When Should Transplant Be Considered for CLL Patients?

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Andrew Schorr:
We gotta mention one thing, Phil.

Dr. Lamanna:
Transplant.

Andrew Schorr:
Transplant. So it used to be, if you had these 17P deletions, etc. I have a friend in Las Vegas, he's a pit boss. Really cool guy. But he's been dealing with CLL for many years. They said, "Well, we think maybe you're gonna need a transplant," before these drugs came out. So first of all, the drugs we just talked about, did they replace the need for transplant, or is there still a place?

Dr. Thompson:
Yeah. It's one of those questions that if you ask…

Dr. Lamanna:
…us.

Dr. Thompson:
10 different CLL specialists, you'll get 10 different answers.

I mean, essentially, transplant is the only proven curative therapy for high-risk CLL. But it comes with a big cost. And the cost is that 20 to 25 percent of patients who have a transplant will die directly from the complications of the transplant. And that happens early, so soon after you have the transplant. And then about half of people who survive long term have this thing called graft-versus-host disease, where the transplanted immune system causes damage to your normal tissue.

Andrew Schorr:
So you've gotten somebody else's cells, and your body's saying that's foreign, and there's this kind of ongoing war.

Dr. Thompson:
Yeah. And it seriously affects people's quality of life. So when I have a patient in front of me, and I'm saying, "Well, you have 17 deletion, and I put you on ibrutinib (Imbruvica)." And you put the patient on ibrutinib, they feel fantastic.

They take a pill a day, and I say, "Well, you could have a transplant, and you might die 20 to 25 percent, and you might get graft-versus-host disease." No patient wants to have that transplant. So essentially, we're doing very few transplants for CLL. It's kind of been pushed further back in the algorithm, and sort of being reserved for patients who may be failing on these newer therapies.

Andrew Schorr:
Okay, so you'd agree with that.

Dr. Lamanna:
Yeah. I mean, to be fair, the issue with transplant also is, remember, the median age of CLL's in the 70s. And so that excludes the majority of patients from getting a transplant, just bottom line. So that's one. And then the second is, now that we do have some of these new oral therapies, they are certainly less toxic than a transplant. And even though we said it's proven that CLL can be cured by a transplant, that data is small. It's really small. So it's a big price to pay. The majority of patients can't go, because they either are older or have other comorbidities.

And so most of the patients with CLL are not going to transplant. But are there select patients? Absolutely.

Andrew Schorr:
If you've had a transplant and are listening to this, I don't want you to feel like, oh my God, I got the wrong thing.

Dr. Lamanna:
No, not at all. There's very select patients that we will still recommend transplant for.

Andrew Schorr:
Okay.

Dr. Thompson:
Right. In fact, we have the occasional patient with what we would say is really high-risk disease who's on ibrutinib, and they might be doing okay, but you know that their relapse risk is really high. And actually, the best time to do a transplant is while their disease is under good control, and they're in good shape. And but that's the time then the patient doesn't want to have the transplant, because they're doing well, and you're talking about something that might happen in the future, so.

Andrew Schorr:
So if you have this CLL, this more aggressive, this is when part of your team needs to be somebody like this, probably at a research center, to look at all your options and get what's individualized for you, right? Nobody goes into a transplant lightly, right?