

SINTOMA 2026

Flash Clinical Cases

Hodgkin · T-Cell Lymphomas · CNS Lymphoma

Day 3 · Saturday May 16, 2026

cHL · PTCL · AITL · Primary CNS Lymphoma

5 Cases · 3–5 min discussion each

 PATIENT

- 26F, advanced classical Hodgkin lymphoma, Stage IIIB
- B symptoms; bulky mediastinal mass (10cm)
- Planning pregnancy after treatment; ECOG PS 1
- IPS: 3/7

 DIAGNOSTICS

- PET: Multiple FDG-avid sites; Deauville 4
- CD30 3+ (strong, diffuse); EBV negative
- BM negative; pulmonary function: normal
- ECHO: Normal EF

 PRIOR THERAPY

- Treatment-naïve
- Oocyte cryopreservation completed
- Discussed with patient: ABVD × 6 (PET-adapted) · BV-AVD × 6 (ECHELON-1) · Nivolumab + AVD (S1826)

 CLINICAL DILEMMA

26-year-old with advanced cHL, IPS 3, bulky disease, fertility concerns. BV-AVD (ECHELON-1) vs. ABVD. Does the PFS/OS benefit of BV-AVD justify brentuximab in a young woman who wants children?

 MANAGEMENT OPTIONS — no single correct answer

- A. BV-AVD × 6 (ECHELON-1)** — superior OS vs. ABVD long-term; no bleomycin; fertility impact similar
- B. ABVD × 2 + PET2-adapted escalation** — PET2-negative: complete ABVD × 4; PET2-positive: BEACOPP
- C. Escalated BEACOPP** — highest CR rates; excessive toxicity, fertility risk; avoid in young women
- D. Nivolumab + AVD (S1826)** — frontline checkpoint; no bleomycin, no brentuximab; excellent PFS
- E. BV-AVD + PET2 adaptation** — de-escalate if Deauville 1-2 at interim

 PATIENT

- 54M, PTCL-NOS, 1st relapse after CHOP
- ECOG PS 1; T2DM, mild CKD; initially declined ASCT at CR1
- CD30 upregulated at relapse (2+ — was weak 1+ at diagnosis)

 DIAGNOSTICS

- CD30: Upregulated at relapse (2+ — was weak 1+ at diagnosis)
- Ki-67 at relapse: 72%; LDH 2.8× ULN
- PET: Diffuse FDG-avid, SUVmax 14; BM 25%
- NGS at relapse: IDH2 WT, TET2, DNMT3A

 PRIOR THERAPY

- L1: CHOP × 6 → CR × 18 months; consolidation ASCT declined by patient
- No prior BV, GDP, or transplant
- Now: 1st relapse, CD30 upregulated

 CLINICAL DILEMMA

PTCL-NOS in 1st relapse with CD30 upregulation. PS 1. Patient previously declined ASCT — now reconsidering. What salvage regimen gives the best bridge to transplant — and is allo-SCT or ASCT the right goal?

 MANAGEMENT OPTIONS — no single correct answer

- A. BV + CHP salvage (CD30 2+ upregulation)** — brentuximab-based; aim for CR2 → ASCT
- B. DHAP/ICE → allo-SCT** — PTCL relapse: allo-SCT offers GVL advantage over ASCT
- C. GDP (gemcitabine + dexamethasone + cisplatin)** — available salvage in Brazil; bridge to transplant
- D. Pralatrexate** — antifolate; approved R/R PTCL; available in Brazil; outpatient option
- E. Palliative intent** — PS 1 but rapid relapse 18 months after CHOP; realistic goals-of-care discussion

PATIENT

- 58M, PTCL-NOS, newly diagnosed
- B symptoms; ECOG PS 1; no significant comorbidities
- PIT score: 2 (intermediate-high risk)

DIAGNOSTICS

- CD30: 2+ (moderate, ~40% of cells); CD4+, CD8–
- Ki-67: 68%; LDH 2.3× ULN; BM negative
- PET: Multiple FDG-avid sites, SUVmax 12; no CNS
- NGS: TET2 mutation; RHOA G17V negative (not AITL)

PRIOR THERAPY

- Treatment-naïve
- Discussed with patient: CHOP · CHOEP · BV-CHP
- ASCT consolidation planned if CR1 achieved

CLINICAL DILEMMA

Newly diagnosed PTCL-NOS with moderate CD30 expression. ECHELON-2 established BV-CHP superiority in CD30+ PTCL. But at CD30 2+, is the threshold met — and does etoposide (CHOEP) still add value in 2026?

MANAGEMENT OPTIONS — no single correct answer

- BV-CHP × 6 — ECHELON-2:** superior PFS/OS in CD30+ PTCL; CD30 2+ meets threshold
- CHOEP × 6 —** etoposide adds benefit in younger fit PTCL; standard in many European centers
- CHOP × 6 —** backbone standard; ASCT consolidation in CR1 offsets induction inferiority
- BV-CHP —** add brentuximab to full CHP; more intensive; neuropathy concern
- CHOP × 2 then restage —** confirm CD30 expression on repeat biopsy before committing to BV

PATIENT

- 71M, PCNSL (DLBCL), relapse post-HD-MTX + ASCT
- ECOG PS 2 (cognitive decline, gait disturbance)
- AF (on apixaban); hypertension
- Lives with daughter; CAR-T center on site

DIAGNOSTICS

- MRI: New right frontal lesion 2.8cm + leptomeningeal enhancement
- CSF: B cells confirmed by flow cytometry
- Systemic restaging: No systemic involvement
- Original biopsy: DLBCL, GCB-like

PRIOR THERAPY

- L1: HD-MTX × 8 → CR × 14 months
- Consolidation: Thiotepa-BCNU ASCT (2 years ago)
- Relapse 16 months post-ASCT
- No prior ibrutinib; no prior CNS-focused targeted therapy

CLINICAL DILEMMA

PCNSL relapsing post-HD-MTX + ASCT in a 71-year-old with cognitive decline and AF on apixaban. Ibrutinib has excellent CNS penetration. But ibrutinib + apixaban = bleeding risk. What is the salvage strategy?

MANAGEMENT OPTIONS — no single correct answer

A. Ibrutinib monotherapy — 50–80% ORR in R/R PCNSL; excellent CNS penetration; manage AF with cardiology

B. Ibrutinib + rituximab (IV/intrathecal) — BTK + CD20 dual targeting; increasing data in R/R PCNSL

C. Temozolomide or pemetrexed — salvage chemo for PCNSL; lower efficacy but available everywhere

D. CAR-T (CD19) — institutional capability; emerging PCNSL CAR-T data; leptomeningeal challenge

E. WBRT palliative — WBRT previously deferred; now reconsider with cognitive baseline already impaired

PATIENT

- 33F, classical Hodgkin lymphoma, 3rd relapse post-ASCT
- ECOG PS 1; prior ASCT 2 years ago
- No prior checkpoint inhibitor; MUD 10/10 available
- Strong desire for further treatment

DIAGNOSTICS

- PET: Multiple FDG-avid sites, SUVmax 9.4; BM negative
- CD30 3+; EBV positive; PD-L1: H-score 280 (strongly positive on RS cells)
- LDH 1.8× ULN

PRIOR THERAPY

- L1: ABVD × 6 → CR × 18 months
- L2: BV + bendamustine → PR × 12 months then relapse
- L3: ASCT (BEAM) 2 years ago → CR × 22 months
- Now: 3rd relapse post-ASCT; no prior PD1 inhibitor

CLINICAL DILEMMA

3rd-relapse cHL post-ASCT, no prior checkpoint inhibitor, MUD available for allo-SCT. Pembrolizumab/nivolumab expected to achieve response. What is the endpoint — bridge to allo-SCT, or long-term checkpoint therapy?

MANAGEMENT OPTIONS — no single correct answer

- A. Pembrolizumab or nivolumab** → bridge to allo-SCT — MUD available; allo-SCT is only curative option
- B. Nivolumab + BV combination** — deeper responses; better bridge quality for allo-SCT
- C. Long-term pembrolizumab without allo-SCT** — durable responses in cHL; spare allo-SCT toxicity at 33
- D. Nivolumab → allo-SCT → no checkpoint maintenance** — maximize GVL; stop checkpoint to avoid GVHD amplification
- E. Proceed directly to allo-SCT without PD1** — MUD available; avoid hyperacute GVHD risk from checkpoint