Abstract

Introduction

Immune thrombocytopaenia (ITP) is known to be associated with arterial and venous thrombosis. However, the management of a patient with resistant ITP who develops an acute myocardial infarction and the inherent challenges this scenario poses is not well defined. We report our experience in managing this unique therapeutic dilemma.

Case presentation

A 75-year-old male, diagnosed with diabetes mellitus, ischaemic heart disease and ITP, presented with multiple mucocutaneous bleeding manifestations. Investigations showed a thrombocytopaenia of 14,000.He was commenced on intravenous methylprednisolone and subsequently converted to oral prednisolone. However, as the platelet response was inadequate a bone marrow biopsy was performed. The findings were in keeping with ITP and megaloblastic anaemia.

Prednisolone was changed to high dose oral dexamethasone for four days and then switched back. Dapsone was also added. This combination led to an improvement in his bleeding manifestations as well as the platelet count. Three days later he developed an acute myocardial infarction (MI) and another drop in the platelet count. The acute coronary event was treated with intravenous unfractionated heparin and statins. Thrombolysis and percutaneous coronary intervention were avoided. Intravenous immunoglobulin together with oral prednisolone and dapsone were used to treat the thrombocytopaenia. This led to a resolution of the coronary ischaemia and an increase in the platelet count.

Conclusions

The combination of high dose oral dexamethasone pulses, oral prednisolone and dapsone are an effective combination for resistant ITP. Acute MI may complicate ITP. In this setting, intravenous immunoglobulin together with oral prednisolone and dapsone leads to a rapid rise in the platelet count and intravenous unfractionated heparin alone is useful for the coronary ischaemia.