CLL Global Research Foundation Virtual Town Hall | October 27, 2026

Jeff Folloder: Hello and welcome. Thank you for joining us for the final CLL Global Research Foundation town hall of 2026. I'm Jeff Folloder. In today's program, you'll hear the latest about CLL research and treatment straight from two CLL experts. And, of course, we'll be answering your questions live. A little about me. I have now entered year 17 of living with CLL. I consider myself a passionate patient advocate. And it is my determined goal to make sure that everyone with CLL and their caretakers know that it is possible to live not just a good life with CLL, but a great life.

Keep in mind that we cannot answer specific questions about your medical treatment. Those should be discussed with your own healthcare team.

Now let's meet our guests for today's program. First up is Dr. Alessandra Ferrajoli. She's joining us today from Rome. Can you please introduce yourself and tell us a little bit about the areas of CLL research that you're involved in?

Dr. Alessandra Ferrajoli: Yes. Thanks, Jeff, and everyone for the invitation. I have been working with CLL for now close to 25 years. And I'm also very passionate about this disease.

And I agree that life with CLL can be pretty much a normal life most of the times. So, what I work on are two main topics. One is the treatment. So, I'm a clinician investigator. I direct clinical trials, I design clinical trials. And I always look at new combinations and better treatment. But I'm also an internist. And I'm very interested in everything that has to do with preventive care. I'm interested, how we can make the person with CLL healthier. How we can use the available tools to reduce the risk for infection, reduce the risk for other cancer, keep the body active, improve the nutrition, and basically make us to live better lives. So, those are the two main topics of my activities.

Jeff Folloder: Most excellent. We're also joined by Dr. Jackie Broadway-Duren from MD Anderson Cancer Center. She's a long-time CLL global collaborator and expert. Dr. Jackie, could you please introduce yourself?

Dr. Jackie Broadway-Duren: Good afternoon, everyone. As you stated, I'm Jackie Broadway-Duren. I've been here a long time now, about 26

years in leukemia in MD Anderson and had the pleasure of working with all these CLL physician experts. I have a PhD in nursing research from Texas Woman's University and doctor of nursing practice, also certified in oncology. And I love CLL. I've worked with it for many years. And I am here to see whatever I can answer and help make your life better and make you feel more comfortable about having CLL.

Look forward to speaking with you later on in the program.

Jeff Folloder: That's wonderful. I would also like to offer a personal comment. This particular presentation is very, very important to me. The reason why it's so important is these two wonderful doctors here have both participated personally in my care, my journey with CLL. So, this is extra special to be able to work with people who've had a hand in making sure that I'm living a great life. I'd also like to point out we are not only in spooky month, we're in spooky season, spooky week. So, I chose orange and black to commemorate Halloween coming up. I'm going to give out enough candy to make sure my wife doesn't get any left over.

Let's move right into the discussion. Dr. Ferrajoli, let's start with your presentation.

Dr. Alessandra Ferrajoli: Thank you. So, I would like to focus on survivorship initiatives that are initiatives that I share with Dr. Broadway-Duren as well. And I always like to start my discussion just taking a little spotlight on what is CLL today. What is very important is there are going to be 22,000 new cases of CLL in 2026. But because people with CLL live with such a long time, it is actually the most prevalent type of leukemia that is in the Western countries with about 235,000 people living with CLL. And it has unique characteristics. Two-thirds of the patients are going to be older than 65.

It's more common in male and in people of white ethnicity. This helps us to understand why we will see certain manifestations in CLL. Then just to put a very positive spin, those are, again, data from the CER, the Center for End Results, that show that the five-year relative survival for patients with CLL is 90 percent. And it's likely to continue to increase because the CER survival for 2017 is already at 92 percent. What is really striking is that if we go back a few years, if we go back to 1975, that percentage was only 68 percent. It's really major, major changes for this disease.

And how did we accomplish this? We accomplished first of all with better treatment. Now that we have treatments that are so good, target therapy, a number of targeted therapy, cellular therapy, monoclonal antibodies that try to trick the CLL cells through different mechanisms, I think that focusing on survivorship and focusing on how to keep people with CLL healthy is even more important because we know that with therapy we can really prolong life and make it to be a normal life. This has been shown, also, again by research. In fact, if we look on the left side of the screen where there is a red line, that red line is going down.

And that is the cause of death in patients with CLL being CLL. So, less and less people are dying of CLL. We are seeing an increase in cause of death by other causes, in particular by cardiovascular disease, by other type of cancer, and to a less number, to infection. So, this is why survivorship is so important. The therapies are so good. The therapies can prolong life. So, it's important now to tackle those other causes of death. And this is the survivorship initiative that we have at our center. It's important to understand that the definition of survivor includes everyone with a diagnosis of cancer from the day first that the diagnosis is made.

So, we should not think that a survivor is only somebody that has completed treatment. No. survivor is from the very first day. In order to support, again, the health of the survivorship, we have designed this algorithm that focuses on several aspects of the wellbeing. But in particular, it focuses on what are the lifestyle assessment and cancer screening and vaccinations. So, those are really the three key factors for survivorship. Assess your lifestyle. Check where you are with your cancer screening. And checking where you are with your vaccinations.

We have reviewed these in detail because everyone may think what we need to do as far as cancer screening is written in stone and is very clear. That is not the case. There are many guidelines that are different from each other and are supported by different organizations. But not only the guidelines can be different, but we created in this review a last column that we call special consideration for CLL. Because we feel that CLL, the counts with immunosuppression, immune dysfunction should be treated differently. And not necessarily what is a guideline for a

healthy individual should be applied for CLL.

As an example, for older patients that are healthy, many guidelines discuss stop screening for prostate cancer at age pretty much 69 or 70. But people with CLL are immunosuppressed. And I think there is support for maybe prolonging the screening and screening past that age. And the same thing for a colonoscopy. It is true that guidelines don't want to screen after age 75. But that is for a healthy individual. For a patient with CLL, I think those guidelines should be not so strict, and a discussion with the physician should be made before we decide whether we should stop screening or not.

In fact, we have conducted, with support of CLL Global, quality improvement initiatives where we have given numerous reminders to our patients when they come for their visits regarding where they are with their cancer screening. What we have seen that is very interesting, because if we didn't plan our quality initiative ran right through the COVID pandemic, we have seen that where the cancer screening decreased during the COVID pandemic here, then it rebounded to the pre-pandemic levels. So, we're doing very well in cancer screening when we alert the patient, when we remind the person with CLL how important this part of their healthcare is.

Where we are doing a little bit less well based on our quality initiative is with vaccination. Because again, we have seen despite a reminder for vaccination and a discussion of the importance of vaccination, the level of vaccination, the percentages of vaccinations that we had pre-pandemic have not yet been reproduced in the post-pandemic years. So, I think this is, again, a message that we want to give that we know there is some hesitation for vaccination. I know there is some concern. However, they are a really important part of the preventive care. And they can be effective in the patients with CLL. Then, as I said, another very important aspect is lifestyle.

It's amazing what positive immune effect are present by both what they call acute and regular exercise. So, short burst of exercise really stimulates our immune system. The same happens for regular exercise. For patient with cancer, various types of cancer, it has really shown exercise during therapy really helps the treatment be more effective and give better results. So, we have, therefore, completed the program

Health for CLL where we showed that by testing different treatment modality, not only are our patients more active, they lose some weight, but there is benefit in their immune system. And we have moved to a new program that is called Health for CLL 2 that we have also recently completed enrollment.

But patients are still going through the intervention to further improve this aspect. So, this is where my focus is for this presentation today. It's for the health support and survivorship.

Jeff Folloder: Thank you very much. If I can, I'd like to play back what I think I heard. One, things are getting better. Our survivorship is getting better. Two, the comorbidities are still a thing and need to be managed. And three, there's hope. Get up out of your chair, go move around, get some exercise in, and live well.

Dr. Alessandra Ferrajoli: Yes.

Jeff Folloder: Thank you Dr. Ferrajoli. Dr. Broadway-Duren, you're up next. What updates in CLL research and care would you like to share with the audience?

Dr. Jackie Broadway-Duren: What I would like to share is that we are pretty much doing frontline therapy now with the BTK inhibitors, the covalent and non-covalent BTK inhibitors. Many of our patients are familiar with those. And those would include where we rarely are using ibrutinib (Imbruvica) anymore, but we have zanubrutinib, (Brukinsa) pirtobrutinib (Jaypirca), and acalubrutinib (Calquence). While Calquence, which many patients come to our clinics questioning that particular one because they see it on the commercials. We're also using as frontline therapy in some cases for unmutated patients, the BTK-I as well as BCL-2, which will be your venetoclax (Venclexta) therapy.

Then there's sequencing for CLL patients. Those who may have started out with BTK-Is and later developed a mutation for the BTK and needed to go on to non-covalent, which would be the pirtobrutinib, as well as combination therapies. So, as I was saying, for patients particularly with that initial relapse, they may or may not be rechallenged with a BTK-I. And they will likely have the – we're doing a lot of combination therapies now where we're combining BTK-Is as well BCL-2 and monoclonal antibody, which in most

cases is obinutuzumab (Gazyva). However, there are a few cases, such as with the MERINO trial where methotrexate (Rheumatrex) was used instead.

And with these studies, we are seeing after three years progression for survivor, many of them are in the high 70s, around 80 percent in most of this patient population. They are now doing studies where they are combining the zanubrutinib as well with venetoclax. So, that's still pretty early on. Most recently, we now have degraders, BTK degraders that we are using. So, those are exactly what they sound like where the BTK is attacking and degrading the protein that can drive the disease. So, this is very interesting. We do have some frontline protocols used in BTK degraders for untreated patients, as well as in patients who have been relapsed.

So, that's just to give you a snapshot of where we are now. We also are combining now BTK degraders with a new BCL-2. Yes, we do have something other than venetoclax now. We have the sonrotoclax (Beqalzi), which is also being incorporated in some of the newer clinical trials. So, just to give you an idea, generally when patients come in and they are untreated, they may be started on single agent BTK inhibitors. As you know, many of the treatment decisions are based on what the prognostic factors look like, such like the FISH test and the next-generation sequencing and those type things.

And they also depend on the age of the patient and their physical status at the time. Whether they are well, whether they have multiple comorbidities that also can help drive and determine treatment strategies for that patient. And lastly, patients are considered for treatment and given the option for a time-limited or fixed-duration therapies. Some choose to just take maybe a BTK inhibitor for continuous. That is something that is decided with the physician and the team and the patient. They are part of the team. So, they get to have input also into those treatment decisions.

Jeff Folloder: Thank you very much. I'm going to redirect a question to you after we talk a little bit about research. I listened to both of you talk, and I'm amazed at how much we have learned in the 16, 17 years that I've been dealing with CLL.

I know that this is research-driven. So, I'd like to encourage our audience, if you want to learn more about research funded by the CLL Global Research Foundation, we have a virtual patient-focused research symposium coming up on November 18th. You can learn more and register at CLLGlobal.org. Now it's time to get your questions in the Q&A portion of the program. As I said when we began, we received many, many questions. We're going to try to get to just as many as possible. I'm going to start off with the one that's at the top of the list from Irv, he's got a question that's near and dear to my heart. Dr. Ferrajoli, I'm going to give this one to you. What are the best ways to treat low platelets and low IgG from relapsed CLL? This is near and dear to my heart because it describes me.

Dr. Alessandra Ferrajoli: So, this is a very challenging question. First of all, we need to determine why the platelets are low. If the platelets are low because there is involvement of the bone marrow by the CLL, then my strategy will be, and the strategy of many will be to treat the disease so that you can reduce the amount of CLL in the bone marrow, and the platelets are likely to improve. However, CLL tends to play tricks on us. Sometimes the low platelets may be due to destruction of those platelets by our immune system. Usually those platelets are destroyed in the split. In this case, we need to take a little bit of a different approach.

We usually tend to use more immunosuppressive therapy or therapies that are directed toward what we call ITP, that is this immune thrombocytopenia. Often, once we have controlled the thrombocytopenia, we tend to end up in the same place as I described before. That is if we treat the underlying CLL, it's less likely the immune thrombocytopenia will reoccur. So, we do, again, the best approach according to what is the cause of the thrombocytopenia. And we can determine that by doing some studies, particularly it's needed to do a bone marrow aspiration to determine whether the bone marrow is producing extra platelets and those are being destroyed or the bone marrow cannot function because there is CLL there.

As far as the second part of the question that is the lowering immunoglobulins, we have noticed that with the more recent therapies, therapies that are very effective, especially when they are given in a timely fashion, once the disease is in remission, with time, the immunoglobulin level will improve. There are, however, occasional patients that even

if the CLL is in remission, it's very well-controlled, they'll still have low immunoglobulins. There is not an effective drug to stimulate those cells to make the immunoglobulin. But if there is an increased risk of infection, we can do infusion of immunoglobin and use them as a supplement to the care of the patient.

Jeff Folloder: Interesting. Very interesting. Dr. Jackie, we in the CLL world love throwing around some acronyms. One of the acronyms that we hear all the time in the support groups is MRD. There's MRD-positive, MRD-negative, and how deep is the MRD. What is MRD? And if someone gets the good MRD rating, I've got another question for you. So, let's start with that one.

Dr. Jackie Broadway-Duren: So, MRD is an acronym for minimal residual disease. That means after you've had your treatment, we go back and evaluate sometimes through the blood, through peripheral, or through the bone marrow and see how much CLL remains at the completion of that course of treatment.

So, it's measured in percentages. Ideally, we'd like to see undetectable MRD, meaning there are no markers that would identify the cells there as CLL cells, which would be reported back to your flow cytometry - CD20 and all those markers. If it's MRD undetectable, then that's the best outcome that we can hope for. Now, the problem with that is many patients think if it's MRD-undetected, that means they are cured. As Dr. Ferrajoli would attest to, we can't say that anybody is cured with CLL yet. I think it's coming one day. But if, in fact, you have it, we try to make patients aware that it's undetectable.

But depending on what your prognostic factors are, again, this is where they are very important. Unmutated 17P, TP53, at some point in time it's going to resurface, so other treatments may be indicated at that time. So, that's what MRD is. It helps guide decisions whether you've reached the end of this regiment, is that good enough, or do we proceed with therapy past this point. There are many other factors that help make that determination.

Jeff Folloder: That's very cool. Let me do a follow-up question. I had it right here in my back pocket. Assuming someone gets to this undetectable MRD status, what percentage of patients stay in remission and for how long? What does MRD-negative look like?

Dr. Jackie Broadway-Duren: It depends on the patient. It depends on if they're on a research protocol.

I had this situation just today that happened. The patient is MRD-negative. He's clonal sequencing-negative. However, the patient didn't understand why would I need to take any additional therapy? But I guess maybe Dr. Ferrajoli could chime in on this. The protocol is written that the patient will continue. I guess we can't continue in patients who we know have poor prognostic factors. May not necessarily stop because you got an undetectable MRD on that patient. I guess it would be more like a maintenance therapy. Dr. Ferraioli, would you care to add to that?

Dr. Alessandra Ferrajoli: Yes. So, as Jackie said, MRD really needs to be seen in the context of that individual patient. It's mostly a tool for us physicians to anticipate our next step, our next movement.

If the patient has really good, favorable prognostic factor and has received a relatively intense time-limited therapy, then there is a possibility the MRD will stay undetectable in a good proportion of patients for maybe two, three years, for a prolonged period of time. But few patients, we know this from the time of the chemo immunotherapy, few patients will stay undetectable for life. If the patient is a patient that instead has some adverse prognostic factor, let's say that this treatment is the second treatment or the third treatment.

Even if MRD negativity is achieved, is reached, then in that context, I would anticipate it will be of shorter duration. Since Jackie kindly gave me the option to chime in, it's really important to understand that return of MRD does not mean being out of remission and does not mean that you need treatment right away. It's really a very sophisticated tool. In fact, there are different levels for if we do MRD by flowcytometry, we can detect 1 in 10,000 cells. If we use the clone SIQ, that is the more sensitive, we can detect 1 in 1M cells.
It's really very sophisticated tool that we physicians use to follow the disease once we have achieved, to push the disease back to a point that by just regular microscope or by regular blood count cannot be detected anymore.

Jeff Folloder: That's very, very interesting. Kim has sent in a question. I'm going to keep you on the line. Everyone wants to know the answer to this question because it's near and dear to our

hearts. Research is very, very important. And we're all grateful to what CLL Global is doing. And we're all grateful to the various research grants that are issued by many governments all around the globe. We all know there's NIH, National Institution of Health, spending cuts. Those cuts are likely going to impact basic science research and progress. Do you think it's going to impact CLL?

Is there reason for concern, or should we still be hopeful? Dr. Ferrajoli?

Dr. Alessandra Ferrajoli: So, I think we should be hopeful because the field is evolving so fast and so well. However, there is definitely reason for concern. The way to see it is that the research that is being impacted, as you said, is the very early research. It's where there is not a financial incentive in conducting that research. That very early research then becomes more advanced research and close to drug development and even further, close to drug approval. The later drug development and drug approval are really mostly supported financially by the pharmaceutical industry or by organizations like CLL Global or ASCO or ASH.

But the early, the very important early research is supported by NIH. I have had many patients asking me this question in the clinic. My way of answering is we won't feel it now, but we are likely going to see a slowdown in progress maybe five, seven years from now.

Jeff Folloder: Got you. Dr. Jackie Broadway-Duren, you are sitting in a clinical exam room with me and Dr. Keating. And the question of when are we going to start treatment came up. Because some things had changed in my journey. You were there. How do we answer this question? How do we know when is it time to start treatment?

I know it's different for a lot of people. But how do you do that matrix? How do you work through that flow chart?

Dr. Jackie Broadway-Duren: Well, one of the main considerations is people want to make everything very technical. But sometimes just a plain, thorough physical examination can give you an idea that therapy may be ready. Meaning that you may have large lymph nodes in several places that are greater that 5 cm. Or maybe you're having drenching night sweats or fatigue to where rest is required by late morning. But more technically, you want to look at those lab tests. You want to look at the

CBC. It's not based on just a white blood cell count. You also have to consider, does this patient, do they have favorable prognostic tests?

If we have a patient who doesn't, they're unmutated, which is considered unfavorable, they have a 17P or TP53 or 11q. So, all those things are taken into consideration. There have been times that patients may need to start therapy and they may only have 28,000 white cells versus someone that may have 128,000 and not need therapy yet because there's nothing that's causing that white count to double. It's the doubling time of the white count. If it's less than six months, then that is an indication for treatment.

If the patient's overall well-being is deteriorating or if the platelets are dropping and the hemoglobin is dropping, all those things may be indication that it's time to start therapy. So, there's no one specific thing. You just combine all these pieces of the puzzle and then try and determine if, in fact, that patient is a candidate to initiate therapy now.

But I think one of the things that we do well in our leukemia department is we monitor the patients closely and try to help guide them to accept the fact that you're likely going to need treatment but maybe not this month. But we'll have them back in six months. So, you've then prepared the patient so that they themselves start looking at all these different aspects. That also can help the clinician make a determination. It's the white count. It's the prognostic test. It's the symptomatology that the patient has. All those things are indicated.

Jeff Folloder: So, that's a better way of saying it depends.

Dr. Jackie Broadway-Duren: It depends. It definitely depends on the patient.

Jeff Folloder: But it does make sense because every patient's journey is different. And I remember specifically when you and I were discussing this, it was a matter of not just the symptoms but how do you feel.

Dr. Jackie Broadway-Duren: Exactly.

Jeff Folloder: Because so many patients, their blood work will be off the charts abnormal, but they feel just fine. So, maybe for them, not so much. It's complicated. But like I just said and like you just said, it depends. Here's a great question, Dr.

Ferrajoli. We got a lot of great new drugs out there. One of our patients is taking Jaypirca. They want to know should I take it forever if it keeps CLL undetectable?

Dr. Alessandra Ferrajoli: Again, this question can only be answered if we know more about that patient. In general, pirtobrutinib, taken by itself as one agent only should be taken as a continuous step.

If we instead take pirtobrutinib as part of a combination regimen and we have developed **at MD Anderson** pirtobrutinib, venetoclax, and obinutuzumab that we call PVO, that is given as a time limited therapy as long as the milestones that we want to achieve are achieved, such as good quality remission, normalization of the counts, and normalization of lymph nodes and spleen. So, it really depends on when pirtobrutinib is introduced in the patient journey, first line, second line, third line, whether it's given alone or in combination.

Jeff Folloder: Fantastic. I know that we have mentioned the concept of comorbidities and all of us needing to manage those comorbidities.

I also know that some of these new treatments have issues with blood glucose levels. Dr. Broadway-Duren, which BTK inhibitors do not increase blood glucose?

Dr. Jackie Broadway-Duren: I believe to my knowledge, that may be the zanubrutinib. I don't know the positive answer to that.

Dr. Alessandra Ferrajoli: I agree, Jackie. I don't think there are any of them that particularly increases the blood glucose. But what happens often is people tend to gain weight on these medications. Sometimes it's because they feel better, they eat more. Also because maybe a spleen that was enlarged that was reducing the ability to have full meals is now normal.

So, I am also not aware of a very strong impact on BTK inhibitor on blood glucose with the exception of often a weight gain that is seen. As we know, weight gain will increase your blood pressure, will increase your blood glucose. If the person is a diabetic, it's really important to review and make sure there is not an interaction with diabetes treatment.

Dr. Jackie Broadway-Duren: To chime in, there are patients, we see them in the clinic that have never been diagnosed with diabetes. It's coincidental

that they now started the BTK. As she stated, they may be eating more now, that blood glucose level is rising.

They actually had underlying Type 2 diabetes and weren't aware of it, in many cases.

Jeff Folloder: That makes sense. That makes sense. I have a question that's a toss-up. It's a great question about side effects. Does anyone else experience serious skin itching without any obvious skin irritation? Is this a CLL thing or a side effect thing?

Dr. Alessandra Ferrajoli: With treatment or without treatment?

Jeff Folloder: The question is not specific about that. I know that in CLL support group I've heard a lot of people who are not on treatment complaining about skin itching. And I've also heard about people who are on treatment complaining about skin itching. So, is this a thing?

Dr. Alessandra Ferrajoli: So, we can make a few considerations.

If somebody's on treatment, usually we see skin dryness with treatment. Skin dryness, if not properly treated with good lotion can be associated with itching without any skin rash. There is also with CLL a particular situation that is called hyperactivity to arthropod attack that is a very sophisticated name to indicate that if a patient with CLL is bitten by a mosquito could have a very large reaction, much larger than what is expected. This indicates that yes, we don't think it's mediated by the B cells, by the CLL cells, but there are some T cells in the skin that in patients with CLL are hyperactive.

And those could also produce some itching. I don't know if Jackie has any other wisdom to add.

Dr. Jackie Broadway-Duren: We did a retrospective medical record review on patients with CLL because they were exhibiting symptoms such as that. And they weren't actively being treated, but they had underlying CLL and found that some of those may be autoimmune associated. I'm not saying everybody that itches has autoimmune disease. I'm just saying if you can't find an answer somewhere else, that may be a consideration. CLL, no matter what it is, CLL gets blamed for everything.

Jeff Folloder: Well, of course, it does because we have CLL. We need to blame something. Dr. Jackie, this is a question that comes up all the time.

Sometimes I think the answer shifts a little bit, but it still needs to be asked. Dietary restriction or dietary choices and supplements, do any of those approaches slow down the progress of CLL? Turmeric, broccoli, Brussels sprouts, tea, does any of this work to slow down CLL?

Dr. Jackie Broadway-Duren: Well, probably during the time that you were our patient, Jeff, there was this big push towards green tea being the cure for CLL. I think that was a short-term study done at the Mayo Clinic regarding green tea. And I think it was the active ingredient in the green tea, ECEG, or whatever it is. But I'm not aware of anyone going in remission because they went on a supplement.

I have limited knowledge when it comes to that. But what I can tell people is don't go out and buy every supplement that someone on the block told you because most of the time it's not going to do what is claimed to do. Some of those supplements are beneficial if you have joint pains and all of those type things. But there's no supplement that I'm aware of that cures CLL. As a matter of fact, we had a patient once in clinic, when he came in the door he had 43 different supplements.

Jeff Folloder: Oh my.

Dr. Jackie Broadway-Duren: But however, the problem with supplements is that they're not regulated by the FDA. So, many times we don't know what quantity of what ingredients are contained in those supplements. So, if they're going to start treatment and we don't know which pathway these things are metabolized in, you have to be very cautious about adding supplements when you're going on therapy or are on therapy.

Jeff Folloder: That makes complete sense. Dr. Ferrajoli, this is another question near and dear to my heart because I did participate in a clinical trial. In your opinion, and we've got a lot of these things cooking right now, which clinical trials show the most promise?

Dr. Alessandra Ferrajoli: I would say that all the clinical trials are showing promise right now. If you're asking me which agents are the most exciting, we always look for the newer kids in the block. And

the newer kids in the block are the BTK degraders, the new BCL-2 inhibitors, bispecific monoclonal antibody, new type of cellular therapy like CAR T, off-the-shelf CAR T

So, those are the most exciting things that we have. But, if you're asking me what is the clinical trial that is right for you, I would say that also depends where you are in your journey. For a patient that is just now entering the need for treatment, I always recommend a Phase II or a Phase III clinical trials. Those are trials with medications that are often approved but what is investigational is how many of them are given together, with which schedule, for how long. If, instead, the patient has had many treatments before, the disease is somehow developing some changes, some resistance, then those are the people that really should be brave.

They should be brave and their doctors should be brave. And using a newer agent, a newer mechanism of action that is usually what we do in Phase I clinical trial can be very successful at times. So, again, the type of treatment, the type of clinical trial depends on where you are.

Jeff Folloder: So, I'm going to ask you to expand on that just a little bit. We're coming towards the end of our allotted time for Q&A. You're talking about it depends for clinical trials. Tell me more about where we are with the CLL research and what it really means for patients. I know so many people who say, "I'm not going to be a guinea pig." Where are we?

Dr. Alessandra Ferrajoli: So, I don't think anyone that participates in a clinical trial is a guinea pig. There are a lot of advantages from participating in clinical trials. What we try to do is improve on things that are already so good. This is why we have clinical trials with BTK inhibitors, we have clinical trials with BCL-2 inhibitors. Those have been really practice changes drugs. Now we are working out the small details of how they should be given, for how long, which one I believe the best when you give them in combination. When you participate in a clinical trial you have an entire team that monitors you, that decides how long you need to be, that looks at every small side effect.

So, we are really providing a very, very good service by offering clinical trials because we're working on making what is already good better. And that is kind of the same thing for earlier clinical trials. We have agents that we have

signals that are really going to be the next best therapy. We use clinical trials to do the test on the road. But we know there is a lot of support. We just don't open a vial and use a chemical. There are years and years of research. There is preclinical study on cells. There are some studies on animal models that really reproduce the same conditions as CLL. Often there've been some studies in humans that support that what we do is safe and likely to be useful.

Jeff Folloder: I believe what I hear you saying is that even though it's a four letter word, hope is here and hope is important.

Dr. Alessandra Ferrajoli: Yeah. If I can expand, I know we talk about cure. Dr. Broadway-Duren said cure is not there yet. However, I want to specify that I have a personal view of cure. That is if my patient with CLL can live a good life as long as they were programmed from the day they were born to live because I give them therapies that work in the same way as the therapy for blood pressure, as the therapy for diabetes, that keeps the condition under check, I think that patient should consider himself or herself cured. Because this is what I call functional cure.

Jeff Folloder: Two four letter words.

Dr. Alessandra Ferrajoli: We have so many things that can help us to achieve that. So many agents.

Jeff Folloder: Indeed. Thank you very much. Yes, both hope and cure are four letter words. I think I'm in love with both of them. Dr. Broadway-Duren, you brought up the word cure at the beginning of this presentation. I know that word is not something that cancer patients are used to hearing in the CLL arena. Keeping that word in mind, what would you like to leave our audience with?

Dr. Jackie Broadway-Duren: I concur with the response that Dr. Ferrajoli gave.

If we can provide a good quality of life, and you can go for many years and live and travel and do all the things that you need to do, then I think that might be a cure, as she stated. But most importantly, just live your life. We're doing all we can here in MD Anderson in the Department of Leukemia to get you to a point where you can survive and thrive. That's the most we can hope for at this time. But we'll keep going. I tell my husband every day I got to go, I got to go make cancer history today. So, that's what we're doing.

Jeff Folloder: That is wonderful. I would like to thank both of you marvelous doctors from MD Anderson, a place, again, that I hold near and dear to my heart. Thank you for taking the time out of your schedules to join us today. Thank you to our audience for tuning and submitting your questions.

They were so important. And I'm sorry that we didn't get to quite all of them.

On behalf of CLL Global, on behalf of my fabulous doctors that have joined me here today, on behalf of the production team, I thank everyone for making this an excellent town hall. I would encourage each and every one of you to remember no matter how you're dealing with CLL, no matter what it's doing in your life right now, focus on living well. Thank you.