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627.AGGRESSIVE LYMPHOMAS: CLINICAL AND EPIDEMIOLOGICAL

Real-World Efficacy and Safety of Rituximab, Lenalidomide and Ibrutinib Combination in Patients with Relapsed and/or Refractory Non-Hodgkin Lymphoma

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Background:
Relapsed or refractory (R/R) Non-Hodgkin Lymphoma (NHL) is associated with poor outcomes and the therapic options are limited. Recently, the combination of rituximab, lenalidomide, and ibrutinib (RLI) suggest promising efficacy in some clinical studies. Consequently, we report outcome of patients with R/R HL treated with RLI in this retrospective study aiming at evaluating efficacy and safety of RLI in a real-life setting.
Methods:
This retrospective, single-center study analyzed the outcomes of RLI as an off label salvage theraphy in patients with R/R NHL between June 2020 and April 2022. All patients received Lenalidomide 10-25 mg po daily on days 1-21 every 28 days and Ibrutinib 560 mg po daily on days 1-28. Patients with diffuse large B-cell lymphoma (DLBCL), primary central nervous system lymphoma (PCNSL), marginal zone lymphoma (MZL) received Rituximab at a dose of 375 mg/m2 iv on day 1 of cycles 1-6 every 28 days, patients with mantle cell lymphoma (MCL) received the same dose of Rituximab once a week for 4 weeks during cycle 1, then on day 1 of cycles 2-12 every 8 weeks. Ibrutinib and/or lenalidomide was administered until progression or unacceptable toxicity. The response was assessed with according to the Lugano criteria. The primary end point was overall response rate (ORR). Secondary endpoints were complete response (CR), partial response (PR), time to response (TTR), duration of response (DoR), overall survival (OS), progression free survival (PFS) and safety.
Results:
We analyzed 21 patients including DLBCL (n = 16), PCNSL (n = 2), MCL (n = 2), MZL (n = 1). The median age was 60 years (range, 24-84). The majority of patients had advanced disease stage (53%) and were refractory to their last therapy (57%). The non-GCB type was more common (67%) in patients with DLBCL and PCNSL. Nine patients (56%) with DLBCL had MYC and BCL2 and/or BCL6 rearrangements. Median number of prior therapies was 3 (range, 2-6). Eleven patients had prior auto and/or allo stem cell transplantation. Median follow-up time was 6.6 months (range, 0.4-22.3). Eleven patients (52%), 6 patients (29%) and 2 patients (10%) received RLI for ≥ 3, 6 and 12 months respectively. Patients had received a median of 3 (range, 1-19) cycles of RLI. Progressive disease (PD) was the most common reason for treatment discontinuation (53%). All of the patients were evaluable for response. The median TTR was 2 months (range, 1.7-3.8). The ORR was 38% (95% CI 15%-61%) with 29% CR and 9% PR. At the time of the analysis, the median DoR was 12.8 monts (range, 4.4-19.5+). Deaths were reported for 13 (62%) patients [n = 10 PD, n = 3 adverse events (AEs)]. The median OS was 7.9 months (95% CI 2.2-13.5) and median PFS was 3.5 months (95% CI 0.0- 8.3). The most common non-hematologic AEs were fatigue (48%), infection (38%), diarrhea (29%). AEs were frequently reported at the 25 mg lenalidomise dose, but the majority (77%) of patients experienced a grade 1-2 AE. The hematologic AEs were neutropenia (48%) [grade 3-4 (100%)], thrombocytopenia (19%) and anaemia (19%). AEs led to discontinuation in 5% (n = 1) of patients (sepsis).
Conclusions:
Our results suggest that RLI is a viable therapeutic option with promising activity and favorable toxicity profile in patients with R/R NHL patients.

Disclosures No relevant conflicts of interest to declare.

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