# Consensus or Controversy? Investigator Perspectives on Practical Issues and Research Questions in Non-Hodgkin Lymphoma

Friday, December 6, 2013 1:00 PM - 3:30 PM New Orleans, Louisiana

> **Moderator** Neil Love, MD

#### **Faculty**

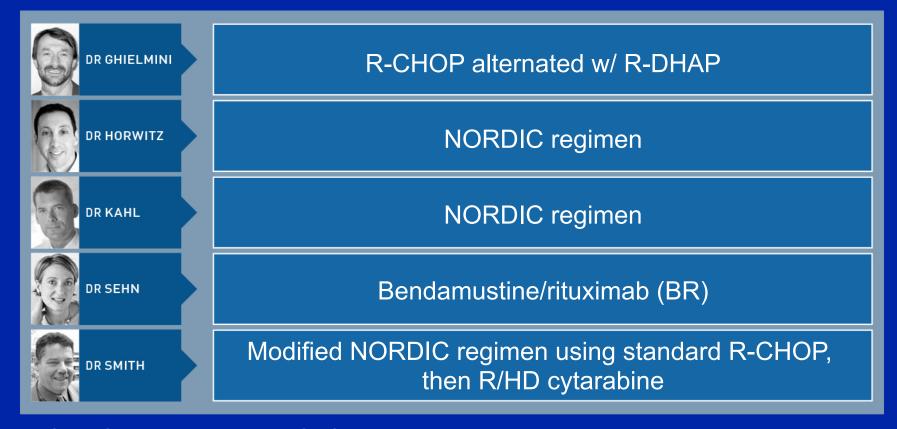
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Research
To Practice®

### MCL

#### MCL induction for younger patients?



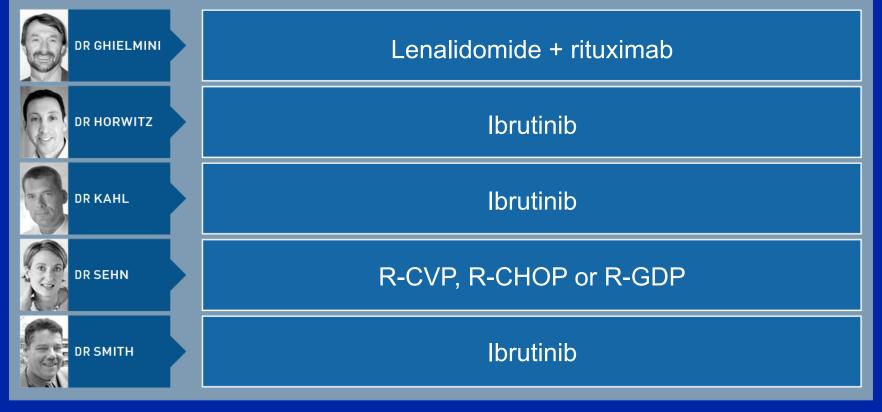
NORDIC regimen = R/maxi-CHOP → R/high-dose (HD) cytarabine

## 70 yo with MCL receives BR. Moderately symptomatic disease progression after 18 months. 2<sup>nd</sup>-line treatment?

DR GHIELMINI	Bortezomib + rituximab
DR HORWITZ	Ibrutinib
DR KAHL	Ibrutinib
DR SEHN	R-CVP, R-CHOP or R-GDP
DR SMITH	Ibrutinib

R-GDP = Rituximab with gemcitabine/cisplatin/dexamethasone

70 yo with MCL receives BR. Moderately symptomatic progression after 18 months. Receives 2<sup>nd</sup>-line bortezomib + rituximab and achieves PR but after 14 months has clinical disease progression. 3<sup>rd</sup>-line treatment?



R-GDP = Rituximab with gemcitabine/cisplatin/dexamethasone

# 90 yo with symptomatic MCL: Up-front treatment? Should ibrutinib be used up front for select patients with MCL?

#### **Up-front Tx**

### Use ibrutinib up front?

DR GHIELMINI	Steroids	Yes
DR HORWITZ	BR	No
DR KAHL	Ibrutinib	Yes
DR SEHN	Ibrutinib	Yes
DR SMITH	R monotherapy	No

## Usual schedule and method of bortezomib administration in relapsed MCL?

DR GHIELMINI	Weekly, subQ
DR HORWITZ	Twice weekly, subQ
DR KAHL	Twice weekly, subQ
DR SEHN	I don't use bortezomib for patients with MCL
DR SMITH	Weekly, subQ

## 75 yo with MCL: PR after 6 cycles of BR. Additional therapy?

DR GHIELMINI	None
DR HORWITZ	R maintenance x 2 years
DR KAHL	R maintenance x 2 years
DR SEHN	R maintenance x 2 years
DRSMITH	R maintenance x 2 years

#### **Proportion of MCL patients observed?**

DR GHIELMINI	10%
DR HORWITZ	5%
DR KAHL	15%
DR SEHN	5%
DR SMITH	10%

### CLL

#### 55 yo with CLL: Usual 1st-line treatment?

1st-line Tx

1st-line treatment if del(17p)?

DR GHIELMINI	FCR	FCR
DR HORWITZ	BR	FCR
DR KAHL	FCR	FCR
DR SEHN	FR	FR
DR SMITH	BR	FCR

1st-line Tx, del(17p)

F = fludarabine; C = cyclophosphamide; R = rituximab

### How often do you use chlorambucil +/-rituximab for CLL?

DR GHIELMINI	Occasionally
DR HORWITZ	Rarely
DR KAHL	Rarely
DR SEHN	Rarely
DRSMITH	Occasionally

#### 80 yo with CLL: Usual 1st-line treatment?

1<sup>st</sup>-line treatment if del(17p)?

Standard risk
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#### **Del(17p)**

DR GHIELMINI	BR	Rituximab + chlorambucil
DR HORWITZ	BR	Alemtuzumab
DR KAHL	BR	Alemtuzumab
DR SEHN	Rituximab + chlorambucil	Rituximab + chlorambucil
DR SMITH	Rituximab + chlorambucil	Alemtuzumab

#### Efficacy of obinutuzumab vs rituximab in CLL?

DR GHIELMINI	Equally efficacious
DR HORWITZ	Equally efficacious
DR KAHL	Not enough information to answer
DR SEHN	Obinutuzumab is more efficacious
DRSMITH	Not enough information to answer

#### Plan for use of obinutuzumab in CLL?



DR GHIELMINI



DR HORWITZ



DR KAHL



DR SEHN



DR SMITH

As monotherapy in relapsed disease

Not currently using, awaiting further data

Not currently using, awaiting further data

Up front with any chemotherapy

Select patients up front with chlorambucil

#### **Lenalidomide +/- rituximab for CLL?**

DR GHIELMINI	Select patients in R/R setting
DR HORWITZ	Select patients in R/R setting
DR KAHL	Select patients in R/R setting
DR SEHN	None
DR SMITH	Select patients in R/R setting

R/R = relapsed/refractory

### **TCL**

#### **Usual induction for PTCL NOS?**

DR GHIELMINI	CHOEP
DR HORWITZ	CHOEP
DR KAHL	CHOEP
DR SEHN	CHOP alternating with GDP
DR SMITH	CHOEP

Older nontransplant-eligible patient with CD30negative PTCL NOS. <u>Asymptomatic, low tumor</u> <u>burden</u> disease progression shortly after receiving CHOP. Usual next therapy outside of a protocol setting?

DR GHIELMINI	Gemcitabine	
DR HORWITZ	Pralatrexate or romidepsin	
DR KAHL	Romidepsin	
DR SEHN	GDP	
DR SMITH	Romidepsin	

## In what situations do you recommend transplant in PTCL NOS?

#### Recommended transplant type?

#### **Recommend transplant?**

#### Type of transplant?

DR GHIELMINI	Consolidation after induction	Autologous
DR HORWITZ	Consolidation after induction; R/R disease and ≥PR after 2 <sup>nd</sup> -line Tx	Autologous or allogeneic, nonmyeloablative
DR KAHL	Consolidation after induction	Autologous
DR SEHN	R/R disease and ≥PR after 2 <sup>nd</sup> -line Tx; Occasional pt at high risk after induction	Autologous or allogeneic, myeloablative
DR SMITH	Consolidation after induction	Autologous

# For TCL or B-cell lymphomas do you recommend CD30 testing in a <u>nonresearch</u>, <u>community setting</u>?

**TCL** 

**B-cell lymphomas** 

DR GHIELMINI	At relapse	No
DR HORWITZ	Up front and at relapse	At relapse
DR KAHL	At relapse	Will consider in elderly pt w/ relapsed large cell lymphoma
DR SEHN	Pts w/ ALCL and select other pts	No
DR SMITH	At relapse	At relapse if post-SCT or SCT ineligible

# Proportion of patients receiving romidepsin who require dose reduction or discontinuation due to toxicity?

Most common dose-limiting side effects?

**Dose reduction/ discontinuation** 

**Dose-limiting side effects** 

DR GHIELMINI	Have not used romidepsin	N/A
DR HORWITZ	25%	Fatigue, nausea/vomiting
DR KAHL	70%	Fatigue
DR SEHN	Have not used romidepsin	N/A
DR SMITH	25%	Fatigue, nausea/vomiting, thrombocytopenia

# Proportion of patients receiving pralatrexate who require dose reduction or discontinuation due to toxicity?

Most common dose-limiting side effects?

**Dose reduction/ discontinuation** 

**Dose-limiting side effects** 

DR GHIELMINI	Have not used pralatrexate	N/A
DR HORWITZ	100%	Mucositis
DR KAHL	90%	Mucositis
DR SEHN	Have not used pralatrexate	N/A
DR SMITH	50%	Mucositis

FL

# Younger patients with FL: Usual induction therapy? Additional treatment for those responding to induction?

<b>Up-front Tx</b>
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### Additional Tx after induction

DR GHIELMINI	R monotherapy	R x 2 years
DR HORWITZ	BR	R x 2 years
DR KAHL	BR	R x 2 years
DR SEHN	BR	R x 2 years
DR SMITH	BR	R x 2 years

#### Efficacy and tolerability of BR vs R-CHOP?

#### **Efficacy**

#### **Tolerability**

DR GHIELMINI	Similar for both	BR more tolerable
DR HORWITZ	Similar for both	Similar for both
DR KAHL	Similar for both	Similar for both
DR SEHN	BR likely more efficacious	BR more tolerable
DR SMITH	Similar for both	BR more tolerable

## Would you use R<sup>2</sup> (lenalidomide/rituximab) in FL outside of a protocol setting?



DR GHIELMINI



DR HORWITZ



DR KAHL



DR SEHN



DR SMITH

Up front in select pts w/ low tumor burden

In select pts w/ recurrent disease and desire to avoid chemo

In select pts w/ recurrent disease after SCT or who are SCT ineligible

Would consider in select pts w/ no further Tx options

In select pts w/ recurrent or R/R disease after at least 2 lines of therapy

# Situations in which you use transplant in FL? For pts in remission with negative bone marrow for FL, what type of transplant do you recommend?

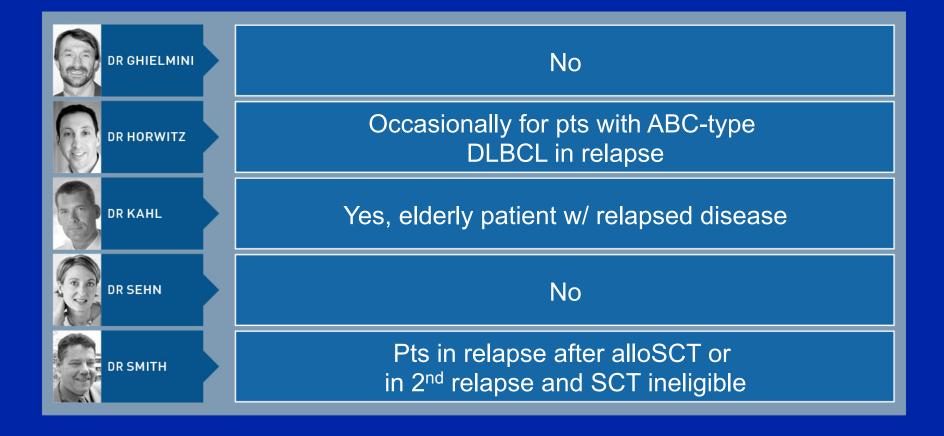
#### **Recommend transplant?**

#### **Type of transplant?**

DR GHIELMINI	Consolidation in 2 <sup>nd</sup> remission	Autologous
DR HORWITZ	Consolidation in 2 <sup>nd</sup> remission; transformation in 1 <sup>st</sup> remission	Autologous or allogeneic, nonmyeloablative
DR KAHL	Consolidation in 3 <sup>rd</sup> remission; transformation in 1 <sup>st</sup> remission	Autologous
DR SEHN	Consolidation in 3 <sup>rd</sup> remission; transformation in 1 <sup>st</sup> remission	Allogeneic, nonmyeloablative
DR SMITH	Consolidation in 3 <sup>rd</sup> remission; transformation in 1 <sup>st</sup> remission	Autologous

### **DLBCL**

#### Use of lenalidomide +/- rituximab in DLBCL?



# DLBCL with disease progression s/p R-CHOP and ineligible for transplant: 2<sup>nd</sup>-line systemic treatment?

DR GHIELMINI	Bendamustine +/- rituximab	
DR HORWITZ	GEMOX +/- rituximab	
DR KAHL	GEMOX +/- rituximab	
DR SEHN	R-GDP	
DR SMITH	Bendamustine +/- rituximab	

## Which biomarker assays should be used in general oncology practice for the management of DLBCL?

DR GHIELMINI	None
DR HORWITZ	Ki-67, C-MYC, BCL-2, t(8;14)
DR KAHL	C-MYC, BCL-2
DR SEHN	C-MYC, BCL-2
DR SMITH	Ki-67, CD20, C-MYC, t(8;14)

### Diagnostic tests you perform <u>during active</u> <u>treatment</u> for DLBCL?

PET-negative CR after 6 cycles of R-CHOP: Approach to follow-up scans?

#### **Diagnostic test**

### Approach to follow-up scans

DR GHIELMINI	СТ	Every 6 months x 2 years
DR HORWITZ	СТ	Every 6 months x 2 years
DR KAHL	СТ	Every 6 months x 2 years
DR SEHN	PET and CT	I don't generally order follow- up scans for these patients
DR SMITH	PET (end of treatment), CT (midtreatment)	At 6, 12 and 24 months

### Treatment for a patient with DLBCL, a history of cardiac disease and moderate cardiomyopathy?

DR GHIELMINI	R-CEOP
DR HORWITZ	R-CEOP
DR KAHL	R-CEOP
DR SEHN	R-CEOP
DR SMITH	R-CEOP