CLL Ireland 2017: Dr. Thornton Discusses the Unmet Needs in CLL - Transcription

Brian Koffman - Hi. I'm Dr. Brian Koffman, a family doctor, and a CLL patient myself, and the Founder and Medical Director of the CLL Society.

Patrick Thornton - Hi, I'm Patrick Thornton. I'm a consultant hematologist in Dublin in Beaumont Hospital and the College of Surgeons. My main interest is CLL and research and CLL clinical trials.

BK - So, as a researcher and a clinician, you would have an insight into what some of the unmet needs are of the CLL community. Could you address that, maybe in particular in Ireland, but could also apply generally to the whole CLL community across the world?

PT - Well I think, there are a few. I'll try and be brief, but comprehensive. CLL primarily is a disease of older people and with increasing age, you have increasing comorbidities.

BK - By comorbidities, you mean other medical conditions, like heart disease or kidney disease or diabetes, or even psychiatric issues can be an issue.

PT - Yes, that is correct. So one of the issues is we need a treatment that is fit for those patients, so reduce the side effects, but still be efficacious. For example, we have Chlorambucil, many years ago, which is tolerated by many people, but didn't work very well as a single agent. Now we have Chlorambucil added with obinutuzumab, which improves the efficacy with not that much increase in the toxicity.

BK - And obinutuzumab is a new antibody that's been used that really bumps up the ability of the old traditional chemotherapy, which is a gentler chemotherapy agent.

PT - Yes, so what we need is we need treatment which is available to all patients with low toxicities and good efficacy, frontline. We also need to improve who needs the targeted therapy. Some people will respond very well to chemotherapy. Some people with a deletion of P53, which is a bad prognostic indicator, shouldn't have chemotherapy, but there is more to it than that. We're working towards identifying the patients who are at-risk before we treat them and there's a focus on research now to identify what you would call "the bad actors" or "the bad prognostic markers", and then the other reasons, how do we do this? What's the best way to do this? You could sequence someone's genome, but it could only be done in a large sensor and it would cost a lot and take a lot of time. Now with what's called next generation sequencing, we're able to sequence the genome and look for these bad targets and that's the way of the future research in Europe and the States to identify the bad actors so we can target the therapy better. The obvious gap in our treatment of CLL is the people who get Richter's transformation. This is where their CLL transforms to a hybrid lymphoma and we still have no great treatment for that, so that is a huge gap in the unmet need.

BK - That's relatively rare, though?

PT - It is rare, but there's very little we seem to be able to do.

BK - And as we're living longer, it's becoming more common. It used to be isolated numbers of 5%, now maybe 10%, maybe even more because we're not dying of our CLL, so we have been living 10 years with CLL and our risks become higher.

PT - Absolutely, and P53, the novel agents do work, but the curve is still going down. So we've done a lot of work on treating P53 deleted CLL, but patients are still relapsing of their disease, so we need to improve on that; and then the ultimate goal is many patients don't want to be on treatment forever. Many patients don't want to have side effects, albeit small, but when they have their disease, they'll tolerate side effects because they can see the benefit. The danger is as disease disappears and they don't have their disease and they're not so much aware of it, then the side effects become an issue. So when you're on a treatment for a very long period of time, side effects then become an issue. Perhaps we need to look at the side effects, but also perhaps, with combination treatments of novel agents, we need a day where the treatment is finite and we can stop it, and so patients are off treatment, and that's a difference between what you would call a relapse-free interval and a treatment-free interval, and so I would like to see the day that our treatments are well tolerated, but also we're actually, possibly able to stop them and monitor patients.

BK - A finite duration of therapies. So we're on the exact same page. We're looking for less-toxic treatments. We're looking for combinations that may be more helpful and, as you said, a finite therapy. We're looking at some of the unmet needs of people who relapse who have the more aggressive forms of CLL, complex karyotype, 17P, P53 deletions, Richter's transformation, these are the things, yeah, and I agree, those are the real unmet needs we have. Any final thoughts you would want to share with the patient community or caregiver community out there?

PT - I would just like to say that, forgive the cliché, but the future seems very bright. If you had had this interview with me perhaps five years ago versus today, what we've done over five years in our understanding and the disease, the frontiers we've pushed with regard to treatments in a very short period of time; hopefully you'll have this interview again in five years time and the way things are moving, and the way patients are benefiting from this, I think the future's encouraging. I think it's a good news story.

BK - Well, we're excited that you're part of that and doing the research because I think the biggest unmet need is to get us to cure, you know, and that's still in the future. Thank you, Dr. Thornton.

PT - Lovely. Thank you.

BK - Thanks.

PT - Thanks a lot. Thank you.