

I See Mantle Cell Lymphoma

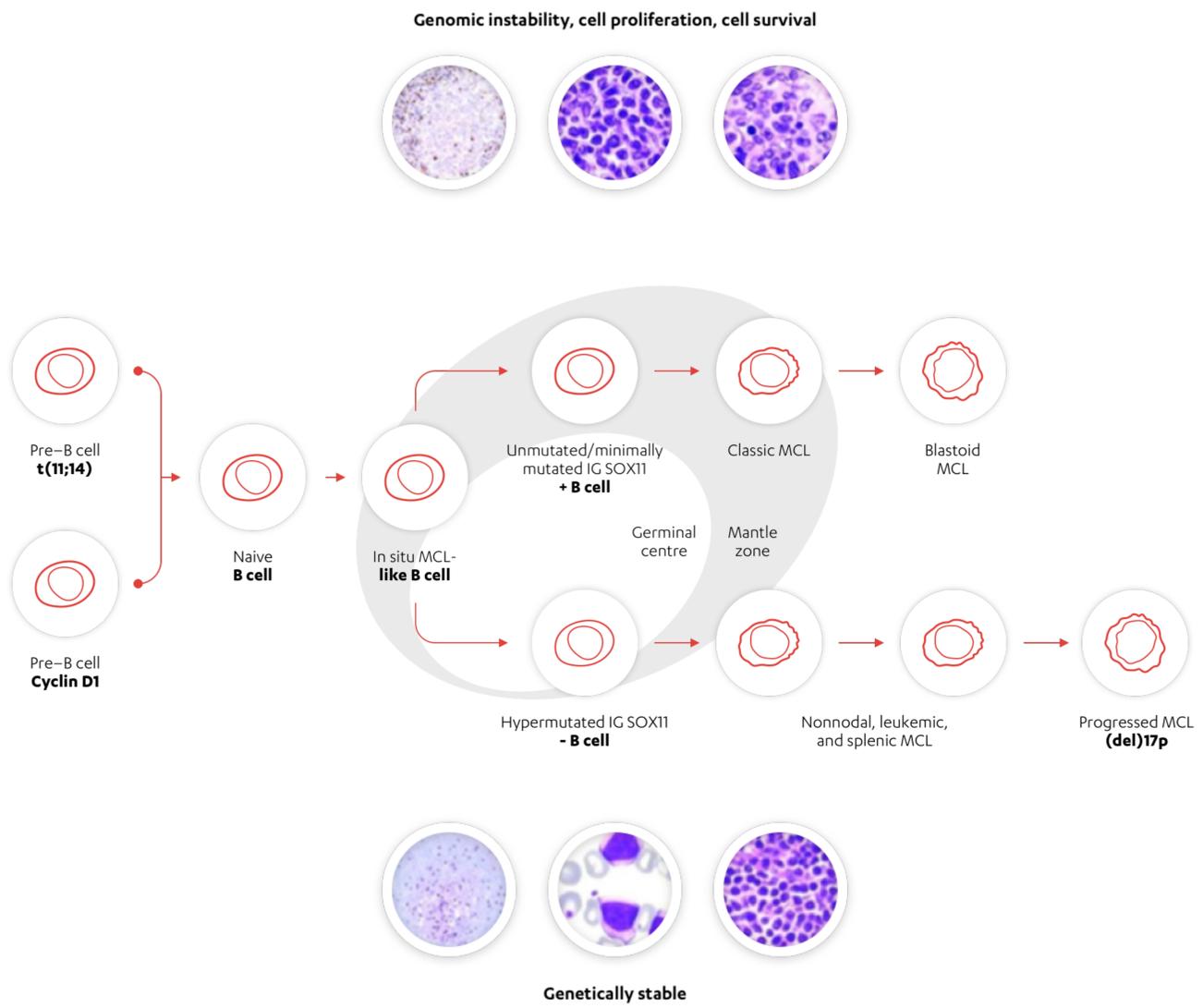
Welcome to I See Mantle Cell Lymphoma, a dedicated resource to help healthcare practitioners find the latest information about the signs, symptoms and diagnosis of MCL.

What is mantle cell lymphoma?

Mantle cell lymphoma (MCL) is a relatively rare, unique subcategory of B-cell non-Hodgkin lymphoma (NHL) with a generally aggressive clinical course.¹

Originally, MCL was classified with other types of lymphomas using different histology-based classification systems.² MCL was only classified as a distinct subtype of B-cell NHL in the 1994 Revised European-American Lymphoma Classification (REAL). It was then confirmed in the World Health Organization (WHO) classification system.³

MCL develops from changes to the outer edge, or mantle, of lymph nodes, causing the development of abnormal B-cells from that region.⁴ It can also affect the spleen, blood and bone marrow.⁴ MCL encompasses a wide range of biological and clinical variants.⁵ The majority of patients present with advanced stage disease and require systemic therapy.⁵



A proposed model of molecular pathogenesis and progression of MCL.⁶
Adapted from Dreyling *et al.* 2017.

Statistics surrounding MCL



MCL incidence rates

MCL has an annual incidence of one case per 200,000 people⁷
MCL represents approximately 5–7% of all malignant lymphomas in Western Europe⁶
MCL is typically sporadic, but it may have a higher incidence in some families⁷

Risk factors for MCL

The causes of MCL are mostly unknown; however, there are certain risk factors that are associated with the disease. These include⁸:

- infection with certain viruses or bacteria
- a weakened immune system
- autoimmune disease
- a previous cancer
- having a close blood relative with MCL

MCL immunophenotype

MCL is a well-characterised **B-cell lymphoma** with markers readily detectable by immunohistochemistry⁹

t(11;14)(q13;q32) translocation associated with overexpression of cyclin D1. Cyclin D1 overexpression is a key event in MCL pathogenesis¹
Overexpression of SOX-11 is observed in a majority of patients with MCL¹

The majority of **MCL cases also show expression of**¹⁰:

CD20
CD5
BCL2

The more aggressive **MCL subtypes**, such as **blastoid variants**, display features such as^{1,4}:

High Ki-67 proliferation index
p53 mutations and p16 deletions

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