



Addressing Disparities in Care for Patients with DLBCL



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TAKE-HOME MESSAGES

- Racial disparities in DLBCL have been observed and the reasons are likely multifactorial.
- We need to improve the recruitment of minority patients to prospective clinical trials.
- Outcomes are comparable when similar treatments are applied.
- Access to affordable and adequate health care has the potential to improve survival for patients with DLBCL.

This newsletter features a discussion with Dr. Nastoupil on the importance of addressing disparities in care for patients with diffuse large B-cell lymphoma (DLBCL), as well as barriers to care, and the need to improve recruitment of minority patients to clinical trials.

It is becoming increasingly clear that there are significant disparities in the treatment and outcomes of patients with DLBCL. It is a complex interaction of a number of variables, not only patient demographics but also socioeconomic status, where these patients reside, access to healthcare, both at the time of diagnosis and also impacting potentially preventative strategies, early detection, access to what we would consider good quality standard of care; but there is probably also some underlying biology of the disease that may describe some of these disparate outcomes.

Differences in outcomes

The SEER database shows that black patients present at a younger age, between 40-50 years, compared to whites, who are usually >70 years old. Two-, five-, and ten-year survival rates are consistently lower for black males than for white males with DLBCL. One explanation might be biological differences. A study in patients with DLBCL found that certain genes were statistically more common in patients of African ancestry, but, as Dr. Nastoupil pointed out, the data needs to be validated and correlated in larger sample sets.

Minority patients with large cell lymphoma, including black patients, are more likely uninsured and are more likely to have Medicaid insurance. Patients who are privately insured have been shown to have better survival, and black or Hispanic patients were less likely to receive standard-of-care, including a stem cell transplant, which is considered a very resource-rich therapy.¹

Different treatments approaches

There is also evidence that minority patients don't receive newly approved therapies at the same rate as other patients. A study looked at the diffusion of immunochemotherapy (alkylating agents plus rituximab) in patients with DLBCL diagnosed between 2001 and 2004 when this concept was still relatively new. Among 38,002 patients with DLBCL, 27% received immunochemotherapy and 50% chemotherapy alone. Patients who had localized disease, who were black, uninsured or Medicaid-insured, or of lower socio-economic status were less likely to receive any form of chemotherapy, and patients who



were black and >60 years were less likely to receive immunochemotherapy. These discrepancies in the timeliness of diagnosis and choice of treatment will impact survival.

Insurance and socio-economic factors influence outcomes

Uninsured or Medicaid-insured patients who have DLBCL present with more advanced-stage disease and comorbid illnesses and have inferior survival rates compared with privately insured patients. Geographic location of residence also plays a role, according to the National Cancer Database, in that patients with DLBCL in rural or urban areas have lower overall survival rates than patients from suburban areas.²

**We do know that when patients have access to the same level of care,
they tend to have similar outcomes.**

A study looking at outcomes of patients with DLBCL who were treated in the VA system where location or insurance status should not matter, showed comparable outcomes among all groups regardless of race and ethnicity.³

Dr. Nastoupil briefly touched on the issue of special patient populations, such as prisoners or undocumented immigrants, and observed that these were especially challenging situations. Language barriers can also create difficulties in communicating and explaining a treatment.

Minorities are underrepresented in clinical trials

Another important point is the fact that minority patients are often underrepresented in clinical trials, which may provide additional benefit, particularly in those later lines of treatment that may also have an impact on overall survival.

As an example, outcomes with CAR-T cell therapy, a new and exciting treatment modality for patients with relapsed DLBCL, were discussed. Do black patients or minority patients have similar access to these novel therapies that are now entering into the treatment landscape? In looking at the geographical distribution of patients receiving this treatment, minority patients tend to be more commonly treated at centers along the East and West coast, as opposed to the middle of the country, possibly as the result of disparate practices. Outcomes show differences as well:

- African American patients were more likely to have comorbid conditions, including moderate to severe pulmonary disease, but were less likely to have a prior cancer than white or Asian cohorts.⁴
- White and Asian patients had higher objective response rates and complete response rates. The black or African American race objective response rate was 57% versus 74% among white patients, and a slightly lower percentage achieved a complete response.⁴

However, there was no difference in overall survival despite having inferior progression-free survival rates, suggesting that these patients were potentially able to go on to subsequent therapy.⁴

What can be done to try and reverse or improve these disparate outcomes?

We need to do a better job of ensuring that these patients have access to good quality care. What we are doing right now is getting the message out so that there is knowledge and awareness of the discrepancies that may impact local practices. In addition, we are exploring certain resources to try and recruit or enhance recruitment of minority patients, particularly to novel therapies that we think might provide improvements to the treatment landscape.



How can we increase minority participation in clinical trials?

We need to have people who can have that conversation with patients in a way that they feel comfortable asking questions and disclosing their concerns. We have tried to incorporate patient navigators, staff that may look and speak like the patients with whom we are trying to communicate.

We have to reduce the barriers in terms of number of visits, number of hours that we monitor patients post-infusion to try and minimize the time away from work, reduce barriers of transportation, parking, missing work, or providing care for an elderly adult or a child while the patient is not there to take care of them.

Summary

In conclusion, there are racial disparities in the diagnosis and treatment of large cell lymphoma, a disease where many patients should anticipate a potential cure, and the reasons are likely multifactorial. Efforts should be made to recruit minority patients to observational cohorts to explore epidemiology and practice patterns. Awareness and access to quality care can eliminate disparities in outcomes.

To view the associated accredited activity please [click here](#).

References

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