To the Editor:

In their review article "Therapy of Chronic Idiopathic Thrombocytopenic Purpura in Adults," Berchtold and McMillan have not mentioned some of the therapeutic modalities that may be useful in patients with chronic idiopathic thrombocytopenic purpura (ITP). Specifically, these are Staphylococcal protein A immunoadsorption therapy and interferon α (IFN-α).

Passage of patient plasma over Staphylococcal protein A removes immune complexes and immunoglobulin G (IgG) antibodies. In two recent reports, this intervention was shown to be beneficial for patients with chronic ITP. In the first report, all four patients responded completely (two patients) or partially (two patients). In the other study, 6 of 10 patients had a partial or complete response. All these responses were unmaintained but the follow-ups were short, with a range of 1 to 6 months.

Reports of IFN-α therapy in ITP have appeared in the literature since 1987, the last one appearing in BLOOD in the November 1, 1989 issue. There is now cumulative data on 13 patients with chronic, refractory ITP who were treated with α2b IFN. Most of the patients received 12 doses of 3 million units each, given subcutaneously 3 times a week. Eleven of these patients responded, three with a complete and the rest with partial response, in 14 days. One patient relapsed but responded to repeat therapy with IFN. The follow-up on these patients ranged from 3 to 55 weeks. It is believed that IFN modifies B-cell activity that may be involved in the autoantibody production. We have used IFN therapy in one of our own patients with success.

It is true that the number of the patients in these studies is small and follow-up relatively short. However, I believe that these treatments deserve a mention in a review article.

In addition, the authors have used and cited data on acute ITP under the subtitle "Long Term Therapy With Corticosteroids." This study pertains to the use of low-dose (0.25 mg/kg/d) versus conventional-dose (1 mg/kg/d) steroids in acute ITP. Incidentally, there was no significant difference between the two treatments.

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REFERENCES

We would agree with Dr Nand that the preliminary results using Staphylococcal protein A immunoadsorption and IFN-α in ITP patients should have been included in our recent review. As noted by Dr Nand, results thus far are preliminary and the follow-up in both instances is short. In reviewing the Staph protein A reports, the study by Muroi et al (Dr Nand's reference 2) showed no significant responses in the four chronic ITP patients (although one patient had a "transient increase in platelets"). The report by Guthrie (Dr Nand's reference 3) was more encouraging. In 10 patients, one had a complete response with platelet counts that have persisted above 100,000/µL and 5 partial responses, with 1 patient improving to a complete response, 3 persisting with partial responses, and 1 relapsing (T.H. Guthrie, personal communication, 1990). Side effects consisted of nausea, vomiting, myalgia, and fever, and resulted in 2 of the 10 patients stopping therapy. A large cooperative study is in progress now and the results should be available for publication within the year (T.H. Guthrie, personal communication, 1990). Until more experience is obtained with this therapy, it cannot be recommended for routine use in view of its considerable expense (each column costs about $700 in addition to the pheresis costs, which are about $1,000 at our institution), and requirement for an invasive procedure with its inherent risks in a thrombocytopenic patient.

Initial results with IFN were quite encouraging with each of the first three patients reaching normal platelet counts (Dr Nand's reference 5). However, when additional patients were treated by the same group (Dr Nand's reference 6), the response rates were less: of 13 patients, 5 patients achieved normal platelet counts (2 responses persist 4 and 55 months posttherapy) and 6 patients attained platelet counts >50,000/µL (5 responses persist with follow-up of 5 to 36 months). These results are encouraging in view of the reasonable cost of the treatment but will require further experience before the role of this agent can be determined.

Finally, the adult data of Belucci et al (Dr Nand's reference 7) were included in the corticosteroid evaluation since it is our opinion that acute ITP is a rare event in adults, and their data are relevant to chronic ITP.

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Therapy of chronic idiopathic thrombocytopenic purpura in adults
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