POST-ORLANDO 2025
Novità dal Meeting della Società Americana di Ematologia

Novità dal Meeting della Società Americana di Ematologia

Torino
Centro Congressi Lingotto
19-21 febbraio 2026

COORDINATORI
Angelo Michele Carella
Pier Luigi Zinzani

BOARD SCIENTIFICO
Paolo Corradini
Mauro Krampera
Fabrizio Pane
Adriano Venditti

Carlo Visco

Linfoma mantellare

Verona

Disclosure Visco

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
AbbVie	X				X	X	
Kite-Gilead						X	
Janssen	x		x		X	X	
Gentili					X	X	
Novartis						X	
Pfizer			x		X	X	
Roche						X	
Incyte					X	X	
Servier					X		
Astra Zeneca					X		
BMS						X	
Kyowa Kirin					X		
Lilly			x		X	X	

TOPICS

FIRST LINE

Update of known trials (ECHO)

Triplets becoming mature (BOVEN, TRAVERSE)
***TP53* mutations**….a problem solved?

R/R SETTING

New drugs and CarT

TOPICS

FIRST LINE

Update of known trials (ECHO)

Triplets becoming mature (BOVEN, TRAVERSE)
***TP53* mutations**….a problem solved?

R/R SETTING

New drugs and CarT

ECHO Study Design

ECHO (NCT02972840): multicenter, double-blind, placebo-controlled, phase 3 trial

Primary endpoint:
- PFS (independent review committee)

Key secondary endpoints:
- ORR (independent review committee)
- OS

Safety

Untreated MCL (N=598)
- Age ≥65 years
- ECOG PS ≤2

Stratification

sMIPI score: Low vs intermediate vs high

Geographic region: North America vs Western Europe vs other

RANDOMIZE 1:1

ABR (N=299)

Bendamustine[a] + Rituximab[b] x 6 cycles → If ≥PR → Maintenance Rituximab (every 2 cycles x 2 years)

Acalabrutinib 100 mg BID, PO until PD or toxicity

PBR (N=299)

Bendamustine[a] + Rituximab[b] x 6 cycles → If ≥PR → Maintenance Rituximab (every 2 cycles x 2 years)

Placebo BID, PO until PD or toxicity

Crossover to acalabrutinib after PD was permitted

1 cycle = 28 days

Enrollment: April 2017 to March 2023
Sites: 195 globally

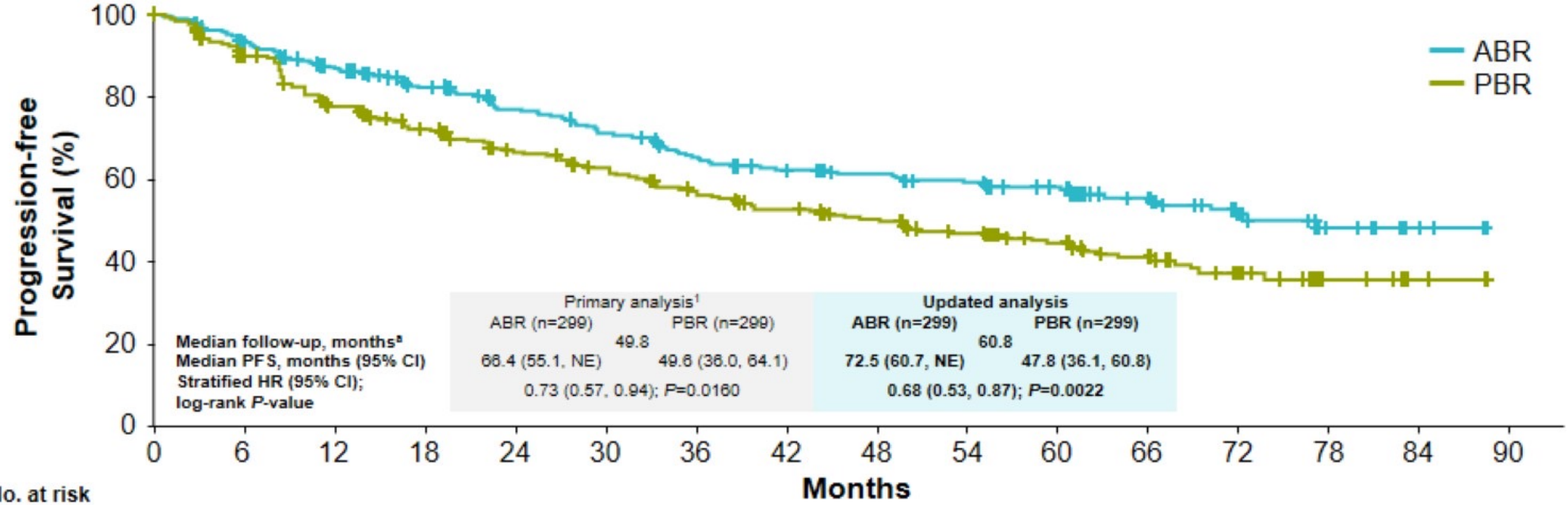
Updated Analysis (1 additional year of follow-up)

Data cutoff date: February 15, 2025

Median time on study: 51.9 (0.03–93.04) months

[a]Bendamustine 90 mg/m² on days 1 and 2. [b]Rituximab 375 mg/m² on day 1.
ABR, acalabrutinib plus bendamustine-rituximab; BID, twice daily; ECOG PS, Eastern Cooperative Oncology Group performance status; KM, Kaplan-Meier; MCL, mantle cell lymphoma; PBR, placebo plus bendamustine and rituximab; PD, progressive disease; PFS, progression-free survival; PR, partial response; ORR, overall response rate; OS, overall survival; PO, orally; sMIPI, simplified MCL International Prognostic Index.

At 60.8 Months of Follow-up, PFS Further Improved With ABR vs PBR



No. at risk																
ABR	299	258	232	205	184	165	147	131	123	115	95	70	39	18	4	0
PBR	299	244	205	182	160	145	128	116	103	89	74	56	27	11	3	0

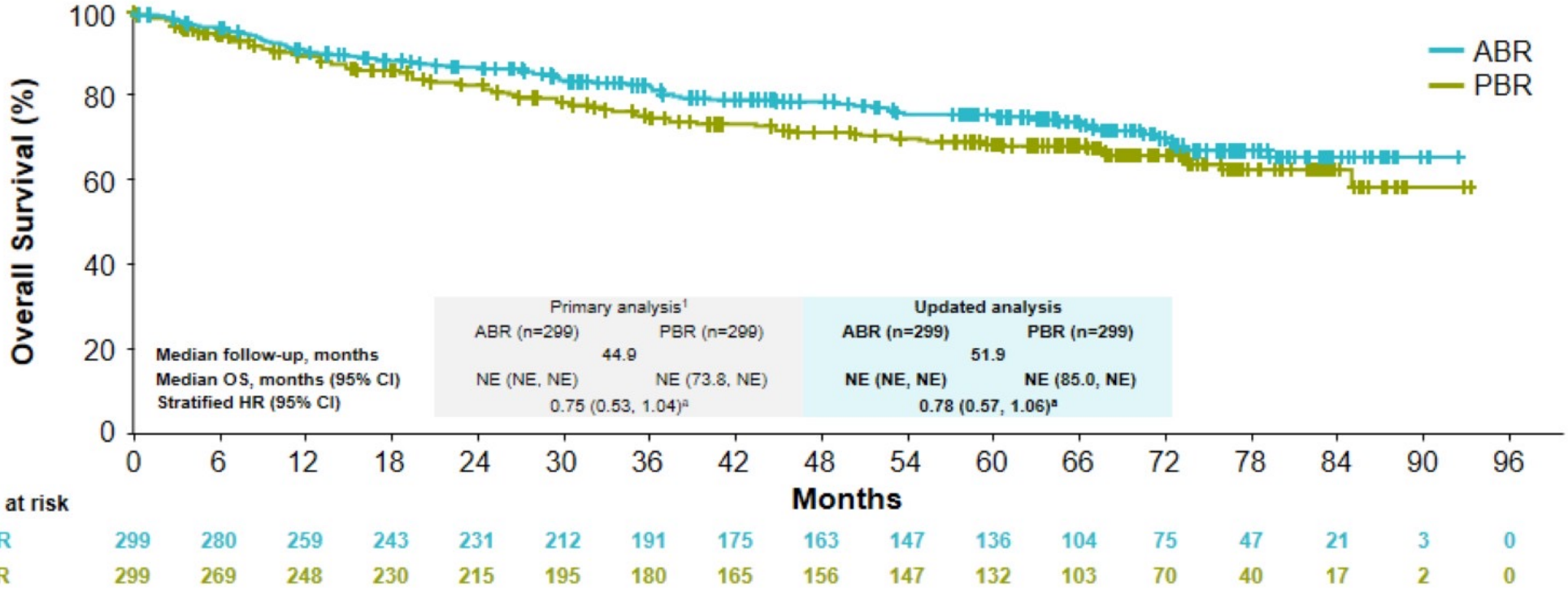
- PFS risk reduction with ABR vs PBR increased from 27% (primary analysis) to 32% (updated analysis)
- Median PFS was longer with ABR vs PBR (6 years vs 4 years)

[a]Median follow up for PFS estimated using the reverse K-M method.
ABR, acalabrutinib plus bendamustine-rituximab; CI, confidence interval; HR, hazard ratio; K-M, Kaplan-Meier; NE, not estimable; PBR, placebo plus bendamustine-rituximab; PFS, progression-free survival.

1. Wang M, et al. *J Clin Oncol*. 2025;43:2276-84.

ECHO Analysis

Prespecified OS Analysis Censoring for COVID-19 Deaths Showed Similar Trend as the Primary Analysis



	Primary analysis[1]		Updated analysis	
	ABR (n=299)	PBR (n=299)	ABR (n=299)	PBR (n=299)
Median follow-up, months	44.9		51.9	
Median OS, months (95% CI)	NE (NE, NE)	NE (73.8, NE)	NE (NE, NE)	NE (85.0, NE)
Stratified HR (95% CI)	0.75 (0.53, 1.04)[a]		0.78 (0.57, 1.06)[a]	

No. at risk																	
ABR	299	280	259	243	231	212	191	175	163	147	136	104	75	47	21	3	0
PBR	299	269	248	230	215	195	180	165	156	147	132	103	70	40	17	2	0

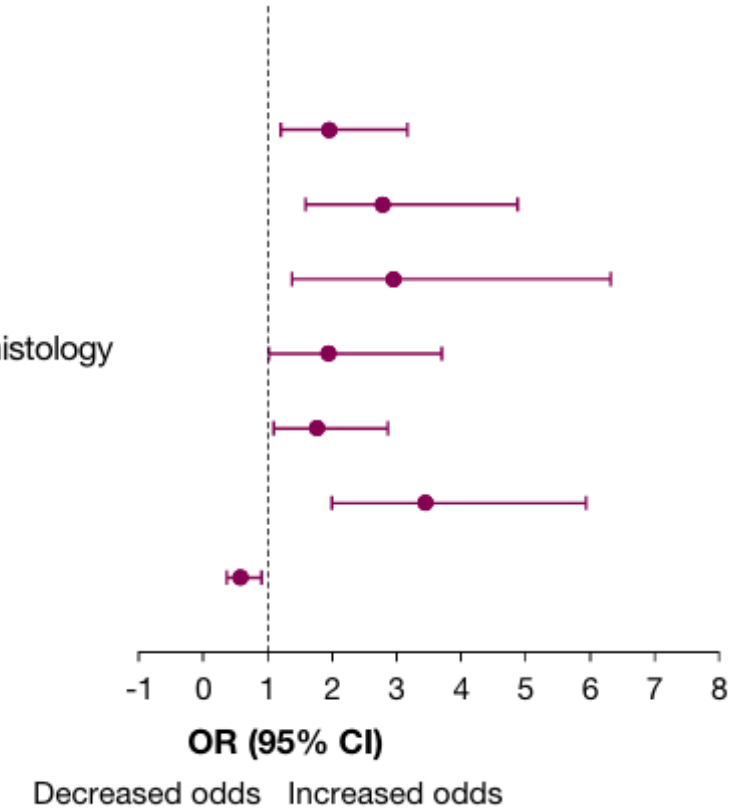
[a]This study was not powered to detect an OS benefit.
ABR, acalabrutinib plus bendamustine-rituximab; CI, confidence interval; HR, hazard ratio; NE, not estimable; OS, overall survival; PBR, placebo plus bendamustine-rituximab.

1. Wang M, et al. *J Clin Oncol*. 2025;43:2276-84.

ECHO Analysis

Factors impacting on **POD24 Status**

Comparison	OR	95% CI	*P*-value
Age ≥75 vs <75 y	1.950	1.200, 3.168	0.0070
Male vs female	2.782	1.587, 4.875	0.0004
Ann Arbor stage IV vs stage I–III	2.951	1.378, 6.320	0.0054
Blastoid/pleomorphic vs classic or other histology	1.943	1.020, 3.701	0.0434
Ki-67 ≥30% vs <30%	1.768	1.091, 2.864	0.0207
LDH ≥ULN	3.444	1.997, 5.939	<0.0001
Acalabrutinib vs Placebo	**0.577**	**0.366, 0.909**	**0.0177**



Cheah C, et al. ASH 2025

8

Need for Subsequent Anticancer Therapy Was 3-fold Higher With PBR

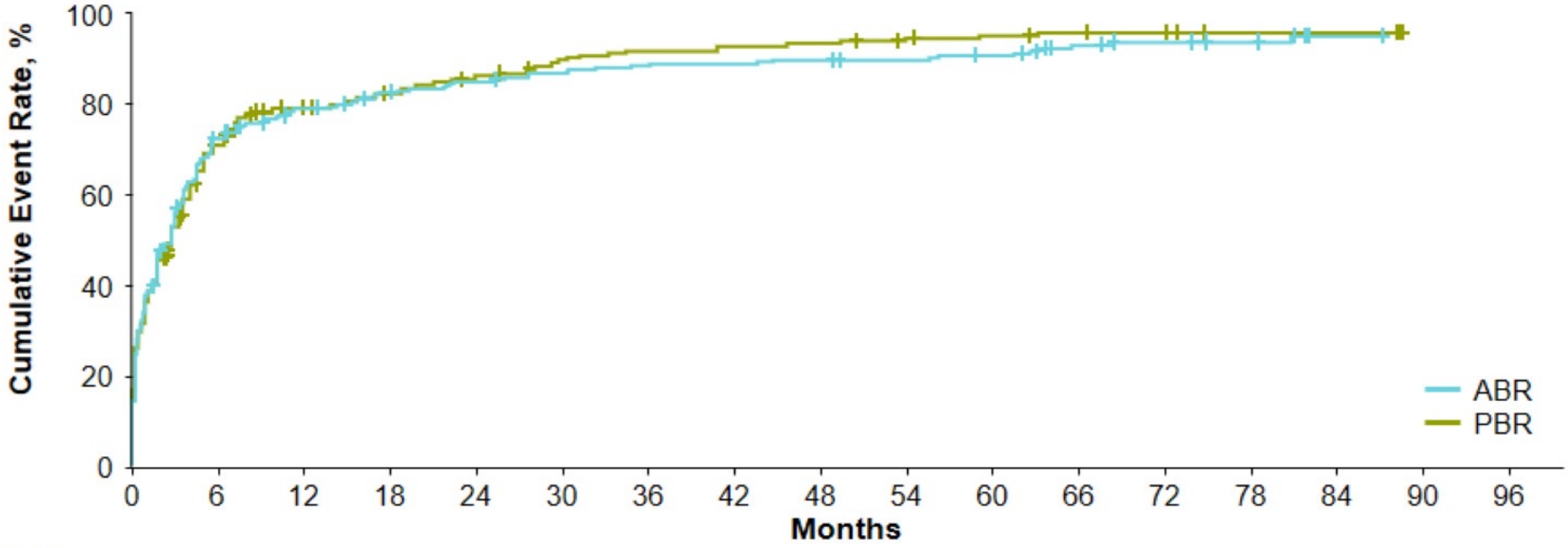
Subsequent therapy was required by 11% with ABR vs 33% with PBR

Number of Patients	ABR (n=299)	PBR (n=299)
≥1 subsequent anticancer therapy	33	100
2L anticancer therapy[a,b]	**33**	**100**
BTKi	12	79
Chemotherapy	11	13
Non-BTKi targeted therapy[c]	9	6[e]
Others[d]	1	3[e]
3L anticancer therapy[a,b]	**10**	**37**
BTKi	3	7
Chemotherapy	4	19
Non-BTKi targeted therapy[c]	3	11
4L+ anticancer therapy[a,b]	**3**	**14**
BTKi	0	5
Chemotherapy	2	7
Non-BTKi targeted therapy[c]	1	7

- 57 of 79 patients in the PBR arm who received BTKis in 2L received acalabrutinib on study as crossover

[a]A patient receiving multiple subsequent anticancer therapies in the same category is counted only once in the corresponding category.
[b]A patient receiving subsequent anticancer therapies in multiple categories is counted once in all categories.
[c]Targeted therapy includes all other non-BTKi targeted therapies, including CAR-T (ABR, n=2; PBR, n=5) and T-cell engager therapy (PBR, n=3).
[d]"Others" category included radiotherapy and Chinese medicine. "Others" category not included under 3L and 4L+ lines due to 0 applicable patients.
[e]One patient received both targeted therapy (sonrotoclax) and other (radiotherapy) therapy.
2L, second-line; 3L, third-line; 4L+, fourth-line or greater; ABR, acalabrutinib plus bendamustine-rituximab; BTKi, Bruton tyrosine kinase inhibitor; CAR-T, chimeric antigen receptor T-cell therapy; PBR, placebo plus bendamustine-rituximab; SCT, stem cell therapy.

Cumulative Event Rate of Grade ≥3 Adverse Events Was Comparable Between Treatment Arms



No. at risk																
ABR	297	80	57	43	36	31	27	26	24	22	19	11	8	6	1	0
PBR	297	81	50	39	31	21	17	15	14	11	8	6	5	2	2	0

Grade ≥3 according to the Common Terminology Criteria for Adverse Events (CTCAE) version 4.03 or higher.

TOPICS

FIRST LINE

Update of known trials (ECHO)

Triplets becoming mature (BOVEN, TRAVERSE)
***TP53* mutations**….a solved problem?

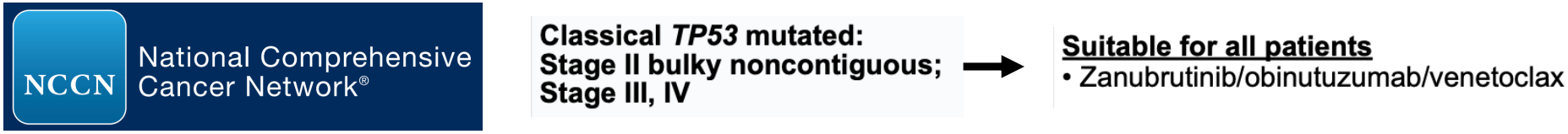
R/R SETTING

New drugs and CarT

Background

- For older MCL patients, frontline treatments are rapidly evolving with incorporation of targeted therapies.

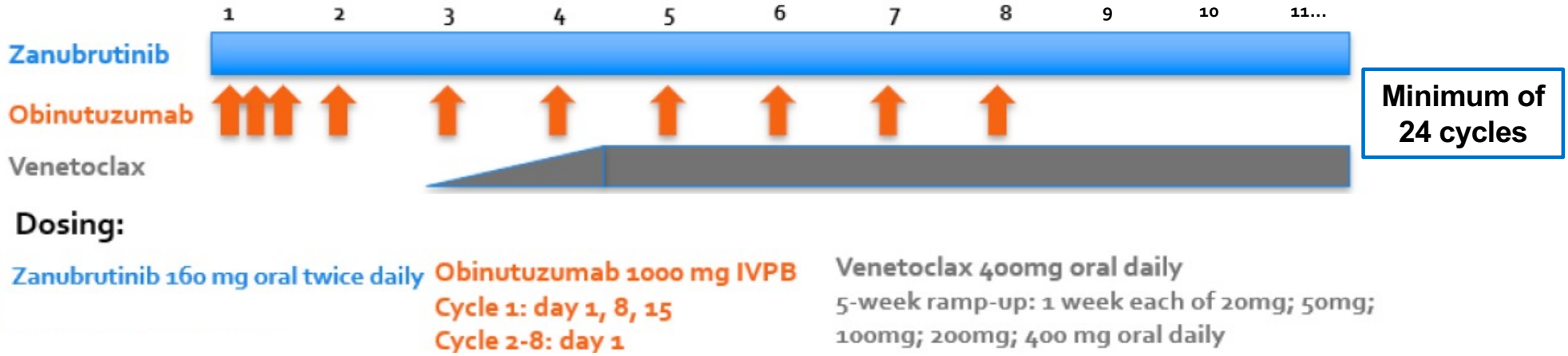
- Results of the BOVen triplet (*Zanubrutinib, Obinutuzumab, and Venetoclax*) for *TP53*-mutant MCL reported on a small series at ASH2024



- The results of 2 phase II, multi-center trials, with triplets in the frontline setting (**BOVEN**, **TRAVERSE**) were reported at ASH2025

Kumar *Blood* 2025
Zelenetz *J Natl Compr Canc Netw* 2025

Study Design for **BOVen**



Dosing:

Zanubrutinib 160 mg oral twice daily

Obinutuzumab 1000 mg IVPB
Cycle 1: day 1, 8, 15
Cycle 2-8: day 1

Venetoclax 400mg oral daily
5-week ramp-up: 1 week each of 20mg; 50mg; 100mg; 200mg; 400 mg oral daily

After 24 cycles, MRD-driven approach to limit treatment duration in selected patients:

CR and uMRD6 →	Stop treatment
<CR and/or dMRD6 →	Continue ZANU and VEN

Key Eligibility Criteria:
- Previously untreated MCL
- ≥ 65 years of age or with comorbidities precluding autologous stem cell transplantation
- ECOG ≤2, adequate organ and hematologic function (ANC >1, PLT >75, HGB ≥9 (unless due to MCL))

Primary Endpoint:
- 3-year progression-free survival
- A promising 3-yr PFS rate ≥70% and an unacceptable rate ≤50% (historical comparison to Bendamustine-Rituximab)

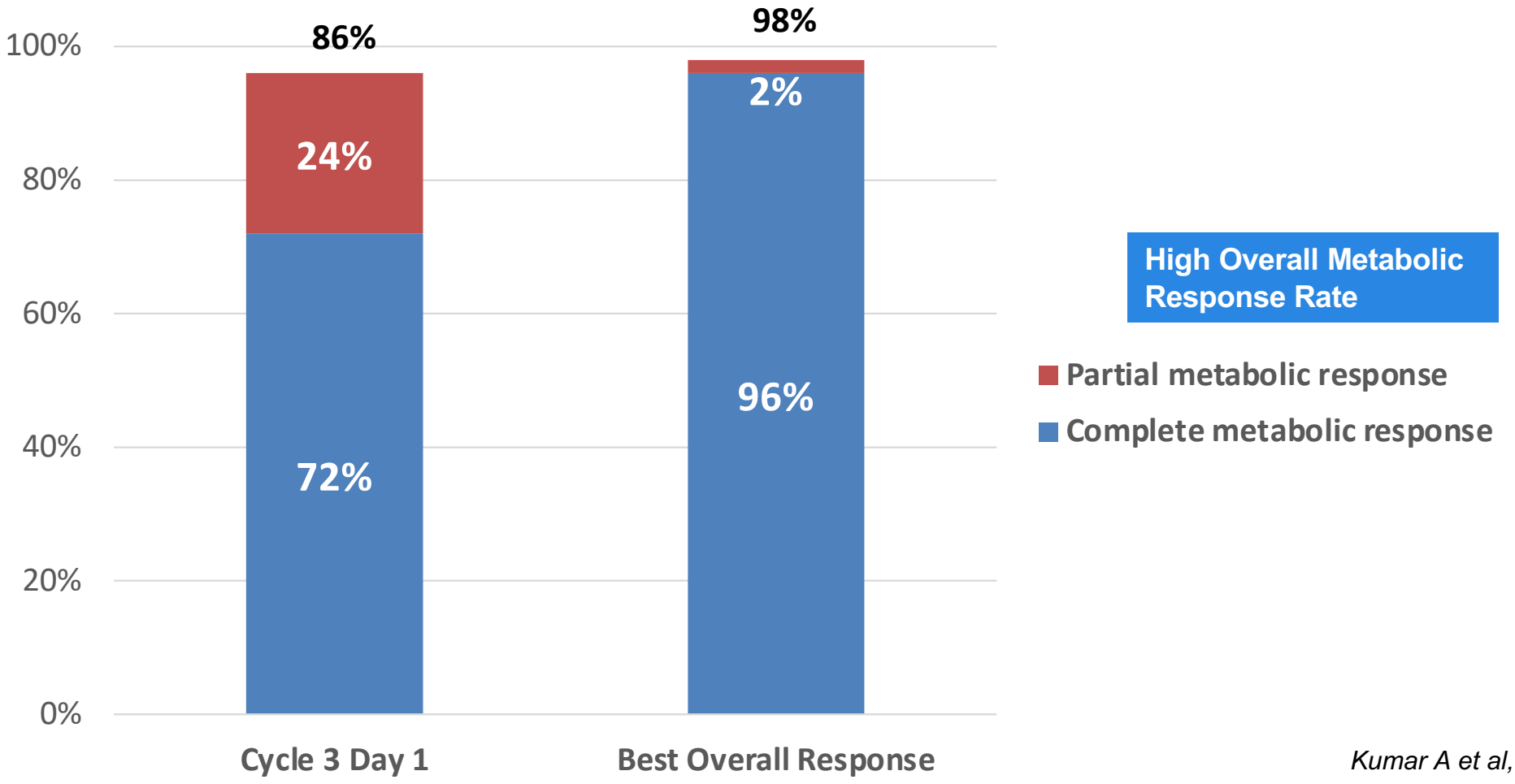
Baseline Patient Characteristics (n=50)

Characteristic	N(%)
Enrollment Site	
Memorial Sloan Kettering	20 (40%)
Massachusetts General Hospital	27 (54%)
Northwestern University	3 (6%)
Age in years	
Median (range)	72 (47-89)
≥75 years of age	17 (34%)
Sex	
Male	32 (64%)
MCL Histology	
Classical	35 (73%)
Blastoid/Pleomorphic	7 (15%)
Non-nodal leukemic	6 (13%)
Unknown	2
MIPI Classification	
Low	4 (8%)
Intermediate	11 (22%)
High	35 (70%)

Characteristic	N(%)
Ki-67 Proliferation Rate	
<30%	24 (49%)
≥30% and <50%	11 (22%)
≥50%	14 (29%)
Unknown	1
***TP53* mutation by NGS**	
Yes	13 (28%)
No	33 (72%)
Unknown	4
17p deletion by FISH / SNP Array	
Yes	10 (20%)
No	40 (80%)
Unknown	
TP53 Mutation and 17p deletion	
Yes	7 (14%)
No	39 (78%)
Unknown	4

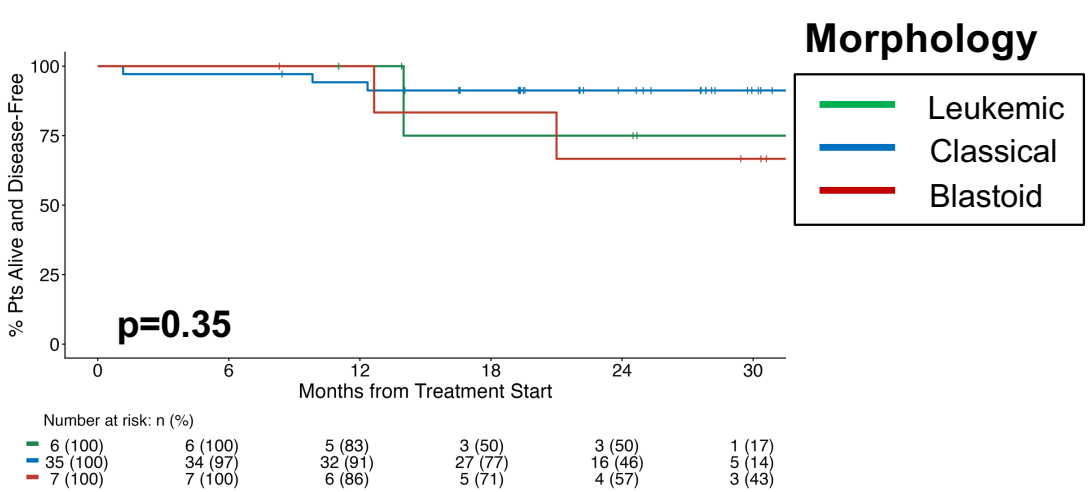
Kumar A et al, ASH 2025

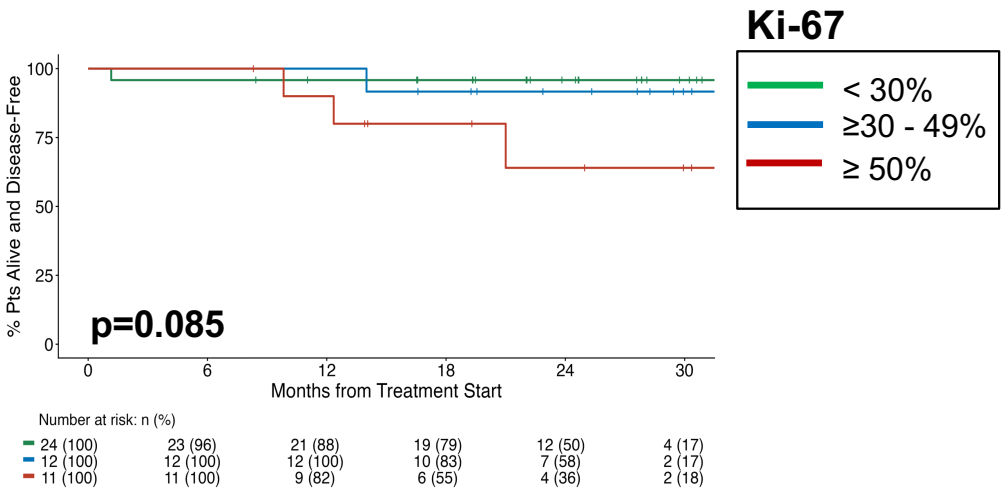
Metabolic Response Rate, n=50

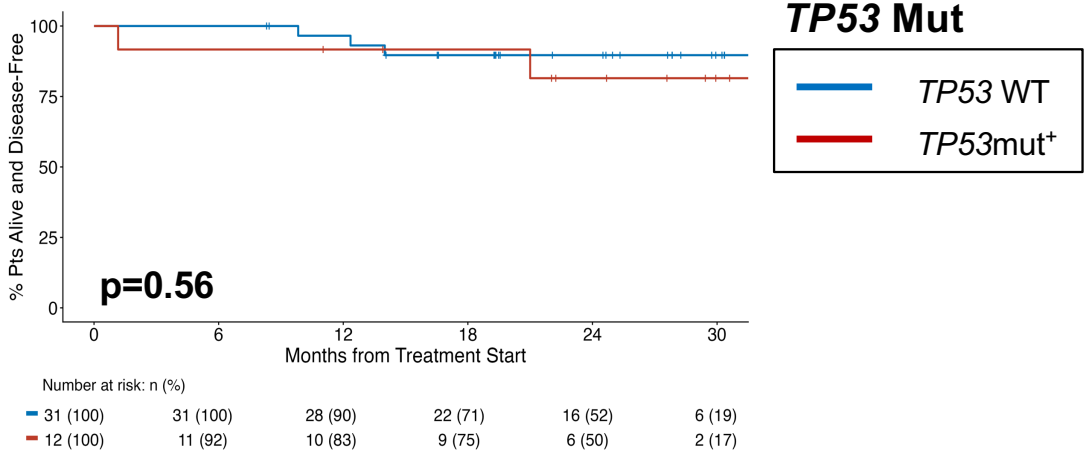


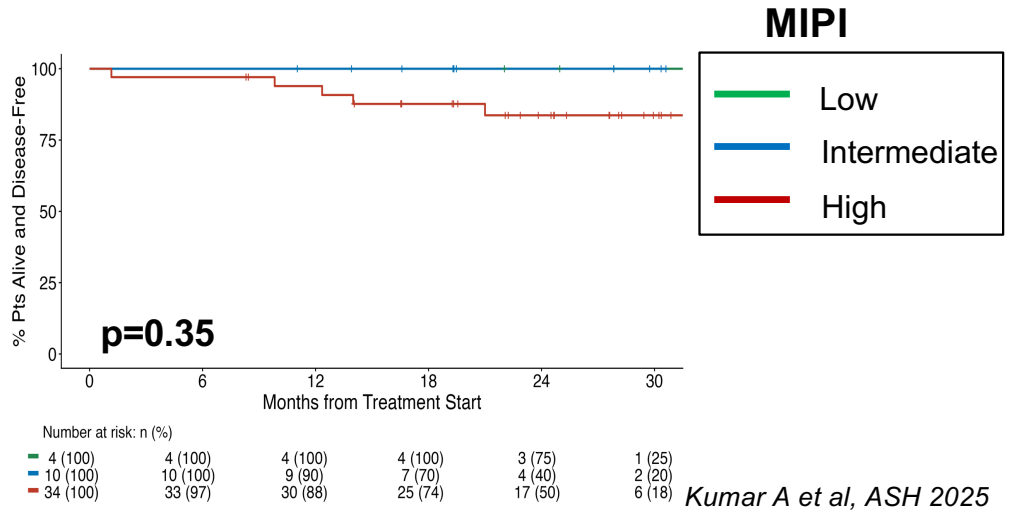
Kumar A et al, ASH 2025

PFS by Baseline Factors









Kumar A et al, ASH 2025

Presentation 884

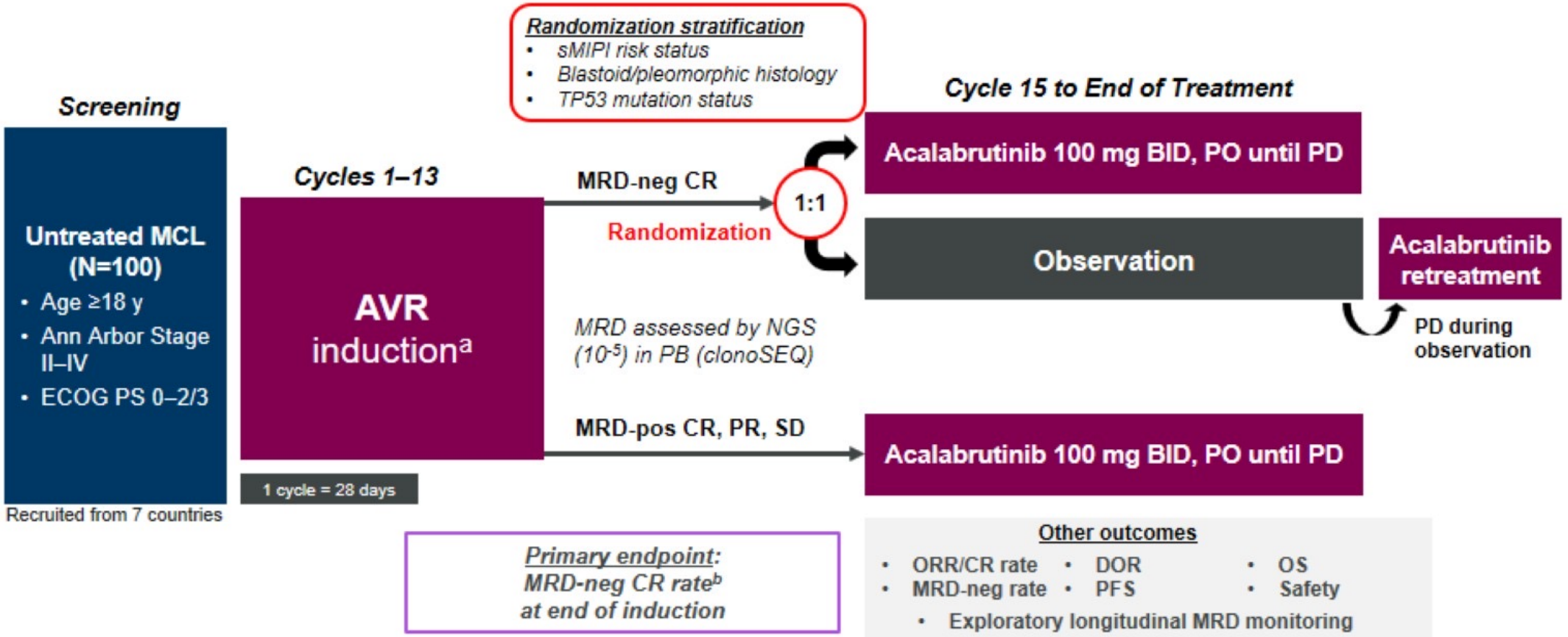
Acalabrutinib Plus Venetoclax and Rituximab in Patients With Treatment-Naive Mantle Cell Lymphoma: Results From the Phase 2 TrAVeRse Study

Eliza A. Hawkes, MBBS, FRACP, DMedSc,[1] Joanna Romejko-Jarosinska, MD, PhD,[2] Wojciech Jurczak, MD, PhD,[3] Sunil Iyengar, MRCP, FRCPath, PhD,[4] Abel Costa, MD,[5] Nimish Shah, MD, MRCP, FRCPath,[6] Monique Menzies Wojtowicz, BAppSc(Pthy), MBBS(Hons), MClinTRes,[7] Allison M. Winter, MD,[8] Adam Witkowski, MD,[9] Neil Chua, MD,[10] Ana Jiménez-Ubieto, MD, PhD,[11] John Kuruvilla, MD, FRCPC,[12] Diego Villa, MD, MPH,[13] Chan Y. Cheah, MBBS, DMSc,[14] Andre Henri Goy, MD,[15] Elise A. Chong, MD,[16] Andrew Wood, FRCPath, PhD,[17] Rachel Fletcher, PhD,[17] Stefanie Meyer, PhD,[18] Rebecca Silva, PhD,[19] Simon Rule, MD, PhD,[17] Michael Wang, MD[20]

[1]Olivia Newton-John Cancer Research Institute at Austin Health, Heidelberg, VIC, Australia; [2]Department of Lymphoid Malignancies, Maria Sklodowska-Curie National Research Institute of Oncology, Warsaw, Poland; [3]Department of Clinical Oncology, Maria Sklodowska-Curie National Research Institute of Oncology, Krakow, Poland; [4]Department of Haematology, Royal Marsden Hospital, London, United Kingdom; [5]Department of Hematology, D'or Institute for Research and Education, São Paulo, Brazil; [6]Department of Haematology, Norfolk and Norwich University Hospitals NHS Foundation Trust, Norwich, United Kingdom; [7]Macquarie University Hospital, Macquarie University, Sydney, NSW, Australia; [8]Department of Hematology and Medical Oncology, Taussig Cancer Institute, Cleveland Clinic, Cleveland, OH, USA; [9]Hematology Department, Szpitale Pomorskie, Gdynia, Poland; [10]Department of Medical Oncology, Cross Cancer Institute, Edmonton, Alberta, Canada; [11]Hematology Department, Hospital Universitario 12 de Octubre, Madrid, Spain; [12]Division of Medical Oncology and Hematology, Princess Margaret Cancer Centre, Toronto, Canada; [13]Division of Medical Oncology, BC Cancer Centre for Lymphoid Cancer and University of British Columbia, Vancouver, BC, Canada; [14]Department of Haematology, Sir Charles Gairdner Hospital, Nedlands, Australia and Medical School, University of Western Australia, Perth, Australia; [15]John Theurer Cancer Center, Hackensack Meridian Health, Hackensack, NJ, USA; [16]Lymphoma Program, Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA, USA; [17]AstraZeneca, Cambridge, UK; [18]AstraZeneca, Waltham, MA, USA; [19]AstraZeneca, Gaithersburg, MD, USA; [20]Department of Lymphoma/Myeloma, MD Anderson Cancer Center, University of Texas, Houston, TX, USA

Presented at the American Society of Hematology (ASH) 67th Annual Meeting; December 6–9, 2025; Orlando Florida

TrAVeRse Study Design: Multicenter, Open-label, Phase 2 Trial



NCT05951959.

[a]AVR induction: acalabrutinib 100 mg BID (C1–C13; also given in C14 post-induction), venetoclax (C2–C13 [5-week ramp-up in C2: 20 mg up to 400 mg daily]), rituximab (375 mg/m² day 1 of C1–12).

[b]MRD-neg (in PB by NGS [10^{-5}; clonoSEQ]) while in CR (per Lugano criteria).

AVR, acalabrutinib + venetoclax + rituximab; BID, twice daily; C, cycle; CR, complete response; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; MCL, mantle cell lymphoma; MRD, measurable residual disease; neg, negative; NGS, next-generation sequencing; ORR, overall response rate; OS, overall survival; PB, peripheral blood; PD, progressive disease; PFS, progression-free survival; PO, orally; pos, positive; PR, partial response; SD, stable disease; sMIPI, simplified Mantle Cell Lymphoma International

TrAVeRse

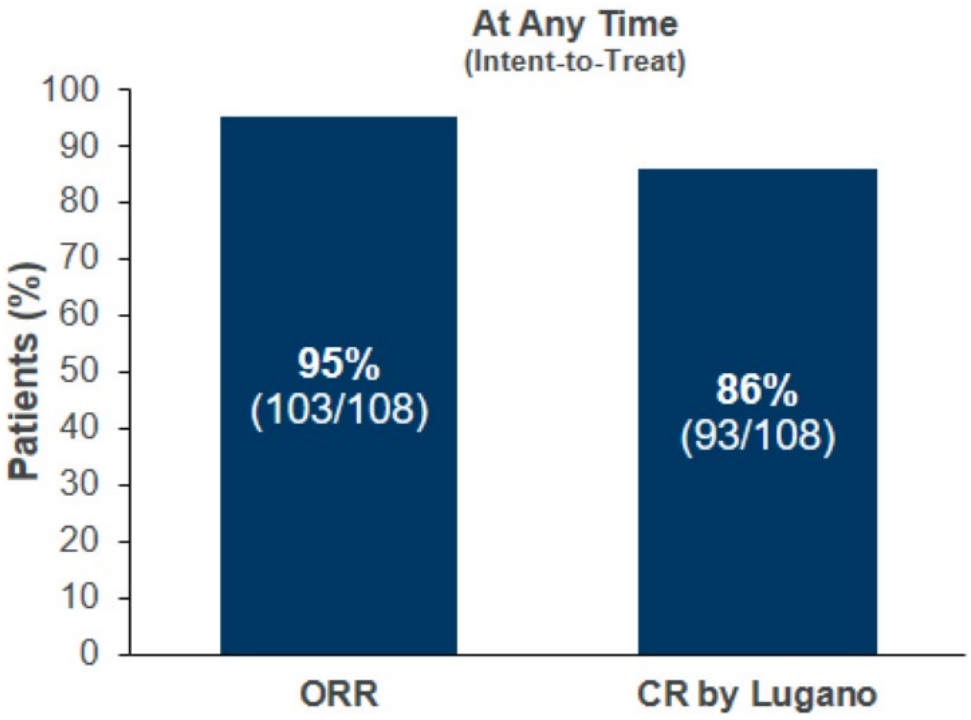
Demographics and Baseline Characteristics

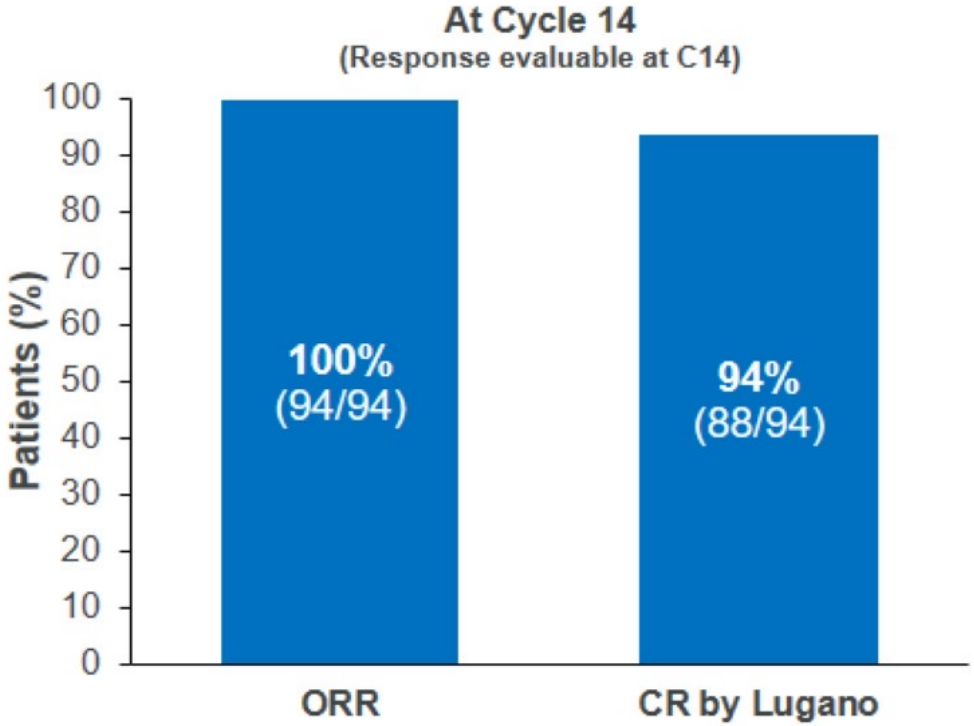
Characteristic	AVR (N=108)
Age, median (range), years	69 (40–89)
Age <65 years, n (%)	42 (38.9)
Male, n (%)	80 (74.1)
White, n (%)	94 (87.0)
Ann Arbor stage IV, n (%)[a]	99 (91.7)
Extranodal involvement, n (%)	102 (94.4)
Bone marrow involvement, n (%)	90 (83.3)
Ki-67 ≥30%, n (%)	41 (38.0)
Blastoid/pleomorphic histology, n (%)[b]	9 (8.3)
p53 expression by IHC, n (%)	
Positive	34 (31.5)
Negative	68 (63.0)
Missing	6 (5.6)
TP53 mutation by NGS, n (%)	
Mutated	17 (15.7)
Unmutated	73 (67.6)
Unknown	18 (16.7)
Simplified MIPI, n (%)	
Low risk (0–3)	30 (27.8)
Intermediate risk (4–5)	45 (41.7)
High risk (≥6)	33 (30.6)

[a]Ann Arbor stage II (n=3; 2.8%) and III (n=6; 5.6%).
[b]Other histology types included classic (n=82; 75.9%), small cell (n=10; 9.3%), and other (n=6; 5.6%); histology type was missing in 1 patient (0.9%).
AVR, acalabrutinib + venetoclax + rituximab; IHC, immunohistochemistry; MIPI, MCL International Prognostic Index; NGS, next-generation sequencing.

Overall Response and Complete Response

94% had CR by Lugano among patients with response assessment at C14

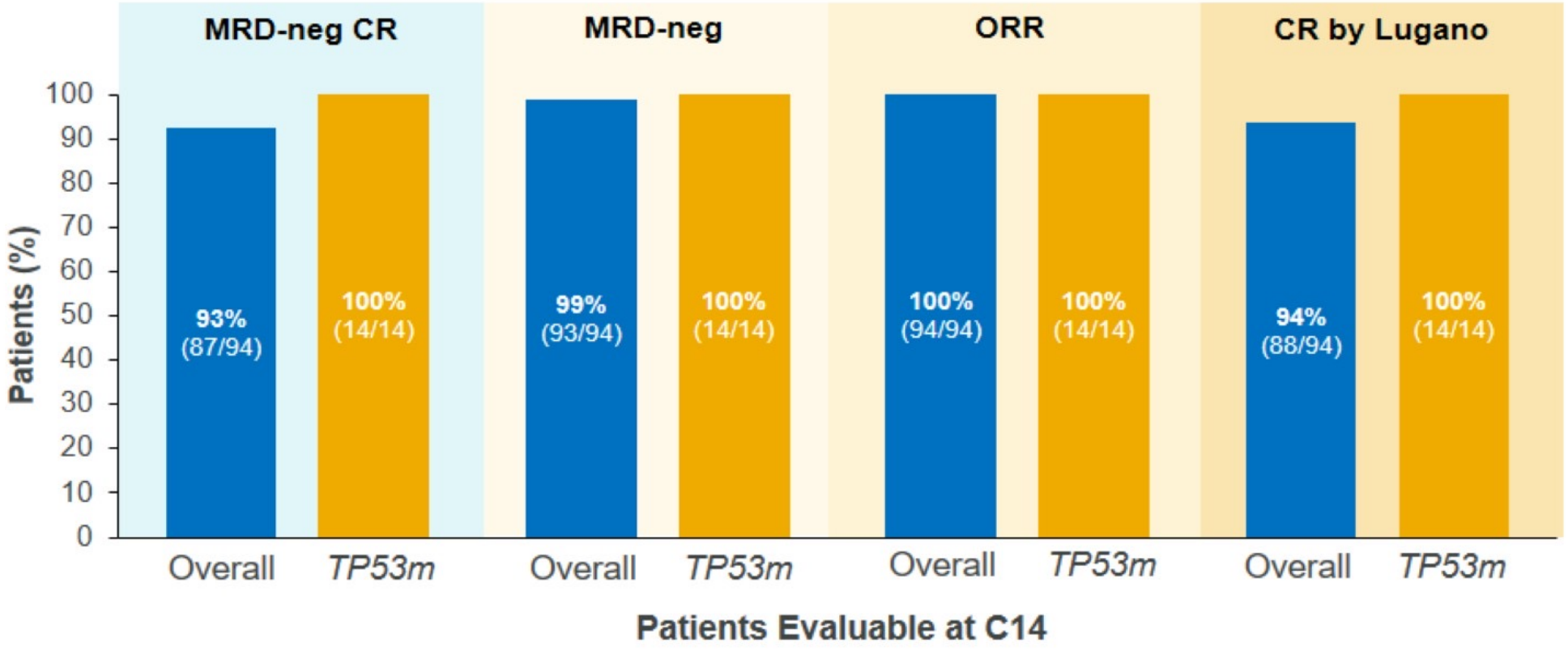




C, cycle; CR, complete response; ORR, overall response rate.

Outcomes at End of Induction in Patients With *TP53* Mutation

Among evaluable patients who completed induction, those with TP53m have comparable benefit

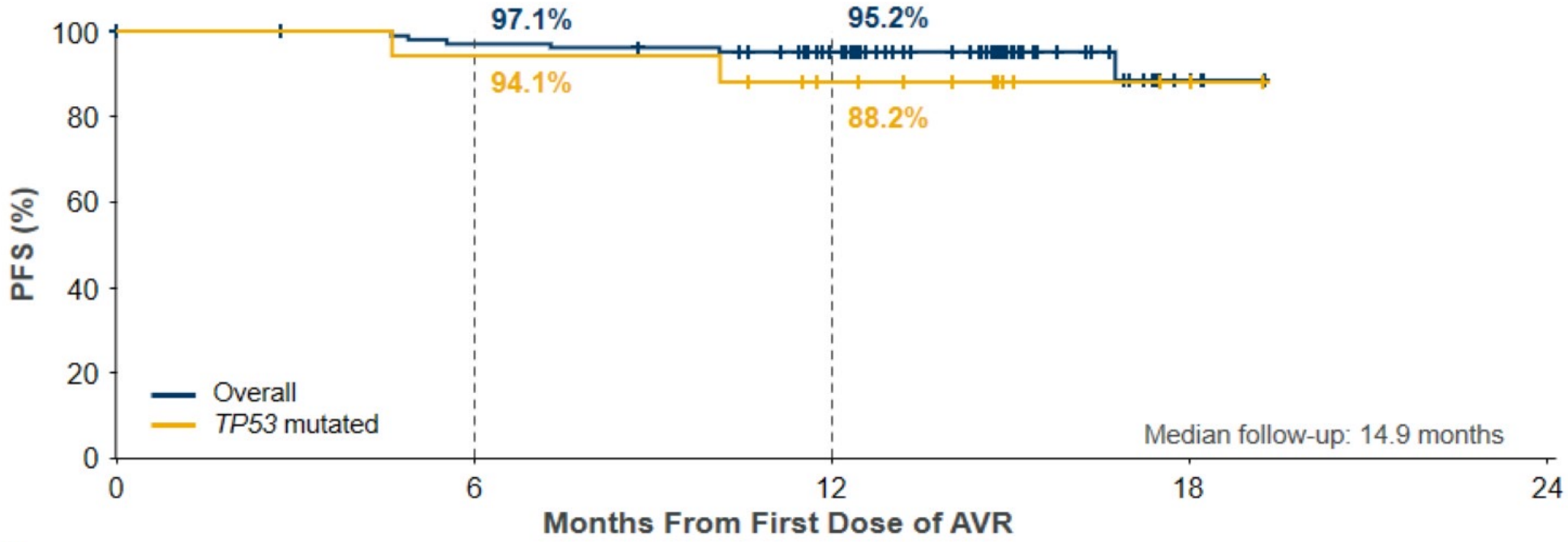


C, cycle; CR, complete response; MRD-neg, measurable residual disease–negative; ORR, overall response rate; *TP53*m, *TP53* mutation.

TrAVeRse

Progression-free Survival

PFS rates were high, regardless of TP53 mutation status

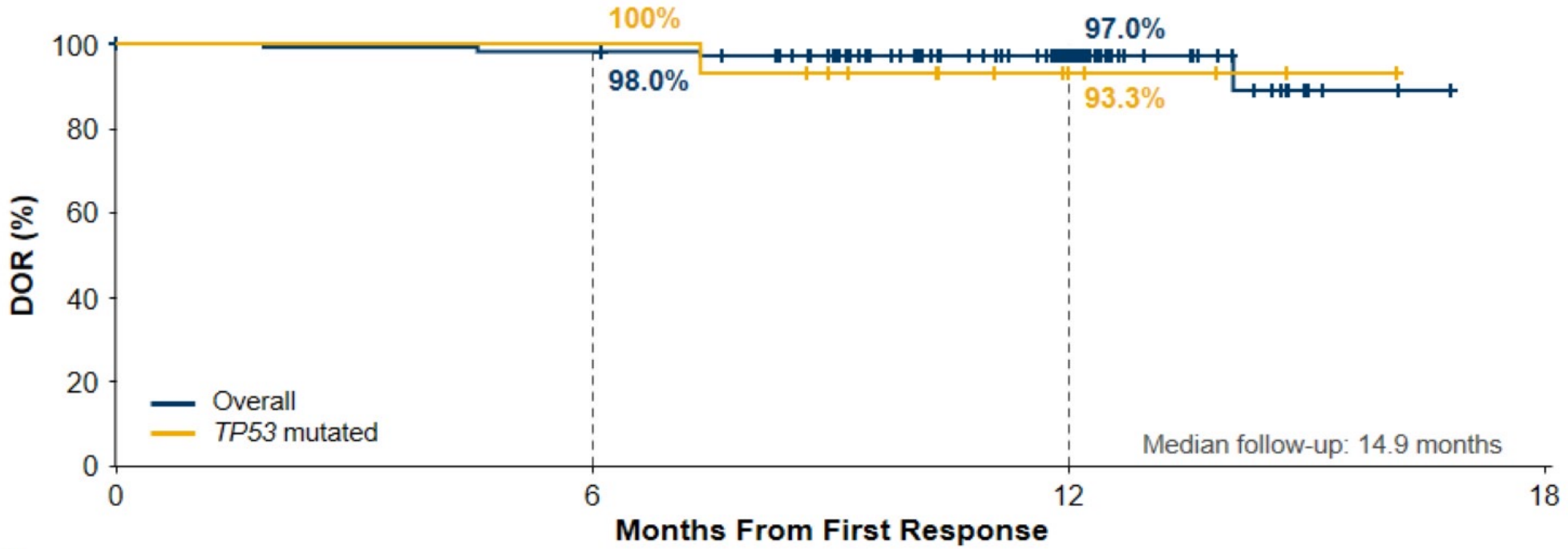


No. at risk					
Overall	108	102	90	3	0
TP53 mutated	17	16	12	2	0

PFS, progression-free survival.

Duration of Response

Responses were durable, regardless of TP53 mutation status



No. at risk				
Overall	103	100	46	0
TP53 mutated	15	15	5	0

13 DOR, duration of response.

TOPICS

FIRST LINE

Update of known trials (ECHO)

Triplets becoming mature (BOVEN, TRAVERSE)
***TP53* mutations**....a solved problem?

R/R SETTING

New drugs and CarT

Sonrotoclax monotherapy in R/R MCL previously treated with a BTK inhibitor: Early results from a phase 1/2 study

	Sonrotoclax	Venetoclax	Differences in Design
Potency (IC_{50})	0.014 nM[1]	0.20 nM[1]	14-fold more potent, which may potentially lead to deeper target inhibition
Selectivity (vs BCL-xL)	2000×[1]	325×[1]	Improved (6-fold) selectivity
Half-life in humans	≈5 hours[2]	26 hours[3]	Short half-life and no accumulation may potentially result in simplified TLS monitoring during sonrotoclax ramp-up

Wang M et al, ASH 2025

BGB-11417-201 (NCT05471843) study design

Eligibility criteria

- Age ≥18 years
- Histologically-confirmed MCL per WHO 2016 classification
- ≥1 line of anti-CD20-based therapy and ≥1 BTK inhibitor
- ECOG PS of 0-2
- No prior BCL2 inhibitor treatment

Study design

Parts 1A + 1B dose escalation and safety expansion

Target dose 2:
320 mg QD (n=12)

Target dose 1:
160 mg QD (n=10)

Safety expansion: up to 2 cohorts at select sonrotoclax target dose levels n≤12 per cohort (including part 1A)

Part 1 endpoints

- Primary: DLTs (part 1A), TEAEs, SAEs, AEs leading to discontinuation, TLS events
- Secondary: preliminary antitumor activity

Part 2 efficacy expansion

Sonrotoclax at RP2D[a] until PD
n=103

Part 2 endpoints

- Primary: ORR by IRC (Lugano 2014)
- Secondary: ORR by INV, DOR by IRC and INV, PFS by IRC and INV, TTR by IRC and INV, HR-QOL, OS, safety

- Sonrotoclax target doses were achieved after a ~4 week ramp-up that did not require hospitalization or 12- or 24-hour post-dose laboratory monitoring

Wang M et al, ASH 2025

Baseline patient demographics and disease characteristics

Parameters	Sonrotoclax 320 mg (n=115)
Age, median (range), years	68 (39-85)
≥65 years, n (%)	74 (64.3)
Male, n (%)	87 (75.7)
Race, n (%)	
Asian	45 (39.1)
Black or African American	3 (2.6)
White	61 (53.0)
Other/not reported	6 (5.2)
Ethnicity, n (%)	
Not Hispanic or Latino	87 (75.7)
Hispanic or Latino	25 (21.7)
ECOG performance status, n (%)	
0	34 (29.6)
1	74 (64.3)
2	7 (6.1)
Disease stage at study entry, n (%)	
III	11 (9.6)
IV	90 (78.3)
Disease status to last prior therapy, n (%)	
Refractory[a]	100 (87.0)
Relapsed[b]	14 (12.2)
MIPI, n (%)	
High	39 (33.9)
Intermediate	41 (35.7)

Parameters	Sonrotoclax 320 mg (n=115)
Bulky disease status, n (%)	
LDi ≥5 cm	46 (40.0)
LDi ≥10 cm	12 (10.4)
Bone marrow involvement at baseline, n (%)	58 (50.4)
Ki67 status, n/N with known status (%)	
Positive	92/98 (93.9)
≥30%	41/98 (41.8)
***TP53* mutation, n/N with known status (%)**	27/78 (34.6)
Prior lines of therapy, median (range)	3 (1-8)
≥3 prior lines, n (%)	68 (59.1)
Prior BTK inhibitor treatment, n (%)	115 (100)
≥2 prior BTK inhibitors	22 (19.1)
Prior ASCT, n (%)	17 (14.8)
Prior CAR-T therapy, n (%)	3 (2.6)
Reason for ending last line of anticancer therapy, n (%)	
Progressive disease	79 (68.7)
Treatment completed	17 (14.8)
Toxicity	12 (10.4)
Other	7 (6.1)

Wang M et al, ASH 2025

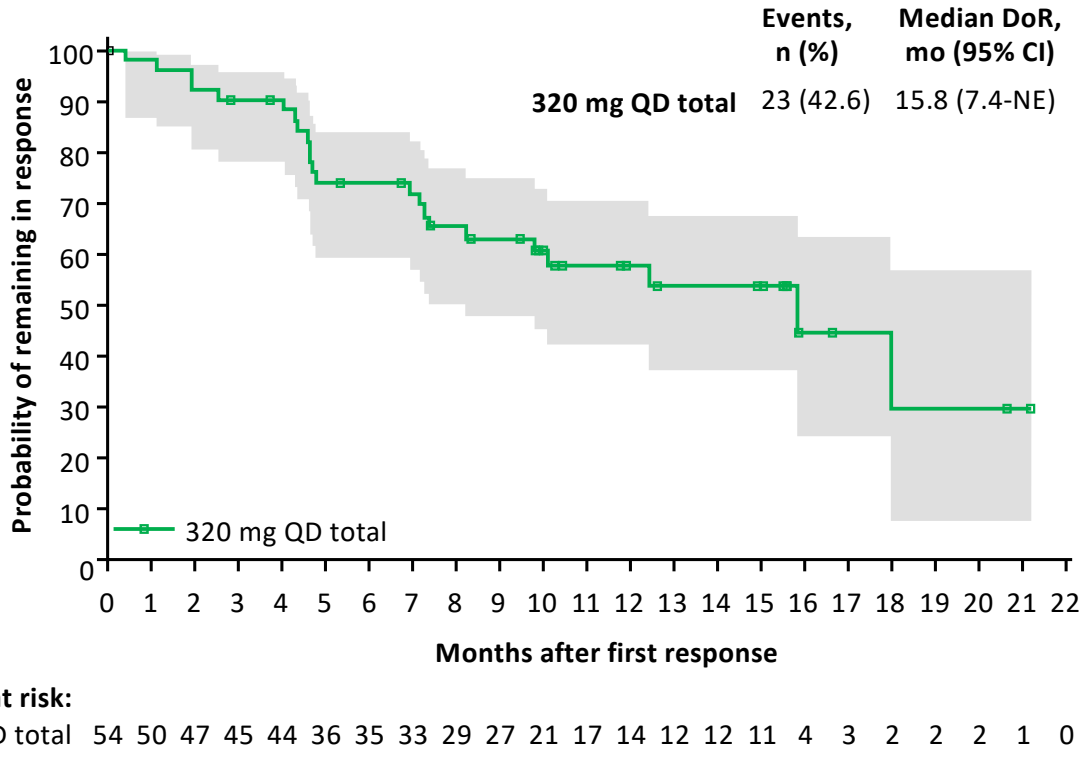
All Grade TEAEs (≥10%) and Grade ≥3 TEAEs

- Most common grade ≥3 TEAEs: hematologic toxicities, infections
- TLS events were reported in 8 patients:
  2 had clinical TLS and 6 had laboratory TLS
  - All events resolved without sequelae
  - No events resulted in death or treatment discontinuation

Patients, n (%)	Sonrotoclax 320 mg (n=115)	
	Any grade	Grade ≥3
Neutropenia[a]	41 (35.7)	22 (19.1)
Thrombocytopenia[b]	28 (24.3)	11 (9.6)
Anemia[c]	28 (24.3)	9 (7.8)
White blood cell count decreased	25 (21.7)	3 (2.6)
Hyperuricemia	22 (19.1)	0
Hypokalemia	20 (17.4)	0
Pneumonia	18 (15.7)	12 (10.4)
Diarrhea	16 (13.9)	5 (4.3)
AST increased	14 (12.2)	1 (0.9)
ALT increased	12 (10.4)	0
Constipation	12 (10.4)	0
Lymphopenia[d]	12 (10.4)	7 (6.1)
Select TEAEs by category/AE/SOC		
Infections (SOC)	45 (39.1)	19 (16.5)
Febrile neutropenia	2 (1.7)	2 (1.7)
TLS (AE)	8 (7.0)	8 (7.0)

Efficacy for Sonrotoclax at RP2D 320 mg QD

	Part 2: Sonrotoclax 320 mg (n=103)
ORR, n (%)	54 (**52.4**)
95% CI, %	42.4-62.4
CR rate, n (%)	16 (**15.5**)
95% CI, %	9.1-24.0
TTR, median (range), months	1.9 (1.6-6.2)



Wang M et al, ASH 2025

News in the Car-T cell field

BREXU-CEL

Long-term RW study found comparable effectiveness and safety outcomes similar to the ZUMA-2 trial. Outcomes were generally consistent irrespective of hepatic, CV, and pulmonary comorbidities, suggesting that age and comorbidity alone should not preclude brexu-cel use in R/R MCL.

Beitinjaneh A et al, ASH 2025

International multicenter study in older pts with R/R MCL. No significant differences in ORR, PFS, or OS were observed between pts aged ≥70 and <70 yrs. Rates of CRS and ICANS were comparable between groups.

Epstein-Peterson *et al, ASH 2025*

News in the Car-T cell field

GLPG5101

- Fresh, early memory-enriched phenotype CD19 CarT product with robust expansion and long-term persistence
- 7-day vein-to-vein time, 4% drop-out rate, no need for bridging (!)
- No grade ≥3 CRS; 100% ORR and 96% CRR despite HR features in 25 patients enrolled in the ATALANTA-1 trial

Kersten MJ et al, ASH 2025

ZAMTO-CEL (LV20.19)

- Lentiviral Anti-CD20/Anti-CD19 CarT product with robust expansion and long-term persistence
- 8-12 days vein-to-vein time, enriched for higher percentages of $T\text{-}_{SCM}$/T-naïve cells
- No grade ≥3 CRS; ICANS 12%; 100% ORR and 88% CRR despite HR features in 17 patients

Shah *J et al, JCO 2025*

Take home messages

- BR+Acalabrutinib soon available and standard option for patients not eligible to ASCT (≥65?)
- Chemo-free triplets (ZVO and AVR) demonstrated early and sustained response consistently >90%, no additive toxicity observed, limited time Tx?
- Comparable benefit was seen in *TP53* mutated patients,
  but numbers still small, and longer follow-up is needed
- In patients R/R after BTKi failure, sonrotoclax new valid option,
  while waiting for combinations

Thanks for your attention

FONDAZIONE ITALIANA LINFOMI

UNIVERSITÀ di VERONA