ESMO Clinical Practice Guidelines

Diffuse Large B Cell Lymphoma Clinical Case Presentation

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Disclosure slide

Roche
Cellgene
Mundipharma
Janssen

Gilead
Bayer
Millenium
Servier

Introduction

- Male, DOB 16.05.1975 (39 y.o.)

PAST MEDICAL HISTORY

- Nothing relevant

HISTORY OF PRESENT ILLNES

03-03/2014: progressive dysponea; loss of appetite
drenching night sweats, fever

Introduction

- Investigated in private clinic for a suspicion of a lymphoproliferative disease.

- Urgent transfer to the ICU of public hospital for gradually increasing leg pain and rapidly developing paresis of the legs.

Introduction

LABORATORY (2.4.2014)

- Hb 134 g/l, Plt and wbc normal
- protein and albumin, liver tests, creatinine normal
- LDH 1248 U/l, β2-microglobuline 3.0 mg/l (normal 1.09-2.53)
- CRP 16 mg/l

INFECTIONS WORK-UP

- Serologies for HIV, HBV, HCV negatives

Introduction

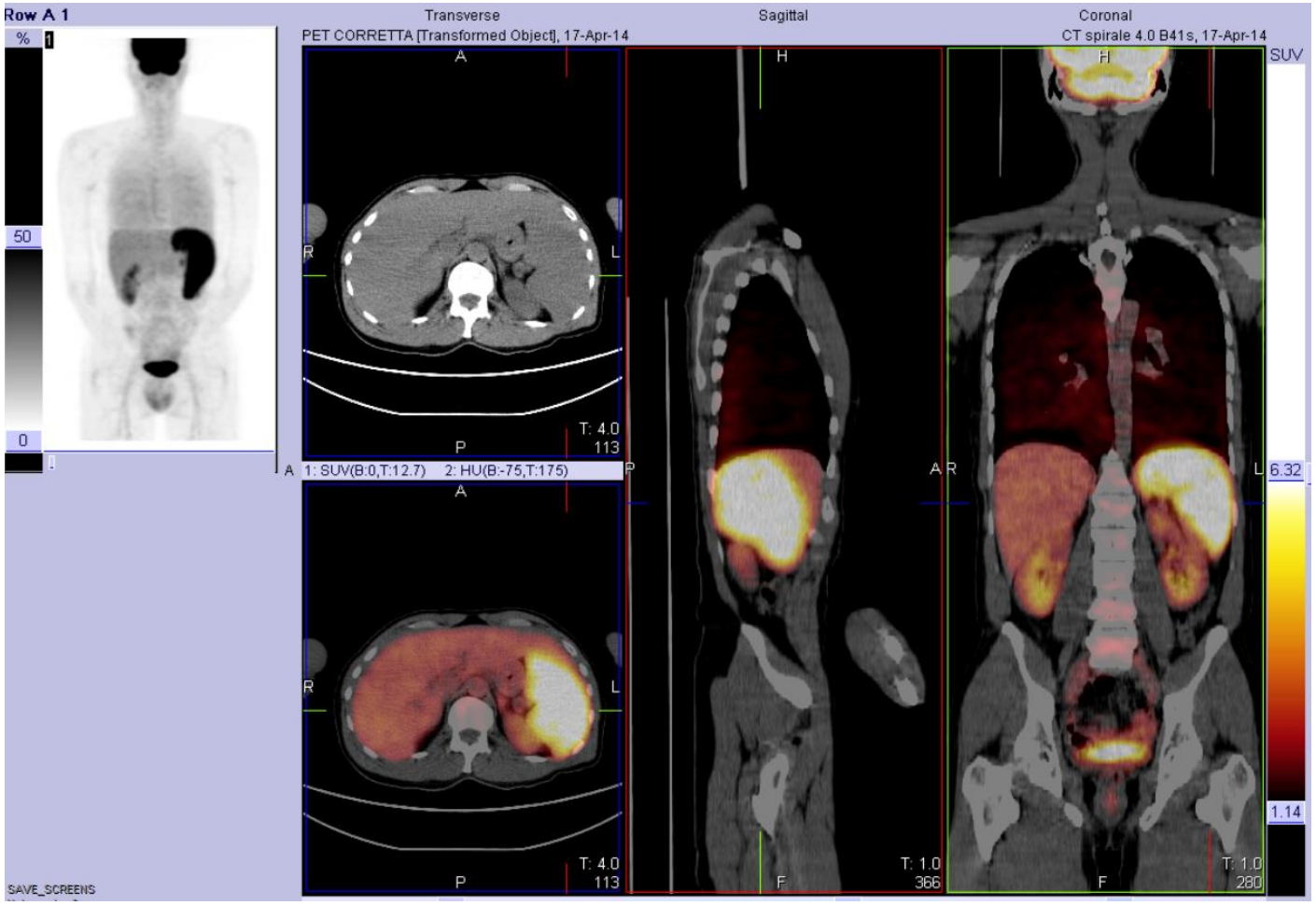
BONE MARROW BIOPSY

- negative for lymphoma

NEUROLOGIC EVALUATION

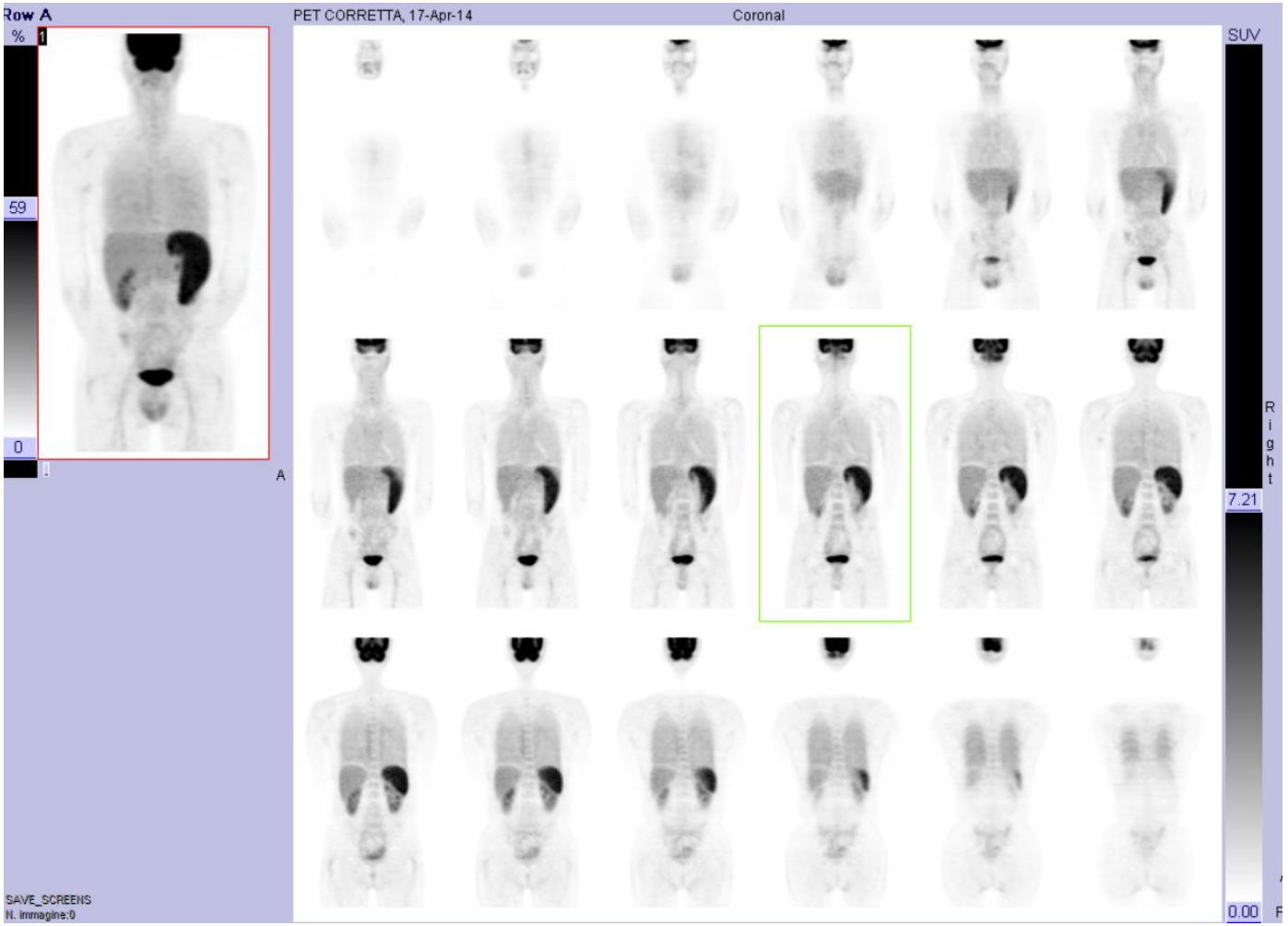
- Lumbar puncture: No lymphoma cells, increased proteins, normal cell counts (**albumino-cytologic dissociation**)
- Brain CT scan: negative
- MRI of the spine: not performed (claustrophobic)

FDG-PET, 18.04.2014



Splenomegaly (17 cm) with increased FDG uptake

FDG-PET, 18.04.2014



Splenomegaly (17 cm) with increased FDG uptake

Q1:How would you proceed?

1. Splenectomy for diagnosis
2. Splenic biopsy for diagnosis
3. Start the patient on steroids
4. Try large spectrum antibiotics
5. Perform additional investigations

SPLENECTOMY (20.04.2014) (B14-09859)

Neoplastic cells were:

positive for CD45, CD20, CD79a, BCL-2 (weak), BCL-6, MUM1 and CD5 (weak)

negative for CD3, CD38, CD23, CD30, CD10, cycline D1

Ki67 90%

Final diagnosis:

DLBCL

Course of disease complicated by:

- significant worsening of dysponea
- worsening of the lower limbs paresis

DIAGNOSIS:

DLBCL of the spleen, stage IBE (S)

Guillain-Barré syndrome as paraneoplastic syndrome

Treatment starts with iv immunoglobulin's and steroids.

Q2:How would you treat the lymphoma?

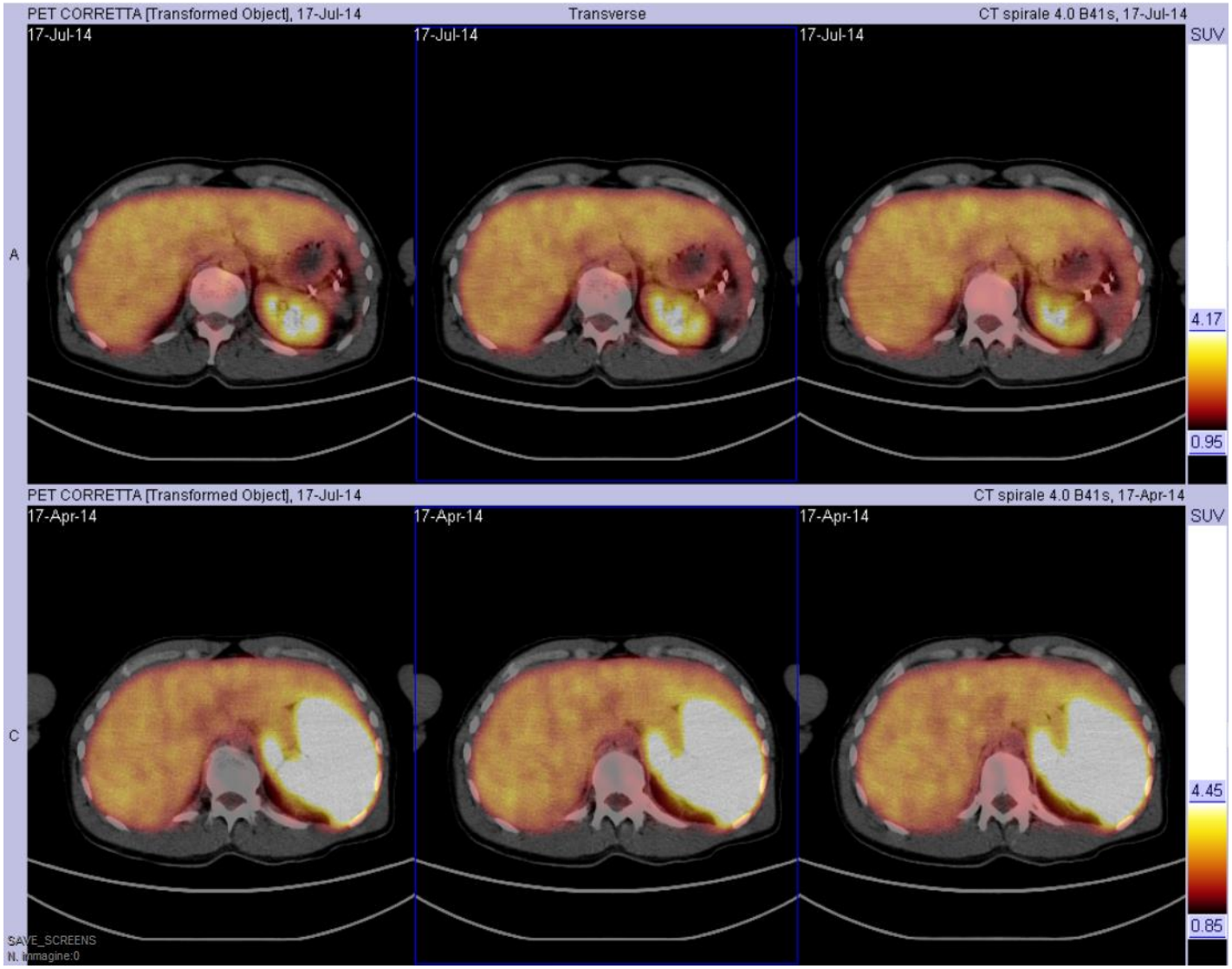
1. R-CHOP
2. R-DA-EPOCH
3. R-Hyper-CVAD-HDArac-MTX
4. R-bendamustine
5. Other «ad-hoc» regimen

THERAPY:

- 6 cycles of R- CH(O)EP from 28.04-27.09.2014 with omission of vincristine
- 2 cycles of HD methotrexate as CNS prophylaxis (27.09 and 11.10.2014)
  - chemotherapy well tolerated, no major toxicity
  - progressive improvement of the neurologic deficits

PET/CT after cycle 2

- complete remission (morphologic and metabolic)



11/2014 (1 month later):

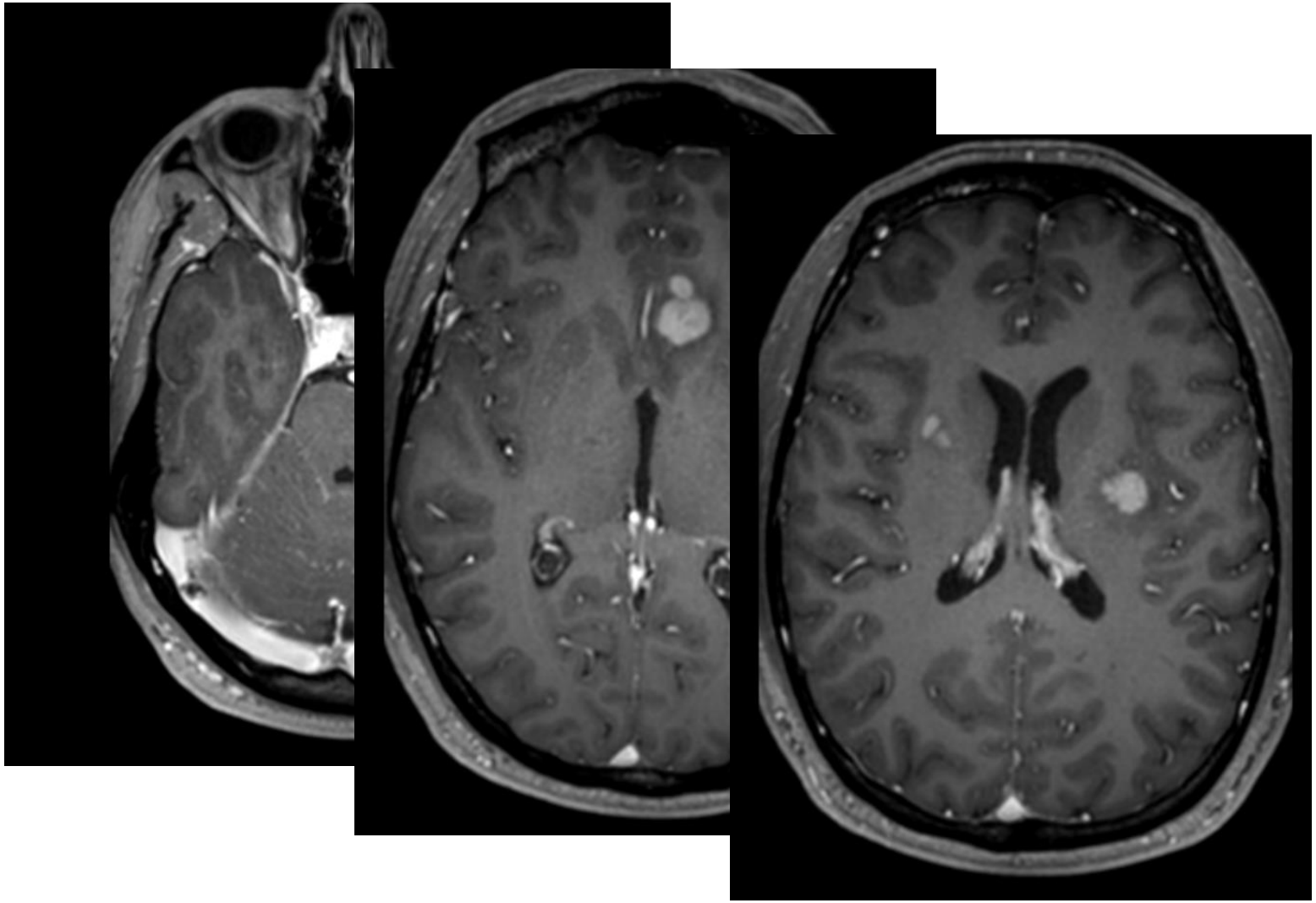
- he represented with episodes of night sweats
- muscular pain in the lower limbs

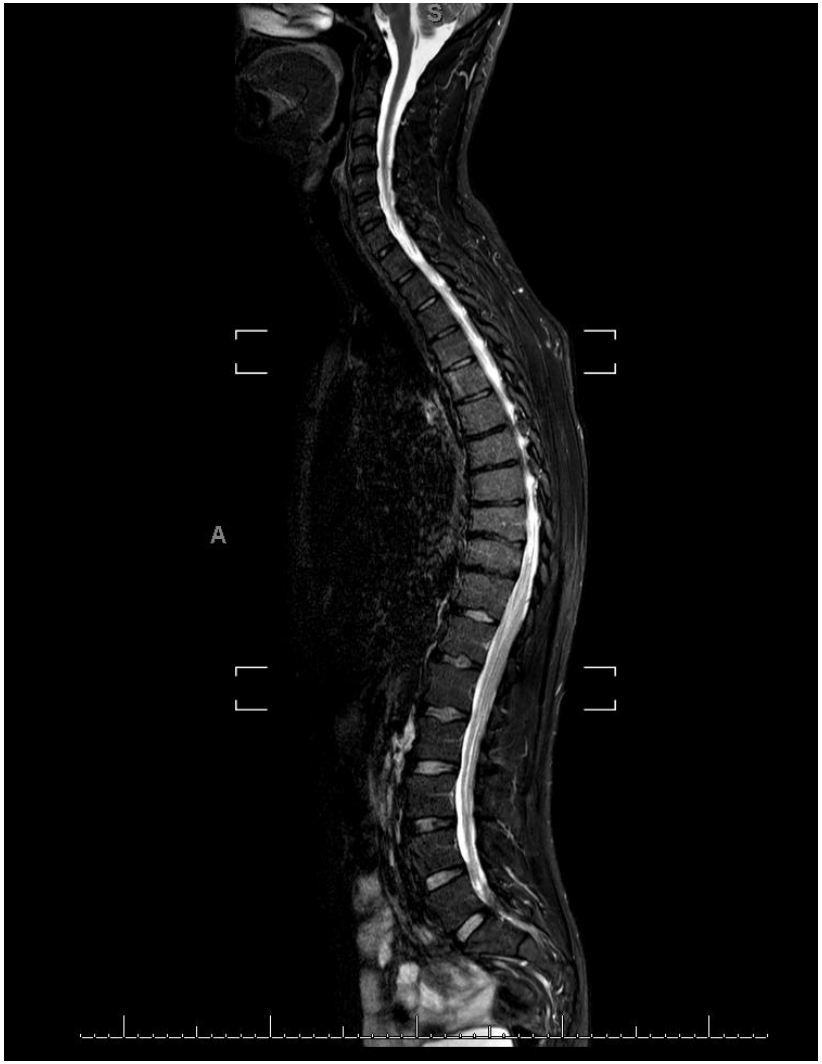
LUMBAR PUNCTION with flow cytometry (7/11/2014)

- clonal B cell population in keeping with secondary lepto-meningeal involvement

BRAIN AND SPINE MRI (7/11/2014)

- multiple contrast-enhancing parenchymal brain lesions (basal ganglia, right temporal and frontal lobe)
- thickening and enhancement of the nerve roots





How would you treat the early CNS relapse?

1. HD-MTX + HD-AraC
2. HD-MTX + HD-AraC + i.t. chemo
3. Chemo + radiotherapy
4. Induction CT + autologous transplant
5. Induction CT + allogeneic transplant

THERAPY:

- 2 cycles of HD cytarabine and etoposide (CYVE) according to C. Soussain jco 2008
- 2 courses of IT sustained release liposomal Ara-C (DepoCyte®)
- stem cell mobilisation after 2nd cycle
- High dose chemotherapy with carmustine (BCNU) and thiotepa followed by autologous stem cell transplant
- Radiotherapy of the residual disease post-treatment in spine

VOLUME 26 · NUMBER 15 · MAY 20 2008
JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Intensive Chemotherapy Followed by Hematopoietic Stem-Cell Rescue for Refractory and Recurrent Primary CNS and Intraocular Lymphoma: Société Française de Greffe de Moëlle Osseuse-Thérapie Cellulaire

Carole Soussain, Khê Hoang-Xuan, Luc Taillandier, Emmanuelle Fourme, Sylvain Choquet, Francis Witz,

Treatment

The salvage treatment consisted of two cycles of the high-dose cytarabine and etoposide (CYVE) regimen administered 28 days apart, as previously described,[13] with cytarabine 2 g/m^2/d on days 2 through 5 in a 3-hour infusion and 50 mg/m^2/d on day 1 through 5 in a 12-hour infusion; and etoposide 200 mg/m^2/d days 2 through 5 in a 2-hour infusion. The doses were slightly

Epicrisis

1 month after the end of the treatment the patient relapsed systemically (liver and CNS) and died.

<u>Questions raised by this case:</u>

1. When is a CNS prophylaxis indicated in DLBCL?
2. Which prophylaxis, if any, is the best?
3. How to treat DLBCL relapsing in the CNS?