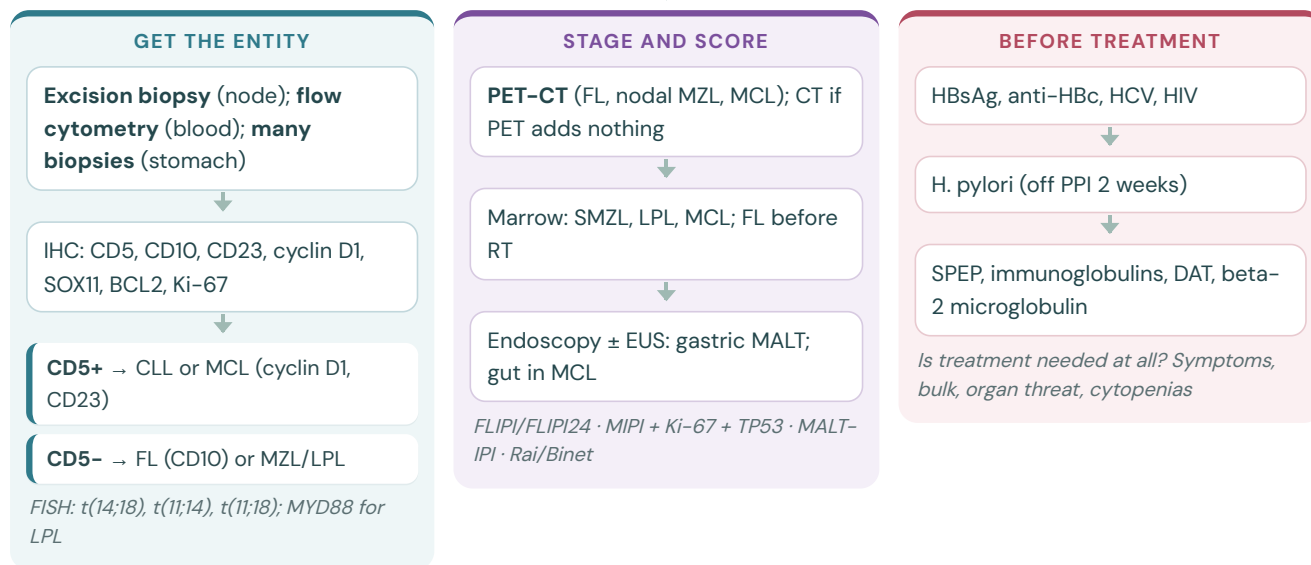


Indolent B-cell Lymphomas: Suspected indolent B-cell lymphoma: to an entity and a plan

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Node that persists or waxes and wanes, lymphocytosis, big spleen, gastric or ocular lesion, IgM spike → tissue or blood flow cytometry before any steroid or anti-TB trial



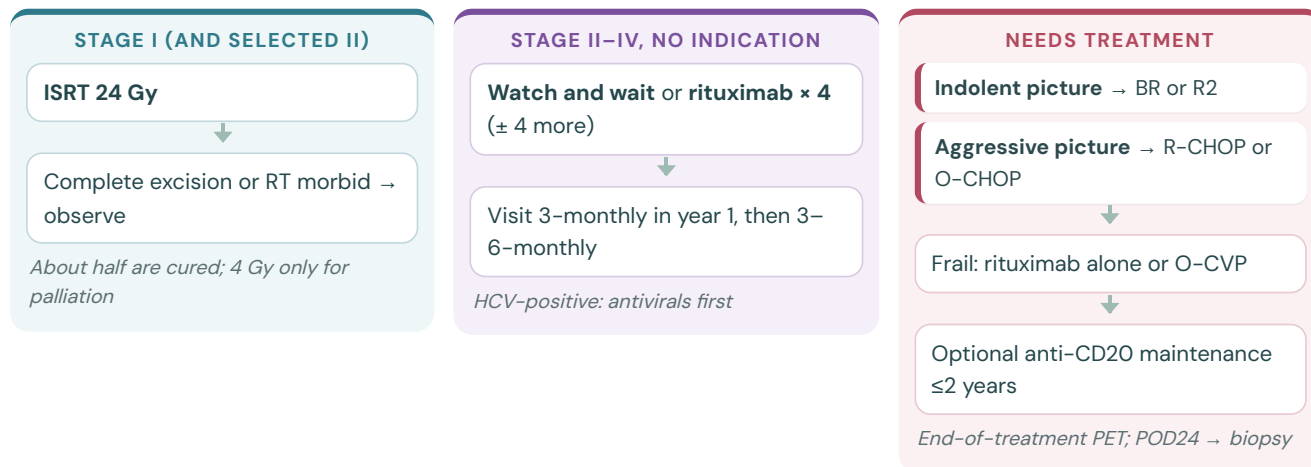
All patients: lymphoma multidisciplinary team · grade 3B follicular or any large-cell component → treat as DLBCL · biopsy any node that grows faster than the rest.

Indolent B-cell Lymphomas: Follicular lymphoma by stage and need for treatment

Dr. Haritha Chiramana

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Oncologist & Hemato-
Oncologist

Classic follicular lymphoma → stage with PET-CT (marrow if apparent stage I–II) → FLIPI, symptoms, bulk, organ function



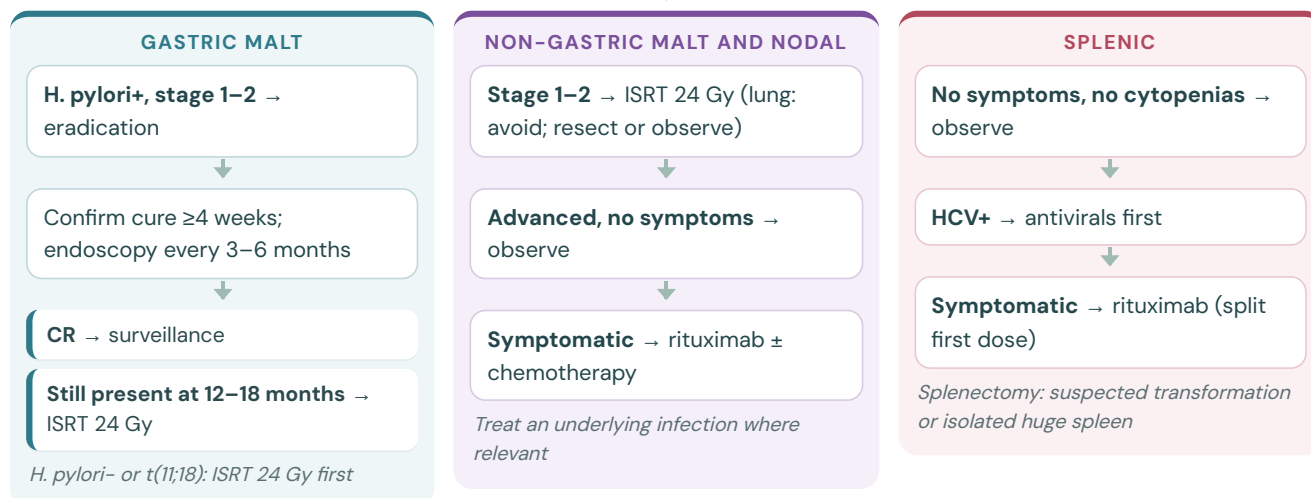
All: HBV prophylaxis with anti-CD20 therapy · over 70: reduce or shorten bendamustine · relapse: biopsy, then choose a regimen not used before.

Indolent B-cell Lymphomas: Marginal zone lymphoma by site

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Marginal zone lymphoma confirmed → site, stage, H. pylori, HCV, t(11;18) → any large-cell component treated as DLBCL



All: HBV and HCV before rituximab · autoimmune cytopenias treated on their own terms · endoscopic surveillance after gastric MALT.

Indolent B-cell Lymphomas: Mantle cell lymphoma first line

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Mantle cell lymphoma → MIPI, Ki-67, morphology, TP53, presentation (nodal vs non-nodal, gut-only) → fitness

INDOLENT PRESENTATION

**Leukaemic non-nodal, gut-only
or low-burden nodal**

Normal LDH, low Ki-67, no
TP53/blastoid

Observe; treat at symptoms

About one in five patients

FIT, ABOUT 65 OR YOUNGER

**Cytarabine-containing
induction (or BR) + rituximab**

Ibrutinib in induction and
maintenance (TRIANGLE)

CR → ASCT (role debated with
ibrutinib)

Less than CR → treat as refractory

Rituximab maintenance × 3 years

OLDER OR UNFIT

BR (± ibrutinib or acalabrutinib),
VR-CAP or **R-lenalidomide**

CR or PR → rituximab maintenance
× 3 years

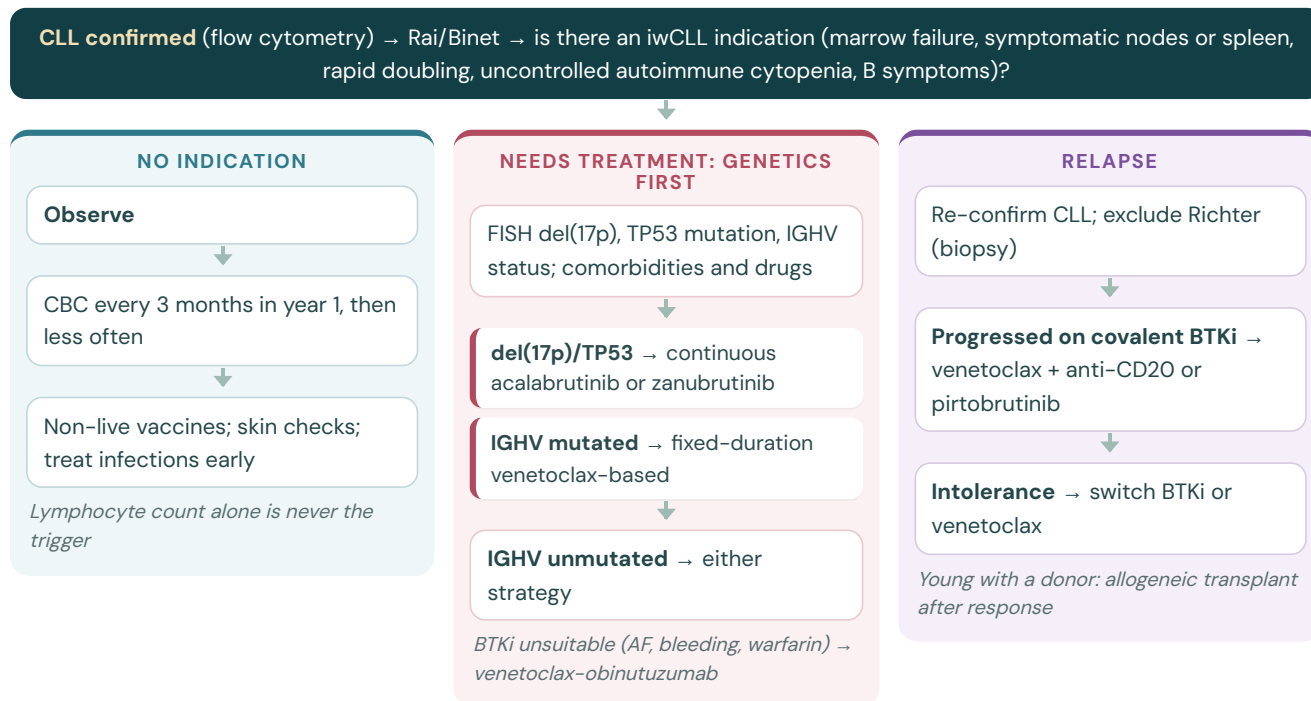
*Avoid R-HyperCVAD; check heart and
drugs before a BTKi*

All: TP53-mutated, blastoid or CNS disease → trial or BTK-inhibitor-based treatment · true stage I is rare: look for gut and marrow disease · HBV prophylaxis.

Indolent B-cell Lymphomas: CLL/SLL: when and how to treat

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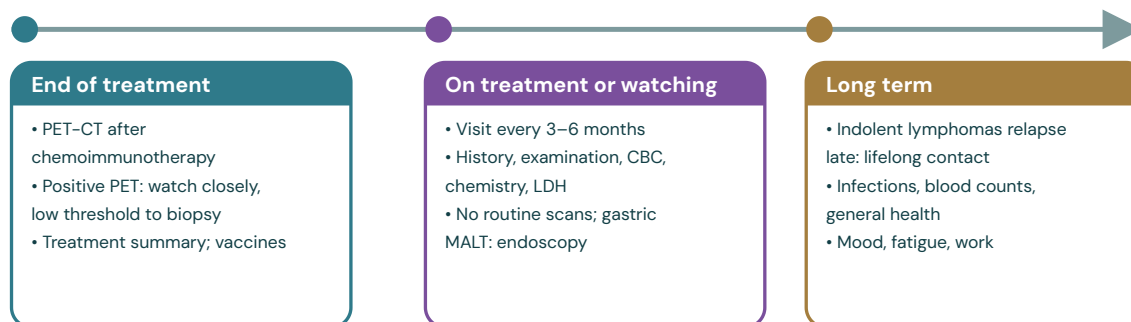
All: HBV before anti-CD20 · tumour lysis ramp-up with venetoclax · IVIG for recurrent serious infections with IgG under 500 mg/dL · repeat TP53 testing at each progression.

Indolent B-cell Lymphomas: Follow-up and survivorship plan

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A simple follow-up rhythm for indolent B-cell lymphomas



Report: a new or fast-growing lump, fevers or sweats, weight loss, new pain, black stools (gastric MALT), or recurrent infections. After rituximab, obinutuzumab or bendamustine: watch for infections for months; no live vaccines; hepatitis B prophylaxis continued as planned.

A simple follow-up rhythm, adapted from the UpToDate follicular, MALT, splenic MZL and mantle cell reviews. Individualise by entity and treatment.

Living with a slow lymphoma

- Watching is a treatment choice
- Keep every review visit
- Hepatitis B tablets if prescribed: never stop early
- Non-live vaccines; no live vaccines
- Keep the written treatment summary

Red flags to report

- A lump that grows faster than the others
- Fevers, drenching sweats, weight loss
- Fever of 38 °C on treatment: same day
- Black stools or vomiting blood (stomach)
- Palpitations or bleeding on BTK tablets

Do not forget

- Biopsy, not just scan, at progression
- Endoscopy follow-up after gastric MALT
- Hepatitis C treated if present
- Report new lumps or fevers early
- Check new medicines with your oncologist

When relapses happen: indolent lymphomas come back, often more than once

Early (within 2 years)

- POD24 in follicular lymphoma: biopsy for transformation
- Mantle cell after short remission: BTK inhibitor era

Late (years later)

- The usual pattern in follicular and MZL
- Often still indolent: watch, rituximab, RT or chemo again

Very late (10+ years)

- Possible; some never relapse (functional cure)
- Always biopsy: may be a new lymphoma

A relapse is not the end: most patients get years of further control with the next treatment.

When relapses happen (Casulo 2015; Shadman 2026, SOO16 15-year results; UpToDate follicular, relapsed follicular and relapsed mantle cell reviews).