ANCO Hematologic Malignancies Update

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Case 1

- 53yo F with Hx stage IIC melanoma s/p resection 2 years ago p/w new L axillary and L supraclavicular lymphadenopathy
- PMHx: back injury from work, obesity, OA, HTN, HLD
- PSurgHx: melanoma WLE, hysterectomy, L TKA
- FamHx: unremarkable
- No fevers/chills, night sweats or weight loss. Feels like R axillary nodes starting to grow

Case 1 continued

- **ROS**: + paresthesias: in hands after whiplash in December, + in feet since back injury; Frequent cystitis/UTI but not recently; no recent hematuria. No change in bowel habits
- Exam: +3cm L supraclav nodal mass, L posterior cervical chain adenopathy, + enlarged L axillary LN, + 2cm R axillary node. No hepatosplenomegaly.
- Labs: WBC 8, nl diff. hgb 11.8, plts 331. CMP WNL, LDH 118

Case 1 continued

- PET/CT: Extensive hypermetabolic nodal masses in left axilla (largest mass 4.5cm, SUV max 17.7), supraclavicular (SUV max 15.7), bilateral pelvic sidewall, inguinal and external iliac nodes (max SUV in right inguinal 2cm node is 15) ; small hypermetabolic nodule in the left breast (SUV max 4.4)
- FNA: non-melanocytic cells
- Surgical excisional Bx: grade 3A CD20+, CD10+, CD5- follicular lymphoma

Case 1 continued

- Assessment: 53yo F with stage IIIB Follicular Lymphoma, FLIPI score 3 (for # nodal sites, hgb, and stage): high risk

Case 1 continued

- First-line therapy?
  - R-CHOP
  - R-CVP
  - R-Bendamustine
  - Obinutuzumab-CHOP
  - R-lenalidomide
  - Rituximab biosimilar-CHOP

Case 1 continued

- Pt treated with BR x6 cycles with remission achieved per PET
- Next step?
  - Observation serial PET
  - Observation without imaging
  - Maintenance rituximab
  - Maintenance ibrutinib

Case 2

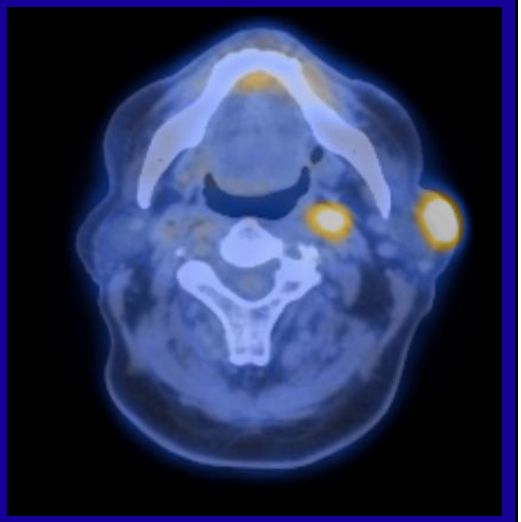
- 75yo M with Hx HTN, glaucoma p/w 6 weeks progressive generalized weakness and 3 wks left neck swelling
- PMHx: also colonic polyps, BPH
- Social Hx: former smoker, 20 pk-yr Hx, quit in 1959, rare EtOH
- FamHx: father lung cancer, brother stomach cancer

Case 2 continued

- ROS: + mild fatigue, No F/C, night sweats or weight loss. Negative for cough or hemoptysis.
- ECOG 2
- Exam: + Two 2-3cm L anterior cervical nodes. Full L supraclav fossa without palpable nodes, no other adenopathy or hepatosplenomegaly. + LLL crackles
- Labs: WBC 4.2 w nl diff, hgb 14.4, plts 167. CMP WNL, LDH 321

Case 2 continued

- PET/CT: Hyperavid disease of left posterior nasopharynx x2 sites, with metastatic adenopathy to the upper left jugular chain and left cheek.



Case 2 continued

- Surgical excisional Bx:

Diffuse large B cell lymphoma, ABC subtype

+ MYC overexpression on IHC

Case 2 continued

- Assessment: 75yo M with stage IIAE DLBCL, ABC subtype, + MYC overexpressor

IPI score 3 (age, elevated LDH, >1 extranodal site): poor risk

Case 2 continued

- First-line therapy?
  - R-CHOP
  - R-Bendamustine
  - R-CVP
  - Obinutuzumab-CHOP
  - DA R-EPOCH
  - R^2-CHOP on clinical trial

Case 2 continued

- Pt deferred clinical trial, received R-EPOCH with refractory disease s/p 4 cycles
- 2^{nd}-line Tx?
  - R-ICE
  - R-GemOx
  - R-DHAP

Case 2 continued

- Pt receives RICE followed by Auto-SCT
- Relapses 6 months after transplant
- Pt typed for Allo-SCT
- 3rd line Tx during BMT workup?
  - R-ESHAP
  - Idelalisib
  - Lenalidomide + rituximab
  - CAR –T

Case 3

- 77yo male hx of MGUS diagnosed in 2008, presents for follow-up with foamy urine
- PMH: BPH, prostate cancer, osteoarthritis
- Psurg: prostate ca s/p RALP, neurogenic bladder needing self-cath
- FHx: No cancer
- SHx: Never smoker, no EtOH, no illicit drugs
- ROS: No bone pain, no weight loss, no decreased appetite, no fevers/chills

Case 3 continued

- Exam: 2+ bilateral edema to the knees
- Labs: CBC with normal diff, eGFR 78 (unchanged), creatinine 0.9, albumin 2.3, calcium normal, LDH and LFTs normal.
- SPEP IgA lambda 0.7gm/dL, IgG lambda 0.2 gm/dL
- lambda-SFLC 78.1, kappa-SFLC 14.1, ratio 0.18
- 24-Urine for total protein 6+ g/24hrs, U-IFE was positive for IgA lambda and lambda LC.
- Kidney Bx showed ???

Case 3 continued

- Bone marrow bx: 10% lambda-restricted plasma cells
- Assessment: 77 yo M with systemic LC amyloidosis, lambda-type due to underlying myeloma, with predominant renal involvement, renal stage 2, CKD 2. Cardiac evaluation revealed stage 1 cardiac involvement.

Case 3 continued

- First line treatment:
  - Len/Dex
  - Len/Bortez/Dex
  - Mel/Bortez/Dex
  - Mel/Dex
  - Mel-ASCT
  - CyBorD and then Mel-ASCT
  - CyBorD
  - Bortez/dex

Case 3 continued

- After 4 cycles, patient has a reduction in M-protein to 0.1 gm/dL (IgG lambda). UPEP with IFE normal. l-SFLC, k-SFLC and ratio normal. Tolerated treatment well except for worsened leg swelling. 24-hr urine protein now 7.7 gm, albumin 1.7
- What's next?
  - Stop chemotherapy, observe q1-2 mo with SFLC and SPEP
  - Continue CyBorD
  - Maintenance with bortez only every other week

Case 4

- 70yo F referred for leukocytosis x 2 years
- No insurance until now
- + Progressive LUQ pain, no F/C, night sweats or weight loss, no adenopathy
- + fatigue, IBS/constipation, generalized joint pain, depression/stress re: finances

Case 4 continued

- PMHx: IBS, environmental allergies/sinusitis
- PSurgHx: appendectomy, tubal ligation
- Social Hx: 2 glasses wine/night, nonsmoker
- FamHx: mother with skin cancer, otherwise negative
- Exam: prominent but not enlarged b/l cervical LNs, + tender liver border and palpable spleen tip

Case 4 continued

- Labs: WBC 45 with 75% lymphs, hgb 10 .7, plts 112, CMP WNL, LDH 178
- CT neck/C/A/P: extensive bilateral adenopathy in neck, axillae, inguinal, iliac chain, and hilar regions. + splenomegaly
- Peripheral blood flow cytometry: CD20+, CD5+, CD10-, CD38+

CLL FISH: + 11q deletion

Case 4 continued

- Assessment: 70yo F with symptomatic Rai III CLL with CD38+ and 11q deletion

Case 4 continued

- First-line treatment?
  - FCR
  - Ibrutinib
  - BR
  - Chlorambucil
  - Ofatumumab + chlorambucil

Case 4 continued

- Pt treated with FCR-lite x4 cycles, but dc'd due to persistent thrombocytopenia and leukopenia
- Recently has developed atrial fibrillation and is now on warfarin.
- In the next several months, develops recurrent adenopathy and weight loss. Repeat flow cytometry of peripheral blood shows recurrent CLL.
- Next Tx?
  - R-bendamustine
  - Rituximab
  - ibrutinib
  - idelalisib
  - ofatumumab
  - venetoclax

Case 5

- 68yo M with Hx atrophic kidney s/p R ureteronephrectomy p/w lytic spinal lesions
- Has chronic back pain prev attributed to arthritis, is admitted with PNA and worsened R shoulder/upper back pain
- Imaging during hospitalization finds multiple compression fractures of thoracic and lumbar spine

Case 5 continued

- ECOG 1
- Exam: comfortable, normal gait, minimal TTP to thoracic spine
- Labs: hgb 9, albumin 2.8, total protein 9,
  Cr 0.98
  SFLC: kappa 122, κ:λ ratio 12, B2M 4
  SPEP: IgG Kappa 1.3g/dL
- BMBx: slightly hypercellular marrow with 65% involvement with kappa restricted plasma cells, +1q, +5, +9, +15 on FISH

Case 5 continued

- Assessment: 68yo M with symptomatic IgG kappa multiple myeloma, rISS stage II

Case 5 continued

- First-line treatment in this fit patient?
  - Rd
  - CyBorD
  - RVD
  - Melphalan-Pred
  - MPR

Case 5 continued

- Pt has biochemical response s/p 3 cycles RVD, then no further change in SPEP and SFLC s/p C4
- Repeat BMBx shows 13% plasma cells
- Next step?
  - Move to Auto-SCT then maintenance lenalidomide
  - Move to Auto-SCT with post transplant consolidation with additional RVD and maintenance lenalidomide
  - Additional RVD before transplant
  - Switch to CyborD and then transplant
  - Switch to KRD and then transplant

Case 5 continued

- Pt undergoes autologous-SCT and post-transplant lenalidomide, but 1-yr later SFLC ratio doubles over a 4 month period. Patient has noticed increasing fatigue, hgb declining
- Next therapy recommended?
  - Continue to observe
  - Ixazomib, Len, Dex
  - Elotuzumab, Len, Dex
  - Carfilzomib, Len, Dex
  - Daratumumab
  - Daratumumab and lenalidomide
  - Pomalidomide-clarithromycin