This conference was about the clinical updates on lymphoid neoplasms and myeloma.

The first part is about non Hodgkin lymphomas and new tools for classification such as molecular features, for example to better separate Burkitt lymphoma and diffuse large B-cell lymphoma which are treated differently, but also how to use existent tools such as PET/CT for an accurate staging and prognostication.

Next they focused on treatment options:

- for follicular lymphoma they discussed the best therapy for remission-induction (R-CVP< R-CHOP< R-Bendamustine in terms of Progression Free Survival PFS), consolidation (Rituximab> Zevalin in terms of PFS) and maintenance (Rituximab in terms of PFS) as well as new antibodies especially Obinutuzimab.
- For DLBCL R-CHOP 21 continues to be the standard although new trials based on molecular subgroups are conducted testing targeted therapy specific of the aberrant signaling pathway.
- For mantle cell lymphoma chemotherapy involving cytarabine is the standard followed by autologous stem cell transplantation for younger patients and rituximab maintenance in elderly. There are also inhibitors of the B cell receptor pathway being developed
- For marginal zone lymphoma the causal infection treatment remains the first line therapy. In case of failed response, involved field radiotherapy and chemo and/or immunotherapy must be considered.

Finally they developed the novel targeted therapy based on the biology of the tumor, clinical trials being performed to redefine treatment. For example Ibrutinib which is a Burton’s Tyrosine Kinase inhibitor targeting the BCR signaling or antibody drug conjugates and monoclonal antibodies blocking checkpoints are under intensive investigation.

The second part is about Multiple Myeloma. They started with a report on updates about diagnostics and staging, especially MRI and cytogenetics evaluation, and then switched on response evaluation with some new definitions, as stringent complete response in the stratification (including a normalization a free light chain ratio in addition to CR criterias). Moreover new tools assessing the response efficacity have been developed as flow cytometry or PCR allowing very sensitive evaluation.

For the treatment of elderly patients a careful geriatric assessment is needed in order to give the the best therapy. In the case of excellent clinical conditions full dose combination should be used (MPT/VMP) or even reduced intensity autologous stem cell transplantation if possible. In frail patients lower doses of each agent are used or gentler approaches with 2 drugs combination. Novel agents such as carfilzomib, pomalidomide are under trials.

In younger patients high dose therapy followed by SCT is the standard and the novel agents have been intensively investigated improving the response before transplantation. In case of unfavorable prognosis, bortezomib combined therapy improved the PFS as well. Alternative agents such as monoclonal antibodies and reduced intensity allogenic transplantation are under investigation.
The third part is about Waldenström’s Macroglobulinemia WM and amyloidosis.

Once again novel therapy are being evaluated in clinical trials. For example thanks to wide genomic analysis, a mutation (MYD88 L265P) present in almost all patient with WM represent a new target for treatment. Chemotherapy combined with rituximab are active and ibrutinib represent a new option recently developed.