Webinars

Cutaneous Lymphoma

EuroBloodNet Topic on Focus

Patients' Organizations

Cutaneous Lymphoma: New therapeutic developments

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LYMPHOMA COALITION

CUTANEOUS LYMPHOMA FOUNDATION

France Lymphome Espoir

EURORDIS RARE DISEASES EUROPE

European Reference Network for rare or low prevalence complex diseases

Network Hematological Diseases (ERN EuroBloodNet)

Takeda, Kyowa Kirin, Innate pharma, 4Sc, Stemline, miRagen Therapeutics,Inc. , Recordati, Galderma, Hoffmann La Roche, Novartis, Abbvie, Janssen, L

1. Therapeutic concepts

2. New therapeutics

3. Future directions

Therapy concept: Key points

- Early-stage mycosis fungoides should be treated with skin-directed therapy.
- In early-stage mycosis fungoides there may be periods of ‘expectant therapy’ when no treatment is preferred.
- In patients with advanced stage mycosis fungoides or Sézary syndrome, systemic treatments may be considered first line.
- In advanced stage disease where life expectancy may be severely reduced allogeneic haematopoietic stem cell transplantation may be considered
- A holistic approach to patient care with consideration of health-related quality of life is essential, and symptomatic relief for pain, itch, insomnia and depression may be needed.

Therapy concept: basic principles

- Avoid cytotoxic therapies as long as possible
- Give skin care with emollients, reducing bacterial colonization!
- Treat additional symptoms
  e.g. pruritus
- Use standard treatments correctly! E.g. PUVA and systemic therapies
- Think about maintenance treatment
- Keep in close contact with your physician!

Treatment strategies depend on the diagnosis and the stage of the disease

MF	MF	MF	MF	SS
Stage 1A-IIA	Stage IIB	Stage III	Stage IV	Stage IVA1
Expectant policy Topical steroids Nb –UVB, PUVA **Chlormethine gel** Bexarotene gel[a] Imiquimod[b] Local RT	SDT + local RT, retinoids, IFNα, TSEBT	SDT + retinoids, IFNα; ECP ± IFNα, retinoids Low dose MTX	Gemcitabine Liposomal encapsulated doxorubicin Brentuximab vedotin	ECP ± IFNα, Retinoids Prednisone + chlorambucil Low-dose MTX **Mogamulizumab**
SDT + retinoids, IFNα; TSEBT	Gemcitabine, Liposomal doxorubicin **Brentuximab vedotin** Combination Cht, AlloSCT	TSEBT **Mogamulizumab**	Combination ChT AlloSCT	Low dose alemtuzumab Gemcitabine Liposomal doxorubicin Combination ChT AlloSCT

Avoid progression of the disease!

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[a] Not approved in Europe but FDA approved in CTCL; [b] Not approved in CTCL

AlloSCT, allogeneic stem cell therapy; Cht, chemotherapy; ECP, extracorporeal photochemotherapy; IFN, interferon; SDT, skin-directed therapy; RT, radiotherapy; TSEBT, total skin electron beam therapy.

Trautinger F, et al. Eur J Cancer. 2017;77:57-74. Willemze R, et al. Ann Oncol. 2018;29:iv30-iv40.
Bagot M, Stadler R. Cutaneous lymphoma. In: Kang S, et al. editors. Fitzpatrick's Dermatology. 9th ed. USA: McGraw Hill; 2019. Ch.119.

Skin directed treatment responses to topical therapies in CTCL

Treatment	Study (N)	Study design	Stage	Response Rate
Topical steroids Class I-III	Zackheim et al 1998 (n = 79)		T1 and T2 Patch/plaque	T1: ORR 94%, CR 63%, PR 31% T2: ORR 82%, CR 25%, PR 57%
Chlormethine solution	Vonderheid et al 1989 (n = 331)	Retrospective	I-IV or Sézary syndrome	T1: CR 80% T2: CR 62%
Chlormethine Gel	Lessin et al 2013 (n = 260)	Randomized controlled trial	IA –IIA	ORR 58.5% vs 47.7% CR 13.8% vs 11.5% PR 44.6% vs 36.2%
Bexarotene Gel	Heald et al 2003 (n = 50)	Multinational, open-label, Phase III	IA-IIA	ORR 54%, CR 10%, PR 44%
Resiquimod	Rook et al 2015 (n = 12)	Open Label Phase I	IA-IIA	ORR 75%, CR 33%, PR 42%

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Management of chlormethine gel treatment in mycosis fungoides patients in two German skin lymphoma centers Ulrike Wehkamp1, Marion Jost1, Janika Gosmann2, Uta Grote1, Michaela Bernard2, Rudolf Stadler2 JDDG 2021

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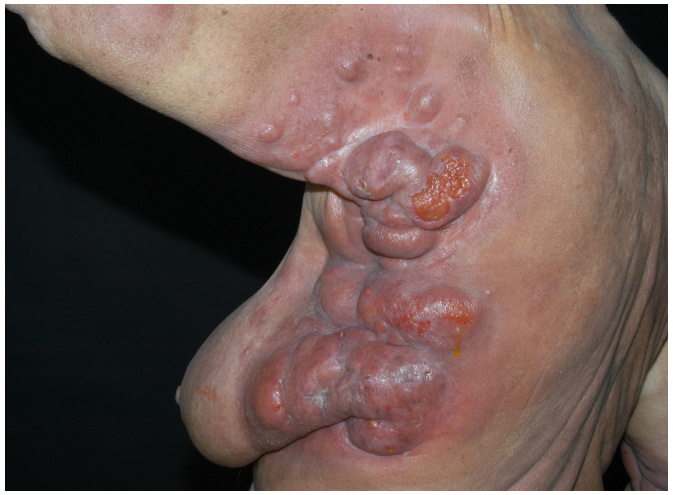
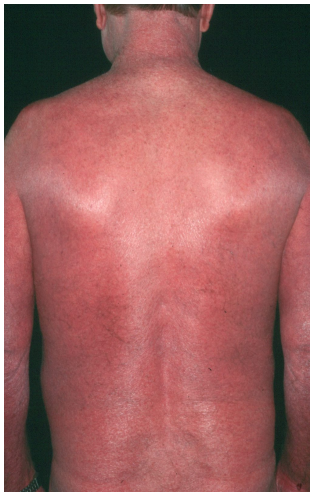
- Zackheim HS, et al. Arch Dermatol. 1998;134:949-54. Lessin SR, et al. JAMA Dermatol. 2013;149:25-32.
- Heald P, et al. J Am Acad Dermatol. 2003;49:801-15. Rook AH, et al. Blood. 2015;126:1452-61. Vonderheid EC, et al. J Am Acad Dermatol. 1989;20:416-28.

Current systemic treatments in advanced MF/SS





- Immunomodulators
  - Rexinoid, Bexarotene; Retinoids Acitretin
  - Interferon, peg. Interferon
  - Extracorporal Photopheresis
- Radiotherapy
  - TSEB and local
- Antibody based therapeutics
  - Brentuximab vedotin
  - Mogamulizumab
- HDAC inhibitors
- Chemotherapy
  - Gemcitabine
  - PEG Doxorubicine
  - CHOP and CHOP-like
- Allogeneic stem cell transplantation

Trautinger F, et al. Eur J Cancer. 2017;77:57-74

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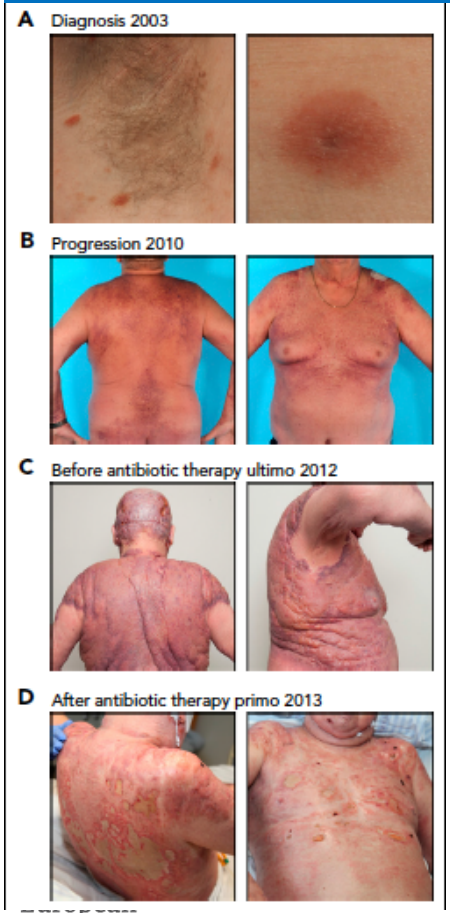
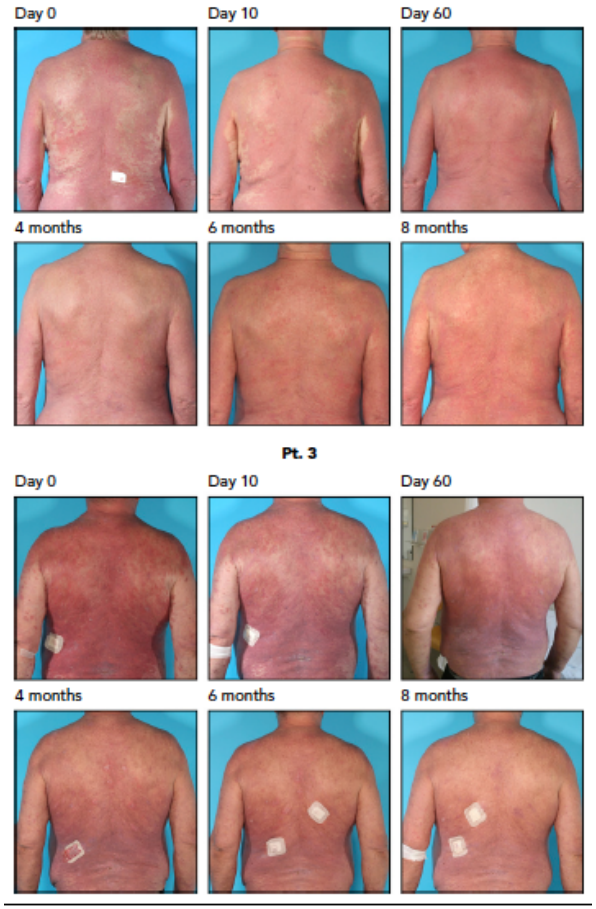
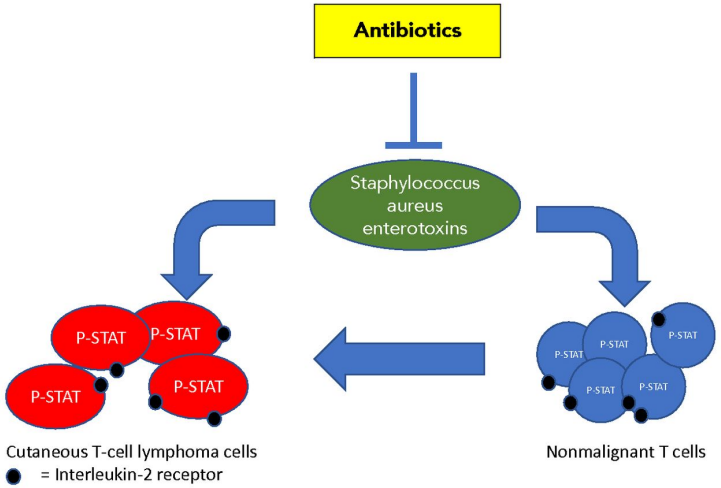
Antibiotics inhibit tumour and disease activity in cutaneous T-cell lymphoma

Lindahl et al , Blood 2019







Cutaneous T-cell Lymphoma n=8

Therapy with Cefuroxim (1.5 g) und Metronidazol (0.5 g) 3 x/ day for 10 days
Followed by oral Amoxicillin und Clavulansäure
(500/125 mg) 3 x /day for 14 days

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Antibody-based Therapies

Functional Classifikation of Antibody-based Therapies	
Funktion	Target
Tumorcell-„Killing“	CD2, CD3, CD4, CD25, CD30, CD47, CD52, CCR4, KIR3DL2
T-cell-activation	PD-1, PD-L1, CTLA-4, CD137, OX40
Tumor-Micromilieu	CD25, PD-1, PD-L1, CD137, OX40, STAT3
Immunpriming	CD40, CD137

Antibody (modified) based therapies for cutaneous T-cell-Lymphoma

- Brentuximab Vedotin
- Mogamulizumab
- Alemtuzumab
- Lacutamab (KIR3DL2)
- Atezolizumab

Final data from the phase 3 ALCANZA study: brentuximab vedotin versus physician's choice in patients with CD30-positive cutaneous T-cell lymphoma

Julia Scarisbrick,[1] Steven M. Horwitz,[2] Reinhard Dummer,[3] Sean Whittaker,[4] Madeleine Duvic,[5] Youn H. Kim,[6] Pietro Quaglino,[7] Pier Luigi Zinzani,[8] Oliver Bechter,[9] Herbert Eradat,[10] Lauren Pinter-Brown,[11] Oleg Akilov,[12] Larisa Geskin,[13] Jose Sanches,[14] Pablo Ortiz-Romero,[15] Michael Weichenthal,[16] David Fisher,[17] Jan Walewski,[18] Judith Trotman,[19] Kerry Taylor,[20] Stephane Dalle,[21] Rudolph Stadler,[22] Julie Lisano,[23] Lisa Brown,[23] Maria Corinna Palanca-Wessels,[23] Veronica Bunn,[24] Meredith Little,[24] H. Miles Prince[25]

[1]Department of Dermatology, University Hospital Birmingham, Birmingham, UK; [2]Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, NY, USA; [3]Department of Dermatology, University Hospital Zürich, Zürich, Switzerland; [4]St John's Institute of Dermatology, Guys and St Thomas NHS Foundation Trust, London, UK; [5]The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [6]Department of Dermatology, Stanford University School of Medicine and Stanford Cancer Institute, Stanford, CA, USA; [7]Department of Medical Sciences, Dermatologic Clinic, University of Turin, Turin, Italy; [8]Institute of Haematology, University of Bologna, Bologna, Italy; [9]Department of General Medical Oncology, University Hospitals Leuven, KU Leuven, Belgium; [10]Division of Hematology-Oncology, David Geffen School of Medicine at UCLA, Los Angeles, CA, USA; [11]Chao Family Comprehensive Cancer Center, University of California, Irvine, CA, USA; [12]Department of Dermatology, University of Pittsburgh, Pittsburgh, PA, USA; [13]Department of Dermatology, Columbia University, New York, NY, USA; [14]Department of Dermatology, University of São Paulo Medical School, São Paulo, Brazil; [15]Department of Dermatology, University Hospital 12 de Octubre, Institute i+12 Medical School, University Complutense, Madrid, Spain; [16]Department of Dermatology, University Hospital of Schleswig-Holstein, Kiel, Germany; [17]Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA, USA; [18]Maria Sklodowska-Curie Institute and Oncology Centre, Warsaw, Poland; [19]Department of Haematology, Concord Repatriation General Hospital, University of Sydney, Concord, NSW, Australia; [20]ICON Cancer Care, South Brisbane, QLD, Australia; [21]Department of Dermatology, Hospices Civils de Lyon, Claude Bernard Lyon 1 University, Lyon, France; [22]University Clinic for Dermatology, Johannes Wesling Medical Centre, Minden, Germany; [23]Seattle Genetics, Inc., Bothell, WA, USA; [24]Millennium Pharmaceuticals, Inc., Cambridge, MA, USA, a wholly owned subsidiary of Takeda Pharmaceutical Company Limited; [25]Division of Cancer Medicine, Peter MacCallum Cancer Centre and Sir Peter MacCallum Department of Oncology, The University of Melbourne, Victoria, Australia.

Brentuximab vedotin or physician's choice in CD30-positive cutaneous T-cell lymphoma (ALCANZA): an international, open-label, randomised, phase 3, multicentre trial

H Miles Prince, Youn H Kim*, Steven M Horwitz, Reinhard Dummer, Julia Scarisbrick, Pietro Quaglino, Pier Luigi Zinzani, Pascal Wolter, Jose A Sanches, Pablo L Ortiz-Romero, Oleg E Akilov, Larisa Geskin, Judith Trotman, Kerry Taylor, Stephane Dalle, Michael Weichenthal, Jan Walewski, David Fisher, Brigitte Dréno, Rudolf Stadler, Tatyana Feldman, Timothy M Kuzel, Yinghui Wang, Maria Corinna Palanca-Wessels, Erin Zagadailov, William L Trepicchio, Wenwen Zhang, Hui-Min Lin, Yi Liu, Dirk Huebner, Meredith Little, Sean Whittaker†, Madeleine Duvic†, on behalf of the ALCANZA study group‡*

Prince HM, et al.Lancet.2017;390:555-66.

Response to brentuximab vedotin versus physician's choice by CD30 expression and large cell transformation status in patients with mycosis fungoides: An ALCANZA sub-analysis

Youn H. Kim et al European Journal of Cancer 148 (2021) 411e421

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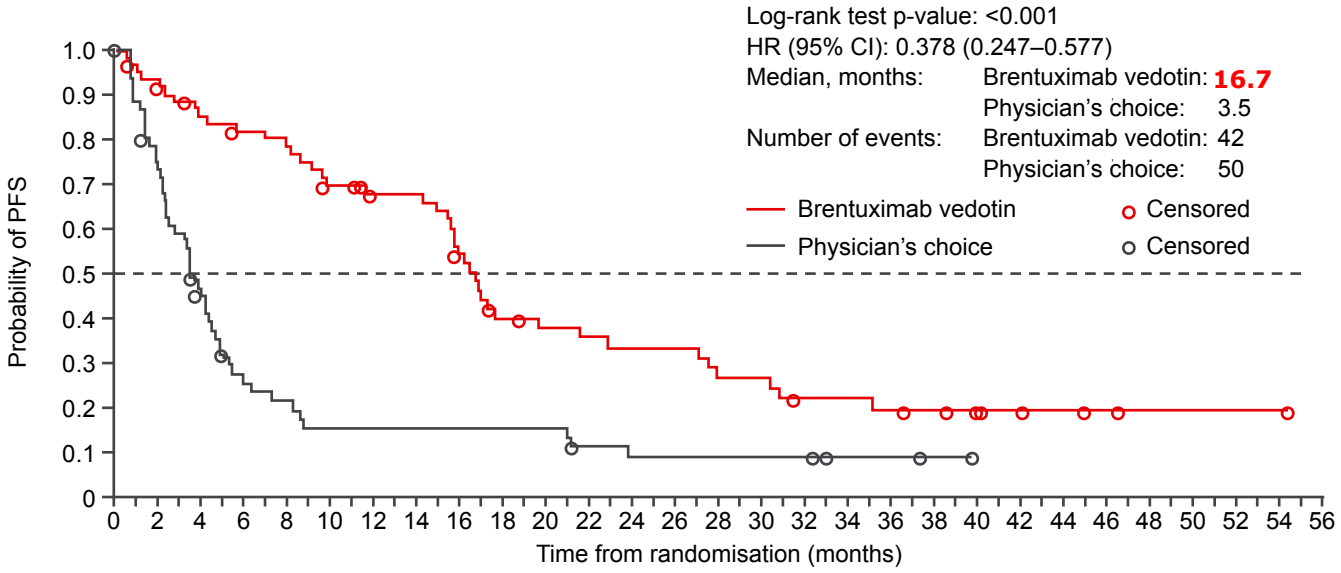
ORR4, best response to treatment, PFS and OS (ITT population)

	Brentuximab vedotin (n=64)	Physician's choice (n=64)	p-value
ORR4 per IRF, n (%)	**35 (54.7)***	**8 (12.5)**	**<0.001**
Best response to treatment per IRF, n (%)			
Overall response (CR + PR)	42 (65.6)	13 (20.3)	<0.001
CR	11 (17.2)	1 (1.6)	0.002
PR	31 (48.4)	12 (18.8)	
SD	10 (15.6)	18 (28.1)	
PD	5 (7.8)	22 (34.4)	
Median PFS per IRF, months†	**16.7**	**3.5**	**<0.001**
3-year OS estimates, % (95% CI)	64.4 (50.7–75.2)†	61.9 (47.3–73.6)‡	
	(HR=0.745; 95% CI: 0.421–1.318)		**0.310**

*Based on additional information provided to the IRF after the May 31, 2016 data cut-off, the IRF determined that 1 patient had not achieved ORR4 as was originally reported; the change in status was determined through a standard IRF adjudication process.
†Median OS follow-up for brentuximab vedotin arm: 48.4 months.
‡Median OS follow-up for PC arm: 42.9 months.
CI, confidence interval; CR, complete response; HR, hazard ratio; IRF, independent review facility; ITT, intent-to-treat; ORR4, objective response rate lasting ≥4 months; OS, overall survival; PC: physician's choice; PD, progressive disease; PFS, progression-free survival; PR, partial response; SD, stable disease.

PFS per IRF (ITT population)

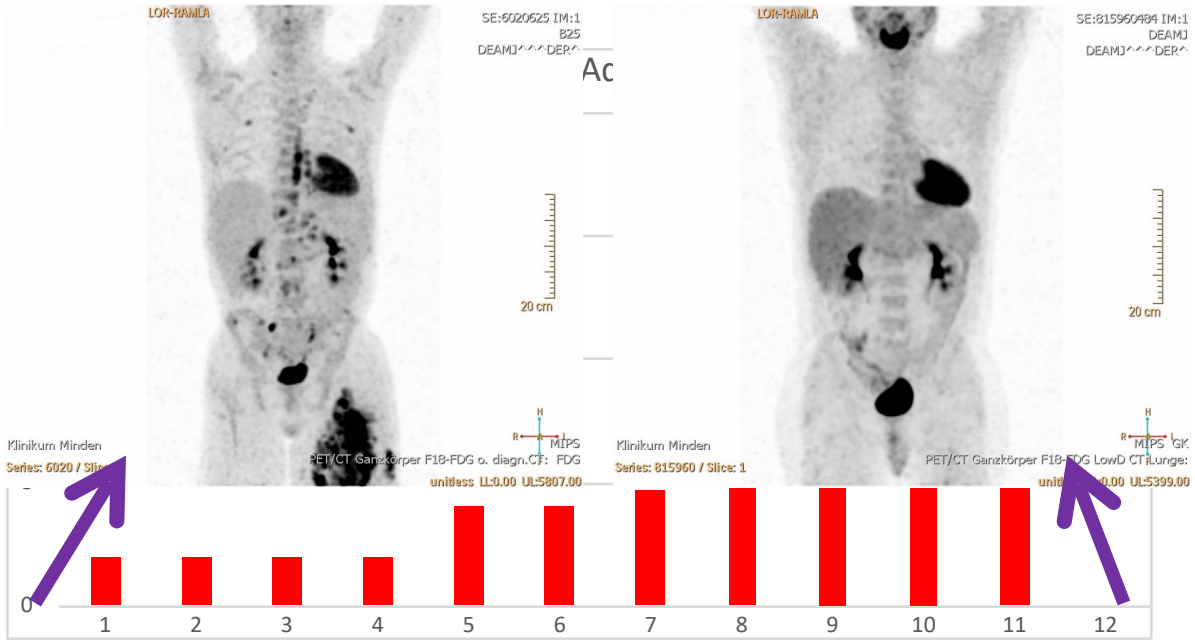


Number of patients at risk:

Brentuximab vedotin	64 59 58 54 51 50 48 47 46 44 40 40 36 35 35 33 27 22 19 18 17 17 16 15 15 15 15 12 12 12 10 9 9 9 9 8 7 7 6 6 4 4 3 3 3 2 1 1 1 1 1 1 1 1
Physician's choice	64 54 42 34 24 17 13 12 11 8 8 8 8 8 8 8 8 8 8 8 8 7 5 5 4 4 4 4 4 4 4 4 4 3 2 2 2 2 1 1

CI, confidence interval; HR, hazard ratio; IRF, independent review facility; ITT, intent-to-treat; PFS, progression-free survival.

CD30-positive, granulomatous Mycosis fungoides



Adcetris®-Infusionen

Brentuximab a novel antibody therapy:real-world use confirms efficacy and tolerability for CD30-positive cutaneous lymphoma

S. Engelina iD , M. Saggu, J. Yoo, F. Shah, A. Stevens,
C. Irwin, S. Chaganti and J.J. Scarisbrick BJD 2020 182, 788-818

Patient, sex, age at diagnosis	Diagnosis	Stage prior to BV	BV cycles, n	Weeks, n	CD30%	Response	Previous systemics, n
1, F, 57	MF	IIB	4	12	10	SD	3
2, M, 60	MF	IIB	9	27	30	CR	3
3, M, 60	MF	IIB	13	39	27	PR	3
4, F, 57	MF	IIIB	7	21	10	CR	4
5, M, 76	MF	IIIB	16	48	100	CR	3
6, M, 47	MF	IVA2	5	15	5	PR	4
7, M, 43	MF	IVA2	9	27	10	PD	4
8, M, 48	MF	IVA2	10	30	100	CR	2
9, F, 50	MF	IVA2	16	48	1·5	PR	1
10, M, 59	pcALCL	T3N0M1	4	12	100	PD	2
11, M, 39	pcALCL	T2cN1M0	6	18	100	CR	1
12, M, 41	pcALCL	T3aN2M0	8	24	100	CR	2

F, female; MF, mycosis fungoides; SD, stable disease; M, male; CR, complete response; PR, partial response; PD, disease progression; pcALCL, primary anaplastic large-cell lymphoma.

Patient characteristics, CD30 status, number of cycles of brentuximab vedotin (BV) received and response achieved

Combination therapy out of 26 patients , median age 67 years,

Identified:

5 patients received due to progression under BV skin directed therapies

MF
(n=4)
PC-CD4+ SM-PTL

Response	n	%
ORR	22/26	84,6
CR	6/26	30.8
PR	14/26	53.8
SD	4/26	11.5
PD	1/26	3.8

Brentuximab vedotin
- 1,8 or 1,2 mg/kg
- Every 3 week (extension of the intervals possible)

PD

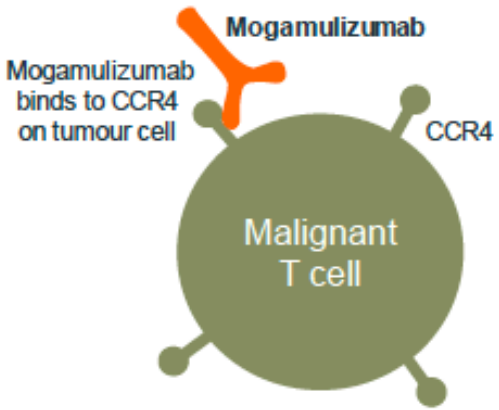
plus

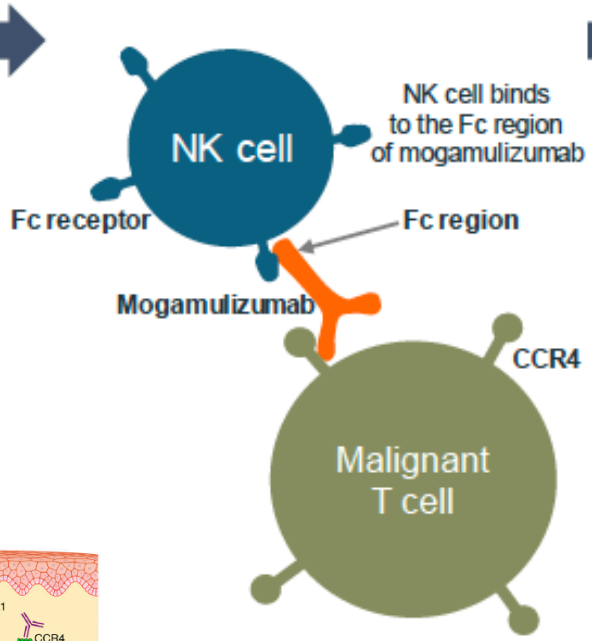
Skin directed Therapies:
- Tumorexzision
- Lokale Radiation
- PUVA

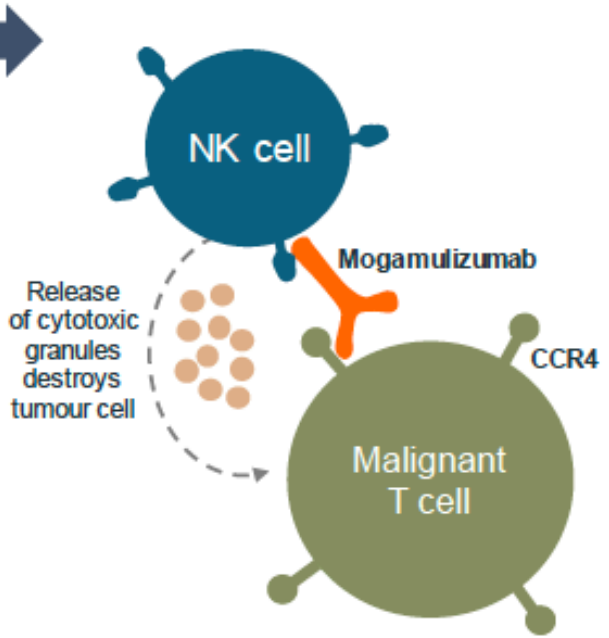
SD / PR (median 7 month)
(without additional toxicity)

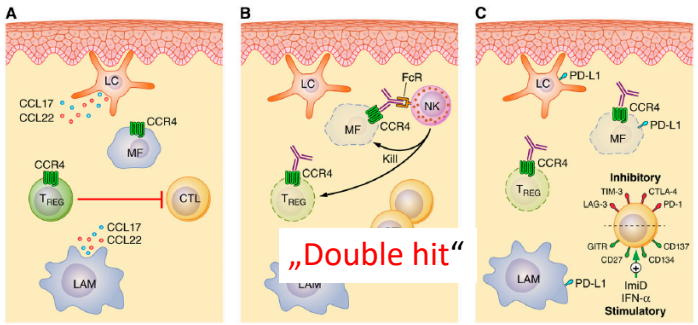
R. Stranzenbach and R. Stadler JDDG 2021

Mogamulizumab: a humanized anti-CCR4 antibody with a defucosylated Fc region









Targets receptor CCR4

Mogamulizumab induces ADCC by binding to CCR4 on tumour cells

NK cells bind to Fc region of mogamulizumab on tumour cells inducing the release of cytotoxic granules and tumour-cell lysis

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Mogamulizumab

Response outcomes

	Mogamulizumab	Vorinostat
ORR[a,b], n/N (%)	**52/186 (28)**	**9/186 (5)**
MF[c]	**22/105 (21)**	**7/99 (7)**
SS[b]	**30/81 (37)**	**2/87 (2)**
Stage IB/IIA	7/36 (19)	5/49 (10)
Stage IIB	5/32 (16)	1/23 (4)
Stage III	5/22 (23)	0/16 (0)
Stage IV	35/96 (36)	3/98 (3)
DOR, median, months	**14**	**9**
MF	13 (n=22)	9 (n=7)
SS	17 (n=30)	7 (n=2)
ORR[a] n/N (%) mogamulizumab after crossover	**41/136 (30)**	

[a]ORR is the percentage of patients with confirmed CR or confirmed PR; [b]P<0.0001; [c]P=0.004.

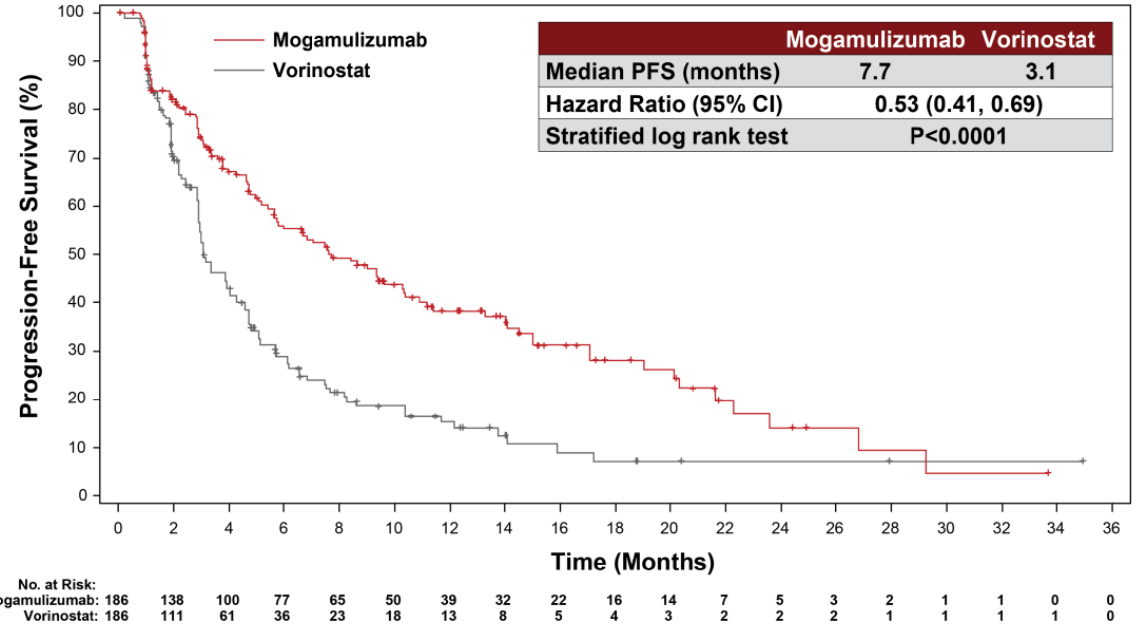
- Median relative dose intensities for mogamulizumab were 97.5% and for vorinostat was 95.1%

ORR=overall response rate; DOR=duration of response.

Dose: The recommended Dose is 1 mg/kg Mogamulizumab as intravenous infusion over at least 60 minutes
Application on day 1, 8, 15 und 22 for the first 28-day cycle.
Followed every two weeks on day 1 and 15 for the following 28-day cycle.

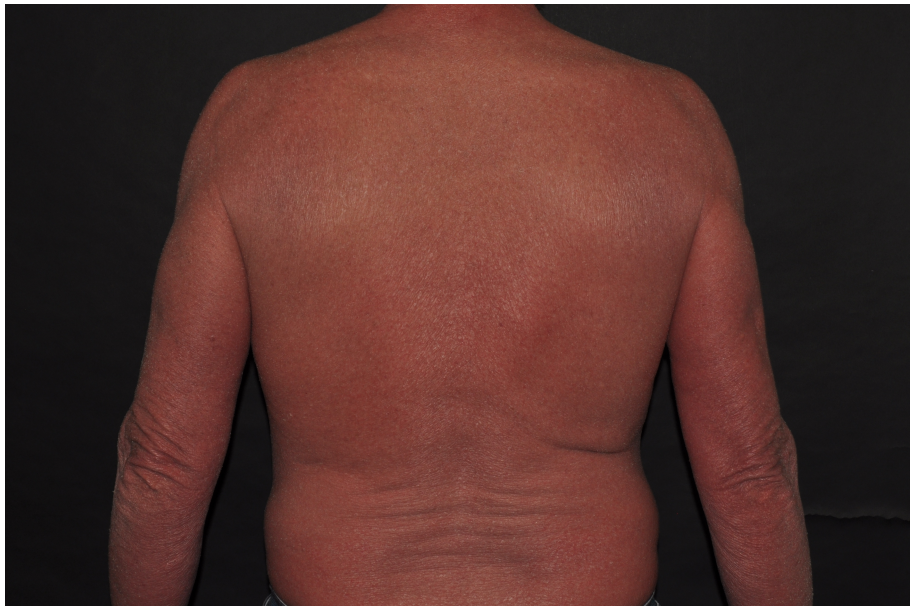
Mogamulizumab

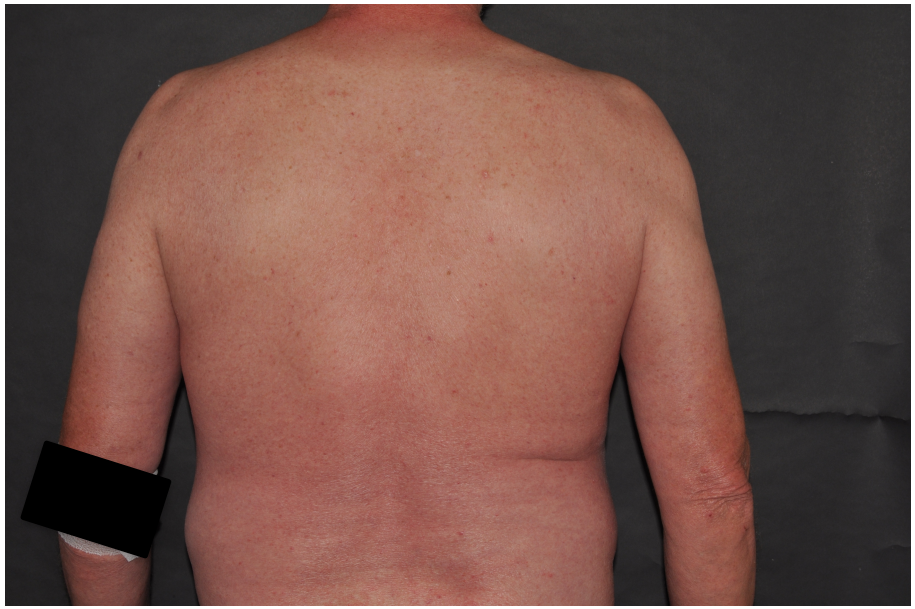
Primary endpoint: Progression-free survival (PFS)



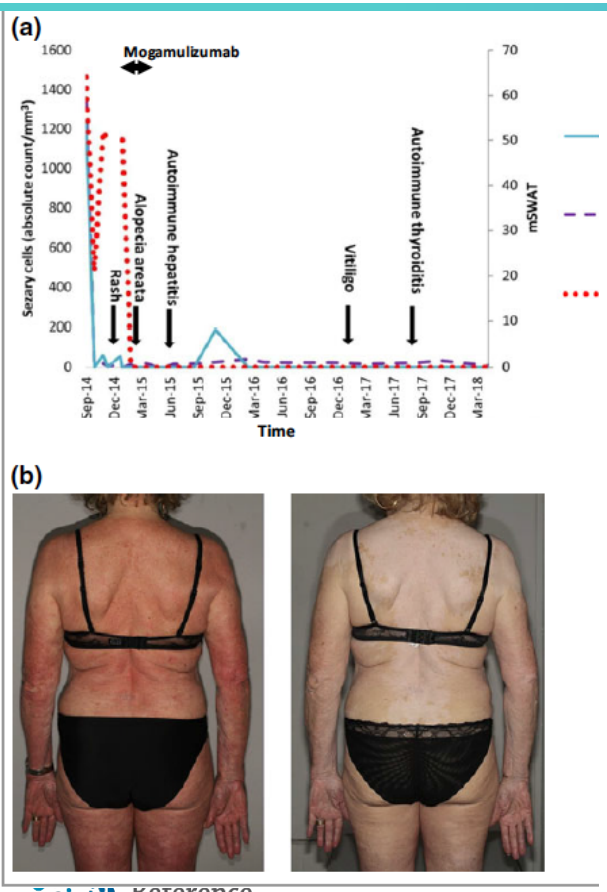
	Mogamulizumab	Vorinostat
Median PFS (months)	7.7	3.1
Hazard Ratio (95% CI)	0.53 (0.41, 0.69)	
Stratified log rank test	P<0.0001	

Sézary syndrome





Mogamulizumab can induce autoimmunity with long lasting effects



- 2 out of 21 patients treated at Saint-Louis Hospital developed autoimmunity
- Both patients were treated long-term either with alemtuzumab or gemcitabine and then progressed
- Patient 1 cleared in the blood compartment but not in the skin and received additional doxorubicin, is now three years free of disease
- Patient 2 developed autoimmune haemolytic anaemia, is now 2 years free of disease
- **The depletion of CCR4-expressing Tregs is believed to activate cytotoxic T lymphocytes**

Association of autoimmunity and long-term remission in patients with Sézary Syndrome treated with mogamulizumab *P. Bonnet Br J Dermatol 2019*

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Available online at www.sciencedirect.com

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journal homepage: www.ejcancer.com

Review

Maintenance therapy in patients with mycosis fungoides or Sézary syndrome: A neglected topic

Rudolf Stadler [a,*], Julia J. Scarisbrick [b]

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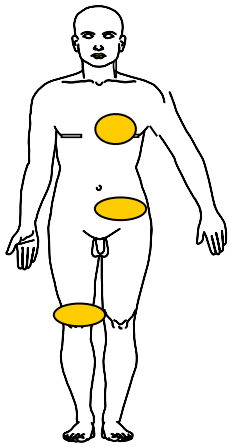
[b] University Hospital Birmingham, Birmingham, United Kingdom

Received 2 August 2020; received in revised form 28 September 2020; accepted 2 October 2020

Concept: Maintenance Therapy

Stage IA

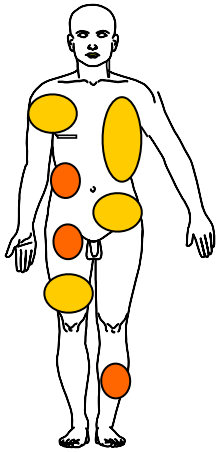
I UVB 311; PUVA
Chlormethine Gel
Steroids



Remission
Observation

Stage IB

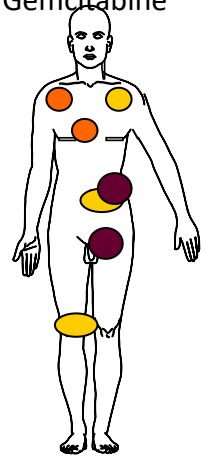
PUVA
+ Interferon α
Bexarotene
TSEB



Remission
e.g. PUVA-Interval Therapy, or Bexarotene or Chlormethin Gel Resminostat???

Stage IIB

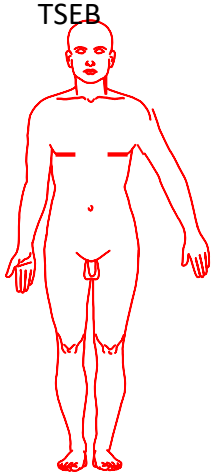
as IB +
Radiatio or
Brentuximab Vedotin
TSEB
Gemcitabine



Remission
e.g. PUVA-Interval Therapy or Bexaroten or Interferon *Resminostat?*

Stage III

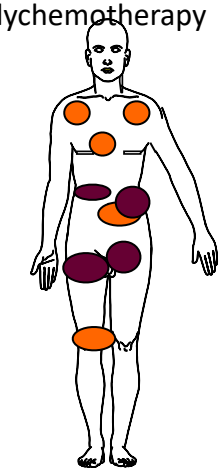
PUVA
Photophereses
+/- IFN α
Bexaroten
Mogamulizumab
TSEB



Remission
Bexaroten, IFN-α Photopheresis *Resminostat?*

Stage IV

Photophoreses
Mogamulizumab
Brentuximab Vedotin
TSEB
AlloTransplant
Polychemotherapy



Remission
Bexarotene, Interferon, *Resminostat??*

Patch Plaques Tumor

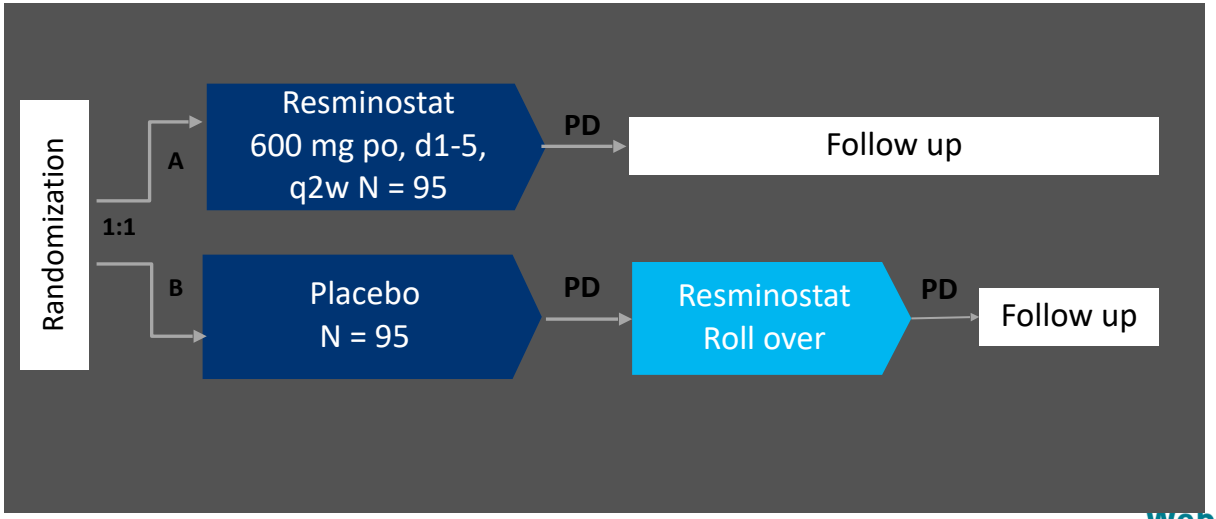
European Reference Network
for rare or low prevalence complex diseases
Network Hematological Diseases (ERN EuroBloodNet)

Webinars
Cutaneous Lymphoma
EuroBloodNet Topic on Focus
Patients' Organizations

Study Design

RESMAIN

Patients:	• Mycosis fungoides (Stage IIB-IVB) or Sézary Syndrome • In disease control (CR;PR;SD) 2-12 weeks after systemic therapy • Target N = *190* patients
Endpoints:	• Primary: PFS • Key secondary: Time to symptom worsening (VAS itching) • Secondary: TTP, TTNT, PFS2, PFS3, ORR, DOR, OS, HrQoL, Safety



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EORTC
and Treatment of Cancer
The future of cancer therapy

Cutaneous Lymphoma: New therapeutic developments

EuroBlood Net Talk

19/07/2021

European Reference Network
for rare or low prevalence complex diseases
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Webinars
Cutaneous Lymphoma
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Agenda

- EORTC/ CTLF Studies : Sponsor: EORTC
  - Completed study
    - 1652 (PARCT) ClinicalTrials.gov : NCT03357224
  - Upcoming studies
    - 1754 (REACH) ClinicalTrials.gov : NCT04218825
    - 1820 (MOGAT) ClinicalTrials.gov : NCT04128072
    - 1636 (PROMPT) ClinicalTrials.gov : open

Completed EORTC/CLTF study

1652-PARCT ClinicaTrials.gov: NCT03357224 Sponsor: EORTC

Phase II trial of atezolizumab (anti-PD-L1) in the treatment of stage IIb-IV mycosis fungoides/Sézary syndrome patients relapsed/refractory after a previous systemic treatment

- **Primary objective**

To determine the antitumor activity of atezolizumab for patients with refractory or relapsed advanced stages of mycosis fungoides and Sézary syndrome, assessed in terms of the overall response rate, according to EORTC-ISCL-USCLC criteria

- **Translational research**

Effect of atezolizumab on PD-1/PD-L1 expression, the tumor infiltrating lymphocyte populations and its activation in the skin.

Upcoming EORTC CLTF studies

1754 REACH

ClinicalTrials.gov : NCT04218825 Sponsor: EORTC

Study to determine the aetiology of chlormethine gel induced-skin drug reaction in early stage mycosis fungoides cutaneous T cell lymphoma (MF-CTCL)

- **Primary objective**

To determine activity of the drug as measured by response rate in patients treated with CL gel without skin drug reaction

To determine activity of the drug as measured by response rate in patients treated with CL gel with skin drug reactions and subsequent reduced CL gel application frequency

- **Translational research**

To discriminate between irritant and allergic contact dermatitis as a side effect to CL gel so that guided management of the skin reaction can occur

To assess malignant T-cell behaviour in case of skin reaction to CL gel

Upcoming EORTC/CLTF studies

1820 MOGAT **ClinicalTrials.gov : NCT04128072 Sponsor: EORTC**

Open-Label, phase II, Multi-Center, study of Anti-CCR4 Monoclonal Antibody (mogamulizumab) Plus Total Skin Electron Beam therapy (TSEB) in patients with stage IB-IIB Cutaneous T-Cell Lymphoma

- **Primary objective**

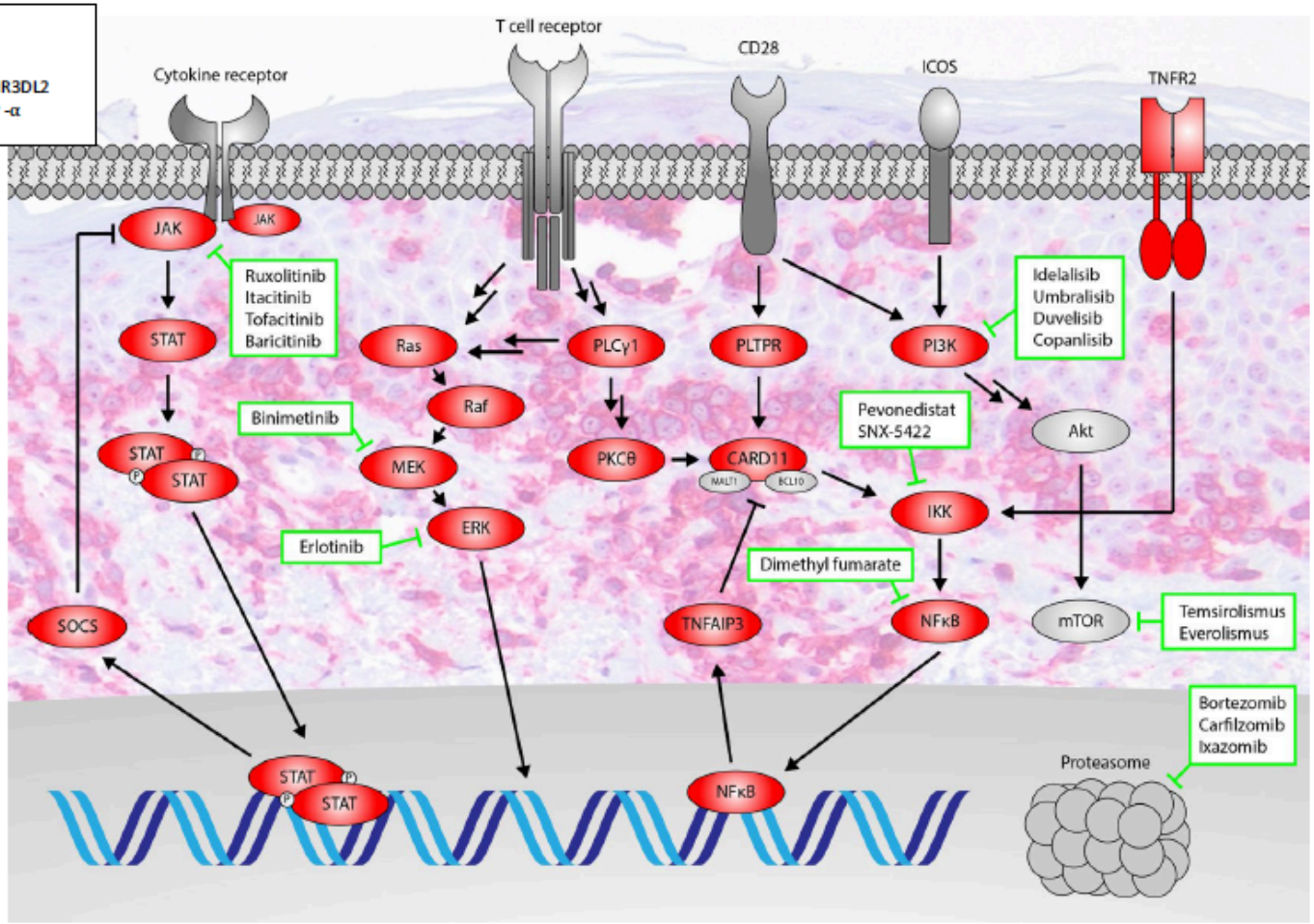
To evaluate the progression free survival rate at 48 weeks (according to EORTC-ISCL-USCLC criteria) of anti-CCR4 monoclonal antibody (mogamulizumab) and TSEB in IB-IIB cutaneous T-cell lymphoma

- **Translational research**

To identify factors in the skin and/or blood that can predict response or resistance to mogamulizumab treatment alone or the combination of mogamulizumab + TSEB

Future Directions

AB against surface molecules:
- Brentuximab vedotin -> CD30
- Mogamulizumab -> CCR4
- IPH410 -> CD158k/KIR3DL2
- e.g. Hu5F9-G4 -> CD47-SIRP -α
- Avelumab -> PD-L1

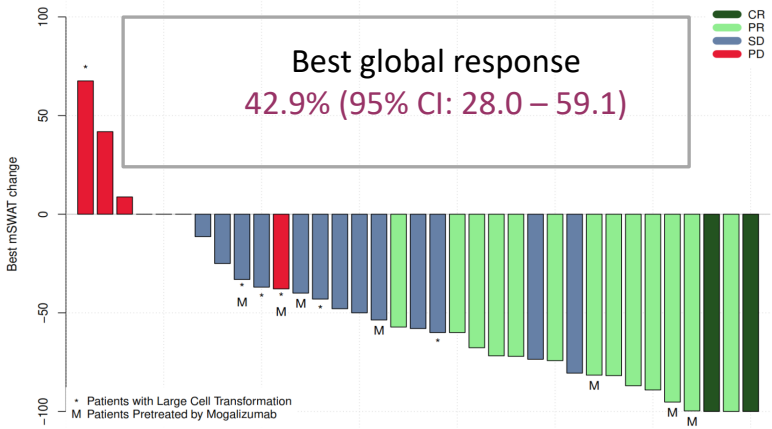


R.Stadler et al Experimental Dermatology. 2020;29:1062–1068.

IPH4102, a first-in-class anti-KIR3DL2 monoclonal antibody, in patients with relapsed or refractory cutaneous T-cell lymphoma: an international, first-in-human, open-label, phase 1 trial

Martine Bagot, Pierluigi Porcu, Anne Marie-Cardine, Maxime Battistella, Basem M William, Maarten Vermeer, Sean Whittaker, Federico Rotolo, Caroline Ram-Wolff, Michael S Khodadoust, Armand Bensussan, Carine Paturel, Cecile Bonnafous, Helene Sicard, Hatem A Azim Jr, Youn H Kim

Lancet Oncol 2019



Enhancing antitumor immunity through checkpoint blockade as therapeutic strategy in T-cell lymphomas

PD-1 inhibition in MF/SS : OR 15-38%, CR 0-8%, 1 year PFS 65%

Pembrolizumab in Relapsed and Refractory Mycosis Fungoides and Sézary Syndrome: A Multicenter Phase II Study

JCO 2019

Michael S. Khodadoust, MD, PhD[1]; Alain H. Rook, MD[2]; Pierluigi Porcu, MD[3]; Francine Foss, MD[4]; Alison J. Moskowitz, MD[5]; Andrei Shustov, MD[6]; Satish Shanbhag, MBBS, MPH[7]; Lubomir Sokol, MD, PhD[8]; Steven P. Fling, PhD[9]; Nirasha Ramchurren, PhD[9]; Robert Pierce, MD[9]; Asa Davis, PhD[9]; Richard Shine, PharmD, BCPS[9]; Shufeng Li, MS[1]; Sophia Fong[1]; Jinah Kim, MD, PhD[1]; Yi Yang, MS[9]; Wendy M. Blumenschein[10]; Jennifer H. Yearley, DVM, PhD, DACVP[10]; Biswajit Das, PhD[11]; Rajesh Patidar, MS[11]; Vivekananda Datta, MD, PhD[11]; Erin Cantu[11]; Justine N. McCutcheon[11]; Chris Karlovich, PhD[11]; P. Mickey Williams, PhD[11]; Priyanka B. Subrahmanyam, PhD[1]; Holden T. Maecker, PhD[1]; Steven M. Horwitz, MD[5]; Elad Sharon, MD, MPH[12]; Holbrook E. Kohrt, MD, PhD[1]†; Martin A. Cheever, MD[9]; and Youn H. Kim, MD[1]

- Treatment responses did not correlate with expression of PD-L1, total mutation burden, or an interferon-g gene expression signature.
- Pembrolizumab demonstrated significant antitumor activity with durable responses and a favorable safety profile

1. Stage adapted therapy in close contact with the patient
2. Antibody based therapies improve CTCL therapy
3. Maintenance therapy as an important concept
4. A holistic approach to patient care
5. Clinical studies to improve the field

Lymphoma: a 21 year "affair"

- 2000 Delayed Diagnostic
- Chemo, Radio, Interferon….
- 2003 Autologous transplant
- 2005, Allogeneic Transplant
- Life after a transplant: A different Story
  - 10 years + of cGVHD
    - Scleroderma, Fasciitis, eyes dryness
  - Side effects from prior treatments: cardio (5 stents…)

France Lymphome Espoir

Patients Advocacy

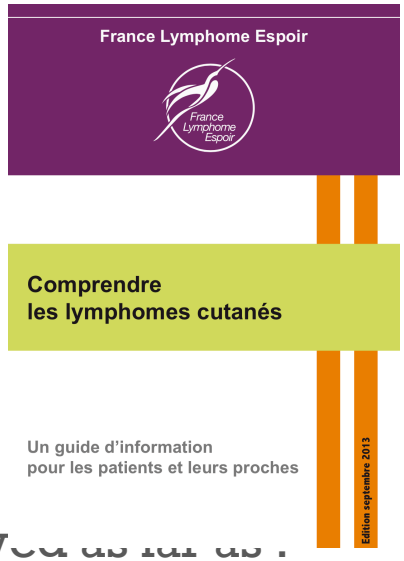
- Founded a Non profit organisation, born in 2006
- Born for observation: No Info in France and ignorance
- Our missions are:
  - Information, education et communication for:
  - Provide any type of support during and after treatments in order to facilitate life with Lymphoma
  - Research
  - Advocate for patients with authorities and regulators
- Board member of the Lymphoma Coalition and LC Europe
  - Organization network, experience sharing (CLF, …)
  - International collaborative work (EBMT, EHA, EORTC…)

LYMPHOMA COALITION

France Lymphome Espoir

CL: Support and challenges

- Support for patients via:
  - Dedicated phone line
  - Forum
  - Meetings
  - Website information
  - brochures



- Challenges:
  - Clearly Cutaneous lymphomas are underserved as far as :
    - Knowledge of the disease
    - Diagnostic process (can take years)
    - Hematology or dermatology?
    - Treatment options and burden
    - Clinical trials

- Social/professional stigmatization

Merger

- We recently merged with the French CLL organization SILLC
- We are now known as ELLyE

France Lymphome Espoir