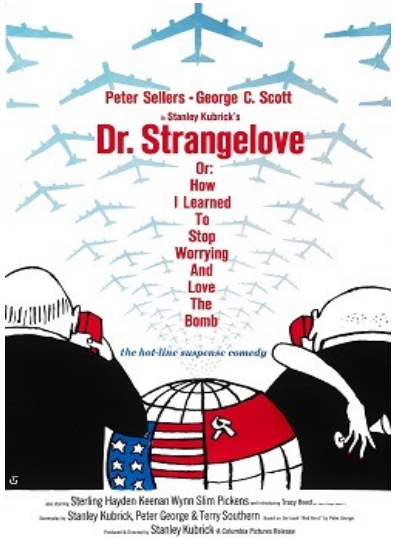
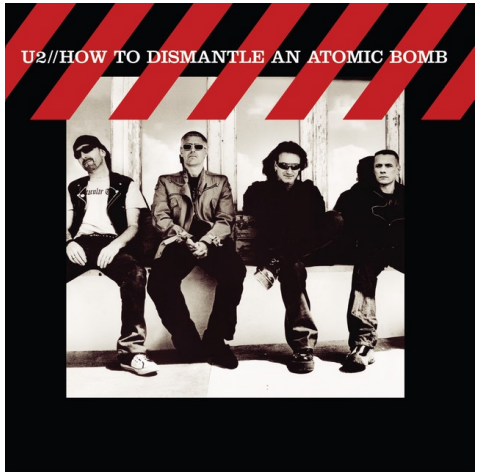
Como desmantelar una bomba atómica?

El porque NO recomendar Transplante Autologo de celulas hematopoeticas para todos los linfomas T nodales en CR1 (y dormir tranquilo)





Jose D. Sandoval Sus, MD FACP

Miembro Asociado

Departamento de hematologia maligna & terapia celular

H. Lee Moffitt Cancer Center at Memorial Health Care System

Profesor asociado, Florida Atlantic University (FAU)

Pembroke Pines, FL

LYMPHOMA Experience

PUERTO VARAS · CHILE · MAR 19-20-21 · 2026

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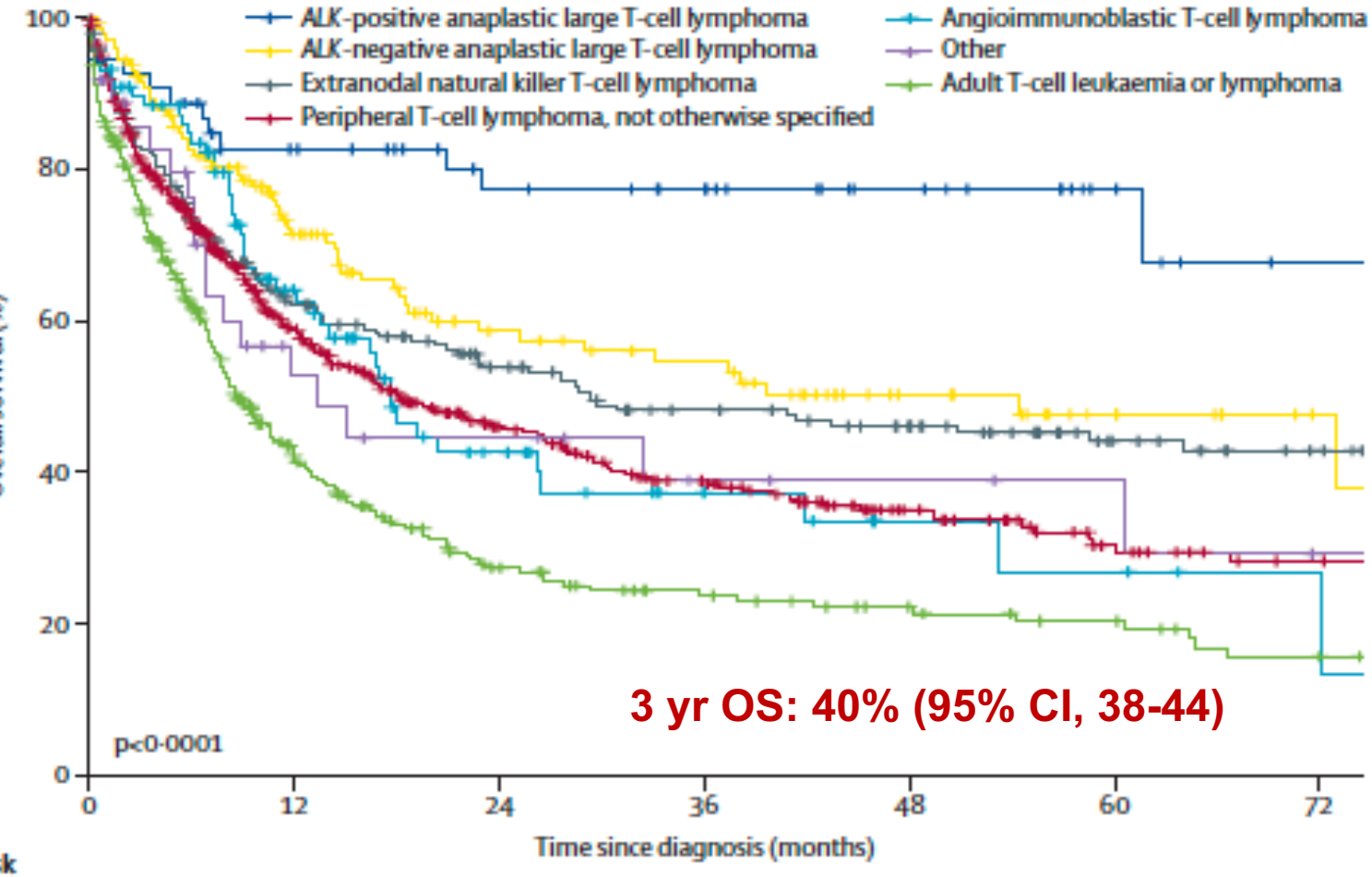
Conflictos of Interes

- **Speaker:** Pfizer
- **Advisory Board:** AstraZeneca, Acrotech, ADC therapeutics, BeOne, BMS, Genentech, Genmab, Janssen, Kite, Novartis, Roche

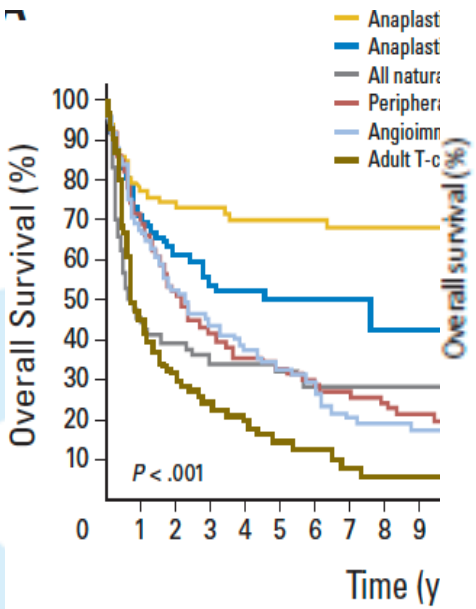
T-cell/NK cells NHL have poor prognosis with standard therapies

Latin AmericanT cell cohort (2000-2023) - GELL



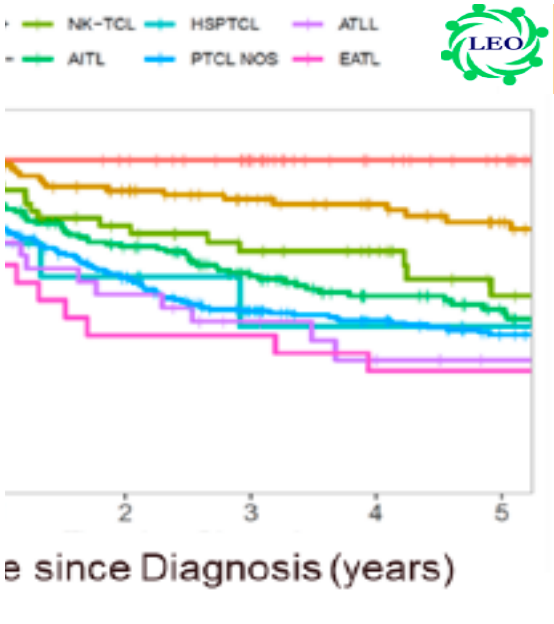
3 yr OS: 40% (95% CI, 38-44)

International T/
(1990-2



5 yr O

EO PTCL consortium
(2002-2022)



OS (PTCL NOS): 39%

Vose J, et al. J Clin Oncol. 2008;26(25):4124-4130.
Ellin F et al. Blood 2014; 124:1570-1577
Ruan J et al. Blood (2023) 142 (Supplement 1): 3079.
Malpica L et al. Lancet Haematol. 2025;12(4):e258-268.

Autologous HCT in frontline Tx: Is it for everyone?

PTCL: Consolidative Autologous Stem Cell Transplant

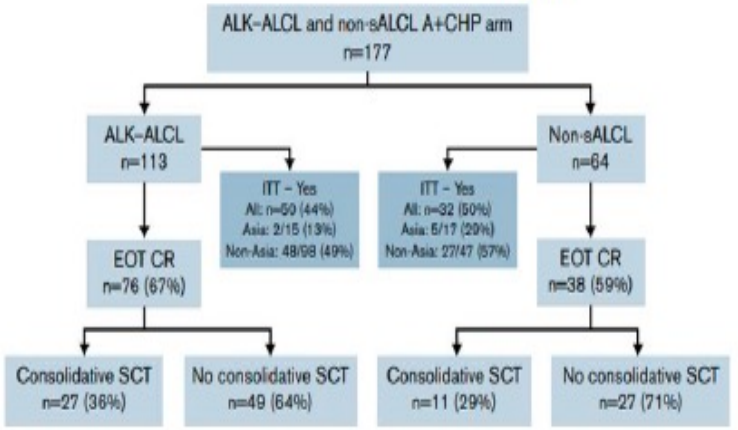
Study	Phase (N)	ORR	CR	PFS	OS
Reimer et al CHOP	II (83)	66%	56%	3-yr @36%	3-yr @48% (71% vs 11%)
D'Amore et al CHOEP / CHOP	II (160)	82%	50%	5-yr @44%	5-yr @51%
Corradini et al MACOP-B or HDS	II (62)	72%	56%	12-yr @30%	12-yr @34%
CIBMTR Smith et al	40	N/R	N/R	3-yr @58%	3-yr @70%
Swedish registry Ellin et al	128	60%	36%	5-yr @41%	5-yr @48%
Netherlands registry Brink et al	128	N/R	N/R	N/R	5-yr @78%

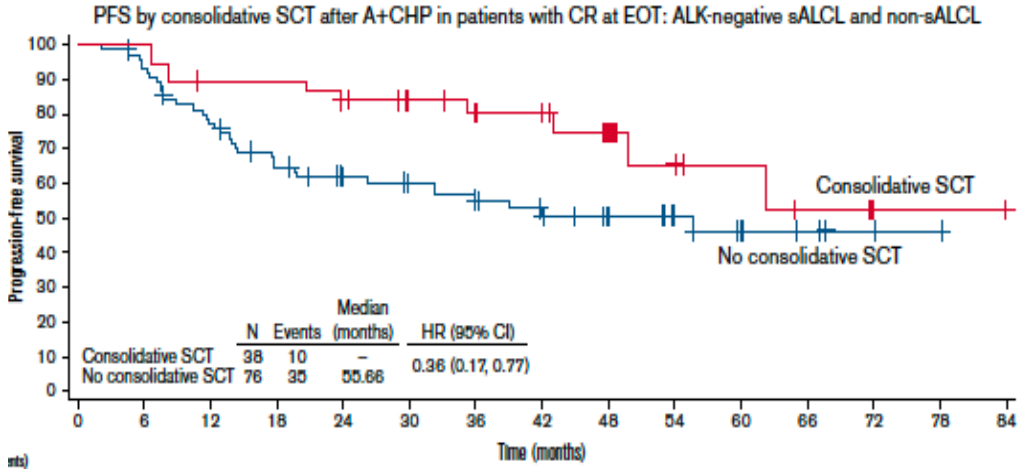
Reimer P, et al. *J Clin Oncol*. 2009;27(1):106-113. d'Amore F, et al. *J Clin Oncol*. 2012;30(25):3093-3099. Corradini P, et al. *Leukemia*. 2006;20(9):1533-1588. Smith SM, et al. *J Clin Oncol*. 2013;31(25):3100-3109. Abramson JS, et al. *Ann Oncol*. 2014;25(11):2211-2217. Ellin F, et al. *Blood*. 2014;124(10):1570-1577. Brink M, et al. *Blood*. 2022;140(9):1009-1019.

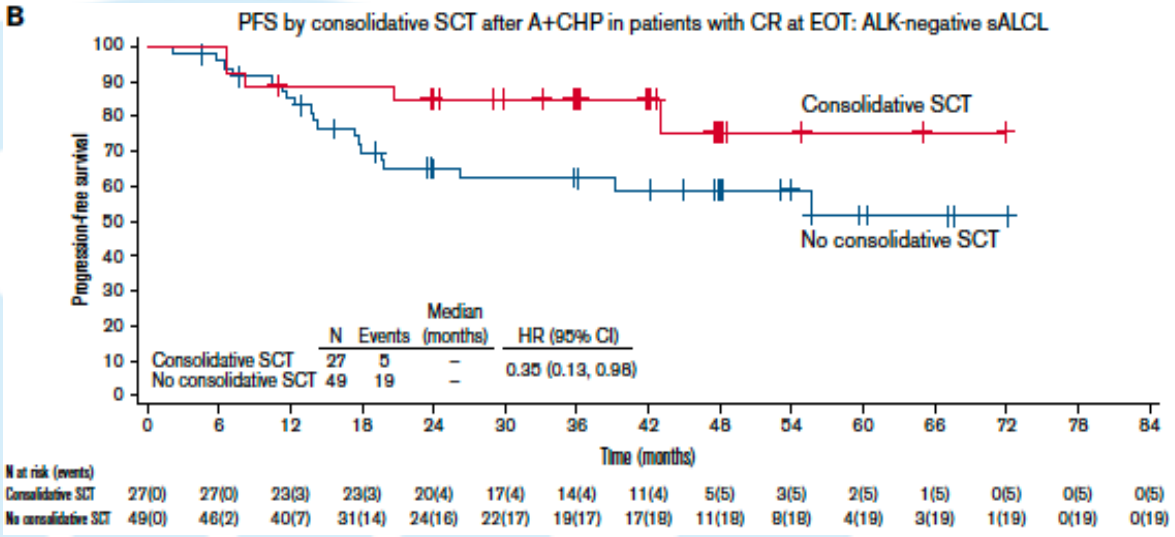
d'Amore F et al. JCO 2012 Sep 1;30(25):3093-9.

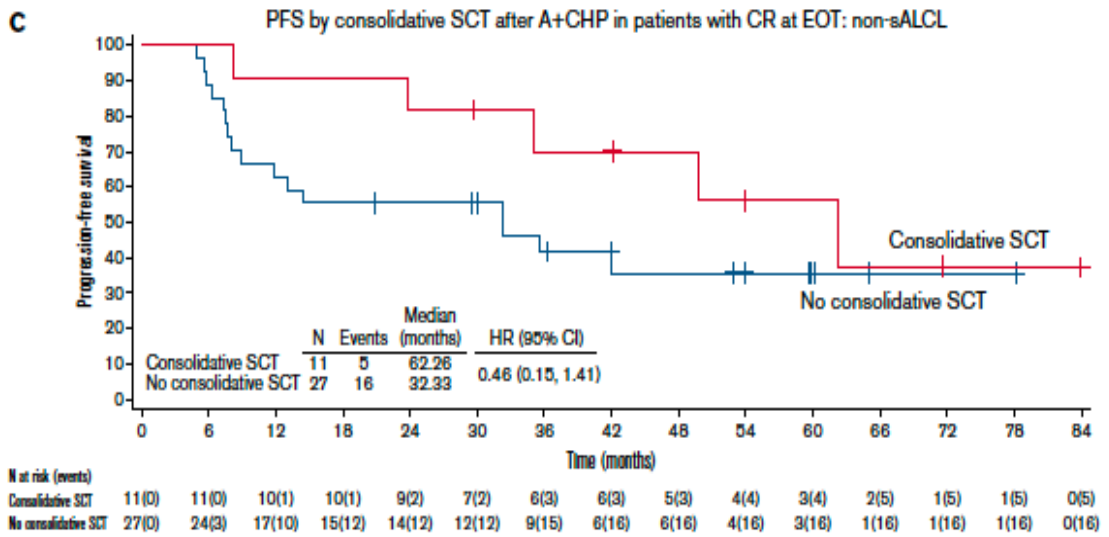
Autologous HCT in CD30+ PTCL following frontline BV-CHP or CHOP

ECHELON-2 Phase III RCT









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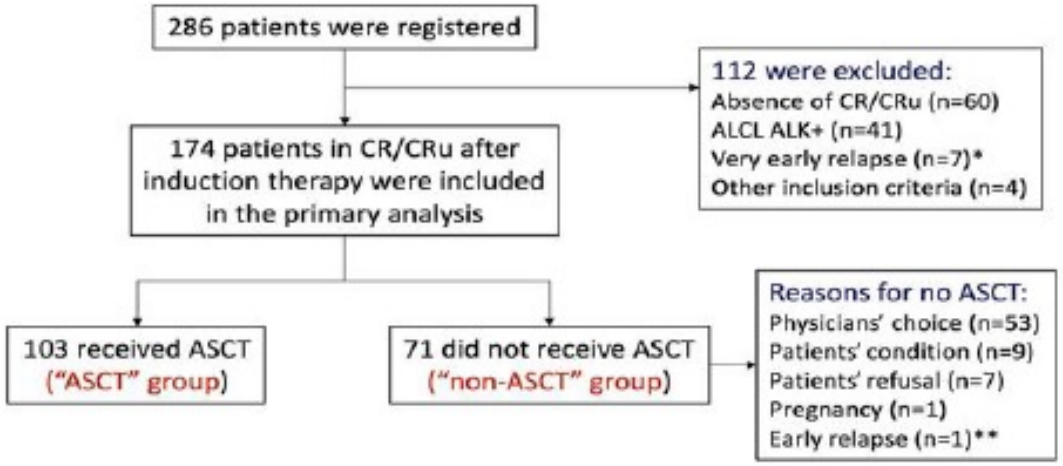
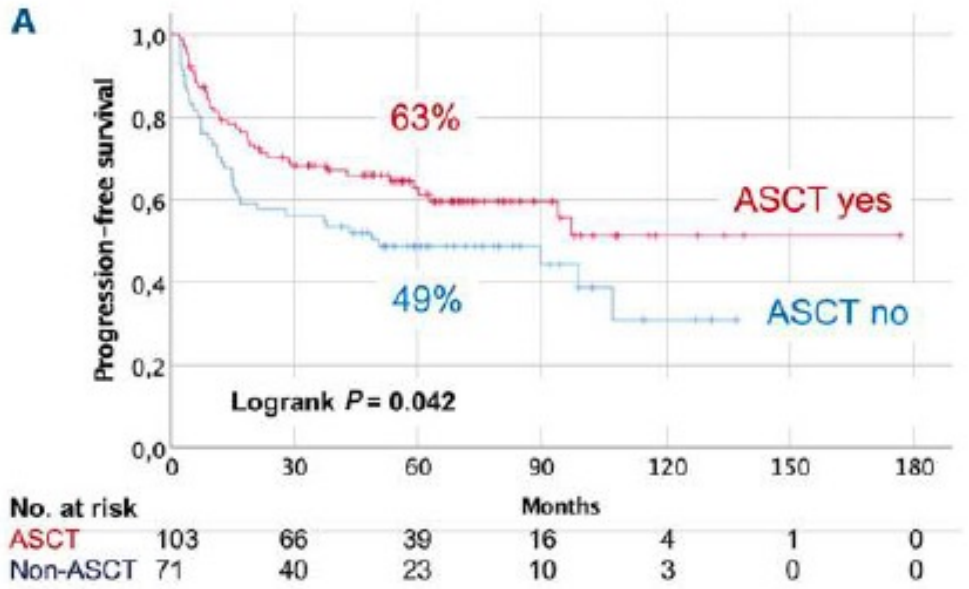
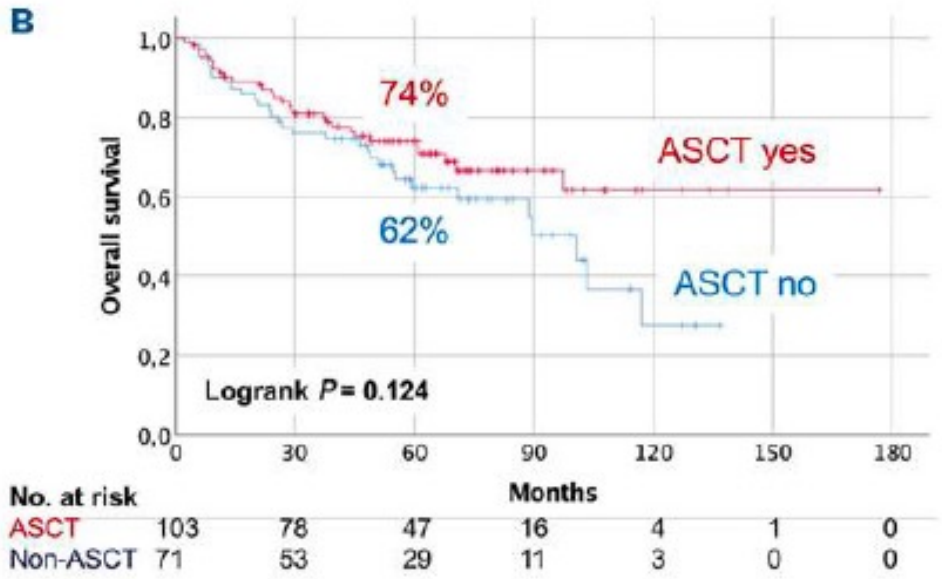
Savage K, et al. Blood Advances 2022 Oct 11;6(19):5550-5555.

GELTAMO/FIL







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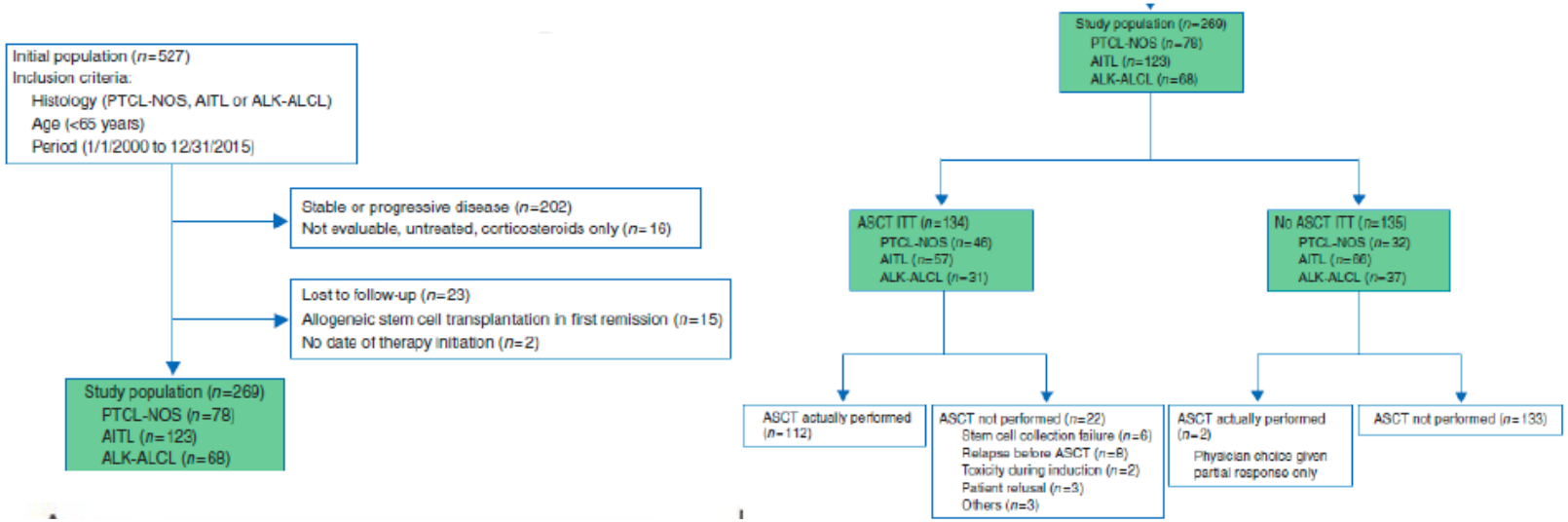
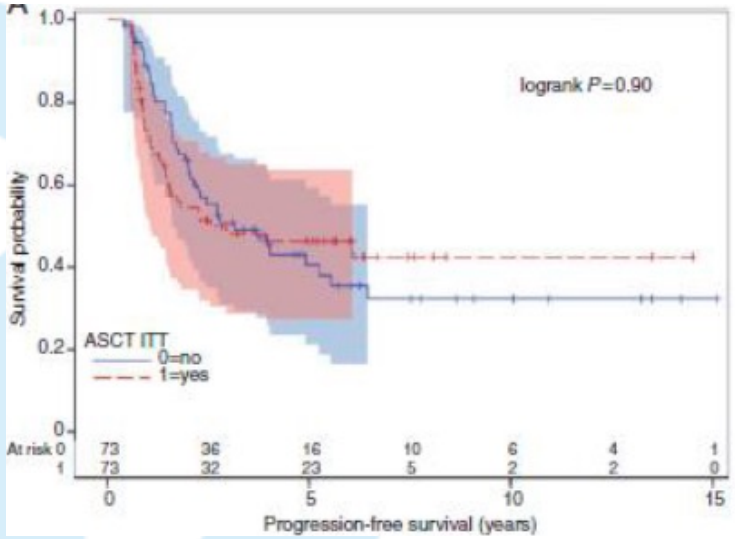
Garcia-Sancho et al. Hamaetologica 2022 Nov 1;107(11):2675-2684.

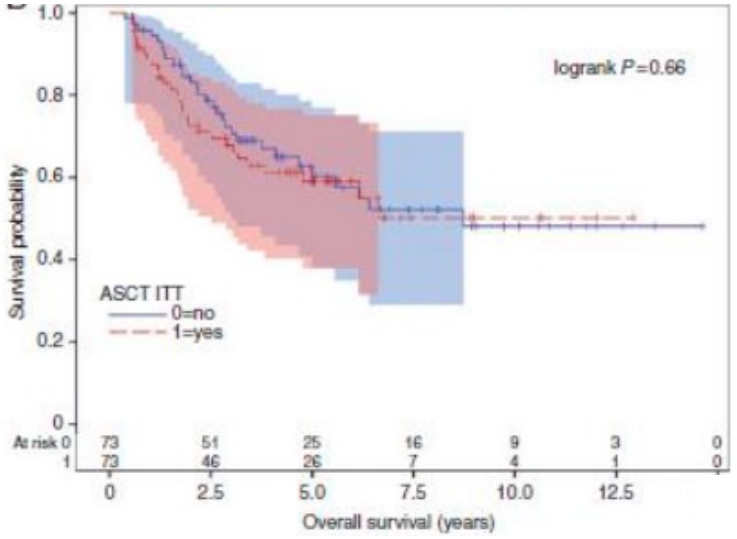
LYSA group (France)



PFS



OS

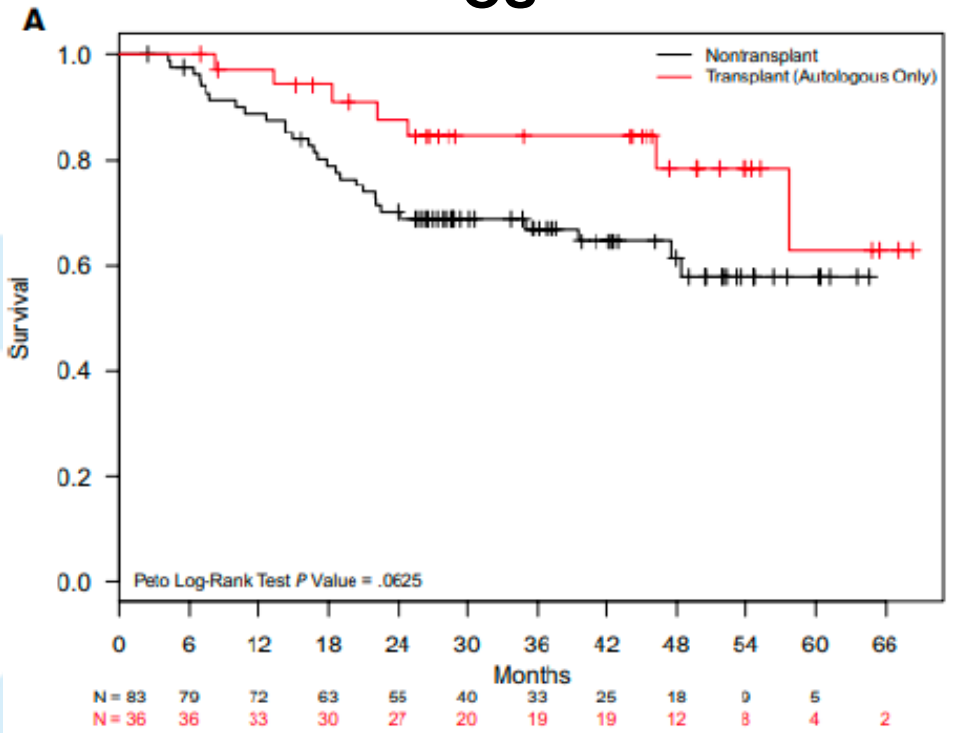


Fossard G et al. Ann Onc 2018 Mar 1;29(3):715-723.

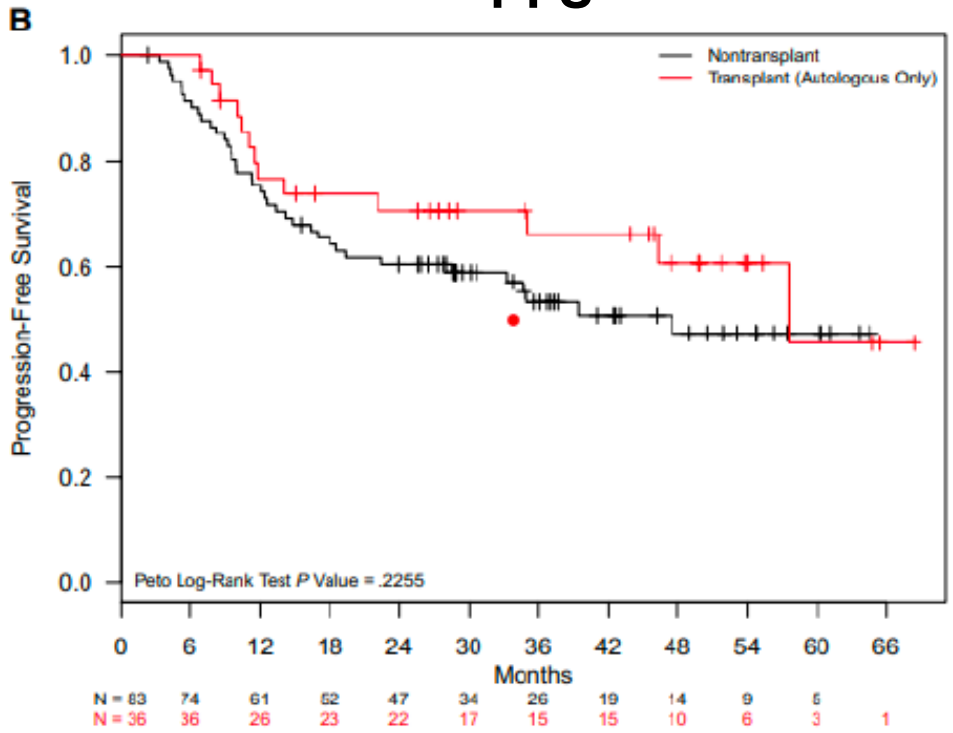
COMPLETE study (USA)

Characteristic	Non-ASCT (n = 83)	ASCT (n = 36)	*P*
Histologic subtype, No. (%)			
AITL	18 (22)	17 (47)	.01
ALK-negative ALCL	26 (31)	4 (11)	.02
PTCL NOS	39 (47)	15 (42)	.59

OS



PFS



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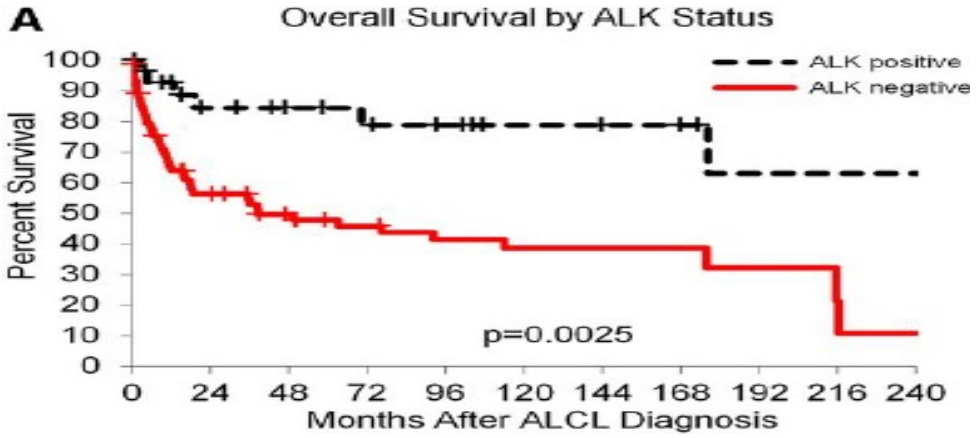
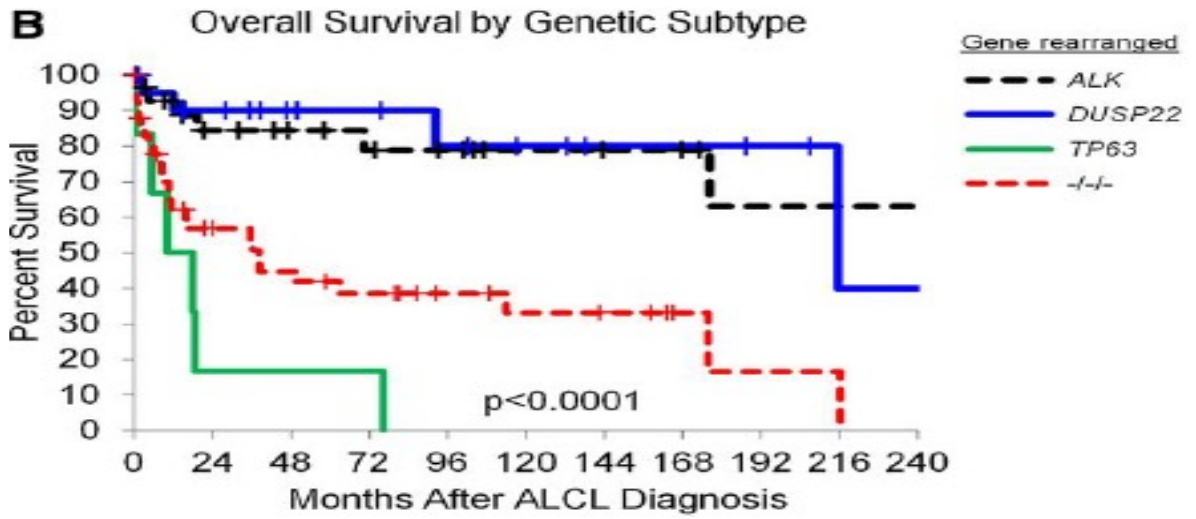
Park et al. Cancer 2019; 125 (9):1507-1517

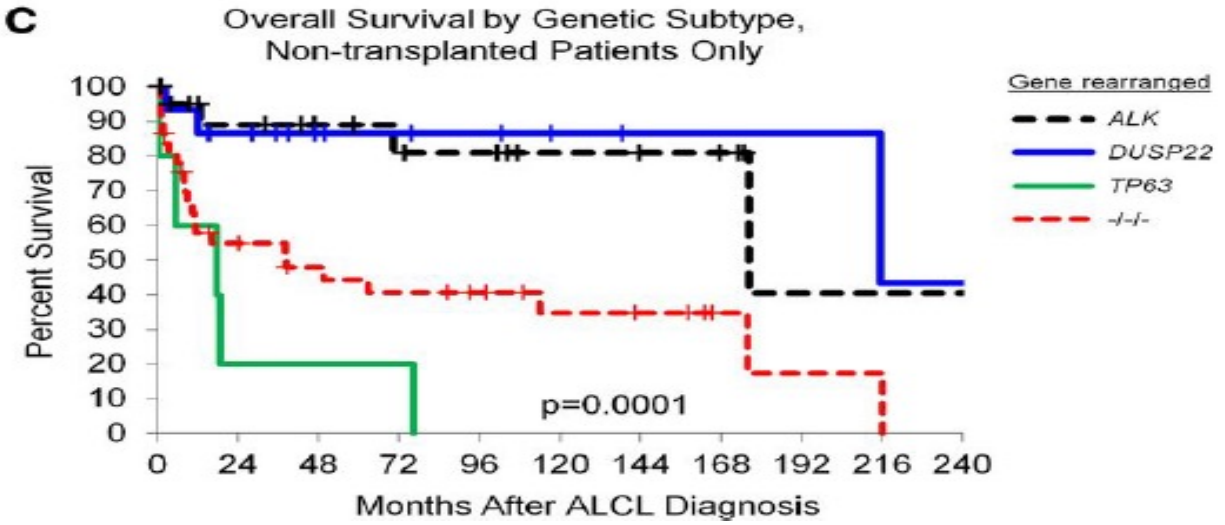
T cell NHL were AutoHCT is *most likely* not indicated

- ✓ **ALK+ ALCL in CR after chemotherapy (hopefully BV CHP!):** with low IPI.
- ✓ **ALK– ALCL in CR1 with DUPS22/IRF4 rearrangement:** lets talk about it!.
- ✓ **Stage I/II extranodal NK/T cell lymphoma treated with chemotx+RTx (i.e., extranasal).**
- ✓ **Mycosis fungoides/Sezary syndrome, SPTCL αβ:** allogeneic HCT in R/R disease.
- ✓ **T-cell LGL leukemia or chronic NK lymphoproliferative:** don't do it (for the love of god!).

ALK (+/-) ALCL, and DUPSS22 or TP63 rearrangements







Parrilla Castellar et al. Blood 2014 124 (9): 1473-80

DUPSS22 rearranged ALK neg ALCL can have variable clinical outcome

Feature	First author (Study location/group)					
	Parilla-Castellar (Mayo)[6]	Pedersen (Denmark)[10]	Hapgood (BC Cancer)[12]	Onaindia (Spain)[11]	Sibon (LYSA)[13]	Qiu (MDACC)[14]
DUSP22-R cases, N	22	5	12	4	47	22
DUSP22-R among ALK-negative cases, %	30	19	19	18	45	28
Age in years, median	53.5	49	61.5	57.5	60	52
Range	36-76	35-85	50-86	39-71	40-86	33-79
Stage 3 or 4, %	85	80	75	100	64	71
Missing data, %	68			25	2	37
PS ≥2, %	nr	0	25	40	30	nr
Missing data, %		50				
IPI ≥3, %	42	40	42	0	48	33
Missing data, %	36			50	2	32
Extranodal sites, %						
Bone	nr	nr	33	nr	32	nr
Bone marrow	nr	nr	17	25	13	6
Skin	28[a]	60	25	25	15	nr
Liver	nr	nr	8	nr	19	nr
CNS relapse %	nr	nr	8	nr	nr	nr
Treatment, %						
CHOP(like)	90	100	92	50[b]	94[c]	90
Consolidative auto-SCT	5	50[d]	8	0	19	27
Missing treatment data	36			25		
5-year PFS, %	nr	nr	40	nr	57	40[d]
5-year OS, %	90	80	40	100	65	40

Savage KJ et al. 2022 Dec 1;108(6):1463–1467.

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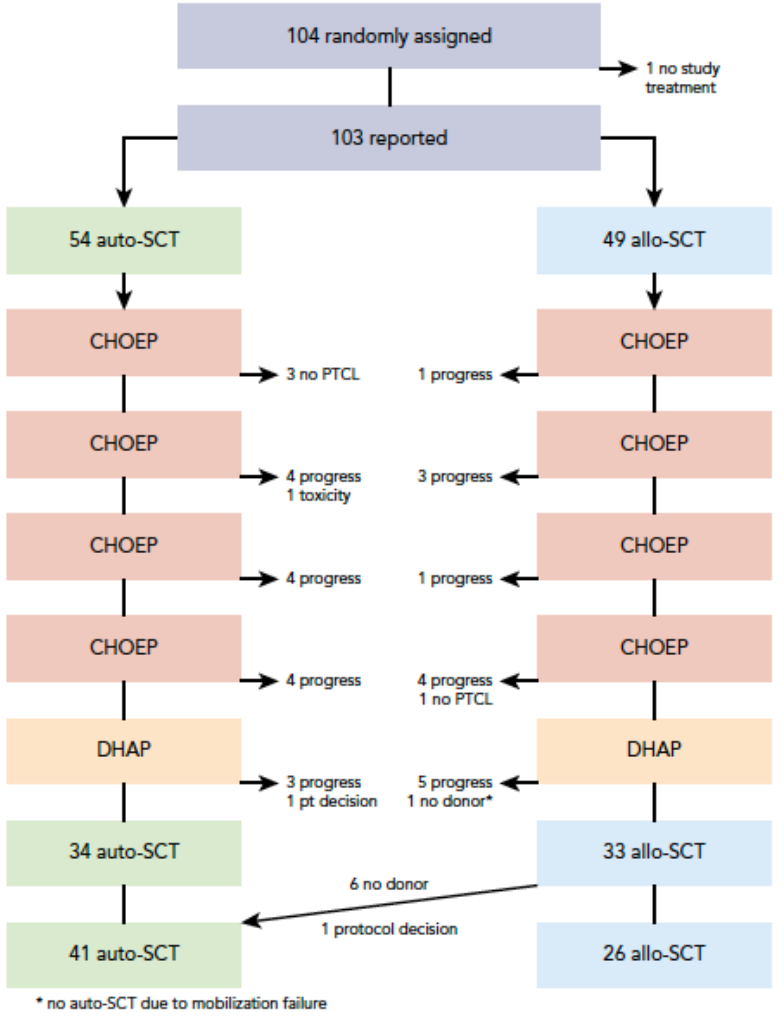
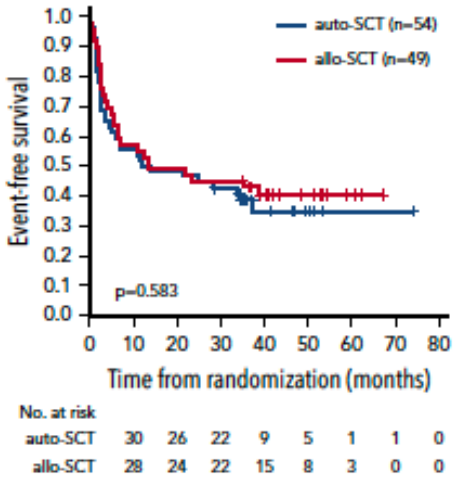
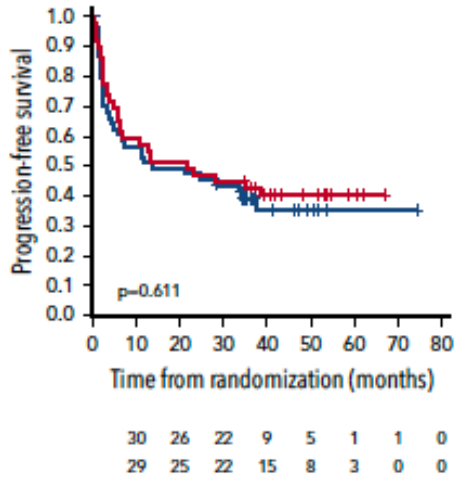
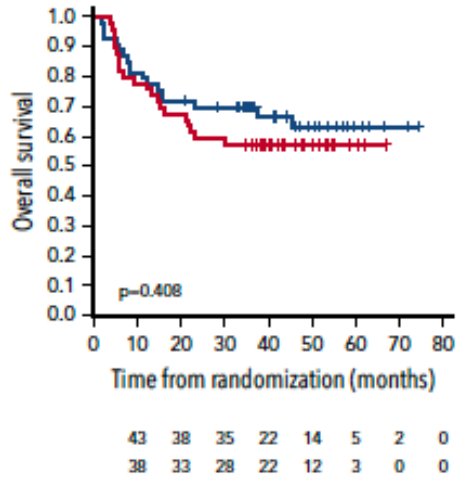
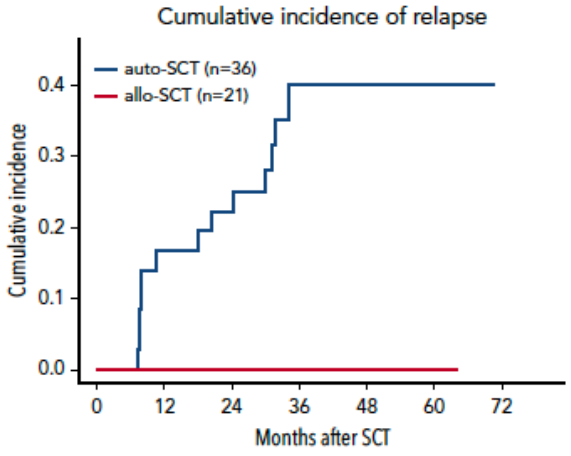
Is there a role for allogeneic HCT on CR1 for PTCL: NO!

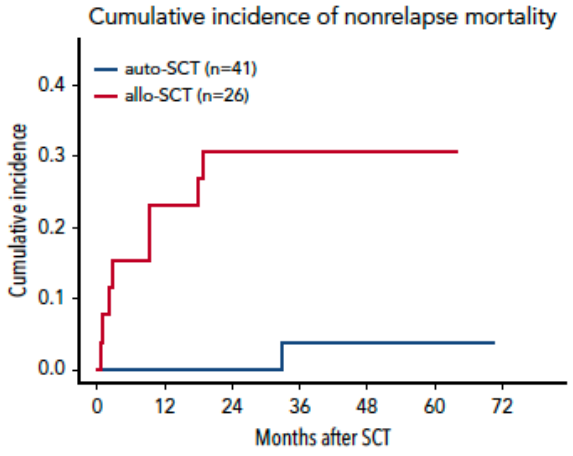












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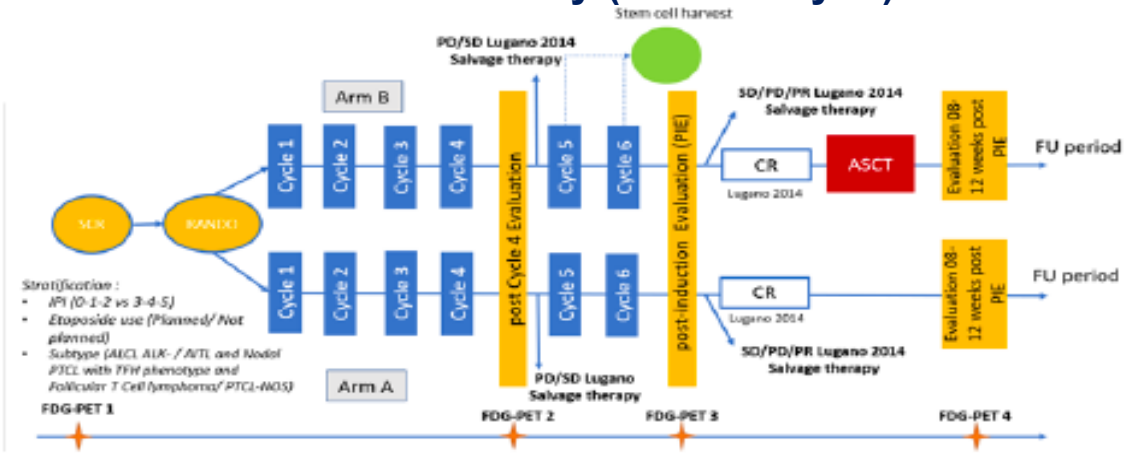
Schmitz, N et al. Blood. 2021;137(19):2646-2656

T cell NHL were AlloHCT is *probably* indicated (cases series & expert consensus).

- ✓ **Hepatosplenic T cell lymphoma on CR1:** dx with poor outcomes.
- ✓ **EATL/MEITL**
- ✓ **Adult T-cell leukemia/lymphoma (acute/lymphoma):** best in lymphoma subtype and in Asian pts.
- ✓ **Stage III/IV ENKTL or NK cell leukemia**: if on CR after asparaginase - based regimen.
- ✓ **R/R Mycosis fungoides/Sezary syndrome.**
- ✓ **SPTCL δγ:** in CR1.

Three ongoing phase III RTC: AutoHCT vs. No AutoHCT in CR1

TRANSCRIPT study (France- Lysa)



ECOG-ACRIN EA4232 (US and others)

N=204; 1st Patient in 8/2022

"Towards a better therapeutic option to reduce relapse in T-cell lymphoma"

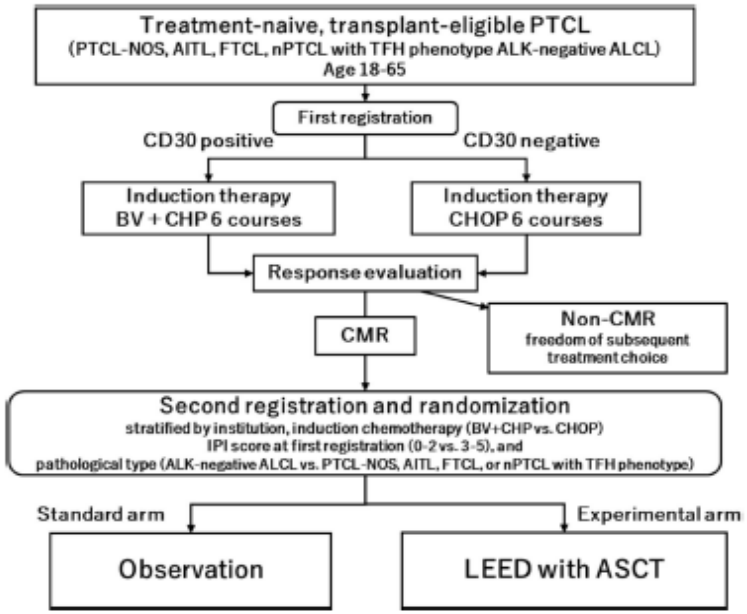
Now Enrolling: EA4232 for Patients With Peripheral T-Cell Lymphoma

February 19, 2025

B-cell lymphoma Lymphoma Non-Hodgkin lymphoma

EA4232 – A Randomized Phase III Study to Evaluate Benefits of Autologous Stem Cell Transplant in Patients with Peripheral T Cell Lymphoma who Achieved a First Complete Remission (CR1) Following Induction Therapy (PTCL-STAT)

JCOG2210
TRANSFER study (Japan)



So, should we be doing AutoHCT consolidation for all Nodal PTCL

Probably not!

- This is a practice widely adopted based on conflicting prospective and retrospective data: there is evidence for and against AutoHCT.
- There are *NO* randomized controlled trails: 3 RCT in the pipeline.
- Relapse risk with short OS remains high with frontline CHOP/CHOP-like chemotherapies alone. Hence, we do it. So..is the AutoHCT consolidation for the patient or for the oncologist?.
- At the end probably the biology is what matters: induction response (tx sensitive vs. tx refractory disease) rather than high dose chemotx + AutoHCT by itself.

Muchas gracias por su atención

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