

dramatic changes in the staging and treatment of Hodgkin's Lymphoma (HL) over the last two decades. 75%–80% of patients with classical HL can achieve long-term remission with contemporary risk-adapted frontline therapy in high income countries. However, 25%–30% of patients with advanced-stage disease experience relapse or have primary refractory disease. For patients with Relapsed/Refractory HL (rrHL), salvage therapy followed by Stem Cell Transplantation (SCT) is the current standard of care. Despite the significant improvement in the diagnosis, staging, the use of risk-adapted approach, introduction of novel agents (CPI, Bv) in frontline setting, the use of post-transplant consolidation maintenance therapy, 50% of patients still experience disease progression, with poor prognosis and shortened survival. Most of the real-world data regarding treatment pathways and clinical outcomes in relapsed refractory HL published from high income countries in Euro and North America. There is a limited data on clinical characteristics and clinical outcomes of HL in low-resourced countries. Very few studies published so far with limited number of patients, single-center experiences, poor data quality, or lack of comprehensive information on patients, treatment, or clinical outcomes. In my presentation, we will highlight the disease entity from diagnosis, staging to treatment options worldwide; the availability and the use of novel agents in frontline and in relapsed refractory setting, availability of stem cell transplantation procedures and compare the clinical outcomes of HL patients in both high- and low-resourced countries.

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10

CLASSIFICATION OF MPN

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The 2022 updated 5th edition of the World Health Organization Classification of myeloproliferative neoplasms and mastocytosis focused on changes in the rationale behind the classification, combined morphologic, immunophenotypic, molecular, and cytogenetic data that help to refine diagnostic criteria and emphasize therapeutically and/or prognostically actionable biomarkers. While a genetic basis for defining diseases is sought where possible, the classification strives to keep practical applicability in perspective. In addition, a new International Consensus Classification (ICC) has been introduced for myeloid neoplasms and acute leukemia. In the context of MPN, the classical subtypes of MPN remained unchanged; however, the experts made an effort to refine the diagnostic criteria to allow a distinction between subtypes. With refinement of the diagnostic criteria, the hope is that clinicians will be able to distinguish between specific subtypes with greater accuracy and present a more definitive and holistic management for patients from diagnosis through disease monitoring.

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11

PREDICTION OF THE RISK OF LEUKEMIA DEVELOPMENT IN AGED HEALTHY POPULATION: IMPLEMENTATION IN THE PUBLIC HEALTH SYSTEM

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In the last 10-years, several scientific reports have provided evidence of the accumulation of somatic mutations in Hematopoietic Stem and Progenitor Cells (HSPC) in subjects aged > 50yrs. This phenomenon is defined as Clonal Hematopoiesis of Indeterminate Potential (CHIP). As discovered and developed by Abelson et.al. (Nature. 2018) these mutations are detectable many years before the clinical onset of Acute Myeloid Leukemia (AML) and are potentially linked to its subsequent evolution. It is important to underline that the correlation between mutations and the development of AML does not represent an early diagnosis but only an increased risk of developing AML. The risk depends on many factors: type of mutations, how many cells carry the mutation, and combination of mutations. A risk score has been established (NEJM 2023); according to this study few subjects with CHIP are going to develop AML. Of note: the studies that document these correlations were retrospective. It might be relevant to emphasize that “early diagnosis of AML” does not seem to have, given the dynamics of cellular proliferation, concrete advantages. The identification early in advances of a constellation of mutations and their combinations possibly associated with the risk of developing AML could instead be very effective, if there were drugs targeting specific mutations. From a precision, personalized and participatory medicine perspective, these studies have led us to launch a prospective project on a healthy population of individuals between 50 and 80-years old. We reasoned that this type of screenings based on complex landscapes of genetic mutations will become more and more present in the evolving scenario of predictive medicine. Thus, the company Dedalus Italia S.p.A. designed the model and the software for implementing these screening studies in the Health Services. The project name is “SInISA”. The experimentation is carried out in the territory of the Regional-Health-Service (ASL5) of Eastern Liguria (Italy), with the aim of verifying and evaluating both the organizational model and the technological infrastructure to support it, with the ambition of initially sequencing the DNA with a panel of about 90 genes. The first step was to identify subjects with higher probability of bearing mutations. The first screening element will be the RDW parameter. Subjects with RDW > 15 have higher probability of bearing mutations in blood cells. It was calculated that to identify individuals with RDW > 15 it is necessary start from a population of approx. 12000 subjects. This study is based on the free and voluntary participation of