



CLL SOCIETY

The CLL Bloodline June 2019

MONTHLY QUIZ: Choose the correct statement below:

1. CLL most commonly presents in men and in the elderly (over 70).
2. CLL has two peak incidences: a smaller peak at age 50 and a largest one at age 72.
3. CLL is most common in women in their 50s and 60s.
4. CLL affects men and women equally.

ANSWER: The correct answer is #1.

CLL is more common in men and the average age at time of diagnosis is 72. It is quite rare but possible for those under 30. It is more common in Ashkenazi Jews and less common in Asian.

THE BASICS: Treatment Choices

In our last issues of *The CLL Society Bloodline*, we covered what needs to be done when first diagnosed, before treatment, and how to know when treatment is needed. In this issue, we broadly discuss frontline treatment choices. Treatment decision should always be individualized and depends on several factors including:

- Your age, your overall health, and any co-morbidities.
- Your prognostic factors (especially FISH, TP53 mutation and IGHV mutation).
- Your personal preference.

Your choices are complicated and there may be significant disagreement between well-meaning experts, making it even harder to make a decision. The approved **frontline** treatments broadly fall into 4 categories with significant overlap:

- 1: Chemo-immunotherapy or CIT including FCR (fludarabine, cyclophosphamide and rituximab) and BR (bendamustine and rituximab) and chlorambucil with obinutuzumab.
- 2: Ibrutinib, a targeted oral therapy with or without obinutuzumab.
- 3: Venetoclax and obinutuzumab (see **NEWS** below about approval last month)
- 4: Clinical trials.

All of these are explained in more detail in the treatment, FAQ, and clinical trial sections of our website and will be the subject of upcoming Bloodlines: <https://CLLSociety.org>

NEWS:

As we mentioned for the groups that met in the last half of May, the combination of venetoclax and obinutuzumab was approved May 15 for treatment naïve patients. It is the 1st fixed duration non-chemotherapy frontline therapy.

On June 4, 2019, at 10:00 – 11:00 AM PDT the CLL Society is doing its 1st webinar on **Financial Toxicity**. For more info and to register, please see: <https://cllsociety.org/moneymatters/>

On July 22, 2019, at 10:00 – 11:00 AM PDT the CLL Society is conducting its 2nd webinar on **Dealing with the CLL Emotional Rollercoaster**. For more info and to register, please see: <https://cllsociety.org/psychology/>

WORD/ACRONYM OF THE MONTH: U-MRD

U-MRD stands for **undetectable minimal residual disease**. When CLL is no longer detectable by imaging of the nodes and other organs and by routine blood and bone marrow tests, we are in a complete remission (CR), but there can still be some amount of residual disease. Using precise testing, we can search for as few as one cancer cell per 10,000. If none is found, we are said to be U-MRD and that is very good news. That doesn't mean there is no cancer. It simply means there is no detectable cancer. MRD can be tested in both blood and bone marrow. Also, it is possible to be MRD negative in both, but still not be in a complete remission if some nodes or the spleen are still enlarged. This may be due to scarring and not residual cancer which prevents the nodes or spleen to shrink back to normal size. We just published an interview with Dr. Wierda from ASH 2018 on MRD.

If the CLL Society has helped you or a loved one, please consider making a donation.