Ashford and St. Peter's Hospitals NHS
NHS Trust

WOMEN'S HEALTH AND PAEDIATRICS
PAEDIATRIC DEPT

ITP Management Guideline

Amendments			
Date	Page(s)	Comments	Approved by
Feb 2016 March 2018	New Guideline	• Bone marrow aspirate no longer recommended unless neutropenia, hepatosplenomegaly, lymphadenopathy, pallor, lassitude, painful limb/abdomen/back or limp • Platelet transfusions not indicated unless severe active haemorrhage • Unvaccinated children with ITP should get their vaccines as normal	Paediatric Guideline Group

Compiled by: Dr Bina Pai, Paediatric Registrar

In Consultation with:

Ratified by: Paediatric Guidelines Group

Date Ratified: Feb 2016

Date Reviewed: March 2018

Next Review Date: March 2021

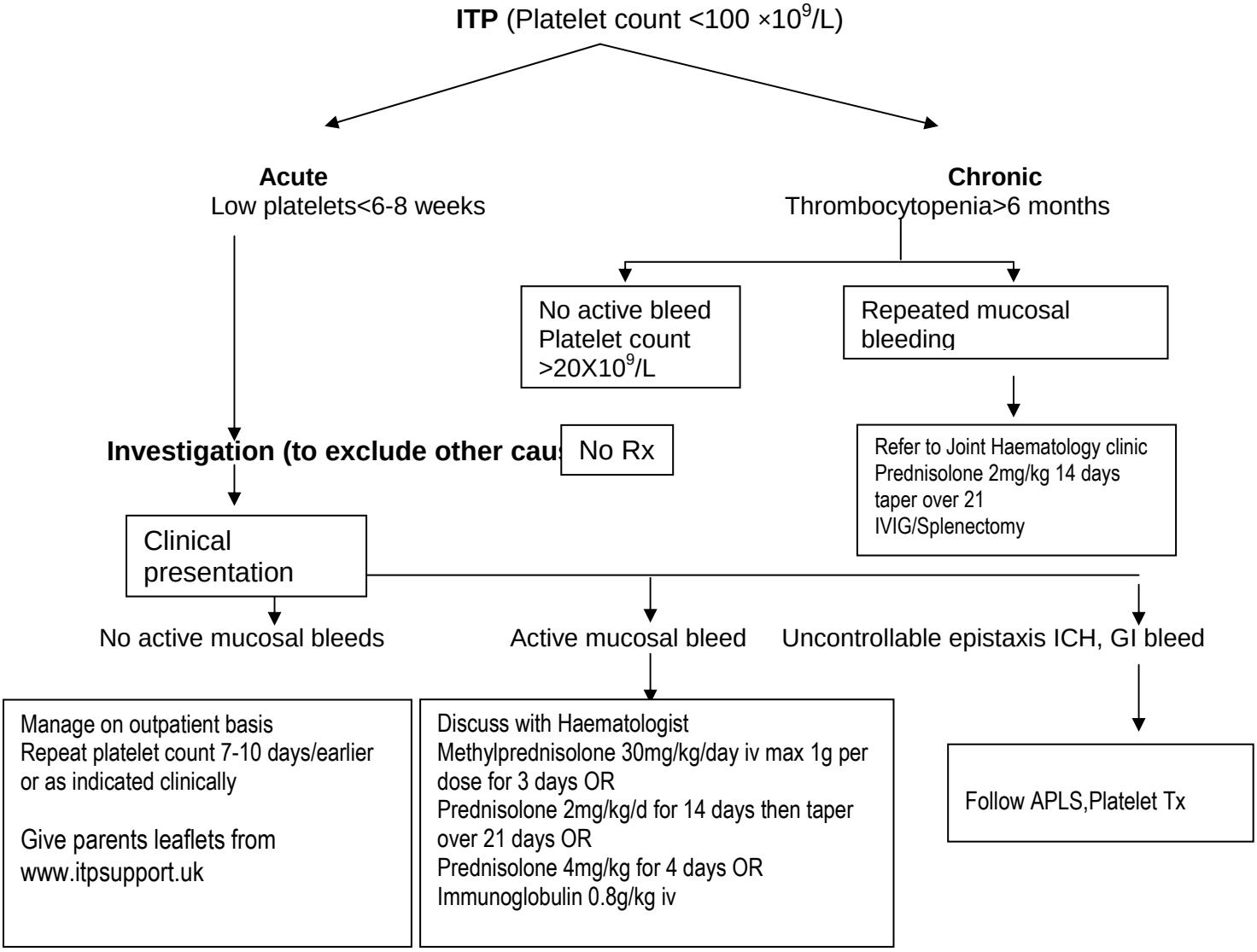
Target Audience: Doctors, nurses and support staff working in Paediatrics

Impact Assessment Carried Out By:

Comment on this document to: Dr Fiona Maccarthy Consultant Paediatrician

CHILDREN'S SERVICES

Guidelines for management of Idiopathic Thrombocytopenic Purpura (ITP) in Children



Dr Bhatti/ St George's Haematology Service

Nomenclature:

- Newly diagnosed ITP- remission occurs before 6 months in 50-70%
- Persistent ITP- remission occurs between 6 months- 1 year 20-30%
- Chronic ITP- symptoms persist beyond 1 year (10-20%)

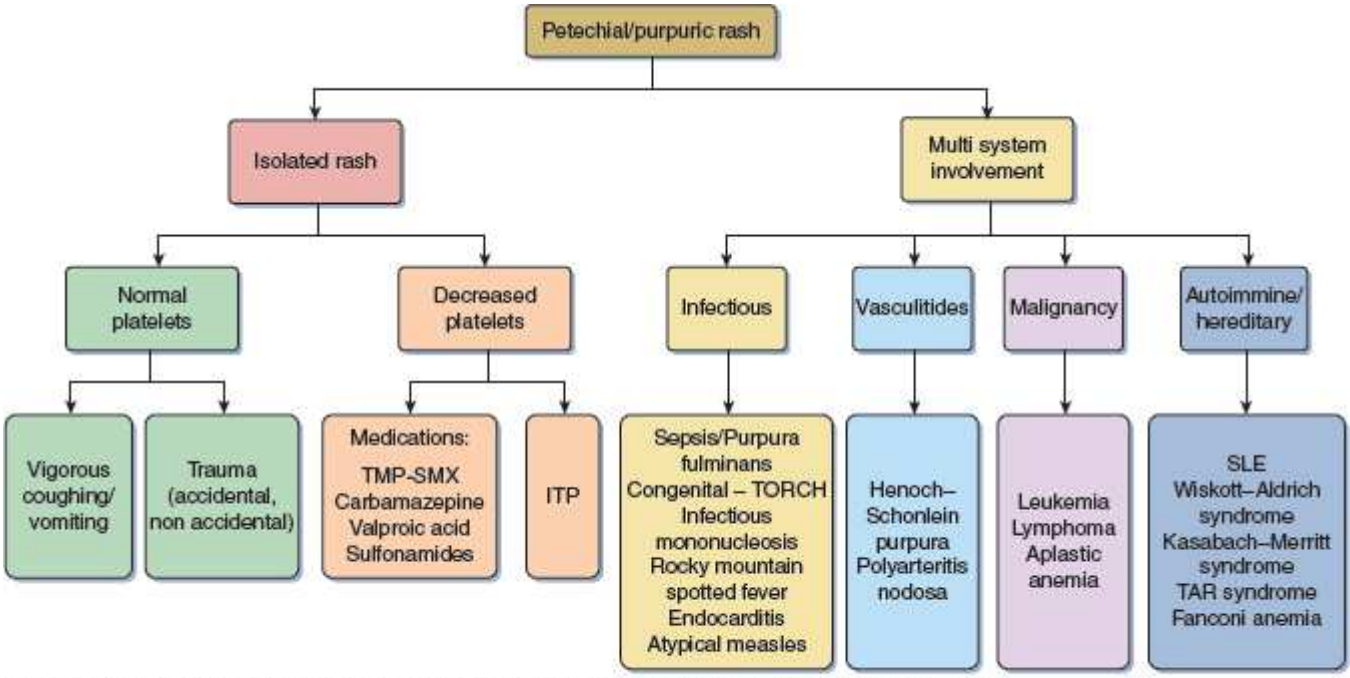
Diagnosis: is by exclusion:

- Detailed history,
- Examination and
- Blood test (FBC, blood film, coagulation screen, +/- Bone marrow aspiration)

Acute ITP

- History-is usually short-purpura for 24-48 hours period
- Preceding viral infection or immunisation
- Platelet count is usually <10-20x10^9/l
- No hepatosplenomegaly
- Well child
- If altered consciousness or abnormal neurological signs-**consider intracranial haemorrhage (ICH) or TTP**
- **Absence of:**
- **Hepatosplenomegaly**
- **Lymphadenopathy**
- **Evidence of serious cause of illness or neurological signs or changes in other cell lines**

Differentials to consider:



Source: Robert Schafermeyer, Milton Tenenbein, Charles G. Macias, Ghazala Q. Sharieff, Loren G. Yamamoto: *Strange and Schafermeyer's Pediatric Emergency Medicine*, 4th Edition: www.accessemergencymedicine.com

Investigations:

- **FBC** and **blood film**-ensure normal Hb,White cell count and blood film. **Blood group**. **Clotting**. Ensure no clot in the sample. Bone marrow examination generally not required

- If ITP low platelets, headache and or neurological signs for urgent CT head

- CMV and EBV IgM- if suggestive viral infection

Management: Immediate

- Most children can be managed at home and do not require hospital admission.
- Parents should be advised to
    - Watch for bleeding
    - Avoidance of contact sports
    - Avoidance of activities with high risk of trauma i.e. head injury
    - Continue other activities as normal
    - Avoid the use of all NSAIDS
      (Evidence level II)
- The full blood count should be repeated within a week of diagnosis to ensure there is no evolution to a serious marrow disorder book appointment on OAK

Specific Treatment in haemorrhage:

All available therapies have significant side effects and none alters the underlying pathology nor increase the chance of remission. These strategies are appropriate for:

- **1) Severe bleeding**
  (eg uncontrollable epistaxis, GI haemorrhage, dental extractions, intracranial bleed) follow APLS give:
- **Platelets-** results will be short lived
- **Immunoglobulin 0.8-1g/kg can be repeated once within 3** days if required.
- **Steroids: methylprednisolone 30mg/kg/day** by intravenous infusion max 1g per dose over 3 days, followed by oral 20mg/kg/day for 4 days

- **2) Moderate Bleeding**
  (eg prolonged mucosal bleeds give prednisolone 2mg/kg daily for 14 days then taper over 21 days OR
- Prednisolone 4mg/kg for 4 days OR
- Immunoglobulin 0.8g/kg iv single dose
- Consider Tranexamic acid for small bleeds
- Avoid NSAIDS
- Discuss newly diagnosed ITP with Dr Bhatti especially if awaiting essential operations or dental extractions

Subsequent Management:

- 75-80% resolve in 6 months
- Favourable outcome irrespective of treatment
- Avoid contact sport
- Parents can find additional information at: www.itpsupport.org.uk
- Monthly FBC and film until recovery
- Repeat sooner if increased bleeding/ bruising

Chronic ITP:

- Thrombocytopenia >6 months
- Management similar to acute ITP.Most children settle with adequate platelet count i.e. 10-20X10^9/l and have no symptoms unless injured.
- In children <10 y, remission likely.
- Children with chronic ITP usually do not need treatment, but should have a regular follow up.
- Should be referred to joint haematology clinic for long-term management.
- Treatment only if PLT less than 10 and repeated mucosal bleeding, menorrhagia, trauma or acute neurological signs. Treatment is same as for acute ITP.

Reference:

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- Sutor A Harms A, et al (2001) Acute immune thrombocytopenic purpura in childhood: retrospective and prospective survey in Germany. Seminars in Thrombosis and Haemostasis, 27,253-267

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