Background

In the past decade, disease progression has been reported as the main cause of death in patients with
LCM. However, refractory disease (RD) may be incurable, despite the availability of novel therapies, including, and, consequently, the likelihood of achieving
effects of
compared with R
PFS24
in the
9
4
25%
8
300. Oral presentation.

Methods

• The data analysis here are from the POLARIX study (data cut-off June 15, 2022; median follow up:
20.7 months), the methods have previously been described.
• Causes of death were disease progression, adverse events (AE), or other.
• Three patient populations were defined based on response to 1L therapy:
  - Patients who were primary refractory (i.e. no complete remission within 12 months after
treatment completion (TC))
  - Patients who were primary non-refractory (i.e. CR or CRi within 12 months after treatment
completion (TC))
  - Patients who achieved PFS24 (no events during the 24-month after treatment initiation).
• Time-to-event data were described using Kaplan-Meier curves and cause-specific cumulative
incidence functions.
• Event decomposition was performed using a competing risk approach.1
• Baseline risk factors for risk of death during follow up were analyzed using multivariate Cox
regression models.
  - There was adjustment for treatment effect, age, sex, Eastern Cooperative Oncology Group performance
status (ECOG-PS), geographic region, International Prognostic Index (IPI) score, bulky disease, lactate
dehydrogenase (LDH) levels (elevated vs normal) were associated with increased risk of death in the POLARIX study.

Results: Causes of death

At data cut-off, 14.7% of patients treated with Pola+R-CHP and 15.6% of patients treated with R-CHP
had died. The main cause of death was disease progression (Table 1). After adjustment for treatment effect, age (continuous), sex (male vs female), ECOG-PS (0-3 vs 0), and LDH
levels (normal vs abnormal) were associated with increased risk of death in the POLARIX study.

Table 1: Cause of death in the POLARIX study (safety-evaluable population)

<table>
<thead>
<tr>
<th>Disease progression</th>
<th>Pola+R-CHP (n=313)</th>
<th>R-CHP (n=269)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>34 (11.0)</td>
<td>36 (13.4)</td>
</tr>
</tbody>
</table>

Results: Effect of primary refractory disease on OS

Pola+R-CHP reduced the risk of primary refractory disease and increased the likelihood of achieving
PFS24 in the 1L DLBCL setting

**Results:**

- **Pola+R-CHP reduced the risk of a PFS event in 24 months by 25% versus R-CHP**

**Methods:**

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20.7 months), the methods have previously been described.
- Three patient populations were defined based on response to 1L therapy:
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**Results: Effect of primary refractory disease on OS**

Based on two-stage analysis, risk of death was 7.6-fold higher in patients with primary refractory disease
in those with non-refractory disease (Figure 2).

**Results: Subsequent therapy according to refractory status**

At data cut-off, 68 (23.3%) and 61 (17.7%) patients had received a new anti-lymphoma therapy (e.g. T) in the primary refractory and non-refractory therapy populations, respectively (Table 1). Patients with primary refractory disease received more novel therapies than those with non-refractory disease, including stem cell transplantation or CAR T cell therapy.

**Results: 1L treatment effect in patients with non-refractory refractory disease**

- **Pola+R-CHP reduced the risk of refractory disease and increased the likelihood of achieving**
  PFS24 in the 1L DLBCL setting

Conclusions

- Despite therapeutic improvements in the refractory/refractory DLBCL setting, progression remained the main cause of death among patients treated with Pola+R-CHP.
- Identification of patients with a high risk of death remains a challenge.
- Innovative strategies are needed to improve outcomes for patients with primary refractory disease, who have a limited treatment option.
- In 1L DLBCL, Pola+R-CHP reduced the risk of refractory disease and increased the likelihood of achieving
  PFS24 versus R-CHP. Together, these results reinforce the value of Pola+R-CHP in 1L DLBCL.

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References


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