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The central graphic features a wireframe globe with a blue and white color scheme. It is surrounded by a network of glowing blue nodes and lines, with several colorful, faceted geometric shapes (polyhedrons) in shades of red, green, and blue scattered around. The text 'EHA 2021 VIRTUAL' is prominently displayed in the center.

# EHA 2021 VIRTUAL

| **Connecting Hematology - For Clinical and Research Excellence**

# Conclusiones de Hematogeriatria

**Raul Cordoba, MD, PhD – Introducción**

**Alberto Lopez, MD – Linfomas & LLC**

**Javier Cornago, MD – Leucemias agudas**

**Raquel Mata, MD – Neoplasias mieloproliferativas crónicas Ph negativas**

**Elham Askari, MD – Mieloma múltiple**

Fundacion Jimenez Diaz University Hospital, Madrid, SPAIN

July 20, 2021



# Follow-up day “Ageing & Hematology”: Best of Theme Session in Geriatric hematology

**Raul Cordoba, MD, PhD**

Fundacion Jimenez Diaz University Hospital, Madrid, SPAIN

July 9, 2021



# DISCLOSURES

**Roche** (Speaker, Travel & Accommodation)

**Janssen** (Speaker, Advisory board, Travel & Accommodation)

**Abbvie** (Speaker, Advisory board, Travel & Accommodation)

**Astra-Zeneca** (Speaker, Advisory board)

**Celgene/BMS** (Speaker, Advisory board, Travel & Accommodation)

**Gilead/Kite** (Speaker, Advisory board, Travel & Accommodation)

**Incyte** (Advisory board)

**Takeda** (Speaker, Advisory board, Travel & Accommodation)

**Kyowa-Kirin** (Advisory board)

**ADCT** (Advisory board)

**Pfizer** (Research grant, Travel & Accommodation)

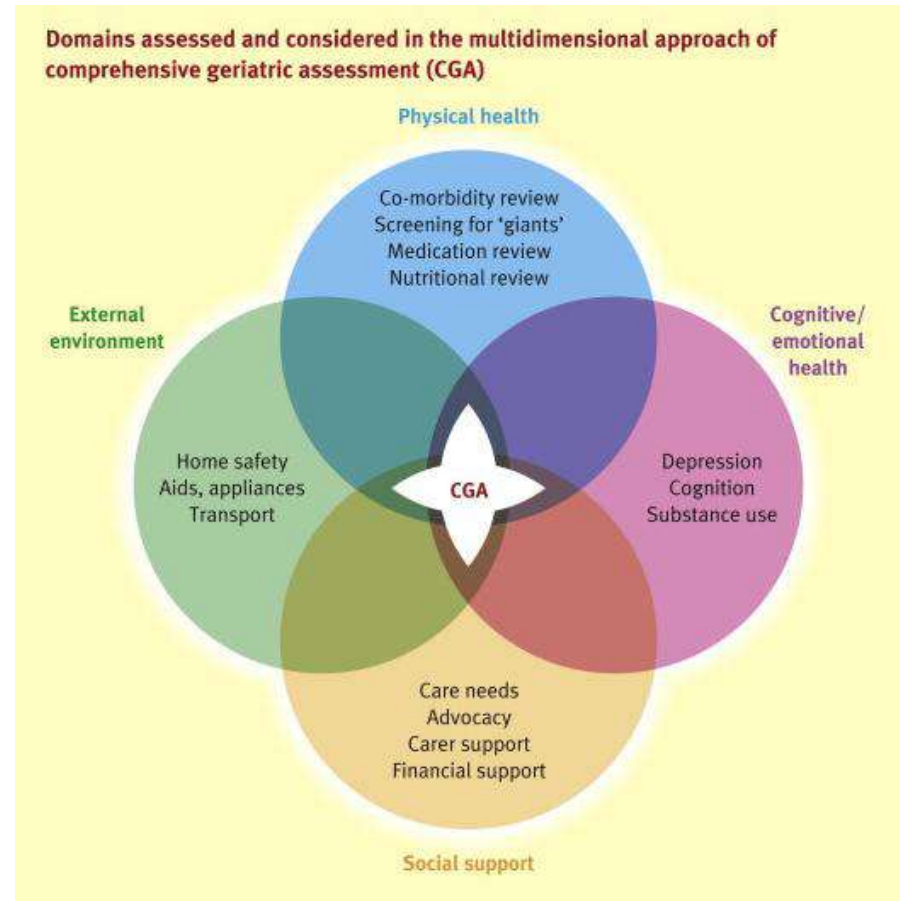


# | Learning objectives

1. To discover the geriatric assessment as a multidisciplinary and multidimensional tool in older adults to evaluate person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances
2. To integrate the geriatric assessment in the development of a treatment plan and follow-up
3. To investigate safety and efficacy features in older adults with new agents



# Geriatric assessment



Source: Stott et al. MEDICINE IN OLDER ADULTS | VOLUME 45, ISSUE 1, P1-5, JANUARY 01, 2017

# Selected abstracts with the keyword “geriatric”

Abstract ID EP513

**COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA**

Abstract ID EP522

**THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.**



## (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

### INTRODUCTION

Diffuse Large B-cell lymphoma is the most common subtype of non-Hodgkin lymphoma in the elderly. Some elderly patients can not tolerate the standard dose of R-CHOP due to age, poor physical condition, and severe complications. At present, the decision to treat a patient is made by clinical experience of clinicians, which is subjective. It is a major challenge to identify which patients can tolerate the standard dose of R-CHOP regimen in our clinical work. Comprehensive Geriatric Assessment has been proposed as an objective tool for supporting treatment decision by age, evaluating activity of daily living, Instrumental activities of daily Living, and Cumulative Illness Rating Score for Geriatrics (CIRS-G). However, It is still unknown whether comprehensive geriatric assessment was more effective than clinical judgment to guide the treatment in elderly patients with diffuse large B-cell lymphoma.

Bai JF et al. EP513. EHA2021 Virtual



## (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

### OBJECTIVE(S)

This prospective, observational, controlled cohort trial aims to investigate whether comprehensive geriatric assessment (CGA) is more effective than clinical judgment to guide the treatment in elderly patients with diffuse large B cell lymphoma (DLBCL) in China.

Bai JF et al. EP513. EHA2021 Virtual



## (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

### METHOD(S)

152 patients in Beijing Hospital were enrolled if they fulfilled the following inclusion criteria: 1) age  $\geq 60$  years; 2) newly diagnosed of DLBCL according to WHO classification by two independent pathologists; 3) no previous history of hematologic malignancies; 76 patients will received CGA-driven therapy at CGA-guided therapy group (intervention), and 76 patients will received therapy based on clinical judgement at clinical judgement-guided therapy group (control). The 2-year Overall Survival (OS), Progression Free Survival (PFS), Overall Response Rate (ORR) and toxicities were analyzed between the two groups.

Bai JF et al. EP513. EHA2021 Virtual



# (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

The classified criteria of patients according to comprehensive geriatric assessment<sup>↵</sup>

	CGA category <sup>↵</sup>		
	Fit <sup>↵</sup>	Unfit <sup>↵</sup>	Frail <sup>↵</sup>
ADL <sup>↵</sup>	6 <sup>↵</sup>	5 <sup>↵</sup>	<5 <sup>↵</sup>
IADL <sup>↵</sup>	And 8 <sup>↵</sup>	Or 6~7 <sup>↵</sup>	Or <6 <sup>↵</sup>
MCIRS-G <sup>↵</sup>	And no comorbidity score 3~4 (and <5 comorbidity score 2) <sup>↵</sup>	Or no comorbidity score 3~4 (and 5~8 comorbidity score 2) <sup>↵</sup>	Or ≥1 comorbidity score 3~4 (or >8 comorbidity score 2) <sup>↵</sup>
Age <sup>↵</sup>	And <80 years <sup>↵</sup>	Or ≥80 years fit <sup>↵</sup>	Or ≥80 years unfit <sup>↵</sup>

Bai JF et al. EP513. EHA2021 Virtual



# (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

## RESULT(S)

**Patients:** Patients baseline characteristics were shown in Table 1. The choice of therapy were shown in Table 2

Table 1 baseline characteristics

	group	Intervention(n=76) n(%)	control(n=76) n(%)	$\chi^2$	P value
Sex	male	44(57.9%)	47(61.8%)	0.246	0.620
	female	32 (42.1%)	29(38.2%)		
ECOG	0-1	61(80.3%)	61(80.3%)	0.000	1.000
	$\geq 2$	15(19.7%)	15(19.7%)		
Ann Arbor stage	I-II	23(30.3%)	33(43.4%)	2.827	0.093
	III-IV	53(69.7%)	43(56.6%)		
B symptoms	Yes	30(39.5%)	27(35.5%)	0.253	0.615
	No	46(60.5%)	49(64.5%)		
Bone marrow involvement	Yes	11(14.5%)	14(18.4%)	0.431	0.512
	No	65(85.5%)	62(81.6%)		
Extranodal disease	0-1	31(40.8%)	30(39.5%)	0.027	0.869
	$\geq 2$	45(59.2%)	46(60.5%)		
LDH	<245	39(51.3%)	58(76.3%)	10.285	0.001
	$\geq 245$	37(48.7%)	18(23.7%)		
IPI	0-2	24(31.6%)	34(44.7%)	2.788	0.095
	3-5	52(68.4%)	42(55.3%)		
Pathological subtypes	GCB	23(31.9%)	18(24.3%)	1.049	0.306
	Non-GCB	49(68.1%)	56(75.7%)		
Double expression	Yes	26(37.7%)	20(35.7%)	0.051	0.821
	No	43(62.3%)	36(64.3%)		

Table 2 The choice of therapy between the two groups

Group	N	intervention		control		
		standard dose R-CHOP therapy	reduced dose of R-CHOP therapy or R-COP therapy	N	standard dose R-CHOP therapy	reduced dose of R-CHOP therapy or R-COP therapy
Fit	41	41 (100%)	0 (0.0%)	41	36 (87.8%)	5 (12.2%)
unfit	4	0 (0.0%)	4 (100.0%)	4	0 (0.0%)	4 (100.0%)
frail	31	0 (0.0%)	31 (100.0%)	31	4 (12.9%)	27 (87.1%)
Total	76	41 (53.9%)	35 (46.1%)	76	40 (52.6%)	36 (47.4%)

Bai JF et al. EP513. EHA2021 Virtual



# (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

**Response and survival:** The overall response rate and overall survival rate between two groups were shown in Table3-4.

Table 3 The response and survival between the two groups

	intervention	control	$\chi^2$	P value
ORR	94.7% (72/76)	81.6% (62/76)	5.104	0.024
CR	73.7% (56/76)	57.9% (44/76)	4.209	0.040
2-year OS	80.9%	63.0%	7.348	0.007
2-year PFS	72.7%	52.7%	10.768	0.001

Table 4 The response and survival between the subgroups

	Fit		$\chi^2$	P value	unfit/frail		$\chi^2$	P value
	intervention	control			intervention	control		
ORR	100% (41/41)	90.2% (37/41)	-	0.116	88.6% (31/35)	71.4% (25/35)	3.214	0.073
CR	82.9% (34/41)	58.5% (24/41)	5.891	0.015	62.9% (22/35)	57.1% (20/35)	0.238	0.626
2-year OS	86.9%	62.1%	16.440	0.000	73.9%	64.3%	0.005	0.944
2-year PFS	76.5%	62.9%	12.678	0.000	70.1%	42.3%	1.172	0.279

Bai JF et al. EP513. EHA2021 Virtual



## (EP513) COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN ELDERLY PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

### CONCLUSION(S)

Using CGA to guide therapy for elderly patients with DLBCL can significantly improve the clinical efficacy and survival rate, and not increase the toxic effect.

Bai JF et al. EP513. EHA2021 Virtual



## (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

### INTRODUCTION

In aging society, the number of elderly patients with diffuse large B cell lymphoma (DLBCL) is increasing. The elderly patients cannot be managed in the same way as the young patients because of their various comorbidities and levels of frailty. However, the establishment of simple geriatric assessment tool to predict prognosis and management in treatment has rarely been reported in DLBCL. the Geriatric 8 (G8) is a simpler and less time-consuming geriatric screening tool for predicting OS, mainly in patients with solid cancers<sup>1,2</sup>.

Oiwa K et al. EP522. EHA2021 Virtual



## (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

### OBJECTIVE

The aim of this study was to verify the prognostic impact of the G8 in elderly DLBCL patients, using a Cox hazards model with restricted cubic spline (RCS) model which is more suitable for reflecting the real-world practice.

Oiwa K et al. EP522. EHA2021 Virtual



# (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

## METHODS

We conducted a retrospective, multicenter analysis of elderly DLBCL patients ( $\geq 65$  years) who received standard therapy between 2007 and 2017 at three tertiary institutions in Japan. Patients treated with the standard regimen as first-line therapy were enrolled in this study. The exclusion criteria were transformed DLBCL, methotrexate-associated lymphoproliferative disorders, central nervous system involvement or undergoing treatment besides standard regimen. The standard regimen was defined as (R-) CHOP regimen (rituximab, cyclophosphamide, adriamycin [ADR], vincristine, and prednisolone) and (R-) THP-COP regimen (the same as CHOP including the doses, except tetrahydropyranyl adriamycin replaced ADR) in

this study. The end point was the impact of the G8 on OS, which was defined as the interval from the date of the diagnosis to the date of all-cause death or the last follow-up visit. A multivariate Cox proportional hazards model was used to identify the predictors that were statistically associated with OS (Table 1 and 2). Non-linear regression model with RCS was used to assess the presence of a non-linear relationship between the G8 score and OS (Fig.1). Diagnostic performance was assessed by receiver operating characteristic (ROC) analysis. The optimal G8 cutoff scores for OS were identified by ROC analysis using the Youden index (Fig.2). Survival curves for each group were estimated using the Kaplan-Meier method, and a comparison between risk groups was performed using the log-rank test (Fig.3).

Oiwa K et al. EP522. EHA2021 Virtual



# (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

## RESULTS

Table 1. Patient characteristics at the diagnosis in survivor and non-survivor patients

	All patients (N = 398)	Deceased group (n = 154)	Survivor group (n = 244)	P value
Age, y - median, range	77 (65–96)	78 (65–96)	76 (65–90)	<0.001
Male - n (%)	194 (48.7)	82 (53.2)	112 (45.9)	0.181
ECOG PS ≥2 - n (%)	133 (33.4)	87 (56.5)	46 (18.9)	<0.001
Extranodal sites ≥2 - n (%)	142 (35.7)	67 (43.5)	75 (30.7)	0.010
Ann Arbor Stage III/IV - n (%)	272 (68.3)	128 (83.1)	144 (59.0)	<0.001
Elevated LDH (>ULN) - n (%)	265 (66.6)	123 (79.9)	142 (58.2)	<0.001
Serum albumin (g/dl) - median, range	(0.6–5.1)	3.2 (0.6–4.7)	3.6 (1.1–5.1)	<0.001
IPI - n (%)				
Low (0, 1)	69 (17.3)	7 (4.5)	62 (25.4)	
Low intermediate (2)	70 (17.6)	18 (11.7)	52 (21.3)	<0.001
High intermediate (3)	88 (22.1)	34 (22.1)	54 (22.1)	
High (4, 5)	171 (43.0)	95 (61.7)	76 (31.2)	
Bulky mass - n (%)	82 (20.6)	38 (24.7)	44 (18.0)	0.126
B symptoms - n (%)	141 (35.4)	68 (44.2)	73 (29.9)	0.005
CCI <sup>3</sup> - n (%)				
0	137 (34.4)	37 (24.0)	100 (41.0)	
1, 2	171 (43.0)	71 (46.1)	100 (41.0)	0.002
3, 4	68 (17.1)	35 (22.7)	33 (13.5)	
≥5	22 (5.5)	11 (7.2)	11 (4.5)	
GNRI <sup>4</sup> - n (%)				
Score - median, range	90.8 (28.6–117.6)	86.4 (28.6–108.7)	94.6 (51.5–117.6)	<0.001
No risk (>98)	109 (27.4)	21 (13.6)	88 (36.1)	
Mild (92–98)	79 (19.8)	23 (14.9)	56 (23.0)	<0.001
Moderate (82 to <92)	107 (26.9)	50 (32.5)	57 (23.3)	
Severe (<82)	103 (25.9)	60 (39.0)	43 (17.6)	
Geriatric 8 - median, range	11 (2–17)	9 (2–16)	12 (3–17)	<0.001

Oiwa K et al. EP522. EHA2021 Virtual



## (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

**Table 2. Cox proportional hazard analysis for clinical factors associated with overall survival**

	Univariate analysis			Multivariate analysis		
	HR	95% CI	P value	HR	95% CI	P value
Male, sex	1.220	0.888-1.677	0.220	1.554	1.116-2.163	0.009
IPI, score	1.763	1.533-2.029	<0.001	1.469	1.240-1.741	<0.001
Bulky mass	1.453	1.006-2.099	0.046	0.968	0.664-1.411	0.866
B symptoms	1.760	1.279-2.423	<0.001	0.966	0.675-1.382	0.849
CCI, score	1.232	1.136-1.336	<0.001	1.086	0.986-1.196	0.094
GNRI, score	0.966	0.956-0.976	<0.001	0.992	0.978-1.005	0.240
G8, score	0.797	0.761-0.835	<0.001	0.854	0.808-0.902	<0.001

Oiwa K et al. EP522. EHA2021 Virtual

# (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

Figure 1. Association between G8 scores and overall survival using a covariate-adjusted Cox hazards model with restricted cubic spline with 4 knots.

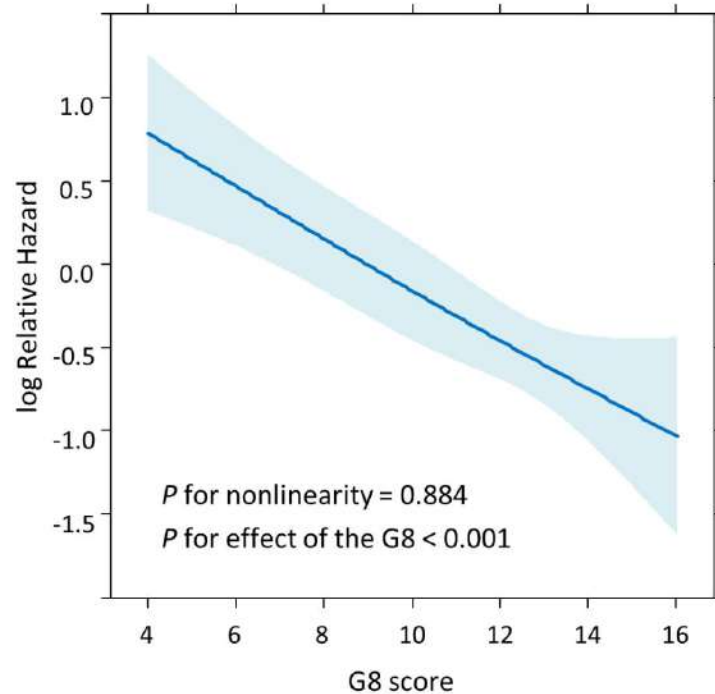
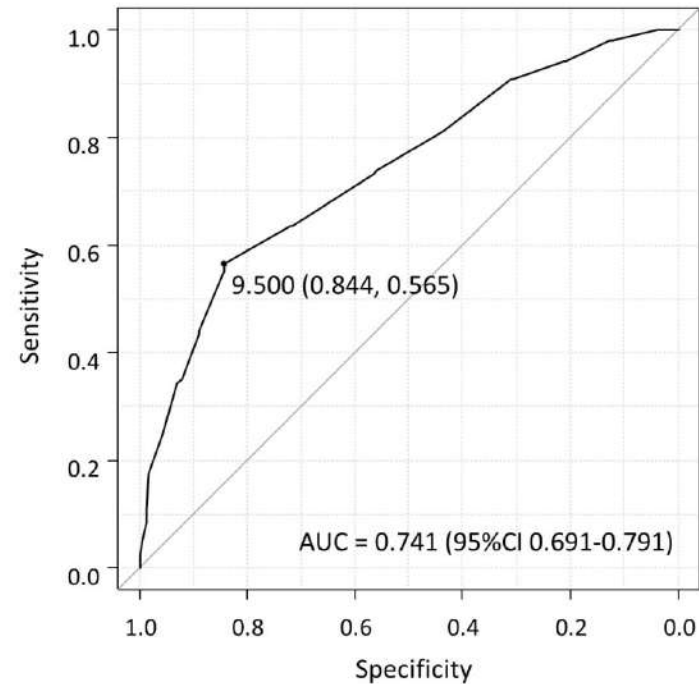


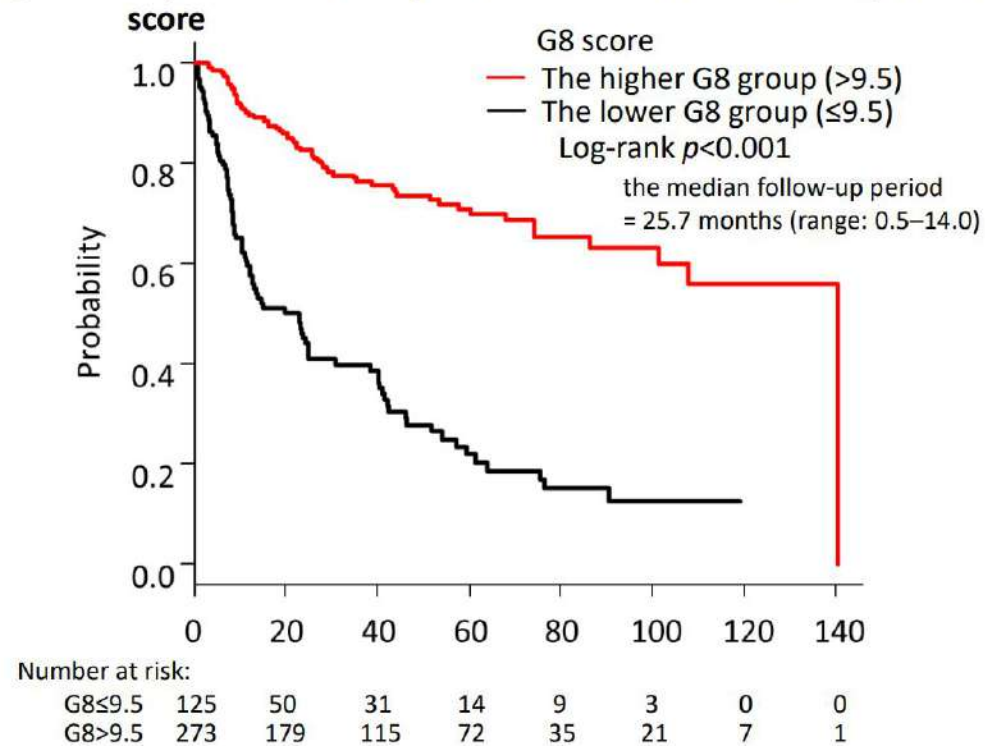
Figure 2. Receiver operating characteristic curve showing the performance of the G8 score for overall survival



Oiwa K et al. EP522. EHA2021 Virtual

# (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

Figure 3. Kaplan–Meier analysis of overall survival according to the G8 score



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## (EP522) THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.

### CONCLUSIONS

Our research has revealed that a clear linear relationship was found between the G8 and OS. The G8 score was found to be an important prognostic predictor in elderly DLBCL patients, in that a lower G8 score proportionally exacerbated the prognosis. The cutoff value for the G8 to increase the mortality risk was 9.5.

Oiwa K et al. EP522. EHA2021 Virtual



# “elderly” vs “older”: language matters

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## When It Comes to Older Adults, Language Matters: *Journal of the American Geriatrics Society* Adopts Modified American Medical Association Style

Nancy E. Lundebjerg MPA, Daniel E. Trucil MA, MPH, Emily C. Hammond BA, William B. Applegate MD, MPH

First published: 01 June 2017 | <https://doi.org/10.1111/jgs.14941> | Citations: 35

Lundebjerg NE et al. J Am Geriatr Soc. 2017 Jul;65(7):1386-1388



# “elderly” vs “older”: language matters

Table 1. A Quick Start Guide to Reframing Aging

Instead of These Words and Cues:	Try:
“Tidal wave,” “tsunami,” and similarly catastrophic terms for the growing population of older adults	Talking affirmatively about changing demographics: “As Americans live longer and healthier lives ...”
“Choice,” “planning,” “control,” and other individual determinants of aging outcomes	Emphasizing how to improve social contexts: “Let’s find creative solutions to ensure we can all thrive as we age ...”
“Seniors,” “elderly,” “aging dependents,” and similar “other-ing” terms that stoke stereotypes	Using more-neutral (older people, Americans) and inclusive (“we” and “us”) terms
“Struggle,” “battle,” “fight,” and similar conflict-oriented words to describe aging experiences	The Building Momentum metaphor: “Aging is a dynamic process that leads to new abilities and knowledge we can share with our communities ...”
Using the word “ageism” without explanation	Defining ageism: “Ageism is discrimination against older people due to negative and inaccurate stereotypes ...”
Making generic appeals to the need to “do something” about aging	Using concrete examples like intergenerational community centers to illustrate inventive solutions

Lundebjerg NE et al. J Am Geriatr Soc. 2017 Jul;65(7):1386-1388



# Selected abstracts with the keyword “elderly”

Abstract ID EP459

**PROGNOSTIC IMPACT OF MINIMAL REDISUAL DISEASE ASSESSMENT IN ELDERLY PATIENTS WITH SECONDARY ACUTE MYELOID LEUKEMIA. A COMPARISON BETWEEN CPX-351 AND INTENSIFIED FLUDARABINE-BASED REGIMENS**

Abstract ID EP463

**THE COMBINATION OF AXL INHIBITOR BEMCENTINIB AND LOW-DOSE CYTARABINE IS WELL TOLERATED AND EFFICACIOUS IN ELDERLY RELAPSED AML PATIENTS: UPDATE FROM THE ONGOING BGBC003 PHASE II TRIAL (NCT02488408)**

Abstract ID EP477

**BCL-2 EXPRESSION IN ELDERLY ACUTE MYELOID LEUKEMIA PATIENTS AND IMPACT ON OUTCOMES ACCORDING TO DIFFERENT THERAPEUTIC STRATEGIES**

Abstract ID EP486

**GLASDEGIB IN COMBINATION WITH LOW DOSE CYTARABINE FOR ELDERLY ACUTE MYELOID LEUKEMIA PATIENTS FAILING HYPOMETHYLATING AGENTS**



# Selected abstracts with the keyword “elderly”

Abstract ID EP494

IMPACT OF TREATMENT INTENSITY, MRD AND HEMATOPOIETIC STEM CELL TRANSPLANTATION IN **ELDERLY** R/R AML PATIENTS: A MONOCENTRIC RETROSPECTIVE STUDY

Abstract ID EP503

MOSUNETUZUMAB (MOSUN) MONOTHERAPY FOR **ELDERLY**/UNFIT PATIENTS (PTS) WITH FIRST-LINE DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) CONTINUES TO SHOW PROMISING SAFETY AND EFFICACY WITH DURABLE COMPLETE RESPONSES

Abstract ID EP513

COMPREHENSIVE GERIATRIC ASSESSMENT-DRIVEN TREATMENT DECISION VERSUS CLINICAL JUDGMENT IN **ELDERLY** PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA IN CHINA

Abstract ID EP514

INFECTION-RELATED MORBIDITY AND MORTALITY FOR **ELDERLY** DLBCL PATIENTS TREATED WITH FULL OR ATTENUATED DOSE R-CHOP



# Selected abstracts with the keyword “elderly”

Abstract ID EP648

**SAFETY AND EFFECTIVENESS OF VENETOCLAX IN COMBINATION WITH RITUXIMAB IN ELDERLY PATIENTS WITH RELAPSED/REFRACTORY CLL TREATED UNDER REAL-LIFE CONDITIONS - DATA FROM THE OBSERVATIONAL STUDY VERVE**

Abstract ID EP795

**RITUXIMAB, BENDAMUSTINE, AND CYTARABINE (R-BAC) COMPARED WITH RITUXIMAB AND BENDAMUSTINE (BR) IN PREVIOUSLY UNTREATED ELDERLY PATIENTS WITH MANTLE CELL LYMPHOMA (BE-VE-BAC STUDY)**

Abstract ID EP797

**TREATMENT PATTERNS AND OUTCOMES OF ELDERLY PATIENTS WITH MANTLE CELL LYMPHOMA UNFIT FOR STANDARD IMMUNOCHEMOTHERAPY: A UK AND IRELAND ANALYSIS**

Abstract ID EP980

**ISATUXIMAB PLUS CARFILZOMIB AND DEXAMETHASONE VERSUS CARFILZOMIB AND DEXAMETHASONE IN ELDERLY PATIENTS WITH RELAPSED MULTIPLE MYELOMA: IKEMA SUBGROUP ANALYSIS**



# Selected abstracts with the keyword “elderly”

Abstract ID EP1121

USE OF RUXOLITINIB IN **ELDERLY** PATIENTS WITH PRIMARY MYELOFIBROSIS

Abstract ID EP1279

GOOD OUTCOME OF HIGH-RISK MYELOFIBROSIS IN **ELDERLY** RECIPIENTS AFTER FULL INTENSITY T-DEplete CONDITIONING WITH FLUDARABINE, BUSULFAN, WITH SINGLE AGENT CICLOSPORIN AS GVHD PROPHYLAXIS.

Abstract ID PB1392

PROGNOSTIC IMPACT OF MOLECULAR MARKERS IN **ELDERLY** PATIENTS AFFECTED BY NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA: MONOCENTRIC EXPERIENCE

Abstract ID PB1450

DOSE-ADJUSTED EDOCH-RITUXIMAB IN **ELDERLY** PATIENTS WITH HIGH GRADE DIFFUSE LARGE B-CELL LYMPHOMA



# Selected abstracts with the keyword “elderly”

Abstract ID PB1466

**COVID INFECTION REVEALING FACTOR XI DEFICIENCY IN ELDERLY PATIENT**

Abstract ID PB1647

**EFFICACY AND SAFETY OF INDUCTION THERAPY WITH IAD VERSUS IRD REGIMEN IN FRAGILE ELDERLY PATIENTS WITH NEWLY DIAGNOSED MULTIPLE MYELOMA-RESULTS OF PROSPECTIVE MULTICENTER CLINICAL TRAIL**

Abstract ID S309

**OUTCOME OF ELDERLY PATIENTS WITH VENOUS THROMBOEMBOLISM TREATED WITH DIRECT ORAL ANTICOAGULANTS - A RETROSPECTIVE COHORT STUDY**



# Selected abstracts with the keyword “older”

Abstract ID EP423

GENOMIC LANDSCAPE IN PATIENTS WITH ACUTE MYELOID LEUKEMIA **OLDER** THAN 70 YEARS

Abstract ID EP457

A PHASE 3 STUDY OF ENASIDENIB (ENA) VERSUS CONVENTIONAL CARE REGIMENS (CCR) IN **OLDER** PATIENTS WITH LATE-STAGE MUTANT-IDH2 (MIDH2) RELAPSED/REFRACTORY ACUTE MYELOID LEUKEMIA (R/R AML)

Abstract ID EP482

INTERMEDIATE OR STANDARD DOSE CYTARABINE AS POST REMISSION THERAPY IN **OLDER** PATIENTS WITH ACUTE MYELOID LEUKEMIA: IMPACTS ON OUTCOMES AND HEALTH CARE RESOURCE CONSUMPTION

Abstract ID EP504

DIFFUSE LARGE B CELL LYMPHOMA (DLBCL) IN PATIENTS **OLDER** THAN 65 YEARS: ANALYSIS OF 3 YEAR REAL WORLD DATA OF PRACTICE PATTERNS AND OUTCOMES IN ENGLAND



# Selected abstracts with the keyword “older”

Abstract ID EP522

**THE IMPACT OF THE GERIATRIC 8 SCORE ON OVERALL SURVIVAL IN OLDER ADULTS WITH DIFFUSE LARGE B-CELL LYMPHOMA.**

Abstract ID EP523

**DOES INTENSIVE CHEMOTHERAPY REALLY HELP OLDER DLBCL PATIENTS LIVE LONGER?**

Abstract ID EP545

**RATIONALE FOR TREATMENT SELECTION, AND COMORBIDITIES IN OLDER PATIENTS (PTS) WITH PREVIOUSLY UNTREATED DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL): INSIGHTS FROM REAL WORLD DATA (RWD)**

Abstract ID EP976

**SURVIVAL AMONG OLDER PATIENTS WITH PREVIOUSLY TREATED MULTIPLE MYELOMA TREATED WITH SELINEXOR, BORTEZOMIB, AND DEXAMETHASONE (XVD) IN THE BOSTON STUDY**



# Selected abstracts with the keyword “older”

Abstract ID EP1207

**ASSOCIATION BETWEEN HOSPITALISED VASO-OCCLUSIVE CRISES AND MORTALITY IN SICKLE CELL DISEASE PATIENTS AGED 16 YEARS AND **OLDER** USING THE FRENCH NATIONAL HEALTH INSURANCE DATABASE (SNDS)**

Abstract ID PB1407

**PEVOLAM: TRIAL DESIGN FOR A RANDOMIZED PHASE 3 MULTICENTER STUDY COMPARING AZACITIDINE PLUS PEVONEDISTAT VS AZACITIDINE IN **OLDER** OR UNFIT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA**

Abstract ID PB1419

**REAL-LIFE EFFICACY OF FIXED-DOSE HYPOMETHYLATING AGENTS IN **OLDER** PATIENTS WITH ACUTE MYELOID LEUKEMIA: A SINGLE CENTER EXPERIENCE**

Abstract ID PB1498

**FEASIBILITY OF MEASURING ADHERENCE TO ORAL ONCOLYTICS IN ROUTINE CLINICAL PRACTICE: A PILOT STUDY IN **OLDER** ADULTS WITH LYMPHOID DISORDERS**



# Selected abstracts with the keyword “older”

Abstract ID PB1567

THE PROGNOSTIC NUTRITIONAL INDEX (PNI) IS AN INDEPENDENT PREDICTOR OF OVERALL SURVIVAL IN **OLDER** PATIENTS WITH FOLLICULAR LYMPHOMA

Abstract ID PB1681

FIRST-LINE TREATMENT OF **OLDER** PATIENTS WITH MULTIPLE MYELOMA (MM) WITH BORTEZOMIB, CYCLOPHOSPHAMIDE AND DEXAMETHASONE (VCD)

Abstract ID PB1753

UNCERTAINTY ABOUT THE FUTURE: INSIGHTS FROM **OLDER** PATIENTS WITH ACUTE MYELOID LEUKAEMIA (AML) ON DIFFERENT TREATMENT PATHS

Abstract ID PB1777

PATIENT-CENTERED FACTORS IN EVALUATION OF ELIGIBILITY AND PROGNOSTICATION IN HEMATOPOIETIC STEM CELL TRANSPLANTATION IN **OLDER** PATIENTS WITH HEMATOLOGIC MALIGNANCIES – A SYSTEMATIC REVIEW



# Selected abstracts with the keyword “older”

Abstract ID PB1681

**FIRST-LINE TREATMENT OF OLDER PATIENTS WITH MULTIPLE MYELOMA (MM) WITH BORTEZOMIB, CYCLOPHOSPHAMIDE AND DEXAMETHASONE (VCD)**

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Abstract ID S130

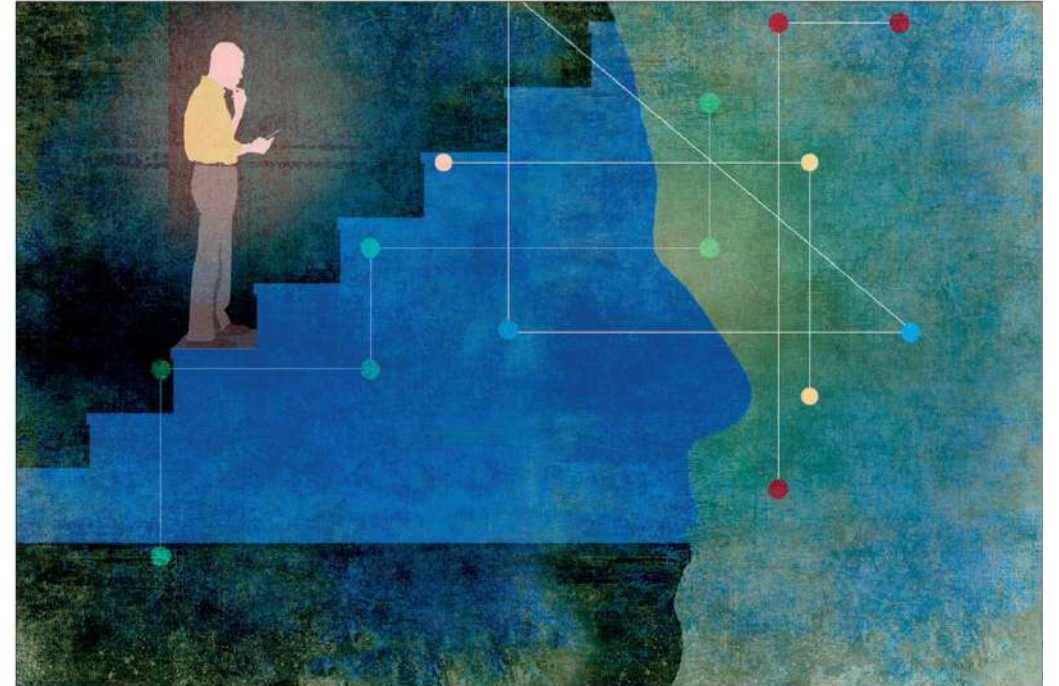
**SEQUENTIAL NCRI AML TRIALS SHOW CONSISTENT BENEFIT FOR RIC TRANSPLANT IN CR1 FOR OLDER PATIENTS >60YEARS THAT IS INDEPENDENT OF MRD STATUS AFTER FIRST INDUCTION**



# Telemedicine in older patients with hematological malignancies

We decided to implement four telemedicine strategies in our institution, Fundacion Jimenez Diaz University Hospital:

1. activating a patient portal for patients to keep in touch with the medical team
2. providing a lymphoma-related and COVID-19-related symptoms questionnaire to complete at home and complement teleconsultations
3. granting all patients access to a patient-reported outcome programme to provide information on patients' wellbeing and patientcentred care
4. and launching a new drug home-delivery system.



Cordoba R. Lancet Haematol. 2020 Sep;7(9):e637.



# Follow-up day “Ageing & Hematology”: Best of Theme Session in Geriatric hematology CLL & Lymphoma

**Alberto Lopez-Garcia, MD**

Fundacion Jimenez Diaz University Hospital, Madrid, SPAIN

July 20, 2021



# DISCLOSURES

**Roche** (Speaker, Travel & Accommodation)

**Janssen** (Speaker, Advisory board, Travel & Accommodation)

**Abbvie** (Speaker, Advisory board, Travel & Accommodation)

**Astra-Zeneca** (Speaker, Advisory board)

**Celgene/BMS** (Speaker, Travel & Accommodation)

**Takeda** (Travel & Accommodation)



# | Selected abstracts of CLL & Lymphoma

**8 posters**

**5 DLBCL 503 504 514 523 545**

**2 MCL 795 797**

**1 CLL 648**

**3 Publications : Prognosis 1567 , safety 1450, and adherence 1498**



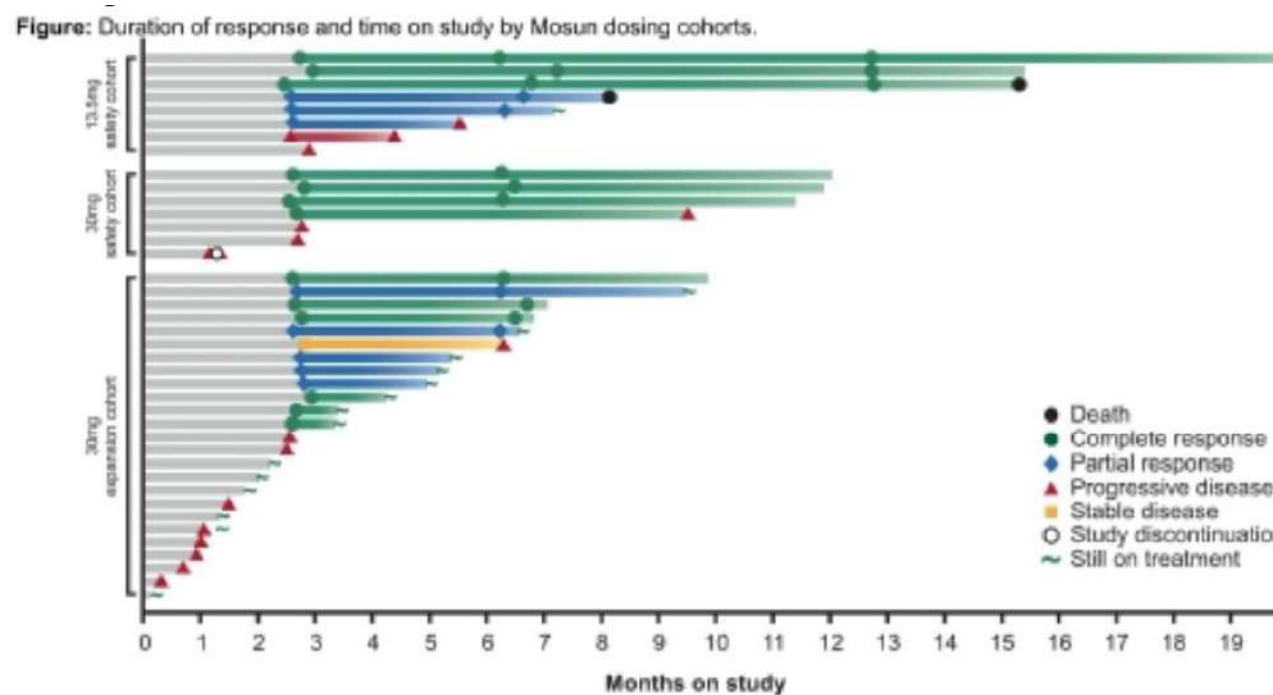
# Posters CLL & Lymphoma

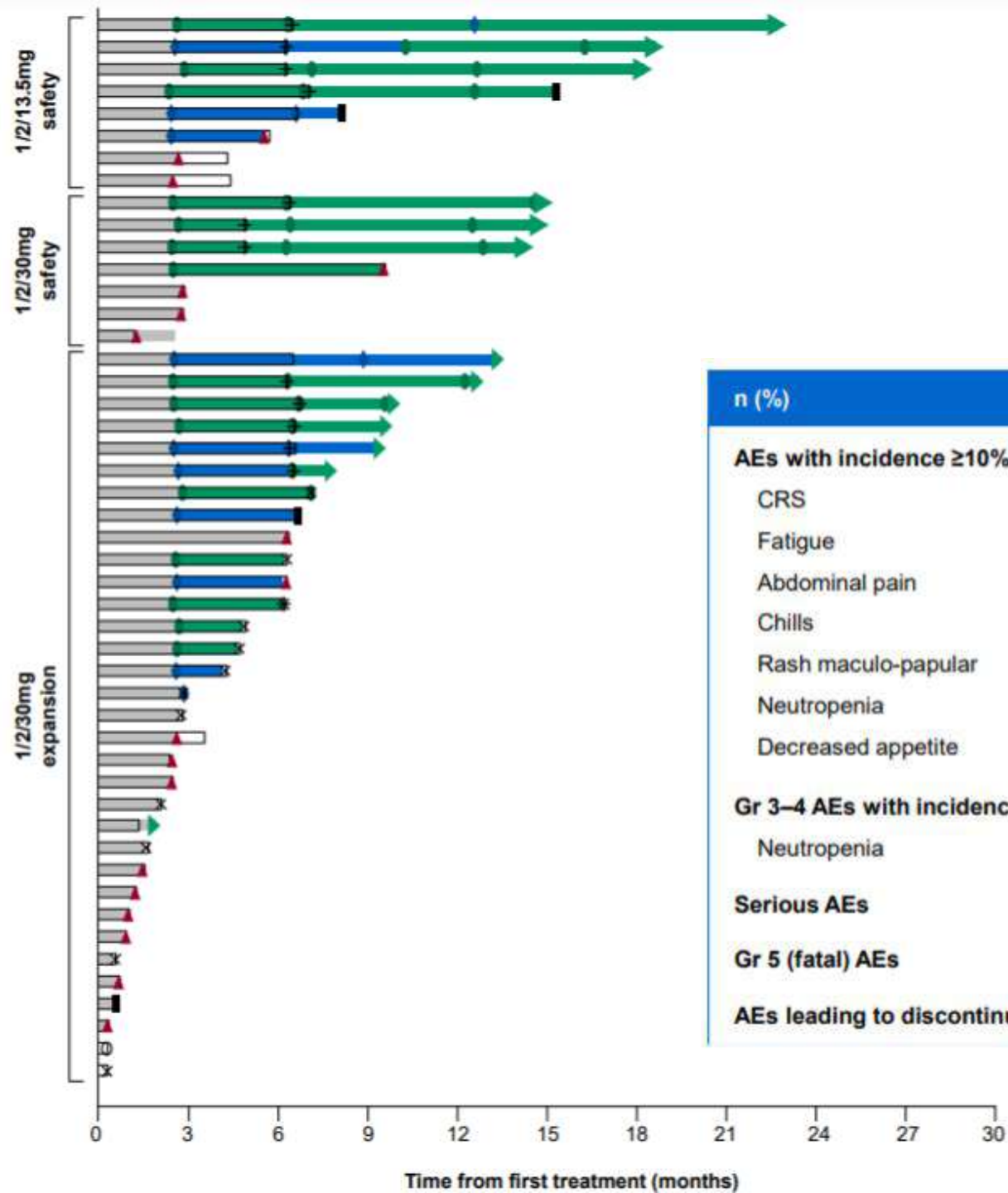


# Selected abstracts of CLL & Lymphoma

EP503

**MOSUNETUZUMAB (MOSUN) MONOTHERAPY FOR ELDERLY/UNFIT PATIENTS (PTS) WITH FIRST-LINE DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) CONTINUES TO SHOW PROMISING SAFETY AND EFFICACY WITH DURABLE COMPLETE RESPONSES**



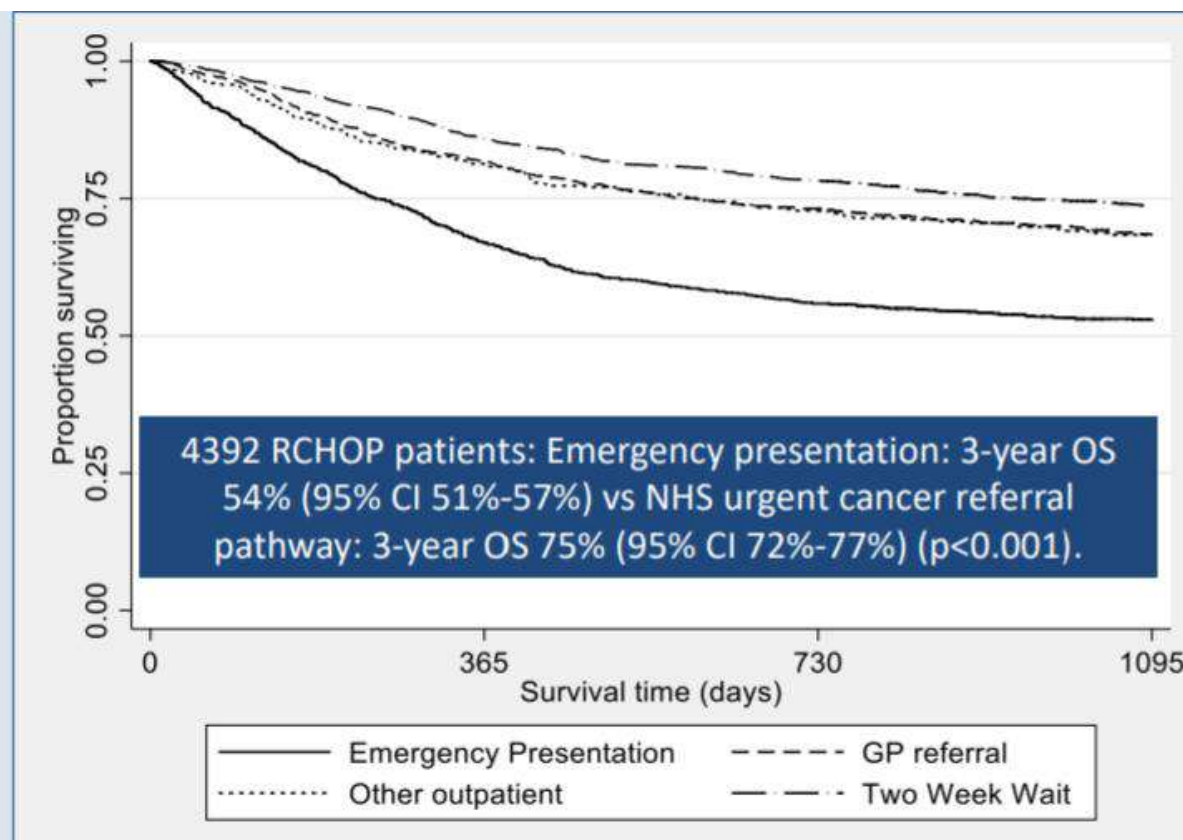
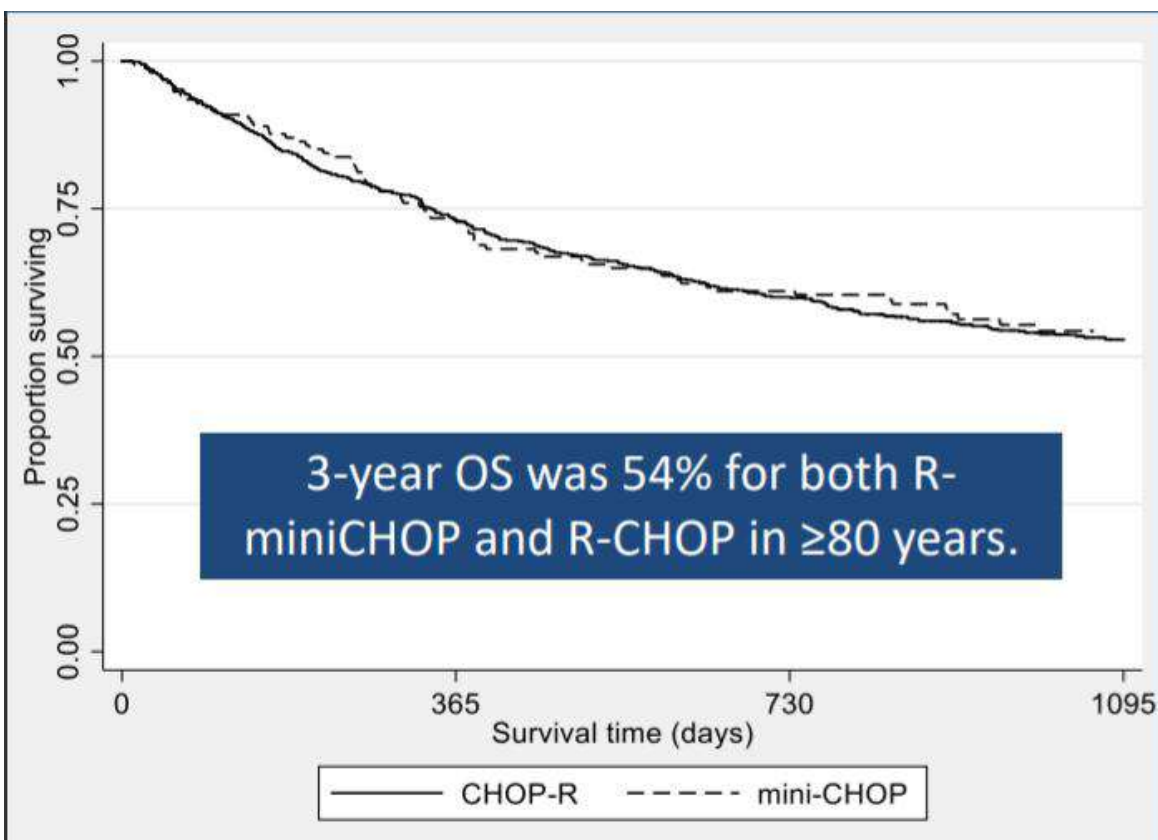


n (%)	1L DLBCL (N=48)
<b>AEs with incidence <math>\geq 10\%</math> by PT</b>	45 (93.8)
CRS	14 (29.2)
Fatigue	9 (18.8)
Abdominal pain	7 (14.6)
Chills	5 (10.4)
Rash maculo-papular	5 (10.4)
Neutropenia	5 (10.4)
Decreased appetite	5 (10.4)
<b>Gr 3–4 AEs with incidence <math>\geq 5\%</math> by PT</b>	17 (35.4)
Neutropenia	5 (10.4)
<b>Serious AEs</b>	17 (35.4)
<b>Gr 5 (fatal) AEs</b>	1 (2.1)
<b>AEs leading to discontinuation</b>	1 (2.1)

# Selected abstracts of CLL & Lymphoma

EP504

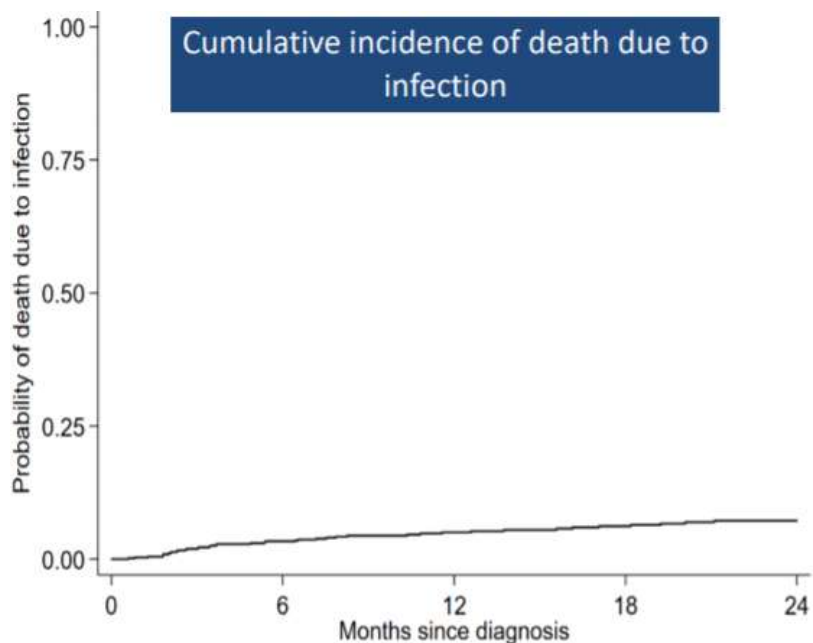
**DIFFUSE LARGE B CELL LYMPHOMA (DLBCL) IN PATIENTS OLDER THAN 65 YEARS:  
ANALYSIS OF 3 YEAR REAL WORLD DATA OF PRACTICE PATTERNS AND OUTCOMES  
IN ENGLAND**



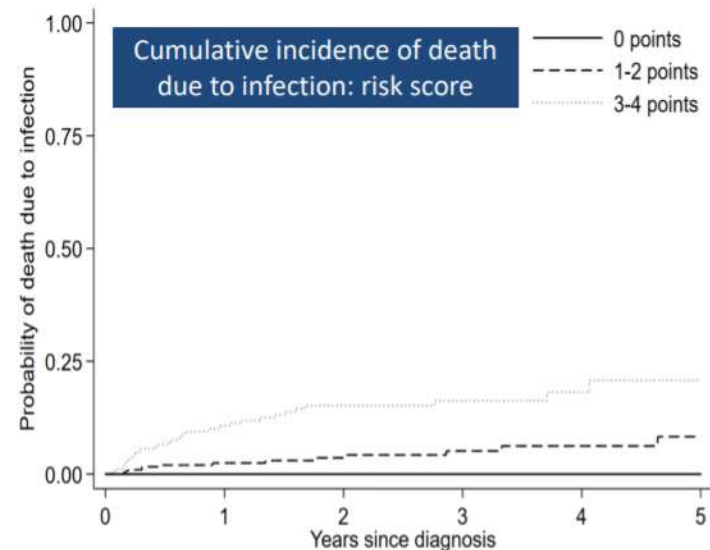
# Selected abstracts of CLL & Lymphoma

EP514

## INFECTION-RELATED MORBIDITY AND MORTALITY FOR ELDERLY DLBCL PATIENTS TREATED WITH FULL OR ATTENUATED DOSE R-CHOP



Time point	Probability of death due to infection (95% CI)
6 months	3.3% (2.2%-5.0%)
12 months	5.0% (3.6%-7.1%)
2 years	7.2% (5.3%-9.8%)



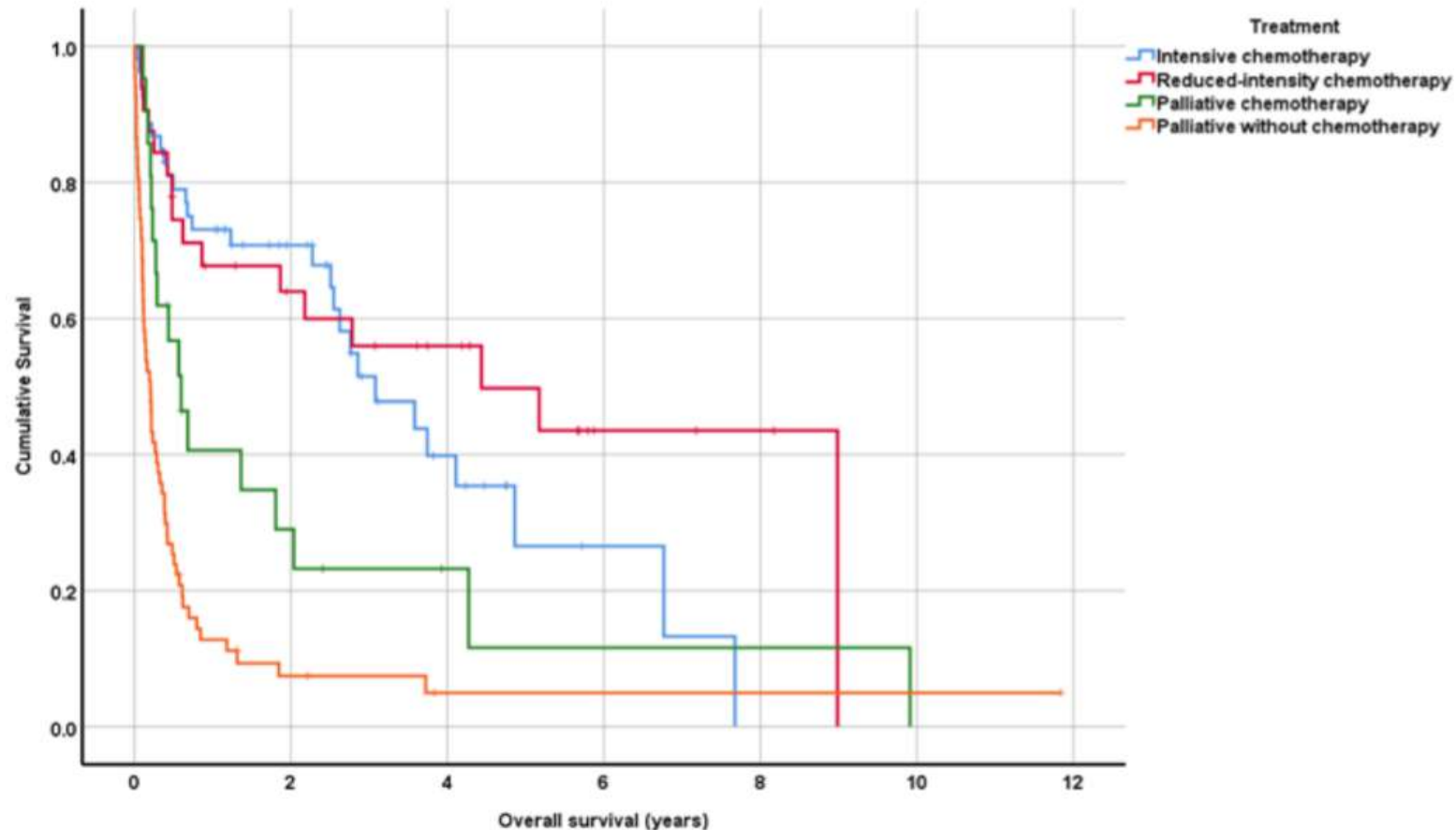
Risk score	Events/N *	HR (95% CI)	P-value	Death due to infection rate	
				2-year	5-year
0	0/106	N/A	<0.001	0%	0%
1-2	13/316	1.00		3.6% (1.8%-6.9%)	8.3% (4.3%-15.8%)
3-4	34/259	3.52 (1.87-6.63)		15.2% (10.8%-21.1%)	20.8% (14.0%-30.3%)
All patients with risk score				7.2% (5.3%-9.8%)	11.1% (7.9%-15.5%)



# Selected abstracts of CLL & Lymphoma

EP523

DOES INTENSIVE CHEMOTHERAPY REALLY HELP OLDER DLBCL PATIENTS LIVE LONGER?



# Selected abstracts of CLL & Lymphoma

EP545

**RATIONALE FOR TREATMENT SELECTION, AND COMORBIDITIES IN OLDER PATIENTS (PTS) WITH PREVIOUSLY UNTREATED DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL): INSIGHTS FROM REAL WORLD DATA (RWD)**

Figure 1. Comorbidities at diagnosis with an incidence of  $\geq 5\%$ .

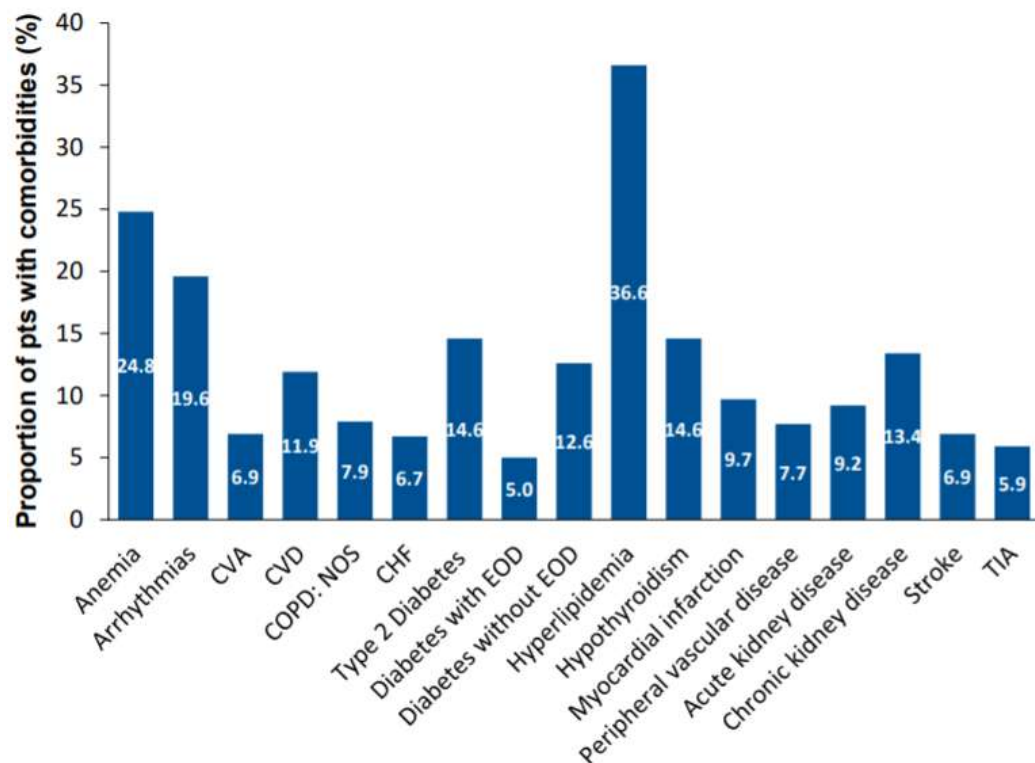
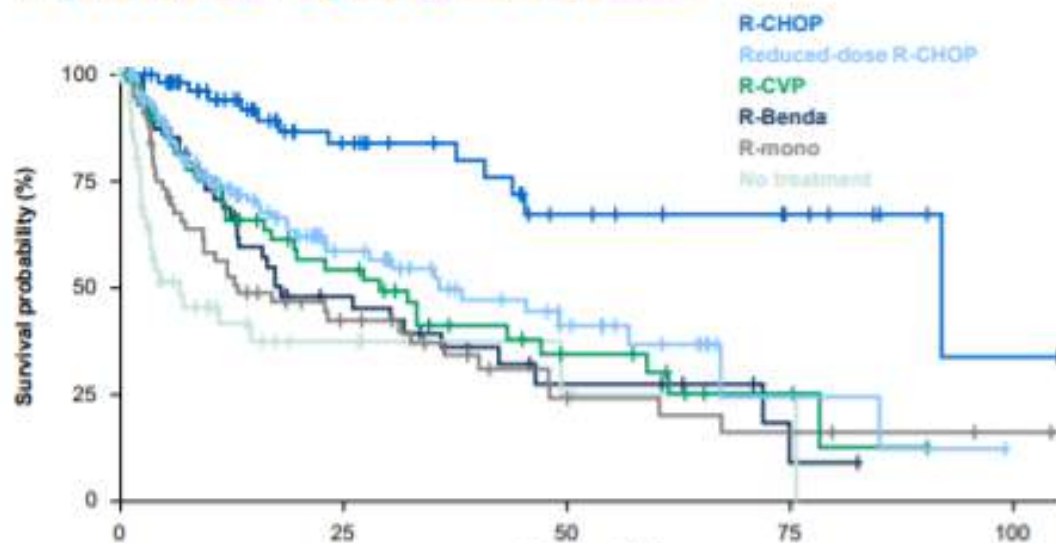


Figure 2. OS\* by treatment status



# Selected abstracts of CLL & Lymphoma

EP545

## RATIONALE FOR TREATMENT SELECTION, AND COMORBIDITIES IN OLDER PATIENTS (PTS) WITH PREVIOUSLY UNTREATED DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL): INSIGHTS FROM REAL WORLD DATA (RWD)

Table 3. Rationale summary for treatment assignment by 1L regimen in pts receiving systemic treatment and radiotherapy

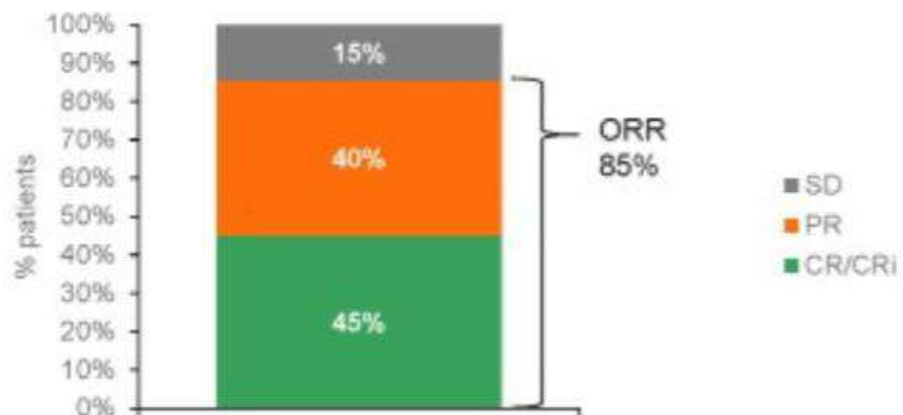
Treatment group	Number of documented rationales	Treatment rationale, n (%) <sup>*</sup>							
		Age	Comorbidity	Patient request	Disease burden	IPI for DLBCL	PS	Other	No rationale stated
Total (N=404) <sup>**</sup>	437	99 (23.8)	70 (16.8)	20 (4.3)	18 (4.8)	0	49 (11.7)	10 (2.4)	148 (35.6)
R-CHOP (n=59)	61	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	0	0	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	51 (83.6)
Reduced-dose R-CHOP (n=115)	139	41 (29.5)	22 (15.8)	≤4 <sup>‡</sup>	7 (5.0)	≤4 <sup>‡</sup>	13 (9.4)	≤4 <sup>‡</sup>	46 (33.1)
R-mono (n=57)	73	21 (28.7)	11 (15.1)	9 (12.3)	6 (8.2)	0	14 (19.2)	≤4 <sup>‡</sup>	11 (15.1)
R-Benda (n=56)	64	12 (18.8)	15 (23.4)	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	0	7 (10.9)	≤4 <sup>‡</sup>	23 (35.9)
R-CVP (n=58)	76	22 (28.9)	20 (26.3)	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	0	12 (15.8)	0	17 (22.4)
No treatment <sup>#</sup> (n=57)	24	≤4 <sup>‡</sup>	5 (21)	7 (29)	≤4 <sup>‡</sup>	0	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>	≤4 <sup>‡</sup>

# Selected abstracts of CLL & Lymphoma

## EP648

### SAFETY AND EFFECTIVENESS OF VENETOCLAX IN COMBINATION WITH RITUXIMAB IN ELDERLY PATIENTS WITH RELAPSED/REFRACTORY CLL TREATED UNDER REAL-LIFE CONDITIONS – DATA FROM THE OBSERVATIONAL STUDY VERVE

Figure 5. Best overall response after 12 months



SD, stable disease; PR, partial remission; CR, complete remission; Cri, complete remission; complete remission with incomplete marrow recovery

AEs	Patients Overall n (%)	Patients during ramp-up, n (%) <sup>1</sup>
<b>Pts with any AE</b>	67 (82)	43 (52)
Infections	16 (20)	3 (4)
Diarrhea	13 (16)	6 (7)
Neutropenia	11 (13)	6 (7)
Thrombocytopenia	10 (12)	8 (10)
Nausea	9 (11)	5 (6)
TLS	9 (11)	9 (11)
Fever	9 (11)	4 (5)
Leukopenia	8 (10)	4 (5)
Anemia	6 (7)	2 (2)
Fatigue	5 (6)	3 (4)
stomach cramp	5 (6)	3 (4)
<b>Pts with AE CTCAE grade 3 - 4</b>	36 (44)	16 (20)
Neutropenia	10 (12)	5 (6)
Infections	7 (9)	2 (2)
Leucopenia	5 (6)	2 (2)
<b>Pts with SAE</b>	21 (26)	7 (9)
Infection	7 (9)	2 (2)

# Selected abstracts of CLL & Lymphoma

EP795

RITUXIMAB, BENDAMUSTINE, AND CYTARABINE (R-BAC) COMPARED WITH RITUXIMAB AND BENDAMUSTINE (BR) IN PREVIOUSLY UNTREATED ELDERLY PATIENTS WITH MANTLE CELL LYMPHOMA (BE-VE-BAC STUDY)

Figure 1. Kaplan-Meier plot for PFS for R-BAC group versus BR group

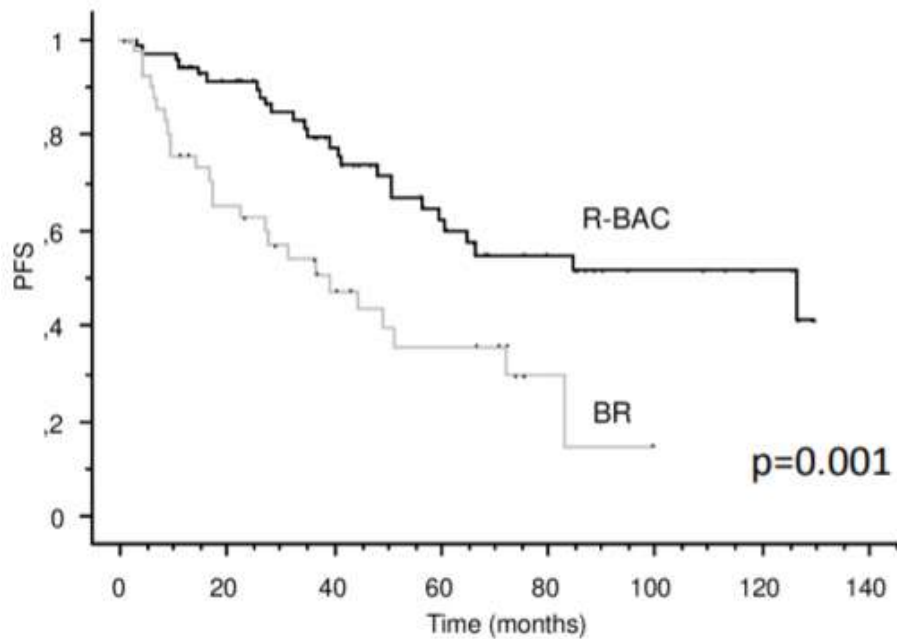
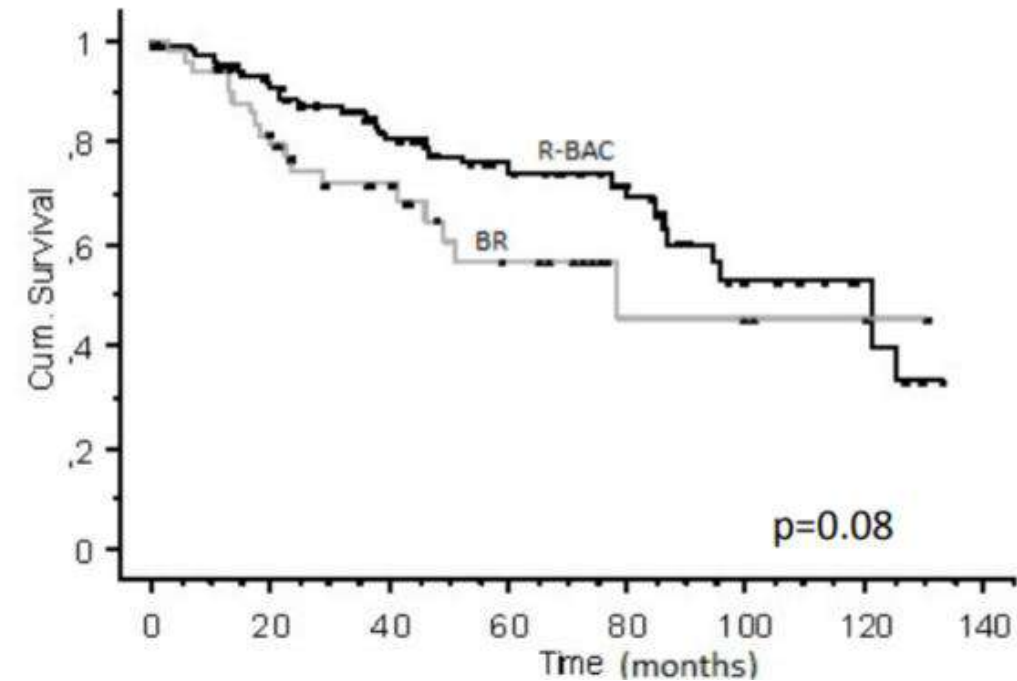


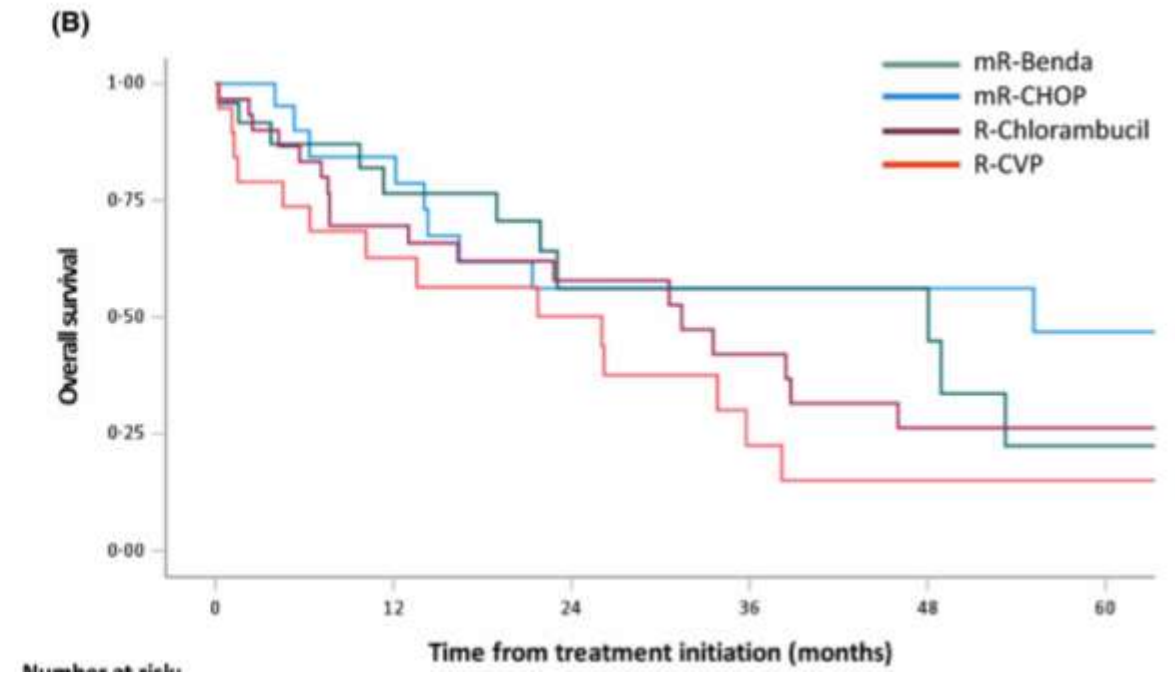
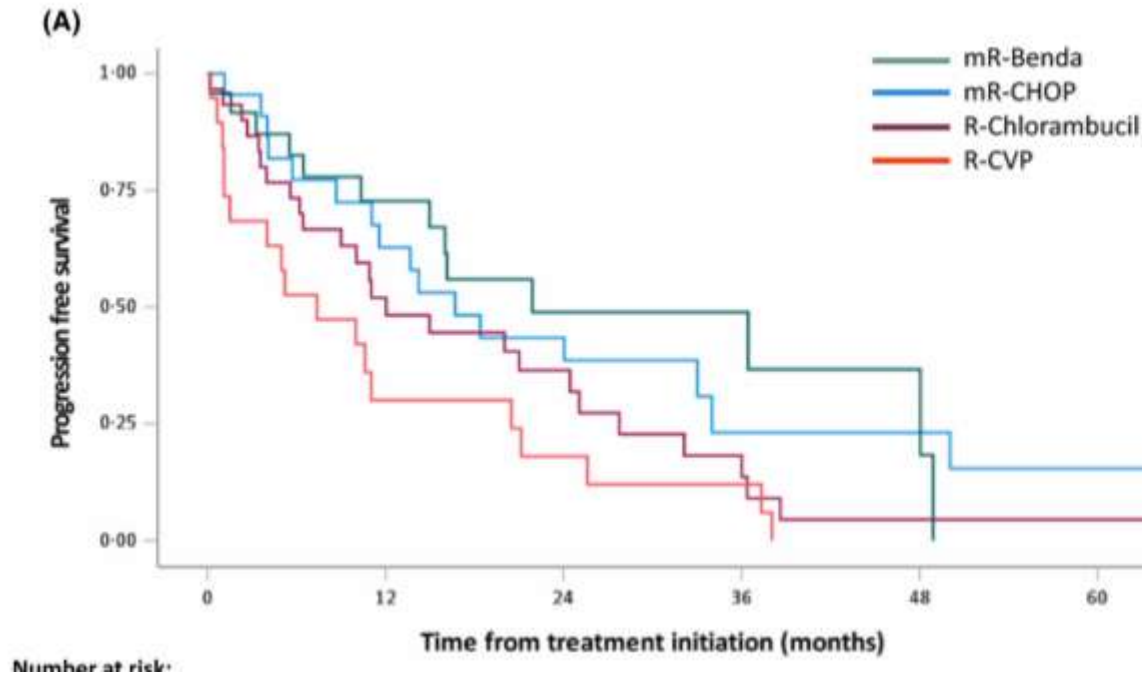
Figure 2. Kaplan-Meier plot for OS for R-BAC group versus BR group



# Selected abstracts of CLL & Lymphoma

EP797

## TREATMENT PATTERNS AND OUTCOMES OF ELDERLY PATIENTS WITH MANTLE CELL LYMPHOMA UNFIT FOR STANDARD IMMUNOCHEMOTHERAPY: A UK AND IRELAND ANALYSIS



# Publications CLL & Lymphoma



# Selected abstracts of CLL & Lymphoma

## PB1450 DOSE-ADJUSTED EDOCH-RITUXIMAB IN ELDERLY PATIENTS WITH HIGH GRADE DIFFUSE LARGE B-CELL LYMPHOMA

PARAMETER	DATA
Gender, n (%)	
Male	14 (56)
Female	11 (44)
Age (years)	
Median	57
Range	34-81
ECOG, n (%)	
0	3 (12)
1	14 (56)
2	8 (32)
3-5	0
Estage, n (%)	
1	2 (8)
2	5 (20)
3	5 (20)
4	14 (52)
IPI, n (%)	
1	5 (20)
2	5 (20)
3	8 (32)
4	5 (20)
5	2 (8)
DLBCL subtypes, n (%)	
Non-Germinal center B-cell	16 (64)
Germinal center B-cell	8 (32)
No data	1 (4)

### Efficacy of EDOCH-R in pts over 60y. 1st line

CR 79% (no RT needed)

Median FU 36 m OS 65% PFS 58%

### Hematologic toxicity G4:

Neutropenia 76% (all neutropenic fever)

Anemia 36%

Thrombocytopenia 34%

2 pt ended therapy because of toxicity

## Selected abstracts of CLL & Lymphoma

### **PB1498 FEASIBILITY OF MEASURING ADHERENCE TO ORAL ONCOLYTICS IN ROUTINE CLINICAL PRACTICE: A PILOT STUDY IN OLDER ADULTS WITH LYMPHOID DISORDERS**

1. To compare the utilization of self-report [brief adherence rating scale (**BARS**)], pill count and Medical Event Monitoring System (MEMS) Cap (an electronic bottle cap) to measure adherence to OTT in OA with CLL.
2. To determine the adherence rate and factors impacting adherence.
3. To correlate adherence rate with disease outcomes.



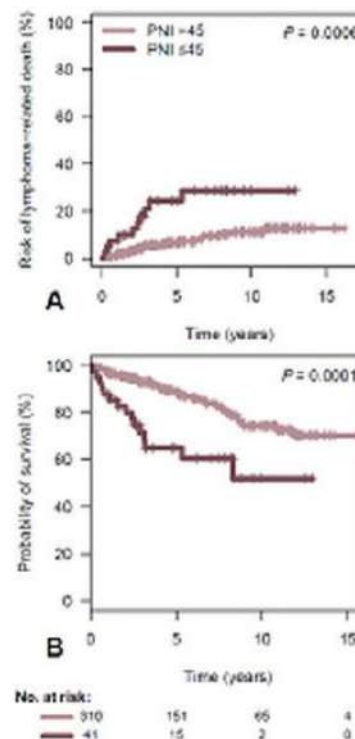
# Selected abstracts of CLL & Lymphoma

## PB1567 THE PROGNOSTIC NUTRITIONAL INDEX (PNI) IS AN INDEPENDENT PREDICTOR OF OVERALL SURVIVAL IN OLDER PATIENTS WITH FOLLICULAR LYMPHOMA

	Prognostic Nutritional Index		
	≤45	>45	P
Number of patients, n (%)	41 (12)	310 (88)	-
Age (median, range)	71 (33-91)	60 (26-86)	<0.001
Female sex, n (%)	25 (61)	166 (54)	NS
Charlson Comorbidity Index ≥2, n (%)	11 (27)	70 (23)	NS
Histological grade 1-2, n (%)	30 (75)	255 (84)	NS
ECOG PS ≥2, n (%)	10 (24)	14 (5)	<0.001
B symptoms, n (%)	11 (27)	30 (10)	0.001
Ann-Arbor stage III/IV, n (%)	33 (81)	231 (75)	NS
Secondary extranodal involvement, n (%)	30 (73)	193 (62)	NS
Bulky mass, n (%)	11 (27)	65 (21)	NS
Elevated serum LDH, n (%)	15 (37)	53 (17)	0.003
Elevated β2-microglobulin, n (%)	27 (73)	122 (40)	<0.001
Hemoglobin <120 g/L, n (%)	23 (56)	42 (14)	<0.001
High-risk FLIPI score, n (%)	20 (49)	69 (22)	<0.001
Frontline treatment with R-CHOP, n (%)	21 (55)	144 (54)	NS
CR rate, n (%)	27 (71)	201 (75)	NS
PFS, % at 10 y (95% CI)	46 (30-70)	53 (45-62)	NS
OS, % at 10 y (95% CI)	52 (35-78)	74 (68-82)	0.0001
Cumulative incidence of lymphoma-related death, % at 10 y (95% CI)	29 (14-45)	11 (7-16)	0.0006

**Table.** Baseline features of the 351 patients, globally and according to the PNI.  
PNI, Prognostic Nutritional Index; ECOG PS, Eastern Cooperative Oncology Group Performance Status; LDH, lactate dehydrogenase; FLIPI, Follicular Lymphoma International Prognostic Index; ULN, upper limit of normal; NS, not statistically significant; CR, complete response; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone; CI, confidence interval; HT, histological transformation; FL, follicular lymphoma; NS, not statistically significant; PFS, progression-free survival; OS, overall survival; SPM, second malignancies.

**Figure. A.** Cumulative incidence of lymphoma-related death according to the PNI. **B.** Overall survival according to the PNI.



## THANK YOUR FOR YOUR ATTENTION

Alberto Lopez-Garcia, MD  
Fundacion Jimenez Diaz University Hospital, Madrid, SPAIN



@DrAlbertoLG





Scientific Working Group “Aging and Hematology” | @DrRaulCordoba



**EHA2021**  
VIRTUAL

# Follow-up day “Ageing & Hematology”: Best of Theme Session in Geriatric hematology

**Elham Askari, MD**

Fundacion Jimenez Diaz University Hospital, Madrid, SPAIN

July 20, 2021



# | Disclosures

**Janssen** (Speaker, Advisory board, Travel & Accommodation)

**Celgene/BMS** (Speaker, Advisory board, Travel & Accommodation)

**Takeda** (Speaker, Advisory board, Travel & Accommodation)

**Abbvie** (Speaker, Advisory board)



## MULTIPLE MYELOMA

- Multiple myeloma (MM) typically affects older patients
- Elderly Patients are more vulnerable to toxicity with anti-MM treatments.
- These pts have significant morbidities resulting in a need for dose modifications or alternative suboptimal treatment options.

Efficacy & Safety of Induction therapy with **IAD** ( Ixazomib/liposome doxorubicin /dexa) versus **IRD** (Ixazomib/Lenalidomide/dexa) Regimen in **Fragile Elderly** patients with NDMM.

Prospective multicenter non-randomized controlled study  
Medina Follow up : 8 months

**Inclusion Criteria :**

- Age => 65y
- IMWG geriatric SS = > 2 points
- Mayo geriatric vulnerability SS : Vulnerable

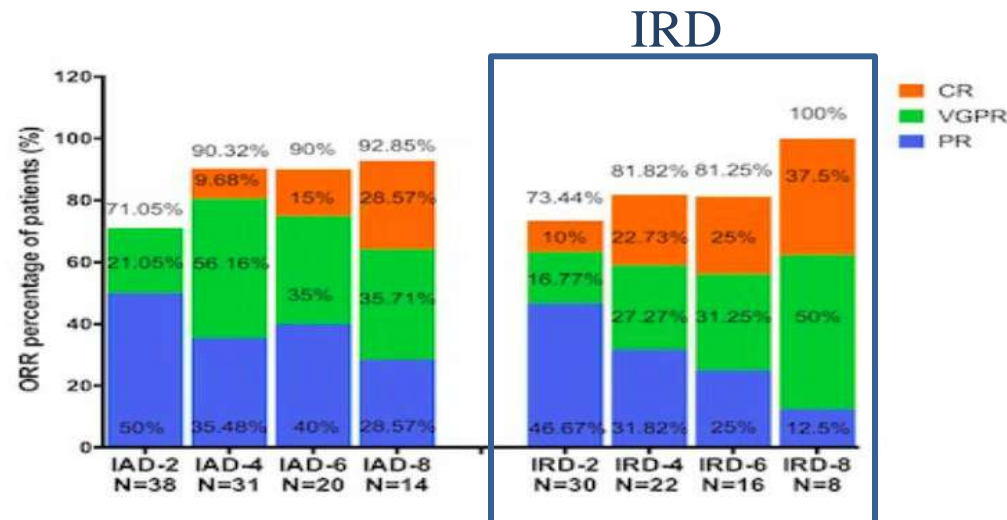
**End Points**

- Primary : ORR
- Secondary : OS, PFS, Tolerability, Toxicity & health related QoL

Patient characteristics	N 79
=> <b>75y</b>	<b>29.1%</b>
<b>Renal Failure</b>	<b>15.2%</b>
<b>Dialysis</b>	2 / 70
Response Rate	
<b>ORR</b>	82.35%
4 cycles completed	77.9 %
8 cycles completed	32.4 %
Median OS & PFS	not achieved
Deaths	15 / 79
<b>OS at 12<sup>th</sup> months</b>	85.7 %

## Conclusions

- The results showed in the interim observation, both three-drug combination regimen of ixazomib was effective, with overall response rate of 82.35% and 12-month OS of 85.7%.
- The adverse reactions were tolerable :(11.8% → > 3 HAE), (16.2% → Pneumonia), (19.1% → >grade 3 GI ).
- AE rate and the interim mortality rate are comparably high in fragile elderly MM pts., still a challenge for treatment.
- Drugs and regimens with low toxicity and high efficacy are needed to continuously explore.



PB 1681 Konstantinos et al

First line treatment of Older patients with Multiple Myeloma with Bortezomib, Cyclophosphamide and Dexamethasone (VCD)

Retrospective, multicenter, cohort study of newly-diagnosed older patients with MM treated with VCD  
Follow up : 25.3 months

Patient characteristics	N 99
Age	76y (70-92)
>80y	16.2%
P. Status =>2	50 %
CCI => 4	51.6 %
ISS 3	37.8%
Renal Failure	27.3%
VCD cycles	Median 6 cycles
Maintenance VCD	24.7%

First line treatment of Older patients with Multiple Myeloma with Bortezomib, Cyclophosphamide and Dexamethasone (VCD)

Response rates	N 99
<b>ORR</b>	<b>83.6%</b>
CR	25.3%
VGPR	28.6%
PR	29.7%
Stable D	11 %

Outcomes	N 99
m OS	62.7m
mPFS	26.6m
<b>Discontinued VCD</b>	<b>&lt; 7%</b>
Dose Adjustment (V)	23.9%
Grade=>2 Neuropathy	19.3%

Conclusions

VCD

- **NO** Difference in **ORR** & **PFS** in **aged < 75** vs **> 75y**
- **Safe**, feasible triplet for older patients with MM.
- High proportion of patients to achieve **≥VGPR (53%)**
- **> 8 cycles** , can be continued for enhanced disease control.
- Associated with **long remissions (PFS 26.6 months)**

EP 976 Holger auner et al

Survival among Older patients with Previously treated Multiple Myeloma , treated with weekly Selinexor, Bortezomib & Dexamethason **XVD**

The **phase 3** randomized BOSTON trial,  
a controlled, open-label study of once weekly **XVd** vs. twice weekly standard **Vd**  
in pts with MM and 1-3 prior treatment regimens.  
N: **402**

Data	N <b>99</b>
Age	76y (70-92)
>65y	<b>141/402</b>
ORR (XVD)	76.1%
ORR (VD)	64.4%
m OS (XVD)	NR
m OS (VD)	28.6m
Incidence of Death (XVD)	29
Incidence of Death (VD)	56

EP 976 Holger auner et al

Survival among Older patients with Previously treated Multiple Myeloma , treated with Selinexor, Bortezomib, & Dexamethason (**XVD**)

## Conclusions

In an **older** patient population with a poor prognosis, **XVd**

- associated with a significant survival benefit : improved PFS and ORR with reduced PN
- requires relatively short and infrequent clinic visits.

**XVd** may be a simple, effective regimen for pts with previously treated **MM** including those **≥65y**.

EP 980 Philippe Moreau et al,  
Isatuximab / Carfilzomib/ Dexamethasone versus Carfilzomib/Dexamethasone in Elderly patients with Relapsed Multiple Myeloma : IKEMA subgroup analysis

A prespecified interim efficacy analysis of the Phase 3 IKEMA study (NCT03275285) subgroup analysis of IKEMA examined → efficacy and safety in pts aged <70 and ≥70 y.

Primary end point : PFS  
Compared outcomes  
in pts <70 vs ≥70y

Patient characteristics	N 302
Age => 70y	28.3%
Isa-Kd	29.1%
Kd	27.6%

EP 980 Philippe Moreau et al,  
 Isatuximab / Carfilzomib/ Dexamethasone ( **Isa-Kd**) versus Carfilzomib/Dexamethasone (**Kd**) in Elderly patients with Relapsed Multiple Myeloma : IKEMA subgroup analysis

## Results

	<70 Years		≥70 Years	
	Isa-Kd (n=127)	Kd (n=89)	Isa-Kd (n=52)	Kd (n=34)
PFS HR (95% CI)	0.609 (0.384–0.968)		0.364 (0.176–0.751)	
CR, %	40.2	29.2	38.5	23.5
≥VGPR, %	72.4	56.2	73.1	55.9
MRD-, %	32.3	13.5	23.1	11.8
Grade ≥3 TEAEs, %*	71.4	63.6	90.2	76.5
Serious TEAEs, %*	54.0	52.3	72.5	70.6
Fatal TEAEs, %*	2.4	3.4	5.9	2.9
TEAEs leading to definitive discontinuation, %*	7.1	10.2	11.8	23.5

\*n=126; n=88; n=51; n=34



Scientific Working Group “Aging and Hematology” | @DrRaulCordoba



**EHA2021**  
VIRTUAL

# Follow-up day “Ageing & Hematology”: Best of Theme Session in Geriatric hematology Acute Myeloid Leukemia (AML)

**Javier Cornago Navascués, MD**

Fundación Jiménez Díaz University Hospital, Madrid, Spain

July 20, 2021



# | DISCLOSURES

**Gilead** (Speaker, Travel & Accommodation)

**Astellas** (Speaker, Travel & Accommodation)

**Jazz Pharmaceuticals** (Speaker, Travel & Accommodation)

**Fresenius-Kabi** (Speaker)

**Novartis** (Collaborator)



# Selected abstracts of AML

EP423

## GENOMIC LANDSCAPE IN PATIENTS WITH ACUTE MYELOID LEUKEMIA OLDER THAN 70 YEARS

N = 294 pacientes con mediana de edad 76 años (70-90)

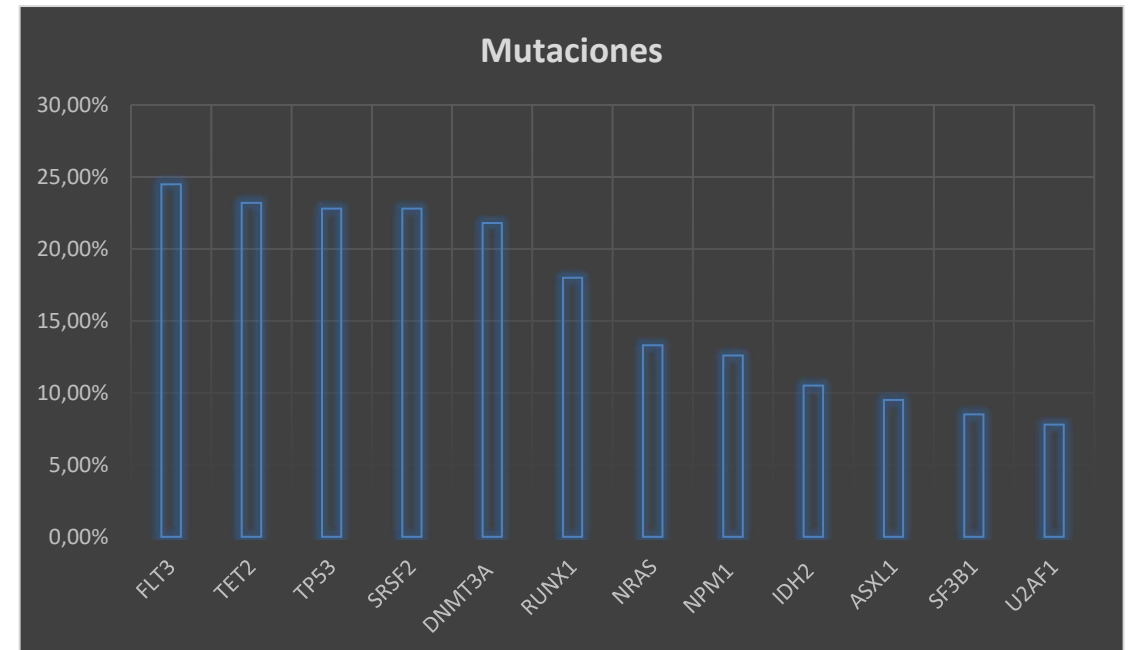
Descritas 1095 mutaciones en 83 genes en el 97% pacientes

**Mediana de 4 mutaciones / paciente** (rango 0-9)

ELN 2017: 4 (12.2%) favorable, 76 (27.3%) intermedio y **168 (60.4%) riesgo adverso**

**Mediana de SG 0,5 años**, sin diferencias significativas según grupos de riesgo; sí según el tipo de tratamiento (QT 0,97; HMA 0,76 y BSC 0,15)

**El efecto beneficioso del HMA sobre el BSC disminuye según aumenta la edad** (70-74 yrs,  $P < .001$ ; 75-80 yrs,  $P = .029$ ;  $\geq 80$  yrs,  $P = .889$ )



# Selected abstracts of AML

## EP457

### A PHASE 3 STUDY OF ENASIDENIB (ENA) VERSUS CONVENTIONAL CARE REGIMENS (CCR) IN OLDER PATIENTS WITH LATE-STAGE MUTANT-IDH2 (MIDH2) RELAPSED/REFRACTORY ACUTE MYELOID LEUKEMIA (R/R AML)

Los adultos mayores con LAM R/R tienen un pronóstico ominoso

Mutaciones en IDH2 se encuentran en 8-19% de las LAM

Enasidenib (inhib IDH2) vs terapia convencional (Aza, LDAC, dosis intermedias AraC y BSC)

319 pacientes > 60 años y ECOG < o = 2 (1:1)

	ENA N=158	CCR N=161
<b>Overall survival (ITT), months, median [95%CI]</b>	<b>6.5 [5.5, 9.5]</b>	<b>6.2 [4.6, 7.7]</b>
HR [95%CI]; log-rank P	0.86 [0.67, 1.10]; P = 0.23	
<b>Overall survival (Efficacy Evaluable)</b>	n=147	n=129
months, median [95%CI]	6.8 [5.7, 9.8]	5.7 [4.6, 7.6]
HR [95%CI]; log-rank P	0.77 [0.59, 1.00]; P = 0.047	
<b>Event-free survival,* months, median [95%CI]</b>	<b>4.9 [3.7, 5.9]</b>	<b>2.6 [1.9, 4.4]</b>
<b>Time to treatment failure,† months, median [95%CI]</b>	<b>4.9 [4.0, 6.0]</b>	<b>1.9 [1.4, 2.5]</b>
<b>Overall response rate (ORR),‡ n (%)</b>	<b>64 (40.5)</b>	<b>16 (9.9)</b>
CR rate, n (%)	37 (23.4)	6 (3.7)
Stable disease, n (%)	64 (40.5)	54 (33.5)
Disease progression, n (%)	13 (8.2)	29 (18.0)
Not evaluable,§ n (%)	17 (10.8)	62 (38.5)
<b>Time to first response (ORR), days, median (range)</b>	<b>92 (24–337)</b>	<b>59 (29–177)</b>
<b>Duration of response (ORR),¶ months, median [95%CI]</b>	<b>7.3 [5.6, 11.1]</b>	<b>NE [2.5, NE]</b>
<b>RBC-Transfusion Independence (TI),‡ n/N (%)</b>		
RBC-TD at BL, achieved TI on-study	33/104 (31.7)	9/97 (9.3)
RBC-TI at BL, retained TI on-study	32/53 (60.4)	7/44 (15.9)
<b>Platelet-TI,‡ n/N (%)</b>		
Platelet-TD at BL, achieved TI on-study	26/88 (29.5)	8/74 (10.8)
Platelet-TI at BL, retained TI on-study	48/69 (69.6)	22/67 (32.8)
<b>Any Hematologic Improvement (HI),‡ n (%)</b>	<b>67 (42.4)</b>	<b>18 (11.2)</b>
HI-Erythroid	21 (13.3)	9 (5.6)
HI-Platelet	31 (19.6)	7 (4.3)
HI-Neutrophil	57 (36.1)	13 (8.1)

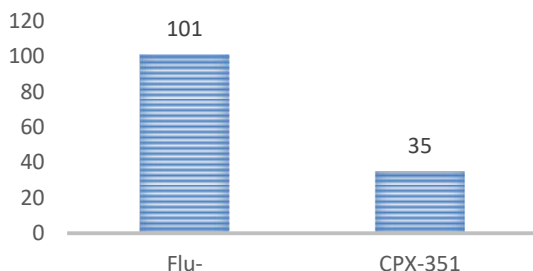
\*Time from randomization to relapse, PD, or death.  
†Treatment discontinuation for any reason.  
‡ORR includes CR, CRi/CRp, PR, and MLFS, per International Working Group (IWG) 2003 response criteria for AML.  
§No postbaseline marrow collected (considered nonresponders; included in denominator for response assessments)  
¶Date of first morphologic response to relapse, PD, or death.  
‡Per IWG 2006 response criteria for MDS.  
BL, baseline; CCR, conventional care regimens; CR, complete remission; CRi/CRp, CR with incomplete blood count/platelet recovery; ENA, enasidenib; HR, hazard ratio; MLFS, morphologic leukemia-free state; PR, partial remission; PD, progressive disease; RBC, red blood cell; TD, transfusion-dependent.

# Selected abstracts of AML

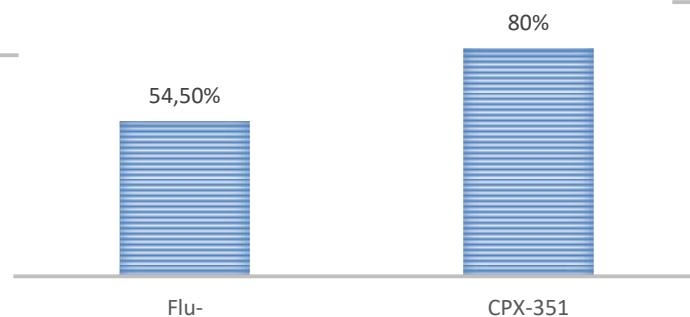
## EP459

### PROGNOSTIC IMPACT OF MINIMAL RESIDUAL DISEASE ASSESSMENT IN ELDERLY PATIENTS WITH SECONDARY ACUTE MYELOID LEUKEMIA. A COMPARISON BETWEEN CPX-351 AND INTENSIFIED FLUDARABINE-BASED REGIMENS

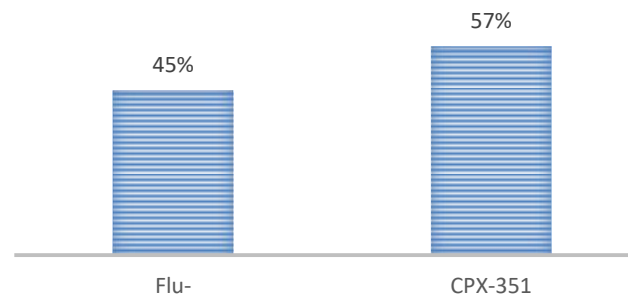
#### PACIENTES TRATADOS



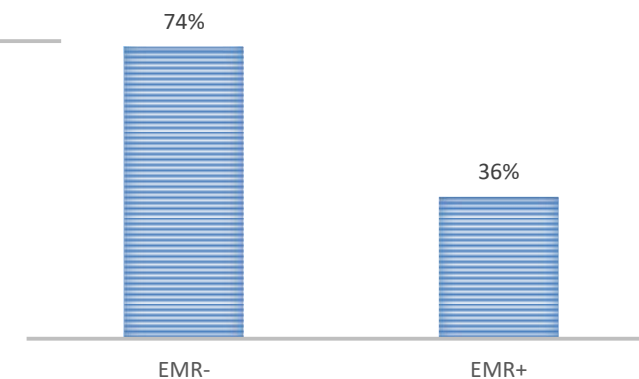
#### RESPUESTAS COMPLETAS



#### EMR NEGATIVA



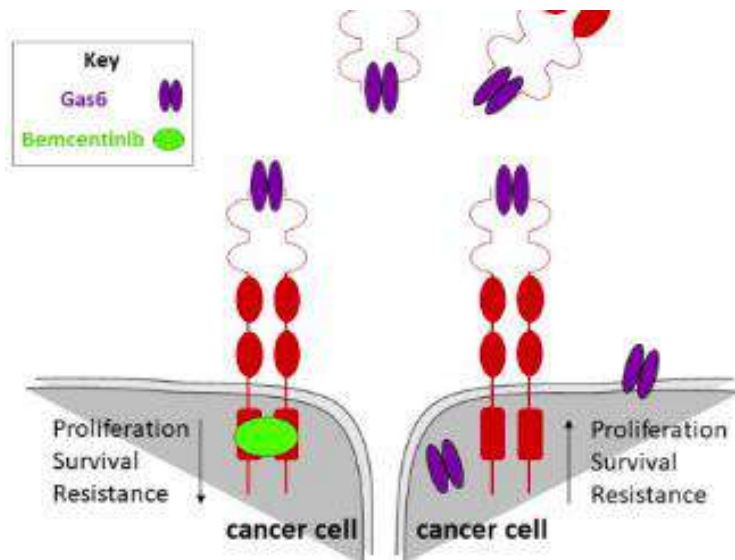
#### SG 2 AÑOS



# Selected abstracts of AML

## EP463

**THE COMBINATION OF AXL INHIBITOR BEMCENTINIB AND LOW-DOSE CYTARABINE IS WELL TOLERATED AND EFFICACIOUS IN ELDERLY RELAPSED AML PATIENTS: UPDATE FROM THE ONGOING BGBC003 PHASE II TRIAL (NCT02488408)**



	BEM + LDAC R/R AML (24 pacientes)	
	Recaída (17)	Refractaria (7)
Mediana líneas tto previas	1	3
Mediana edad (años)	75	
Riesgo CG adverso (%)	29	
Blastos screening (%)	32	40
RC/RP (%)	42	0
EE (%)	25	0

# Selected abstracts of AML

EP477

## BCL-2 EXPRESSION IN ELDERLY ACUTE MYELOID LEUKEMIA PATIENTS AND IMPACT ON OUTCOMES ACCORDING TO DIFFERENT THERAPEUTIC STRATEGIES

114 pacientes, mediana 68 años (65-85)

LAM de novo (43%); s-LAM (57%)

Riesgo ELN 2017 (%)

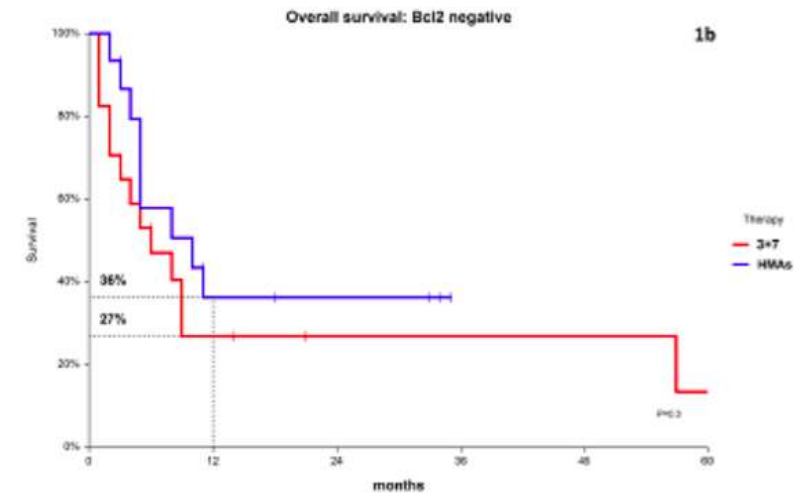
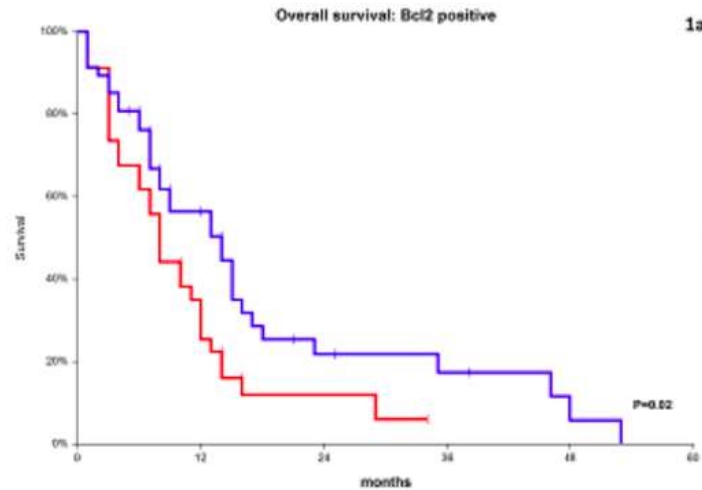
Favorable (15)

Intermedio (42)

Adverso (43)

Expresión BCL-2: 71%

3x7 (45%) vs HMA (55%)

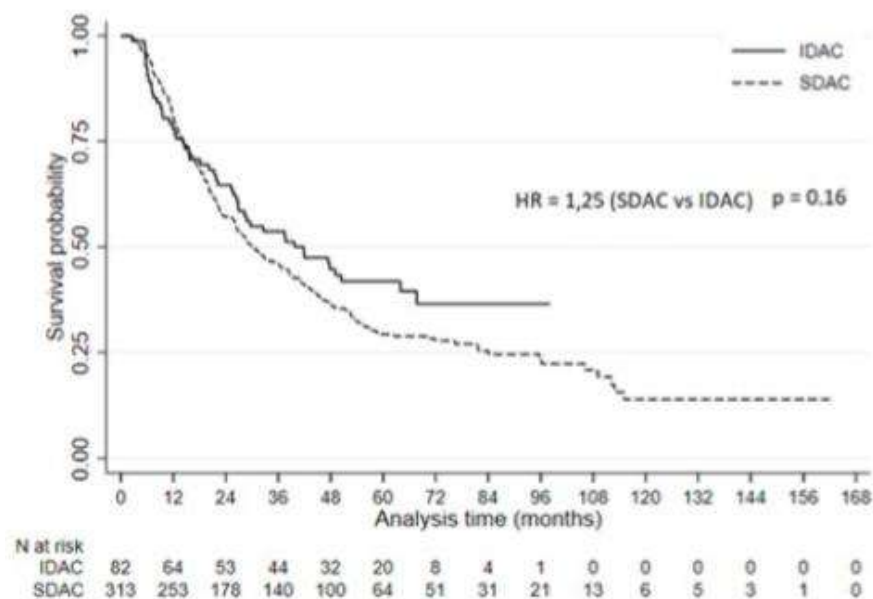


# Selected abstracts of AML

EP482

INTERMEDIATE OR STANDARD DOSE CYTARABINE AS POST REMISSION THERAPY IN OLDER PATIENTS WITH ACUTE MYELOID LEUKEMIA: IMPACTS ON OUTCOMES AND HEALTH CARE RESOURCE CONSUMPTION

Figure 1: overall survival of study population



	SDAC	IDAC
Pacientes (n)	313	82
Mediana edad (años)	69	65
Riesgo CG adverso (%)	11	31
s-LAM (%) / t-LAM (%)	18 / 3	35 / 18
Mediana ciclos	5	3
Mediana SG (meses)	30	40
Mediana SLE (meses)	17,5	21
<b>Necesidad ATB iv (%)</b>	<b>36,1</b>	<b>74,4</b>
<b>Bacteriemia (%)</b>	<b>15,7</b>	<b>41,5</b>
<b>Mediana Tx CH (n) / Tx CP (n)</b>	<b>1 / 0,8</b>	<b>3 / 2,5</b>
<b>Hospitalización (días)</b>	<b>12</b>	<b>32,5</b>

# Selected abstracts of AML

## EP486

### GLASDEGIB IN COMBINATION WITH LOW DOSE CYTARABINE FOR ELDERLY ACUTE MYELOID LEUKEMIA PATIENTS FAILING HYPOMETHYLATING AGENTS

16 pacientes; mediana edad 77 años (71 – 86)

88% 1 línea previa; 12% 2 líneas previas; 25% Ven previo

CG adversa 38%

13 pacientes evaluables

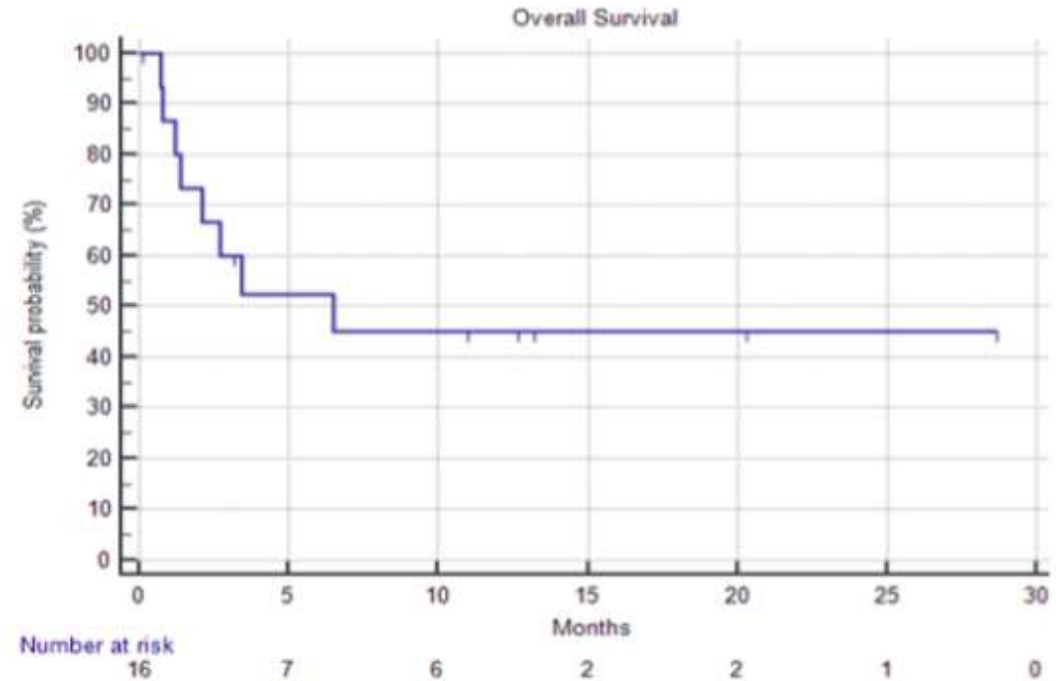
ORR 46% (4 RC, 1 RCi, 1 RP)

EE 23% (3)

PE 31% (4)

Mediana duración respuesta: 2 meses

Mediana SG: 6,5 meses



# Selected abstracts of AML

## EP494

### IMPACT OF TREATMENT INTENSITY, MRD AND HEMATOPOIETIC STEM CELL TRANSPLANTATION IN ELDERLY R/R AML PATIENTS: A MONOCENTRIC RETROSPECTIVE STUDY

Unicéntrico, retrospectivo

236 pacientes; > 60 años

Tratamiento empleado en 2ª línea: intensivo (50%), semi-intensivo [LDAC – HMA] (24,6%) o BSC (25,4%)

Mediana SG: 15,3 meses

#### Según tratamiento empleado (p 0,02)

Intensivo: 19,2 meses

Semi-intensivo: 21,6 meses

BSC: 14 meses

Otros factores que impactan en supervivencia

#### - Estado mutacional NPM1 / FLT3

Mediana SG (p < 0,001)

- NPM1+ / FLT3-: 25,4 meses
- NPM1+ / FLT3+: 14,3 meses
- NPM1- / FLT3+: 7 meses

#### - Tiempo hasta la recaída

Recaída > 12 meses mejor pronóstico que < 12 meses o refractariedad

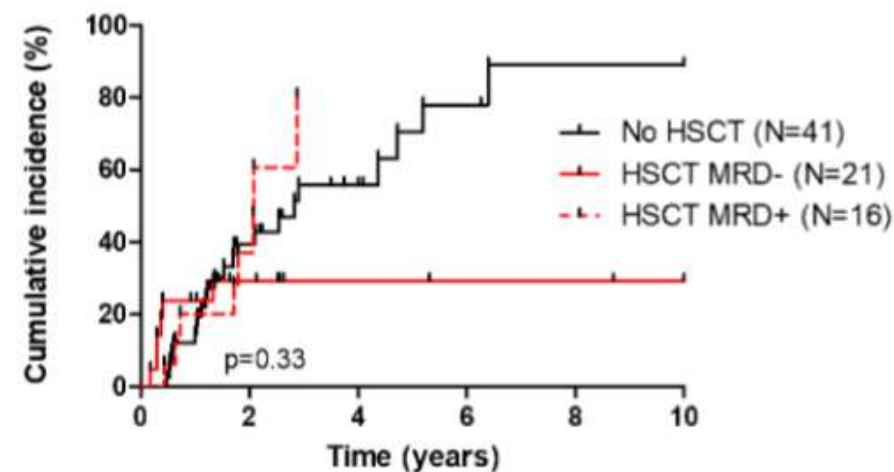
# Selected abstracts of AML

## EP494

### IMPACT OF TREATMENT INTENSITY, MRD AND HEMATOPOIETIC STEM CELL TRANSPLANTATION IN ELDERLY R/R AML PATIENTS: A MONOCENTRIC RETROSPECTIVE STUDY

	RC	RCi / MLFS
% pacientes	21,2	23,7
Mediana SG (meses)	34,9	21,2
EMR- (%)	60,9	NA

	EMR-	EMR+
Recaída a 3 años (%)	49,5	77,5



# Selected abstracts of AML

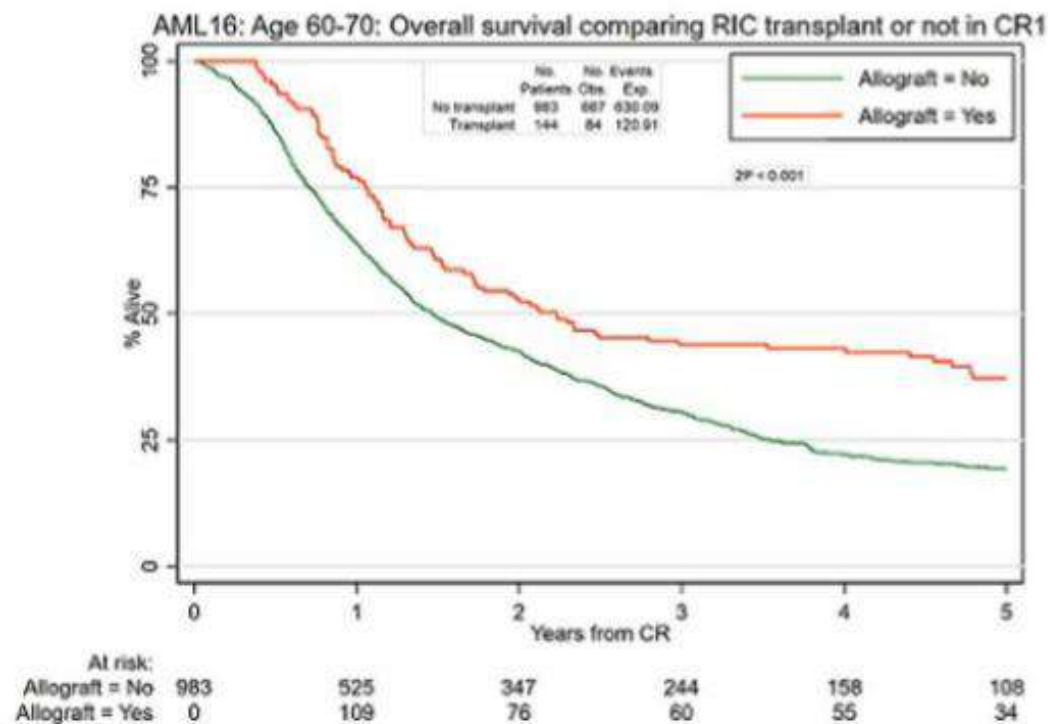
## S130

### SEQUENTIAL NCRI AML TRIALS SHOW CONSISTENT BENEFIT FOR RIC TRANSPLANT IN CR1 FOR OLDER PATIENTS >60YEARS THAT IS INDEPENDENT OF MRD STATUS AFTER FIRST INDUCTION

	AML-16	AML-18
Pacientes (n) / TPH (n)	983 / 144 (15%)	648 / 201 (31%)
SG 5 años (TPH / No TPH, %)	37 / 19	
SG 3 años (TPH / No TPH, %)		48 / 37,4

AML-16: TPH favorable en todos los grupos (edad, CG, PS...)

AML-18: La administración de consolidación (objetivo EMR-) tras la RC post-inducción mejora el pronóstico del TPH



# Selected abstracts of AML

## PB1392 PROGNOSTIC IMPACT OF MOLECULAR MARKERS IN ELDERLY PATIENTS AFFECTED BY NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA: MONOCENTRIC EXPERIENCE

	Global population	Favorable risk	Intermediate risk	Adverse risk
Patients (n)	75	17	40	18
Median age (range), years	66 (60-77)	64 (60-73)	65 (60-73)	69 (60-77)
ECOG score n (%)				
0	64 (85)	16 (94)	36 (90)	12 (66)
1	7 (9)	1 (6)	3 (7)	3 (17)
2	4 (6)	0	1 (3)	3 (17)
Gender n (%)				
M	50 (67)	15 (88)	26 (65)	9 (50)
F	25 (33)	2 (12)	14 (35)	9 (50)
Mutations or karyotype abnormalities n (%)				
NPM1	24 (32)	14 (82)	10 (25)	0
FLT3-ITD	19 (25)	3* (18)	9 (22)	7 (39)
FLT3-TKD	5 (7)	3 (18)	2 (5)	0
T(8;21)	0	0	0	0
INV(16) o t(16;16)	3 (4)	3 (18)	0	0
INV (3)	1 (1)	0	0	1 (6)
1 <sup>st</sup> line chemotherapy n (%)				
FLA	51 (68)	8 (47)	28 (70)	15 (82)
FLAI	8 (11)	3 (18)	5 (13)	0
3+7	4 (5)	1 (6)	2 (5)	1 (6)
3+7 + Midostaurin	8 (11)	4 (24)	3 (7)	1 (6)
CPX 351	3 (4)	0	2 (5)	1 (6)
ICC	2 (3)	2 (12)	0	0
Hematological CR n (%)	32 (43)	13 (77)	10 (25)	9 (50)
Relapse n (%)	18 (56)	8 (61)	5 (50)	5 (56)
Alogenic HSCT n (%)	11 (29)	4 (24)	7 (18)	2 (11)
Median OS (range), months	6 (0-59)	9 (0-59)	5 (0-56)	4 (0-43)
Median DFS (range), months	8 (1-58)	8 (1-58)	5 (2-55)	11 (2-27)

Análisis multivariante

Aumento de la SG

**Trasplante alogénico** HR:15.19;CI:3.34-69.05;p<0.005

**RC tras inducción** HR:2.55;CI:1.30- 5.00;p=0.006

No resulta significativo riesgo favorable ELN 2017 respecto int/adv ni el estado mutacional NPM1 y FLT3

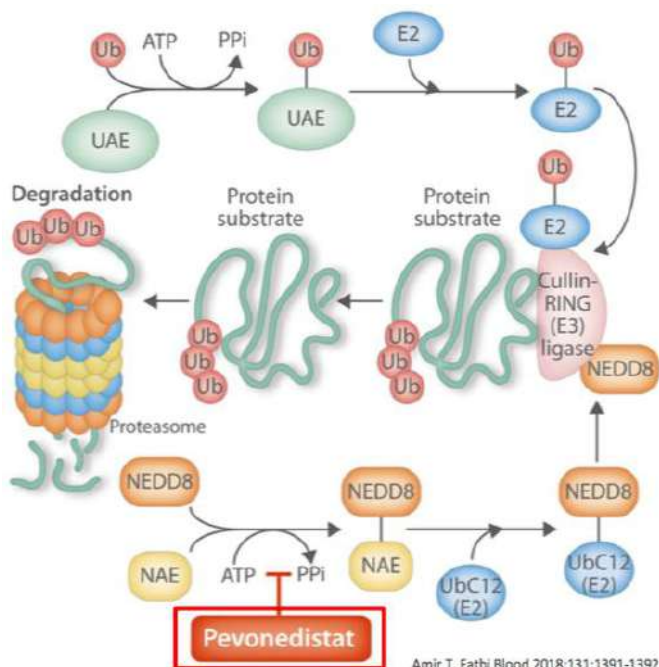
No diferencias en términos de SLE

En adultos mayores, es necesario establecer variaciones en los scores pronósticos habituales: edad, PS, elegibilidad para TPH...

# Selected abstracts of AML

## PB1407 PEVOLAM: TRIAL DESIGN FOR A RANDOMIZED PHASE 3 MULTICENTER STUDY COMPARING AZACITIDINE PLUS PEVONEDISTAT VS AZACITIDINE IN OLDER OR UNFIT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA

Inhibidor enzima activadora de NEDD8



n = 450

Randomization

1:1

### Pevonedistat + Azacitidine

Pevo: 20 mg/m<sup>2</sup> on Days 1, 3, 5

Aza: 75 mg/m<sup>2</sup> Days 1-5, 8, 9

Repeat every 28 days

### Azacitidine

Aza: 75 mg/m<sup>2</sup> Days 1-5, 8, 9

Primary endpoint:

- EFS

Secondary endpoints:

- OS

**C. Inclusión:**

- LAM ND
- ECOG < 3
- No candidato a QT intensiva
- LAM 2<sup>a</sup>

**C. Exclusión:**

- L > 25.000/mm<sup>3</sup>
- Tto previo para SMD, LMMC y/o NMPc

# Selected abstracts of AML

## PB1419 REAL-LIFE EFFICACY OF FIXED-DOSE HYPOMETHYLATING AGENTS IN OLDER PATIENTS WITH ACUTE MYELOID LEUKEMIA: A SINGLE CENTER EXPERIENCE

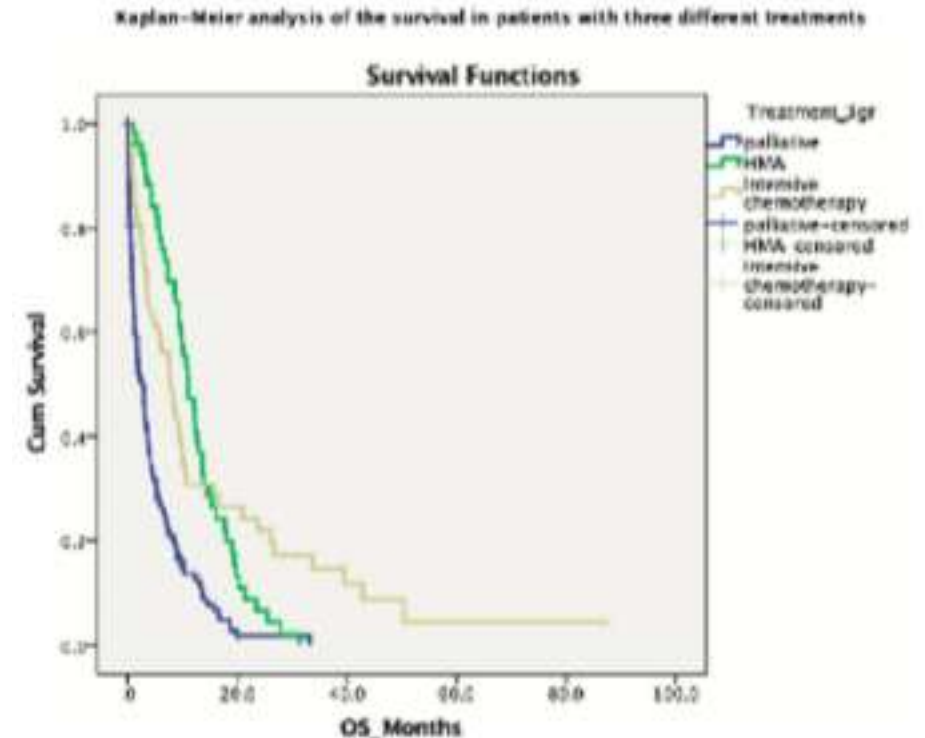
Estudio unicéntrico (Tailandia), retrospectivo

243 pacientes, > 60 años (71 +/- 8 años); LAM ND

70% LAM de novo; riesgo CG adverso 32,9%

Mediana SG: 5 meses

	QT intensiva	HMA dosis fija	Tto paliativo
Pacientes (%)	23,5	21,3	55,1
Mediana SG (meses)	7,7	11	2,5



Tratamiento paliativo genera resultados inferiores

No diferencias significativas entre QT intensiva y empleo HMA (HR 0.89: 95% CI 0.57-1.38)

# Selected abstracts of AML

## PB1777 PATIENT-CENTERED FACTORS IN EVALUATION OF ELIGIBILITY AND PROGNOSTICATION IN HEMATOPOIETIC STEM CELL TRANSPLANTATION IN OLDER PATIENTS WITH HEMATOLOGIC MALIGNANCIES – A SYSTEMATIC REVIEW

Objetivo: Establecer la importancia del empleo de escalas para determinar la elegibilidad del paciente para TPH

Revisión sistemática de la literatura: MEDLINE / Web of science

AloTPH	Impacto en supervivencia		
	Estudios	Univariante	Multivariante
PS (n) (%)	67	61	81
Comorbilidad (n) (%)	128	58	67
Estado nutricional (n) (%)	10	33,3	60
Calidad de vida (n) (%)	6	66,6	100

PS y comorbilidad son factores bien conocidos; estados nutricional y funcional, así como calidad de vida, están en auge



Scientific Working Group “Aging and Hematology” | @DrJCornago



**EHA2021**  
VIRTUAL

# Follow-up day “Ageing & Hematology”: Best of Theme Session in Geriatric hematology Myelofibrosis

**Raquel Mata, MD**

Fundación Jiménez Díaz University Hospital, Madrid, Spain

July 20, 2021



# Abstracts con la palabra “elderly” en Mielofibrosis

Presentation ID EP1121

**(EP1121) USE OF RUXOLITINIB IN ELDERLY PATIENTS WITH PRIMARY MYELOFIBROSIS**

Presentation ID EP1279

**(EP1279) GOOD OUTCOME OF HIGH-RISK MYELOFIBROSIS IN ELDERLY RECIPIENTS AFTER FULL INTENSITY T-DEplete CONDITIONING WITH FLUDARABINE, BUSULFAN, WITH SINGLE AGENT CICLOSPORIN AS GVHD PROPHYLAXIS.**

Raquel Mata Serna  
Servicio de Hematología  
Fundación Jiménez Díaz (Madrid)

**(EP1121) USE OF RUXOLITINIB IN ELDERLY PATIENTS WITH PRIMARY MYELOFIBROSIS**

**Objetivo:** Comparar la supervivencia de pacientes con Mielofibrosis primaria (MP)  $\geq 65$  años tratados o no con ruxolitinib. Análisis retrospectivo de 70 pacientes (2010-2019).

**Tabla 1. Características de los pacientes**

Characteristics	
Age (years; median, range)	74 (65-92)
Male sex, (nb, %)	49 (70)
Primary myelofibrosis, (nb, %)	57 (81)
Follow-up (months; median, range)	30 (0,1-126)
Constitutional symptoms (nb, %)*	29 (41)
Palpable splenomegaly (nb, %) <sup>‡</sup>	38 (54)
Leukocyte count (x10 <sup>9</sup> /L; median, range)	12,7 (12,2)
Hemoglobin level (g/dL; median, range)	11,5 (2,8)
Platelet count (x10 <sup>9</sup> /L; median, range)	513 (380)
Circulating blasts $\geq 1\%$ (nb, %)	13 (19)
Lactate dehydrogenase $>1x$ ULN (nb, %)	57 (81)
Driver mutation (median, %)	
<i>JAK2</i> <sup>V617F</sup>	50 (71)
<i>MPL</i>	5 (7)
<i>CALR</i>	10 (14)
Triple negative	5 (7)
Reticulin fibrosis grade $\geq 2$ (nb, %)	46 (66)
DIPSS score (nb, %) <sup>†</sup>	
Low risk	2 (3)
Intermediate-1 risk	41 (59)
Intermediate-2 risk	15 (21)
High risk	11 (16)

\*17, ‡4, †1 missing data.

**Tabla 2. Líneas de tratamiento**

Therapeutic lines	
Patients who underwent treatment (nb, %)	61 (87)
Therapeutic lines $\geq 2$ (nb, %)*	14 (20)
Hydroxiurea (nb, %) <sup>‡</sup>	54 (77)
Interferon- $\alpha$ (nb, %)	5 (7)
Ruxolitinib (nb, %)	12 (17)
Allogeneic stem cell transplant (nb, %) <sup>†</sup>	0 (0)
Transfusion dependency (nb, %)	18 (26)
Splenectomy (nb, %) <sup>‡</sup>	0 (0)

\*3, ‡3, †2, ‡2 missing data

## (EP1121) USE OF RUXOLITINIB IN ELDERLY PATIENTS WITH PRIMARY MYELOFIBROSIS

Tabla 3. Variables clínicas y analíticas en tratados y no tratados con Ruxolitinib

%	t-Ruxolitinib	nt-Ruxolitinib	p-value
Age (years; median, range)	69	75	<b>0,011</b>
Male sex	83,3	67,2	0,268
Reticulin fibrosis grade $\geq 2$	100	58,6	<b>0,006</b>
Post-PV/ET myelofibrosis	50	12,1	<b>0,002</b>
Constitutional symptoms	66,7	52,3	0,429
Palpable splenomegaly	91,7	50	<b>0,008</b>
Hemoglobin level $< 12\text{g/dL}$	83,3	50	<b>0,034</b>
Leukocyte count $> 11 \times 10^9/\text{L}$	33,3	44,8	0,464
Lactate dehydrogenase $> 1 \times$ ULN	100	77,6	0,069
Circulating blasts $\geq 1\%$	33,3	16,1	0,168
JAK2 <sup>V617F</sup> mutation	83,3	68,9	0,316
JAK2 <sup>V617F</sup> VAF	73	33	<b>0,029</b>
Transfusion dependency	25	25,7	0,095
Therapeutic lines $\geq 2$	66,7	10,3	<b>&lt;0,001</b>
Progression to LMA	16,7	18,7	0,398

PV, polycythemia vera; ET, essential thrombocythemia

Tabla 4. Análisis de variables con impacto en supervivencia libre de progresión (PFS) y supervivencia global (OS)

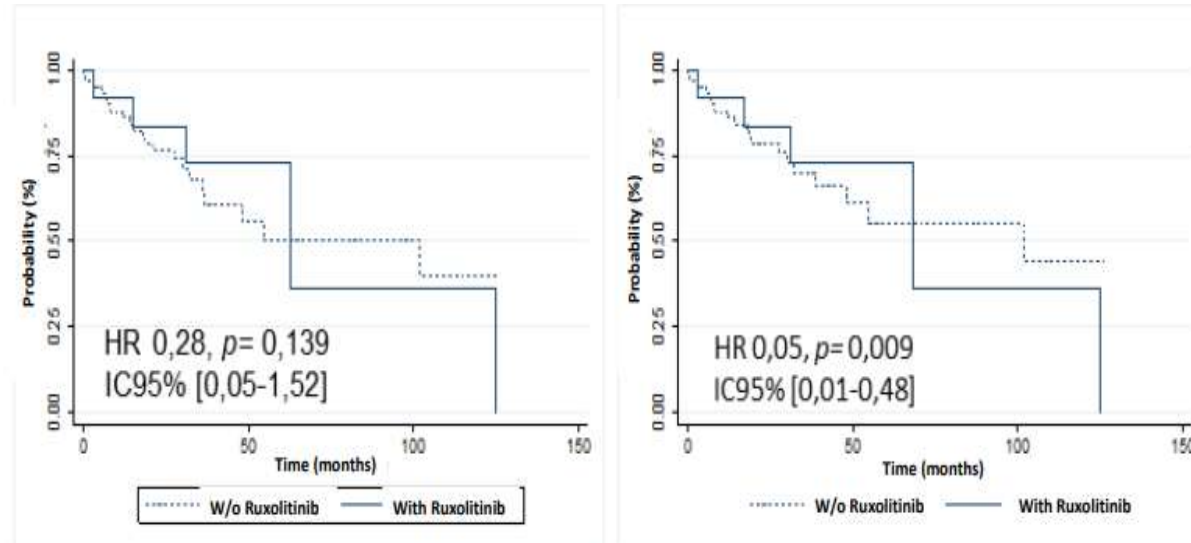
%	PFS		OS	
	HR	p-value	HR	p-value
Age (years; median, range)	<b>1.07</b>	<b>0.009</b>	<b>1.07</b>	<b>0.013</b>
Primary myelofibrosis	0.88	0.812	0.78	0.656
Constitutional symptoms	<b>10.28</b>	<b>0.002</b>	<b>10.17</b>	<b>0.002</b>
Palpable splenomegaly	<b>3.28</b>	<b>0.022</b>	<b>4.05</b>	<b>0.016</b>
Hemoglobin level $< 12\text{g/dl}$	<b>2.98</b>	<b>0.014</b>	<b>3.26</b>	<b>0.012</b>
Leukocyte count $> 11 \times 10^9/\text{L}$	1.56	0.270	1.56	0.291
Lactate dehydrogenase $> 1 \times$ ULN	5.47	0.096	4.99	0.116
Circulating blasts $\geq 1\%$	<b>3.02</b>	<b>0.018</b>	<b>3.40</b>	<b>0.010</b>
JAK2 <sup>V617F</sup> mutation	1.68	0.274	1.44	0.448
Reticulin fibrosis grade $\geq 2$	2.32	0.075	<b>3.37</b>	<b>0.029</b>
IPSS Intermediate-2/High risk	<b>16.54</b>	<b>0.006</b>	<b>3.16</b>	<b>0.008</b>
DIPSS Intermediate-2/High risk	<b>3.22</b>	<b>0.005</b>	<b>16.31</b>	<b>0.007</b>
Therapeutic lines $\geq 2$	0.78	0.602	0.85	0.755
Transfusion dependency	<b>4.52</b>	<b>&lt;0.001</b>	<b>4.43</b>	<b>0.001</b>

IPSS, International Prognostic Scoring System; DIPSS, Dynamic IPSS; HR, high

## (EP1121) USE OF RUXOLITINIB IN ELDERLY PATIENTS WITH PRIMARY MYELOFIBROSIS

Figura 1. PFS y OS en pacientes tratados o no con Ruxolitinib

**PFS media:** 62,7 meses  
**OS media:** 101,8 meses



### Conclusiones

1. Ruxolitinib tiene un efecto beneficioso en la supervivencia global en los pacientes con MF  $\geq$  65 años (incluyendo pacientes con IPSS/DIPSS de alto riesgo)
2. La edad no debería ser una limitación para su uso

## (EP1279) GOOD OUTCOME OF HIGH-RISK MYELOFIBROSIS IN ELDERLY RECIPIENTS AFTER FULL INTENSITY T-DEplete CONDITIONING WITH FLUDARABINE, BUSULFAN, WITH SINGLE AGENT CICLOSPORIN AS GVHD PROPHYLAXIS.

**Objetivo:** Establecer el papel del trasplante alogénico de progenitores hematopoyéticos mieloablativo en pacientes mayores de 55 años con MF de alto riesgo (DIPSS).

**Métodos:** Análisis retrospectivo (Abr-2012 a Dic-2018) de 22 pacientes

Edad media	61 años (44-68)
DIPPS	Alto (10); Intermedio-2 (12)
Acondicionamiento	Fludarabina 15 mg/m <sup>2</sup> (Días -9 a -5) Busulfán 3,2 mg/Kg (Días -6 a -3)
Profilaxis EICR	Timoglobulina (5,5 o 5 mg/Kg) Ciclosporina (1,5 mg/Kg hasta día+90)
Número de células CD34+ infundidas/Kg	5x10 <sup>6</sup> (3,2-6)
Tipo donante	Familiar idéntico (10) No emparentado (11): 1 con un mismatched
Mobilización con GCSF y recogida de progenitores hematopoyéticos de sp	Todos

## (EP1279) GOOD OUTCOME OF HIGH-RISK MYELOFIBROSIS IN ELDERLY RECIPIENTS AFTER FULL INTENSITY T-DEplete CONDITIONING WITH FLUDARABINE, BUSULFAN, WITH SINGLE AGENT CICLOSPORIN AS GVHD PROPHYLAXIS.

### Resultados:

Supervivencia global a los 24 meses	<b>60% (Media no alcanzada)</b>
Injerto neutrófilos >1.000/mcl Injerto de plaquetas > 20.000/mcl	<b>13 días (11-56)</b> <b>19 días (12-161)</b>
Media quimerismo día +100	97% (CD3) y 99% (CD15)
Incidencia EICR aguda Incidencia EICR crónica	<b>54%</b> (I-II: 50%; III-IV: 50%) <b>31%</b> (Leve: 57%; Moderado: 28%; Severo: 15%)
Reactivación CMV	40%; Media 50 días (29-165)
Incidencia de Enfermedad veno-oclusiva (EVO)	13%
Mortalidad global	50%; (3 EICR; 2 sepsis; 1 EVO; 1 LAM derivada de donante; 1 recaída; 1 desconocido; 1 proceso linfoproliferativo post-trasplante)
Fallo injerto	Primario: 0; Fallo de injerto plaquetar: 1 (4 meses después, fallo secundario)

### Conclusiones:

- El trasplante alogénico mieloablativo es una opción curativa y eficaz para MF de alto riesgo (↑ OS, injerto rápido, ↓ EVO)
- Es preciso optimizar la profilaxis de EICR sin aumentar tasa de infecciones oportunistas o recaídas

**EICR:** Enfermedad de injerto contra receptor; **CMV:** citomegalovirus; **LAM:** Leucemia aguda mieloide.



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# Final conclusions

1. We should generate more evidence of using a comprehensive geriatric assessment to guide therapy and follow-up in our older adults with hematological malignancies
2. It would be desire to see frailty assessment beyond retrospective studies. Future trials enrolling older adults should have a geriatric assessment in the screening procedures to better understand the efficacy and safety profile in this subgroup of patients
3. New treatment strategies, mostly “chemo-free” regimens, are coming to the therapeutic armamentarium and could be of interest as an alternative for older patients not candidates to intensive regimens
4. Future collaborations between scientific societies or working groups and pharmaceutical companies are encouraged



# Acknowledgements

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