Sistema Socio Sanitario
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FOLLICULAR LYMPHOMA

Epidemiology

Follicular lymphoma (FL) is the second most frequent subtype of lymphoma in Europe. The annual incidence has risen from 2-3/100.000 during the 1950s to 5/100.000 recently.

Signs and symptoms

FL is usually discovered when a patient has a swollen, painless lymph node in neck, armpits, or groin, typically without associated symptoms. However, patients with FL may sometimes experience symptoms like loss of weight, fever, night sweats, abdominal bloating or pain, sense of fullness or discomfort from enlarged tonsils, liver, or spleen, fatigue.

Diagnosis and risk stratification

the diagnosis of FL should be based on a surgical specimen/excisional lymph node biopsy, allowing the definition of grading, which may range from grade 1 to grade 3B based on average number of centroblasts/high-power field. FL grade 3B is considered an aggressive lymphoma and treated as such, whereas grades 1, 2 and 3A should be treated as indolent disease. FL is characterized by t(14;18) translocation, involving BCL2 and IgH genes, that can be detected on peripheral blood cells or bone marrow blood cells by PCR assessment in 50-60% of cases. Because treatment largely depends on the stage of the disease, initial staging should be thorough, particularly in the small proportion of patients with apparent early stages I and II (10%-15%). Initial work-up should include a bone marrow aspirate and biopsy and a computed tomography (CT) scan of the neck, thorax and abdomen and a positron emission tomography (PET)–CT scan.
There are some variables that have prognostic relevance: age, stage, number of nodal areas involved by lymphoma, bone marrow involvement, largest diameter of largest lymph node involved, LDH levels, b2-microglobulin levels and hemoglobin levels, early progression within 24 months from diagnosis.

Treatment

Treatment of FL depends on stage. In fact, in the small proportion of patients with limited low tumour burden stages I-II, radiotherapy (RT)-based treatment (involved-site RT 24 Gy) is the preferred approach with a curative intent. On the contrary, the treatment of patients with advanced-stage (III-IV) and high tumor burden (defined by GELF criteria of symptomatic/active disease) is systemic and is represented by a combination o fan anti-CD20 monoclonal antibody (Rituximab or Obinutuzumab) and chemotherapy, including CVP, CHOP or bendamustine, followed in responding patients by maintenance with the same anti-CD20 used during the induction (every 2 months for 2 years). Our treatment approach is based on International guidelines (i.e. ESMO doi.org/10.1093/annonc/mdx223).
In case of relapsed or refractory disease, there are many treatment options, including alternative immuno-chemotherapy regimens, autologous stem cells transplantation in young patients, targeted therapies like PI3 kinase inhibitors (i.e. Idelalisib). In our center, patients with unsatisfactory responses to standard therapy can be evaluated for clinical trials. For more information about the hematologic trials available in Varese, please visit the section “Trial Unit” of the Institutional website (https://www.asst-settelaghi.it/ematologia).