## Haematology audit template

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| Date of completion  | (To be inserted when completed) |
| Name of lead author/participants | (To be inserted) |
| Specialty | Haematology |
| Title | An audit of compliance with the British Society for Haematology guideline for the diagnosis and management of mantle cell lymphoma |
| Background | The British Society for Haematology (BSH) has published guidance on the diagnosis and management of mantle cell lymphoma (MCL).1 This audit will review compliance with some of the main recommendations made. |
| Aim and objectives | This audit template is a tool to review whether:* investigations are performed appropriately in the diagnosis of MCL

patients with MCL are being managed appropriately. |
| Standards and criteria | **Criteria range:** 100%, or if not achieved, there is documentation in the case notes that explains the variance.**Prognostic models**1. The presence of Ki-67% (or equivalent) should be reported in all MCL biopsies wherever possible and reported as <30% versus ≥30% as a minimum.
2. All patients should undergo *TP53* mutational analysis at diagnosis (in preference to fluorescence in situ hybridisation [FISH] analysis for 17p deletions).

**Front-line autologous stem cell transplantation (ASCT)-fit patients**1. Younger, fit patients should receive a first-line induction regimen containing rituximab and high-dose cytarabine.
2. Patients should be offered maintenance rituximab (subcutaneous or intravenous) post-ASCT.

**First-line treatment of MCL-unfit for transplant** 1. In patients unsuitable for high dose cytarabine-based induction and ASCT, rituximab (R)-chemotherapy combinations should be offered as current standard of care.
2. Previously untreated patients unsuitable for ASCT should be offered R‑cyclophosphamide, doxorubicin, vincristine, prednisolone (R-CHOP); R-bendamustine; rituximab, bendamustine and cytarabinecytarabine (R-BAC); and bortezomib, rituximab, cyclophosphamide, doxorubicin and prednisone (VR-CAP).
3. Patients should be offered rituximab maintenance post-R-CHOP induction.

**Management at first relapse**1. Patients at first relapse should be offered ibrutinib monotherapy as an approved and reimbursed standard of care option in the United Kingdom.

**Chimeric antigen receptor (CAR)-T cell therapy**1. Potential candidates for future CAR-T cell treatment should be risk assessed at first relapse prior to initiation of a Bruton tyrosine kinase inhibitor (BTKi). All high-risk cases should be discussed with a CAR-T cell centre. High risk includes: blastoid/pleomorphic morphology, Ki67% >50, *TP53* mutation, high‑risk simplified MCL International Prognostic Index (sMIPI), bulk >5 cm or progression of disease within 24 months (POD24).
2. High-risk patients starting ibrutinib should have computed tomography (CT) or positron emission tomography (PET)-CT re-staging within 8–12 weeks (earlier if concerned). Lack of early response with stable or progressive disease on ibrutinib should prompt an urgent referral to a CAR-T cell centre
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| Method | **Sample selection:** All patients diagnosed with MCL in the preceding 12 months up to a maximum of 20 consecutive patients.**Data to be collected on proforma (see below).** |
| Results | (To be completed by the author)The results of this audit show the following compliance with the standards.

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| Investigation | No. audited | No. compliant | % compliance |
| Prognostic models |
| The presence of Ki-67% (or equivalent) was reported in all MCL biopsies wherever possible and reported as <30% versus ≥30% as a minimum |  |  |  |
| Patients underwent *TP53* mutational analysis at diagnosis |  |  |  |
| Front-line ASCT-fit patients |
| Younger, fit patients received a first-line induction regimen containing rituximab and high-dose cytarabine  |  |  |  |
| Patients were offered maintenance rituximab (subcutaneous or intravenous) post-ASCT |  |  |  |
| First-line treatment of MCL-Unfit for transplant  |
| Patients that were unsuitable for high dose cytarabine-based induction and ASCT, were offered R-chemotherapy combinations as current standard of care |  |  |  |
| Previously untreated patients unsuitable for ASCT were offered R-CHOP, R-bendamustine, R-BAC or VR-CAP  |  |  |  |
| Patients were offered rituximab maintenance post-R-CHOP induction |  |  |  |
| Management at first relapse |
| Patients at first relapse were offered ibrutinib monotherapy as an approved and reimbursed standard of care option in the United Kingdom  |  |  |  |
| CAR-T cell therapy |
| Potential candidates for future CAR-T cell treatment were risk assessed at first relapse prior to initiation of a BTKi. All high-risk cases were discussed with a CAR-T cell centre. High risk includes: blastoid/pleomorphic morphology, Ki67% >50, *TP53* mutation, high-risk sMIPI, bulk >5 cm or POD24  |  |  |  |
| High-risk patients starting ibrutinib had CT or PET-CT re-staging within 8–12 weeks (earlier if concerned). Lack of early response with stable or progressive disease on ibrutinib prompted an urgent referral to a CAR-T cell centre |  |  |  |

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| Conclusion | (To be completed by the author) |
| Recommend-ations for improvement | Present the result with recommendations, actions and responsibilities for action and a timescale for implementation. Assign a person(s) responsible to do the work within a timeframe. For local sites to consider auditing these guidelines against their practice. |
| Action plan | (To be completed by the author – see attached action plan proforma) |
| Re-audit date | (To be completed by the author) |
| References | 1. Eyre TA, Bishton MJ, McCulloch R, O'Reilly M, Sanderson R, Menon G *et al*. Diagnosis and management of mantle cell lymphoma: A British Society for Haematology Guideline. *Br J Haematol* 2024;204:108–126.
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## Data collection proforma for patients (Diagnosis and management of mantle cell lymphoma)

## Audit reviewing practice

Unit number(s)

Date of transfusion:

(Note: a separate form should be completed for each transfusion episode.)

**Given to:**

Patient name:

Hospital number:

Date of birth:

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| Standard | **1****Yes**  | **2****No** | **3** If shaded box not ticked, was there documentation to explain the variance?**Yes/No** plus free-text comment | **4** Compliant with guideline if shaded box ticked or an appropriate explanation from column 3. **Yes/No**(Record if standard not applicable) |
| **Prognostic models** |
| **1**  The presence of Ki-67% (or equivalent) was reported in all MCL biopsies wherever possible and reported as <30% versus ≥30% as a minimum |  |  |  |  |
| **2**  Patients underwent *TP53* mutational analysis at diagnosis  |  |  |  |  |
| **Front-line ASCT-fit patients** |
| **1**  Younger, fit patients received a first-line induction regimen containing rituximab and high-dose cytarabine |  |  |  |  |
| **2**  Patients were offered maintenance rituximab (subcutaneous or intravenous) post-ASCT |  |  |  |  |
| **First-line treatment of MCL-unfit for transplant**  |
| **1**Patients that were unsuitable for high dose cytarabine-based induction and ASCT, were offered R-chemotherapy combinations as current standard of care |  |  |  |  |
| **2**Previously untreated patients unsuitable for ASCT were offered R-CHOP, R-bendamustine, R-BAC or VR-CAP  |  |  |  |  |
| **3**Patients were offered rituximab maintenance post-R-CHOP induction |  |  |  |  |
| **Management at first relapse** |
| **1**Patients at first relapse were offered ibrutinib monotherapy as an approved and reimbursed standard of care option in the United Kingdom  |  |  |  |  |
| **CAR-T cell therapy** |
| **1**Potential candidates for future CAR-T cell treatment were risk assessed at first relapse prior to initiation of a BTKi. All high-risk cases were discussed with a CAR-T cell centre. High risk includes: blastoid/pleomorphic morphology, Ki67% >50, *TP53* mutation, high-risk sMIPI, bulk >5 cm or POD24 |  |  |  |  |
| High-risk patients starting ibrutinib had CT or PET-CT re-staging within 8–12 weeks (earlier if concerned). Lack of early response with stable or progressive disease on ibrutinib prompted an urgent referral to a CAR-T cell centre |  |  |  |  |

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| **Audit action plan** An audit of compliance with the BSH guideline (Diagnosis and management of mantle cell lymphoma) |
| Audit recommendation | Objective | Action | Timescale | Barriers and constraints | Outcome | Monitoring |
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