Dear CAPhO members,

My name is Stephanie Lee and I work as a hematology pharmacist at Extend Pharmacy. In my practice I provide pharmaceutical care to patients who receive oral therapies to treat their benign & malignant hematology disorders (e.g., aplastic anemia, myelodysplastic syndrome, acute myeloid leukemia and chronic lymphoblastic leukemia).

I recently traveled to South Korea to attend the 2025 Korean Society of Hematology International Conference & 66th Annual Meeting in Seoul. At the conference, I learned from world-renowned experts about healthcare in non-Western settings, novel interventions in diagnosing and treating malignant hematology disorders; and networked with other healthcare professionals. Attending the conference has better informed my practice as a hematology pharmacist and helped me stay current in a therapeutic area which is rapidly changing.

Hematologists from Vietnam and Armenia presented on how they treat acute lymphoblastic leukemia in their respective countries; a common theme was difficulty in accessing drug and diagnostic resources. Specifically in Vietnam, costly therapies such as CAR T-cell therapy, bispecific T-cell engager therapy, and newer tyrosine kinase inhibitors are inaccessible due to lack of healthcare funding and economic resources. Similarly, the hematologist from Armenia also highlighted the need for better medical infrastructure and reported that the Chernobyl disaster still affects them to this day, as is reflected in the higher rates of cancer in her country. I realized how lucky we are to live in a country like Canada where access to healthcare and treatment can be taken for granted.

Another presentation I found particularly interesting was the review of the EVE trial, which supports dose reduction of apixaban to 2.5mg twice daily upon completion of 6-months of full-dose anticoagulation. This study is pertinent to the patient population that I work with as many therapies for hematologic malignancies can increase the patient's baseline risk of bleeding, so instituting a dose reduction of their anticoagulant when appropriate can minimize such risk.

Lastly, a heavily discussed topic was the use of minimal residual disease testing in acute myeloid leukemia, acute lymphoblastic leukemia and multiple myeloma, to tailor subsequent treatment. For example, if patients have detectable disease after induction therapy, the hematologist may opt to intensify therapy to achieve a deeper response or to push the patient to a stem cell transplant - the only curative treatment for most leukemias. Conversely, if the patient does not have detectable disease there may be an opportunity to deescalate treatment and minimize additive toxicity.

I am sincerely grateful to CAPhO for awarding me the Wild Card Travel Grant and giving me the opportunity to attend the conference. I have learned so much from the conference and I am excited to share what I have learned with my colleagues and implement the most up-to-date evidence in my practice.

Sincerely,

Stephanie Lee