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Exploring Treatment Approaches in CLL Management

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

Dr. Turck:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Charles Turck and joining me to share some collaborative approaches and best practices in the management of chronic lymphocytic leukemia, or 'CLL', are Drs. Elizabeth Brém and Ehab L. Atallah. Dr. Brém is an Assistant Professor in the Division of Hematology/Oncology in the Department of Medicine at UCI School of Medicine in Irvine, California. Dr. Brém, welcome to the program.

Dr. Brém:
Thank you. Happy to be here.

Dr. Turck:
Dr. Atallah is a Professor of Medicine and Section Head of Hematological Malignancies in the Medical College of Wisconsin's Division of Hematology and Oncology. Dr. Atallah, it's great to have you with us.

Dr. Atallah:
Thank you very much.

Dr. Turck:
So, let's just dive right in and consider some of the biggest challenge areas you both encounter in managing patients with CLL. Dr. Brém, starting with you, what would you say are the main unmet needs for your patients dealing with this diagnosis?

Dr. Brém:
Well, I think one of the harder things when you first meet a patient with this diagnosis is how to frame the diagnosis for the patient, because they've often been told by someone prior to seeing them that they have leukemia and their mind usually goes to acute leukemia because that's what they have the frame of reference for. And a lot of that first visit, and sometimes the second and the third visit, is trying to really frame that this is an acute process and the fact that many of these patients could even be watchfully waited for an extended period of time, rather than initially diving into therapy. And I think setting up that paradigm and that mindset can take some time and can be difficult in many situations. Many people think cancer must have treatment and then when you try to tell them that we can actually delay therapy, sometimes it's an uphill battle to, kind of, get people to really understand that, particularly since their frame of reference is usually acute leukemia and sometimes the time when they first meet you, they're afraid they're going to die.

Dr. Turck:
Dr. Atallah, what are your thoughts?

Dr. Atallah:
I really agree with that. I think it just takes them a while to, like, I have cancer, I have leukemia and all you're doing is just sitting there and watching it, that's so hard for patients to wrap their mind around that. The other side of it is patients who need treatment when we treat them, we do have very good treatment. We always, though, end up with we cannot cure the disease or only that this is a chronic disease that they would live with, that they will get treatment and even if we stop treatment, they may need treatments again. So, the incurability of it also is the other spectrum for this disease.

Dr. Turck:
Dr. Atallah, staying with you for a moment, where do multi-disciplinary teams factor into addressing some of these challenge points, from your experience?

Dr. Atallah:
The clinic team is so important. The APP, the advanced practice provider, the nurse department, we really do work, together, look at patients' comorbidities and I think patients, when they need treatment, the teaching, the follow-up after they start treatment. We have an oral chemotherapy program, which I think a lot of institutions do have where the pharmacist and the nurse follow-up with the patient over the phone and check on them and make sure they're getting their treatments, not having any major side effects. All that is so important to take care of the patient as a whole.

Dr. Turck:
And Dr. Brém, how has your practice incorporated voice share from care teams and patients to arrive at preferred management plans?

Dr. Brém:
I think one of the other key resources that we utilize for many of these patients is the social work team. There's a lot of anxiety that comes with treatment, there's a lot of anxiety that comes with not being treated, and I feel like I'm very frequently reaching out for help in those arenas to try to get the patient additional resources whether that be counseling or what have you to deal with a lot of those anxieties.

Dr. Turck:
Let's focus on one area that generates a lot of questions around best practices and that's contrasting fixed time duration to treat-to-progression approaches in CLL treatment. Dr. Atallah, what's your vantage point on this?

Dr. Atallah:
I think a fixed treatment duration in my personal opinion would always be preferable. I personally don't want to take a pin every day. Currently the fixed treatment duration does involve some intravenous antibodies such as obinutuzumab and that to some patients may not be preferable or something they would not want to, to do. There are definitely some patients that fixed duration treatment is not ideal for patients with high-risk features. We know that even if they do get a fixed treatment duration, the chances that their disease would relapse soon after is pretty high, so it ends up not really being fixed treatment duration. And in those patients I would recommend continuous treatment for example with a BTK inhibitor. So in some way there's a place for both, but for any patient that I engage fix treatment duration would work and probably keep them in remission for longer periods of time. I'd pick a fixed treatment duration, for sure.

Dr. Turck:
And Dr. Brem, mind if I get your thoughts on that, as well?

Dr. Brém:
I share a lot of the sentiment that was shared, already. I mean, I think so much of it depends on the patient in front of you, not only their preferences, how easy it is for them to get to the infusion center for obinutuzumab or rituximab treatment versus as mentioned their disease biology. So, for example, a patient with a 17p deletion, I wouldn't feel comfortable on fixed duration therapy. That's a patient where I would favor a BTK inhibitor, as was mentioned. But as I often tell patients, I really think this is a very much an evolving field. As was mentioned, currently the fixed duration approaches, namely obinutuzumab/venetoclax, again involves a anti-CD20 infusional antibody. But there's a lot of studies going on right now looking at combinations of, for example, ibrutinib and venetoclax and either fixed duration or MRD-guided duration of therapy. So, we could in the not-too-distant future have a fixed duration approach or the option of a fixed duration approach that wouldn't involve a trip to the infusion center.

Dr. Turck:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck and today I'm speaking with Drs. Elizabeth Dr. Brém and Ehab L. Atallah about current collaborative strategies in CLL management.

So, Dr. Brém, continuing on our last thread, how in your experience do care plans with a manageable ramp-up period compare to the long-term management of CLL on a treat-to-progression basis?

Dr. Brém:
So, when we're talking about the fixed duration therapy, we're essentially talking about an anti-CD20, namely obinutuzumab with venetoclax. And when we're talking about a treat-to-progression strategy, we're mainly talking about a BTK inhibitor. So, when we're having this discussion about which way to go, I'm always very up front with patients that while we have the advantage, potentially, of that fixed duration with the venetoclax/obinutuzumab, it is going to be more complicated in the beginning. It's not just the anti-CD20,

which is given once a week for the first month, but it's also the ramp-up of the venetoclax. We know that, for better or for worse, venetoclax causes a fair amount of what's called tumor lysis syndrome and while that's a good thing, it has to be managed in many patients. And so, we need, the very minimal need weekly labs, some patients may need to come in for hydration to the infusion center, some patients may even need to be admitted to the hospital because they're at such high risk of TLS. So, I am always up front with patients that while starting the oral BTK inhibitor in the beginning is simpler, treat-to-progression approach, that there is a lot more intensity, you're asking a lot more out of the patients in the first about two months of the fixed duration therapy because of both the infusion and the venetoclax ramp-up.

Dr. Turck:
And Dr. Atallah, what's your perspective?

Dr. Atallah:
When we're picking a fixed duration, we need to discuss the amount of time they have to come to the hospital. There are days when they have to be checked even twice a day. There are certain blister packets for the different doses that are used for venetoclax. Having said that, once, when patients starts with obinutuzumab and they get their day one, two, eight, and fifteen for the first month, usually by then, by day fifteen or day twenty-two when the venetoclax is supposed to start, which is on day twenty-two, the tumor burden is much lower and the risk for TLS is much lower. Patients need to be still monitored properly, but the risk of TLS is much, much lower.

Dr. Turck:
Now, before we close, let's come back to the team modeling subject and review some of what's been talked about here in the context of real-world scenarios. Dr. Atallah, do you have an experience in mind that brought out some of the strengths in multi-disciplinary care approaches to CLL treatment?

Dr. Atallah:
I'm very fortunate in the clinic is that I have a pharmacist and a nurse, and an APP that work with me and then, when a patient is about to start the obinutuzumab and venetoclax they actually do the bulk of the teaching. They create a calendar for the patient, schedule the labs, even schedule the twice-a-day labs that needs to be monitored for TLS. The nurse, the pharmacist, and the APP follow those and only if there's a problem do they they alert me and especially if there's a problem with the labs. So, honestly the, having all of them taking care of the patients we've been able to do this or to do the fixed duration very faithfully, to just about all, or most of my CLL patients.

Dr. Turck:
And Dr. Brem, how 'bout from your practice; any memorable experiences you can share?

Dr. Brém:
Well, I guess this is a good opportunity to give a shout-out to our clinical nursing staff who do organize whether it's the admission, whether it's the infusion center, whether it's the labs, they really do make everything happen and make it happen safely. I had mentioned earlier that I send most of my patients to some external resources, namely LLS, Lymphoma Research Foundation, and the CLL Society. And in fact, I've had one patient who has gotten so involved with the CLL Society, which has been really empowering for him in terms of just information and decision-making, that has even led to him being a co-author on certain publications being presented at national meetings, which I find extremely satisfying, charming, I just love that he is using his experience to get data out there and help other people learn.

Dr. Turck:
Well, with those perspectives and shared experiences in mind, I wanna thank my guests, Drs. Elizabeth Brem and Dr. Ehab L. Atallah for helping us better understand how we can apply multi-disciplinary approaches to managing patients with CLL. Dr. Brém, Dr. Atallah, it was great speaking with you both, today.

Dr. Brém:
Same here. Thanks for having us.

Dr. Atallah:
Thank you, very much.

Announcer:
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