So today’s will be the second part of our series about updates from the American Society of Hematology, with the highlights today focusing on lymphoid malignancy’s. As you probably know, we have six sessions within this series. We had the myeloma session last week and this actually has been recorded and available on the website. For those who could not attend last week, so feel free to check their website and we will also be including the slides for your own reference next week on.
January 29th will be the update on my load malignancy’s February 5th will be pediatric leukemia and acute for plastic leukemia and pediatric oncology. February 12 will be the classical or benign hematology and February 19 will be cell therapy and transplantation. All of those are on Fridays and at 12:00 PM noon. All of those sessions will be recorded and the slides will be available along with the recordings after the sessions. There will be CME credit for those who submit for it at the end of the entire series, and they’ll be a form for feedback.
where we would love to get your input about what you like and what you don’t like about the series and how we can improve it going forward. This is the first time we’re doing the hematology post ash highlights, and I hope to keep this going for the next few years with a combination of virtual and in person. For today’s session, it’s a pleasure to have three of our faculty presenting and we will be starting with Doctor Schelling, Kothari or Assistant Professor of Medicine who will go over aggressive lymphoid malignancy’s B cell type.
Doctor Francis Commentary will cover for us the indolent B cell malignancies and Doctor Turchin City.

Also Assistant Professor of Medicine will be covering the T cell malignancies, both indolent and aggressive.

At the end we will have a Q&A. The talks will be around 40 to 45 minutes in total and the last 15 minutes will have a question and answer session and this will be moderated by our Assistant Professor of Medicine Doctor Scott Huntington, who will be joining at the panel.
at the panel at the end.

So without further ado, I'd like to introduce Doctor Schelling Kothari, who will start us off. Thank you.

Thank you Amar.

So today I'm going to talk about updates from Astronium 20 focusing on aggressive B cell informers. One very heavily participated and we were one of the top accruing sites of oral triple combination of BTK number M, Tor inhibitor animite, and relapse refractory Richter's transformation and Dean over DL BCL and then...
I'll talk about more sooner to Zoom app, which is a T cell engaging bispecific antibody in aggressive lymphomas. I will not cover the other 3T cell engaging bispecific antibodies, but they were also presented at. Lastly roll off CNS prophylaxis in high risk DLP CL. So this is the first study is the once daily ordered triple combination of the three agents that I talked about in Richter’s transformation and in over...
diffuse large B cell lymphoma. This was presented at ASH 2020 by Doctor Mato.

Other preclinical studies. This was a national combination based on synthetic synthetic lethality.

As you can see on the left, the tumor volume of in mice drastically reduced in the triple combination arm in comparison to the vehicle or a single agent.

On the right you just see the B cell receptor pathway and other pathways that further help. In Onco Genesis an how the triple combination therapy could help prevent tumor resistance by targeting
different pathways together,

namely employment pathway AKT, mtor pathway, BTK pathway,

and I have four inhibition.

The key eligibility criteria for this 3 + 3 design is age more than 18.

Life expectancy more than 12 weeks, with other standard inclusion criteria.

The stage one, which is what we are presenting today is the BTK monotherapy,

like not in combination in one pill but three separate pills of DRM 12 which is the BTK inhibitor.

Novel became a bitter in combination with.

Letter from Little Mind and
everolimus and then eventually.

We are will start accruing

the Stage 2 instead of three,

which is a single pill with

three two different drugs,

and then eventually all three

and then eventually all three

drugs in one pill for patient

convenience and ease of use.

This is these other patient characteristics.

Here you can see that in

Richter’s transformation panel,

most patients had gotten our chop while in

DLB seal all patients had gotten our job.

So these patients were heavily treated.

Median prior therapies were three in

Victor’s transformation into Indy.
LBC, Elko hurt, so these were in general.
The point is that they were heavily pretreated patients.
At this is the data, so overall response rate in Richter’s transformation is 46%, which is quite phenomenal in such an aggressive disease,
Indian over DLB sell, it was 45%.
These are the CRN PR’s.
This is the waterfall plot, essentially looking at the percentage of tumor reduction.
Yellow being the LBC, Ellen blue Richter’s transformation.
You see that there is a significant tumor reduction in both the cohorts.

Cytopenias were present for sure. Given the triple combination neutropenia, 33% grade, 321% grade, 429% Grade 3 thrombocytopenia, and 8% Grade 4 thrombocytopenia. The non heme toxicities were low. You know 4% odds are only in one patient and there were no grade for side effects.

So the conclusion of this study was that the primary endpoint was met, that the triple combination therapy has an acceptable study safety profile. The main safety findings were expected and manageable, and currently we are
NOTE Confidence: 0.83318603
00:07:25.036 --> 00:07:28.270 accruing for the phase two study.
NOTE Confidence: 0.83318603
00:07:28.270 --> 00:07:30.085 It is underway targeting patients
NOTE Confidence: 0.83318603
00:07:30.085 --> 00:07:32.430 with novel agents exposed to relapse,
NOTE Confidence: 0.83318603
00:07:32.430 --> 00:07:34.735 refractory CLL and other non
NOTE Confidence: 0.83318603
00:07:34.735 --> 00:07:37.660 Hodgkin lymphoma’s. Um?
NOTE Confidence: 0.83318603
00:07:37.660 --> 00:07:40.452 The next study I will talk about is
NOTE Confidence: 0.83318603
00:07:40.452 --> 00:07:42.980 the single agent motion resume AB,
NOTE Confidence: 0.83318603
00:07:42.980 --> 00:07:45.584 which is a T cell engaging bispecific
NOTE Confidence: 0.83318603
00:07:45.584 --> 00:07:48.574 antibody and this was presented by Doctor
NOTE Confidence: 0.83318603
00:07:48.574 --> 00:07:50.829 Adam Orlowski from Brown University.
NOTE Confidence: 0.83318603
00:07:50.830 --> 00:07:53.290 And this was studied in the
NOTE Confidence: 0.83318603
00:07:53.290 --> 00:07:54.110 frontline setting,
NOTE Confidence: 0.83318603
00:07:54.110 --> 00:07:57.206 so treatment naive elderly unfit patients
NOTE Confidence: 0.83318603
00:07:57.206 --> 00:08:00.529 with diffuse large B cell lymphoma.
NOTE Confidence: 0.83318603
00:08:00.530 --> 00:08:02.651 Up to 30% of patients aged more
NOTE Confidence: 0.83318603
00:08:02.651 --> 00:08:05.106 than 25 years do not receive
NOTE Confidence: 0.83318603
00:08:05.106 --> 00:08:06.585 standard chemo immunotherapy,
NOTE Confidence: 0.83318603
00:08:06.590 --> 00:08:09.150 so there is a lot of unmet need
NOTE Confidence: 0.83318603
00:08:09.150 --> 00:08:11.565 and there is need to develop
NOTE Confidence: 0.83318603
00:08:11.565 --> 00:08:13.675 therapies which are less toxic
NOTE Confidence: 0.83318603
00:08:13.675 --> 00:08:16.449 more sooner to some apples in IgG,
NOTE Confidence: 0.83318603
00:08:16.450 --> 00:08:17.899 one CD20 CD.
NOTE Confidence: 0.83318603
00:08:17.899 --> 00:08:19.831 Three bispecific antibody that
NOTE Confidence: 0.83318603
00:08:19.831 --> 00:08:22.787 redirects T cells to engage and
NOTE Confidence: 0.83318603
00:08:22.787 --> 00:08:24.687 eliminate malignant B cells.
NOTE Confidence: 0.83318603
00:08:24.690 --> 00:08:27.222 So here Doctor ourselves keep presented
NOTE Confidence: 0.83318603
00:08:27.222 --> 00:08:29.752 early clinical data with single agent
NOTE Confidence: 0.83318603
00:08:29.752 --> 00:08:32.468 most Natuzzi my best first line therapy.
NOTE Confidence: 0.83318603
00:08:32.470 --> 00:08:34.110 The key inclusion criterias,
NOTE Confidence: 0.83318603
00:08:34.110 --> 00:08:34.955 treatment, naive,
NOTE Confidence: 0.83318603
00:08:34.955 --> 00:08:35.825 ideal BCL,
00:08:35.825 --> 00:08:38.870 patients or high grade B cell informers

00:08:38.951 --> 00:08:41.759 for patients who were 60 to 79 they

00:08:41.759 --> 00:08:44.677 they would have to have impairment in

00:08:44.677 --> 00:08:47.366 adls or inability to tolerate full.

00:08:47.366 --> 00:08:50.096 Those immunotherapy for whatever reason.

00:08:50.100 --> 00:08:52.185 Just like with all other

00:08:52.185 --> 00:08:53.436 bispecific antibody trials,

00:08:53.440 --> 00:08:56.562 typically it’s done in a ramp up

00:08:56.562 --> 00:08:59.729 fashion to decrease the chances and

00:08:59.729 --> 00:09:02.624 severity of cytokine release syndrome.

00:09:02.630 --> 00:09:05.924 Study design allowed pre face therapy

00:09:05.924 --> 00:09:08.664 with Prednisone and vincristine and

00:09:08.664 --> 00:09:11.430 responses estimates were done at interim

00:09:11.430 --> 00:09:15.205 cycle four in Cycle 8 and every six months.

00:09:15.210 --> 00:09:16.918 There are two doors.
Levels are studied 13.5 and 30 at day 15.

So you start with one milligram to milligram in 13.5 or 1, and then there was continued every 21 weeks.

Patient population is shown here. So 29 elderly unfit patients were enrolled in this study of eight patients less than 80 years old. Five patients had impairment in renal function. As you can see here, we do see clinically patients who have worse performance status, but given the clinical trial design,
it isn’t. It is quite understandable that they were enrolling. Quite a few. Almost 50% of Asia. With stage four disease and 50% elevated LDH, so overall a good real world characterization of patients here. Side effects were present, but relatively easy to manage, rash, fatigue, abdominal pain, infusion related reaction, decreased appetite and dry mouth. Cytokine release syndrome was also present, but the grade three and four CRS events were very low.
The best oral response rate was seen in 63.5% of patients and in the highest dose cohort, 30 milligrams. 50% of the patients achieved complete response. This is still sure the durability of response. The ones in green are the patients with complete response and most of them continue to enjoy the durable response rate. Immediate duration of response was not reached and this is only a 5.4 months of median follow-up, so clearly very early data, we need to wait for the data too much or.
So these are the authors conclusions early clinical data indicates that single agent is manageable and acceptable. Has acceptable safety profile. Encouraging efficacy was seen in this setting, although they did some correlated studies and they did not find any clear association with peripheral T cell activation and response. This paves way for either single agent or combination therapies with most senators. Mab in frontline setting, especially in elderly unfit. Patients. The third study I would like to
talk about is the predictive power of early sequential MRD monitoring in mental cell lymphoma following autologous stem cell transplantation with or without rituximab maintenance. This was presented by Doctor Callanan on behalf of the Lisa Group. The study was designed as such so the patients with classical mantle lymphoma had baseline MRD analysis followed by 4 cycles of our dehab transplant, MRD analysis and then you know high dose chemotherapy and then again post autologous transplant MRD analysis and
00:12:30.165 --> 00:12:32.613 then patients were either randomized to

00:12:32.613 --> 00:12:34.788 trucks or maintenance or observation.

00:12:34.788 --> 00:12:39.092 That type of MRD that was done was.

00:12:39.100 --> 00:12:39.935 Yeah,

00:12:39.935 --> 00:12:42.440 so IGHQ PCR.

00:12:42.440 --> 00:12:46.615 Looking at VDJ recombination region.

00:12:46.620 --> 00:12:48.948 Am the only talk about the first name

00:12:48.948 --> 00:12:51.336 given in interest of time is the

00:12:51.336 --> 00:12:53.548 prognostic impact of MRD status pre

00:12:53.548 --> 00:12:55.990 and post autologous stem cell transplant.

00:12:58.560 --> 00:13:00.947 This is the survival curve for pre

00:13:00.947 --> 00:13:02.720 autologous stem cell transplant,

00:13:02.720 --> 00:13:06.113 MRD status, so the one in red is MRD,

00:13:06.120 --> 00:13:08.731 negative green, blue is MRD positive so

00:13:08.731 --> 00:13:11.529 you can see that there is clear split
in PFS and OS with improvement in PFS
and OS in patients with MRD negativity.
And hence essentially,
this figure shows that there is a
prognostic value in doing MRD analysis.
The next question that the authors looked at was to look at impact of
maintenance therapy and MRD negative patients so the one the curve in
patients who got Rituxan.
red is patients who are an observation and were MRD negative so you can see that even though these patients.
and were MRD negative so you can see that even though these patients.
MRD negative that is a clear split and MRD negative that is a clear split and
difference with PFS OS benefit in patients who got rituximab maintenance. The same thing holds true for post autologous stem cell transplant, MRD also. Hence, the data is a bit humbling. Where we would you know would love to use MRD for therapeutic decisions, but it is pretty clear that maintenance rituximab still remains gold standard in classical mental cell lymphoma and it’s definitely a proof of concept that MRD is a good prognostic tool and should be used in addition to other tools such as pet imaging.
Lastly, I will talk about CNS prophylaxis in aggressive non Hodgkin lymphoma's. There were two abstracts presented in the oral session at ASH 2020 and both kind of guide us in different directions in terms of what we do in clinics as of today, but there is a big caveat that both are retrospective studies and I would say that we need more prospective data before we change our or practice patterns. Traditionally, the CNS relapse risk is calculated as CNS IPI scoring, which includes age, each status, LDH, stage of the patient. The number of external sites and kidney and adrenal involvement.
So patients who have intermediate or high CNS IPI score are thought to benefit from CNS prophylaxis, mainly high dose Ivy methotrexate. Rather than intrathecal methotrexate. The first study that I’ll talk about here. Their objective was to determine if high dose methotrexate reduced CNS relapse rates and this was based in Alberta, Canada. The design was retrospective include patients were 18 to 70 years of age with DL BCL treated between 2012 and 2019. These patients CNS involvement at diagnosis were excluded, as evident here. What is interesting is that at this
site where they had identified high risk patients only out of 326 identified high risk patients, only 115 had gotten high dose methotrexate for unknown reasons to under 911 patients. It's difficult to make any strong conclusions. But here high dose methotrexate was used was associated with younger age, more the next one external site could bring additional involvement and double hit lymphoma. Multivariate analysis is shown here.
where you can see that the Reflected high dose methotrexate did not show any improvement in CNS relapse and the same holds true for intensive immunochemotherapy such as our dose adjusted epoch or are high perceive. Add in comparison to R. Chop consolidative autologous stem cell transplantation was definitely showed more impact, although it did still cross the. Hazard ratio of 1. Here I’m showing multivariate analysis for PFS and OS. You can see that prophylactic high
dose methotrexate and intensive immunochemotherapy did not show any statistically significant difference, although there was difference in PFS and OS in consolidative, autologous stem cell transplanted patients. Authors conclusions were there CNS relapse affect 6% of DCL patients and risk of CNS relapse or similar with or without high dose methotrexate and as a proof of concept similar to rates reported in prior publications. Consolidative autologous stem cell transplantation or intensive immunochemotherapy trended to reduce CNS relapse of finding that is worthy of
further study in a prospective setting.

The other study that I will quickly go over before I hand over to Doctor said he is the CNS relapse by prophylaxis route.

So the this study was a US multi center retrospective study where they found that from all the centers with patients 100 and 1000 patients total 5.5% had overall CNS relapse rate of the patients who got into tickle. 5.3% had CNS relapse and of the patients who got intravenous prophylaxis.

Seven point, 1% had CNS relapse. So there there are many other
findings from this study, but in interest of time, I'll briefly discuss their conclusions. What I found interesting from this study was that not only CNS IPI scoring is important, but they also found a significant CNS relapse rate in patients who had involvement of testis or liver. So that's something that we should keep in mind in our clinics, but overall, you know CNS relapse rates were similar, following prophylaxis, either intrathecal or high dose methotrexate. They are going to do comparisons of single versus dual route so intra fickle. In high doses in the future and also
compare pro flexes and no pro flexes, which would I think be of interest to all of us? But overall outcomes for following CNS relapse remain poor without clear benefit from existing treatment options.

Thank you and please use the chat window for questions while we go along with more presentations.

Hi everyone. So I'll be presenting the update on primarily focusing on the Salem farmers. And. So just one at a couple of abstracts for indolent lymphoma. I have no relevant disclosures.
So just starting with a brief overview. You know, dealing with the challenging field of T cell informers. You know there were a few studies that were presented that are off. Note that I'd like to highlight it in frontline peripheral T cell lymphoma. A couple of studies including the combination romidepsin job and as I said in chapter. Presented in relapsed refractory PTCL we had an update. On developer and relapsed refractory CDCR. There was a novel interleukin antagonist BNZ one, and then I will shift gears in touch on a couple of CLL studies.
At the end.

So talking about property selling former really the frontline treatment of this aggressive disease is a major area of clinical need and.

You know, we most of us have been using CHOP or chop like regiments as the backbone chemotherapy backbone of frontline therapy. However, unfortunately, unlike diffuse large B cell lymphoma where our job has almost doubles, the CR rates that are seen with PTCL. So with PCL, which job we’re looking at CR rates of just 35 to 40% in the setting of an aggressive lymphoma.
This is really.

A very challenging situation.

Chip has been studied and shown to be

of some limited success in certain in

subtypes of patients in a subset of patients,

specially those younger than 60 years of age.

Much higher toxicity was seen in.

Higher age group and those adjusted are.

Suggested the bug is really considered

for more aggressive subtypes like ATL and

clinically aggressive presentations of PTCL.

It’s only recently that.

No one study has changed the

standard of care in CD.

TCL primarily in LCL Septics,
where there was the most robust data for the combination of brentuximab, CHP from the Echelon two trial. But outside of this you know other studies that have tried to build on the chop backbone have not been very successful. So with this I’m going to present two frontline trials for PTCL, one that was phase three conducted by the Lisa Group and a study conducted by the Lisa Group and again a frontline treatment of PTCL. It was presented by Doctor Vashi. So this study was based on the
Phase 1B prior Phase 1B data. That showed. Basically a phase two dose of 12 milligram per meter squared was the one that was associated with, you know, but the best safety data given on day one and data for 21 day cycle with CHOP given on day one. This particular this is this prior study did have. Basically they give 8 cycles and a total of about 37 patients were studied. So in this present study presented by Doctor Bashi, this was a randomized controlled trial phase three data where the army was chop alone,
and then I’m be had romidepsin,
given in addition to chop again
days 121 and eight at a dose of 12 milligram per meter squared.
The recommended phase two dose from the Phase 1B study.
So in the study population,
I do want to highlight that like many T cell lymphoma trials,
it did include a very heterogeneous population of all aggressive
histologies and then also looking at.
One thing that is relevant really here is that patients undergoing autologous or allogeneic transplant
planned as a consolidation

were excluded from this study,

which is really important to note because.

A lot of people,

even based on controversial data

you consider autologous stem cell

transplant for most patients who are

eligible in first remission after

The primary endpoint of this study

secondary endpoints included safety as

well as additional efficacy endpoints.

Again,

baseline characteristics I want to

highlight about half of the patients
NOTE Confidence: 0.83324665
00:26:18.918 --> 00:26:21.788 were of an ITL subtype and then,
NOTE Confidence: 0.83324665
00:26:21.790 --> 00:26:23.106 as expected,
NOTE Confidence: 0.83324665
00:26:23.106 --> 00:26:28.370 PCL and LCL where the other common subtypes.
NOTE Confidence: 0.83324665
00:26:28.370 --> 00:26:30.131 So here, unfortunately,
NOTE Confidence: 0.83324665
00:26:30.131 --> 00:26:32.479 like many other studies.
NOTE Confidence: 0.83324665
00:26:32.480 --> 00:26:34.958 But that have used chopped backbone.
NOTE Confidence: 0.83324665
00:26:34.960 --> 00:26:37.228 This was a this study did not
NOTE Confidence: 0.83324665
00:26:37.228 --> 00:26:39.379 meet its primary endpoint of
NOTE Confidence: 0.83324665
00:26:39.379 --> 00:26:41.587 improved progression free survival.
NOTE Confidence: 0.83324665
00:26:41.590 --> 00:26:44.269 The hazard ratio.
NOTE Confidence: 0.83324665
00:26:44.270 --> 00:26:49.262 For Rd shop versus R Chop Chop was
NOTE Confidence: 0.83324665
00:26:49.262 --> 00:26:53.635 appointed one with a P value of .096.
NOTE Confidence: 0.83324665
00:26:53.640 --> 00:26:54.694 And again,
NOTE Confidence: 0.83324665
00:26:54.694 --> 00:26:57.329 a subgroup analysis based on
NOTE Confidence: 0.83324665
00:26:57.329 --> 00:26:59.790 where this IPI factors.
NOTE Confidence: 0.83324665
As well as histologies did not really show any significant subsets that were that achieve greater benefit from this regimen. But patients with AI TL did have. There was a trend too. Some benefit in this particular population, again looking at the overall and the complete response rates, the complete response rate was 41% compared with 37%, which is consistent with historical data that we have from. Job. Again, without. Fighting any increase, additional efficacy. Rd job was more toxic.
A substantial number of patients were not able to receive all doses of romidepsin as well as job and also significant number of patients are received. Had to undergo jobs reduction or interruption because of increased toxicity, which is primarily increased. Haematological toxicity so really, in summary for this study, Roach up increase toxicity without improving efficacy in frontline improving treatment of PTCL possible future directions really is based on whether CHOP is the right backbone.
We do notes there. Drugs like romidepsin are more active in certain subtypes of PTCL like PTCL with T follicular helper, cell subtype and AI TL and so maybe's patient selection. And based on Histology and then there is another trial that is being. But it's basically has been proposed by NCI where they're looking at the combination of Doxorubicin 5 as a a sighted in oral and then romidepsin and develops it in T cell lymphoma. So those would be, you know, interesting things to look forward to.
Our next study that was presented in Frontline PTCL was oral, is cited in CC-486 plus job. This was presented by Doctor Rowan from Kernel. So again, this particular study actually highlighted the point that an oral PCL with T follicular helper cell subtype is associated with. These mutations are not only present in the two T follicular helper cell subtype is associated with.
subtype AI TL but also some PTCL, PTCL nosc and so that was the rationale for using is cited in.

As an epigenetic. So this they proceeded straight to a phase two study because there was Phase one data for safety of this combination from B cell lymphoma. Uh, the they do. They do include all PTCL subsets.

However they did prioritize enrollment of the T follicular helper cells upset and as you will see of the 20 patients 17 where of TFH subset here? The primary endpoint was complete.
NOTE Confidence: 0.69032043
00:30:33.535 --> 00:30:36.000 response rate and secondary endpoint
NOTE Confidence: 0.69032043
00:30:36.079 --> 00:30:38.689 was overall response rate and safety.
NOTE Confidence: 0.69032043
00:30:38.690 --> 00:30:41.690 They also looked at some genomic
NOTE Confidence: 0.69032043
00:30:41.690 --> 00:30:44.830 markers so this was an. Interesting.
NOTE Confidence: 0.801746250000001
00:30:47.220 --> 00:30:50.286 Study design and treatment regimen where
NOTE Confidence: 0.801746250000001
00:30:50.286 --> 00:30:53.726 initially CC 486 was given as a lead
NOTE Confidence: 0.801746250000001
00:30:53.726 --> 00:30:57.128 in from day minus 6 two day one for
NOTE Confidence: 0.801746250000001
00:30:57.128 --> 00:30:59.840 the first cycle and then subsequently
NOTE Confidence: 0.801746250000001
00:30:59.840 --> 00:31:03.848 from and subsequently four cycles.
NOTE Confidence: 0.801746250000001
00:31:03.850 --> 00:31:09.160 125 they received CC-486 on.
NOTE Confidence: 0.801746250000001
00:31:09.160 --> 00:31:11.728 Days 8 to 21 which basically
NOTE Confidence: 0.801746250000001
00:31:11.728 --> 00:31:14.509 so every so for cycle one.
NOTE Confidence: 0.801746250000001
00:31:14.510 --> 00:31:17.331 So this present this acted as priming
NOTE Confidence: 0.801746250000001
00:31:17.331 --> 00:31:20.760 phase for the next cycle of chemotherapy.
NOTE Confidence: 0.838634521428572
00:31:23.600 --> 00:31:27.744 So. After 21 patients that were enrolled,
20 were evaluable for response and of these almost half of them.

These patients actually did go on to receive autologous stem cell transplant or one patient who received Alo.

Here we see the overall CR response rate in these patients, and of all patients considering all patients as well as patients with PTCL default color helper cell subtype.

It was seen that 88% CR rate was seen in TFs subtype compared with 75% all comers. Really, majority of the patients were of TFs subtype.
Here are the results from the here.
The survival curves, so the median follow up of 15 months. One year PFS was 66% for all patients and one year overall survival was 80% and the corresponding numbers for TFs subtype were almost 70% and 94%. This was a relatively well tolerated regimen with expected side effects of. Aside opinion, specially neutropenia, but other than the hematological toxicity, there were no additional significant unexpected side effects. This study also looked at mutational analysis.
and it’s worth mentioning that they found that tattoo was associated with a favorable prognosis in this cohort of patients and DMD MT3. Oh was associated with worse overall survival. So this was a surprisingly promising study and of this combination. Again, this is very early data of only 20 patients. So this is a, you know, a combination that is being tested further. One particular study that is worth highlighting is this alliance study, which is actually going to be rich is going to include patients with a C30 negative.
00:33:41.420 --> 00:33:44.087 PTCL non alc else Histology and it

00:33:44.087 --> 00:33:47.652 has it had three comparator arms one

00:33:47.652 --> 00:33:50.572 including CC 4861 including development

00:33:50.572 --> 00:33:54.493 and the third one is Chopper show up here

00:33:54.493 --> 00:33:57.154 with these combination they are using

00:33:57.154 --> 00:34:00.400 the backbone of Cho Absolute as well.

00:34:00.400 --> 00:34:04.636 It'll be worth looking at the.

00:34:04.640 --> 00:34:10.930 We can see. Of this these combinations.

00:34:10.930 --> 00:34:13.695 Next, I'd like to go onto a

00:34:13.695 --> 00:34:15.830 study with Dibella sub again,

00:34:15.830 --> 00:34:17.458 another promising new agent

00:34:17.458 --> 00:34:19.086 and T cell lymphoma.

00:34:19.090 --> 00:34:21.255 This was in relapsed refractory

00:34:21.255 --> 00:34:23.420 peripheral T cell lymphoma and

00:34:23.496 --> 00:34:25.758 this was updated data from the

NOTE Confidence: 0.8612848
phase two Premier trial where they looking at those optimization and to go over that a little bit. This was presented by Doctor Pro from Northwest. Dualism is a dual appearance. We know that is FDA approved in relapsed refractory follicular lymphoma and CLL and the doors in these patients in these two diseases they approved doses 25 milligram vid when they tested this drug in T cell lymphoma. the Mac the MTD was 75 milligram PID vid and that was the dose.
NOTE Confidence: 0.7310265
00:35:01.324 --> 00:35:03.574 tested in T cell lymphoma which
NOTE Confidence: 0.7310265
00:35:03.651 --> 00:35:05.726 showed an overall response rate
NOTE Confidence: 0.7310265
00:35:05.726 --> 00:35:07.688 of 50% in relapsed refractory,
NOTE Confidence: 0.7310265
00:35:07.688 --> 00:35:10.988 PTCL and 33% in cutaneous T cell.
NOTE Confidence: 0.7310265
00:35:10.988 --> 00:35:11.530 Former.
NOTE Confidence: 0.7310265
00:35:11.530 --> 00:35:14.202 So the reason that was the reason for
NOTE Confidence: 0.7310265
00:35:14.202 --> 00:35:16.155 designing this dose optimization study
NOTE Confidence: 0.7310265
00:35:16.155 --> 00:35:18.585 was to see whether these patients
NOTE Confidence: 0.7310265
00:35:18.585 --> 00:35:20.727 truly need 75 milligrams pob ID.
NOTE Confidence: 0.7310265
00:35:20.730 --> 00:35:24.250 Or are we overtreating them?
NOTE Confidence: 0.7310265
00:35:24.250 --> 00:35:25.778 So the study design.
NOTE Confidence: 0.7310265
00:35:25.778 --> 00:35:28.045 Again, there was a dose optimization
NOTE Confidence: 0.7310265
00:35:28.045 --> 00:35:30.350 phase followed by those expansion phase.
NOTE Confidence: 0.7310265
00:35:30.350 --> 00:35:32.858 It did include.
NOTE Confidence: 0.7310265
00:35:32.860 --> 00:35:34.520 The various,
not subtypes that we discussed and. So develop the cohort one included patient develops if patients received develops.

If 25 milligram B ID and cohort two. They received 75 milligram vid as the starting dose. The primary endpoint was overall response rate with these two doses and then the secondary endpoints again looked at additional safety and efficacy endpoints. So here we are looking at cohort one and go to each had 13 evaluable patients. So the overall response rates. Sorry so the overall response rates. Seen here with the 25 milligram.
NOTE Confidence: 0.7310265
00:36:20.250 --> 00:36:23.862 I was basically 35 to 40% by the
NOTE Confidence: 0.7310265
00:36:23.862 --> 00:36:25.726 investigator and the committee
NOTE Confidence: 0.7310265
00:36:25.726 --> 00:36:28.472 and compared with 75 it was
NOTE Confidence: 0.7310265
00:36:28.472 --> 00:36:30.076 a higher response rate.
NOTE Confidence: 0.7310265
00:36:30.080 --> 00:36:33.827 Overall response rate of 54 to 62% and
NOTE Confidence: 0.7310265
00:36:33.827 --> 00:36:38.763 then similar trends being seen in CR rates.
NOTE Confidence: 0.7310265
00:36:38.770 --> 00:36:40.680 When they looked at looking
NOTE Confidence: 0.7310265
00:36:40.680 --> 00:36:42.590 here at the waterfall plot,
NOTE Confidence: 0.7310265
00:36:42.590 --> 00:36:45.033 it was seen that all the early
NOTE Confidence: 0.7310265
00:36:45.033 --> 00:36:47.376 dropouts based of you to progression
NOTE Confidence: 0.7310265
00:36:47.376 --> 00:36:50.225 were in the 25 milligram dose cohort,
NOTE Confidence: 0.7310265
00:36:50.230 --> 00:36:53.989 and therefore they did in those expansion
NOTE Confidence: 0.7310265
00:36:53.989 --> 00:36:56.948 phase they decided to go on with.
NOTE Confidence: 0.7310265
00:36:56.950 --> 00:36:59.995 Using a adoes starting with a dose
NOTE Confidence: 0.7310265
00:36:59.995 --> 00:37:03.008 of 75 milligrams vid for two cycles.
NOTE Confidence: 0.7310265
In those patients who had Disease Control, they would go on to receive 25 milligrams pob ID. And now with this combination of doses, an overall response rate of 50% was seen with the CR rate of 36% and so there for this was the overall those expansion phase, including included 25 patients and this is a swimmer plot showing the duration of response for these patients. Again, in terms of side effects, there were no unexpected side effects, and the combination of those was associated with 25 milligram.
NOTE Confidence: 0.8531919
00:37:55.219 --> 00:37:56.854 better tolerability overall.

NOTE Confidence: 0.7353012
00:37:58.930 --> 00:38:00.955 So again, this study highlights

NOTE Confidence: 0.7353012
00:38:00.955 --> 00:38:03.442 that develop is definitely an active

NOTE Confidence: 0.7353012
00:38:03.442 --> 00:38:05.776 agent in T cell lymphoma specific,

NOTE Confidence: 0.7353012
00:38:05.780 --> 00:38:08.410 especially in relapsed refractory PTCL.

NOTE Confidence: 0.7353012
00:38:08.410 --> 00:38:11.400 And that this going forward.

NOTE Confidence: 0.7353012
00:38:11.400 --> 00:38:15.320 This study provides data.

NOTE Confidence: 0.7353012
00:38:15.320 --> 00:38:18.728 For using this dual dose of 75 milligram,

NOTE Confidence: 0.7353012
00:38:18.730 --> 00:38:21.510 starting those with 25 milligram.

NOTE Confidence: 0.7353012
00:38:21.510 --> 00:38:25.895 Having a. Efficacy while balancing

NOTE Confidence: 0.7353012
00:38:25.895 --> 00:38:28.925 the toxicity of this single agent.

NOTE Confidence: 0.9055894
00:38:30.950 --> 00:38:35.989 So the last. See the last

NOTE Confidence: 0.9055894
00:38:35.989 --> 00:38:38.154 study in T cell lymphoma.

NOTE Confidence: 0.9055894
00:38:38.160 --> 00:38:41.528 Later, like to highlight is that and this

NOTE Confidence: 0.9055894
00:38:41.528 --> 00:38:45.538 is I'm going to go over this very briefly,
but this looked at knew novel
Interleukin antagonist.
Starting the call going ambition of
aisle to aisle 9 and I'll 15 by BNZ 1.
And this was studied in a Phase 1
two study and it was presented by
Doctor Klarfeld from City of Hope.
Today study different dose levels
two of two
milligram per kilogram was decided as the.
Phase two day for phase two dose based
on the PK PD data there was
this drug was not associated with any
major side effects and so therefore
there was no MTD and based on the.
So considering everything,
including the efficacy data they discarded around to, go ahead with the dose of 2 milligram per kilogram. So this I want to highlight the fact this is was a really highly refractory population of CCL patients with medium file median 5 prior lines of therapy and without any major side effects of an overall response rate of 52% was seen. A subset of patients which is definitely makes this a very promising agent to go further in studies. They do did highlight that you know being targeted blocker of aisle.
00:40:13.803 --> 00:40:15.849 to aisle 15 an aisle 9.
NOTE Confidence: 0.9055894

00:40:15.850 --> 00:40:19.290 It has a 3 prong.
NOTE Confidence: 0.9055894

00:40:19.290 --> 00:40:22.258 I can see where.
NOTE Confidence: 0.9055894

00:40:22.260 --> 00:40:25.460 Including direct anti tumor effect.
NOTE Confidence: 0.9055894

00:40:25.460 --> 00:40:27.962 Reduction of T regs and basically
NOTE Confidence: 0.9055894

00:40:27.962 --> 00:40:30.156 activation of anti tumor immune
NOTE Confidence: 0.9055894

00:40:30.156 --> 00:40:32.832 response and then also an anti
NOTE Confidence: 0.9055894

00:40:32.832 --> 00:40:34.680 inflammatory effect seen through
NOTE Confidence: 0.9055894

00:40:34.680 --> 00:40:37.272 I'll 15 blockade which is relevant
NOTE Confidence: 0.9055894

00:40:37.272 --> 00:40:40.258 for patients with PTCL who have a
NOTE Confidence: 0.9055894

00:40:40.258 --> 00:40:41.946 robust inflammatory reaction that
NOTE Confidence: 0.9055894

00:40:41.946 --> 00:40:44.689 leads to mobility in this disease.
NOTE Confidence: 0.79830873

00:40:47.080 --> 00:40:48.295 So with that,
NOTE Confidence: 0.79830873

00:40:48.295 --> 00:40:50.725 I’d like to quickly shipgirls too,
NOTE Confidence: 0.79830873

00:40:50.730 --> 00:40:53.970 and I will go through this very briefly.
NOTE Confidence: 0.79830873

00:40:53.970 --> 00:40:55.990 A couple of CLL abstracts,
so the first one is locked, so 305.

This is the next generation, highly selective non covalent BTK inhibitor in previous previously treated CLL SLL. And this was a Phase 1 two study presented by Doctor Matot. So lock the three or five. It’s as previously mentioned, the highly selective non covalent BTK inhibitor in it inhibits both wild type as well as C481 mutated BTK. So when we see look at patients who have a BTK resistance, the most common cause of that is because of the mutations in BTK.
And this drug does target that population of patients. But this was a these patients were heavily pretreated, including patients who had failed or discontinued, became a better for due to toxicity and also had this is a high risk population of patients with 17 P deletion and TP 53 mutation present present in a total of over 50% of patients. So the Phase one study, so the date data presented is from the Phase one study which included patients with CLL and SLL.
This loss of three or five safety profile was unique, as in the most common grade three side effect was actually fatigue and the typical. Side effects associated with other BTK innovators like atrial fibrillation. The side effects were not very prominent with locks or two or five. Since there was no DLT's, the maximum tolerated dose was not reached, and. Based on the PK data and the efficacy data dose of 200 milligrams was decided as the recommended phase two dose. Again, here it was in a heavily
pretreated well population.

Locks or three or five was found to be.

Continue to have.

Made up a very good efficacy in this.

Beta in this patient population and looking

So it was.

It was a very.

Good basically good response in

this without a lot of toxicity

in this patient population.

So lots of three or five was

active at all those levels,

and typical became a bitter or

related toxicities were not seen.

These responses were independent,
BTK mutation and even patients who had received BCL2 inhibitor. When I took LAX as well as three kinase inhibitors, did respond to this drug. So there's a safety and efficacy signal in CLL. Yeliz will be passed participating in the phase two portion of this study. Um? And then finally I just want to mention this particular study that was open at Yale in the past and that is umbrella civs and you've lytic seemab you two study which
00:44:22.968 --> 00:44:25.344 used a novel dual inhibitor ,
NOTE Confidence: 0.725289520333333
00:44:25.350 --> 00:44:27.320 three kinase and casein kind
NOTE Confidence: 0.725289520333333
00:44:27.320 --> 00:44:29.700 is money in a better and.
NOTE Confidence: 0.8235949
00:44:31.770 --> 00:44:34.269 The only issues with this study was
NOTE Confidence: 0.8235949
00:44:34.269 --> 00:44:36.527 that you know the comparator arm
NOTE Confidence: 0.8235949
00:44:36.527 --> 00:44:39.124 was a bit as a map chlorambucil,
NOTE Confidence: 0.8235949
00:44:39.130 --> 00:44:41.356 which is not really a very
NOTE Confidence: 0.8235949
00:44:41.356 --> 00:44:43.549 relevant in this day and age,
NOTE Confidence: 0.8235949
00:44:43.550 --> 00:44:45.746 But this is being studied further
NOTE Confidence: 0.8235949
00:44:45.750 --> 00:44:47.622 in combination both in frontline
NOTE Confidence: 0.8235949
00:44:47.622 --> 00:44:49.396 and relapsed refractory setting.
NOTE Confidence: 0.8235949
00:44:49.396 --> 00:44:51.268 That’s all I have.
NOTE Confidence: 0.8955445
00:44:53.740 --> 00:44:54.560 Tell everybody.
NOTE Confidence: 0.82034147
00:45:15.680 --> 00:45:16.550 Hello everybody, I’m going to go over the.
NOTE Confidence: 0.76212716
00:45:27.840 --> 00:45:32.224 Abstract relevant to heart killing
NOTE Confidence: 0.76212716
00:45:32.230 --> 00:45:34.556
form for the sake of time I’ll try to be brief and uncover only heart killing form at this time. So since the introduction of Brentuximab and Odin and checkpoint inhibitors in general, the paradigm of treatment for this disease is changed substantially, and. And this agent, that now you been used earlier and earlier in the course of the disease. So I will review the knew, the updates and the new data relevant these agents in first line in the relapsed refractory setting and maintenance.
Adding after transplant and in the elderly population. So let’s start with that. The five year update of action on one, as we all know, this is a. A very large open label, multicenter randomized phase. Three study that was initially presented at three years ago at the Ash meeting with a 2 year follow up over 1300 patients were randomized either to get brentuximab avd for six cycles or abvd, which is the standard treatment at city was performed after two cycles, but this was not a pet adapted approach. The primary endpoint of the
study was a modified PFS. Which is which included time to progression that and not completely response and use of subsequent chemotherapy. This modified PFS was meant to capture all the events that reflected the failure and were followed up with the serial imaging. The first data set that was presented from this dialogue after a follow up Papa to essentially two years showed a benefit in using a plus abvd A plus. Abd compared to a DVD with an absolute in benefit of 5%.
survival was 82 versus 77.

This came at the cost of significant increase in side effects.

Neutropenia 58% versus 45 from Europe.

But there was a big big one with a 67% incidents.

An informercial city was the one that was reduced due to the omission of the. Bleomycin.

So why this is the five year update is important.

We nearly all recurrences of Hodgkin lymphoma happen usually within five years,

so we think that PFS of five year is a good surrogate for cure.

an here the five year data we
NOTE Confidence: 0.8009456
00:48:19.433 --> 00:48:22.369 do see the PFS for the A plus.
NOTE Confidence: 0.8009456
00:48:22.370 --> 00:48:25.636 A vd is the red curve 82% of five
NOTE Confidence: 0.8009456
00:48:25.636 --> 00:48:28.150 years compared to 75% in the
NOTE Confidence: 0.8009456
00:48:28.150 --> 00:48:30.350 ABVD Ann and these disadvantage.
NOTE Confidence: 0.8009456
00:48:30.350 --> 00:48:32.320 And that was observed initially
NOTE Confidence: 0.8009456
00:48:32.320 --> 00:48:33.896 persisted overtime maybe depend.
NOTE Confidence: 0.8009456
00:48:33.900 --> 00:48:36.518 And this was how they threw in
NOTE Confidence: 0.8009456
00:48:36.518 --> 00:48:38.535 in patients achieving the path
NOTE Confidence: 0.8009456
00:48:38.535 --> 00:48:40.590 to negativity after two cycles.
NOTE Confidence: 0.8009456
00:48:40.590 --> 00:48:43.958 This hopper curb is 2 cars here compared
NOTE Confidence: 0.8009456
00:48:43.958 --> 00:48:46.788 to those that were at negative.
NOTE Confidence: 0.8009456
00:48:46.790 --> 00:48:49.838 So this was not a fat adapted approach.
NOTE Confidence: 0.8009456
00:48:49.840 --> 00:48:50.196 Again,
NOTE Confidence: 0.8009456
00:48:50.196 --> 00:48:52.688 the rates of if you remember the
NOTE Confidence: 0.8009456
00:48:52.688 --> 00:48:54.788 data from this work started.
NOTE Confidence: 0.8009456
Yes,

816 trial where patients had positive after two cycles received ended up receiving escalated Beacopp for six cycles. This PFS compared favorably to patients that received and much more aggressive course of treatment with a very high rate of secondary malignancies, applications are in the trial.

Or the essentially all the group favored the use of brentuximab plus avd.

So I think that was a highlighted and I think it’s very important to note is
that the peripheral neuropathy, which was one of the concern major concern when the initial results were released, has really improved or complete. Completely resolved in the vast majority of the patient and with an improvement that. Happened progressively over the course of the years and currently patients will receive one. Prefer neuropathy, have a really low grade of peripheral neuropathy, if any. Another thing that was noted in this five year update is that the rate of secondary malignancy. And the rate of successful
pregnancies compared well to the ABVD.

Um, so I think that with this five year update of the action and one, we have more compelling. Data now to support the use of this. Judgment and more widely in the upfront setting in hybrids, three and four patients. Um, I just want to briefly mention this. This trial, which was presented as a post office there is more that concept that was presented because this is an ongoing trial and we’re part of it at Yale. He said as we just reviewed the
addition of brentuximab window tint

addition of brentuximab window tint to avd improves PFS in advanced age,

but still 15 to 20% patients are relapse, relapse or refractory and BV

addition increases toxicity and require growth factors.

So this is the largest. North American Cooperative group

trials in Advanced Hodgkin study that is being conducted in collaboration with Canada and even with the collaboration of the children.

The theology.

Patrick Oncology group for Hodgkin is a study that is planning to enroll
987 patients and two randomized

NOTE Confidence: 0.8391127

them either to nivolumab avd versus

NOTE Confidence: 0.8391127

Brentuximab and Odin and Avd for six cycles.

NOTE Confidence: 0.8391127

The patients are going to be satisfied

NOTE Confidence: 0.8391127

based on the age Ipsy and intended

NOTE Confidence: 0.8391127

use of radiation and the primary

NOTE Confidence: 0.8391127

endpoint is progression free survival,

NOTE Confidence: 0.8391127

but a lot of other data are planned

NOTE Confidence: 0.8391127

to be gathered.

NOTE Confidence: 0.8391127

And in particular,

NOTE Confidence: 0.8391127

patient reported outcomes including fatigue,

NOTE Confidence: 0.8391127

neuropathy, scoring and quality of life.

NOTE Confidence: 0.8391127

So despite covid,

NOTE Confidence: 0.8391127

it looks like the TARDIS.

NOTE Confidence: 0.8391127

This trial is at the target of the

NOTE Confidence: 0.8391127

expected accrual and the results
of this trial are eagerly awaited.

So let’s move them to the salvage treatment.

What’s new in the salvage treatment?

So usually provision that are relapsed refractory after the first line of treatment of the general approach is to proceed to salvage chemotherapy. Usually platinum based or genocide happen based with an expected response rate in the 50-60% range with introduction of brentuximab concurrently or sequentially in the salvage regiment, we now expect responses in the 60-70% range, but the use of a print aksamit now is
getting limited by the fact that is used more widely in the first line and therefore alternative strategies that are being explored in this study. Specifically, is a face to study using bumper lizama in addition to our regular salvage treatment GD, which is one of the historically used salvage treatment as a second line for relapsed refractory article informal and eligibility dissipation that our love story factory. The first line of treatment. Primary endpoint is the PCR rate because that’s the most important
factor that we have to achieve after salvage treatment.

With Adima to pursue transplant.

So patients received the regular GBD combination and they ate with addition of populism on day one.

After two cycles of patients but positive patient back,

negative were allowed to pursue directly to transplant.

Otherwise everybody received 4 cycle and then that was evaluated at the end of treatment before the transplant.

So let’s see what happened.

There were 939 patients enrolled in this
study, with a median age of 38 years.

Importantly, most of the patients were advanced age of the initial diagnosis and the time of enrollment. When they relapsed, many patients had extranodal site, 1/3 of them extranodal sites of disease involvement, and the symptoms was present in 15% of the patient. Almost like 40% were refractory or either they relapsed in first year so very high risk patient.

received up front was primarily ABVD,
but some patients reserved receive the print axiom an and or Veeco approaches.

So after the first 2 cycles of pembrolizumab T 92% of the patients were found to be in a CR, and that’s unprecedented data for a salvage attachment. And after an additional 2 cycles and there was an additional CR rate, so the total see CR rate for this group of patients was 95 percent, proceeding to transplant and a good amount about a third of them preceded to maintenance with the print accent windowed in for a year.
Based on the accurate trial study, an none of the patient with limited follow up that we have now for this study at progression of disease. After the transplant. So why this this? This regiment works so well. It even outperformed what checkpoint plus chemotherapy does in first line. Sony Vollmer Avd does not have the same efficacy and one of the reasons that the others are looking into is if there is anything specific in this may be the synergy between the chemotherapy agent that is unique to checkpoint inhibitor in particular.
00:55:43.257 --> 00:55:45.647 the ability of selectively eliminate. 

00:55:45.650 --> 00:55:48.188 That my little derived suppressor cells, 

00:55:48.190 --> 00:55:50.788 so these exciting results poised base 

00:55:50.788 --> 00:55:53.688 for the next court on this study, 

00:55:53.690 --> 00:55:56.728 were actually the aim is to treat 

00:55:56.728 --> 00:55:59.607 everybody with Pembidge EBD for four cycles, 

00:55:59.610 --> 00:56:01.980 and then skip the Trump’s transplant 

00:56:01.980 --> 00:56:04.690 altogether and have the patient instead. 

00:56:04.690 --> 00:56:07.222 Being on maintenance with 13 cycles 

00:56:07.222 --> 00:56:08.488 of pembrolizumab maintenance. 

00:56:08.490 --> 00:56:12.765 So this is going to be very exciting to 

00:56:12.765 --> 00:56:17.340 see what the outcome of this patient is. 

00:56:17.340 --> 00:56:18.064 Moving forward, 

00:56:18.064 --> 00:56:19.874 let’s talk about consolidation after 

00:56:19.874 --> 00:56:21.392 transplant. What’s new in that? 

80
We know that patients at high risk of relapse after the transplant based on the characteristic primary refractory disease. As general involvement with symptoms of relapse order requiring more than one line of salvage treatment, not in CR, the time of transplant, they are higher risk of relapsing after transplant. So now there have been strategies that have been explored that to improve their PFS and. We all know about the if their trial where baby consolidation was utilized after atleast himself transplant.
with an improvement of the PFS, although with a significant drop off patients that could not complete the study due to neuropathy and another study that has been done used that embolism up in this setting. It was much smaller study only with 30 patient and patient population and better risk factors. So the apotheosis behind this study is to use the these two agents in combination Vivian Evil as consolidation and utilizing only eight cycles instead of the 16 cycles.
that was used in the fair trial,

and again, patients that were enrolled,

59 patients were enrolled in this trial and they were started on that.

These are the combination between evil about them,

between 30 and 6075 days after a transplant.

And I just want to point out that there was a lot of patients that could not complete the eight cycles that were planned. 59% could not complete the treatment plan and only 76% completed 8 cycles of either brentuximab or nivolumab.

So the take home message from this, that is that the treatment the maintenance after transplant is a much.
It is very difficult. Treatment too, for the patients to undergo as the side effects associated with the utilization of these agents in this setting. Is associated with an increased side effects, in particular immune related adverse event that we’re seeing up to 27% of the patients enrolled in this study. But nevertheless, it’s very encouraging that there is a 92% progression free survival in this high risk patients for relapse even despite their prior exposure either to BB and anti PD one.
And since I want to leave sometimes for question. I’m just going to mention briefly that this study think the merit of this study has been literally to enroll older patients which are under representative in most of the Hodgkin lymphoma trial. They have less prognosis and unfortunately it’s not a randomized trial, so patients were received either BV chemotherapy and just to be very, very quick. The take home messages that DV monotherapy has been with.
Very, very active, but as shown, the employer in prior studies, the PFS, was not very long, whereas when we’ve is combined with chemotherapy, the risks are outside effects increases, but it is associated with that much longer PFS. The only thing that they want I like is that the brand tax amount window 10 plus bendamustine armor was closed due to an excess of toxicity is not a good treatment in this elderly population.
And with this I left panel open for question.

Thank you all for presenting.

It was really quite comprehensive.

We’re going to go over our allotted hour and folks can stay in.

Will have a little question answer period.

While we’re on the topic of Hodgkin, that was really nice.

Presentation documents tomorrow.

How do you interpret and how do you take together?

You know the five year data

on the TV

and first line.

Incredible salvage options

for patients you know.
How do you put that together when you have someone that has advanced stage first line has come before you are you? You know the five year data compelling you to give more BVD or you still doing adaptive kind of raffle approach?

This is a very good question. Interesting isn’t it? It’s very I mean, one of the argument against intensifying Firstline treatment is that is so well tolerated and that we have so many, I mean salvage therapy works in our chicken. So in order to improve. A small percentage of the outcome of all the patients you end up
01:01:15.946 --> 01:01:17.920 like exposing a lot of patients
NOTE Confidence: 0.84333193
01:01:17.920 --> 01:01:20.370 to a more aggressive treatment.
NOTE Confidence: 0.84333193
01:01:20.370 --> 01:01:23.352 While you could have served salvage only
NOTE Confidence: 0.84333193
01:01:23.352 --> 01:01:26.610 to those that do not respond to a DVD.
NOTE Confidence: 0.84333193
01:01:26.610 --> 01:01:29.258 So, but I think that this this five
NOTE Confidence: 0.84333193
01:01:29.258 --> 01:01:32.315 year update I really like to see that
NOTE Confidence: 0.84333193
01:01:32.315 --> 01:01:34.377 the peripheral neuropathy was not
NOTE Confidence: 0.84333193
01:01:34.377 --> 01:01:36.562 was getting better progressively year
NOTE Confidence: 0.84333193
01:01:36.562 --> 01:01:39.606 after year and there were not major
NOTE Confidence: 0.84333193
01:01:39.606 --> 01:01:41.766 sequelae regarding that approach and.
NOTE Confidence: 0.84333193
01:01:41.770 --> 01:01:44.360 I really like the fact that there
NOTE Confidence: 0.84333193
01:01:44.360 --> 01:01:47.499 was no not an increase of
NOTE Confidence: 0.84333193
01:01:47.499 --> 01:01:51.950 secondary malignancy or of. The.
NOTE Confidence: 0.84333193
01:01:51.950 --> 01:01:53.900 Any bad outcome on pregnancies,
NOTE Confidence: 0.84333193
01:01:53.900 --> 01:01:57.104 but what I really think is the value of
NOTE Confidence: 0.84333193
01:01:57.104 --> 01:02:00.023 this approach as compared to PET adopted
one is that you don’t need to adopt it.
The PFS of patients that have a pet positive after 2 cycle is very good and is as good as the one that you get using escalated beacopp and especially population. That’s a really nice summary and I have very similar feelings of that, so it’s a complicated conversation that certainly patients should be presented both. Kind of adaptive Anet DVD and tailored to patient preferences and kind of a profile.
Not surprisingly, there are a number of questions about CNS prophylaxis of Doctor Kothari can step up to the plate, but you know how? How do you interpret the two abstracts that were presented oral session? I know there was a lot of kind of discussion during that meeting. Has that informed how you approach patients that are high risk for sinas that relapse? I think both abstracts kind of confused us further. To be honest. I mean it’s great set of data, especially the second set of data that I presented which is a multi institutional US.
You know study where there are more than thousand patients so you know the end was pretty good to have meaningful interpretation, but I think. Overall, I think my summary of, I think both abstracts would be that we need better, stronger frontline regiments to eradicate the real high risk DCL from get go because that eventually leads to a CNS relapse and that was shown through the Alberta, Canada study where patients who got intensive chemo immunotherapy.
CNS relapse rates.

And I guess the same could be told even you know the fact that autologous stem cell transplant was helpful. So overall, I would say that this these abstracts don’t change my practice of using high dose methotrexate with R, CHOP or most likely into fecal methotrexate with those adjusted epoch in high risk blpi atients. What I would say I think, which was interesting to note, is the liver involvement and testicular involvement, which we traditionally don’t.
Think of it that way, although there are some scattered papers about it, I think this is just to highlight that you know liver and testicle involvement also portends higher CNS relapse rate. Thank you for that and then Doctor Safi. Really, I think lots of exciting early phase studies in T cell. But certainly I think we need kind of larger randomized prospective data and basically everyone with T cell lymphoma should be on.
protocol, right? If we’re going to really start improving the outcomes, can you talk about some of the trials that we have open in T cell lymphoma either currently or in the future? We hope to kind of increase our accruals for.

Yes, absolutely. Actually we have a few exciting things coming down the Pike so we do use those adjusted epoch quite a bit for aggressive T cell lymphoma here at Yale. And so we have an IIT that is in the works which is funded and
basically the protocol is being developed. And that’s with those suggested epoch with mogamulizumab as frontline therapy in these patients and. So epoch does have overall, you know, looking at the chop response rates of like 3540% CR rates, epoch does tend to have a better overall response rate in CR rates in the 60% think you know 60% range. So the idea is really to try to get this. These patients and the deepest remission that you can and you know then then take them to transplants and. It’s really an excited study.
It is a phase two single arm study, but I think it’s a novel combination that we’re excited about.

As far as the present studies are concerned, the ones that we are still enrolling on, we have a couple of oral agents, including the DIETY study, which is basically an IDH one, IDH, two inhibitor.
And it has to be.

It has, you know, single agent activity in relapsed refractory T cell lymphoma, and definitely something that we’ve seen responses with, and sometimes it’s just the right treatment to try to get these patients in remission, take them to transplant.

Thank you so much and this was great. Amazing talks and thanks God for this the moderation. The questions as you heard a lot of exciting developments.
going on in the informal work.

We have a lot of actually active clinical trials,

so feel free to reach out to any further Informa experts or any questions about your patience or any referrals for clinical trials.

Reminder that a recording of this session will be available next week and along with the slides and should be an enduring material.

For your future reference, next week will have the by Lloyd updates and thank you so much everyone and have a great weekend.

Thank you.