Letter to the Editor

Anti-D and intravenous immunoglobulin treatments in chronic idiopathic thrombocytopenic purpura

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Treatment of chronic idiopathic thrombocytopenic purpura

To the Editor,

In the last issue of Turkish Journal of Haematology, Ünsal et al have reported "Anti-D and intravenous immunoglobulin treatments in chronic idiopathic thrombocytopenic purpura"[1]. Their treatment regimens consisted of either anti-D as a single dose of 50 μg/kg over 3-5 minutes or intravenous immunoglobulin (IVIG), 2 g/kg/day for 3-5 consecutive days. The authors' treatment indication of chronic idiopathic thrombocytopenic purpura (ITP) was a platelet count < 50.000/mm^3. Eight of 29 patients were splenectomized. There was no information on these patients' bleeding symptoms. The complete response rates under anti-D and IVIG treatments were 18.1% and 55.5%, and the partial response rates were 27.2% and 5.5%, respectively.

Immune thrombocytopenic purpura is an acquired autoimmune disorder caused by autoantibody-mediated thrombocytopenia and characterized by low platelet counts and mucocutaneous bleeding[2]. It is classified as acute (duration of less than six months) and chronic or as primary and secondary due to the etiological factors such as heparin and quinidine treatments. In adult patients ITP is often diagnosed incidentally during a routine platelet count, usually has an insidious onset and rarely resolves spontaneously. The diagnosis of ITP is principally based on the history, physical examination, complete blood count, and examination of the peripheral smear, which should exclude other causes of thrombocytopenia[3]. The most effective treatment of chronic ITP in adults which bleeding symptoms and platelet counts < 30.000/mm^3 is splenectomy. Treatment may not be necessary for asymptomatic patients even if the platelet counts are < 30.000/mm^3. Steroids, IVIG or anti-RhD treatments may be used for symptomatic patients with chronic ITP. Patients who do not respond to splenectomy are considered as refractory ITP and the approach to these patients differ from that of chronic ITP. IVIG treatment is a very expensive treatment modality with limited efficacy in chronic ITP[4,5]. IVIG administration has only a transient effect on platelet counts in chronic ITP with a duration of 3-4 weeks. Therefore it should not be considered in the curative treatment of chronic ITP[6]. Anti-RhD treatment achieves significant improvements in platelet counts of more than 50% of patients lasting over three weeks[7]. Ünsal et al have reported platelet increments due to IVIG and anti-RhD treatments, that continued at the 60th day of treatments[1]. Although encouraging, these results are inconsistent with the current literature. The authors have not suggested splenectomy as an alternative in the treatment of chronic ITP in their report. They suggested anti-RhD treatment for the severe hemorrhages in ITP prior to surgical procedures such as splenectomy. Internal bleedings like intra-cranial haemorrhage or the need for immediate surgical procedures are examples to the conditions, which necessitate emergent treatments such as hospitalization, platelets infusions (2-3 times a day), IV methylprednisolone infusion (1 g/day for three days) and IVIG (2 g day for five days) in chronic ITP. Vincristin (1 mg/day, IV, for one week), plasmapheresis, factor VII and antifibrinolytic treatments may also be useful[8,9]. I would like to state that high dose IV methylprednisolone (HDIVMP) treatment should also be considered as an effective and much more cheaper treatment alternative as compared to anti-RhD or IVIG treatments. HDIVMP treatment may also be used as a preparing regimen prior to splenectomy in chronic ITP[10].

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Address for Correspondence:

Zahit BOLAMAN, MD

Adnan Menderes Üniversitesi Tıp Fakültesi
İç Hastalıkları Anabilim Dalı, Hematoloji Bilim Dalı
Aydın, TURKEY