Slow Elevation in Protein C Activity without a PROC Mutation in a Neonate with Intracranial Hemorrhage

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Abstract

Severe protein C (PC) deficiency leads to purpura fulminans and stroke in newborns. However, the clinical impact of plasma PC activity on the development of neonatal cerebral disease remains elusive. We report a case of hemorrhagic stroke associated with neonatal asphyxia and severe PC deficiency. Plasma PC and protein S activity 7 days after birth was 12% and 43%, respectively. No PROC mutation was found. PC levels did not exceed 20% until 2 months of age, even in the absence of consumption coagulopathy or vitamin K deficiency. Neither thromboembolic nor hemorrhagic events occurred during the infusion of activated PC concentrate (twice weekly, up to 68 days after birth). The PC activity levels gradually increased to the standard value for age by 9 months of age. The present case showed that neonatal PC deficiency without a PROC mutation caused an intracranial hemorrhage before a slow increase in PC activity.

Keywords
► neonatal stroke
► hemorrhagic infarction
► protein C deficiency
► PROC mutation

Protein C (PC) is an anticoagulant factor synthesized in hepatocytes. Activated PC, augmented by protein S (PS), inhibits coagulation factors Va and VIIIa. PC deficiency leads to thromboembolic events; however, in neonates it often causes purpura fulminans and intracranial hemorrhage.1

Neonatal PC deficiency can be divided into the inherited and noninherited types. The inherited type is caused by mutations in the protein C gene (PROC). However, the clinical impact of plasma PC activity on the development of neonatal cerebral disease remains elusive. Little is known about the cause and presentation of neonatal noninherited PC deficiency.2 The present case showed that neonatal PC deficiency without a PROC mutation was associated with hemorrhagic stroke before a slow increase in PC activity.

Case Report

A male infant weighing 2,216 g was born by cesarean section at 36 weeks of gestation due to a previous cesarean section and early labor pains. Fetal growth was normal, and the
placenta revealed no thromboembolic obstructions. There was no family history of blood coagulation disorder. The patient showed an Apgar score of 2, 4, and 7 at 1, 5, and 10 minutes, respectively.

A subarachnoid hemorrhage, subdural hematoma, and cerebral hemorrhage were found, and ischemic encephalopathy was disclosed by ultrasound and computed tomography at age 1 day. His blood test revealed leukocytes 20,340/μL, hemoglobin 189 g/L, platelets 216 × 10^9/L, fibrinogen 1.05 g/L, prothrombin time-international normalized ratio (PT-INR) 1.2, activated partial thromboplastin time (aPTT) 85.6 second, antithrombin activity 37.1%, and D- dimer 1.05 g/L, prothrombin time-international normalized ratio (PT-INR) 1.2, activated partial thromboplastin time (aPTT) 67.4 second, and PT-INR 1.13 (Fig. 1). Follow-up T2-weighted magnetic resonance imaging at 9 days old (E) shows no new intracranial embolism or hemorrhage. Dissociation between changes in protein C (PC) and protein S (PS) activity. Closed circles and solid lines indicate PC activity; open circles and dotted lines indicate PS activity. PC activity increased slowly compared with the increase in PS activity.

In conclusion, our case of neonatal PC deficiency without a PROC mutation demonstrated an intracranial hemorrhage and slowly increasing PC activity. Further studies are needed to clarify the pathomechanism of neonatal transient PC deficiency.

Discussion

The present case of neonatal PC deficiency with an intracranial hemorrhage is remarkable because it illustrates the pathophysiology of the disease without a PROC mutation. PC levels in healthy term infants are ~30% to 40% at age 5 days and ~40% to 50% at age 1 month. Levels reach the adult range at about age 6 to 9 months. Manco-Johnson et al showed that the PC activity in some infants increased from a very low level to a normal level, and that some of the infants suffered from thromboembolic events. They also reported that low PC levels occurred most frequently in preterm infants with respiratory distress and infants from twin gestations. The PC deficiency which occurred in these patients might also occur in stressed neonates like our patient.

There are a few case reports of neonatal noninherited PC-deficient patients born to healthy parents, having normal PC activity, and showing a presentation similar to that of neonates with a PROC mutation. Two of seven Japanese PC-deficient patients who underwent the PROC gene test had no mutation. As in our case and a previous case without a PROC mutation, low PC activity during the early infantile period increased more slowly than the PS activity.

In conclusion, our case of neonatal PC deficiency without a PROC mutation demonstrated an intracranial hemorrhage and slowly increasing PC activity. Further studies are needed to clarify the pathomechanism of neonatal transient PC deficiency.

Statement of Ethics

The institutional review board of our hospital approved this investigation. Informed consent was obtained from the caretakers for publication of this case report and accompanying images.

Conflict of Interest

None.

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