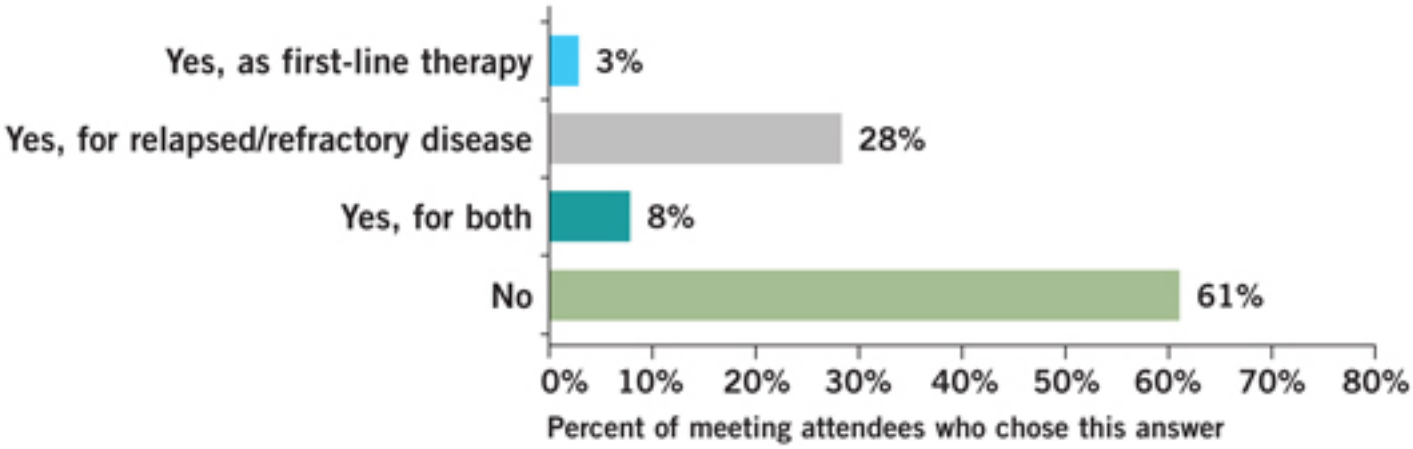
Year in Review

Proceedings from a Multitumor CME Symposium Focused on the Application of Emerging Research Information to the Care of Patients with Common Cancers

Diffuse Large B-cell and T-Cell Lymphomas — Michelle A Fanale, MD

Do you generally use lenalidomide outside of a protocol setting for patients with diffuse large B-cell lymphoma (DLBCL)?



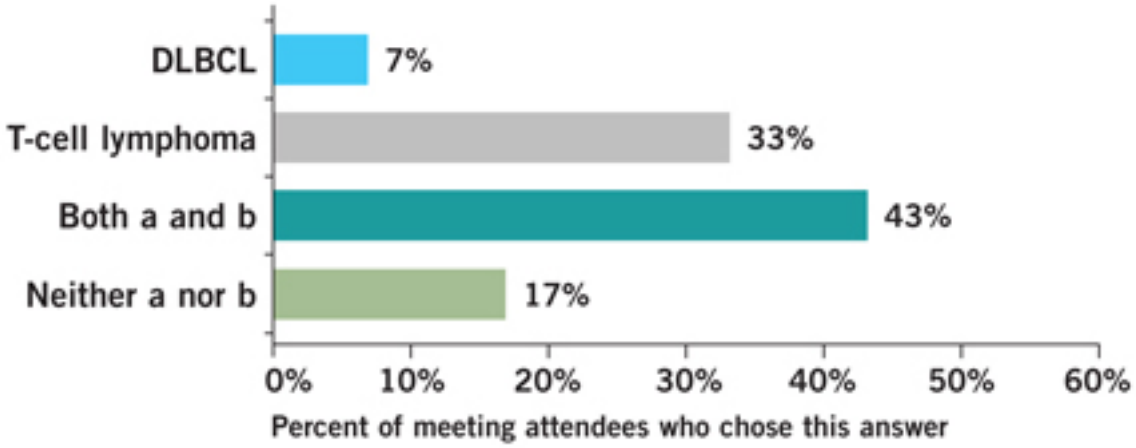
DR LOVE: We hear from investigators that they're using lenalidomide in relapsed/refractory diffuse large B-cell. But you can see here that there's not as much use in practice. What are your thoughts, Michelle, about lenalidomide outside a trial setting in relapsed/refractory diffuse large B-cell?

DR FANALE: I have very occasionally used it. It's generally a patient who's already gone through transplant and, let's say, has poor counts. They wouldn't qualify for any other clinical trials. They're not a good chemotherapy candidate. I think in the front-line setting, for the nongerminal-center phenotype, there definitely does seem to be a potential emerging role. In the relapsed setting, best response to my recollection for the combination of R^2 is about 50%, but the durability is rather short.

DR LOVE: Craig, maybe you can comment on what you think the role is of molecular subtyping in general oncology practice.

DR MOSKOWITZ: I think you guys get the information back on your pathology report. It's fairly straightforward. And now that both lenalidomide and ibrutinib appear to have only activity in a specific subtype, you should use that information, at least in the palliative setting. I check on all patients. For someone who needs palliative for an ABC subtype large cell lymphoma who's study ineligible, my first choice is giving R^2.

Do you generally recommend CD30 testing for your patients with...



DR LOVE: I was curious where people stand in terms of doing CD30 testing. A lot of the audience do it both in diffuse large B-cell as well as T-cell, some just in T-cell. Michelle, what do you do in your practice in terms of CD30 testing?

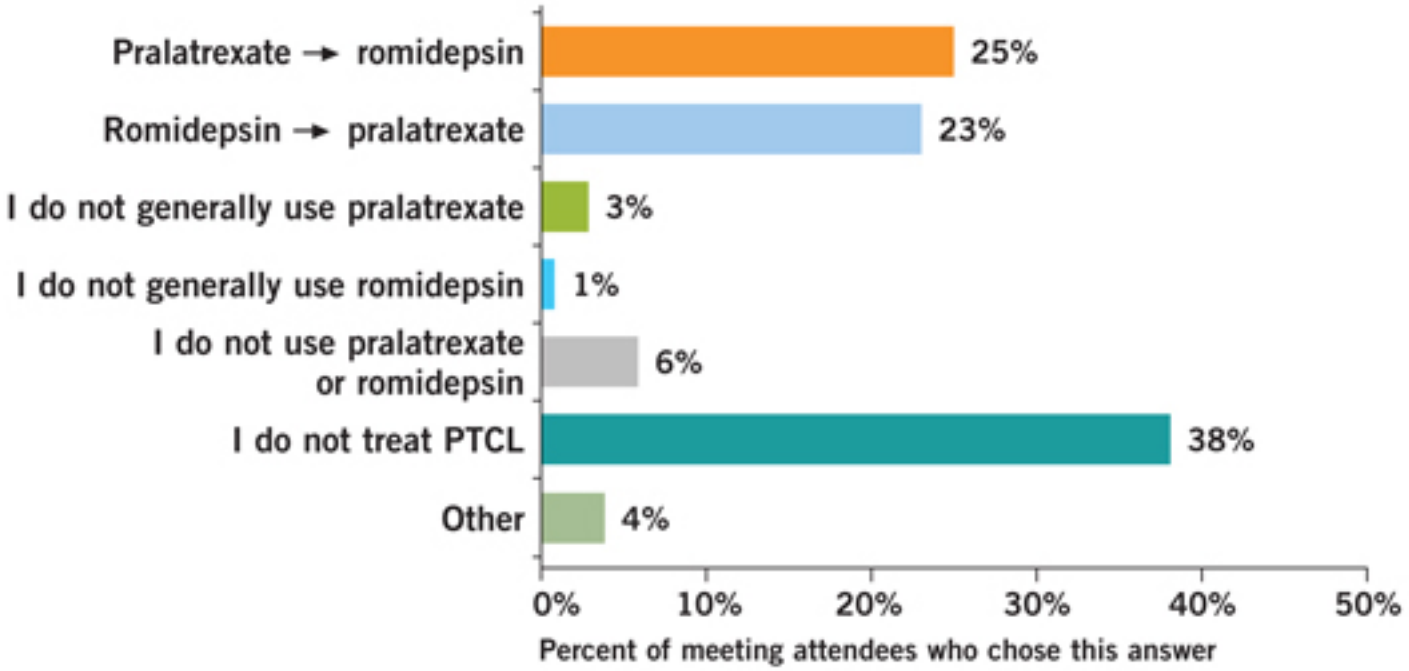
DR FANALE: In terms of my practice style, unless a patient is going to be going on a protocol, it's not something that I always test for. A scenario where I might test for it would be a patient who has angioblastic T-cell lymphoma. They've already received several other lines of treatment. I'm considering them, potentially, for brentuximab vedotin monotherapy. Typically, those patients, from prior publications, did the best in terms of the relapsed T-cell lymphoma group, from Steve Horwitz's publication. So for those patients, I potentially would test.

But the other issue is that both the relapsed large B-cell lymphoma and also the relapsed T-cell lymphoma trials have not really shown a clear correlation between CD30 levels of expression and response.

DR LOVE: Craig, what about in diffuse large B-cell in terms of B-vedotin? Have you seen patients treated? And have you seen useful responses?

DR MOSKOWITZ: Patients are treated. I think that I am a skeptic with brentuximab vedotin in large cell lymphoma for the reason that, in primary mediastinal large cell lymphoma, where 80% of the patients' tumors expresses CD30, there are minimal responses to single-agent brentuximab vedotin. That, to me, sets up a red flag for this drug in large cell lymphoma. I do know, of course, there are large studies that are being done. But there's only so many clinical trials one can open at your center. You're going to have to make a commitment for a couple of years of which one to pick. Doing R-CHOP plus or minus brentuximab vedotin for large cell lymphoma would not be one of my choices.

How do you generally sequence pralatrexate and romidepsin for an otherwise healthy patient with slowly progressing relapsed peripheral T-cell lymphoma (PTCL) who is asymptomatic?



DR LOVE: Michelle, not that many people are comfortable talking about T-cell lymphoma. I think you're about 1 of about 5 in the country that we can get to talk about it. But this is a problem, or an issue, that comes up in practice. And there are a couple of agents that are available, that have been approved. We're just curious how people sequence them. We can see most of the people here don't actually treat peripheral T-cell. I'm curious what your algorithm is, Michelle. How do you decide which one of these first?

DR FANALE: When I usually think about the agents that are really approved beyond the setting of patients who have anaplastic large cell lymphoma, where you would be considering BV, of course, for them, it's really kind of the 30% club to me. You look at overall response rates, and they're generally around 30%.

For this particular question, I actually favored going with romidepsin first because now, in follow-up data, just looking at romidepsin alone, the durability seems to be the best durability of the responses, approaching now about 25 to 28 months. Most patients generally tolerate the treatment well. Then, even for certain situations like a patient with angioblastic T-cell lymphoma, you could even consider a maintenance-based strategy as well.