KDIGO 2026 · REVIEWED NOVEMBER 6, 2026

CKD anemia: iron decisions

Adult clinical reference · Initiation and ongoing treatment are different decisions

Population / decision	KDIGO 2026 guidance
Anemia + hemodialysis (HD): initiate iron	Ferritin ≤500 ng/mL **and** TSAT ≤30%. IV iron is suggested; use a proactive, monitored approach.
Anemia + non-dialysis CKD or peritoneal dialysis (PD): initiate iron	Ferritin <100 ng/mL **and** TSAT <40%, **or** ferritin ≥100 and <300 ng/mL **and** TSAT <25%.
Route outside HD	Choose oral or IV iron using severity, response, tolerance, preference, availability, and cost. Switch an optimal oral regimen to IV if ineffective after 1–3 months or poorly tolerated.
Withhold routine iron	Ferritin >700 ng/mL **or** TSAT ≥40%. An elevated ferritin alone does not diagnose iron overload.
Systemic infection	Consider temporarily suspending iron. Inflammation without infection needs clinical assessment rather than an automatic infection diagnosis.
Monitoring during iron treatment	Hb, ferritin, TSAT every 3 months in non-dialysis CKD/PD; every 1–3 months in HD, often monthly. Test sooner after blood loss, hospitalization, ESA escalation, or rapidly changing iron indices.

Before acting

Confirm anemia and evaluate symptoms, bleeding, infection, iron exposure, and reversible causes. Ferritin can rise with inflammation. A high ferritin alone does not establish iron overload. Respect formulation-specific dose and infusion limits.

Source: KDIGO 2026 Anemia in CKD, Kidney International 109 (Suppl 1S), S1–S99. renalcarematters.com · Reviewed November 6, 2026.

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ESA review and monthly HD checklist

Adult clinical reference · Use clinical judgment and the locally approved product label

Decision	KDIGO 2026 guidance
Adult HD or PD: consider initiation	After reversible causes are addressed, consider ESA when Hb is ≤9–10 g/dL. Select the threshold within that range using symptoms, risks, and patient preferences.
Non-dialysis CKD, including transplant recipients	Individualize initiation using symptoms, potential benefit, transfusion avoidance, ESA risks, and preferences; Hb <10 alone is not an automatic start order.
Adult maintenance goal	Target Hb **below 11.5 g/dL (115 g/L)**, individualized. A common working range is about 10 to <11.5 g/dL; this is not an anemia diagnostic range.
Dose changes	Use the lowest effective dose. Generally avoid adjustments more often than every 4 weeks. If Hb rises >1 g/dL in 2–4 weeks, reduce by 25–50%. Prefer reduction to holding while Hb does not exceed 11.5, as clinically appropriate.
Monitoring	Hb every 2–4 weeks after initiation or adjustment; at least every 3 months during maintenance, usually more often in HD.
Stroke, thrombosis, and cancer	Consider suspending ESA during hospitalization for acute stroke, vascular access thrombosis, or thromboembolism. Active or previous cancer calls for shared decision-making, especially when treatment aims at cure. Uncontrolled hypertension and product-specific contraindications require review.

Record at the review

Date: _____ Patient: _____ Symptoms / bleeding / infection: _____

Hb: _____ g/dL Previous Hb/date: _____ TSAT: _____ % Ferritin: _____ ng/mL

ESA / native dose / interval: _____ Last change: _____ Iron formulation / exposure: _____

BP / dialysis adequacy / nutrition / reversible causes: _____

Plan, reason, and next laboratory review: _____

Additional safeguards

Trend ERI; no universal KDIGO cutoff of 10 or 14. Do not combine ESA and HIF-PHI. HIF-PHI trials in hyporesponsiveness require discussion of limited evidence and discontinuation after 3–4 months without the desired response. For chronic CKD anemia, transfusion decisions are based on symptoms and signs rather than an arbitrary Hb threshold.

Source: KDIGO 2026 Anemia in CKD, Kidney International 109 (Suppl 1S), S1–S99. renalcarematters.com · Reviewed November 6, 2026.