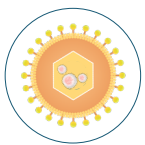




Unmet Needs in EBV⁺ PTLD



Not every transplant recipient develops PTLD

- Deciding on the extent of patient monitoring and the **timing of preemptive intervention** is challenging

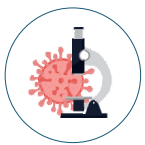


Tools are needed to predict occurrence of PTLD to make timing and approach of preemptive intervention efficient and consistent

What Do Guidelines Say About Treatment?



Treatment of EBV⁺ PTLD should restore the patient's immunity by reducing immunosuppressive therapy



Accounting for histology and clinical characteristics, clinical guidelines have recommended:

- Rituximab monotherapy
- Rituximab in combination with cyclophosphamide, doxorubicin, vincristine, and prednisolone



Treatment response has been effective

- Toxicity has been problematic
- PTLD has a relatively high mortality rate

Monitoring EBV+ PTLD

Management includes continual evaluation of the patient along with the following:



Drug indications



Dosing strategies



Frequent symptomatic monitoring



Disease- and treatment-related complications



Drug associated adverse events or toxicities



Concomitant drug interactions associated with immunosuppressive medications

Management of EBV+ PTLD

Clinical evaluation for EBV+ PTLD includes:



Risk stratification



Prevention



Pre-emptive measures

- Monitoring EBV DNAemia
 - » Range of 1000 copies/mL to 40,000 copies/mL
- Balancing treatment options
- Using a combination of reduction of immune suppression, anti-B cell therapy, and cytotoxic T lymphocytes

There is insufficient evidence to determine when to initiate further treatment



Recommendations suggest to wait no longer than 4 weeks to begin treatment



Initiate further therapy unless there is a complete or at least good partial remission



If clinical and histological findings indicate rapidly progressive disease, initiate additional therapy significantly earlier