The young side of
LYMPHOMA

gli under 40 a confronto

Verona, Centro Congressi Camera di Commercio
26-27 settembre 2025

Nuove terapie per il paziente con MCL R/R (non solo CAR-T)

Rita Tavarozzi

AOU SS Antonio e Biagio e Cesare Arrigo, Alessandria
Università degli Studi del Piemonte Orientale

Disclosures of Rita Tavarozzi

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
AbbVie					x		
BeOne					x		
Lilly			x		x		
Roche							x

Mantle Cell Lymphoma – *Case Presentation*

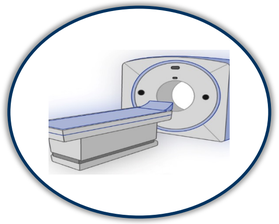
Nov 2020

•**Patient:** 58-year-old male
•**History:** Hypertension, hyperlipidemia

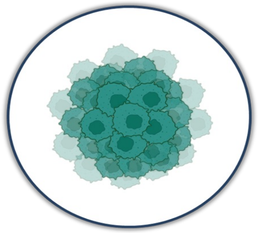
•**Symptoms:**
•Fatigue
•Weight loss (8 kg / 6 months)
•Night sweats
•Painless lymphadenopathy

•**Exam:**
•Cervical, axillary, inguinal lymphadenopathy
•Splenomegaly

•**Labs:**
•Mild anemia (Hb 11.2 g/dL)
•Elevated LDH
•Normal renal/liver function

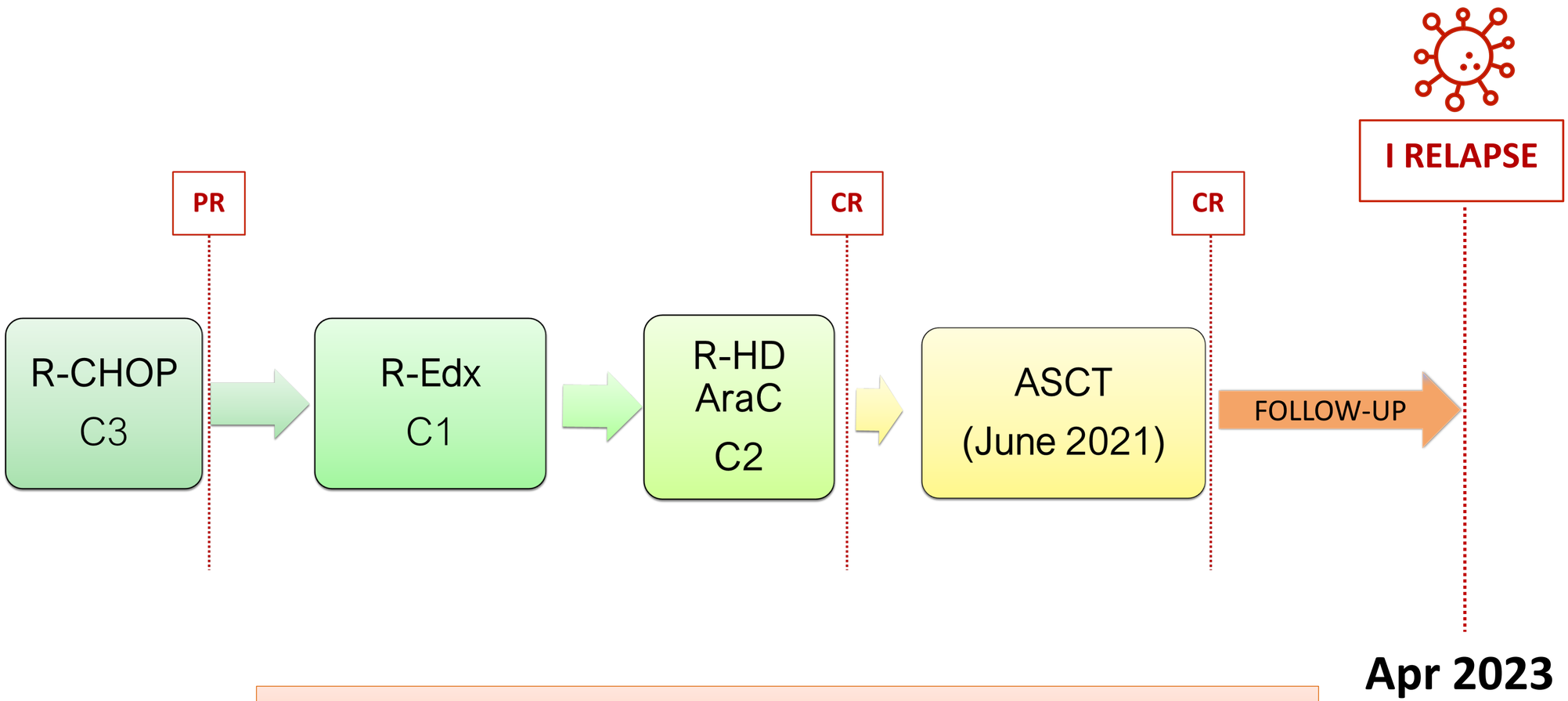


Imaging:
•Generalized lymphadenopathy
•Splenomegaly



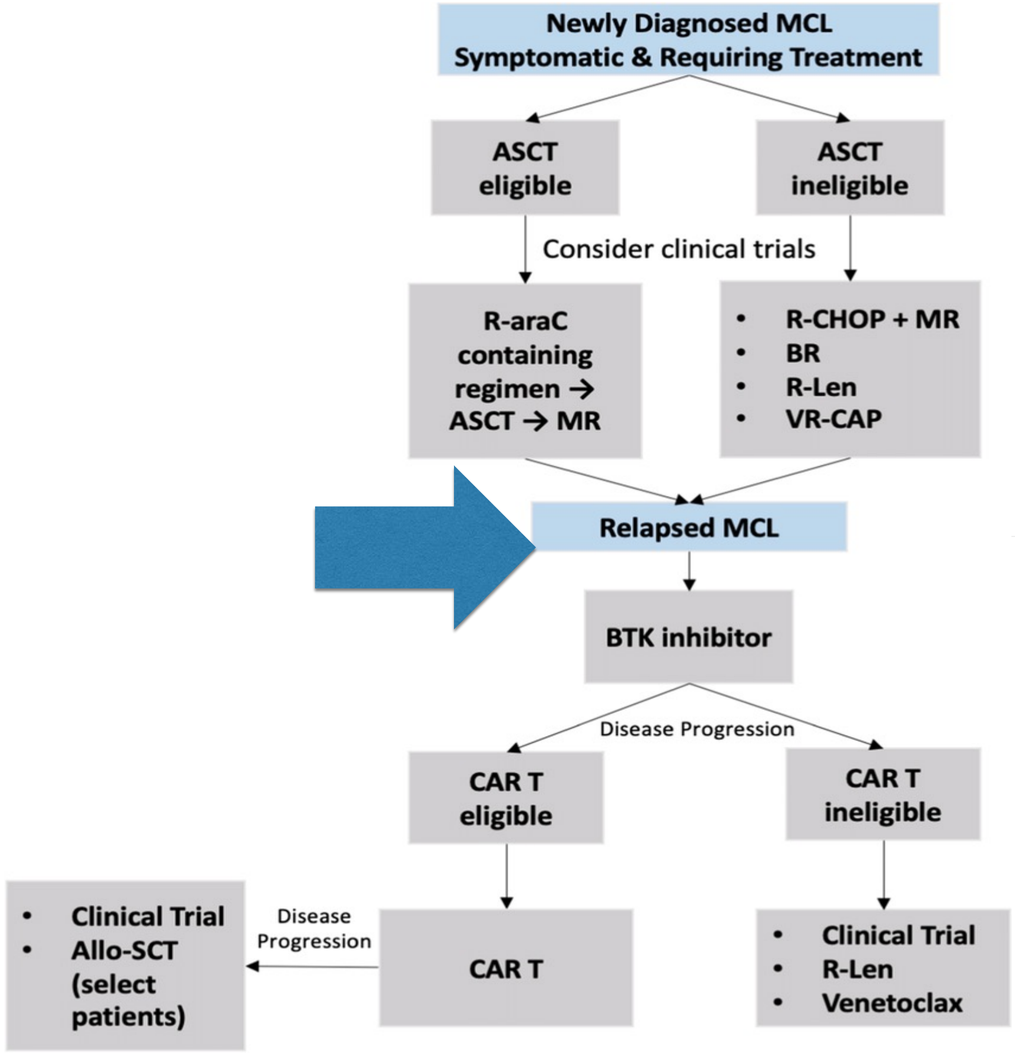
BM Biopsy:
Histology: diffuse lymphoid proliferation
Immunophenotype: CD20+, CD5+, Cyclin D1+
Ki-67: 40%
TP53: wild-type

Diagnosis:
Mantle Cell Lymphoma (Stage IVB, MIPI high-risk)



1st relapse: MCL IVA BM, colon (TP53 wt)

PRE-TRIANGLE ERA



CURRENT IS

The NEW ENGLAND JOURNAL of MEDICINE

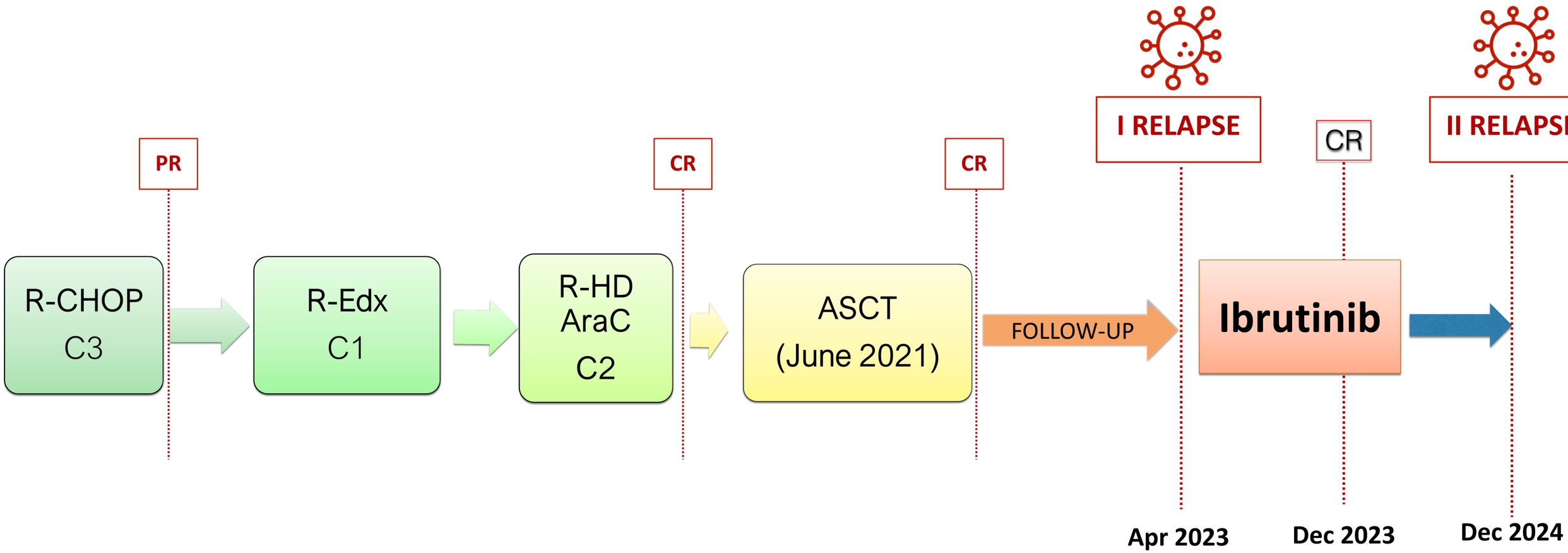
ORIGINAL ARTICLE

Targeting BTK with Ibrutinib in Relapsed or Refractory Mantle-Cell Lymphoma

Authors: Michael L. Wang, M.D., Simon Rule, M.D., Peter Martin, M.D., Andre Goy, M.D., Rebecca Auer, M.D., Ph.D., Brad S. Kahl, M.D., Wojciech Jurczak, M.D., Ph.D., +23 , and Kristie A. Blum, M.D. Author Info & Affiliations

Published August 8, 2013 | N Engl J Med 2013;369:507-516 | DOI: 10.1056/NEJMoa1306220 | VOL. 369 NO. 6

Romancik, Jason, Cohen, Jonathon, Sequencing of Novel Therapies for Mantle Cell Lymphoma- 10.1007/s11864-021-00907-3. Current Treatment Options in Oncology


PR
CR
CR
I RELAPSE
CR
II RELAPSE
R-CHOP
C3
R-Edx
C1
R-HD
AraC
C2
ASCT
(June 2021)
FOLLOW-UP
Ibrutinib
Apr 2023
Dec 2023
Dec 2024

What can I do now?

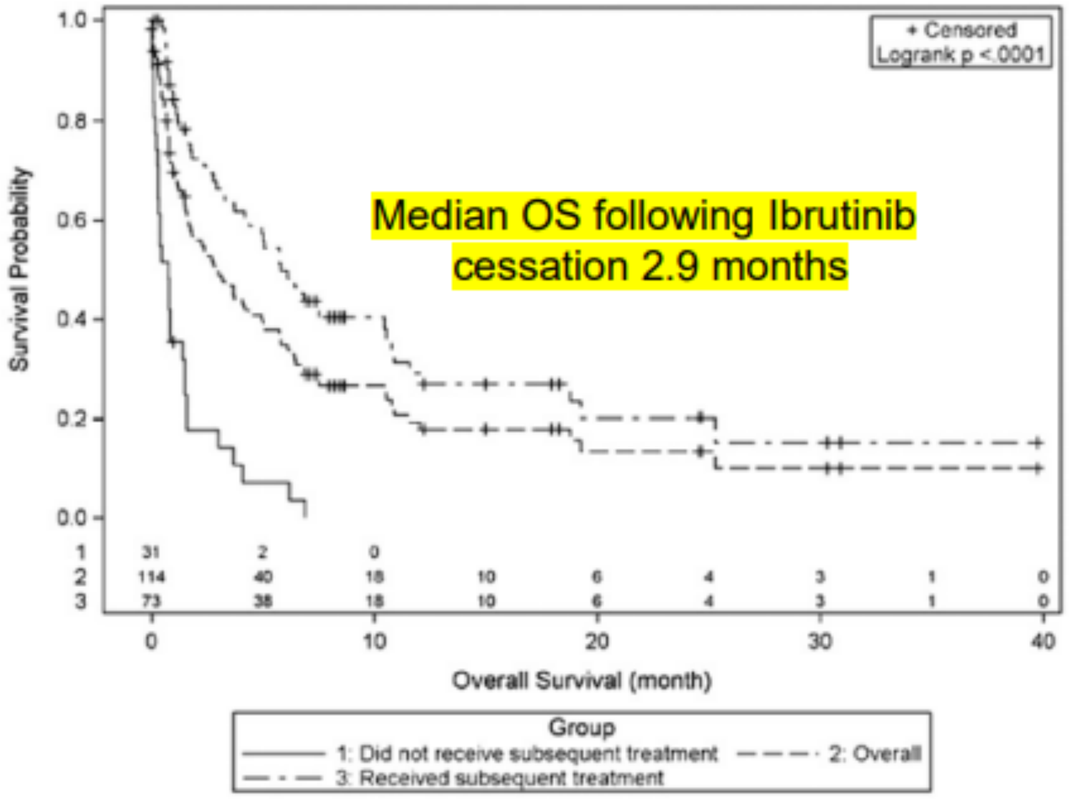
What to do after BTK inhibitor failure?

What are the treatment options after BTK inhibitor failure?

What are the available treatment options after BTK inhibitor failure?

What alternative therapies are available?

Poor outcome after BTKi failure



Characteristics	Number	Range, %, or 95% CI
All	114	
Median Age	68 y	46-85
Median prior systemic therapies	3	0-10

Response rates 29-32%

Few patients surviving beyond one year

Comment on Martin et al, page 1559

Ibrutinib: a force with a dark side?

Martin P et al, Blood 2016
Smith MR, Blood 2016
Wang M et al, ASH 2017

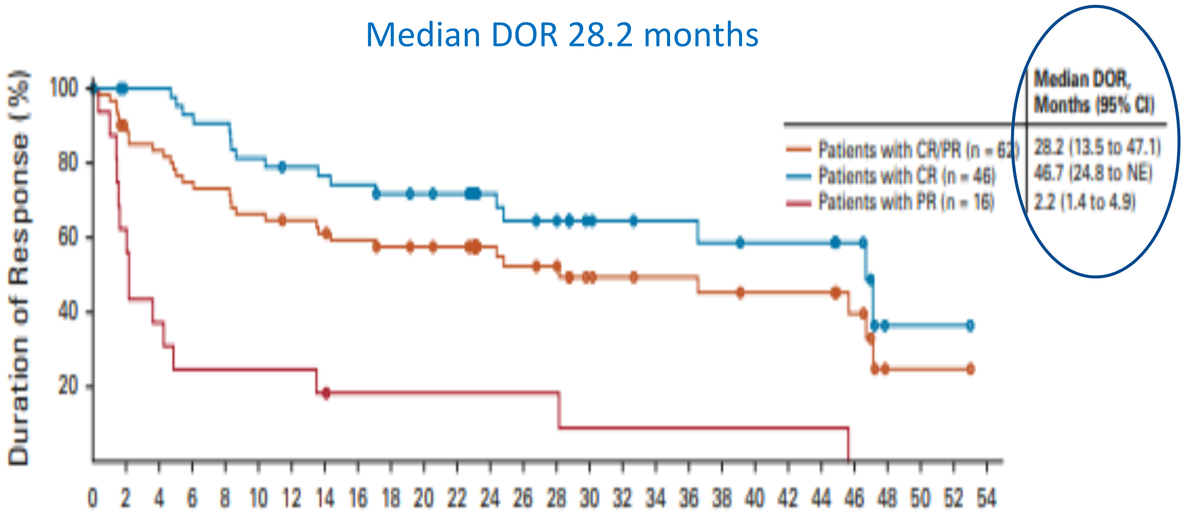
NON C'E' NOTTE TANTO LUNGA E BUIA DA NON PERMETTERE AL SOLE DI RISORGERE

Jim Morrison

CAR-T cells therapy: KTE-X19 – ZUMA 2 trial

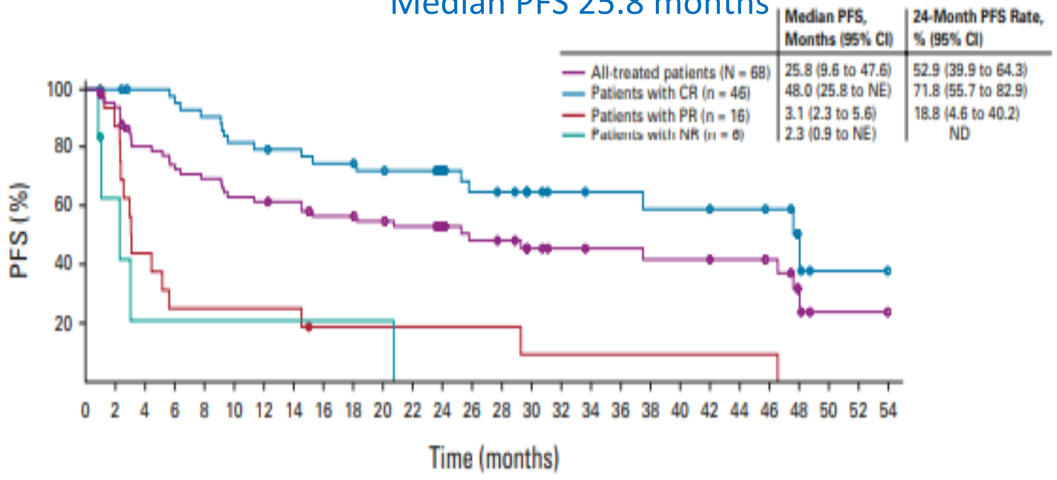
A

Median DOR 28.2 months



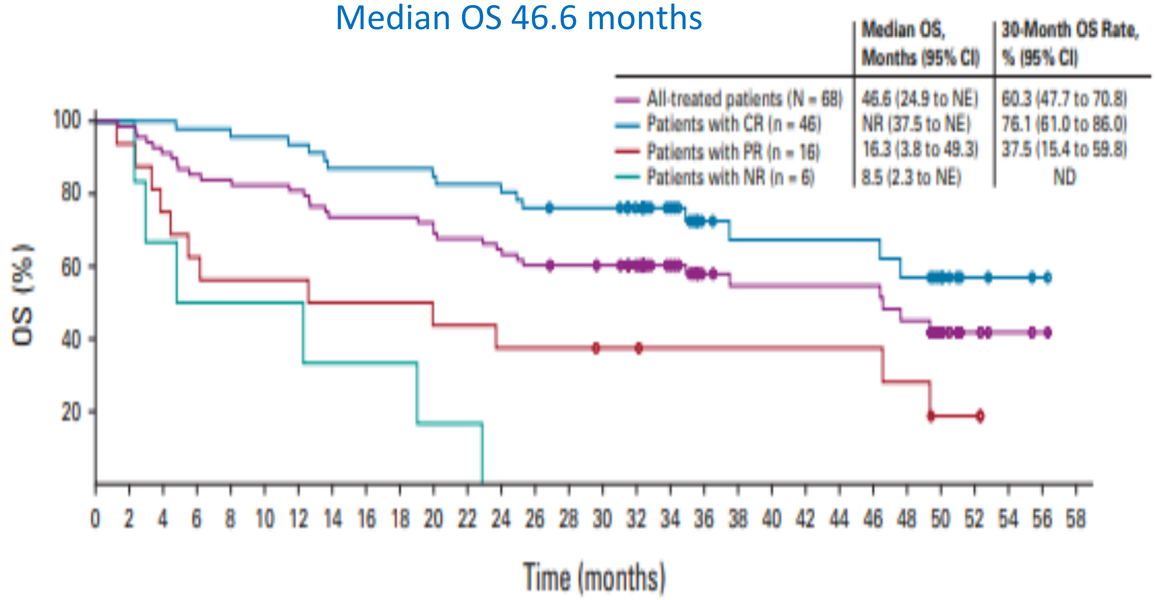
B

Median PFS 25.8 months



C

Median OS 46.6 months



Associations with long-term benefits of KTE-X19:

- ✓ high-peak CAR T-cell expansion in responders
- ✓ predictive value of minimal residual disease for relapse

Wang et al. JCO,2022 Jun 4;JCO2102370.

Table 5. Brexucel real-world studies in r/r MCL.

	UK [82]	DESCAR-T [87]	SIE [83]	DRST/GLA/ SAKK [98]	US CART consortium [26]
Study type	Registry retrospective	Registry retrospective	Registry retrospective	Registry retrospective	Registry retrospective
Eligibility	≥2L incl. BTKi; PS 0-1; no CNS disease	EMA label	≥2L; r/r to BTKi; ZUMA-2 eligible	EMA label	FDA label
N					
# intended	119	178	n.a.	n.a.	n.a.
# apheresed (%)	104 (87%)	n.a.	n.a.	n.a.	189
# infused (%)	83 (70%)	152 (85%)	106	111	168 (89%)
Period	2021–2023	2019–2023	2019–2024	2021–2023	2020–2021
Age (years; median (range))	68 (41–80)	68 (39–83)	63 (42–79)	68 (50–84)	67 (34–89)
PS > 1 (ECOG)	0	12%	0	7%	14%
High-risk features					
Ki-67 ≥ 30%	78%	79%	54%	79%	78%
Blastoid/pleomorph.	42%	31%	30%	33%	40%
TP53abn	53%	30%	29%	27%	48%
POD24	57%	n.a.	42%	n.a.	51%
Prior lines/median (range)	2 (2–7)	3 (1–9)	3 (2–5)	3 (1–8)	3 (1–10)
Prior autoHCT	34%	40%	58%	55%	28%
Prior alloHCT	13%	6%	-	8%	3%
BTKi refractory	30%	n.a.	35%	58%	76%
Holding/Bridging	90%	83%	79%	74%	68%
CIT	50%	n.a.	31%	35%	34%
BTKi ± CD20.	17%	n.a.	45%	28%	24%
Venetoclax ± x	10%	n.a.	13%	20%	27%
Response to Bridging	41% (37/91)	41% (51/125)	18% (15/83)	65% (42/65)	33% (32/95)
Toxicity					
Neurotox ≥ G3 (any)	22% (55%)	15% (55%)	18% (48%)	28% (54%)	32% (61%)
Late ICAHT ≥ G2	59%	9% (≥G3)	4.4% (≥G3)	n.a.	>18%
Severe infection	>30%	>25%	n.a.	31%	>21%
ICU admission	27%	34%	18%	22%	20%
T cell recovery 6mo	na	na	na	23%	na
Non-relapse mortality (12mo)	18%[d]	18%[a]	7.3%	10%[a]	7.1% 10.7%[d]
Best ORR/CR	87%/81%	85%/72%	88%/75%	88%/64%	90%/82%
PFS from infusion (12mo)	62%	46%	62%	69%	69%
OS from infusion (12mo)	74%	70%[c]	82%	74%	82%
Median follow-up (months)	13	12	12	12	14

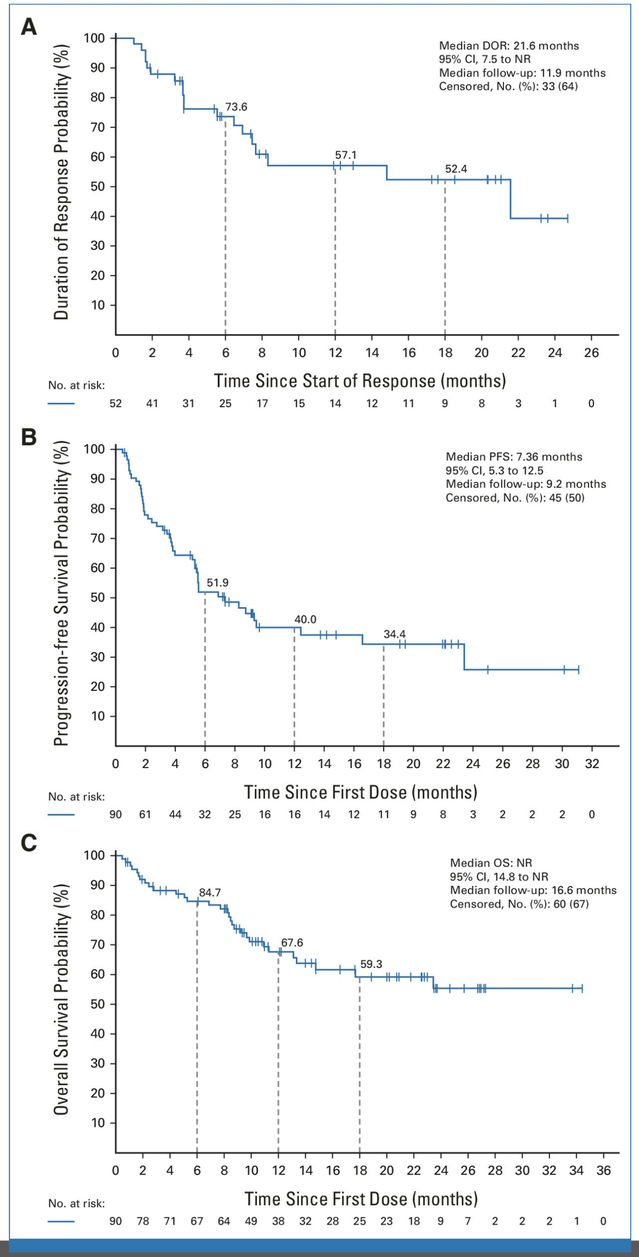
CAR-T cells therapy: Real World data

Dreger, P., Ahmed, S., Bazarbachi, A. et al. How we treat mantle cell lymphoma with cellular therapy in 2025: the European and American perspectives. Bone Marrow Transplant 60, 759–768 (2025).

TABLE 2. Efficacy of Pirtobrutinib in Patients With cBTKi Pre-treat and cBTKi-Naïve MCL

Response	cBTKi Pretreated MCL (n = 90)	cBTKi-Naïve MCL (n = 14)
Overall response rate, % (95% CI)	57.8 (46.9 to 68.1)	85.7 (57.2 to 98
Best overall response, No. (%)		
Complete response	18 (20.0)	5 (35.7)
Partial response	34 (37.8)	7 (50)
Stable disease	14 (15.6)	0
Progressive disease	15 (16.7)	1 (7.1)
Not evaluable[a]	9 (10.0)	1 (7.1)
DOR		
Patients with a response, No.	52	12
Patients with censored data, No. (%)	33 (63.5)	12 (100)
DOR, months, median (95% CI)	21.6 (7.5 to NR)	NR (NR to NR)
Median follow-up, months	11.9	7.1
PFS		
Patients with censored data, No. (%)	45 (50.0)	13 (92.9)
PFS, months, median (95% CI)	7.4 (5.3 to 12.5)	NR (NR to NR)
Median follow-up, months	9.2	8.6
OS		
Patients with censored data, No. (%)	60 (66.7)	13 (92.9)
OS, months, median (95% CI)	NR (14.8 to NR)	NR (NR to NR)
Median follow-up, months	16.6	9.4

NOTE. Overall response and best response were determined accord to the 2014 Lugano criteria[20] and on the basis of independent rev committee assessment.
Abbreviations: cBTKi, covalent Bruton tyrosine kinase inhibitor; DC duration of response; MCL, mantle-cell lymphoma; NR, not reached; overall survival; PFS, progression-free survival.
[a]Patients without postbaseline disease assessment were not



OPEN ACCESS | RAPID COMMUNICATIONS | May 16, 2023

Pirtobrutinib in Covalent Bruton Tyrosine Kinase Inhibitor Pretreated Mantle-Cell Lymphoma

Authors: Michael L. Wang, MD, Wojciech Jurczak, MD, PhD, Pier Luigi Zinzani, MD, PhD, Toby A. Eyre, MD, MBChB, DipMedEd, MRCP, FRCPath, Chan Y. Cheah, MD, Chaitra S. Ujjani, MD, Youngil Koh, MD, ... SHOW ALL ..., and Nirav N. Shah, MD | AUTHORS INFO & AFFILIATIONS

Publication: Journal of Clinical Oncology • Volume 41, Number 24 • https://doi.org/10.1200/JCO.23.00562

TABLE 3. Adverse Events in At Least 10% of All Patients With MCL

	MCL Safety Population (n = 164)			
	TEAE, (≥10%), No. (%)		TRAE, No. (%)	
Adverse Event	Any Grade	Grade ≥3	Any Grade	Grade
Fatigue	49 (29.9)	4 (2.4)	34 (20.7)	4 (2.4
Diarrhea	35 (21.3)	0	20 (12.2)	0
Dyspnea	27 (16.5)	3 (1.8)	15 (9.1)	1 (0.6
Contusion	24 (14.6)	0	16 (9.8)	0
Anemia	21 (12.8)	8 (4.9)	10 (6.1)	4 (2.4
Back pain	21 (12.8)	2 (1.2)	2 (1.2)	0
Cough	20 (12.2)	0	10 (6.1)	0
Pyrexia	19 (11.6)	0	6 (3.7)	0
Constipation	18 (11.0)	0	3 (1.8)	0
Nausea	18 (11.0)	0	7 (4.3)	0
Pneumonia	17 (10.4)	14 (8.5)	5 (3.0)	4 (2.4
Myalgia	17 (10.4)	0	14 (8.5)	0
Adverse event of special interest[a]				
Infections	59 (36.0)	28 (17.1)	24 (14.0)	5 (3.0
Bleeding	45 (27.4)	6 (3.7)	26 (15.9)	1 (0.6
Thrombocytopenia	24 (14.6)	11 (6.7)	2 (1.2)	0
Neutropenia[b]	23 (14.0)	22 (13.4)	15 (9.1)	14 (8.5
Bruising[c]	27 (16.5)	0	19 (11.6)	0 (0.0
Hemorrhage	25 (15.2)	6 (3.7)	11 (6.7)	1 (0.6
Atrial fibrillation/atrial flutter[d]	6 (3.7)	2 (1.2)	1 (0.6)	0 (0.0

NOTE. There were 11 grade 5 adverse events, none of which were considered treatment-related (two respiratory failure and one each of pneumo COVID-19 pneumonia, multiple organ dysfunction syndrome, cardiac arrest, hemorrhage, malignant pleural effusion, mucormycosis, streptococ infection, and sudden death).
Abbreviations: cBTKi, covalent Bruton tyrosine kinase inhibitor; MCL, mantle cell lymphoma; TEAE, treatment-emergent adverse event; TRA treatment-related adverse event.
[a]Adverse events of special interest are those that were previously associated with cBTKi and are all composite terms.
[b]Combines neutrophil count decreased, neutropenia, febrile neutropenia, and neutropenic sepsis.
[c]Bruising includes contusion, petechia, ecchymosis, and increased tendency to bruise.

Qual è un criterio clinico che può influenzare la scelta tra CAR-T e trattamenti farmacologici alternativi?

A) Età del paziente

B) Stato mutazionale

C) Comorbidità

D) Tutti i precedenti

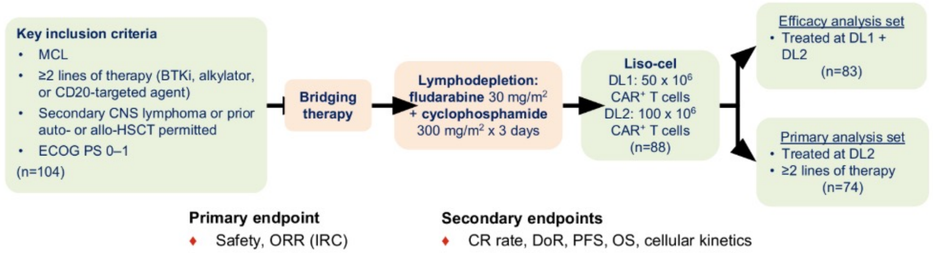
FUTURE PERSPECTIVES

- Novel BTK Inhibitor Platforms
- Bispecific : GLOFITAMAB
- Novel CAR-T product : LISO-CEL
- Clinical trials

Novel CAR-T product : *LISO-CEL*

Lisocabtagene maraleucel in R/R MCL: primary results from the MCL cohort of the TRANSCEND NHL 001 study

- To evaluate the safety and efficacy of lisocabtagene maraleucel (liso-cel, a CD19-directed CAR T cell therapy) in patients with R/R MCL in the TRANSCEND NHL 001 study



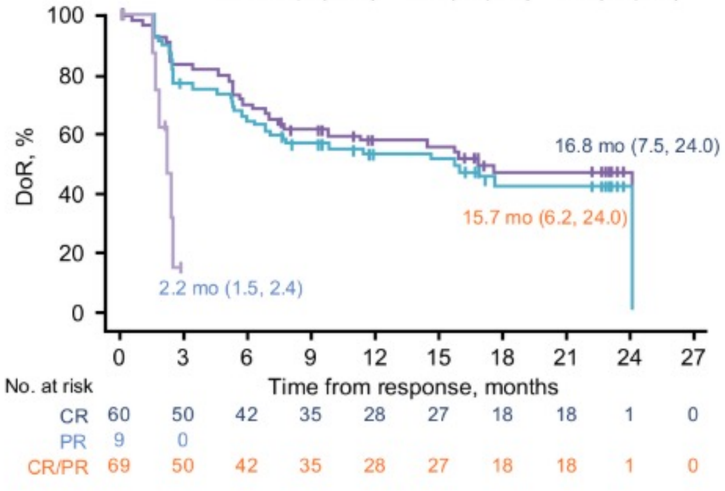
Primary endpoint
- Safety, ORR (IRC)

Secondary endpoints
- CR rate, DoR, PFS, OS, cellular kinetics

This oral presentation was presented at 17-ICML (13–17 June 2023 - www.icml.ch)
Wang M, et al. *Hematol Oncol* 2023;41(suppl 42):Abstract LBA3

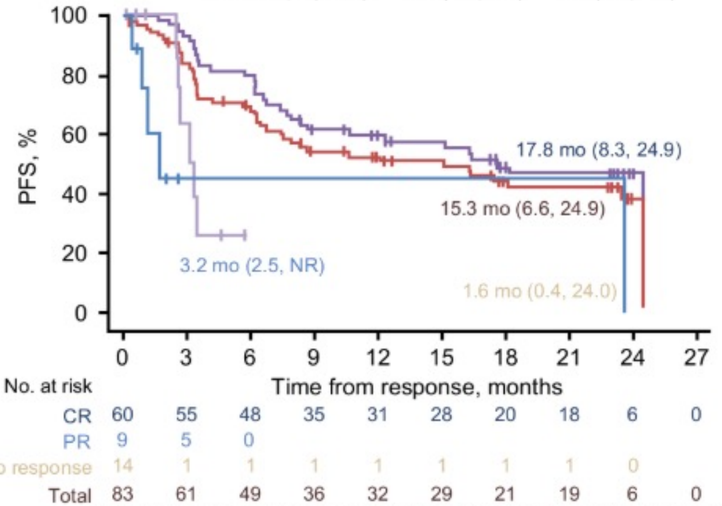
Duration of response

	Responders (n=69)	Patients with CR (n=60)
12-mo rate, % (95%CI)	52.9 (40.1, 64.2)	57.8 (44.2, 69.2)
18-mo rate, % (95%CI)	42.7 (29.9, 54.9)	46.7 (32.8, 59.4)



Progression-free survival

	Total (n=83)	Patients with CR (n=60)
12-mo rate, % (95%CI)	52.8 (40.6, 63.6)	59.8 (46.3, 71.0)
18-mo rate, % (95%CI)	43.9 (31.8, 55.4)	49.4 (35.7, 61.8)



This oral presentation was presented at 17-ICML (13–17 June 2023 - www.icml.ch)
Wang M, et al. *Hematol Oncol* 2023;41(suppl 42):Abstract LBA3

OPEN ACCESS | ORIGINAL REPORTS | October 04, 2024

Glofitamab in Relapsed/Refractory Mantle Cell Lymphoma: Results From a Phase I/II Study

Authors: Tycel Jovelle Phillips, MD, Carmelo Carlo-Stella, MD, Franck Morschhauser, MD, PhD, Emmanuel Bachy, MD, PhD, Michael Crump, MD, FRCPC, Marek Trněný, MD, Nancy L. Bartlett, MD, ... SHOW ALL ... , and Michael Dickinson, MBBS, DMedSc | AUTHORS INFO & AFFILIATIONS

Publication: Journal of Clinical Oncology • Volume 43, Number 3 • https://doi.org/10.1200/JCO.23.02470

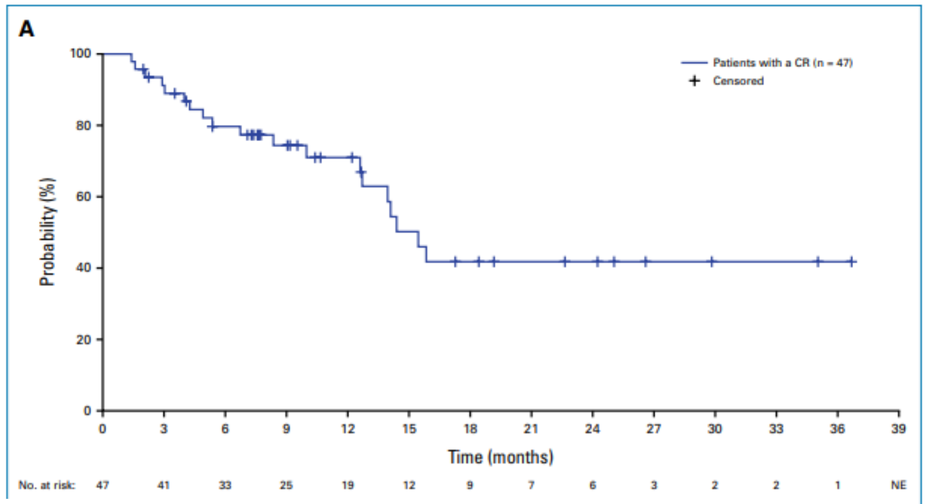


TABLE 2. Efficacy in the Overall Population (efficacy-evaluable population), and in Patients With and Without Previous BTKi Treatment

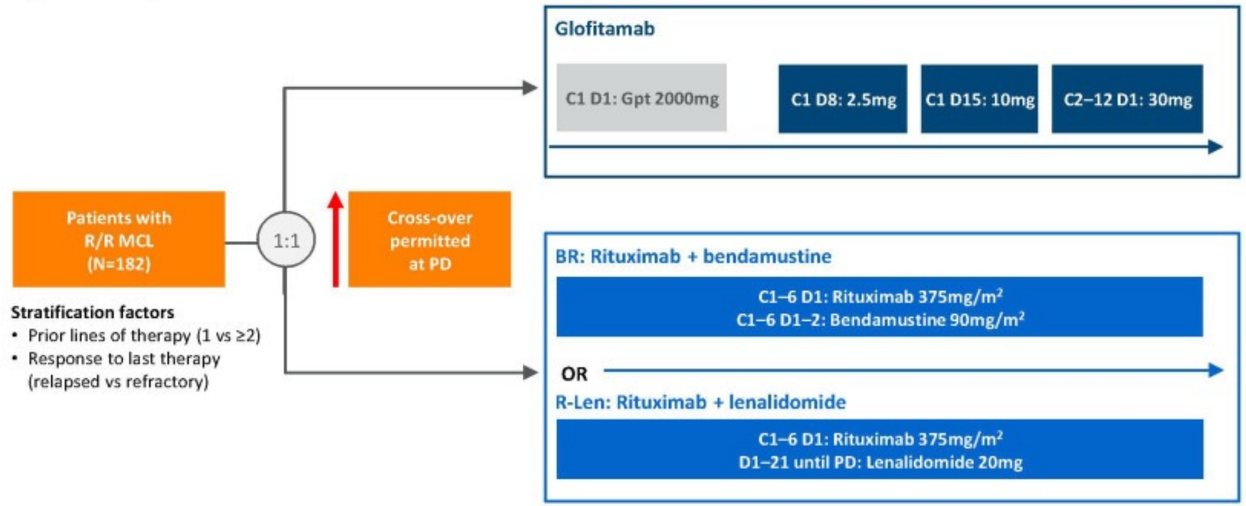
	Glofitamab SUD		All Patients		
Efficacy (INV-assessed)	1,000 mg Gpt Cohort (n = 16)	2,000 mg Gpt Cohort (n = 44)	Previous BTKi (n = 31)	No Previous BTKi (n = 29)	All Patients (N = 60)
Complete response rate					
No. (%)	11 (68.8)	36 (81.8)	22 (71.0)		
95% CI	41.3 to 89.0	67.3 to 91.8	52.0 to 85		
Partial response rate					
No. (%)	1 (6.3)	3 (6.8)	1 (3.2)		
95% CI	0.2 to 30.2	1.4 to 18.7	0.1 to 16.		
Overall response rate					
No. (%)	12 (75.0)	39 (88.6)	23 (74.2)		
95% CI	47.6 to 92.7	75.4 to 96.2	55.4 to 88		

TABLE 4. Summary of Safety in the Overall Population and by Cohort (safety-evaluable population)

	Glofitamab SUD, No. (%)		
AE	1,000 mg Gpt Cohort (n = 16)	2,000 mg Gpt Cohort (n = 44)	All Patients (N = 60)
Any AE	16 (100.0)	44 (100.0)	60 (100.0)
Grade 3/4 AE	13 (81.3)	26 (59.1)	39 (65.0)
SAE	15 (93.8)	32 (72.7)	47 (78.3)
AE leading to glofitamab withdrawal[a]	1 (6.3)	3 (6.8)	4 (6.7)
AE leading to glofitamab dose interruption	10 (62.5)	26 (59.1)	36 (60.0)
AE related to glofitamab	16 (100.0)	39 (88.6)	55 (91.7)
AE related to glofitamab leading to glofitamab withdrawal	0	1 (2.3)	1 (1.7)
AE related to glofitamab leading to glofitamab dose interruption	7 (43.8)	15 (34.1)	22 (36.7)
Grade 3/4 AEs related to glofitamab	13 (81.3)	22 (50.0)	35 (58.3)
SAE related to glofitamab	12 (75.0)	24 (54.5)	36 (60.0)
Grade 5 AE	2 (12.5)	7 (15.9)	9 (15.0)
Grade 5 AE related to glofitamab	0	0	0

GLOBRYTE: A Phase III, Open-Label, Multicenter, Randomized Trial Evaluating Glofitamab Monotherapy in Patients with Relapsed or Refractory Mantle Cell Lymphoma

Figure. Study schema



B, bendamustine; C, cycle; D, day; Gpt, obinutuzumab pretreatment; Len, lenalidomide; MCL, mantle cell lymphoma; PD, progressive disease; R/R, relapsed/refractory; R, rituximab. Relapsed disease is defined as disease progression after the last regimen; refractory disease is defined as failure to achieve a partial response or complete response to the last regimen.

MD01-01_I01_PFIL06

FONDAZIONE ITALIANA LINFOMI

Clinical Protocol

Title

A phase II, multicenter study of GlOfitamab in patients with mantle cell Lymphoma and inaDequate response or relapse following CAR T-cell therapy (GOLD)

Novel BTK Inhibitor Platforms: Is Rechallenge a Viable Option?

Ibrutinib plus venetoclax in relapsed or refractory mantle cell lymphoma (SYMPATICO): a multicentre, randomised, double-blind, placebo-controlled, phase 3 study

Michael Wang, Wojciech Jurczak, Marek Trneny, David Belada, Tomasz Wrobel, Nilanjan Ghosh, Mary-Margaret Keating, Tom van Meerten, Ruben Fernandez Alvarez, Gottfried von Keudell, Catherine Thieblemont, Frederic Peyrade, Marc Andre, Marc Hoffmann, Edith Szafer-Glusman, Jennifer Lin, James P Dean, Jutta K Neuenburg, Constantine S Tam

SYMPATICO Study Design

- SYMPATICO (NCT03112174) is multinational, randomized, double-blind, placebo-controlled, phase 3 study

SYMPATICO (N=267)
- Age ≥18 years
- R/R MCL
- 1–5 prior therapies for MCL
- ≥1 prior rituximab/anti-CD20-containing regimen
- ECOG PS 0–2

Randomized 1:1

Ibrutinib + venetoclax (n=134)
Ibrutinib 560 mg once daily + venetoclax 5-week ramp-up to 400 mg once daily for 24 months

Ibrutinib + placebo (n=133)
Ibrutinib 560 mg once daily + placebo once daily for 24 months

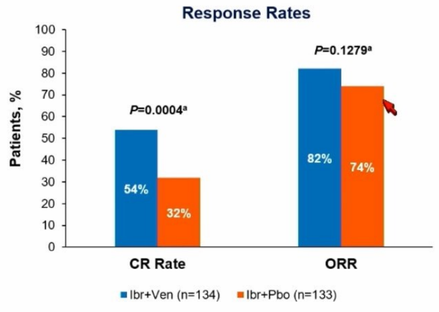
Single-agent ibrutinib 560 mg once daily until PD or unacceptable toxicity

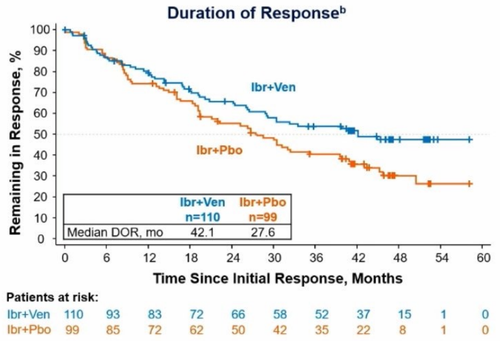
Stratification: ECOG PS, prior lines of therapy, TLS risk[a]

- **Primary endpoint:**
  - PFS by investigator assessment using Lugano criteria
- **Secondary endpoints (tested hierarchically in the following order):**
  - CR rate by investigator assessment
  - TTNT[b]
  - OS (interim analysis)
  - ORR by investigator assessment

CR, complete response; ECOG PS, Eastern Cooperative Oncology Group performance status; PD, progressive disease; PFS, progression-free survival; ORR, overall response rate; OS, overall survival; TLS, tumor lysis syndrome; TTNT, time to next treatment.
[a]Increased TLS risk was defined as at least 1 lesion >10 cm, or at least 1 lesion >5 cm with circulating lymphocytes >25,000 cells/mm³, and/or creatinine clearance <60 mL/min. [b]For hierarchical testing per US FDA censoring, TTNT was tested after OS.

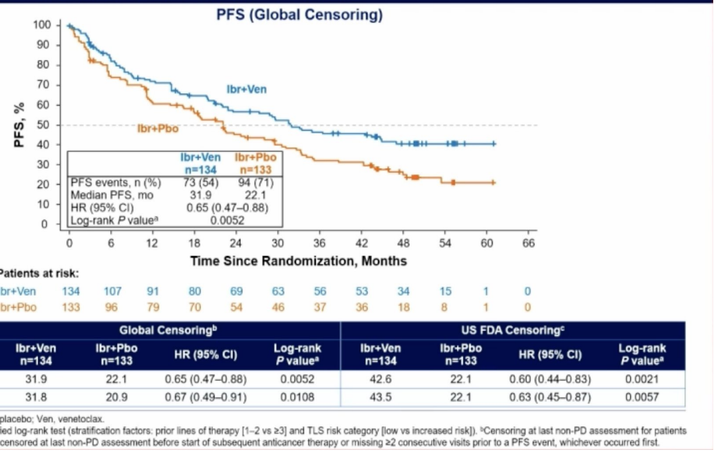
CR Rate Was Significantly Improved With Ibrutinib + Venetoclax





DOR, duration of response.
[a]*P* values were determined by stratified Cochran-Mantel-Haenszel test (stratification factors: prior lines of therapy [1–2 vs ≥3] and TLS risk category [low vs increased risk]). [b]Global censoring (censoring at last non-PD assessment for patients without PD or death).

Primary Endpoint: Investigator-Assessed PFS Was Significantly Improved With Ibrutinib + Venetoclax Versus Ibrutinib + Placebo



Median PFS, mo	Global Censoring[b]				US FDA Censoring[c]			
	Ibr+Ven n=134	Ibr+Pbo n=133	HR (95% CI)	Log-rank *P* value[a]	Ibr+Ven n=134	Ibr+Pbo n=133	HR (95% CI)	Log-rank *P* value[a]
Investigator assessment	31.9	22.1	0.65 (0.47–0.88)	0.0052	42.6	22.1	0.60 (0.44–0.83)	0.0021
IRC assessment	31.8	20.9	0.67 (0.49–0.91)	0.0108	43.5	22.1	0.63 (0.45–0.87)	0.0057

HR, hazard ratio; Ibr, ibrutinib; Pbo, placebo; Ven, venetoclax.
[a]*P* values were determined by stratified log-rank test (stratification factors: prior lines of therapy [1–2 vs ≥3] and TLS risk category [low vs increased risk]). [b]Censoring at last non-PD assessment for patients without PD or death. [c]Patients were censored at last non-PD assessment before start of subsequent anticancer therapy or missing ≥2 consecutive visits prior to a PFS event, whichever occurred first.

Michael Wang, et al. Ibrutinib Combined with Venetoclax in Patients with Relapsed/Refractory Mantle Cell Lymphoma: Primary Analysis Results from the Randomized Phase 3 Sympatico Study. *Blood, Volume 142, Supplement 2, 2023, Page LBA-2*

PR

R-CHOP
C3

R-Edx
C1

I RELAPSE

Apr 2023

CR

Dec 2023

II RELAPSE

Dec 2024

LOW-UP

Ibrutinib

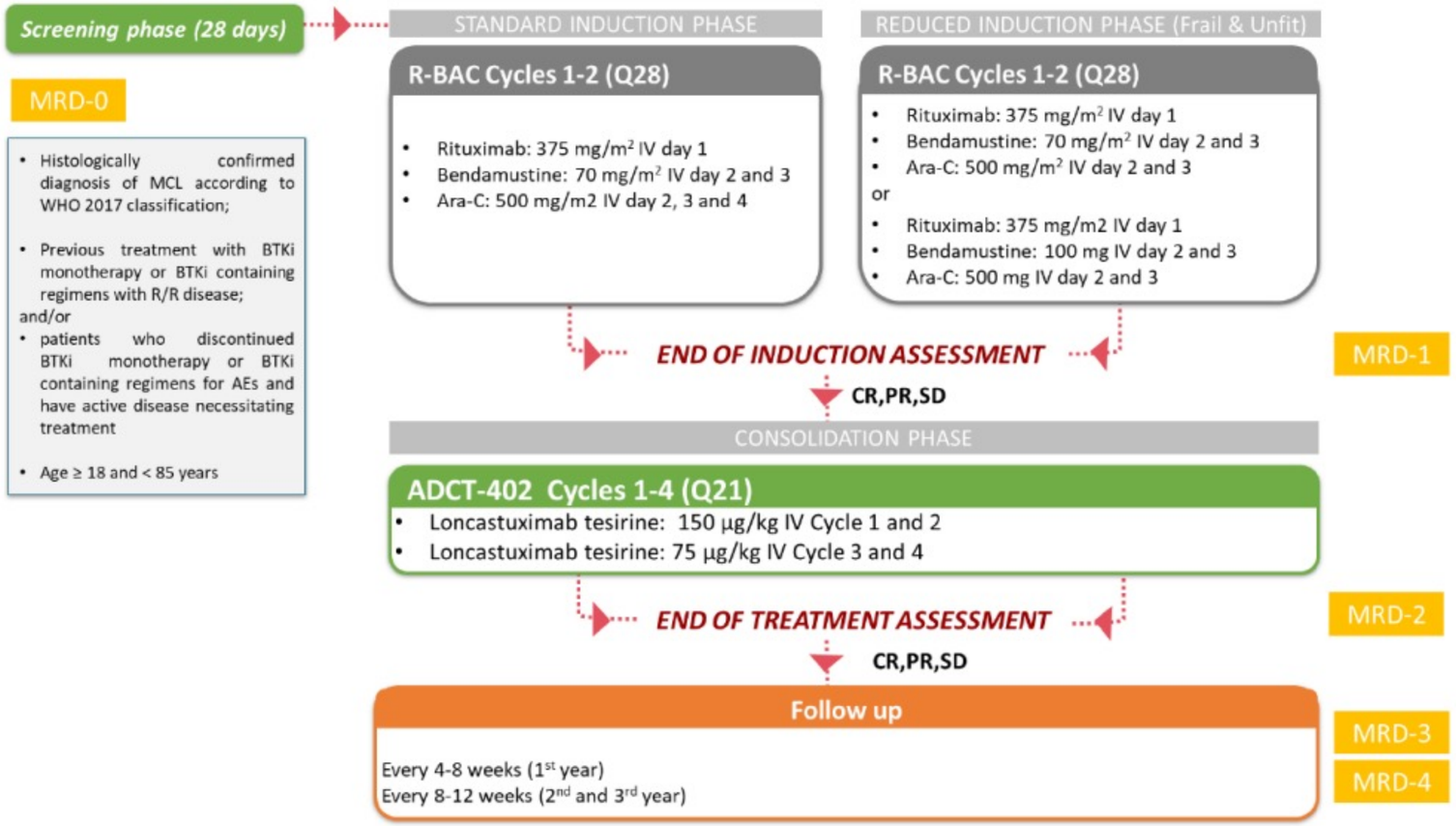
FONDAZIONE ITALIANA LINFOMI

Clinical Protocol

Consolidation with ADCT-402 (loncastuximab tesirine) after a short course of immunochemotherapy: a phase II study in BTKi-treated (or BTKi intolerant) Relapsed/Refractory (R/R) Mantle Cell Lymphoma (MCL) patients

ID Study: FIL_COLUMN

EudraCT number: 2021-000715-23



ACTIVE RECRUITING

STUDY COORDINATORS Marco Ladetto
Carlo Visco

Quale combinazione terapeutica è stata studiata molto recentemente nei pazienti con MCL RR?

A) Lenalidomide + Dexametasone

B) Rituximab + CHOP

C) Ibrutinib + Venetoclax

D) Obinutuzumab + Idelalisib

Biol Blood Marrow Transplant 19 (2013) 625–631

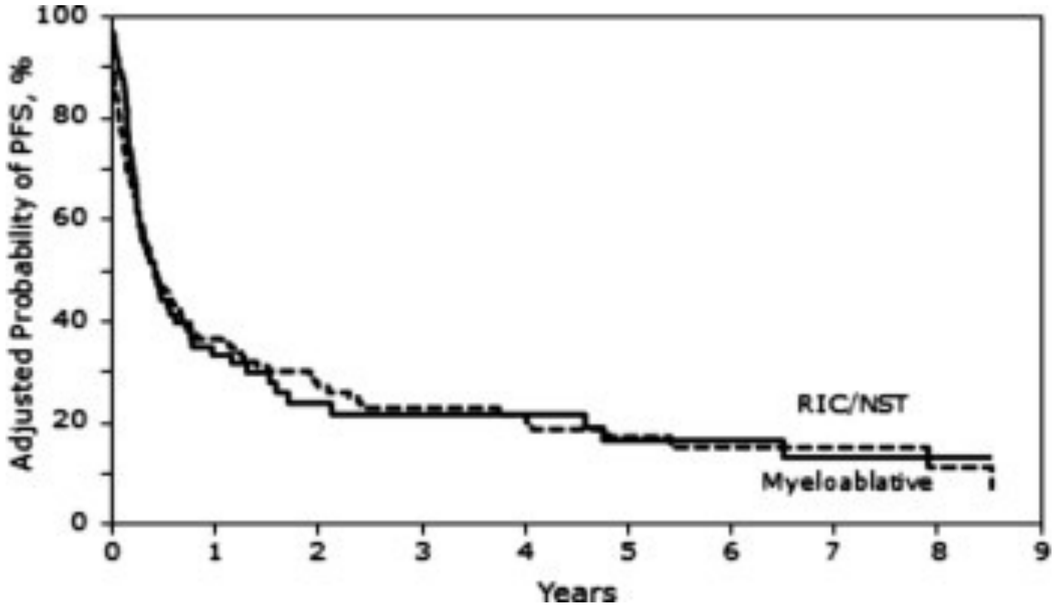
Allogeneic Hematopoietic Cell Transplantation for Chemotherapy-Unresponsive Mantle Cell Lymphoma: A Cohort Analysis from the Center for International Blood and Marrow Transplant Research

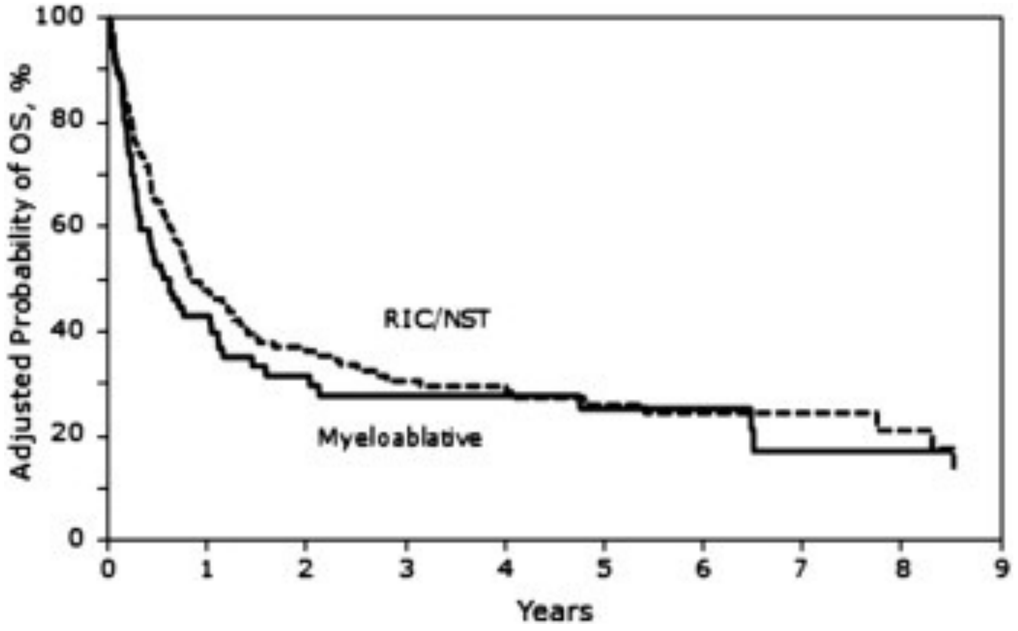
Mehdi Hamadani [1], Wael Saber [2,*], Kwang Woo Ahn [2], Jeanette Carreras [2], Mitchell S. Cairo [3], Timothy S. Fenske [4], Robert Peter Gale [5], John Gibson [6], Gregory A. Hale [7], Parameswaran N. Hari [2], Jack W. Hsu [8], David J. Inwards [9], Rammurti T. Kamble [10], Anderas Klein [11], Dipnarine Maharaj [12], David I. Marks [13], David A. Rizzieri [14], Bipin N. Savani [15], Harry C. Schouten [16], Edmund K. Waller [17], Baldeep Wirk [8], Hillard M. Lazarus [18]

Table 3
Causes of Death

Cause of Death	MA, n (%)	RIC/NST, n (%)
Total number	56	93
Graft rejection	2 (4)	1 (1)
Infection	8 (14)	11 (12)
Pulmonary syndrome	0	2 (2)
Acute respiratory distress syndrome	0	1 (1)
GVHD	3 (5)	12 (13)
Primary disease	22 (39)	39 (42)
Organ failure	7 (13)	8 (9)
2nd malignancy	0	2 (2)
Hemorrhage	3 (5)	2 (2)
Accidental death	0	1 (1)
Vascular	0	1 (1)
Toxicity	2 (4)	3 (3)
Other cause, not specified*	9 (16)	10 (11)

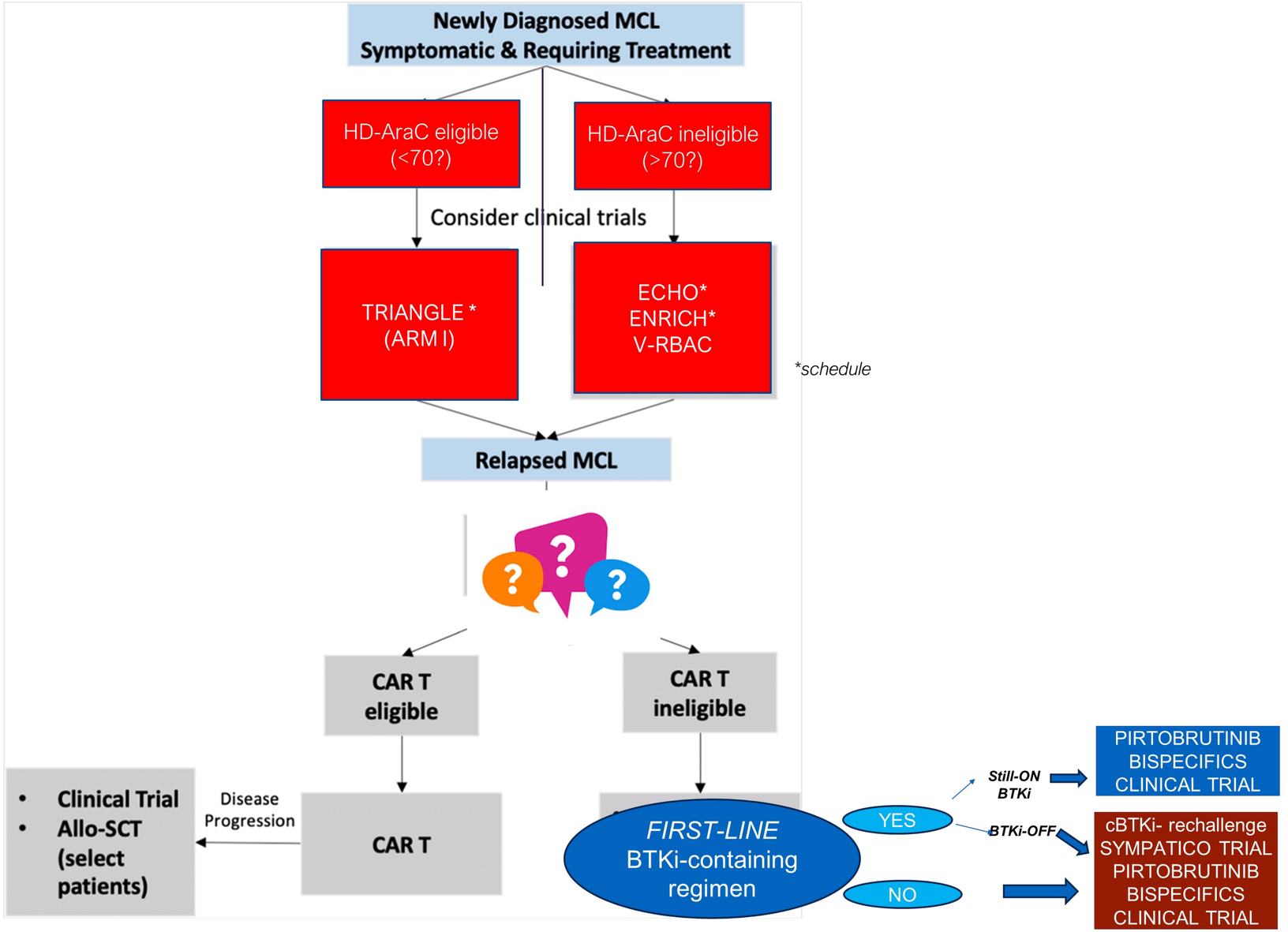
* Six cases reported as "other HSCT related cause."





BTKi ERA

Personal Opinion



CONCLUSION

- The therapeutic algorithm of MCL is rapidly evolving.
- As BTKi are moving to first line, R/R patient's management will be a critical issue.
- BTKi rechallenge shows promising activity, even after prior BTKi exposure.
- CAR-T cell therapy represents a powerful option after BTKi failure, especially in younger or fit patients, with durable responses.
- Glofitamb is emerging as a promising off-the-shelf immunotherapy, showing high response rates even in heavily pretreated patients post-BTKi.


Ευχαριστώ
謝謝
Merci
Gracias
Thank you
Danke
감사합니다
شكرا
Merci
谢谢
Danke
謝謝
Dziękuję
Gracias
Obrigado