**SHORT REPORT**

### Thrombocytopenia and *Plasmodium falciparum* malaria in children with different exposures

F Moulin, F Lesage, A-H Legros, C Maroga, A Moussavou, P Guyon, E Marc, D Gendrel

We studied thrombocytopenia during acute *Plasmodium falciparum* malaria in 64 traveller children from Paris (France), 85 children from Dakar (Senegal) with an intermittent exposure (69 with severe attack or cerebral malaria), and 81 children from Libreville (Gabon) with a perennial exposure (43 with severe attack or cerebral malaria). Initial thrombocytopenia was present in 43–58% of children with *P falciparum* malaria but was not more frequent in severe outcome or cerebral malaria. Low parasitaemia may lead to the misdiagnosis of malaria and delayed treatment when there is associated thrombocytopenia.

Initial blood cell and platelet counts were determined by an automatic method; diagnosis of *P falciparum* malaria was made after thin film microscopic examination.

**RESULTS**

Table 1 presents the results. None of the patients had bleeding or clinical symptoms of disseminated intravascular coagulation, but fibrin degradation products were not measured. Within each subgroup, there was no clinical difference, especially in terms of splenomegaly, between children with or without thrombocytopenia.

### Paris

The study population consisted of 68 traveller children living in France (60 African, eight French; 30 males; mean age 7.6 years, range 8 months to 15 years) and hospitalised with acute *P falciparum* malaria. No patient had severity criteria according to WHO guidelines.

<table>
<thead>
<tr>
<th>Platelet count (/mm³)</th>
<th>Mean (range)</th>
<th>&lt;50000</th>
<th>&lt;150000</th>
<th>Haemoglobin (g/l)</th>
<th>Mean (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-chemoprophylaxis</td>
<td>161000 (46000–353000)</td>
<td>3/34 (8.8%)</td>
<td>15/34 (44.1%)</td>
<td>97 (75–134)</td>
<td></td>
</tr>
<tr>
<td>Chemoprophylaxis</td>
<td>159000 (31000–470000)</td>
<td>3/34 (8.8%)</td>
<td>16/34 (47%)</td>
<td>104 (70–136)</td>
<td></td>
</tr>
<tr>
<td>Dakar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>121000 (30000–309000)</td>
<td>4/16 (25%)</td>
<td>6/16 (37.5%)</td>
<td>88 (52–132)</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>174000 (8000–524000)</td>
<td>4/44 (9%)</td>
<td>20/44 (45.5%)</td>
<td>64 (18–132)</td>
<td></td>
</tr>
<tr>
<td>Cerebral malaria</td>
<td>160000 (34000–420000)</td>
<td>4/25 (16%)</td>
<td>11/25 (44%)</td>
<td>77 (35–103)</td>
<td></td>
</tr>
<tr>
<td>Libreville</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>142000 (20000–565000)</td>
<td>6/38 (15.8%)</td>
<td>19/38 (50%)</td>
<td>89 (63–125)</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>161000 (21000–426000)</td>
<td>6/35 (17.1%)</td>
<td>25/35 (71.4%)</td>
<td>78 (21–128)</td>
<td></td>
</tr>
<tr>
<td>Cerebral malaria</td>
<td>180000 (63000–346000)</td>
<td>0/8</td>
<td>3/8 (37%)</td>
<td>81 (31–131)</td>
<td></td>
</tr>
</tbody>
</table>

---

**Table 1** Platelet counts and haemoglobin levels in children with *P falciparum* malaria in the three areas
criteria, 16 patients had acute malaria and were not hospitalised, 44 had severe malaria, and 25 had cerebral malaria and were hospitalised. A thrombocytopenia < 50 000/mm$^3$ was found in 14.1% of the children and < 150 000/mm$^3$ in 43.6%. There was no difference between the three severity groups. Three of the 85 patients died. Their platelet counts were respectively 77 000, 164 000, and 186 000/mm$^3$. In all patients with thrombocytopenia, platelet count returned to normal in 2–5 days.

**Libreville**

The study population consisted of 81 hospitalised patients (40 males; mean age 6.1 years, range 7 months to 15 years); 38 had acute malaria (non-hospitalised), 35 severe malaria, and eight cerebral malaria (hospitalised). A thrombocytopenia < 50 000/mm$^3$ was found in 14.8% of children and < 150 000/mm$^3$ in 58%; there was no correlation with severity. One child with cerebral malaria died. His platelet count was 170 000/mm$^3$.

**DISCUSSION**

This study shows that thrombocytopenia is a common feature of *Plasmodium falciparum* malaria and is independent of importance of parasite exposure. In the three different populations studied, a platelet count < 150 000/mm$^3$ was found in 43–58% of children, and profound thrombocytopenia < 50 000/mm$^3$ was not more frequent in cerebral malaria or severe forms than in acute attacks. In Paris where no severe malaria was diagnosed, the rate of thrombocytopenia is the same as in Dakar or Libreville. In the present study, four children died, but only one had thrombocytopenia < 150 000/mm$^3$. When thrombocytopenia is associated with low number of parasites, thrombocytopenic purpura is often diagnosed, which delays antimalarial treatment and increases the risk of complications.

The mechanism of thrombocytopenia in malaria is probably the consequence of several factors. Experimental data and clinical studies have successively emphasised the role of immune factors and the destruction or sequestration of platelets. In severe forms, platelet and erythrocyte sequestrations are frequent, and thrombocytopenia is present. However, no studies have shown that thrombocytopenia at the initial stage of acute malaria could be a marker of severity. Patients with *P vivax* malaria, a mild infection without severe forms, also frequently have thrombocytopenia. Activation of the coagulation cascade occurs even in mild malaria, but is probably proportional to disease severity. Fibrin degradation products and plasma antithrombin III activity were not measured in our patients, but no bleeding or other clinical symptoms of disseminated intravascular coagulation were found, and thrombocytopenia was also detected in ambulatory children with common acute malaria. In this study, thrombocytopenia appeared to be frequent in acute *P falciparum* malaria. Thrombocytopenia might be a useful indicator of malaria in children, but not a marker of severity.

Authors’ affiliations

F Moulin, A-H Legros, E Marc, D Gendrel, Hospital Saint Vincent de Paul, Paris, France

F Lesage, P Guyon, Hospital Principal, Dakar, Sénégal

C Maroga, A Moussavou, Hospital Pédiatrique d’Owendo, Libreville, Gabon

Correspondence to: Professeur Dominique Gendrel, Hospital Saint Vincent de Paul, 82 Avenue Denfert-Rochereau, 75014 Paris, France; dominique.gendrel@svp.ap-hop-paris.fr

Accepted 2 October 2002

**REFERENCES**


Thrombocytopenia and *Plasmodium falciparum* malaria in children with different exposures

F Moulin, F Lesage, A-H Legros, C Maroga, A Moussavou, P Guyon, E Marc and D Gendrel

*Arch Dis Child* 2003 88: 540-541
doi: 10.1136/adc.88.6.540