**Patient:** Sarah Ramirez (DOB 1989-11-15)  
**Medical Record Number:** 753942  
**Date of Admission:** 2025-03-24  
**Date of Discharge:** 2025-03-29  
**Admitting Physician:** Dr. L. Morgan (Hematology)  
**Consulting Physician:** Dr. A. Williams (Rheumatology)

**Discharge Diagnosis: Primary Immune Thrombocytopenia (ITP)**

**1. Detailed Hematological Diagnosis:**

Primary Diagnosis: Primary Immune Thrombocytopenia (ITP)  
Date of Diagnosis: March 24, 2025 (current admission)

Classification:

* Primary ITP (no identifiable cause)
* Newly diagnosed
* Severe (platelet count < 10 × 10^9/L with significant bleeding symptoms)

Presenting Laboratory Values:

* Platelet count: 4 × 10^9/L (reference range: 150-400 × 10^9/L)
* Hemoglobin: 13.2 g/dL (reference range: 12.0-16.0 g/dL for females)
* WBC: 6.8 × 10^9/L (reference range: 4.0-11.0 × 10^9/L)
* Normal WBC differential
* Reticulocyte count: 1.2% (reference range: 0.5-2.5%)
* Peripheral blood smear: Severe thrombocytopenia with normal RBC and WBC morphology. No schistocytes, large platelets present.

Diagnostic Workup:

* Direct antiglobulin test (DAT): Negative
* HIV serology: Negative
* Hepatitis B and C serology: Negative
* Pregnancy test: Negative
* Helicobacter pylori stool antigen: Negative
* Immunoglobulin levels (IgG, IgA, IgM): Within normal range
* Thyroid function tests: Within normal range
* Vitamin B12 and folate: Normal
* Complement levels (C3, C4): Reduced
* Antinuclear antibody (ANA): Positive
* Xray of chest, ultrasound of abdomen: No lymphadenopathy or splenomegaly

Clinical Presentation:

* Multiple petechiae on extremities and trunk
* Mucosal bleeding: gingival bleeding, epistaxis
* Menorrhagia (heavy menstrual bleeding)
* No prior history of bleeding disorders
* No family history of bleeding disorders or autoimmune diseases

**2. Current Hematological Treatment:**

First-Line Therapy:

* Corticosteroids:
  + Methylprednisolone 1 mg/kg/day IV (80 mg daily) for 3 days (March 24-26, 2025)
  + Transitioned to prednisone 1 mg/kg/day PO (80 mg daily) on March 27, 2025
* Intravenous Immunoglobulin (IVIG):
  + 1 g/kg/day for 2 days (March 24-25, 2025)
  + Total dose: 160 g (80 kg patient)

Supportive Therapy:

* Platelet transfusions:
  + 2 units of single donor platelets on admission (March 24, 2025) due to active mucosal bleeding
  + No additional platelet transfusions required after IVIG administration
* Tranexamic acid 1000 mg IV q8h for 48 hours (March 24-26, 2025) for control of mucosal bleeding
* Iron supplementation: Ferrous sulfate 325 mg PO daily

Response to Treatment:

* Platelet count increased from 4 × 10^9/L on admission to 52 × 10^9/L at discharge
* Resolution of active mucosal bleeding by day 2 of admission
* Gradual fading of petechiae
* No new bleeding events during hospitalization

**3. History of Hematological Treatment:**

This is the initial diagnosis and first treatment for ITP. No prior hematological treatments.

**4. Comorbidities:**

* Migraine with aura (diagnosed 2018, well-controlled with sumatriptan PRN)
* Gastroesophageal reflux disease (GERD, diagnosed 2020)
* History of appendectomy (2012)
* Status post right ankle fracture with ORIF (2019, hardware in place)
* Non-severe persistent asthma (diagnosed in childhood, well-controlled)
* Allergies: Latex (contact dermatitis)

**5. Physical Exam at Admission:**

General: 35-year-old female in no acute distress but appearing anxious.

Vitals: BP 122/76 mmHg, HR 88 bpm, RR 16/min, Temp 36.8°C, SpO2 99% on room air.

HEENT: Normocephalic, atraumatic. Conjunctivae pink, sclera anicteric. Mild gingival bleeding noted. Oropharynx otherwise clear. Small areas of epistaxis noted in right naris.

Neck: Supple. No lymphadenopathy or thyromegaly.

Cardiovascular: Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops.

Respiratory: Lungs clear to auscultation bilaterally. No wheezes, rales, or rhonchi.

Abdomen: Soft, non-tender, non-distended. No hepatosplenomegaly. Normal bowel sounds. Appendectomy scar in right lower quadrant.

Extremities: No edema. Full range of motion. Surgical scar on right ankle. Numerous petechiae on extremities, particularly lower legs.

Skin: Multiple petechiae on extremities and trunk. No ecchymoses, hematomas, or jaundice.

Neurological: Alert and oriented x3. Cranial nerves II-XII intact. Motor strength 5/5 throughout. Sensation intact to light touch. Normal reflexes throughout.

**6. Hospital Course Summary:**

Mrs. Ramirez is a 35-year-old female who presented to the emergency department with a 3-day history of progressive petechial rash, gingival bleeding, epistaxis, and unusually heavy menstrual bleeding. Initial laboratory workup revealed isolated severe thrombocytopenia with a platelet count of 4 × 10^9/L. Hemoglobin, white blood cell count, and coagulation studies were within normal limits.

The patient was admitted to the hematology service for urgent management of severe thrombocytopenia and bleeding. She received 2 units of single donor platelets on admission due to active mucosal bleeding. First-line therapy for presumed ITP was initiated with intravenous methylprednisolone (1 mg/kg/day) and IVIG (1 g/kg/day for 2 days). Tranexamic acid was administered for 48 hours to help control mucosal bleeding.

A comprehensive diagnostic workup was performed to rule out secondary causes of thrombocytopenia, including infectious, autoimmune, and neoplastic etiologies. The patient responded well to first-line therapy with resolution of active bleeding by day 2 of hospitalization and progressive increase in platelet count. By day 3, her platelet count had increased to 28 × 10^9/L, and by discharge on day 5, it reached 52 × 10^9/L. Methylprednisolone was transitioned to oral prednisone on day 3 once active bleeding had resolved and platelet count was increasing.

The diagnosis of primary ITP was established based on severe isolated thrombocytopenia, absence of other identifiable causes, and response to ITP-specific therapy.

A comprehensive education session was provided regarding ITP pathophysiology, treatment options, expected course, potential complications, and follow-up requirements. The patient was counseled on activity restrictions and precautions to minimize bleeding risk while her platelet count remains below normal.

She will be discharged on a tapering course of prednisone with close outpatient follow-up in the hematology clinic to monitor treatment response, manage potential steroid side effects, and determine the need for second-line therapy if remission is not achieved or maintained.

**7. Medication at Discharge:**

New Medications:

* Prednisone 80 mg PO daily for 7 days, then taper as follows:
  + 60 mg daily for 7 days
  + 40 mg daily for 7 days
  + 30 mg daily for 7 days
  + 20 mg daily for 7 days
  + 10 mg daily for 7 days
  + 5 mg daily for 7 days, then discontinue
* Atovaquone 1500mg PO daily (while on steroids)
* Calcium carbonate 600 mg + Vitamin D 400 IU PO BID (while on steroids)
* Ferrous sulfate 325 mg PO daily

Chronic Medications:

* Montelukast 10 mg PO daily (for asthma)
* Fluticasone/salmeterol 100/50 mcg inhaler, 1 puff BID (for asthma)
* Sumatriptan 50 mg PO PRN for migraine (maximum 2 doses/24 hours)
* Omeprazole 40 mg PO daily (increased while on steroids)
* Albuterol inhaler 2 puffs Q4H PRN for wheezing

Medications to Avoid:

* NSAIDs (ibuprofen, naproxen, aspirin, etc.)
* Antiplatelet agents
* Anticoagulants
* Intramuscular injections

**8. Further Procedure / Follow-up:**

Hematology Follow-up:

* Follow up with Dr. L. Morgan in 1 week (April 7, 2025) for clinical assessment and CBC
* CBC twice weekly for 2 weeks, then weekly until stable
* Call or seek immediate medical attention for any signs of bleeding, particularly head trauma or severe headache

Monitoring and Testing:

* Monitor for steroid-related complications (hyperglycemia, hypertension, mood changes, insomnia)
* Check blood glucose weekly while on high-dose steroids
* Monitor blood pressure at home if possible

Activity Restrictions:

* Avoid contact sports and activities with high risk of trauma until platelet count >50 × 10^9/L
* Avoid competitive sports until platelet count >100 × 10^9/L
* May resume normal daily activities as tolerated
* Avoid tooth flossing and use soft toothbrush while platelet count <50 × 10^9/L

Patient Education Provided:

* ITP disease process and natural history
* Warning signs requiring immediate medical attention
* Bleeding precautions
* Medication schedule and potential side effects
* Importance of follow-up appointments and laboratory monitoring

Long-term Planning:

* If no sustained response to first-line therapy, consider second-line options:
  + Thrombopoietin receptor agonists (TPO-RAs)
  + Rituximab
  + Splenectomy (discussed as a potential future option)
* Need for long-term monitoring due to risk of relapse

**9. Lab Values:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Admission (3/24/2025)** | **Day 3 (3/26/2025)** | **Discharge (3/29/2025)** | **Units** | **Reference Range** |
| Platelets | 4 | 28 | 52 | × 10^9/L | 150-400 |
| Hemoglobin | 13.2 | 12.8 | 12.9 | g/dL | 12.0-16.0 (F) |
| WBC | 6.8 | 10.2 | 11.5 | × 10^9/L | 4.0-11.0 |
| Neutrophils | 65 | 75 | 80 | % | 40-70 |
| Lymphocytes | 28 | 20 | 15 | % | 20-40 |
| PT | 12.1 | - | - | seconds | 11.0-13.0 |
| INR | 1.0 | - | - | ratio | 0.9-1.1 |
| aPTT | 30 | - | - | seconds | 25-35 |
| Creatinine | 0.8 | 0.9 | 0.8 | mg/dL | 0.5-1.1 |
| ALT | 24 | - | 35 | U/L | 7-56 |
| AST | 22 | - | 38 | U/L | 8-48 |
| Glucose | 95 | 140 | 135 | mg/dL | 70-100 |

**Electronically Signed By:**  
Dr. L. Morgan (Hematology)  
Date/Time: 2025-03-29 14:45

Dr. A. Williams (Rheumatology)  
Date/Time: 2025-03-28 16:30