

small cohort, this real-world data contributes to a better understanding of treatment responses and adverse effects. The reported outcomes were similar to those found in the literature, particularly in real-world studies. Therefore, anti-CD19 CAR-T appears to be a potentially curative option in R/R B-cell ALL, even in cases of relapse after allo-HSCT, with the advantage of not requiring an RC prior to its administration.

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INITIAL EXPERIENCE WITH ANTI-CD19 CHIMERIC ANTIGEN RECEPTOR T-CELL THERAPY IN PATIENTS WITH RELAPSED/REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA IN A BRAZILIAN CANCER CENTER

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Introduction: Chimeric antigen receptor T-cell (CAR-T) therapy anti-CD19 has emerged as a promising therapeutic modality for patients with relapsed or refractory (R/R) diffuse large B-cell lymphoma (DLBCL). Since the approval of axicabtagene ciloleucel (axi-cel) and tisagenlecleucel (tisa-cel) in Brazil in 2022, access to cellular therapy has significantly expanded. However, real-world data regarding their feasibility, outcomes and associated toxicities remain limited. This study aims to describe a initial institutional experience with CAR-T cell therapy in patients with R/R DLBCL, comparing the 2 anti-CD19 products available at the time. **Case report:** 23 patients were included, 11 treated with tisa-cel (47.8%) and 12 with axi-cel (52.2%). The median age was 56 (tisa-cel) and 52 (axi-cel), with a male predominance in both groups (14 vs 9 female). Functionality was assessed by ECOG: most axi-cel patients were ECOG 0 (91.7%), while tisa-cel patients were split between ECOG 0/1 (45.5% each). Advanced stage disease (Ann Arbor III/IV) and elevated lactate dehydrogenase (median value: 321 U/L; upper limit:227) were similar between groups. Bulky disease was more common in patients submitted to tisa-cel (36,4% vs 16,7% axi-cel). Most patients received ≥ 3 prior therapy lines, with 4 lines predominant in axi-cel (50%) and 3 in tisa-cel (45.5%). At infusion, progressive disease (PD) was more frequent in tisa-cel (81.1%), while partial response (PR) predominated in axi-cel (50%). Median brain-to-vein time was 109 days (tisa-cel) vs 122 days (axi-cel). Hematologic toxicity risk (CARHEMATOTOX > 2) was higher in the tisa-cel group, with 18.2% scoring 6. Infections were more frequent with tisa-cel (90.9% vs 66.7%). ICU admission was similar (63.6%), but stays were longer with axi-cel (16 vs 4 days). Intubation was also more common with axi-cel (25% vs 9.1%). Grade 2 CRS predominated in both groups; grade 3 occurred only with tisa-cel. Tocilizumab use was similar. ICANS was more frequent with axi-cel (75%), leading to greater anakinra

use (50%), while 72% of tisa-cel patients had no ICANS. At day 30, 34% achieved CR (75% tisa-cel, 25% axi-cel), 13% PR (66% axi-cel, 34% tisa-cel), and 21% PD (40% tisa-cel, 60% axi-cel). At day 60, CR was 30% (57% tisa-cel, 43% axi-cel), 1 PR (axi-cel), and 30% PD (28% tisa-cel, 72% axi-cel). At day 180, 13% were in CR (66% tisa-cel, 34% axi-cel), 1 PR (axi-cel), and 17% (n=4) in PD - all axi-cel. There were 7 deaths: one at day 30 (axi-cel), one at day 60 (tisa-cel), and three at day 180 (2 tisa-cel, 1 axi-cel). Follow-up was unavailable for 20% at day 30, 8% at day 60, and 30% at day 180. **Conclusion:** Both products are feasible but differ in efficacy and toxicity. Tisa-cel showed superior early responses despite higher-risk disease, while axi-cel was associated with more neurologic toxicity and early mortality. However, it's important to highlight the limitations of our data, considering the small sample size, missing follow-up registries and the heterogeneity in baseline characteristics, precluding a robust comparative analysis between products. Finally, real-world challenges, such as the prolonged brain-to-vein time and high ICU utilization, under-score logistical and toxicity management hurdles in middle-income countries like Brazil.

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INSUFICIÊNCIA PANCREÁTICA EXÓCRINA APÓS TRANSPLANTE DE CÉLULAS-TRONCO HEMATOPOIÉTICAS ALOGÊNICO: RELATO DE CASO

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Introdução: A insuficiência pancreática exócrina (IPE) é uma complicação rara do transplante de células-tronco hematopoéticas (TCTH), usualmente de apresentação tardia e considerada uma forma de manifestação atípica da doença do enxerto contra hospedeiro (DECH) crônica. O objetivo deste trabalho é relatar um caso de IPE precoce após TCTH alogênico. **Relato de caso:** Paciente feminino, 12 anos, com diagnóstico prévio de anemia falciforme, foi submetida em dezembro de 2024 a TCTH alogênico haploidenteico, ABO compatível, com condicionamento mieloablativo (tiotepa, fludarabina e melfalano), e profilaxia contra DECH com timoglobulina, ciclofosfamida pós-transplante, micofenolato e sirolimo. O enxerto apresentou critérios para pega neutrofílica no dia +26, e pega plaquetária no dia +31. A paciente fez uso de nutrição parenteral do dia +13 ao +27, com reintrodução de dieta enteral a partir do dia +23. Dentre as complicações pós-transplante, apresentou neutropenia febril, mucosite grau 3 e colite por *Clostridium difficile*. No dia +17, a paciente desenvolveu síndrome de encefalopatia posterior reversível (PRES), atribuída ao sirolimo, com suspensão temporária do mesmo e início de metilprednisolona 1,5 mg/kg/