

Corticosteroid resistant immune thrombocytopenic purpura, is it a marker of future graves disease?

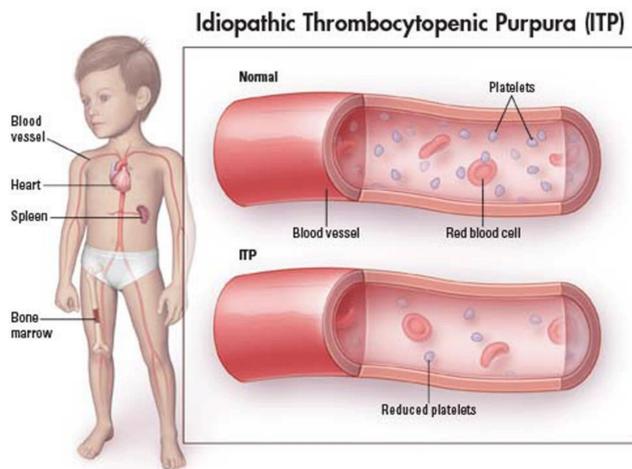


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Introduction

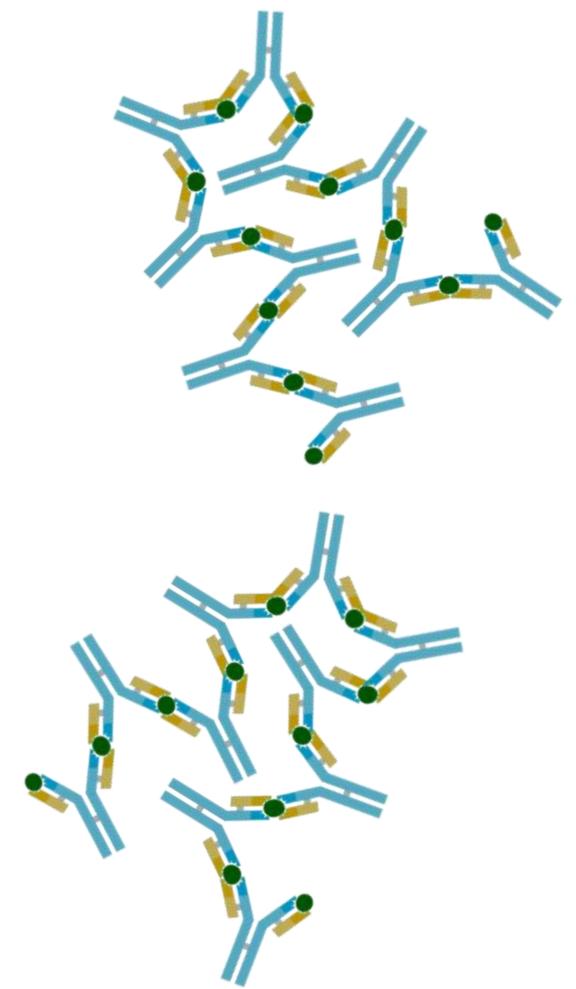
The Immune Thrombocytopenic Purpura (ITP) and Graves Disease (GD) have in common an autoimmune physiopathology. ITP is characterized by a platelet count less than $100 \times 10^6/L$ in the absence of other cause. On one hand, ITP has been associated with thyroid dysfunction, without developing GD. On the other hand, GD might develop with moderate thrombocytopenia, generally more than $100 \times 10^9/L$. It is described that in most cases ITP might appear first and then after some years the patient develops hyperthyroidism that points to a GD.



Summary of the case

We present the case of an oriental 5-year-old previously healthy female patient who presented petechiae throughout the body without any signs of external bleeding. The peripheral blood count revealed severe thrombocytopenia ($3 \times 10^9/L$). Other causes of thrombocytopenia were ruled out. Corticosteroid treatment was initiated, and therapeutic response was achieved. Four months after the thrombocytopenia relapsed and corticosteroid treatment was not effective, and Rituximab was initiated.

After two years of the initial diagnosis the patient began having distal tremors in the hands and tachycardia. An ultrasonography of the thyroid was performed, and it showed a relative enlarged thyroid gland, with high vascularization which can be presented in thyroiditis. Laboratory findings showed suppressed TSH with elevated FT4 levels and positive antithyroid antibodies (TSI and anti-TPO). Methimazole treatment was initiated and euthyroidism was achieved.



Conclusion

Thyroid function should be evaluated if there is any indication of resistance to corticosteroid treatment, since *it might be a prediction marker for future thyroid disease*.

