HIV Case: A 15 Year Old Girl with Thrombocytopenia
History, Part 1

- 15 yo female, seen at the clinic since 2005 at the age of 9, when she was diagnosed with HIV during work-up of persistent cough
- Survivor of sexual assault at age 8, presumed source of HIV infection
- Initiated on 3TC/d4T/EFV in 7/2005
- No opportunistic infection history (chronic cough ultimately asthma)
History, Part 2

- Recently has had poor ARV compliance, attributed to “pill fatigue,” missing much of the prior month’s doses, and missing a scattering of pills around 10/2009
- Now presents in 7/2010 with 3 weeks of bleeding gums and spontaneous bruising, as well as 2 days of “heavy periods” – on exam, noted to have pronounced menorrhagia
- Also reports mounting fatigue and some loss of appetite in preceding weeks
- URI symptoms approximately 1 month prior to clinic visit
- Review of systems in detail otherwise negative
History, Part 3

- Prior medical history:
  - Shingles in 2005
  - Asthma, mild
  - Otitis media
  - Recurrent dental infections
- Allergies: none known
- Medications: ARVs as discussed below; intermittent budesonide use; no ASA or herbal medication use
- Social History: lives with supportive family, sober habits, dating but not sexually active
CD4 and Viral Load Trend

<table>
<thead>
<tr>
<th>Date</th>
<th>14/7/10</th>
<th>3/12/09</th>
<th>14/09/09</th>
<th>28/4/09</th>
<th>8/10/08</th>
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</thead>
<tbody>
<tr>
<td>CD4 %</td>
<td>15</td>
<td>17</td>
<td>15</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>CD4</td>
<td>278</td>
<td>250</td>
<td>424</td>
<td>800</td>
<td>632</td>
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<tr>
<td>Viral Load</td>
<td>1700</td>
<td>27</td>
<td>1500</td>
<td>&lt;25</td>
<td>&lt;25</td>
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All prior viral loads <25 once suppression was achieved, and CD4 % >25 for more than 3 years
Physical Examination

- **Vitals**: BP 105/65, HR 80, apyrexial
- **Gen**: no acute distress
- **HEENT**: gums oozing blood, poor dentition, otherwise well
- **Cor**: regular, s1 and s2 without murmurs, rubs, or gallops
- **Pulm**: clear bilaterally
- **Abd**: no organomegaly, soft, non-acute
- **Skin**: small, scattered bruising across arms and legs; no petechiae
- **Lymph**: no appreciable lymphadenopathy
- **Gyn**: profuse menorrhagia soaking pads and clothing
Initial Labs

- **FBC**: WBC, Hgb 11.6, Plt 4
- **INR**: 0.99
- **PTT**: 29.7
- Electrolytes and renal function within normal limits
## FBC Trend

<table>
<thead>
<tr>
<th>Date</th>
<th>14/7/10</th>
<th>16/3/10</th>
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<th>29/10/07</th>
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<tbody>
<tr>
<td>Hgb</td>
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<td>13.1</td>
<td>11.9</td>
<td>13.8</td>
<td>12.7</td>
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<tr>
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<tr>
<td>Plt</td>
<td>4</td>
<td>217</td>
<td>167</td>
<td>186</td>
<td>312</td>
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</table>
Lab Results

- Hepatitis B Core Total Ab, B Surface Ag, B Core IgM all negative
- Hepatitis A IgM negative
- Hepatitis C negative
- CMV IgG positive, IgM negative
- ANF negative
- Coombs negative
- Parvovirus, EBV pending (Addington Hospital)
Management

- Initially admitted, placed on prednisone 30mg daily with cessation of menorrhagia and increase in platelets to 41 within 4 days
- Started on TDF/3TC/Aluvia (lopinavir/ritonavir)
- Recurrent bleeding from gums and dental abscess with platelet nadir of 2; prednisone increased to 60mg, admitted to hospital again, transfused platelets as well
- Platelet count stabilized at present moment; on slow taper of prednisone, 5-10mg a week with weekly platelet checks
# FBC Trend After Therapy

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<th>2/9/10</th>
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<th>12/8/10</th>
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<th>16/3/10</th>
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<tr>
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<td>2</td>
<td>41</td>
<td>4</td>
<td>217</td>
<td>167</td>
<td>186</td>
<td>312</td>
</tr>
</tbody>
</table>

- Increased dose up to 40mg
- Increased dose up to 60mg
- Decreased dose to 20mg
- Dose down to 20mg
- Started on prednisone, 40mg
Acknowledgements

- Dr. Nesli Basgoz
- Dr. James Hudspeth
- Dr. Henry Sunpath