



THROMBOCYTOPENIC PURPURA (WERLHOF'S DISEASE)

Qo'yliyev Humoyun

Shodmonqulova Diyora

Mingyasharova Mehriniso

Abdujabborova E'zoza

Students of Tashkent Medical Academy

<https://doi.org/10.5281/zenodo.10890863>

ARTICLE INFO

Received: 22th March 2024

Accepted: 27th March 2024

Online: 28th March 2024

KEYWORDS

Thrombocytopenic purpura, Werlgof's disease, antibodies, uterus, gastrointestinal tract, anemia.

ABSTRACT

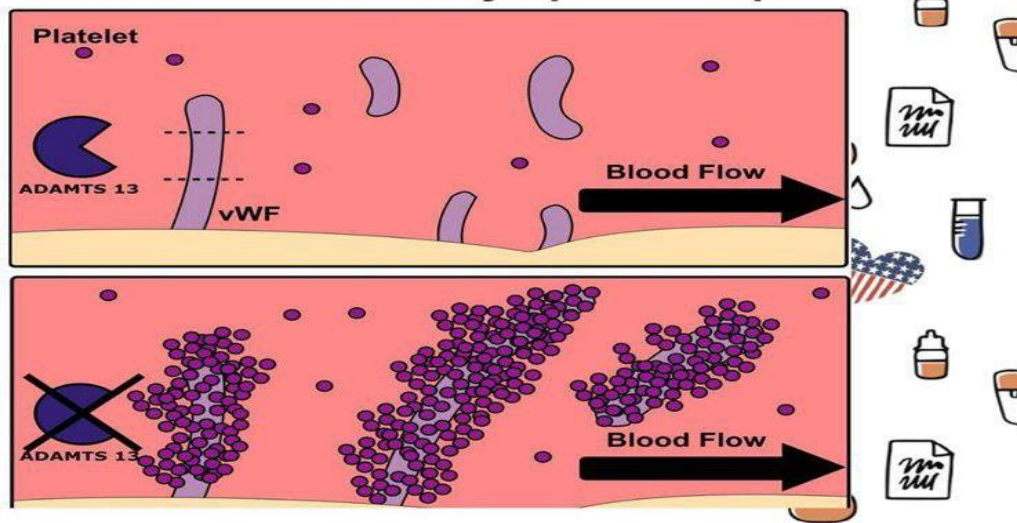
Thrombocytopenic purpura or Werlgof's disease belongs to the group of hemorrhagic diatheses, which is related to changes in platelets and is mostly of immune origin. The first clinical description of the disease was given by Werlhof in 1735 under the name of spot hemorrhagic disease.

Etiology. The pathogenesis of the disease has not been sufficiently studied. TP is based on an autoimmune reaction directed against one's own platelets. There is no known cause for secondary thrombocytopenia (5-10% of all immune thrombocytopenia), such as lymphoproliferative disorders, HIV infection, hepatitis C, AFS, SKV, and Willebrand's disease. Antibodies to platelets are not always detected in the bloodstream. The onset of ITP in children often precedes acute respiratory viral infections.

Pathogenesis:

- ✚ the basis of the disease is the low production of thrombocytes of bone marrow megakaryocytes or their unknown (idiopathic form) or quality failure under the influence of known factors;
- ✚ the importance of the body's immune system (immunogenic theory); according to this theory, the disease develops as a result of the accumulation of antiplatelet autoantibodies that destroy the patient's platelets. Antibodies in platelets can be detected using the Coombs reaction, but they are not always found. Accordingly, immune and non-immune thrombocytopenic purpura are distinguished;
- ✚ certain importance is attached to infections (mostly to viruses), vaccination, vascular wall permeability disorders (the disease is associated with the indicated factors in most children).
- ✚ currently active participation of the spleen in the production of thrombocytic antibodies has been determined, which allows their destruction and, consequently, a decrease in the amount of platelets.

Thrombotic Thrombocytopenic Purpura



Clinic. It depends on the course of the disease (acute, chronic, recurring forms), the level of anemia, and the duration of the process.

I. Subjective data: complaints, and most of them appear for no reason, various types of bleeding (from the gums, nose, mouth, mostly from the uterus, gastrointestinal tract); rashes on different parts of the body; complaints typical of patients with anemia (in the late stages of the disease).

II. Logical assessment of subjective data.

III. Objective information:

1. General overview: - there may be signs of anemia; - hemorrhages on the skin and mucous membranes, they can be in the form of spots or ecchymoses of various sizes, shapes and colors, and most of them are located on the front surface of the body, arms and legs, but the chest, abdomen, back can also take over. Most major hemorrhages are observed; - various types of bleeding with appropriate symptoms are observed (most of them appear spontaneously, less often due to injuries); from the nose, gums, uterus (bleeding into the ovary looks like an extrauterine pregnancy), into the bushlid (bleeding from the gastrointestinal tract, kidney, bleeding into the pleural cavity, peritoneum, pericardium, etc.);

2. Review of organs and systems: — in the absence of accompanying pathology and bleeding, changes are usually not observed by internal organs: myocardiodystrophy events are seen by the heart (in the case of posthemorrhagic anemia); About 10% of patients have slight splenomegaly.

IV. Information on additional inspection methods:

✚ peripheral blood: unchanged (in remission, mild), acute or chronic posthemorrhagic anemia; neutrophilic leukocytosis (in remission) or tendency to leukopenia (during remission); thrombocytopenia (sometimes they are one or two), an increase in the number of young and degenerative forms of platelets, blood clotting retraction disorder (or absence); prolonged bleeding; blood coagulation (especially during remission) is normal; the presence of antibodies to platelets (in immune form); endothelial symptom (pinch, jgut) positive;

✚ bone marrow punctate: megakaryocytic row hyperplasia with an increase in the number of megakaryoblasts and promegakaryocytes. Disorders of erythro- and leukopoiesis are observed when anemia progresses;



✚ if necessary, biochemical, immunological and instrumental (ECG, X-ray, etc.) examination methods are carried out.

Course and prognosis. The course of Verlgof's disease is divided into acute, chronic (recurrent) forms, and forms with a course of nausea.

✚ the acute form is noted in most children, it begins suddenly, in 80% of cases, an infection (viruses) or vaccination has taken place before;

✚ the chronic form passes with the moderate manifestation of the symptoms of Werlgof's disease (bleeding, hemorrhaging in the skin and mucous membranes, anemia); in the form of nausea, there is a slight thrombocytopenia, it usually goes well:

✚ in the form of nausea, when there is not a lot of bleeding and there is little anemia, the prognosis is usually good. The prognosis depends on the severity of the process and modern treatment.

Diagnostics. The diagnosis depends on the typical anamnesis, hemorrhagic syndrome, thrombocytopenia, coagulation retraction disorder, prolonged bleeding, and the presence of antiplatelet antibodies. Verlgof's disease should be distinguished from other forms of GD, hypoplastic anemia, hemoblastosis and other diseases.

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