Kompetenznetz Maligne Lymphome

Lymphom Kompetenz KOMPAKT

KML KONGRESSE

Expert:innen berichten zu Lymphomen & Leukämien

Kompetenznetz
Maligne Lymphome

Lymphom
Kompetenz
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Expert:innen berichten zu
Lymphomen & Leukämien

Prof. Dr. med. Martin Dreyling
Klinikum der Universität München

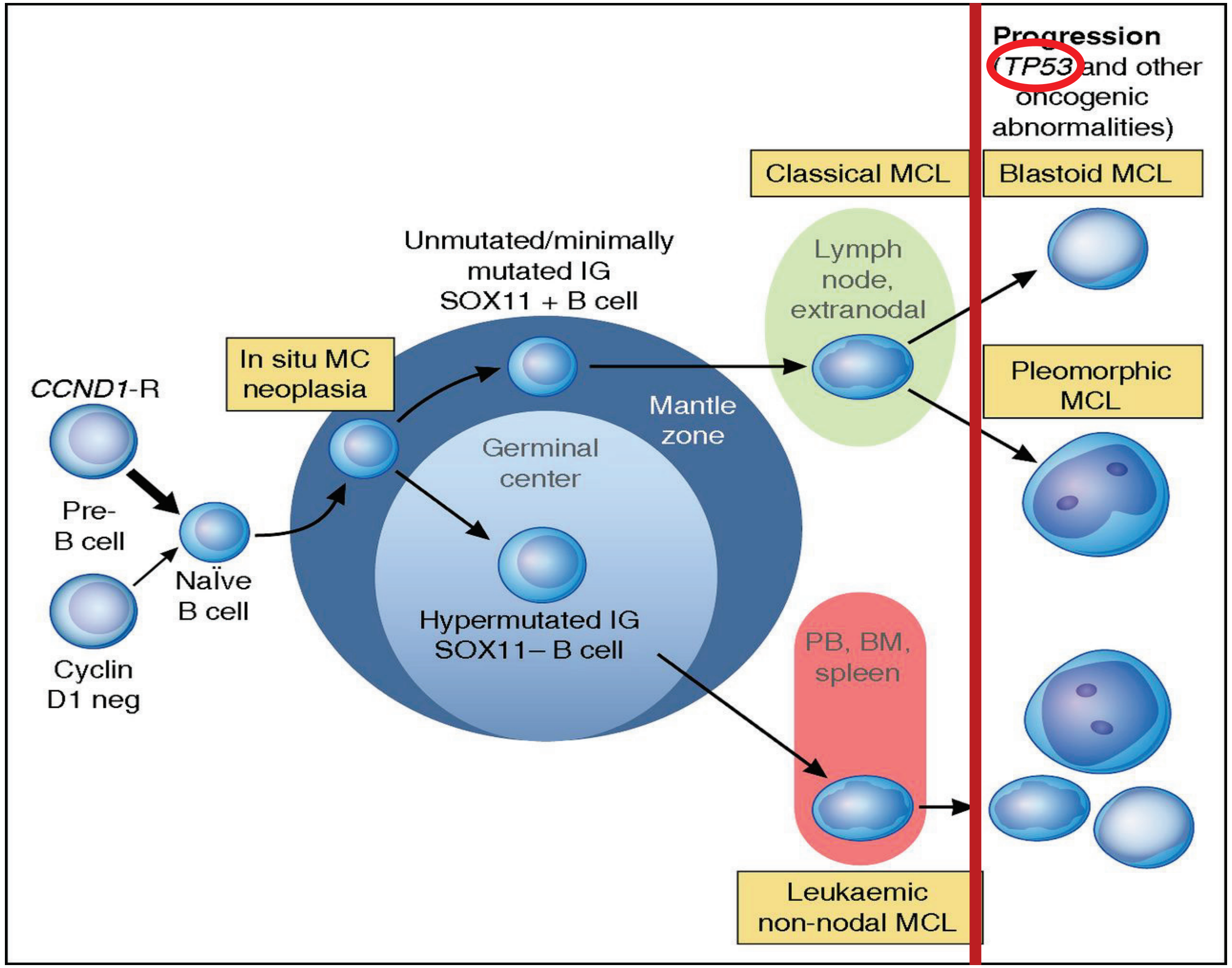
Mantelzell-Lymphom (MCL)

Offenlegung potentieller Interessenskonflikte

LymphomKompetenz KOMPAKT – ASH2025 wird in Kooperation mit acht unterstützenden Firmen durchgeführt.
Meine persönlichen Disclosures betreffen:

Research Support (institution)	**Abbvie, Bayer, BMS/Celgene, Gilead/Kite, Janssen, Roche**
Employee	**-**
Major Stockholder	**-**
Speakers Bureau	**-**
Speakers Honoraria	**Astra Zeneca, Beigene, Gilead/Kite, Janssen, Lilly, Novartis, Roche**
Scientific Advisory Board	**Abbvie, Astra Zeneca, Beigene, BMS/Celgene, Gilead/Kite, Janssen, Lilly/Loxo, Novartis, Roche**

Mantelzell-Lymphom
Spektrum der Erkrankung

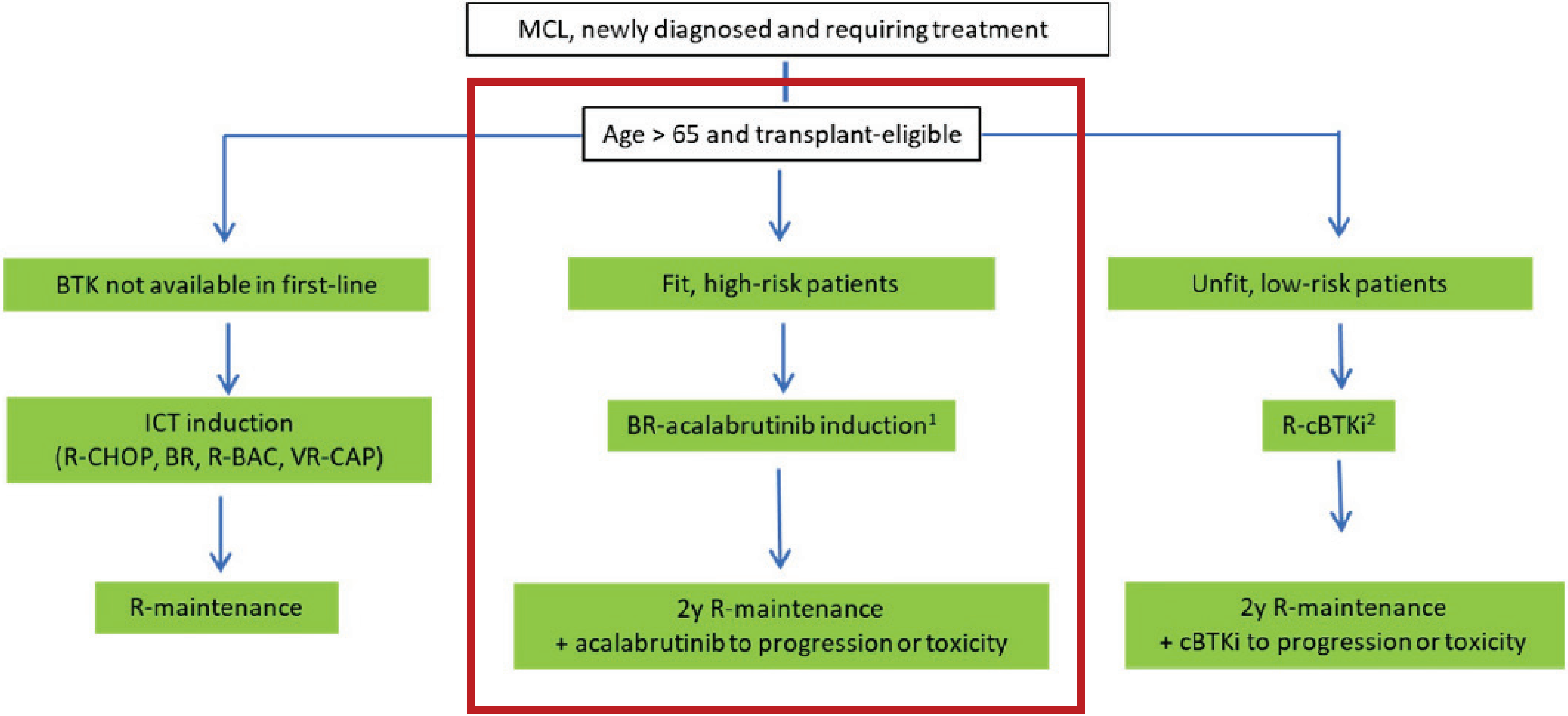


Dreyling, Ann Oncol 2017

Kapitel 1

Erstlinie

How do I treat MCL (elderly patients)
Suggested Therapeutic algorithm



Silkenstedt, Dreyling, Hematological Oncology 2025

Presentation 885

Time to Third-Line Treatment After Bendamustine-Rituximab With or Without Acalabrutinib in Patients With Previously Untreated Mantle Cell Lymphoma: Updated Analysis of the Phase 3 ECHO Trial After 50 Months of Follow-up

Michael L. Wang, MD,[1] Jonas Paludo, MD,[2] João Samuel de Holanda Farias, MD,[3] Diego Villa, MD, MPH,[4] Cecily Forsyth, MD,[5] Ellie John, PhD,[6] Menglu Che, PhD,[7] Harneet Arora, PhD,[7] Craig Delury, PhD,[6] Victoria Otero, MD,[8] Yuqin Song, MD[9]

[1]Department of Lymphoma/Myeloma, MD Anderson Cancer Center, University of Texas, Houston, TX, USA; [2]Division of Hematology, Department of Medicine, Mayo Clinic, Rochester, MN, USA; [3]Hematology Department, Hospital Erasto Gaertner, Curitiba, PR, Brazil; [4]Division of Medical Oncology, BC Cancer Centre for Lymphoid Cancer and University of British Columbia, Vancouver, BC, Canada; [5]Central Coast Haematology, North Gosford, Australia; [6]AstraZeneca, Cambridge, United Kingdom; [7]AstraZeneca, Mississauga, Ontario, Canada; [8]AstraZeneca, Gaithersburg, MD, USA; [9]Key Laboratory of Carcinogenesis and Translational Research, Department of Lymphoma, Peking University Cancer Hospital & Institute, Beijing, China

Presented at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, Florida

ECHO Study Design

ECHO (NCT02972840): multicenter, double-blind, placebo-controlled, phase 3 trial

Untreated MCL (N=598)

- Age ≥65 years
- ECOG PS ≤2

Stratification

sMIPI score: Low vs intermediate vs high

Geographic region: North America vs Western Europe vs other

RANDOMIZE 1:1

ABR (N=299)

Bendamustine[a] + Rituximab[b] x 6 cycles → If ≥PR → Maintenance Rituximab (every 2 cycles x 2 years)

Acalabrutinib 100 mg BID, PO until PD or toxicity

PBR (N=299)

Bendamustine[a] + Rituximab[b] x 6 cycles → If ≥PR → Maintenance Rituximab (every 2 cycles x 2 years)

Placebo BID, PO until PD or toxicity

1 cycle = 28 days

Crossover to acalabrutinib after PD was permitted

Primary endpoint:
- PFS (independent review committee)

Key secondary endpoints:
- ORR (independent review committee)
- OS

Safety

Enrollment: April 2017 to March 2023
Sites: 195 globally

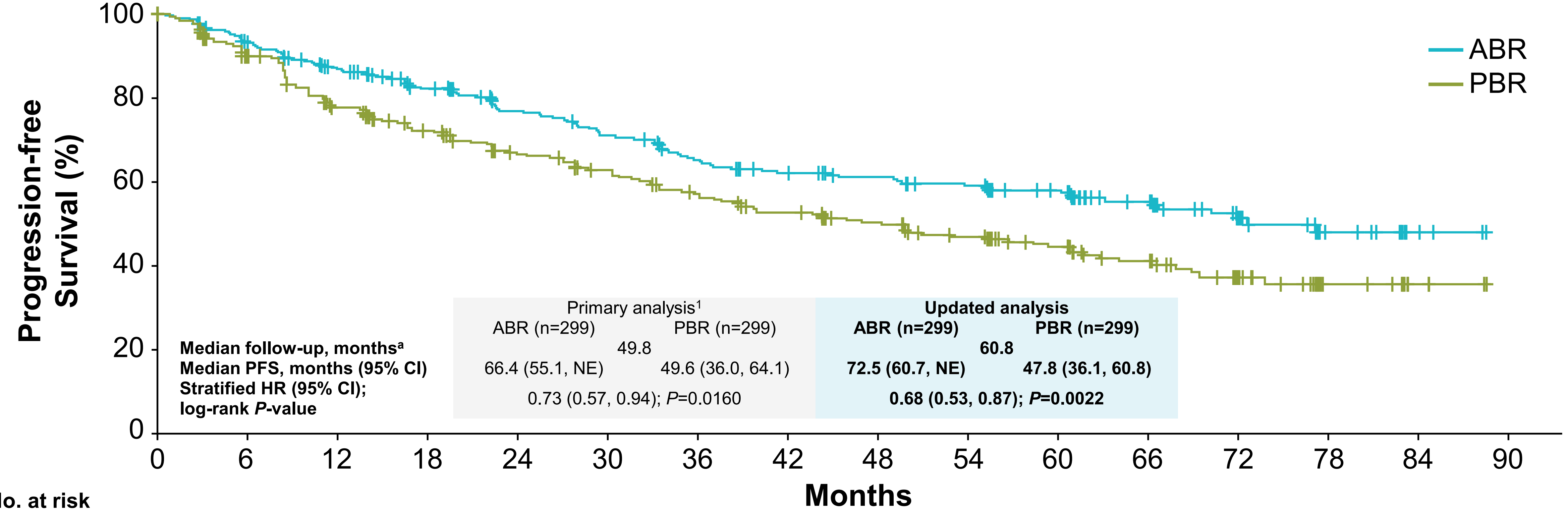
Updated Analysis (1 additional year of follow-up)

Data cutoff date: February 15, 2025

Median time on study: 51.9 (0.03–93.04) months

[a]Bendamustine 90 mg/m^2 on days 1 and 2. [b]Rituximab 375 mg/m^2 on day 1.
ABR, acalabrutinib plus bendamustine-rituximab; BID, twice daily; ECOG PS, Eastern Cooperative Oncology Group performance status; KM, Kaplan-Meier; MCL, mantle cell lymphoma; PBR, placebo plus bendamustine and rituximab; PD, progressive disease; PFS, progression-free survival; PR, partial response; ORR, overall response rate; OS, overall survival; PO, orally; sMIPI, simplified MCL International Prognostic Index.

At 60.8 Months of Follow-up, PFS Further Improved With ABR vs PBR



	Primary analysis[1]		Updated analysis	
	ABR (n=299)	PBR (n=299)	**ABR (n=299)**	**PBR (n=299)**
Median follow-up, months[a]	49.8		**60.8**	
Median PFS, months (95% CI)	66.4 (55.1, NE)	49.6 (36.0, 64.1)	**72.5 (60.7, NE)**	**47.8 (36.1, 60.8)**
Stratified HR (95% CI); log-rank *P*-value	0.73 (0.57, 0.94); *P*=0.0160		**0.68 (0.53, 0.87); *P*=0.0022**	

No. at risk																
ABR	299	258	232	205	184	165	147	131	123	115	95	70	39	18	4	0
PBR	299	244	205	182	160	145	128	116	103	89	74	56	27	11	3	0

- PFS risk reduction with ABR vs PBR increased from 27% (primary analysis) to 32% (updated analysis)
- Median PFS was longer with ABR vs PBR (6 years vs 4 years)

[a]Median follow up for PFS estimated using the reverse K-M method.
ABR, acalabrutinib plus bendamustine-rituximab; CI, confidence interval; HR, hazard ratio; K-M, Kaplan-Meier; NE, not estimable; PBR, placebo plus bendamustine-rituximab; PFS, progression-free survival.

1. Wang M, et al. *J Clin Oncol*. 2025;43:2276-84.

ECHO Analysis

Need for Subsequent Anticancer Therapy Was 3-fold Higher With PBR

Subsequent therapy was required by 11% with ABR vs 33% with PBR

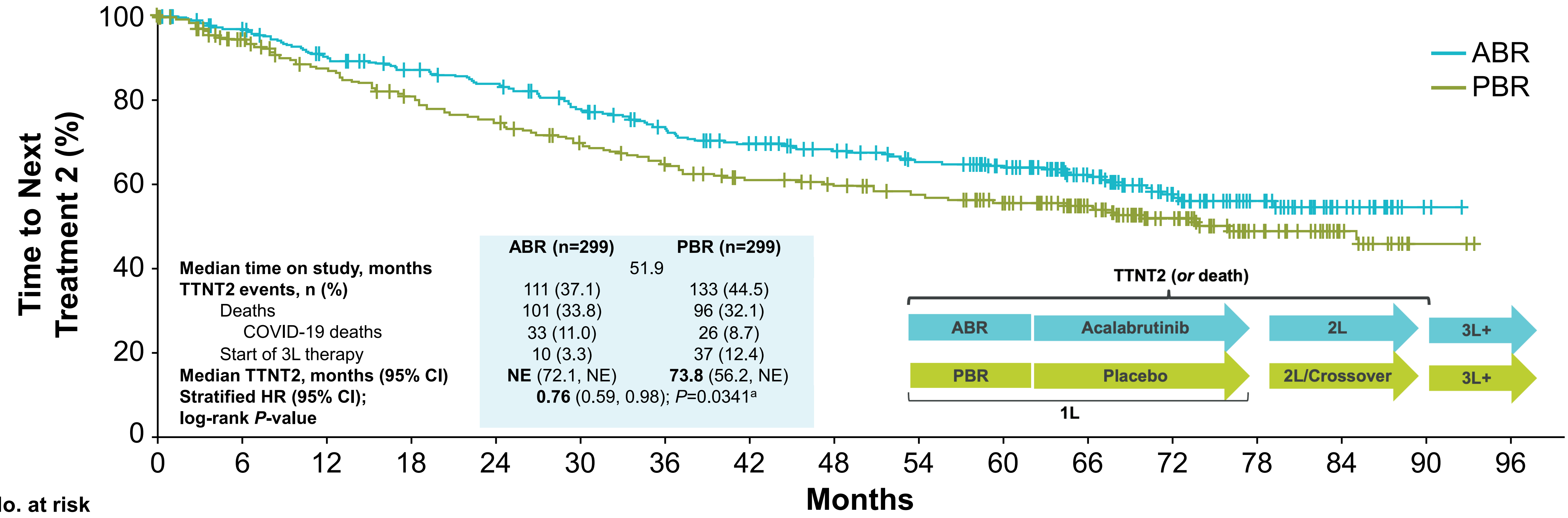
Number of Patients	ABR (n=299)	PBR (n=299)
≥1 subsequent anticancer therapy	33	100
2L anticancer therapy[a,b]	**33**	**100**
BTKi	12	79
Chemotherapy	11	13
Non-BTKi targeted therapy[c]	9	6[e]
Others[d]	1	3[e]
3L anticancer therapy[a,b]	**10**	**37**
BTKi	3	7
Chemotherapy	4	19
Non-BTKi targeted therapy[c]	3	11
4L+ anticancer therapy[a,b]	**3**	**14**
BTKi	0	5
Chemotherapy	2	7
Non-BTKi targeted therapy[c]	1	7

- 57 of 79 patients in the PBR arm who received BTKis in 2L received acalabrutinib on study as crossover

[a]A patient receiving multiple subsequent anticancer therapies in the same category is counted only once in the corresponding category.
[b]A patient receiving subsequent anticancer therapies in multiple categories is counted once in all categories.
[c]Targeted therapy includes all other non-BTKi targeted therapies, including CAR-T (ABR, n=2; PBR, n=5) and T-cell engager therapy (PBR, n=3).
[d]"Others" category included radiotherapy and Chinese medicine. "Others" category not included under 3L and 4L+ lines due to 0 applicable patients.
[e]One patient received both targeted therapy (sonrotoclax) and other (radiotherapy) therapy.
2L, second-line; 3L, third-line; 4L+, fourth-line or greater; ABR, acalabrutinib plus bendamustine-rituximab; BTKi, Bruton tyrosine kinase inhibitor; CAR-T, chimeric antigen receptor T-cell therapy; PBR, placebo plus bendamustine-rituximab; SCT, stem cell therapy.

ECHO Analysis

ABR Lowered the Risk of Needing 3L Therapy (TTNT2) by 24% Compared With PBR



	ABR (n=299)	PBR (n=299)
Median time on study, months	51.9	
TTNT2 events, n (%)	111 (37.1)	133 (44.5)
Deaths	101 (33.8)	96 (32.1)
COVID-19 deaths	33 (11.0)	26 (8.7)
Start of 3L therapy	10 (3.3)	37 (12.4)
Median TTNT2, months (95% CI)	**NE** (72.1, NE)	**73.8** (56.2, NE)
Stratified HR (95% CI); log-rank *P*-value	**0.76** (0.59, 0.98); *P*=0.0341[a]	

No. at risk

ABR	299	280	256	241	230	210	190	175	162	147	134	102	72	45	20	2	0
PBR	299	269	244	223	205	187	172	157	149	139	125	95	65	38	17	2	0

- At 48 months, the rate of patients who had not yet initiated 3L therapy or had not died was 67.6% for ABR vs 59.2% for PBR

[a]*P*-value is exploratory and should be interpreted with caution. A *P*-value close to or below 0.05 should not be considered statistically significant or confirmatory; it is unadjusted for multiplicity and from an analysis that was not powered or pre-planned.
3L, third-line; ABR, acalabrutinib plus bendamustine-rituximab; CI, confidence interval; HR, hazard ratio; NE, not estimable; PBR, placebo plus bendamustine-rituximab; TTNT2, time to second subsequent treatment.

European MCL Network
Study generation 2025

LMU KLINIKUM

	< 65 years	> 60 years	> 65 years	
+ chemo	*MCL younger:* R-CHOP/DHAP =>ASCT R-CHOP+I/DHAP =>ASCT => I R-CHOP+I/DHAP => I	*MCL elderly R2:* R-CHOP vs R-CHOP/Ara-C => Rituximab M +/- Lenalidomide	BR +/- BTKi ⇒ Rituximab M +/- BTKi	*VR-BAC:* R-BAC ⇒ Venetoclax ⇒ (only high risk)

vs. chemo	*CARMAN (high risk):* R-Ibrutinib => CAR-T vs. R-Ibrutinib + chemo	*ENRICH:* R-CHOP/Benda vs R-Ibrutinib	BR vs. BTKi-R	*OASIS 2:* R-Ibrutinib +/- Venetoclax	*MCL elderly 3:* BR (Ibrutinib) vs R-Venetoclax-Ibrutinib

Relapse

Ibrutinib/ Bortezomib	Ibrutinib +/- ABT-199	Pirtobrutinib + Glofitamab

TrAVeRse Study Design: Multicenter, Open-label, Phase 2 Trial

Screening

Untreated MCL (N=100)
- Age ≥18 y
- Ann Arbor Stage II–IV
- ECOG PS 0–2/3

Recruited from 7 countries

Cycles 1–13

AVR induction[a]

1 cycle = 28 days

MRD-neg CR

Randomization

1:1

Randomization stratification
- *sMIPI risk status*
- *Blastoid/pleomorphic histology*
- *TP53 mutation status*

MRD assessed by NGS (10^{-5}) in PB (clonoSEQ)

MRD-pos CR, PR, SD

Cycle 15 to End of Treatment

Acalabrutinib 100 mg BID, PO until PD

Observation

Acalabrutinib retreatment

PD during observation

Acalabrutinib 100 mg BID, PO until PD

Primary endpoint:
MRD-neg CR rate[b]
at end of induction

Other outcomes
- **ORR/CR rate**
- **PFS**
- **MRD-neg rate**
  - **Exploratory longitudinal MRD monitoring**
- **OS**
- **DOR**
- **Safety**

NCT05951959.

[a]AVR induction: acalabrutinib 100 mg BID (C1–C13; also given in C14 post-induction), venetoclax (C2–C13 [5-week ramp-up in C2: 20 mg up to 400 mg daily]), rituximab (375 mg/m^2 day 1 of C1–12).
[b]MRD-neg (in PB by NGS [10^{-5}; clonoSEQ]) while in CR (per Lugano criteria).
AVR, acalabrutinib + venetoclax + rituximab; BID, twice daily; C, cycle; CR, complete response; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; MCL, mantle cell lymphoma; MRD, measurable residual disease; neg, negative; NGS, next-generation sequencing; ORR, overall response rate; OS, overall survival;
PB, peripheral blood; PD, progressive disease; PFS, progression-free survival; PO, orally; pos, positive; PR, partial response; SD, stable disease; sMIPI, simplified Mantle Cell Lymphoma International Prognostic Index; TN, treatment-naive.

Demographics and Baseline Characteristics

Characteristic	AVR (N=108)
Age, median (range), years	69 (40–89)
Age <65 years, n (%)	42 (38.9)
Male, n (%)	80 (74.1)
White, n (%)	94 (87.0)
Ann Arbor stage IV, n (%)[a]	99 (91.7)
Extranodal involvement, n (%)	102 (94.4)
Bone marrow involvement, n (%)	90 (83.3)
Ki-67 ≥30%, n (%)	41 (38.0)
Blastoid/pleomorphic histology, n (%)[b]	9 (8.3)
p53 expression by IHC, n (%)	
Positive	34 (31.5)
Negative	68 (63.0)
Missing	6 (5.6)
TP53 mutation by NGS, n (%)	
Mutated	17 (15.7)
Unmutated	73 (67.6)
Unknown	18 (16.7)
Simplified MIPI, n (%)	
Low risk (0–3)	30 (27.8)
Intermediate risk (4–5)	45 (41.7)
High risk (≥6)	33 (30.6)

[a]Ann Arbor stage II (n=3; 2.8%) and III (n=6; 5.6%).
[b]Other histology types included classic (n=82; 75.9%), small cell (n=10; 9.3%), and other (n=6; 5.6%); histology type was missing in 1 patient (0.9%).
AVR, acalabrutinib + venetoclax + rituximab; IHC, immunohistochemistry; MIPI, MCL International Prognostic Index; NGS, next-generation sequencing.

TrAVeRse

Events of Clinical Interest During AVR Induction Up to End of C14

n (%)	Up to End of C14 (ITT; N=108)	
	Any Grade	Grade ≥3
Cardiac events	16 (14.8)[a]	2 (1.9)
Atrial fibrillation/flutter	4 (3.7)	2 (1.9)
Ventricular tachyarrhythmias	2 (1.9)[b]	0
Anemia	12 (11.1)	3 (2.8)
Neutropenia[c]	52 (48.1)[d]	37 (34.3)
Thrombocytopenia[c]	22 (20.4)	6 (5.6)
Major hemorrhage	5 (4.6)	2 (1.9)
Hepatotoxicity	18 (16.7)	2 (1.9)
Hypertension	5 (4.6)	1 (0.9)
Infections	71 (65.7)	18 (16.7)
Interstitial lung disease/pneumonitis	1 (0.9)	0
Second primary malignancies	11 (10.2)	4 (3.7)
Excluding non-melanoma skin	6 (5.6)	4 (3.7)
Tumor lysis syndrome	1 (0.9)[e]	0

Table includes AEs with an onset date or that worsen on or after the date of first dose and up to and including 30 days following the date of last dose of treatment in AVR induction + C14 treatment period, the day prior to first dose in the post-AVR induction period, or up to the day prior to start of subsequent antilymphoma therapy or unplanned radiation, whichever comes first.

[a]Events included angina pectoris, atrial fibrillation, atrial flutter, bundle branch block right, cardiac valve disease, palpitations, pericarditis, sinus bradycardia, sinus tachycardia, and ventricular extrasystoles.

[b]Comprised ventricular extrasystoles in 2 patients, both grade 2.

[c]Grouped term.

[d]Includes 5 patients (4.6%) with grade ≥3 febrile neutropenia.

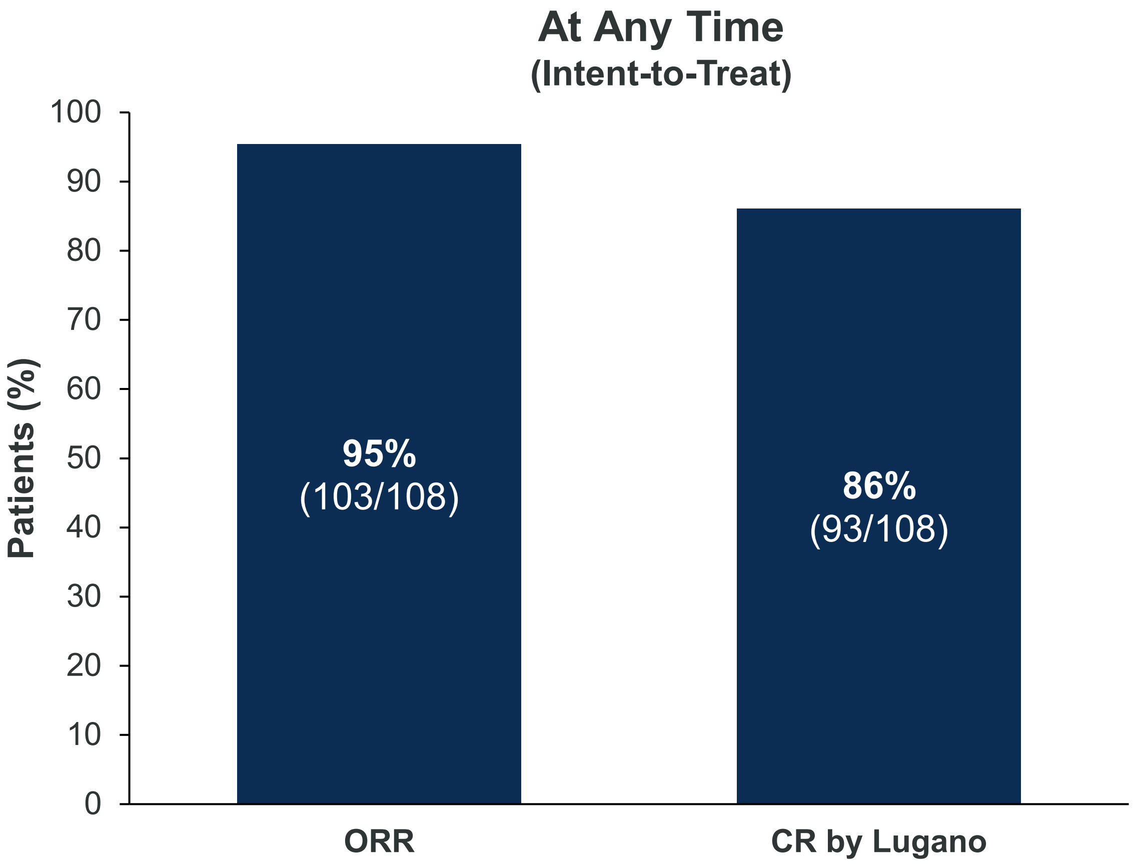
[e]Determined by laboratory result only.

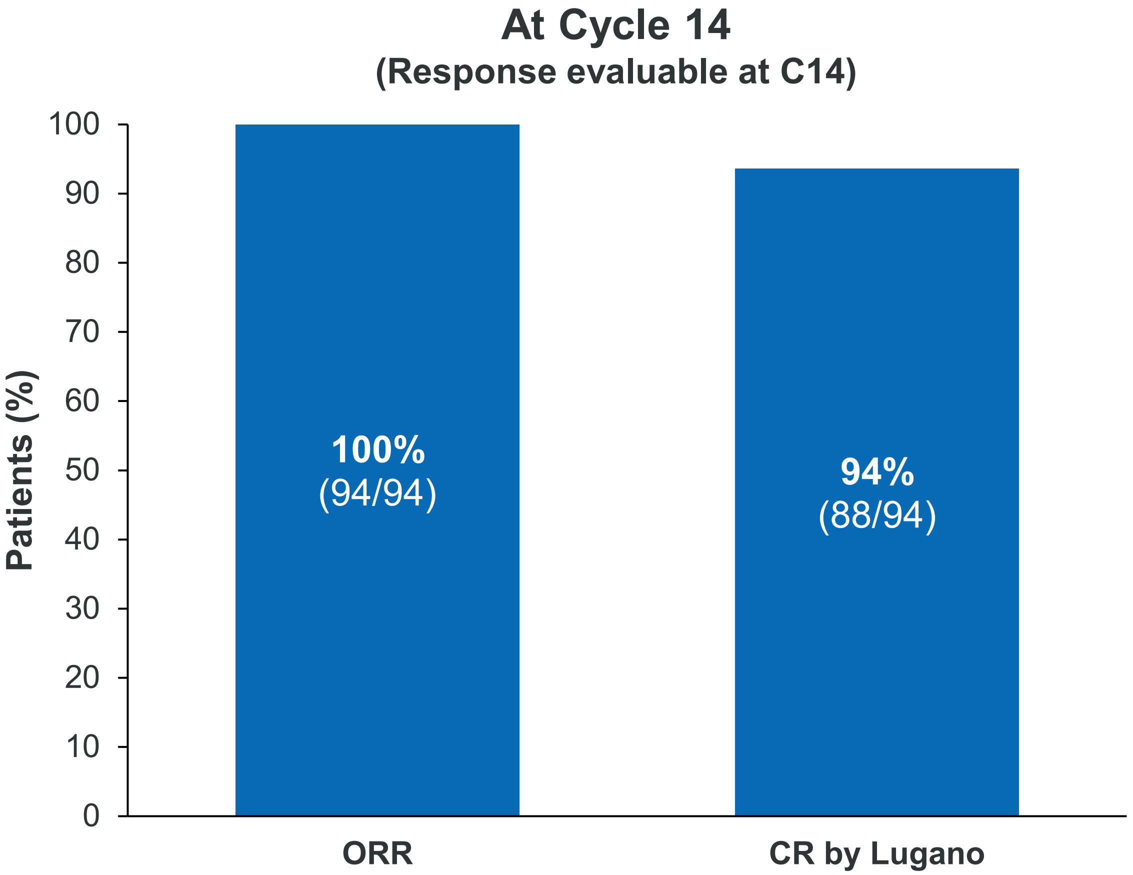
AE, adverse event; AVR, acalabrutinib + venetoclax + rituximab; C, cycle.

TrAVeRse

Overall Response and Complete Response

94% had CR by Lugano among patients with response assessment at C14



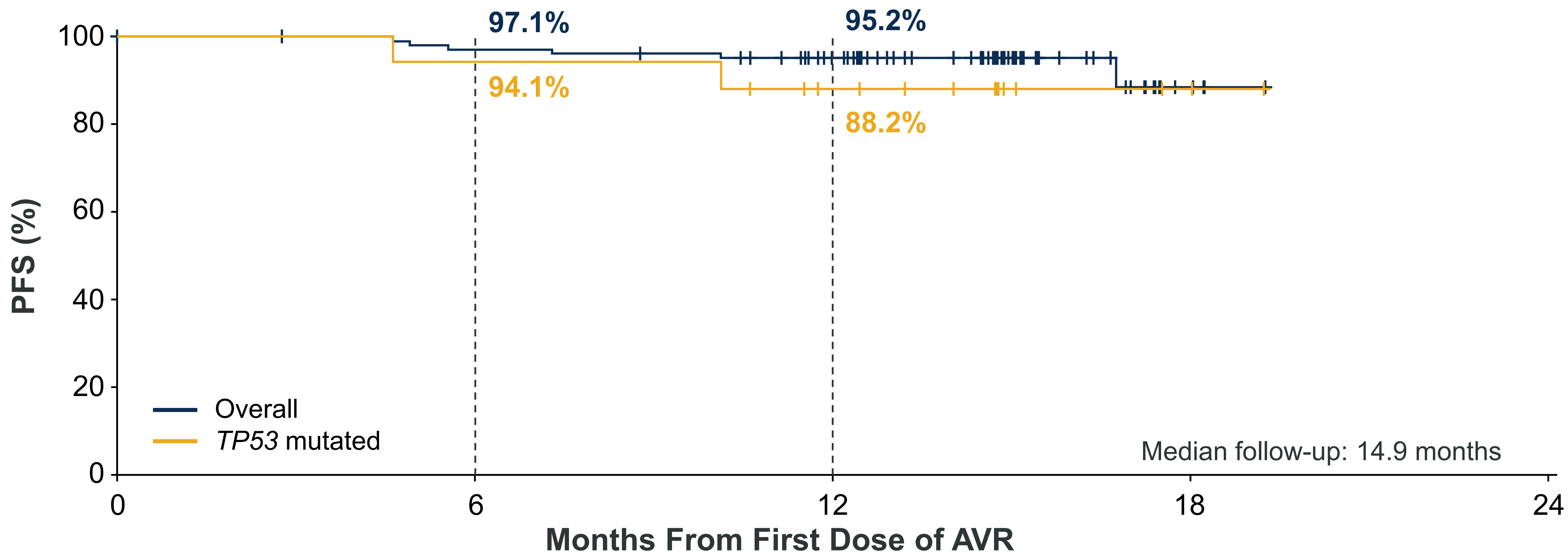


C, cycle; CR, complete response; ORR, overall response rate.

TrAVeRse

Progression-free Survival

PFS rates were high, regardless of TP53 mutation status



No. at risk

Overall	**108**	**102**	**90**	**3**	**0**
***TP53* mutated**	**17**	**16**	**12**	**2**	**0**

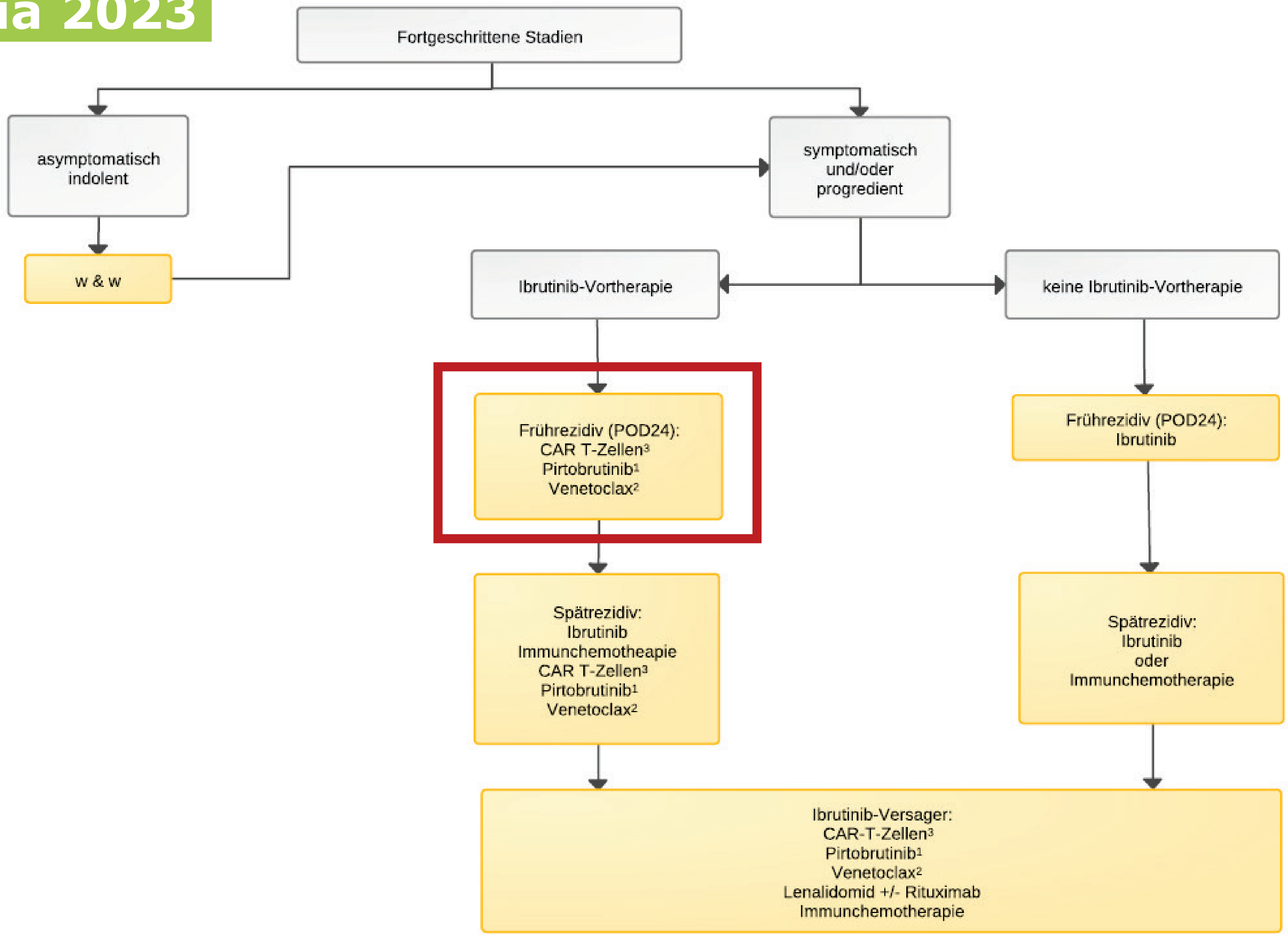
 PFS, progression-free survival.

TrAVeRse

Kapitel 2

Rezidiv

Relapsed Mantle cell Lymphoma
Onkopedia 2023



Pirtobrutinib Safety Profile in Patients With MCL

Treatment-Emergent AEs	Pirtobrutinib (n=166)			
	All-cause AEs, %		TRAEs, %	
AEs (≥15%)	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Fatigue	31.9	3.0	21.1	2.4
Diarrhea	22.9	0.0	13.3	0.0
Dyspnea	18.1	1.2	9.6	0.6
Anemia	18.1	8.4	7.8	3.0
Platelet count decreased	15.1	7.8	7.8	3.0
AEs of interest[a]				
Infections[b]	44.0	21.1	18.1	5.4
Bruising[c]	16.3	0.0	11.4	0.0
Rash[d]	15.7	0.6	10.2	0
Arthralgia	9.0	1.2	2.4	0.0
Hemorrhage[e]	10.2	2.4	4.2	0.6
Hypertension	4.8	0.6	1.8	0.0
Atrial fibrillation/flutter[f,g]	3.6	1.8	0.6	0.0

Median (IQR) time on treatment was 5.5 (1.8-15.6) months for the MCL cohort

Discontinuations due to TRAEs occurred in 3.6% (n=6) of patients with MCL[h]

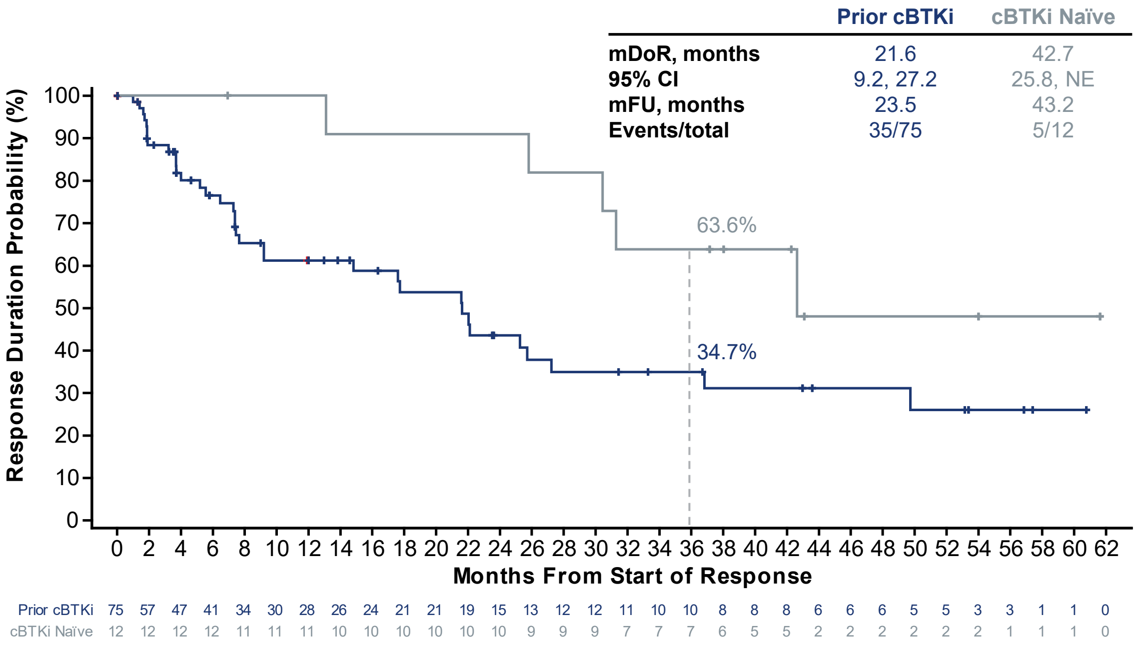
Dose reductions due to TRAEs occurred in 4.8% (n=8) of patients with MCL

[a]AEs of interest are those that were previously associated with cBTKis. [b]Aggregate of all preferred terms indicating infection, including COVID-19. [c]Aggregate of contusion, bone contusion, ecchymosis, and increased tendency to bruise. [d]Aggregate of all preferred terms indicating rash. [e]Aggregate of all preferred terms including hemorrhage or hematoma. [f]Aggregate of atrial fibrillation and atrial flutter. [g]Of 6 total atrial fibrillation and atrial flutter TEAEs, 3 occurred in patients with a prior medical history of atrial fibrillation. [h]In the MCL cohort, TRAEs leading to discontinuation included weight decrease/alopecia/fatigue (1), neutropenia (1), platelet count decreased (1), pneumonitis (1), cholecystitis (1), and pericarditis (1).

Abbreviations: AE, adverse event; cBTKi, covalent Bruton tyrosine kinase inhibitor; COVID-19, coronavirus disease 2019; IQR, interquartile range; MCL, mantle cell lymphoma; TEAE, treatment-emergent AE; TRAE, treatment-related AE.

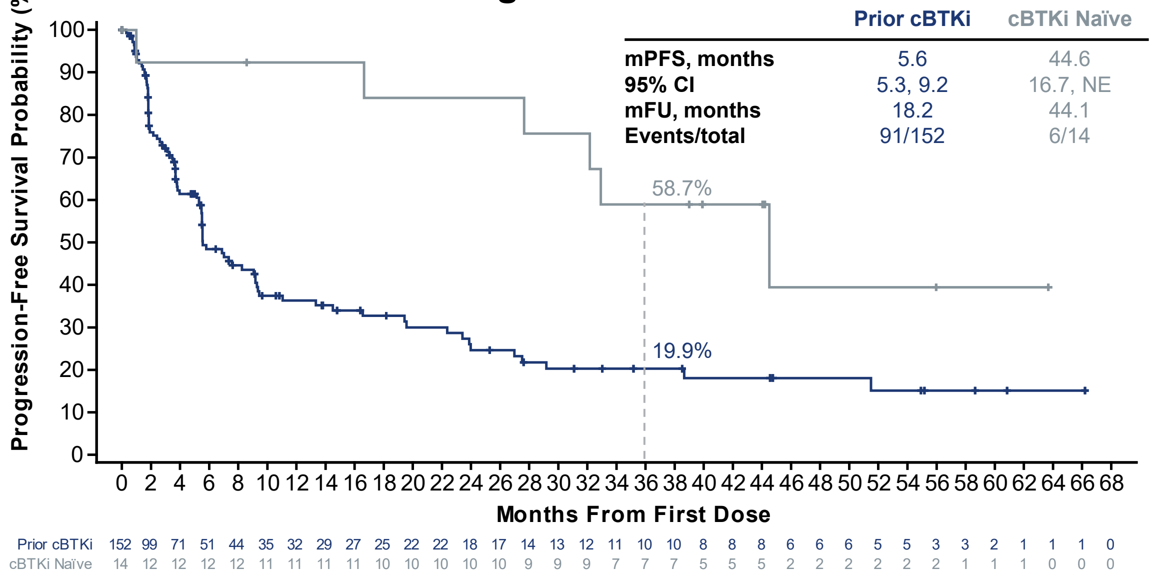
Pirtobrutinib Outcomes in Prior cBTKi and cBTKi-Naïve Patients With MCL

Duration of Response

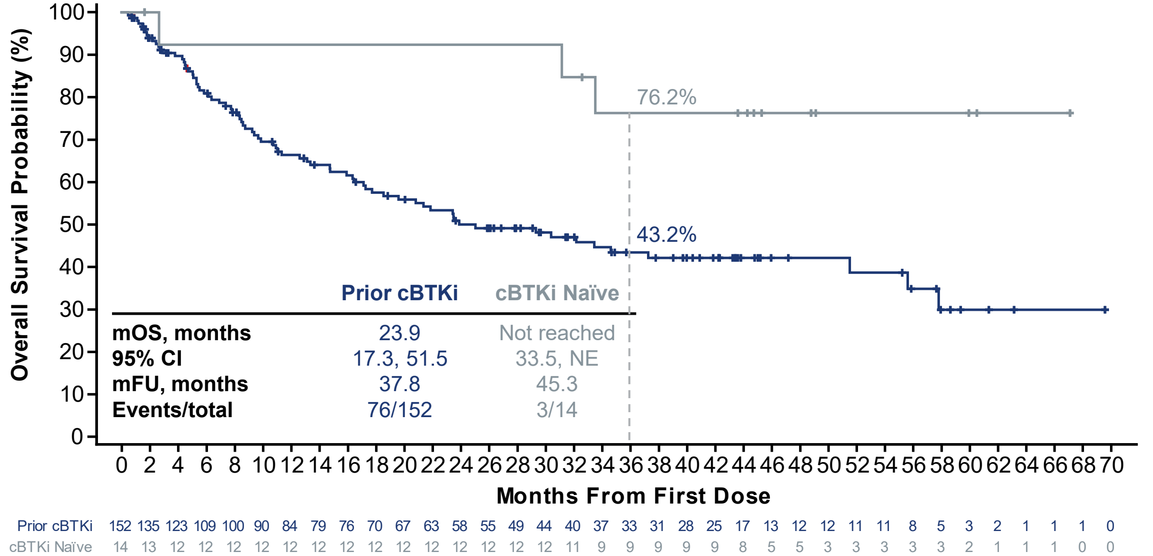


Outcome by Reason of Discontinuation From Prior BTKi	PD	Toxicity/Other
mDoR, months	14.8	25.3
95% CI	4.0, 27.2	7.5, NE
mPFS, months	5.5	27.0
95% CI	3.8, 7.4	9.3, NE
mOS, months	18.5	57.8
95% CI	11.3, 33.5	32.2, NE

Progression-Free Survival



Overall Survival



Abbreviations: BTKi, Bruton tyrosine kinase inhibitor; cBTKi, covalent BTKi; CI, confidence interval; MCL, mantle cell lymphoma; mDoR, median duration of response; mFU, median follow-up; mOS, median overall survival; mPFS, median progression-free survival; NE, not estimable; PD, progressive disease.

ATALANTA-1 (NCT06561425) Study Design

Key eligibility criteria

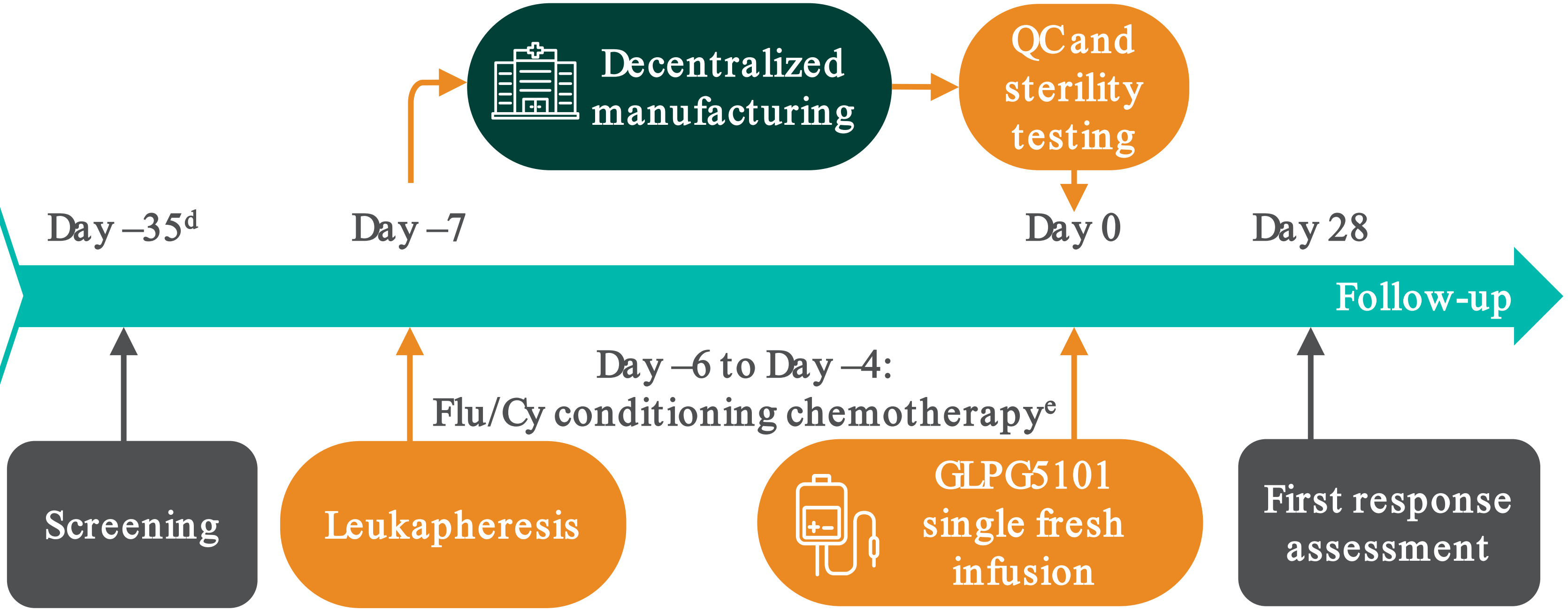
- No prior CD19-targeted therapies

Phase 1 dose escalation:

- DLBCL
  - Primary refractory or first relapse
- FL, MZL, MCL[a,b,c]
  - Relapsed or refractory after 2 prior treatments

Phase 2 expansion cohorts:

- DLBCL, HR DLBCL, FL + MZL, MCL, BL, PCNSL, RT, CLL



- **Primary objectives:** safety, determination of a recommended Phase 2 dose, ORR
- **Secondary objectives:** safety, efficacy (including DOR), pharmacokinetics, pharmacodynamics, and feasibility of decentralized manufacturing, health-related quality of life

[a]Relapsed/refractory disease after $\geq$2 prior lines of therapy; or relapsed/refractory disease after 1 prior line of therapy if a BTKi was administered in first line, or if the patient was BTKi naïve, the patient must have had POD24 or be primary refractory (defined as having PD as best response to first-line therapy or POD6). [b]One patient had 1 prior line of therapy. [c]Patients with active CNS involvement were excluded, except if CNS involvement had been effectively treated (patient was asymptomatic with CSF or imaging clear of lymphoma) and local treatment was completed $\geq$4 weeks prior to screening. [d]Screening could take place within 28 days prior to leukapheresis. [e]Conditioning chemotherapy: Flu IV (30 mg/m^2/day); Cy IV (300 mg/m^2/day). BL, Burkitt lymphoma; BTKi, Bruton tyrosine kinase inhibitor; CLL, chronic lymphocytic leukemia; CNS, central nervous system; CSF, cerebrospinal fluid; Cy, cyclophosphamide; (HR) DLBCL, (high-risk) diffuse large B-cell lymphoma; DOR, duration of response; FL, follicular lymphoma; Flu, fludarabine; IV, intravenously; MCL, mantle cell lymphoma; MZL, marginal zone lymphoma; ORR, objective response rate; PCNSL, primary central nervous system lymphoma; PD, progressive disease; POD6, relapse within 6 months of date of diagnosis; POD24, progression of disease within 24 months of initiation of first-line therapy; QC, quality control; RT, Richter transformation.

NCT06561425: clinicaltrials.gov/study/NCT06561425. Accessed 10 October 2025.

No Grade ≥3 CRS and One Single Grade ≥3 ICANS Observed

CRS and ICANS

	All patients[a] N=24
CRS, n (%)	15 (63)
Grade 1	9 (38)
Grade 2	6 (25)
Grade 3	0
ICANS, n (%)	6 (25)
Grade 1	5 (21)
Grade 2	0
Grade 3	1 (4)

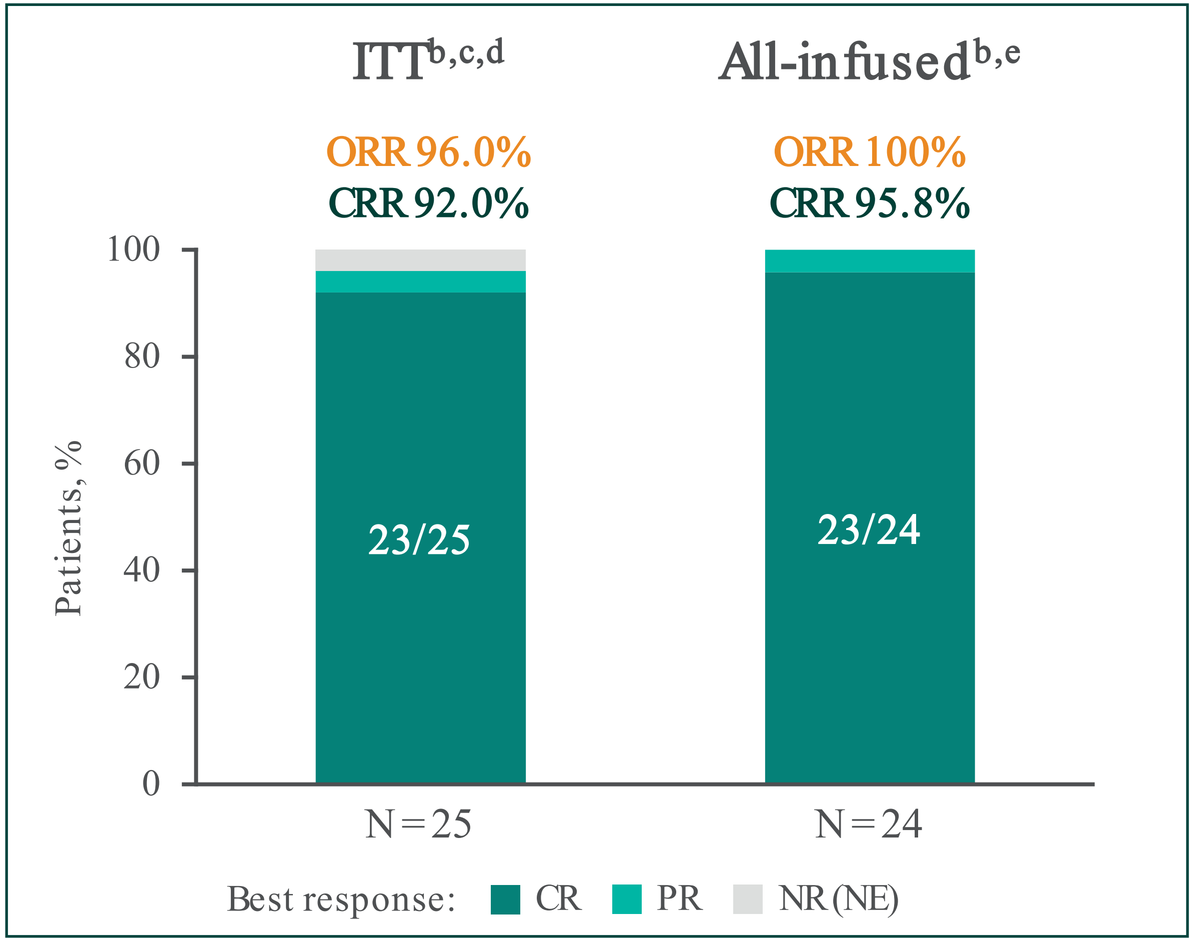
CRS	All patients[a] N=24
Time to onset, median (range), days	7 (1–24)
Duration, median (range), days	4 (2–7)
Toxicity management, n (%)	10 (42)
Dexamethasone	6 (25)
Tocilizumab	10 (42)
Tocilizumab and dexamethasone	6 (25)

ICANS	All patients[a] N=24
Time to onset, median (range), days	9 (8–43)
Duration, median (range), days	4.5 (2–48)
Toxicity management, n (%)	3 (13)
Dexamethasone	3 (13)
Methylprednisolone	1 (4)
Tocilizumab	1 (4)
Tocilizumab and dexamethasone	1 (4)

[a]Safety analysis set = all patients who received fresh CAR T-cell infusion at any dose, excluding those whose product failed to meet ≥1 of the established acceptance release criteria other than the dose criterion, regardless of whether the dose criterion is met. **Data cutoff: 2 September 2025**.
CAR, chimeric antigen receptor; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome.

High ORR and CRR Observed in 3L+ R/R MCL[a]

Best Response to Treatment at Any Time After a GLPG5101 Infusion



MRD[f] negativity:

90% (9/10) of MRD-evaluable patients were MRD-negative at CR

- 7/9 MRD-negative patients remained in CR at time of data cutoff

[a]Only 1 patient had 1 prior line of therapy. [b]Data presented exclude patients who were alive and still in the study at data cutoff without a first confirmed response assessment. [c]One patient who did not receive a CAR T-cell infusion was not evaluable. [d]ITT set = all leukapheresed patients. [e]All infused set = all patients who received a CAR T-cell infusion at any dose. [f]MRD was evaluated using next-generation sequencing with the cloneSEQ® assay (Adaptive Biotechnologies, Seattle, WA, USA). Data are pooled across DLs: DL1, 35–50 × 10^6; DL2, 85–110 × 10^6 CAR T cells. **Data cutoff: 2 September 2025.**

3L+, third or later lines of therapy; CAR, chimeric antigen receptor; CR, complete response; CRR, complete response rate; DL, dose level; ITT, intention-to-treat; MCL, mantle cell lymphoma; MRD, minimal residual disease; NE, not evaluable; NR, no response; ORR, objective response rate; PR, partial response; R/R, relapsed/refractory.

Mantelzell-Lymphom
Take home message ASH 2025

LMU KLINIKUM

- **Biologische Risikofaktoren beachten: Ki-67, p53, blastoid**

- **Erstlinie ältere Patienten:**

  BR-Acalabrutinib erzielt signifikant verlängertes PFS

- **In Studien Triple-Kombination (Obi/Acala/Ven)**

- ***Rezidiv: neue Therapieoptionen (Sonrotoclax, CAR-T)***

European MCL Network
Study generation 2025

LMU KLINIKUM

	< 65 years	> 60 years	> 65 years	
+ chemo	*MCL younger:* R-CHOP/DHAP =>ASCT R-CHOP+I/DHAP =>ASCT => I R-CHOP+I/DHAP => I	*MCL elderly R2:* R-CHOP vs R-CHOP/Ara-C => Rituximab M +/- Lenalidomide	BR +/- BTKi ⇒ Rituximab M +/- BTKi	*VR-BAC:* R-BAC ⇒ Venetoclax ⇒ (only high risk)

vs. chemo

CARMAN (high risk): R-Ibrutinib => CAR-T vs. R-Ibrutinib + chemo	*ENRICH:* R-CHOP/Benda vs R-Ibrutinib	BR vs. BTKi-R	*OASIS 2:* R-Ibrutinib +/- Venetoclax	*MCL elderly 3:* BR (Ibrutinib) vs R-Venetoclax-Ibrutinib

Relapse

Ibrutinib/ Bortezomib	Ibrutinib +/- ABT-199	Pirtobrutinib + Glofitamab

Studientreffen 2024, München

Die Kurzpräsentationen sind online unter

www.lymphome.de/ash2025

Für den Inhalt verantwortlich:

Prof. Dr. med. Martin Dreyling

Klinikum der Universität München

Das Informationsprojekt wird unterstützt von den Firmen:

Diese hatten keinen Einfluss auf die Inhalte.