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A Patient-Centered Approach to Managing Anemia in Myelofibrosis

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is brought to you by Glaxo Smith Kline. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *Project Oncology* on ReachMD, and I'm Dr. Brian McDonough. Joining me to talk about how we can tailor treatment plans for myelofibrosis patients with anemia are Drs. John Mascarenhas and Lucia Masarova. Dr. Mascarenhas is a Professor of Medicine at the Icahn School of Medicine and the Director of the Center of Excellence for Blood Cancers and Myeloid Disorders at Mount Sinai in New York. Dr. Mascarenhas, thanks for being here today.

Dr. Mascarenhas:
Well, thanks for having me.

Dr. McDonough:
And Dr. Masarova is an Assistant Professor in the Department of Leukemia within the Division of Cancer Medicine at the University of Texas MD Anderson Cancer Center in Houston. Dr. Masarova, it's great to have you with us as well.

Dr. Masarova:
Thank you so much for the invitation.

Dr. McDonough:
So to give us some background, Dr. Mascarenhas, can you talk about why managing anemia is important in myelofibrosis care?

Dr. Mascarenhas:
Absolutely. So anemia is a fundamental aspect of myelofibrosis. It's the consequence of multiple aspects of the disease, whether it's poor production of red cells, sequestration in the spleen, destruction, or blood loss, and then it's sometimes therapy related. So it's a very well-described adverse prognostic marker. It's part of the diagnostic criteria of the disease and has significant treatment implications as well.

Dr. McDonough:
Knowing why it's so important, Dr. Masarova, let's zero in on how we can incorporate anemia management into our care plans. First, what are the patient-specific factors you consider when selecting a treatment plan for anemia?

Dr. Masarova:
I think it's very important to look at the whole patient as well as the burden of the anemia that comes with the entire disease and management. As we know, a lot of the medications cannot completely tackle the anemia to the point that patients don't need transfusions—actually, they often do. So that is time-consuming and a burden to family, patients, and the staff. So we have to consider very important measures like patients not coming that often to clinics to get checked up, and then adverse events, possibly from transfusions. So with patients having underlying comorbidities—heart issues, lung issues— it could easily get fully overloaded. So those aspects are very important for the care of the patients and the frequency of the visits, as well as the quality of life that should be considered with every single assessment.

Dr. McDonough:
Moving on to the patient perspective, Dr. Mascarenhas, what counseling strategies do you use to uncover individual goals and

preferences for treatment?

Dr. Mascarenhas:
So when assessing a patient with myelofibrosis, you and the patient really have to understand the goals of treatment. Is it spleen and symptom reduction? Is it alleviating the burden of anemia? Is it potentially curing a patient with a transplant? So I think having a sense of where the patient is, what those burdens may be, and how to prioritize those aspects is really important. It has to be individualized for each patient. Anemia is clearly one of those, and as Lucia pointed out really nicely, it's often a consequence of a lot of therapies that we do give to alleviate spleen and symptom burden.

Dr. McDonough:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Drs. John Mascarenhas and Lucia Masarova about personalizing anemia management in myelofibrosis patients.

So once you determine what matters most to your patients, Dr. Masarova, how do you balance all that with your own priorities to create an individualized treatment plan?

Dr. Masarova:
I think that's very important in the era of more options for our patients, where in the last couple of years, we have expanded on different therapies or options for patients, including therapies that are given orally or by other intravenous methods that could be used across the board—so really discussing and choosing the right option.

Also, strategy is very important. Patients would prefer coming to the clinic more often and getting checked more often versus not getting oral medications to have improvements in the anemia. It's very important to set up the expectations correctly, because although we believe, or hope, for the transfusion medicine to work—or any other medicine to help with transfusions—it may not happen completely in every single patient. So get that discussion straight there. And then also realize why the anemia settled in and whether we actually have the ability to completely help with the anemia, to only decrease the transfusions in patients that are transfusion dependent, or to somehow just slow down the whole process.

And then, as correctly pointed out, anemia is usually connected with other issues that our patients face. Specifically, we also need to help with symptoms with the spleen, and there could be other accounts that need to be addressed. So medications that may help anemia may not be completely helping all of those parts of the disease, and some of them could. So those are also very important management strategies to utilize for patients.

Dr. McDonough:
Now, before we close, I'd like to ask each of you one more question. Dr. Mascarenhas, using this tailored approach, what outcomes have you seen in myelofibrosis patients with anemia?

Dr. Mascarenhas:
So as we've been saying, it's really a complex disease process, and the treatment approaches have to be individualized. We typically embark on an algorithm looking at the endogenous EPO level and trying an ESA. That may work in 20 to 30 percent of patients. Drugs like danazol or immunomodulatory drugs like thalidomide and lenalidomide also collectively work in about 20 to 30 percent of patients. But one of the problems is, even when they do work, as Lucia is pointing out, it could be a partial response, or the durability of the response may not be there. So prepare the patient for those expectations and explore clinical trials. And there are a number of trials that are looking at very novel endpoints to mediate the effects of anemia.

So referring them early on is really important. And I will point out that, although we are talking about treatments that can often worsen anemia—many of the JAK inhibitors like ruxolitinib and fedratinib, which are excellent, don't typically improve anemia—we do have JAK inhibitors like momelotinib and pacritinib through ACVR1 inhibition that can improve anemia in some patients. So we're now able to really tailor these therapies to address spleen symptoms and even anemia, and sequence these therapies as well. But I always encourage patients and physicians, please don't forget: rare disease is still a lot of unmet need. Think about referring patients for clinical trials.

Dr. McDonough:
And how about you, Dr. Masarova? What has your experience been with personalized treatment plans in clinical practice?

Dr. Masarova:
I think that was perfectly said. We're both coming from academic centers using and having options for clinical trials. We are all up to the path to advance the field, and we realize the shortcomings or limitations of the currently available therapies. We are very happy that we have more options for patients, including, finally, oral medications that ease out on how many times patients need to come to the clinic.

They just take a pill rather than come in every 3 weeks, 2 weeks, or 4 weeks—whatever the schedule was before—to have a supportive therapy for the anemia. But again, we have to take into consideration what this medication could do. Are we only helping the anemia, or are we helping the entire disease?

So in those terms, we do prefer clinical trials for any innovations we could offer. However, coming from Texas, we also have to acknowledge the distance and logistics for our patients. So if a clinical trial only offers the same benefit, our patients will often prefer standard of care if it's reasonably effective and could offer them very good outcomes, versus patients who are desperate for better because they already tried everything, have nothing, and would go for a clinical trial regardless of where they live.

So those are very important factors we always have to consider here. But I have to emphasize that the options of having novel trials that could improve upon what we already have are very important. And the communication with the local oncologists or referral centers are equally important so we can spread the novelties and the options to our patients. And we both see from a clinic and academic centers that patients these days have connections with social media and are asking actively for better therapies that could last longer and that could have significant impact on the quality of lives. They are much more keen to enroll in these clinical trials, even it takes more hurdles to travel and encounter.

Dr. McDonough:
With those perspectives in mind, I want to thank my guests, Drs. John Mascarenhas and Lucia Masarova, for joining me to talk about tailored treatment plans for myelofibrosis patients with anemia. Dr. Mascarenhas, Dr. Masarova, it was great having you both on the program.

Dr. Mascarenhas:
Thank you.

Dr. Masarova:
Thank you so much.

Announcer:
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