Routine imaging in patients with follicular lymphoma in remission

B-cell lymphomas are a heterogeneous group of malignancies originating from B lymphocytes. Modern day chemotherapy is effective in inducing disease remission in a large percentage of patients for most of the subtypes. Some of these subtypes, the so-called indolent lymphomas, of which follicular lymphoma (FL) is the most common, are not curable but are slow-growing and the goal of treatment is to obtain prolonged periods of remission, rather than the cure. Most patients with follicular lymphoma have a long life expectancy and many will eventually die of other causes. For most of the other subtypes, the so-called aggressive lymphomas, chemotherapy can cure patients, but those do not respond to treatment or relapse after it have a high chance of early death due to lymphoma.

The use of routine imaging (most often computed tomography [CT] scans) in patients in remission in an attempt to detect potential relapses early has been standard of practice for many years. However, there is no evidence supporting it and it has potential downsides, including radiating patients, a large economic burden, and the psychological distress that some patients experience in the days to weeks before the scan and the medical visit.

Most recently, this practice has come under scrutiny. In diffuse large B-cell lymphoma, the most common subtype of aggressive lymphoma, several studies have found that most relapses are symptomatic (rather than detected by routine imaging) and that routine imaging does not decrease mortality.

For indolent lymphoma generally, and follicular lymphoma in particular, answering this question comes with additional complexities. The slow pattern of relapses and the generally better prognosis of these relapses, would require a large study and a long follow-up. In addition, unlike in aggressive lymphomas, relapses do not always require treatment in indolent lymphomas (because they are not curable, treatment is only recommended when the disease causes symptoms).

Yet the potential harm of routine imaging is greater in indolent lymphomas because patients live longer and the disease is not curable, potentially leading patients to be exposed to periodic imaging for decades and a longer life-expectancy during which to develop cancers secondary to radiation.

In a small study we retrospectively assessed the role of routine imaging in clinical practice patients with FL. Of 93 patients who achieved remission after front-line treatment, 25 had relapsed. This relapse was detected clinically in 13 and by routine imaging in 12. Of these 12 patients, detection of relapse had no immediate therapeutic implications in 6. Importantly, of 404 routine CT scans performed on the 93 patients in remission, only 12 (3%) detected a relapse. In terms of survival, patients with a clinical relapse (as opposed to one detected by routine imaging) had a shorter progression-free survival after relapse. However, they also had higher disease risk features at

relapse, leading us to hypothesize that a clinical relapse is a surrogate marker for higher disease risk.

We concluded by calling for studies comparing a “no/reduced surveillance strategy” vs. a “standard surveillance strategy” to determine the clinical value of routine imaging in patients with FL.

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