Peripheral T-cell lymphomas (PTCLs) represent a relatively uncommon heterogeneous group of non-Hodgkin’s lymphomas (NHLs) with an aggressive clinical course and poor prognosis. Anthracycline-based multiagent chemotherapy with or without radiation therapy followed by first-line consolidation with high-dose therapy followed by autologous stem cell rescue (HDT/ASCR) is the standard approach to most of the patients with newly diagnosed PTCL. Relapsed or refractory disease is managed with second-line systemic therapy followed by HDT/ASCR or allogeneic stem cell transplant, based on the patient’s eligibility for transplant. In recent years, several newer agents have shown significant activity in patients with relapsed or refractory disease across all 4 subtypes of PTCL. These NCCN Guideline Insights highlight the important updates to the NCCN Guidelines for NHL, specific to the management of patients with relapsed or refractory PTCL.
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Overview

Peripheral T-cell lymphomas (PTCLs) are a heterogeneous group of lymphoproliferative disorders arising from mature T cells of post-thymic origin. PTCLs represent a relatively uncommon group of hematologic malignancies within non-Hodgkin’s lymphomas (NHLs) and account for approximately 10% of all NHL cases. PTCL not otherwise specified (PTCL-NOS; 26%) is the most common subtype, followed by angioimmunoblastic T-cell lymphoma (AITL; 18.5%), ALK-positive anaplastic large cell lymphoma (ALCL; 7%), ALK-negative ALCL (6%), and enteropathy-associated T-cell lymphoma (<5%). Recent molecular and genetic studies have identified molecular subgroups of ALK-negative ALCL and PTCL-NOS with distinct clinical outcomes (ALK-negative ALCL with dual-specificity phosphatase 22 [DUSP22] rearrangements and PTCL-NOS characterized by high expression of GATA3 or TBX21). Breast implant–associated...
ALCL has also been recently reported to be a distinct entity from systemic ALCL.  

PTCLs are less responsive to and have less frequent durable remissions with standard combination chemotherapy regimens, and thus carry a poorer prognosis compared with diffuse large B-cell lymphomas (DLBCLs). In general, ALK-positive ALCL is associated with better clinical outcomes than ALK-negative ALCL, PTCL-NOS, orAITL, although the favorable prognosis of ALK-1 positivity decreases with older age and higher prognostic risk scores. First-line consolidation with high-dose therapy followed by autologous stem cell rescue (HDT/ASCR) is associated with improved outcomes in patients who experience a good response to induction therapy.

Second-line systemic therapy followed by HDT/ASCR or allogeneic stem cell transplant (SCT), based on the patient’s eligibility for transplant, is the standard treatment approach for patients with relapsed/refractory disease. The management of patients with relapsed/refractory PTCL, however, remains suboptimal. These NCCN Guidelines Insights highlight the major discussion points regarding the recommendations for the management of patients with relapsed or refractory PTCL.
Management of Relapsed/Refractory PTCL
Role of Transplant

HDT/ASCR in patients with relapsed or refractory PTCL-NOS has been evaluated in several retrospective studies. Although HDT/ASCR has been reported to result in survival rates comparable to those of DLBCL in patients with chemosensitive relapsed/refractory PTCL, one retrospective analysis of outcomes based on major PTCL subtypes showed that event-free survival (EFS) rates were inferior in patients with PTCL-NOS (23%; \( P = .028 \)) and that those with ALCCL had a nonsignificant trend toward improved EFS rates (67%; \( P = .41 \)). In another retrospective analysis of data from the Spanish Group for Lymphoma and Autologous Transplantation (GEL/TAMO) registry (n=115), the 5-year OS rate was 45% for the patients with PTCL treated with HDT/ASCR in the second-line setting (n=78) compared with 80% for those who received a transplant in their first complete response (CR; n=37; \( P = .007 \)).

For the patients treated in the second-line setting, 5-year OS rates for those who underwent HDT/ASCR in first partial remission (PR), those who experienced CR at second-line or later lines of therapy, or those with refractory disease were 46%, 54%, and 0%, respectively. The number of regimens received before transplant, having chemosensitive disease at the time of transplant, and the second-line age-adjusted international prognostic index have been identified as significant prognostic factors for clinical outcome.

Recent reports have shown that allogeneic SCT using myeloablative conditioning or reduced-intensity conditioning (RIC) may provide an option for patients with relapsed or refractory PTCL. In a phase II study, Corradini et al investigated the role of RIC allogeneic SCT in patients with relapsed or refractory PTCL (N=17); estimated 3-year progression-free sur-
vival (PFS) and OS rates were 64% and 81%, respectively. Donor lymphocyte infusion induced responses in some patients whose disease progressed after allo-grafting. The estimated probability of nonrelapse mortality (NRM) at 2 years was 6%. In a retrospective analysis of data from the French registry of patients who received allogeneic SCT with myeloablative conditioning (N=77; PTCL-NOS, 35%; ALC, 35%; AITL, 14%), the 5-year EFS and OS rates were 53% and 57%, respectively. The 5-year transplant-related mortality rate was 34% and at 100 days was 21%. Patients who previously received a median of 2 prior therapies (range, 1–5), and 74% had received myeloablative conditioning before transplantation. Those who received 2 or fewer lines of prior chemotherapy had significantly higher 5-year OS rates compared with those who received more than 2 lines (73% vs 39%; P=0.003). The 5-year OS rate was also significantly higher among patients who underwent a transplant in remission (CR or PR) compared with those who received a transplant with less than a PR (69% vs 29%; P=0.003). No significant differences in outcomes (OS, EFS, or transplant-related mortality) were observed between types of conditioning regimen. Based on multivariate analysis, resistant disease at the time of transplantation and severe acute graft-versus-host disease were significant independent predictors of worse survival outcomes. A retrospective study of data from the European Society for Blood and Marrow Transplantation database showed that allogeneic SCT induced long-term remissions in patients with AITL (N=45; 62% had ≥2 lines of therapy before transplantation). Myeloablative conditioning was performed in 56% of patients and the remainder underwent RIC. The cumulative NRM rate at 1 year was 25%; these rates were similar between myeloablative conditioning (29%) and RIC (24%). The estimated 3-year relapse rate was 20%, and 3-year PFS and OS rates

SUGGESTED TREATMENT REGIMENS

First-line Therapy

Chop 2002: Cisplatin, Vincristine, Prednisone, Cyclophosphamide

GIMEMA 2015: Cisplatin, Vincristine, Prednisone, Carmustine

Dose-adjusted EPOCH

GDP (gemcitabine, dexamethasone, cisplatin)

GND (gemcitabine, vinorelbine, liposomal doxorubicin)

ICE (ifosfamide, carboplatin, etoposide)

ICE-R (ifosfamide, carboplatin, etoposide and rituximab)

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Chop is a standard chemotherapy regimen for the treatment of aggressive non-Hodgkin lymphoma. The regimen consists of four drugs: cyclophosphamide, doxorubicin, vincristine, and prednisone. It is used as first-line therapy for patients with aggressive non-Hodgkin lymphoma who are not candidates for autologous stem cell transplantation. The regimen is typically administered over 6-8 weeks with cycles repeated every 21-28 days.

GDP is another chemotherapy regimen that combines gemcitabine, dexamethasone, and cisplatin. This regimen is used for patients with relapsed or refractory aggressive non-Hodgkin lymphoma. Gemcitabine is a nucleoside analogue that inhibits DNA synthesis, dexamethasone is a glucocorticoid that suppresses the immune system, and cisplatin is a chemotherapy drug that affects DNA replication.

GND is a chemotherapy regimen that combines gemcitabine, vinorelbine, and liposomal doxorubicin. This regimen is used for patients with relapsed or refractory aggressive non-Hodgkin lymphoma. Gemcitabine and vinorelbine are both chemotherapy drugs that inhibit DNA synthesis, while liposomal doxorubicin is a chemotherapy drug that affects DNA replication.

ICE is a chemotherapy regimen that combines ifosfamide, carboplatin, and etoposide. This regimen is used for patients with relapsed or refractory aggressive non-Hodgkin lymphoma. Ifosfamide is a chemotherapy drug that affects DNA replication, carboplatin is a chemotherapy drug that affects DNA synthesis, and etoposide is a chemotherapy drug that inhibits DNA synthesis.

ICE-R is a chemotherapy regimen that combines ifosfamide, carboplatin, etoposide, and rituximab. This regimen is used for patients with relapsed or refractory aggressive non-Hodgkin lymphoma. It is similar to ICE, but includes rituximab, a monoclonal antibody that targets CD20 on the surface of B cells.

These regimens are typically administered intravenously and may require hospitalization. Patients may experience side effects such as nausea, vomiting, fatigue, and fever. Follow-up care may include blood work, imaging studies, and periodic assessments of response to treatment.

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Among 40 patients treated with PTCL-NOS and AITL were the dominant histologic types. Among those who underwent HDT/ASCR (n=41) or allogeneic SCT (n=35) for relapsed disease, 4-year OS rates were 50% and 36%, respectively (P<.001). The 4-year PFS rates were not statistically significantly different between the 2 groups (38% vs 28%). The 4-year OS rates were 59% and 53%, respectively, for patients who were in second and third CR at transplant; corresponding survival rates for those in PR were 55% and 22%, respectively. Patients with chemorefractory disease had inferior outcomes compared with those with chemosensitive disease; however, the results were not significantly different between HDT/ASCR and allogeneic SCT. The 4-year OS rates were 29% and 35%, respectively (P=.6), and the 4-year PFS rates were 25% and 18%, respectively (P=.4). The 4-year NRM rate was significantly higher with allogeneic SCT (40% vs 17% for HDT/ASCR; P<.001).

Second-Line Systemic Therapy

In prospective randomized studies, PTCLs have been included with aggressive B-cell lymphomas. In comparison chemotherapy regimens used for relapsed/refractory PTCL are derived from aggressive lymphoma clinical trials that have also included a limited number of patients with PTCL. However, it has not been possible to assess the impact of chemotherapy in this subgroup of patients with PTCLs due to small sample size and very limited data available for the specific use of combination chemotherapy regimens in patients with relapsed/refractory PTCL. Aggressive second-line chemotherapy with ICE (ifosfamide, carboplatin, etoposide) followed by HDT/ASCR was evaluated in patients with relapsed/refractory PTCL. Among 40 patients treated with ICE, 27 (68%) underwent HDT/ASCR. Based on intent-to-treat analysis, median PFS was 6 months from the time of last ICE therapy; 70% of patients experienced relapse within 1 year. Patients with relapsed disease had a significantly higher 3-year PFS rate compared with those who had primary refractory disease (20% vs 6%; P=.0005). Gemcitabine, dexamethasone, and cisplatin (GDP) followed by HDT/ASCR has also been shown to be effective for the treatment of patients with relapsed or refractory PTCL. In a retrospective analysis of 51 patients with relapsed (n=31) or primary refractory (n=20) PTCL identified in the BC Cancer Agency Lymphoid Cancer Database, GDP resulted in an overall response rate (ORR) of 80% (CR, 47%). The 2-year PFS and OS rates were 25% and 43%, respectively, with no differences among the histologic subtypes. The median follow-up was 10.4 months. Among patients who were treated subsequently with HDT/ASCR, the 2-year posttransplant OS rate was 53%, with no difference in survival rates between patients with relapsed and refractory disease (P=.23). For all nontransplanted patients, the median PFS and OS after treatment with GDP were 4.4 and 6.8 months, respectively. In another trial that evaluated GDP followed by HDT/ASCR in 25 patients with relapsed/refractory PTCL (14 patients with PTCL-NOS and 4 patients with AITL), the ORR was 72% (48% CR and 24% PR) after a median of 4 cycles of GDP and the median

PFS was 9.3 months. Results of a recent retrospective analysis showed that gemcitabine, vinorelbine, and doxorubicin (GND) was effective and well tolerated by patients with refractory or relapsed T-cell lymphomas (n=49; 28 patients with PTCL-NOS), with an ORR of 65.2% and a median OS of 36 months. The 5-year estimated OS rate was 32.4%. Until recently, data to guide the treatment of relapsed and refractory PTCL with various single agents (such as alemtuzumab, bortezomib, gemcitabine, lenalidomide, and cyclosporine) came from small single-institution series.

In a pilot study, alemtuzumab at standard dose schedule produced an ORR of 36% (CR, 21%) among patients with relapsed or chemotherapy-refractory PTCLs (n=14). However, alemtuzumab was associated with significant hematologic toxicity and infectious complications, including 5 deaths due to opportunistic infections. The preliminary results of another phase II study showed that in patients with pretreated T-cell lymphoma (n=10; PTCL, n=6), alemtuzumab at a reduced dose was less toxic and as equally effective as the standard dose used in the prior pilot study. In the subset of patients with PTCL-NOS, the ORR was 50% (CR, 33%). The median duration of response was 7 months. Cytomegalovirus reactivation was observed only in 10% of patients, compared with 42% of the patients reported by Enblad et al.

Long-term follow-up data from a small series of 39 patients with pretreated relapsed/refractory T-cell lymphoma showed that single-agent gemcitabine resulted in an ORR of 55% (CR, 30%) in a subgroup of 20 patients with PTCL-NOS; 5 of these patients were in continuous CR with a median response duration of 34 months (range, 15–60 months). Bortezomib also has demonstrated activity in patients with relapsed or refractory cutaneous T-cell lymphomas (CTCL; 10 patients with mycosis fungoides and 2 patients with PTCL-NOS with isolated skin involvement), resulting in an ORR of 67% (17% CR and 50% PR). Histologically, responses were observed in 7 patients with CTCL and one patient with PTCL-NOS with isolated skin involvement. All responses were durable, lasting from 7 to 14 or more months.

Lenalidomide monotherapy has also been effective in the treatment of relapsed or refractory PTCL, resulting in an ORR of 24%. The median OS and PFS were 12 and 4 months, respectively, with a median duration of response of 5 months. The results of a multicenter, single-arm, phase II trial (EXPECT) that evaluated the efficacy of lenalidomide monotherapy in patients with relapsed or refractory PTCL (n=54), showed that lenalidomide was particularly active in patients with relapsed or refractory AITL. The ORR was 22% (11% CR or unconfirmed CR [CRu]) for the entire study population. The median PFS and median duration of response were 2.5 and 3.6 months, respectively, in the intent-to-treat population. Among patients with AITL, the ORR, median PFS, and median duration of response were 31% (15% CR/CRu), 4.6 months, and 3.5 months, respectively.

Cyclosporine has also been reported as treatment option for patients with relapsed AITL. In a small series of 12 patients with relapsed/refractory AITL for whom prior steroid therapy or multiagent chemotherapy failed, cyclosporine, at fairly high doses, induced CRs and PRs in 3 and 5 patients, respectively. A more recent case report also demonstrated that cyclosporine is an effective treatment for AITL relapsing after HDT/ASCR.

In recent years, several newer agents, such as pralatrexate, romidepsin, belinostat, and brentuximab vedotin, have demonstrated significant activity in multicenter clinical trials for the management of patients with relapsed or refractory PTCL. Pralatrexate is a new antifolate with a high affinity for reduced folate carrier type 1 (RFC-1), and has shown significant activity in patients with relapsed/refractory T-cell lymphoma. The pivotal, international, phase II study (PROPEL) evaluated pralatrexate in heavily pretreated patients with relapsed or refractory PTCL (n=109; 59 patients with PTCL-NOS; 13 patients with AITL; and 17 patients with ALCL). Patients on this study had received a median of 3 prior systemic therapies; 63% were refractory to their most recent prior therapy, 24% had never responded to any prior therapy, and 16% had received prior autologous SCT. Pralatrexate resulted in an ORR of 29% (CR, 11%; response assessed by an independent central review). Although the study was not statistically designed to analyze the ORR in specific subsets, response analyses by key subsets indicated that the ORR was lower in AITL (8%) than in the other 2 subtypes (32% and 35%, respectively, for PTCL-NOS and ALCL). The median duration of response was 10 months. For all patients, the median PFS and OS were 3.5 and 14.5 months, respec-
tively. The most common grade 3/4 adverse events included thrombocytopenia (32%), neutropenia (22%), anemia (18%), and mucositis (22%). In September 2009, pralatrexate became the first FDA-approved single agent for the treatment of patients with relapsed or refractory PTCL.

Bendamustine was evaluated in a multicenter phase II study (BENTLEY trial) in patients with relapsed or refractory PTCL (n=60; AITL, 53%; PTCL-NOS, 38%). Patients had received a median of 1 prior therapy (range, 1–3), and 45% were considered refractory to their last therapy; 92% had received prior CHOP or CHOP-like regimens. Forty patients (67%) had completed 3 or more cycles of bendamustine; 25% received all 6 cycles of therapy. The ORR after 3 cycles of bendamustine was 50%, with CR (including CRu) in 28% of patients. The median duration of response was short at only 3.5 months. The ORR for AITL and PTCL-NOS was 69% and 41%, respectively (P=0.47). However, this study was not powered to show differences in response rates between the different histologic subtypes.32 The median PFS and OS for all patients were 3.6 and 6.3 months, respectively. The most common grade 3 or 4 toxicities included neutropenia (30%), thrombocytopenia (24%), and infectious events (20%).

Histone deacetylase (HDAC) inhibitors, including romidepsin and belinostat, have shown single-agent activity in patients with relapsed or refractory PTCL. Romidepsin was approved by the FDA in June 2011 for the treatment of patients with relapsed PTCL based on the results of the pivotal multicenter phase II study that evaluated romidepsin in 130 patients with relapsed/refractory PTCL (PTCL-NOS, n=69 [53%]; AITL, n=27 [21%]; ALK-negative ALCL, n=21 [16%]). Patients had received a median of 2 prior systemic therapies (range, 1–8), and prior autologous HSCT failed in 16%. Updated results from this study confirmed that responses were durable across all 3 subtypes of PTCL. At a median follow-up of 22.3 months, there were no significant differences in ORR or rates of CR/CRu between the 3 most common subtypes of PTCL. The ORR was 29%, 30%, and 24%, respectively, for patients with PTCL-NOS, AITL, and ALK-negative ALCL. The corresponding rates of CR/CRu were 14%, 19%, and 19%, respectively. The median PFS was 20 months for all responders and it was significantly longer for patients who achieved CR/CRu for 12 months or more compared with those who achieved CR/CRu for less than 12 months or PR (29, 13, and 7 months, respectively). The median OS was not reached for patients who achieved CR/CRu and was 18 months for those who were in PR.35 The most common grade 3 or greater adverse events included thrombocytopenia (24%), neutropenia (20%), and infections (19% for any; including pneumonia [5%] and sepsis [5%]). The BELIEF trial evaluated belinostat in 129 patients with relapsed or refractory PTCL (pretreated with >1 prior systemic therapy). The ORR in 120 evaluable patients was 25.8% (CR rate of 10.8% and PR rate of 15%). The median duration of response, median PFS, and median OS were 13.6, 1.6, and 7.9 months, respectively. The 1-year PFS rate was 19.3%. The ORR was higher for AITL compared with other subtypes (45.5% vs 23.3% and 15.3%, respectively, for patients with PTCL-NOS and ALK-negative ALCL). Anemia (10.8%), thrombocytopenia (7%), dyspnea (6.2%), and neutropenia (6.2%) were the most common grade 3 or 4 adverse events. Belinostat was approved by the FDA in July 2014 for the treatment of relapsed or refractory PTCL.

Brentuximab vedotin is an antibody-drug conjugate that targets CD30-expressing malignant cells by binding to CD30 on the cell surface. The safety and efficacy of brentuximab vedotin (1.8 mg/kg intravenously every 3 weeks, up to 16 cycles) in patients with relapsed or refractory systemic ALCL was established in a multicenter phase II study (n=58). Patients had received a median of 2 prior systemic therapies (range, 1–6) and 62% were considered to have primary refractory disease; in addition, 50% of patients were refractory to their most recent prior therapy and 22% had never responded to any therapy. In August 2011, based on the results from this study, brentuximab vedotin was approved by the FDA for the treatment of patients with systemic ALCL after failure of at least one prior multiagent chemotherapy regimen. Long-term follow-up results confirmed the durability of clinical benefit of brentuximab vedotin in patients with relapsed or refractory systemic ALCL. After a median follow-up of approximately 4 years, the ORR of 83% (62% CR rate) was similar to the previously reported ORR of 86% (59% CR) evaluated by an independent review committee. The estimated 4-year survival rate was 64%. The median duration of objective response for all patients was 13.2 months (the median duration
of response for patients with a CR was 26.3 months. The planned subset analysis of a phase II multicenter study that evaluated the efficacy and safety of brentuximab vedotin in relapsed/refractory CD30-positive NHL showed that it was also effective in other subtypes of relapsed PTCL, particularly AITL. This analysis included 35 patients with PTCL (22 patients with PTCL-NOS and 13 patients with AITL); the ORR, median duration of response, and median PFS for all patients with T-cell lymphomas were 41%, 7.6 months, and 2.6 months, respectively. The ORR (54% vs 33%) and the median PFS (6.7 vs 1.6 months) were better for patients with AITL than those with PTCL-NOS.

NCCN Recommendations
Participation in a clinical trial is strongly preferred for patients with relapsed/refractory disease. In the absence of a suitable clinical trial, the initial treatment for relapse/refractory disease depends largely on the patient's eligibility for transplant. Second-line systemic therapy followed by consolidation with HDT/ASCR or allogeneic SCT for those with a CR or PR is recommended for patients who are candidates for transplant. Localized relapse (limited to 1 or 2 sites) may be treated with involved-site RT before or after HDT/ASCR. Allogeneic SCT, when feasible, should be considered as a more reliably curative therapy for most patients with relapsed/refractory disease. HDT/ASCR may be an appropriate option for patients, particularly those with ALCL and for selected patients with other subtypes with chemosensitive relapsed disease. Patients who are not candidates for transplant should be treated with second-line systemic therapy or palliative radiotherapy.

Selection of Second-Line Systemic Therapy
Brentuximab vedotin should be the preferred choice of second-line therapy for relapsed/refractory ALCL. Belinostat induced responses across all types of PTCL (with the exception of ALK-positive ALCL) and response rates were significantly higher for AITL than for other subtypes. Bendamustine also induced higher response rates in patients with AITL compared with those with other subtypes. Pralatrexate has very limited activity in AITL compared with other subtypes. However, the aforementioned studies were not sufficiently powered to evaluate the response rates in specific subtypes. Cyclosporine has been shown to be an effective treatment option for relapsed or refractory AITL.

There are not enough data to support the use a particular regimen for second-line therapy based on the subtype, with the exception of ALCL. The selection of second-line chemotherapy regimen (single agent vs combination regimen) should be based on the patient's age, performance status, donor availability, agent's side effect profile, and goals of therapy. For instance, if the intent is to transplant, ORR or CR rate may be more important than the ability to give a treatment in an ongoing or maintenance fashion without cumulative toxicity. For patients who are intended for transplant soon, combination chemotherapy prior to transplant is often preferred, if HDT/ASCR is being considered. However, for many patients with intention to proceed to allogeneic SCT, the use of single agents as a bridge to transplant may be more appropriate because it is necessary to sustain response until a suitable donor is identified and worked up. Combination chemotherapy may be preferred for patients who are ready to proceed to allogeneic SCT when a suitable donor has already been identified. However, if there is no donor available, the use of intensive combination chemotherapy is not recommended due to the inability to maintain a response for longer periods with the continuous treatment. Single agents may also be more appropriate for older patients with a limited performance status or patients who are unable to tolerate combination chemotherapy.

Summary
The poor results with conventional chemotherapy regimens led to the development of novel targeted therapies, resulting in improved clinical outcomes in patients with relapsed/refractory disease across many PTCL subtypes. The selection of appropriate treatment strategy for relapsed or refractory PTCL should be based on the patient's age, performance status, and eligibility for transplant; the agent's side effect profile; and the goals of therapy. Second-line systemic therapy followed by consolidation therapy with HDT/ASCR or allogeneic HSCT is recommended for patients who are candidates for transplant. Patients who are not candidates for transplant should...
be treated with second-line systemic therapy or palliative radiotherapy.

References


1. A 59-year-old man presents to his primary care physician with diffuse abdominal pain. He was previously treated with anthracycline-based chemotherapy, followed by HDT, followed by ASCR for ALK-1–negative ALCL. A CT scan of abdomen/pelvis shows a mesenteric mass, and a core biopsy confirms recurrent ALCL. What is the appropriate option for second-line therapy?
   a. Gemcitabine and oxaliplatin
   b. Involved-site radiation therapy
   c. Brentuximab vedotin
   d. Ifosfamide, carboplatin, and etoposide (ICE)

2. Which of the following single agents induces higher response rates in patients with angioimmunoblastic T-cell lymphoma than in those with other subtypes of PTCL?
   a. Pralatrexate
   b. Belinostat
   c. Romidepsin
   d. None of the above

3. True or False: Allogeneic SCT should be considered a more reliable curative therapy for most transplant-eligible patients with relapsed/refractory disease.

Instructions for Completion
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Posttest Questions
1. A 59-year-old man presents to his primary care physician with diffuse abdominal pain. He was previously treated with anthracycline-based chemotherapy, followed by HDT, followed by ASCR for ALK-1–negative ALCL. A CT scan of abdomen/pelvis shows a mesenteric mass, and a core biopsy confirms recurrent ALCL. What is the appropriate option for second-line therapy?
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   b. Belinostat
   c. Romidepsin
   d. None of the above

3. True or False: Allogeneic SCT should be considered a more reliable curative therapy for most transplant-eligible patients with relapsed/refractory disease.