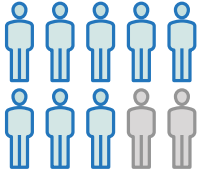


IMMUNE THROMBOCYTOPENIA (ITP)

UNDERSTANDING IMMUNE THROMBOCYTOPENIA (ITP)

ETIOLOGY AND DIAGNOSIS

Diagnosis is generally based on the patient's history, physical examination, laboratory assessments (complete blood count), and peripheral blood film. However, ITP remains a diagnosis of exclusion as no robust clinical or laboratory parameters are yet available to establish a diagnosis^{1,2}



80% of patients are diagnosed with primary ITP vs 20% with secondary ITP³

Primary ITP

Defined as platelet counts $< 100 \times 10^9/L$ in the absence of other potential causes of thrombocytopenia⁴ (Normal platelet counts range from $150\text{--}450 \times 10^9/L$)⁵

Secondary ITP

Defined as occurring in association with other underlying disorders such as autoimmune diseases, chronic lymphocytic leukemia, and infections (eg, hepatitis C virus, HIV, *Helicobacter pylori*)^{1,3}

Signs and symptoms^{1,6}

- Petechiae or purpura
- Fatigue
- Persistent bleeding symptoms from cuts/other injuries
- Mucosal bleeding
- Frequent/heavy nose bleeds
- Hemorrhage from any site

Phases of ITP based on time from diagnosis:^{2,4}



Newly diagnosed
< 3 months

Persistent*
3–12 months

Chronic
> 12 months

*Includes patients not meeting spontaneous remission or not maintaining complete response off therapy

Epidemiology



INCIDENCE⁷

1.6–3.9
per 100,000
person-years
among adults

MEDIAN AGE⁸



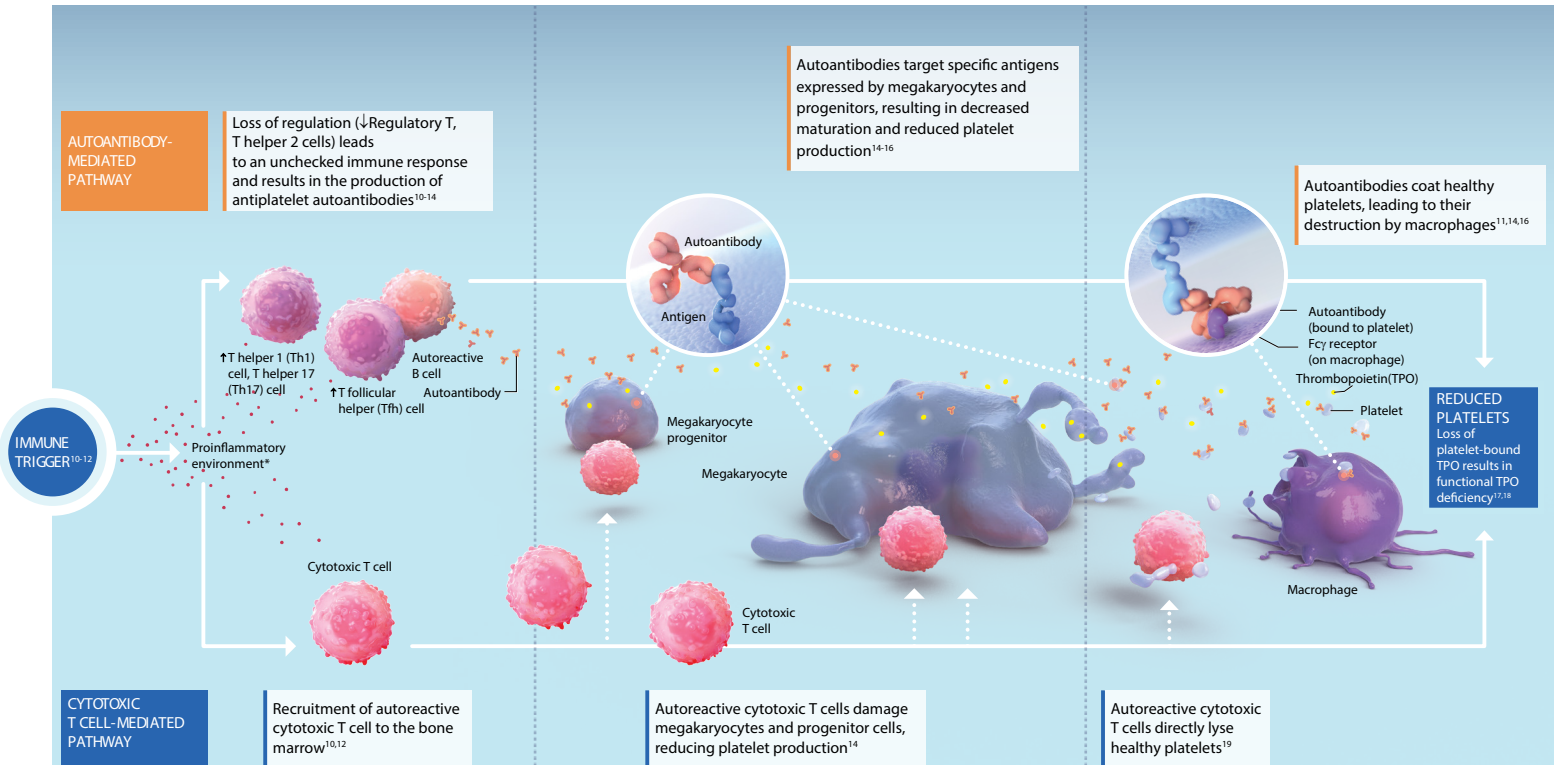
56 years

SEX⁹



ITP occurs more frequently in females between the ages of 5–65 years old

MECHANISM OF DISEASE



*Imbalanced milieu of cytokines including interferon gamma, interleukin (IL)-2, IL-17, and IL-18^{11,14,19}

IMMUNE THROMBOCYTOPENIA (ITP)

CLINICAL BURDEN OF DISEASE

IMPACT OF ITP

1%–2%
DEVELOP INTRACRANIAL
HEMORRHAGE^{20, 21}

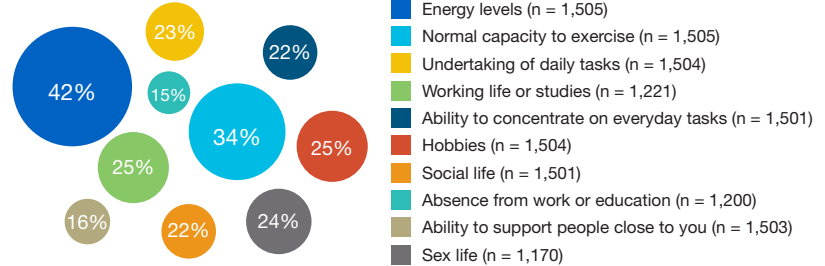
MAJORITY OF ADULTS WILL
EXPERIENCE **AT LEAST ONE
SIGNIFICANT BLEEDING** EVENT,
WITH A HIGHER RISK IN ELDERLY
PATIENTS (AGE > 60 YEARS)²²

PATIENTS
WITH
ITP

**INCREASED
MORBIDITY**
(PRIMARILY DRIVEN BY A
HIGH RISK OF BLEEDING-
RELATED EVENTS)²³

ITP HAS AN IMPACT ON
PATIENT LIVES SIMILAR TO
OR WORSE THAN OTHER
CHRONIC CONDITIONS²⁴

Patients Whose Daily Living Was Impacted by ITP All the Time or More Than Half the Time²⁵



GUIDELINE RECOMMENDATIONS FOR TREATING ITP

TREATMENT GOALS²

- Personalize to the patient and the phase of the disease
- Prevent severe bleeding episodes
- Maintain a target platelet level > 20–30 x 10⁹/L
- Ensure minimal toxicity
- Improve health-related quality of life (HRQL)



FACTORS FOR ASSESSING TREATMENT¹

- Disease duration
- Access to care
- Quality-of-life implications
- Patient and provider preferences
- Risk factors for bleeding (eg, comorbidities, medications, and age)

2019 - Updates to recommendations for ITP treatment

American Society of Hematology (ASH) recommendations¹

Limit first-line steroid use	• ≤ 6 weeks of steroid treatment is strongly preferred (includes taper)
Defer splenectomy for ≥ 1 year	• Splenectomy: Delay until ≥ 1 year
Shared decision-making	• Incorporate patient voice and values into the decision-making process

International Consensus Report (ICR) recommendations²

• 6 weeks of steroid treatment (8 weeks maximum) when response is achieved, even if platelet counts drop during taper
• If no response by week 2, rapidly taper over 1 week
• Splenectomy: Defer until ≥ 1 to 2 years
• Incorporate a new focus on the patients' perspective

Guidelines for assessing response and remission

Definitions of response¹

Durable Response

A platelet count ≥ 30 x 10⁹/L and at least a 2-fold increase in platelet count from baseline at 6 months

Early Response

A platelet count ≥ 30 x 10⁹/L and at least a 2-fold increase in platelet count from baseline at 1 week

Initial Response

A platelet count ≥ 30 x 10⁹/L and at least a 2-fold increase in platelet count from baseline at 1 month

Definition of remission

ASH Guidelines¹

Platelet count > 100 x 10⁹/L at 12 months after ITP diagnosis

ICR Guidelines²

Platelet count ≥ 30 x 10⁹/L in the absence of any ITP-specific treatment

*ASH defines corticosteroid dependent as an ongoing need for continuous prednisone > 5 mg/day (or corticosteroid equivalent) or frequent courses of corticosteroids to maintain a platelet count ≥ 30 x 10⁹/L and/or to avoid bleeding¹

Learn more about ITP

Scan the QR codes below to directly access each resource

ITP: An Autoimmune Disorder

An overview of ITP, including a poster on the role of TPO and disease pathogenesis



Pediatric ITP Fact Sheet

A short but comprehensive overview of ITP in pediatric patients



ITP: Fast Facts

An ITP resource center with podcasts, videos, and brochures



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