AUTOLOGOUS TRANSPLANT FOR EARLY RELAPSING NHL

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DISCLOSURES

Consulting/Ad Board: Janssen, Kite/Gilead, Seattle Genetics, Celgene, Cellectar, Aptitude Health, Adicet

Research funding: Astra Zeneca, Settle Genetics, BMS, Takeda, LAM,Beigene, Genentech, Novartis, Bioinvent

SOME GENERAL POINTS OF AGREEMENT

- Patients with early relapsing DLBCL have a historically poor prognosis and disease that is difficult to treat.
- CAR-T has significantly improved outcomes for patients with relapsed/refractory DLBCL
- This debate is not about patients with chemo-refractory disease – those patients are very unlikely to be cured with autologous transplant.
- Allogeneic transplant is almost never the right answer in the current era.

- What are we talking about then?

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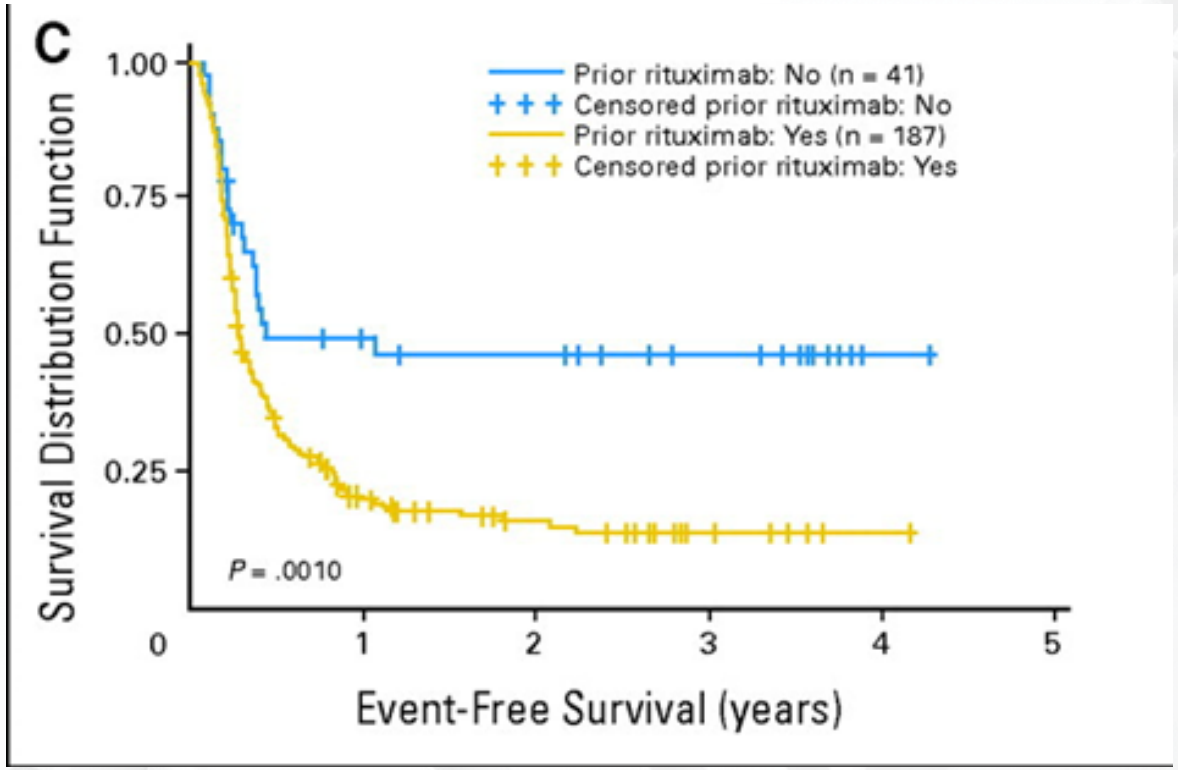
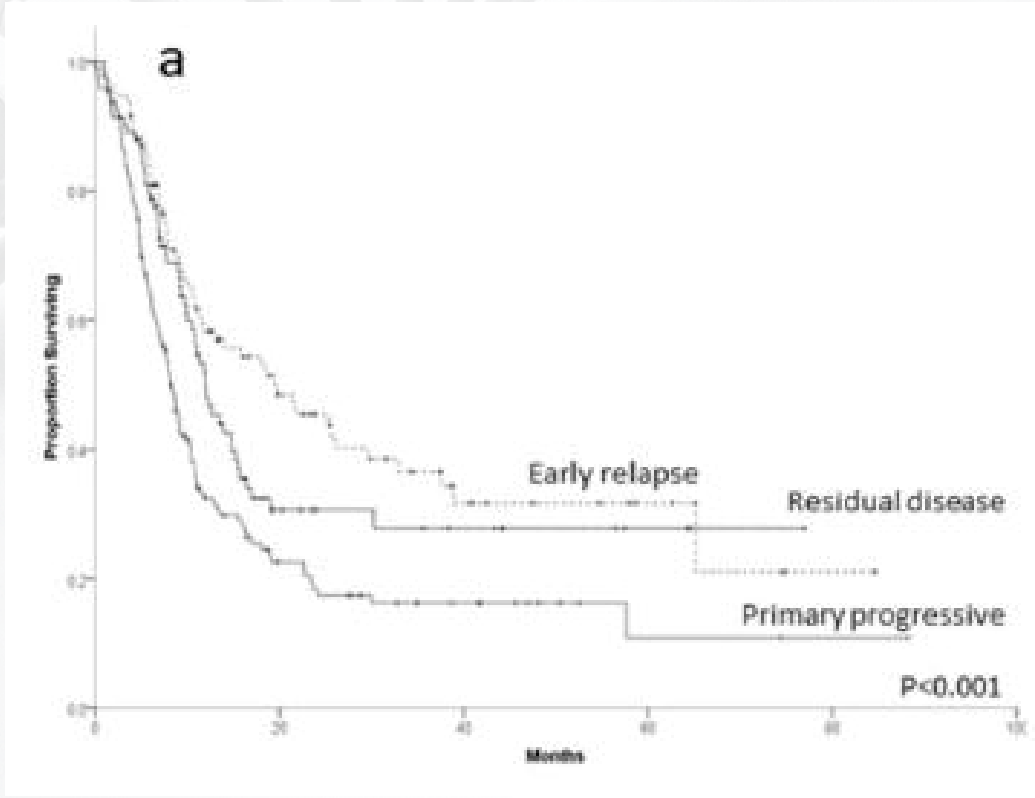
- What are we talking about then?

If a patient presents with confirmed early relapse/progression of DLBCL, which definitive therapy should you explain will be the goal?

EARLY RELAPSING/PRIMARY REFRACTORY DLBCL ASSOCIATED WITH POOR PROGNOSIS

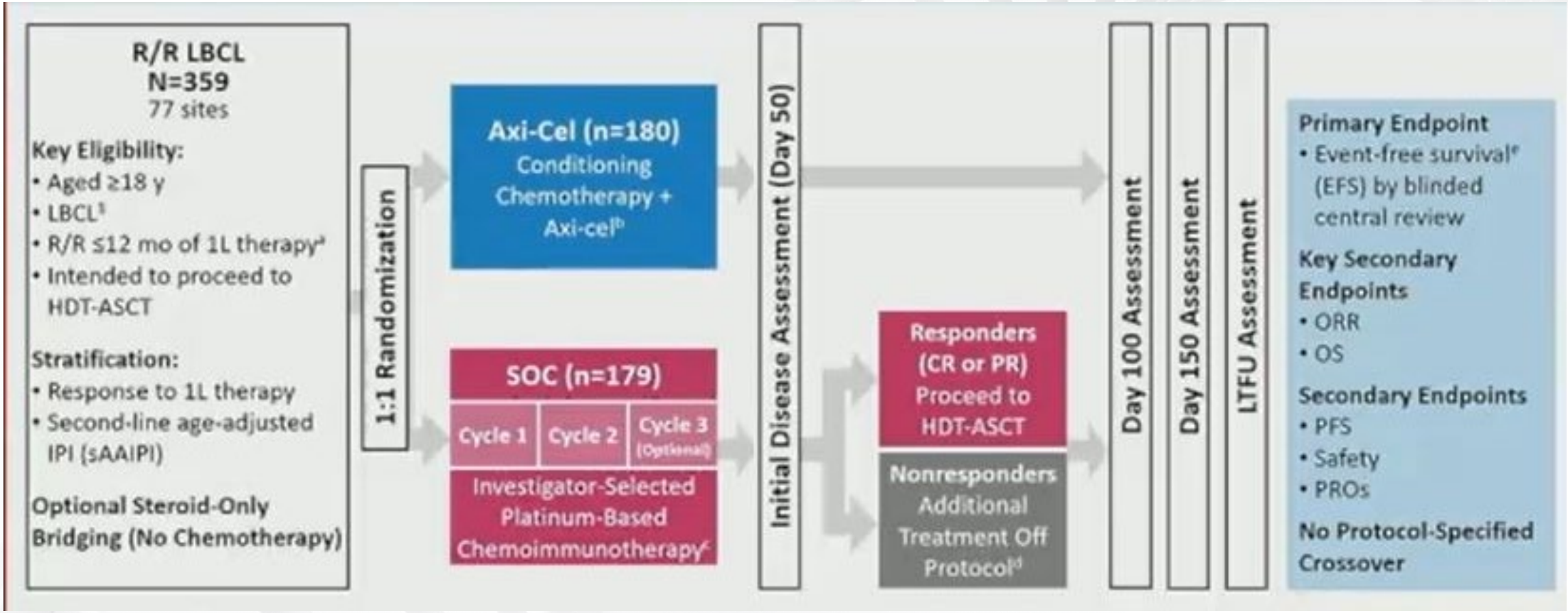


Gisselbrecht et al, J Clin Oncology 2010



Costa et al, American J Haematology 2017

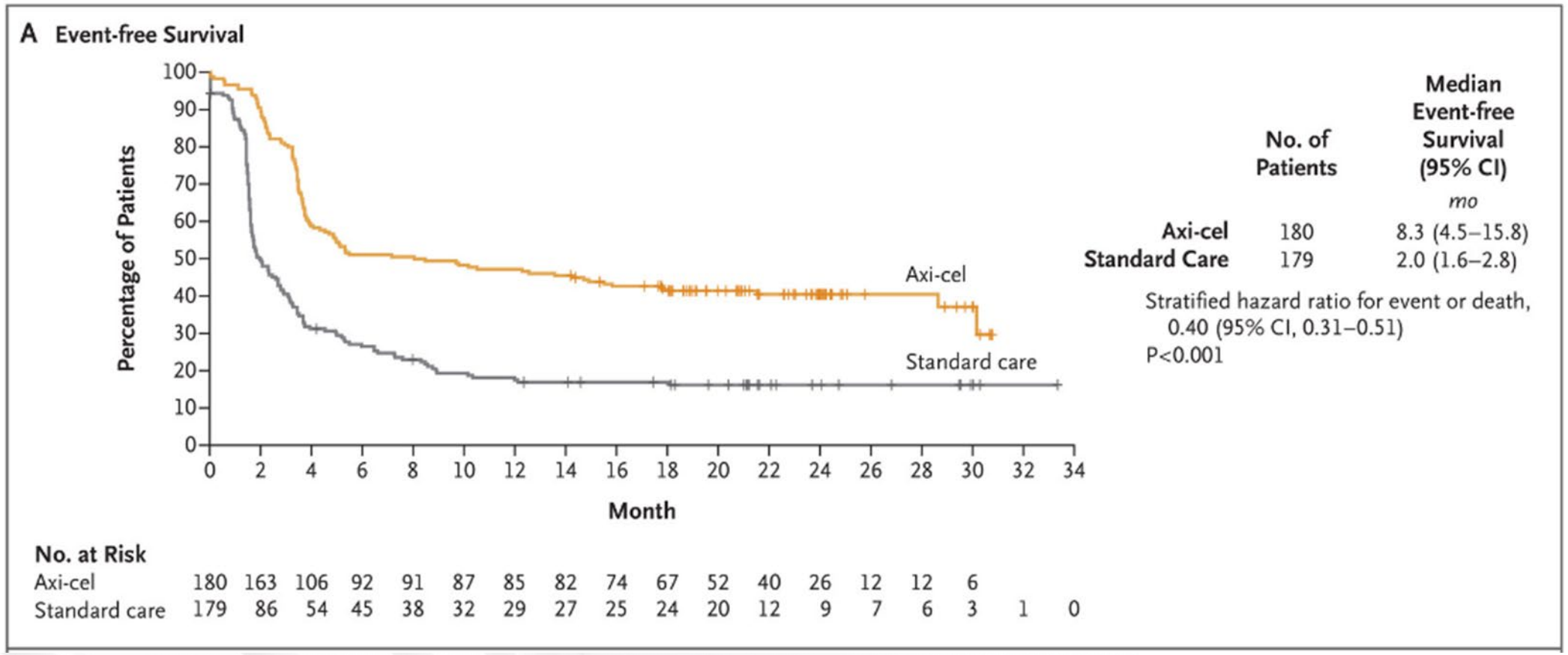
CAR-T VS AUTO SCT FOR EARLY RELAPSING DLBCL (ZUMA-7)



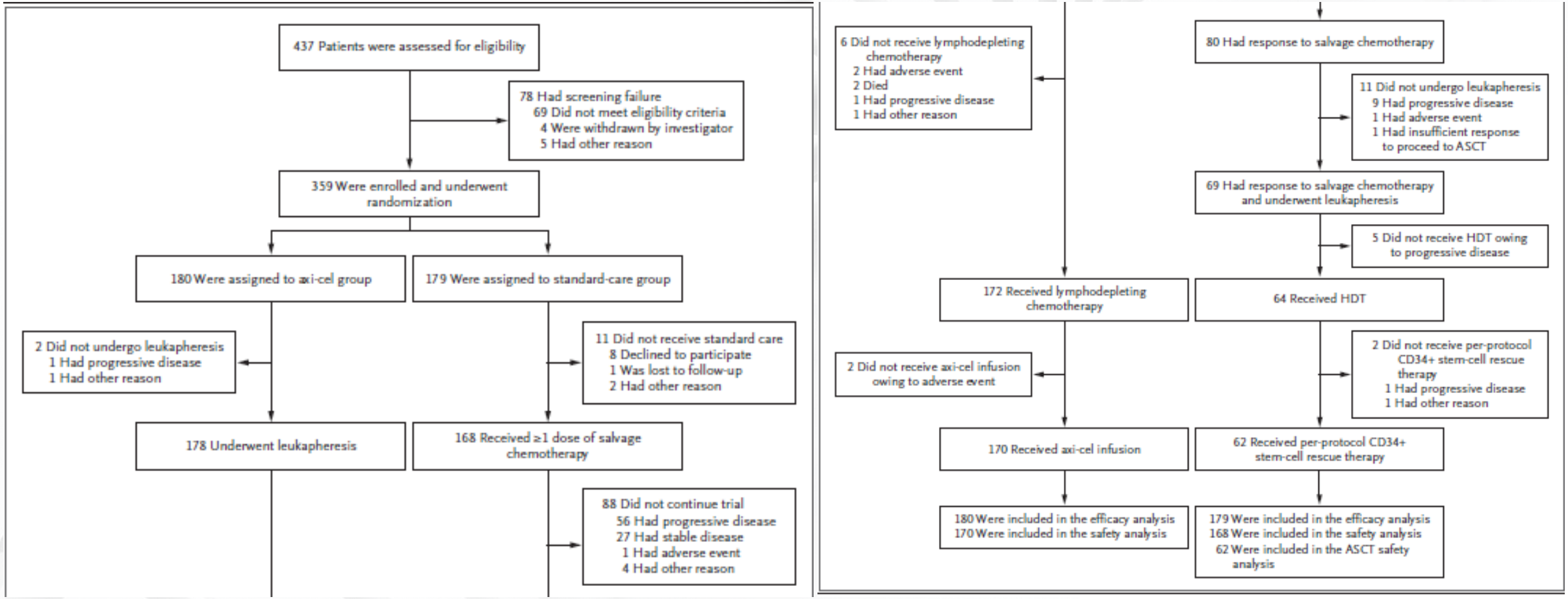
EFS started at time of randomization

Locke et al, NEJM 2020

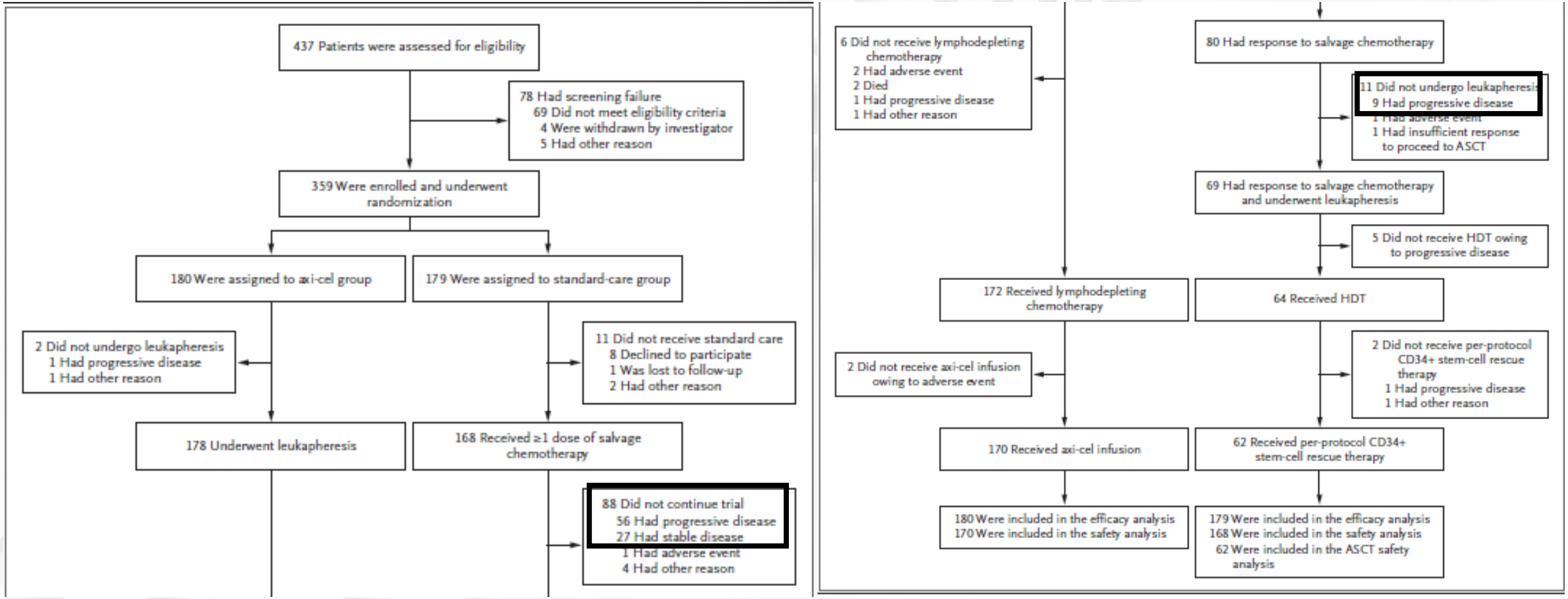
ZUMA-7 EVENT-FREE SURVIVAL



CONSORT DIAGRAM

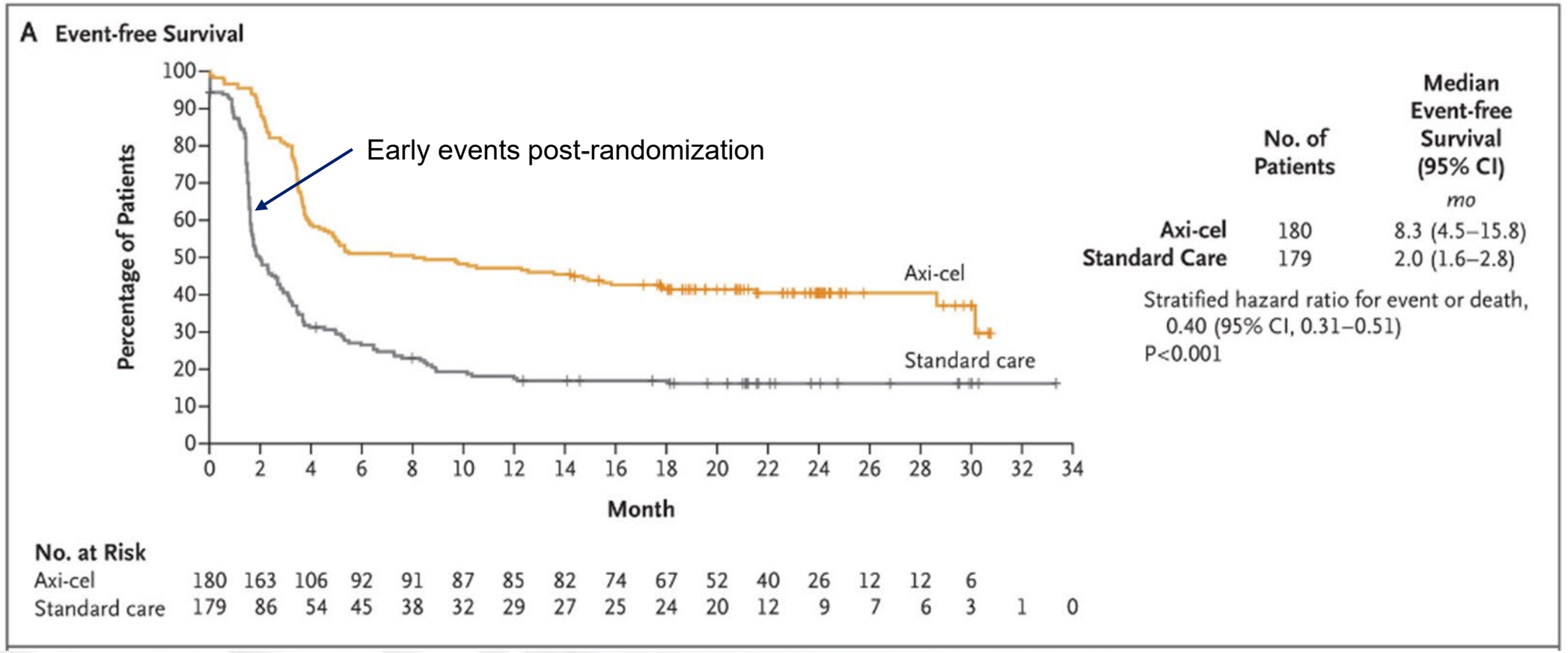


CONSORT DIAGRAM



92 patients randomized to auto transplant did not undergo stem cell collection→ Events

ZUMA-7 EVENT-FREE SURVIVAL

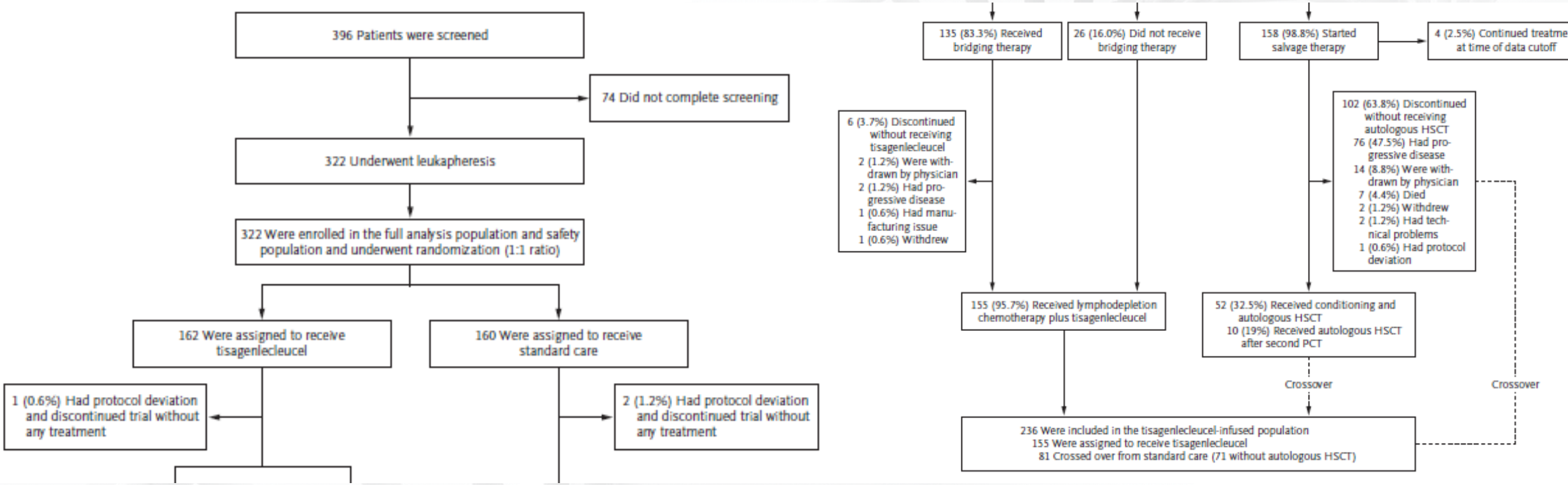


CART VS AUTO TRANSPLANT: JULIET TRIAL

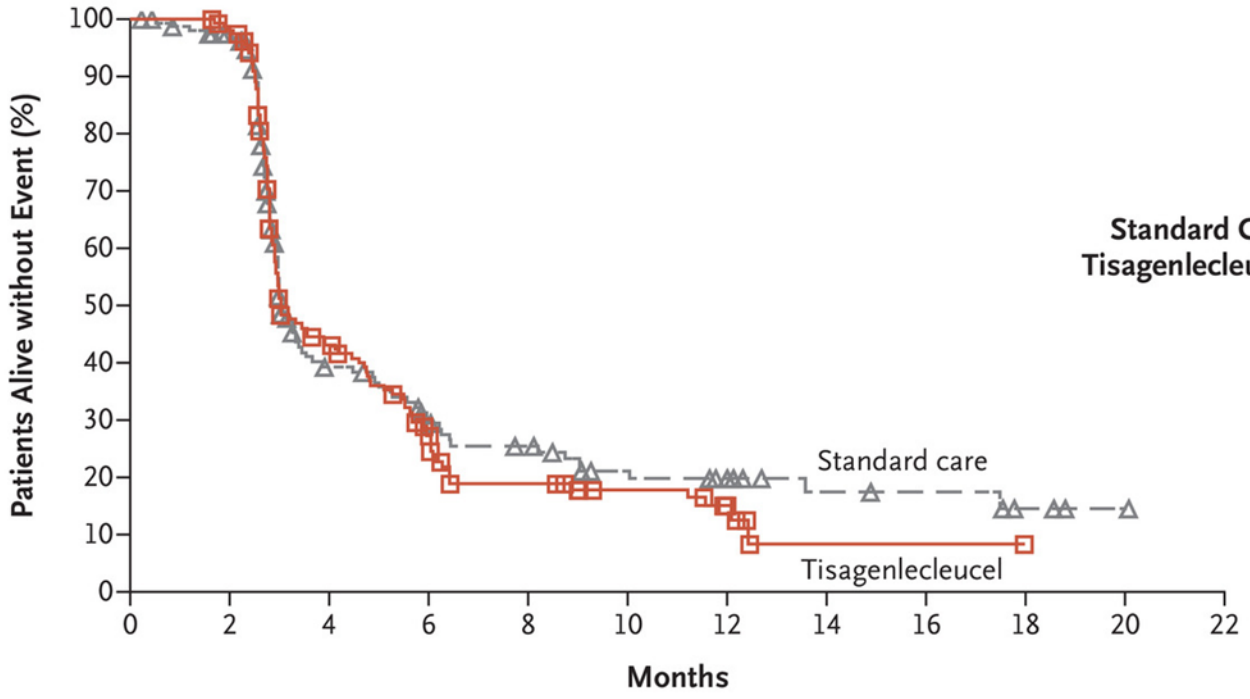
Design Similarities and Differences:

- Early relapsing/primary refractory
- All patients completed leukapheresis prior to randomization
- Bridging therapy was permitted in the CART arm
- Crossover permitted for patients who did not respond to salvage therapy
- Primary End Point: EFS (defined as time from randomization to SD/PD at 12 weeks or later OR death from any cause)

JULIET CONSORT DIAGRAM



JULIET EFS OUTCOMES



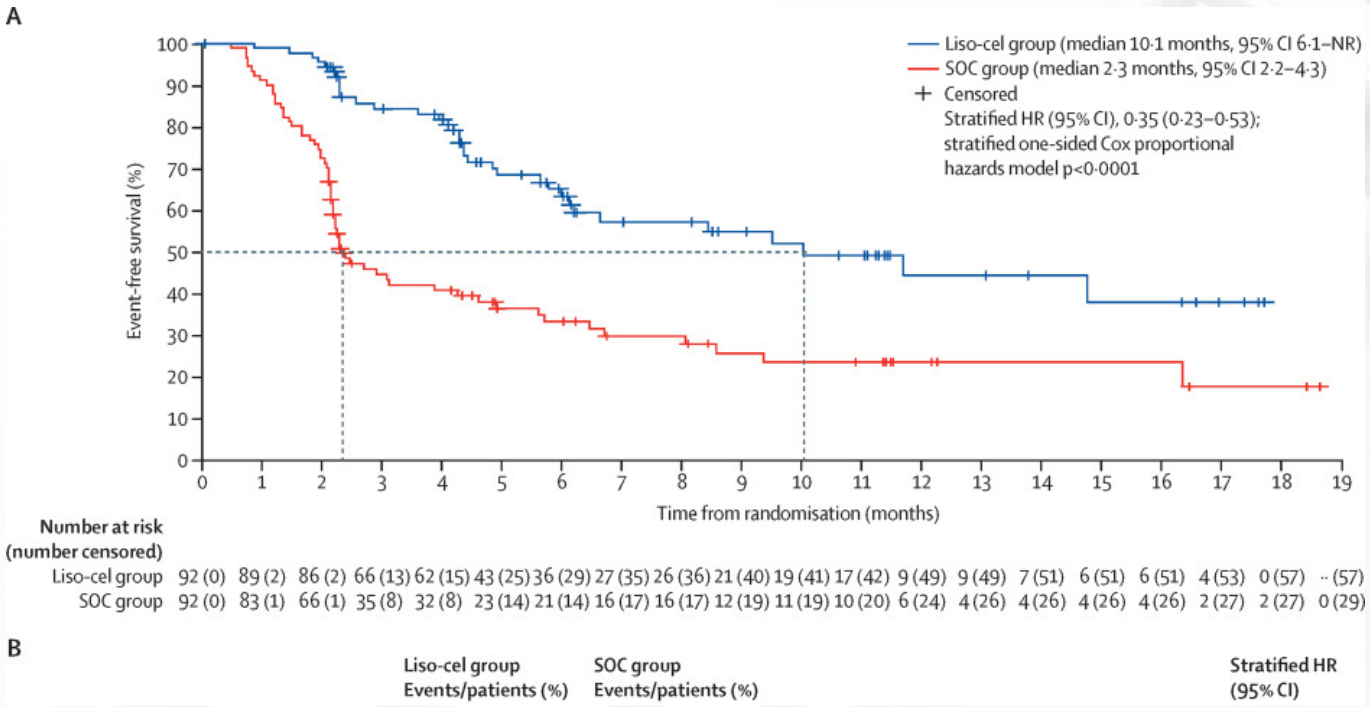
	No. of Patients	No. of Events	Median Event-free Survival (95% CI)
			mo
Standard Care	160	104	3.0 (3.0–3.5)
Tisagenlecleucel	162	117	3.0 (2.9–4.2)

Hazard ratio for event or death (tisagenlecleucel vs. standard care), 1.07 (95% CI, 0.82–1.40)
P=0.61

No. at Risk

Standard care	160	148	45	31	25	17	12	7	6	3	1	0
Tisagenlecleucel	162	156	57	32	19	13	6	1	1	0	0	0

TRANSFORM: LISO-CEL VS AUTO TRANSPLANT



- Bridging therapy allowed
- Crossover allowed
- 43 / 92 patients assigned to SOC received HDT

Kamdar et al, Lancet 2022

GENERAL THOUGHTS REGARDING CART VS AUTO TRANSPLANT

- Patients with early relapsing disease and/or primary refractory disease at high risk for poor outcome
- A high number of patients with early relapsing NHL do not respond to second-line therapy. These patients are not well-served by auto transplant and in fact, the initial indication for CAR-T would have allowed these patients to move to CAR-T.

- Patients who *do* have chemo-sensitive disease may still be cured with auto transplant (39% in CORAL study).
- CAR-T associated with prolonged cytopenias and can still be considered if needed post-auto.
- Recent studies do not compare outcomes for patients who received auto vs those who received CAR-T
- Also…unclear efficacy of current CD19-directed therapies in DLBCL for patients who receive CAR-T

Patients should be given the chance to get to auto transplant, with CAR-T reserved for patients without chemo-sensitive disease or who relapse later.

THANK YOU!