

Transcript Details

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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Examining the Evolving MDS Treatment Landscape in Today's Climate

Announcer:

Welcome to ReachMD. This is a medical industry feature sponsored by Taiho Oncology. This program is intended for healthcare professionals only.

Moderator:

Today we're joined by two highly experienced hematologist-oncologists who will be discussing myelodysplastic syndromes, known as MDS. In this first episode, we will touch on current events, and the impact of the pandemic on patients living with MDS. We will also discuss trends in the treatment landscape and some of the experiences our guests have shared in their practices. Let's begin by giving our listeners a little background on your practices, and the patients in your practice who have been diagnosed with MDS.

Dr Komrokji:

Hi I'm Rami Komrokji. I'm the section head for leukemia and MDS at Moffitt Cancer Center. I'm highly specialized in myelodysplastic syndromes so most of my practice are patients with myelodysplastic syndromes, where we see the patients, treat them, and conduct clinical trials.

Dr Raza:

Hi, my name is Azra Raza. I'm a professor of medicine at Columbia University Medical Center, where I'm also Director of the MDS Center. It is an urban tertiary care university setting. I have been in the United States for over 3 decades. I am one of the 8 or 10 oncologists who take care of MDS patients at our center, and I specialize of course in myelodysplastic syndromes. At our institution we see anywhere from 150 to 200 new cases of MDS each year, but at any given time, we have 500 to 600 MDS patients being cared for in follow-up as well as treatment and supportive care measures.

Dr Komrokji:

Well, we are still not sure what exactly causes MDS—which makes it idiopathic or unknown etiology, and there are no clear risk factors, but there are genetic and environmental factors that play a part. It can occur in any age group but is seen more commonly in older adults over the age of sixty. There are about 20,000 new cases of MDS diagnosed in the United States every year and the number is only increasing. MDS is comprised of a rare and diverse group of blood disorders we call hematologic neoplasms that occur as a result of the bone marrow failing to produce enough mature, healthy, and functioning blood cells. They affect platelets, causing thrombocytopenia, white blood cells, causing neutropenia, and red blood cells, causing anemia. When someone has MDS, the blood cells that should function properly fail to develop and enter the bloodstream, causing low blood counts. Anemia is generally the most common symptom and patients will experience the result in complications of those low blood counts.

Dr Raza:

And anemia can cause weakness or bruising; some individuals will feel dizzy or tired, experience regular headaches or bleeding, and be susceptible to bacterial or fungal infections. There are some cases where patients progress to acute myeloid leukemia, which you may know as AML—this is a life-threatening failure of the bone marrow. On the other hand, there are some individuals who remain stable, with mild symptoms for years.

Moderator:

And how would you describe the rate of progression?

Dr Komrokji:

The rate of progression can vary. Some of my patients get worse in a matter of months, while others can live with mild symptoms for many years. As my colleague just mentioned, about 30 percent of MDS cases eventually progress to acute myeloid leukemia.

Moderator:

And the other cases?

Dr Komrokji:

These patients may see a slower deterioration in marrow function, which could cause a worsening of their anemia and thrombocytopenia and which can cause potentially fatal bleeding. And neutropenia leads to patients being immunocompromised and at higher risk of infection.

Moderator:

And how do you go about diagnosing MDS? Do most of your patients arrive in your office with a diagnosis, or are they still searching for answers when they reach you?

Dr Komrokji:

We tend to acquire referral patients who know that something is not right or have had a physical that showed abnormal blood test results. Then we will run complete blood counts. And depending on those results, we may decide on obtaining a bone marrow aspiration biopsy, which also includes checking molecular data such as cytogenetics and gene mutations.

Moderator:

Would you explain MDS classification to our listeners?

Dr Raza:

Well, there are quite a few subtypes of MDS that are categorized by the type and number of blasts in the bone marrow, and according to factors listed under classification systems. When we classify MDS, it helps us predict the outlook for our patients so we can decide how and when to treat them. I have colleagues who use the French, American, and British “FAB” classification, which lists five subtypes: refractory anemia, refractory anemia with sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia.

Then there's the WHO Prognostic Scoring System, which is based on three factors: the type of MDS using the WHO classification by blast percentage, chromosome abnormalities, and the need or lack of need for regular blood transfusions. At the university, we use the IPSS-R, which stands for Revised International Prognostic Scoring System. It is based on five factors: the percentage of blasts in our patient's bone marrow, the type and number of chromosome abnormalities in the cells, hemoglobin level, white blood cell count, and platelet count. Then, we score each of those factors and place our patients in a risk group ranging from very low to very high risk. We use the WHO system and place our patients in very similar risk groups, which help us understand how likely a patient is to progress to AML and how to best treat their MDS.

Moderator:

And are there other factors that help to predict your patient's outlook?

Dr Raza:

Of course! We look at factors that may not have been accounted for: their age, the results of other blood tests, how severe their low blood cell counts are, and finally gene or chromosomal changes that might not be included in the scoring system we use at the practice.

Moderator:

Let's talk about treatment, or the planning process to get you to a treatment. Do most of your patients with MDS depend on blood transfusions?

Dr Raza:

Up to ninety percent of patients with MDS require red blood cell transfusions due to anemia, which leads to transfusion dependence. And, since we touched upon the scoring systems ranging from very low risk to very high risk, I should mention that the median survival ranges from nine months in patients with very high-risk MDS to three years in those with intermediate-risk MDS. Supportive care is a common treatment approach; this includes red blood cell transfusions, growth-stimulating factors, and iron chelation therapy—which removes excess iron from the body.

Dr Komrokji:

And the only potential cure for MDS is allogeneic stem cell or bone marrow transplant— which most patients are not even eligible for. This means that MDS requires life-long treatment if patients are transplant-ineligible. And despite transplant being the best chance for a cure, there are still transplant-related mortality and a risk of relapse.

Moderator:

Why is that—why are most patients ineligible?

Dr Zeidan:

Our MDS patients are mainly older patients, so age and comorbidities make them ineligible. We also have trouble finding treatments, as many of them are not able to sustain intensive chemotherapy.

Moderator:

And those are the only options for treating MDS patients?

Dr Raza:

Well, no. Aberrant DNA methylation is involved in an underlying molecular pathogenesis of MDS, and treatment with hypomethylating agents, or HMAs, has been shown to induce durable hematologic responses, and also to delay the progression to acute myeloid leukemia in patients with MDS.

Moderator:

Is that what you are using in your practices?

Dr Raza:

Yes, we use HMAs. They are pretty much all we use for patients who are ineligible for transplant.

Dr Komrokji:

We have experience with hypomethylating agents as well, as they are able to be used with transplant ineligible patients, but some are not able to endure long-term treatment that needs to be administered at an infusion center for five or seven days each cycle, and hours at a time. We have had a few patients and caregivers that are unable to travel to and from the office so frequently.

Dr Raza:

We typically use HMAs in intermediate- or high-risk patients who aren't suitable for intensive treatments like chemo or a transplant, or in low-risk patients whose disease has progressed based on clinically relevant thrombocytopenia, or neutropenia, or increased marrow blasts. We have also used them as a bridge to transplant. If a patient isn't eligible for transplant, as we just mentioned, treatment is lifelong. There are advancements in this category that have us excited for the future of MDS treatment.

Moderator:

And how do you learn about them? Are your sources mainly through word of mouth, conferences, or journals?

Dr Raza:

I talk to my peers quite a bit about recent advancements in the hematologic space, and pre-pandemic, attended quite a few clinical conferences. I also used to go to speaker programs, but everything has been virtual as of late.

Dr Komrokji:

I read a lot of journals, and network with my peers as well. I have been heavily involved in clinical trials in MDS and attended a few virtual conferences this year as well.

Moderator:

Tell me more about the virtual clinical conferences—any exciting news?

Dr Raza:

I virtually attended both ASCO and ASH. What I did hear and see was the impact of COVID-19 on patients with hematologic disorders.

Dr Komrokji:

I did too! Did you read about the [E-COVID-EHA] study information?

Dr Raza:

Yes. There was discussion after ASH about this study, not that I was surprised that hematologic malignancy would be associated with severe symptoms from COVID-19. Between the risk of exposure while receiving treatments and their immunosuppression, we should be well aware of the fact that the infection causes severe disease and high mortality rates in our patients.

Moderator:

Well, let's discuss MDS treatment in today's climate. Has the pandemic had an impact on your practices, or the way you prescribe at all?

Dr Raza:

It absolutely has had an impact on us, I mean how could it not? Patients are immunocompromised, and we have had to take even more severe precautions with our high-risk patient population. We also have quite a few older patients in our practice, so they have been extra cautious in scheduling their appointments. A few of our patients have been concerned about possible exposure simply coming to the offices for treatments.

Dr Komrokji:

We have switched to a partial virtual office for those who are able. I read about an oncology center that established a drive-through shot clinic to monitor patients without possible exposure. After a year of the pandemic, we are starting to see a new normal for care in the hematologic space to help protect our patients who are already immunocompromised.

Moderator:

It seems as though there's a retailoring going on in medicine and the way we treat patients. Am I right in saying this?

Dr Komrokji:

Absolutely. Will they last post-pandemic? I'm not sure, but I'm keeping my finger on the pulse of the latest innovations in treatment and the way we are treating patients.

Moderator:

Doctors, I cannot thank you enough for educating me and our listeners today. This has been extremely eye-opening. And a special thank you for being guest speakers on our very first episode. Grab a seat and join us for the next episode of Word of Mouth, where we talk to two seasoned nurse practitioners about their experiences in the hematologic space and hear their take on the advancements we touched on today.

Announcer:

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