FRIDAY, SEPTEMBER 11, 2026 VOLUME 3 OF 4

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Insider DAILY EDITION

Daily news from the SOHO 2026 Annual Meeting

Defining the next steps in myelodysplastic syndromes

By Guillermo Garcia-Manero, MD

Myelodysplastic syndromes (MDS) comprises a highly heterogeneous group of clonal myeloid neoplasms that occur predominantly in older adults and in patients previously exposed to chemotherapy or radiation therapy. During the past several years, we have made meaningful progress in treating anemia associated with lower-risk MDS through agents such as luspatercept and imetelstat, as well as in the development of oral hypomethylating therapy with decitabine/cedazuridine. In contrast, improving survival in higher-risk MDS has remained extraordinarily difficult. This challenge was most recently illustrated by the VERONA trial, in which adding venetoclax to azacitidine improved response measures but did not significantly prolong overall survival (OS).

At the same time, emerging results from lower-risk MDS studies raise the possibility that earlier intervention could alter the natural history of the disease. In the COMMANDS trial, luspatercept produced higher and more durable rates of transfusion independence than epoetin alfa. A preplanned secondary analysis also suggested a favorable OS signal. Although these findings do not yet establish disease modification, they challenge us to reconsider both the timing of treatment and the endpoints used in future trials.

Several priorities should guide the next generation of MDS research.

1. Incorporate molecular biology directly into clinical trial design

Major efforts are underway to improve

SEE *NEXT STEPS* ON PAGE 7

The state of SOHO: a year of growth and opportunity

By Janet M. Cesak, MBA, BS

As executive director of the Society of Hematologic Oncology (SOHO), it has been my privilege to witness the extraordinary growth of our society and the community it serves.

When SOHO was founded in 2012, we envisioned a society that would provide education, insight, connection, and meaningful opportunities for collaboration among clinicians and

SEE *THE STATE OF SOHO* ON PAGE 13

Advancing care through collaborative science: a European perspective

By Valeria Santini, MD

As the incoming SOHO president for 2026–2027, it is my great pleasure to welcome you to the SOHO 2026 Annual Meeting. This year's meeting theme, Advancing Care Through Collaborative Science, was chosen by outgoing SOHO President **John DiPersio, MD, PhD**.

The theme is both timely and important, and I would like to share my perspective

SEE *INCOMING PRESIDENT* ON PAGE 11

PLENARY SESSION SPOTLIGHT

Friday plenary features NIH scientist and aplastic anemia expert Dr. Neal S. Young

By Leah Sherwood

Neal S. Young, MD

The final plenary at the SOHO 2026 Annual Meeting will feature **Neal S. Young, MD,** whose research has shaped the modern treatment of aplastic anemia and advanced the understanding of immune-mediated bone marrow failure.

"Dr. Neal Young is one of the deepest thinkers in hematology," said **Guillermo Garcia-Manero, MD,** who will be introducing Dr. Young during Friday's plenary session. "His work has transformed our understanding and treatment of aplastic anemia and other bone marrow failures. He has also trained a generation of leaders in research and care of these disorders. It will be an honor to learn from him at SOHO."

A senior investigator at the National Institutes of Health (NIH), Dr. Young helped establish immunosuppressive

SEE *DR. YOUNG* ON PAGE 10

For more on aplastic anemia, read the editorial from Amy DeZern, MD, MHS, on page 12.

SOHO ANNUAL MEETING 2026

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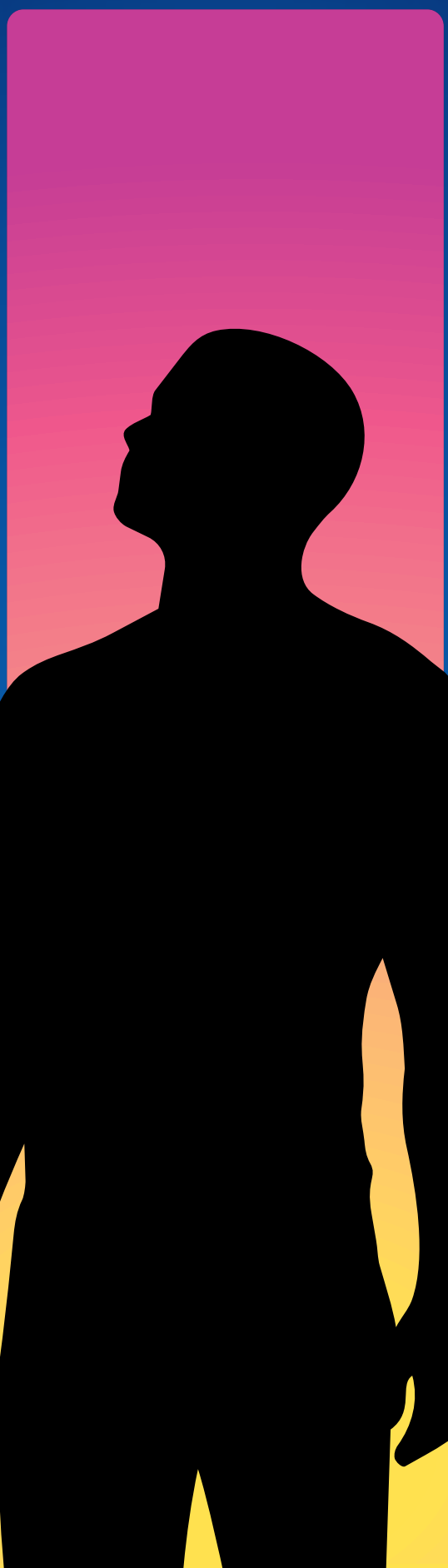

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TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
INDUSTRY EXPERT SESSION VI: BREAKFAST (Non-Accredited)			**GRAND BALLROOM C, THEATER 3**
6:45 AM	Explore a Treatment Option for Your Patients With R/R Multiple Myeloma ***This activity is sponsored by Regeneron***	Abdullah Khan, MD	Ohio State University Columbus, Ohio, USA
BREAKFAST WITH THE EXPERT II			**LEVEL 3, GENERAL ASSEMBLY**
6:45 AM	Managing Complications of Modern Treatment Strategies in AML (DS, Duration on Ven, QT Prolongation)	Martha Arellano, MD	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
7:45 AM	**BREAK**		
SESSION VIII: T-CELL LYMPHOMA **Session Chairs: Ali Bazarbachi, MD, PhD and Barbara Pro, MD**			**LEVEL 3, GENERAL ASSEMBLY**
8:15 AM	Revisiting the Immunology of CTCL	Larisa J. Geskin, MD, FAAD	Columbia University New York, New York, USA
8:30 AM	Q&A		
8:33 AM	Epigenetic Approaches to Treat TFH Cell Lymphoma	Enrica Marchi, MD, PhD	Dana-Farber Cancer Institute Boston, Massachusetts, USA
8:48 AM	Q&A		
8:51 AM	Targeted Therapies for T Cell Lymphomas – a Personalized Treatment Approach	Robert Stuver, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
9:06 AM	Q&A		
9:09 AM	Targeted Therapy of Adult T-Cell Leukemia/Lymphoma	Ali Bazarbachi, MD, PhD	American University of Beirut Beirut, Lebanon
9:24 AM	Q&A		
9:27 AM	Autologous vs Allogeneic Transplant for T Cell Lymphomas	Mary Jo Lechowicz, MD	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
9:42 AM	Q&A		
9:45 AM	**Oral Abstract | TCL-418:** Updated Clinical Data From the Phase 1 Study of Dibotatug (DR-01), a Nonfucosylated Anti-CD94 Antibody, in Patients With Large Granular Lymphocytic Leukemia	Tapan Kadia, MD	MD Anderson Cancer Center Houston, Texas, USA
9:55 AM	**BREAK**		
SESSION IX: INDOLENT B-CELL LYMPHOMA **Session Chairs: Kim Linton, MBChB, MRCP, PhD and Gilles A. Salles, MD, PhD**			**LEVEL 3, GENERAL ASSEMBLY**
10:25 AM	How to Incorporate Bispecific Antibodies in FL	John M. Burke, MD	SCRI at Rocky Mountain Cancer Centers Denver, Colorado, USA
10:40 AM	Q&A		
10:43 AM	Can We Personalize Care in FL?	Kim Linton, MBChB, MRCP, PhD	The University of Manchester Manchester, United Kingdom
10:58 AM	Q&A		
11:01 AM	Risk Stratification of FL in the Modern Era	Gilles A. Salles, MD, PhD	Memorial Sloan Kettering Cancer Center New York, New York, USA
11:16 AM	Q&A		
11:19 AM	With 5 Years of Follow Up, Can We Claim CAR T Can Cure FL?	Paolo Caimi, MD, MBA	Cleveland Clinic Cleveland, Ohio, USA
11:34 AM	Q&A		
11:37 AM	**Oral Abstract | IBCL-1332:** Phase 3 Results From the EPCORE FL-1 Trial of Epcoritamab (E) With Lenalidomide and Rituximab (R2) Versus R2 for Relapsed or Refractory Follicular Lymphoma (R/R FL)	Bradley D. Hunter, MD, MPH	Intermountain Health, LDS Hospital Salt Lake City, Utah, USA
11:47 AM	**BREAK**		
INDEPENDENT SATELLITE SYMPOSIA VIII: LUNCH SESSION			**GRAND BALLROOM A, THEATER 1**
12:17 PM	**Today's CLL/SLL Decisions, Tomorrow's Options: Practical Strategies for the Community Clinic** Chair | Jennifer Brown, MD, PhD | Dana-Farber Cancer Institute | Boston, Massachusetts, USA Shuo Ma, MD, PhD | Robert H. Lurie Comprehensive Cancer Center | Chicago, Illinois, USA Mazyar Shadman, MD, MPH | Fred Hutchinson Cancer Center | Seattle, Washington, USA *In support of improving patient care, Global Learning Collaborative is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team. This activity is supported by independent educational grants from BeOne Medicines and Merck.*		

Friday, September 11, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
INDEPENDENT SATELLITE SYMPOSIA IX: LUNCH SESSION			**GRAND BALLROOM C, THEATER 3**
12:17 PM	**Diffuse Large B-Cell Lymphoma Redefined: A Case-Based Journey From Frontline Breakthroughs to Relapsed/Refractory Frontiers** Chair | Gilles A. Salles, MD, PhD | Memorial Sloan Kettering Cancer Center | New York, New York, USA Kami J. Maddocks, MD | Ohio State University | Columbus, Ohio, USA Ayushi Chauhan, MD | MD Anderson Cancer Center | Houston, Texas, USA *This live educational symposium is certified by Medscape, LLC is jointly accredited with commendation by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team. Both live and enduring components of this educational activity will be certified for AMA PRA Category 1 Credit™, ANCC contact hours, ACPE contact hours, and IPCE credit. This activity is supported by independent medical educational grants from ADC Therapeutics, AstraZeneca, Incyte, and Regeneron Pharmaceuticals, Inc.*		
POSTER WALK III			**LEVEL 3, POSTER HALL B3**
12:17 PM	POSTER WALK - ABCL, IBCL, CT		
1:17 PM	**BREAK**		
PLENARY SESSION III			**LEVEL 3, GENERAL ASSEMBLY**
Session Chair: Guillermo Garcia-Manero, MD			
1:47 PM	Curing Aplastic Anemia	Neal S. Young, MD	National Institutes of Health (NIH) Bethesda, Maryland, USA
SESSION X: AGGRESSIVE B-CELL LYMPHOMA **Session Chairs: Ann LaCasce, MD, MMSc and Juan Alderuccio, MD**			**LEVEL 3, GENERAL ASSEMBLY**
2:07 PM	Selecting Frontline Therapy for DLBCL: The Role of FISH, GEP and Genomic Classifiers	Brian T. Hill, MD, PhD	Cleveland Clinic Cleveland, Ohio, USA
2:22 PM	Q&A		
2:25 PM	Update on Second-Line Approaches to R/R DLBCL	Elizabeth Budde, MD, PhD	City of Hope Duarte, California, USA
2:40 PM	Q&A		
2:43 PM	Beyond CAR T-Cell Therapy and Bispecifics - Strategies for Treating R/R DLBCL	Juan Alderuccio, MD	Sylvester Comprehensive Cancer Center Miami, Florida, USA
2:58 PM	Q&A		
3:01 PM	Novel Approaches to Managing Elderly and Unfit Patients With DLBCL	Pallawi Torka, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
3:16 PM	Q&A		
3:19 PM	Optimizing Therapy of PMBCL in the Modern Era	Ann LaCasce, MD, MMSc	Dana-Farber Cancer Institute Boston, Massachusetts, USA
3:34 PM	Q&A		
3:37 PM	Practical Management of CAR T-Cell Therapy and Bispecific Antibody Toxicities	Michael Jain, MD, PhD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
3:52 PM	Q&A		
3:55 PM	**Oral Abstract | ABCL-489:** Primary Outcomes From the Phase 3 Study of Tafasitamab (Tafa) Plus Lenalidomide (Len) and R-CHOP for Patients With Newly Diagnosed Diffuse Large B-Cell Lymphoma (DLBCL) (frontMIND)	Jason R. Westin, MD, MS, FACP, FASCO	MD Anderson Cancer Center Houston, Texas, USA
4:05 PM	**BREAK**		
SESSION XI: MANTLE CELL LYMPHOMA **Session Chairs: Kami J. Maddocks, MD and Brad Kahl, MD**			**LEVEL 3, GENERAL ASSEMBLY**
4:35 PM	Maximizing the Role of BTK Inhibition in MCL	Yucai Wang, MD, PhD	Mayo Clinic Rochester Rochester, Minnesota, USA
4:50 PM	Q&A		
4:53 PM	Is There Still a Role for Transplant in MCL?	Brad Kahl, MD	Washington University St. Louis, Missouri, USA
5:08 PM	Q&A		
5:11 PM	Novel Treatments in the Pipeline for MCL	Preetesh Jain, MD, DM, PhD	Mays Cancer Center, UT Health San Antonio San Antonio, Texas, USA
5:26 PM	Q&A		
5:29 PM	Risk-Based Strategies for MCL: From Watch and Wait to High Intensity	Kami J. Maddocks, MD	Ohio State University Columbus, Ohio, USA
5:44 PM	Q&A		
5:47 PM	**Oral Abstract | MCL-575:** Updated Results From the Phase 3 ECHO Trial of Bendamustine-Rituximab With or Without Acalabrutinib in Patients With Previously Untreated Mantle Cell Lymphoma: 50 Months of Follow-Up	Michael Wang, MD	MD Anderson Cancer Center Houston, Texas, USA

Friday, September 11, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
5:57 PM	**BREAK**		
SESSION XII: HODGKIN LYMPHOMA **Session Chairs: Nancy L. Bartlett, MD and Stephen M. Ansell, MD, PhD**			**LEVEL 3, GENERAL ASSEMBLY**
6:12 PM	How to Select a Frontline Regimen for Advanced Stage Hodgkin Lymphoma	Stephen M. Ansell, MD, PhD	Mayo Clinic Rochester Rochester, Minnesota, USA
6:27 PM	Q&A		
6:30 PM	Relapsed/Refractory Hodgkin Lymphoma After Nivo-AVD - What to Do?	Alison J. Moskowitz, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
6:45 PM	Q&A		
6:48 PM	**Oral Abstract | HL-1412:** PET-Guided Nivolumab-Based First-Line Strategy in Advanced-Stage Classical Hodgkin Lymphoma: Interim Clinical Results	Hunan Julhakyan, MD, PhD	National Scientific Center for Hematology Moscow, Russia
6:58 PM	**BREAK**		
INDUSTRY EXPERT SESSION VII: DINNER (Non-Accredited)			**GRAND BALLROOM A, THEATER 1**
7:08 PM	1 DLBCL: Primary and Latest PFS Data ***This activity is sponsored by Genentech***	Daniel A. Kerr, MD, PhD	Tampa General Hospital Cancer Institute Tampa, Florida, USA
INDUSTRY EXPERT SESSION VIII: DINNER (Non-Accredited)			**GRAND BALLROOM C, THEATER 3**
7:08 PM	Exploring the Evolving Evidence of an Oral Treatment for Myelofibrosis ***This activity is sponsored by SOBI, Inc.***	Ghaith Abu-Zeinah, MD	NewYork-Presbyterian New York City, New York, USA
8:08 PM	**BREAK**		
INDUSTRY EXPERT SESSION IX: DESSERT (Non-Accredited)			**GRAND BALLROOM A, THEATER 1**
8:18 PM	Ph+ CML-CP: A Nilotinib Treatment Option With 12 Months of Real-World Evidence (RWE) ***This activity is sponsored by Azurity Pharmaceuticals***	M. Yair Levy, MD	Baylor University Medical Center Dallas, Texas, USA
INDUSTRY EXPERT SESSION X: DESSERT (Non-Accredited)			**GRAND BALLROOM C, THEATER 3**
8:18 PM	Cilta-Cel (CARVYKTI®) in Practice: Lessons From the CARTITUDE Program and Real-World Evidence ***This activity is sponsored by Legend Biotech***	Krina K. Patel, MD, MSc	MD Anderson Cancer Center Houston, Texas, USA

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MDS classification and prognostication through molecular characterization. We now recognize that TP53 is among the most important adverse molecular abnormalities in MDS. At referral centers such as MD Anderson, TP53 mutations may be present in 30% to 40% of patients with higher-risk disease.

Patients with TP53-mutated MDS do not appear to derive the same benefit from certain therapies, including venetoclax-based combinations, as patients with TP53 wild-type disease. Higher-risk MDS should therefore no longer be treated as a single biological entity in phase 3 studies. Trials should incorporate molecular stratification at enrollment, prospectively defined subgroup hypotheses, and therapies selected according to the genetic and biological features of the disease.

2. Determine whether earlier treatment of anemia can modify the disease

In lower-risk MDS, the results achieved through modulation of transforming growth factor–β superfamily signaling with luspatercept are significant. We are learning that earlier use of this agent is associated with very high response rates and prolonged transfusion independence. The critical question is whether these benefits extend beyond the correction of anemia and ultimately alter disease progression or survival.

The next generation of lower-risk MDS trials should evaluate not only hematologic response and transfusion independence but also OS, progression-free survival, time to higher-risk MDS or acute myeloid leukemia (AML), quality of life, and cumulative transfusion burden. Translational studies should also investigate whether these agents influence broader signaling pathways, the marrow microenvironment, or immune function.

3. Account for comorbidities and competing causes of mortality

Because most patients with MDS are older and frequently have multiple comorbidities, OS is influenced by factors beyond the hematologic disease. We must determine how cardiovascular, pulmonary, renal, inflammatory, and other conditions affect treatment tolerance, response, and survival.

Future studies should incorporate standardized comorbidity assessments and distinguish disease-related mortality from competing causes of death. This will be particularly important when evaluating whether a therapy for lower-risk MDS truly modifies the natural history of the disease.

4. Expand treatment objectives beyond anemia

Most therapeutic development in lower-risk MDS has focused on anemia Thrombocytopenia, however, remains a major unmet need and can result in bleeding, recurrent platelet transfusions, treatment delays, and substantial impairment in quality of life.

We need therapies specifically directed at improving platelet production and reducing clinically meaningful bleeding. Future trials should incorporate platelet transfusion independence, bleeding events, and patient-reported outcomes rather than relying exclusively on conventional hematologic response criteria.

5. Identify patients who benefit from BCL-2 inhibition

Higher-risk MDS remains the greatest therapeutic challenge. We are now conducting the GLORA-4 trial, which evaluates lisaftoclax plus azacitidine using a design similar to that of VERONA. The central question is no longer simply whether BCL-2 inhibition is active in MDS, as it clearly is in AML. Rather, we must identify the biological and clinical subsets of patients with MDS that derive the greatest benefit from this class of therapy.

The field should be more selective when designing large randomized, phase 3 doublet studies, particularly those involving BCL-2 inhibitors. Molecular subtype, TP53 status, blast percentage, age, disease risk, biological evidence of BCL-2 dependence, and transplant eligibility should all be considered during trial design. Future studies may require biomarker-enriched or adaptively enriched designs instead of broad all-comer enrollment.

6. Address the impact of stem cell transplantation on clinical trial outcomes

Outcomes following allogeneic stem cell transplantation have improved substantially, with long-term disease control approaching 50% in appropriately selected patients. This progress has important implications for the interpretation of clinical trials in higher-risk MDS.

In a randomized study, patients assigned to the control arm may subsequently undergo transplantation and achieve long-term survival. This can attenuate differences in OS between treatment groups, even when the investigational therapy produces deeper or more frequent responses. The VERONA experience illustrates the importance of this issue.

Future trials should stratify patients according to transplant eligibility and intent, prospectively capture transplantation and all subsequent therapies, and define transplantation as an important intercurrent event in the statistical analysis. OS should remain a critical endpoint, but it should be complemented by endpoints such as the rate of successful transition to transplantation, depth of response before transplantation, post-transplant relapse, and transplant-free survival. Both intention-to-treat and prespecified transplant-focused analyses will be required to understand the true contribution of the investigational therapy.

MDS research has reached a pivotal moment. We have effective new therapies for anemia, increasingly sophisticated molecular classification systems, emerging targeted agents, and improving transplantation outcomes. Our principal challenge is to integrate these advances into more biologically precise clinical trials. By selecting the right therapy for the right molecular subset, using endpoints that capture meaningful changes in the disease, and accounting appropriately for comorbidities and transplantation, we can continue to improve outcomes for patients with MDS.

Guillermo Garcia-Manero, MD, is the interim chair of the Department of Leukemia and Chief of the Section of Myelodysplastic Syndromes at the University of Texas MD Anderson Cancer Center. He is also a past president of SOHO and the incoming editor-in-chief of SOHO Insider.

Hot topics in MCL: BTK inhibitors, transplant, novel agents, and risk-based treatment strategies

By Kami Maddocks, MD

SESSION HIGHLIGHT

SESSION NAME:
Mantle Cell Lymphoma

WHEN:
September 11 at 4:35 PM

WHERE:
Level 3, General Assembly

Treatment for mantle cell lymphoma (MCL) has evolved, and I am looking forward to a great MCL-focused session with fantastic speakers at this year's annual meeting.

The impact of BTK inhibitors

Yucai Wang, MD, PhD, of the Mayo Clinic in Rochester, Minnesota, will kick off the session with a discussion on maximizing the role of Bruton's tyrosine kinase (BTK) inhibition. BTK inhibitors revolutionized the MCL treatment landscape in the relapsed and refractory setting when the first BTK inhibitor, ibrutinib, was approved. Since then, we have seen the approval of two second-generation BTK inhibitors, acalabrutinib and zanubrutinib, which have less off-target kinase inhibition, leading to improved toxicity profiles.


Yucai Wang, MD, PhD

Treatment with a single-agent BTK inhibitor had long been the standard of care, although small trials suggested doublet and triplet combinations could improve outcomes, and eventually the randomized SYMPATICO trial showed the benefit of adding BCL-2 inhibition.

After years of awaiting results from clinical trials that included BTK inhibitors in frontline treatment combinations, the ECHO trial led to the FDA's approval of the first BTK inhibitor in combination with chemoimmunotherapy. How we best incorporate BTK inhibitors to provide the greatest benefit to patients—whether in combination with immunotherapy, targeted therapy, or chemotherapy; given as time-limited maintenance or given until progression; and given as retreatment after time-limited therapy—is not known. These are just a few of the questions we have yet to answer, and I look forward to hearing Dr. Wang's approach.

Can patients be spared transplant?

For years, including when I trained and for most of my time practicing, patients with newly diagnosed MCL deemed fit to tolerate consolidation with autologous hematopoietic cell transplant (AHCT) were recommended this approach after induction chemoimmunotherapy. While long practiced, this approach was based on a single trial that incorporated AHCT consolidation with CHOP induction.


Brad Kahl, MD

In the second talk of the session, we will hear from **Brad Kahl, MD,** of Washington University in St. Louis, Missouri, about the role of AHCT in the context of our current MCL therapies.

Two large randomized studies challenged the role of AHCT in MCL. The TRIANGLE trial evaluated the role of AHCT in the setting of BTK inhibitors for induction and maintenance therapy and found that patients treated with the addition of BTK inhibitors did better than standard treatment. Patients treated with BTK inhibitors with elimination of AHCT had improved outcomes over standard treatment, which suggests that patients with certain high-risk disease features may still benefit from the inclusion of AHCT, albeit at the cost of greater toxicity.

The second trial, ECOG-ACRIN 4151, was a randomized trial evaluating the role of consolidation AHCT in patients who achieved undetectable measurable residual disease. This trial was based on the knowledge that patients who were able to achieve a deeper remission going into AHCT had longer time to relapse, suggesting that there may be a cohort of patients who did not require this additional treatment. Indeed, patients with deep molecular remissions after induction did just as well with rituximab maintenance as those who had consolidation AHCT and rituximab maintenance, indicating that most patients could be spared the toxicity, time, and expense of AHCT without impacting outcomes.

Whether there is a role for AHCT consolidation in particular patient populations—such as those with high-risk disease features, without access to BTK inhibitors in the frontline setting, and/or who do not achieve a deep molecular remission after induction—is hopefully something Dr. Kahl will answer for us.

Novel therapies for MCL

MCL remains an incurable disease, and despite significant advances, including improved overall survival, there still exists a need for improved therapies, particularly in patients who are refractory and those with high-risk MCL.

While not completely novel given the approval in other B-cell malignancies, the CD20×CD3 bispecific antibodies have shown very promising activity in MCL. Single-agent glofitamab and mosunetuzumab

INSIDE THE MIND OF DR. MADDOCKS

You've been kidnapped for your hematology expertise. Your captors give you a choice: become the personal hematologist for a colony of vampires or a pack of werewolves. Who are you treating?

Vampires

in combination with the antibody drug conjugate (ADC) polatuzumab vedotin have been impressive in early trials. Targeting CD19 has shown to be highly effective in MCL, and early results of CD19×CD3 bispecific antibodies are also very promising. Speaking of targeting CD19, the ADC loncastuximab has potential as an active agent in MCL.

There are still promising oral therapies as well. The BCL-2 inhibitor sonrotoclax recently received FDA approval in relapsed and refractory MCL, and combination studies are ongoing. The noncovalent BTK inhibitor nemtabrutinib is under investigation, with the first noncovalent BTK inhibitor pirtobrutinib already approved. Targeting BTK is effective in MCL, and BTK degraders have shown early promise as agents that degrade instead of inhibit the protein.

Preetesh Jain, MBBS, MD, DM, PhD

Cellular therapy has made a major impact on the treatment of B-cell malignancies, and MCL is no different, with two approved CD19-directed products. However, there are opportunities for improvement and cellular therapies targeting dual or triplet antigens, and alternate targets are in development. I am excited to hear the discussion from **Preetesh Jain, MBBS, MD, DM, PhD,** of the University of Texas MD Anderson Cancer Center, on promising agents in the pipeline.

I have the distinct privilege of being the last speaker in the session, tasked with a discussion on risk-based approaches to treating MCL. As we have come to understand more about the biology of this disease, we are able to personalize treatment-based approaches for patients, taking into consideration the best option for their disease while limiting toxicity and time on therapy when not indicated.

I look forward to seeing you all there.

Kami Maddocks, MD, is an editor at SOHO Insider and a professor in the Division of Hematology at The Ohio State University. She is co-chair of the MCL session.

Treatment unmet needs in relapsed or refractory DLBCL

By Leah Sherwood

Juan Pablo Alderuccio, MD

On Friday, September 11, **Juan Pablo Alderuccio, MD,** associate professor of medicine in the Division of Hematology and lymphoma clinical site disease group leader at Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine, will discuss strategies for treating relapsed or refractory diffuse large B-cell lymphoma (DLBCL) in patients whose disease progresses after chimeric antigen receptor (CAR) T-cell therapy and bispecific antibodies.

Outcomes for this post-CAR T-cell and post-bispecific patient population are exceptionally poor. Data from the French LYSA group demonstrated a two-year overall survival rate of only 31% following progression after CAR T-cell therapy and treatment with the CD20×CD3 bispecific antibody glofitamab.

“These are the patients with DLBCL that represent the current unmet need and the high-risk population where further clinical trials need to be developed in order to improve outcomes,” Dr. Alderuccio said.

While approved options offer immediate availability, post-CAR T-cell remissions remain brief.

Dr. Alderuccio highlighted data from the ECHELON-3 trial supporting FDA-approved brentuximab vedotin with lenalidomide and rituximab as an option that can be provided in any clinic. Other approved choices show limited durability. Tafasitamab plus lenalidomide demonstrated a median progression-free survival of 1.7 months after CAR T-cell therapy, while loncastuximab tesirine yielded similarly brief remissions.

“The goal, if the patient achieves a remission, needs to be consolidation with allogeneic stem cell transplant because this is a potentially curative approach,” Dr. Alderuccio said. This strategy applies to complete responders following either standard or investigational therapies.

Investigational agents in development aim to overcome molecular heterogeneity and treatment resistance. Pipeline options include the CELMoD golcadomide, BCL6 degraders, and AstraZeneca’s CD19×CD3 bispecific surovatamig, which achieved complete response rates of 35.5% among patients previously treated with CAR T-cell therapy and 45.5% among those previously treated with bispecific antibodies.

Next-generation trispecific antibodies are also steadily emerging. PIT565, a CD19×CD2×CD3 trispecific antibody, was evaluated in a phase 1 clinical trial that is no longer recruiting, leaving its further development unclear. Johnson & Johnson’s CD79b×CD20×CD3 trispecific antibody, JNJ-80948543, remains under development, although no publicly available clinical data have been reported.

“I think that this combination is going to be the next step that we need to study in clinical trials,” Dr. Alderuccio said, referring to regimens that combine distinct mechanisms of action and resistance.

Leah Sherwood is the editorial director of SOHO Insider.

SESSION HIGHLIGHT

SESSION NAME:
Beyond CAR T-cell therapy and bispecifics: strategies for treating R/R DLBCL

WHEN:
September 11 at 2:43 PM

WHERE:
Level 3, General Assembly

SESSION HIGHLIGHT

SESSION NAME:
Curing Aplastic Anemia

WHEN:
September 11 at 1:47 PM

WHERE:
Level 3, General Assembly

... DR. YOUNG FROM PAGE 1

therapy as the standard treatment for severe aplastic anemia and later demonstrated the benefit of adding the thrombopoietin receptor agonist eltrombopag to the standard therapy at the time. His work has directly improved survival for patients with a rare disease that was once almost uniformly fatal.

dysregulation," she said. "All of our hematologic malignancies involve alterations of the immune system, but in this disease, immune dysfunction is the primary pathogenic event. We can all learn by understanding what is happening in the bone marrow of patients with aplastic anemia."

A FORCE BEHIND APLASTIC ANEMIA TREATMENT

> **"Dr. Neal Young is one of the deepest thinkers in hematology. His work has transformed our understanding and treatment of aplastic anemia and other bone marrow failures. He has also trained a generation of leaders in research and care of these disorders. It will be an honor to learn from him at SOHO."**
>
> — Guillermo Garcia-Manero, MD

Incoming SOHO President **Valeria Santini, MD,** said the plenary will appeal well beyond clinicians who specialize in aplastic anemia. Understanding how the immune system disrupts normal blood formation can inform research into other bone marrow disorders, including myelodysplastic syndromes and acute myeloid leukemia.

"Aplastic anemia is a model of immune

Dr. Young is chief of the Hematology Branch at the National Heart, Lung, and Blood Institute within the NIH. He has received numerous honors recognizing his contributions to hematology and bone marrow failure research. According to his NIH biography, he has published almost 300 research articles, more than 100 reviews and book chapters, and has written or edited 10 monographs, including a textbook on hematology.

According to the NIH, his current laboratory projects include gene editing and single-cell RNA sequencing to investigate bone marrow failure disorders, along with studies of paroxysmal nocturnal hemoglobinuria, immune-mediated marrow failure, and the effects of sex hormones on bone marrow cells.

For attendees, the plenary offers an opportunity to hear from one of the investigators whose work has influenced the field for decades.

"[Dr.] Young has a philosophical view of science that not many people have," Dr. Santini said. "Listening to him is really an experience."

Leah Sherwood is the editorial director of SOHO Insider.

INCOMING PRESIDENT FROM PAGE 1

as a clinician practicing in Europe on what collaborative science looks like from a European point of view.

While the goal for clinicians to improve outcomes for our patients is universal, the way we build research programs in Europe can differ greatly from the United States.

In Europe, collaboration is often the foundation of how research begins, as there are relatively few opportunities for individual investigators to build research programs entirely on their own. With the exception of programs such as the European Research Council grants, many of our major funding opportunities are designed around collaboration.

Many European funding programs require investigators from several countries to work together from the beginning of a research project. Before a single grant proposal is submitted, we identify the expertise needed to advance the program. For instance, if my research team does not have a particular technique or specialized laboratory, we look for collaborators who provide that expertise. Together, we build the project, demonstrate the feasibility at each participating center, and submit a single proposal.

This approach is intellectually stimulating because it brings together different expertise that no single center may have. It is also a challenge. Building a collaborative project takes time, coordination, and a great deal of preparation. Yet, I have found that these partnerships often strengthen both the science and the questions we are trying to answer. It gives us access to methods that may not exist in our own laboratories and allows us to learn from colleagues whose experiences are different from our own.

From my perspective, this process differs from the way many projects are developed in the United States, where an investigator often builds a proposal within a single institution. In Europe, my first question is usually not, “How do I develop this project?” It is, “Who should I work with to make this project possible?”

Collaborative science also requires patience. It takes time to build consensus and coordinate across institutions. It means sharing ideas at an early stage and trusting others to strengthen them. This is not always the easiest way to work, but I believe it often leads to better science.

Many European funding programs also encourage the inclusion of countries with fewer research resources. I think this is important because it creates opportunities for collaboration that might not otherwise develop and brings different expertise into a project.

This is where organizations such as SOHO have an important role to play. By bringing together investigators from around the world, SOHO creates opportunities for conversations to become collaborations. Many research partnerships begin with a discussion at a scientific meeting. Those relationships often continue long after the meeting has ended and can grow into projects that advance our understanding of disease and improve patient care.

As Dr. DiPersio said in his welcome address, scientific progress does not happen in a vacuum: We must create the environment to advance treatments. Part of that environment is collaborating and building relationships. Many of the questions we face cannot be answered by one laboratory or one institution alone. They require different expertise and a willingness to work together toward a common goal.

I look forward to officially stepping into my role as the next president of SOHO. Until then, I leave you with this thought: the next time you pass a colleague in a hallway here or at another meeting, remember that the next major treatment advance in patient care may begin with a simple conversation.

Valeria Santini, MD, is an associate professor of hematology at the University of Florence Medical School in Italy. She is SOHO president-elect and assumes the role of presidency on September 12, 2026.

INSIDE THE MIND OF DR. SANTINI

You’ve suddenly found yourself in Doctor Strange in the Multiverse of Madness and come face-to-face with a version of yourself from another universe. What bizarre situation do the two of you find yourselves in?

In the parallel world, there is a Valeria with green hair and endowed with magic powers. She can fly. I met her by chance, and we decided to merge forces to save hematologic patients without actual therapy.

You’ve been kidnapped for your hematology expertise. Your captors give you a choice: become the personal hematologist for a colony of vampires or a pack of werewolves. Who are you treating?

Of course, I would treat vampires! They drink blood; I would try to understand why, and which blood group specifically. What is their biological defect? Moreover, there is a real disease, porphyria, that could be at the basis of this myth.

In the Odyssey, characters are given epithets that are repeated throughout: Odysseus is “the man of many ways,” Athena is “bright-eyed Athena,” and Penelope is “wise Penelope.” If you were a character in an ancient Greek epic, what would your epithet be?

Resilient Valeria

Is the field of severe aplastic anemia undergoing a critical transition that will redefine future care?

By Amy DeZern, MD, MHS

Severe aplastic anemia (SAA) remains one of the most consequential nonmalignant hematologic disorders, defined by profound bone marrow failure and life-threatening cytopenias. Although technically not a cancer, its natural history, treatment toxicity, and long-term complications have long demanded the same level of therapeutic urgency and innovation seen in malignant hematology. The rarity of SAA has never diminished the intensity of research in this field; rather, its curability has driven decades of progress aimed at restoring hematopoiesis efficiently, safely, and durably.

Idiopathic acquired SAA—characterized by marrow cellularity below 25% and severe cytopenias including ANC <0.5×10^9/L, platelets <20×10^9/L, and reticulocytes <60×10^9/L—remains uniformly fatal without timely intervention. Immune suppression with horse ATG and cyclosporine has been the historical backbone of therapy, and the addition of eltrombopag has improved early response rates. Yet durability remains a major limitation, particularly in younger patients, where relapse, clonal evolution, and prolonged dependence on immunosuppression continue to shape long-term outcomes. Even in the modern era, relapse rates approach 40%, and evolution to myeloid neoplasms remains a persistent concern.

These realities underscore the need for therapeutic strategies that not only induce hematologic recovery but also eliminate the long-term evaluation of the goals of initial therapy as well as risks inherent to immunosuppressive therapy (IST)-based approaches.

Transformative transplantation

In parallel, allogeneic hematopoietic cell transplantation has undergone a profound transformation. Advances in HLA typing, reduced-toxicity conditioning, and supportive care have dramatically improved survival. Importantly, donor availability has expanded beyond matched siblings to include unrelated donors and haploidentical family donors, supported by the success of post-transplant cyclophosphamide (PTCy) in mitigating graft-versus-host disease (GVHD) and enabling safe transplantation across HLA barriers. These developments have reshaped the therapeutic landscape, making curative transplantation feasible for many more patients with SAA.

Contemporary data now demonstrate that a uniform PTCy-based transplant platform can achieve survival exceeding 90% at three years across pediatric and adult populations, including those with treatment-naïve disease and those with relapsed or refractory SAA. Notably, this includes patients with very severe aplastic anemia (ANC <200×10^9/L), a group historically associated with early mortality on IST. The rapid hematopoietic recovery, early cessation of immunosuppression, and freedom from transfusion dependence seen with this approach represent meaningful advantages over prolonged IST courses. When transplantation can be delivered with low early toxicity, minimal GVHD, and durable cure, the rationale for defaulting to IST, especially in younger patients, becomes increasingly difficult to justify.

The long-term consequences of IST further reinforce this shift. Even with eltrombopag-augmented regimens, event-free survival remains less than ideal at two years, and extended cyclosporine exposure, with its inherent toxicities, is required to maintain responses. Four-year follow-up data reveal relapse rates approaching 40% and clonal evolution around 15%, outcomes that inevitably lead many patients back to transplantation after years of cumulative toxicity, anxiety, and healthcare utilization. In contrast, modern transplant platforms eliminate clonal hematopoiesis, shorten the total duration of therapy, and reduce the long-term burden of medical surveillance when successful.

Transplant-related late effects remain important to monitor, including secondary malignancies, though the low-dose radiation used in contemporary conditioning regimens is less clearly implicated in solid tumor development than historical approaches. Early outpatient-focused transplant delivery models further reduce cost and resource utilization, making curative therapy more accessible and less disruptive to patients' lives. It does remain a very personalized clinical decision, but patients should be given all options when possible to allow for informed choices.

Taken together, the field is approaching an inflection point. When a transplant platform offers cure, rapid hematopoietic recovery, minimal long-term immunosuppression, preserved fertility potential, and no greater early toxicity than IST, the justification for reserving transplantation as salvage becomes increasingly tenuous. While novel IST-based strategies and randomized trials continue to emerge, the overarching goal should be uniformity of approach, prioritizing short-term safety, and long-term benefit. For many patients with SAA—particularly the young and those with very severe disease—early allogeneic transplantation represents a compelling, contemporary standard that aligns with these principles.

Amy DeZern, MD, MHS, is an editor at SOHO Insider and a professor of oncology at Johns Hopkins University School of Medicine.

INSIDE THE MIND OF DR. DeZERN

In The Odyssey, characters are known by recurring epithets: "wise Penelope," "bright-eyed Athena." What would your ancient Greek epithet be?

The Steadfast

••• THE STATE OF SOHO FROM PAGE 1

researchers working across the field of hematologic oncology. That vision has grown far beyond what we could have imagined. Today, SOHO is a global community of 13,000 members and counting, united by a shared commitment to advancing research, improving clinical practice, mentoring the next generation of clinicians, and delivering better treatments to patients with hematologic malignancies.

> "Together, we are shaping the future of hematologic oncology."

Our members give SOHO its purpose. Every program we develop is designed to support the clinicians, investigators, and other healthcare professionals whose work moves our field forward. By bringing together leading researchers, practicing clinicians in our communities, and early-career clinicians, SOHO creates an environment in which knowledge can be shared across institutions, specialties, career stages, and geographic boundaries.

This exchange is especially important for the next generation of hematologic oncology leaders. Over the years, recipients of our young investigator scholarships have told us that they met a mentor, began a collaboration, or discovered a new professional opportunity with the support of the society's funding.

At our annual meeting, leading researchers come together to share their knowledge and engage directly with younger members in the field. Those interactions can have multiple downstream effects, including shaping careers, inspiring new research questions, and ultimately contributing to the development of innovative treatments for patients.

In 2026, we expanded that commitment through a new fellowship program launched in partnership with SOHO President **John DiPersio, MD, PhD**. The program was created to help more young clinicians and investigators attend the annual meeting and participate in all of its educational opportunities. By reducing barriers to participation, we hope to give emerging leaders greater access to the mentors, colleagues, and ideas that can support them as their careers advance.

We remain dedicated to supporting early-career researchers through our longstanding Young Investigator Program, which provides scholarships to attend the annual meeting, present their research, and pursue professional development opportunities.

At the same time, our Ambassador Program extends SOHO's reach throughout the international hematology community.

Our ambassadors connect colleagues in their regions with SOHO's programs and resources, including those in underresourced areas or who may be unable to travel to other meetings.

This year has been an outstanding one for SOHO in many other ways. As our membership and programming have grown, we have expanded our internal team to support the society's growing needs and develop new resources for our members.

Chief among these new resources is our Ask-the-Expert forums led by prominent hematologic oncologists in the field. This resource was designed for clinicians seeking guidance on difficult cases from the world's leading specialists. The forum gives members an accessible way to raise clinical questions and exchange perspectives.

To read more about the program, see page 10 or scan the QR code.

I am also excited to announce the launch of our second podcast, SOHO Spotlight, an education-focused program featuring timely conversations about developments in hematologic oncology. It complements our established SOHO Insider podcast and expands our growing collection of digital educational offerings. Read more about this podcast on page 36.

Another important addition is SOHO's Clinical Trial database, designed to make it easier for clinicians to search for relevant studies and identify potential trial opportunities for their patients. Clinical trial information can be difficult and time-consuming to navigate. By bringing these resources together in a more accessible format, we aim to help clinicians connect eligible patients with studies that may offer additional treatment options.

As we celebrate this progress, I would like to express our sincere appreciation to Dr. DiPersio for his leadership, enthusiasm, and dedication during his tenure as SOHO president. His ideas, openness, and commitment to the society have helped us develop new opportunities for our members while preserving the collaborative spirit that defines SOHO.

We are also delighted to welcome **Valeria Santini, MD,** a founding member of SOHO, as our next president. Dr. Santini has been part of the society since its earliest days and understands both the vision on which SOHO was founded and the expanding needs of our global community. We look forward to her leadership as SOHO enters its next chapter.

SOHO has grown tremendously since 2012, but our purpose remains clear: to bring the hematologic oncology community together, make expert knowledge widely accessible, support clinicians and investigators throughout their careers, and help accelerate progress for patients. I am deeply grateful to every member, volunteer, faculty participant, ambassador, young investigator, and staff member who has contributed to this mission. Together, we are shaping the future of hematologic oncology.

Sincerely,

Janet M. Cesak, MBA, BS

Don't forget to register for **SOHO Breakthroughs in Blood Cancers** (SBBC) happening on November 12. This one-day virtual meeting, chaired by **Hagop Kantarjian, MD,** delivers the latest cutting-edge science in hematologic malignancies. SOHO members can register for free at **soho.click/SBBC**.

SOHO invests in next generation of hematologic oncologists

By Leah Sherwood

Through its Young Investigator Program and other initiatives, SOHO has expanded its support for early-career clinicians beyond the annual meeting.

Throughout its 14-year history, the Society of Hematologic Oncology (SOHO) has made the development of early-career clinician-scientists one of its highest priorities. Each year, SOHO awards travel scholarships to budding early-career physicians and researchers to attend the SOHO Annual Meeting in Houston, Texas, to present their research.

The awards are made possible through the Young Investigator Program and include travel support, complimentary meeting registration, hotel accommodations, meals, and dedicated networking opportunities with distinguished faculty from the top cancer centers.

For **Janet M. Cesak, MBA, BS,** SOHO executive director and one of the founding members of the society, the program is among the most significant missions of the society.

"The overall goal of the society is to improve outcomes for patients with blood cancers," Cesak said. "What we would like to see, if at all possible, is a potential cure for every single patient diagnosed with a blood cancer. Since we have the brightest minds from all over the world coming together and producing novel ideas and potential solutions, we hope that we can reach that goal together, faster."

Throughout the meeting, young investigators participate in scientific sessions and networking events, including the young investigator luncheon, where they meet directly with internationally recognized faculty members.

"They're meeting with the top global experts who are working with cutting-edge treatments," Cesak said. "If there's a good fit, young investigators may find a potential opportunity at a top institution. Making that kind of connection could change the entire course of their careers."

Cesak said these conversations that happen at the SOHO Annual Meeting are difficult to have at larger meetings.

"It gives them opportunities that are unlikely elsewhere," she said. "Who gets to sit down at lunch with the top leaders in the hematologic oncology field when you're unknown and still in training? They get to do that at SOHO."

EAGLE Program

SOHO expanded its educational initiatives through the Exchange for Advanced Global Learning and Education (EAGLE) Program, launched in 2025 under the leadership of past SOHO President **Phillip Scheinberg, MD, PhD**. The program connects hematologic oncology fellows and early-career physicians with leading academic centers for short-term educational experiences with the goal of providing additional opportunities for specialized training and international collaboration.

"We want this to be a transformative experience," Dr. Scheinberg said. "This is about creating connections that will benefit participants throughout their careers."

To learn more about the EAGLE program, scan the QR code or go to soho.click/EAGLE.

Continuous Learning Collaborative

The Continuous Learning Collaborative was a multiphase educational pilot developed as a collaboration between SOHO and the Medical Learning Institute. The program focused on improving the treatment of relapsed or refractory chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL).

The first phase began in summer 2025 with a cohort of 25 young investigators. Participants were within 10 years of entering practice and worked in community oncology or smaller academic settings. They contributed information about their treatment approaches through de-identified patient records, surveys, and case-based exercises. The findings were used to identify areas of uncertainty and shape the program's live educational component.

The initiative addressed an important need as the number of therapies available for relapsed or refractory CLL and SLL continued to grow. Clinicians increasingly faced questions about how to select and sequence treatments after previous therapies stopped working or caused unacceptable side effects. The program examined how clinicians approached these decisions and where additional guidance could help strengthen care.

A second phase took place during the 2025 SOHO Annual Meeting. Unlike the initial phase, the 90-minute live intensive was open to all meeting attendees, including clinicians who had been in practice for more than 15 years. Participants worked through patient cases, discussed treatment challenges, and received feedback from faculty experts.

The pilot found that structured education could help clinicians apply current evidence to treatment decisions. Participants reported plans to improve their use of clinical guidelines and make treatment choices based on individual patient needs.

One participant commented, "It will impact not only my practice but the life of the patients."

Scan the QR code to read more about the program.

50/50 Fellowship Attendance Match

Additionally, in 2026, SOHO President **John F. DiPersio, MD, PhD,** launched the 50/50 Fellowship Attendance Match, a junior faculty outreach initiative that provides matching support to fellowship programs so more early-career investigators can attend the annual meeting.

"We're introducing a new program this year

that provides one-for-one support to bring fellows and junior faculty to the meeting," Dr. DiPersio said. "The society is supporting new blood coming to the meeting, and I'm looking forward to seeing more young investigators take part in the discussions."

clinical content and the access they gain to the top physician-scientists in the field.

"This is a great opportunity for fellows to come to a practical meeting," said **Kristin Gusack,** deputy director at SOHO. "SOHO

educational and networking opportunities it provides to them."

The SOHO Young Investigator Program supports aspiring hematologic oncologists to attend the Annual Meeting in Houston and provides the opportunity to meet with leaders in the field.

> **"Throughout its 14-year history, the Society of Hematologic Oncology has made the development of early-career clinician-scientists one of its highest priorities."**

Many early-career investigators have praised the SOHO Annual Meeting as being among the most valuable educational experiences of their training because of its focused

is invested in the next generation of clinical hematologists. We hear fellows saying this is a must-attend meeting, and they want to attend every year because of the

Scan the QR code to read more about the program.

Leah Sherwood is the editorial director of SOHO Insider.

Young Investigator Program

Meet some of the SOHO 2026 Young Investigators

Julie Braish, MD

Moffitt Cancer Center

What do you like most about attending the SOHO Annual Meeting?
I really like how focused the meeting is. Compared with larger conferences like ASH and ASCO, it's much easier to interact with faculty, meet people, and build connections. It's less overwhelming, and I feel like you learn a lot more, continue learning, and connect with other trainees and experts in the field.

Madho Mal, MD

Chief Resident
(Research Chief)
Marshall University
Joan C. Edwards School of Medicine

What does it mean to attend the SOHO Annual Meeting as a Young Investigator?
Attending as a Young Investigator is a great honor and an important milestone in my career. As an internal medicine resident pursuing a future in hematology-oncology, this opportunity allows me to learn from leaders in the field, share ideas with fellow researchers, and build collaborations that will help me improve patient care. This scholarship motivates me to continue pursuing meaningful clinical and research contributions.

Saad Nasir, MD

University of Texas
MD Anderson Cancer Center

What are you excited about for this year's SOHO Annual Meeting?
There are two things: (1) Now that I'm in Houston, I'm going to attend locally, which is a huge improvement from the travel fatigue I previously experienced; and (2) I did a project last year, which I submitted on behalf of my junior fellows back in Pakistan. Going from being a mentor to now mentoring someone who is coming in to present our work at this year's meeting is very exciting.

SOHO has had a huge impact on physicians in Pakistan, especially in their training community. I remember the first time I came to the meeting, it was wonderfully managed, and the second year I already knew what to expect, so it was even better.

The other thing I'm excited about are the lymphoma sessions. There are wonderful talks, especially regarding CAR-T and BiTE sequencing; those are the things I'm actually very excited about.

Izel Okcu, MD

Mayo Clinic

What session are you most looking forward to?
This year will be my third year attending SOHO, and each year has been an invaluable experience. Before starting internal medicine residency, I spent almost three years focused on research in aggressive B-cell lymphomas, and I am now an internal medicine resident with the goal of pursuing a fellowship in hematology/oncology.

When I first attended SOHO as a research fellow, I was impressed by how well organized and educational the sessions were. As someone early in my training, I found the presentations easy to follow while providing in-depth discussions of recent developments in the field.

During my second year at SOHO, while I was in residency, I attended sessions across different hematologic malignancies to broaden my knowledge beyond my primary research area. I found this especially helpful as I transitioned from a primarily research-focused role into clinical training and began preparing for fellowship.

> "I really like how focused the meeting is. Compared with larger conferences like ASH and ASCO, it's much easier to interact with faculty, meet people, and build connections." —Julie Braish, MD

Muluken Megiso, MD

Marshall University
Joan C. Edwards School of Medicine

What session are you most looking forward to?
I am honored and excited to attend as a Young Investigator, and I am particularly interested in the MDS and leukemia sessions, where I hope to learn about emerging targeted therapies, novel drug combinations, and practice-changing clinical trial results.

I also look forward to exploring the latest abstracts; connecting with fellow trainees, program directors, and mentors; and gaining a clearer perspective on the future of hematologic oncology. This scholarship is a meaningful opportunity to strengthen my development as an aspiring hematologist-oncologist.

Thura Win Htut, MD

University of Texas
MD Anderson Cancer Center

What does it mean to attend the SOHO Annual Meeting as a Young Investigator?
Attending the SOHO Annual Meeting as a Young Investigator is a valuable opportunity to learn, connect, and grow. It inspires me to pursue impactful research and reminds me of the collective effort required to advance treatments and improve patients' lives.

Maria Felix Torres, MD

Jacobi Medical Center/
Albert Einstein College of Medicine

What are you looking forward to at the SOHO Annual Meeting?
I'm looking forward to meeting people who are interested in different aspects of hematologic malignancies. I'm also looking forward to meeting the other scholarship awardees so we can share our experiences and see which pathways or projects we may be able to collaborate on.

What are you presenting on this year at the meeting?
I'm sharing a case report describing a patient with a rare FGFR1-rearranged myeloid/lymphoid neoplasm who presented with an unusual clinical picture that initially obscured the diagnosis. We treated the patient upfront with pemigatinib, and the patient achieved a rapid complete hematologic response and is currently waiting to undergo hematopoietic cell transplantation.

The case adds to prior evidence supporting targeted therapy for this rare, aggressive malignancy. This is just a single case report, but it also goes along with emerging literature showing good outcomes with pemigatinib. We are looking forward to sharing it.

What session are you most looking forward to?
I am looking forward to the sessions on novel cellular therapies, particularly CAR T-cell therapy and bispecific antibodies, as well as advances in leukemia and lymphoma. These areas are rapidly transforming the treatment of hematologic malignancies, and I am excited to learn about the latest research and how these advances can translate into better patient outcomes.

Megan Melody, MD
Tampa General Hospital

Highlights in lymphoma: considering QoL, extending survival, and treatment sequencing decisions

Megan Melody, MD, shares her thoughtson the important lymphoma abstracts being shared at the meeting.

Fjoralba et al.

Health-Related Quality of Life of Patients With Advanced-Stage Classic Hodgkin Lymphoma Treated With BrECADD and eBEACOPP: Results From the HD21 Study

This post-hoc analysis of patient-reported outcomes (PROs) from the HD21 trial adds a meaningful survivorship perspective to the previously reported efficacy and safety advantages of BrECADD over eBEACOPP for newly diagnosed advanced-stage classic Hodgkin lymphoma (cHL). In approximately 1000 evaluable participants, health-related quality of life (HRQoL) was assessed longitudinally with the EORTC QLQ-C30 with up to 60 months of follow-up. Both regimens were associated with recovery in global health and QoL, physical functioning, fatigue, and dyspnea after therapy; however, BrECADD was generally associated with smaller declines in QoL during treatment, particularly in global health, fatigue, and dyspnea, as well as favorable longer-term functioning.

These findings are clinically relevant in a highly curable disease that frequently affects younger adults. When selecting a treatment regimen for this patient population, it is important to balance durable disease control with preservation of physical function and QoL. Strengths of this analysis include the randomized parent trial, well-balanced treatment groups, repeated longitudinal PRO assessments, adjustment for key baseline covariates, and follow-up extending to three years. Together with the established efficacy of BrECADD, these data support a patient-centered rationale for considering treatment burden alongside progression-free survival (PFS).

The applicability of these data to the US patient population is particularly interesting. Nivolumab-AVD (Nivo-AVD) is now the most common standard frontline approach for advanced-stage cHL in the United States. BrECADD has not been widely adopted as frontline therapy in the United States and is not currently a standard escalation strategy for patients with progression of disease after Nivo-AVD. eBEACOPP remains the more established escalation approach in this setting. Therefore, the direct frontline relevance of a BrECADD-versus-eBEACOPP comparison is limited in US practice, where eBEACOPP is now rarely selected upfront because of advances in novel agent-containing strategies. Nevertheless, the marked efficacy of BrECADD, together with better HRQoL and long-term functioning, raises an important question: Should BrECADD be prospectively studied as a potentially less toxic alternative escalation regimen for select patients with cHL who require treatment intensification on Nivo-AVD?

Reddy Gillela et al.

Did Novel Agents Change the Curve? Survival Acceleration in Hodgkin Lymphoma After 2016: SEER Analysis

The therapeutic landscape of cHL has shifted significantly over the past 10 years, and this SEER-based study suggests that those changes are now visible at the population level. Evaluating 27,250 adults diagnosed between 2005 and 2022, the investigators found progressively better survival across successive treatment eras. Relative to 2005 to 2010, mortality was lower during the brentuximab vedotin era, with an adjusted hazard ratio (HR) of 0.85, and lower still during the 2018 to 2022 era, with an adjusted HR of 0.76. The pace of HL-specific mortality reduction also accelerated after an estimated 2016 inflection point, increasing from 5.4% annually to 12.0% annually. Importantly, improvements extended across demographic and clinical subgroups, including patients aged 18 to 75 years.

The analysis is notable for its thoughtful effort to distinguish cHL-specific progress from general improvements in oncology care. Follicular lymphoma was used as a negative control, and the significant era-by-disease interaction supports a cHL-specific association between modern treatment eras and improved survival. In a disease that has long been considered highly curable, these findings reinforce that meaningful gains remain possible when effective novel agents are incorporated into treatment algorithms.

The likely drivers are multifactorial. Frontline BV-AVD and Nivo-AVD have expanded options for advanced-stage disease, while brentuximab vedotin- and PD-1 inhibitor-based salvage strategies (including BV-ICE, BV-Nivo, and pembrolizumab-GVD) have improved the ability to achieve disease control in the second-line setting. Although this is meaningful data, SEER lacks granular data on regimen selection, disease response, PFS, relapse timing, transplantation, comorbidity, and late toxicity and cannot determine whether the survival benefit arose primarily from first-line therapy, more effective salvage, improved transplant outcomes, or supportive care advances. Nonetheless, the magnitude and timing of the observed trend are encouraging.

This study also raises important questions regarding whether modern frontline regimens, including BV-AVD, Nivo-AVD, and BrECADD, reduce the proportion of patients who require second-line therapy compared with historical treatment regimens. Long-term follow-up is equally important to assess whether reduced cytotoxic chemotherapy exposure translates into fewer secondary malignancies. Repeating this analysis in five to 10 years, after broader adoption of Nivo-AVD as frontline standard of care for advanced-stage cHL, may provide a clearer view of the full impact of modern therapy.

Biswas et al.

Pirtobrutinib-First vs Brexucabtagene Autoleucel–First Sequencing Post Covalent BTK Inhibitor Failure in Mantle Cell Lymphoma: A Propensity-Matched Real-World Analysis

This is the largest real-world comparison to

date of two key post-covalent BTK inhibitor (cBTKi) treatment strategies for mantle cell lymphoma (MCL): pirtobrutinib and brexucabtagene autoleucel (brexu-cel). Using the TriNetX Research Network, the investigators identified 274 patients across 112 US healthcare organizations, including 200 who received pirtobrutinib and 74 who received brexu-cel after cBTKi therapy. In unadjusted analyses, overall survival (OS) favored brexu-cel, with an HR for death of 2.01 for pirtobrutinib compared with brexu-cel. This difference persisted after propensity score matching, with an HR of 1.82 and median OS of 828 days in the pirtobrutinib group versus not reached in the brexu-cel group.

Although these data raise interesting insights, it is important to note a few limitations. The brexu-cel cohort was small, and TriNetX does not capture key disease- and treatment-specific variables, including MCL biology, prior lines of therapy, TP53 status, disease burden, response to prior therapy, bridging treatment, and manufacturing timelines.

In multivariable analysis adjusting for age, sex, hemoglobin, lactate dehydrogenase, chronic kidney disease, prior sepsis, and other fitness-related characteristics, the survival difference between these two treatment modalities was no longer statistically significant. This suggests that patients able to proceed to CAR T-cell therapy may have more favorable performance status, disease kinetics, and organ function, as well as sufficient clinical stability to allow for referral to a treatment center, leukapheresis, manufacturing time, and tolerance of treatment-related toxicities. Therefore, the study provides useful comparative data but should not be interpreted as demonstrating a definitive survival advantage for brexu-cel over pirtobrutinib across all patients.

Clinically, both approaches remain important after cBTKi failure. Brexu-cel may provide durable disease control in eligible patients, whereas pirtobrutinib can be initiated rapidly and is more readily delivered in community practice. Prospective studies or carefully curated registries that incorporate disease kinetics, cellular therapy eligibility, PROs, toxicity, and access measures are needed to inform optimal sequencing.

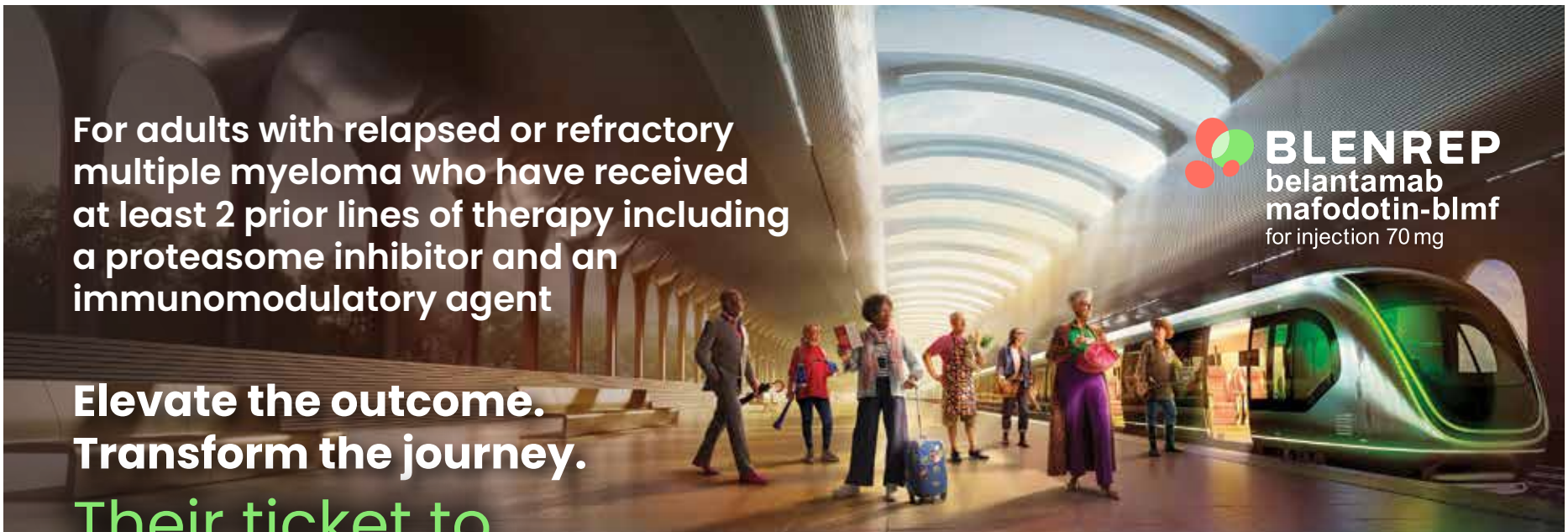
Wang et al.

Updated Results From the Phase 3 ECHO Trial of Bendamustine-Rituximab With or Without Acalabrutinib in Patients With Previously Untreated Mantle Cell Lymphoma: 50 Months of Follow-up

The updated ECHO analysis strengthens the evidence supporting incorporation of acalabrutinib into initial therapy for older adults with MCL. At a median follow-up of 60.8 months, acalabrutinib plus bendamustine and rituximab (BR) prolonged median PFS to 72.5 months compared with 47.8 months with BR alone, corresponding to a 32% reduction in the risk of progression or death (hazard ratio, 0.68; *P*=0.002). The analysis also showed delayed time to third-line therapy or death, with the median not reached in the acalabrutinib arm versus 73.8 months with placebo plus BR. This finding is notable because crossover to acalabrutinib was permitted after progression in the placebo group, yet the time-to-third-line endpoint continued to favor upfront acalabrutinib. These results support the concept that earlier BTK inhibition may provide clinical benefit that is not fully recaptured with delayed treatment.

Overall, these mature data demonstrate sustained PFS improvement with the addition of acalabrutinib to a BR backbone, as well as a clinically relevant post-hoc assessment of time-to-third-line treatment. However, the absence of a statistically significant OS benefit remains important. Interpretation of time-to-third-line therapy should also be cautious because this was a post-hoc endpoint and may be influenced by physician practice patterns, access to subsequent therapies, and crossover. In addition, the results apply specifically to patients aged 65 years or older receiving BR-based therapy and may not be generalizable to younger, transplant-eligible patients or to patients treated with emerging chemotherapy-sparing approaches.

Future studies should identify the biologic and clinical subgroups most likely to benefit from this approach, including patients with TP53 aberrations, blastoid or pleomorphic morphology, and high-risk MIPI scores. Comparative studies against other contemporary frontline strategies, together with analyses of measurable residual disease, QoL, late toxicity, and sequencing after acalabrutinib exposure, will be essential to refine individualized first-line management.



For adults with relapsed or refractory multiple myeloma who have received at least 2 prior lines of therapy including a proteasome inhibitor and an immunomodulatory agent

BLENREP
belantamab mafodotin-blmf
for injection 70 mg

Elevate the outcome.
Transform the journey.

Their ticket to
3x mPFS vs a daratumumab-based triplet
is within reach

PFS (HR=0.31 [95% CI: 0.21-0.47]); mPFS was 31.3 months (95% CI: 23.5-NR) for BVd (N=108) vs 10.4 months (95% CI: 7-13.4) for DVd (N=109).[1]

The data presented are based on a post hoc exploratory subgroup analysis (N=217) and not adjusted for multiplicity nor powered to detect a statistical difference.

Please scan for full Prescribing Information, including Boxed Warning, for BLENREP.

BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CI, confidence interval; DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); HR, hazard ratio; mPFS, median progression-free survival; NR, not reached.

INDICATION

BLENREP is indicated in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least 2 prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

IMPORTANT SAFETY INFORMATION

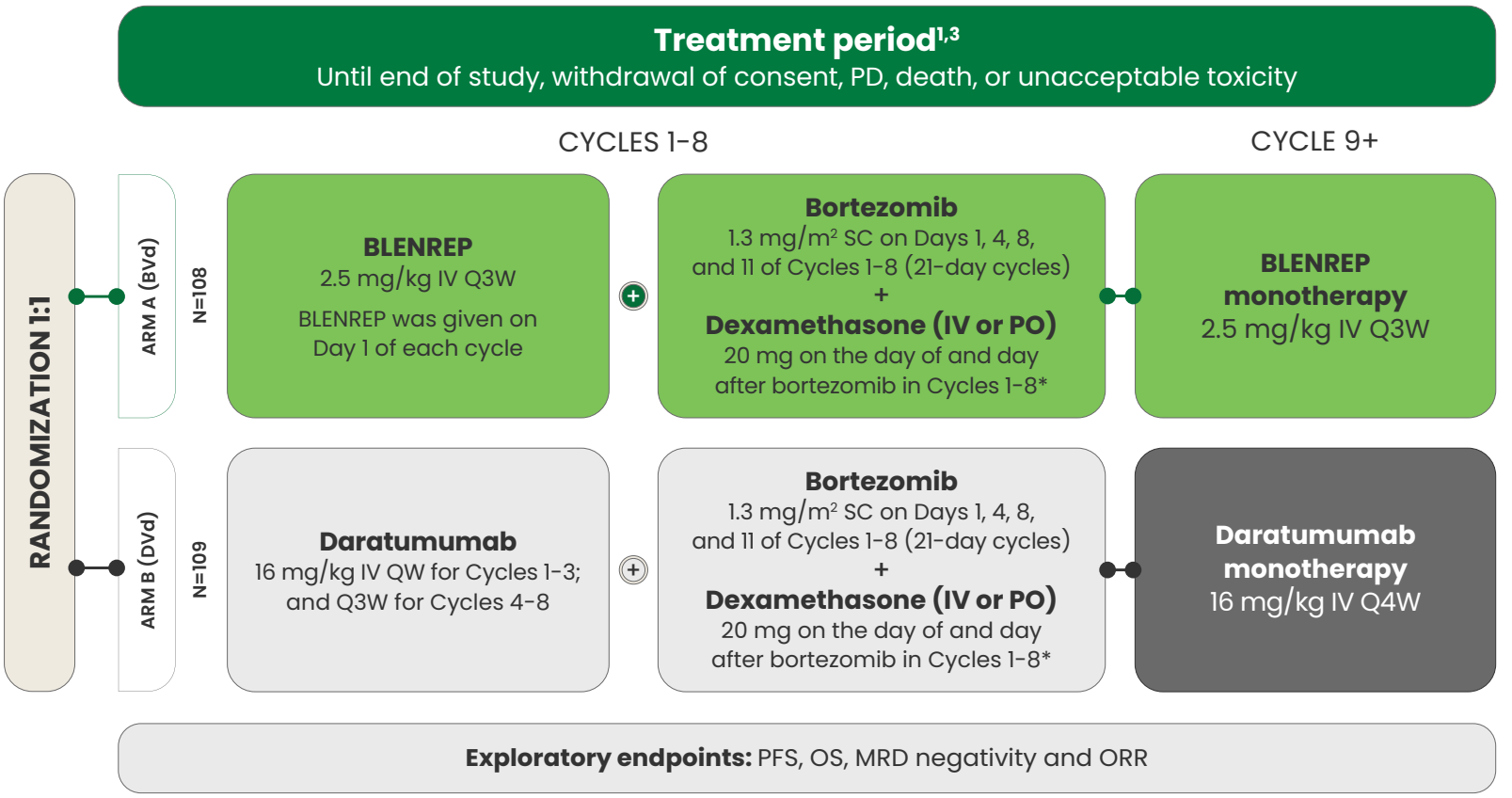
WARNING: OCULAR TOXICITY

- **BLENREP causes changes in the corneal epithelium resulting in changes in vision, including severe visual impairment, and symptoms such as blurred vision and dry eyes. In the clinical study, corneal ulcers, including cases with infection, also occurred.**
- **Conduct ophthalmic exams at baseline, before each dose, promptly for new or worsening symptoms, and as clinically indicated. In the clinical study, 83% of patients required a dosage modification due to ocular toxicity. Withhold BLENREP until improvement and resume or permanently discontinue, based on severity.**
- **Because of the risk of ocular toxicity, BLENREP is available only through a restricted program called the BLENREP Risk Evaluation and Mitigation Strategy (REMS).**

Please see additional Important Safety Information, including Boxed Warning, and the Brief Summary of Prescribing Information for BLENREP on the following pages.

DREAMM-7 was a pivotal Phase 3 trial designed to study a triplet combination vs a daratumumab-based triplet[1,2]

- FDA approval was based on a post hoc exploratory subgroup analysis of patients with at least 2 prior lines of therapy, including a proteasome inhibitor and immunomodulatory agent
- DREAMM-7 was an open-label, randomized (1:1), multicenter study in adult patients with multiple myeloma who received at least 1 prior line of therapy[1]



- **Follow-up period:** PFS Q3W.† Disease assessment Q3W. Follow-up for OS Q12W[3,‡]

Select eligibility criteria for efficacy population[1,3]

Inclusion criteria:

- Adults with RRMM
- 2 prior lines of MM therapy including a proteasome inhibitor and immunomodulatory agent
- Progressive disease during or after most recent therapy

Exclusion criteria:

- Prior treatment with anti-BCMA therapy
- Refractory to or intolerant of daratumumab or bortezomib
- Current corneal epithelial disease§

Patients were stratified by prior lines of treatment (1 vs 2 or 3 vs ≥4), R-ISS stage (I vs II/III), and prior bortezomib (yes vs no)[3]

***The dose of dexamethasone in each arm was reduced by half in patients aged ≥75 years.[1] †For patients who discontinue due to reasons other than PD.[3] ‡For patients who discontinue due to PD or other reasons.[3] §Patients with current corneal disease, except for mild punctate keratopathy, were excluded.[1]**

BCMA, B-cell maturation agent; BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); FDA, US Food and Drug Administration; IV, intravenous; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PO, by mouth; QW, every week; Q3W, every 3 weeks; Q4W, every 4 weeks; Q12W, every 12 weeks; R-ISS, Revised International Staging System; RRMM, relapsed or refractory multiple myeloma; SC, subcutaneous; Vd, bortezomib (V) + dexamethasone (d).

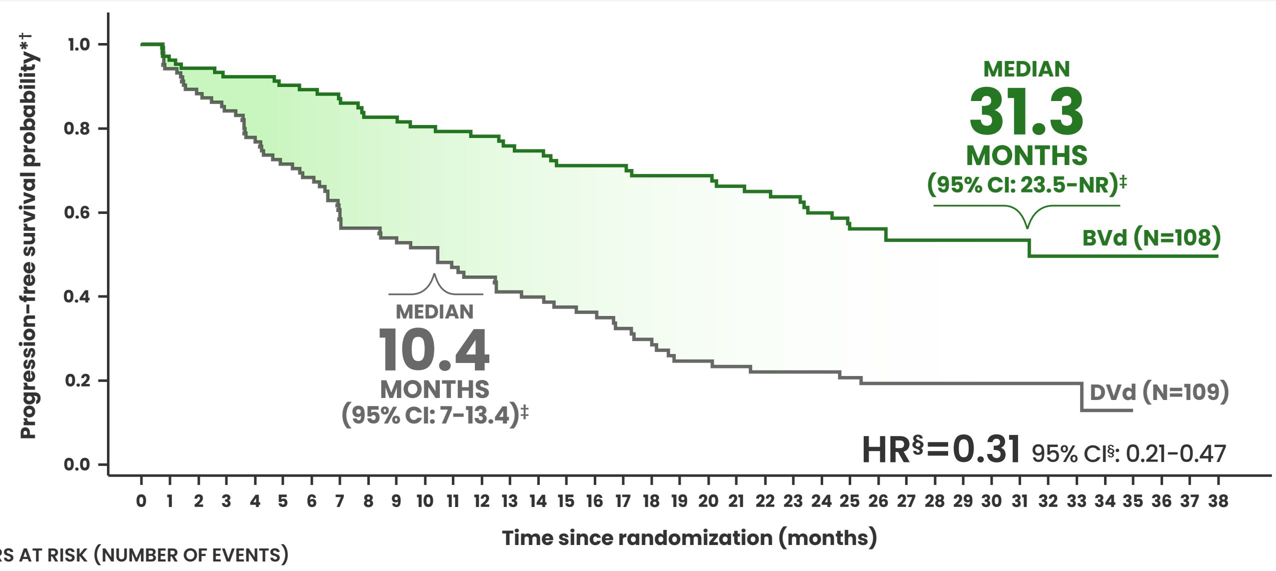
FDA approval was based on a post hoc exploratory subgroup analysis of patients with at least 2 prior lines of therapy, including a proteasome inhibitor and immunomodulatory agent.

The data presented are based on a post hoc exploratory subgroup analysis (N=217) and not adjusted for multiplicity nor powered to detect a statistical difference.

BLENREP
belantamab mafodotin-blmf
for injection 70 mg

BLENREP triplet combination (BVd) delivered 3x mPFS vs a daratumumab-based triplet (DVd)[1]

BVd is the first and only triplet that improved median PFS vs a daratumumab-based triplet, with durable benefit observed[1]



NUMBERS AT RISK (NUMBER OF EVENTS)

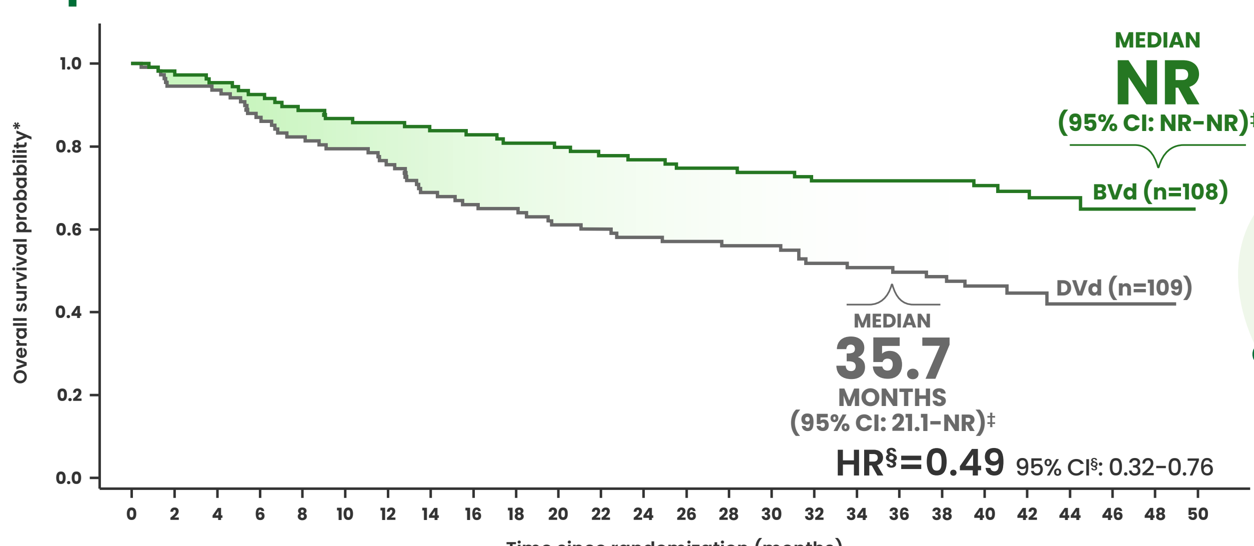
Month	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
BLENREP + bortezomib/dexamethasone	108 (0)	101 (4)	96 (6)	91 (8)	90 (8)	88 (10)	85 (11)	81 (13)	74 (17)	74 (17)	71 (19)	69 (20)	68 (21)	65 (23)	64 (24)	61 (27)	61 (27)	59 (27)	57 (29)	57 (29)
Daratumumab + bortezomib/dexamethasone	109 (0)	96 (6)	87 (12)	81 (16)	73 (23)	67 (28)	64 (31)	50 (42)	49 (42)	45 (45)	44 (46)	40 (50)	38 (52)	35 (55)	33 (56)	31 (58)	28 (59)	25 (62)	22 (65)	19 (68)

Month	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
BLENREP + bortezomib/dexamethasone	56 (29)	53 (31)	52 (32)	50 (33)	47 (36)	45 (38)	42 (39)	38 (41)	31 (41)	29 (41)	26 (41)	18 (41)	13 (42)	10 (42)	7 (42)	5 (42)	3 (42)	3 (42)	0 (42)
Daratumumab + bortezomib/dexamethasone	19 (68)	18 (69)	17 (70)	17 (70)	16 (70)	15 (71)	14 (72)	12 (72)	8 (72)	7 (72)	6 (72)	5 (72)	3 (72)	3 (72)	1 (73)	0 (73)	0 (73)	0 (73)	0 (73)

Response was based on Independent Review Committee per International Myeloma Working Group criteria.[1]

- PFS data had a median follow-up of 27.9 months[1]

BVd improved overall survival benefit vs DVd[1]



51% reduction in risk of death with BVd vs a daratumumab-based triplet[1]

NUMBERS AT RISK (NUMBER OF EVENTS)

BLENREP + bortezomib/dexamethasone	108 (0)	107 (1)	106 (2)	103 (3)	101 (5)	98 (7)	97 (8)	95 (10)	91 (12)	91 (12)	89 (14)	88 (15)	88 (15)	87 (16)	85 (17)	85 (17)	84 (18)	82 (18)	80 (20)	80 (20)	79 (21)	78 (22)	77 (23)	77 (23)	76 (24)	76 (24)
Daratumumab + bortezomib/dexamethasone	109 (0)	108 (1)	103 (6)	103 (6)	101 (7)	97 (9)	92 (14)	88 (18)	87 (19)	84 (21)	83 (22)	83 (22)	79 (26)	75 (30)	71 (33)	70 (34)	68 (36)	67 (37)	66 (37)	64 (39)	62 (41)	61 (41)	60 (42)	58 (44)	58 (44)	57 (45)

BLENREP + bortezomib/dexamethasone	74 (26)	74 (26)	74 (26)	73 (27)	72 (27)	72 (27)	70 (29)	70 (29)	70 (29)	70 (29)	69 (29)	69 (29)	67 (29)	67 (29)	55 (30)	48 (31)	44 (31)	35 (32)	27 (32)	22 (33)	16 (33)	13 (33)	9 (33)	4 (33)	0 (33)
Daratumumab + bortezomib/dexamethasone	56 (45)	55 (45)	54 (46)	54 (46)	53 (46)	52 (47)	49 (50)	49 (50)	48 (51)	48 (51)	46 (52)	46 (52)	44 (53)	41 (54)	36 (55)	27 (55)	20 (56)	16 (57)	14 (57)	12 (57)	9 (57)	9 (57)	5 (57)	1 (57)	0 (57)

- mOS for BVd was not reached. At the time of the interim analysis data cutoff, fewer patients on BVd (33; 31%) had an event vs DVd (57; 52%)[1]
- OS data had a median follow-up of 38.7 months[1]

*Based on all randomized patients who had received at least 2 prior lines of therapy including a proteasome inhibitor and immunomodulatory agent.[1] †Median follow-up of 27.9 months.[1] ‡By Brookmeyer and Crowley method.[1] §Based on stratified Cox regression model.[1]

BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CI, confidence interval; DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); HR, hazard ratio; mOS, median OS; mPFS, median progression-free survival; NR, not reached; OS, overall survival.

BLENREP has a well-characterized safety profile[1]

In DREAMM-7, the safety of BLENREP with bortezomib and dexamethasone (n=242) compared to daratumumab with bortezomib and dexamethasone (n=246) was assessed in patients who received at least 1 prior line of therapy. Safety of BLENREP in combination with bortezomib and dexamethasone in patients who have received only 1 prior line of therapy (n=125) has not been established.

Adverse reactions (≥20%) in patients with relapsed or refractory multiple myeloma who received BLENREP in DREAMM-7[1]

Adverse Reaction*	BLENREP + Vd N=242		Daratumumab + Vd N=246	
	All Grades (%)	Grades 3+4 (%)	All Grades (%)	Grades 3+4 (%)
Eye Disorders				
Reduction in BCVA†	89	57	44	9
Corneal exam findings†	86	72	19	3
Blurred vision	66	22	11	0.8
Dry eye‡	51	7	7	0
Photophobia	47	2	2	0
Foreign body sensation in eyes‡	44	3	4	0
Eye irritation	43	5	5	0
Eye pain‡	33	0.8	4	0.4
Cataract‡	24	8	14	3
Gastrointestinal Disorders				
Diarrhea	32	4	31	4
Infections				
Upper respiratory tract infection‡,§	38	2	36	2
Pneumonia‡,§	26	16	17	5
COVID-19§	24	5	20	2
Hepatobiliary Disorders				
Hepatotoxicity‡	33	14	16	2
General Disorders and Administration Site Conditions				
Fatigue‡	26	6	27	4

- **Serious adverse reactions** occurred in 50% of patients who received BVd. Serious adverse reactions in ≥2% of patients included pneumonia (18%), pyrexia (5%), thrombocytopenia (5%), COVID-19 (5%), upper respiratory tract infection (4%), sepsis (4%), second primary malignancy (3%), and anemia (2%)[1]
- **Fatal adverse reactions** occurred in 10% of patients who received BVd. Fatal adverse reactions which occurred in >1 patient included pneumonia (4%), sepsis (2%), COVID-19 (1%), respiratory failure (<1%), and intracranial hemorrhage (<1%)[1]
- **Permanent discontinuation** of BLENREP due to an adverse reaction occurred in 17% of patients. Adverse reactions which resulted in permanent discontinuation of BLENREP in ≥3% of patients included ocular toxicity (9%) and pneumonia (4%)[1]

*Adverse reactions, except ophthalmic exam findings, were graded according to CTCAE v5.0.[1] †Based on ophthalmic exam findings.[1] ‡Grouped term includes other related terms.[1] §Includes the following fatal adverse reactions: BVd: pneumonia (n=10), COVID-19 (n=3), upper respiratory tract infection (n=1); DVd: pneumonia (n=7), COVID-19 (n=5), pyrexia (n=1).[1]

BCVA, Best-Corrected Visual Acuity; BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CTCAE, Common Terminology Criteria for Adverse Events; Vd, bortezomib (V) + dexamethasone (d).

Please see additional Important Safety Information, including Boxed Warning, and the Brief Summary of Prescribing Information for BLENREP on the following pages.

IMPORTANT SAFETY INFORMATION (cont'd)

BLENREP
belantamab
mafodotin-blmf
for injection 70 mg

WARNINGS AND PRECAUTIONS

Ocular Toxicity

BLENREP causes ocular toxicity, defined as changes in the corneal epithelium and changes in BCVA based on ophthalmic exam (including slit lamp exam), or other ocular adverse reactions as defined by the CTCAE.

In DREAMM-7, ocular toxicity occurred in 92% of patients, including Grade 3 or 4 in 77% of patients. The most common ocular toxicities (>25%) were reduction in BCVA (89%) and corneal exam findings (86%) based on ophthalmic exam findings, blurred vision (66%), dry eye (51%), photophobia (47%), foreign body sensation in eyes (44%), eye irritation (43%), and eye pain (33%).

Ocular toxicity based on ophthalmic exam findings was reported as Grade 2 in 9% of patients, Grade 3 in 56% of patients, and Grade 4 in 21% of patients. The median time to onset of the first Grade 2 to 4 ophthalmic exam findings was 43 days (range: 15 to 611 days). The median duration of all Grade 2 to 4 ophthalmic exam findings was 85 days (range: 5 to 813 days). Patients experienced a median of 3 episodes (range: 1 to 11 episodes) of ocular toxicity based on ophthalmic exam findings. Of the patients with Grade 2 to 4 ophthalmic exam findings, 42% had improvement of the last event to Grade 1 or better; 22% had resolution of the last event based on return to baseline or normal ophthalmic exam findings.

The most commonly reported corneal exam findings included superficial punctate keratopathy, microcyst-like deposits, epithelial changes, and haze. Cases of corneal ulcer, including cases with infection, have been reported and should be managed promptly by an eye care professional.

A reduction in BCVA to 20/50 or worse in at least one eye occurred in 69% of patients, including 29% who experienced a change in BCVA to 20/100 or worse, and 12% who experienced a change in BCVA to 20/200 or worse. Of the patients with reduced BCVA to 20/50 or worse in at least one eye, 61% had resolution of the last event to baseline or better. Of the patients with reduced BCVA to 20/100 or worse, 57% had resolution of the last event. Of the patients with reduced BCVA to 20/200 or worse, 48% had resolution of the last event.

Ophthalmic exams (including slit lamp exam and BCVA assessment) should be conducted by an eye care professional, such as an ophthalmologist or optometrist, at baseline, before each dose of BLENREP, promptly for new or worsening symptoms, and as clinically indicated. Perform baseline exam within 4 weeks prior to the first dose. Perform each follow-up exam within 10 days prior to the next planned dose. All effort should be made to schedule the exam as close to BLENREP dosing as possible. Withhold BLENREP until improvement in both corneal exam findings and change in BCVA to Grade 1 or less and resume at same or reduced dose or permanently discontinue based on severity.

Counsel patients to promptly inform their healthcare provider of any ocular symptoms. Counsel patients to use preservative-free artificial tears at least 4 times a day starting with the first infusion and continuing until the end of treatment, and to avoid wearing contact lenses for the duration of therapy. Bandage contact lenses may be used under the direction of an eye care professional.

Changes in visual acuity may be associated with difficulty for driving and reading. Counsel patients to use caution when driving or operating machinery.

BLENREP Risk Evaluation and Mitigation Strategy (REMS)

BLENREP is available only through a restricted program called the BLENREP REMS because of the risk of ocular toxicity.

Further information is available at www.BLENREPREMS.com and 1-855-690-9572.

IMPORTANT SAFETY INFORMATION (cont'd)

Thrombocytopenia

Thrombocytopenia of any grade occurred in 100% of patients in DREAMM-7.

Grade 2 thrombocytopenia occurred in 10% of patients, Grade 3 in 29% of patients, and Grade 4 in 45% of patients. Clinically significant bleeding (Grade ≥2) occurred in 7% of patients with concomitant low platelet levels (Grade 3 or 4).

Monitor complete blood cell counts at baseline and periodically during treatment as clinically indicated. Withhold or reduce the dose of BLENREP based on severity.

Embryo-fetal Toxicity

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman because it contains a genotoxic compound (the microtubule inhibitor, monomethyl auristatin F [MMAF]) and it targets actively dividing cells.

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with BLENREP and for 4 months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose.

ADVERSE REACTIONS

The most common adverse reactions (≥20%) with BLENREP in combination with bortezomib and dexamethasone are reduction in BCVA, corneal exam findings, blurred vision, dry eye, photophobia, foreign body sensation in eyes, eye irritation, upper respiratory tract infection, hepatotoxicity, eye pain, diarrhea, fatigue, pneumonia, cataract and COVID-19.

The most common Grade 3 or 4 (≥10%) laboratory abnormalities are decreased platelets, decreased lymphocytes, decreased neutrophils, increased gamma-glutamyl transferase, decreased white blood cells, and decreased hemoglobin.

Please see accompanying full Prescribing Information, including BOXED WARNING, for BLENREP. For more information, please visit www.BLENREPhcp.com

Please see Brief Summary of Prescribing Information for BLENREP on the following pages.

References:

1. BLENREP. Prescribing information. GSK; 2025.
2. Hungria V, et al. *N Engl J Med*. 2024;391(5):393-407.
3. Hungria V, et al. *N Engl J Med*. 2024;391(5)(suppl):1-31.

PMUS-BLMJRNA260006 July 2026
Produced in USA.

Please see additional Important Safety Information, including Boxed Warning, on this spread and the Brief Summary of Prescribing Information for BLENREP on the following pages.

BLENREP
belantamab
mafodotin-blmf
for injection 70 mg

BRIEF SUMMARY

BLENREP (belantamab mafodotin-blmf) for injection, for intravenous use

The following is a brief summary; see full Prescribing Information for additional product information

WARNING: OCULAR TOXICITY

- **BLENREP causes changes in the corneal epithelium resulting in changes in vision, including severe visual impairment, and symptoms such as blurred vision and dry eyes. In the clinical study, corneal ulcers, including cases with infection, also occurred *[see Warnings and Precautions (5.1)]*.**
- **Conduct ophthalmic exams at baseline, before each dose, promptly for new or worsening symptoms, and as clinically indicated. In the clinical study, 83% of patients required a dosage modification due to ocular toxicity. Withhold BLENREP until improvement and resume or permanently discontinue, based on severity *[see Dosage and Administration (2.3), Warnings and Precautions (5.1)]*.**
- **Because of the risk of ocular toxicity, BLENREP is available only through a restricted program called the BLENREP Risk Evaluation and Mitigation Strategy (REMS) *[see Warnings and Precautions (5.2)]*.**

1 INDICATIONS AND USAGE

BLENREP is indicated in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ocular Toxicity

BLENREP causes ocular toxicity, defined as changes in the corneal epithelium and changes in BCVA based on ophthalmic exam (including slit lamp exam), or other ocular adverse reactions as defined by the CTCAE *[see Adverse Reactions (6.1)]*.

In DREAMM-7, ocular toxicity occurred in 92% of patients, including Grade 3 or 4 in 77% of patients. The most common ocular toxicities (>25%) were reduction in BCVA (89%) and corneal exam findings (86%) based on ophthalmic exam findings, blurred vision (66%), dry eye (51%), photophobia (47%), foreign body sensation in eyes (44%), eye irritation (43%), and eye pain (33%) *[see Adverse Reactions (6.1)]*.

Ocular toxicity based on ophthalmic exam findings was reported as Grade 2 in 9% of patients, Grade 3 in 56% of patients, and Grade 4 in 21% of patients. The median time to onset of the first Grade 2 to 4 ophthalmic exam findings was 43 days (range: 15 to 611 days). The median duration of all Grade 2 to 4 ophthalmic exam findings was 85 days (range: 5 to 813 days). Patients experienced a median of 3 episodes (range: 1 to 11 episodes) of ocular toxicity based on ophthalmic exam findings. Of the patients with Grade 2 to 4 ophthalmic exam findings, 42% had improvement of the last event to Grade 1 or better; 22% had resolution of the last event based on return to baseline or normal ophthalmic exam findings.

The most commonly reported corneal exam findings included superficial punctate keratopathy, microcyst-like deposits, epithelial changes, and haze. Cases of corneal ulcer, including cases with infection, have been reported and should be managed promptly by an eye care professional *[see Adverse Reactions (6.1)]*.

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5.1 Ocular Toxicity (cont'd)

A reduction in BCVA to 20/50 or worse in at least one eye occurred in 69% of patients, including 29% who experienced a change in BCVA to 20/100 or worse, and 12% who experienced a change in BCVA to 20/200 or worse. Of the patients with reduced BCVA to 20/50 or worse in at least one eye, 61% had resolution of the last event to baseline or better. Of the patients with reduced BCVA to 20/100 or worse, 57% had resolution of the last event. Of the patients with reduced BCVA to 20/200 or worse, 48% had resolution of the last event.

Ophthalmic exams (including slit lamp exam and BCVA assessment) should be conducted by an eye care professional, such as an ophthalmologist or optometrist, at baseline, before each dose of BLENREP, promptly for new or worsening symptoms, and as clinically indicated. Perform baseline exam within 4 weeks prior to the first dose. Perform each follow-up exam within 10 days prior to the next planned dose. All effort should be made to schedule the exam as close to BLENREP dosing as possible. Withhold BLENREP until improvement in both corneal exam findings and change in BCVA to Grade 1 or less and resume at same or reduced dose or permanently discontinue based on severity *[see Dosage and Administration (2.1, 2.3) of the full Prescribing Information]*.

Counsel patients to inform their healthcare provider of any ocular symptoms. Counsel patients to use preservative-free artificial tears at least 4 times a day starting with the first infusion and continuing until the end of treatment, and to avoid wearing contact lenses for the duration of therapy. Bandage contact lenses may be used under the direction of an eye care professional *[see Dosage and Administration (2.1) of the full Prescribing Information]*.

Changes in visual acuity may be associated with difficulty for driving and reading. Counsel patients to use caution when driving or operating machinery.

5.2 BLENREP Risk Evaluation and Mitigation Strategy (REMS)

BLENREP is available only through a restricted program called the BLENREP REMS because of the risk of ocular toxicity *[see Warnings and Precautions (5.1)]*. Notable requirements of the BLENREP REMS include the following:

- Prescribers must be certified in the BLENREP REMS by enrolling and completing training.
- Prescribers must counsel patients receiving BLENREP on the risk of ocular toxicity, the need for monitoring via ophthalmic exams before each dose, and provide patients with the BLENREP REMS Patient Guide.
- Patients must be enrolled in the BLENREP REMS and adhere to monitoring.
- Healthcare settings that dispense BLENREP must be certified in the BLENREP REMS by enrolling and must obtain authorization prior to dispensing.
- Wholesalers and distributors must distribute BLENREP only to certified healthcare settings.

Further information is available at www.BLENREPREMS.com and 1-855-690-9572.

5.3 Thrombocytopenia

Thrombocytopenia of any grade occurred in 100% of patients in DREAMM-7 *[see Adverse Reactions (6.1)]*.

Grade 2 thrombocytopenia occurred in 10% of patients, Grade 3 in 29% of patients, and Grade 4 in 45% of patients. Clinically significant bleeding (Grade ≥2) occurred in 7% of patients with concomitant low platelet levels (Grade 3 or 4).

Monitor complete blood cell counts at baseline and periodically during treatment as clinically indicated. Withhold or reduce the dose of BLENREP based on severity *[see Dosage and Administration (2.3) of the full Prescribing Information]*.

5.4 Embryo-fetal Toxicity

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman because it contains a genotoxic compound (the microtubule inhibitor, monomethyl auristatin F [MMAF]) and it targets actively dividing cells.

(continued on next page)

5.4 Embryo-fetal Toxicity (cont'd)

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with BLENREP and for 4 months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose *[see Use in Specific Populations (8.1, 8.3)]*.

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Ocular Toxicity *[see Warnings and Precautions (5.1)]*
- Thrombocytopenia *[see Warnings and Precautions (5.3)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Relapsed or Refractory Multiple Myeloma in Combination with Bortezomib and Dexamethasone

The safety of BLENREP with bortezomib and dexamethasone (n = 242) compared with daratumumab with bortezomib and dexamethasone (n = 246) was evaluated in DREAMM-7 in patients with relapsed or refractory multiple myeloma who received at least one prior line of therapy *[see Clinical Studies (14) of the full Prescribing Information]*. Patients received BLENREP 2.5 mg/kg of actual body weight once every 3 weeks in combination with bortezomib and dexamethasone (BVd) for the first 8 cycles, followed by BLENREP as a single agent or daratumumab in combination with bortezomib and dexamethasone (DVd) for the first 8 cycles, followed by daratumumab as a single agent. Among patients who received BLENREP, 69% were exposed for 6 months or longer and 55% were exposed for greater than one year. The safety of BLENREP in combination with bortezomib and dexamethasone in patients who received only one prior line of therapy (n = 125) has not been established.

Serious adverse reactions occurred in 50% of patients who received BVd. Serious adverse reactions in ≥2% of patients included pneumonia (18%), pyrexia (5%), thrombocytopenia (5%), COVID-19 (5%), upper respiratory tract infection (4%), sepsis (4%), second primary malignancy (3%), and anemia (2%). Fatal adverse reactions occurred in 10% of patients who received BVd. Fatal adverse reactions which occurred in >1 patient included pneumonia (4%), sepsis (2%), COVID-19 (1%), respiratory failure (<1%), and intracranial hemorrhage (<1%).

Permanent discontinuation of BLENREP due to an adverse reaction occurred in 17% of patients. Adverse reactions which resulted in permanent discontinuation of BLENREP in ≥3% of patients included ocular toxicity (9%) and pneumonia (4%).

Dosage interruptions of BLENREP due to an adverse reaction occurred in 78% of patients. Adverse reactions which required dosage interruption of BLENREP in ≥3% of patients included ocular toxicity based on ophthalmic exam findings (74%), blurred vision (32%), upper respiratory tract infection (20%), dry eye (14%), photophobia (14%), pneumonia (14%), eye irritation (13%), COVID-19 (12%), foreign body sensation in eyes (12%), eye pain (10%), thrombocytopenia (9%), visual impairment (7%), cataract (5%), diarrhea (4%), and neutropenia (4%).

Dosage reductions of BLENREP due to an adverse reaction occurred in 36% of patients. Adverse reactions which required dosage reductions for BLENREP in ≥3% of patients included ocular toxicity based on ophthalmic exam findings (30%), thrombocytopenia (14%), and blurred vision (10%).

The most common adverse reactions (≥20%) were reduction in BCVA, corneal exam findings, blurred vision, dry eye, photophobia, foreign body sensation in eyes, eye irritation, upper respiratory tract infection, hepatotoxicity, eye pain, diarrhea, fatigue, pneumonia, cataract, and COVID-19. The most common Grade 3 or 4 laboratory abnormalities (≥10%) were decreased platelets, decreased lymphocytes, decreased neutrophils, increased gamma glutamyltransferase, decreased white blood cells, and decreased hemoglobin.

Table 4 summarizes the adverse reactions in DREAMM-7.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

Table 4. Adverse Reactions (≥10%) in Patients with Relapsed or Refractory Multiple Myeloma Who Received BLENREP in DREAMM-7

Adverse Reactiona	BLENREP + Bortezomib and Dexamethasone N = 242		Daratumumab + Bortezomib and Dexamethasone N = 246	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Eye disorders				
Reduction in BCVA[b]	89	57	44	9
Corneal exam findings[b]	86	72	19	3
Blurred vision	66	22	11	0.8
Dry eye[c]	51	7	7	0
Photophobia	47	2	2	0
Foreign body sensation in eyes[c]	44	3	4	0
Eye irritation	43	5	5	0
Eye pain[c]	33	0.8	4	0.4
Cataract[c]	24	8	14	3
Visual impairment	11	5	2	0.4
Gastrointestinal disorders				
Diarrhea	32	4	31	4
Nausea	16	0.8	12	0
Infections				
Upper respiratory tract infection[c,d]	38	2	36	2
Pneumonia[c,d]	26	16	17	5
COVID-19[d]	24	5	20	2
Hepatobiliary disorders				
Hepatotoxicity[c]	33	14	16	2
General disorders and administration site conditions				
Fatigue[c]	26	6	27	4
Pyrexia[c,d]	19	0.4	11	2

BCVA = best-corrected visual acuity; BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone.

[a] Adverse reactions, except ophthalmic exam findings, were graded according to Common Terminology Criteria for Adverse Events v5.0.

[b] Based on ophthalmic exam findings.

[c] Grouped term includes other related terms.

[d] Includes the following fatal adverse reactions: BVd: pneumonia (n = 10), COVID-19 (n = 3), upper respiratory tract infection (n = 1); DVd: pneumonia (n = 7), COVID-19 (n = 5), pyrexia (n = 1).

Clinically relevant adverse reactions in <10% of patients who received BVd included: increased lacrimation, vomiting, diplopia, albuminuria, sepsis, eye pruritus, infusion-related reactions, corneal ulcer (including cases with infection), and pneumonitis.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

Table 5 summarizes the laboratory abnormalities in DREAMM-7.

Table 5. Select Laboratory Abnormalities (>10%) That Worsened from Baseline in Patients with Relapsed or Refractory Multiple Myeloma Who Received BLENREP in DREAMM-7

Laboratory Abnormality	BLENREP + Bortezomib and Dexamethasone[a]		Daratumumab + Bortezomib and Dexamethasone[a]	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Hematology				
Platelets decreased	100	74	88	48
Lymphocytes decreased	90	53	92	56
Leukocytes decreased	59	11	67	17
Neutrophils decreased	52	17	53	13
Hemoglobin decreased	51	10	60	12
Chemistry				
Aspartate aminotransferase increased	88	5	40	0
Gamma glutamyltransferase increased	73	15	44	3
Alanine aminotransferase increased	71	5	54	1
Creatinine increased	51	2	53	<1
Creatine phosphokinase increased	48	3	31	3

BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone.

[a] The denominator used to calculate the rate varied from 238 to 241 (BVd) and 243 to 246 (DVd) based on the number of patients with a baseline value and at least one post-treatment value.

Patient-reported ocular symptoms were assessed using the Patient-Reported Outcomes Common Terminology Criteria for Adverse Events (PRO-CTCAE) and Ocular Surface Disease Index (OSDI).

PRO-CTCAE assessments were collected at baseline and then every 3 weeks until treatment discontinuation. Completion rates in both arms were ≥90% at baseline and ≥81% at subsequent timepoints where >50% of patients remained on treatment. OSDI assessments were collected every 3 weeks until Dose 6 and then every 6 weeks thereafter until treatment discontinuation for BVd and every 3 weeks until Cycle 6 and then every 12 weeks thereafter until treatment discontinuation for DVd. Completion rates in both arms were ≥90% at baseline and ≥52% at subsequent timepoints where >50% of patients remained on treatment.

Table 6 summarizes the patient-reported symptom of blurred vision as assessed by PRO-CTCAE.

Table 6. Patient-Reported Symptom of Blurred Vision Assessed by PRO-CTCAE in Patients with Relapsed or Refractory Multiple Myeloma in DREAMM-7

Symptom (Attribute)[a]	Any Symptom Before Treatment[b]		Score 3 or 4 Before Treatment[c]		Any Symptom on Treatment[d,e]		Score 3 or 4 on Treatment[d,f]	
	BVd (%) n = 232	DVd (%) n = 227	BVd (%) n = 232	DVd (%) n = 227	BVd (%) n = 238	DVd (%) n = 239	BVd (%) n = 238	DVd (%) n = 239
Blurred vision (severity)	28	24	<1	2	93	74	55	15

BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone; PRO-CTCAE = patient-reported outcomes common terminology criteria for adverse events.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

[a] Symptom attribute scoring defined as severity with a score of 0 = 'none'; 1 = 'mild'; 2 = 'moderate'; 3 = 'severe'; 4 = 'very severe'.

[b] Percentage of patients whose symptom score before treatment was 1 to 4.

[c] Percentage of patients whose symptom score before treatment was 3 or 4.

[d] Number of patients who provided at least one on-treatment score.

[e] Percentage of patients whose maximum post-baseline score was 1 to 4 on treatment.

[f] Percentage of patients whose maximum post-baseline score was 3 or 4 on treatment.

Driving at night was assessed using the OSDI. At baseline, the proportion of patients who reported limitations with driving at night "all of the time" or "most of the time" during the last week was 9% in the BVd arm and 4% in the DVd arm. The proportion of patients who reported limitations with driving at night "all of the time" or "most of the time" during the last week was highest in the BVd arm at 47% at Week 13 and in the DVd arm at 12% at Week 76.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman, because it contains a genotoxic compound (the microtubule inhibitor, MMAF) and it targets actively dividing cells *[see Clinical Pharmacology (12.1), Nonclinical Toxicology (13.1) of the full Prescribing Information]*. Human immunoglobulin G (IgG) is known to cross the placenta; therefore, belantamab mafodotin-blmf has the potential to be transmitted from the mother to the developing fetus. There are no available data on the use of BLENREP in pregnant women to evaluate for drug-associated risk. No animal reproduction studies were conducted with BLENREP. Advise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

8.2 Lactation

Risk Summary

There are no data on the presence of belantamab mafodotin-blmf in human milk or the effects on the breastfed child or milk production. Because of the potential for serious adverse reactions in the breastfed child, advise women not to breastfeed during treatment with BLENREP and for 3 months after the last dose.

8.3 Females and Males of Reproductive Potential

BLENREP can cause fetal harm when administered to pregnant women *[see Use in Specific Populations (8.1)]*.

Pregnancy Testing

Verify the pregnancy status of females of reproductive potential prior to initiating BLENREP.

Contraception

Females: Advise females of reproductive potential to use effective contraception during BLENREP treatment and for 4 months after the last dose.

Males: Because of the potential for genotoxicity, advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose *[see Nonclinical Toxicology (13.1) of the full Prescribing Information]*.

(continued on next page)

8.3 Females and Males of Reproductive Potential (cont'd)

Infertility

Based on findings in animal studies, BLENREP may impair fertility in females and males. The effects were not reversible in male rats but were reversible in female rats *[see Nonclinical Toxicology (13.1) of the full Prescribing Information]*.

8.5 Geriatric Use

Of 242 patients who received BLENREP in DREAMM-7, 121 patients (50%) were aged 65 years or older and 37 patients (15%) were 75 years or older. No overall differences in the safety of BLENREP were observed between patients 65 years of age and older and younger adult patients.

Of the 108 patients who received BLENREP and were evaluated for efficacy in the DREAMM-7 study, there was an insufficient number of older adult patients to determine if the effectiveness in patients 65 years of age and older is different than in younger adult patients.

8.6 Hepatic Impairment

No dose adjustment is recommended for patients with mild hepatic impairment (total bilirubin > upper limit of normal [ULN] to ≤1.5 × ULN and any aspartate aminotransferase [AST] or total bilirubin ≤ULN with AST >ULN).

The recommended dose of BLENREP has not been established in patients with moderate or severe hepatic impairment *[see Clinical Pharmacology (12.3) of the full Prescribing Information]*.

Manufactured by:

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For:

GlaxoSmithKline

Durham, NC 27701

BLP:1BRS

Approved: 10/2025

PMUS-BLMJRNA260006 July 2026
Produced in USA.

Let's get social! Tag #SOHO2026

Jessica Altman, MD
@jaltmanmd

I do not envy Dr. Pieters who is debating @DrHKantarjian in the role of minimizing #chemotherapy in #ALL during @SocietyofHemOnc 2026! Dr. Kantarjian's talk elegantly highlighted the remarkable progress in ALL.

Fieke Hoff
@FiekeHoff

Back at @SocietyofHemOnc, great talks and people!! #SOHO26 @UTMDAnderson @beatallleukemia

Naveen Pemmaraju, MD
@doctorpemm

👉👉👉 Fantastic to be at @SocietyofHemOnc #SOHO26 #SOHO2026 with friends & colleagues! #leusm #BPDCN #MPNSM

Jessica Altman, MD
@jaltmanmd

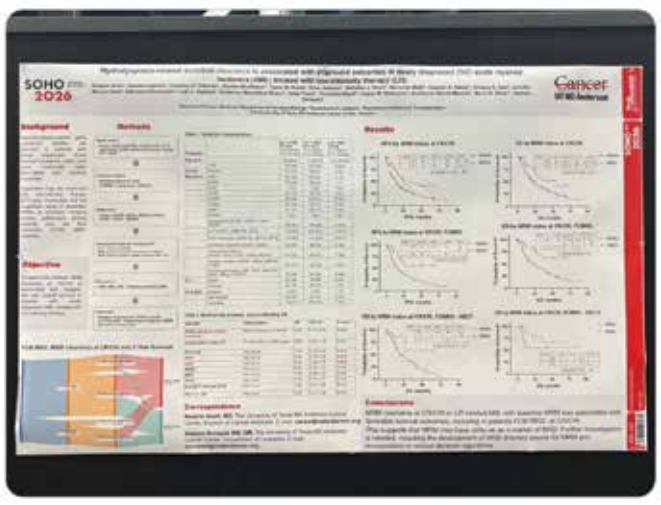
@yasminabaza1 and I ran into this T cell during #SOHO2026! @SocietyofHemOnc

Gaby Hobbs
@GabyHobbs

Great start to #SOHO2026 got to take first photo with my awesome fellow, Dr. Kate Feder presenting our experience at #MGH with ropeg. Excited to present this morning on novel therapies in ET and PV which included 2 new approved drugs! 🥳#mpnsm

Naszrin Arani, M.D.
@naszrinMD

Grateful to @jayastuMD for his mentorship on our work being presented at #SOHO2026! We found that myelodysplasia-related mutation clearance in newly diagnosed AML treated with low-intensity therapy was associated with improved survival. #AML @UTMDAnderson @SocietyofHemOnc



Mike Thompson, MD, PhD, FASCO
@mtmdphd

There are a number of Wisconsinites in Houston, TX for #SOHO2026 - @lauracmichaelis @NatalieCal51870 Fenske, Atallah et al. #mpnsm #leusm #lymsm #mmsm

Ready, set, SOHO!


SAFETY, TOLERABILITY AND CLINICAL ACTIVITY OF ANITO-CEL IN RRMM
SOHO 2026
BACKGROUND
METHODS
CONCLUSION
RESULTS
DISCUSSION


SOHO
ANNUAL MEETING
2026
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SOHO Spotlight brings clinical education into focus

This year, SOHO launched SOHO Spotlight, a new podcast dedicated to in-depth educational conversations in hematologic malignancies.

SOHO Spotlight complements the SOHO Insider podcast, launched in 2025 as an extension of the society's official media platform. While SOHO Insider focuses on reporting from major meetings, breaking developments, and conversations with experts shaping the field, SOHO Spotlight takes a deeper educational approach, exploring how emerging evidence can inform clinical practice.

SOHO Spotlight offers in-depth conversations on emerging therapies and practice-changing developments in leukemias, lymphomas, myelomas, myelodysplastic syndromes, and myeloproliferative neoplasms. The podcast provides clinicians with timely, real-world perspectives from the field's leading voices.

The first episode of SOHO Spotlight was released this summer and featured **Jae Park, MD,** chief of the Cellular Therapy Service at Memorial Sloan Kettering Cancer Center, and **Nicholas Short, MD,** associate professor in the Department of Leukemia at the University of Texas MD Anderson Cancer Center.

The episode, titled "Optimizing Outcomes in Adult Acute Lymphoblastic Leukemia (ALL) with CAR-T Cell Therapies," covered topics such as emerging evidence that supports safer outpatient treatment, individualized decisions regarding stem cell transplant after CAR T-cell therapy, and the potential for CAR-T to move into earlier lines of treatment, with the goal of improving long-term outcomes.

New episodes of SOHO Spotlight can be found under the Education tab on **sohoonline.org**.

You can also listen to episodes on Spotify, Amazon, Apple Podcast, and YouTube.

EPISODE 1 HIGHLIGHTS

0:50–2:45	**Why early referral matters**	"Getting these patients early, thinking about CAR T-cell therapy early… making that email, phone call, or text to a neighboring CAR T center is critical."
3:35–6:40	**Comparing today's CAR T therapies**	"The great news is that both products work very well… response rates in the range of 80%, which is pretty incredible in these relapsed/refractory patients."
5:20–6:35	**A safer generation of CAR T**	"With obecabtagene… severe CRS and neurotoxicity are in the 3–5% range, dramatically lower than 25%."
7:45–10:20	**Who needs a transplant after CAR T?**	"This is probably the most difficult and challenging question… We make these decisions based on what we know from clinical trials and real-world data."
11:40–13:50	**The future: outpatient CAR T and improving access**	"Now we're beginning to administer more of this CAR T-cell therapy as an outpatient… It's good for patients—they spend less time in the hospital."
12:35–13:50	**The biggest takeaway**	"We have an effective therapy, now a safer therapy… we want to see patients early and make decisions earlier rather than later."
14:45–16:20	**Where the field is headed**	"The biggest potential I see with CAR T-cell therapy is its limited duration of treatment… Can we replace blocks of chemotherapy and potentially cure patients with much less treatment?"
15:50–16:40	**Looking toward the future**	"If successful, CAR T could reduce the need for years of chemotherapy and even decrease the number of lumbar punctures patients undergo."

Meet the team: SOHO Spotlight

Latha Shivakumar, PhD

Senior Director, Clinical Education and Research at SOHO

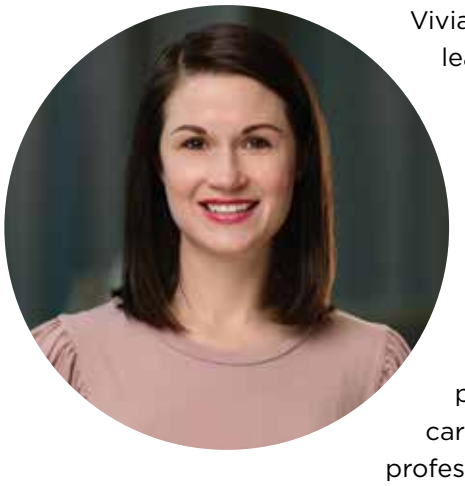
Dr. Shivakumar is a strategic healthcare leader with more than 20 years of experience developing oncology education, research, and quality improvement initiatives. She specializes in building high-impact partnerships, securing grant funding, and translating strategic priorities into programs that advance hematologic oncology education and patient care.

What is the best part of working at SOHO?
The best part is collaborating with a passionate global community of hematologic oncology professionals and helping create educational initiatives that can ultimately improve patient care.

What do you do in your free time?
I enjoy spending time outdoors hiking, biking, exploring local trails, and playing with my dog, Twilight, who always keeps me active and entertained.

Vivian Dondlinger, MPH

Program Manager at SOHO



Vivian is a healthcare program leader with over 10 years of experience managing clinical, research, education, and workforce initiatives. Her expertise includes strategic program improvement, grant management, CME/CE education, stakeholder engagement, and developing programs that improve cancer care and support oncology professionals.

What is the best part of working at SOHO?
I am grateful that I am already enjoying my job so much after just a few weeks. I enjoy everyone I work with, and I am excited to be working on so many new educational initiatives.

What do you do in your free time?
When I am not with my kids, I enjoy reading (a lot), walking (with audiobooks), bingeing reality TV, connecting with friends, and trying new restaurants.

soho SPOTLIGHT
society of hematologic oncology

2026 CALENDAR OF EVENTS

October

Optimizing the Outcomes for Diffuse Large B-cell Lymphoma in the Community

Jeremy Abramson, MD, MMSC
Director, Jon and Jo Ann Hagler Center for Lymphoma
Professor of Medicine, Harvard Medical School

Joshua Brody, MD
Director, Lymphoma Immunotherapy Program
Icahn School of Medicine at Mount Sinai
Hess Center for Science and Medicine

November

Closing the Referral Gap: Why Early HCT Consultation Changes Outcomes — and How to Get There

December

Navigating Antibody Drug Conjugates in Relapsed/Refractory Multiple Myeloma

To subscribe to the podcast, visit **soho.click/spotlightpodcast-subscribe**.

SOHO WORD SEARCH

W	F	N	R	Y	I	Z	O	S	A	V	K	Y	L	S	H	L	G
V	R	F	L	P	T	J	R	L	W	S	M	B	U	C	B	C	W
T	R	J	X	A	C	J	U	S	I	K	P	O	S	E	B	S	K
M	B	N	D	R	F	L	G	A	O	H	E	F	U	H	J	L	L
H	Y	U	L	E	D	C	V	T	N	N	P	Q	W	X	C	D	D
V	N	W	B	H	A	I	W	W	A	S	J	O	W	Q	B	Q	C
D	A	Y	G	T	G	F	Y	T	Y	Y	C	I	R	I	Z	I	H
I	I	K	A	R	I	I	U	O	K	A	B	Q	N	T	T	N	A
P	J	D	Y	A	X	C	H	W	H	O	O	I	U	U	U	O	K
E	R	I	P	L	B	E	M	Z	H	V	T	Z	E	T	G	E	F
R	A	X	X	U	L	P	B	O	M	A	F	P	T	U	W	Y	N
S	T	B	S	L	P	S	S	D	N	L	A	Y	K	F	J	K	E
I	N	S	I	L	D	I	H	O	C	R	X	I	H	X	C	X	H
O	A	M	R	E	T	R	P	L	E	C	A	T	L	I	C	D	I
U	K	Q	I	C	J	T	I	H	V	Q	E	W	H	S	Y	H	B
C	S	U	O	E	N	A	T	U	C	B	U	S	U	K	D	Q	V
X	E	L	Z	I	F	T	O	M	E	N	I	B	N	D	C	P	B
L	I	S	O	C	E	L	K	O	T	T	T	E	V	T	A	J	Z

BPCDN
CELLULAR THERAPY
CILTACEL
DIPERSIO
DLBCL
KANTARJIAN
LISOCEL
NEUTROPHIL
PONATINIB
SOHO
SUBCUTANEOUS
ZIFTOMENIB
THERAPEUTIC
TRISPECIFIC

RECRUITING

A Phase 3 Study of Pelabresib (DAK539) and Ruxolitinib in Myelofibrosis (MF) (MANIFEST-3)

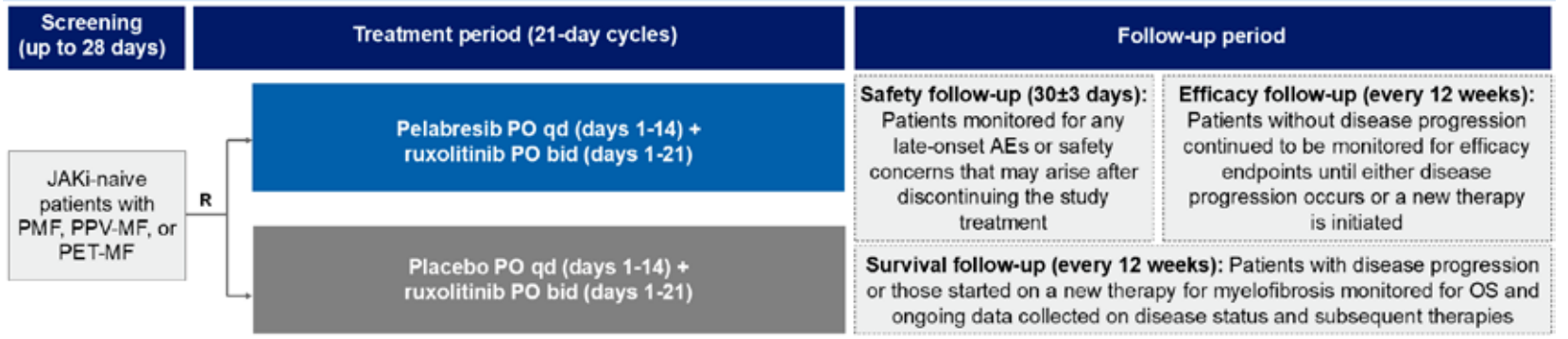
NCT07357727

The purpose of this trial is to evaluate whether treatment with pelabresib in combination with ruxolitinib leads to improved clinical outcomes compared to ruxolitinib alone in patients with primary myelofibrosis (PMF), post-polycythemia vera myelofibrosis (PPV-MF), or post-essential thrombocythemia myelofibrosis (PET-MF) who have not previously received Janus kinase (JAK) inhibitor therapy.

Key Inclusion Criteria[1]:

- Patients (≥18 years) with a diagnosis of PMF, PPV-MF, or PET-MF (per the International Consensus Classification of Myeloid Neoplasms and Acute Leukemias 2022) and a DIPSS risk category of intermediate-1, intermediate-2, or high-risk
- Patients must have a spleen volume ≥450 cm^3, average TSS ≥15 (MFSAF v.4.0) within 7 days prior to randomization, and an ECOG PS 0-2
- Patients with blasts <5% in peripheral blood and platelet count ≥100 x 10^9/L without growth factor or transfusions for the previous 4 weeks

Study Design[1]: N ≈ 460



Primary Endpoints[1]

- Patients with baseline TSS ≥25
  - SVR35 response at week 24
  - Absolute change in TSS at week 24
- Patients with baseline TSS ≥15
  - SVR35 response at week 24
  - Absolute change in TSS at week 24

Secondary Endpoints[1]

- SVR35 response at week 12, week 36, week 48, and thereafter
- Absolute and percentage change in spleen volume from baseline over time
- Time to first SVR35 response and duration of first SVR35 response
- TSS50 response at week 12, week 24, week 36, week 48, and thereafter
- Time to first TSS50 response and duration of first TSS50 response
- Absolute and percentage change in TSS from baseline over time
- Dual response (SVR35 + TSS50), OS, PFS, and LFS
- Hemoglobin and anemia response, and change in hemoglobin from baseline over time
- AEs/SAEs, and EAIR in patients with leukemic transformation
- Change from baseline over time in fatigue (measured by PROMIS SF v1.0 Fatigue 7a) and overall QoL and functional scales (measured by EORTC QLQ-C30)
- Pelabresib plasma concentrations, and pelabresib plasma PK parameters in patients enrolled in China and Japan

For More Information About the Study Design or Enrollment

- See the Novartis medical representative at this booth
- US residents may call our clinical trials hotline at 1-888-NOW-NOVA (1-888-669-6682)
- For countries outside the United States, please contact your local Novartis medical representative
- Visit www.clinicaltrials.gov for eligibility criteria

Acronyms:

AE, adverse event; bid, twice a day; DIPSS, Dynamic International Prognostic Scoring System; EAIR, exposure-adjusted incidence rate; ECOG PS, Eastern Cooperative Oncology Group performance status; EORTC QLQ-C30, European Organisation for Research and Treatment of Cancer – quality of life questionnaire – core 30; JAK, Janus kinase; JAKi, JAK inhibitor; LFS, leukemia-free survival; MF, myelofibrosis; MFSAF v.4.0, MF symptom assessment form version 4.0; OS, overall survival; PFS, progression-free survival; PK, pharmacokinetics; PO, per oral; PROMIS SF, Patient-reported outcomes measurement information system short form; qd, once daily; QoL, quality of life; SAE, serious AE; SVR35, ≥35% reduction in spleen volume; TSS, total symptom score; TSS50, TSS reduction of 50%.

REFERENCES: 1. ClinicalTrials.gov. NCT07357727. Accessed February 1, 2026. https://clinicaltrials.gov/study/NCT07357727

Compound(s) are either investigational or being studied for (a) new use(s). Efficacy and safety have not been established and there is no guarantee that they will become commercially available for the use(s) under investigation.

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Novartis Pharmaceuticals Corporation
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*Based on eligibility requirements and Terms and Conditions.

†*MyNavCare* Patient Engagement Liaisons are part of the *MyNavCare Patient Support by Genmab* Program and do not provide medical advice or work under the direction of the prescribing healthcare providers. They are trained to direct patients to speak with their HCP about any treatment-related questions.

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