Lymphoma – Is there still a role for chemo?

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TRANSCRIPT

On March 4, 2016, the FDA approved the use of ibrutinib as first-line therapy in patients with chronic lymphocytic leukemia. And this has raised the question in many patients: What is the role, if any, of conventional chemotherapy in the management of the disease? First we have to look at the question of what was actually studied in the patients who were on the RESONATE-2 trial which compared cholorambucil, a treatment that is largely not used by itself any more in the United States, and compared it to ibrutinib. It is clear that the patients treated with ibrutinib had a very significantly improved progression-free survival, that is, time until the disease started to progress. And they had a better overall survival, in part an artifact of the very poor activity associated with chlorambucil, which is why we don't routinely use this in clinical practice. This trial is a good example of one which was done to clearly identify the role of ibrutinib for regulatory purposes, but was actually less helpful for us to help drive clinical decisions.

I believe that the older patient, the frail patient, the patient with deletion chromosome 17p, probably will benefit from treatment with single-agent ibrutinib as up-front treatment. However, this is chronic therapy (patients are on therapy for a long time) and there is a risk of toxicity developing during the course of treatment. Furthermore, the RESONATE-2 trial has very limited follow-up so far.

So for the patient in whom chemotherapy is appropriate today (in 2016), because it remains time-limited and we don't know if there is a clear survival advantage in starting with ibrutinib, I feel that starting with chemo-immunotherapy is still a very reasonable choice. These are discussions that need to be had between the patient and their treating doctor.