משוב הסדנה

- סרקו את הברקוד וענו על השאלות
- תודה על המשוב!

Cases

Nov 2025

Ron Ram

Case 1

- A 61-year-old with primary-refractory LBCL, LDH 2×ULN, bulky 9 cm mass, prior R-CHOP. PET shows no CNS uptake; CSF negative but high CNS-IPI. Which initial plan best aligns with current practice?
  A. Immediate leukapheresis → no bridging
  B. Leukopheresis → polatuzumab-BR bridging to control bulk
  C. Pola-BR for 2 cycles, then apheresis if PR
  D. Involved-site RT only → apheresis

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- Assuming commercial CAR-T access to axi-cel, liso-cel, tisa-cel, which choice best balances efficacy for high-risk disease with neurotoxicity awareness per recent real-world data?
  A. Axi-cel (higher efficacy signal; higher ICANS risk)
  B. Liso-cel (lower efficacy; lowest ICANS)
  C. Tisa-cel (best PFS)
  D. Any—no signal differences exist

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Case 1

- Day +5: Grade 2 CRS; ICE 10/10. Best next step?
  A. Start dexamethasone 10 mg q6h immediately
  B. Tocilizumab now; hold steroids unless ICANS
  C. Anakinra first-line for CRS
  D. Observe only

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Case 1

- Day +12: afebrile, ferritin 12,000, rising AST/ALT, coagulopathy, cytopenias, minimal/no CRS—concern for IEC-HS. Best initial management?
  A. High-dose IVIG alone
  B. IL-1 blockade
  C. Repeat tocilizumab doses
  D. High-dose steroids and ruxolitinib
  E. Siltuximab if fibrinogen<150

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Case 2

A 68-year-old MCL progressed after RCHOP/RDHAP and then covalent BTKi. What strategy aligns with current practice?
A. Allo-HCT upfront; CAR-T only if relapse post-HCT
B. Venetoclax bridge to allo-HCT; avoid CAR-T at 68
C. Bispecific preferable; avoid CAR-T if bulky disease
D. Brexu-cel as preferred next step; allo-HCT reserved for post-CAR-T failure/selected fit pts

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- Pre-infusion disease control approach?
  A. Multi-agent cytotoxic chemo to CR
  B. Venetoclax +/- BTKi
  C. Prolonged steroids
  D. BTKi re-challenge

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Case 2

- Received brexu-cel, achieved CR, and now relapses 9 months later with nodal and marrow involvement. ECOG 1, 10/10 MUD available. Which next management step is most appropriate according to recent data?

A. Proceed to allo-HCT if PR/CR achieved after short bridging
B. Repeat CAR-T infusion with liso-cel
C. Glofitamab for remission induction followed by maintenance rituximab only
D. R-DHAP followed by auto-HCT consolidation

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Case 3

- A 72-year-old man with AML, adverse cytogenetics, achieves CR1 after 6 cycles of VEN-AZA, but remains MRD+. He has a 10/10 unrelated donor and HCT-CI score of 3. ECOG 0. Which approach most closely reflects current practice for patients like this?

A. Defer transplant and continue azacitidine + venetoclax until MRD negativity
B. Proceed with MAC regimen to overcome MRD positivity
C. Use RIC
D. Avoid transplant due to HCTCI> 2
E. Autologous HCT after salvage chemotherapy

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- 2 potential donors:

A 10/10 matched unrelated donor (MUD) offering a BM graft

A haploidentical son donor

Which donor is preferable?

A. 10/10 MUD BM graft with only CNI as prophylaxis (no MTX)

B. Cord-blood transplant as safest option in the elderly

C. Haploidentical PBSC graft to maximize GVL

D. 10/10 MUD BM graft with PTCy-based GVHD prophylaxis

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- Day +35: new hypertension, LDH 2× ULN, creatinine rising, proteinuria 1.2 mg/mg, schistocytes on smear. What is the most appropriate next step?

A. Observe—likely calcineurin toxicity – self limited
B. Start plasmapheresis immediately with maintenance rituximab
C. Stop CNI and initiate complement-directed therapy if high-risk
D. Begin high-dose steroids
E. Start ruxolitinib

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Case 4

- A 55-year-old with steroid-refractory cGVHD (skin/fascia + mouth), prior calcineurin inhibitor. Next best systemic option?
  A. Belumosudil or ruxolitinib
  B. Acalabrutinib
  C. Photopheresis mandatory before meds
  D. High-dose cyclophosphamide

Case 4

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Case 4

- A 62-year-old man with severe cGVHD (skin + fascia) starts ruxolitinib 10 mg BID. After 6 weeks, platelets fall to 55 × 10^9/L, Hb 8.5 g/dL, ANC 1.2 × 10^9/L. What is the best next step?

A. Continue same dose — cytopenias usually transient
B. Hold ruxolitinib for 1 week then restart full dose
C. Switch to belumosudil immediately
D. Reduce ruxolitinib to 5 mg BID
E. Add G-CSF and continue 10 mg BID

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- According to the 2020 NIH/EBMT chronic GVHD risk model, which of the following factors most strongly predicts non-relapse mortality and overall survival?

A. Extent of skin involvement (>50% BSA)
B. Presence of oral GVHD alone
C. Thrombocytopenia (<100 × 10^9/L)
D. Time from transplant >12 months
E. History of acute GVHD

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Case 5

- A 63-year-old woman, day +25 after axi-cel, remains neutropenic (ANC 0.6 × 10^9/L) with IgG < 400 mg/dL. Which of the following best reflects the recommended prophylaxis strategy after CAR-T therapy?
- A. Levofloxacin for 6 months
  B. No need for PJP prophylaxis if ANC > 0.5 × 10^9/L and IgG > 200 mg/dL
  C. Use IVIG only when IgG < 200 mg/dL or symptomatic infections with high CD4/CD8
  D. Live vaccines may start at 3 months post-infusion
  E. Continue antiviral + PJP prophylaxis for ≥6–12 months or until CD4 > 200

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- Same patient, 6 months post-CAR-T, clinically well, IgG > 500 mg/dL, no ongoing immunosuppression. When should **revaccination** begin?
- A. Immediately after lymphocyte recovery
  B. Inactivated vacc. at 3–6 months; live vacc. ≥ 12 months
  C. All vaccines delayed ≥ 24 months
  D. Live and inactivated vaccines both at 6 months
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- At day +90, patient's IgG remains < 300 mg/dL despite no infection and slow B-cell recovery. What is the best approach?
- A. Give a single IVIG dose and stop prophylaxis
  B. Begin routine monthly IVIG for 12 months regardless of infections
  C. Start IVIG only if febrile neutropenia develops
  D. Add broad-spectrum antibiotics instead of IVIG
  E. initiate IVIG replacement

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- A 62-year-old AML patient in CR1 has A 1-Ag mismatched unrelated donor (MMUD) PBSC graft planned with RIC Flu/Bu2. Which GVHD-prophylaxis platform reflects modern best practice?
- A. PTCy + tacrolimus + MMF
  B. Ruxolitinib with MMF
  C. Tacrolimus + MTX only
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Case 6

- Day +25 post-HCT the patient develops grade II skin + GI GVHD while on PTCy–Tac–MMF. What is the recommended first-line treatment?

A. Methylprednisolone 2 mg/kg/day
B. ECP with Tac levels above 20 ng/ml
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E. Withdraw tacrolimus to boost GVL

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Case 6

- Developed grade II acute skin + lower GI GVHD on day +25. After 7 days of methylprednisolone 2 mg/kg/day, there is no clinical improvement. What is the most appropriate next management step?

A. Increase steroid dose to 4 mg/kg/day
B. Add ATG
C. Ruxolitinib 10 mg BID
D. Switch immunosuppression to sirolimus monotherapy
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Case 7

- A 58-year-old man with DLBCL relapsed 8 months after R-CHOP. He received 2 cycles of R-DHAP, achieving PR on PET (Deauville 4). According to current evidence and guidelines, which statement best reflects modern practice?

A. Autologous HCT.
B. CAR-T.
C. CAR-T if double-hit cytogenetics in PR.
D. High dose melphalan and autologous HCT only if good performance status.
E. Observation and treat only if progression documented.

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- The same patient's salvage PET shows residual 3 cm uptake (SUV 6). The transplant team plans BEAM conditioning. Which statement is most accurate regarding conditioning and disease control before auto-HCT?

A. TBI-based conditioning is superior to BEAM in DLBCL.
B. Patients in PR after salvage can proceed to BEAM auto-HCT, but CR is better than PR.
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- The patient relapses 6 months post-auto-HCT with bulky nodal disease, LDH ↑, ECOG 1. He receives bridging pola-BR before **axi-cel** infusion. Which pre-CAR-T factor best predicts **ICANS** and **non-response**?

A. CR prior to CART is associated with no expansion and response

B. Bendamustine as bridging prior to infusion is associated with decreased incidence of ICANS

C. Patient age > 60 y independently increases severe ICANS risk

D. Elevated ferritin at infusion correlates with higher CRS/ICANS risk and lower response

E. Prior auto-HCT is associated with decrease response

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