## BioChem final 👬 💯

- iron : not free , bound mostly to erythrocytes , less in women , absorbed as ferrous +2 , (DMT1) is iron transporter + c-dependent , heme absorbed by (HCP-1) from meat , PPI inhibits iron absorption .
- iron storage in intestine cells as ferritin Fe+3 , (shedding = loss ) , iron loss by : gastrectomy , Gi bleeding + hookworms , H. Pylori , celiac, Crohn .
- iron transported as tow Fe+3 in transferrin by ferroxidase (or plasma protein ceruloplasmin), NTBI binds exceed iron . transferrin receptor prefers saturated transferrin , then endocytosis , then STEAP3 reduce ferric into ferrous to cytosol (c dependent).
- normally TFR1 bound to TFE , iron replaces TFE , TFE goes to TFR2 (sensor ) to send message to hepcidin .
- bacterial infection ▲ inflammation ▲ IL-6 = ▲ Hepcidin .
- more iron in BM = BMPR is bound to hemojuvelin (HJV) = ♪ hepcidin.
- hypoxia + anemia = errythropoietin = V hepcidin.
- iron regulatory element on mRNA (3 or 5 untranslated ), binds to IRP on TFR + DMT-1 to increase absorption //// + decrease storage by IRP 2 binds to IRE on Fpn 
  (ferritin + ALAS)
- HIGH iron level IRP to decrease absorption increase storage .
- Hereditary hemochromatosis : 1 most common (HFE-dependent) , 2A (HJV-dependent) , 2B (hepcidin-dependent), 3 (TfR2-dependent) , 4 (ferroprotein-dependent) .
- type 1 & A2 &B2 &3 are Autosomal recessive disorders , type 4 is Autosomal dominant disorder.
- 50 gm exceed Iron damage proteins = hemosiderin .
- Juvenile hemochromatosis : type 2 (A&B) , CHILDREN cause high iron , low hepcidin .
- Iron-deficiency anemia : low iron = hypoxia .
- blood coagulation : first platelets adhesion then aggregation then coagulation . platelets have receptors on surface like : thrombin , thromboxane , GP for collagen + vWB+ other platelets .
- activation of thrombin receptor activate PLC B = IP3 + DAG = release of ca+, release arachidonic from phospholipid by PLA2, arachidonic releases by cox vasoconstrictors like prostaglandins.
- aspirin inhibits cox, and prostacyclin which means: it is vasodilator + anti-inflammatory, risk of bleeding in older people.
- ca+ also activates MLCK altered platelet morphology, induced motility, and release of granules.
- ADP from DAG changes platelets morphology to bind to fibrinogen .
- Non-enzymatic protein cofactors (factors VIII, V, and tissue factor), all factors are from liver except tissue factor from platelets.
- Gla domain carboxylation with ca+ by reduction of vit K by quinine reductase (warfarin inhibits the reduction).
- neonate has vit K deficiency due to its fat solubility not in milk, not in placenta .
- tissue factors are initiators of coagulation after damaged cells , factor 7 extrinsic + factor 12 intrinsic .

- Factor XII is autoactivated by prekallikrein, they also activate HMW kininogen releasing bradykinin (a peptide with potent vasodilator action).
- tenase complexes : factor 7 + tissue factor and factors 8&9 activate factor x . factor 5+8 are co factors not enzyme .
- von Willbrand factor deficiency decrease factor 8 half-life .
- The complex of factor Xa/Va/Ca2+ is the "prothrombinase complex", Thrombin cleaves fibrinogen = "soft clot", then into hard clot by (factor 13, stabilizer)transglutaminase that is activated by thrombin.
- by thrombin binding to thrombomodulin, protein c activated and activates protein S (vit K dependent) , inhibits factors 8+5 .
- Antithrombin III requires Heparin sulfate to inhibits coagulation, Tissue factor pathway inhibitor (TFPI) inhibits the pro-thrombinase complex also accelerates protein S function.
- fibrinolysis : activated protein C = ▲ tPA = ▲ plasminogen = ▲ plasmin . Streptokinase & Urokinase UPA increase plasminogen conversion , (TAFI) removes lysine residues and prevents fibrinolysis.

GOOD LUCK 👏