Notably, venetoclax-based therapy was associated with a lower induction-related mortality and a higher rate of refractory disease, underscoring the distinct response dynamics of these regimens. These findings highlight the nuanced risk-benefit profiles of venetoclax and intensive chemotherapy, warranting further prospective validation to optimize patient selection and treatment strategies in fit AML patients.

Table 1 Baseline characteristics of the matched cohort.

	7+3 n = 26	Ven+HMA/LDAC n = 26	p.overall
Age at diagnosis, median (range)	46.5 (21–59)	47 (27–60)	0.56
Gender, n (%)			0.26
Male	8 (30.8)	13 (50)	
Female	18 (69.2)	13 (50)	
ELN 2022 risk, n (%)			1.00
Favorable	3 (11.5)	3 (11.5)	
Intermediate	10 (38.5)	10 (38.5)	
Adverse	13 (50)	13 (50)	
Secondary AML, n (%)			1.00
No	20 (76.9)	20 (76.9)	
Yes	6 (23.1)	6 (23.1)	
Midostaurin, n (%)			1.00
No	22 (84.6)	22 (84.6)	
Yes	4 (15.4)	4 (15.4)	

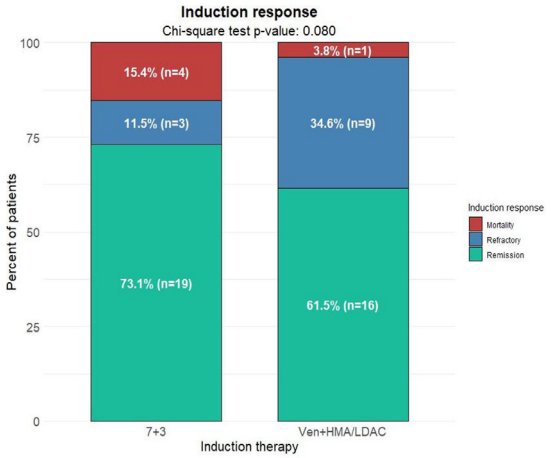

Figure 1 Comparison of induction response.

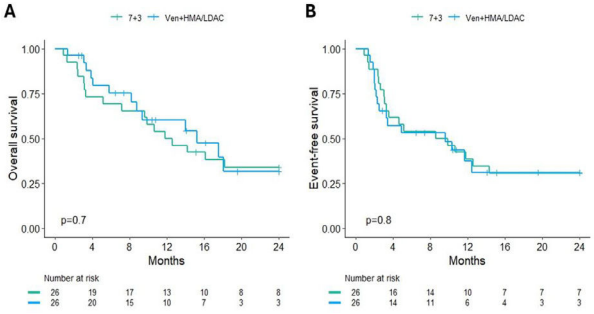

Figure 2 Comparisons of overall (A) and event-free survival (B).

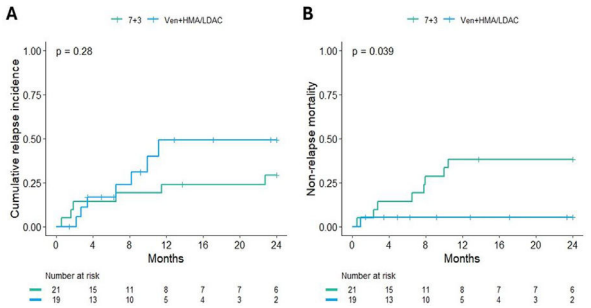

Figure 3 Comparisons of cumulative relapse incidence (A) and non-relapse mortality (B).

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PREDICTORS OF RESPONSE TO RUXOLITINIB THERAPY IN PATIENTS WITH MYELOFIBROSIS

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Presentation Type: Oral. **Abstract Category:** Adult Hematology Abstract Categories -> Myeloproliferative Neoplasms. **Objective:** Since the introduction of targeted therapy for myelofibrosis and the incorporation of ruxolitinib into clinical practice, overall survival rates have significantly improved. Despite initial effectiveness, most patients eventually lose their response, and after stopping treatment, they have poor Overall Survival rates (OS). Currently, response criteria that can predict a response or indicate treatment failure are not well studied in patients receiving ruxolitinib. **Aim:** To analyze therapy with ruxolitinib and identify early predictors of response or treatment failure **Methodology:** The study included 225 patients (79 men and 145 women). The median age at the start of ruxolitinib therapy was 60 years (range 27–84).

- 149 patients (65%) were diagnosed with primary myelofibrosis;
- 55 patients (25%) had post-polycythemia vera myelofibrosis;
- 16 patients (7%) had post-thrombocythemia myelofibrosis;
- 8 patients (3%) were diagnosed with essential thrombocythemia.

For 169 patients (75%), the time to ruxolitinib therapy initiation was more than two years. According to the DIPSS prognostic scale, 88 patients (39%) were in the intermediate-1 risk

group, 110 patients (49%) were in the intermediate-2 risk group, and 26 patients (12%) were in the high-risk group. Most patients (82%) had the JAK2V617F mutation, 13% had a mutation in the CALR gene, 2% had a mutation in the MPL gene, and 4 patients were triple negative. 121 patients (54%) had a normal karyotype, and 51 patients (23%) had an unfavorable karyotype. An enlarged spleen size of more than 10 cm upon palpation was observed in 108 patients. **Results:** The median duration of ruxolitinib therapy was 22 months (range 7–123). In 91% of cases, the therapeutic dose of the drug was 30 mg per day or more, and in 9% it was less due to the presence of thrombocytopenia.

- Disease stabilization was recorded in 7 patients (35%);
- Clinical improvement was observed in 86 patients (38%);
- Disease progression was noted in 60 patients (27%).

In 75% of cases, a reduction in spleen size compared to baseline was achieved, and in 80 patients (40%), some reduction in disease symptoms was observed. In 70% of cases, there was no need for blood transfusion therapy. Ruxolitinib therapy led to an increase in the proportion of patients with low and intermediate-1 risk (53% vs. 39%). At the time of the current analysis, 184 patients (82%) were alive, and 40 patients (18%) had died. Overall survival rates were 72% in the intermediate-1 risk group, 60% in the intermediate-2 group, and 48% in the high-risk group ($p < 0.0001$). To build a predictive model of the response to therapy, a new RR6 calculator was used. The low-risk group included 46 patients (overall survival – 86%), the intermediate-risk group – 60 patients (overall survival – 83%), and the high-risk group – 59 patients (overall survival – 55%) ($p < 0.0015$). **Conclusion:** Ruxolitinib is the standard of care for patients with myelofibrosis. The RR6 prognostic model can be applied to patients with myelofibrosis after 6 months of ruxolitinib treatment to identify risk groups with an unfavourable course and those requiring a change in treatment strategy.

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