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 malignancies. As you probably know, we have six sessions within this series. We had the myeloma session last week and this is 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 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. Components, so 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.
So without further ado, I’d like to introduce Doctor Schelling Kothari, who will start us off. Thank you.

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 rule 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 OncoGenesis how the triple combination therapy could help prevent tumor resistance by targeting...
00:04:29.884 --> 00:04:31.438 different pathways together, namely employment pathway AKT, mtor pathway, BTK pathway,
00:04:31.440 --> 00:04:33.240 00:04:33.240 --> 00:04:35.040 00:04:35.040 --> 00:04:37.290 and I have four inhibition.
00:04:37.290 --> 00:04:40.600 The key eligibility criteria for this
00:04:43.588 3 + 3 design is age more than 18. Life expectancy more than 12 weeks,
00:04:43.588 --> 00:04:47.676 00:04:47.680 --> 00:04:50.506 with other standard inclusion criteria.
00:04:50.510 --> 00:04:52.870 The stage one, which is what we are
00:04:52.870 --> 00:04:56.486 presenting today is the BTK monotherapy,
00:04:56.486 --> 00:05:02.444 like not in combination in one pill but three separate pills of DRM 12 which is the BTK inhibitor.
00:05:02.444 --> 00:05:05.388 Novel became a bitter in combination with.
00:05:05.388 --> 00:05:08.447 Letter from Little Mind and
00:05:08.450 --> 00:05:12.174 00:05:12.180 --> 00:05:15.480
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 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
than 25 years do not receive standard chemo immunotherapy, so there is a lot of unmet need and there is need to develop therapies which are less toxic more sooner to some apples in IgG, one CD20 CD. Three bispecific antibody that redirects T cells to engage and eliminate malignant B cells. So here Doctor ourselves keep presented early clinical data with single agent most Natuzzi my best first line therapy. The key inclusion criterias, treatment, naive, 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 at 13.5 and 30 at the 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 and 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. 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 so the patients with classical mantle lymphoma had baseline MRD analysis followed by 4 cycles of dehab, followed by pre autologous transplant, MRD analysis and then high dose chemotherapy and then again post autologous transplant MRD analysis and
then patients were either randomized to trucks or maintenance or observation. That type of MRD that was done was. Yeah, so IGHQ PCR. Looking at VDJ recombination region. Am the only talk about the first name given in interest of time is the prognostic impact of MRD status pre and post autologous stem cell transplant. This is the survival curve for pre autologous stem cell transplant, autologous stem cell transplant, MRD status, so the one in red is MRD, negative green, blue is MRD positive so 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
red is patients who got Rituxan.
red is patients who are an
observation and were MRD negative so you
can see that even though these patients.
MRD negative that is a clear split and
that is you know statistically significant
NOTE Confidence: 0.80789965
00:13:55.225 --> 00:13:58.217 difference with PFS OS benefit in
NOTE Confidence: 0.80789965
00:13:58.217 --> 00:14:00.707 patients who got rituximab maintenance.
NOTE Confidence: 0.80789965
00:14:00.710 --> 00:14:02.640 The same thing holds true
NOTE Confidence: 0.80789965
00:14:02.640 --> 00:14:04.184 for post autologous stem,
NOTE Confidence: 0.80789965
00:14:04.190 --> 00:14:06.438 cell transplant, MRD also.
NOTE Confidence: 0.80789965
00:14:06.438 --> 00:14:09.430 Hence, the data is a bit humbling.
NOTE Confidence: 0.80789965
00:14:09.430 --> 00:14:11.726 Where we would you know would love
NOTE Confidence: 0.80789965
00:14:11.726 --> 00:14:14.680 to use MRD for therapeutic decisions,
NOTE Confidence: 0.80789965
00:14:14.680 --> 00:14:17.648 but it is pretty clear that maintenance
NOTE Confidence: 0.80789965
00:14:17.648 --> 00:14:19.891 rituximab still remains gold standard
NOTE Confidence: 0.80789965
00:14:19.891 --> 00:14:22.597 in classical mental cell lymphoma and
NOTE Confidence: 0.80789965
00:14:22.597 --> 00:14:24.860 it’s definitely a proof of concept
NOTE Confidence: 0.80789965
00:14:24.860 --> 00:14:27.198 that MRD is a good prognostic tool
NOTE Confidence: 0.80789965
00:14:27.198 --> 00:14:29.984 and should be used in addition to
NOTE Confidence: 0.80789965
00:14:29.984 --> 00:14:32.458 other tools such as pet imaging.
NOTE Confidence: 0.83317065
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. There was no. 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. CNS prophylaxis, 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
00:19:35.608 --> 00:19:37.699 compare pro flexes and no pro flexes,
00:19:37.700 --> 00:19:39.716 which would I think be of interest
00:19:39.716 --> 00:19:41.490 to all of us?
00:19:41.490 --> 00:19:43.580 But overall outcomes for following
00:19:43.580 --> 00:19:46.227 CNS relapse remain poor without clear
00:19:46.227 --> 00:19:48.657 benefit from existing treatment options.
00:19:50.710 --> 00:19:52.810 Thank you and please use the chat
00:19:52.810 --> 00:19:54.765 window for questions while we go
00:19:54.765 --> 00:19:56.097 along with more presentations.
00:20:42.590 --> 00:20:47.316 Hi everyone. So I'll be presenting
00:20:47.316 --> 00:20:50.236 the update on primarily focusing
00:20:50.236 --> 00:20:55.080 on the Salem farmers. And.
00:20:55.080 --> 00:20:57.957 So just one at a couple of
00:20:57.957 --> 00:21:00.040 abstracts for indolent lymphoma.
00:21:00.040 --> 00:21:02.300 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. 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. 30 positive. TCL primarily in LCL Septics,
where which 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, two frontline treatment and so starting with Rd shop. So this was a phase three. 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 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 frontline treatment of PCL.

The primary endpoint of this study was progression free survival and 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 a 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

38
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. In summary for this study, Roach up increase toxicity without improving efficacy in frontline 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 based on Histology and then there is another trial that is being.

And that is yet to start accruing. But it’s basically has been proposed by NCI where they’re looking at the combination of Doxorubicin 5 as 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, 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 and this was the rational. These mutations are not only present in the two T follicular helper cell.
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.
00:30:33.535 --> 00:30:36.000 response rate and secondary endpoint
00:30:36.079 --> 00:30:38.689 was overall response rate and safety.
00:30:38.690 --> 00:30:41.690 They also looked at some genomic markers so this was an interesting.
00:30:41.690 --> 00:30:44.830 Study design and treatment regimen where
00:30:47.220 --> 00:30:50.286 initially CC 486 was given as a lead
00:30:50.286 --> 00:30:53.726 in from day minus 6 two day one for
00:30:53.726 --> 00:30:57.128 the first cycle and then subsequently
00:30:57.128 --> 00:30:59.840 so every so for cycle one.
00:30:59.840 --> 00:31:03.848 from and subsequently four cycles.
00:31:03.850 --> 00:31:09.160 125 they received CC-486 on.
00:31:09.160 --> 00:31:11.728 Days 8 to 21 which basically
00:31:11.728 --> 00:31:14.509 so every so for cycle one.
00:31:14.510 --> 00:31:17.331 So this present this acted as priming
00:31:17.331 --> 00:31:20.760 phase for the next cycle of chemotherapy.
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 in these 20 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 TF s 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 in patients with a C30 negative.
PTCL non alc else Histology and it has had three comparator arms one including CC 4861 including development and the third one is Chopper show up here with these combination they are using the backbone of Cho Absolute as well. It'll be worth looking at the. We can see. Of this these combinations. Next, I'd like to go onto a study with Dibella sub again, another promising new agent and T cell lymphoma. This was in relapsed refractory peripheral T cell lymphoma and this was updated data from the.
phase two Premier trial where they looking at those optimization and I'll go over that a little bit.

This was presented by Doctor Pro from Northwest.

So dualism is a dual appear three kindness Delta inhibitor. We know that is FDA approved in relapsed refractory, follicular lymphoma and CLL and the doors in these patients in

doses 25 milligram vid when they tested this dosin T cell lymphoma.

the Mac the MTD was 75 milligram PID vid and that was the dose
tested in T cell lymphoma which showed an overall response rate of 50% in relapsed refractory, PTCL and 33% in cutaneous T cell. So the reason was the reason for designing this dose optimization study to see whether these patients truly need 75 milligrams p o b ID. Or are we overtreating them? Again, there was a dose optimization phase followed by those expansion phase. It did include. The various,
not subtypes that we discussed and.

So develop the cohort one included patient

If 25 milligram B ID and cohort two.

They received 75 milligram

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.
I was basically 35 to 40% by the investigator and the committee and compared with 75 it was a higher response rate. Overall response rate of 54 to 62% and then similar trends being seen in CR rates. When they looked here at the waterfall plot, it was seen that all the early dropouts based on progression were in the 25 milligram dose cohort, and therefore they did in those expansion phase they decided to go on with. Using a dose starting with a dose of 75 milligrams for two cycles.
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 there for this was the overall those expansion phase, including 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 reduction 25 milligram was associated with
00:37:55.219 --> 00:37:56.854 better tolerability overall.
00:37:58.930 --> 00:38:00.955 So again, this study highlights that develop is definitely an active agent in T cell lymphoma specific, especially in relapsed refractory PTCL.
00:38:00.955 --> 00:38:03.442 So again, this study highlights that develop is definitely an active agent in T cell lymphoma specific, especially in relapsed refractory PTCL.
00:38:03.442 --> 00:38:05.776 And that this going forward.
00:38:05.780 --> 00:38:08.410 And that this going forward.
00:38:08.410 --> 00:38:11.400 This study provides data.
00:38:11.400 --> 00:38:15.320 For using this dual dose of 75 milligram, starting those with 25 milligram.
00:38:15.320 --> 00:38:18.728 For using this dual dose of 75 milligram, starting those with 25 milligram.
00:38:18.730 --> 00:38:21.510 Having a. Efficacy while balancing the toxicity of this single agent.
00:38:21.510 --> 00:38:25.895 Having a. Efficacy while balancing the toxicity of this single agent.
00:38:25.895 --> 00:38:28.925 So the last. See the last study in T cell lymphoma.
00:38:30.950 --> 00:38:35.989 So the last. See the last study in T cell lymphoma.
00:38:35.989 --> 00:38:38.154 Later, like to highlight is that 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 and it was those level 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 being targeted blocker of aisle.
to aisle 15 an aisle 9.

It has a 3 prong.

I can see where.

Including direct anti tumor effect.

Reduction of T regs and basically

activation of anti tumor immune response and then also an anti inflammatory effect seen through blockade which is relevant for patients with PTCL who have a robust inflammatory reaction that leads to mobility in this disease.

So with that,

I’d like to quickly ship girls too,

and I will go through this very briefly.

A couple of CLL abstracts,
00:40:55.990 --> 00:40:59.230 so the first one is locked, so 305.

00:40:59.230 --> 00:41:01.255 This is the next generation,

00:41:01.260 --> 00:41:04.200 highly selective non covalent BTK inhibitor

00:41:04.200 --> 00:41:06.760 in previous previously treated CLL SLL.

00:41:06.760 --> 00:41:09.651 And this was a Phase 1 two

00:41:09.651 --> 00:41:12.180 study presented by Doctor Matot.

00:41:12.180 --> 00:41:14.778 So lock the three or five.

00:41:14.780 --> 00:41:16.864 It’s as previously mentioned,

00:41:16.864 --> 00:41:19.990 the highly selective non covalent BTK

00:41:20.075 --> 00:41:22.409 inhibitor in it inhibits both wild

00:41:22.409 --> 00:41:25.369 type as well as C481 mutated BTK.

00:41:25.370 --> 00:41:27.351 So when we see look at patients

00:41:27.351 --> 00:41:29.279 who have a BTK resistance,

00:41:29.280 --> 00:41:31.716 the most common cause of that is

00:41:31.716 --> 00:41:34.099 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 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 at the overall response rate of 63%.

So it was. 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 data. 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
used a novel dual inhibitor, three kinase and casein kind.

The only issues with this study was that you know the comparator arm was a bit as a map chlorambucil, which is not really a very relevant in this day and age, at least for treatment naive patients. But this is being studied further in combination both in frontline and relapsed refractory setting. That’s all I have.

Tell everybody. Hello everybody, I’m going to go over the.
00:45:34.556 --> 00:45:38.004 form for the sake of time I'll try to be brief and uncover only heart killing form at this time.

00:45:41.357 --> 00:45:44.097 So since the introduction of Brentuximab and Odin and checkpoint inhibitors in general, the paradigm of treatment for this disease is changed substantially, and.

00:45:46.858 --> 00:45:49.458 earlier in the course of the disease.

00:45:49.460 --> 00:45:51.932 And this agent, that now you been used earlier and earlier in the course of the disease.

00:45:51.932 --> 00:45:53.990 So I will review the knew, the updates and the new data relevant to the uses regarding the using of 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 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, but this was not a pet adapted approach. The primary endpoint of the
The study was a modified PFS. Which included time to progression and not completely response. This modified PFS was meant to capture all the events that reflected the failure of frontline treatment and patient 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
00:48:19.433 --> 00:48:22.369 do see the PFS for the A plus.

00:48:22.370 --> 00:48:25.636 And is the red curve 82% of five

00:48:25.636 --> 00:48:28.150 years compared to 75% in the

00:48:28.150 --> 00:48:30.350 ABVD Ann and these disadvantage.

00:48:30.350 --> 00:48:32.320 And that was observed initially

00:48:32.320 --> 00:48:33.896 persisted overtime maybe depend.

00:48:33.900 --> 00:48:36.518 And this was how they threw in

00:48:36.518 --> 00:48:38.535 in patients achieving the path

00:48:38.535 --> 00:48:40.590 to negativity after two cycles.

00:48:40.590 --> 00:48:43.958 This hopper curb is 2 cars here compared

00:48:43.958 --> 00:48:46.788 to those that were at negative.

00:48:46.790 --> 00:48:49.838 So this was not a fat adapted approach.

00:48:49.840 --> 00:48:50.196 Again,

00:48:50.196 --> 00:48:52.688 the rates of if you remember the

00:48:52.688 --> 00:48:54.788 data from this work started.

68
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, and based on the profile and different risk characteristics. 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 in untreated stage, 4, 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 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

them either to nivolumab avd versus

Brentuximab and Odin and Avd for six cycles.

The patients are going to be satisfied

based on the age Ipsy and intended

use of radiation and the primary

endpoint is progression free survival,

but a lot of other data are planned

And in particular,

patient reported outcomes including fatigue,

neuropathy, scoring and quality of life.

So despite covid,

it looks like the TARDIS.

This trial is at the target of the

expected accrual and the results
NOTE Confidence: 0.8391127
00:52:02.697 --> 00:52:05.115 of this trial are eagerly awaited.
NOTE Confidence: 0.8391127
00:52:05.120 --> 00:52:08.240 So let’s move them to the salvage treatment.
NOTE Confidence: 0.8391127
00:52:08.240 --> 00:52:10.580 What’s new in the salvage treatment?
NOTE Confidence: 0.8391127
00:52:10.580 --> 00:52:13.112 So usually provision that are relapsed
NOTE Confidence: 0.8391127
00:52:13.112 --> 00:52:15.589 refractory after the first line of
NOTE Confidence: 0.8391127
00:52:15.589 --> 00:52:17.731 treatment of the general approach is
NOTE Confidence: 0.8391127
00:52:17.731 --> 00:52:20.078 to proceed to salvage chemotherapy.
NOTE Confidence: 0.8391127
00:52:20.080 --> 00:52:22.355 Usually platinum based or genocide
NOTE Confidence: 0.8391127
00:52:22.355 --> 00:52:24.630 happen based with an expected
NOTE Confidence: 0.8391127
00:52:24.709 --> 00:52:27.392 response rate in the 5060% range with
NOTE Confidence: 0.8391127
00:52:27.392 --> 00:52:29.056 introduction of brentuximab concurrently
NOTE Confidence: 0.8391127
00:52:29.056 --> 00:52:31.739 or sequentially in the salvage regiment,
NOTE Confidence: 0.8391127
00:52:31.740 --> 00:52:34.332 we now expect responses in the
NOTE Confidence: 0.8391127
00:52:34.332 --> 00:52:35.984 60 and 70% range,
NOTE Confidence: 0.8391127
00:52:35.984 --> 00:52:39.170 but the use of a print aksamit now is
NOTE Confidence: 0.8391127
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 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 to transplant.

So patients received the regular GBD combination and they want 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. population and the treatment they 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.

95% 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, 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.
the ability of selectively eliminate.

That my little derived suppressor cells, so these exciting results poised base

for the next court on this study, were actually the aim is to treat everybody with Pembridge EBD for four cycles, and then skip the Trump’s transplant altogether and have the patient instead. Being on maintenance with 13 cycles of pembrolizumab maintenance.

So this is going to be very exciting to see what the outcome of this patient is. Moving forward, let’s talk about consolidation after transplant. What’s new in that?
00:56:21.392 --> 00:56:23.556 We know that patients at high risk
NOTE Confidence: 0.7681064
00:56:23.556 --> 00:56:25.436 of relapse after the transplant
NOTE Confidence: 0.7681064
00:56:25.436 --> 00:56:27.531 based on the characteristic primary
NOTE Confidence: 0.7681064
00:56:27.531 --> 00:56:28.589 refractory disease.
NOTE Confidence: 0.7681064
00:56:28.590 --> 00:56:30.485 As general involvement with symptoms
NOTE Confidence: 0.7681064
00:56:30.485 --> 00:56:32.380 of relapse order requiring more
NOTE Confidence: 0.7941296
00:56:32.445 --> 00:56:34.395 than one line of salvage treatment,
NOTE Confidence: 0.7941296
00:56:34.400 --> 00:56:36.934 not in CR, the time of transplant,
NOTE Confidence: 0.7941296
00:56:36.940 --> 00:56:39.844 they are higher risk of
NOTE Confidence: 0.7941296
00:56:38.755 --> 00:56:40.175 relapsing after transplant.
NOTE Confidence: 0.7941296
00:56:38.755 --> 00:56:42.154 So now there have been strategies
NOTE Confidence: 0.7941296
00:56:42.154 --> 00:56:44.475 that have been explored that
NOTE Confidence: 0.7941296
00:56:44.095 --> 00:56:45.780 to improve their PFS and.
NOTE Confidence: 0.7941296
00:56:45.780 --> 00:56:48.284 We all know about the if their trial
NOTE Confidence: 0.7941296
00:56:48.284 --> 00:56:50.882 where baby consolidation was was utilized
NOTE Confidence: 0.7941296
00:56:50.882 --> 00:56:52.778 after at least himself transplant
NOTE Confidence: 0.7941296
00:56:52.778 --> 00:56:55.330 with an improvement of the PFS,
NOTE Confidence: 0.7941296
00:56:55.330 --> 00:56:57.320 although with a significant there
NOTE Confidence: 0.7941296
00:56:57.320 --> 00:57:00.104 was a 33% and drop off patients
NOTE Confidence: 0.7941296
00:57:00.104 --> 00:57:02.480 that could not complete the study
NOTE Confidence: 0.7941296
00:57:02.502 --> 00:57:04.502 due to neuropathy and another
NOTE Confidence: 0.7941296
00:57:04.502 --> 00:57:07.303 study that has been done used that
NOTE Confidence: 0.7941296
00:57:07.303 --> 00:57:09.258 embolism up in this setting.
NOTE Confidence: 0.7941296
00:57:09.260 --> 00:57:11.384 It was much smaller study only
NOTE Confidence: 0.7941296
00:57:11.384 --> 00:57:13.387 with 30 patient and patient
NOTE Confidence: 0.7941296
00:57:13.387 --> 00:57:15.927 population and better risk factors.
NOTE Confidence: 0.7941296
00:57:15.930 --> 00:57:18.048 So the apotheosis behind this study
NOTE Confidence: 0.7941296
00:57:18.048 --> 00:57:20.915 is to use the these two agents
NOTE Confidence: 0.7941296
00:57:20.915 --> 00:57:23.220 in combination Vivian Evil as
NOTE Confidence: 0.7941296
00:57:23.220 --> 00:57:25.034 consolidation and utilizing only
NOTE Confidence: 0.7941296
00:57:25.034 --> 00:57:27.904 eight cycles instead of the 16 cycles
NOTE Confidence: 0.7941296

82
that was used in the fair trial, and again, patients that were enrolled, 59 patients were enrolled in the 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 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

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

I mean it's not a randomized trial,

so patients were received either BV

in monotherapy or in combination with

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 combined with chemotherapy, the risks are outside effects increases, but it is associated with that much longer PFS. The only thing that they want is that the brand tax amount 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
like exposing a lot of patients to a more aggressive treatment. While you could have served salvage only to those that do not respond to a DVD. So, but I think that this five year update I really like to see that the peripheral neuropathy was not getting better progressively year after year and there were not major sequelae regarding that approach and. I really like the fact that there was no not an increase of secondary malignancy or. Any bad outcome on pregnancies, but what I really think is the value of this approach as compared to PET adopted
01:02:00.023 --> 01:02:03.617 one is that you don’t need to adopt it.

01:02:03.620 --> 01:02:06.357 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.

01:02:08.802 --> 01:02:12.055 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.

01:02:14.365 --> 01:02:16.790 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 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 both abstracts would be that we need better, stronger frontline regiments to eradicate the real high risk DCL from the 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. The trend was towards better
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
01:04:48.906 --> 01:04:50.520 protocol, right? If we’re
NOTE Confidence: 0.82776004
01:04:50.520 --> 01:04:51.729 going to really
NOTE Confidence: 0.82776004
01:04:51.730 --> 01:04:52.939 start improving the
NOTE Confidence: 0.82776004
01:04:52.940 --> 01:04:54.950 outcomes, can you talk about
NOTE Confidence: 0.82776004
01:04:54.950 --> 01:04:56.159 some of the
NOTE Confidence: 0.82776004
01:04:56.160 --> 01:04:59.380 trials that we have open in T cell
NOTE Confidence: 0.82776004
01:04:59.380 --> 01:05:01.510 lymphoma either currently or in
NOTE Confidence: 0.82776004
01:05:01.510 --> 01:05:03.850 the future that? We hope to kind
NOTE Confidence: 0.7535696
01:05:03.850 --> 01:05:05.120 of increase our accruals for.
NOTE Confidence: 0.7535696
01:05:06.930 --> 01:05:09.080 Yes, absolutely. Actually we have.
NOTE Confidence: 0.7535696
01:05:09.080 --> 01:05:11.978 We do have a few exciting things
NOTE Confidence: 0.7535696
01:05:11.978 --> 01:05:15.298 coming down the Pike so we do use
NOTE Confidence: 0.7535696
01:05:15.298 --> 01:05:18.293 those adjusted epoch quite a bit for
NOTE Confidence: 0.7535696
NOTE Confidence: 0.7535696
01:05:21.520 --> 01:05:24.630 And so we have an IIT that is in the
NOTE Confidence: 0.7535696
01:05:24.720 --> 01:05:28.171 works which is 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 35-40% 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 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 additional study would be in CD 30 positive patients looking at the combination of rituximab with pembrolizumab and that’s kind of an idea that I wrote at Vanderbilt that we’re hoping to open. In the coming months as well. 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.