Value of frontline autologous stem-cell transplantation in peripheral T-cell lymphoma

We read with interest the article presented by Mercadal et al. [1], a prospective trial of high-dose CHOP/E-SHAP (cyclophosphamide, vincristine, doxorubicin and prednisone/etoposide, methylprednisolone, cytarabine and cisplatin) regimen followed by autologous stem-cell transplantation (ASCT) in high-risk peripheral T-cell lymphoma (PTCL), where the authors express their doubts about the contribution of ASCT in preventing relapse, on the basis of the absence of significant differences in the overall survival (OS) of chemosensitive patients transplanted versus those chemosensitive not transplanted. We would like to argue four aspects in this debate:

1. Retrospective works and several recently reported ongoing prospective trials carried out by us and others seem to achieve the opposite results [2, 3] pointing to a positive role of ASCT in preventing relapse in PTCL.

2. In most prospective trials reported, the percentage of patients not reaching ASCT is ~25% [2]. In the trial of Mercadal et al., however, this figure is particularly high (59%). Thus, in an intention-to-treat analysis this fact may have conditioned the outcome of any strategy designed to evaluate the role of consolidation with ASCT.

3. We consider that the suggestion of Mercadal et al. [1, 4] of the lack of efficacy of ASCT in preventing relapse cannot be sustained if it is only on the basis of OS data. In fact, the authors did not present a full comparison of results between both chemosensitive samples in terms of relapse rate or event-free survival (EFS). These parameters are important, as actually they are the keys to evaluating the results of the procedure, as OS may be influenced by further therapy. This missing information was, however, reported in a recent communication of the same group in the Annual Meeting of the ASH 2006 [4] showing 2.5-fold more relapses in the chemosensitive non-transplanted group: 4 of 7 (57%) for non-transplanted versus 4 of 17 (23%) for transplanted, as well as a 2-fold more 4-year EFS in the chemosensitive transplanted sample (59%) versus the non-transplanted patients (29%). Thus if anything, this study goes in the direction of other recently reported prospective studies but with a lack of statistical power due to a reduced sample [2, 3].

4. Obviously, this question could only be definitively answered by a randomized prospective clinical trial. Given the poor results provided by the standard chemotherapy regimens used, however, a trial randomizing ASCT is premature until we can obtain better results with new induction regimens. In fact, an international randomized study [ACT-1 (alemtuzumab and CHOP in T-cell lymphomas, younger group) sponsored by the Nordic Lymphoma Group] is currently comparing two induction regimens and both arms are consolidated with ASCT, taking into account the available data of retrospective and prospective phase II studies supporting the value of ASCT in high-risk PTCL. The current recommendations of the National Comprehensive Cancer Network are similar.

In conclusion, we would like to emphasize that results from the prospective trials reported until now (included those presented by Mercadal et al.) are closer to supporting than excluding a beneficial role of frontline ASCT in preventing relapse in high-risk PTCL and more solid arguments, on the basis of studies with enough statistical power, should be provided to refute it.

A. Gutierrez1 & J. Rodriguez2*

1 Service of Hematology, University Hospital Son Dureta, Palma de Mallorca, 2 Service of Oncology, Hospital Gregorio Marañon, Madrid, Spain (*E-mail: jrodriguez@hsd.es)

references


doi:10.1093/annonc/mdn399