A Changing AML Treatment Landscape: Personalizing Therapy for the Patient

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Andrew Schorr:
So, Dr. Ritchie, I'm going to start with you for a second. So, are we right? It seems like someone's head can spin, with all of the new drug approvals, and then, also trying to make sense of what's right for what patient. So, how much have things changed in AML?

Dr. Ritchie:
Well, AML used to be a really simple disease, because we had two drugs, and that's how we treated patients. Now, it's a more complicated disease, partially, because we're learning a lot more about this disease molecularly. And there are new targeted agents, which have been recently approved, in the last year, for the treatment of AML. Many of them, just recently, in the past few days. Gilteritinib (Xospata), which is a second FLT3 inhibitor was in there last week. A lot of these drugs are drugs that fall into two categories, some which target mutations that may be relatively infrequent like IDH1, IDH2, FLT3.

And these are for those specific populations who have those particular mutations.

There are also drugs that are more blanket that cover patients who have really any abnormality, which are added to standard therapy like venetoclax (Venclexta). Venetoclax was initially approved for the treatment of CLL and has recently had a new label to add to low dose ARA-C or to hypomethylating agents, for the treatment of AML. And that's an exciting new development where the response rate with hypomethylating agents goes from about 40 percent to 70 percent. So, it's a real advance, for those particular patients.

Also, in the really older and frail population, I always have problems saying it, glasdegib (Daurismo), which is really a drug, which is directed at the leukemic stem cell together with low dose ARA-C. These have been approved really for patients who are a little bit more frail and older.

And it's a regimen that is more easily tolerated by that age group.

Andrew Schorr:
So, just a follow up. So, how much of a difference—the FDA approves effective therapies effective therapies, which, hopefully, make people's life better and longer. So, is that the hope for our viewers watching that whether it's themselves or an adult parent or grandparents that they can have a better, longer life?

Dr. Ritchie:
Well, there are a lot of aspects to leukemic care. It's not only having a longer life but having a higher quality of life. So, it's the quality of life that you have, as well as the length of life that you have. So, just to put it in reference, standard induction chemotherapy, where we use two drugs, daunorubicin and cytarabine, which my father used to use when he practiced medicine, and those days are—it's an old combination. But it really requires the patient be in the hospital for 30 days. And these patients are sick. And they require transfusions.

And most of them require antibiotics. And they don't feel very well, and it's a difficult time. So, for older patients, are you really willing to spend a month of your life or maybe two months of your life where you really feel terrible in the hospital? That's not necessarily something that you want to do. So, part of the breakthrough is not just that we may improve overall survival, which we don't really know, until it's out in the community, and we see how it works. But whether we can improve the overall quality of life of older patients who have AML. So, and rather than being in hospital, you can have your therapy, in an outpatient setting.

And rather than it being all intravenous, you might have an oral medical that you could take at home, like you do your hypertension pill, really, for your AML. So, these are really important advances because it enhances the quality of life of patients who have acute leukemia.

Esther Schorr:
Well, and it also sounds like you referenced that a lot of the patients are older with this. And I just can't imagine what it must be like, if you have two much older people, and one person is, as you mentioned when we were talking earlier, one is out of commission.

The other is not only going to need support from family, but if their partner doesn't have to be in the hospital to be able to at least be home, there's some level of support there.

Dr. Ritchie:
Right. Well, you guys can chime in. But a typical situation, really, is two older people who are living together where they're doing just fine as a symbiotic couple. But they both have their illnesses or both have their problems. But once you take one person out of the picture, and that person is very, very sick, it can be very difficult for the other elderly person to actually handle all of the stress of taking care of themselves and all of the stress of taking care of another person. So, one of the key factors, I think, in overall survival and quality of life in patients who are older who have AML is having a caretaker who is reliable for them.

And that may be your child.

It may be your sister. It may be a good friend. But there has to be someone in your life, beyond just your spouse, who can be a caretaker for you for a successful therapeutic result.

Dr. Lee:
And one thing that is great about the medicines that are coming out are that they're very well tolerated, especially the IDH drugs and venetoclax. They're very well tolerated. You can do it outpatient. So, for a lot of older patients, as you know, if you stay in the hospital more, you're exposed to infections. Your performance status may decline. So, patients actually do better with an outpatient therapy.

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