



No. 31. Why don't we see an immunologist?

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Title: **Who should care for ITP?**

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I was asked by Shirley to write something about an interesting question 'why do people see the clinician specialising in the part of the body that is being attacked, rather than the clinician specialising in the part of the body that has gone wrong, i.e. the immune system.' In other words, with respect to ITP, why do those who have ITP see the haematologists rather than immunologists when it is the immune system which attacks the platelets – would it be not logical for an immunologist to deal with the cause rather than the effect?

The answer to this is not perfect although it may be said that there are many autoimmune diseases (at least 50 different types) which can affect different parts of the body. Commonly, it includes those affecting the thyroid gland, many joints, a protein in the gut which facilitates vitamin B12 absorption, red cells and rarely, the nervous system. Since the antibodies which affect the platelets, may also attack the other organs, many autoimmune conditions may co-exist in the same individual. How is this knowledge of associated autoimmune conditions relevant to ITP?

Firstly, it is now well-recognised that persons with ITP have higher levels of fatigue compared to those who have normal levels of platelets. Several reasons have been put forward to this including low levels of platelet serotonin, the viral infection which may have 'started' the ITP etc. But one of the important and relevant tests which need to be performed in this regard is the one to check the adequacy of the thyroid gland function. Underactive thyroid is a well-known cause for fatigue and can often be missed since the symptoms are often vague. So, it may be worthwhile in those with severe fatigue that any thyroid abnormalities are excluded.

Secondly, since many autoimmune conditions co-exist, the treatment of one can often make the other one better suggesting a common mechanism for both. For example, in those who may have SLE (lupus)-related ITP, the treatment of lupus can make the platelet count better and at the same time, a flare of lupus can make the platelet count worse. Often similar trigger factors like infections contribute to the worsening of the co-existing autoimmune conditions.

Thirdly, it is important for the ITP physician to be on the look-out for symptoms of other autoimmune conditions at the routine clinic visits. This is necessary since the early detection of a problem like vitamin B12 deficiency is crucial so that late complications can be prevented by appropriate treatment.

To return to the original question, -- historically physicians tended to concentrate on the affected organs much more commonly than the mechanism which led to the disease. However, the medicine landscape is changing. In the field of ITP itself, we have immense progress with respect to treatment options compared to about ten years ago, mainly due to the better understanding of the mechanisms leading to ITP.

So, should it be the immunologists or haematologists – I would leave 'The Platelet' readers to decide?!