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Approaches for sAML Early Identification and Diagnosis

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by Jazz Pharmaceuticals. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss strategies for the earlier identification of secondary acute myeloid leukemia, or sAML for short, is Dr. Keith Pratz's. Dr. Pratz is the Director of the Leukemia Program and an Associate Professor of Medicine at the Hospital of the University of Pennsylvania.

Dr. Pratz, it's great to have you with us.

Dr. Pratz:
Great to be here, Dr. Turck. Thank you for asking me to participate in this forum.

Dr. Turck:
Well, to start out, Dr. Pratz, would you tell us about the prognosis that's typically associated with sAML?

Dr. Pratz:
Yeah, this is about a third of the patients with acute myeloid leukemia have some secondary form of acute myeloid leukemia there are patients with treatment-related disease in this subset, and there are patients with a secondary form of AML that's related to prior NDS. Historically, these patients have done less well than the average patient with conventional treatments. And we're looking for better strategies to improve those outcomes.

Dr. Turck:
So then if we turn our attention to its diagnosis, what are some risk factors and symptoms that we should look out for?

Dr. Pratz:
This subset of disease encompasses a group where history-taking is critical. Obviously, patients who have had prior chemotherapy for other malignancies would fall into this subset. Often, patients will have had intermittent blood work done in the past where there may be some abnormalities that may suggested antecedent myelodysplastic syndrome, so careful assessment of patient history is key to putting patients into this secondary AML subset.

Now there's also a third subset beyond the two I mentioned, which includes a group of patients with predisposition syndromes for acute myeloid leukemia, or MDS. These would come from taking careful family histories to understand if there's a risk factor associated with family with this disease.

Dr. Turck:
And what are some obstacles that prevent a timely and accurate diagnosis of sAML?

Dr. Pratz:
One of the big challenges is getting access to prior historical blood work. It's great when the patient's been treated in one place, but a lot of our patients go to doctors in various places where access to their histories are challenging. That's one major issue that I deal with on a regular basis.

Dr. Turck:

For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Keith Pratz about the early diagnosis of secondary acute myeloid leukemia.

So given the obstacles you just discussed, Dr. Pratz, how can we address them to ensure we're able to make an accurate and timely diagnosis?

Dr. Pratz:
Well, one strategy beyond historical data is to do a more sophisticated work-up of the patient's cancer itself. More or less, standard-of-care now is to do a molecular sequencing panel or an NGS panel, which is a multi-gene sequence to understand the molecular drivers of patients with a secondary leukemia. There are now a number of genes in the consensus guidelines that would take patients with AML and put them into a secondary category based on myelodysplasia-associated genetic changes. The more common subsets include molecular changes in ASXL1, DMP3A, RUNX1. These patients often have had an antecedent MDS and now are categorized as such in the current ELN and WHO and Consensus guidelines. This will fill in the gaps we may have had in knowing patient's prior history and perhaps more appropriately, stratify them for outcomes with their therapies.

Dr. Turck:
And once a patient is diagnosed with sAML, what are some key considerations when navigating myelodysplasia-related changes and determining fitness for intensive chemotherapy?

Dr. Pratz:
The biggest first decision you need to make with the patient with secondary AML is, is the patient fit for conventional induction chemotherapy? There are a number of criteria we use for this. Conventionally, folks with this diagnosis over age 75 wouldn't be considered for high intensity treatments. Under age 75, patient's performance status at baseline comes into discussion. Patients with a performance status three or higher typically are more difficult to treat with higher intensity treatments, and lower intensity approaches are offered in those settings. But the other patients under age 75 with the good performance status, good cardiac function, good renal function, would be considered for higher intensity treatments, and that would be the first set of assessments we make deciding whether the patient should be given a higher intensity treatment.

Dr. Turck:
And what kind of impact can early identification and a patient-centered approach to care have on outcomes in sAML?

Dr. Pratz:
Once a patient has been identified with secondary AML, a decision early can help guide the first choice of therapy. The first choice of therapy with this disease, like many others, is the most important one we make because that's our best chance of getting the patient in remission, and hopefully to a curative type of therapy, such as stem cell transplant. So we're quickly identifying the patient's type of disease in the treatment options that are out there for the patient will in my opinion lead to a better outcome by allowing us to choose the most appropriate therapy for their treatment.

Dr. Turck:
And lastly, Dr. Pratz's, global view, any thoughts on where we are with the early diagnosis and management of sAML?

Dr. Pratz:
I think we're getting more data in a timely manner for these patients. It used to take three to four weeks to get some of the genetic markers back and the pathology finalized to understand what kind of disease the patient has. The timelines of these turnarounds are improving to one to two weeks now, which allows us to weed out those results in most patients to allow us to choose the best therapy initially. There are a number of reviews recently that have established the safety of waiting for the diagnostic material to allow us to choose the best available therapy in first treatment. So I would advocate that in the patient that's clinically stable, to support them with transfusions if needed for the time it takes to get their results back, and then choose the best available therapy at that point based on what you want have now understood about the drivers of their disease.

Dr. Turck:
Well, considering how everything we discussed today can impact our patients, I want to thank my guest, Dr. Keith Pratz, for providing his insights on diagnosing secondary acute myeloid leukemia.

Dr. Pratz, it was great having you on the program.

Dr. Pratz:
Great. Thank you, Dr. Turck.

Announcer:

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