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► To cite this version:

Diane Beauvais, Laura Venditti, Olivier Chassin, Bérangère Joly, Alain Ameri, et al.. Inherited Thrombotic Thrombocytopenic Purpura Revealed by Recurrent Strokes in a Male Adult: Case Report and Literature Review. *Journal of Stroke and Cerebrovascular Diseases*, 2019, 28, pp.1537 - 1539. 10.1016/j.jstrokecerebrovasdis.2019.03.011 . hal-03484712

HAL Id: hal-03484712

<https://hal.science/hal-03484712>

Submitted on 20 Dec 2021

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Inherited thrombotic thrombocytopenic purpura revealed by recurrent strokes in a male adult: case report and literature review.

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Title: 127 characters; **Short title:** 44 characters; **Abstract:** 180 words; **Text word count:** 372;

References: 8; **Table:** 1.

Short title: Upshaw-Schulman syndrome revealed by stroke

Disclosure: none.

Abstract

Thrombotic thrombocytopenic purpura (TTP) is a thrombotic microangiopathy related to a severe deficiency of *ADAMTS13* (a disintegrin and metalloprotease with thrombospondin type 1 repeats, member 13). In this article, we describe the first case of a young male adult suffering from a hereditary TTP revealed by recurrent strokes, relapsing despite antiplatelet and anticoagulant therapy. Because of the persistent moderate thrombocytopenia, plasmatic *ADAMTS13* activity was investigated and was found lower than 5% in the absence of anti-*ADAMTS13* IgG. Direct sequencing of *ADAMTS13* gene led to the diagnosis of Upschaw-Schulman syndrome (USS). Inherited TTP or USS is a rare autosomal recessive inherited disease leading to a severe deficiency of *ADAMTS13* mostly beginning in childhood or in young female adult during pregnancy. Our patient was treated with fresh frozen plasma every two weeks. One year after diagnosis, he was free of neurological symptoms. Around 12 cases of inherited TTP diagnosed in adults (outside pregnancy) are described in literature. Only 4 of them exhibited a stroke. This case is the first late onset genetic TTP revealed by recurrent strokes, moderate thrombocytopenia without anemia.

Key words: Stroke ; Thrombocytopenia *ADAMTS13* ; Thrombotic thrombocytopenic purpura ; Neurogenetic

1. Observation

A 33-year-old Caucasian without any family history presented to the emergency department because of an acute left-side weakness that spontaneously recovered after thirty minutes. Cerebral magnetic resonance imaging (MRI) revealed an acute right parietal ischemic stroke. Neck and intra-cranial arteries explored were normal. 24-hour electrocardiogram monitoring excluded arrhythmia. Body tomodensitometry revealed both renal and spleen infarcts. Transesophageal echography and hematologic parameters (bone marrow smear and biopsy, screening for mutations of myeloproliferative syndroms) were normal. The patient was treated with aspirin.

Recurrence occurred one month later with right-side weakness revealing a new cerebral infarct in the superficial left parietal lobe on MRI. Biological examinations were still negative except a moderate thrombocytopenia ($100 \times 10^9/L$) without signs of hemolysis. Patient was administered anticoagulation therapy (apixaban).

A third episode occurred two months later. Lumbar puncture and X-rays cerebral arteriography were normal. Because of the thrombocytopenia, *ADAMTS13* (a disintegrin and metalloprotease with thrombospondin type 1 repeats, member 13) activity (measured using the FRETs-VWF73 assay as previously described)(1) was investigated and was found lower than 5%, in the absence of anti-*ADAMTS13* IgG. Direct sequencing of *ADAMTS13* gene showed two heterozygous mutations in exon 24 consisting in one missense mutation p.Arg1060Trp and one truncating mutation p.Trp1067Serfs*47. Also, several single nucleotide polymorphisms (SNPs) were identified either at the homozygous state (p.Arg7Trp) or at the heterozygous state (p.Gln448Glu, p.Pro618Ala and p.Ala1033Thr). This result led to the diagnosis of congenital TTP. The patient was treated with fresh frozen plasma. One year after diagnosis, the patient did not relapse.

2. Discussion

TTP is a thrombotic microangiopathy related to a severe deficiency of *ADAMTS13*(2,3) leading to a spontaneous formation of platelet thrombi responsible for a mechanical hemolytic anemia, a thrombocytopenia and a multivisceral ischemia with often brain involvement (stroke, seizure or confusion). Indeed, *ADAMTS13* plays a key role in the control of platelet adhesion and aggregation by cleaving the von Willebrand factor (vWF) multimers. In almost 90% of cases, TTP is acquired(1). In the other cases, TTP is inherited via bi-allelic autosomal recessive mutations of *ADAMTS13* gene (Upschaw-Schulman syndrome)(4). Clinical presentation of USS is variable, mostly beginning in childhood or in young female adult during pregnancy. Around 12 cases diagnosed in adults (outside pregnancy) are described in literature. Only 4 of them (Table 1)(5–8) exhibited a stroke. All these cases had severe thrombocytopenia and microangiopathic haemolytic anemia.

3. Conclusion

This case is the first late onset genetic TTP revealed by recurrent strokes, moderate thrombocytopenia without anemia. A stroke with thrombocytopenia, even moderate, needs to discuss a TTP and *ADAMTS13* activity should be tested. The absence of anemia or schistocytes should not call into question the diagnosis of TTP. In perspective, impact of acquired or genetically inherited low *ADAMTS13* activity to promote strokes will remains to be explored in future large studies (9).

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Reference	Sex, age at diagnosis, origin	Medical history before diagnosis	Symptoms at diagnosis	Stroke	Triggering factor	Treatment	Biological results	ADAMTS13 activity	Mutations of ADAMTS13 gene	Evolution
Meyer et al ⁵	Male, 20, Tunisian	17 years old: petechial bleeding and epistaxis with thrombocytopenia and anemia without signs of hemolysis. Diagnosis of idiopathic thrombocytopenic purpura, treated by corticosteroids	Ischemic stroke with generalized seizures	Lacunar strokes	0	Polyvalent intravenous immune-globulins and sessions of plasmapheresis. FFP after diagnosis of inherited TTP.	Platelets: 13x10 ⁹ /L Hemolytic anemia (Hb 77 g/L; total bilirubin 107 μmol/L; and LDH 1,095 IU, normal range 91–180 IU). Schistocytes: only detected at the 3rd crisis.	< 5% (diagnosis at 21 years old, on third hemolytic crisis)	Homozygous for a missense mutation: p.Ser119Phe in the metalloprotease domain of ADAMTS13	Follow-up of 2.5 years: sustained remission (platelet count >100x10 ⁹ /L) with persistent mild renal insufficiency (serum creatinine 150 μmol/l), however, without neurological sequelae.
Antoine et al ⁶	Male, 21, "white" "patient A1 born in 1964"	0	Ictere, renal failure, somnolence, abdominal pain. Relapses: renal failure, strokes and seizures	25 years old: ischemic stroke in the right medium cerebral artery territory	First relapse following febrile illness and acetylsalicylic acid intake. Other episodes preceded by infection or surgery.	Hemodialysis, FFP. After the 10 th bout of TTP, prophylactic plasmapheresis sessions every 4 months were instituted.	Platelets: 15x10 ⁹ /L. Hb: 108g/L at diagnosis and chronic low-grade microangiopathic hemolysis on follow-up. Schistocytes: present at every bout	<3%	Compound heterozygote with 2 mutations: p.Arg732Val (exon 18) and p.Arg1336Trp (exon 28)	More than 10 years' follow-up, with 10 bouts including one occurring during the prophylactic treatment with FFP every 4 months

Fattah et al ⁷	Female, 48, Caucasian	32 years old: stroke involving multiple territories. Thrombocytopenia, hemolytic anemia. Treated with 3 days of plasma exchange for suspected TTP. She developed progressive chronic kidney disease that was presumed secondary to hypertension.	Kidney transplantation for renal end-stage disease	32 years old: strokes in multiple vascular territories	Kidney transplantat ion	FFP	Her hemoglobin (Hb) concentration decreased from 10 to 8 g/dL	< 5%	Compound heterozygote: p.Arg916Cys (exon 22) and at Exon 29 (c4143insA) results in a frame shift of the protein sequence starting with glutamic acid at Codon 1382 (p.Glu1382fs)	No relapse
Hyla-Klekot et al ⁸	Male, 52, Polish	He experienced a few episodes of ischemic stroke with ongoing neurological deficiency and developed chronic kidney disease.	NA	Ischemic strokes without more precision	NA	NA	NA	NA	Compound heterozygote: missense mutation p.Gly761Ser (exon 19) and mutation of exon 29 (4143_4144insA)	NA

Abbreviations: NA, not available. FFP, fresh frozen

Table 1: Review of previously reported late onset inherited TTP with stroke.