

AN UNUSUAL BLEEDING FOLLOWING CIRCUMCISION: A CASE REPORT.IBRAHIM AG, ALIYU S, LAWAN AM, SALIM UM.

ABSTRACT

Male circumcision is a common surgical procedure that involve excision of the prepuce, which is practiced all over the world for religious and cultural reasons. Medically it has the advantages of preventing phimosis, paraphimosis, balanitis, and decreases the risk of cancer of the penis. Common complications of circumcision are hemorrhage, sepsis, and inadvertent trauma. Excessive unusual bleeding may follow circumcision in hemophilia and other bleeding disorders. We report a case of such bleeding that necessitated transfusion of blood and fresh frozen plasma.

KEYWORDS : Circumcision, Bleeding, Hemophilia, Fresh Frozen Plasma.

INTRODUCTION

Male circumcision is performed in 1 of 6 males globally¹. The main potential benefits in support of the practice include prevention of phimosis, paraphimosis, balanitis, a decrease in the risk of cancer in the penis and reduction in the risk of urinary tract infections^{2,3}. Common complications of circumcision include hemorrhage, sepsis and trauma^{4,5} with overall complication rate of 0.2 – 5 %⁶. We report hemorrhagic complication from circumcision in a hemophilic patient.

CASE SUMMARY

The patient is a 9 year old boy who was brought in for circumcision the indication of which was cultural. He neither suffers from sickle cell disease nor any systemic disorder. He is the eighth child in the family of eleven children. On examination, he was fit, not pale, anicteric, with good hydration status and normal male external genitalia with intact prepuce.

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Circumcision was done as a day case under local anesthesia. Two days after the procedure patient was admitted with history of persistent bleeding. He was found to be pale with PCV of 18%. Circumcision wound was actively bleeding Fig. 1, necessitating transfusion of 3 units of fresh whole blood which improved the PCV to 31% however bleeding persisted, and this raised our suspicion of bleeding disorder. The liver function test did not suggest liver disease. The family history revealed the fourth child (male) died in infancy following bleeding after uvulectomy, the sixth child (male) died at the age of nine years of excessive bleeding from a minor scalp laceration. Therefore, in retrospect, a working diagnosis of bleeding complicating circumcision in a patient with hemophilia was made. The platelet count was $180 \times 10^9/l$, Prothrombin (PT) Time was 24sec (range 11 – 14sec), Partial Thromboplastin Time Kaolin (PTTK) was 66sec, and control is 47sec. The factor viii activity was found to be < 10% activity confirming the diagnosis of hemophilia. The wound was reviewed and dressed with suffratulle daily. Recovery was uneventful and patient was referred to hematologist for further management, and hospital stay was 2 weeks.

DISCUSSION

Hemophilia A, and B are bleeding disorders caused by genetic mutations in the factor V111, and 1X genes that result in deficiencies of the respective factors, inherited as x-linked



recessive inheritance. The incidence of Hemophilia A is 1 in 5000 while B is 1 in 25000 live births. The clinical presentation of Hemophilia A and B varies from spontaneous bleeding, or bleeding following trivial injury or surgical procedures. The disease in most cases is detected before the age of 5 years. The diagnosis is based on clinical presentation of abnormal bleeding confirmed by low level of factor VIII and IX, prolonged PTT, prolonged or normal PT, with normal platelets count which were seen in this patient. In mild disease (6-35% factor activity) bleeding may only occur with major trauma or surgery and not spontaneous. In moderate disease (1-5% factor activity) bleeding may occur with minimal trauma or minor surgery, while severe disease (< 1% factor activity) they have high risk of severe spontaneous bleeding. In this patient the diagnosis was made at nine years in retrospect following mishap of bleeding post circumcision in keeping with milder form of the disease. Where diagnosis is made before surgery, patients are adequately prepared by infusion of appropriate amount of coagulation factor concentrates, fresh frozen plasma or cryoprecipitate⁷. The post circumcision bleeding is treated by supplementary coagulation therapy as systematic approach. Though the international

guidelines for surgery in hemophilia has been established, it is sometimes not practicable in developing countries due to limited availability of factor concentrates⁸⁻⁹. In this patient the diagnosis was made after surgery therefore no preoperative preparation was made. In the management of this patient fresh blood and fresh frozen plasma were given in the absence of specific factor concentrate in keeping with standard practice. The circumcision wound was dressed with suffrutulle, however abnormally bleeding wound are best dressed with fibrin glue dressing^{10,11}. Circumcision, though a minor procedure with potential medical benefits also has serious life threatening risks.

In conclusion, circumcision is a frequent minor surgical procedure carried out from time in memorial as a religious and or cultural obligation. Patients for circumcision should be thoroughly evaluated to avoid potential risk including uncontrolled bleeding in patients with undiagnosed bleeding disorders.

We recommend that all patients going for circumcision should be thoroughly clerked and appropriate investigations carried out before the procedure. ■



Fig.1: Haemophilic patient post circumcision.

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