2026 ASH Guidelines on Diagnosis of Iron Deficiency

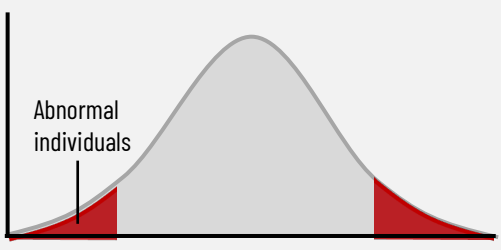
Implementation Tool

The ASH Guidelines on the Diagnosis of Iron Deficiency have redefined the serum ferritin thresholds used to diagnose iron deficiency. ***ASH is now calling on you*** to advocate for implementation of these thresholds in your institution's laboratory reports.

Why implementation matters: Implementation of evidence-based serum ferritin thresholds across laboratories ensures that patients with iron deficiency are diagnosed consistently and appropriately – regardless of where they are tested.

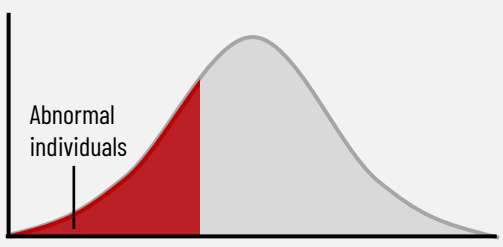
This tool is designed to support your efforts by providing relevant data, terminology, and an understanding of laboratory workflows to help you ***make the case for change***.

The problem with statistical "normal"



The limitation of the 95% confidence interval: Most labs define "normal" ranges using the middle 95% of a population. When a condition affects more than 2.5% of people, many affected individuals will be missed. This is the case in iron deficiency, which affects an estimated 14% of adults and 40% of females of reproductive age.[1–4]

The alternative: Clinical Decision Limits (CDLs)



A **clinical decision limit (CDL)** is a laboratory threshold that uses evidence to find the point of optimal sensitivity and specificity for diagnosing a condition. CDLs are commonly used for labs including 25-OH vitamin D, hemoglobin A1c and lipid panels.

The power of guidelines

ASH Guidelines provide laboratories with an evidence-based framework for considering a shift from laboratory-defined reference ranges to CDLs for serum ferritin.

"Abnormal" flags matter!

Clinicians and patients primarily rely on flags that the lab reports to identify abnormal results and guide clinical decisions. When evidence-based thresholds are not reflected in these flags, iron deficiency may go unrecognized.

Standardization promotes equity

Standardizing serum ferritin thresholds across laboratories reduces variation in care and helps ensure that a patient's diagnosis of iron deficiency does not depend on the testing platform or laboratory used.

How to lead the change at your institution

Identify the decision makers
Contact the Chemistry division leaders in your institution's laboratory, typically pathologists or biochemists (medical or clinical)

Generate buy-in
Share data with laboratorians and clinicians that the implementation of a CDL for serum ferritin has been shown to be feasible[5] and acceptable to clinicians.[6]

Link diagnosis to treatment
Consider advocating for tools to link abnormal lab test result flags to suggested treatment for iron deficiency to facilitate appropriate care.

Address the "overidentification" myth
Prepare to explain that an increase in abnormal results Is not "overdiagnosis" but rather accurate identification of patients previously mislabeled as having adequate iron stores.

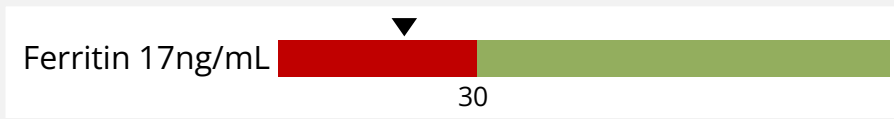
From guideline to implementation: Proposed CDLs for serum ferritin

Below are proposed CDLs for implementation by laboratories based on the ASH Guidelines on the Diagnosis of Iron Deficiency.

Child, age ≤10y	Serum ferritin CDL: ≤20ng/mL
Adolescent, age ≥11y, and adult	Serum ferritin CDL: ≤30ng/mL

Example of a *clinician-facing* appearance for an adult with a serum ferritin of 17ng/mL

Example of a *patient-facing* appearance for an adult with a serum ferritin of 17ng/mL



Proposed accompanying text to append the results for clinicians and patients

Result ≤30ng/mL consistent with iron deficiency. For additional guidance, see American Society of Hematology Guidelines on the Diagnosis of Iron Deficiency.

References: (1) Auerbach M et al. JAMA. 2025 May 27;333(20):1813-23. (2) Demirdjian SP, et al. J Nutr. 2024 Oct;154(10):3048-3059. (3) Wen, et al. Am J Hematol. 2024 Aug;99(8):1492-99. (4) Weyand AC, et al. JAMA. 2023 Jun 27;329(24):2191-93. (5) Abdelhay A, et al. Am J Hematol. 2026 Mar;101(3):439-46. (6) Tang CH, et al. Br J Haematol. 2025 Nov;207(5):2219-23.