quimioterápico são a cardiomiopatia e insuficiência cardíaca descompensada. São fatores de risco para o desenvolvimento destas complicações o sexo feminino; a dose cumulativa maior que 400 mg/m^2; o uso concomitante de outros quimioterápicos cardiotóxicos como a ciclofosfamida; radioterapia prévia; rápida infusão da medicação, extremos de idade e doenças prévias com comprometimento cardiovascular. **Conclusão:** Conclui-se imprescindível uma busca ativa minuciosa do histórico do paciente oncológico em busca de doenças cardiovasculares prévias. Diante de esquema quimioterápico que contemple a doxorrubicina, é recomendado rastreamento precoce de lesão miocárdica, dando preferência à troponina ultrassensível ou técnica do Global Longitudinal Strain sobre a ecocardiografia. Sempre que identificado dano miocárdico, deve-se intervir precocemente com tratamento adequado e acompanhamento cardiológico de longa duração, pois estas lesões tendem a permanecer a longo prazo.

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REAL-WORLD SEQUENTIAL USE OF CD19-DIRECTED THERAPIES FOR RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA: TAFASITAMAB PRECEDING CHIMERIC ANTIGEN RECEPTOR T-CELL THERAPY

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Objectives: Potential CD19 antigen loss following CD19-directed therapy has raised concerns over sequential use of these therapies, and real-world data are limited. Tafasitamab, a CD19-targeting immunotherapy, combined with lenalidomide, is approved by the US Food and Drug Administration for treatment of relapsed or refractory diffuse large B-cell lymphoma (R/R DLBCL) in adults ineligible for autologous stem cell transplantation. Here, we examine characteristics and outcomes of patients who received tafasitamab for R/R DLBCL preceding CD19-directed chimeric antigen receptor T-cell (CAR-T) therapy in a real-world setting. **Material and methods:** In this retrospective, multisite, medical chart review study, participating physicians from Cardinal Health's Oncology Provider Extended Network abstracted data from US adults who initiated tafasitamab (with or without lenalidomide) on or after October 21, 2020, for R/R DLBCL outside clinical trial settings. Patients were required to have ≥4 months of follow-up after tafasitamab initiation unless deceased. Initial data collection (February-March 2023) identified 181 eligible patients, and follow-up data were collected approximately 10 months thereafter. Results for patients who received tafasitamab preceding CAR-T therapy were summarized using descriptive statistics. **Results:** Nine patients (median age at tafasitamab initiation, 63 years; 3 male; 6 White) received tafasitamab and lenalidomide (tafa+len) as a line of therapy immediately preceding CAR-T therapy. Median (Q1-Q3) follow-up time since tafasitamab initiation was 26.1 (18.0-28.0) months and after CAR-T administration was 9.3 (1.9-16.7) months. At tafasitamab initiation, 7 patients had Eastern Cooperative Oncology Group performance status 0-1 and 2 had primary refractory disease. Of the 9 patients, 4 had complete response, 4 had partial response, and 1 had stable disease as best real-world response to tafa+len; all discontinued tafasitamab due to disease progression. Median (Q1-Q3) tafasitamab therapy duration was 11.0 (8.1-14.1) months. Three patients had CD19 testing following tafasitamab discontinuation, and all test results were positive. Median (Q1-Q3) time from tafasitamab discontinuation to CD19 testing was 7 (6-9) days. Among the 9 patients, median (Q1-Q3) time from tafasitamab discontinuation to initiation of CAR-T therapy was 3.2 (2.3-3.6) months. Four patients had complete response, 3 had partial response, and 1 had progressive disease as best real-world response to CAR-T therapy; 1 patient was not evaluable. **Discussion:** These results suggest that in patients treated with tafasitamab, CD19 expression remains detectable following treatment discontinuation, and disease response can be achieved with subsequent CD19-directed CAR-T therapy. However, this study is limited by small sample size. **Conclusion:** This small real-world analysis demonstrated disease response to CD19-directed CAR-T therapy and detectable CD19 expression following tafasitamab treatment for R/R DLBCL. Further studies with larger sample sizes are warranted to confirm these findings. **Funding:** Incyte Corporation.

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REAL-WORLD USE OF TAFASITAMAB FOR RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA IN THE UNITED STATES BY AGE GROUP (> 70 YEARS AND 70 YEARS)

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Objectives: Diffuse large B-cell lymphoma (DLBCL) is an aggressive form of lymphoma that occurs more frequently in older adults. Tafasitamab, a CD19-targeting immunotherapy, combined with lenalidomide, was approved by the US Food and Drug Administration for treatment of relapsed or refractory (R/R) DLBCL in adults ineligible for autologous stem cell transplantation (ASCT). In a recent US real-world study of tafasitamab treatment for R/R DLBCL, more than half of the patients were older than 70 years. Here, we describe patient characteristics, treatment patterns, and outcomes observed in this study by

patient age at tafasitamab initiation (> 70 years, ≤ 70 years). **Material and methods:** This was a retrospective chart review wherein physicians from Cardinal Health's Oncology Provider Extended Network abstracted data from patients' medical records into electronic case report forms. Eligible patients (aged ≥ 18 years) initiated tafasitamab for R/R DLBCL on or after October 21, 2020, and had ≥ 4 months of follow-up; however, patients who died during follow-up were also eligible. Results were summarized by patient age at tafasitamab initiation (> 70 years, ≤ 70 years) using descriptive statistics. **Results:** Among the 181 patients included in this analysis, 102 (56%) were > 70 years and 79 (44%) were ≤ 70 years of age at time of tafasitamab initiation. Median age at tafasitamab initiation was 75.2 and 64.2 years for the > 70 and ≤ 70 years subgroups, respectively. Overall, median (Q1-Q3) follow-up time was 6.5 (5.0-8.6) months. At time of data abstraction, 76 patients (75%) in the > 70 years and 68 (86%) in the ≤ 70 years subgroups were still alive, of whom 67 (88%) and 54 (79%) were still receiving tafasitamab, respectively. Approximately half of patients (49%) in the ≤ 70 years group and 23% in the > 70 years group had no comorbidities associated with the National Cancer Institute Comorbidity Index. At the time of tafasitamab initiation, 54% and 39% of patients in the > 70 and ≤ 70 years subgroups had an ECOG PS ≥ 2; most patients (86%, > 70 years; 74%, ≤ 70 years) had a revised International Prognostic Index score of 3-5. In both subgroups, the majority of patients (79%, > 70 years; 62%, ≤ 70 years) received tafasitamab as second-line therapy. Nearly a quarter of patients (23%) in the ≤ 70 years group and 3% in the > 70 years group had undergone ASCT prior to tafasitamab treatment. Real-world overall response rates (95% CI) were 70.6% (61.7-79.4%) and 69.6% (59.5-79.8%) in the > 70 and ≤ 70 years subgroups, respectively. **Discussion:** Results from this analysis indicate favorable response rates with tafasitamab treatment among patients with R/R DLBCL in both the > 70 and ≤ 70 years subgroups. At tafasitamab initiation, the majority of patients in both subgroups had revised International Prognostic Index scores indicative of a poor prognosis. Despite meaningful comorbidity burden and limitations in performance status, at time of data abstraction, 88% of patients in the > 70 years group were still receiving tafasitamab. However, follow-up was limited in duration. **Conclusion:** These real-world findings support the clinical benefit of tafasitamab among older (> 70 years) and younger (≤ 70 years) patients with R/R DLBCL. Longer follow-up is warranted to better assess long-term outcomes with tafasitamab by age. **Funding:** Incyte Corporation.

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EVOLUÇÃO E IMPACTO DO LINFOMA NÃO HODGKIN DIFUSO DE GRANDES CÉLULAS B NO BRASIL: UMA ANÁLISE COMPARATIVA DOS CASOS EM 2012 E 2022

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Introdução: O linfoma não Hodgkin difuso de grandes células B é um tipo de câncer linfoproliferativo maligno, caracterizado pelo crescimento desordenado dos linfócitos B no sistema linfático, comprometendo significativamente a qualidade de vida dos indivíduos afetados e apresentando uma alta taxa de mortalidade. Essas células derivam das células-tronco hematopoiéticas na medula óssea e se desenvolvem através de maturação e seleção nos centros germinativos dos linfonodos, onde os linfócitos B sofrem hipermutação somática e recombinações gênicas, gerando uma alta diversidade de anticorpos, crucial para a imunidade humoral. Este linfoma é frequentemente caracterizado por uma alta instabilidade genômica, com numerosos rearranjos cromossômicos e alterações no número de cópias de genes, contribuindo para a diversidade clonal e a agressividade da doença. Dessa forma, quando ocorrem mutações nesses linfócitos B, resultam em um crescimento acelerado das células tumorais em órgãos como medula óssea, nódulos linfáticos, ossos e cérebro. Apesar de sua agressividade, esse tipo de linfoma responde bem aos tratamentos disponíveis, apresentando taxa 75% de cura dos casos diagnosticados. Os sintomas frequentemente observados incluem nódulos periféricos indolores, especialmente em regiões como axilas e virilhas, além de febre, sudorese noturna e perda de peso, indicando a necessidade de uma avaliação por um hematologista para um diagnóstico preciso. O diagnóstico envolve um exame físico detalhado, seguido por uma biópsia do linfonodo afetado e análises imuno-histoquímicas para identificar o tipo específico de célula cancerosa. **Objetivo:** Desvendar padrões e identificar tendências sobre o linfoma não Hodgkin difuso de grandes células B no Brasil entre os anos de 2012 e 2022. **Materiais e métodos:** Este estudo adotou uma abordagem analítica, transversal e retrospectiva, onde os dados foram coletados a partir do banco de dados DATASUS, na aba "Morbidade hospitalar do SUS (SIH/SUS)". **Conclusão:** Os resultados obtidos nesta pesquisa mostram que os casos de Linfoma não Hodgkin difuso de grandes células aumentaram na região Sul do Brasil principalmente, entre os dados de 2012 e 2022, porém foi houve uma queda sutil nos números das taxas de mortalidades. O gênero com predominância de casos é o masculino com idade de maior prevalência sendo dos 40 aos 59 anos. Podemos notar também que de acordo com a raça declarada pelos pacientes, a predominância atinge indivíduos brancos em sua maior parte.

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ANÁLISE DO IMPACTO DA EDUCAÇÃO COMO FATOR DE RISCO PARA LINFOMAS NÃO-HODGKIN

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Introdução: Analisamos os casos de Linfomas Não-Hodgkin (LNH) diagnosticados no período 2019 a 2023, em serviço de