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Case Report

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Atypical presentation of immune thrombocytopenia (ITP) with multiple somatic complaints without bleeding manifestations

Abstract

Immune Thrombocytopenia (ITP) is a hematologic disorder characterized by immune mediated destruction of platelets leading to isolated thrombocytopenia. It presents as sudden onset of acute self-limiting episodes of bleeds which are usually minor but may present with intracranial hemorrhage. ITP is a clinical diagnosis of exclusion. No confirmatory diagnostic tests are available. Management depends on severity of bleeding rather than platelet counts. Here is a case report of a 16 years old female patient presenting with multiple somatic complaints and no history of bleeding manifestations with isolated thrombocytopenia and hematologic malignancy ruled out.

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Introduction

Immune Thrombocytopenia (ITP) is a hematologic disorder characterized by immune mediated destruction of platelets leading to isolated thrombocytopenia. Thrombocytopenia is defined as platelet count <100×109/L. ITP can be newly diagnosed, persistent, chronic and recurrent based on duration of symptoms.[1,2] It can be primary and secondary based on presence of underlying disorders.[2] Severity of disease defined by severity of bleeding and not defined by platelet counts. Viral infections and/or live virus vaccinations are common triggers of ITP.[3,4] Immune response elicits antibodies against platelets in peripheral blood and against megakaryocytes in bone marrow leading to increased platelet destruction and impaired platelet production.[3] 70% cases were reported from age group of 1-10 years with 10% from 3-12 months and 20% cases were of >10 years of age.[5] Male and female are equally affected. It presents as sudden onset of acute self-limiting episodes of bleeds which are usually minor but may present with intracranial hemorrhage.[5] ITP presents with less severe bleeding as compare to other thrombocytopenia of decreased production.[6] Diagnosis of ITP is clinical with supportive evidence of laboratory investigations. It is diagnosis of exclusion. Typical clinical features include sudden onset of skin bleeds along with pallor proportionate to bleeds and absence of fever, lymphadenopathy, hepatosplenomegaly, bone pains.[7] No confirmatory diagnostic tests are available. Complete blood counts show isolated thrombocytopenia with peripheral smear showing giant platelets.[3] Bone marrow examination can be conducted to rule out leukemia and aplastic anemia. Management depends on severity of bleeding rather than platelet counts. As per guidelines of American Society of Hematology in 2011, only observation is recommended in cases with no or mild bleeding regardless of platelet count.[1] First line treatment drugs are IVIG, anti-D and corticosteroids.

Case report

A 16 years old female patient presented with complaints of undocumented fever associated with headache, intermittent episodes of fast breathing, recurrent pain abdomen and pain both lower limbs for a few days. No other significant past and family history. On examination, patient was conscious, alert, cooperative and well oriented to time, place and person. GCS 15/15, pulse rate 83/min, respiratory rate 17/min, saturation with pulse oximetry 98% on room air, blood pressure 114/76mmHg. No pallor, icterus, cyanosis, clubbing and lymphadenopathy was there. Respiratory and cardiovascular system examination was normal. On examination of nervous system, generalized weakness of limb muscles with power grading of 3/5 was present with no other abnormality detected. On per-abdomen examination, epigastric tenderness was noted with no organomegaly. On investigations, complete blood counts showed hemoglobin of 12.3gm/dl, TLC 5700/ul, platelet count 8000/ul with other investigations were within normal limits. On review of history and examination, no evidence of any bleeding manifestations was found. In view of multiple somatic complaints and unusual age for ITP, peripheral blood smear and bone marrow biopsy performed to rule out malignancy. Peripheral blood smear showed giant platelets with bone marrow assessment ruled out malignancy. Patient was managed conservatively with symptomatic management and counseling sessions in view of ITP triggered by initial viral illness. On follow up visit after 3 months, platelet counts were 120000/ul indicating self-limiting course of the disease known as ITP.

Discussion

ITP presents with sudden onset bleeds in a well child with minor bleeds are more common. In this case report, an adolescent female patient found to have incidental finding of isolated thrombocytopenia on presenting to a physician for multiple somatic complaints which were manifestations of a viral illness. Viral infection triggered ITP but without any bleeding manifestations leading to investigations to rule out malignancy.

Conclusion

Most common presentation of ITP is minor bleeding but it may present with systemic illness like in malignancy. Thrombocytopenia is present before the involvement of other cell lines in leukemia, so it is important to rule out malignancy in such cases. Asymptomatic thrombocytopenia in ITP resolves without any specific management irrespective of actual platelet count.

Conflicts of interest

The author declares no conflict of interest.

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