

in patients with chronic myeloid leukemia. *Leuk Lymphoma*. 2014 Nov;55(11):2614-9.

8. Natarajan H, Kumar L, Bakhshi S, et al. Imatinib trough levels: a potential biomarker to predict cytogenetic and molecular response in newly diagnosed patients with chronic myeloid leukemia. *Leuk Lymphoma*. 2019 Feb;60(2):418-425.
9. Parikh P. Report of chronic myeloid leukemia in chronic phase from Tata Memorial Hospital, Mumbai, 2002-2008. *Indian J Med Paediatr Oncol*. 2013 Jul;34(3):164-7.
10. Scalzulli, E., Colafigli, G., Latagliata, R. et al. Switch from branded to generic imatinib: impact on molecular responses and safety in chronic-phase chronic myeloid leukemia patients. *Ann Hematol* 99, 2773–2777 (2020).
11. Xuelin Dou, Yazhen Qin, Yueyun Lai, et al. Comparable Efficacy and Safety of Generic Imatinib and Branded Imatinib in Patients With Newly Diagnosed Chronic Myeloid Leukemia With a Consideration of Socioeconomic Characteristics: A Retrospective Study From a Single Center, *Clinical Lymphoma Myeloma and Leukemia*, Volume 20, Issue 6, 2020, Pages e304-e315.

<https://doi.org/10.1016/j.htct.2021.10.947>

Sp03

REVIEW OF NEW INDICATIONS – JOURNAL OF CLINICAL APHERESIS PERSPECTIVE

Huy Pham

Therapeutic apheresis is used to treat various types of disorders. The American Society for Apheresis (ASFA) publishes evidence-based guidelines every 3 years to assist apheresis practitioners in the rationale and management of apheresis patients and outlines basic technical specifications for procedures. However, the ASFA guidelines on the use of therapeutic apheresis published by the Journal of Clinical Apheresis only include indications that have enough evidence in the medical literature to provide apheresis recommendations. The guidelines do not include all the diseases that were reported in the medical literature or the ones that may be potentially treated by apheresis in the future. For new factsheet development, the committee responsible for developing the ASFA guidelines review requests from apheresis practitioners. One or more committee members will evaluate the available literature for evidence for the use of therapeutic apheresis in the disease or indication. A minimum of 10 cases, preferably by at least 2 groups, published in the last decade in peer-reviewed journals. In the current version of the ASFA guidelines (2019), the committee considered several potential new indications; however, none of them had enough evidence to be included in the current guidelines as new factsheets. Of note, the committee will review and issue interim factsheets for new indications if necessary before the release of the next version of the guidelines.

Furthermore, due to COVID-19 pandemic, the next version of the ASFA Guidelines will be released in 2023.

<https://doi.org/10.1016/j.htct.2021.10.948>

Sp04

HOW I TREAT NEWLY DIAGNOSED MULTIPLE MYELOMA PATIENTS?

María-Victoria Mateos

Although Multiple Myeloma (MM) remains as a potential incurable disease, important advances are occurring in the knowledge of the disease as well as in the treatment and management and as result, the overall survival is significantly improving. This benefit is applicable along the course of the disease, but the first line of therapy is crucial because almost 100% of patients will receive the first line of therapy and this is the place where patients will get the maximum benefit.

The deeper the response, the longer the progression free and overall survival and patients therefore should receive the combinations of therapies resulting in the highest rates of complete response or undetectable measurable residual disease using sensitive techniques for its detection inside and outside of the bone marrow. This is applicable to both transplant and non-transplant eligible patients and this distinction should be based on biological age together with comorbidities more than in the classical chronological age.

For transplant eligible newly diagnosed MM patients, the treatment should include induction followed by high-dose therapy and autologous stem cell transplantation and maintenance. Induction should include three-drugs based combinations (proteasome inhibitor plus immunomodulatory drug and dexamethasone) and now it is possible to add the monoclonal antibodies targeting CD38 daratumumab to the combination of VTD. Melphalan at high doses followed by transplant has demonstrated to upgrade the response and it results as a complementary rather than an alternative strategy, although in the future risk cytogenetic together with the depth of response will be introduced in the algorithm and some patients could not need transplant. Consolidation might be considered if the response previously achieved could be upgraded and maintenance will be able to maintain the response achieved and under the lenalidomide platform, new combinations are emerging like lenalidomide plus either daratumumab or carfilzomib.

In the setting of transplant ineligible patients, the old standards of care bortezomib, melphalan and prednisone and continuous therapy with lenalidomide and dexamethasone have been replaced by daratumumab plus either VMP or Rd because the addition of daratumumab significantly improved the responses rate including complete responses and undetectable measurable disease but also the outcomes in terms of progression free and overall survival. Bortezomib, lenalidomide and dexamethasone is another combination maybe of choice for fit patients and the platform to which monoclonal antibodies anti CD38 are going to be added.

<https://doi.org/10.1016/j.htct.2021.10.949>