



CLL SOCIETY

The CLL Bloodline February 2021

Over the course of a year, the CLL Bloodline will teach the BASICS needed to understand CLL in monthly meetings, share news, explain acronyms and new vocabulary, as well as offer a simple and fun quiz.

MONTHLY QUIZ QUESTION: Chemo-immunotherapy (CIT), specifically FCR (fludarabine, cyclophosphamide, and rituximab) can result in very long remissions. Some would go so far as to say that this treatment option is starting to look like a cure when used as a frontline therapy for CLL patients who:

- A. Are missing the short arm of chromosome 17, also known as deletion 17p.
- B. Have mutated IgHV.
- C. Have unmutated IgHV.
- D. There is no way to predict who is more likely to respond to CIT.

ANSWER: The correct answer is B. FCR has been proven as the best CIT in CLL when used in young healthy patients. It has resulted in long remissions for some low-risk patients with mutated IgHV who have no other negative prognostic factors, including no 17p or 11q deletions or mutated TP53. Sadly, only about one in seven CLL patients fit into this group. Over half of those with mutated IgHV who were treated with FCR had no CLL progression for 13 years. More recent reports show no new cases of progression or deaths occurring for up to four years after that. In fact, for healthy young patients with all the best prognostic factors, if FCR gets them to where there is undetectable measurable disease (U-MRD), sometimes also referred to as undetectable minimal residual disease, then they have an almost 80% chance of never needing more treatment.

However, if one does not fit into that specific low-risk group, outcomes are much worse. FCR is nearly always ineffective in those with deletion 17p or TP53 mutations. Testing for IgHV mutation, deletion 17p or TP53 mutations should be *mandatory* before starting FCR. CLL Society's motto is: **TEST BEFORE TREAT™**. Unfortunately, testing is often not performed prior to treatment in many community hematology settings.

NEWS:

On 01/25/2021, information from the first head-to-head comparison study of two approved BTK inhibitors became available. Researchers reported that acalabrutinib and ibrutinib worked equally well in high-risk relapsed/refractory CLL. It was also reported that there was less atrial fibrillation with acalabrutinib.

THE BASICS: What do you do when you are first diagnosed?

CLL is usually slow growing, which provides plenty of time to form a treatment plan. Please do not neglect routine preventive care, since CLL increases the risk of many secondary cancers. Especially age and gender appropriate cancer screenings such as PAP smears, mammography, prostate exams, colon cancer screening, and particularly skin checks. Stay up to date with vaccinations, including the annual flu shot. However, avoid live vaccines (such as yellow fever and MMR) as they are not known to be safe in CLL. Most importantly, take time to carefully put together your treatment team (see the CLL Society's online Toolkit for tips), join a support group, and learn as much as you possibly can about your disease.

WORD/ACRONYM OF THE MONTH: LYMPHOCYTES

Lymphocytes are white blood cells. There are three types: B cells, T cells, and natural killer (NK) cells. CLL is a cancer of the B cells. Normal B cells, part of our adaptive immunity, mature into plasma cells that make antibodies that fight infections. T cells are the soldiers of our adaptive immune system that either direct or do the killing of infected or cancerous cells. NK cells are the first responders, part of the more primitive innate immune system, killing cells infected with viruses, and detecting and controlling early cancers. All together, they are quite the team!

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