25th Multidisciplinary Management of Cancers: A Case-based Approach

Lymphoma Tumor Board Cases 2025

Saturday, March 8, 2025, 11:00 AM

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25th Multidisciplinary Management of Cancers: A Case-based Approach

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Session Chair: Michael Khodadoust, MD PhD
Stanford University

Fellow, Case Presenter: Navika Shukla, MD, Stanford University

Panelists:

- Charalambos (Babis) Andreadis, MD, *UCSF*
- Michael Binkley, MD, *Stanford*
- Sushma Bharadwaj, MD, *Stanford*
- Erik Eckhert, MD, *TPMG*
- Naseem Esteghamat, MD, *UC Davis*
- Lisa Law, MD, *TPMG*
- Mwanasha Merrill, MD, *UCSF*
- Joe Schroers-Martin, MD, *Stanford*
- Michael Spinner, MD, *UCSF*
- Joseph Tuscano, MD, *UC Davis*

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Disclosures

Faculty Name	Role	Type of Financial Relationship	Company
Michael Khodadoust	**Chair**	Consultant Grants/Research Support	Ono Pharma and Ephla Bio Ono Pharma and Nutcracker Bio
Navika Shukla	**Fellow**	Disclosed no relevant financial relationships.	
Babis Andreadis	Panelist	Advisory Board or Panel Grants/Research Support	Abbvie, BMS, Genentech, Genmab, Kite Pharmaceuticals, Pharmacyclics, and Seattle Genetics BMS,Genentech, Genmab, and Lilly
Sushma Bharadwaj	Panelist	Grants/Research Support	Allogene
Michael Binkley	Panelist	Disclosed no relevant financial relationships.	
Erik Eckhert	Panelist	Disclosed no relevant financial relationships.	
Naseem Esteghamat	Panelist	Disclosed no relevant financial relationships.	
Lisa Law	Panelist	Disclosed no relevant financial relationships.	
Joe Schroers-Martin	Panelist	Consultant Other Financial or Material Support (royalties, patents, etc.)	Pierre Fabre Pharmaceuticals Travel - Genentech and Beigene
Mwanasha Merrill	Panelist	Disclosed no relevant financial relationships.	
Michael Spinner	Panelist	Advisory Board or Panel Consultant Grants/Research Support	ADC Therapeutics Gilead/Kite Foresight Diagnostics, Seattle Genetics/Pfizer, and Allogene
Joseph Tuscano	Panelist	Grants/Research Support	ADC therapeutics, Genentech, Pharmacyclics, Abbvie, Genmab, Regeneron, Pfizer

ANCO and i3 Health have mitigated all relevant financial relationships.

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Outline

1. DLBCL
2. Follicular Lymphoma
3. AITL
4. Hodgkin Lymphoma

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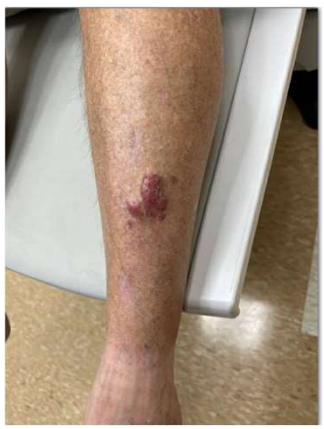
Case 1

- 78 yo M presents to urology with painless L testicular swelling. In-office ultrasound unremarkable, initially treated with a course of antibiotics without improvement.
- 3 months later, exam shows a non-tender rash on L calf and ankle
- Labs show a normal LDH, CBC unremarkable
- Excellent performance status, ECOG 0
- New leg lesion biopsy demonstrates **primary cutaneous leg-type vs systemic DLBCL**. CD20 highlights the vast majority of the large, atypical infiltrate. BCL2 and MUM1 are diffusely positive. C-MYC positive by IHC.



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DADC1

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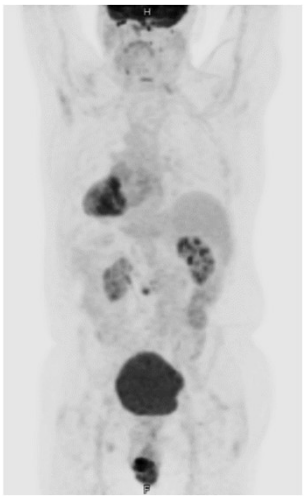
- PET/CT shows a single enlarged retroperitoneal lymph node (1.3 x 0.8 cm, SUV 5.3) and abnormal, enlarged appearance of the left testicle
- Consistent with **primary cutaneous DLBCL, non-GCB**
- HemeSTAMP (NGS molecular testing) demonstrates the following mutations:
  - MYD88 L265P mutation (VAF 32%)
  - CD79B Y196S mutation (VAF 30%)
  - TNFAIP3 mutation (VAF 30%)



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DLBCL Genetic Subtypes

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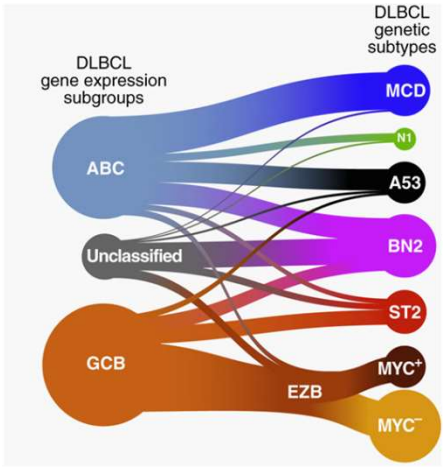
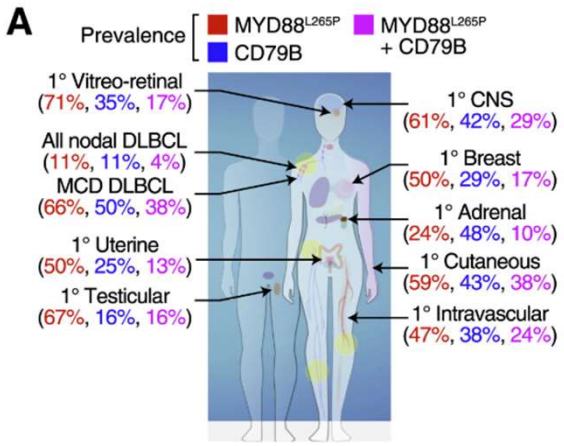


Wright et al, Cancer Cell, 2020



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Slide 7

DADC1 .

Dr. A. Dimitrios Colevas, 2/12/2025

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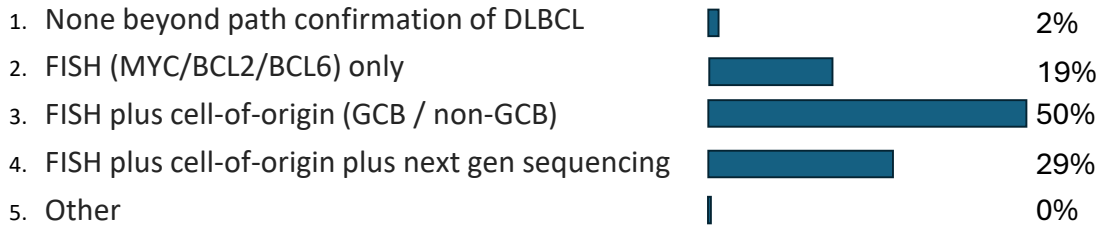
What molecular characterization do you require for new diagnosis DLBCL?



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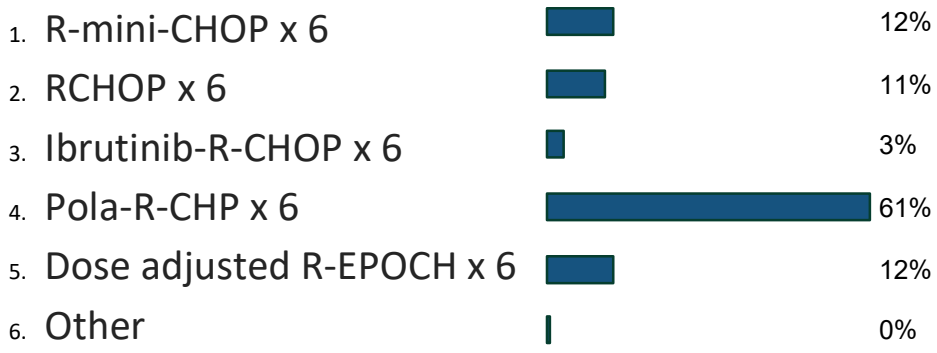
What initial chemotherapy would you give this 78 yo patient with cutaneous and testicular involvement?



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DADC3

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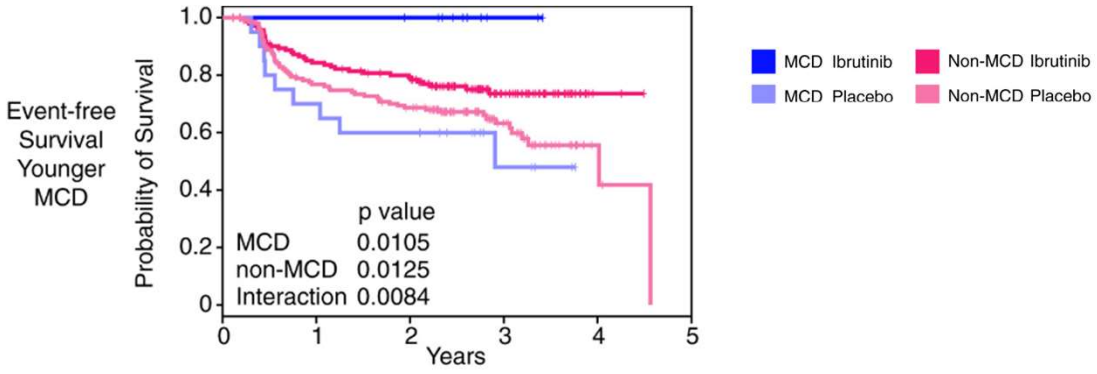
Phoenix Trial: The addition of ibrutinib to RCHOP in non-GCB DLBCL
MCD subtype



- 3 year EFS 100% (ibrutinib + RCHOP) compared to 48% (RCHOP alone)

Younes et al, JCO, 2019

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DADC4

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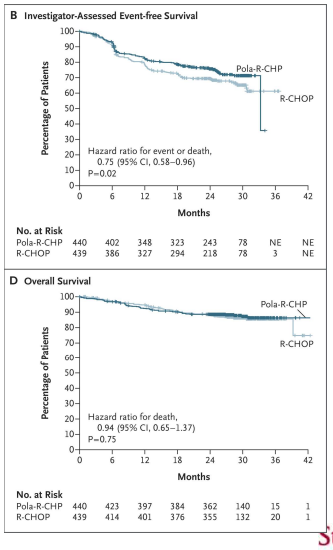
Polarix Trial: pola-R-CHP demonstrates improved PFS, EFS, DFS compared to R-CHOP, but not OS



- 2 yr PFS higher for pola-R-CHP: **76.7%** [95% CI 72.7-80.8] vs **70.2%** [95% CI 65.8-74.6]
- 2 yr OS not significantly different for pola-R-CHP: **88.7%** [95% CI 85.7-91.6] vs **88.6%** [95% CI 85.6-91.6]

Tilly et al, NEJM, 2021

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Slide 13

DADC3 call ABC or non GCB?

Dr. A. Dimitrios Colevas, 2/12/2025

Slide 14

DADC4 graphs not readable. select 1-2 bigger?

Dr. A. Dimitrios Colevas, 2/12/2025

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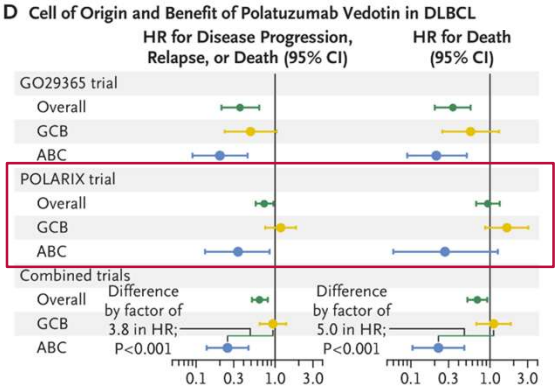
ABC tumors are more responsive than GCB tumors to regimens containing polatuzumab vedotin



Modest overall benefit to pola-R-CHP seen in the POLARIX trial arises from the large benefit in ABC DLBCL

Palmer et al, NEJM, 2023

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How do you manage the possible CNS risk?

1. Intercalate high dose IV methotrexate into your regimen with each cycle — 6%
2. Give intrathecal methotrexate with each cycle — 20%
3. Give high dose IV methotrexate x 2-4 cycles after completion of chemotherapy regimen — 53%
4. Give a combination of IT chemotherapy plus high dose IV methotrexate — 5%
5. Do not give CNS prophylaxis — 14%
6. Other — 2%

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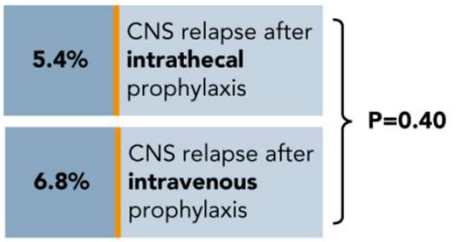
Data around CNS PPx Remains Mixed

LYMPHOID NEOPLASIA | JANUARY 20, 2022

Single-route CNS prophylaxis for aggressive non-Hodgkin lymphomas: real-world outcomes from 21 US academic institutions



Key findings:

1. CNS relapse rates similar to CNS-IPI predictions, despite all patients receiving prophylaxis
2. PPx route did not significantly affect CNS relapse rate
3. Higher CNS relapse risk despite single-route PPx with:
   - Testicular involvement
   - Non-GCB subtype
   - Increased extranodal burden

Orellana-Noia et al, Blood, 2022

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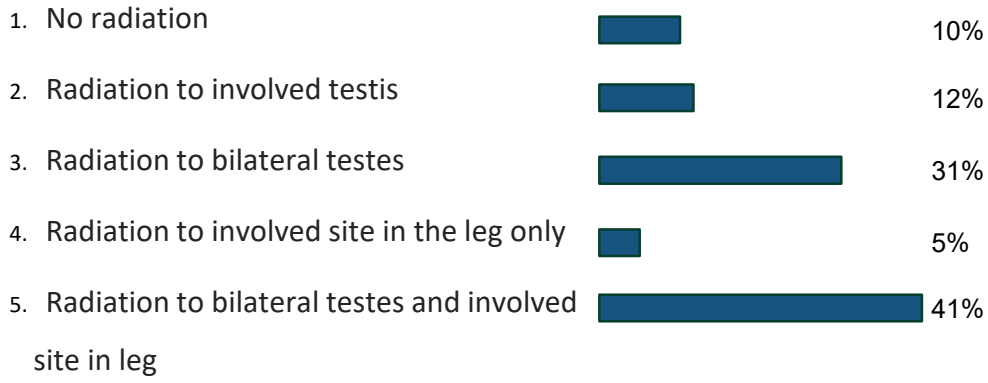
In addition to systemic chemotherapy, what radiation plan do you recommend?



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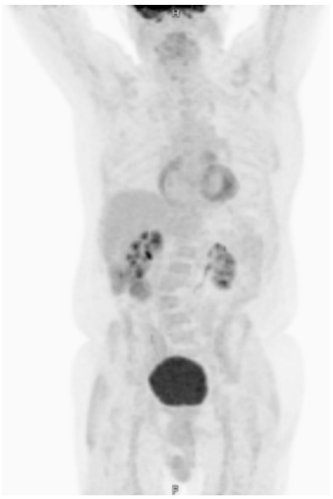
- The patient is treated with 6 cycles of R-CHOP and 4 doses of IT MTX
- Additionally receives consolidative XRT to testes bilaterally and the L lower leg
- EOT PET demonstrates a CR
- 3 months later, noted to have biopsy proven **skin recurrence of left lower leg** that is progressing with multiple lesions in the leg



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How do you treat this now 79yo patient's relapsed disease?

1. Platinum chemotherapy followed by autologous SCT — 4%
2. CD19 targeting CAR-T therapy — 65%
3. CD20/CD3 bi-specific antibody +/- chemotherapy — 2%
4. Antibody or Antibody drug conjugate (polatuzumab-based regimen, loncastuximab, or tafasitimab+lenalidomide) — 6%
5. BTK inhibitor +/- anti CD20 — 2%
6. Radiation — 22%

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Evidence for some R/R DLBCL Regimens

	ORR (CR)	PFS	≥grade 3 AEs
Axi-cel (ZUMA-7) [n=180]	83% (65%)	24m PFS: 46%	91%
Glofitamab [n=154]	52% (39%)	12m PFS: 37%	62%
Glofit + BR (STARGLO) [n=183]	60% (50%)	12m PFS: 51.7%	78%
Epcoritamab (EPCORE NHL-1) [n=157]	63% (40%)	24m PFS: 27.8%	45%
Pola + BR [n=35]	43% (34%)	mPFS: 5.2m (5.4m median follow-up)	89%

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CAR-T in patients ≥80 years old

Octogenerians have:

- Similar response rates
- Similar PFS (47% octogenarian vs 56% ages 65-79)
- Grade 3 ICANS 33% vs 25%
- Hospital stay 21 days vs 14 days (P <0.05)
- One year non-relapse mortality 11% vs 1%

Lee, Bharadwaj, et al, ASH, 2024

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- He elects to pursue axi-cel therapy, proceeded by FluCy lymphodepletion

How do you consider bridging therapy before planned CAR-T?

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- Course is complicated by Grade 3 ICANS and Grade 2 CRS, requiring tocilizumab, anakinra, and steroids
- Achieves a CR
- 17 months post-treatment, PET/CT demonstrates an ongoing CR
- 21 months post-treatment, PET/CT demonstrates New small intensely hypermetabolic cutaneous and subcutaneous nodule on the right posterior-superior calf as well as other punctate skin foci in this region are suspicious for **recurrent DLBCL**.
- Biopsy confirms diffuse large B-cell lymphoma, non-germinal center type, CD19 positive

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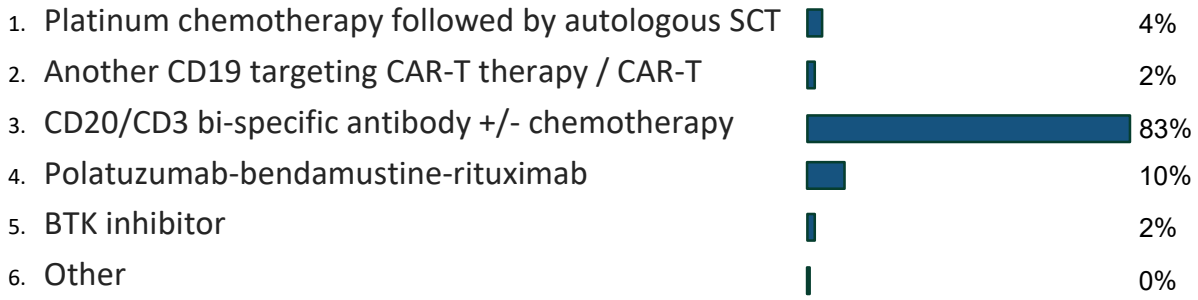
How do you treat this patient's second relapsed disease after CAR-T?



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Case 1 – Summary

- Polarix Trial:
  - ABC tumors are more responsive than GCB tumors to regimens containing polatuzumab vedotin
- The role of CNS prophylaxis remains unclear
- No age restriction on CAR-T
- Numerous options for refractory DLBCL, and field is rapidly evolving

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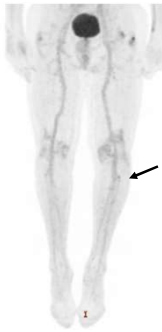
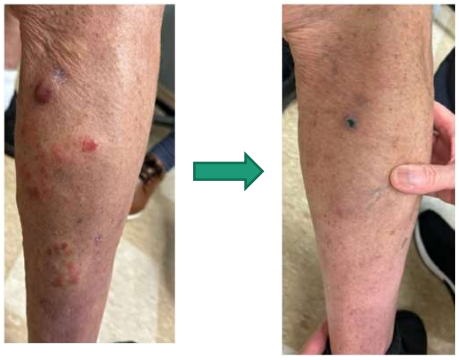
- He starts Epcoritamab
- 2 months into tx, PET/CT shows decreased FDG activity and size of cutaneous and subcutaneous nodule on the right posterior-superior calf. Other punctate mild cutaneous foci in this region are nearly resolved.
- Epicoritamab is continued with ongoing CR





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Case 2

- 55 yo F presents with a L lower mandible nodule. No fevers, night sweats, or weight loss.
- **Initial CT NCAP:** only an enlarged L mandibular LN 1.6 x 1.7 x 2.4 cm.
- **Labs:** LDH 155 (wnl), CBC wnl, CMP wnl
- **Excisional biopsy:** neoplastic cells positive for CD20, CD10,and BCL2; they are negative for CD3 or CD5. Focal areas show increased centroblasts; however overall, they represent <15 per high-power field, consistent with **follicular lymphoma grade 1-2**. No sheet of large cells is identified.
- **Stage IA, FLIPI score 0:** low risk, 10yr OS ~70%

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How do you initially manage her?

1. Observation only — 44%
2. Rituximab only — 2%
3. Bendamustine and Rituximab or Obinutuzumab — 7%
4. Radiation to excised prior site — 41%
5. Get additional info to make decision (e.g. m7-FLIPI) — 7%
6. Other — 0%

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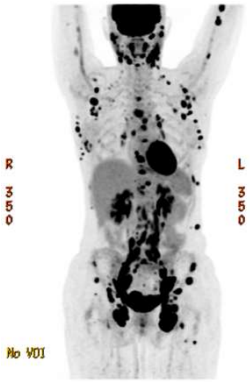
Case 2

- Patient is observed without treatment
- One year later, presents with growing palpable lymphadenopathy, fatigue, and night sweats
- **Labs**: CBC wnl, LDH 175 (wnl), albumin 4.4, CMP wnl
- **PET/CT shows:** innumerable LN above and below the diaphragm involving every nodal station, osseous and subcutaneous lesions (ie. left inguinal nodal conglomerate measuring: 4.3 x 4.2 cm, SUV: 18.5)
- Excisional biopsy consistent with **Stage IV Follicular Lymphoma, WHO Grade 1-2**
- No signs of large cell transformation
- **FLIPI score 2:** intermediate risk, 10 yr OS ~50%



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Now how do you manage her?

1. Observation only — 8%
2. Rituximab only — 12%
3. Bendamustine and Rituximab — 65%
4. R-CHOP — 5%
5. Rituximab/lenalidomide — 10%
6. Other — 0%

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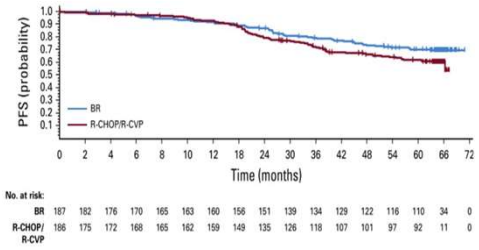
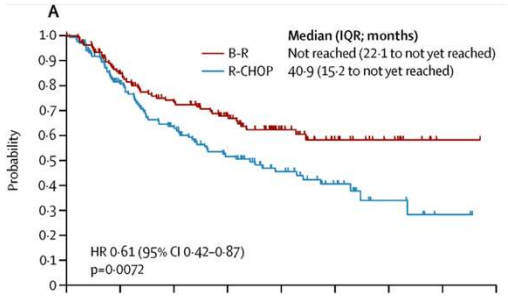
BRIGHT and STiL trials – BR better than R-CHOP





- The initial BRIGHT trial comparing BR to R-CHOP/R-CVP, favored BR in FL5-yr follow-up data show improved PFS with BR:
- Difference in PFS = **HR of 0.61** (95% CI, 0.45 to 0.85; ***P* = .0025**)

- The estimated 10-year survival rates were **71%** for B-R and **66%** for CHOP-R.

Flinn et al, Blood, 2014
Flinn et al, JCO, 2019

Rummel et al, Lancet, 2013
Rummel et al, JCO, 2017

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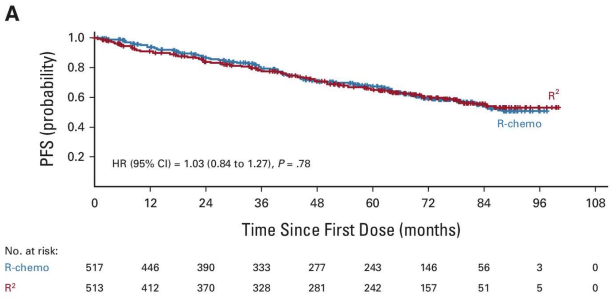
RELEVANCE Trial: R² vs R-Chemo Frontline – 6 yr follow-up



- Lenalidomide + rituximab versus rituximab-chemotherapy demonstrated comparable 6yr PFS (60% vs 59%) and OS (89% for both groups)

Morschhauser et al, JCO, 2022

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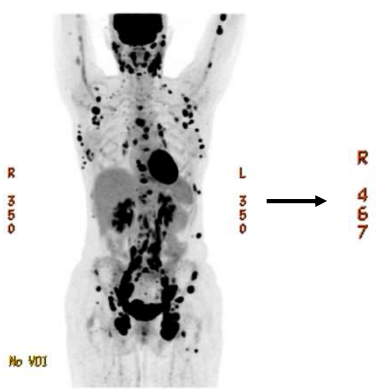
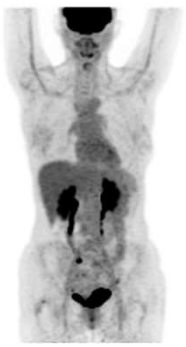
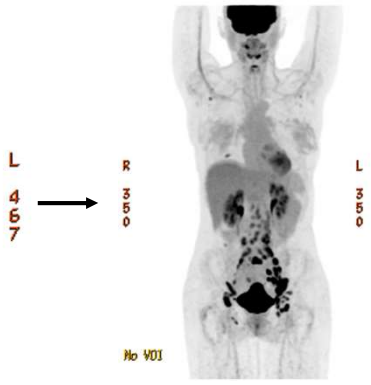
Case 2 – Patient receives BR



Before treatment



After 4 cycles of BR



9 mos after completing BR, she progresses

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56 yo with low grade FL, POD24 after BR (9 months)
Biopsy shows low grade FL only

Now how do you manage her?

1. High dose chemotherapy with autoSCT — 9%
2. Targeted agent (tazemetostat or zanubrutinib + Obinutuzumab) — 22%
3. R-CHOP — 3%
4. CAR-T — 50%
5. Rituximab/lenalidomide — 12%
6. Other — 3%

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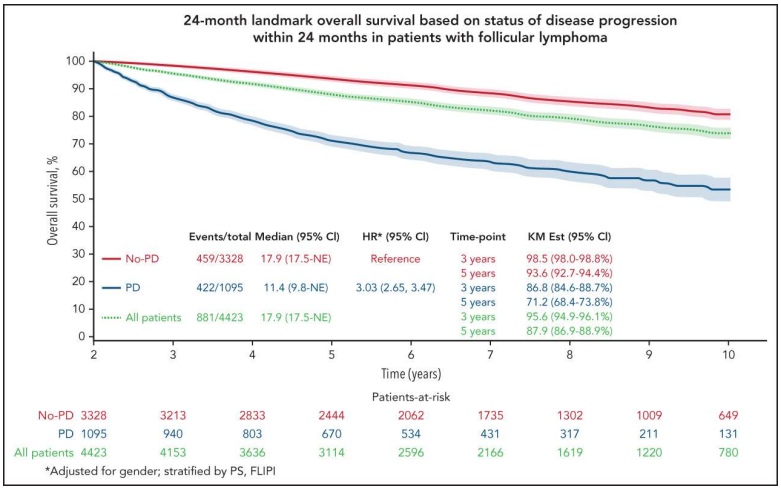
POD24: Progression of disease within 24mos of frontline therapy



Casulo et al, Blood, 2022

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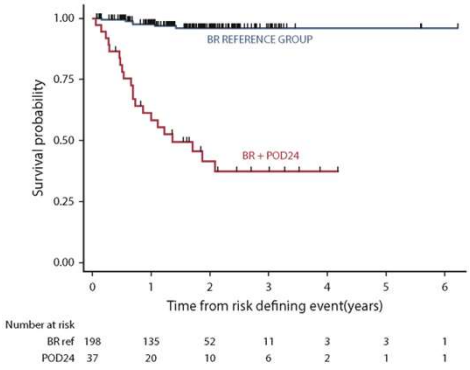
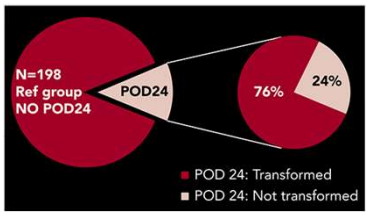
Patients treated with rituximab + benda
POD24 vs other



Freeman et al, Blood, 2019



POD24 after bendamustine has a high risk of transformed disease in FL

Biopsy these patients thoughtfully

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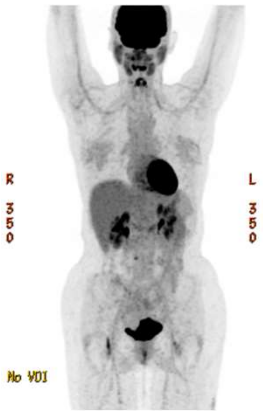
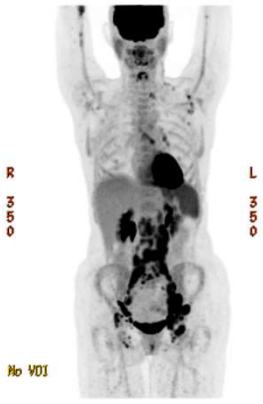
Case 2: Receives rituximab and lenalidomide



PET after lenalidomide + rituximab demonstrates a CR



Surveillance **PET 26 months later shows progression**; still low grade FL

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Slide 44

DADC6 really hard to read graphs too small

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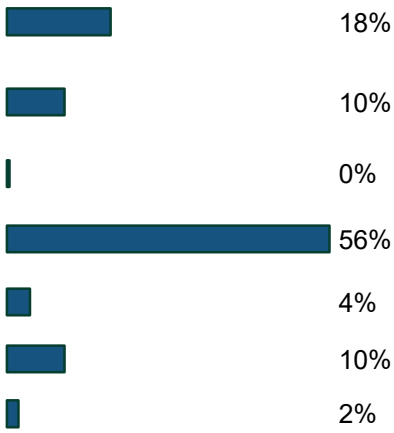
Now how do you manage her?

1. High dose chemotherapy with autoSCT
2. Targeted agent (tazemetostat or zanubrutinib + Obinutuzumab)
3. R-CHOP
4. CAR-T
5. Repeat Rituximab/lenalidomide
6. Bispecific CD20/CD3
7. Other



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DADC7

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Mosunetuzumab in R/R iNHL

- ORR 65.7%, CR rate 49.3%
- Median PFS 12.2 months

Tazemetostat in R/R FL

EZH2-mutated:
- ORR 69%, CR rate 13%
- Median PFS: 13.8 months

EZH2-WT:
- ORR 35%, CR rate 4%
- Median PFS: 11.1 months

Zanu + obin in R/R FL

Zanu + obin:
- ORR 69%, CR rate 39%
- Median PFS: 28 months

Budde et al, JCO, 2024
Zinzani et al, JCO, 2023
Morschhauser et al, Lancet, 2020

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Slide 48

DADC7 prob too much to go through

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Efficacy and safety of CAR T-cell therapy in Follicular Lymphoma

	Axi-cel (n=124)	Liso-cel (n=130)	Tisa-cel (n=97)
Median follow-up	41.7 months	18.9 months	9.9 months
ORR (CR)	94% (79%)	3L FL: 97% (94%) 2L FL: 96% (100%)	86.2% (69.1%)
Median PFS	40.2 months	Not reached	Not reached
Median DOR	38.6 months	Not reached	Not reached
CRS (≥Grade 3)	78% (6%)	58% (1%)	49% (0%)
Neuro Events (≥Grade 3)	56% (15%)	15% (2%)	37.1% (4.1%)
Any ≥Grade 3 AE	83%	3L FL: 75% 2L FL: 61%	78.4%

Dreyling et al, Blood, 2024
Neelapu et al, Blood, 2024
Jacobson et al, The Lancet, 2022
Morschhauser et al, Nature Medicine, 2024

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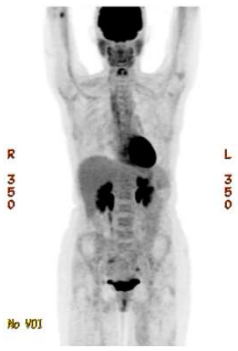
Case 2

- She declines CAR-T and is started on mosunetuzumab
- Experiences grade 1 CRS and rash, which self-resolve
- After four cycles, PET/CT demonstrates a mCR
- She continues to do well, now s/p 8 cycles of treatment and off treatment



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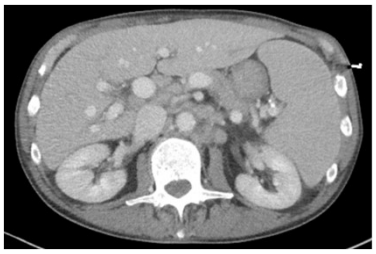
Case 2 – Summary

- POD within 24 mos of frontline therapy is prognostic
- BRIGHT and STiL demonstrate a benefit to BR over RCHOP/RCVP in frontline therapy for FL
- In the relapsed refractory setting, mosun, taz, vs zanu + obin have demonstrated good response rates
- Axicel, tisacel, and lisocel have demonstrated benefit in the R/R setting

Case 3

- 73 yo M presents to the ER with several weeks of SOB and cough. Eruption of new pruritic rash.
- CT CAP demonstrates diffuse adenopathy throughout the base of the neck, chest, abdomen and pelvis and hepatosplenomegaly
- Labs: elevated LDH, undetectable haptoglobin, and positive Coombs test. Treated for **warm AIHA**



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Case 3

- Lymph node biopsy reveals atypical T cell infiltrate with a T follicular helper cell immunophenotype, including expression of PD-1, CD10, BCL-6, ICOS, and CXCL13, that is associated with residual but disrupted B cell follicles with irregular expansion of follicular dendritic meshworks and high endothelial venules. these T cells also express at least partial CD25 and **CD30 (10%).** Consistent with **nodal T follicular helper cell lymphoma, angioimmunoblastic-type**

- Next generation sequencing reveals the following mutations:
  - TET2 Q1414fs, VAF 13%
  - DNMT3A W327*, VAF 9%
  - **RHOA G17V, VAF 8%**
  - CD28 T195I, VAF 6%

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How would you treat him?

1. CHOP x 6 — 25%
2. CHOEP x 6 — 12%
3. BV-CHP x 6 — 60%
4. Alternative monotherapy (belinostat, romidepsin, azacitidine, duvelisib) — 4%
5. Other — 0%

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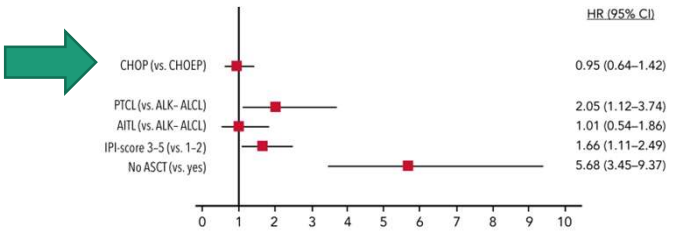
25th Multidisciplinary Management of Cancers: A Case-Based Approach

CHOEP vs CHOP does not improve OS in AITL



- CHOEP improved OS in ALK$^+$ ALCL but not in ALK$^-$ ALCL, AITL, or PTCL NOS
- In ALK$^-$ ALCL, AITL, or PTCL NOS, use of etoposide did not translate into an OS benefit when corrected for IPI score, PTCL subtype, and use of ASCT.

Brink et al, Blood, 2022

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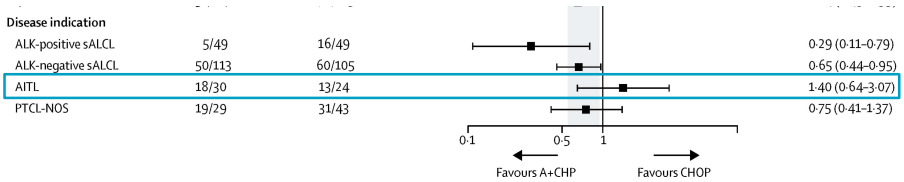
25th Multidisciplinary Management of Cancers: A Case-Based Approach

ECHELON-2: Frontline A-CHP vs CHOP in CD30+ PTCL



- Brentuximab-CHP was not superior to CHOP in frontline therapy for AITL with respect to PFS (shown above) or OS
- Safety profile of both regimens was comparable (similar neuropathy and neutropenia), GI side effects more common with Brentuximab-CHP

Horwitz et al, The Lancet, 2019

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Slide 57

DADC14 what is A-CHP?

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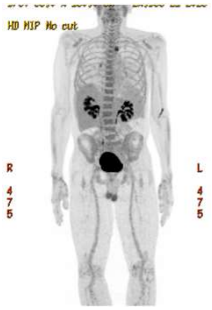
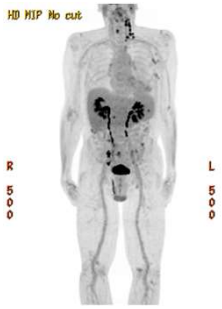
25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 3

- He is started on CHOP
- Interim PET/CT demonstrates CR after 2 cycles
- However, EOT PET after 6 cycles demonstrates recurrence, biopsy confirms **recurrent AITL**

Interim PET





EOT PET

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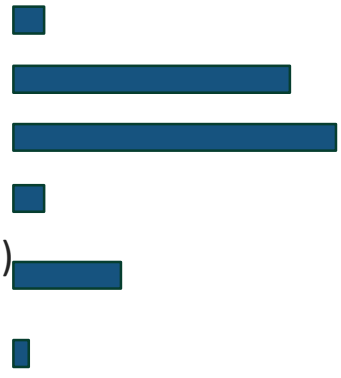
Patient is not felt to be good candidate for allogeneic transplant. Now how do you treat in second line?

1. ICE — 4%
2. Romidepsin +/- azacitidine — 35%
3. Brentuximab +/- bendamustine — 41%
4. Duvelisib — 4%
5. Gemcitabine regimen (e.g GemOx or GDP) or pralatrexate — 14%
6. Other — 2%



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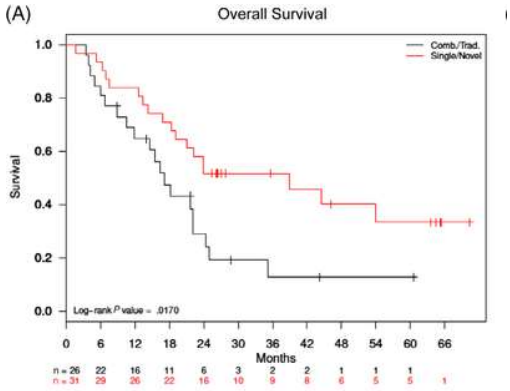
DADC15

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Single agents vs combination chemotherapy in R/R PTCL



- **Median OS** was **38.9 months** in the single agent group vs **17.1 months** in the combination therapy group
- **Median PFS** was **11.2 months** in the single agent group vs **6.7 months** for the combination therapy group

Stuver et al, Am J Hematol, 2021

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	Romidepsin	Romidepsin+ Azacitidine	Brentuximab+ bendamustine	Duvelisib
PTCL (other than Tfh)				
ORR	32%	61%	53%	49%
CR	21%	12.5%	29%	-
PFS(months)	2.1	2.3	2.7	3.5
AITL/Tfh				
ORR	54%	80%	67%	62%
CR	25%	60%	50%	51%
PFS(months)	4.1	8.9	9.7	8.3

Aubrais Blood Adv 2023
Ghione Blood Adv 2020
Mehta-Shah ASH 2024
Falchi et al, Blood, 2021

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Slide 61

DADC15 strange slide . what single, which combo?
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Slide 62

DADC21 table too small, un readable
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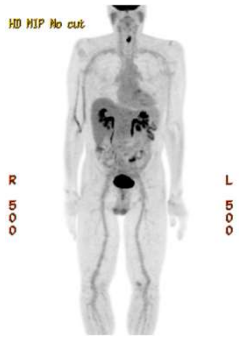
Case 3

- He is started on romi + aza, achieves a CR after 2 cycles
- CR continues to persist, now s/p six cycles



PET after 2 cycles with CR

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24th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 3 – Summary

AITL Upfront:

- The addition of etoposide to CHOP in frontline therapy does not improve outcomes in AITL
- ECHELON-2: Even in CD30+ disease, BV-CHP was not superior to CHOP for AITL

AITL relapsed:

- Romidepsin + azacitidine, bendamustine + brentuximab, and duvelisib all with good activity

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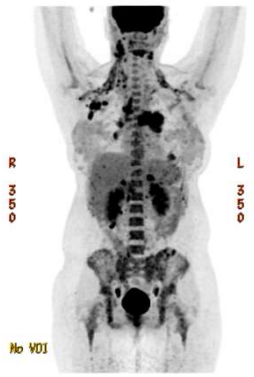
25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 4

- 23 yo F presents with waxing/waning cervical adenopathy, fevers, night sweats, and dyspnea
- Staging labs show: WBC 17.3, ALC 0.78, 4.5% lymph, Hgb 11.6, Plts 514, Alb 3.8, ESR 47
- PET/CT shows hypermetabolic masses/nodes in the anterior mediastinum, above/below the diaphragm, and peribronchial pulmonary consolidations
- Biopsy reveals **Stage IV classic Hodgkin lymphoma**, nodular sclerosis type. CD30+, CD20 -, CD15+, EBER -, PAX5 dimly positive. **IPS 4.**



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How would you treat her?

1. BrECADD — 2%
2. Brentuximab+AVD — 29%
3. Nivolumab+AVD — 52%
4. ABVD x2 then PET adapted to AVD vs BrECADD (modified RATHL) — 17%
5. Other — 0%

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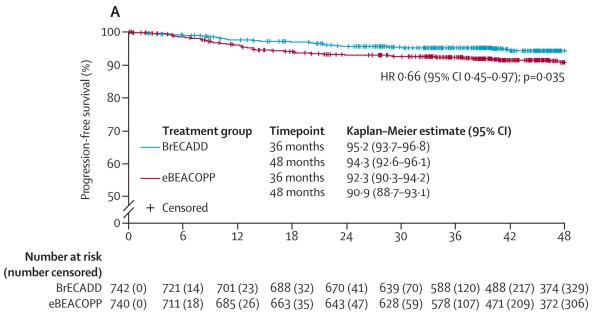
DADC19

25th Multidisciplinary Management of Cancers: A Case-Based Approach

HD-21: Phase 3 Trial Comparing BrECADD vs eBEACOPP



- 4yr PFS with BrECADD was **94.3%** vs **90.9%** with eBEACOPP (p-0.035)
- Treatment-related morbidity was significantly lower with BrECADD (312 **[42%]** of 738 patients) than with eBEACOPP (430 **[59%]** of 732 patients; relative risk **0·72** [95% CI 0·65–0·80]; p<0·0001).

Borchmann et al, The Lancet, 2024

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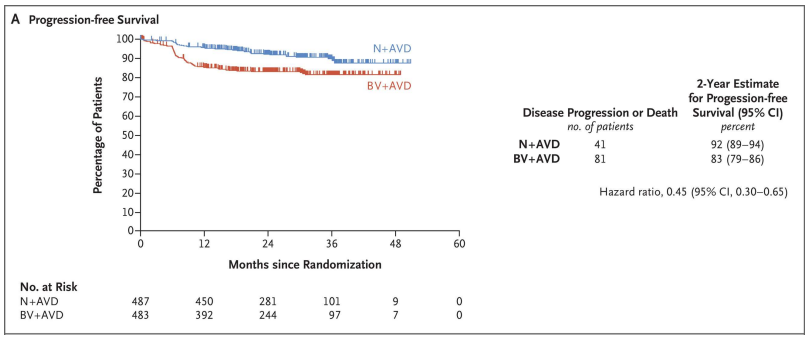
S1826: Nivolumab+AVD in Advanced-Stage Classic Hodgkin's Lymphoma



- N+AVD resulted in longer PFS than BV+AVD
- High grade adverse events > with BV+AVD except neutropenia (**56%** with N+AVD vs **34%** with BV+AVD)
- Neuropathy: **29%** with N+AVD vs **56%** with BV+AVD

Herrera et al, NEJM, 2024

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Slide 68

DADC19 could really sharten bullets make graphs larger too small to read now

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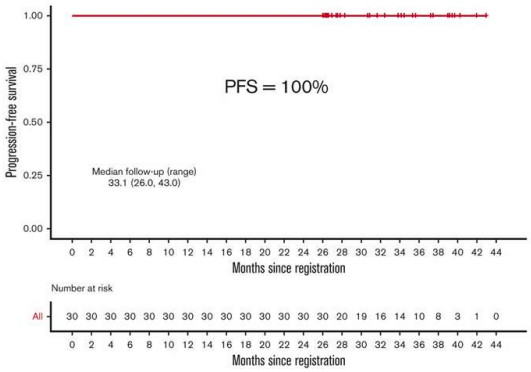
Sequential Pembro+AVD in Untreated Hodgkin's Lymphoma



- Ongoing trial: NCT06164275 with 3 to 6 cycles of pembro followed by AVD for 2 to 6 cycles
- Phase 2 study of pembrolizumab for 3 cycles followed by AVD chemotherapy for 4 to 6 cycles

Allen et al, Blood Advances, 2023

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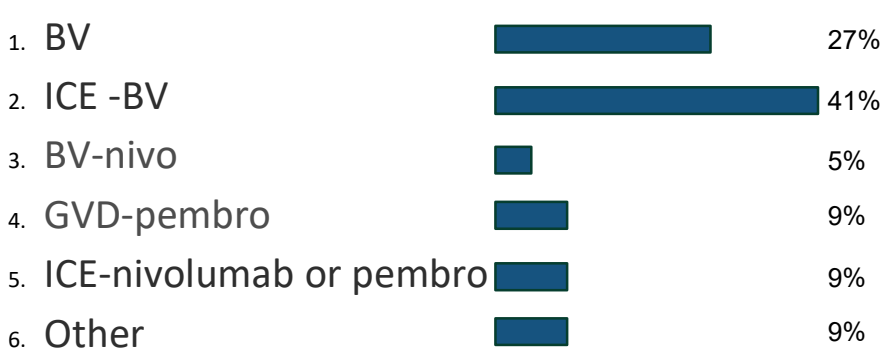
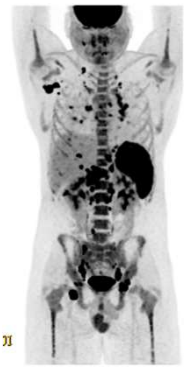
Patient receives Nivo-AVD but 6 months after initial metabolic CR, develops relapsed disease, what would you do next?





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25th Multidisciplinary Management of Cancers: A Case-Based Approach

Phase 2 (n=38):

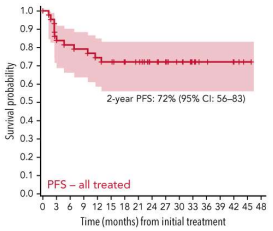
Pembro-GVD for R/R cHL

Characteristic	Pembro-GVD × 2 (n = 38)[a]
ORR, % (95% CI)	100 (91 to 100)
CR, % (95% CI)	92 (79 to 98)
PR, % (95% CI)	8 (2 to 21)
Best response, No. (%)	
CR	35 (92)
PR	3 (7.9)

ORR was **100%** and CR was **95%**

Phase 2 (n=42):

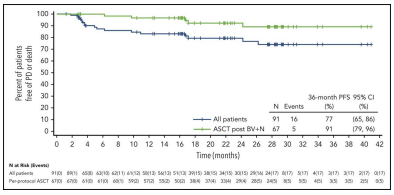
Nivo/Nivo-ICE in R/R cHL



ORR was **93%** and CR was **91%**

Phase 1/2 (n=91):

3yr Follow-Up of BV+Nivo in R/R cHL



ORR was **85%** and CR was **67%**

Advani et al, Blood, 2021
Mei et al, Blood, 2022
Moskowitz, JCO, 2021

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25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 4

- Patient receives ICE-BV x 3
- Subsequent PET shows Deauville 4 with a solitary hypermetabolic mesenteric lymph node
- Eventual biopsy shows persistent lymphoma

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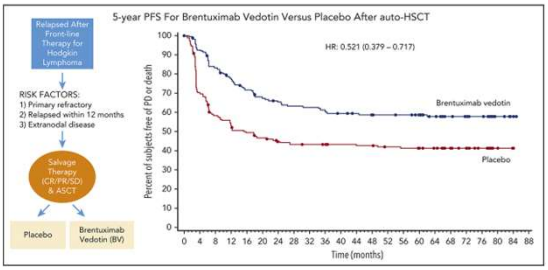
How would you treat her now?

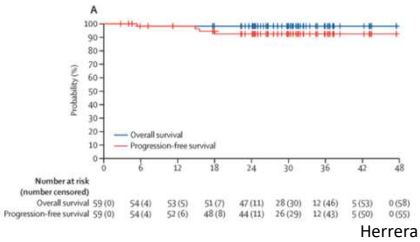
1. Radiation alone to solitary lymph node — 0%
2. Radiation plus maintenance BV — 18%
3. AutoSCT +/- radiation — 18%
4. AutoSCT +/- radiation and maintenance treatment — 55%
5. Switch to an alternative systemic regimen — 9%

Case 4

- AETHERA trial showed PFS benefit with 16 cycles of BV
- Real world data suggest perhaps less BV is as effective and less toxic
- BV+Nivo maintenance also shows strikingly good results



Moskowitz et al, Blood, 2018



Herrera et al, Lancet Haem, 2023

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Case 4 – Summary

- Nivo-AVD has replaced brentuximab-AVD as standard of care in the frontline setting for cHL given greater efficacy and tolerability
- Sequential PET-adapted treatments with immunotherapy are being studied
- Treatment for relapsed/refractory disease is not well defined in patients who received immunotherapy in the first line

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Thank You!

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