

If it ain't broke, don't fix it!

We read with interest the manuscript on the revision of the WPSS by Malcovati *et al.* in a recent issue of the journal.¹ However, we cannot see the advantage of a prognostic system that bases its evaluation more on seemingly "objective" measurements of blood values than on transfusion dependence. First, the impression that hemoglobin or platelet measurements are an objective description of the patient's true hemoglobin or thrombocyte level is mistaken. Especially in patients with lower than normal levels, many laboratory devices used in hematologists' offices for rapid screening of peripheral blood values show a high variability and deviation to the standard laboratory devices used in hospitals. Still, many practicing hematologists might rely on those values and use them in the revised WPSS, which significantly curbs the notional "gain" in accuracy. Second, the big advantage of the WPSS was the fact that red blood cell transfusions are being given on a personalized basis. The doctor decides whether to transfuse his patients, not only on the basis of the actual hemoglobin level (this is probably relatively rare), but according to symptoms that occur due to anemia, namely dyspnea, cardiac symptoms, dizziness or other neurological symptoms, and fatigue. These subjective symptoms are highly influenced by comorbidities. This was precisely the

appeal of the WPSS; it included a notion of comorbidity in the prognostification of MDS, a novel idea that had never been contemplated before. We agree that this concept had never been evaluated in randomized trials; however, we do feel that the idea was convincing enough to be included in a novel prognostic scoring system. In our opinion, it is a step backwards to now try and revise the WPSS by making it more similar to the IPSS by going back to laboratory values. Therefore: if it ain't broke, don't fix it!

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References

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