

KALITSAL ERİTROSİT ENZİM EKSİLİĞİ İLİŞKİLİ HEMOLİTİK ANEMİLER

18. BÖLÜM

Ayşe UYSAL¹

Giriş

Yaşam döngülerinde eritrositler, olgunlaşma sırasında nükleus, mitokondri ve diğer organellerini kaybetmelerinden dolayı oksidatif fosforilasyon, protein ve lipit sentezi yapamazlar. Hücresel fonksiyonların sürdürülebilmesi için enerji gereksinimini anaerobik glikoliz ile sağlarlar ve yine hücre bütünlüğünün ve esnekliğinin korunması, oksijenin taşınması, eritrositler için toksik bir takım nükleotid öncüllerinin uzaklaştırılması, hücrenin oksidatif hasardan korunması birçok enzimin görev aldığı metabolik yollar ile sağlanmaktadır. Bu yollar Embden-Meyerhof yolu, heksoz monofosfat şantı, glutatyon yolu, Rapoport-Luebering şantı ve nükleotid metabolizmasıdır. Bu yollar ve görevli enzimler **Şekil 1' de** gösterilmiştir (1-5).

Enzimleri kodlayan genlerde oluşan mutasyonlar sonucu bu yollarda görevli enzimlerde eksiklikler ya da defektler oluşur. Bu durum eritrositlerin enerji dengesini bozarak oksidatif strese yol açar ve hücre bütünlüğü bozulur. Enzim eksikliğinin tipine ve rol aldığı yola göre hematolojik ya da non-hematolojik klinik durumlar oluşur. Bu hematolojik klinik durumlardan bir tanesi de non-sferositik hemolitik anemilerdir (5,6).

Hemolitik anemi oluşturan en sık enzim eksiklikleri ise adenozin trifosfat (ATP) enerji gereksiminin %90' ını sağlayan yolak olan Embden-Meyerhof yolağında görevli olan piruvat kinaz eksikliği ve enerji üretiminin geri kalan kısmından sorumlu olan yolak olan heksoz monofosfat şantında görevli enzim olan glukoz-6 fosfat dehidrogenaz (G6PD) eksikliğidir (6,7).

¹ Doktor Öğretim Üyesi, Balıkesir Üniversitesi Tıp Fakültesi, drayseorucuysal@gmail.com

Sonuç

Enzim eksikliklerine bağlı hemolitik anemiler nadir görülseler de immün olmayan hemolitik anemi, açıklanamayan sarılık, dalak büyüklüğü gibi durumlarda akılda tutulması gereken hastalık grubudur. Çoğunluğu asemptomatik seyretse de erken müdahale edilmediğinde mortal kliniklere neden olabilirler.

KAYNAKÇA

1. Jacobasch G and Rapoport SM. Hemolytic anemias due to erythrocyte enzyme deficiencies. *Mol Aspects Med.* 1996; 17 (2), 143-70. Doi: 10.1016/0098-2997(96)88345-2.
2. Koralkova P, van Solinge WW and van Wijk R. Rare hereditary red blood cell enzymopathies associated with hemolytic anemia - pathophysiology, clinical aspects, and laboratory diagnosis. *Int J Lab Hematol.* 2014; 36 (3), 388-97. Doi: 10.1111/ijlh.12223.
3. Gallagher PG. Diagnosis and management of rare congenital nonimmune hemolytic disease. *Hematology. American Society of Hematology. Education Program.* 2015; 2015 392-9. Doi: 10.1182/asheducation-2015.1.392.
4. Risinger M, Emberesh M and Kalfa TA. Rare Hereditary Hemolytic Anemias: Diagnostic Approach and Considerations in Management. *Hematol Oncol Clin North Am.* 2019; 33 (3), 373-392. Doi: 10.1016/j.hoc.2019.01.002.
5. van Wijk R and van Solinge WW. The energy-less red blood cell is lost: erythrocyte enzyme abnormalities of glycolysis. *Blood.* 2005; 106 (13), 4034-42. Doi: 10.1182/blood-2005-04-1622.
6. Grace RF and Glader B. Red Blood Cell Enzyme Disorders. *Pediatr Clin North Am.* 2018; 65 (3), 579-595. Doi: 10.1016/j.pcl.2018.02.005.
7. Cohn J, Hanel HK, Sorensen SA, et al. [Hereditary hemolytic anemia resulting from erythrocyte enzyme defects. Biochemical, genetic and clinical aspects]. *Ugeskr Laeger.* 1976; 138 (39), 2372-6. Doi:
8. Mallouh AA. (2012). Other Red Cell Enzymopathies. A. Y. Elzouki, H. A. Harfi, H. M. Nazer, F. B. Stapleton, W. Oh and R. J. Whitley(Ed.), *Textbook of Clinical Pediatrics* içinde (s.2981-2983). Berlin, Heidelberg: Springer Berlin Heidelberg.
9. Martinov MV, Plotnikov AG, Vitvitsky VM, et al. Deficiencies of glycolytic enzymes as a possible cause of hemolytic anemia. *Biochim Biophys Acta.* 2000; 1474 (1), 75-87. Doi: 10.1016/s0304-4165(99)00218-4.
10. Zanella A, Fermo E, Bianchi P, et al. Red cell pyruvate kinase deficiency: molecular and clinical aspects. *Br J Haematol.* 2005; 130 (1), 11-25. Doi: 10.1111/j.1365-2141.2005.05527.x.
11. Zanella A and Bianchi P. Red cell pyruvate kinase deficiency: from genetics to clinical manifestations. *Baillieres Best Pract Res Clin Haematol.* 2000; 13 (1), 57-81. Doi: 10.1053/beha.1999.0057.
12. Ferreira P, Morais L, Costa R, et al. Hydrops fetalis associated with erythrocyte pyruvate kinase deficiency. *Eur J Pediatr.* 2000; 159 (7), 481-2. Doi: 10.1007/s004310051314.
13. Grace RF, Mark Layton D and Barcellini W. How we manage patients with pyruvate

- kinase deficiency. *Br J Haematol.* 2019; 184 (5), 721-734. Doi: 10.1111/bjh.15758.
14. Zanella A, Fermo E, Bianchi P, et al. Pyruvate kinase deficiency: the genotype-phenotype association. *Blood Rev.* 2007; 21 (4), 217-31. Doi: 10.1016/j.blre.2007.01.001.
 15. Grace RF, Zanella A, Neufeld EJ, et al. Erythrocyte pyruvate kinase deficiency: 2015 status report. *Am J Hematol.* 2015; 90 (9), 825-30. Doi: 10.1002/ajh.24088.
 16. Kugler W and Lakomek M. Glucose-6-phosphate isomerase deficiency. *Baillieres Best Pract Res Clin Haematol.* 2000; 13 (1), 89-101. Doi: 10.1053/beha.1999.0059.
 17. Kedar PS, Dongerdiye R, Chilwirwar P, et al. Glucose Phosphate Isomerase Deficiency: High Prevalence of p.Arg347His Mutation in Indian Population Associated with Severe Hereditary Non-Spherocytic Hemolytic Anemia Coupled with Neurological Dysfunction. *Indian J Pediatr.* 2019; 86 (8), 692-699. Doi: 10.1007/s12098-019-02928-1.
 18. Kaur R and Gupta N. Hemolytic Anemia and Neurological Manifestations - An Uncommon Combination. *Indian J Pediatr.* 2019; 86 (8), 673-674. Doi: 10.1007/s12098-019-02997-2.
 19. Repiso A, Oliva B, Vives-Corróns JL, et al. Red cell glucose phosphate isomerase (GPI): a molecular study of three novel mutations associated with hereditary nonspherocytic hemolytic anemia. *Hum Mutat.* 2006; 27 (11), 1159. Doi: 10.1002/humu.9466.
 20. Kanno H. Hexokinase: gene structure and mutations. *Baillieres Best Pract Res Clin Haematol.* 2000; 13 (1), 83-8. Doi: 10.1053/beha.1999.0058.
 21. Murakami K, Kanno H, Tancabelic J, et al. Gene expression and biological significance of hexokinase in erythroid cells. *Acta Haematol.* 2002; 108 (4), 204-9. Doi: 10.1159/000065656.
 22. Nakajima H, Raben N, Hamaguchi T, et al. Phosphofructokinase deficiency; past, present and future. *Curr Mol Med.* 2002; 2 (2), 197-212. Doi: 10.2174/1566524024605734.
 23. Raben N and Sherman JB. Mutations in muscle phosphofructokinase gene. *Hum Mutat.* 1995; 6 (1), 1-6. Doi: 10.1002/humu.1380060102.
 24. Schneider AS. Triosephosphate isomerase deficiency: historical perspectives and molecular aspects. *Baillieres Best Pract Res Clin Haematol.* 2000; 13 (1), 119-40. Doi: 10.1053/beha.2000.0061.
 25. Stincone A, Prigione A, Cramer T, et al. The return of metabolism: biochemistry and physiology of the pentose phosphate pathway. *Biol Rev Camb Philos Soc.* 2015; 90 (3), 927-63. Doi: 10.1111/brv.12140.
 26. Duffieux F, Van Roy J, Michels PA, et al. Molecular characterization of the first two enzymes of the pentose-phosphate pathway of *Trypanosoma brucei*. Glucose-6-phosphate dehydrogenase and 6-phosphogluconolactonase. *J Biol Chem.* 2000; 275 (36), 27559-65. Doi: 10.1074/jbc.M004266200.
 27. Cappellini MD and Fiorelli G. Glucose-6-phosphate dehydrogenase deficiency. *Lancet (London, England).* 2008; 371 (9606), 64-74. Doi: 10.1016/s0140-6736(08)60073-2.
 28. Luzzatto L, Nannelli C and Notaro R. Glucose-6-Phosphate Dehydrogenase Deficiency. *Hematol Oncol Clin North Am.* 2016; 30 (2), 373-93. Doi: 10.1016/j.hoc.2015.11.006.
 29. Howes RE, Battle KE, Satyagraha AW, et al. G6PD deficiency: global distribution, genetic variants and primaquine therapy. *Adv Parasitol.* 2013; 81 133-201. Doi:

- 10.1016/b978-0-12-407826-0.00004-7.
30. Glucose-6-phosphate dehydrogenase deficiency. WHO Working Group. *Bull World Health Organ.* 1989; 67 (6), 601-11. Doi:
 31. Mason PJ, Bautista JM and Gilsanz F. G6PD deficiency: the genotype-phenotype association. *Blood Rev.* 2007; 21 (5), 267-83. Doi: 10.1016/j.bre.2007.05.002.
 32. Minucci A, Giardina B, Zuppi C, et al. Glucose-6-phosphate dehydrogenase laboratory assay: How, when, and why? *IUBMB Life.* 2009; 61 (1), 27-34. Doi: 10.1002/iub.137.
 33. Martini G, Toniolo D, Vulliamy T, et al. Structural analysis of the X-linked gene encoding human glucose 6-phosphate dehydrogenase. *Embo j.* 1986; 5 (8), 1849-55. Doi:
 34. Ruwende C and Hill A. Glucose-6-phosphate dehydrogenase deficiency and malaria. *J Mol Med (Berl).* 1998; 76 (8), 581-8. Doi: 10.1007/s001090050253.
 35. Wajcman H and Galactéros F. [Glucose 6-phosphate dehydrogenase deficiency: a protection against malaria and a risk for hemolytic accidents]. *C R Biol.* 2004; 327 (8), 711-20. Doi: 10.1016/j.crv.2004.07.010.
 36. Luzzatto L and Bienzle U. The malaria/G-6-P.D. hypothesis. *Lancet (London, England).* 1979; 1 (8127), 1183-4. Doi: 10.1016/s0140-6736(79)91857-9.
 37. Luzzatto L and Arese P. Favism and Glucose-6-Phosphate Dehydrogenase Deficiency. *N Engl J Med.* 2018; 378 (1), 60-71. Doi: 10.1056/nejmra1708111.
 38. Mehta AB. Glucose-6-phosphate dehydrogenase deficiency. *Postgrad Med J.* 1994; 70 (830), 871-7. Doi: 10.1136/pgmj.70.830.871.
 39. Albano E, Tomasi A, Mannuzzu L, et al. Detection of a free radical intermediate from divicine of *Vicia faba*. *Biochem Pharmacol.* 1984; 33 (10), 1701-4. Doi: 10.1016/0006-2952(84)90299-5.
 40. Youngster I, Arcavi L, Schechmaster R, et al. Medications and glucose-6-phosphate dehydrogenase deficiency: an evidence-based review. *Drug Saf.* 2010; 33 (9), 713-26. Doi: 10.2165/11536520-000000000-00000.
 41. Luzzatto L and Seneca E. G6PD deficiency: a classic example of pharmacogenetics with on-going clinical implications. *Br J Haematol.* 2014; 164 (4), 469-80. Doi: 10.1111/bjh.12665.
 42. Le Pommelet C, Le Moullec N and Zunic P. Diabetic ketoacidosis revealing glucose-6-phosphate dehydrogenase deficiency: description of an adult case. *Diabetes Metab.* 2006; 32 (6), 636-7. Doi: 10.1016/s1262-3636(07)70320-8.
 43. Lai YK, Lai NM and Lee SW. Glucose-6-phosphate dehydrogenase deficiency and risk of diabetes: a systematic review and meta-analysis. *Ann Hematol.* 2017; 96 (5), 839-845. Doi: 10.1007/s00277-017-2945-6.
 44. Fiorelli G, Martinez di Montemuros F and Cappellini MD. Chronic non-spherocytic haemolytic disorders associated with glucose-6-phosphate dehydrogenase variants. *Baillieres Best Pract Res Clin Haematol.* 2000; 13 (1), 39-55. Doi: 10.1053/beha.1999.0056.
 45. Dhaliwal G, Cornett PA and Tierney LM, Jr. Hemolytic anemia. *Am Fam Physician.* 2004; 69 (11), 2599-606. Doi:
 46. Tantular IS and Kawamoto F. An improved, simple screening method for detection of glucose-6-phosphate dehydrogenase deficiency. *Trop Med Int Health.* 2003; 8 (6), 569-74. Doi: 10.1046/j.1365-3156.2003.01055.x.
 47. Kaplan M and Hammerman C. The need for neonatal glucose-6-phosphate dehyd-

- rogenase screening: a global perspective. *J Perinatol.* 2009; 29 Suppl 1 S46-52. Doi: 10.1038/jp.2008.216.
48. Elyassi AR and Rowshan HH. Perioperative management of the glucose-6-phosphate dehydrogenase deficient patient: a review of literature. *Anesth Prog.* 2009; 56 (3), 86-91. Doi: 10.2344/0003-3006-56.3.86.
 49. Cunningham AD, Hwang S and Mochly-Rosen D. Glucose-6-Phosphate Dehydrogenase Deficiency and the Need for a Novel Treatment to Prevent Kernicterus. *Clin Perinatol.* 2016; 43 (2), 341-54. Doi: 10.1016/j.clp.2016.01.010.
 50. Haley K. Congenital Hemolytic Anemia. *Med Clin North Am.* 2017; 101 (2), 361-374. Doi: 10.1016/j.mcna.2016.09.008.
 51. Stanton RC. Glucose-6-phosphate dehydrogenase, NADPH, and cell survival. *IU-BMB Life.* 2012; 64 (5), 362-9. Doi: 10.1002/iub.1017.