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

UCCH / UCCSH Pathway

Guideline
Posttransplant Lymphoproliferative Disorders (PTLD)

Version Jan/2024

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Version 03, Jan/2024

According to WHO classification of lymphoid neoplasms, 4th edition
and Ann-Arbor staging system

Posttransplant Lymphoproliferative Disorders (PTLD)

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Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

TB

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

Pathway: PTLD

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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 and lymphocyte subpopulations)
- Hepatitis B[1]/C; HIV serology
- EBV / CMV viral load (PCR)
- Neck, chest, abdominal and pelvic CT
- Bone marrow aspirate & biopsy (including cytogenetics and flow cytometry)
- Biopsy[2]
- Lumbar puncture (10% CNS involvement)
- Serum level of immunosuppressive medication
- Imaging, including CNS

Facultative:

- PET-CT[3]
- ECG, Echocardiography and lung function test (pretreatment evaluation)
- Pregnancy testing, discussion of fertility issues and sperm banking
- Gastroscopy, colonoscopy[4]

Supportive Measure at any stage:

- Offer contact to self help group
- Offer psychooncological support

TB

- **Early lesions**
- **Polymorphic PTLD**
- **Monomorphic PTLD**
  - Diffuse large B-cell lymphoma
  - Burkitt lymphoma
  - Plasma cell neoplasm
  - Peripheral T cell lymphoma (NOS)
  - Classical Hodgkin lymphoma-like

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.

2 The histological report should give the diagnosis according to the World Health Organization classification. Fine needle aspirations are inappropiate for a reliable diagnosis.

3 If contrast not feasible, e.g. after kidney transplant

4 If symptoms apparent

PTLD after allogeneic HSCT

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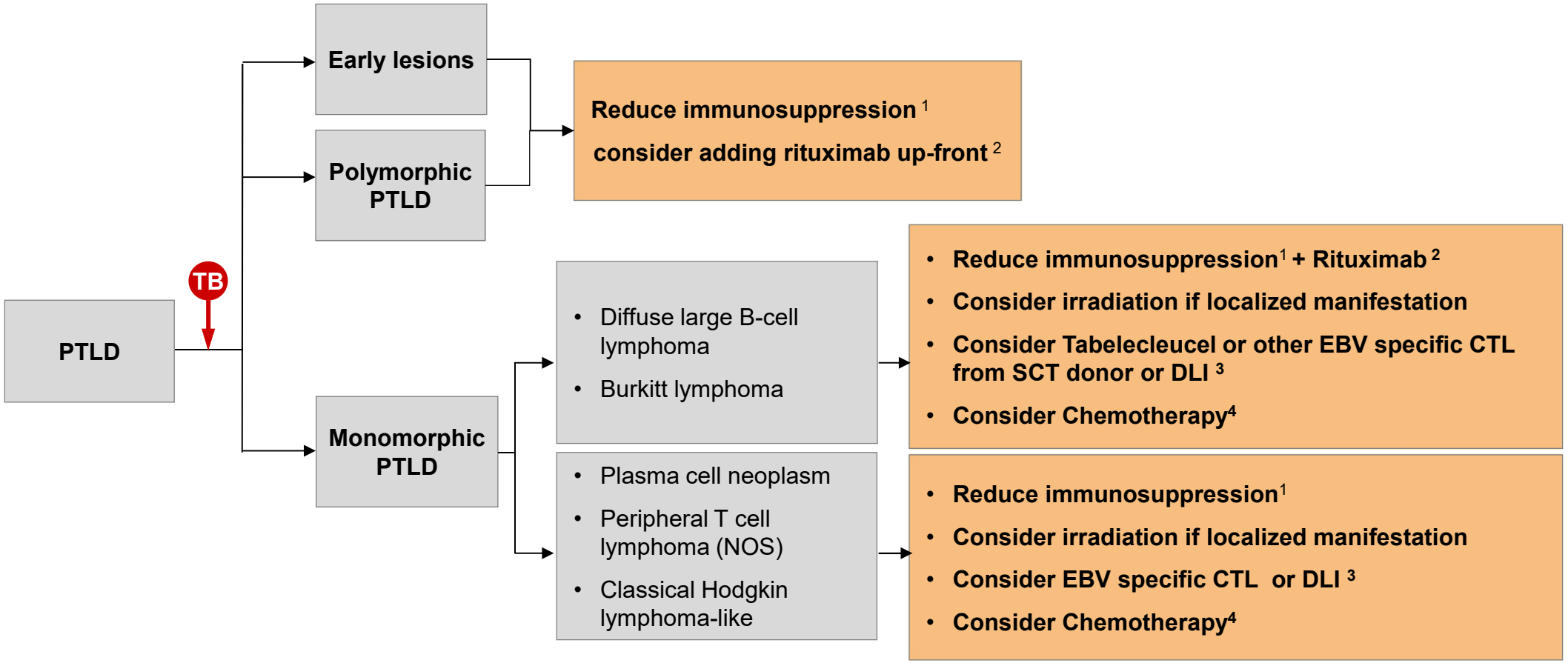

1 Reduce immunosuppression depending on risk of GVHD in collaboration with transplant specialist, reevaluate within 2-4 weeks.

2 Rituximab day 1, 8, 15, 22 (if CD20+), response evaluation day 40-50. If PR/CR and IPI< 3, consolidation with Rituximab day 50, 72, 94, 116

3 Ebvallo (Tabelecleucel) is indicated as from 2nd-line for EBV+ PTLD. If no response to reduction of immunosuppression and Rituximab, consider DLI (donor lymphocyte infusions) or EBV-CTL (EBV-specific cytotoxic lymphocytes) from donor if EBV positiv PTLD, taking risk of GVHD into account.

4 If no response to cellular therapy or rapid progression consider chemotherapy with (R)-CHOP or according to protocolls for T cell lymphoma, myeloma or Hodgkin lymphoma as appropriate

PTLD after solid organ transplantation

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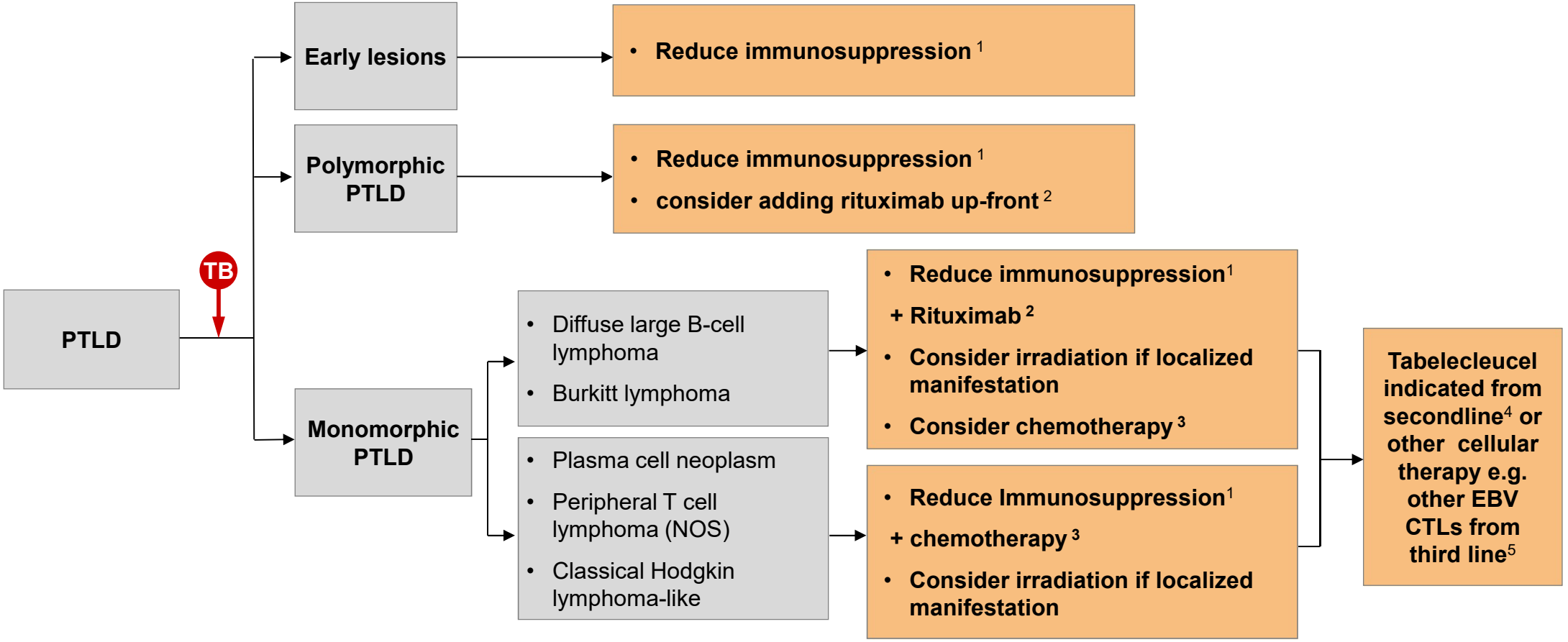

1 Reduce immunosuppression depending on risk of organ rejection and salvage options (e.g. dialysis in case of kidney rejection) in collaboration with transplant specialist, reevaluate within 2-4 weeks.

2 Rituximab day 1, 8, 15, 22 (if CD20+), response evaluation day 40-50. If PR/CR and IPI< 3, consolidation with Rituximab day 50, 72, 94, 116

3 If no response to reduction of immunosuppression, or rapid progression and CD20 neg, add chemotherapy (CHOP or according to protocolls for T cell lymphoma, myeloma or Hodgkin lymphoma as appropriate)

4 Ebvallo (Tabelecleucel) indicated as from 2nd-line for EBV+ PTLD. For patients with solid organ transplantation, 1st-line therapy must have included chemotherapy, unless chemotherapy considered inappropriate.

5 Consider other cellular therapy as alternative to chemotherapy or if chemotherapy not feasible e.g. due to poor organ functions including hematopoetic reserve, or if lack of response to chemotherapy

Follow up

<u>After systemic treatment:</u>

Every 3 months for 2 years, then every 6 months until year 5, afterwards yearly

- History and clinical examination, lab exam (including full blood count and differential)
- Minimal adequate radiological or ultrasound examinations every 6 months for two years with focus on initially pathological findings, additional imaging as clinically indicated
- Annual evaluation of thyroid function in patients with irradiation of the neck
- Offer contact to self help group and psychooncological support whenever necessary

<u>After local radiotherapy:</u>

Every 6 months for 2 years, subsequently once a year if clinically indicated:

- History and physical examination
- Offer contact to self help group and psychooncological support whenever necessary