Treatment Patterns and Adverse Events in Patients With Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma in France, Italy, and the United Kingdom

HSD114

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INTRODUCTION

- Chronic lymphocytic leukemia (CLL) is the most common leukemia in Europe and the United States. The incidence of CLL is 4.2 cases per 100,000 people per year, increasing to >30 cases per 100,000 people per year in those aged >80 years[1]
- In most cases, CLL or small lymphocytic lymphoma (SLL) remains an incurable disease; therefore, the goals of therapy are to improve quality of life and prolong survival[1]
- Since the approval of the first Bruton tyrosine kinase inhibitors in 2014, the treatment landscape for CLL has significantly changed, and newly approved treatments are emerging[2]
- Research in other cancers shows that treatment toxicity is associated with increased caregiver burden and reductions in health-related quality of life for the caregiver and patient[3]; however, such research is limited in CLL/SLL
- Furthermore, there is little knowledge of the treatment patterns and adverse events (AEs) in patients with CLL/SLL in a real-world setting[4]

METHODS

- Real-world data were drawn from the Adelphi CLL Disease Specific Programme™, a cross-section survey with elements of retrospective data collection conducted in France, Italy, and the UK between October 2022 and March 2023
- Hemato-oncologists and hematologists completed patient record forms for their next 8 consecutive patients with CLL/SLL as follows:
  - Three patients receiving first-line (1L) treatment at the time of data collection
  - Five patients receiving second-line or later (2L+) treatment at the time of data collection
- The data collected included patient demographics, clinical characteristics, treatment patterns, and AEs with treatment at the time of data collection
- Eligibility criteria
  - Physician inclusion criteria
    - Specialty of hematology or hemato-oncology
    - Consultation with ≥6 patients with CLL/SLL per month, with ≥4 patients with relapsed/refractory disease
    - Active involvement in prescribing decisions for patients with CLL/SLL
  - Patient inclusion criteria
    - Age ≥18 years with confirmed diagnosis of CLL/SLL and receipt of active drug treatment
    - No involvement in a clinical trial at the time of data collection
- The Adelphi Disease Specific Programme™ methodology has been previously published and validated[5-7]
- Ethics
  - An ethics exemption for this research was obtained from the PEARL Institutional Review Board
- Statistical analysis
  - Descriptive analyses were conducted and any missing data were excluded; statistical comparisons were not conducted

RESULTS

- In total, 158 physicians (France, n=62; Italy, n=65; UK, n=31) provided data from 1325 patients with CLL/SLL (France, n=525; Italy, n=528; UK n=272)
- The minimum number of patients per physician was 1, and the maximum was 18; 84% of physicians had between 5 and 9 patients
- In total, 534 patients were receiving 1L treatment at data collection, and 791 were receiving 2L+ treatment

Patient Characteristics

- Mean (SD) age was 70.8 (8.53) years, 60% of patients were male, 70% were not working due to retirement, and 85% had an Eastern Cooperative Oncology Group performance status of 0 or 1 at the time of data collection (**Table 1**)
- The top 3 most common symptoms reported at the time of data collection were fatigue (39%), lymphocytosis (38%), and thrombocytopenia (29%)

Table 1. Patient Demographics and Clinical Characteristics

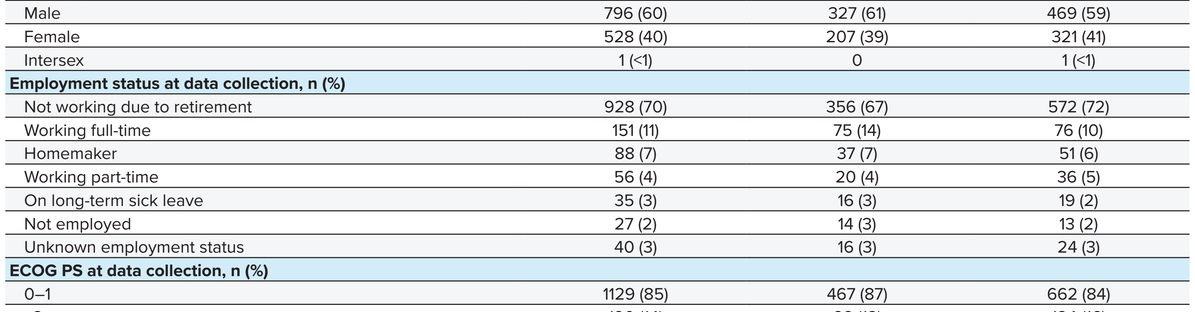
	All Patients (N=1325)	Line of Therapy at Data Collection	
		1L (n=534)	2L+ (n=791)
Diagnosis, n (%)			
CLL	1237 (93)	503 (94)	734 (93)
SLL	88 (7)	31 (6)	57 (7)
Age at data collection, years			
Mean (SD)	70.8 (8.53)	69.8 (8.99)	71.4 (8.16)
Sex, n (%)			
Male	796 (60)	327 (61)	469 (59)
Female	528 (40)	207 (39)	321 (41)
Intersex	1 (<1)	0	1 (<1)
Employment status at data collection, n (%)			
Not working due to retirement	928 (70)	356 (67)	572 (72)
Working full-time	151 (11)	75 (14)	76 (10)
Homemaker	88 (7)	37 (7)	51 (6)
Working part-time	56 (4)	20 (4)	36 (5)
On long-term sick leave	35 (3)	16 (3)	19 (2)
Not employed	27 (2)	14 (3)	13 (2)
Unknown employment status	40 (3)	16 (3)	24 (3)
ECOG PS at data collection, n (%)			
0–1	1129 (85)	467 (87)	662 (84)
≥2	190 (14)	66 (12)	124 (16)
Unknown	6 (<1)	1 (<1)	0
Most common symptoms at data collection, n (%)			
Fatigue	519 (39)	211 (40)	308 (39)
Lymphocytosis	499 (38)	189 (35)	310 (39)
Thrombocytopenia	382 (29)	152 (28)	230 (29)

1L, first-line; 2L+, second-line or later; ECOG PS, Eastern Cooperative Oncology Group performance status.

Treatment Patterns

- For all patients in the 1L setting (n=534), the most common treatments being received at data collection were ibrutinib monotherapy (27%), fludarabine, cyclophosphamide, and rituximab in combination (FCR; 14%), and acalabrutinib monotherapy (14%) (**Figure 1**)
  - In the UK, the most common treatments were acalabrutinib monotherapy (30%), FCR (19%), and venetoclax in combination with obinutuzumab (19%)
- Among the patients receiving 2L+ treatment at the time of data collection (n=791), the most common 1L treatments previously received were FCR (France, 33%; Italy, 32%; UK, 37%) and bendamustine plus rituximab (BR; 17%, 32%, and 15%, respectively) (**Figure 2**)
- In patients receiving 2L+ treatment at the time of data collection (n=791), the most common 2L treatment received was ibrutinib monotherapy (France, 35%; Italy, 42%; UK, 42%) (**Figure 3**)
  - The second most common treatment received in France and Italy was venetoclax in combination with rituximab (16% and 18%, respectively) and in the UK it was acalabrutinib (22%)

Figure 1. Top 5 Treatments Received by Patients Receiving 1L Treatment at Data Collection

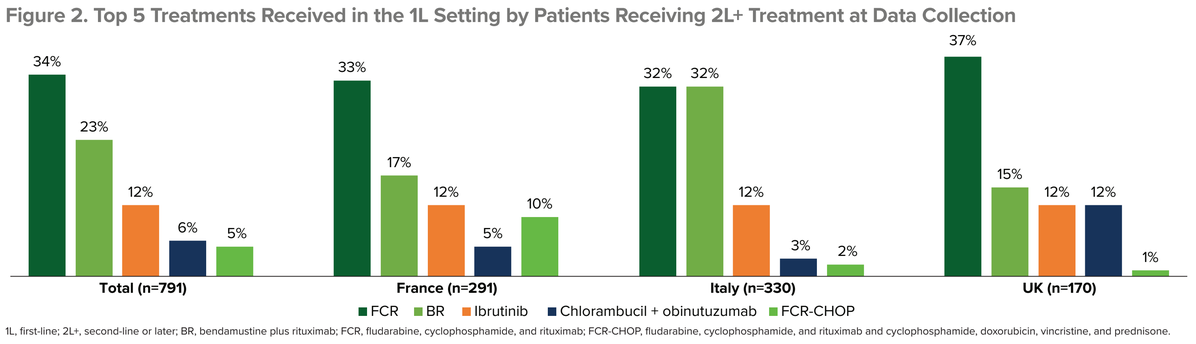


1L, first-line; BR, bendamustine plus rituximab; FCR, fludarabine, cyclophosphamide, and rituximab.

CONCLUSIONS

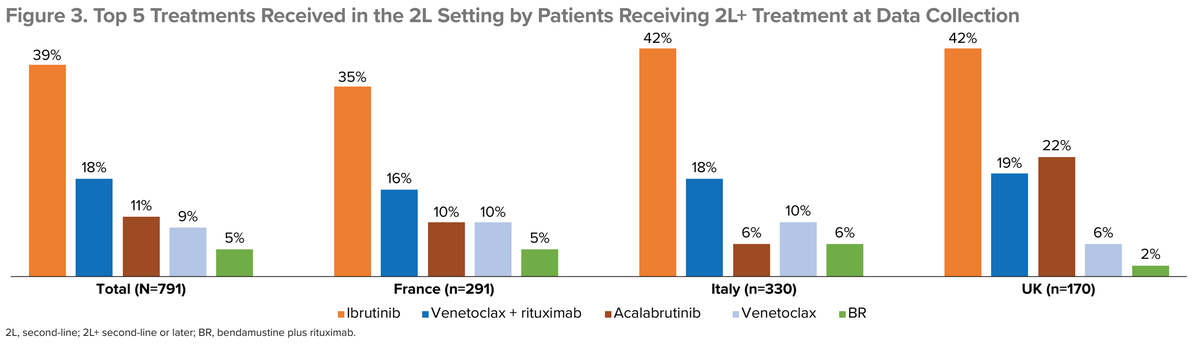
- In France, Italy, and the UK, ibrutinib monotherapy, FCR, and acalabrutinib monotherapy were the most common treatments received by patients with CLL/SLL in the 1L setting. This is consistent with the European Society for Medical Oncology (ESMO) guidelines, which recommend ibrutinib and FCR for symptomatic early-stage disease[1]
- In patients receiving 2L+ treatment at data collection, FCR and BR were the most common treatments that had been received in the 1L setting across all 3 countries
- Consistent with the ESMO guidelines for patients who experience relapse,[1] ibrutinib monotherapy and venetoclax in combination with rituximab were the most common 2L treatments reported in France and Italy in patients receiving 2L+ treatment at data collection
  - In the UK, ibrutinib monotherapy and acalabrutinib monotherapy were the top 2L treatments
- Disease remission, regimen completion, disease progression, and treatment intolerance were the most common reasons for treatment discontinuation in the 1L and 2L settings
- Approximately one-quarter of patients experienced AEs during data collection
  - The 3 most common AEs in patients receiving 1L treatment at data collection were anemia, nausea, and fatigue; in patients receiving 2L treatment, neutropenia, anemia, and fatigue were the most common
- Despite our study showing good evidence that ESMO guidelines are being followed in the management of patients with CLL/SLL, treatments that are better tolerated are warranted and further research is required to determine the severity of, and how to efficiently manange, AEs in the real world

Figure 2. Top 5 Treatments Received in the 1L Setting by Patients Receiving 2L+ Treatment at Data Collection



1L, first-line; 2L+, second-line or later; BR, bendamustine plus rituximab; FCR, fludarabine, cyclophosphamide, and rituximab; FCR-CHOP, fludarabine, cyclophosphamide, and rituximab and cyclophosphamide, doxorubicin, vincristine, and prednisone.

Figure 3. Top 5 Treatments Received in the 2L Setting by Patients Receiving 2L+ Treatment at Data Collection

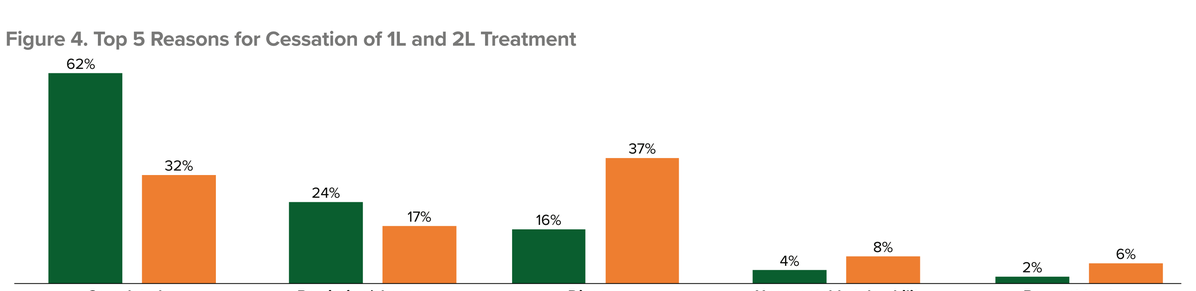


2L, second-line; 2L+ second-line or later; BR, bendamustine plus rituximab.

Reasons for Cessation at Each Line of Therapy

- In patients who discontinued 1L primary therapy (n=819), the primary reasons for cessation were regimen completion (62%), disease remission (24%), disease progression (16%), and unacceptable tolerability (4%) (**Figure 4**)
- In patients who discontinued 2L primary therapy (n=106), the primary reasons for cessation were also regimen completion (32%), disease remission (17%), disease progression (37%), and unacceptable tolerability (8%) (**Figure 4**)

Figure 4. Top 5 Reasons for Cessation of 1L and 2L Treatment

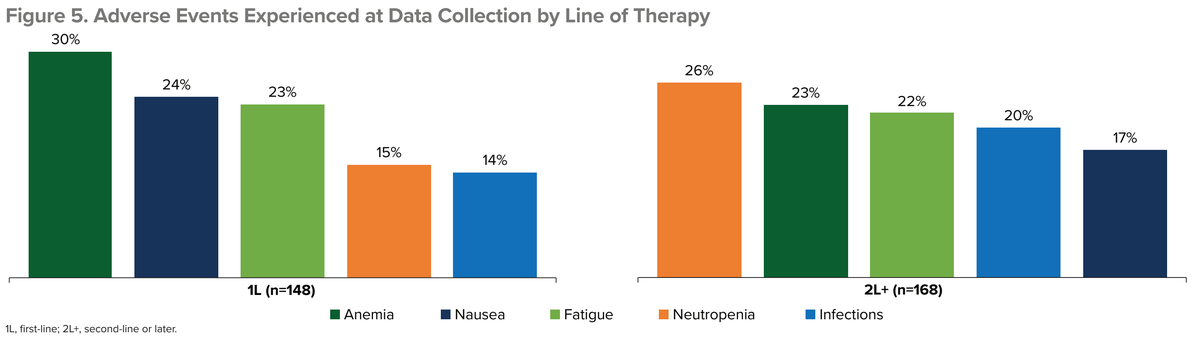


1L, first-line; 2L, second-line.

AEs by Line of Therapy

- At data collection, physicians reported that 24% (316/1325) of patients with CLL/SLL experienced AEs
- Of patients receiving 1L treatment, 28% (148/534) were reported as experiencing AEs at data collection; anemia (30%), nausea (24%), and fatigue (23%) were the most common (**Figure 5**)
- Of patients receiving 2L+ treatment, 21% (168/791) were reported as experiencing AEs at data collection; neutropenia (26%), anemia (23%), and fatigue (22%) were the most common (**Figure 5**)

Figure 5. Adverse Events Experienced at Data Collection by Line of Therapy



1L, first-line; 2L+, second-line or later.

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DISCLOSURES

The Adelphi Real World Disease Specific Programme™ is a wholly owned Adelphi product, of which BeiGene is one of multiple subscribers.
LY Symposia: BeiGene. **NM**, **CK** Employment: Adelphi Real World, which received funding from BeiGene to conduct this study. **NB**, **AP** Employment: BeiGene.

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