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“Just because your doctor has a name for your condition doesn’t mean he knows what it is.” Bertrand Russell

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For many years, numerous risk scores, for example, International Prognostic Index for non-Hodgkin lymphoma (NHL) or Revised International Prognostic Scoring System for myelodysplastic syndrome (MDS) were introduced to predict outcome. The subtle prediction of outcome was contrasted by only a small number of therapeutic options and Cyclophosphamide, Hydroxydaunorubicin, Oncovin and Prednisone (CHOP) chemotherapy or supportive therapy was standard of care in the aforementioned entities. More recently positron emission tomography (PET) was preferred to identify early NHL responders who were likely to have a long-term survival. As a consequence, current trials used escalated therapy for the poor risk group but failed to improve poor outcome of PET-positive NHL as described by M. Fridrik [1]. A continuous understanding of biology and oncogenic pathways by translational research appeared more reasonable and tremendous progress was seen by introduction of targeted therapy, for example, using rigosertib in relapsed MDS or vosaroxin in refractory AML as discussed by M. Pfeilstöcker [2]. D. Heintel [3] describes the emerging activity of nivolumab, an anti-programmed cell death-1 (PD-1) monoclonal antibodies (MoAb) resulting in an overall response rate (OOR) of 87% heavily pretreated Hodgkin lymphoma including 78% patients with prior autologous stem cell transplantation (ASCT). Unfortunately, the same drug failed to show high activity in peripheral T-NHL as stated by P. Staber [4], underscoring the different biology warranting further exploration of genomic signatures. In chronic lymphocytic leuke-

mia (CLL), Rituximab, Cyclophosphamide, Fludarabine (R-FC) remains standard of care as first-line therapy, at least in fit patients <65 years. M. Steurer [5] provides an overview of maintenance concepts in relapsed CLL patients with anti CD20 MoAb, which are leading to an improvement of progression-free survival (PFS). However, orally available targeted drugs, for example, ibrutinib or idelalisib represent a new therapeutic era and will be explored even in early course and maintenance in CLL and indolent NHL as described by M. Steurer [5] and T. Nösslinger [6]. Oral available proteasome inhibitor Ixazomib and, long awaited for multiple myeloma (MM), MoAb, will lead to new therapeutic strategies. Moreover recently published revised guidelines for venous thromboembolic disease were elegantly incorporated in this issue by C. Feistritz and B. A. Mosheimer [7].

In conclusion, the reports in the current edition of *Memo* focus on the newest developments in hematological neoplasias and hemostaseology presented at the last American Society of Hematology (ASH) meeting, please read them thoroughly and MEMOize!

Conflict of interest

The author declares that no conflict of interest exists.

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