1. Special Considerations for Secondary ITP:
   Secondary ITP (HIV-associated):
   • Treatment of the underlying HIV infection with antiviral therapy should be considered prior to other treatment options unless the patient has clinically significant bleeding.
   • IVlg, corticosteroids, or anti-D may be used initially for patients requiring further therapy.
   • Splenectomy is considered preferable to other agents in symptomatic patients who have failed initial drug therapy.

   Secondary ITP (HCV-associated):
   • Antiviral therapy should be considered in the absence of contraindications, but the platelet count should be closely monitored in these situations due to a risk of worsening thrombocytopenia attributable to interferon.
   • If treatment is required, the initial management should be with IVlg.

   Secondary ITP (H. pylori-associated):
   • Routine testing for H. pylori is not recommended in asymptomatic children with unresolved ITP.
   • Screening for H. pylori should be considered in adults for whom eradication therapy would be undertaken if testing were positive.
   • Eradication therapy for H. pylori should be administered to patients who are found to have infection.

2. MMR-related ITP:
   • Children with a history of ITP who are not immunized should receive their scheduled first MMR vaccine.
   • In children with either non-vaccine or vaccine-related ITP who have already received their first dose of MMR vaccine, vaccine titers can be checked. If the child displays full immunity, no further MMR vaccine should be given. If the child does not have adequate immunity, then the child should be re-immunized at the recommended age.

3. ITP in Pregnancy:
   • Pregnant patients requiring treatment should receive either corticosteroids or IVlg.
   • For pregnant women with ITP, the mode of delivery should be based on obstetric indications.

This document summarizes the recommendations from: Neunert C, Lim W, Crowther M, Cohen A, Silberg L, and Crowther MA. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011;117(16):4190-4207. The American Society of Hematology (ASH) published a landmark paper in 1996 designed to assist clinicians in the management of Immune Thrombocytopenia (ITP). Since then, there have been numerous advances in the management of ITP mandating an update to the published guidelines. The guideline update uses an evidence-based approach, interpretation, and presentation of the available evidence and provides treatment recommendations using the GRADE system.

Use of the terminology “Immune Thrombocytopenia” in the title of the quick reference guide as well as the guideline is referenced in the 2011 ITP Guideline publication as follows: “The disease and its most widely accepted abbreviation, ITP, has variably been defined as ‘immune thrombocytopenic purpura’, ‘idiopathic thrombocytopenic purpura’ and most recently, ‘immune thrombocytopenia’. “

Background Image: Peripheral smear in a patient with ITP showing an almost total absence of platelets. A large, young platelet is seen in the center of the smear. From the ASH Image Bank, courtesy of John Lazarchick, MD.

Guidelines provide the practitioner with clear principles and strategies for quality patient care and do not establish a fixed set of rules that preempt physician judgment.

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Copyright 2011 by the American Society of Hematology. All rights reserved.
The goal of all treatment strategies for ITP is to achieve a platelet count that is associated with adequate hemostasis, rather than a normal platelet count. The decision to treat should involve a discussion with the patient and consideration of the severity of bleeding, anticipated surgical procedures, medication side effects, and health-related quality of life.

I. Initial Management of ITP

1. Assessment of Disease Status:
   - What is the patient’s presenting illness?
   - What is the timing, location, and severity of bleeding symptoms?
   - What is the patient’s history of bleeding?
   - Is the patient’s bleeding associated with a recent infection or a new medication?
   - Does the patient have a history of bleeding disorders?
   - Is this patient likely to comply with recommended treatments?
   - Is a surgical procedure anticipated?
   - Is there a change in the patient’s health status or medications?

2. General Considerations for Initial Management:
   - The majority of patients with no bleeding or mild bleeding (defined here as skin manifestations only, such as petechiae and bruising) can be managed conservatively.
   - Those with a history of significant bleeding should be treated with observation, prior to initiation of treatment with corticosteroids, prior to splenectomy, or in patients who fail intravenous immunoglobulin (IVIg) therapy.

3. Special Considerations for Adults and Children:
   - Adults: Consider treatment for patients with a platelet count < 30 x 10^9/L.
   - Children: A single dose of IV Ig (≥ 0.8-1.0 g/kg) or a short course of corticosteroids should be used as first-line treatment.
   - IV Ig should be used instead of corticosteroids if a more rapid increase in platelet count is required.
   - There is no evidence to support using corticosteroids for long-term use.
   - Anti-D may be considered for first-line therapy in Rh-negative patients with recognition of the risks outlined above.

II. Subsequent Management of ITP

1. Assessment of Disease Status:
   - What is the patient’s current platelet count?
   - What is the patient’s response to previous treatments?
   - Is the patient asymptomatic or experiencing symptoms?
   - Is the patient’s platelet count stable or decreasing?

2. General Considerations for Subsequent Management:
   - Adults: Consider treatment for patients with a platelet count < 30 x 10^9/L.
   - Children: Consider treatment for patients with a platelet count < 30 x 10^9/L.
   - If IV Ig is used in conjunction with corticosteroids or IV Ig, anti-D should be used one more rapidly than corticosteroids alone.
   - Reconsideration of treatment options should be considered if there is no response to treatment.
   - Consideration of alternative agents such as immunosuppressive therapy, rituximab, thrombopoietin receptor agonists, or high-dose dexamethasone may be considered for patients who fail to respond to corticosteroids, IV Ig, or anti-D.

3. Special Considerations for Children and Adults:

- **Splenectomy**
  - Recommended for adults who have failed corticosteroids, IV Ig, or anti-D and/or have a lack of response to any one specific agent.

- **Rituximab**
  - May be considered for children with severe bleeding and/or a need for improved quality of life.

- **High-Dose Dexamethasone**
  - May be considered for adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IV Ig, or anti-D.

- **Thrombopoietin Receptor Agonists**
  - Studies are ongoing, and there is limited published data to guide the use of these agents in children.

- **Immunosuppression**
  - Multiple agents have been reported for children and adolescents with ITP who have achieved an insufficient response to corticosteroids, IV Ig, and/or anti-D.

- **Dexamethasone**
  - Recommended for children with a platelet count < 30 x 10^9/L and are symptomatic and need for improved quality of life.

- **Rituximab**
  - May be considered for children with severe bleeding and/or a need for improved quality of life.

- **High-Dose Dexamethasone**
  - May be considered for adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IV Ig, or anti-D.

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  - Recommended for children with a platelet count < 30 x 10^9/L and are symptomatic and need for improved quality of life.

- **Rituximab**
  - May be considered for children with severe bleeding and/or a need for improved quality of life.

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  - May be considered for children with severe bleeding and/or a need for improved quality of life.

- **High-Dose Dexamethasone**
  - May be considered for adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IV Ig, or anti-D.
The goal of all treatment strategies for ITP is to achieve a platelet count that is associated with adequate hemostasis, rather than a normal platelet count. The decision to treat should involve a discussion with the patient and consideration of the severity of bleeding, anticipated surgical procedures, medication side effects, and health-related quality of life.

I. Initial Management of ITP

1. Assessment of Disease Status:
   - What is the bleeding the patient experiencing?
   - Determine the timing, location, and severity of bleeding symptoms.
   - Does this patient have any additional risk factors for bleeding such as use of antithrombotic agents or high-risk occupation?
   - Is a surgical procedure anticipated?
   - Is this patient likely to comply with recommended treatments?
   - Is the bleeding experienced by this patient interfering with his or her daily life and causing significant impacts?

2. General Considerations for Initial Management:
   - The majority of patients with no bleeding or mild bleeding (defined here as skin manifestations only, such as petechiae and bruising) can be treated with observation alone regardless of platelet count.
   - First-line treatment includes observation, corticosteroids, IVIg, or anti-thrombopoietin (anti-D). Some patients may require further investigation with a bone marrow examination or other appropriate investigations before the diagnosis of ITP is made.

3. Additional Considerations
   - All patients with newly diagnosed ITP should undergo testing for HIV and HCV.
   - There is insufficient evidence to support the routine use of anti-platelet, antiphospholipid, and anti-nuclear antibodies, thrombopoietin levels, or platelet autoantibodies in patients with intravenous immunoglobulin (IVIg) therapy.
   - The presence of abnormalities in the history, physical examination, or the complete blood count and peripheral blood smear should be further investigated, e.g. with a bone marrow examination or other appropriate investigations, before the diagnosis of ITP is made. This is especially critical in children with typical ITP prior to initiation of treatment with corticosteroids, prior to splenectomy, or in patients who fail intravenous immunoglobulin (IVIg) therapy.

3. Special Considerations for Adults and Children:

   **Adults:**
   - Consider treatment for patients with a platelet count < 50 x 10^9/L.
   - Longer courses of corticosteroids are preferred over shorter courses of corticosteroids or IVIg.
   - IVIg may be used in conjunction with corticosteroids if a more rapid increase in platelet count is required.
   - Either IVIg (1 g/kg for one dose followed by 250 mg/kg daily) or anti-D (in appropriate patients) may be used as a first-line treatment if corticosteroids are contraindicated.

   **Children:**
   - A single dose of IVIg (0.8–1.0 g/kg) or a short course of corticosteroids should be used as first-line treatment.
   - IVIg should be used instead of corticosteroids if a more rapid increase in platelet count is required.
   - There is no evidence to support using corticosteroids for longer than six weeks in children.
   - Anti-D may be considered for first-line therapy in Rh- non-splenectomized children with recognition of the risks outlined above.

II. Subsequent Management of ITP

1. Assessment of Disease Status:
   - What is the bleeding the patient experiencing? Determine the timing, location, and severity of bleeding symptoms.
   - Does this patient have a change in history or physical examination that requires evaluation for another diagnosis that could be causing thrombocytopenia?
   - Does this patient have any contraindications to splenectomy?
   - Is the diagnosis of ITP affecting the patient’s ability to work, go to school, or participate in his or her current drug therapy?
   - Is the patient experiencing side effects from chronic medicinal use?
   - Is the patient coping psychologically with having a low platelet count?

2. General Considerations for Subsequent Management:
   - Adults who have a platelet count > 50 x 10^9/L and are asymptomatic following splenectomy do not require further therapy.
   - In children, splenectomy or other interventions with potentially serious complications should be considered if a platelet count of 30 x 10^9/L is not maintained for at least 12 months and the patient is not experiencing significant ongoing bleeding and/or has a need for improved quality of life.
   - If previous courses of corticosteroids with corticosteroids, IVIg, or anti-D has been successful, these options may be used as needed to prevent bleeding.
   - If previous treatment with corticosteroids, IVIg, or anti-D has been unsuccessful, subsequent treatment may include splenectomy, rituximab, thrombopoietin receptor agonists, or more potent immunosuppression.

*Of the pharmacologic options listed above, the thrombopoietin receptor agonists have FDA approval in adults with chronic ITP who have an insufficient response to corticosteroids, immunoglobulins, or splenectomy. Desmopressin has FDA approval for treatment of ITP in adults. All other therapies are considered off-label one.
The goal of all treatment strategies for ITP is to achieve a platelet count that is associated with adequate hemostasis, rather than a normal platelet count. The decision to treat should involve a discussion with the patient and consideration of the severity of bleeding, anticipated surgical procedures, medication side effects, and health-related quality of life.

I. Initial Management of ITP

1. Assessment of Disease Status
   - What is the bleeding patient experiencing? Determine the timing, location, and severity of bleeding symptoms.
   - Does the patient have any additional risk factors for bleeding such as use of antithrombotic agents or high-risk occupation?
   - Is a surgical procedure anticipated?
   - Is this patient likely to comply with recommended treatments?

2. General Considerations for Initial Management:
   - The majority of patients with no bleeding or mild bleeding (defined here as skin manifestations only, such as petechiae and bruising) can be treated with observation alone regardless of platelet count.
   - First-line treatment includes observation, corticosteroids, IVlg, or anti-CD20 monoclonal antibodies (anti-D).
   - Anti-D should be used with caution given recent FDA warnings of severe hemolysis. It is therefore not advised in patients with bleeding who could be causing a decline in hemoglobin, or those with evidence of autoimmune hemolysis.

3. Special Considerations for Adults and Children:
   - Children: A single dose of IVlg (0.8-1.0 g/kg) or a short course of corticosteroids should be used as first-line treatment.
   - IVlg should be used in preference to corticosteroids if a more rapid increase in platelet count is required.
   - There is no evidence to support using corticosteroids for longer than 10 days unless warranted by severe disease unresponsive to other measures or due to quality of life considerations.
   - If previous courses of corticosteroids with corticosteroids, IVlg, or anti-D has been successful, these options may be used as needed to prevent bleeding.
   - If previous treatment with corticosteroids, IVlg, or anti-D has been unsuccessful, subsequent treatment may include splenectomy, rituximab, thrombopoietin receptor agonists, or more potent immunosuppression.

II. Subsequent Management of ITP

1. Assessment of Disease Status
   - What is the bleeding patient experiencing? Determine the timing, location, and severity of bleeding symptoms.
   - Does this patient have a history of bleeding or is there a history of ongoing bleeding and/or have a need for improved quality of life despite conventional treatment? Also may be considered as an alternative to splenectomy in children with chronic ITP or as therapy in those who have failed splenectomy.
   - Does the patient respond intermittently to this or other current drug therapy?
   - Is the patient experiencing side effects from chronic medicinal use?

2. General Considerations for Subsequent Management: Adults:
   - Adults who have a platelet count > 30 x 10^9/L and are asymptomatic following splenectomy do not require further therapy.
   - In children, splenectomy or other interventions with potentially serious complications should be reserved for patients who relapse after at least 12 months unless warranted by severe disease unresponsive to other measures or due to quality of life considerations.

3. Special Considerations for Adults and Children:
   - Adults: Consider treatment for patients with a platelet count < 50 x 10^9/L.
   - Longer courses of corticosteroids are preferred over shorter courses of corticosteroids or IVlg.
   - IVlg may be used in conjunction with corticosteroids if a more rapid increase in platelet count is required.
   - Either IVlg (1g/kg for one dose, 2g/kg for two doses) or anti-D (in appropriate patients) may be used as a first-line treatment if corticosteroids are contraindicated.

III. Splenectomy

- Recommended for children with complicated bleeding and lack of response to other therapies such as corticosteroids, IVlg, and anti-D, and/or who have a need for improved quality of life.

- Recommended for adults who have failed corticosteroid therapy with similar efficacy for open or laparoscopic procedures.

- May be considered for adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IVlg or splenectomy.

- Studies are ongoing but there is no published data to guide the use of these agents in children.

- Recommended for adults at risk of bleeding who relapse after splenectomy or who have a contraindication to splenectomy and who have failed at least one other therapy.

- These agents may also be considered for adults at risk of bleeding who have failed one line of therapy such as corticosteroids or IVlg and who do not undergo splenectomy.

- May be considered for children with chronic ITP who have significant ongoing bleeding and/or have a need for improved quality of life. Also may be considered as an alternative to splenectomy in children with chronic ITP or as therapy in those who have failed splenectomy.

- Recommended for children or adolescents with ITP who have significant ongoing bleeding and/or have a need for improved quality of life despite conventional treatment. Also may be considered as an alternative to splenectomy in those with chronic ITP or in those who have failed splenectomy.

- No comment in current guidelines.

- Multiple agents have been reported however data is insufficient for any one specific agent to consider for specific recommendations.

- Multiple agents have been reported however data is insufficient for any one specific agent to consider for specific recommendations.

- Of the pharmacological options listed above, the thrombopoietin receptor agonist has FDA approval in adults with chronic ITP who have an insufficient response to corticosteroids, immunoglobulins, or splenectomy. Danazol has FDA approval for treatment of ITP in adults. All other therapies are considered off-label one.
DIAGNOSIS

1. Necessary Evaluation
   • History: Isolated bleeding symptoms consistent with thrombocytopenia without constitutional symptoms (e.g., significant weight loss, bone pain, night sweats).
   • Physical examination: Bleeding symptoms in the absence of hepatosplenomegaly, lymphadenopathy, or stigmata of con genital conditions.

2. Bone Marrow Evaluation
   • Bone marrow examination is unnecessary in patients with the typical features of ITP outlined above, irrespective of the age of the patients.
   • Bone marrow examination is felt to be unnecessary in children with typical ITP prior to initiation of treatment with corticosteroids, prior to splenectomy, or in patients who fail intravenous immunoglobulin (IVIg) therapy.
   • The presence of abnormalities in the history, physical examination, or the complete blood count and peripheral blood smear should be further investigated, e.g. with a bone marrow examination or other appropriate investigations, before the diagnosis of ITP is made.

3. Additional Evaluations
   • All patients with newly diagnosed ITP should undergo testing for HIV and HCV.
   • There is insufficient evidence to support the routine use of anti-platelet, antithrombophilic, and anti-nuclear antibodies, thrombocytopenia levels, or platelet function tests (PFT) on automated analyzers in the evaluation of patients with suspected ITP.

MANAGEMENT

The goal of all treatment strategies for ITP is to achieve a platelet count that is associated with adequate hemostasis, rather than a normal platelet count. The decision to treat should involve a discussion with the patient and consideration of the severity of bleeding, anticipated surgical procedures, medication side effects, and health-related quality of life.

I. Initial Management of ITP

1. Assessment of Disease Status
   • What is the patient experiencing? Determine the timing, location, and severity of bleeding symptoms.
   • Does this patient have any additional risk factors for bleeding such as use of antithrombotic agents or high-risk occupation?
   • Is a surgical procedure anticipated?
   • Is this patient likely to comply with recommended treatments?
   • Is the bleeding experienced by this patient interfering with his or her ability to function?

2. General Considerations for Initial Management:
   • The majority of patients with no bleeding or mild bleeding (defined here as skin manifestations only, such as petechiae and bruising) can be treated with observation alone regardless of platelet count.
   • First-line treatment includes observation, corticosteroids, IVIg, or anti-thrombopoietin (anti-D).
   • Anti-D should be used with caution given recent FDA warnings of severe hemolyis. It is therefore not advised in patients with bleeding causing a decline in hemoglobin, or those with evidence of autoimmune hemolyis.

3. Special Considerations for Adults and Children:
   • In children, splenectomy or other interventions with potential complications should be performed after a 4-week to 8-week period of observation for children without risk factors for severe bleeding.
   • There is no evidence to support using corticosteroids for longer courses of treatment with IVIg or anti-D.

II. Subsequent Management of ITP

1. Assessment of Disease Status
   • What is the patient experiencing? Determine the timing, location, and severity of bleeding symptoms.
   • Does this patient have a change in history or physical examination that requires evaluation for another diagnosis that could be causing thrombocytopenia?
   • Does this patient have any contraindications to splenectomy?
   • How is the diagnosis of ITP affecting the patient’s ability to work, go to school, or participate in activities?
   • Does the patient respond intermittently to his or her current drug therapy?
   • Is the patient experiencing side effects from chronic immunosuppressive use?
   • How is the patient coping psychologically with having a low platelet count?

2. General Considerations for Subsequent Management:
   • Adults: who have a platelet count > 50 x 10^9/L and are asymptomatic following splenectomy do not require further therapy.
   • In children, splenectomy or other interventions with potential complications should be performed after at least 12 months, unless warranted by severe disease unresponsive to other measures or due to quality of life considerations.
   • If previous courses of corticosteroids with corticosteroids, IVIg, or anti-D has been successful, these options may be used as needed to prevent bleeding.
   • If previous treatment with corticosteroids, IVIg, or anti-D has been unsuccessful, subsequent treatment may include splenectomy, rituximab, thrombopoietin receptor agonist, or more potent immunosuppression.

3. Special Considerations for Children and Adults:
   • Children: A single dose of IVIg (0.8-1.0 g/kg) or a short course of corticosteroids should be used as first-line treatment.
   • IVIg should be used in lieu of corticosteroids if a more rapid increase in platelet count is required.
   • There is no evidence to support using corticosteroids for longer courses of treatment with IVIg or anti-D.
   • Anti-D may be considered for first-line therapy in Rh non-splenectomized children with recognition of the risks outlined above.

Splenectomy

Recommended for children with active bleeding and lack of responses or intolerance of other therapies such as corticosteroids, IVIg, and anti-D, and/or who have failed for improved quality of life.

Rituximab

May be considered for children with active bleeding and lack of responses or intolerance of other therapies such as corticosteroids, IVIg, and anti-D.

Thrombopoietin Receptor Agonists

Studies are ongoing, but there are no current guidelines to guide the use of these agents in adults.

Dexamethasone

Recommended for adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IVIg, or splenectomy.

High-Dose Immunosuppression

Multiple agents have been reported for initial treatment in those who have failed one line of therapy such as corticosteroids or IVIg and have significant ongoing bleeding and/or have in sufficient response to conventional treatment. Also may be considered as an alternative to splenectomy in children with chronic ITP or as a therapy in those who have failed splenectomy.

Therapy in those who have failed one line of therapy such as corticosteroids or IVIg and have failed splenectomy.

Immunosuppression

Multiple agents have been reported for initial treatment in those who have failed one line of therapy such as corticosteroids or IVIg and have significant ongoing bleeding and/or have insufficient response to conventional treatment.

No comment in current guidelines.

*The pharmacology of ITP is poorly understood, the pathophysiology of ITP is complex, and the management of ITP is based on expert opinion and case reports. The goals of therapy for ITP are to achieve adequate platelet counts and to improve quality of life for patients with ITP.
1. Special Considerations for Secondary ITP:

Secondary ITP (HIV-associated):
- Treatment of the underlying HIV infection with antiviral therapy should be considered prior to other treatment options unless the patient has clinically significant bleeding.
- IV Ig, corticosteroids, or anti-D may be used initially for patients requiring further therapy.
- Splenectomy is considered preferable to other agents in symptomatic patients who have failed initial drug therapy.

Secondary ITP (HCV-associated):
- Antiviral therapy should be considered in the absence of contraindications, but the platelet count should be closely monitored in these situations due to a risk of worsening thrombocytopenia attributable to interferon.
- If treatment is required, the initial management should be with IV Ig.

Secondary ITP (H. pylori-associated):
- Routine testing for H. pylori is not recommended in asymptomatic children with unresolved ITP.
- Screening for H. pylori should be considered in adults for whom eradication therapy would be undertaken if testing were positive.
- Eradication therapy for H. pylori should be administered to patients who are found to have infection.

2. MMR-related ITP:
- Children with a history of ITP who are not immunized should receive their scheduled first MMR vaccine.
- In children with either non-vaccine or vaccine-related ITP who have already received their first dose of MMR vaccine, vaccine titers can be checked. If the child displays full immunity, no further MMR vaccine should be given. If the child does not have adequate immunity, then the child should be re-immunized at the recommended age.

3. ITP in Pregnancy:
- Pregnant patients requiring treatment should receive either corticosteroids or IV Ig.
- For pregnant women with ITP, the mode of delivery should be based on obstetric indications.


The American Society of Hematology (ASH) published a landmark paper in 1996 designed to assist clinicians in the management of Immune Thrombocytopenia (ITP). Since then, there have been numerous advances in the management of ITP mandating an update to the published guidelines. The guideline update uses an evidence-based approach, interpretation, and presentation of the available evidence and provides treatment recommendations using the GRADE system.

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Background Image: Peripheral smear in a patient with ITP showing an almost total absence of platelets. A large, young platelet is seen in the center of the smear. From the ASH Image Bank, courtesy of John Lazarchick, MD.

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1. Special Considerations for Secondary ITP:

Secondary ITP (HIV-associated):
- Treatment of the underlying HIV infection with antiretroviral therapy should be considered prior to other treatment options unless the patient has clinically significant bleeding.
- IVlg, corticosteroids, or anti-D may be used initially for patients requiring further therapy.
- Splenectomy is considered preferable to other agents in symptomatic patients who have failed initial drug therapy.

Secondary ITP (HCV-associated):
- Antiviral therapy should be considered in the absence of contraindications, but the platelet count should be closely monitored in these situations due to a risk of worsening thrombocytopenia attributable to interferon.
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2. MMR-related ITP:
- Children with a history of ITP who are not immunized should receive their scheduled first MMR vaccine.
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3. ITP in Pregnancy:
- Pregnant patients requiring treatment should receive either corticosteroids or IVlg.
- For pregnant women with ITP, the mode of delivery should be based on obstetric indications.

Further Considerations:


The American Society of Hematology (ASH) published a landmark paper in 1996 designed to assist clinicians in the management of Immune Thrombocytopenia (ITP). Since then, there have been numerous advances in the management of ITP mandating an update to the published guidelines. The guideline update uses an evidence-based approach, interpretation, and presentation of the available evidence and provides treatment recommendations using the GRADE system.

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- Routine testing for H. pylori is not recommended in asymptomatic children with unresolved ITP.
- Screening for H. pylori should be considered in adults for whom eradication therapy would be undertaken if testing were positive.
- Eradication therapy for H. pylori should be administered to patients who are found to have infection.

2. MMR-related ITP:
- Children with a history of ITP who are not immunized should receive their scheduled first MMR vaccine.
- In children with either non-vaccine or vaccine-related ITP who have already received their first dose of MMR vaccine, vaccine titers can be checked. If the child displays full immunity, no further MMR vaccine should be given. If the child does not have adequate immunity, then the child should be re-immunized at the recommended age.

3. ITP in Pregnancy:
- Pregnant patients requiring treatment should receive either corticosteroids or IV Ig.
- For pregnant women with ITP, the mode of delivery should be based on obstetric indications.


The American Society of Hematology (ASH) published a landmark paper in 1996 designed to assist clinicians in the management of Immune Thrombocytopenia (ITP). Since then, there have been numerous advances in the management of ITP mandating an update to the published guidelines. The guideline update uses an evidence-based approach, interpretation, and presentation of the available evidence and provides treatment recommendations using the GRADE system.

Use of the terminology “Immune Thrombocytopenia” in the title of the quick reference guide as well as the guideline is referenced in the 2011 ITP Guideline publication as follows: “The disease and its most widely accepted abbreviation, ITP, has variably been defined as ‘immune thrombocytopenic purpura,’ ‘idiopathic thrombocytopenic purpura’ and most recently, ‘immune thrombocytopenia.’”

Background Image: Peripheral smear in a patient with ITP showing an almost total absence of platelets. A large, young platelet is seen in the center of the smear. From the ASH Image Bank, courtesy of John Lazarich, MD.

Guidelines provide the practitioner with clear principles and strategies for quality patient care and do not establish a fixed set of rules that preempt physician judgment.

For further information, please see the complete guidelines located at www.hematology.org/practiceguidelines. You may also contact the ASH Government Relations & Practice Department at (202)776-0544. Copyright 2011 by the American Society of Hematology. All rights reserved.