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Title: Case Report: A case of Preterm Pregnancy with ***ITP*** with Pre-Eclampsia with severe features with Severe IUGR and Oligohydramnios

Introduction-

ITP is an autoimmune disorder characterised by a low platelet count, which can lead to an increased risk of bleeding. ITP can either be pre-existing (Chronic ITP) or develop during pregnancy (Gestational ITP). This condition requires meticulous monitoring of platelet levels and treatment balance of maternal and fetal safety. Treatment strategies often involve corticosteroids, IVIg and other immunosuppressive therapies.

Aim-

This presentation aims to outline the clinical management of preterm patient with ITP along with Severe Pre-Eclampsia and Oligohydramnios with IUGR and Rh-negativity.

Objectives-

- To provide an overview on ITP
- To discuss the impact of ITP on pregnancy.
- Highlight diagnostic approaches.
- Review treatment options and outcomes.
- Emphasize the role of multidisciplinary collaboration.

Background-

Pt was diagnosed as a case of **ITP 4yrs back**. Pt had multiple fainting attacks and c/o generalized weakness over a period of 1month for which she went to AIIMS Delhi, where she was diagnosed as a case of ITP after ruling out other hematological and immunological disorders and was started on medication-

Tb Aspirin 150 OD

Tb Prednisolone 20 OD

H/o taking IVIg transfusion 2months back before her positive pregnancy test.

Case study-

- G2A1 at 15wks with c/o- multiple petechiae and bleeding from gums over last 2days→Rx: 8vials i.e 40gm IVIg given
- At 31wk4d gest, with c/o bleeding PR; ICT-negative, Anti-D given.
- At 36wk 6d- admitted electively as a case of FGR

(On Aspirin 150 OD, Prednisolone 20BD, Eltrombopeg 25OD)

	At 19wk 5d	At 31wk 2d	At 36wk 6d
AGA	17wk 3d Normal TIFFA	28wk 1d	30wk 5d
EFW		1167gm	1678gm
Liquor	adequate	AFI 9	AFI 4
Placenta	Anterior	Anterior	Anterior
Presentation	Unstable lie	cephalic	cephalic
Doppler		Normal	S/D ratio 4.4

	15wks	24wks	31wks	37wks
Total platelet count	17000	16400	11000	23000
Hb	12.1	10.9	11.2	13.3

37wk 2d:BP-180/100mmHg→Inj Labetalol 20 iv stat→160/90 mm Hg →Inj Labetalol 40 IV stat→140/90mm Hg

Pt planned for emergency LSCS(SPE with stage-3 FGR with oligohydramnios);; 1st unit SDP given at TPC 23000

36wk 6d	37wk	37wk 1d
2 units RDP given	5 units RDP given	1 unit RDP given
	Day1-Inj. methylprednisolone 100 mg in 100ml NS	D-2 Inj Methylprednisolone
	Tb Eltrombopeg50OD	Tb Eltrombopeg 50
		Adv- Inj IVIG 55gms infusion over 12hrs,prior to LSCS

LSCS under GA | female | 1.3kg | Baby cried soon after birth.
APGAR- 6/10>>after 5mins→8/10; baby sent to SNCU for LBW
ATONIC PPH occurred→ not controlled with inj syntocinon, inj carboprost, inj tranexa→ B/L uterine artery ligation& utero-ovarian Artery anastomosis ligation done.
Uterus closed in double layer with vicryl and catgut
Multiple oozing points over rectus muscle bed.
Abdomen closed after securing hemostasis. App.blood loss-1 litre
Appropriate post-op management done along with BP control.
2nd unit SDP given;
11 vials i.e 55gms of IVIg given
Restarted on tb prednisolone and eltrombopeg on POD-3

Conclusion-This case underscores the need of early diagnosis and the need of comprehensive multidisciplinary approaches in managing complex obstetric cases involving ITP, severe pre-eclampsia, Rh negative status, and fetal growth restriction.

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