Patients with Newly Diagnosed, Typical ITP - 3 mos. – 18 yrs. via ED

Assessment

History:	▪ First episode of isolated bleeding symptoms ▪ Absence of constitutional symptoms (unexplained fever, weight loss, bone/joint pains, night sweats)
Physical Examination:	▪ Absence of adenopathy, hepatomegaly, splenomegaly, other signs of chronic diseases or physical anomalies
Complete Blood Count:	▪ Platelets < $100x10^9$/L with normal rest of CBC, differential, and blood smear ▪ Normal Hb (unless mildly low and explained by bleeding history) ▪ Normal or low MCV ▪ Normal WBC and/or neutrophil count (Accept WBC ≤ $20x10^9$/L if otherwise typical ITP) ▪ Normal RBC, WBC or platelet morphology on blood smear (non-specific red cell changes and/or large/giant platelets are OK)

If platelets < $20x10^9$/L, consult Hematology or Paediatric Medicine (via Intake) – see below
Provide family with information sheet (www.aboutkidshealth.ca)
http://www.aboutkidshealth.ca/En/HealthAZ/ConditionsandDiseases/blooddisorders/Pages/ITP-what-happens-after-diagnosis.aspx
Draw DAT, reticulocyte count, and type & screen with initial blood work; if <1-year-old, add IgG, IgA, IgM

DETERMINE BLEEDING SEVERITY

Management

None or Mild Bleeding (77%)	Moderate Bleeding (20%)	Severe Bleeding (3%)
▪ No bleeding; or bruising, petechiae, occasional mild epistaxis ▪ No or very little interference with daily living ▪ May include non-oozing petechiae on oral mucosa or resolved mild epistaxis	▪ More severe skin manifestations with some mucosal lesions and more troublesome epistaxis or menorrhagia	▪ Bleeding episodes (epistaxis, melena, menorrhagia and/or intracranial hemorrhage) requiring hospital admission and/or blood transfusions
▪ **Hematology consult in the ED** ▪ Hematology consult team discusses risks, benefits, and preferences of: • Observation; **OR** • Prednisone or Prednisolone 4 mg/kg/day x 4 days (max 150mg/day); **OR** • IVIG 0.8-1 g/kg x1 (round to nearest vial; do baseline DAT, reticulocyte count, type and screen prior) ▪ If outpatient management deemed appropriate (in consultation with hematology staff), discharge from ED with hematology clinic follow-up ▪ If inpatient admission required, (e.g. IVIG recommended), ED calls Intake team ▪ Intake team assesses; if appropriate (logistic, family, medical perspectives), same or next day admit to ACE (following discussion with Paed Med staff); otherwise admit to Paed Med. ▪ Confirm time with ACE nurses (x203978; ace.requests@sickkids.ca)	▪ **Intake team consult in the ED** ▪ If available and appropriate (logistic, family, medical perspectives), same day admit to ACE (following discussion with Paed Med staff); otherwise admit to Paed Med ▪ Confirm with ACE nurses (x203978; ace.requests@sickkids.ca) ▪ Formal Hematology consult when patient is on ACE or Paed Med ▪ Discuss with family risk and benefits of the following options: • Prednisone or Prednisolone 4 mg/kg/day x 4 days (max 150mg/day) **OR** • IVIG 0.8-1 g/kg x1 (round to nearest vial; do baseline DAT, reticulocyte count, type and screen prior) ▪ Start selected therapy immediately	▪ **Hematology consult AND Intake consult (for admission) in the ED** ▪ For non-life-threatening bleeding, follow moderate bleeding algorithm ▪ For **life-threatening** bleeding, give combination of IV Methylprednisolone (30 mg/kg/dose; max 1g) **AND** IVIG **AND** platelet transfusion. Also consider recombinant FVIIa

Discharge

Discharge Criteria:
▪ Bleeding severity none or mild; Patient well with stable vital signs; Teams and family in agreement with discharge plan

Discharge Information:
▪ Contact information for Hematology fellow on call
▪ Provide anticipatory guidance re: injury avoidance and contact hematology nurse or return to ED if bleeding
▪ From ED: specific follow-up instructions for hematology clinic (usually 4-7 days) or ACE
▪ From Inpatient Unit/ACE: ambulatory follow-up or referral for appointment in Hematology Clinic within 4-7 days with CBC, differential and smear (add DAT and reticulocyte count if patient received IVIG)