Hematology MDT: Non-Hodgkin Lymphoma

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Speaker disclosures

• Advisory boards: Abbvie, Celgene, Gilead, Janssen, Roche, Takeda, Servier

• Speaker: BMS, Celgene, Gilead, Janssen, Roche, Servier

• Travel and accommodation expenses: Abbvie, Celgene, Janssen, Roche
Higher incidence in older people

NIH, National Institute of Health; SEER, Surveillance, Epidemiology, and End Results Program
Higher mortality in older people

NIH, National Institute of Health

1. Undertreatment?
2. Toxicity?
Improvement of outcome in older adults with DLBCL

Treatment and relative survival in very elderly patients with DLBCL in The Netherlands: a population-based study, 1989 to 2015

Treatment of diffuse large B-cell lymphoma in the elderly

Trend of initial immunochemotherapy choices among elderly patients with diffuse large B-cell lymphoma from 2000 to 2006 (n = 8262). ACR, anthracycline-containing regimen; R, rituximab

Tien YY et al. Leukemia & Lymphoma, January 2015; 56(1): 65–71
Treatment of diffuse large B-cell lymphoma in the elderly

Kaplan–Meier curve for overall survival among elderly patients with diffuse large B-cell lymphoma from 2000 to 2006 (n = 8262). Note: all patients were censored at 36 months of follow-up. ACR, anthracycline-containing regimen; R, rituximab

Tien YY et al. Leukemia & Lymphoma, January 2015; 56(1): 65–71
Nov. 8, 2016 - Management of chronic lymphocytic leukaemia in the elderly: position paper of a SIOG Task Force

CLL task force

November 8, 2016


March 13, 2015

Screening tools for multidimensional health problems warranting a geriatric assessment in older cancer patients: an update on SIOG recommendations.

February 10, 2015

Approach to therapy of diffuse large B-cell lymphoma in the elderly: the International Society of Geriatric Oncology (SIOG) expert position commentary.

January 29, 2015
The G8 screening tool detects relevant geriatric impairments and predicts survival in elderly patients with a haematological malignancy

Marije E. Hamaker • M. Mitrovic • R. Stauder

• 108 consecutive patients
• Median age: 78.2 years (13% >85 years)
• WHO performance status was 2/3 in 47% patients
• Most common diagnoses:
  − Acute myeloid leukaemia (29%)
  − Aggressive non-Hodgkin lymphoma (29%)
  − Myelodysplastic syndromes (23%)
• Median total CIRS-G comorbidity score: 6.5 (range 0–20)
• 31% of patients had ≥1 grade 4 or 2 grade 3 comorbidities

CIRS-G, cumulative illness rating scale for geriatrics; WHO, World Health Organisation
Balducci’s classification of frailty

**FIT**
- Total functional independence
- No severe comorbidities
- No geriatric syndromes

**FRAIL**
- Dependence for IADL
- Less than 2 severe comorbidities
- No geriatric syndromes

**UNFIT**
- Dependence for ADL
- More than 2 severe comorbidities
- Geriatric syndromes

**Treatment Options**
- **Standard treatment**
- **Adapted treatment**
- **Symptomatic treatment**

Treatment algorithm for aggressive B-cell NHL

Adapted from: Friedberg JW. Hematology Am Soc Hematol Educ Program. 2011
Practical Assessment in Older Patients Receiving Chemotherapy: ASCO Guideline for Geriatric Oncology

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predict chemotherapy toxicity</td>
<td>CARG, CRASH</td>
</tr>
<tr>
<td>Estimate (noncancer) life expectancy</td>
<td>ePrognosis</td>
</tr>
<tr>
<td>Functional assessment</td>
<td>IADL</td>
</tr>
<tr>
<td>Comorbidity assessment</td>
<td>CIRS-G, CCI</td>
</tr>
<tr>
<td>Screening for falls</td>
<td>How many falls have you had in the previous 6 months (or since your last visit)?</td>
</tr>
<tr>
<td>Screening for depression</td>
<td>GDS</td>
</tr>
<tr>
<td>Screening for cognitive impairment</td>
<td>Mini-COG</td>
</tr>
<tr>
<td>Screening for malnutrition</td>
<td>weight loss/body mass index</td>
</tr>
</tbody>
</table>

Mohile SG et al. J Clin Oncol 2018; 14(7):442-446
### SIOG guidelines on DLBCL in the elderly: Impact of prognosis, comorbidities, geriatric assessment\(^1\) and approach to therapy\(^2\)

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>Treatment agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Anthracyclines</td>
</tr>
<tr>
<td>Renal dysfunction</td>
<td>Platinum derivates</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Platinum derivatives, vinca alkaloids, lenalidomide</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Prednisone</td>
</tr>
<tr>
<td>Pre-existent marrow compromise (prior chemotherapy, radiation)</td>
<td>Any myelosuppressive agents</td>
</tr>
<tr>
<td>Dementia</td>
<td>All therapies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapy</th>
<th>n</th>
<th>Median age, years (range)</th>
<th>Efficacy, CR rate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCHOP</td>
<td></td>
<td></td>
<td>RCHOP</td>
<td></td>
</tr>
<tr>
<td>CHOP vs RCHOP21</td>
<td>399</td>
<td>69 (60–80)</td>
<td>76%</td>
<td>63%</td>
</tr>
<tr>
<td>CHOP vs RCHOP14</td>
<td>1222</td>
<td>69 (60–80)</td>
<td>78%</td>
<td>68%</td>
</tr>
<tr>
<td>CHOP vs RCHOP21</td>
<td>632</td>
<td>69 (60–80)</td>
<td>77%</td>
<td>76%</td>
</tr>
<tr>
<td>RCHOP21 vs RCHOP14</td>
<td>602</td>
<td>70 (60–80)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCHOP21 vs RCHOP14</td>
<td>1080</td>
<td>61 (19–88)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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CGA to support treatment decisions in older patients with aggressive lymphoma
Data from the Italian Lymphoma Foundation (FIL)

Tucci A et al. Leuk Lymphoma 2015; 56(4): 921–926
CGA to support treatment decisions in older patients with aggressive lymphoma
Data from the Italian Lymphoma Foundation (FIL)

OS of fit (a), unfit (b) and frail (c) older patients with DLBCL

Tucci A et al. Leuk Lymphoma 2015; 56(4): 921–926
R-miniCHOP for patients 80+

D1 375 mg/m\(^2\) rituximab
D1 400 mg/m\(^2\) cyclophosphamide
D1 25 mg/m\(^2\) doxorubicin
D1 1 mg vincristine
D1-5 40 mg/m\(^2\) prednisone

Peyrade F et al. Lancet Oncol. 2011 May;12(5):460-8
Median overall survival was 29 months (95% CI 21 to upper limit not reached; the 2-year overall survival rate was 59% (95% CI 49–67)
Impact of intended and relative dose intensity of R-CHOP in elderly DLBCL patients treated with curative intent

Patient’s journey in the Lymphoma Unit

Hematologist/Oncologist
- Past Medical History

Hematology Nurse
- G8, GAH, CIRS-G
  - Nutrition, Anxiety/Depression, Social
- Case management
  - Referrals

Geriatrician
- Balducci phenotype:
  - robust / vulnerable or frail / unfit
- Geriatric intervention:
  - Deprescribing, Nutrition, Exercise

Cardiologist
- CV risk assessment
  - LVEF and strain
  - Cardioprotection (if indicated)

Lymphoma Tumor Board
- Treatment decision:
  - standard / adapted / palliative

Oncology Pharmacist
- Treatment plan
- Polypharmacy, adherence
- DDI
  - Monitor adherence
  - Pharmacosurveillance

All
- QoL, PRO
  - Management of toxicity
- Follow-up
  - Reassessment
Take-home messages

• There is an increased incidence of NHL in older patients

• We need to identify fit older patients with aggressive NHL to receive full standard dose at first-line (R-CHOP when possible; R-miniCHOP if 80+)

• In those frail patients with poor prognosis, at least do not harm

• We have tools to assess comorbidity and frailty in our older patients with lymphoma to adapt the therapy
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