



No. 64 - "I have ITP. Should I be taking this blood

American Perspective reprinted from: **Mar 2018**

Title: "I have ITP. Should I be taking this blood thinner?"

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The question of whether or not a patient with immune thrombocytopenic purpura or ITP could take a blood thinner (called "anticoagulants") is one that is asked of hematologists commonly by both physicians and patients alike. While on the surface it might seem strange to think that a patient with ITP might develop a blood clot of the legs or lungs, patients with ITP appear to be at slightly greater risk for both venous and arterial thrombotic events than the general population. Therefore the more important question that has to be asked is not whether or not an ITP patient can take a blood thinner. More specifically, what level of platelets would be considered safe to take a blood thinner?

The risk of bleeding is the most common side effect that can be seen with all blood thinners. While the risk of bleeding may be decreased with some of the newer oral anticoagulants (apixaban, rivaroxaban, dabigatran) compared to warfarin (which has been the common anticoagulant for 50 years), the risk of bleeding with all anticoagulants will be increased when patients also have a platelet count that is lower than normal. Similarly, patients who take a baby aspirin daily to prevent heart disease or stroke can also have an increased risk for bleeding with a lower than normal platelet count. Physicians prefer to rely on clinical trials to more accurately understand the risks and benefits of any particular treatment, but in many situations there just are just no such studies or data to rely on. One example is the question: At what level of platelet count can a patient safely take a blood thinner or aspirin? Is there a specific platelet count above which there is no increased risk of bleeding on a blood thinner or aspirin?

Physicians as much as patients ask and seek an exact number for which they can be confident that it is "safe" to be on a blood thinner. There is a belief held by many hematologists that patient with ITP may have a level of platelet function that is greater than what is measured by the platelet count, based upon the hypothesis that younger platelets are larger and may have increased function. It is also thought that an ITP patient's platelets may still retain some function even after they are coated by anti-platelet antibodies prior to being cleared by their immune system. A platelet count of 50 is presumed to be safe by most hematologists and surgeons for the majority of surgical procedures, so physicians have typically worked from this starting point and presumed that at a platelet count of 50 it is "safe" to be on a blood thinner. Is there, however, an exact number that can be used for this decision?

The best (and most honest) answer that can be given is that there is no absolute number that can be used. The lower the platelet count, the greater the risk for bleeding complications with a blood thinner. The reason for needing anticoagulation is also a very important factor in this decision. In situations such as an acute blood clot to the lungs or atrial fibrillation with an increased risk for stroke, anticoagulation can be life-saving. Then () physicians would tolerate a lower platelet count for treating with anticoagulation. Therefore the decision is really a balance of the risks and benefits that should be discussed with the patient. In some cases where the platelet count is much lower (less than 30, for example) and there is an urgent need for a blood thinner, patients may begin anticoagulation but also require treatment for their ITP, to increase their platelet count. So there really is no exact platelet count that can be relied upon to determine when it is safe to be on an

anticoagulant. Rather, there should be an ongoing discussion regarding the risks and benefits of being on an anticoagulant or aspirin (or not) in the context of their ITP and their typical platelet count.