MDS in 2021 (and beyond)

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Agenda

- Case
- Diagnosis and Prognosis
- Therapeutic algorithm
- New approved agents
- Clinical trials

Case

- 71 yo male
- Retired teacher
- PMH: HTN, type 2 diabetes, osteoarthritis of his back
- Family history: no cancer
- Married with 2 grown children, 4 grandchildren
- Walks 1 hour daily
- Past smoker, ETOH social

Case-continued

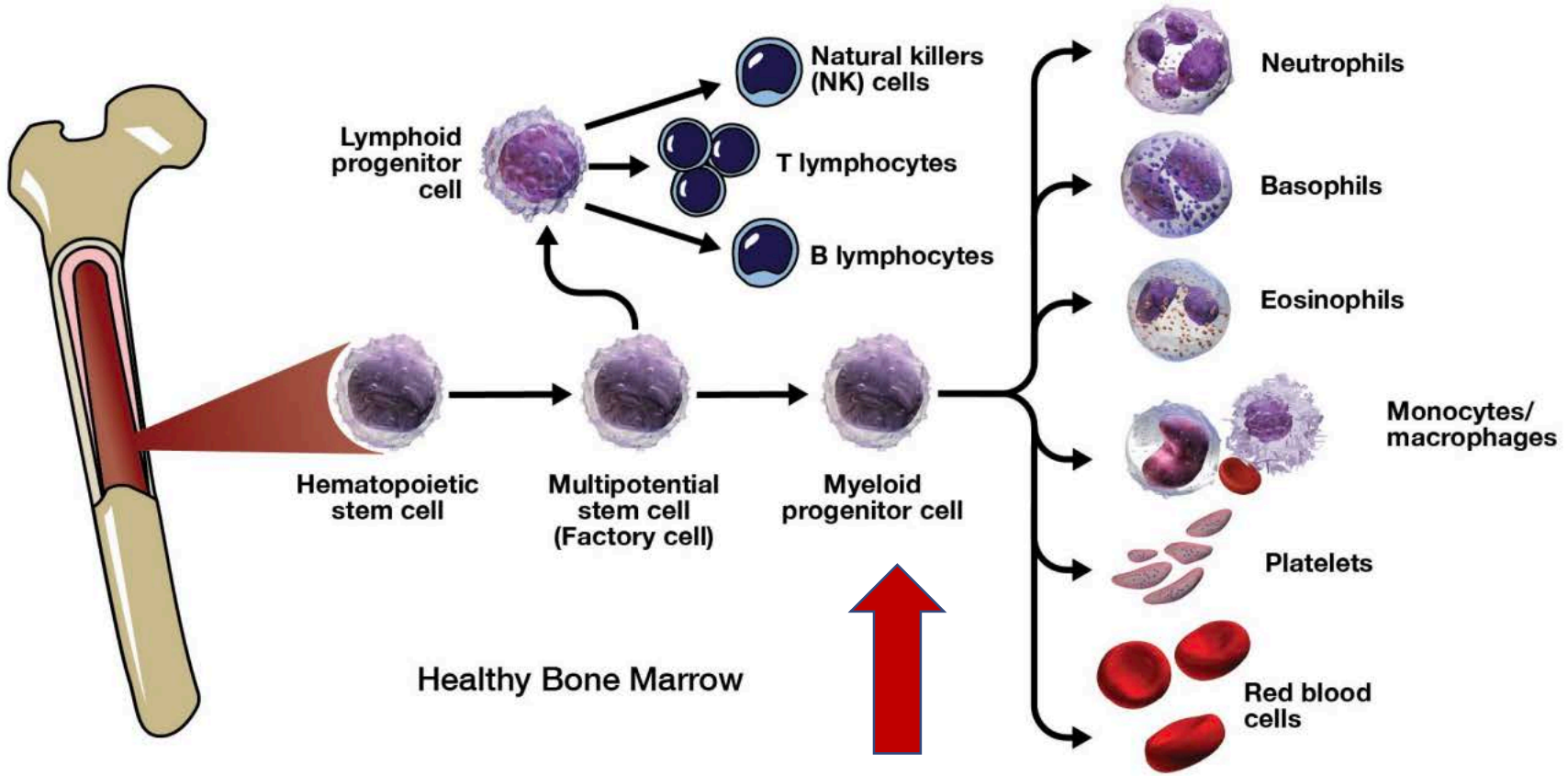
- Complains to GP of increasing fatigue over the last 2 months, decreased stamina, some SOB when climbing stairs
- No weight loss, infections, swelling, skin rashes or change in organ function
- Exam normal
- Blood work: hgb 105 (normal 135-175), WBC 3.5 (normal 5-10),Neutrophils are 1.5, platelets are 130 (normal 150-400)
- Referred to me- Bone marrow biopsy is performed
- Diagnosis is MDS: RCMD with ring sideroblasts; blasts are 3%
- Chromosomes are normal

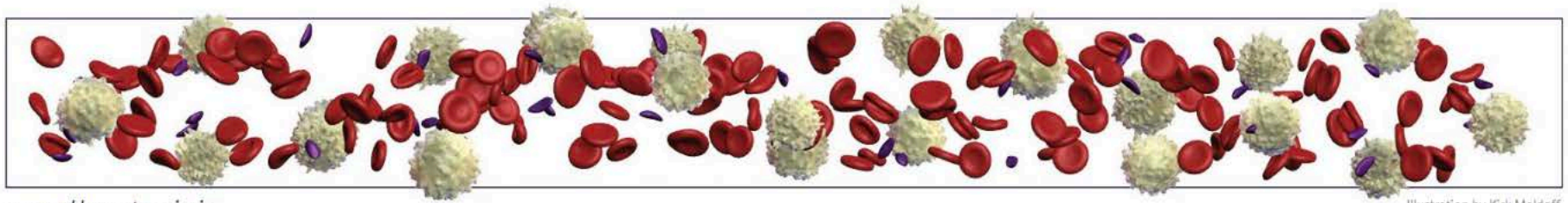
Case continued

- What is this diagnosis?
- What is his prognosis?
- Is it curable?
- What are his treatment options?

Myelodysplastic syndromes

- Heterogenous group of blood cancers (clonal stem cell disorder)
- Incidence is 4/100,000
  - 8700 new cases each year in Canada
- More common in men
- May arise after previous chemotherapy or radiation or occupational exposures
- Presents with low blood counts, infections, bleeding
- 25-30% will develop acute myeloid leukemia
- Bone marrow transplant is the only cure





normal hematopoiesis

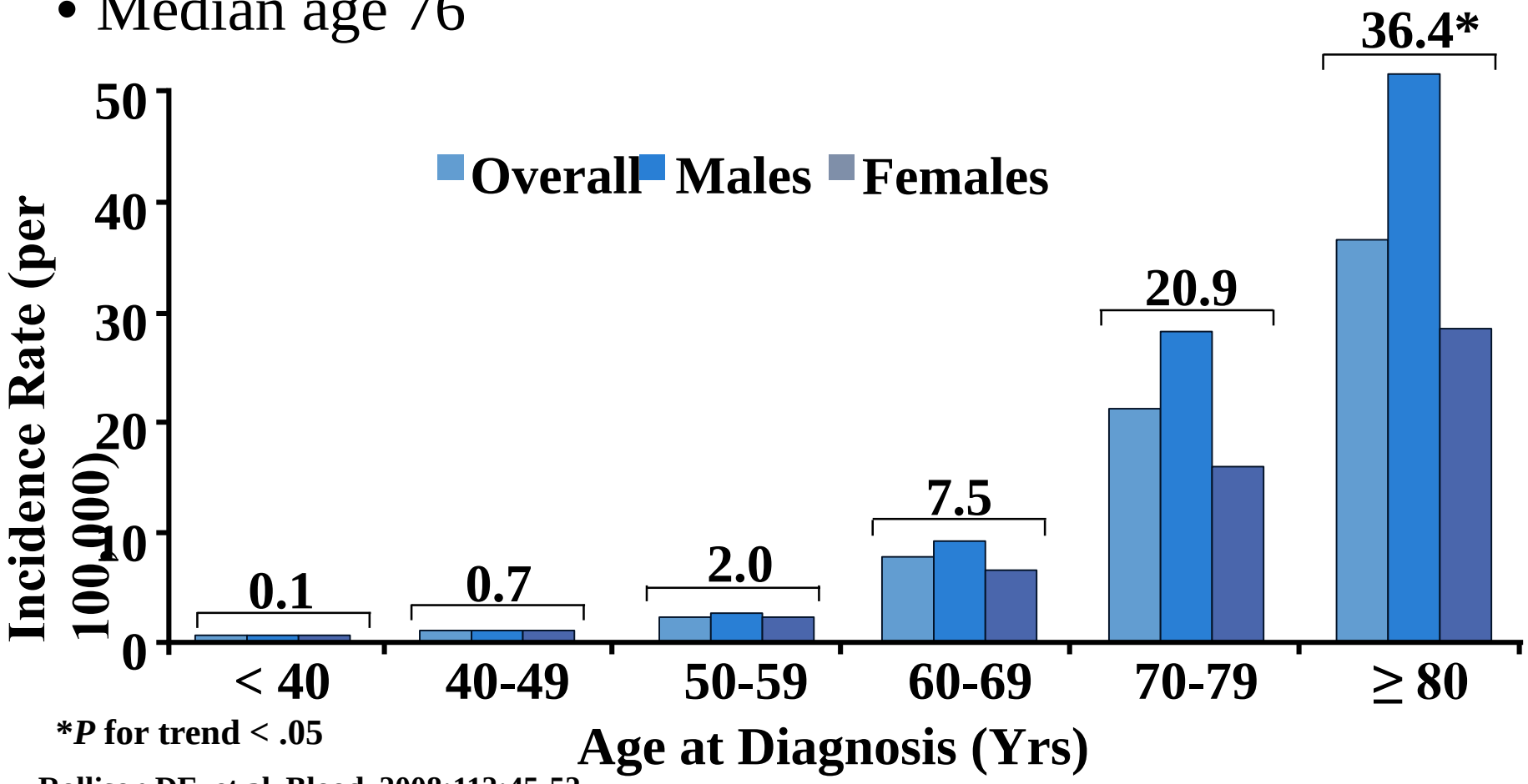
Illustration by Kirk Moldoff

Symptoms of MDS

- Fatigue
- Breathlessness
- Easy bruising or bleeding
- Weight loss
- Loss of stamina
- Asymptomatic

Epidemiology

- Median age 76



*P for trend < .05

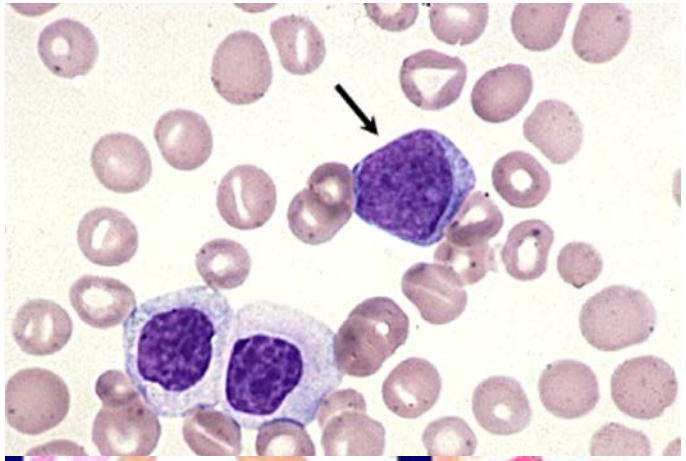
Rollison DE, et al. Blood. 2008;112:45-52.

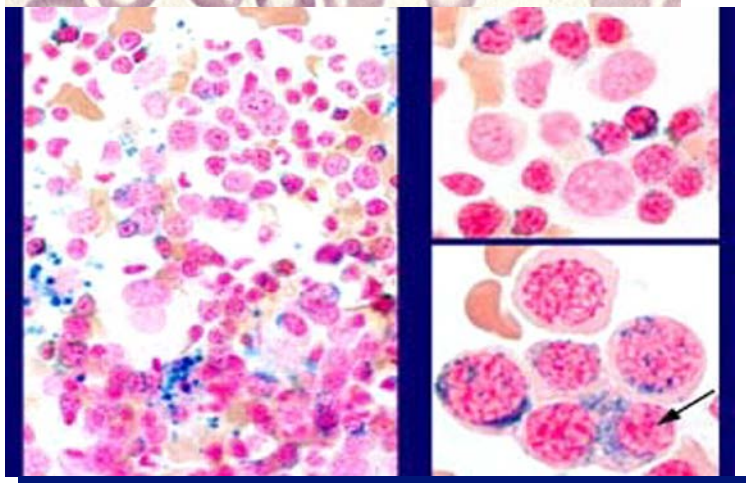
Risk factors

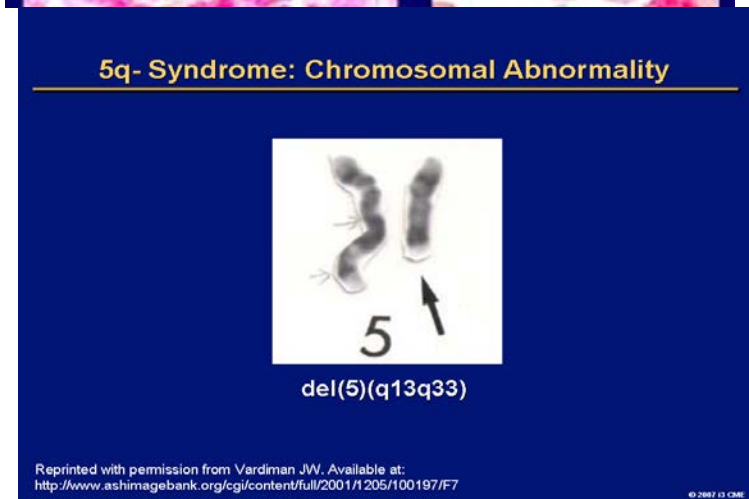
- Unknown in 80%
- Age, male sex
- Mutagenic exposures:
  - Radiation
  - Chemotherapy
    - Alkylators: cyclophosphamide, melphalan
    - Topo-2 inhibitors: mitoxantrone, etoposide
- Environmental/occupational- heavy metals, benzene
- Smoking
- Autoimmunity
- Obesity (BMI $\geq$ 25)
- Hereditary

Diagnosis

- Bone marrow aspirate and biopsy
- Classification using WHO
  - How many blood lineages look abnormal
  - What % blasts
  - Chromosome del5q or other chromosome abnormalities
  - Are there ring sideroblasts







Prognosis

- IPSS
- IPSS-R
- IPSS-M

- Provide estimations of overall survival (years) and probability of developing AML

Prognostic Values for Determining IPSS-R Score

Value/Score	0	0.5	1	1.5	2	3	4
Cytogenetics Risk Group	Very Good		Good		Intermediate	Poor	Very Poor
Blasts (%)	<2%		>2%-<5%		5-10%	>10%	
Hemoglobin (g/dL)	≥10		8-<10	<8			
Platelets	≥100,000	50-<100,000	<50,000				
ANC	≥0.8	<0.8					

Cytogenetics play a very important role in estimating prognosis for a patient with MDS. The IPSS-R is based on a revised grouping of cytogenetic abnormalities (see: *IPSS-R calculator at* www.mds-foundation.org/ipss-r-calculator)

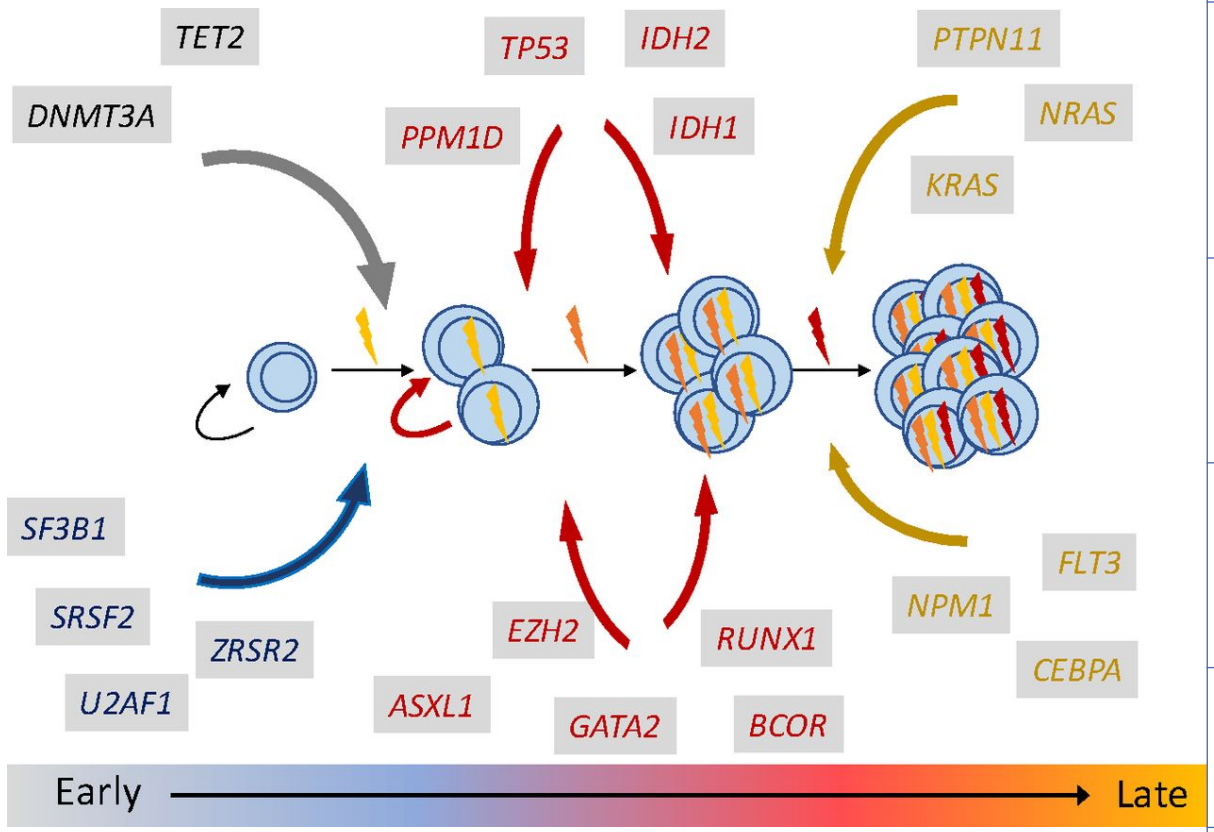
Cytogenetic Risk Group	Cytogenetic Abnormalities	Estimated Survival
Very Good	del(11q), -Y	5.4 years
Good	Normal, del(5q), del(12p), del(20q), double including del(5q)	4.8 years
Intermediate	del(7q), +8, +19, i(17q), any other single or double independent clones	2.7 years
Poor	-7, inv(3)/t(3q)/del(3q). double including -7/del(7q) Complex: 3 abnormalities	1.5 years
Very Poor	Complex: >3 abnormalities	0.7 years

There are five overall risk scores in the IPSS-R with estimated survival and median risk of AML:

Score	≤1.5 Very Low	>1.5-3 Low	>3-4.5 Intermediate	>4.5-6 High	>6 Very High
Overall Survival (mean)	8.8 years	5.3 years	3.0 years	1.6 years	0.8 years
Risk of AML in 25% of patients (median)	Not reached	10.8 years	3.2 years	1.4 years	0.73 years

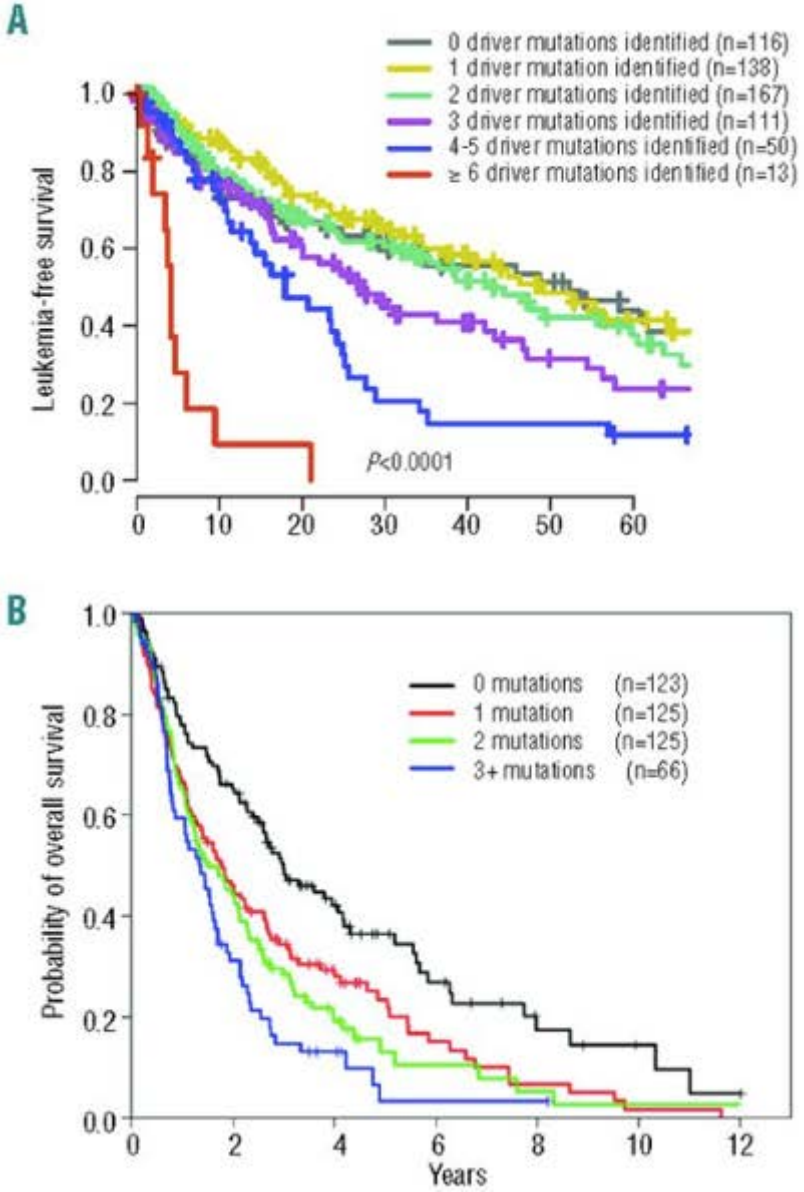
Our patient:
IPSS-R is 2: low risk

Uncoding the genetic heterogeneity of myelodysplastic syndrome

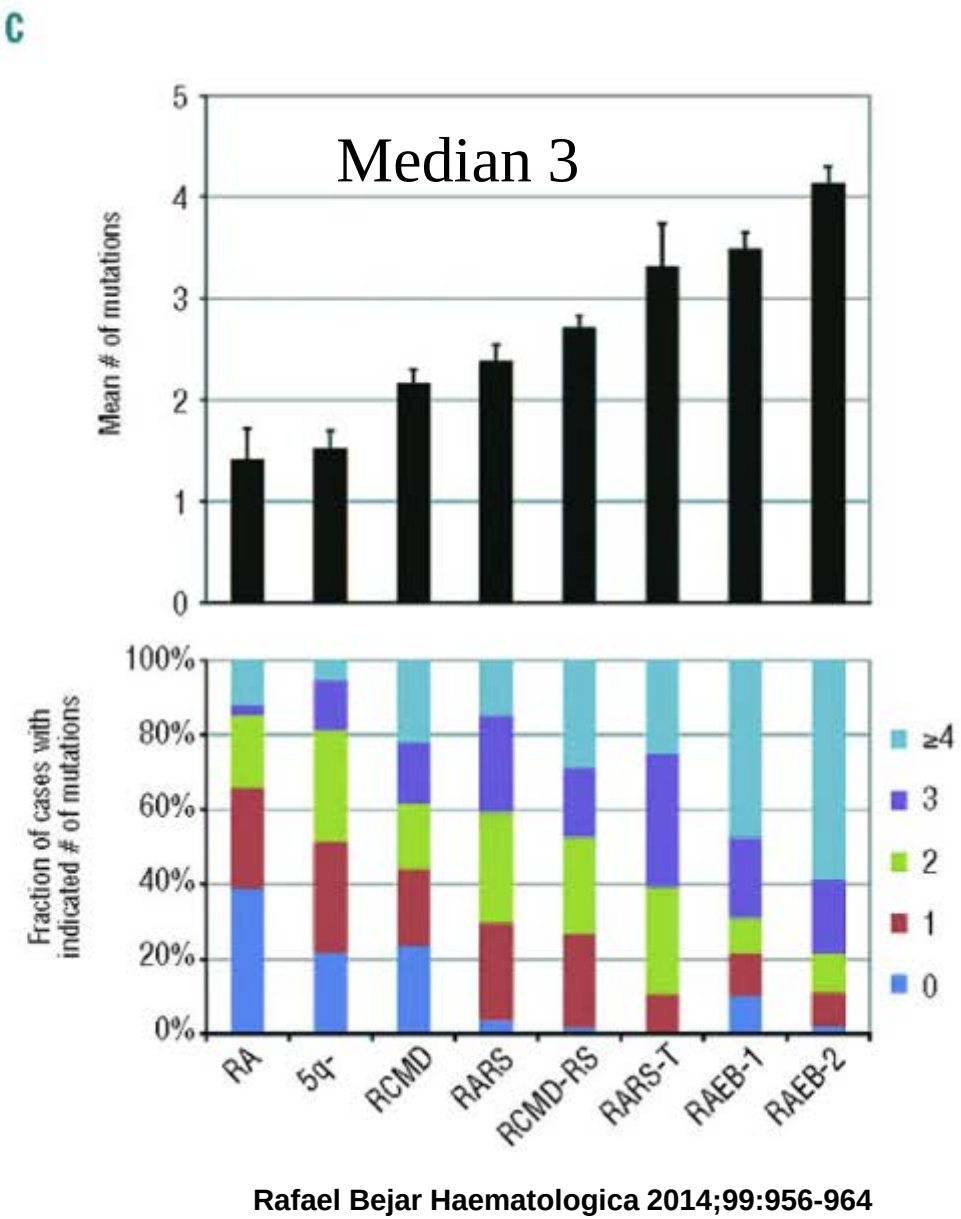


R. Coleman Lindsley, Am Soc Hematol Educ Program, 2017, Figure 2.

Pathways and genes	Frequency, %
RNA Splicing	
SF3B1	15–30
SRSF2	10–20
U2AF1	<10
ZRSR2	<10
DNA methylation	
TET2	20–30
DNMT3A	10–15
IDH1/IDH2	5
Chromatin modification	15–20
ASXL1	
EZH2	5
RAS pathway	
CBL	<5
NRAS/KRAS	<5
Transcription	
RUNX1	10
BCOR	<5
Tumor suppressor	
TP53	5



Papaemmanuil E et al. Blood (2013)
Haferlach T et al., Leukemia (2014)

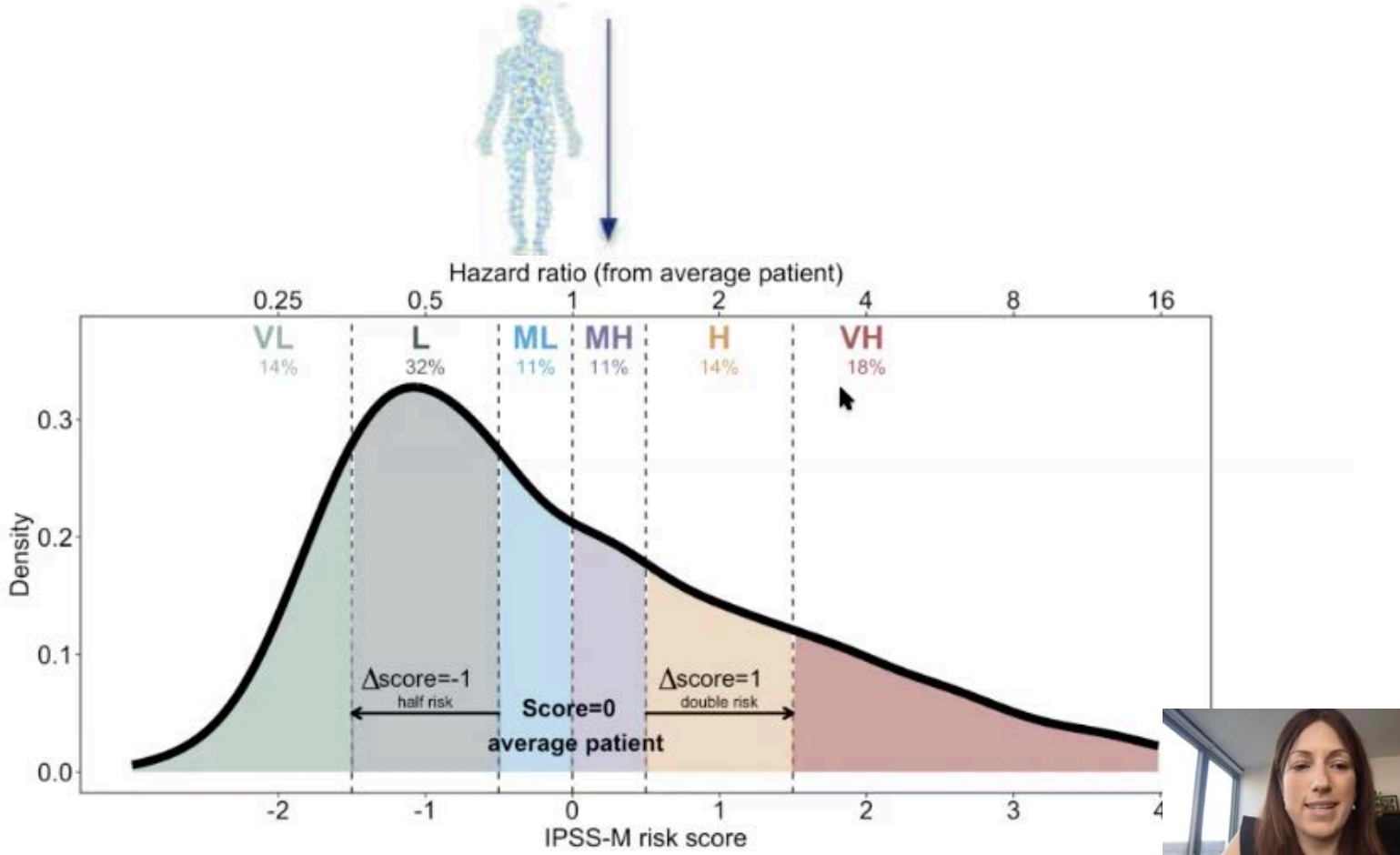


Rafael Bejar Haematologica 2014;99:956-964

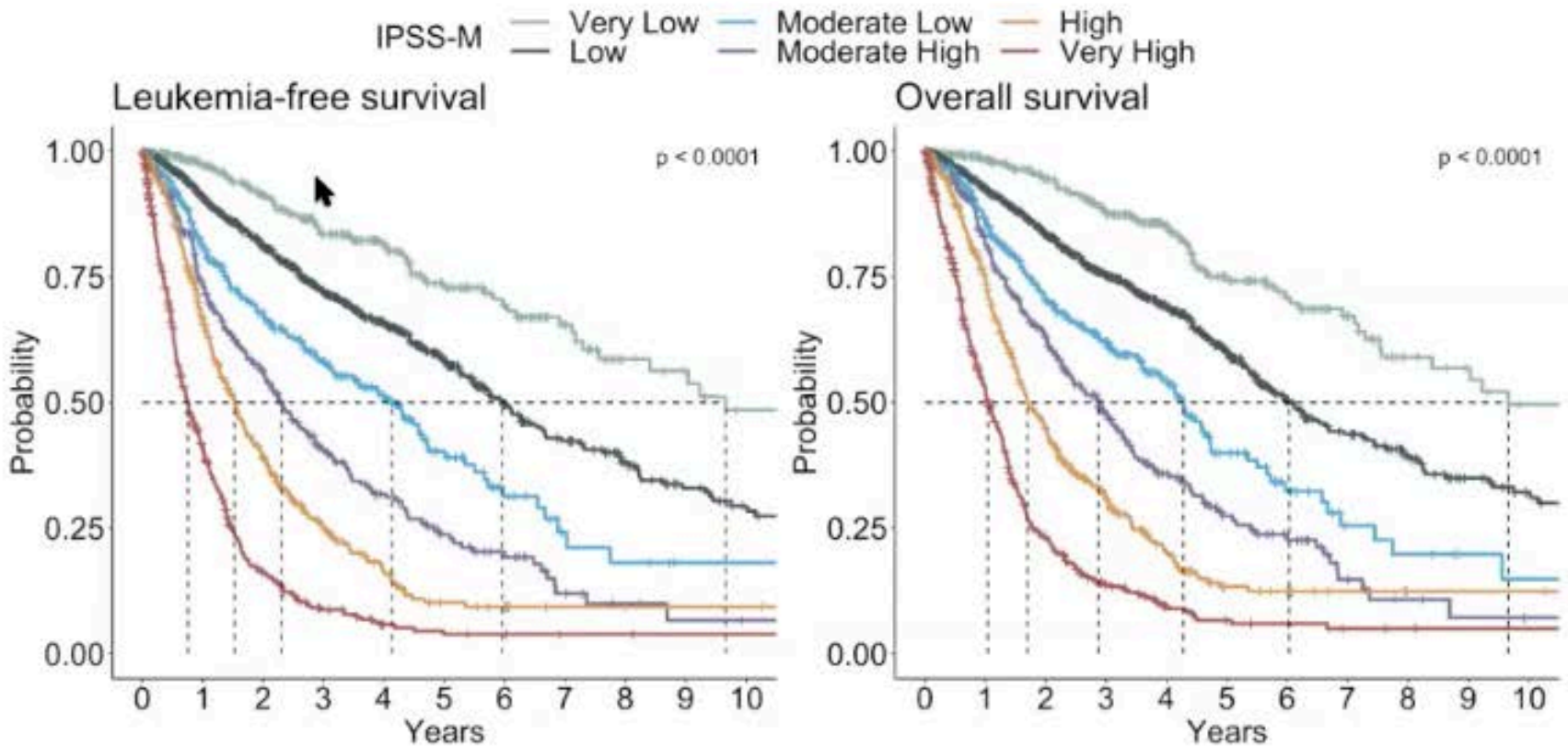
Category	Variable
confounder	½₀ **Age**, in years **Sex**:Male **Type**:Secondary/Therapy-related
clinical	½ **Bone Marrow Blasts**, in % ½₁₀₀ min(**Platelets**,250), in x10⁹/L **Hemoglobin**, in g/dL
cytogenetics	**IPSS-R category vector**[4]
gene main effects 22 variables, 21 genes	*TP53*[mult] *MLL*[PTD] *FLT3*[ITD+TKD] *SF3B1*[HR] *NPM1* *RUNX1* *IDH2* *NRAS* *ETV6* *EZH2* *SETBP1* *CBL* *SRSF2* *U2AF1* *DNMT3A* *ASXL1* *KRAS* *NF1* *STAG2* *BCOR* *CEBPA* *SF3B1*[*]
gene residuals[3] 1 variable, 17 genes	min(**Nres**,2)

Patient tailored risk score

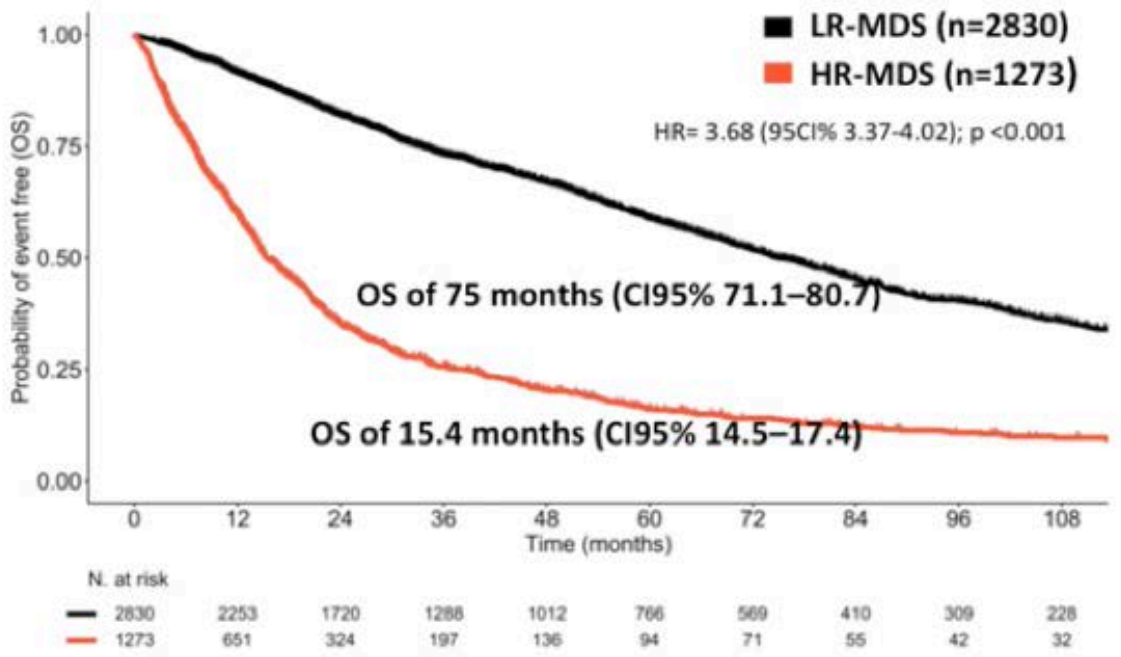
$$\text{score} = \frac{1}{\log 2} \sum_{\text{variables } j} w_j (x_j - x_j^{\text{mean}}) = -1.1873 + \frac{1}{\log 2} \sum_{\text{variables } j} w_j x_j$$



IPSS-M risk strata

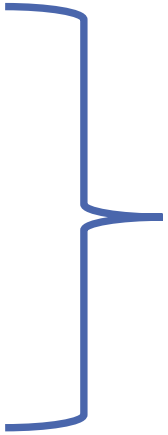


IPSS-R score of > 3.5 distinguishes lower from higher risk disease



Other prognostic factors

- Fatigue
- Frailty
- Disability
- Comorbidity



Refine prognosis
further by 20-30%

Goals of Treatment

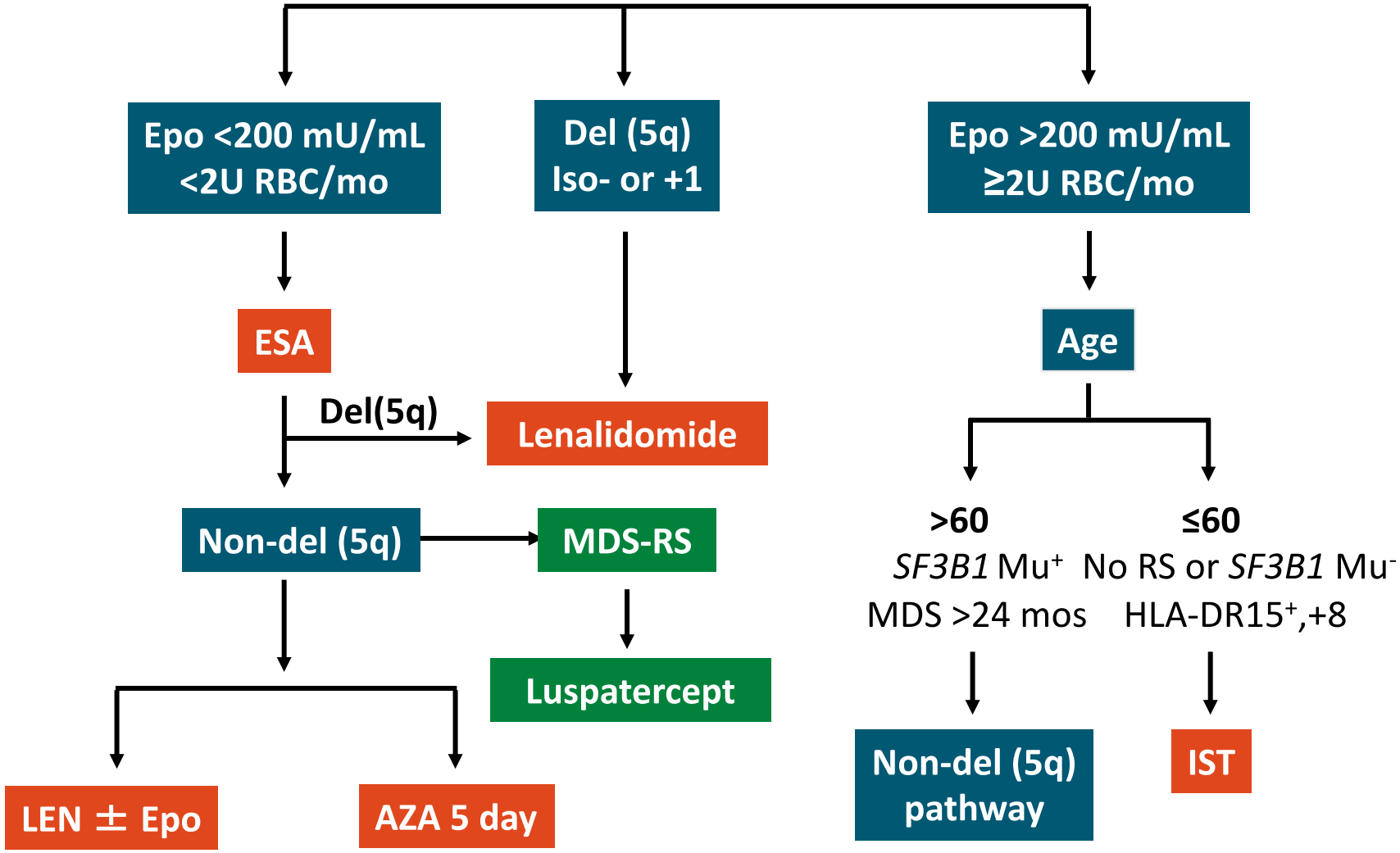
Lower risk disease

- Improve BM function
- Decrease or eliminate transfusions
- Improve quality of life
- Improve overall survival

Higher risk disease

- Delay time to acute leukemia
- Improve overall survival
- Improve quality of life
- Decrease or eliminate transfusions

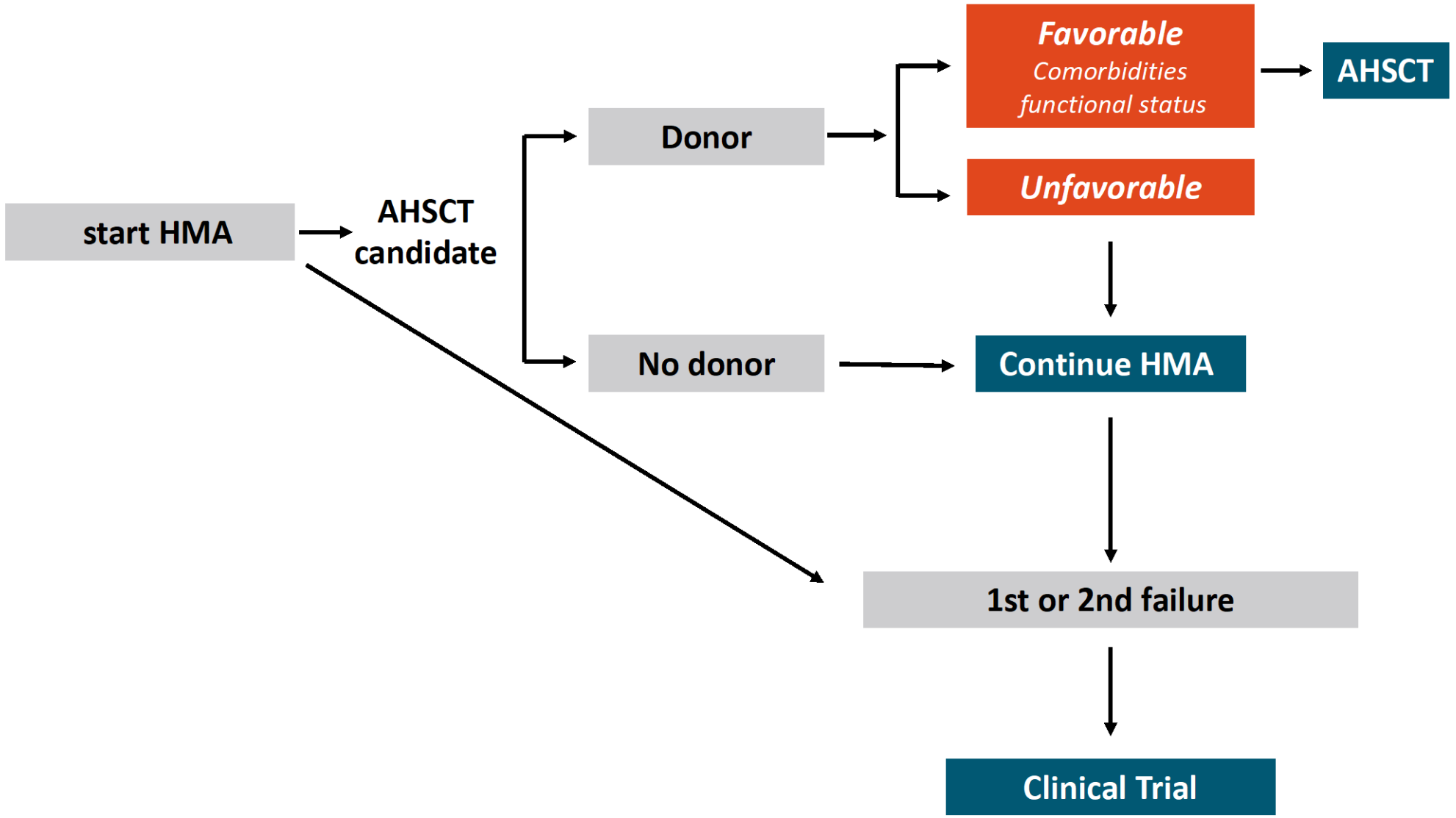
Anemia Management Algorithm in LR-MDS



Volpe. Ther Adv Hematol. 2021;12:2040620720986641.

Slide credit: clinicaloptions.com

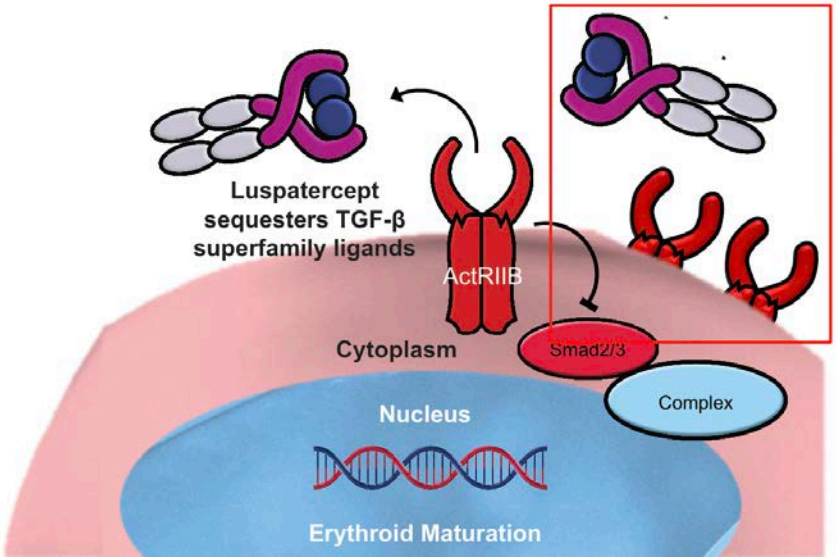
Treatment Algorithm: Higher-Risk MDS

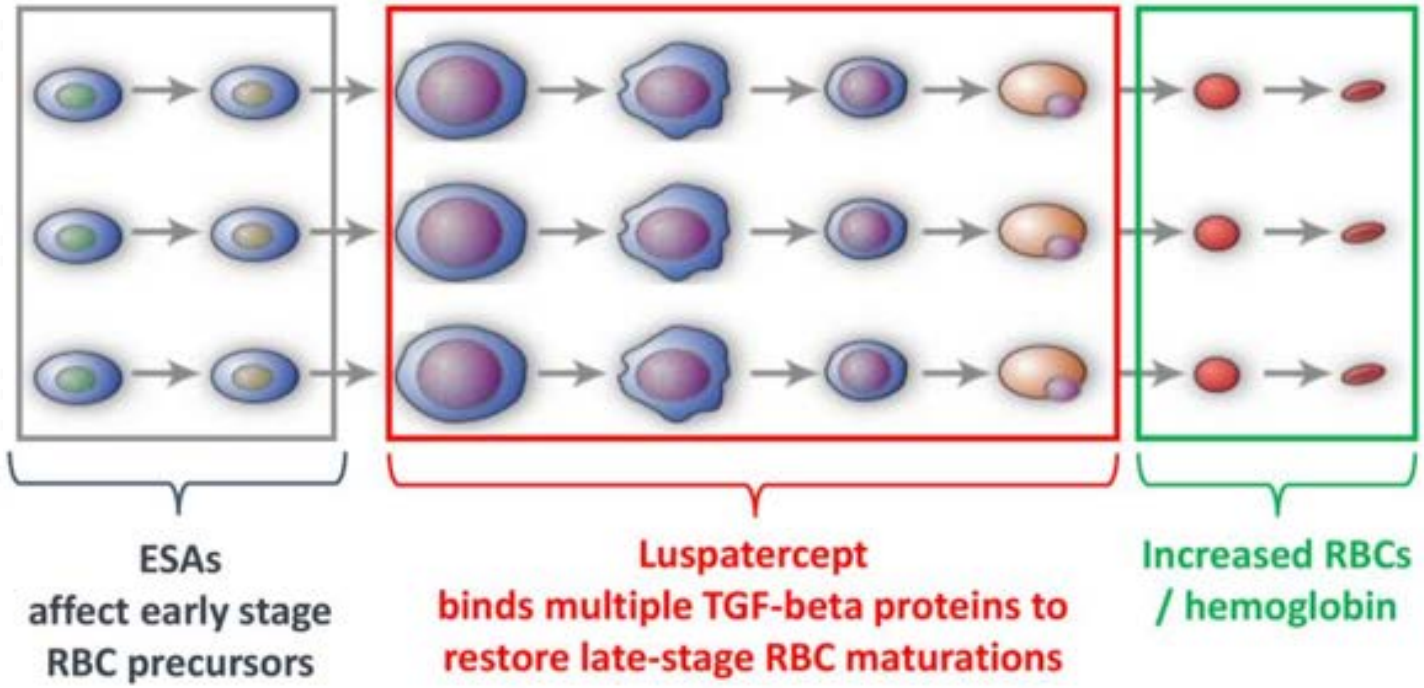


Slide credit: clinicaloptions.com

Luspatercept's Novel Mechanism Restores RBC's Ability to Mature

ACCELERON





Luspatercept is an ActRIIB/IgG1 Fc recombinant fusion protein[1,2]

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Luspatercept in Patients with Lower-Risk Myelodysplastic Syndromes

P. Fenaux, U. Platzbecker, G.J. Mufti, G. Garcia-Manero, R. Buckstein, V. Santini, M. Díez-Campelo, C. Finelli, M. Cazzola, O. Ilhan, M.A. Sekeres, J.F. Falantes, B. Arrizabalaga, F. Salvi, V. Giai, P. Vyas, D. Bowen, D. Selleslag, A.E. DeZern, J.G. Jurcic, U. Germing, K.S. Götze, B. Quesnel, O. Beyne-Rauzy, T. Cluzeau, M.-T. Voso, D. Mazure, E. Vellenga, P.L. Greenberg, E. Hellström-Lindberg, A.M. Zeidan, L. Adès, A. Verma, M.R. Savona, A. Laadem, A. Benzohra, J. Zhang, A. Rampersad, D.R. Dunshee, P.G. Linde, M.L. Sherman, R.S. Komrokji, and A.F. List

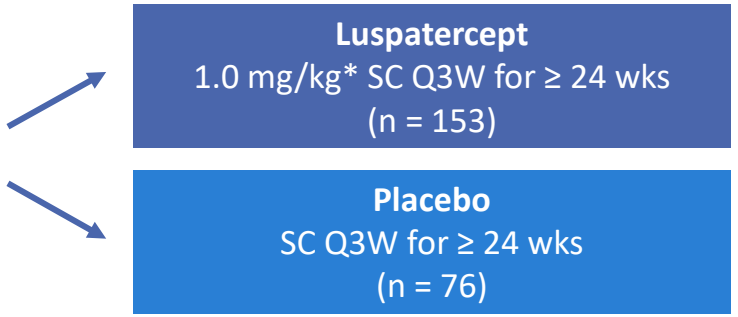
ABSTRACT

MEDALIST: Study Design

- International, randomized, double-blind, placebo-controlled phase III trial

Randomized 2:1

Patients ≥ 18 yrs of age with non-del(5q) MDS and ring sideroblasts per WHO 2016 criteria; IPSS-R risk that is very low, low, or intermediate; refractory, intolerant, or ineligible for ESAs; RBC transfusion dependent
(N = 229)



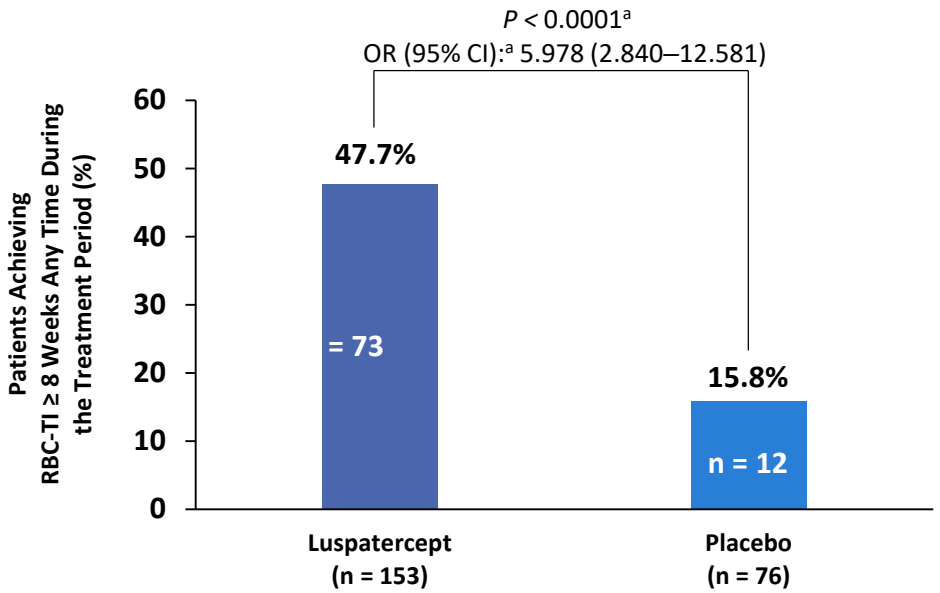
*Could be titrated up to 1.75 mg/kg if needed.

Treatment continued until lack of clinical benefit or PD

- Primary endpoint: RBC-TI for ≥ 8 wks between Wk 1 and Wk 24
- Secondary endpoints: RBC-TI for ≥ 12 wks between Wk 1 and Wk 24, modified hematologic improvement–erythroid response per IWG 2006 criteria, DoR, Hb change from baseline

Fenaux. ASH 2019. Abstr 841. NCT02631070.

RBC-TI ≥ 8 weeks Achieved any time during treatment period



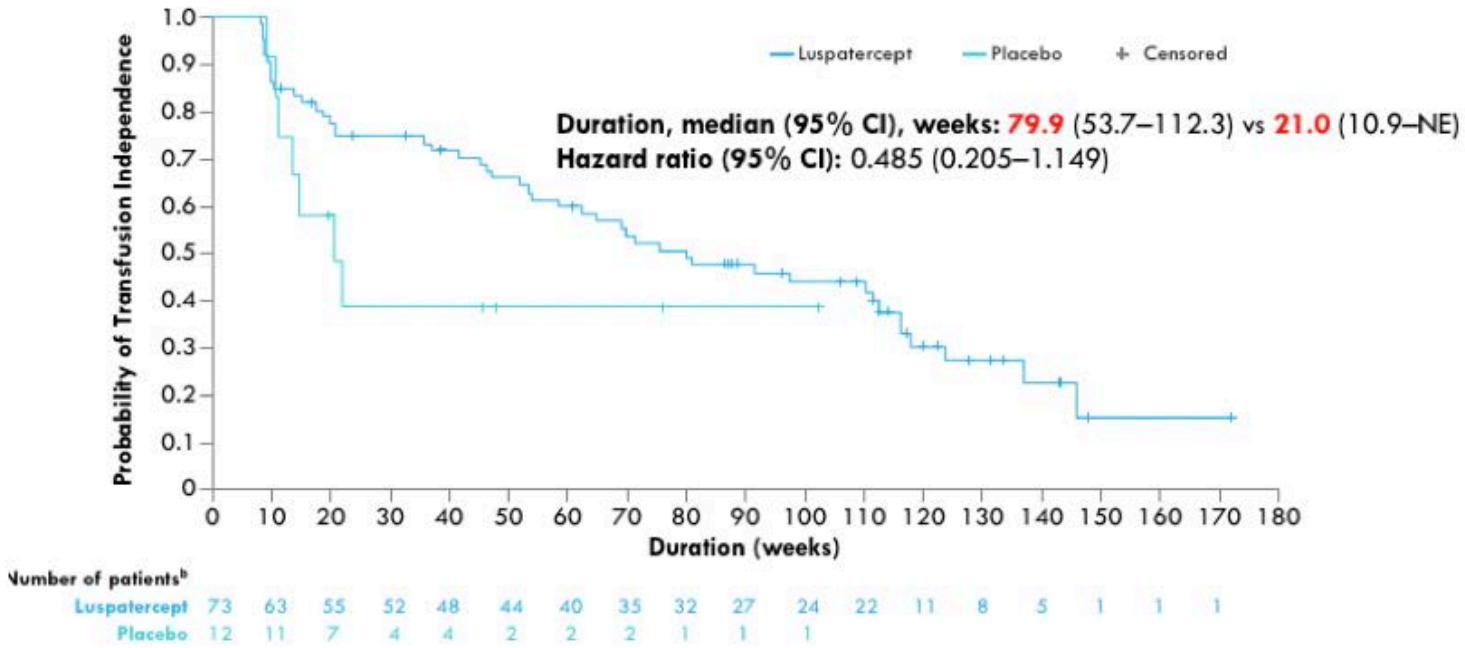
- **Primary endpoint previously reported:** **37.9%** luspatercept versus **13.2%** placebo patients achieved RBC-TI ≥ 8 weeks during Weeks 1–24 ($P < 0.0001$)[1]
- **Secondary endpoint :** **52.9%** luspatercept versus 11.8% placebo patients achieved modified HI-E responses per IWG 2006 criteria

CI, confidence interval; OR, odds ratio.

Data cutoff: July 1, 2019.

1. MEDALIST authors. Blood. 2018;132:abstract 1.

Luspatercept



Over 48 weeks:

12 fewer units of blood and 6 fewer transfusions

How is luspatercept given?

- Under the skin, every 3 weeks
- 3 dose escalations 6 weeks (1, 1.33, 1.75 mg/kg)

Side effects of luspatercept

System Organ Class/Preferred Term	Luspatercept (N=153) Any Grade, n (%)	Placebo (N=76) Any Grade, n (%)
General disorder or administration-site condition		
Fatigue[a]	70 (46)	19 (25)
Gastrointestinal disorder		
Diarrhea	34 (22)	7 (9)
Nausea[b]	31 (20)	6 (8)
Constipation	17 (11)	7 (9)
Nervous system disorder		
Dizziness	30 (20)	4 (5)
Headache	24 (16)	5 (7)
Syncope/presyncope	10 (7)	1 (1)
Renal and urinary disorders		
Renal impairment[b,c]	11 (7)	2 (3)

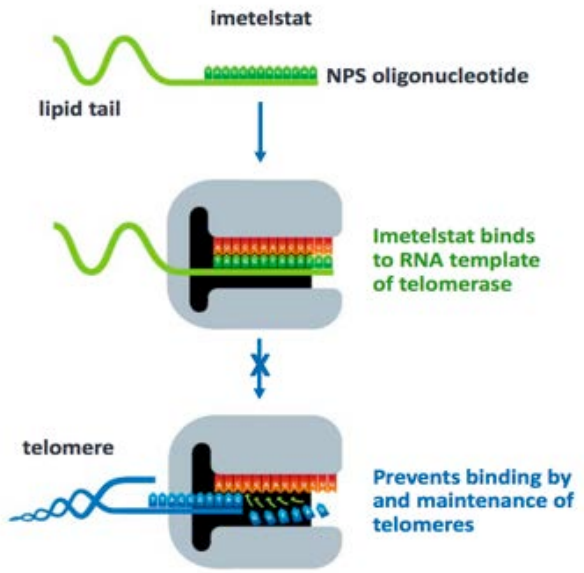
Side Effects of Luspatercept

Organ System Class/Preferred Term	Luspatercept (N=153) Any Grade, n (%)	Placebo (N=76) Any Grade, n (%)
Musculoskeletal or connective-tissue disorder		
Back pain[a]	29 (19)	5 (7)
Myalgia	13 (8)	5 (7)
Infection or infestation		
Bronchitis[a]	17 (11)	1 (1)
Urinary tract infection[a]	17 (11)	4 (5)
Upper respiratory tract infection	15 (10)	3 (4)
Viral upper respiratory tract infection	12 (8)	4 (5)
Influenza	10 (7)	0 (0)
Vascular Disorders		
Hypertension[b]	13 (9)	7 (9)

Other agents for transfusion dependent lower risk MDS

- Imetelstat
- Roxadustat
- Decitabine-cedazuridine

Imetelstat : A first-in-class telomerase inhibitor



IMERGE: IMETELSTAT PHASE II/III IN LOWER RISK MDS

LR MDS patients:

- Non-del(5q), IPSS low or int-1
- Relapsed/refractory to ESA or EPO >500 mU/ml; HMA/Len naïve
- Transfusion dependent: ≥ 4 units RBC/8 weeks over 16 week pre-study period

Primary endpoint: 8-week RBC transfusion independence (TI)

Key secondary endpoints: 24-week RBC TI/duration of TI/HI-E

Enrollment Complete

Phase 2
Single arm, open label
LR MDS R/R to ESA

Imetelstat (n = 38)
7.5 mg/kg IV q4w

Currently Enrolling

Phase 3
Double-blind, placebo-controlled
N ~ 170

Randomize

Imetelstat (n ~ 115)
7.5 mg/kg IV q4w

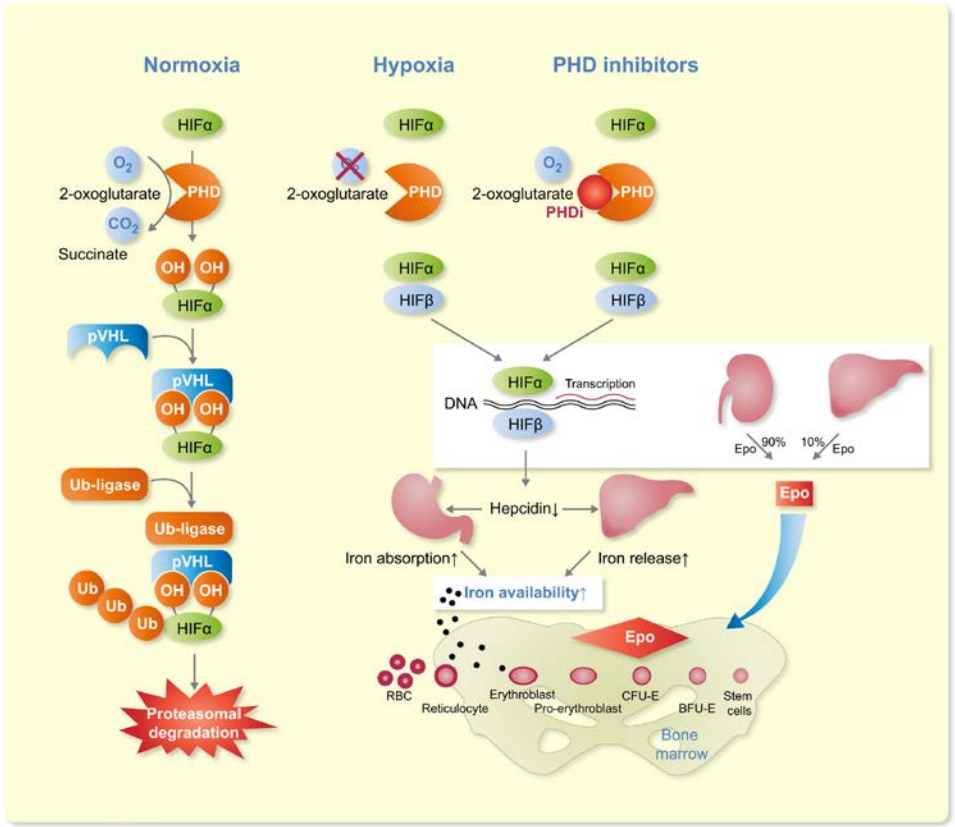
Stratification:
- Transfusion burden (≤6 vs. >6 units)
- IPSS risk category (low vs intermediate-1)

Placebo (n ~ 115)

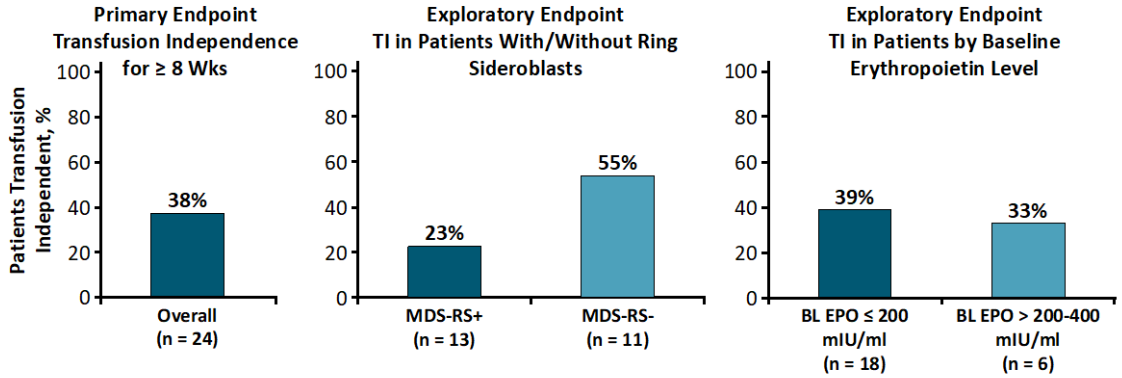
Parameter	Subset (n=38)
8 week TI	42%
Median time to onset	8.3 weeks
Median duration of TI	86 weeks
HI-E (IWG 2006)	68%

Platzbecker U et al. EHA 2020. Abstract S183. Steensma D et al. JCO 2021.

HIFa prolyl hydroxylase domain inhibitor: Roxadustat



Roxadustat Transfusion Independence at 28 and 52 Weeks (Combined Data)



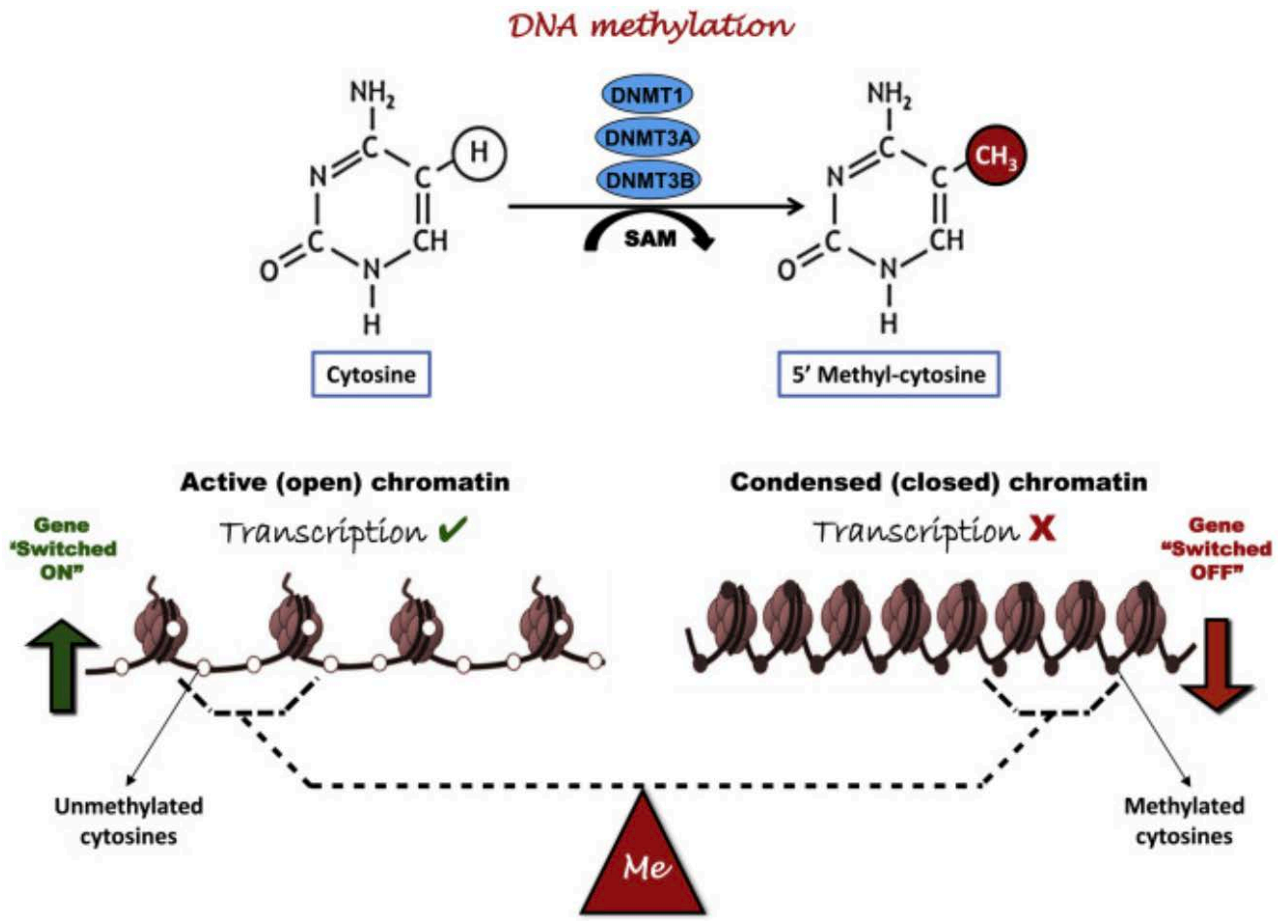
- 78% (7/9) who achieved transfusion independence were receiving roxadustat 2.5 mg/kg
- During first 8 wks of fixed-dose treatment, transfusion independence achieved by 25% of patients receiving roxadustat 1.5 mg/kg and 50% of patients receiving roxadustat 2.0 mg/kg

Henry. ASH 2020. Abstr 1277. Reproduced with permission.

- **58% had reduction in RBC transfusions of > 50%**
- **Ongoing phase III study versus placebo (n=156)**

Acta Physiologica, Volume: 227, Issue: 3; Henry D et al. ASH 2020, abstract 1277

Hypomethylating agents are effective in MDS

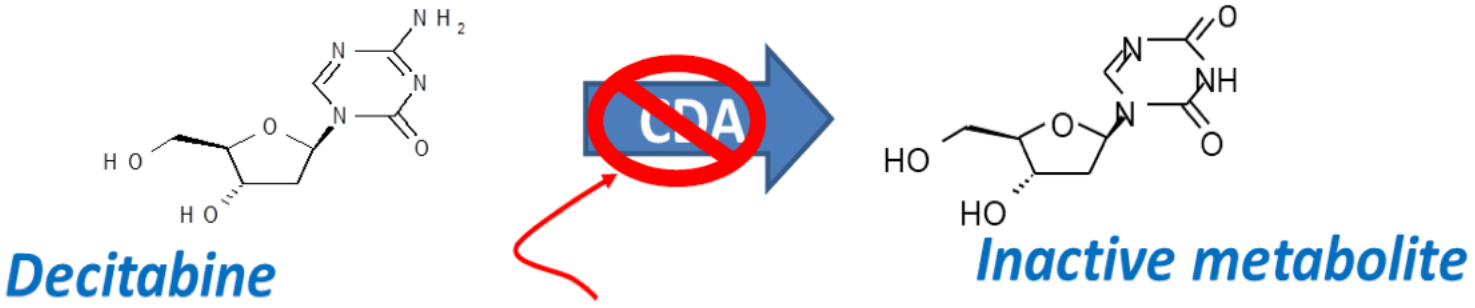


DNA methyltransferases in MDS

Azacytidine: 75 mg/m2 SC x 7 days

Decitabine: 20 mg/m2 IV x 5 days

Inqovi: Decitabine + Cedazuridine



35 mg

100 mg

DEC-C Phase 3: Randomized Crossover Design[1,2]

(int/high risk MDS; CMML; AML 20–30% blasts)

Ascertain MDS and CMML

At least 118 evaluable patients with adequate PK in Cycles 1 and 2

1:1 Randomization

	Cycle 1	Cycle 2	≥3 Cycles
Sequence A n = 66	DEC-C (100mg/35mg) 1 tablet x 5 d	IV DEC 20mg/m^2 1 h IV infusion x 5 d	DEC-C (100mg/35mg) 1 tablet x 5 d
Sequence B n = 67	IV DEC 20mg/m^2 1 h IV infusion x 5 d	DEC-C (100mg/35mg) 1 tablet x 5 d	

Major Inclusion criteria

- Candidates for IV DEC
- ECOG PS 0–1
- Life expectancy of ≥3 months
- Adequate Organ Function
- No major surgery in <30 days

Primary endpoint

- Total 5-d DEC AUC equivalence (Oral/IV 90% CI between 80% and 125%)

Secondary endpoints

- Efficacy: Overall Response rate; Transfusion independence; duration of response; Leukemia-free and overall survival
- Safety of DEC-C
- Max LINE-1 demethylation

1. Astex Pharmaceuticals. https://astx.com/astex-pharmaceuticals-and-otsuka-announce-results-of-the-phase-3-ascertain-study-of-the-novel-oral-cedazuridine-and-decitabine-fixed-dose-combination-C-DEC-in-patients-with-myelodysplastic-syndrom/. Accessed July 23, 2019; 2. Guillermo Garcia-Manero 61stASH Annual Meeting, Orlando, FL. Dec 7-10, 2019. Abstract #846

DEC-C Phase 3: Patient Baseline Characteristics[1]

Characteristics		Total Treated N=133 (n%)
Median age, y (range)		71 (44–88)
Sex	Male	87 (65%)
	Female	46 (35%)
Median weight, kg (range)		83 (45 -158)
Median BSA, m^2 (range)		1.98 (1.4 - 2.9)
CMML		16 (12%)
MDS, IPSS classification	High risk	21 (16%)
	Int-1 and 2	90 (68%)
	Low risk	6 (5%)
Transfusion dependent	RBCs	53 (39%)
	Platelets	12 (9%)
ECOG PS	0	55 (41%)
	1	78 (59%)

53% lower risk
36% higher risk

~7.5% of patients had received prior HMAs: Decitabine/Azacitidine; (≤1 cycles)

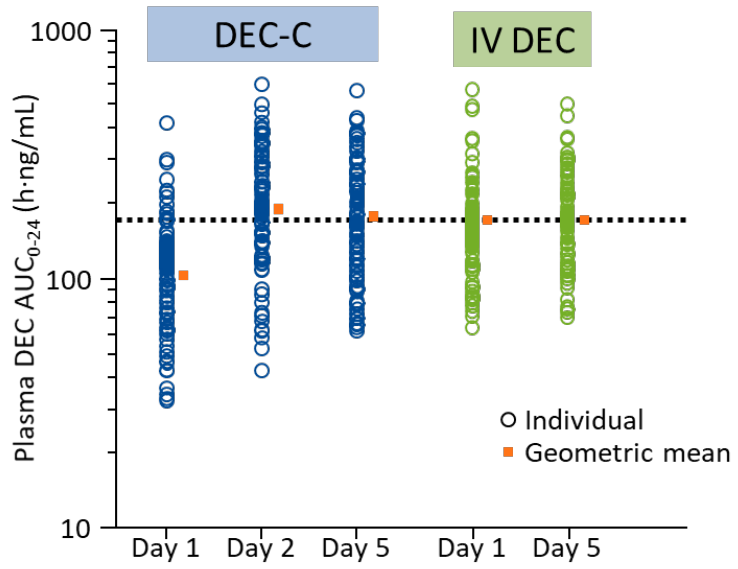
1. Clinical Efficacy and Safety of Oral Decitabine/Cedazuridine in 133 Patients with Myelodysplastic Syndromes (MDS) and Chronic Myelomonocytic Leukemia (CMML), Michael R. Savona et al, Session 637, Abstract # 1230 presented at the ASH Virtual Annual Meeting, Dec 5 – 8, 2020

Phase - 3 Results: AUC equivalence, Demethylation[1]

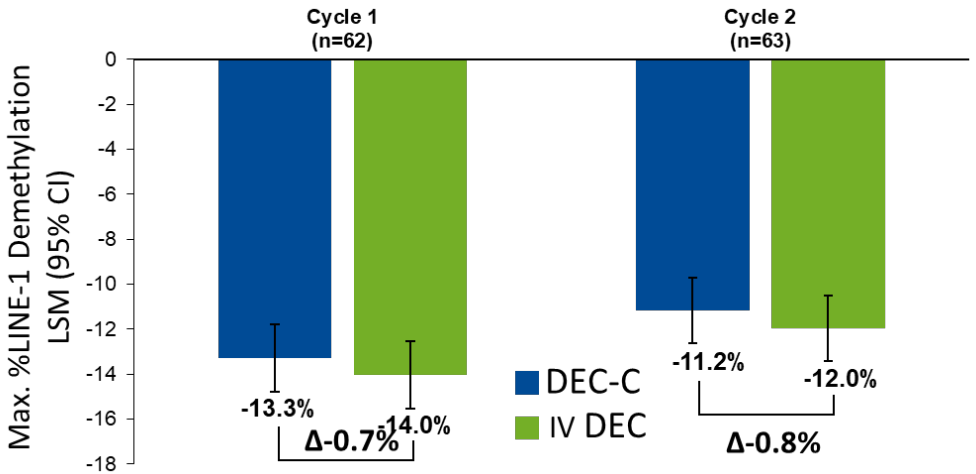
DEC 5-day AUC_{0-24} (h·ng/mL)		IV DEC		DEC-C		Ratio of Geo. LSM Oral/IV, % (90% CI)	Intrasubject (%CV)
		N	Geo. LSM	N	Geo. LSM		
Primary Analysis	**Paired***	**123**	**864.9**	**123**	**855.7**	**98.9 (92.7, 105.6)**	**31.7**

Geo. LSM = Geometric Least Squares Means

AUC equivalence



LINE-1 demethylation



No significant difference in *% LINE-1* DNA demethylation between DEC-C and IV DEC (<1% difference in each cycle)

1. Guillermo Garcia-Manero et al, 61s tASH Annual Meeting. Dec 7-10, 2019. Abstract #846;

Results Phase-3: Efficacy Response[1]

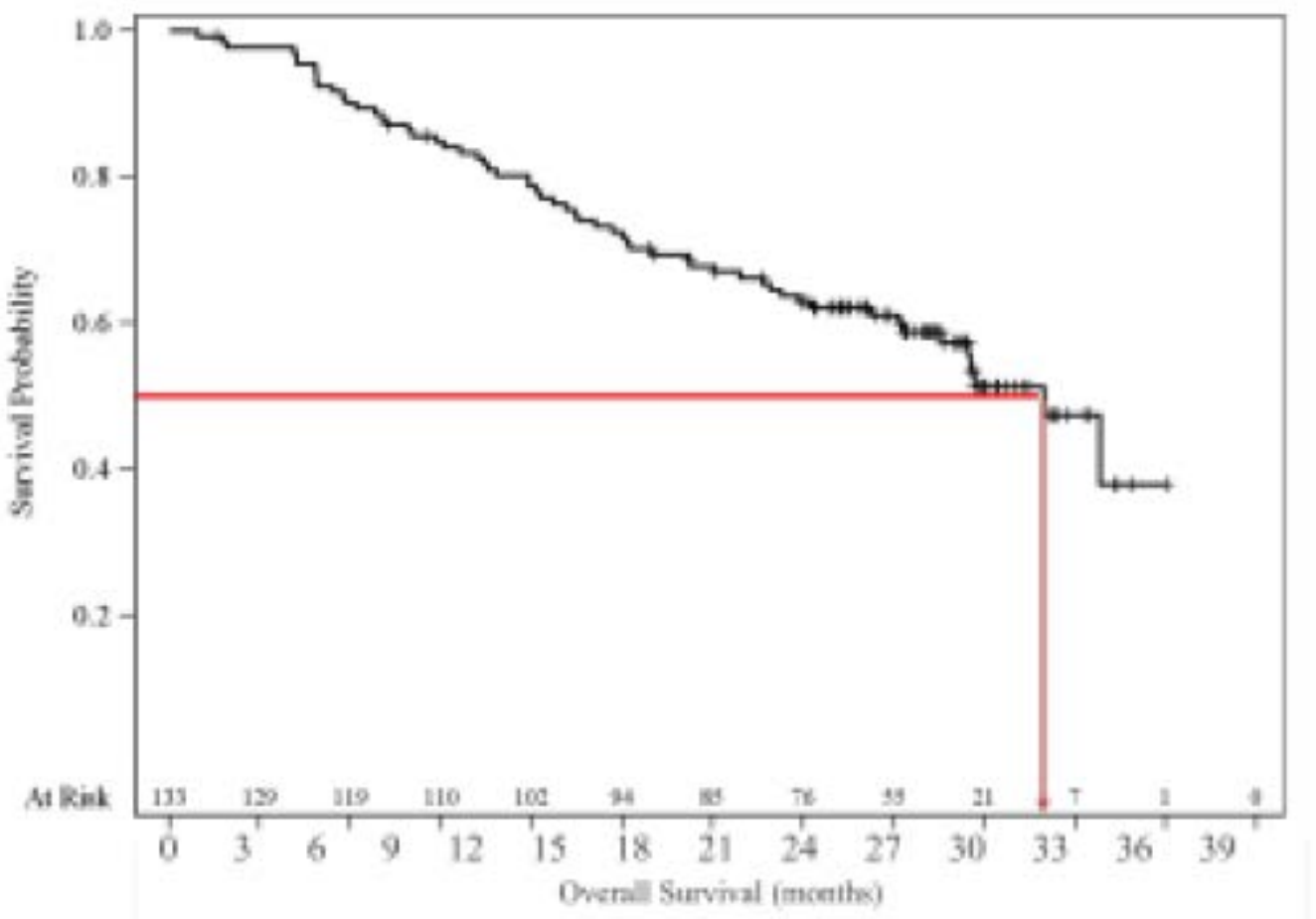
Response category	Treated Patients (N=133), n (%)	95% CI
Complete response (CR)	29 (22%)	(15.1,29.8)
Partial response (PR)	0	
Marrow CR (mCR)	43 (32.3%)	(24.5,41.0)
mCR with hematologic improvement	22 (16.5%)	(10.7,24.0)
Hematologic improvement (HI)	10 (7.5%)	(3.7,13.4)
HI-erythroid	2 (1.5%)	(0.2,5.3)
HI-neutrophils	1 (0.8%)	(0.0,4.1)
HI-platelet	7 (5.3%)	(2.1,10.5)
Overall response (CR + PR + mCR + HI)	82 (61.7%)	(52.8,69.9)
Progressive Disease	6 (4.5%)	(1.7,9.6)
No Response	28 (21.1%)	(14.5, 29.0)
Non-evaluable	17 (12.8%)	(7.6, 19.7)

Median time to	Median time (months)
Time to CR	4.5
Time to marrow CR	2.2
Duration of CR	14.0
Duration of best response	12.7

- 34 (26%) of subjects proceeded to HCT
- Transfusion independence (RBC and or platelets): 30/50 (53%)[2]
- Median number of cycles: 9[3]

1. Clinical Efficacy and Safety of Oral Decitabine/Cedazuridine in 133 Patients with Myelodysplastic Syndromes (MDS) and Chronic Myelomonocytic Leukemia (CMML), Michael R. Savona et al, Session 637, Abstract # 1230 presented at the ASH Virtual Annual Meeting, Dec 5 – 8, 2020
2. INQOVI (decitabine/cedazuridine) tablets [product monograph]. Oakville, ON: Taiho Pharma Canada, Inc; July 03, 2020
3. Prolonged Survival Observed in 133 MDS Patients Treated with Oral Decitabine/Cedazuridine, Michael R. Savona et al, Abstract P648, © Poster presented at: 16th International Congress on Myelodysplastic Syndromes (MDS), virtual meeting, September 23 26, 2021

Results Phase-3: Overall Survival[1]



- Median follow up is 32 months
- mOS for the 133 patients is 31.7months (95% CI: 28.0, NE).
    - mOS for higher risk disease: 15 months
- Leukemia free survival is 29.1 months (95% CI:22.1, NE)

1. Prolonged Survival Observed in 133 MDS Patients Treated with Oral Decitabine/Cedazuridine, Michael R. Savona et al, Abstract P648, © Poster presented at: 16th International Congress on Myelodysplastic Syndromes (MDS), virtual meeting, September 23 26, 2021

Savona et al. MDS-F meeting 2021

Safety of decitabine/cedazuridine

Table 3. Results: Safety - Treatment Emergent Adverse Events in >10% of Patients*

Preferred Term	Phase 3 Total (N=133, n [%])	Phase 3 Total Grade 3 or higher
Neutropenia	68 (51%)	65 (49%)
Thrombocytopenia	71 (53%)	62 (47%)
Anaemia	55 (41%)	47 (35%)
Leukopenia	33 (25%)	29 (22%)
Febrile Neutropenia	18 (14%)	17 (13%)
Fatigue	32 (24%)	3 (2%)
Diarrhea	22 (17%)	2 (2%)
Nausea	33 (25%)	0 (0%)
Decreased Appetite	19 (14%)	0 (0%)
Constipation	18 (14%)	0 (0%)

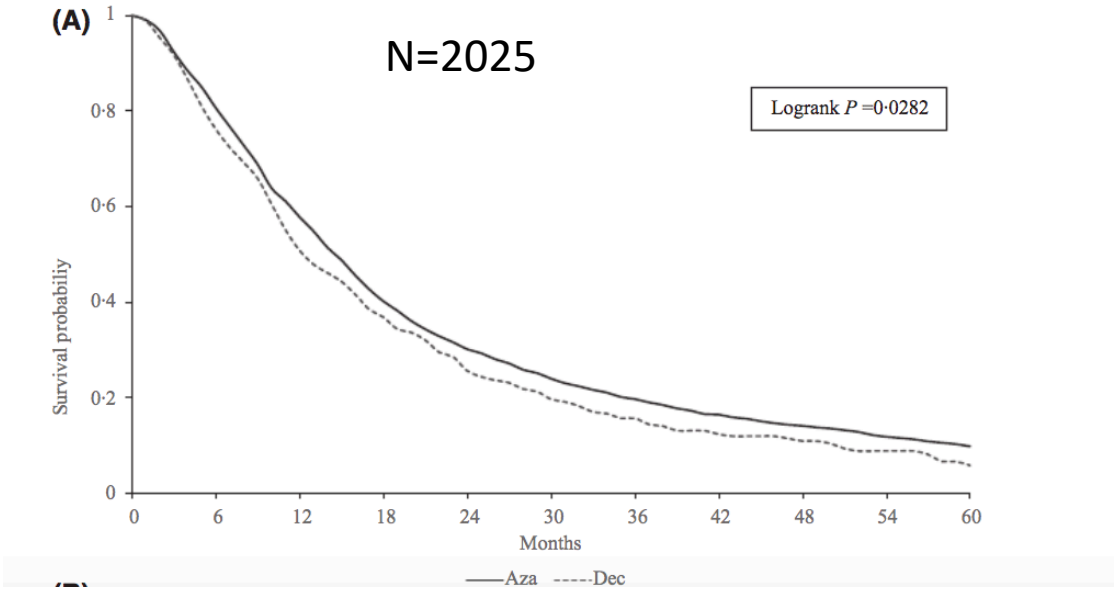
*Events attributable to oral decitabine/cedazuridine

- Safety profile consistent with that of IV decitabine.
- No new safety concerns with longer follow up.

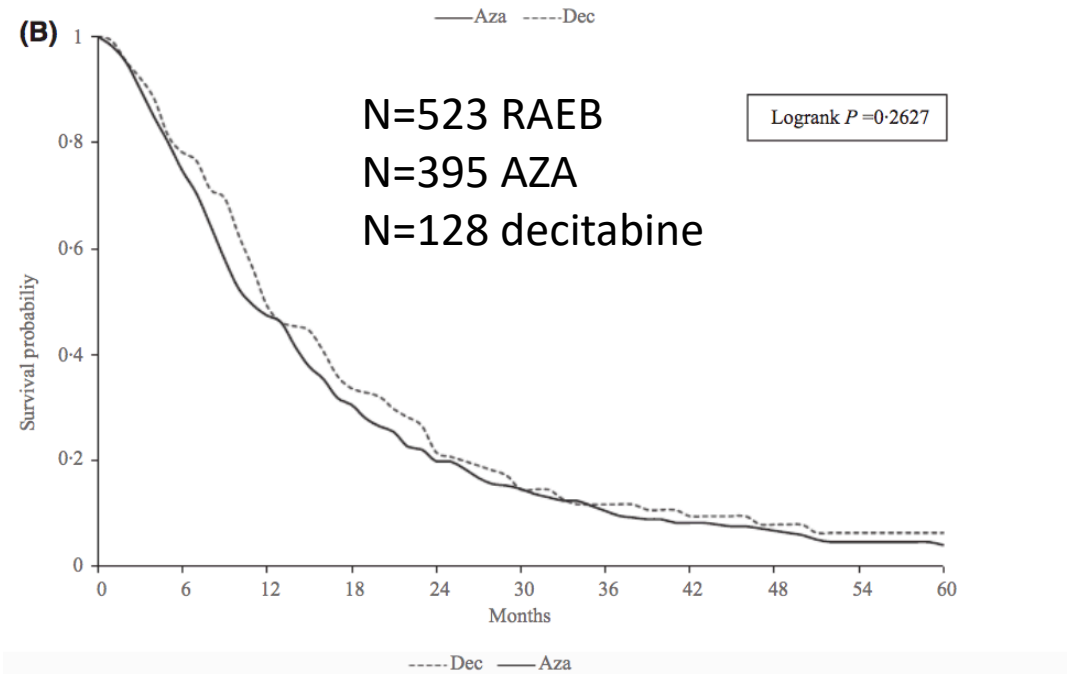
Savona et al. MDS-F meeting 2021

Which HMA to use for higher risk disease?

SEER Medicare study 2004-2011



Median OS 15 mos



Median OS 11 months

Zeidan A et al. BJH 2016

Advantages and Disadvantages: AZA

Advantages

- Known survival benefit
- Not too tough on the blood counts
- Can be used as bridge to transplant
- May achieve RBC transfusion independence in 40%
- Flexibility in dose adjustment

Disadvantages

- Can take 6 cycles to work
- Requires regular in person visits
- Not funded for lower risk disease

Advantages and Disadvantages of DEC-C

Advantages

- Oral
- Works quickly to reduce blasts
- May be used as bridge to transplant
- Achieves RBC transfusion independence in 50%
- Available for lower risk disease

Disadvantages

- No randomized trial for OS benefit
- Unclear if equivalent to AZA
- More suppressive of blood counts at the beginning
- Less flexibility in dose adjustment
- Not yet funded

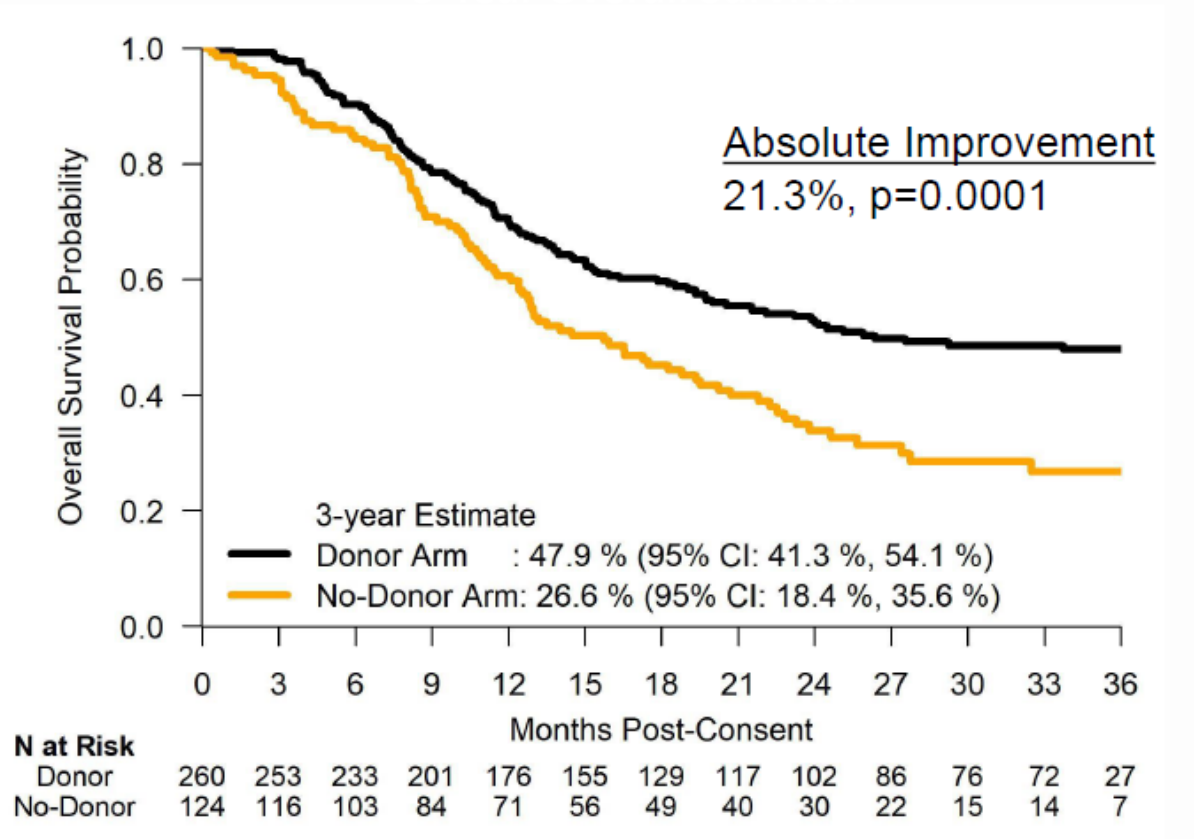
Select Current Phase III Clinical Trials for Newly Diagnosed High Risk MDS

	Sabatolimab TIM3 Inhibitor[1]	Tamibaterone RARα agonist[2]	Magrolimab CD47 mAb[3]	Venetoclax BCL2 inhibitor[4]
Current Status	Ongoing	Ongoing	ENHANCE recruiting	VERONA recruiting
Population	Intermed High Very high CMML-2	RARα + Intermed High Very high	Intermed High Very high	Intermed High Very high
Planned "n"	500	190	520	500
Comparator	AZA + PBO	AZA + PBO	AZA + PBO	AZA + PBO
Dosing of IP (PLUS SOC AZA)	IV q4 weeks	Oral D8-28	C1:D1,4,8,11,15, 22 C2: D1, 8, 15, 22 ≥C3 Q2W	Oral D1-14
Endpoint	OS	CR	CR and OS	CR and OS

1. NCT04266301. 2. NCT04797780. 3. NCT04313881. 4. NCT04401748.

Allo vs Hypomethylating/Best Supportive Care in MDS (BMT CTN 1102)

- Open-label, multicenter, biologic assignment study
- Assignment based on high-resolution typing to identify 8/8 HLA-matched related or unrelated donors
  - Mismatched, haploidentical and umbilical cord blood excluded
  - Donor arm subjects expected to undergo HCT within 6 months
- Subjects: Randomized 260 = Donor; 124 No Donor
  - Age 50-75
  - Primary MDS with intermediate-2 or high risk by IPSS
  - Candidates for traditional reduced-intensity transplantation
  - Transplant/non-transplant therapy per institutional standards

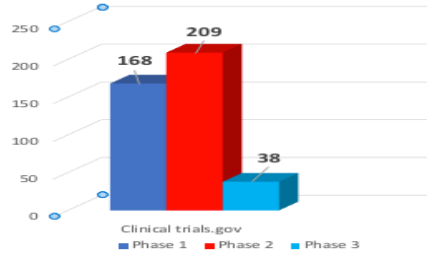


Nakamura. ASH 2020. Abstract 75. NCT02016781.

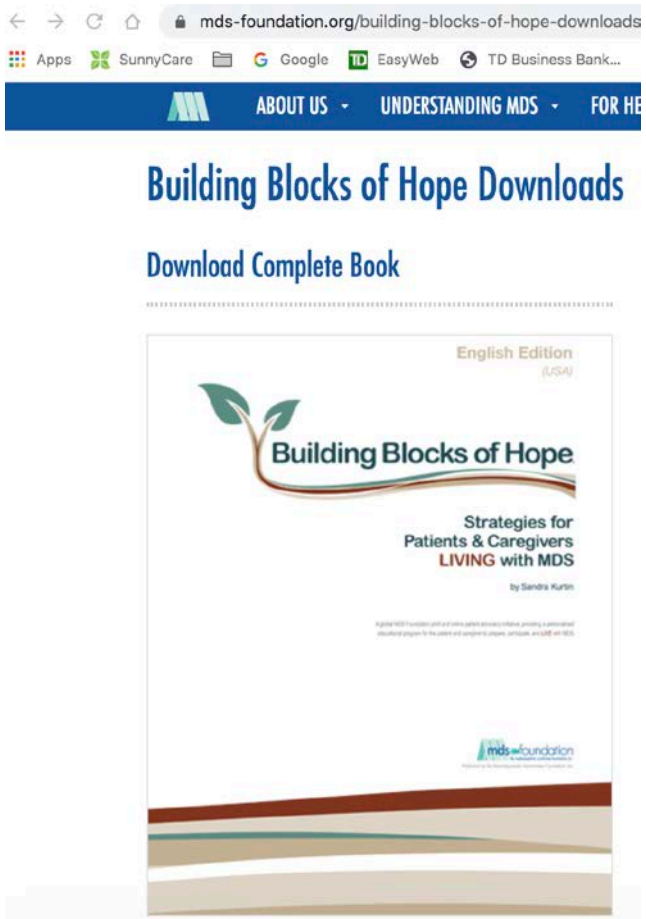
Slide credit: clinicaloptions.com

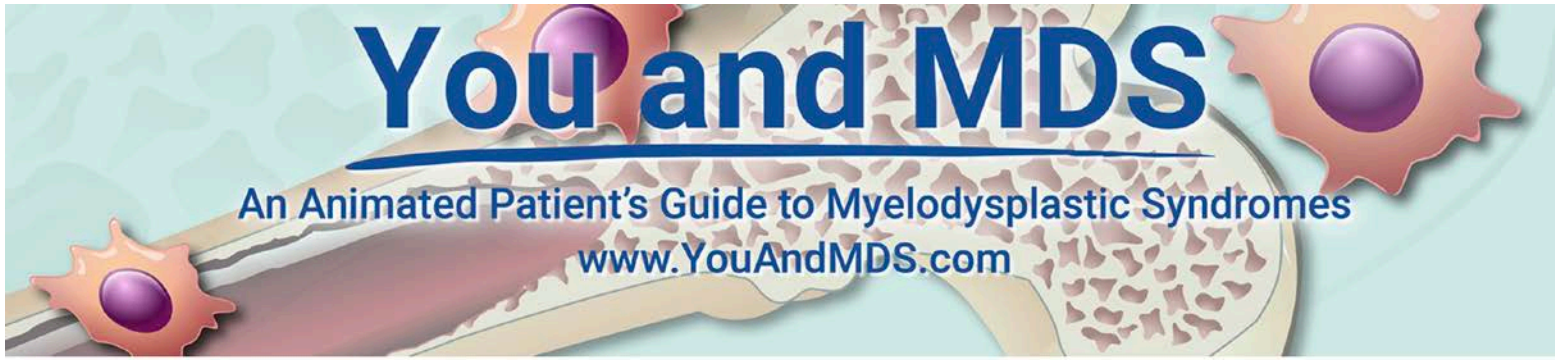
Summary

- MDS is a disease of the myeloid blood stem cell that leads to bone marrow failure and a propensity to AML
- Life expectancy is truncated by the disease
- Treatment is geared according to risk score
- Many patients receive supportive care with transfusions
- Allogeneic transplant is the only potential cure (< 10% qualify)
- Oral hypomethylating agent are now available
- Luspatercept is approved for patients with RS who are TD and will reduce or eliminate transfusions in > 50% of patients who have already received ESAs.
- Numerous clinical trials are underway



Mds-foundation.org





You and MDS – An Animated Patient's Guide to Myelodysplastic Syndromes

BECOME A MEMBER >

We are excited to announce the MDS Foundation's new online patient education resource, titled **"You and MDS: An Animated Patient's Guide to Myelodysplastic Syndromes"**. Please click **here** to be directed to the **You and MDS** resource.