Variance in Practice Between Experts and Oncology Healthcare Professionals for Follicular Lymphoma: Analysis of an Online Treatment Decision Tool

Abstract #1922

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Background and Aim

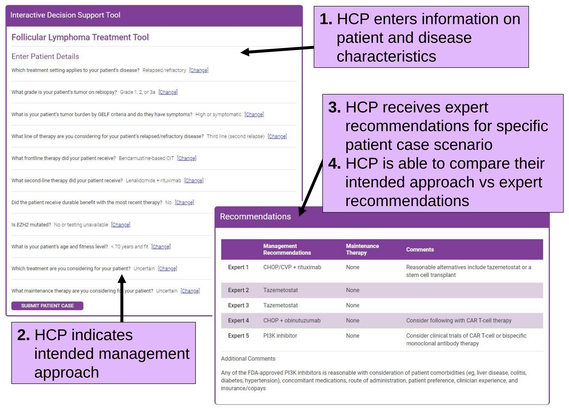
Follicular lymphoma (FL) is an incurable disease with a persistent risk of relapse and shorter durations of response with each line of therapy. As a result, management of patients with FL is complex, requiring multiple lines of therapy using various regimens with different mechanisms of action.

We developed an online treatment decision tool designed to provide oncology healthcare professionals (HCPs) with case-specific, individual management recommendations from experts in FL care in both the newly diagnosed and relapsed/refractory (R/R) disease settings. Here, we report an analysis of cases entered into this tool by HCPs comparing their planned treatment with expert recommendations and assessing the impact of those recommendations on intended HCP treatment decisions.

Tool Design and Analysis

- 5 lymphoma experts provided therapy recommendations in November 2020 for 264 unique case scenarios in newly diagnosed and R/R FL
- Case scenarios were defined by key patient and disease characteristics considered by the expert panel to be important for treatment decisions, including disease stage, tumor grade, tumor burden, presence of symptoms, age, and fitness as well as previous therapy, duration of response, and *EZH2* mutation status for relapsed disease
- To use the tool, HCPs entered their patient's information along with their intended treatment plan. Expert treatment recommendations were then shown to the HCP for that specific patient case scenario
  - **Tool available at:** www.clinicaloptions.com/FLtool
- HCPs were then asked to indicate if the expert recommendations affected their planned treatment approach

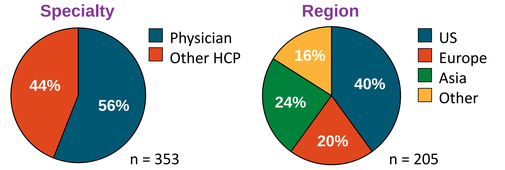
Tool Screenshots (Examples)



Results

Tool Participant Demographics

- 353 patient cases were entered by 235 HCPs from March 2021 to November 2021



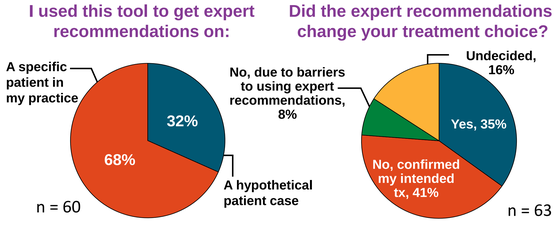
- Most responding HCPs (n = 60) were from academic medical centers (43%) and community practice/hospitals (33%). Of responding HCPs, 74% reported being in practice for ≥5 years (n = 57) and 66% reported treating >5 patients with lymphoma per month (n = 56)

Characteristics of Patient Cases Entered by HCPs

Case Characteristics, n (%)	N = 353
Newly diagnosed	**182 (51)**
▪ Stage I/II contiguous	55 (30)
▪ Stage II noncontiguous or III/IV FL	127 (70)
R/R	**172 (49)***
▪ Grade 1, 2, 3a/low tumor burden/asymptomatic	35 (20)
• Second line	17 (49)
• Third line	16 (46)
▪ Grade 1, 2, 3a/high tumor burden/symptomatic	89 (52)
• Second line	34 (38)
• Third line	48 (54)

*n = 48 (28%) of R/R cases were grade 3b, had suspected transformation, or the grade was unknown because rebiopsy was not done.

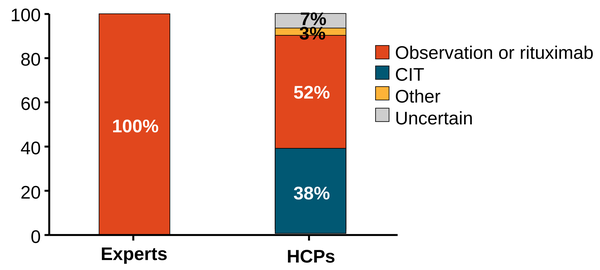
Use of Tool and Impact on Treatment Plan



- For HCPs reporting on the tool's clinical impact, 60% who initially selected another treatment option or who were uncertain indicated that they would change their intended therapy to match the experts

Treatment Decisions for Newly Diagnosed, Grade 1-3a, Stage II Noncontiguous* or III/IV FL

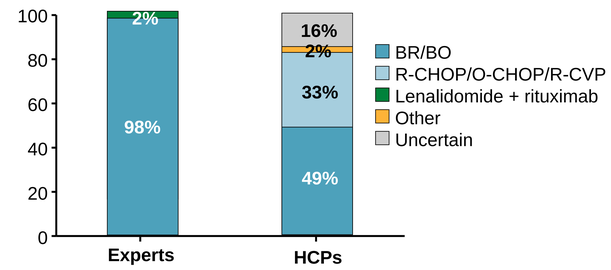
Low tumor burden,† asymptomatic (n = 29)



- **Key Observations:** For patients with newly diagnosed FL with low tumor burden and no symptoms, all experts recommended observation or single-agent rituximab whereas 38% of HCPs chose chemoimmunotherapy (CIT) in this setting

*Or not within a clinically acceptable radiation field. †By GELF criteria.

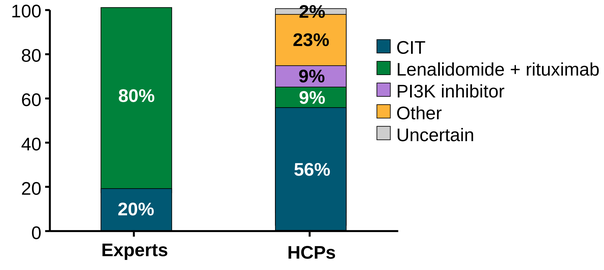
High tumor burden,† symptomatic (n = 51)



- **Key Observations:** For patients with newly diagnosed FL with high tumor burden and symptoms, 82% of HCPs chose CIT in agreement with expert consensus in this setting; however, experts exclusively recommended a bendamustine-based CIT regimen whereas 33% of HCPs chose a CHOP- or CVP-based CIT regimen

Treatment Decisions for R/R, Grade 1-3a, High Tumor Burden, Symptomatic FL

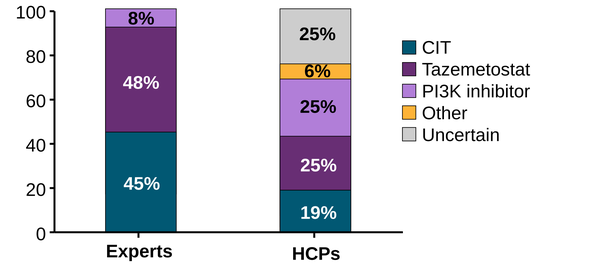
Second-line after relapse on first-line CIT‡ (n = 43)



- **Key Observations:** In the second-line setting for R/R FL with high tumor burden and symptoms, experts recommended lenalidomide plus rituximab for the majority of patients with relapse on frontline CIT whereas only 9% of HCPs chose this regimen, with over two-thirds instead selecting another CIT regimen or a PI3K inhibitor

‡Bendamustine-, CHOP-, or CVP-based CIT.

Third-line after relapse on first-line CIT‡ and second-line lenalidomide + rituximab (n = 16)



- **Key Observations:** For symptomatic cases with high tumor burden and relapse on first-line CIT and second-line lenalidomide plus rituximab, experts favored tazemetostat, regardless of *EZH2* mutation status, or another CIT regimen; by contrast, HCPs were fairly evenly split between tazemetostat, a PI3K inhibitor, or another CIT regimen

B, bendamustine; CHOP, cyclophosphamide/doxorubicin/vincristine/prednisone; CVP, cyclophosphamide/vincristine/prednisone; O, obinutuzumab; R, rituximab.

Conclusions

- Data from this tool suggest differences in clinical practice between experts and HCPs for cases of newly diagnosed and R/R FL, including examples of potential overtreatment such as the use of CIT in asymptomatic patients with newly diagnosed FL and low tumor burden
  - Of note, treatment options in the third-line setting continue to evolve, with experts recommending clinical trial enrollment if available
- In most cases, HCPs who initially selected treatment options that diverged from expert recommendations or were uncertain about treatment choice changed their intended therapy to match the experts
- Online support tools with expert guidance, like this decision support tool, may help to increase the number of HCPs making optimal management decisions for patients with FL

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