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"Hodgkin lymphoma has this incredibly unusual look under the microscope."



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2026 year-end editors' highlights

Elias Jabbour, MD

University of Texas
MD Anderson Cancer Center



Newly diagnosed ALL is moving toward chemotherapy-free regimens or regimens with less chemotherapy.

Early integration of CAR T-cell therapy in ALL may further improve outcomes and spare patients the need for allogeneic stem cell transplantation.

Thomas Martin, MD

The University of California, San Francisco
Helen Diller Family Comprehensive
Cancer Center



The myeloma treatment landscape continues to evolve, and several clinical trial results reported within the past 12 months are changing the way in which we approach and treat early relapsed multiple myeloma. Novel immunotherapies, like CAR T-cell therapies and BCMA-targeted bispecific antibodies, initially showed promise in late relapse (ie, in patients who had experienced multiple relapses and received more than three prior lines of therapy). However, the latest data have tested these therapeutics and additional novel agents in patients with early relapse disease (one to three prior lines of therapy), showing even more dramatic results.

One of the most impressive results was reported from the MajesTEC-3 study, in which patients were randomly assigned to either the combination of daratumumab (Dara) and teclistamab (Tec) or a standard triplet of daratumumab, pomalidomide and dexamethasone (DPd) or daratumumab, bortezomib and dexamethasone (DVd). Tec-Dara decreased the risk of progression or death by more than 80%, and the 36-month progression-free survival rate was 83%, a new benchmark for myeloma therapeutics.

Several additional phase 3 studies have been reported, including single-agent teclistamab vs. DPd or DVd; talquetamab + Dara or talquetamab + Dara + Pom vs. DPd/DVd; and the novel CELMoD iberdomide + daratumumab + dexamethasone (Iber-Dara-dex) versus daratumumab + bortezomib + dexamethasone. In all studies, there were significant improvements in depth of response and PFS in the experimental arms.

Thus, when a patient has early relapse, I offer CAR T-cell therapy if they are a candidate, as the first option, but also have a detailed discussion about Tec-Dara, Iber-Dara-dex, Tal-Dara-dex and the art of sequencing. The early relapse MM discussion is now the longest discussion and one of the most important.

For the first time ever, it is possible that a significant number of patients may never experience a subsequent relapse after "salvage" therapy and that their second remission duration will be longer than their remission after frontline therapy.

Still more trials will be presented in 2026 and 2027, and it is truly an amazing time to be treating patients with MM.

Susan O'Brien, MD

University of California, Irvine
School of Medicine



Pirtobrutinib, the only FDA-approved noncovalent BTK inhibitor for patients who have progressed on a covalent BTK inhibitor, has now also received frontline approval in CLL. It will be interesting to see how much first-line use it gets, because everyone knows it works after progression on a covalent BTK inhibitor, but we don't know whether the reverse sequence would also work.

At EHA in June 2026, a randomized trial comparing pirtobrutinib, venetoclax, and rituximab (PirtoVenR) with venetoclax and rituximab (VenR), a standard regimen in relapsed disease, showed that PirtoVenR produced a better PFS. This will likely lead to FDA approval of this triplet for relapsed CLL by next year.

Acalabrutinib plus venetoclax received FDA approval as the first all-oral, fixed-duration regimen for CLL in the US. Ibrutinib plus venetoclax is approved in more than 50 countries outside the US, but not in the US. Until now, the only approved fixed-duration regimen was venetoclax-obinutuzumab (VenO), and obinutuzumab is a monoclonal antibody that must be given intravenously.

The final analysis of the CLL14 trial, which led to the approval of VenO, was also presented at EHA. With a median follow-up of more than 9 years, it showed a median PFS of 76.6 months, a median time to next treatment of just over 7.5 years, and a median OS not yet reached, all with only 1 year of fixed-duration therapy.

Finally, BTK degraders from both Nurix and BeOne are producing exciting efficacy results with an excellent safety profile in heavily pretreated patients with CLL. No degraders are FDA approved in CLL yet.

Jerald Radich, MD

Fred Hutchinson Cancer Center



CML: For wealthy countries, the long-term data on asciminib confirm excellent efficacy and better tolerability than other TKIs. For the rest of the world, the Max Foundation's demonstration that treatment-free remission is possible in low-resource settings could be a worldwide game changer.

Pathways & Perspectives with Ann LaCasce, MD, MMSc

By Leah Sherwood



Ann LaCasce, MD, MMSc

Ann LaCasce, MD, MMSc, took an unexpected path to becoming a lymphoma specialist. After someone stole her organic chemistry notebook in college, she traded pre-med for the art world, spending five years working in a contemporary art gallery before returning to medicine. Her artistic sensibility found a home in lymphoma. “Hodgkin lymphoma has this incredibly unusual look under the microscope.”



Photo courtesy of Ann LaCasce, MD, MMSc.

What first inspired you to pursue medicine, and what specifically drew you to lymphoma?

My dad was an internist. I grew up in Downeast Maine, and he was a community doctor, a primary care physician. I used to work in his office in the summers, taking people’s blood pressures and EKGs. I loved what he did. He just seemed to derive so much pleasure from it. He had patients he followed for many years, including a lot of elderly patients, and I enjoyed that.

I went to college as a pre-med student at Bowdoin, a small liberal arts college where everyone in my family had gone. There were a lot of pre-med students, and someone stole my organic chemistry notebook. I thought, ‘You know what? I don’t want to work with these people. I’m going to do something else.’

I had taken an art history class, and I decided to work in an art gallery. My parents were supportive, even though it was an odd choice. I worked at a contemporary art gallery for five years. I almost thought I would become an art restorer as it seemed like a good marriage of art and science. But I realized I hated crafts, so I applied to medical school.

When I was a first-year medical student at Tufts, we had this course taught by Jane F. Desforges, who was a lymphoma specialist, who I identified with. During my oncology rotations, I then found that I loved working with the lymphoma patient population. I ended up at Brigham for residency, where we did a lot of oncology, and I did a lot of inpatient hematologic malignancies. I loved it, and it sort of sealed that this was what I wanted to do. I love the visual aspects of lymphoma, too, looking at scans and slides. Between that, the research and the patients, it was the perfect fit for me.

When you say lymphoma is visual, how is it different from other blood cancers in that respect?

Hodgkin lymphoma, which is probably my favorite disease to treat, has this incredibly unusual look under the microscope. Looking at the slides, they’re art. They’re visually interesting, and it’s a lot of pattern recognition.

Now it’s become much more complex. We do a lot of molecular tests and fancy tests to diagnose these different diseases. But looking at the slides under the microscope, lymphoma is what caught my attention.

What has been the biggest shift in how patients are treated or how medicine has changed since you started your career?

I’ve been a lymphoma physician for about 25 years. The diagnostics, the ability to get PET scans and look at the images myself on the computer and really understand someone’s stage, and the molecular diagnostics that allow us to precisely subclassify lymphoma have been amazing.

There are so many different subtypes of lymphoma, and that number keeps growing as we take things we used to lump together and recognize them as biologically discrete subtypes. That’s been amazing.

Not only are the therapies so much better, but even our supportive care has improved. I think about what we used to use for nausea and how we got patients through treatment when I first started compared with now.

It’s been an explosion of drugs with all the novel agents and immunotherapies. It’s been incredible to watch that happen in real time.

Has AI affected your practice yet, or are you still waiting for the revolution?

It has, to a certain extent. In oncology and lymphoma, there’s a lot of internal medicine, and things have certainly evolved since I was training as an internist before going into oncology. I use AI to look up drugs I’m unfamiliar with or the management of other illnesses. I also find it helpful for identifying references and case series. If you have a rare type of lymphoma, finding the relevant data

in PubMed can be a little clunky. AI quickly pulls up references and allows you to delve deeper much faster than before.

If I'm seeing a rare T-cell lymphoma or something I don't see often, I want to make sure I'm not missing a therapeutic option. I practice in an amazing lymphoma group, and we talk among ourselves all the time. I always ask colleagues for input when I'm unsure of the best approach, but it's also nice to ask AI, "What am I missing? Am I forgetting to consider something?" It's like having an assistant with you all day long.

But it doesn't take the place of that interpersonal connection. You still have to examine your patients. AI will never examine your patients for you or be able to tell you that a patient doesn't look well, or who's sick and who's well. Those are things I think we can't let go of. In an era of AI, I think it's so important to maintain the humanity of our job and our interactions with patients.

Looking back on your career, who has influenced you along the way?

Well, Jane Desforges, for one. I've had a winding career, and there have been a lot of people who have influenced me along the way. The former fellowship program director, Bob Mayer, whom I took over for 15 years ago, was a big influence. Margaret Shipp, a laboratory-based lymphoma scientist, was my mentor when I was a fellow. I learned from her and continue to learn from her. In addition, peer mentors, like Kerry Savage, Jonathan Friedberg and Soni Smith, to name a few have been so important to my career.

There are also people in the clinic, including Arnie Freedman, and colleagues who are more junior to me who, in some ways, serve as informal mentors. The Lymphoma Research Foundation and the Alliance have introduced me to peers at different institutions. I think that's the key to mentorship. You need a lot of people who serve different roles.

In your mind, what is the biggest unresolved debate in lymphoma care today?

I think one is the debate around CAR T-cell therapy and bispecific antibodies for aggressive and indolent non-Hodgkin lymphoma. We've used CAR T-cell therapy with curative intent in people with relapsed disease, and we have longer-term follow-up. But are bispecific antibodies as good? We don't have as much long-term follow-up, and they've never been compared head-to-head. There's a lot of debate about which will ultimately be better, although there's probably room for both.



Photo courtesy of Ann LaCasce, MD, MMSc.

What piece of advice do you have for early career clinicians?

The most important thing in academic medicine is mentorship. Figure out what you love to do and identify the right mentors to work with as you move forward. I work with a lot of junior faculty and fellows, and I think more than anything else, aside from their own grit and interest, having the right mentor who can help make introductions and guide their career development is so important.

What do you believe about being a physician today that you might not have believed early in your career?

There are three reasons why I love being a physician: the patients, the science, and the colleagues. I don't think I recognized early on how much joy you get from working with colleagues, whether it's collaborating on a trial, caring for patients together, or working with nurse practitioners and others within your practice. I didn't appreciate how much those relationships would contribute to my quality of life at work and why I love what I do.

What has been the most rewarding aspect of your career?

Besides caring for patients, the most rewarding thing has been running our fellowship program. We have a big program, and seeing the fellows graduate, go on to careers of their own and be successful has been very rewarding for me.

How do you spend your time outside of work?

Spending time with my family, especially my husband and son, Henry. I love going to Maine—I'm a Mainer—and I love skiing, swimming in the lake, reading fiction and watching British murder mysteries.

The holidays are coming up. What's a good, cozy murder mystery that you can recommend?

I haven't read it, but Louise Penny's new book is out. She crafts such an amazing mystery, and I'm looking forward to reading it over the holidays.

If you could instantly master any skill unrelated to medicine, what would it be?

I would love to be able to ski the moguls better, to really master the bumps.

Ann LaCasce, MD, MMSc, is an associate professor of medicine, a lymphoma specialist and the director of the Dana-Farber/Mass General Brigham Fellowship program.

This interview has been edited for clarity and length.



Hematologic oncology researchers persevere under shadow of unpredictable federal funding

Changes in the way basic and translational research are funded are creating challenges for emerging and established scientists. What does that mean for the pipeline of breakthrough drugs, next-gen advances and physician scientists?

By Emily Hayes

A National Institutes of Health (NIH) research award for $3.46 million in August supporting the investigation of biomarkers of response and resistance to standard-of-care acute myeloid leukemia (AML) treatment was cause for celebration.



Uma Borate MBBS, MS

Despite the "challenging funding environment," researchers had received a notice of award for their R01 application, **Uma Borate, MBBS, MS**, a co-principal investigator, announced on X, to much fanfare and words of congratulations. The grant from the National Cancer Institute (NCI), part of the NIH, provides funding over five years to researchers at the Ohio State University Comprehensive Cancer Center (OSUCCC), where Dr. Borate is a professor of hematology, and the University of California, San Francisco (UCSF).

About one third of newly diagnosed older AML patients don't respond to standard-of-care combination therapy with venetoclax (Venclexta), a BCL-2 inhibitor, and azacitidine, a chemotherapy drug. Building on the phase II OPTI-AML study, which was backed by the nonprofit Blood Cancer United, Dr. Borate and co-investigators will use bulk and single-cell sequencing of patient samples to examine response and treatment resistance in this setting.

Funding for cancer research, including in hematologic oncology, has been getting more competitive in recent years, amid changing processes and national priorities. In fiscal year (FY) 2023, NCI's funding cutoff, known as the payline, was the 12th percentile based on peer review scores for R01 grant applications from established and new investigators. That tightened to the 10th percentile in 2024. In 2025, the NCI didn't set an official payline but reported funding applications through the 9th percentile. The institute cautioned that policy changes, including upfront funding for multiyear grants, make it difficult to compare 2025 to prior years.

For R21 grants, which support exploratory or developmental projects, the NCI payline

changed from the 9th percentile in FY 2023 to the 10th percentile in 2024 and the 7th percentile in 2025.

"If you think about the number of people applying for these grants, including new people who are entering the field and are not as experienced, this really puts them at a big disadvantage," Dr. Borate said in an interview with SOHO Insider. "I think it has gotten more challenging."

Overall, at the NIH, the number of funding opportunities has been falling as programs were consolidated and the application process was simplified.

"Certain opportunities that used to exist before no longer exist because programs have become consolidated, and that has really impacted the availability of federal funding," commented Dr. Borate, who is clinical section head and clinical research director in acute leukemia at OSUCCC.

In a recent analysis, STAT reported that the NIH spent its entire external grants budget of $34 billion in FY2026 but noted the number of projects funded has been falling in recent years. Furthermore, STAT reported, funding processes are opaque, leaving even seasoned academics "unsure their ideas will be funded until they receive final notices."

Previously, in early 2025, the NIH had announced it was capping reimbursement for indirect costs at research institutions at 15%, though this move was blocked in the courts. The same year, the Trump administration froze or canceled research funding at particular universities, like Harvard and Columbia, although much of the funding was restored after legal challenges. Furthermore, the administration's proposal to cut the NIH budget by approximately 40% for FY2026 was rejected by Congress.



Gerald Hsu MD, PhD

On paper, medical universities are not much worse off this year compared to 2025, but the climate continues to be uncertain for scientific research – and "the chill hasn't quite gone away," said **Gerald Hsu, MD, PhD**, who directs the hematology/oncology fellowship program at UCSF, in a recent interview.

For FY27, the administration proposed a 12% cut to the NIH budget, but similar funding for the NCI (+0.1%). Dr. Hsu said he expects to continue to see proposals from the administration to cut budgets of the institutions that form the bedrock for scientific research funding, as well as ongoing targeted disinvestment of programs at specific institutions.

Innovation at risk?

For the practicing hematologic oncologist, funding changes could negatively affect drug development and the number of new treatments in the pipeline, interviewees for this article caution.

"Innovation thrives off continued research and investment, and when you slow that down, I think there's going to be hesitation to invest in a particular technology or treatment," Dr. Borate said.

Federal funding has been at the heart of important developments in cancer drug research. Basic research into basic immunology in fighting cancer was funded for decades by the NCI, culminating in the development of immune checkpoint inhibition by James Allison, PhD.



George Mulligan PhD

Many breakthroughs grew out of understanding cancer signaling and the spectrum of cancer mutations, said **George Mulligan, PhD**, chief scientific officer at the Multiple Myeloma Research Foundation (MMRF). For example, the US Food and Drug Administration approval this year of daraxonrasib (Rasonque) for pancreatic cancer reflects research advances in the ability to target RAS. In multiple myeloma, government and foundation support for developing large myeloma datasets led to the discovery of the GPRC5D target, which is widely expressed in myeloma tumors and can be targeted with an antibody, Dr. Mulligan noted.

"The vast majority of breakthrough drug development comes from basic discovery in labs that are not necessarily corporate," Dr. Mulligan said in an interview.

Dr. Borate said she is particularly concerned about the future for translational research to develop older, off-patent drugs for new

> **It might require the extra amount of resilience and commitment and passion and that will probably lead to some attrition.**
>
> **— Gerald Hsu, MD, PhD**
> **University of California, San Francisco**

uses, as this work is not typically done by pharmaceutical companies, and investigators depend on federal funding. Funding for trials that examine effects in particular patient populations is also at risk because of federal policies discouraging research in studying health disparities and grants mentioning race or ethnicity.

In a JAMA Oncology study of 11,681 trials conducted in the United States from 2008 to 2024, researchers found that industry was more likely to fund studies of single agent therapy, while federally funded studies tend to focus on nontreatment interventions, multimodal treatment strategies, treatment de-escalation and research in rare and pediatric cancers, including acute lymphoblastic leukemia and lymphoma.

"These findings provide an empirical characterization of the complementary and essential roles of federal and industry sponsors in the cancer clinical trial enterprise," wrote Joseph Unger, PhD, of the Fred Hutchinson Cancer Center in Seattle, Washington, and colleagues.

However, the authors also noted that between 2018 and 2022, industry trials accounted for nine of 10 enrollments of adults with cancer.

"Because the number of patients willing to participate in clinical trials is limited, this imbalance raises concerns that research questions lacking commercial incentives may go unanswered," Dr. Unger et al wrote.

Dr. Mulligan of the MMRF expects more challenges around developing the next

generation of drugs that offer better side effect profiles and more convenient dosing. For example, the first BTK inhibitors were associated with significant cardiac side effects, but later entrants to the class had improved cardiovascular profiles.

"There's a concern that clinicians will start to see slower development of those options, which really impact their ability to deliver what they want for patients," Dr. Mulligan said.

While CAR-T therapies have produced durable remissions in lymphomas, the relapse rates are high in the multiple myeloma setting, and challenging delayed neurotoxicity have been reported, including Parkinsonism and Guillain-Barré syndrome. It's possible that a combination strategy would be effective and research is needed into finding out who is the best patient, what's the best dose and what's the best combination, said Dr. Mulligan.

The role of foundations

Even though multiple myeloma has been an active area of research and there are 15-plus drugs approved for this indication in the United States, there is still a need for more research, said Dr. Mulligan, who formerly led biomarker and translational research strategy at Millennium/Takeda.

"For us as a foundation, we want to make sure people are cured, can go off therapy and not have a late toxicity," he explained.

But it takes a lot of time for studies to pay off. Pharmaceutical companies need to develop a 10-year strategic plan to get an agent approved and into a certain segment of the market, and "if there's dramatic uncertainty along the way, that is very, very challenging," Dr. Mulligan said.

Acknowledging the unpredictable climate for research funding, the MMRF said it was scaling up investment in its Myeloma Investment Fund, a venture philanthropy arm that supports early-stage research at biotech companies.

The MMRF also fosters collaboration through its Myeloma Accelerator Challenge program, encouraging four or five centers to work together and also with the foundation on data generation and analysis, Dr. Mulligan said.

"That's an important way to make things more sustainable," he said.

> **Innovation thrives off continued research and investment, and when you slow that down, I think there's going to be hesitation to invest in a particular technology or treatment.**
>
> **— Uma Borate, MBBS, MS**
> **Ohio State University**
> **Comprehensive Cancer Center**

However, he acknowledged that there's only so much philanthropic funding by foundations can do, given that even a relatively small phase 2 study can cost tens of millions of dollars.

Filling the people pipeline

If there is a slowdown in funding and it becomes increasingly unclear how research will lead to drug approvals and ultimately influence clinical practice, the scientific people pipeline could be negatively affected. In a survey in Spring 2025 of NIH-funded investigators, 18% reported funding disruptions and 18% were not sure if they would continue research.

In response to the changes taking place nationally, the MMRF is also trying to give more awards to promising young researchers in training, so they see myeloma as an attractive research opportunity, Dr. Mulligan said. The MMRF supports young researchers through its Scholars Program, which provides up to $400,000 in funding over four years, and a research fellowship program, which provides up to $75,000 in research support for one year.

However, the NIH has very big shoes to fill when it comes to supporting basic research.

"Our societies are certainly positioned to support trainees and have done a remarkable job historically doing so," said Dr. Hsu of UCSF. "It's just a very heavy burden to shoulder."

Alerting his community to the implications of federal funding cuts in an article last year in the San Francisco Chronicle, Dr. Hsu wrote that in addition to threatening innovation, the changes were threatening careers. For example, a physician in his program who had completed a hematology/oncology fellowship and another three years as a postdoctoral research fellow faced challenges in 2025 getting funded for work in novel leukemia immunotherapies. As it turns out, she did get a career development award, but while it's heartening that she "stayed in the game and persisted," Dr. Hsu said that other physician scientists have instead shifted to the pharmaceutical industry or clinical practice.

Many who are in the pipeline as basic science researchers and physician scientists are looking at the uncertainty of the research funding landscape and deciding for themselves that it's not worth the fight or that it isn't a viable path, Dr. Hsu explained to SOHO Insider.

"When you have people who committed to finishing not just college and graduate school, but postdoctoral training and at the cusp of becoming independent researchers saying, 'This isn't for me,' you lose a generation potentially of scientific researchers," Dr. Hsu said. "The erosion in the pipeline is what's concerning for an educator like me."

Granted, scientific research has never been an easy path; it's always required a high degree of resilience. The people who stay with it and who are really engaged and committed and passionate about their work can and will still make it happen, he added.

"It might require the extra amount of resilience and commitment and passion and that will probably lead to some attrition, unfortunately," Dr. Hsu said. "But I don't advise against pursuing it. For some people, it's the kind of thing you just can't not do."

Emily Hayes is a contributing writer for SOHO Insider.

Tracking regulatory news worldwide

BLA submitted to FDA for BCMA-directed, 2nd-generation bispecific antibody in R/R myeloma

A Biologics License Application was submitted to the US Food and Drug Administration for the BCMA-directed, second-generation bispecific antibody etentamig for the treatment of relapsed or refractory multiple myeloma, as reported by the drug's manufacturer, AbbVie.

Etentamig is a second-generation BCMA x CD3 bispecific antibody T-cell engager administered intravenously for the treatment of adults with relapsed or refractory multiple myeloma. The submission is supported by results from the global, phase 3, multicenter, randomized CERVINO study. Investigators in the study evaluated etentamig versus investigator's choice of standard available therapies in patients with triple-class exposed relapsed or refractory MM who had received at least two prior lines of therapy.

In a presentation at the 23rd Annual Meeting and Exposition of the International Myeloma Society in Glasgow, Scotland, the CERVINO investigators, led by **Peter Voorhees, MD,** wrote that the data support etentamig monotherapy as a new standard of care with convenient dosing suitable for global outpatient and community use.

CHMP backs talquetamab combinations for relapsed or refractory multiple myeloma

The European Medicines Agency Committee for Medicinal Products for Human Use has recommended an indication extension for talquetamab (TALVEY) plus daratumumab with or without pomalidomide; the recommendation covers adults with relapsed or refractory multiple myeloma who have received at least one prior therapy, according to a press release from the drug's manufacturer, Johnson & Johnson.

The recommendation followed the phase 3 MonumenTAL-3 trial in 864 patients previously exposed to lenalidomide and a proteasome inhibitor. Compared with daratumumab, pomalidomide and dexamethasone, the talquetamab combinations significantly reduced the risk of disease progression or death, with 24-month progression-free survival rates reaching 81.3% with pomalidomide and 77.6% without pomalidomide and an overall survival rate of 89.2% versus 87.9%, respectively. Minimal residual disease-negative complete response rates reached 52.3% and 46.3% compared to 15.9% in the control arm, according to the press release.

FDA approves pirtobrutinib for untreated chronic lymphocytic leukemia and small lymphocytic lymphoma

The US Food and Drug Administration approved pirtobrutinib (Jaypirca) for adult patients with previously untreated chronic lymphocytic leukemia or small lymphocytic lymphoma with no known 17p deletion.

The FDA approval is based on results from the primary analysis of the BRUIN CLL-313 clinical trial. Results demonstrated a significant improvement in progression-free survival for the pirtobrutinib arm compared to the control arm, with a hazard ratio of 0.20 and a median follow-up of 28 months, according to the press release by Eli Lilly and Company, the therapy's manufacturer.

"This approval is grounded in data from BRUIN CLL-313, which showed a significant delay in disease progression for pirtobrutinib compared to chemoimmunotherapy, along with safety and tolerability consistent with its established profile," **Jennifer A. Woyach, MD**, said in the release. "Doctors can now consider pirtobrutinib for appropriate patients when initial therapy is needed, not just later in a patient's treatment journey. Given the efficacy and tolerability of modern targeted therapies—coupled with factors like age or comorbidity–many people diagnosed with CLL or SLL today may only receive one or two lines of therapy, making initial treatment choices critically important."

China NMPA approves pirtobrutinib in CLL/SLL across all lines of therapy

The China National Medical Products Administration has approved pirtobrutinib (Jaypirca), a non-covalent Bruton tyrosine kinase inhibitor, as a monotherapy for adult patients with CLL or SLL across all lines of therapy and regardless of prior covalent BTK inhibitor treatment, according to Innovent Biologics, the manufacturer of the drug.

This expanded indication is based on data from the global phase 3 BRUIN CLL-313 and BRUIN CLL-314 trials. BRUIN CLL-313 demonstrated a statistically significant progression-free survival benefit for pirtobrutinib compared with bendamustine plus rituximab in treatment-naïve patients, while BRUIN CLL-314 met its primary endpoint of non-inferiority for overall response rate compared to a covalent BTK inhibitor, according to a press release by Innovent.

"This approval has the potential to provide a new option for Chinese patients with CLL/SLL across all lines of therapy, meaningfully advancing the management of CLL/SLL throughout the treatment journey," according to **Prof. Jianyong Li,** principal investigator of the BRUIN CLL-313 study in China.

FDA receives sNDA filing for selinexor, ruxolitinib in myelofibrosis

The FDA received a supplemental New Drug Application for selinexor (XPOVIO) in combination with ruxolitinib for patients with myelofibrosis, according to Karyopharma Therapeutics, the drug's manufacturer.

The submission is based on data from the phase 3 SENTRY trial, which evaluated the combination in JAK inhibitor-naive patients and demonstrated spleen volume reduction and an overall survival signal, according to a press release by Karyopharma.

FDA approves 1st new treatment for essential thrombocythemia in nearly three decades

The FDA has approved ropeginterferon alfa-2b-njft (BESREMi) for the treatment of adults with essential thrombocythemia.

This marks the first new FDA-approved treatment for ET in nearly three decades, according to PharmaEssentia, the manufacturer of the drug.

The indication covers adult patients regardless of genotype or disease status, including newly diagnosed patients who have not previously received cytoreductive therapy. The FDA's decision was primarily supported by clinical data from the global phase 3 SURPASS-ET clinical trial, which demonstrated that the therapy achieved durable modified European LeukemiaNet responses and robust hematologic control, according to a press release by PharmaEssentia.

"The approval of ropeginterferon alfa-2b-njft provides an important new treatment option that works at the source of the disease rather than solely managing symptoms," said **Ruben Mesa, MD, FACP**, principal investigator of the SURPASS-ET trial.

LYT-200 receives FDA Fast Track Designation for relapsed or refractory high-risk MDS

The FDA has granted Fast Track Designation to LYT-200 in combination with a hypomethylating agent for the treatment of patients with relapsed or refractory high-risk myelodysplastic syndromes, according to PureTech Health, the developer of the drug.

LYT-200 is a first-in-class monoclonal antibody that targets galectin-9 to selectively eliminate disease-driving cells across a broad population of patients who lack actionable mutations, according to the company.

The designation follows a successful end-of-phase 1 meeting with the FDA and is supported by positive data showing clinical efficacy and a consistent safety profile in heavily pretreated patients, according to a press release from PureTech Health.

Feedback from the FDA supports advancing the therapy into STRIDE-MDS, a randomized, double-blind, placebo-controlled phase 2 clinical trial evaluating the efficacy, safety, and dose selection of LYT-200.

"Patients with higher-risk MDS who relapse or become refractory to HMA treatment have very limited therapeutic options and poor outcomes, and the literature and clinical practice suggest that fewer than 5% of these patients typically respond to retreatment with an HMA rechallenge," said **Amer Zeidan, MBBS, MHS**, who will be the global principal investigator of the phase 2 STRIDE-MDS trial. "Against this backdrop, the clinical activity observed with LYT-200 in combination with an HMA in the Phase 1b study is particularly encouraging. STRIDE-MDS will allow us to further evaluate this activity in a randomized, placebo-controlled study."

FDA approves first-in-class therapy for polycythemia vera

The FDA has approved rusfertide (Mimrylo) as a first-in-class hepcidin mimetic to treat erythrocytosis in adults with polycythemia vera.

The medication regulates iron distribution to help patients maintain target hematocrit levels and reduce the physical burden of frequent therapeutic blood draws, according to Takeda, the manufacturer of the drug.

In a press release, Takeda stated approval was supported by results from the global randomized phase 3 VERIFY trial involving 293 patients, which showed that patients receiving rusfertide demonstrated a higher clinical response rate, including maintained hematocrit control and reduced phlebotomy requirements, compared to placebo alongside standard care.

"For patients living with PV, uncontrolled hematocrit can have serious consequences …The strength and consistency of the VERIFY data give me real confidence in its potential to advance how we treat PV in everyday practice and to maintain hematocrit control," said **Andrew T. Kuykendall, MD**, VERIFY lead investigator.

FDA approves first targeted therapy for warm autoimmune hemolytic anemia

The FDA has approved nipocalimab-aahu (IMAAVY) as the first treatment for warm autoimmune hemolytic anemia (wAIHA) in adults and pediatric patients ages 12 years and older who are currently or previously treated with corticosteroids.

Nipocalimab-aahu is an immunoselective neonatal fragment crystallizable receptor blocker designed to reduce pathogenic immunoglobulin G autoantibodies while preserving B-cell function, according to Johnson & Johnson, the manufacturer of the drug.

The approval is based on the phase 2/3 ENERGY study, which evaluated the efficacy and safety of intravenous nipocalimab in patients with warm autoimmune hemolytic anemia which was reported at the European Hematology Association 2026 meeting in June.

"These data from the phase 2/3 ENERGY study showed the rapid onset of effect and durable improvement in anemia, which occurs by targeting the autoantibody-mediated destruction of red blood cells in people living with warm autoimmune hemolytic anemia," said **Bruno Fattizzo, MD**, assistant professor at the Department of Oncology and Hematology-Oncology, University of Milan, Italy. "Achieving hemoglobin improvements this quickly and at this scale is important in clinical practice, as it could help improve the debilitating fatigue that people living with warm autoimmune hemolytic anemia experience."

FDA grants accelerated approval to iberdomide combo in multiple myeloma

The FDA has granted accelerated approval to iberdomide (Zenbexus) in combination with daratumumab and hyaluronidase-fihj and dexamethasone for adults with multiple myeloma (MM) who have received at least one prior line of therapy including a proteasome inhibitor and an immunomodulatory agent, according to Bristol Myers Squibb, the manufacturer of the drug.

In a press release, Bristol stated the approval is based

on results from the phase 3 EXCALIBER-RRMM trial, which showed iberdomide significantly improved minimal residual disease-negative complete response rates.

Bristol reported that the FDA approval was the first based on MRD-negative CR in relapsed or refractory MM.

"The FDA approval of iberdomide marks the anticipated arrival of a new therapeutic class for relapsed or refractory multiple myeloma and has the potential to make a meaningful difference for patients," said **Sagar Lonial, MD, FACP, FASCO**, EXCALIBER-RRMM lead investigator and CMO of the Winship Cancer Institute of Emory University. "The strong results observed with the CELMoD-based combination within a familiar triplet approach creates the potential for a new treatment foundation in MM."

FDA approves subcutaneous isatuximab-irfc in MM

The FDA has approved isatuximab-irfc (Sarclisa Escena) for subcutaneous injection in combination with the standard-of-care therapy in adult patients with MM, according to a press release from Sanofi, the manufacturer of the drug.

In the press release issued by Sanofi, clinical data supporting the approval included the randomized phase 3 IRAKLIA trial, which demonstrated non-inferiority for the subcutaneous delivery method compared with the intravenous form.

"MM is a malignancy that often requires frequent IV infusions or its Good Manufacturing Practice facility in Hangzhou.

NMPA grants approval to felzartamab in MM

The NMPA has approved felzartamab (Jingfei), a human monoclonal antibody targeting CD38, in combination with lenalidomide and dexamethasone for adult patients with multiple myeloma who have received at least one prior line of therapy, according to TJ Biopharma, the manufacturer of the drug.

The global development and commercial rights of felzartamab are managed by Biogen.

Under an agreement reached in April 2026, Biogen acquired exclusive rights to felzartamab in Greater China. Biogen will be responsible for product commercialization, while TJ Biopharma will handle commercial drug supply through manual subcutaneous injections. Treatment administration can be a cumbersome experience for patients, while also placing a strain on providers by requiring physical effort to push high-resistance syringes for several minutes," said **Sikander Ailawadhi, MD**, the principal investigator of the IRAKLIA study. "The comparable efficacy observed across multiple studies and the patient-centric design of the [on-body injector] offers an opportunity to impact the patient experience while upholding Sarclisa's consistent efficacy."

Isatuximab-irfc is currently approved across three indications in the US, including in combination with bortezomib, lenalidomide and dexamethasone in patients with newly diagnosed MM who are not eligible for autologous stem cell transplant, Sanofi reported in the release.

FDA approves rituximab biosimilar for B-cell malignancies

The FDA has approved a rituximab biosimilar candidate developed by pharmaceutical company Dr. Reddy's Laboratories.

Rituximab is a monoclonal antibody that targets CD20 on B cells to treat adult B-cell malignancies, including non-Hodgkin lymphoma and chronic lymphocytic leukemia.

Under an exclusive commercialization agreement, the global healthcare company Fresenius Kabi holds rights to commercialize the drug in the United States. The product was developed, manufactured, and submitted for approval by Dr. Reddy's Laboratories, according to a press release.

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ABHH

SOHO/ABHH Joint Session

SOHO held a joint session with ABHH at the Congresso HEMO/ABHH 2026 in Rio de Janeiro, Brazil, in October 2026.

The session was titled "Relapsed/Refractory B-cell Lymphoma: Integrating Novel Therapies into Clinical Practice" and featured talks by Phillip Scheinberg, MD, PhD; Juan Pablo Alderuccio, MD; and Alvaro Alencar, MD.



SOHO ANNUAL MEETING 2026 Highlights


















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SOHO 2026 Meeting News

Oral abstract ALL-584 takes top honors in SOHO 2026 abstract awards

Oral abstract ALL-584 was awarded first place for the SOHO 2026 abstract award. The abstract was titled "Safety and Preliminary Efficacy of Olverembatinib (HQP1351) Combined With Lisaftoclax (APG-2575) in Children and Adolescents With Relapsed/Refractory Philadelphia-Positive Acute Lymphoblastic Leukemia: Results of a Phase 1b Study."

The lead author of the study is **Jingliao Zhang, MD,** a medical researcher and hematologist at the Institute of Hematology and Blood Diseases Hospital of the Chinese Academy of Medical Sciences and Peking Union Medical College in Tianjin, China.

Second place was awarded to **Colton Jones, MD,** of the University of Texas Health, San Antonio, for the poster MM-626, "GLP-1 Receptor Agonist Exposure and Survival Outcomes in Newly Diagnosed Multiple Myeloma Treated With Daratumumab-Based Quadruplet Therapy: A Target Trial Emulation."

In Dr. Jones' target-trial emulation of more than 1,000 patients with newly diagnosed multiple myeloma (MM) and metabolic comorbidities (type 2 diabetes or obesity) starting frontline D-VRd, GLP-1 receptor agonist exposure was associated with an overall survival (OS) benefit (HR, 0.30; 95% CI, 0.19-0.47) and higher rates of complete response or better (HR, 1.20), with no significant difference in relapse. An E-value of 6.1 indicates the survival association is relatively robust to unmeasured confounding.

Three practical points to walk away with:

- A metabolic-immune interaction may matter in the quadruplet era. Obesity, insulin resistance, and IL-6-driven inflammation are established drivers of inferior MM outcomes, and the anti-inflammatory/immunomodulatory effects of GLP-1 Ras offer a biologically plausible mechanism for synergy with anti-CD38 therapy.
- This extends a converging literature from prevention to treatment. Prior data tie GLP-1 RAs to lower MM incidence and reduced MGUS-to-MM progression; this is among the first analyses to examine survival and response depth in a uniformly D-VRd-treated population.
- Interpret with appropriate caution. The magnitude of the OS benefit, which is disproportionate to the modest response gain and null relapse effect, suggests contributions from reduced competing/non-myeloma events (infection, cardiometabolic death) and healthy-adherer bias, alongside residual confounding and EHR-based response ascertainment.

Bottom line: These hypothesis-generating data support metabolic optimization as a modifiable target and justify prospective evaluation of GLP-1 RAs as an adjunct in metabolically comorbid newly diagnosed MM, but do not yet support initiating them for antimyeloma benefit.

Third place was awarded to **Pranati Shah, MD,** of Loma Linda University Medical Center in California, for poster, "Safety, Tolerability and Clinical Activity of Anito-Cel in RRMM"

Takeaways from Dr. Shah's abstract regarding the safety, tolerability, and clinical activity of anito-cel in patients with relapsed/refractory MM across the phase 1 and 2 portions of the iMMagine-1 trial.

- Exceptional and deep efficacy. Anito-cel demonstrated high overall response rates across both cohorts—100% in phase 1 and 95% in phase 2—with complete/stringent complete response rates of 79% and 62%, respectively.
- High rates of measurable residual disease (MRD) negativity. MRD-negativity was achieved by ~90% of evaluable patients in both phase 1 (89%) and phase 2 (92%), driving durable responses even in heavily pretreated and refractory populations.
- Durable PFS and OS. At a median follow-up of 34 months in phase 1, the 27-month PFS and OS rates were 52% and 78%, respectively. In phase 2 (median follow-up, 10.3 months), the six-month PFS and OS rates were 90% and 95%, respectively.
- Manageable safety profile with low severe neurotoxicity. Cytokine release syndrome was frequent but manageable (84% to 95%), while immune effector cell-associated neurotoxicity syndrome (ICANS) was primarily low-grade, with grade ≥3 ICANS remaining low across both phases (5% in phase 1; 2% in phase 2).

Olverembatinib plus lisaftoclax induces rapid, deep responses in TKI-exposed pediatric patients with Ph-positive ALL

By Patrick Daly

Treatment with olverembatinib plus lisaftoclax yielded rapid, deep responses in children and adolescents with relapsed or refractory Philadelphia chromosome (Ph)–positive acute lymphoblastic leukemia who failed previous tyrosine kinase inhibitor therapy.

The chemotherapy-free oral regimen showed both central nervous system penetration and activity across ABL1 mutants, supporting its potential for this high-risk pediatric patient population, wrote the study's authors, led by **Jingliao Zhang, MD.** Dr. Zhang is medical researcher and hematologist at the Institute of Hematology and Blood Diseases Hospital of the Chinese Academy of Medical Sciences and Peking Union Medical College in Tianjin, China.

The findings were presented at the Fourteenth Annual Meeting of the Society of Hematologic Oncology in Houston, Texas. The research was awarded first place at the abstract award ceremony during the meeting.

The study enrolled patients aged less than 18 years with relapsed or refractory Ph–positive ALL resistant or intolerant to one or more prior TKIs. Participants received monotherapy with olverembatinib, a third-generation TKI,

against BCR-ABL1 followed by combination therapy with lisaftoclax, a selective BCL-2 inhibitor, plus dexamethasone. The cohort consisted of 17 patients with a median age of 13 years (range, 9-15). Six out of 15 evaluable patients carried baseline ABL1 kinase domain mutations, including four with T315I mutation. A total of 16 patients received combination therapy.

The overall response rate among nine evaluable patients after olverembatinib monotherapy was 55.6%, increasing to 88.9% on day 15 of cycle two (C2D15). The rate of complete cytogenetic response after olverembatinib monotherapy was 40%, increasing to 88.9% at C2D15. The rate of measurable residual disease negativity after olverembatinib monotherapy was 25%, increasing to 66.7% at C2D15. By day 28 of cycle two, 93.3% of patients achieved a major molecular response or better.

Responses occurred across dose levels and ABL1 variants, and pharmacokinetic analyses showed predictable exposure comparable to adults, no significant accumulation or drug to drug interactions, and CNS penetration by both olverembatinib and lisaftoclax, according to the abstract.

REFERENCE

Zhang J, Wang J, Liu T, et al. Safety and Preliminary Efficacy of Olverembatinib (HQP1351) Combined With Lisaftoclax (APG-2575) in Children and Adolescents With Relapsed/ Refractory Philadelphia-Positive Acute Lymphoblastic Leukemia: Results of a Phase 1b Study. Abstract ALL-584. Presented at the 2026 Society of Hematologic Oncology Annual Meeting; September 9-12, 2026; Houston.

Real-world analyses supports efficacy, safety of commercial liso-cel for patients with relapsed or refractory MCL

By Patrick Daly

A retrospective analysis of the Center for International Blood and Marrow Transplant Research (CIBMTR) database showed treatment with lisocabtagene maraleucel (liso-cel) achieved high response rates with early signs of durable benefit for real-world US patients with relapsed or refractory mantle cell lymphoma.

The analysis, led by **Jennifer J. Huang, MD, PhD,** of Fred Hutchinson Cancer Center of the University of Washington in Seattle, was presented at the Fourteenth Annual Meeting of the Society of Hematologic Oncology in Houston, Texas.

The analysis enrolled 121 eligible patients from the CIBMTR database. The cohort was 73% male, had a median age of 71 years (range, 46-85), and 66% had one or more clinically significant comorbidities. In addition, 13% of patients had a largest nodal mass over 10 cm and 31% had two or more areas of extranodal involvement. The median number of prior lines of therapy, including transplant and cellular therapy, was four (range, 2-12), and 72.5% of patients received bridging therapy.

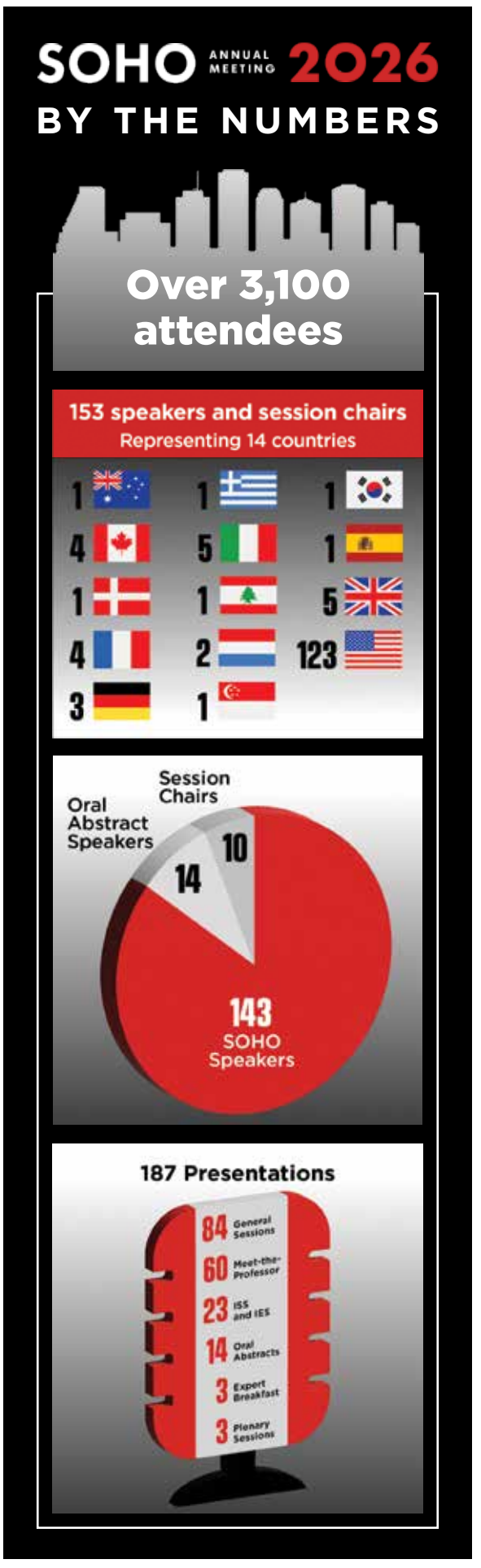
After a median follow-up of six months (95% CI, 5.9-6.2), the objective response rate was 89% (95% CI, 82-94), and the complete response rate was 79% (95% CI, 71-86). The median duration of response, progression-free survival, and overall survival were not reached, while six-month DoR, PFS, and OS rates were 81% (95% CI, 66.5-90), 79% (95% CI, 70-86), and 92% (95% CI, 85-96), respectively.

Overall, 65% of patients had any-grade cytokine release syndrome and 36% had immune effector cell–associated neurotoxicity syndrome, with grade 3 or higher events in 2% and 14%, respectively. In addition, 24% of patients had clinically significant infections, 17% had cytopenia at day 30 post-infusion, and 7% had secondary primary malignancies, most commonly skin malignancies. In total, 14 patients died, including 10 due to disease persistence or progression. The six-month non-relapse mortality rate was 2% (95% CI, 0.3-5.5). Among 47 (39%) patients who had outpatient infusion, 60% were hospitalized post-infusion, with a median time to hospitalization of 5.5 days (range, 1-51) and a median duration of stay of five days (range, 1-32).

“Liso-cel was associated with high response rates in a broad population of patients with relapsed or refractory MCL, with early signs of durable benefit and a safety profile consistent with that reported in TRANSCEND NHL 001,” Dr. Huang and colleagues wrote.

REFERENCE

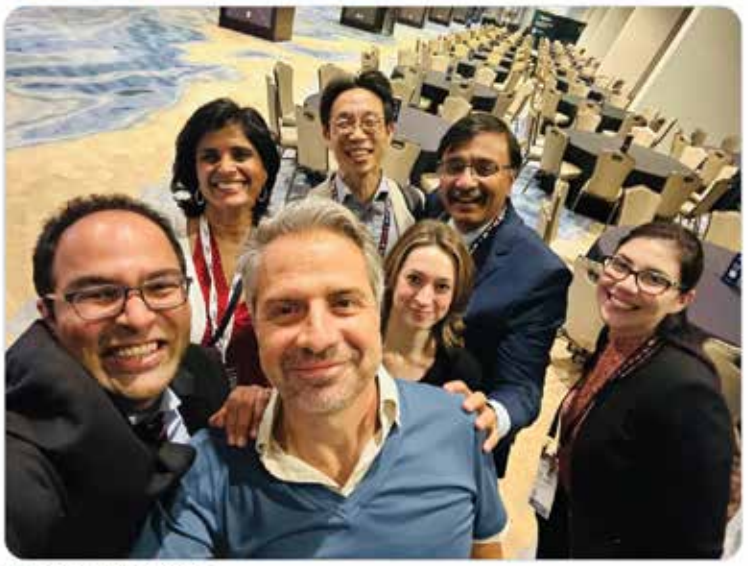
Huang JJ, Brooks T, Romancik J, et al. Outcomes of Lisocabtagene Maraleucel in Patients With Relapsed or Refractory Mantle Cell Lymphoma: First Real-World Data From the Center for International Blood and Marrow Transplant Research. Abstract CT-228. Presented at the 2026 Society of Hematologic Oncology Annual Meeting; September 9-12, 2026; Houston.



Top tweets from the Society of Hematologic Oncology 14th Annual Meeting

Naveen Pemmaraju, MD @doctorpemm · Sep 10

🙏 @SocietyofHemOnc #SOHO26 **#SOHO2026** for bringing us all together! @beatalleukemia @jaeparkmd @NitinJainMD @HannahGoulart @r_sazevedo 👏 #leusm #MPNSM #BPDCN



VJHemOnc and 4 others

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Hira Mian @HiraSMian · Sep 10

Excited to be at SOHO in Houston with this faculty @thanosdimop @szusmani @AjayNookaMD @NoopurRajeMD @TomMartinMD @End_myeloma **#SoHo2026**

> **Thanos Dimopoulos** @thanosdimop · Sep 10
> Today at SOHO Privileged to join a panel of prestigious colleagues



1 · 4 · 26 · 1.8K

Dr. Islam Sadek @islamsadek18 · Sep 13

Just wrapped up an incredible few days at #SOHO2026 . One of best hematology meetings, bringing together cutting-edge science, research & clinical updates to advance care for patients with hematologic malignancies. Outstanding meeting & organization. Looking forward to #SOHO2027!

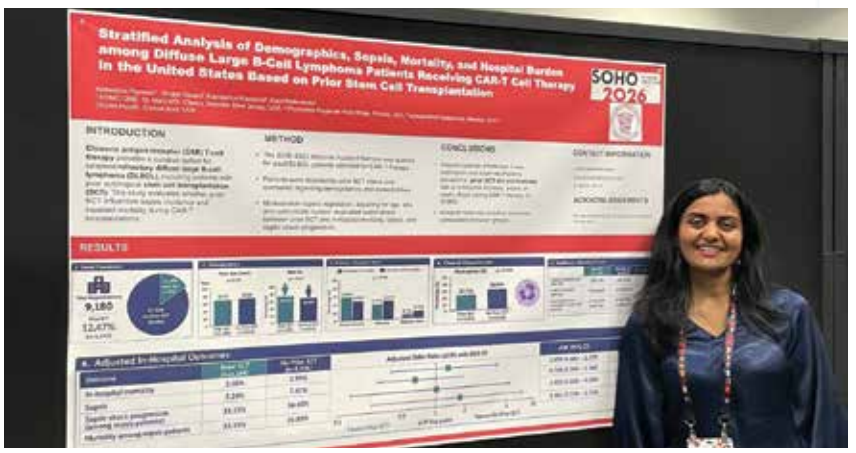


Society of Hematologic Oncology (SOHO)

1 · 1 · 24 · 1.1K

Aishwarya Ramesh @Aish_Rmsh

Happy to have presented our studies on cellular therapies at SOHO!! #SOHO2026 #YIP #Cellulartherapy



Society of Hematologic Oncology (SOHO) and IMG Oncologists

11:14 PM · Sep 11, 2026 · **1,363** Views

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23rd Annual Meeting and Exposition of the International Myeloma Society (IMS 2026)

5-year remission rates with cilta-cel in earlier-line relapsed or refractory multiple myeloma

By Patrick Daly

Half of patients with earlier-line relapsed or refractory multiple myeloma treated with ciltacabtagene autoleucel (cilta-cel) in the CARTITUDE-2 trial achieved remissions lasting five years or more, according to a presentation at the 23rd Annual Meeting and Exposition of the International Myeloma Society (IMS 2026) in Glasgow, Scotland.

The analysis reviewed 20 patients from cohort A of the CARTITUDE-2 trial that rolled over to the 15-year follow-up study, CARTinue. This cohort was refractory to lenalidomide with one to three prior lines of therapy, similar to the population in the pivotal CARTITUDE-4 trial.

After a median follow-up of 60.7 months, 10 out of 20 patients remained alive and progression-free. The median progression-free survival was 60.5 months (95% CI, 12.9-not evaluable) and the median overall survival was not reached. The five-year OS rate was 69.2%. Three patients underwent measurable residual disease testing at five years, and all were negative.

Compared with patients with progressive disease or progressive disease-related death, patients alive and progression-free at five years showed a trend toward lower baseline tumor burden, higher rates of 30% or lower bone marrow plasma cells, higher levels of CD4–positive–naive T-cells at apheresis, and higher CAR–positive, CD4–positive central memory T-cell levels at peak expansion. Of the 10 patients disease-free at five years, five had one or more high-risk cytogenetic features, including four with two or more high-risk features.

“These results build on the long-term outcomes from CARTITUDE-1 and suggest that earlier use of cilta-cel may be associated with a higher likelihood of achieving five-year remissions,” Dr. Cohen and colleagues wrote.

REFERENCE

Cohen AD, Mateos M, Cohen YC, et al. Long-Term (≥5-Year) Remission and Survival With Ciltacabtagene Autoleucel (Cilta-Cel) in Relapsed/Refractory Multiple Myeloma (RRMM) With 1–3 Prior Lines of Therapy: CARTITUDE-2 Cohort A. Abstract PA-288. Presented at the 23rd Annual Meeting and Exposition of the International Myeloma Society; September 23-26, 2026; Glasgow.

Etentamig significantly improves response, PFS for patients with heavily pretreated myeloma in the CERVINO trial

By Patrick Daly

Treatment with etentamig significantly improved overall response rate and progression-free survival compared with standard available therapies for heavily pretreated patients with triple-class exposed relapsed or refractory multiple myeloma, according to data from the phase 3 CERVINO trial presented at IMS 2026.

Etentamig is a second-generation bispecific T-cell engager targeting CD3 and B-cell maturation antigen with a low-affinity CD3 binding domain, potentially reducing rates of cytokine release syndrome and infection, wrote the study’s authors.

This prespecified interim analysis of CERVINO covered 196 patients randomized to etentamig and 197 to standard therapy. The cohort had a median age of 70 years, including 68.2% aged 65 years or older, and 14.5% were enrolled in the United States. Among US patients randomized to etentamig, 41.7% were treated in community settings and 45.8% started treatment in outpatient settings.

The cohort had a median time from diagnosis of 5.2 years and a median of three prior lines of therapy. Overall, 51.9% of patients were triple-class refractory, 90.1% were refractory to their last line of therapy, 86% were refractory to anti-CD38 monoclonal antibodies, and 23.4% had high-risk cytogenetics.

After a median follow-up of 11.4 months, the ORR was 74% (95% CI, 67.25-79.97) with etentamig and 45.7% (95% CI, 38.59-52.91; P<.0001) with standard therapy. The median PFS was not reached (95% CI, 14.55-not estimable) with etentamig and 6.2 months (95% CI, 4.63-7.26) with standard therapy (hazard ratio [HR], 0.4; 95% CI, 0.29-0.54; P<.0001). The PFS benefit was observed across all prespecified subgroups, according to the presentation.

The 12-month OS rates were 87.9% and 72% (HR, 0.48; 95% CI, 0.29-0.77; nominal P=.0012) for etentamig and standard therapy, respectively. The efficacy boundary for OS was not crossed by the time of presentation.

The safety analysis included 195 patients in the etentamig arm and 193 in the standard therapy arm. Overall, treatment-emergent adverse events occurred in 97.9% and 95.3%, grade 3 or 4 TEAEs in 73.3% and 64.2%, and serious TEAEs in 51.8% and 40.4% of the etentamig and standard therapy arms, respectively. Compared with standard therapy, the etentamig arm had fewer TEAE–related discontinuations or fatal TEAEs, and lower rates of grade 3 or higher infections.

In the etentamig group, the rates of CRS and immune effector cell–associated neurotoxicity syndrome were 39.5% and 3.6%, respectively, both predominantly grade 1 or 2. Rates of CRS and ICANS were both lower in patients who received a single step-up dose.

Ultimately, the data support etentamig monotherapy as a new standard of care with convenient dosing suitable for global outpatient and community use, Dr. Voorhees and colleagues wrote.

REFERENCE

Voorhees P, Manteca MVM, Costa L, et al. CERVINO: Phase (Ph) 3 Results of Etentamig vs Investigator’s Choice of Standard Available Therapies (SAT) in Patients (Pts) With Triple-Class Exposed Relapsed or Refractory Multiple Myeloma (RRMM). Abstract LB-01. Presented at the 23rd Annual Meeting and Exposition of the International Myeloma Society; September 23-26, 2026; Glasgow.

Inaugural SOHO Central Europe meeting held in Budapest

The inaugural SOHO Central Europe (SOHO CE) meeting was held in Budapest, Hungary, October 9-10, 2026.

"Everything worked fantastic. The audience is interested. They're asking questions. The level of the presentations is exceptional," **Imre Bodó, MD, PhD, DSc**, said. Dr. Bodó is the SOHO CE ambassador and organized the meeting.

The next SOHO CE will be organized by **Ciprian Tomuleasa, MD, PhD**. The date will be announced in the future.

Watch Phillip Scheinberg, MD, PhD, interview Drs. Bodó and Tomuleasa at SOHO Central Europe.













5th SOHO France meeting held in Paris

SOHO France was held in Paris between October 14 and 16. The meeting drew approximately two hundred people from across the region and featured top clinicians from France and the United States.















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AUGUST 25-28

SOHO ANNUAL MEETING 2027