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# POSTER ABSTRACTS

## 623.MANTLE CELL, FOLLICULAR, AND OTHER INDOLENT B CELL LYMPHOMAS: CLINICAL AND EPIDEMIOLOGICAL

### Real World Outcomes of Black Americans with Mantle Cell Lymphoma

*Victoria A. Vardell, MD*[1], *Boyu Hu, MD*[1], *Lindsey Fitzgerald, MD*[1], *Harsh Shah, DO*[1], *Allison M. Bock, MD*[1], *Deborah M. Stephens, DO*[1], *Daniel A. Ermann, MD*[1]

[1] Huntsman Cancer Institute, University of Utah, Salt Lake City, UT

**Introduction**

Mantle cell lymphoma (MCL) is a rare subtype of non-Hodgkin lymphoma (NHL), accounting for approximately 6-8% of all NHL cases. MCL generally affects older, White, male patients, having a significantly lower incidence in Black patients. Thus, clinical outcomes of Black Americans with MCL are poorly characterized, though multiple sources have reported relatively poor survival outcomes when compared to their White counterparts. We aimed to evaluate the overall survival outcomes and explore potential factors contributing to poor survival outcomes for Black patients with MCL in the United States.

**Methods**

The National Cancer Database was used to identify MCL patients diagnosed from 2004-2020. Demographic and treatment characteristics were compared between White and Black MCL patients, by self-identified race. Patients of other races were excluded. Kaplan Meier and adjusted Cox regression survival analysis were used to compare overall survival (OS) by race, and stratified for age $\leq$ 65 or age > 65 years old. Finally, a propensity matched analysis was performed to compare OS in Black and White Americans matched by age, comorbidity burden, insurance status, and zip code income.

**Results**

A total of 34,872 patients with MCL were identified, of which 93.1% (N=32,407) were White, 4.2% (N=1,465) were Black, and 1.7% (N=942) identified as another race and were excluded from the dataset. Black patients were more likely to be female (34% Black vs. 29% White), have a younger age at diagnosis (mean age 65 years [SD $\pm$ 13] vs. 68 years [SD $\pm$ 12], p<0.001), more likely to have $\geq$1 co-morbidity (30% vs. 23%), and more likely to be uninsured (4% vs. 2%) when compared to White patients. Both Black and White patients had equal rates of stage IV disease (68% vs. 68%) and receipt of systemic therapy at diagnosis (84% vs. 84%), however White patients were more likely to receive stem cell transplant compared to Black patients (13% vs.11%).

With a median follow-up of 40 months, the median OS for all MCL patients was 70 months (95% CI 66-71). Compared to White patients of the same age, Black patients age $\leq$ 65 years had worse median OS (116 months [95% CI 92-139] vs. 140 [95% CI 134-146] months for White patients) along with decreased 1-year (87% vs. 90%), 5-year (62% vs. 70%) and 10-year OS (38% vs. 55%), (all p <0.001). For MCL patients age > 65 years old, Black MCL patients had shorter median OS compared to their White counterparts (36 months [95% CI 28-43] vs. 43 months [95% CI 41-44]), and decreased 1-year (70% vs. 75%) and 5-year OS (40% vs. 41%) (all p=0.030), though by ten years there was no survival disparity. On age-adjusted cox regression, Black race was associated with increased hazard for all-cause death for MCL patients (hazard ratio [HR] 1.17, CI 1.08-1.26; p<0.001). However, when Black and White patients were 1:1 propensity score matched by age, co-morbidity score, insurance status, and income quartile of zip code, there was no significant difference in risk of death by race alone (HR 0.99, CI 0.91-1.08; p=0.61).

**Conclusion**

This is the largest study to-date evaluating outcomes among Black patients with MCL. Patients who are Black with MCL are more likely to present at a younger age, have female predominance, and have worse overall survival outcomes than White patients of similar age. Notably, we found that this survival difference was lost when controlling for surrogate markers of healthcare access, such as insurance and income. This study highlights existing disparities for Black patients with MCL, which appear to be related to socioeconomic disparities that may impact access to treatment, supportive care, and other vital aspects of care for MCL. Future studies may seek to evaluate the role of known high risk features for MCL such as TP53 status or blastoid/pleomorphic morphology in these populations. Interventions aimed at improving healthcare access for underserved populations, including racial minorities, are essential.

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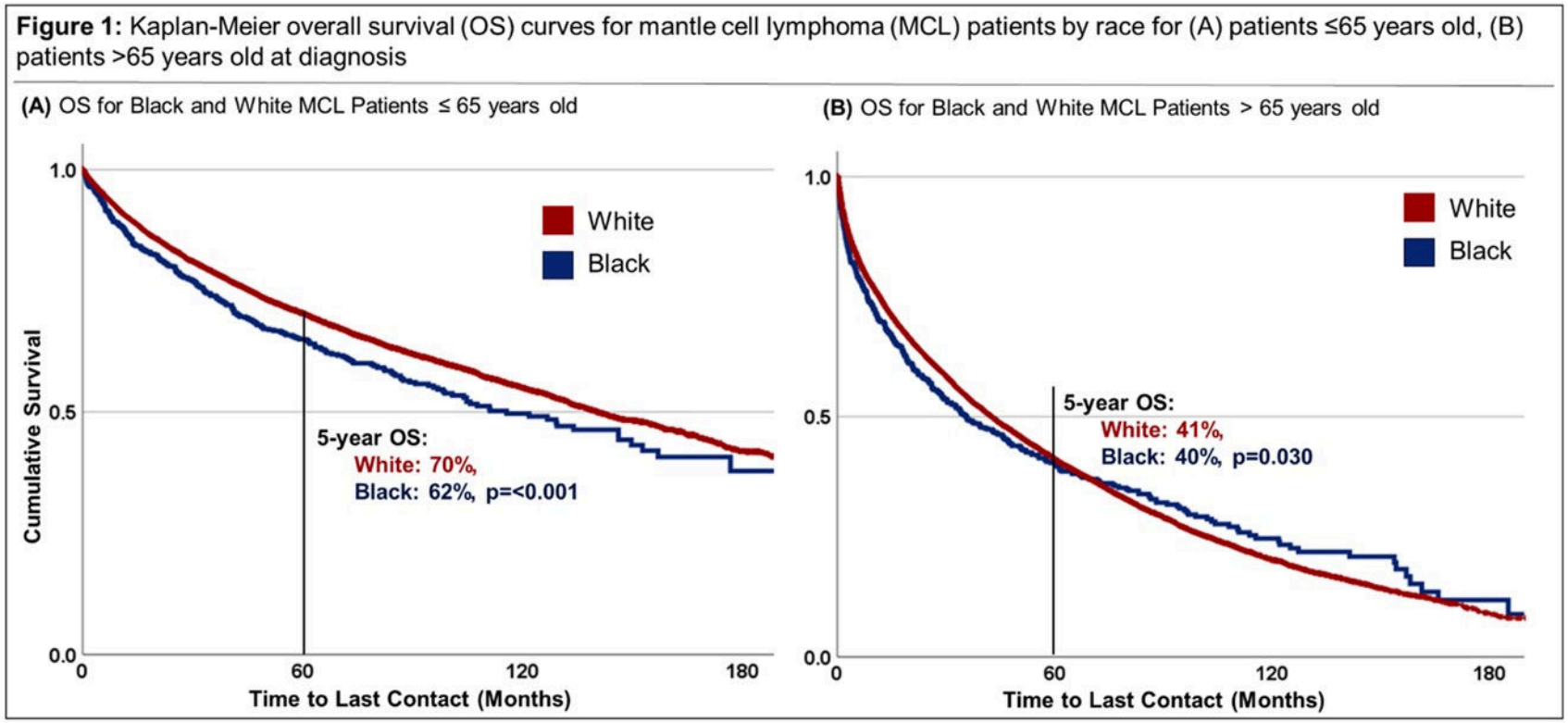


**Figure 1**