Kompetenznetz Maligne Lymphome

Lymphom Kompetenz KOMPAKT

KML-Expert:innen berichten vom

EHA2022 HYBRID

Kompetenznetz Maligne Lymphome

Lymphom Kompetenz KOMPAKT

Prof. Dr. med. Christian Buske
Institut für Experimentelle Tumorforschung | Universitätsklinikum Ulm

Morbus Waldenström (WM) & Marginalzonen-Lymphom (MZL)

EHA2022 HYBRID

Offenlegung potentieller Interessenskonflikte

LymphomKompetenz KOMPAKT – EHA2022 wird in Kooperation mit sechs unterstützenden Firmen durchgeführt.
Meine persönlichen Disclosures betreffen:

Anstellungsverhältnis, Führungsposition	--
Beratungs-/ Gutachtertätigkeit	Roche, Janssen, AbbVie, Novartis, Bayer, Celltrion, Incyte, Beigene
Besitz von Geschäftsanteilen, Aktien oder Fonds	--
Patent, Urheberrecht, Verkaufslizenz	--
Honorare	Roche, Janssen, AbbVie, Novartis, Bayer, Celltrion, Incyte, Pfizer, Beigene
Finanzierung wissenschaftlicher Untersuchungen	Roche, Janssen, Bayer, Celltrion, MSD
Andere finanzielle Beziehungen	
Immaterielle Interessenkonflikte	

Kapitel 1

Morbus Waldenström

Qual der Wahl – welchen BTKi Inhibitor sollen wir nehmen?

HemaSphere

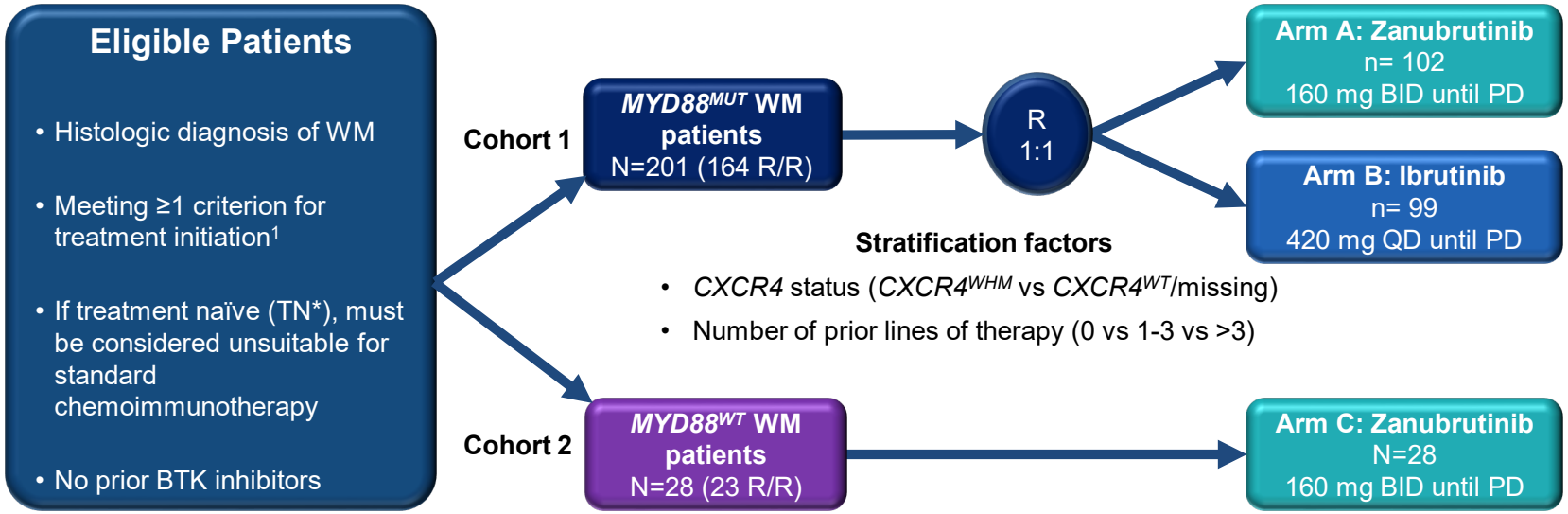
EHA EUROPEAN HEMATOLOGY ASSOCIATION

P1161 ASPEN: LONG-TERM FOLLOW-UP RESULTS OF A PHASE 3 RANDOMIZED TRIAL OF ZANUBRUTINIB (ZANU) VS IBRUTINIB (IBR) IN PATIENTS (PTS) WITH WALDENSTRÖM MACROGLOBULINEMIA (WM)

Topic: 18. Indolent and mantle-cell non-Hodgkin lymphoma - Clinical

Meletios Dimopoulos[1], Stephen Opat[2], Shirley D'Sa[3], Wojciech Jurczak[4], Hui-Peng Lee[5], Gavin Cull[6], Roger G. Owen[7], Paula Marlton[8], Bjorn E. Wahlin[9], Ramon Garcia-Sanz[10], Helen McCarthy[11], Stephen Mulligan[12], Alessandra Tedeschi[13], Jorge J. Castillo[14], Jaroslaw Czyz[15], Carlos Fernandez De Larrea Rodriguez[16], David Belada[17], Edward Libby[18], Jeffrey Matous[19], Marina Motta[20], Tanya Siddiqi[21], Monica Tani[22], Marek Trneny[23], Monique Minnema[24], Christian Buske[25], Veronique Leblond[26], Steven P. Treon[14], Judith Trotman[27], Wai Y. Chan[28], Jingjing Schneider[28], Heather Allewelt[28], Aileen Cohen[28], Jane Huang[28], Constantine S. Tam[29]

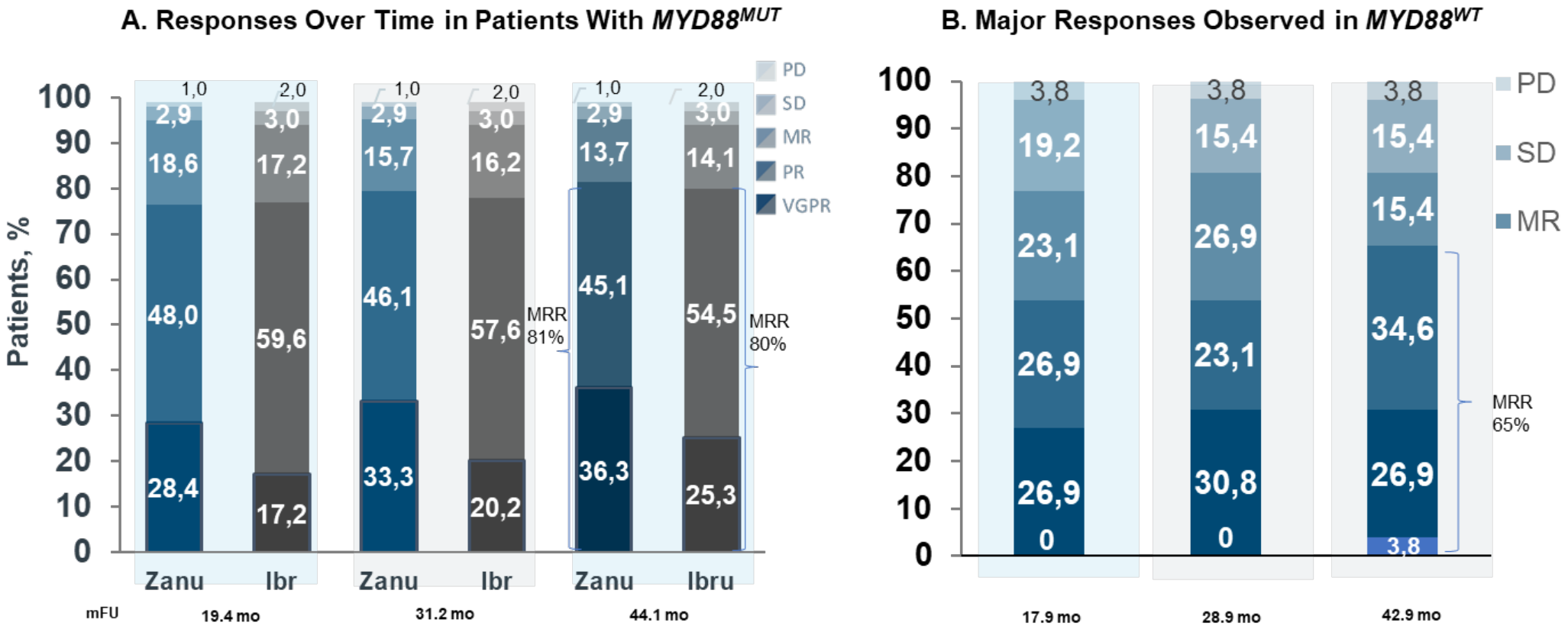
ASPEN study design: zanubrutinib vs ibrutinib in *MYD88*^{MUT} WM



Demographics and disease characteristics

Characteristics, n (%)	Overall ITT	
	Ibrutinib (n=99)	**Zanubrutinib (n=102)**
Age, years median (range)	70.0 (38, 90)	70.0 (45, 87)
>65 years	**70 (70.7)**	61 (59.8)
>75 years	22 (22.2)	**34 (33.3)**
Gender, n (%)		
Male	65 (65.7)	69 (67.6)
Female	34 (34.3)	33 (32.4)
Prior Lines of Therapy, n (%)		
0	18 (18.2)	19 (18.6)
1–3	74 (74.7)	76 (74.5)
>3	7 (7.1)	7 (6.9)
Genotype by central lab*, n (%)		
$MYD88^{L265P}/CXCR4^{WT}$	90 (90.9)	91 (89.2)
$MYD88^{L265P}/CXCR4^{WHIM}$	8 (8.1)	11 (10.8)
IPSS WM[1]		
Low	13 (13.1)	17 (16.7)
Intermediate	42 (42.4)	38 (37.3)
High	44 (44.4)	47 (46.1)
Hemoglobin ≤110 g/L	53 (53.5)	**67 (65.7)**

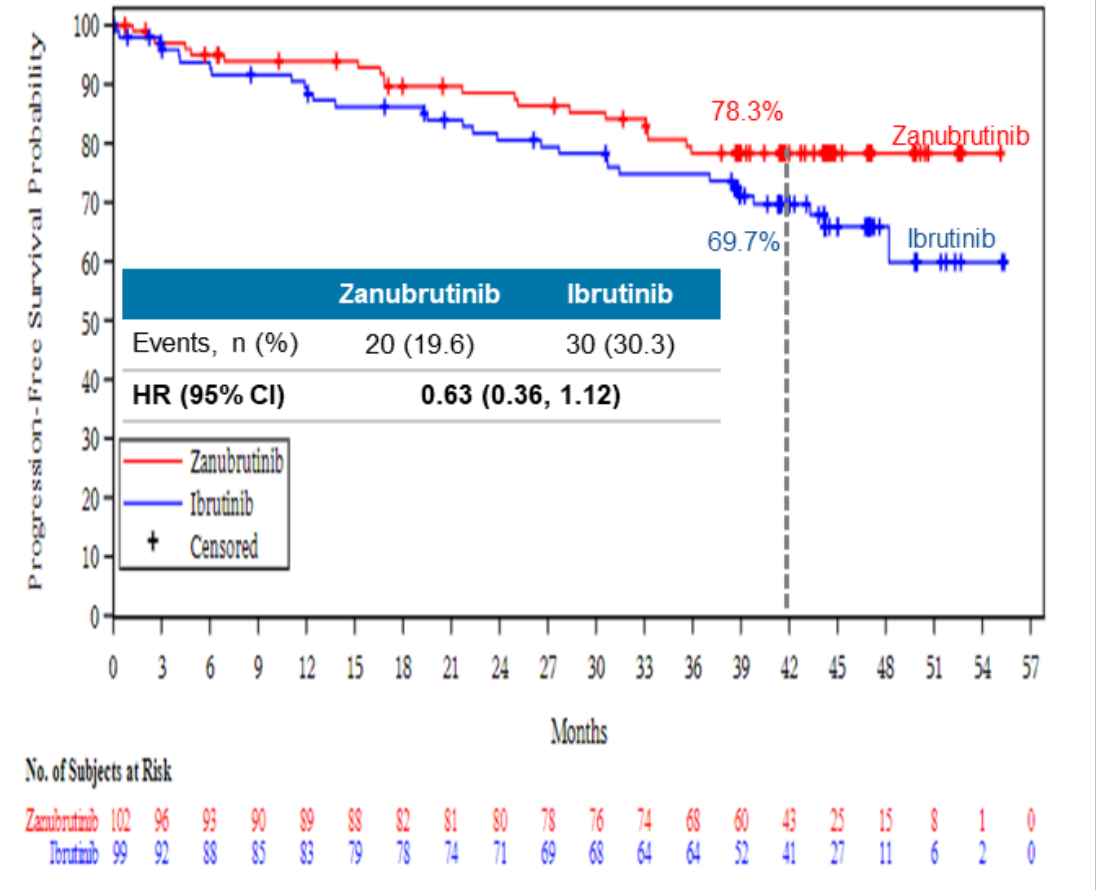
Best Overall Response by Investigator Over Time



Data cutoff: October 31, 2021.
CR, complete response; MR, major response; MRR, major response rate; PD, progressive disease; PR, partial response; SD, stable disease; VGPR, very good partial response.

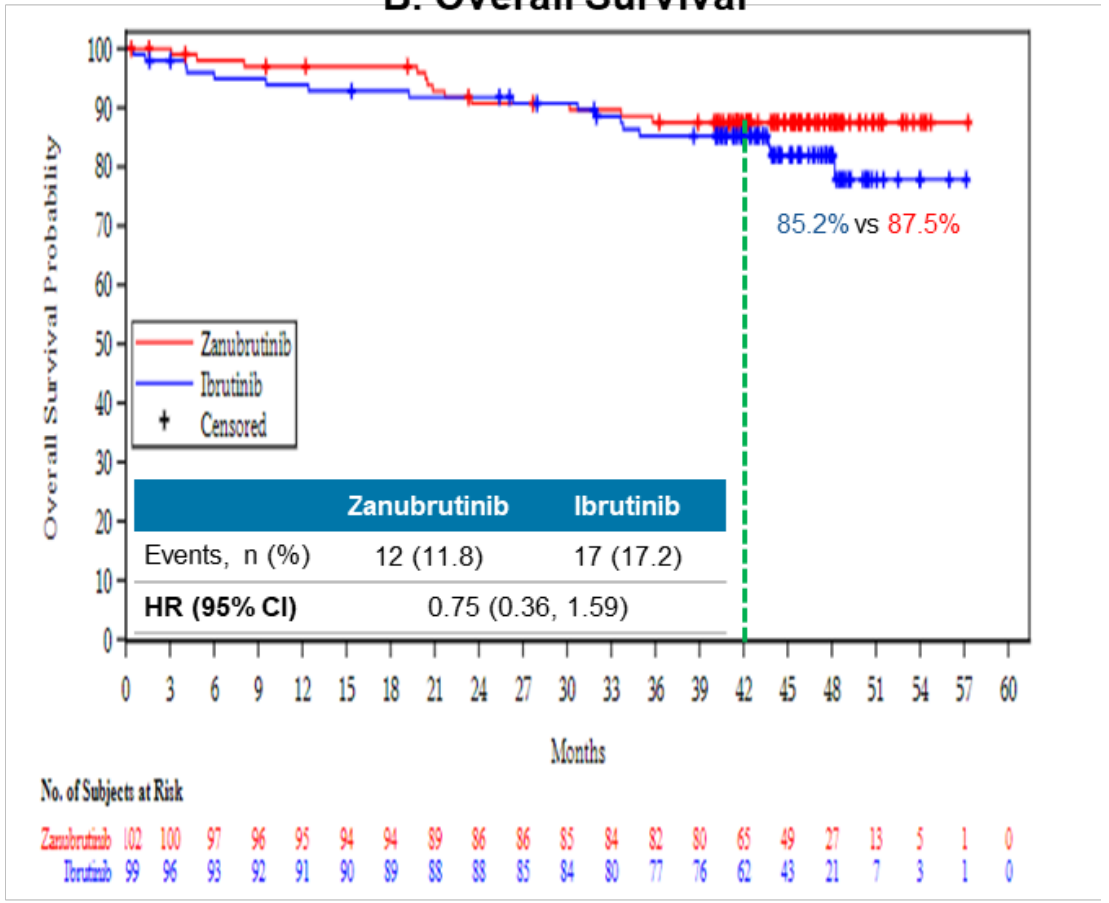
Progression-Free and Overall Survival in ITT population

A. Progression-Free Survival[a]



	Zanubrutinib	Ibrutinib
Events, n (%)	20 (19.6)	30 (30.3)
HR (95% CI)	**0.63 (0.36, 1.12)**	

B. Overall Survival[a]

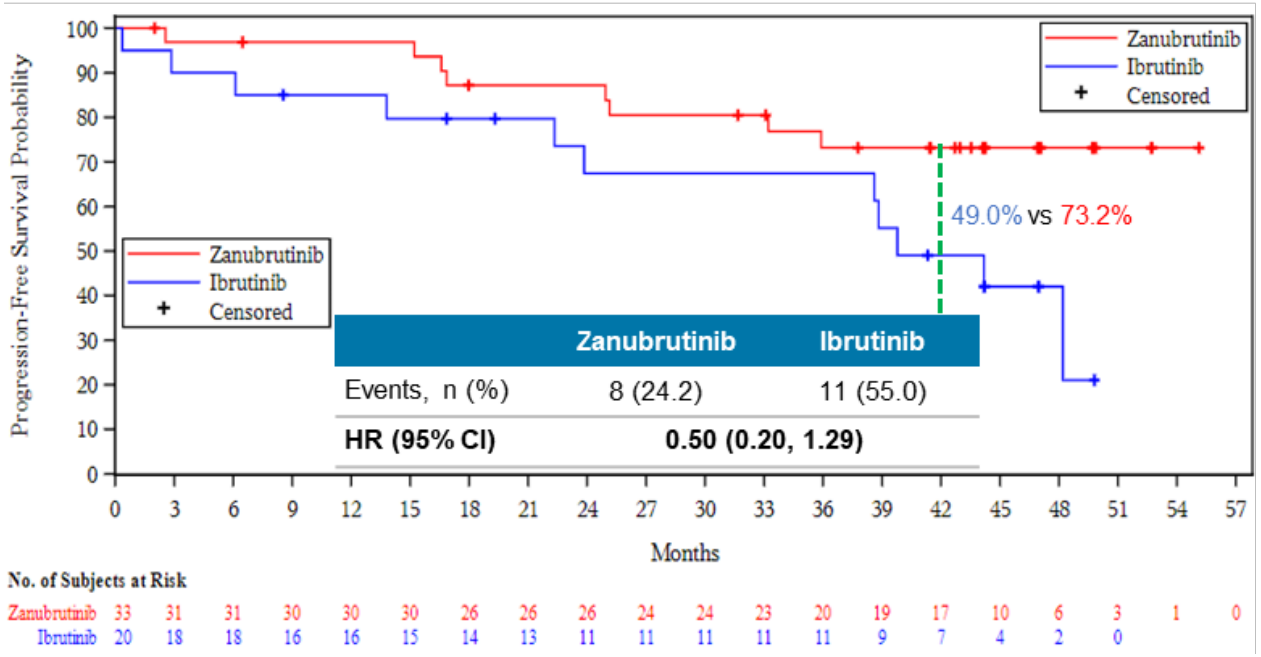


	Zanubrutinib	Ibrutinib
Events, n (%)	12 (11.8)	17 (17.2)
HR (95% CI)	**0.75 (0.36, 1.59)**	

Data cutoff: October 31, 2021.
[a]By investigator assessment.
OS, overall survival; PFS, progression-free survival.

Progression-Free Survival in Patients With *CXCR4*^{MUT}

Progression-Free Survival in Patients With *CXCR4*^{MUT}



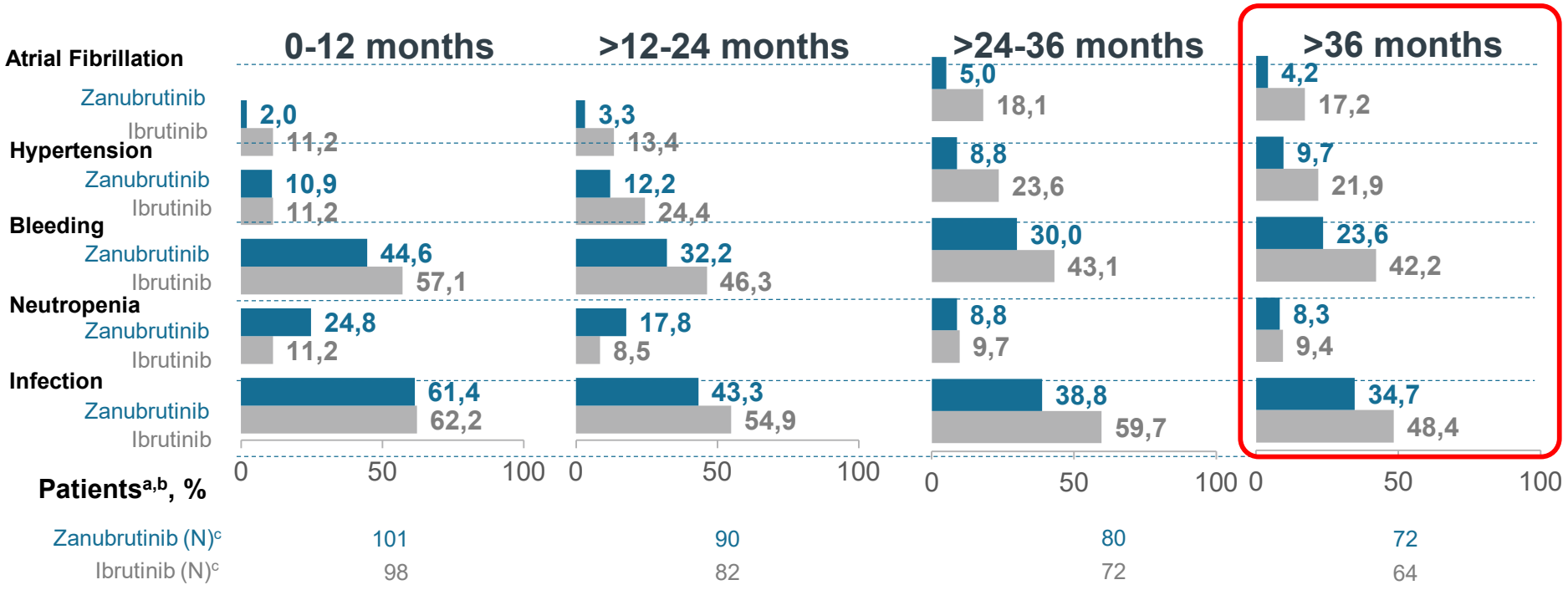
Response Assessment by *CXCR4* Status[a]

	CXCR4^{MUT}		*CXCR4*^{WT}	
	Ibrutinib (N=20)	Zanubrutinib (N=33)	Ibrutinib (N=72)	Zanubrutinib (N=65)
VGPR or better	2 (10.0)	**7 (21.2)**	22 (30.6)	**29 (44.6)**
Major response	13 (65.0)	**26 (78.8)**	61 (84.7)	54 (83.1)
Overall response	19 (95.0)	30 (90.9)	68 (94.4)	63 (96.9)
Time to major response, median (months)	6.6	3.4	2.8	2.8
Time to VGPR, median (months)	31.3	11.1	11.3	6.5

Bold text indicates >10% difference between arms.

Data cutoff: October 31, 2021.
[a]*CXCR4* mutation determined by NGS. 92 ibrutinib patients and 98 zanubrutinib patients had NGS results available.
CI, confidence interval; *CXCR4*, C-X-C chemokine receptor type 4 gene; NGS, next-generation sequencing; MUT, mutant; PD, progressive disease; PFS, progression-free survival; VGPR, very good partial response; WT, wild-type.

Prevalence analysis for adverse events of interest



Data cutoff: October 31, 2021.

[a]Events of the same preferred term that occurred within 1 day of the previous event were combined as one event. Patients with ongoing or new events in the interval is counted. [b]Percentage is based on N. [c]N is the number of patients who are on treatment in each time interval or who discontinued treatment but the time from first dose date to the earliest date of (last dose date + 30 days, initiation of new anticancer therapy, end of study, death or cutoff date) is within the time interval.

Kapitel 2

Marginalzonenlymphom

Rituximab/Lenalidomid – wo stehen wir mit der Kombination beim MZL?

HemaSphere

EHA EUROPEAN HEMATOLOGY ASSOCIATION

P1156 MAGNIFY PHASE 3B STUDY OF LENALIDOMIDE + RITUXIMAB (R2) FOLLOWED BY MAINTENANCE IN RELAPSED/REFRACTORY INDOLENT NON-HODGKIN LYMPHOMA: COMPLETE INDUCTION PHASE ANALYSIS

Topic: 18. Indolent and mantle-cell non-Hodgkin lymphoma - Clinical

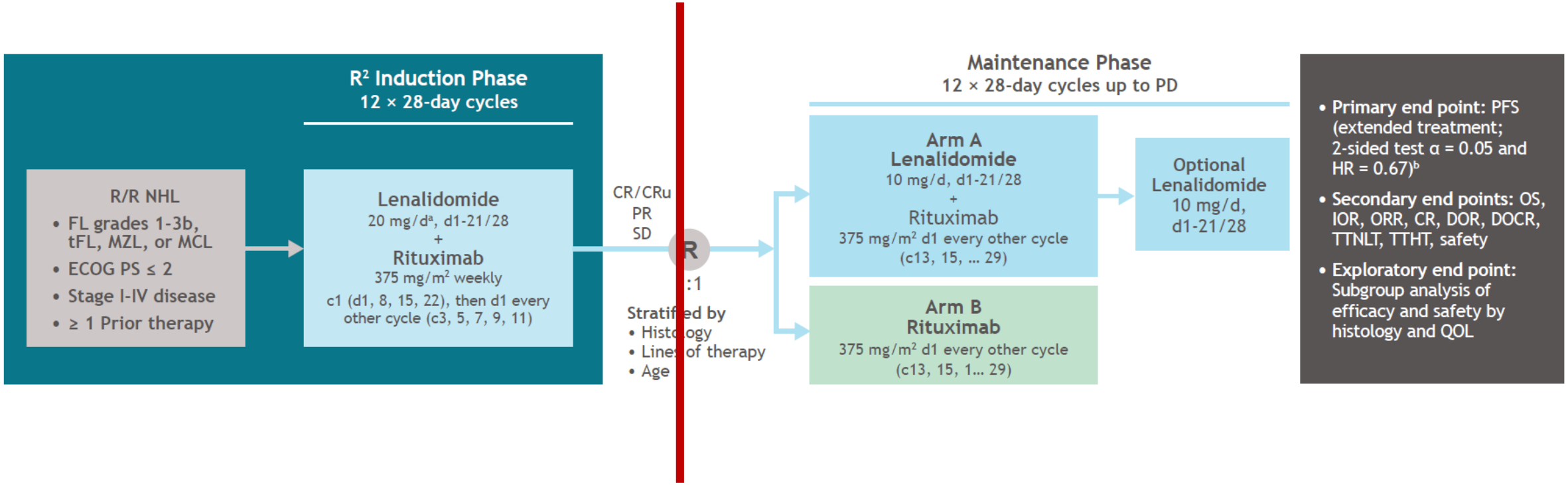
Frederick Lansigan[1], David Jacob Andorsky[2], Morton Coleman[3], Abdulraheem Yacoub[4], Jason M. Melear[5], Suzanne R. Fanning[6], Kathryn S. Kolibaba[7], Chris Reynolds[8], Grzegorz S. Nowakowski[9], Mecide Gharibo[10], Jung Ryun Ahn[10], Ju Li[10], Mathias J. Rummel[11], Jeff P. Sharman[12]

MAGNIFY phase 3B study of lenalidomide + rituximab (R^2) followed by maintenance in relapsed/refractory indolent non-hodgkin lymphoma: Complete induction phase analysis

Frederick Lansigan, MD,[1] David Jacob Andorsky, MD,[2] Morton Coleman, MD, FACP,[3] Abdulraheem Yacoub, MD,[4] Jason M. Melear, MD,[5] Suzanne R. Fanning, DO,[6] Kathryn S. Kolibaba, MD,[7] Chris Reynolds, MD,[8] Grzegorz S. Nowakowski, MD,[9] Mecide Gharibo, MD,[10] Jung Ryun Ahn, MD,[10] Ju Li, PhD,[10] Mathias J. Rummel, MD, PhD,[11] and Jeff P. Sharman, MD,[12] on behalf of the MAGNIFY Trial Investigators

[1]Dartmouth-Hitchcock Medical Center, Lebanon, NH, USA; [2]Rocky Mountain Cancer Centers, US Oncology Research, Boulder, CO, USA; [3]Clinical Research Alliance Inc, Weill Cornell Medicine, New York, NY, USA; [4]University of Kansas Cancer Center, Westwood, KS, USA; [5]Texas Oncology – Austin, US Oncology Research, Austin, TX, USA; [6]Prisma Health, US Oncology Research, Greenville, SC, USA; [7]US Oncology Research, Vancouver, WA, USA; [8]IHA Hematology Oncology Consultants – Ann Arbor, Ypsilanti, MI, USA; [9]Mayo Clinic, Rochester, MN, USA; [10]Bristol Myers Squibb, Princeton, NJ, USA; [11]Justus-Liebig Universität, Giessen, Germany; [12]Willamette Valley Cancer Institute and Research Center, US Oncology Research, Eugene, OR, USA

Studiendesign



Patient Characteristics

Table 1. Baseline patient characteristics

Characteristic, n (%)	Overall (N = 394)
Age, median (range), y	66 (35-91)
≥ 65 y	221 (56)
Male	210 (53)
ECOG PS at enrollment	
0	193 (49)
1	192 (49)
2	9 (2)
Positive bone marrow involvement	123 (31)
Ann Arbor disease stage at enrollment	
I/II	66 (17)
III	99 (25)
IV	229 (58)
Bulky disease (> 7 cm or > 3 cm x 3)	161 (41)
FL	318 (81)
Grade 1	116 (29)
Grade 2	147 (37)
Grade 3a	55 (14)
MZL	76 (19)
MALT[a]	15 (4)
Nodal	44 (11)
Splenic	17 (4)

Data cutoff March 5, 2021.
ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; MALT, extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue; MZL, marginal zone lymphoma.
[a]Three patients had gastric MALT.

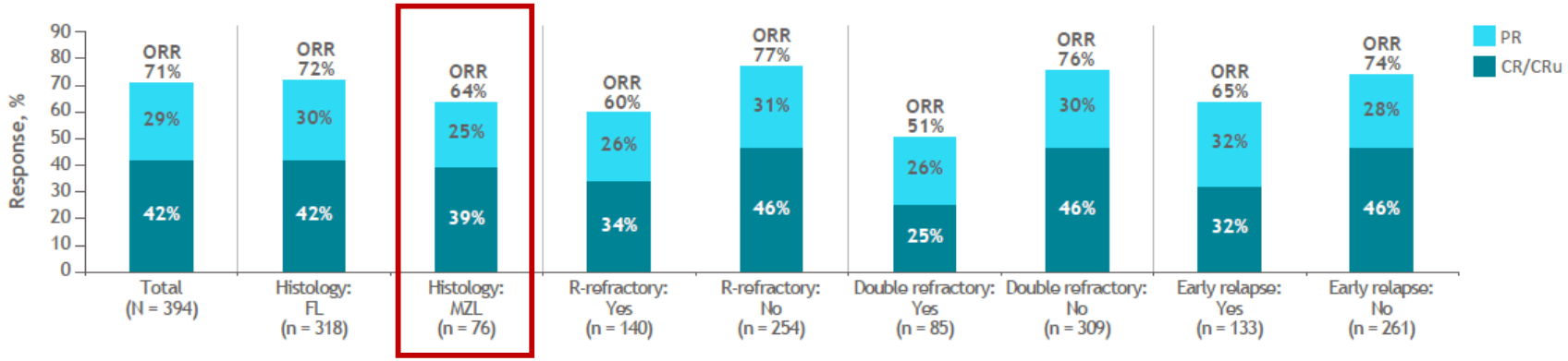
Table 2. Treatment history

Characteristic, n (%)	Total (N = 394)
Prior lines of antilymphoma treatment, median (range)	2 (1-8)
Prior therapies	
Rituximab containing	372 (94)
Rituximab + chemotherapy	289 (73)
Rituximab monotherapy	159 (40)
Rituximab refractory[a]	140 (36)
Double refractory[b]	85 (22)
Early relapse[c]	133 (34)

Data cutoff March 5, 2021.
[a]Defined as experiencing a best response of PD or SD to rituximab or rituximab-containing regimen or a response lasting < 6 months after last rituximab dose.
[b]Defined as being refractory to both rituximab and an alkylating agent.
[c]Defined as progressing or relapsing within 2 years of initial diagnosis.

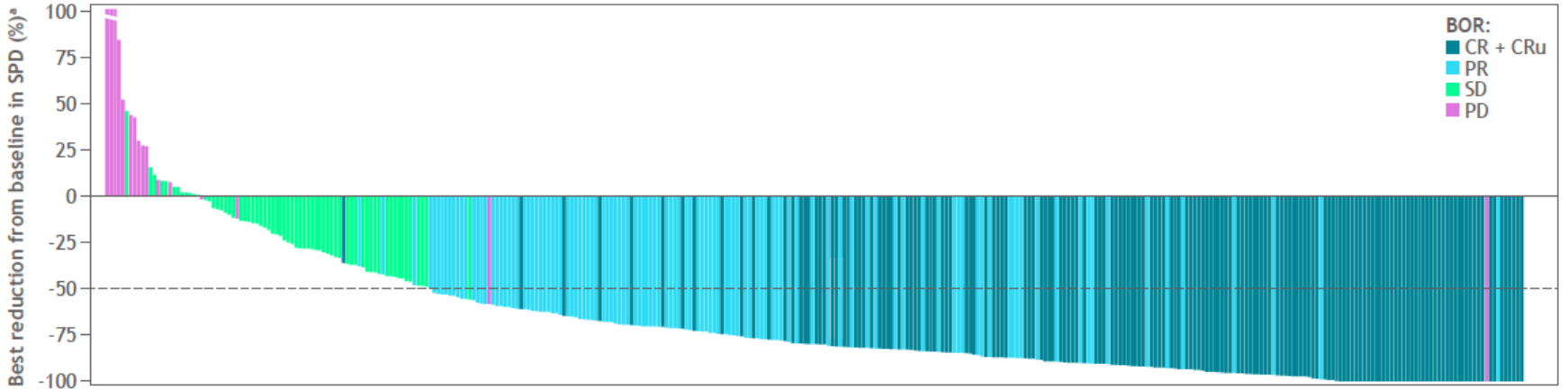
Response

Figure 3. Best overall response in R² induction treatment phase



Data cutoff March 5, 2021.
[a]ORR may not equal PR + CR due to rounding.
CR, complete response; CRu, CR unconfirmed; FL, follicular lymphoma; MZL, marginal zone lymphoma; ORR, overall response rate; PR, partial response; R, rituximab.

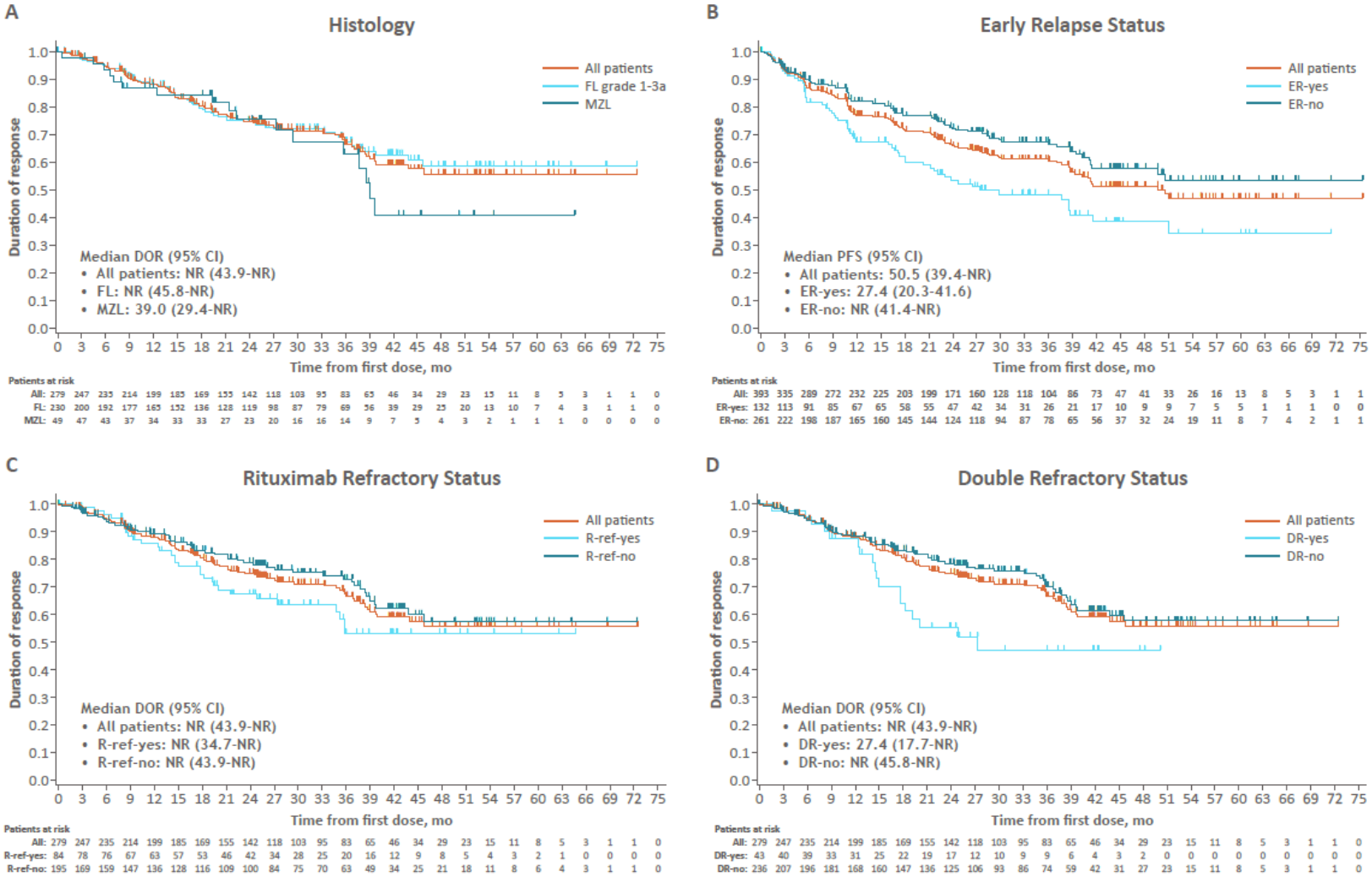
Figure 4. Change in tumor burden by best overall response



Data cutoff March 5, 2021.
[a]Axis truncated at 100%. 4 patients had change > 100%.
BOR, best overall response; PD, progressive disease; SD, stable disease; SPD, sum of the products of diameters.

Duration of Response

Figure 5. Duration of response[a]



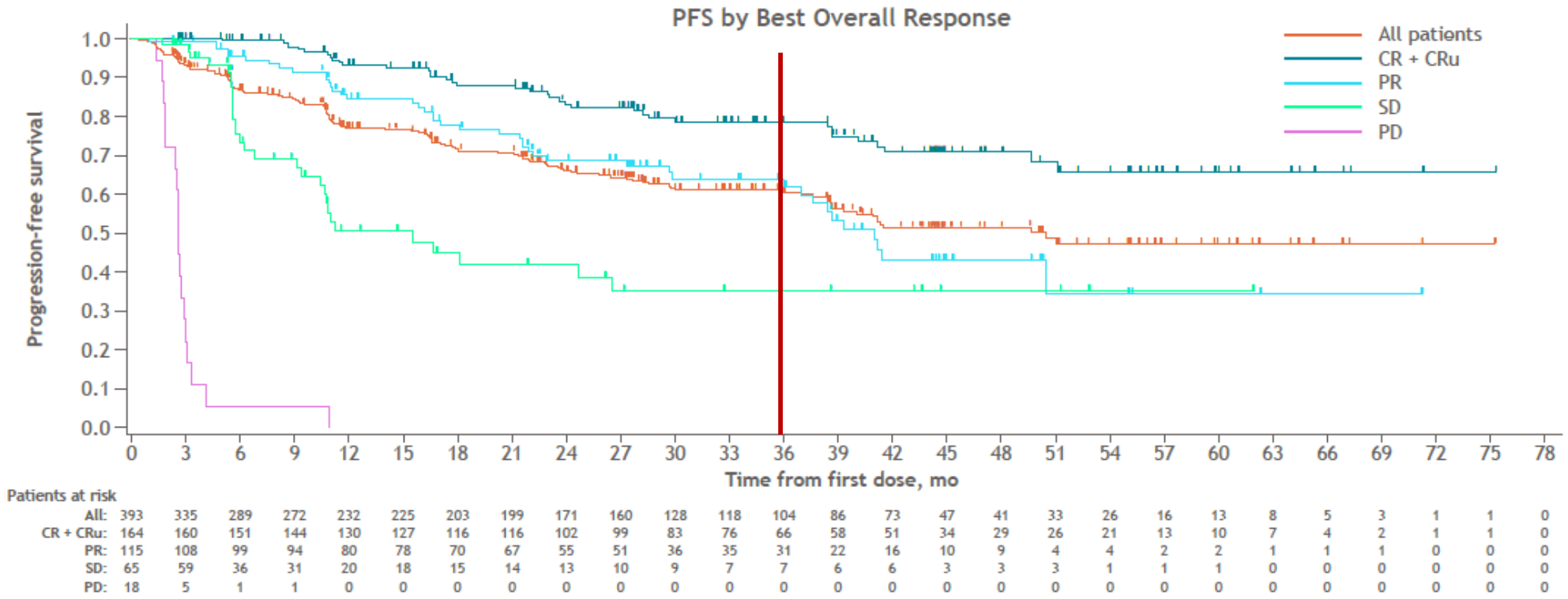
Data cutoff March 5, 2021.

[a]Induction treatment ITT population. If patients were already in maintenance at data cutoff, then response assessments also contributed to DOR.

DOR, duration of response; DR, double relapse; ER, early relapse; FL, follicular lymphoma; MZL, marginal zone lymphoma; NR, not reached; R-ref, rituximab refractory.

PFS

Figure 6. Progression-free survival[a]



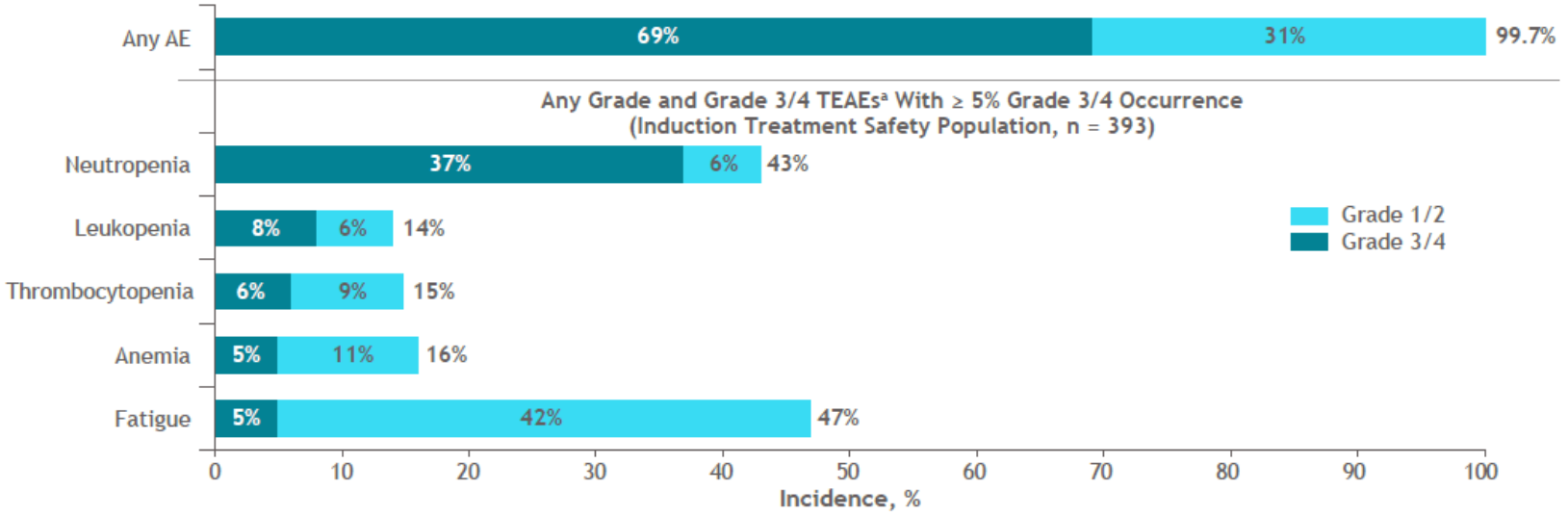
Data cutoff March 5, 2021.

[a]Induction treatment ITT population. If patients were already in maintenance at data cutoff, then response assessments also contributed to PFS.

CR, complete response; CRu, CR unconfirmed; PD, progressive disease; PFS, progression-free survival; PR, partial response; SD, stable disease.

Toxicity

Figure 7. Treatment emergent adverse events



Data cutoff March 5, 2021.
[a]Assessed per National Cancer Institute Common Terminology Criteria for Adverse Events version 4.03. TEAEs include any AEs occurring on or after first dose date of induction treatment through 28 days after the last dosing date of study treatment.

Table 3. Dose modifications due to TEAEs

Patients with ≥ 1 TEAE leading to dose modification in induction period, n (%)	Total (n = 393)
Early lenalidomide discontinuation	75 (19)
Early rituximab discontinuation	46 (12)
Lenalidomide dose reduction/interruption	252 (64)
Rituximab dose interruption	116 (30)

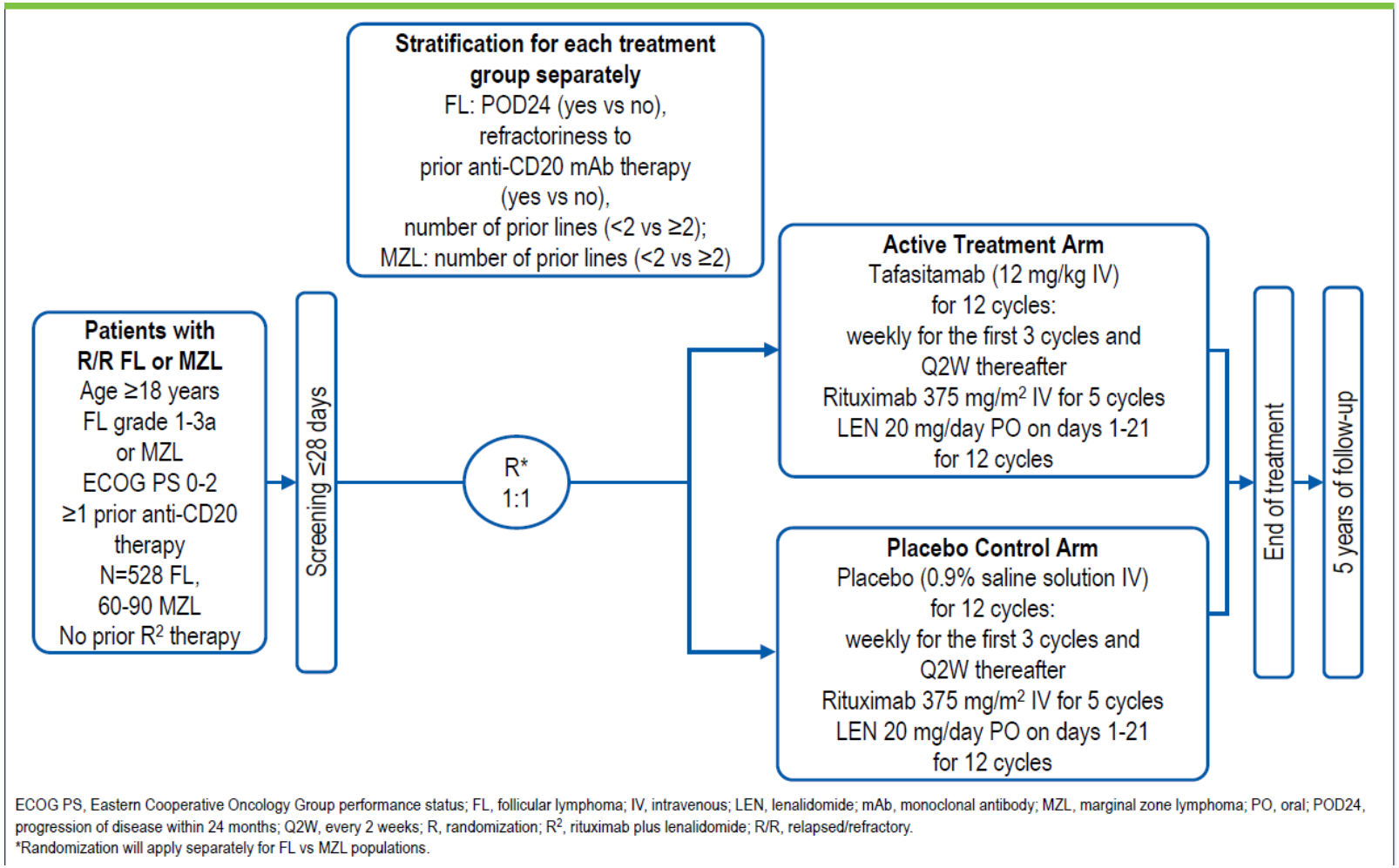
Data cutoff March 5, 2021.
TEAE, treatment emergent adverse event.

P1103

Presented at the
European Hematology Association (EHA) Hybrid Congress
Vienna, Austria • June 9-12, 2022

inMIND: A Phase 3 Study of Tafasitamab Plus Lenalidomide and Rituximab Versus Placebo Plus Lenalidomide and Rituximab for Relapsed/Refractory Follicular Lymphoma or Marginal Zone Lymphoma

Laurie H. Sehn,[1] Kai Hübel,[2] Stefano Luminari,[3] Antonio Salar,[4] Björn E. Wahlin,[5] Ajay K. Gopal,[6] Christophe M. Bonnet,[7] Shankara Paneesha,[8] Marek Trněný,[9] Hafsat U. Mashegu,[10] Christine Lihou,[10] Di Li,[10] Christian W. Scholz[11]
Contact: Lsehn@bccancer.bc.ca



ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; IV, intravenous; LEN, lenalidomide; mAb, monoclonal antibody; MZL, marginal zone lymphoma; PO, oral; POD24, progression of disease within 24 months; Q2W, every 2 weeks; R, randomization; R², rituximab plus lenalidomide; R/R, relapsed/refractory.
*Randomization will apply separately for FL vs MZL populations.

Kapitel 3

Marginalzonenlymphom

PI3K? – Chronos 3

Copanlisib plus rituximab *vs* rituximab plus placebo in patients with relapsed indolent non-Hodgkin lymphoma: updated safety and efficacy from the Phase III CHRONOS-3 trial

P1138

Pier Luigi Zinzani,[1,2] Muhit Özcan,[3] Katya Sapunarova,[4] Wojciech Jurczak,[5] Aryan Hamed,[6] Krimo Bouabdallah,[7] Guray Saydam,[8] Klaus Geissler,[9] Árpád Szomor,[10] Mihaela Lazaroiu,[11] Antonio Salar,[12] Adrian Tempescul,[13] Meliha Nalcaci,[14] Liana Gercheva,[15] Miklos Egyed,[16] Panayiotis Panayiotidis,[17] Lidia Mongay Soler,[18] Anjun Cao,[18] Charles Phelps,[18] Barrett H Childs,[18] Matthew J Matasar[19]

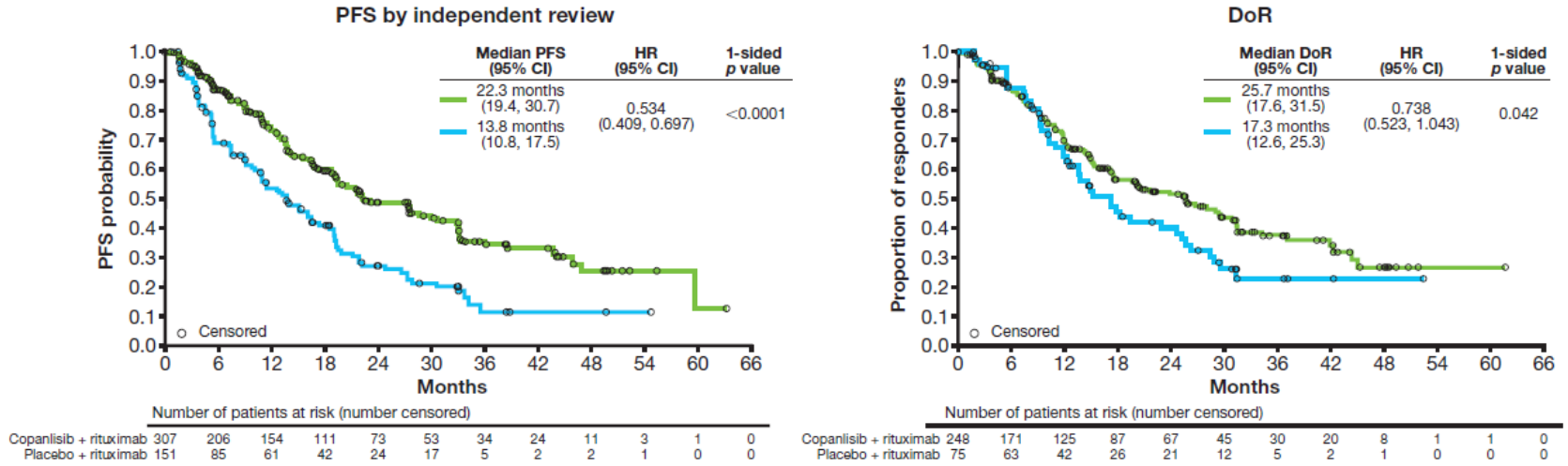
[1]IRCCS Azienda Ospedaliero-Universitaria di Bologna, Istituto di Ematologia "Seràgnoli", Bologna, Italy; [2]Dipartimento di Medicina Specialistica, Diagnostica e Sperintale, Universita di Bologna, Bologna, Italy; [3]Ankara University School of Medicine, Ankara, Turkey; [4]Medical University, Plovdiv, Bulgaria; [5]Maria Sklodowska Curie National Research Institute of Oncology, Krakow, Poland; [6]Petz Aladár Megyei Oktató Kórház, Gyor, Hungary; [7]Hematology and Cellular Therapy Department, University Hospital of Bordeaux, Bordeaux, France; [8]Ege Üniversitesi Tip Fakültesi, Izmir, Turkey; [9]Sigmund Freud University, Vienna, Austria; [10]Pécsi Tudományegyetem Klinikai Központ, Pécs, Hungary; [11]S.C. Policlinica de Diagnostic Rapid S.A., Brasov, Romania; [12]Hospital del Mar, Barcelona, Spain; [13]Hôpital Morvan - Brest, Brest, France; [14]Istanbul Universitesi Istanbul Tip Fakultesi, Istanbul, Turkey; [15]MHAT Sveta Marina EAD, Varna, Bulgaria; [16]Somogy Megyei Kaposi Mor Oktato Korhaz, Kaposvar, Hungary; [17]First Department of Propaedeutic Internal Medicine, National and Kapodistrian University of Athens, School of Medicine, Athens, Greece; [18]Bayer HealthCare Pharmaceuticals, Inc., Whippany, NJ, USA; [19]Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, NY, USA

Table 1. Patient demographics and baseline cancer characteristics (full analysis set)

	Copanlisib + rituximab (*n*=307)	Placebo + rituximab (*n*=151)	Total (*N*=458)
Male, *n* (%)	153 (49.8)	85 (56.3)	238 (52.0)
Median age, years (range)	63 (28-91)	62 (34-85)	63 (28-91)
Medical history of diabetes, *n* (%)	45 (14.7)	22 (14.6)	67 (14.6)
Medical history of hypertension, *n* (%)	114 (37.1)	53 (35.1)	167 (36.5)
Histology of lymphoma, *n* (%)			
FL	184 (59.9)	91 (60.3)	275 (60.0)
Grade 1	56 (18.2)	31 (20.5)	87 (19.0)
Grade 2	88 (28.7)	40 (26.5)	128 (27.9)
Grade 3a	40 (13.0)	20 (13.2)	60 (13.1)
MZL	66 (21.5)	29 (19.2)	95 (20.7)
SLL	35 (11.4)	15 (9.9)	50 (10.9)
LPL/WM	22 (7.2)	16 (10.6)	38 (8.3)
Median time since last systemic therapy, months (range)	25.1 (1.0-192.5)	25.3 (0.8-161.2)	25.2 (0.8-192.5)
Median time since initial diagnosis, months (range)	62.8 (10.3-349.2)	72.4 (13.3-245.7)	63.2 (10.3-349.2)
Progression- and treatment-free for ⩾12 months since last rituximab-containing regimen, *n* (%)	247 (80.5)	121 (80.1)	368 (80.3)
Unwilling or unfit to receive chemotherapy, *n* (%)	60 (19.5)	30 (19.9)	90 (19.7)
Previous lines of anti-cancer therapy, *n* (%)			
1	150 (48.9)	71 (47.0)	221 (48.3)
2	75 (24.4)	40 (26.5)	115 (25.1)
3	38 (12.4)	23 (15.2)	61 (13.3)
⩾4	44 (14.3)	17 (11.3)	61 (13.3)

FL, follicular lymphoma; LPL/WM, lymphoplasmacytic lymphoma/Waldenström macroglobulinemia; MZL, marginal zone lymphoma; SLL, small lymphocytic lymphoma

Figure 2. Efficacy endpoints (full analysis set)



Copanlisib plus rituximab *vs* rituximab plus placebo in patients with relapsed indolent non-Hodgkin lymphoma: updated safety and efficacy from the Phase III CHRONOS-3 trial

P1138

Pier Luigi Zinzani,[1,2] Muhit Özcan,[3] Katya Sapunarova,[4] Wojciech Jurczak,[5] Aryan Hamed,[6] Krimo Bouabdallah,[7] Guray Saydam,[8] Klaus Geissler,[9] Árpád Szomor,[10] Mihaela Lazaroiu,[11] Antonio Salar,[12] Adrian Tempescul,[13] Meliha Nalcaci,[14] Liana Gercheva,[15] Miklos Egyed,[16] Panayiotis Panayiotidis,[17] Lidia Mongay Soler,[18] Anjun Cao,[18] Charles Phelps,[18] Barrett H Childs,[18] Matthew J Matasar[19]

[1]IRCCS Azienda Ospedaliero-Universitaria di Bologna, Istituto di Ematologia "Seràgnoli", Bologna, Italy; [2]Dipartimento di Medicina Specialistica, Diagnostica e Sperintale, Universita di Bologna, Bologna, Italy; [3]Ankara University School of Medicine, Ankara, Turkey; [4]Medical University, Plovdiv, Bulgaria; [5]Maria Sklodowska Curie National Research Institute of Oncology, Krakow, Poland; [6]Petz Aladár Megyei Oktató Kórház, Gyor, Hungary; [7]Hematology and Cellular Therapy Department, University Hospital of Bordeaux, Bordeaux, France; [8]Ege Üniversitesi Tip Fakültesi, Izmir, Turkey; [9]Sigmund Freud University, Vienna, Austria; [10]Pécsi Tudományegyetem Klinikai Központ, Pécs, Hungary; [11]S.C. Policlinica de Diagnostic Rapid S.A., Brasov, Romania; [12]Hospital del Mar, Barcelona, Spain; [13]Hôpital Morvan - Brest, Brest, France; [14]Istanbul Universitesi İstanbul Tip Fakultesi, Istanbul, Turkey; [15]MHAT Sveta Marina EAD, Varna, Bulgaria; [16]Somogy Megyei Kaposi Mor Oktato Korhaz, Kaposvar, Hungary; [17]First Department of Propaedeutic Internal Medicine, National and Kapodistrian University of Athens, School of Medicine, Athens, Greece; [18]Bayer HealthCare Pharmaceuticals, Inc., Whippany, NJ, USA; [19]Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, NY, USA

Table 2. Median PFS, ORR, and CRR by histology

	Overall		FL		MZL		SLL		LPL/WM	
	C + R (*n*=307)	P + R (*n*=151)	C + R (*n*=184)	P + R (*n*=91)	C + R (*n*=66)	P + R (*n*=29)	C + R (*n*=35)	P + R (*n*=15)	C + R (*n*=22)	P + R (*n*=16)
Median PFS, months (95% CI)	22.3 (19.4, 30.7)	13.8 (10.8, 17.5)	23.2 (19.2, 33.1)	16.6 (11.0, 19.6)	27.6 (13.8, 38.6)	12.9 (5.6, 19.4)	16.3 (10.9, 21.9)	5.7 (3.5, 11.0)	36.1 (15.5, NE)	16.6 (4.4, NE)
HR (95% CI)	0.534 (0.409, 0.697)		0.57 (0.41, 0.80)		0.53 (0.28, 0.99)		0.22 (0.10, 0.49)		0.42 (0.15, 1.16)	
p value	0.000001		0.000534		0.021534		0.000025		0.041688	
ORR[a], % (95% CI)	80.8 (75.9, 85.0)	49.7 (41.4, 57.9)	84.8 (78.8, 89.6)	56.0 (45.2, 66.4)	75.8 (63.6, 85.5)	44.8 (26.4, 64.3)	77.1 (59.9, 89.6)	13.3 (1.7, 40.5)	68.2 (45.1, 86.1)	56.3 (29.9, 80.2)
p value	<0.000001		<0.000001		0.001655		0.000014		0.225774	
CRR, % (95% CI)	34.9 (24.5, 40.5)	14.6 (9.4, 21.2)	38.0 (31.0, 45.5)	20.9 (13.1, 30.7)	39.4 (27.6, 52.2)	10.3 (2.2, 27.4)	20.0 (8.4, 36.9)	0	18.2 (5.2, 40.3)	0
p value	<0.000001		0.002100		0.002318		0.030901		0.035683	

[a]ORR is defined as the proportion of patients who have a best overall response of complete response, very good partial response, partial response, or minor response (very good partial response and minor response apply to Owen criteria only[3])

FL, follicular lymphoma; LPL/WM, lymphoplasmacytic lymphoma/Waldenström macroglobulinemia; MZL, marginal zone lymphoma; NE, not evaluable; SLL, small lymphocytic lymphoma

Kapitel 4

Marginalzonenlymphom

BTKi? - die Reise geht weiter

HemaSphere

EHA EUROPEAN HEMATOLOGY ASSOCIATION

P1129 ACALABRUTINIB IN PATIENTS WITH RELAPSED/REFRACTORY (R/R) MARGINAL ZONE LYMPHOMA (MZL): RESULTS OF A PHASE 2, MULTICENTER, OPEN-LABEL TRIAL

Topic: 18. Indolent and mantle-cell non-Hodgkin lymphoma - Clinical

Paolo Strati[1], Morton Coleman[2], Don Stevens[3], Shuo Ma[4], Caterina Patti[5], Moshe Levy[6], Izidore S. Lossos[7], Praveen Ramakrishnan Geethakumari[8], Selay Lam[9], Roser Calvo[10], Kara Higgins[11], Lihua Budde[12]

[1] The University of Texas MD Anderson Cancer Center, Houston, TX, United States;[2] Clinical Research Alliance/Weill Cornell Medicine, New York City, NY, United States;[3] Norton Cancer Institute, Louisville, KY, United States;[4] Robert H. Lurie Comprehensive Cancer Center, Northwestern University Feinberg School of Medicine, Chicago, IL, United States;[5] A.O.O.R. Villa Sofia-Cervello, U. O. Ematologia I, Palermo, Italy;[6] Baylor University Medical Center, Dallas, TX, United States;[7] Sylvester Comprehensive Cancer Center, University of Miami–Miller School of Medicine, Miami, FL, United States;[8] Harold C. Simmons Comprehensive Cancer Center, University of Texas Southwestern Medical Cente, Dallas, TX, United States;[9] London Health Sciences Centre, London, Ontario, Canada;[10] AstraZeneca, Gaithersburg, MD, United States;[11] AstraZeneca, South San Francisco, CA, United States;[12] City Of Hope National Medical Center, Duarte, CA, United States

Patients
R/R MZL
(N=43)

Median age, y	Median # prior therapies
69	1

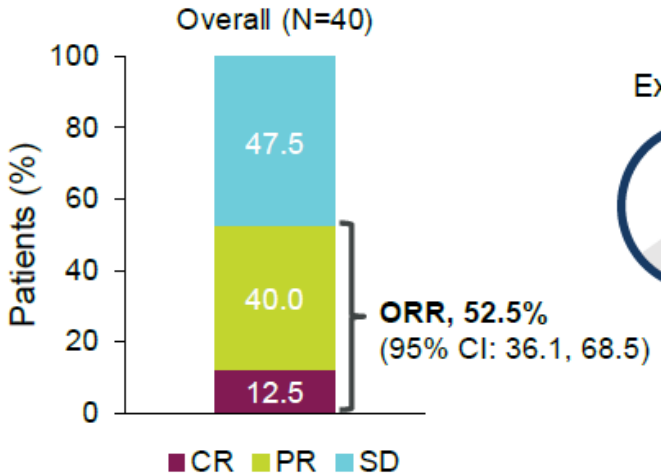
Subtype

Extranodal	Nodal	Splenic
44%	30%	26%

Acalabrutinib monotherapy
PO 100 mg BID

Median follow-up 13.3 mo Data cutoff January 4, 2022

Investigator-Assessed ORR in Evaluable Patients

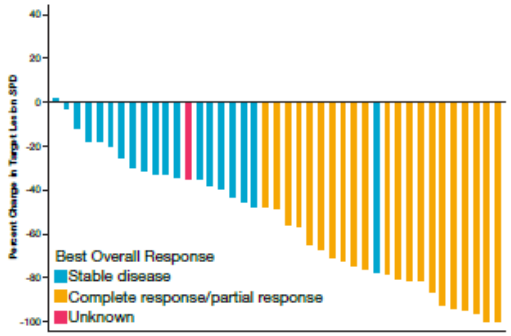


- Median duration of response was not estimable
- 12-month duration of response rate: 75.8%

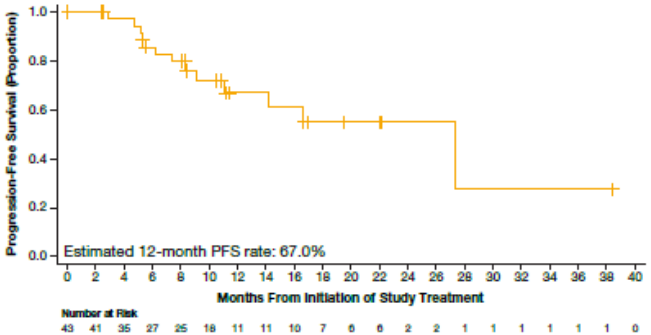
ORR by Subtype

Extranodal	Nodal	Splenic
65%	42%	45%

Best Percent Change in Sum of Product Diameters



Progression-free Survival



Safety

- Most adverse events were **grade 1 or 2 in severity**
- **5% discontinued acalabrutinib** due to adverse events
- **No atrial fibrillation/flutter,** ventricular arrhythmias, or major hemorrhage
- **One death** due to adverse event (septic shock)

Conclusions

- **With an ORR of 53%, these results support acalabrutinib as an alternative therapy for patients with R/R MZL**
- **Adverse events reported were consistent with the known safety profile of acalabrutinib**

BID, twice daily; CI, confidence interval; CR, complete response; MZL, marginal zone lymphoma; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; PO, orally; PR, partial response; R/R, relapsed/refractory; SD, stable disease; SPD, sum of product diameters.

Zusammenfassung | Take-Home-Messages

- **Morbus Waldenström**
  - Zanubrutinib mit hoher Wirksamkeit und guter Verträglichkeit, gute Option bei CXCR4 mutierten und MYD88 WT Patienten
- **Marginalzonenlymphom**
  - Rituximab/Lenalidomid als wirksame Substanz beim MZL: 39% CR, DOR 39 Monate → weitere Entwicklung – R2 plus Tafasitamab? R2 plus Bi-specifics?
  - PI3K Inhibitors mit Zukunft? Copanlisib 28 Monate median PFS, 39% CR – Zulassung?
  - BTK Inhibitoren wirken! Acalabrutinib mit Wirksamkeit und guter Verträglichkeit als Einzelsubstanz bei rezidivierten MZL. Zulassung?

Die Kurzpräsentationen sind online unter

www.lymphome.de/eha2022

Für den Inhalt verantwortlich:

Prof. Dr. med. Christian Buske

Universitätsklinikum Ulm

Kompetenznetz Maligne Lymphome

Lymphom Kompetenz KOMPAKT

Das Informationsprojekt wird unterstützt von den Firmen:

abbvie

AMGEN

AstraZeneca

Bristol Myers Squibb™

gsk

HEXAL
A Sandoz Brand

janssen
PHARMACEUTICAL COMPANIES OF Johnson&Johnson

Diese hatten keinen Einfluss auf die Inhalte.