

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

**Brad S Kahl, MD
Mitchell R Smith, MD, PhD
Steven M Horwitz, MD**

**Michele E Ghilmini, MD, PhD
Laurie H Sehn, MD, MPH**

Research
To Practice®

MCL

Research
To Practice®

MCL induction for younger patients?



DR GHIELMINI

R-CHOP alternated w/ R-DHAP



DR HORWITZ

NORDIC regimen



DR KAHL

NORDIC regimen



DR SEHN

Bendamustine/rituximab (BR)








DR SMITH

Modified NORDIC regimen using standard R-CHOP,
then R/HD cytarabine

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

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



DR GHIELMINI

Lenalidomide + 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

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 GHELMINI

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



DR SMITH

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 treatment if del(17p)?

1st-line Tx

1st-line Tx, del(17p)

	<u>1st-line Tx</u>	<u>1st-line Tx, del(17p)</u>
 DR GHIELMINI	FCR	FCR
 DR HORWITZ	BR	FCR
 DR KAHL	FCR	FCR
 DR SEHN	FR	FR
 DR SMITH	BR	FCR

F = fludarabine; C = cyclophosphamide; R = rituximab

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



DR GHELMINI

Occasionally



DR HORWITZ

Rarely



DR KAHL

Rarely



DR SEHN

Rarely



DR SMITH






Occasionally

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

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

Standard risk

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



DR SMITH

Not enough information to answer

Plan for use of obinutuzumab in CLL?



DR GHELMINI

As monotherapy in relapsed disease



DR HORWITZ

Not currently using, awaiting further data



DR KAHL

Not currently using, awaiting further data



DR SEHN

Up front with any chemotherapy



DR SMITH

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

Research
To Practice®

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 CD30-negative PTCL NOS. Asymptomatic, low tumor burden 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?

	<u>Recommend transplant?</u>	<u>Type of transplant?</u>
 DR GHIELMINI	Consolidation after induction	Autologous
 DR HORWITZ	Consolidation after induction; R/R disease and \geq PR after 2 nd -line Tx	Autologous or allogeneic, nonmyeloablative
 DR KAHL	Consolidation after induction	Autologous
 DR SEHN	R/R disease and \geq PR after 2 nd -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 nonresearch, community setting?






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?






	<u>Dose reduction/ discontinuation</u>	<u>Dose-limiting side effects</u>
 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






Research
To Practice®

Younger patients with FL: Usual induction therapy?

Additional treatment for those responding to induction?

Up-front Tx






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 R² (lenalidomide/rituximab) in FL outside of a protocol setting?



DR GHIELMINI

Up front in select pts w/ low tumor burden



DR HORWITZ

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



DR KAHL

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



DR SEHN

Would consider in select pts w/ no further Tx options



DR SMITH






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

DLBCL

Use of lenalidomide +/- rituximab in DLBCL?



DR GHIELMINI

No



DR HORWITZ

Occasionally for pts with ABC-type
DLBCL in relapse



DR KAHL

Yes, elderly patient w/ relapsed disease



DR SEHN

No



DR SMITH

Pts in relapse after alloSCT or
in 2nd relapse and SCT ineligible

DLBCL with disease progression s/p R-CHOP and ineligible for transplant: 2nd-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 GHELMINI

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 during active treatment 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	CT	Every 6 months x 2 years
 DR HORWITZ	CT	Every 6 months x 2 years
 DR KAHL	CT	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