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Idiopathic Thrombocytopenic Purpura In Pregnancy: A Case Report

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I. Introduction:

Idiopathic thrombocytopenic purpura (ITP) is an immune mediated disorder characterised by isolated thrombocytopenia in the absence of obvious initiating or underlying cause [1]. It affects 1-3 per 1000 pregnancies, induced by platelet specific IgG antibodies [2]. The risk of intracranial haemorrhage in the newborn infant in such a case is alarming [3]. The American Society of Haematology (ASH) suggests a safe platelet count of at least 50,000/cumm for both vaginal delivery and caesarean section [4].

II. Case Report:

A 36yrs old, multigravida who presented in her 23rd week with threatened abortion. She was a G6P1L0A4 who had a term IUD in her first pregnancy. In her subsequent pregnancies, she had spontaneous abortions between 2-3months gestational age. She conceived after infertility treatment. Being a case of recurrent pregnancy loss, she was started on injection low molecular weight heparin at 8wks which was continued on every alternate day. She was a known case of ITP since 2009 for which she was on steroids. She also had history of anaemia with multiple whole blood transfusions.

The admission platelet count was 30,000/cumm and oral steroids was continued. Steroid was given for foetal lung maturity at 28wks. Her ANA and anti-ds DNA were negative. At 32wks, she complained of watery discharge per vagina. Blood bank intimidated in prior for the provision of blood and blood products and single donor platelets. After transfusion of 1 unit single donor platelet, her platelet count increased to 1,00,000/cumm. High risk consent was taken and she was planned for emergency caesarean section within 6 hours of leaking. Intraoperative period was uneventful. She delivered a baby boy of weight 2.6kg who was shifted to NICU for evaluation of foetal thrombocytopenia. The patient was given one more unit of single donor platelet post operatively and was discharged after 72 hrs of surgery. Her platelet count on discharge was 98,000/cumm.

III. Discussion:

Immune thrombocytopenic purpura accounts for 3-4% of the cases of thrombocytopenia detected in pregnancy [3]. As ITP is a diagnosis of exclusion, it is therefore prudent to consider all causes of thrombocytopenia before making a diagnosis of ITP [4]. The causes of thrombocytopenia are listed as follows [6]

Causes of thrombocytopenia	
Gestational thrombocytopenia	Antiphospholipid antibody syndrome
Preeclampsia/ HELLP syndrome	Disseminated intravascular coagulation
Acute fatty liver of pregnancy	Viral infection
TTP	Nutritional deficiency
HUS	Drug use
SLE	Primary bone marrow disorder

Gestational thrombocytopenia is the most common cause [4]. ITP is classified according to its severity- Mild: platelet count 1,00,000 to 1,50,000/cumm. Moderate: platelet count 50,000 to 99,000/cumm. Severe: platelet count <50,000/cumm. Presenting symptoms include bruising, epistaxis, gum bleeding, petechial rash, more significant haemorrhage, however increasingly asymptomatic women are being diagnosed [3]. Maternal haemorrhage and foetal intracranial haemorrhage is seen in moderate to severe cases of thrombocytopenia [5]. Oral corticosteroids ,i.e , prednisone at 1-1.5mg/kg body weight is started. Intravenous immunoglobulin (IVIg) is given in cases refractory to steroids or with very low platelets [2]. Laparoscopic splenectomy is considered if not responding to medical therapy [3]. Such cases should be dealt with very tactfully. It requires a multidisciplinary approach consisting of a team having obstetrician, haematologist and a neonatologist.

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