Steroid-refractory immune thrombocytopenia in the era of the new thrombomimetic drugs: is there still a role for rituximab?

TO THE EDITOR: Although corticosteroids and splenectomy represents the main therapeutic strategies [1, 2] for immune thrombocytopenia (ITP), some steroid-refractory patients may be unsuitable for the surgical procedure and therefore require alternative treatment options currently available, such as rituximab [2, 3] and thrombomimetic drugs [4, 5]. Although rituximab is usually used in refractory ITP patients who have failed multiple previous treatments [3], its role in the era of thrombomimetic drugs represents an open question. Herein, we would like to provide our perspective on this topic in the light of our clinical experience, reporting indications to rituximab in a small series of consecutive steroid–refractory/relapsed ITP patients treated with rituximab. There were seven patients (4 male) with a median age of 38 (19-43) years. Rituximab (4 wk infusions of 375 mg/m^2) was given after 50 (6–84) months from the date of ITP diagnosis. One patient suffered from active bleeding requiring platelet transfusions and was refractory to all measures, including thrombomimetic agents (eltrombopag and then romiplostim); he achieved a complete response (CR) with rituximab and was soon after splenectomized, having taken into account the high risk of recurrence and his severe bleeding tendency. Splenectomy was offered to four other patients who refused; in the remaining two patients, splenectomy as well as thrombomimetic agents were not indicated given suspected underlying autoimmune disorders and thrombophilic states. All patients who received rituximab achieved a fast response; indeed, a significant increase in platelet count was recorded early during the course of treatment: one week after the first rituximab infusion in five and after two weeks in the remaining two patients respectively. All patients maintained a sustained CR; six did not necessitate further therapy whereas one was splenectomized soon after the response to rituximab. In all patients, CR was durable and persisted after a median follow-up of 19 months (range, 6-64). No patients relapsed. Based on these findings, rituximab therapy allowed, in our experience, for long-lasting remission in patients with relapsed or refractory ITP, with a good safety profile. All patients but one, who successfully received rituximab as a bridge to splenectomy, refused or presented contraindications for the surgical procedure. Although thrombopoietin agonists, such as eltrombopag or romiplostim, in light of their high efficacy, have substantially changed the clinical scenario and the management of steroid refractory ITP [4, 5], this treatment option requires prolonged administration, namely for the remainder of one's life and without a predictable suspension of therapy. Indeed, the option of a potentially life-long treatment with thrombopoietin agonists was offered to patients who refused splenectomy after a thorough explanation of the expected benefits and possible disadvantages from the therapy. The long-lasting and dependent therapy, virtually to be administered for life, was the main reason patients sought out an alternative treatment; they wanted to induce a prolonged remission of their disease without needing to depend on the therapy for life. This concern, in the setting of patients who refuse or are unsuitable for splenectomy, can allow them to find a therapy the administration of which can be predictable and carried out in limited time. This includes rituximab, the role of which is yet to be defined for selected indications even in the era of the new thrombomimetic medications.

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