Clinical Practice Guideline - Immune Thrombocytopenic Purpura (ITP)

Preface
This guideline provides evidence-based recommendations for the management of children with Immune Thrombocytopenic Purpura (ITP) presenting at Princess Margaret Hospital for Children who require admission.

Most children with ITP can be managed as outpatients as per the PMH ED guidelines

Definition of Terms

ITP is a common disorder in children, presenting with bruising, mucosal bleeding and petechiae. The condition is the result of thrombocytopenia caused by immune destruction of platelets, often precipitated by intercurrent viral infections.

Assessment
Children will generally present with:

- a short history of petechiae & bruising over 24 - 48hrs
- possible mucosal bleeding, epistaxis; rarely rectal bleeding or haematuria
- NO pallor, lymphadenopathy or hepatosplenomegaly

Severity of illness should be decided on clinical picture NOT platelet count
Investigations

FBC and film reported by a laboratory haematologist to ensure only platelets are affected, no leukaemia, no pancytopenia
NO INR, APTT required unless significant haemorrhage or non-accidental injury (NAI) suspected
NO bone marrow aspirate required

Indications for Admission

1. Significant bleeding including:
   - Epistaxis > 1 hour
   - Hematemesis
   - Haemoptysis
   - Intracranial haemorrhage
   - Melaena

2. Unclear diagnosis – ie history, examination or investigation suggestive of differential diagnosis of leukaemia, aplastic anaemia, non-accidental injury or meningococcal disease. Consider SLE when family history of SLE or rheumatoid arthritis, an older child or higher risk ethic background (Aboriginal, African, Asian, Maori).

3. Problematic social circumstances - admission at a local or regional hospital may be appropriate

Management of significant bleeding (see also treatment algorithm)

Resuscitate the patient as required.
Manage bleeding in consultation with surgical speciality as indicated.
Discuss treatment with on–call clinical Haematologist
Group and hold+/-cross matched cells
Platelet transfusions should only be given for intra-cranial haemorrhage or other life-threatening bleeding.

In the presence of **significant bleeding**, consider Intravenous immunoglobulin (IVIg) 0.8g/kg as it can raise the platelet count rapidly.

A short course of high dose methylprednisolone 5mg/kg six hourly may be given for intracranial haemorrhage after IVIg and platelets, with treatment titrated against the platelet count and with rapid tapering.

Emergency splenectomy is rarely indicated in childhood acute ITP.

**Discharge and follow up**

**Patients discharged with ITP require:**

Review by a senior doctor to reassure parents and discuss outpatient management

- GP Letter
- FBP form

Day stay (ACDF) review should be arranged within 2 weeks of initial presentation for FBP and review.

GP follow up weekly initially, then PRN until symptoms resolve.

General Paediatric outpatient review @ 6 weeks, 3 months and 6 months

Haematology referral if unclear diagnosis, ITP unresolved after 6 months or if FBP suggests pancytopenia or haematological malignancy.

Rheumatology referral if history or examination suggestive of SLE, particularly a positive family history of SLE or rheumatoid arthritis, older child, higher risk ethnic background (Aboriginal, African, Asian, Maori).

**Health Facts**

**Links**

- GP Letter
- ED guideline
Most patients with ITP can be managed as outpatients as per PMH Emergency Medicine Guidelines

Significant Bleeding?
- resuscitate patient
- manage bleeding
- surgical consultation as indicated
- discuss with on call clinical Haematologist
- Group and hold +/- cross match
- consider platelets (life-threatening bleed/ICH only)
- start IV Ig 0.8g/kg
- consider IV methylprednisolone 5mg/kg six hourly

Unclear Diagnosis?
- investigate and manage as indicated

Problematic Social Circumstances?
- consider transfer to local hospital
- arrange social work review

- no significant bleeding
- no other indications for treatment
- clear diagnosis
- social circumstances addressed
- blood film reviewed by a laboratory haematologist

Discharge requirements:
- Review by a senior doctor to reassure parents and discuss outpatient management
- GP Letter
- FBP form
- Arrange day stay review with FBP within 2 weeks of initial presentation then GP follow up.
- General Paediatric outpatient review @ 6 weeks, 3 months and 6 months
- Haematology referral if diagnosis unclear or ITP unresolved after 6 months
- Rheumatology referral if history or examination suggestive of SLE
- Health Facts given to parents
References: Immune Thrombocytopenic Purpura

