11th International Conference on Malignant Lymphoma

Conference Review

Making Education Easy

11th ICML; 15–18 June 2011, Lugano, Switzerland

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Independent commentary by Dr Leanne Berkahn, FRACP, FRCPA, Haematologist Auckland City Hospital, Senior Lecturer Dept of Molecular Medicine and Pathology University of Auckland.

Welcome to our review of the 11th International Conference on Malignant Lymphoma (ICML) held 15–18 June 2011 in Lugano, Switzerland.

The ICML attracted ~3000 physicians from around the world to attend the principal international forum for lymphoid neoplasm research. This review has been created to allow those unable to attend, but with a keen professional interest, to access a summary of some of the abstracts presented at the conference.

I hope you enjoy this review of the 11th ICML.

Kind regards,

Leanne Berkahn

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Session 15: Hodgkin Lymphoma

Abstract 160: Durable complete remissions in a pivotal phase 2 study of SGN-35 (brentuximab vedotin) in patients with relapsed or refractory Hodgkin lymphoma (HL)

Authors: Younes A et al

Summary: Outpatients with relapsed or refractory HL (n=102) received ≤16 cycles of 30-minute IV infusions of brentuximab vedotin (SGN-35; selectively induces CD30+ apoptosis) 1.8 mg/kg every 3 weeks initiated after autologous stem-cell transplantation. The objective response rate (primary endpoint; assessed by independent review facility [Cheson 2007]) and complete response rate were 75% and 34%, respectively; the median duration of response among participants with complete responses had not been reached at the time of reporting. Treatment-related adverse events reported in ≥15% of participants were diarrhoea, fatigue, nausea, neutropenia and peripheral sensory neuropathy, and grade ≥3 adverse events reported in ≥5% of participants were anaemia, neutropenia, peripheral sensory neuropathy and thrombocytopenia.

Comment: This was one of the most impressive posters at the conference. Finally, an immunotherapy for HL that shows promise, even when launched in such an advanced group of patients. Most of this young patient cohort were in the poor-risk, early relapse postautologous transplant category. Almost all had either a partial or complete response to this anti-CD30 antibody linked to an auristatin (monomethyl auristatin E). This was a welcome finding in view of the unimpressive response in trials of the naked anti-CD30 antibody. The 49% incidence of neuropathy may be more of an issue when combined with other chemotherapeutic agents; however, it was reversible in 80%. The next round of trials will study the prophylactic use in high-risk patients postautologous transplant and also an upfront treatment with ABVD.

Reference: Ann Oncol 2011;22(suppl 4):iv138

http://annonc.oxfordjournals.org/content/22/suppl_4/iv138.full.pdf+html

Abstract 166: Gonadal function in women after treatment of early unfavourable Hodgkin lymphoma (HL): first results of the fertility research project within the 5th trial generation, German Hodgkin study group (GHSG)

Authors: Behringer K et al

Summary: Young women with HL and without progression or relapse ≥1 year after treatment received four cycles of ABVD (evaluable n=131) or two cycles of BEACOPPesc plus two cycles of ABVD (122) followed by involved field irradiation. Participants from the ABVD only arm had significantly more favourable follicle-stimulating hormone (FSH) levels than those from the BEACOPPesc plus ABVD arm, but there were no between-group differences for regular menstrual cycle rates (88% and 84%), times to recovery of regular menstruation (maximum 1 year), pregnancy rates, birth rates (11% and 18%) or menopausal symptoms. Menopausal symptoms among the study participants were greater than reference values, while motherhood rates were similar to normal German population rates.

Comment: Many have adopted the HD14 treatment plan of 2 × escalated BEACOPP and 2 × ABVD with involved field radiotherapy for early stage HL with unfavourable characteristics. As full treatment courses with BEACOPPesc have an adverse impact on fertility, it is often difficult to convince young women to have this treatment over 4 × ABVD. This poster alleviates these concerns in view of the similar rates of motherhood, not only compared with the ABVD arm, but to the age-matched German population. This is useful information to bring to the discussion table with your patients.

Reference: Ann Oncol 2011;22(suppl 4):iv140

http://annonc.oxfordjournals.org/content/22/suppl_4/iv138.full.pdf+html

Session 3: Mantle cell lymphoma

Abstract 015: Differential expression of *SOX11*, *HDGFRP3*, and *DBN1* identifies two subgroups of MCL with different clinical outcome and genetic features

Authors: Royo C et al

Summary: Genetic signatures associated with an indolent clinical course in mantle cell lymphoma (MCL) have been identified using microarrays, which is not a widely available technology. This analysis of peripheral blood samples from 76 patients with MCL and 37 with other leukaemic B-cell neoplasms found that 4-year overall survival was significantly shorter in patients with MCL who had higher expression of *SOX11*, *HDGFRP3* and *DBN1* genes, compared with lower expression, when measured by quantitative reverse transcriptase PCR (50% vs. 95%; p<0.001). Furthermore, 22/23 cases with low expression of these genes also had ≥2 immunoglobulin heavy chain variable (IGHV) mutations, while 33/41 with high expression had no IGHV mutations (p<0.001), and there were fewer genomic imbalances among those with low expression (2.6 vs. 9.2; p=0.02). Among patients with MCL, both subgroups (low and high expression) had similar cyclin D1 expression levels.

Comment: Confirming what clinicians had long since suspected, there are now two subtypes of MCL emerging with very different clinical behaviours. Patients with low *SOX11*, *HDGFRP3* or *DBN1* expression had better overall survival at 4 years than those with high expression. Similar to the scenario in CLL, patients with low *SOX11* expression also had mutated IGHV chains and a lower number of genomic imbalances. As many centres adopt the Nordic approach to MCL, it is important to identify those older patients for whom less intensive treatment may be applicable.

Reference: Ann Oncol 2011;22(suppl 4):iv86

http://annonc.oxfordjournals.org/content/22/suppl_4/iv86.full.pdf+html

Session 7: Aggressive lymphoma

Abstract 072: A randomized multicentre phase III study for first line treatment of young patients with high risk (aaIPI 2-3) diffuse large B-cell lymphoma (DLBCL): rituximab (R) plus dose-dense chemotherapy CHOP14/MegaCHOP14 with or without intensified high-dose chemotherapy (HDC) and autologous stem cell transplantation (ASCT): results of DLCL04 trial of Italian lymphoma foundation (FIL)

Authors: Vitolo U et al

Summary: This phase III RCT with a 2×2 factorial design compared R-CHOP14 with R-MegaCHOP14 (cyclophosphamide 1200 mg/m^2, doxorubicin 70 mg/m^2 and standard vincristine/prednisone), with or without subsequent high-dose chemotherapy (rituximab, high-dose cytarabine, mitoxantrone, dexamethasone, BEAM) plus ASCT (HDT) in 375 evaluable patients with high-risk diffuse large B-cell lymphoma. The participants received eight cycles of R-CHOP14 only, 6 cycles of R-MegaCHOP14 only, 4 cycles of R-CHOP14 plus HDT or 4 cycles of R-MegaCHOP14 plus HDT. At the time of reporting, the complete, partial and no response rates were 74%, 6% and 12%, respectively, and the toxic death and dropout rates were 3% and 5%, respectively. A significantly higher 2-year progression-free survival rate was seen in the HDT arms compared with the non-HDT arms over median follow-up of 23 months (72% vs. 59%; p=0.008). No significant difference was seen between these groups for overall survival, or for progression-free survival between the R-CHOP14 and R-MegaCHOP14 arms. Cox modelling using the R-CHOP14 only arm as a reference found a significantly reduced risk of relapse in the R-CHOP14 plus HDT arm (hazard ratio 0.47 [95% CI 0.27, 0.81; p=0.007]), and a *"minor effect"* in the R-MegaCHOP14 plus HDT arm (0.69; p=0.15).

Comment: Patients deemed high risk were those with extranodal disease, bulky mediastinal disease or aaIPI2-3. This study suggests that R-CHOP14 plus HDT reduces the relapse rate in high-risk DLBCL, but that there is no advantage for more aggressive dose-dense induction therapy prior to HDT. There is no survival advantage, presumably because patients who relapsed in the chemotherapy arm were able to be salvaged by ASCT at the time. However, as 60% of patients in the chemotherapy only arm did not relapse, transplant in CR1 would have been unnecessary. We need to better define the 'high-risk' group prior to advocating SCT in CR1. The recent SWOG study presented at ASCO, for example, suggested that SCT in CR1 may only be beneficial to those with a high IPI (4–5) alone.

Reference: Ann Oncol 2011;22(suppl 4):iv106

http://annonc.oxfordjournals.org/content/22/suppl_4/iv106.full.pdf+html

Abstract 076: Autologous stem cell transplantation remains beneficial for patients relapsing after R-CHOP and who respond to salvage chemotherapy

Authors: Moore S et al

Summary: This study retrospectively compared post-ASCT outcomes between patients with relapsed or refractory DLBCL who had received R-CHOP (n=33) versus CHOP (n=72) for induction therapy and responded to salvage chemotherapy. Patients who had received rituximab with CHOP during induction therapy did not have significantly lower progression-free or overall survival rates post-ASCT compared with those who received CHOP only (51% vs. 72% [p=0.41] and 64% vs. 73% [p=0.10], respectively). Only 22% of patients who relapsed post-ASCT received a reduced intensity allogeneic transplant.

Comment: Recent publication of the final results of the CORAL study found a disappointing outcome with salvage ASCT for patients who relapse following R-CHOP (3-year event-free survival of just 21% compared with 51% after CHOP). This single centre retrospective review, however, showed no difference between those who received CHOP versus R-CHOP with a 5-year progression-free survival of 72% for the R-CHOP cohort and 51% for the CHOP cohort. Therefore, ASCT still offers a good likelihood of cure for relapsed patients, although risk factors such as early relapse and failure to respond to salvage chemotherapy predict for a poor outcome.

Reference: Ann Oncol 2011;22(suppl 4):iv107

http://annonc.oxfordjournals.org/content/22/suppl_4/iv106.full.pdf+html

Abstract 073: Conventional chemoimmunotherapy (R-CHOEP-14) or high-dose therapy (R-MEGA-CHOEP) for young, high-risk patients with aggressive B-cell lymphoma: final results of the randomized MEGA-CHOEP-trial of the German High-Grade Non-Hodgkin Lymphoma Study Group (DSHNHL)

Authors: Schmitz N et al

Summary: Patients aged <61 years with CD20+ aggressive B-cell lymphoma (73.3% aaIPI 2 and 26.7% aaIPI 3) were randomised to receive 6 infusions of rituximab with either 8 cycles of CHOEP-14 (including etoposide 300 mg/m^2; n=130) or 4 cycles of MegaCHOEP (cyclophosphamide 1500/4500/4500/6000 mg/m^2, doxorubicin 70 mg/m^2, vincristine 2 mg/m^2, etoposide 600/960/960/1480 mg/m^2 and prednisone 500mg; n=132) followed by repeated autologous stem-cell transplantation; 44 participants were not evaluable. After a median follow-up of 43 months, the overall response rate was 77.9%, with complete (including unconfirmed) and partial response rates of 75.1% and 2.8%, respectively). There were no significant differences between the R-CHOEP-14 and R-MegaCHOEP arms for: i) treatment mortality rates (3.1% vs. 5.6%; p=0.348); ii) 3-year progression-free survival rates (73.7% vs. 69.8%; p=0.475); and iii) 3-year overall survival rates (84.6% vs. 77.0%; p=0.081). Among participants with aaIPI 2 (but not aaIPI3) disease, R-CHOEP-14 was associated with better overall survival.

Comment: The addition of etoposide 300 mg/m^2 to each cycle of R-CHOP-14 usurped the need for high-dose therapy (HDT) in this study of an undefined 'high-risk' group of young DLBCL patients. This was particularly true for the aaIPI 2 rather than aaIPI 3 group. Fewer patients allocated to the transplant arm actually had HDT, and when the cohort that actually received HDT was analysed, the transplant arm looked more promising. The German group maintained that R-CHOEP-14 is the new standard of care for young patients with high-risk DLBCL. The rest of the world is yet to be convinced, and this has not been universally adopted. I think we need to wait the full publication of all four of these recent studies on this topic (German, GOELAMS, SWOG and Italian), as there are a number of statistical loopholes in the abstracts as presented.

Reference: Ann Oncol 2011;22(suppl 4):iv106–7

http://annonc.oxfordjournals.org/content/22/suppl_4/iv106.full.pdf+html

"Focus on. . ." session: radiotherapy and early stage

Abstract 028: Treatment of limited-stage DLBCL can be effectively tailored using a PET-based approach

Authors: Sehn LH et al

Summary: An update on experiences associated with the PET-based algorithm (FDG-PET/CT scan following 3 cycles of R-CHOP, with one further cycle of R-CHOP for PET-negative patients and involved-field radiotherapy (IFRT) for PET-positive patients) to treat limited-stage DLBCL in British Columbia was presented in this abstract. Patients treated over a ~5-year period were included. Relapse was seen in three of the 103 PET-negative patients (100 received additional R-CHOP), including three delayed relapses, and nine of 30 PET-positive patients (29 received IFRT), all of which were distant from the original disease site and one with follicular lymphoma. PET-negative and -positive patients had estimated 3-year time to progression (TTP) rates of 92% and 60%, respectively, and the respective overall survival rates were 96% and 83%. One patient with an indeterminate PET result received IFRT and remained in remission. A multivariate analysis found the only predictors of TTP were PET status, age and prognostic score.

Comment: This abstract from the reputable BCCA database retrospectively examined the use of interim PET-directed therapy for limited-stage DLBCL with no adverse features. The estimated 3-year TTP was 92% in patients from the interim PET-negative arm, who received 4 × R-CHOP and no radiotherapy. Three of seven PET-negative patients that relapsed had disease localised only to the original site, suggesting they may have benefited from IFRT. However, radiotherapy was successfully avoided in 100 of the 107 PET-negative patients, supporting this approach for this patient group. The patients who had a positive interim PET received RT after 4 cycles of R-CHOP, but had an unacceptably high rate of distant relapses, suggesting chemotherapy in this group needs to be more intensive.

Reference: Ann Oncol 2011;22 (suppl 4):iv90–1

http://annonc.oxfordjournals.org/content/22/suppl_4/iv90.full.pdf+html

Abstract 026: Should radiation therapy (XRT) be the standard therapeutic approach for stage I follicular lymphoma (FL)? A comparative effectiveness analysis of the National Lymphocare Study (NLCS)

Authors: Friedberg J et al

Summary: This analysis of patients with stage I follicular lymphoma (FL) with complete staging from the NLCS investigated the effectiveness of the following treatment regimens: i) watchful waiting (n=34); ii) rituximab alone (n=26); iii) rituximab plus chemotherapy (n=62); iv) involved-field radiotherapy (IFRT) alone (n=56); and v) chemotherapy plus IFRT (combined modality; n=21). There were 34 progression events, including six deaths, over a median follow-up of 49 months. A Cox regression analysis found: i) no difference in progression-free survival (PFS) between IFRT and watchful waiting; and ii) rituximab-containing chemotherapy was the only modality associated with statistically improved PFS outcomes compared with watchful waiting (hazard ratio 0.2 [CI 0.05, 0.6]). Outcomes were excellent for patients who received combined modality therapy, but the numbers were too small to calculate an estimated effect.

Abstract 027: Follicular lymphoma: curability by radiotherapy in limited stage nodal disease? Updated results of a randomized trial

Authors: Engelhard M et al

Summary: Patients aged ≤65 years with stage I–II or limited stage III FL (n=202) were randomised to receive extended-field or total lymphatic irradiation, 30Gy boosted by 10/14Gy depending on lymphoma size. In a prospective observational trial, 53 patients aged 66–75 years with stage I–II or limited stage III FL received extended-field radiotherapy, and those aged >75 years received involved-field radiotherapy. For both studies combined, the overall survival was 97% after a median observation of 51 months, the 5-year relapse and progression-free survival rates were 60% and 59%, respectively, the complete remission rate was 92%, and relapse had occurred in 24% after a median of 24 months. The majority of relapses (92%) were new manifestations, with 79% at a new site alone, 73% out-of field, and 68% located on the opposing side of the diaphragm. They were mostly entirely nodal (76%) and rarely bone marrow (8%) or extranodal (10%). Histology of relapses (65%) revealed 30% had transition into secondary diffuse large B-cell lymphoma 7–96 months from diagnosis. Second tumours were solid tumours (n=6), sarcoma (1), acute myeloid leukaemia (1) and possible myelodysplastic syndrome (2) after 4–119 months. Unblinding had not been reached in the randomised study at the time of reporting.

Reference: Ann Oncol 2011;22(suppl 4):iv90

http://annonc.oxfordjournals.org/content/22/suppl_4/iv90.full.pdf+html

Comment: More surprising results from the study by Friedberg et al, with no improvement in IFRT over observation alone in early-stage FL. This contradicts current clinical practice, in which early-stage FL has a 40–60% chance of prolonged PFS, if not cure, with IFRT. Rather, the study showed that PFS was superior with the addition of chemotherapy to IFRT or chemotherapy alone. PET scan at diagnosis did not improve the PFS in patients who had been fully staged with CT and marrow staging. As PET scanning is often used to define radiotherapy fields, this finding may reflect the relative ineffectiveness of RT in this study. Some of these findings may reflect the limitations of a multicentre observational study and the relatively small numbers in each treatment arm. We are fortunate in NZ to be participating in the TROG study, which randomises early-stage FL patients between R-CVP plus IFRT and IFRT alone, and should provide more valid results. Meanwhile, in the abstract by Engelhard et al, the Germans, disappointed by late relapses in out-of-field sites after IFRT alone, have moved to the addition of single-agent rituximab plus IFRT for early-stage FL.

Session 13: Indolent lymphoma

Abstract 135: R-CVP vs. R-CHOP vs. R-FM for the initial treatment of patients with advanced stage follicular lymphoma: preliminary results of FOLL05 IIL trial

Authors: Federico M et al

Summary: This abstract reported a preliminary analysis from a study comparing the efficacy of 8 rituximab doses associated with 8 cycles of CVP (R-CVP), 6 cycles of CHOP (R-CHOP) or fludarabine 25 mg/m² on d1–3 and mitoxantrone 10 mg/m² on d1 (R-FM) in 504 evaluable patients with previously untreated stage II–IV follicular lymphoma (62% stage IV; 37% FLIPI score >2). The overall response rate after induction therapy among all participants was 89%. The 3-year time-to-treatment-failure rate after a median 25-month follow-up period was significantly lower in the R-CVP arm than the R-CHOP and R-FM arms (47% vs. 57% and 60% [p values 0.026 and 0.023], respectively). At the time of reporting, there were no significant between-group differences for progression-free survival, and the 3-year overall survival rates for the R-CVP, R-CHOP and R-FM arms were 97%, 96% and 92%, respectively. Grade 3–4 neutropenia was reported in 56% of the participants, with significantly higher neutropenia rates in the R-FM arm than the R-CVP and R-CHOP arms (odds ratios 9.37 [p<0.001] and 1.96 [p=0.004]).

Comment: Finally, a randomised trial designed to discover the superior induction regimen in advanced follicular lymphoma – the real question being whether R-CHOP deserves to be the favoured induction regimen over R-FM. The inferiority of R-CVP was not a surprise finding, but R-CHOP and R-FM had similar efficacies. There was significantly more grade 3–4 neutropenia with R-FM, and the authors have leapt on this to declare R-CHOP 'the winner'. However, there was no difference in the rate of infection between the two arms, so I believe either regimen is appropriate as induction therapy.

Reference: Ann Oncol 2011;22(suppl 4):iv128

http://annonc.oxfordjournals.org/content/22/suppl_4/iv128.full.pdf+html

PET

Abstract 220: Risk-adapted therapy using biopsy confirmation of abnormal interim FDG-PET for patients with advanced stage diffuse large B cell lymphoma (DLBCL), and exploratory evaluation of FLT-PET

Authors: Moskowitz CH et al

Summary: After undergoing CT with contrast, FDG-PET and research ^{18}flourothymidine (FLT)-PET scan, patients with advanced stage DLBCL or primary mediastinal large B-cell lymphoma (PMBCL) received induction therapy with 3 cycles of R-CHOP-14 then one of CHOP-21, with a repeat FDG-PET 17–20 days later, and biopsy if FDG-PET positive. Consolidation therapy was risk-adapted. If interim FDG-PET or biopsy was negative, treatment consisted of 3 cycles of ICE for PI <80% and two cycles of augmented RICE for PI ≥80%, and if biopsy was positive, treatment was 2 cycles of augmented RICE followed by HDT/ASCR. FLT-PET was repeated after cycles 1 and 2 in the first and subsequent 30 patients, respectively. Data from 50 evaluable participants at the time of reporting showed that after a median 18 months of follow-up, the progression-free survival (PFS) and overall survival rates were 86% and 96%, respectively. No pretreatment clinical or pathological risk factors assessed (including PI >80, cell of origin, DLBCL vs. PMBCL and aaIPI HR disease) were prognostic. As was seen in these researchers' previous investigations, PFS was not worse among patients with a positive versus negative interim FDG-PET, and PFS was similar between those with a negative scan and those with a negative interim biopsy. A trend for inferior PFS was seen in the six participants with an interim delta SUV <70%. Four of the six participants with a true positive FDG-PET at the end of treatment experienced progression.

Comment: This abstract lies at the centre of the great debate on the role of interim PET in DLBCL. An intensification of therapy from the baseline of 4 cycles of intensified R-CHOP followed by ICE therapy was directed not by the interim PET status, but by the Ki67%. All those with a positive PET (≥3 on the Deauville scale) had a biopsy, and only 2/16 were positive. This triggered a lot of debate, of which the bottom line was PET has a high negative predictive value, but poor positive predictive value. Analysis of the patients who had an interim PET on the GELA trial also found PET was not predictive for PFS. Unlike Hodgkin lymphoma, there is no current role for interim PET in DLBCL outside of a trial.

Reference: Ann Oncol 2011;22(suppl 4):iv158

http://annonc.oxfordjournals.org/content/22/suppl_4/iv157.full.pdf+html

Session 10: CLL

Abstract 122: The BTK inhibitor PCI-32765 is highly active and tolerable in patients with poor-risk CLL: interim results from a phase IB/II study

Authors: O'Brien S et al

Summary: This abstract reported data from a phase Ib/II study, in which patients aged ≥65 years with treatment-naïve chronic lymphocytic leukaemia (CLL; n=12) or relapsed/refractory CLL treated with ≥2 prior treatment regimens (at least one of which contained fludarabine; n=27) received 28-day cycles of PCI-32765 (a Bruton tyrosine kinase inhibitor) 420mg once daily until disease progression; 30%, 21% and 70% had del17p, del11q and unmutated IgVH, respectively. The nodal response rate (≥50% reduction in target lesion) in the evaluable participants with lymphadenopathy at the time of reporting (n=28) was 89%, and did not differ between patients with and without poor-risk molecular features. A transient increase in absolute lymphocyte count was seen in 75% of participants with measurable lymphadenopathy. Among 13 patients with baseline thrombocytopenia, platelet counts improved in 69%. After a median follow-up period of 4 months, five participants had discontinued PCI-32765 for adverse events, disease progression or by their own decision. Grade ≥3 adverse events potentially related to PCI-32765 were reported in 31% of participants, and <5% of participants experienced grade ≥3 neutropenia; no renal or hepatic adverse events were reported.

Comment: PCI-32765 aims to disrupt signalling through the B-cell receptor, which is thought to be fundamental to the ongoing viability of a B lymphocyte. In a patient group of whom 2/3 were relapsed/refractory, including 17p-deleted patients, 89% achieved a ≥PR. There was no discrimination between poor molecular risk patients and others. Given the minimal toxicity, I can envisage this oral agent being complementary to other CLL therapies, and it will be interesting to see phase II results of combination therapies using Bruton tyrosine kinase inhibitors. Another phase I study in an assortment of relapsed B-cell lymphomas was presented, with responses seen in all subtypes and the highest responses in CLL.

Reference: Ann Oncol 2011;22(suppl 4):iv124

http://annonc.oxfordjournals.org/content/22/suppl_4/iv123.full.pdf+html

Session 11: T-cell lymphomas

Abstract 125: Durable remissions with SGN-35 (brentuximab vedotin): updated results of a phase 2 study in patients with relapsed or refractory systemic anaplastic large cell lymphoma (sALCL)

Authors: Shustov A et al

Summary: Patients with relapsed or refractory systemic anaplastic large-cell lymphoma (n=58) received ≤16 cycles of 30-minute infusions of IV brentuximab vedotin (SGN-35; selectively induces CD30+ apoptosis) 1.8 mg/kg every 3 weeks. The objective response rate (primary endpoint; assessed by independent review facility [Cheson 2007]) and complete response rate were 86% and 53%, respectively; the median duration of objective responses had not been reached at the time of reporting. Fourteen of the 15 participants with malignant cutaneous lesions at baseline experienced resolution of all lesions in a median of 4.9 weeks. Fourteen participants underwent stem-cell transplantation (seven allogeneic and seven autologous) after achieving remission. Treatment-related adverse events reported in ≥15% of participants were diarrhoea (19%), fatigue (22%), nausea (24%), neutropenia (17%) and peripheral sensory neuropathy (36%), and grade ≥3 adverse events reported in ≥10% of participants were neutropenia (21%), peripheral sensory neuropathy (10%) and thrombocytopenia (14%); there were no grade 5 treatment-related adverse events.

Comment: Similar to the abstract in Hodgkin's lymphoma on p1, this study of brentuximab vedotin is in a highly refractory poor-risk group of patients with anaplastic large-cell lymphoma – 72% ALK-negative, 52% refractory to last treatment and 22% unresponsive to any prior treatment. Sound familiar? The results with this single agent can only be described as stunning, with a 57% complete response rate and 86% ≥partial remission. Again, a striking waterfall plot was produced. The median duration of response was 13.5 months. This may provide the window needed to tee up an allogeneic stem-cell donor.

Reference: Ann Oncol 2011;22(suppl 4):iv125

http://annonc.oxfordjournals.org/content/22/suppl_4/iv125.full.pdf+html

Roche

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