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appendix 6: Chronic lymphocytic leukaemia: eUpdate published online September 2016 (http://www.esmo.org/Guidelines/Haematological-Malignancies)

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clinical practice guidelines eUpdate. Chronic lymphocytic leukaemia: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up [Ann Oncol 2015; 26 (Suppl 5): v78-v84.]

1. Front-line treatment

section and text: treatment of advanced disease stage - *Front-line treatment*

The Btk inhibitor ibrutinib was superior to chlorambucil alone regarding PFS and overall survival in a phase III study including mostly elderly patients [1]. If access is available, ibrutinib can be considered as an alternative treatment option to chlorambucil-based chemoimmunotherapy. However, lack of long-term experience with front-line therapy with ibrutinib must be taken into consideration [I, C].

Patients with TP53 deletion/mutation have a poor prognosis even after FCR therapy [2]. Therefore, it is recommended that patients with TP53 deletion/mutation are treated with ibrutinib in front-line [V, A]. Because of severe infectious complications, the PI3K inhibitor idelalisib combined with rituximab is only recommended for frontline therapy in patients not suitable for Btk inhibitors, if anti-infective prophylaxis is taken and

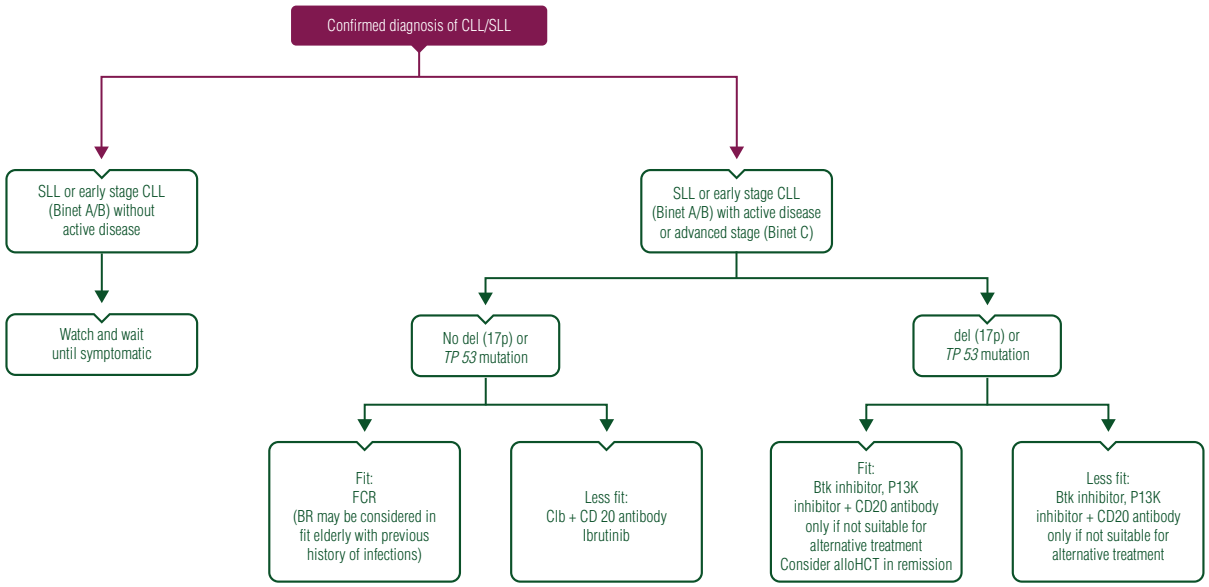

Figure 1. Algorithm for frontline treatment.

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measures to prevent infection are followed. In the relapse setting, ibrutinib and idelalisib plus rituximab are treatment options.

recommendations.

- Frontline therapy with ibrutinib can be considered as an alternative to chlormbucil-based chemoimmunotherapy, if access is available [I, C].
- It is recommended that patients with TP53 deletion/mutation are treated with ibrutinib or idelalisib plus rituximab in frontline and relapse settings [V, A]. In front-line, idelalisib plus rituximab should only be considered if patients are not suitable for ibrutinib.

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2. Treatment of complications

section and text: treatment of advanced disease stage - *Treatment of CLL complications*

Infections are a common complication in CLL patients, therefore use of immunosuppressive agents, as for example corticosteroids, should be restricted to a possible minimum. The use of prophylactic systemic immunoglobulin does not have an impact on OS [1, 2], and is only recommended in patients with severe hypogammaglobulinaemia and repeated infections [I, A]. Antibiotic and antiviral prophylaxis should be used in patients with recurrent infections and/or very high risk of developing infections (for example, pneumocystis prophylaxis with cotrimoxazole during treatment with chemoimmunotherapies based on purine analogues or bendamustine or during treatment with idelalisib plus rituximab) [IV, B]. Pneumococcal vaccination as well as seasonal flu vaccination is recommended in early stage CLL [IV, B]. Cytomegaly virus surveillance is recommended during treatment with idelalisib plus rituximab.

recommendations.

- The use of prophylactic systemic immunoglobulin is only recommended in patients with severe hypogammaglobulinaemia and repeated infections [I, A].
- Antibiotic and antiviral prophylaxis should be used in patients with recurrent infections and/or very high risk of developing infections [IV, B].
- Pneumococcal vaccination as well as seasonal flu vaccination is recommended in early stage CLL [IV, B].

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