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Personalizing Relapsed/Refractory CLL Care: Key Factors to Consider

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

Dr. Turck:
This is *Project Oncology* on ReachMD and I'm Dr. Charles Turck. Today we're going to discuss how we can take a tailored approach to treating patients with relapsed refractory chronic lymphocytic leukemia, or CLL for short, with Dr. Lindsey Roeker. She's a hematologist and medical oncologist at the Memorial Sloan Kettering Cancer Center in New York City. Dr. Roeker, thanks for being here today.

Dr. Roeker:
Thanks so much for having me. I'm excited to have a conversation.

Dr. Turck:
To start us off, Dr. Roeker, would you give us an overview of the current treatment landscape for relapsed refractory CLL?

Dr. Roeker:
Absolutely. So we have a couple classes of really effective novel agents for CLL. We have BTK inhibitors, which includes the covalent BTK inhibitors ibrutinib, acalabrutinib, and zanubrutinib. And then we have a noncovalent BTK inhibitor, which is pirtobrutinib that was recently FDA approved. And then we have the BCL-2 inhibitor venetoclax. These drugs can all be used either alone or in combination with CD20 antibodies, and the data on combinations is different for each agent.

Dr. Turck:
And with those treatments in mind, what disease- and patient-specific factors do you consider when selecting a therapeutic approach?

Dr. Roeker:
When I'm thinking about how to approach a patient with relapsed refractory CLL, I think about what they had received previously. So is this a patient who previously received a BTK inhibitor? Previously received venetoclax? Or received neither and they were chemoimmunotherapy treated in the past but have not received a novel agent? And then I think about what the reason was that they stopped their previous therapy. So was it that they had a side effect where they had to stop the drug? Was it that they were on a medication and progressed through it? Or was it that they stopped after a time-limited therapy and completed all their planned therapy and are now progressing after a period of treatment-free observation? Because the approach to each of those is really different.

And then thinking also about patient age, comorbidities, and their performance status; those are all reallyimportant considerations as we're figuring out what treatment is right for someone.

Dr. Turck:
Now those are certainly important considerations, but I'd also like to ask about which counseling strategies you use to find out what the patient prefers.

Dr. Roeker:
I really talk about what the logistics of each of these treatments look like and what the anticipated AE profile looks like. Because those are the pieces that the patient is going to experience and needs to be kind of on board with what they're getting themselves into. So I really try to be clear about what it looks like to be on each type of therapy in terms of when are they taking pills? What are the side effects that they might expect? How often do they need to come in for clinic visits? And really make sure that it's clear so that they understand what they're getting themselves into.

When patients are having a hard time, even with all that information, sometimes I do describe it in kind of a dichotomous way so that patients can see which kind of priorities they more align themselves with. So I'll say, “For some people, the idea of taking a couple pills a day and having it just be an added part of their regimen seems easy and like something that they're totally able to do, and they don't want to go through the rigmarole of extra clinic visits, understanding that they'll be on medications for a longer term.” And for some patients, they say, “Whatever I have to do in the next little bit to get on a medication to safely down the road have a time where I'm not on medication, that's really what I want to prioritize.” And sometimes when it's presented in that way, people are able to identify which ones they align more with and what might be the strategy that's better for them.

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. Lindsey Roeker about personalizing the treatment of relapsed/refractory CLL.

So, Dr. Roeker, once you've gathered all that information, how do you balance those factors when selecting a therapeutic approach?

Dr. Roeker:
For each patient, it's different. Some people have a history of a near life-threatening toxicity, which really limits your ability to use certain agents and pushes you one direction. Some people have comorbidities that make particular treatment decisions really challenging. In which case, the options are fewer.

For patients who have really the full range of options available to them based on what they had received before, why they had stopped it, as well as their medical problems, age, and preferences, then I think the dependence really is on their preference and making sure that we are clear in what each treatment regimen looks like as well as what we expect from the regimen and what the patient should anticipate moving forward. And I think that that's a situation where really having the detailed discussion with your patient so that they understand why they would select one option over the other really allows you to get their buy-in and their agreement with the treatment plan so that you can have a shared decision-making process in selecting that treatment.

Dr. Turck:
And once a patient begins treatment, are there any best practices you use when monitoring their response to therapy?

Dr. Roeker:
The first pieces are looking at getting on medications safely, and then there's also the longer-term look at how are they responding to therapy. So with BTK inhibitors, I typically start a medication and, depending on what their counts look like at the beginning, I recheck their counts in a few weeks to ensure that their counts look okay and that they're tolerating medication okay. That's kind of a good check-in. And at that point, if the counts are looking totally stable, then you can space out visits thereafter. If patients have more cytopenias at baseline and need more frequent monitoring, then that’s obviously a different treatment schedule depending on what the patient is experiencing.

When you're using venetoclax in the relapsed refractory setting, it's important to remember that the venetoclax dose ramp does require that 5-week dose escalation for CLL. And with each of those dose escalations, you want to make sure that you're monitoring for tumor lysis and ensuring that patients are starting that therapy safely.

In terms of monitoring response for BTK inhibitors, it's important to remember that patients often experience a lymphocytosis kind of early in therapy that often does tend to decline over time. And that's evidence of response. So if you see a climbing white count as patients start BTK inhibitors, do not be alarmed; that's what you're looking for.

With venetoclax, you should see counts coming down pretty quickly. And then you should see other counts improving if they started with baseline cytopenias. I often monitor clinically, so I look at blood counts, I do physical exams, and I really ensure that I'm not sensing any growing adenopathy, growing splenomegaly, or new or emergent cytopenias. If patients are having symptoms where I'm concerned that there's growing lymphadenopathy, then I do scan. But in the absence of any symptoms or signs that make me concerned that there's growing adenopathy and with a physical exam where I’m seeing response, I typically just monitor clinically.

Dr. Turck:
Now we're almost out of time for today, so just to bring this all together before we close, Dr. Roeker, why is personalized care so important? And what kind of impact can it have on our patients with relapsed refractory CLL?

Dr. Roeker:
So I think CLL is a very unique disease in that it's a chronic one. And it's one that patients are going to require therapy over the course of many, many years in many cases. And, further, people do well. So we want to make sure that not only are people receiving effective therapies, but they're really benefiting from the therapy. And that means having a response but also tolerating the medication well so that

they can live their lives in the way that they want to. And I think that understanding upfront of what are patients' priorities and what are the factors that are going to allow for effective use of these agents really can help make the overall treatment experience in the relapsed refractory setting just a lot smoother for both patients and providers.

Dr. Turck:
Well, given the impact that customized care can have on our patients, I want to thank my guest Dr. Lindsey Roeker for joining me to discuss best practices for personalizing the treatment of relapsed refractory chronic lymphocytic leukemia. Dr. Roeker, it was great having you on the program.

Dr. Roeker:
Thanks so much for having me.

Announcer:
This episode of *Project Oncology* was sponsored by Lilly. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!