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RESEARCH ARTICLE

CASE SERIES OF IDIOPATHIC THROMBOCYTOPENIA IN PREGNANCY IN A TERTIARY CARE HOSPITAL

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ABSTRACT

Objective: Management and outcome of pregnancy in Idiopathic thrombocytopenia
Methods: Five pregnant women with Idiopathic Thrombocytopenic Purpura admitted in Lady Goschen Hospital Mangalore, from April 2015 to september 2015, were studied in this prospective study; course and perinatal outcome of pregnancies were studied.
Results: Out of 5 patients with idiopathic thrombocytopenic purpura, 3 were already diagnosed while 2 were diagnosed during present pregnancy. Four patients had severe thrombocytopenia, and one of them showed hemorrhagic manifestation. Four patients required steroids during pregnancy. One patient received immunoglobulin therapy. During the antenatal period one patient developed Eclampsia. She was on steroids in antenatal period. There was no postpartum hemorrhage or maternal death. None of the neonates had bleeding complication, irrespective of mode of delivery.3 patients out of 5 delivered vaginally, 2 by caesarean for obstetric indication.
Conclusion: We conclude that most women with ITP, and even those with severe thrombocytopenia during pregnancy have good outcome. Safe outcome of pregnancy in women with ITP requires teamwork between haematologists, obstetricians and neonatologist. Timely detection and appropriate management has a favourable outcome in thrombocytopenia.

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INTRODUCTION

Immune thrombocytopenia (ITP)[1] occurs in one or two of every 1,000 pregnancies[2], and accounts for 5% of cases of pregnancy-associated thrombocytopenia. ITP is the most common cause of isolated thrombocytopenia in the first and early second trimesters [2-4].

AIMS AND OBJECTIVES

Management and outcome of pregnancy in Idiopathic thrombocytopenia

MATERIALS AND METHOD

Five pregnant women with Idiopathic Thrombocytopenic Purpura admitted in Lady Goschen Hospital Mangalore, from April 2015 to september 2015, were studied in this prospective study; Maternal and fetal outcome of pregnancies was studied.

Case Report 1

Mrs k, 31 yrs primigravida at 35 wks by dates with ITP with anaemia. Mrs k, 31 yrs primigravida at 35 wks by dates with ITP with anaemia with history of splenectomy done 2 yrs back, during road traffic accident and was diagnosed to have ITP. On admission platelet count was 80 thousand, was repeated weekly, started on Tab Prednisolone. At 38 wks planned for induction, platelet count dropped to 15000 platelet transfusions done, parenteral steroids started. Labour was induced at 38 wks with misoprostol augmented with oxytocin for 8 hours and underwent full term vaginal delivery. Delivered baby of Weight 2.5 kg, with no thrombocytopenia in baby and normal APGAR. Platelet count following delivery was 50000 and patient was discharged on Tab prednisolone.

Case Report 2

Mrs N, 23 yrs old, admitted as G2A1 at 36 wks period of gestation, known case of Ebstein anomaly with Idiopathic thrombocytopenic purpura with Eclampsia. Diagnosed with ITP at 28 wks by dates with antiplatelet antibodies. Admitted in LGH at 35 wks with petechial rashes all over body and conjuctival haemorrhage, with platelet count 3000. Ebsteins Anomaly diagnosed at 20 wks started on tab aldactone and tab lasix and Eclampsia at 36wks Inj mgso4 given. Twenty units

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platelet concentrate transfused. Inj Dexamethasone 8mg 12th hrly. Immunoglobulins 1gm/kg weight, Inj Methylprednisolone 1 gm iv in 100ml normal saline over 1 hour given for 3 days. Emergency LSCS done for Non reassuring fetal heart status with Eclampsia. No PPH intra operatively and postoperatively platelet count 42000. Patient shifted to ICU following delivery. Preterm baby weight 2.1kg, No thrombocytopenia in baby and normal APGAR in baby. Patient was discharged with platelet count of 45000 on Tab prednisolone.

Case Report 3

Mrs V, 28yrs old, known case of ITP diagnosed 4 yrs back during previous pregnancy admitted as G2P1L1 at 38 wks with Prev LSCS. Previous pregnancy 2yrs back, diagnosed with ITP, was on Tab prednisolone in that pregnancy, LSCS done for Contracted Pelvis. Patient was on regular follow up with Haematologist, This pregnancy not started on steroids. Platelet count on admission was 85000 Elective LSCS done for previous LSCS with recurring indication. No postoperative and intraoperative PPH seen. Term baby weight 3kg delivered with no thrombocytopenia in baby and normal APGAR. Patient was discharged with platelet count of 85000.

Case Report 4

Mrs S 25 yrs G2PIL1 at 38 wks with thrombocytopenia, platelet count 32000 on admission. Previous pregnancy 2.5yrs back with history of thrombocytopenia and anaemia diagnosed at 32 wks in Lady Goschen Hospital. 22 platelets, 4 FFPs and 7 packed cell were transfused in previous pregnancy. Managed with steroids and Immunoglobulins. Eight units platelet concentrate transfused. Inj Dexamethasone 8mg 12th hrly started, Intravenous antibiotics given. Patient went into spontaneous labour and delivered term baby of weight 2.6 kg with no thrombocytopenia in baby and normal APGAR. No PPH seen and platelet count was 45000 postnatally.

Case Report 5

Mrs R, 25 yrs old, admitted as primigravida at 38 wks period of gestation with thrombocytopenia with anaemia. Not diagnosed with thrombocytopenia before admited with platelet count of 61000. Seven units platelet concentrate transfused, three units packed cell transfused, Inj Dexamethasone 8mg 12th hrly started and Intravenous antibiotics given. Patient went into spontaneous labour augmented with oxytocin. She delivered a term baby of 2.4 kg with no thrombocytopenia in baby and normal APGAR. No PPH observed during or after delivery.

RESULTS

Out of 5 patients with idiopathic thrombocytopenic purpura, 3 were already diagnosed while 2 were diagnosed during present pregnancy. Four patients had severe thrombocytopenia, and one of them showed hemorrhagic manifestation. Four patients required steroids during pregnancy.

One patient received immunoglobulin therapy. During the antenatal period one patient developed Eclampsia. She was on steroids in antenatal period. There was no postpartum hemorrhage or maternal death. None of the neonates had bleeding complication, irrespective of mode of delivery.3 patients out of 5 delivered vaginally, 2 by caesarean for obstetric indication.

DISCUSSION

The clinical management of pregnancy-associated ITP is a complex task. Pregnant women with ITP require careful monitoring, and should be seen monthly in the first and second trimester, every 2 weeks after 28 weeks, and weekly after 36 weeks. Due to their efficacy and low cost, many consider corticosteroids to be first line treatment for ITP in pregnancy[3,6]. Neonatal bleeding complications does not correlate with the mode of delivery, and thus caesarean section should be reserved for obstetric indications only.

Studies	Maternal outcome	Fetal outcome
Fakhrolmolouk yassaee *et al*[7](2012), 21 patients	• Rate of gestational diabetes and PPH is higher	• Severe thrombocytopenia bleeding uncommon
Ozkan H *et al*[8] (2010)	• Majority of deliveries were vaginal	• No neonate had complication attributable to vaginal delivery. • 50% neonates had thrombocytopenia
Suri Aggarwal *et al*[9] (2006)	• No PPH	• No thrombocytopenia in newborn
Present Study (2015)	• No PPH • Caesarean deliveries for maternal indication	• No fetal thrombocytopenia noted

CONCLUSION

We conclude that most women with ITP, and even those with severe thrombocytopenia during pregnancy have good outcome. Safe outcome of pregnancy in women with ITP requires teamwork between haematologists, obstetricians and neonatologist. Timely detection and appropriate management has a favourable outcome in thrombocytopenia.

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