LIVING WITH EBV+ PTLD

A Resource for Clinicians

Hematology DIALOGUES LIVE

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

Nijland ML, et al. *Transplant Direct.* 2015 Dec 15;2(1):e48.
Lindsay J, et al. *Curr Opin Infect Dis.* 2021 Dec 1;34(6):635-645.