Autoimmune haemolytic anaemia in a newborn infant

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The case is reported of an infant with autoimmune haemolytic anaemia of perinatal onset. Combined treatment with steroids and cyclosporin was necessary to improve haemolysis and reduce the high transfusion requirements. Treatment was discontinued at 13 months of age. The child was healthy at the follow up at 24 and 36 months of age.

Autoimmune haemolytic anaemia (AIHA) is a rare disease; the annual incidence is about one case in 80 000 live births. It is more common than acquired aplastic anaemia and less common than immune thrombocytopenic purpura.1 Infants of any age can be affected, although neonatal occurrence is considered exceptional. We describe a patient with severe haemolytic anaemia of perinatal onset.

CASE REPORT

The male infant was born by normal vaginal delivery at term with a birth weight of 3120 g. Apgar scores were 9 at one and five minutes. The direct antiglobulin test (DAT) on cord blood was slightly positive (titre 1:64). Twelve hours after birth, he was transfused with packed red cells because of severe anaemia. Two weeks later, he needed another blood transfusion, and at 23 days of life he was transferred to our hospital because of the persistence of anaemia. His family history showed no significant disease; his parents were nonconsanguineous. The mother's blood type was A Rh positive, and the infant's O positive.

Physical examination showed pallor, hepatosplenomegaly, and no lymphadenomegaly.

Haemoglobin concentration was 59 g/l (17% packed cell volume; red blood cells 1870 × 10^9/l), reticulocytes were absent, platelets were 314 × 10^9/l. Leucocyte count was 8.6 × 10^9/l (neutrophils 54%, lymphocytes 36%, and monocytes 6%). A blood smear showed anisopoikilocytosis and spherocytosis.

DAT was positive (titre 1:250). Serum lactate dehydrogenase concentration was 1314 U/l.

Clotting tests (prothrombin time, partial thromboplastin time, fibrinogen) were normal, and the autoantibody assay (anti-nuclear, anti-extractable nuclear antigens, anti-DNA, anti-cardiolipin) was negative. Investigations for HIV, Epstein-Barr virus, cytomegalovirus, herpes simplex virus 1-2, and hepatitis A, B, and C viruses did not indicate a congenital infection. Serology for parvovirus showed positivity of IgG and negativity of IgM in both mother and infant.

A tibial bone marrow aspiration showed normal cellularity, the presence of megakaryocytes, and normal granulocytic and lymphocytic lineages. A paucity of erythroid precursors, blocked at the stage of basophil erythroblast, was observed. No abnormal blast cells or malignant cytological abnormalities were found.

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Cultures of peripheral blood cells, obtained by separation of mononuclear cells and stimulated with several cytokines (granulocyte colony stimulating factor, erythropoietin, interleukin 3), showed normal growth of haematopoietic progenitor cells.2

Figure 1 Number of transfusions (indicated by arrows) and schedule of treatment related to packed cell volume and reticulocyte counts, during the first 13 months of life in an infant with autoimmune haemolytic anaemia.

Lymphocyte phenotype was characterised by a reduction in total T cells, with inversion of T4/T8 ratio and relative increase in T activated lymphocytes and B cells: CD3, 33%; CD3/DR+, 18%; CD4, 16%; CD8, 18%; CD5, 50%; HLA-DR, 58%; CD19, 24%; CD16, 30%; TCRγδ/CD4/CD8, 1%; CD95, 78%.

Serial measurements of polyspecific DAT showed a stable positivity with titre 1:256 up to first 8 weeks of age. These findings, along with a negative indirect Coombs test and irregular antibody test in the mother, suggested AIHA.

A monospecific anti-human globulin test was positive for anti-IgG, and negative for anti-IgA, anti-IgM, anti-C3c, and anti-C3d.

Immunosuppressive treatment with methylprednisolone at a dose of 2 mg/kg/day was started. After four weeks, because of the persistence of significant haemolysis (high transfusion

Abbreviations: AIHA, autoimmune haemolytic anaemia; DAT, direct antiglobulin test.
One baby died as a consequence of refractory AIHA. Remained dependent on steroids, and underwent splenectomy. Months of age with severe watery diarrhoea. One child was also affected by autoimmune enteropathy, died at 6 improvement of anaemia, although for only two could so far been reported (table 1). Six responded to treatment with methylprednisolone (20 mg/kg/day for three consecutive erythropoiesis (reticulocytopenia), two courses of high dose antibodies is limited by an immature immune and reticulo-endothelial system. Early immunological stimulation usually results in the production of low titre IgM specific antibodies, and the use of cyclosporin successfully treated the hypoplastic phase, and the use of cyclosporin controlled the disease (fig 1).

As a consequence of steroid treatment, the child initially showed hyposomia (length < 3rd centile). However, clinical evaluation at 24 and 36 months of age showed that length and growth had been regained (> 25th centile), and there was no recurrence of haemolysis.

**DISCUSSION**

To our knowledge, only seven young infants with AIHA have so far been reported (table 1). Six responded to treatment with improvement of anaemia, although for only two could treatment be discontinued without relapse. One of these, who was also affected by autoimmune enteropathy, died at 6 months of age with severe watery diarrhoea. One child remained dependent on steroids, and underwent splenectomy. One baby died as a consequence of refractory AIHA.

During the first 6 weeks of life, an infant’s ability to form antibodies is limited by an immature immune and reticulo-endothelial system. Early immunological stimulation usually results in the production of low titre IgM specific antibodies, with a delayed switch from the IgM to the IgG class. However, the impaired responsiveness of the neonate is variable and the possibility of synthesis of autoimmune antibodies cannot be excluded.

Neonatal occurrence of AIHA is very rare. In only one of the reported patients’ was the diagnosis made at birth as in our case. As AIHA is so rare, few data on clinical management and treatment strategies are available. The use of steroids is widely accepted, although long term treatment during infancy is associated with appreciable side effects, such as neurological and somatic growth retardation, hypertension, and hypertrophic cardiomyopathy.

**REFERENCES**