In addition to hemolytic anemia, the patient also had neurologic abnormalities, renal involvement, and thrombocytopenia. The hemolytic anemia and thrombocytopenia were sufficient to raise our suspicion of TTP and to consider initiation of plasma exchange. Only 5% of patients with TTP demonstrate the classic pentad of clinical features,[1] ie, thrombocytopenia, microangiopathic hemolytic anemia, fluctuating neurologic signs, renal impairment, and fever.

In 1991, when plasma exchange was introduced for TTP, the survival rate of patients increased from 10% to 78%.[1,3] Thus, the diagnosis of TTP is an urgent indication for plasma exchange. We normally do plasma exchange daily until the platelet levels improve.

Our patient received methylprednisone 125 mg intravenously every 12 hours and plasma exchange daily. After three cycles of plasma exchange, she regained normal consciousness, and her platelet count had increased to 20.5 × 10^9/L on the day of discharge from our hospital.

TTP is a life-threatening hematologic disorder. Evidence of microangiopathic hemolytic anemia on a peripheral blood smear is vital to the suspicion of TTP. The diagnosis should be confirmed by ADAMTS13 testing, which should show decreased activity (< 10%) or increased inhibition, or both. Rapid management with plasma exchange and steroids can lead to a satisfactory outcome.

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CORRECTION

Pancreatectomy and islet cell autotransplantation

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The article "Total pancreatectomy and islet cell autotransplantation: Definitive treatment for chronic pancreatitis" (Arce KM, Lin YK, Stevens T, Walsh RM, Hatipoglu BA. Cleve Clin J Med 2016; 83:435–442) incorrectly stated that Paul Lacy and David Scharp performed research at the University of Washington at Seattle. They did their work at Washington University in St. Louis, Missouri.