CLL Society

Transcription: iwCLL 2017: Prof. Hillmen on MRD Negativity in CLL

Dr. Brian Koffman - Hi. I'm Dr. Brian Koffman. I'm a family doctor, CLL patient, and the medical director of the CLL Society, here in the last minutes of iwCLL and I'm here with a friend from the United Kingdom.

Professor Peter Hillmen - Hi, I'm Professor Peter Hillmen, and I'm a hematologist from Leeds and I chair the UK CLL group and I'm here enjoying iwCLL.

BK - So, Professor Hillmen, you talked a little bit today about MRD negativity.

PH - Mm-hmm. (affirmatively)

BK - Well, first, could you explain what MRD is, and why that might be important to a patient?

PH - So, MRD stands for minimal residual disease, or we could call it “measurable”, so it's the least disease we can measure with our most sensitive tests. So, that means we can identify down to 1 cell in 10 or a 100 thousand, and most people consider MRD, if you're negative, it's the best remission you can get because you can't detect CLL.

BK - And we've known for a long time that getting to MRD negative with the old medications, chemoimmunotherapy (like FCR), gave you a better prognosis. But, there was some new data today where we are starting to get some emerging information about the new drugs and how important that would be. Could you kind of explain to patients what's going on there?

PH - So, we're now getting, certainly with single agents, with venetoclax particularly, but also with combinations with these non-chemotherapy drugs, higher proportions of patients into remissions that we can't measure the disease and we're starting to combine the new treatments to with each other. It's a non-chemotherapy, and seeing even higher response rates. So, I think that we're using that in several ways. One is, these drugs at the moment are used indefinitely and we are hoping to drive the disease to such a low level that maybe it won't come back or it'll take a long time to come back when we stop therapy. So, that obviously has an advantage. And secondly, in the frontline setting particularly, but I think generally, with thinking that, can we cure patients with combinations of non-chemotherapy treatments? It's a high aim, but I think we all think, and the patients I am sure think, that's what we should be doing. It'll take us a few years to prove it, but the data we're getting is very encouraging.

BK - And I always say, you can't get your cure without passing through MRD.

PH - Mm-hmm

BK - So, any final thoughts for patients about MRD, whether their physicians should be measuring that, about how that fits in for a CLL patient today?

PH - Well, I think MRD at the moment is in the trials and I certainly thinks it's a useful… I use it outside of trials as a useful measure of what's happening with patients with a good response. So, I think knowing about MRD is useful. I don't think at the moment we should be changing things outside of the trials. I would encourage patients to go into trials because we are really

making progress in it and the combinations we are seeing in trials are innovative and that's where we're seeing the best responses.

BK - Professor Hillmen, thanks so much for the work you're doing for your patients and for the CLL community. Thanks.

PH - Thanks, Brian. Cheers!