ASH Updated Draft Recommendations on Treatment of Adult Immune Thrombocytopenia (ITP)

INTRODUCTION

American Society of Hematology (ASH) guidelines are based on a systematic review of available evidence. Through a structured process, a guideline panel makes judgments about the evidence and forms recommendations.

The public comment period occurs after recommendations are formed but before ASH organizational approval of the guidelines. Comments collected during the open comment period are provided to the guideline panel for review prior to finalizing the guidelines.

These draft recommendations are not final and therefore are not intended for use or citation.

To submit comments on the draft recommendations, please email **guidelines@hematology.org**. Evidence Profiles and Evidence to Decision Frameworks are available via links below. If you are unable to access these links, please email Rachel Cohen at rcohen@hematology.org

The public comment period for these draft recommendations will be open until **December 12, 2025**.

DEFINITIONS

- **Durable response:** Platelet count ≥30 x 10_9/L and at least doubling of the baseline count at 6 months on or off treatment
- **Sustained Response off-treatment (SRoT) at 6 months-** Any platelet count response (≥30 x 10_9/L and at least doubling) after stopping all ITP treatments for at least 6 months
- **Sustained Response off-treatment (SRoT) at 12 months-** Any platelet count response (≥30 x 10_9/L and at least doubling) after stopping all ITP treatments for at least 12 months
- **Time to Response**- Time from starting treatment to time of achievement of complete response (any platelet count of at least 100 x 10^9/L) or response (any platelet count between 30 and 100 x 10^9/L and at least doubling of the baseline count)
- **Reduce the Need for Rescue Therapy**- reduction of need for glucocorticoids, IVIG, anti-RhD immune globulin, or platelet transfusion administered in a rescue manner
- **Major Bleeding**- At risk to become life-threatening in a matter of hours or is organ-threatening or, 2) Capable of causing long-term functional impairment or 3) Associated with a significant decrease in hemoglobin levels (≥2 g/dL)
- **Minor Bleeding**- Any bleeding not meeting the criteria for "major bleeding"

BACKGROUND

A 2022 review (Neunert et al., 2024) of the 2019 guidelines (Neunert et al., 2019) prompted a focused update on "second-line management" (original Recommendations 7–9). In this update, Recommendation 5 (rituximab as initial therapy) will also not be carried forward based on the new recommendations. The remaining 2019 adult recommendations and good practice statements will be carried forward as appropriate in the final publication. Pediatric recommendations remain unchanged, as their evidence was not re-reviewed. The full 2019 ASH ITP guidelines are available here, but are not open for public comment.

RECOMMENDATIONS

Updated recommendations for adult ITP are provided below, with Question 1 newly introduced and Question 2 focused on treatment following corticosteroids:

- **Question 1.** *In adults with primary ITP receiving initial therapy should corticosteroids (with or without IVIG) plus an additional agent (anti-CD20, MMF, TPO-RA/TPO), or corticosteroids (with or without IVIG) alone be used?*
  - **Recommendation 1.** In adults with primary ITP requiring initial therapy, the ASH guideline panel ***suggests either*** rituximab plus corticosteroids (with or without IVIG) or a thrombopoietic agent plus corticosteroids (with or without IVIG) rather than mycophenolate mofetil plus corticosteroids (with or without IVIG) or corticosteroids (with or without IVIG) alone [(conditional recommendation based on low certainty in the evidence ⨁⨁◯◯) (TPO-RA/TPO; anti-CD20 (recommendation limited to rituximab))]. If rituximab and thrombopoietic agents are not available options, the panel ***suggests*** corticosteroids (with or without IVIG) alone rather than mycophenolate mofetil (MMF) plus corticosteroids (with or without IVIG) [conditional recommendation based on very low certainty in the evidence ⨁◯◯◯ (MMF; corticosteroids alone)].
    - **Remarks:**
      - If combination therapy is used, the best studied corticosteroid regimen is dexamethasone 40 mg daily × 4 days for 1 to 3 cycles.
      - If combination therapy with rituximab is used, the best studied regimen is 375 mg/m^2 × 4 weekly doses. However, other doses and schedules may be used according to local practice. Biosimilars are suitable substitutes for rituximab.
      - If combination therapy with a thrombopoietic agent is used, any approved thrombopoietic agent at a standard starting dose may be used. The optimal duration of therapy with a thrombopoietic agent is uncertain; it is typically guided by clinical response and platelet count stability. If a thrombopoietic agent and corticosteroids are used together, in a patient who responds, it may be prudent to taper the corticosteroids before the thrombopoietic agent.
  - **Evidence Profile**
  - **Evidence-to-Decision Framework**
- **Question 2.** *In adults with primary ITP needing additional treatment after initial therapy with corticosteroids (with or without IVIG), should an anti-CD20 agent, azathioprine, a BTK inhibitor, MMF, a SYK inhibitor, or a TPO-RA/TPO agent be used, or should corticosteroids (with or without IVIG) be continued?*
  - **Recommendation 2a.** In adults with primary ITP needing additional treatment after initial therapy with corticosteroids (with or without IVIG), the ASH guideline panel ***recommends*** a thrombopoietic agent (strong recommendation based on moderate certainty in the evidence of effects ⨁⨁⨁◯) or ***suggests*** rituximab (conditional recommendation based on low certainty in the evidence ⨁⨁◯◯).
    - **Remarks:**

        - Rituximab may be preferable for patients who value avoiding chronic medication, or who have a contraindication to, are unable to access, or cannot tolerate thrombopoietic agents.
        - If rituximab is used, the best studied regiment is 375 mg/m^2 X 4 weekly doses. However, other doses and schedules may be used according to local practice. Biosimilars are suitable substitutes for rituximab.
    - **Recommendation 2b.** For adults with primary ITP needing additional treatment after initial therapy with corticosteroids (with or without IVIG), who are either ineligible for or choose not to receive a thrombopoietic agent or rituximab, the ASH guideline panel suggests a BTK inhibitor, MMF, or a SYK inhibitor (conditional recommendation based on very low certainty in the evidence ⨁◯◯◯).
        - **Remarks:**
            - The panel concluded that current evidence is insufficient to definitively rank BTK inhibitors, MMF, or SYK inhibitors. Side effect profiles, cost, availability, and shared decision-making may be considered in selecting an agent.
            - The panel concluded that azathioprine has a less favorable benefit to harm ratio; therefore, it is not equivalent to the other suggested treatment options.
    - **Evidence Profile**
    - **Evidence-to-Decision Framework**

Good Practice Statements

Splenectomy Good Practice Statements

- **Good Practice Statement.** If possible, splenectomy should be delayed for at least one year after diagnosis because of the potential for remission (either spontaneous or induced by medical treatment).
- **Good Practice Statement.** The treating provider should ensure that patients receive appropriate immunizations at least two weeks prior to splenectomy, when feasible, and counseling regarding antibiotic prophylaxis, thrombosis risk, and sepsis risk following splenectomy. The treating provider should educate the patient on prompt recognition and management of fever with antibiotics. After splenectomy, patients should be followed at least annually for platelet count monitoring, counseling, and to ensure adherence to recommended immunization schedules.

TPO-RA Switching Good Practice Statements

- **Good Practice Statement.** During or after treatment with a TPO-RA, switching to a different TPO-RA) should be considered due to insufficient response, adverse effects, comorbidities, poor adherence, or patient preference.
    - **Remark**: This statement applies to patients who switch from one TPO-RA to an entirely different TPO-RA. It does not apply to patients who switch from a TPO-RA to a generic or biosimilar of the same drug.
- **Good Practice Statement.** 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.