Wessex Haematology NETWORK

MANTLE CELL LYMPHOMA

First-line treatment

Offer a clinical trial if available

New MCL

For MDT
Histology
PET-CT
mIPI and TP53 mutation

Asymptomatic
Low-risk MCL[1], low tumour burden or leukaemic non-nodal

Stage I
PET-CT, marrow and OGD

Symptomatic
Stage II–IV

Active surveillance

Consider IFRT

ASCT fit

ASCT unfit

Frail

TREATMENT OF CHOICE

TRIANGLE†
R-CHOP + ibrutinib alternating with R-DHAP or R-DHAOx
then ibrutinib + rituximab maintenance for 2 years

If TRIANGLE not suitable
R-DHAOx
NORDIC

R-Benda
R-Benda + Acala[2]
R-BAC^

Attenuated BR ± Acala
R-CVP
R-Chlor
Single-agent rituximab

Ibrutinib + rituximab maintenance
Ibrutinib for 2 years
Rituximab for 2 years (usually 8-weekly)
ASCT not required

TP53 mutated or blastoid MCL
No ASCT
Maintenance rituximab
CR – consider allograft discussion

TP53 wild type / failed
Consider ASCT in PR/CR
Maintenance rituximab

Maintenance rituximab

1 High risk: any of TP53 mutated, Ki67 > 30%, blastoid/pleomorphic histology.

2 No overall survival benefit (Dreyling et al., JCO 2025).

† TRIANGLE (Dreyling et al., Lancet 2024). Recommended by NICE (final draft guidance, September 2026); check funding approval before starting.

^ Do not offer maintenance rituximab.