

ITP and anticoagulation

This guidance is for the management of patients with confirmed immune thrombocytopenia (ITP) who require anticoagulation or antiplatelet drugs. Full immune thrombocytopenia (ITP) guidance is available on the [NSSG website](#).

A multi-disciplinary discussion including the patient's ITP consultant, haematology, cardiology, stroke medicine, neurology or other appropriate specialities is recommended to establish optimal treatment. Recommended algorithms for anticoagulation (figure 1) and antiplatelet drugs (figure 2) are included below. A summary of platelet thresholds and strategies for anticoagulants or antiplatelet drugs is included in table 1.

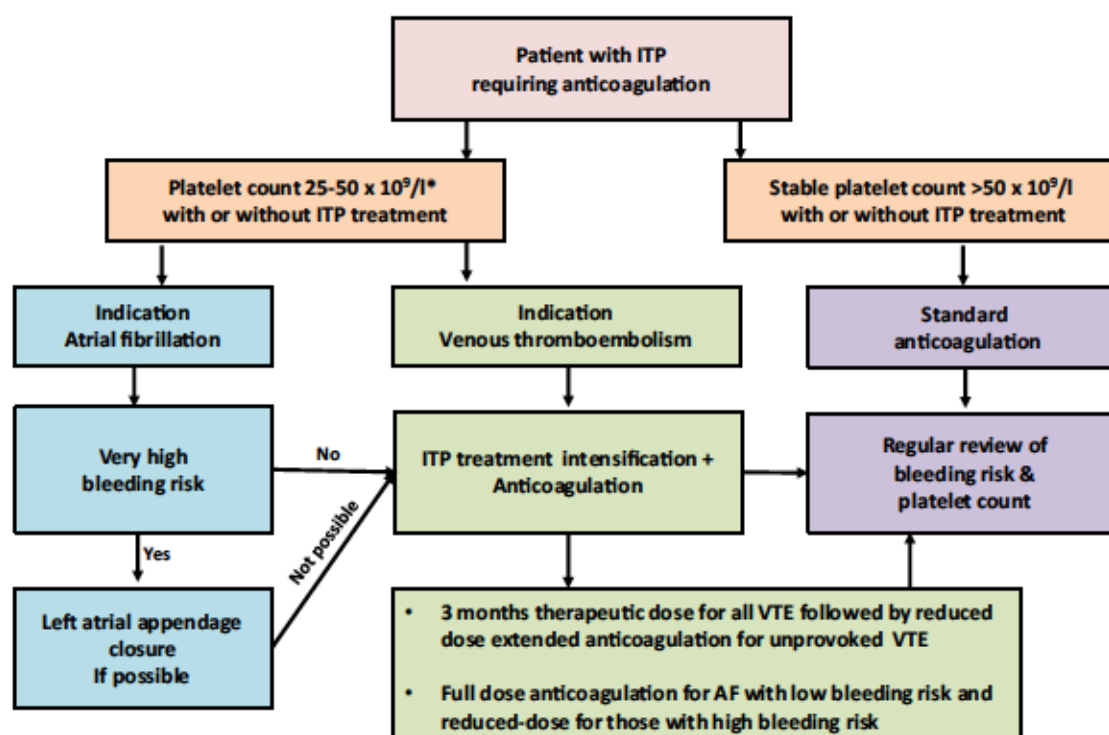


Figure 1. Algorithm for the management of a patient with ITP requiring anticoagulation. *A case-by-case decision should be made in patients at very high risk of both bleeding and thrombosis, with multidisciplinary team input from haematology and cardiology/stroke medicine where appropriate to assess the patient's individual risk: benefit ratio regarding anticoagulation. VTE, venous thromboembolism; AF, atrial fibrillation.

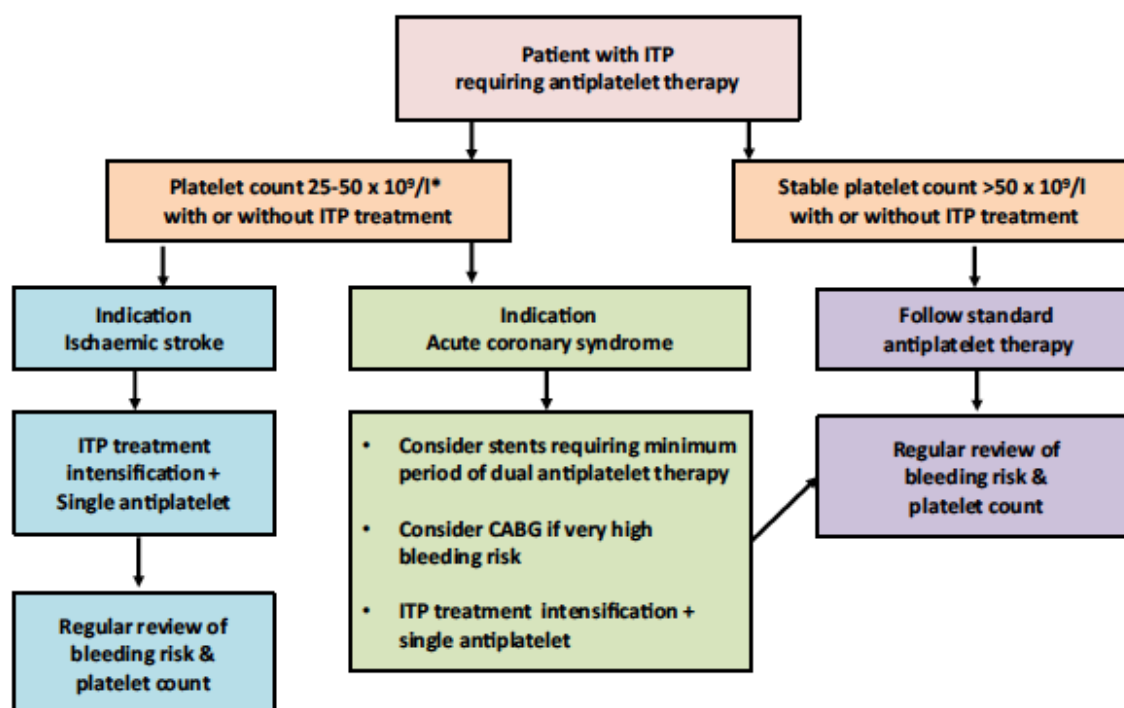


Figure 2. Algorithm for the management of a patient with ITP requiring anti-platelet therapy. *A case-by-case decision should be made in patients at very high risk of both bleeding and thrombosis, with multidisciplinary team input from haematology and cardiology/stroke medicine to assess the patient's individual risk: benefit ratio regarding anti-platelet therapy. CABG, coronary artery bypass graft.

Platelet count	Venous thrombosis	Arterial thrombosis
Less than 25 $\times 10^9/L$	Consider ITP treatment to bring platelets to 50 $\times 10^9/L$ or more Do not anticoagulate while platelet count $<25 \times 10^9/L$	Consider ITP treatment to bring platelets to 50 $\times 10^9/L$ or more Do not give antiplatelet drugs while platelet count $<25 \times 10^9/L$
25 to 49 $\times 10^9/L$	Consider ITP treatment to bring platelets to 50 $\times 10^9/L$ or more Consider anticoagulation with 50% therapeutic dose LMWH (e.g. dalteparin 100units/kg once a day)	Consider ITP treatment to bring platelets to 50 $\times 10^9/L$ or more Single agent antiplatelet drugs may be used (e.g. aspirin 75mg once a day)
50 $\times 10^9/L$ or more	No restriction on anticoagulation Consider split dose LMWH if bleeding risk high (e.g. dalteparin 100units/kg twice daily) Consider ITP treatment if high risk of platelet count falling below 50 $\times 10^9/L$.	All antiplatelet therapy may be used but avoid prasugrel and ticagrelor when possible. Consider ITP treatment if high risk of platelet count falling below 50 $\times 10^9/L$
Active bleeding at any platelet count	Consider risks and benefits of withholding anticoagulation	Consider risks and benefits of withholding antiplatelet drugs

Table 1. Summary of recommendations for ITP therapy and anticoagulation or antiplatelet therapy and different platelet counts. ITP treatments for rapid improvement in platelet count include: Intravenous immunoglobulin 1g/kg, Prednisolone 1mg/kg once a day (max 80mg/day)

Reference

Guidance adapted from: Swan et al. Thrombosis in immune thrombocytopenia – current status and future perspectives. *Br J Haematol* 2021;194(5):822-34

REVIEW

Name	Revision	Date	Version	Review date
Michael Desborough, Consultant Haematologist	New protocol	Nov 2021	V1.0	Nov 2023
Claire Davies, Consultant Haematologist NSSG Immunohaematology Group	Annual protocol review day	May 2022	V1.1	May 2024
Michael Desborough, Consultant Haematologist	Protocol Review	Feb 2024	V1.2	Feb 2027

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IM.2 ITP and anti-coagulation	Authorised by Dr Michael Desborough	Published: Nov 2021 Updated: Feb 2024 Review: Feb 2027	Version 1.2
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