Despite improvement of lymphoma treatments, many patients still relapse, the majority of whom being elderly and reluctant or unable to receive IV chemotherapy. It is known that treatment with all-oral protocols lowered management costs, without impairing efficacy. In our study, outpatient oral chemotherapy schemes were specifically designed to offer a well tolerated and easy to administer therapeutic option. This program was planned by clinicians, psycho-oncologists and hospital pharmacists, the latter providing detailed information on drugs management. Molecules of widespread use and moderate cost were employed: NIET (idarubicin50mg/qm d1, Procarbazine 100mg/qm d1-4, Etoposide100mg/qm d1-4, DEX 20 mg d1-4), FC (Fludarabine 25 mg/qm, Cyclophosphamide 150 mg/qm d1-4), CD (Cyclophosphamide 100 mg/qm d2i-5 DEX 20 mg d1) and Chlorambucil 10mg d1-10. A total of 100 patients were evaluated: median age at treatment start was 77 y (33 – 95), the majority of patients were unfit (57%) or frail (46%) according to multiparametric geriatric evaluation. Fifty-five patients had indolent lymphoma (Chronic Lymphocytic Leukemia, CLL 29; Small Lymphocytic Lymphoma, SLL 12; others 14), 45 had aggressive lymphoma (Diffuse Large B cell Lymphoma, DLBCL 28, Mantle Cell Lymphoma,MCL 6 and T-cell lymphoma 6, others 5). Twenty-nine patients had no prior treatment, 49 underwent 1-4 previous lines of therapy, 11 patients 5-6 lines and 11 patients more than 6 lines. Efficacy and toxicity were evaluated on 62 patients receiving at least 3 cycles of therapy: 74% had an objective benefit, 14% had stable disease, 12% had a progressive disease. G3-4 haematological toxicity was detected in 12 cases and non-haematological G3-4 toxicity in 2. Psycho-oncological tests revealed that 72% of the patients had a HADS (Hospital Anxiety and Depression Scale) score below the cut-off, both at T0 and at T1, suggesting low psychological distress. What is more, 88% of the patients judged positively the information about the treatment and the presence of the pharmacist. These data showed that chemotherapy does not negatively impact the psychological status. Our all-oral approach is an efficient alternative to traditional IV chemotherapy for elderly and frail patients with no cure expectation. The therapy shows some efficacy, improves the comfort from symptoms, is well tolerated and has restricted costs.

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ORAL CHEMOTHERAPY: AN INNOVATIVE CHOICE

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Despite improvement of lymphoma treatments, many patients still relapse, the majority of whom being elderly and reluctant or unable to receive IV chemotherapy. It is known that treatment with all-oral protocols lowered management costs, without impairing efficacy. In our study, outpatient oral chemotherapy schemes were specifically designed to offer a well tolerated and easy to administer therapeutic option. This program was planned by clinicians, psycho-oncologists and hospital pharmacists, the latter providing detailed information on drugs management. Molecules of widespread use and moderate cost were employed: NIET (idarubicin50mg/qm d1, Procarbazine 100mg/qm d1-4, Etoposide100mg/qm d1-4, DEX 20 mg d1-4), FC (Fludarabine 25 mg/qm, Cyclophosphamide 150 mg/qm d1-4), CD (Cyclophosphamide 100 mg/qm d2i-5 DEX 20 mg d1) and Chlorambucil 10mg d1-10. A total of 100 patients were evaluated: median age at treatment start was 77 y (33 – 95), the majority of patients were unfit (57%) or frail (46%) according to multiparametric geriatric evaluation. Fifty-five patients had indolent lymphoma (Chronic Lymphocytic Leukemia, CLL 29; Small Lymphocytic Lymphoma, SLL 12; others 14), 45 had aggressive lymphoma (Diffuse Large B cell Lymphoma, DLBCL 28, Mantle Cell Lymphoma,MCL 6 and T-cell lymphoma 6, others 5). Twenty-nine patients had no prior treatment, 49 underwent 1-4 previous lines of therapy, 11 patients 5-6 lines and 11 patients more than 6 lines. Efficacy and toxicity were evaluated on 62 patients receiving at least 3 cycles of therapy: 74% had an objective benefit, 14% had stable disease, 12% had a progressive disease. G3-4 haematological toxicity was detected in 12 cases and non-haematological G3-4 toxicity in 2. Psycho-oncological tests revealed that 72% of the patients had a HADS (Hospital Anxiety and Depression Scale) score below the cut-off, both at T0 and at T1, suggesting low psychological distress. What is more, 88% of the patients judged positively the information about the treatment and the presence of the pharmacist. These data showed that chemotherapy does not negatively impact the psychological status. Our all-oral approach is an efficient alternative to traditional IV chemotherapy for elderly and frail patients with no cure expectation. The therapy shows some efficacy, improves the comfort from symptoms, is well tolerated and has restricted costs.

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NEUPLY DiAGNOSED DiFFUSE LARGE B-CELL LYMPHOMAS TREATED WITH RITUXIMAB - CHOP: DEFINITION AND VALIDATION OF A PROGNOSTIC SCORE MODEL BASED ON MYC, BCL2 AND BCL6 EXPRESSION IN IMMUNOHISTOCHEMISTRY

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Overexpression of MYC and BCL2 and low expression of BCL6 assessed by HIC have been reported as negative prognostic factors in DLBCL. Recently, (Botto B, ASH 2014) a pilot study, that suggested a prognostic score based on overexpression of MYC, BCL2 and low expression of BCL6, assessed by HIC, in a retrospective cohort of 69 de novo DLBCL, with a high proliferation index (MIB1 >70%), treated with R-CHOP between 2010 and 2013. The aim of the present study was to expand the analysis and validate this prognostic score in a larger retrospective cohort of DLBCL, without restrictions of MIB1 de novo DLBCL patients, treated with R-CHOP between 2003 and 2015 were included. Cases enrolled in the previous pilot study were considered as control group. Samples were investigated using TMA sections for MYC, while BCL2 and BCL6 staining had been evaluated at diagnosis. Positivity was defined for MYC and BCL2/BCL6 expression by immunostain if >40%, >40% and 25% of cells showed positive expression, respectively. FISH is ongoing. Among 119 patients eligible, 99 were evaluable, 20 were not due to missing clinical data. Clinical characteristics were: median age 65.5 years (IQR 52.73), 66 (68%) stage III-IV, 27 (28%) with LDH upper normal and 50 (50%) with IPi>2. These characteristics are superimposable to those of the pilot study, a part for a lower rate of FIPi-2 (30% vs 67%). Median MIB1 at diagnosis was 70% (IQR 60-85). At the moment of the present analysis, MYC was investigated in 45/99 cases and an overexpression was detected in 10 (22%), BCL2 and BCL6 were analyzed in 77 and 74 cases, with BCL2 overexpression in 64 (83%) and BCL6 low expression in 25 (34%). Median 2y-PFS and OS were 71% and 84% respectively. Applying the prognostic score defined in the previous pilot study (risk of 2 points for MYC or BCL2 positivity and 1 point for BCL6 negativity, pooled scores 0-1, 2 and >3) 2y-PFS were different across the 3 groups: 100% vs 83% vs 64% (p 0.002). While in the pilot study no differences in OS were observed in 3 cases and an overexpression was detected in 10 (22%), BCL2 and BCL6 were analyzed in 77 and 74 cases, with BCL2 overexpression in 64 (83%) and BCL6 low expression in 25 (34%). Median 2y-PFS and OS were 71% and 84% respectively. Applying the prognostic score defined in the previous pilot study (risk of 2 points for MYC or BCL2 positivity and 1 point for BCL6 negativity, pooled scores 0-1, 2 and >3) 2y-PFS were different across the 3 groups: 100% vs 83% vs 64% (p 0.002). While in the pilot study no differences in OS were observed.