General measures

Citation	LOE	Study design	Patient numbers	Summary
Neunert et al. *Pediatr Blood Cancer* 2008;51(4):513–516	IV	Survey of members of the American Society of Pediatric Hematology-Oncology (ASPHO) that described a 5-year-old female with ITP for 1 year who was unresponsive to steroids, IVIG, and anti-D immune globulin and having frequent epistaxis causing interference with her daily activities		Primary measure: a 13-item questionnaire evaluated physician decision-making Primary outcome: 33% stated they would recommend splenectomy; 67% would instead treat with rituximab. If initial drug therapy failed, 47% would proceed with splenectomy. Physician management of patients with chronic ITP is diverse
Kuhne et al. *Lancet* 2001;358:2122–2125.	IV	Data from a registry analysed to prospectively survey the presenting features and the diagnostic evaluation and management practices used for children with ITP worldwide	1496	Primary measure: data on newly diagnosed children with ITP from the Intercontinental Childhood ITP Registry collated from 209 physicians from 136 institutions in 38 countries Primary outcome: occurrence of childhood ITP peaked during spring and reached a nadir in the autumn. Initial management consisted of no drug treatment in 612 patients (31%), IVIg in 576 (29%), corticosteroids in 651 (33%), or both in 137 (7%). The variable approaches to management of childhood ITP demonstrate the need for prospective clinical trials
Sutor et al. *Semin Thromb Haem* 2001;27:253–267	IV	A retrospective and a prospective survey were carried out to determine the present therapeutic approach and outcomes for acute childhood ITP in Germany		Primary outcome: although 83% of patients had a platelet count $<20 \times 10^9$/L (56% $<10 \times 10^9$/L), almost all (97.5%) had only mild bleeding symptoms (2.5% had serious bleeding symptoms). Conclusions about the effectiveness of treatment cannot be drawn from the results of these surveys. Recommendations based primarily on platelet counts must be reconsidered

Clinical classification

Citation	LOE	Study design	Patient numbers	Summary
Buchanan et al. J Padiatr	IV	Development of an instrument to allow semi-quantitative assessment of	54	Primary measure: bleeding severity was graded on a scale of 0 to 4 in 4 different sites (overall, oral,

2002;141:683–688		hemorrhage in children with ITP		epistaxis, and skin) on the basis of history during the previous 24 hours and physical examination Primary outcome: grade of bleeding correlated inversely with platelet count. Grade 4 mucosal or internal hemorrhage was noted in 7 patients; none had life-threatening or fatal bleeding. Scoring of hemorrhage is possible in children with ITP and the grade of hemorrhage may represent a clinically meaningful endpoint in future studies
Grainger et al. ASH 2008; abs 3411	IV	A UK national paediatric ITP registry was set up in January 2007 designed to collect data from all newly diagnosed ITP over at least a subsequent 10 year period	114	Primary measure: details about epidemiology, presentation and management were collated Primary outcome: the proportion of children receiving platelet raising treatment was noted to decrease from 60.5% in 1995 to 37.8% in 2000. The current 2007 registry data shows a continued decrease in treatment to 20% of all the children
Edslev et al. *Br J Haematol* 2007;138:513–516	IIb	Prospective study initiated by the Nordic Society for Pediatric Haematology and Oncology, investigating children with newly diagnosed ITP	409	Primary measure: to describe the course of disease Primary outcome: morbidity occurred mainly in children with thrombocytopenia lasting >3 months, whereas, the risk period with platelet counts <20 × 10^9/L was short and the number of bleeding events low, in children with shorter disease duration. Uneventful courses predicted by developing a scoring system based on 6 clinical features: abrupt onset (weight, 5), age <10 years (3), preceding infection (2), platelet count <5 × 10^9/L, wet purpura (1) and male gender (1)

Watch and wait

Citation	LOE	Study design	Patient numbers	Summary
Roganovic et al. *Pediatr Blood Cancer* 2005;47:662–664	III	Retrospective review of hospital records over 15 years, of patients ≤18 years of age with a discharge diagnosis of idiopathic or immune ITP	78	Primary measure: clinical characteristics, management practices and outcomes of children with ITP analysed over 15-year period Primary outcome: watch and wait policy adopted for 77% of patients

Sandoval et al. *Pediatr Blood Cancer* 2004;42:109–112	IIb	Retrospective analysis of paediatric patients (median age 16 months) treated between 1987 and 2002 to determine clinical features of ITP and treatment outcomes	79	Primary measure: risk of chronic ITP with advancing age Primary outcome: infants with ITP respond favourably to treatment and are less likely to develop chronic ITP compared to older children
Bolton-Maggs et al. *Semin Thromb Hemost* 2001;27:269–275	IV	Review of management strategies for childhood acute ITP	N/A	Primary measure: treatment approaches Primary outcome: lack of suitable evidence upon which to base management decisions

Prednisolone

Citation	LOE	Study design	Patient numbers	Summary
Ou et al. *Acta Paediatr Taiwan* 2006;47:226–231	IIa	Comparative study of platelet count elevation and chance of developing persistent, profound thrombocytopenia by IVIg or prednisolone, in the treatment of children aged 3 months to 14 years with ITP	87	Primary measure: patients had initial platelet count less than 20 × 10(3)/mm^3. Platelet counts were evaluated on presentation days 2, 3, 5, 7, 30, 60, 90, 120, 150 and 180 Primary outcome: at 6 months, no difference was observed in developing persistent platelet counts lower than 20 × 10(3)/mm^3 between IVIg and prednisolone-treated groups

High-dose methyl-prednisolone

Citation	LOE	Study design	Patient numbers	Summary
Ancona et al. *J Pediatr Hematol Oncol* 2002;24:540–544	Ib	Prospective, randomised trial comparing IVIg with high-dose IV methylprednisolone in the treatment of children with ITP	77	Primary measure: patients received IVIg 1 g/kg/dose × 2 (42) or methylprednisolone 30 mg/kg/dose × 3 (35). Platelet counts were evaluated at presentation, 24, 48, 72 hours, 1 week, and 2 to 4 weeks. Primary outcome: 80% of patients treated with IVIg and 60% of patients treated with methylprednisolone demonstrated an increase in platelet count of 50,000/μL or more within 48 hours. Higher initial platelet counts produced by

				IVIg may not justify the additional cost and potential risks of this agent
Erduran et al. *Turk J Pediatr* 2003;45:295–300	Ib	Randomised study of 42 children (1–13 years) with ITP and platelet counts ≤20,000 × 10^9/L	42	Primary measure: patients received mega-dose methylprednisolone (MDMP) 30 mg/kg/d for 3 days and 20 mg/kg/d for 4 days (20 patients) or IVIg 1 g/kg/d for 2 days (22 patients). Platelet counts were determined at diagnosis, at 2, 4, 7, 14, 30, 60, 90, 120, 150, and 180 days and at 3-month intervals after the 6th month Primary outcome: the mean platelet counts of both groups gradually increased and peaked on the 7th day. No significant differences between the mean platelet counts of patients, in the two groups on treatment days 0, 2, 4, 7, and 14. Mean time to achieve platelet counts above 20,000/microg in the MDMP group and the IVIg group was 4.1 and 2.9 days and above 50,000 × 10^9/L, was 5.0 and 5.2 days, respectively. IVIg and MDMP were equally effective in the treatment of ITP, but lower costs, reduced side effects and oral administration made MDMP the preferred option in this setting
Pansini et al. EHA 2007:abs 0750	III	Large unicentric, retrospective case review of children with ITP receiving different therapies, to contribute to solving the problem of whether, when, and how to treat ITP in children	265	Primary measure: autoimmunity and serology for common viral infections, platelet count Primary outcome: 92.1 % children reached a persistent CR, 89.4% after a first-line treatment or the wait and see strategy. No significant differences were evident between the therapeutical approaches in terms of the % of CR. IVIg and high-dose methylprednisolone (HDMP) at 7.5 mg/kg for 4 days seemed to be the best treatments, quickly reaching a safe platelet level and a CR (7–11 days). Among NR patients, 7 were splenectomised and only 3 reached a stable CR. The cost benefits of HDMP in this patient group were emphasised

High-dose dexamethasone

Citation	**LOE**	**Study design**	**Patient numbers**	**Summary**

Mazzucconi et al. *Blood* 2007;109:1401–1407	IIa	2 prospective pilot studies (monocentric and multicentric) concerning use of repeated pulses of HD-DXM in untreated ITP patients (adults and children) Monocentric study: HD-DXM was given in 4-day pulses every 28 days, for 6 cycles Multi-centric study: HD-DXM was given in 4-daypulses every 14 days, for 4 cycles	32	Primary outcome: monocentric study – response rate was 89.2%; relapse-free survival (RFS) was 90% at 15 months; long-term responses, lasting for a median time of 26 months (range 6–77 months) were 25 of 37 (67.6%) Multi-centric study: response rate (85.6%). RFS at 15 months 81%; long-term responses, lasting for a median time of 8 months (range 4–24 months) were 67 of 90 (74.4%)

IVIg

Citation	LOE	Study design	Patient numbers	Summary
Benesch et al. *J Pediatr Hematol Oncol* 2003;25:797–800	Ib	Prospective, randomised study comparing two different IVIg doses for initial treatment of childhood acute ITP. Patients received either 1 g/kg body or 0.3 g/kg body weight IVIg per day for 2 consecutive days	34	Primary measure: efficacy and side effects of two different IVIg dose regimens Primary outcome: platelet counts increase rapidly after high-dose IVIg administration within the first 72 hours. Platelet count of more than 20×10^9/L can be achieved with low-dose IVIg in most children with acute ITP. For patients with very low platelet counts, doses higher than 0.6 g/kg may be more effective
Hedlund-Treutinger et al. *J Ped Hematol Oncol* 2003;25:139–144	Ib	2:1 randomised study of children with chronic ITP receiving dexamethasone or IVIg	23	Primary measure: platelet count, with short-term response defined as a platelet count of at least 30×10^9/L (and an increase in platelet count compared with day 1) on day 3 of the first treatment cycle. Primary outcome: IVIg produced a transient increase in platelets in children
Niebanck et al. *J Pediatr Hematol Oncol* 2005;27:145–147	IIb	Retrospective, comparative study investigating the incidence of absolute neutrophil count (ANC) following IVIg therapy in a large cohort of children with ITP	104	Primary measure: post-treatment ANCs were compared between patients who received IVIg and patients who received anti-D immunoglobulin Primary outcome: neutropenia (ANC, 1500/mL), developed during 18 of 64 (28%) treatment courses with IVIg, compared with 0 of 46 (0%) treatment courses with anti-D immunoglobulin. IVIg treatment associated with neutropenia

Tamminga et al. ASH 2007:abs 3917	III	Registry analysis to obtain worldwide prospective data on the natural history of ITP in children	2605	Primary outcome: IVIg treatment of acute childhood ITP may reduce risk of developing chronic ITP
Ou et al. *Acta Paediatr Taiwan* 2006;47:226–231	III	Comparative study of platelet count elevation to determine the chance of developing persistent profound thrombocytopenia, by IVIg or prednisolone in the treatment of children aged 3 months to 14 years with ITP	87	Primary measure: patients had initial platelet count less than 20 × 10(3)mm^3. Platelet counts were evaluated on presentation, days 2, 3, 5, 7, 30, 60, 90, 120, 150 and 180 Primary outcome: at 6 months, no difference was observed in developing persistent platelet counts lower than 20 × 10(3)/mm^3 between IVIg and prednisolone-treated groups
Beck et al. *J Pediatr* 2005;147:521–527	III	Systematic review and meta-analysis of randomised controlled trials to compare the effectiveness of corticosteroids and IVIg in children (between 3 months and 18 years) presenting for the first time with primary acute ITP	401	Primary measure: number of patients with a platelet count >20,000/mm^3, 48 hours after treatment initiation Primary outcome: patients treated with corticosteroids are 26% less likely to achieve the primary measure when compared with children treated with IVIg

Anti-(Rh)D

Citation	LOE	Study design	Patient numbers	Summary
El Alfy et al. *Acta Haematol* 2006;115:46–52	Ib	Randomised trial comprised 34 patients with chronic ITP (18 boys, 16 girls) with recurrent bleeding episodes	34	Primary measure: efficacy and safety of IV anti-D compared with low-dose IVIg in the treatment of children with chronic ITP. Bleeding manifestations, complete blood cell and reticulocyte counts were assessed at baseline and 3, 7, 14 and 28 days after infusion Primary outcomes: single IV anti-D and low-dose IVIg effectively increased platelet count in patients at risk of bleeding or those with previous bleeding episodes. Repeated doses of anti-D could maintain PC above critical values or double baseline counts in nearly two thirds of the patients showing good control of bleeding anti-D is effective as maintenance therapy in children with chronic ITP and may avoid splenectomy
Tarantino et al. *J*	Ib	Randomised prospective trial of immune	105	Primary measure: patients were monitored for

Pediatr 2006;148:489–494		globulin treatment for Rh+ children with newly diagnosed ITP. Eligible patients received either a single IV dose of 50 µg/kg anti-D, 75 µg/kg anti-D, or 0.8 g/kg IVIg		response to treatment and AEs Primary outcome: a single 75 µg/kg dose of anti-D raised the platelet count in children with newly diagnosed ITP more rapidly than standard-dose anti-D and as effectively as IVIg, with an acceptable safety profile
Kjaersgaard et al. ASH 2007:abs 1312	IIa	Investigation into the platelet-enhancing effect of subcutaneous anti-D in children with ITP	21	Primary measure: platelet count Primary outcome: subcutaneous anti-D is effective as maintenance therapy in children with ITP
Turkkan et al. ASH 2006:abs 3967	III	Reports of 5 RhD-positive, paediatric, non-splenectomised patients with chronic ITP, treated with anti-D	5	Primary measure: complete blood cell and renal function tests were assessed at baseline and 1, 7, 14 and 28 days after infusion Primary outcome: a single 75 µg/kg dose of anti-D may increase the platelet count in some children with chronic resistant ITP, with an acceptable safety profile
Roberti et al. *Clin Ped* 2001:61–62	III	Case study of ITP female patient receiving anti-D	1	Primary outcome: anti-D treatment associated with renal failure in adolescent girl
Alioglu et al. *J Pediatr Hematol Oncol* 2007;29:636–639	III (case report)	Case study of ITP male patient receiving anti-D	1	Primary outcome: anti-D treatment associated with prolonged intravascular haemolysis and neutropenia in adolescent boy
Semple et al. *Am J Hematol* 2002;69:225–227	III	Prospective, 4-cycle, crossover trial of ITP patients	7	Primary measure: platelet count, pro- and anti-inflammatory cytokines Primary outcome: platelet counts increased in all patients by day 8 post-treatment. Treatment with anti-D in children results in initial storm of cytokine/chemokine activity
Wetzel et al. ASH 2006:abs 3305	III	Cost-minimisation analysis (CMA) comparing cost of using anti-D vs IVIg for the initial treatment of non-emergent ITP	N/A	Primary measure: cost of using IVIg compared to anti-D Primary outcome: using anti-D vs IVIg for the initial treatment of ITP yielded a significant cost saving

Rituximab

Citation	**LOE**	**Study design**	**Patient numbers**	**Summary**
Wang et al. *J Pediatr* 2005;146:217–221	IIa	Pilot study examining the efficacy and safety of rituximab in children with chronic	24	Primary measure: platelet response was characterised as complete (CR) if count

		ITP		>150,000/mcL was achieved; partial (PR) if 50,000 to 150,000/mcL; minimal (MR) if the count increased by >20,000/mcL to a peak count >30,000/mcL but <50,000/mcL; or no response (NR) Primary outcome: 63% of children with chronic ITP achieved a CR. Rituximab may be a useful treatment for chronic ITP in children with a >50% CR rate lasting an average of 13 months
Bennett et al. *Blood* 2006;107:2639–2642	IIa	Prospective phase I/II study assessing safety and efficacy of rituximab in patients with severe chronic ITP	36	Primary measure: The primary outcome of sustained platelets above 50 × 10^9/L (50,000/mm^3) during 4 consecutive weeks Primary outcome: 31% of children with chronic ITP achieved a response (platelets >50 × 10^9/L)
Parodi et al. *Int J Hematol* 2006;84:48–53	IIb	Retrospective review of rituximab in ITP patients; patients received from 2 to 5 weekly infusions of rituximab (375 mg/m(2))	19	Primary measure: overall response rate was 68% Primary outcome: 6 responders relapsed at a median of 4.5 months (range, 3–8 months). 7 patients still displayed a platelet count >150,000/microL at a median of 33 months (range, 14–43 months) after rituximab treatment. Rituximab effective for chronic refractory ITP
Brons et al. EHA 2007:abs 1320	III	Case study of patient suffering from cITP treated with rituximab		Primary measure: platelet count Primary outcome: after 3 weeks platelet count 16 × 10^9/L, another 3 weeks later platelet count normalised to 253 × 10^9/L, 1 year after incomplete rituximab platelet counts still normal. Single low-dose rituximab (54 mg/m^2) effective; dosing needs further assessment
Bengston et al. *J Pediatr* 2003;143:670–673	III	Case study of infant suffering from ITP treated with rituximab	1	Primary measure: platelet count, laboratory evaluations Primary outcome: platelet count rose to >200 × 10^9/L within 3 weeks of initiating rituximab therapy and has remained in the normal range for >18 months. Rituximab may be effective in treatment of childhood chronic refractory ITP
Pusiol et al. *Eur J Pediatr* 2004;163:305–307	III	Case study of 2 children suffering from ITP treated with rituximab	2	Primary measure: normalisation of platelet count Primary outcome: platelet counts normalised after treatment with rituximab, 375 mg/m^2 given weekly in 4 doses. Rituximab may be effective for refractory ITP in children

Roganovic. *Eur J Pediatr* 2005;164:334	III	Case study of patient suffering from refractory chronic ITP treated with rituximab	1	Primary measure: response to treatment Primary outcome: rituximab not effective in chronic refractory ITP
Moschovi et al. *J Paediatr Child Health* 2005;41:384–386	III	Case study of 2 children suffering from ITP treated with rituximab	2	Primary measure: B lymphocytes, platelet count, group I responders, platelet count >100 × 10^3/μL; group II responders, platelet count between 50 and 100 × 10^3/μL; group III responders, no rise in platelet count or rise does not exceed 50 × 10^3/μL. Primary outcome: after first infusion, one patient group II responder, one a group III responder. B lymphocytes undetectable for 3 months. 375 mg/m^2 rituximab once weekly for 4 weeks may be effective for chronic refractory ITP in children
Bay et al. *Pediatr Int* 2006;48:514–516	III	Case study of 4 children with refractory chronic ITP treated with rituximab	4	Primary measure: CR platelet count >150 × 10^9/L, PR platelet count >50 × 10^9/L but <150 × 10^9/L, MR >20 × 10^9/L but <50 × 10^9/L, no response <20 × 10^9/L. Primary outcome: CR achieved in case 1, PR in case 2, MR in case 3, no response in case 4. Rituximab may be effective for chronic refractory ITP in children
Russo et al. *Eur J Pediatr* 2004;163:569	III	Case study of patients suffering from ITP treated with rituximab	3	Primary measure: response measured as platelet count >50 × 10^9/L Platelet outcome: only 1 patient responded for duration of 80 days. Rituximab not effective in chronic refractory ITP
Prakash Yadav et al. ASH 2006: abs 3892	III	Retrospective analysis examining efficacy and safety of rituximab in children with chronic ITP and Burkitt's lymphoma	5	Primary measure: response measured by platelet count Primary outcome: 1 patient responded platelets >100,000/mm^3 for 8 months then dropped to 15,000/mm^3. Other 2 cases had sustained response with platelets >l00,000/mm^3 till after 12 months. 4th patient responded after 4 courses of weekly rituximab maintained platelets >50,000 except during chemotherapy blocks with follow-up of 10 months. 5th patient with Burkitt's lymphoma, residual tumour cleared after 2 courses chemotherapy and rituximab. Rituximab effective for chronic ITP

Splenectomy

Citation	LOE	Study design	Patient numbers	Summary
Kuhne et al. *Pediatr Blood Cancer* 2007;49:829–834	IIb	Prospective registry analysis of data from intercontinental childhood group to assess effectiveness splenectomy	134	Primary measure: analysis of paediatric data to gauge effectiveness of splenectomy in children Primary outcome: immediate platelet response to splenectomy in 113 patients (86.3%); 80% maintained response during following 4 years. Older age, longer duration of ITP, and male gender correlated with a CR
Wang et al. *Acta Haematol* 2006;115:39–45	IIb	A retrospective review of a single centre experience in China between 1990 and 2003 with splenectomy for chronic ITP in children in order to determine initial and long-term haematological response, morbidity, mortality, predictors of response to splenectomy and the therapy in children who failed splenectomy.	65	Primary measure: clinical response to splenectomy Primary outcome: overall immediate clinical response to splenectomy was 89.2%. Median post-splenectomy follow-up time was 52 months (8-124). The risk of fulminant sepsis remains an omnipresent concern
El-Alfy et al. *Acta Haematol* 2003;110:20–24	IIb	Retrospective review of medical records of 288 children and adolescents with chronic ITP between 1980 and 1996	288	Primary measure: response measured by platelet count Primary outcome: at 5 years, 44 (45%) remained in CR and 34 (35%) in PR. In multivariate analysis, steroid-resistant patients were more likely to relapse after an initial CR
Aronis et al. *Acta Pediatr* 2004;93:638–642	IIb	Retrospective analysis of data to review the long-term safety and efficacy of splenectomy in ITP children	33	Primary measure: review the long-term efficacy and safety of splenectomy in children with chronic idiopathic thrombocytopenic purpura Primary outcome: 85% of patients had excellent or PR to splenectomy. 15% failed to respond. 25% responders experienced transient recurrence of thrombocytopenia within 6 months to 4 years from splenectomy. Mortality rate due to severe sepsis was 3%. Splenectomy remains the only effective therapeutic modality for children with cITP, although it is associated with transient recurrence and rarely with post-splenectomy sepsis, which could be fatal

Multi-agent therapy

Citation	LOE	Study design	Patient numbers	Summary
Gereige & Barrios. *P R Health Sci J* 2000;19:15–18	IIb	4-year retrospective study of hospitalised acute ITP patients to compare the effectiveness of HDMP vs IVIg vs the combination of IVIg/HDMP	148	Primary measure: response measured by platelet count Primary outcome: IVIg and HDMP combination demonstrated to be superior to HDMP alone in raising the platelet count within first 24 hours. Combination of HDMP and IVIg statistically superior to IVIg and HDMP as single agents
Matsubara et al. *Rinsho Ketsui* 2007;48:235–239	III	Case study of boy with refractory chronic ITP successfully treated with combination therapy composed of low-dose cyclosporin A (CsA), azathiopurine, and prednisolone	1	Primary measure: response measured by platelet count Primary outcome: CR achieved within 2 weeks and platelet counts remained >50 × 10^3/microl even after tapering off the prednisolone and azathiopurine at 6 and 12 months, respectively and have remained normal for more than 10 months after completion of 2 years of CsA treatment. Combination of cyclosporin A, azathioprine and prednisolone successful in 1 patient with splenectomy failure
Boruchov et al. *Blood* 2007;110:3526–3531	III	Case study in 35 patients unresponsive to IVIg or high-dose steroid treatment treated with a 3- or 4-drug combination including IVIg, IV methylprednisolone, vinca alkaloids, and maintenance therapy with oral combination of danazol and aziothriprine	35	Primary measure: response measured by platelet count of >20 × 10^9/L to >30 × 10^9/L Primary outcome: a total of 71% of patients responded to IV combination therapy. Two thirds of patients on maintenance therapy achieved stable platelet count >50 × 10^9/L with no other treatment.

Interferon alpha

Citation	LOE	Study design	Patient numbers	Summary
Dikici et al. *Ped Int* 2001;43:577–580	IIb	Study designed to evaluate the effect of IFN-α in patients unresponsive to conventional therapy	8	Primary measure: good response platelet count >100 × 10^9/L , PR platelet 20 to 100 × 10^9/L, non-response platelet count below 20 × 10^9/L Primary outcome: no response in 1 patient, PR in 1, and good response in 6 patients on 28th day of

				treatment. In good responding patients, platelet levels were increased in a short time. No long-term benefit of IFN-α therapy in refractory ITP in childhood
Donato et al. *J Ped Hematol Oncol* 2001;23:598–603	IIb	Investigation into α-IFN therapy for children with chronic ITP	14	Primary measure: CR platelet count >150 × 10^9/L for more or less of 3 months, PR maximum platelet count <150 × 10^9/L more or less 6 weeks, no response platelet count no increase or increase <15% initial count, worsening a decrease to >10% initial count Primary outcome: significant increase achieved during 14 of 17 courses (82.4%). All but 2 responses transitory, and platelets returned to initial values after IFN discontinuation

Platelet transfusions

Citation	LOE	Study design	Patient numbers	Summary
Ferrara et al. *Hematology* 2007;12:297–299	III	Retrospective review of the safety of low platelet thresholds for prophylactic transfusions in children with various thrombocytopenic disorders	673	Primary measure: bleeding events, platelet count Primary outcome: the restrictive policy of platelet transfusions was proved safe