UCCH Universitäres Cancer Center Hamburg
UCCSH Universitäres Cancer Center Schleswig-Holstein

UCCH / UCCSH Pathway

Guideline
Follicular Lymphoma

Version Jan/2024

Guideline Follicular Lymphoma
Version 01, Jan/2024

according to the WHO classification V and the ICC 2022

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Implemented	Jan/2024
Revised	
Next planned review	Jan/2026

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Follicular Lymphoma

Version Jan/2024
2.03.01 Anlage 32 UCCH
ID: 487441 UCCSH

Work up

Baseline:

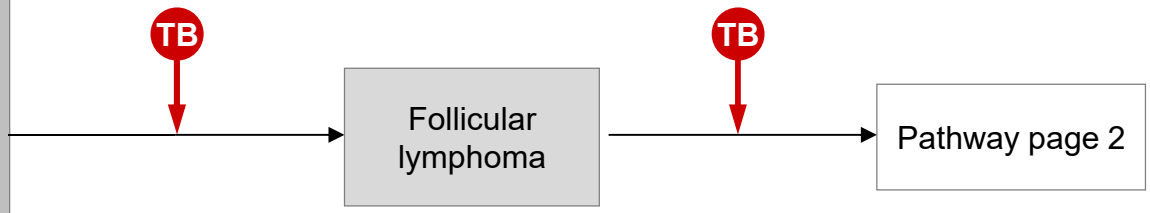
- History (incl. B-symptoms)
- Physical examination (incl. palpation of all lymph node areas, spleen and liver)
- Lab exam (including CBC with differential, LDH, uric acid, β-2 microglobulin, electrophoresis and serum immunoglobulins)
- Hepatitis B[1]/C; HIV serology
- Neck, chest, abdominal and pelvic CT **or** PET-CT[2]
- Bone marrow aspirate & biopsy (including flow cytometry)
- Biopsy[3]

Facultative:

- PET-CT[2]
- ECG, Echocardiography and lung function test (pretreatment evaluation)
- Pregnancy testing, discussion of fertility issues and sperm banking
- Gastroscopy, colonoscopy
- Bone marrow cytogenetics

Supportive:

- Offer contact to self help group
- Offer psychooncological support

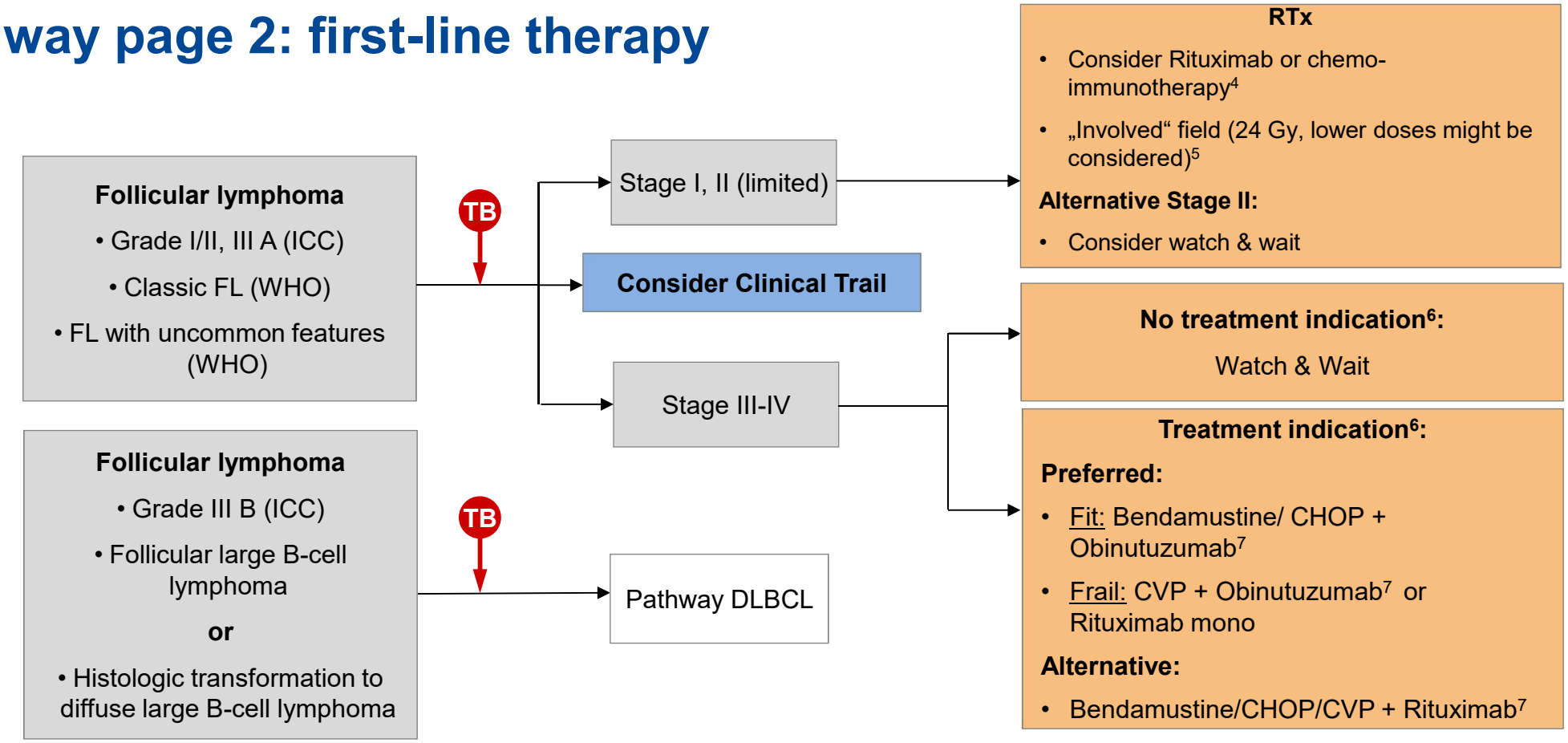


[1] Hepatitis B testing is recommended because of the risk of reactivation with immunotherapy and chemotherapy. Antiviral prophylaxis is indicated in patients with positive Hepatitis B serology (HBs Ag positive) including occult carriers (HBs Ag negative and anti-core positive) in dependence of viral load. PCR is also recommended for patients with prior anti-B cell treatment

[2] CT is not required after PET-CT! PET-CT is strongly recommended in stage I and regional stage II follicular lymphoma for confirmation of localized disease or optional in follicular lymphoma in initial staging for estimating prognosis. CAVE: PET-CT at diagnosis for indolent lymphoma is not generally covered by public health insurance and funding might require a special application

[3] The histological report should give the diagnosis according to the World Health Organization WHO) and international consensus (ICC) classification. Fine needle aspirations are inappropiate for a reliable diagnosis. For differentiation between the NHL lymphoma subtypes cytogenetics for t14/18 and FISH t11/14 might be useful. CD19 Expressionstatus should be assessed

Pathway page 2: first-line therapy



RTx Radiotherapy

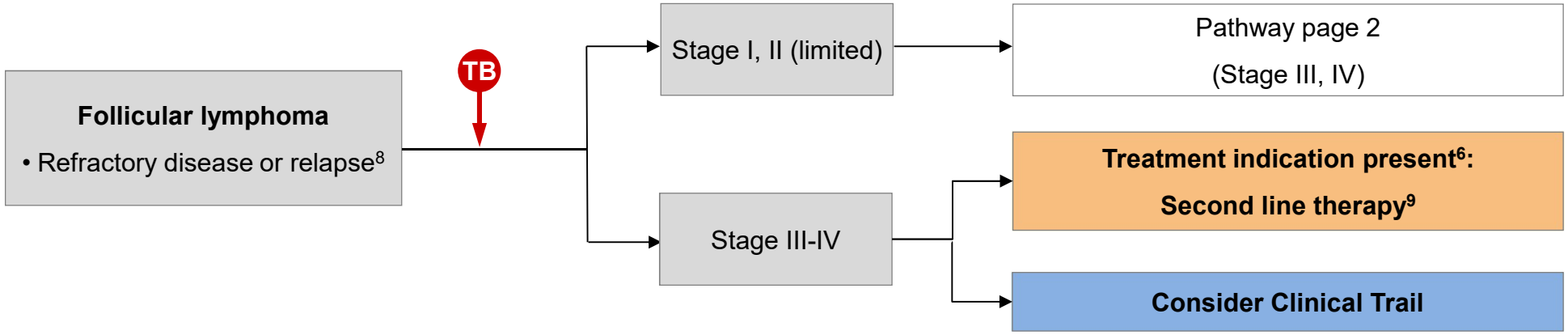
4 Consider combination of radiation therapy with Rituximab according to MIR-trial of the German Lymphoma Study Group

5 Patients with contraindication against RT AND treatment indication are treated analogous stage III-IV

6 GELF criteria: B-symptoms, hematopoetic impairment (leuco <1/nl, plt.<100/nl) leucemic disease (>5/nl malignant cells), bulky disease >7cm, ≥ 3 nodes in ≥3 distinct regions >3 cm, vital organ compression, massive splenomegalia, ascites, pleural effusion, elevated LDH or ßmicroglobulin

7 Followed by antibody maintenance with Obinutuzumab (in case of Rituximab containing first line therapy with Rituximab) for two years

Pathway page 3: Follicular lymphoma refractory disease or relapse



6 GELF criteria: B-symptoms, hematopoietic impairment (leuco <1/nl, plt.<100/nl) leukemic disease (>5/nl malignant cells), bulky disease >7cm, ≥ 3 nodes in ≥3 distinct regions >3 cm, vital organ compression, massive splenomegaly, ascites, pleural effusion, elevated LDH or ßmicroglobulin

8 Repeated biopsy is strongly recommended to rule out a secondary transformation into aggressive lymphoma. Consider PET-CT for performing targeted biopsy.

9 Second or third line therapy options depending on previous therapy, age, comorbidities and response duration:

- Immunochemotherapy: In early relapses (<12 months) a non-cross-resistant scheme should be preferred (e.g. CHOP or CVP after Bendamustine and vice versa). Re-exposition of rituximab is recommended if the previous antibody-containing scheme achieved > 6-12 months duration of remission. Obinutuzumab is approved in combination with bendamustine in bendamustine-sensitive Rituximab refractory cases. Consider rituximab maintenance for two years in patients who have not received antibody as first-line therapy.
- Myeloablative high-dose therapy followed by autologous stem cell transplantation as consolidation is an option in younger pat. and early recurrences within 2 years
- Combination of Lenalidomide with rituximab in pretreated patients with follicular lymphoma (grade I-IIIa)
- CAR-T cells for patients relapsing or refractory after 2 or more (Kymriah) or 3 or more (Yescarta) lines of systemic therapy
- Monotherapy with Monusetuzumab in patients whose disease has relapsed or did not respond to two previous treatments.
- Monotherapy with Idelalisib in patients whose disease has relapsed or did not respond to two previous treatments.
- In selected younger patients with high risk profile or relapse after ASCT, early relapses, or refractory disease a potentially curative allogeneic stem cell transplantation might be discussed.

Page 4: Palliative care screening tool

Screening items			Points
1.	• Presence of metastatic or locally advanced cancer		**2**
2.	• ECOG score (functional status score, performance status)		**0-4**
3.	• Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)		**1**
4.	• Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)		**1**
5.	• Presence of palliative care problems		**1**
	a.	• Symptoms uncontrolled by standard approaches	**1**
	b.	• Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	• Patient/family requests palliative care consult	**1**
	d.	• Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	• Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015