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.

https://doi.org/10.1016/j.htct.2021.10.166

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

M Coleman [a], DJ Andorsky [b], A Yacoub [c], JM Melear [d], SR Fanning [e], KS Kolibaba [f], F Lansigan [g], C Reynolds [h], G Nowakowski [i], M Gharibo [j], E Ahn [j], J Li [j], MJ Rummel [k], JP Sharman [l]

[a] *Clinical Research Alliance Inc, Weill Cornell Medicine, New York, United States*
[b] *Rocky Mountain Cancer Centers, US Oncology Research, Boulder, United States*
[c] *University of Kansas Cancer Center, Westwood, United States*
[d] *Texas Oncology – Austin, US Oncology Research, Austin, United States*
[e] *Prisma Health, US Oncology Research, Greenville, United States*
[f] *US Oncology Research, Vancouver, United States*
[g] *Dartmouth–Hitchcock Medical Center, Lebanon, United States*
[h] *IHA Hematology Oncology Consultants – Ann Arbor, Ypsilanti, United States*
[i] *Mayo Clinic, Rochester, United States*
[j] *Bristol-Myers Squibb, Princeton, United States*
[k] *Justus-Liebig Universität, Giessen, Germany*
[l] *Willamette Valley Cancer Institute and Research Center, US Oncology Research, Eugene, United States*

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.

https://doi.org/10.1016/j.htct.2021.10.167

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

RD Velasques [a,b], WF Silva-Júnior [a,b], M Bellesso [a,b,c], V Rocha [a,b,d], J Pereira [a,b]

[a] *Divisão de Hematologia, Instituto do Câncer do Estado de São Paulo (ICESP), São Paulo, SP, Brazil*
[b] *Divisão de Hematologia, Hemoterapia e Divisão Celular, Hospital das Clínicas, Faculdade de Medicina, Universidade de São Paulo (HCFMUSP), São Paulo, SP, Brazil*
[c] *Instituto Hemomed de Oncologia e Hematologia, São Paulo, SP, Brazil*
[d] *Churchill Hospital, Oxford University, Oxford, United Kingdom*

Introduction: Primary Mediastinal B-cell Lymphoma (PMBCL) is an uncommon entity, comprising less than 4% of non-Hodgkin lymphomas. R-CHOP plus radiotherapy (RT) has been the standard upfront regimen but DA-EPOCH-R has enabled better results with the preclusion of RT, whilst there are no prospective comparative studies. Features and treatment outcomes of PMBCL in low/middle incomes countries are still largely unknown. In this retrospective, single-center, chart-review study, we aimed to ascertain the characteristics of our patients with this disease and the outcomes between R-CHOP/R-CHOEP and DA-EPOCH-R, in a resource-constrained real-life scenario. **Material and methods:** Patients with PMBCL diagnosed between 2008 - 2018 treated with rituximab-based first-line therapy were eligible. Treatment response was based on the original radiology reports (CT or PET-CT, according to Cheson and Lugano criteria, respectively). **Results:** A total of 95 patients were included. Median age was 28 years (15 – 74 years) and 59.1% were female. Stages I-II performed 57.1% and 31.9% had extranodal disease. Bulky disease was detected in 92.1%, performance status 0-2 in 91.2% and thromboembolic events in 37% of patients. DA-EPOCH-R (41.9%), R-CHOP (35.5%), R-CHOEP (19.3%) and a 'reduced'R-CHOEP (3.2%) comprised the upfront regimen. Cytoreductive chemotherapy was administered in 50%. Age, staging and presence of bulky disease were similar in the three main regimens. Overall interim assessment (after four cycles) ensured complete response (CR), partial response (PR) and progressive disease (PD) rates of 40%, 55.7% and 4.5%, respectively. At the end of treatment, metabolic CR and rate was 56.8% while 11.1% experienced progression. Mediastinal RT was performed in 42.1% of DA-EPOCH-R, 75% of R-CHOP and 83% of R-CHOEP groups ($p = 0.002$) and switched PR to CR in 73.7% of them. Estimated 5-year PFS and OS were 77.2% and 77.4%, respectively, and there was no statistical association between treatment and OS, PFS or relapse treatment. In a multivariable analysis, only LDH levels remained independently associated with PFS (HR = 3.1, $p = 0.02$). **Discussion:** Our cohort showed similar features described in other papers and although near one-third of our patients received R-CHOP as a frontline treatment, a gradual replacement by DA-EPOCH-R could be observed. In many cases, however, we were forced to shift back to a R-CHOEP regimen, due to unavailability of hospital beds. Albeit DA-EPOCH-R showed remarkable results on its original reports, our experience suggests it might not be better than R-CHOP/CHOEP, and allowing yet, the omission of RT. Despite our excessive referral to RT, which could be associated to residual mediastinal uptake at final PET-CT, RT showed to be profitable for partial responders. **Conclusion:** Albeit the limited number of patients and the retrospective aspect of this chart-review study, we found no difference in outcomes between a more intensified inpatient and conventional outpatient treatment regimens. Hence, in a resource-constrained scenario, such as Brazil, where a 4-day inpatient chemotherapy infusion could be logistically problematic, R-CHOP or R-CHOEP plus radiotherapy may be still safely adopted. Further studies on economic costs of each approach are still needed.

https://doi.org/10.1016/j.htct.2021.10.168

RELATO DE CASO: LINFOMA NÃO HODGKIN LINFOPLASMOCÍTICO NÃO IGM

JO Matias, JAD Rodrigues, ACF Bassani, CDM Guedes, CS Cunha, RSA Avila

Hospital Unimed, Volta Redonda, RJ, Brasil

Objetivos: Discutir e divulgar o raríssimo Linfoma Não Hodgkin linfoplasmocítico não IgM (ou seja, não macroglobulinemia de Waldenström), mostrando a importância de sua suspeição e diagnóstico diferencial com mieloma múltiplo. **Material e métodos:** Análise retrospectiva de um caso de Linfoma não Hodgkin linfoplasmocitico IgG em acompanhamento no serviço de hematologia do Hospital Unimed Volta Redonda (HUVR) - RJ. Para a revisão de literatura, foram levantados os mais recentes artigos sobre o tema nas bases de dados do site PEBMED. Resultados – Relatamos o caso de uma paciente de 48 anos, sexo feminino, natural e procedente de Volta Redonda- RJ, enfermeira, sem comorbidades. Foi Internada no HUVR com quadro de dor em coluna lombar há um ano, que tornou-se mais intensa e incapacitante há cerca de 2 meses, avaliada pela neurocirurgia e solicitada ressonância magnética de coluna lombar que mostrou fratura patológica e colapso do corpo da vértebra L3. A ressonância magnética de coluna cérvico-torácica e quadril assim como as Tomografias de Tórax, pescoço e abdome total não apresentavam alterações. Não possuía alterações no hemograma, na função renal ou em nível sérico de cálcio. Eletroforese de proteínas séricas mostrando aumento de beta 2 (2.2 g/dL) e pico monoclonal em beta 2 de 1,67 G/DL. Imunofixação sérica evidenciando componente monoclonal IgG lambda. Dosagem sérica de IgG de 2761 mg/DL. A imunohistoquimica de biópsia de vértebra apresentava 9% de linfo-plasmócitos BCL2 +, BCL6 -, CD3-, CD5-, CD10-, CD20+, CD23-, CD138+, ciclina D1 -, lambda +, kappa-, KI6715%, MUM-1 +. Compatível com Linfoma não Hodgkin B linfoplasmocítico. A biópsia de medula óssea apresentava em 80% de celularidade, moderada quantidade de linfócitos e plasmócitos com o mesmo perfil imunohistoquimico supracitado concluindo Linfoma não-Hodgkin B linfoplasmocítico, com restrição de cadeia leve Lambda. A Imunofenotipagem de medula óssea evidenciava população linfo-plasmocitária equivalente a 9% da celularidade global, com aberrancia fenotípica, CD19+/60%, CD20++, CD38+++, CD45+/30%, CD56++, CD117-, CD138++ e perfil de cadeias leves clonal Lambda: Considerar diagnóstico diferencial com