A PHILIPPINE FIRST | GLOFITAMAB FOR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA AFTER MULTIPLE TREATMENT FAILURES: A CASE REPORT AND LITERATURE REVIEW

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Introduction

Relapsed/Refractory Diffuse Large B cell Lymphoma (R/R DLBCL) presents a significant therapeutic challenge, with up to 50% of patients failing first-line chemoimmunotherapy. Advanced treatments like chimeric antigen receptor T cell (CAR T) therapy are the standard for early relapse and primary refractory disease but remain inaccessible in the Philippines due to cost and infrastructure barriers. The availability of Bispecific Antibodies (BsAb) may fundamentally change this treatment landscape. Glofitamab's unique 2:1 structure, bivalent for CD20 on B cell, and monovalent for CD3 on T cells, efficiently offers potent off-the-shelf immunotherapy for patients who have exhausted conventional options.

Case Presentation

A 64-year-old female presented with primary adrenal, double-expressor, non-GCB DLBCL Stage IV, high-risk disease. She exhibited a highly refractory course with progression after multiple lines of standard and salvage therapies.

PRIOR TREATMENT FAILURES

1st Line: Progressive Disease
R-CHOP ± tafasitamab/lenalidomide

2nd Line: Progressive Disease
Polatuzumab vedotin + bendamustine/rituximab

3rd Line: Progressive Disease
Rituximab + ICE (R-ICE)

The patient was ineligible for autologous stem cell transplant (ASCT) and had no access for CAR T therapy, representing a significant unmet medical need.

We followed the protocol from the pivotal Phase II study (NCT03075696) for patients with R/R DLBCL after ≥2 prior therapies.

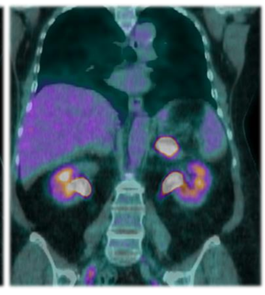
- **Pre-treatment:** 1000 mg Obinutuzumab 7 days prior to Glofitamab to mitigate Cytokine Release Syndrome (CRS).
- **Glofitamab Step-Up Dosing:**
  1. **C1D1**: 2.5 mg
  2. **C1D8**: 10 mg
  3. **C2-C12:** 30 mg on Day 1 of each cycle



Initial PET/CT scan showing large, hypermetabolic lesions in both adrenal glands (Deauville 5).



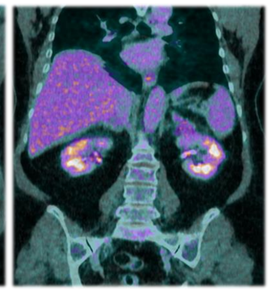
End-of-treatment PET/CT scan after R-CHOP showing primary refractory disease.



Partial response after salvage Polivy-BR but had progressive disease after the 6th cycle.



PET/CT scan after 3rd-line R-ICE therapy showing progressive, intensely FDG-avid disease in bilateral adrenal glands.



Complete metabolic response after Glofitamab monotherapy.

Result & Discussion

Patient achieved a **complete metabolic response** after only 3 cycles of Glofitamab monotherapy.

The size of lesions in both adrenal glands, which measures 3 x 1.5 x 2.6 cm (previously 3.2 x 2.4 x 3.1 cm) in the right, and 3.1 x 1.5 x 3.1 cm (previously 3.4 x 2.2 x 3.5 cm) on the left. FDG avidity has resolved with uptake in the bilateral adrenal glands appear relatively like the liver (SUV right 3.8; SUV left 3.6; **Deauville 2**). No hypermetabolic nodal disease or enlarged lymph nodes in the body.

This case demonstrates the remarkable efficacy of Glofitamab in a heavily pre-treated, high-risk patient who had exhausted standard therapeutic options. The rapid and deep metabolic response underscores its potential in highly refractory disease. In low- to middle-income countries like the Philippines, where CAR T is unavailable, Glofitamab provides a critical, accessible, and effective 'off-the-shelf' immunotherapy. The treatment was well-tolerated, with no incidence of cytokine release syndrome and no significant neutropenia during the step-up dosing phase.

Conclusion & Implications

The successful use of Glofitamab in this case of primary adrenal relapsed/refractory DLBCL after multiple lines of therapy emphasises its potential as a crucial treatment option in the Philippines, where access to advanced therapies remains limited. Glofitamab achieved a complete metabolic response, demonstrating its efficacy in a highly refractory disease setting. The integration of bispecific antibody into the treatment paradigm for R/R DLBCL may provide a feasible and effective approach to improving outcomes in patients who are transplant-ineligible or refractory to multiple lines of therapy. Our experience indicates that Glofitamab demonstrates significant efficacy and safety and could significantly improve survival outcomes for Filipino patients.

References

[1] Ip A, Mutebi A, Wang T, Jun M, Kalsekar A, Navarro FR, Wang A, Kamalakar R, Sacchi M, Elliott B. Treatment Outcomes with Standard of Care in Relapsed/Refractory Diffuse Large B-Cell Lymphoma: Real-World Data Analysis. Adv Ther. 2024 Mar;41(3):1226-1244. doi: 10.1007/s12325-023-02775-9. Epub 2024 Feb 2. PMID: 38302846; PMCID: PMC10879405.
[2] Dickinson MJ, Carlo-Stella C, Morschhauser F, Bachy E, Corradini P, Iacoboni G, Khan C, Wróbel T, Offner F, Trněný M, Wu SJ, Cartron G, Hertzberg M, Sureda A, Perez-Callejo D, Lundberg L, Relf J, Dixon M, Clark E, Humphrey K, Hutchings M. Glofitamab for Relapsed or Refractory Diffuse Large B-Cell Lymphoma. N Engl J Med. 2022 Dec 15;387(24):2220-2231. doi: 10.1056/NEJMoa2206913. Epub 2022 Dec 11. PMID: 36507690.
[3] Saleh K, Khoury R, Khalife N, Chahine C, Ibrahim R, Tikriti Z, Le Cesne A. The Evolving Role of Bispecific Antibodies in Diffuse Large B-Cell Lymphoma. J Pers Med. 2024 Jun 21;14(7):666. doi: 10.3390/jpm14070666. PMID: 39063920; PMCID: PMC11278258.

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