Defining your patient's treatment plan

Find out what your next steps should be in planning your patient's treatment.

Challenges of treating MCL

MCL follows an aggressive course, and relapse is inevitable, even after intense chemoimmunotherapy.[1,2] With each successive relapse, MCL becomes harder to treat.[2]

Management strategies for MCL are patient- and disease stage–specific, and aim to achieve balance between efficacy outcomes and toxicity.[3] Whilst treatment strategies should consider key patient considerations, such as age, fitness, tumour burden, and clinical presentation, they must also account for younger patients' desire to preserve fertility.[3] Although the boundaries are not clear-cut, intensive therapies in this framework are generally reserved for younger and fitter patients, and non-intensive therapies for older or more frail patients.[3]

MCL is responsive to a variety of initial therapies, but conventional chemotherapy regimens achieve relatively short-term remissions.[4] Studies show that aggressive therapies in younger patients with symptomatic MCL may improve the outcomes.[5]

A 'watch and wait' strategy for patients who are asymptomatic, have a low MIPI, or who are elderly should be considered due to a poor prognosis and lack of curative treatments.[4]

Guideline therapy recommendations should be considered in conjunction with local practices and available treatment options.

Treatment considerations[3,4]

Newly diagnosed MCL

Symptomatic	**Asymptomatic**
Aggressive, symptomatic, high-risk disease	Asymptomatic/indolent disease or elderly/frail
↓	↓
Patient factors Aged ≤65–70 years, minimal co-morbidities; fit for aggressive therapy Aged ≥65–70 years, multiple co-morbidities Frail, not candidate for chemotherapy	Consider watch and wait

MCL staging

The treatment offered to patients will differ depending on the stage of their disease.[3] This staging is carried out according to a modified version of the Ann Arbor system and is known as the Lugano classification.[1]

The Lugano classification stages a patient's disease according to the number of sites involved and where the disease is located.[1]

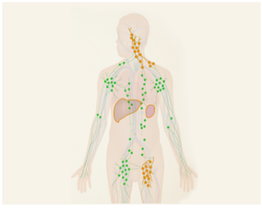
Stage I
Disease is located within a single lymph node region or extranodal organ.[1]

Stage II
Disease is found on the same side of the diaphragm in ≥2 lymph node regions, or presence of localised involvement of an extranodal site.[6]

Stage III
Disease is present on both sides of the diaphragm or in nodes above the diaphragm with spleen involvement.[1]

Stage III$_E$
Includes Stage III alongside localised involvement of an extranodal site.[7]

Stage III$_S$
Includes Stage III alongside involvement of the spleen.[7]



Stage IV
Disease is widespread, located in the lymph nodes and other parts of the body.[1,7] Localised involvement of the liver or bone marrow.[7]

To treat or not to treat?

The classification of MCL and MIPI-c grading will guide the next stage in disease management.[8] At the point of diagnosis, approximately 70% of patients are symptomatic and require immediate therapy.[9]

Asymptomatic/indolent patients[9]
Can be watched without any compromise to long-term outcome
More likely in patients with less proliferative disease
Normal LDH
No lymphoma-related symptoms
No aggressive histological variants of blastoid or pleomorphic disease

Symptomatic/aggressive disease[9]
Treatment choice is based on patient's age and fitness
Young/fit patients are offered intensive combination regimens, usually followed by autologous stem cell transplantation
Older individuals are frequently not suitable for a dose-intensive style of therapy, and therefore chemoimmunotherapy currently remains the backbone of treatment

Emerging strategies seek to incorporate newer, targeted therapies into frontline treatment and use prognostic markers.[5]

CLL=chronic lymphocytic leukaemia; LDH=lactate dehydrogenase; MCL=mantle cell lymphoma; MIPI-c=combined MCL International Prognostic Index.

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