Celebrating 60 years of community

Our 60th anniversary is a time for recognising the breadth of roles within the multidisciplinary haematology team and acknowledging the contribution of haematology professionals to the advancement of medicine and the transformation of patient care.

Visit our website to explore our haematology timeline, Past Presidents' videos, anniversary themes, haematology team animation and more!

www.b-s-h.org.uk/bsh-at-60
Contents Page

Welcome ........................................................................................................................................ 05
Looking Back .................................................................................................................................. 06
BSH 60th Anniversary Celebrations ................................................................................................. 08
Sponsor Acknowledgements ............................................................................................................. 10
Society Personnel ............................................................................................................................. 12
Session Organisers & Abstract Reviewers ......................................................................................... 14
Programme Overview ...................................................................................................................... 15
Social .................................................................................................................................................... 43
Industry Partner Information .............................................................................................................. 45
BSH Annual Scientific Meeting .......................................................................................................... 75
Welcome

Welcome to the British Society for Haematology (BSH) Annual Scientific Meeting 2021. Although we would love to be all together in Liverpool, we are absolutely delighted to build on the success of last year’s virtual conference and provide you with another excellent online event.

For those of you familiar with the BSH Annual Scientific Meeting, you will recognise key highlights such as the combined plenary sessions with the American Society of Hematology and European Hematology Association, as well as the BSH Presidential Session & Medal Lecture.

If this is your first experience of a BSH event, we welcome you and hope to see you at a face-to-face event in the not too distant future.

We would like to thank our key stakeholders as, without their help, we wouldn’t be able to deliver such a detailed and thorough event. We would like to extend our thanks to the scientific programme committee, session leads, faculty, the BSH team and of course our valued industry partners.

We realise that it is difficult to dedicate your time fully to an online event when there are so many distractions at home or work but we do urge you to take some time out for your personal development and learning over the coming days. We have an outstanding programme of sessions as well as the opportunity to meet with poster presenters and engage with sponsors.

Of course, the Annual Scientific Meeting is not just about the latest developments in haematology, we also want you to engage and have fun as well. What better way to limber up for a day of sessions than with a morning yoga session! We all need a bit of fun so please join an exclusive performance from one of Britain’s Got Talent’s finest comedians, Daliso Chaponda, on Tuesday evening. Do please also take the time to access ‘Wonder’ from the home page of the BSH portal. Here you will be able to drop in and have a coffee and chat with other delegates; something we have all been craving for this past 12 months.

However you plan to engage with the BSH 2021 ASM programme over the coming days, do enjoy the experience. Let us know how you are getting on via social media channels, using the hashtags #BSH2021 and #BSHatHome. A feedback survey will be sent on the final day of the ASM, your thoughts and feedback are hugely valuable in shaping plans for future events.

We hope to have the opportunity to see you all in Manchester next year for the 2022 Annual Scientific Meeting – 3-5 April 2022, put the date in your diaries.

Best Regards

Adele Fielding
President, British Society for Haematology

Tamara Everington
Chair, Programme Committee
Looking Back

We are absolutely delighted to present the programme virtually this year, although there is an element of sadness that we can't yet meet with our friends and colleagues. We're very much looking forward to the opportunity to make new connections and see you all face to face at a BSH event in the not too distant future.
60th Anniversary

The British Society for Haematology celebrated it’s 60th anniversary in 2020. Although we weren’t able to celebrate at the Annual Scientific Meeting in Birmingham, or at the series of activities that we had planned for our birthday in November 2020, we were able to showcase commemorative elements on the BSH website.

Please do take the time to view the hours of footage and articles on the BSH website at the following link - https://b-s-h.org.uk/bsh-at-60. We are very grateful to the vast number of individuals and organisations that contributed to the anniversary project.

As we reflect back on 60 years of the British Society for Haematology, we recognise the challenges that our members have faced during 2020 due to the COVID-19 pandemic that has impacted on all our members across the breadth of our membership. BSH asked members to submit their photos of 2020. These are just some of those received.

Dr. Leena Karnik, consultant paediatric haematologist, St. Mary’s Hospital, London in a T-shirt painted by her patients.

Professor Barbara Bain. Professor of Diagnostic Haematology, Imperial College London and Honorary Consultant Haematologist, St Mary’s Hospital, London.
A welcome hug with a pet when you can’t hug your friends and family.
Saskia Ottignon

Getting ready for the pandemic. Making sure our patients could have apheresis procedures during lockdown #sicklecell. Dr Sara Trompeter on behalf of the UCLH apheresis team.

Last rose of autumn.
Katy Amberley.

Nawal’s NHS Rainbow.
Summer Zebian.
Sponsor Acknowledgements

Thank you to our sponsors for their continued support of the British Society for Haematology Annual Scientific Meeting. This meeting is part sponsored by the companies below, no sponsor has influence on event content other than that related to their exhibition profile and industry sessions.

Platinum

NOVARTIS
SANOFI GENZYME

Silver

abbvie  astellas  AstraZeneca  BeiGene

Bronze

Bristol Myers Squibb  Kite  Bristol Myers Squibb  Pfizer

Janssen Oncology  Pfizer  Pfizer Oncology  Incyte

Roche  Jazz Pharmaceuticals
Partners

AMGEN  
Bayer  
BD  
GRIFOLS  
medac  
Nova Laboratories Ltd  
Rosemont  
Takeda

Partner Societies

Lymphoma action  
CLL SUPPORT  
EHA  
Leukaemia Care  
LAB TESTS ONLINE UK  
MDS UK  
MPN voice  
NHS Blood and Transplant  
Wiley  
Thrombosis UK  
Myeloma UK  
Sickle Cell Society  
Blood Cancer UK  
UK NEQAS  
WMUK
Society Personnel

Board of Trustees

Officers
President – Professor Adele Fielding, Vice President – Dr Josh Wright, Treasurer – Dr John Ashcroft, Secretary – Dr Jim Seale

Elected Trustees
Dr Humayun Ahmad, Dr Subarna Chakravorty, Dr Maria Gilleece, Dr Fergus Jack, Dr Banu Kaya, Dr Amit Patel, Mr Huw Rowswell

Lay Trustees
Trevor Jones, Susannah Randall, Kate Fielding, Keith Ward

Interim Trustee
Dr Mai Khalifa

Programme Committee
Our Programme Committee works with the haematology community to organise the BSH Annual Scientific Meeting.

Dr Tamara Everington (Chair), Dr Tom Butler, Dr Subarna Chakravorty, Miss Stavroula Chante (Nurse Representative), Dr Adele Fielding (President), Dr Christopher Fox, Dr Stephen Hibbs (Trainee Representative), Dr Fergus Jack, Mr Trevor Jones, Ms Sarah Jordan (Nurse Representative), Dr Jahanzaib Khwaja (Trainee Representative), Professor Guy Pratt, Mr Huw Rowswell (Nurse Representative), Professor Simon Stanworth, Miss Harriet Tipple (Student Representative), Professor Paresh Vyas, Dr Fenella Willis, Josh Wright (Vice Chair and BSH Vice President)
Communications and Special Interest Group Chairs

Communications – Dr Katrina Farrell
Education – Dr Tom Butler
External Affairs – Kate Fielding
Finance Audit and Risk – Dr John Ashcroft
Global Haematology SIG – Professor Imelda Bates
Guidelines Executive – Professor Jo Howard
Lymphoma SIG – Dr Kate Cwynarski Nominations
Governance and Awards – Dr Jim Seale
Obstetric Haematology SIG – Dr Sue Pavord and Professor Beverley Hunt
Paediatric SIG – Dr John Grainger
Scientific and Publications – Professor Guy Pratt
Teenage and Young Adult – Dr Ben Uttenthal

BSH Staff

Chief Executive Officer – Katy Amberley
Guidelines Project Manager – Rita Gupta
Communications & Membership Manager – Saskia Ottignon
Guidelines and SIG Officer – Summer Zebian
Finance Officer – Cristopher Olivella
Education Officer – Angela Rausch, Team Administrator – Andrew Choi
Communications Officer – Zoe Oparah
Facilities and Team Support Officer – Maxwell McCreton
Head of Education (Maternity Cover) – Theresa Crossley
Session organisers

The British Society for Haematology would like to thank all of the Session Organisers whose contribution towards the programme is greatly appreciated:

Adele Fielding, Andrew Davies, Andy Pettitt, Ben Uttenthal, Beverley Hunt, Charlie Craddock, Claire Harrison, Dan Hart, David Roberts, Donal McLornan, Eric Watts, Farrukh Shah, Huw Rowswell, Jahanzaib Khwaja, Jenny Darlow, Jo Howard, John Ashcroft, John Grainger, Karen Stanley, Kate Cwynarski, Keith Gomez, Marion Wood, Marty Tallman, Mike Murphy, Piers Patten, Pip Nicolson, Pratima Chowdary, Quentin Hill, Ram Malladi, Rebecca Hallam, Renata Walewska, Roger Owen, Sally Killick, Sarah Jordan, Sarah Whitaker, Seye Kolade, Shameem Mahmood, Sheila O'Connor, Simon Stanworth, Sonia Wolf, Stephen Hibbs, Subarna Chakravorty, Sue Pavord, Tamara Everington, Tom Butler, Trevor Jones

Abstract reviewers

The British Society for Haematology would like to thank all of the Abstract Reviewers whose contribution is greatly appreciated:

Julia Anderson, Peter Baker, Catherine Booth, Kris Bowles, Patrick Carrington, Mark Catherwood, Subarna Chakravorty, Deepak Chandra, Charlie Craddock, Jonathan Cullis, Kate Cwynarski, Mike Dennis, Lydia Eccersley, Mark Ethell, Tamara Everington, Adele Fielding, Christopher Fox, Mamta Garg, Jane Graham, John Grainger, Claire Harrison, Stephen Hibbs, Daniel Hodson, Jo Howard, Ian Jennings, Shireen Kassam, Sajida Kazi, Jonathan Kell, Paul Kerr, Rachel Kesse-Adu, Safaah Khaled, Steve Knapper, Will Lester, Jindriska Lindsay, Mike Makris, Andrew McMillan, Fiona Miall, Ken Mills, Mike Murphy, Shruthi Narayan, Elspeth Payne, Guy Pratt, Kavita Raj, Farhan Rauf, David Rees, Simon Stanworth, Sara Stuart-Smith, Henry Watson, Stella Williams, Fenella Willis
# Programme

## Saturday 24th April 2021

**Avoiding Pitfalls today and in the future of Haematology**

**Chairs:** Suzy Morton, Birmingham and Tom Butler, London

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.30-11.15</td>
<td>Pitfalls in managing patients on the new haemophilia agents</td>
<td>William Lester, Birmingham</td>
</tr>
<tr>
<td>11.15-12.00</td>
<td>Pitfalls in CLL</td>
<td>Helen Marr, Newcastle</td>
</tr>
<tr>
<td>12.00-12.30</td>
<td>Lunch Break</td>
<td></td>
</tr>
<tr>
<td>13.15-14.00</td>
<td>Pitfalls in the future of CAR-T cells</td>
<td>Tobias Menne, Newcastle</td>
</tr>
<tr>
<td>14.00-14.20</td>
<td>Comfort Break</td>
<td></td>
</tr>
<tr>
<td>14.20-15.05</td>
<td>Pitfalls in the future of Global Haematology</td>
<td>Imelda Bates, Liverpool</td>
</tr>
<tr>
<td>15.05-15.15</td>
<td>Pitfalls closing remarks</td>
<td>Suzy Morton, Birmingham and Tom Butler, London</td>
</tr>
</tbody>
</table>
## Sunday 25th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-08:45</td>
<td><strong>Welcome Address</strong>&lt;br&gt;President Adele Fielding, London and Chair of the Programme Committee Tamara Everington, Basingstoke</td>
</tr>
<tr>
<td>08:45-09:00</td>
<td><strong>Comfort break</strong></td>
</tr>
<tr>
<td>09:00-10:15</td>
<td><strong>BSH Presidential Session &amp; Medal Lecture</strong>&lt;br&gt;&lt;br&gt;<strong>Chair:</strong> Adele Fielding, London&lt;br&gt;&lt;br&gt;<strong>Beverley Hunt, London</strong>&lt;br&gt;BSH Medal Lecture: – Thrombosis care: 2021 and beyond&lt;br&gt;&lt;br&gt;<strong>David Rees, London</strong>&lt;br&gt;The determinants of severity in sickle cell disease&lt;br&gt;&lt;br&gt;<strong>Andrew Goddard, London</strong>&lt;br&gt;The Medical Workforce&lt;br&gt;&lt;br&gt;<strong>Orin Lewis OBE</strong>&lt;br&gt;The Inspiring Story of the African-Caribbean Leukaemia Trust</td>
</tr>
<tr>
<td>10:15-10:30</td>
<td><strong>Comfort break</strong></td>
</tr>
<tr>
<td>10:30-12:00</td>
<td><strong>British Society for Haemostasis &amp; Thrombosis</strong>&lt;br&gt;&lt;br&gt;<strong>Chair:</strong> Keith Gomez, London&lt;br&gt;&lt;br&gt;<strong>Vittorio Pengo, Italy</strong>&lt;br&gt;Antiphospholipid Syndrome&lt;br&gt;&lt;br&gt;<strong>Lara Roberts, London</strong>&lt;br&gt;Predicting the risk of recurrence in Venous Thrombosis&lt;br&gt;&lt;br&gt;<strong>Johnny Mahlangu, Johannesburg, South Africa</strong>&lt;br&gt;How to choose between therapeutic options for patients with haemophilia&lt;br&gt;&lt;br&gt;<strong>UK Myeloma Forum</strong>&lt;br&gt;&lt;br&gt;<strong>Chairs:</strong> John Ashcroft, Yorkshire, Gordon Gook, Leeds&lt;br&gt;&lt;br&gt;<strong>Alessandra Larocca, Torino, Italy</strong>&lt;br&gt;Clinical assessments of frailty in myeloma&lt;br&gt;&lt;br&gt;<strong>Jonathan Kaufman, Georgia, USA</strong>&lt;br&gt;Biomarkers and lab assessments of frailty&lt;br&gt;&lt;br&gt;<strong>Gordon Cook, Leeds</strong>&lt;br&gt;How do we design clinical trials and affect clinical practice?</td>
</tr>
</tbody>
</table>
## Sunday 25th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 - 12:15</td>
<td>Comfort break</td>
</tr>
</tbody>
</table>
| 12:15 - 13:00 | Meet the Expert and Round Table Sessions  
View the Programme on page 33 |
| 13:00 - 14:30 | **UK Chronic Lymphocytic Leukaemia Forum**  
*Chairs:* Renata Walewska, Bournemouth and Piers Patten, London  
**Othman Al-Sawaf, Cologne, Germany** Treating CLL with novel agents: single agents or combinations in front line CLL treatment  
**Talha Munir, Leeds** Treating CLL with novel agents: single or combinations in relapsed CLL  
**Jennifer Brown, Boston, USA** Treating CLL with novel agents: understanding and managing side effects  
| 13:00 - 14:30 | **Haemoglobinopathies – Improving Outcomes in Sickle Cell Disease**  
*Chair:* Farrukh Shah, London  
**Julie Makani, Tanzania** Improving outcomes in Sickle Cell Disease: Experience from Sickle In Africa.  
**Subarna Chakravorty, London** Improving clinical outcomes through the peer review programme  
**Jo Howard, London** Improving outcomes for patients with haemoglobinopathies through the new haemoglobinopathy networks  |
|             | **Industry symposia**  
See p37 for more details |
### Sunday 25th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:30 - 14:45</td>
<td>Comfort break</td>
</tr>
</tbody>
</table>
| 14:45 - 16:15 | Myeloproliferative Neoplasms  
**Chairs:** Claire Harrison, London and Donal McLornan, London  
**Stefan Constantinescu, Brussels, Belgium**  
JAK2 V617F and acquired JAK2 activating mutations from CHIP to clonal MPN diseases  
**Claire Harrison, London**  
Prevention of thrombosis in PV  
**Donal McLornan, London**  
BMT in Myelofibrosis - who, how, when  
**Francesco Onida, Milan, Italy**  
CMML- diagnosis and management  
**Paediatric Session**  
**Chair:** John Grainger, Manchester  
**Sally Kinsey, Leeds**  
Childhood ALL treatment over the last 60 years  
**Mary Mathias, London**  
Paediatric haemophilia management over the last 60 years  
**Bob Phillips, Leeds**  
Supportive care in haemato-oncology over the last 60 years  
**Industry symposia**  
See p37 for more details |
| 16:15 - 16:30 | Comfort break |
## Sunday 25<sup>th</sup> April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Events</th>
</tr>
</thead>
</table>
| 16:30 - 17:15 | **MacFarlane-Biggs Lecture**  
**Chair:** Keith Gomez, London  
**Katherine High. Pennsylvania, USA**  
Haemophilia and Gene Therapy  
**Industry symposia**  
See p37 for more details  
**Industry symposia**  
See p37 for more details |
| 18:00 - 18:45 | **Meet the Expert and Round Table Sessions**  
View the Programme on page 33 & 41 |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30 - 08:15</td>
<td>Meet the Expert and Round Table Sessions</td>
</tr>
<tr>
<td></td>
<td>View the Programme on page 34 &amp; 41</td>
</tr>
<tr>
<td>08:30 - 10:00</td>
<td>Lymphoma Special Interest Group</td>
</tr>
<tr>
<td></td>
<td>Chair: Kate Cwynarski, London and Andrew Davies, Southampton</td>
</tr>
<tr>
<td></td>
<td>Christopher Fox, Nottingham</td>
</tr>
<tr>
<td></td>
<td>Clinical prognostication in lymphoma</td>
</tr>
<tr>
<td></td>
<td>Cathy Burton, Leeds</td>
</tr>
<tr>
<td></td>
<td>Molecular biomarkers in lymphoma</td>
</tr>
<tr>
<td></td>
<td>Judith Trotman, Sydney, Australia</td>
</tr>
<tr>
<td></td>
<td>Functional imaging: 'PET-pearls, PET-falls: the role of PET in Follicular</td>
</tr>
<tr>
<td></td>
<td>lymphoma</td>
</tr>
<tr>
<td>08:30 - 10:00</td>
<td>National Institute of Health Research (NIHR): Better Blood Research</td>
</tr>
<tr>
<td></td>
<td>Chairs: Dan Hart, London and Pip Nicolson, Birmingham</td>
</tr>
<tr>
<td></td>
<td>Emma Drasar, London and Paul Telfer, London</td>
</tr>
<tr>
<td></td>
<td>New therapies for Haemoglobinopathies - clinical trials success and</td>
</tr>
<tr>
<td></td>
<td>future vision</td>
</tr>
<tr>
<td>08:30 - 10:00</td>
<td>Industry symposia</td>
</tr>
<tr>
<td></td>
<td>See p38 for more details</td>
</tr>
</tbody>
</table>

**Monday 26th April 2021**

07:30 - 08:15: Meet the Expert and Round Table Sessions

08:30 - 10:00: Lymphoma Special Interest Group
- Chair: Kate Cwynarski, London and Andrew Davies, Southampton
- Christopher Fox, Nottingham
- Clinical prognostication in lymphoma
- Cathy Burton, Leeds
- Molecular biomarkers in lymphoma
- Judith Trotman, Sydney, Australia
- Functional imaging: 'PET-pearls, PET-falls: the role of PET in Follicular lymphoma

08:30 - 10:00: National Institute of Health Research (NIHR): Better Blood Research
- Chairs: Dan Hart, London and Pip Nicolson, Birmingham
- Emma Drasar, London and Paul Telfer, London
- New therapies for Haemoglobinopathies - clinical trials success and future vision
- Richard Buka, West Midlands
- HaemSTAR RAPIDO: Auditing real-world use of reversal agents for DOACs in the UK using the power of the HaemSTAR network
- Charlotte Bradbury, Bristol
- REMAP-CAP – anticoagulation domain insights to platform study delivery, international collaboration and results
- Deepa Arachchillage, London
- Ca-COVID study – insights to collaboration, study set up, delivery and interim results

08:30 - 10:00: Industry symposia
- See p38 for more details
Monday 26th April 2021

<table>
<thead>
<tr>
<th>10:00 - 10:15</th>
<th>Comfort break</th>
</tr>
</thead>
</table>
| 10:15 - 11:45 | **Too Much Haematology? Questioning our Approach to Asymptomatic Conditions**  
**Chairs:** Stephen Hibbs, London and Trevor Jones, Lay Trustee  
**Chris Fegan, Cardiff, Wales**  
CLL Survivorship - watch and wait, the neglected cohort  
**Neil Rabin, London**  
What does early diagnosis of paraprotein disorders achieve  
**Rebecca Lynch**  
An anthropological perspective on risk and responsibility  
**Lesley Perkins, London and Osman Bhatti, London**  
Managing the fear of “missing something”: the experience of two GPs  
There will be a panel discussion at the end of this session. |
|               | **The CAR T-Cell Revolution**  
**Chair:** Ram Malladi, Birmingham  
**Sridhar Chaganti, Birmingham**  
The optimal third line therapy for Diffuse Large B cell Lymphoma: Is CAR T now the standard of care?  
**Andrea Kuhnl, London**  
Current outcomes and future prospects for CAR T-cell therapy |
|               | **Industry symposia**  
See p38 for more details |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:45 - 12:00</td>
<td>Comfort break</td>
<td></td>
</tr>
<tr>
<td>12:00 - 12:45</td>
<td>Meet the Expert and Round Table Sessions</td>
<td>View the Programme on page 34 &amp; 41</td>
</tr>
<tr>
<td>13:00 - 14:30</td>
<td>UK Haemophilia Centre Doctors’ Organisation Symposium</td>
<td>Chair: Pratima Chowdary, London</td>
</tr>
<tr>
<td></td>
<td>Mary Mathias, London Inherited plasminogen deficiency and new therapeutic options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roseline d’Oiron, Paris, France Management of pregnancy in carriers and patients with inherited bleeding disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peter Collins, Cardiff, Wales Modern management of inhibitor patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing/Allied Health Professional</td>
<td>Chair: Sarah Jordan, London</td>
</tr>
<tr>
<td></td>
<td>Sarah Jordan, London, Gavin Cooper, London and Sonia Thomas, London Using technology to find new ways of educating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rebecca McLoughlin, London Pain management programme for people living with sickle cell</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Helen O’Toole The Changing Face of Nurse Education through a Pandemic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Industry symposia</td>
<td>See p38 for more details</td>
</tr>
</tbody>
</table>
### Monday 26th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:30-14:45</td>
<td>Comfort break</td>
</tr>
<tr>
<td>14:45-16:15</td>
<td><strong>BSH Guidelines</strong>&lt;br&gt;Chair: Jo Howard, London&lt;br&gt;Haemostasis and Thrombosis Task Force&lt;br&gt;Keith Gomez, London&lt;br&gt;Clinical and Laboratory Diagnosis of Heritable Platelet Disorders&lt;br&gt;William Lester, Birmingham&lt;br&gt;Guidelines on the assessment of bleeding risk prior to surgery or invasive procedures&lt;br&gt;<strong>General Haematology Task Force</strong>&lt;br&gt;Eugene Oteng-Ntim, London&lt;br&gt;Guidelines on the Management of sickle cell disease in pregnancy&lt;br&gt;<strong>Nicholas Cross, Southampton</strong>&lt;br&gt;Good Practice Paper Genetic tests to diagnose and manage patients with myeloproliferative and myeloproliferative/myelodysplastic neoplasms</td>
</tr>
<tr>
<td></td>
<td><strong>Advanced Care Planning</strong>&lt;br&gt;Chair: Karen Stanley, London&lt;br&gt;Helen McNaught&lt;br&gt;CAR T Patient perspective interview&lt;br&gt;Debbie Yeatman, Bristol&lt;br&gt;Supportive &amp; Palliative Care involvement for patients eligible for CAR-T Cell therapy&lt;br&gt;Jackie Green, London, Caroline Adams, Debbie Yeatman, Bristol and Rebecca Hallam, Bristol&lt;br&gt;Live Palliative care panel discussion around ACP and the idea of parallel planning with treatment and palliative care</td>
</tr>
<tr>
<td></td>
<td><strong>Industry symposia</strong>&lt;br&gt;See p38 for more details</td>
</tr>
</tbody>
</table>


### Monday 26th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:15 - 16:30</td>
<td>Comfort break</td>
</tr>
</tbody>
</table>
| 16:30 - 18:00 | **BSH - ASH Plenary**  
**Chairs:** Adele Fielding, London and Marty Tallman, USA  
Richard Dillon, London - Different Care for AML  
Lachelle Dawn Weeks, Boston, USA - Diversity in the haematology workforce |
| 18:00 - 19:30 | **A roadmap for recovery in lymphoma**  
**Chair:** Andy Pettitt, Liverpool  
Andy Pettitt, Liverpool - Welcome & Introduction  
Graham Collins, Oxford - Hodgkins Lymphoma  
Christopher Fox, Nottingham - High Grade NHL  
Kim Linton, Manchester - Low Grade NHL  
Jude Fitzgibbon, London - Science Subgroup  
Live Q&A |
| 18:30 - 19:15 | Meet the Expert and Round Table Sessions  
View the Programme on page 34 |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 - 08:45</td>
<td>Meet the Expert and Round Table Sessions</td>
</tr>
<tr>
<td></td>
<td>View the Programme on page 35</td>
</tr>
<tr>
<td>09:00 - 10:30</td>
<td><strong>Who’s Looking After Me? Personal Cost and Joy in our Profession</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Chairs:</strong> Stephen Hibbs, London and Sarah Whitaker, Portsmouth</td>
</tr>
<tr>
<td></td>
<td><strong>Roger Amos, Scotland</strong> Lessons learnt from encounters with sickle cell disease patients</td>
</tr>
<tr>
<td></td>
<td><strong>Tracy Torres, London</strong> Empty blood fridges and facing investigations - the challenges of being a BMS</td>
</tr>
<tr>
<td></td>
<td><strong>Saket Badle, London</strong> Seeking professional support as a haematology registrar</td>
</tr>
<tr>
<td></td>
<td><strong>Kerry Baker, London</strong> Understanding and supporting haematology nurses</td>
</tr>
<tr>
<td></td>
<td><strong>Lucy Warner, UK</strong> Experiences of providing care to doctors</td>
</tr>
<tr>
<td></td>
<td><strong>British Blood Transfusion Society – American Association of Blood Banks Symposium</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Chairs:</strong> Simon Stanworth, Oxford and Mike Murphy, Oxford</td>
</tr>
<tr>
<td></td>
<td><strong>Chris Tormey, USA</strong> Use and misuse of point-of-care testing for difficult bleeding problems</td>
</tr>
<tr>
<td></td>
<td><strong>Rebecca Cardigan, Cambridge</strong> New blood products for the management of bleeding</td>
</tr>
<tr>
<td></td>
<td><strong>Mike Desborough, London</strong> Management of upcoming emergency surgery or major bleeding in patients on anti-platelet agents</td>
</tr>
<tr>
<td></td>
<td><strong>Industry symposia</strong> See p39 for more details</td>
</tr>
<tr>
<td>10:30 - 10:45</td>
<td>Comfort break</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 10:45 - 12:00 | **BSH - EHA Plenary:**  
Martin Hutchings - Bispecific antibodies  
Emma Morris - Dacie Wilkinson Lecture: Adult Immunodeficiency Disorders  
Nichola Cooper - Intelligent platelets: more than just bleeding |
| 12:00 - 12:15 | Comfort break |
| 12:15 - 13:00 | Meet the Expert and Round Table Sessions  
View the Programme on page 35 & 42 |
| 13:00 - 14:30 | **UK Myelodysplastic Syndrome Forum**  
Chair: Sally Killick, Bournemouth  
Matthew Collin, Newcastle  
When to look for a congenital bone marrow failure syndrome  
Alan Warren, Cambridge  
Shwachman-Diamond Syndrome  
Victoria Potter, London  
Transplanting patients with inherited bone marrow failures (MDS and AA) - considerations and challenges  
**The Role of Artificial Intelligence (AI) in Clinical Practice and Education**  
Chairs: Tom Butler, London and Suzy Morton, Birmingham  
Tanya Pankhurst, Birmingham  
The role of AI in healthcare  
Ander Cohen, London  
AI in thrombosis & haemostasis clinical practice and research  
Nasir Rajpoot, Warwick  
The role of AI in Pathology |
<p>| 14:30 - 14:45 | Comfort break |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Chair/Speakers</th>
<th>Industry Symposia</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:45-16:15</td>
<td>Obstetric Haematology – Then and Now</td>
<td>Sue Pavord, Oxford; Beverley Hunt, London</td>
<td>See p39 for more details</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mark Kilby, Birmingham</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Magbor Akanni, Milton Keynes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developments in the management of RhD disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helena Maybury, Leicester</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modern management of post partum haemorrhage</td>
<td></td>
</tr>
<tr>
<td>16:15-16:30</td>
<td>Comfort break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:30-18:00</td>
<td>UK ITP Forum: Autoimmune Haematology 2021</td>
<td>Quentin Hill, Leeds; Drew Provan, London</td>
<td>See p39 for more details</td>
</tr>
<tr>
<td></td>
<td></td>
<td>An update on adults with ITP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>John Grainger, Manchester</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An update on children with ITP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quentin Hill, Leeds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Marie Scully, London</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An update on AIHA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An update on TTP</td>
<td></td>
</tr>
<tr>
<td>18:00-18:15</td>
<td>Comfort break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:15-19:00</td>
<td>Meet the Expert and Round Table Sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>View the Programme on page 35 &amp; 42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Wednesday 28th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30 - 08:15</td>
<td>Meet the Expert and Round Table Sessions</td>
</tr>
<tr>
<td></td>
<td>View the Programme on page 36</td>
</tr>
<tr>
<td>08:30 - 10:00</td>
<td><strong>The Crucible: What Lessons can Haematology Learn from Others?</strong></td>
</tr>
<tr>
<td></td>
<td>Judges: Jenny Darlow Manchester, Subarna Chakravorty London, Rebecca Hallam Bristol, Seye Kolade Blackpool and Simon Stanworth Oxford</td>
</tr>
<tr>
<td></td>
<td><strong>Speakers:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Marquita Camilleri, London</strong></td>
</tr>
<tr>
<td></td>
<td>Lessons from oncology and palliative care: it's about time</td>
</tr>
<tr>
<td></td>
<td><strong>Amy Cooper, London</strong></td>
</tr>
<tr>
<td></td>
<td>What can haematology learn from linguistics? Back to basics</td>
</tr>
<tr>
<td></td>
<td><strong>Joel Cunningham, Norwich</strong></td>
</tr>
<tr>
<td></td>
<td>Valid consent and shared decision-making in clinical practice</td>
</tr>
<tr>
<td></td>
<td><strong>Michelle Kenyon, London</strong></td>
</tr>
<tr>
<td></td>
<td>Why separate the inseparable? Integrating mind and body care in haematology</td>
</tr>
<tr>
<td></td>
<td>Voting and announcements</td>
</tr>
</tbody>
</table>
## Wednesday 28\textsuperscript{th} April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10:15 - 11:45</strong></td>
<td><strong>Laboratory Management: Challenges and Opportunities</strong>&lt;br&gt;<strong>Chairs:</strong> Eric Watts, Essex and Marion Wood, Essex&lt;br&gt;<strong>Eric Watts, Essex</strong>&lt;br&gt;Laboratory Management - Basic Principles, Networks and Reconfigurations&lt;br&gt;<strong>Marion Wood, Essex</strong>&lt;br&gt;Getting it Right First Time Update&lt;br&gt;<strong>Sasha Karakusevic, Bristol</strong>&lt;br&gt;What has the future ever done for us? Opportunities for laboratory medicine</td>
</tr>
<tr>
<td></td>
<td><strong>Global Haematology</strong>&lt;br&gt;<strong>Chair:</strong> David Roberts, Oxford&lt;br&gt;<strong>Tara Tancred, London</strong>&lt;br&gt;Implementation Research, Social Science and...Haematology?&lt;br&gt;<strong>Adama Ladu, Nigeria</strong>&lt;br&gt;The spleen in Sickle Cell Disease: An African perspective&lt;br&gt;<strong>Amin Islam, Essex</strong>&lt;br&gt;Experience in Dhaka of using thalidomide to reduce transfusion dependence in thalassaemia</td>
</tr>
<tr>
<td></td>
<td><strong>Industry symposia</strong>&lt;br&gt;See p40 for more details</td>
</tr>
<tr>
<td><strong>11:45 - 12:00</strong></td>
<td>Comfort break</td>
</tr>
<tr>
<td><strong>12:00 - 12:45</strong></td>
<td>Meet the Expert and Round Table Sessions&lt;br&gt;View the Programme on page 36 &amp; 42</td>
</tr>
</tbody>
</table>
### Wednesday 28th April 2021

**13:00 - 14:30**

**Acute Myeloid Leukaemia**

**Chair:** Charlie Craddock, Birmingham

**Paresh Vyas, Oxford**
New therapeutic options in older adults with AML

**Sylvie Freeman, Birmingham**
How to use MRD quantitation to optimise treatment in adult AML

**Hervé Dombret, Paris, France**
New therapies in the management of fit adults with AML

**Charlie Craddock, Birmingham**
Who should we transplant in AML, and how

**Current Issues in Haemostasis**

**Chair:** Tamara Everington, Basingstoke

**John Dean, Exeter**
Transgender issues in haematology

**Simon Noble, Cardiff**
Anticoagulation in advanced cancer: when to start, when to stop and when to call the priest

**Jennifer Cole, London**
The approach of the Infected Blood Inquiry

**Industry symposia**
See p40 for more details

**14:30 - 14:45**

**Comfort break**
### Wednesday 28th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:45 - 16:15</td>
<td><strong>TYA Haematology – Looking to the Future</strong>&lt;br&gt;<strong>Chairs:</strong> Ben Uttenthal, Cambridge and Ben Carpenter, London&lt;br&gt;Rachael Hough, London&lt;br&gt;The future in TYA ALL – new strategies for the front line and relapse&lt;br&gt;<strong>Victoria Potter,</strong> London&lt;br&gt;Aplastic anaemia in young patients – should everyone be transplanted?&lt;br&gt;<strong>Sheila Lane,</strong> Oxford&lt;br&gt;Does fertility really matter?</td>
</tr>
<tr>
<td></td>
<td><strong>Psychiatry and Mental Health in Haematology Patients</strong>&lt;br&gt;<strong>Chair:</strong> Sonia Wolf, London&lt;br&gt;Christian Williams, London&lt;br&gt;Recognising and addressing mental health needs in haemato-oncology&lt;br&gt;<strong>Gary Bridges,</strong> London&lt;br&gt;Transitional care issues in young people (16-24) with sickle cell disease&lt;br&gt;<strong>Chloe Beale,</strong> London&lt;br&gt;Capacity, consent and the law</td>
</tr>
<tr>
<td></td>
<td><strong>Industry symposia</strong>&lt;br&gt;See p40 for more details</td>
</tr>
<tr>
<td>16:15 - 16:30</td>
<td><strong>Comfort break</strong></td>
</tr>
<tr>
<td>16:30 - 17:30</td>
<td><strong>Amyloid Session</strong>&lt;br&gt;<strong>Chair:</strong> Ayesha Shameem Mahmood, London&lt;br&gt;<strong>Ayesha Shameem Mahmood,</strong> London&lt;br&gt;All you need to know about amyloid diagnosis, typing and investigations&lt;br&gt;<strong>Ashutosh Wechalekar,</strong> London&lt;br&gt;Treatment of AL Amyloidosis – Where are we in 2021?</td>
</tr>
<tr>
<td></td>
<td><strong>Morphology</strong>&lt;br&gt;<strong>Chairs:</strong> Roger Owen, Leeds&lt;br&gt;Sheila O’Connor, Leeds&lt;br&gt;<strong>6 Case Studies presented by</strong>&lt;br&gt;Amany Mohamed Leeds&lt;br&gt;Dan Lock, Leeds&lt;br&gt;Richard Leach, Leeds&lt;br&gt;Rukhsaar Ali, Leeds</td>
</tr>
<tr>
<td></td>
<td><strong>Industry symposia</strong>&lt;br&gt;See p40 for more details</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>
| 18:00 - 18:30 | Take Away Messages | Jahanzaib Khwaja, Wolverhampton  
Subarna Chakravorty, London |
| 18:30 - 18:45 | Closing Remarks      | President Adele Fielding, London and Chair of the Programme Committee  
Tamara Everington, Basingstoke |
Meet the Expert sessions

Please see below the list of Meet the Expert Sessions taking place over the for day programme.

Attendance at Meet the Expert sessions can be secured 24 hours prior to the session start time. Select the add to my schedule option from the session page. Participants will then be able to join the session at the allotted time

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:15 – 13:00</td>
<td>Hypoplastic MDS and its overlap with other bone marrow failures’</td>
<td>Austin Kulasekaraj &amp; Henry Wood</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>Update on AL amyloidosis</td>
<td>Ashutosh Wechalekar &amp; Guy Pratt</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>Management of MPN</td>
<td>Claire Harrison &amp; Donal McLornan</td>
</tr>
<tr>
<td>18:00 – 18:45</td>
<td>Transfusion and Haemoglobinopathies (sickle cell disease and thalassaemia)</td>
<td>Sara Trompeter &amp; Rosanna Ghinai</td>
</tr>
<tr>
<td>18:00 – 18:45</td>
<td>Intravital imaging of NETs, platelets and coagulation</td>
<td>Craig Jenne &amp; Carsten Deppermann</td>
</tr>
</tbody>
</table>
### Monday 26th April 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30 – 08:15</td>
<td>CD19 CAR T Therapy or DLBCL: who, when and how?</td>
<td>Andrea Kuhnl &amp; Claire Roddie</td>
</tr>
<tr>
<td>07:30 – 08:15</td>
<td>Perioperative management of DOACs for scheduled surgery and urgent procedures</td>
<td>Marc Samama</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td>Meet the BSH: A Society Built by its Members</td>
<td>Adele Fielding, Josh Wright, Mai Khalifa and Edwin Massey</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td>How GPs manage the fear of “missing” something</td>
<td>Lesley Perkins &amp; Osman Bhatti</td>
</tr>
<tr>
<td>18:30 – 19:15</td>
<td>COVID, immune dysfunction and vaccination</td>
<td>Alex Richter &amp; Benard Maybury</td>
</tr>
<tr>
<td>18:30 – 19:15</td>
<td>Treatment of AML patients older than 60 - ven/aza or not</td>
<td>Mike Dennis &amp; Emma Searle</td>
</tr>
<tr>
<td>18:30 – 19:15</td>
<td>What’s the modern approach to ITP management/how do we manage ITP in the modern era?</td>
<td>Drew Provan &amp; Julia Czuprynska</td>
</tr>
<tr>
<td>Time</td>
<td>Session Title</td>
<td>Speaker(s)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>08:00 - 08:45</td>
<td>AI and Epidemiology of VTE and AF</td>
<td>Alexander Cohen &amp; Miroslaw Bober</td>
</tr>
<tr>
<td>08:00 - 08:45</td>
<td>Treatment of myelofibrosis</td>
<td>Adam Mead</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>Haemostatic management of intracerebral haemorrhage</td>
<td>Michael Desborough</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>Genomic testing: managing consent, incidental findings and variants of uncertain significance</td>
<td>Keith Gomez &amp; Kate Downes</td>
</tr>
<tr>
<td>12:15 – 13:00</td>
<td>What’s new in patient blood management?</td>
<td>Suzy Morton &amp; Andy Charlton</td>
</tr>
<tr>
<td>18:15 – 19:00</td>
<td>Selecting and sequencing novel therapies for CLL in 2021</td>
<td>Talha Munir &amp; Sreetharan Munisamy</td>
</tr>
<tr>
<td>18:15 – 19:00</td>
<td>Thrombosis - what’s new</td>
<td>William Lester &amp; Pip Nicolson</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Speakers</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>07:30 – 08:15</td>
<td><strong>Sequencing of myeloma therapy in 2021</strong></td>
<td>Graham Jackson &amp; Alex Langridge</td>
</tr>
<tr>
<td>07:30 – 08:15</td>
<td><strong>How to support your doctors, nurses and other practitioners</strong></td>
<td>Sarah Whitaker &amp; Laura Flower</td>
</tr>
<tr>
<td>07:30 – 08:15</td>
<td><strong>Molecular Biomarkers in Lymphoma</strong></td>
<td>Cathy Burton &amp; Dan Hodson</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td><strong>In utero treatment of haemoglobinopathy - can this be the future of stem cell therapies in sickle cell disease and thalassaemia?</strong></td>
<td>Panicos Shangaris &amp; Stavros Loukogeorgakis</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td><strong>When should patients with Haematological malignancies meet Palliative care teams?</strong></td>
<td>Jane Neerkin, Caroline Stirling, Katy Burke, Caroline Williams, Emily Anderson, Sara Delgado and Jo Bennetts</td>
</tr>
</tbody>
</table>
Industry Led Sessions

We would like to thank our industry partners for their support in delivering a range of symposia, roundtable and Meet the Expert sessions.

**Symposium programme**

The following symposia are taking place within the programme. All symposia include live Q&A sessions providing you with the chance to question the faculty. The symposia will be recorded and made available for on demand viewing.

### Sunday 25th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Topic</th>
<th>Speakers</th>
</tr>
</thead>
</table>
| Roche           | 10:30 – 12:00 | Optimising the treatment pathway for patients with relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL) | Andrew Davies, Southampton  
Andrew McMillan, Nottingham  
Lisa Lowry, Taunton  
Wendy Osborne, London |
| Janssen BMS     | 13:00 – 14:30 | Shaping the future of CAR T-cell therapy in multiple myeloma together: Lessons learned from the UK lymphoma experience | Graham Jackson, Newcastle  
Graham Collins, Oxford  
Rakesh Popat, London  
Rose Ellard, London |
| Pfizer          | 14:45 – 16:15 | Unravelling therapeutic challenges in patients with Leukaemia        | Priyanka Mehta, Bristol  
Tobias Menne, Newcastle  
Dragana Milojkovic, London |
| Novartis        | 16:30 – 18:00 | The burden of vaso-occlusive crises in patients with sickle cell disease | Jo Howard, London |
| Novartis        | 16:30 – 18:00 | Myeloproliferative Neoplasms (MPN): The importance of the multidisciplinary team (MDT) in patient management | Claire Harrison, London  
Claire Woodley, London  
Lauren Urwin, London  
Toni Wyatt, London |
## Monday 26th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Session Title</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanofi Genzyme</td>
<td>08:30 - 10:00</td>
<td>New advances in the treatment of iTTP – what are the real-world implications?</td>
<td>Marie Scully, London&lt;br&gt;Richard Gooding, Leicester&lt;br&gt;Rory McCulloch, Gloucester&lt;br&gt;Matt Stubbs, London&lt;br&gt;Rebecca Shaw, Liverpool&lt;br&gt;Mari Thomas, London</td>
</tr>
<tr>
<td>Incyte</td>
<td>10:15 - 11:45</td>
<td>Challenges in the management of DLBCL in 2021</td>
<td>Kate Cwynarski, London&lt;br&gt;Wendy Osborne, Newcastle&lt;br&gt;Clare Rowntree, Cardiff&lt;br&gt;Graham Collins, Oxford</td>
</tr>
<tr>
<td>Novartis</td>
<td>13:00 - 14:30</td>
<td>The road so far with CAR-T and where do we go next?</td>
<td>Antonio Pagliuca, London&lt;br&gt;Amit Patel, Manchester&lt;br&gt;Ben Uttenthal, Cambridge&lt;br&gt;David Porter, Philadelphia, United States</td>
</tr>
<tr>
<td>BMS-Pfizer Alliance</td>
<td>14:45 - 16:15</td>
<td>Updates in VTE Management</td>
<td>Ander Cohen, London&lt;br&gt;Raza Alikhan, Cardiff</td>
</tr>
<tr>
<td>Time</td>
<td>Organization</td>
<td>Session Title</td>
<td>Speakers</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 09:00 - 10:30| Sanofi Genzyme                       | The kidney matters in Relapsed Refractory Multiple Myeloma (RRMM)             | Karthik Ramasamy, Oxford  
Jennifer Pinney, Birmingham  
Neil Rabin, London  
Ceri Bygrave, Cardiff |
| 13:00 - 14:30| AstraZeneca                          | Unlocking new options for patients with CLL                                  | Anna Schuh, Oxford  
Talha Munir, Leeds  
Renata Walewska, Poole  
Piers Patten, London  
Orla Stewart, London |
| 14:45 - 16:15| Novartis                             | I-WISH to improve the HCP-patient dialogue                                  | Drew Provan, London  
Dr John Grainger, Manchester  
Ana Cabrera London  
Alistair Duff, Leeds  
Nichola Cooper, London  
Jonny Mellor, Stockport |
| 16:30 - 18:00| Kite, A Gilead Company               | CAR T in the UK: Reaching new indications in B-cell malignancies             | Kate Cwynarski, London  
Sridhar Chaganti, Birmingham  
Maeve O'Reilly, London |
<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Session Title</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jazz</td>
<td>10:15 - 11:45</td>
<td>Optimising care for fit patients with high-risk AML</td>
<td>Amit Patel, Manchester&lt;br&gt;Thomas Cluzeau, Nice, France&lt;br&gt;Sree Munisamy, Canterbury</td>
</tr>
<tr>
<td>Beigene</td>
<td>13:00 - 14:30</td>
<td>Expert Discussion: Current Advances in the Management of Waldenstrom Macroglobulinaemia</td>
<td>Roger Owen, Leeds&lt;br&gt;Rebecca Auer, London&lt;br&gt;Shirley D'Sa, London</td>
</tr>
<tr>
<td>Beigene</td>
<td>13:00 - 14:30</td>
<td>Expert Discussion: Current Advances in the Management of Waldenstrom Macroglobulinaemia</td>
<td>Roger Owen, Leeds&lt;br&gt;Rebecca Auer, London&lt;br&gt;Shirley D’Sa, London</td>
</tr>
<tr>
<td>Beigene</td>
<td>13:00 - 14:30</td>
<td>Expert Discussion: Current Advances in the Management of Waldenstrom Macroglobulinaemia</td>
<td>Roger Owen, Leeds&lt;br&gt;Rebecca Auer, London&lt;br&gt;Shirley D’Sa, London</td>
</tr>
<tr>
<td>Beigene</td>
<td>13:00 - 14:30</td>
<td>Expert Discussion: Current Advances in the Management of Waldenstrom Macroglobulinaemia</td>
<td>Roger Owen, Leeds&lt;br&gt;Rebecca Auer, London&lt;br&gt;Shirley D’Sa, London</td>
</tr>
<tr>
<td>Astellas Pharma Ltd</td>
<td>14:45 - 16:15</td>
<td>Managing FLT3mut+ R/R AML in 2021: How to navigate the evolving treatment landscape</td>
<td>Manoj Raghavan, Birmingham&lt;br&gt;Anne-Louise Latif, Glasgow</td>
</tr>
</tbody>
</table>
Industry Led Meet The Expert Sessions

The following Industry Led Meet the Expert Sessions have been created with our industry partners. Meet the Expert sessions allow you to pose questions to faculty in an informal session. Places at the Meet the Expert sessions are limited, make sure of your place by adding to your schedule 24hrs prior to the session start time.

### Sunday 25th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Session Title</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novartis</td>
<td>18:00 – 18:45</td>
<td>Diagnosis, testing and management of FLT3+ AML patients</td>
<td>Asim Khwaja, London</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Andrew Wilson, London</td>
</tr>
<tr>
<td>Novartis</td>
<td>18:00 – 18:45</td>
<td>Managing Myelofibrosis Patients with Confidence</td>
<td>Ruben Mesa, Texas, United States</td>
</tr>
</tbody>
</table>

### Monday 26th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Session Title</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medac</td>
<td>07:30 – 08:15</td>
<td>Advances in conditioning regimens for allogeneic stem cell transplantation</td>
<td>Amit Patel, Manchester</td>
</tr>
<tr>
<td>Novartis</td>
<td>12:00 – 12:45</td>
<td>Roundtable discussion: An interactive discussion exploring challenges and opportunities regards how to optimise access to CAR-T for Paediatric and Teenage &amp; Young</td>
<td>Rachel Hough, London</td>
</tr>
<tr>
<td>Janssen</td>
<td>12:00 – 12:45</td>
<td>Optimising outcomes for patients treated with Imbruvica: A case study in the management of cardiac arrhythmias and bleeding</td>
<td>Paul Moss, Birmingham, Rick Steeds, Birmingham</td>
</tr>
</tbody>
</table>
### Tuesday 27th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Event</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janssen</td>
<td>12:15 – 13:00</td>
<td>Practicalities and Clinical Significance of MRD Testing in Myeloma</td>
<td>Dean Smith, Nottingham</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ruth de Tute, Leeds</td>
</tr>
<tr>
<td>Beigene</td>
<td>12:15 – 13:00</td>
<td>Expert Discussion: Management of Waldenstrom Macroglobulineamia in 2021</td>
<td>Roger Owen, Leeds</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guy Pratt, Birmingham</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jaimal Kothari, Oxford</td>
</tr>
<tr>
<td>AstraZeneca</td>
<td>18:15 – 19:00</td>
<td>Adapting to a ‘new normal’ in CLL management: Opportunities and ways forward</td>
<td>George Follows, Cambridge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anna Schuh, Oxford</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sunil Iyengar, London</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Orla Stewart, London</td>
</tr>
</tbody>
</table>

### Wednesday 27th April 2021

<table>
<thead>
<tr>
<th>Company</th>
<th>Time</th>
<th>Event</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novartis</td>
<td>12:00 – 12:45</td>
<td>The ITP treatment landscape: current unmet needs</td>
<td>Vickie McDonald, London</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nichola Cooper, London</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gillian Lowe, Birmingham</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sue Pavord, Oxford University Hospitals</td>
</tr>
<tr>
<td>AbbVie</td>
<td>12:00 – 12:45</td>
<td>Reviewing CLL patient cases</td>
<td>Talha Munir, Leeds</td>
</tr>
</tbody>
</table>
Social

Join us for the chance to limber up your body and your funny bone with us.

We’re delighted to bring some opportunities to take a step back and enjoy a yoga session and top-notch comedy.

**Yoga**

Join Rachel Sugden, a world-class yoga instructor, for a morning stretch before starting your day. The session is designed for all abilities. Whether you’re an experienced yogi that can twist and turn like the best of them or just keen to dip your toe (and a few other body parts). Rachel Sugden will be gentle with you. You’ll be limbered up and ready to enjoy the day’s sessions.

Join Rachel at the following times live:

- **Monday 26th**
  - 07:30 – 08:15
- **Tuesday 27th**
  - 08:00 – 08:45
- **Wednesday 28th**
  - 07:30 – 08:15

**Comedy**

You won’t want to miss Daliso Chaponda, one of Britain’s finest comedians performing live and exclusive for you.

You may recognise Daliso from his third-place finish in the 2017 edition of Britain’s Got Talent or his brilliant BBC Radio 4 show Citizen of Nowhere. You won’t want to miss this exclusive performance.

**Join the session on**

**Tuesday 27th April - 19:00**

**Coffee and a chat**

We know everyone is missing the opportunity to catch up with friends and make new acquaintances over a coffee. We bring to you the next best thing. On the home page of the platform follow the link to Wonder. Here you will need to enter some basic information and can add a profile picture.

Once in, you’ll be able to freely roam throughout the screen. It does take a few minutes to get to grips with controlling your avatar but once you have grasped it, move around, join the conversation and see who you can find in there. The Wonder platform will be open throughout the live days of the event. Feel free to pop in throughout.
Join BSH and enjoy discounted courses and events

If you are training or practising in the field of haematology we invite you to join the UK’s largest professional network for the specialty. With almost 60 years’ experience, we aim to utilise science and experience to shape professional development and patient care in haematology.

Apply today at www.b-s-h.org.uk/membership
BEIGENE AT THE BSH 2021 VIRTUAL ANNUAL SCIENTIFIC MEETING

Expert Discussion: Management of Waldenstrom Macroglobulinaemia in 2021

**BeiGene Virtual Meet the Expert session**
Join us on **27th April 2021** from 12.15–13.00 h (GMT) at the BSH 2021 Virtual Annual Meeting platform
The session will be chaired by Dr Roger Owen (UK), joined by Dr Guy Pratt (UK) and Dr Jaimal Kothari (UK). The session will include case report presentations in both treatment naive and relapsed/intolerant Waldenstrom Macroglobulinaemia, with treatment plans and outcomes.
The experts will answer questions on the treatment of patients with difficult disease and/or co-morbidities such as refractory disease, ibrutinib resistance, continuous anti-coagulant drugs and ongoing fungal infection. [Click here to join us on 27th April 2021!](#)

Satellite Symposium: Current Advances in the Management of Waldenstrom Macroglobulinaemia

**BeiGene Virtual Satellite Symposium**
Join us on **28th April 2021** from 13.00–14.30 h (GMT) at the BSH 2021 Virtual Annual Meeting platform
The symposium will be chaired by Dr Roger Owen (UK), joined by Prof Constantine Tam (Australia), Dr Rebecca Auer (UK) and Dr Shirley D’Sa (UK) to discuss current advances in the management of Waldenstrom Macroglobulinaemia.
The symposium will inform and educate on the emerging role of BTK inhibition in Waldenstrom Macroglobulinaemia in various situations, review the frontline treatment, and explore disease related complications. [Click here to join us on 28th April 2021!](#)

Meet us at the BeiGene Virtual Booth and start a chat with a BeiGene representative!
Discover our range of free, interactive oncology and haematology resources intended for healthcare professionals and get your questions answered! Visit us at [beigenemedical.eu](http://beigenemedical.eu)
Developing solutions that aid adherence is in our blood.

New Imatinib 80mg/ml Oral Solution
Easier to take, easier to titrate.


Posology and Method of Administration: Therapy should be initiated in patients experiencing in the treatment of patients with chronic myeloid leukemia and myeloid sarcomas. CML in adult patients: 400 mg/day for adult patients in chronic phase CML, 600 mg/day in accelerated phase CML. In patients with newly diagnosed T-cell acute lymphoblastic leukemia, 800 mg/day for 2 weeks, followed by 400 mg/day while achieving complete remission. In patients with myelodysplastic syndrome, 800 mg/day for 2 weeks, followed by 400 mg/day while achieving complete remission. For chronic phase CML, the dose of 800 mg/day should be increased to 1,200 mg/day in adult patients, 400 mg/day in children with CML below 4 years of age and 400 mg/day in older patients with newly diagnosed CML. In patients with newly diagnosed acute lymphoblastic leukemia, 340 mg/m² once or twice daily. Dose increases may be considered in changed circumstances. The patients should be monitored closely following dose escalation.

Effects on Ability to Drive and Use Machines: Caution should be recommended when driving a car or operating machinery.

Unwanted Effects: Drug interactions: Therapy should be initiated under the care of a physician experienced in the treatment of patients with haematological malignancies and myeloid sarcomas. CML in adult patients: 400 mg/day for adult patients in chronic phase CML, 600 mg/day in accelerated phase CML. In patients with newly diagnosed Ph+ ALL in children: dose of 800 mg) once or twice daily. Dose increases may be considered in changed circumstances. The patients should be monitored closely following dose escalation.

Special Warnings and Precautions for use:

Information for Patients: Caution should be recommended when driving a car or operating machinery.

Marketing Authorisation Holder: Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE, UK. Legal Category: PS (P). Pack Size and NHS Price: 30’s, 60’s, 90’s. Marketing Authorisation Reference: PL 00427/0255. Marketing Authorisation holder: Rosemont Pharmaceuticals Ltd. Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds LS11 9XE T +44 (0)113 244 1400 F +44 (0)113 245 3567 E infodesk@rosemontpharma.com S Customer/Service Number: T +44 (0)113 246 0738 F +44 (0)113 246 0738 W www.rosemontpharma.com

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400 or via infodesk@rosemontpharma.com. Sales/Customer Service: +44 (0)113 244 1999 F +44 (0)113 246 0738 W www.rosemontpharma.com
Immune thrombocytopenia (ITP) patients’ lives are often dictated by their platelet count. The ITP World Impact Survey (I-WISH) provided insight into the patient experience.\(^1\) It is now imperative we move forward and talk about the numbers that matter to patients and look beyond platelet counts.

**ARE YOU JOINING THE CONVERSATION?**

**AGENDA**

**14:45 – 14:50**

*Welcome and introduction*

Dr Drew Provan

**14:50 – 15:05**

*The impact of ITP: the global vs. UK landscape*

Dr Drew Provan

**15:05 – 15:25**

*Listening to the younger voice: a key focus on the paediatric ITP population*

Dr John Grainger and Nurse Ana Cabrera

**15:25 – 15:45**

*Understanding the patient psyche: connecting with your ITP patients*

Dr Alistair Duff and Jonny Mellor

**15:45 – 16:05**

*Defining treatment success beyond platelet count: a round-table discussion*

Facilitated by Dr Nichola Cooper (all faculty incl.)

**16:05 – 16:15**

*In summary: practical guidance for a holistic ITP management approach*

Dr Nichola Cooper and Dr Alistair Duff

**SPEAKERS**

**Dr John Grainger**
Chair of British Society of Haematology Paediatric Haematology Committee

**Ana Cabrera**
Clinical nurse specialist oncology and haematology

**Dr Drew Provan**
Lead author on the International Consensus Report on ITP management

**Dr Alistair Duff**
Consultant clinical psychologist and honorary clinical associate professor

**Dr Nichola Cooper**
Consultant haematologist at Hammersmith Hospital and St. Mary's Hospital

**Jonny Mellor**
British long-distance runner and ITP patient

---

BSH, British Society of Haematology; HCP, healthcare professional; ITP, immune thrombocytopenia; I-WISH, ITP World Impact Survey.


Novartis products may be mentioned in this symposium, PI will be available.
NEW ADVANCES IN THE TREATMENT OF iTTP
WHAT ARE THE REAL-WORLD IMPLICATIONS?

Please join the faculty for a fresh look at immune-mediated thrombotic thrombocytopenic purpura (iTTP).

We will review the latest evidence and critically examine how to improve outcomes by optimising speed of diagnosis, treatment approaches and follow up.

A live Q&A session will allow you to put your challenging questions to the faculty.

Date of preparation March 2021
MAT-GB-2100955(V1.0)

This is a promotional symposium organised and funded by Sanofi.
Presentation: Each vial of powder contains 10 mg of caplacizumab. Each pre-filled syringe of solvent contains 1 ml of water for injections.

Indication: Cablivi is indicated for the treatment of adults and adolescents of 12 years of age and older weighing at least 40 kg experiencing an episode of acquired thrombotic thrombocytopenic purpura (aTTP), in conjunction with plasma exchange and immunosuppression.

Dosage and Administration: Treatment with Cablivi should be initiated and supervised by physicians experienced in the management of patients with thrombotic microangiopathies. First dose: Intravenous injection of 10 mg of caplacizumab prior to plasma exchange. Subsequent doses: Daily subcutaneous administration of 10 mg of caplacizumab, into the abdomen, after completion of each plasma exchange for the duration of daily plasma exchange treatment, followed by daily subcutaneous injection of 10 mg of caplacizumab for 30 days after stopping daily plasma exchange treatment. Injections into the area around the navel should be avoided and consecutive injections should not be administered in the same abdominal quadrant. Patients or caregivers may inject the medicinal product after proper training in the subcutaneous injection technique. If at the end of this 30 day period there is evidence of unresolved immunosuppression regimen, it is recommended to optimise the immunosuppression regimen and continue daily subcutaneous administration of 10 mg of caplacizumab until the signs of underlying immunosuppressive disease are resolved (e.g. sustained normalisation of ADAMTS13 activity level). In the clinical development program, caplacizumab has been administered daily for up to 65 days. No data on retreatment with caplacizumab are available. Missed dose: If a dose of Cablivi is missed, it can be administered within 12 hours. If ≥12 hours have passed since the dose was to have been given, the missed dose should not be administered and the next dose should be administered per the usual dosing schedule. Special Populations: Renal impairment: No dose adjustment necessary. Mild-moderate hepatic impairment: No dose adjustment necessary. Elderly: Experience in the elderly is limited, however there is no evidence to suggest that dose adjustment or special precautions are necessary. Paediatric population: The safety and efficacy of caplacizumab in the paediatric population have not been established in clinical trials. The posology of Cablivi in adolescents of 12 years of age and older weighing at least 40 kg is the same as in adults. No recommendations can be made on the posology of Cablivi for paediatric patients below 40 kg of body weight.

Contraindication: Hypersensitivity to the active substance or to any of the excipients.

Precautions and Warnings: Active clinically significant bleeding: In this case, treatment with Cablivi should be interrupted. If needed, the use of von Willebrand Factor concentrate could be considered to correct haemostasis. Cablivi should only be restarted upon the advice of a physician experienced in the management of thrombotic microangiopathies. Increased risk of bleeding: In the setting of concomitant use of oral anticoagulants or high dose heparin: Due to a potential increased risk of bleeding, initiation or continuation of these treatments requires a benefit/risk assessment and close clinical monitoring. In the setting of concomitant use of anti-platelet agents and / or low molecular weight heparin (LMWH): No increased risk of bleeding was observed in clinical trials, however concomitant treatment with anti-platelet agents and / or LMWH requires a benefit/risk assessment and close clinical monitoring. In patients with coagulopathies (e.g. hemophilia, other coagulation factor deficiencies): Due to a potential increased risk of bleeding, use of Cablivi in these patients is to be accompanied by close clinical monitoring. In patients undergoing surgery: If a patient is to undergo elective surgery or a dental procedure, the patient should be advised to inform the physician or dentist that they are using Cablivi, and treatment should be stopped at least 7 days before the planned intervention. The patient should also notify the physician who supervises the treatment with Cablivi about the planned procedure. If emergency surgery is needed, the use of von Willebrand Factor concentrate could be considered to correct haemostasis. Severe hepatic impairment: No data available in patients with severe acute or chronic hepatic impairment. Use of Cablivi in this population requires a benefit/risk assessment and close clinical monitoring. Traceability: In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Pregnancy: There are no data on the use of caplacizumab in pregnant women. Studies in guinea pigs showed no effect of caplacizumab on the dams or foetuses. As a precautionary measure, it is preferable to avoid the use of Cablivi during pregnancy. Breastfeeding: No data available in women. It is unknown whether caplacizumab is excreted in human milk. Therefore, risk to the child cannot be excluded, and decision must be made whether to discontinue breastfeeding or to abstain/discontinue from therapy, considering the benefit of breastfeeding for the child and the benefit of therapy for the woman. Fertility: The effects of caplacizumab on fertility in humans are unknown. Interactions: No data available.

Adverse Reactions: Very common: Headache, epistaxis, gingival bleeding, urticaria, pyrexia and fatigue. Common: Cerebral infarction, eye haemorrhage, haematoma, dyspnoea, haemoptysis, haematemesys, haematoecheia, melaena, haemorrhage (upper gastrointestinal haemorrhoidal, rectal), abdominal wall haematoma, myalgia, haematuria, menorrhagia, vaginal haemorrhage, injection site haemorrhage, injection site pruritus, injection site erythema, injection site reaction and subarachnoid haemorrhage.

List price (UK only): Cablivi 10mg injection x 1 vial: £4,143; x 7 vials £29,000.

Date of Preparation: June 2020.
On 18 March, NICE recommended CALQUENCE as monotherapy for adults in the following populations:1

- Untreated CLL with a 17p deletion or TP53 mutation; or
- Untreated CLL with no 17p deletion or TP53 mutation, and for whom FCR or BR is unsuitable; or
- Previously treated CLL

CALQUENCE indications:2

- CALQUENCE as monotherapy or in combination with obinutuzumab is indicated for the treatment of adult patients with previously untreated CLL
- CALQUENCE as monotherapy is indicated for the treatment of adult patients with CLL who have received at least one prior therapy

The NICE recommendations are based on positive results from phase 3 clinical trials:

- **ELEVATE-TN**: patients with previously untreated CLL3
  - Statistically significant superiority compared with standard of care OClb3
  - 93% estimated 24-month PFS with CALQUENCE + O, 87% with CALQUENCE, vs 47% with OClb at a median follow up of 28.3 months (p<0.0001)3

- **ASCEND**: patients with relapsed or refractory CLL4
  - Statistically significant superiority compared with IdR or BR*4
  - 83% estimated 15-month PFS for CALQUENCE vs 55% for IdR or BR,* at a median follow up of 16.1 months (p<0.0001)2,4

Most common (≥5%) adverse drug reactions Grade ≥3 for CALQUENCE + O and CALQUENCE monotherapy respectively included neutropenia (30%/14.2%), leukopenia (30%/14.3%), infection (21.5%/17.6%), thrombocytopenia (9%/4.8%) and anaemia (5.8%/7.8%) (pooled analysis)2

Low rates of discontinuation and dose reduction due to AEs2

Prescribing information can be found on the next page.

*Investigator’s choice.

**Abbreviations:** AE, adverse event; BR, bendamustine + rituximab; BTKi, Bruton tyrosine kinase inhibitor; CLL, chronic lymphocytic leukaemia; FCR, fludarabine + cyclophosphamide + rituximab; IdR, idelalisib + rituximab; NICE, National Institute for Health and Care Excellence; NR, not reached; O, obinutuzumab; OClb, obinutuzumab + chlorambucil; PFS, progression-free survival.


These promotional meetings have been organised and sponsored by AstraZeneca UK.
Prescribing Information

CALQUENCE® 100mg HARD CAPSULES ▼ (acalabrutinib)
Consult Summary of Product Characteristics before prescribing.

**Indication:** Calquence as monotherapy or in combination with obinutuzumab is indicated for the treatment of adult patients with previously untreated chronic lymphocytic leukemia (CLL). Calquence as monotherapy is indicated for treatment of adult patients with CLL who have received at least one prior therapy.

**Dosage and Administration:**
- **Recommended dose is 100mg acalabrutinib twice daily.**
- The dose interval is 12 hours approximately and treatment should be continued until disease progression or unacceptable toxicity. Refer to SmPC for recommended dose modifications of Calquence for Grade ≥ 3 adverse reactions and interactions with CYP3A4 inhibitors or inducers and gastric acid reducing agents.

**Elderly:** No dose adjustment required for patients (aged ≥ 65 years).

**Renal impairment:**
- No dose adjustment needed in patients with mild to moderate renal impairment (<30mL/min creatinine clearance) if benefit outweighs risk.
- Patients with moderate hepatic impairment should be closely monitored for signs of toxicity. Calquence is not recommended in patients with severe hepatic impairment (Child-Pugh C or total bilirubin >3 x ULN and any AST).

**Severe cardiac disease:** Patients should be monitored for the development of atrial fibrillation/flutter occurred in patients with haematological malignancies treated with Calquence monotherapy and in combination with obinutuzumab. These infections predominantly occurred in patients with severe hepatic impairment (Child-Pugh C or total bilirubin >3 x ULN and any AST). Patients with severe cardiovascular disease were excluded from studies. Paediatric population: The safety and efficacy of Calquence in children and adolescents aged 0 to 18 years have not been established.

**Contraindications:** Hypersensitivity to the active substance or to any of the excipients.

**Warnings and Precautions:**
- **Haemorrhage:** Major haemorrhagic events including central nervous system and gastrointestinal haemorrhage, some with fatal outcomes, have occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Patients receiving antithrombotic agents may be at increased risk of haemorrhage. Exercise caution with antithrombotic agents and consider additional monitoring for signs of bleeding when concomitant use is medically necessary. Warfarin or other vitamin K antagonists should not be administered concomitantly with Calquence. Consider benefit-risk of withholding Calquence for at least 3 days pre- and post-surgery.
- **Infections:** Serious infections (bacterial, viral or fungal) including fatal events have occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. These infections predominantly occurred in the context of a prior or concomitant immunosuppressive therapy. Consider PML in differential diagnosis where there are new or worsening neurological, cognitive or behavioural signs or symptoms. If PML is suspected, appropriate diagnostic evaluations should be undertaken and treatment with Calquence should be stopped until PML is excluded. Pharyngitis should be considered in patients who are at increased risk for opportunistic infections. Monitor for signs and symptoms of infection. **Cytopenias:** Treatment-emergent Grade 3 or 4 cytopenias, including neutropenia, anaemia and thrombocytopenia, occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor complete blood counts. **Secondary primary malignancies:** Skin and non-skin cancers, occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor for appearance of skin cancers and advise protection from sun exposure. **Atrial fibrillation/flutter:** Atrial fibrillation/flutter occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor for appearance of atrial fibrillation/flutter (e.g. palpitations, dizziness, syncope, chest pain, dyspnoea) and obtain ECG. If atrial fibrillation is developed in patients on CalQUENCE, treatment should be interrupted. If atrial fibrillation/flutter occurs, patients may not eliminate the interaction with CalQUENCE and therefore concomitant use should be avoided. Exercise caution if co-administering acalabrutinib with CYP3A4 substrates with narrow therapeutic range administered orally (e.g. cyclosporine, ergotamine, pimozide). Co-administration with CYP3A4 substrates (e.g. theophylline, caffeine) may decrease their exposure. Acalabrutinib may increase exposure to co-administered BCRP substrates (e.g. methotrexate) by inhibition of intestinal BCRP. To minimise the potential of an interaction in the gastrointestinal tract, oral narrow therapeutic range BCRP substrates such as methotrexate should be taken at least 6 hours before or after acalabrutinib. ACP-5862 (active metabolite of acalabrutinib) may increase exposure to co-administered MATE1 substrates (e.g. metformin) by inhibition of MATE1. Patients should be monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst taking Calquence.

**Undesirable Events:**
- **Severe:** Atrial fibrillation/flutter occurred in patients with haematological malignancies treated with Calquence monotherapy and in combination with obinutuzumab. Monitor for appearance of atrial fibrillation/flutter, ecchymoses, gastrointestinal haemorrhage, intracranial haemorrhage, epistaxis, asthenia. **Uncommon:** (≥ 1/1,000 to < 1/100): Pneumonia, urinary tract infection, nasopharyngitis, bronchitis, herpes viral infections, non-melanoma skin malignancy, PML including fatal ones have been reported following use of Calquence within the context of a prior or concomitant immunosuppressive therapy. Consider PML in differential diagnosis where there are new or worsening neurological, cognitive or behavioural signs or symptoms. If PML is suspected, appropriate diagnostic evaluations should be undertaken and treatment with Calquence should be stopped until PML is excluded. Pharyngitis should be considered in patients who are at increased risk for opportunistic infections. Monitor for signs and symptoms of infection. **Cytopenias:** Treatment-emergent Grade 3 or 4 cytopenias, including neutropenia, anaemia and thrombocytopenia, occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor complete blood counts. **Secondary primary malignancies:** Skin and non-skin cancers, occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor for appearance of skin cancers and advise protection from sun exposure. **Atrial fibrillation/flutter:** Atrial fibrillation/flutter occurred in patients with haematological malignancies treated with CalQUENCE monotherapy and in combination with obinutuzumab. Monitor for appearance of atrial fibrillation/flutter (e.g. palpitations, dizziness, syncope, chest pain, dyspnoea) and obtain ECG. If atrial fibrillation is developed in patients on CalQUENCE, treatment should be interrupted. If atrial fibrillation/flutter occurs, patients may not eliminate the interaction with CalQUENCE and therefore concomitant use should be avoided. Exercise caution if co-administering acalabrutinib with CYP3A4 substrates with narrow therapeutic range administered orally (e.g. cyclosporine, ergotamine, pimozide). Co-administration with CYP3A4 substrates (e.g. theophylline, caffeine) may decrease their exposure. Acalabrutinib may increase exposure to co-administered BCRP substrates (e.g. methotrexate) by inhibition of intestinal BCRP. To minimise the potential of an interaction in the gastrointestinal tract, oral narrow therapeutic range BCRP substrates such as methotrexate should be taken at least 6 hours before or after acalabrutinib. ACP-5862 (active metabolite of acalabrutinib) may increase exposure to co-administered MATE1 substrates (e.g. metformin) by inhibition of MATE1. Patients should be monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst taking Calquence.

**Drug Interactions:** Concomitant use with strong CYP3A4/P-gp inhibitors should be avoided. If strong CYP3A4/P-gp inhibitors (e.g. ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, ritonavir, telaprevir, posaconazole, voriconazole) is used short-term, treatment with Calquence should be interrupted. CYP3A4 inducers may decrease acalabrutinib plasma concentrations. Concomitant use of strong inducers (e.g.phenytoin, rifampicin, carbamazepine) should be avoided. Use of St. John’s wort should be avoided. If treatment with a gastric acid reducing agent is required, consider using an antacid (e.g. calcium carbonate) or H2-receptor antagonist (e.g. ranitidine or famotidine). Due to the long-lasting effect of proton pump inhibitors, separation of dosing with Calquence may not eliminate the interaction with Calquence and therefore concomitant use should be avoided. Exercise caution if co-administering acalabrutinib with CYP3A4 substrates with narrow therapeutic range administered orally (e.g. cyclosporine, ergotamine, pimozide). Co-administration with CYP3A4 substrates (e.g. theophylline, caffeine) may decrease their exposure. Acalabrutinib may increase exposure to co-administered BCRP substrates (e.g. methotrexate) by inhibition of intestinal BCRP. To minimise the potential of an interaction in the gastrointestinal tract, oral narrow therapeutic range BCRP substrates such as methotrexate should be taken at least 6 hours before or after acalabrutinib. ACP-5862 (active metabolite of acalabrutinib) may increase exposure to co-administered MATE1 substrates (e.g. metformin) by inhibition of MATE1. Patients should be monitored for signs of changed tolerability as a result of increased exposure of the concomitant medication whilst taking Calquence.

**Further Information is Available From:** AstraZeneca UK Ltd., 600 Capability Green, Luton, LU1 3LU, UK.
CALQUENCE is a trade mark of the AstraZeneca group of companies.

Date of preparation: 11/2020.
Further Information is Available From: AstraZeneca AB, SE-151 85 Södertälje, Sweden.
Further Information is Available From: AstraZeneca UK Ltd., 600 Capability Green, Luton, LU1 3LU, UK.
CALQUENCE is a trade mark of the AstraZeneca group of companies.

**Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.**
Adverse events should also be reported to AstraZeneca by visiting https://eereporting.astrazeneca.com or by calling 0800 783 0033.
A satellite symposium organised and funded by Astellas Pharma Ltd at BSH 2021 and intended for healthcare professionals only.

Managing $\text{FLT3}^{\text{mut+}}$ R/R AML in 2021: How to navigate the evolving treatment landscape

**Wednesday 28 April 2021 | 14:45–16:15 BST**

This Astellas-sponsored symposium at BSH 2021 will update healthcare professionals on the current management of AML, with an emphasis on $\text{FLT3}^{\text{mut+}}$ R/R cases. Dr Manoj Raghavan will explain the adverse prognostic impact of $\text{FLT3}$ mutations and the importance of testing. His talk will include data from the ADMIRAL trial on the management of $\text{FLT3}^{\text{mut+}}$ R/R AML and the role of gilteritinib (XOSPATA) in this setting. Dr Raghavan will also discuss the sequencing of $\text{FLT3}$-targeted therapies. Dr Anne-Louise Latif will then address the role of HSCT as the only curative treatment for patients with $\text{FLT3}^{\text{mut+}}$ AML and the use of gilteritinib before and after HSCT.

Throughout this symposium, there will be an emphasis on applying the presented data to everyday clinical practice. The speakers will present clinical case studies to illustrate key points and the Q&A session will allow for discussion of practical issues.

**AGENDA**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>SESSION TITLE</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:45–14:50</td>
<td>Welcome and introduction</td>
<td>Dr Manoj Raghavan</td>
</tr>
<tr>
<td>14:50–15:25</td>
<td>Emerging treatment options for $\text{FLT3}^{\text{mut+}}$ R/R AML</td>
<td>Dr Manoj Raghavan</td>
</tr>
<tr>
<td>15:25–15:50</td>
<td>Role of HSCT in $\text{FLT3}^{\text{mut+}}$ AML</td>
<td>Dr Anne-Louise Latif</td>
</tr>
<tr>
<td>15:50–16:10</td>
<td>Discussion and Q&amp;A session</td>
<td>All faculty</td>
</tr>
<tr>
<td>16:10–16:15</td>
<td>Conclusions and meeting close</td>
<td>Dr Anne-Louise Latif</td>
</tr>
</tbody>
</table>

**FACULTY**

**Dr Manoj Raghavan**
Consultant Haematologist, Centre for Clinical Haematology, Queen Elizabeth Hospital, Birmingham, UK

**Dr Anne-Louise Latif**
Honorary Clinical Senior Lecture, School of Medicine, Dentistry & Nursing, Institute of Cancer Sciences, Garscave Estate, Beatson Institute, Glasgow, UK

Gilteritinib is indicated as monotherapy for the treatment of adult patients with $\text{FLT3}^{\text{mut+}}$ R/R AML.\(^1\)

AML, acute myeloid leukaemia; $\text{FLT3}$, FMS-like tyrosine kinase 3; HSCT, haematopoietic stem cell transplantation; R/R, relapsed/refractory.

1. XOSPATA (gilteritinib). Summary of Product Characteristics. Prescribing Information can be found on the next page.

Gilteritinib is indicated as second-line therapy for patients with relapsed/refractory AML. Gilteritinib should be given to patients who have a FLT3 mutation.

Assessment of Gilteritinib:

- Assess the patient for a FLT3 mutation before initiating treatment with gilteritinib.
- Gilteritinib is generally well tolerated, and the most common adverse reactions are organ toxicities and constitutional symptoms.

Contraindications:

- Hypersensitivity to the active substance or any of the excipients listed in section 6.1 of the SPC.
- Patients with severe hepatic impairment (Child-Pugh Class C).

Warnings and Precautions for Use:

- Gilteritinib has been associated with QTc prolongation, and patients should be monitored for cardiac toxicity.
- Gilteritinib is associated with a risk of differentiation syndrome.
- Symptoms of differentiation syndrome may include fever, dyspnea, pleural effusion, pericardial effusion, pleural effusion, and pericardial effusion, and patients should be monitored for these symptoms.

Adverse Reactions:

- The most common adverse reactions reported during clinical trials were organ toxicities and constitutional symptoms.
- The most common Grade 3 or 4 adverse reactions included organ toxicities and constitutional symptoms.

Mechanism of Action:

- Gilteritinib is a selective inhibitor of FLT3, which is a receptor tyrosine kinase.

Indications:

- Gilteritinib is indicated as second-line therapy for patients with relapsed/refractory AML.

Prescribing Information:

- Gilteritinib is administered orally, once daily, with or without food.
- The recommended starting dose is 120 mg once daily.
- Gilteritinib should be interrupted in patients who have a QTcF >500 msec (see SPC section 4.2). The decision to re-introduce gilteritinib treatment after an event of QT prolongation should be based on careful consideration of benefits and risks.

Gilteritinib is primarily metabolised by CYP3A enzymes, which can be induced or inhibited by a number of concomitant medicinal products. Special Warnings and Precautions for Use above for further information on this and the effects of gilteritinib on these enzymes.

Legal classification:

- Legal classification: 53
- Date of preparation: April 2021.
- XOSPATA 40 mg film-coated tablets containing 40 mg gilteritinib (as fumarate).

Gilteritinib is primarily metabolised by CYP3A enzymes, which can be induced or inhibited by a number of concomitant medicinal products. Special Warnings and Precautions for Use above for further information on this and the effects of gilteritinib on these enzymes.
Dear Colleagues,

I’m delighted to invite you to the Novartis-sponsored virtual symposium at the British Society for Haematology Annual Scientific Meeting 2021.

The symposium will provide an overview of the pathophysiology of Sickle Cell Disease (SCD), the impact of vaso-occlusive crises (VOC) on end-organ damage and what this means for patients. The complications of VOCs will be discussed and strategies in managing acute and chronic pain in SCD will be identified.

I will also discuss new therapies in SCD and share my own experience.

There is a 30-minute Q&A session, where I welcome and encourage you to share your questions and opinions so we can have an insightful and informative discussion.

This symposium will be available on-demand following the meeting on the BSH virtual platform and at health.novartis.co.uk as part of the Novartis Haematology Academy.

I look forward to welcoming you.

Professor Jo Howard
Consultant Haematologist at Guy’s and St Thomas’ NHS Foundation Trust, and Honorary Professor in Haemoglobinopathies, King’s College London

The burden of vaso-occlusive crises in patients with Sickle Cell Disease
Sunday 25 April, 16:30 – 18:00

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:30 – 17:30</td>
<td>The burden of vaso-occlusive crises in patients with</td>
<td>Professor Jo Howard</td>
</tr>
<tr>
<td></td>
<td>Sickle Cell Disease</td>
<td></td>
</tr>
<tr>
<td>17:30 – 18:00</td>
<td>Live audience Q&amp;A</td>
<td>Professor Jo Howard</td>
</tr>
</tbody>
</table>

For more information, refer to the ADAKVEO® (crizanlizumab) prescribing information available here and on the next page.

UK | 111745 | March 2021
**Prescribing Information:**

**Adakveo® 10 mg/ml concentrate for solution for infusion (crizanlizumab)**

**Important note:** Before prescribing, consult Summary of Product Characteristics (SmPC).

**Presentation:** One vial of 10 ml contains 100 mg crizanlizumab. Crizanlizumab is a monoclonal antibody produced in Chinese Hamster Ovary (CHO) cells by recombinant DNA technology.

**Indications:** Adakveo is indicated for the prevention of recurrent vaso-occlusive crises (VOCs) in sickle cell disease patients aged 16 years and older. It can be given as an add on therapy to hydroxyurea/hydroxycarbamide (HU/HC) or as monotherapy in patients for whom HU/HC is inappropriate or inadequate.

**Dosage and administration:** Treatment should be initiated by physicians experienced in the management of sickle cell disease. The recommended dose of crizanlizumab is 5 mg/kg at week 0, week 2, and every 4 weeks thereafter. *Elderly:* Crizanlizumab has not been studied in elderly patients. The pharmacokinetics of crizanlizumab in adults are not affected by age. *Renal impairment:* Based on the population pharmacokinetic results, no dose adjustment is required in patients with mild or moderate renal impairment. Data from patients with severe renal impairment are too limited to draw conclusions on this population. *Hepatic impairment:* Safety and efficacy in patients with hepatic impairment have not been established. Crizanlizumab is a monoclonal antibody and is cleared via catabolism, a change in dose is not expected to be required for patients with hepatic impairment. *Paediatric population:* Safety and efficacy in paediatric patients from 6 months to 16 years have not been established. No data are available. There is no relevant use of crizanlizumab in infants aged less than 6 months for the indication of prevention of recurrent vaso occlusive crises.

**Method of administration:** Adakveo should be diluted with sodium chloride 9 mg/ml (0.9%) solution for injection or dextrose 5% before administration. The diluted solution must be administered through a sterile, non pyrogenic 0.2 micron in line filter by intravenous infusion over a period of 30 minutes. It must not be administered by intravenous push or bolus.

**Contraindications:** Hypersensitivity to the active substance, any of the excipients or to CHO cell products.

**Warnings/Precautions:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. *Infusion related reactions:* In clinical studies, infusion related reactions (defined as occurring within 24 hours) were observed in 2 patients (1.8%) treated with crizanlizumab 5 mg/kg. Patients should be monitored for signs and symptoms of infusion related reactions, which may include fever, chills, nausea, vomiting, fatigue, dizziness, pruritus, urticaria, sweating, shortness of breath or wheezing. In the event of a severe reaction, crizanlizumab should be discontinued and appropriate therapy should be instituted. *Laboratory test interference: automated platelet counts:* Interference with automated platelet counts (platelet clumping) has been observed, in particular when tubes containing EDTA were used. There is no evidence that crizanlizumab causes a reduction in circulating platelets or has a pro aggregant effect in vivo. It is recommended to run the test as soon as possible (within 4 hours of blood collection) or use citrate tubes. Platelet counts can be estimated via a peripheral blood smear.

**Interactions:** Interactions between crizanlizumab and other medicinal products have not been investigated in dedicated studies. In clinical studies, HU/HC had no effect on crizanlizumab pharmacokinetics in patients. No effect on exposure of co administered medicinal products is expected.

**Fertility, pregnancy and lactation:** There is limited data from the use of Adakveo in pregnant women. Based on animal studies, crizanlizumab has the potential to cause foetal losses. It is preferable to avoid the use of Adakveo during pregnancy and in women of childbearing potential not using contraception. To help determine the effects in pregnant women, healthcare professionals are encouraged to report all pregnancy cases and complications during pregnancy in order to allow monitoring of these patients. It is unknown whether crizanlizumab is excreted in human milk. There are no data on the effects of crizanlizumab on the breast fed newborn/infant or on milk production. A risk to the newborn/infant cannot be excluded. A decision must be made whether to discontinue breast feeding or to discontinue Adakveo therapy, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. There are no data on the effect of Adakveo on human fertility. Available non clinical data do not suggest an effect on fertility.

**Undesirable effects:** Very Common (≥ 1/10): nausea, abdominal pain, arthralgia, back pain, pyrexia. Common (≥ 1/100 to < 1/10): oropharyngeal pain, diarhoea, vomiting, pruritus, myalgia, musculoskeletal chest pain, infusion site reaction, infusion related reaction. *Other Adverse Effects:* Please consult the Summary of Product Characteristics for a detailed listing of all adverse events before prescribing.

**Legal classification:** POM

**Marketing Authorisation (MA) number, quantities and price:** EU/1/20/1476/001 £1,038.00 per 10ml vial

**Date of last revision of prescribing information:** October 2020

**Full Prescribing Information available from:** Novartis Pharmaceuticals UK Ltd, 2nd Floor, The WestWorks Building, White City Place, 195 Wood Lane, London, W12 7FQ. Telephone: (01276) 692255.

103764

**Date of preparation:** January 2021

---

**Adverse events should be reported.** Reporting forms and information can be found at [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard). Adverse events should also be reported to Novartis via [uk.patientsafety@novartis.com](mailto:uk.patientsafety@novartis.com) or online through the pharmacovigilance intake (PVI) tool at [www.report.novartis.com](http://www.report.novartis.com). If you have a question about the product, please contact Medical Information on 01276 698370 or by email at [medinfo.uk@novartis.com](mailto:medinfo.uk@novartis.com).
UNRAVELLING THERAPEUTIC CHALLENGES IN PATIENTS WITH LEUKAEMIA
AML • CML • ALL
A LIVE AND INTERACTIVE CASE-BASED WORKSHOP
Sunday 25th April 2021, 14:45 – 16:15
BSH 2021 Virtual ASM

Pfizer is delighted to invite you to join our esteemed panel of leukaemia experts as they share their approach to clinical decision-making using real-world patient case studies, with a focus on multidisciplinary collaboration and patient-centred care. In this fast-paced session, the expert panel will discuss how pivotal data can be applied to the management of chronic and acute leukaemia patients in everyday clinical practice.

The symposium will be fully LIVE and interactive polling questions for the audience and the ability to put your questions and thoughts to our expert panel during the LIVE Q&A session.

Meet our expert speakers:

AML patient case study
• Goals and practicalities of managing a patient with de novo AML

Dr Priyanka Mehta - Chair
Consultant Haematologist
University Hospitals Bristol
NHS Foundation Trust

CML patient case study
• Navigating the treatment pathway for complex patients

Dr Dragana Milojkovic
Consultant Haematologist
Imperial College Healthcare
NHS Trust

Relapsed or refractory ALL patient case study
• Optimising patient outcomes with effective patient management

Dr Tobias Menne
Consultant Haematologist
Newcastle upon Tyne Hospitals
NHS Foundation Trust

Scan here to add the symposium to your schedule

This promotional symposium is organised and funded by Pfizer Limited and may include reference to Pfizer medicines relevant to the agenda topics. Please note that, under the law and the ABPI Code of Practice, Pfizer may only promote its medicines to members of the healthcare professions and other relevant decision-makers. Therefore, no unqualified person (e.g. medical students, non-medical spouses, partners) may be invited to or attend Pfizer meetings.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Pfizer Medical Information on 01304 616161

To contact Pfizer for any purpose, including adverse event reports or medical information requests, please call 01304 616161.

ALL, acute lymphoblastic leukaemia; AML, acute myeloid leukaemia; CML, chronic myeloid leukaemia.

PP-ONC-GBR-1863 | Date of preparation: April 2021
IMNOVID® (pomalidomide): a foundation for present and future therapies?

This promotional symposium is organised and funded by Celgene, a Bristol-Myers Squibb Company, and is intended for healthcare professionals in the UK and Ireland. Please click here for prescribing information. This item is for online use only and should not be printed or further distributed. Please contact medical.information@bms.com should you require more information.

Dr Karthik Ramasamy
Lead Clinician for Myeloma and other Plasma Dyscrasias in the Oxford University Hospitals NHS Foundation Trust; Associate Professor of Haematology, Oxford University; Oxford, UK

Professor Paul G. Richardson
Clinical Program Leader and Director of Clinical Research, Jerome Lipper Multiple Myeloma Center and RJ Corman Professor of Medicine, Harvard Medical School, Boston, MA, USA

Session details
Available on-demand beginning 25 April 2021

The landscape for managing patients with relapsed and/or refractory multiple myeloma (R/RMM) is continually evolving, but IMNOVID® remains a constant foundation for current and future combination treatments.

Our distinguished speakers will explore the use of IMNOVID® in adult patients with R/RMM and its use in a variety of doublet and triplet combinations. The experts will also discuss case studies and common clinical questions, including practical patient management strategies in challenging R/RMM cases.

Programme: 60 minutes

<table>
<thead>
<tr>
<th>Topic</th>
<th>Detail</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical data on IMNOVID® (pomalidomide)</td>
<td>Rationale for combining IMNOVID® with dexamethasone and other anti-MM agents</td>
<td>Paul Richardson</td>
</tr>
<tr>
<td>as a foundation in doublet and triplet therapies for R/RMM</td>
<td>Findings from the MM-003, MM-014, OPTIMISMM, ELOQUENT-3, and ICARIA-MM trials</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential for use of IMNOVID® in R/RMM treatment</td>
<td></td>
</tr>
<tr>
<td>Case studies covering practical care decisions for challenging cases</td>
<td>Use of IMNOVID® in R/RMM patients with renal impairment</td>
<td>Karthik Ramasamy</td>
</tr>
<tr>
<td></td>
<td>IMNOVID® use in R/RMM patients with high-risk genetic features</td>
<td></td>
</tr>
<tr>
<td>Discussion session</td>
<td>Review of common clinical questions regarding the treatment of patients with R/RMM and adjustments in therapy to manage adverse events</td>
<td>Paul Richardson and Karthik Ramasamy</td>
</tr>
<tr>
<td>Summary and close</td>
<td></td>
<td>Karthik Ramasamy</td>
</tr>
</tbody>
</table>

This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information.

Adverse events should be reported. Reporting forms and information can be found at:

UK: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.
Ireland: via HPRA Pharmacovigilance at www.hpra.ie

Adverse events should also be reported to Bristol-Myers Squibb via: medical.information@bms.com or 0800 731 1736 (UK) | 1 800 749 749 (Ireland).

© 2021 Bristol-Myers Squibb Company 2204-GB-2100060 | April 2021
Gilteritinib is indicated as monotherapy for the treatment of adult patients with FLT3mut+ R/R AML.1

AML, acute myeloid leukaemia; FLT3, FMS-like tyrosine kinase 3; R/R, relapsed/refractory.

1. XOSPATA (gilteritinib). Summary of Product Characteristics. Prescribing Information can be found on the next page.

An on-demand bite-sized symposium organised and funded by Astellas Pharma Ltd at BSH 2021 and intended for healthcare professionals only.

Optimising care for patients with acute myeloid leukaemia: The role of the acute leukaemia clinical nurse specialist

Available to view from Sunday 25 April 2021

This on-demand bite-sized symposium at BSH 2021 will be led by Gemma Trout, a leukaemia clinical nurse specialist, and will provide an overview of the role of the clinical nurse specialist in the management of patients with AML. Gemma will discuss the support system for patients with leukaemia, emphasising the importance of the multidisciplinary team and the responsibilities of the clinical nurse specialist at each stage in the patient pathway. She will share best practice for the optimal management of AML and discuss how the service organisation will evolve with the introduction of oral targeted therapies, including gilteritinib (XOSPATA™) for adult patients with R/R AML. Gemma will also discuss the importance of the role of the clinical nurse specialist in outpatient clinics, as well as for care visits and patient reviews. A brief explanation of COVID-19 management and restrictions will be relayed. Finally, Gemma will provide guidance on the proactive management of adverse events and dose modifications, focusing again on the follow up of patients receiving oral therapies.

**AGENDA**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>SESSION TITLE</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Welcome and introduction</td>
<td>Gemma Trout&lt;br&gt;Leukaemia Clinical Nurse Specialist, University College London Hospitals NHS Foundation Trust, London, UK</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Optimising care for patients with acute myeloid leukaemia: The role of the acute leukaemia clinical nurse specialist</td>
<td></td>
</tr>
<tr>
<td>5 minutes</td>
<td>Q&amp;A session and meeting close</td>
<td></td>
</tr>
</tbody>
</table>

**FACULTY**

**Gemma Trout**<br>Leukaemia Clinical Nurse Specialist,<br>University College London Hospitals NHS Foundation Trust, London, UK

Gilteritinib is indicated as monotherapy for the treatment of adult patients with FLT3mut+ R/R AML.1
Gilteritinib is indicated as monotherapy for the treatment of adult patients who have relapsed or refractory acute myeloid leukaemia (AML) with a FLT3 mutation (internal tandem duplication [ITD] or tyrosine kinase domain [TKD]) with a FLT3 receptor signalling and proliferation in cells excessively expressing FLT3 including FLT3ITD, FLT3ITD835Y (also known as TKD mutation), and FLT3ITD/TKD355Y. Gilteritinib induces apoptosis in leukemic cells expressing FLT3 and overcomes FLT3-dependent cell survival and proliferation by preferentially targeting FLT3 in FLT3-mutant AML. Gilteritinib has been shown to improve survival in patients with FLT3-mutant AML, a subtype of AML that is associated with worse outcomes and poorer survival. Gilteritinib was primarily metabolised in patients following haematopoietic stem cell transplantation (HSCT). Plackett HSCT Interrupt treatment week one prior to administration of the conditioning regimen for HSCT. Treatment can be resumed 30 days after HSCT if engraftment was successful, the patient did not have grade ≥2 acute graft versus host disease and was ≥18 years of age. It is advised that the patient undergo a physical examination and testing for organ function or dosage modifications. Failure to dose adjustment is required in patients ≥65 years of age (see section 5.2). Early initiation of treatment explained in detail below by category frequency. Frequency categories are defined as follows: very common (≥1/100); common (≥1/100 to <1/100); uncommon (≥1/1000 to <1/1000); rare (<1/1000 to <1/10000); very rare (<1/10000). Within each frequency category, adverse reactions are presented in order of decreasing seriousness. Immune system disorders: Anaphylactic reaction (common); All Grades 1.3%, Grades ≥3 1.3%. Nervous system disorders: Dizziness (very common); All Grades 20.4%, Grades ≥3 5.3%. Cardiac disorders: Cardiac arrest (very common); All Grades 19%, Grades ≥3 4.8%. Hepatic disorders: Hepatic failure: No dose adjustment is required in patients with mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment. Gilteritinib is not recommended for use in patients with severe (Child-Pugh Class C) hepatic impairment, as safety and efficacy have not been established in such patients. Patients with moderate or severe renal impairment should be initiated with a dose of 120 mg and titrated to the lowest dose tolerated based on toxicity. Due to the risk of acute kidney injury, there is a potential impact on cardiac development in patients less than 6 months of age. Contraindications: Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the Summary of Product Characteristics (SPC). Gilteritinib is contraindicated in patients with a history of severe renal impairment (see section 5.2). Gilteritinib is primarily metabolised by CYP3A4 enzymes, which can be induced or inhibited by a number of concomitant medicinal products. See Special Warnings and Precautions for Use section above for further information on this and the effects of gilteritinib on products that target 5HT2B receptor or sigma nonspecific receptors. Gilteritinib is an inhibitor of CYP3A4. Gilteritinib should be used with caution in combination with products that induce or inhibit CYP3A4 and/or CYP2C19 (see section 4.5). Gilteritinib is an inhibitor of CYP3A4 and should be avoided unless essential for the care of the patient (see section 4.5). Gilteritinib is primarily metabolised by CYP3A4 enzymes, which can be induced or inhibited by a number of concomitant medicinal products. See Special Warnings and Precautions for Use section above for further information on this and the effects of gilteritinib on products that target 5HT2B receptor or sigma nonspecific receptors. Gilteritinib is an inhibitor of CYP3A4. Gilteritinib should be used with caution in combination with products that induce or inhibit CYP3A4 and/or CYP2C19 (see section 4.5). Gilteritinib is an inhibitor of CYP3A4 and should be avoided unless essential for the care of the patient (see section 4.5).
DEBORAH WAS FIRST DIAGNOSED WITH MULTIPLE MYELOMA IN 2017.

Discover Deborah's story with myeloma by clicking here or scanning the adjacent QR code.
DARZALEX: ▼ 20 mg/ml Concentrate for Solution for Infusion and 1,800 mg Solution for Injection.

PRESENTING INFORMATION

ACTIVE INGREDIENT: Daratumumab

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

INDICATION(S): Newly diagnosed multiple myeloma: In combination with lenalidomide/dexamethasone or bortezomib/melphalan/prednisone in adults, ineligible for autologous stem cell transplant; in combination with bortezomib, thalidomide and dexamethasone in adults, eligible for autologous stem cell transplant. Relapsed/Refractory multiple myeloma: Monotherapy for adults whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on last therapy. In combination with lenalidomide/dexamethasone or bortezomib/dexamethasone in adults who have received one prior therapy.

DOSEAGE & ADMINISTRATION: Administration by healthcare professional where resuscitation facilities available, intravenous (IV) infusion or subcutaneous (SC) injection. For SC injection, resuscitation facilities required only for first dose. Adult Dose: IV dose 16 mg/kg body. Dilute with sodium chloride 0.9% solution for injection and administer by intravenous infusion. SC dose: Inject 15 mL DARZALEX solution for SC injection into the subcutaneous tissue of the abdomen, approximately 7.5 cm to the right or left of the navel over approximately 3.5 minutes according to dosing schedule. Patients > 120 kg, flat-dose 1,800 mg SC, efficacy not established. For SC injection, no dose adjustments based on body weight recommended. Check the vial labels to ensure that the appropriate formulation (IV or SC formulation) and dose is being given as prescribed. For dose and schedule of medicinal products administered with DARZALEX, refer to SmPC 4.1 and the corresponding SmPC for other products.

Refer to SmPC for further details.

Recommended concomitant medications for management of infusion/ injection-related reactions (IRRs): administer pre-IV infusion/ SC injection medicinal products 1-3 hours prior to administration (corticosteroids, antipyretics and antihistamines). For SC injections, pre-medications can be given orally from the first dose. When dexamethasone is background regimen specific corticosteroid, this dose will serve as pre medication on infusion days. If dexamethasone given on infusion day, do not take additional background regimen specific corticosteroids (e.g. prednisone). Post- IV infusion/ SC injection medicinal products should be administered to reduce the risk of delayed IRRs: administer oral corticosteroid. If the patient experiences no major IRRs after the first three SC injections, post-injection corticosteroids (excluding any background regimen corticosteroids) may be discontinued. Consider branchiodilators and inhaled corticosteroids in patients with history of chronic obstructive pulmonary disorder. Darzalex Infusion: Any grade/severity IRRs, interrupt Darzalex infusion immediately and manage symptoms. Re-starting Darzalex infusion: reduce infusion rate (refer to SmPC), Grade 4 IRRs (or third occurrence of Grade 3) – permanently discontinue. No dose reductions of Darzalex recommended. Consider anti viral prophylaxis for prevention of herpes zoster virus reactivation.

Children: No data available.

Elderly/Renal impairment/Hepatic impairment: No dose adjustments.

CONTRAINDICATIONS: Hypersensitivity to active substance or excipients.

SPECIAL WARNINGS & PRECAUTIONS: IRRs: can cause serious IRRs including anaphylactic reactions. Majority occurred following first IV infusion/SC injection. Monitor for IRRs throughout the IV infusion, continue monitoring post- IV infusion until symptoms resolve. For SC injection, median time to onset of IRRs was 3.7 hours following injection, monitor IRRs especially in the first and second SC injection. Darzalex solution for SC injection should never be injected into areas where the skin is red, bruised, tender, hard or areas where there are scars. During treatment with Darzalex SC injection, do not administer other medicinal products for subcutaneous use at the same site as Darzalex. Both IV and SC Darzalex: if an anaphylactic reaction or life threatening (Grade 4) IRR occurs, initiate appropriate emergency resuscitation immediately and discontinue Darzalex immediately and permanently. Neutropenia/Thrombocytopenia: Darzalex may increase neutropenia and thrombocytopenia induced by background therapy; monitor for infections & periodic complete blood cell counts (refer to relevant SmPCs); consider supportive care. Indirect Antiglobulin Test (Indirect Coombs Test): Daratumumab binds to CD38, may mask detection of antibodies to minor antigens; ABO and Rh blood typing not impacted. Interference may occur up to 6 months post-treatment. Type and screen patients prior to starting daratumumab; consider phenotyping; red blood cell genotyping not affected by daratumumab. Inform blood transfusion centres when appropriate. If emergency transfusion required, give non-cross-matched ABO/Rh-compatible RBCs. Hepatitis B virus (HBV) reactivation: Fatal cases reported in patients treated with Darzalex. Perform HBV screening before initiation of treatment. Suspend treatment in patients who develop reactivation of HBV while on Darzalex. Patient’s with body weight >120 kg, potential for reduced efficacy. Infusion contains sodium: SC injection contains sorbitol.

SIDE EFFECTS: Very common: IRRs, pneumonia, bronchitis, upper respiratory tract infection, anaemia, neutropenia, thrombocytopenia, lymphopenia, leukopenia, decreased appetite, peripheral sensory neuropathy, paraesthesia, headache, hypertension, cough, dyspnoea, nausea, diarrhoea, constipation, vomiting, back pain, muscle spasms, fatigue, pyrexia, peripheral oedema, asthenia. SC only: insomnia, arthralgia. Common: urinary tract infection, influenza, sepsis, cytomegalovirus infection, hyperglycaemia, hypocalcaemia, dehydration, atrial fibrillation, pulmonary oedema, pancreatitis, chills. SC only: dizziness, muscularkeletal chest pain, rash, pruritus, injection site erythema/reactions.

Serious side effects: HBV reactivation (uncommon), anaphylactic reaction (rare).

Refer to SmPC for other side effects.

PREGNANCY: Effective contraception during and for 3 months after treatment in women of child-bearing potential. Do not use during pregnancy unless benefits outweigh potential risks to foetus.

LACTATION: Not known if daratumumab is excruted into breast milk.

INTERACTIONS: No studies performed. Not anticipated to alter drug-metabolising enzymes. Daratumumab binds to CD38 on RBCs and interferes with compatibility testing (including antibody screening and cross matching). Interference mitigation methods include treating-reagent RBCs with diethylnetriol (DTE) to disrupt daratumumab binding or other locally validated methods. However, Kell-negative units should be supplied after ruling out/identifying allantobodies using DTT-treated RBCs. Alternatively, consider phenotyping or genotyping prior to starting treatment. Daratumumab detected on serum protein electrophoresis (SPE) and immunofixation (IFE) assays, can impact determination of complete response and disease progression in some patients. Consider using a validated daratumumab-specific IFE assay to facilitate determination of a complete response in patients with persistent very good partial response.

Refer to SmPC for full details of interactions.

LEGAL CATEGORY: POM

PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S) & BASIC NHS COSTS

<table>
<thead>
<tr>
<th>Presentations</th>
<th>Pack Sizes</th>
<th>Marketing Authorisation Numbers</th>
<th>Basic NHS Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 ml vial</td>
<td>X1</td>
<td>EU/1/16/101/001</td>
<td>£360</td>
</tr>
<tr>
<td>(100mg daratumumab)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 ml vial</td>
<td>X1</td>
<td>EU/1/16/101/002</td>
<td>£1,440</td>
</tr>
<tr>
<td>(400mg daratumumab)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 ml vial</td>
<td>X1</td>
<td>EU/1/16/101/004</td>
<td>£4,320</td>
</tr>
<tr>
<td>(1800 mg daratumumab)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MARKETING AUTHORISATION HOLDER: Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium.

FURTHER INFORMATION IS AVAILABLE FROM: Janssen-Cilag Limited, 50-100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG, UK.

Prescribing information last revised: December 2020

© Janssen-Cilag Limited 2020
Jakavi® (ruxolitinib) is indicated for the treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis. Jakavi® (ruxolitinib) is also indicated for the treatment of adult patients with polycythaemia vera who are resistant to or intolerant of hydroxyurea.
Serious bacterial, mycobacterial, fungal, viral and other opportunistic infections have occurred in patients treated with Jakavi. Patients should be assessed for the risk of opportunistic infections on initiation of treatment. It is important to observe patients receiving Jakavi for signs and symptoms of infections and initiate appropriate treatment promptly. Treatment with Jakavi should not be started until active serious infections have resolved. Tuberculosis has been reported in post-polycythaemia vera myelofibrosis patients starting Jakavi. During treatment, patients should be evaluated for active and inactive (‘latent’) tuberculosis per local recommendations. Hepatitis B viral load (HBV-DNA titre) increases, with and without associated elevations in alanine aminotransferase and aspartate aminotransferase, have been reported in patients with chronic HBV infections taking Jakavi. It is recommended to screen for HBV prior to commencing treatment. Patients with chronic HBV infection should be treated and monitored according to clinical guidelines.

Hepatic impairment: Adequate data regarding the impact of hepatic impairment on the safety and efficacy of Jakavi are not available. However, caution is advised in patients with severe hepatic impairment (Child-Pugh score >10). Inadequate experience has been obtained in patients with moderate hepatic impairment.

Neurological or psychiatric events: No cases of aseptic meningitis, encephalopathy, leucoencephalopathy (PML) or any other serious central nervous system disorders have been reported in patients treated with Jakavi. However, the risk of developing these events cannot be excluded.

Acute bleeding events: Although a study in healthy subjects indicated that ruxolitinib did not affect hemostasis, bleeding events were associated with manageable cytopaenias in patients treated with Jakavi. Patients should be monitored for signs and symptoms of bleeding. Avoidance of unnecessary invasive or surgical procedures is advised.

Liver toxicity: No cases of liver failure, hepatic injury or jaundice have been reported in patients treated with Jakavi. However, cases of liver injury have been observed in patients treated with Jakavi. Patients should be monitored for signs and symptoms of liver injury.
Challenges in the Management of Diffuse Large B-Cell Lymphoma (DLBCL) in 2021

Please join us for this educational, interactive non-promotional symposium, presented by a panel of expert speakers, exploring the current challenges that remain in the management of DLBCL.

<table>
<thead>
<tr>
<th>TIME</th>
<th>SESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:15</td>
<td>Welcome and introduction</td>
</tr>
<tr>
<td></td>
<td><strong>DR KATE CWYNARSKI, UNIVERSITY COLLEGE LONDON HOSPITAL</strong></td>
</tr>
<tr>
<td>10:25</td>
<td>Case presentation: Progression in a fit patient with DLBCL: How should we select and sequence treatment?</td>
</tr>
<tr>
<td></td>
<td><strong>DR WENDY OSBORNE, FREEMAN HOSPITAL, NEWCASTLE UPON TYNE</strong></td>
</tr>
<tr>
<td>10:40</td>
<td>Case presentation: Relapse following autologous stem cell transplant (ASCT): Choices in the modern age</td>
</tr>
<tr>
<td></td>
<td><strong>DR GRAHAM COLLINS, OXFORD UNIVERSITY HOSPITALS</strong></td>
</tr>
<tr>
<td>10:55</td>
<td>Case presentation: Advanced stage DLBCL: Management of older, transplant ineligible patients</td>
</tr>
<tr>
<td></td>
<td><strong>DR CLARE ROWNTREE, CARDIFF AND VALE UHB</strong></td>
</tr>
<tr>
<td>11:15</td>
<td>Live discussion and Q&amp;A</td>
</tr>
<tr>
<td></td>
<td><strong>CHAIRIED BY DR KATE CWYNARSKI</strong></td>
</tr>
<tr>
<td>11:45</td>
<td>Meeting close</td>
</tr>
</tbody>
</table>

**Speakers**

- **Dr Cwynarski** is Lead of the UK Primary CNS Lymphoma Group and a member of the National Cancer Research Institute (NCRI) Lymphoma Clinical Studies Group. She is also Chair of the BSH Lymphoma Specialist Interest Group and is highly involved in lymphoma clinical trials.

- **Dr Osborne** is a member of the NCRI high grade and Hodgkin lymphoma subgroups, BSH lymphoma special interest group and is a principal investigator and co-investigator for numerous clinical trials. She is Associate Lecturer and teaching lead for the haematology undergraduate programme at Newcastle University.

- **Dr Collins** sits on the NCRI high grade and Hodgkin lymphoma subgroups and is a member of the lymphoma guidelines development group of NICE. He co-authored the national guidelines for relapsed Hodgkin Lymphoma and is a trustee of the national Lymphoma Association.

- **Dr Rowntree** is clinical director for Haematology and Immunology at Cardiff and Vale UHB. She is also Chair of the NCRI ALL subgroup and a member of the BSH Lymphoma Specialist Interest Group and highly involved in lymphoma clinical trials.
SANOFI GENZYME PRESENTS:

The Kidney Matters in Relapsed and Refractory Multiple Myeloma (RRMM)

Join Dr Karthik Ramasamy and expert faculty members, and find out about how frail and elderly RRMM patients including those with disease-associated renal impairment could benefit from treatment with SARCLISA in combination with pomalidomide and dexamethasone (Pd).

Gain clinical understanding of what the data from ICARIA-MM means for your patients

Join us on Tuesday 27th of April 2021 at 09.00–10.30am

<table>
<thead>
<tr>
<th>DURATION</th>
<th>TOPIC</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–09:05</td>
<td>Welcome and introduction</td>
<td>Chair: Dr Karthik Ramasamy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultant Haematologist, Oxford University Hospitals and Royal Berkshire Hospital NHS Trust</td>
</tr>
<tr>
<td>09:05–09:25</td>
<td>Renal impairment in patients with RRMM and the impact of treatment</td>
<td>Dr Jennifer Pinney</td>
</tr>
<tr>
<td></td>
<td>Kidney issues associated with RRMM, how to manage these patients, and the relationship between renal recovery and clinical outcomes.</td>
<td>Consultant Nephrologist, University Hospitals Birmingham NHS Foundation Trust</td>
</tr>
<tr>
<td>09:25–09:45</td>
<td>Reframing expectations for patients with RRMM and renal impairment</td>
<td>Dr Neil Rabin</td>
</tr>
<tr>
<td></td>
<td>Results from ICARIA-MM multinational clinical study comparing SARCLISA + Pd to Pd in adult patients with RRMM, with a focus on patients with renal impairment and looking at the renal response in these patients.</td>
<td>Consultant Haematologist, University College Hospital, London</td>
</tr>
<tr>
<td>09:45–10:00</td>
<td>Reframing expectations for elderly and frail patients in RRMM</td>
<td>Dr Ceri Bygrave</td>
</tr>
<tr>
<td></td>
<td>Results from the ICARIA-MM trial in elderly and frail patients, a real-world patient case study, and practical considerations for treating this patient population.</td>
<td>Consultant Haematologist, Cardiff &amp; Vale University Health Board</td>
</tr>
<tr>
<td>10:00–10:30</td>
<td>Live Q&amp;A</td>
<td>All</td>
</tr>
</tbody>
</table>

Prescribing information and adverse event reporting information can found here.  
Date of preparation: April 2021 | MAT-GB-2100992(v1.0)
SANOFI GENZYME PRESENTS:

The Kidney Matters in Relapsed and Refractory Multiple Myeloma (RRMM)

Join Dr Karthik Ramasamy and expert faculty members, and find out about how frail and elderly RRMM patients including those with disease-associated renal impairment could benefit from treatment with SARCLISA in combination with pomalidomide and dexamethasone (Pd).

Gain clinical understanding of what the data from ICARIA-MM means for your patients

Join us on Tuesday 27th of April 2021 at 09.00–10.30am

<table>
<thead>
<tr>
<th>DURATION</th>
<th>TOPIC</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–09:05</td>
<td>Welcome and introduction</td>
<td>Chair: Dr Karthik Ramasamy&lt;br&gt;Consultant Haematologist, Oxford University Hospitals and Royal Berkshire Hospital NHS Trust</td>
</tr>
<tr>
<td>09:05–09:25</td>
<td>Renal impairment in patients with RRMM and the impact of treatment</td>
<td>Dr Jennifer Pinney&lt;br&gt;Consultant Nephrologist, University Hospitals Birmingham NHS Foundation Trust</td>
</tr>
<tr>
<td>09:25–09:45</td>
<td>Reframing expectations for patients with RRMM and renal impairment</td>
<td>Dr Neil Rabin&lt;br&gt;Consultant Haematologist, University College Hospital, London</td>
</tr>
<tr>
<td>09:45–10:00</td>
<td>Reframing expectations for elderly and frail patients in RRMM</td>
<td>Dr Ceri Bygrave&lt;br&gt;Consultant Haematologist, Cardiff &amp; Vale University Health Board</td>
</tr>
<tr>
<td>10:00–10:30</td>
<td>Live Q&amp;A</td>
<td>All</td>
</tr>
</tbody>
</table>

Prescribing information and adverse event reporting information can be found [here](#).
To find out even more and learn about the key primary outcomes from the ICARIA-MM trial and discover real-world patient cases studies, why not check out the CPD accredited BSH 2020 symposium recording.

SARCLISA is indicated, in combination with pomalidomide and dexamethasone (Pd), for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on the last therapy.1


Date of preparation: April 2021 | MAT-GB-2100992(v1.0)
Join Novartis at the British Society for Haematology 2021 Virtual Annual Scientific Meeting

The road so far with CAR-T... Where do we go next?
Symposium: Monday 26 April, 13:00–14:30

Dear Colleagues,

It is my great pleasure to invite you to the Novartis-sponsored symposium, taking place at the British Society for Haematology 2021 Virtual Annual Scientific Meeting. My esteemed colleagues, Dr Amit Patel, Dr Ben Uttenthal and Dr David Porter, will focus on the evolution of CAR-T cell therapy, how to optimise outcomes in clinical practice and the future of CAR-T management. During this symposium there will be opportunity to:

- Explore the latest data in CAR-T including real-world evidence, and review the importance of complete response in clinical practice
- Understand what the new real-world data means in practice
- Evaluate what we have learnt in terms of managing and referring potentially eligible patients for CAR-T to achieve the most optimal outcomes
- Consider how we should plan for the future, with respect to the practical aspects of implementing an outpatient model, relieving capacity issues with more indications and the availability of products

You will also be provided the opportunity to submit your questions to our expert panel in our live Q&A discussion session.

I look forward to welcoming you to what will be an informative and engaging symposium.

Professor Tony Pagliuca

For more information, refer to the Kymriah® (tisagenlecleucel) prescribing information available here and on the next page.
Lymphodepleting chemotherapy is recommended to be administered before flow. A leukocyte depleting filter, at approximately 10 to 20 mL per minute by gravity, should be available per patient prior to infusion. The treatment centre must have access to additional doses of tocilizumab within 8 hours.

Presentation:

- Patients with uncontrolled infection should be treated with broad-spectrum antibiotics, fluids and other supportive care, as medically indicated. Patients may continue to exhibit cytopenias for several weeks following lymphodepleting chemotherapy. Patients treated with Kymriah may develop secondary malignancies or recurrence of their cancer. They should be monitored life-long for secondary malignancies. In the event of febrile neutropenia, infection should be evaluated and managed appropriately.

Dosage and Administration:

Kymriah must be administered in a qualified treatment centre. Tocilizumab for use in the event of cytokine release syndrome and pneumoencephalopathy should be available per patient prior to infusion. The treatment centre must have access to additional doses of tocilizumab within 8 hours.

- For patients 50 kg and below: 0.2 to 5 x 10^9 CAR-positive viable T cells/kg body weight.
- For patients above 50 kg: 0.1 to 2.5 x 10^9 CAR-positive viable T cells (non-weight based).

Lymphodepleting chemotherapy is recommended to be administered before Kymriah infusion unless the white blood cell (WBC) count within one week prior to infusion is <5,000 cells/mm^3 and other toxicities. Physicians should consider hospitalisation for the first 10 days post infusion at the first signs/symptoms of CRS and/or neurological events. After the first 10 days following the infusion, the patient should be monitored by the patient's physician. Patients should be instructed to remain within proximity (2 hours of travel) of a qualified clinical facility for at least 4 weeks following infusion.

Adverse Events:

- Cytarabine (500 mg/m^2 intravenous daily for 4 days) and etoposide (150 mg/m^2 intravenous daily for 3 days)
- Bendamustine (90 mg/m^2 intravenous daily for 2 days)
- Cyclophosphamide-containing regimen administered shortly before lymphodepleting chemotherapy, then the following should be used:
  - Cytarabine (500 mg/m^2 intravenous daily for 2 days) and etoposide (150 mg/m^2 intravenous daily for 3 days)
  - Fludarabine (25 mg/m^2 intravenous daily for 3 days) and cyclophosphamide (250 mg/m^2 intravenous daily for 3 days starting with the first dose of fludarabine).

LBCL recommended lymphodepleting chemotherapy regimen is:

- Cyclophosphamide (500 mg/m^2 intravenous daily for 4 days) and fludarabine (250 mg/m^2 intravenous daily for 3 days starting with the first dose of fludarabine).

- For patients with a history of active CNS disorder or with evidence of CNS dysfunction syndrome, alanine aminotransferase increased, blood bilirubin increased, fibrin D dimer increased, activated partial thromboplastin time increased, antithrombin decreased, white blood cell count decreased, haemoglobin decreased, neutrophil count decreased, platelet count decreased, aspartate aminotransferase increased, alanine aminotransferase increased, lactate dehydrogenase increased, white blood cell count decreased.

- Bendamustine (90 mg/m^2 intravenous daily for 2 days) and etoposide (150 mg/m^2 intravenous daily for 3 days)

- Cytarabine (500 mg/m^2 intravenous daily for 2 days)

Teratogenicity: Teratogenicity data is not available. Studies are needed in pregnancy in animals or in humans.
Come and join Imbruvica’s BSH 2021 Expert Talk session on:

Optimising outcomes for patients treated with Imbruvica

Led by Professor Paul Moss & Dr Richard Steeds

April 26th
12:00-12:45pm

Registration details can be found on the BSH agenda

See overleaf for prescribing information & adverse event reporting.
IMBRUVICA® 140mg, 280mg, 420mg and 560mg Film-coated Tablets

PRESCRIBING INFORMATION

ACTIVE INGREDIENT: ibrutinib

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

INDICATIONS: As a single agent for adults with relapsed or refractory mantle cell lymphoma (MCL) as a single agent or in combination with rituximab or obinutuzumab for adults with chronic lymphocytic leukemia (CLL) who are previously untreated. As a single agent or in combination with bendamustine and rituximab (BR) for adults with CLL who have received ≥ one prior therapy. As a single agent for adults with Waldenström’s macroglobulinemia (WM), who have received ≥ one prior therapy or first line in patients unsuitable for chemoimmunotherapy. In combination with rituximab for adults with WM.

DOSAGE & ADMINISTRATION: Adults: Orally, once daily, swallowed whole with water. MCL - 560 mg. CLL and WM - 420 mg as single agent or in combination (refer to SmPC). Concomitant moderate CYP3A4 inhibitors - reduce dose to 280mg. Withhold IMBRUVICA therapy for any new onset/worsening grade ≥ 3 non-haematological toxicity, grade ≥ 3 neutropenia with infection/fever, or grade ≥ 4 haematological toxicity/new/worsening grade ≥ 3 toxicities resolved to grade 1 or baseline. If toxicities recur, reduce dose by 140mg. A second dose reduction of 140mg may be considered if needed. Discontinue IMBRUVICA if toxicities persist/recur following two dose reductions. Children: Safety/efficacy not established ≤ 18 years old.

Elderly: No dose adjustment required. Renal impairment: Mild/moderate - no dose adjustment. Severe - no data; consider benefit/risk and monitor closely. No data with dialysis. Hepatic impairment: Mild (Child-Pugh class A) - 280mg daily; moderate (Child-Pugh class B) - 140mg daily; severe (Child-Pugh class C) - not recommended. Monitor for toxicities. Severe cardiac disease: No clinical data.

CONTRAINDICATIONS: Hypersensitivity to active substance/excipients. St. John’s Wort preparations.

SPECIAL WARNINGS & PRECAUTIONS: Bleeding-related events: minor and major events reported, some fatal. Do not use with warfarin or other vitamin K antagonists. Risk of major bleeding increased with use of anticoagulants and antiplatelet agents. Monitor for signs, symptoms of bleeding. Avoid fish oil and vitamin E preparations. Regularly monitor, treat as appropriate. Cerebrovascular accidents: Risk of atrial fibrillation/flutter, ventricular tachycardia, and cardiac failure. Consider prophylaxis in increased risk patients. Invasive fungal infections: Invasive fungal infections have been associated with fatal outcomes. Progressive Multifocal Leuкоencephalopathy (PML): Infections (e.g. rosuvastatin).

Hepatitis B reactivation reported, including fatal events; establish HBV status before starting treatment; if positive HBV consult specialist physician; if positive hepatitis B serology, consult a liver disease expert before starting treatment and monitor/manage to prevent hepatitis B reactivation. Tumour lysis syndrome: cases reported. Monitor at risk patients closely, take precautions. Non-melanoma skin cancer: cases reported; monitor patients.

Hypertension: Monitor BP regularly, treat as appropriate. Haemophagocytic lymphohistiocytosis (HLH): cases reported including fatal cases; inform patients of HLH symptoms. Drug-drug interactions: Strong/moderate CYP3A4 inhibitors may increase ibrutinib exposure; CYP3A4 inducers may decrease ibrutinib exposure; avoid strong inhibitors and strong/moderate inducers, of CYP3A4 where possible; if not monitor closely for toxicities/lack of efficacy.

SIDE EFFECTS: Very common: Pneumonia, upper respiratory tract infection, skin infection, neutropenia, thrombocytopenia, lymphocytosis, hyperuricaemia, dizziness, headache, haemorrhage, bruising, hypertension, diarrhoea, vomiting, stomatitis, nausea, constipation, rash, arthralgia, musculoskeletal pain, pyrexia, oedema peripheral, muscle spasms, blood creatinine increased. Common: Sepsis, urinary tract infection, sinusitis, non-melanoma skin cancer, basal cell carcinoma, squamous cell carcinoma, febrile neutropenia, leukocytosis, interstitial lung disease, peripheral neurophyaxis, vision blurred, cardiac failure, atrial fibrillation, ventricular tachycardia, epistaxis, petechiae, urticaria, erythema, onycholysis. Other side effects: Hepatitis B reactivation, leukostasis syndrome, hepatic failure, panniculitis, Stevens-Johnson syndrome, angioedema, subdural haematoma, fungal infections (Cryptococcal, Pneumocystis, Aspergillus), cerebrovascular accidents, transient ischaemic attack, ischaemic stroke, neutrophilic dermatoses. Refer to SmPC for other side effects.

PREGNANCY: Women of child-bearing potential must use highly effective contraceptive measures during and for 3 months after stopping treatment. Not to be used during pregnancy.


INTERACTIONS: CYP3A4 inhibitors: Strong: Avoid where possible or reduce IMBRUVICA dose (or withhold for ≤ 7 days) and monitor closely; e.g. ketoconazole, indinavir, nelfinavir, ritonavir, saquinavir, clarithromycin, telithromycin, itraconazole, nefavudine, coxibitast, voriconazole, posaconazole. Moderate: Avoid where possible or reduce IMBRUVICA dose and monitor closely; e.g. erythromycin, ampranavir, aprepitant, azithromycin, cyclosporin, ceftriaxone, diltiazem, fluconazole, fosapenavir, imatinib, verapamil, amiodarone, dronedaron. Avoid grapefruit and Seville oranges. Mild: No dose adjustment required; monitor closely. CYP3A4 inducers: Strong: moderate: Avoid or monitor closely for lack of efficacy; e.g. carbamazepine, rifampicin, phenytoin. Mild: May be used; monitor for lack of efficacy. Potential interactions: Oral narrow therapeutic range P-gp or breast cancer resistance protein (BCRP) substrates (e.g. cyclosporin, methotrexate) should be taken ≥ 6 h before/after IMBRUVICA. Ibrutinib may inhibit BCRP in the liver and so increase exposure of drugs undergoing BCRP-mediated hepatic efflux (e.g. rosuvastatin). Refer to SmPC for full details of interactions.

LEGAL CATEGORY: POM

PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S) & BASIC NHS COSTS

<table>
<thead>
<tr>
<th>Presentations</th>
<th>Pack Sizes</th>
<th>Marketing Authorisation Numbers</th>
<th>Basic NHS Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>140mg blister pack</td>
<td>28 tablets</td>
<td>EU/1/14/945/007</td>
<td>£1,430.80</td>
</tr>
<tr>
<td>280mg blister pack</td>
<td>28 tablets</td>
<td>EU/1/14/945/009</td>
<td>£2,861.60</td>
</tr>
<tr>
<td>420mg blister pack</td>
<td>28 tablets</td>
<td>EU/1/14/945/011</td>
<td>£4,292.40</td>
</tr>
<tr>
<td>560mg blister pack</td>
<td>28 tablets</td>
<td>EU/1/14/945/012</td>
<td>£5,723.20</td>
</tr>
</tbody>
</table>

MARKETING AUTHORISATION HOLDER: Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium.

FURTHER INFORMATION IS AVAILABLE FROM: Janssen-Cilag Limited, 50-100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG, UK.

Prescribing information last revised: January 2021

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Janssen-Cilag Limited on 01494 567447 or at dsafety@its.jnj.com.

© Janssen-Cilag Limited 2021
ON DEMAND SATELLITE SYMPOSIUM
During the virtual BSH Annual meeting
April 24 to 28 2021

The Holmes and Watson approach to differential diagnosis: Thrombocytopenia and Anaemia

Chaired by Dr Richard Gooding, our speakers take the Sherlock & Watson approach to review the evidence and clues presented as part the differential diagnosis of unexplained thrombocytopenia and anaemia.

Join them to navigate the potential decision making process using real patient case studies from their clinical practice.

Welcome and Introduction
Dr Richard Gooding

Case 1: A surprising discovery in suspicious circumstances
Dr Haris Kartsios

Case 2: Elements not elementary, my dear Watson!
Dr Richard Gooding

Concluding remarks and key take home messages
Dr Richard Gooding

This is a promotional symposium organised and funded by Sanofi Genzyme

Date of Preparation April 2021
MAT-GB-2101199 (v2.0)
Prescribing Information: Cerezyme® (imiglucerase) 400 Units powder for concentrate for solution for infusion

Please refer to the Summary of Product Characteristics (SPC) before prescribing. Presentations: Each vial of Cerezyme contains 400U of the active substance imiglucerase. Following reconstitution, the solution contains 40 units (approximately 1mg) of imiglucerase per ml. Indications: Cerezyme (imiglucerase) is indicated for use as long-term enzyme replacement therapy in patients with a confirmed diagnosis of non-neuronopathic (Type 1) or chronic neuronopathic (Type 3) Gaucher disease who exhibit clinically significant non-neurological manifestations of the disease. The non-neurological manifestations of Gaucher disease include one or more of the following conditions: anaemia after exclusion of other causes, such as iron deficiency; thrombocytopenia; bone disease after exclusion of other causes such as Vitamin D deficiency; hepatomegaly or splenomegaly.

Dosage and administration: Disease management should be directed by physicians knowledgeable in the treatment of Gaucher disease. Dosage should be individualised for each patient based on a comprehensive evaluation of the clinical manifestations of the disease and individual treatment goals. A range of dosage regimens have proven effective towards some or all non-neurological manifestations. Initial doses of 60 U/kg of body weight once every 2 weeks have shown improvement in haematological and visceral parameters within 6 months of therapy, and continued use has either stopped progression of, or improved, bone disease. Administration of doses as low as 15 U/kg of body weight once every 2 weeks has been shown to improve haematological parameters and organomegaly, but not bone parameters. After reconstitution and dilution, the preparation is administered by intravenous infusion at a usual frequency of infusion is once every 2 weeks. At initial infusions, Cerezyme should be administered at a rate ≤0.5 unit/kg body weight per minute. Subsequent administrations, the infusion rate may be increased ≤1 unit/kg body weight per minute. Infusion rate increases should always occur under supervision of a healthcare professional. Infusion of Cerezyme at home: may be considered for patients who are tolerating their infusions well for several months. This decision should be made after evaluation and recommendation by the treating physician and the patient or caregiver must receive training by a healthcare professional in a clinical setting on how to carry out infusions. The patient or caregiver will be instructed in infusion technique and the keeping of a treatment diary. Patients experiencing adverse events during the infusion must immediately stop the infusion and seek the attention of a healthcare professional. Subsequent infusions may need to occur in a clinical setting. Dose and infusion rate should remain constant while at home, and not be changed without supervision of a healthcare professional. Medical or healthcare professionals are encouraged to register Gaucher patients, including those with chronic neuronopathic manifestations of the disease, in the “ICGG Gaucher Registry”.

Special populations: No dose adjustment is necessary for the paediatric population. The efficacy of Cerezyme on neurological symptoms of chronic neuronopathic Gaucher patients has not been established and no special dosage regimen can be recommended. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and Precautions: Hypersensitivity: Approximately 15% of the treated patients develop IgG antibodies to imiglucerase within the first year of treatment. It appears that patients who will develop these antibodies are most likely to do so within 6 months of treatment and rarely after 12 months. Patients suspected of a decreased response to the treatment should be monitored periodically for IgG antibody formation to imiglucerase. Patients with antibody to imiglucerase have a higher risk of hypersensitivity reactions. If a reaction suggestive of hypersensitivity appears, subsequent testing for imiglucerase antibodies is advised. As with any intravenous protein product, severe allergic-type hypersensitivity reactions are possible, but occur uncommonly. If these reactions occur, immediate discontinuation of the Cerezyme infusion is recommended and appropriate medical treatment should be initiated and the current medical standards for emergency treatment are to be observed. Patients who have developed antibodies or symptoms of hypersensitivity to Ceredase (algglucerase) should be treated with caution when administering Cerezyme (imiglucerase). Sodium: This medicinal product contains sodium and is administered in 0.9% sodium chloride intravenous solution. To be taken into consideration by patients on a controlled sodium diet. Pregnancy and lactation: Limited experience (~150 pregnancy outcomes) suggests that use of Cerezyme is beneficial to control the underlying Gaucher disease in pregnancy. These data indicate no malformative toxicity for the foetus by Cerezyme, although the statistical evidence is low. Foetal demise has been reported rarely, although it is not clear whether this related to the use of Cerezyme or to the underlying Gaucher disease. It is not known whether Cerezyme passes via the placenta to the developing foetus. In pregnancy and those intending to become pregnant, a risk-benefit treatment assessment is required. Patients who have Gaucher disease and become pregnant may experience a period of increased disease activity during pregnancy and the puerperium. This includes an increased risk of skeletal manifestations, exacerbation of cytopenia, haemorrhage, and an increased need for transfusion. Both pregnancy and lactation are known to stress maternal calcium homeostasis and to accelerate bone turnover. This may contribute to skeletal disease burden in Gaucher disease. Treatment naïve women should be advised to consider commencing therapy prior to conception in order to attain optimal health. In women receiving Cerezyme treatment continuation throughout pregnancy should be considered. Close monitoring of the pregnancy and clinical manifestations of Gaucher disease is necessary for the individualization of dose according to the patient’s needs and therapeutic response. It is not known whether Cerezyme is excreted in human milk, however if so the enzyme is likely to be digested in the child’s gastrointestinal tract. Adverse effects: In approximately 3% of patients, symptoms suggestive of hypersensitivity have been noted. Common (≥1/100 to <1/10): dyspnoea, coughing, hypersensitivity reactions, urticaria/angioedema, pruritus, rash. Please refer to the SPC for more information. Legal category: POM. UK List price and Marketing Authorisation Numbers: £1071.29 x 1 vial. EU/1/97/053/003. Marketing authorisation holder: Genzyme Europe B.V. Paasheuvelweg 25, 1105 BP Amsterdam, The Netherlands. Further information is available from: Medical Information, Sanofi, 410 Thames Valley Park Drive, Reading, Berkshire, RG6 1PT, UK. uk-medicalinformation@sanofi.com. Date of preparation: July 2020.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

Adverse events should also be reported to the Sanofi drug safety department on Tel: 0800 0902 314. Alternatively, send via email to UK-drugsafety@sanofi.com
Prescribing Information: Cerezyme® (imiglucerase) 400 Units powder for concentrate for solution for infusion

Please refer to the Summary of Product Characteristics (SPC) before prescribing.

Presentations: Each vial of Cerezyme contains 400U of the active substance imiglucerase. Following reconstitution, the solution contains 40 units (approximately 1mg) of imiglucerase per ml.

Indications: Cerezyme (imiglucerase) is indicated for use as long-term enzyme replacement therapy in patients with a confirmed diagnosis of non-neuronopathic (Type 1) or chronic neuronopathic (Type 3) Gaucher disease who exhibit clinically significant non-neurological manifestations of the disease. The non-neurological manifestations of Gaucher disease include one or more of the following conditions: anaemia after exclusion of other causes, such as iron deficiency; thrombocytopenia; bone disease after exclusion of other causes such as Vitamin D deficiency; hepatomegaly or splenomegaly.

Dosage and administration: Disease management should be directed by physicians knowledgeable in the treatment of Gaucher disease. Dosage should be individualised for each patient based on a comprehensive evaluation of the clinical manifestations of the disease and individual treatment goals. A range of dosage regimens have proven effective towards some or all non-neurological manifestations. Initially, doses of 60 U/kg of body weight once every 2 weeks have shown improvement in haematological and visceral parameters within 6 months of therapy, and continued use has either stopped progression of, or improved, bone disease. Administration of doses as low as 15 U/kg of body weight once every 2 weeks has been shown to improve haematological parameters and organomegaly, but not bone parameters. After reconstitution and dilution, the preparation is administered by intravenous infusion at a usual frequency of infusion is once every 2 weeks. At initial infusions, Cerezyme should be administered at a rate ≤0.5 unit/kg body weight per minute. Subsequent administrations, the infusion rate may be increased ≤1 unit/kg body weight per minute. Infusion rate increases should always occur under supervision of a healthcare professional.

Infusion of Cerezyme at home: may be considered for patients who are tolerating their infusions well for several months. This decision should be made after evaluation and recommendation by the treating physician and the patient or caregiver must receive training by a healthcare professional in a clinical setting on how to carry out infusions. The patient or caregiver will be instructed in infusion technique and the keeping of a treatment diary. Patients experiencing adverse events during the infusion must immediately stop the infusion and seek the attention of a healthcare professional. Subsequent infusions may need to occur in a clinical setting. Dose and infusion rate should remain constant while at home, and not be changed without supervision of a healthcare professional. Medical or healthcare professionals are encouraged to register Gaucher patients, including those with chronic neuronopathic manifestations of the disease, in the “ICGG Gaucher Registry”.

Special populations: No dose adjustment is necessary for the paediatric population. The efficacy of Cerezyme on neurological symptoms of chronic neuronopathic Gaucher patients has not been established and no special dosage regimen can be recommended. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and Precautions: Hypersensitivity: Approximately 15% of the treated patients develop IgG antibodies to imiglucerase within the first year of treatment. It appears that patients who will develop these antibodies are most likely to do so within 6 months of treatment and rarely after 12 months. Patients suspected of a decreased response to the treatment should be monitored periodically for IgG antibody formation to imiglucerase. Patients with antibody to imiglucerase have a higher risk of hypersensitivity reactions. If a reaction suggestive of hypersensitivity appears, subsequent testing for imiglucerase antibodies is advised. As with any intravenous protein product, severe allergic-type hypersensitivity reactions are possible, but occur uncommonly. If these reactions occur, immediate discontinuation of the Cerezyme infusion is recommended and appropriate medical treatment should be initiated and the current medical standards for emergency treatment are to be observed. Patients who have developed antibodies or symptoms of hypersensitivity to Ceredase (alglucerase) should be treated with caution when administering Cerezyme (imiglucerase).

Sodium: This medicinal product contains sodium and is administered in 0.9% sodium chloride intravenous solution. To be taken into consideration by patients on a controlled sodium diet.

Pregnancy and lactation: Limited experience (~150 pregnancy outcomes) suggests that use of Cerezyme is beneficial to control the underlying Gaucher disease in pregnancy. These data indicate no malformative toxicity for the foetus by Cerezyme, although the statistical evidence is low. Foetal demise has been reported rarely, although it is not clear whether this related to the use of Cerezyme or to the underlying Gaucher disease. It is not known whether Cerezyme passes via the placenta to the developing foetus. In pregnancy and those intending to become pregnant, a risk-benefit treatment assessment is required. Patients who have Gaucher disease and become pregnant may experience a period of increased disease activity during pregnancy and the puerperium. This includes an increased risk of skeletal manifestations, exacerbation of cytopenia, haemorrhage, and an increased need for transfusion. Both pregnancy and lactation are known to stress maternal calcium homeostasis and to accelerate bone turnover. This may contribute to skeletal disease burden in Gaucher disease. Treatment naïve women should be advised to consider commencing therapy prior to conception in order to attain optimal health. In women receiving Cerezyme treatment continuation throughout pregnancy should be considered. Close monitoring of the pregnancy and clinical manifestations of Gaucher disease is necessary for the individualization of dose according to the patient’s needs and therapeutic response. It is not known whether Cerezyme is excreted in human milk, however if so the enzyme is likely to be digested in the child’s gastrointestinal tract. Adverse effects: In approximately 3% of patients, symptoms suggestive of hypersensitivity have been noted. Common (≥1/100 to <1/10): dyspnoea, coughing, hypersensitivity reactions, urticaria/angioedema, pruritus, rash. Please refer to the SPC for more information. Legal category: POM. UK

List price and Marketing Authorisation Numbers: £1071.29 ± 1 vial. EU/1/97/053/003. Marketing authorisation holder: Genzyme Europe B.V. Paasheuveldweg 25, 1105 BP Amsterdam, The Netherlands. Further information is available from: Medical Information, Sanofi, 410 Thames Valley Park Drive, Reading, Berkshire, RG6 1PT, UK. uk-medicalinformation@sanofi.com.

Date of preparation: July 2020.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

Adverse events should also be reported to the Sanofi drug safety department on Tel: 0800 0902 314. Alternatively, send via email to UK-drugsafety@sanofi.com.
Save the Date

2022

British Society for Haematology Annual Scientific Meeting 2022

Manchester Central
Sunday 3 April - Tuesday 5 April

www.bshconferences.co.uk