

SINTOMA 2026

Flash Clinical Cases

Diffuse Large B-Cell Lymphoma

Day 3 · Saturday May 16, 2026

DLBCL · Frontline · R/R · CAR-T · Bispecifics · Frail

5 Cases · 3–5 min discussion each

 PATIENT

- 48M, DHL DLBCL, newly diagnosed
- Rapid progression × 3 weeks; borderline ICU at presentation
- ECOG PS 2 (acute); CAR-T center on site; now stabilized

 DIAGNOSTICS

- DLBCL GCB; MYC+ (3' IGH), BCL2+ → Double-Hit
- BCL6 negative (not triple-hit); Ki-67 92%
- IPI 4/5; LDH 8× ULN; 11cm mediastinal mass; CNS negative

 PRIOR THERAPY

Treatment-naïve

- Discussed with patient: DA-EPOCH-R · R-CHOP · Pola-R-CHP
- CAR-T center on site

 CLINICAL DILEMMA

DHL DLBCL, IPI 4, LDH 8×. DA-EPOCH-R has been the traditional DHL standard — but CALGB 50303 found no superiority vs. R-CHOP. Is DA-EPOCH-R still justified in 2026?

 MANAGEMENT OPTIONS — no single correct answer

- A. DA-EPOCH-R × 6** — traditional DHL standard; dose-adjusted intensity
- B. Pola-R-CHP × 6 (POLARIX)** — polatuzumab may address MYC-driven resistance; POLARIX excluded DHL
- C. R-CHOP × 6 + CNS prophylaxis** — CALGB 50303: DA-EPOCH-R not superior including DHL subgroup
- D. Intensive approach (R-HyperCVAD)** — IPI 4, LDH 8×, age 48; leukemia-like approach
- E. CAR-T consolidation planning upfront** — plan CAR-T if less than CMR after frontline

 PATIENT

- 67F, DLBCL — primary refractory (no R-CHOP response)
- ECOG PS 2 (disease-related; was PS 1 at diagnosis)
- HTN, T2DM; lives alone; daughter available as caregiver

 DIAGNOSTICS

- DLBCL ABC subtype; IPI 4/5; CD19 3+; no MYC
- PET after cycle 4: Deauville 5 (progressive disease)
- LDH 3.1× ULN post-R-CHOP; BM 10% DLBCL

 PRIOR THERAPY

- L1: R-CHOP × 4 → primary refractory (PD confirmed)
- No prior CAR-T; no prior salvage chemo
- PS 2 disease-related; daughter available as caregiver

 CLINICAL DILEMMA

Primary refractory DLBCL, ABC subtype, PS 2, age 67, lives alone. ZUMA-7/TRANSFORM support CAR-T in 2L. Does PS 2 and age 67 exclude her — or is she exactly who needs CAR-T most?

 MANAGEMENT OPTIONS — no single correct answer

- A. Axi-cel CAR-T (ZUMA-7)** — primary refractory 2L standard; PS 2 not absolute exclusion; caregiver available
- B. Liso-cel CAR-T (TRANSFORM)** — step-up dosing; more comorbid patients included; outpatient start
- C. Salvage chemo (R-ICE, pola-R-DHAX) then reassess** — reduce disease burden; improve PS before CAR-T
- D. Epcoritamab** — CD19+; approved R/R DLBCL in Brazil; outpatient; lower intensity for PS 2
- E. Tafasitamab + lenalidomide** — chemo-free; approved R/R DLBCL; avoids CAR-T toxicity in frail patient

PATIENT

- 82M, DLBCL GCB, newly diagnosed; neck mass × 3 weeks
- ECOG PS 2; mild cognitive impairment
- CHF (EF 38%), AF, CKD 3b
- G8: 9/17 (vulnerable/frail)

DIAGNOSTICS

- DLBCL GCB; IPI 4/5; LDH 2.4× ULN
- CD20+ 3+; MYC negative; no high-risk features
- EF 38%; creatinine 1.7; CT: 8cm neck mass + diffuse LAD

PRIOR THERAPY

- Treatment-naïve
- Anthracycline contraindicated (EF 38%)
- Family: 'We want aggressive treatment'
- G8 9/17; cardiology + oncology in disagreement

CLINICAL DILEMMA

82-year-old with GCB DLBCL, favorable genomics, PS 2, EF 38%, CKD, G8 9/17. Anthracycline contraindicated by cardiology. Family requests aggressive treatment. What is the optimal approach?

MANAGEMENT OPTIONS — no single correct answer

- A. R-miniCHOP (dose-reduced R-CHOP)** — GELA elderly data; includes doxorubicin; EF 38% relative contraindication
- B. Non-anthracycline regimen (R-GCVP, liposomal dox R-CDOP)** — substitute anthracycline; cardiac safety
- C. Rituximab + lenalidomide (R²)** — non-chemo; ~50–60% ORR in elderly DLBCL; cardiotoxicity-free
- D. Pola-BR** — anthracycline-free; used 1L in unfit elderly; ECOG PS 2 feasible
- E. Rituximab alone + BSC** — EF 38%, G8 9/17, cognitive impairment; R mono palliates but does not cure

 PATIENT

- 72M, DLBCL GCB — 1st relapse; late relapse (26 months after R-CHOP)
- ECOG PS 1; mild fatigue; no significant comorbidities
- 'I got very sick with chemotherapy — I do not want to do that again'

 DIAGNOSTICS

- Relapse biopsy: DLBCL GCB — CD19+, CD20+; favorable biology
- PET: 3 FDG-avid sites, SUVmax 7.4; BM negative
- LDH 1.3× ULN; IPI 2; no CNS involvement

 PRIOR THERAPY

- L1: R-CHOP × 6 → CR; severe nausea, fatigue, hospitalisation × 1
- Relapse 26 months after completion (late — favorable)
- No prior tafasitamab, epcoritamab, or loncastuximab

 CLINICAL DILEMMA

72M, 1st late relapse, PS 1, CD19+, favorable biology. Refuses further conventional chemotherapy after severe R-CHOP toxicity. Not interested in CAR-T. Tafasitamab+len, epcoritamab, and loncastuximab all approved in Brazil. Which chemo-free option fits this patient?

 MANAGEMENT OPTIONS — no single correct answer

- A. Tafasitamab + lenalidomide (L-MIND)** — CD19+; 1st relapse; chemo-free; outpatient; fits L-MIND profile
- B. Epcoritamab** — CD20 bispecific; SC; approved in Brazil; fixed duration; no chemotherapy
- C. Loncastuximab tesirine (CD19 ADC)** — CD19+; approved in Brazil; IV q3w; single agent; no chemo
- D. Pola-BR** — anthracycline-free but contains chemotherapy; patient has explicitly declined chemo
- E. Revisit CAR-T** — 1st late relapse + PS 1 + good biology: ideal CAR-T window; address patient concerns

 PATIENT

- 59M, DLBCL — 2nd relapse, 8 months after axi-cel CAR-T
- ECOG PS 1; no significant comorbidities
- Post-CAR-T: grade 2 ICANS (resolved)

 DIAGNOSTICS

- Relapse biopsy: DLBCL — CD19 negative (antigen escape)
- CD20: Positive (retained); BCL2+
- LDH 2.8× ULN; multiple LAD, largest 4.2cm

 PRIOR THERAPY

- L1: R-CHOP × 6 → PR; early relapse at 6 months
- L2: Axi-cel CAR-T → CR × 8 months, then relapse with CD19 escape
- No prior CD20 bispecific; no prior loncastuximab; no prior tafa+len

 CLINICAL DILEMMA

DLBCL relapsing post-CAR-T with CD19 antigen escape. CD20 retained. Epcoritamab, tafa+len, and loncastuximab approved in Brazil. What is the optimal next step after CD19 escape?

 MANAGEMENT OPTIONS — no single correct answer

- A. Epcoritamab (CD20 × CD3)** — CD19 escaped but CD20 retained; approved in Brazil; logical pivot
- B. Tafasitamab + lenalidomide** — CD19 IHC negative but residual antigen may remain; approved in Brazil
- C. Loncastuximab tesirine (CD19 ADC)** — IHC-negative CD19 may retain residual antigen for ADC mechanism
- D. Pola-BR** — CD20 target; anthracycline-free; salvage before alloSCT consideration
- E. AlloSCT** — GVL + curative intent after response; PS 1 allows consideration