# 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[1]

Children will generally present with:

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

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

## Investigations[1]

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

NO bone marrow aspirate required

## Indications for Admission[1]

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 ethnic 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)[1-3]

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

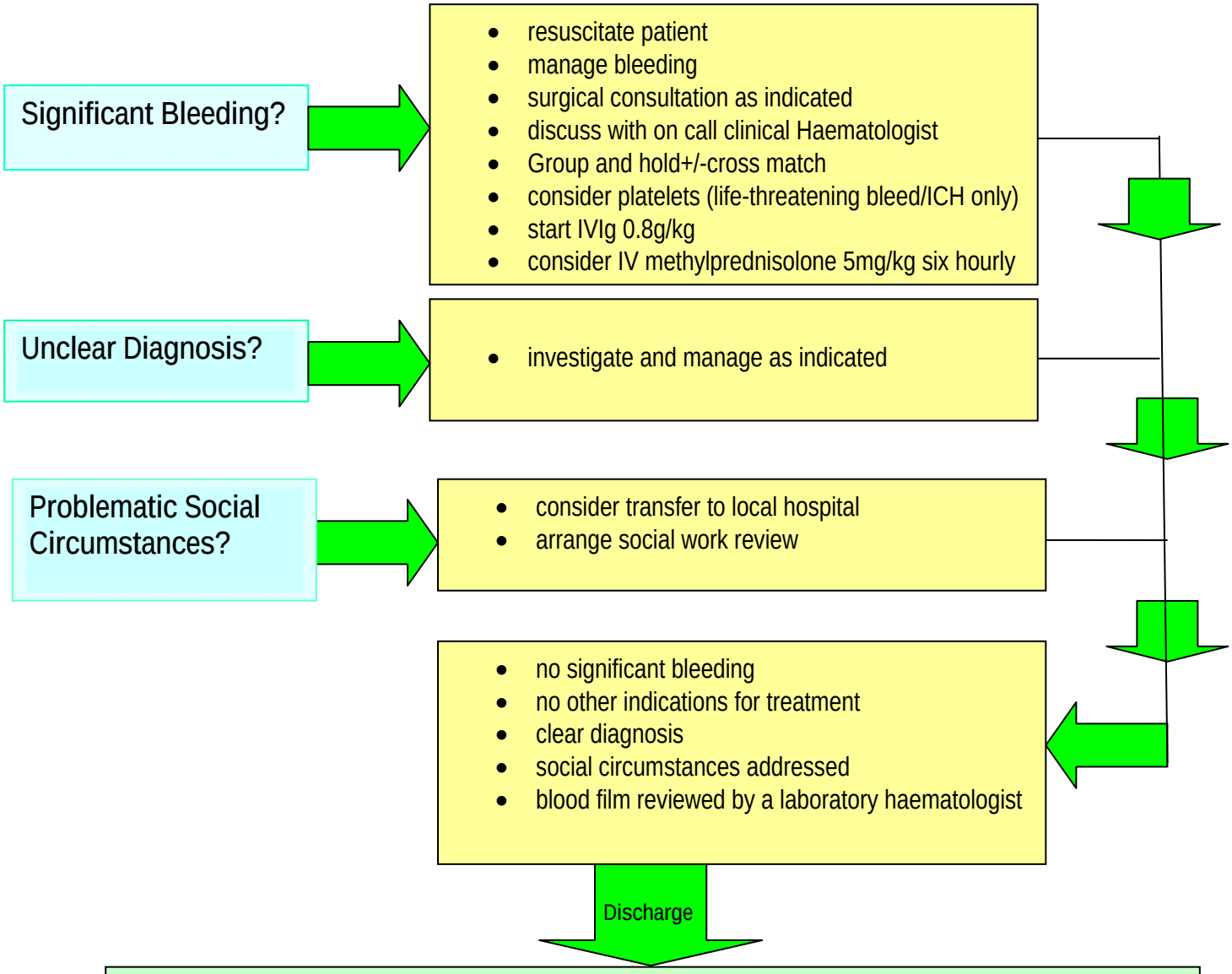
GP Letter

ED guideline

Treatment Algorithm

Clinical Practice Guideline for Immune Thrombocytopenic Purpura

**Most patients with ITP can be managed as outpatients as per PMH Emergency Medicine Guidelines**




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


1. Provan D SR, Newland A C, et al. International consensus report on the investigation and management of primary immune thrombocytepnia. Blood. 2010;115(2):168-86.
2. Haematology BSf. Guidelines for the investigation and managment of idiopathic thrombocyotpenic purpura in adults, chldren and in pregnancy. British Journal of Haematology. 2003;120:574-96.
3. Blanchette V B-MP. Childhood Immune Thrombocytopenic Purpura: Diagnosis and Management. Pediatric Clinics of North America. 2008;(55):393-420.