



CLL SOCIETY

## The CLL Bloodline August 2020

### MONTHLY QUIZ: CT scans should be used in CLL:

1. At time of diagnosis to establish a baseline.
2. Before treatment to assess staging.
3. After treatment to assess response.
4. Only in combination with a PET scan to assess both anatomy and the metabolic activity of any nodes or masses.
5. While they may be needed in some circumstances, outside of a clinical trial there is no mandatory role for CT imaging.

**The correct answer is #5.** While there are many circumstances where a CT may be helpful, their routine use with diagnosis or treatment is not generally indicated. PET scans measure metabolic activity and are used to look for a second cancer such as Richter's Transformation (RT). RT is more metabolically active than CLL and therefore will "light up" on a PET scan. Outside of clinical trials, CT and PET scans are not helpful in the routine management of our CLL. For more details, see:

<http://cclsociety.org/beyond-the-basics/what-about-ct-scans/>

### NEWS:

COVID 19 is still dominating the news and our lives. In recent weeks, articles were published in two prestigious peer-reviewed journals – BLOOD and NATURE – that shared data about ~200 CLL patients each who had contracted COVID-19. 90% were hospitalized and approximately 1 in 3 died. The results should give us pause but remember this was collected early in the pandemic when we had less-effective therapies. Also, we don't know how many had mild disease and were not included in this data as their hematologist only cared for the sickest patients. Dr. Koffman has written extensively on this topic on the website and has inserted links to the full articles and perspectives from the researchers in text and video. For now, it is best to try to practice what we know limits our risk: social distancing, facemasks, handwashing, and avoiding most non-essential contacts. Visit the CDC website and the CLL Society's COVID-19 Updates page for all the latest information as this situation develops.

### BASICS: Response to Therapy

In order to be consistent, doctors and researchers have agreed on standard ways to describe response to therapy. The definitions are actually quite technical and are still evolving. This is a simplified version. If you are in a trial or on treatment, ask about your response status. We go from worst to best:

- **Progressive disease (PD):** As the name suggests, the CLL continues to grow despite therapy. This is not good news.
- **Stable disease (SD):** The cancer neither progresses nor recedes. This can be a durable and an OK circumstance, especially if the CLL is not causing problems.
- **Partial Remission (PR):** The cancer has been knocked back, but there are still cancer cells to be found in the blood or marrow or nodes. PR requires at least a 50% reduction in the size of lymph nodes and in the number of lymphocytes in the peripheral blood stream.
- **Complete Remission (CR):** The absence of clonal lymphocytes in the blood is one of the major criteria. All lymph nodes need to be normal size (<1.5 cm). In a clinical trial, the confirmation of a CR usually requires a bone marrow biopsy that shows no CLL. There is ongoing debate as to whether the maximum size of a node that is still considered normal should be redefined upwards.
- **Undetectable Minimal (or measurable) Residual Disease (uMRD):** This is the best news with the longest durations of response. Flow Cytometry can be used to find a single CLL cell hiding among 10,000 cells in the blood or bone marrow. Next generation sequencing (clonoSEQ) can find 1 cancer cell in a million. If no cells are found, you are uMRD, a very good thing. Just to confuse things, it is possible to be uMRD and be in a PR if your nodes are still enlarged. This happens when enlarged nodes don't shrink back to normal size but are cancer free. Research is pointing us in the direction that achieving uMRD might be more important than reaching a CR.

### WORD OR ACRONYM OF THE MONTH: ALC

ALC stands for absolute lymphocyte count is the number of lymphocytes per microliter ( $\mu\text{L}$ ) of blood. It is the only lymphocyte number that matters, and even it doesn't matter that much. If the ALC is too high ( $>5,000$ ), CLL may be the diagnosis. A rapid rise in ALC (increase of  $> 50\%$  over a 2-month period or a lymphocyte doubling time [LDT]  $<6$  months) may mean treatment for CLL is imminent. A high ALC is not a reason on its own to treat CLL. Ignore the lymphocyte percentage. It is not helpful in CLL management.

*The CLL Society is invested in your long life. Please invest in the long life of the CLL Society*