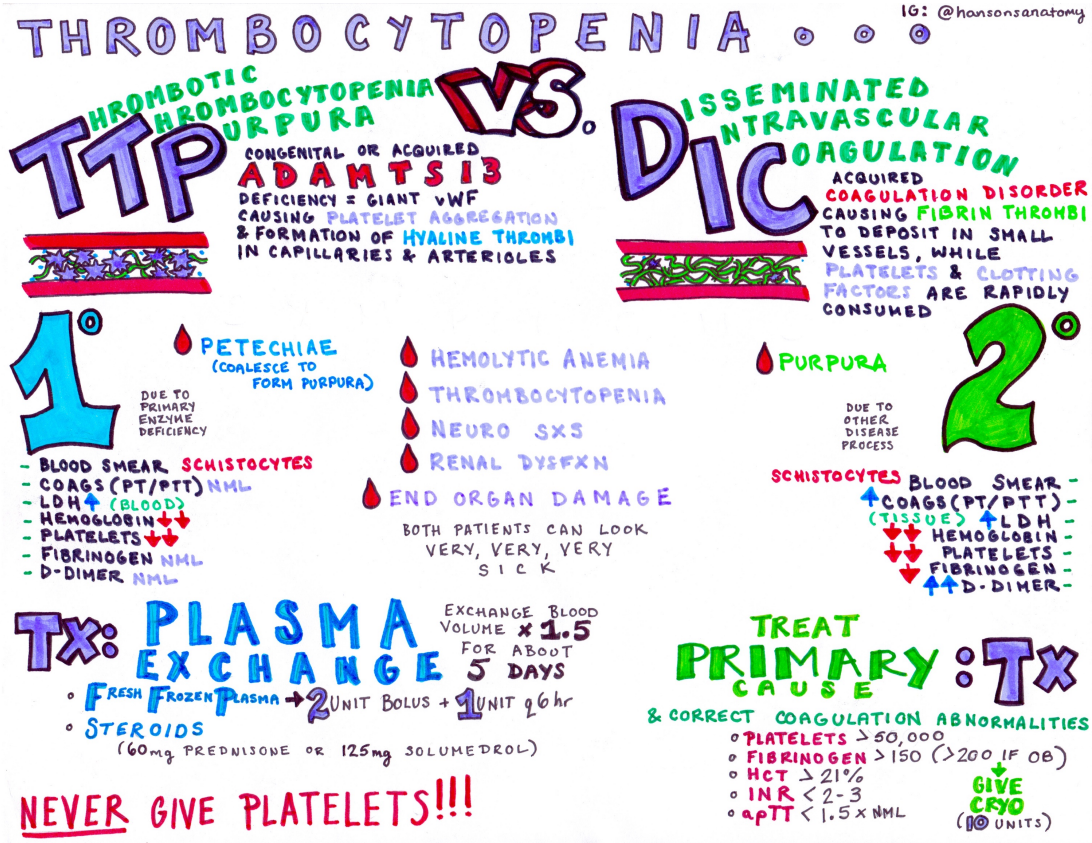
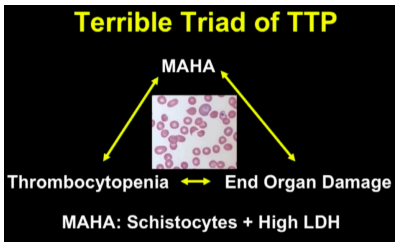
TTP vs DIC NOTES



Thrombotic Thrombocytopenic Purpura (TTP):



- A disease of *platelets* that start to excessively aggregate and lead to end organ damage.
- This is caused by a **lack** of protein called ADAM-TS-13.
    - ADAM-TS-13 can take the lab 12 days to return, therefore it's a clinical dx.
- It's always the patient's primary
- No schistocytes = no TTP
- Symptoms wax and wane.

*MAHA = Microangiopathic hemolytic anemia
**High LDH meaning in the 500+ levels (where normal is in the 200 range)

Tx:

- **Never Give Platelets**
- **Plasma Exchange is the treatment of choice**
- Temporize with 2 units of Plasma, then 1 unit q6 hrs until plasma exchange
- Give Steroids (i.e. 125 mg solumedrol or similar)
- Send ADAMSTS13 find out how long it takes and make sure it is sent before plasma exchange:

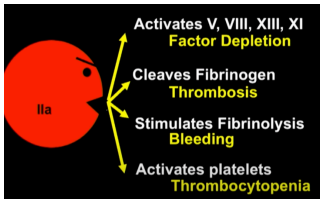
Goals:

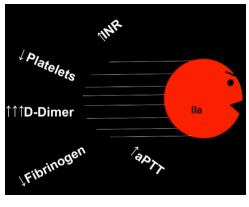
1. PLT target >150,000 on 2 draws
2. Normalized LDH
3. Neuro symptoms fixed

After goals have been met, keep them for monitoring for two days then they can be released home.

Disseminated Intravascular Coagulation (DIC)

- A disease of increased *thrombin (factor 2/IIa)* generation and this over activation of coagulation.
- It's always a secondary problem from something else (i.e. major trauma, sepsis, etc).





Tx: Treat underlying cause.

Transfuse to:

- Fibrinogen >150 (200 in OB disasters) - Give 10-pack of cryo and recheck (even in places that have fibrinogen concentrations).
- PLT >50
- HCT >21
- PTT <1.5x control
- INR <2-3