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Have maintenance rituximab and RIC allograft blown away the need for autografts in follicular lymphoma?



There is a possibility that despite the long term follow up data on traditional protocols; some patients with follicular lymphoma are now curable, perhaps with transplantation and perhaps without. We have known for some time that radiation therapy may cure some patients with localised disease, and the evidence from anti CD20 antibodies, sometimes given with conventional chemo-therapy, sometimes to eliminate minimal residual disease and sometimes in the radio labelled situation pre transplant, clearly now shows a further incremental reduction in the bulk of the disease beyond traditional conventional therapy. In addition, Registry data for autograft and allograft, the low treatment related mortality of mini allograft and the minimal relapse in patients after so called “conventional” allograft all serve as additional information that relapse can be reduced. The advent of maintenance rituximab proven in a randomised trial may vitiate the need for other approaches such as autograft if it produces fewer relapses.

We are left currently with the problem as to who might get maintenance therapy with follicular lymphoma, who should get an autograft and who should get an allograft – and of what kind? Probably all second remission patients, if the healthcare system

permits, should have maintenance. Some first remission patients with advanced disease again for whom the healthcare system permits should have it, and all patients in a further remission beyond CR if they have never had maintenance. Today, those who may get an auto transplant might be those in second CR when the first CR has been very prolonged and no matched sibling is available. This would be particularly suitable for patients in the older age group between 40 and 60 for whom age and lack of a matched sibling might make an allograft risky. Such patients would today still go on to maintenance. Allogeneic transplants might be offered to those with a matched sibling under 65 years old after two failures of treatment or even one (there is a very short CR). An unrelated donor transplant might be offered to those up to the age of 55 or 60, of two or more failures with responding disease single performance status. No randomised study has yet been done of high dose therapy vs. rituximab maintenance in comparable patients (and there is never likely to be one now). The CUP study was done pre rituximab and the LYM1 study was caught in the era of the emergence of rituximab. auto transplant in follicular lymphoma might therefore be becoming yesterday’s treatment.