ASH 2015: CLL Research Highlights

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Carol Preston:
Hello everyone and welcome. I'm Carol Preston. I'm at ASH, the American Society of Hematology, in Orlando, Florida, the largest blood cancer meeting on the planet. And we are so fortunate to have us, one of the experts in CLL. Would you introduce yourself, please?

Dr. Furman:
I'm Dr. Richard Furman from Weill Cornell Medical College in Manhattan, and I'm director of the CLL Research Center.

Carol Preston:
Now, Dr. Furman, we have heard a lot news at this meeting interestingly about multiple myeloma. That is not your area, but—and CLL had a huge year last year with the approval of a couple of those oral agents, but you've got some news of your own that you've reported on.

Dr. Furman:
Absolutely. I mean, I think, you know, CLL has had also a tremendous year this past year as well, and there are a lot of data coming out, you know, in follow-up of these novel agents in combination with chemotherapy or even in new patient populations, like the RESONATE 2 study, which compared ibrutinib (Imbruvica) to chlorambucil (Leukeran) in untreated patients. So the hope, of course, is that now ibrutinib will obtain sort of an FDA approval for untreated CLL patients and really allow us to move this therapy to frontline, which from my perspective is the most important thing we can do for patients.

But what's also I think very encouraging are the two other new agents that are emerging right now. So venetoclax, which will also hopefully be approved soon, works through a different mechanism. It inhibits Bcl-2 and really has tremendous ability to generate very deep remissions. So with venetoclax we know by the end of three months whether or not you're someone who may actually achieve MRD-negative remission and very well could be done for a very, very long time.

Carol Preston:
Dr. Furman, there's been so much exciting news on a number of blood cancer fronts about this targeted therapy, about really going after the molecular medicine, if you will, going after the defects in the cell and targeting them specifically. Is that what we're looking at for CLL?

Dr. Furman:
So what's really interesting about CLL is that it really doesn't follow the mold, and the novel agents that we have really work not even because of a specific defect in the CLL cells, but they get at the heart of the CLL machinery itself. So these B-cell receptor antagonists, you know, attack the B-cell receptor pathway. And we know that that's a critical pathway, but

it's not a pathway that seems to be necessarily defective in CLL patients. So we have an ability to work regardless of the underlying defect of the CLL.

And that's really why I think these agents have such broad applicability in all CLL patients and why we really—you know, precision medicine doesn't really help us much with one exception, which is sort of identifying the—you know, in those patients who progress in these targeted therapies, you know, we can sometimes find some specific mutations that demonstrate for that for us.

Carol Preston:
Well, let's talk about emerging therapies, what's on the horizon for patients, and I'm a CLL patient and relapsed once, doing fine right now, but emerging therapies for relapsed or refractory patients.

Dr. Furman:
So the two agents that are coming down and are coming out shortly that I'm most interested in is one is venetoclax, which is a Bcl-2 inhibitor, formerly known as ABT-199. And the other is ACP-196, which is a novel second-generation Btk inhibitor, also known as acalabrutinib.

Carol Preston:
And what do you see these doing that is not being done with the current agents available to CLL patients?

Dr. Furman:
So ACP-196 really has the ability to work as well as ibrutinib does with fewer side effects, better tolerability. And since venetoclax actually works by a totally different mechanism of action, for those few patients who progress on Btk inhibitor therapy we now have an option that can rescue these patients. And the thing that's going to be really intriguing over the coming years is with the combination of these agents we can get such deep remissions, you know, it's finally possible to start talking about having patients, you know, receive treatment for a defined period of time and then just stopping treatment for a long, long time.

Carol Preston:
Maybe forever?

Dr. Furman:
Maybe forever.

Carol Preston:
Are you using the cure word at all?

Dr. Furman:
I'm not using the cure word, because I think the truth is even if a patient were to—you know, these are nongenotoxic therapies, so unlike…

Carol Preston:
Meaning?

Dr. Furman:
…meaning that basically we don't damage the DNA like chemotherapy does. So when a patient gets treated with chemotherapy what comes back is often more difficult to treat, and that's why subsequent remissions are always shorter.

With these new agents if someone were to get a very deep remission and relapse five years later, it's not a big deal, because they'll likely just respond again to the same agents, and in which case, you know—so really it's about overall survival. So even if they're not cured, we're still doing a very, very good thing.

Carol Preston:
So a couple of new emerging therapies on the horizon, one looking for FDA approval pretty soon and the other one hopefully not far behind. It's really very, very good news. And Dr. Furman, I hope when we talk to you next year, you'll have even more exciting and better news for CLL patients. Thank you so much.

Dr. Furman:
My pleasure.

Carol Preston:
Appreciate Dr. Furman's insight. And, again, patients, please speak with your physicians about what is out there and make sure that you're all on the same page.

I'm Carol Preston at ASH. Thanks for watching.