Cancer Q&A: Understanding the Role and Reality of CAR (Chimeric Antigen Receptor) T-Cell Therapy for Non-Hodgkin Lymphoma

*A CME/MOC-Accredited Webinar Developed in Partnership with Cancer*Care®

Wednesday, November 12, 2025

5:00 PM – 6:00 PM ET

Faculty

Jeremy S Abramson, MD, MMSc
Loretta J Nastoupil, MD

Moderator

Neil Love, MD

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Faculty

Jeremy S Abramson, MD, MMSc
Director, Center for Lymphoma
Massachusetts General Hospital
Professor of Medicine
Harvard Medical School
Boston, Massachusetts

Loretta J Nastoupil, MD
Oncologist
Southwest Oncology
CommonSpirit Mercy Hospital
Durango, Colorado

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

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Survey Participants

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Associate Professor
Clinical Director of Lymphoma Services
Morton and Sandra Saffer Endowed Chair in Hematology Research
Division of Hematology, Hematologic Malignancies
University of Colorado Cancer Center
Aurora, Colorado

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Professor
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Associate Vice Chair of Research, Department of Medicine
Assistant Vice Chancellor for Clinical Research
Fred and Pamela Buffett Cancer Center
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Omaha, Nebraska

Jason Westin, MD, MS
Director, Lymphoma Clinical Research
Section Chief, Aggressive Lymphoma
Professor, Department of Lymphoma and Myeloma
The University of Texas MD Anderson Cancer Center
Houston, Texas

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Dr Westin — Disclosures
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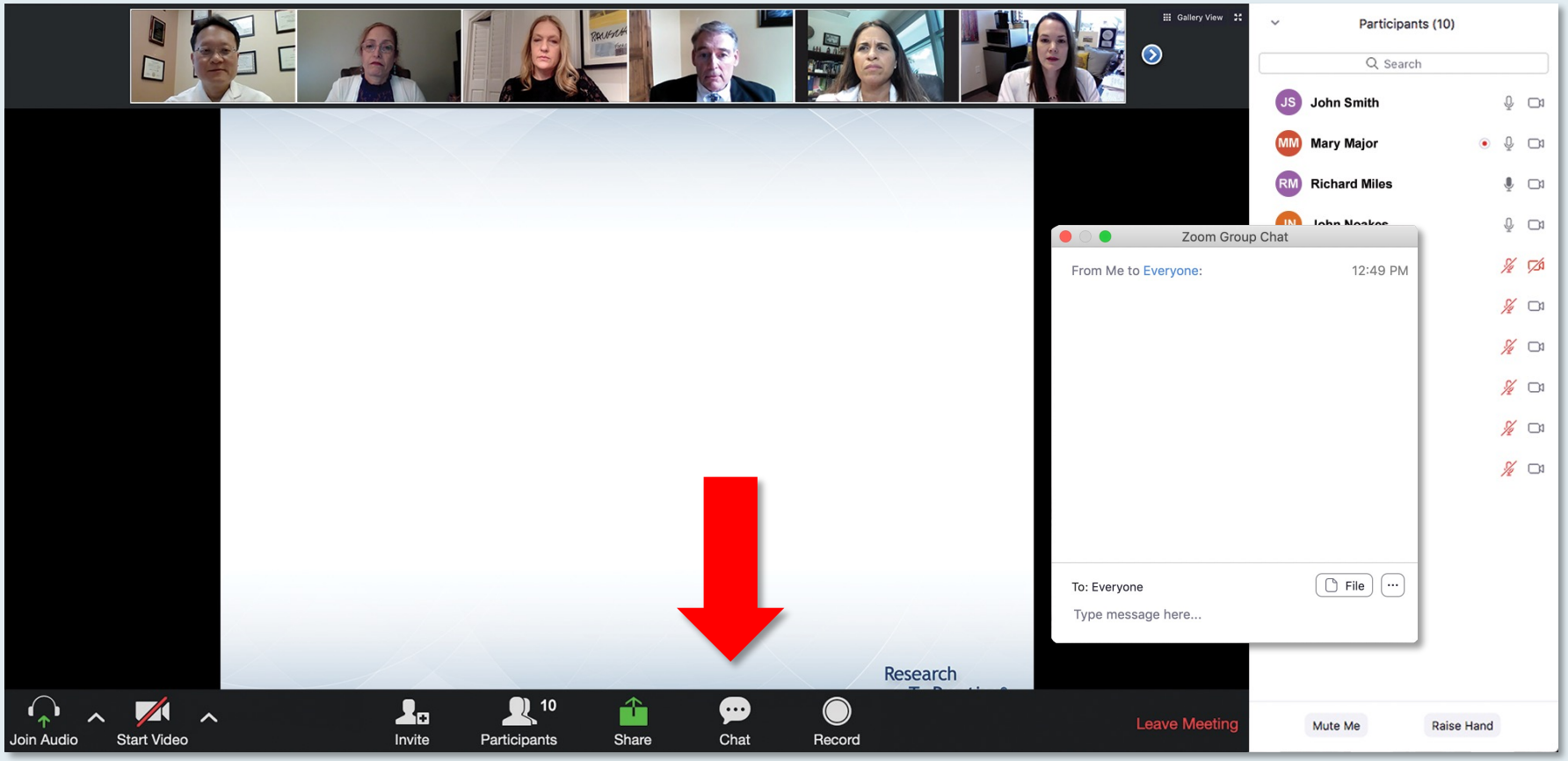

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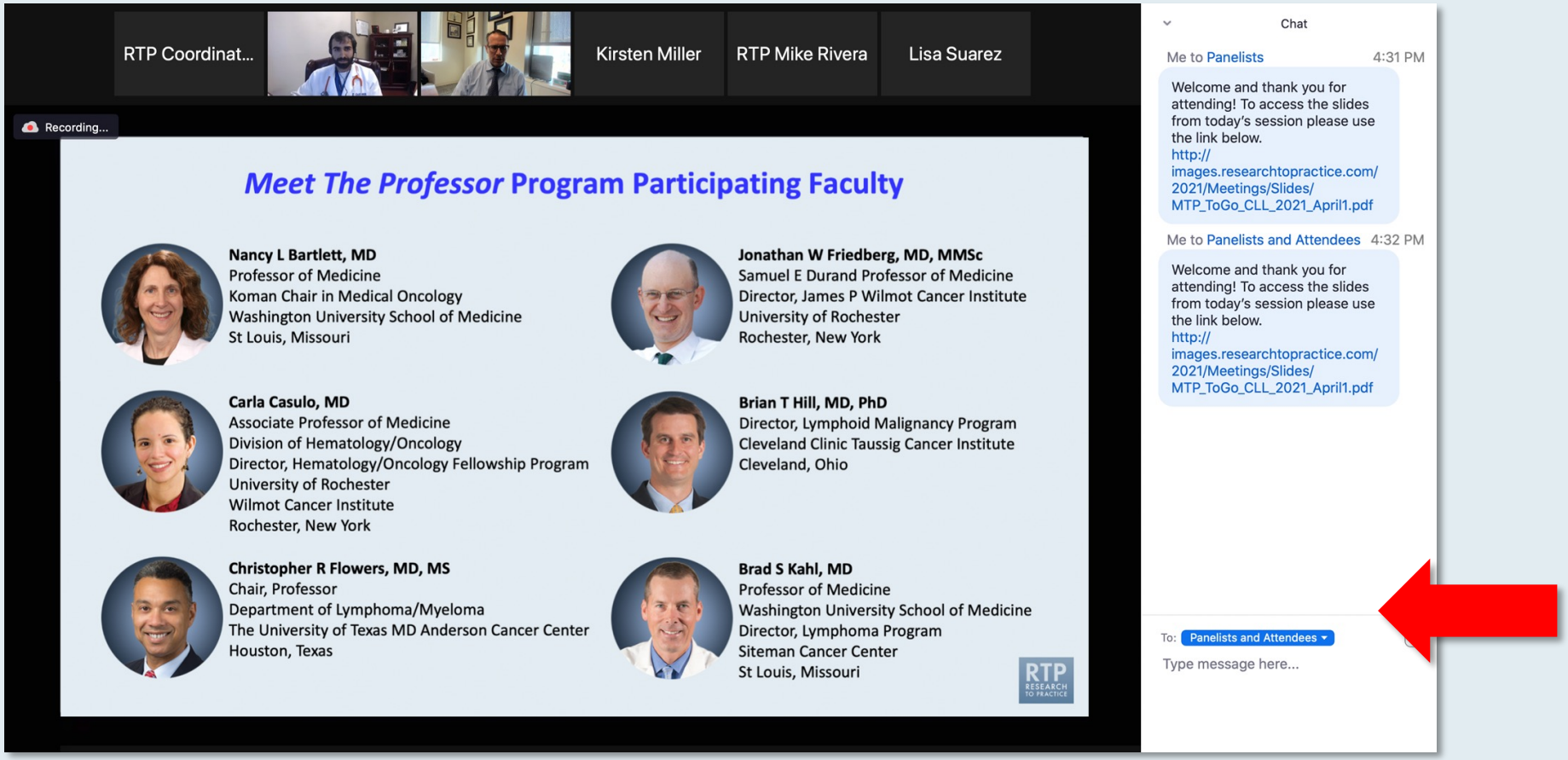

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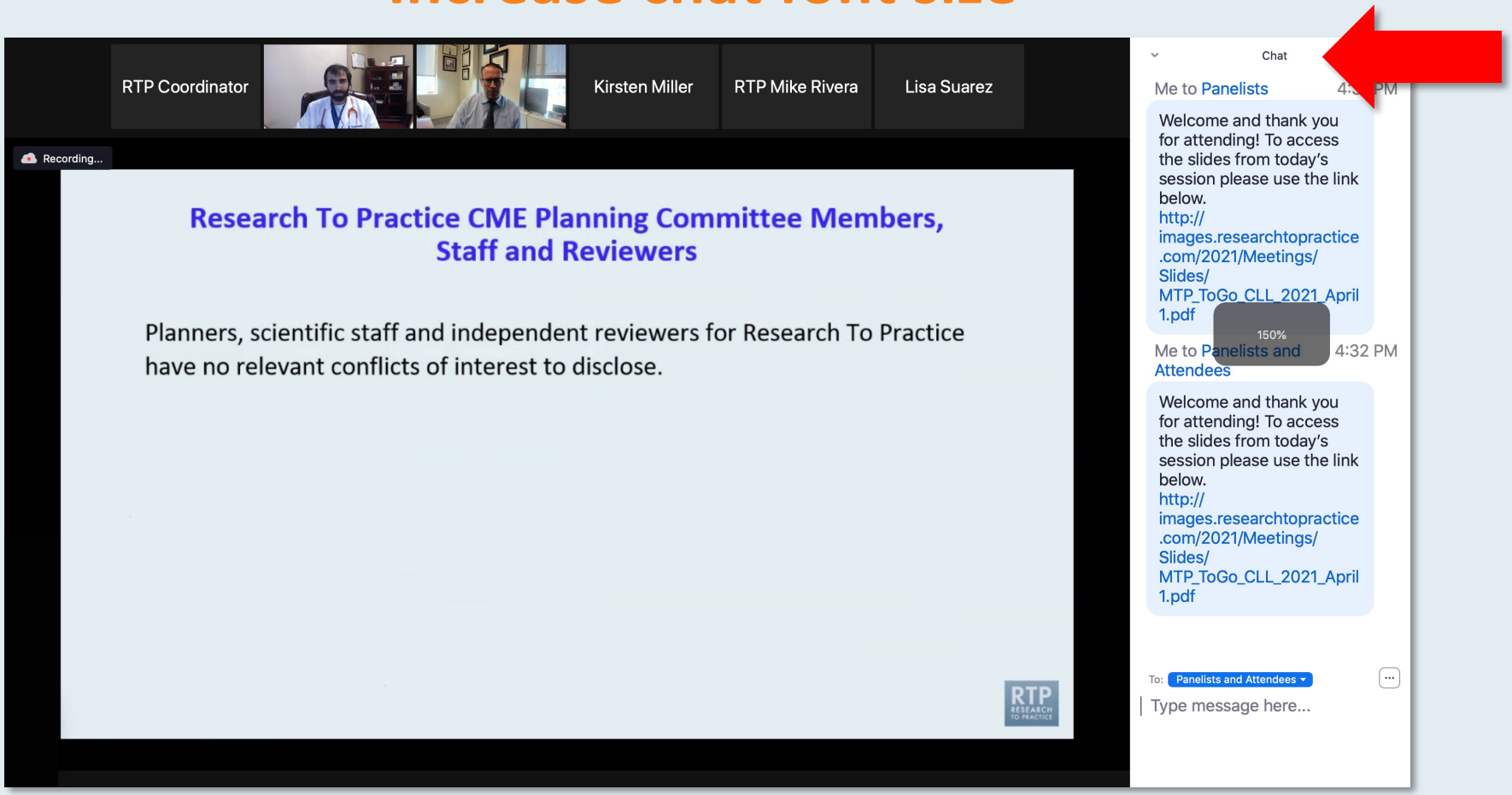

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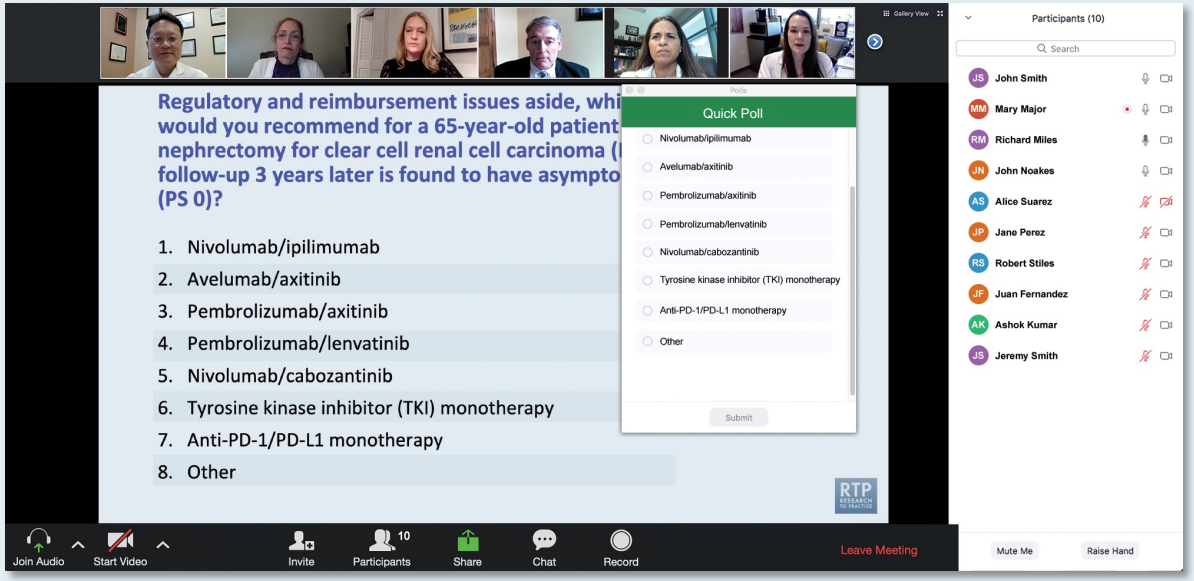

Non-Hodgkin Lymphoma — The Implications of Recent Datasets for Current and Future Disease Management

DR CARLA CASULO
WILMOT CANCER INSTITUTE

DR BRAD S KAHL
SITEMAN CANCER CENTER

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Cancer Conference Update: 2025 ESMO Annual Meeting — Breast Cancer Highlights

CME/MOC-Accredited Live Webinar

Thursday, November 13, 2025
5:00 PM – 6:30 PM ET

Faculty

Professor Giuseppe Curigliano, MD, PhD
Priyanka Sharma, MD

Moderator

Neil Love, MD

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Practical Perspectives: Clinical Investigators Review Actual Cases of Patients with Advanced Gastroesophageal Cancers

A CME/MOC-Accredited Live Webinar

Tuesday, November 18, 2025
5:00 PM – 6:00 PM ET

Faculty

Yelena Y Janjigian, MD

Moderator

Neil Love, MD

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Preventing and Managing Toxicities Associated with Antibody-Drug Conjugates in the Management of Metastatic Breast Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, November 19, 2025

5:00 PM – 6:00 PM ET

Faculty

Lisa A Carey, MD, ScM, FASCO

Rita Nanda, MD

Moderator

Neil Love, MD

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Cancer Conference Update: ESMO Congress 2025 — Urothelial Bladder Cancer and Prostate Cancer

A CME/MOC-Accredited Live Webinar

Thursday, November 20, 2025
5:00 PM – 6:00 PM ET

Faculty

Terence Friedlander, MD
Rana R McKay, MD

Moderator

Neil Love, MD

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Exciting CME Events You Do Not Want to Miss

A Friday Satellite Symposium Series Preceding the 67th ASH Annual Meeting

Friday, December 5, 2025

Acute Myeloid Leukemia
7:30 AM – 9:30 AM ET

Myelofibrosis and Systemic Mastocytosis
3:15 PM – 5:15 PM ET

Chronic Lymphocytic Leukemia
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Cases from the Community: Investigators Discuss the Optimal Management of Breast Cancer

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Endocrine-Based Therapy

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Grand Rounds

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November 2025 to April 2026

Two Series

Optimizing Treatment for Patients with Relapsed/Refractory Chronic Lymphocytic Leukemia

Optimizing the Use of Novel Therapies for Patients with Diffuse Large B-Cell Lymphoma

Host a 1-hour session at your institution:
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or call (800) 233-6153

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Save The Date

Fifth Annual
National General Medical Oncology Summit

A Multitumor CME/MOC-, NCPD- and ACPE-Accredited Educational Conference Developed in Partnership with Florida Cancer Specialists & Research Institute

Friday to Sunday, April 24 to 26, 2026

The Ritz-Carlton Orlando, Grande Lakes | Orlando, Florida

Moderated by Neil Love, MD

Thank you for joining us! Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us.

Information on how to obtain CME and ABIM MOC credit will be provided at the conclusion of the activity in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

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Blood Cancers Patient Support Group

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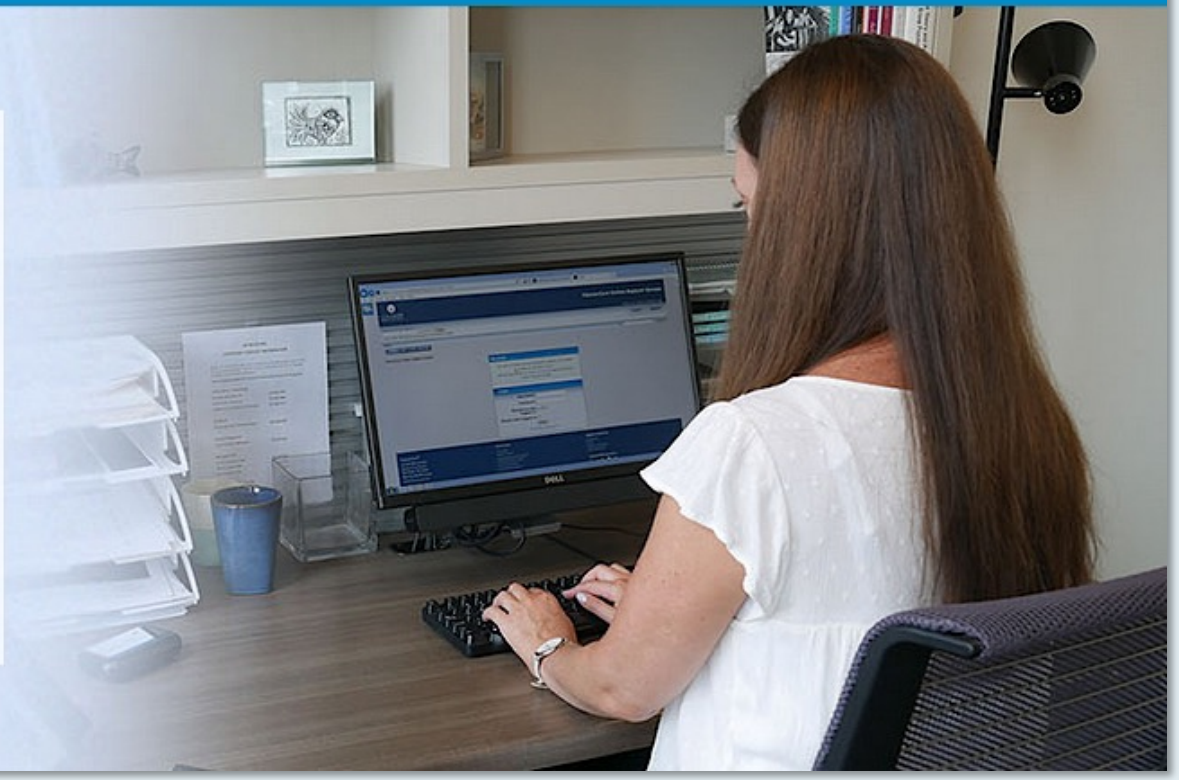
Our blood cancers patient support group **provides a safe space to connect with others** coping with a blood cancer and is **led by an oncology social worker** who provides emotional and practical support.



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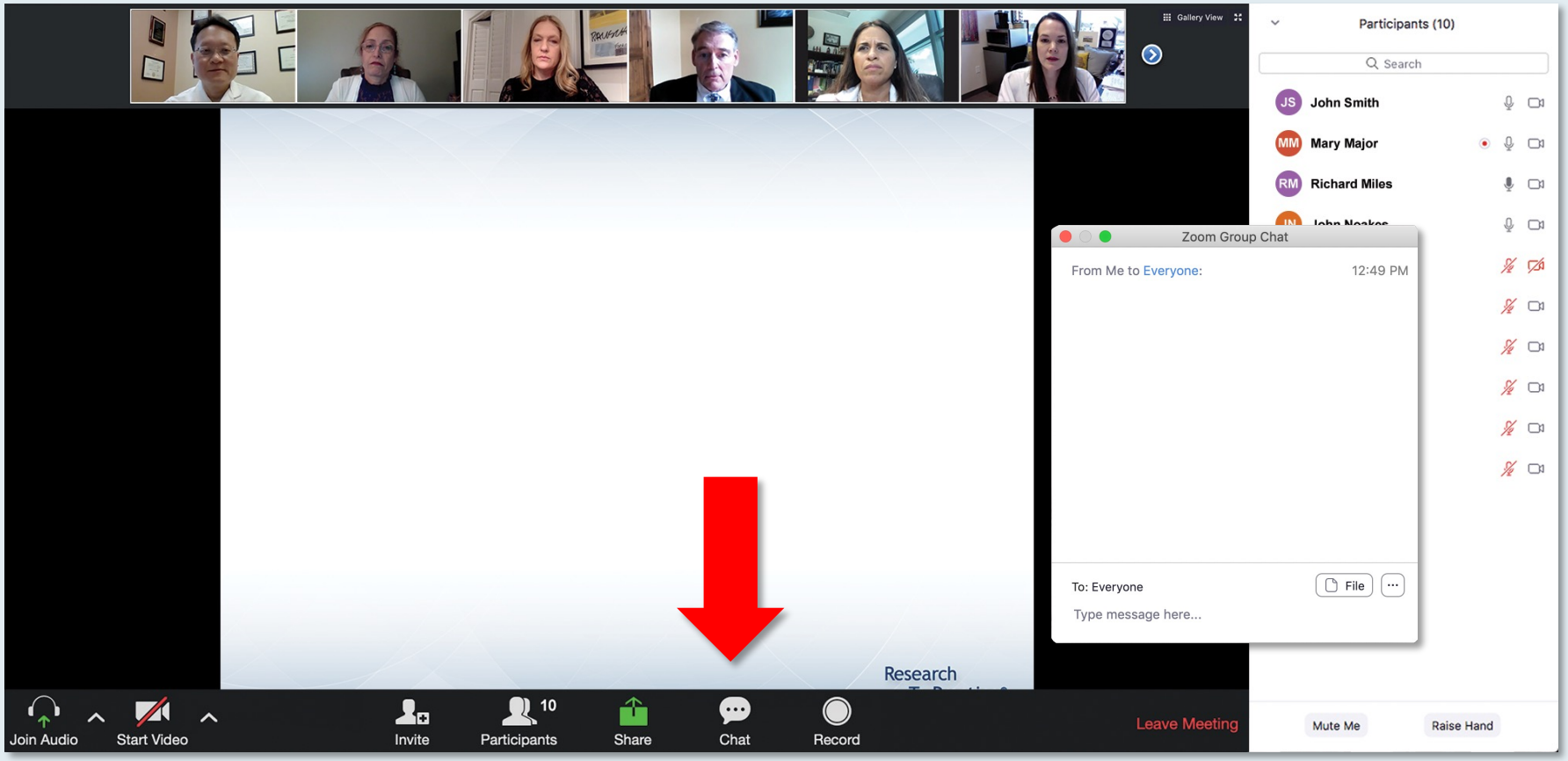

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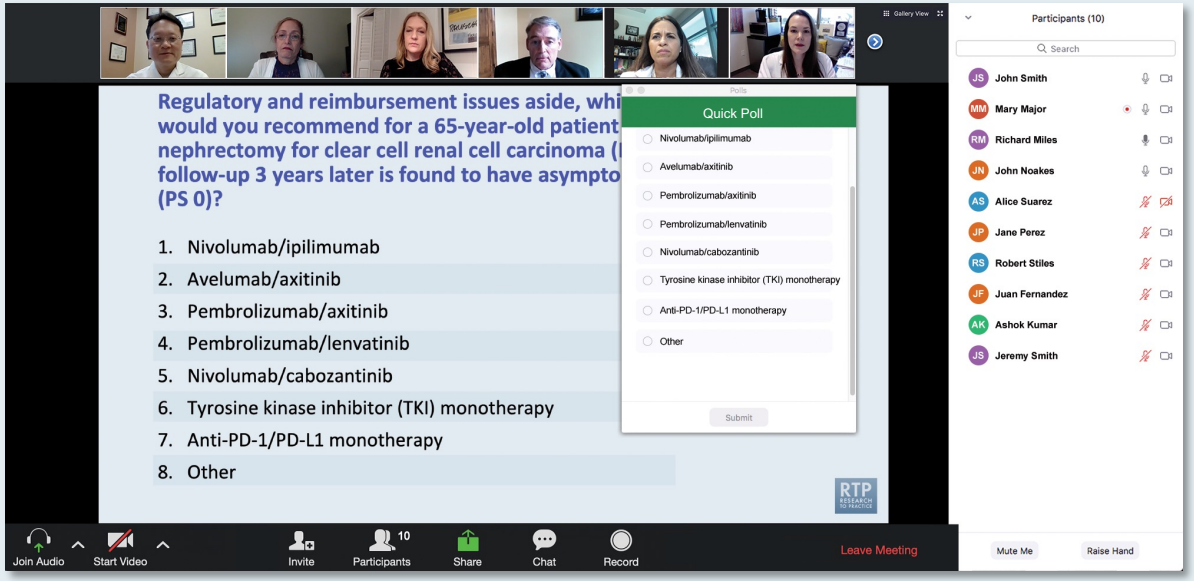

Non-Hodgkin Lymphoma — The Implications of Recent Datasets for Current and Future Disease Management

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Moderated by Neil Love, MD

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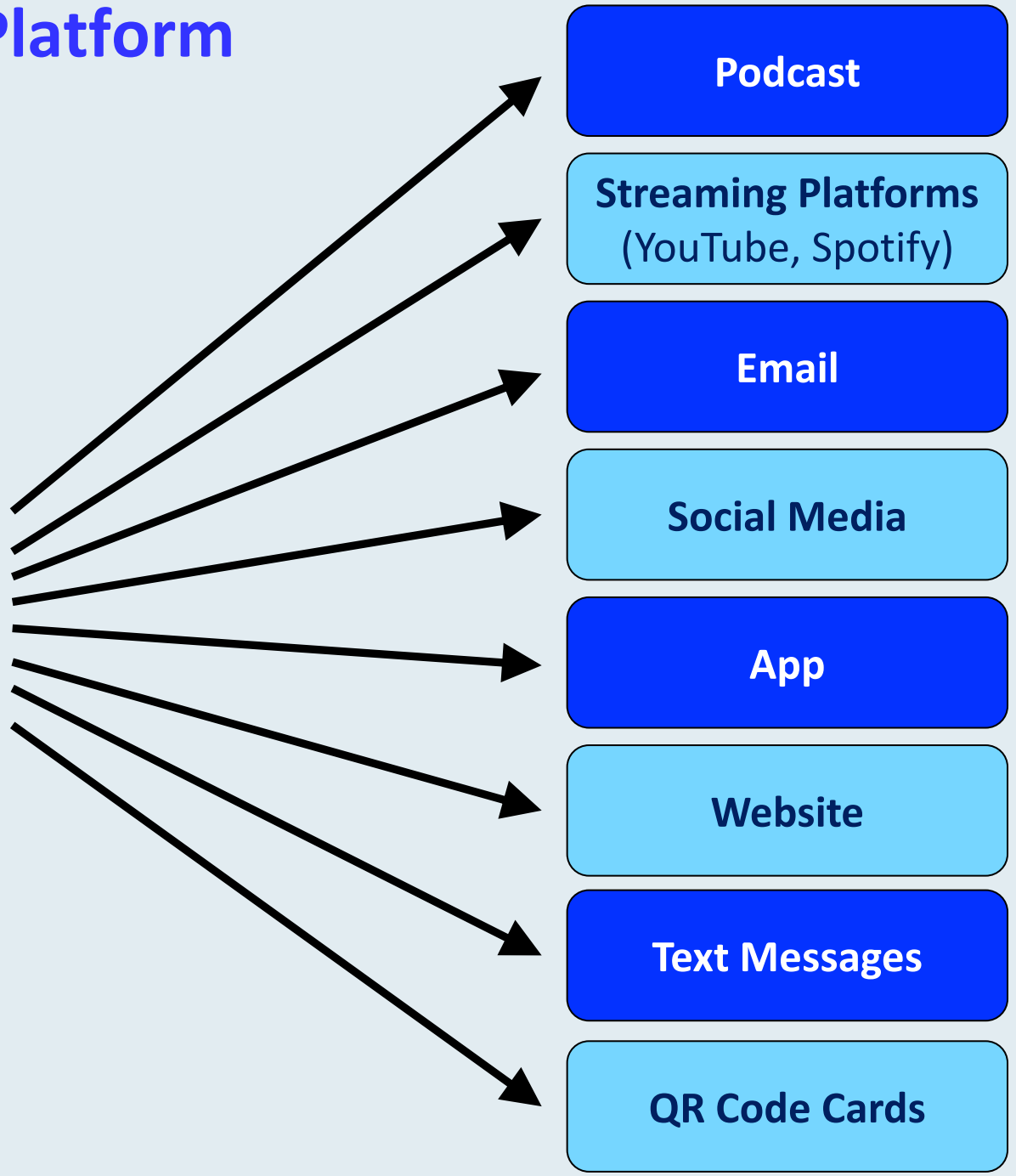
	Year	Month
Total (hours)	280	24
Recordings	93	7
Webinars	41	4
Cases	62	5
Meetings	84	7
Final	218	18



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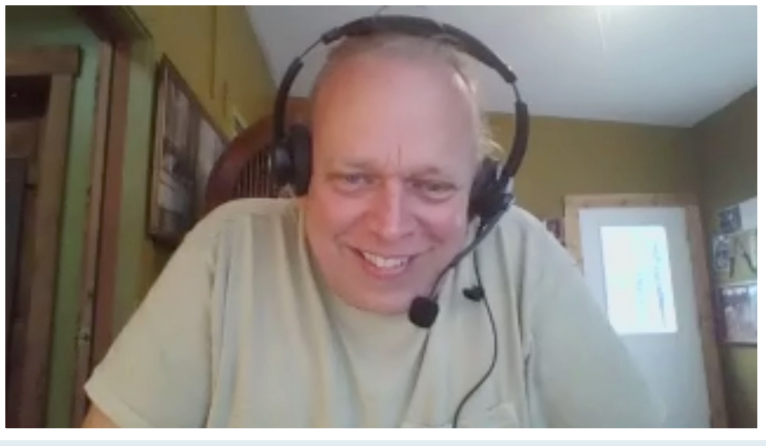

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Cancer Q&A
CAR T-Cell Therapy for Non-Hodgkin Lymphoma

Module 1: Overview of CAR T-Cell Therapy

Module 2: Potential Treatment Benefits of CAR T-Cell Therapy

Module 3: CRS (Cytokine Release Syndrome) and ICANS (Immune Effector Cell-Associated Neurotoxicity Syndrome)

Module 4: Finding Information About CAR T-Cell Therapy; Clinical Trials

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Overview of CAR T-cell therapy

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Overview of CAR T-Cell Treatment

 Dr Abramson	CAR T cells harness the power of your own immune system to fight the lymphoma. Both CAR T-cell products have identical efficacy. One is less toxic but takes about a week longer to manufacture.
 Dr Nastoupil	Liso-cel is generally associated with lower rates of CRS and neurotoxicity. The one limitation is the median manufacturing time is about 24 days.
 Dr Kamdar	Cytopenias, secondary malignancy risk and infection risk are similar across constructs. Manufacturing time is different across different products.
 Dr Lunning	I often start with the fact that no head-to-head trials are comparing CAR T for third line plus as well as high risk second-line population. I pay a lot of attention on mitigating the risk of high-grade toxicity, which I feel leads to long-term disability and length of stay issues.
 Dr Phillips	All CAR products are derived from the patients own T cells. They are modified to better recognize and kill cancer cells. Axi-cel/brexu-cel has a Ferrari engine; Liso-cel and tis-cel have a Corvette engine.
 Dr Westin	The approved products are very similar – we take T cells and turn them in to lymphoma-fighting weapons, which are more effective to get and stay in remission than other treatments. The main differences are logistics and side effects.

CRS = cytokine release syndrome; CAR T = CAR T-cell therapy

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Discussion Question

Of the patients with NHL who you would consider to be good candidates for CAR-T therapy, what fraction end up being evaluated by a CAR-T center and what fraction of those patients actually receive treatment?

Key Time Points in the CAR T-Cell Therapy Journey
Manali Kamdar, MD, MBBS

I map out the process clearly:

1. Initial consult and eligibility review
2. Apheresis (cell collection)
3. Bridging therapy (if needed)
4. Manufacturing period (usually 3-5 weeks)
5. Lymphodepleting chemotherapy
6. Cell infusion (day 0)
7. Monitoring phase (days 0-14) for CRS or ICANS
8. Response assessment at day 30 or 90, depending on institutional programmatic approach
9. Follow-up phase: infection prophylaxis, labs and clinic visits for at least 6 months

I reassure them that if the first 2 weeks go smoothly, they can often transition home or to local lodging, continuing close follow-up.

Key Timepoints in the CAR T-Cell Therapy Journey

 Dr Abramson	CAR T cells are a multi-step process, but the actual treatment is given as a single infusion, not multiple cycles like many other therapies.
 Dr Nastoupil	Patients are monitored at the treating center until they are deemed safe to return home. Patients are followed closely for the first 90 days.
 Dr Kamdar	I map out the process clearly. I reassure them that if the first 2 weeks go smoothly, they can often transition home or local lodging, continuing close follow-up.
 Dr Lunning	Brain to Vein encapsulates desire to do it and actually getting to go to apheresis. The challenge here is insurance approval, tests necessary, and getting a chair for apheresis. Once apheresed then we are in the Vein to Vein time, which we very reliably now infuse products to near 100%.
 Dr Phillips	The first step is insurance approval. This can vary from patient to patient. Next step after approval is obtaining an apheresis slot, for which thereafter we will collect cells.
 Dr Westin	The key time points are the decision, the approval, the collection, the manufacturing, the delivery, and the follow-up. For follow-up, patients have testing like PET/CT scans and blood work, and to work with their local oncologist on recovering from any leftover side effects.

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Discussion Question

What is the role of bridging therapy? Adding in systemic treatment (eg, a Bruton tyrosine kinase inhibitor)?

Bridging Therapy

 Dr Abramson	Bridging therapy is treatment used to control the disease and symptoms while the CAR T cells are being manufactured. We have both systemic options and radiation therapy.
 Dr Nastoupil	Patients are likely to have better outcomes regarding both safety and efficacy if they proceed with CAR T with disease regressing as opposed to progressing.
 Dr Kamdar	Bridging therapy is anything we do to stabilize disease while CAR T cells are being manufactured. The goal is to keep the disease under control.
 Dr Lunning	I use apheresis as a split in bridging as I may do something different before apheresis (pre-aph) and after apheresis (post-aph). In pre-aph, I focus on disease stabilization without making them too sick for CAR T. In the post-aph period we use what we've learned to customize therapy.
 Dr Phillips	Bridging therapy is needed to slow the progression of cancer long enough to allow for collection, manufacture and return of the CAR product; especially helpful for rapidly progressive disease.
 Dr Westin	Bridging therapy is not always required, especially if the amount of lymphoma is low and speed of disease growth is slow.

CAR T = CAR T-cell therapy

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Discussion Question

How do you select a CAR-T product? What is the relative efficacy and efficiency of product preparations, and what are their associated toxicities?

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Selecting a CAR T-Cell Therapy Product
Manali Kamdar, MD, MBBS

When I choose a CAR-T product, I consider:

- Disease subtype and efficacy data for that construct in that histology
- Tumor burden, patient symptoms, time it will take to manufacture one construct versus the other
- Patient profile: age, comorbidities, performance status, caregiver support
- Logistics: inpatient versus outpatient feasibility, manufacturing time and caregiver support

The goal is to tailor the product to both disease biology and patient resilience.

Selecting a CAR T-Cell Therapy Product

 Dr Abramson	We consider multiple factors, including efficacy, safety, manufacturing time and ability to administer in the outpatient setting.
 Dr Nastoupil	Key factors are type of lymphoma, line of therapy, response to prior treatment, comorbid conditions, disease burden and tempo.
 Dr Kamdar	I consider disease subtype, efficacy data, tumour burden, patient symptoms, time it will take to manufacture, patient age, comorbidities, performance status, caregiver support.
 Dr Lunning	I look at it backwards: high-grade ICANS and then work my way backwards, next being high-grade CRS — we've gotten so much better at managing CRS that it is quite rare. In the end, I believe liso-cel checks the box of balance with efficacy vs safety.
 Dr Phillips	Liso-cel is appropriate alternative to axi-cel for DLBCL. For a patient w/ high burden or aggressive disease the choice might be axi-cel. For FL, the preference is liso-cel. For MCL the preference is brexu-cel.
 Dr Westin	I weigh the pros and cons of each product: If the disease is progressing quickly, I choose speed and reliability of manufacturing. If the patient is frail, I choose safety of the toxicity profile.

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Potential treatment benefits of CAR T-cell therapy

Discussion Question

What are the projected benefits of CAR T-cell therapy in diffuse large B-cell lymphoma? Where does CAR T fit in?

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Diffuse Large B-Cell Lymphoma (DLBCL)

 Dr Abramson	The majority of patients will respond; about half will go into complete remission. Close to 40% will be cured.
 Dr Nastoupil	I generally favor liso-cel for older or frailer patients given the favorable toxicity profile. For young, fit patients, I prefer axi-cel with the favorable manufacturing time.
 Dr Kamdar	I generally prefer liso-cel for DLBCL. The 5-year follow-up data across all constructs suggest a roughly 40% chance of long-term remission or cure, but liso-cel has a more favorable safety profile.
 Dr Lunning	I would prefer liso-cel, given its balance of efficacy and safety in multiply relapsed DLBCL. I do believe it carries the least likelihood of having high-grade neurotoxicity compared to the other products.
 Dr Phillips	Preference would be based on age/fitness; for younger/fit patients axi-cel and for older patients liso-cel. This would be administered w/ the intent to cure. Patients in remission at day 90 have a great chance of long-term cure.
 Dr Westin	Axi-cel. For your relapsed DLBCL, we have one chance to provide a curative intent therapy and thus reliability of manufacturing is key. Axi-cel cures about 40% of patients with this otherwise fatal disease.

Discussion Question

What are the projected benefits of CAR T-cell therapy for follicular lymphoma? Where does CAR T fit in?

Follicular Lymphoma (FL)

 Dr Abramson	Responses to CAR T last about 5 years on average, but far longer responses are possible. Some patients will never relapse after this treatment.
 Dr Nastoupil	I recommend liso-cel primarily because it is associated with a manageable safety profile.
 Dr Kamdar	My preferred CAR T is lisocabtagene maraleucel (liso-cel), which offers an attractive balance of efficacy and tolerability. Remission can be long-lasting — and possibly curative.
 Dr Lunning	Despite longer data and follow-up with axi-cel, I do feel that the toxicity profile matters as FL is a marathon, not a sprint. I would consider liso-cel, which has excellent activity in obtaining a complete response.
 Dr Phillips	My preference is liso-cel; the hope is that w/ time we might identify a subset of patients that could potentially achieve a cure or a “functional” cure.
 Dr Westin	Axi-cel. We choose this treatment because more than half of patients are alive and did not require additional lymphoma therapy with more than 5 years of follow up – hopefully some of those patients are cured.

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Discussion Question

What are the projected benefits of CAR T-cell therapy for mantle cell lymphoma? Where does CAR T fit in?

Mantle Cell Lymphoma (MCL)

 Dr Abramson	The vast majority of patients in this situation will respond, and most will go into complete remission. Remissions last 1-2 years on average, but remission may last much longer. Pirtobrutinib may be used as bridging therapy.
 Dr Nastoupil	I would prefer liso-cel for multiply-relapsed MCL. I would favor brexu-cel for a young, fit patient with high-risk disease in first relapse.
 Dr Kamdar	For younger, fit patients, brexucabtagene autoleucel (brexu-cel) remains my preferred choice. For older or frail patients, I favor liso-cel due to its lower toxicity and outpatient feasibility.
 Dr Lunning	Considering the activity of both in mantle cell lymphoma post-BTK exposure, I would prefer Liso-cel over Brexu-cel due to its safety profile, noting the differences in these single-arm trials.
 Dr Phillips	Preference is brexu-cel. Treatment is not curative and the disease will relapse. For those unable to receive brexu-cel we use liso-cel.
 Dr Westin	Liso-cel. For your relapsed MCL, we want to balance concerns for effective treatment and risk of side effects. The other options are impressive, but have a higher risk of severe side effects.

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CRS (cytokine release syndrome) and ICANS (immune effector cell-associated neurotoxicity syndrome)

Discussion Question

What is the clinical spectrum of CRS? Role of preemptive tocilizumab?

CRS

 Dr Abramson	The most common symptom is fever, but it can uncommonly get worse. We give an antidote called tocilizumab with or without steroids which rapidly improves the CRS and usually prevents if from becoming severe.
 Dr Nastoupil	The spectrum of CRS is dependent on the product regarding the likelihood of experiencing it at all and how serious it might be. Nearly all patients will have fever. Generally, the course of CRS is relatively short.
 Dr Kamdar	I describe CRS as the “immune storm” that tells us the CARs are expanding — fever, chills, low blood pressure, shortness of breath — ranging from mild to severe.
 Dr Lunning	High-grade CRS, I would argue, is less common now than high-grade ICANS. I focus on discussing if we see CRS, especially if early post-infusion, we act quickly as I believe this is the biggest predictor of odds of having ICANS.
 Dr Phillips	CRS is manifested by fever but this is generally preceded by tachycardia. Some patients require ICU.
 Dr Westin	I describe CRS as similar to having an infection like the flu — sometimes you can have fever and body aches and that’s it, other times you can see low blood pressure and a trip to the ICU.

Discussion Question

What is the clinical spectrum of ICANS and other neurotoxicities? How are these managed?

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ICANS

 Dr Abramson	The most common symptoms are confusion, sleepiness or word-finding difficulties.
 Dr Nastoupil	ICANS is variable and unpredictable. It generally will occur after a patient has experienced CRS. It can be rapid in onset and resolution.
 Dr Kamdar	ICANS often follows or overlaps with CRS, most commonly within 8-14 days post infusion. Early recognition is key, and we maintain daily neurologic checks during the acute phase.
 Dr Lunning	If ICANS does occur I've already readied them for a longer inpatient stay and that they may need acute rehab. We do steroids prophylaxis and are very aggressive with CRS management if CRS onset in first 72 post-infusion.
 Dr Phillips	Initial management is w/ steroids and depends on severity and duration of symptoms. For most patients this is reversible.
 Dr Westin	ICANS is brain dysfunction, which is nearly always reversible. There are no effective preventative strategies, and treatments can prevent ICANS from worsening.

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Finding information about CAR T-cell therapy; clinical trials

Discussion Question

What is known about mechanisms of resistance and clinical limitations to CAR T-cell therapy, and what research avenues are being pursued to improve it?

What are some of the exciting clinical trial initiatives in CAR T-cell therapy?

Cancer Q&A
CAR T-Cell Therapy for Non-Hodgkin Lymphoma

Financial issues; risk of infection

Discussion Question

What are some of the financial issues that arise with CAR T-cell therapy? Outpatient CAR T?

Financial Issues

 Dr Abramson	Insurance covers the CAR T cells and associated care. Costs may be associated with needing to stay near our center for 2-4 weeks, but support and reimbursement programs are available.
 Dr Nastoupil	Insurance coverage may impact which centers are available and this can result in long travel. Patients have several visits to the treating center and are generally not able to work and this too can be a financial stressor.
 Dr Kamdar	I emphasize the importance of caregiver support, possible work or income disruption, and the option of FMLA for caregivers. Financial counselors and social workers assist.
 Dr Lunning	Medicare with managed plan or private insurance requires single-case agreement, which delays apheresis. I know what insurance they have before I walk into the consult room as that may impact my Brain to Vein decision. Rarely after that is it an issue.
 Dr Phillips	Work can be an important issue. Also, there is need for a caregiver, which requires another person to be off work for an extended period, which for some is not financially feasible.
 Dr Westin	As anything complicated, CAR-T treatment can have financial challenges, like needing to be away from home for monitoring and needing to have a caregiver(s) to take off work.

Discussion Question

What are some of the long-term issues with CAR T-cell therapy, including hypogammaglobulinemia, infections, preemptive antimicrobials and vaccines?

Potential Long-Term Complications

 Dr Abramson	Prophylactic antibiotics are used until healthy lymphocytes have recovered. We also monitor antibody levels, and may use IVIG. We will also consider vaccines to help prevent infections.
 Dr Nastoupil	B-cell depletion can increase the risk of infection, particularly viral infections. Monitoring IgG levels and IVIG replacement is also a consideration to reduce the risk of infection.
 Dr Kamdar	The primary concern is immunosuppression and infection risk due to prolonged B-cell aplasia and hypogammaglobulinemia. I keep patients on antiviral and PJP prophylaxis for at least 6 months.
 Dr Lunning	We use anti-infection prophylaxis, but I don't do IVIG post-CAR T without infection. Secondary malignancies are real, but it is way more myeloid than T-cell concerns.
 Dr Phillips	We continue anti-infection prophylaxis until blood count recovery.
 Dr Westin	CAR T cells kill B cells, both good and bad ones, and not having good B cells for months afterwards can open you up to unusual infections.

IVIG = intravenous immunoglobulin; PJP = Pneumocystis jirovecii pneumonia; CAR T = CAR T-cell therapy

Discussion Question

Are there complementary strategies that are useful in managing toxicities with CAR T-cell therapy?

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Coping with anxiety; healing and moving on

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Discussion Question

What advice do you give to patients and families to cope with anxiety and depression?

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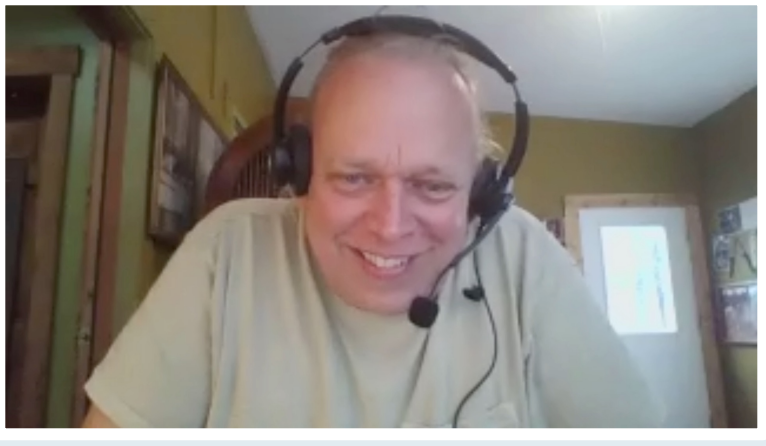

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Cancer Conference Update: 2025 ESMO Annual Meeting — Breast Cancer Highlights

CME/MOC-Accredited Live Webinar

Thursday, November 13, 2025
5:00 PM – 6:30 PM ET

Faculty

Professor Giuseppe Curigliano, MD, PhD
Priyanka Sharma, MD

Moderator

Neil Love, MD

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