ISOLATED THROMBOCYTOPENIA IN HOMOSEXUAL MEN -
LONGITUDINAL FOLLOW-UP

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One of the most clinically challenging, yet infrequently discussed, of the AIDS-associated syndromes is the problem of immune thrombocytopenic purpura (ITP). ITP is a diagnosis more frequently encountered in its acute form in children following viral infections and in its chronic presentation in middle-aged women. Morris et al published their account of auto-immune thrombocytopenic purpura in homosexual men in June 1984(1). Their manuscript described a cluster of ITP in 12 homosexual men with backgrounds similar to those recognized in patients with acquired immunodeficiency syndrome. Subsequently the problem has also been recognized in narcotics addicts and hemophiliacs without other manifestations of AIDS(2,3). To date, 32 homosexual men with isolated thrombocytopenia of immune origin have been evaluated in the AIDS Clinic at San Francisco General Hospital. Our experience with this group constitutes the basis of the following discussion.

Thrombocytopenia itself is a recognized complication of many of the confirmed AIDS diagnoses. A percentage of our patients with Kaposi's sarcoma are noted either at the time of diagnosis or during treatment to develop low platelet counts(4). A similar phenomenon has been seen in those patients diagnosed with AIDS-related lymphomas. Patients with Pneumocystis pneumonia may present with mild thrombocytopenia at the time of their initial diagnosis. However, it is more common for thrombocytopenia to develop during the course of treatment for this opportunistic infection (5). Often the platelet count lowers to an alarming level with dramatic rapidity. This is generally assumed to be drug-induced thrombocytopenia. The majority of our patients who have been tested at the time of their thrombocytopenia during antibiotic treatment have demonstrated platelet-associated immunoglobulin. Mild platelet count depression to the 100,000 to 150,000 ul range has been found in approximately 5% of patients undergoing evaluation for the syndrome of persistent generalized lymphadenopathy in our clinic(6). Thrombocytopenia associated with other features of the lymphadenopathy syndrome appears to be
associated with an increased risk of progression from lymphadenopathy syndrome to bona fide AIDS in our natural history study(7). Although one-quarter of the patients evaluated for the problem of isolated thrombocytopenia without other manifestations of AIDS did have peripheral lymphadenopathy on physical examination, the magnitude of their thrombocytopenia justified their inclusion in the ITP cohort.

The demographic backgrounds of the 32 homosexual men with isolated thrombocytopenia evaluated in our clinic are similar to those of AIDS patients(8). The mean and median age of the group is 33 years. Twenty-nine men are Caucasian with 3 ITP patients of Hispanic origin. One patient was diagnosed with ITP in 1980, 5 in 1982, and 17 in 1983. There was an apparent cluster of 14 of the 1983 cases diagnosed in the four-month period from April until August. The significance of this seasonal variation is unclear. The same pattern was demonstrated in cases diagnosed in 1984.

The clinical presentation of patients with isolated thrombocytopenia has been generally benign. No patient has suffered major gastrointestinal or central nervous system bleeds during the course of follow-up. Six patients denied any antecedent bleeding prior to their diagnosis of ITP which was made on routine hematologic problems performed for unrelated reasons. Easy bruising with ecchymoses and petechiae were reported in over half of the patients. Five patients noted gum bleeding, 3 rectal bleeding, 2 epistaxis, and 2 patients sought medical attention for blood in their seminal ejaculate leading to the diagnosis of ITP. The mean duration from onset of symptoms to the diagnosis of ITP in this group has been one month.

Initial laboratory findings in the cohort of patients with isolated thrombocytopenia revealed a platelet count of 20,000/ul (range 3000 to 55,000). A mild degree of anemia (Hct. 37 to 40%) was found in only 3 of 32 patients evaluated. White blood cell counts averaged 6600/ul. The absence of anemia or leukopenia defined these patients as having isolated thrombocytopenia. Numerous patients with AIDS or prodromal symptoms have presented to our clinic with pancytopenia. Although these patients may also demonstrate platelet-associated immunoglobulin on testing, patients demonstrating pancytopenia are not included in this ITP cohort discussion.

Bone marrow examinations in patients with isolated thrombocytopenia have revealed adequate to increased megakaryocytes in 25 patients studied. Platelet-associated immunoglobulin was detected in all members of this cohort. Anti-lymphocyte antibodies were also present in the majority of patients(9).

Lymphocyte subset abnormalities are common in patients with auto-immune phenomenon such as immune thrombocytopenic purpura. Normally, in such situations, the helper cell population is increased yielding a T-lymphocyte helper-to-suppressor ratio greater than normal. The patients in this study demonstrated a mean of 1700 lymphocytes/ul (range 800 to 3100). A marked decrease in both number and percentage of