Letter to the Editor

Pregnancy and immune trombocytopenia: New trends

Turgutkaya and Yavaşoğlu. Pregnancy and ITP: New trends

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To the Editor;
I’ve read the article written by Kalaycı H. et al with interest. (1). I’d like to emphasize a few points. The term “idiopathic trombocytopenic purpura” is abandoned and changed as immune trombocytopenia by Vicenza Concensus at 2009 by understanding the pathophysiology of the disease, although the abbreviation “ITP” remained as the same. Also from the diagnosis, the first 3 months, between 3-12 months and after 12 months was determined as acute, persistent and chronic ITP respectively. It is named as primary ITP unless another condition such as autoimmune disorders co-exist. To diagnose ITP, trombocyte count should be below 100 x 10⁹/L (2). ITP is diagnosed of 1 to 10 among 10,000 pregnancies and 30% of cases need therapy. If no other hemostatical abnormality exists, trombocyte count at delivery should be at 75 to 80 x 10⁹/L supported by most guidelines. The “safe” platelet level to prevent post-partum bleeding was suggested as 50 x 10⁹/L in one study similar to yours. (2,3) American Society of Hematology and International Working Group guidelines support intravenous immunoglobulin and/or corticosteroids as the first line treatment, and they seem to be equally potent in enhancing trombocyte counts. The trombocyte concentrates should not be used unless there’s a potential life threatening bleeding. Fetal malformation risk restricts the choice for second-line treatment. Azathioprine may be considered to spare steroids. Anti-RhD immune globulin, cyclosporine, and rituximab could be good alternatives because of their successful reports but yet they cannot be routinely used. (4) In an experimental study, recombinant human thrombopoietin may be a safe and effective option for the treatment of pregnant ITP patients. Romiplostim treatment in refractory ITP is reported in some pregnancies. (5) Although all the data we have so far, pregnancy-ITP relationship remains to be illuminated with further prospective studies.

References
2-Rodeghiero F, Stasi R, Gernsheimer T, Michel M, Provan D, Arnold DM et al,

