

## ESSENTIAL THROMBOCYTHEMIA AND PREGNANCY

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Sir,  
the management of essential thrombocythemia (ET) in young patients is still controversial and represents an intriguing problem especially, during pregnancy.

We have read with interest the article by Radaelli *et al.*,<sup>1</sup> which reports a concise review of published data on the course of pregnancies in ET, and we would like to add a brief description of our experience. The main data on six pregnancies in four woman affected by ET are shown in Table 1.

In case #1, the first pregnancy ended in a late spontaneous abortion, and the high platelet count found at the time was interpreted as reactive thrombocytosis. A diagnosis of ET was made several months later and therapy with  $\alpha$ -interferon ( $\alpha$ -IFN) was started. The patient became pregnant for a second time during IFN therapy<sup>2</sup> and continued this treatment for two months. After this period, low doses of aspirin (ASA; 100 mg/day) were started and maintained until the delivery.

The second patient was diagnosed with ET

during pregnancy and did not receive any treatment.

The third patient, who was resistant to recombinant and natural IFN, refused any further treatment and returned to our observation at the eighth week of gestation with an internal abortion.

During a second pregnancy she was treated with ASA (100 mg/day) and delivered a full-term, healthy male infant without complications. The placenta weighed 500 g and did not show any infarctual areas.

The fourth patient became pregnant during remission obtained with  $\alpha$ -IFN therapy, which was stopped two months before conception. A low platelet count was maintained without therapy throughout the entire pregnancy and the patient delivered a full-term baby. During the *postpartum* period the platelet count gradually increased and, after two months, we had to start  $\alpha$ -IFN treatment again.

This is the first case reported in the literature where a remission obtained with  $\alpha$ -IFN lasted long enough to allow a normal course of preg-

Table 1. Pregnancies in essential thrombocythemia: platelet counts and outcome.

Pts.	Age	Plt count at diagnosis ( $\times 10^9/L$ )	Pregnancy	Plt range during pregnancy ( $\times 10^9/L$ )	Plt count after pregnancy ( $\times 10^9/L$ )	Therapy	Outcome	Complications
1	34	700	First Second	700-800 428-722	750 886	— IFN ASA	SA (6 months) CD (37th week)	— postpartum bleeding and superficial thrombophlebitis in the puerperium
2	30	1300	First	957-1200	1789	—	ND	—
3	25	1179	First Second	563-920 563-1020	1000 1123	— ASA	IA (8 weeks) ND	— —
4	30	1120	First	219-301	801	—	ND	—

IFN:  $\alpha$ -interferon; ASA: aspirin 100 mg/day; SA: spontaneous abortion; CD: cesarean delivery; ND: normal delivery; IA: internal abortion.

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nancy and delivery.

We observed a decrease of the platelet count during pregnancy in three cases, as had already been noticed by Leone in the first trimester,<sup>3</sup> but in different months of gestation and a fluctuation of values was always found.

We did not find any information in the literature about the therapeutic strategy employed during the *postpartum* period. In our case #1, aspirin was stopped a few days before the delivery to assure good hemostasis but the patient suffered *postpartum* bleeding and superficial thrombophlebitis, although these complications were not severe. Since patient #3 showed a normal bleeding time, antiaggregant treatment was continued with success.

We agree with Radaelli's conclusion about the utility of antiaggregant therapy in improving

the course of pregnancies in ET patients without a history of bleeding. In fact, in our limited experience aspirin allowed us to successfully manage a second pregnancy in two women with a previous abortion. It is hoped that additional reports on pregnancies in ET will be published but effective data, able to guide our therapeutic choices, can only come from multicentric studies.

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### References

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