



# Patient Power

## Advocating for the Latest CLL Treatment Options

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**Andrew Schorr:**

Hello and welcome to Patient Power. I'm Andrew Schorr, and welcome to our first in our Partners series of programs and thank Pharmacyclics for helping sponsor these programs through educational support.

What's Partners all about? Well, I'm in California, long-time CLL patient, and I've been down the road, and I've had various doctors I've had to work with so that hopefully I get the care that's right for me. And I'm joined by two other veteran patients and a leading specialist, and we're going to discuss how you can play a strong role in your CLL care in, let's face it, a changing environment in CLL. So I want to interview my friends who are with us today who are going to help us in this discussion, and we hope in the end it will help you get the care you need and deserve.

So first let's go to Valley Stream Long Island, just outside New York City. Bob has a party. Bob, you've been living with CLL how many years now?

**Bob Azopardi:**

I have it since 2000, so it will be 19 years in April, 19 years, a long time.

**Andrew Schorr:**

And, Bob, it started in Florida with a community oncologist, and over the years at various times you've had so many different treatments. You've been a really sick puppy some of the time, but today in one of the modern medicines you're doing well.

**Bob Azopardi:**

Yes, Andrew, that's for sure. I started with a regular oncologist, and the key to the whole thing was moving forward to be treated by a specialist, and that's what turned it around for me.

**Andrew Schorr:**

All right. We're going to talk about that. And we should mention you've been in a clinical trial. It's helped a lot too. Okay.

Let's skip up to Boston, Michele Nadeem-Baker. Some people have seen her on some of her Facebook Live programs that we do at Patient Power. Michelle, you've been living with CLL how long now?

**Michele Nadeem-Baker:**

I've had it, I was diagnosed towards the end of 2012, so a little over six years I have had it. That I know.

**Andrew Schorr:**

And how are you doing?

**Michele Nadeem-Baker:**

I am doing very well. I just had a big day of tests and meetings with my oncology team at Dana-Farber, and I am actually doing great. I'm on a clinical trial as well but a different one than Bob is on.

**Andrew Schorr:**

Okay. All right. I'm so glad to hear it. Now it's not without you know, the issues that some people facing CLL. Michele has dealt with fatigue. Sometimes you've had skin issues you've been concerned about, all of that. But both these people that I've introduced you to, and I guess me too, we've played a great role in our care. Okay.

So Bob mentioned a magic word, CLL specialist. Let's meet one of our favorites, Dr. Bill Wierda who is the Medical Director in the Department of Leukemia at MD Anderson Cancer Center in Houston, one of our foremost centers. Bill, thanks for being with us once again.

**Dr. Wierda:**

Well, thank you for having me, Andrew.

**Andrew Schorr:**

Okay. So we call this the Partners program. What's your view of partnership with patients today, Bill?

**Dr. Wierda:**

What's my view of partnership with patients. Partnership with patients for me is having patients understand their disease, having me work with them through the course of their disease, working with them and allowing them to participate in the discussion and contribute to the decisions that they need to make through their treatment. So guiding them through their treatment and directing them in the best treatment to get the best outcomes that they can for their disease.

**Andrew Schorr:**

Okay. And you don't object at all to what I would call a smarter patient like the three of us here?

**Dr. Wierda:**

No, not at all.

**Andrew Schorr:**

Okay. So, Bob, you said getting to a specialist, and you learned along the way to advocate for yourself. From what you know in CLL today why do you think that's so important?

**Bob Azopardi:**

The time that I spent with a regular oncologist was like a—it was difficult because it was a constant routine of chemotherapy, etcetera, etcetera. To get with a specialist is completely different, you know. And today it's not that difficult, because a new patient has the social media and Patient Power to begin with to research their disease and at least move forward to someone who deals with that on a daily basis.

A regular oncologist deals with all different types of cancer. The CLL specialist, that's his job. This is what he gave his life into. This is what he does on a daily basis, and he sees many different CLL patients. So with that and then the objective of possibly getting onto a clinical trial you need to be with a specialist, and that's exactly what happened with me.

**Andrew Schorr:**

Well said. It probably saved your life given how sick you were.

**Bob Azopardi:**

No doubt.

**Andrew Schorr:**

When he went into his—Dr. Furman, when he went into the doctor, specialist where he ultimately was in a clinical trial you went in in a walker, right?

**Bob Azopardi:**

Right. I was with a walker for 22 months, and I also had my wheelchair with me. And when the prognosis came down from Dr. Furman and the clinical trial came up I—at first I wasn't really in favor of it, but I guess we'll discuss that further also, and I was told I really had no choice in the matter. So I took it, and it was a long road ahead, but it turned my life around. Turned my life around.

**Andrew Schorr:**

And you have a great boat. You go out on Long Island Sound and all that.

**Bob Azopardi:**

Yes, thank God. It was the—first trial I was on it gave me my life back. And, Andrew, as you know, prior to Dr. Furman I had seen many upscale physicians and especially one who was well renowned, and again by seeing Dr. Furman and having that clinical trial offered to me, you know, was it. I wouldn't be here if it wasn't for that.

**Andrew Schorr:**

Some of it is timing for sure, what's available and where.

So, Michele, you, of course, also go to a major center, Dana-Farber, and have another renowned specialist Jennifer Brown, but you talk to a lot of patients as well. So what would you say to people about the importance of being a self-advocate wherever you get care?

**Michele Nadeem-Baker:**

If I hadn't been a self-advocate, and as Bob was just saying, if he hadn't been, we would not have ended up with potentially the best treatment that is out there at the time. So one of the things by being, by advocating for ourselves, we were able to find out some of the options that are out there. When I was first diagnosed, even in 2012 there wasn't that much on the Internet that was all that credible. That's how I found you, Andrew, and Patient Power. You were just about one of the only few at the time that had anything that was truly credible and backed up by the medical community, the leaders in the community. So that helped guide me what to do.

I was from Boston to begin with, so I knew of Dana-Farber. If it wasn't for Dana-Farber, I would have gone somewhere else though if I wasn't familiar with it. It is so important to get a specialist and one of the leaders in CLL for us, because that helps us, at least for me, helps me have more confidence in what my oncologist is doing for me.

In Florida, it was a general oncology/hematology department, and I just did not have confidence in the care and the way the diagnosis was even given or in the doctor. I knew it wasn't going to work in a partnership. I would not have had confidence had he suggested any treatment.

So I think it's important for patients to also not only research what they have in the options, but to have confidence in, as Dr. Wierda was saying, the partnership with the doctor. From the other side, from the patient's side, you need to have confidence in that partnership.

**Andrew Schorr:**

So, Dr. Wierda, I don't want to be disrespectful to community hematology/oncologists. They're very devoted, and certainly there are some that take a special interest in CLL, and you spend a lot of time also in medical education trying to help get everybody up to speed, but how has CLL changed? I mean, it used to be there was sort of one-size-fits-all

approaches, going back to chlorambucil (Leukeran). It's changed dramatically now. So is it the complexity and maybe even the speed of change that makes it harder? What's changed?

**Dr. Wierda:**

I don't know that there's been a lot that's changed. We've gotten a lot of new drugs, and there have been nuances about managing chronic lymphocytic leukemia versus other types of leukemia all the way along since I've been involved in the field.

I think the comment that I would make with regard to the community oncologists, community oncologists work very hard. I went through the medical education process and trained as a hematologist and oncologist, and you have to know a lot about a lot of different cancers. And over the last 20 years, treatments have become super specialized among and across all of those cancers. The community oncologists have a huge task in terms of keeping up, and they for the most part will keep up very well with the common cancers, breast cancer, colon cancer, lung cancer, the types of cancers that they see a lot of in their community practice.

CLL, while it's the most common type of leukemia is a relatively uncommon disease, so it's another disease that they will take care of, they can sort of keep up, but the nuances and the data that's come out and the new treatments for CLL have made it—it's hard for a community oncologist to keep up with everything. And so for that reason it's very important I think for patients with CLL to get a consult and to get an opinion from a specialist, particularly at the time that they are discussing treatment with their oncologist.

Now, the one thing I would say, I was just this weekend at a meeting with a whole bunch of specialists, specialists from New York, from Boston, from all across the country and Michael Hallek was at this meeting. And even among the specialists you will get different opinions and different approaches to managing CLL. So I think it's important to talk to a specialist. If you start going from specialist to specialist, and some patients do that, you will realize that there are different approaches, and you have to be sort of cautious. And that's where sort of this partnership is important and what's your philosophy and what's important to you in terms of management of your disease becomes very important. So I think that's something to consider.

**Andrew Schorr:**

Right. Well, I've had that very discussion. So my specialist now in San Diego, Bill, you used to work with, Tom Kipps, we had a discussion about infused therapy versus oral therapy. What was right for me? Which would be effective? Which would be more convenient? Which would be covered by insurance and to what extent? So there are a lot of discussions that you have, but I think part of what Michele and Bob and I would say is you need to find someone that have confidence in and also check in with a specialist or two to get their take on the range of options.

Now, let me talk about the range of options for a minute. So, Dr. Wierda, you're at a major research center, and in New York City, Bob has gone to major research centers and Michele in Boston, and so often that's where there are trials as well. So part of the discussion today is not just about an individual approved therapy or a new combination, it's also about something that could be in trials as well. It's like it could all be laid on the table, right? Both experimental on one end and standard old therapy on the other, and that's part of the discussion, isn't it?

**Dr. Wierda:**

So that is part of the discussion. We, when patients come to our center, would like to have a clinical trial available for everyone. So that spans the gamut of patients who have high-risk features and don't necessarily need treatment and will go on to a treatment protocol such as a vaccine trial all the way across the spectrum to patients who have failed the standard treatments and need an alternative new treatment, a new drug that we're working on to develop in patients who are refractory to all of the standard treatments.

**Andrew Schorr:**

Okay. So it's the whole range. So, Bob, is that what you asked for and would expect now, is, hey, doc, put it all out on the table for me? What have you got in the closet, and what do you have on the table right now?

**Bob Azopardi:**

Definitely. Definitely because I always speak with Dr. Furman, and I always say to him, you know, I'm fine now, but I know there are other novel therapies coming down the pike. What else is there? Suppose for some reason this doesn't

continue to work for me, it fails me, where do we go from there? Just lay it out for me so I know. And I think I can make a better discussion based on what he presents to me.

**Andrew Schorr:**

So you ultimately were in a trial for a drug that became known ultimately as venetoclax (Venclexta), but you were in the trial. But you'd been on other drugs. Some of those drugs have worked for other people.

**Bob Azopardi:**

That's correct.

**Andrew Schorr:**

Just didn't keep working for you. And for you, Michele, you had both what had become sort of the standard, the FCR treatment but then adding ibrutinib or Imbruvica to that, which you continue to be on today.

**Michele Nadeem-Baker:**

That's correct.

**Andrew Schorr:**

Okay. And both of you are doing well. So how about this, Dr. Wierda, you talked about the nuances of CLL treatment. We have more sophisticated testing than ever before, so that we're not all the same. You talked about high-risk features and this and that, you alluded to that. So is step one for a patient and their doctor to really get a clear picture of what's their CLL story at that time?

**Dr. Wierda:**

For me it is, and the reason for that is I like to have a clear picture of the patient's disease and what to expect or what we might expect given the particular characteristics of the disease. Now, you don't need to have all that information in order to manage patients, and you do need that information when you start a treatment, when they progress and have active disease that needs to be treated. You don't necessarily need it before that.

I like to have all that information, because it helps me to have an understanding of the patient's disease, how frequently I need to see the patient. And it sort of directs the conversations that we have in getting them sort of mentally prepared if I think they're going to need treatment in the not-too-distant future to give them some things to think about and decisions that they need to potentially make in the near future.

**Andrew Schorr:**

Now, you're talking about the patient making decisions, but it used to be more of us just said, well, doctor, take care of it. And maybe there's some people, they just say that. You do it. I don't want to know. Bob, what's your view of that now, today, because if you could, you wish the doctor could just flip a switch, and they'd take care of it, and you'd get better? It's not that way, is it?

**Bob Azopardi:**

No, it's not that way. And you do it, I don't want to know is a valid point. There are a lot of patients that go ahead and do that, but you always have to have that push and that understanding that with the way medicine is today and with what is coming down the pike for specifically CLL, there are options out there other than to just to flip the switch. Andrew, I was on the flip the switch, and let's see where we land you up for quite a while, you know, and it was always in my head that that five-year window at the age of 49 was closing in rather quickly.

**Andrew Schorr:**

You were told you had five years to live.

**Bob Azopardi:**

That's it. Five years and that was it. And as a sidebar, you know that my wife was a very big inspiration to me, and she did most of the research, because I was almost a basket case going through this. And if it wasn't for Linda, you know I would have never come out of Florida to be treated at New York Presbyterian. So I may have stuck with that, well, yeah, go ahead. Let's just treat me the way you want to treat me. We'll go from there.

But you know, your caregiver has to also fill in where you don't, where you fail. And like I said that's also very important. A caregiver who sometimes doesn't get most of the accolades that the patient gets or the physician gets, they fit in there very importantly, you know.

**Andrew Schorr:**

Right. Well, sometimes we'll go into greater detail about the love story of Linda really helping save Bob's life.

But also, Michele, you have your spouse, Brian, and he's been very active in your care and helping you be on track with getting the right care.

**Michele Nadeem-Baker:**

He has in researching the trials that are out there and coming to every single doctor's appointment, every single treatment, it's wonderful to have that support. I know not everyone is as lucky as Bob is and I am and you, Andrew, and it really does help make a difference to have someone else there along the way in case you miss something.

Last week, I had just a bone marrow biopsy, so I was a little out of it when I had my doctor's appointment following to update how my test results were. So to have someone else there to remember where I perhaps was not as clear-minded was integral to my making a decision whether to stay on the ibrutinib or not.

**Andrew Schorr:**

So, Dr. Wierda, so we alluded to this sort of changing array of treatment options in CLL and the nuances today. It seems like it's more than ever now. In your career, you've seen so much change, and you at MD Anderson you mentioned vaccines and such, you have a window into what could be next. You and I have talked about refinements in CAR-T therapy. Sort of CAR-T version 2.0, can that be more affordable for a wider array of patients. So how does someone—how did does a patient—they can't keep it all straight themselves, so how do they have this ongoing discussion with their doctor about what's right for them?

**Dr. Wierda:**

So it depends on if they're being followed regularly by their community oncologists or by their specialist. So the discussion about keeping up with what's new and ongoing in the clinical trial area, that discussion should happen with the specialist, because the specialist will have clinical trials available for the patient that they won't be able to get access to in the community.

Most of the time, the clinical trials are not done in the community. So the discussion should be with the CLL specialist about clinical trial options and what's available not only with that particular specialist but what may also be available at other centers and what's interesting and what's exciting, what people are hearing about and talking about.

When I'm interested in looking at what's open in clinical trials I go to [clinicaltrials.gov](http://clinicaltrials.gov). [Clinicaltrials.gov](http://clinicaltrials.gov) is a website that the government maintains that is current with regard to all of the active, ongoing clinical trials, Phase I, Phase II, Phase III clinical trials. So with that website you can pull up any trial right now that's active and ongoing. It has a search engine, and you can do a very good search with it. You've got to know the terms to use and what you're looking for, but it's a very good source if you're interested in doing some searching on your own.

But I think the discussion really should be with the specialist. And, you know, we have meetings, we have ASCO, with we have ASH. We hear about preliminary reports from clinical trials, Phase I trials. We hear about activity with, for example, CAR T-cell therapy and those. So we have two CAR T-cell trials open here. We didn't have that, say, a year ago. So we were hearing about the activity, and there were centers that were doing CAR-T work, so for patients who were refractory at the time we were referring them to Seattle or to UPenn to enroll on one of the active studies.

We have a lot right now of studies for patients who have failed standard treatments, who have failed ibrutinib and/or have failed venetoclax. We're having difficulty enrolling in those trials right now, because we have a lot of them, and patients are doing very well and there are fewer patients today than we had, say, three, five years ago who had had standard treatments and needed something new. So it's an important discussion to have, and it's best to be had with your specialist rather than your community oncologist.

**Andrew Schorr:**

Well, the good news is, as you say, many people are doing well, and we have two patients, one on venetoclax, one on ibrutinib right here who are doing well and me, who had infused therapy with obinutuzumab, or Gazyva, doing well after having FCR years ago.

So we have different stories, and I think that's one thing I wanted to get at. Each of you patients, Bob and Michele, you talk to other patients, and wouldn't you agree that what people have to hear is that your story may be different from mine. What works for you may not work for me or vice versa. We may have different side effects. Bob, do you tell people that, that it's not a one-size-fits-all?

**Bob Azopardi:**

Exactly. You're exactly correct, Andrew. You know, from the people I have met—it's been a long journey, and I hope this journey continues. However, you know, when you're sitting in an atmosphere of having, let's say, chemotherapy, if we go back to that for just a second. Chemotherapy works different on everyone. I had somebody sitting next to me who was doing fine, and I got deathly sick on rituximab (Rituxan) after I had taken 15 treatments of it, so go figure that. So you really never know. It's not defined and put down in stone that my side effects to any of these drugs and/or trials is going to be the same as someone else's.

**Andrew Schorr:**

Absolutely. So, Michele, listening to this what would you say to people today so that they get what's right for them? We have more sophisticated treatments. We have even a variety of thinking sometimes among the specialists, and we have a moving target of medical science moving forward with all of us hopefully having a very long-term condition. So what do you tell people?

**Michele Nadeem-Baker:**

For those who are newly diagnosed, I generally say to them that things have changed, that there is so much out there already to treat them or in the pipeline that it's important to get, if you're comfortable with it, on a clinical trial to get tomorrow's treatment today, which, as Dr. Wierda was saying, is available at the different larger centers or to go in for a consult on that. Go to [clinicaltrials.gov](http://clinicaltrials.gov) to find the clinical trials in your area.

But the other thing is, I'll reiterate what Bob was saying, it is not one size fits all. The three of us here probably all have different genetic indicators, like I'm 11q IGH unmutated. I know you're different than that, Andrew, and Bob, I'm not sure.

**Andrew Schorr:**

We're mutated.

**Michele Nadeem-Baker:**

So that also I know goes into what's going to be more effective for you versus me, and then there are other factors as well. So to have the big picture, to understand what you have is also the other integral part, to understand what it is they've got. You don't just say I have CLL, as we know, just three of us here. As patients there are all sorts of varieties of this disease. So that's also good to know yourself, what there is, so that when you're starting to research things you can see what's happening out there and what would be best for you.

**Andrew Schorr:**

Yeah. So we call this the Partners series. So I have my ongoing discussions I did with my community oncologist who is very dedicated to CLL as well. When I used to live in Seattle, and I was in a long remission, and we would have these ongoing discussions, just like Bob said. What's changing? What could be an improvement for me should my remission end? Or if you're in watch and wait what's changing and what applies now?

And we kind of became friends, and, Bill, I'm sure, thank God, with many of your patients now, you're still a relatively young guy, but some of the people you've known for many years. I mean, you've known me for many years, and so that truly can be a partnership with your provider on kind of a continuing discussion of what's right for you at different points along the journey.

**Dr. Wierda:**

Yesterday, I saw three patients in the clinic who I had seen for 20 years since I started working here at MD Anderson. That's just in one day. So now more than ever we're having very long remissions and very good outcomes, particularly with the newer agents where you're exactly right, patients—and my opinion these days is that the life span of an individual with CLL, particularly for people who are over 65, 70, their lifespan should be and probably is what it would be if they didn't have a diagnosis of CLL, even if they need treatment. And that wasn't the case 10 years ago.

**Andrew Schorr:**

Wow. And on the flip side, frankly, we do get emails from some younger people, and I'm sure you see them with CLL, but the landscape of what you're doing in research could well pay off for them to hopefully give them such a long life as well. Wouldn't you agree?

**Dr. Wierda:**

Absolutely. And we are very excited. Most recently we've been doing a lot of work with combination trials and getting extremely deep remissions with the combinations that we're testing, for example ibrutinib plus venetoclax. We won't know for a few years how much of an advance that is, but we will eventually have that data. So on the clinical trials that we're doing now we think that we are achieving better responses, better depths of remission and fundamentally changing the biology of the disease and the outcomes for patients with CLL.

**Andrew Schorr:**

Well, it's certainly an encouraging story. One of the physicians that Bob saw along the way is sort of, along with Dr. Keating, one of the grand older men, in this case pretty old, Dr. Rai in CLL, and we had a conversation with him years ago as he began to identify some of the factors that were affecting CLL patients in different ways, and we talked about how they were starting to have a lot of furniture in the room. They knew there was this characteristic and that characteristic, not all CLL was the same. And I said, well, someday you're going to learn how to arrange the furniture. And it seems like that's happening now. You're starting to group drugs together, like you just talked about a novel combination, and know who it's right for. And I think that's very exciting.

So I think, Michele, it seems like the patient's responsibility, or Bob talked about, referred to Linda, his lovely wife or you Brian, with help from your loved one who is your partner in this, is to stay informed because you're a moving target perhaps with whatever, wherever the CLL goes, and the treatments are a moving target. And so you have to stay up on that.

**Michele Nadeem-Baker:**

Absolutely. The lesson always learned is just because you're doing well and hopefully you'll continue to but you don't know for how long yet. So that's said to be proven and it's good to stay on top of what's about to come out, as it's good for your partner as well so that they are also prepared.

**Andrew Schorr:**

And do you view your doctor as your partner as well?

**Michele Nadeem-Baker:**

I do. Because she is in one respect the gatekeeper and knows more of some of the clinical trials that are yet to happen, yet to be open, which is also—she is the holder of that particular information that may not be yet on [clinicaltrials.gov](http://clinicaltrials.gov). And she possesses a lot of the knowledge out there—the trial I'm on happens to be, originated at Dana-Farber, so the data points for the trial I'm on are held there, so they would know them first. So, yes, she is absolutely my partner. Inaudible.

**Andrew Schorr:**

Let's just underscore that point before we go. So I was in a clinical trial with one of Bill Wierda's mentors, Dr. Keating, way back in 2000, the original FCR Phase II trial, and it led to a 17-year remission. So I'm very grateful I went the extra mile to see a CLL specialist, made a big difference for me. So I think again you owe it to yourself to have that consultation. Bob went first, initially in Florida and then up to New York, connecting with different specialists there and ultimately New York Presbyterian, and that's led to a great remission for you, too.

So Michele put in a commercial for clinical trials, Dr. Wierda referred to it too, but we also, I want to underscore that Dr. Wierda mentioned and many people are doing very well on ibrutinib today. Many patients are doing well on

venetoclax, and there may be other even individual therapies to come, so that discussion of is there an individual therapy, is there a combination therapy that's approved for you, or is there a trial and stay informed about it as best you can. Bob, did I sum it up pretty well?

**Bob Azopardi:**

You got it, Andrew. Right to the point, sir, you're exactly correct.

**Andrew Schorr:**

Okay. All right. So, Bill Wierda, you okay with people speaking up and not feeling like they're being disrespectful of their doctor?

**Dr. Wierda:**

I don't know that it's necessarily—I mean, I don't think any of us in the CLL community physician-wise, the specialists, feel that they're being challenged or questioned when we get questions from patients. I think it's very important if you go to see a specialist that you do your homework, you read about the disease, you know what your own characteristics are of your disease and you have done your homework and read about that. You write your questions down.

You should have a list of questions for your physician, a specialist when you see them so that you can have a good discussion and feel like you have a better understanding. Because you don't always have to have a discussion necessarily about selecting a treatment at the time or—it's very important that you have an understanding and sort of a long-term view of the disease because right now we are getting more and more standard treatment options.

I was at a meeting this weekend where we reviewed the CLL14 data. Now, the CLL14 data was a frontline trial. It will probably lead to the approval of venetoclax and obinutuzumab in the frontline setting. So in the frontline setting when that happens we will have venetoclax-obinutuzumab. We will have ibrutinib, and those two treatments have never been compared so we don't know which is better of those two. And then we also still have chemoimmunotherapy in the frontline setting, which most of the specialists would not go to these days. But we will have two options, and it's a discussion about which of those two options is better for any particular individual. And so do your homework and write your questions down.

**Andrew Schorr:**

Okay. And just to define it for people, when you talk about chemoimmunotherapy you were talking about bendamustine (Bendeke), Rituxan or...

**Dr. Wierda:**

FCR.

**Andrew Schorr:**

...fludarabine-cyclophosphamide-rituximab (Fludara-Cytosan-Rituxan).

**Dr. Wierda:**

Yes. Chemo, which most of us would like to see go away in the CLL community. And I think that's going to happen. We just need to have some data. And right now for the first treatment really FCR would be the standard treatment for young, fit patients who have a mutated immunoglobulin, and we—most of us wouldn't use it for anybody else.

**Andrew Schorr:**

Okay. All right. Well, first of all, Bob Has a Party. I am so delighted to see you on video. You're my best friend, and I just am so delighted you're doing well, Bob. And one of these days I'm going to come from California, we're going to go take a ride in your boat.

**Bob Azopardi:**

I would suggest doing this in the summertime.

**Andrew Schorr:**

In the summer.

**Bob Azopardi:**

If you come tomorrow it wouldn't be that well.

**Andrew Schorr:**

Okay. And, Michele Nadeem-Baker—first of all, all the best to Linda with you, Bob. And Michele Nadeem-Baker, you look ravishing, as you always do, and Brian's a lucky guy. And thank you. I'm glad you're doing so well, Michele.

**Michele Nadeem-Baker:**

Thank you. Thank you. You too, Andrew. Glad to see you're doing so well.

**Andrew Schorr:**

Thank you. And, Dr. Bill Wierda, as always, thank you for your dedication to patients, Bill and I'm excited that you have so much to work with now, and may you have many 20-year, 30-year, 40-year patients, okay?

**Dr. Wierda:**

Yes, thank you, Andrew. And thank you for all of your service to the CLL community and your educational efforts. I think it's extremely important. And my experience has been that the CLL community in general more than probably any other community is a very well informed, well informed community. And I think that's in part due to the work that you do.

**Andrew Schorr:**

Well, thank you. I've got a great Patient Power team. There's some wonderful advocates along the way. So partnership, right? This is the first of our Partners series working together with folks like Dr. Wierda or whoever your doctor is that you have confidence in so that you get what's right for you. And with help from a partner in your family perhaps who is on your side as well. Thanks to Pharmacyclics for sponsoring this series. In Carlsbad, California with Bob in Boston—rather, Bob in New York and Michele in Boston and Dr. Wierda in Houston.

Remember, knowledge can be the best medicine of all.

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