INTERVIEW

Lauren C Pinter-Brown, MD

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Tracks 1-14

Select Excerpts from the Interview

Track 3

DR LOVE: How do you approach the off-protocol treatment of peripheral T-cell lymphoma (PTCL)?

DR PINTER-BROWN: I am currently using CHOP but substituting etoposide for the doxorubicin. At my institution when a patient has a complete response he or she will receive high-dose chemotherapy and autologous stem cell rescue up front.

We have 2 FDA-approved agents for PTCL — pralatrexate and romidepsin — to use in the relapsed or refractory setting (4.1, 4.2). These are both administered intravenously but belong to totally different classes of drugs.

Pralatrexate is an antifolate and romidepsin is an HDAC inhibitor. So we should see no interference of one drug with another, and if a patient does not respond to one agent,

that should have no implications regarding the chance of response to the other agent. The primary toxicity of pralatrexate is mucositis, and one tries hard to preserve the quality of life (QOL) while at the same time achieving a response.

DR LOVE: What are the side effects of romidepsin, and how are they managed?

DR PINTER-BROWN: The biggest toxicities affect QOL. Patients tend to develop low-grade nausea and fatigue, which can be managed in several ways, such as using antiemetics or ensuring that the patient is well hydrated. Neurostimulatory agents have been used to treat fatigue. In practice, I've administered the drug every other week,

4.1

Results from the Pivotal PROPEL Study of Pralatrexate for Patients with Relapsed or Refractory Peripheral T-Cell Lymphoma (PTCL)

Response	Pralatrexate (n = 111)
Response rate	29%
Median duration of response	10.1 months
Median progression-free survival	3.5 months
Median overall survival	14.5 months
Select adverse events (Grade ≥3)	
Thrombocytopenia	33%
Mucositis	22%
Neutropenia	22%
Anemia	18%

Conclusion: "To our knowledge, PROPEL (Pralatrexate in Patients with Relapsed or Refractory Peripheral T-Cell Lymphoma) is the largest prospective study conducted in patients with relapsed or refractory PTCL. Pralatrexate induced durable responses in relapsed or refractory PTCL irrespective of age, histologic subtypes, amount of prior therapy, prior methotrexate, and prior autologous stem-cell transplant. These data formed the basis for the US Food and Drug Administration approval of pralatrexate, the first drug approved for this disease."

O'Connor OA et al. *J Clin Oncol* 2011;29(9):1182-9.

4.2

Results from a Pivotal Phase II Study of Romidepsin in Relapsed or Refractory Peripheral T-Cell Lymphoma (PTCL) After Prior Systemic Therapy

Response	Romidepsin (n = 130)
Objective response rate	25%
Median duration of response	17 months
Select adverse events (Grade ≥3)	
Thrombocytopenia	24%
Neutropenia	20%
Infections	19%

Conclusion: "Single-agent romidepsin induced complete and durable responses with manageable toxicity in patients with relapsed or refractory PTCL across all major PTCL subtypes, regardless of the number or type of prior therapies. Results led to US Food and Drug Administration approval of romidepsin in this indication."

Coiffier B et al. *J Clin Oncol* 2012;30(6):631-6.

instead of 3 weeks on and 1 week off, because the patients tend to feel quite good on the week off. I've also tried dose reduction.

Tracks 4-5

DR LOVE: Would you discuss the efficacy and safety of everolimus in Hodgkin lymphoma?

DR PINTER-BROWN: I've been extremely impressed with everolimus. I participated in the Phase II trial of this agent in 42 patients with relapsed or refractory Hodgkin lymphoma (Johnston 2012; [4.3]). Some had complete remissions and went on to receive a transplant, and several patients have been on the trial for about 2 years. These are patients for whom ASCT had failed quickly. They have sustained partial responses and a superb QOL with everolimus. I would like to see the data expanded because I believe everolimus could be even more useful than brentuximab vedotin in Hodgkin lymphoma.

Approximately 40% of patients with relapsed or refractory Hodgkin lymphoma who received brentuximab vedotin in a Phase II trial developed peripheral neuropathy (Younes 2012). Although some patients respond, the duration of response to brentuximab vedotin is short. In my experience, many patients develop peripheral neuropathy around the eighth dose and need to stop therapy. If the patient has a complete response, it may be the only therapy needed because complete responses are durable. If the patient has a partial response, I would see it more as a bridge to move rapidly to transplantation. ■

4.3

Everolimus for Relapsed or Refractory Classical Hodgkin Lymphoma in an Open-Label, Single-Arm, Phase II Study

Best overall response	Everolimus (10 mg/d) (N = 42)
Overall response rate Complete response (CR)* Partial response (PR)	38.1% 7.1% 30.95%
Stable disease (SD)	28.6%
Progressive disease	14.3%
Unknown	19.0%

* Defined as resolution of all adenopathy
Disease control rate (CR + PR + SD) = 66.7%

Johnston PB et al. *Proc ASCO* 2012;**Abstract 8028**.

SELECT PUBLICATIONS

Coiffier B et al. **Results from a pivotal, open-label, phase II study of romidepsin in relapsed or refractory peripheral T-cell lymphoma after prior systemic therapy.** *J Clin Oncol* 2012;30(6):631-6.

Johnston PB et al. **Everolimus (EVE) for relapsed/refractory classical Hodgkin lymphoma (cHL): Open-label, single-arm, phase II study.** *Proc ASCO* 2012;**Abstract 8028**.

O'Connor OA et al. **Pralatrexate in patients with relapsed or refractory peripheral T-cell lymphoma: Results from the pivotal PROPEL study.** *J Clin Oncol* 2011;29(9):1182-9.

Younes A et al. **Results of a pivotal phase II study of brentuximab vedotin for patients with relapsed or refractory Hodgkin's lymphoma.** *J Clin Oncol* 2012;30(18):2183-9.