tem sido o tratamento padrão para o linfoma difuso de grandes células B (LDGCB) há mais de 20 anos. Apesar de seu uso disseminado, não há um padrão aceito na dose de prednisona nesse cenário. Há duas estratégias, a primeira com dose fixa (100 mg diários por cinco dias) e a segunda com a dose ajustada pela área de superfície corpórea (ASC), que varia de 40-100 mg/m^2 diários por cinco dias. **Objetivos:** Foi feita uma revisão sistemática e metanálise para determinar se a prednisona em dose fixa durante o tratamento com R-CHOP resultaria em desfechos equivalentes em comparação com a dose ajustada pela ASC. **Material e métodos:** Uma busca abrangente em várias bases de dados, na língua inglesa foi feita em junho de 2022 e atualizada em abril de 2024. Os resultados da busca foram revisados por dois membros da equipe, de forma independente para seleção e inclusão final. Discrepâncias foram resolvidas por um terceiro membro e revisadas pelo autor sênior. **Discussão e conclusão:** O resultado desta sistemática e metanálise, combinando 30 estudos prospectivos e um total de 3573 pacientes diagnosticados com LDGCB tratados com R-CHOP em primeira linha, não encontrou diferença nos desfechos clínicos entre pacientes tratados com prednisona em dose fixa e dose ajustada pela ASC. Essa revisão sistemática e metanálise fornecem evidências científicas para a prática disseminada de limitar a prednisona à dose máxima de 100 mg diários por cinco dias, potencialmente evitando efeitos adversos desnecessários da dose ajustada pela ASC.

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EPIDEMIOLOGICAL ANALYSIS OF THE INCIDENCE OF EARLY-ONSET NON-HODGKIN LYMPHOMA STRATIFIED BY COUNTRY AND CONTINENT

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Introduction: Non-Hodgkin lymphoma (NHL) comprises a heterogeneous group of lymphoid malignancies with diverse clinical behaviors and histological subtypes. Although more commonly diagnosed in older adults, a considerable number of cases occur in individuals under 50 years, herein defined as early-onset non-Hodgkin lymphoma (EO-NHL). These early-onset cases may differ biologically and epidemiologically from those diagnosed later in life and can significantly affect quality of life, productivity, and long-term outcomes. Identifying global epidemiological trends in EO-NHL may clarify underlying genetic predispositions, infectious exposures (such as HIV or EBV), and environmental and socioeconomic factors contributing to disparities in incidence and diagnosis. **Objectives:** To analyze the global incidence of EO-NHL (ages 0-49) in 2022, stratified by country, continent, United Nations (UN) region, Human Development Index (HDI), and World Bank income classification, and to explore potential genetic, environmental, and socioeconomic factors in specific populations. **Material and methods:** This is a descriptive epidemiological study based on data extracted from the Cancer Today platform of the International Agency for Research on Cancer (IARC), part of the World Health Organization (WHO). Incidence estimates for NHL in individuals aged 0-49 years in 2022 were analyzed. The age-standardized rate (ASR, per 100,000 inhabitants) was used for comparisons. Stratifications were made by geographic (country, continent, and UN region), socioeconomic (HDI), and economic (World Bank income classification) parameters to identify patterns and disparities. **Results:** A total of 120,037 new cases were identified globally in 2022, with an ASR of 1.9 per 100,000. The highest ASRs were observed in Malawi (6.3), Zimbabwe (6.1), Trinidad and Tobago (5.4), and other sub-Saharan African and small island countries. Bhutan and São Tomé and Príncipe reported zero cases. North America had the highest continental ASR (3.7), followed by Oceania (3.3), Europe (2.7), Africa (2.5), Latin America (2.1), and Asia (1.4). UN regional analysis revealed the highest rates in Southern Europe (3.5), Australia-New Zealand (3.4), and Melanesia (3.3); the lowest occurred in Eastern Asia (1.4), Polynesia (1.4), South-Central Asia (1.1), and Micronesia (0.8). HDI stratification showed very high HDI countries with an ASR of 2.8, compared to 2.0 in low, 1.7 in high, and 1.4 in medium HDI nations. Regarding income level, high-income countries had the highest ASR (3.0), followed by low- (2.2), upper-middle- (1.8), and lower-middle-income nations (1.5). Brazil reported 3,153 cases, with an ASR of 1.7, below both the global and South American (2.0) averages. **Discussion and conclusion:** The global burden of EO-NHL is unevenly distributed, reflecting complex interactions between environmental exposures, infections, genetics, and health system capacity. Some of the highest ASRs are found in African nations, possibly linked to HIV prevalence and endemic infections, whereas developed countries exhibit higher incidence rates, likely due to better diagnostic access and registry systems. Conversely, underreporting and limited diagnostic capabilities may underestimate incidence in low-resource settings. The findings highlight the necessity of strengthening cancer surveillance, improving access to early diagnosis and care, and investing in research on EO- NHL etiology, particularly in high-incidence and underserved regions.

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