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Prevalence of bleeding disorders in women with menorrhagia

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Menorrhagia is a common problem in women of reproductive age group and 5% of women between 30 and 49 years of age group consult their general practitioner for this problem. The etiology can be local or systemic disorders but a specific cause is identified in less than 50% of the cases and dysfunctional uterine bleeding is diagnosed. Menstruation is an important haemostatic challenge in women with bleeding disorders. Most of these women present with puberty onset menorrhagia. Bleeding disorders like von Willebrand Disease, single coagulation factor deficiencies particularly factor XI, VIII, Factor V and platelet function disorders like Glanzmanns disease, Bernard Soulier's have been found to be prevalent in patients presenting with menorrhagia. Hence, clinicians should be alert in women with menorrhagia. History taking should include: History of epistaxis, easy bruising, prolonged bleeding after tooth extraction, prolonged bleeding after any injury, bleeding in the oral cavity, GIT or any other internal organ and excessive post surgical bleeding. All the patients should be subjected to screening investigations which include bleeding time, activated partial thromboplastin time, prothrombin time and complete blood count including peripheral smear evaluation for platelet morphology. Based on the results of screening investigations, confirmatory tests like specific factor evaluation (Coagulation factors II, V, VII, VIII, IX, X, XI and XII), von Willebrand factor antigen estimation by ELISA, von Willebrand Ristocetin cofactor essay (VWF:Rco), platelet function studies including platelet aggregation using ADP and Ristocetin can be done. Hence, adolescents with known bleeding disorders should be counseled prior to menarche and before pregnancy for the possibilities of excessive bleeding in future and should also be explained about the available treatment modalities. Bleeding disorders should be kept as one of the differentials in diagnosing patients presenting with menorrhagia.

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Lesson from outbreaks of HIV-1, HCV and HAV among Korean hemophiliacs in 1990s

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There were outbreaks of HIV-1, HCV and HAV transmission among Korean hemophiliacs B from late 1989 and 1998, respectively. In 1994, first investigation committee for HIV-1 transmission (IC) reported that the clotting factor is presumed as cause, based on that several lots of domestic clotting factor (DCF) were significantly associated ($P<0.05$). The whole story on this issue through me who interviewed all HIV-1 infected persons at division of AIDS, Korean NIH in 1990-1993 was introduced in a potent daily newspaper in Korea in September 2002. Thus, 2nd IC was established by health authority and I was sued by manufacturer of DCF. Luckily, we had stocked almost all sera obtained from all HIV-1 infected individuals diagnosed in 1990-1993. Thus, we could contribute to clarify the genetic relationships among HIV-1 viruses found in four cash-paid plasma donors whose pre-seroconversion plasma was used to produce DCF, 20 hemophiliacs infected with Korean subclade B (KSB) and local controls although I felt the pain with the relevant litigations. Phylogenetic and signature pattern analyses on *pol* and *vif* sequences by RT-PCR confirmed that 20 hemophiliacs were infected with KSB through infusion of DCF. The Supreme Court of Korea ruled that a domestic company was responsible for the infection with HIV-1 of hemophiliacs B in 2011. Twenty hemophiliacs had been treated with Korean red ginseng (KRG). Among the 20 hemophiliacs, 16 are alive with ginseng based combination therapy since 1998. The lesson on these viruses transmission that should not happen is worth to share.

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