

# Platelet Alteration in *Plasmodium vivax* Malaria Patients in Thailand

## ABSTRACT

**Introduction:** Malaria remains a global health problem. Malaria is often linked to thrombocytopenia as well as other hematological variations.

**Objective:** The aim of this study is to find the platelet changes in *Plasmodium vivax* malaria patients. This retrospective cross-sectional study included 204 malaria patients admitted to the Hospital for Tropical Diseases, Bangkok, Thailand.

**Results:** Thrombocytopenia ( $<150 \times 10^3/\mu\text{l}$ ) was seen in 170 (83.3%) patients with a mean (SD) of  $101 \times 10^3/\mu\text{l}$  (56.5). Mild ( $150 \times 10^3/\mu\text{l}$ - $50 \times 10^3/\mu\text{l}$ ), moderate ( $50 \times 10^3/\mu\text{l}$ - $20 \times 10^3/\mu\text{l}$ ) and severe ( $<20 \times 10^3/\mu\text{l}$ ) thrombocytopenia were seen in 141 (69.1%), 25 (12.2%) and 4 (2%) patients respectively. None of these patients with thrombocytopenia showed any sign of bleeding or required platelet transfusion.

**Conclusion:** This study showed thrombocytopenia as a classic feature of *vivax* malaria presenting more than 80% of cases. In patients with profoundly low thrombocyte counts there was no manifestation of bleeding nor was any platelet transfusion required.

*Keywords: Malaria; vivax; platelet; thrombocytopenia; Thailand*

## 1. INTRODUCTION

In 2017, an estimated 219 million cases of malaria occurred worldwide (95% confidence interval [CI]: 203–262 million), compared with 239 million cases in 2010 (95% CI: 219–285 million) and 217 million cases in 2016 (95% CI: 200–259 million). Most malaria cases in 2017 were in the WHO African Region (200 million or 92%), followed by the WHO South-East Asia Region with 5% of the cases and the WHO Eastern Mediterranean Region with 2%. The incidence rate of malaria declined globally between 2010 and 2017, from 72 to

59 cases per 1,000 population at risk. Although *Plasmodium falciparum* is the most prevalent malaria parasite in the WHO African Region, accounting for 99.7% of estimated malaria cases in 2017, *P. vivax* was reported in many areas: South-East Asia (37.2%), the Eastern Mediterranean (31%) and the Western Pacific (28.1%). *P. vivax* is the predominant parasite in the WHO Region of the Americas, representing 74.1% of malaria cases [1]. *P. vivax* infections affect people of all ages. Although the effects of repeated attacks of *P. vivax* through childhood and adult life are only rarely directly lethal, they can have major deleterious effects on personal well-being, growth, development and the economic performance at the individual, family and community. With invention of molecular diagnosis, it is now evident that *P. vivax* mono-infection could be involved in multiple organ dysfunction and severe life threatening disease as seen in *P. falciparum*. Severe *P. vivax* cases have been reported from several countries including India and Thailand [2]. Thrombocytopenia has been studied in malaria previously but its prognostic value in context of low platelet count with clinical presentation has not been evaluated in large studies.

The aims of this study were to evaluate frequency and severity of thrombocytopenia exclusively in *P. vivax* patients. We also determined if laboratory values of severe thrombocytopenia corresponded to clinical severity in vivax malaria patients.

## 2. MATERIAL AND METHODS

This study was a retrospective cross-sectional study. Two hundred and four patients admitted to the Hospital for Tropical Diseases, Bangkok, Thailand from 2008 to 2012 were collected from medical records of the patients. For data collection we prepared case record forms and collected data of patients' records. The admitted patients had history of fever and other associated symptoms with positive blood films for vivax malaria. Inclusion criteria included in-patients with complete medical records of twenty-eight days, age  $\geq 15$  years, patients with confirmative diagnosis of *Plasmodium vivax* malaria nono-infection with thick or thin blood film by light microscopy. Exclusion criteria were patients with non-*P. vivax* or mixed infection, pregnant and lactating women or co-infections (with leptospirosis, scrub typhus, dengue or melioidosis). Duration of the study was from October 2012 to April 2013. Data collection took place at the Hospital for Tropical Diseases, Faculty of Tropical Medicine, Mahidol University, Bangkok, Thailand. The cut off point for thrombocytopenia was considered as platelet count less than 150,000/ $\mu$ l. According to previous articles the low thrombocyte count classification for mild, moderate and severe were considered as following [3]:

- a. Mild thrombocytopenia: - having platelet counts between  $50-150 \times 10^3$  cells/ $\mu$ l
- b. Moderate thrombocytopenia: - having platelet counts between  $20-50 \times 10^3$  cells/ $\mu$ l
- c. Severe thrombocytopenia: - having platelet counts less than  $20 \times 10^3$  cells/ $\mu$ l

Demographic data, clinical symptoms, physical examinations, baseline laboratory tests such as complete blood count and **biochemistry profiles were collected.** Information obtained from the patients' records were analyzed. Statistical Package for the Social Science (SPSS) version 15 software was used for statistical analysis. The distribution of data was assessed for normality using the Kolmogorov-Smirnov test. Data **were** expressed as means and standard deviations (SD) if the data showed normal distribution. If the data did not show any normal distribution, the results were expressed as medians. Descriptive statistics were used for most of the data. For analytical part, non-parametric statistical tests such as Chi-square and Spearman's correlation tests were used. Microsoft Excel **was** used for descriptive statistics and graphic demonstration. The **P-value** was set at significance level of 0.05.

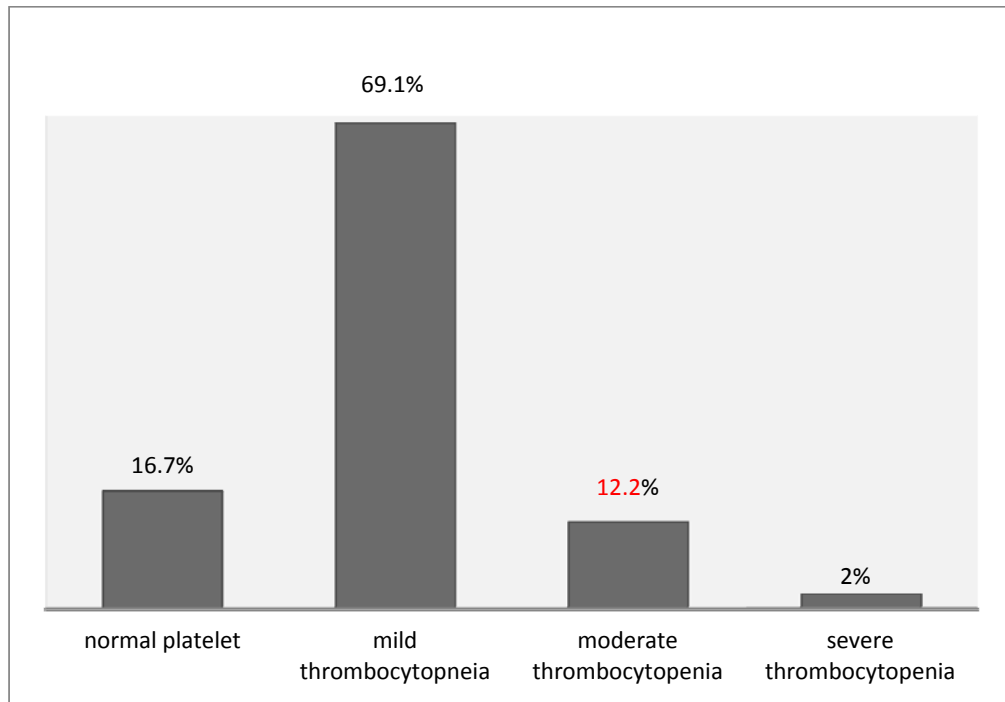
### **3. RESULTS**

We included 204 vivax malaria patients. The male predominance in number was observed. 201 (98.5%) among 204 were males and 3 (1.5%) were females. Male comprised large number of patients with vivax malaria. This indicated that majority of patients diagnosed and treated in this hospital for vivax malaria **were** male patients. The age of patients varied from 15 years to 60 with a mean (SD) of 26 (8.4). Patients regarding their age were classified to three subcategories of 15-30 years old, 31-45 years old, 45-60 years old and the number of patients in each category was 155 (76%), 42 (20.6%) **and** 7 (3.4%) respectively. This indicates the highest number of patients were between age 15 to 30 years. The frequency of some common symptoms reported by patients in our study **were** fever in 204 (100%) patients, headache in 172 (84%) patients, myalgia in 161 (78.9%), chill in 154 (75.5%), nausea in 39 (19.1%), abdominal pain in 35 (17.2%), vomiting in 29 (14.2%), arthralgia in 14 (6.9%) and cough in 1 (0.5%) patient. Others were myalgia in 161 (78.9%), nausea in 39 (19.1%) and abdominal pain in 35 (17.2%) patients respectively. Anemia, hepatomegaly, splenomegaly and jaundice were found in 98 (48%), 68 (33.3%), 40 (19.6%) and 19 (9.3%) respectively.

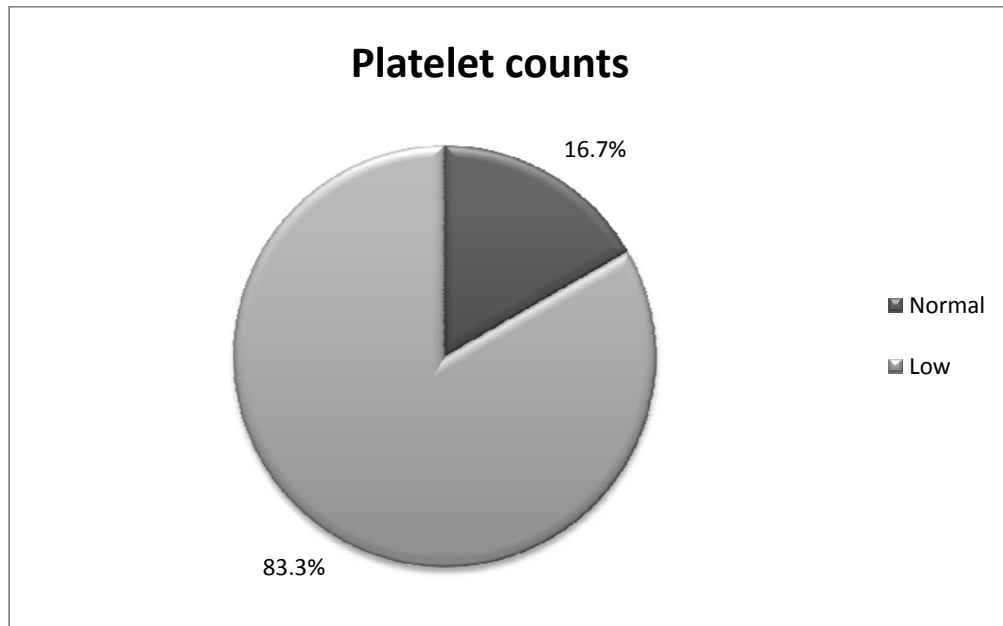
**Table 1. Hematological profiles of the patients (N=204)**

<b>Parameter</b>	<b>Spearman's correlation of platelet count</b>	<b>P-value</b>
Hemoglobin	-0.069	0.327
Hematocrit	-0.073	0.303
WBC	0.239	0.001
Neutrophils	-0.197	0.005
Lymphocytes	0.059	0.401
Eosinophils	0.386	<0.001
Basophils	0.063	0.374
Monocytes	0.215	0.002

WBC = white blood cells



**Fig. 1. Platelet levels regarding to severity in vivax malaria patients**



**Fig. 2. Normal and low platelet counts in vivax malaria patients (N=204)**

UNDER PEER REVIEW

**Table 2. The table showed correlation values between platelet counts and biochemical profiles of patients in the study (N = 204)**

<b>Parameter</b>	<b>Spearman's correlation of platelet counts</b>	<b>P-value</b>
Bicarbonate	0.12	0.083
Sodium	0.271	<0.001
Potassium	0.157	0.025
Chlorine	0.11	0.119
Direct bilirubin	-0.535	<0.001
Total bilirubin	-0.429	<0.001
AST	-0.153	0.03
ALT	-0.41	0.558
Total protein	0.41	<0.001
Albumin	0.353	<0.001

Using statistical program for further analyses we looked for correlation between platelet count and hematologic profile Tables 1 and 2; Figs 1 and 2 of the patients. The result of our analyses showed significant correlation between platelet counts and some components of hematologic profiles in the patients. Hemoglobin changes were not seen to have any significant correlation with platelet changes with  $P=0.327$  which was not significant. Similarly, hematocrit changes did not show any significant correlation with platelet count. Moving further to white blood cells (WBC), we found there was a significant statistical correlation with  $P<0.001$  between WBC count and platelet count in vivax malaria patients. There was a strong positive correlation between platelet count and eosinophil count with  $P<0.001$ , on the contrary, a negative correlation between neutrophil count and platelet count was observed with  $P<0.005$ . Basophil count showed no correlation but monocyte count also showed a positive correlation with  $P<0.002$  with the platelet count.

Correlation values between platelet count and biochemistry profiles in patients were evaluated. For the electrolytes, only sodium displayed a strong positive correlation with  $P<0.001$ , the other components of electrolytes including potassium, chlorine and bicarbonate showed no significant correlation with platelets. For the liver function tests, direct and total bilirubin levels were both showing a strong negative correlation with  $P<0.001$ . The negative correlation meant that platelet drop was associated with rise of bilirubin values in vivax malaria patients. Unlike bilirubin, serum protein and serum albumin showed a strong positive correlation with platelet changes in malaria patients.

Chi-square test showed association between clinical features and platelet status in the patients. From symptoms table we independently checked fever, chills, myalgia, arthralgia, nausea, abdominal pain, vomiting and cough with platelets to find if there was any correlation between them. No significant correlation was observed between symptoms with platelet count. Association of patients' clinical conditions including anemia, jaundice, hepatomegaly, and splenomegaly with platelet status showed no significant correlation with platelet count.

#### **4. DISCUSSION**

To evaluate frequency and severity of thrombocytopenia in vivax malaria patients, the range for normal platelet was considered as platelet count of  $300,000\pm 150,000/\mu\text{l}$ . In this study, platelet count varied among patients, ranging from  $14,000/\mu\text{l}$  to  $357,000/\mu\text{l}$  with a mean of  $101,000/\mu\text{l}$ . We later classified thrombocytopenia to three categories of mild, moderate and severe groups. The normal platelet count was seen in 34 (16.7%) patients. Thrombocytopenia was seen in 170 (83.3%) patients. Mild thrombocytopenia was observed in 141 (69.1%), moderate thrombocytopenia in 25 (12.2%) and severe thrombocytopenia in only 4 (2%) patients. Our study showed thrombocytopenia



as a very common phenomenon occurring in 83.3% of vivax malaria patients. The frequency **did not** correlate with severity **of the** patients. In our study more than eighty percent of patients were detected with low platelet count but among them the largest portion was seen in the mild group. The severe group (platelet count below  $20 \times 10^3$  cells/ $\mu$ l) comprised only four patients. Patients with thrombocytopenia were not seen with any bleeding manifestation. Mild or moderate thrombocytopenia is a common feature of malaria and is rarely associated with hemorrhagic manifestations or a component of disseminated intravascular coagulation. In most clinical studies, thrombocytopenia is not usually associated with mortality in malaria.

Using statistical analysis, we looked for correlation between WBC count and platelet count. There was a significant statistical correlation between WBC and platelet count ( $P < 0.001$ ). Positive correlation **meant** that platelet drop **was** associated with a drop of WBC count in vivax patients. As patients **tended** to develop thrombocytopenia their WBC meanwhile **tended** to drop to minimally normal or lower than normal count. This positive correlation **confirmed** our finding of malaria associated with low WBC count. Later, when we subsequently looked for correlation between platelet count and differential WBC count, we found significant positive correlation with eosinophil count and negative correlation with neutrophil count. The statistical correlations **could** sometimes correspond to clinical correlations with significant outcomes or they **could occur without any clinical importance.**

We also evaluated correlation values between platelet and biochemistry profile in patients. For the liver function tests, **both** direct and total bilirubin levels showed strong negative correlation with  $P < 0.001$ . The negative correlation **implied** that decrease in platelet **was** associated with a rise of bilirubin value in vivax malaria patients. This finding **was** consistent with a previous case control study where they found malaria association with an increase in bilirubin value when compared to control group [4]. Unlike bilirubin, serum protein and serum albumin displayed a strong positive correlation with platelet changes in malaria patients. This positive correlation in vivax malaria patients **indicated** the relationship between serum protein and platelet level in a manner that decrease in platelet **was** associated with a decrease in total protein and albumin level in the serum and vice versa. Previous studies done on evaluating serum protein and albumin level **showed** malaria **was** associated with low serum total protein and albumin level [5]. Patients with *P. vivax* infections **had** minimal abnormalities in liver profiles, increased levels of bilirubin, aminotransferases, alkaline phosphatases, and hypoalbuminemia [6]. Although, the mean value for total protein and albumin **were** normal in this study, nevertheless we found a

very strong positive correlation ( $P < 0.001$ ) of platelet count with serum protein and albumin levels.

## 5. CONCLUSION

Thrombocytopenia is a characteristic feature of malaria patients. Our study showed the frequency of thrombocytopenia in vivax malaria as common as in falciparum malaria patients. Thrombocytopenia was usually mild, however some patients might present with severe thrombocytopenia. Severe thrombocytopenia usually did not correspond to any clinical severity in malaria. Patients usually had no bleeding manifestation and platelet transfusion was rarely required [7-10]. This explained a rather benign nature of thrombocytopenia in vivax malaria patients in Thailand.

## CONSENT

As per international standard, informed and written participant consents have been collected and preserved by the authors.

## ETHICAL APPROVAL

As per international standard, this study was approved by the Ethics Committee, Faculty of Tropical Medicine, Mahidol University, Thailand (Approval number: FTM ECF-019-02).

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