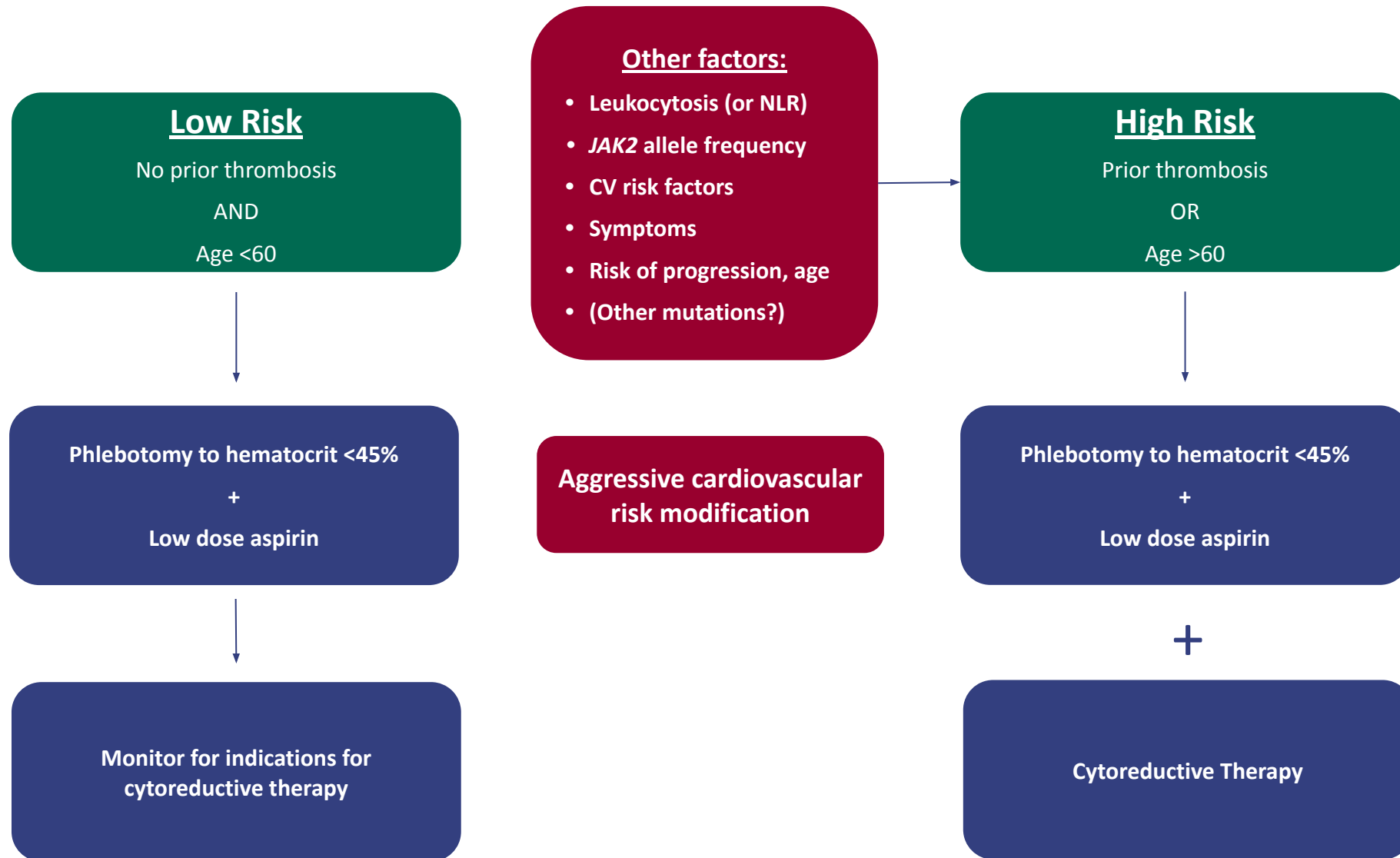


Rethinking PV Management in 2026

Anthony Hunter, MD
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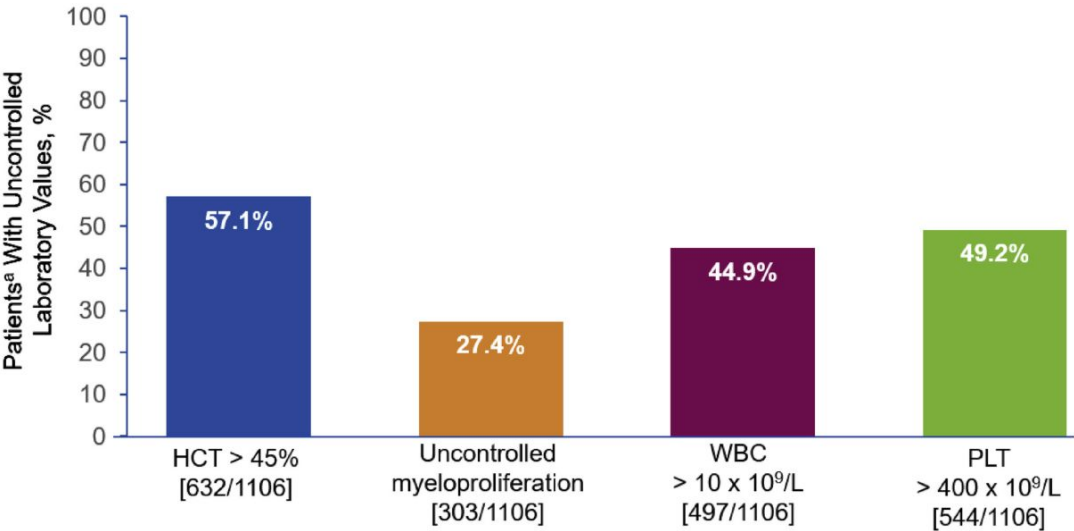
Rethinking Risk Stratification and Treatment Goals



Real-World Data Demonstrates Inadequate Disease Control in US Clinical Practice

Table 2. Treatment patterns.

	Overall (N = 5871)
High risk at diagnosis	<i>n</i> = 4185
First-line cytoreductive treatment,* <i>n</i> (%)	
Hydroxyurea	2068 (49.4)
Ruxolitinib	182 (4.3)
Anagrelide	47 (1.1)
Interferon/PEGylated interferon	2 (0.0)
Busulfan	3 (0.1)
Radiophosphorus	1 (0.0)
No pharmacologic cytoreductive treatment	1882 (45.0)
Low risk at diagnosis	<i>n</i> = 1686
First-line cytoreductive treatment, <i>n</i> (%)	
Hydroxyurea	480 (28.5)
Ruxolitinib	45 (2.7)
Anagrelide	12 (0.7)
Interferon/PEGylated interferon	3 (0.2)
No pharmacologic cytoreductive treatment	1146 (68.0)



Results



Received
HU as 1L
treatment



High-risk
patients
received
pharmacologic
cytoreductive
treatment

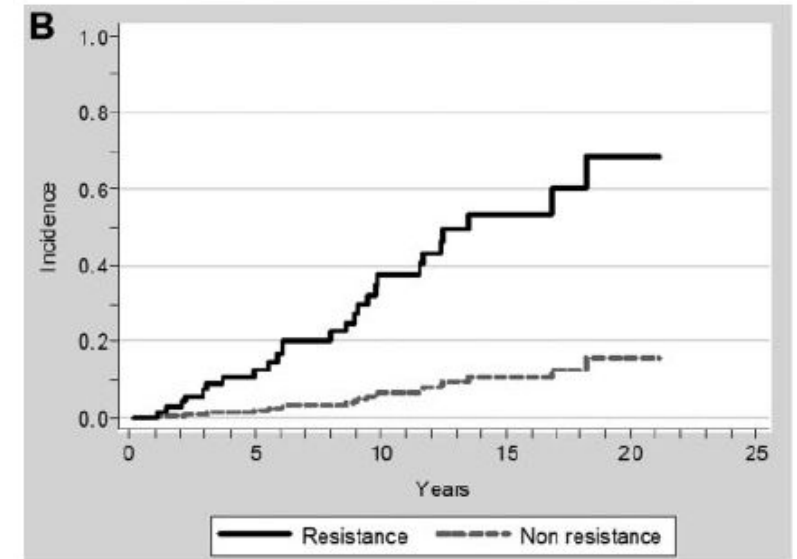
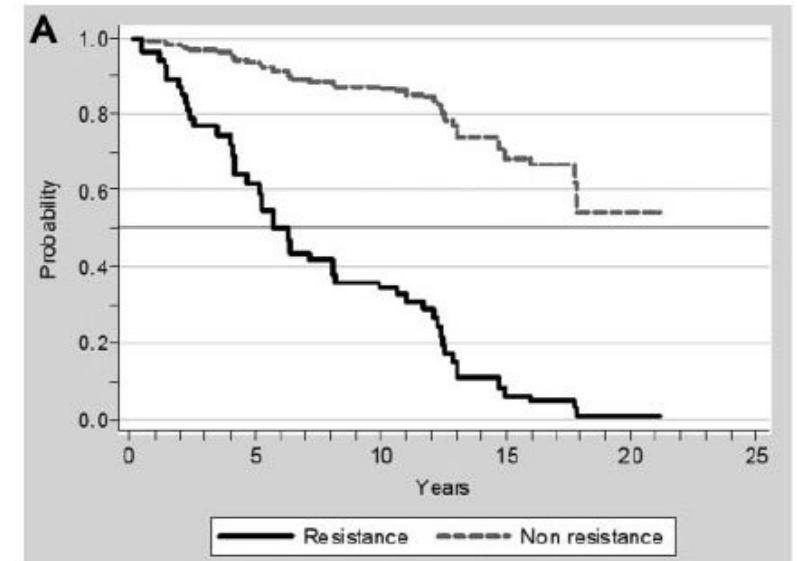


Had
suboptimal
response[†]
after 6
months of
pharmacologic
cytoreductive
treatment

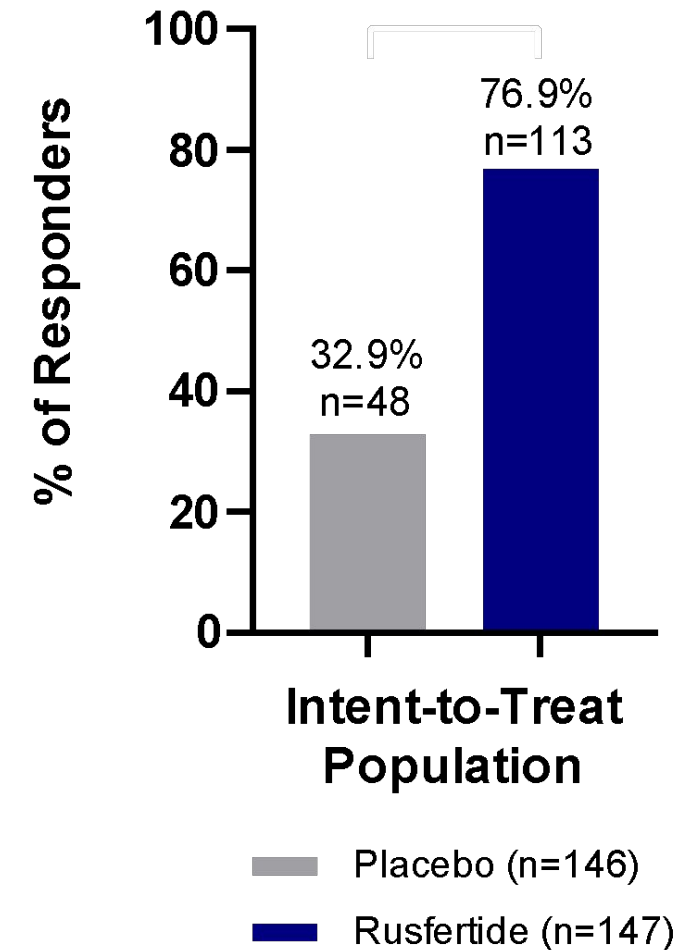
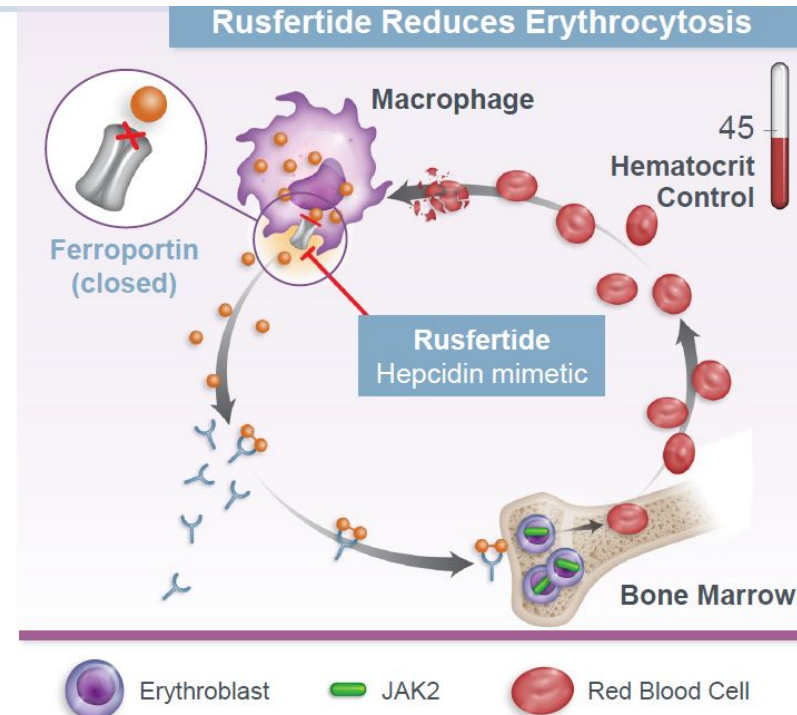
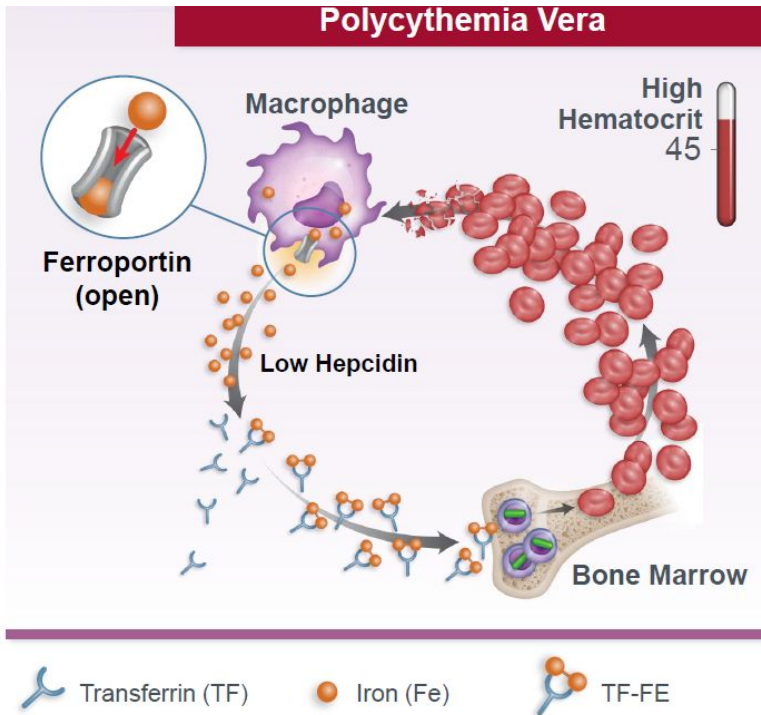
Hydroxyurea Resistance Predicts Inferior OS and Risk of Progression

Definition of Resistance/Intolerance to Hydroxyurea

1. Need for phlebotomy to keep hematocrit <45% after 3 months of at least 2 g/d of hydroxyurea, OR
2. Uncontrolled myeloproliferation (ie, platelet count >400 x 10⁹/L AND WBC count >10 x 10⁹/L) after 3 months of at least 2 g/d of hydroxyurea, OR
3. Failure to reduce massive* splenomegaly by >50% as measured by palpation OR failure to completely relieve symptoms related to splenomegaly after 3 months of at least 2 g/d of hydroxyurea, OR
4. Absolute neutrophil count <1.0 x 10⁹/L OR platelet count <100 x 10⁹/L OR hemoglobin <10 g/dL at the lowest dose of hydroxyurea required to achieve a complete or partial clinicohematologic response,[†] OR
5. Presence of leg ulcers or other unacceptable hydroxyurea-related nonhematologic toxicities, such as mucocutaneous manifestations, GI symptoms, pneumonitis, or fever at any dose of hydroxyurea

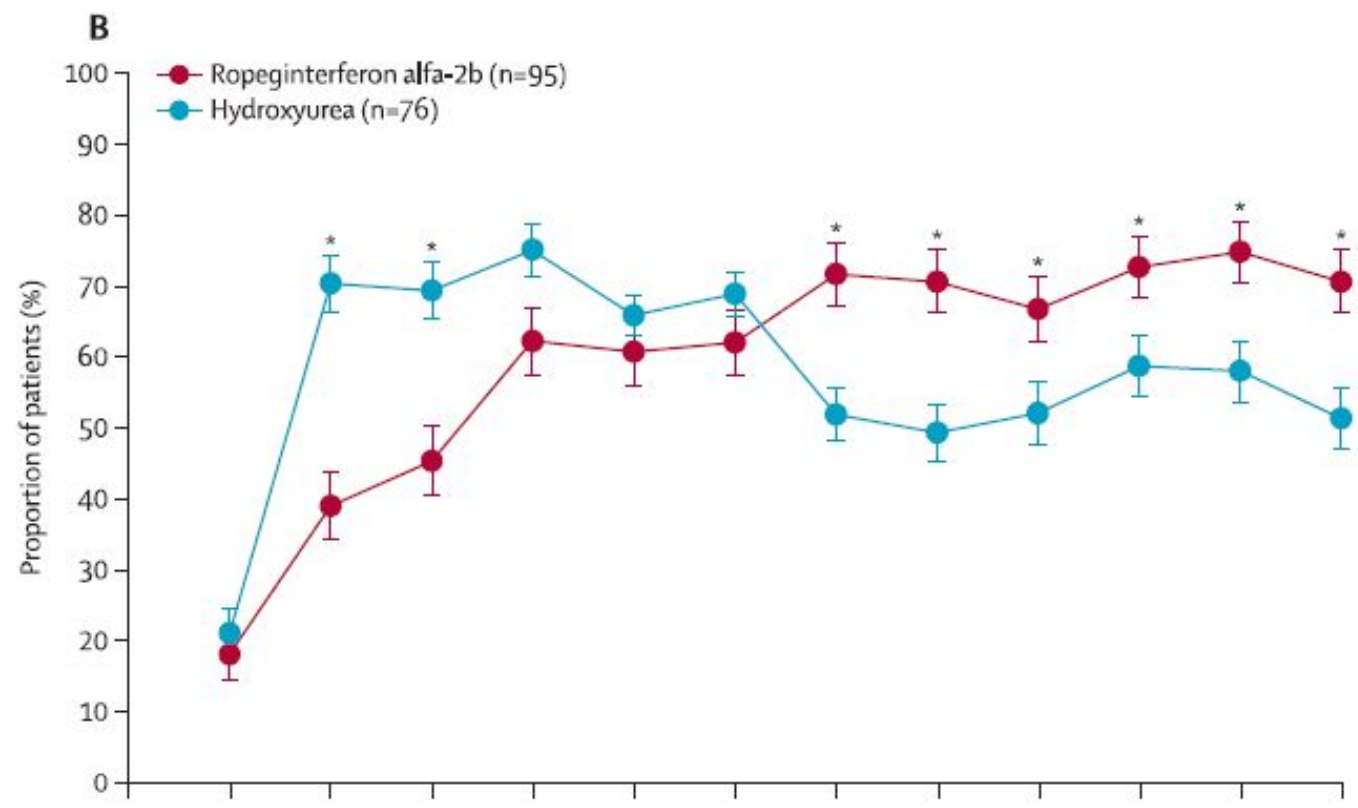


Rusfertide Provides Effective Hematocrit Control in Patients with PV



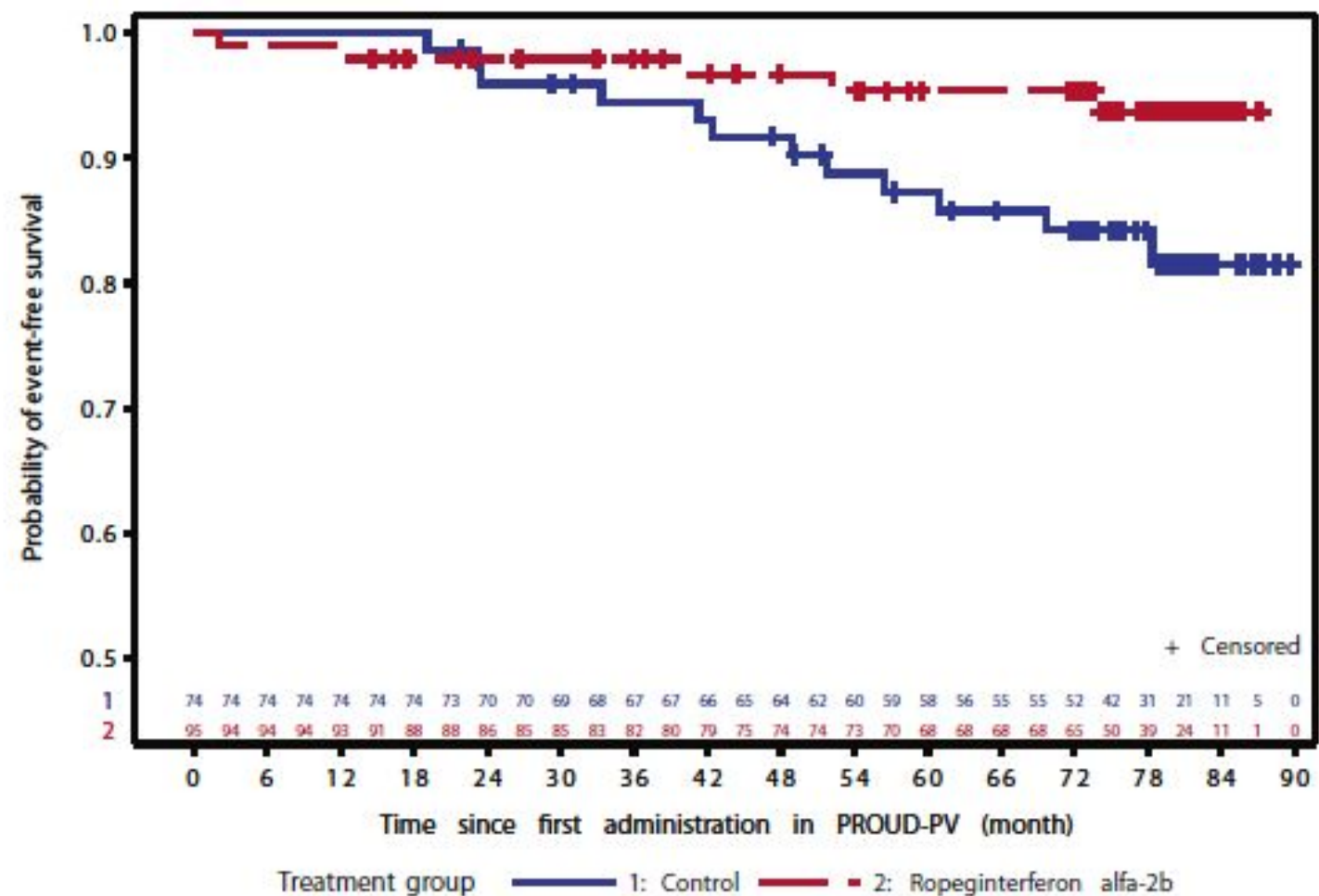
Responder = absence of phlebotomy eligibility (confirmed Hct $\geq 45\%$ and $\geq 3\%$ higher than baseline Hct OR Hct $\geq 48\%$), no phlebotomies, and completion of Part 1a.

Ropeginterferon Provides Effective Long-term Hematologic Control



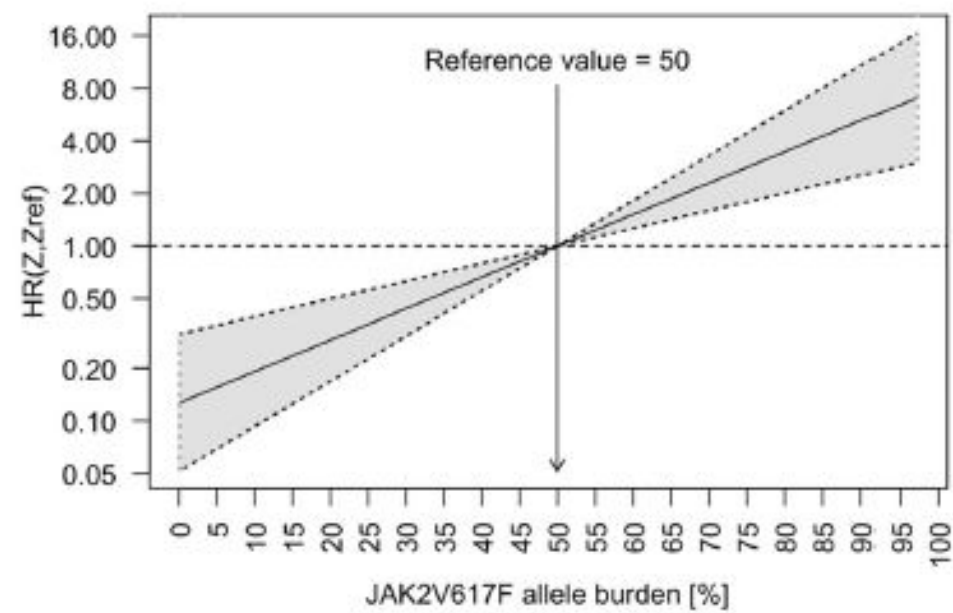
Discontinuation at 5 years	
Hydroxyurea	25.0%
Ropeginterferon	26.3%

Moving Beyond Hematocrit Control: Ropeginterferon Provides Evidence of Disease Modification in PV

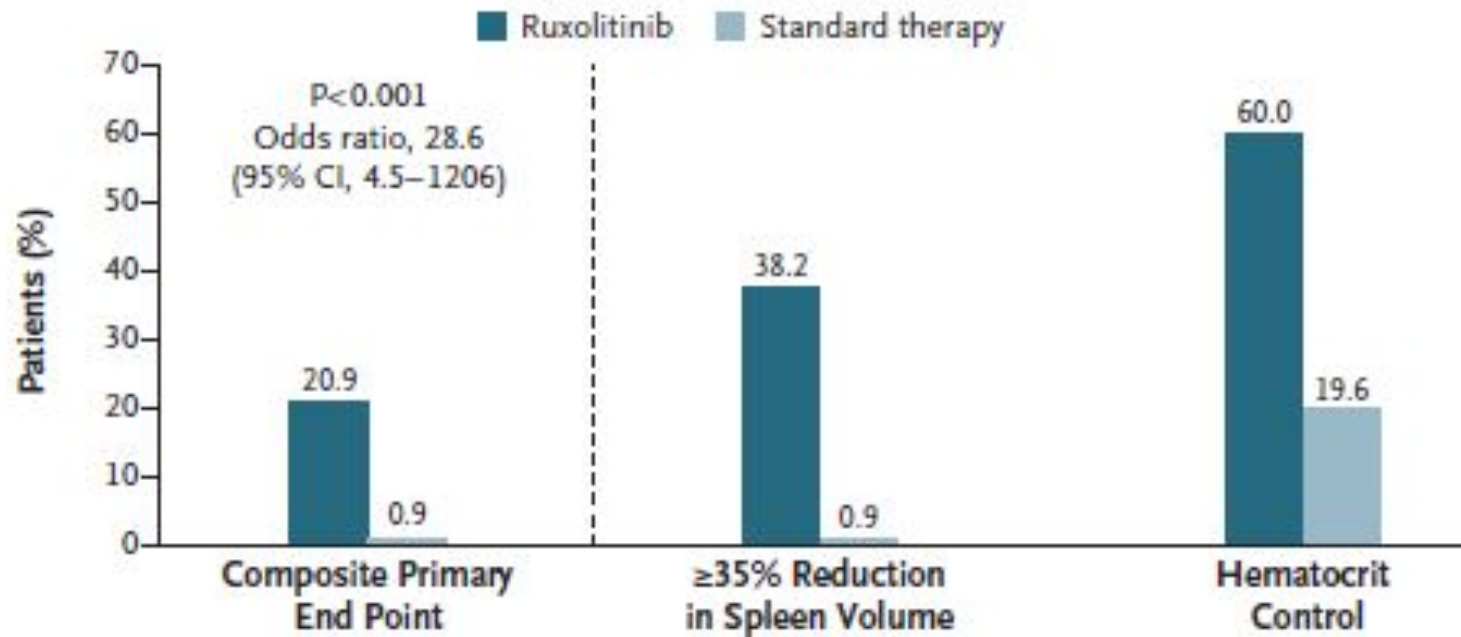


Ropeginterferon Demonstrates Superior Molecular Response which Correlates with EFS

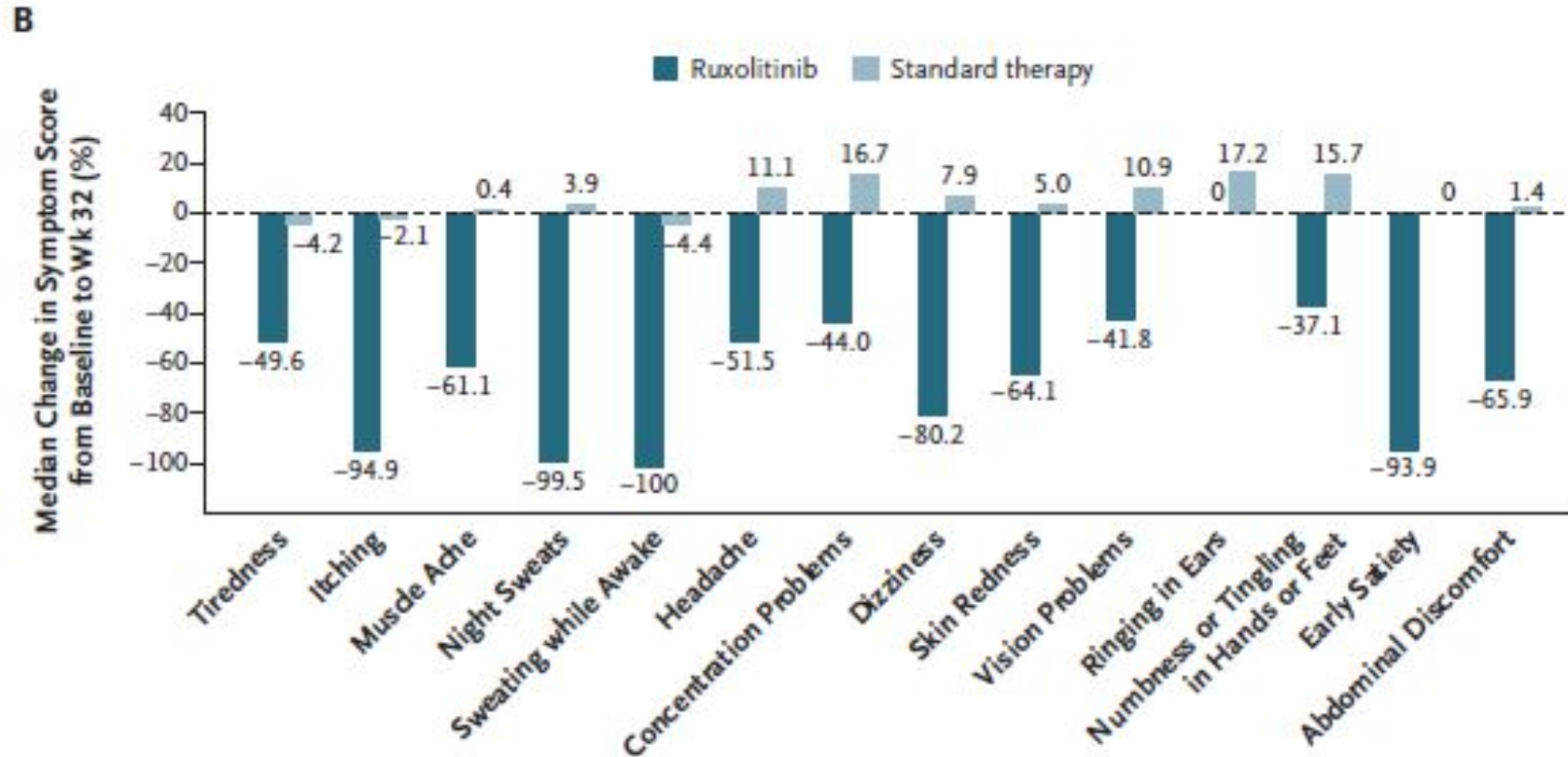
At 6 years	Hydroxyurea	Ropeginterferon
Molecular Response	19.4%	66.0%
Median JAK2 V617F allele burden	50.4% (baseline 39.4%)	8.5% (baseline 37.3%)



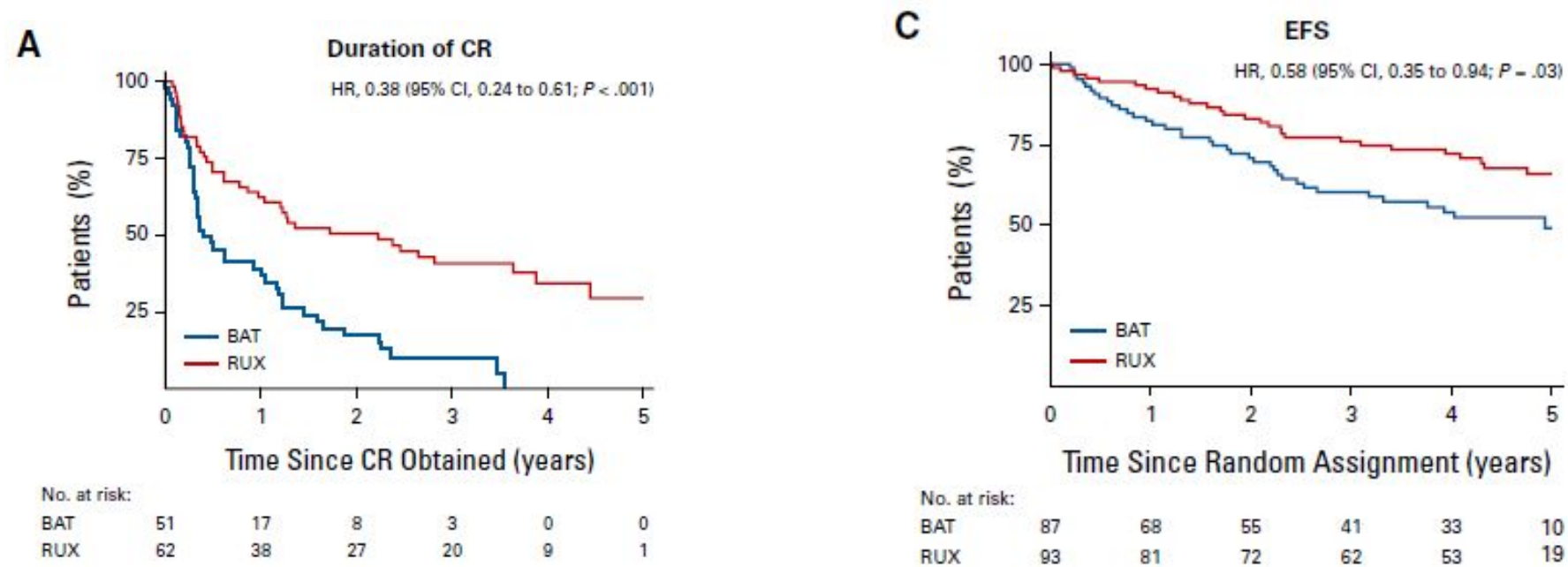
Ruxolitinib is Effective in Patients with Resistance/Intolerance to Hydroxyurea



Ruxolitinib Highly Effective at Controlling PV-Related Symptomatology

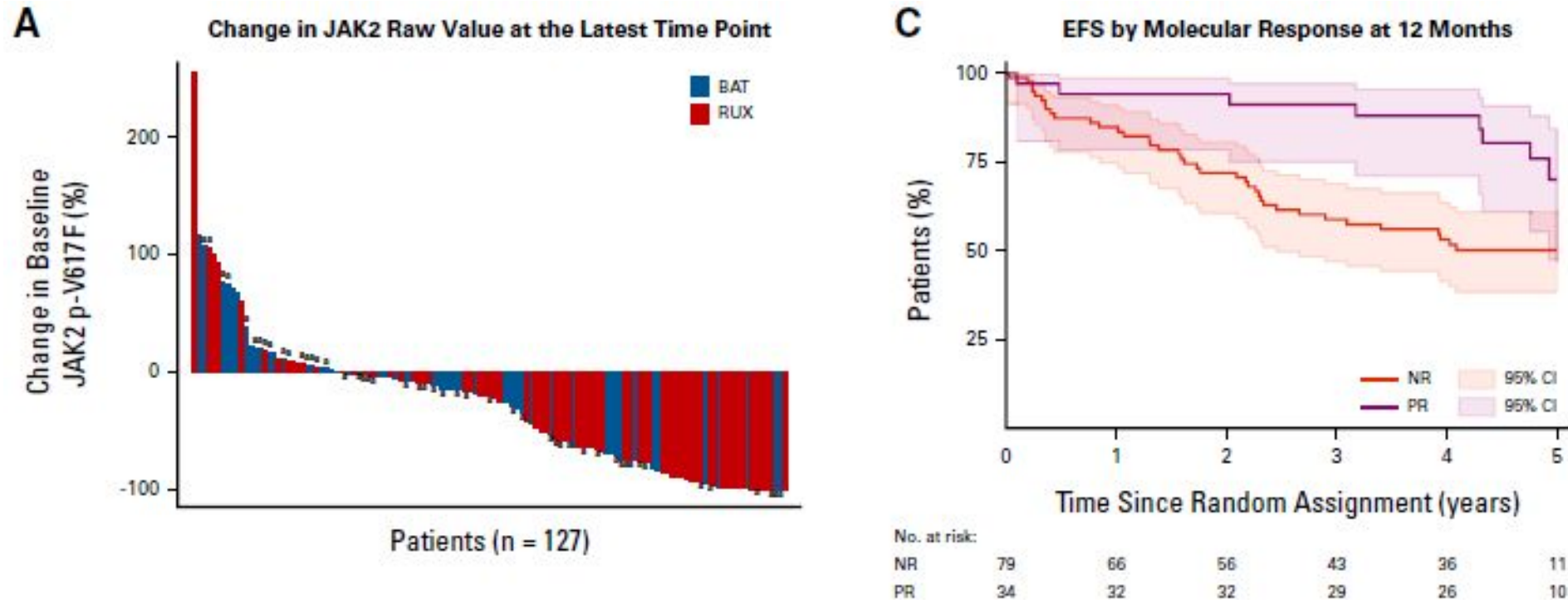


Beyond Hydroxyurea: Ruxolitinib Provides Benefit Beyond Hematologic Control in PV



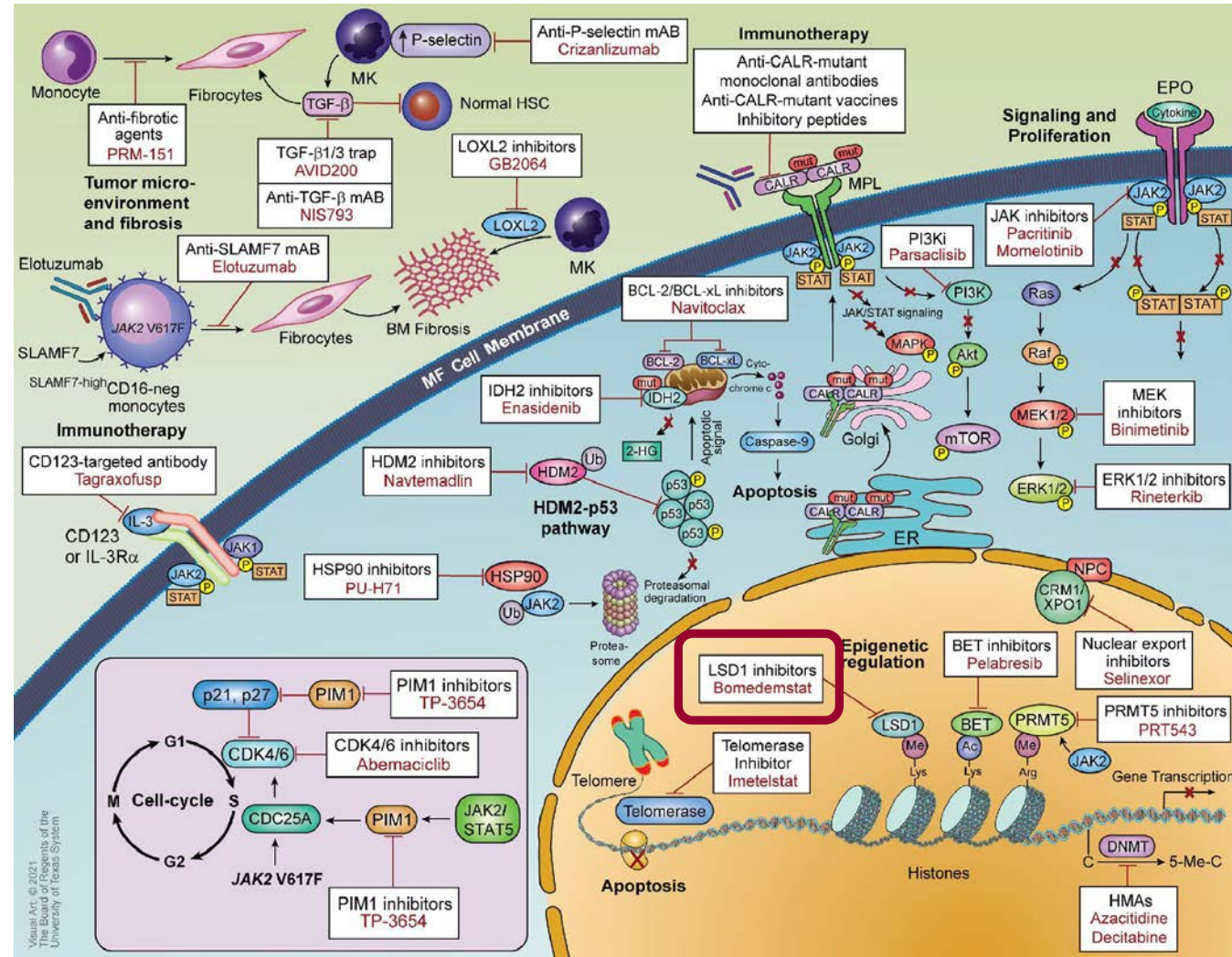
- **CR rate:** 46% vs. 23% with BAT (ORR 97% vs. 93%)

Molecular Response Observed with Ruxolitinib and Correlates with EFS



- **Molecular response (>50% JAK2 V617F VAF reduction):** 56% vs. 25%
- **PFS, EFS, and OS** all correlated with molecular response at last timepoint in total cohort and ruxolitinib-treated patients (not in BAT)

Many Novel Agents are Under Development in MPNs



Key Points

- Decision to initiate cytoreduction should involve factors beyond age >60 and history of thrombosis
- Rusfertide improves hematocrit control and restores iron levels with modest symptom benefit
- Ropeginterferon and ruxolitinib demonstrate potential for broad disease control beyond hematologic response
 - Frequent molecular responses which correlate with EFS
- Therapeutic choice should be individualized based on a variety of patient and disease-related characteristics