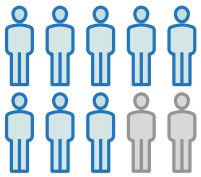
IMMUNE THROMBOCYTOPENIA (ITP)

UNDERSTANDING IMMUNE THROMBOCYTOPENIA (ITP)

ETIOLOGY AND DIAGNOSIS

Diagnosis is generally based on the patient's history, physical examination, laboratory assessments (complete blood count), and peripheral blood film. However, ITP remains a diagnosis of exclusion as no robust clinical or laboratory parameters are yet available to establish a diagnosis[1,2]



80% of patients are diagnosed with primary ITP vs 20% with secondary ITP[3]

Primary ITP

Defined as platelet counts < 100 x 10^9/L in the absence of other potential causes of thrombocytopenia[4]
(Normal platelet counts range from 150–450 x 10^9/L.)[5]

Secondary ITP

Defined as occurring in association with other underlying disorders such as autoimmune diseases, chronic lymphocytic leukemia, and infections
(eg, hepatitis C virus, HIV, *Helicobacter pylori*)[1,3]

Signs and symptoms[1,6]

- Petechiae or purpura
- Fatigue
- Persistent bleeding symptoms from cuts/other injuries
- Mucosal bleeding
- Frequent/heavy nose bleeds
- Hemorrhage from any site

Phases of ITP based on time from diagnosis:[2,4]

Newly diagnosed < 3 months → **Persistent*** 3–12 months → **Chronic** > 12 months

*Includes patients not meeting spontaneous remission or not maintaining complete response off therapy

Epidemiology

INCIDENCE[7]

1.6–3.9 per 100,000 person-years among adults

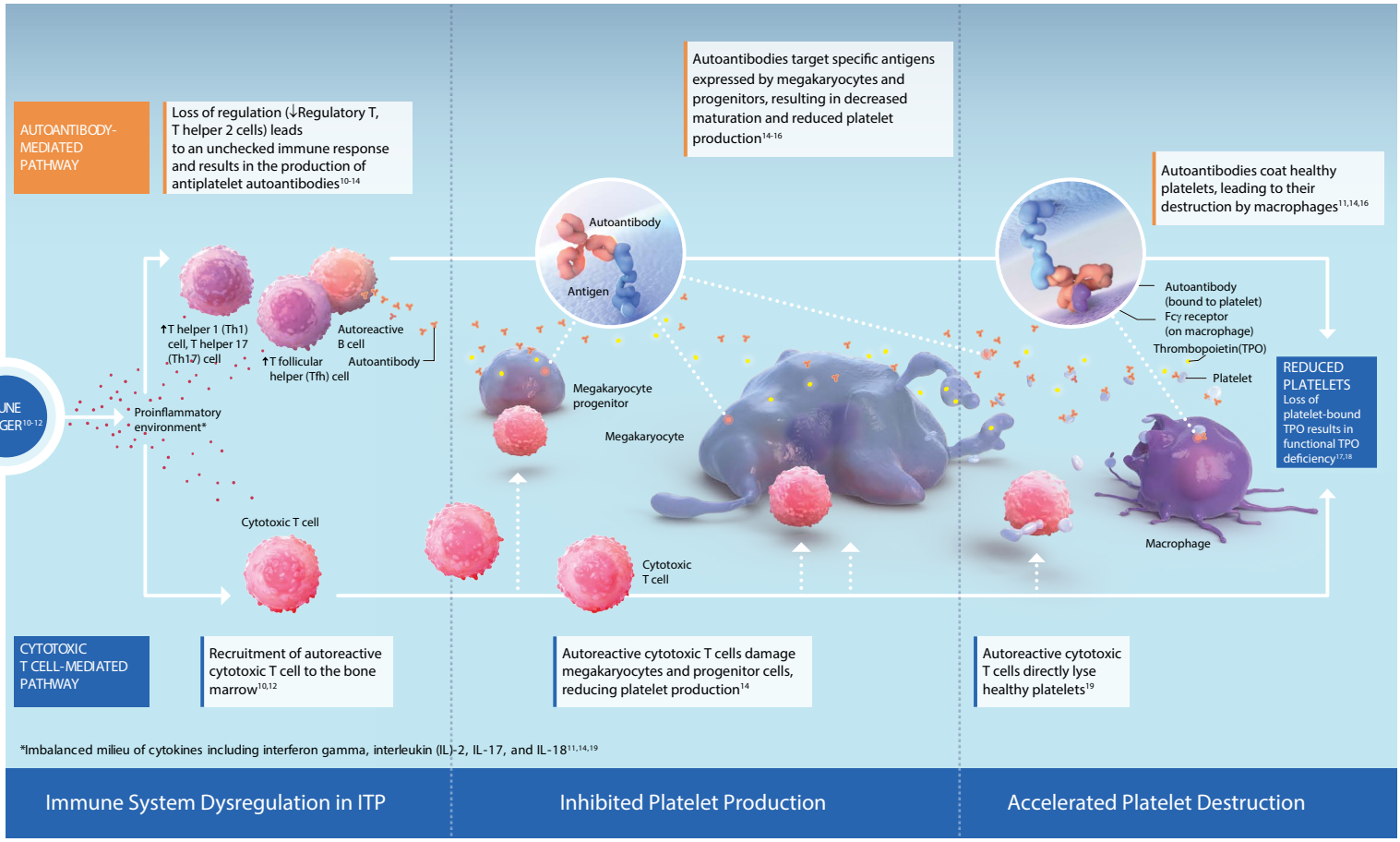
MEDIAN AGE[8]

AGE — 56 years

SEX[9]

ITP occurs more frequently in females between the ages of 5–65 years old

MECHANISM OF DISEASE



IMMUNE THROMBOCYTOPENIA (ITP)

CLINICAL BURDEN OF DISEASE

IMPACT OF ITP

PATIENTS WITH **ITP**

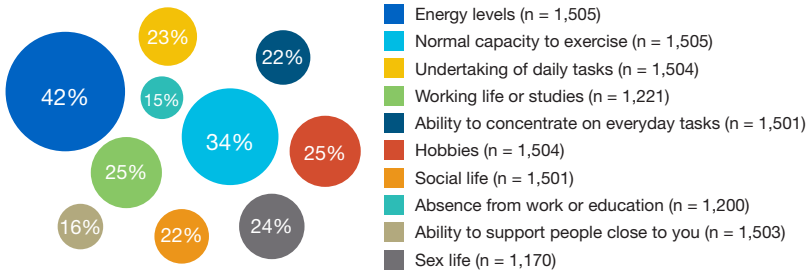
1%–2%
DEVELOP INTRACRANIAL HEMORRHAGE[20, 21]

MAJORITY OF ADULTS WILL EXPERIENCE **AT LEAST ONE SIGNIFICANT BLEEDING** EVENT, WITH A HIGHER RISK IN ELDERLY PATIENTS (AGE > 60 YEARS)[22]

INCREASED MORBIDITY (PRIMARILY DRIVEN BY A HIGH RISK OF BLEEDING-RELATED EVENTS)[23]

ITP HAS AN IMPACT ON PATIENT LIVES SIMILAR TO OR WORSE THAN OTHER CHRONIC CONDITIONS[24]

Patients Whose Daily Living Was Impacted by ITP All the Time or More Than Half the Time[25]



GUIDELINE RECOMMENDATIONS FOR TREATING ITP

TREATMENT GOALS[2]

- Personalize to the patient and the phase of the disease
- Prevent severe bleeding episodes
- Maintain a target platelet level > 20–30 x 10^9/L
- Ensure minimal toxicity
- Improve health-related quality of life (HRQOL)

FACTORS FOR ASSESSING TREATMENT[1]

- Disease duration
- Access to care
- Quality-of-life implications
- Patient and provider preferences
- Risk factors for bleeding (eg, comorbidities, medications, and age)

2019 - Updates to recommendations for ITP treatment

	American Society of Hematology (ASH) recommendations[1]	International Consensus Report (ICR) recommendations[2]
Limit first-line steroid use	• ≤ 6 weeks of steroid treatment is strongly preferred (includes taper)	• 6 weeks of steroid treatment (8 weeks maximum) when response is achieved, even if platelet counts drop during taper • If no response by week 2, rapidly taper over 1 week
Defer splenectomy for ≥ 1 year	• Splenectomy: Delay until ≥ 1 year	• Splenectomy: Defer until ≥ 1 to 2 years
Shared decision-making	• Incorporate patient voice and values into the decision-making process	• Incorporate a new focus on the patients' perspective

Guidelines for assessing response and remission

Definitions of response[1]

Durable Response
A platelet count ≥ 30 x 10^9/L and at least a 2-fold increase in platelet count from baseline at 6 months

Early Response
A platelet count ≥ 30 x 10^9/L and at least a 2-fold increase in platelet count from baseline at 1 week

Initial Response
A platelet count ≥ 30 x 10^9/L and at least a 2-fold increase in platelet count from baseline at 1 month

Definition of remission

ASH Guidelines[1]	ICR Guidelines[2]
Platelet count > 100 x 10^9/L at 12 months after ITP diagnosis	Platelet count ≥ 30 x 10^9/L in the absence of any ITP-specific treatment

*ASH defines corticosteroid dependent as an ongoing need for continuous prednisone > 5 mg/day (or corticosteroid equivalent) or frequent courses of corticosteroids to maintain a platelet count ≥ 30 x 10^9/L and/or to avoid bleeding[1]

Learn more about ITP

Scan the QR codes below to directly access each resource

ITP: An Autoimmune Disorder
An overview of ITP, including a poster on the role of TPO and disease pathogenesis

Pediatric ITP Fact Sheet
A short but comprehensive overview of ITP in pediatric patients

ITP: Fast Facts
An ITP resource center with podcasts, videos, and brochures

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References

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