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A Case of Idiopathic Thrombocytopenic Purpura-Presented as Secondary PPH

Dr. Meda Greeshma[1], Dr. Ch.Gangadevi[2], Dr.Ch. Sai Praneetha Reddy[3]

[1]Final Year Postgraduate, Siddhartha Medical College, Vijayawada
Corresponding Author E-mail: *drgreeshma143[at]gmail.com*
Mobile No. 8008475175

[2]Assistant Professor, Siddhartha Medical College, Vijayawada
E-mail: *dr.gangakzunnu[at]gmail.com*

[3]Post Graduate, Siddhartha Medical College
E-mail: *chetlapraneetha[at]gmail.com*

Abstract: ***A 28year old P2L2 postnatal day 15 came with complaints of heavy bleeding since 3 days with haemoglobin 2 gm%, platelet count 4000. She was given 4 bottles of whole blood, but her bleeding continued and her Hb was 2.7gm%, platelet count less than 10,000. After all investigations and patient not improving with repeated blood transfusions, a diagnosis of Idiopathic thrombocytopenic purpura (ITP) was made as diagnosis of exclusion and she was started with IV steroids, which showed improvement clinically and her bleeding stopped then converted to oral steroids and discharged with Hb 8.5gm%, platelet count 95000.ITP is diagnosis of exclusion. The case is presented to highlight that in management of PPH, if the treatment does not respond one should think of rare cause like ITP. It is the awareness of the doctors that can help the patients.***

Keywords: idiopathic thrombocytopenic purpura, awareness, steroids, postpartum haemorrhage

1. Introduction

Postpartum haemorrhage is one of leading cause of maternal morbidity and mortality. Identifying the cause of PPH plays a key role in its management and preventing future blood loss. The major causes of PPH are atonicity, trauma, tissue, thromplastin but rare causes of PPH also should be in the mind of treating obstetrician in cases of intractable and unresponsive PPH which helps in guiding the treatment, preventing maternal morbidity & mortality due to haemorrhage, helps in improving health care.

2. Case Report

History of presenting illness:
Patient complaints of heavy bleeding since 3 days .The bleeding was bright red in colour without passage of clots and was not foul smelling. The patient had delivered a term 2kg male baby in Jaggaiyapeta CHC on 18-jan-2023, spontaneous vaginally and there was history of primary PPH, then she was discharged on postnatalday-5. In home she had bouts of bleed since 3 days with generalized weakness, giddiness and fall down twice. So, she has attended SMC emergency on 3-feb-2023.

History of present pregnancy:
All trimesters were uneventful. No H/o high blood pressure recording. No H/o drug exposure, X-ray exposure. She had spontaneous onset of labour pains in home and was taken to CHC, jaggaiyapeta and delivered a male baby of weight 2kg without episiotomy, she had primary PPH after delivery of baby.

Other history:
No history of jaundice, hypertension, DM, TB, rheumatic fever, asthma, kidney disease, blood dyscariasis. No h/o blood transfusions in past. She had not underwent any major surgical interventions.

History of allergies:
Not significant.

Examination
Appearance- ill looking, mental status-alert, conscious, well oriented to time, place, person. Severe pallor present. No icterus, no lymphadenopathy, no edema feet, no local rise of temperature, per abdomen: soft, no local rise of temperature, no tenderness, spleen & liver not palpable.

Perineum examination: vulval pad and clothes soaked with fresh blood. Perspeculum examination: no cervical, vaginal tears or lacerations, no paraurethral injuries. Bimanual examination: uterus enlarged to 8weeks size, non-tender, free fornices.

Investigations:
Complete blood picture, platelet count, viral markers, bleeding time, clotting time, thyroid profile, renal function tests, liver function tests, LDH, uric acid, APTT, PT, INR, ANA profile, CRP, bone marrow aspiration.

Differential diagnosis:
ITP, DIC, SLE, infections, HUS, TTP, leukaemia, radiation exposure, drug induced, a plastic anemia, pre-eclampsia.

Basic information about ITP:
Adult ITP is usually a chronic condition, often occurring among young women. The incidence is 3% of all cases of thrombocytopenia. It is a diagnosis of exclusion. In ITP

autoantibodies or immune complex bind to platelets and causes their premature peripheral destruction .chronic ITP is an indolent disorder of insidious onset with multiple remisions and relapses occurs predominantly in female: male(3:1) and not preceded by infection or associated with any underlying disease. Spleen in not palpable.

Management:
Initially she was given repeated blood transfusions, as she was presented with secondary PPH with uterus size corresponding to 8 weeks, D&E was done two times but she didn't responded to it and complete blood picture revealed Giant cells (characteristic of ITP). Empirically started with IV solumetrol (methyl prednisolone) 8th hrly then she improved and bleeding reduced continued for 3 days and converted to oral prednisolone 80mg tid in divided doses for 14days and tapered to 40mg for 14 days one month, discharged. She came for follow-up which revealed a Hb-9.2gm%, platelet count-1.4lakh. Her general condition is well and steroids futured tapered. She is doing well till last contacted over phone.

Provisional diagnosis:
28year P2L2 with postnatal day 15 with heavy bleeding since 3 days, severe pallor, not responding to D & E, antibiotics, repeated blood transfusions has provisionally diagnosed as a case of secondary PPH due to ITP.

3. Conclusion

When usual management of PPH does not respond, one should think of other rare causes of ITP. History and clinical examination are more important than laboratory diagnosis. ITP is diagnosis of exclusion. It is a multidisciplinary approach of Haemotologist, pathologist, gynaecologist for diagnosis and management of ITP.

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