



2ND meeting of the European Research Consortium on ITP

NEW INSIGHTS INTO IMMUNE
THROMBOCYTOPENIA

Paris Crowne Plaza Paris République

April 23-24, 2026



A large, stylized number '2' in a dark blue, brush-stroke font, with the letters 'ND' in a smaller, light blue font positioned above it.

meeting of the European Research Consortium on ITP

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April 23-24, 2026

The new EHA-ERCI guidelines: current status

Waleed Ghanima and Mario Csenar

Disclosures of

Waleed Ghanima

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
SOBI	+		+			+	
Grifols	+		+			+	
Sanofi	+		+			+	
Novartis			+			+	
Amgen						+	
Takeda			+			+	

Disclosures of

Mario Csenar

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
None							

EHA-ERCI Guideline

Immune Thrombocytopenia (ITP)



Comprehensive

The most comprehensive ITP guidelines available

360°

Full Topic Coverage

Covers all topics surrounding ITP management



GRADE Methodology

Rigorous GRADE methodology for evidence assessment



Evidence + Consensus

Combined evidence-based and consensus-based approach



Dynamic Updates

Updated regularly as new evidence emerges



App-Based Access

Available as an app for easy clinical use

GRADE = Grading of Recommendations, Assessment, Development and Evaluations



Includes 11 Sections

EHA-ERICI Guideline on Immune Thrombocytopenia

11 Guideline Sections & Leads

Section	Section leads
Adult primary ITP	Francesco Zaja
Adult secondary ITP	Marc Michel
Pediatric ITP	Nichola Cooper
Pregnancy	Catherine Lambert
Elderly	Nicola Vianelli
Bleeding	Guillaume Moulis
Thrombosis	Alexandros Arvanitakis
Quality of Life	Esther Oliva
Laboratory investigations	Matthieu Mahevas
Vaccination	Valerio De Stefano
Patients' care	Ana Cabrera

Guideline panellists in total: 47

Key experts: Mario Csenar, Monia Marchetti, Quentin Hill

Key question refinement and prioritisation



GPS = Good practice recommendations

Where do we stand?

ACTIVE

Solely consensus-based recommendation

Revised:

- Adult and elderly [4]
- Pediatrics [4]
- Bleeding [3]
- Thrombosis [4]
- QoL [2]
- Pregnancy [5]
- Lab & diagnostics [5]
- Secondary ITP [8]

ACTIVE

Evidence-based recommendations

- Adult and elderly [11]

FUTURE

Publication

Final guideline publication and dissemination

Selection of evidence-based questions on adult ITP treatment

Treatment naïve setting

QUESTION 1

Treatment initiation vs. observation
in newly diagnosed adult ITP
patients with PLT < 30 G/L

QUESTION 2

Corticosteroids alone vs.
combination therapies

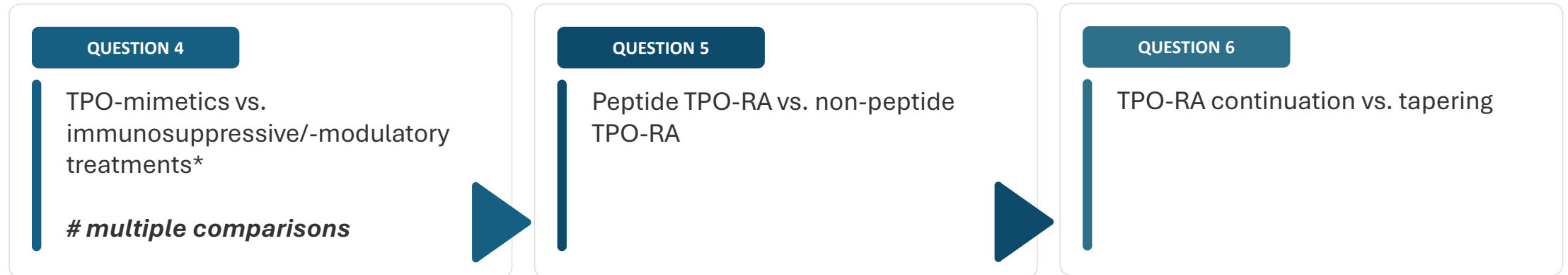
multiple comparisons

QUESTION 3

Dexamethasone vs. prednis(ol)one
or methylprednisolone

Selection of evidence-based questions on adult ITP treatment

Treatment pre-exposed (corticosteroid refractory, dependent or intolerant)



*cyclosporine A, azathioprine, MMF, rituximab, fostamatinib, rilzabrutinib, danazole, dapsone

TPO-RA non-response



4 consensus-based questions on adult ITP treatment

QUESTION 1

Platelet transfusion vs. no platelet transfusion (+ other treatment) in serious/life-threatening bleeding

QUESTION 2

Low-dose corticosteroids (CS) beyond 2 mts vs. switch to other treatment

QUESTION 3

CS rechallenge vs. second-line therapy after relapse to first-line CS

QUESTION 4

Hospitalization vs outpatient care in newly suspected ITP with platelet counts of $< 20 \times 10^9/L$, without need of urgent intervention

Where do we stand?

ACTIVE

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ACTIVE

Evidence-based recommendations

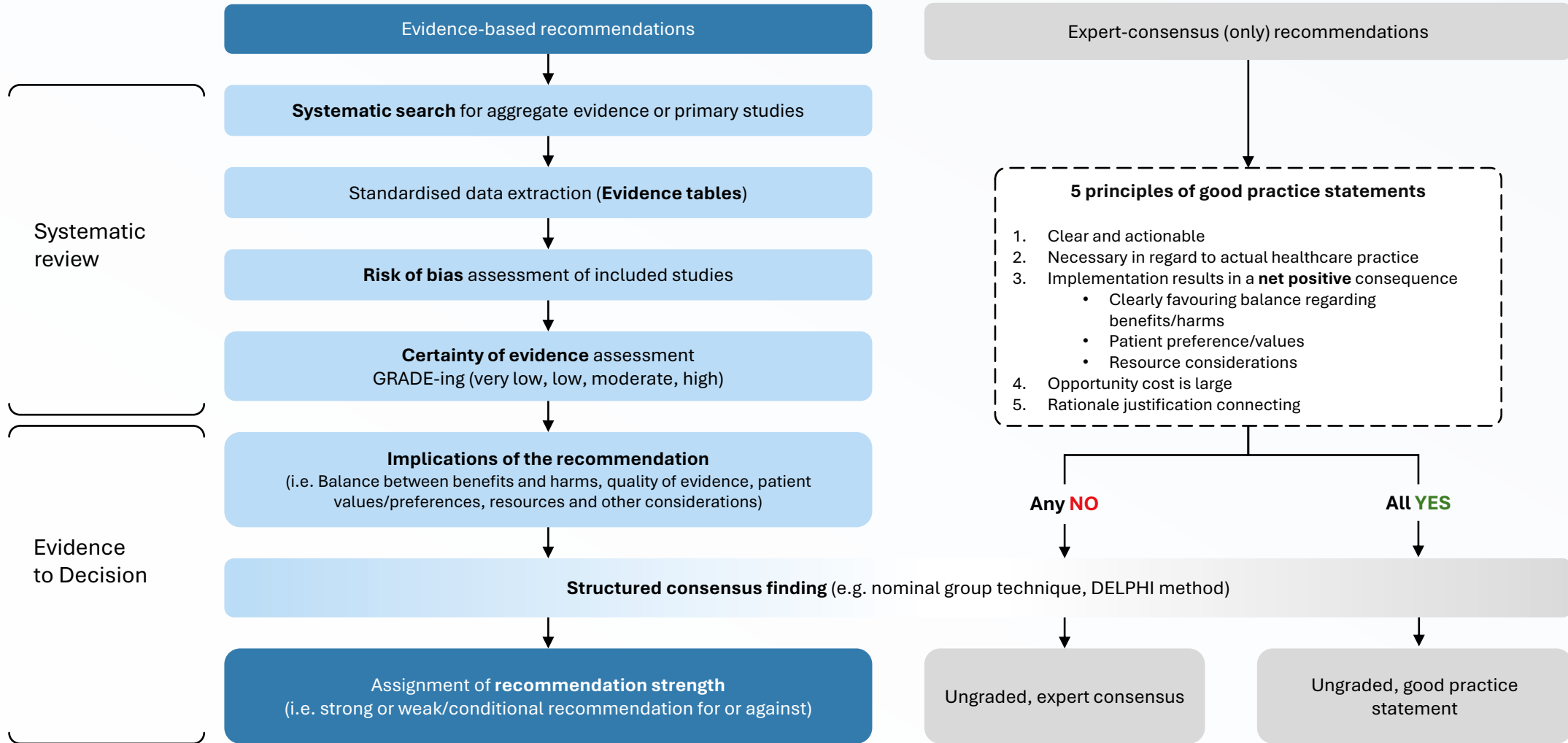
- Adult and elderly [11]

FUTURE

Publication

Final guideline publication and dissemination

Development process



Literature search and screening



Systematic reviews

1,311

records

Last search: 29.01.26

Databases:

- Medline
- Epistemonikos
- CENTRAL



Randomised controlled trials

2,304

records

Last search: 30.01.26

Databases:

- Medline
- CENTRAL



Non-randomised studies

11,273

records

Last search: 30.12.24

Databases:

- Medline
- Embase

Core outcome priorities

Survival analysis

Overall survival (mortality)

Relapse-free survival (or duration of response)

Response assessment

Sustained response (at 6 mts)

Sustained response (at 12 mts)

Time-to-response

Quality of life

Disease-specific QoL (total score)

Overall QoL (total score)

Symptom-specific QoL

Morbidity

Serious bleeding (mWHO ≥ 2 , or equivalent)

Any bleeding events

Adverse events

Severe adverse events (CTCAE ≥ 3 , or serious adverse events if not reported otherwise); any adverse events if severe are not reported

Severe infectious complications (CTCAE ≥ 3); lower respiratory tract infection if not reported

Thromboembolism (DVT, PE)

Hospitalisations

GRADE guidance: ideally limit number of patient-important outcomes to < 7

Relative outcome importance based on health-state utility values



Outcome	Utility value	Reference(s)
Death	0.00	-
Intracerebral haemorrhage	0.04	[3]
Gastrointestinal bleeding	0.41-0.54	[3-8]
Inpatient bleed/significant bleed	0.41-0.54	[3-8]
Outpatient bleed/minor bleed	0.52-0.84	[3-6, 9]
Platelets \geq 50, no bleed	0.63-0.99	[3-6, 9, 10]
Inpatient pneumonia	0.05-0.71	[11]
Outpatient pneumonia	0.35-0.83	[11]
Deep vein thrombosis	0.63-0.93	[12]
Pulmonary embolism	0.64-0.99	[12]
Experiencing serious adverse event	-0.10-0.40 (disutility increment)	[6, 9]
Experiencing any adverse event	-0.10 (disutility increment)	[6, 9]

Minimally important differences (MID) for PROMs not listed

First-line treatment

Corticosteroid monotherapy vs. combination regimens

12 RCTs investigating 1st line steroid combinations

+ 4 rituximab

+ TPO-RA: rhTPO [1], romiplostim (RODEX) [1], eltrombopag (XPAG-ITP) [1]

+ mycophenolate mofetil (FLIGHT) [1]

+ tacrolimus [1]

+ all-trans retinoic acid [1]

+ oseltamivir [1]

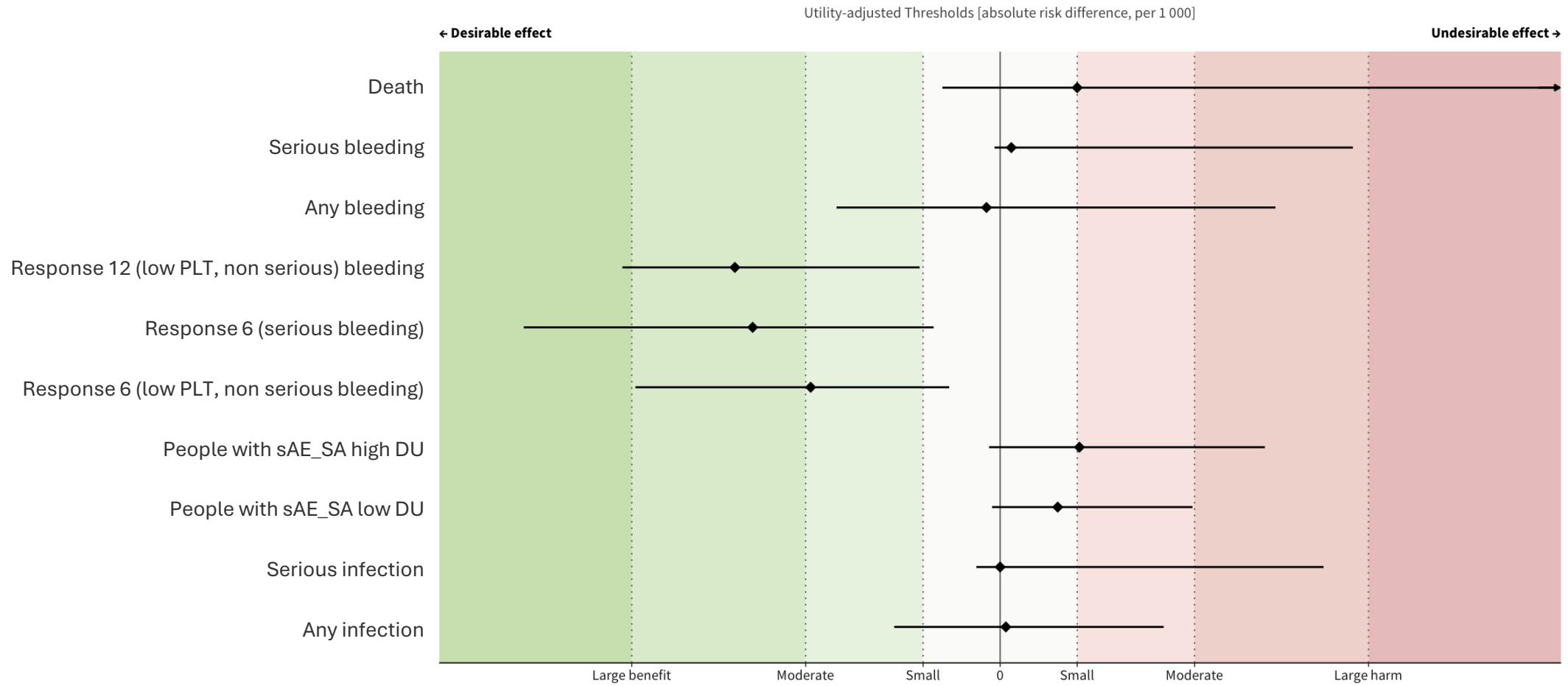
+ baricitinib [1]

+ ianalumab [1] (VAYHIT1 – ongoing)

*Arnold et al. 2012 and Hamed et al. 2023 not included
(‘1.5 line’ treatment; ca. 1 month of standard treatment prior to randomisation)

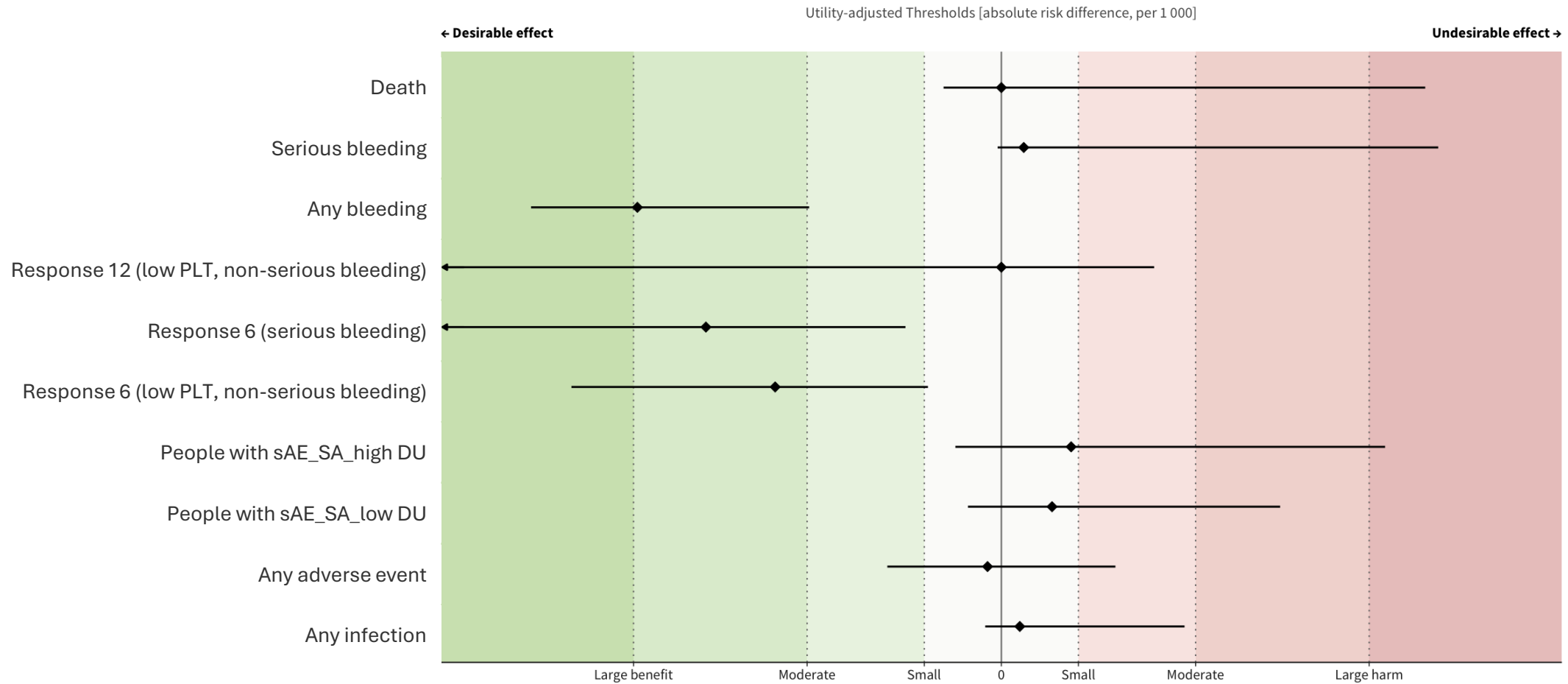
First-line treatment

Corticosteroids + mycophenolate mofetil (MMF)



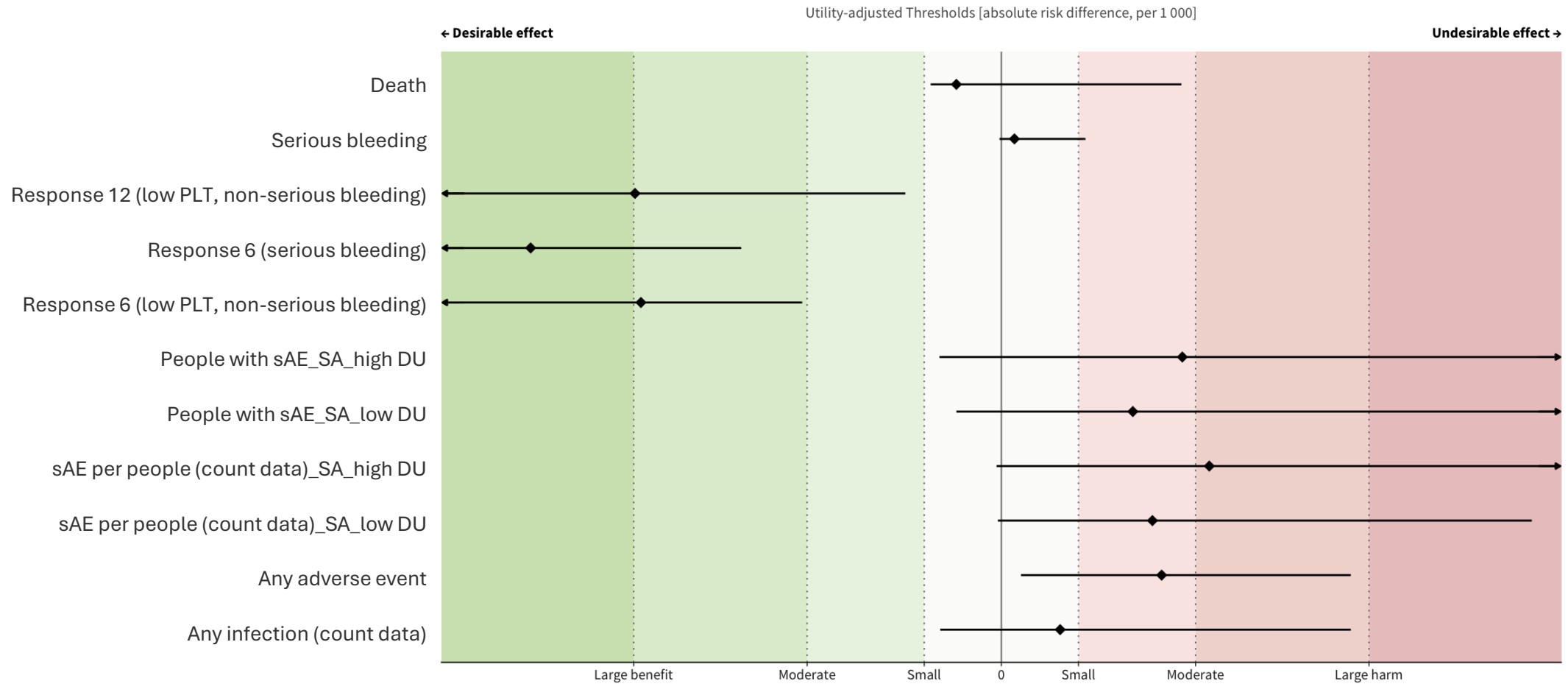
First-line treatment

Corticosteroids + thrombopoietin mimetic



First-line treatment

Corticosteroids + rituximab



First-line treatment

Corticosteroid monotherapy vs. combination regimens

PRELIMINARY

RECOMMENDATION

In treatment-naïve patients with newly diagnosed ITP, the panel **suggests** treatment with corticosteroid monotherapy over the upfront use of combination regimens.
 If a combination regimen is chosen, the panel **suggests** using either corticosteroids + TPO-RAs or rituximab over mycophenolate mofetil.

Conditional recommendation

Low certainty evidence ●●○○

Agreement: XX% in XX Abstentions: XX

SUBGROUP CONSIDERATION

In patients with severe bleeding who do not respond to upfront corticosteroids (± IVIG), TPO-RAs may be added.

ASH Guidelines update 2025

Out for public comments

In adults with primary ITP receiving initial therapy, should CS + an additional agent (anti-CD20, MMF, TPO-RA), or CS alone be used?

ASH guideline panel **suggests:**

✓ Rituximab or TPO-RA + CS

rather than

X MMF + CS or CS alone

Same evidence ≠ same recommendation?

Framing of the question

- **Day one** combination vs. monotherapy
- Slightly different handling of evidence (e.g. Hamed et al. 2023)
- Early 2nd line after ~1 month of corticosteroids

Weighing of outcome importance

- **No evidence for difference in 'hard' endpoints** with low to very low certainty — mainly due to imprecision (rarity of events)
- Utility-adjusted decision thresholds
- Impact on natural history of disease: long-term gains justify the risk? ('Kairos principle')

Other contextualising factors

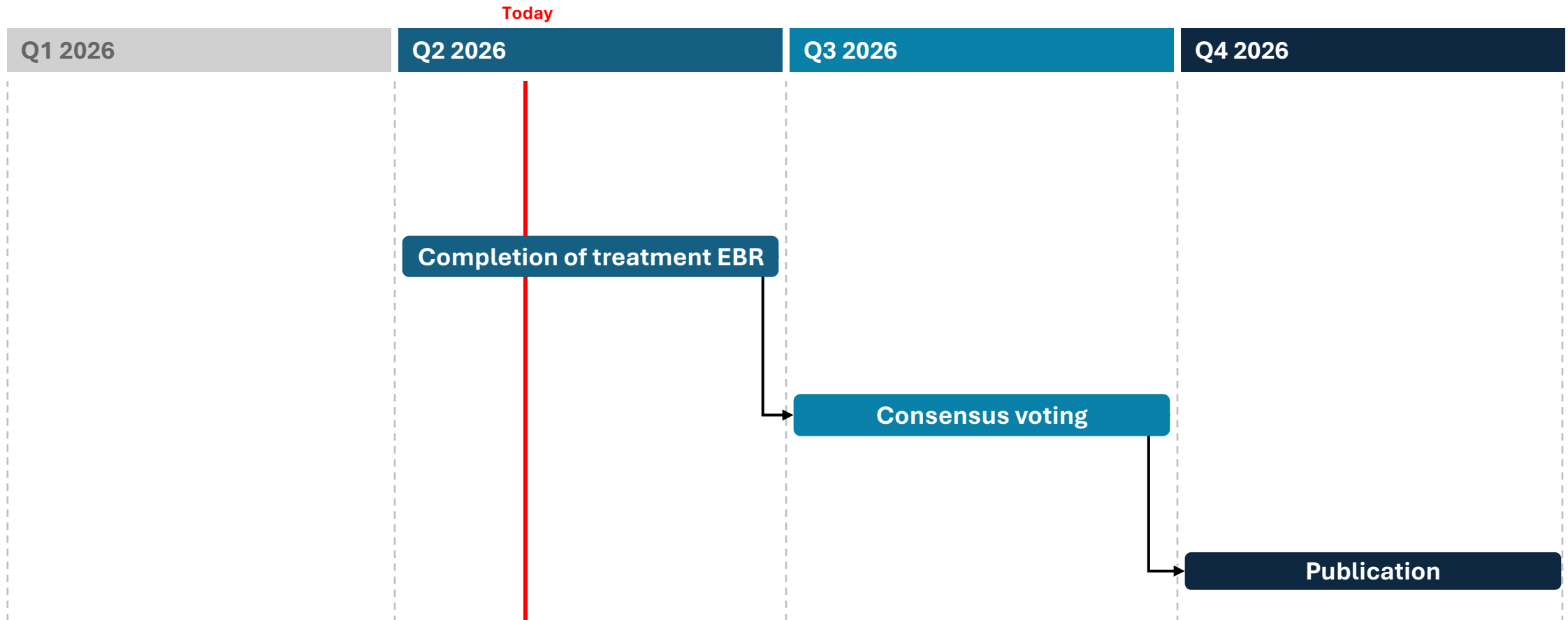
- Uncertainty about treatment regimen → deprescribing issue
- Timing: completion of diagnostic testing vs. immediate starting

Sorry USA – We disagree with you here too

Bauchner H, Ioannidis JPA. The Subjective Interpretation of the Medical Evidence. JAMA Health Forum. 2024 Mar 1;5(3):e240213. doi: 10.1001/jamahealthforum.2024.0213. PMID: 38551587.



Plan



Thank You

&

Stay tuned!



Vigeland Park, Oslo