Case Report

Chronic asymptomatic thrombocytopenia needs more evaluation than treatment

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Abstract

Background: Chronic asymptomatic thrombocytopenia (platelet count <150 × 10^3/μL for >6 months without bleeding) is an increasingly common incidental finding due to routine laboratory screening. While a low count often triggers clinical concern, data from 2026 indicates that patients with stable counts above 30–50 × 10^3/μL rarely experience spontaneous hemorrhage and may not require active treatment. This case demonstrates how a systematic evaluation can identify benign or secondary causes, preventing the risks associated with unnecessary immunosuppression

Key words: Thrombocytopenia; Eltrombopag; Azathioprine; hrombocytopenia-thrombasthenia syndrome

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1. Case Presentation

A 44-year-old male with diabetes and hypertension underwent a routine health checkup at a Chennai multispecialty hospital. Both his diabetes and hypertension appeared to be well-controlled.

2. Clinical Findings

Marked Thrombocytopenia: Platelet count < 10,000/cu.mm.

Moderate Splenomegaly: Spleen measured 18 cm.

Fatty Liver: Initial imaging reported hepatic steatosis.

Personal History: Occasional petechial rashes following minor trauma since childhood, but no history of major overt bleeding or hospitalizations.

3. Treatment & Management

Based on the profound thrombocytopenia, the patient was treated. Despite intensive therapy, there was zero response to: He was offered IVIG 1g/Kg x 2 doses, Pulse Methylprednisolone x 3 days (high dose corticosteroids), Followed by oral Prednisolone daily, Eltrombopag (Thrombopoietin agonist which increases platelet production and also prolongs its survival in circulation) and Azathioprine (immunosuppressive agent to prolong platelet survival which works by halting lymphoproliferation). PET CT was

done to rule out a malignancy and it was not contributory. He was planned for Rituximab (anti CD20 monoclonal antibody which is again an immunosuppressive agent) or a splenectomy. He spent 2 weeks there and exhausted Rs 5-6 lakhs.

Family member came for an opinion. He was reviewed here,

Peripheral smear: Revealed marked thrombocytopenia and few giant platelets but no other abnormality

USG: Revealed increased liver echotexture, caudate lobe hypertrophy and mild ascites)

OGD Scopy: Revealed no varices

NGS: Revealed a heterozygous mutation involving GFI 1B gene at exon 4 showing it to be a hereditary thrombocytopenia- thrombasthenia syndrome where platelets are both low in number as well as defective in function. Asthenia denotes a weak function.

GFI 1B (Growth Factor Independent 1B) is a crucial zinc-finger transcription factor in humans, primarily active in blood cell development (hematopoiesis), especially for platelets (megakaryocytes) and red blood cells (erythrocytes).

4. Conclusion

All immunosuppressive agents were discontinued. He was asked to be followed by MGE regularly for liver disease, portal hypertension. If any bleeding symptoms he was asked to contact emergency where he may require large dose platelet transfusion momentarily to cease bleeding and it may not give a sustained response due to a large spleen. Offering splenectomy is a too big call for an asymptomatic individual at this point of time

Few learning Points from this case

- Asymptomatic and chronic thrombocytopenia needs evaluation before treatment
- Immune thrombocytopenia with a significant Splenomegaly is almost unlikely
- Careful review and extensive evaluation may be needed to rule out a chronic liver disease before calling it an immune thrombocytopenia. Fibroscan or OGD can help in picking up early and suspicious cases.
- There is no contra indication for an OGD scopy in the background of thrombocytopenia (atleast a diagnostic scopy can be attempted though a biopsy cannot be taken)
- Platelet transfusion in Splenomegaly does not help especially when there is no bleeding. Consumption continues and it increases risk of alloimmunisation.
- Try avoiding high dose immunosuppressive agents to the best possible in patients with organ failure (as CLD here)
- Steroids are best avoided for hypersplenism just to improve cytopenia
- IVIG is a frontline agent for ITP during acute bleeding and there is no cost benefit when used in chronic asymptomatic patients