Meet The Professor
Management of Chronic Lymphocytic Leukemia

Prof John G Gribben, MD, DSc, FMedSci
Chair of Medical Oncology
Barts Cancer Institute
Queen Mary University of London
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London, United Kingdom

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Commercial Support

These activities are supported by educational grants from AbbVie Inc and AstraZeneca Pharmaceuticals LP.

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Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following commercial interests: AbbVie Inc, Acerta Pharma — A member of the AstraZeneca Group, Adaptive Biotechnologies Corporation, Agendia Inc, Agios Pharmaceuticals Inc, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Astellas, AstraZeneca Pharmaceuticals LP, Bayer HealthCare Pharmaceuticals, Biodesix Inc, bioTheranostics Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol-Myers Squibb Company, Celgene Corporation, Clovis Oncology, Daiichi Sankyo Inc, Dendreon Pharmaceuticals Inc, Eisai Inc, EMD Serono Inc, Epizyme Inc, Exelixis Inc, Foundation Medicine, Genentech, a member of the Roche Group, Genmab, Genomic Health Inc, Gilead Sciences Inc, GlaxoSmithKline, Grail Inc, Guardant Health, Halozyme Inc, Helsinn Healthcare SA, ImmunoGen Inc, Incyte Corporation, Infinity Pharmaceuticals Inc, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, administered by Janssen Scientific Affairs LLC, Jazz Pharmaceuticals Inc, Karyopharm Therapeutics, Kite, A Gilead Company, Lexicon Pharmaceuticals Inc, Lilly, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Merck, Merrimack Pharmaceuticals Inc, Myriad Genetic Laboratories Inc, Natera Inc, Novartis, Oncopeptides, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Prometheus Laboratories Inc, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Sandoz Inc, a Novartis Division, Sanofi Genzyme, Seagen Inc, Sirtex Medical Ltd, Spectrum Pharmaceuticals Inc, Sumitomo Dainippon Pharma Oncology Inc, Taiho Oncology Inc, Takeda Oncology, Tesaro, A GSK Company, Teva Oncology, Tokai Pharmaceuticals Inc and Verastem Inc.

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Prof Gribben — Disclosures

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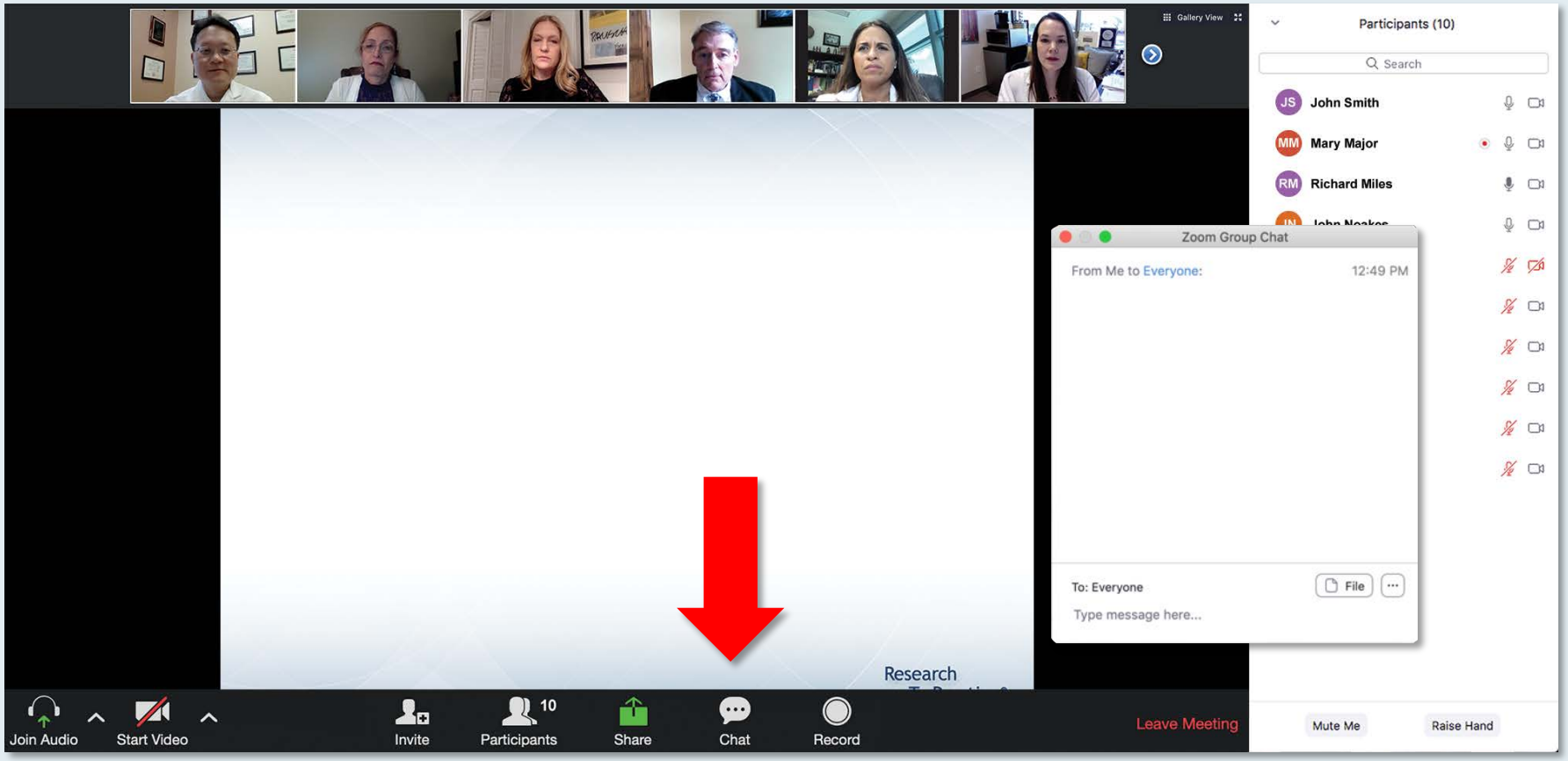
We Encourage Clinicians in Practice to Submit Questions



Feel free to submit questions now before the program begins and throughout the program.

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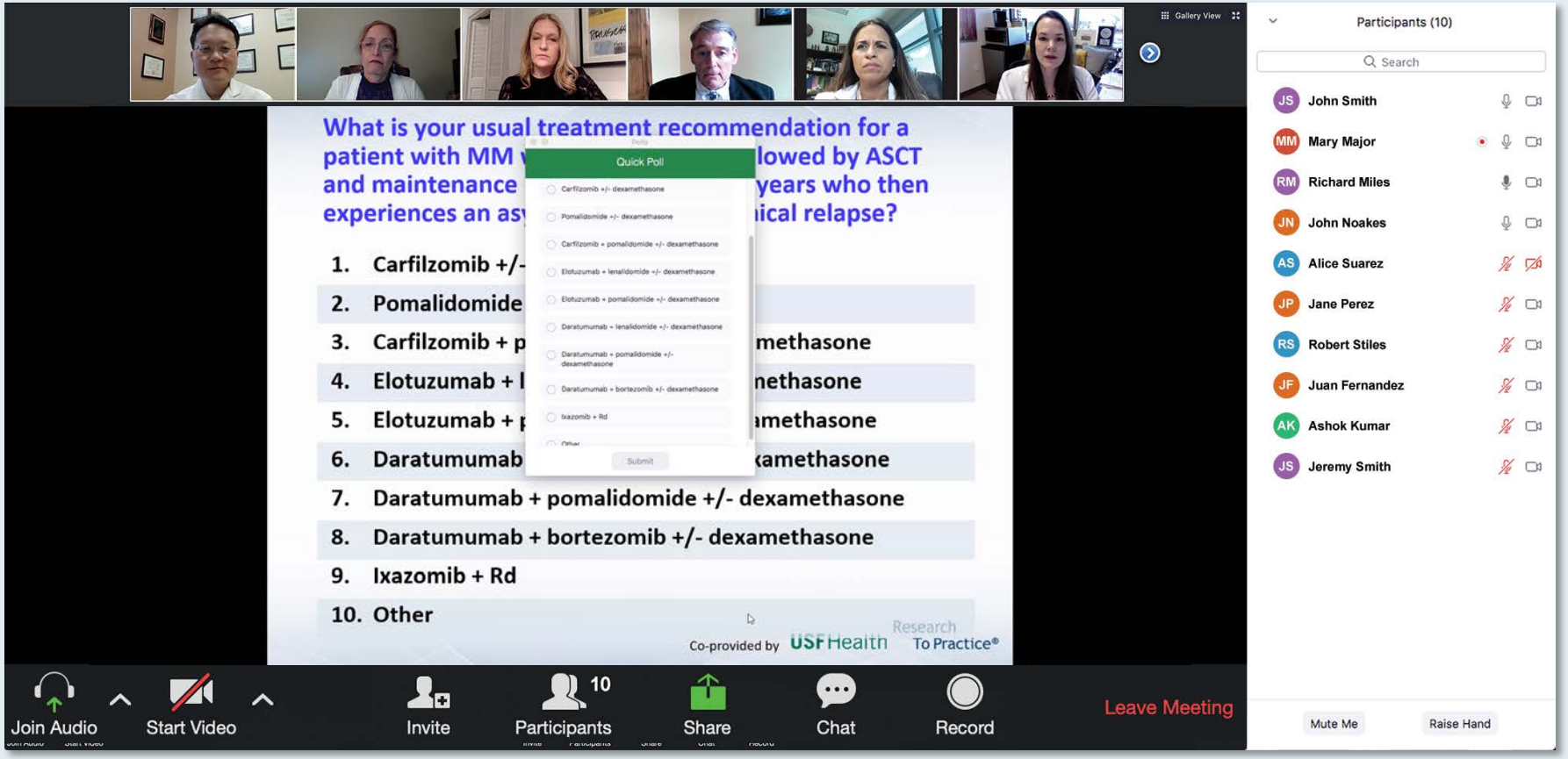
Familiarizing Yourself with the Zoom Interface

How to answer poll questions



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Upcoming Webinars

Monday, November 23, 2020
12:00 PM – 1:00 PM ET

Meet The Professor: Management of Ovarian Cancer

Faculty
Deborah K Armstrong, MD

Moderator
Neil Love, MD

Tuesday, December 1, 2020
5:00 PM – 6:00 PM ET

Year in Review: Clinical Investigators Provide Perspectives on the Most Relevant New Publications, Data Sets and Advances in Oncology Prostate Cancer

Faculty
Emmanuel S Antonarakis, MD
Andrew J Armstrong, MD, ScM

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Friday, December 4, 2020

Consensus or Controversy? Investigators Discuss Clinical Practice Patterns and Available Research Data Guiding the Management of Hematologic Cancers

A 4-Part Friday Satellite Symposia Live Webinar Series Preceding the 62nd ASH Annual Meeting

Moderator

Neil Love, MD

Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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ONCOLOGY TODAY

SPECIAL EDITION: FRONT-LINE TREATMENT OF CHRONIC LYMPHOCYTIC LEUKEMIA

WITH DR NEIL LOVE

DR JOHN PAGEL
SWEDISH CANCER INSTITUTE
SEATTLE, WASHINGTON

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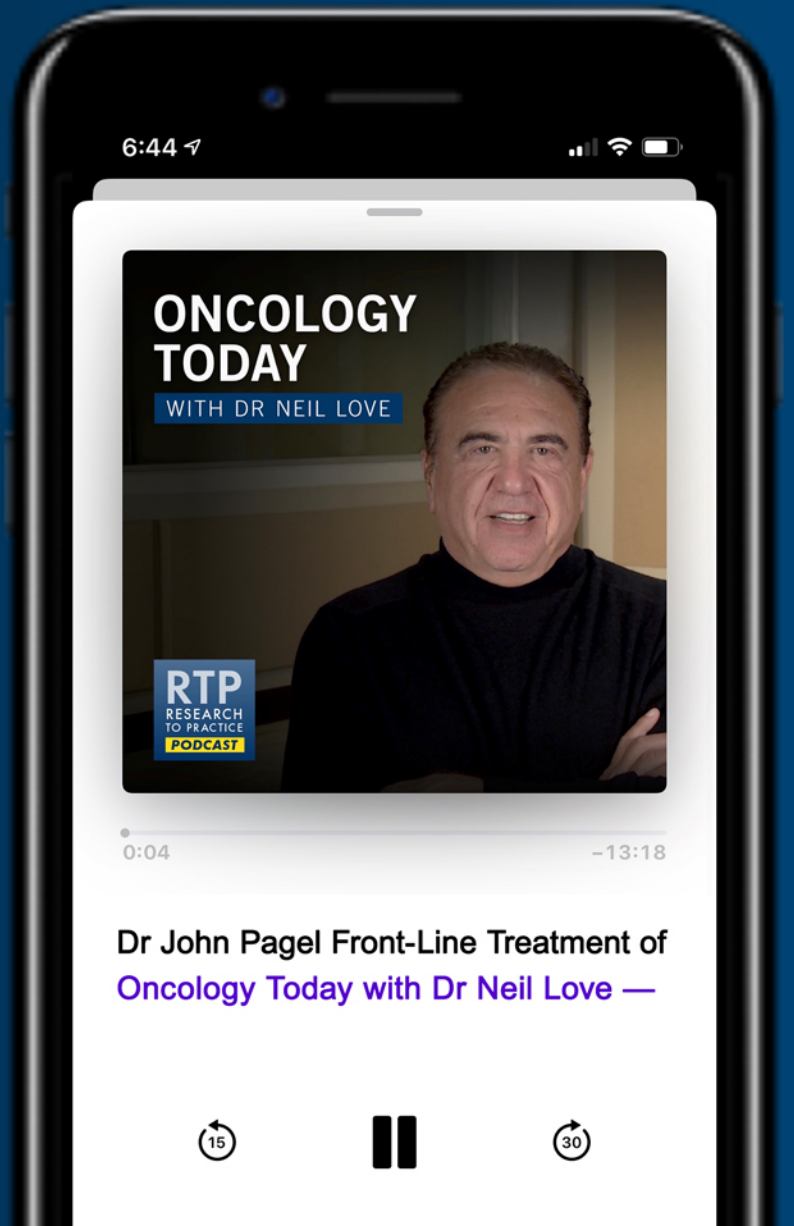
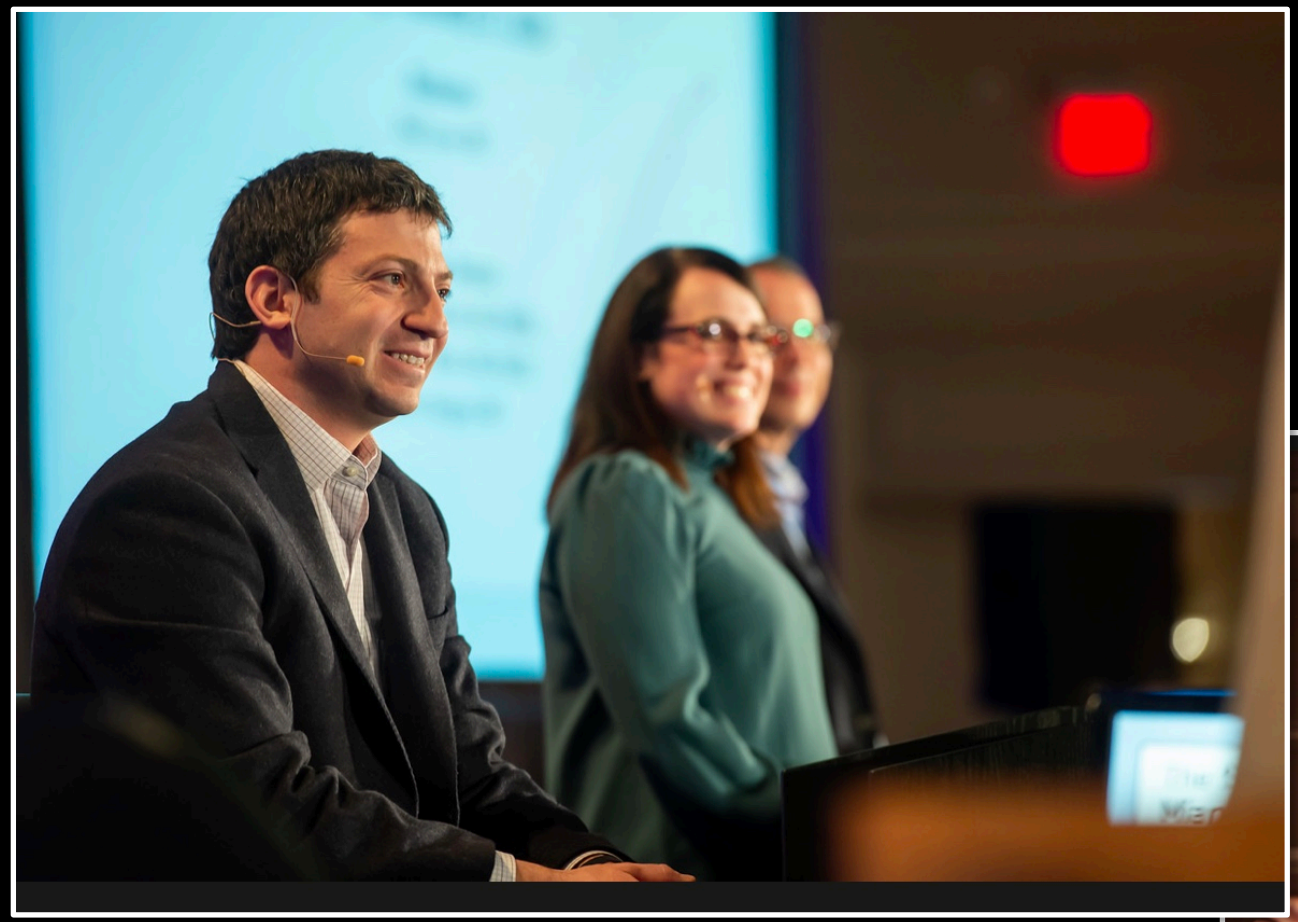



What would be your most likely approach for a patient with newly diagnosed CLL to whom you decide to administer up-front venetoclax/obinutuzumab who has detectable MRD after completing 1 year of treatment?




What are the key studies in selecting front line therapy?

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London, United Kingdom

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Meet The Professor Program Participating Faculty

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Brad S Kahl, MD
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Director, Lymphoma Program
Siteman Cancer Center
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Meet The Professor Program Participating Faculty

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Chief of Hematologic Malignancies
Center for Blood Disorders and Stem Cell Transplantation
Swedish Cancer Institute
Seattle, Washington

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Columbus, Ohio

Jeff Sharman, MD
Willamette Valley Cancer Institute and Research Center
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US Oncology
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Tanya Siddiqi, MD
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Director, Chronic Lymphocytic Leukemia Program
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City of Hope National Medical Center
Duarte, California

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Associate Center Director for Clinical Investigations
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Jennifer Woyach, MD
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Division of Hematology
Department of Internal Medicine
The Ohio State University
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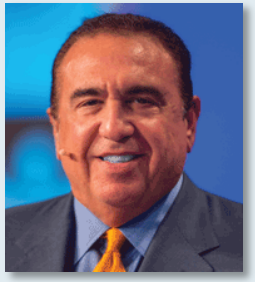
Columbus, Ohio

William G Wierda, MD, PhD
DB Lane Cancer Research
Distinguished Professor
Department of Leukemia
Division of Cancer Medicine
The University of Texas
MD Anderson Cancer Center
Houston, Texas



Project Chair
Neil Love, MD
Research To Practice
Miami, Florida

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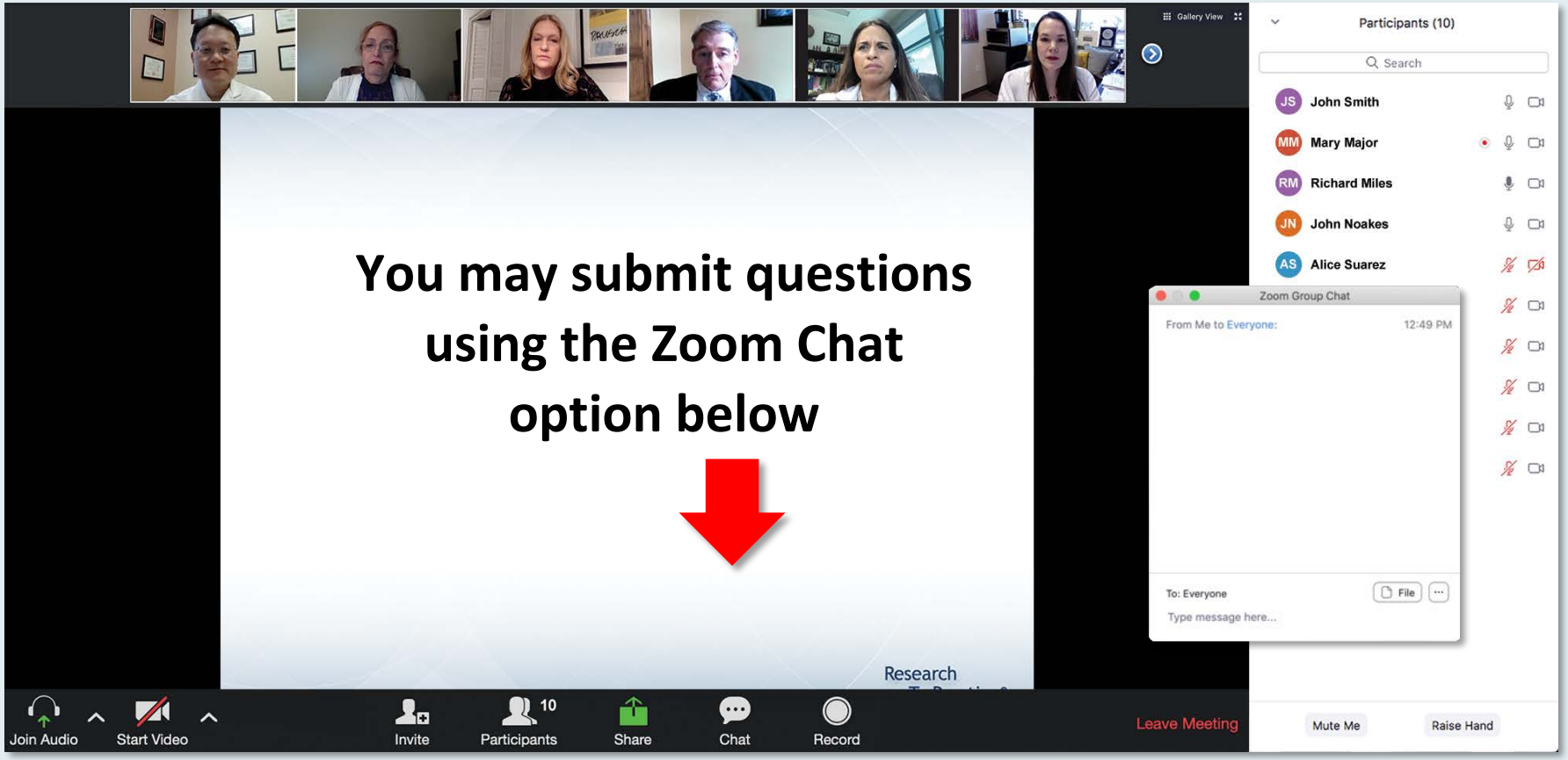
We Encourage Clinicians in Practice to Submit Questions



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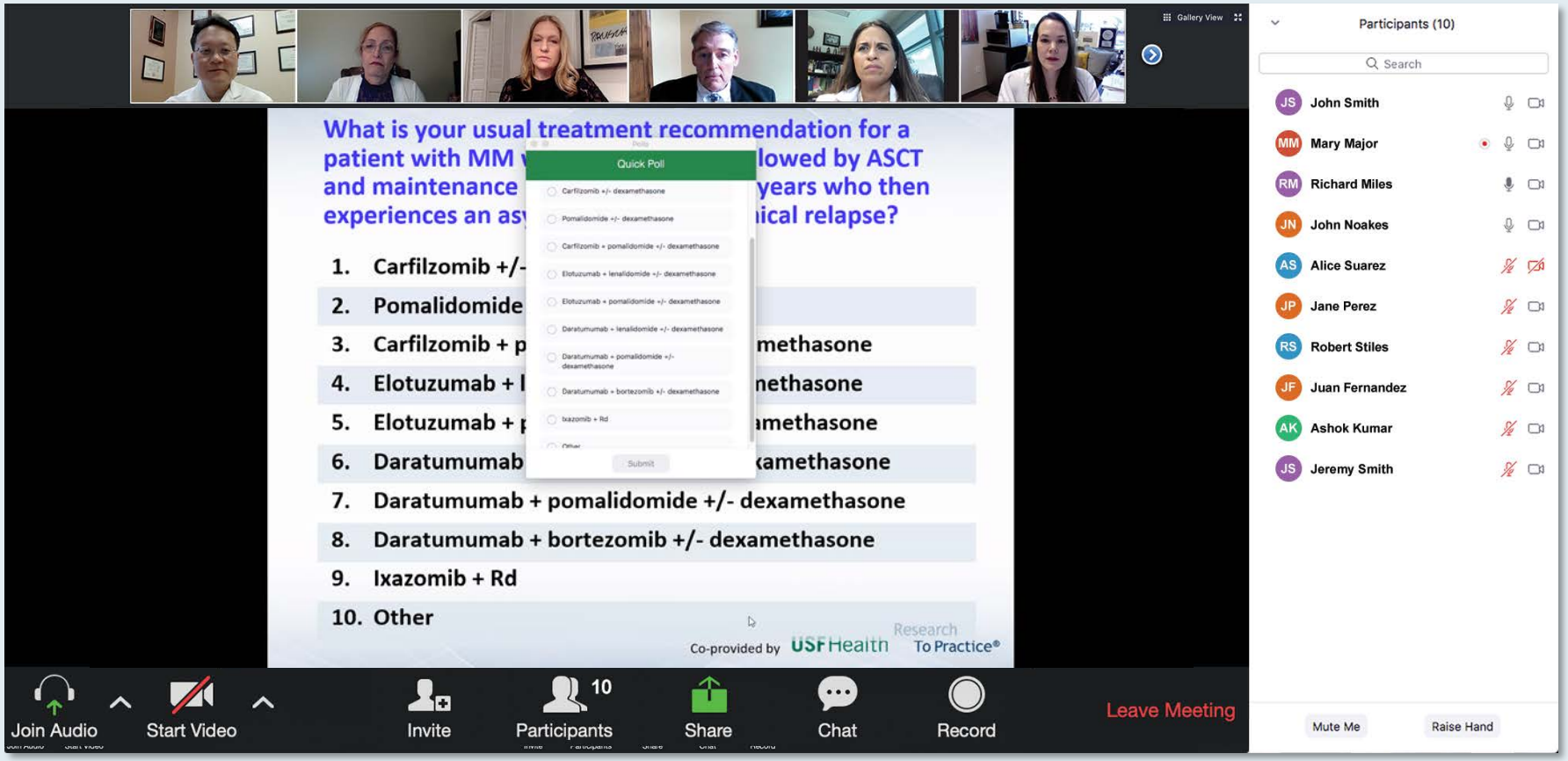

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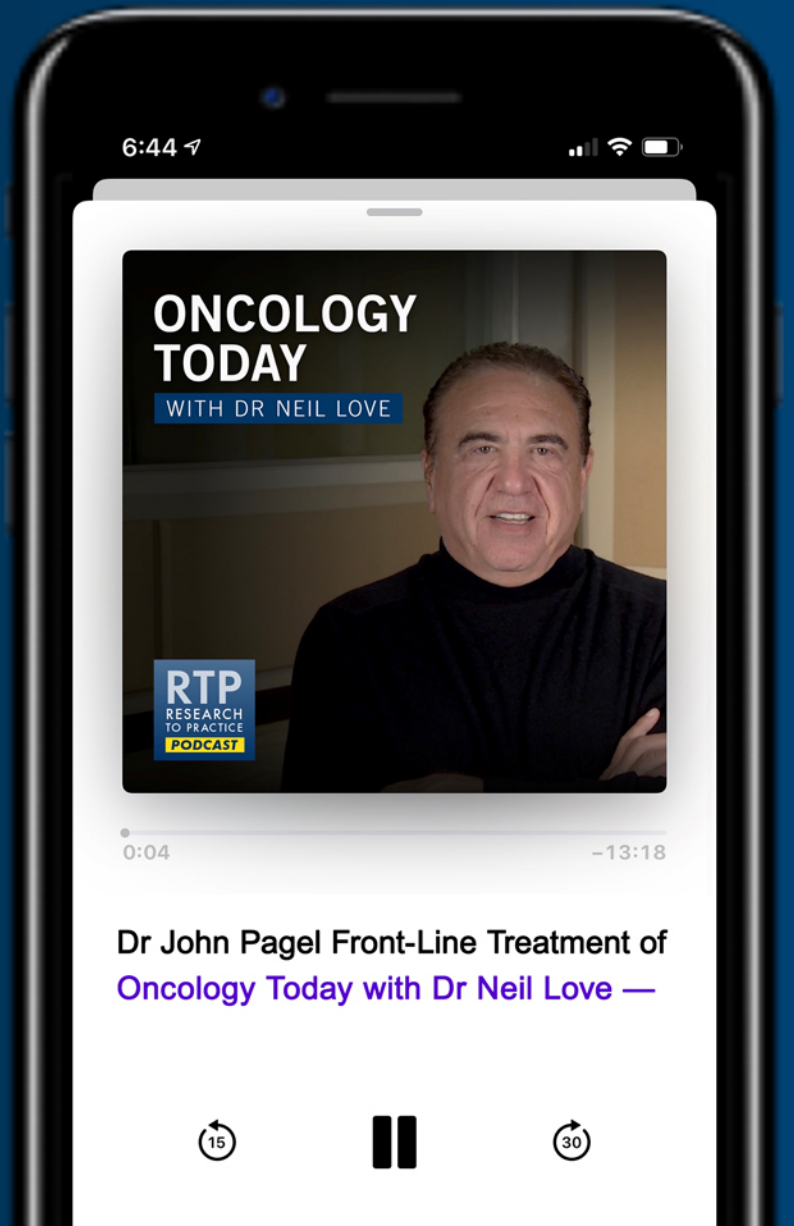

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Consensus or Controversy? Investigators Discuss Clinical Practice Patterns and Available Research Data Guiding the Management of Hematologic Cancers

A 4-Part Friday Satellite Symposia Live Webinar Series Preceding the 62nd ASH Annual Meeting

Friday, December 4, 2020

Multiple Myeloma
8:30 AM – 10:00 AM Pacific Time
(11:30 AM – 1:00 PM ET)

Chronic Lymphocytic Leukemia
12:00 PM – 1:30 PM Pacific Time
(3:00 PM – 4:30 PM ET)

Acute Myeloid Leukemia
3:00 PM – 4:30 PM Pacific Time
(6:00 PM – 7:30 PM ET)

Hodgkin and Non-Hodgkin Lymphoma
7:00 PM – 8:30 PM Pacific Time
(10:00 PM – 11:30 PM ET)

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Namrata I Peswani, MD
Hematologist Oncologist
UT Southwestern/Harold C Simmons Comprehensive Cancer Center
Richardson, Texas

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Kerry Rogers, MD
Assistant Professor in the Division of Hematology
The Ohio State University
Columbus, Ohio

Meet The Professor with Prof Gribben

MODULE 1: Cases from Drs Peswani and Rogers

- Dr Peswani: A 60-year-old man (30 pack-year smoking history) with CLL and non-small cell lung cancer
- Dr Rogers: A 71-year-old man with high-risk, relapsed/refractory CLL – del(17p), no IGHV mutation – Part 1
- Dr Rogers: A 71-year-old man with high-risk, relapsed/refractory CLL – del(17p), no IGHV mutation – Part 2
- Dr Peswani: A 52-year-old woman with CLL – IGHV mutation
- Dr Peswani: A 63-year-old man with CLL and ZAP70+, IGHV mutation – Primary refractory to ibrutinib – Part 1
- Dr Peswani: A 63-year-old man with CLL and ZAP70+, IGHV mutation – Primary refractory to ibrutinib – Part 2

MODULE 2: CLL Journal Club with Prof Gribben

MODULE 3: Beyond the Guidelines – Clinical Investigator Approaches to Common Clinical Scenarios

MODULE 4: Key Recent Data Sets

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Case Presentation – Dr Peswani: A 60-year-old man (30 pack-year smoking history) with CLL and non-small cell lung cancer

Dr Namrata Peswani

- Diagnosed with CLL, del(13q), IGHV mutated (ALC 8,000)
- Observation x 3 months → New rash, anemia, thrombocytopenia
  - CT: Extensive adenopathy, including hilar and mediastinal LNs, right lung infiltrate
  - Bronchoscopy: CLL
- Ibrutinib → (ALC 4,500), with response in lymphadenopathy except hilar and mediastinal nodes
- 3 months later: Scan and biopsy of RLL nodule: NSCLC, PD-L1 100%

Questions

- Could this patient be treated with pembrolizumab in order to control his NSCLC along with his CLL?

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Case Presentation – Dr Rogers: A 71-year-old man with high-risk, relapsed/refractory CLL – del(17p), no IGHV mutation – Part 1

Dr Kerry Rogers

- 2008: Diagnosed with CLL after donating platelets, but no enlarged lymph nodes; Asymptomatic → Observation
- 2009: Bulky lymph nodes → FCR x 6
- 2012: Bedamustine/rituximab → relapsed <6 months later → Sent to referral center
- Cytogenetics: FISH del(17p), normal karyotype, IGHV unmutated

Case Presentation – Dr Rogers: A 71-year-old man with high-risk, relapsed/refractory CLL – del(17p), no IGHV mutation – Part 2

Dr Kerry Rogers

- 2008: Diagnosed with CLL after donating platelets, but no enlarged lymph nodes; Asymptomatic → Observation
- 2009: Bulky lymph nodes → FCR x 6
- 2012: Bedamustine/rituximab → relapsed <6 months later → Sent to referral center
- Cytogenetics: FISH del(17p), normal karyotype, IGHV unmutated
- ***Dinaciclib/ofatumumab on clinical trial***
- ***2015: Enlarged lymph nodes, cytogenetics unchanged***
- ***Acalabrutinib on clinical trial***
  - ***5/2017: BTK C481S noted on testing, VAF 0.4%***
  - ***2/2018: Small enlarged lymph nodes, BTK C481S VAF 87%***
- ***2020: Venetoclax ongoing, BTK C481S VAF 0%***

Questions

- What clinical testing for ibrutinib resistance mutations are you doing in your practice?

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Case Presentation – Dr Peswani: A 52-year-old woman with CLL – IGHV mutation

Dr Namrata Peswani

- Diagnosed with CLL, del(13q), IGHV mutated
- ALC 15,000 and palpable, small cervical LAD, mild anemia (Hgb: 11), Platelets: 130,000
- Observation x 6 months → 50% increase in ALC, rapid increase in adenopathy, Hgb<10, Platelets: 80,000
- Offered ibrutinib but patient declines long-term medication
- FCR x 6 months, with CR, but patient is now anxious about not receiving any medication and requests ibrutinib

Questions

- Is there any role for maintenance therapy after chemoimmunotherapy?

Case Presentation – Dr Peswani: A 63-year-old man with CLL and ZAP70+, IGHV mutation – Primary refractory to ibrutinib – Part 1

Dr Namrata Peswani

- 6/2019: Bilateral lower extremity edema, scrotal edema, extensive bulky retroperitoneal lymphadenopathy (17-cm), lymphocyte count: 10,000
- Biopsy: CLL/SLL, trisomy 12, deletion 11q, ZAP70-positive, IGHV mutated
- 9/2019: Ibrutinib 420 mg, with improvement in edema and initial decrease in leukocytosis
  - Rash, eye changes, nail changes, hypertension, AV block
- Second opinion due to plateau of symptoms, “not feeling well” on ibrutinib
- 7/2020: Bulky retroperitoneal LAD (16-cm), normal WBC/ALC, Hgb 10, platelets 80,000

Case Presentation – Dr Peswani: A 63-year-old man with CLL and ZAP70+, IGHV mutation – Primary refractory to ibrutinib – Part 2

Dr Namrata Peswani

- 6/2019: Bilateral lower extremity edema, scrotal edema, extensive bulky retroperitoneal lymphadenopathy (17-cm), lymphocyte count: 10,000
- Biopsy: CLL/SLL, trisomy 12, deletion 11q, ZAP70-positive, IGHV mutated
- 9/2019: Ibrutinib 420 mg, with improvement in edema and initial decrease in leukocytosis
- Second opinion due to plateau of symptoms, "not feeling well" on ibrutinib
  - Rash, eye changes, nail changes, hypertension
- 7/2020: Bulky retroperitoneal LAD (16-cm), normal WBC/ALC, Hgb 10, platelets 80,000
- HTN, AV block, nasal lesion, skin rash and nail changes since starting ibrutinib
- ***Discussed switching to venetoclax/rituximab, but patient is reluctant***

Questions

- What are your thoughts about reducing the dose of ibrutinib to better manage side effects?
- What are your thoughts about switching therapy to acalabrutinib?

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Meet The Professor with Prof Gribben

MODULE 1: Cases from Drs Peswani and Rogers

MODULE 2: CLL Journal Club with Prof Gribben

- Clinical outcomes of COVID-19 in patients with hematologic cancers
- Effect of ibrutinib on obinutuzumab-induced cytokine secretion
- Assessment and practical management of venetoclax-associated tumor lysis syndrome (TLS)
- CLARITY trial: Ibrutinib/venetoclax
- Umbralisib with ublituximab for CLL
- EHA position paper on personalized treatment for hematologic diseases
- Bone marrow niches in hematologic cancers
- iLLUMINATE trial: Ibrutinib/obinutuzumab
- Minimal residual disease response after obinutuzumab/bendamustine in the GADOLIN trial
- Ibrutinib versus chlorambucil/obinutuzumab in previously untreated CLL
- GALLIUM trial: Obinutuzumab/chemotherapy versus rituximab/chemotherapy
- Measuring clinical benefit of treatments
- Do we need to analyze everything at CLL diagnosis?
- Biosimilar agents in hematology
- Growth dynamics in naturally progressing CLL

MODULE 3: Beyond the Guidelines – Clinical Investigator Approaches to Common Clinical Scenarios

MODULE 4: Key Recent Data Sets

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Clinical outcome of coronavirus disease 2019 in haemato-oncology patients

Aries J et al. *Br J Haematol* 2020;190(2):e64-7.

Ibrutinib Decreases Obinutuzumab-Induced Secretion of Cytokines Associated with Infusion-Related Reactions in Patients with CLL: Analysis from the Illuminate Study

Greil R et al.

ICML 2019;Abstract 163.

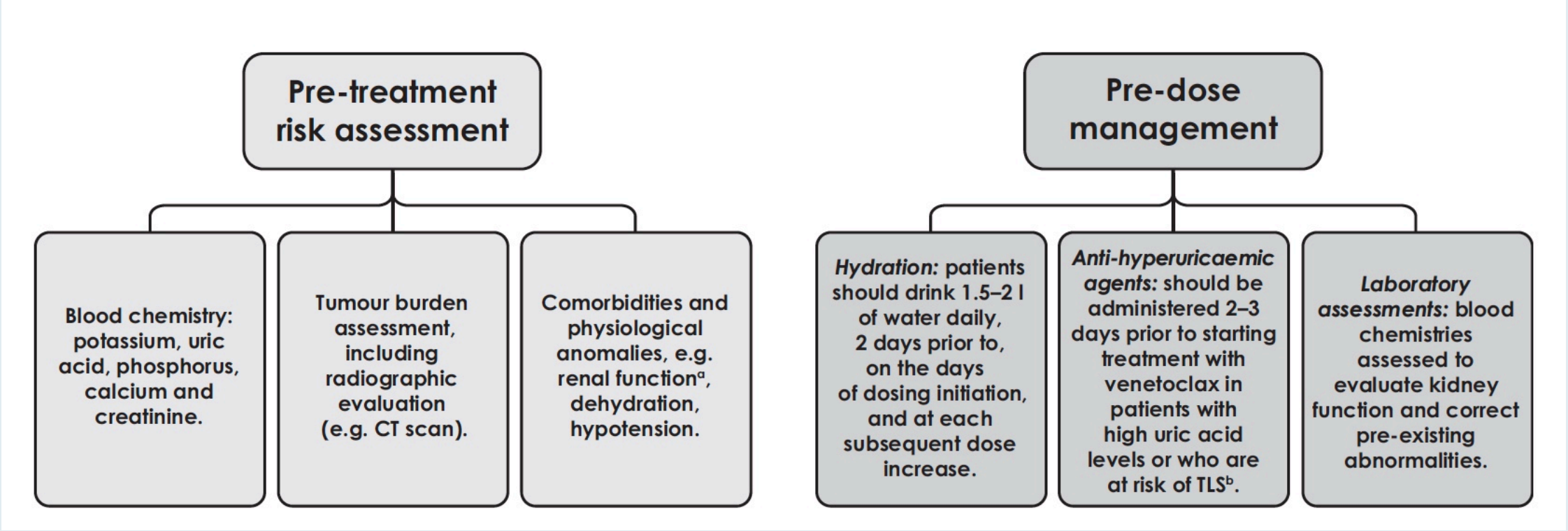
Br J Haematol 2020;188(6):844-51

bjh emergencies in haematology

Practical management of tumour lysis syndrome in venetoclax-treated patients with chronic lymphocytic leukaemia

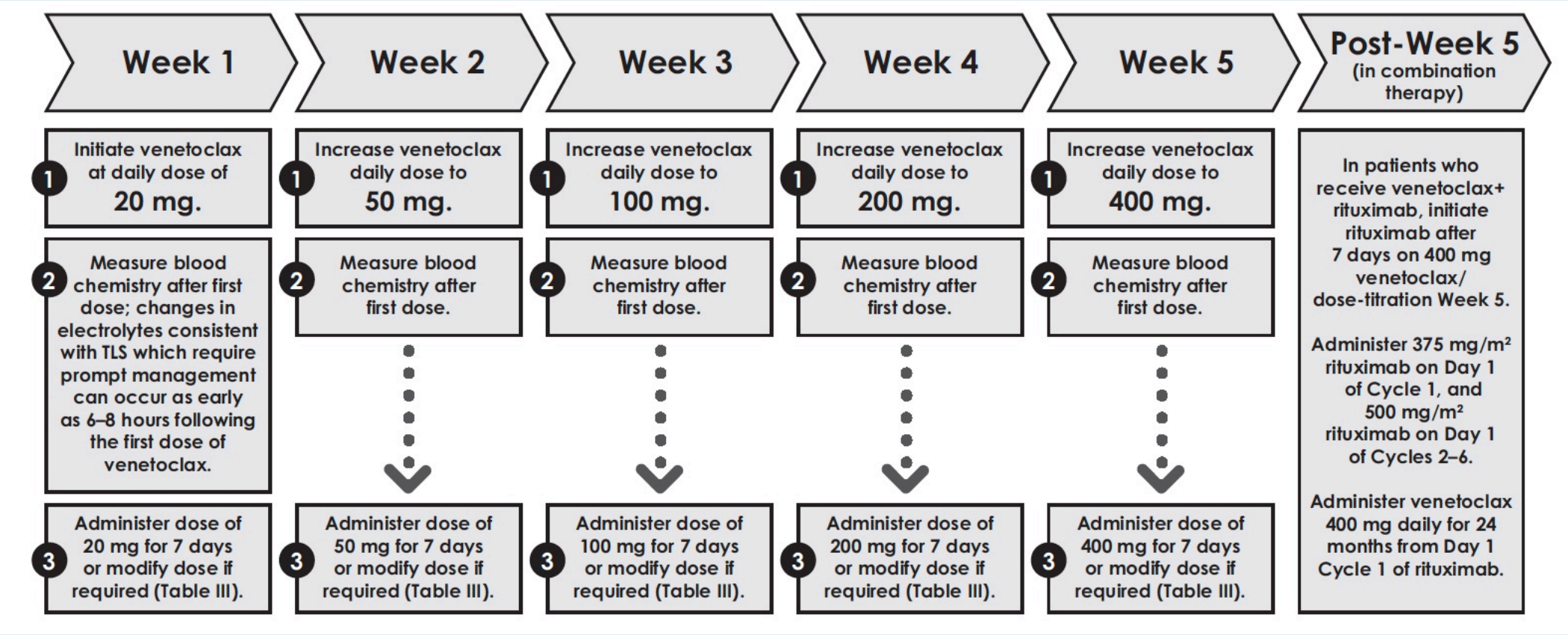
John G. Gribben

Predose Initiation for Venetoclax



Gribben JG. *Br J Haematol* 2020;188(6):844-51.

Venetoclax 5-Week Dose Titration Schedule



Gribben JG. *Br J Haematol* 2020;188(6):844-51.

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rapid communication

Ibrutinib Plus Venetoclax in Relapsed/Refractory Chronic Lymphocytic Leukemia: The CLARITY Study

Peter Hillmen, MBChB, PhD[1,2]; Andy C. Rawstron, PhD[2]; Kristian Brock, MSc[3]; Samuel Muñoz-Vicente, MSc[3]; Francesca J. Yates, PhD[3]; Rebecca Bishop[3]; Rebecca Boucher, MSc[3]; Donald MacDonald, PhD[4]; Christopher Fegan, MD[5,6]; Alison McCaig, PhD[7]; Anna Schuh, MD, PhD[8]; Andrew Pettitt, MA, MB BChir, PhD[9]; John G. Gribben, MD, DSc[10]; Piers E.M. Patten, MBChB, PhD[11,15]; Stephen Devereux, PhD[11]; Adrian Bloor, MA, MB BChir, PhD[12]; Christopher P. Fox, MBChB, PhD[13]; Francesco Forconi, MD, DM, PhD[14,16]; and Talha Munir, MBBS[2]

J Clin Oncol 2019 Oct 20;37(30):2722-2729

Continued Long Term Responses to Ibrutinib + Venetoclax Treatment for Relapsed/Refractory CLL in the Blood Cancer UK TAP Clarity Trial

Hillmen P et al.

ASH 2019;Abstract 124.

Umbralisib plus Ublituximab (U2) Is Superior to Obinutuzumab plus Chlorambucil (O + Chl) in Patients with Treatment Naïve (TN) and Relapsed/Refractory (R/R) Chronic Lymphocytic Leukemia (CLL): Results from the Phase 3 Unity-CLL Study

Gribben JG et al.

ASH 2020;Abstract 543.

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HemaTopics

OPEN ACCESS

Personalized Treatment for Hematologic Diseases in Europe: An EHA Position Paper

Ulrich Jäger[1], Peter Kapitein[2], John Gribben[3]

Hemasphere 2020;4(5):e474

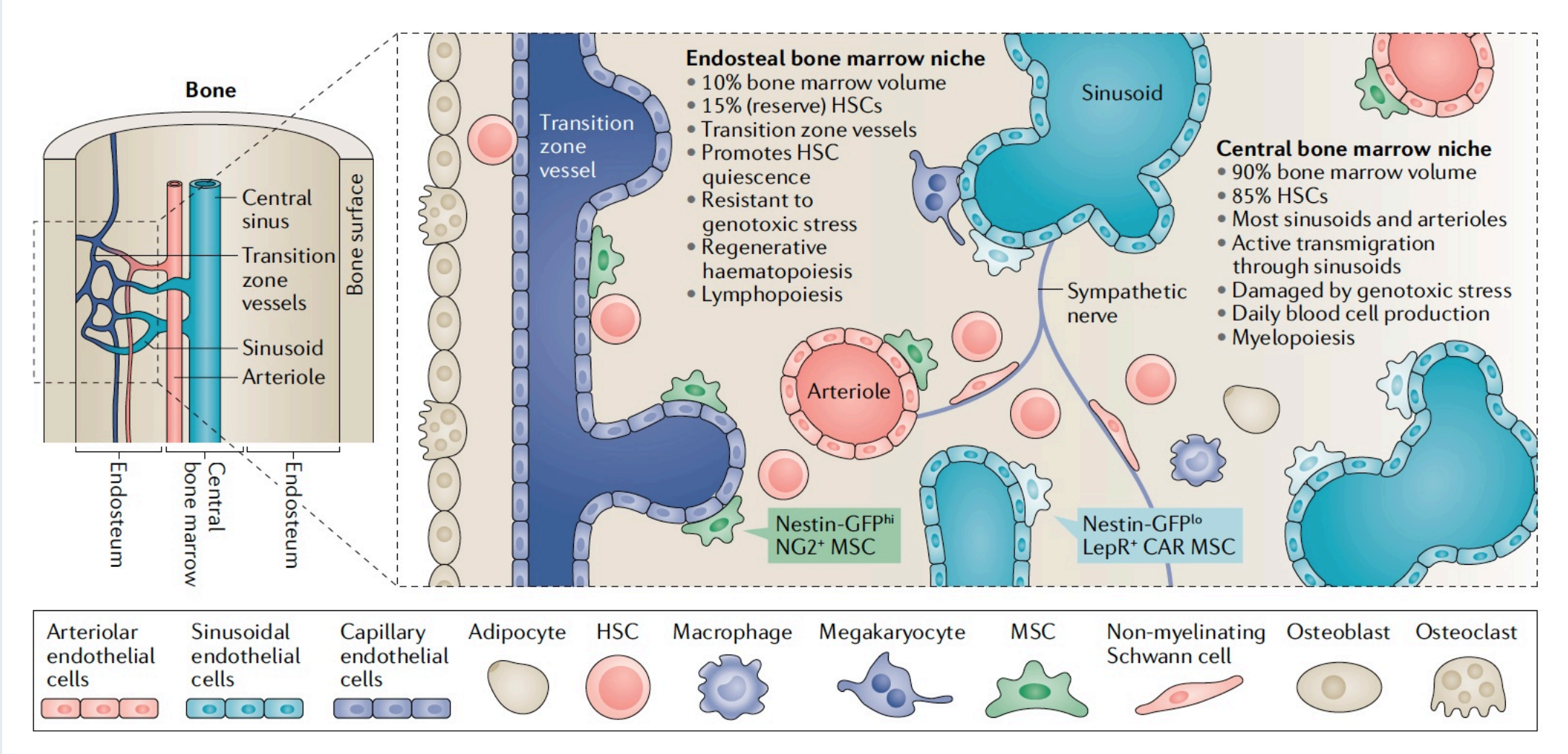
Nat Rev Cancer 2020;20(5):285-98

PERSPECTIVES

Bone marrow niches in haematological malignancies

Simón Méndez-Ferrer, Dominique Bonnet, David P. Steensma, Robert P. Hasserjian, Irene M. Ghobrial, John G. Gribben, Michael Andreeff and Daniela S. Krause

Features of Anatomically Defined Hematopoietic Stem Cell Niches in Mouse Bone Marrow



Méndez-Ferrer S et al. *Nat Rev Cancer* 2020;20(5):285-98.

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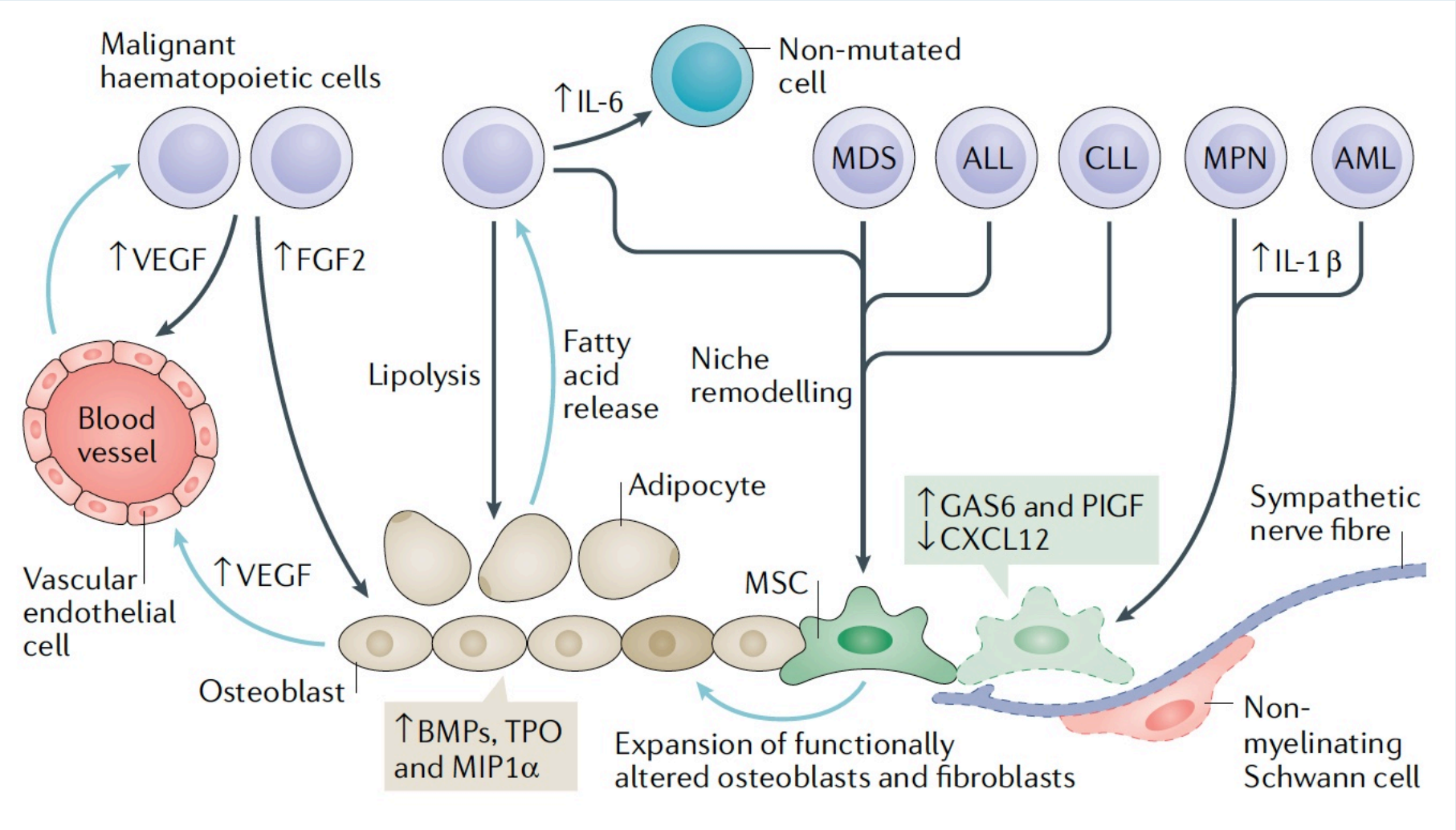
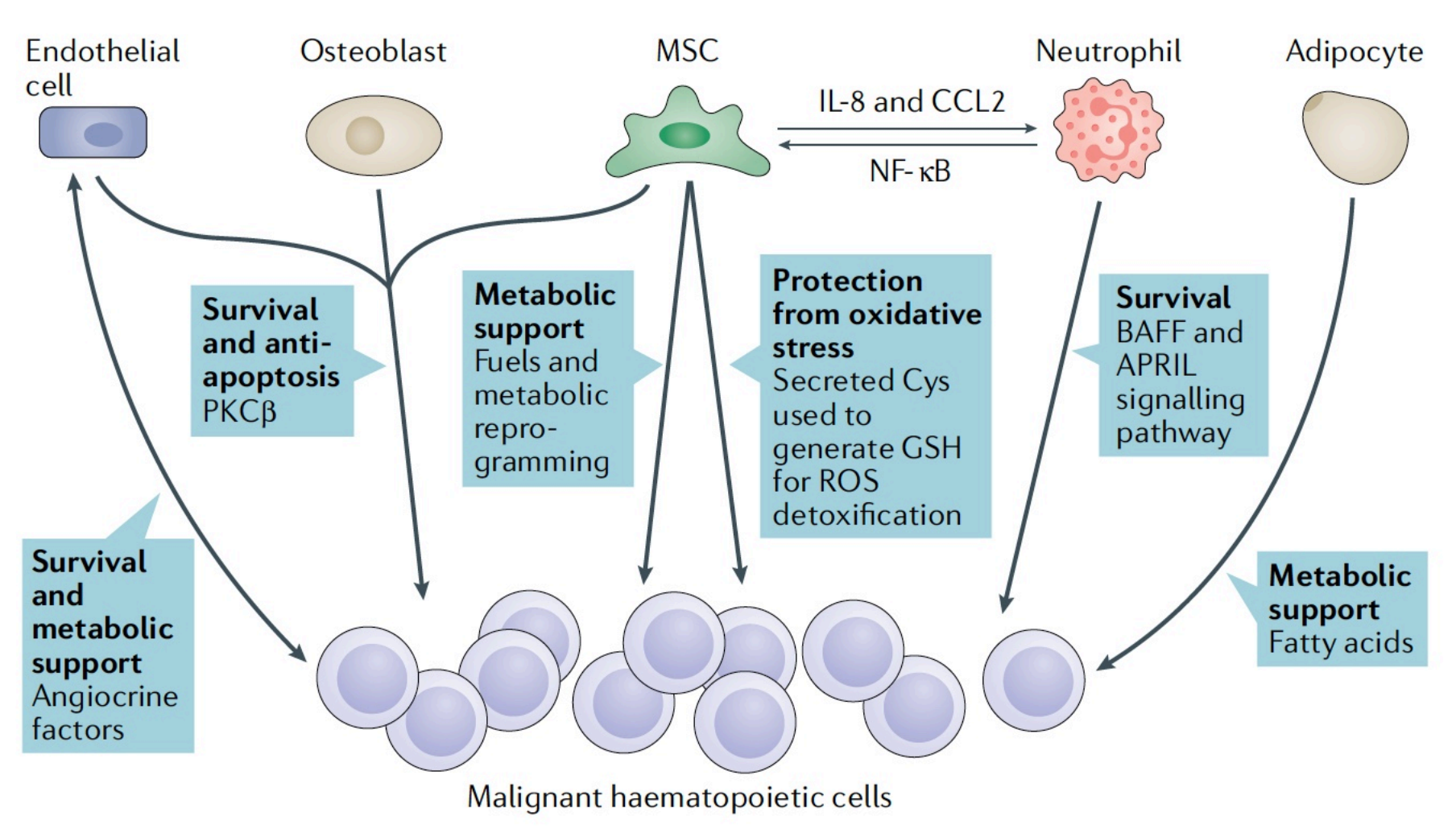
Bone Marrow Niche Remodeling Favors Disease Progression in Hematologic Cancer



Méndez-Ferrer S et al. *Nat Rev Cancer* 2020;20(5):285-98.

Contributions of the Bone Marrow Niche to Survival and Chemoresistance of Malignant Hematopoietic Cells



Méndez-Ferrer S et al. *Nat Rev Cancer* 2020;20(5):285-98.

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Lancet Oncol 2019;20(1):43-56

Ibrutinib plus obinutuzumab versus chlorambucil plus obinutuzumab in first-line treatment of chronic lymphocytic leukaemia (iLLUMINATE): a multicentre, randomised, open-label, phase 3 trial

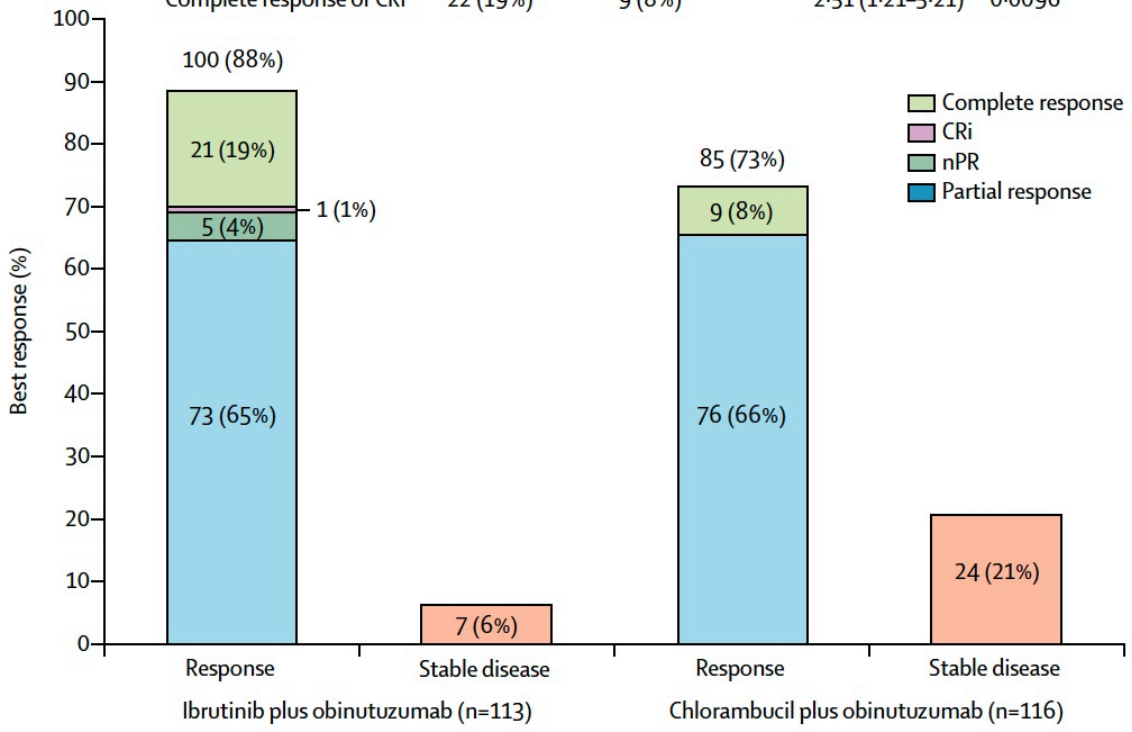
Carol Moreno, Richard Greil, Fatih Demirkan, Alessandra Tedeschi, Bertrand Anz, Loree Larratt, Martin Simkovic, Olga Samoilova, Jan Novak, Dina Ben-Yehuda, Vladimir Strugov, Devinder Gill, John G Gribben, Emily Hsu, Chih-Jian Lih, Cathy Zhou, Fong Clow, Danelle F James, Lori Styles, Ian W Flinn

Best Overall Response: Ibrutinib and Obinutuzumab versus Chlorambucil and Obinutuzumab

IRC Assessed

A

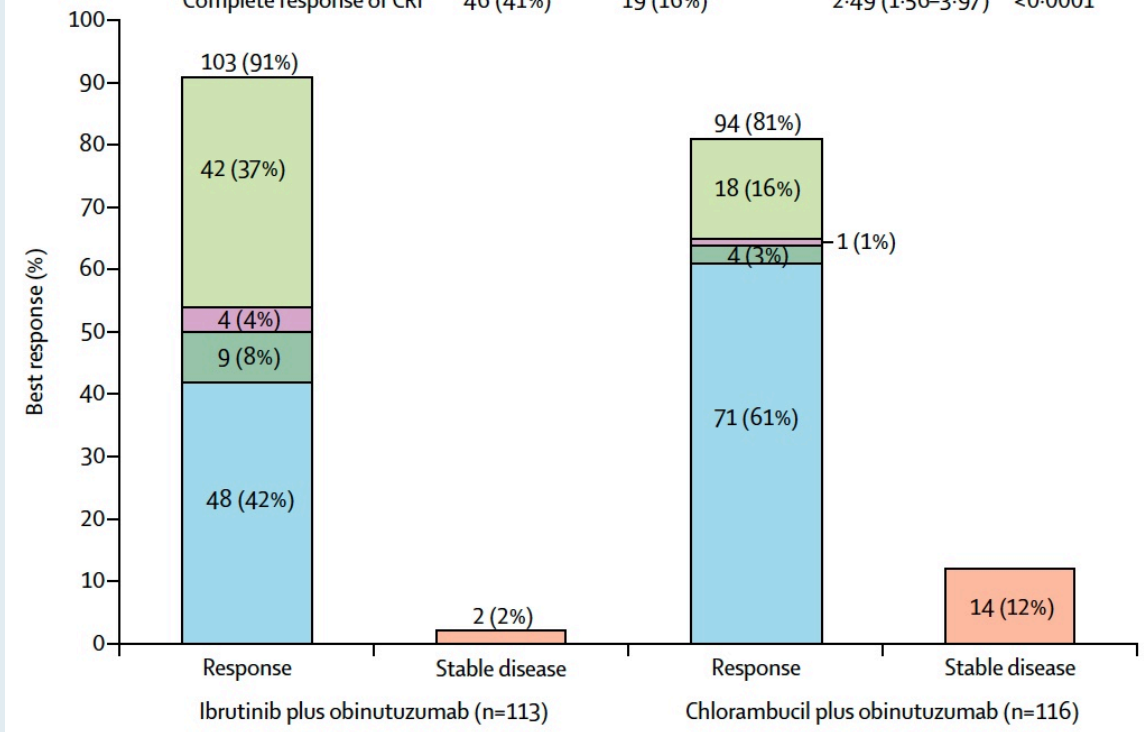
Best response	Ibrutinib plus obinutuzumab	Chlorambucil plus obinutuzumab	Rate ratio (95% CI)	p value
Overall response	100 (88%)	85 (73%)	1·21 (1·06–1·37)	0·0035
Complete response or CRi	22 (19%)	9 (8%)	2·51 (1·21–5·21)	0·0096



Investigator Assessed

B

Best response	Ibrutinib plus obinutuzumab	Chlorambucil plus obinutuzumab	Rate ratio (95% CI)	p value
Overall response	103 (91%)	94 (81%)	1·13 (1·01–1·25)	0·0273
Complete response or CRi	46 (41%)	19 (16%)	2·49 (1·56–3·97)	<0·0001



Moreno C et al. *Lancet Oncol* 2019;20(1):43-56.

RTP RESEARCH TO PRACTICE

Leukemia (2020) 34:522–532
https://doi.org/10.1038/s41375-019-0559-9

ARTICLE

Lymphoma

MRD response in relapsed/refractory FL after obinutuzumab plus bendamustine or bendamustine alone in the GADOLIN trial

Christiane Pott[1] · Laurie H. Sehn[2] · David Belada[3] · John Gribben[4] · Eva Hoster[5] · Brad Kahl[6] · Britta Kehden[1] · Emmanuelle Nicolas-Virelizier[7] · Nathalie Spielewoy[8] · Guenter Fingerle-Rowson[8] · Chris Harbron[9] · Kirsten Mundt[8] · Elisabeth Wassner-Fritsch[8] · Bruce D. Cheson[10]

Assessment of Tumor Lysis Syndrome in Patients with Chronic Lymphocytic Leukemia Treated with Venetoclax in the Clinical Trial and Post-Marketing Settings

Seymour JF et al.

ASH 2020;Abstract 2231.

LETTERS TO THE EDITOR

Tedeschi A et al. *Haematologica* 2020 Apr;105(4):e164-e168

A cross-trial comparison of single-agent ibrutinib *versus* chlorambucil-obinutuzumab in previously untreated patients with chronic lymphocytic leukemia or small lymphocytic lymphoma

Comparison of Efficacy and Safety with Obinutuzumab plus Chemotherapy versus Rituximab plus Chemotherapy in Patients with Previously Untreated Follicular Lymphoma: Updated Results from the Phase III Gallium Study

Townsend W et al.

ASCO 2020;Abstract 8023.

HemaSphere
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Hemasphere 2020;4(2):e354

EHA EUROPEAN HEMATOLOGY ASSOCIATION

Editorial

OPEN ACCESS

Measuring Clinical Benefit of Treatments for Hematologic Malignancies: Critical First Steps Accomplished—What is Next?

John G. Gribben[1], Elisabeth de Vries[2], Nathan I. Cherny[3], Pieter Sonneveld[4]

bjh commentary

Do we need to analyse everything at diagnosis in chronic lymphocytic leukaemia?

John G. Gribben

Br J Haematol 2020 May;189(4):603-604

HemaSphere
Powered by EHA

Hemasphere 2019;3(6):e323

EHA EUROPEAN HEMATOLOGY ASSOCIATION

Editorial

OPEN ACCESS

Here to Stay: Biosimilars in Hematology

John Gribben[1], Giampaolo Merlini[2], Anton Hagenbeek[3], On behalf of EHA

Nature. 2019 June ; 570(7762): 474–479.

Growth dynamics in naturally progressing chronic lymphocytic leukaemia

Michaela Gruber[1,2,3], **Ivana Bozic**[4], **Ignaty Leshchiner**[2], **Dimitri Livitz**[2], **Kristen Stevenson**[5], **Laura Rassenti**[6], **Daniel Rosebrock**[2], **Amaro Taylor-Weiner**[2], **Oriol Olive**[1], **Reaha Goyetche**[1], **Stacey M. Fernandes**[1], **Jing Sun**[1], **Chip Stewart**[2], **Alicia Wong**[2], **Carrie Cibulskis**[2], **Wandi Zhang**[1], **Johannes G. Reiter**[7], **Jeffrey M. Gerold**[7], **John G. Gribben**[8], **Kanti R. Rai**[9], **Michael J. Keating**[10], **Jennifer R. Brown**[1,11,12], **Donna Neuberg**[5], **Thomas J. Kipps**[6], **Martin A. Nowak**[7,13], **Gad Getz**[2,12,14,15], and **Catherine J. Wu**[1,2,11,12]

Meet The Professor with Prof Gribben

MODULE 1: Cases from Drs Peswani and Rogers

MODULE 2: CLL Journal Club with Prof Gribben

- Clinical outcomes of COVID-19 in patients with hematologic cancers
- Effect of ibrutinib on obinutuzumab-induced cytokine secretion
- Assessment and practical management of venetoclax-associated tumor lysis syndrome (TLS)
- CLARITY trial: Ibrutinib/venetoclax
- Umbralisib with ublituximab for CLL
- EHA position paper on personalized treatment for hematologic diseases
- Bone marrow niches in hematologic cancers
- iLLUMINATE trial: Ibrutinib/obinutuzumab
- Minimal residual disease response after obinutuzumab/bendamustine in the GADOLIN trial
- Ibrutinib versus chlorambucil/obinutuzumab in previously untreated CLL
- GALLIUM trial: Obinutuzumab/chemotherapy versus rituximab/chemotherapy
- Measuring clinical benefit of treatments
- Do we need to analyze everything at CLL diagnosis?
- Biosimilar agents in hematology
- Growth dynamics in naturally progressing CLL

MODULE 3: Beyond the Guidelines – Clinical Investigator Approaches to Common Clinical Scenarios

MODULE 4: Key Recent Data Sets

RTP
RESEARCH
TO PRACTICE

What is your usual preferred initial regimen for a 60-year-old patient with CLL with IGHV mutation but no del(17p) or TP53 mutation who requires treatment?

1. FCR
2. Ibrutinib
3. Ibrutinib + rituximab
4. Ibrutinib + obinutuzumab
5. Acalabrutinib
6. Acalabrutinib + obinutuzumab
7. Venetoclax + obinutuzumab
8. Other

What is your usual preferred initial regimen for a 60-year-old patient with CLL with IGHV mutation but no del(17p) or TP53 mutation who requires treatment?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Venetoclax + obinutuzumab
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	FCR
 BRIAN T HILL, MD, PHD	Venetoclax + obinutuzumab or BR
 BRAD S KAHL, MD	Venetoclax + obinutuzumab
 ANTHONY R MATO, MD, MSCE	FCR
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Ibrutinib or FCR
 JEFF SHARMAN, MD	FCR
 TANYA SIDDIQI, MD	Venetoclax + obinutuzumab
 MITCHELL R SMITH, MD, PHD	FCR
 WILLIAM G WIERDA, MD, PHD	FCR
 JENNIFER WOYACH, MD	Venetoclax + obinutuzumab

BR = bendamustine/rituximab; FCR = fludarabine/cyclosphosphamide/rituximab (FCR)

RTP RESEARCH TO PRACTICE

What is your usual preferred initial regimen for a 75-year-old patient with CLL with IGHV mutation but no del(17p) or TP53 mutation who requires treatment?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Acalabrutinib
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Venetoclax + obinutuzumab
 BRIAN T HILL, MD, PHD	Obinutuzumab
 BRAD S KAHL, MD	Venetoclax + obinutuzumab
 ANTHONY R MATO, MD, MSCE	Acalabrutinib
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Acalabrutinib or venetoclax + obinutuzumab
 JEFF SHARMAN, MD	Venetoclax + obinutuzumab
 TANYA SIDDIQI, MD	Acalabrutinib + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Ibrutinib
 WILLIAM G WIERDA, MD, PHD	Venetoclax + obinutuzumab
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

What is your usual preferred initial regimen for a 60-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who requires treatment?

1. FCR
2. Ibrutinib
3. Ibrutinib + rituximab
4. Ibrutinib + obinutuzumab
5. Acalabrutinib
6. Acalabrutinib + obinutuzumab
7. Venetoclax + obinutuzumab
8. Other

What is your usual preferred initial regimen for a 60-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who requires treatment?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Venetoclax + obinutuzumab
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Ibrutinib
 BRIAN T HILL, MD, PHD	Venetoclax + obinutuzumab
 BRAD S KAHL, MD	Venetoclax + obinutuzumab
 ANTHONY R MATO, MD, MSCE	Venetoclax + obinutuzumab
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Acalabrutinib or venetoclax + obinutuzumab
 JEFF SHARMAN, MD	Acalabrutinib
 TANYA SIDDIQI, MD	Venetoclax + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Venetoclax + obinutuzumab
 WILLIAM G WIERDA, MD, PHD	Venetoclax + obinutuzumab
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

What is your usual preferred initial regimen for a 75-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who requires treatment?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Acalabrutinib
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Ibrutinib
 BRIAN T HILL, MD, PHD	Venetoclax + obinutuzumab
 BRAD S KAHL, MD	Venetoclax + obinutuzumab
 ANTHONY R MATO, MD, MSCE	Acalabrutinib
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Acalabrutinib or venetoclax + obinutuzumab
 JEFF SHARMAN, MD	Acalabrutinib
 TANYA SIDDIQI, MD	Acalabrutinib + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Ibrutinib
 WILLIAM G WIERDA, MD, PHD	Acalabrutinib
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

What is your usual preferred initial regimen for a 75-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who requires treatment and has bulky disease?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Acalabrutinib
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Ibrutinib
 BRIAN T HILL, MD, PHD	Venetoclax + obinutuzumab
 BRAD S KAHL, MD	Venetoclax + obinutuzumab
 ANTHONY R MATO, MD, MSCE	Acalabrutinib + obinutuzumab
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Acalabrutinib
 JEFF SHARMAN, MD	Acalabrutinib
 TANYA SIDDIQI, MD	Acalabrutinib + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Venetoclax + obinutuzumab
 WILLIAM G WIERDA, MD, PHD	Acalabrutinib
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

What is your usual preferred initial regimen for a 60-year-old patient with del(17p) CLL who requires treatment?

 MATTHEW S DAVIDS, MD, MMSC	Ibrutinib
 IAN W FLINN, MD, PHD	Acalabrutinib
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Ibrutinib
 BRIAN T HILL, MD, PHD	Acalabrutinib
 BRAD S KAHL, MD	Acalabrutinib + obinutuzumab
 ANTHONY R MATO, MD, MSCE	Acalabrutinib
 JOHN M PAGEL, MD, PHD	Acalabrutinib
 KERRY A ROGERS, MD	Ibrutnib
 JEFF SHARMAN, MD	Acalabrutinib
 TANYA SIDDIQI, MD	Acalabrutinib + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Venetoclax + obinutuzumab
 WILLIAM G WIERDA, MD, PHD	Acalabrutinib
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

What would be your most likely approach for a patient with newly diagnosed CLL to whom you administer up-front venetoclax/obinutuzumab who has detectable MRD after 1 year of treatment?

1. Continue treatment
2. Discontinue treatment

What would be your most likely approach for a patient with newly diagnosed CLL to whom you administer up-front venetoclax/obinutuzumab who has detectable minimal residual disease (MRD) after 1 year of treatment?

 MATTHEW S DAVIDS, MD, MMSC	Discontinue treatment
 IAN W FLINN, MD, PHD	Discontinue treatment
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Discontinue treatment
 BRIAN T HILL, MD, PHD	Discontinue treatment
 BRAD S KAHL, MD	Discontinue treatment
 ANTHONY R MATO, MD, MSCE	Continue treatment
 JOHN M PAGEL, MD, PHD	Continue treatment
 KERRY A ROGERS, MD	Discontinue treatment
 JEFF SHARMAN, MD	Discontinue treatment
 TANYA SIDDIQI, MD	Continue treatment
 MITCHELL R SMITH, MD, PHD	Discontinue treatment
 WILLIAM G WIERDA, MD, PHD	Continue treatment
 JENNIFER WOYACH, MD	Discontinue treatment

RTP RESEARCH TO PRACTICE

What would be your most likely approach for a patient with newly diagnosed CLL to whom you administer up-front venetoclax/obinutuzumab who has achieved undetectable MRD status after 1 year of treatment?

 MATTHEW S DAVIDS, MD, MMSC	Discontinue treatment
 IAN W FLINN, MD, PHD	Discontinue treatment
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Discontinue treatment
 BRIAN T HILL, MD, PHD	Discontinue treatment
 BRAD S KAHL, MD	Discontinue treatment
 ANTHONY R MATO, MD, MSCE	Discontinue treatment
 JOHN M PAGEL, MD, PHD	Discontinue treatment
 KERRY A ROGERS, MD	Discontinue treatment
 JEFF SHARMAN, MD	Discontinue treatment
 TANYA SIDDIQI, MD	Discontinue treatment
 MITCHELL R SMITH, MD, PHD	Discontinue treatment
 WILLIAM G WIERDA, MD, PHD	Discontinue treatment
 JENNIFER WOYACH, MD	Discontinue treatment

RTP RESEARCH TO PRACTICE

Which second-line systemic therapy would you recommend for a 60-year-old patient with CLL with no IGHV mutation and no del(17p) or TP53 mutation who responds to ibrutinib and then experiences disease progression 3 years later?

1. Acalabrutinib
2. Acalabrutinib + obinutuzumab
3. Venetoclax
4. Venetoclax + rituximab
5. Venetoclax + obinutuzumab
6. Idelalisib
7. Duvelisib
8. Other

RTP
RESEARCH
TO PRACTICE

Which second-line systemic therapy would you recommend for a 60-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who responds to ibrutinib and then experiences disease progression 3 years later?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + rituximab
 IAN W FLINN, MD, PHD	Venetoclax + obinutuzumab
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Venetoclax + rituximab
 BRIAN T HILL, MD, PHD	Venetoclax + rituximab
 BRAD S KAHL, MD	Venetoclax + rituximab
 ANTHONY R MATO, MD, MSCE	Venetoclax + rituximab
 JOHN M PAGEL, MD, PHD	Venetoclax
 KERRY A ROGERS, MD	Venetoclax + rituximab
 JEFF SHARMAN, MD	Venetoclax + rituximab
 TANYA SIDDIQI, MD	Ibrutinib + obinutzumab OR venetoclax + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Venetoclax + obinutuzumab
 WILLIAM G WIERDA, MD, PHD	Venetoclax + rituximab
 JENNIFER WOYACH, MD	Venetoclax + rituximab

RTP RESEARCH TO PRACTICE

Which second-line systemic therapy would you recommend for a 60-year-old patient with CLL with no IGHV mutation and no del(17p) or TP53 mutation who responds to venetoclax/obinutuzumab and then experiences disease progression 3 years later?

1. Ibrutinib
2. Ibrutinib + rituximab
3. Ibrutinib + obinutuzumab
4. Acalabrutinib
5. Acalabrutinib + obinutuzumab
6. Idelalisib
7. Duvelisib
8. Other

Which second-line systemic therapy would you recommend for a 60-year-old patient with CLL with unmutated IGHV and no del(17p) or TP53 mutation who responds to venetoclax/obinutuzumab and then experiences disease progression 3 years later?

 MATTHEW S DAVIDS, MD, MMSC	Venetoclax + obinutuzumab
 IAN W FLINN, MD, PHD	Acalabrutinib
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Ibrutinib
 BRIAN T HILL, MD, PHD	Acalabrutinib
 BRAD S KAHL, MD	Acalabrutinib
 ANTHONY R MATO, MD, MSCE	Venetoclax + rituximab
 JOHN M PAGEL, MD, PHD	Acalabrutinib

 KERRY A ROGERS, MD	Ibrutinib
 JEFF SHARMAN, MD	Acalabrutinib
 TANYA SIDDIQI, MD	Acalabrutinib + obinutuzumab
 MITCHELL R SMITH, MD, PHD	Ibrutinib
 WILLIAM G WIERDA, MD, PHD	Venetoclax + rituximab
 JENNIFER WOYACH, MD	Ibrutinib

RTP RESEARCH TO PRACTICE

A 60-year-old patient with CLL, an absolute lymphocyte count of 20,000 and several involved lymph nodes that are smaller than 2 centimeters is about to receive venetoclax. What preemptive measures, if any, would you take to address tumor lysis syndrome prior to the initiation of therapy?

 MATTHEW S DAVIDS, MD, MMSC	Encourage oral hydration and allopurinol
 IAN W FLINN, MD, PHD	IV hydration and allopurinol
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	Encourage oral hydration and allopurinol
 BRIAN T HILL, MD, PHD	Encourage oral hydration and allopurinol
 BRAD S KAHL, MD	Encourage oral hydration and allopurinol
 ANTHONY R MATO, MD, MSCE	IV hydration and allopurinol
 JOHN M PAGEL, MD, PHD	Encourage oral hydration and allopurinol
 KERRY A ROGERS, MD	Encourage oral hydration and allopurinol
 JEFF SHARMAN, MD	Give the obinutuzumab first to debulk, then after 1 month can start as outpatient with hydration and allopurinol
 TANYA SIDDIQI, MD	Encourage oral hydration and allopurinol
 MITCHELL R SMITH, MD, PHD	Encourage oral hydration and allopurinol
 WILLIAM G WIERDA, MD, PHD	Encourage oral hydration and allopurinol
 JENNIFER WOYACH, MD	Encourage oral hydration and allopurinol

RTP RESEARCH TO PRACTICE

A 60-year-old patient with CLL, an absolute lymphocyte count of 80,000 and several involved lymph nodes that are larger than 5 centimeters is about to receive venetoclax. What preemptive measures, if any, would you take to address tumor lysis syndrome prior to the initiation of therapy?

 MATTHEW S DAVIDS, MD, MMSC	Admit to hospital
 IAN W FLINN, MD, PHD	Debulk with obinutuzumab
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	IV hydration and allopurinol
 BRIAN T HILL, MD, PHD	Admit to hospital
 BRAD S KAHL, MD	Admit to hospital
 ANTHONY R MATO, MD, MSCE	Admit to hospital
 JOHN M PAGEL, MD, PHD	Admit to hospital
 KERRY A ROGERS, MD	Admit to hospital
 JEFF SHARMAN, MD	Obinutuzumab for 1 month to lower patient risk, then outpatient hydration and allopurinol
 TANYA SIDDIQI, MD	Admit to hospital
 MITCHELL R SMITH, MD, PHD	Admit to hospital
 WILLIAM G WIERDA, MD, PHD	Admit to hospital
 JENNIFER WOYACH, MD	IV hydration and allopurinol

RTP RESEARCH TO PRACTICE

For your patients with CLL whom you admit to the hospital to receive venetoclax, for how long do you typically admit them?

 MATTHEW S DAVIDS, MD, MMSC	8 days
 IAN W FLINN, MD, PHD	2 days
 PROF JOHN G GRIBBEN, MD, DSC, FMEDSCI	1 day
 BRIAN T HILL, MD, PHD	2 days (<48 hours)
 BRAD S KAHL, MD	2 days
 ANTHONY R MATO, MD, MSCE	2-3 days
 JOHN M PAGEL, MD, PHD	1 day

 KERRY A ROGERS, MD	2 nights for each dose escalation
 JEFF SHARMAN, MD	2 days
 TANYA SIDDIQI, MD	1-2 days each week during early ramp-up
 MITCHELL R SMITH, MD, PHD	1- 2 days
 WILLIAM G WIERDA, MD, PHD	2 days
 JENNIFER WOYACH, MD	2 days or rapid escalation to full dose over 5 days

RTP RESEARCH TO PRACTICE

Meet The Professor with Prof Gribben

MODULE 1: Cases from Drs Peswani and Rogers

MODULE 2: CLL Journal Club with Prof Gribben

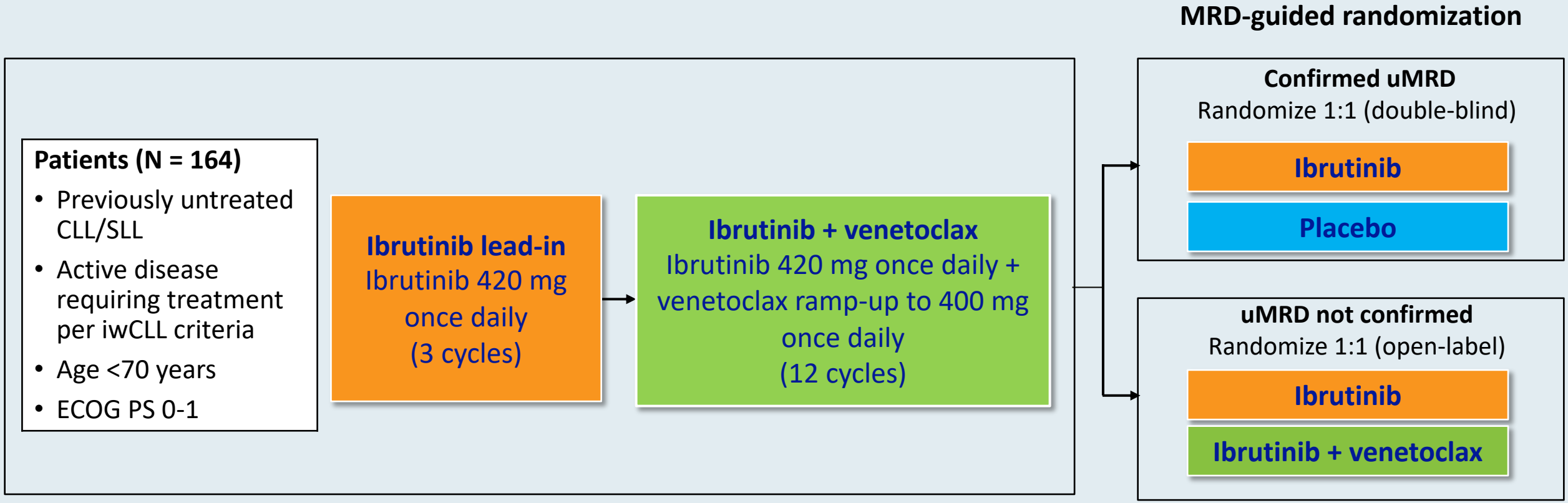
- Clinical outcomes of COVID-19 in patients with hematologic cancers
- Effect of ibrutinib on obinutuzumab-induced cytokine secretion
- Assessment and practical management of venetoclax-associated tumor lysis syndrome (TLS)
- CLARITY trial: Ibrutinib/venetoclax
- Umbralisib with ublituximab for CLL
- EHA position paper on personalized treatment for hematologic diseases
- Bone marrow niches in hematologic cancers
- iLLUMINATE trial: Ibrutinib/obinutuzumab
- Minimal residual disease response after obinutuzumab/bendamustine in the GADOLIN trial
- Ibrutinib versus chlorambucil/obinutuzumab in previously untreated CLL
- GALLIUM trial: Obinutuzumab/chemotherapy versus rituximab/chemotherapy
- Measuring clinical benefit of treatments
- Do we need to analyze everything at CLL diagnosis?
- Biosimilar agents in hematology
- Growth dynamics in naturally progressing CLL

MODULE 3: Beyond the Guidelines – Clinical Investigator Approaches to Common Clinical Scenarios

MODULE 4: Key Recent Data Sets

RTP RESEARCH TO PRACTICE

CAPTIVATE MRD Cohort: Study Design

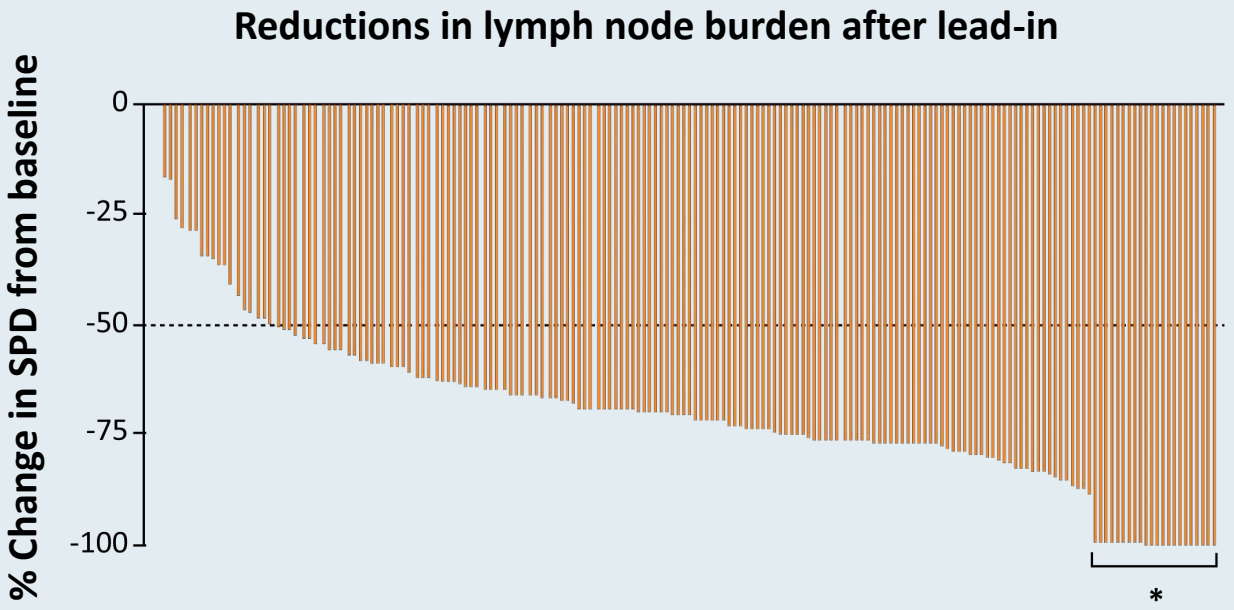


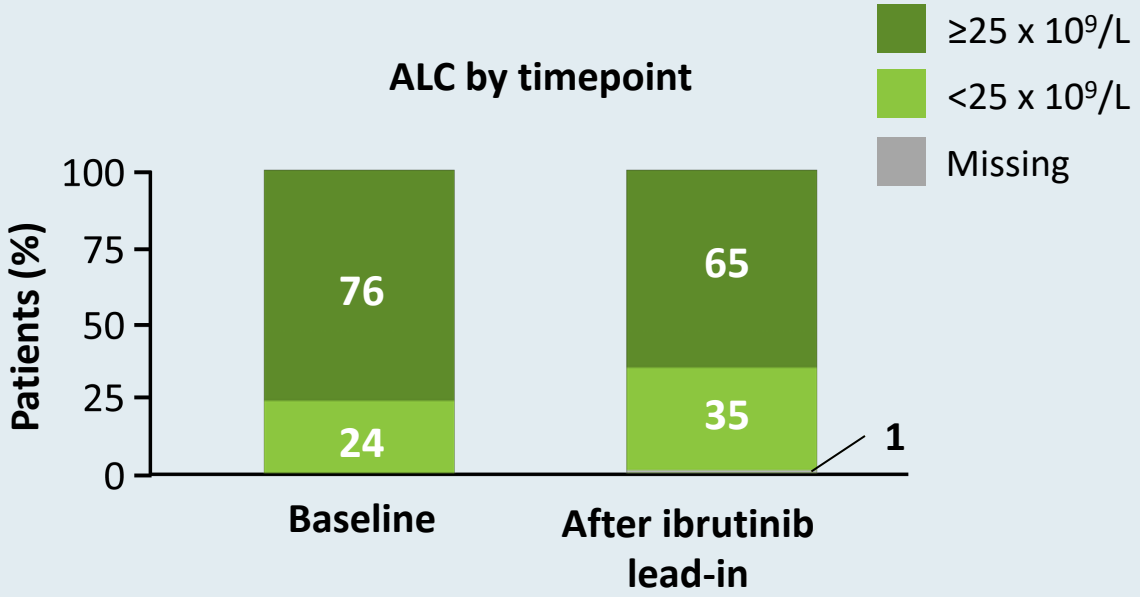
uMRD = undetectable minimal residual disease

Results presented for prerandomization phase of the MRD cohort (n = 164) with 12 cycles of ibrutinib + venetoclax prior to MRD-guided randomization

Siddiqi S et al. EHA 2020;Abstract S158.

CAPTIVATE MRD Cohort: 3 Cycles of Ibrutinib Lead-In





Three cycles of ibrutinib lead-in reduces TLS risk and indication for hospitalization

Siddiqi S et al. EHA 2020;Abstract S158.

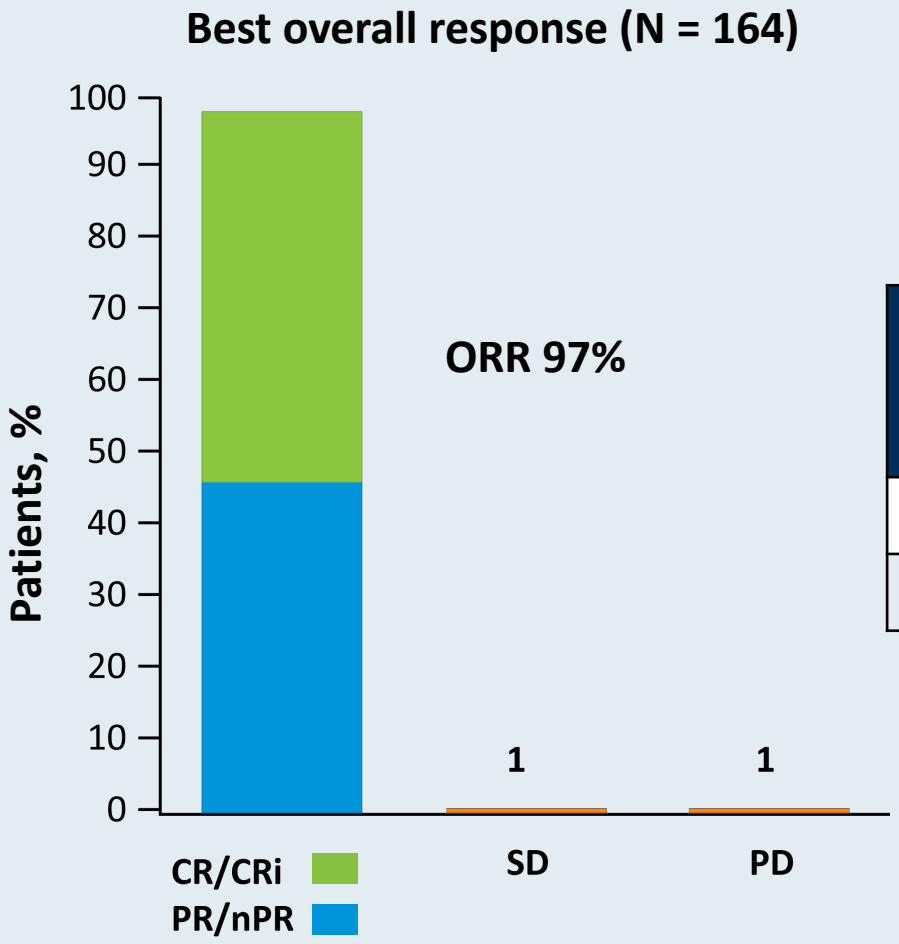
CAPTIVATE MRD Cohort: Undetectable MRD Rate

	Peripheral blood n = 163	Bone marrow n = 155
Best response of undetectable MRD in evaluable patients (95% CI)	**75%** (68-82)	**72%** (64-79)

- Rates of undetectable MRD in peripheral blood and bone marrow were highly concordant at Cycle 16 (91%)
- In the all-treated population (N = 164), undetectable MRD was achieved in 75% of patients in peripheral blood and in 68% of patients in bone marrow with up to 12 cycles of combination ibrutinib/venetoclax

Siddiqi S et al. EHA 2020;Abstract S158.

CAPTIVATE MRD Cohort: Undetectable MRD in Patients with CR/PR



Best overall response (up to Cycle 16)	CR n = 84	PR n = 75	ORR (CR + PR) n = 159
Undetectable MRD in PB, n (%)	71 (85)	52 (69)	123 (77)
Undetectable MRD in BM, n (%)	67 (80)	44 (59)	111 (70)

At 15 months, 98% of patients were progression free with no deaths

Siddiqi S et al. EHA 2020;Abstract S158.

CAPTIVATE MRD Cohort: Summary of Grade 3 and 4 AEs of Interest

AEs, n (%)	Ibrutinib lead-in (3 cycles) N = 164		Ibrutinib + venetoclax combination (12 cycles) N = 159		Overall (15 cycles) N = 164
	Grade 3	Grade 4	Grade 3	Grade 4	Grade 3-4
Atrial fibrillation	2 (1)	0	1 (1)	0	3 (2)
Major hemorrhage	0	0	1 (1)	0	1 (1)
Infections	4 (2)	0	10 (6)	0	14 (9)
Neutropenia	4 (2)	7 (4)	27 (17)	26 (16)	58 (35)
Febrile neutropenia	1 (1)	0	2 (1)	0	3 (2)
Laboratory TLS	0	0	2 (1)	0	2 (1)

- Low rates of Grade 3 atrial fibrillation, major hemorrhage, infections, febrile neutropenia and laboratory TLS (no Grade 4 event)
- No patients developed clinical TLS
  - Laboratory TLS reported as AE in 3 patients (only 1 met Howard criteria)
- No fatal AEs

Siddiqi S et al. EHA 2020;Abstract S158.

Ongoing Phase III EA9161 Trial Schema

Stratifications
Age: <65 yr vs ≥ 65 yr and <70 yr
PS: 0, 1, vs 2
Stage: 0, 1, or 2 vs 3, 4
Del11q22.3 vs others

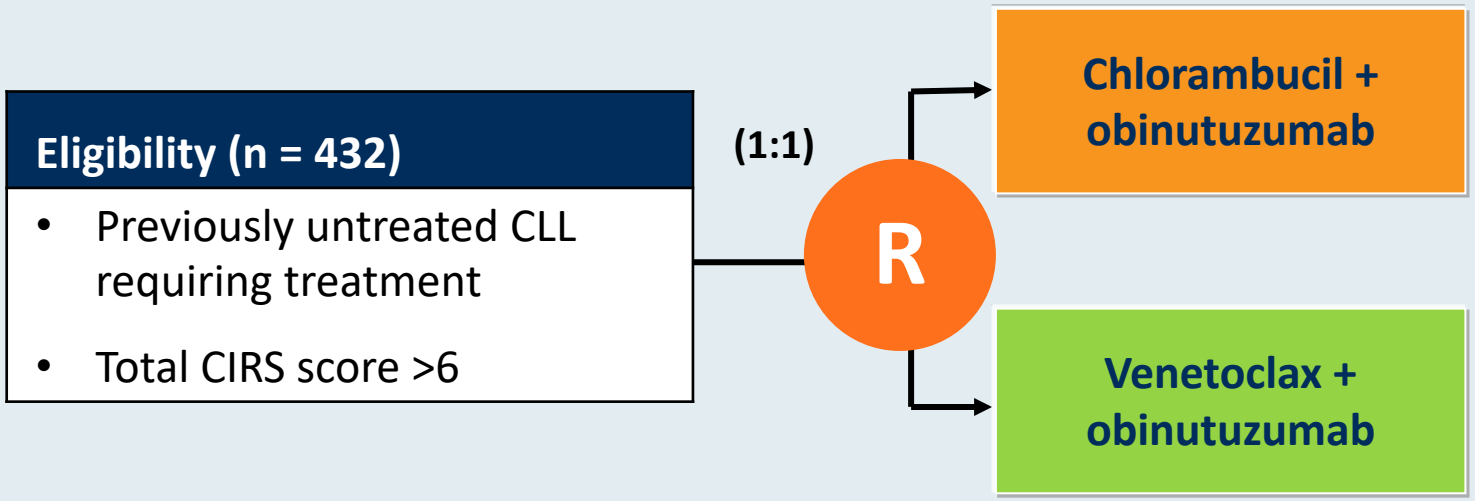
Randomize

Arm A
Ibrutinib: Cycles 1-19:d1-28 420mg PO daily
Obinutuzumab: C1 **:** D1:100 mg IV, D2:900 mg IV, D8: 1000 mg IV, D15: 1000 mg IV; C2-6: D1 1000 mg IV
Venetoclax: C3 D1-7 20mg PO daily D8-14 50mg PO daily D15-21 100mg PO daily; D22-28 200 mg PO daily; C4-14: D1-28 400mg PO daily

Arm B
Ibrutinib: Cycles 1-19+:d1-28 420mg PO daily
Obinutuzumab: C1 **:** D1:100 mg IV, D2:900 mg IV, D8: 1000 mg IV, D15: 1000 mg IV; C2-6: D1 1000 mg IV

Courtesy of Brad Kahl, MD

CLL14 Phase III Study Schema

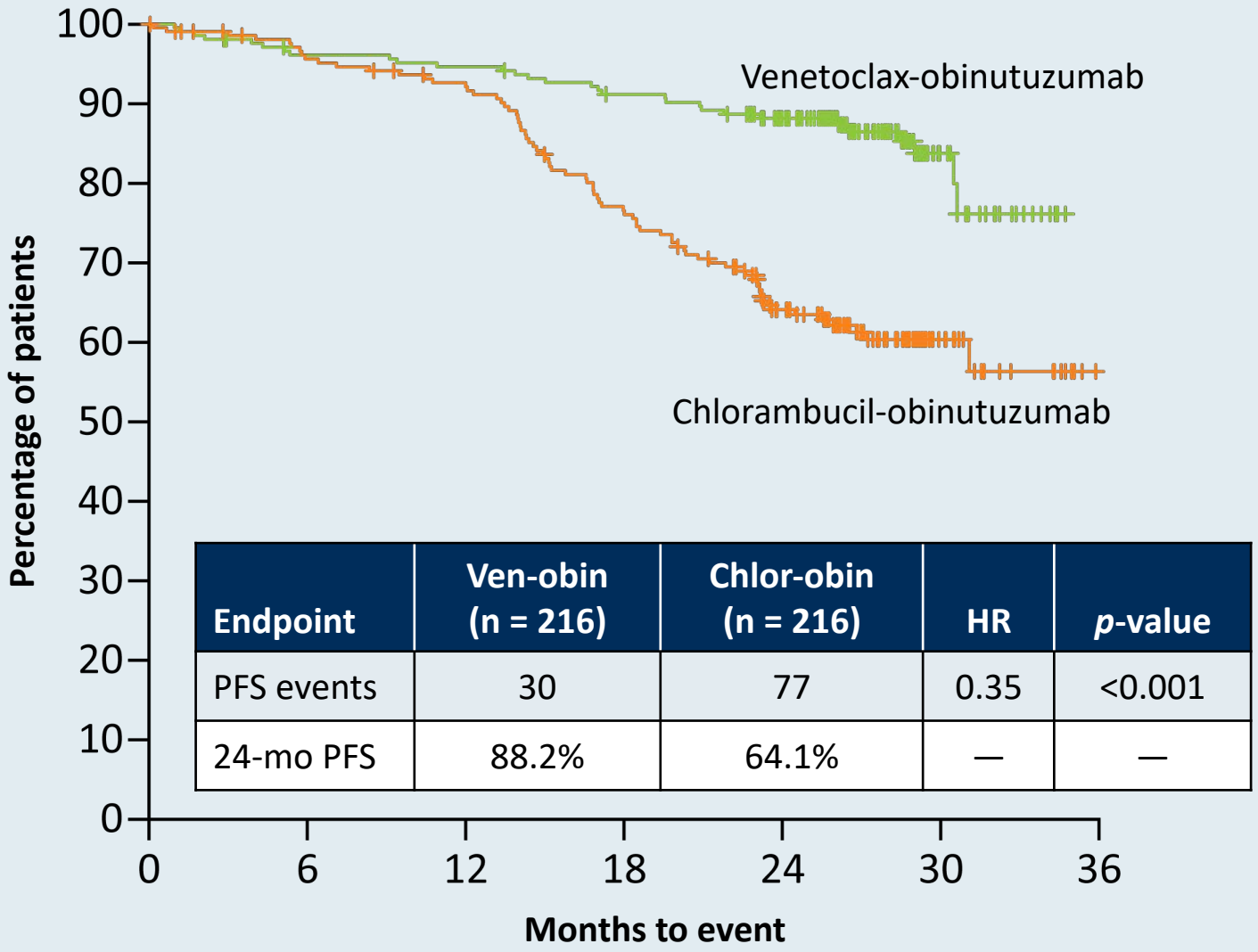


Primary endpoint: Progression-free survival

- Treatment duration in both groups: 12 cycles, 28 days each
- No crossover was allowed
- Daily oral venetoclax regimen:
  - Initiated on day 22 of cycle 1, starting with a 5-week dose ramp-up (1 week each of 20, 50, 100 and 200 mg, then 400 mg daily for 1 week)
  - Thereafter continuing at 400 mg daily until completion of cycle 12

www.clinicaltrials.gov (NCT02242942). Accessed August 2020.
Fischer K et al. *N Engl J Med* 2019;380(23):2225-36.

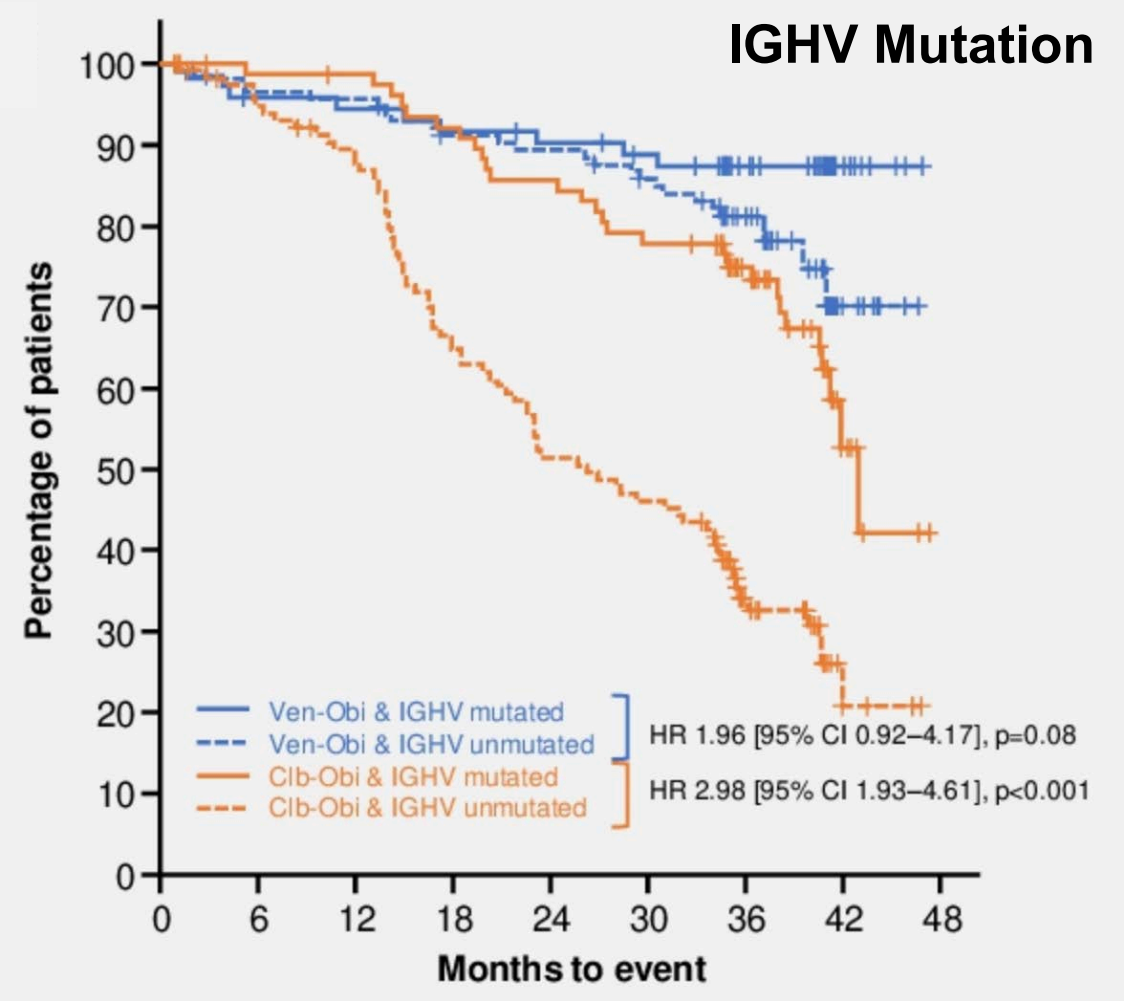
CLL14: Investigator-Assessed Progression-Free Survival

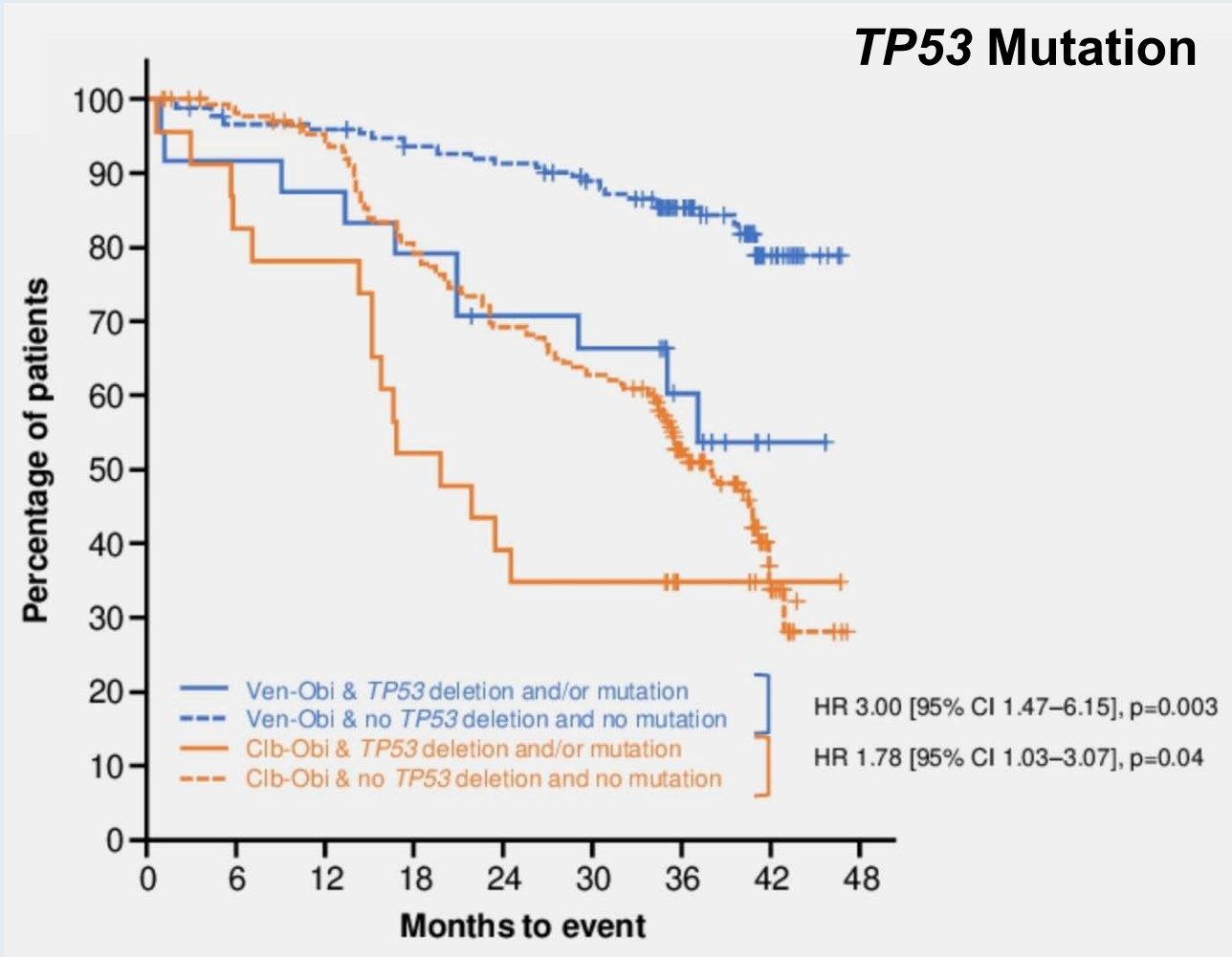


Endpoint	Ven-obin (n = 216)	Chlor-obin (n = 216)	HR	*p*-value
PFS events	30	77	0.35	<0.001
24-mo PFS	88.2%	64.1%	—	—

Fischer K et al. *N Engl J Med* 2019;380(23):2225-36.

CLL14: PFS by IGHV and TP53 Mutation Status





Al-Sawaf O et al. ASCO 2020;Abstract 8027.

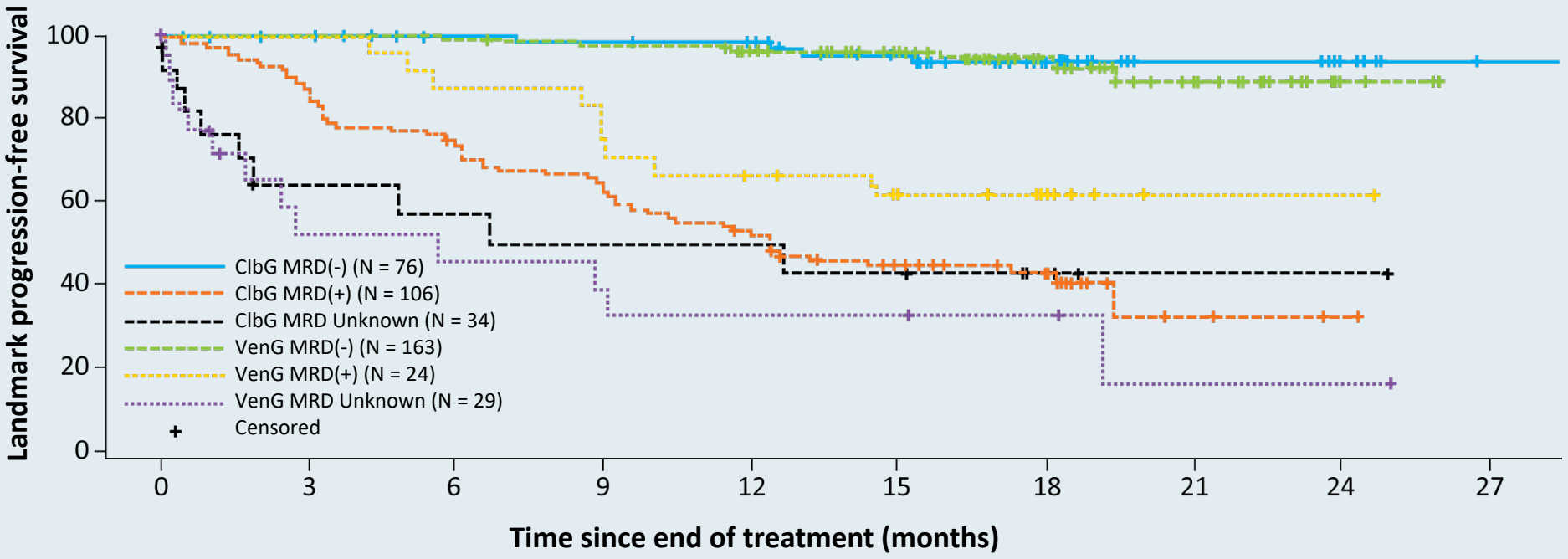
RTP RESEARCH TO PRACTICE

CLL14: Minimal Residual Disease 3 Months After Treatment

MRD 3 months after treatment	MRD-negative		MRD responders	
	Veneto/obin (N = 216)	Chloram/obin (N = 216)	Veneto/obin (N = 216)	Chloram/obin (N = 216)
MRD in bone marrow	56.9%	17.1%	33.8%	10.6%
Odds ratio, *p*-value	OR 6.4, $p < 0.0001$		OR 4.3, $p < 0.0001$	
MRD in peripheral blood	75.7%	35.2%	42.1%	14.4%
Odds ratio, *p*-value	OR 5.7, $p < 0.0001$		OR 4.3, $p < 0.0001$	

Fischer K et al. *N Engl J Med* 2019;380(23):2225-36.

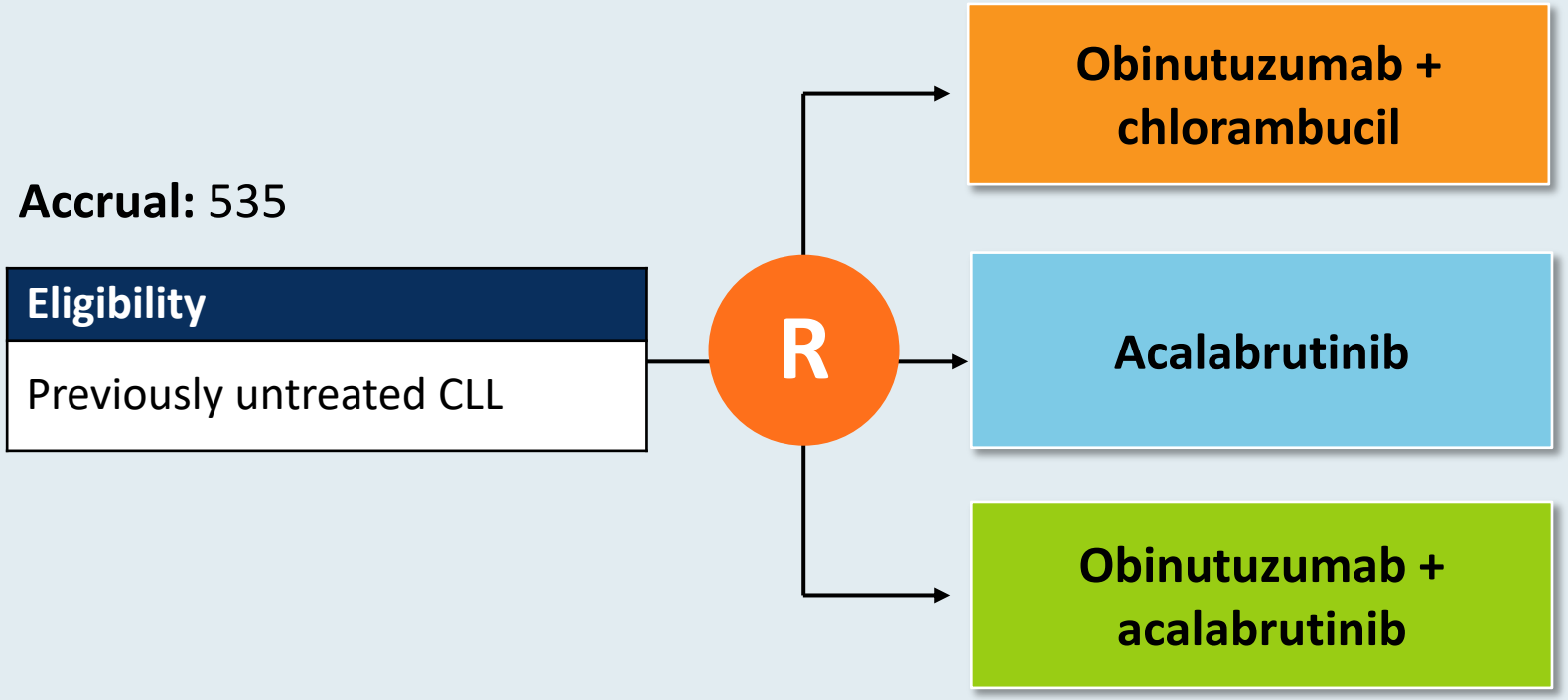
CLL14: Landmark Analysis from End of Therapy PFS by MRD Group



Further landmark analysis of PFS by MRD status showed that undetectable MRD translated into improved PFS regardless of the clinical response status at end of therapy.

Fischer K et al. ASH 2019;Abstract 36.

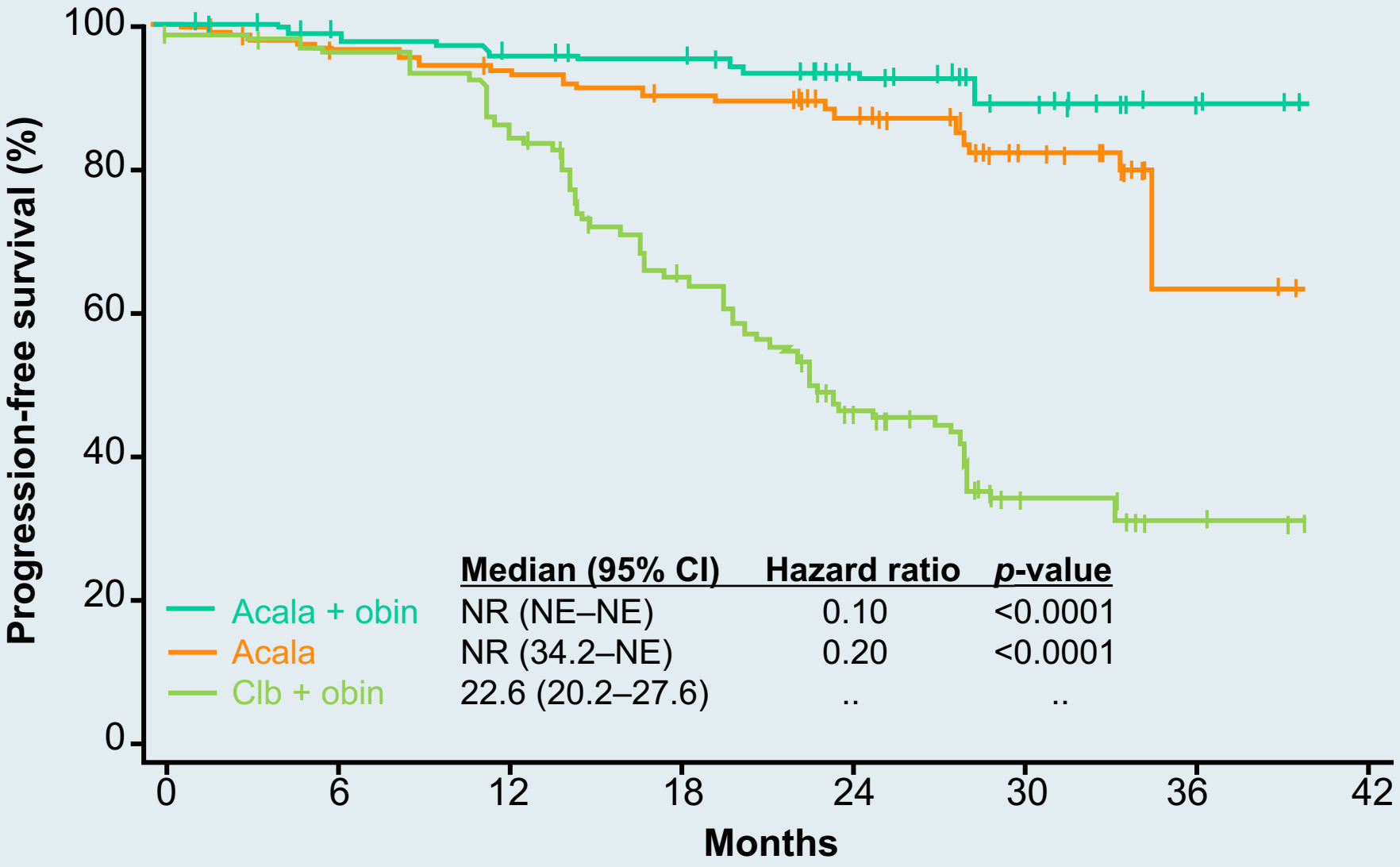
ELEVATE-TN Phase III Trial Schema



Primary endpoint: Progression-free survival

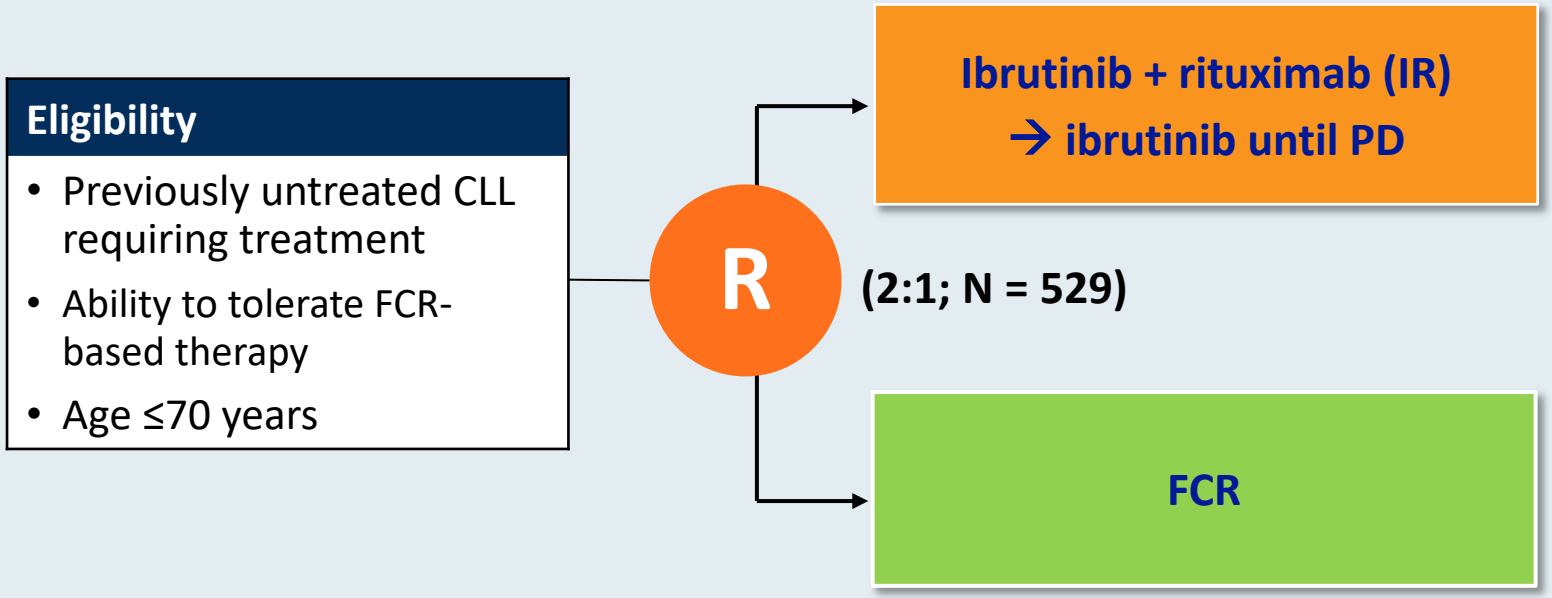
www.clinicaltrials.gov (NCT02475681). Accessed August 2020.

ELEVATE-TN: PFS (IRC)



Sharman JP et al. *Lancet* 2020;395:1278-91.

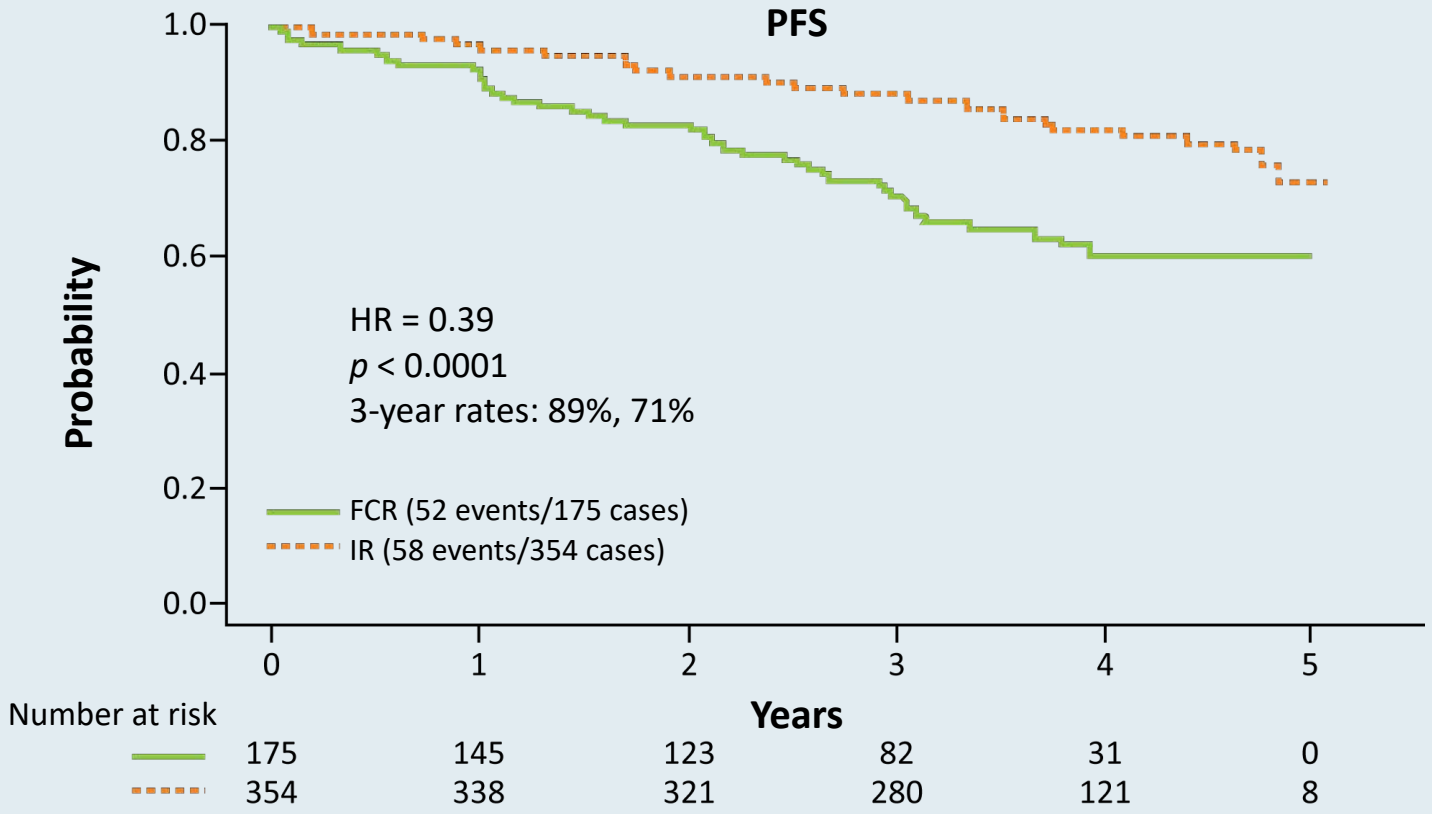
Phase III ECOG-ACRIN E1912 Study Design



Primary endpoint: PFS
Secondary endpoints: OS, ORR, Toxicity and Tolerability

ECOG-ACRIN E1912 Physician Fact Sheet, version 01/15/16;
www.clinicaltrials.gov (NCT02048813); Shanafelt TD et al. ASH 2018;Abstract LBA-4.

ECOG-ACRIN E1912 Extended Follow-Up: Up-Front IR Compared to FCR for Younger Patients with CLL



- Grade ≥3 treatment-related AEs were reported in 70% of patients receiving IR and 80% of patients receiving FCR (odds ratio = 0.56; $p = 0.013$).
- Among the 95 patients who discontinued ibrutinib, the most common cause was AE or complication.

Shanafelt TD et al. ASH 2019;Abstract 33.

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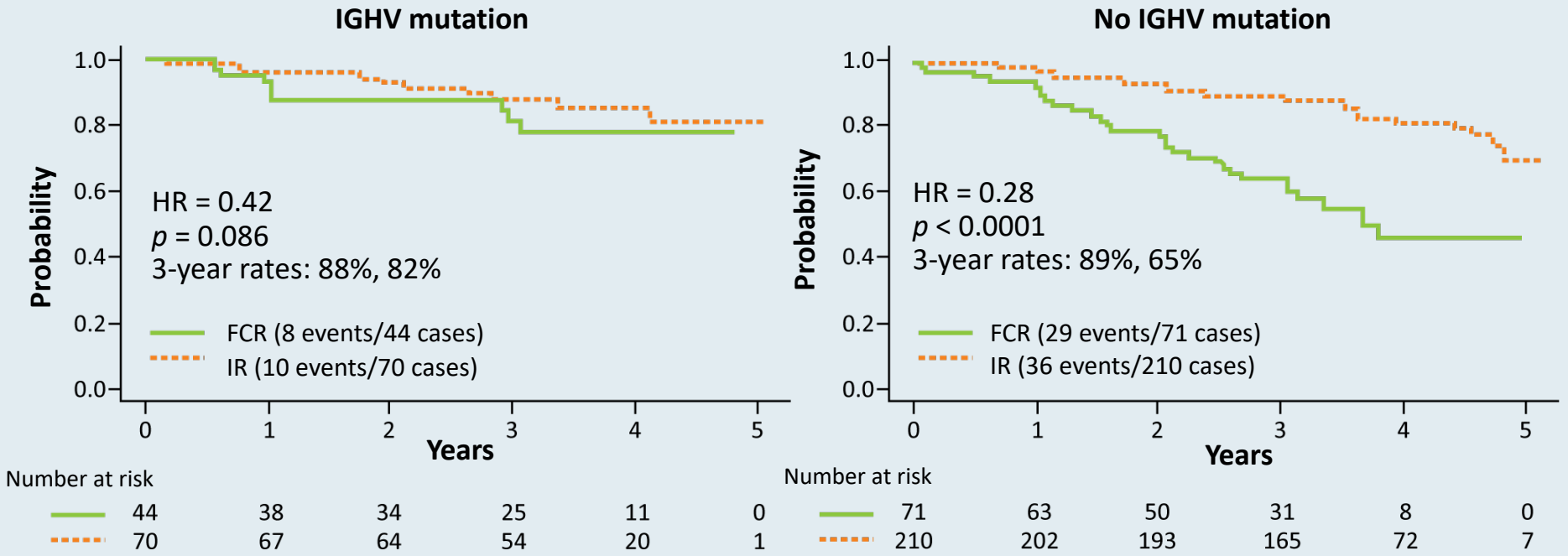
ECOG-ACRIN E1912 Extended Follow-Up: PFS by IGHV Mutation Status



- On subgroup analysis by IGHV mutation status, IR was superior to FCR for CLL with no IGHV mutation (HR = 0.28; $p < 0.0001$).
- With current follow-up the difference between IR and FCR is not significant for CLL with IGHV mutation (HR = 0.42; $p = 0.086$).

Shanafelt TD et al. ASH 2019;Abstract 33.

Meet The Professor
Management of Lung Cancer

Wednesday, October 28, 2020
12:00 PM – 1:00 PM ET

Faculty

Professor Solange Peters, MD, PhD

Moderator

Neil Love, MD

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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