



Patterns of Care Survey for Acute Myeloid Leukemia (AML)

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CME INFORMATION

OVERVIEW OF ACTIVITY

Acute myeloid leukemia (AML) and the myelodysplastic syndromes (MDS) account for approximately 20 percent of all hematologic cancer and related hemopathies diagnosed on an annual basis. Emerging and continuing clinical research has resulted in an increased understanding of the heterogeneous nature of these diseases and in the availability of novel treatment strategies and options. In order to offer optimal patient care — including the option of clinical trial participation — the practicing medical oncologist must be well informed of the rapidly evolving data sets in AML and MDS. To bridge the gap between research and patient care, this CME activity will deliver a serial review of recent key presentations and publications and expert perspectives on how these new evidence-based concepts can be applied to routine clinical care. This activity will assist medical oncologists and other cancer clinicians in the formulation of optimal clinical management strategies for AML and MDS.

LEARNING OBJECTIVE

- Evaluate management issues for patients with AML for whom relative agreement and heterogeneity exist in patterns of care, and make treatment decisions considering this information.

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FACULTY — The following faculty (and their spouses/partners) reported real or apparent conflicts of interest, which have been resolved through a conflict of interest resolution process:

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Last review date: November 2009
Expiration date: November 2010

Inside this issue: Four interesting AML nuggets:

1. **A Phase II study** evaluating clofarabine in 112 older patients (median age 71) with AML and one or more adverse prognostic factors. Treatment was “well tolerated” and resulted in 38% CRs.
2. **A Phase II study** of the hypomethylating agent decitabine in 55 older patients (median age 74) with AML. Morphologic CR was observed in 24%; febrile neutropenia was observed in 24%.
3. **A literature review** suggesting that assays for NPM1mut and FLT3 ITDneg could be the new ER and HER2 of AML. (Ok, maybe that is an overstatement, but these are highly prognostic and predictive.)
4. **A retrospective analysis** demonstrating roughly similar results with allogeneic hematopoietic stem cell transplant in patients with AML over and under age 65.

Editor’s comment: Who should treat patients with AML?

Mike Schwartz, a Memorial-trained medical oncologist practicing in Miami Beach, is one of several dozen “master clinicians” across the country who have assisted us with our CME programs. Mike’s most recent contribution was helping us plan an upcoming **Satellite Symposium** that we will host in New Orleans on Friday night, December 4, preceding the ASH annual meeting.

Dr Schwartz will join four other community-based physicians as they present challenging cases of AML, MDS, CML, and myeloma from their practices to our all-star faculty. In addition to discussing these carefully selected patients, we will also reveal the results of our recent **national Patterns of Care survey** of US-based oncologists, specifically focusing on the management of the cases being presented at the meeting.

One interesting survey question that we will discuss live is “Do you treat some or most patients with AML or do you generally refer them to a tertiary center?” To my mild surprise, more than two thirds of the survey respondents generally manage these patients themselves, and that includes Mike, who will present a 59-year-old woman recently diagnosed with AML.

Our prior surveys have documented that oncologists in practice see about as many cases of breast cancer a year as breast cancer investigators, but AML is a complicated disease that occurs at less than one tenth the frequency.

Of course there is more than science required in these intense situations, as evidenced by Mike's patient, an Asian woman, who asked if she could take traditional therapeutic herbs during chemo (Mike said "No," as did 79 percent of the oncologists surveyed).

Certainly physicians who offer patients a local means to receive treatment for a very scary disease must do their best to keep up with the gradual but definite progress in AML. In New Orleans, we'll see what our faculty has to say about Mike's patient and whether they think she, like many others, can be effectively managed in the community. From my standpoint, this woman is fortunate to be receiving care from one of the many, many extraordinary clinicians working outside of academic medicine.

Next up on 5-Minute Journal Club: The final four papers highlighted in our series along with results from our Patterns of Care study documenting oncologists' management of MDS.

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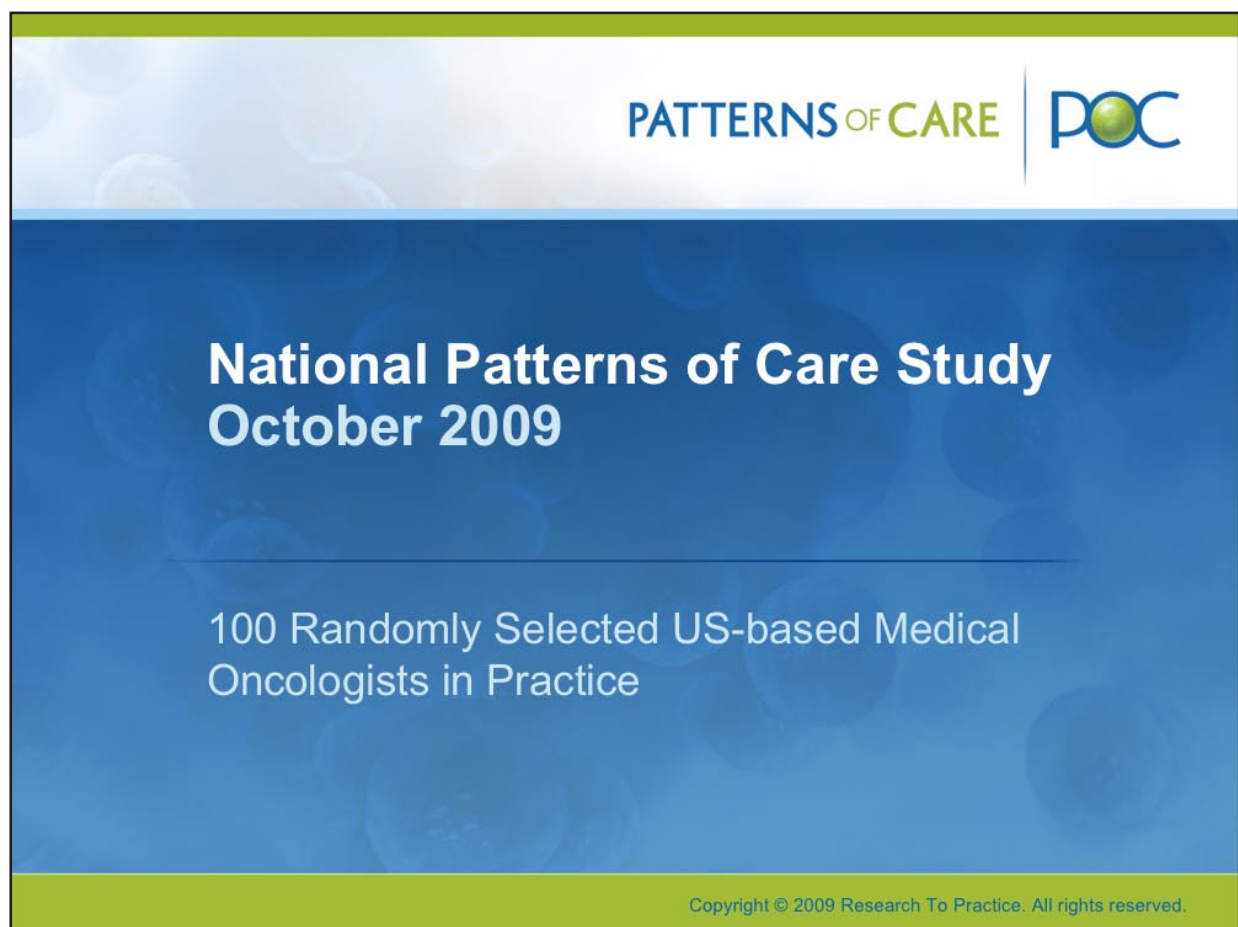
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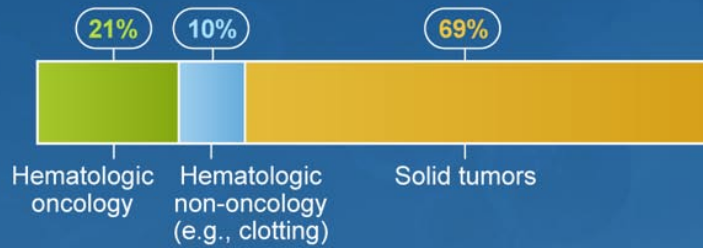
Presentation discussed in this issue:

Research To Practice Patterns of Care Study, October 2009.

Slides from a national Patterns of Care study and transcribed comments from a recent interview with Gail J Roboz, MD (11/20/09) below

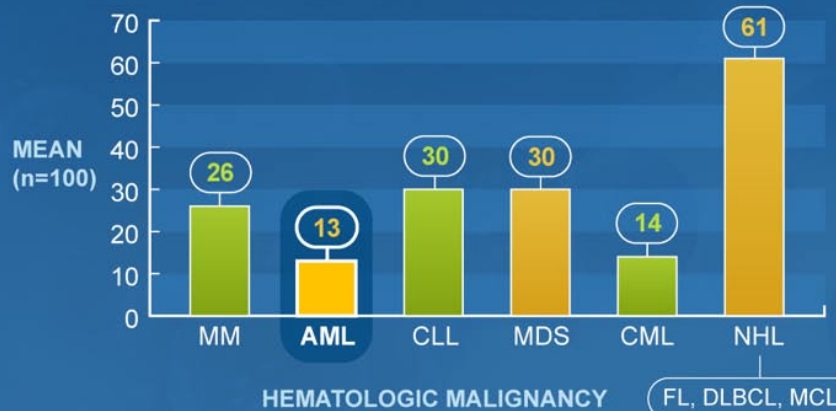


Approximately what percentage of your practice involves treatment of solid tumors versus hematologic issues?

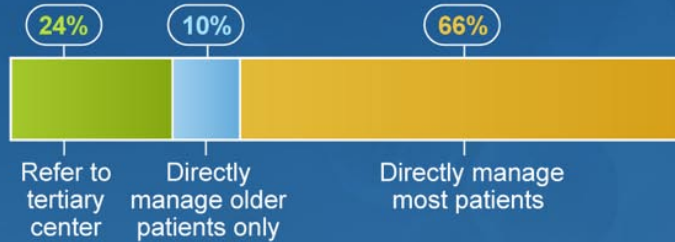


Source: National Patterns of Care study of 75 randomly selected US-based medical oncologists in practice, **October 2008**

In the past year, how many patients have you seen with...



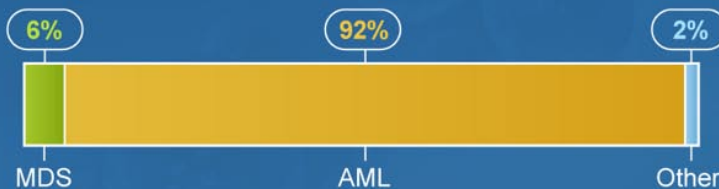
Do you generally directly manage patients with AML or refer them to a tertiary center?



CASE 1

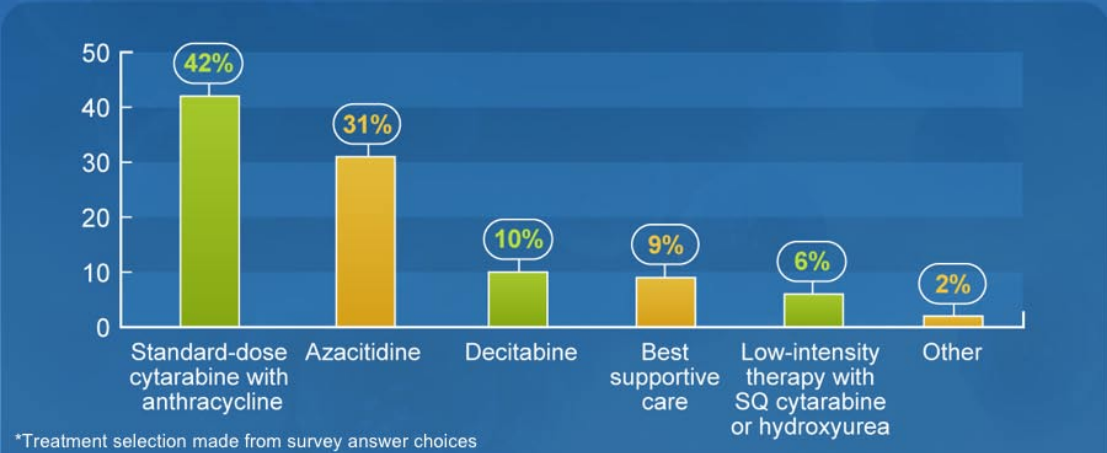
- 68-year-old woman
- Hgb 9.6 g/dL, WBC $2.0 \times 10^3/\text{mm}^3$, Platelets $160,000/\mu\text{L}$
- 32% blasts by flow cytometry
- Specimen insufficient for cytogenetics

What is this patient's diagnosis?



CASE 1

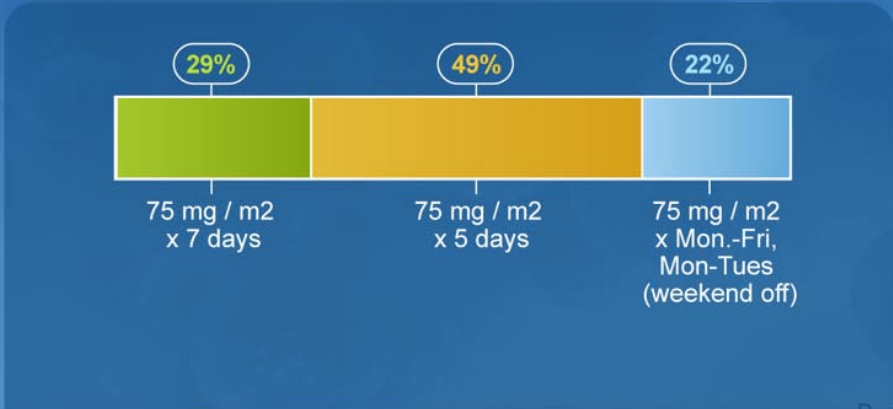
Which treatment*, if any, would you recommend at this time?



*Treatment selection made from survey answer choices

CASE 1

If the patient were treated with azacitidine, which initial dose and schedule would you recommend?

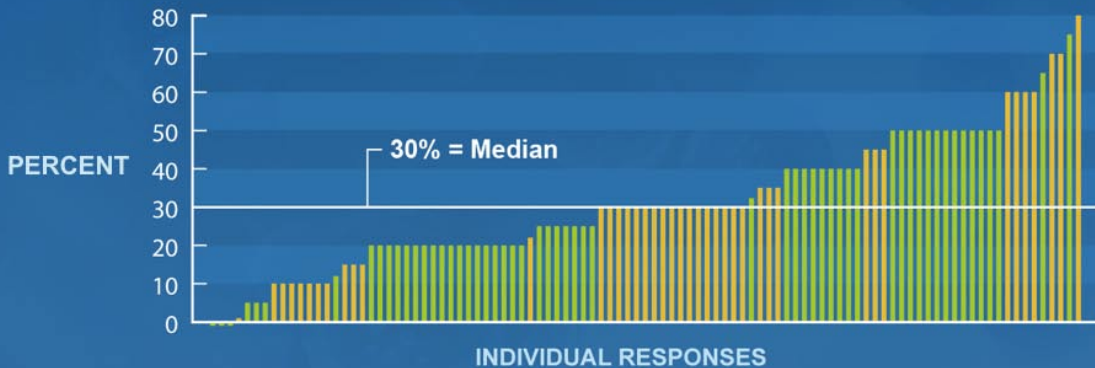


CASE 2

- 59-year-old woman
- Hgb 8.5 g/dL, WBC $1.7 \times 10^3/\text{mm}^3$, Platelets $30,000/\mu\text{L}$
- 60% blasts on bone marrow biopsy
- CD33 and CD34 positivity; normal chromosome analysis

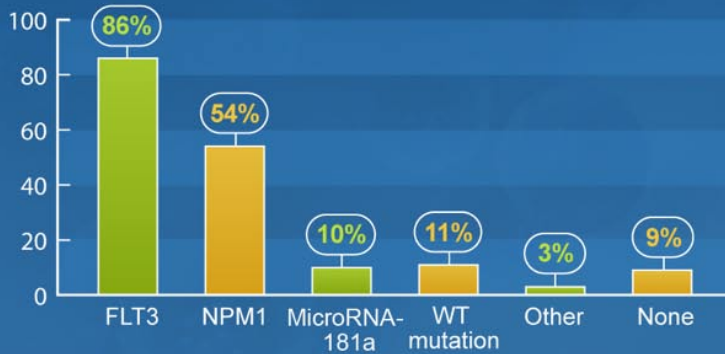
CASE 2

How would you respond if this patient asked you what her chance of cure was with conventional treatment?



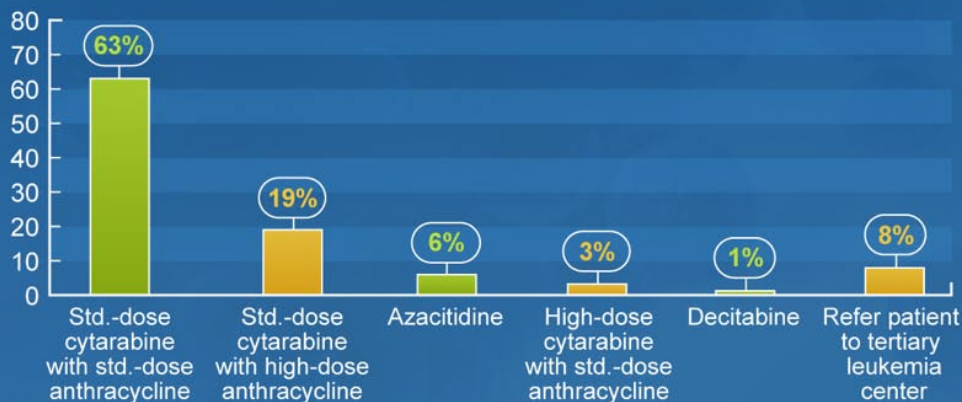
CASE 2

Which additional molecular studies, if any, would you recommend for a patient with AML and normal cytogenetics?



CASE 2

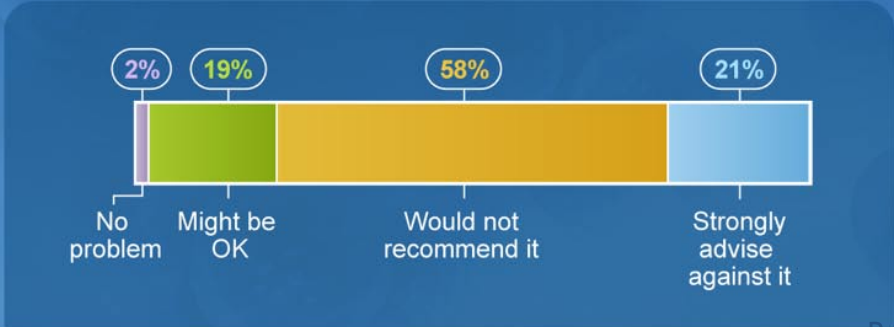
Which treatment*, if any, would you recommend at this time?



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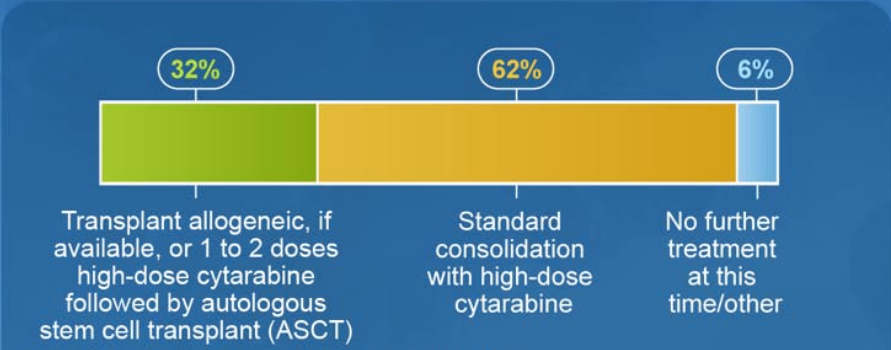
CASE 2

The patient would like to take an herbal supplement in addition to conventional treatment and asks your opinion. How would you respond?



CASE 2

Assume this patient received standard induction with 7 + 3 cytarabine and idarubicin and achieved remission. Which course of therapy* would you recommend at this point?



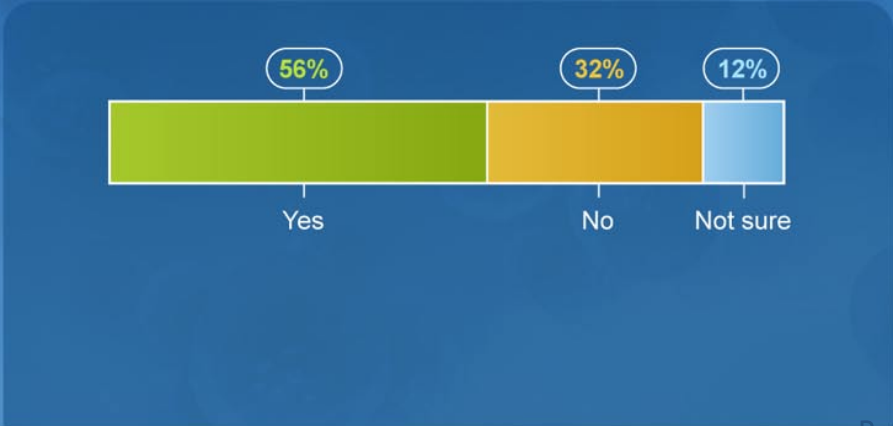
*Course of therapy selection made from survey answer choices

CASE 3

- 81-year-old woman
- Generalized bruising and fever (100.4° F)
- CBC: Hgb 8.6 g/dL with MCV 112 fl, WBC 4.8 x 10³/mm³
- Platelets 19,000/ μ L
- 90% myeloblasts in the peripheral blood

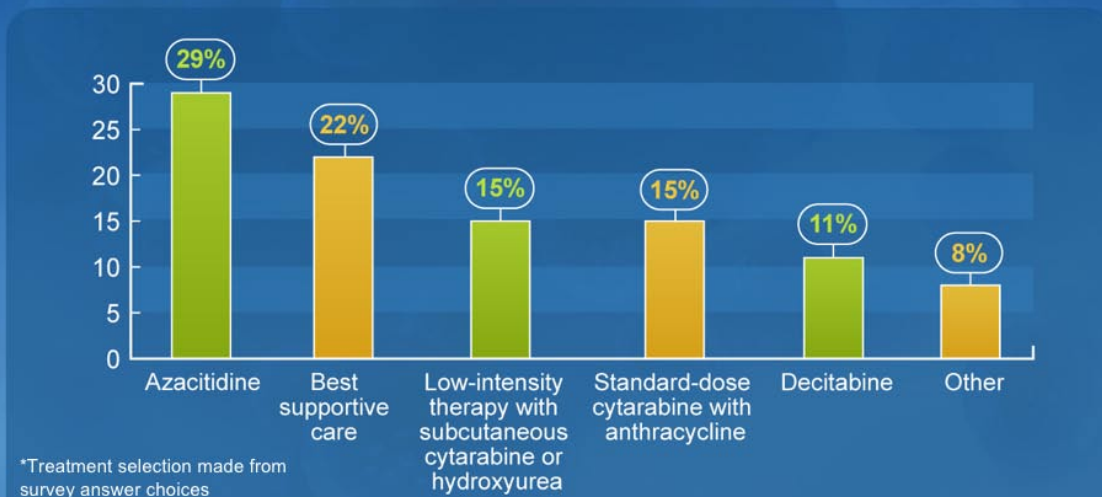
CASE 3

Would you perform a confirmatory bone marrow biopsy on this patient?



CASE 3

Which treatment*, if any, would you recommend?



DR ROBOZ: My impression here in New York is that many oncologists in practice make an effort to send patients with AML to an academic setting, but it would be interesting to see how this relates to geography and distance from tertiary centers.

DR LOVE: Our CME group is presenting a poster at ASH on how 203 patients with newly diagnosed myeloma were managed in community practice since 2008. It would be interesting to do the same thing in AML and, for that matter, MDS, and see what was going on.

DR ROBOZ: That would be an incredible piece of work. I would love to work with you on that. When we go out and give lectures and talk about clinical trials and so forth, I think we all have in our minds that there are threshold levels of commuting, but if we could actually figure out the key factors, it would be fascinating.

DR LOVE: I was surprised that so many physicians in this survey generally manage patients with AML, as opposed to referring them to an academic center.

DR ROBOZ: I have definitely heard it said on a reasonably regular basis that, first of all, the data with AML have not convincingly shown that anything is better than "7 + 3," and secondly, that academic data have not shown — especially for older patients — a significant improvement in overall survival. So a lot of people in the community say, "What's the point in referring?" — and it's tough to argue with that.

In private practice, if you're really convinced that a patient has a disease that by going to a tertiary center, will result in a better outcome, you're going to refer the patient. But some physicians question putting patients through a miserable commute and uprooting them from their families when the outcome is going to be the same anyway.

DR LOVE: Interesting. OK so we'll see what you and Dr Giagounidis think about the other findings in this survey and these cases in New Orleans a week from Friday.

Dr Roboz is Associate Professor of Medicine and Director of the Leukemia Program at Weill Medical College of Cornell University at NewYork-Presbyterian Hospital in New York, New York.