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Polatuzumab based chemoimmunotherapy showing complete response in a patient of r/r diffuse large b-cell lymphoma

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Objective: Diffuse large B-cell lymphoma (DLBCL) is the most common subtype of non-Hodgkin lymphoma and it is curable in approximately half of cases with current therapy. However, some of the patients require 3 or more line of therapy. Optimal management for patients who experience two or more relapses of DLBCL is unknown. New treatment options are needed and are being investigated. One of them, polatuzumab vedotin (PV) is a monoclonal antibody that targets CD-79B. We would like to talk about a relapse refractory (R/R)-DLBCL patient who had received 4 previous line of therapy with a follow-up time of about 15 years and showed complete response to PV based chemoimmunotherapy.

Case report: The patient, 47 years old male was diagnosed with stage-IE DBBHL after orchiectomy in 2006 and received 6 cycles of R-CHOP chemoimmunotherapy. After the patient followed up for 8 years in complete remission, isolated central nervous system relapse confirmed by biopsy in 2014. A protocol including 3 cycles of high-dose methotrexate and cytosine arabinoside was applied to the patient. Since the patient failed mobilization with chemotherapy + granulocyte colony stimulating factor (G-CSF) and plerixafor + G-CSF, the treatment of the patient was completed with cranial radiotherapy. The patient followed in remission then developed a second relapse with an abdominal bulky mass that invaded the bladder, ureter and rectum in 2018. Relapse was demonstrated by a biopsy. Although more than 50% response was observed after 3 cycles of gemcitabine-oxaliplatin plus rituximab, there was a loss of response after 6 cycles. Radiation therapy was applied in 2019 and then ibrutinib was used. After radiation therapy and 3 months of ibrutinib treatment, the patient continued to be treated with ibrutinib with a response rate of more than 50%. In the 7th month of treatment a disease progression developed, and the patient was included in the Polatuzumab vedotin (1.8 mg/kg) + Bendamustin (90 mg/m^2) + Rituximab (375 mg/m^2) (Pola-BR) early access program in August 2019. After 3 cycles of PV based chemoimmunotherapy with complete response, the treatment of the patient was completed to 6 cycles in January 2020. Then, lenalidomide was started for maintenance therapy. The patient is still asymptomatic and being followed in remission.

Results: The general recommendation in relapse patients is autologous stem cell transplant (ASCT) after rescue chemotherapy. For patients with second or later relapse, relapse after ASCT and chemoresistant disease, prognosis is poor. The treatment options at this stage include if appropriate, allogeneic stem cell transplantation, monoclonal antibodies such as obinituzumab and PV, oral agents such as ibrutinib and lenalidomide, and CAR-T cell treatments. In June 2019, the FDA granted accelerated approval to polatuzumab vedotin with BR for the treatment of adults with RR-DBBHL who received a minimum of two rows of treatment. A trial that randomly assigned 80 transplant-ineligible patients to bendamustine plus rituximab (BR) versus BR plus PV reported that PV based treatment arm achieved superior outcomes. In our case with recurrent intraabdominal bulky disease, despite the 4th order treatment, dramatic response was obtained with Pola-BR.

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MYELOMA

PP 30

Isatuximab plus carfilzomib and dexamethasone vs. carfilzomib and dexamethasone in relapsed/refractory multiple myeloma (ikema): interim analysis of a phase 3, randomized, open-label study

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Objective: To demonstrate benefit of adding Isatuximab (Isa) to (Kd) vs. Kd in relapsed/refractory multiple myeloma (RRMM).

Methodology: In this Phase-3 study (NCT03275285), patients with RRMM and 1–3 prior lines of therapy were randomized 3:2 and stratified by number of prior lines and R-ISS to receive Isa-Kd or Kd. Isa-Kd arm received Isa (10 mg/kg IV) weekly for 4 weeks, then every 2 weeks. Both arms received K (20 mg/m^2 days 1–2, 56 mg/m^2 thereafter) twice-weekly for 3 of 4 weeks, and d (20 mg) twice-weekly. Treatment continued until disease progression or unacceptable adverse events (AE). Primary objective: increase in PFS of Isa- Kd vs. Kd, determined by an Independent Response Committee (IRC). Comparison between arms conducted through log-rank testing. Key secondary objectives: overall response rate (ORR), rate of very good partial response (VGPR) or better, complete response (CR) rate, MRD negativity-rate (10^5 by NGS), and