ASH CLINICAL PRACTICE GUIDELINES

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

www.hematology.org/ITPguidelines

In 2026, ASH updated guidelines on initial and second-line therapy for adults with primary immune thrombocytopenia (ITP). This document summarizes the 2 new recommendations (covering 3 recommendation statements: 1, 2a, and 2b) added to reflect new evidence. 5 recommendations from the 2019 guideline have been retired and replaced by the 2026 recommendations, and 19 recommendations from the 2019 guideline were not addressed in this focused update but are included here for reference. This document is intended to be a quick reference guide. Please consult the full guideline manuscript for remarks and evidence profiles for each recommendation.

New Recommendations *Added to the 2026 ITP guideline*

No.	Population	Recommendation	Strength	Evidence Certainty	Changes from 2019
1	Adults with primary ITP requiring initial therapy	Suggests either rituximab plus corticosteroids (±IVIG) or a thrombopoietic agent plus corticosteroids (±IVIG) rather than MMF plus corticosteroids (±IVIG) or corticosteroids (±IVIG) alone.	✓	⊕⊕◯◯	New in 2026 – replaces recommendation 5 from the 2019 ITP guidelines
		If rituximab and thrombopoietic agents are not available, suggests corticosteroids (±IVIG) alone over MMF plus corticosteroids (±IVIG).	✓	⊕◯◯◯	
2a	Adults with primary ITP needing additional treatment after initial therapy with corticosteroids (±IVIG)	Recommends a thrombopoietic agent or suggests rituximab	✓ ✓	⊕⊕⊕◯ ⊕⊕◯◯	New in 2026 – replaces recommendations 6 – 9 from the 2019 ITP guidelines
2b	Adults with primary ITP needing additional treatment after initial corticosteroids (±IVIG), who are ineligible for or decline a thrombopoietic agent or rituximab	Suggests a BTK inhibitor, MMF, or a SYK inhibitor	✓	⊕◯◯◯	New in 2026 – replaces recommendations 6 – 9 from the 2019 ITP guidelines

IVIG: Intravenous Immunoglobulin; MMF: Mycophenolate Mofetil; TPO: Thrombopoietic agent; BTK: Bruton Tyrosine Kinase; SYK: Spleen Tyrosine Kinase

Recommendation & Evidence Rating ✓ Recommends ✗ Recommends against ✓ Suggests ✗ Suggests against High ⊕⊕⊕⊕ Moderate ⊕⊕⊕◯ Low ⊕⊕◯◯ Very Low ⊕◯◯◯

REFERENCE
Cuker A, Terrell DR, Sowdagar H, et al. American Society of Hematology 2026 Guidelines for Immune Thrombocytopenia (ITP): Initial and Second-Line Therapy in Adults with Primary ITP. Blood Advances. doi: [DOI to be added upon publication]

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Retired Recommendations *Replaced in 2026 to reflect new evidence*

No.	Population	Recommendation	Strength	Evidence Certainty	Changes from 2019
5 (2019)	Adults with newly diagnosed ITP	Suggests corticosteroids alone rather than rituximab + corticosteroids for initial therapy	✓	⊕◯◯◯	This recommendation is retired and replaced with recommendation 1 of the 2026 ASH ITP guidelines.
6 (2019)	Adults with ITP ≥3 months, corticosteroid-dependent/unresponsive, treated with TPO-RA	Suggests either eltrombopag or romiplostim	✓	⊕◯◯◯	This recommendation is retired and replaced with recommendation 2 of the 2026 ASH ITP guidelines.
7 (2019)	Adults with ITP ≥3 months, corticosteroid-dependent/no response	Suggests either splenectomy or a TPO-RA	✓	⊕◯◯◯	This recommendation is retired and replaced with recommendation 2 of the 2026 ASH ITP guidelines.
8 (2019)	Adults with ITP ≥3 months, corticosteroid-dependent/no response	Suggests rituximab rather than splenectomy	✓	⊕◯◯◯	This recommendation is retired and replaced with recommendation 2 of the 2026 ASH ITP guidelines.
9 (2019)	Adults with ITP ≥3 months, corticosteroid-dependent/no response	Suggests a TPO-RA rather than rituximab	✓	⊕◯◯◯	This recommendation is retired and replaced with recommendation 2 of the 2026 ASH ITP guidelines.

ITP: Immune Thrombocytopenia; TPO-RA: Thrombopoietin Receptor Agonist

Recommendation & Evidence Rating ✓ Recommends ✗ Recommends against ✓ Suggests ✗ Suggests against High ⊕⊕⊕⊕ Moderate ⊕⊕⊕◯ Low ⊕⊕◯◯ Very Low ⊕◯◯◯

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2019 Recommendations – *Not Updated*

Supporting evidence not reviewed, recommendations not discussed in 2026 guideline

No. (Year)	Population	Recommendation	Strength	Evidence Certainty	Changes from 2019
1a (2019)	Adults, newly dx ITP, platelets <30×10⁹/L, asymptomatic/minor bleeding	Suggests corticosteroids rather than observation	✓	⊕◯◯◯	The threshold for initiating therapy has not been updated. The choice of therapy has been updated from corticosteroids alone to corticosteroids plus rituximab or a thrombopoietic agent.
1b (2019)		Recommends against corticosteroids; in favor of observation	✗	⊕◯◯◯	
2a (2019)	Adults, newly dx ITP, platelets <20×10⁹/L, asymptomatic/minor bleeding	Suggests hospital admission rather than outpatient management	✓	⊕◯◯◯	Not updated in 2026
2b (2019)	Adults, established ITP, platelets ≥20×10⁹/L, asymptomatic/minor bleeding	Suggests outpatient management rather than hospital admission	✓	⊕◯◯◯	Not updated in 2026
3 (2019)	Adults, newly dx ITP	Recommends against a prolonged course (>6 weeks) of prednisone; in favor of a short course (≤6 weeks)	✗	⊕◯◯◯	The duration of prednisone has not been updated. The choice of therapy has been updated from corticosteroids alone to corticosteroids plus rituximab or a thrombopoietic agent.
4 (2019)	Adults, newly dx ITP	Suggests either prednisone (0.5–2.0 mg/kg/day) or dexamethasone (40 mg/day × 4 days) as initial corticosteroid	✓	⊕◯◯◯	The choice of prednisone vs. dexamethasone has not been updated. The choice of therapy has been updated from corticosteroids alone to corticosteroids plus rituximab or a thrombopoietic agent.

ITP: Immune Thrombocytopenia; IVIG: Intravenous Immunoglobulin; Anti-D: Anti-D Immunoglobulin; TPO-RA: Thrombopoietin Receptor Agonist; HRQoL: Health-Related Quality of Life

Recommendation & Evidence Rating ✓ Recommends ✗ Recommends against ✓ Suggests ✗ Suggests against High ⊕⊕⊕⊕ Moderate ⊕⊕⊕◯ Low ⊕⊕◯◯ Very Low ⊕◯◯◯

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Recommendation & Evidence Rating System

Recommendation Strength			
"Recommends…"	"Recommends against…"	"Suggests…"	"Suggests against…"
			

	Interpretation of Strong Recommendations	Interpretation of Conditional Recommendations
Patients	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. Decision aids may be useful in helping patients to make decisions consistent with their individual risks, values, and preferences.
Clinicians	Most individuals should follow the recommended course of action. Formal decision aids are not likely to be needed to help individual patients make decisions consistent with their values and preferences.	Different choices will be appropriate for individual patients; clinicians must help each patient arrive at a management decision consistent with the patient's values and preferences. Decision aids may be useful in helping individuals to make decisions consistent with their individual risks, values, and preferences.
Policymakers	The recommendation can be adopted as policy in most situations. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator.	Policymaking will require substantial debate and involvement of various stakeholders. Performance measures should assess if decision making is appropriate.
Researchers	The recommendation is supported by credible research or other convincing judgments that make additional research unlikely to alter the recommendation. On occasion, a strong recommendation is based on low or very low certainty in the evidence. In such instances, further research may provide important information that alters the recommendations.	The recommendation is likely to be strengthened (for future updates or adaptation) by additional research. An evaluation of the conditions and criteria (and the related judgments, research evidence, and additional considerations) that determined the conditional (rather than strong) recommendation will help identify possible research gaps.

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.

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