Follicular Lymphoma News From ASH 2015

Jeff Sharman, MD
Medical Director, Hematology Research
The US Oncology Network

Andrew Schorr:
Welcome to Patient Power. I'm Andrew Schorr. We're on location at the ASH meeting, American Society of Hematology, in Orlando, Florida. That's where thousands of doctors gather to talk about blood-related conditions, and we're always interested in blood-related cancers. One of them, of course, is what's known as follicular lymphoma, so one of the non-Hodgkin lymphomas. With me is an expert in the field, Dr. Jeff Sharman from the US Oncology Network. Thank you for being with us, Jeff.

Dr. Sharman:
Thank you, Andrew. Happy to be here.

Andrew Schorr:
Okay. So, Jeff, progress in helping people with follicular lymphoma, you have oral therapies and monoclonal antibodies. Can this now be managed better as a chronic condition?

Dr. Sharman:
Yeah, I think for your audience many of the patients who have had CLL have really been in the vanguard of the new wave of therapies. Follicular lymphoma is a little bit behind but also makes very rapid progress, and some of the areas where progress in follicular lymphoma, some of the new drugs, it's normally about medications and how we use those. But I think we are poised that over the next five to seven years we're going to be seeing changes in follicular lymphoma that are of similar magnitude to chronic lymphocytic leukemia.

Andrew Schorr:
So you have monoclonal antibodies, and you have oral therapies, and going back you use chemotherapy and all that. So are we in the nonchemotherapy world now?

Dr. Sharman:
Not as far as we are in chronic lymphocytic leukemia. However, the study that I think might be most able to upset that apple cart utilizes a combination of drugs called lenalidomide and rituximab. Lenalidomide (Revlimid) is what we call an immunomodulatory drug. It helps reawaken aspects of the immune system that have been put to sleep by the cancer.

There's this really interesting interaction between the cancer cells and the microenvironment that they're in, and lenalidomide has the ability to overcome some of that immune grogginess, if you will. There really is a term. We call it pseudoexhaustion, and rituximab (Rituxan) can help focus the immune system in a way that once you reawaken it you want to focus it, and so this combination of drugs is really quite provocative.

And so we have seen similar results from a variety of clinical trials all showing very good efficacy of the combination. There is a randomized Phase III study that has fully accrued, and we're merely waiting for what we call events. We're waiting over time to see how the outcome of this study plays out, but in this study patients were either treated with R-CHOP or RCVP or Revlimid-rituximab, lenalidomide-rituximab. And the study, if that reads out as either equivalent or perhaps even better, we may see a change towards nonchemotherapy-based treatment at the start of therapy.

That same regimen is being evaluated amongst patients in relapsed-refractory, and that's, you know, playing out as a nice regimen for patients who have relapsed as well. Not FDA approved, so to be very clear, this is speaking off-label, but we anticipate we will see approval in this space.

Frontline follicular lymphoma is still largely a choice where we segregate based upon how much disease somebody has, either they're low tumor burden or high tumor burden. And for those patients with high tumor burden, at least as of today we're generally using chemoimmunotherapy. For those patients with low tumor burden we consider maybe rituximab monotherapy, or even watch and wait, which can remain appropriate.

When we move through sequential relapse therapies, though, we are also here seeing new developments, and one such development is a drug called idelalisib (Zydelig). This was approved last year based upon a clinical trial that showed the efficacy of this drug even amongst patients who are resistant or refractory to rituximab and some types of chemotherapy. So we're seeing changes in that field, and we anticipate additional studies will begin to show us how we can combine idelalisib with other drugs such as bendamustine (Treanda) or rituximab or the combination of the two and so forth.

Andrew Schorr:
So are you hopeful for people with NHL? Obviously, there are people in watch and wait, but there are others that needed these successive lines of therapy that you have something for them?

Dr. Sharman:
Well, there's almost always some option available in clinical trials. And for patients who have exhausted some of their conventional options, I would strongly encourage looking into clinical trials, because there are a multitude of agents that have activity currently being studied that you can only gain access to in the context of a research study, and hopefully that's something that's available at your treatment center. But if it's not, it might be worth considering looking around you for clinical trials that you may not otherwise have access to.

Andrew Schorr:
Okay. Dr. Jeff Sharman, thanks for the update.

Dr. Sharman:
You bet.

Andrew Schorr:
And we wish you well in all your pursuits in helping patients. Thank you very much.

Dr. Sharman:
Thank you, Andrew.

Andrew Schorr:
Andrew Schorr with an update from the ASH meeting in Orlando, Florida. And, as we always like to say, remember, knowledge can be the best medicine of all.