médico especialista e o recebimento de diagnóstico foi de 28 dias, em contrapartida, o tempo médio entre diagnóstico e início do tratamento foi de 124 dias e é superior para pacientes diagnosticados em estágios 3 (157 dias) e 4 (118 dias). **Discussão:** O linfoma do manto é um subtipo raro do linfoma não Hodgkin e, assim como outros tipos de câncer, o tempo até o recebimento do diagnóstico é fator decisivo no tratamento. A falta de acesso à saúde é o principal fator para a demora no diagnóstico e acesso ao tratamento, tendo em vista que há uma dificuldade em acessar a atenção secundária, na qual acontece o atendimento ambulatorial especializado e há uma grande demora para acessar a unidade terciária, onde são feitas as terapias e procedimentos de alta complexidade. **Conclusão:** O Panorama de atendimento de pacientes diagnosticados com linfoma do manto evidenciou que a maioria dos pacientes já possuíam diagnóstico anterior da doença e que a maior proporção do diagnóstico ocorre em estadiamentos avançados. Além da maioria dos pacientes ser diagnosticados tardiamente, existe um grande intervalo de tempo até o início do tratamento que é mais intensificado em estádios 3 e 4 da doença. Torna-se necessário a implementação de ações de saúde que promovam a detecção precoce do câncer e o rápido início do tratamento, tendo em vista que são as principais estratégias para melhorar o prognóstico do câncer e a qualidade de vida do paciente.

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PATIENTS WITH RELAPSED/REFRACTORY MARGINAL ZONE LYMPHOMA IN THE MAGNIFY PHASE 3B INTERIM ANALYSIS OF INDUCTION R2 FOLLOWED BY MAINTENANCE

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Objectives: Relapse is expected when treating patients with follicular lymphoma (FL) and marginal zone lymphoma (MZL), with a shortened response associated with each relapse. Lenalidomide combined with rituximab (R^2) has shown enhanced activity, with a recently reported median progression free-survival (PFS) of 39.4 months in patients with relapsed/refractory (R/R) indolent non-Hodgkin lymphoma, including those with FL and MZL (Augment; J Clin Oncol. 2019;37:1188). **Materials and methods:** MAGNIFY is a multicenter, phase 3b trial (NCT01996865) in patients with R/R follicular lymphoma (FL) grades 1–3b, transformed FL (tFL), MZL, and mantle cell lymphoma (MCL). Lenalidomide 20 mg on d 1–21 of a 28-d cycle + rituximab 375 mg/m^2/wk cycle 1 and then every 8 wk starting with cycle 3 (R^2) is given for 12 cycles followed by 1:1 randomization in patients with stable disease, partial response, or complete response/complete response unconfirmed (CR/CRu) to R^2 vs rituximab maintenance for 18 mo. The primary end point is progression-free survival (PFS) by 1999 International Working Group criteria. Secondary end points include safety, CR rate, duration of response (DOR), duration of CR, time-to-response, time-to-next antilymphoma therapy, and overall survival. Data presented here focus on induction R^2 in efficacy-evaluable patients with MZL compared with the overall population of FL grades 1–3a+MZL (not including FL grade 3b, tFL, or MCL) receiving ≥ 1 treatment with baseline/post-baseline assessments. **Results:** As of August 28, 2020, 394 patients with FL grades 1–3a and MZL enrolled; 76 (19%) had MZL. The median age of patients with MZL was 68 years (range, 46–90), 68 (89%) had stage III/IV disease, and 72 (95%) had prior rituximab-containing therapy. Overall response rate in the MZL and overall population was 66% and 75% with 39% and 44% having a CR/CRu. Median DOR was 38.6 months (95% CI, 29.4–not reached [NR]) and NR (95% CI, 38.6–NR). The median PFS was 40.9 months (95% CI, 27.8–NR) and 41.2 months (95% CI, 38.7–NR). In the MZL population, 43 patients (57%) have completed 12 cycles of R^2, and 42 (55%) have been randomized and entered maintenance. Twenty-eight patients (37%) prematurely discontinued both lenalidomide and rituximab, primarily due to adverse events (AEs; n = 11; 14%) and progressive disease (n = 6; 8%). The most common (≥ 20%) all-grade AEs were neutropenia (49%), fatigue (43%), diarrhea (37%), thrombocytopenia (24%), constipation (24%), and anemia (22%). Most common (≥ 10%) grade 3/4 AEs were neutropenia (41%; 1 patient [1%] had febrile neutropenia), thrombocytopenia (13%), and leukopenia (13%). **Discussion:** R^2 is active with a tolerable safety profile in patients with R/R MZL. The efficacy and safety profile of R^2 in patient with MZL were similar to results observed in the overall MAGNIFY population. **Conclusions:** These results suggest that R^2 should be considered as a therapeutic option for patients with R/R MZL.

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PRIMARY MEDIASTINAL B-CELL LYMPHOMA IN BRAZIL: INTENSIFIED REGIMEN DOESN'T SEEM TO IMPROVE OUTCOMES WHEN COMPARED TO R-CHOP IN A RESOURCE-CONSTRAINED SCENARIO – A RETROSPECTIVE CHART-REVIEW STUDY