Identificación precoz y seguimiento de pacientes tratados con CAR-T

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Conflitos de Interés

Speaker’s Bureau: Janssen, Roche, Takeda, Abbvie, BMS, Lilly, BeiGene, Astra Zeneca, Abbvie

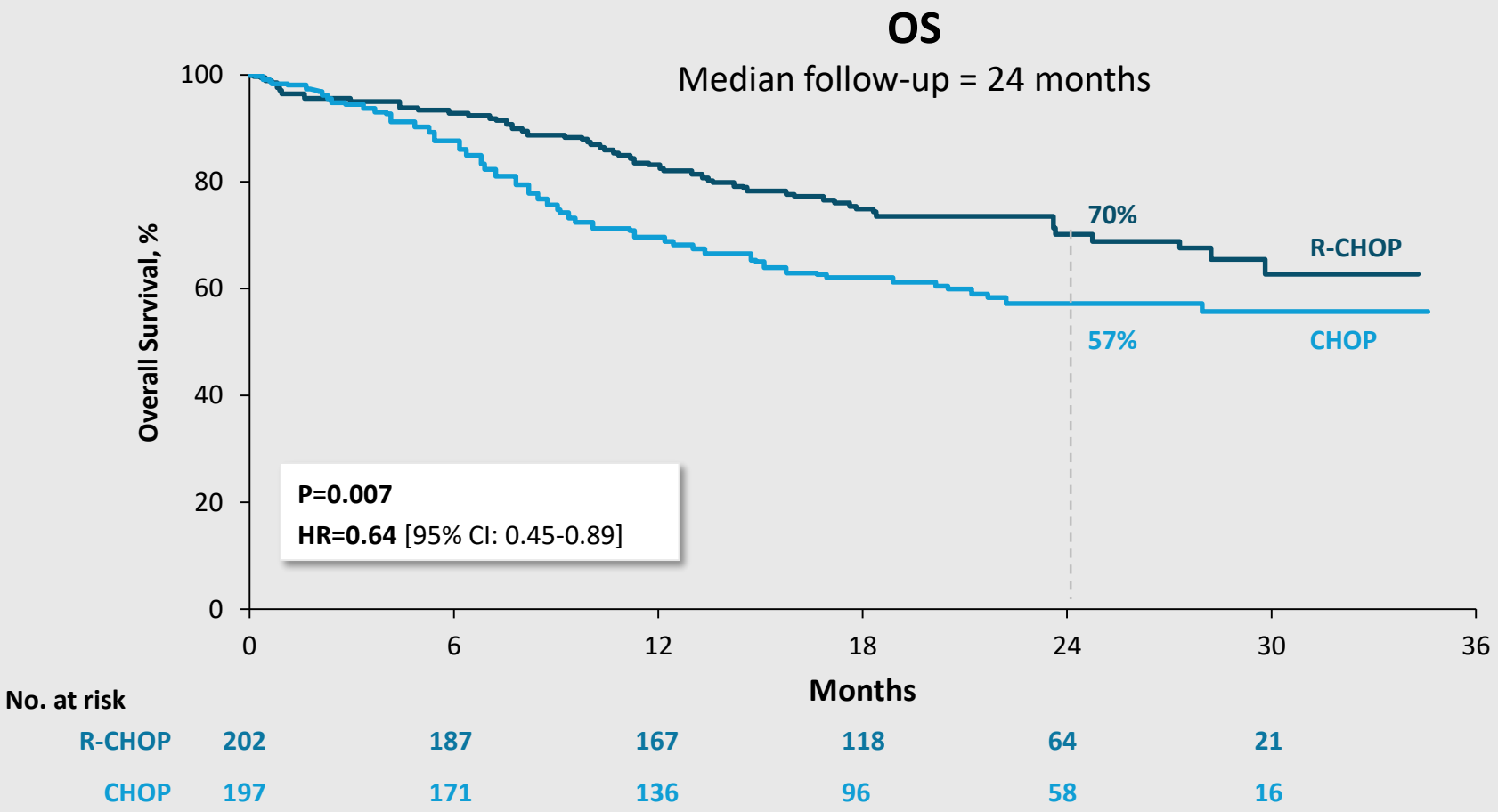
Educational Support: Janssen, Takeda, Roche, Abbvie

Advisory Board: Janssen, Roche, Abbvie, Astra Zeneca, Takeda

Research: Janssen, Millenium, Merck, BMS, BeiGene, MSD, Abbvie, Lilly, AstraZeneca

Esta presentación está destinada exclusivamente a profesionales de la salud. No es de naturaleza promocional y solo tiene fines educativos y de intercambio científico. El contenido puede incluir información sobre productos, indicaciones o usos que no están registrados o aprobados en el país. Cualquier información de este tipo se comparte únicamente para fomentar el diálogo profesional y no constituye un respaldo o recomendación.

R-CHOP was established as the SoC in 2002 in previously untreated patients age 60-80 years with DLBCL

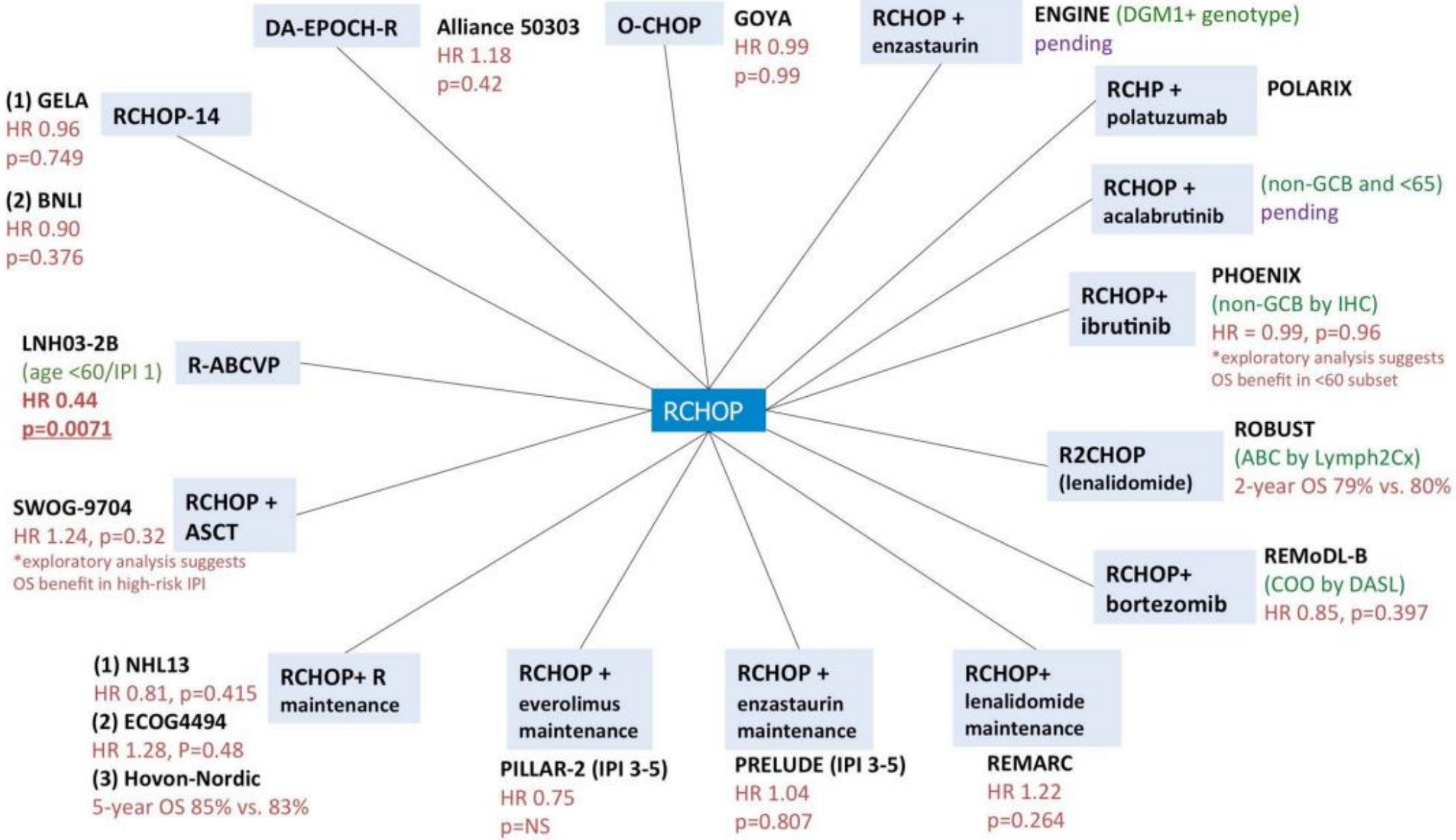


Response	R-CHOP	CHOP
ORR	**82%**	**69%**
CR	52%	37%
uCR	23%	26%
PR	7%	6%

Safety	R-CHOP	CHOP
Grade 3/4 AEs		
Infection	12%	20%
Lung toxicity	8%	11%
Neurologic toxicity	5%	9%
No difference in SAEs		

AE, Adverse Event; CHOP, Cyclophosphamide, Doxorubicin Hydrochloride, Vincristine Sulfate, Prednisone; CI, Confidence Interval; CR, Complete Response; DLBCL; Diffuse Large B-cell Lymphoma; HR, Hazard Ratio; Mo, Months; No, Number; ORR, Overall Response Rate; OS, Overall Survival; R-CHOP, Rituximab-CHOP; SAE, Serious AE; SoC, Standard Of Care; uCR, Unconfirmed CR.

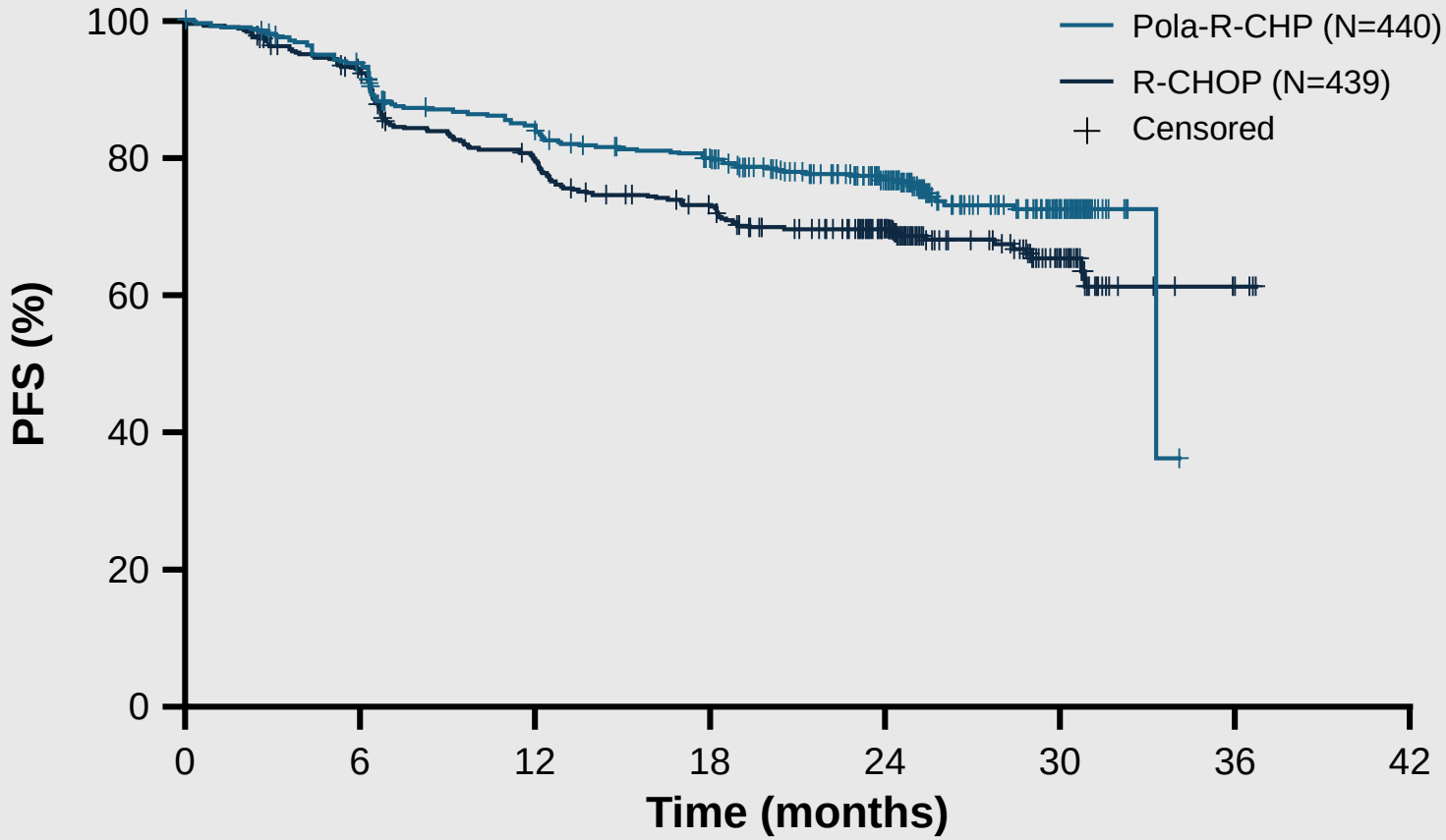
Adapted from Coiffier B, et al. N Engl J Med. 2002;346(4):235-42.


DA-EPOCH-R
Alliance 50303
HR 1.18
p=0.42
O-CHOP
GOYA
HR 0.99
p=0.99
RCHOP + enzastaurin
ENGINE (DGM1+ genotype)
pending
(1) GELA
HR 0.96
p=0.749
RCHOP-14
RCHP + polatuzumab
POLARIX
(2) BNLI
HR 0.90
p=0.376
RCHOP + acalabrutinib
(non-GCB and <65)
pending
RCHOP+ ibrutinib
PHOENIX
(non-GCB by IHC)
HR = 0.99, p=0.96
*exploratory analysis suggests OS benefit in <60 subset
LNH03-2B
(age <60/IPI 1)
HR 0.44
p=0.0071
R-ABCVP
RCHOP
R2CHOP (lenalidomide)
ROBUST
(ABC by Lymph2Cx)
2-year OS 79% vs. 80%
SWOG-9704
HR 1.24, p=0.32
*exploratory analysis suggests OS benefit in high-risk IPI
RCHOP + ASCT
RCHOP+ bortezomib
REMoDL-B
(COO by DASL)
HR 0.85, p=0.397
(1) NHL13
HR 0.81, p=0.415
(2) ECOG4494
HR 1.28, P=0.48
(3) Hovon-Nordic
5-year OS 85% vs. 83%
RCHOP+ R maintenance
RCHOP + everolimus maintenance
PILLAR-2 (IPI 3-5)
HR 0.75
p=NS
RCHOP + enzastaurin maintenance
PRELUDE (IPI 3-5)
HR 1.04
p=0.807
RCHOP+ lenalidomide maintenance
REMARC
HR 1.22
p=0.264

POLARIX Primary Endpoint: Progression-Free Survival

INITIAL ANALYSIS

Pola-R-CHP Significantly Improved PFS Versus R-CHOP



No. of patients at risk								
Pola-R-CHP	440	404	353	327	246	78	NE	NE
R-CHOP	439	389	330	296	220	78	3	NE

HR 0.73 **95% CI, 0.57, 0.95**

- Pola-R-CHP demonstrated a **27% reduction in the relative risk of disease progression, relapse, or death** versus R-CHOP
- **24-month PFS:**
  76.7% with Pola-R-CHP versus
  70.2% with R-CHOP (**Δ=6.5%**)

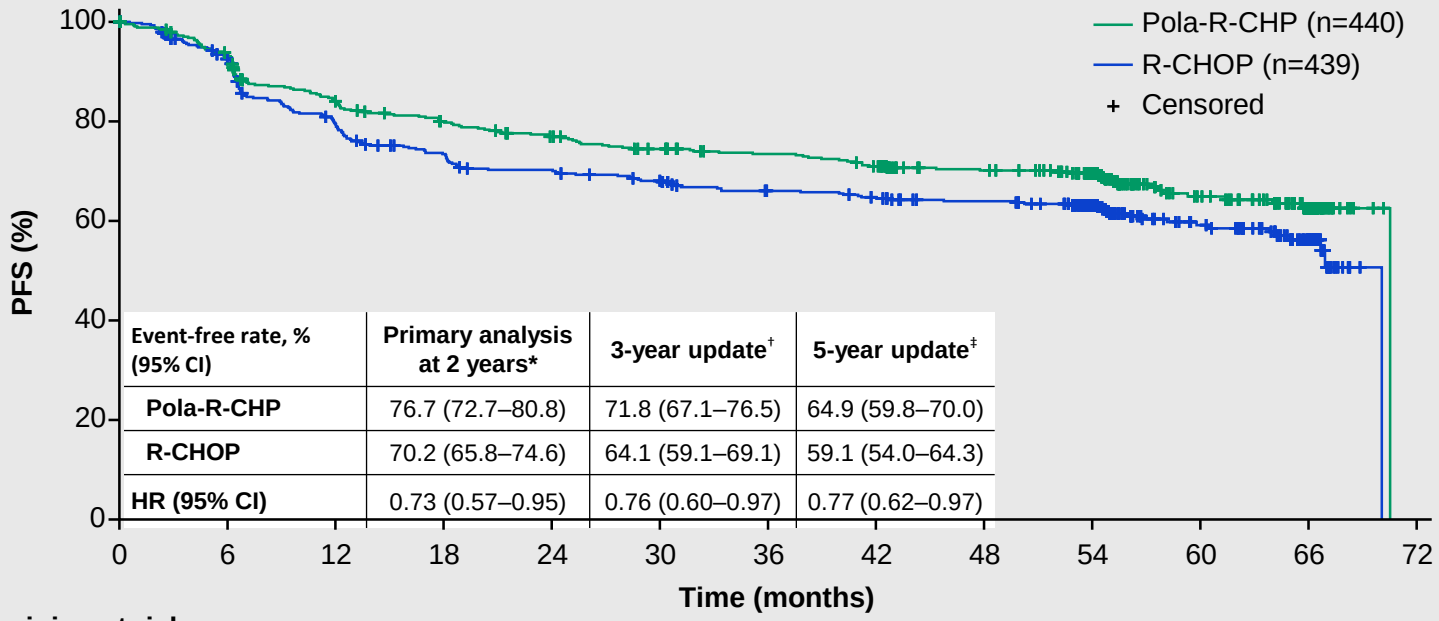
ITT population. Data cut-off: June 28, 2021; median 28.2 months' follow-up.
NE, not evaluable.

Tilly H et al. *N Engl J Med*. 2022;386(4):351-363.

Initial PFS benefit of Pola-R-CHP over R-CHOP is maintained at 5 years

UPDATED ANALYSIS

PFS in the global ITT population



Event-free rate, % (95% CI)	Primary analysis at 2 years*	3-year update†	5-year update‡
Pola-R-CHP	76.7 (72.7–80.8)	71.8 (67.1–76.5)	64.9 (59.8–70.0)
R-CHOP	70.2 (65.8–74.6)	64.1 (59.1–69.1)	59.1 (54.0–64.3)
HR (95% CI)	0.73 (0.57–0.95)	0.76 (0.60–0.97)	0.77 (0.62–0.97)

Patients remaining at risk

Pola-R-CHP	440	407	357	335	318	303	292	280	258	213	100	56	NE
R-CHOP	439	391	332	302	287	274	258	251	240	192	95	54	NE

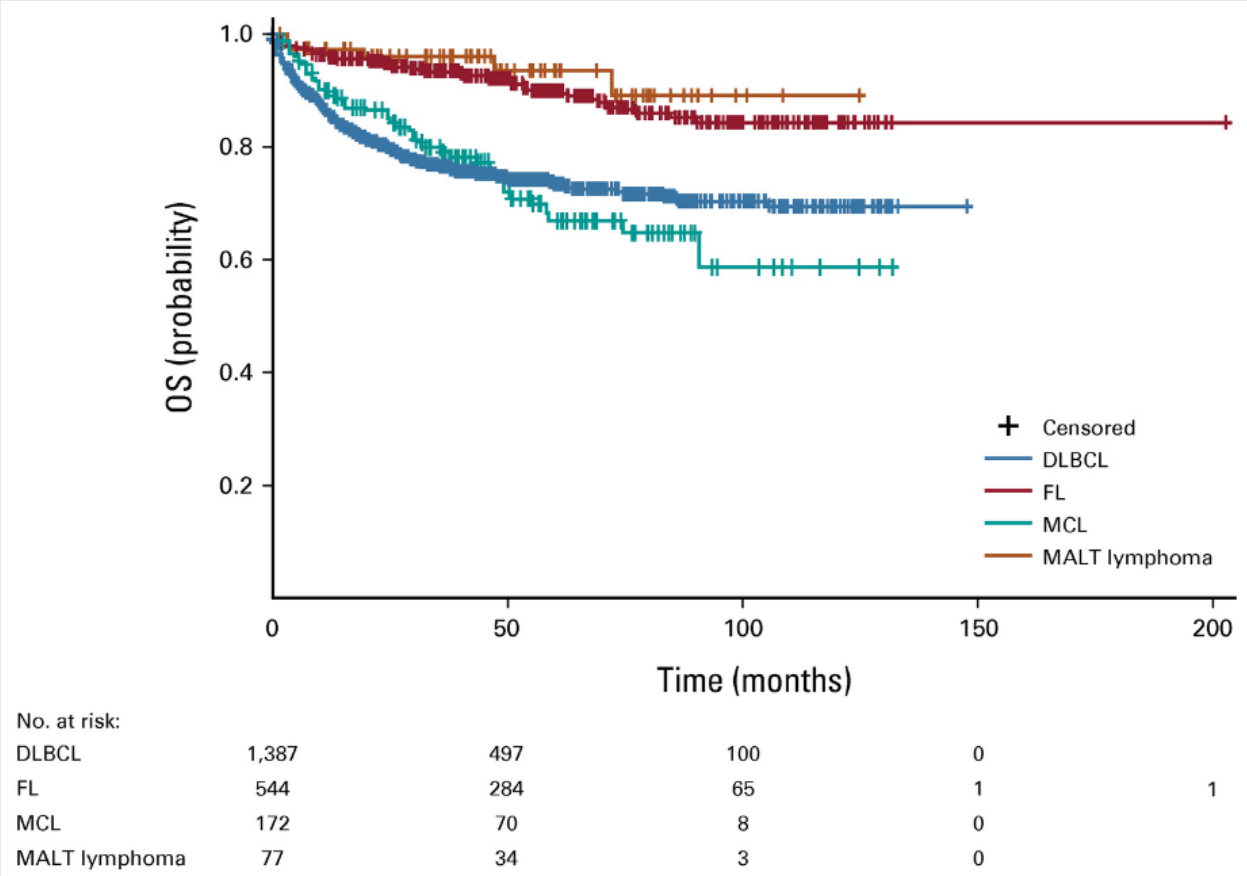
At the 5-year follow up, Pola-R-CHP had a **sustained and significant PFS benefit**, confirming results from the primary analysis of PFS at 2 years of follow up (HR 0.73).[1]

*Data cut-off: June 28, 2021; †Data cut-off: June 15, 2022; ‡Data cut-off: July 5, 2024.
CI, confidence interval; HR, hazard ratio; NE, not evaluable.

Morschhauser F. et al. JCO 2025.

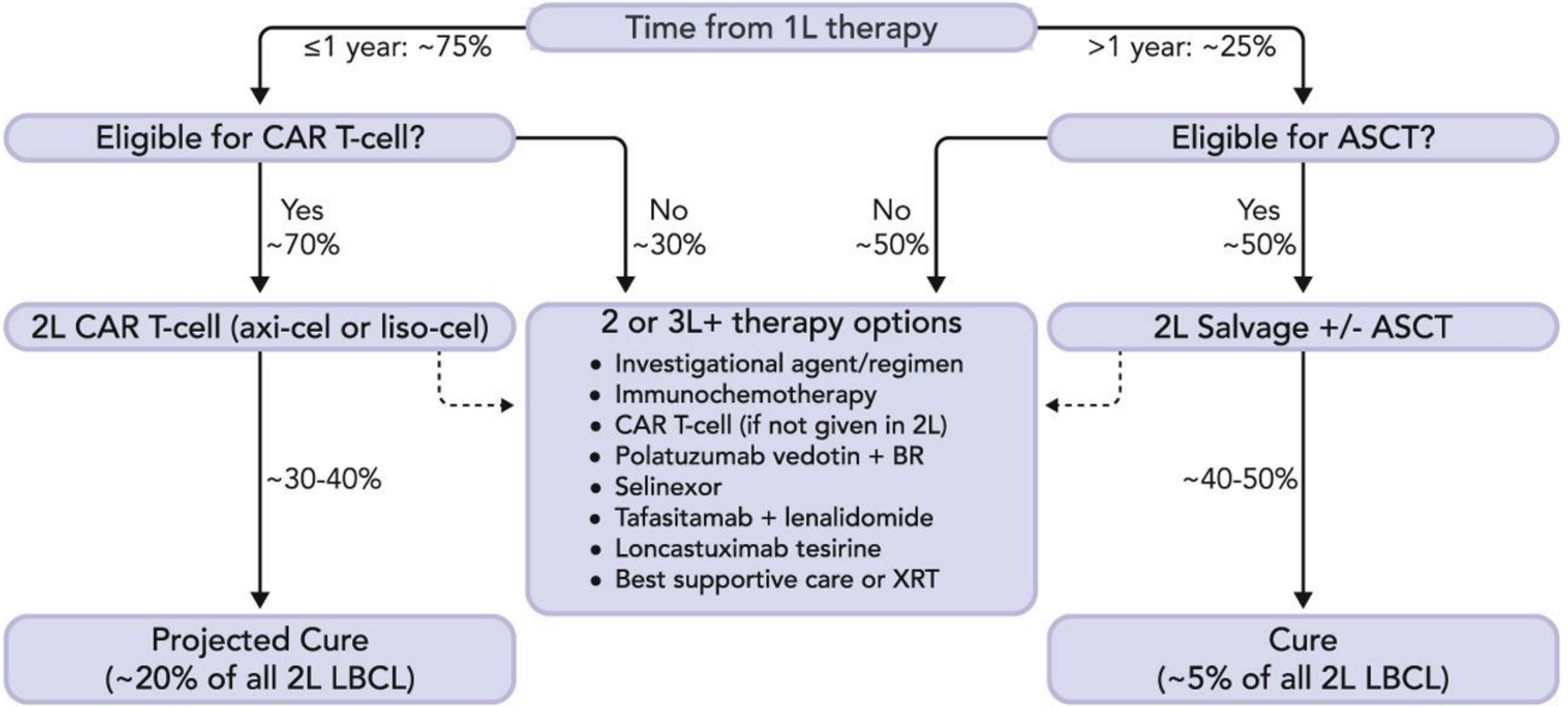
Pero no todos se curan…

Miguel Pavlovsky, JGO 2022

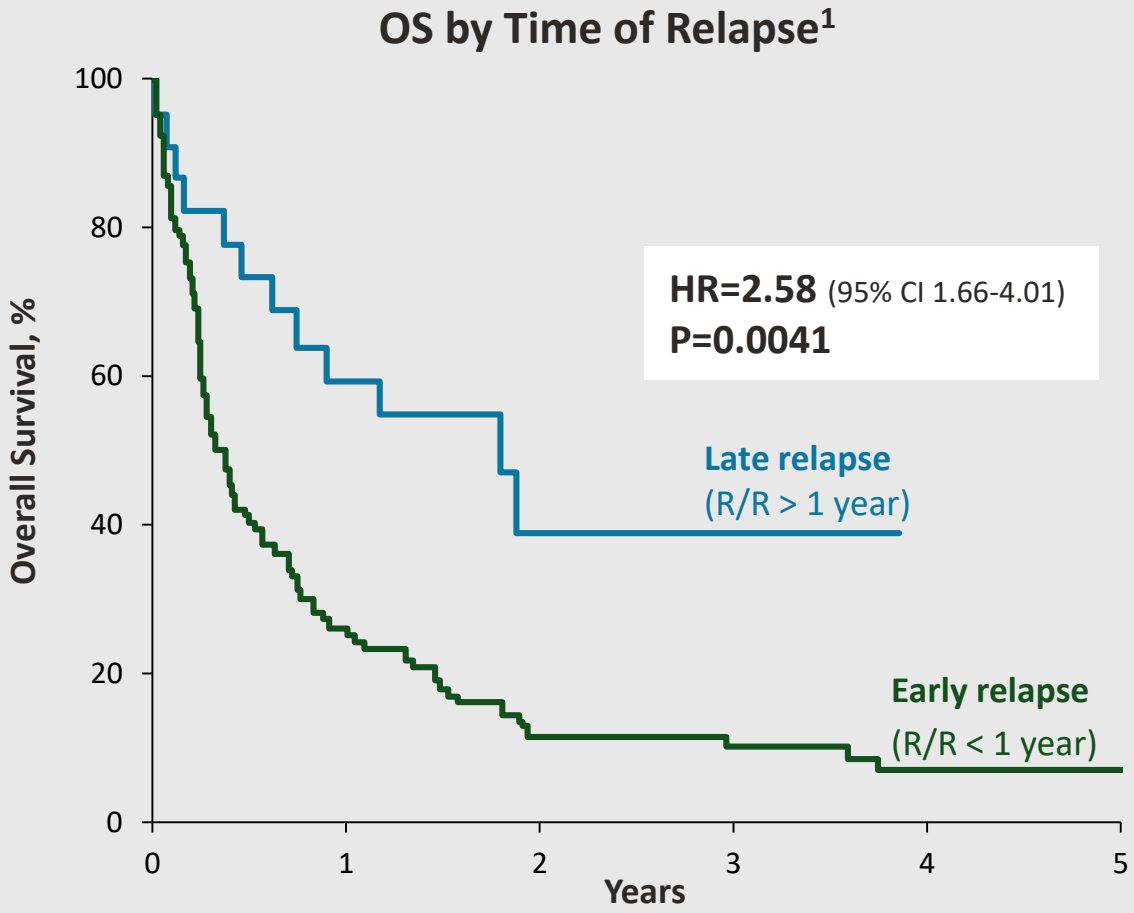


5-Year Survival Rate (%)	DLBCL	FL	MCL	MALT	Burkitt
Overall	69	87.6	57.1	90.8	55.7
Argentina	72.6	86.6	66.5	100	69.3
Brazil	50.8	71.3	35.4	92.3	57.1
Chile	81.7	87.3	38.1	75	NA
Colombia	62.1	96.1	75.1	91.7	47.6
Mexico	71.7	95.3	75.7	92.9	0
Panama and Guatemala	93.8	93.3	85.7	NA	NA

Algorithm for Second-line Therapy of LBCL



Time to relapse after first-line treatment is an important prognostic factor



~25% **of patients experience late relapse,** relapsing greater than 1 year from initial therapy, and should be considered for **ASCT if transplant-eligible**.[2,3]

~75% **of patients experience early relapse,** relapsing within 1 year of completion of initial therapy, and should be considered for **CAR T-cell therapy if eligible**.[3]

Patients who relapse more than 1 year after first-line treatment have better outcomes than those who relapse within 1 year, however, 3-year overall survival is less than 50% in either group.[1]

ASCT, Autologous Stem-Cell Therapy; CAR T, Chimeric Antigen Receptor T-Cell; CI, Confidence Interval; HR, Hazard Ratio; LBCL, Large B-Cell Lymphoma; OS, Overall Survival; R/R, Relapse/Refractory.

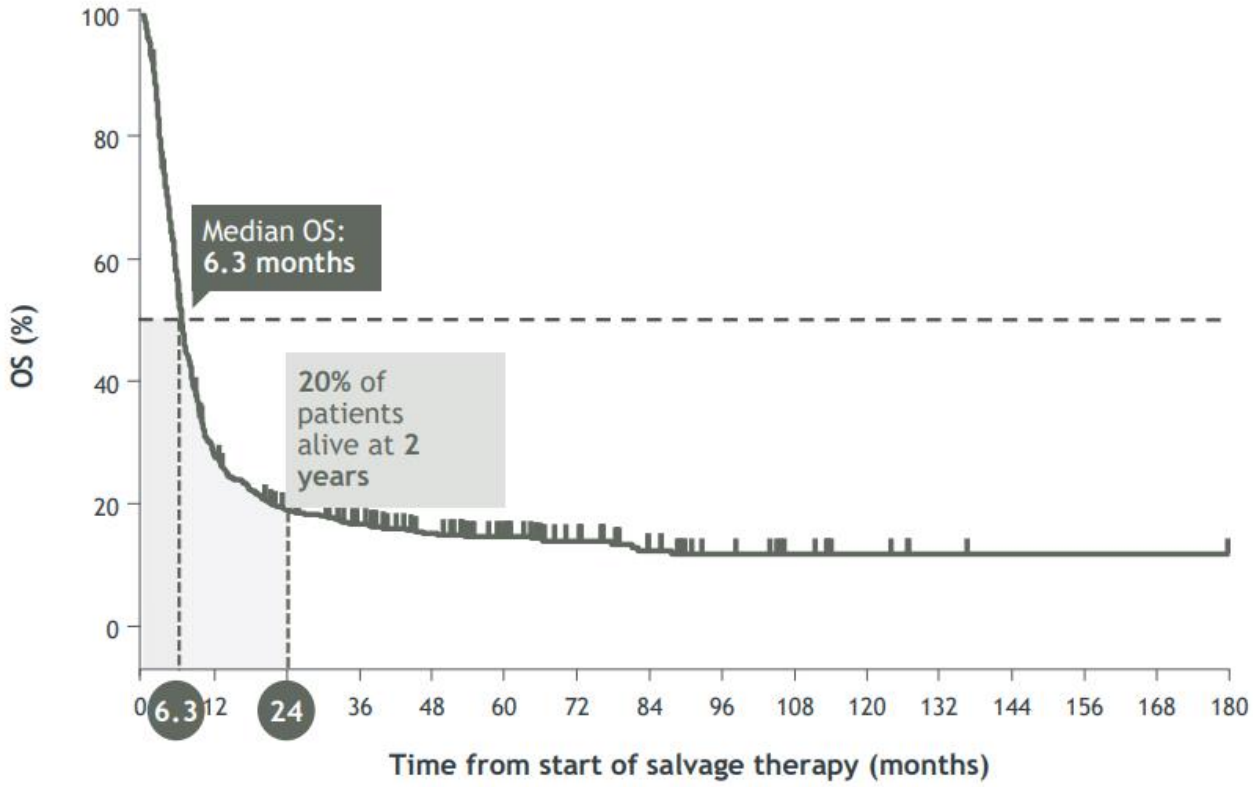
Adapted from 1. Puckrin R, et al. *Transplantation and Cellular Therapy*, *28*(4), 218-e1. 2. Nastoupil L, Bartlett N. J Clin Oncol. 2022;41:903-91. 3. Westin J, Sehn LH. Blood. 2022;139(18):2737-2746.

No response or early relapse in 1L DLBCL correlates with poorer survival outcomes

SCHOLAR-1

Retrospective analysis of outcomes in patients with R/R DLBCL (N=636)

Patients were primary refractory, refractory to ≥2 lines of therapy or relapsed ≤12 months post ASCT



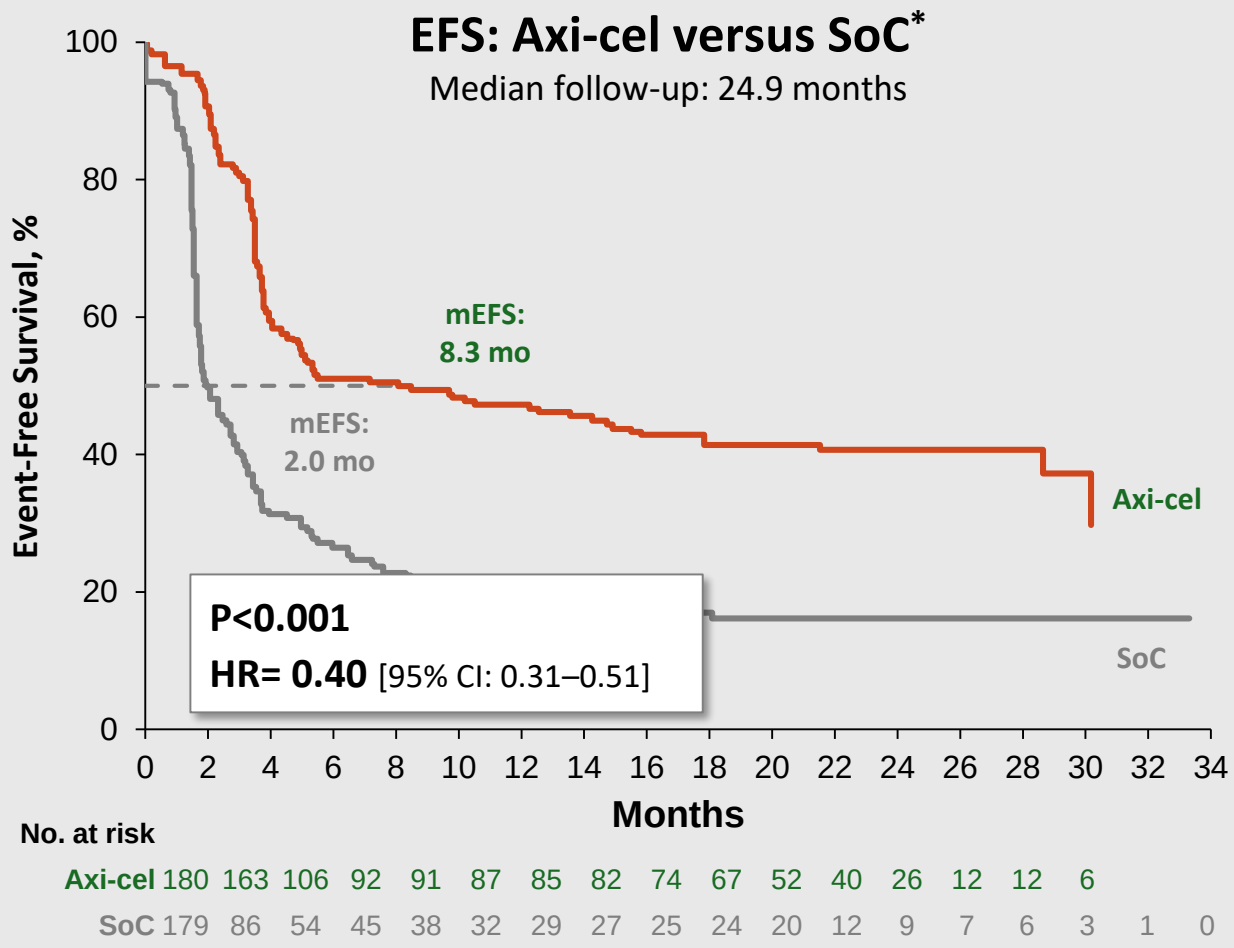
Prior to new therapies, **median OS** for patients with R/R DLBCL was **6.3 months**

OS: overall survival

Crump M, *et al*. *Blood* 2017; 130:1800-1808.

Axicabtagene ciloleucel

ZUMA-7: Axi-cel versus SoC in R/R DLBCL within 12 mo of R-CHOP



Characteristics	Axi-cel	SoC
GCB subgroup	61%	55%
HGBCL	17%	14%
Primary refractory	74%	73%

Safety	Axi-cel	SoC
Gr3+ AEs >25%		
Neutropenia	69%	41%
Anemia	30%	39%
Leukopenia	29%	22%
SAEs	50%	46%
CRS, any Gr (Gr3+)	92% (6%)	--
Neuro event, any Gr (Gr3+)	60% (21%)	20% (1%)

Bridging therapy: received by **36% of patients** in axi-cel cohort

- **dexamethasone** ≤40 mg for ≤4 days (no chemotherapy)

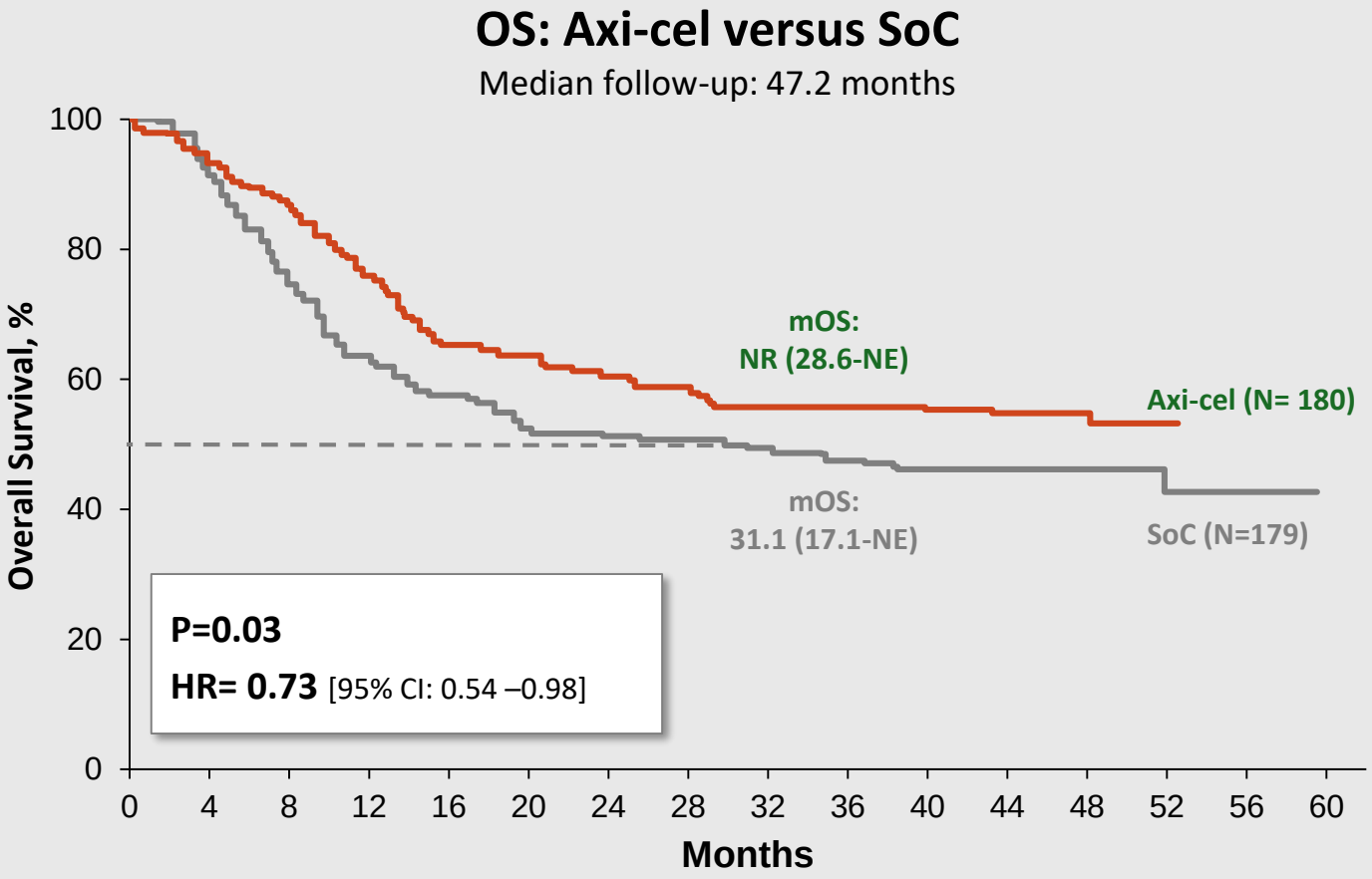
Crossover therapy: none, but **56% of patients** from the SoC cohort **received cellular therapies off-protocol**

Received intended CAR T: **94%** **Received ASCT (SoC)**: **36%**

AE, Adverse Event; ASCT, Autologous Stem Cell Transplant; Axi-cel, Axicabtagene Ciloleucel; CAR T, Chimeric Antigen Receptor T-cell; CI, Confidence Interval; CRS, Cytokine Release Syndrome; DLBCL, Diffuse Large B-cell Lymphoma; EFS, Event-Free Survival; GCB, Germinal Center B-cell-like; HR, Hazard Ratio; Gr, Grade; m, Median; SAE, Serious AE; SoC, Standard Of Care.
Adapted from Locke FL, et al. N Engl J Med. 2022;386(7):640-654.

*SoC was two or three cycles of investigator-selected, protocol-defined chemoimmunotherapy, followed by high-dose chemotherapy with autologous stem-cell transplantation in patients with a response to the chemoimmunotherapy.

Axicabtagene ciloleucel
ZUMA-7: 5 Year Follow-Up



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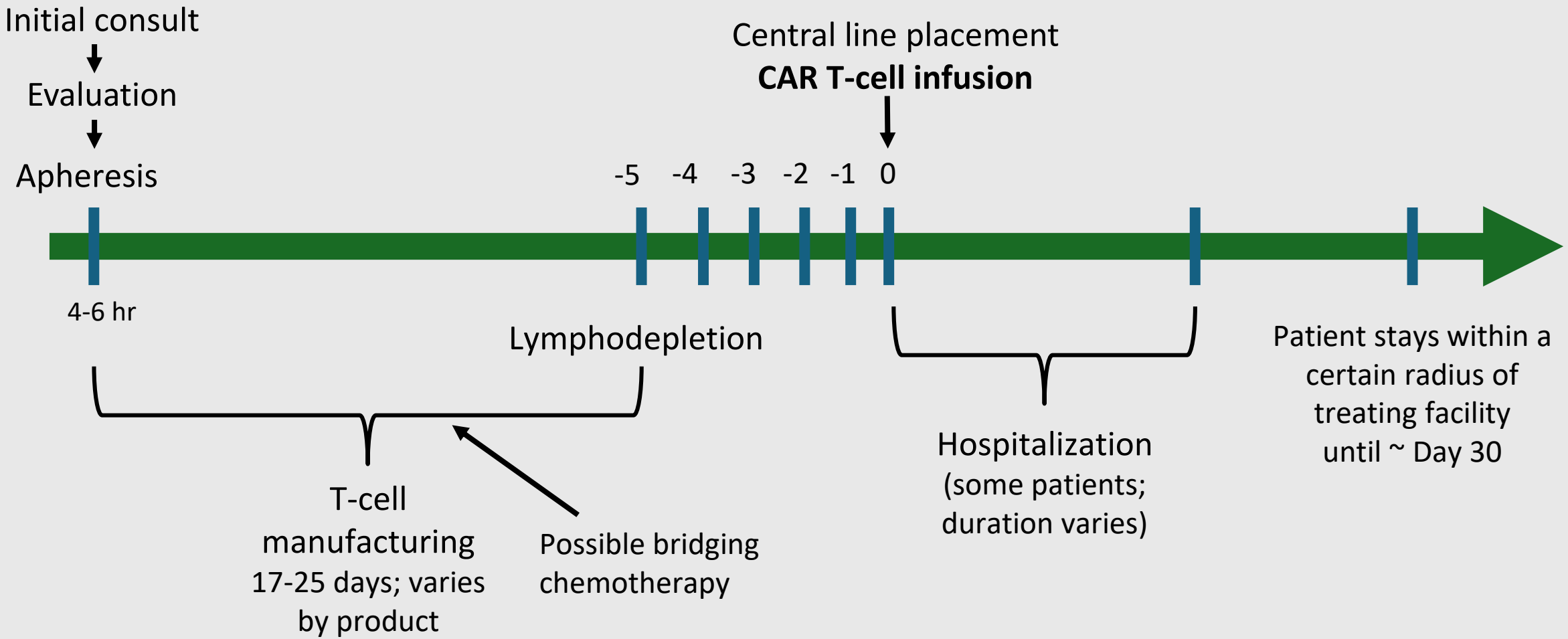
Axi-cel demonstrated significantly longer OS compared to standard of care at a median follow-up of 47.2 months.

AE, Adverse Event; Axi-cel, Axicabtagene Ciloleucel; CI, Confidence Interval; CRS, Cytokine Release Syndrome; DLBCL, Diffuse Large B-cell Lymphoma; EFS, Event-Free Survival; GCB, Germinal Center B-cell-like; HR, Hazard Ratio; Gr, Grade; m, Median; OS, Overall Survival; SAE, Serious AE; SoC, Standard Of Care.
Adapted from Westin et al. N Engl J Med 2023;389:148-157.

La terapia CAR-T requiera planeamiento



Tempo Mediano de Manufactura: 24 – 47 dias

Beaupierre. J Adv Pract Oncol. 2019;10(suppl 3):29. Perica. Biol Blood Marrow Transplant. 2018;24:1135.

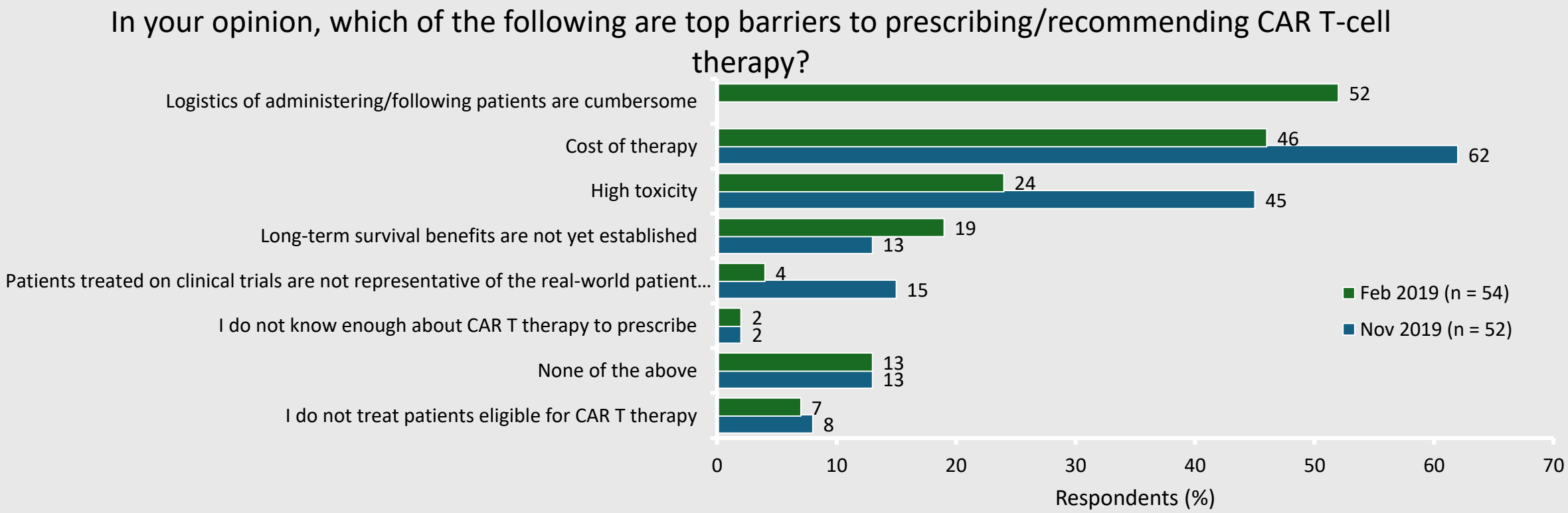
Por que no tardar a encaminar?

- La derivación temprana y eficiente es fundamental para el éxito de las terapias CAR-T
- Aspectos logísticos:
  - Disponibilidad del centro de CART
  - Autorización de las aseguradoras
  - Logística para pacientes de otras ciudades/países

- Aspectos clínicos:
  - Criterios para la terapia CAR-T
  - Rápido deterioro del paciente
  - Necesidad de terapia puente/holding
  - Biología de la enfermedad.

Perceptions of Community Hematologists/Oncologists on Barriers to CAR T-Cell Therapy for DLBCL

- 2019 survey of US community hematologists and oncologists



Gajra. Immunotherapy. 2020;12:725.

Slide credit: clinicaloptions.com

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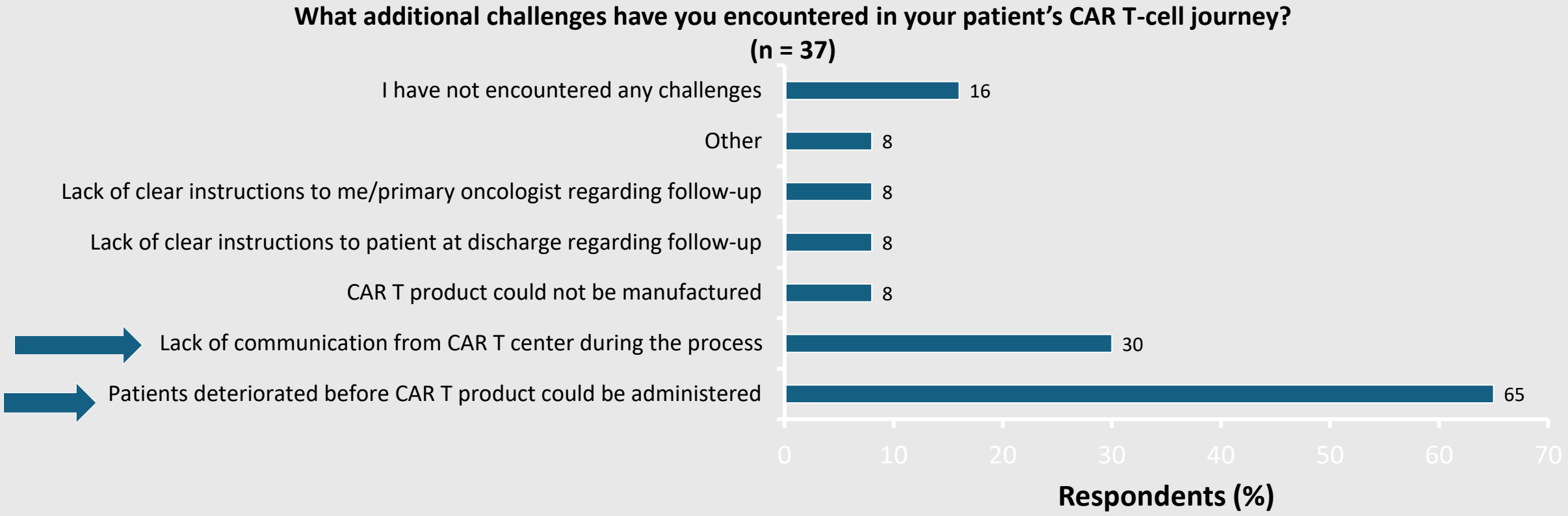

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Slide credit: clinicaloptions.com

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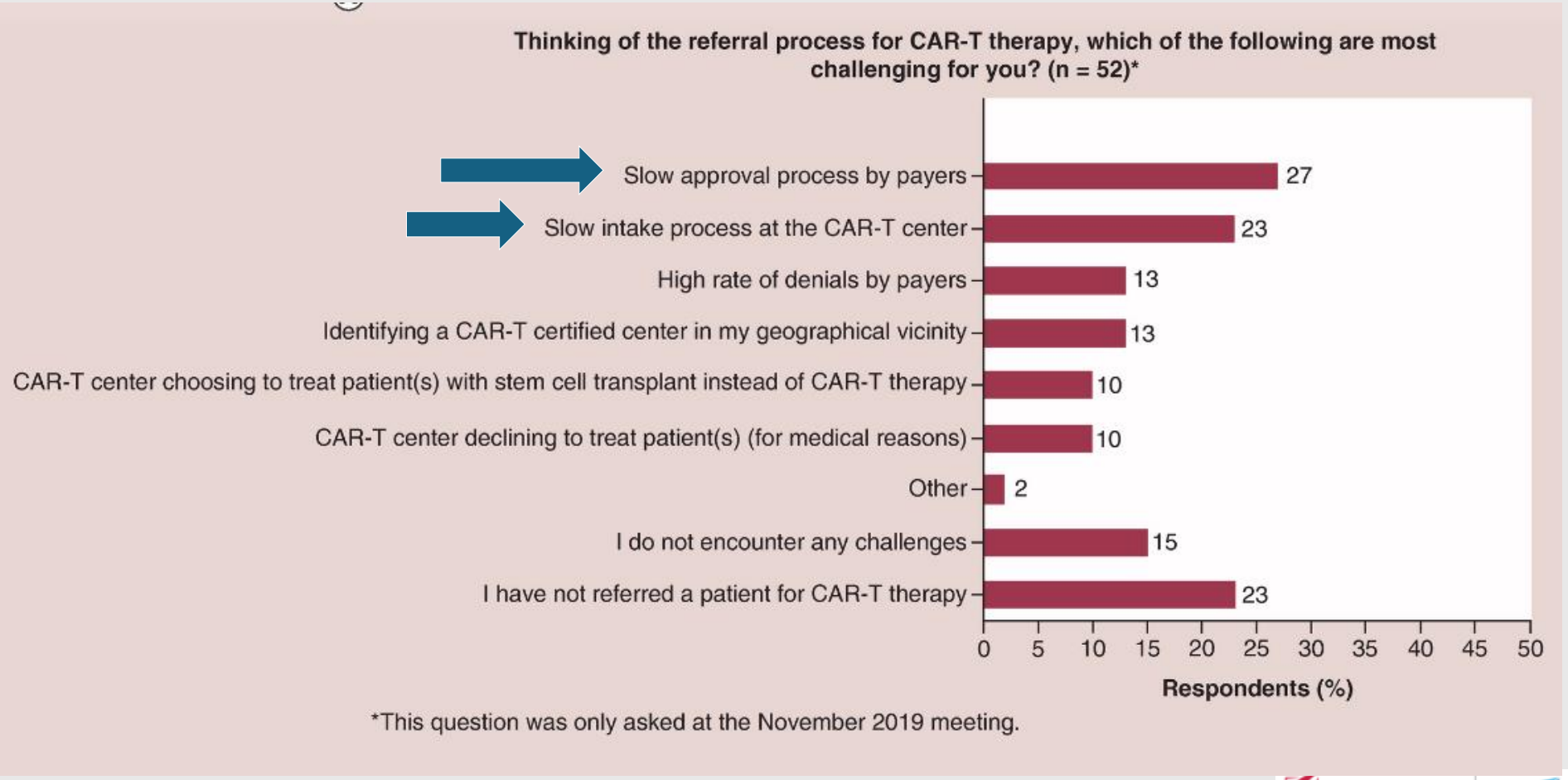


Gajra. Immunotherapy. 2020;12:725.

¿Cómo acelerar el acceso al CART?

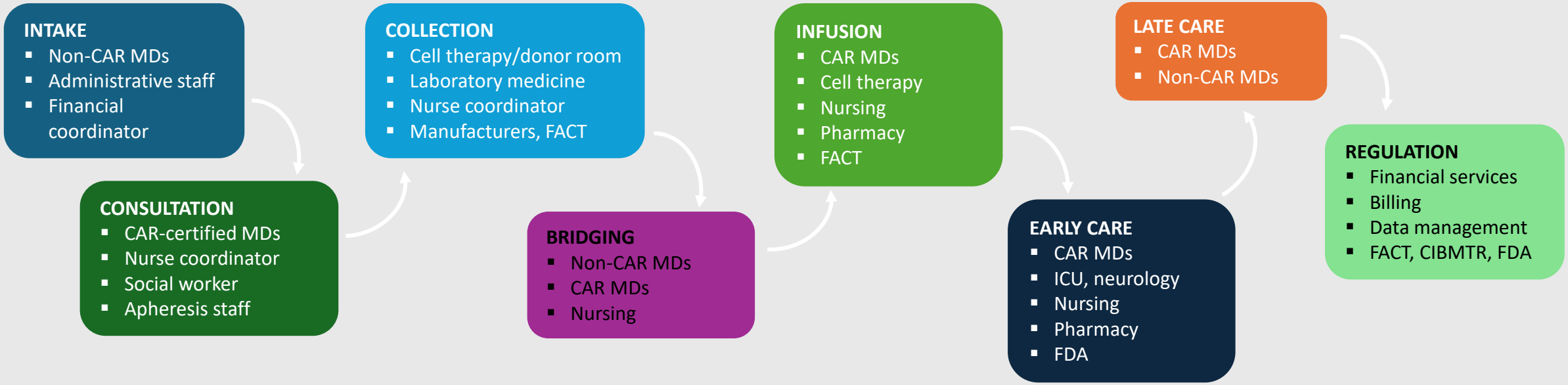
- Referral Centers:
  - Evaluación de recaída (confirmación por biopsia)
  - Contacto temprano con el centro de terapia con células T (CarT)
  - Planificación del momento de la aféresis con el equipo del centro de terapia con células T (CarT)
  - Planificación de la terapia de rescate/puente en conjunto con el centro

¿Cómo acelerar el acceso al CART?

- Centro CarT
  - Servicio de Comunicación Institucional > Médico tratante
  - Comités de tumores (Tumorboads) para la priorización
  - Enfermera de enlace
  - Modelos estructurados para aseguradoras
  - Equipo de negociación especializado

Diferentes players en el proceso dos CarT

Essential Steps and Required Personnel



Perica. Biol Blood Marrow Transplant. 2018;24:1135. Axicabtagene ciloleucel PI. Brexucabtagene autoleucel PI. Tisagenlecleucel PI. Lisocabtagene maraleucel PI.

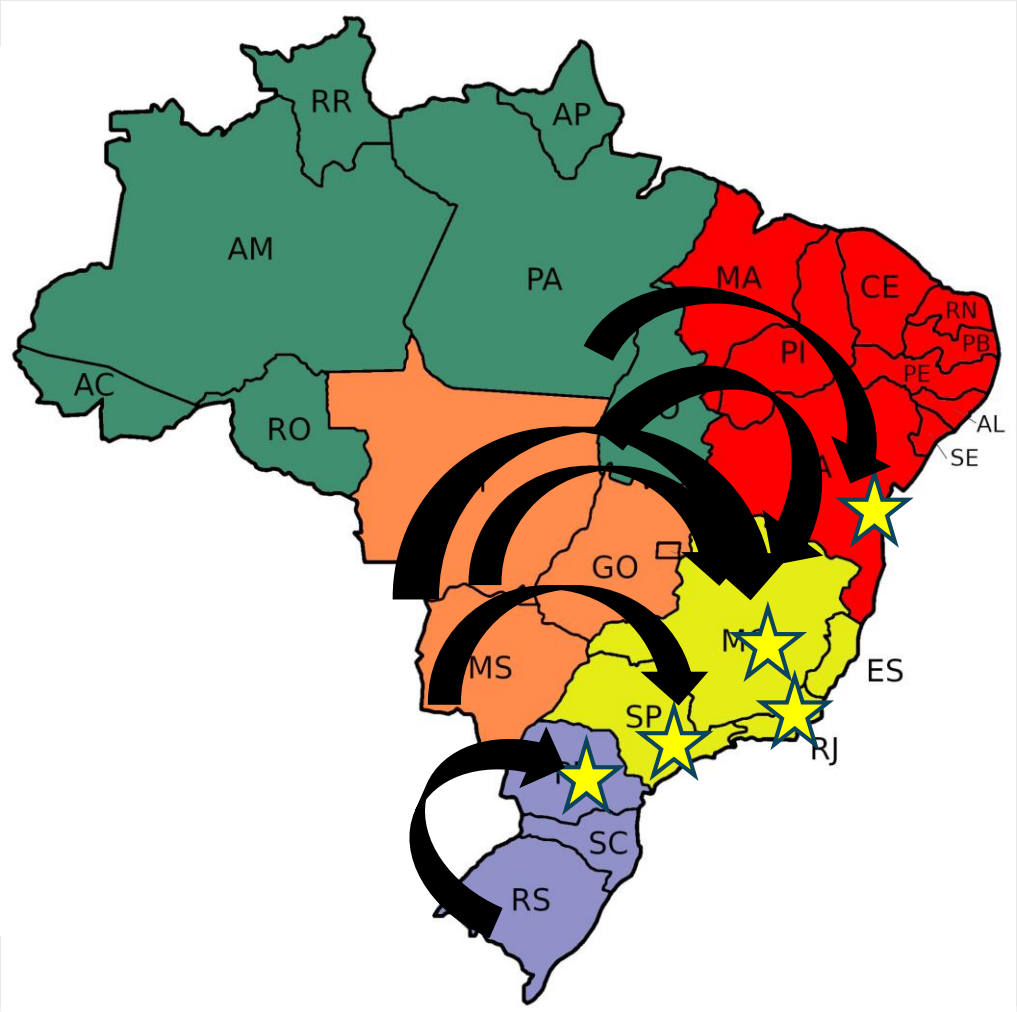
Nuestro Problema en Brasil

Patients
- Limited number of treatment centers
- Travel, lodging, and meal expenses
- Utilization management policies
- Out-of-pocket costs
- Toxicities and side effects

Provider
- Geography
- Logistics of follow up
- Reimbursement uncertainty
- Staff time and resources

Potential barriers to CAR-T treatment access

Provider
- Lingering manufacturing issues
- Difficulties with scaling up CAR-T manufacturing
- Payment issues
- Threats to future innovation



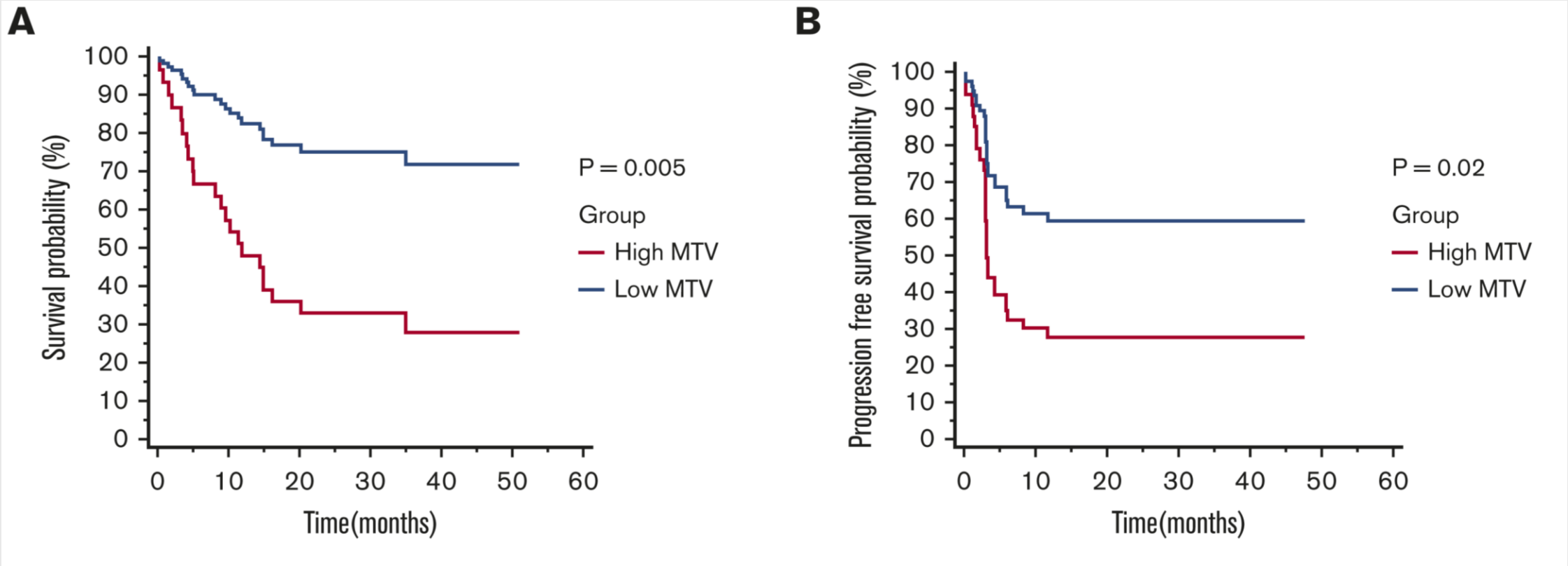
Kamal-Bahl et al, Future Medicine 2022

Questões Clínicas na Tomada de Decisão

Factor	Comments
Indications	▪ Does the patient meet a current indication for an FDA-approved CAR T-cell therapy? ▪ Does the patient meet the criteria for a clinical trial?
Kinetics of disease progression	▪ Would the patient be able to go through leukapheresis (without immediate use of steroids/chemotherapy) and remain stable until the T-cell infusion (3-4 wk)? ▪ Does the patient need alternative therapy prior to CAR T-cell therapy consideration?
Immediate prior therapy	▪ How would this affect the ability to successfully manufacture CAR T-cells (ie, obtain sufficient numbers of T-cells and expand)?
Concomitant immunosuppressive therapy	Can this be safely stopped prior to collection?
Active infection	▪ Higher risk of complications if patient experiences CRS
Nondisease-related comorbidities	eg, severe cardiac dysfunction, active symptomatic neurologic symptoms (difficult to accurately assess neurotoxicity)

¿Pq encaminar precozmente?

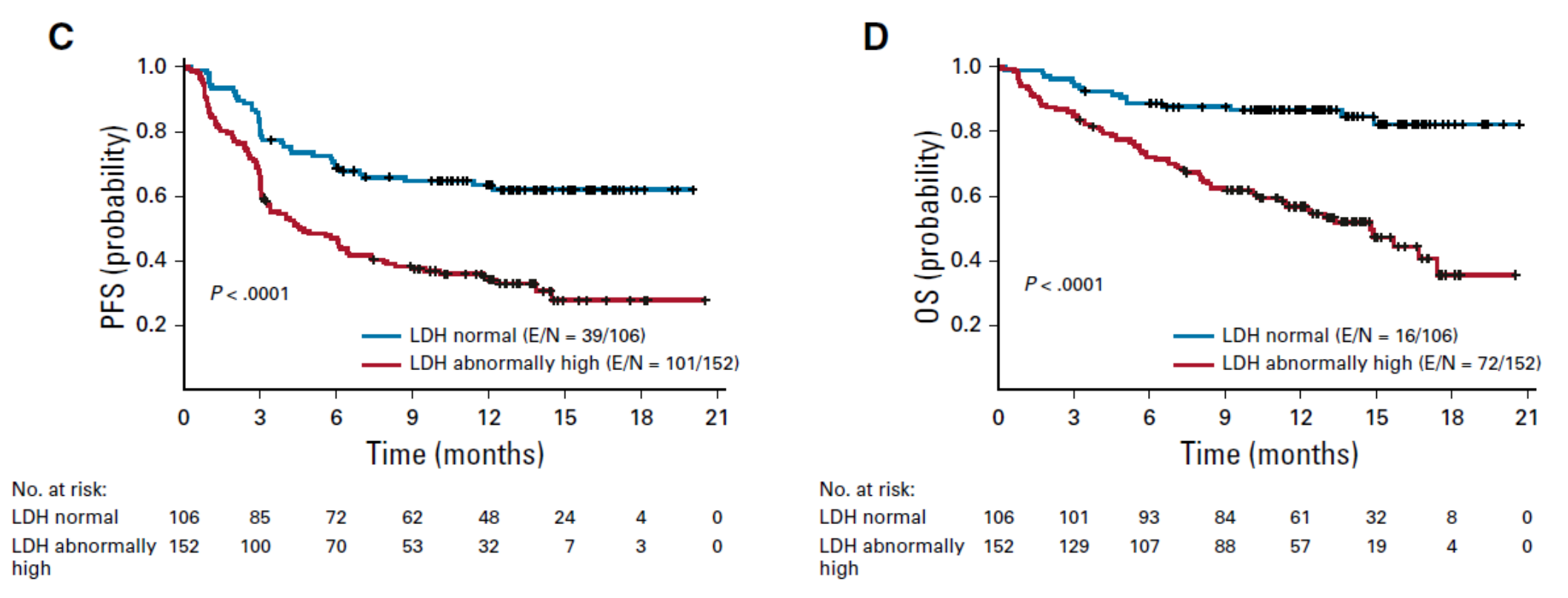
Carga Tumoral



Dean EA, Blood Adv 2020

¿Pq encaminar precozmente?

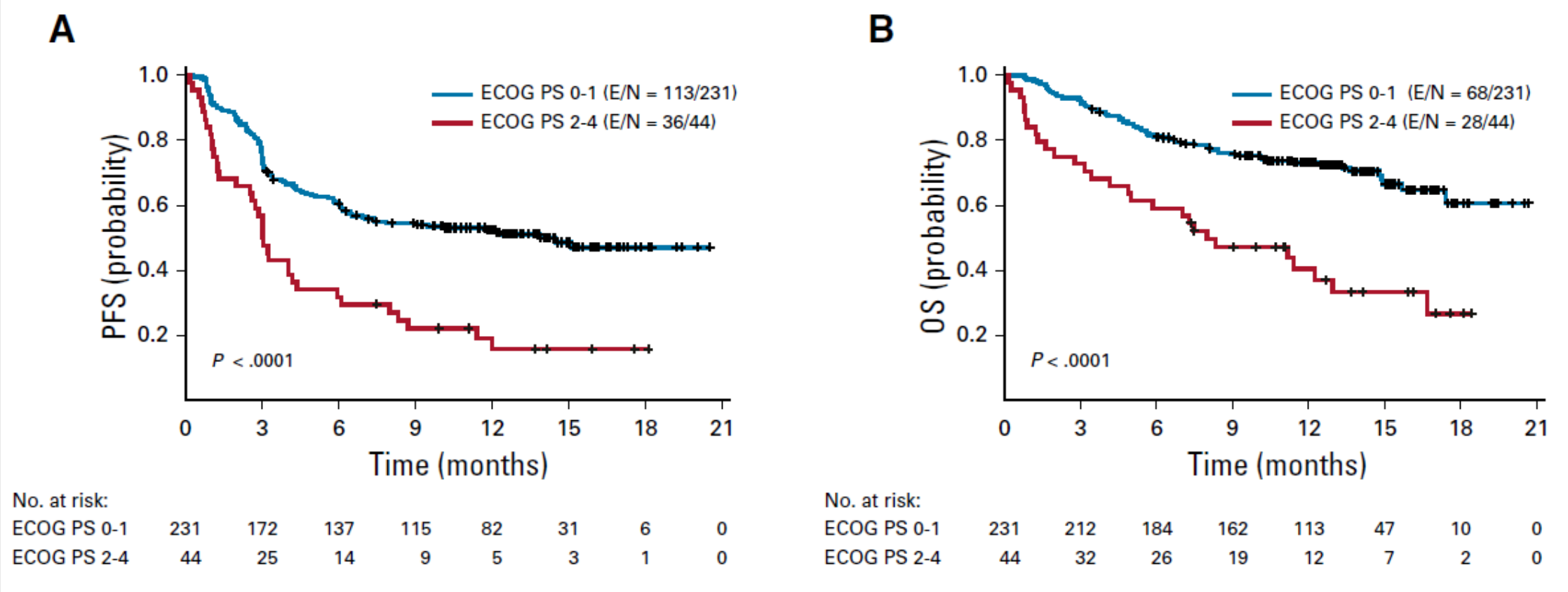
Carga Tumoral (DHL)



Nastoupill L, JCO 2020

¿Pq encaminar precozmente?

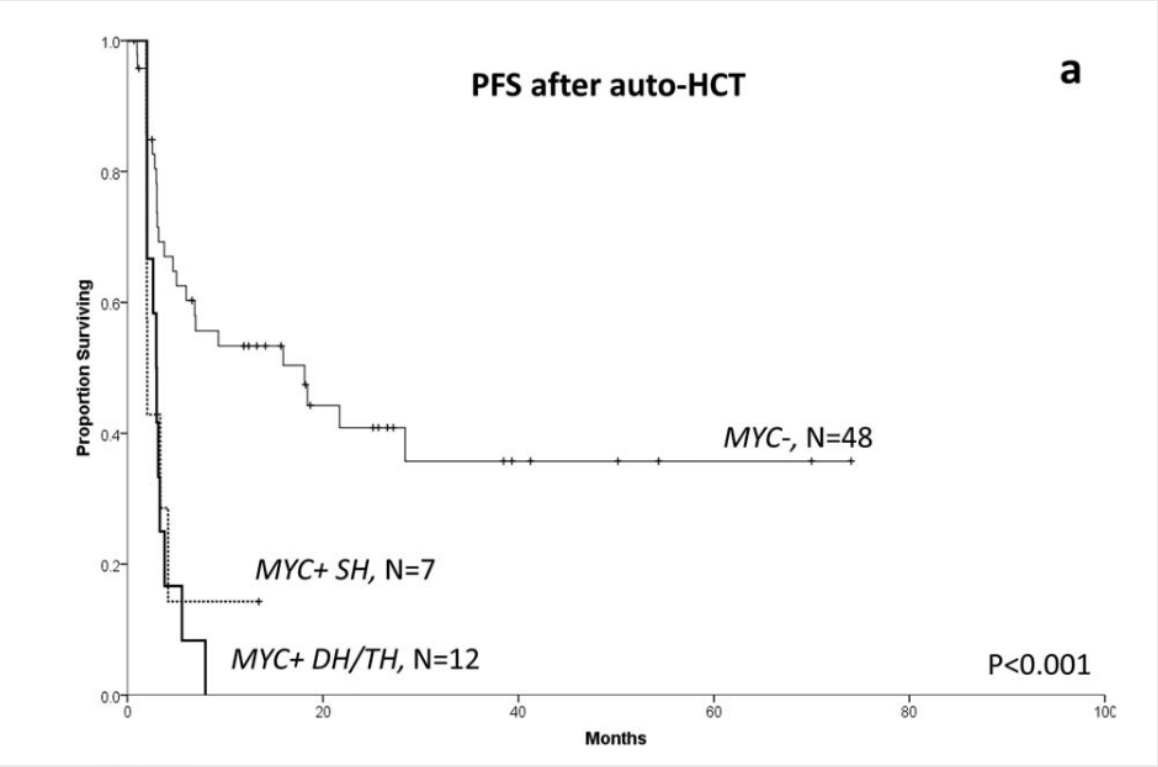
- Peora del PS



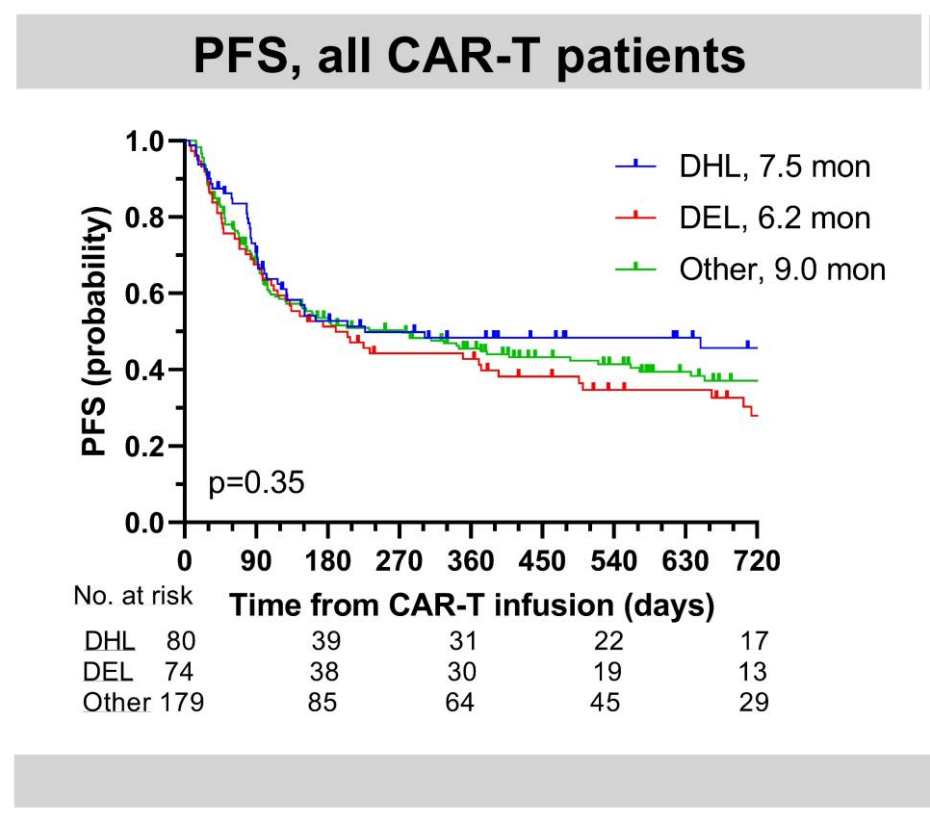
Nastoupil L, JCO 2020

¿Pq encaminar precozmente?

- Por que en algunos subtipos, NADA va a tener control de la enfermedad

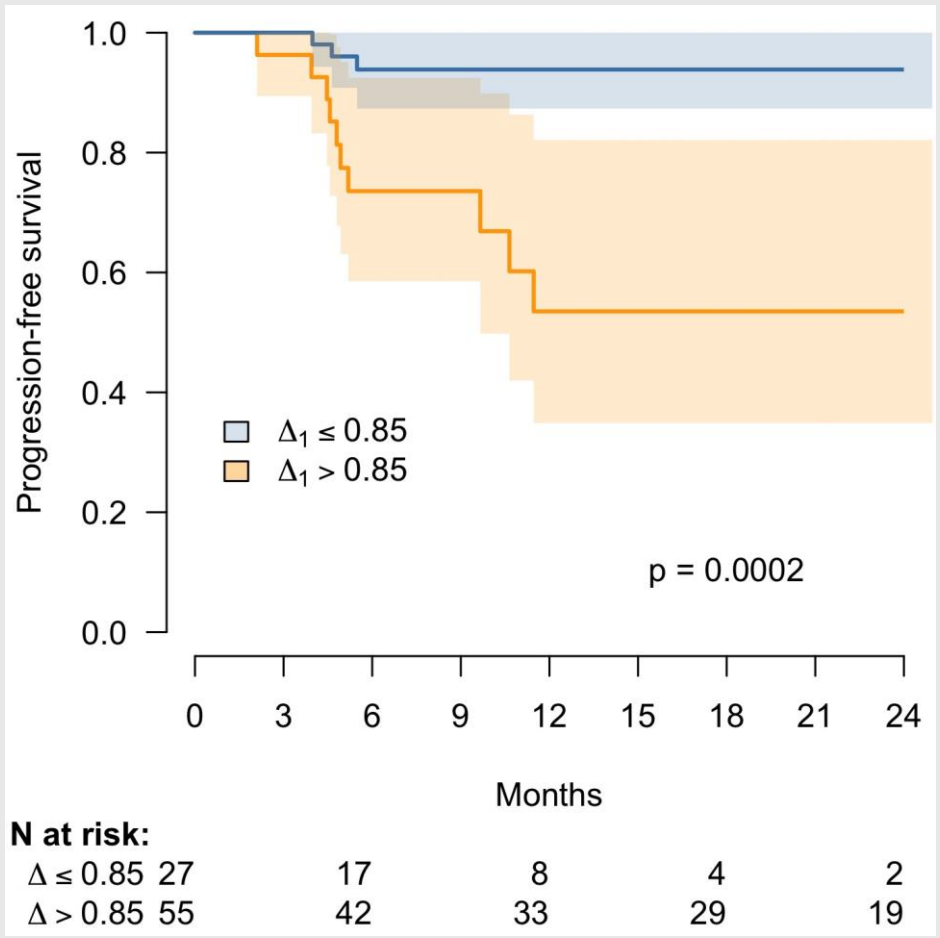


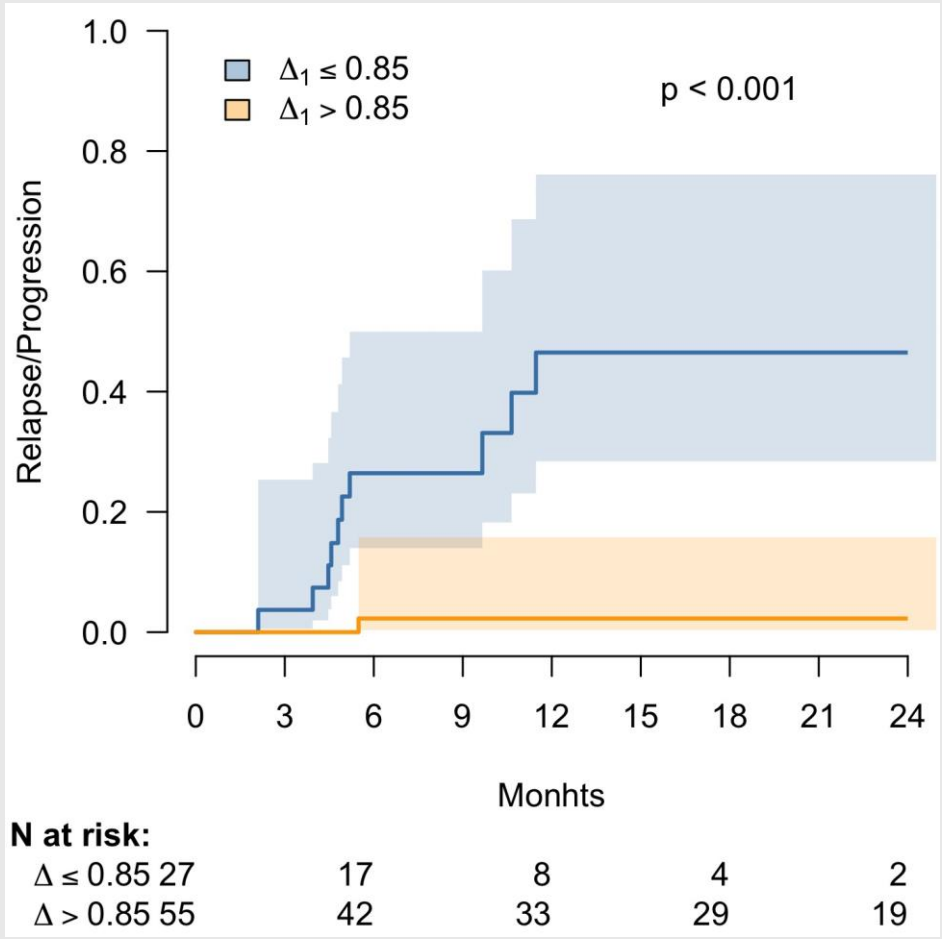
Zurko J et al, Abstract 154, ASH 2022



Zurko J et al, Abstract 154, ASH 2022

Como indentificas pacientes de alto Riesgo para Cart?





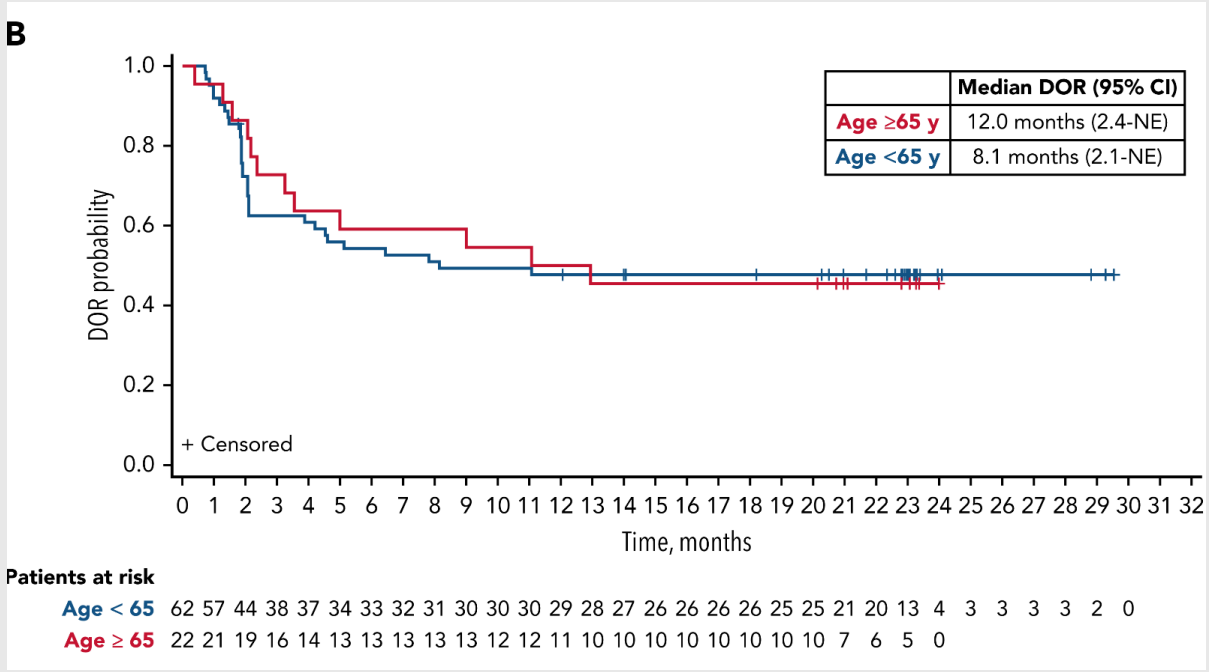
Feres C et al, #ASH 2021

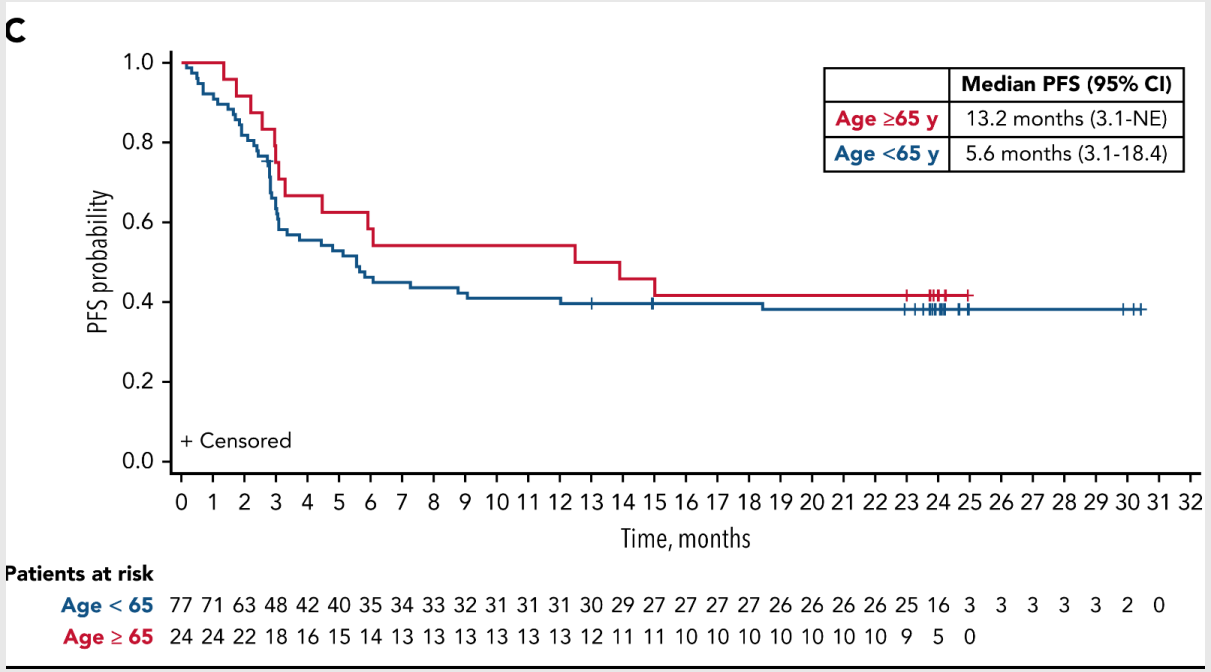
Transplant-Ineligible, CarT-Eligible (TICE)

- Algunos pacientes no serán candidatos a trasplante autólogo de células madre hematopoyéticas (ASCT), pero sí a terapia con células T de rescate (CART)
  - Edad
  - Comorbilidades
  - Control insatisfactorio de la enfermedad con terapias de rescate
  - Fallo en la recolección de células

- Estos pacientes deben ser considerados candidatos a CART y derivados precozmente
  - CGA
  - Enfoque multidisciplinario

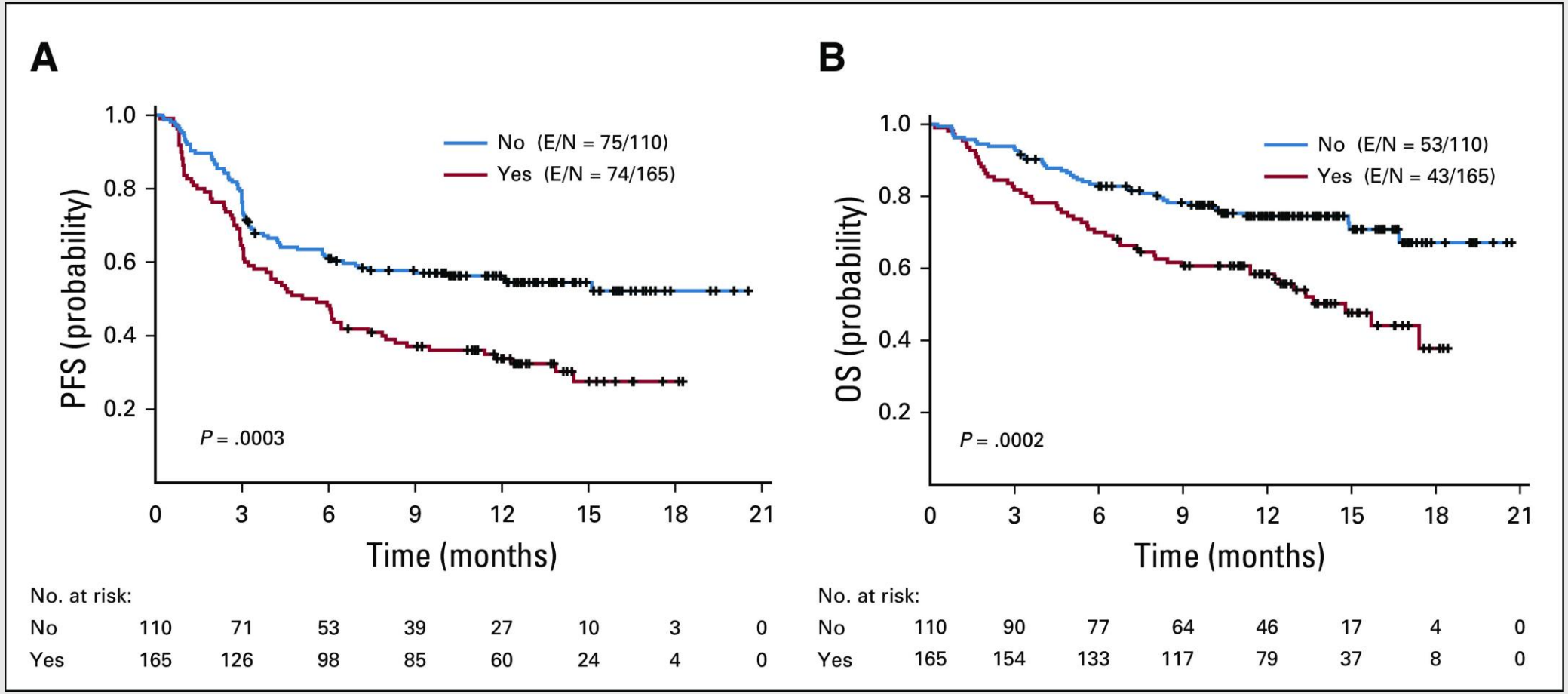
TICE – La edad no es un factor limitante!





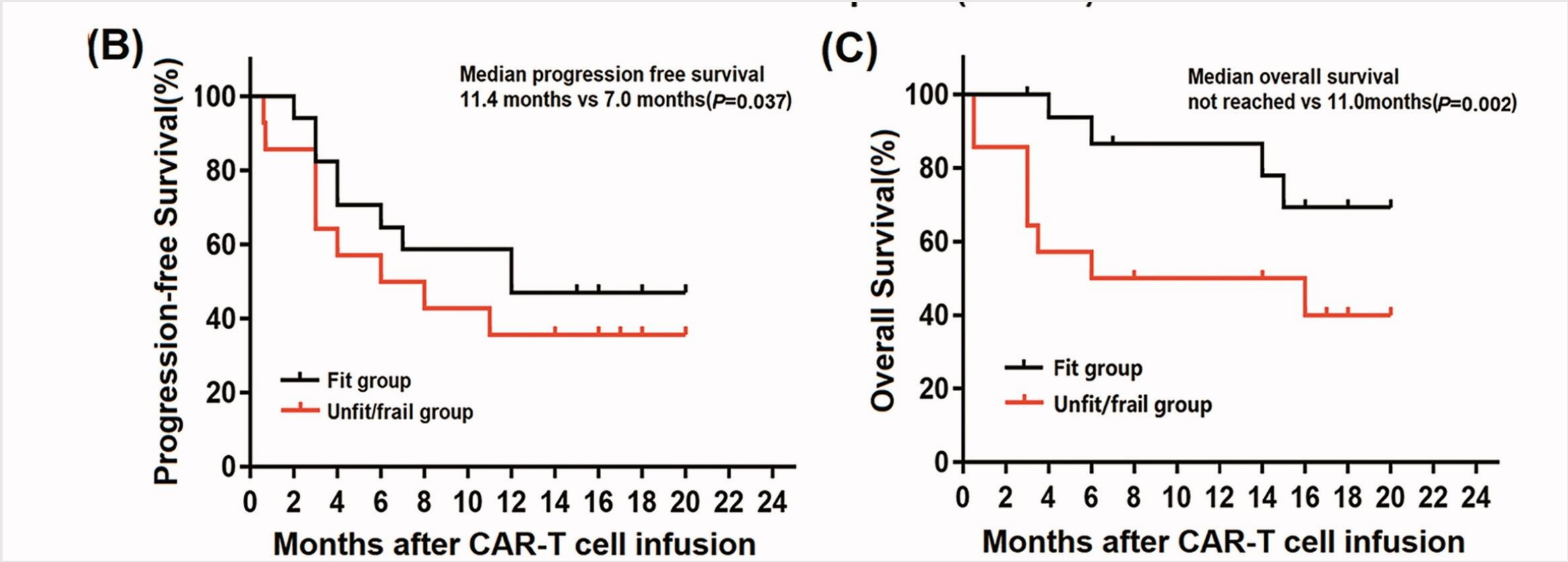
Neelapu S et al, Blood 2020

TICE – pero comorbilidades…



Nastoupill L, JCO 2020

TICE – Impacto de Evaluacíon Geriátrica

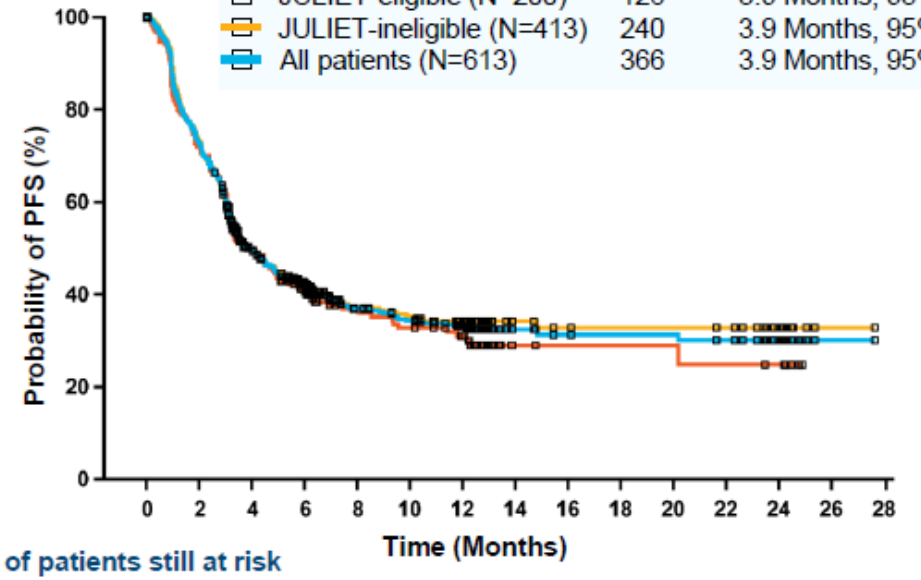


Huang Z et al, Leuk Lymphoma 2021

Progression-free survival

PFS by JULIET eligibility

Censoring times	Events (n)	Kaplan–Meier medians
JULIET-eligible (N=200)	126	3.9 Months, 95% CI [3.16–5.13]
JULIET-ineligible (N=413)	240	3.9 Months, 95% CI [3.29–4.93]
All patients (N=613)	366	3.9 Months, 95% CI [3.36–4.80]

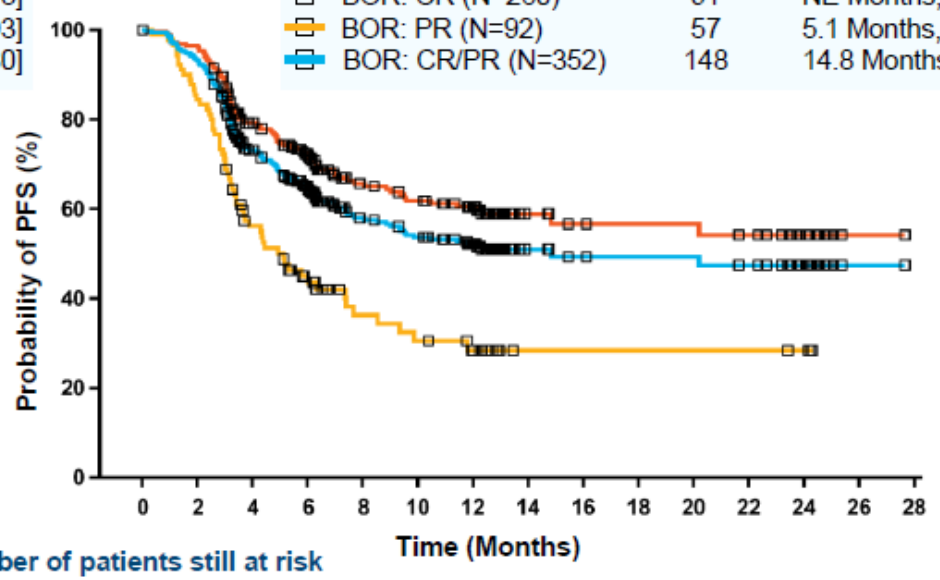


Number of patients still at risk

JULIET-eligible	200	137	88	66	45	40	34	8	7	7	7	6	5	0	
JULIET-ineligible	413	289	168	129	82	75	65	24	21	20	20	19	12	1	0
All patients	613	426	256	195	127	115	99	32	28	27	27	25	17	1	0

PFS by BOR

Censoring times	Events (n)	Kaplan–Meier medians
BOR: CR (N=260)	91	NE Months, 95% CI [14.84–NE]
BOR: PR (N=92)	57	5.1 Months, 95% CI [3.62–7.40]
BOR: CR/PR (N=352)	148	14.8 Months, 95% CI [9.34–NE]



Number of patients still at risk

BOR: CR	260	247	177	147	104	96	85	28	24	23	23	21	14	1	0
BOR: PR	92	76	46	31	19	16	12	4	4	4	4	4	3	0	
BOR: CR/PR	352	323	223	178	123	112	97	32	28	27	27	25	17	1	0

Month 12 PFS rates were similar between JULIET-ineligible patients (34.2%) and the overall CIBMTR population (33.1%); both reflect that seen in JULIET (34.6%)[1]

BOR, best overall response; CI, confidence interval; CIBMTR, Center for International Blood and Marrow Transplant Research; CR, complete response; NE, not estimable; PFS, progression-free survival; PR, partial response

1. Andreadis C *et al. Blood* 2019;134(Suppl 1):2883 [poster]

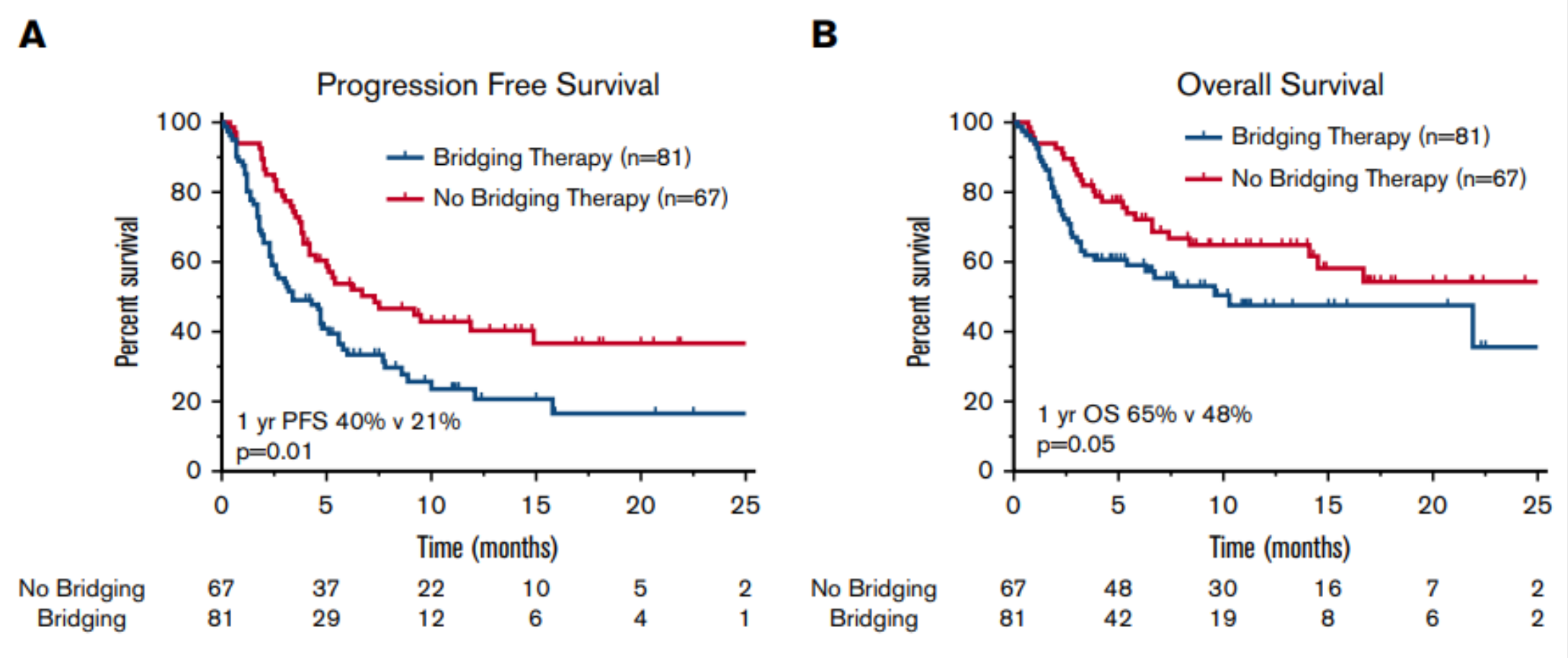
Oral presentation at the 2021 ASH Annual Meeting & Exposition, held December 11–14, 2021

Terapias de Rescate y Puente

- Las terapias de rescate pueden afectar la calidad del producto y deben coordinarse con el Centro CarT
- El tiempo de washout y los tipos de terapia pueden influir significativamente en los resultados del paciente
- También se debe analizar la terapia puente con el equipo CarT.

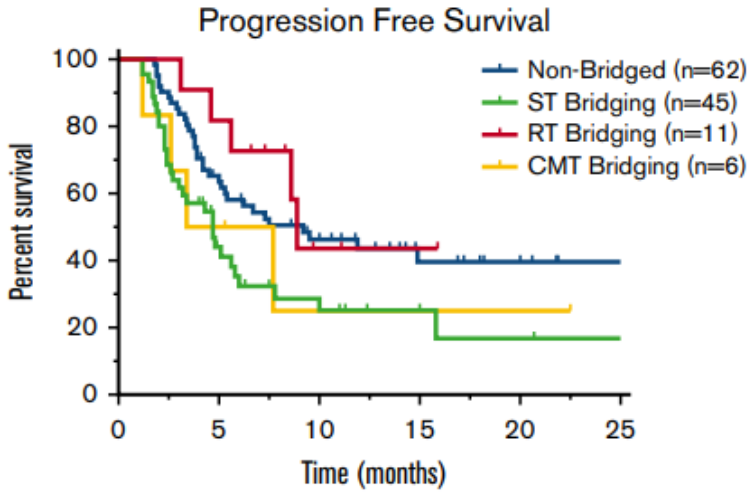

Terapias de Rescate/Puente
Time de Aférese
Time CarT

Impacto da Terapia de Ponte



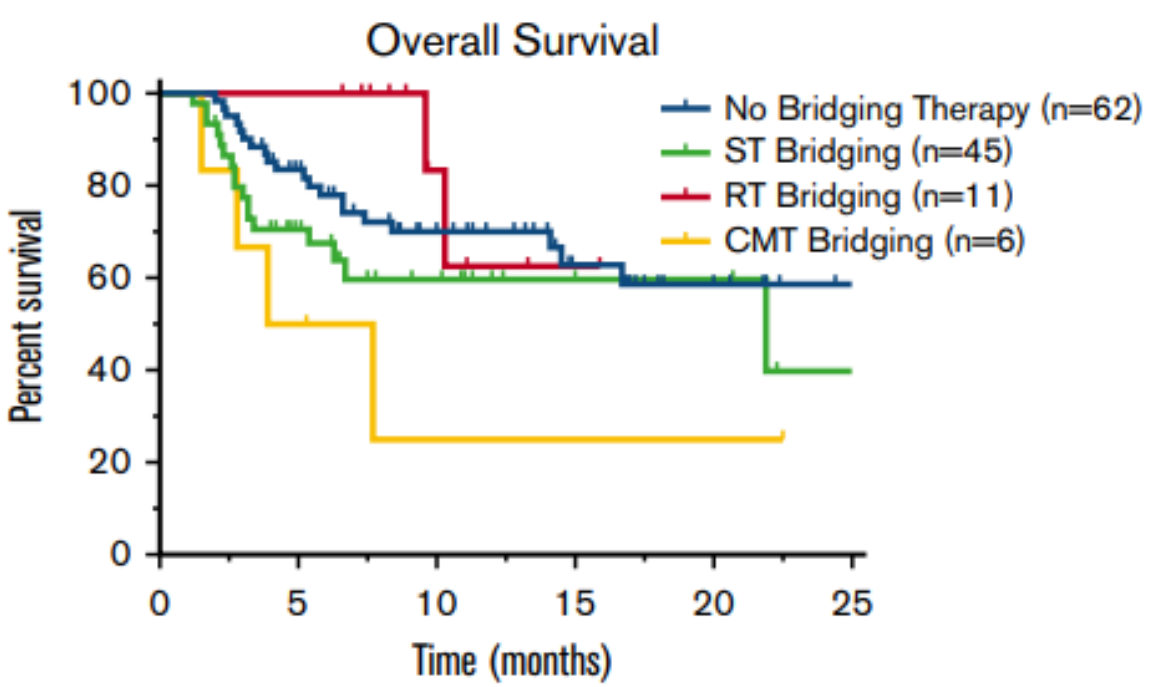
Pinnix C et al, Blood Adv 2020

Impacto da Terapia de Ponte



No Bridging	62	37	22	11	5	1
ST Bridging	45	16	8	4	3	1
RT Bridging	11	10	3	2	0	0
CMT Bridging	6	4	2	2	1	0

No bridging vs ST p=0.01
No bridging vs RT p=0.52
No bridging vs CMT p=0.36
ST vs RT p=0.05
ST vs CMT p=0.78
RT vs CMT p=0.17



Pinnix C et al, Blood Adv 2020

¿Pq encaminar precozmente?

- Impacto de terápias anteriores

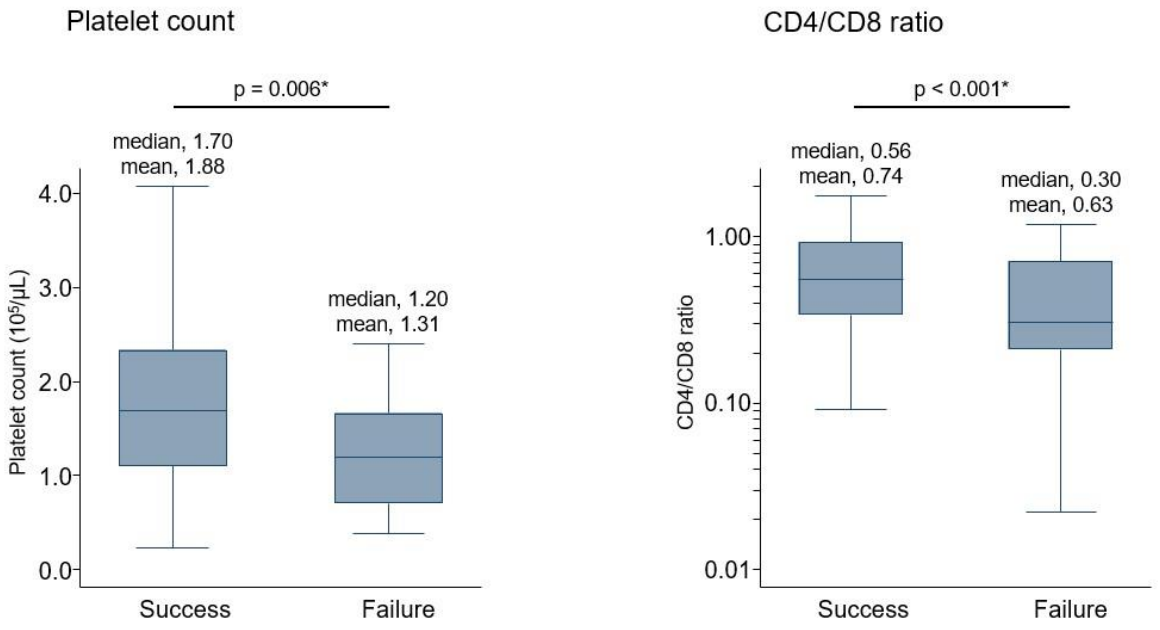
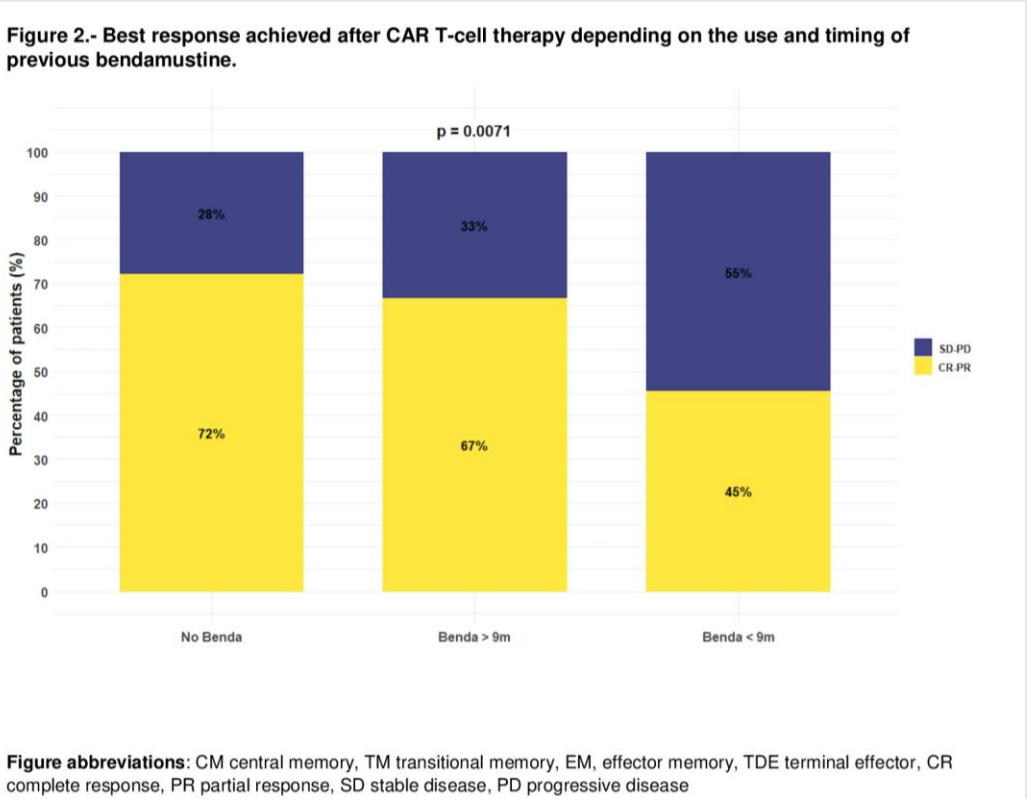


Figure 1. Comparison of platelet count and CD4/CD8 ratio in peripheral blood at apheresis between the failed and successful group

JoT et al, Abstract 664, ASH 2022



Iacoboni G et al, Abstract 658, ASH 2022

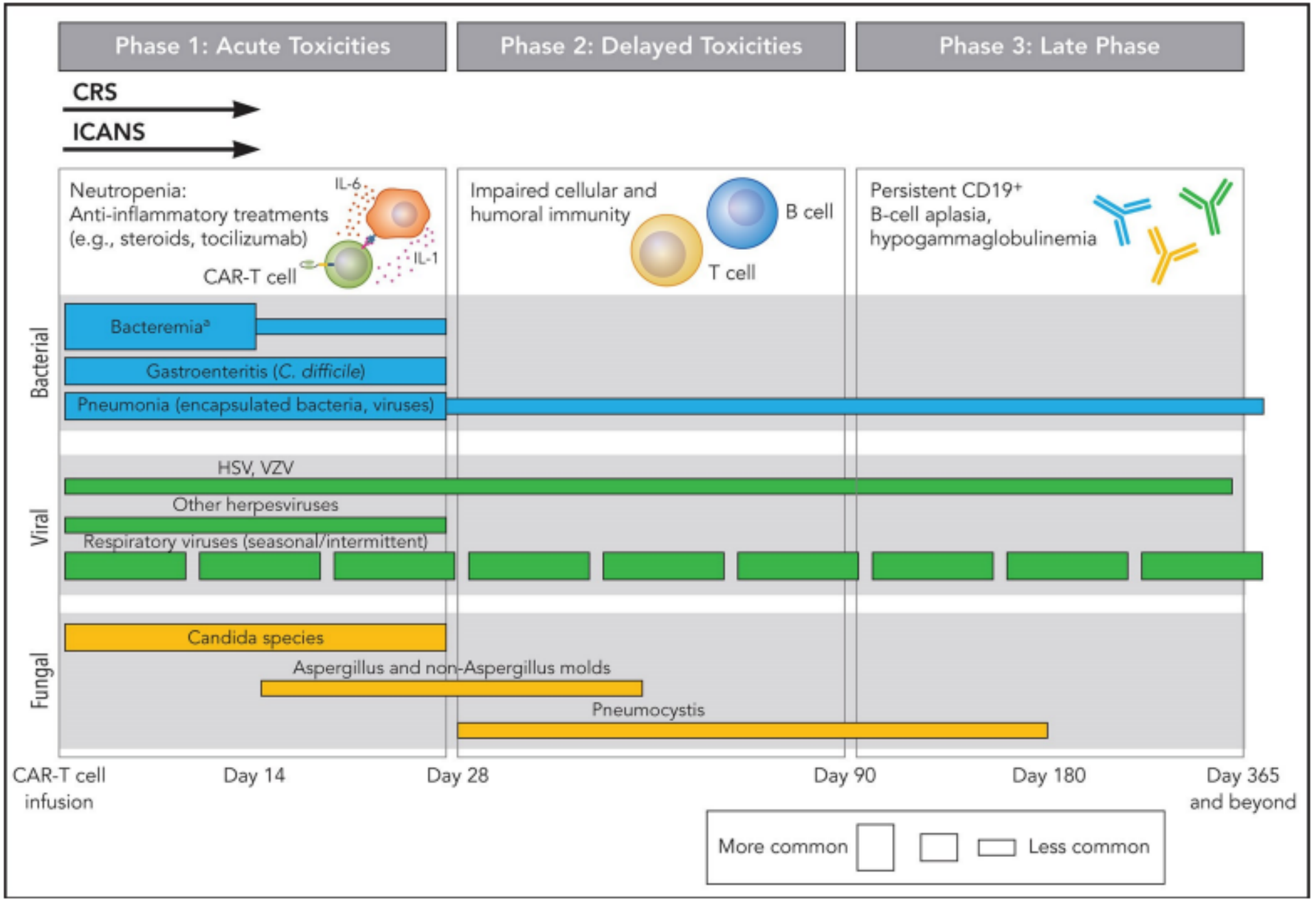
Optimización de pacientes para CART

- La derivación temprana es crucial.
- Idealmente, después de la primera recaída.
- A más tardar, después del tratamiento de segunda línea.
- La terapia CarT es un procedimiento que requiere tiempo:
  - Aprobación de las aseguradoras
  - Disponibilidad del centro
  - Logística de viaje
  - Aféresis
  - Manufactura

Optimización de pacientes para CART

- La coordinación entre los médicos remitentes y el equipo de terapia CART es fundamental:
  - Identificación de casos prioritarios
  - Elección del momento óptimo para la aféresis
  - Evaluación completa, especialmente en pacientes más frágiles
  - Elección de la terapia de holding
  - Elección de la terapia puente

Y después del CarT?


Phase 1: Acute Toxicities
Phase 2: Delayed Toxicities
Phase 3: Late Phase
CRS
ICANS
Neutropenia:
Anti-inflammatory treatments
(e.g., steroids, tocilizumab)
IL-6
IL-1
CAR-T cell
Impaired cellular and
humoral immunity
B cell
T cell
Persistent CD19+
B-cell aplasia,
hypogammaglobulinemia
Bacterial
Bacteremia[a]
Gastroenteritis (C. difficile)
Pneumonia (encapsulated bacteria, viruses)
Viral
HSV, VZV
Other herpesviruses
Respiratory viruses (seasonal/intermittent)
Fungal
Candida species
Aspergillus and non-Aspergillus molds
Pneumocystis
CAR-T cell infusion
Day 14
Day 28
Day 90
Day 180
Day 365 and beyond
More common
Less common

Follow Up despúes del CarT

Frecuencia de visitas:

Hasta el alta hospitalaria (D+60): semanal

Del D+60 al D+100: quincenal

Ferritina, perfil de coagulación

PCR cuantitativa para CMV: Si IgG es positiva, semanal hasta el D+30 y, si se están tomando corticosteroides, semanal hasta 30 días después de su suspensión

Niveles de inmunoglobulinas mensuales durante los primeros 6 meses

Citometria de flujo: CD3/CD4/CD8/CD19/CD56: Mensual hasta el día +90 y trimestralmente a partir de entonces.

Persistencia de células CAR-T: No disponible comercialmente; para la LLA, utilizar reconstitución de células B aplásicas.

Evaluación del estado de la enfermedad y la respuesta: Días +30, +90, +180, +360 y anualmente a partir de entonces.

Estar atento a la posible aparición de enfermedades mieloides relacionadas con el tratamiento en caso de nuevas citopenias.

Follow Up despúes del CarT

- Hayden PJ, Annals of Oncol. 2021

Tests	EBMT/EHA recommendations		Comments
	Purpose	Frequency	
FBC, biochemistry panel, AST, ALT, bilirubin, LDH, fibrinogen, CRP	Standard follow-up	At every visit and as clinically indicated	
CMV, EBV, adenovirus, COVID-19	Viral reactivation/infection (post-allo-HCT)	As clinically indicated	
Quantitative immunoglobulins or serum protein electrophoresis	Immune reconstitution	1-3 monthly	Consider i.v. (or s.c.) immunoglobulin replacement
Peripheral blood immunophenotyping—CD3/4/8/16+56/19+	Immune recovery	Once monthly for first 3 months, three monthly thereafter in first year	Guide to anti-infective prophylaxis and vaccination schedule
CAR-T monitoring	CAR-T persistence	Peripheral blood flow cytometry or transgene by molecular methods as clinically indicated	This is not feasible in most centres For B-ALL, B-cell aplasia may be used as a surrogate for persistenc

Table 12. Infection prophylaxis post-CAR-T

	EBMT/EHA recommendation	Comments
Neutropenia	G-CSF to shorten duration of neutropenia from day +14 or after resolution of CRS or ICANS Can consider starting earlier, e.g. day 5,[a] if patient is at high risk of infection, e.g. ALL, post-allo-HCT, high-dose steroids. For persistent neutropenia ($<0.5 \times 10^9$/l) following day +28, consider G-CSF	Avoid if patient has CRS or ICANS
Antibacterial prophylaxis	Not routinely recommended[b]	Can be considered in case of prolonged neutropenia and should be based on local guidelines, e.g. with levofloxacin or ciprofloxacin
Anti-viral	Valaciclovir 500 mg bid or aciclovir 800 mg bid	Start from LD conditioning until 1-year post-CAR T-cell infusion AND until $CD4^+$ count $>0.2 \times 10^9$/l
Anti-pneumocystis	Co-trimoxazole 480 mg once daily or 960 mg three times each week To start from LD conditioning until 1-year post-CAR-T cell infusion AND until $CD4^+$count $>0.2 \times 10^9$/l Where there is prolonged myelosuppression, postpone start after ANC $>0.5 \times 10^9$/l	Can be started later depending on centre guidelines In case of co-trimoxazole allergy (or cytopenias precluding use of co-trimoxazole), pentamidine inhalation (300 mg once every month), dapsone 100 mg daily or atovaquone 1500 mg once daily can be considered
Systemic anti-fungal prophylaxis	Not recommended routinely; consider posaconazole (300 mg/day) or fluconazole (200 mg/day) or micafungin (50 mg i.v./day) in patients with severe (ANC $<0.5 \times 10^9$/l) or prolonged (>14 days) neutropenia and/or in patients on long-term or high-dose (>72 h) corticosteroids or in patients post-allo-HCT	In patients with prior allo-HCT, prior invasive aspergillosis and those receiving corticosteroids, posaconazole prophylaxis should be considered
i.v. Immunoglobulin	Routine in children. Consider in adults with serious/ recurrent infections with encapsulated organisms and hypogammaglobulinemia (<4 g/l)	Clinical evidence does not support routine use in adults following allo-HCT

Follow up D+100

- Días +100 a 1 año: Mensual
- 1 a 2 años: Semestral
- 2 a 15 años: Anual

- Perfil hormonal: TSH, T4L, FSH, LH, estradiol, progesterona, cortisol, testosterona total y libre, perfil lipídico y evaluación ósea (densitometría ósea)

- Autoinmunidad: ANA, ENA, FR, ANCA, anti-TPO) e investigación específica de eventos inmunitarios tardíos (neumonitis, gastritis, colitis, enfermedad granulomatosa, dermatitis, etc.)

- Neoplasias secundarias: Screening de neoplasias hematológicas (SMD, LMA, trastornos linfoproliferativos de células T), cáncer de piel (screening dermatológico) y screening de neoplasias sólidas (endoscopia, colonoscopia, PSA total y libre, mamografía, citología vaginal)

- Trastornos neuropsiquiátricos y calidad de vida: Evaluación y apoyo multidisciplinario si es necesario

Follow up D+100

Table 14. Recommended minimum frequency of attendance at CAR-T centre for patients in remission for late effects monitoring

Period	EBMT/EHA recommendations	
	Visit frequency	Outcomes to be monitored
Day +100 to 1 year 1-2 years 2-15 years	Monthly Six-monthly Annually	• Disease—remission, minimal residual disease (MRD) status, relapse, death • Subsequent treatments including allo-HCT and other IEC therapy/ATMP • Immunological status—immune cell markers, immunoglobulins, CAR-T persistence • New cancers/secondary myeloid diseases • Autoimmunity and new autoimmune diseases • Endocrine, reproductive and bone health including growth and development • Neurological status (recovery from ICANS) • Psychological status and quality of life • Cardiovascular disease, including risk factors such as metabolic syndrome • Respiratory function • Gastrointestinal and liver health

Conclusiones

- Antes y Después, la integración de los centros és una estratégia necesaria
- CarT es una (si no la mejor) terapia en LNH DCBG RR, pero és un trabajo de equipo, no de 1 persona solo
- En LATAM, necesitamos trabajar para que los centros derivadores se queden confortables en toda ruta del paciente

Gracias!
Muito Obrigado!

Guilherme.Perini@einstein.br

GELL
Grupo de Estudio Latinoamericano de
Linfoproliferativos

FASE 3
LYMPHOMA Experience
PODCAST
BY cytohance

HAPPY AUER PODCAST
SUA DOSE DE HEMATOLOGIA

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Obrigado!

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