ASH 2015 Follicular Lymphoma News: Moving Beyond Chemotherapy

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Andrew Schorr:
Hello and welcome to Patient Power. I'm Andrew Schorr joined by...

Carol Preston:
Carol Preston.

Andrew Schorr:
Okay. Both of us have been living with CLL, and, of course, we're vitally interested in leukemias but also a condition that's very—sort of a cousin to that is what we call low-grade follicular lymphoma, and that's what we're going to talk about now with a clinician in the field, hematologist/oncologist Jennifer Cultrera, who joins us from Florida Cancer Specialists. And you're in the villages here in Florida, and we're recording this here in Florida, in Orlando. Thank you for being with us.

Dr. Cultrera:
Thank you. Thank you for having me.

Andrew Schorr:
So, Dr. Cultrera, tell us now about progress in follicular lymphoma. There certainly has been.

Dr. Cultrera:
As with all of the non-Hodgkin lymphoma, follicular lymphoma has had great strides. I think we've entered an era where we're no longer thinking of using chemotherapy for patients with cancer, and follicular lymphoma is definitely an example of that. We have medications, both in the targeted therapy arena, immunotherapy. Both of these can be administered either by pill form or intravenously and offer patients very little side effects. We don't have to see them suffer, you know, with the nausea, the vomiting and the low quality of life, the suppressed immune system. They can live their lives almost as normal lives, going out, doing jobs, doing what their normal—normally do.

Carol Preston:
Dr. Cultrera, there's so much hope that is being discussed in terms of the precision and the targeted therapy for cancer, but there's also the reality of accessing the information and physicians in the field understanding what to do and what tests. So how do you approach it in your office?

Dr. Cultrera:
That's a great question, and I'm lucky to be part of Florida Cancer Specialists where we're a larger group, and we have access to great hematopathologists. So first thing first is making the diagnosis, and you have to have a pathologist that understands lymphomas and leukemias to really understand making that fine diagnosis of follicular lymphoma, what grade it is versus CLL, versus diffuse large B cell, and we do have access to that. And we oftentimes if even our pathologists can't get the right answers, they're sent out, so we do use resources like the NIH. We do use our local resources like Moffitt hematopathologists, University of Florida and Mayo Clinic to really confirm those diagnoses.

Carol Preston:
And you're—I remember that you said you had eight trials under your belt, so are you generally nudging your patients toward participating in a clinical trial?

Dr. Cultrera:
Yes. We definitely—you know, patients need access to these targeted therapies, and they're not all readily available. So first things first. If I have a clinical trial and it's efficacious to put the patient on it, they're going to get access to it. We're lucky that we also have across the state of Florida different practices, and several of them have the capability of running Phase II, Phase III trials. And we have two centers in the state of Florida that have Phase I trials running along with our three large academic centers that are within about a hundred mile radius of us.

Andrew Schorr:
All right. So let's go through this for a second. So, first of all, you emphasized at the beginning it's very important for someone to have an accurate diagnosis. What are you dealing with? Okay. And then in this age of we're trying to move there, precision oncology, precision medicine, getting the treatment that's right for you, which could be one of these approved therapies, or it could be something in a clinical trial, and I know you're often a principal investigator of some trials. And now you're looking at combining therapies, right? So the idea is cancer tries to make an end run around an individual drug. Is that the idea of combining therapies?

Dr. Cultrera:
Yes. Definitely. So as these drugs now don't have extreme side effects where in the past we couldn't combine many different routes of chemotherapy because of the toxicity that they would can imply, these targeted agents, we can combine them especially if we can detect what mutations are driving the cancer. If there [are] two or three mutations, we may be able to combine two or three agents to hit the cancer where really what's driving it and shut it down and keep—make cancer a chronic disease.

Andrew Schorr:
Okay. One other question I want to ask—excuse me, Carol—was there's been a lot of buzz about immuno-oncology, immunotherapy, can medicines be given to boost your immune system and have that fight these cancerous cells? Where are we with that for lymphoma?

Dr. Cultrera:
So actually non-Hodgkin lymphoma is where immunotherapy began, so rituximab being the big, you know, the most original immunotherapy drug. And from there we've just come leaps and bounds with other monoclonal antibodies, monoclonal antibodies that now have other toxins piggy-backed on them to deliver the drug directly to the cell in question.

And, of course, we have checkpoint inhibitors, which are now into solid oncology, and they are now being tested in both leukemias and lymphomas, including follicular lymphoma. So coming soon, I mean, we're going to see just an explosion of these new agents coming out. And in essence, we've kind of reversed what we used to do in just suppressing the immune system in our toxicity of chemotherapy, now we're using the immune system to our advantage to seek out and destroy the malignancy.

Carol Preston:
You know, you're talking a lot about there's a lot of hope, but there's also the reality. And the fact of the matter is that a year ago you had some patients that are no longer with you today. So what keeps you going? You know, what gets you out of bed in the morning when you've lost somebody or many patients?

Dr. Cultrera:
I think the drive to—the fact that we do have so much available and that is incoming. When I started looking into oncology as I was studying medicine, I actually thought to myself that same question. I said how am I going to deal with such bad lows? But knowing that I'm getting up every morning and I'm dedicated to research and I'm dedicating to finding the capability of saving that next patient or at least making the patient be able to live longer or live a better quality of life, that's what keeps me going.

Andrew Schorr:
Okay. So we always want to bring people a message of hope. With the research you're doing, with the new agents you have, oral medicines included for some people where they just may take a pill, are you hopeful? Are you encouraged for the people watching now?

Dr. Cultrera:
Definitely. Definitely. I think—I'm a science fiction buff, and one of the things I read once that Arthur C. Clark imagined in 3001 that cancer patients would take a daily pill that would have their cocktail of anticancer medicine in it, and they could live their lives normally. And I think that we don't even have to wait until 3001 to let that happen. So I think we're—it may not be this year or next year, but I'm hoping that it's going to be in our lifetime.

Andrew Schorr:
Right. And one more thing for you because you're a younger physician is let's get a cure for all this, okay? Let's work on that.

Dr. Cultrera:
Yes. Definitely.

Andrew Schorr:
Let's work on that.

Carol Preston:
Amen.

Andrew Schorr:
Jennifer Cultrera, thank you so much for being with us from Florida Cancer Specialists. Carol, thank you for joining in with a message of hope.

I'm Andrew Schorr. Remember, knowledge can be the best medicine of all.

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