Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/medical-industry-feature/monitoring-for-neutropenia-in-acute-myeloid-leukemia/11618/

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

Monitoring for Neutropenia in Acute Myeloid Leukemia

Announcer:

Welcome to ReachMD.

The following program, “Monitoring for Neutropenia in Acute Myeloid Leukemia” is developed and sponsored by AbbVie. This activity is intended for United States and Puerto Rico health care professionals only.

The following speaker, has received compensation from the US Medical Affairs department of AbbVie Inc. to prepare and present the following information and is speaking on behalf of AbbVie.

Ilene Galinsky:

Hi, I’m Ilene Galinsky, Senior Program Research Nurse Practitioner for the Leukemia Program at Dana Farber Cancer Institute and I’ll be talking about infection prophylaxis and risk monitoring for neutropenia in AML patients starting venetoclax therapy.

Patients with AML are at high risk for febrile neutropenia or profound, protracted neutropenia.

- Reported rates of febrile neutropenia in patients with AML are 85-95%. Factors increasing risk include ages of 65 or older, ECOG PS greater than or equal to 2, and increasing number of comorbidities.

According to the ASCO/IDSA Clinical Practice Guidelines, antibacterial and antifungal prophylaxis can reduce the risk of infection in immunosuppressed patients, such as patients with AML/MDS or HSCT treated with myeloablative conditioning regimens.

Methods and protocols for implementing infection prophylaxis differ between institutions. Some reflexively place all heme-malignancy patients in isolation as a general policy and initiate rigid transplant protocols throughout each admission, while other institutions take more selective approaches based on neutrophil count thresholds, length of neutropenia, and other risk factors.

For me, the more important factor superseding differences in hospital guidelines is the provision of 24-hour healthcare that can administer medications and transfusions when needed for these patients.

I don’t recommend starting therapy for AML without this coverage readily available at the patient’s institution of choice, given how often we see febrile neutropenia develop in AML and the need to respond quickly when it does .

These high rates of febrile neutropenia, as well as other cytopenias in AML, make cytopenia management an essential part of the therapeutic planning for AML patients. Here are some recommendations for specific interventions:

- In case of sepsis and other life-threatening infections, growth factors may be considered during induction as per ASCO guidelines with the intent to shorten the duration of neutropenia; however, this approach should be used with caution, and should be avoided in those who have active disease.
- Platelet transfusion is recommended for patients with platelets <10,000 or with any signs of bleeding.
- Likewise, RBC transfusion is recommended when RBC counts for Hb drop below 7-8 g/dL or the particular institution’s threshold, or with symptoms of anemia

With all of this in mind, let's consider the neutropenia risks and recommended dose modification strategies for AML patients starting venetoclax therapy.

- Studies have shown that baseline neutrophil counts worsened in 95% to 100% of patients treated with venetoclax in combination with azacitidine or decitabine or low-dose cytarabine.
- It's also important to remember that neutropenia can recur with subsequent cycles of therapy.

For these reasons, we're always monitoring for the risk of neutropenia in these patients. But recommended dose modifications based on toxicities for AML vary based on when the AE occurs and the number of occurrences.

- To determine whether the cytopenia is due to disease or treatment, we perform bone marrow biopsies after cycle 1 or as clinically indicated to assess for remission.

If hematologic toxicity occurs prior to remission, in most instances, treatment should not be interrupted.

However, if there is persistent neutropenia, I look to get a bone marrow biopsy between day 21 and day 28 to see if there are still a lot of blasts or if they've been ablated. If they're completely wiped out, I'll consider interrupting treatment so as to let the counts recover, then do a repeat marrow biopsy and initiate another treatment cycle.

If hematological toxicity occurs after remission, treatment should be delayed and blood counts should be monitored.

- Venetoclax may be resumed upon resolution to Grade 1/2 cytopenia. In the case of subsequent occurrences, the cycle may also be reduced by 7 days.
- For me, it's important that in the context of multiple cycles of venetoclax therapy, we should be doing more frequent bone marrows to better assess disease status and response.

Now let's take a moment to review the indication and safety summary for venetoclax.

Announcer:
Venetoclax Indication and Safety Overview for AML
Indication

Venetoclax is a BCL-2 inhibitor indicated:

- In combination with azacitidine, or decitabine, or low-dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia (AML) in adults:
  - who are age 75 years or older, or
  - who have comorbidities that preclude use of intensive induction chemotherapy.

Warnings and Precautions

- **TLS:** Tumor lysis syndrome (TLS), including fatal events and renal failure requiring dialysis, has occurred in patients treated with venetoclax. Anticipate TLS; assess risk in all patients. Premedicate with anti-hyperuricemics and ensure adequate hydration. Employ more intensive measures (intravenous hydration, frequent monitoring, hospitalization) as overall risk increases.
- **Neutropenia:** Monitor blood counts. Interrupt dosing and resume at same or reduced dose. Consider supportive care measures.
- **Infections:** Fatal and serious infections such as pneumonia and sepsis have occurred in patients treated with venetoclax. Monitor for signs and symptoms of infection and treat promptly. Withhold venetoclax for Grade 3 and 4 infection until resolution and resume at same or reduced dose
- **Immunization:** Do not administer live attenuated vaccines prior to, during, or after venetoclax treatment until B-cell recovery.
- **Embryo-Fetal Toxicity:** May cause embryo-fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception.
- **Increased mortality in patients with multiple myeloma (MM) when venetoclax is added to bortezomib and dexamethasone.** In a randomized trial in patients with relapsed or refractory MM, the addition of venetoclax to bortezomib plus dexamethasone, a use for which venetoclax is not indicated, resulted in increased mortality. Treatment of patients with MM with venetoclax in combination with bortezomib plus dexamethasone is not recommended outside of controlled clinical trials.

Adverse Reactions

- In **AML**, the most common adverse reactions (≥30%) in combination with azacitidine, or decitabine, or low-dose cytarabine were nausea, diarrhea, thrombocytopenia, constipation, neutropenia, febrile neutropenia, fatigue, vomiting, edema, pyrexia, pneumonia, dyspnea, hemorrhage, anemia, rash, abdominal pain, sepsis, musculoskeletal pain, dizziness, cough, oropharyngeal pain, and hypotension.

Review full prescribing information for additional information at www.rxabbvie.com or contact AbbVie Medical Information at 1-800-633-9110 or go to abbviemedinfo.com.

Ilene Galinsky:

Thank you for your time today. I hope this has been helpful.

Announcer:

This program was brought to you by AbbVie.

If you missed any part of this discussion or to find others in this series, visit ReachMD.com/LeukemiaCare. This is ReachMD. Be part of the knowledge.

AbbVie | BCL2-US-00040-MC, Version 1.0 | Approved December 2020