Abstract

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Doctor but if I bleed what do I do?

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Background

Thrombocytopenia is the most common coagulation disorder among intensive care patients, occurring in 1/5 of medical patients and 1/3 of surgical patients.

Clinical Case

57-year-old man, history of hypothyroidism on hormone replacement treatment, type 2 diabetes mellitus on insulin treatment. More hospital admissions following evidence of thrombocytopenia after an episode of haematuria. Furthermore, during the first infusion of platelets, the patient had presented an allergic reaction treated with infusion corticosteroid therapy and antihistamines. Admitted to our department for continuation of therapy and treatment in "marked persistent thrombocytopenia after therapy with IgVena and steroids". Carried out positive autoimmune screening with detection of ANA 1:160, positive anti-RO (SS-A) antibodies, positive anti-ENA antibodies, negative HP research on stools performed rheumatologic evaluation which paid attention to the treatment of the prevailing haematological condition at the moment and then re-evaluation after three months in the connective tissue clinic. The haematological evaluation indicated an indication for treatment with revealed and in the absence of a switch response to Avatrombopag. The patient also carried out an immunological evaluation which gave indications to carry out a genetic screening for Gaucher, which turned out to be negative, to complete the diagnosis and to start a new cycle of intravenous immunoglobulin's (preferably Privigen) at a dosage of 0.4 g/kg/day for 5 days; during hospitalization, the patient underwent a CT scan of the abdomen with evidence of an enlarged spleen of homogeneous density; accessory splenic nucleus of 19 mm in the lower polar site. However, the patient continued to present platelet values such as to require transfusions and once stabilized he was discharged with a diagnosis of thrombocytopenia did in hypothyroidism and arterial hypertension, on therapy with Avatrombopag, Ramipril, Levothyroxine sodium, pantoprazole and insulin therapy. A territorial outpatient visit of hematology and rheumatology was booked for periodic checks.

Discussion

The patient was discharged to the territory, stabilized, but awaiting a definitive diagnosis of the origin of the thrombocytopenia, with therapy and outpatient booking of specialist visits and with the indication to access urgently if the plt values required transfusions .Hospitalisation has become increasingly coercive and is often not really adequate to the patient's clinical conditions and to therapies response's. This is often due to an insufficient or absent response of the territory, where times are just as long. Therefore, an increasingly close collaboration between the hospital and the territory would be desirable for a satisfactory response to the patient's needs.