Which CLL Tests Should You Have and When?

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Andrew Schorr:
So these questions are how often should I have tests and what? So, Dr. Kipps, you know, mention this array of tests, but like, you know, let's say we've been treated for CLL—like I had FCR years ago, somebody may have had BR or whatever it was or chlorambucil (Leukeran), whatever—how often, if you're not on active therapy now, or even maybe we could bring in maybe the oral therapies, how often do you need to be monitored to see what's going on? And this FISH testing that you mentioned, how often does that come in? So how do you decide, Dr. Kipps?

Dr. Kipps:
Well, if things are moving quickly, we need to have more frequent exams. And if things are moving slowly, then the exams can be spaced out. I think that we have to use some clinical judgment here as to how frequently we should get a CBC. I mentioned to you that we have had patients who had lymphocyte doubling times of two weeks, and it would be inappropriate for me to say come back in three months, and we'll check your CBC again. On the other hand, we have patients who we are hard-pressed to even tell where their lymphocyte counts are going to double up, and I think it would be excessive to expect them to come in every couple weeks for a CBC.

So I think it's really dependent upon the tempo at which things are changing, and when you want to monitor a patient. Even a patient who has very stable disease, you can pick an appropriate interval of time to be able assess whether there are any changes in how that patient is doing.

We do know that patients who are doing very well can sometimes have a small number of cells or one sub-clone that takes on an attitude and starts to divide more quickly than the rest of its cells in the leukemia clone, and that could cause progression that was not apparent over the past few years. And so I think it is prudent for us not to ignore it and say, gee, my lab tests have been stable over the past year, I may not need it again for maybe 10 years. I don't think that's wholly appropriate either. I think that—so the frequency of the lab tests of course is dictated by the tempo of the progression or changes.

Andrew Schorr:
Okay. And that applies to FISH.

Dr. Kipps:
Yeah. FISH analysis is important too. It's an expensive test, and I'm still shocked. I was in Australia giving talks, and they still don't reimburse for FISH analysis, but they recommend patients all get chemoimmunotherapy at the time they need therapy. I don't like that, and I've actually criticized the Australian government to try and change that.

I do think getting a FISH analysis and genetic analysis is appropriate at the time when we say, okay, we've been following you now. We have come to the conclusion that treatment is not a question of if but a question of when. And sometimes in CLL with particularly less aggressive progression, but that is relentless, and we are able to actually bank on it. We do know that we'll get into problems sooner or later.

But I want to say that patients are empowered to then say, okay, they're going to look at the problem and try to define the best time, the best timing for engaging in treatment so that they are not doing a million and one things when they are trying to get treatment. Because sometimes when you start therapy things can be a little bit metastable, and you might have changes or require tests that would be inconvenient if you were on the road and traveling and keeping a very vigorous schedule.

So it does put patients in charge then of finding when would be the most convenient time to try and schedule therapy. Like we don't have to panic. We just have to take care of it. And I think getting a FISH at that time and then using that as a means it goes through all the different options that we may have for treatment and defining what type of treatment works best for me.

There are pros and cons for every therapy. There's no safe therapy, there's no dangerous therapy other than, of course, some crazy therapies I wouldn't recommend, but quite frankly each therapy has a downside that we have to discuss, and it also could mean as simple a thing of how it interferes with the patient's lifestyle. If the treatment itself is affecting the quality of life and the patient's quality of life was pretty good before they got treated, that's no fun either.

So I think we need to assess what we get into when we talk about therapy. What is the duration? What are the problems? What do I have to go through? Is there going to be increased risk of this or that? Typically, we do see increased risk for, say, things like infection and what have you we have to be mindful of. So I think that we need to be able to outline these different treatments and decide what therapy works best for me, because there's no therapy that fits all.

Andrew Schorr:
Hey, friends, don't I have a great doctor? I've had great doctors along the way, Dr. Keating, Dr. Kipps, and I'm very grateful. Okay.

So, Susan, so he mentioned earlier you know 17p—Ps and Qs. Okay. So could you just explain to our audience just so we get it? This can change. So in other words, that FISH analysis that was done at one point, maybe like for me years ago, and now again sometime later, which has probably happened at UC San Diego, it may come up differently, right? How does that happen? It changes, right, Susan?

Dr. Leclair:
Yes, it does. And by the way for those who are confused, you have Ps and Qs. I always found P for petite, like French, small, was always a good way to remember that that was the upper half of the chromosome, which is an easy way to keep them separated in your head.

And the answer to your concern is that life happens, and so we are born with a complete set of, well at the moment I'm going to call them perfect, chromosomes. They are exactly what we were supposed to have in order to be born. But then you went out in the sun far too many times, and some small mutations happened because, as we all know, the sun, energy, can cause mutations in cells.

But one of them made you a little bit slower on digesting, I don't know, carbohydrates, and then another mutation made you a little faster on healing. I think we'd all like something like that. And as you live, as you find out that the boy or girl that you spent the afternoon with in 1st grade had chickenpox, or—and so did you then as a consequence—or some drug that you took for a legitimate reason for disease A might have done something inappropriate in another cell. These things

are—occur to us, I don't want to call it every day, because that would frighten people—but they occur because we live, and we are exposed to things.

Now, certainly, everybody knows that you really don't want to be exposed to a large amount of radiation, so there are things that you can do to mitigate your exposures, but they happen. And so what happens to people is as they age, as they meet up with different things, some people are lucky, and the only thing that they get is maybe a small basal cell on their cheek that's removed. Some others aren't so lucky. So that kind of modification is going to occur throughout life for everybody.