Co-existence of Crohn’s disease and primary immune thrombocytopenia and its implications in treatment

Dear Editor:

Inflammatory bowel disease (IBD) is a multisystemic disease in which 30% of affected patients develop some type of extraintestinal manifestation (EIM). Extraintestinal manifestations may emerge at different stages during the disease, and may or may not be associated to the level of activity.1,2

Among the haematologic manifestations of IBD is primary immune thrombocytopenia (PIT), formerly known as idiopathic thrombocytopenic purpura. It is characterised by an isolated platelet count less than 100,000/mm³ in the absence of an initiating cause. It is diagnosed by the exclusion of other causes in patients with persistent thrombocytopenia (Table 1).1,3,4

The association between IBD and PIT in children is rare, with prevalences estimated at 0.1–0.48%, and with a higher frequency of association with ulcerative colitis (UC) compared to Crohn’s disease (CD).3,5 We describe two cases of concurrent IBD and PIT, which are of interest considering the rarity of the association and the effects that the administered treatment may have on the course of disease.

Patient 1

Female aged 11 years with a history of CD (Paris classification A1a L2 B1 G0) diagnosed based on the Oporto criteria at age 4 years and undergoing maintenance treatment with azathioprine (AZA) at 2.5 mg/kg/day. At 9 years of age, while in clinical remission, she presented with ecchymosis and petechiae of sudden onset. Blood testing found a platelet count of 2000/mm³, and diagnostic tests were negative. The patient was given two doses of gammaglobulin (0.8 g/kg/dose) and intravenous corticosteroids (2 mg/kg/day) with no improvement, leading to diagnosis of PIT, and requiring maintenance therapy with gammaglobulin every three to four months (0.8 g/kg/dose) for persistent thrombocytopenia. Eighteen months after being diagnosed with PIT, the patient had a clinical and endoscopic relapse of CD (PCDAI 35; SES-CD, 6). Induction therapy was initiated with humanised anti-TNF factor alpha (adalimumab [ADA]) following the standard dosage with administration every two weeks (160, 80 and 40 mg by the subcutaneous route), after which the patient went into remission (PCDAI 0; faecal calprotectin [FC], 15 mg/kg). The patient responded favourably, with stabilisation of the platelet levels, and corticosteroid therapy was discontinued. At present, the patient is being treated with combined AZA-ADA, and has not required additional courses of gammaglobulin or corticosteroids 24 months after initiation of ADA. The patient is awaiting a control colonoscopy, based on which a switch to monotherapy will be considered.

Patient 2

Male aged 15 years with a CD diagnosis (A1bl2B1G0) undergoing maintenance treatment with mercaptopurine (6-MP) (1.5 mg/kg/day). Seven months after the diagnosis, while in clinical remission (PCDAI 0), the patient developed isolated thrombocytopenia (85,000/mm³). To rule out thiopurine-induced cytopenia (even though the rest of the cell counts and the thiopurine methyltransferase activity were normal), treatment was discontinued temporarily; the patient showed no improvement, with platelet levels reaching 9000/mm³, so treatment was resumed. The PIT diagnosis was reached after diagnostic test results came up negative. The patient was treated with gammaglobulin (0.8 g/kg/dose) and showed an initial favourable response, although he subsequently needed corticosteroid therapy (0.4–1 mg/kg/day) for maintenance. At present, 19 months following the PIT diagnosis, the patient remains...

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Table 2  Cases of Crohn’s disease associated with primary immune thrombocytopenia described in the paediatric age group.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age at disease onset</th>
<th>Sex</th>
<th>Type of onset and time elapsed until first evidence of association</th>
<th>Localisation of CD</th>
<th>Platelets at onset of PIT</th>
<th>Treatment of PIT</th>
<th>Treatment of CD</th>
<th>Surgery</th>
<th>Remission of CD and PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11 years</td>
<td>M</td>
<td>CD 2.5 years before PIT</td>
<td>Colon</td>
<td>&lt;10,000/mm³</td>
<td>Gammaglobulin, corticosteroids</td>
<td>Mercaptopurine</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>2 years</td>
<td>F</td>
<td>CD 3 months before PIT</td>
<td>Ileocolonic</td>
<td>6000/mm³</td>
<td>Corticosteroids</td>
<td>5-ASA</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>5 years</td>
<td>F</td>
<td>PIT 6 years before CD</td>
<td>Ileocolonic</td>
<td>&lt;10,000/mm³</td>
<td>Gammaglobulin, corticosteroids</td>
<td>5-ASA, cyclosporin, tacrolimus</td>
<td>Yes</td>
<td>Splenectomy, colectomy</td>
</tr>
<tr>
<td>4</td>
<td>17 years</td>
<td>F</td>
<td>CD 6 years before PIT</td>
<td>Colon</td>
<td>&lt;10,000/mm³</td>
<td>Gammaglobulin, corticosteroids</td>
<td>5-ASA, corticosteroids, azathioprine, corticosteroids, infliximab</td>
<td>Yes</td>
<td>Colectomy No</td>
</tr>
<tr>
<td>5</td>
<td>14 years</td>
<td>F</td>
<td>PIT 6 months before CD</td>
<td>Colon</td>
<td>4000/mm³</td>
<td>Gammaglobulin, corticosteroids</td>
<td>5-ASA, corticosteroids</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

CD, Crohn’s disease; F, female; M, male; PIT, primary immune thrombocytopenia; AIT, autoimmune thrombocytopenia; 5-ASA, sulfasalazine.
in clinical remission with stable laboratory results (PCDAI 0; FC, 20 mg/kg) under low-dose corticosteroid treatment (0.1 mg/kg/day) with concurrent administration of mercaptopurine.

There are few descriptions of the association of CD and PIT in the literature (Table 2). The onset of PIT in association with IBD is variable, although based on the published cases it seems to occur more frequently after the diagnosis of IBD. Since the cases described in the literature involved UC more frequently than CD, we think it is worth noting that our patients with CD had exclusive colonic involvement, which supports the hypothesis that the inflammation of the colonic mucosa and/or the dysregulation of the local immune system may be associated with the development of PIT in these patients.3,5

Studies in adults have described cases of PIT refractory to conventional treatment that responded well to treatment with anti-TNF factor, and it has been hypothesised that the pathogenic mechanism involves the apoptosis of monocytes and macrophages (which produce TNF alpha, as do CD4 lymphocytes), with a decline in the anti-platelet antibodies produced by B lymphocytes.6

We believe that in the cases reviewed here, while conventional therapy was used when PIT first developed (gamma-globulin and corticosteroids), the adequate control of CD with anti-TNF factor agents in case 1 and thiopurines in case two allowed for the improved management and outcomes of PIT, without requiring further gamma-globulin doses. The additional option of discontinuing corticosteroid treatment in our patient treated with anti-TNF factor makes the possibility of escalating treatment in patient 2 attractive if his CD does not respond favourably.

To conclude, it could be said that the association between PIT and CD is rare. The treatment used for maintaining CD in remission can also achieve adequate control of PIT. Thus, aggressive treatments can be avoided, improving quality of life in these patients.

References


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Hepatic hemangiomas:
Spectacular response to treatment with propranolol

Hemangiomas hepáticos: respuesta espectacular al tratamiento con propranolol

Dear Editor,

Infantile haemangiomas (IH) are the most common benign soft tissue tumour of infancy. They affect 1–2.6% of newborns and up to 10% by 1 year of age.1 They typically present as solitary skin lesions. In some cases, IH may be multiple and involve extracutaneous organs, most commonly the liver.1,2

Hepatic hemangioma (HH) is the most frequent benign liver tumour in infancy,3 with a preponderance of female infants.4 They have been classified into three categories: focal, multifocal and diffuse.1 Focal HHs usually consist of solitary and asymptomatic lesions and generally do not require intervention.1 They seem to be equivalent to the skin lesions of rapidly involuting congenital haemangioma (RICH), and as happens in the latter condition, patients do not express the GLUT-1 glucose transporter that is usually found in HHS.1,3 Multifocal and diffuse HHSs are true HHSs. Multifocal HH presents as multiple spherical lesions that may remain asymptomatic until their spontaneous resolution, and less frequently they may lead to heart failure secondary to arteriovenous or portovenous shunting. In diffuse HHs, there is near-total replacement of liver parenchyma, which may trigger abdominal compartment syndrome due to mass effect. It may also be associated to hypothyroidism due to high production of type III thyronine deiodinase.5

Traditionally, corticosteroids have been used as the first-line treatment of symptomatic HHSs, alone or in combination with vincristine (VCR), which started to be used as an