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Symptomatic vs. Asymptomatic detection of relapse in follicular lymphoma

Follicular lymphoma (FL) is a common subtype of indolent (generally incurable) lymphoma but patients have a long life expectancy. In fact, it is standard practice to offer routine surveillance imaging to patents in remission after therapy. The goal of this study was to assess whether routine surveillance is useful, considering its well-known side effects. We compared the survival of patients with FL in whom relapse was detected by routine surveillance computed tomography (CT) with that of those suffering a symptomatic relapse. The authors concluded that the apparent longer progression-free survival among patients with asymptomatic relapse was due to lower risk relapses in this group. However, it is important to realize that the design of this study could not aim to answer the main question, leaving an open door to further studies.

Follicular lymphoma (FL) is a common subtype of lymphoma characterized by the malignant proliferation of germinal center lymphocytes. It is an indolent lymphoma, therefore, slow-growing and generally incurable but it is highly radio- and chemosensitive. With modern day care, patients have a median overall survival of 15-20 years and, in most cases, similar to the age-and-sex matched population. It is unknown whether routine surveillance computed tomography (CT) is useful in patients in remission after therapy, but it is standard of practice despite its well-

known side effects, including ionizing radiation, psychological distress and health care costs. Surveillance imaging is actively discouraged in other lymphoma subtypes, particularly diffuse large B cell lymphoma, because there is solid evidence supporting a lack of usefulness. Finally, detection of an asymptomatic relapse in a CT does not necessarily mean that treatment is indicated because, given that FL is an incurable disease, treatment is only indicated when the disease is symptomatic.

Against this background, a small retrospective study was conducted in our institution. We compared the survival of patients with FL in complete or partial remission after frontline therapy in whom relapse was detected by routine surveillance CT with that of those suffering a symptomatic relapse (detected either by physical exam or through imaging testing ordered upon suspicion of relapse). Of 93 screened patients with FL, 25 had relapsed. Of those, 13 had suffered a symptomatic and 12 an asymptomatic relapse. The latter seemed to have a longer second line progression-free survival (i.e., the time from second line treatment until disease progression or death, which was a median of 44 months for patients with asymptomatic vs. 18 in those with symptomatic relapse, p value 0.077). However, they also had lower risk relapses, particularly because the time from front-line treatment until relapse (a well-established risk factor for a worse overall survival in FL) appeared longer. Other interesting findings were that half of the patients with asymptomatic relapse remained untreated at 6 months after detection of relapse and that only 12 of 404 (2.9%) routine CT actually detected relapses.

We concluded that the apparently longer progression-free survival among patients with asymptomatic relapse was due to the lower risk relapses in this group. It is important to realize that this study could not settle the question of whether routine CT are useful since the two groups were not comparable in aspects that may act as confounders. To definitively answer this question a trial randomizing patients to standard surveillance or a no routine imaging strategy would be needed. While unlikely to be carried out (given that such a trial would require many patients and a very long follow-up because of the long disease-free periods obtained with modern day treatments), it would help learn whether this widespread practice, with well-recognized side effects and without sòlid supporting evidence, is really justified in FL.

Marc Sorigué
Hematology Department, CO-Hospital Germans Trias i Pujol
Institut de Recerca Josep Carreras
Universitat Autònoma de Barcelona, Badalona, Spain.
msorigue@iconcologia.net

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