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Acute idiopathic thrombocytopenic purpura in a hemodialysis patient

Lavinia-Oltita Bratescu, Cristina Moga, Marta Gemene and Diana Copaceanu
Diaverum Morarilor Nephrology and Dialysis Medical Center, Romania

Background: Idiopathic Thrombocytopenic Purpura (ITP) is defined as an autoimmune hematologic disorder, characterized by isolated thrombocytopenia without a clinically apparent cause. ITP is determined by the presence of antibodies directed against platelet membrane components. The clinical presentation may be acute with severe bleeding or insidious with slow development with mild or no symptoms. The incidence of ITP is 50-100 new cases per million per year with children accounting for half of that amount and the median age of adults at the diagnosis is 56-60. Acute ITP is most commonly seen in young children (2 to 6 years old) and the more common hematological disorders observed by pediatric hematologists. At children, acute ITP usually has a very sudden onset and the symptoms usually disappear spontaneously in less than six months (often within a few weeks) but in adults, treatment is often needed. The onset of an ITP in an adult hemodialysis patient, who has an immune-compromised status, is not common.

Case Presentation: A 69-year-old female patient, known for type-2 diabetes with insulin, hypertensive, chronic kidney disease stage 5 KDIGO in chronic hemodialysis program for 2 years, reported spontaneous bruising and persistent left anterior epistaxis, since past 2 weeks. The lower bilateral limbs purpura, sclera-tegumentary pallor, generalized bruises in different stages of evolution and bleeding bubbles in the mouth, without hepatosplenomegaly, were in evolution observed. Laboratory tests highlighted: Moderate anemia, normochromic, normocytic, severe thrombocytopenia (3000/mmc); neutrophils and lymphocytes were within normal limits; FL: N2 S88 L6 M4, moderate anisocytosis, polychromatophilic macrocytes, light hypochromy, rare hyperlobulate granulocytes; increased LDH. Coagulogram and hemodialysis parameters were within normal limits. The patient is urgently transferred in a hematology clinic. In the medulogram were present: 68-70% granulocyte series, 3-4% myoblasts, 25-26% erythroblast series, present megakaryocytes with reduced thrombocytosis. HIV antibodies were negative. ANA, direct antiglobulin, lupus anticoagulant and thyroid functions were normal. Drug-induced thrombocytopenia was excluded. The patient required substitution treatment with 2 u CEr and 3 u CTb. Intravenous corticosteroid therapy (60 mg/day) was urgently initiated with the occurrence of significant hyperglycemia, which required fast insulin administration. During hospitalization, the patient presented a febrile episode with hypoxemia. Haemocultures were positive for methicillin resistant Staphylococcus aureus. Chest X-ray revealed a small infiltrated infrared alveolar right. Antibiotic therapy was instituted (ceftriaxone, linezolid) according to creatinine clearance. On day 14 from admission in the hematology clinic, treatment with Cyclophosphamide 100 mg/day was initiated, resulting in increased platelet count. One month after onset, a fusion protein analog of thrombopoietin, a hormone that regulates platelet production was administered (Romiplastim 2 mcg/kilogram body). The Cyclophosphamide dose was decreased to 50 mg/day with interruption after 2 months after initiation. The corticosteroid therapy with the progressive dose drop being maintained for 3 months. IV immunoglobulins have not been administered. Clinical and paraclinical evolution was very good.

Conclusion: ITP in adults is typically a chronic disease. The particularity of the case is constituted by acute onset of idiopathic thrombocytopenic purpura in a relatively immunosuppressed hemodialysis adult. The data show that spontaneous remission of chronic ITP occurs infrequently.

Biography

Lavinia-Oltița Brătescu completed her Graduation at University of Medicine and Pharmacy from Timisoara, in Romania. From 2007, she worked as a Nephrologist at Sf. Pantelimon International Healthcare Systems Nephrology and Dialysis Medical Center, in Bucharest. From 2012, she became the Chief Physician of the same clinic. From January 2016, Dr. LaviniaOltița Brătescu is Chief Physician at Diaverum Morarilor Nephrology and Medical Center in Bucharest, Romania. She completed her PhD in November 2013