Disclosures

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Advisory Boards :

Sandoz Novartis, Roche, Celtrion, Janssen, Acerta, Astra Zeneca, Abbvie, TG Therapeutics, Takeda, NovoNordisk, Gilead, Servier

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Polish Lymphoma Research Group

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CENTRUM ONKOLOGII – INSTYTUT IM. MARII SKŁODOWSKIEJ-CURIE

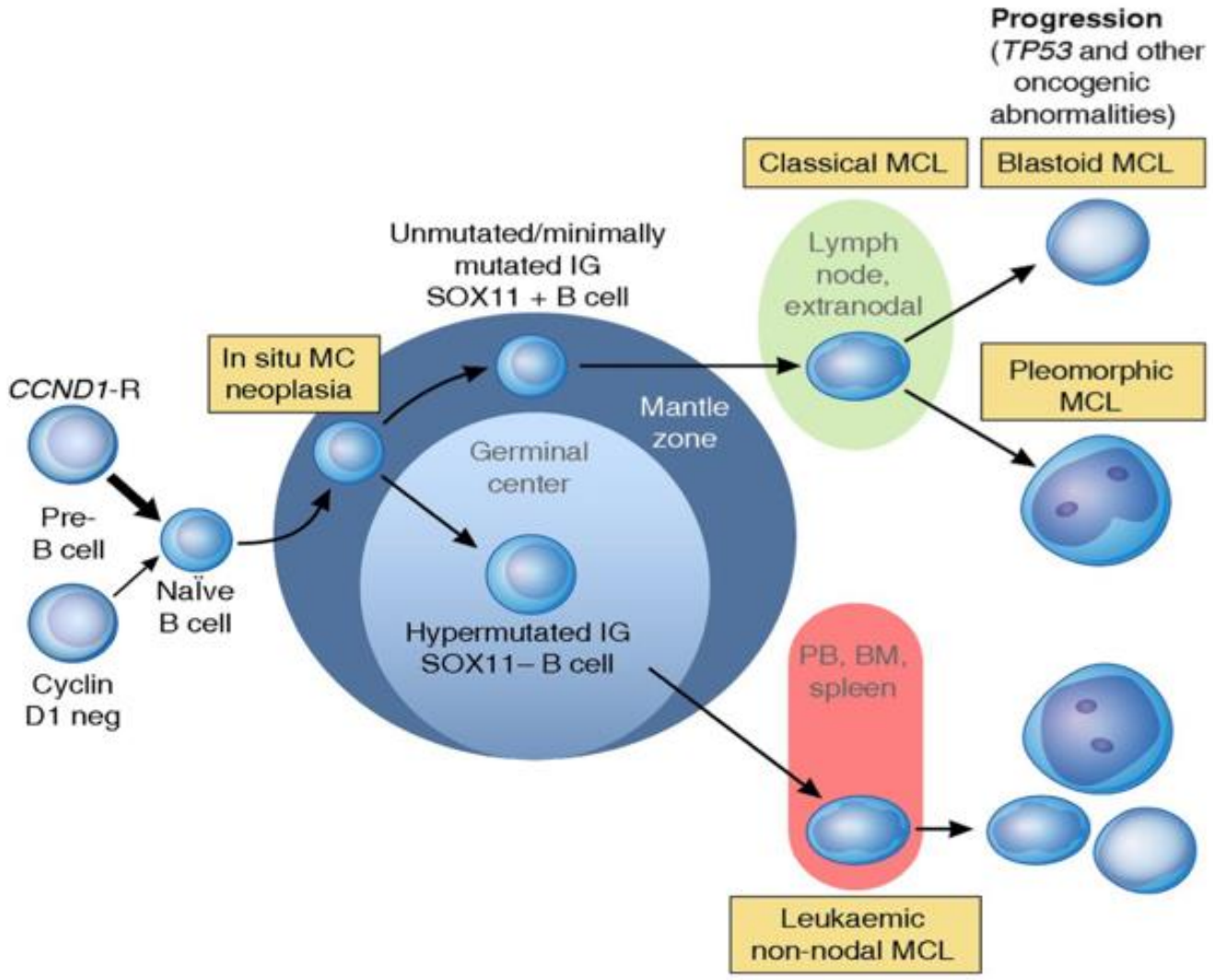
Will targetted therapies change the landscape in MCL?

Prof. dr hab. n. med. Wojciech Jurczak
Centrum Onkologii – Instytut
Im. Marii Skłodowskiej - Curie

Polish Lymphoma Research Group

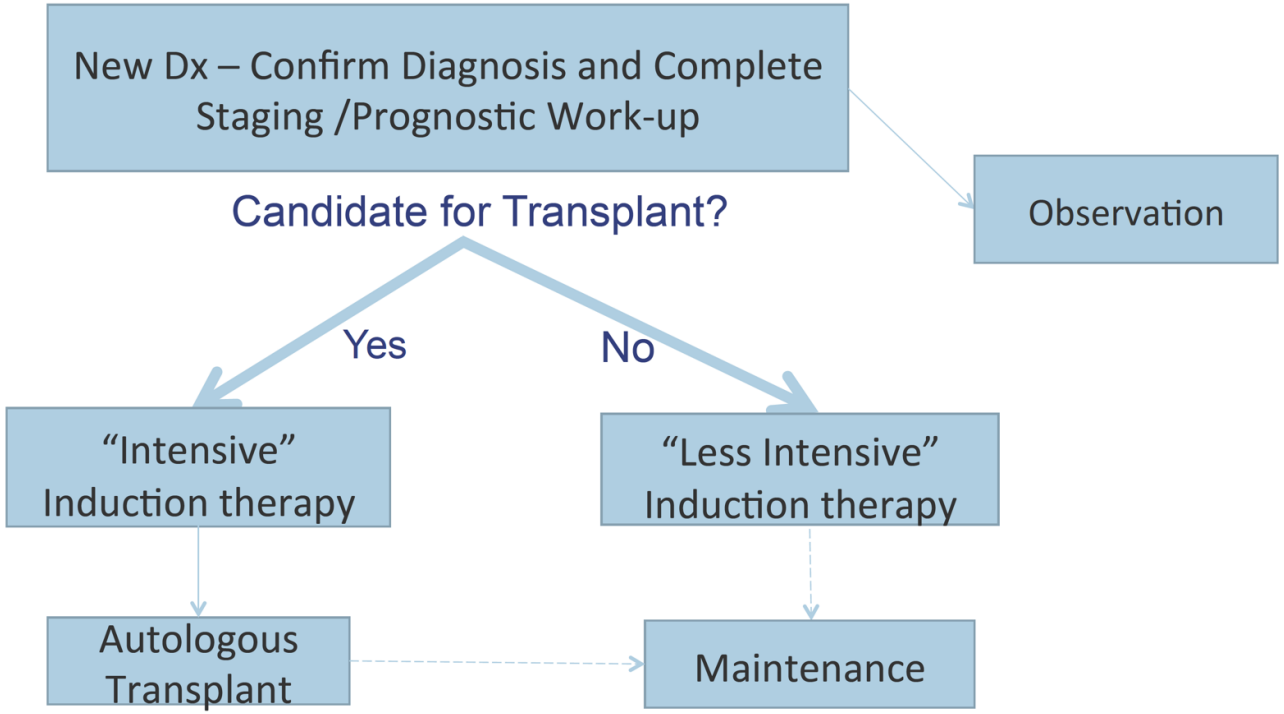
CENTRUM ONKOLOGII – INSTYTUT IM. MARII SKŁODOWSKIEJ-CURIE

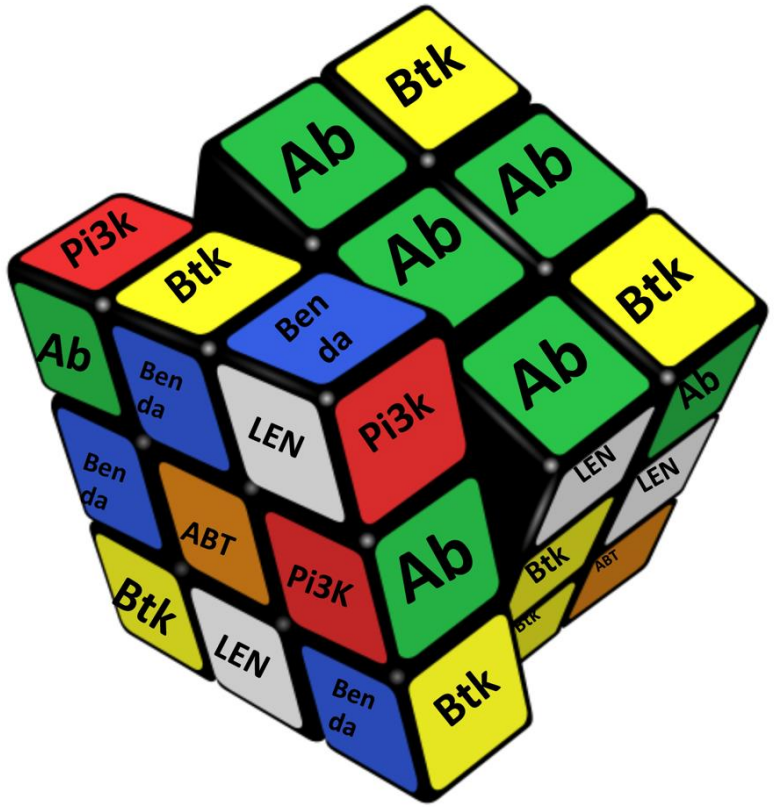
MCL – the disease we know better and better



Courtesy of E Campo

“Traditional” vs „Targeted” Approaches in MCL





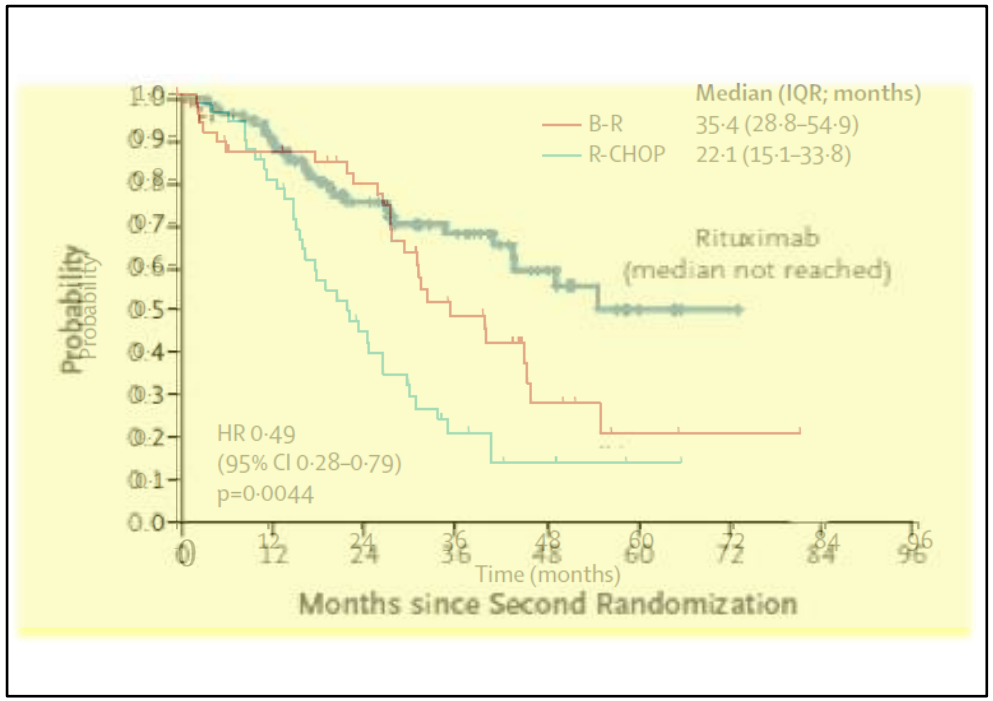
Courtesy of S.Rule

MCL – present European standard of care

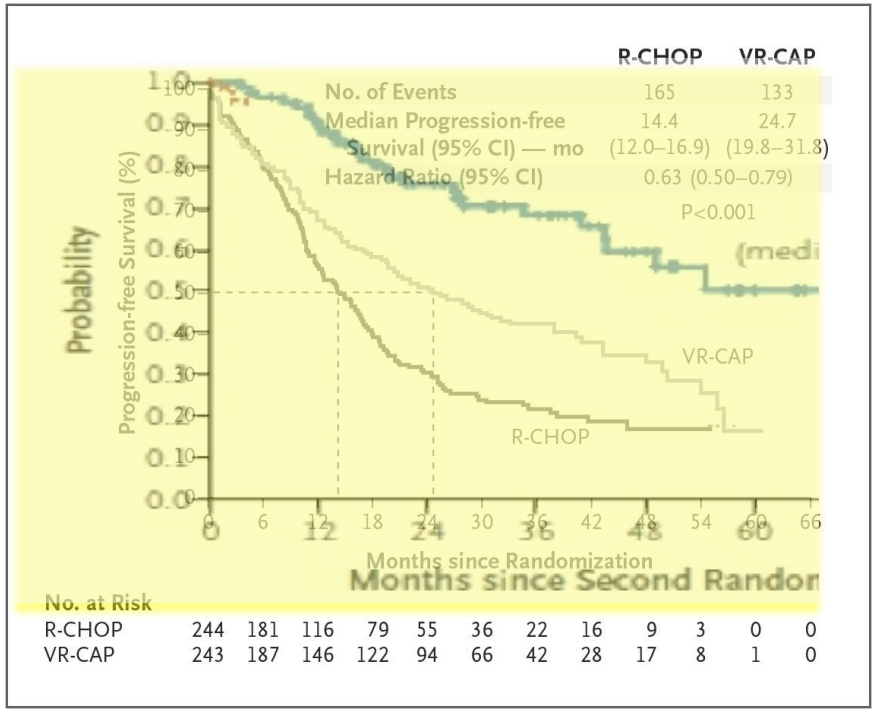
Young Patients (<65)	Elderly (>65)	„Compromised”
I line therpy		
Dose-intensified (R-CHOP + R-high dose Ara-C → ASCT) + Rit Maintenance	Conventional Immuno-chemotherapy (e.g. R-CHOP, BR, VR-CAP,) + Rit maintenance	Best supportive care R-Chlorambucil BR (dose reduced) R-CVP
1 relapse		
Immuno-chemotherapy (e.g., R-BAC, BR) or targeted approaches Discuss: - Rit maintenance - Allo SCT	Immuno-chemotherapy (e.g., R-BAC, BR) or targeted approaches Discuss: - Rit maintenance - Radioimmunotherapy - Autologous SCT	Immuno-chemotherapy (e.g. BR) or targeted approaches
Higher relapse		
Targeted approaches (Ibrutynib, Lenalidomide, Temsirolimus, Bortezomib (preferably in Combinations) Alternatively – repeat previous therapy if in long remissions		

Dreyling, ESMO 2017

I line immuno-chemotherapy in elderly MCL patients



Rummel et al, Lancet 2013



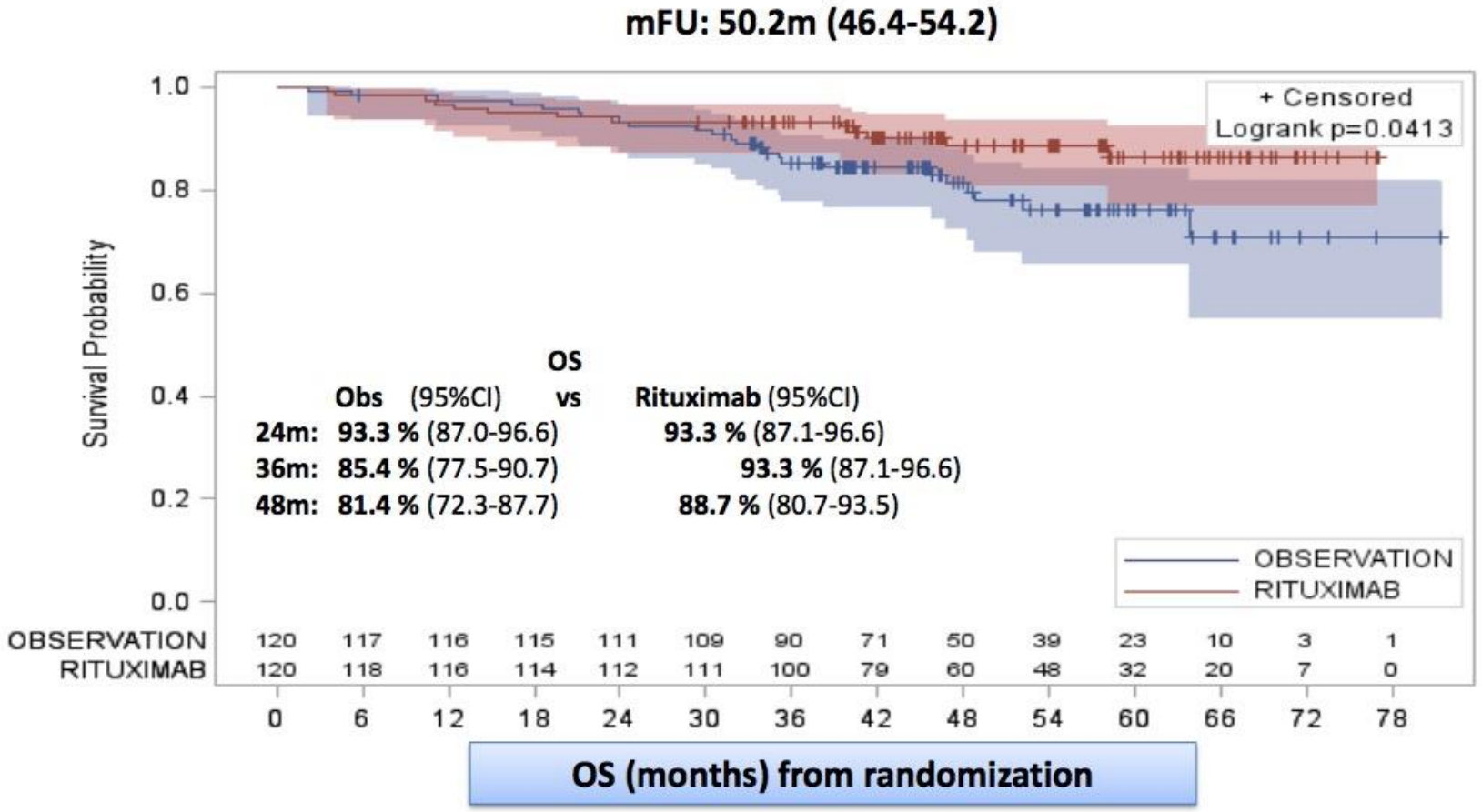
Robak et al, NEJM 2015

R-CHOP + Rituximab maintenance was however always better

„Younger” MCL patients - necessity of maintenance after ASCT

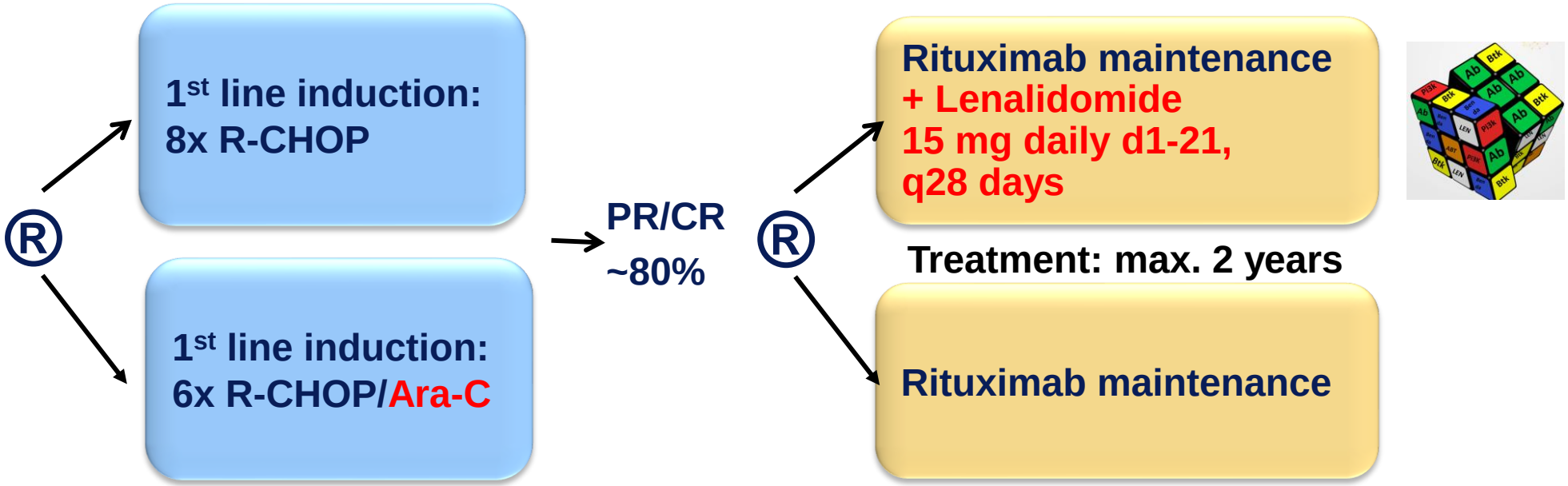
FRENCH INNOVATIVE LEUKEMIA ORGANIZATION

LyMa trial

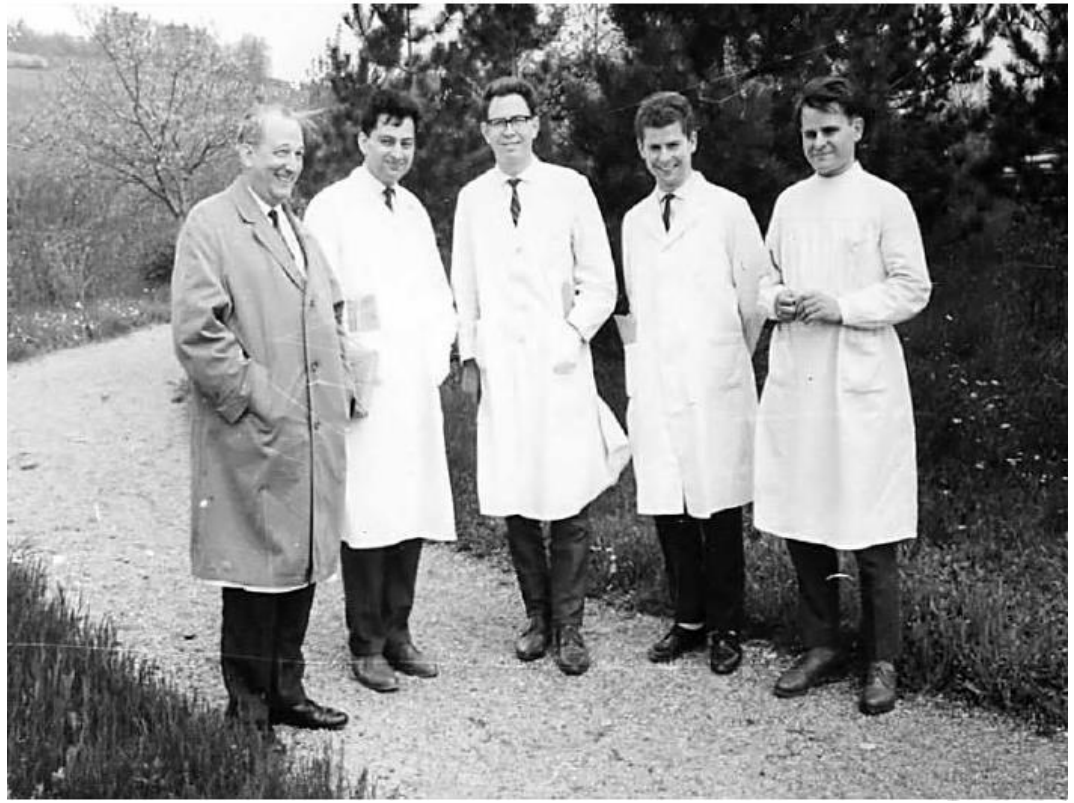


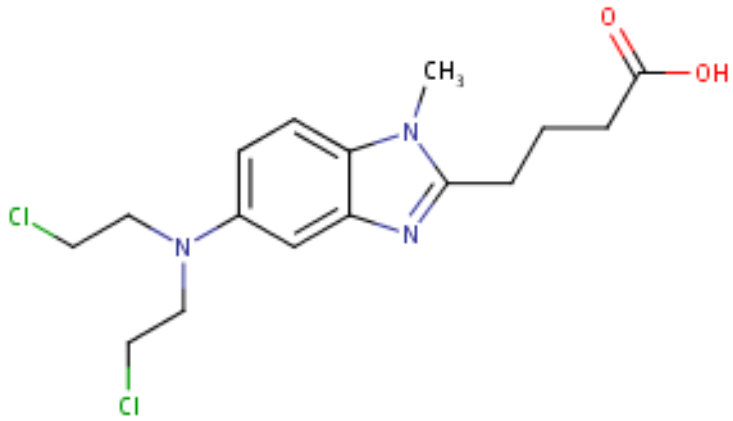
Le Gouill et al. NEJM 2017

I line immuno-chemotherapy in elderly MCL patients *(≠)*



Bendamustine: An ‘agent’ with a long history





Synthesis : W.Ozegowski, D.Krebs, Institute of Microbiology and Experimental Therapy, Jena (1962)

Praktische Chemie, Vol. 20, issue 3-4, 1963

BR and Rituximab maintenance +/- BTK inhibitor *(≠)*

1:1

Placebo +
Rituximab maintenance (2 years)

BTK inhiobitor +
Rituximab maintenance (2 years)

Study	SHINE PCI-32765MCL3002	Acerta 196	Acerta 306
Study details	N=520 Phase III Ibrutinib	N=48 Phase I Acalabrutinib	N=546 Phase III Acalabrutinib
Recruitment status	completed	completed	On - going
Primary Objective	PFS		PFS
Secondary Objectives	**OS**, RR, CR, DOR, Safety		**OS**, RR, CR, DOR

A Window of Opportunity – Ibrutinib with Rituximab Induction

PART A: Chemo-free Window with Rituximab-Ibrutinib

Current Standard is Chemo-immunotherapy
R-HyperCVAD
R-MTX/Ara C
8 Cycles

Toxicity ↓

Survival ↑

PART B: Less chemotherapy (only 4 cycles HyperCVAD)

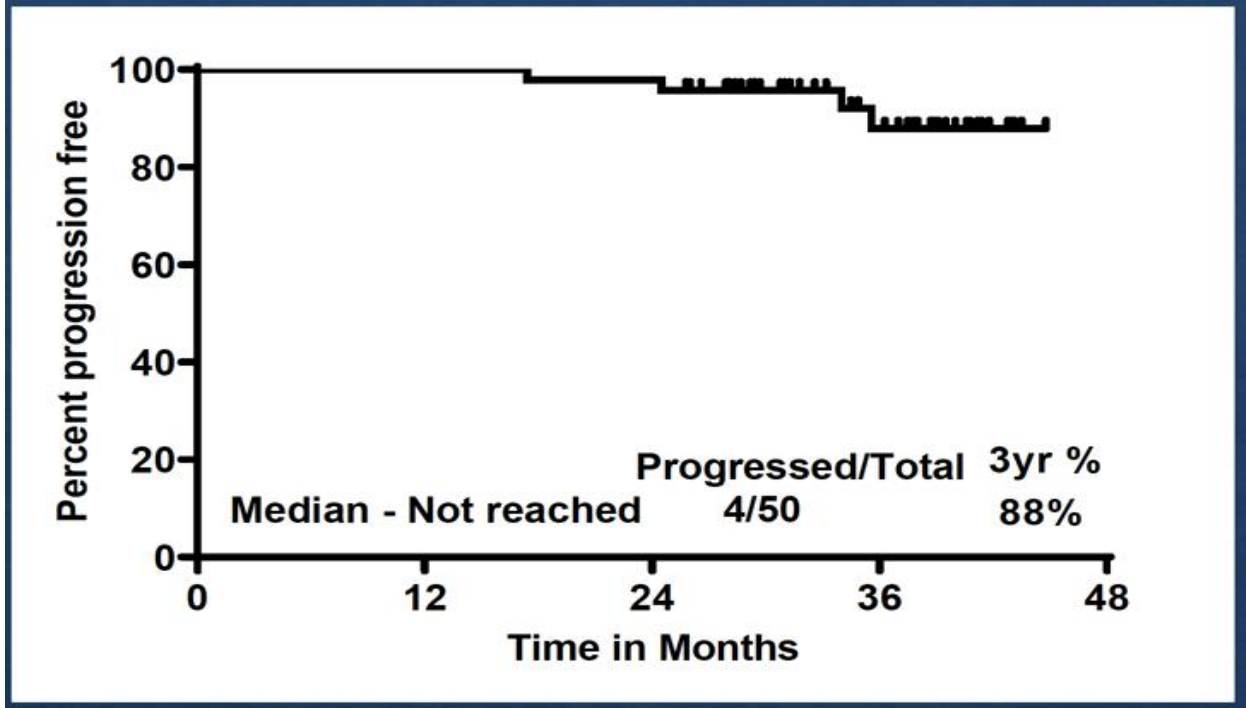
Window of Opportunity

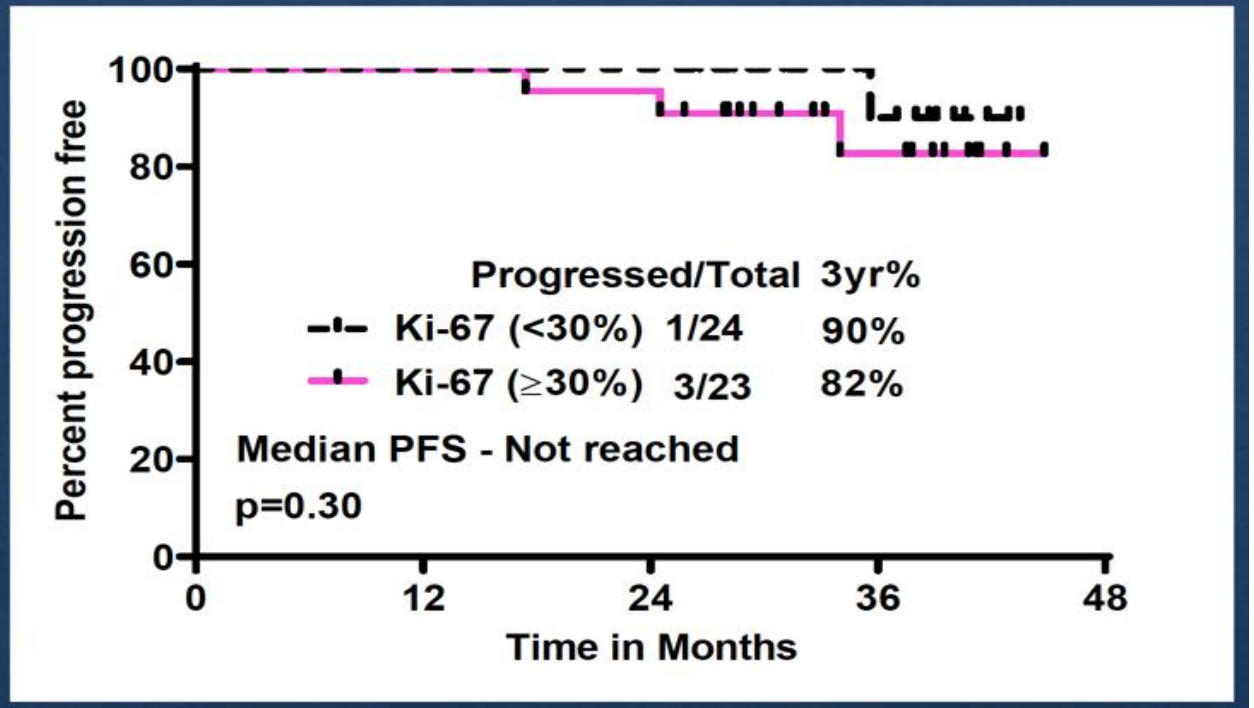
WINDOW-1 Trial Interim Analysis Patient Characteristics (N=50)

Median Age (Range)	55 (35-65)
Male (%)	44 (88%)
Bone Marrow Involvement	42 (84%)
Simplified MIPI	
Low Risk	36 (72%)
Intermediate Risk	11 (22%)
High Risk	3 (6%)
Blastoid/Pleomorphic	2 (4%)
Spleen Size	
15-19 cm	9 (18%)
20-32 cm	6 (12%)
Ki-67%	
<30%	24 (51%)
≥30%	23 (49%)
Unavailable	3 (6%)

Among the 18 patients with available samples – 3 had TP53 mutations

WINDOW-1 Trial Interim Analysis
Time to event outcomes





- 3 year median follow up
- Median PFS not reached
- Four patients had progressed after 17, 24, 34, 35 months of treatment (3 pts had Ki-67% ≥ 30% and one was denovo blastoid MCL and 2 transformed)
- Median OS not reached and none died

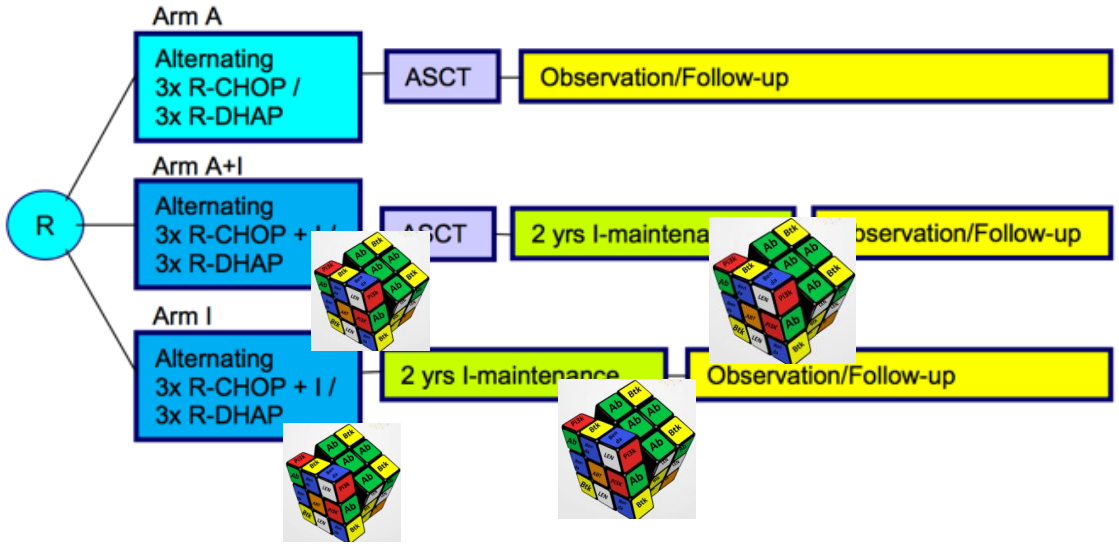
„Younger” MCL patients - necessity of maintenance after ASCT *(≠)*

MCL0208 study

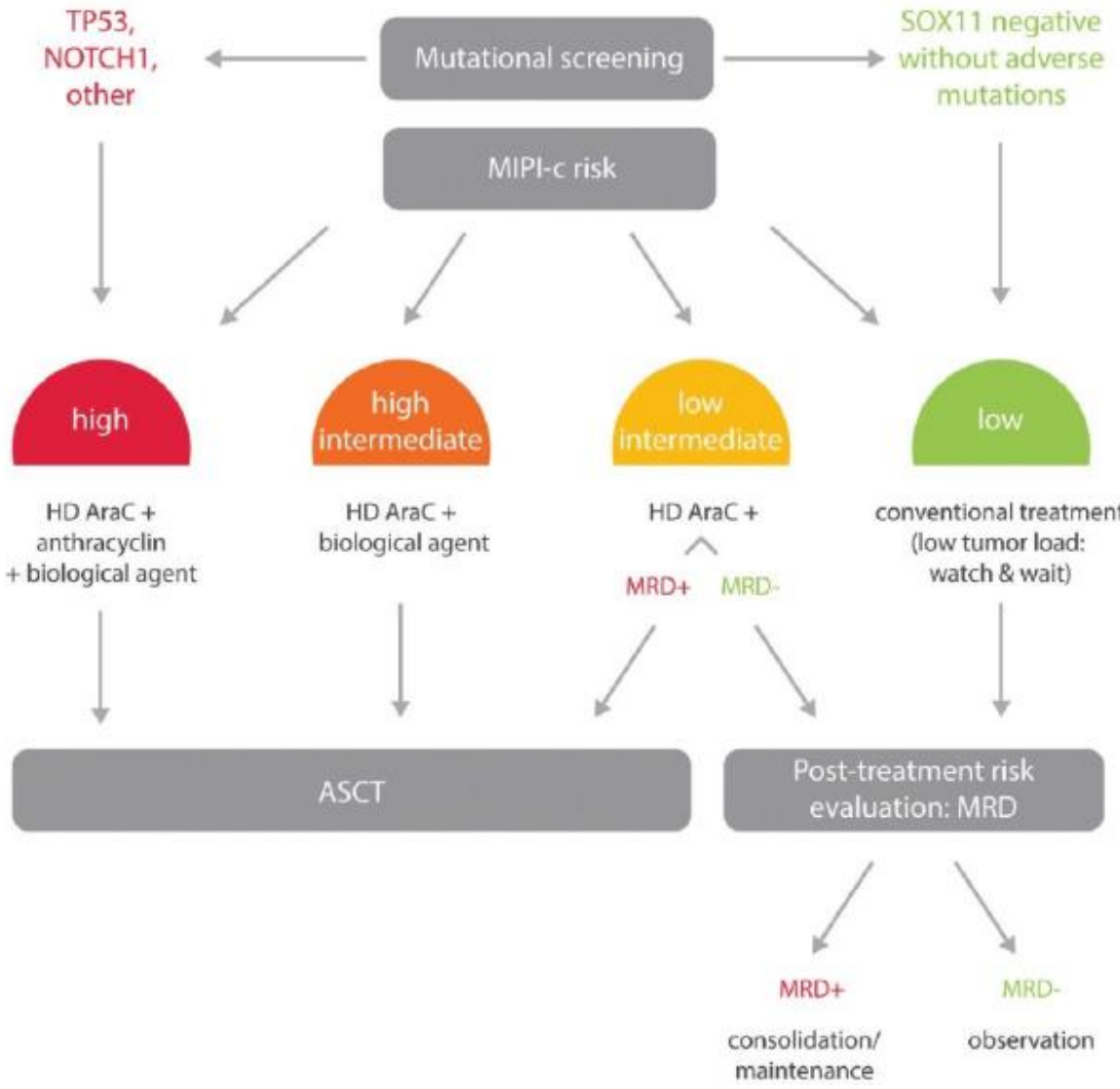
1. Induction: R-CHOP-21 x 3 — Staging
2. Consolidation: CTX 4g/m² — Restaging
   R-HD-Ara-C 2g/m² q12h x 3
   Ritux 375mg/m² d 4, 10 — Harvest CD34+
   R-HD-Ara-C 2g/m² q12h x 3
   Ritux 375mg/m² d 4, 10 — 2° Harvest CD34+
   Restaging
   PR <50%, SD, NR
   Off-study
   BEAM-PBSCT — Restaging
   CR/PR
3. Maintenance:
   RANDOM observation vs. lenalidomide
   15 mg (plts >100x10⁹/ L) or 10 mg (plts 60-100x10⁹/L) once daily on days 1-21 every 28 day cycle) for 24 months.

„Triangle” study

European MCL Network

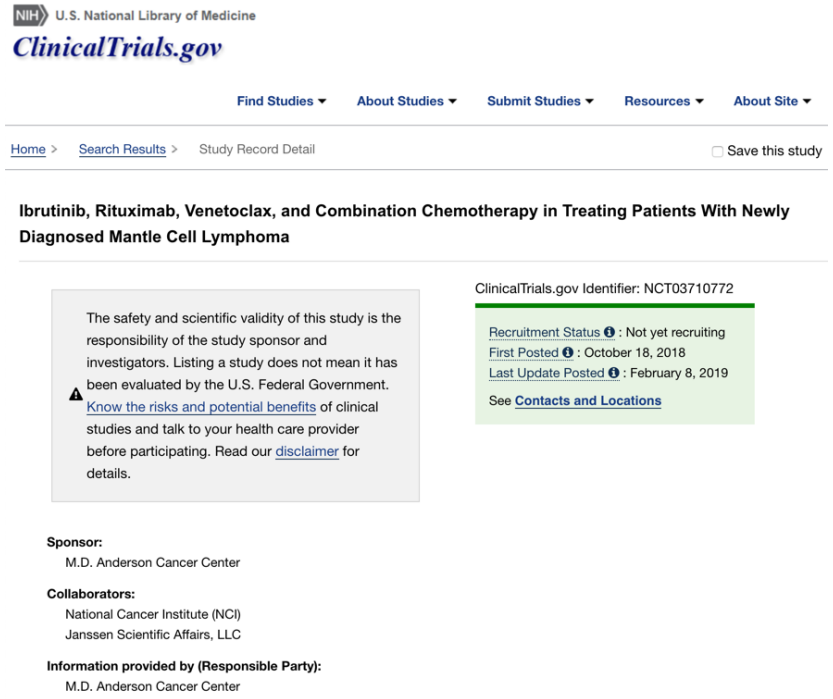


Are we ready for first line risk adopted therapy ? *(≠)*



Are we ready for first line non chemo option ? *(≠)*

- R^2 (Rituximab + Lenalidomide)
- Rituximab, Ibrutinib, Venetoclax



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Ibrutinib, Rituximab, Venetoclax, and Combination Chemotherapy in Treating Patients With Newly Diagnosed Mantle Cell Lymphoma

The safety and scientific validity of this study is the responsibility of the study sponsor and investigators. Listing a study does not mean it has been evaluated by the U.S. Federal Government. Know the risks and potential benefits of clinical studies and talk to your health care provider before participating. Read our disclaimer for details.

ClinicalTrials.gov Identifier: NCT03710772

Recruitment Status : Not yet recruiting
First Posted : October 18, 2018
Last Update Posted : February 8, 2019

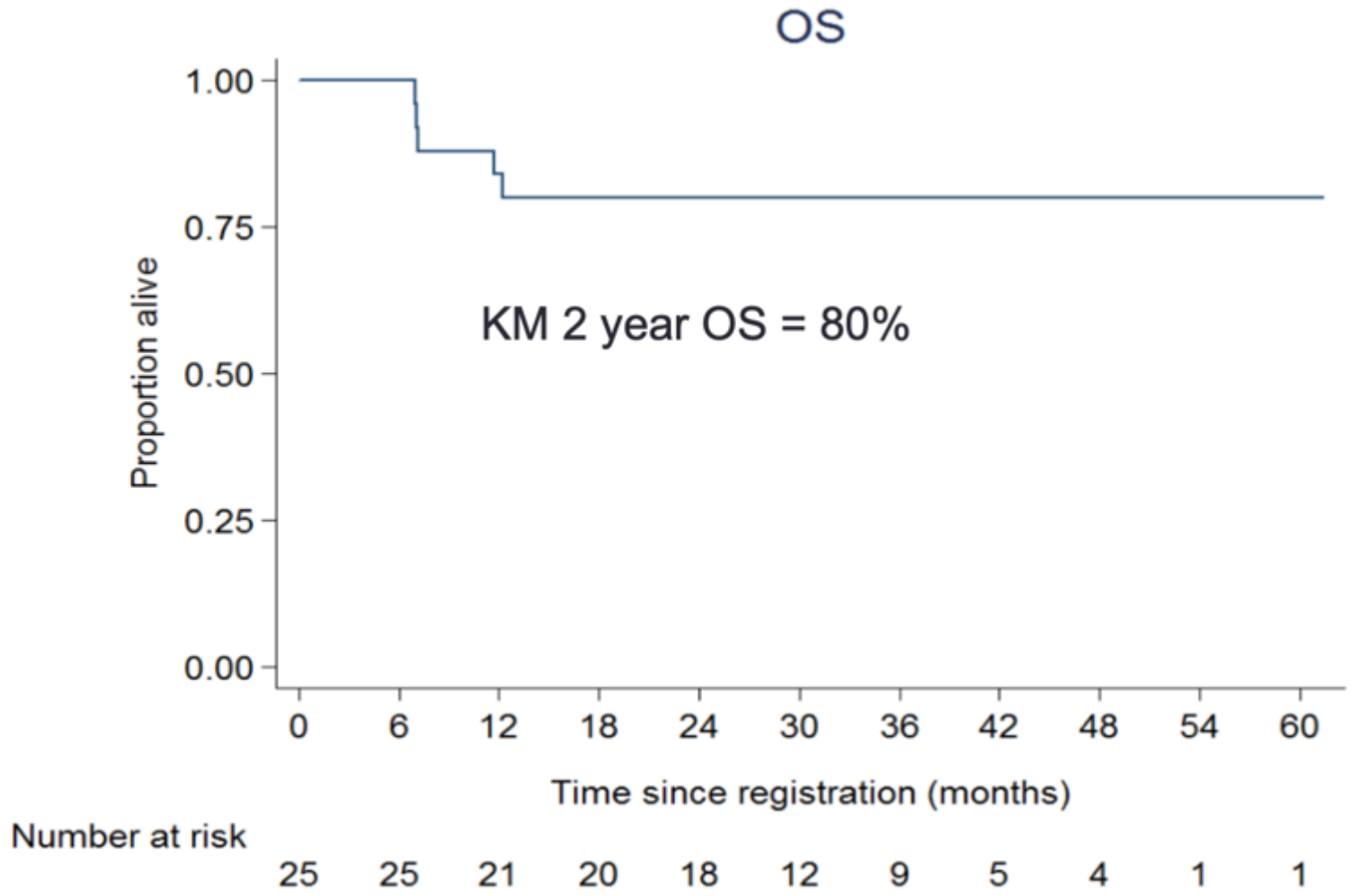
See Contacts and Locations

Sponsor:
M.D. Anderson Cancer Center

Collaborators:
National Cancer Institute (NCI)
Janssen Scientific Affairs, LLC

Information provided by (Responsible Party):
M.D. Anderson Cancer Center

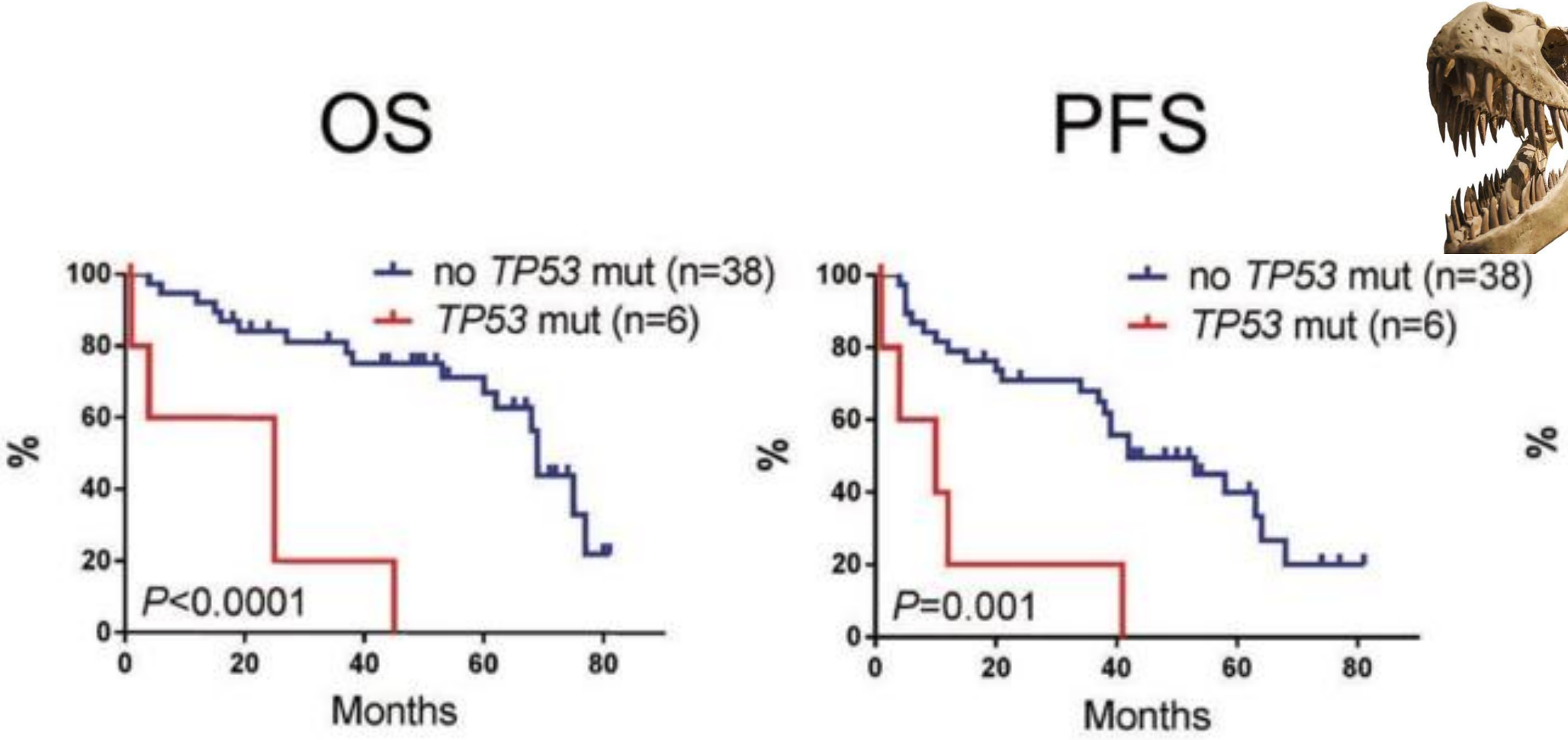
Are we ready for first line „mini allo” *(≠)*



Peggs et al. 2018

Relapsing/Refractory MCL

TP53 mutation is an independent RF in R/R MCL

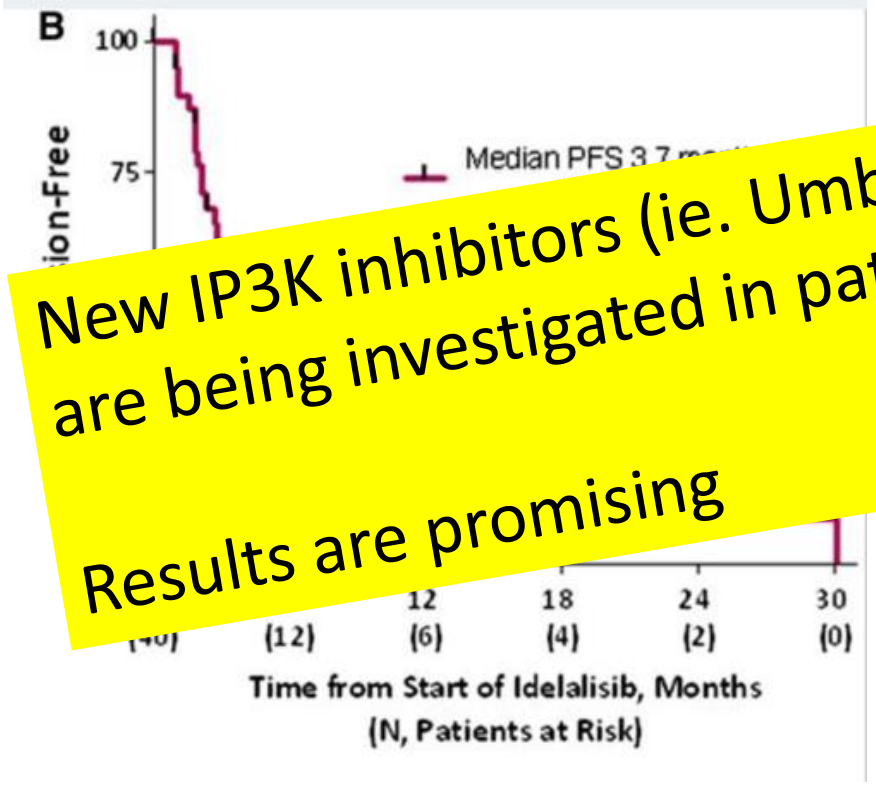


Eskelund et al., Haematologica 2018

Novel Agents - results in relapsing/refractory (‡)

Regimen	N	ORR% (CR%)	mPFS (months)	mOS	Reference
Idelalisib	40	40 (5)	**3.7**	n/a	Kahl, Blood 2014
Temsirolimus	54	22 (2)	**4.8**	12.8	Hess, JCO 2009
Everolimus	35	20 (6)	**5.5**	n/a	Wang, BJH 2014
Bortezomib	141	33 (8)	**6.7**	23.5	Fisher, JCO 2006
Lenalidomide	134	28 (8)	**8,6**	19	Trneny, Lancet O 2016
Ibrutinib	110	68 (21)	**13.9**	n/a	Wang, NEJM 2013

Efficacy of PI3kinase inhibition in R/R MCL (≠)



New IP3K inhibitors (ie. Umbralisib, Parsaclisib) are being investigated in patients refractory to Ibrutinib.

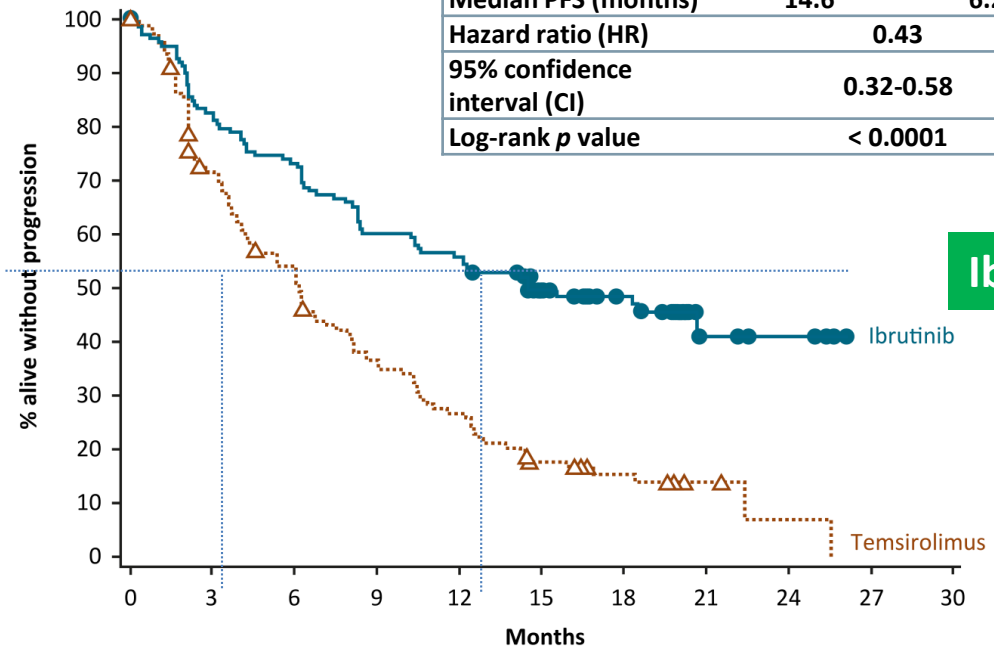
Results are promising

- 40 patients with relapsed / L were
- tory to
- with CR
- 40 (5%) patients.
- ORR 69% in patients getting 150 mg twice daily or higher
- Median DOR was 2.7 months, median PFS was 3.7 months
- 1-year PFS was 22%.

Kahl et al. Blood. 2014; 123(22):3398-405.

Temsirolimus is approved in EC for R/R MCL

	Ibrutinib	Temsirolimus
Median PFS (months)	14.6	6.2
Hazard ratio (HR)	0.43	
95% confidence interval (CI)	0.32-0.58	
Log-rank *p* value	< 0.0001	



Ibrutynib

Patients at risk

Ibrutinib	139	114	101	83	77	45	34	8	5	0	0
Temsirolimus	141	93	69	45	33	19	11	3	1	0	0

Hess et al., JCO 2009,
Jurczak et al. Leuk Lymph 2017

Dreyling, Jurczak et al, Lancet 2016
Rule, Jurczak et al, Leukemia 2018

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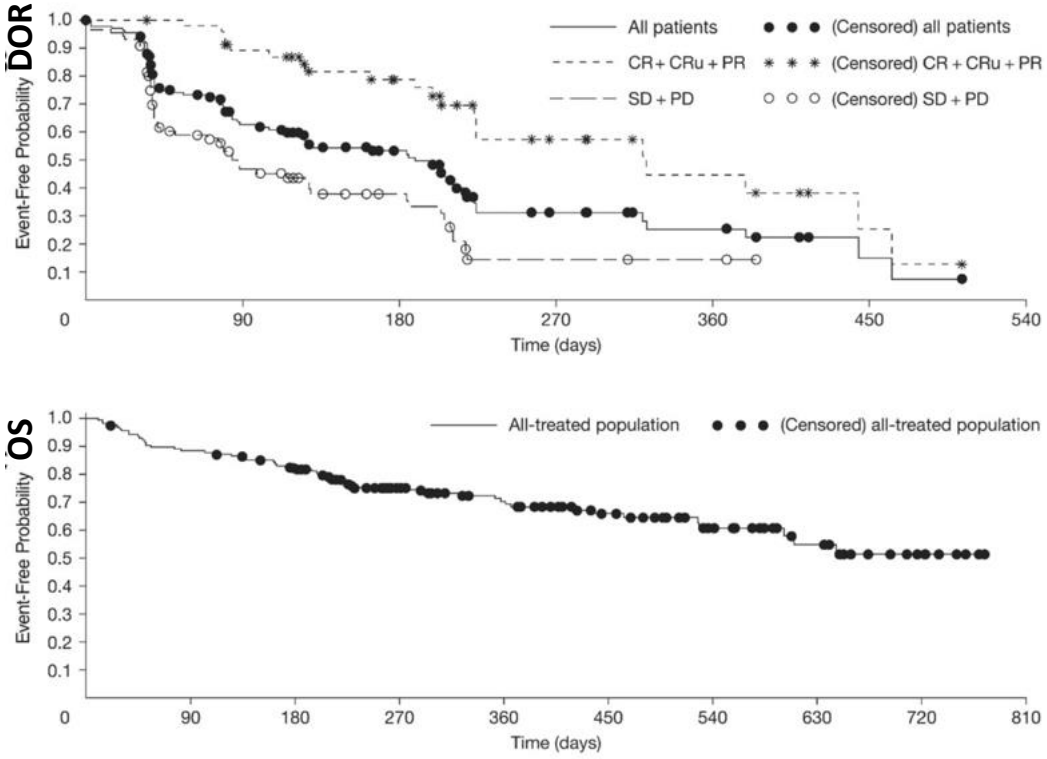
Bortezomib in Relapsed MCL

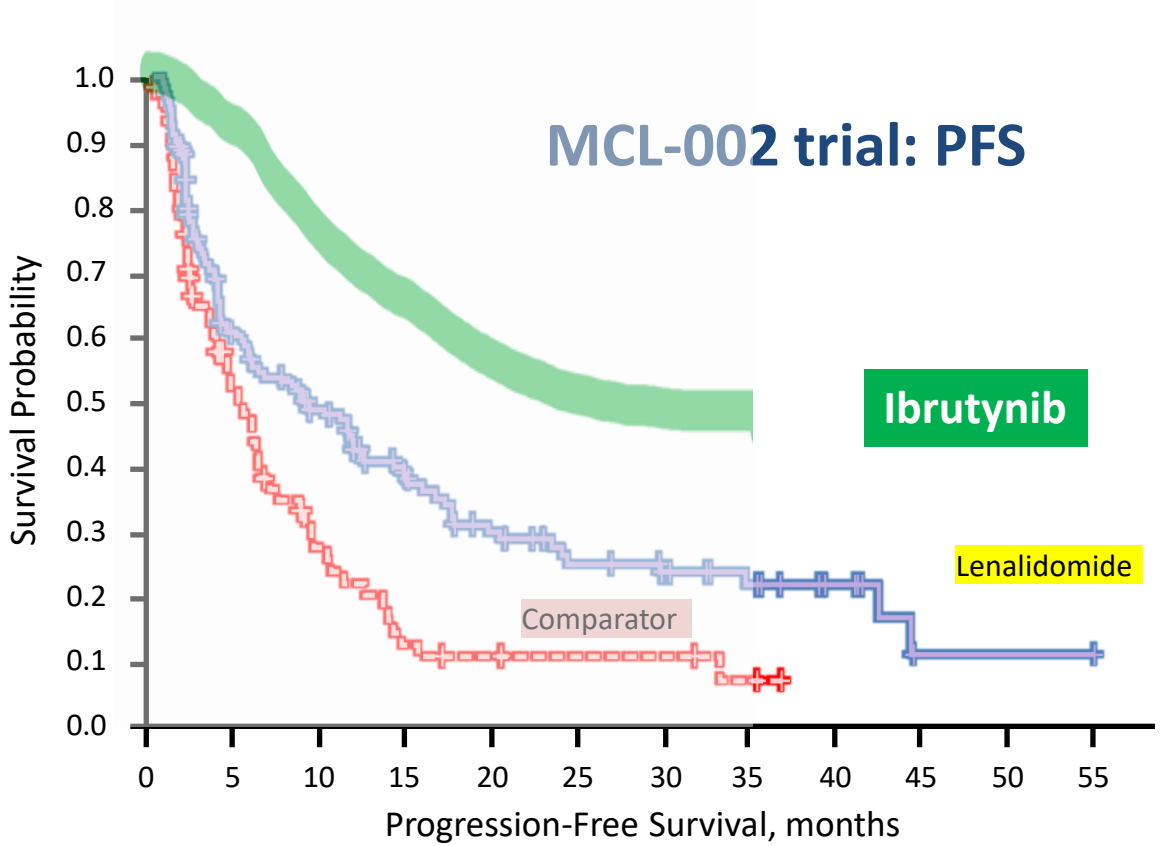


- 155 relapsing/refractory pts
- in 141 patients **RR was 33% including 8% CRs.**
- **Median DOR was 9.2 months**.
- Median TTP was 6.2 months.
- Median OS not reached after a median follow-up of 13.4 mo.

Approved in US:
- **In R/R MCL**
- **BR-CAP as I line therapy**

Fisher R I et al. JCO 2006;24:4867-4874

Lenalidomide in R/R MCL



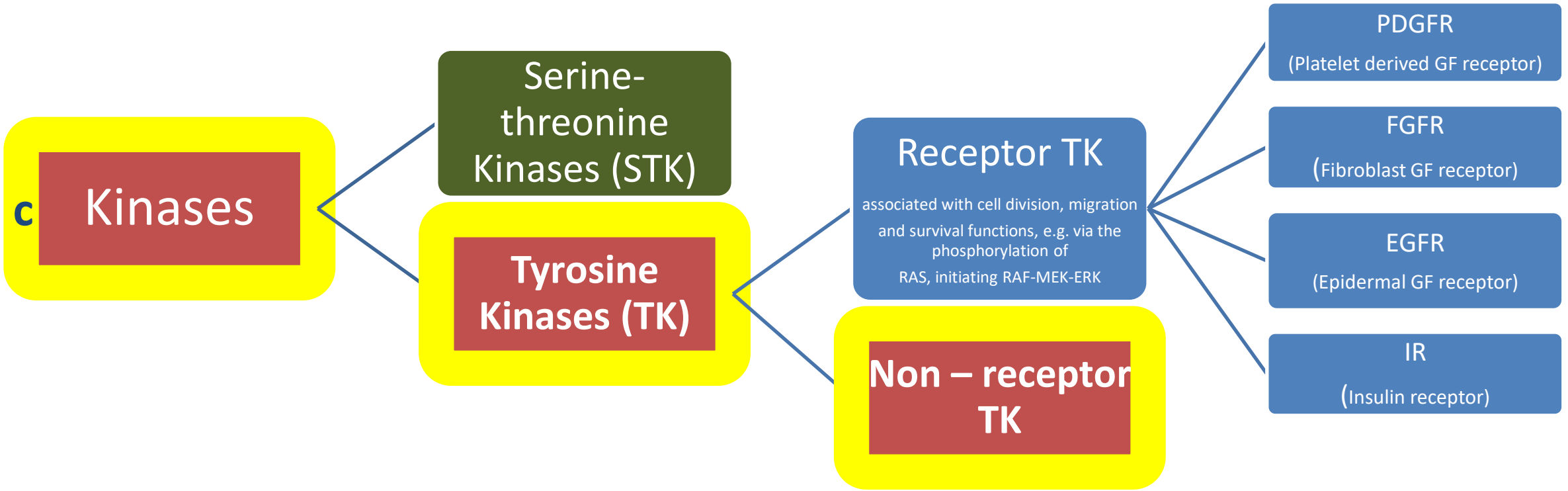
	Lenalidomide (n = 170)	IC (n = 84)
Median PFS, mo (95% CI)	8.6 (5.5-12.1)	5.2 (3.6-6.9)
HR (95% CI)	0.61 (0.44-0.84); P = 0.004	

Lenalidomide vs IC showed a 39% reduction in the risk of PD or death, reflected as an estimated improvement in median PFS of 3.4 months

Regimen	N	ORR% (CR%)	mPFS	mOS	Reference
Lenalidomide	**134**	**28 (8)**	**8,6**	**19**	**Trneny, L.Oncol 2016**
Len + R	**52**	**56 (36)**	**11.1**	**24.3**	**Wang, Lancet 2012**
Thal+R+PEPC	**25**	**73 (32)**	**10**	**45%@2y**	**Ruan, Cancer 2010**

Trneny et al, Lancet Oncology 2016

Kinases



Siveen et al., Mol Cancer 2018

Non – receptor tyrosine kinases

SRC kinase (membrane associated)

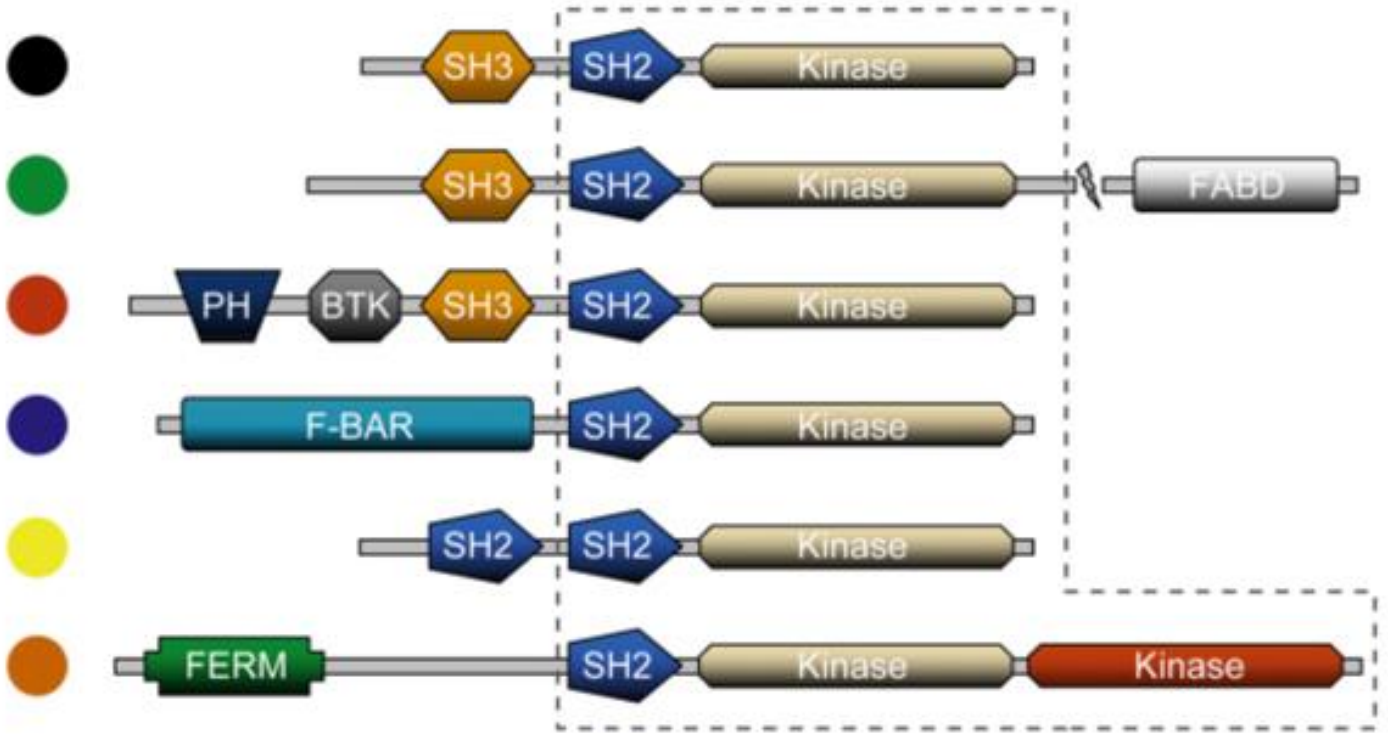
Abl (Abelson kinases family)

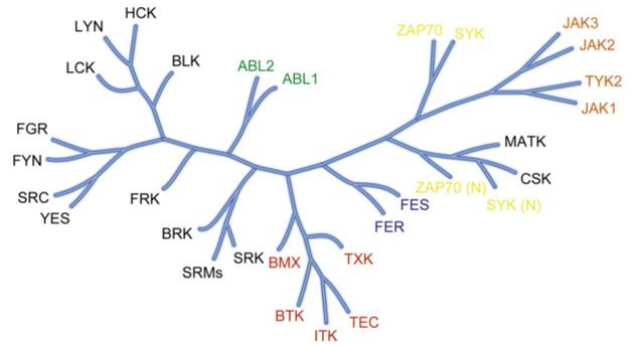
TEC kinases

FES (Feline Sarcoma kinases)

SYK (spleen Thyrosine kinase)

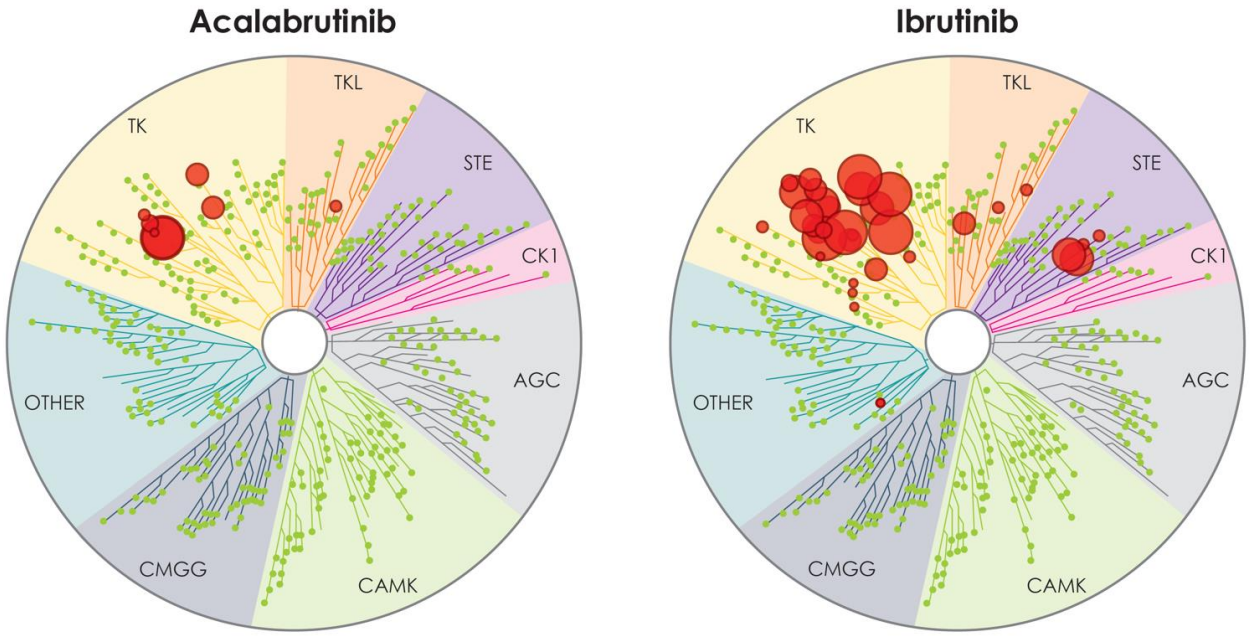
JAK (Janus kinase activating STAT)





Siveen et al., Mol Cancer 2018

How selective BTK inhibitors are ?



Larger red circles represent stronger inhibition

Kinase Inhibition Average IC_{50} (nM)[4]										
Kinase	BTK	TEC	ITK	BMX	TXK	EGFR	ERBB2	ERBB4	BLK	JAK3
Acalabrutinib	5.1	126	>1000	46	368	>1000	~1000	16	>1000	>1000
Ibrutinib	1.5	10	4.9	0.8	2.0	5.3	6.4	3.4	0.1	32

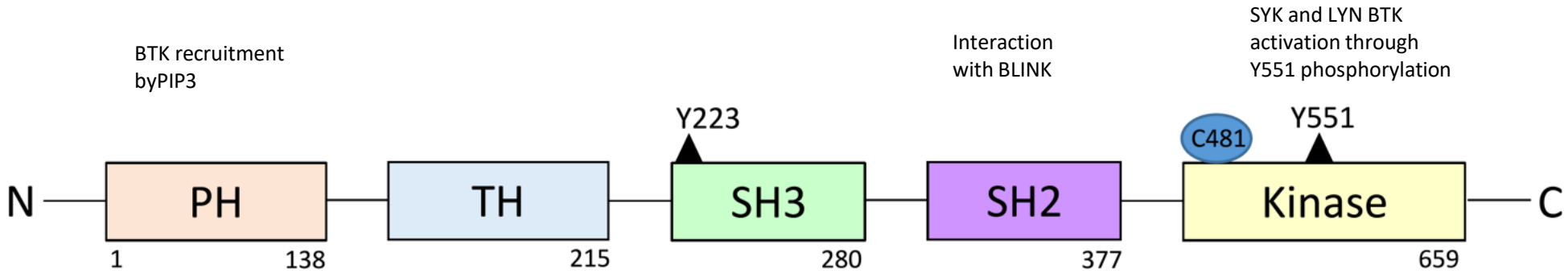
TEC kinases: non-receptor tyrosine kinases with a highly conserved carboxyl-terminal kinase domain:

- **BTK** (Bruton Tyrosine kinase)
- **BMX** (bone marrow tyrosine kinase on chromosome X)
- **TXK** (tyrosine-protein kinase)
- **ITK** (interleukin 2-inducible T-cell kinase)
- **TEC** (tyrosine kinase expressed in hepatocellular carcinoma)

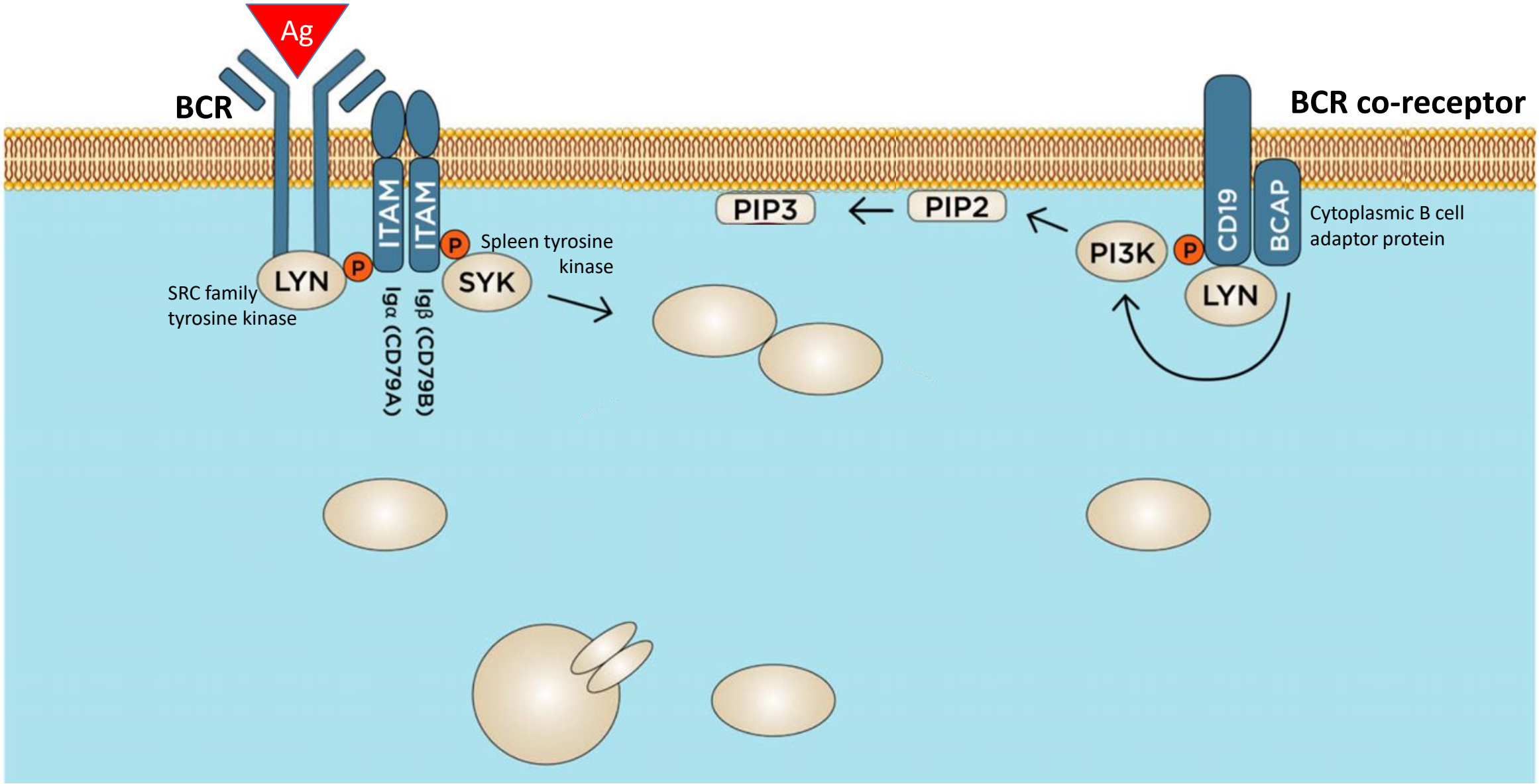
Barf et al. Jnl of Pharmacol and Exp Therap 2017

Bruton Tyrosine Kinase

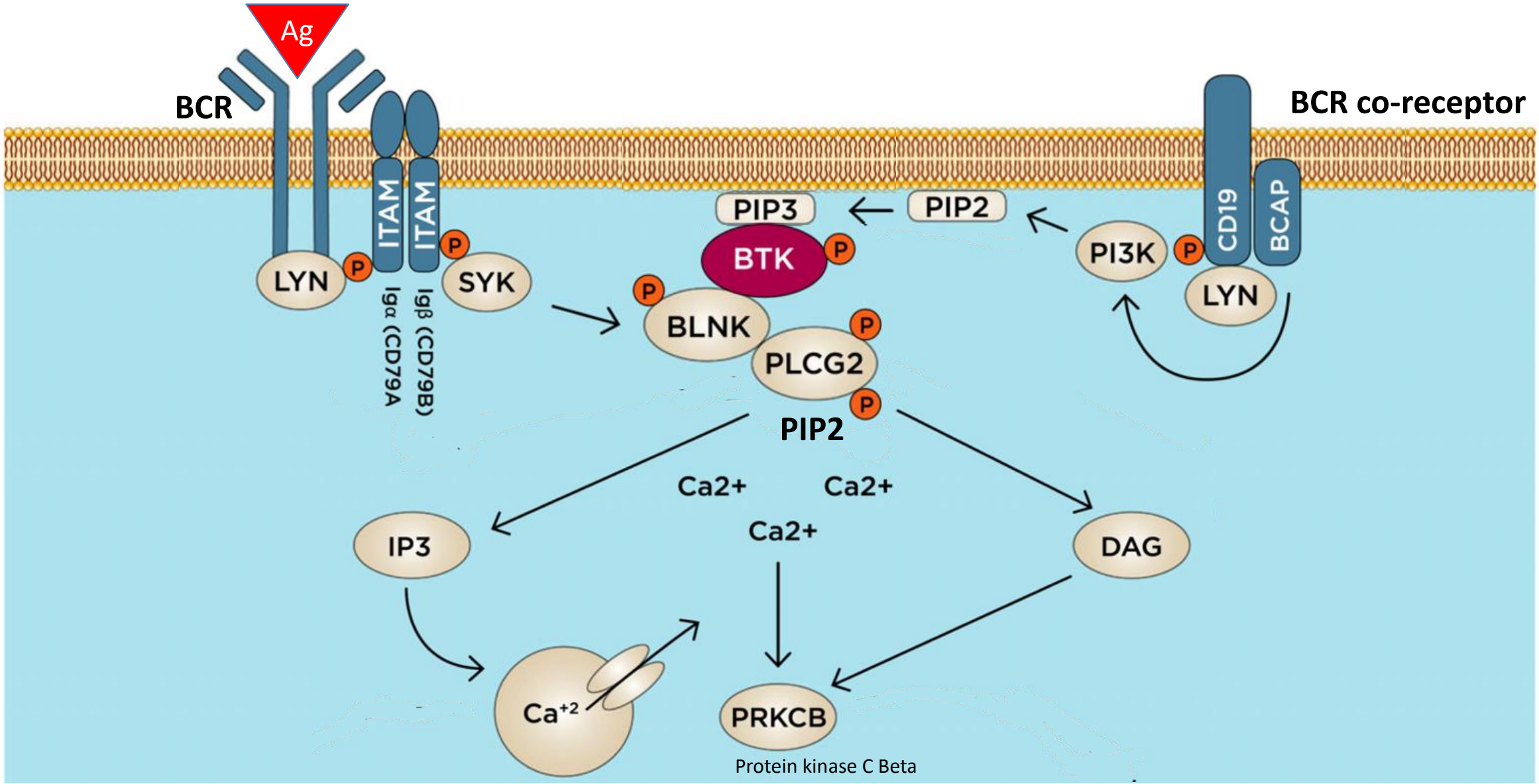
- BTK is essential for B cell maturation, formation of GC, plasma cell proliferation
- BTK activation may provoke autoantibody production and auto-immunopathy
- BTK is defective in primary immunodeficiency X-linked agammaglobulinemia (XLA)



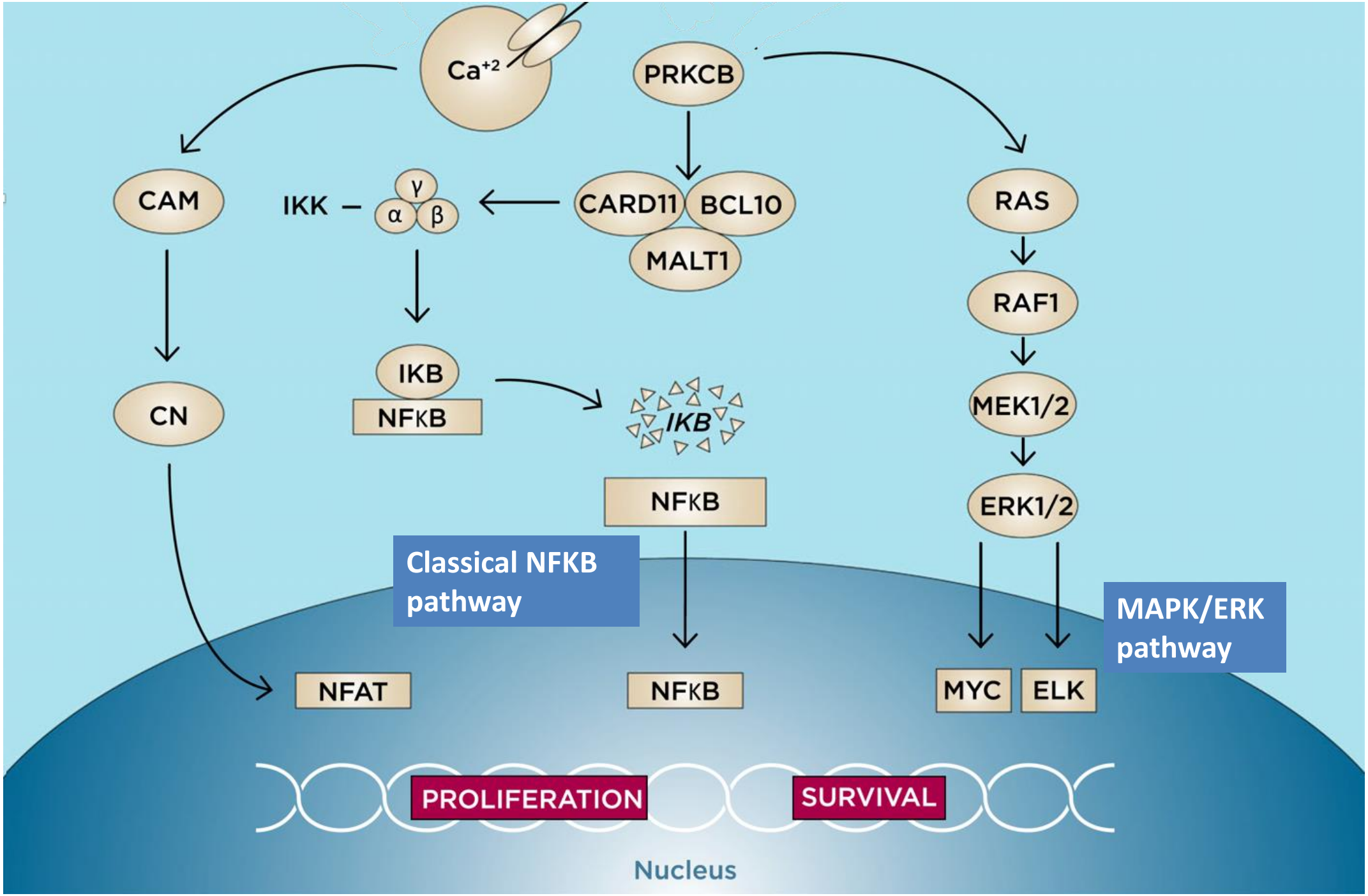
- **BCR signalling**
- CD19, CD38, CD40, G-protein coupled receptors and chemokine receptors, TNF, Toll like receptor signalling

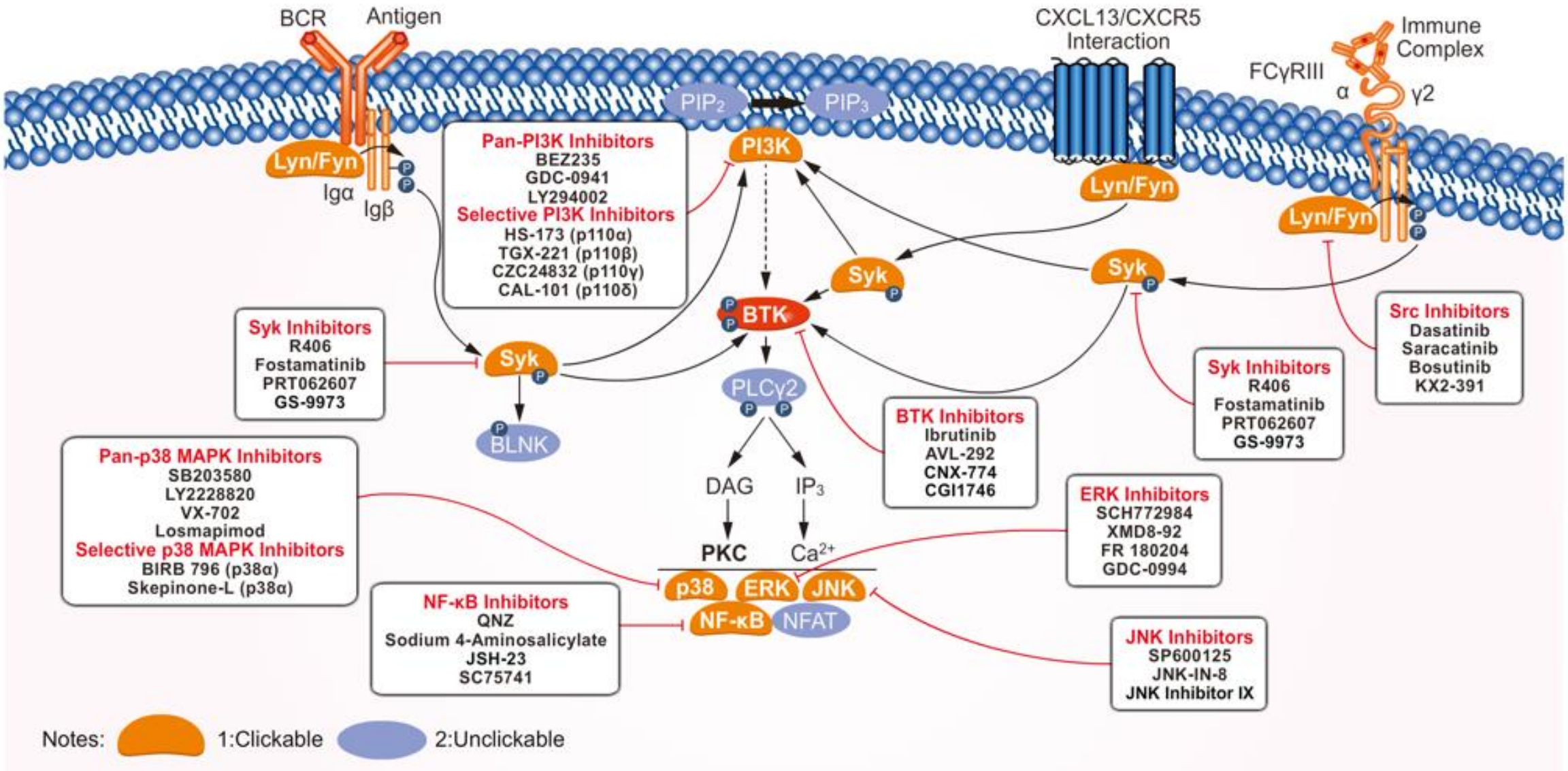


Hershkovitz-Rokah et al., BJH 2018



Hershkovitz-Rokah et al., BJH 2018

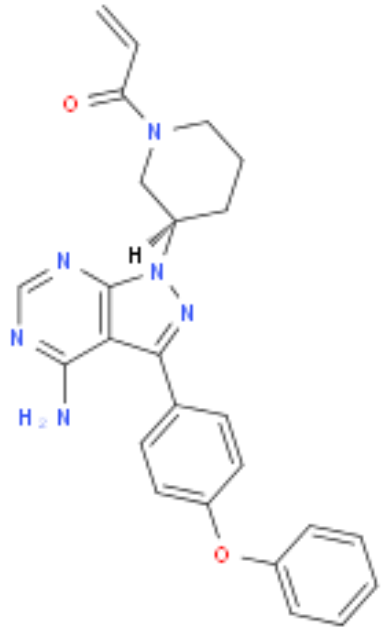

Ca+2
PRKCB
CAM
IKK
γ
α
β
CARD11
BCL10
MALT1
RAS
RAF1
MEK1/2
ERK1/2
IKB
NFKB
CN
IKB
NFKB
NFKB
Classical NFKB pathway
MAPK/ERK pathway
NFAT
NFKB
MYC
ELK
PROLIFERATION
SURVIVAL
Nucleus



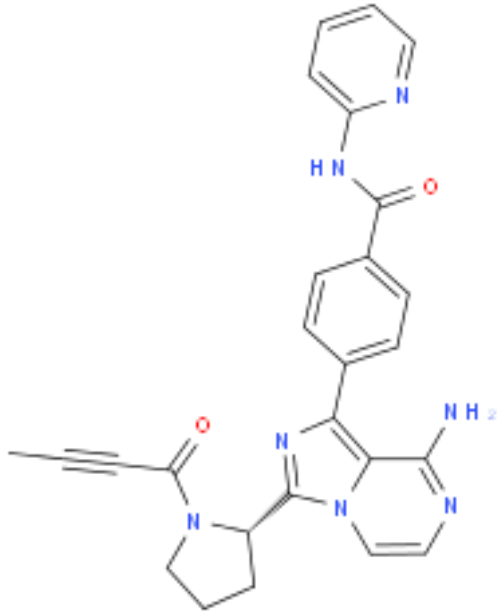
https://www.selleckchem.com

Comparison of BTK inhibitors

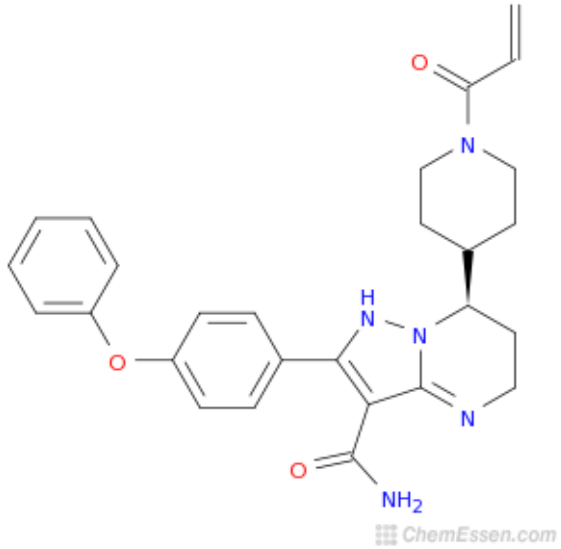
Ibrutynib (PCI 32765)



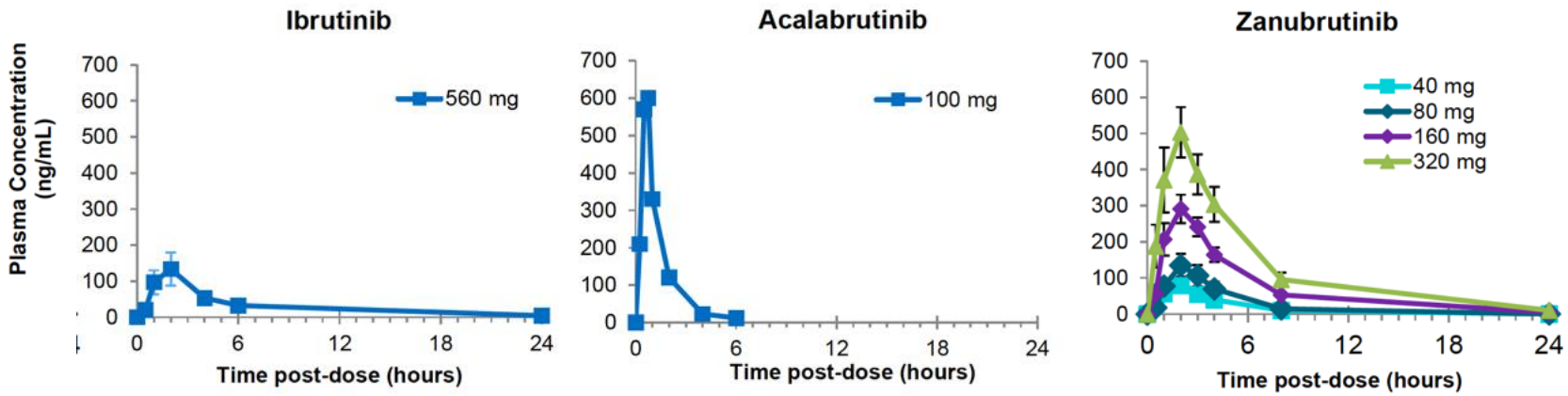
Acalabrutinib (ACP-196)



Zanubrutynib (BGB-311)



Comparison of BTK inhibitors - Plasma Exposure By Dose

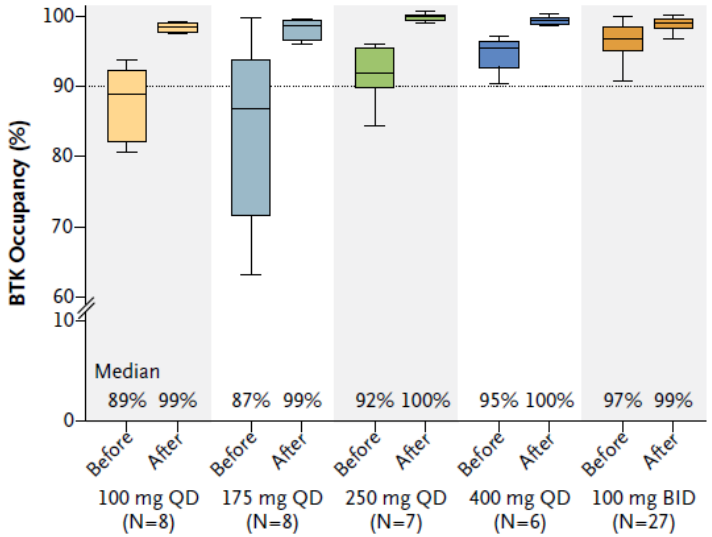


in vitro BTK inhibition IC50 relative to Ibrutinib:	1	3.4-7.2	1
Dose in MCL:	1 x 560 mg	2 x 100 mg	2 x 160 mg

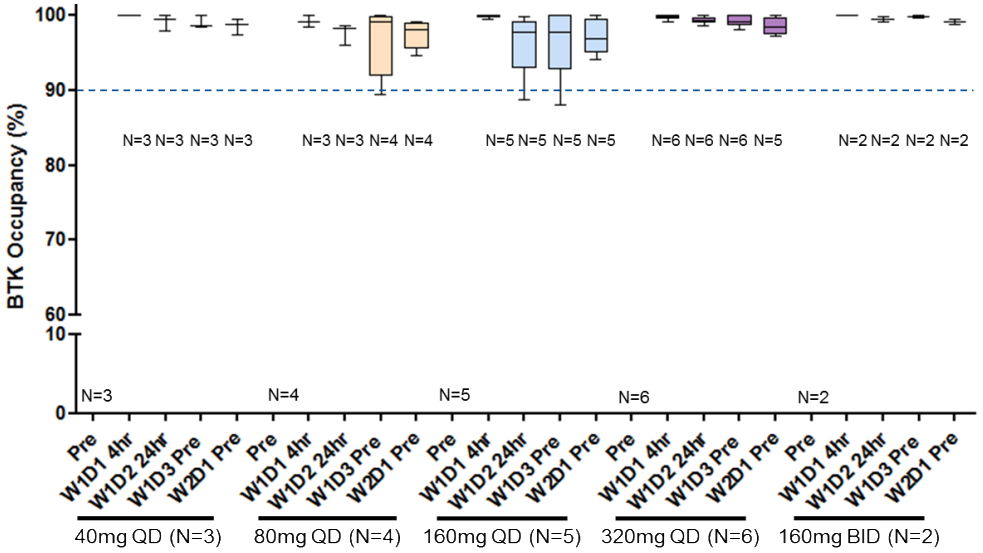
Advani et al., JCO 2013; Byrd et al. NEJM 2015,

Comparison of BTK inhibitors – Target Occupancy

Acalabrutinib (ACP-196)



Zanubrutynib (BGB-311)



Advani et al., JCO 2013; Byrd et al. NEJM 2015,

Two uncomparable clinical studies

	PCYC-1104-CA	ACE-LY-004
Study Name	Safety and Efficacy of PCI-32765 in Participants with Relapsed/Refractory MCL	An Open-label, Phase 2 Study of ACP-196 in Subjects with MCL
Study Timeline	February 2011 – January 2014	March 2015 - February 2017
Inclusion Criteria: • Men and women ≥ 18 years of age. • Pathologically confirmed MCL, with documentation of monoclonal B cells that have a chromosome translocation t(11;14)(q13;q32) and/or overexpress cyclin D1 and measurable disease on cross sectional imaging that is ≥ 2 cm in the longest diameter and measurable in 2 perpendicular dimensions • Relapsed/refractory after at least 1, but no more than 5, prior treatment regimens for MCL • Eastern Cooperative Oncology Group (ECOG) performance status of ≤ 2.		
Number of patients, median age	115, median age 68	124, median age 68

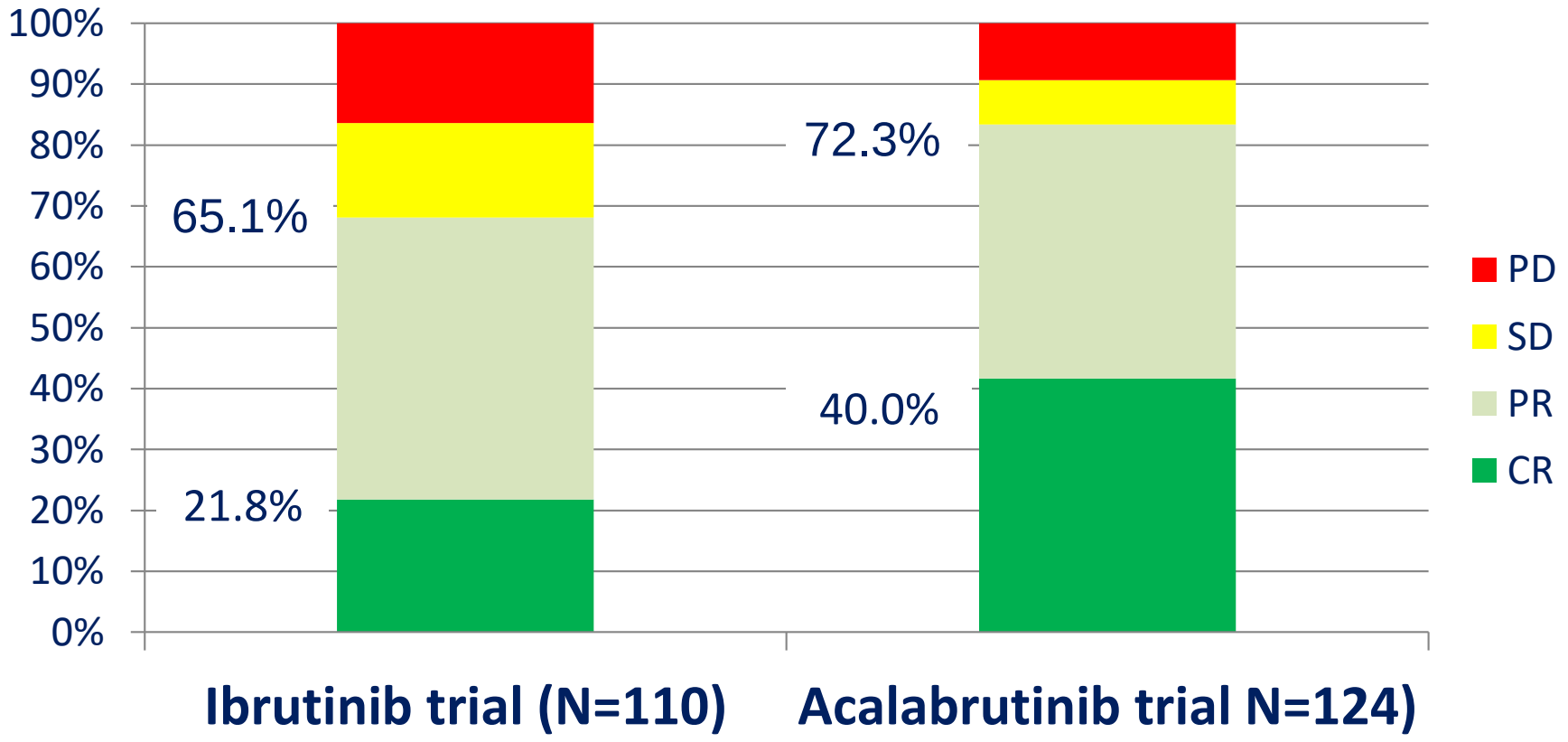
Wang et al., NEJM 2013; Wang et al. Lancet 2018

Two uncomparable clinical studies

	PCYC-1104-CA	ACE-LY-004
Number of previous therapies	**3 (1-5)**	2 (1-5)
Previous ASCT	11%	**18%**
% of patients with intermediate-or high-risk (MIPI)	**86%**	60%
Refractory disease	**45%**	24%
Bulk > 5 and > 10 cm	39% and 8% respectively	37% and 8% respectively
Primary endpoint - ORR (*):	ORR – 68% CR - 21% PR - 47%	**ORR - 81%** **CR - 40%** PR - 41%
Median time to initial response (months)	1.9 (range 1.4-13.7)	1.9 (range 1.5-4.4)
Median time to CR (months)	5.5 (range 1.7-24.7)	**3.4** (range 1.9–5.5)
Duration of Response (DOR)	median - 17.5 months	**72% at 12 months**
Progression Free Survival (PFS)	median - 13.9 months	**67% at 12 months**
Overall Survival (OS)	58% at 18 months	**87 at 12 months**

Wang et al., NEJM 2013; Wang et al. Lancet 2018

BTK inhibitors in R/R MCL - Response to therapy



CT based follow-up
PET and BM only in CT CR

PET based follow-up
BM only in PET CR

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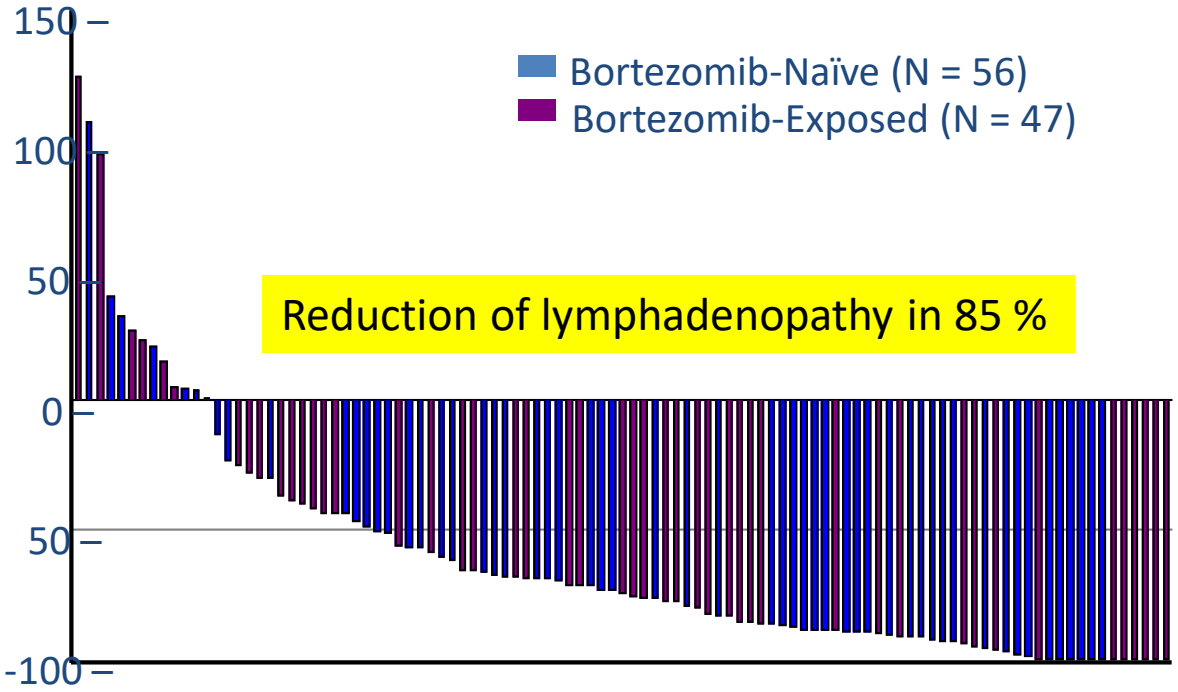
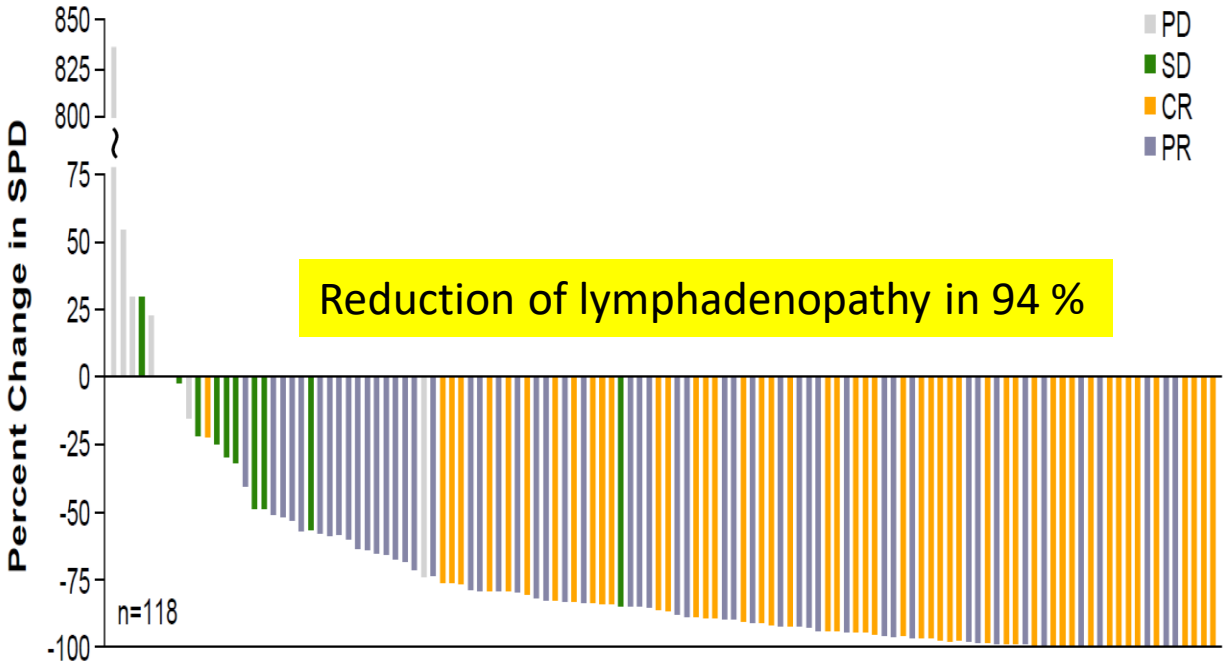
BTK inhibitors in R/R MCL - Response to therapy (SPD)



Ibrutinib trial



Acalabrutinib trial

CT Scans of Tumor Response to Acalabrutinib

- Axial images of a 92-year-old male with chemorefractory MCL treated with acalabrutinib

Before Treatment

After 7 Months of Treatment

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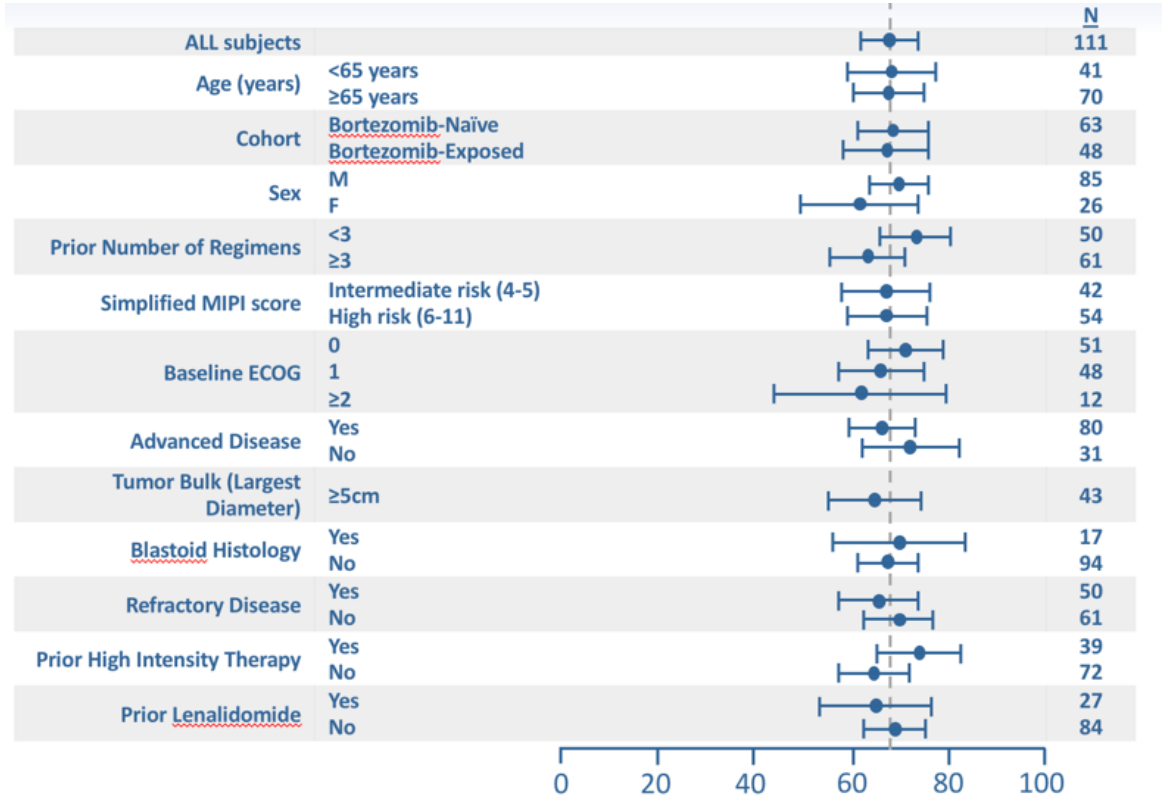
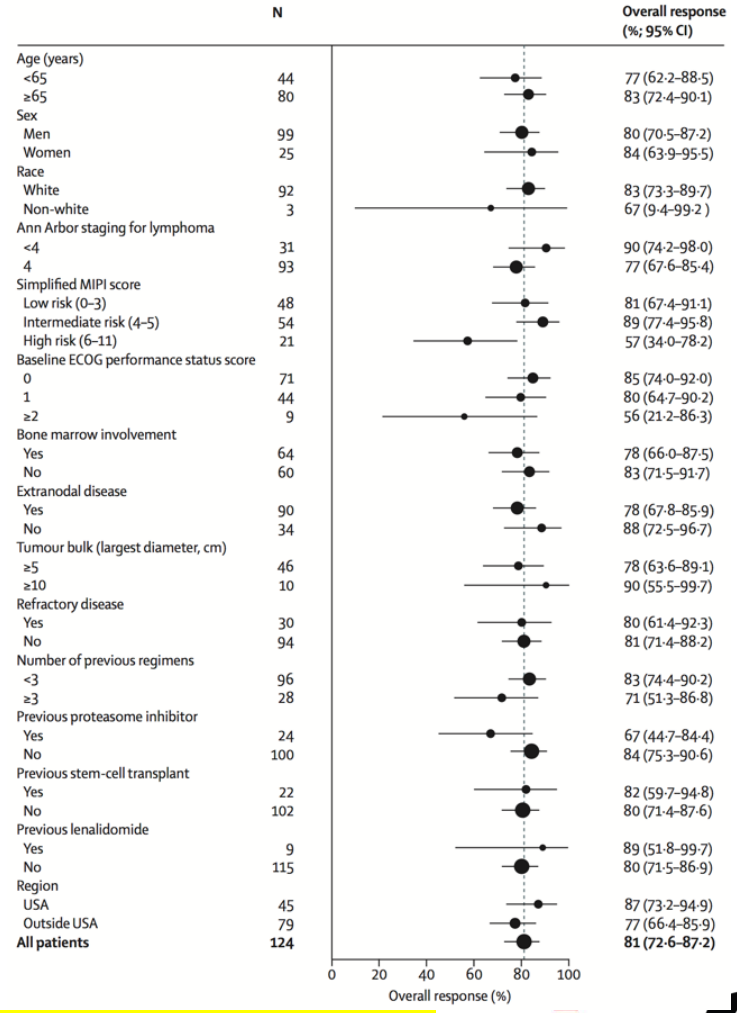
CENTRUM ONKOLOGII – INSTYTUT IM. MARII SKŁODOWSKIEJ-CURIE

Prof. Wojciech Jurczak MD,PhD

Response to BTK inhibitors is Independent of Patient Characteristics and Risk Factors



Ibrutinib trial

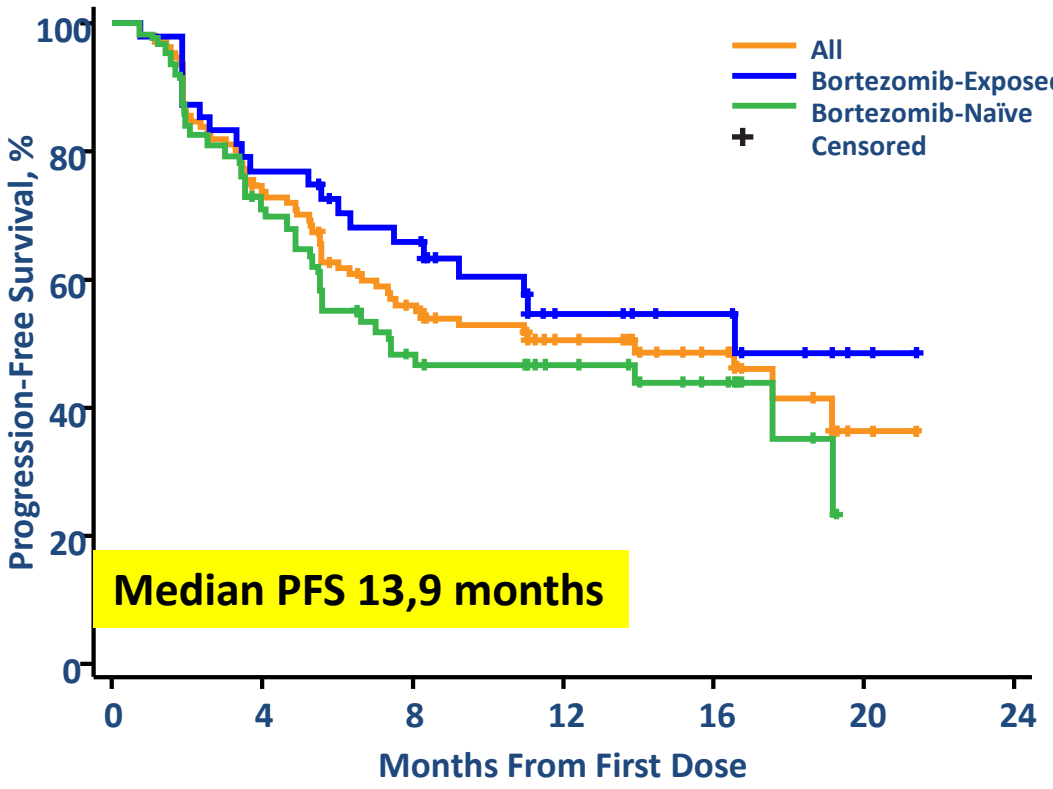


Acalabrutinib trial

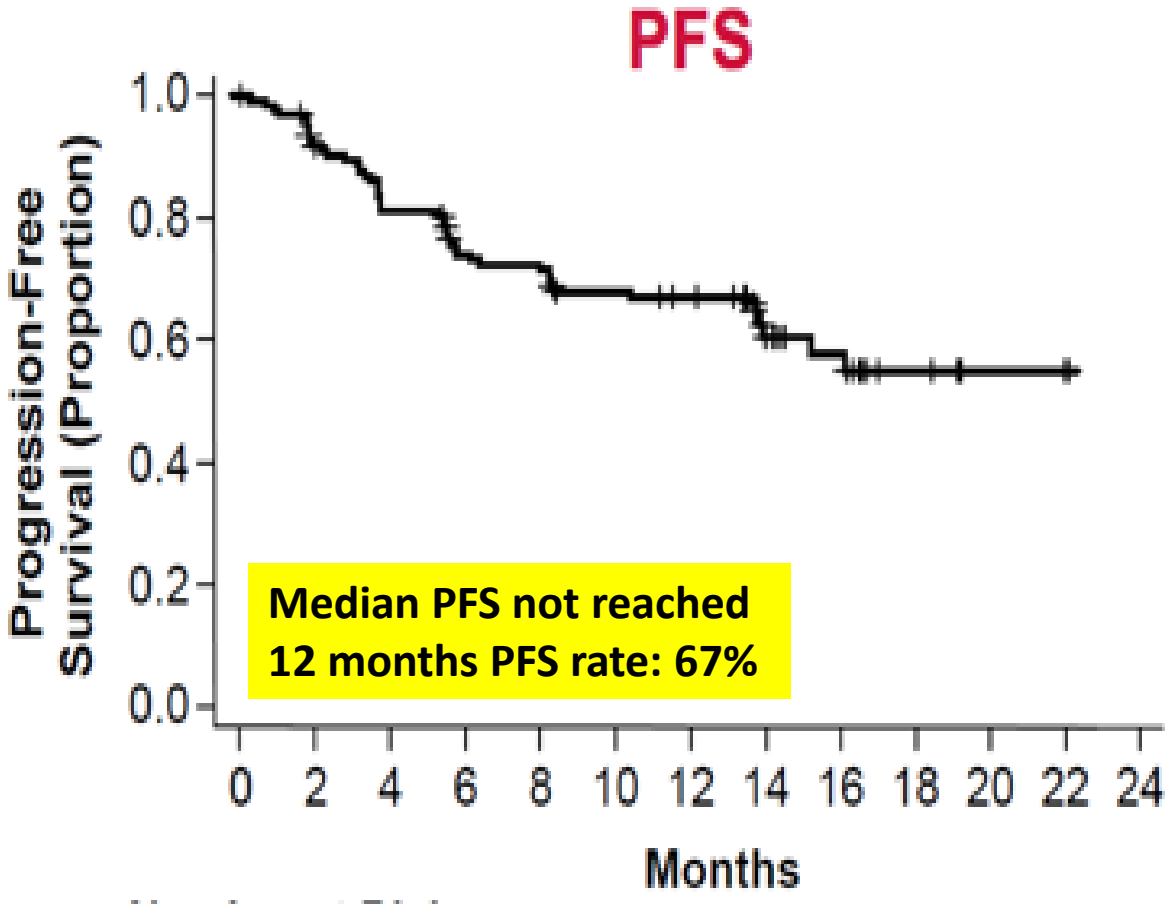
Lymphoma Research Group

CENTRUM ONKOLOGII – INSTYTUT IM. MARII SKŁODOWSKIEJ-CURIE

BTK inhibitors in R/R MCL - PFS

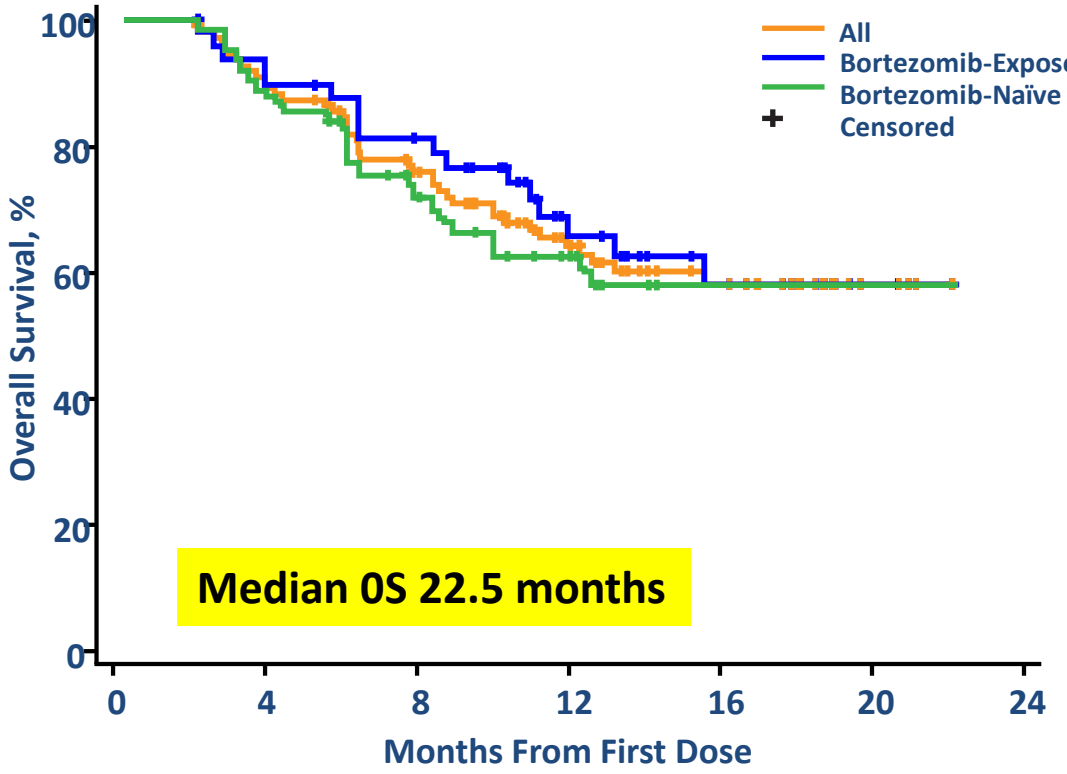


Ibrutinib trial



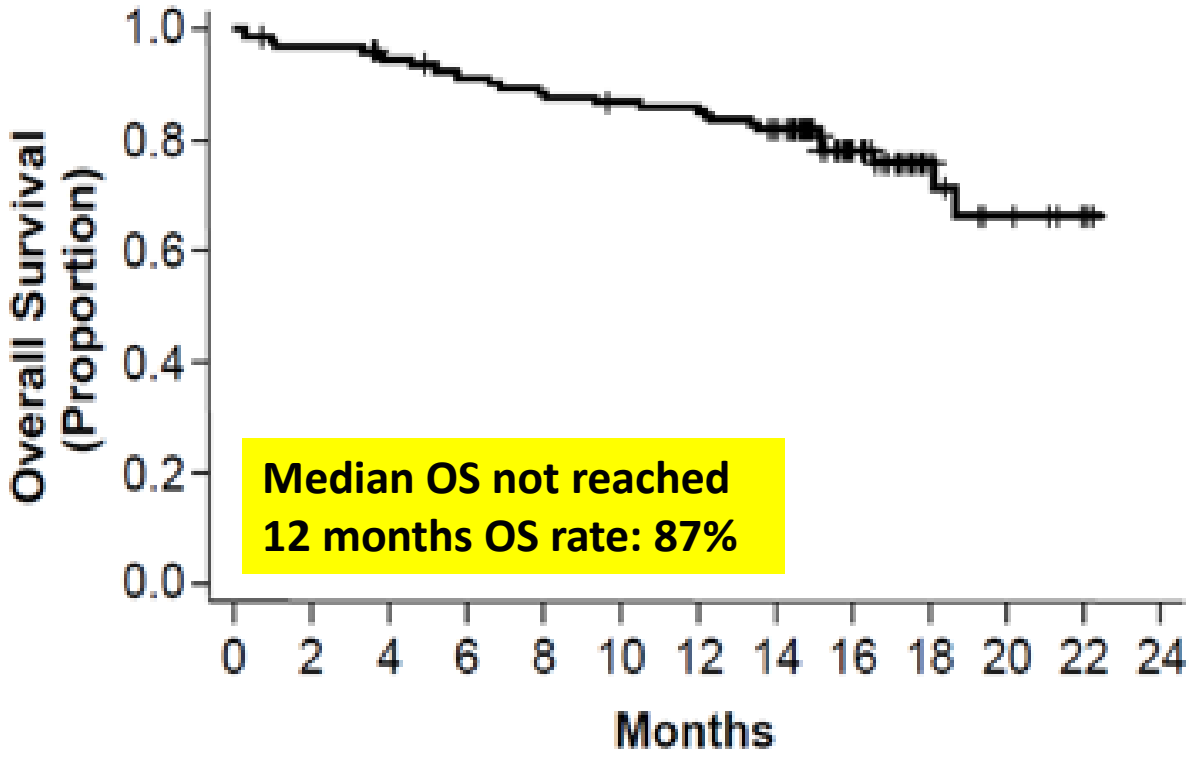
Acalabrutinib trial

BTK inhibitors in R/R MCL - OS



Median 0S 22.5 months

Ibrutinib trial



Median OS not reached
12 months OS rate: 87%

Acalabrutinib trial

Two uncomparable clinical studies

	PCYC-1104-CA	ACE-LY-004
Hematological AE: any /3-4 grade (%):		
Neutropenia	17 /16	14/14
Anemia	11 / 10	15/11
Thrombocytopenia	**13 /11**	**<5%**
Most Common AE any grade/grade 3-4 (%):		
Headache	0	**38/2**
Diarrhea	**53/6**	31/3
Fatigue	**49/5**	27/1
Myalgia	**17/0**	21/1
Nausea	**33/1**	18/1
AE of special interest any grade/grade 3-4 (%)		
Pneumonia	7 / 6	7/6
Atrial fibrillation	**7/ 6**	0/0
Bleeding events	**41/6**	31/1
Patients discontinuing therapy due to AE (%)	**11**	6

Wang et al., NEJM 2013; Wang et al. Lancet 2017

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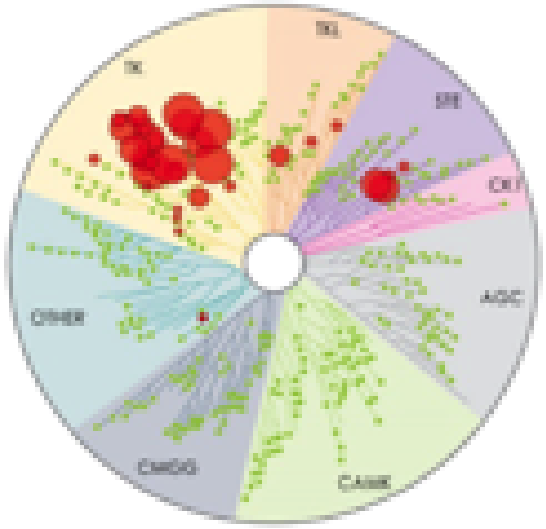
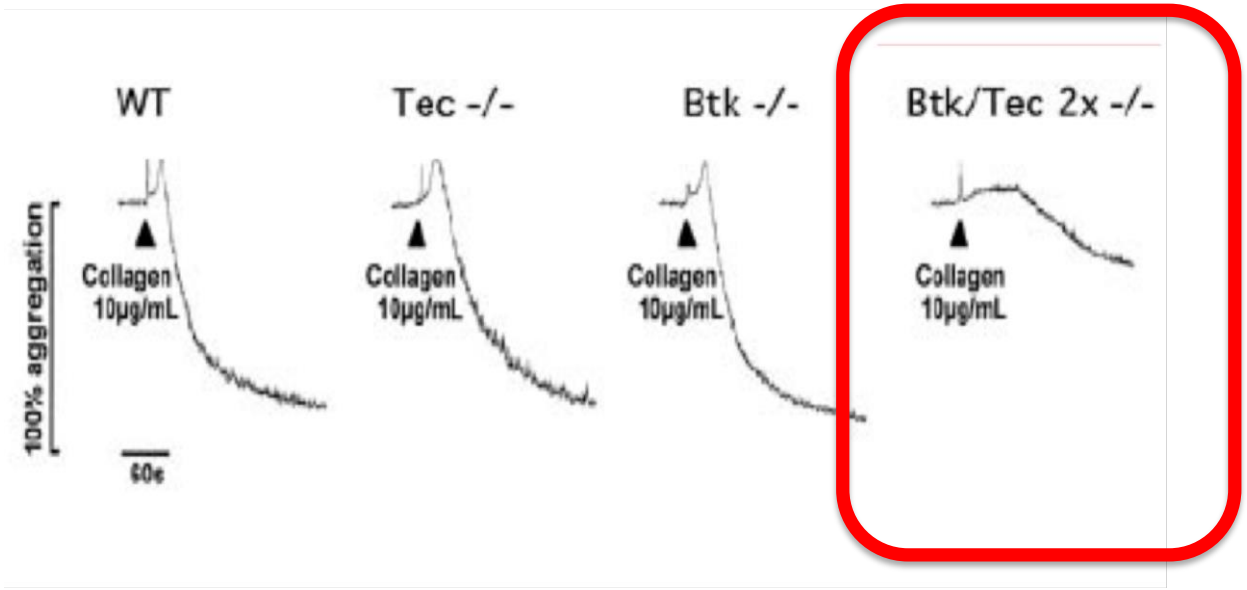
Ibrutinib - Concurrent BTK/TEC inhibition disrupts collagen-mediated platelet aggregation



Kinase Inhibition IC_5 (nmol/L)[1]

Kinase	Ibrutinib
BTK	1.5
TEC	7.0
BMX	0.8
TXK	2.0
ERBB2	6.4
EGFR	5.3
ITK	4.9
JAK3	32
BLK	0.1

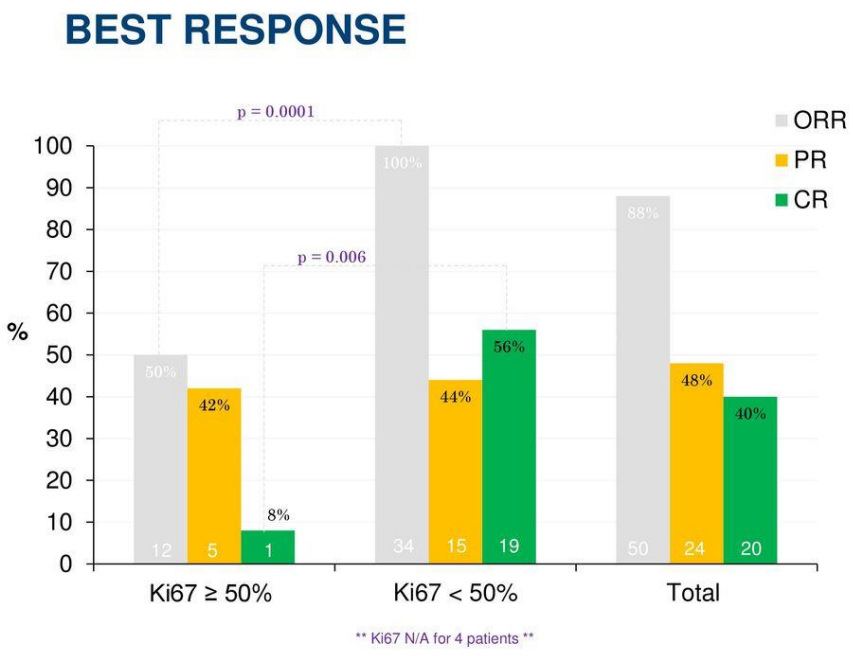


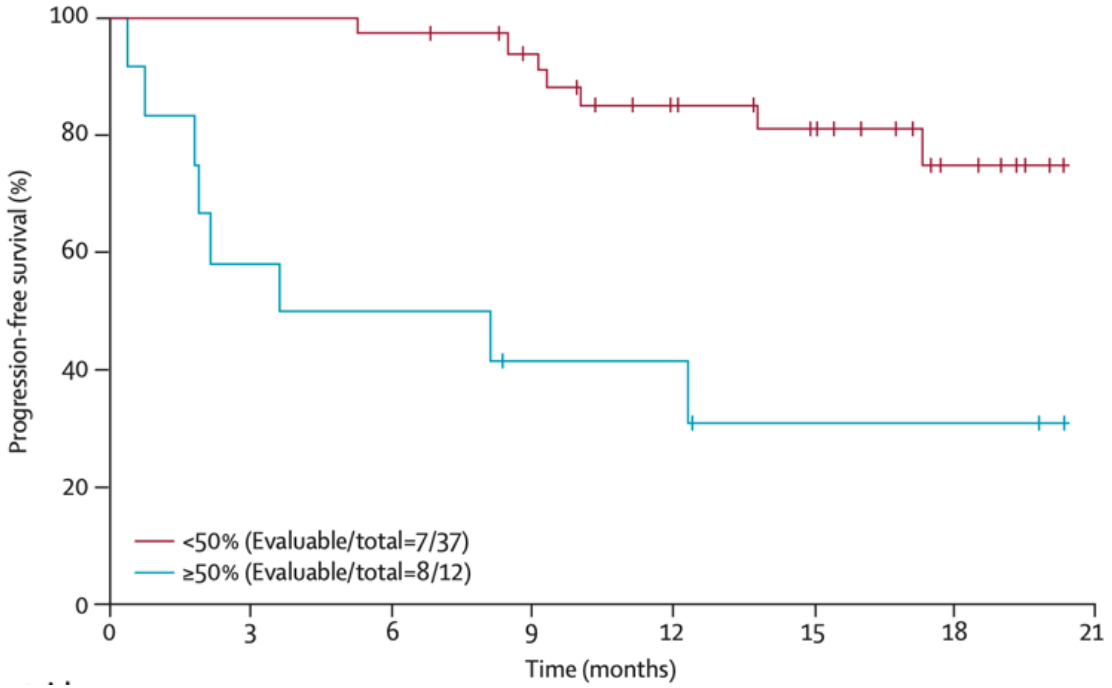
Atkinson et al, 2003

Polish Lymphoma Research Group

Ibrutinib + Rituximab in R/R MCL (≠)

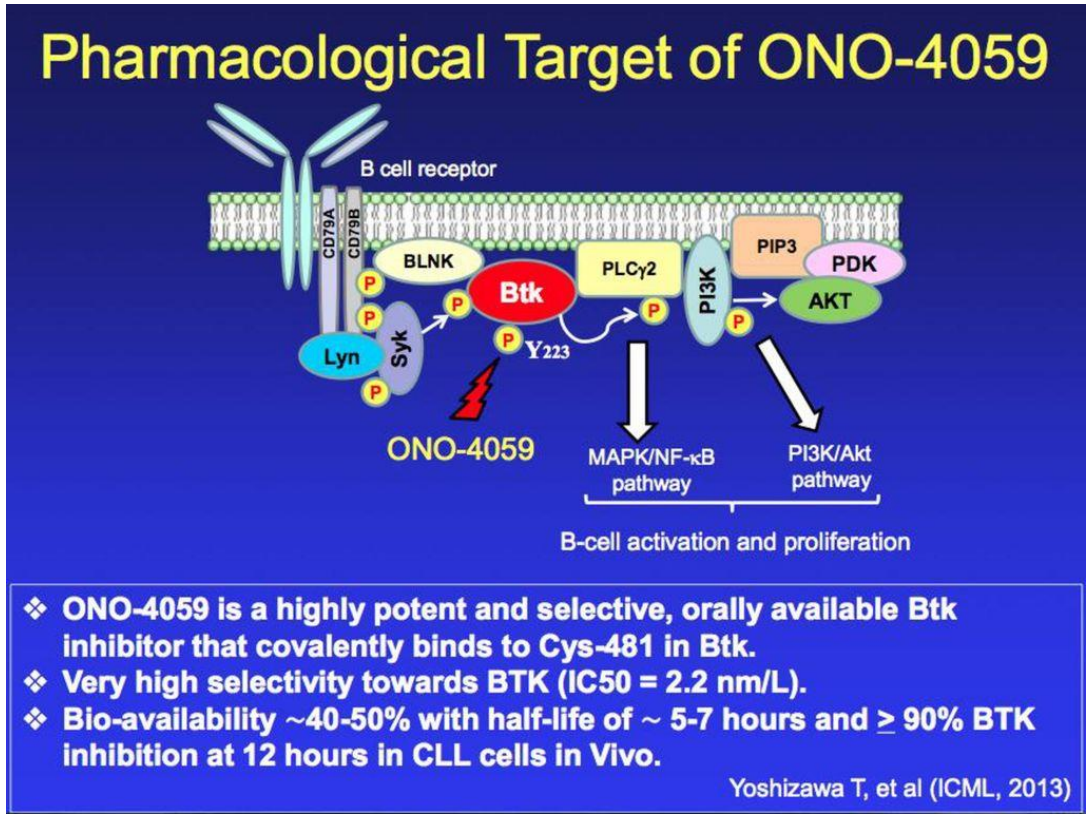
Very promising results in those with ki67 expression < 50 %

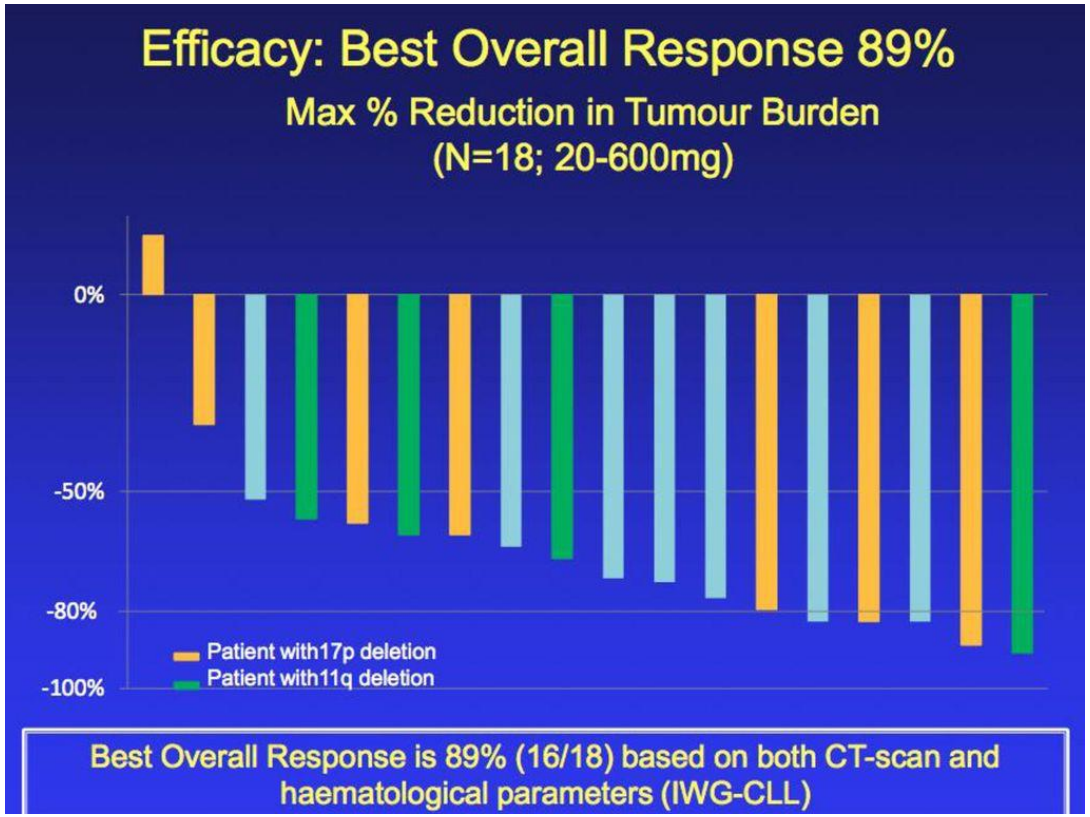




Wang et al.; Lancet Oncol 2016

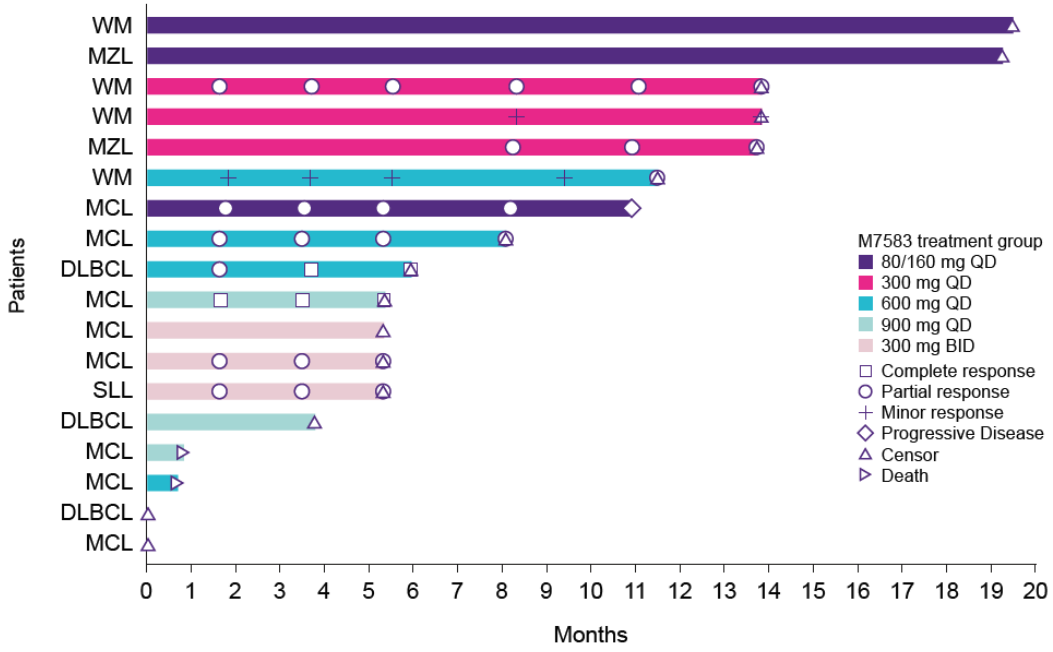
ONO-4059 in MCL *(≠)*





Yoshizawa et al., ICML 2013

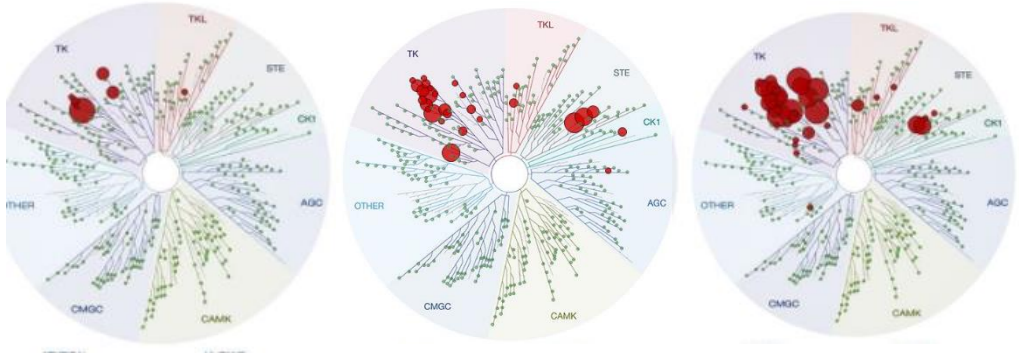
M7583 in R/R B cell NHL (≠)



Jurczak et al., ESMO 2018

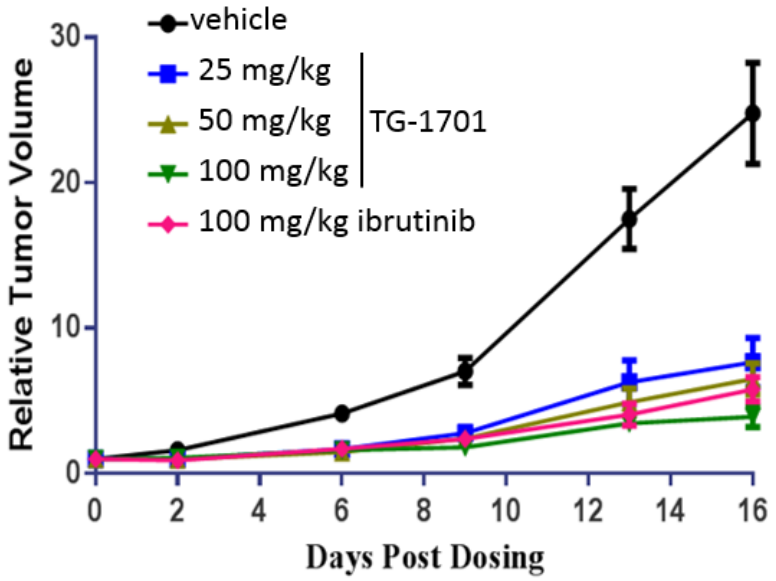
TG-1701 in MCL and WM *(≠)*

Acalabrutinib TG-1701 ibrutinib



Larger red circles represent stronger inhibition

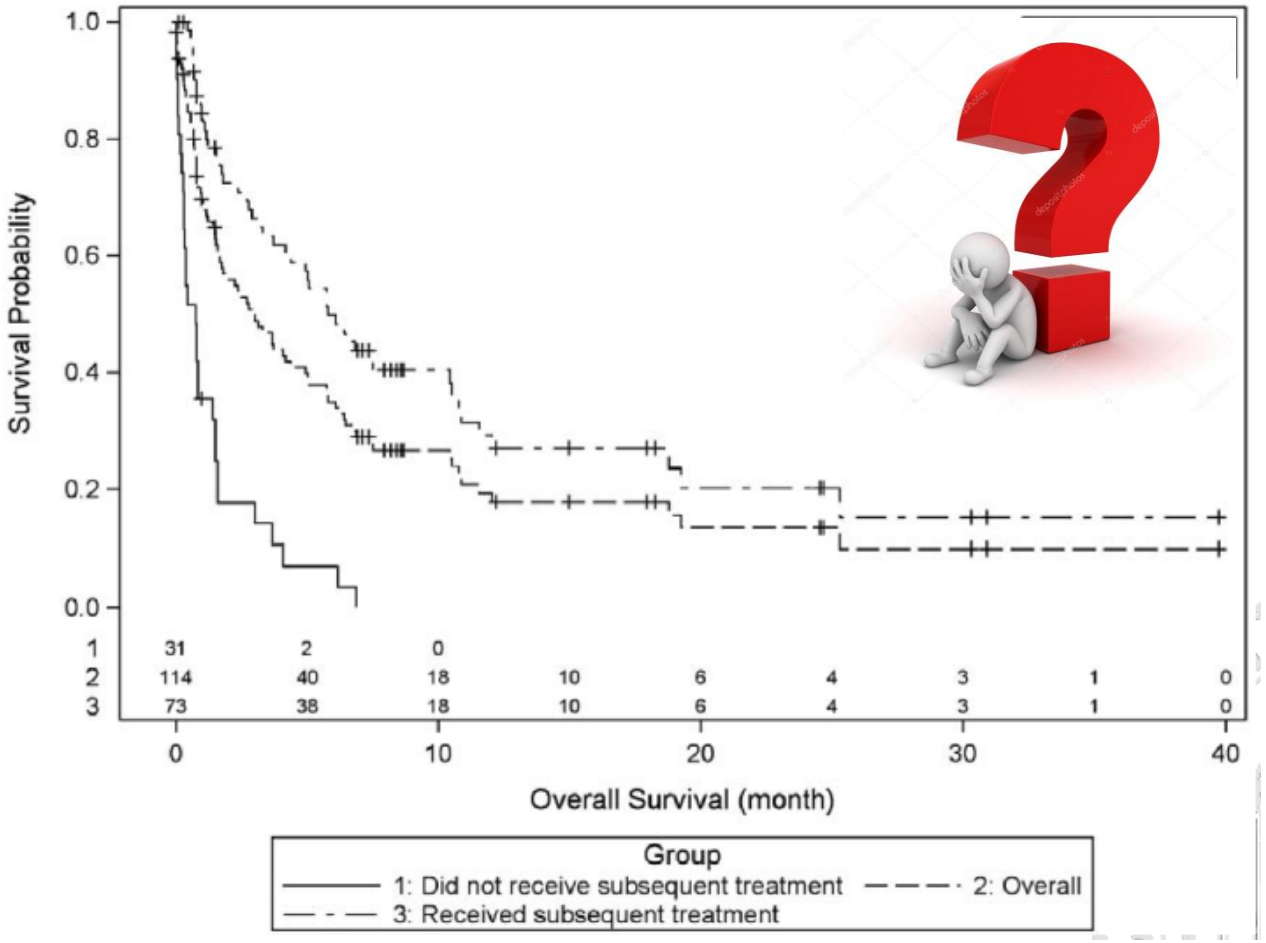
kinase	acalabrutinib	TG-1701	ibrutinib
BTK	5.1	3	1.5
TEC	93	4	7
BMX	46	72% at 1000	0.8
TXK	368	136	2
ERBB2	1000	> 3000	6.4
EGFR	> 1000	270	5.3
ITK	> 1000	> 3000	4.9
JAK3	> 1000	> 3000	32
BLK	> 1000	54% at 1000	0.1



Clinical trials with Ibrutinib in R/R MCL

	Wang et al (2013b)	Cheah et al (2015)	Martin et al (2016)	Dreyling et al (2016)	Epperla et al (2017)
Study design	Prospective, phase 2 (2011–12)	Retrospective (2011–14)	Retrospective (NA)	Prospective, phase 3, (2012–13)	Retrospective (2013–2015)
Sites, n	18	1	15	21	8
Patients, n	111	78	114	280 (139 on Ibrut.)	97
Median prior treatments (range)	3 (1–5)	2 (1–8)	3 (0–10)	2 (1–9)	2 (1–8)
Median Ibrutinib (cycles/duration)	9 cycles	6-5 cycles	4-7 months	14-4 months	NA
CR	NA	30%	11%	NA	NA
ORR to ibrutinib	68%	NA	55%	72%	65%
Median DOR to ibrutinib	17-5 months	6 months	NA	NR	17 months
Ibrutinib discontinuation	58%	54%	NA	53%	50%
Progression (%)	45%	35%	100%	40%	25% PD, 10% SD
Primary resistance	**32%**	**10%**	**32%**	**28%**	**35%**
Acquired resistance	**NA**	**25%**	**54%**	**NA**	**17%**

How to treat MCL after BTKi failure ?

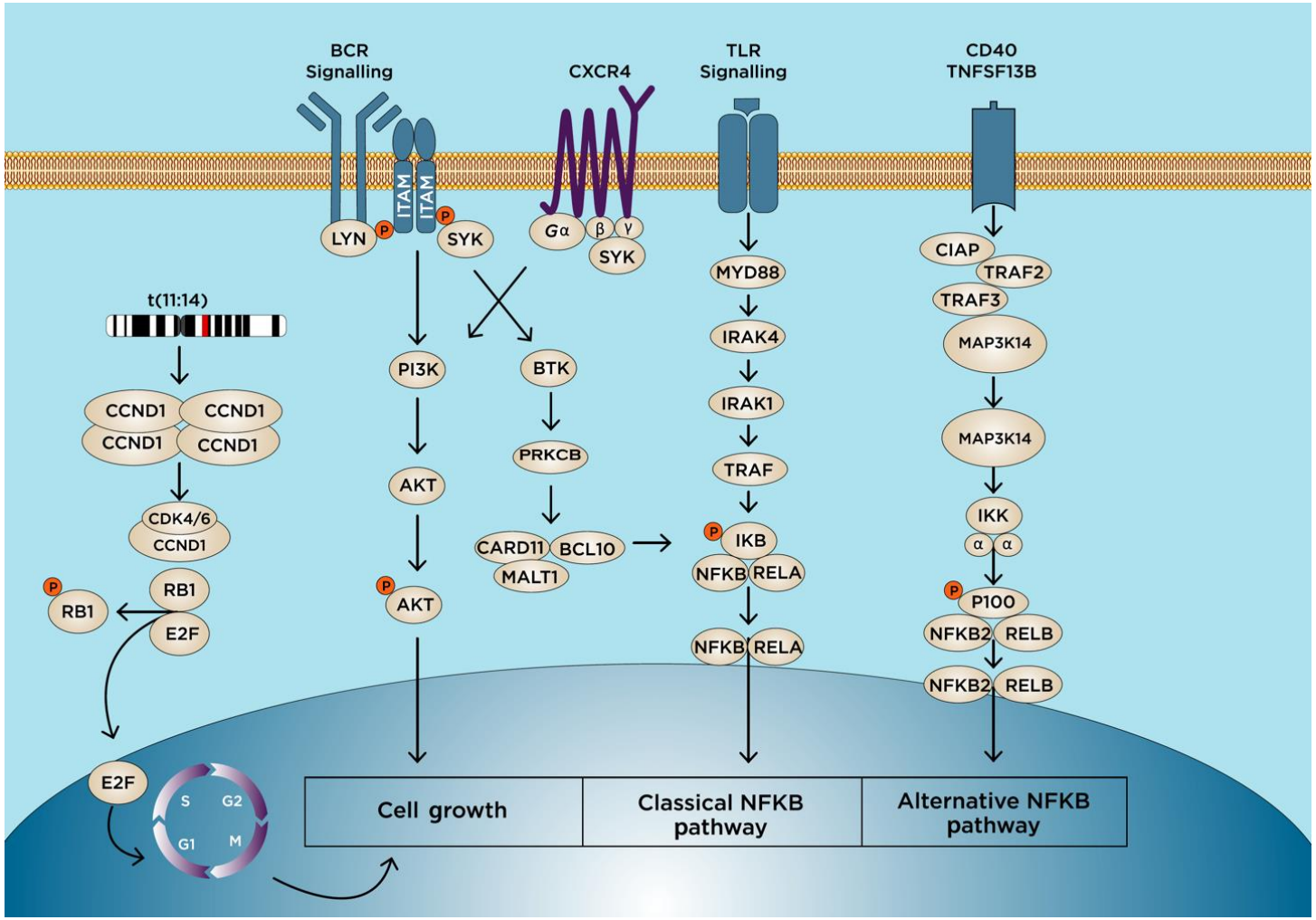


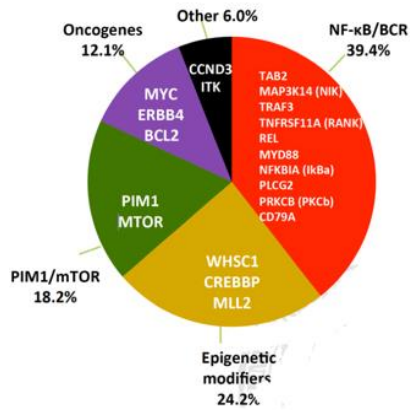
Primary resistance

Acquired resistance

Martin et al., Blood 2016

Mechanisms of primary Ibrutinib resistance

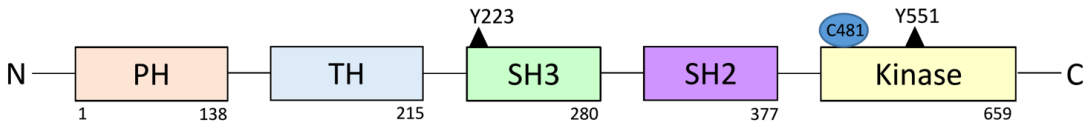




- sustained **distal BCR signaling** such as activation of **PIK3** and protein kinase B (AKT) pathway,
- activation of the classical and **alternative NFkB pathways**,
- initiation of **cell cycle progression**

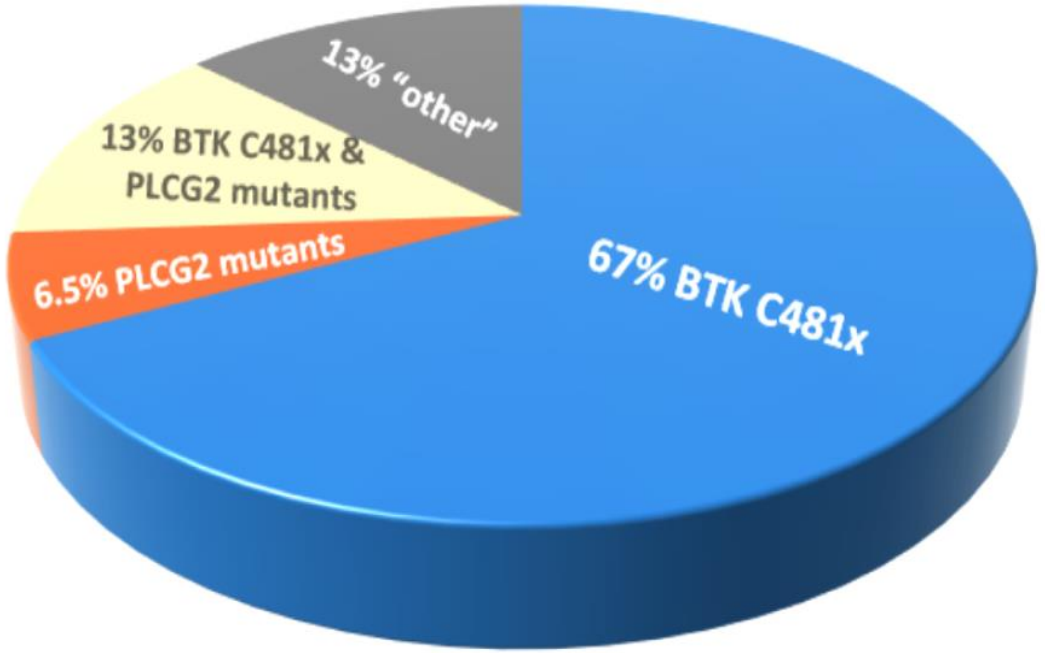
Hershkovitz-Rokah et al., BJH 2018

Mechanisms of acquired Ibrutinib resistance



Ineffective inhibition due to BTK mutation (10 – 30% of MCL patients)

Cysteine to Serine mutation of BTK binding site of Ibrutinib:



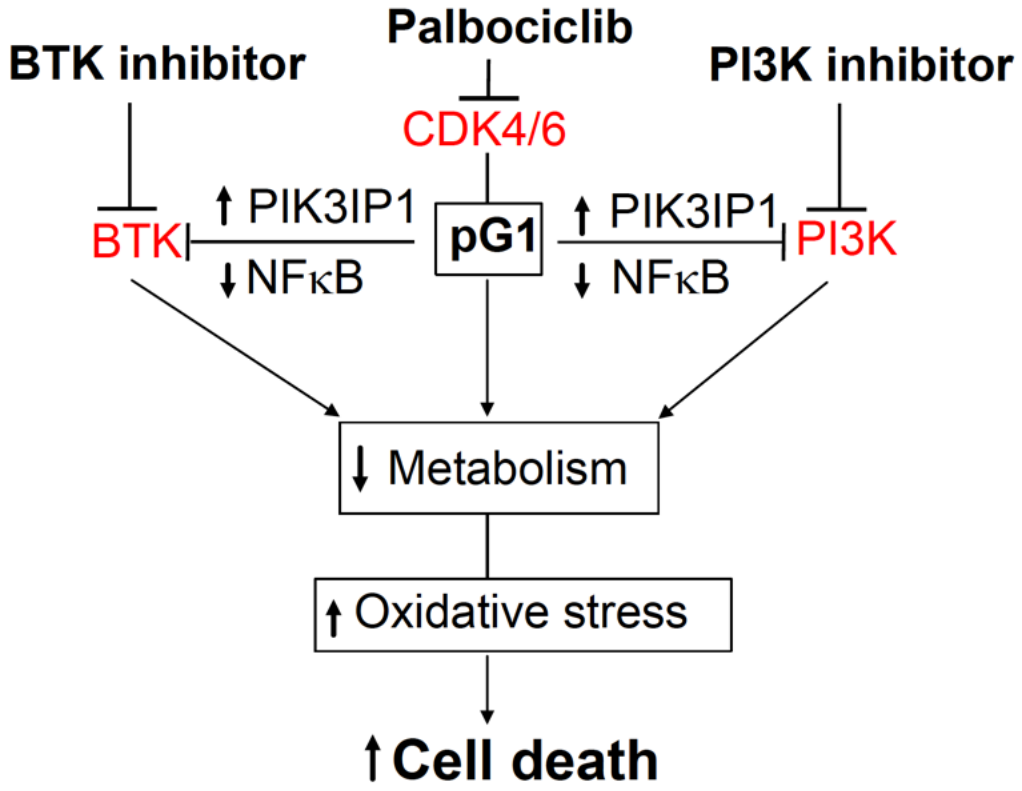
[1]Woyach et al. N Engl J Med. 2014; 370:2286–94, [2]Byrd et al. N Engl J Med. 2016; 374:323–32; [3]Woyach et al. J Clin Oncol. 2017; 35:1437–43; [4]Xu et al. Blood. 2017; 129:2519–25; [5]Hershkovitz-Rokah et al. Br J Haematol. 2018; 181:306–19

How to overcome Ibrutinib resistance ?

BTK inhibitor „combos” & „triplets”

Novel BTK inhibitors

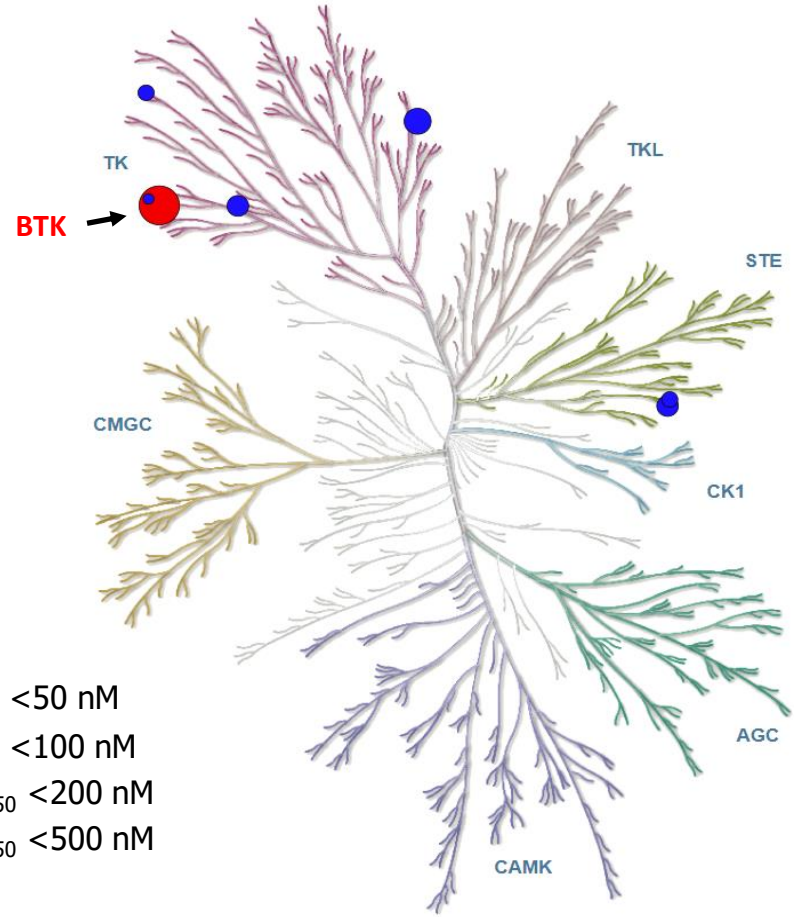
Loxo-305 – Loxo Oncology
ARQ 351 – ArQuele
Vecabrutinib – Sunesis
GDC583 - Genethech



IMIDS

Venetoclax

LOXO-305 potently and selectively inhibits BTK and BTK C481S



- IC_{50} <10 nM
- 10 nM < IC_{50} <50 nM
- 50 nM < IC_{50} <100 nM
- 100 nM < IC_{50} <200 nM
- 200 nM < IC_{50} <500 nM

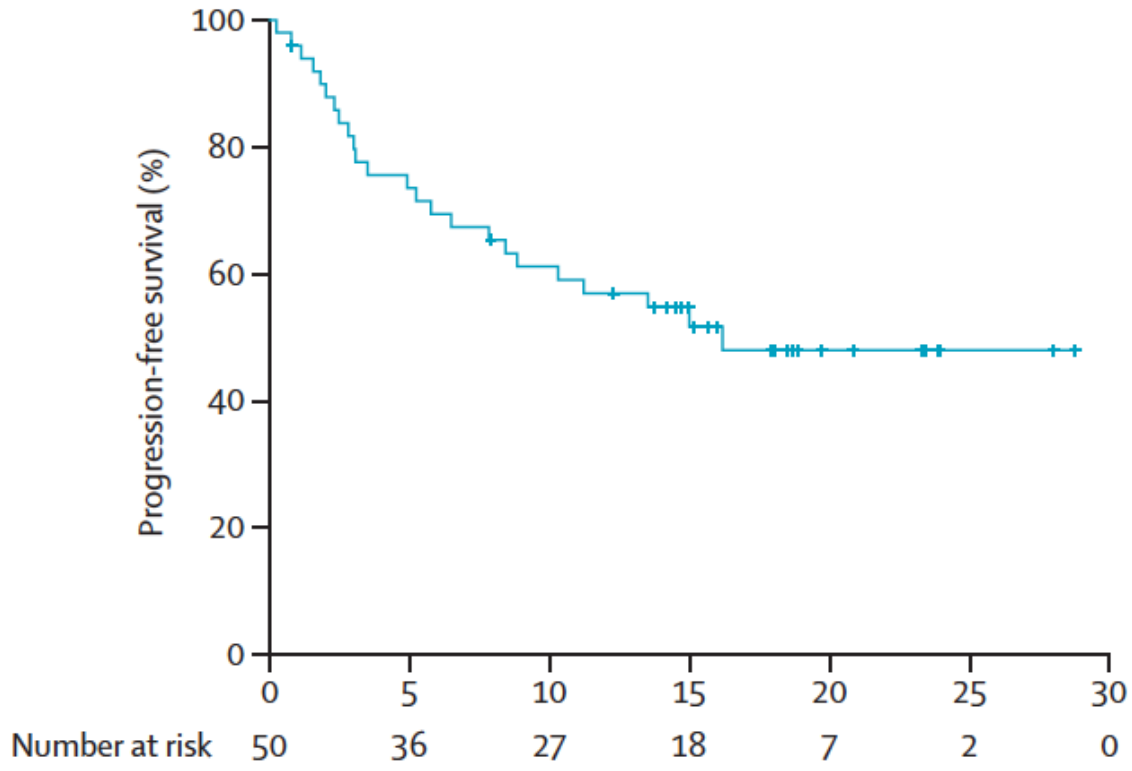
LOXO-305 IC_{50}, [ATP] = K_M
BTK C481S = 1.42 nM
BTK = 3.15 nM

Kinase	Percent of control @1 µM LOXO-305, [ATP] = K_M (%)	IC_{50} [ATP] = K_M (nM)	Fold selectivity over BTK
BTK C481S	ND	1.42	0.5 X
BTK	1.8	3.15	1.0 X
ERBB4	2.6	13.3	4.2 X
BRK	10.3	54.3	17 X
MEK2	7.6	82.7	26 X
MEK1	12.2	147	47 X
YES1	38.6	157	50 X
TXK	19.6	209	66 X
BMX	70.2	1155	367 X
TEC	64.6	1234	392 X
BLK	72.8	4100	1302 X
EGFR	60.6	>1000	>317 X
ITK	103	>5000	>1587 X
SRC	90.5	>5000	>1587 X
JAK1	96.4	>30000	>9524 X
JAK2	94.5	ND	ND
JAK3	97	ND	ND

PHILEMON study in R/R MCL (N-50)
Ibrutynib + Lenalidomide + Rituximab *(≠)*

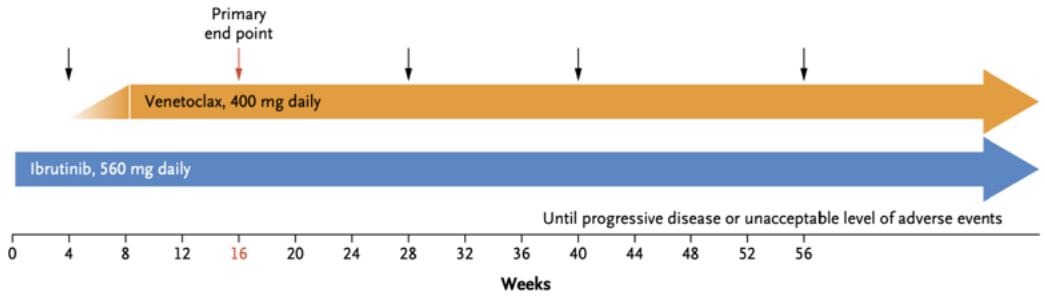
	All patients (n=50)
Age (years)	69 (45–85)
Sex	
Female	14 (28%)
Male	36 (72%)
ECOG performance status score 0–1	45 (90%)
MIPI score	
Low risk (<5·7)	8 (16%)
Intermediate risk (5·7–6·1)	15 (30%)
High risk (>6·2)	23 (46%)
Missing	4 (8%)
Ann Arbor stage IV disease	42 (84%)
Bone marrow involvement	34 (68%)
Refractory disease	8 (16%)
Number of previous therapies	2 (1–7)
Previous therapy	
Autologous stem-cell transplantation	21 (42%)
Allogeneic stem-cell transplantation	3 (6%)
Ibrutinib	4 (8%)
Lenalidomide	1 (2%)

Data are n (%) or median (range). ECOG=Eastern Cooperative Oncology Group. MIPI=Mantle Cell Lymphoma International Prognostic Index.

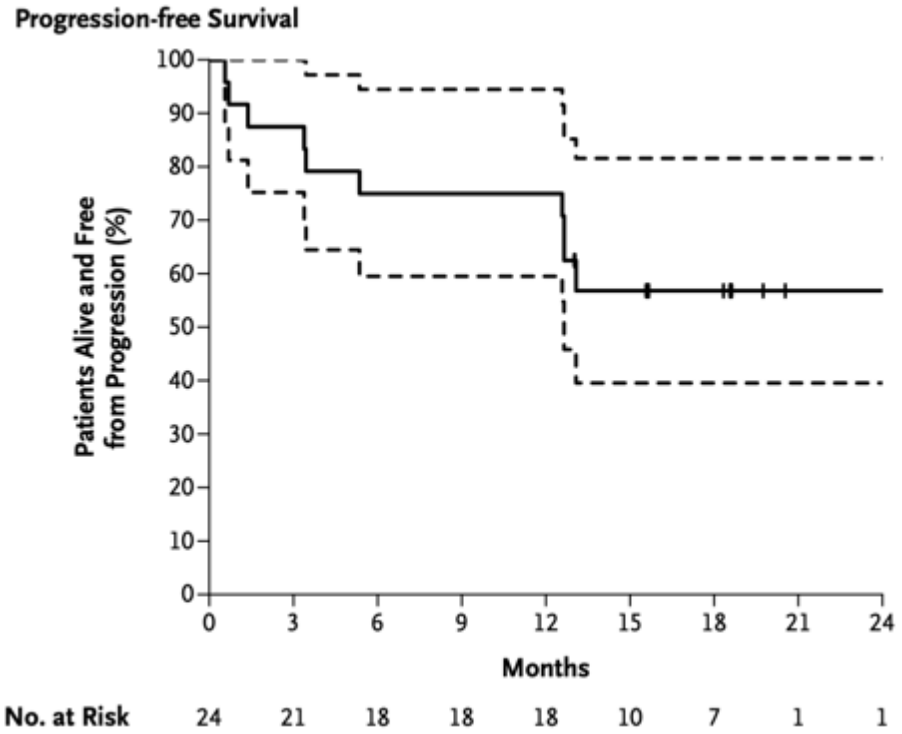


Jerkman et al., Lancet Haematol. 2018

Ibrutinib + Venetoclax in R/R MCL *(≠)*

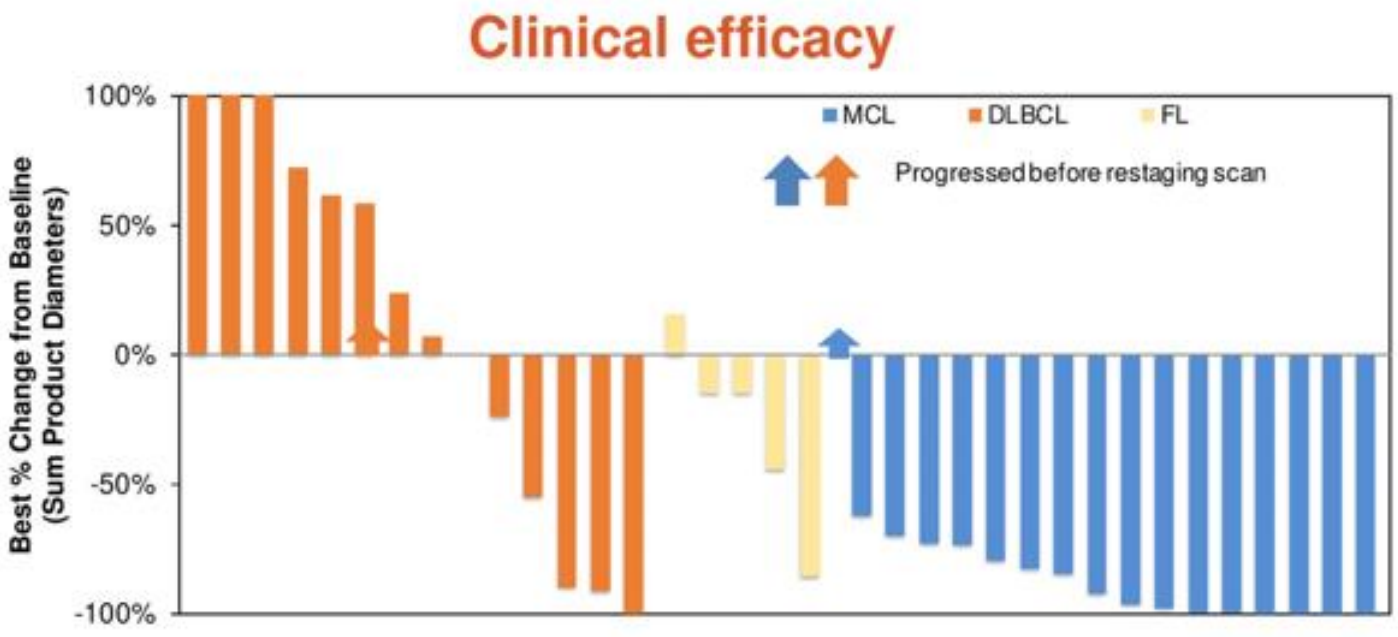


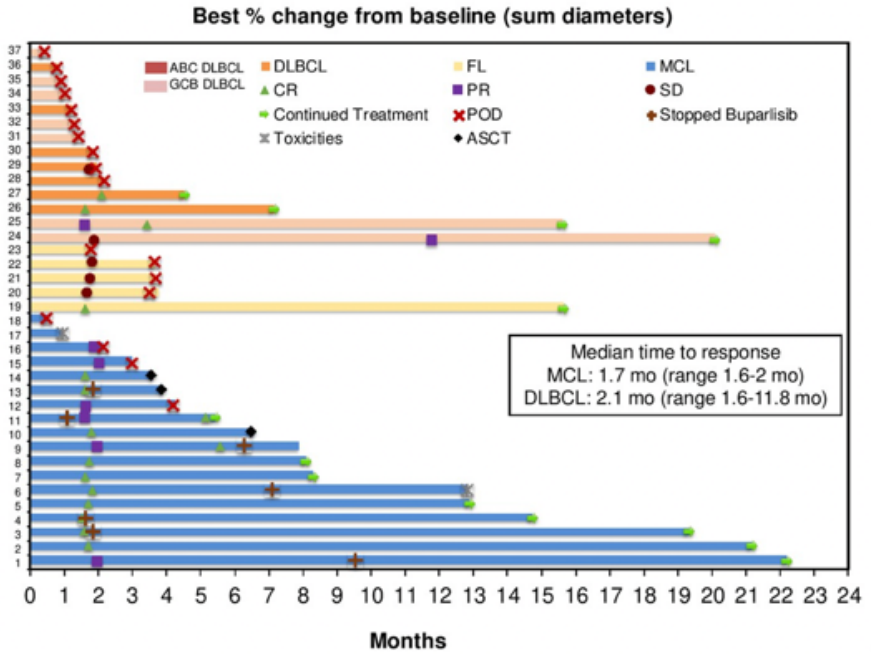
Ki-67 ≥30% — no./total no. (%)	9/21 (43)
TP53 status — no. (%)	
Mutated with deletion	4 (17)
Mutated without deletion	7 (29)
Deletion without mutation	1 (4)
NF-κB pathway mutations in *CARD11*, *BIRC3*, or *TRAF2* — no. (%)	6 (25)



Tam et al., NEJM 2018

Ibrutynib + Bupralisib in R/R B cel NHL *(≠)*

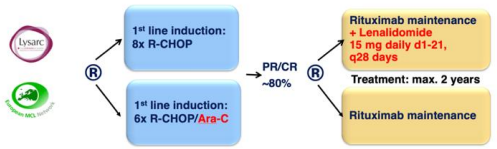




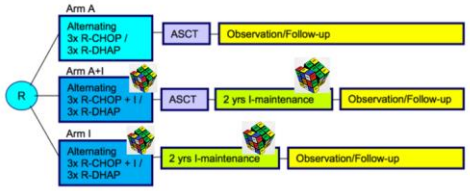
Batlevi et al., 2018

Badania kliniczne w Krakowie u chorych z MCL

„Elderly study”



„Triangle” study



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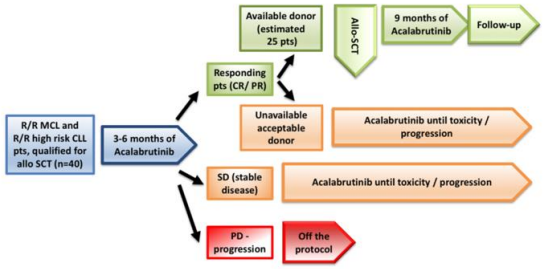
ACALLO - PLRG 12



Pratia

De novo		*Wznowa*	
ACERTA-106	Rituximab + ACP-196 + Venetoclax M.Majewska-Polak	BIOINVENT	Rituximab + Lek badany A.Macuda
ACERTA-308	ACP-196/placebo + Rituximab + Bendamustyna A.Macuda	IMBRUVICA-1143	Ibrutinib + Venetoclax / placebo A.Sawiec
		CITADEL-205	tabletki INCB 50465-205 A.Macuda

– w przygotowaniu – od października
We wskazaniach rejestracyjnych dla Ibtuynibu:
- Badanie z LOXO
- Badanie z nowym iBTK TG Therapeutics

Polish Lymphoma Research Group

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Podsumowanie

- **Rokowanie chorych z MCL poprawia się**
- **Inhibitory kinazy Brutona, nieodwracalnie zmieniły standard leczenia MCL**
- Optymalne skojarzenie inhibitorów BTK, leków immunomodulujących (IMID) i wenetoklaksu jest przdmiotem toczących się badań klinicznych.
- **Jedyną możliwością leczenia chorych z R/R MCL w sposób zgodny ze standardem, jest w Polsce, włączanie ich do toczących się badań klinicznych**

POKONAJ CHŁONIAKA β WERSJA BETA

ZESPÓŁ LECZENIA CHŁONIAKÓW

www.chloniak.org

KONTAKT | 5 KROKÓW w walce z chłoniakiem | STREFA WIEDZY

Co powinno Cię zaniepokoić?

OBJAWY CHŁONIAKA

Bolesne i tkliwe powiększone węzły chłonne to raczej objaw infekcji niż chłoniaka. Niepokój powinny wzbudzić NIEBOLESNE węzły chłonne oraz pozostałe objawy.

WIĘCEJ

Jeśli pojawiły się u Ciebie objawy.

DIAGNOSTYKA

Najważniejsze jest postawienie prawidłowego rozpoznania. Mniej istotne jest to, czy rozpoczniemy leczenie od razu, ważne czy będzie one prawidłowo dobrane!

WIĘCEJ

Usłyszałeś diagnozę? Poznaj chorobę!

PODTYPY CHŁONIAKA

Chłoniaki to zespół chorób o wielkiej różnorodności i dynamice. Przebiegają one w sposób agresywny lub nie wymagający leczenia latami.

WIĘCEJ

Jak walczy się z chłoniakiem?

METODY LECZENIA

Leczenie chłoniaków jest coraz skuteczniejsze, ostatnie lata przyniosły przełom w postaci rozwoju leków celowanych, które zmieniły standard leczenia.

WIĘCEJ

Kiedy metoda leczenia nie jest refundowana...

BADANIA KLINICZNE

Większość najnowszych metoda jest w Polsce nierefundowana lub limitowana. Dla pacjenta drogą do ich stosowania w leczeniu są badania kliniczne.

WIĘCEJ

CHŁONIAK TO DIAGNOZA, NIE WYROK

CENTRUM INFORMACJI | JAK KORZYSTAĆ Z TEJ STRONY? | DLACZEGO WERSJA BETA

Witaj w serwisie Pokonaj Chłoniaka!

Najważniejszą informacją dla pacjentów

ze zdiagnozowanym chłoniakiem oraz ich rodzin jest możliwość leczenia tego nowotworu na każdym etapie choroby!

CHŁONIAKI to nowotwory, które mogą być leczone coraz skuteczniej i mniej obciążająco dla pacjenta.

POKONAJ CHŁONIAKA
ZESPÓŁ LECZENIA CHŁONIAKÓW
CHŁONIAKI
BADANIA KLINICZNE
ZESPÓŁ
KONTAKT
5 KROKÓW w walce z chłoniakiem
STREFA WIEDZY
POZNAJ NASZ ZESPÓŁ
Pratia
POKONAJ CHŁONIAKA
ZESPÓŁ LECZENIA CHŁONIAKÓW
W wyniku 25 letniej współpracy doświadczenia w pracy badawczej w ośrodkach krakowskich prof. dr hab. n. med. Wojciech Jurczak zaprosił do współpracy lekarzy z sąsiednich województw, którzy pracować będą wg wspólnych procedur we współpracy z ośrodkiem badań klinicznych w grupie Pratia MCM Kraków, umożliwiając wymianę doświadczeń, wiedzy i konsultacji, a także zwiększanie dostępności do pełnego europejskiego standardu leczenia pacjentów z chłoniakami.
www.chloniak.org