The replies to the question ‘Do you hospitalize such patients?’ indicated a trend to admit the more severe cases to hospital, while for the milder scenario A, hospital referral was not seen as essential. The distribution of the various responses is shown in Fig. 5.

The answers to the question ‘Would you perform a bone marrow aspirate before starting corticosteroid treatment?’ are summarised in Fig. 6. This approach is far from being standard, although this survey showed a strong trend to perform bone marrow aspiration or biopsy.

In reply to the question ‘Would you perform a bone marrow aspirate even if you are not going to administer corticosteroids?’, from 36 to 47 responders per scenario would always do a bone marrow study even if they did not plan to give prednisone. This question was only asked for scenarios B, C and D. The answers are shown in Fig. 7.

**Discussion**

The survey describes some differences of approach to the child with ITP among our 101 responders. Most cases are treated in academic centres, indicating a high rate of referrals. Two-thirds of the private paediatricians would treat the patients themselves; the remaining third rarely saw any cases and would rather refer them to tertiary hospitals.

Even in the mild scenario A, the vast majority of doctors would prescribe steroids or immunoglobulins and only a limited number of practitioners would adopt the conservative approach. On analysing these data further, it appeared that those responders who would opt for conservative management were working in the government health care system, while private practitioners would always treat such cases. Prednisone dosages of 2 mg/kg/day for 7 days or 4 mg/kg/day for 4 days were the most common regimens used. In the severe cases the tendency was to use steroids or immunoglobulins, while about one-third of respondents would use combinations of the two therapies. Only 1 respondent would use anti-D. This may be due to the high cost of this therapy.

Most responders would do a bone marrow aspirate before prescribing steroid therapy. This investigation would rule out the rare but possible leukaemia, which sometimes manifests with haemorrhagic features and thrombocytopenia. As steroids would delay the institution of appropriate therapy and even worsen the prognosis in cases of leukaemia, many

**This survey showed a strong trend to perform bone marrow aspiration or biopsy.**
authors recommend a marrow aspirate before corticosteroid therapy is started. Many of the respondents would also perform a bone marrow examination even when they were not intending to prescribe steroids. However, this approach is controversial and many experts incline not to test the bone marrow in such cases, except when there is doubt about the diagnosis.\textsuperscript{1,7}

Most respondents would admit the child with ITP to hospital, probably owing to the frequent use of medications to speed up the increase in the platelet count. However, there were no questions related to the social circumstances of the child’s family, the availability of transport or the distance to the hospital, although these factors might have been considered when rejecting an expectant approach combined with outpatient follow-ups.

This survey indicates that controversy over the diagnosis and management of childhood idiopathic purpura exists in South Africa and is similar to that highlighted in published overseas studies.\textsuperscript{3,8-10} The Standard Treatment Guidelines and Essential Drug List, Hospital Level, Paediatrics, published by the Department of Health in 2006,\textsuperscript{11} contains guidelines for the treatment of ITP at district and regional hospital level. These are presumably either not known or not accepted at the tertiary or private health care level where most patients with ITP are treated, and a wide diversity in treatment strategies for this disease therefore still exists.

Several limitations to this study are acknowledged. Firstly, the response rate was low (25%). Secondly, the respondents do not constitute a representative sample of the practitioners who treat childhood ITP in South Africa, because of small numbers and disproportional representation of specialists. Thirdly, a small bias might result from the fact that several doctors working in the same institution might follow the same protocols.

However, this first and only survey on ITP, which is the most common bleeding disorder in children in South Africa, provides substantial evidence of the multitude of management approaches in childhood ITP. The data presented highlight the need for the implementation of a common practice guideline.

References