# ITP IN ADULTS

Quick Reference Card | ASH 2019 · NICE TA221 · NICE TA853 · IWG 2009

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### Definition (IWG 2009)

Isolated thrombocytopenia **platelets < 100 × $10^9$/L** in the absence of any identifiable underlying cause. Diagnosis of **exclusion** — no single test confirms ITP. Prior threshold was <150; updated by IWG 2009.

### Classification by duration (IWG 2009)

| Newly Diagnosed | Persistent | Chronic |
|---|---|---|
| < 3 months | 3 – 12 months | > 12 months |
| From diagnosis | Not in remission | >12 m from diagnosis |

## ■ WHEN TO TREAT vs OBSERVE (ASH 2019)

| Clinical situation | Approach | Action / note |
|---|---|---|
| Plt ≥ 30 × $10^9$/L + no bleeding | OBSERVE | Repeat FBC 1–2 weeks; patient education on bleeding signs |
| Plt < 30 × $10^9$/L + asymptomatic / minor bruising | Individualise | Consider patient lifestyle, age, comorbidities; steroids if treating |
| Any count + significant mucosal bleeding | TREAT | Prednisolone ± IVIG; add tranexamic acid for mucosal bleeding |
| Any count + upcoming surgery / invasive procedure | TREAT pre-procedure | Target plt ≥ 50 (minor), ≥ 80–100 (major/neuraxial); IVIG for speed |
| Any count + severe/life-threatening bleeding | EMERGENCY — see below | IV methylprednisolone + IVIG + platelet transfusion |
| Chronic ITP, plt 20–50, no bleeding | Often OBSERVE | Avoid prolonged steroids for count maintenance alone |

## A FIRST-LINE TREATMENT (ASH 2019)

**A — Prednisolone** — Standard first-line

1 mg/kg/day (max 80 mg/day) × 2–4 weeks, then taper

70–80% initial response; <30% durable remission

**Do not continue beyond 6 weeks (ASH 2019)**

**B — Dexamethasone**

40 mg/day × 4 days; up to 3 cycles (14–28-day intervals)

Similar long-term remission to prednisolone at 6–12 months

**C — IVIG**

1 g/kg IV; repeat after 24 h if needed (max 2 g/kg total)

Plt rises within 24–48 h; effect lasts 2–4 weeks

**D — H. pylori eradication**

Test all newly diagnosed. Eradication may improve plt count

## B SECOND-LINE OPTIONS

| Agent | Approval | Key data |
|---|---|---|
| Romiplostim (SC weekly) | NICE TA221 | 79–88% response (NICE TA221) |
| Avatrombopag (oral OD) | NICE TA853 | Approved Dec 2022; oral TPO-RA (NICE TA853) |
| Rituximab 375 mg/m² × 4 | Off-label | ~60% initial; ~20% 5-yr remission [1,2] |
| Splenectomy | Surgical | 60–70% LT response; defer ≥12 m; pre-op vaccines essential [1] |

*TPO-RAs do not induce remission — relapse on discontinuation is common. Bone marrow biopsy required before splenectomy.*

## ■ EMERGENCY MANAGEMENT — SEVERE / LIFE-THREATENING BLEEDING

**1.** Haematology on-call — do not manage in isolation

**2.** IV methylprednisolone 1 g/day × 3 days (or high-dose IV dexamethasone)

**3.** IVIG 1 g/kg — repeat after 24 h if needed

**4.** Platelet transfusion — at least 2 adult doses; combine with IVIG

**5.** Tranexamic acid 1 g TDS for mucosal bleeding

**6.** ICH: neurosurgery + ICU involvement; consider emergency splenectomy

## ■ PLATELET TRANSFUSION — KEY PRINCIPLE

**NOT routine in ITP.** Transfused platelets are destroyed by the same immune mechanism. Indication: active severe/life-threatening bleeding or urgent surgery — not a low platelet count alone. Give ≥ 2 adult doses; combine with IVIG to prolong survival.

## ✗ KEY PITFALLS — AVOID THESE

- Blood film before any treatment — exclude pseudothrombocytopenia & TTP
- Exclude TTP before starting steroids (check film for schistocytes)
- Do not treat plt ≥ 30 + no bleeding — ASH 2019: observe
- Do not prolong steroids beyond 6 weeks — plan second-line instead
- Do not transfuse platelets prophylactically — only for active bleeding
- Check HIV + HCV in all patients — treatable causes of thrombocytopenia
- Test all for H. pylori at diagnosis

**References:** [1] Neunert C et al. Blood Adv 2019;3:3829. [2] Neunert C et al. Blood Adv 2024;8:3578. [3] NICE TA221 (2018). [4] NICE TA853 (2022). [5] Rodeghiero F et al. Blood 2009;113:2386.