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Case Report

A rare and successfully managed case of idiopathic thrombocytopenic purpura (ITP) with previous caesarean with splenectomy with hepatitis C positive

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ABSTRACT

ITP occurs in approximately 2 of 1000 pregnant women. ITP may develop at any time during pregnancy, but is often initially recognized in the first trimester and is the most common cause of isolated thrombocytopenia in this time period. A 33 year old, married since 6 years, G2p1l1 with 33 weeks gestation referred to our tertiary centre. She was a known case of ITP with splenectomy done. She had a 5 year old male child, delivered by LSCS. She was diagnosed as having ITP at the age of 12 years. HCV antibody was weakly positive. ANA was positive. Emergency LSCS was done in view of scar tenderness. Post op she developed epistaxis, bleeding gums and per vaginum. Patient received multiple FFP, platelet transfusions and responded to treatment with methylprednisolone. The diagnosis and management of ITP in pregnancy is similar to that in the non-pregnant adult patient, but the risks to the developing fetus must be taken into account when choosing treatment and the maintenance of a safe platelet count, rather than prolonged remission, is the goal. Mode of delivery must be guided by obstetrical indications.

Keywords: Idiopathic thrombocytopenic purpura, ITP with pregnancy

INTRODUCTION

Thrombocytopenia is a common finding in pregnancy. Establishing the diagnosis of immune thrombocytopenia (ITP) in a pregnant patient is similar to doing so in a non-pregnant patient, except that the evaluation must specifically rule out other disorders of pregnancy associated with low platelet counts that present different risks to the mother and fetus and may require alternate distinct therapy.

With proper management and monitoring, positive outcomes can be expected in the majority of patients. We report a successfully managed case of a known case of ITP with splenectomy done with HCV antibody positive with previous LSCS, the management of which was challenging.

CASE REPORT

Patient was a 33 year old, married since 6 years, G2p1l1 with 33 weeks gestation referred from a government hospital to our tertiary centre. She was a known case of ITP with splenectomy done. She had a 5 year old male child, delivered by LSCS done due to non-progress of labour. She was diagnosed as having ITP at the age of 12 years (1983) after she had hematuria, menorrhagia, epistaxis. Splenectomy was one in 1989.She was given multiple blood, platelet, FFP transfusions in the past. Pneumococcal vaccine was given in 1994. In 2009 she had right sided lymphadenopathy. Biopsy was suggestive of reactive lymphoid hyperplasia. She was allergic to septran. On admission vitals were stable. There was no pallor, cyanosis, clubbing. Respiratory and cardiologic systemic examination was unremarkable. On per

abdomen examination uterus was 28-30 weeks size, relaxed. Per speculum examination - cervix, vagina healthy. On per vaginum examination os was closed, posterior. On admission her hemoglobin was 10.3, CBC was 19200 and platelet count was 141000. Coagulation profile was normal. Peripheral smear - hypochromasia, anisocytosis, Howell-Jolly bodies, giant platelets. HCV antibody was weakly positive. ANA was positive, Coombs factor, RA factor, anti-ds DNA was negative. USG obstetrics and abdomen had normal findings. Patient developed painful swelling over right mastoid region. USG s/o inflammatory origin on the swelling. Antibiotics were given. Patient went into spontaneous labour and emergency LSCS was done in view of scar tenderness. Patient was given 2pints of platelets and 4 pints of FFP introperatively. In post op period patient had high grade fever on 3rd day of LSCS responded to Anti malarials. Afterward post op course was uneventful till 16th post op day when patient started bleeding per vaginum. Her haemoglobin was 9 g%, platelets 138000, coagulation profile normal. On 18th post-operative day she had bleeding from gums, per vaginum and epistaxis. Platelet count was 20000. 20 pints platelets and 2 pint blood given. Patient was given inj. methyl prednisolone injectable followed by oral. Patients platelet count improved and patient became symptomatically better and responded to our treatment and was discharged with a healthy baby.

DISCUSSION

Pregnant women with ITP can be asymptomatic or may present with a history of easy bruisability, bleeding into the mucous membranes (epistaxis or gingival bleeding), or purpura ITP occurs in all races and is diagnosed more commonly in females than males (ratio 3:1) specially in women of child bearing age (2nd and 3rd decade of life) with an incidence of one to two in 1000 pregnancies. They may have a history of menorrhagia or menometrorrhagia prior to pregnancy, history of delivering a term newborn with thrombocytopenia, visceral or intracranial hemorrhage, or spontaneous or prolonged bleeding after venipuncture.[4] Most women with ITP have normal findings on physical examination (splenomegaly is absent) and purpura may be present especially in the lower limb.[1-8]

ITP occurs in approximately 2 of 1000 pregnant women.[9] ITP may develop at any time during pregnancy, but is often initially recognized in the first trimester and is the most common cause of isolated thrombocytopenia in this time period. In some cases, ITP presents for the first time during pregnancy, whereas preexisting cases of ITP may either worsen or remain quiescent.[10,11] ITP in the first and second trimesters is generally treated when the patient is symptomatic with bleeding, platelet counts are in the 20-30000/μL range, or a planned procedure requires a higher platelet count. Therapy late in gestation is generally based on the risk of maternal hemorrhage at delivery. First-line therapy for ITP in pregnancy is similar to the management of acute ITP: corticosteroids[12] and IVIgs.[13] ITP in the mother is not an indication for caesarean section, and the mode of delivery in a pregnant patient with ITP is based on obstetric indications. Most neonatal hemorrhage occurs at 24-48 hours and is not related to trauma at the time of delivery.[14,15]

CONCLUSION

Other disorders that may be associated with thrombocytopenia must be considered and ruled out so that appropriate therapy can be instituted. The diagnosis and management of ITP in pregnancy is similar to that in the non-pregnant adult patient, but the risks to the developing fetus must be taken into account when choosing treatment and the maintenance of a safe platelet count, rather than prolonged remission, is the goal. Mode of delivery must be guided by obstetrical indications. A history of ITP or ITP in a previous pregnancy is not a contraindication to pregnancy, and the majority of patients deliver non-thrombocytopenic or only mildly thrombocytopenic infants.

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