Consult Request

SPECIALTY

Gastroenterology

CHIEF COMPLAINT

Thrombocytopenia

COMMENTS TO SPECIALIST

The patient is a 61-year-old male with a history of cerebrovascular accident (CVA), hepatitis C virus (HCV), which is treatment-naïve, and congestive heart failure (CHF) - referred for management of liver disease, HCV, heart failure, worsening liver function tests (LFTs), and thrombocytopenia. Aspartate aminotransferase to platelet ratio index (APRI) 4.3 pts.

MAIN QUESTION

Please review the attached documents and provide recommendations for further treatment and diagnostics.

Specialist Response

SUMMARY

Treatment options are available at the primary care level.

DETAILS

This can be caused by low platelets due to portal hypertension from cirrhosis. Given that your notes mention possible radiologic evidence of cirrhosis on computed tomography (CT) four years ago and that he has HCV and abnormal LFTs.

There are no lab findings such as low albumin or elevated bilirubin, nor any reported physical signs or symptoms, such as edema,
ascites or encephalopathy to further suggest cirrhosis, but they need not be present.

- Agree with a sonogram of the abdomen.
- Check coagulation.

For reference only. This eConsult is based on an actual request for specialist consultation. The primary care provider, specialist, and patient are de-identified to protect private health information (PHI).

- Also, check alpha-fetoprotein (AFP) and fibrosis score / FibroTest, if available, depending on your lab.
- Ensure no alcohol (EtOH) use.
- Agree with HCV evaluation for treatment.
- Screen for human immunodeficiency virus (HIV) and hepatitis B virus (HBV) if not already done.

If there is no active bleeding or a plan for an invasive procedure or surgery, there is no need to treat solely the low platelet count, which may represent platelet sequestration in the spleen and does not necessarily imply an increased bleeding risk. The patient has a history of CVA and, therefore, still likely has a benefit > risk from remaining on anticoagulants and/or aspirin.

If cirrhosis is suspected, then referral for esophagogastroduodenoscopy (EGD) to screen for esophageal varices is warranted.

If the above tests do not point toward cirrhosis or if there is a concern about the risk/benefit of continued anticoagulant use, then a consult with Hematology may be warranted.

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