# Facebook Live Event Transcript
# Ask Me Anything – Featuring
# Dr. Alan Skarbnik and Michele Nadeem-Baker
**November 15, 2024**

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Hello everyone and welcome to the CLL Society's Ask Me Anything virtual event.

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I'm honored to be your host today.

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I'm Michele Nadeem-Baker, a CLL reporter, advocate,..

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co-founder of Kicking Cancer in Heels, and like many of you watching,..

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I am also a CLL patient.

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I'd love to welcome my co-host, Dr. Skarbnik.

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Thank you for being with us.

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And would love for you to please tell our audience a bit about yourself.

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First thing, thank you so much for the invitation to the CLL Society. I'm Alan Skarbnik. I am the Director of the Lymphoma and CLL program at the Novant Health Cancer Institute in North Carolina.

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I've been working solely with CLL and lymphoma for the better part of the last decade.

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I've been a member of the Medical Advisory Board for the CLL Society and…

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I am very happy to participate in this, and uh,..

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answer questions and thank you for the work of the CLL Society and you, Michelle, as a patient advocate.

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It's always great to be working together with the patients and their…

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and their advocates to further the field and improve their lives.

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Well, it's a pleasure to be here with you today, doctor. We have so many questions that have been sent in and we thank…

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those of you who sent them in who are watching us today, and we have more questions coming in live through our Q&A. And if you have any questions for those of you in the audience,..

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please go to the Q&A button at the bottom of your screen and send them in.

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And we'll get to as many as we can today. So let's start out doctor, talking about treatments and testing.

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This is, of course, what we all want to know as patients is what's happening out there and the best for us.

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So are there any CLL treatments that you expect…

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to be FDA approved next or in the near future?

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Well, this is a very good question. There's a number of…

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new treatments on the horizon,..

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like treatments that are not at all approved yet…

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and there are treatments, there are combinations of things that we already have that may be approved…

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in the near future. So, what people are looking at now, I mean, one of our goals is to…

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minimize duration of treatment for patients, their side effects associated with that, and also financial toxicity so…

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AMPLIFY is being presented at ASH this year as an example of…

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one of many trials being presented…

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which is looking in the fixed duration combination of acalabrutinib with venetoclax with or without obinutuzumab.

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So the top results seem very positive and hopefully, that those combinations will be approved in the near future.

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There are studies with BTK degraders, which is a different way to tackle BTK, and we have been seen in patients…

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who received BTK inhibitors and the drug is not working anymore…

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so instead of blocking the molecule, these drugs degrade the strider molecule itself…

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so that's an exciting area of study in CLL.

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There are studies with bispecific antibodies as well. There are studies with other cellular therapies. We know that CAR-T cell was approved this year…

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for the treatment of CLL. So,..

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very exciting new things. We always wait for the annual meeting of the American Society of Hematology to know what's going to come next so…

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hopefully by January, we have a better grasp of what's going on.

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Well, we look forward to learning more about those. And do you think that degraders are on the horizon of being approved already or is there more work to be done on them?

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Now, there's going to be more work, but that's kind of what I'm waiting to be approved in the…

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next couple of years, that's kind of the next in line that we're really excited about.

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I'm excited to learn about all these as well. What tests are available to determine a complete remission in CLL…

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leukemia with 100% certainty?

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Okay. I tell my vision, nothing is 100%, right? I mean, we can never be 100% sure of anything.

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Okay.

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So, there are the definition of confirmation that are defined by the iwCLL 2018 criteria, which is…

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recovery of the blood counts...

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to normal levels; if lymph nodes, there are no lymph nodes that are larger than 1.5 centimeters on a scan;..

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and in the bone marrow biopsy, there's no evidence of CLL, there's no…

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lymphocyte nodules in the bone marrow and things like that.

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So that's the definition of complete remission.

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Now, we tend to go a step further…

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in clinical studies right now, which is checking for minimal residual disease or measurable residual disease...

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because this test only goes so far.

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Uh, and we look…

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at a molecular level, if we can capture the presence of CLL cells...

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and the level that a test can capture. So the deeper test we have commercially available right now is what's called next generation sequencing,..

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people may call it clonoSEQ. It's been adaptive as a company. It can be done in the blood. It can be done in the bone marrow.

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And the task captures…

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one cell in a million cells. So, if we'll evaluate a million cells with next generation sequencing…

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Okay.

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that test is able to capture a single abnormal CLL cell.

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But if there's one in 10 million, that test won't be able to capture. So that's the level of detection.

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So that will be the most…

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reliable testing…

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to show full remission.

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So if my testing comes back…

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and it isn't clonoSEQ, but my testing comes back that I am extremely close

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Mm-hmm.

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to undetectable minimal residual disease but that initial testing through my blood…

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or perhaps a traditional bone marrow biopsy result…

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is not at UMRD, do I still request clonoSEQ?

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You're talking about other forms of testing MRD because it's either multicolor full cytometry…

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or PCR or next generation sequencing.

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Those other tasks have a lower threshold level is general 1 to 10 to the minus four,..

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so it's one in 100,000 cells.

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I'm sorry, one in 10,000 cells…

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that that test dates.

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So the detection level is a little lower. It depends what you're using this for.

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The older trials,..

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older, the trials that have been reported for the past couple of years…

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have used 10 to the minus 4 as the threshold of MRD detectability.

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The newer trials are going further. We know that…

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ten, undetectable at 10 to the minus 4 in the bone marrow…

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is a very good endpoint for measurable residual disease.

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We know, but, you know, bone marrows are…

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painful, bothersome, it's a procedure not everyone wants to do it multiple times.

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They're not fun.

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They're not fun. I can attest to that.

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We don't want to keep doing that for patients as well.

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So, we can test it in the blood. In the blood, if there is 10 to the minus five in the blood, which next generation sequencing…

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is able to get, it does correlate to 10 to the minus 4 in the bone marrow.

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So, it's an easy task. It's commercially available. It's covered by most insurances visits here.

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So if someone is looking at that level of testing,..

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that's the best we have right now.

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Great.

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But I want to remind that, you know, and this is kind of like nitpicky here but…

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you know there may be patients that the lymph nodes are a little larger than 1.5 centimeters because sometimes they may never come back to the normal size if they were too large to start with,..

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doesn't necessarily mean there's active disease there. It's just a criteria, that the consensus criteria, but you can have that will be called a partial remission…

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So you can still have undetectable MRD in the blood and in the bone marrow with that.

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So, you know, we have to take those things a little bit in stride,..

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and I mean, I don't know, the person who was asking that question we need to understand…

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what the goal of determining remission is, right? I mean, if you were on a continuous therapy with a BTK inhibitor, for instance,..

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most patients have partial remission and they do quite well…

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for many years, the disease is controlled so…

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not necessarily complete remission

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is the goal. It depends on what we're doing.

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So speaking of MRD negativity and complete remission or not.

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We have another question is, would you recommend prolonging venetoclax and obinutuzumab treatment to better ensure…

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testing MRD negative.

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Okay, that's a controversial question.

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Okay.

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I think it is a discussion I have with every patient.

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Okay.

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So to put things in perspective here,..

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the study that looked at venetoclax obinutuzumab is called CLL14. It was designed to treat 12 cycles.

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It's six cycles of obinutuzumab and 12 cycles total of therapy with the venetoclax...

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for everyone. And it was not what I call MRD guided so there's no continuation…

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of treatment in the study beyond the fixed duration time point…

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if MRD was detectable…

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at the end of treatment. They tested actually at three months after the end of 12 cycles.

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And we did see that patients,..

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70% of patients, give or take, had undetectable MRD at the end of treatment. So it's a pretty good chunk…

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there in the study. Of the 30%, the people had earlier progression of disease…

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were the patients who had…

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MRD detectable at the end of treatment now…

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that didn't mean that those patients…

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need a treatment at progression. I mean, it goes to the same kind of paradigm as we have…

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with active surveillance. I hate calling it watch and wait, by the way. I don't like the name. I think you're waiting for something bad to happen.

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It doesn't necessarily

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ring true. I mean, I have many patients who are decades…

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being monitored.

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So what do you prefer?

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Other than.

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Active surveillance. I think active surveillance is a better term, a number of other doctors feel the same way.

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You know, we are surveilling you. We know what we're doing. You know what you're doing as a patient.

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We know what to do if something happens, but we're not waiting for something to happen. I think just know…

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The wait part is just like, you know,..

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you're waiting for something bad to happen. It's like, I mean, to me psychologically, it makes a difference.

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But at any rate, the paradigm is the same. We're surveilling the disease until it gets to the point where criteria match for treatment to be…

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indicated again.

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Now, having said that,..

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this is a multi-layered question here. So give me a little latitude here because it's controversial.

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Will do. Will do.

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I think it's not. It is not for everyone. My take on it, when we looked at the study,..

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most patients who had..

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undetectable MRD at the end of treatment…

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had it at seven months, right after obinutuzumab was over.

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The patients who had were tested at that time point and still had detectable MRD at seven months…

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with additional treatment….

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to the end of the study, as it was designed,

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50% of those patients had a decrease in the MRD...

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or became undetectable, and the rest is either stable or was going up.

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Right? So uh,

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I think one single time point, it's hard to say.

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If we're going to look at MRD at the end of treatment...

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and we're going to discuss with the patient, should we continue or not, we should have that time point before as well.

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So usually what I do with patients that are interested in that, they check at seven cycles, I check at 12.

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And seven, if it's negative, it's likely to be negative at 12 as well. But if it was positive at 7 and it's still positive at 12, I'm looking at the trend, right? If the trend is going down and patients are almost there, have a discussion and say, hey, perhaps we should…

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continue venetoclax for a couple more months and see where we get.

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If the trend  table is going up, I don't believe additional therapy at that point…

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will be beneficial, actually, because we're seeing where the disease is going.

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So, it's a discussion I have with the patients. It's not necessarily for everyone.

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The data is questionable on that. This is a controversial kind of…

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approach and is a discussion you should have with your physician.

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You know, if it's the frontline therapy, it's the first line therapy,..

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most people do really well with 12 months of therapy and then afterwards.

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And we know we can retreat those patients with the same regimen if the disease comes back. So, there's that opportunity for that as well.

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So, I'm going to take a break for a second on venetoclax and obinutuzumab, which we have a lot of questions about, but..

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let's, let's um…

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let's go back a bit and that some of our viewers are asking…

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things such as what would be indications for treatment, never mind the treatment, but what…

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to just go back to some basics here.

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Okay.

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How do you know as a doctor that it's time…

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for one of your patients to start treatment?

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That's a phenomenal question.

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So there are the iwCLL 2018 criteria which…

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Thank you.

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help us identify who would…

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most likely benefit from treatment at that time. Now, having said that,..

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it doesn't mean that if those criteria are met, the treatment is mandatory.

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At that point, treatment may be beneficial. It's the minimum…

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that we need to say you should receive treatment in general...

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or to have a treatment discussion.

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So there are some criteria, there are more…

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clear cut and you know we should treat and there are some criteria that like…

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okay, we can have a discussion so…

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the criteria are if your lymphocyte count is doubling in less than six months or increasing more than 50% over 50% over two months.

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If you have rapidly, fast growing lymph nodes.

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If you have any very large lymph nodes, namely more than 10 centimeters in size, which is…

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three and a half inches, give or take for people who are not familiar with the metric system.

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If you have a very large spleen so, usually seven centimeters below the rib cage, if you have a very large liver,..

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if you have symptomatic involvement of any organ, if you have…

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flourishes or accumulation of fluid around the lungs because of CLL, if you have symptomatic skin infiltration because of CLL, for instance.

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If you have autoimmune destruction of your platelets and…

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or your hemoglobin because of the CLL and this is not responsive to steroids,...

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if you have progressive anemia.

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Generally, we use a cutoff of 10 grams per deciliter of the hemoglobin...

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to consider treatment or if you have progressive…

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thrombocytopenia, which is your platelets dropping, generally use 100 as the cutoff there…

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or if you have what are called B symptoms, severe fatigue that's attributable to the CLL,

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so it's just not like I'm feeling down, it's like you really, you know,..

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are not as functional as you were before.

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If you have drenching night sweats that happen most nights for at least a month,..

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fevers, that are unexplained and happens most days for at least three weeks…

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or weight loss that's unexpected of more than 10% of your base weight within six months.

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The symptoms, I think, are clear cut. People who are having drenched night sweats for a month,..

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you know, they are symptomatic from the disease. I think that those should be treated. Now,..

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is there a difference…

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in someone who has a hemoglobin at 10.1 and someone who has a hemoglobin at 9.9?

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Not really. So, you know, if patients are asymptomatic and it's taking a long time to get there…

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and there is some hesitancy about treatment,..

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we sit tight and we continue with the surveillance…

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knowing that the time for treatment may be coming up soon. So those are not, oh, it happened, you have to get treatment…

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but it needs to at least some of these things, or one of the things happen for us to consider treatment in the first place.

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And I know it's always free for doctors. That's always, there's so many..

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variables, right, for CLL to determine. Now, regarding night sweats,..

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someone had mentioned in the questions that they have them all day long.

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Mm-hmm.

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And…

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they're wondering if that counts as night sweats…

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when they have them like 24/7…

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or is that something else when it's during the day? I know personally,

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Well...

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I had them, it seemed all the time, but also um,..

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it's kind of hard to determine when you're of a certain age in life...

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Yeah.

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between what's happening, you know, are they hot flashes and night sweats? Are they just night sweats?

00:28:57.000 --> 00:29:00.000
But they're more than nighttime.

00:29:00.000 --> 00:29:02.000
Is it possible?

00:29:02.000 --> 00:29:08.000
It is. Now you have to exclude the other possibilities, right? Particularly, you know, in perimenopausal…

00:29:08.000 --> 00:29:16.000
women are they hot flashes or are they actual sweats? Yes,..

00:29:16.000 --> 00:29:18.000
sweats can happen during the day.

00:29:18.000 --> 00:29:24.000
It is at nighttime, it's a little more specific of this. It's just because of…

00:29:24.000 --> 00:29:28.000
deregulation of your internal thermostat that happens...

00:29:28.000 --> 00:29:33.000
with inflammation and that drives to that because your body temperature…

00:29:33.000 --> 00:29:40.000
should drop at nighttime so that's kind of why this becomes a little more specific.

00:29:40.000 --> 00:29:47.000
But yes, it can happen at daytime. If it is at that point, generally that's not the only symptom.

00:29:47.000 --> 00:29:55.000
People are tired, right? You are seeing a change in their blood counts that's significant or…

00:29:55.000 --> 00:30:03.000
lymph nodes are growing or your LDH is going up. I mean, usually you start seeing that happening too.

00:30:03.000 --> 00:30:07.000
So usually that doesn't come alone...

00:30:07.000 --> 00:30:13.000
in my experience. But yes, they can happen during the day too.

00:30:13.000 --> 00:30:21.000
Okay, we have so many questions. Thank you all for sending them in and those of you who sent them in ahead of time.

00:30:21.000 --> 00:30:23.000
So,..

00:30:23.000 --> 00:30:28.000
getting back to some of the treatments, we have a lot of questions about Calquence...

00:30:28.000 --> 00:30:32.000
and how long you need to stay on Calquence…

00:30:32.000 --> 00:30:36.000
and how long it takes to kick in and…

00:30:36.000 --> 00:30:42.000
it gets you to UMRD is one of the questions.

00:30:42.000 --> 00:30:43.000
So I know that's,..

00:30:43.000 --> 00:30:45.000
Okay.

00:30:45.000 --> 00:30:47.000
going to be a bit of a complicated answer from you.

00:30:47.000 --> 00:30:53.000
Okay, so Calquence and all the BTK inhibitors

00:30:53.000 --> 00:30:59.000
as a single agent or even in particular Calquence when combined obinutuzumab, that's the only one…

00:30:59.000 --> 00:31:01.000
that had a study, well it's approved…

00:31:01.000 --> 00:31:07.000
like that. Ibrutinub had a study with obinutuzumab too but that…

00:31:07.000 --> 00:31:16.000
that combination is a little different. Nevertheless, any BTK inhibitor, so there'll be ibrutinib, acalabrutinib, zanubrutinib, so Imbruvica, Calquence, or Burkinsa,...

00:31:16.000 --> 00:31:23.000
they as single agents, they were studied in a continuous fashion. So it was treatment until…

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either progression of disease or intolerability. So, side effects are too much and people could not…

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take it and the reason for it is that the molecule to inhibit BTK is recycled on a daily basis in cellular level so you need this continuous inhibition of the molecule…

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to prevent the cells from…

00:31:43.000 --> 00:31:45.000
proliferating.

00:31:45.000 --> 00:31:48.000
We need to look at…

00:31:48.000 --> 00:31:55.000
how do these medications work? So BTK inhibitors, in general, they are what we call anti-proliferative…

00:31:55.000 --> 00:32:01.000
medications or they're preventing, some cells are dying, but largely they're preventing the cells from, from…

00:32:01.000 --> 00:32:05.000
making more cells, you know, on a continuous basis.

00:32:05.000 --> 00:32:10.000
We know they're removing that inhibition allows the cells to regain that capability.

00:32:10.000 --> 00:32:20.000

As single agents, most of the BTK inhibitors do not lead to undetectable MRD, do not lead to complete responses either. They lead mostly to partial responses in most people.

00:32:20.000 --> 00:32:25.000
And that's one of the reasons why they should be taken…

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continuously. Now, having said that,..

00:32:29.000 --> 00:32:35.000
I do have patients who are on Calquence or Imbruvica or whatever one of these medications for a number of years.

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They are with very good control of disease, they have complete response or near that…

00:32:40.000 --> 00:32:44.000
and the patients are…

00:32:44.000 --> 00:32:50.000
either requesting a treatment holiday because they had some side effects and they want to be off of it.

00:32:50.000 --> 00:32:52.000
It's not…

00:32:52.000 --> 00:32:59.000
wrong to do it. It's not impossible to do it. It is a discussion that each patient needs to have with their doctor, but knowing…

00:32:59.000 --> 00:33:04.000
how their disease is behaving. It cannot be a blanket recommendation for everyone,..

00:33:04.000 --> 00:33:09.000
so it's reasonable…

00:33:09.000 --> 00:33:19.000
to have that discussion. It is expected that they will need to be retreated at some point in the not too distant future because of disease recurrence.

00:33:19.000 --> 00:33:23.000

But, you know, I've had patients who had controlled disease for a year or two after they…

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stop those medications because…

00:33:26.000 --> 00:33:30.000
of non-disease progression because of other issues. So it's possible,...

00:33:30.000 --> 00:33:32.000
it's not recommended.

00:33:32.000 --> 00:33:35.000
I hope that answers the question.

00:33:35.000 --> 00:33:37.000
Thank you, doctor.

00:33:37.000 --> 00:33:44.000
Getting back to venetoclax and obinutuzumab, there are many questions about this particular protocol…

00:33:44.000 --> 00:33:47.000
and one is,..

00:33:47.000 --> 00:33:54.000
does the decision to change to ven and obin depend on initial prognosticators,

00:33:54.000 --> 00:33:56.000
such as 17P…

00:33:56.000 --> 00:33:58.000
deletion.

00:33:58.000 --> 00:34:00.000
The decision to start that treatment?

00:34:00.000 --> 00:34:03.000
Well, they said change they're not um

00:34:03.000 --> 00:34:05.000
I…

00:34:05.000 --> 00:34:06.000
don't know if they have…

00:34:06.000 --> 00:34:07.000
that would be a very specific question.

00:34:07.000 --> 00:34:08.000
Yeah.

00:34:08.000 --> 00:34:12.000
Yeah, they don't mention, I guess perhaps this other one is from them that perhaps they're on a…

00:34:12.000 --> 00:34:16.000
acalabrutinib currently.

00:34:16.000 --> 00:34:18.000
Okay, I would…

00:34:18.000 --> 00:34:24.000
Let me break it down into different ways right now, yea.

00:34:24.000 --> 00:34:29.000
At the baseline, patients who have not received any treatment when we are deciding between…

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acala, zanu, or ibutinib…

00:34:32.000 --> 00:34:36.000
versus venetoclax, obinutuzumab,..

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one is a continuous therapy, the other one is a one-year therapy.

00:34:40.000 --> 00:34:43.000
Some of the things…

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we take into consideration are the prognostic markers,..

00:34:46.000 --> 00:34:50.000
namely, 17P deletion TP53 mutation…

00:34:50.000 --> 00:34:53.000
what we call complex karyotype, which is…

00:34:53.000 --> 00:34:57.000
if there are multiple chromosome abnormalities, uh,..

00:34:57.000 --> 00:35:00.000
use the cutoff of at least five.

00:35:00.000 --> 00:35:02.000
That's an ever-changing goal,..

00:35:02.000 --> 00:35:04.000
a goal post there.

00:35:04.000 --> 00:35:10.000
Does a CLL with a higher risk of progression,..

00:35:10.000 --> 00:35:16.000
a higher chance of not achieving a detectable MRD at the end of treatment with a fixed duration therapy.

00:35:16.000 --> 00:35:21.000
For those patients, my personal preference is to use a continuous BTK inhibitor…

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because it seems we can have a longer control of disease...

00:35:25.000 --> 00:35:33.000
with that, but you need to continue on therapy for a longer time, so that's the downside of that.

00:35:33.000 --> 00:35:39.000
But also, absolutely correct if patients want to or doctors want to treat for venetoclax obinutuzumab.

00:35:39.000 --> 00:35:43.000
That is my preference based on what we have with the data so far.

00:35:43.000 --> 00:35:47.000
Now, for someone who is on BTK inhibitor...

00:35:47.000 --> 00:35:50.000
and has a 17p deletion,..

00:35:50.000 --> 00:35:54.000
I would not change to a different treatment unless there's progression of disease. I mean,...

00:35:54.000 --> 00:35:58.000
if the disease is controlled and it's being treated, it's not getting worse,...

00:35:58.000 --> 00:36:00.000
I don't see a reason to…

00:36:00.000 --> 00:36:05.000
to burn the bridge and go to another therapy. We'll go to another therapy when it's necessary,...

00:36:05.000 --> 00:36:11.000
meaning there is progression and patients don't need treatment, that's when we would change.

00:36:11.000 --> 00:36:15.000
Okay.

00:36:15.000 --> 00:36:18.000
More questions on ven and obin.

00:36:18.000 --> 00:36:25.000
Should I be concerned if some lymph nodes on the throat are still palpable…

00:36:25.000 --> 00:36:30.000
following completion of obinutuzumab...

00:36:30.000 --> 00:36:34.000
along with venetoclax timed treatment protocol?

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And I know before you had mentioned on…

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that sometimes lymph nodes are one point a lot higher than 1.5.

00:36:43.000 --> 00:36:48.000

But what about if they're palpable?

00:36:48.000 --> 00:36:50.000
Is that something that someone should be concerned…

00:36:50.000 --> 00:36:51.000
about following treatment?

00:36:51.000 --> 00:36:54.000
Well, that's a very…

00:36:54.000 --> 00:36:56.000
single patient specific question, I guess.

00:36:56.000 --> 00:37:05.000
It's hard to tell me. I mean, it depends, what probably if there are lymph nodes that are one centimeter and they're going to be palpable too. It depends. Are you a…

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thin person, you know, depends where it is like here, you know, if you're a thin person, lymph nodes can be easily palpable here, even if they're below 1.5 centimeters.

00:37:15.000 --> 00:37:26.000
The 1.5 centimeters in me, I wouldn't be able to feel it probably. So, I think it depends on a lot of things. How large was the lymph node to start with? I mean, did it shrink?

00:37:26.000 --> 00:37:34.000
Do you have a five centimeter lymph node to start with, and now you have a 1.8 centimeter lymph node. That's a tremendous response.

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And as I said before, even that will be considered partial response doesn't mean you necessarily have…

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MRD positivity, uh,..

00:37:44.000 --> 00:37:48.000
you know as long as the things went in the right direction…

00:37:48.000 --> 00:37:55.000
there is a potential for you to have. So residual disease at the end of treatment with venetoclax or obinutuzumab…

00:37:55.000 --> 00:38:00.000
and it may take years for that disease to progress after discontinuation to the point that…

00:38:00.000 --> 00:38:03.000
someone will need treatment again.

00:38:03.000 --> 00:38:05.000
So that's very…

00:38:05.000 --> 00:38:12.000
specific to each case. It's very hard to answer that question without knowing the entirety of the process.

00:38:12.000 --> 00:38:14.000
Of,..

00:38:14.000 --> 00:38:21.000
no more questions. What are the benefits and detriments of the various dose levels of ibrutinib…

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and what factors created change in dosage recommendation?

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So, I know that sometimes patients are cut back to half doses or perhaps down by a third...

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of BTK inhibitors.

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So, I think this is based on that.

00:38:42.000 --> 00:38:44.000
Okay.

00:38:44.000 --> 00:38:49.000
The initiation dose of any of the BTK inhibitors should be…

00:38:49.000 --> 00:38:52.000
the study dose or the full dose.

00:38:52.000 --> 00:38:57.000
I do believe that starting at a low dose and trying to go up is not the right approach.

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Having said that…

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for patients who have side effects on the medications, there are guidelines on how to…

00:39:06.000 --> 00:39:12.000
change the dose if needed, and we can do it without significant detriment…

00:39:12.000 --> 00:39:15.000
to the efficacy of those drugs.

00:39:15.000 --> 00:39:18.000
So, if someone is on ibrutinib,..

00:39:18.000 --> 00:39:21.000
to the questioning point,..

00:39:21.000 --> 00:39:31.000
they can, if they have side effects and they hold the drug and the side effects come back after they resume the drug, yes, the indication is to decrease…

00:39:31.000 --> 00:39:33.000
wants to happen to dose.

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So, you know, if you were planning to go to 280 and now going  to 140,

00:39:38.000 --> 00:39:42.000
there are doses that are now based on weight so there are doses for everyone.

00:39:42.000 --> 00:39:51.000
So, it's okay to decrease if there are reasons to decrease the dose. If there are no reasons to decrease the dose…

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in terms of side effects, I wouldn't change it.

00:39:54.000 --> 00:39:57.000

We'll go with that,..

00:39:57.000 --> 00:40:00.000
the dose that were studied in was efficacious.

00:40:00.000 --> 00:40:04.000
There was a study back in the day when I started using BTK inhibitors…

00:40:04.000 --> 00:40:09.000
looking at decreasing the dose…

00:40:09.000 --> 00:40:14.000
irrespective of that. And yeah, patients remain with efficacy…

00:40:14.000 --> 00:40:22.000
for a while. We do know, however, with BTK inhibitors, if you have a prolonged interruption in the first year of treatment…

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that just degrades your outcome that this…

00:40:25.000 --> 00:40:32.000
deteriorate your outcomes. I mean, did this deteriorate progress a little earlier?

00:40:32.000 --> 00:40:35.000
It's okay to decrease if needed. I think that's the bottom line.

00:40:35.000 --> 00:40:38.000
Okay.

00:40:38.000 --> 00:40:44.000
Can you explain the value of seeing a CLL specialist before treatment is needed?

00:40:44.000 --> 00:40:46.000
Um,..

00:40:46.000 --> 00:40:51.000
so CLL, it's a uh,..

00:40:51.000 --> 00:41:02.000
is a disease with a lot of variables. It's a very heterogeneous disease, meaning there's very different presentations, right?

00:41:02.000 --> 00:41:11.000
There is a cytogenetic abnormalities that come into play. There is patient…

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comorbidities like other diseases that come into play, there are certain ways to look at the data, as we discussed before, that come into play.

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And each patient is a different person and what's important for the patient, for their families, what's their lifestyle,...

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things like that should come into play as well.

00:41:33.000 --> 00:41:36.000
It's a disease that has a lot of data...

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and even though is the most common blood cancer,..

00:41:41.000 --> 00:41:46.000
most physicians who are general oncologists and who are very smart

00:41:46.000 --> 00:41:50.000
people and great physicians, they end up not seeing that many

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during the year in comparison to things

00:41:54.000 --> 00:41:59.000
that are more common like colon cancer, breast cancer, lung cancer, prostate cancer…

00:41:59.000 --> 00:42:08.000
etc. So CLL specialist, we're very restricted in what we do and what we see and we tend to be…

00:42:08.000 --> 00:42:14.000
on top of things that are in development, sometimes that haven't even…

00:42:14.000 --> 00:42:16.000
been published yet…

00:42:16.000 --> 00:42:20.000

but also to we are up on top and…

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We're the people, we studied…

00:42:23.000 --> 00:42:31.000
like the nitty gritty of it, the question of changing the dose, for instance, or the question of looking at MRD…

00:42:31.000 --> 00:42:39.000
or which treatment is better than maybe better than the other for a particular patient.

00:42:39.000 --> 00:42:44.000
I think it's important to have the opinion of people who…

00:42:44.000 --> 00:42:46.000
mostly do CLL,..

00:42:46.000 --> 00:42:50.000
particularly because it's a disease that generally you have time to do that.

00:42:50.000 --> 00:42:58.000
Like, you know, it's not something that generally you need an urgent therapy, like an aggressive lymphoma or an acute leukemia for instance.

00:42:58.000 --> 00:43:03.000
You have the time to go to see a second opinion and see your physician who specializes in that.

00:43:03.000 --> 00:43:09.000
CLL Society has a program to provide a virtual consultation…

00:43:09.000 --> 00:43:19.000
for free to patients who want, to don't have access to a CLL expert. So, you know, it's a good tool.

00:43:19.000 --> 00:43:24.000
I think for any disease, I mean, it's good to see an expert, not only CLL.

00:43:24.000 --> 00:43:35.000
Absolutely. And that's what I found having gone first to a generalist and then to a CLL specialist, the differences were…

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they were outstanding in the case of seeing a specialist.

00:43:40.000 --> 00:43:43.000
There's just so many nuances to this disease.

00:43:43.000 --> 00:43:48.000
Yeah, absolutely. Thanks for sharing that on the patient side, yeah.

00:43:48.000 --> 00:43:57.000
So we have a few questions regarding immunity and once you're done with treatment.

00:43:57.000 --> 00:44:03.000
And some of them, and perhaps you can give one answer if I combine a few of them. One has to do with…

00:44:03.000 --> 00:44:11.000
when you reach minimal residual disease, is your immunity better and you're off of treatment? The other has to do with being…

00:44:11.000 --> 00:44:17.000
when you're on treatment, is your immunity further,..

00:44:17.000 --> 00:44:22.000
I guess, challenged would be the best way to put it.

00:44:22.000 --> 00:44:28.000
I know we only have about 27 minutes left and I just want to combine as much as we can here.

00:44:28.000 --> 00:44:40.000
Okay. That's a difficult question. I don't believe MRD and immunity necessarily have a correlation there. I mean, I think if a disease…

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most of the time for diseases under control…

00:44:43.000 --> 00:44:45.000
and you had an immune…

00:44:45.000 --> 00:44:49.000
disruption because of the disease itself, you will improve over time.

00:44:49.000 --> 00:44:56.000
But it has the other side too. So it depends on the initial presentation before treatment started, actually, to be sincere.

00:44:56.000 --> 00:44:59.000
There's a number of patients who are presenting with…

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multiple infections because the CLL is depressing the immune system. They have low IgG levels, they have hypogammaglobulinemia, they may require…

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intravenous immunoglobulin, which is just a…

00:45:14.000 --> 00:45:18.000
replenishment of antibodies for their immune system.

00:45:18.000 --> 00:45:24.000
The CLL can cause that and lots of times treating the CLL will reconstitute their immune system…

00:45:24.000 --> 00:45:27.000
to some extent, where the things do get better.

00:45:27.000 --> 00:45:33.000
Now, on the other hand, are patients who have a somewhat intact immune system to start with…

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and go under treatment, lots of times we depress the immune system because of the treatment, I mean,..

00:45:39.000 --> 00:45:51.000
all the treatments for CLL, they are immunosuppressive. The CLL affects cells of the immune system themselves. There are B cells. They're the cells that produce the antibodies that we use to fight…

00:45:51.000 --> 00:45:55.000
mainly viral infections, but other infections as well.

00:45:55.000 --> 00:45:59.000
So the treatments are all immunosuppressive, all of them.

00:45:59.000 --> 00:46:08.000
We do know that the anti-CD20 antibodies are more immunosuppressive. So obinutuzumab in particular, is very immunosuppressive.

00:46:08.000 --> 00:46:13.000
So regimens that contain that may depress the immune system a little bit more.

00:46:13.000 --> 00:46:21.000
But, you know, being on a continuous BTK inhibitor, for instance, for years, rather than stopping the treatment…

00:46:21.000 --> 00:46:27.000
may impair the immune system for a more prolonged…

00:46:27.000 --> 00:46:36.000
period of time, but this is very variable. As I said before, this is a heterogeneous disease. It's really going to depend on the patient or CLL presentation, how disease is going…

00:46:36.000 --> 00:46:42.000
and how that's affecting each one's immune system. As a blanket recommendation,...

00:46:42.000 --> 00:46:50.000
we do state to patients, even patients who are not in treatment, patients who are diagnosed with CLL. This is the first thing I discuss with my patients.

00:46:50.000 --> 00:46:55.000
When they come in and they're not going into treatment, we are in active surveillance of like…

00:46:55.000 --> 00:47:02.000
everyone asks, what can I do, right? What can I do to prevent problems to make my life better? What you can do is…

00:47:02.000 --> 00:47:04.000
keep your vaccinations up to date.

00:47:04.000 --> 00:47:06.000
See a dermatologist every year…

00:47:06.000 --> 00:47:12.000
because 20% of patients with CLL have skin cancer, it does increase their risk for skin cancer and other cancers.

00:47:12.000 --> 00:47:17.000
So keep all your screenings up-to-date because it is an immunosuppressive disease,..

00:47:17.000 --> 00:47:21.000
any immunosuppressive condition does increase the risk of cancers.

00:47:21.000 --> 00:47:26.000
But particularly now melanoma, skin cancer in CLL patients is a higher risk…

00:47:26.000 --> 00:47:30.000
so you should see a dermatologist at least once a year to do a skin check.

00:47:30.000 --> 00:47:32.000
Keep your vaccinations up-to-date.

00:47:32.000 --> 00:47:35.000
That's the best recommendation we can give.

00:47:35.000 --> 00:47:43.000
We've had a few questions regarding is there still a need, speaking of immunity, is still a need to wear masks…

00:47:43.000 --> 00:47:44.000
Uh.

00:47:44.000 --> 00:47:46.000
in public or mass, even when you're at home and you have grandkids around.

00:47:46.000 --> 00:47:49.000
So, um.

00:47:49.000 --> 00:47:58.000
What do you think about that? It is a pain in the neck. I know that I have to confess, I still at times will wear a mask,

00:47:58.000 --> 00:48:00.000
it all depends on the situation.

00:48:00.000 --> 00:48:02.000
I think you answered the question.

00:48:02.000 --> 00:48:03.000

Uh, uh

00:48:07.000 --> 00:48:09.000
it's hard to say. I mean,..

00:48:09.000 --> 00:48:11.000
listen, we…

00:48:11.000 --> 00:48:21.000
we lived years pre-pandemic where no one was wearing a mask anywhere and flu was out there, RSV was out there, all these other diseases were out there.

00:48:21.000 --> 00:48:24.000
Uh you know and, and, and,..

00:48:24.000 --> 00:48:29.000
people did, okay, yes, patients with CLL or other cancers would get infections and we'll treat it.

00:48:29.000 --> 00:48:35.000
As anything, it is harder, particularly in CLL patients. It takes a little longer to shake off a cold, for instance.

00:48:35.000 --> 00:48:39.000
But people live, they took planes, they…

00:48:39.000 --> 00:48:45.000
you know, did their things without necessarily wearing a mask. Okay, they will wear a mask to go to a rock concert or something like that.

00:48:45.000 --> 00:48:54.000
And then we were hit with the pandemic and certainly during the height of the pandemic where we didn't know what to do with COVID, we didn't have vaccinations.

00:48:54.000 --> 00:49:01.000
We didn't have pre-exposure prophylaxis. COVID was very virulent and people were really, really dying...

00:49:01.000 --> 00:49:06.000
all the time from that, absolutely everyone should wear a mask all the time,..

00:49:06.000 --> 00:49:08.000
CLL or not CLL, I mean,...

00:49:08.000 --> 00:49:17.000
that we had to control it. I think right now we're in a different situation. Yes, COVID is out there. Yes, it's still a risk,..

00:49:17.000 --> 00:49:23.000
is not as high a risk as it was in 2020, 2021, even beginning of 2022, the risk is lower.

00:49:23.000 --> 00:49:29.000
People who are contracting COVID are not getting as sick…

00:49:29.000 --> 00:49:33.000
as we were before, the virus has changed. People are vaccinated…

00:49:33.000 --> 00:49:36.000
but you want to prevent it.

00:49:36.000 --> 00:49:41.000
Yes, wear a mask. I think it depends on a lot of personal choice here.

00:49:41.000 --> 00:49:47.000
It's a question I have all the time in the office, and it's a very hard question to answer.

00:49:47.000 --> 00:49:50.000
You know, I think it's a lot of common sense.

00:49:50.000 --> 00:49:55.000
If you're going to a place that you have zero control and there's a lot of people…

00:49:55.000 --> 00:49:59.000
and you are concerned, wear a mask. You're going on a flight, wear a mask. It's fine.

00:49:59.000 --> 00:50:05.000
If you're going to visit your family and you can ask them, hey, is anyone feeling sick here?

00:50:05.000 --> 00:50:09.000
And, you know, you have some control of the situation,…

00:50:09.000 --> 00:50:11.000
I don't think it's necessary.

00:50:11.000 --> 00:50:17.000

Sure, your grandkid who is two years old is not going to tell you if they're sick or not. And, you know, I have kids.

00:50:17.000 --> 00:50:19.000
And I know how that works.

00:50:19.000 --> 00:50:23.000
But if there's no visible signs…

00:50:23.000 --> 00:50:28.000
of anything and you want your grandkids to see your face,..

00:50:28.000 --> 00:50:31.000
please let them see your face. Wash your hands,..

00:50:31.000 --> 00:50:33.000
use hand sanitizer.

00:50:33.000 --> 00:50:38.000
Personally, I don't think it's a big problem.

00:50:38.000 --> 00:50:44.000
But it's very situational as you posted, Michelle. I mean, that's my personal opinion.

00:50:44.000 --> 00:50:47.000
And I concur with your opinion, doctor.

00:50:47.000 --> 00:50:48.000
Okay, thank you.

00:50:48.000 --> 00:50:51.000
Not that that matters.

00:50:51.000 --> 00:50:52.000
Yeah, no, it absolutely does.

00:50:52.000 --> 00:50:56.000
But yes, um.

00:50:56.000 --> 00:51:03.000
Yeah, I'm about to meet friends who flew in from out of town and I have to take a check on how they are in…

00:51:03.000 --> 00:51:05.000
their cynical factor you know…

00:51:05.000 --> 00:51:06.000
Yeah.

00:51:06.000 --> 00:51:07.000
when we go out to lunch today. So,..

00:51:07.000 --> 00:51:08.000
Yeah.

00:51:08.000 --> 00:51:14.000
you know, someone is, a lot of people here are asking, uh, if…

00:51:14.000 --> 00:51:17.000
there is anything else they can do to boost immunity?

00:51:17.000 --> 00:51:20.000
Are there any supplements?

00:51:20.000 --> 00:51:24.000
What do you suggest on that?

00:51:24.000 --> 00:51:30.000
Not that we really know. I mean, I think that's the best answer I can get.

00:51:30.000 --> 00:51:33.000
I think integrative medicine,..

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what we used to call alternative medicine,..

00:51:38.000 --> 00:51:43.000
the name is gone as integrative medicine, I mean, we're doing things that are not…

00:51:43.000 --> 00:51:50.000
necessarily allopathic or drugs or things like that, there are supplements that can help in a number of different things.

00:51:50.000 --> 00:51:53.000
Things that may be well studied,..

00:51:53.000 --> 00:52:01.000
I think consulting with an integrative medicine specialist is always a good idea. A lot of cancer centers have that. We have that.

00:52:01.000 --> 00:52:04.000
Every time a patient has a question about supplements,..

00:52:04.000 --> 00:52:11.000
I refer to my integrative medicine colleagues. They are experts in supplements. They have pharmacists who are experts in supplements.

00:52:11.000 --> 00:52:16.000
They will look into the medications the patients are receiving if they are being treated for CLL to make sure there's no interactions…

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and there's no detriment to what you're receiving. So, I think it's a specialty that really helps out in that.

00:52:23.000 --> 00:52:32.000
Now, having a single supplement, they're going to say, hey, this is going to boost your immune system. To my knowledge, I don't think we have anything…

00:52:32.000 --> 00:52:40.000
like that but you know there's people who like to stick turmeric for anti-inflammation. They really have no problem with that, although it may increase your risk of bleeding a little bit so…

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be careful with BTK inhibitors, for instance.

00:52:44.000 --> 00:52:46.000
There was…

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some questions about green tea and CLL in the past. Many studies were done,..

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really doesn't seem to pan out in terms of that kind of any benefit. In fact, the doses they saw…

00:52:56.000 --> 00:53:03.000
that were needed for green tea in the lab to have any kind of a cellular effect…

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were super high. It would be too much caffeine for anyone.

00:53:06.000 --> 00:53:09.000
So, you know,..

00:53:09.000 --> 00:53:13.000
short answer, I don't think so but…

00:53:13.000 --> 00:53:19.000
I think it's a good idea to see an integrative medicine specialist to discuss those questions.

00:53:19.000 --> 00:53:26.000
There's just so many questions. We need four hours, I think. And I'm thanking the audience on this.

00:53:26.000 --> 00:53:29.000
I just want to let the audience know that…

00:53:29.000 --> 00:53:43.000
we will be having, the CLL Society will be having another program on December 13th that will be talking about immunity. So a lot of them that you have here will be answered then, but we're going to try to get through as many as we can here.

00:53:43.000 --> 00:53:47.000
So as soon as you're speaking about supplements.

00:53:47.000 --> 00:53:50.000
There is a question on vitamin D and CLL.

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And that there's an Israeli study that came out…

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talking about that vitamin D could help…

00:53:58.000 --> 00:54:01.000
stave off treatment.

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So first of all,...

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do you agree with these results? And secondly,..

00:54:07.000 --> 00:54:13.000
what is the maximum vitamin D level that's acceptable? I know in the study it ranged…

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from, I believe, 400 to 600 was the average.

00:54:18.000 --> 00:54:26.000
But the recommendation, I think, is 600 if you're under 70 and 800 IUs if you're over 70.

00:54:26.000 --> 00:54:33.000
But first of all, what about vitamin D, doctor, and CLL? Does it do anything?

00:54:33.000 --> 00:54:39.000
We don't know for sure. I think it goes same thing with the other thing. Vitamin D...

00:54:39.000 --> 00:54:45.000
is the most touted supplement of all times. I mean, if you go into…

00:54:45.000 --> 00:54:50.000
PubMed and do a search for vitamin D, you're going to have hundreds and hundreds of…

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studies. There's a number of studies that were, there's a number of evidence that came before that vitamin D can prevent falls. Vitamin D can prevent…

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this or that and with longer studies with, with larger studies, this did not pan out to be true.

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You know, I think the Israeli data is preliminary and not conclusive of anything it's…

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suggestive, right? So we need larger studies to evaluate that. We have to look at people who…

00:55:25.000 --> 00:55:30.000

get it versus people who don't get it and it should be a standard dosage, things like that too…

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you know that they're not uh, uh…

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that may not include bias. A lot of studies may be, you know, people who are going to the studies are people who are feeling well to start with and their disease…

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would take a long time to need treatment to start with, and it just happened to be on that study because they are on active surveillance and they're taking vitamin D and, hey,..
00:55:53.000 --> 00:55:55.000
you know, it took a long time for you to,..

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to have your disease treated in comparison to the general CLL population. I mean, you have to take all comers to look into that...

00:56:02.000 --> 00:56:08.000
not only so there's inclusion bias in the studies. Is there selection bias in studies.

00:56:08.000 --> 00:56:16.000
So it's hard to say. Am I against someone taking vitamin D? No, you may be just spending money for nothing sometimes...

00:56:16.000 --> 00:56:18.000
because those vitamins are not cheap,..

00:56:18.000 --> 00:56:22.000
lots of times. Is it going to stave off…

00:56:22.000 --> 00:56:34.000
how long it's going to take for your CLL to be treated? We don't really know. I mean, I'm not going to say it won't or I'm going to say will. We just don't really have a firm answer on that.

00:56:34.000 --> 00:56:38.000
I know, like on so many other things, right? It's just, uh it's…

00:56:38.000 --> 00:56:40.000
what you know.

00:56:40.000 --> 00:56:51.000
So we talked a little bit, well, probably a lot of it over time, COVID, the boosters and everything else, but what are your thoughts on PEMGARDA?

00:56:51.000 --> 00:56:53.000
Is that formulated…

00:56:53.000 --> 00:57:01.000
to protect people from the latest variants and how much protection does it give to us?

00:57:01.000 --> 00:57:03.000
Maybe explain what PEMGARDA is for those who don't know as well.

00:57:03.000 --> 00:57:09.000
Yeah, PEMGARDA is a pre-exposure prophylaxis. People can take that, particularly if you have higher risk.

00:57:09.000 --> 00:57:12.000
And it's supposed to…

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decrease more than anything, decrease the severity of symptoms if you contract COVID.

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It's an antibody.

00:57:21.000 --> 00:57:29.000
The way it was designed for previous variants. It was approved much earlier in the year,..

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it took some time for it to be priced. It took some time for…

00:57:34.000 --> 00:57:41.000
hospital systems, pharmacists to kind of pick it up, have it on formulary and things like that.

00:57:41.000 --> 00:57:46.000
COVID is ever changing. The variants are mutating…

00:57:46.000 --> 00:57:53.000

Quickly, uh you know, every couple of months we have a new variant. I am not a COVID expert by any means.

00:57:53.000 --> 00:58:01.000
My understanding is that PEMGARDA does not cover the current variants right now.

00:58:01.000 --> 00:58:05.000
On this event, as you said on December 13,..

00:58:05.000 --> 00:58:09.000
things like that will be discussed. So it's a good idea if people have questions…

00:58:09.000 --> 00:58:13.000
to log into that.

00:58:13.000 --> 00:58:18.000
You know,  how much protection it gives, it's hard to say...

00:58:18.000 --> 00:58:26.000
at this point, I mean, with the current variants and we don't have a lot of data in that. We don't have a lot of data particularly for CLL patients.

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You know, the studies were larger than that so…

00:58:31.000 --> 00:58:33.000
this, again, a question that I get in the office all the time.

00:58:33.000 --> 00:58:37.000
I cannot tell how much protection…

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you're going to have from this. I mean, oh, are you an untreated patient? Are you a patient who is in a third line of therapy? Is your disease, how long you have? What's your…

00:58:46.000 --> 00:58:51.000
immunoglobulin levels? I mean, there's so many variants that come into it to predict how…

00:58:51.000 --> 00:58:55.000
protected that's going to be. It's hard.

00:58:55.000 --> 00:58:57.000
So, uh…

00:58:57.000 --> 00:59:03.000
patients who want to get it, I'm like, okay, I have no problem with it.

00:59:03.000 --> 00:59:11.000
But I'm not recommending everyone to get it or say you have to get it. It's just not there. My take right now is like,..

00:59:11.000 --> 00:59:18.000
my patients will come and they would like to get it with this discussion. We don't have a lot of data. We review the safety profile.

00:59:18.000 --> 00:59:22.000
And they're like, I still would like to get it. I'm okay with that. Let's do it.

00:59:22.000 --> 00:59:26.000
But it's not necessarily something I'm recommending for everyone.

00:59:26.000 --> 00:59:31.000
What about, I don't know if you say it Enovid or anovid,

00:59:31.000 --> 00:59:35.000
the spray out of Israel, does that truly help

00:59:35.000 --> 00:59:40.000
you avoid COVID when exposed?

00:59:40.000 --> 00:59:41.000
Okay.

00:59:41.000 --> 00:59:45.000
I don't know. I'll be since you with that. There's not something I have a deep knowledge of.

00:59:45.000 --> 00:59:53.000
Yeah, as we're running short on time, how about the next few questions? We do like a lightning round? Are you up for it?

00:59:53.000 --> 00:59:55.000
Sure.

00:59:55.000 --> 01:00:00.000
Okay. If you are on a BTK inhibitor and you…

01:00:00.000 --> 01:00:04.000
get COVID, should you go off of the BTK inhibitor?

01:00:04.000 --> 01:00:10.000
No. No, if you don't have severe symptoms and just a quick thing on this.

01:00:10.000 --> 01:00:19.000
Early in COVID, we found out that some patients with BTK actually could be a treatment for COVID. We published a paper on that.

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I personally had a patient who was intubated…

01:00:23.000 --> 01:00:32.000
with COVID back in 2020, and we gave him full dose of ibrutinib and the patient was intubated, meaning mechanical ventilation.

01:00:32.000 --> 01:00:38.000
And he was out of the ICU within 40 hours after we started the BTK. He had all the other treatments so…

01:00:38.000 --> 01:00:44.000
this was great. We published that. There were a couple of studies with BTK inhibitors for Covid,..

01:00:44.000 --> 01:00:53.000
there is an interaction between COVID and inflammasome, which is molecule that causes inflammation and BTK inhibits that interaction.

01:00:53.000 --> 01:00:55.000
So, uh,...

01:00:55.000 --> 01:01:00.000
I generally don't stop it unless the patient is severely symptomatic.

01:01:00.000 --> 01:01:04.000
Okay, a few questions about what do you…

01:01:04.000 --> 01:01:10.000

think are going to be the hottest studies out of ASH for CLL. Now, I know you and I discussed this, but…

01:01:10.000 --> 01:01:14.000
no one here was privy to that conversation.

01:01:14.000 --> 01:01:20.000
I think AMPLIFY will be a good study. I'm biased as I'm a co-author on the study, so…

01:01:20.000 --> 01:01:22.000
Spoiler alert on that one.

01:01:22.000 --> 01:01:27.000
spoiler alert, you know, uh,..

01:01:27.000 --> 01:01:35.000
there's a number of updates on other studies that are coming up. I'm always interested in a lot of the real world data…

01:01:35.000 --> 01:01:43.000
for CLL, you know, in the post-trial world, we're looking at this because you know trial patients are highly selected…

01:01:43.000 --> 01:01:46.000
so we do have a couple of…

01:01:46.000 --> 01:01:49.000
real world studies on…

01:01:49.000 --> 01:01:54.000
timing of venetoclax versus BTK inhibitor, for instance, this is one of the studies.

01:01:54.000 --> 01:02:02.000
Another hot topic right now is the landscape for mutations in the BTK molecule,..

01:02:02.000 --> 01:02:09.000
particularly because pirtobrutinib has been approved and we're trying to understand how to sequence those drugs.

01:02:09.000 --> 01:02:16.000
There's going to be an update, if I'm not mistaken, of BTK degraders it's still early on. It's still like early phase studies…

01:02:16.000 --> 01:02:21.000
but it's going to be an update at ASH.

01:02:21.000 --> 01:02:23.000
Off the top of my head,..

01:02:23.000 --> 01:02:33.000
those are the main studies. I do believe that the larger study in CLL that's going to be presented is AMPLIFY at ASH. I know you looked…

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obviously sincere, all the abstracts were just released…

01:02:35.000 --> 01:02:44.000
on the day of the election this year. And then, you know, I've been going through that, but there was a…

01:02:44.000 --> 01:02:52.000
a week I was on service too, so I didn't have time to go over completely over all the abstracts but off the top of my head, these are the ones I'm looking into.

01:02:52.000 --> 01:02:55.000
What about you, Michelle? I'm sure you looked into, into…

01:02:55.000 --> 01:02:56.000
that as well. Is there anything that you.

01:02:56.000 --> 01:02:59.000
I have been. AMPLIFY, one of the um,..

01:02:59.000 --> 01:03:02.000
you know, mutations…

01:03:02.000 --> 01:03:05.000
is huge, I think, for example…

01:03:05.000 --> 01:03:08.000
to look at. I,..

01:03:08.000 --> 01:03:14.000
I do think a lot of the AI stuff is fascinating. I am unsure what I think about them…

01:03:14.000 --> 01:03:17.000

but that they're actually being given time at ASH…

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to be presented tells me that we really are, are…

01:03:21.000 --> 01:03:30.000
going light years ahead and using AI. But again, I know they are preliminary studies and they're being presented so…

01:03:30.000 --> 01:03:36.000
again, my jury's out on that, but there seem to be so many others. Degraders last year, we heard about them.

01:03:36.000 --> 01:03:43.000
And I look forward to learning how that's progressed in just a year's time, as well as…

01:03:43.000 --> 01:03:45.000
sequencing of drugs and that's something…

01:03:45.000 --> 01:03:48.000
that we all want to learn about.

01:03:48.000 --> 01:03:49.000
Yeah.

01:03:49.000 --> 01:03:51.000
Is there a magic formula to the sequencing?

01:03:51.000 --> 01:03:55.000
I think that's the biggest question we have right now. How do you sequence those drugs?

01:03:55.000 --> 01:03:56.000
Yeah.

01:03:56.000 --> 01:03:58.000
Okay, so…

01:03:58.000 --> 01:04:01.000
wow, I cannot believe what time it is.

01:04:01.000 --> 01:04:06.000

Can we just stay on for a few more hours here, folks? I mean, it's just there is so much here.

01:04:06.000 --> 01:04:10.000
Oh, someone wrote here, melanoma new,..

01:04:10.000 --> 01:04:14.000
a Nevo vaccine being trialed at Dana-Farber,..

01:04:14.000 --> 01:04:17.000
for naive, non-mutated…

01:04:17.000 --> 01:04:20.000
IGVH for CLL.

01:04:20.000 --> 01:04:24.000
I don't know if that's being presented or maybe you're telling it's being presented. I'll have to look,..

01:04:24.000 --> 01:04:26.000
check that out.

01:04:26.000 --> 01:04:31.000
I'd ask you if there are any results. Not that I know.

01:04:31.000 --> 01:04:33.000
Okay, great.

01:04:33.000 --> 01:04:44.000
All right, so as we're starting to close, one last question. Oh, do you use the NCCN guidelines to decide when to start treatment?

01:04:44.000 --> 01:04:49.000
I'm just going to, before I do that, I'm just going to…

01:04:49.000 --> 01:04:55.000
put a reminder here from Dr. Koffman, which is very important, that BTKis may interact with Paxlovid…

01:04:55.000 --> 01:05:02.000
for people who are asking about COVID before we talked about PEMGARDA, but not Paxlovid…

01:05:02.000 --> 01:05:07.000
which is the post-exposure people who had Covid,

01:05:07.000 --> 01:05:11.000
contracted COVID and then should be taken after that to decrease symptoms.

01:05:11.000 --> 01:05:16.000
Absolutely right. BTKs interact with that. They need to be held…

01:05:16.000 --> 01:05:22.000
during that treatment and there are some dose adjustments, if I'm not mistaken. This is my pharmacist. They take care of that…

01:05:22.000 --> 01:05:28.000
but there is an interaction there so be careful with that if you're on BTKi and taking Paxlovid.

01:05:28.000 --> 01:05:33.000
They're asking if I use NCCN guidelines to decide when to start treatment.

01:05:33.000 --> 01:05:43.000
I use the iwCLL guidelines, the NCCN guidelines reflect that largely, so it's pretty similar.

01:05:43.000 --> 01:05:50.000
The NCCN guidelines are suggestions more than anything else. They're broad.

01:05:50.000 --> 01:05:54.000
The iwCLL is a little bit more specific on,…

01:05:54.000 --> 01:05:58.000
they're just looking at that. I mean, it's a little different…

01:05:58.000 --> 01:06:04.000
but yes, what the NCCN guidelines say, it's fair.

01:06:04.000 --> 01:06:09.000
And as someone who had COVID for quite a while, about a year ago,..

01:06:09.000 --> 01:06:15.000
I was taken, I was on Paxlovid and taken off a BTK inhibitor during it.

01:06:15.000 --> 01:06:17.000

And things improved more quickly.

01:06:17.000 --> 01:06:18.000
Good.

01:06:18.000 --> 01:06:21.000
So I'm proof of that, it does work when they take.

01:06:21.000 --> 01:06:28.000
That works. Yeah. Yeah, I don't know. Paxlovid I'm all for, I mean, Paxlovid is more clear than PEMGARDA for sure. I mean,..

01:06:28.000 --> 01:06:33.000
our patients have COVID, we generally do that. We use Paxlovid.

01:06:33.000 --> 01:06:36.000
Well, doctor, as we're coming to a close,..

01:06:36.000 --> 01:06:43.000
what are your closing thoughts for our audience on the landscape of what's ahead of us with CLL?

01:06:43.000 --> 01:06:46.000
Okay.

01:06:46.000 --> 01:06:56.000
Well, first of all, thank you for the CLL Society and Michelle for the wonderful work that you all do. I mean, it's great to be able to have this channel of communication…

01:06:56.000 --> 01:07:01.000
with patients and advocates and give our thoughts outside of a clinical setting…

01:07:01.000 --> 01:07:08.000
with my Rolling Stones tongue on top of my head. So thank you for the invitation.

01:07:08.000 --> 01:07:18.000
I think CLL went a long, long way over the past decade. This year marks 10 years since ibrutinib was approved for CLL,...

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was in 2014. That just coincidentally started when I became the director of CLL at my previous institution,..

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right before ibrutinib was approved. And I was like, oh, okay, things seem to be changing.

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Because that's up to that time, all we had was chemo.

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We are at a point in CLL where most patients who will be diagnosed with CLL today,..

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they should have the same life expectancy that people their age who don't have CLL.

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So I think that says a lot.

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This is a lot where we came to this is a lot where we stand.

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It is, you know, it became truly a chronic disease.

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Every time I'm just like, you know, you have hypertension, diabetes or diseases that can have more effect on your health…

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than CLL today. I mean, it is a cancer. It's a chronic disease. We have many, many good treatments for it. Unfortunately, a percentage…

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of patients will have more aggressive courses or transformations, things like that. Fortunately, it's a minority...

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of people presenting with this, but people diagnosed today are expected to have…

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the same life expectancy as their counterparts who don't have CLL…

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which is great.

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We always want aiming for a cure. I know we only have two minutes here. Hopefully we'll be able to get to that.

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We're looking into novel combinations, novel medications, cellular therapy, bispecific antibodies, BTK degraders.

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I do firmly believe that…

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not during my life, but during the extent of my career, because I do hope to retire someday…

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that we will be able to…

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cure CLL. I do believe that firmly. I think we're very, very close to it.

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So I think that the future is very, very bright.

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I think the newer combinations, particularly combination of BTKi and…

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venetoclax...

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are tremendously promising…

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to the point where you can put most patients on it and have a long-term control of disease…

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with a fixed duration therapy….

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right or there's what we call MRD guided therapy coming down the road. That's where we're studying right now,...

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if when to stop treatment based on MRD.

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And I think that's really changing the landscape for CLL and we're going to have more patients…

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with controlled disease, not on treatment.

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That's the goal.

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We'll get there.

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Those are, amen to that. I'll leave that simple. I'm all for all that you said.

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And I just would also love to thank the CLL Society…

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for having us join you and be part of this.

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I am Michelle Nadeem-Baker. Thank you for joining us today here. And our next webinar for the CLL Society…

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will be Common Infections with CLL: Prevention and Treatment on December 13th.

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I'm Michelle Nadeem-Baker and thank you for joining us today.

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Thank you so much everyone.