High-dose Immunoglobulin Infusion for Thrombotic Thrombocytopenic Purpura Refractory to Plasma Exchange and Steroid Therapy

Seh Jong Park, M.D., Seok Jin Kim, M.D., Hee Yun Seo, M.D., Moon Ju Jang, M.D., Doyeun Oh, M.D., Byung Soo Kim, M.D., and Jun Suk Kim, M.D.

Department of Internal Medicine, Korea University College of Medicine, Seoul, Korea; Department of Internal Medicine, Bundang CHA Hospital, College of Medicine, Pochon CHA University, Seongnam, Korea

The outcomes of the treatment of thrombotic thrombocytopenic purpura (TTP) have been shown to be improved by the administration of plasma exchange. However, treatment options are currently limited for cases refractory to plasma exchange. The autoantibodies that block the activity of ADAMTS13 have been demonstrated to play a role in the pathogenesis of TTP; therefore, high-dose immunoglobulin, which can neutralize these autoantibodies, may be useful for refractory TTP. However, successful treatment with high-dose immunoglobulin for TTP refractory to plasma exchange and corticosteroids has yet to be reported in Korea. Herein, we describe a refractory case which was treated successfully with high-dose immunoglobulin. A 29-year-old male diagnosed with TTP failed to improve after plasma exchange coupled with additional high-dose corticosteroid therapy. As a salvage treatment, we initiated a 7-day regimen of high-dose immunoglobulin (400 mg/kg) infusions, which resulted in a complete remission, lasting up to the last follow-up at 18 months. High-dose immunoglobulin may prove to be a useful treatment for patients refractory to plasma exchange; it may also facilitate recovery and reduce the need for plasma exchange.

Key Words: Thrombotic Thrombocytopenic Purpura; Plasma Exchange; Glucocorticoids; Immunoglobulin

INTRODUCTION

Thrombotic thrombocytopenic purpura (TTP) is a condition characterized by thrombocytopenia, microangiopathic hemolytic anemia, and less frequently with neurological deficits, renal failure, and fever. TTP is a rare disease, and has been reported to affect only 3.7 persons per one million annually in the United States. It frequently follows a fatal course; 95% of patients die within three months if not treated. TTP pathogenesis has been associated with deficiencies in the metalloproteinase, ADAMTS13 (A Desintegrin And Metalloprotease with a ThromboSpondin like domain 13). The principal function of ADAMTS13 involves the cleavage of unusually large forms of von Willebrand factor (ULVWF), thereby preventing ULVWF multimers from accumulating in the circulation; platelet aggregation in TTP is thought to be the consequence of the binding of the platelets from ULVWF remaining in the circulation. Immunoglobulin G (IgG) autoantibodies that block the activity of ADAMTS13 have been detected in patients suffering from TTP; this may account for the impairment of ADAMTS13 characteristically observed in cases of TTP.

Plasma exchange was introduced in the 1980s as a treatment for TTP, and is currently the treatment of choice for the condition. The principal mechanism of action relevant to plasma
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Figure 1. SDS-agarose gel electrophoresis with normal human plasma calibration shows severe deficiency, less than 5%, of ADAMTS13 in the patient sample. The multiple observed represent the von Willebrand factor-multimer, which is not degraded due to the lack of ADAMTS13. Thus, multiple bands on SDS-agarose gel electrophoresis indicate a lack of ADAMTS13 activity. On the X-axis, the number 100 designates the intact activity of ADAMTS13, i.e., 100% activity of ADAMTS13 results in an absence of multiple bands. However, the patient’s sample shows multiple bands, indicating decreased ADAMTS13 activity. N: Normal healthy control, P: Patient’s sample.

Figure 2. Serial changes of platelet counts, hemoglobin, and serum LDH. Plasma exchange alone failed to improve the hematological parameters; the addition of high-dose methylprednisolone did not result in improvement. However, improvement in all hematological parameters was observed following the administration of high-dose immunoglobulin regimen.

CASE REPORT

A 29-year-old male presented with disturbed mentality; aphasia had developed one day prior to presentation. The patient had a history of frequent epistaxis over the previous two weeks. The patient was otherwise healthy, with an unremarkable medical history. Upon physical examination, the conjunctivas were anemic, and multiple petechiae were detected on the patient’s trunk. The results of the admission blood tests were as follows: hemoglobin (Hb) 7.1 g/dL, white blood cells (WBC) 5,540/μL, platelet (PLT) counts 4,000/μL, reticulocytes 18.9%, and serum LDH 1,655 IU/L. The brain MRI revealed no abnormal findings, such as hemorrhaging or inflammation; an 18-channel EEG revealed moderate to severe cerebral dysfunction. A mild fatty liver and splenomegaly were noted on abdominal US. The peripheral blood smear evidenced normocytic normochromic anemia and severe thrombocytopenia; these findings were compatible with microangiopathic hemolysis including schistocytosis. The results of both direct and indirect Coombs’ tests were negative. SDS-agarose gel electrophoresis for ADAMTS 13 indicated that the ADAMTS 13 activity was as low as 0.89% (Reference value: 50~150%, Figure 1).

The patient was diagnosed with TTP, and plasma exchange was immediately initiated. However, after 14 days of daily plasma exchange treatments with fresh frozen plasma or cryoprecipitate-depleted plasma, the patient’s hematological and cognitive abnormalities remained unimproved: Hb 7.3 g/μL, WBC...
DISCUSSION

Since the introduction of plasma exchange as a treatment, the mean number of plasma exchanges required to induce complete remission for TTP has been reported to be 7 to 16 exchanges. An initial response is normally observed within the first three days of treatment. However, 10 to 20 percent of patients evidence a transient, incomplete, or no response to plasma exchange; it is not currently possible to identify poor responders prior to treatment. Thus far, no treatment strategy for TTP refractory to plasma exchange has been established. In cases of poor response or resistance to plasma exchange, several treatment modalities have been recommended.

First, the frequency of plasma exchange can be increased from once daily to twice daily; twice-daily exchanges of one volume of plasma have been demonstrated to constitute a more effective replacement therapy than increasing the volume of a single daily exchange. However, the economics inherent to such an approach must be considered, as only a limited number of plasma exchanges are covered by Korean medical insurance. Second, the cryosupernatant fraction of the plasma (also known as the cryoprecipitate-depleted plasma) can be employed, rather than fresh frozen plasma; the efficacy of plasma exchange may be attenuated by WF multimers which normally remain in the fresh frozen plasma. Cryoprecipitate-depleted plasma tends to contain a very low level of WF, because cryoprecipitate is quite rich in WF. However, a randomized, controlled trial identified no difference in efficacy between whole plasma and cryoprecipitate-poor plasma. In our case, we attempted to use cryoprecipitate-depleted plasma, but effected no improvements in either the neurological or hematological manifestations.

Third, additional immunosuppressive treatments have been shown to elicit successful responses in cases of refractory TTP. These treatments utilize high-dose steroids or other immunosuppressive agents, including cyclophosphamide, vincristine, and cyclosporine. However, there is currently no data from clinical trials to corroborate the efficacy of such treatments. In the case described herein, we applied high-dose steroids with intravenous infusions of methylprednisolone (125 mg) twice daily while continuing plasma exchanges. However, this treatment failed to improve the patient’s condition. Recently, the anti-CD20 monoclonal antibody, rituximab, has been reported to induce complete remission in cases of TTP refractory to plasma exchange. Weekly infusions of rituximab (375 mg/m²) proved effective in the control of the neurological and hematological manifestations, ostensibly as the result of the depletion of B-lymphocytes, which were generating the IgG autoantibodies. These findings support notion that IgG autoantibodies against ADAMTS13 are important in the management of TTP. In addition, a previous report suggested that high titers of IgG autoantibodies might be associated with resistance to plasma exchange in TTP patients.

Another possible treatment approach is high-dose immunoglobulin infusions. The rationale for the use of immunoglobulin is based on the fact that immunoglobulin is capable of neutralizing IgG autoantibodies against ADAMTS13. Although a retrospective study has reported that the application of immunoglobulin had no additional benefits, many case series reports have noted the efficacy of immunoglobulin in the management of TTP refractory to plasma exchange. Our experience supports the use of high-dose immunoglobulin infusion as an effective salvage treatment for cases of TTP refractory to plasma exchange.

Plasma exchange should continue to be the first-line treatment for patients diagnosed with TTP. However, appropriate salvage treatment should be considered without delay in cases refractory to both repeated plasma exchange and high-dose steroid therapy. High-dose immunoglobulin infusions may represent a useful treatment option for these refractory cases. In addition, this treatment may facilitate recovery and reduce the plasma exchange requirements. However, further study is warranted to determine the optimal treatment protocols for high-dose immunoglobulin therapy.

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