**Dr [redacted], FRCP, FRCPath**
**Consultant Clinical Haematologist**
GMC No. [redacted]

[redacted] HOSPITAL
[redacted]
Tel. [redacted] (appointments)
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[redacted] OUTPATIENT CENTRE
([redacted] Hospital)
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**PRIVATE & CONFIDENTIAL**

Dr [redacted]
[redacted]

Email encrypted to: [redacted]

Clinic Date: 20 April 2021 (video consultation)
Letter Date: 21 April 2021

Dear Dr [redacted]

**Re: Ms [redacted] - d.o.b. [redacted]/1951**
**[redacted]**
**Email: [redacted] Tel: [redacted]**
**[redacted] Hospital No. [redacted]**

**Diagnosis**

1. Probable Autoimmune Thrombocytopenia (*aka* Idiopathic Thrombocytopenic Purpura – 'ITP').
2. Commenced prednisolone steroid therapy (60 mg daily) on 14 April 2021

**Blood test results ([redacted] Hospital - 13/04/21)**

- Hb 137 g/L, WBC 5.7 x 10^9/L, platelets 16 x 10^9/L
- Blood film: no platelet clumps, some large platelets seen. No abnormal red or white cells.
- Unremarkable coagulation screen. D-dimer <270 ng/mL FEU
- Unremarkable renal (kidney), liver and bone biochemistry
- Normal thyroid function test results
- Virology screen for HIV, hepatitis B and hepatitis C all negative
- SARS CoV-2 RNA test negative

Thank you for asking me to advise on [redacted], who has very recently been diagnosed with probably Autoimmune Thrombocytopenia (*aka* Idiopathic Thrombocytopenic Purpura – 'ITP'). I had a video consultation with her on 20 April 2021.

A week prior to her consultation with me she awoke to find bruises on the insider of her leg and in retrospect she recalls that she had noticed some bruising over the previous few weeks. She presented to the Accident and Emergency (A&E) Department at the [redacted] Hospital where a blood count showed a markedly reduced platelet count at only 16 x 10^9/L

(normal range 150 – 400). The medical officer who examined her noted some purpura on her lower legs. As far as I am aware she did not have any mucosal bleeding.

She is otherwise very healthy and regularly exercises and leads what she describes as a "pure" life (no smoking, drinking etc.) Her past medical history included a torn knee ligament in September 2020 and a repair of her right hip some four years ago.

I noted that she had received her first dose of the Astra-Zeneca COVID-19 vaccine about 8 – 10 weeks prior to her presenting to the [redacted] Hospital A&E Department.

The working diagnosis was considered to be Autoimmune Thrombocytopenia, also known as Idiopathic Thrombocytopenic Purpura (ITP). She was started on prednisolone steroids at 60 mg once daily along with a proton pump inhibitor (omeprazole). She weighs about 11½ stone (about 73 kg), so her starting steroid dose is a little less than 1 mg per kg.

Her main concern relates to the side effects of steroids. She finds it difficult to sleep and thinks that the steroids may be affecting facial hair growth as well as causing her weight to increase. She also commented that she had some discomfort in her upper abdomen, which came on the day she had her consultation with me (20 April).

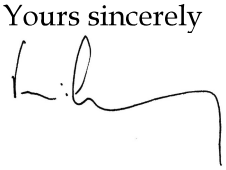
We discussed the management of ITP. I explained that steroids are the cornerstone of first line management and that we would not routinely use as first line treatment either intravenous immunoglobulin (IVIg) or rituximab in someone who was not bleeding dangerously, although these remain an option if she does not respond to steroids. IVIg is subject to the need for formal authorisation as there is a national shortage of this drug (or even worldwide shortage) and rituximab monoclonal antibody is immunosuppressive. Most importantly, I stressed that steroids are no longer used long term at significant doses in the management of ITP as the side effects of such treatment is now much better recognised than before. The plan is for her to have another blood count on Wednesday, 21 April and the dose of prednisolone may be adjusted in the light of this result, depending on her platelet response to the last week of treatment. In any event, we would reduce the dose of prednisolone after 2 weeks (or occasionally 3 weeks) of full dose treatment, irrespective of her response to the treatment; if she responds well then the steroid dose can be tapered off, and if she does not respond then steroids would be withdrawn as longer periods of treatment don't confer additional benefit but do increase the risk of side effects. In addition to this strategy, there are other ways of giving steroids (e.g. pulses of dexamethasone) but I did not discuss all this in detail.

She was, I think, reassured to know that long term use of significant doses of steroids in ITP is no longer practiced. I have encouraged her to continue the prednisolone and to keep her appointments at the [redacted] Hospital and am copying this letter to my colleague, Dr [redacted], who leads our Haemostasis and Thrombosis service at the hospital.

Thank you very much for asking me to advise her.

Kind regards

Yours sincerely



Dr [redacted], FRCP, FRCPath
Consultant Haematologist

Copy to:
Ms [redacted](by encrypted email).
[redacted] Hospital Evolve notes
Dr [redacted], Consultant Haematologist, [redacted] Hospital