Chairman's Letter

Michael J. Hennessy, Sr

This issue of *The American Journal of Hematology/Oncology®* focuses on reviews about mantle cell lymphoma (MCL), HER2-positive breast cancer, pathological features, cumulative risk, and risk modifiers for invasive breast carcinoma, and a case report on managing pyrexia in a patient who was administered dabrafenib/trametinib therapy. The CME this month addresses *FLT3* mutations in patients with acute myeloid leukemia (AML).

Integrating new therapeutic strategies in managing patients with MCL, though encouraging, can pose a clinical challenge—it is not entirely clear how to translate these strategies in untreated patients with MCL. "Frontline Therapy in Mantle Cell Lymphoma: New Standards in 2017," by Morgane Cheminant, MD, and Olivier Hermine, MD, PhD, looks at treatment approaches based on monitoring minimal residual disease (MRD) that may enable tailored treatment strategies to help select patients who may benefit from targeted therapies, such as Bruton tyrosine kinase inhibitors. They contend that obtaining a complete response with MRD negativity (and/or negative PET scan) by reducing toxicity during induction will become the future therapeutic objective.

Reshma Mahtani, DO, and colleagues describe the clinical trials that led to the approval of trastuzumab, which not only showed improvement in disease-free survival, but also in overall survival. The authors also review the current evidence for the use of adjuvant HER2-targeted therapy in breast cancer in their article, "Update on HER2-Positive Adjuvant Therapy."

In "Pathology and Current Management of Borderline Breast Epithelial Lesions," Walia and coauthors note that although histological criteria have been established for borderline epithelial lesions, these are not uniformly applied. In addition, some overlap exists with epithelial hyperplasia and in situ carcinoma, which can affect diagnostic accuracy.

Jesus Vera Aguilera, MD, and colleagues submit a case report involving dabrafenib- and trametinib-associated pyrexia in a patient with metastatic melanoma. Historically, dose interruptions for grade 2 pyrexia can last a median of 11.5 days. By incorporating colchicine into the treatment regimen, they were able to limit dose interruptions to 3 to 4 days over a period of 80 days. Colchicine was generally well tolerated except for thrombocytopenia, which improved over time, they note.

In the CME article this month, Amir T. Fathi, MD, MSC, assistant professor of medicine, Harvard Medical School, and director, Leukemia Program, Massachusetts General Hospital, discusses current and emerging targeted strategies in *FLT3*-mutated AML, with an emphasis on the practice-changing results of the RATIFY trial.

Michael J. Hennessy, Sr
Chairman and Chief Executive Officer