# About treatment of idiopathic thrombocytopenic purpura (ITP)

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I would like to sincerely congratulate Dr. Gürsel and her colleagues for their careful long-term follow-up results in the treatment of patients with ITP[1].

Although the authors used the term of immune thrombocytopenic purpura for ITP, I would like to repeat that every immune thrombocytopenic purpura is not ITP, but the reverse is true[2]. Since direct Coombs test and antinuclear antibodies were determined in each case, Evans syndrome and other immune thrombocytopenic purpuras were most likely ruled out by the authors.

Their treatment results with megadose methylprednisolone (MDMP) support fairly closely our complete remission results, though theirs was a retrospective evaluation. In our prospective, comparative study, antiplatelet antibodies were also determined[3]. Their 80% complete remission rate (mistakenly written as 66% in the text) with MDMP administration was much better than other therapeutic approaches (prednisolone and intravenous immunoglobulin [IVIG]) in the first month, though written as not significantly different. Similar to our results, complete improvement at one month was better in the untreated group compared to the prednisolone group, which we were the first to point out[3]. Surprisingly, the recurrence rate was found higher (22%) by the authors than shown by our results in which MDMP was given for a much longer (35 days) period iv. Recurrence rate and chronicity seemed to be related to the dose and the duration of MDMP treatment[4].

Complete and partial platelet responses to MDMP treatment of the authors' chronic ITP patients were found impressively better than other therapeutic modalities, as in our results, though we administered MDMP for a longer period (30 mg/kg/day and 20 mg/kg/day; each dose given for a week)[4].

In Gürsel's report, the side effects of MDMP such as transient hypertension and hyperglycemia (3.6% and 2.4%, respectively) and weight gain were much higher in all patients than observed in our patients. Therefore, the time of administration of MDMP should be questioned. MDMP doses were given before 9 am (preferably around 6 am) at once iv, orally and we did not admit the patients to the hospital, which makes the MDMP treatment more cost-effective.

The results obtained by the authors following splenectomy were very close to our earlier results[6].

Taking into consideration the authors' statement "None of the children experienced a major bleeding episode or fatal bleeding after start of MDMP treatment", I would repeat that MDMP should be the preferred approach for ITP when treatment is considered.

Lastly, although I am happy to see wider acceptance of MDMP treatment, I would hope to be acknowledged for having initiated this kind of treatment in medicine, since I devoted great time and effort to this work.

**REFERENCES**

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