Webinar: A Case-Based Conversation on FNAIT: Fetal and Neonatal Thrombocytopenia

Webinar held live May 12, 2021

• Can you recap briefly how the HLA-DR affects the diagnosis and fetal outcome?

*If we consider DRB3*0101 in a woman with HPA-1b1b, the chances anything bad will happen to the fetus/newborn is miniscule compared to somewhere between 1 in 4 and 1 in 12 if the woman has this DR antigen. A fantastic summary is in I believe Blood Advances 2019 with first author Kjeldsen-Kragh.*

• With the FcRn inhibitors, would it block transfer of other protecting IgG from mother to fetus?

They would block all IgG transfer so yes. That is why at least for the fetus/newborn with a serious risk of sepsis if he/she remains hypogammaglobulinemic for months, giving IgG is important. This could be to the mother in the week pre-delivery after the FcRn block is removed or by giving IVIG directly to the newborn. The mother, with a mature immune system and normal IgA and IgM and normal T cell immunity should not be at any great risk and studies suggest that 3-6 weeks later the maternal IgG level should be back to normal or very close to it.

• What is the recommendation of screening the general population for HPA1?

The recommendation is to do a study to find out which is the plan. There is one study from Norway that screened over 100,000 pregnancies demonstrating feasibility. Issues include whether the outcome estimates are correct and whether prophylaxis can be safely and effectively administered. If, as estimated, prophylaxis is needed for 1/200 pregnancies and is given to 3-4 mothers to prevent one case of serious FNAIT, this is likely worth it.

**Responses to questions not addressed during the webinar provided by Jim Bussel, MD, Professor Emeritus of Pediatrics at Weill Cornell Medicine*