Treatment of idiopathic thrombocytopenia purpura in children essay sample

Family, Children

There is a controversial issue regarding when to start treatment of ITP in children. Gonzalez, Sandler and Shad (2005) discuss this matter, showing that the American Society of Hematology (ASH) base their decision on initiating therapy when finding a low platelet count. On the other hand Gonzalez et. al (2005) discuss that the British Society for Hematology (BSH) prefer to use a ‘ watch and wait’ approach, because as Demiricioglu, Irken, Oren, Saygi and Yilmaz (2009) reveal in their study, some children suffering from acute ITP, tend to get better with time without any medical interventions. Gonzalez et. al (2005) argue that there are not enough clinical studies regarding this issue and hence the recommendations provided by the BSH and the ASH are merely based on practice in their clinical field. Gonzalez et. al (2005) add that there is a preference to provide medical treatment as soon as the child is diagnosed with ITP in order to avoid bleeding complications such as intracranial hemorrhage which is critical. On the other hand Demiricioglu et. al (2009) argue that there is no clinical evidence proving that early treatment prevents such life-threatening situations.

Corticosteroids are recommended as first-line treatment as mentioned both in an analysis by Su, Xu, Yu, Dai, Xian and Xiao (2009) and the BSH as stated by Gonzalez et. al (2005). Corticosteroids increase the platelet counts and decreases time of bleeding (Bhave, Menon & Nair 2007). In the literature review by Gonzalez et. al (2005) such corticosteroids provide a beneficial effect by impeding the obliteration of platelets which are important for the child’s immune system and in this way bleeding will be reduced. In a retrospective analysis, Su et. al (2009) compared the effect of two

corticosteroids; Methylprednisolone and Dexamethasone. Su et. al (2009) concluded that both drugs can be used to treat children with ITP as no statistical differences were noted. The children in this study had very similar response rates to both corticosteroids but only a vaguely elevated fraction of side effects in those who had received Dexamethasone (Su et. al, 2009). In the study performed by Gonzalez et. al (2005), it is proposed that oral prednisolone of 1-4 mg/kg should be given for 3-4 weeks.

In emergency, children are suggested to be given intravenous methylprednisolone and it is shown that 60% of such cases with a platelet count of less than 10 000/ μl, recovered within 2 days. The united kingdom recommend that if corticosteroids have to be initiated as first-line therapy, Prednisolone should be prescribed but should not be prolonged further than 3 weeks to avoid unnecessary side-effects like hypercortisolism including moon face, weight gain and also more prone to infections (Gonzalez et. al, 2005). The clinical study provided by Demirciogly et. al (2009) compared the effect of corticosteroid methylprednisolone and intravenous immunoglobulin (IVIg). It was concluded that corticosteroids are more efficient and cost less than IVIg, however none of these proved to have eliminated the likelihood that acute ITP can advance to chronic ITP.

Reference

Bhave. S, Menon. P and Nair. M. (2007). Partha’s fundamentals of Pediatrics. Jaypee Brothers medical publishers. India.