adjustment for ASHD, diabetes, hyperlipidemia, OR=0.92 (0.85-0.99), $P < 0.020$.
**Conclusion:** The risk of HBP is significantly lower in HEM than non-HEM patients, associated with lower risk of ASHD, hyperlipidemia, and diabetes. Prospective studies are warranted.
**Disclosure of Interest:** None Declared.

## PO278-WED
## A case of acute cerebral infarction in a patient with hemophilia B

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**Background:** Hemophilia A or B is a disease characterized by hemostatic abnormalities. As the hemophilia patients grow older, the geriatric diseases such as hypertension, diabetes mellitus or cardiovascular diseases may develop.
**Aims:** Cerebral hemorrhage is one of the common cause of death in hemophiliacs. But cerebral infarction is rare. We report a case of hemophilia B patient suffering from acute cerebral infarction.
**Methods:** 58 year old male with hemophilia B visited our hospital for right hand motor weakness. The brain MR imaging showed acute cerebral infaction in left middle cerebral artery territory. We managed him with antiplatelet drugs cautiously, giving the recombinant coagulation factor 9, Benefix, within the limits of the Korean health insurance.
**Results:** The patient's symptom was improved and the complications such as hemorrhagic transformation or organ/tissue bleeding did not occur.
**Conclusion:** When cerebrovascular accidents like infarction develop in hemophiliacs, the balance between antiplatelet drugs and coagulation factor may be important.
**Disclosure of Interest:** None Declared.

## PO279-WED
## The use of secondary prophylaxis in the haemophilia A patients

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**Background:** Recurrent joint bleeding leading to progressive musculoskeletal damage (hemophilic arthropathy), in spite of on-demand replacement with deficient factor concentrates, is the clinical hallmark of severe hemophilia A. Prophylactic treatment for severe haemophilia A is likely to be more effective than treatment when bleeding occures, however prophilaxis is costly.Whereas the benefits of primary prophylaxis are well documented, data related to secondary prophylaxis are limited.
**Aims:** Our aim is to share our data regarding to secondary prophylaxis and to point out the benefits of secondary prophylaxis.
**Methods:** We are presenting the data of 115 male with the diagnosis of haemophilia A, aged between 11–338 months. Patients were grouped in to four according to bleeding frequencies. The target joint involvements were recorded. Patients response to prophylaxis treatment were also recorded by comparing the frequencies of bleedings before and after prophylaxis by chi-square test .
**Results:** Of all the patients, 42 were under secondary, three were under primary prophylaxis. By secondary prophylaxis bleeding episodes decreased by 78%. Nine had no change in bleeding (16%). By comparison of bleeding frequencies before and after prophylaxis by chi-square test, it was shown that the difference was statistically significant ($P < 0,01$). Three patients under primary prophylaxis had no significant bleeding.
**Conclusion:** Secondary prophylaxis is useful in controlling bleeding and preventing progression of joint destruction in hemophilia A patients. Failure of prophylaxis may be related to underlying status of the joints, poor compliance and participation in high-risk activities. The cost of secondary prophylaxis in adolescents and young adults is likely to be higher, as larger doses of factor concentrate are required because of patient weight, but the potential benefits of reduced absence from school, incresed work based productivity and reduced need for orthopaedic surgery may be significant.
**Disclosure of Interest:** None Declared.

## PO280-WED
## Comparative study of the prevalence of clotting factor deficiency in carriers of hemophilia A and B

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**Background:** Hemophilia carriers are characterized by a wide range of clotting factor activity and heterogeneity of bleeding phenotype. The plasma concentrations of factor VIII (FVIII) in hemophilia A (HA) and factor IX (FIX) in hemophilia B (HB) carriers are determined by the process not entirely understood. Additionally, it is unknown whether there is a difference between values of clotting factor levels in HA and HB carriers.
**Aims:** The aim of this study was to compare the prevalence of clotting factor deficiency between carriers of HA and HB.
**Methods:** We conducted a single center study comprising all HA and HB carriers defined by genetic mutation. Additional data collected included FVIII or FIX levels and affiliation to families. Clotting factor deficiency was defined as FVIII or FIX levels $< 0.50$ IU $mL^{-1}$.
**Results:** In our center, 123 carriers of HA and 48 carriers of HB met inclusion criteria. The median level of FVIII in HA carriers and FXI in HB carriers was 0.61 and 0.59 IU $mL^{-1}$, respectively ($P = 0,69$). However, a slightly higher prevalence of clotting factor deficiency was found in carriers of HB (22 patients, 46%) then of HA (42 patients, 34%). Moreover, the factor deficiency was found in 34%, 33% and 31% of patients carrying severe, moderate and mild HA, respectively, compared to 46%, 50% and 36% of patients carrying severe, moderate and mild HB, respectively.
**Conclusion:** This study demonstrates higher prevalence of clotting factor deficiency among carriers of HB then HA. Besides, our results indicate that carriers of severe and moderate HB have higher risk of having factor deficiency then carriers of severe and moderate HA. The underlying mechanism of this phenomenon is unknown. Furthermore, this finding has the impact on the management of HB carriers, since they, unlike carriers of HA who can benefit from treatment with desmopressin, depend on the replacement therapy with factor IX concentrates.
**Disclosure of Interest:** None Declared.

## PO281-WED
## Prevalence and incidence of hemophilia in the North of Tunisia

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**Background:** Hemophilia is a hereditary genetic bleeding disorder. Its prevalence and its incidence, estimated bye the World Federation of