ASH 2026 Guidelines for Immune Thrombocytopenia (ITP): Initial and Second-Line Therapy in Adults with Primary ITP

Visual Summary of Recommendations

Initial Therapy

Adults with Primary ITP Requiring Initial Therapy

Rituximab or thrombopoietic agent available and appropriate?

Yes → Assess patient values and preferences

- Patient places a high value on avoiding regular medication
- Patient places a high value on avoiding immunosuppression

No

Suggests corticosteroids (± IVIG) ⊕◯◯◯

Suggests rituximab + corticosteroids (with or without IVIG) ⊕⊕◯◯

- Most studied rituximab regimen is 375 mg/m² × 4 weekly doses.
- Other doses/schedules used according to local practice.
- Biosimilars are suitable substitutes.

Suggests thrombopoietic agent + corticosteroids (with or without IVIG) ⊕⊕◯◯

- Any approved thrombopoietic agent at standard starting dose.
- Optimal duration typically guided by clinical response, toxicity, and platelet count stability.
- Taper corticosteroids before thrombopoietic agent if a response is achieved.

- Short course (≤2 weeks) of corticosteroids (± IVIG) alone may be given to support diagnosis of ITP before starting combination therapy.
- Most studied corticosteroid component of combination therapy is dexamethasone 40 mg daily for 4 consecutive days for 1 to 3 cycles administered every 2 to 4 weeks. Also reasonable to use prednis(o)one at a starting dose of 0.5-2 mg/kg/day.
- Whether corticosteroids are used as part of combination therapy or alone, it is advisable to limit their administration to 6 weeks or less to minimize toxicity.

Second-Line Therapy

Adults with Primary ITP Requiring Additional Treatment After Initial Therapy with Corticosteroids (with or without IVIG)

Rituximab or thrombopoietic agent available and appropriate?

Yes

Recommends thrombopoietic agent ⊕⊕⊕◯

- Any approved thrombopoietic agent at standard starting dose.
- Duration typically guided by clinical response, toxicity, and platelet count stability.

Although thrombopoietic agents are recommended, rituximab may be preferable for patients who value avoiding chronic medication.

Suggests rituximab ⊕⊕◯◯

- Most studied rituximab regimen is 375 mg/m² × 4 weekly doses.
- Other doses/schedules used according to local practice.
- Biosimilars are suitable substitutes.

No

Suggests BTK inhibitor ⊕◯◯◯

Suggests Mycophenolate mofetil (MMF) ⊕◯◯◯

Suggests SYK inhibitor ⊕◯◯◯

Evidence is too indirect to definitively rank BTK inhibitors, MMF, or SYK inhibitors. Consider side effect profiles, cost, availability, and shared decision-making.

Azathioprine is not equivalent to the other suggested treatment options. It may be useful in some settings due to its low cost, global availability, and safety profile in pregnancy.

Splenectomy

Consider splenectomy if:

1) Failure/intolerance of multiple medical therapies
2) Desire to avoid long-term medication
3) Severe thrombocytopenia needing emergent treatment with poor response to medical therapy

GOOD PRACTICE — If possible, splenectomy should be delayed for at least one year after diagnosis because of the potential for remission.

GOOD PRACTICE — Patients should receive immunizations ≥2 weeks before splenectomy when feasible, and counseling on antibiotic prophylaxis and lifelong risk of sepsis and thrombosis. Educate on prompt recognition of fever and urgent antibiotic use.

GOOD PRACTICE — After splenectomy, arrange at least annual follow-up for platelet counts, counseling, and immunization adherence.

Special Consideration: Pregnancy

Normalization of platelet count following splenectomy does not prevent transplacental passage of maternal anti-platelet antibodies during pregnancy, which can cause neonatal thrombocytopenia.

Special Consideration: ILAPS

Consider indium-labeled autologous platelet scan (ILAPS), which predicts response to splenectomy, if available.

Thrombopoietic Agent Switching

GOOD PRACTICE

Switching to a different thrombopoietic agent may be considered based on:

- Insufficient response
- Adverse effects
- Poor adherence
- Comorbidities
- Patient preference

GOOD PRACTICE — Shared decision-making with the patient, documentation of the rationale for switching, avoidance of treatment gaps, and close monitoring around the time of switching are good practices to ensure optimal outcomes and continuity of care.

Learn more about the ASH 2026 Clinical Practice Guidelines on Immune Thrombocytopenia (ITP) at hematology.org/ITP-guidelines

Recommendation Strength

"Recommends..."	"Recommends against..."	"Suggests..."	Suggests against..."
✓	✗	✓	✗
STRONG RECOMMENDATIONS		**CONDITIONAL RECOMMENDATIONS**	
Most individuals in this situation would want the recommended course of action, and only a small proportion would not.		Most individuals in this situation would want the suggested course of action, but many would not.	

Additional Statements

GOOD PRACTICE — **Good practice statement:** Good practice statements endorse interventions or practices that the guideline panel agreed have unequivocal net benefit yet may not be widely recognized or used. Good practice statements in these guidelines are not based on a systematic review of available evidence. Nevertheless, they may be interpreted as strong recommendations.

Evidence Certainty

High Certainty	
⊕⊕⊕⊕	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate Certainty	
⊕⊕⊕◯	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low Certainty	
⊕⊕◯◯	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very Low Certainty	
⊕◯◯◯	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

REFERENCE

Cuker A, Terrell DR, Sowdagar H, Arnold DM, Audia S, Bussel JB, González-López TJ, Grace RF, Masias C, McCrae KR, Mitrovic M, Neunert C, Panch SR, Shah S, Shy B, VandeVelde J, Cines DB, Vesely SK. American Society of Hematology 2026 guidelines for immune thrombocytopenia (ITP): initial and second-line therapy in adults with primary ITP. Blood Adv. 2026. doi:10.1182/bloodadvances.2026021269.