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# MANTLE CELL LYMPHOMA

## CLINICAL CASE PRESENTATION

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# DISCLOSURE

Janssen - grants, personal fees and non-financial support

Celgene – grants, personal fees and non-financial support

Abbvie - grants and non-financial support

Acerta – personal fees

Gilead - grants, personal fees and non-financial support

# CASE 1

An elderly patient with mantle cell lymphoma

# CASE 1

- Female, born 1932
- Retired textile designer, from Denmark
- Previously healthy
- 2016 lymphocytosis detected (10 x $10^9$/L), normal haemoglobin and platelet count
- CT scan shows abdominal lymphadenopathy, up to 2 cm in size, spleen slightly enlarged
- Bone marrow biopsy shows 25% CD20+/CD5+/CyclinD1+ cells – mantle cell lymphoma
- No symptoms



CT, computed tomography

# CASE 1

## Q1. What would be your proposed treatment strategy?

1. Rituximab and chlorambucil
2. Rituximab and bendamustine
3. R-CHOP
4. Watch-and-wait



R-CHOP, rituximab/cyclophosphamide/doxorubicin/vincristine/prednisone

# CASE 1

Female, born 1932

- January 2018, progressive lymphocytosis (40 x $10^9$/L), Hb 100 g/L, normal platelet count
- Fatigue, needs a nap twice a day



Hb, haemoglobin

# CASE 1

## Q2. What would be your proposed treatment strategy?

1. Rituximab and chlorambucil
2. Rituximab and bendamustine
3. R-CHOP
4. Watch-and-wait



R-CHOP, rituximab/cyclophosphamide/doxorubicin/vincristine/prednisone

# CASE 1

Female, born 1932

- In February 2018, she is started on R-bendamustine. Bendamustine dose reduced to 50% (1 day only). 6 cycles are planned
- After 2 cycles, she is hospitalised due to dyspnoea and fever, and diagnosed with a pneumocystis pneumonia. Treated with cotrimoxazole, and discharged after 10 days
- After 4 cycles, she asked to stop due to worsening fatigue. By then, lymphocytosis is normalised, no remaining lymphadenopathy or splenomegaly
- No maintenance rituximab is planned
- In August 2018, two months after stopping treatment, the patient feels well



R, rituximab

# CASE 2

Another story

# CASE 2

- Man born 1953
- Social worker
- Previously diagnosed with mitral insufficiency and impaired hearing

- November 2016 – admitted at local hospital with suspected acute lymphocytic leukemia (ALL)
  - WBC 320 x $10^9$/L, hepatosplenomegaly, general lymphadenopathy
  - Immunophenotyping peripheral blood: MCL, *t(11;14)*+
- Initally treated as ALL with corticosteroids, vincristine, cyclophosphamide, but WBC -> 450
- Blood sample analysed for *TP53* mutation - positive



MCL, mantle cell lymphoma; WBC, white blood cell

# CASE 2

## Q3. What would be your proposed treatment strategy?

1. Nordic MCL2 protocol – including high dose chemotherapy with ASCT
2. Include in European TRIANGLE trial
3. R-Bendamustine-Cytarabine (R-BAC)
4. Ibrutinib as bridge to an allogeneic transplant



ASCT, autologous stem cell transplant; MCL, mantle cell lymphoma; WBC, white blood cell

# CASE 2

- Man born 1953
- Received high dose cytarabine as in Nordic MCL2 – only transient response
- Started on rituximab + ibrutinib 560 mg/day
- March 2017 – CR. Unrelated donor identified. Allo-SCT planned ASAP. Patient hesitant – prefers to wait until after summer

- August 2017 - minimal bone marrow involvement
- September 2017 – bulky abdominal mass
- Ibrutinib resistance – stopped, started on R-bendamustine
- After 2 weeks rapid progression – bilateral hydronephrosis – dies Oct 2017 due to progressive MCL



Allo-SCT, allogeneic hematopoietic stem cell transplantation; MCL, mantle cell lymphoma