HIV infection are unclear; however, previous studies have indicated an increased risk of plasma cell neoplasms in patients with HIV infection.3 In this context, future studies should aim at understanding the mechanisms of B-cell dysregulation in patients with persistent HIV and EBV infection and the risk of plasma cell dyscrasias in these patients.

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REFERENCES


identified or how many ultimately contributed to recommendations. Articles should be rated according to level of evidence, so case report findings and results from advanced phase studies are not given equal weight. Check—though note that meta-analyses garner the same score as randomized control trials. Finally, panelists are locked in a room and forced to listen to Barbara Stensland music until they come to a consensus on recommendations, which are graded according to level of evidence, consistency of results across studies, and applicability to the patient population—in this case, people with MDS. Check. And this took three consensus conferences (I suspect with music being unnecessary).

The ELN authors then took on the broad task of addressing all aspects of MDS, starting with making the diagnosis. They included standard procedures, such as the necessity for a bone marrow biopsy and cytogenetics (although including such obvious procedures in panel recommendations may seem superfluous, neither one is routinely performed, even in the United States) and more sophisticated approaches such as single nucleotide polymorphism arrays to detect cryptic chromosomal defects. They reaffirmed the utility of the World Health Organization classification of myeloid neoplasms and covered the broad collection of risk assessment tools available. Interestingly, while they acknowledged the shortcomings of the International Prognostic Scoring System (IPSS), they recommended its use to stratify risk for all MDS patients, given the large body of data supporting its applicability in therapeutic decisions and the relative paucity of data that have been generated for its revised successor. That will change in due time.

Rather than dividing the therapy section into treatments directed to disease severity (commonly defined as lower- vs higher-risk MDS using the IPSS and based on relative blast percentage, karyotypic abnormalities, and numbers of cytopenias), the ELN focused on each treatment modality itself. They started with watchful waiting, which may have been prescient, given the recent brouhaha over a National Cancer Institute panel’s recommendation to stop calling certain premalignant conditions “cancer.” Next, without identifying them as such, the authors introduced treatments for higher-risk MDS (stem cell transplantation, cytotoxic therapy, and hypomethylating agents), lower-risk disease (hematopoietic growth factors, immunomodulatory drugs, and immunosuppressive therapy), and ended with supportive care issues, which are germane to both.

In summary, the recommendations are rigorous, and they are comprehensive. But are they useful for those general hematologists and oncologists in practice, flying on their trapezes from patient to patient without a LeukemiaNet? In some ways no, and in some ways yes. In a patient with suspected MDS, the ELN gives equal weight to taking a good history of prior chemotherapy and radiation exposure and to obtaining a family history of Fanconi’s anemia and telomere disorders. While 10% of my patients have therapy-related MDS, I have yet to encounter someone with either of the latter conditions. In addition, for the uninitiated, while the therapy section is helpful in assigning levels of evidence to treatments being considered, it is difficult to navigate in answering the question, “for the patient sitting in my clinic with this subtype of MDS, what drug should I use?”

Impressively though, the ELN panel confirms minimum criteria for diagnosing and classifying MDS, which is more challenging than is widely appreciated. They also make clear statements regarding recommendations on controversial topics, such as remission induction therapy preceding stem cell transplantation or the use of iron chelation therapy, along with a recommendation grade. Although I may not agree with all of these recommendations, I can appreciate how they can guide physicians who do not have the time or interest to immerse themselves in the nuances of MDS literature and can keep them from falling to the floor of the Big Top.

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REFERENCES

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Comment on Walker et al, page 3034

Redirecting traffic using the XPO1 police

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In this issue of Blood, Walker et al investigate the preclinical potential of KPT-330, an exportin-1 (XPO1, also known as chromosome maintenance protein 1 [CRM1]) inhibitor, against both accelerated phase (AP) and blast crisis chronic myeloid leukemia (CML-BC) and against Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL), all of which are diseases of significant unmet clinical need. The authors provide encouraging data from both a leukemic mouse model and a single CML-AP patient, corroborating mechanistic studies suggesting that KPT-330 efficacy relies on targeting abundantly expressed XPO1, followed by the reactivation of protein phosphatase 2A (PP2A).
Flying without a net in MDS

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