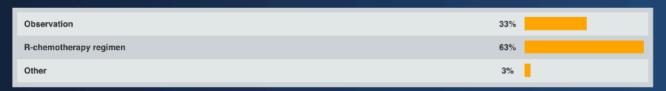
A 60-year-old patient presents with a white blood cell count of 50,000. Scans are notable for mild splenomegaly but no adenopathy, and bone marrow biopsy shows mantle cell lymphoma (MCL) with Sox-11 expression. Ki-67 is 20%. What would you recommend?

Observation	57%
BR	21%
RBAC (rituximab/bendamustine/cytarabine)	14%
Other	7%

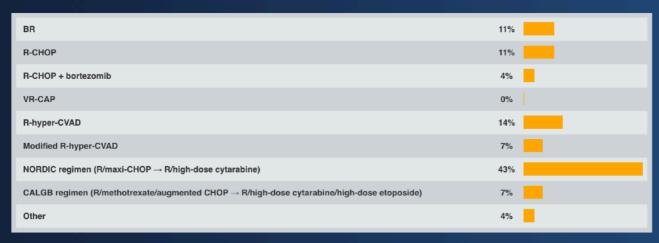
A 60-year-old man being evaluated for kidney stones is found to have abnormal bowel wall thickening. Colonoscopy reveals isolated MCL with extensive gastrointestinal involvement, but the patient is asymptomatic. What would you recommend?



A 60-year-old asymptomatic patient is found to have a 4-cm cervical lymph node that demonstrates MCL (bone marrow and pan-endoscopy negative). What treatment would you recommend?

Observation	17%
Definitive ISRT	48%
Definitive ISRT and rituximab	10%
R-chemotherapy regimen	7%
R-chemotherapy regimen and radiation therapy	14%
Other	3%

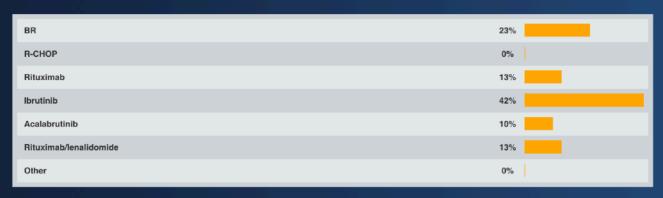
In a 60-year-old patient with newly diagnosed MCL who requires treatment, what induction regimen would you most likely recommend? (Assume therapy is prior to transplant if indicated.)



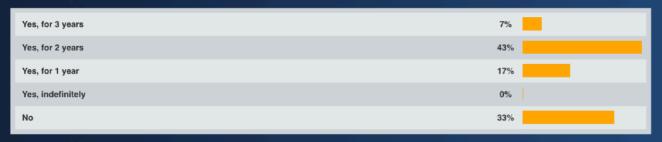
In an 80-year-old patient with newly diagnosed MCL who requires treatment, what induction regimen would you most likely recommend?

BR	77%
R-CHOP	0%
Rituximab	3%
Ibrutinib	13%
Acalabrutinib	0%
Rituximab/lenalidomide	6%
Other	0%

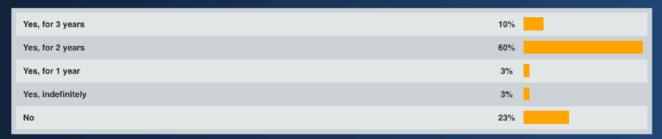
In a 90-year-old patient with newly diagnosed MCL who requires treatment, what induction regimen would you most likely recommend?



Do you generally use maintenance rituximab for younger patients with MCL who have undergone transplant?



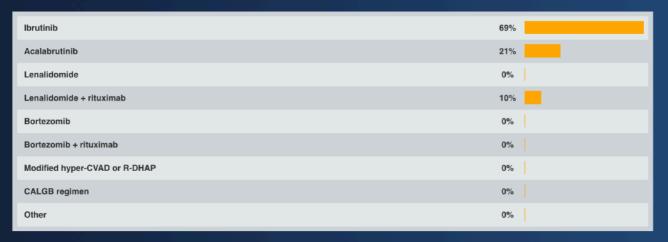
Do you generally use maintenance rituximab for patients with MCL who are not transplant candidates?



In general, how, if at all, have you incorporated subcutaneous rituximab into your management of MCL?

I am routinely substituting subcutaneous rituximab for IV rituximab	23%
For all patients after they have demonstrated tolerability to IV rituximab	13%
Only in the maintenance setting	10%
I have not incorporated subcutaneous rituximab into my practice	47%
Other	7%

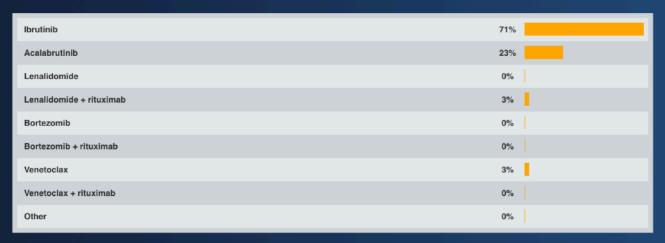
A 60-year-old patient with MCL initially treated with the NORDIC regimen followed by autologous transplant and 2 years of rituximab maintenance relapses 3 years later. What would you recommend?



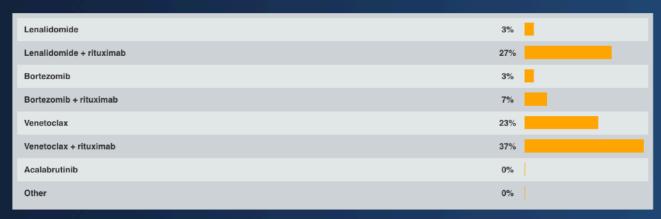
The patient in the previous scenario receives ibrutinib and achieves a complete response. What would you do next?

Continue ibrutinib until disease progression	69%
Consider allotransplant	28%
Other	3%

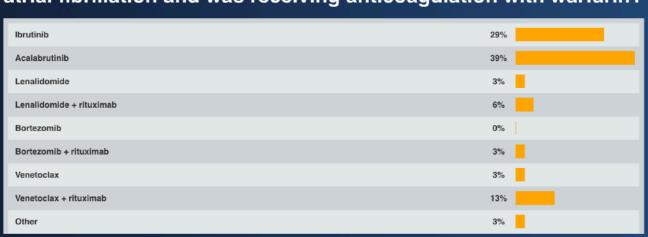
An 80-year-old patient with MCL responds to BR followed by rituximab maintenance but after 3 years develops disease progression. The patient is not a candidate for transplant. In general, what would be your most likely next treatment recommendation?



In general, what would be your most likely treatment recommendation for a transplant-ineligible 60-year-old patient with MCL who responds to R-hyper-CVAD and then ibrutinib on relapse but subsequently develops disease progression?



A 60-year-old patient with MCL responds to R-hyper-CVAD followed by autologous transplant and rituximab maintenance but after 1 year develops disease progression. The patient is no longer a candidate for transplant. What would be your most likely next treatment recommendation if the patient had a history of atrial fibrillation and was receiving anticoagulation with warfarin?



A 60-year-old patient with MCL responds to BR and then ibrutinib on relapse but develops atrial fibrillation requiring anticoagulation with warfarin. Regulatory and reimbursement issues aside, what would you recommend?

Continue ibrutinib at the same dose	43%
Continue ibrutinib at a reduced dose	17%
Lenalidomide	0%
Lenalidomide + rituximab	0%
Bortezomib	0%
Bortezomib + rituximab	0%
Venetoclax	10%
Venetoclax + rituximab	7%
Acalabrutinib	23%
Other	0%

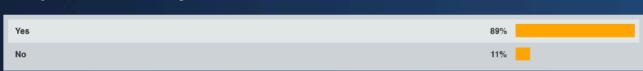
Based on current clinical trial data and your personal experience, how would you compare the efficacy of acalabrutinib to that of ibrutinib in MCL?

	100 Hills 100 Hills
About the same	59%
Acalabrutinib is more efficacious	3%
Ibrutinib is more efficacious	0%
There are not enough available data at this time	14%
I don't know	24%

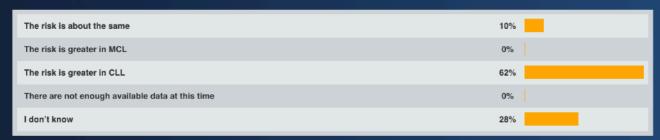
Based on current clinical trial data and your personal experience, how would you compare the tolerability/toxicity of acalabrutinib to that of ibrutinib in MCL?

About the same	20%
Acalabrutinib has less toxicity	37%
Ibrutinib has less toxicity	0%
There are not enough available data at this time	30%
I don't know	13%

Based on available data and reimbursement issues aside, would you attempt to access venetoclax for select patients with relapsed/refractory MCL?



How would you compare the risk of tumor lysis syndrome in patients with MCL receiving venetoclax to that of patients with CLL receiving venetoclax?



A <u>60-year-old</u> patient with MCL, an absolute lymphocyte count of 7,000 and several involved lymph nodes that are <2 cm is about to receive venetoclax. What preemptive measures, if any, would you take to address tumor lysis syndrome prior to the initiation of therapy?

None	0%
Encourage oral hydration and allopurinol	73%
IV hydration and allopurinol	17%
Encourage oral hydration and rasburicase	3%
IV hydration and rasburicase	7%
Admit to hospital	0%
Other	0%

An <u>80-year-old</u> patient with MCL, an absolute lymphocyte count of 7,000 and several involved lymph nodes that are <2 cm is about to receive venetoclax. What preemptive measures, if any, would you take to address tumor lysis syndrome prior to the initiation of therapy?

None	0%
Encourage oral hydration and allopurinol	47%
IV hydration and allopurinol	33%
Encourage oral hydration and rasburicase	7%
IV hydration and rasburicase	3%
Admit to hospital	10%
Other	0%