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R-ESHAP as salvage therapy for patients with relapsed or refractory diffuse large B-cell lymphoma: influence of prior autologous stem-cell transplantation on outcome

We have read with interest the excellent editorial by Sud and Friedberg about salvage therapy for relapsed or refractory diffuse large B-cell lymphoma (DLBCL).[1] The authors cite and comment upon our recently published GEL/TAMO study which evaluates the influence of prior rituximab use on response rates and survival in patients with DLBCL treated with R-ESHAP as salvage therapy.[2] As the editorial authors mention, our study is the first comprehensive analysis of the efficacy of rituximab in salvage therapy in patients with prior exposure which is relevant to the current standard of care.

We agree with the authors that our study may have important shortcomings, as do many other retrospective multicenter studies. However, we disagree that patients with previous autologous stem-cell transplantation (ASCT) should have been excluded from the analysis (taking into account that these patients have historically been poorly responsive and potentially incurable with further therapy). In our study, 16 patients were treated with ASCT in first complete remission prior to R-ESHAP due to high-risk disease at diagnosis. These patients received the R-ESHAP regimen with a curative purpose. Thirteen out of 16 patients had not previously been exposed to rituximab. The median age of these patients was 54 years (range 23-62). The overall response rate to R-ESHAP was 100%, with 11 patients achieving complete remission and 2 partial remission. Three patients were treated with a second ASCT, and one patient with an allogeneic transplantation. In this group of 13 patients who had not been exposed to rituximab prior to R-ESHAP, progression-free survival and overall survival (both estimated at five years) were 74% and 83%, respectively. These excellent results are all the more remarkable considering the poor prognosis of patients relapsing after an ASCT. The remaining 3 patients had previously been exposed to rituximab. These patients were 34, 48 and 49 years of age, and they had a very good performance status. Although these patients had little hope of being cured, a second ASCT or an allogeneic transplant could be a possibility if they reached a good response after the salvage therapy. Two of the 3 patients achieved partial remission to R-ESHAP, and one patient was treated with allogeneic transplantation after the salvage therapy. All 3 patients died within the first year after R-ESHAP administration. This data strongly supports the main conclusion of the study that the survival outcome after R-ESHAP is significantly better in rituximab-naïve patients. For these reasons, these 16 patients were not excluded from the analysis.

The influence of prior ASCT on survival is explained in the survival analysis section of our paper and is also mentioned in the discussion section.[2]

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