Adapted CHOP plus rituximab in non-Hodgkin’s lymphoma in patients over 80 years old

Treatment of very old patients with non-Hodgkin’s lymphoma remains controversial. Indeed, patients over 80 years old are usually not included in trials. We show here that addition of rituximab to reduced-dose CHOP chemotherapy seems to be a good compromise between toxicity and efficacy, allowing clinicians to treat very elderly patients with a curative intent.
Letters to the Editor

Doses were reduced in all cases from the first cycle, on the basis of the clinician’s decision. A total of 125 cycles were administered with a mean of 5.2 courses (range 1–8) per patient. Eight patients (33%) received at least one course of granulocyte colony-stimulating factors during their treatment. The overall response rate was 79% with 15 patients (62.5%) achieving a complete or unconfirmed complete response and four (16.5%) a partial response. After a median follow-up of 23 months, the 2-year OS and EFS were 63% and 50%, respectively (Figure 1). Considering only newly diagnosed patients with diffuse large B-cell lymphoma (n=15), the 2-year OS and EFS were 76% and 62.5%, respectively. The toxicity, mainly hematologic, was manageable, febrile neutropenia occurred in 6% of the courses and there were no toxic deaths. No significant adverse events related to infusion of the rituximab were noted. Twenty-two patients (92%) in our study received reduced doses of doxorubicin (mean dose reduction, 30%). Analyzing the reasons for these dose reductions revealed that old age was the sole cause in 20 cases and poor performance status was the cause in the other two cases.

Several studies have reported that elderly patients are able to tolerate full-dose doxorubicin-containing regimens. However none of these studies has focused on very elderly patients (≥80 years). Moreover, although granulocyte colony-stimulating factor may allow completion of therapy in elderly NHL patients, and may reduce the duration and severity of neutropenia, significant differences in hospitalization, infections, and in particular, survival, have not been clearly demonstrated in this population. So, dose reduction, especially for doxorubicin given its hematotoxicity, seems to be a reasonable option. The 2-year OS of 63% in our study population was much higher than the 30% in an unselected group of NHL patients more than 80 years old in whom treatment was considered as optimal by the authors in only 17% of the cases. This suggests that poorer outcome in older patients with NHL, as previously reported, is at least partially due to inadequate treatment.

Despite the usual limitations of retrospective analyses, our study shows that addition of rituximab to reduced-
Standard treatment options are typically palliative between toxicity and efficacy, allowing clinicians to treat very elderly patients with a curative intent.

This underscores the fact that age alone should not be used as a reason to deny patients with NHL an adapted and potentially curative treatment. Thus, at the time of writing, the Groupe d’Etudes des Lymphomes de l’Adulte (GELA) is considering a prospective phase II study of an attenuated R-CHOP regimen in patients over 80 years old.

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References