Has Chemo Become a "Dirty" Word?

Michael Keating, MB, BS
Professor of Medicine, Department of Leukemia
The University of Texas MD Anderson Cancer Center

Jeff Sharman, MD
Medical Oncologist, Willamette Valley Cancer Institute and Research Center
Medical Director, The US Oncology Network

Kathryn Kolibaba, MD
Hematologist/Oncologist
Compass Oncology

Andrew Schorr:
So first of all, Dr. Sharman: we have medicines that we've taken for a long time, and they've been—let's just talk about those—for a long time. Taya, we're going to this slide here. Yeah, maybe you can see this Dr. Sharman.

These medicines have been the old standbys for a long time, right? Do we still use them? So chlorambucil (Leukeran) was around for, like, 40 years or something a long time.

Dr. Sharman:
Oh, 1950s.

Andrew Schorr:
Okay, is there—is there still a place for this, Dr. Keating?

Dr. Keating:
As they say in the classics, hell no. If any of you get a recommendation to go onto chlorambucil, get a second opinion.

Andrew Schorr:
Okay, well, all right. So you can scratch that one off. And years ago, with the FCR, so fludarabine (Fludara) was the F, and the C cyclophosphamide. And that was the trial, the Phase II trial, I was on starting in 2000, and I got a 17-year remission out of it. Adding the rituximab (Rituxan). So, Dr. Keating, you devised that. Is there still an FCR use?

Dr. Keating:
Not exactly. We still use the FC backbone of chemotherapy in people that have a mutated immunoglobin gene, but we've replaced the R with G, or Gazyva, or obinutuzumab, and we've combined it together with ibrutinib.

That's the only group of patients—probably only about 10 percent of the patients that I see go on to a chemotherapy program.

Andrew Schorr:
Okay. Dr. Sharman, is "chemo" a dirty word?

Dr. Sharman:
You know, it's an interesting time right now because roughly in 2014 we had a number of drugs approved that really upended the status quo in the field. It was a chemotherapy field, and in relatively short order we had the approval for ibrutinib, idelalisib (Zydelig); obinutuzumab, which is Gazyva, became available. We now have venetoclax (Venclexta). The whole field has really shifted, almost with whiplash proportions, from a chemotherapy-only to now a, "Where does chemotherapy fit, and does it fit?"

And I think that you could find really thoughtful individuals who debate about the appropriate role for chemotherapy in the management of patients with chronic lymphocytic leukemia. There are some seasoned, thoughtful experts who really don't use chemotherapy any further, and there are others who think that in appropriately selected individuals, the use of chemotherapy is a nice way to get prolonged disease remission such as yours, without the need for continuous therapy. And so perhaps later today we'll talk about some of those patients, and who might fit under which circumstances.

Andrew Schorr:
Yeah, we'll have to talk about that. So, Dr. Kolibaba, we've had—and Dr. Sharman just mentioned it—all these new drugs, and it kinda—does it make your head spin? I mean, we're grateful that so much has been happening, it gives people a great deal of hope.

Dr. Kolibaba:
It does give people a great deal of hope. And that's one reason that participating in clinical trials is so exciting. Because many of these drugs will go on to be FDA-approved.

Because we're working with targets; these are not just a random chemical that you pull off the shelf, but rather something designed to interfere with how CLL causes trouble.