Submission guidelines:

https://www.hematology.org/meetings/annual-meeting/abstracts/call-for-abstracts

Abstract submission deadline: August 4, 2026, 11:59 p.m. Pacific time

Disposition: by Early October

Abstract poster presentation materials due: November 16, 2026, 11:59 p.m. Pacific time

Category: 623. Mantle Cell, Follicular, Waldenstrom's, and Other Indolent B Cell Lymphomas: Clinical and Epidemiological

Title (22 words (The abstract title should be brief and clearly indicate the nature of the abstract)): Real-World Treatment Patterns Across the Pre-Bruton's tyrosine kinase inhibitor(BTKi) and BTKi Era and Time to Next Treatment in Patients with Mantle Cell Lymphoma in Japan

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Keywords (multiple options possible, min. 1 – max. 4): Mantle Cell Lymphoma, BTKi, Real-World

Abstract: 4368 characters (Maximum: 4500)

Background:
Mantle cell lymphoma (MCL) is an aggressive subtype of non-Hodgkin lymphoma associated with poor outcomes. Chemoimmunotherapy (CIT) remains the mainstay of treatment, but treatment selection remains heterogeneous in clinical practice. In Japan, Bruton's tyrosine kinase inhibitors (BTKis) were introduced in 2016 and expanded to first-line (1L) use in 2023, potentially reshaping treatment patterns. However, real-world evidence describing these changes and associated outcomes remains limited.

Aims:
To describe changes in treatment patterns across the pre-BTKi and BTKi eras from 1L to 3L, and to evaluate time-to-next treatment or inpatient death (TTNT) among patients with MCL in Japan.

Methods
This retrospective cohort study used the MDV database, one of the largest hospital-based claims databases in Japan. Adult patients with newly diagnosed MCL (ICD-10: C83.1) between January 2012 and July 2025 were included. The index date was defined as the first recorded MCL diagnosis, and patients were followed until the end of the study period or loss to follow-up. Treatment patterns were categorized into five mutually exclusive groups: ibrutinib (IBR)-based therapies, bendamustine plus rituximab (BR), other CIT (including R-CHOP), and stem-cell transplantation (SCT). To describe treatment pattern, patients were classified by the initiation date of each treatment line into the pre-BTKi era (January 2012–December 2017) or the BTKi era (January 2018–July 2025), reflecting routing clinical adoption of BTKi in Japan. TTNT from 1L to 2L, 2L to 3L, and 3L to 4L was estimated using Kaplan–Meier method by treatment group.

Results

A total of 2,712 patients with newly diagnosed MCL were identified. Of these, 73.4% were male, the median age was 73 years (Q1–Q3, 65–80), and 56.3% and 43.7% had a Charlson Comorbidity Index (CCI) score of 2 and ≥3, respectively. Among them, 1,908, 950, and 568 patients initiated 1L, 2L, and 3L therapies, respectively, with BTKi-era patients accounting for 66.8%, 69.8%, and 74.1% of each line. Baseline characteristics were generally similar across eras and treatment lines, except for higher CCI scores among patients initiating 3L therapy. Median follow-up was 694, 607, and 393 days for 1L, 2L, and 3L therapy, respectively. In 1L, other CIT use declined from 64.7% in the pre-BTKi era to 30.9% in the BTKi era. The use of R-CHOP similarly decreased from 26.7% to 9.6%, whereas BR and IBR-based therapies increased from 22.4% to 42.2% and from 1.0% to 13.9%, respectively. Among IBR-based therapies used in the BTKi era, IBR monotherapy was the most common regimen (10.8%), followed by IBR+BR or IBR+B (2.6%) and IBR+R (0.5%). In 2L, other CIT use decreased from 55.1% to 40.0%, while BR decreased from 34.5% to 19.9%, potentially reflecting greater use of BR in 1L therapy. IBR use increased substantially from 3.8% to 31.1%. Similar trends were observed in 3L. SCT use remained stable across eras and treatment lines (4%–8%). Median TTNT from 1L to 2L was longest with IBR-based therapies (29.7 months; 95% CI, 23.2–40.7), followed by BR (24.0 months; 95% CI, 18.6–29.4) and SCT (14.3 months; 95% CI, 10.9–34.6). Although TTNT generally shortened in later lines of therapy, the same ranking held from 2L to 3L and from 3L to 4L. IBR-based therapies remained longest (15.2 months [95% CI, 10.8–20.0] and 13.6 months [95% CI, 11.2–19.8], respectively), followed by BR (14.1 months [95% CI, 11.4–20.0] and 12.5 months [95% CI, 8.2–17.5]) and SCT (12.6 months [95% CI, 9.7–26.2] and 10.3 months [95% CI, 5.1–43.4]). CIT demonstrated the shortest TTNT across all treatment lines.

Conclusion

Treatment patterns shifted substantially after BTKi introduction: CHOP-like regimens gave way to BR in 1L, while other CIT remained a key option overall. BTKi uptake increased markedly , especially in 2L and later lines. IBR-based therapies showed the longest TTNT across all treatment transitions. These findings highlight the evolving treatment landscape of MCL in Japan following the introduction of BTKi.

Disclosures: Collected separately