab Haematol* 1983;5(2):157-63.
4. Hermans C, de Moerloose P, Fischer K, Holstein K, Klamroth R, Lambert T, et al; European Haemophilia Therapy Standardisation Board. Management of acute haemarthrosis in haemophilia A without inhibitors: literature review, European survey and recommendations. *Haemophilia* 2011;17(3):383-92.
5. Mathews V, Viswabandya A, Baidya S, George B, Nair S, Chandy M, Srivastava A. Surgery for hemophilia in developing countries. *Semin Thromb Hemost* 2005 Nov;31(5):538-43.
6. Gomis M, Querol F, Gallach JE, Gonzalez LM, Aznar JA. Exercise and sport in the treatment of haemophilic patients: a systematic review. *Haemophilia* 2009;15(1):43-54.
7. Mulder K. Exercises for People with Hemophilia. Montreal: World Federation of Hemophilia 2006.
8. Heijnen L, Buzzard BB. The role of physical therapy and rehabilitation in the management of hemophilia in developing countries. *Semin Thromb Hemost* 2005;31(5):513-7.
9. Ingram GI, Mathews JA, Bennett AE. Controlled trial of joint aspiration in acute haemophilic haemarthrosis. *Ann Rheum Dis* 1972;31:423.
10. Rodriguez-Merchan EC. Aspects of current management: orthopaedic surgery in haemophilia. *Haemophilia* 2012;18(1):8-16.
11. Aronstam A, Browne RS, Wassef M, Hamad Z. The clinical features of early bleeding into the muscles of the lower limb in severe haemophiliacs. *J Bone Joint Surgery* 1983;65-B(1):19-23.
12. Beyer R, Ingerslev J, Sørensen B. Current practice in the management of muscle haematomas in patients with severe haemophilia. *Haemophilia* 2010;16(6):926-31.
13. Railton GT, Aronstam A. Early bleeding into upper limb muscles in severe haemophilia clinical features and treatment. *J Bone Joint Surgery* 1987;69-B(1):100-102.
14. Rodriguez-Merchan EC. Musculoskeletal complications of hemophilia. *HSSJ* 2010;6:37–42.
15. Singleton T, Kruse-Jarres R, Leissinger C. Emergency department care for patients with hemophilia and von Willebrand disease. *J Emerg Med* 2010 Aug;39(2):158-65.
16. Llinás A, Silva M, Pasta G, Luck JV, et al. Controversial subjects in musculoskeletal care of haemophilia: cross fire. *Haemophilia* 2010;16(Suppl 5):132-5.
17. Rodriguez-Merchan EC. Orthopedic management in hemophilia: a Spanish outlook. *Semin Hematol* 2008;45(2 Suppl 1):S58-63.
18. Blamey G, Forsyth A, Zourikian N, et al. Comprehensive elements of a physiotherapy exercise programme in haemophilia—a global perspective. *Haemophilia* 2010;16(Suppl 5):136-45.
19. Beeton K, Cornwell J, Alltree J. Rehabilitation of muscle dysfunction in hemophilia, 2nd edn. World Federation of Hemophilia Treatment of Hemophlia monograph 24. Montreal: World Federation of Hemophilia, 2012.
20. Ashrani AA, Osip J, Christie B, Key NS. Iliopsoas haemorrhage in patients with bleeding disorders- -experience from one centre. *Haemophilia* 2003;9(6):721-6.
21. Balkan C, Kavakli K, Karapinar D. Iliopsoas haemorrhage in patients with haemophilia: results from one centre. *Haemophilia* 2005;11(5):463-7.
22. Fernandez-Palazzi F, Hernandez SR, De Bosch NB, De Saez AR. Hematomas within the iliopsoas muscles in hemophilic patients: the Latin American experience. *Clin Orthop Relat Res* 1996;(328):19-24.
23. Ljung RC. Intracranial haemorrhage in haemophilia A and B. *Br J Haematol* 2008;140(4):378-84.
24. Nakar C, Cooper DL, DiMichele D. Recombinant activated factor VII safety and efficacy in the treatment of cranial haemorrhage in patients with congenital haemophilia with inhibitors: an analysis of the Hemophilia and Thrombosis Research Society Registry (2004-2008). *Haemophilia* 2010;16(4):625-31.
25. Patiroglu T, Ozdemir MA, Unal E, Altuner Torun Y, Coskun A, Menku A, Mutlu FT, Karakukcu M. Intracranial hemorrhage in children with congenital factor deficiencies. *Childs Nerv Syst* 2011;27(11):1963-6.
26. Zanon E, Iorio A, Rocino A, Artoni A, Santoro R, Tagliaferri A, Coppola A, Castaman G, Mannucci PM; the Italian Association of Hemophilia Centers. Intracranial haemorrhage in the Italian population of haemophilia patients with and without inhibitors. *Haemophilia* 2012;18(1):39-45.
27. Traivaree C, Blanchette V, Armstrong D, et al. Intracranial bleeding in haemophilia beyond the neonatal period--the role of CT imageing in suspected intracranial bleeding. *Haemophilia* 2007;13(5):552-9.
28. Witmer CM, Manno CS, Butler RB, Raffini LJ. The clinical management of hemophilia and head trauma: a survey of current clinical practice among pediatric hematology/oncology physicians. *Pediatr Blood Cancer* 2009;53(3):406-10.
29. Bush MT, Roy N. Hemophilia emergencies. *J Emerg Nurs* 1995 Dec;21(6):531-8.
30. Guthrie TH Jr, Sacra JC. Emergency care of the hemophiliac patient. *Ann Emerg Med* 1980 Sep;9(9):476-9.
31. Kouides PA, Fogarty PF. How do we treat upper gastrointestinal bleeding in adults with haemophilia. *Haemophilia* 2010;16(2):360-2.
32. Mittal R, Spero JA, Lewis JH, Taylor F, Ragni MV, Bontempo FA, Van Thiel DH. Patterns of gastrointestinal hemorrhage in hemophilia. *Gastroenterology* 1985;88(2):515-22.
33. Quon DV, Konkle BA. How we treat haematuria in adults with haemophilia. *Haemophilia* 2010;16(4):683-5.
34. Ghosh K, Jijina F, Mohanty D. Haematuria and urolithiasis in patients with haemophilia. *Eur J Haematol* 2003;70(6):410-2.
35. Kane MJ, Silverman LR, Rand JH, Paciucci PA, Holland JF. Myonecrosis as a complication of the use of epsilon amino-caproic acid: a case report and review of the literature. *Am J Med* 1988 Dec;85(6):861-3.
36. Mannucci PM. Hemostatic drugs. *N Engl J Med* 1998 Jul 23;339(4):245-53.
37. Franchini M, Rossetti G, Tagliaferri A, et al. Dental procedures in adult patients with hereditary bleeding disorders: 10 years experience in three Italian Hemophilia Centers. *Haemophilia* 2005;11:504–9.
38. Vinall C, Stassen LF. The dental patient with a congenital bleeding disorder. *J Ir Dent Assoc* 2008 Feb-Mar;54(1):24-8.
39. D’Young AI. Domiciliary application of CryoCuff in severe hemophilia: qualitative questionnaire and clinical audit. *Haemophilia* 2008; 14:823-7.

## 6 COMPLICATIONS OF HAEMOPHILIA

**Key practice points**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 6.1** | Musculoskeletal complications are common in patients with haemophilia, and are best managed through a multidisciplinary approach that includes input from physiotherapy and musculoskeletal experts (including rheumatology and/or orthopaedics specialists). |
| **PP 6.2** | Acute synovitis should be managed aggressively to reduce the risk of the development of chronic complication. Adequate factor replacement, pain control and physiotherapy input are important. Other interventions require further investigation. |
| **PP 6.3** | Chronic arthropathy management requires a multi-modal approach. Strategies to delay the time to joint replacement are important. |
| **PP 6.4** | Inhibitor management is often complex. Management of new patients with inhibitors, including tolerisation, should be referred to the AHCDO Tolerisation Advisory Committee (TAC) for discussion. |
| **PP 6.5** | Transfusion related infection with HIV and the hepatitis viruses has been an important cause of morbidity and mortality in the haemophilia community. The ongoing treatment and monitoring for complications of these conditions in liaison with other speciality teams (including infectious disease and hepatology) is an important role of HTCs. |

**Significant changes from the original WFH Guidelines**

1. The results of a systematic review regarding the efficacy and safety of selective and non-selective non-steroidal anti-inflammatory drugs and intra-articular steroid in the management of synovitis and chronic arthropathy are incorporated.
2. Chemical synovectomy is not generally recommended.
3. The role of the tolerisation advisory committee as a resource to guide the management of patients with inhibitors is emphasised.
4. The role of triple therapy in HCV management is added.

### 6.1 Musculoskeletal complications

6.1.1 The most common sites of bleeding are the joints and muscles of the extremities.

6.1.2 Depending on the severity of the disease, bleeding episodes may be frequent and without apparent cause (see Table 1-1).

6.1.3 In the child with severe haemophilia, the first haemarthrosis typically occurs when the child begins to crawl and walk: usually before two years of age, but occasionally later.

6.1.4 If inadequately treated, repeated bleeding will lead to progressive deterioration of the joints and muscles, severe loss of function due to loss of motion, muscle atrophy, pain, joint deformity, and contractures within the first one to two decades of life. [1,2]

#### Synovitis

6.1.5 Following acute haemarthrosis, the synovium becomes inflamed, is hyperaemic and extremely friable.

6.1.6 Failure to manage acute synovitis may result in repeated haemarthroses. [1,2]

6.1.7 In patients who develop acute synovitis developing joint protection with use of a removable splint or compressive bandaging should be considered.

6.1.8 Activities should be restricted until swelling and temperature of the joint return to baseline.

6.1.9 In some cases, COX-2 inhibitors may be useful.

A systematic review was performed to evaluate the efficacy and safety of COX-2 inhibitors in patients with haemophilia with and without pre-existing haemophilic arthropathy or synovitis. (Appendix C) The following conclusions were made after available evidence was assessed using the GRADE criteria;

1. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the impact of COX-2 inhibitors on recurrent haemarthrosis.
2. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the impact of COX-2 inhibitors on development of a target joint.
3. Therefore while COX-2 inhibitors are used in patients with acute synovitis the impact of their use on the rate of further bleeding events or the development of a target joint is unclear. Further evaluation in properly performed studies is warranted before routine use can be recommended.

6.1.10 Range of motion is preserved in the early stages. Differentiation between haemarthrosis and syno­vitis is difficult, particularly in patients who have established target joints. Expert rheumatology and physiotherapy review is critical.

6.1.11 The presence of synovial hypertrophy may be confirmed by MRI or ultrasonography. Plain MRI will assist in defining the extent of osteochondral changes.

6.1.12 With repeated bleeding, the synovium becomes chronically inflamed and hypertrophied, and the joint appears swollen (this swelling is usually not tender to touch): this is chronic synovitis. Again expert rheumatology and physiotherapy review is recommended to ensure accurate diagnosis and appropriate treatment.

6.1.13 As the swelling continues to increase, articular damage, muscle atrophy, and loss of motion will progress to chronic haemophilic arthropathy. A joint can have changes of chronic haemophilic arthropathy but still get episodes of bleeding with acute synovitis. In these cases, treatment of the acute synovitis is necessary as this is usually the cause of pain and swelling rather than the mechanical arthropathy.

6.1.14 **The goal of treatment is to deactivate the synovium as quickly as possible and preserve joint function.[3,4]** Options include:

* **factor concentrate replacement, ideally given with the frequency and at dose sufficient to prevent recurrent bleeding [5-8]**
* Short treatment courses (6-8 weeks) of secondary prophylaxis with intensive are beneficial
* **physiotherapy [9,10]** including:
* daily exercise to improve muscle strength and maintain joint motion
* modalities to reduce secondary inflamma­tion, if available [11]
* functional training [12]
* **a course of NSAIDs (COX-2 inhibitors), which may reduce inflammation (see point 6.1.9 above) [13,14]**
* functional bracing, with physiotherapy oversight where possible, which allows the joint to move but limits movement at the ends of range where the synovium can be pinched and which may prevent new bleeding [15]
* synovectomy
* the role of intra-articular steroids to limit active synovitis and reduce the risk of recurrent bleeding is unclear. A systematic review was performed to evaluate the efficacy of intra-articular steroid injection in patients with haemophilia with and without pre-existing haemophilic arthropathy or synovitis. (Appendix C) The following conclusions were made after available evidence was assessed using the GRADE criteria;

1. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on recurrent haemarthrosis
2. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on development of a target joint.
3. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on bleeding rates/events.
4. In patients with haemophilia and haemophilic arthropathy, no studies were found that evaluated the effect of intra-articular steroid on development of or change in arthropathy.
5. Further studies to assess the efficacy and safety of intra-articular steroid injection in patients with haemophilia and acute synovitis are warranted.

#### Synovectomy

6.1.15 **Synovectomy should be considered if chronic synovitis persists with frequent recurrent bleeding not controlled by other means. Options for synovectomy include radioisotopic synovectomy, and arthroscopic or open surgical synovectomy. Removal of the synovium should only be considered in HTCs that have experience with this procedure. [16,17]**

* + 1. Non-surgical synovectomy is the procedure of choice.

6.1.17 **Radioisotopic synovectomy (performed in Australia using yttrium-90) is highly effective, has few side effects, and can be accom­plished in an out-patient setting. [18,19]**

* A single dose of clotting factor is often suffi­cient for a single injection of the isotope.
* Rehabilitation is less intense than after surgical synovectomy but is still required to help the patient regain strength, proprioception, and normal functional use of the joint.

6.1.20 Chemical synovecetomy has a limited role in the Australian setting.

6.1.19 Surgical synovectomy, whether open or arthroscopic, requires cover with clotting factor for both surgery and the rehabilitation period. The procedure must be performed by an experi­enced team at a dedicated HTC. It is only considered when other less inva­sive procedures fail.

#### Chronic haemophilic arthropathy

6.1.20 Chronic haemophilic arthropathy can develop any time from the second decade of life (and sometimes earlier), depending on the severity of bleeding and its treatment. It is less common in Australia due to the availability of clotting factor concentrate.

6.1.21 The process is set in motion by the immediate effects of blood on the articular cartilage during haemarthrosis [1,2] and reinforced by persistent chronic synovitis and recurrent haemarthroses, resulting in irreversible damage.

6.1.22 With advancing cartilage loss, a progressive arthritic condition develops that includes:

* secondary soft tissue contractures
* muscle atrophy
* angular deformities

6.1.23 Deformity can also be enhanced by contracture following muscle bleeds or neuropathy.

6.1.24 Loss of motion is common, with flexion contrac­tures causing the most significant functional loss.

6.1.25 Joint motion and weight bearing can be extremely painful.

6.1.26 As the joint deteriorates, swelling usually subsides due to progressive fibrosis of the synovium and the capsule.

6.1.27 If the joint becomes ankylosed, pain may diminish or disappear.

6.1.28 The radiographic features of chronic haemophilic arthropathy depend on the stage of involvement.

* Radiographs will only show late osteochon­dral changes [22,23]
* Ultrasound or MRI examination will show early soft tissue and osteochondral changes [24-26]
* Bony erosions and subchondral bone cysts will develop, causing collapse of articular surfaces that can lead to angular deformities
* Fibrous/bony ankylosis may be present. [27]

6.1.29 The goals of treatment are to improve joint function, relieve pain, and assist the patient to continue/resume normal activities of daily living.

6.1.30 Treatment options for chronic haemophilic arthropathy depend on:

* the stage of the condition
* the patient’s symptoms
* the impact on the patient’s lifestyle and func­tional abilities

Such patients should ideally be reviewed by a multidisciplinary team that includes physiotherapy, and a musculoskeletal medical specialist.

6.1.31 **Pain should be controlled with appropriate anal­gesics. Certain COX-2 inhibitors may be used to relieve arthritic pain (see ‘Pain Management’, section 1.9). [13,14]**

6.1.32 **Supervised physiotherapy aiming to preserve muscle strength and functional ability is a very important part of management at this stage. Secondary prophylaxis may be necessary if recurrent bleeding occurs as a result of phys­iotherapy. [9,10]**

6.1.33 Other conservative management techniques include:

* serial casting to assist in correcting deformi­ties [28,29]
* bracing and orthotics to support painful and unstable joints [15]
* walking aids or mobility aids to decrease stress on weight-bearing joints
* adaptations to the home, school, or work envi­ronment to allow participation in community activities and employment and to facilitate activities of daily living. [30]

6.1.34 If these conservative measures fail to provide satisfactory relief of pain and improved func­tioning, surgical intervention may be considered. Surgical procedures, depending on the specific condition needing correction, may include:

* extra-articular soft tissue release to treat contractures
* osteotomy to correct angular deformity
* prosthetic joint replacement for severe disease involving a major joint (knee, hip, shoulder, elbow) [32]
* elbow synovectomy with radial head excision [33]
* arthrodesis of the ankle, which provides excel­lent pain relief and correction of deformity with marked improvement in function. Recent improvements in ankle replacement surgery may pose an alternative for persons with haemo­philia in the future. [34,35]

Strategies should be developed to delay the time to first prosthetic joint replacement due to the life expectancy of joint replacements and the increasing level of difficulty and complications with each subsequent replacement.

6.1.35 **Adequate resources, including sufficient factor concentrates and post-operative rehabilitation, must be available in order to proceed with any surgical procedure. [36-38]**

#### Principles of physiotherapy/physical medicine in haemophilia

6.1.36 Physiotherapists and occupational therapists should be part of the core haemo­philia team. Their involvement with patients and their families should begin at the time of diag­nosis, and they remain important to the patient throughout their lifespan.

6.1.37 Their role in the management of the patient with haemophilia includes the following: [9,39-41]

* Assessment
* Determining the site of an acute bleed
* Regular assessment throughout life
* Pre-operative assessment
* Assessment of musculoskeletal pain not due to bleeds
* Education
* Of the patient and family regarding muscu­loskeletal complications and their treatment
* Of school personnel regarding suitable activities for the child, immediate care in case of a bleed, and modifications in activ­ities that may be needed after bleeds.
* Treatment of acute bleeds, chronic synovitis, and chronic arthropathy

6.1.38 Podiatry input regarding the potential benefit of orthotics is also of benefit in targeted patients, particularly those individuals with ankle arthropathy.

#### Pseudotumours

6.1.39 Pseudotumour formation, although uncommon in Australia, is a potentially limb and life-threatening condition unique to haemophilia that occurs as a result of inadequately treated soft tissue bleeds, usually in muscle adjacent to bone which can then be secondarily involved. It is most commonly seen in a long bone or the pelvis.

6.1.40 If not treated, the pseudotumour can reach enormous size, causing pressure on the adja­cent neurovascular structures and pathologic fractures. A fistula can develop through the over­lying skin.

6.1.41 Diagnosis is made by the physical finding of a localised mass.

6.1.42 Radiographic findings include a soft tissue mass with adjacent bone destruction.

6.1.43 A more detailed and accurate evaluation of a pseudotumour can be obtained with CT scan and MRI.

6.1.44 Management depends on the site, size, rate of growth, and effect on adjoining structures. Options include factor replacement and moni­toring, aspiration, and surgical ablation.

* **A six-week course of treatment with factor is recommended, followed by repeat MRI. If the tumour is decreasing, continue with factor and repeat MRI for three cycles [42,43]**
* Proceed to surgery if necessary, which will be much easier if the tumour has shrunk
* **Aspiration of the pseudotumour followed by injections of fibrin glue, arterial emboliza­tion, or radiotherapy may heal some lesions. Surgery may be needed for others [44,45]**
* Surgical excisions, including limb amputations, may be necessary for large pseudotumours, particularly if they erode long bones. Large abdominal pseudotumours present a special challenge in surgical management of haemo­philia; surgery must only be performed by teams with experience in haemophilia.

#### Fractures

6.1.45 Fractures are not frequent in people with haemo­philia, possibly due to lower levels of ambulation and intensity of activities. [46] Nevertheless, with an increase in quality of life and the life expectancy fractures may become more common, particularly in patients of advanced age. A person with haemophilic arthropathy may be at risk for fractures around joints that have significant loss of motion and in bones that are osteoporotic.

6.1.46 **Treatment of a fracture requires immediate factor concentrate replacement. [46-48]**

6.1.47 **Clotting factor levels should be raised to at least 50% and maintained for three to five days. [3,46-48]**

6.1.48 Lower levels may be maintained for 10–14 days while the fracture becomes stabilised and to prevent soft tissue bleeding.

6.1.49 The management plan should be appropriate for the specific fracture, including operative treat­ment under appropriate coverage of clotting factor concentrates.

6.1.50 **Circumferential plaster should be avoided; splints are preferred. [46]**

6.1.51 Compound/infected fractures may require external fixators. [49]

6.1.52 **Prolonged immobilisation, which can lead to significant limitation of range of movement in the adjacent joints, should be avoided. [46,47]**

6.1.53 Physiotherapy should be started as soon as the fracture is stabilised to restore range of motion, muscle strength, and function. [39]

6.1.54 Treatment should be in collaboration with a recognised HTC.

#### Principles of orthopedic surgery in haemophilia

For important considerations related to performing surgical procedures in persons with haemophilia, please see “Surgery and invasive procedures”, section 1.10. Specific issues in relation to orthopaedic surgery include:

6.1.55 Orthopaedic surgeons should have had specific training in surgical management of persons with haemophilia. [3]

6.1.56  **Performing multiple site elective surgery in a simultaneous or staggered fashion to use clot­ting factor concentrates judiciously should be considered. [50]**

6.1.57  **Local coagulation enhancers may be used. Fibrin glue is useful to control oozing when operating in extensive surgical fields. [36,51,52]**

6.1.58  **Post-operative care in patients with haemophilia requires closer monitoring of pain and often higher doses of analgesics in the immediate post-operative period. [36]**

6.1.59 Good communication with the post-operative rehabilitation team is essential. [39] Knowledge of the details of the surgery performed and intra-operative joint status will facilitate planning of an appropriate rehabilitation program.

6.1.60 Post-operative rehabilitation should be carried out by a physiotherapist experienced in haemo­philia management.

6.1.61 Rehabilitation may have to progress more slowly in persons with haemophilia.

6.1.62 Adequate pain control is essential to allow appro­priate exercise and mobilisation.

6.1.63 These principles also apply to fixation of frac­tures and excision of pseudotumours.

### 6.2 Inhibitors

6.2.1 “Inhibitors” in haemophilia refer to IgG anti­bodies that neutralise clotting factors.

6.2.2 In the current era in which clotting factor concen­trates have been subjected to appropriate viral inactivation, inhibitors to FVIII or FIX are considered to be the most severe treatment-related complication in haemophilia.

6.2.3 The presence of a new inhibitor should be suspected in any patient who fails to respond clinically to clotting factors, particularly if he has been previously responsive. In this situation, the expected recovery and half-life of the transfused clotting factor are severely diminished.

6.2.4 Inhibitors are more frequently encountered in persons with severe haemophilia compared to those with moderate or mild haemophilia.

6.2.5 The cumulative incidence (i.e. lifetime risk) of inhibitor development in severe haemophilia A is in the range of 20-30% and approximately 5-10% in moderate or mild disease. [53-54]

6.2.6 In severe haemophilia A, the median age of inhibitor development is three years or less in developed countries. In moderate/mild haemophilia A, it is closer to 30 years of age, and is often seen in conjunction with intensive FVIII expo­sure with surgery. [55,56]

6.2.7 In severe haemophilia, inhibitors do not change the site, frequency, or severity of bleeding. In moderate or mild haemophilia, the inhibitor may neutralise endogenously synthesized FVIII, thereby effectively converting the patient’s pheno­type to severe.

6.2.8 Bleeding manifestations in moderate/mild haemo­philia complicated by an inhibitor are more frequently reminiscent of those seen in patients with acquired haemophilia A (due to auto-anti­bodies to FVIII), with a greater predominance of mucocutaneous, urogenital, and gastrointes­tinal bleeding sites. [57] Consequently, the risk of severe complications or even death from bleeding may be significant in these patients.

6.2.9 Inhibitors are much less frequently encountered in haemophilia B, occurring in less than 5% of affected individuals. [58]

6.2.10 In all cases, inhibitors render treatment with replacement factor concentrates difficult. Patients on clotting factor therapy should therefore be screened for inhibitor development.

6.2.11 **Confirmation of the presence of an inhibitor and quantification of the titre is performed in the laboratory, preferably using the Nijmegen-modified Bethesda assay.**

6.2.12 **For children, inhibitors should be screened once every five exposure days until 20 expo­sure days, every 10 exposure days between 21 and 50 exposure days, and at least two times a year until 150 exposure days. [61]**

6.2.13 **For adults with more than 150 exposure days, apart from a 6-12 monthly review, any failure to respond to adequate factor concentrate replace­ment therapy in a previously responsive patient is an indication to assess for an inhibitor. [56,62-64]**

6.2.14 **Inhibitor measurement should also be done in all patients who have been intensively treated for more than five days, within four weeks of the last infusion. [63,65]**

6.2.15 **Inhibitors should also be assessed prior to surgery or if recovery assays are not as expected, and when clinical response to treatment of bleeding is sub-optimal in the post-operative period. [53,63,66]**

6.2.16 A low responding inhibitor is defined as an inhib­itor level that is persistently < 5 BU/ml, whereas a high responding inhibitor is defined by a level ≥ 5 BU/ml.

6.2.17 High responding inhibitors tend to be persis­tent. If not treated for a long period, titre levels may fall or even become undetectable, but there will be a recurrent anamnestic response in three to five days when challenged again with specific factor products.

6.2.18 Some low titre inhibitors may be transient, disappearing within six months of initial docu­mentation, despite recent antigenic challenge with factor concentrate.

6.2.19 Very low titre inhibitors may not be detected by the Bethesda inhibitor assay, but by a poor recovery and/or shortened half-life (T-1/2) following clotting factor infusions.

#### Management of bleeding

6.2.20 **Management of bleeding in patients with inhib­itors must be in consultation with a HTC experienced in their management. [63,67]**

6.2.21 **Choice of treatment product should be based on titre of inhibitor, records of clinical response to product, and site and nature of bleed. [63,68]**

6.2.22 **Patients with a low-responding inhibitor may be treated with specific factor replacement at a much higher dose, if possible, to neutralise the inhibitor with excess factor activity and stop bleeding. [63,68]**

6.2.23 **Patients with a history of a high responding inhibitor but with low titres may be treated similarly in an emergency until an anamnestic response occurs, usually in three to five days, precluding further treatment with concentrates that only contain the missing factor. [63,68]**

6.2.24 With an inhibitor level > 5 BU, the likelihood is low that specific factor replacement will be effec­tive in overwhelming the inhibitor without ultra high dose continuous infusion therapy.

6.2.25 Alternative agents include bypassing agents such as recombinant factor VIIa (rFVIIa) and prothrombin complex concentrates (PCC), including the activated forms (APCC).

6.2.26 **The efficacy of two doses of rFVIIa and one dose of APCC for management of joint bleeding has been shown to be essentially equivalent. [69]**

6.2.27 **Notably, however, some patients respond better to one agent than the other, highlighting the need to individualise therapy. [69,70]**

6.2.28 An anamnestic immune response should be expected in patients with haemophilia B and a FIX inhibitor treated with prothrombin complex concentrates – whether activated or not – since these concentrates all contain FIX.

6.2.29 On the other hand, the risk of anamnesis in patients with haemophilia A and an inhibitor treated with a(n) (activated) prothrombin complex concentrate will vary depending on the concentrate and its content of FVIII, which is generally minimal. It is estimated that APCC leads to an anamnestic response in approximately 30% of FVIII inhibitor patients.

6.2.30 Although there has been interest in the use of immunosuppressive therapies in patients with inhibitors, their role is not yet defined, and there is no consensus as to whether they have a place in the management of these patients.

#### Allergic reactions in patients with haemophilia B

6.2.31 Up to 50% of haemophilia B patients with inhibi­tors may have severe allergic reactions, including anaphylaxis, to FIX administration. Such reac­tions can be the first symptom of inhibitor development.

6.2.32 **Newly diagnosed haemophilia B patients, partic­ularly those with a family history and/or with genetic defects predisposed to inhibitor devel­opment, should be treated in a clinic or hospital setting capable of treating severe allergic reac­tions during the initial 10-20 treatments with FIX concentrates. Reactions can occur later but may be less severe. [71-72]**

#### Immune tolerance induction

6.2.33 **ITI is supported and monitored by the AHCDO Tolerisation Advisory Committee (TAC). It is recommended that all new cases of high titre inhibitors are referred to the TAC for discussion and that AHCDO has a central role in coordinating cases of ITI.**

6.2.34 **In patients with severe haemophilia A, eradica­tion of inhibitors is often possible by immune tolerance induction (ITI) therapy. [72,73]**

6.2.35 **Before ITI therapy, high-responding patients should avoid FVIII products to allow inhibitor titres to fall and to avoid persistent anamnestic rise. As noted, some patients may develop an anamnestic response to the inactive FVIII mole­cules in APCC as well. [74]**

6.2.36 Optimal regimen (product or dose) for ITI remains to be defined. An international trial comparing 50 IU/kg three times a week to 200 IU/kg daily was recently stopped due to safety concerns (higher number of intercurrent bleeds) in the low-dose arm pending detailed analysis and interpretation of the data. [75] A typical regimen is 100 IU/kg/day recombinant FVIII with review by the TAC, followed by reassessment every three months with escalating treatment in difficult cases. Alternatively cases which pose a particular high risk of failure (e.g. strong family history or multi-domain gene deletion) may use either a higher dose or plasma derived products.

6.2.37 Response to ITI may be less favourable in patients with moderate/mild haemophilia. [63] Optimal management of patients with mild and moderate haemophilia with inhibitors should be a focus of ongoing research.

6.2.38 Experience with ITI for haemophilia B inhibitor patients is limited. The principles of treatment in these patients are similar, but the success rate is much lower, especially in persons whose inhib­itor is associated with an allergic diathesis.

6.2.39 Haemophilia B inhibitor patients with a history of severe allergic reactions to FIX may develop nephrotic syndrome during ITI, which is not always reversible upon cessation of ITI therapy. Alternative treatment schedules, including immunosuppressive therapies, are reported to be successful. [76]

#### Patients switching to new concentrates

6.2.40 For the vast majority of patients, switching prod­ucts does not lead to inhibitor development.

6.2.41 However in rare instances, inhibitors in previ­ously treated patients have occurred with the introduction of new FVIII concentrates.

6.2.42 In those patients, the inhibitor usually disappears after withdrawal of the new product.

6.2.43 **Patients switching to a new factor concentrate should be monitored for inhibitor develop­ment before and after switching product. [53]**

### 6.3 Transfusion-transmitted and other infection-related complications

6.3.1 The emergence and transmission of HIV, HBV and HCV through clotting factor products resulted in high mortality of people with haemo­philia in the 1980s and early 1990s. [77,78]

6.3.2 Many studies conducted all over the world indi­cate that HIV, HBV, and HCV transmission through factor concentrate has been almost completely eliminated. [79,80]

6.3.3 This is a result of the implementation of several risk-mitigating steps, which include careful selec­tion of donors and screening of plasma, effective virucidal steps in the manufacturing process, and advances in sensitive diagnostic technologies for detection of various pathogens. [81]

6.3.4 Recombinant factor concentrates have been adopted over the past two decades, particularly in developed countries. Recombinant products have contributed significantly to infection risk reduction.

6.3.5 The new challenge remains emerging and re-emerging infections, many of which are not amenable to current risk reduction measures. These include the non-lipid enveloped viruses and prions, for which diagnosis and elimination methods are still a challenge. [80,82,83]

6.3.6 As new treatments are continually emerging in this rapidly changing field, transfusion-trans­mitted infections in people with haemophilia are best managed by a specialist.

#### Principles of management of HIV infection in haemophilia

6.3.7 Knowledge and expertise in the treatment of HIV-infected people with haemophilia is currently limited to case series and reports. HIV treatment in people with haemophilia is therefore largely informed by guidelines used in the non-haemo­philia population.

6.3.8 **As part of the haemovigilance program, all people with haemophilia treated with plasma-derived products that are not adequately virus-inactivated should be tested for HIV at least every 6-12 months and whenever clini­cally indicated. [84]**

6.3.9  **The diagnosis, counselling, initiation of treat­ment, and monitoring of HIV, as well as the treatment of HIV-associated complications in infected people with haemophilia, should be the same as in the non-haemophilic population. [85,86]**

6.3.10 **None of the currently available classes of anti- HIV drugs are contraindicated in people with haemophilia. [87-89]**

#### Principles of management of HCV infection in haemophilia

6.3.11 Assessment of HCV in people with haemophilia should include:

* anti-HCV serology to determine exposure
* HCV polymerase chain reaction (PCR) in those who are anti-HCV positive
* Baseline viral load
* HCV genotyping in those who are HCV PCR positive
* liver function tests and non-invasive assess­ment of fibrosis and liver architecture including fibroscan

It is recommended that diagnostic testing should be consistent with the Australian national policy (<http://testingportal.ashm.org.au>).

6.3.12 **The diagnosis, counselling, initiation of treat­ment, and monitoring of HCV, as well as the treatment of HCV-associated complications in infected people with haemophilia, should be the same as in the non-haemophilic population.**

6.3.13 New antiviral therapies, usually given in combination, improve virologic response rates and are likely to be available in the lifetime of this guideline. [97]

6.3.14 **Where HCV eradication cannot be achieved, regular monitoring (every 6- months) for end-stage liver complication is recommended. [98]**

#### Principles of management of HBV infection in haemophilia

6.3.16 **All people with haemophilia treated with plasma-derived products that are not adequately virus-inactivated should be screened for hepa­titis B antigen and anti-hepatitis B at least every 6-12 months and whenever clinically indicated.[99] It is recommended that diagnostic testing should be consistent with the Australian national policy (**[**http://testingportal.ashm.org.au**](http://testingportal.ashm.org.au)**).**

6.3.17 Active HBV infection should be managed as per local infectious disease guidelines and protocols.

6.3.18 **Those without HBV immunity should be given the anti-HBV vaccine. Protective**

**seroconversion should be rechecked following vaccination. [99-101]**

6.3.19 **People with haemophilia who do not seroconvert should probably be revaccinated with double the hepa­titis B vaccine dose. [99,102]**

#### Principles of management of bacterial infection in haemophilia

6.3.20 The risk factors for bacterial infections in people with haemophilia are venous access catheter insertion, surgical arthroplasty, and other surgical interventions. [103-105]

6.3.21 In general, joint aspiration to treat haemarthrosis should be avoided, unless done early under appro­priate cover of factor replacement and with strict aseptic precautions to prevent infection. [106,107]

6.3.22 Bleeding is likely to delay healing and worsen infection and should therefore be well controlled. [108]

6.3.23 Control of the source of infection is of paramount importance in persons with haemophilia (PWH). [109,110]

**References**

1. Llinás A. Haemophilic arthropathy. *Haemophilia* 2010 Jul;16(Suppl 5):121.
2. Rodriguez-Merchan EC. Musculoskeletal complications of hemophilia. *HSSJ* 2010 Feb; 6(1): 37-42.
3. Rodriguez-Merchan EC. Aspects of current management: orthopaedic surgery in haemophilia. *Haemophilia* 2012;18(1):8-16.
4. Seuser A, Berdel P, Oldenburg J. Rehabilitation of synovitis in patients with haemophilia. *Haemophilia* 2007;13 Suppl 3:26-31.
5. Aronstam A, Arblaster PG, Rainsford SG, Turk P, Slattery M, Alderson MR, et al. Prophylaxis in haemophilia: a double-blind controlled trial. *Br J Haematol* 1976;33(1):81-90.
6. Feldman BM, Pai M, Rivard GE, Israels S, et al; Association of Hemophilia Clinic Directors of Canada Prophylaxis Study Group.Tailored prophylaxis in severe hemophilia A: interim results from the first 5 years of the Canadian Hemophilia Primary Prophylaxis Study. *J Thromb Haemost* 2006 Jun;4(6):1228-36.
7. Gringeri A, Lundin B, Mackensen SV, et al. A randomized clinical trial of prophylaxis in children with hemophilia A (the ESPRIT Study). *J Thromb Haemost* 2011;9(4):700-10.
8. Manco-Johnson MJ, Abshire TC, Shapiro AD, et al. Prophylaxis versus episodic treatment to prevent joint disease in boys with severe hemophilia. *N Engl J Med* 2007;357:535–544.
9. Blamey G, Forsyth A, Zourikian N, Short L, Jankovic N, De Kleijn P, Flannery T. Comprehensive elements of a physiotherapy exercise programme in haemophilia - a global perspective. *Haemophilia* 2010;16 Suppl 5:136-45.
10. Gomis M, Querol F, Gallach JE, Gonzalez LM, Aznar JA. Exercise and sport in the treatment of haemophilic patients: a systematic review. *Haemophilia* 2009;15(1):43-54.
11. Watson T. Current concepts in electrotherapy. *Haemophilia* 2002;8:413–418.
12. De Kleijn P, Gilbert M, Roosendaal G, Poonnose PM, Narayan PM, Tahir N. Functional recovery after bleeding episodes in haemophilia. *Haemophilia* 2004;10:157–160.
13. Rattray B, Nugent DJ, Young G. Celecoxib in the treatment of haemophilic synovitis, target joints, and pain in adults and children with haemophilia. *Haemophilia* 2006;12(5):514-7.
14. Tsoukas C, Eyster ME, Shingo S, et al. Evaluation of the efficacy and safety of etoricoxib in the treatment of hemophilic arthropathy. *Blood* 2006;107(5):1785-90.
15. Querol F, Aznar JA, Haya S, Cid A. Orthoses in haemophilia. *Haemophilia* 2002;8(3):407-12.
16. Llinás A. The role of synovectomy in the management of a target joint. *Haemophilia* 2008;14 (Suppl 3):177-80.
17. Yoon KH, Bae DK, Kim HS, Song SJ. Arthroscopic synovectomy in haemophilic arthropathy of the knee. *Int Orthop* 2005;29(5):296-300.
18. Thomas S, Gabriel MB, Assi PE, Barboza M, Perri ML, Land MG, et al. Radioactive synovectomy with Yttrium90 citrate in haemophilic synovitis: Brazilian experience. *Haemophilia* 2011;17(1):e211-e216.
19. van Kasteren ME, Nováková IR, Boerbooms AM, Lemmens JA. Long term follow up of radiosynovectomy with yttrium-90 silicate in haemophilic haemarthrosis. *Ann Rheum Dis* 1993;52(7):548-50.
20. Bernal-Lagunas R, Aguilera-Soriano JL, Berges-Garcia A, Luna-Pizarro D, Perez-Hernandez E. Haemophilic arthropathy: the usefulness of intra-articular oxytetracycline (synoviorthesis) in the treatment of chronic synovitis in children. *Haemophilia* 2011 Mar;17(2):296-9.
21. Caviglia HA, Fernandez-Palazzi F, Galatro G, Perez- Bianco R. Chemical synoviorthesis with rifampicin in haemophilia. *Haemophilia* 2001 Jul;7 Suppl 2:26-30.
22. Arnold WD, Hilgartner MW. Hemophilic arthropathy. Current concepts of pathogenesis and management. *J Bone Joint Surg Am* 1977;59(3):287-305.
23. Pettersson H, Ahlberg A, Nilsson IM. A radiologic classification of hemophilic arthropathy. *Clin Orthop Relat Res* 1980;(149):153-159.
24. Doria AS, Lundin B, Miller S, Kilcoyne R, Dunn A, Thomas S, Rivard G, Moineddin R, Babyn PS; Expert Imageing Working Group of The International Prophylaxis Study Group. Reliability and construct validity of the compatible MRI scoring system for evaluation of elbows in haemophilic children. *Haemophilia* 2008 Mar;14(2):303-14.
25. Keshava S, Gibikote S, Mohanta A, Doria AS. Refinement of a sonographic protocol for assessment of haemophilic arthropathy. *Haemophilia* 2009 Sep;15(5):1168-71.
26. Zukotynski K, Jarrin J, Babyn PS, Carcao M, Pazmino- Canizares J, Stain AM, Doria AS. Sonography for assessment of haemophilic arthropathy in children: a systematic protocol. *Haemophilia* 2007 May;13(3):293-304.
27. Solimeno L, Goddard N, Pasta G, Mohanty S, Mortazavi S, Pacheco L, Sohail T, Luck J. Management of arthrofibrosis in haemophilic arthropathy. *Haemophilia* 2010 Jul;16 Suppl 5:115-20.
28. Fernandez-Palazzi F, Battistella LR. Non-operative treatment of flexion contracture of the knee in haemophilia. *Haemophilia* 1999 Mar;5(Suppl 1):20-4.
29. Gilbert MS, Radomisli TE. Management of fixed flexion contracture of the elbow in haemophilia. *Haemophilia* 1999 Mar;5(Suppl 1):39-42.
30. Spilsbury M. Models for psychosocial services in the developed and developing world. *Haemophilia* 2004 Oct;10(Suppl 4):25-9.
31. Wiedel JD. Arthroscopic synovectomy: state of the art. *Haemophilia* 2002; 8:372-4.
32. Goddard NJ, Mann HA, Lee CA. Total knee replacement in patients with end-stage haemophilic arthropathy: 25-year results. *J Bone Joint Surg Br* 2010 Aug;92(8):1085-9.
33. Silva M, Luck JV Jr. Radial head excision and synovectomy in patients with hemophilia. Surgical technique. *J Bone Joint Surg Am* 2008 Oct;90 Suppl 2 Pt 2:254-61.
34. Barg A, Elsner A, Hefti D, Hintermann B. Haemophilic arthropathy of the ankle treated by total ankle replacement: a case series. *Haemophilia* 2010;16(4):647-55.
35. Tsailas PG, Wiedel JD. Arthrodesis of the ankle and subtalar joints in patients with haemophilic arthropathy. *Haemophilia* 2010 Sep 1;16(5):822-31.
36. Hermans C, Altisent C, Batorova A, et al. Replacement therapy for invasive procedures in patients with haemophilia: literature review, European survey and recommendations. *Haemophilia* 2009;15(3):639-58.
37. Lobet S, Pendeville E, Dalzell R, et al. The role of physiotherapy after total knee arthroplasty in patients with haemophilia. *Haemophilia* 2008;14(5):989-98.
38. Mathews V, Viswabandya A, Baidya S, George B, Nair S, Chandy M, Srivastava A. Surgery for hemophilia in developing countries. *Semin Thromb Hemost* 2005 Nov;31(5):538-43.
39. De Kleijn P, Blamey G, Zourikian N, Dalzell R, Lobet S. Physiotherapy following elective orthopaedic procedures. *Haemophilia* 2006;12 Suppl 3:108-12.
40. Heijnen L, Buzzard BB.The role of physical therapy and rehabilitation in the management of hemophilia in developing countries. *Semin Thromb Hemost* 2005;31(5):513-7.
41. Hermans C, de Moerloose P, Fischer K, et al; European Haemophilia Therapy Standardisation Board. Management of acute haemarthrosis in haemophilia A without inhibitors: literature review, European survey and recommendations. *Haemophilia* 2011 May;17(3):383-92.
42. D’Young AI. Conservative physiotherapeutic management of chronic haematomata and haemophilic pseudotumours: case study and comparison to historical management. *Haemophilia* 2009;15(1):253-60.
43. Rodriguez-Merchan EC. The haemophilic pseudotumour. *Int Orthop* 1995;19(4):255-60.
44. Alcalay M, Deplas A. Rheumatological management of patients with hemophilia. Part II: Muscle hematomas and pseudotumors. *Joint Bone Spine* 2002 Dec;69(6):556-9.
45. Espandar R, Heidari P, Rodriguez-Merchan EC. Management of haemophilic pseudotumours with special emphasis on radiotherapy and arterial embolization. *Haemophilia* 2009;15(2):448-57.
46. Rodriguez-Merchan EC. Bone fractures in the haemophilia patient. *Haemophilia* 2002; 8(2):104-11.
47. Lee VN, Srivastava A, Nithyananth M, Kumar P, Cherian VM, Viswabandya A, et al. Fracture neck of femur in haemophilia A - experience from a cohort of 11 patients from a tertiary centre in India. *Haemophilia* 2007;13(4):391-4.
48. Mortazavi SM, Heidari P. Retrograde intramedullary nailing of supracondylar femoral fractures in haemophilic patients. *Haemophilia* 2008;14(3):661-664.
49. Lee VN, Srivastava A, PalaniKumar C, Daniel AJ, Mathews V, Babu N, Chandy M, Sundararaj GD. External fixators in haemophilia. *Haemophilia* 2004;10(1):52-57.
50. . Schild FJ, Mauser-Bunschoten EP, Verbout AJ, Van Rinsum AC, Roosendaal G. Total knee arthroplasty in hemophilic arthropathy: efficiency of clotting factor usage in multijoint procedures. *J Thromb Haemost* 2009;7(10):1741-3.
51. Kavakli K. Fibrin glue and clinical impact on haemophilia care. *Haemophilia* 1999;5(6):392-6.
52. Serban M, Poenaru D, Pop L, Schramm W, et al. Surgery--a challenge in haemophiliacs with inhibitors. *Hamostaseologie* 2009;29(Suppl 1):S39-41.
53. Astermark J, Altisent C, Batorova A, et al; European Haemophilia Therapy Standardisation Board. Non-genetic risk factors and the development of inhibitors in haemophilia: a comprehensive review and consensus report. *Haemophilia* 2010;16(5):747-66.
54. Wight J, Paisley S. The epidemiology of inhibitors in haemophilia A: a systematic review. *Haemophilia* 2003;9(4):418-35.
55. Eckhardt CL, Menke LA, Van Ommen CH, et al. Intensive peri-operative use of factor VIII and the Arg593 ->Cys mutation are risk factors for inhibitor development in mild/moderate hemophilia A. *J Thromb Haemost* 2009;7:930-37.
56. Kempton CL, Soucie JM, et al. In non-severe hemophilia A the risk of inhibitor after intensive factor treatment is greater in older patients: a case-control study. *JTH* 2010 Oct;8(10):2224-31.
57. Hay CR. Factor VIII inhibitors in mild and moderate-severity haemophilia A. *Haemophilia* 1998;4(4):558-63.
58. Bolton-Maggs PH, Pasi KJ. Haemophilias A and B. *Lancet* 2003 May 24;361(9371):1801-9.
59. Meijer P, Verbruggen B. The between-laboratory variation of factor VIII inhibitor testing: the experience of the external quality assessment program of the ECAT foundation. *Semin Thromb Hemost* 2009;35(8):786-93.
60. Verbruggen B, van Heerde WL, Laros-van Gorkom BA. Improvements in factor VIII inhibitor detection: from Bethesda to Nijmegen. *Semin Thromb Hemost* 2009;35:752–9.
61. de Moerloose P, Fischer K, Lambert T, Windyga J, Batorova A, Lavigne-Lissalde G, Rocino A, Astermark J, Hermans C. Recommendations for assessment, monitoring and follow-up of patients with haemophilia. *Haemophilia* 2012 May; 18(3): 319-25.
62. Berntorp E, Collins P, D’Oiron R, et al. Identifying non-responsive bleeding episodes in patients with haemophilia and inhibitors: a consensus definition. *Haemophilia* 2011;17(1):e202-10.
63. Hay CR, Brown S, Collins PW, Keeling DM, Liesner R. The diagnosis and management of factor VIII and IX inhibitors: a guideline from the United Kingdom Haemophilia Centre Doctors Organisation. *Br J Haematol* 2006;133:591–605.
64. McMillan CW, Shapiro SS, Whitehurst D, et al. The natural history of factor VIII:C inhibitors in patients with hemophilia A: a national cooperative study. II. Observations on the initial development of factor VIII:C inhibitors. *Blood* 1988;71(2):344-8.
65. Sharathkumar A, Lillicrap D, Blanchette VS, et al. Intensive exposure to factor VIII is a risk factor for inhibitor development in mild hemophilia A. *J Thromb Haemost* 2003;1(6):1228-36.
66. Teitel JM, Carcao M, Lillicrap D, et al. Orthopaedic surgery in haemophilia patients with inhibitors: a practical guide to haemostatic, surgical and rehabilitative care. *Haemophilia* 2009; 15(1):227-39.
67. Colvin BT, Astermark J, Fischer K, Gringeri A, Lassila R, Schramm W, Thomas A, Ingerslev J; Inter Disciplinary Working Group. European principles of haemophilia care. *Haemophilia* 2008;14(2):361-74.
68. Teitel JM, Berntorp E, Collins P, et al. A systematic approach to controlling problem bleeds in patients with severe congenital haemophilia A and high-titre inhibitors. *Haemophilia* 2007;13: 256–63.
69. Astermark J, Donfield SM, DiMichele DM, et al. A randomized comparison of bypassing agents in hemophilia complicated by an inhibitor: the FEIBA Novoseven Comparative (FENOC) Study. *Blood* 2007;109(2):546-51.

Berntorp E, Shapiro A, Astermark J, et al. Inhibitor treatment in haemophilias A and B: summary statement for the 2006 international consensus conference. *Haemophilia* 2006;12(Suppl 6):1–7.

1. Chitlur M, Warrier I, Rajpurkar M, Lusher JM. Inhibitors in factor IX deficiency a report of the ISTH-SSC international FIX inhibitor registry (1997-2006). *Haemophilia* 2009;15(5):1027-31.
2. Recht M, Pollmann H, Tagliaferri A, et al. A retrospective study to describe the incidence of moderate to severe allergic reactions to factor IX in subjects with haemophilia B. *Haemophilia* 2011;17(3):494-9.
3. Coppola A, Di Minno MN, Santagostino E. Optimizing management of immune tolerance induction in patients with severe haemophilia A and inhibitors: towards evidence-based approaches. *Br J Haematol* 2010;150(5):515-28.
4. DiMichele DM, Hoots WK, Pipe SW, Rivard GE, Santagostino E. International workshop on immune tolerance induction: consensus recommendations. *Haemophilia* 2007;13 Suppl 1:1-22.
5. DiMichele DM. Immune tolerance induction in haemophilia: evidence and the way forward. *J Thromb Haemost* 2011 Jul;9 Suppl 1:216-25.
6. Hay CR, Dimichele DM. The principal results of the International Immune Tolerance Study: a randomized dose comparison. *Blood* 2012;119:1335-1344.
7. Beutel K, Hauch H, Rischewski J, Kordes U, Schneppenheim J, Schneppenheim R. ITI with high-dose FIX and combined immunosuppressive therapy in a patient with severe haemophilia B and inhibitor. *Hamostaseologie* 2009 May;29(2):155-7.
8. Arnold DM, Julian JA, Walker IR, et al; Association of Hemophilia Clinic Directors of Canada. Mortality rates and causes of death among all HIV-positive individuals with hemophilia in Canada over 21 years of follow-up. *Blood* 2006;108(2):460-4.
9. Lee CA, Sabin CA, et al. Morbidity and mortality from transfusion-transmitted disease in haemophilia. *Lancet* 1995;345(8960):1309.
10. Farrugia A, Evers T, Falcou PF, Burnouf T, Amorim L, Thomas S. Plasma fractionation issues. *Biologicals* 2009 Apr;37(2):88-93.
11. Mauser-Bunschoten EP, Posthouwer D, Fischer K, van den Berg HM. Safety and efficacy of a plasma-derived monoclonal purified factor VIII concentrate during 10 years of follow-up. *Haemophilia* 2007 Nov;13(6):697-700.
12. Ludlam CA, Mannucci PM, Powderly WG; European Interdisciplinary Working Group. Addressing current challenges in haemophilia care: consensus recommendations of a European Interdisciplinary Working Group. *Haemophilia* 2005;11(5):433-7.
13. Farrugia A, Manno CS, Evatt BL. Emerging and receding risks of therapeutic regimens for haemophilia. *Haemophilia* 2004;10(Suppl 4):47-54.
14. Tapper ML. Emerging viral diseases and infectious disease risks. *Haemophilia* 2006;12(Suppl 1):3-7.
15. Evatt BL, Austin H, Leon G, Ruiz-Sáez A, de Bosch N. Haemophilia therapy: assessing the cumulative risk of HIV exposure by cryoprecipitate. *Haemophilia* 1999;5(5):295-300.
16. Mannucci PM, Gringeri A, Savidge G, et al; European- Australian Haemophilia Collaborative Study Group. Randomized double-blind, placebo-controlled trial of twice-daily zidovudine in asymptomatic haemophiliacs infected with the human immunodeficiency virus type 1. *Br J Haematol* 1994;86(1):174-9.
17. Ragni MV, Amato DA, LoFaro ML, et al. Randomized study of didanosine monotherapy and combination therapy with zidovudine in hemophilic and nonhemophilic subjects with asymptomatic human immunodeficiency virus-1 infection. *Blood* 1995;85(9):2337-46.
18. Humphreys EH, Chang LW, Harris J. Antiretroviral regimens for patients with HIV who fail first-line antiretroviral therapy. *Cochrane Database Syst Rev* 2010 Jun 16;(6):CD006517.
19. Spaulding A, Rutherford GW, Siegfried N. Tenofovir or zidovudine in three-drug combination therapy with one nucleoside reverse transcriptase inhibitor and one non-nucleoside reverse transcriptase inhibitor for initial treatment of HIV infection in antiretroviral-naïve individuals. *Cochrane Database Syst Rev* 2010 Oct 6;(10):CD008740.
20. Spaulding A, Rutherford GW, Siegfried N. Stavudine or zidovudine in three-drug combination therapy for initial treatment of HIV infection in antiretroviral-naïve individuals. *Cochrane Database Syst Rev* 2010 Aug 4;(8):CD008651.
21. Denholm JT, Wright EJ, Street A, Sasadeusz JJ. HCV treatment with pegylated interferon and ribavirin in patients with haemophilia and HIV/HCV co-infection. *Haemophilia* 2009;15(2):538-543.
22. Franchini M, Mengoli C, Veneri D, Mazzi R, Lippi G, Cruciani M. Treatment of chronic hepatitis C in haemophilic patients with interferon and ribavirin: a meta-analysis. *J Antimicrob Chemother* 2008;61(6):1191-200.
23. Hartwell D, Jones J, Baxter L, Shepherd J. Peginterferon alfa and ribavirin for chronic hepatitis C in patients eligible for shortened treatment, re-treatment or in HCV/HIV co-infection: a systematic review and economic evaluation. *Health Technol Assess* 2011 Apr;15(17):i-xii, 1-210.
24. Operskalski EA, Kovacs A. HIV/HCV co-infection: pathogenesis, clinical complications, treatment, and new therapeutic technologies. *Curr HIV/AIDS Rep* 2011 Mar;8(1):12-22.
25. Posthouwer D, Mauser-Bunschoten EP, Fischer K, Makris M. Treatment of chronic hepatitis C in patients with haemophilia: a review of the literature. *Haemophilia* 2006;12(5):473-8.
26. Schulze Zur Wiesch J, Pieper D, et al. Sustained virological response after early antiviral treatment of acute hepatitis C virus and HIV coinfection. *Clin Infect Dis* 2009;49(3):466-72.
27. W Kemp S Roberts Pegylated Interferon and Ribavirin for the Treatment of Chronic Hepatitis C Clinical Medicine Insights: Therapeutics 2011:3.
28. Lok AS, Gardiner DF, Lawitz E, et al. Preliminary Study of Two Antiviral Agents for Hepatitis C Genotype 1. *NEJM* 2012;366(3):216-224.
29. Santagostino E, Colombo M, Rivi M, et al. A 6-month versus a 12-month surveillance for hepatocellular carcinoma in 559 hemophiliacs infected with the hepatitis C virus. *Blood* 2003;102(1):78-82.
30. Steele M, Cochrane A, Wakefield C, Stain AM, Ling S, Blanchette V, et al. Hepatitis A and B immunization for individuals with inherited bleeding disorders. *Haemophilia* 2009;15:437–447.
31. Miller EJ, Lee CA, Karayiannis P, Holmes S, Thomas HC, Kernoff PB. Immune response of patients with congenital coagulation disorders to hepatitis B vaccine: suboptimal response and human immunodeficiency virus infection. *J Med Virol* 1989;28:96–100.
32. Pillay D, Pereira C, Sabin C, Powell L, Zuckerman AJ, Lee CA. A long-term follow-up of hepatitis B vaccination in patients with congenital clotting disorders. *Vaccine* 1994;12:978–83.
33. Mannucci PM, Gringeri A, Morfini M, et al. Immunogenicity of a recombinant hepatitis B vaccine in hemophiliacs. *Am J Hematol* 1988;29(4):211-4.
34. Buehrer JL, Weber DJ, Meyer AA, et al. Wound infection rates after invasive procedures in HIV-1 seropositive versus HIV-1 seronegative hemophiliacs. *Ann Surg* 1990;211(4):492-8.
35. Monch H, Kostering H, Schuff-Werner P, et al. Hemophilia A, idiopathic thrombocytopenia and HTLV-III-infection impressive remission after splenectomy: a case report. *Onkologie* 1986; 9(4):239-40.
36. Trieb K, Panotopoulos J, Wanivenhaus A. Risk of infection after total knee arthroplasty in HIV-positive hemophilic patients. *J Bone Joint Surg Am* 2003;85-A(5):969-70.
37. Ashrani AA, Key NS, Soucie JM, Duffy N, Forsyth A, Geraghty S; Universal Data Collection Project Investigators. Septic arthritis in males with haemophilia. *Haemophilia* 2008;14:494 –503.
38. Zuber TJ. Knee joint aspiration and injection. *Am Fam Physician* 2002;66(8):1497-500.
39. Tourbaf KD, Bettigole RE, Southard SA. Infection in hemophilia. Local bleeding and prophylactic treatment. *NY State J Med* 1976;76(12):2034-6.
40. Heyworth BE, Su EP, Figgie MP, Acharya SS, Sculco TP. Orthopedic management of hemophilia. *Am J Orthop* 2005 Oct;34(10):479-86.
41. Rodriguez-Merchan EC. Orthopaedic surgery of haemophilia in the 21st century: an overview. *Haemophilia* 2002 May;8(3):360-8.

## 7 PLASMA FACTOR LEVEL AND DURATION OF ADMINISTRATION

**Key practice points**

|  |  |
| --- | --- |
| **No.** | **Key Practice Point** |
| **PP 7.1** | Factor replacement may be episodic for the management of acute bleeding or surgery, or prophylactic to limit or prevent haemophilic arthropathy. |
| **PP 7.2** | Standard doses for prophylaxis in the Australian setting range from 25 to 40 IU/kg three weekly or alternate daily. |
| **PP 7.3** | Further research is required to define the optimal prophylaxis regimen and the long-term effectiveness of current dosing regimens. |
| **PP 7.4** | The duration and dosing of episodic therapy will depend on the severity of the haemophilia and the nature of the bleed or surgical procedure being managed. |
| **PP 7.5** | Dosing according to individual pharmacokinetic profile should be considered, particularly in patients undergoing major surgery. |
| **PP 7.6** | The presence of an inhibitor should be excluded in patients undergoing surgery. Follow up inhibitor testing is also recommended 6 to 8 weeks following intense factor VIII exposure in patients with mild or moderate haemophilia A. |

**Significant changes from the original WFH Guidelines**

1. Guidelines for factor concentrate dosing in a resource constrained environment are removed

### 7.1 Choice of factor replacement therapy protocols

7.1.1 The correlation shown in Figure 7-1 between possible factor replacement therapy protocols and overall outcome depicts the choices that one needs to make when selecting doses and regimen of clotting factor concentrates.

7.1.2 While enabling a completely normal life should remain the ultimate goal of factor replacement therapy, this cannot be achieved immediately in people with haemophilia in all situations.

7.1.3 Table 7-1 presents commonly followed guidelines on plasma factor peak levels and duration of replacement that reflect the different practice in countries where there is no significant resource constraint.

7.1.4 The doses listed in Table 7-1 have been shown to avoid joint damage, but the optimal dose needed to achieve this remains to be defined.

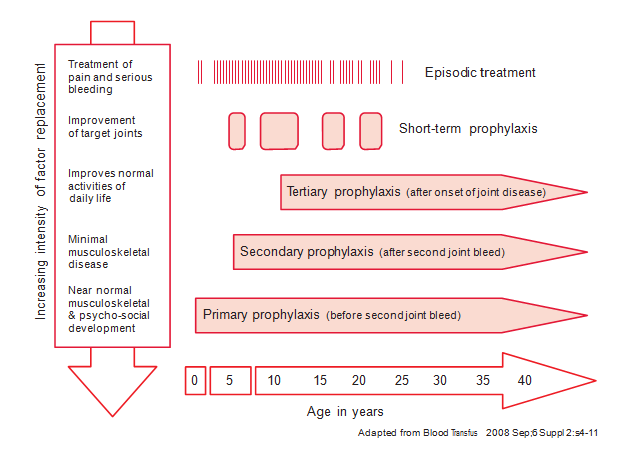
7.1.5 Observational studies documenting the musculo­skeletal outcome of doses and protocols of factor replacement are extremely important in defining these issues.

7.1.6 Doses for prophylactic replacement of factor concentrates vary between different countries and also among centres in the same country.

7.1.7 **Commonly-used dosage for prophylactic factor replacement is 25-40 IU/kg 3-4 times weekly in countries with less resource constraints (see Section 1 for details). [1-3]**

**FIGURE 7-1:**

**STRATEGIES FOR CLOTTING FACTOR REPLACEMENT AT DIFFERENT AGES AND IMPACT ON OUTCOMES**



Increasing intensity of factor replacement

**TABLE 7-1:**

**SUGGESTED PLASMA FACTOR PEAK LEVEL AND DURATION OF ADMINISTRATION (WHEN THERE IS NO SIGNIFICANT RESOURCE CONSTRAINT) [6]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | HAEMOPHILIA A | | HAEMOPHILIA B | |
| DESIRED LEVEL  TYPE OF HAEMORRHAGE (IU/DL) | | DURATION (DAYS) | DESIRED LEVEL  (IU/DL) DURATION (DAYS) | |
| Joint | 40–60 | 1–2, may be longer if response is inadequate | 40–60 | 1–2, may be longer if response is inadequate |
| Superficial muscle/no NV  compromise (except iliopsoas) | 40–60 | 2–3, sometimes longer if response is inadequate | 40–60 | 2–3, sometimes longer if response is inadequate |
| Iliopsoas and deep muscle with NV  injury, or substantial blood loss |  |  |  |  |
| ■ initial | 80–100 | 1–2 | 60–80 | 1–2 |
| ■ maintenance | 30–60 | 3–5, sometimes longer as secondary prophylaxis during physiotherapy | 30–60 | 3–5, sometimes longer as secondary prophylaxis during physiotherapy |
| CNS/head |  |  |  |  |
| ■ initial | 80–100 | 1–7 | 60–80 | 1–7 |
| ■ maintenance | 50 | 8–21 | 30 | 8–21 |
| Throat and neck |  |  |  |  |
| ■ initial | 80–100 | 1–7 | 60–80 | 1–7 |
| ■ maintenance | 50 | 8–14 | 30 | 8–14 |
| Gastrointestinal |  |  |  |  |
| ■ initial | 80–100 | 7–14 | 60–80 | 7–14 |
| ■ maintenance | 50 |  | 30 |  |
| Renal | 50 | 3–5 | 40 | 3–5 |
| Deep laceration | 50 | 5–7 | 40 | 5–7 |
| Surgery (major) |  |  |  |  |
| ■ Pre-op | 80–100 |  | 60–80 |  |
| ■ Post-op | 60–80  40–60  30–50 | 1–3  4–6  7–14 | 40–60  30–50  20–40 | 1–3  4–6  7–14 |
| Surgery (minor) |  |  |  |  |
| ■ Pre-op | 50–80 |  | 50–80 |  |
| ■ Post-op | 30–80 | 1-5, depending on type of procedure | 30–80 | 1–5, depending on type of procedure |

NV; neurovascular  
CNS; central nervous system

**References**

1. Astermark J, Petrini P, Tengborn L, Schulman S, Ljung R, Berntorp E. Primary prophylaxis in severe haemophilia should be started at an early age but can be in dividualized. *Br J Haematol* 1999 Jun;105(4):1109-13.
2. Blanchette VS. Prophylaxis in the haemophilia population. *Haemophilia* 2010;16(Suppl 5):181-8.
3. Gringeri A, Lundin B, von Mackensen S, Mantovani L, Mannucci PM; ESPRIT Study Group. A randomized clinical trial of prophylaxis in children with hemophilia A (the ESPRIT Study). *J Thromb Haemost* 2011 Apr;9(4):700-10.
4. Fischer K, van der Bom JG, Mauser-Bunschoten EP, Roosendaal G, Prejs R, Grobbee DE, van den Berg HM. Changes in treatment strategies for severe haemophilia over the last 3 decades: effects on clotting factor consumption and arthropathy. *Haemophilia* 2001 Sep;7(5):446-52.
5. Wu R, Luke KH, Poon MC, Wu X, Zhang N, Zhao L, Su Y, Zhang J. Low dose secondary prophylaxis reduces joint bleeding in severe and moderate haemophilic children: a pilot study in China. *Haemophilia* 2011 Jan;17(1):70-4.
6. Rickard KA. Guidelines for therapy and optimal dosages of coagulation factors for treatment of bleeding and surgery in haemophilia. *Haemophilia* 1995;1(S1):8–13

## 8 THE FRAMEWORK FOR MANAGEMENT OF BLEEDING DISORDERS IN AUSTRALIA

### Introduction

Australia has a well-established framework of policy, funding, health service and stakeholder arrangements for the care of people with bleeding disorders.

Within this framework, five key elements contribute towards the following complementary objectives:

1. Ensuring an appropriate and high-quality standard of care for people with bleeding disorders.
2. Ensuring an effective and efficient use of clotting factor products, which comprise a significant part of the treatment of many people with bleeding disorders.

These five key elements are shown in the following diagram and are explained further below.

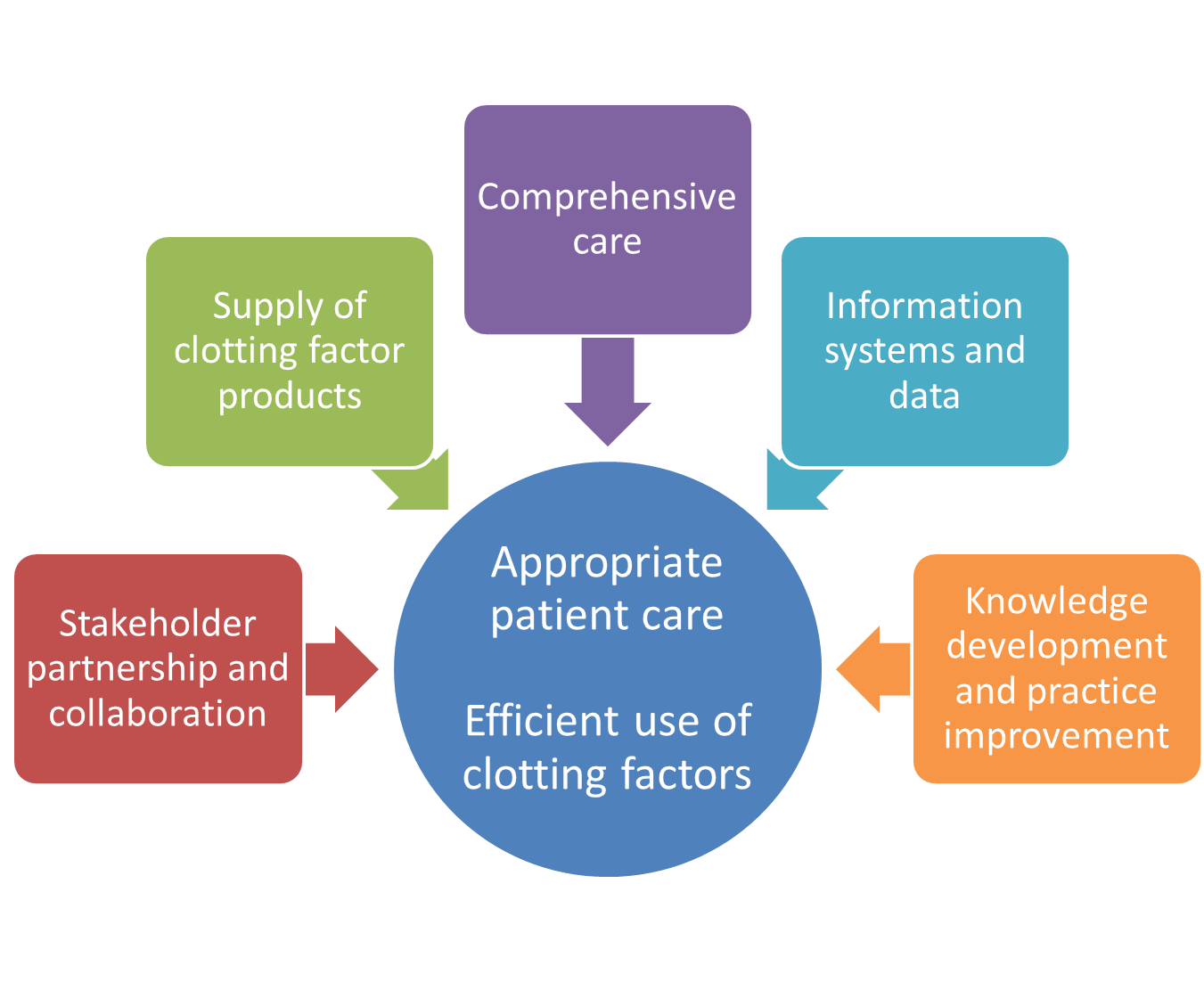


Figure Key Elements of Australian Framework for Management of Bleeding Disorders

### Comprehensive Care

Comprehensive care is a model of care that provides and coordinates hospital and outpatient care and associated services to people with bleeding disorders and their carers and families. The comprehensive care model seeks to ensure the co-ordinated management of all aspects of haemophilia by a multi-disciplinary team with specialised expertise.

The identified benefits of comprehensive care include:

* Reduced hospital days and treatment costs[[2]](#footnote-2)
* Reduced number of hospitalisation episodes, decreases in school or work absences or unemployment[[3]](#footnote-3)
* Improved mortality and quality of life[[4]](#footnote-4), [[5]](#footnote-5)

#### Implementation of comprehensive care in Australia

In Australia the majority of people with haemophilia and other bleeding disorders receive care through specialist Haemophilia Treatment Centres (HTCs). HTCs were established following a decision by Australian Health Ministers Advisory Council (AHMAC) in 1998, to provide a leadership role within their hospital, city and outlying areas to ensure optimal care and an equitable distribution of professional and therapeutic resources, together with responsible record-keeping. The locations of the HTCs in Australia are shown in Figure 2.

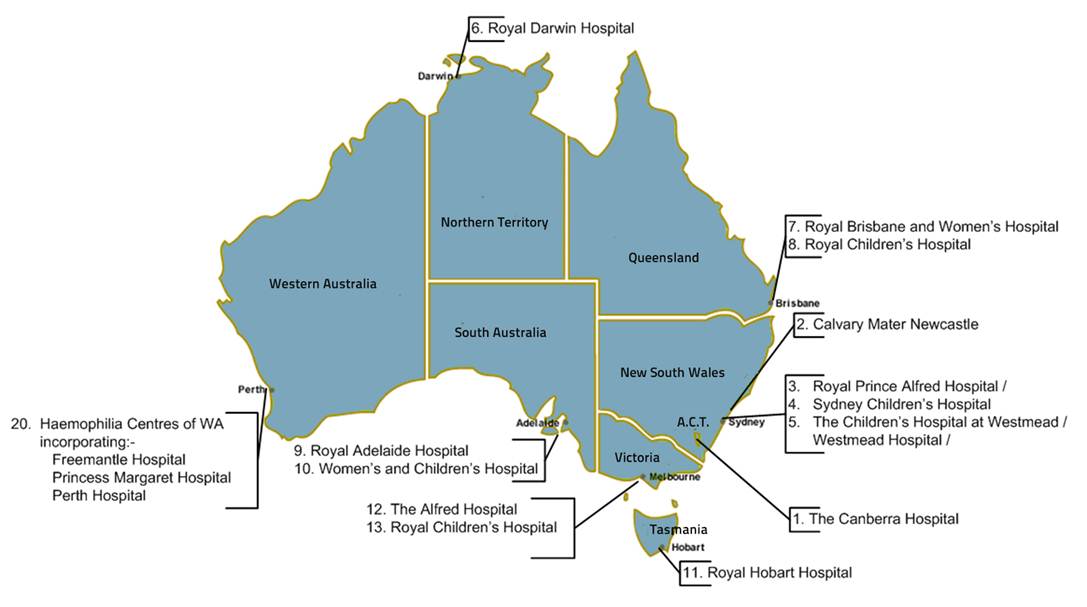


Figure 2 Location of Haemophilia Treatment Centres

The operating concept of HTCs is to coordinate and, where possible, integrate patient care, research and education to provide the optimal use of expertise and resources within hospitals and the community. Specifically, HTCs are intended to provide:

* Co-ordination of the clinical management of patients with haemophilia and patients with other bleeding disorders that includes:
* access to specialist medical services including haematology and nursing services.
* access to or coordination with other medical and allied health services including surgery, rheumatology, infectious diseases, dental and general practice services, and physiotherapy, social work and podiatry services.
* a counselling and advisory service for people with bleeding disorders and their families including genetic counselling and family planning.
* a laboratory service able to carry out all investigations required for accurate diagnosis and effective management of bleeding disorders
* a resource and potentially an outreach service for isolated patients with bleeding disorders and their treating clinicians
* A single point of contact with responsibility for the coordination, allocation and distribution of therapeutic resources, i.e. coagulation products derived either from blood donors or recombinant technologies. This includes organisation and supervision of home therapy programs.
* A system to record all relevant investigations, treatments, complications and adverse reactions, including data management resources. In Australia this data should be recorded in the Australian Bleeding Disorder Registry (ABDR).
* The capability to participate in research including clinical trials.
* Educational programs for medical staff and other personnel, and for people with bleeding disorders and their carers and families.
* Coordination and cooperation with patient groups supporting people with bleeding disorders and their carers and families

The implementation of the model for HTCs varies between States and Territories in relation to resourcing, availability of a relevant range of medical and allied health services, and centralisation and organisation of services, and also in relation to the demographics of the patient population.

Some care for people with bleeding disorders is managed by clinicians or health services that are not associated with a HTC. This may occur where a patient chooses to attend a private medical practitioner or health service, or where a bleeding disorder has not previously been identified and is initially diagnosed outside an HTC, or becomes apparent as a complication of other medical treatment.

### Supply of clotting factor products

A significant part of contemporary medical care of people with bleeding disorders is the use of clotting factor concentrates. These products are infused to replace the specific blood plasma protein that is not present or functional at adequate levels in that particular individual. The aim is to achieve sufficient levels of that blood plasma protein level to either avoid bleeding symptoms or to stop bleeding that has already occurred.

Clotting factors can be derived from human blood plasma through the plasma fractionation manufacturing process. Factors VIII, IX and VIIa are also able to be manufactured by commercial scale expression from recombinant cell technology. While current plasma derived clotting factors have an excellent safety record, recombinant products, where available, are preferred by patients and clinicians due to the lower risk of transmission of diseases that are theoretically transmissible through donated plasma. A number of manufacturers have new versions of recombinant clotting factor products in development.

Clotting factor products may be used to treat and manage bleeding disorders in a number of ways:

* ‘on demand’ treatment for specific bleed events
* short term prophylaxis to cover a specific surgery or other high risk interventions or activities
* immune tolerisation therapy, or bypass therapy, where a patient has developed inhibitory antibodies to first line clotting factor therapy, or
* routine prophylaxis to maintain functional trough levels of clotting factor sufficient to prevent bleeding occurring.

#### Supply under national blood arrangements

Since 2003, clotting factor products have been supplied and funded in Australia through arrangements established under the National Blood Agreement. These arrangements provide an adequate, safe, secure and affordable supply of clotting factor products for the Australian health system. Products are supplied under these arrangements to meet clinical requirements in the scenarios above.

The National Blood Authority (NBA) conducts national tendering and contract negotiation for the supply of clotting factor products. The NBA manages the national contracts and makes payment for products supplied. Funding is provided to the NBA for this purpose by the commonwealth and state/territory governments through the cost sharing arrangements under the National Blood Agreement. Successive tendering and negotiation rounds conducted by the NBA since 2003 have provided significant improvement in value for money for these products.

The national contracts managed by the NBA provide for supply of both plasma derived and recombinant clotting factors (full access to which has been funded by Australian governments since 2005), from both Australian and imported sources. The NBA collaborates with AHCDO and state and territory representatives to undertake national supply planning, and to establish protocols for management of supply risk scenarios which may eventuate. The National Blood Agreement also includes a process for evidence-based evaluation of proposals to add new or materially changed products into the national funding and supply arrangements.

In addition to a primary obligation to supply to meet orders, national supply contracts include obligations for holding of contingency supply reserves and other supplier obligations to ensure supply continuity, as well as obligations to provide product support services and resources suitable for clinical personnel and (through a health care provider) to patients. Suppliers are also required to provide services to support delivery of product direct to suitable patients, for home based therapy under the supervision of a relevant HTC.

In determining the specific requirements and approach for a national tendering round, the NBA seeks input from clinical and patient group stakeholders and from industry, and obtains policy guidance from funding governments. Clinical and patient stakeholders are involved to provide expert or user input in the tender development and evaluation process.

For some products, the outcome of a tender process may involve a change in the specific brands of clotting factor products supplied under the national arrangements, and the NBA cooperates closely with clinical and patient stakeholders and suppliers in planning and supporting the transition process between products.

#### Other products

In addition to clotting factors, other pharmaceuticals products, medical devices and therapeutic interventions may be important for the care of people with bleeding disorders and may be supplied and funded outside the national blood arrangements via hospital supply or under the Pharmaceutical Benefits Scheme or Medicare Benefits Scheme. These include tranexamic acid, DDAVP (desmopressin), analgesia, antiviral therapy, immune modulating therapy, other fractionated blood products platelets, and mobility aids.

### Stakeholder partnership and collaboration

The effective treatment and care of patients with bleeding disorders in Australia benefits from the involvement of a number of important clinical and patient stakeholder groups or organisations:

* **Haemophilia Foundation of Australia** (HFA) and state and territory member bodies, which represent the Australian community of people with bleeding disorders and their carers and families. HFA is committed to improving treatment and care through representation and advocacy, education and the promotion of research.
* **Australian Haemophilia Centre Director’s Organisation** (AHCDO) which is the national medical body for haemophilia and other bleeding disorders in Australia. The NBA provides funding to AHCDO for a range of advice, services and management activities to support the effective management of bleeding disorders in Australia.
* A number of specialist health professional groups which are supported by HFA and facilitate professional expertise in a number of disciplines which support the comprehensive care of people with bleeding disorders including:
  + **Australian Haemophilia Nurses Group**
  + **Australia/New Zealand Haemophilia Social Workers’ and Counsellors’ Group**
  + **Australian and New Zealand Physiotherapy Haemophilia Group**
* The **ABDR Data Managers’ Group** which is supported by AHCDO, in order to coordinate the protocols for entry of data into the Australian Bleeding Disorders Registry (ABDR).

These groups collaborate through formal partnerships or informal processes to oversee key outcomes or undertake projects to support or improve haemophilia care. Some key examples include:

* Management of patients with inhibitors through the Tolerisation Advice Committee.
* Annual education meetings around topics on bleeding disorders.
* Redevelopment of the ABDR and development of the MyABDR patient recording application. The processes for detailed design, and for ongoing operation and enhancement of ABDR and MyABDR have been greatly assisted over an extended period of time by the involvement of representatives of all patient and clinical stakeholder groups. The Australian Bleeding Disorder Registry Steering Committee which oversees the development and operation of ABDR and MyABDR is chaired by AHCDO and includes representatives of AHCDO, HFA, state/territory governments and the NBA. Under the oversight of this Committee, the governance and management of ABDR and MyABDR is conducted as an effective partnership between the key patient and clinical groups and governments.
* Tender evaluation and associated consultation, reference group or transition committees that oversee major national procurement actions for clotting factors. Australia’s national procurement arrangements realise the best product price and associated service arrangements available globally. Best price enhances affordability, and hence provision of effective haemophilia care[[6]](#footnote-6). The expertise and involvement of key clinical and patient stakeholder groups in these processes greatly assists in achieving these outcomes.
* Clinical and stakeholder reference groups that oversee the development of supporting clinical guidelines, such as the current document. These guidelines record an increasing level of national consensus on significant aspects of the care and management of bleeding disorders, and the key indicators to be used to guide future quality improvement.

### Information systems and data

#### Australian Bleeding Disorders Registry

The Australian Bleeding Disorders Registry (ABDR) is a database that is designed to collect clinical information related to the treatment of people with inherited bleeding disorders. This includes information about patient diagnosis, viral status, treatment details, hospital admissions and administrative information as well as details on ordering, supply and use of clotting factor products. Information is entered into the ABDR web enabled software by staff at HTCs.

ABDR provides the following benefits:

* A single point of access to all relevant individual clinical data relating to the management of haemophilia for clinicians treating patients with bleeding disorders
* Exchange of selected information between states and HTCs
* National demographic information (age, sex etc.) of persons with bleeding disorders
* National data on inhibitor incidence and outcomes of treatment
* Allied health (physiotherapy and social work) interactions and outcomes
* Recording of personal usage of factor replacement for clinical monitoring
* Data for forward planning and funding of factor concentrates on a national basis

The ABDR provides health care teams and support staff with a record enabling them to monitor and manage treatment over time to improve patients’ quality of life. De-identified information from the ABDR may be used for research purposes by authorised organisations to understand and improve treatment for bleeding disorders. Considerations for the release of any information for research are made under specific governance arrangements. The ABDR also provides governments with information on total clotting factor product requirements to inform supply planning to meet the needs of all Australians with bleeding disorders.

The ABDR is managed on a day to day basis by the National Blood Authority (NBA) in accordance with the guidance and policy oversight provided by the ABDR Steering Committee. The Committee consists of representatives of the key stakeholders involved in the clinical management, advocacy and funding of treatment for people with bleeding disorders.

There is an extremely robust Governance framework that oversees the management and operation of the ABDR. An AHCDO member chairs the Steering Committee tasked with these responsibilities. The Steering Committee also includes the Executive Director of Haemophilia Foundation Australia to ensure patient needs are met. Patient privacy and confidentiality are paramount to these arrangements. Individual patients are required to give consent for their data to be recorded in the ABDR.

In addition, there are stringent security protocols embedded into the technical architecture of the ABDR. These effectively control access to personal data ensuring this information is only accessible to treating health professionals and authorised support staff.

#### MyABDR

MyABDR is a secure app for use on smartphones or home computers, developed by the NBA, for use by people with bleeding disorders or parents/caregivers. MyABDR can be used to record home treatments for both prophylaxis or bleeding episodes, and to manage treatment product stock. The MyABDR app and web site link directly to the ABDR and therefore data entered is available to the patients treating clinician. By enhancing the accurate recording of bleed frequency and factor usage, and making that information accessible to the clinician, MyABDR can help to aid decision making regarding treatment regimens and optimise patient care. MyABDR is the preferred method of patient record keeping in Australia.

#### Data reporting

The data recorded in ABDR is able to be used by health professionals for the care and treatment of individual patients and by HTCs in managing the provision of comprehensive care services. It is planned that benchmarking data will be made available to individual HTC’s to identify variation in management among centres, and to help identify areas in which differences can be examined to help standardise practice.

In addition, a number of useful national level reports are produced from de-identified data in ABDR:

* Annual reporting, including published report and the above HTC benchmarking reports
* Adverse event reporting and recording as the AUSHASS reporting scheme
* National contributions to the WFH survey

Individual centres are also able to submit data requests for summary data regarding their patient population to enhance clinical management.

### Knowledge development and practice improvement

The other elements of the national framework for management of bleeding disorders in Australia enable and support a range of activities which seek to evaluate, maintain and improve an appropriate and high-quality standard of patient treatment care, and the effective and efficient use of clotting factor products.

These activities include

* **Education and training** – members of AHCDO and other healthcare professionals are regular involved in educational activities including registrar training events, the annual AHCDO education day, participation in national and international conferences, and contribution to patient education material in partnership with HFA.
* **Practice benchmarking, development and peer review** – forums for peer discussion of difficult clinical management decisions are provided by the tolerisation advisory committee and the complex patient advisory group. The planned provision of regular benchmarking data to individual HTC’s will enable the examination of variation in practice and aid in the standardisation of management where appropriate.
* **Guidelines and consensus statements** – AHCDO is committed to the development of clinical guidelines such as these to provide a framework to guide the management of patients with haemophilia. Ongoing activity including detailed systematic review of clinical questions and the development of consensus statements in areas not covered by these guidelines are planned.
* **Research and publications** – ethics approval for use of the ABDR for demographic research is a key component of examining national data to help answer key research questions (see ‘Areas for further Research’, Appendix D). AHCDO has a mechanism for providing funding for local research initiatives in collaboration with the NBA.

# Appendix A Acronyms and abbreviations

|  |  |
| --- | --- |
| ASA | acetylsalicylic acid |
| ABDR | Australian Bleeding Disorder Registry |
| ACHDO | Australian Haemophilia Centre Director's Association |
| AHMAC | Australian Health Ministers Advisory Council |
| aPCC | activated prothrombin complex concentrates |
| AUSHASS | Australian Haemophilia Safety Surveillance System |
| BMD | bone mineral density |
| BMI | body mass index |
| CHO-KLAT | Canadian Hemophilia Outcomes: Kids' Life Assessment Tool |
| CNS | central nervous system |
| CT | computed tomography |
| CVS | chorionic villus sampling |
| DDAVP | Desmopressin |
| DIC | disseminated intravascular coagulation |
| DM | diabetes mellitus |
| DNA | deoxyribonucleic acid |
| ECAT | External quality Control of diagnostic Assays and Tests |
| EQAS | external quality assessment scheme |
| factor IX | FIX |
| factor VIII | FVIII |
| FEIBA | factor eight inhibitor bypassing activity |
| FFP | fresh frozen plasma |
| FISH | Functional Independence Score in Haemophilia |
| FVII | factor VII |
| FX | factor X |
| FXI | factor XI |
| GI | gastrointestinal |
| GRADE | Grading of Recommendations Assessment, Development and Evaluation |
| HAL | Haemophilia Activities List |
| HAV | hepatitis A virus |
| HBV | hepatitis B virus |
| HCB | hepatitis C virus |
| HDL | high-density lipoprotein |
| HIV | human immunodeficiency virus |
| HJHS | Haemophilia Joint Health Score |
| HTC | Haemophilia Treatment Centre |
| ICU | intensive care unit |
| IgG | immunoglobulin G |
| IQC | internal quality control |
| ITI | immune tolerance induction |
| IV | intravenous |
| LDL | low-density lipoprotein |
| MMR | measles, mumps and rubella |
| MRI | magnetic resonance imaging |
| NAT | nucleic acid testing |
| NATA | National Association of Testing Authorities |
| NBA | National Blood Authority |
| NEQAS | National External Quality Assessment Service |
| NSAIDs | non-steroidal anti-inflammatory drugs |
| NV | neurovascular |
| PCC | prothrombin complex concentrates |
| PCI | percutaneous cardiac intervention |
| PCR | polymerase chain reaction |
| PedHAL | Paediatric Haemophilia Activities List |
| PEG-INF | pegylated interferon |
| PK | pharmacokinetic |
| PRICE | protection, rest, ice, compression, and elevation |
| PWH | persons with haemophilia |
| RCPA | Royal College of Pathologists of Australia |
| rFIX | recombinant factor IX |
| rFVIIa | recombinant activated factor VIIa |
| RhD | Anti-D immunoglobulin |
| ROM | range of motion |
| TAC | Tolerisation Advisory Committee |
| UGI | upper gastrointestinal |
| vCJD | variant Creutzfeldt-Jakob disease |
| vWD | von Willebrand disease |
| vWF | von Willebrand factor |
| WFH | World Federation of Haemophilia |

# Appendix B Development process

In 2013, the NBA and AHCDO agreed that guidance for the management of haemophilia patients should be developed for the Australian setting for the following reasons:

* Guidelines that provide multidisciplinary guidance on the management of the patients with haemophilia relevant to the Australian setting are not currently available
* It is suspected that there is variation in approaches to some aspects of the management of haemophilia in Australia
* The Australian *Evidence-based clinical practice guidelines for the use of recombinant and plasma-derived FVIII and FIX products* were due for revision
* The *National Safety and Quality Health Service Standards* requires that blood product policies, procedures and/or protocols are consistent with national evidence based guidelines for pre-transfusion practices, prescribing and clinical use.

The NBA and AHCDO agreed that the WFH’s *Guidelines for the management of hemophilia (2nd edition)* provided a good basis upon which to develop Australian guidance. However, in order to maximise the opportunity of standardising haemophilia care in Australia, some adaptation of the WFH guideline was required.

Each chapter of the WFH guideline was reviewed by at least two AHCDO members who were asked to appraise the chapter, assess the need for a systematic review and draft additional content, while being mindful of the Australian setting, the sustainability of products, the appropriateness of treatment regimens and the need for a consensus approach. An additional chapter on the framework for the management of bleeding disorders in Australia was also drafted for inclusion in the guideline.

During the review of the WFH guideline, AHCDO members identified a number of research areas requiring further consideration and possible systematic review. Following an initial scan of literature, AHCDO recommended that a systematic review should be conducted to address two research questions:

1. *In patients with haemophilia what is the effect of anti-inflammatory medication (including aspirin) compared to no anti-inflammatory or a different type of anti-inflammatory medication on bleeding events?*
2. *In patients with haemophilia who have presented with an acute joint bleed or historical joint bleeds, what is the effect of therapy to reduce inflammation compared to no therapy on recurrent joint haemorrhage and subsequent arthropathy?*

The findings were considered by AHCDO and incorporated into the guideline. Further details on the systematic review can be found at Appendix C (Systematic review methodology).

The revised chapters were then reviewed for consistency, consolidated and circulated to nominated clinical experts as well as the Haemophilia Foundation of Australia in a ‘critical friends’ consultation process. Eight submissions were received. All comments received were not considered to be controversial and were incorporated into the draft guideline in preparation for the open public consultation process.

Public consultation was conducted for six weeks from Wednesday 11 November 2015 to Wednesday 23 December 2015, during which time the draft guideline was available on the AHCDO and NBA websites. [xx] submissions were received. AHCDO members considered all the public consultation submissions and, where necessary, revised the guideline in accordance with the submissions.

During the development process, all AHCDO members and ‘critical friends’ were asked to declare any conflicts of interest before contributing to the development process. No conflicts were declared during the development process.

# Appendix C Systematic review methodology

The WFH’s *Guidelines for the management of hemophila* contain several recommendations for the management of haemophilia patients. In that guideline, all statements in bold font were supported by the best practice evidence available at that time and were graded using the 2011 Oxford Centre for Evidence-Based Medicine levels of evidence (See Appendix G). The WFH guidelines also contain guidance that fell outside the selection for practice statements. These references are included in the guideline but are not highlighted in bold font. AHCDO and the NBA agreed to retain the presentation of the clinical guidance for the Australian guideline.

During a review of the WFH’s *Guidelines for the management of hemophila*, AHCDO members identified a number of research areas requiring further consideration and possible systematic review. Following an initial scan of literature, AHCDO recommended that a systematic review should be conducted to address two research questions:

1. *In patients with haemophilia what is the effect of anti-inflammatory medication (including aspirin) compared to no anti-inflammatory or a different type of anti-inflammatory medication on bleeding events?*
2. *In patients with haemophilia who have presented with an acute joint bleed or historical joint bleeds, what is the effect of therapy to reduce inflammation compared to no therapy on recurrent joint haemorrhage and subsequent arthropathy?*

The NBA engaged an expert systematic review team from HealthConsult, on behalf of AHCDO, to conduct a systematic review of the scientific literature using GRADE methodology.

Electronic searches of EMBASE.com and the Cochrane Library were conducted using search terms related to the clinical questions. The search of EMBASE.com was conducted on 18 February, 2015 and the search of the Cochrane Library was conducted on 19 February, 2015. In addition to the database search, the reference lists of relevant primary studies were hand-searched to identify additional studies, and guideline websites such as the National Guidelines Clearinghouse and the Guidelines International Networked were searched on 24 February, 2015. Identified guidelines were checked to ensure all relevant studies were identified. The literature searches resulted in the identification of a total of 773 citations for Question 1, and 54 citations for Question 2.

The eligibility criteria for inclusion in the systematic review were underpinned by the main components of the research question. Specifically, studies were excluded for the following reasons: (i) not a clinical study (excludes narrative reviews, editorials, surveys, individual case reports, animal studies and in vitro studies); (ii) wrong intervention; (iii) wrong indication; and (iv) wrong outcomes. Studies were also excluded if they were not published in English or included duplicate data published in another included study. The study sample size was restricted to ≥ 5 subjects, due to the small number of studies available. In addition, study type was not restricted; due to the small number of Level II studies (randomised controlled trials (RCTs)) and Level III studies (cohort and case-control) available, Level IV studies (case series) were also eligible for inclusion[[7]](#footnote-7). The exclusion criteria were initially applied to the titles/abstracts of the identified citations. Full text articles of the remaining citations were then retrieved and the exclusion criteria were again applied. This resulted in 13 studies being included for Question 1 and 7 studies being included for Question 2.

Study and patient characteristics for each included study, as well as the results of the selected outcomes, were extracted into data extraction tables. The data extraction tables also included a judgement on the quality of each included study, and a brief description of how this quality judgement was made. Quality assessment was performed using checklists related to specific study types (i.e. RCTs and cohort studies) which are based on quality criteria defined by the National Health and Medical Research Council (NHMRC) (2000) and the Scottish Collegiate Guidelines Network[[8]](#footnote-8). It should be noted that as they presented the lowest level of evidence, Level IV studies (case series) were not assessed for quality and were automatically given a poor quality rating.

Results from each of the studies were brought together into evidence summary tables that were organised by outcome. The body of evidence for each comparison and outcome was then assessed using *Grading of Recommendations Assessment, Development and Evaulation* (GRADE) methodology (Guyatt et al., 2011).

The overall quality of the body of evidence for each outcome was assessed using an Evidence Profile table, and scored based on the included study types and the gradings of the following critera: limitations, inconsistency, indirectness, imprecision and publication bias. Systematic reviews are considered to provide the strongest evidence as they summarise one or more well-designed and well-executed RCTs and yield consistent and directly applicable results[[9]](#footnote-9). In the GRADE methodology, systematic reviews and RCTs both start as high-quality evidence. However, the quality of RCT evidence can be downgraded to moderate, low, or even very low, depending on the presence of one or more of the following five factors: (i) limitations in the design and implementation of available studies suggesting high likelihood of bias; (ii) unexplained heterogeneity or inconsistency of results (including problems with subgroup analyses); (iii) indirectness of evidence (indirect population, intervention, control, outcomes); (iv) imprecision of results (wide confidence intervals); and (v) high probability of publication bias. The moderate strength category is populated by RCTs with important limitations. Observational studies are generally graded as low-quality evidence. If, however, these studies yield large effects and there is no obvious bias explaining those effects, reviewers may rate the evidence as moderate or – if the effect is large enough – even high quality. The following three factors may lead to a study receiving a higher rating: (i) large magnitude of effect; (ii) all plausible confounding would reduce a demonstrated effect or suggest a spurious effect when results show no effect; and (iii) dose-response gradient. Very low quality evidence includes, but is not limited to, studies with critical problems and unsystematic clinical observations (e.g. case series or case reports).

Upon completion of the Evidence Profile tables, evidence statements were developed for each question and its associated comparisons and outcomes. In order to ensure consistency of the evidence statements across different questions and outcomes, a standard sentence format was applied in which the strength of the statement reflected the quality of the underlying evidence.

The systematic review findings were considered by AHCDO and incorporated into the guideline.

# Appendix D Areas for further research

The following areas were identified by AHCDO as priority areas for future research.

1. What is the optimal regimen when initiating primary prophylaxis in previously untreated patients?
2. What are the benefits of continuation of prophylaxis into adulthood?
3. What is the role of anti-inflammatory medication, in particular COX-2 inhibitors, in the management of acute joint bleeds, synovitis, and chronic arthropathy?
4. What impact does joint aspiration, with or without intra-articular steroid injection, following acute haemarthrosis have on the development of haemophilia arthropathy?
5. How good are clinicians and patients at distinguishing acute bleeding events from other causes of joint pain and should additional investigations be performed to aid diagnosis?
6. What frequency of inhibitor testing is optimal for patient outcomes?

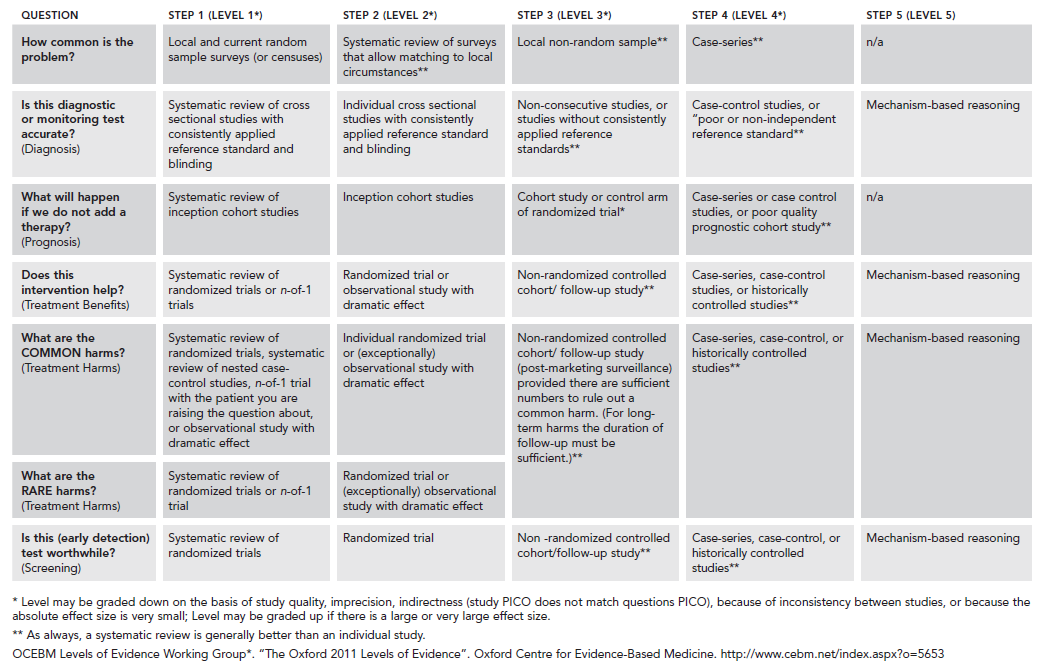
# Appendix E Patient information

Patient information designed for the Australian setting can be obtained from the website of the Haemophilia Foundation of Australia at [www.haemophilia.org.au](http://www.haemophilia.org.au)

# Appendix F Implementation and review of the Australian haemophilia guidelines

[AHCDO and the NBA will use the feedback received during public consultation to develop an implementation plan for the *Guidelines for the management of haemophilia in Australia*. Details regarding implementation and review will be included in the guideline before it is published.]

# Appendix G Oxford Centre for Evidence-Based Medicine - 2011 levels of evidence



1. 8 weeks [↑](#footnote-ref-1)
2. Levine Arch Int Med. 1976;136:792 [↑](#footnote-ref-2)
3. Smith Am J Publ Health. 1984;74:616–7 [↑](#footnote-ref-3)
4. Soucie Blood. 2000;15;96(2):437–42 [↑](#footnote-ref-4)
5. Plug J Thromb Haemost. 2006;4(3):510–6 [↑](#footnote-ref-5)
6. Hay Haemophilia (2013), 19, 660–667 [↑](#footnote-ref-6)
7. Studies were assigned a level of evidence based on the NHMRC evidence hierarchy for intervention questions. [↑](#footnote-ref-7)
8. <http://www.sign.ac.uk/methodology/checklists.html> [↑](#footnote-ref-8)
9. Institute for Clinical Systems Improvement (2011). Reviewing evidence using GRADE. Viewed on 4th December, 2014 at: <https://www.icsi.org/_asset/7mtqyr/ReviewingEvidenceUsingGRADE.pdf> [↑](#footnote-ref-9)