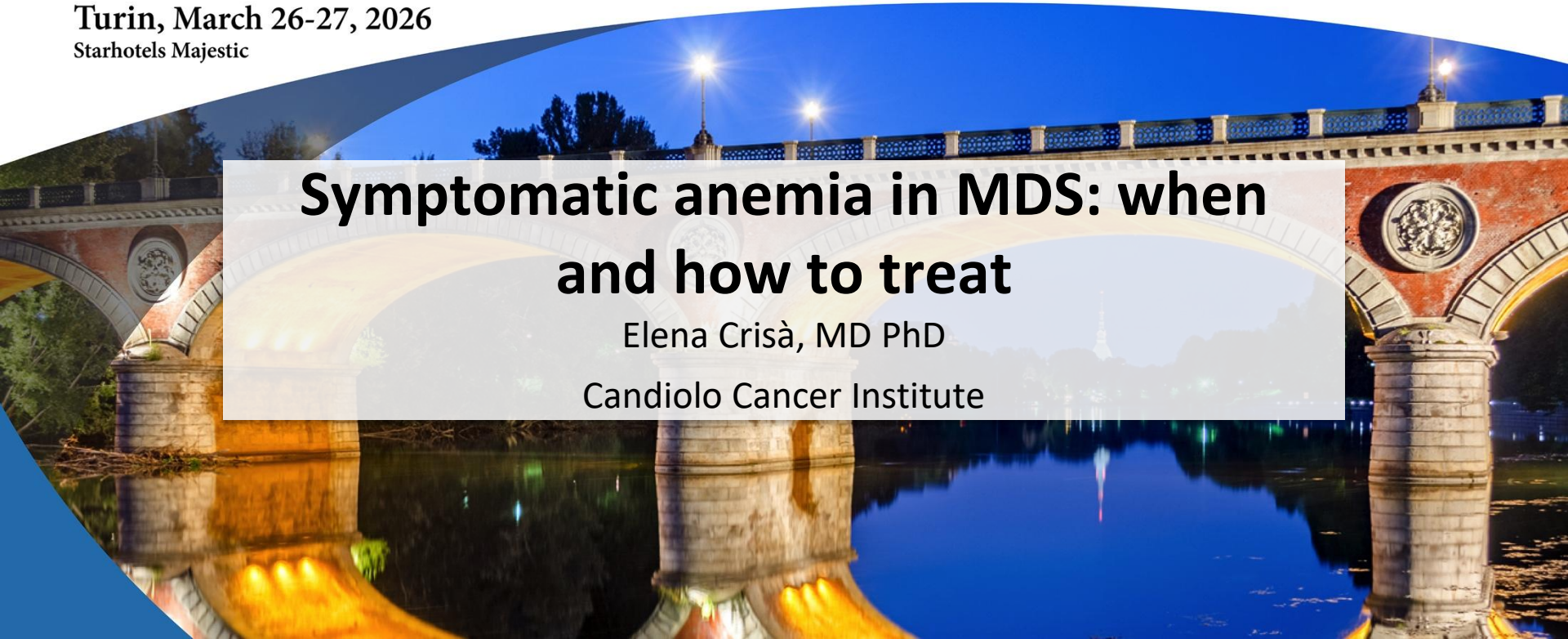
4th edition

Unmet challenges in high risk hematological malignancies: from benchside to clinical practice

Turin, March 26-27, 2026

Starhotels Majestic

Scientific board:
Marco Ladetto (Alessandria)
Umberto Vitolo (Candiolo-TO)



Symptomatic anemia in MDS: when and how to treat

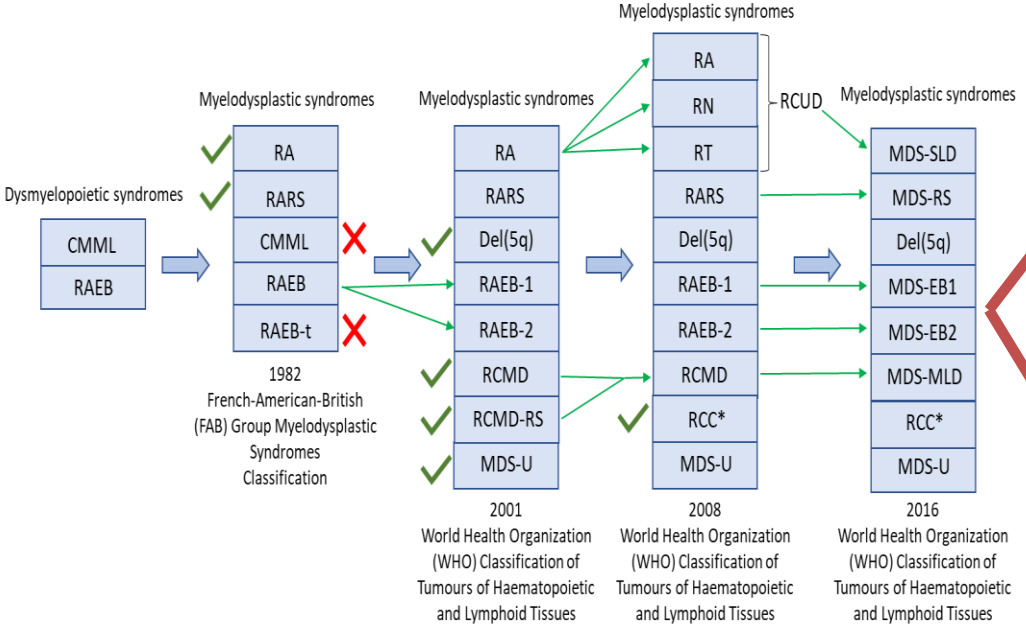
Elena Crisà, MD PhD

Candiolo Cancer Institute

Disclosures of Elena Crisà

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
GSK						x	
BMS					x		
NOVARTIS							x

MDS classification has evolved over time



Key
= new addition to respective classification
= removed from subsequent classification

WHO 2022

Leukemia www.nature.com/leu

REVIEW ARTICLE OPEN

The 5th edition of the World Health Organization Classification of Haematolymphoid Tumours: Myeloid and Histiocytic/ Dendritic Neoplasms

Joseph D. Khoury, Eric Solary, Oussama Abla, Yassmine Akkari, Rita Alaggio, Jane F. Apperley, Rafael Bejar, Emilio Berti, Lambert Busque, John K. C. Chan, Weina Chen, Xueyan Chen, Wee-Joo Chng, John K. Choi, Isabel Colmenero, Sarah E. Coupland, Nicholas C. P. Cross, Daphne De Jong, M. Tarek Elghetany, Emiko Takahashi, Jean-Francois Emile, Judith Ferry, Linda Fogelstrand, Michaela Fontenay, Ulrich Germing, Sumeet Gujral, Torsten Haferlach, Claire Harrison, Jennelle C. Hodge, Shimin Hu, Joop H. Jansen, Rashmi Kanagal-Shamanna, Hagop M. Kantarjian, Christian P. Kratz, Xiao-Qiu Li, Megan S. Lim, Keith Loeb, Sanam Loghavi, Andrea Marcogliese, Soheil Meshinchi, Phillip Michaels, Kikkeri N. Naresh, Yasodha Natkunam, Reza Nejati, German Ott, Eric Padron, Keyur P. Patel, Nikhil Patkar, Jennifer Picarsic, Uwe Platzbecker, Irene Roberts, Anna Schuh, William Sewell, Reiner Siebert, Prashant Tembhare, Jeffrey Tyner, Srdan Verstovsek, Wei Wang, Brent Wood, Wenbin Xiao, Cecilia Yeung and Andreas Hochhaus

ICC 2022

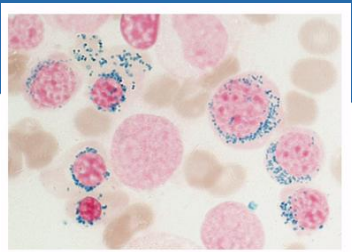
The International Consensus Classification of Myeloid Neoplasms and Acute Leukemias: Integrating Morphological, Clinical, and Genomic Data

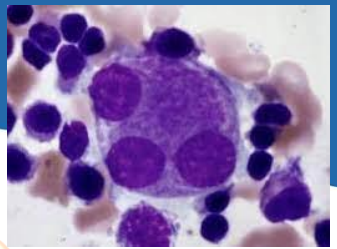
Daniel A. Arber, Attilio Orazi, Robert P. Hasserjian, Michael J. Borowitz, Katherine R. Calvo, Hans-Michael Kvasnicka, Sa A. Wang, Adam Bagg, Tiziano Barbui, Susan Branford, Carlos E. Bueso-Ramos, Jorge E. Cortes, Paola Dal Cin, Courtney D. DiNardo, Herve' Dombret, Eric J. Duncavage, Benjamin L. Ebert, Elihu H. Estey, Fabio Facchetti, Kathryn Foucar, Naseema Gangat, Umberto Gianelli, Lucy A. Godley, Nicola Gökbuget, Jason Gotlib, Eva Hellström-Lindberg, Gabriela S. Hobbs, Ronald Hoffman, Elias J. Jabbour, Jean-Jacques Kiladjian, Richard A. Larson, Michelle M. Le Beau, Mignon L-C. Loh, Bob Löwenberg, Elizabeth Macintyre, Luca Malcovati, Charles G. Mullighan, Charlotte Niemeyer, Olatoyosi M. Odenike, Seishi Ogawa, Alberto Orfao, Elli Papaemmanuil, Francesco Passamonti, Kimmo Porkka, Ching-Hon Pui, Jerald P. Radich, Andreas Reiter, Maria Rozman, Martina Rudelius, Michael R. Savona, Charles A. Schiffer, Annette Schmitt-Graeff, Akiko Shimamura, Jorge Sierra, Wendy A. Stock, Richard M. Stone, Martin S. Tallman, Jürgen Thiele, Hwei-Fang Tien, Alexandar Tzankov, Alessandro M. Vannucchi, Paresh Vyas, Andrew H. Wei, Olga K. Weinberg, Agnieszka Wierzbowska, Mario Cazzola, Hartmut Döhner and Ayalew Tefferi

Zeidan A et al, Blood Reviews, 2019; Khoury J et al, Leukemia; Arber D et al, Blood 2022

Diagnostic tools in MDS

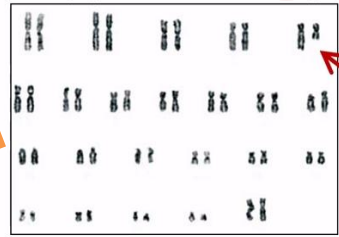
Full blood count and peripheral blood smear



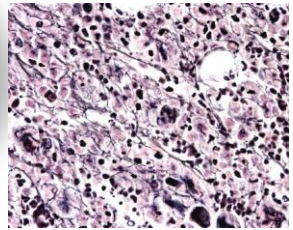


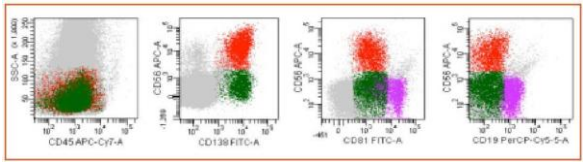
Bone marrow aspirate and biopsy

Del(5q)

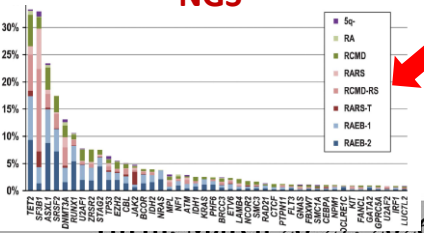


Molecular biology



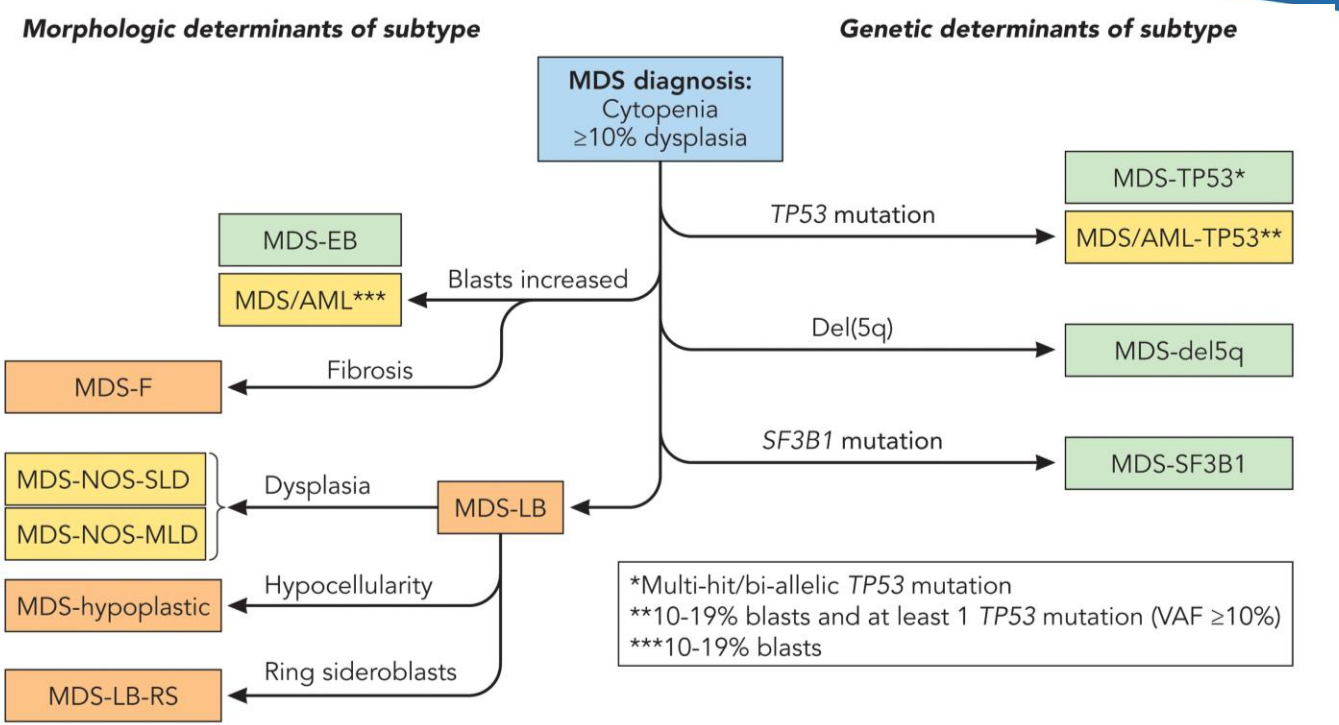


NGS



TP53

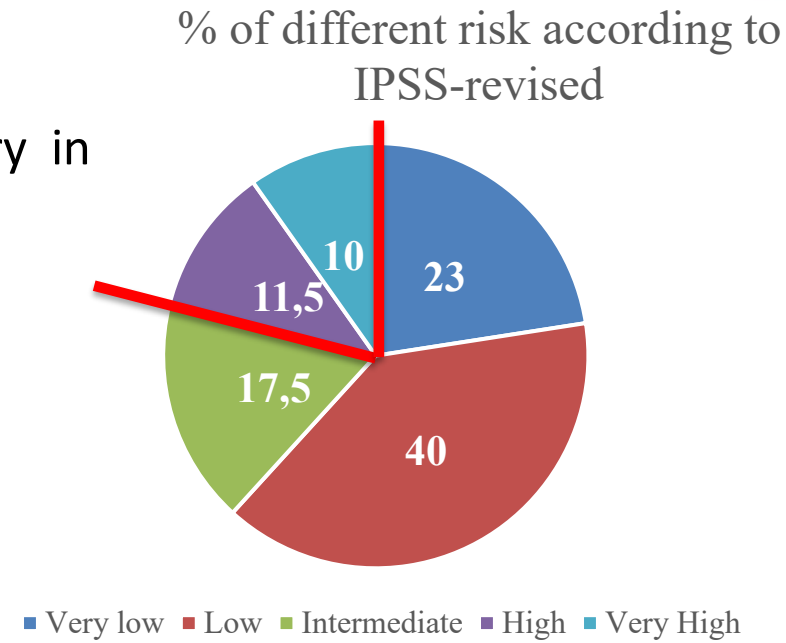
SF3B1



Robert P. Hasserjian,Ulrich Germing,Luca Malcovati, Diagnosis and classification of myelodysplastic syndromes, Blood, 2023, Figure 2.

Anemia in lower risk IPSS-r MDS : a significant clinical burden

- 80% of MDS are in the lower risk category in FISiM registry. In this group:
  - 80% have HB <12 g/dl
  - 48% HB <10 g/dl

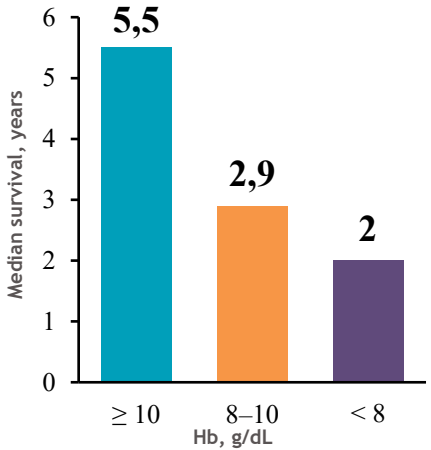


Data on 5503 MDS patients in FISiM registry with available IPSS revised score

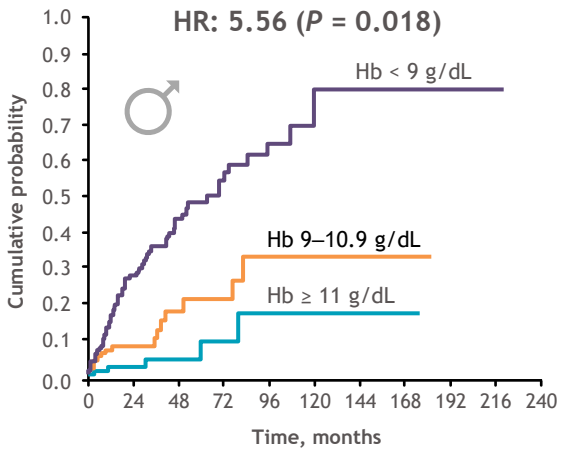
FONDAZIONE ITALIANA SINDROMI MIELODISPLASTICHE

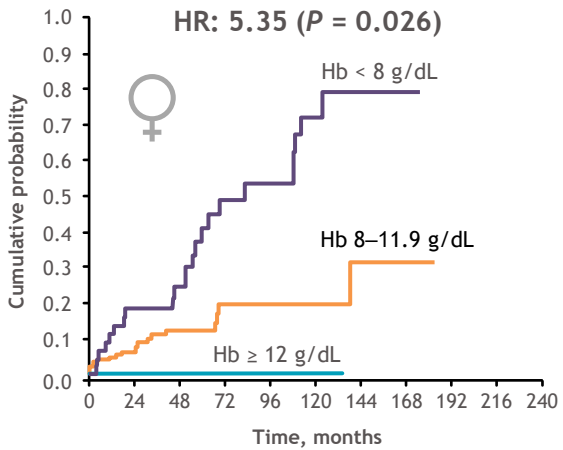
Anemia occurs in up to 90% of patients with MDS resulting in significantly increased risk of mortality

Severity of anemia and OS[3,a]



Probability of non-leukemic death[2,b]





[a]Based on combined international databases of 7012 patients with primary untreated MDS used to create the IPSS-R.[3]
[b]Based on a prospective, observational cohort analysis of 840 patients with MDS at Pavia, Italy and 504 patients with MDS at Düsseldorf, Germany.[2]
Hb, hemoglobin; IPSS-R, International Prognostic Scoring System; MDS, myelodysplastic syndromes; OS, overall survival.

1. Zeidan AM, et al. Blood Rev. 2019;34:1–15; 2. Malcovati L, et al. Haematologica. 2011;96:1433–1440; 3. Greenberg PL, et al. Blood. 2012;120:2454–2465.

Improving anemia translates into improved survival in lower-risk MDS

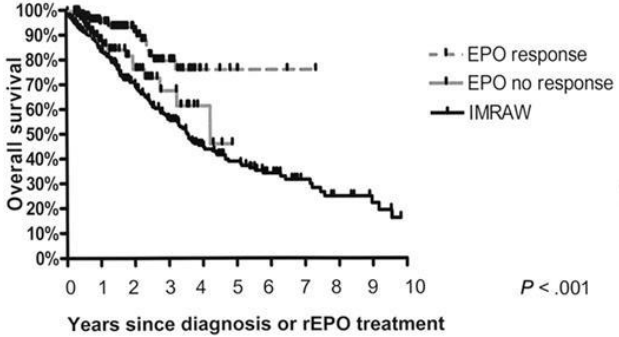
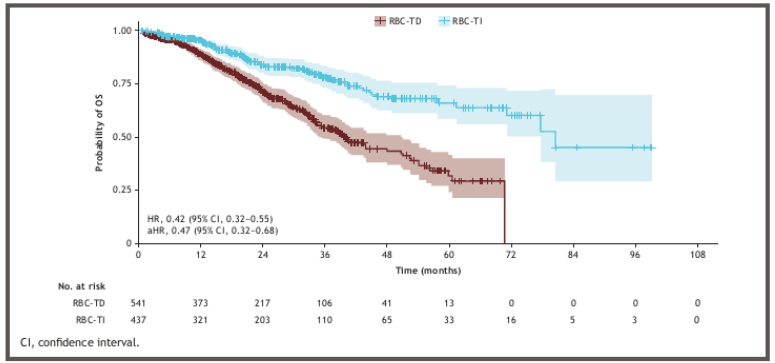
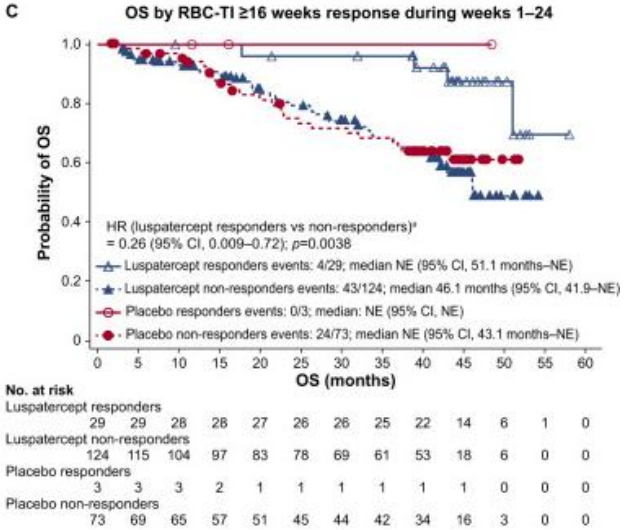


Figure 1. Kaplan-Meier curve for OS

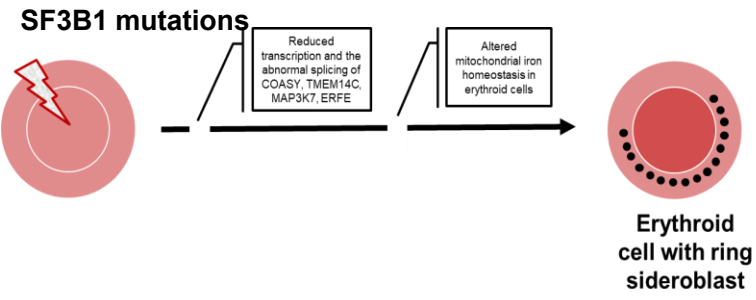


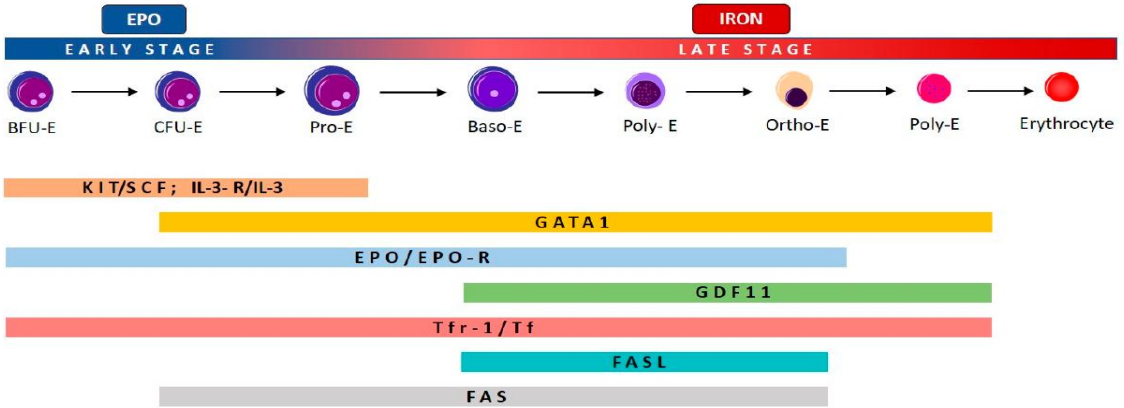


meta-analyses on 6 clinical trials on TD LR-MDS:—3 luspatercept trials (COMMANDS, MEDALIST, and PACE ; 3 lenalidomide trials (5013-MDS-0036 [NCT00065156], 5013-MDS-0047[NCT00179621], and 5013-MDS-0058 [NCT01029262])

Platzbecker et al , Leukemia 2023;Park S et al Blood 2008; Malcovati L et al. EHA 2024 Poster P782

Anemia in MDS is due to ineffective erythropoiesis



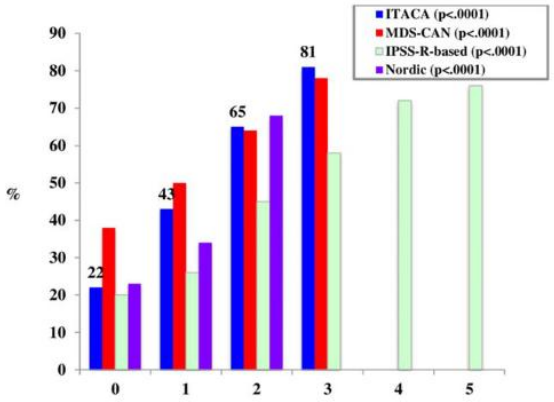


The main pathways involved in anemia in MDS are those regulated by

- Transforming growth factor (TGF)-β, which negatively regulates erythrocyte differentiation and maturation
- Erythropoietin (EPO), which acts on the early-stage erythropoiesis.

Cazzola et al, Blood, 2022, Mian et al, SCT 2023,Burke, et al, Hemasphere, 2025, Boultwood et al. 2002. Blood
Gupta R et al, Hematol Oncol Clin North Am 2018; Oikonomidou PR et al, Blood Rew 2018; Bewersdorf JP et al, Leukemia 2019; Hata A et al, Cold Spring Harb Perpect Biol 2018

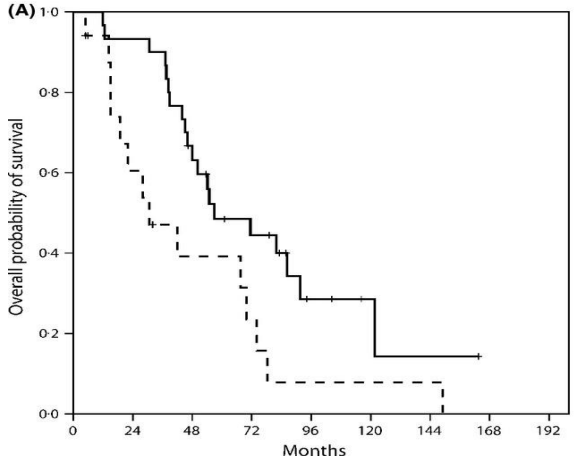
Recombinant Erythropoetin



	ITACA N=681 (p<.0001)		MDS-CAN N=702 (p<.0001)		IPSS-R-based N=524 (p<.0001)		Nordic N=846 (p<.0001)	
Score	n	% ORR	n	% ORR	n	% ORR	n	% ORR
0	53	22	119	38	5	20	17	23
1	149	43	112	50	7	26	162	34
2	267	65	215	64	36	45	667	68
3	212	81	256	78	91	58		
4					134	72		
5					55	76		

FIGURE 1 Response according to predictive scores.

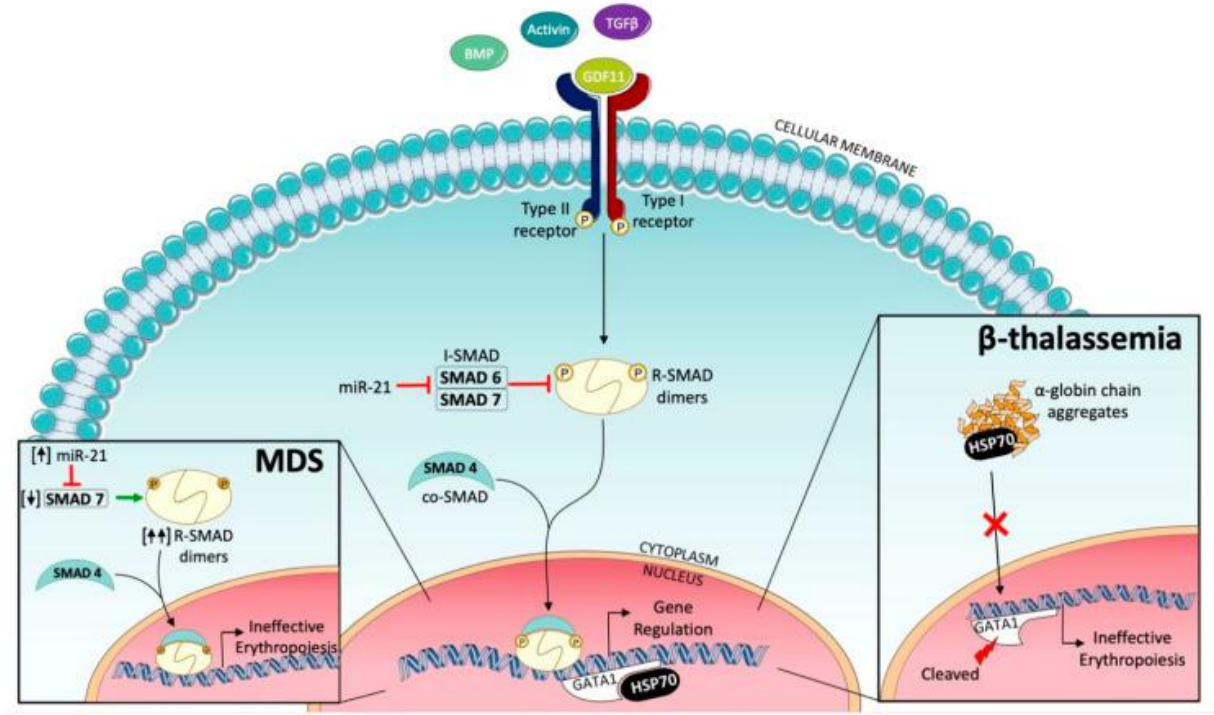
- **Recombinant Erythropoietin (EPO) & glycosylated forms (darbepoetin)** (+/- GCSF)→ **current first line treatment of non TD LR MDS**
- Response rates range from 30% to 60% depending on study. Higher if
  - **RBC-TI/low transfusion burden** (ORR 79% vs 54% and 30,6 vs 12.7 mo)
  - Low EPO level (< 200 mIU)
  - IPSS low risk
- Response duration 12-24 months
- Impact of erythroid response on survival and QoL
- no impact on AML progression



OS according to erythroid response: *P* 0·013.

Park et al., 2008;Jädersten, 2005; Greenberg et al Blood 2009; Crisà BJH 2012; Buckstein R. Et al, AJH 2017

TGF-β superfamily signaling is altered in MDS



- MDS patients display an overactivation of SMAD2/3 signaling due to the altered expression of mir-21 and SMAD7

➔ Luspatercept

Parisi S, et al. Int J Mol Sci. 2021

Luspatercept – phase III MEDALIST trial in TD MDS-RS

Patients with MDS[a] (N = 229)

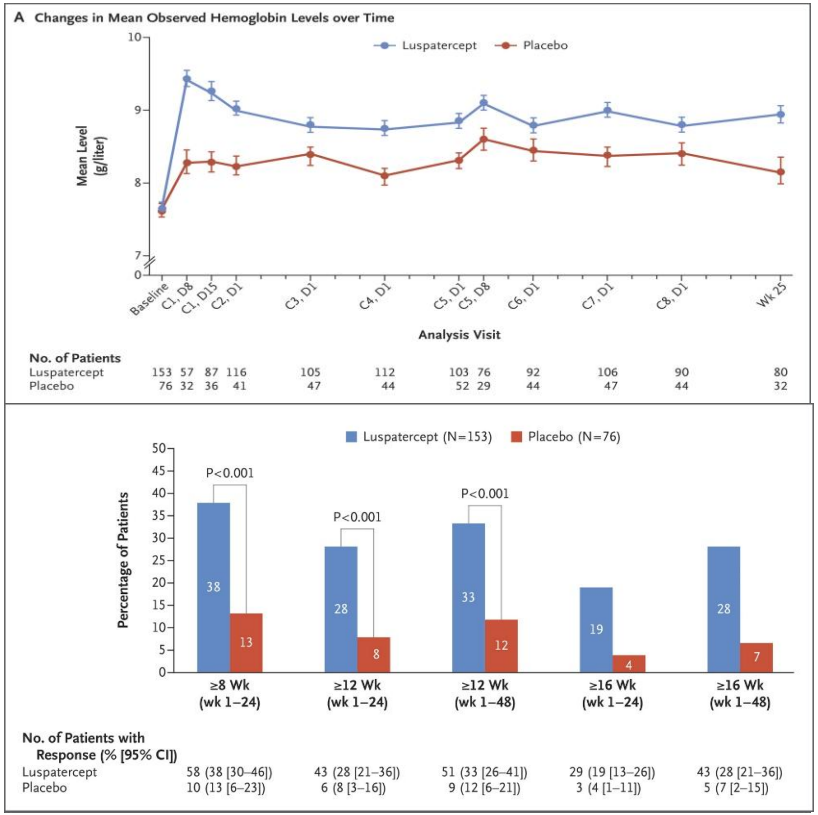
- MDS-RS (WHO): ≥ 15% RS or ≥ 5% with *SF3B1* mutation
- < 5% blasts in BM
- No del(5q) MDS
- IPSS-R Very low-, Low-, or Intermediate-risk
- **Prior ESA response**
  - **Refractory, intolerant**
  - **ESA naïve: EPO > 200 U/L**
- Average **RBC transfusion burden ≥ 2 units/8 weeks**
- **No prior** treatment with disease-modifying agents (e.g. **IMiD, HMAs**)

Luspatercept (n = 153)
Starting dose 1.0 mg/kg
Titration to 1.75 mg/kg allowed
s.c. every 3 weeks

24 weeks

Placebo (n = 76)
s.c. every 3 weeks

Week 25 Assessment



Primary endpoint:
RBC-TI ≥ 8 weeks (Weeks 1-24)

Fenaux P et al, NEJM 2020

COMMANDS: phase III trial rEPO vs luspatercept in TD MDS

Key eligibility criteria
- Aged ≥18 years
- IPSS-R very low-, low-, or intermediate-risk MDS (with or without RS) by WHO 2016, with <5% blasts in BM[a]
- Required RBC transfusions (2-6 pRBC units/8 weeks for a minimum of 8 weeks immediately prior to randomization)
- Endogenous sEPO <500 U/L
- ESA naive

Patients stratified by:
- Baseline sEPO level
- Baseline RBC transfusion burden
- RS status

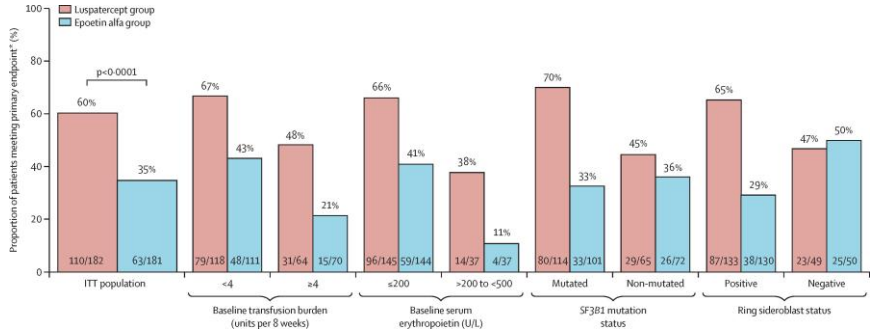
R
1:1

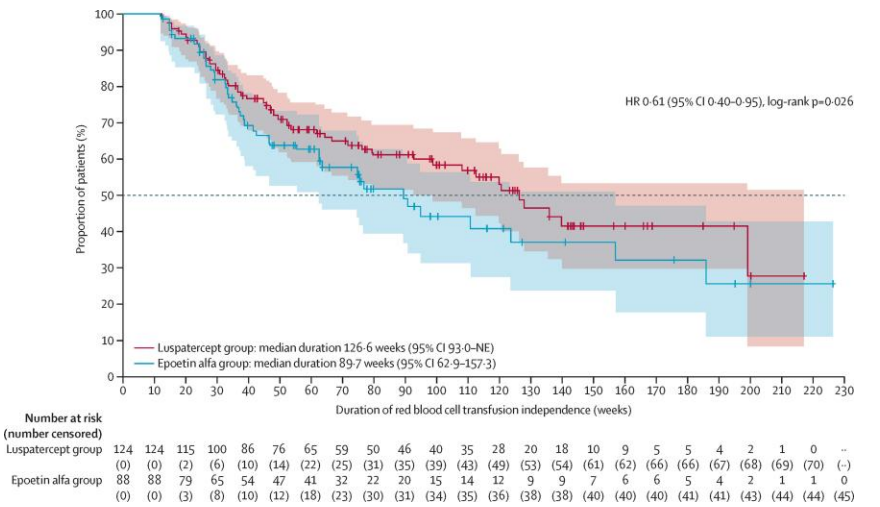
Luspatercept (n = 178)
1.0 mg/kg SC Q3W
titration up to 1.75 mg/kg

Epoetin alfa (n = 178)[b]
450 IU/kg SC QW
titration up to 1050 IU/kg

Response assessment at day 169 and every 24 weeks thereafter

EOT
Due to lack of clinical benefit[c] or disease progression per IWG criteria





Primary endpoint (weeks 1-24)

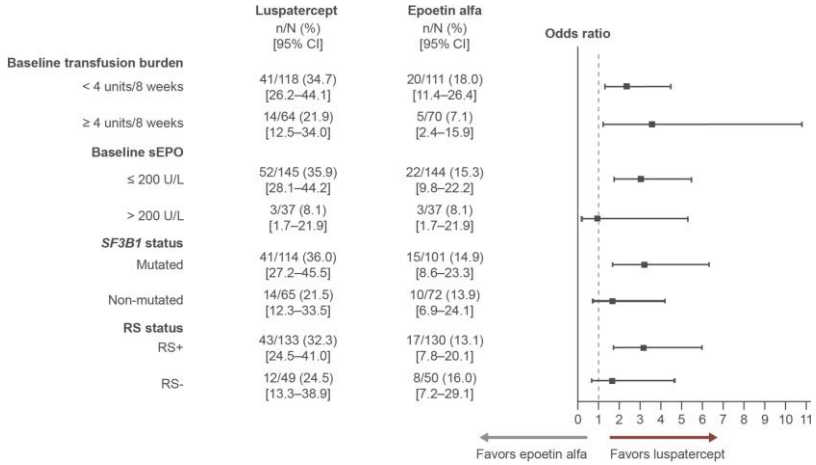
RBC-TI for ≥ 12 weeks **WITH CONCURRENT** mean Hb increase ≥ 1.5 g/dL

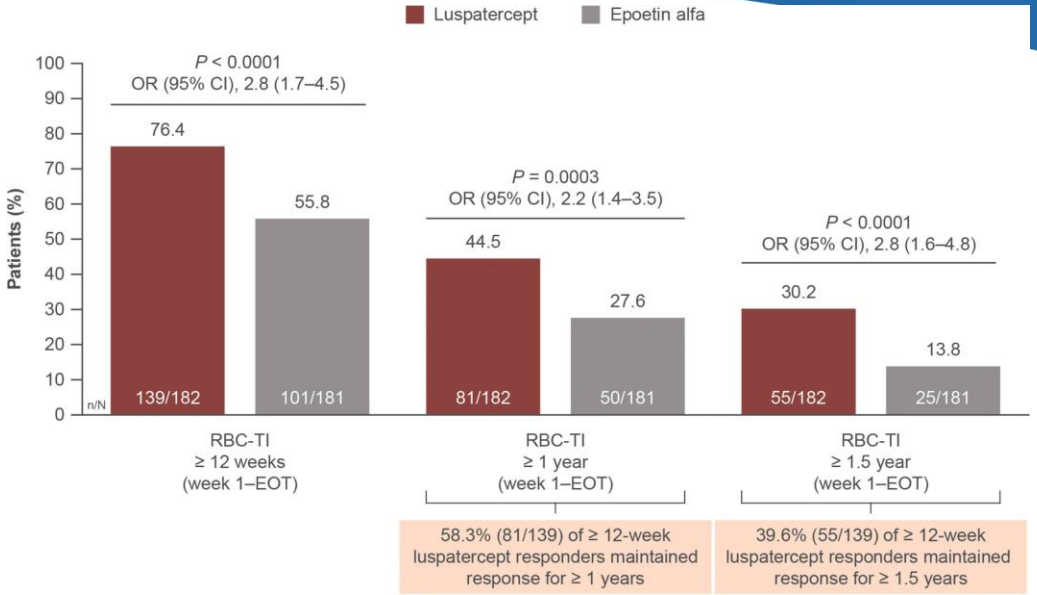
Key secondary endpoints (weeks 1-24)
- HI-E response ≥ 8 weeks per IWG 2006 criteria[2]
- RBC-TI: 24 weeks, ≥ 12 weeks
- Preplanned exploratory analysis of RBC-TI: ≥ 24 weeks (weeks 1-48)

Platzbecker U, et al. *Lancet* 2023 Jul;402:373–385; Della Porta MG, et al. *Lancet Haematol* 2024;11:e646–e648.

COMMANDS: long term results

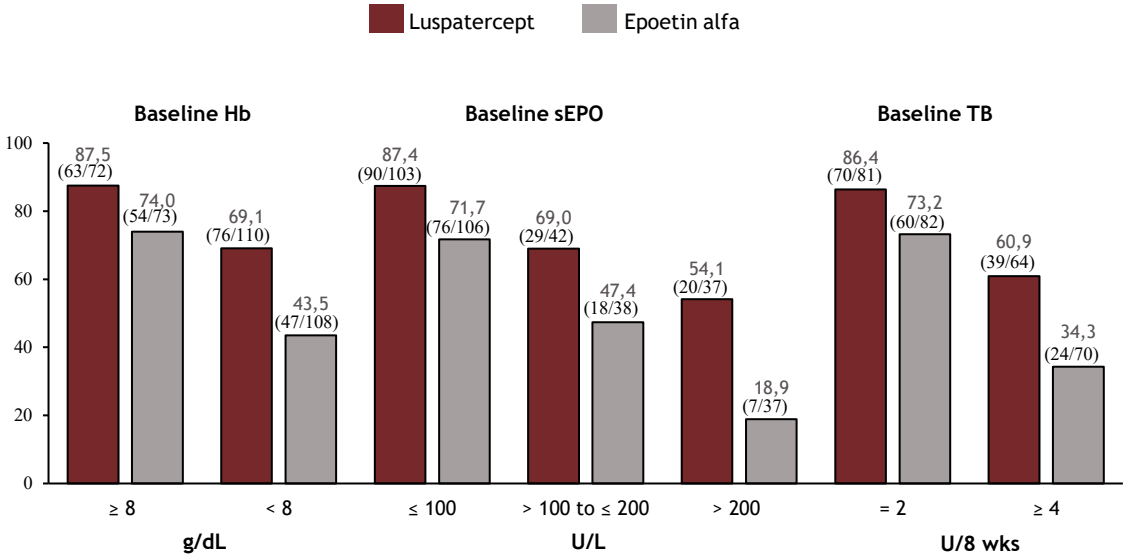
- Luspatercept continued showing a significant superiority on EPO at later time points
- The rate of response remained superior even in subgroup analysis





Garcia Manero G et al Adv Ther (2025)

COMMANDS: long term results



patients with less advanced disease characteristics (Hb ≥ 8 g/dL; sEPO ≤ 100 U/L; TB = 2 U/8 wks) achieved higher response rates and improved durability than those with more advanced disease

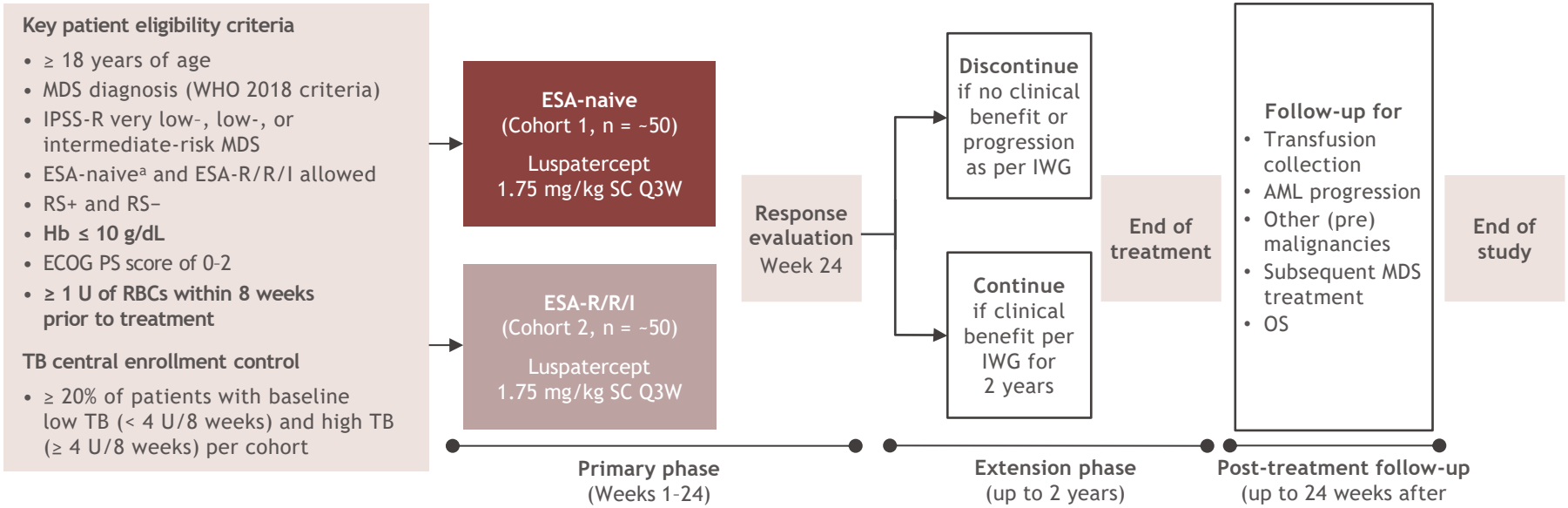
Safety overview

	MEDALIST[a] Luspatercept (n = 153) vs placebo (n = 76)[1,2]	COMMANDS[4,c] Luspatercept (n = 182) vs epoetin alfa (n = 179)
Fatigue	Any-grade events:[2] **30.7%** vs **14.5%** Grade 3/4 events:[1] **4.6%** vs **2.6%** *Fatigue occurred more frequently during cycles 1-4 of luspatercept treatment*	Any-grade events: **19%** vs **8%** Grade 3/4 events: **1%** vs **1%** *Fatigue decreased after the first few weeks of treatment*
HTN	Any-grade events:[2] **13.1%** vs **9.2%** Grade 3/4 events:[1] **3.3%** vs **3.9%**	Any-grade events: **16%** vs **9%** Grade 3/4 events: **10%** vs **4%** *Most hypertension adverse events resolved while on study treatment with medical management and did not lead to drug withdrawal*
TEE	Any-grade events:[2] **4.6%** vs **3.9%** *Anti-thrombotic agents were used by 34.0% vs 38.2% of patients, respectively, and 27.5% of patients were on anti-thrombotic agents prior to enrollment[3]*	Any-grade events: **7%** vs **3%** Grade 3/4 events: **4%** vs **1%** *The incidence of TEEs were similar between the 2 groups when adjusted for exposure*
Discont.	Discontinuations due to TEAEs:[1,2,b] **15.7%** vs **7.9%** *TEAEs leading to ≥ 2 discontinuations with luspatercept were fatigue (n = 2), sepsis (n = 2) and transformation to AML[3,a]*	Discontinuations due to TEAEs: **6%** vs **3%** *Two events were suspected to be related to luspatercept treatment, including non-serious grade 3 dyspnea on exertion and serious grade 4 transformation to AML (n = 1 each)*

- HTN, hypertension.
- 1. Fenaux P, et al. *N Engl J Med* 2020;382:140–151; 2. Santini V, et al. *Blood* 2023;142:915; 4. Della Porta MG, et al. *Lancet Haematol* 2024;11:e646–e658.

MAXILUS: study design

MAXILUS (NCT06045689) is a phase 3b, open-label, non-randomized, 2-cohort trial



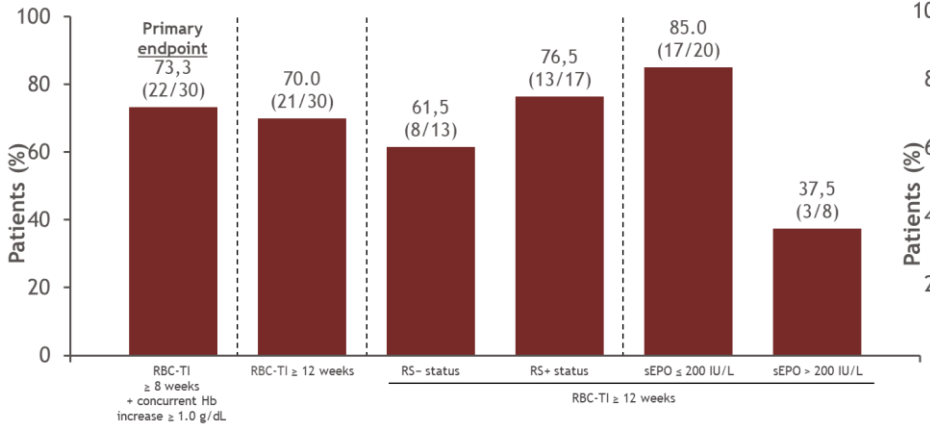
- Primary endpoint: RBC-TI for ≥ 8 weeks with a concurrent mean Hb increase of ≥ 1.0 g/dL from Weeks 1 to 24
- Secondary endpoints: RBC-TI for ≥ 8 weeks from Weeks 1 to 24, RBC-TI for ≥ 12 weeks from Weeks 1 to 24, disease progression to AML, and safety
- At this preplanned interim analysis (data cutoff date April 14, 2025), ~40% of the ESA-naive cohort and ~80% of the ESA-R/R/I cohort were expected to be eligible for the primary efficacy analysis
- At the primary analysis, ~90% of patients in both cohorts are expected to be eligible for the primary efficacy analysis

AML, acute myeloid leukemia; ECOG PS, Eastern Cooperative Oncology Group performance status; Hb, hemoglobin; IPSS-R, International Prognostic Scoring System-Revised; IWG, International Working Group; MDS, myelodysplastic syndromes; OS, overall survival; Q3W, every 3 weeks; RBC, red blood cell; R/R/I, relapsed/refractory/intolerant; RS, ring sideroblast; SC, subcutaneous; TB, transfusion burden; U, unit; WHO, World Health Organization.

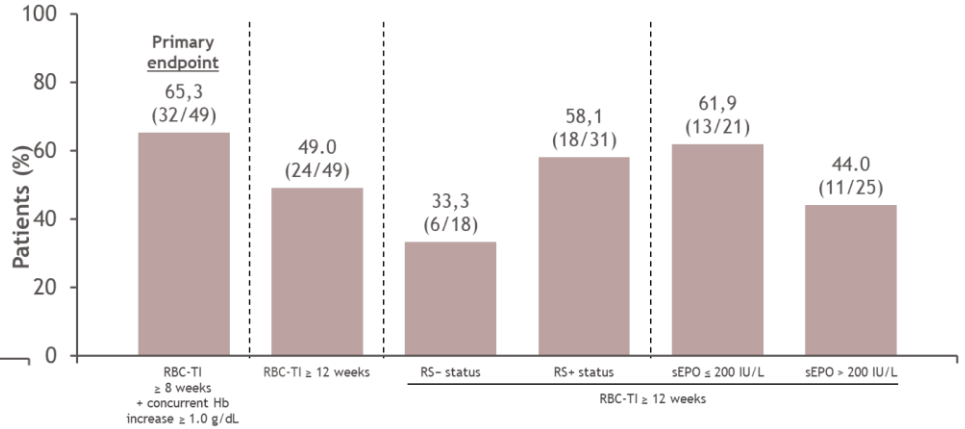
[a]Maximum of 2 doses.

MAXILUS: RBC-TI (Weeks 1-24)

ESA-naive cohort



ESA-R/R/I cohort



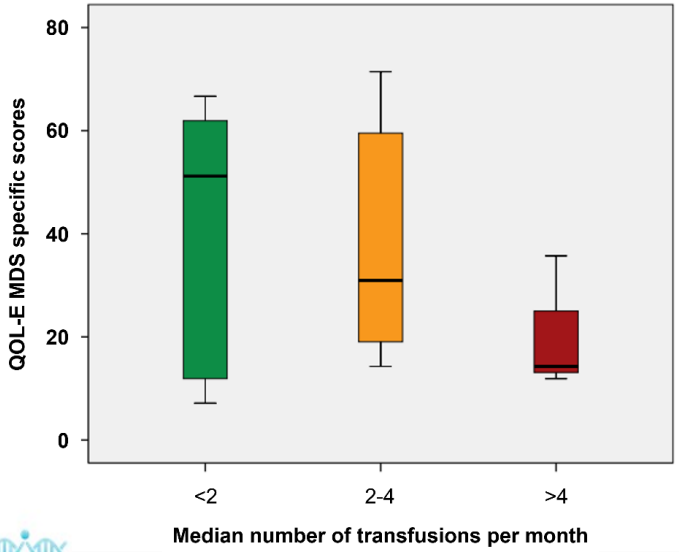
Data cutoff date: April 14, 2025. Median (IQR) follow-up was 5.8 (3.3-8.2) months for the ESA-naive cohort.
[a]Data from the ESA-naive cohort (n = 30), which included patients who received their first treatment ≥ 24 weeks prior to data cutoff (ESA-naive, n = 30).

When to stop luspatercept

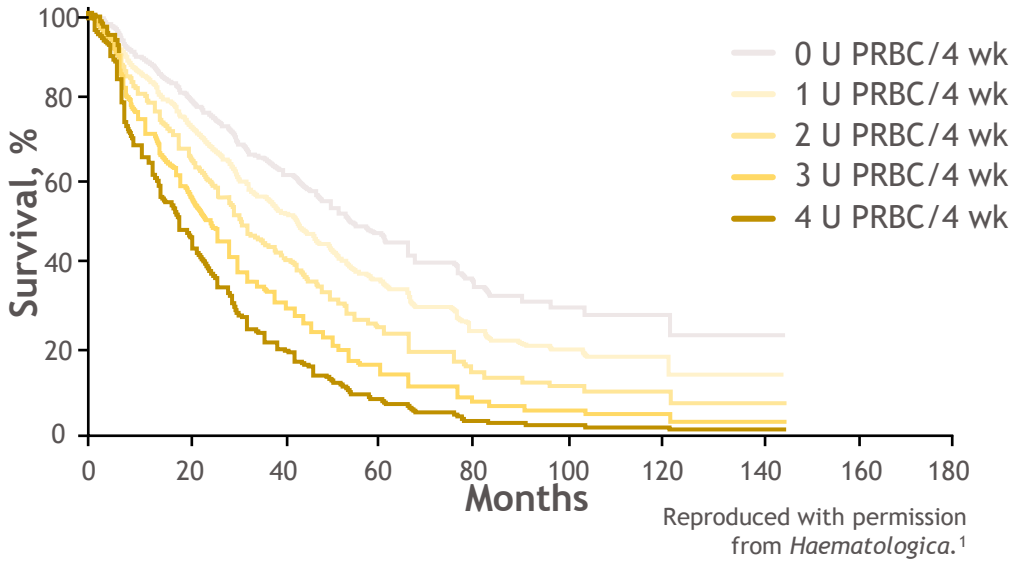
No response: no decrease in transfusion burden/ no significant increase inHb levels after 6 weeks at maximum dose 1.75 mg/kg , **no clinical benefit**

Unaccepatable toxicity

Response loss



Crisà E. et al Cancers 2025

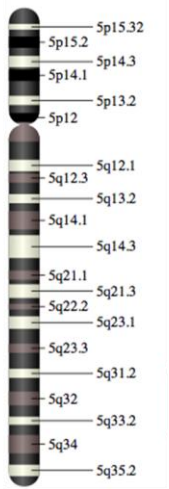


Reproduced with permission from *Haematologica.*[1]

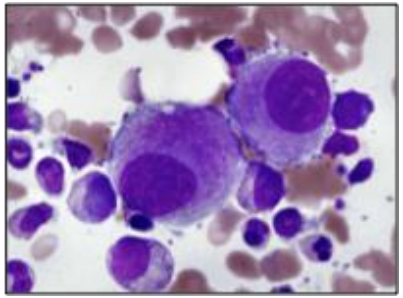
Malcovati L, et al. Haematologica. 2006;91:1588–1590

MDS with del(5q)

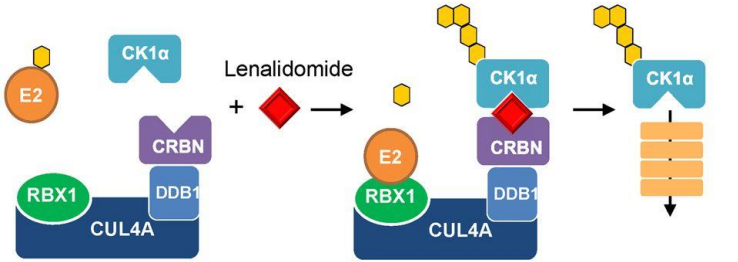
		WHO 2022	ICC 2022
Del 5q	MDS with isolated del(5q)	**MDS-5q:** MDS with low blasts and isolated del 5q or with 1 other cytogenetic abnormality except -7/del(7)	**MDS del(5q):** MDS with isolated Del 5q or with 1 other cytogenetic abnormality except -7/del(7)



haplodeficiency for several genes located on 5q (particularly CSNK1 A1, RPS14, EGR1, miR-145, and miR-146a)
→hematological phenotype
→selective sensitivity to lenalidomide



Lenalidomide in del(5q) MDS



CRL4-CRBN
E3 Ubiquitin Ligase

Proteosomal degradation

Lenalidomide can lead to red blood cell-transfusion independence (RBC-TI) in 60 - 70% of del(5q) RBC-transfusion dependent MDS patients, and to complete cytogenetic response (CCyR) in 30-40% of the cases.

- Median time to reponse 4-6 weeks

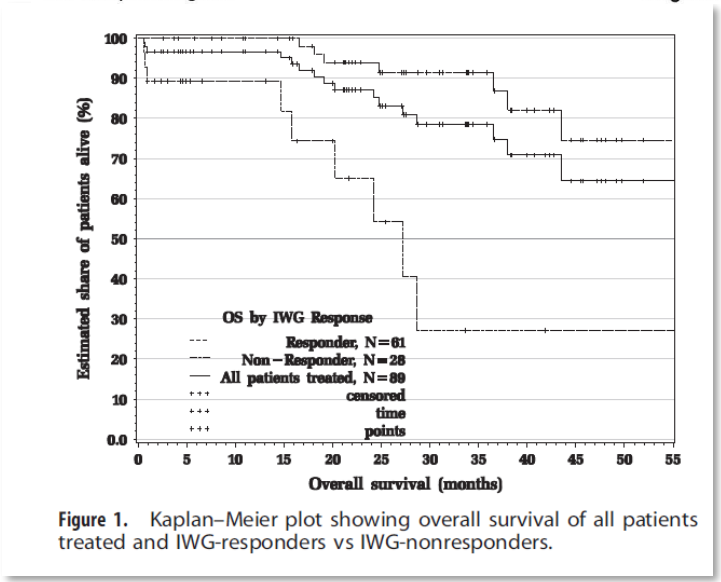
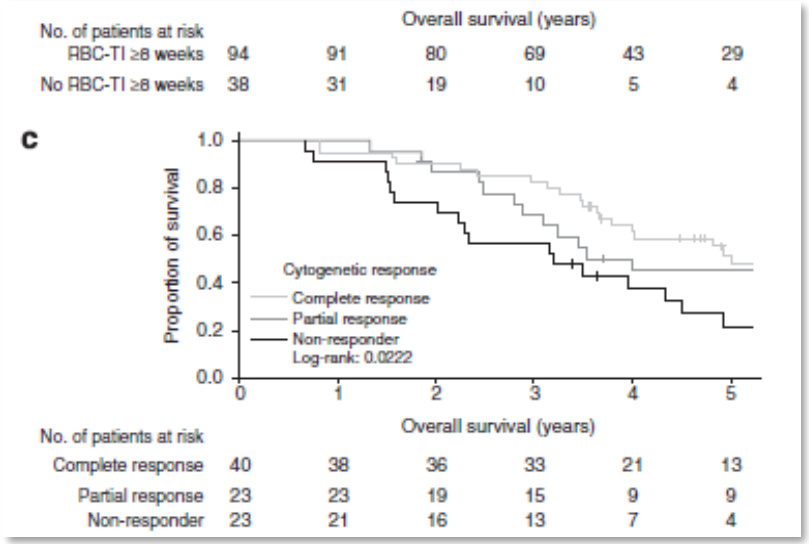


Figure 1. Kaplan–Meier plot showing overall survival of all patients treated and IWG-responders vs IWG-nonresponders.

LE-MON 5 *Schuler E. et al. Leukemia 2016*

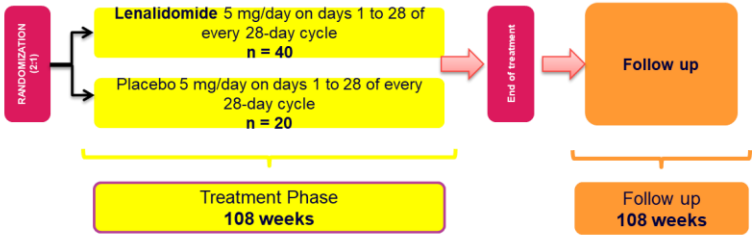


MDS 003 List et al, Leukemia 2014

Sintra Rev trial : MDS del(5q) non-TD

Patient Population

- MDS diagnosis (WHO 2008)
- IPSS-Low or Intermediate-1
- No RBC transfusion requirements
- Anemia (Hb<12 g/dL)
- del(5q) MDS solely and/or + other abnormality

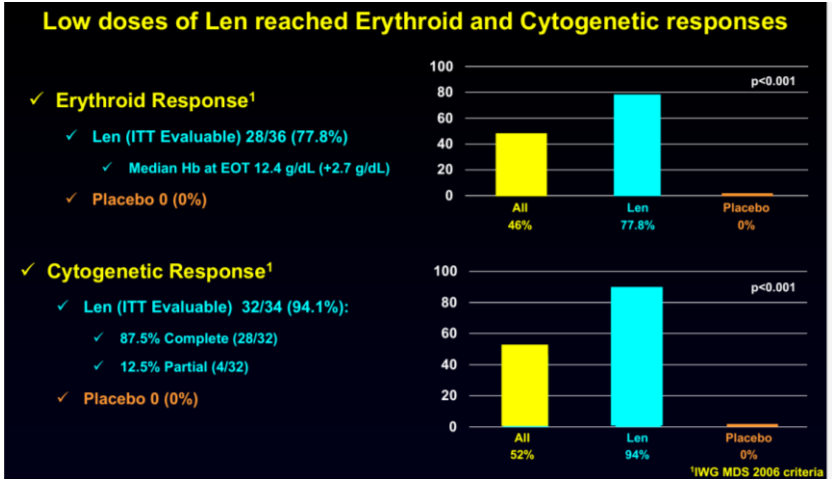


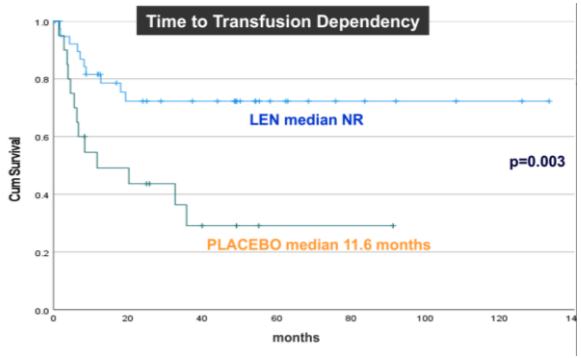
Primary endpoint:

- Time to disease progression

Key secondary endpoints:

- Erythroid response
- DurationofRBC-TI
- Cytogenetic/marrow response
- Safetya
- OS,EFS and timeb to AML
- Clonal evolution(NGS)





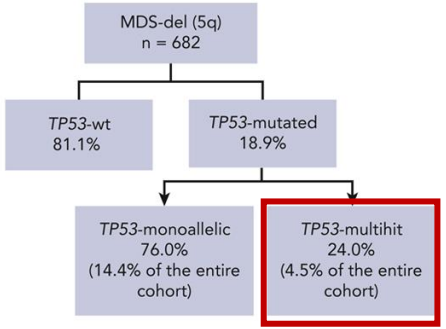
Len decreased in 69.8% the risk of TD: HR 0.302, p 0.005

Diéz-Campleo, Lancet 2024

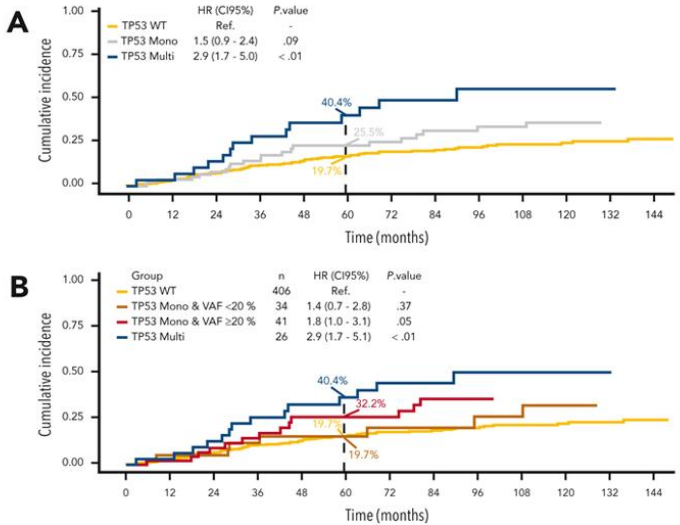
TP53 and risk of progression to AML in MDS del(5q)

- **TP53 mutated at low VAF** (<~20%) LEN + close monitoring
- **TP53 mutated at high VAF or multi-hit** → benefit often modest and transient
  - consider early alternative strategies / transplant (if eligible)
  - monitor clonal evolution
  - calculate IPSS M

Classification of patients with MDS-del (5q) according to *TP53* gene alterations



Risk of AML evolution according to a) *TP53* allelic state and b) *TP53* VAF cutoff point of 20%



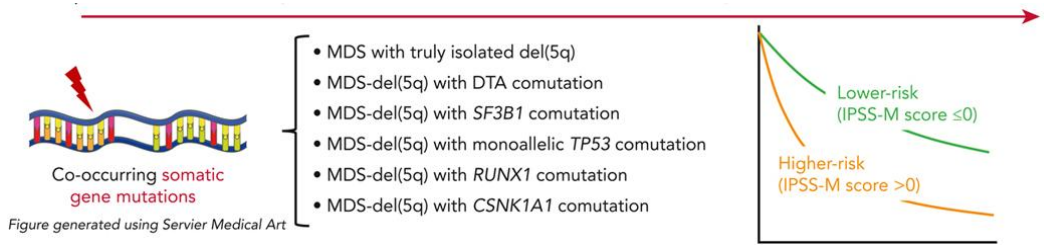
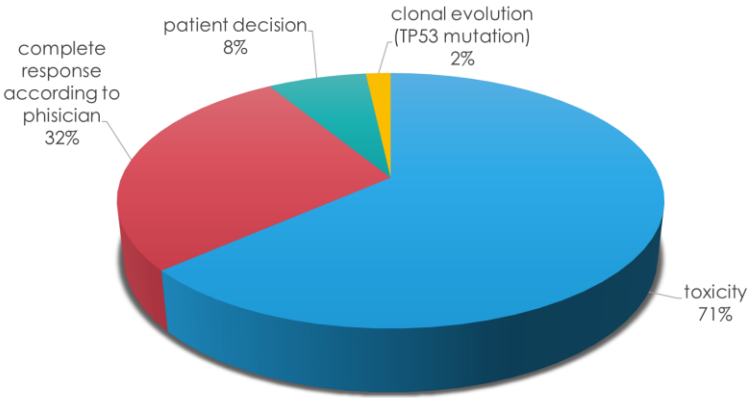


Figure generated using Servier Medical Art

Roncador et al. DOI: 10.1182/blood.2025028619blood; Montoro *MJ, et al ,Blood. 2024*

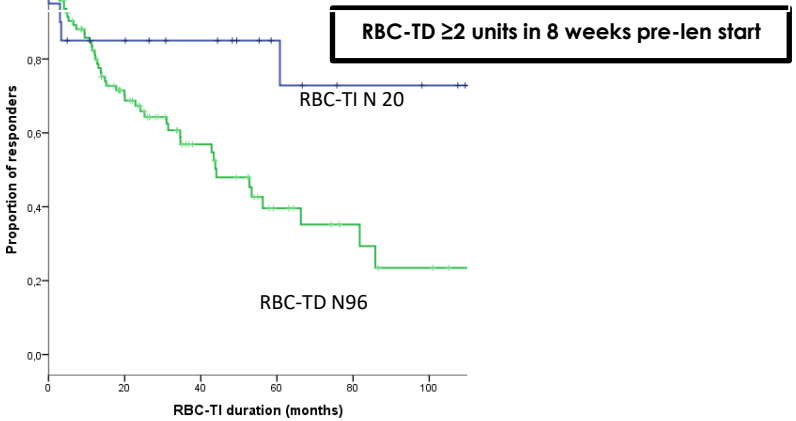
Retrospective study of lenalidomide discontinuation in patients with MDSdel(5q). A HARMONY Alliance study

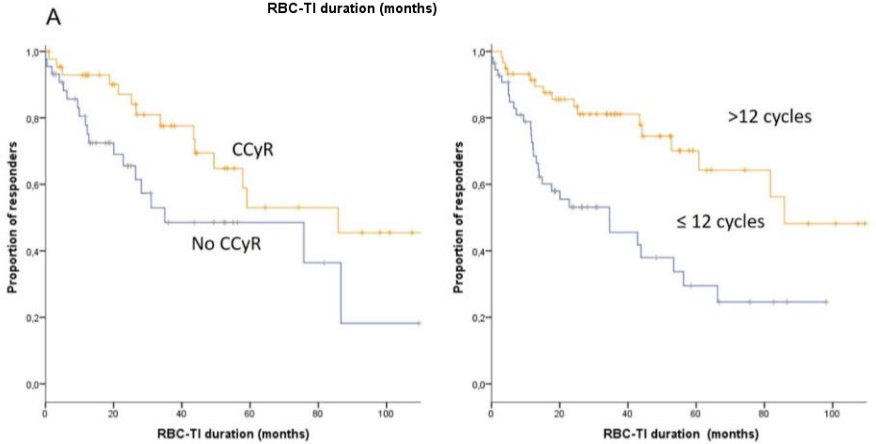
Reason for lenalidomide discontinuation



46 patients were re-treated with lenalidomide for response loss and 56% achieved at least a hematological response (3 also a CCyR)

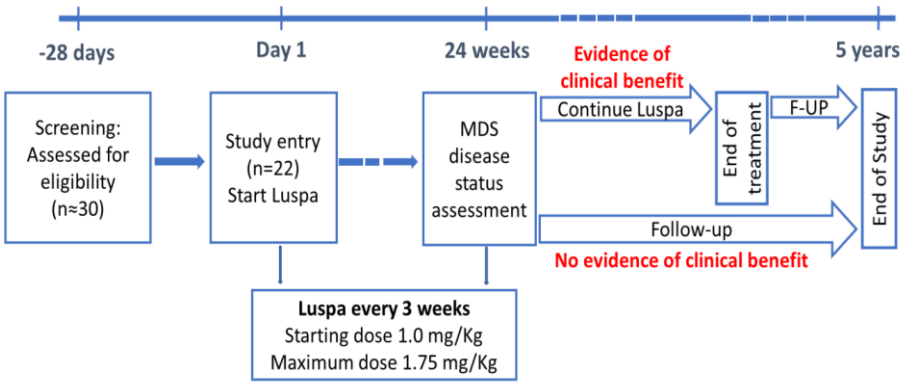
Median FUP from lenalidomide stop: 40 months (range 2-213)





Crisà et al., Leukemia 2024

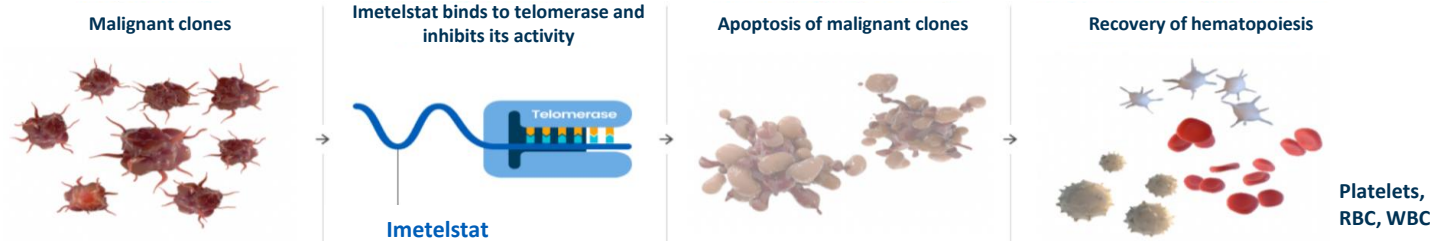
Luspatercept for the treatment of transfusion-dependent anemia in patients with MDS with del 5q, refractory/resistant/intolerant to prior treatments (QOL-ONE PHOENIX)



- Eight patients (36%) achieved RBC-TI, with concurrent improvements in Hb levels, while maintaining a favorable safety profile
- notable improvement in QoL is reported

Oliva, ASH 2025

Imetelstat in Lower Risk MDS:IMerge Phase 3 Trial Design



Phase 3
Double blind, randomized
118 Clinical sites in 17 countries

Patient Population (ITT N=178)

- IPSS low- or intermediate 1- risk MDS
- Relapsed/refractory[a] to ESA or EPO >500 mU/mL (ESA ineligible)
- **Transfusion dependent: ≥4 units RBCs/8 weeks over 16-week pre-study**
- Non-deletion 5q
- No prior treatment with lenalidomide or HMAs

60% RS+

R 2:1

Imetelstat
7.5 mg/kg IV/4 weeks
(N = 118)

Stratification:

- Transfusion burden (4-6 vs >6 units)
- IPSS risk category (low vs Intermediate 1)

Supportive care, including RBC and platelet transfusions, myeloid growth factors (e.g., G-CSF), and iron chelation therapy administered as needed on study per investigator discretion

Placebo
(N=60)

Safety population (treated) N=177
Imetelstat N=118
Placebo N=59

Primary endpoint:

- 8-week RBC-TI[b]

Key secondary endpoints:

- 24-week RBC-TI[b]
- Duration of TI
- Hematologic improvement-erythroid
- Safety

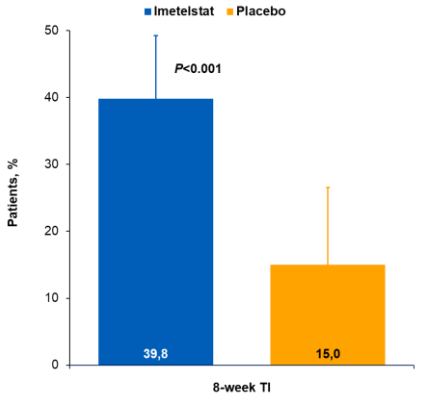
Key exploratory endpoints:

- VAF changes
- Cytogenetic response
- PRO: fatigue measured by FACIT-Fatigue

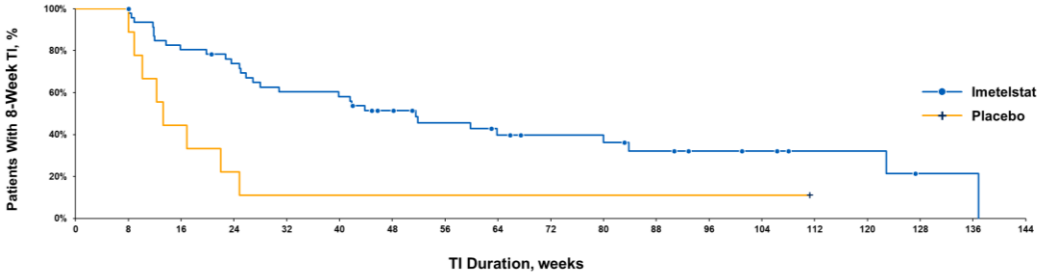
ESA, erythropoiesis-stimulating agent; HMA, hypomethylating agent; LR-MDS, lower risk myelodysplastic syndromes; RBC, red blood cell; TI, transfusion independence; WBC, white blood cell.

1. Asai A, et al. *Cancer Res.* 2003;63(14):3931-3939; 2. Herbert B-S, et al. *Oncogene.* 2005;24(33):5262-5268; 3. Mosoyan G, et al. *Leukemia.* 2017;31(11):2458-2467; 4. Wang X, et al. *Blood Adv.* 2018;2(18):2378-2388; 5. Steensma DP, et al. *J Clin Oncol.* 2021;39(1):48-56;

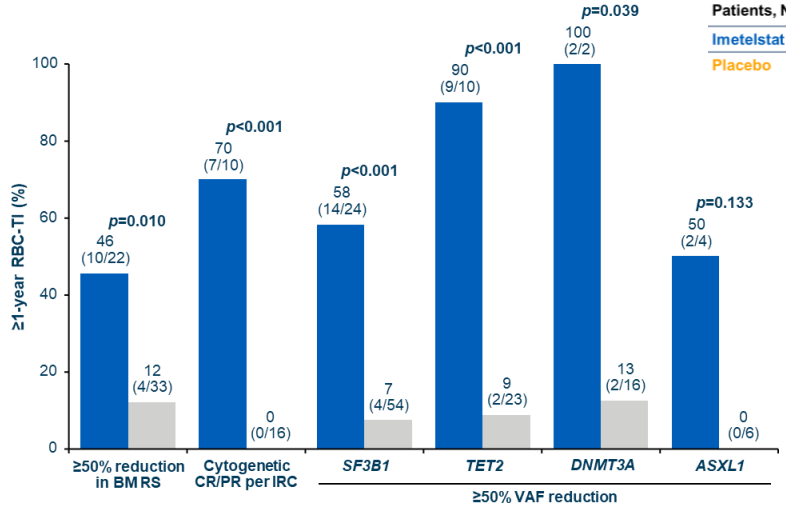
Higher 8-Week RBC-TI Rate and Longer-Term Duration of RBC-TI with Imetelstat vs Placebo



8-Week TI Responders	Imetelstat (N=47)	Placebo (N=9)	HR (95%CI)[a]	*P*-Value[b]
Median duration of RBC-TI, weeks (95% CI)	51.6 (26.9–83.9)	13.3 (8.0–24.9)	0.23 (0.09–0.57)	<0.001



Patients, N																			
Imetelstat	47	47	37	33	27	26	20	16	13	11	11	8	6	5	3	3	1	1	0
Placebo	9	9	4	2	1	1	1	1	1	1	1	1	1	1	0				



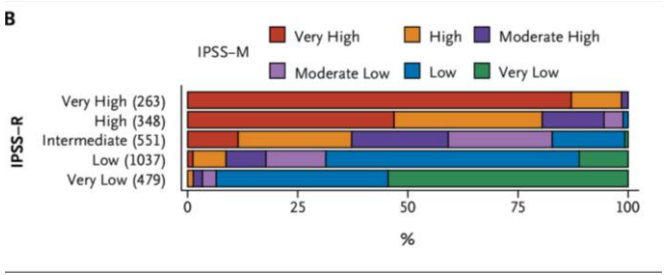
Imetelstat modulates clonal burden, which may suggest disease-modifying potential

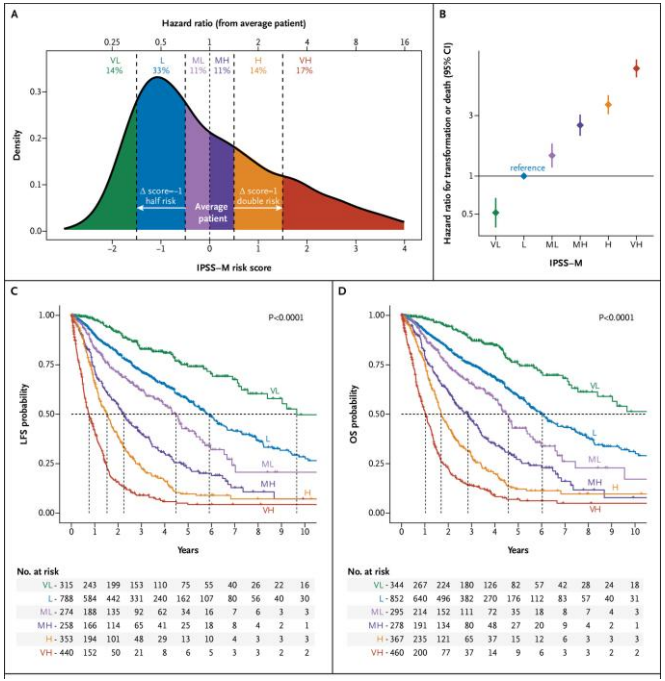
Platzbecker U et al. Lancet 2024; Santini V, et al. *Leukemia*. 2025

ALLOGENEIC HSCT IN LOW-INT R-IPSS RISK MDS

Current recommendation for allogeneic HSCT in lower-risk MDS:

- patients with severe cytopenia (including >2 RBC units per month or life-threatening cytopenias as ANC <0.3 X 109/L or pls <30 X 109/L)
- Patients with progressive disease
- **Patients in whom conventional treatment has failed.**
- Patients with additional unfavorable factors (MB fibrosis or **unfavorable IPSS-M).**

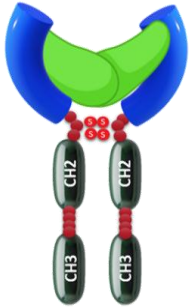




Bernard E et al. NEJEV 2022

De Witte, Bood 2017. Kroger, Haematologica 2025,

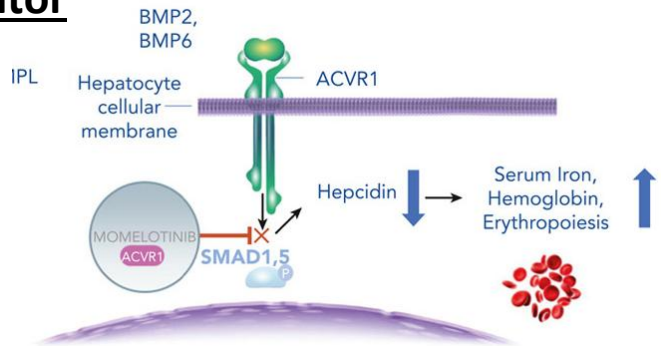
What next?



Elritercept (KER-050)

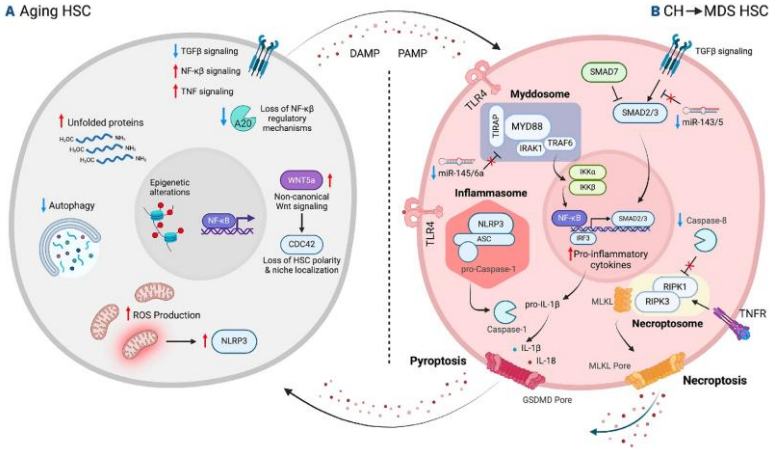
- Designed to inhibit select TGF-beta ligands, including Activin A, which has been associated with ineffective hematopoiesis, disease pathogenesis and progression[1,2]

Momelotinib, a JAK1/JAK2/ACVR1 inhibitor



Combination strategies:

- Luspatercept +EPO
- Luspatercept +momelotinib



Adapted from Villaume MT and Savona MR Haematologica 2025

CONCLUSIONS

- **Anemia is the prevalent cytopenia in MDS**
- **Anemia and transfusion dependence impact on OS and quality of life**
- **Anemia in MDS is still unmet clinical need as current available treatments (**rEPO, luspatercept, lenalidomide, iron chelation) **are limited**
- **Treatment of anemia should start early to avoid transfusions /reduce transfusion burden** (ongoing trial with luspatercept in NTD MDS)
- Transplant should be considered in eligible patients, integrating molecular data into treatment decision
- **Possible future perspectives:** therapeutic intervention aimed at restoring hematopoietic homeostasis in the aging population and potentially even preventing MDS (inhibitors of inflammatory mediators, new targetable immune checkpoints..).

Candiolo Cancer Institute: Hematology Team

Umberto Vitolo
MD

Delia Rota Scalabrini
MD

Fabrizio Carnevale Schianca
MD

Marco Fizzotti
MD

Mirko Frascione
MD

Danilo Faraci
MD

Francesca Bonello
MD

Daniela Caravelli
MD

THANK YOU

ISTITUTO DI CANDIOLO - IRCCS