Hope and Progress in CLL Treatment: Updates From iwCLL 2019

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Carol Preston:
There is an awful lot going on. This is the time of year where there are meetings and patients really wanna know—you’ve just come from a big workshop on CLL in Scotland and then there is the big meeting in the United States in early December called ASH. And so, patients really wanna know is there more progress that’s being made? And what can they look forward to going forward?

Dr. Lamanna:
Yeah, absolutely. I mean, it was an exciting meeting in Scotland and a lot of this, again, will appear itself when we go to Orlando for ASH, which will then be a lot more, I think, transparent because it’s a much bigger meeting. And that means a lot of oncologists in the community get to also benefit by hearing all these sessions as opposed to our small meeting where we get together and collaborate, which is what we did in Scotland.

There are a lot of things going forward. We’re looking more at, again, fine-tuning what we call minimal residual disease testing, so looking at lower levels of disease. How do we use that for patients going forward on therapies? Can we truncate or shorten their oral therapies? There’s gonna be a lot of data being shown about combination therapies with some of these new oral targeted therapies, whether they be with another targeted oral agent or in combination with an antibody or with even chemoimmunotherapy. There’s a lot of progress being made about how to push the field forward, looking at different treatment options for patients.

Patients have a lot of things to look forward to because of all the clinical trials that we’re doing that are examining how to move the field forward and how to combine and look at reducing side effects of therapy, truncating therapy. It’s really, really an exciting time in CLL for patients. And for researchers.

Carol Preston:
Well, I was gonna say, you as a researcher, much of the time, although you do see patients a couple times a week, are mainly about the data. Patients are all about the results and the outcomes. So when you talk about MRD testing and whether it has to be negative, whether they can live with some detectable cells, what is your thinking about that right now?

Dr. Lamanna:
Yeah, absolutely. And this is a complicated field so I think by no means, I think is this gonna be—it is not ready, necessarily, for primetime because we’re still, from a CLL community, from the researcher standpoint, we’re trying to figure out how to utilize minimal residual testing to the patient’s advantage. And so, I think for right now, when patients have a little bit of disease left, that means they’re MRD-positive, whether or not those individuals, they can be monitored probably, yes. The short answer is the question we’re all looking forward to is how long will that response last? So, their time to their next
therapy, whether they are negative or positive with this minimal residual disease testing.

This is still very immature, this data that we have, so we need many more years to follow that up. We’re refining techniques, so how we test for minimal residual disease is being evaluated so that we can get to finer levels of sensitivity. So this is gonna take some time so I don’t want patients to think oh, if they have a little bit of some disease left by this testing that this is—you know, I think it can be anxiety-provoking sometimes when they hear some of these data. I think it’s something we’re still trying to evaluate and take that forward because we have plenty of patients that we know still have low levels of disease, but are off therapies and doing remarkably well.

So I think this is something that’s in evolution and hopefully then we can refine this. And then make it more mainstream so that we can take this and really do this in mass for everybody. So we’re still gathering this data on clinical trials and I think we just need to stay tuned.

Carol Preston:
Here’s an unfair question.

Dr. Lamanna:
Is any question unfair?

Carol Preston:
Yeah, you know, how far down the line are you thinking? You might have more answers in a year? In two years? Five years?

Dr. Lamanna:
Absolutely. I think that – no, that’s not an unfair question. I think, you know, obviously with some of the trials, and I’m gonna reference one of them just because it’s probably the one we have most data on, the MURANO Trial, which looked at venetoclax (Venclexta) and rituximab (Rituxan). We’re capturing that data. So, going forward, each year we actually renew those data results. In other words, we re-present and look further. Having longer increments of time is gonna be very helpful.

I think also at the meeting that we talked at in Scotland, we finally are looking, or looking to use MRD testing with our regulatory and government agencies. This was a thing that we never were able to do before, look at MRD and have that as part of really meaningful clinical endpoints as part of our clinical trials. And now the FDA’s willing to look at that data. So, I do think this will shift and it will become more mainstream over the next several years. But I think in terms of data, for sure it’d be nice to see a good five years, even ten years, but I do think it will make its way in practice sooner. We’re already seeing that change in practice because of the recent approvals of venetoclax-based combinations, even in frontline settings.

So patients are, you know, physicians, I think, are utilizing that to say hey, look, after this much therapy we’re gonna stop therapy on patients with venetoclax and follow that data. So we already see it making its way into clinical practice now.

Carol Preston:
I’m listening to you as a patient and I’m hearing a lot of hope from you as a researcher and as a practicing specialist. Do I read you correctly?

Dr. Lamanna:
You absolutely read me correctly. You know, for somebody who started a long time ago doing chemoimmunotherapy and watching that data and being—participating in those chemoimmunotherapy trials with FCR, PCR, and so on, now using all these novel agents and going forward is a really exciting time and we have a lot more choices available to our patients so patients—it’s wonderful for patients. And we are learning much more about the disease biology and also these medications and how to use them better. So I think—every patient has a very good reason to be hopeful.

Carol Preston:
Thank you very much, Dr. Lamanna.
Dr. Lamanna:
Absolutely. Thank you.

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