

Thrombocytopenia, immune thrombocytopenia and idiopathic thrombocytopenic purpura

To the Editor

I have read with interest the article entitled "Immune thrombocytopenic purpura associated with pulmonary tuberculosis" by Akyıldız et al. in the recent issue of the Journal (2009; 51: 271-274).

Every thrombocytopenia is not immune thrombocytopenia as mentioned by the authors, and I would like to add that every immune thrombocytopenia is not idiopathic thrombocytopenic purpura (ITP)¹.

The authors' patient had thrombocytopenia and moderate anemia (hemoglobin:7.9 g/dl hematocrit 26.6%) with microcytosis (mean corpuscular volume: [MCV] 73.5 g/dl) which is more frequently seen in iron deficiency and thalassemia but not with acute bleeding. Although teardrop erythrocytes were not described by the authors, myelofibrosis related to tuberculosis should also be remembered. Although pancytopenia with myelofibrosis is generally rare in children, as stated by the authors, it has been reported relatively frequently in our country²⁻⁴.

The authors' diagnosis basically depends on increased of megakaryocytes in the bone marrow (which is suggestive of rather than consistent with ITP). I would advise antiplatelet antibody determination for the ITP diagnosis, which could also be determined in serum several years after improvement in thrombocytopenia as shown by us previously⁵⁻⁷.

I would also like to point out that pulse steroid therapy (as written in the summary is different from megadose methylprednisolone administration (MDMP, 30 mg/kg/day previously known as high dose)⁷.

Since antiplatelet antibodies were not investigated, I believe thrombocytopenia associated with pulmonary tuberculosis would be more appropriate for the authors' case rather than "immune complication" or/as "a result" of tuberculosis.

Lastly, I would like to stress that neither the bone marrow smear nor gastric lavage picture was clear enough for this presentation.

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