ADAM10- or ADAM17-mediated cleavage. Solving the interesting and important puzzle of ADAM10 and ADAM17 activation, however, will not address the mechanism by which molecules that bind GPVI directly induce shedding in vivo. Because targeting the GPVI/FcRγ-chain complex represents a promising therapeutic approach—not only for its potential to selectively limit platelet reactivity to collagen, while preserving other platelet-activation pathways, 11 but also for its potential to dampen inflammatory disease 22—the intriguing observations of Bender et al that GPVI is shed in vivo in an ADAM10/ADAM17-independent manner warrant further investigation. Identification of the protease responsible for mediating in vivo cleavage of this unique platelet adhesion and signaling receptor may very well reveal additional molecular targets that extend beyond GPVI biology for treating thrombotic and inflammatory human disease.

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consequence, we need to be prepared to care for the transplantation recipient in the long-term.

There are guidelines to address screening studies to prevent the long-term complications of stem cell transplantation, however, the degree to which these guidelines are followed at individual centers is likely to be low, as the tests recommended often lie outside the realm of expertise of the transplantation physician, and some require consultation with subspecialists. These tests can be particularly hard to arrange for patients who travel episodically long distances to transplant centers for follow up. Unfortunately, over time, patients who require these services are seen less frequently at the transplant center, and more frequently by primary care physicians, who may not be aware of the long-term complications of transplantation. One solution to this problem is the Transplant Survivorship Clinic, a model recently adapted at our Institute. The Survivorship Clinic is staffed by subspecialists in oral medicine, ophthalmology, dermatology, cardiology, and endocrinology, as well as a stem cell transplantation physician. Equally important, however, are the specialists in dietary counseling, exercise physiology, physical therapy, and psychosocial guidance who see patients in this clinic as well. This clinic offers one-stop shopping for patients to obtain screening for the adverse outcomes of transplantation, and to counsel patients on behavior to prevent some of the long-term complications of transplantation. Under the premise that cancer is a “teachable moment,” this multidisciplinary clinic promotes the concept of healthy cancer survivorship. Individualization of care plans is crucial among cancer survivors because it is known that cancer survivors do not have better patterns of preventative health behavior compared with noncancer patients.

While the emergence of chronic health conditions cannot be altered with screening practices alone, hopefully the severity and consequences of the resulting conditions can be altered. This is particularly relevant because more than 10% of the 2-year survivors in the Sun report subsequently died of nonrelapse-related causes. Despite this, it is estimated that 5-year survivors have long-term survival that approaches survival rates in age-matched populations. Primary changes to the way transplantation is performed can ultimately lead to fewer long-term health consequences. The movement away from total body irradiation–based autologous transplantation has reduced the rate of secondary malignancies after autologous transplantation, and it is possible that reduced-intensity allogeneic transplantation may ultimately reduce the rates of some late complications after allogeneic transplantation as well. Only time will tell if this promise of a reduced-toxicity transplantation holds true; preliminary data suggest that long-term cardiovascular and renal health are equivalent regardless of conditioning intensity. Changes to the way postransplantation care is delivered can hopefully have an impact on cancer survivorship as well.

Surviving the underlying transplantable disorder is our first and most important goal, but chronic medical problems are acceptable only to the degree that we identify them and work to ameliorate them. Survivorship after transplantation is a “problem” we strived for years to intentionally create. While we are far from the goal of universal cure for all transplantation recipients, it is high time we become prepared to deal with the consequences of our own therapeutic success.

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Transplant survivorship: a call to arms

Corey Cutler