Lymphocyte Predominant B-cell Lymphoma (NLPBL). Nodular sclerosis, mixed cellularity, lymphocyte depletion, and lymphocyte–rich HL are subgroups of classical HL. Risk Stratification An accurate assessment of the stage of disease in patients with HL is critical for the selection of the appropriate therapy. Prognostic models that identify patients at low or high risk for recurrence, as well as the response to therapy as determined by Positron Emission Tomography (PET) scan, are used to optimize therapy. Risk–Adapted Therapy Initial therapy for HL patients is based on the histology of the disease, the anatomical stage and the presence of poor prognostic features. Patients with early–stage disease are typically treated with combined modality strategies utilizing abbreviated courses of combination chemotherapy followed by involved–field radiation therapy, whereas those with advanced stage disease receive a longer course of chemotherapy often without radiation therapy. However, newer agents including brentuximab vedotin and anti–PD–1 antibodies are now standardly incorporated into frontline therapy. Management of Relapsed/Refractory Disease High–Dose Chemotherapy (HDCT) followed by an Autologous Stem Cell Transplant (ASCT) is the standard of care for most patients who relapse following initial therapy. For patients who fail HDCT with ASCT, brentuximab vedotin, PD–1 blockade, non–myeloablative allogeneic transplant or participation in a clinical trial should be considered. The AETHERA study (NCT01100502) shows that Brentuximab Vedotin (BV) improves Progression-Free Survival (PFS) after ASCT in patients with Refractory or Relapsed HL (R/R HL). For patients who relapse after ASCT, BV, and anti-PD-1, monoclonal antibodies were considered incurable, and their outcome is rather dismal, with a median Overall Survival (OS) of 2-years. For Refractory or Relapsed cHL (R/R cHL) patients who have failed both ASCT and BV, Chimeric Antigen Receptor T-cell (CAR-T) therapy offers a new therapeutic option.

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08

HISTORY OF BLOOD TRANSFUSION

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It is not easy to cover the history of transfusion in all its aspects. In the era when blood transfusion was first tried, the indications for blood transfusion were also very different: mental illness, gaining strength, rejuvenation, etc. Blood transfusion process has gone through many dangerous and difficult stages, from obtaining the blood to its safe application in peace, in war, and in the laboratory. This presentation focuses on some stages and developments in the application of blood transfusion. The main developments are summarized in Table 1. The main problems encountered in the history of transfusion can be summarized as follows:

- Blood clotting and preservation could be prevented by the use of 0.2% sodium citrate and dextrose.
- Severe transfusion reactions could mostly be prevented after the ABO blood groups were identified.
- Infection problems that could be partially controlled with antiseptic agents.

In this presentation, various obstacles encountered in the history of blood transfusion and developments regarding their solutions are presented.

Table 1 Important stages in the history of blood transfusion.

1628	William Harwey (GB)	Discovery of human blood circulatory system
1666	Richard Lower (Oxford)	Experiments of blood transfusion beetween animals
1667	Jean Denis (Paris)	Transfusion blood from animals to humans
1818	James Blundell (London)	First blood transfusion from one human to another
1854	J Bovell E Hodder (Toronto)	Cow's milk transfusions was first attempted
1901	Karl Landsteiner (Wienna)	Discovery of ABO blood groups (Nobel Prize in 1930)
1915	Richard Lenwinsohn (NY)	Developing 0.2% sodium citrate as anticoagulant
1921	Percy Oliver (London)	The first blood donor service is established
1932	in the SU and the USA	Cadaveric blood began to be used
1937	Bernard Fantus (Chicago)	The first blood bank
1940	Edwin Cohn (Boston)	A method for fractionation of plasma proteins
1951	Edwin Cohn (Boston)	Developping the first blood cell separator
1971		Hepatitis B surface antigen testing of donated bloods
1982	J Goldstein	Developing universal type O blood by enzyme treatment
1983	L. Montaignier (Paris)	Isolation of the virus that causes AIDS
From 1987 to 2008		A series of tests are developed to screen donated blood for infectious diseases
2010	Seifinejad A et al.	RBCs generated from human induced pluripotent SCs
2020	Ebrahimi M, et al.	Differentiation of human induced pluripotent stem cells into RBCs

SU, Soviet Union; USA, United States of America; RBCs, Red Blood Cells; SCs, Stem Cells.

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09

TREATMENT FOR HODGKIN'S LYMPHOMAS IN COUNTRIES WITH LIMITED RESOURCES

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The incidence and long-term clinical outcome of Hodgkin Lymphoma (HL) vary according to different patient, disease-related factors and geographic location. There have been