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What ASCO's first ctDNA guideline means for lymphoma

By Emily Hayes

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Pathways & Perspectives

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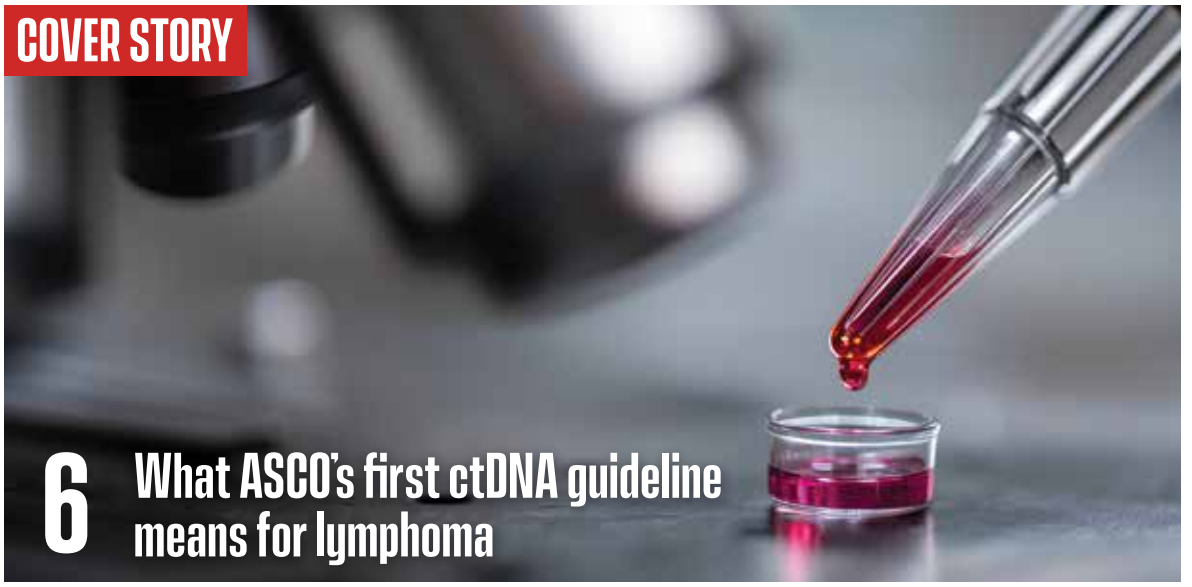

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Meet SOHO 2026 YIP recipient: Maria Felix Torres, MD

For Maria Felix Torres, MD, the path to treating blood cancers began far from where she is training today. Originally from a small bay town in northern Peru, she knew from an early age that she wanted to become a physician and work closely with patients. After earning her medical degree in Lima, she moved to the United States, where she is now beginning her third year of internal medicine residency at Jacobi Medical Center/Albert Einstein College of Medicine in New York. Although she initially envisioned a career in general oncology, her interest in hematologic malignancies grew after caring for patients in Peru.

All photos courtesy of Dr. Torres.

"I had the chance to work in Peru as a general physician on an inpatient malignant hematology service," she explained. "That gave me the opportunity of taking care of patients undergoing chemotherapy and managing treatment-related complications." During her residency in the United States, Dr. Torres became even more intrigued by the field.

"I was able to see the impact of new therapies and how research is helping people have better access to treatment and better outcomes," she said. "I also had the chance to do electives in bone marrow transplantation, which is another area that I'm very interested in."

This year will be Dr. Torres' first time attending the SOHO Annual Meeting, an opportunity made possible through the SOHO Young Investigator Program.

"I wasn't able to attend last year," she said. "Having the opportunity to do it now through the [YIP] scholarship alongside my research is something that I really look forward to."

Of the mentors who have shaped her career, Dr. Torres pointed to Jean Bustamante, MD, MS, an oncologist at Jacobi Medical Center/Albert Einstein College of Medicine, with whom she works closely caring for patients and has collaborated on research projects. (Dr. Bustamante is the program director of the hematology-oncology fellowship program at Jacobi.)

She also credits Adam Burgoyne, MD, PhD, an associate clinical professor of medicine at the University of California, San Diego, with teaching her the importance of research in advancing cancer care and communicating complex science clearly. Dr. Burgoyne treats gastrointestinal and hepatobiliary cancers.

"He taught me how research and different treatment options can improve patient outcomes," she explained. "At the same time, he taught me how to translate the science to make it real and understandable for patients, so that they're able to ask as many questions as possible."

In her personal life, Dr. Torres enjoys exploring New York City on foot, especially walks through Central Park. She also takes salsa and traditional Peruvian dance classes whenever she can and enjoys cooking, which she says helps her relax after busy days.

Pathways & Perspectives with William Wierda, MD, PhD

In this interview, Dr. Wierda, a professor of medicine and center medical director for the Department of Leukemia at the University of Texas MD Anderson Cancer Center, discusses how his doctoral research sharpened his critical thinking skills. Outside of work, he enjoys restoring the historic Houston home that once belonged to MD Anderson himself.

By Leah Sherwood

> We've made tremendous breakthroughs in therapies over the last decade. It has reached the point where most patients diagnosed with CLL will have a normal lifespan, even if they require treatment.

William Wierda, MD, PhD, is a professor of medicine and center medical director for the Department of Leukemia, Division of Cancer Medicine at The University of Texas MD Anderson Cancer Center. For the past 25 years he has focused on CLL research and treatment.

Where did you grow up, and when did you decide you wanted to become a clinician?

I grew up in a Southern California suburb called La Crescenta. I lived there until I went to college. It was a very small, middle-class, homogeneous suburb.

Since I was a kid, as early as I can remember, I was interested in becoming either a doctor, a lawyer, or a teacher. When I was in high school, I volunteered in a local emergency room, which is where I became more interested in medicine and decided I wanted to go to medical school. I attended a premed program at UC Riverside, a city halfway between Los Angeles and Palm Springs in the Southern California desert. After graduating, I moved to Chicago for medical school, where I completed an MD-PhD program in microbiology and immunology and earned my medical degree in 1993.

It was during my time at Riverside that I became interested in immunology. I worked in the lab of an immunologist named Carl Ware, volunteering and learning more about the field. That experience led me to pursue an MD-PhD with a focus in microbiology and immunology.

I was interested in cancer and in the idea of using the immune system to treat it. From early on, I knew I wanted to be a physician-scientist. I did a lot of lab work as an undergraduate and as an MD-PhD student.

After medical school, I completed an internal medicine residency at Duke. I then went to UC San Diego for a hematology-oncology fellowship, where I worked in Tom Kipps's lab. My interest in chronic lymphocytic leukemia developed through my work with Tom, and that has been the focus of my career ever since.

After my fellowship, I spent two years as an instructor at UC San Diego before being recruited to MD Anderson in Houston. I've been at MD Anderson for 25 years and have worked in a variety of areas in CLL treatment development.

What interested you in CLL?

It was the work that I did with Tom Kipps, who is an immunologist and physician-scientist. The immune system in patients with CLL is abnormal because of the presence of the CLL cells. That was where my interest was piqued, because there were unusual features about the disease from an immunological perspective and a unique opportunity to study the immune system.

I was interested in B cells and B-cell biology. My doctoral work was in natural killer cells, and I had interest in recruiting those as cancer therapeutic tools. For the CLL aspect of it, when I was with Tom Kipps, I worked on a vaccine for CLL, which was developed by Tom in his lab. It was based on an immune trigger to stimulate an immune reaction against the CLL cells. That was where my interest in CLL's uniqueness and the therapeutic opportunities started and grew.

Who were your mentors and how did they help shape your career?
Tom Kipps continues to have a significant impact on my work in CLL, and we continue to collaborate. Michael Keating and Susan O'Brien also influenced me.

At MD Anderson, my mentors included Hagop Kantarjian, whom I've worked with closely for many years, and Emil Freireich, the father of the leukemia program at MD Anderson. He was a giant in cancer care and leukemia care and a truly impressive person.

MD Anderson has been a wonderful environment for drug and therapeutic development. It's a unique institution because it's large enough to allow faculty to focus on a single disease. That ability to specialize leads to a deep understanding of the disease and puts people in a strong position to develop new treatments and conduct clinical research. You don't see that in many other places.

It's a unique feature of MD Anderson because of its size. There's a critical mass of people with shared expertise, and our leukemia program has grown tremendously over the years. Even when it was smaller, it was a fertile environment for discovery and collaboration, and it's been a wonderful place to work.

How did your doctoral research shape your approach to medicine?
As a clinician, it gave me a broader perspective and a deeper understanding of biology. It also taught me a different way to approach and think about problems. Clinicians are trained to think differently than scientists, who develop hypotheses, generate new data in the laboratory, and consider alternative explanations.

The PhD training strengthened my critical thinking and hypothesis generation while giving me a deeper understanding of biology. That has been invaluable throughout my career.

It is often said that CLL is now a chronic disease. Because of this label, some might feel it is a field that is no longer worth pursuing. What are your thoughts on where CLL research stands today, and what is the next major challenge that needs to be solved for patients?
You're completely correct in the sense that the sentiment has shifted about the work being done in CLL because we've made tremendous breakthroughs in therapies over the last decade. It has reached the point where most patients diagnosed with CLL will have a normal lifespan, even if they require treatment.

When you think about cancer more broadly, there are other diseases with a greater need for breakthroughs, such as lung cancer, pancreatic cancer, and acute myeloid leukemia. We've made tremendous progress in CLL. However, there are still important unmet needs.

One is Richter's transformation, where CLL transforms into a much more aggressive disease that patients can die from. We still don't have a good understanding of why it happens in some individuals and not others, and we haven't made as much progress as we'd like in developing therapies for patients with Richter's transformation. It affects a relatively small proportion of patients today, but it remains a significant unmet need.

I mentioned that CLL is an interesting disease from an immunological perspective. Patients have an impaired immune system simply because they have CLL, and that immune deficiency doesn't go away even when they achieve a deep remission. It increases their risk of infections and secondary cancers. Another major unmet need is understanding the mechanisms behind that immune deficiency and developing strategies to restore normal immune function. We now have highly effective treatments that can put the disease into remission. The next challenge is figuring out how to repair the immune system so patients are no longer at increased risk for infections and other cancers. That's an area I'm focused on now.

Finally, we've been very successful in developing therapies. Most patients achieve deep remissions that can last for many years, but those treatments are not yet considered curative. One of the last major hurdles in CLL is achieving a true cure by eliminating all of the leukemia cells so the disease never returns. That's another area I'm interested in, particularly developing vaccine strategies and other immune-based treatments that could eliminate the remaining disease.

So, there are still important unmet needs in CLL, although the urgency is not what it was in the past or what it is today for cancers such as AML.

Are CLL patients today relatively able to go about their daily lives and function normally while undergoing treatment?
Yes, our treatments are extremely effective, and they're extremely well tolerated. We've virtually eliminated chemotherapy for treatment of CLL. Most of the treatments that we use are oral agents. Sometimes we'll add an IV medication. Patients can go about their normal activities. Those who work continue to work and their lifestyle is not significantly impacted by treatment.

What are your favorite hobbies and interests outside of work?
A fun fact: I bought a house about six or seven years ago near Rice University. The house was built in 1934, and it was the home of MD Anderson himself before he died. Working on the house and the yard has become my newest hobby.

My other hobby is my dogs, Chloe and Hope. I'm particularly interested in working with Hope's breed. She's a Barbet, a rare French water dog. I've become involved with the Barbet Club of America and enjoy learning more about the breed.

I love to fish and take every opportunity I can to get out on the water. I used to ski more, but I don't as much these days because I'm getting older and don't want to put myself out of commission.

I also listen to a lot of music and enjoy spending time with family. I don't have children of my own, but I've always been close to my nieces and nephews. My nephew and his wife live down the street with their two-and-a-half-year-old daughter, and they recently welcomed a baby boy. I'm the on-call babysitter, so we spend a lot of time together.

If you could have dinner with any scientist living or deceased, who would it be?
I would like to meet and talk to Einstein.

This interview has been edited for length and clarity.

What ASCO's first ctDNA guideline means for lymphoma

By Emily Hayes

The new circulating tumor DNA guideline from the American Society of Clinical Oncology sets a basic framework for testing in lymphoma, though it is short on details for this group of malignancies.

ASCO's first guideline on ctDNA testing in solid tumors and lymphoma was published by **Christina Lockwood, PhD**, head of the Genetics and Solid Tumors Laboratory at the University of Washington Medical Center, in the Journal of Clinical Oncology in June.

The guideline doesn't include any commentary on lymphomas and there are no lymphoma studies listed in tables of meta-analyses in the JCO paper.

Rena Xian, MD

Photo courtesy of Jon Christofersen, MA, Director of Photography, Digital Imaging and Computer Graphics Laboratory, Johns Hopkins Medicine.

Lymphoma was included in the guideline with solid tumors because it typically presents as masses in lymph nodes or other tissues, explained hematopathologist and guideline co-author **Rena Xian, MD**, in an interview. And unlike leukemia, it doesn't typically present with circulating malignant cells, so disease has traditionally been evaluated and monitored with imaging studies, not blood tests.

Currently, the main way to evaluate treatment response in lymphoma and many solid tumors is with CT or PET/CT imaging, and ctDNA has potential to add to that information, especially in the post-treatment setting, to understand disease control, said Dr. Xian, who is an associate professor of pathology and oncology at the Johns Hopkins University School of Medicine.

Among other key findings, a panel assembled by ASCO to create the guideline recommended ctDNA testing for genetic alterations in cases where tumor tissue testing is not possible.

"Clinical judgment is crucial in determining when tumor biopsy is too challenging to perform immediately, or is unfeasible, or presents a risk that is unacceptable to the clinician or the patient," Lockwood and colleagues advised.

The guideline was released now in response to the "tremendous" increase of published data on ctDNA testing in recent years — yet with all of that information there are still many uncertainties and controversies about how to best use ctDNA in clinical practice, the authors explained.

To develop the guideline, ASCO assembled an expert panel that conducted a systematic review of literature published from January 2017 to February 2025, ultimately basing the guideline recommendations on 54 meta-analyses and 22 study reports. Seven randomized trials were included in the review. The panel included representatives of patients, community oncology, the College of American Pathologists and the Association for Molecular Pathology.

The panel also considered findings from a prior review of the literature on ctDNA

ASCO guideline recommendations for ctDNA testing

RECOMMENDATION	
1	Outside of a clinical trial, ctDNA testing should only be offered if the results of testing could be applied to clinical decision making.
2	Testing for tumor genetic alterations is reasonable and appropriate for a first assessment, replacement, or as additional testing to tissue-based testing in these situations: • Tissue testing is challenging, not feasible, or too risky for the patient. • Tissue testing is not available in time to guide management. • A drug's approved indication allows for or requires ctDNA testing.
3	Other than testing for tumor genetic alterations, ctDNA testing may be offered with standard-of-care testing and procedures if a specific, evidence-based action can be taken with the results, or it could help resolve a conflict or ambiguity with standard-of-care assessments.
4	CTDNA testing is not recommended as a replacement for any other form of testing, except as noted in Recommendations 2 and 3.
5	Fractional, percentage, or concentration-based measures of ctDNA or total cfDNA concentration are not recommended as a surrogate measure of disease burden to make treatment decisions outside of clinical research.

Source: Adapted from Lockwood et al, JCO

testing by ASCO and CAP. Summarizing those findings in the JCO in 2018, **Jason Merker, MD, PhD**, and colleagues had flagged the lack of evidence for "the majority of ctDNA assays in advanced cancer."

"There is no evidence of clinical utility and little evidence of clinical validity of ctDNA assays in early-stage cancer, treatment monitoring, or residual disease detection," the review authors concluded in 2018.

The fact that ASCO as an organization is now saying ctDNA can be used as the first assessment or replacement when tissue testing is not available, though with caveats, is a big change from that prior assessment, Dr. Xian noted.


Apostolia Tsimberidou, MD

The field has evolved and the ability to analyze hundreds of genes from a blood sample has fueled growing interest in ctDNA testing among patients and oncologists and created a need for a guideline to streamline practice, commented **Apostolia Tsimberidou, MD**, an expert oncologist at the University of Texas MD Anderson Cancer Center and a panelist for both reviews.

"On one hand, we want to streamline it and make sure it [ctDNA testing] is used as indicated," Dr. Tsimberidou said in an interview. "On the other hand, it is important for all patients to have access."

The recommendations are more focused on ctDNA testing to identify tumor genetic alterations. However, the language in Recommendation 3 leaves room for clinicians to use ctDNA testing in other areas when "clear evidence of clinical utility is available." Also, the authors acknowledged the need for updates.

"The panel recognizes this is a rapidly evolving field and guidelines are anticipated to change, bringing in tumor-type specific recommendations and incorporating more data on molecular residual disease settings," Dr. Lockwood and colleagues wrote.

In lymphoma today, there is a lot of interest in testing to see if patients get to the state where molecular residual disease is undetectable, in order to predict long-term remission and to follow patients after


Timothy Voorhees, MD

chemotherapy for early detection of relapse, commented **Timothy Voorhees, MD**, a lymphoma expert at the Ohio State University Comprehensive Cancer Center.

New data is becoming available all the time in different areas, including the emerging use of MRD testing after CAR-T cell therapy.

"I think we've clearly seen that obtaining an MRD-undetectable state after CAR-T cell therapy is very important to long-term outcomes," said Dr. Voorhees, who was not involved in the ASCO guideline development.

Many trials are looking at how patients with low positive MRD results would benefit from alternative additional therapies, even in the absence of a biopsy proven relapse, Dr. Voorhees said. However, while ctDNA shows promise for detecting residual disease, it's crucial to get to a point of high confidence in MRD assays before they could replace biopsy, because many things can mimic lymphoma recurrence, he added.

The guideline authors found that ctDNA testing may have clinical validity in predicting the risk of or detecting relapse, recurrence, or progression, but the prospective evidence for ctDNA testing as a replacement or way to augment standard-of-care testing strategies for monitoring or surveillance is lacking.

"Without such evidence, the true benefit of ctDNA is highly uncertain, and there is the potential for harm in unfounded patient anxiety in response to false-positive results or inappropriate reassurance and potentially changes in surveillance in response to false-negative results," Dr. Lockwood and colleagues wrote. "CtDNA testing cannot be recommended generally or, at this time, in any specific context for recurrence monitoring."

The guideline is evidence-based and the research in lymphoma is ongoing—interventional studies are needed to broaden recommended uses of ctDNA testing. Currently, ctDNA is used more for peace of mind as opposed to contributing to management, but Dr. Xian expects that in the coming years, it will see greater use in assessing treatment response and guiding subsequent therapy.

In early 2025, the National Comprehensive Cancer Network guidelines were updated to include ctDNA MRD testing as an alternative to biopsy for evaluating PET-positive results in patients with diffuse large B-cell lymphoma.

Some AIDS Malignancy Consortium studies are assessing how ctDNA results correlate with outcomes in treatment of HIV-associated lymphomas, noted Dr. Xian.

Dr. Voorhees commented that clinical trials are increasingly incorporating MRD into their design, using MRD status to identify patients for different treatment strategies. Patients who achieve undetectable MRD after treatment may benefit from less intensive therapy while those who remain MRD positive could be directed to alternative approaches.

While interest in applications is growing, a number of important variables have not been standardized, making it hard to compare clinical trial results. Some groups run a ctDNA blood test paired with imaging after the second cycle of therapy, while others are testing at the end of therapy.

"There are a lot of different timepoints and none of that is standardized," Dr. Xian said.

The literature search cutoff date for the 2026 ASCO guideline was February 2025 so there is already a year and a half's worth of new data available. Guidance is needed on what group of biomarkers to look for, how to define MRD, and the intervals for testing, Dr. Xian suggested. It would also be helpful to have guidance on what sensitivity you need in an assay and how to manage positive or negative signals on ctDNA tests.

"As a lab director who administers and offers these tests clinically, I would love to know what is most clinically relevant," Dr. Xian said.

Emily Hayes is a contributing writer for SOHO Insider.

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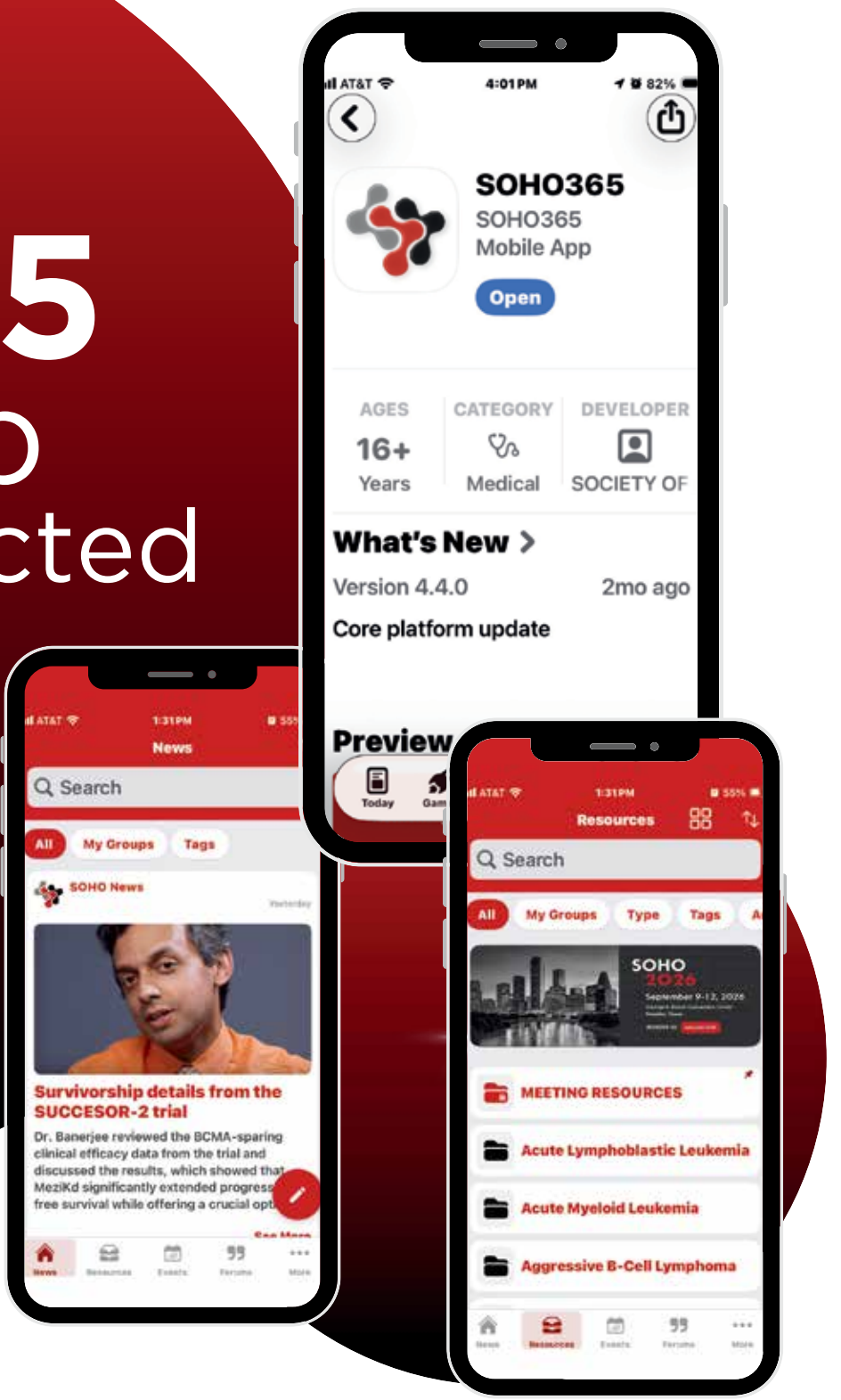

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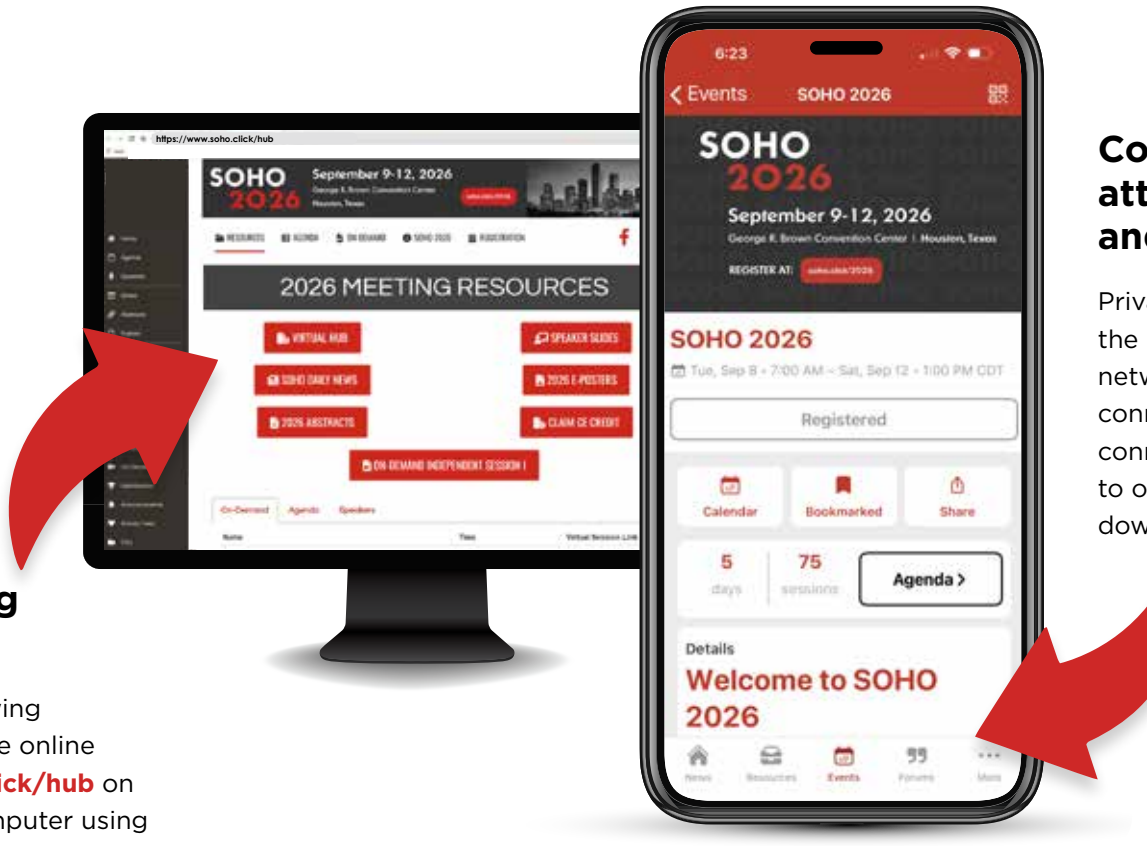

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Tracking regulatory news worldwide

FDA accepts NDA for mezigdomide combo in relapsed or refractory myeloma

The US Food and Drug Administration has accepted a new drug application for mezigdomide in combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma.

The decision was based on results from the phase 3 SUCCESSOR-2 trial that evaluated mezigdomide, an oral cereblon E3 ligase modulator, or CELMoD, in combination with carfilzomib and dexamethasone versus carfilzomib and dexamethasone alone in patients with relapsed or refractory multiple myeloma. The trial details were published in The Lancet in June 2026.

CELMoDs are a new distinct drug class that have transformed myeloma, according to Paul G. Richardson, MD, a principal investigator on the SUCCESSOR-2 trial.

“I think it’s important for our audience to understand that they are quite distinct as a class from the original IMiDs, which have transformed myeloma management over the last three decades,” he said in a roundtable discussion on the topic.

The FDA has a set a target decision date of May 13, 2027 for this indication, according to the therapy’s manufacturer Bristol-Myers Squibb.

EC grants marketing authorization to epcoritamab combo in second-line FL

The European Commission has granted marketing authorization to epcoritamab (TEPKINLY®) in combination with rituximab and lenalidomide (R2) for the treatment of relapsed or refractory follicular lymphoma in the second-line setting.

The marketing authorization was granted based on the phase 3 EPCORE FL-1 trial, a randomized, open-label trial that evaluated the triplet against R2 alone in patients with relapsed or refractory FL. The study demonstrated epcoritamab + R2 reduced the risk of disease progression or death by 79% (HR, 0.21; 95% CI, 0.13 – 0.33; P<0.0001) compared with R2 alone, according to a press release from AbbVie, the manufacturer. The company reported that the most common (≥ 20%) adverse reactions included neutropenia, rash, upper respiratory tract infections, and cytokine release syndrome. Serious adverse reactions occurred in 44% of patients, according to the company, and in ≥ 5% of patients those included CRS, pneumonia, COVID-19, and febrile neutropenia.

“Follicular lymphoma is a persistent form of cancer that remains incurable, which means patients need more treatment options. Patients often relapse and experience shorter remissions and have fewer treatment options each time the disease returns,” said Catherine Thieblemont, MD, PhD, head of the hemato-oncology department at Paris Cité University, Hôpital Saint-Louis Assistance-Publique-Hopitaux de Paris. “The results shown in the EPCORE FL-1 trial are clinically meaningful, demonstrating the potential for TEPKINLY + R2 to change the treatment paradigm for patients, offering the chance at a durable response with a chemotherapy-free option.”

The triplet regimen was approved by the FDA in 2025.

FDA approves ropeginterferon alfa-2b-njft pen for polycythemia vera

The FDA has approved and launched a new prefilled pen device for ropeginterferon alfa-2b-njft (BESREMi Pen) for adult patients with polycythemia vera, according to PharmaEssentia, the manufacturer.

The pen offers a more convenient self-administration option than the currently available prefilled syringe and is expected to become commercially available in the United States in the coming weeks, according to a press release by PharmaEssentia.

“The US approval of the BESREMi Pen™ is a significant milestone both for our company, as well as the patients we serve,” said Samuel Lin, Head of Global Operations at PharmaEssentia. “With this new device, we’re empowering more people living with PV to manage their condition with greater ease and confidence. It reflects our continued commitment to delivering not only innovative therapeutics, but also smarter, more intuitive ways to support long-term care.”

In June, the company announced that the Taiwan Ministry of Health and Welfare granted the drug its first global approval in a different indication: adult patients with essential thrombocythemia.

Taiwan regulatory body approves ropeginterferon alfa-2b-njft in ET

Taiwan’s Ministry of Health and Welfare has approved ropeginterferon alfa-2b-njft (BESREMi) for adult patients with essential thrombocythemia, according to PharmaEssentia, the manufacturer of the drug.

The company reported that this is the first global approval of ropeginterferon alfa-2b-njft in this indication and represents the first new therapy approved for ET in nearly three decades.

This decision by Taiwan’s regulatory agency was based on the phase 3 SURPASS-ET clinical trial. The data showed ropeginterferon alfa-2b-njft achieved superior durable response rates compared to standard treatments in high-risk patients, and it has been added to the National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology for the treatment of ET, Pharma Essentia reported.

“This first global approval of BESREMi® in ET represents an important strategic milestone for PharmaEssentia and further strengthens the Company’s leadership position in myeloproliferative neoplasms,” said Ko-Chung Lin, PhD, founder and CEO of PharmaEssentia. “We believe ET represents a major long-term growth opportunity for BESREMi® and has the

potential to significantly expand the reach of the Company's hematology franchise globally. This approval also advances our broader strategy to expand the global BESREMi® franchise as we continue preparations for a potential US approval and commercial launch in ET later this year."

The FDA is currently reviewing a Supplemental Biologics License Application for the therapy, with a regulatory target action date set for late August 2026.

The treatment holds Orphan Drug status in the US for the treatment of polycythemia vera in adult patients. Ropeginterferon alfa-2b-njft has received regulatory approval in over 40 countries, including from the European Medicines Agency (2019), the FDA (2021), and the Pharmaceuticals and Medical Devices Agency in Japan (2023).

FDA accepts sBLA for mosunetuzumab and polatuzumab vedotin combo in relapsed or refractory large B-cell lymphoma

The FDA has accepted a sBLA for mosunetuzumab (Lunsumio VELO) in combination with polatuzumab vedotin (Polivy) to treat adults with relapsed or refractory large B-cell lymphoma who have received at least one prior systemic therapy.

The submission is supported by findings from the phase 3 SUNMO trial evaluating the subcutaneous formulation of mosunetuzumab alongside intravenous polatuzumab vedotin for patients who are ineligible for an autologous stem cell transplant.

Mosunetuzumab is a bispecific antibody designed to target CD20 and CD3, while polatuzumab vedotin is an antibody-drug conjugate that targets CD79b to deliver a cytotoxic agent directly into lymphoma cells.

According to a press release by Roche, the manufacturer of the drug, this investigational combination reduced the risk of disease progression or death and prolonged progression-free survival compared to a standard regimen of rituximab, gemcitabine, and oxaliplatin.

The FDA is anticipated to issue an approval decision by February 9, 2027.

China NMPA grants accelerated approval to rocbrutinib for relapsed or refractory mantle cell lymphoma

China's National Medical Products Administration has granted accelerated approval to rocbrutinib in adult patients with relapsed or refractory mantle cell lymphoma. Eligible patients must have received at least two prior systemic therapies, including a bruton tyrosine kinase inhibitor.

As a fourth-generation inhibitor, the drug utilizes a dual covalent and non-covalent mechanism to target resistant mutations and overcome acquired drug resistance, according to a press release by Lupeng Pharmaceutical, the manufacturer of the drug.

The NMPA approval was based on data from the phase 2 ROCK-1 study evaluating rocbrutinib monotherapy in patients with MCL who had relapsed or were refractory after prior treatment with covalent BTK inhibitors. As of June 5, 2025, clinical trial data showed an objective response rate of 63.9%, a complete response rate of 23%, and a median duration of response of 16.5 months.

In April 2026, the Chinese Society of Clinical Oncology Guidelines for the Diagnosis and Treatment of Lymphoma included rocbrutinib as a Category 2 recommendation for the treatment of MCL.

"The successful approval of rocbrutinib is a major milestone in Lupeng Pharmaceutical's development," Tan Fenlai, co-founder and CEO of Lupeng Pharmaceutical, stated in the release. "It will bring a new and effective treatment option to MCL patients who have experienced disease progression after earlier-generation BTK inhibitor therapy. Furthermore, it demonstrates Lupeng's global leadership in advancing BTK-targeted innovation. Going forward, we will continue to advance clinical studies of rocbrutinib in other indications, such as diffuse large B-cell lymphoma and chronic lymphocytic leukemia/small lymphocytic lymphoma, to help more patients with various hematologic malignancies."

In January 2026, a global phase 3 trial was initiated to evaluate rocbrutinib against the third-generation non-covalent BTK inhibitor pirtobrutinib in relapsed or refractory CLL/SLL.

FDA grants fast track designation to STX-0712 in relapsed or refractory CMML

The FDA has granted fast track designation to the investigational therapy STX-0712 for the treatment of patients with relapsed or refractory chronic myelomonocytic leukemia.

STX-0712 is a CyTAC™ (cytotoxicity targeting chimera) targeting the CCR2 receptor, highly expressed on malignant monocytes and bone marrow blasts to selectively eliminate disease-driving cells, according to a press release by Solu Therapeutics, the manufacturer of the drug.

The company is also exploring the potential of the therapy in other hematologic malignancies, including acute myeloid leukemia.

A phase 1 open-label study evaluating the drug as a monotherapy is currently ongoing, with initial clinical data planned for submission to a hematology conference later this year, according to the press release.

Singapore's HSA approves NDA for CAR-T therapy eque-cel in relapsed or refractory myeloma

The Singapore Health Sciences Authority has approved the new drug application for equecabtagene autoleucel (FUCASO) for adult patients with relapsed or refractory multiple myeloma. The indication applies to patients who progressed on their last therapy and received at least three prior lines of treatment, including a proteasome inhibitor and an immunomodulatory agent, and have demonstrated disease progression.

According to a press release by the manufacturer of the drug, IASO Bio, the company plans to supply the therapy globally from its manufacturing infrastructure in China using an international cold-chain logistics network.

Eque-cel, an anti-BCMA CAR-T, has been approved in China for treating patients with relapsed or refractory myeloma who have progressed after at least three prior lines of treatment.

••• Continued on page 18

China NMPA approves supplemental application for generic denosumab

The NMPA of China has approved a supplemental application for Mabwell's denosumab injection (Maiweijian) for the treatment of patients with bone metastases from solid tumors or patients with multiple myeloma, to delay or reduce the risk of skeletal-related events (pathological fracture, spinal cord compression, bone radiotherapy, or bone surgery).

Developed by Mabwell's wholly owned subsidiary T-mab, this new clearance specifically covers the use of the drug in reducing severe skeletal-related complications such as spinal cord compression, bone surgery, fractures, and radiation.

Head-to-head trials published in the peer-reviewed medical journal JAMA Oncology have confirmed that the generic option matches the original drug's safety and efficacy profiles, according to a press release from the company.

Beyond its current distribution in China and Pakistan, the drug is now under regulatory review across more than 30 countries globally.

Tafasitamab combo approved in Japan for relapsed, refractory DLBCL

Japan's Ministry of Health, Labour and Welfare has approved tafasitamab (Minjuvi) in combination with lenalidomide for the treatment of adults with relapsed or refractory DBLCL, according to Incyte Biosciences Japan G.K, the manufacturer of the drug. The regulatory approval specifically targets patients who are ineligible for an autologous stem cell transplant.

The clinical approval was based on data from the international phase 2 L-MIND trial and the domestic phase 1b/2 J-MIND trial in Japan. In the international study, patients treated with the tafasitamab combination achieved an overall response rate of 58.8% with a 41.3% complete response rate, according to a press release from the company.

"This approval provides a new option for patients in Japan living with relapsed or refractory DLBCL, an aggressive disease with historically limited treatment options," said Yasuyuki Ishida, general manager at Incyte Biosciences Japan. "We are committed to helping address critical unmet needs for patients and their families affected by this challenging cancer."

The domestic Japanese study demonstrated an overall response rate of 71.4% and a 45.2% complete response rate, with the main adverse events reported across the clinical programs included neutropenia and thrombocytopenia.

This is the second approval for tafasitamab in Japan, following its previous approval for adult patients with relapsed or refractory follicular lymphoma.

CHMP recommends approval of isatuximab subcutaneous formulation for MM

The European Medicines Agency's Committee for Medicinal Products for Human Use has adopted a positive opinion recommending the approval of isatuximab (SARCLISA) subcutaneous formulation to treat patients with multiple myeloma. The recommendation covered all currently approved indications for the intravenous formulation in the European Union, including both newly diagnosed and relapsed or refractory disease.

If approved by the European Commission, isatuximab would be the first anticancer treatment administered through an on-body injector or manual injection. A regulatory submission for the subcutaneous formulation was also under review with the FDA.

The recommendation was based on results from the phase 3 IRAKLIA trial, which demonstrated that the subcutaneous formulation was noninferior to intravenous administration in patients with relapsed or refractory myeloma. Additional data from the phase 3 GMMG-HD8 study and the IZALCO and ISASOCUT phase 2 trials supported the comparable efficacy and safety profile of the treatment, according to the press release by Sanofi.

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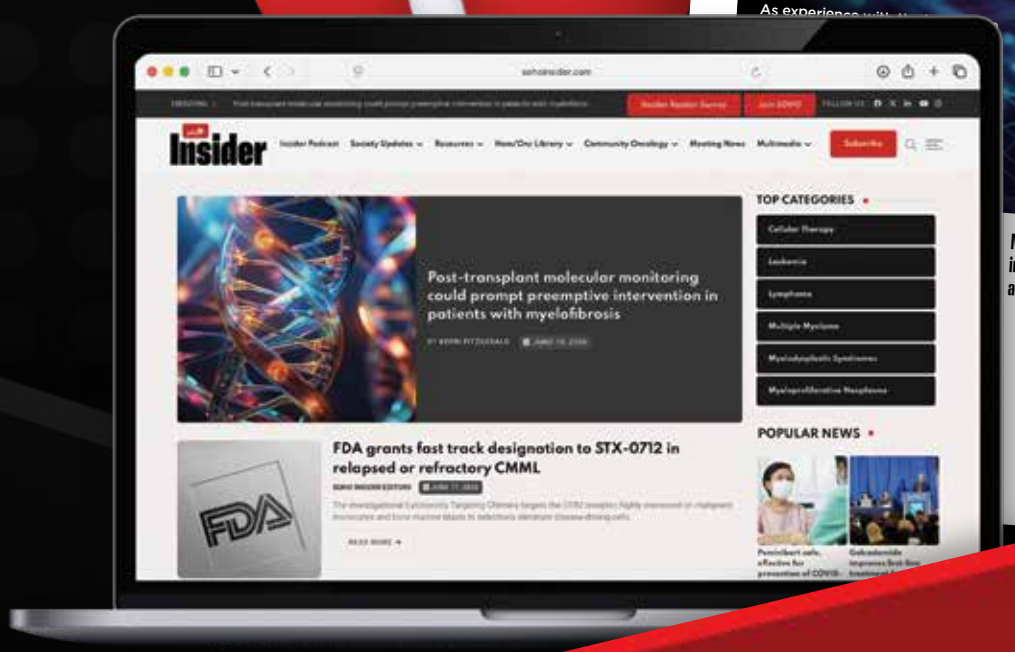

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News from the 31st Annual Congress of the European Hematology Association

Study identifies new standard of care for relapsed or refractory MM in the second line and beyond

BY KERRI FITZGERALD

Results from the MONUMENTAL-3 study showed that the combination of talquetamab and daratumumab with or without pomalidomide (Tal-DP/Tal-D) significantly improved survival compared with daratumumab, pomalidomide, and dexamethasone (DPd) in patients with relapsed or refractory multiple myeloma.

This "represents a new standard of care... as early as [second line] across all practice settings," according to **Peter Voorhees, MD**, of Atrium Health/Levine Cancer Institute, and colleagues who presented the findings at the 2026 EHA Congress.

The phase III study included 864 patients who were randomized to receive Tal-DP (n=287), Tal-D (n=387), or DPd (n=290); median age was 64 years, and patients had received a median of two prior lines of therapy.

At a median follow-up of 24.6 months, median progression-free survival (PFS) was significantly improved in the Tal-DP (hazard ratio [HR], 0.28; P<0.0001) and Tal-D (HR, 0.33; P<0.0001) cohorts compared with DPd. The 24-month PFS rates favored Tal-DP (81.3%) and Tal-D (77.6%) versus DPd (51.2%), and the PFS benefit was consistent across subgroups.

The overall response rate was higher in the Tal groups compared with DPd (88.2% and 88.5% vs 77.6%), and measurable residual disease-negative complete response rates or better were significantly higher with Tal-DP (52.3%) and Tal-D (46.3%) compared with DPd (15.9%).

Overall survival also favored the Tal-DP and Tal-D cohorts (HRs, 0.47 and 0.51, respectively).

More patients in the Tal cohorts remained on treatment at data cutoff: 70.3% Tal-DP, 69.7% Tal-D, and 47.3% DPd.

Overall grade 3/4 adverse event rates were 96.7% in the Tal-DP cohort, 78.8% in the Tal-D cohort, and 95.8% in the DPd cohort, with adverse events resulting in treatment discontinuation in 10.5%, 8.0%, and 6.7% of patients, respectively.

Infection rates were similar across the cohorts (87.3%, 84.3%, and 83.0%, respectively). Cytokine release syndrome occurred in 67.8% and 58.4% of Tal-DP and Tal-D patients, while immune effector cell-associated neurotoxicity syndrome occurred in 2.9% and 1.8%, respectively.

REFERENCE

Voorhees P, Mina R, Rodríguez-Otero P, et al. Phase 3, randomized study of talquetamab (TAL) plus daratumumab (DARA) ± pomalidomide (POM) vs DARA plus POM and dexamethasone (DPD) in relapsed/refractory multiple myeloma (RRMM): MONUMENTAL-3. Abstract #2503. Presented at the European Hematology Association 2026 Congress; June 11-14, 2026; Stockholm, Sweden.

Novel germline JAK2 mutation linked to progression to MF in MPN

BY PATRICK DALY

A study identified that the germline JAK2G127D mutation synergizes with the somatic JAK2V617F mutation to drive progression to myelofibrosis in patients with myeloproliferative neoplasms.. Additionally, the JAK2G127D and JAK2V617F mutation synergy significantly potentiated in vitro activation of the JAK-STAT signaling pathway.

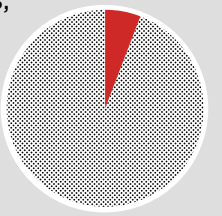
Yanjie Lan, MD, PhD, of the Second Hospital of Tianjin Medical University in China, presented the study at the 2026 EHA Congress in Stockholm, Sweden.

The analysis reviewed clinical data and samples from patients with MPN diagnosed at the authors' center from 2018 to 2025 to characterize the prevalence and impact of JAK2G127D mutations. Next-generation sequencing was used to detect genetic mutations in samples, and cell models were used to evaluate the functional impact of co-occurring mutations. Out of 249 samples positive for JAK2V617F mutations, 15 carried a concurrent JAK2G127D mutation. Notably, JAK2G127D mutations only co-occured with JAK2V617F mutations.

Out of 249 samples positive for JAK2V617F mutations,

15

carried a concurrent JAK2G127D mutation.



Compared with patients with only JAK2V617F mutation, those with concurrent JAK2V617F and JAK2G127D mutations had significantly shorter myelofibrosis-free survival outcomes (P=.0062) and significantly higher levels of transforming growth factor-beta. In addition, double-mutated patients with advanced disease had higher grades of myelofibrosis and higher JAK2V617F variant allele frequency.

The researchers modeled JAK2 wild type, JAK2V617F, JAK2G127D, and concurrent JAK2V617F and JAK2G127D, in Ba/F3 and 32D cells expressing erythropoietin receptors and found comutation enhanced cytokine-independent cellular proliferation and "markedly" activated the JAK2-STAT5 signaling pathway.

Dr. Lan and colleagues planned to develop a murine model to further investigate the functional role of JAK2G127D in patients with MPN.

REFERENCE

Lan Y, Zhang Y, Teng G, et al. A novel germline JAK2 mutation JAK2G127D cooperation with JAK2V617F to accelerate myelfibrosis progression in MPNS. Abstract #EHA-6219. Presented at the European Hematology Association 2026 Congress; June 11-14, 2026; Stockholm, Sweden.

MajesTEC-3 trial post-hoc analysis: Teclistamab regimen boosts survival across risk in myeloma

BY PATRICK DALY

Teclistamab plus daratumumab improved rates of progression-free survival and measurable residual disease –negative complete response for patients with relapsed or refractory multiple myeloma regardless of high-risk cytogenetic abnormalities (HRCAs) or functional high-risk (FHR) status, according to a post-hoc subgroup analysis of the MajesTEC-3 trial presented at the 2026 EHA Congress in Stockholm, Sweden.

The findings support teclistamab plus daratumumab as a steroid-sparing standard of care as early as first relapse, regardless of risk status, said presenting author **Rahul Banerjee, MD, FACP**, of Fred Hutchinson Cancer Center in Seattle, Washington.

The MajesTEC-3 trial compared teclistamab plus daratumumab with standard daratumumab plus dexamethasone and pomalidomide or bortezomib (DPd/DVd). In the previous primary analysis, teclistamab plus daratumumab met the primary PFS endpoints and all key secondary endpoints including CR or better, MRD negativity, and overall survival rates.

In the post-hoc analysis, the prespecified definition of high risk was one or more of the following HRCAs: t(4;14), t(14;16), or deletion 17p. The high risk definition was later revised to include two additional HRCAs: three copies of gain(1q21) or four or more copies of amp(1q21). FHR was defined as one prior line of therapy plus progressive disease within 18 months of autologous stem cell transplantation or start of initial therapy. The analysis reported on the following subgroups: prespecified standard-risk or high-risk; revised standard-risk or high-risk; one or two or more HRCAs, and FHR or non-FHR.

After a median follow-up of 34.5 months, teclistamab plus daratumumab had more favorable PFS and higher MRD-negative CR rates compared with DPd/DVd across all HRCA and FHR subgroups. Specifically, the estimated 36-month PFS rates for teclistamab plus daratumumab versus DPd/DVd were 87.4% versus 37.1% in prespecified standard-risk patients and 77.7% versus 11.5% in high-risk patients, respectively. In the FHR subgroup, estimated 36-month PFS rates were 77.3% with teclistamab plus daratumumab versus 0% with DPd/DVd (HR, 0.22; 95% CI, 0.08-0.62). Teclistamab plus daratumumab was also favored versus DPd/DVd in patients with one prior line of therapy without FHR status.

The post-hoc analysis findings build on the positive results from the primary MajesTEC-3 analysis and support that teclistamab plus daratumumab attenuate the poor prognosis associated with high-risk relapsed or refractory multiple myeloma, Dr. Banerjee and colleagues wrote.

Nanobody-based anti-CD5 CAR T agent improves efficacy in relapsed or refractory T-cell ALL

BY PATRICK DALY

A novel alpaca-derived, nanobody-based, anti-CD5 bispecific epitope CAR T-cell vector showed excellent antigen specificity, cytotoxicity, and efficacy for patients with relapsed or refractory T-cell acute lymphoblastic leukemia (ALL), according to preclinical and phase 1/2 data presented at the 2026 EHA Congress in Stockholm, Sweden.

The nanobody-based CD5 CAR T-cells had superior antigen-dependent activation compared with humanized CD5 CAR T-cells, said lead author, **Jing Pan, MD, PhD**, of the Chinese Academy of Medical Sciences and Peking Union Medical College in Tianjin, China.

The researchers constructed the CD5 CAR T-cell vector using a 15 kDa alpaca VHH antibody to improve T-cell expansion compared with their previous humanized CD5 CAR T-cell construct.

After successful preclinical in vitro and murine model evaluation, the nanobody-based CD5 CAR T-cell was trialed in six patients with relapsed or refractory T-cell ALL, four of whom were refractory to prior anti-CD7 CAR T-cell therapy.

Adverse events within 30 days included grade 1 cytokine release syndrome in all six patients, grade 2 immune effector cell-associated neurotoxicity syndrome in 1 patient, and grade 1 to 2 graft-versus-host disease in two patients. All patients achieved complete remission by day 30, and by day 90, five patients had continued to allogeneic stem cell transplantation and four patients had negative measurable residual disease. One patient had CD5–diminished relapse at day 88 and another had CD5–negative relapse at day 45 and died on day 51. The peak expansion of CAR T-cells was at day 10 (range, 7-21).

The trial was ongoing, and would generate further data on long-term efficacy, safety, and immune reconstitution, wrote Dr. Pan and colleagues.

News from the 2026 ASCO Annual Meeting

Pemivibart safe, effective for prevention of COVID-19 in immunocompromised cancer patients

BY LEAH SHERWOOD

Treatment with the long-acting monoclonal antibody pemivibart for the prevention of COVID-19 was well tolerated and was associated with no development of symptomatic COVID-19 in the Cohort A oncology subset of the phase 3 CANOPY trial, according to a post hoc analysis.

The results were presented in a poster session at the 2026 ASCO Annual Meeting in Chicago.

The study assessed the safety and outcomes of pemivibart in the oncology subset from the open-label, single-arm, immunocompromised Cohort A of the phase 3 CANOPY trial. The oncology subset included 55 Cohort A participants (18.0% of 306 Cohort A participants).

Among the oncology subset, 40 (73%) had a hematologic malignancy, and 20 (36%) were being actively treated for a solid tumor or hematologic malignancy. Eight participants (14.5%) were receiving immunosuppressants, including 6 (10.9%) receiving corticosteroids.

All Cohort A participants were dosed with 4500 mg of pemivibart (intravenous) on day 1, with a second dose at month 3. Data were analyzed through month 6.

Pemivibart was well tolerated in the CANOPY Cohort A oncology subset. Serious adverse events occurred in 5 (9.1%) participants, with none considered drug-related. No anaphylaxis was reported.

Following pemivibart dosing, sVNA titers in the oncology subset were elevated to levels associated with protection against COVID-19. Through month 6, there was no RT-PCR-confirmed symptomatic COVID-19 in the oncology subset.

The study was funded by Invivyd, Inc.

Frontline tafasitamab, lenalidomide plus R-CHOP improves outcomes in B-cell lymphomas

BY PATRICK DALY

Tafasitamab plus lenalidomide plus R-CHOP (Tafa-Len-R-CHOP) improved progression-free survival (PFS) compared with R-CHOP alone and had manageable safety for patients with aggressive B-cell lymphomas in the phase 3 frontMIND study, according to a presentation at the 2026 ASCO Annual Meeting.

The frontMIND trial enrolled patients with newly diagnosed, high-intermediate or high risk diffuse large B-cell lymphoma or high-grade B-cell lymphoma. In the overall population of 899 patients, after a median follow-up of 35.2 months, Tafa-Len-R-CHOP significantly improved PFS compared with R-CHOP (hazard ratio [HR], 0.75; 95% CI, 0.59-0.96; P=.019). Tafa-Len-R-CHOP also improved PFS outcomes versus R-CHOP in the subset of 773 patients with centrally confirmed lymphoma subtypes with 24-month PFS rates of 72.7% versus 62.2% (HR, 0.68; 95% CI, 0.52-0.88), respectively. An interim overall survival analysis favored Tafa-Len-R-CHOP with a HR of 0.85.

Any-grade treatment-emergent adverse events occurred in 98.6% of the Tafa-Len-R-CHOP arm versus 97.1% of the R-CHOP arm. Grade 3 or higher TEAEs occurred in 86.7% of the Tafa-Len-R-CHOP arm versus 76.1% of the R-CHOP arm. Discontinuation due to TEAEs occurred in 25.7% of the Tafa-Len-R-CHOP arm versus 17.9% of the R-CHOP arm. Deaths due to TEAEs occurred in 5.9% of the Tafa-Len-R-CHOP arm versus 3.8% of the R-CHOP arm, however, there were fewer deaths overall with Tafa-Len-R-CHOP (18.5%) compared with R-CHOP (21.7%).

Tafa-Len-R-CHOP represents a potential new first-line standard of care for patients with high-risk DLBCL or high-grade B-cell lymphoma, regardless of cell of origin subtype, said first author **Georg Lenz, MD, PhD**, of University Hospital Münster in Germany.

Which AML patients get lasting benefit from olutasidenib?

BY EMILY HAYES

Participants with relapsed rather than refractory AML, as well as females, were more likely to get a durable response from the oral IDH1 inhibitor olutasidenib (Rezlidhia), according to a new analysis of pivotal trial data.

The drug was evaluated in a phase II registrational study in IDH1-mutated relapsed/refractory AML or myelodysplastic syndromes (NCT02719574). In the study, the complete remission (CR)/CR with partial hematologic recovery (CRh) rate was 35%, with a median CR/CRh duration of 25.9 months, supporting US approval in 2022.

In an analysis presented at ASCO 2026, **Justin Watts, MD**, of the University of Miami and colleagues explored what baseline factors, including sex, disease stage and molecular characteristics, were associated with longer-term responders who did not go on to receive a transplant.

Out of 147 evaluable patients in the registrational study, 51 had achieved CR/CRh, of which 26 responded for more than 12 months and did not get a transplant.

Researchers found that disease status at the time of enrollment (relapsed vs refractory) and sex (female) were associated with the likelihood of maintaining a benefit for more than 12 months in multivariable analyses (OR, 0.19 and OR, 0.21, respectively).

They did not find differences in the

likelihood to get a >12 month benefit based on the type of IDH1 variant, the presence of non-IDH1 mutations (eg, DNMT3A, NPM1), age, number of prior therapies or dependence on transfusions at baseline.

The longest response in the cohort of patients with Cr/CRh for more than 12 months without going on to transplant was 54 months, researchers reported.

REFERENCE

Watts J, Jonas B, Pigneux A, et al. Association of acute myeloid leukemia (AML) patient, disease, and molecular characteristics with a long-term (LT) response to olutasidenib. Abstract #6523. Presented at the 2026 ASCO Annual Meeting; May 29-June 2, 2026; Chicago.

Data support COVID-19 vaccination in patients receiving CAR-T therapy

BY EMILY HAYES

A retrospective analysis of real-world data is reassuring about the efficacy and safety of mRNA Covid-19 vaccines for patients with hematologic cancers on CAR-T therapy.

There have been concerns about whether vaccines work well in patients who have received CAR-T therapy and whether vaccination would increase the risk of cytokine release syndrome or other immune-related toxicities in this vulnerable population.

The study, which is being presented at the ASCO 2026 meeting, evaluated patient data via TriNetX, a global health research company.

Jowan Al-Nusair, MD, of Marshall University, and colleagues identified 3,199 patients with hematologic malignancies and who had received CAR-T therapy. Of these, 222 had also received an mRNA COVID-19 vaccine. Then they used propensity scoring to match the data by age, sex, race, staging, and comorbidities and wound up with two cohorts with 218 patients each to evaluate in the study.

The all cause three-year mortality rate was 39% lower for the cohort that got the mRNA vaccines (P=0.01). Researchers reported that the rate of Grade 1/2 cytokine CRS was higher in vaccinated patients (P=0.03), but they didn't have enough cases of Grade 3/4 events for the comparison. No significant difference was seen in immune effector cell-associated neurotoxicity syndrome between the two cohorts.

REFERENCE

Al-Nusair J, Elchouemi M, Eysha M, et al. Impact of mRNA SARS-CoV-2 vaccination on CAR T-cell therapy outcomes in hematologic malignancies: a multi-center real-world analysis. Abstract #11001. Presented at the 2026 ASCO Annual Meeting; May 29-June 2, 2026; Chicago.

Patients with myelofibrosis and anemia respond to antihemojuvelin drug

BY EMILY HAYES

The activity of DISC-0974, an investigational monoclonal antibody targeting hemojuvelin (HJV), in treating anemia in patients with myelofibrosis is being evaluated in an open label phase 2 study of patients with myelofibrosis and anemia.

The investigational drug blocks the expression of HJV in order to reduce hepcidin. It is in mid-stage development by Disc Medicine. Updated data from the phase 2 open label RALLY-MF study were presented at the EHA 2026 and ASCO 2026 meetings in June.

The study tested the drug in adults with primary or secondary MF with anemia serious enough to result in persistently low hemoglobin or the need for red blood cell transfusions. Participants were permitted to be on a Janus kinase (JAK) inhibitor, such as momelotinib (Ojjaara) or ruxolitinib (Jakafi).

As of January 2026, there were 54 participants — of which 31 completed treatment, 23 entered the continuation part of the study, and 6 withdrew. Withdrawals were not due to adverse events, Mayo Clinic's **Naseema Gangat, MBBS**, and colleagues reported.

The overall response rate was 70% and was consistent regardless of whether participants were also on a JAK inhibitor.

Researchers evaluated participants divided in three categories, based on anemia severity, and found the following response rates:

- Non-transfusion dependent: 15/28 (54%)
- Low transfusion requirement: 6/9 (67%)
- High transfusion requirement: 3/6 (50%)

As for safety, researchers reported 48 had at least one adverse event, of which 11 were determined to be related to the study drug. No serious adverse events were reported. The drug's manufacturer plans to share additional data later this year and to have a meeting with the U.S. Food and Drug Administration by end-2026.

REFERENCE

Gangat N, Tefferi A, Hexner E, et al. RALLY-MF: Initial efficacy of a phase 2 Study of DISCO-0974, an anti-hemojuvelin antibody, to treat anemia in myelofibrosis. Abstract# EHA-2314. Presented at the European Hematology Association annual meeting. June 11-14, 2026; Stockholm.

Anito-cel manufacturing builds on CAR T-cell learnings in multiple myeloma trials

BY PATRICK DALY

Anitocabtagene autoleucel (anito-cel), an anti-BCMA chimeric antigen receptor (CAR) T-cell therapy, was successfully manufactured for the majority of participants with relapsed or refractory or newly diagnosed multiple myeloma in the iMMagine-3 and GEM-AnitoFIRST trials, according to a poster presented at the 2026 ASCO Annual Meeting.

"The anito-cel CAR T-cell manufacturing process has been optimized by leveraging the learnings from the robust development process of another CAR T-cell therapy, axicabtagene ciloleucel (axi-cel)," said lead author, **Krina Patel, MD, MSc**, of the University of Texas MD Anderson Cancer Center in Houston.

The anito-cel analysis covered 104 patients enrolled and leukapheresed in iMMagine-3 or GEM-AnitoFirst from September 2024 to October 2025. Anito-cel lots were successfully manufactured for all patients, and 101 out of 102 lots were manufactured successfully on the first pass. The median turnaround time from leukapheresis to quality release of final anito-cel product for the 101 released lots was 18 days (interquartile range, 17-20).

"Our results demonstrate rapid and reliable anito-cel manufacturing for multiple myeloma clinical trials globally, with high manufacturing success rates and consistent turnaround times. These results were consistent with axi-cel manufacturing outcomes and highlight the importance of leveraging axi-cel manufacturing experience in the development of anito-cel," Dr. Patel and colleagues said.

2026 SOHO Brazil meeting attracts nearly 1,000 attendees

SOHO Brazil, also known as Sintoma, welcomed nearly 1,000 attendees this year. Phillip Scheinberg, MD, PhD, led the meeting and brought together hematology experts from across Brazil and beyond. Dr. Scheinberg is a past president of SOHO and has served as a SOHO Ambassador since 2018. The program featured advances in hematologic oncology and provided opportunities for education, collaboration, and professional networking.

Held annually in São Paulo, SOHO Brazil is part of the SOHO Ambassador Program, which supports regional meetings around the world to expand education in hematologic oncology.

"These regional SOHO meetings have added a lot of value to physicians and hematologists all over the world, which is one of the major missions of SOHO," Dr. Scheinberg told SOHO Insider in an interview last year.

All photos courtesy of Dr. Scheinberg/ Sintoma'26.

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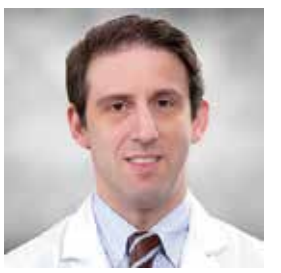

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