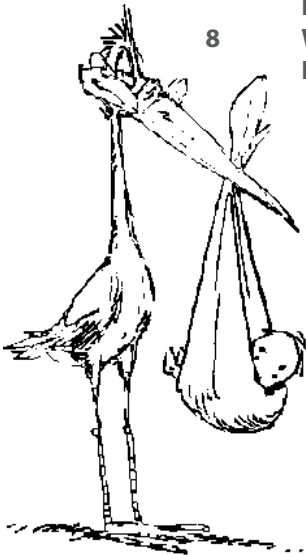




ITP & Pregnancy

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Introduction

This booklet has been written as an information source for women in one of the following categories:

1. Gestational Thrombocytopenia

This is a condition which arises only during pregnancy in an otherwise healthy woman. Many women who have never previously had any problem with their blood may experience a small drop in their platelet count during pregnancy. This will be called gestational thrombocytopenia if the count drops below 100.

2. Pregnancy in ITP

This group of women are those who already have chronic (ongoing) ITP and are pregnant or wish to plan a pregnancy.

3. Pregnancy in remission from ITP

Some women may have had one or more episodes of ITP as an adult or child and are concerned that a pregnancy may cause a relapse.

We hope this booklet answers some of your questions and helps you put Immune Thrombocytopenia into perspective. If you are newly diagnosed with thrombocytopenia you probably have never heard of it, don't know if ITP is a serious illness, and wonder whether it is treatable or even life threatening to you and your baby. Medical science is changing rapidly, and it is important to remember that your consultant may have more up to date information about ITP and its management than was available when this booklet was last revised. If you are in doubt on any matter, do not be afraid to ask your questions as no book or information pack can replace the essential face to face discussions which take place between obstetrician and patient.

What is ITP?

Formerly known as Idiopathic Thrombocytopenic Purpura (Idiopathic = of unknown cause, purpura = bruising), it is now called Immune ThrombocytoPenia, meaning a shortage of blood platelets caused by a disorder of the immune system. If skin or body tissue is cut or injured, normal blood contains a sufficient number of platelets to form the initial plug which helps stop the bleeding and allows the wound to heal. When ITP is diagnosed, it means that there are not enough platelets to do this job properly and the patient can suffer excessive bleeding and bruises.

What symptoms could I experience?

The first sign of ITP may be unexpected bruising, nosebleeds or heavier than usual periods. Sometimes these are accompanied by blood blisters in the mouth and a rash of pinprick spots (called petechiae) caused by leaking blood capillaries.

In pregnancy, ITP may be diagnosed on a routine blood test and you may have experienced no symptoms at all.

What is the cause?

It is not understood why ITP occurs. It is not contagious and cannot be caught from anyone. ITP is an autoimmune disease in which the body's immune system gets confused and attacks itself. In ITP the immune system mistakes platelets as an infection and makes antibodies to destroy them. The body removes these damaged platelets to the spleen. This reduces the number of platelets available to stop blood leakages from wounds and seal up blood capillaries as cells are renewed.

What's the difference between ITP and hæmophilia?

In normal blood, after any injury which causes bleeding, the platelets form a plug as the first part of the clotting process, after which the other factors combine to complete the process and effectively stop

the bleeding. A person with ITP is only short of platelets, but a person with hæmophilia is deficient in one or more of the other factors. Both are bleeding disorders, but whereas hæmophilia is inherited and permanent, ITP can develop at any age and can get better by itself.

How is it diagnosed?

The number of platelets can be counted in a blood sample. A normal platelet count is between 150 and 400. In some hospitals (and in the U.S.) this may also be referred to as 150,000 to 400,000. As all blood cells are made in the bone marrow your doctor may wish to examine some of the marrow blood. This usually involves a small sample being taken from the pelvic bone but is unlikely to be done during pregnancy.

What is the effect of pregnancy on the platelet count?

The number of platelets tends to fall as pregnancy progresses, even in 7-8% of normal healthy women. A mildly low platelet count (120-150), occurring without any other medical condition, is not uncommon in the late stages of normal pregnancy. This does not usually cause any problems for the pregnancy, labour or delivery.



National hæmatology guidelines recommend that for ITP the platelet count should ideally be maintained above 20 for the first and second trimester and if possible, over 50 for the delivery. Bleeding in early pregnancy can affect anyone, even with normal platelets, and it often settles down.

Does a low platelet count cause serious bleeding?

Bleeding due to a low platelet count is unusual in pregnancy. In particular, serious bleeding, including vaginal bleeding, is very unlikely if the platelet count is above 50.

Will my ITP get worse if I get pregnant?

ITP varies from person to person and it is not possible to predict what will happen to the platelet count in individuals with ITP who become pregnant. At least half of pregnant women who have ITP before pregnancy have a progressive decrease in their platelet count during their pregnancy, especially in the 3rd trimester. Some women in remission from ITP may experience a drop in platelet counts during pregnancy.

Will ITP affect the delivery?

Your obstetrician will advise you on the best and safest method of delivery and pain relief. He will base his advice on your previous obstetric history and will take your platelet count into consideration.

Will my platelet count require treatment?

Your doctor and obstetrician will monitor your platelet count throughout pregnancy and decide, based on your platelet count, any symptoms you may have as well as the proposed type of delivery, if you require treatment. Common treatments are steroids (prednisolone) and immunoglobulin.

Does the treatment work?

In most cases the treatment given will be effective in raising the platelet count to a satisfactory level.

Are there any side effects to the treatment?

Steroids in the mother's blood are broken down by the placenta and will not usually have any significant effect on the baby. If used

for a long period they may cause changes in the mother's weight, blood pressure and blood sugar, so the doctor will wish to monitor these whilst the steroids are being taken. If the mother is taking steroids late in the pregnancy an increased dose may be given to help deal with the stress of labour.

Side effects with immunoglobulin are uncommon, but some people may have a reaction to the first dose of treatment. To prevent this the first dose is usually administered slowly under close supervision. Temporary side effects such as light headedness or fever are usually mild.

Are there any precautions I should take?

There are no specific precautions that you should take. If you are worried about anything please ask your doctor or obstetrician who will advise if there are any risks with any particular activity you wish to undertake.

As with every pregnancy you should always enquire from your doctor if any drug preparation you wish to take is safe to be taken in pregnancy (and with ITP).

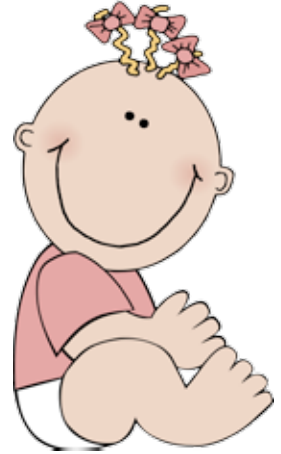
What pain relief can I have in labour?

Women with ITP can usually have the same types of pain relief in labour as women with normal platelet counts. In some situations, depending on your platelet count at the end of the pregnancy, you may not be able to have an epidural or spinal anaesthetic. It would be helpful to discuss this with an anaesthetist during your pregnancy and before the onset of labour.



Could my baby be affected by my ITP?

You cannot pass on ITP as it is not an inherited condition. However it is possible that the antibodies in your blood may enter your baby's blood (even if your platelet count is now normal following splenectomy). The risk of your baby being affected is low and as soon as these antibodies are cleared from your baby's system the platelet count will rise into the normal range. It usually takes between two weeks to two months, but occasionally can take even longer.



What about delivery if my baby's count is low?

In general the obstetrician will want to treat the pregnancy as normally as possible. If there is concern that the baby may be affected, or you have previously had a baby affected by your antibodies, then the obstetrician will usually avoid management which could provoke bleeding such as forceps or a ventouse delivery. (This latter is where a suction cap is placed on the baby's head to help delivery.) If the baby's platelet count is low this could lead to bleeding and bruising.

Will my baby's platelet count be checked?

Your obstetrician will advise if a blood sample to measure the platelet count should be taken, and if necessary this will usually be taken from the cord at the time of delivery or from the baby following delivery. Very rarely a platelet count may be required before delivery but this is avoided nowadays if at all possible and would be discussed with you first. If a low platelet count is found at birth it will be monitored until it returns to normal. If your baby requires treatment intravenous immunoglobulin is usually given and this will rapidly raise the platelet count in the vast majority of cases. Occasionally steroids may be used but are avoided if possible. Once the platelet count has returned to normal it is very unlikely that your child will have any further problems with ITP.

Is it safe to breast feed?

There is absolutely no reason why women with ITP should not breast feed. If the mother's ITP is being treated with steroids the usual doses of steroid will only be found in small quantities in breast milk and will not upset the baby. Steroids have not been found to hinder the production of breast milk. If high doses of steroids are required your doctor will advise if any precautions need to be taken with your baby.



Will the ITP come back in future pregnancies?

If you have experienced a low platelet count in this pregnancy it is likely that your platelet count will be monitored throughout any future pregnancies. If a low platelet count is found you will be monitored and treated along the same lines as your current pregnancy.

How should my antenatal care be managed?

By an obstetrician with an interest in bleeding disorders in pregnancy or by an obstetrician working closely with your haematologist.

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Published by the ITP Support Association,
The Platelet Mission, Kimbolton Road,
Bolnhurst, Beds, MK44 2EL
E-mail info@itpsupport.org.uk
Tel: 01234 376559
Web: www.itpsupport.org.uk

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