90-min SDI from C2 onwards. Pts with a Gr 3 IRR in C1 received G at the standard infusion rate in C2, and received G SDI from C3 onwards if no Gr ≥3 IRR occurred. Pts with a second Gr 3 IRR discontinued G. At EOI, responding pts received maintenance G (1000mg) as SDI for 2 yrs or until PD. The primary endpoint was incidence of Gr ≥3 IRR during C2. IRR was defined as any event occurring during or within 24 hrs of infusion and judged related to treatment.

Results: As of December 3, 2020, 113 pts had completed EOI treatment. Median age was 62.0 yrs, 50.4% were male, 61.9% had stage IV FL and 45.1% were classified as high-risk FLIPI. Of the 110 pts who received G SDI in C2, none experienced a Gr ≥3 IRR. One patient experienced a Gr 3 IRR with SDI in C5 (hypertension). All other IRRs with SDI were Gr 1/2. Median SDI duration in C2–8 was 95–98 mins, and SDI duration was ≤110 mins in >90% of pts (**Table**). From C1 onwards, AEs were reported in 99.1% (112/113) of pts. Gr ≥3 AEs were observed in 72.6%. Common Gr ≥3 AEs (>5%) were neutropenia (50.4%), leukopenia (11.5%), lymphopenia (10.6%), thrombocytopenia (7.1%), IRR (6.2%) and febrile neutropenia (5.3%). Gr 5 (fatal) AEs were reported in 2 pts (cardiac arrest and aspiration pneumonia; both considered unrelated to treatment). CT-imaging at EOI demonstrated that: 76/113 (67.3%) pts had a CR; 22 (19.5%) had a PR; and six (5.3%) had PD; 9 pts had no response assessment.

Conclusions: In GAZELLE, G SDI from C2 onwards appeared to be safe. No Gr ≥3 IRRs were observed in C2 and only one Gr 3 IRR was reported in subsequent cycles. No new safety signals were reported and response data were in line with previous studies. SDI time was ≤110 mins in >90% of pts. G SDI is likely to improve convenience for pts and efficiency for infusion facilities.

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Conflicts of interests pertinent to the abstract

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119 | UPDATED RESULTS OF THE FIL "MIRO" STUDY, A MULTICENTER PHASE II TRIAL COMBINING LOCAL RADIOTHERAPY AND MRD-DRIVEN IMMUNOTHERAPY IN EARLY-STAGE FOLLICULAR LYMPHOMA

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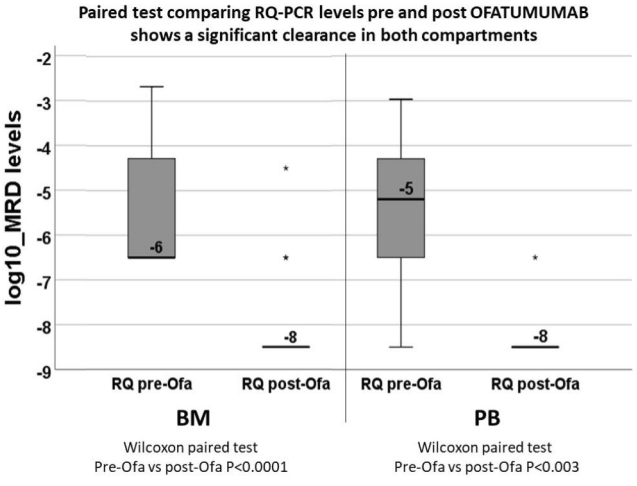
Background: Early-stage follicular lymphoma (FL) is usually managed with involved field radiotherapy (IFRT), allowing a complete and long lasting eradication of the disease only in 40-50% of patients (pts). The aim of this multicenter phase II prospective study was to evaluate the role of MRD in identifying pts unlikely to be cured by IFRT, for whom an immunotherapy consolidation could improve outcome.

Methods: 110 pts with stage I/II FL were enrolled and treated with 24 Gy IFRT. Peripheral blood (PB) and bone marrow (BM) samples were centralized to the FIL (Fondazione Italiani Linfomi) MRD Network of EuroMRD-certified laboratories. In BCL2/IGH+ pts at baseline by both nested PCR (NEST) and RQ-PCR (RQ) in BM a/o PB, MRD was analyzed after IFRT and every 6 months over a 3-year period. Pts with MRD+ by both NEST and RQ in BM a/o PB after IFRT or who became MRD+ during the follow-up were treated with 8 weekly doses of the anti-CD20 MoAb ofatumumab (OFA). The primary objective of the study was to define the efficacy of immunotherapy in obtaining a negative MRD.

Results: Of the 106 evaluable pts, 50 were males. Median age was 55 y (29-83). The FLIPI score was 0 in 59% of pts, 1 in 35%, 2 in 6%. 68% of pts had inguinal site involvement. At baseline, 30% of pts had a BCL2/IGH rearrangement (30 MBR, 1 MBR and mcr, 1 mcr) in BM a/o PB; the concordance between compartments was 90%. All but one pt achieved a clinical response after IFRT; one additional pt died soon after IFRT of unrelated causes. MRD evaluation after IFRT revealed the persistence of BCL2/IGH+ cells in PB a/o BM in 60% of pts. MRD + pts, either after IFRT (n = 18) or in case of conversion to MRD+ during the follow-up (n = 6), received OFA, obtaining a conversion to MRD- in 22/24 pts (91.7% - CI 73.0-99.0), significantly superior to the expected 50% (Fig). After a median F-U of 38 m, 17 pts who achieved a MRD- with OFA are still negative; 5 converted to MRD+ (2 received OFA retreatment, achieving a second MRD-; 2 pts were not re-treated due to Sars-Cov2 pandemic; 1 relapsed). A clinical relapse or progression was observed in 23 pts: 18 (24.6%) among the 73 "no marker" pts and 5 (15.6%) among the 32 BCL2/IGH+ at baseline (p = 0.3), with no significant difference in PFS (p = 0.25). Two early relapses were observed among the 12 pts who became MRD- after IFRT and 3 among the 24 treated at least once with OFA (1 MRD+, 1 MRD-, 1 converted from MRD- to MRD+). Only 1 Pt relapsed while MRD- after OFA.

Conclusions: MRD data indicate that RT alone is often insufficient to eradicate the disease, inducing a MRD- only in 40% of pts, notably long-lasting only in half of them. The primary objective of this study - MRD conversion after immunotherapy - was largely achieved. The strategy of an immunotherapy consolidation after IFRT in MRD+ pts allowed increasing molecular responses. However, this strategy is applicable only to 30% of enrolled pts. A clinical advantage of the MRD driven treatment strategy is suggested although not significant.



Keywords: Molecular Targeted Therapies, Immunotherapy

Conflicts of interests pertinent to the abstract

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120 | CLINICAL OUTCOMES AND THE ROLE OF OBSERVATION IN EARLY-STAGE FOLLICULAR LYMPHOMA

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Introduction: Management of early-stage follicular lymphoma (FL) is widely variable. We utilized our Follicular Lymphoma Outcomes Database (FLOD) to assess outcomes and understand the role of initial observation in patients (pts) with early-stage FL.

Methods: We retrospectively identified 295 pts with grade 1-3A, stage I-II FL diagnosed between 1998 and 2009 at Memorial Sloan Kettering Cancer Center while excluding pts with fully resected disease, incomplete imaging at diagnosis, and pts not prescribed rituximab in frontline systemic therapy. Pts were categorized as immediately treated if localized or systemic treatment was started within 6 months of diagnosis. Pts were stratified by age at diagnosis (years): 20-40 *vs.* 40-60 *vs.* 60-75 *vs.* 75-95, to analyze the percentage of immediate treatment or observation in each group.

Results: In the cohort, 137 (46%) pts were initially observed, and 158 (54%) pts received immediate treatment, consisting of radiation (n = 108), systemic treatment (n = 29), or combined modality treatment (n = 21). With a median follow-up of 8.4 years (range 0.3-17.2), the estimated 10-year overall survival (OS) and disease-