POST-NEW ORLEANS 2022
Novità dal Meeting della Società Americana di Ematologia

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Milano
Teatro Dal Verme
2-3-4 Febbraio 2023

2° SESSIONE - LINFOMA II	M. MARTELLI
15.55 Stato dell'arte	M. MARTELLI
16.05 Linfomi indolenti	M. LADETTO
16.25 Linfomi aggressivi di derivazione B linfocitaria	A.J.M. FERRERI
16.45 Terapie di salvataggio con anticorpi monoclonali	L. RIGACCI
17.05 Discussione	

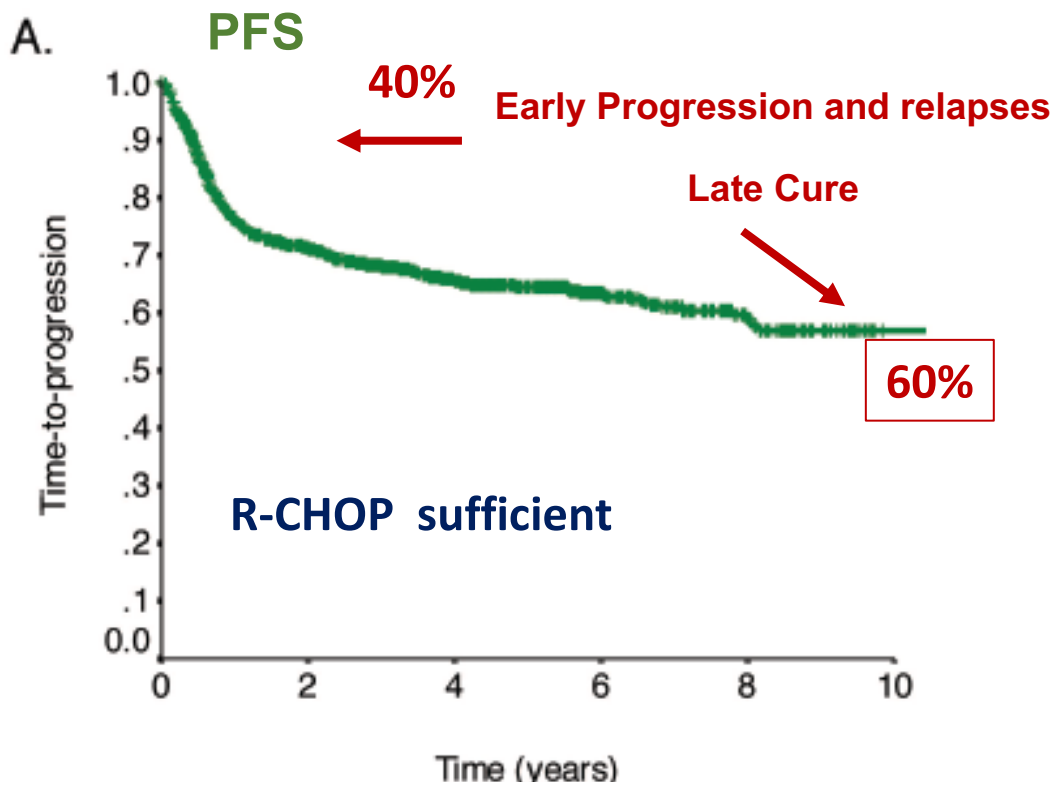
Stato dell'arte

Maurizio Martelli
Ematologia Sapienza Roma

DICHIARAZIONE Maurizio Martelli

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
Roche					X	X	
Gilead					X	X	
Novartis						X	
Takeda						X	
Eusapharma					X	X	
Incyte					X	X	
Janssen					X	X	
BMS						X	
Beigene					X		
Alexion	x						

Heterogeneity of outcomes in DLBCL treated with R-CHOP



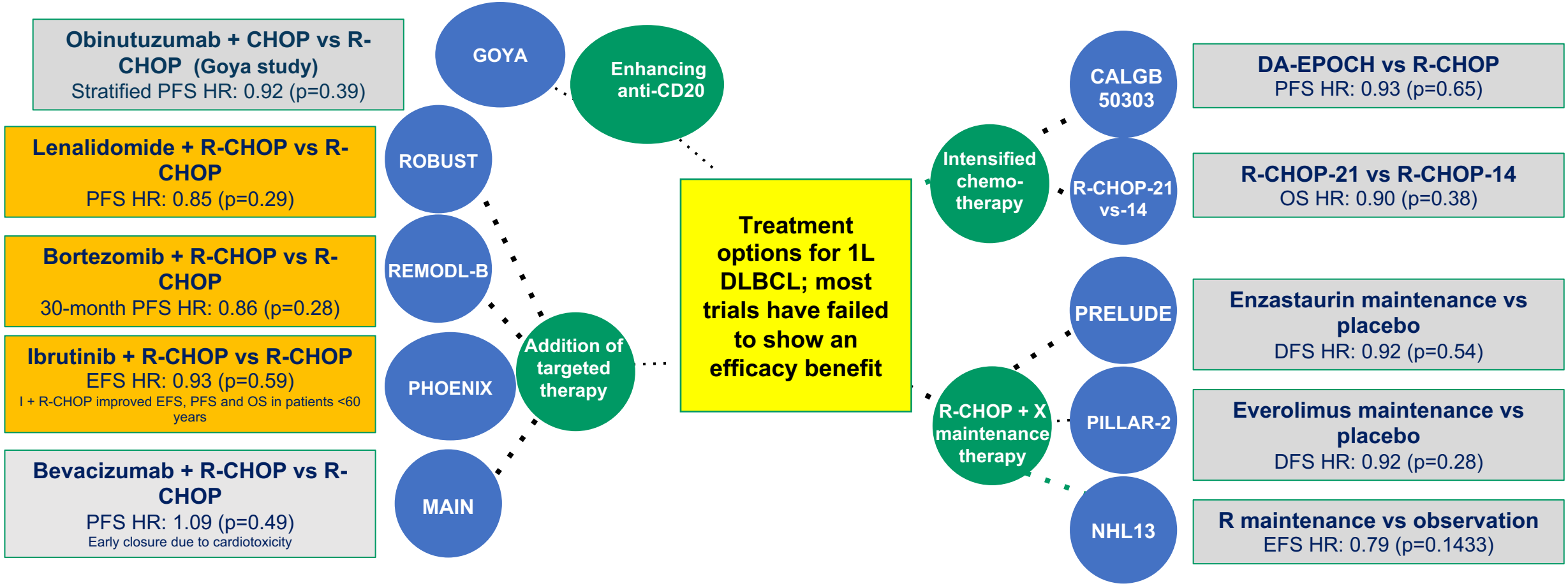
Patients with DLBCL treated with R-CHOP-21 at BCCA (n = 1,476)

R-CHOP is insufficient in 40% of DLBCL:

- **Clinical factors**
  - IPI (R-IPI)
- **GEP**
  - ABC vs GCB
- **Protein expression**
  - MYC and BCL2
- **TP-53 expression**
- **Chromosomal alterations**
  - MYC, BCL2, BCL6
- **Deep sequencing mutation/combined expression analysis**

Sehn LH and Salles G N.Engl.J.Med 2021

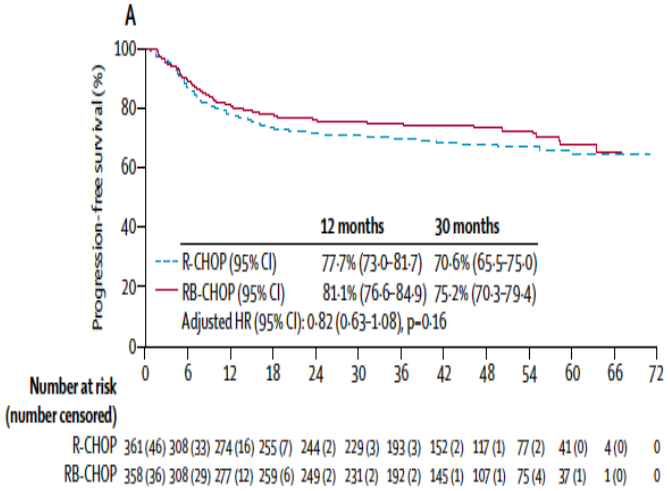
Treatment options to improve first line DLBCL



R-CHOP+ X targeting ABC: results of phase III trial

R-CHOP + Bortezomib

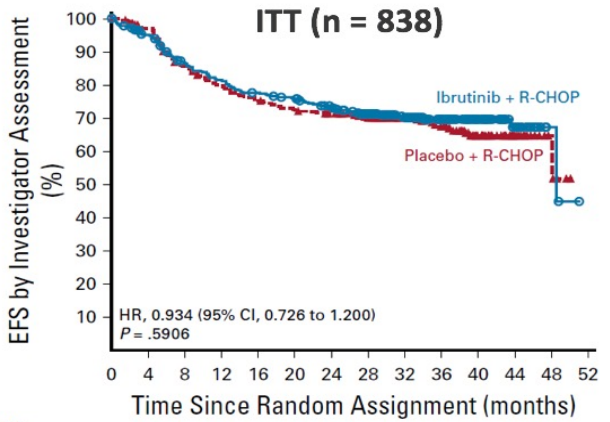
ReMoDL- B



Davies A, et al. Lancet Oncol 2019;

R-CHOP + Ibrutinib

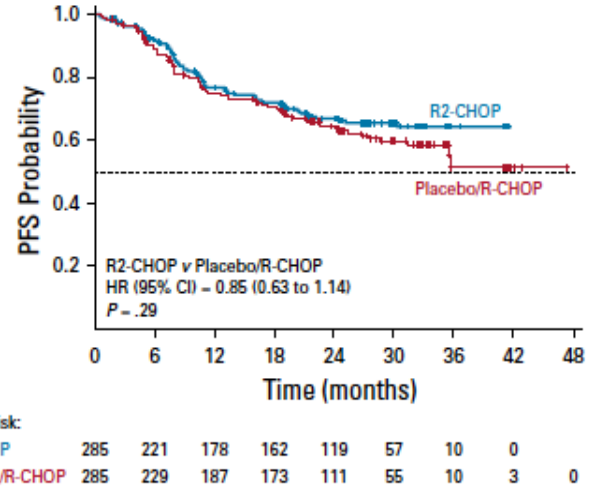
Phoenix



Younes A, et al. J Clin Oncol 2019;

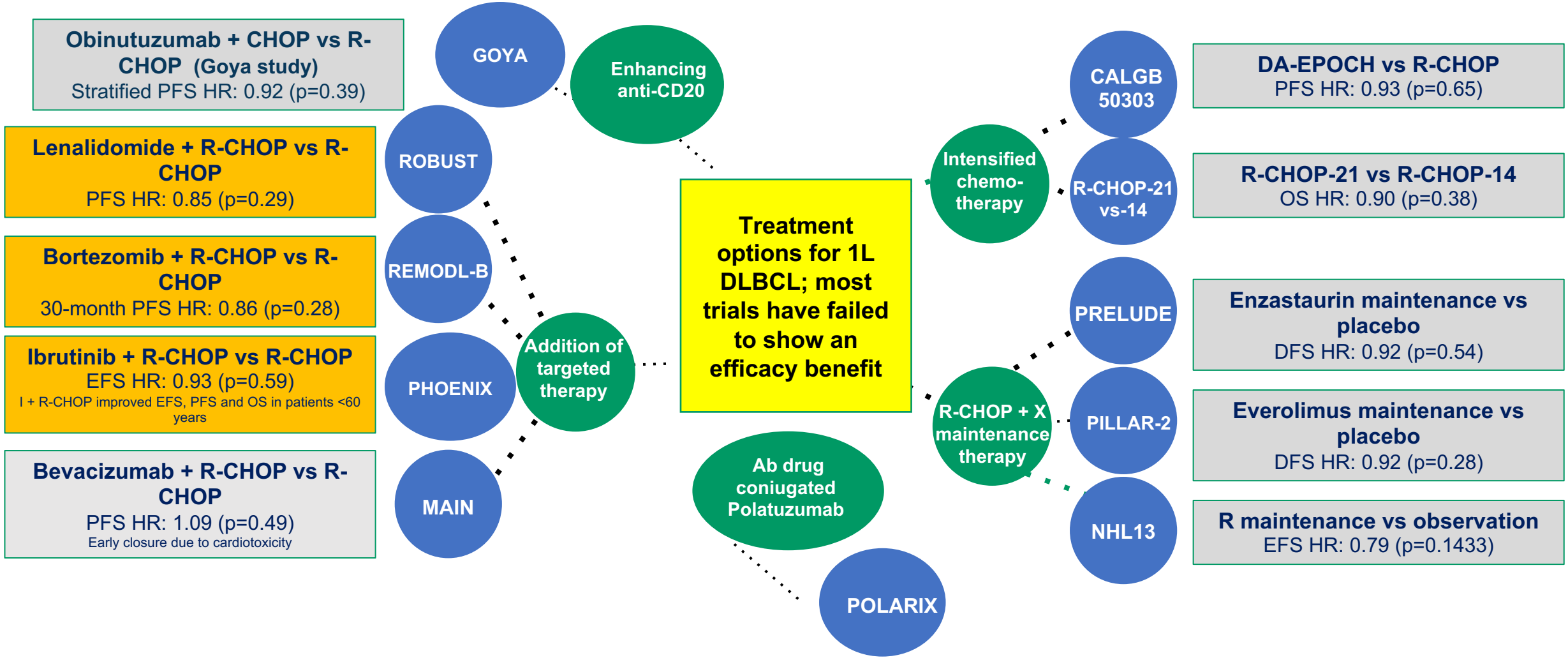
R-CHOP + Lenalidomide

Robust



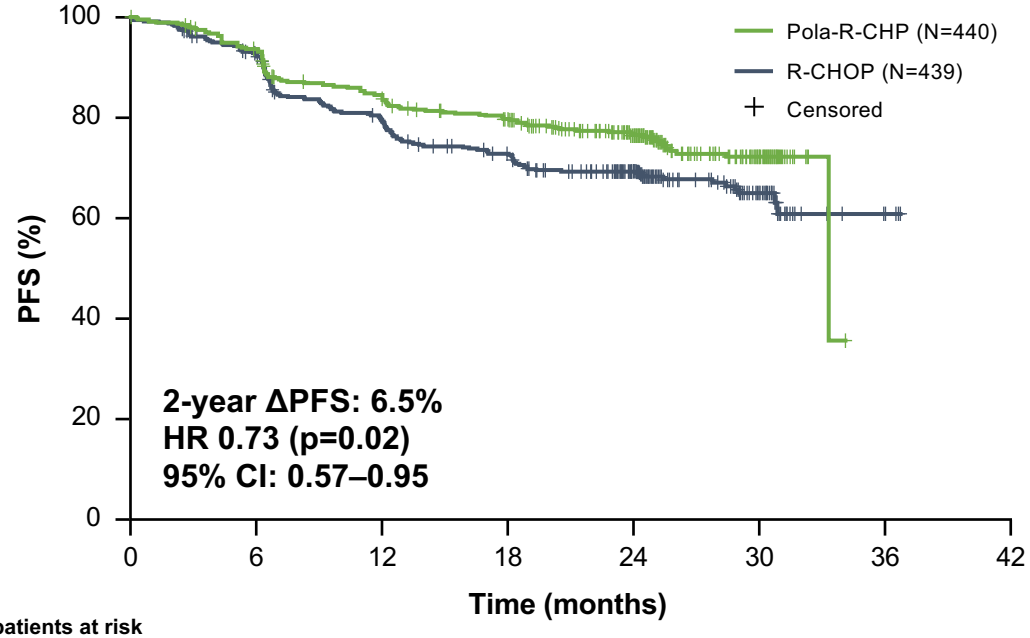
Nowakowski G, et al. J Clin Oncol 2021.

Treatment options to improve first line DLBCL



POLARIX: Polatuzumab Vedotin + R-CHP vs R-CHOP
Primary endpoint: PFS

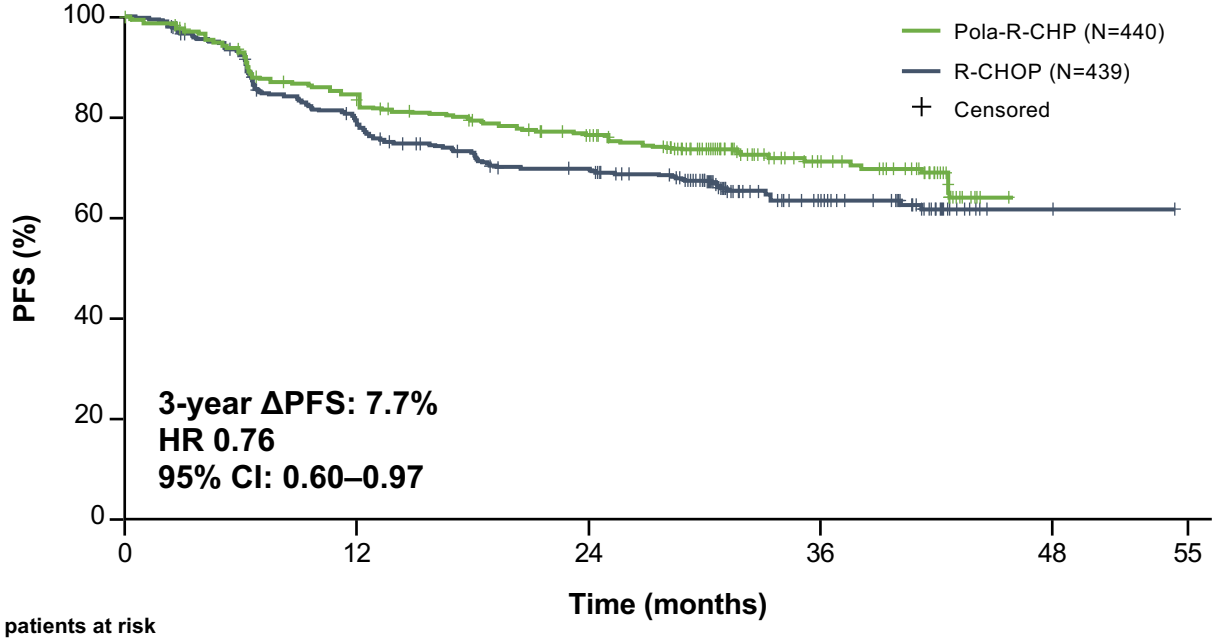
Primary analysis (CCOD: June 28, 2021)[1]
Median follow-up: 28.2 months



No. of patients at risk

Pola-R-CHP	440	404	353	327	246	78	0	0
R-CHOP	439	389	330	296	220	78	3	0

Updated results (CCOD: June 15, 2022)
Median follow-up: 39.7 months



No. of patients at risk

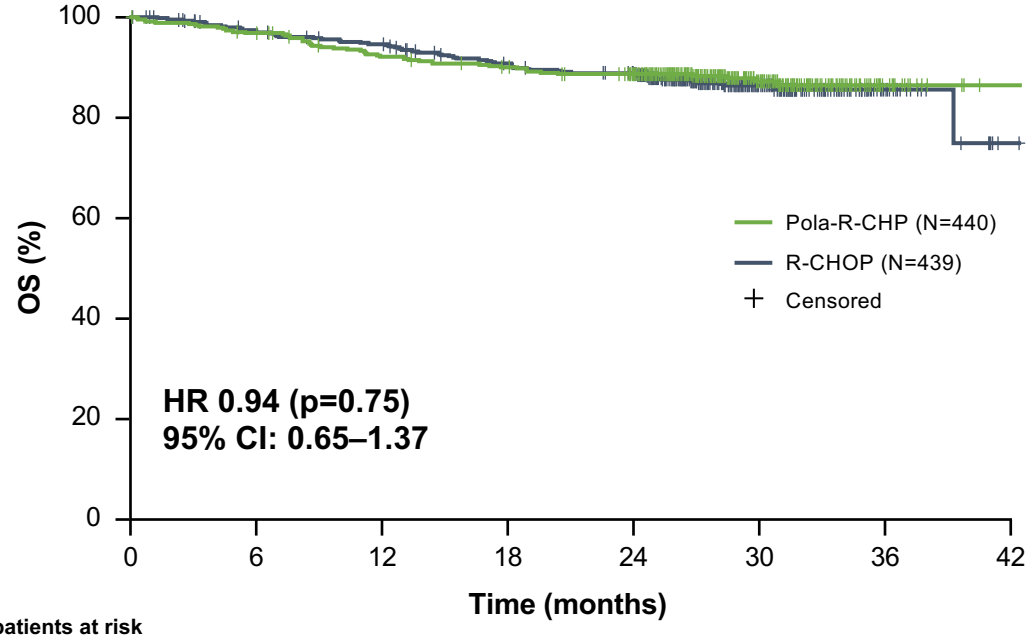
Pola-R-CHP	440	405	354	331	313	242	103	66	0	0
R-CHOP	439	390	331	300	284	222	94	59	2	1

- Best overall response rate: **95.9 %** vs **94.1%**
  - Complete response rate: **86.6%** vs **82.7%**

Tilly H, et al. N Engl J Med 2022;386:351–63.

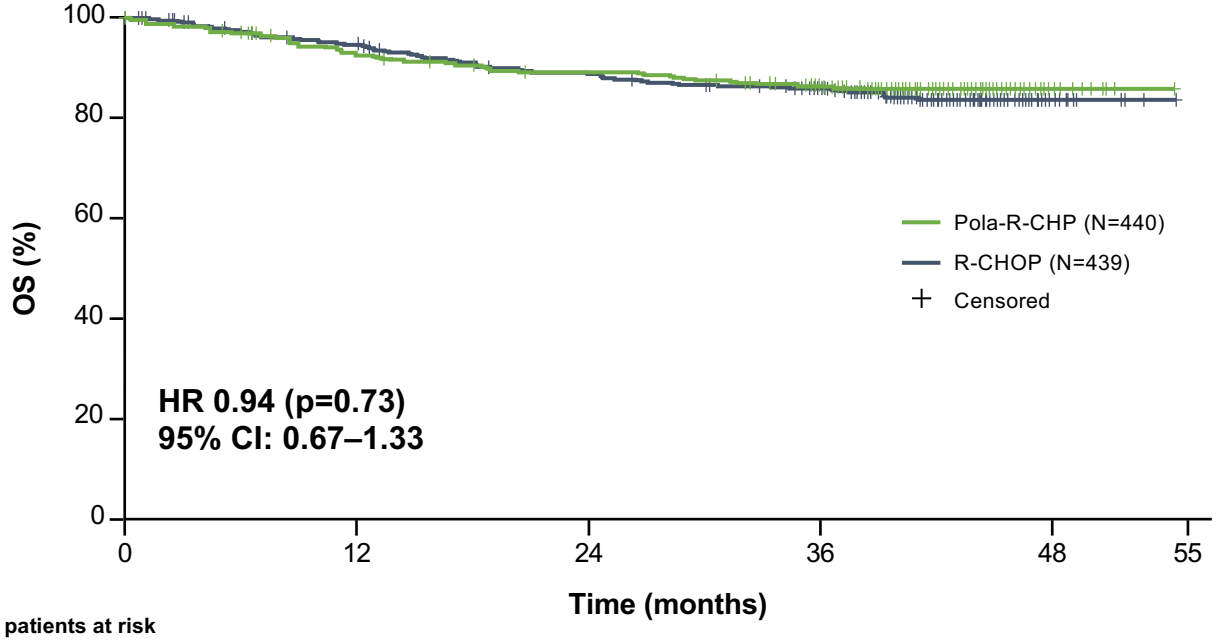
POLARIX: Polatuzumab Vedotin + R-CHP vs R-CHOP
No difference for OS

Primary analysis (CCOD: June 28, 2021)[1]
Median follow-up: 28.2 months



No. of patients at risk								
Pola-R-CHP	440	423	397	384	362	140	15	1
R-CHOP	439	414	401	376	355	132	20	1

Updated results (CCOD: June 15, 2022)
Median follow-up: 39.7 months



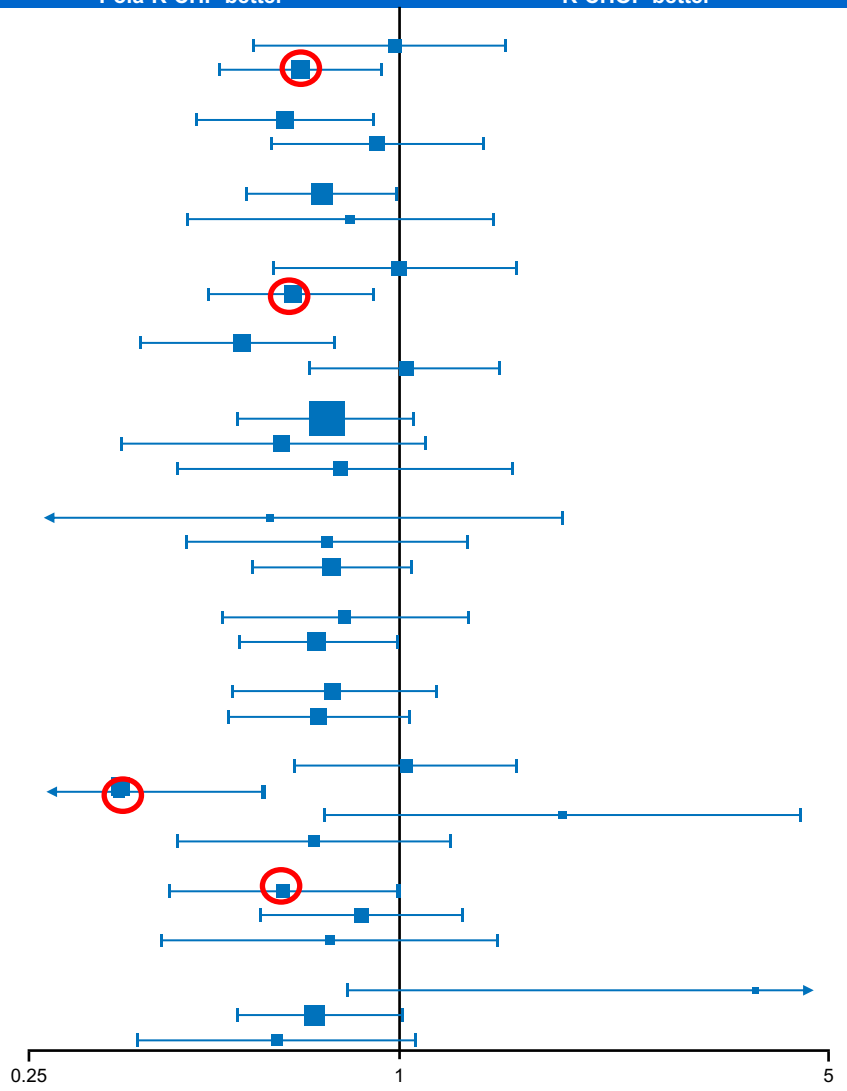
No. of patients at risk										
Pola-R-CHP	440	423	398	387	379	371	338	129	13	1
R-CHOP	439	415	403	382	372	361	329	124	18	1

No new safety signals have been identified with longer follow-up compared with the primary analysis

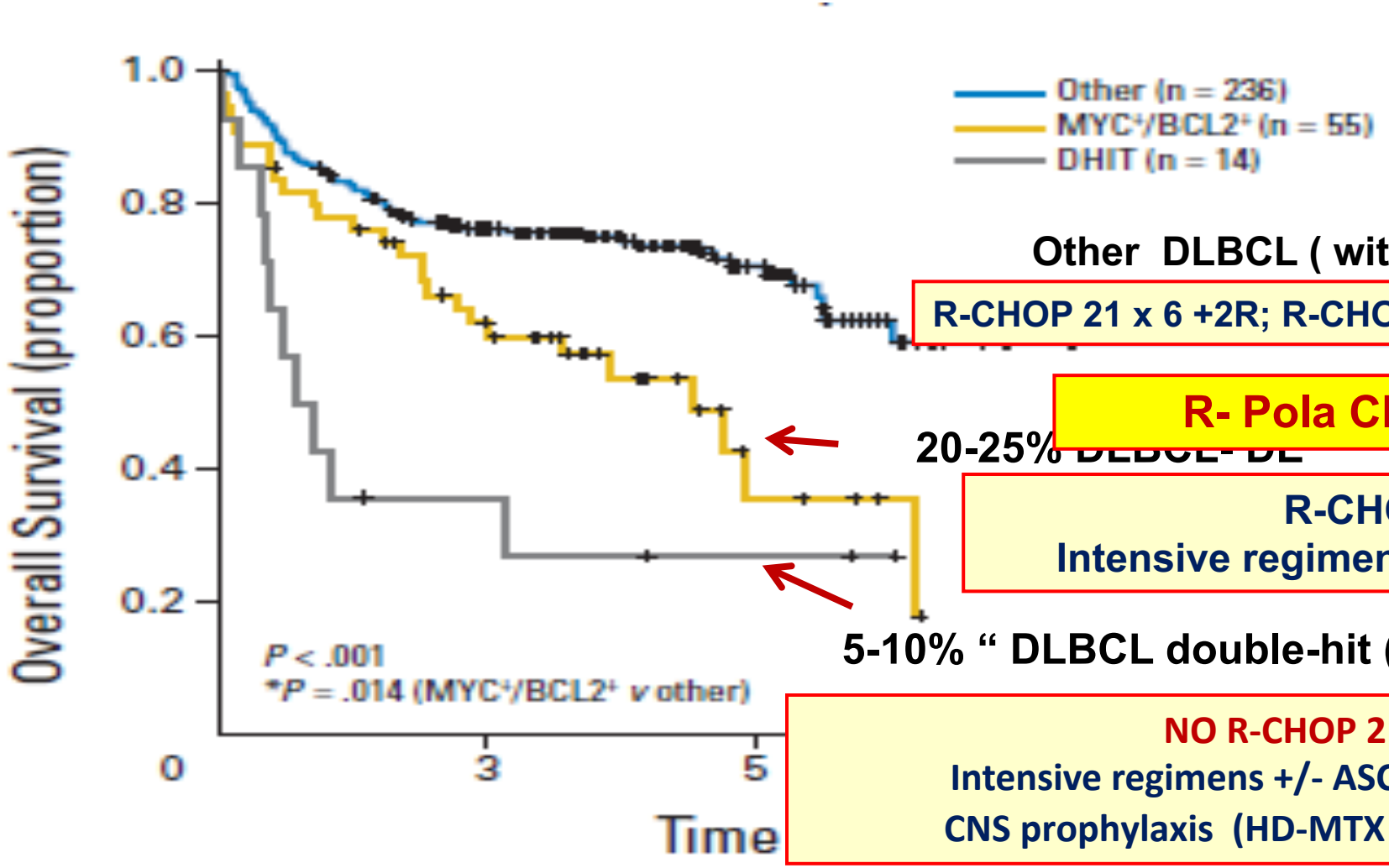
Tilly H, et al. N Engl J Med 2022;386:351–63.

POLARIX : PFS by subgroup (unstratified)

Baseline risk factors	Total N	Pola-R-CHP (N=440) n	Pola-R-CHP (N=440) 2-year rate	R-CHOP (N=439) n	R-CHOP (N=439) 2-year rate	Hazard ratio	95% Wald CI
Age group							
≤60	271	140	74.1	131	71.9	0.9	(0.6 to 1.5)
>60	608	300	77.9	308	69.5	0.7	(0.5 to 0.9)
Sex							
Male	473	239	75.9	234	65.9	0.7	(0.5 to 0.9)
Female	406	201	77.7	205	75.2	0.9	(0.6 to 1.4)
ECOG PS							
0–1	737	374	78.4	363	71.2	0.8	(0.6 to 1.0)
2	141	66	67.2	75	65.0	0.8	(0.5 to 1.4)
IPI score							
IPI 2	334	167	79.3	167	78.5	1.0	(0.6 to 1.6)
IPI 3–5	545	273	75.2	272	65.1	0.7	(0.5 to 0.9)
Bulky disease							
Absent	494	247	82.7	247	70.7	0.6	(0.4 to 0.8)
Present	385	193	69.0	192	69.7	1.0	(0.7 to 1.5)
Geographic region							
W. Europe, US, Canada, Australia	603	302	78.6	301	72.0	0.8	(0.6 to 1.1)
Asia	160	81	74.3	79	65.6	0.6	(0.4 to 1.5)
Rest of world	116	57	70.8	59	67.3	0.9	(0.6 to 1.5)
Ann Arbor stage							
I–II	99	47	89.1	52	85.5	0.6	(0.2 to 1.8)
III	232	124	80.7	108	73.6	0.8	(0.5 to 1.3)
IV	548	269	72.6	279	66.1	0.8	(0.6 to 1.1)
Baseline LDH							
≤ULN	300	146	78.9	154	75.6	0.8	(0.5 to 1.3)
>ULN	575	291	75.4	284	67.2	0.7	(0.5 to 1.0)
No. of extranodal sites							
0–1	453	227	80.2	226	74.5	0.8	(0.5 to 1.1)
≥2	426	213	73.0	213	65.8	0.7	(0.5 to 1.0)
Cell-of-origin							
GCB	352	184	75.1	168	76.9	1.0	(0.7 to 1.5)
ABC	221	102	83.9	119	58.8	0.4	(0.2 to 0.6)
Unclassified	95	44	73.0	51	86.2	1.9	(0.8 to 4.5)
Unknown	211	110	73.8	101	64.3	0.7	(0.4 to 1.2)
Double expressor by IHC							
DEL	290	139	75.5	151	63.1	0.6	(0.4 to 1.0)
Non DEL	438	223	77.7	215	75.7	0.9	(0.6 to 1.3)
Unknown	151	78	76.0	73	69.8	0.8	(0.4 to 1.5)
Double- or triple-hit lymphoma							
Yes	45	26	69.0	19	88.9	3.8	(0.8 to 17.6)
No	620	305	76.8	315	70.3	0.7	(0.5 to 1.0)
Unknown	214	109	78.5	105	66.4	0.6	(0.4 to 1.1)



Front-line therapy of DLBCL in 2022-23



Other DLBCL (without DH and DE)

R-CHOP 21 x 6 +2R; R-CHOP x 4+2R (very low IPI)

R- Pola CHP 21 x 6 +2R

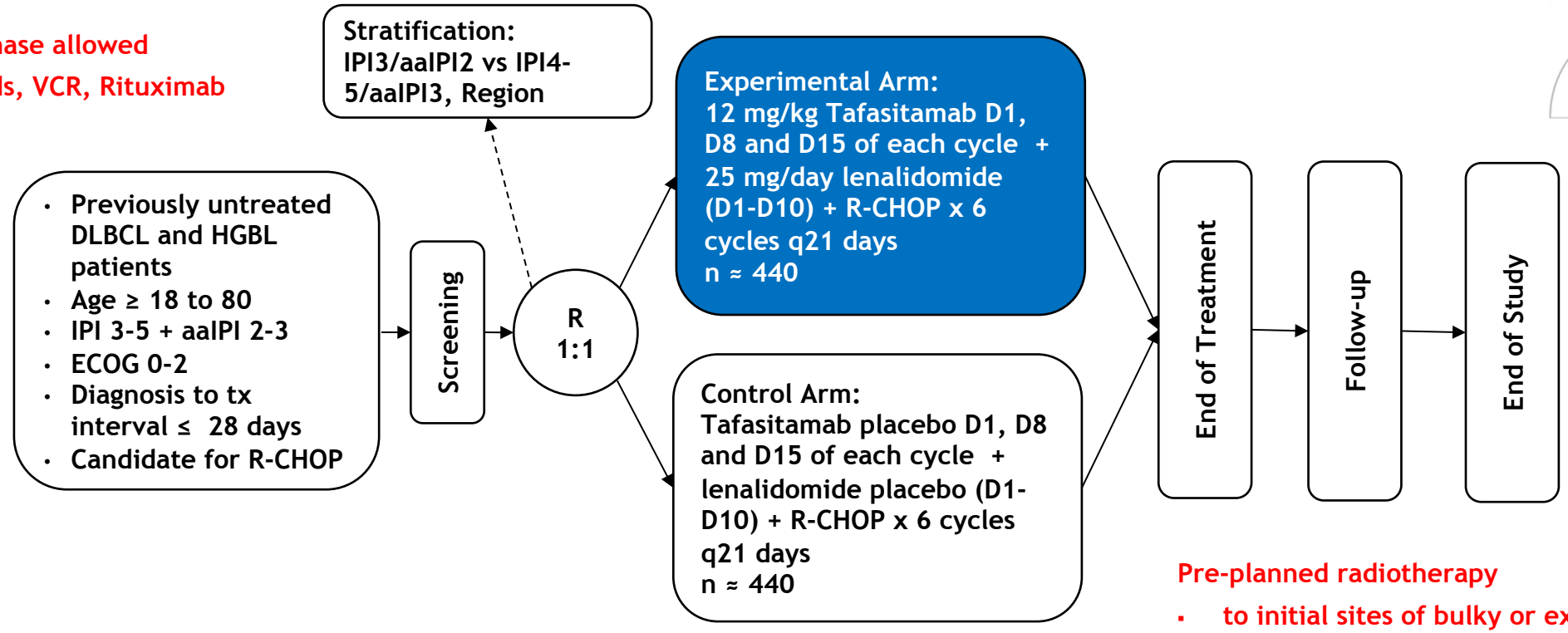
20-25% DLBCL- DE

R-CHOP-21?
Intensive regimens (DA-EPOCH-R)?

5-10% " DLBCL double-hit (DH-TH)"

NO R-CHOP 21 !!!!
Intensive regimens +/- ASCT or DA-EPOCH-R
CNS prophylaxis (HD-MTX /ARAC or IT MTX)

FRONTMIND – STUDY DESIGN



Pre-planned radiotherapy

- to initial sites of bulky or extranodal disease per institutional guidelines

Pre-planned CNS prophylaxis with IV Methothrexate

- Primary endpoint: PFS assessed by investigator (Cheson 2014 criteria)
- Sample size: 880 patients
- Target hazard ratio: 0.70, analysis at 274 PFS events, ~43 months after 1st patient 1st visit (FPFV)
- Power: 83%; Interim analysis for futility at 274 PFS events, 18 months after FPFV; IDMC review; Safety run-in first 40 patients

Vitolo U et al. Abs 2947, ASH 2022

Novel and Emerging Combinations: Next Wave of R-CHOP "Plus"

- R-CHP + polatuzumab vedotin
- Bispecific antibodies plus:
  - R-CHOP +glofitamab
- R^2-CHOP + tafasitamab
- Loncastuximab tesirine + R-CHOP
- R-CHOP + Acalabrutinib

Agnostic

- CAR T-cell therapy
- Tafasitamab/lenalidomide
- Loncastuximab tesirine
- Polatuzumab vedotin

- BTK inhibitors
- PI3K inhibitors
- BCL2 inhibitors
- IRAK4 inhibitors

blood
Regular Article

FONDAZIONE ITALIANA LINFOMI

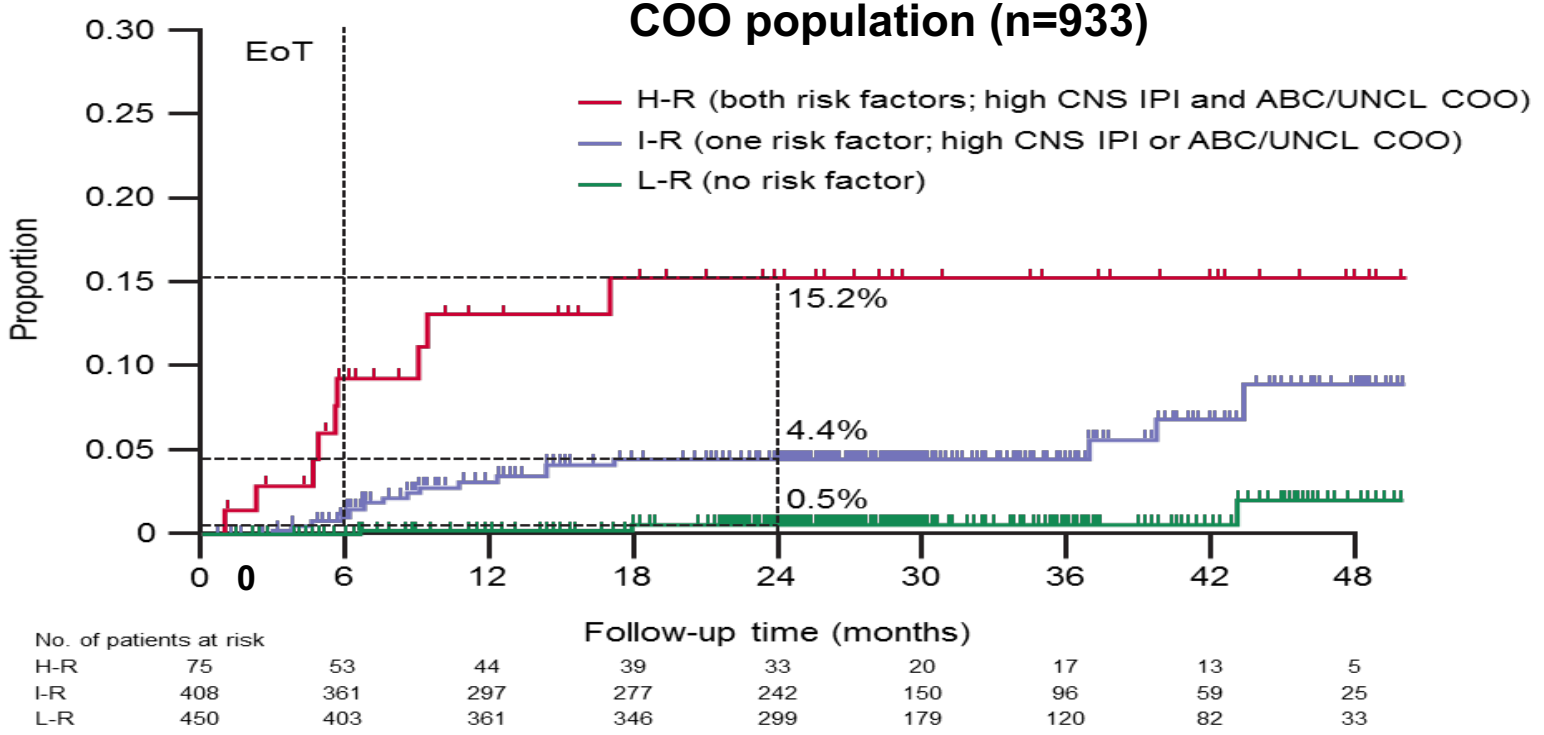
CLINICAL TRIALS AND OBSERVATIONS

Integration of cell of origin into the clinical CNS International Prognostic Index improves CNS relapse prediction in DLBCL

Magdalena Klanova,[1-3] Laurie H. Sehn,[4] Isabelle Bence-Bruckler,[5] Federica Cavallo,[6] Jie Jin,[7] Maurizio Martelli,[8] Douglas Stewart,[9] Umberto Vitolo,[10] Francesco Zaja,[11] Qingyuan Zhang,[12] Federico Mattiello,[13] Gila Sellam,[3] Elizabeth A. Punnoose,[14] Edith Szafer-Glusman,[14] Christopher R. Bolen,[15] Mikkel Z. Oestergaard,[16] Guenter R. Fingerle-Rowson,[3] Tina Nielsen,[3] and Marek Trneny[1]

Risk of CNS relapse by CNS-IPI-COO, COO population (n=933)

GOYA STUDY



CNS IPI *CNS-IPI-COO*

CNS IPI	n (%)	2-year relapse rate	n (%)	2-year relapse rate
H-R	165 (17.7%)	9.6%	75 (8.0%)	15.2%
I-R	596 (63.9%)	2.2%	408 (43.7%)	4.4%
L-R	172 (18.4%)	1.4%	450 (48.2%)	0.5%

bjh good practice papers

The prevention of central nervous system relapse in diffuse large B-cell lymphoma: a British Society for Haematology good practice paper

Who and What… ?

High CNS IPI (4-6)

Age > 60 years
LDH > normal
ECOG PS > 1
Stage III/IV disease
Extranodal involvement > 1
Kidney and/or adrenal

Testis and Kidney and/or adrenal glands if only involved

Double HIT

Double-expressor and COO ABC according to CNS IPI

CNS-directed prophylaxis should be offered to patients at high-risk of CNS relapse

•4-6 cycles of IT prophylaxis (MTX, Ara-C) + 2 courses of MTX 3g/m^2 or 2-4 courses of MTX 1.5 g/m^2 in elderly pts and/or comorbidity (dose-adjusted according to creatinine clearance)

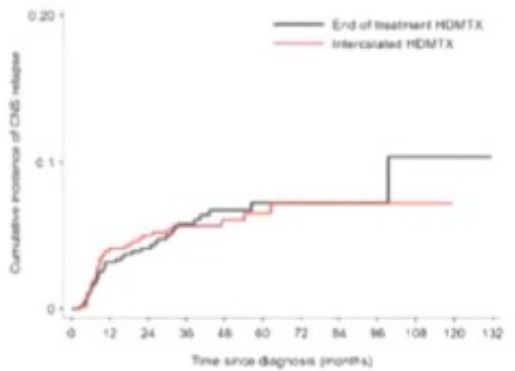
Timing of high dose methotrexate CNS prophylaxis in DLBCL: a multicentre international analysis of 1,384 patients

Matthew R. Wilson*, Toby A. Eyre, Amy A. Kirkwood, Nicole Wong Doo, Carole Soussain, Sylvain Choquet, Nicolás Martinez-Calle, Gavin Preston, Matthew Ahearne, Elisabeth Schorb, Marie-Pierre Moles-Moreau, Matthew Ku, Chiara Rusconi, Jahanzaib Khwaja, Mayur Narkhede, Katharine L. Lewis, Teresa Calimeri, Eric Durot, Loïc Renaud, Andreas Kiesbye Øvlisen, Graham McIlroy, Timothy J. Ebsworth, Johnathan Elliot, Anna Santarsieri, Laure Ricard, Nimish Shah, Qin Liu, Adam S. Zayac, Francesco Vassallo, Laure Lebras, Louise Roulin, Naelle Lombion, Kate Manos, Ruben Fernandez, Nada Hamad, Alberto Lopez-Garcia, Deirdre O'Mahony, Praveen Gounder, Nathalie Forgeard, Charlotte Lees, Kossi Agbetiafa, Tim Strüessmann, Thura Win Htut, Aline Clavert, Hamish Scott, Anna Guidetti, Brett R Barlow, Jeffery Smith, Fiona Miall, Christopher P. Fox, Chan Y. Cheah, Tarec Christoffer El Galaly, Andrés J. M. Ferreri, Kate Cwynarski, Pamela McKay

*Beatson West of Scotland Cancer Centre, Glasgow, United Kingdom

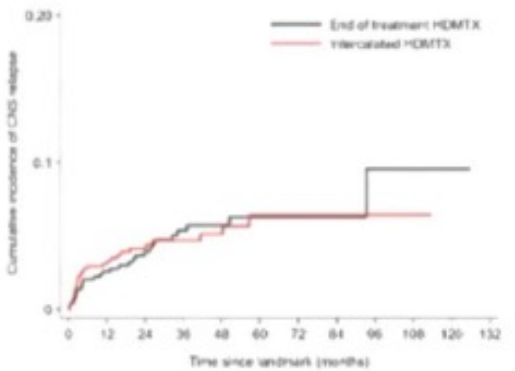
'Intercalate' HD-MTX between R-CHOP cycles (i-HD-MTX)	Vs	Deliver HD-MTX at end of R-CHOP therapy (EOT)
Delivers early CNS prophylaxis		May not prevent early CNS progression
Toxicity e.g. renal may compromise R-CHOP delivery		No risk of interruption to R-CHOP therapy

All patients (n=1,384)



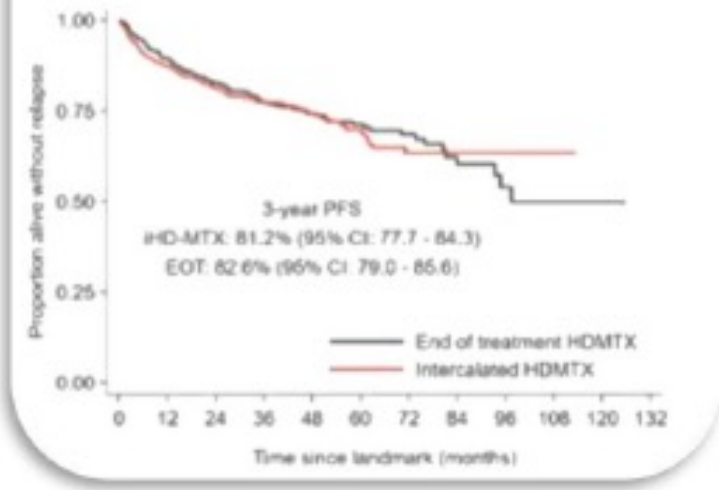
3-year CNS relapse rates: 5.8% vs 5.7%
HR: 1.01 (95% CI: 0.65-1.57)
3-year difference: 0.04% (95% CI: -2.0 to 3.1)

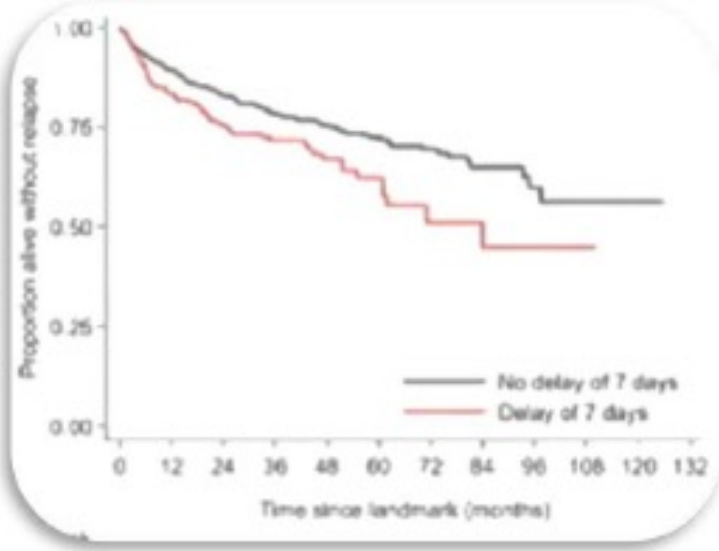
Landmark analysis (n=1,253)



3-year CNS relapse rates: 4.7% vs 4.7%
HR: 0.99 (95% CI: 0.60-1.66)
3-year difference: -0.03% (95% CI: -1.0 to 3.0

Results for landmark cohort (n=1,25



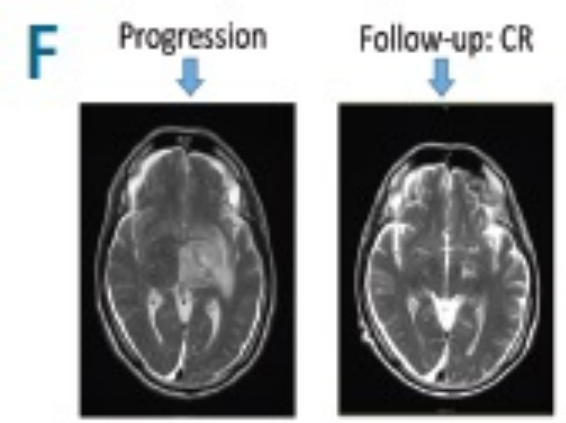


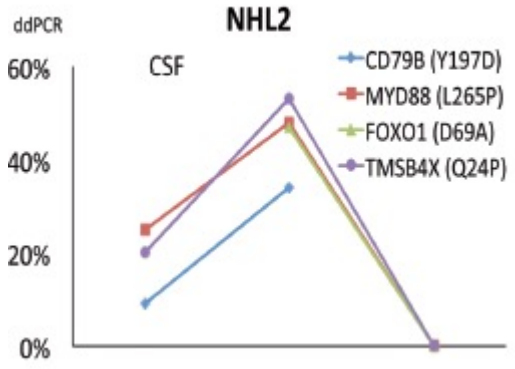
Wilson M , et al. ASH 2021

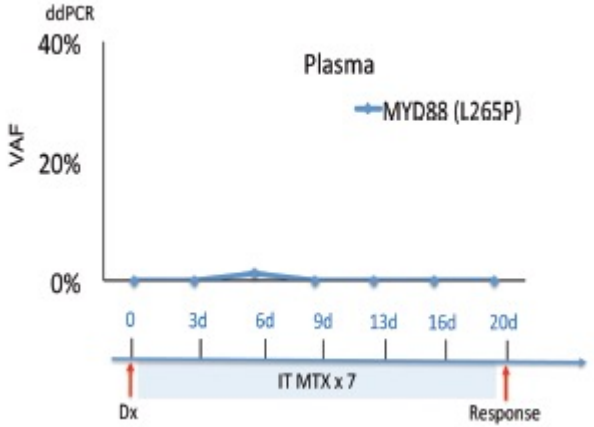
Cell free circulating tumor DNA in cerebrospinal fluid detects and monitors central nervous system involvement of B-cell lymphomas

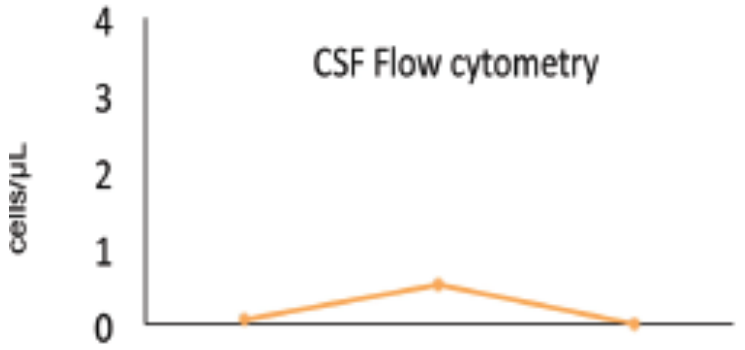
Sabela Bobillo,[1*] Marta Crespo,[1*] Laura Escudero,[2*] Regina Mayor,[2] Priyanka Raheja,[1] Cecilia Carpio,[1] Carlota Rubio-Perez,[2] Bárbara Tazón-Vega,[1] Carlos Palacio,[1] Júlia Carabia,[1] Isabel Jiménez,[1] Juan. C. Nieto,[1] Julia Montoro,[1] Francisco Martínez-Ricarte,[3] Josep Castellví,[4] Marc Simó,[5] Lluis Puigdefàbregas,[1] Pau Abrisqueta,[1] Francesc Bosch[1#] and Joan Seoane[2,6#]

Haematologica 2021
Volume 106(2):513-521



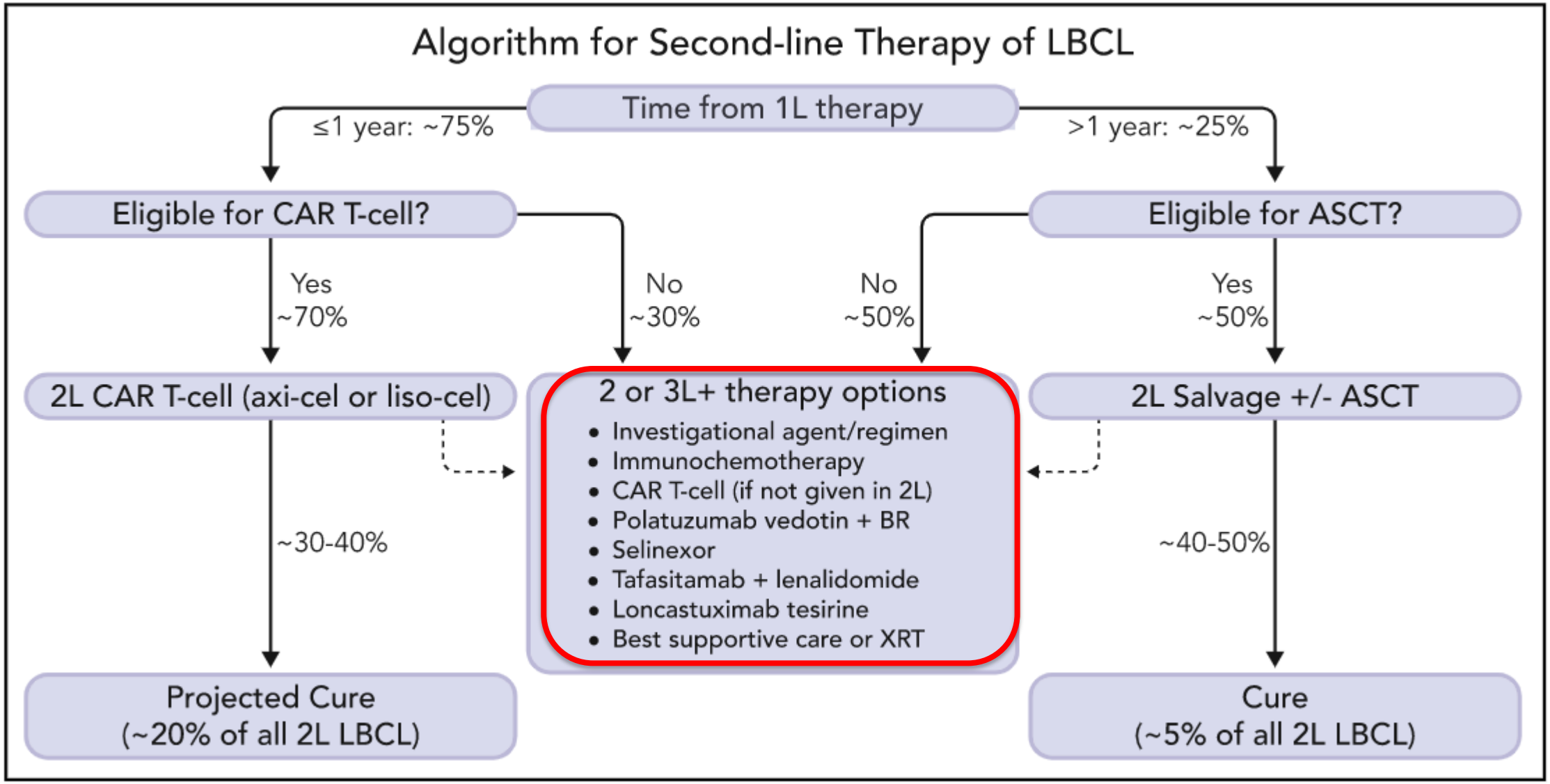






- Circulating tumor DNA (CT DNA) in the CSF of patients with CNS Lymphoma is more abundant than in plasma
- CT DNA in the CSF fluid exhibts higher sensitivity than flow cytometry in detecting CNS lesions
- CT DNA in CSF fluid can be used to monitor CNS tumor burden and response to treatment

A new treatment algorithm for patients with R/R DLBCL after first-line therapy



Westin J, Blood 2022;139

Novel therapies approved in RR-DLBCL

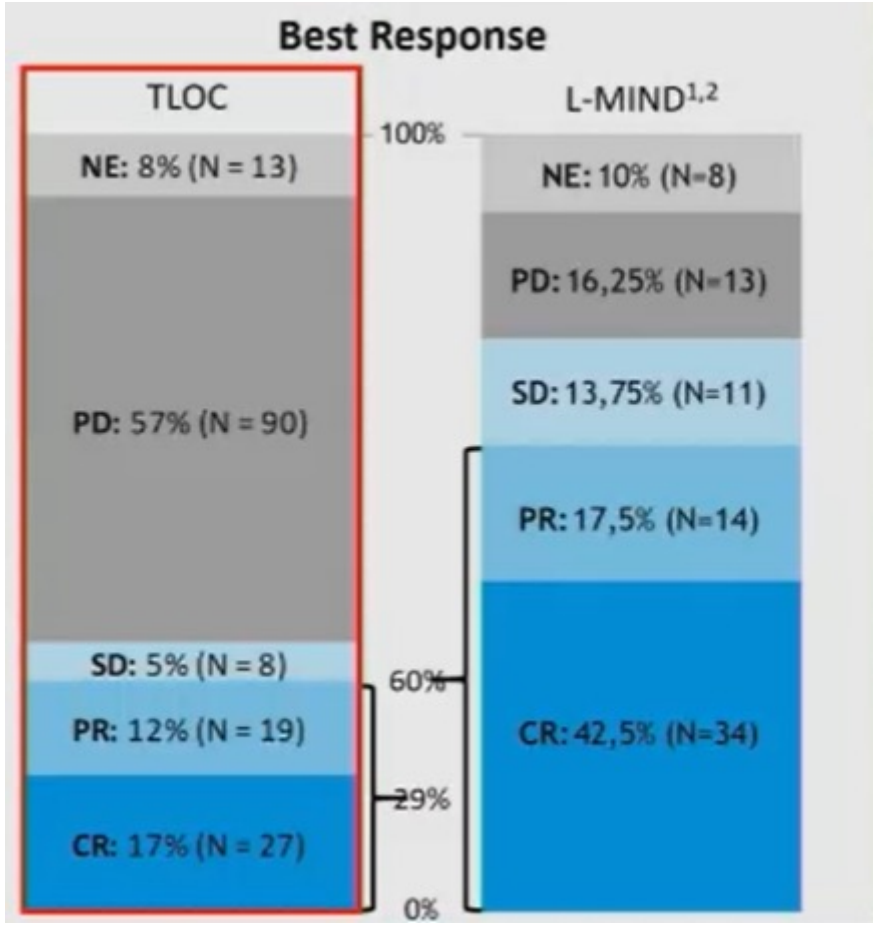
	Pola-BR	Selinexor	Tafasitamab/Lenalidomide	Locastuximab Tesirine
MOA	Anti-CD79b ADC	XPO-1 inhibitor	Anti-CD19 mAb/Immunomodulator	Anti-CD19 ADC
ORR	45%	28%	58%	48%
CR rate	40%	10%	40%	24%
PFS	9.2 m	2.6 m	11.6 m	4.9 m
DOR	12.6 m	9.3 m	43.9 m	10.3 m
OS	12.4 m	NR	33.5 m	9.9 m

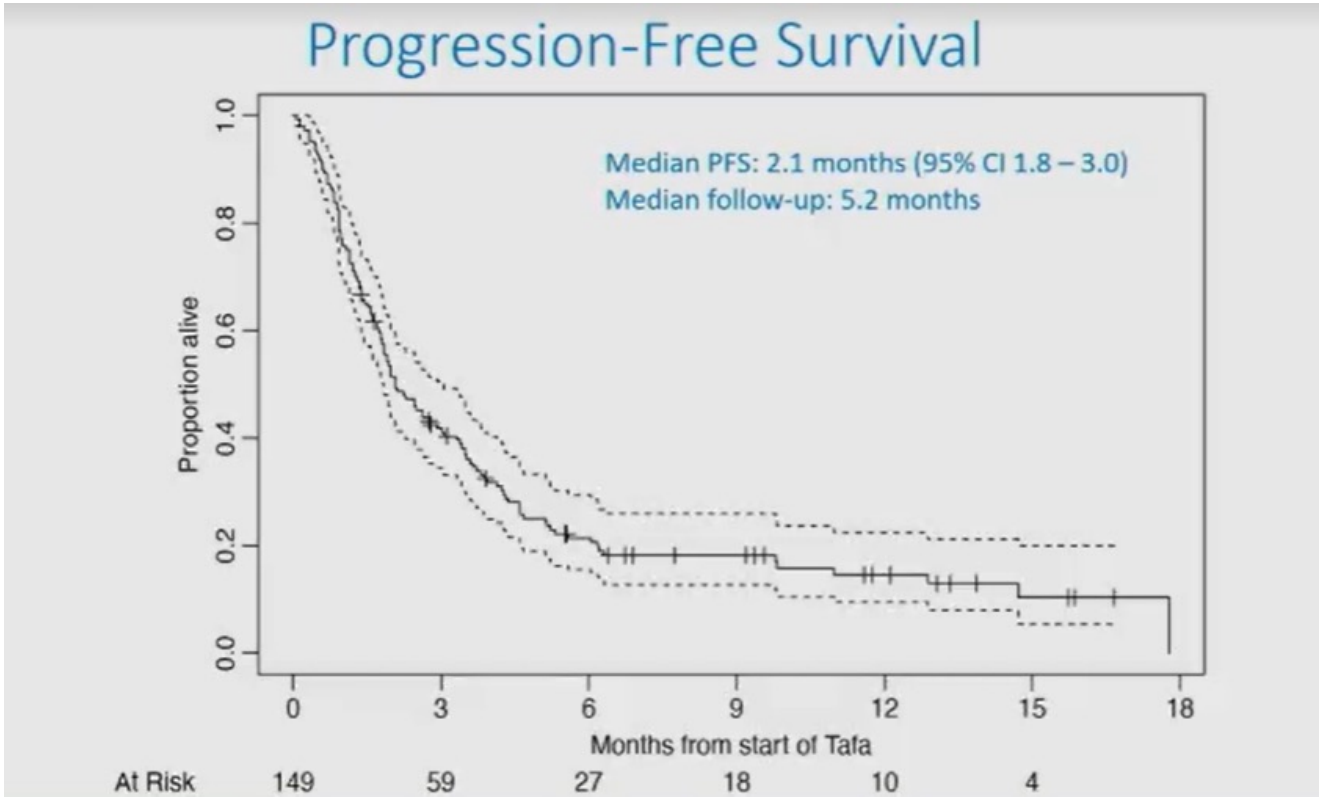
Sehn LH et al Blood Adv.2022; Kalakonda Lancet Haematol 2020; Duell J.et al Haematologica 2021.; Caimi PF et al Lancet Oncol. 2021

Pola-BR in real life setting

	n	Refractory to last prior therapy	mOS months	mPFS months	CR rate	ORR	mFUP months
Vodicka et al.	21	76.2	8.7	3.8	23.8	33.3	6.8
Dimou et al.	49*	78.0	8.5	4.0	20.0 25.0 (best)	35.0 43.0 (best)	10.8
Segman et al.	47	23.0	8.3	5.6	40.0	61.0	6.8
Liebers et al.	54*	87	5.5	3.25	14.8 (best)	48.1 (best)	7.5
Northend et al.	133	68.4	8.2	4.8	31.6 (best)	57.0(best)	7.7
Pellegrini et al.	55	81.8	9.0	4.9	18.2 27.3 (best)	32.7 49.1(best)	11

Real-world Tafa-len treatment N= 157 (retrospective study): Responses and Progression-Free Survival





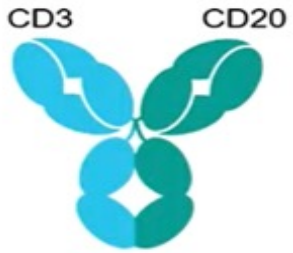
42 patients (28%) had CAR-T before TL

- 4/19 CD19 not reported , more prior lines of tx, more prior refractory

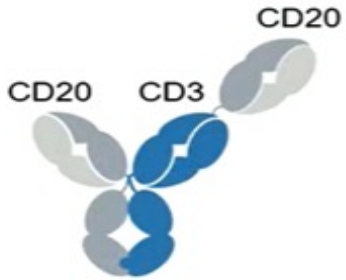
Worse PFS was seen in patients with refractory disease, ≥ 3 lines of therapy, higher IPI

Quall D. et al. Abs 323, ASH 2022.

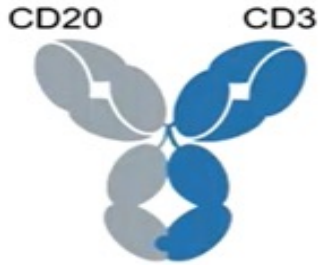
Bispecific antibodies CD3xCD20



Epcoritamab
DuoBody-CD3×CD20
IgG1

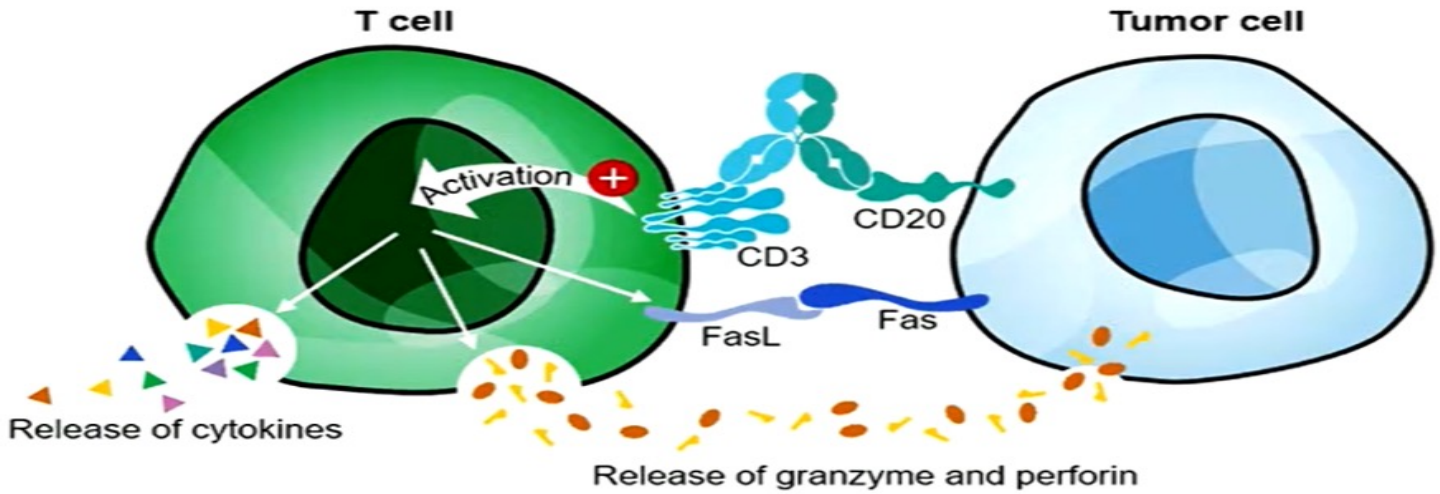


Glofitamab
2+1 CrossMab
IgG1



Mosunetuzumab
Knob-in-hole
IgG1

Odronextamab
VELOCI-Bi
IgG4



Schuster SJ Hematological Oncology 2021; You G et al, Vaccines 2021, Engelberts PJ et al, EBioMedicine 2020

Subcutanoues Epcoritamab in R/R DLBCL: a phase 2 study in 157 patients

EPCORE NHL-1: LBCL Expansion Cohort

Dose escalation → **Dose expansion data cutoff: January 31, 2022; Median follow-up: 10.7 mo**

B-NHL:
- ✓ No DLTs
- ✓ MTD not reached
- ✓ RP2D identified
- ✓ Manageable safety profile
- ✓ Encouraging antitumor activity

Key inclusion criteria:
- R/R CD20+ mature B-cell neoplasm
- ECOG PS 0–2
- ≥2 prior lines of antineoplastic therapy, including ≥1 anti-CD20 mAb
- FDG PET–avid and measurable disease by CT/MRI
- Prior CAR T allowed

Step-up dosing[a]

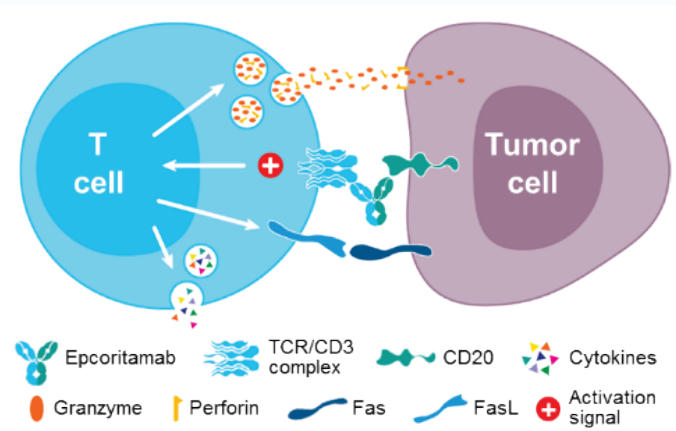
Epcoritamab SC RP2D 48 mg
QW C1–3,
Q2W C4–9,
Q4W C10+

→ **Treatment until PD[b,c] or unacceptable toxicity**

→ **LBCL Cohort N=157**
DLBCL, HGBCL, PMBCL, and FL Gr3B

- To ensure patient safety and better characterize CRS, inpatient monitoring was required at first full dose for 24 h in this part of the study
- **Primary endpoint:** ORR by independent review committee (IRC)
- **Key secondary endpoints:** DOR, TTR, PFS, OS, CR rate, and safety/tolerability

– **Induces T-cell activation** by binding to CD3 on T cells and CD20 on malignant B cells
– **Promotes immunological synapse** between bound cells, resulting in apoptosis of B cells
– **Binds to a distinct epitope on CD20**, different from the epitopes of rituximab and obinutuzumab
– **Retains activity** in the presence of CD20 mAbs



Thieblemont C et al 2022

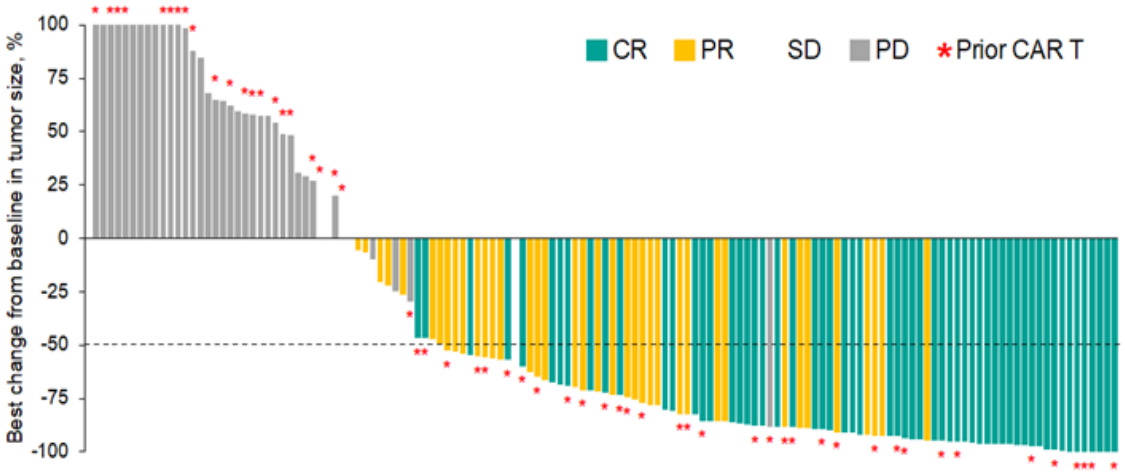
Subcutanoues Epcoritamab in R/R DLBCL:

Patients Were Challenging to Treat and Highly Refractory

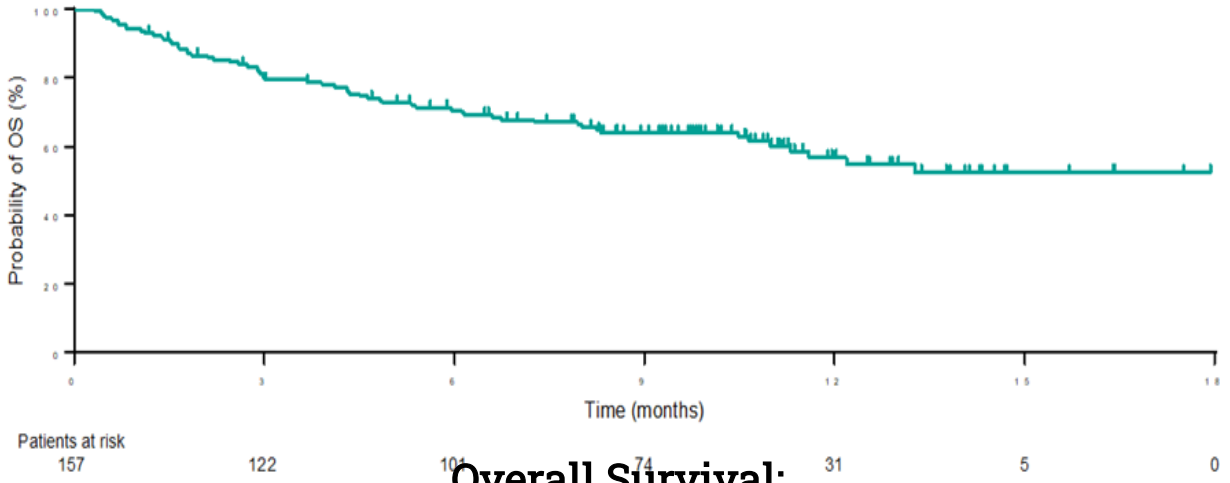
Demographics	LBCL, N=157
Median age (range), y	64 (20–83)
<65 y, n (%)	80 (51)
65 to <75 y, n (%)	48 (31)
≥75 y, n (%)	29 (18)
ECOG PS, n (%)	
0	74 (47)
1	78 (50)
2	5 (3)

Disease Characteristics[a]	LBCL, N=157
Disease type, n (%)	
DLBCL	139 (89)
De novo	97/139 (70)
Transformed	40/139 (29)
Unknown	2/139 (1)
HGBCL	9 (6)
PMBCL	4 (3)
FL Gr3B	5 (3)

Prior Treatments	LBCL, N=157
Median time from initial diagnosis to first dose, y	1.6
Median time from end of last therapy to first dose, mo	2.4
Median prior lines of therapy (range)	3 (2–11)
≥3 Lines of therapy, n (%)	111 (71)
Primary refractory[b] disease, n (%)	96 (61)
Refractory[b] to last systemic therapy, n (%)	130 (83)
Refractory[b] to ≥2 consecutive lines of therapy, n (%)	119 (76)
Prior ASCT, n (%)	31 (20)
Prior CAR T therapy, n (%)	61 (39)
Progressed within 6 mo of CAR T therapy	46/61 (75)



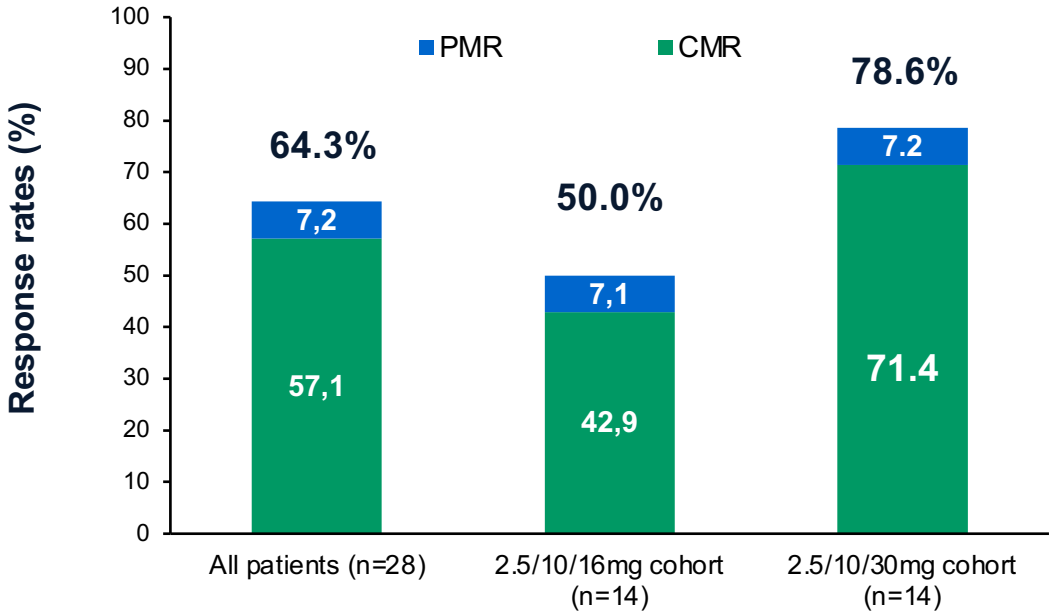
Response rate:
ORR 63%, CR 39%, prior CART 34%



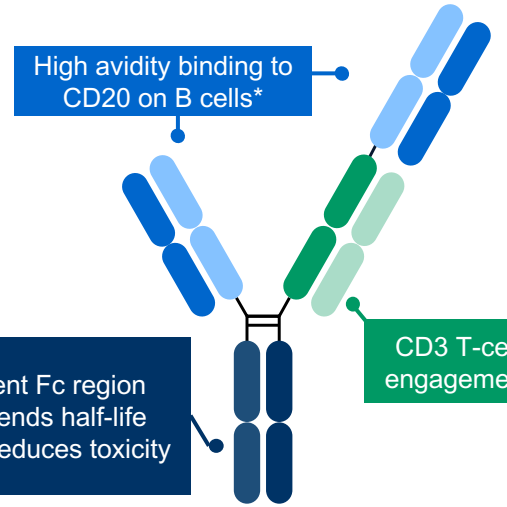
Overall Survival:
Median not reached, 6 mo 71%, 12 mo 57%

Glofitamab in R/R B-cell lymphoma patients.

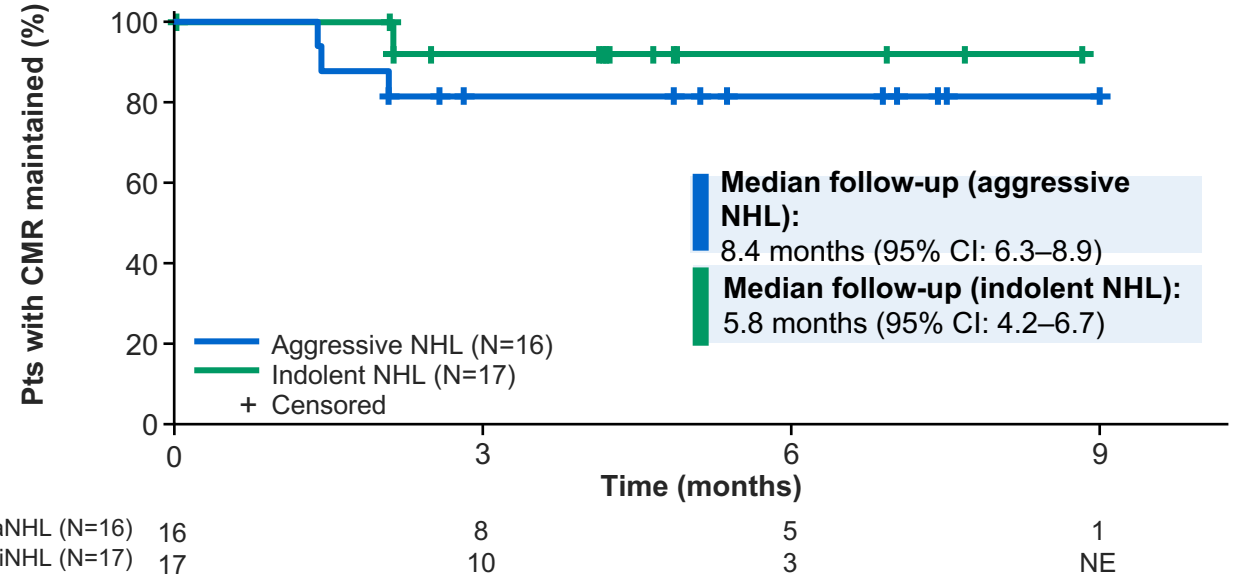
Response rate: Aggressive NHL



For aggressive NHL, a trend of improved response was observed at the RP2D (2.5/10/30mg; N=14), with a **CMR rate of 71.4%**



Duration of Complete Response



- The median duration of response for complete responders have not been reached
- **Aggressive NHL**: 13/16 CMRs are ongoing, 8 CMRs lasting >3 months; 5 CMRs lasting >6 months
- **Indolent NHL**: 16/17 CMRs are ongoing, 10 CMRs lasting >3 months; 3 CMRs lasting >6 months

Hutchings M et al, JCO 2021, Carlo-Stella, ICML-16.

CD20xCD3 bispecific antibodies + SoC

Rational combinations of targeted therapies

Mosunetuzumab/glofitamab (+obi) + lenalidomide
Phase 1, R/R FL
NCT04246086 (est. completion Aug 2022)

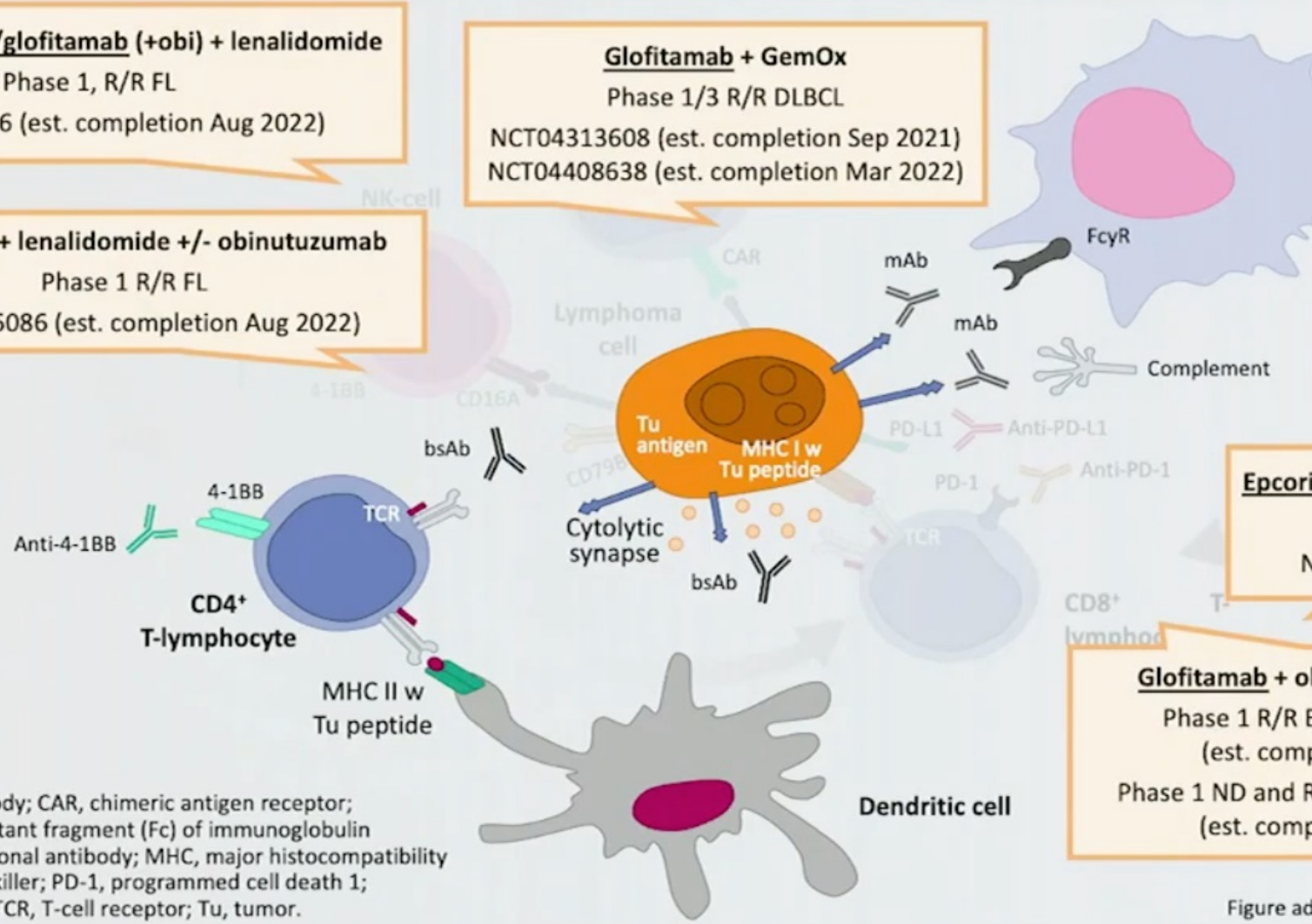
Glofitamab + GemOx
Phase 1/3 R/R DLBCL
NCT04313608 (est. completion Sep 2021)
NCT04408638 (est. completion Mar 2022)

Glofitamab + lenalidomide +/- obinutuzumab
Phase 1 R/R FL
NCT04246086 (est. completion Aug 2022)

Epcoritamab + SoC
Phase 1b/2 ND or R/R DLBCL, ND or R/R FL
NCT04663347 (est. completion Jan 2022)

Epcoritamab + investigator's choice chemotherapy
Phase 3 R/R DLBCL
NCT04628494 (est. completion Jun 2023)

Glofitamab + obi ± obi pre-treatment
Phase 1 R/R B-NHL NCT03075696
(est. completion Jun 2023)
Phase 1 ND and R/R B-NHL NCT03467373
(est. completion Dec 2023)

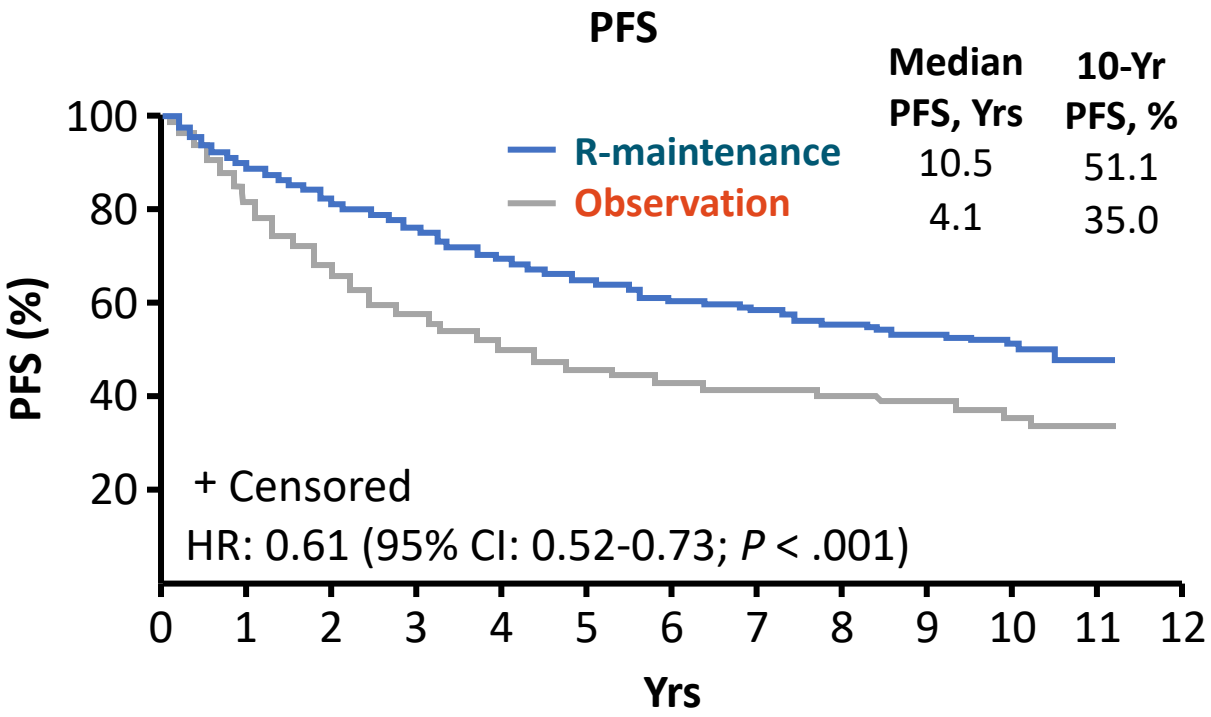


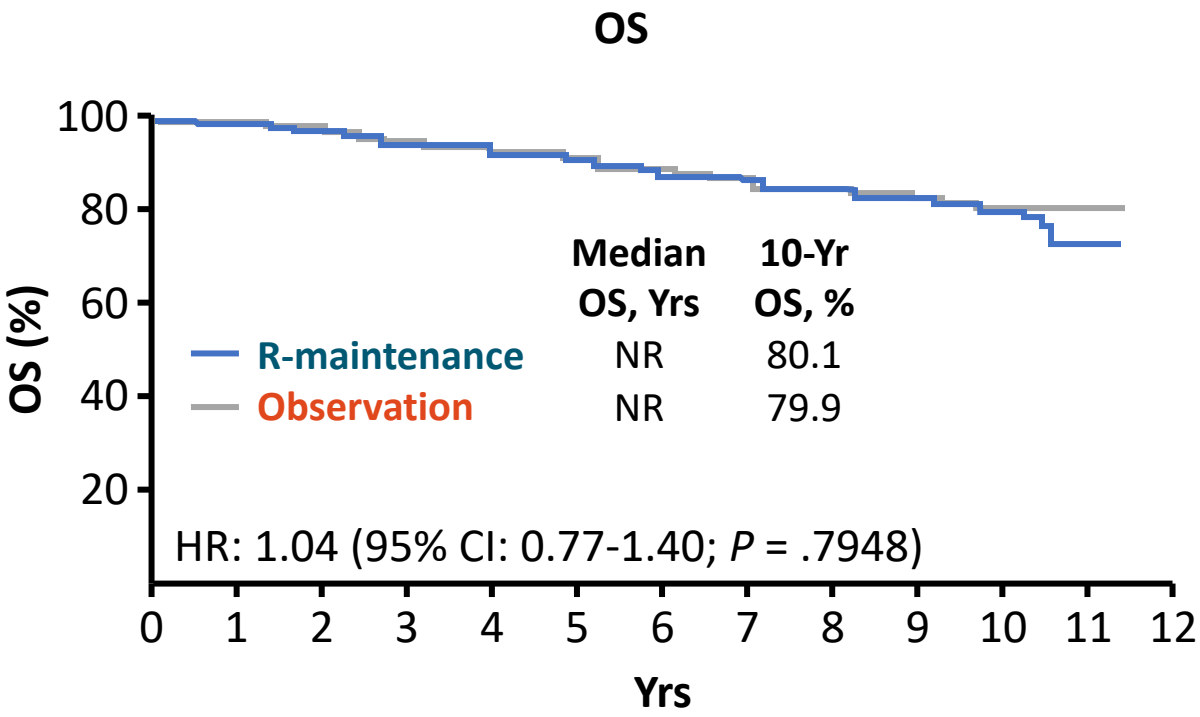
bsAb, bispecific antibody; CAR, chimeric antigen receptor; FcR, receptor for constant fragment (Fc) of immunoglobulin gamma; mAb, monoclonal antibody; MHC, major histocompatibility complex; NK, natural killer; PD-1, programmed cell death 1; PD-L1, PD-1 ligand 1; TCR, T-cell receptor; Tu, tumor.

Figure adapted from: Pytlik R, *et al. Vaccines (Basel)* 2020; **8**:708.

By courtesy of Salles G, ICML 2021

PRIMA Long-term Follow-up: PFS but Not OS Improved with Maintenance Rituximab vs Observation





Patients at Risk, n

R-maint	505	445	406	372	333	309	284	231	208	170	67	4	0
Obs	513	415	336	290	251	217	200	155	147	122	41	1	0

Patients at Risk, n

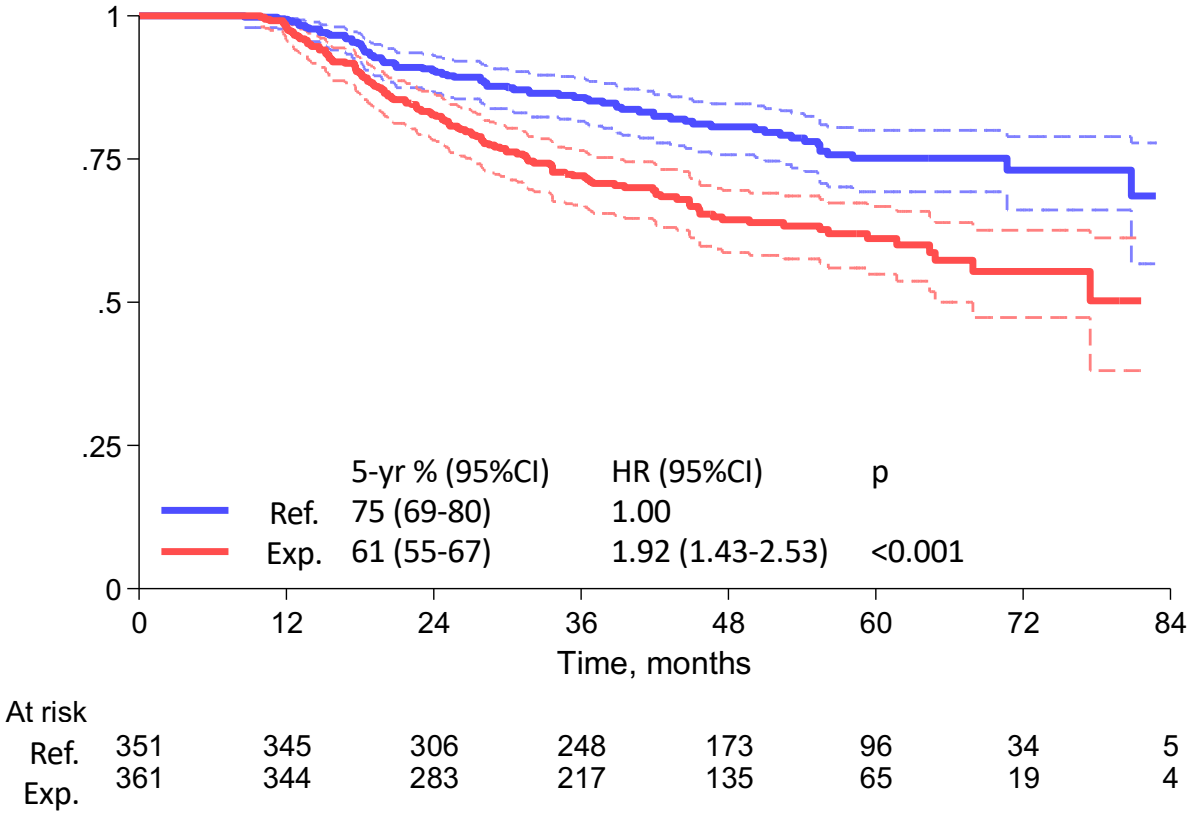
R-maint	505	492	480	464	449	432	407	341	313	261	107	8	0
Obs	513	501	485	472	460	440	412	319	297	256	91	8	0

Bachy. JCO. 2019;37:2815.

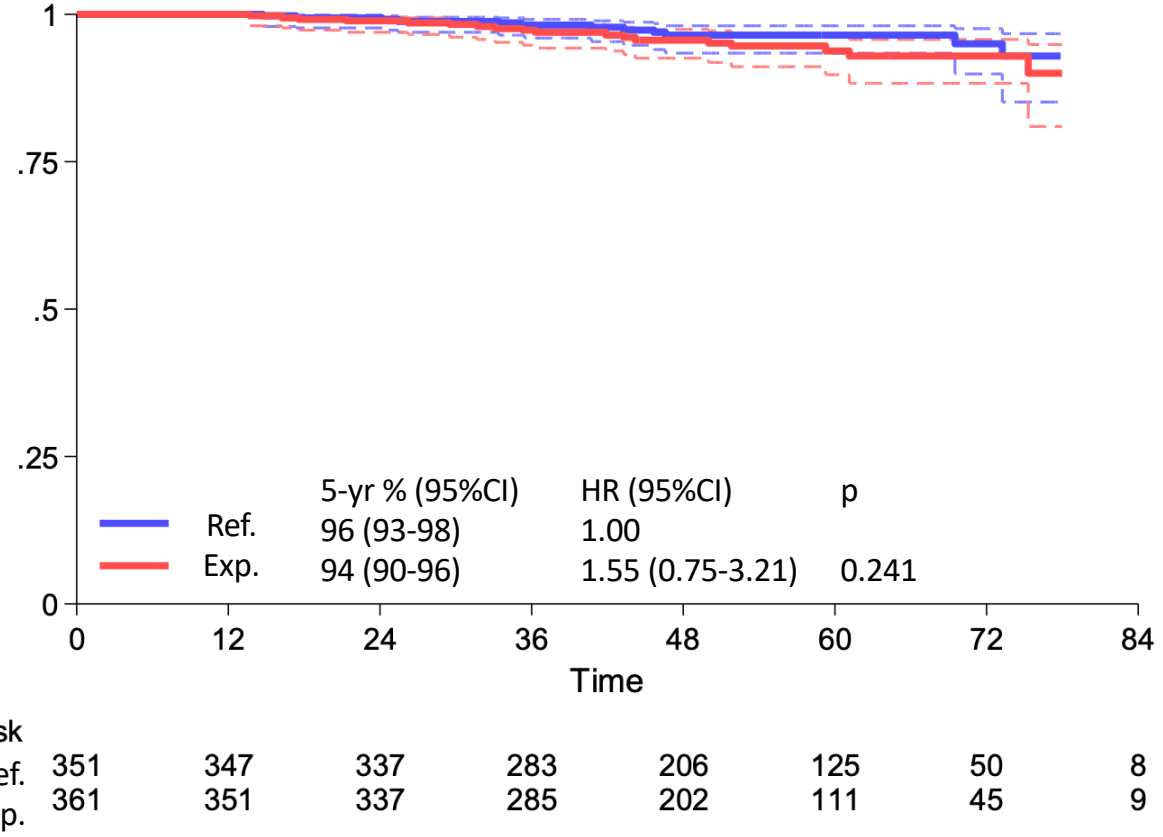
Updated results of the FOLL12 trial

N=712, Med f-up 53m, 197 PFS events , 30 deaths

PFS



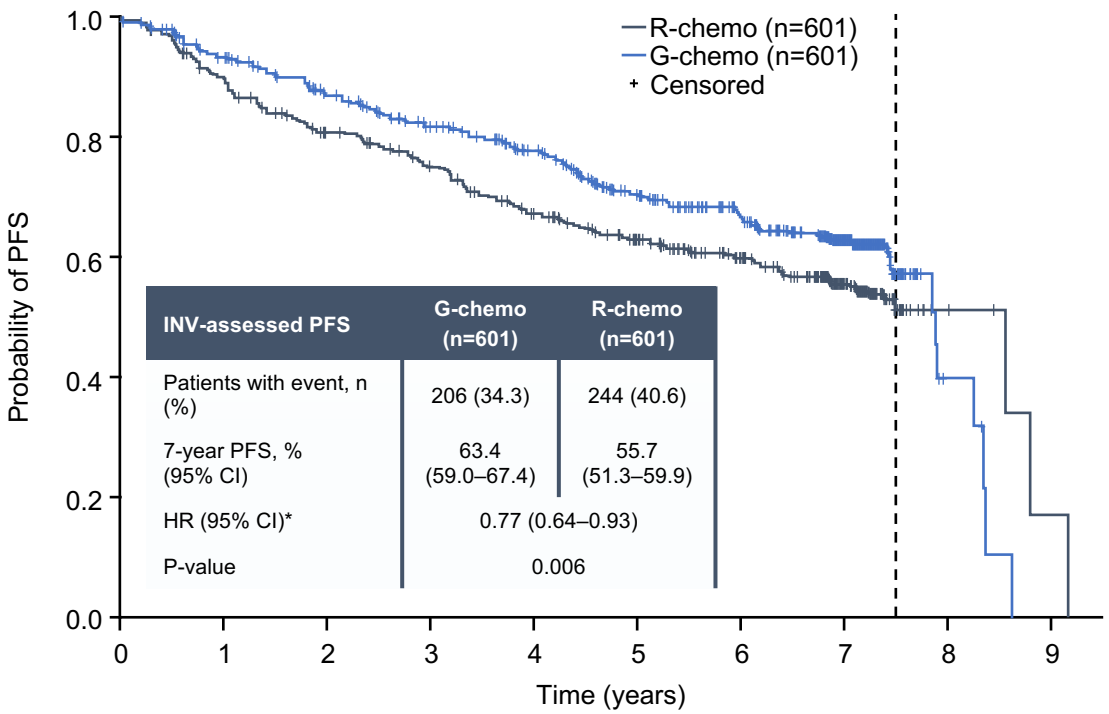
OS



Luminari et al JCO 2022

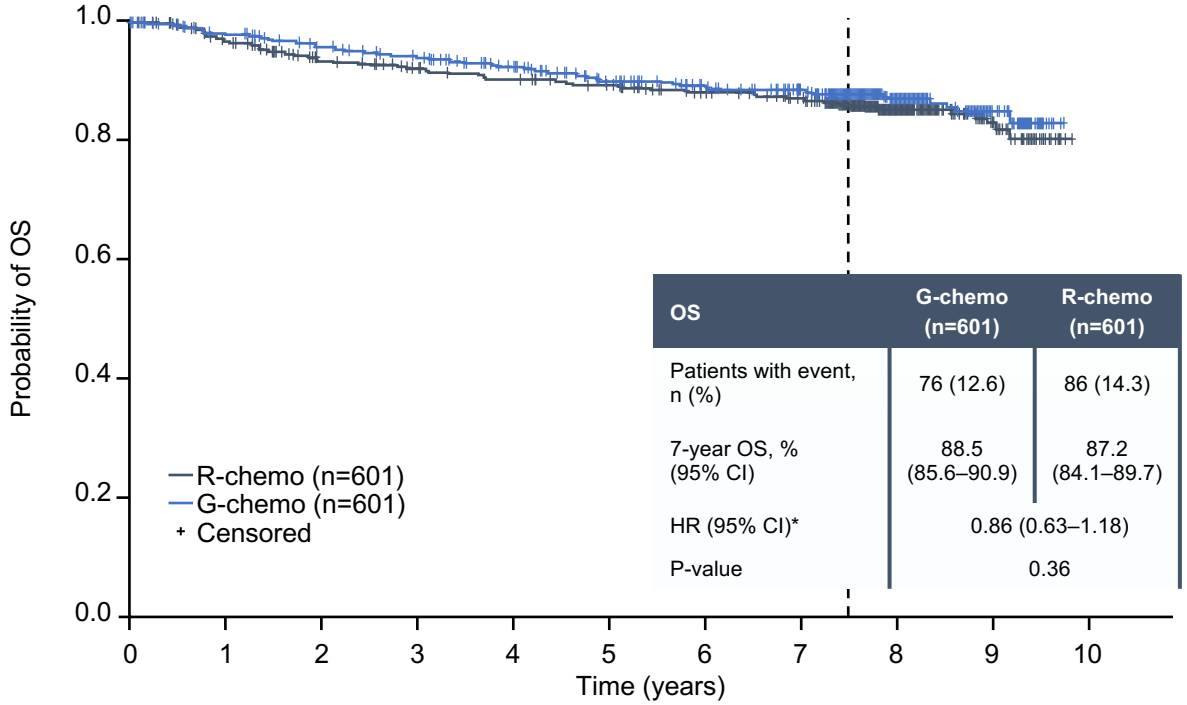
GALLIUM study first line follicular lymphoma

PFS



INV-assessed PFS	G-chemo (n=601)	R-chemo (n=601)
Patients with event, n (%)	206 (34.3)	244 (40.6)
7-year PFS, % (95% CI)	63.4 (59.0–67.4)	55.7 (51.3–59.9)
HR (95% CI)*	0.77 (0.64–0.93)	
P-value	0.006	

OS

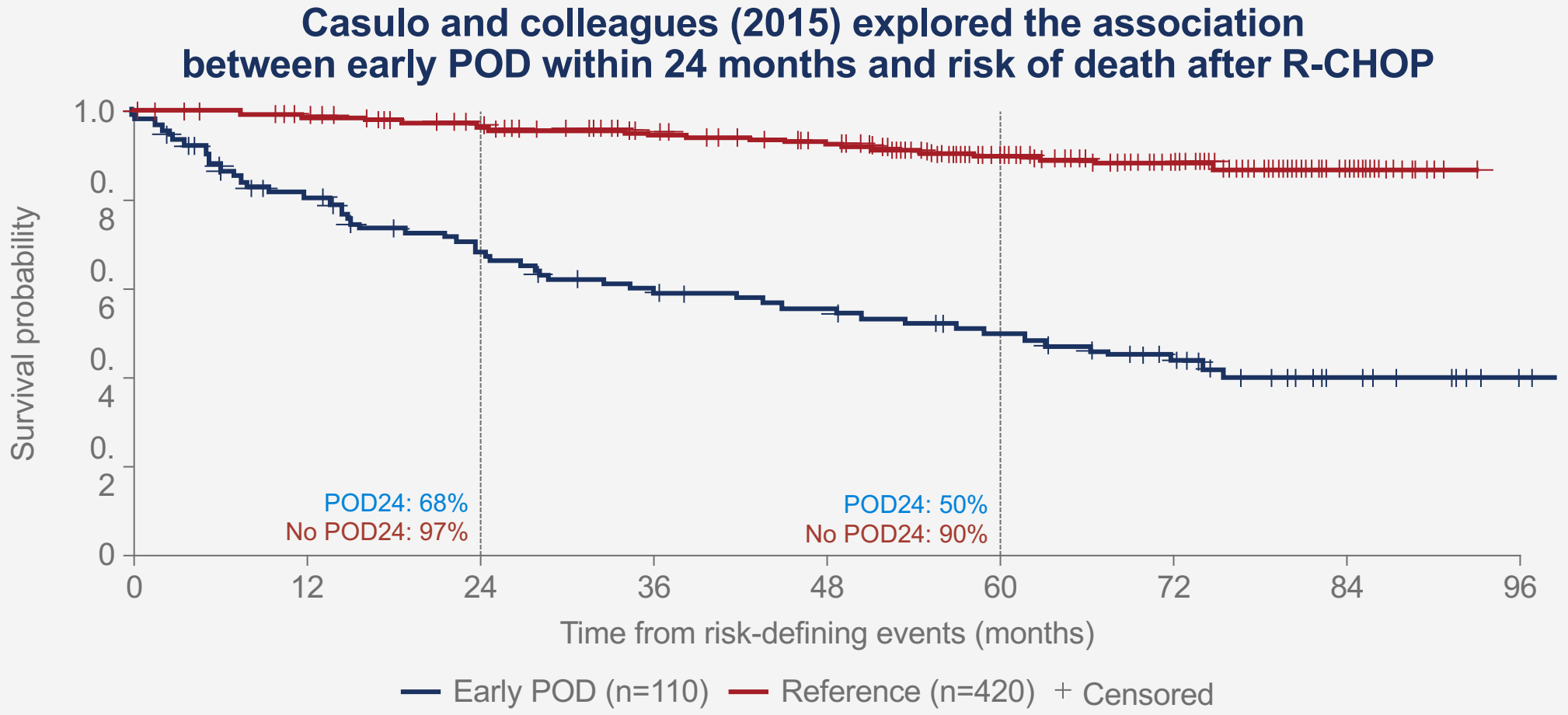


OS	G-chemo (n=601)	R-chemo (n=601)
Patients with event, n (%)	76 (12.6)	86 (14.3)
7-year OS, % (95% CI)	88.5 (85.6–90.9)	87.2 (84.1–89.7)
HR (95% CI)*	0.86 (0.63–1.18)	
P-value	0.36	

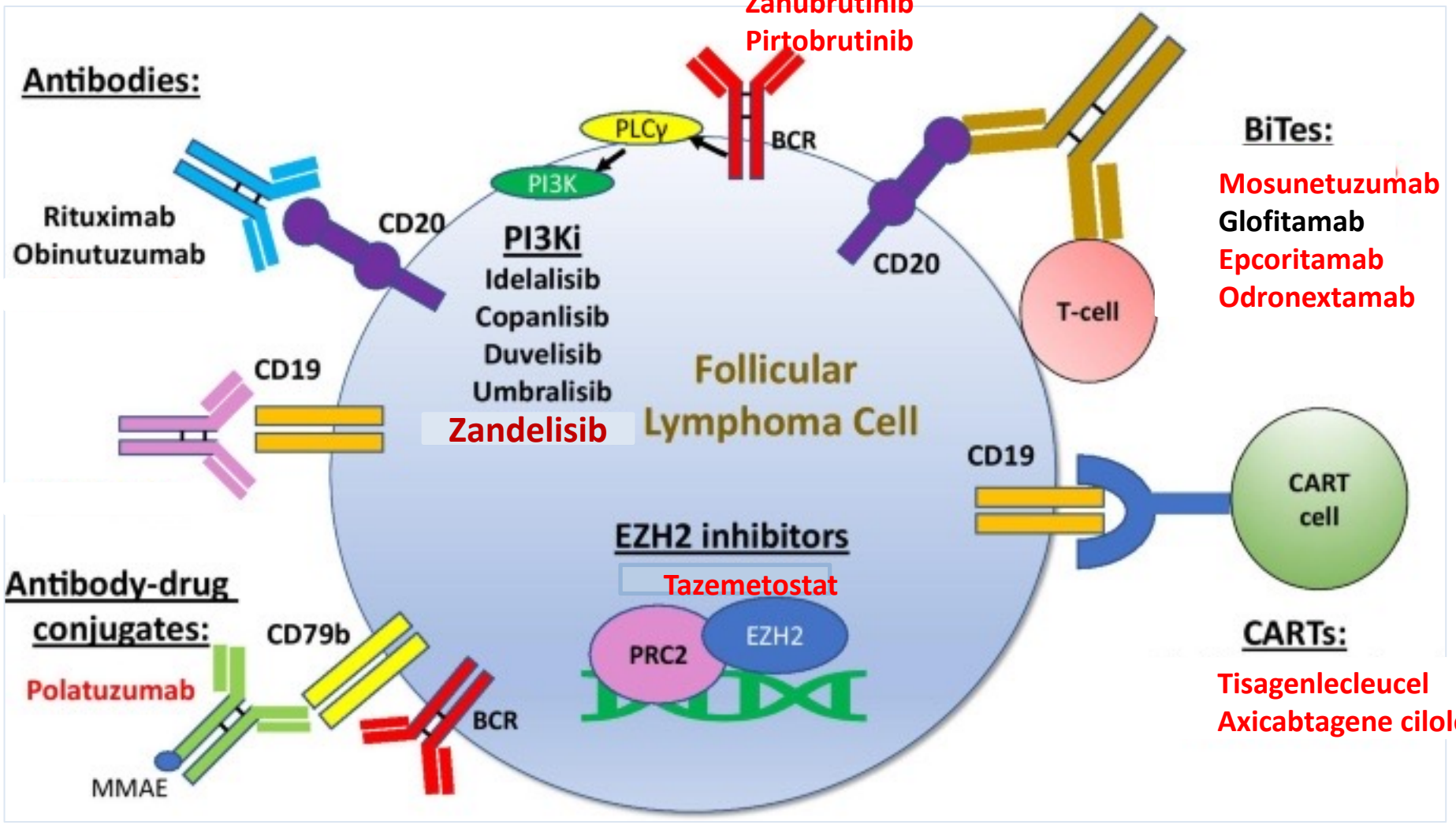
PFS favored G-chemo vs R-chemo in patients with an intermediate-to-high-risk (2–5) FLIPI score

Marcus R. N Engl J Med. 2017;377:1331-44. Thowsend et al . ASH 2021

Patients with advanced stage FL who progress in their first or second years of treatment have poorer outcomes



Casulo, et al. 2015



Novel agents investigated in RR-Follicular/Indolent

Hanel, W., Epperla, N. Evolving therapeutic landscape in follicular lymphoma: a look at emerging and investigational therapies. J Hematol Oncol 14, 104 (2021).

POST-NEW ORLEANS 2022
Novità dal Meeting della Società Americana di Ematologia

Novità dal Meeting della Società Americana di Ematologia

Milano
Teatro Dal Verme
2-3-4 Febbraio 2023

COORDINATORI
Angelo Michele Carella
Pier Luigi Zinzani

BOARD SCIENTIFICO
Paolo Corradini
Mauro Krampera
Fabrizio Pane
Adriano Venditti

16.05 Linfomi indolenti	M. LADETTO
16.25 Linfomi aggressivi di derivazione B linfocitaria	A.J.M. FERRERI
16.45 Terapie di salvataggio con anticorpi monoclonali	L. RIGACCI
17.05 Discussione	

Grazie
per la cortese attenzione