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Maximizing B-Cell Lymphoma Outcomes with CAR T-Cell Therapy and Personalized Care

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by Kite Pharma, a Gilead company. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Project Oncology* on ReachMD, and I'm Dr. Charles Turk. Joining me to share key considerations for managing B-cell lymphomas in the second-line setting is Dr. Tara Graff. She's a medical oncologist who leads a community-based clinical trial program at Mission Cancer + Blood in Des Moines, Iowa. Dr. Graff, welcome to the program.

Dr. Graff:
Thank you for having me.

Dr. Turck:
So to kick things off, Dr. Graff, what treatment options are presently available for patients with relapsed or refractory B-cell lymphoma?

Dr. Graff:
So, it's an interesting question. Things obviously have changed so much in the non-Hodgkin's lymphoma treatment landscape. You have to look at a patient now in second line and really think about when was their relapse? Was it within 12 months of their frontline therapy or greater than 12 months? At least that's how I approach my second-line patients. If it was less than 12 months, these are patients that you really need to be thinking about CAR T-cell therapy. Obviously, more goes into that, deciding who may want it, who's eligible, and different social factors. But that is a category where I think CAR T really needs to be looked at. On the flip side, for patients who have relapsed greater than 12 months, that's where patients are still sort of thought about for transplant. Obviously, there's other treatment options as well, different novel therapies. Chemo is always there, but chemo is definitely becoming further down the line with all of our newer novel therapies that are coming out as well. So it's definitely an interesting space to be with a lot of different options for our patients in second line that didn't exist a few years ago.

Dr. Turck:
And zeroing in on CAR T-cell therapy specifically in this setting, would you share some key data on its overall safety and efficacy with us?

Dr. Graff:
Absolutely. You know, CAR T-cell therapy I think is an excellent treatment option. I mean, T-cell directed therapies in general, you know, using your body's own T-cell repertoire and sort of revving them up, if you will, to come back and combat that lymphoma I just think is just such a cool way to be able to treat this disease. But with these novel therapies such as CAR T-cell therapy, we have to be aware of safety, right? We're revving up our own immune system, and by revving up those T cells, we release chemicals or cytokines, if you will, into our bloodstream and into our system. And with that, when we kind of excite the immune system, we have to think about things like cytokine release syndrome and ICANS, or what we call neurotoxicity. These are things that definitely make CAR T-cell therapy different from other therapies that we may use in second line. And that's why those patients need to be monitored at the CAR T-cell center to be watched carefully for these things that occur.

Now in terms of efficacy, when you think about patients in the second line, especially patients that have relapsed within 12 months of their frontline therapy, these are more aggressive lymphomas, right? Their disease is more aggressive and more resistant. And so when

you think about a treatment, you want to get a lot of bang for your buck out of it, if you will. And as for the efficacy surrounding these therapies, the overall response rate is like 83 to 86 percent depending on the agent we're speaking of. And that's a big deal. So for a patient that's relapsed quickly, has more aggressive disease, and still has an overall response rate above 80 percent, I think that's a really great therapy and a great option for these patients in second line, especially when you're talking about a potential one-and-done therapy; it's not ongoing, right? If this works and these patients achieve remission, that might be the last treatment they ever need.

Dr. Turck:
Well, with those data in mind, which of our patients might be eligible for CAR T?

Dr. Graff:
So I sort of spoke about knowing and figuring out when the patient relapsed, whether it was less than 12 months from their frontline therapy or greater than 12 months. And not that you can't consider CAR T in all options, but it's really that less-than-12-month group that we really need to be thinking about CAR T-cell therapy. And “eligible” is kind of an interesting term, right? We always tend to think about eligible in terms of transplant, right? Transplant eligible, transplant ineligible, it's not always about health, right? You know, there are patients that go on and get CAR T that may not be considered for transplant because they're “too old,” right? And I don't look at it like that.

There are patients that are well over 80 that can go on and get CAR T, but I think CAR T is also something that we are finding more is a social factor; are they socially eligible? Because they need to have a support system. They need to be able to get to a CAR T-cell center. They need to be able to stay close at the CAR T-cell center for 30 days, monitoring for CRS, neurotoxicity, and different things that may potentially come up during their treatment. And a lot of patients don't want to travel, they don't want to drive to the CAR T-cell center, they don't want to stop working, and they don't want to leave their loved ones. So it's not always a matter of medically eligible, but there's a big thing with social eligibility too. So it's multifaceted. And I find it really interesting when you're talking to different patients in different locations in the state or different locations in the country and how they view these therapies.

Dr. Turck:
For those just joining us, this is *Project Oncology* on ReachMD. I'm Dr. Charles Turk, and I'm speaking with Dr. Tara Graff about management strategies for patients with relapsed or refractory B-cell lymphoma.

Now, if we switch gears and focus on how we can personalize our patient's care, Dr. Graff, would you break down your approach to shared decision-making?

Dr. Graff:
Absolutely. I'm glad that you bring up the concept of shared decision-making because I think that's very important. Not every site is going to be a site that does CAR T-cell therapy, right? So you really need to know your colleagues; you need to know who's in the area and who you can rely on. Because if it comes to needing a patient evaluated for potential CAR T-cell therapy, that shouldn't be something that you don't consider because you don't know what to do or where to send them. So for example, when I have a patient that I think is a good candidate for CAR T, I phone a friend; I will call a nearby colleague who does CAR T and I'll say, “Hey, I've got this patient, this is what I'm thinking. I want to give them this, but I want to make sure you're okay with it so I don't do anything to burn out their bone marrow or hinder collection.” And sometimes, that patient will go on to the CAR T center for consultation right away. Sometimes, we'll potentially do one round of a therapy and then do a consultation.

But I think the earlier that you involve your shared decision-making team, the better because then you're all on the same team. And what I've learned is that it boasts confidence in the patient when they know that they have two physicians or maybe two physicians and a nurse practitioner, or whatever that looks like all communicating and communicating from the get go on their case, that confidence they have knowing they're well cared for and that everyone's on the same page. I have learned that that is really so essential to medical care. So I think the earlier the better in making that connection with a CAR T-cell center if you're thinking about that for your patient. Don't sort of decide, “Okay, I'm going to treat them first, and then I'll worry about it.” I really can't hit home enough that early consultation, phone a friend, if you will, is really imperative in the patient journey.

Dr. Turck:
Now, in addition to those factors, how else could we provide patient-centered care?

Dr. Graff:
Well, I think you really, again, need to have that team. So for example, you have to let the patient know early on because this is a big fear: they think if you refer them to a CAR T-cell center that you're not going to get them back. You're no longer their doctor, right? So they're leaving their home base. And that can be scary for some patients and one of the reasons why they decline going for CAR T-cell therapy. So I think you just have to have that back-and-forth highway and that constant communication from the home base or the

primary oncologist with the CAR T-cell physician, and then vice versa. I think it's just open communication. If you have open communication, which I am so fortunate that I do have here where I'm located, you're just co-managing and that's really what it is. It's co-management, and I just can't stress that enough. That it's so vital in this process.

Dr. Turck:
Now as we come to a close, Dr. Graff, from a global perspective, do you have any final thoughts about why tailoring our treatment approach to a patient's individual needs is so important?

Dr. Graff:
So we're in the era of personalized medicine, right? Personalized in terms of targeting certain mutations, personalized in so many different ways. And I think that's exactly what we're doing when we're selecting the best therapy, right? We are involving our patients. So we're going back to patient-centered care. It has to be about the patient. The patient has to be the one ultimately making the decision. We can't be making that decision for them. So I bring that patient in, I grab a big piece of paper off of the medical exam table, and I just start drawing for them. I start talking to them about all different ideas. If they're a CAR T-cell candidate, I say, "Okay, this is what CAR T-cell looks like. If you don't want to do CAR T, here's the other option, and this is why I think this option is good or bad, but this is what this looks like. Here's the side effects, here's the pros and cons of everything." And then let them make a decision. And you can say, "Hey, go for a consultation. You may decide at the end of the day you don't want to do CAR T, and then you come right back and then we'll go on to option B or option C," whatever it is that they choose. But you need to make them feel part of the team; it's patient centered. You can't have a football team without the quarterback. You can't have a treatment plan without the patient. And so I think that's just so important and catering to their needs if they have a sick spouse at home and that's their concern about traveling or financial concerns. A lot of these programs have such wonderful access support with these novel agents in CAR T-cell therapy. You know, you have to cater to what they need. If they feel you're really listening to them and catering to their needs, whether medical, social, or financial, at the end of the day, I think you're all going to be on the same page and it's just going to be a better outcome for the patient.

Dr. Turck:
Well, given all those considerations, I want to thank my guest, Dr. Tara Graff, for joining me to discuss these management strategies for patients who require second-line treatment for B-cell lymphoma. Dr. Graff, it was great having you on the program.

Dr. Graff:
It was fun being here. Thank you.

Announcer:
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