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Optimizing Outcomes in Steroid-Refractory Chronic GVHD with Early Intervention

Announcer:
You're listening to *Project Oncology* on ReachMD. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and joining me to examine top intervention strategies for steroid-refractory chronic graft versus host disease, or GVHD for short, is Ms. Erin Kopp. Not only is she an acute care nurse practitioner, but she's also the Director of Advanced Practice Providers within the City of Hope Comprehensive Cancer Center in Duarte, California. Ms. Kopp, thanks for being here today.

Ms. Kopp:
Thank you.

Dr. Turck:
So let's just dive right in, Ms. Kopp. What are some of the key clinical signs of chronic GVHD?

Ms. Kopp:
Well, that's such an interesting question because it's a chronic process. And it's very nuanced. Anyone who has experienced patients who come in with chronic GVHD can probably tell you that it was something we had to look for or it was so blatantly obvious that it was later in the process. So I like to give clinicians, patients, and caregivers alike the advice that know what your new normal is. Contextually, these are individuals who have gone through chemotherapy or through transplant; they may have had complications, and they don't feel well. And so identifying what's my baseline? Am I taking naps during the day? Am I feeling nauseated all the time? Am I able to eat three meals a day normally? So if that changes for longer than 2 or 3 days, that is the signal to come and tell us.

The difference between acute graft versus host disease that we see in the hospital or in the first really focused 100 days or so, it's skin, gut, liver. In chronic GVHD, it's everything from integumentary, to the gut, to GU, to lungs, to the heart. And the way that it presents, especially in the early phases, cannot be defined by one specific way to look for it. Because even if we talk about the manifestations, what it looks like in skin on me might be a change of some erythema. What it looks like in somebody else is sclerotic changes. So it is, by definition, a change in what the individual is experiencing normally. And so we're just going to teach patients if you don't feel the same, let me know.

Dr. Turck:
And what are some of the more subtle manifestations that we should be on the lookout for?

Ms. Kopp:
It's a great question because I have had individuals who literally have said to me, 'I can't open my mouth as wide,' or I've noticed that when they're talking, they've mentioned, 'Well, my wrist doesn't seem to bend as much as it used to when I'm trying to write or when I'm trying to pick something up.' Other things that I've had people say, 'Well, you know, my eyes feel like they're bigger than my stomach.' Another thing that you'll see, especially if you're in an air-conditioned room, people might keep their sunglasses on in the clinician's office. And that's because they're experiencing dry eye, and just the air conditioning is enough to cause them discomfort.

So it's really about doing a thorough assessment of the individual every time they come to you, and not just focusing on what can be catastrophic. Right? But what is really going to impact that individual's quality of life because that's generally how a lot of our earlier signs, especially of graft versus host disease in the chronic setting, will show.

Dr. Turck:
So with those symptoms in mind, would you walk us through the NIH consensus diagnostic criteria for chronic GVHD?

Ms. Kopp:
So diagnostic criteria is exactly what it sounds like. There are symptoms or manifestations that are diagnostic. Meaning, just the presentation of that in and of itself is enough for a diagnosis of chronic GVHD. So an example for the skin, leucoderma; in the mouth, lichen planus changes. If we're talking about the GI tract, especially in the esophagus, that is an EGD and finding esophageal stricture, that's different than what is distinctive. So anyone who has been in practice and has individuals in their practice who have chronic GVHD will say, 'Oh yeah, these symptoms, we know that we see them very often; they're distinctive, but they're not diagnostic alone.' And so in that case, we need to look at the context of what's going on, definitely rule out any other cause. And some of those examples might be the changes that we see in the nails or the changes that we see on the scalp, or issues that are air trapping on a CT as opposed to changes in the actual PFTs, the FEV-1, and this criteria is outlined.

And then other things are clinical features that we see but don't fit into either one of those categories. So we may have clinical judgment to know that they accompany chronic GVHD. We would be remiss to not look for a diagnostic or distinctive characteristic. To make matters slightly more confusing, there are symptoms or manifestations that are seen commonly in both acute and chronic graft versus host disease. And those, again, are outlined very well within the NCCN guidelines because then we can say, oh, we're looking at this. This is very common. We need to rule out is it acute or chronic GVHD. Those diagnostics and where we see the disease will allow us to quantify what can be a subjective finding and give a diagnosis in a space where something like a biopsy or a blood test is not always available to say this is chronic GVHD or it's not.

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 acute care nurse practitioner Ms. Erin Kopp about diagnostic criteria for patients with steroid refractory chronic graft versus host disease, otherwise known as GVHD.

So Ms. Kopp, once we diagnose a patient, how do we currently approach treating them?

Ms. Kopp:
So with diagnosis of a patient where we've identified diagnostic distinctive criteria and ruled out everything else with chronic GVHD, the next step is really grading and scoring based on organ involvement. So within NCCN, you can find the NIH consensus criteria of how we will grade that. We're looking at skin, lung, GI, liver, joints, and fascia, and the involvement or the presentation can be given a score of 0, 1, 2. Those scores are added up, and then you're able to say, okay, this is mild chronic GVHD because these organ systems are involved at this level versus moderate or severe. Why that's important, it's going to give you a baseline, a touchpoint, to compare progression or response when you start therapy. Now in the last decade or so, really the number one consensus among providers was corticosteroids, and start them quick because we know that if we don't identify and treat chronic GVHD early on, the risk of permanent damage is high. We can see permanent damage with fibrotic changes that can occur in the fascia or the organs and the eyes. So we want to get in. And corticosteroids tend to work quickly. So depending on the institution that you're working in, there are all different approaches. One milligram per kilogram per day tends to be a standard. And when you look at NCCN guidelines, that is really what you're going to base, is this individual responding? Are we seeing progression? And what do we do next?

Dr. Turck:
So I was wondering if you would walk us through any key considerations for moving a patient to next line therapy?

Ms. Kopp:
Sure. So if an individual is having progression at greater than or equal to 1 milligram per kilogram per day of corticosteroids, after about 1 to 2 weeks, they're looked at as either being steroid refractory or steroid resistant. The other thing that we want to think about though is steroid dependence. Corticosteroids have a myriad of adverse effects that can happen with long-term use so we can get the effect we're looking for with reducing or mitigating chronic GVHD effects. But if we have the corticosteroid side effects that we're looking at, high risk of infection, hyperglycemia, psychosis, you know, potential AVN; all of these risk factors are something we need to consider as well. So we want to ensure that we're treating with the best outcome with the least number of potential side effects. Right? So if I identify either steroid refractoriness or resistance or steroid dependence, then we're looking at what could be the second line.

NCCN definitely recommends anytime there's a clinical trial that potentially is appropriate for the patient that you're looking into that. Clinical trials may or may not be available, but in the case that they are not or not appropriate for the patient, there are a list of medications within NCCN guidelines. There's not sufficient data to really say, well do this in this order. Try this for this organ compartment. You should really do this instead of this at this time. But there's a list of these medications in multiple different classes in conjunction with corticosteroids to address those patients who are steroid refractory or resistant.

Dr. Turck:
And how do you decide between some of those medications?

Ms. Kopp:
Well really, I will say I always go back to the data. I'm going to look first, how old is my patient? You know, in our practice, I'm an adult acute care nurse practitioner, but we do have pediatrics at our institution. Are they 10 years old? Are they 12 and over? Many of the medications will be indicated for adults only or pediatrics from a certain age. I will look at the data to see, what is it that I am looking for? Were there different organ compartments that were identified in the clinical trials that had higher efficacy or lower efficacy? If a patient has upper GI or lower GI GVHD? Is this somebody who can tolerate and process oral medications? Is that even addressed in the prescribers' information? There are many things that are taken into account when I'm looking at what the options are.

Dr. Turck:
Now lastly, Ms. Kopp, how might early intervention and treatment impact the quality of care and quality of life for patients with chronic GVHD?

Ms. Kopp:
This is really the crux of it. I alluded to the fact that there are changes that can happen with chronic GVHD that are irreversible. So I tell everybody, patients, caregivers, and providers alike, it is our job to be committed to identifying changes early on, to investigate them, to identify is it chronic graft versus host disease, because the sooner we can catch something, the more likely we are to prevent long-term devastating effects.

Dr. Turck:
Well given the importance of the topic, I want to thank my guest, Ms. Erin Kopp, for joining me to discuss how we can optimize our approach to steroid-refractory chronic graft versus host disease. Ms. Kopp, it was great having you on the program.

Ms. Kopp:
Thank you so much.

Announcer:
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