TREATMENT OF RELAPSED AND REFRACTORY LYMPHOMAS WITH NIVOLUMAB IN A LIMITED RECURSIVE COUNTRY

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Background Programmed cell death proteins and their ligands have been under research in recent years, as their inhibitors provide promising results in relapsed and refractory lymphoma treatment.1 However, in Armenia, number of patients receiving Nivolumab is small and does not represent a real indication number, since it is problematic to provide it. The main aim of this monocenter retrospective study is to evaluate the outcome with Nivolumab among Armenian lymphoma cases.

Methods Data was taken from the Hematology Center after prof. R. Yeolyan ambulatory cards. Study duration: 2013-2021. Patient number: 10. Eight patients were diagnosed with Hodgkin’s lymphoma (HL), one patient with Primary mediastinal B large cell lymphoma (PMBCL), another one with ALK-positive T-large cell anaplastic lymphoma (ALK+ ALCL). In all patients, the primary diagnosis was established in advanced stages.

Results Nivolumab performed after 2nd relapse in 5 patients, of which 4 were with HL and one with ALK+ ALCL. First-line therapy was started with BEACOPP scheme in all HL patients, after which BV, ABVD, VGPP, DHAP, CVPP, VIG-EPP3 were also the regimens of choice over Nivolumab. The PMBCL patient was treated with R-CHOEP, R-DHAP before Nivolumab + Venetoclax. At initial diagnosis he had skin necrosis of about 15 cm, which worsened after radiation, but partial skin recovery was observed after Nivolumab + Venetoclax regimen, skin biopsy showed no tumour activity. The patient with ALK+ ALCL was treated with R-CHOP, BV-CHP, BV before Nivolumab. 3 patients received Nivolumab after initial therapy failure, 1 of them with PMBCL and 2 with HL. One patient did not attend after Nivolumab+ BV courses, but no mortality status. One HL patient was diagnosed with HIV and is currently in partial remission (PR) after BEACOPP + Nivolumab + auto-HSCT. CR after Nivolumab was achieved in 3 patients, 2 of them with HL and 1 with PMBCL. PR was achieved in one HL patient. Progression after Nivolumab was observed in 5 patients, of which 4 had HL and one had ALK+ ALCL. Auto-HSCT was performed in 3 patients, 2 of them with HL and 1 with PMBCL, and CR was achieved in PMBCL.

Conclusions Overall, CR was achieved in 30% of lymphoma patients, among whom patients received Nivolumab at doses of 100, 160 and 200 mg. Some patients received reduced doses of Nivolumab 40 mg and did not respond to a treatment. Based on a limited number of patients, additional studies are needed for a definitive conclusion.

REFERENCE
