

evaluate the safety and efficacy of nara in combination with RTX in patients (pts) with relapsed and/or refractory (R/R) DLBCL and other forms of B-NHL.

Methods: R/R B-NHL pts with 1-6 prior lines of treatment were recruited to two study parts. In Part 1, which included a safety run-in, pts received 0.7 mg/kg nara in combination with 375 mg/m² RTX every 3 weeks (Q3W). In Part 2, only R/R DLBCL pts were included. Pts were assigned to either the Q3W regimen, or to a weekly regimen of 0.4, 0.2, and 0.2 mg/kg nara administered on days 1, 8, and 15, respectively, combined with 375 mg/m² RTX on day 1. Treatment was administered for 6 cycles with possible extension. Primary endpoints were treatment emergent adverse events (TEAEs) and ORR. Safety is reported in all pts; efficacy only in DLBCL pts. Data cut-off was 30-Sep-2020, when the trial was still ongoing; final data from the end of study will be available in the full presentation (FP) (NCT02564744).

Results: 100 pts were enrolled in the study: 80 DLBCL and 20 other B-NHL pts, of whom 82 (82%) experienced grade ≥ 3 TEAEs, the most common being neutropenia 54 (54%), lymphopenia 17 (17%) and thrombocytopenia 11 (11%). Only 10 (10%) pts discontinued nara due to a TEAE. Only very few grade ≥ 3 TEAEs, known to be associated with free DM1, were reported: 1 (1%) serious AE of toxic hepatitis with no sequelae; and 2 (2%) cases of non-serious neuropathy (1 motor and 1 sensory). At the time of data cutoff, of the 80 DLBCL pts, 74 (32% refractory to 1st and/or last line) were efficacy evaluable (had one screening assessment and at least one post-baseline tumor assessment or clinical progressive disease [PD]). The ORR was 43.2%, with 24 (32.4%) complete responses and 8 (10.8%) partial responses. In addition, 11 (14.9%) stable disease and 31 (41.9%) PD were observed. Median duration of response was not reached, (95% confidence interval 10.4 - NA months [mo]). Median duration of follow-up in responders was 13.7 mo.

Conclusions: The combination of nara with RTX was well tolerated, with a manageable safety profile of expected, mainly hematological AEs. A preliminary analysis shows promising efficacy. Final data, regimen comparison, and related analyses will be available in the FP. The research was funded by: Debiopharm International S.A.

Keywords: Molecular Targeted Therapies, Aggressive B-cell non-Hodgkin lymphoma, Combination Therapies

Conflicts of interests pertinent to the abstract

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245 | PROSPECTIVE EVALUATION OF LYMPHOMA RESPONSE TO IMMUNOMODULATORY THERAPY CRITERIA (LYRIC) IN GATA TRIAL FROM THE LYSA GROUP

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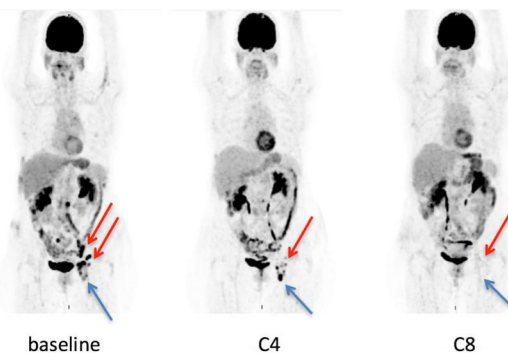
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Introduction: Checkpoint blockade may complicate response assessment by a flare reaction or pseudoprogression (PP). To avoid the mistake of considering a new agent ineffective, it was proposed to add the category "indeterminate response" (IR) to Lugano classification, in the LYmphoma Response to Immunomodulatory Therapy Criteria (LYRIC): 1/ increase in overall tumor burden in the first 12 weeks of therapy, without clinical deterioration (IR1), 2/ development of new lesions without overall progression (IR2), or 3/ increased FDG avidity despite no change in lesion size (IR3). These patterns are defined as progressive metabolic disease (PMD) in the Lugano criteria. A PP was defined as an IR that became a partial or complete metabolic response (PMR or CMR) at next evaluation. The aim of this study is to assess in a practical and prospective manner the LYRIC criteria in relapsed/refractory (R/R) DLBCL and FL treated with atezolizumab, venetoclax and obinutuzumab (GATA trial), and measuring the incidence of PP.

Methods: The GATA study is a LYSA sponsored multicenter phase 2 trial (NCT03276468) evaluating the combination of atezolizumab, obinutuzumab and venetoclax in biopsy-confirmed R/R DLBCL and FL patients who failed at least one line of therapy (rituximab and anthracycline containing regimen). Local imaging practitioners used the Lugano and LYRIC classification. Clinical investigators were warned of the possibility of PP, and a coordinating investigator's approval was required before stopping treatment. A centralized imaging review on PET-CT scan was performed at three time points: baseline, cycle 4 (C4, 12 weeks) and cycle 8 (C8, 24 weeks), on Lugano and LYRIC criteria.

Results: Our study has included 116 patients (58 DLBCL, 58 FL) from GATA trial. The overall metabolic response rate at C8 was 23.6% and 53.6% with a median follow up of 9 months and 14.5 months for DLBCL and FL patients, respectively. Ninety-five patients had a centralized review at C4 and 57 at C8. Missing patients are those who progressed prior to the restaging by PET-CT scan. In *Lugano criteria*, 84 reviewed responses (88.4%) were concordant with local response at C4, and 47 (82.5%) at C8. In *LYRIC criteria*, 9 patients (4 DLBCL and 5 FL) were classified at C4 as IR by both local reading and centralized review, with a discordance in the type of IR (1, 2 or 3) in 6/9 cases. During the follow-up, 4 cases turned out to be PP (1 DLBCL and 3 FL) and 5 cases real progressive diseases (PD). One PP is illustrated in Figure 1 (IR3 at C4, CMR at C8). At C8, 7 patients were classified as IR by centralized review (IR2 and IR3), only 2 of them were IR by local reading. During the follow-up, all of those cases turned out to be real PD within 1 to 3 cycles of therapy.



Conclusions: We observed a low frequency of 3.4% of PP at C4. Interestingly, all IRs at C8 were found to be real PD. Overall, these data are in favor of using the LYRIC classification, but only for early evaluation.

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Keywords: PET-CT, Aggressive B-cell non-Hodgkin lymphoma, Indolent non-Hodgkin lymphoma

No conflicts of interests pertinent to the abstract.

ONGOING TRIALS

246 | RADIATION FREE THERAPY OR THE INITIAL TREATMENT OF GOOD PROGNOSIS EARLY NON-BULKY HODGKIN LYMPHOMA, DEFINED BY A LOW METABOLIC TUMOR VOLUME AND A NEGATIVE PET-2 - RAFTING TRIAL

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Introduction: Early-stage Hodgkin Lymphoma (eHL) is a curable disease with a 5-Y PFS and OS > 85-95% and 95%, respectively, after combined modality treatment (CMT) with 2-4 cycles of chemotherapy (CT) followed by 20 or 30 Gy Involved-node radiotherapy (RT). However, the efficacy of CMT is offset by a long-term morbidity, with a cumulative incidence of Second Primary Malignancy (SPM) at