



SINTOMA²⁶

14 A 16 DE MAIO | HOTEL INTERCONTINENTAL | SÃO PAULO

PARCERIA **soho**
society of hematologic oncology

APOIO INSTITUCIONAL Faculdade **bp**

GERENCIAMENTO
E PRODUÇÃO

RV+
EVENTOS

Frontline CLL Therapy in 2026: BTK Inhibitors, Fixed-Duration Regimens, and MRD-Guided Strategies

Thursday May 14, 16:05–16:23

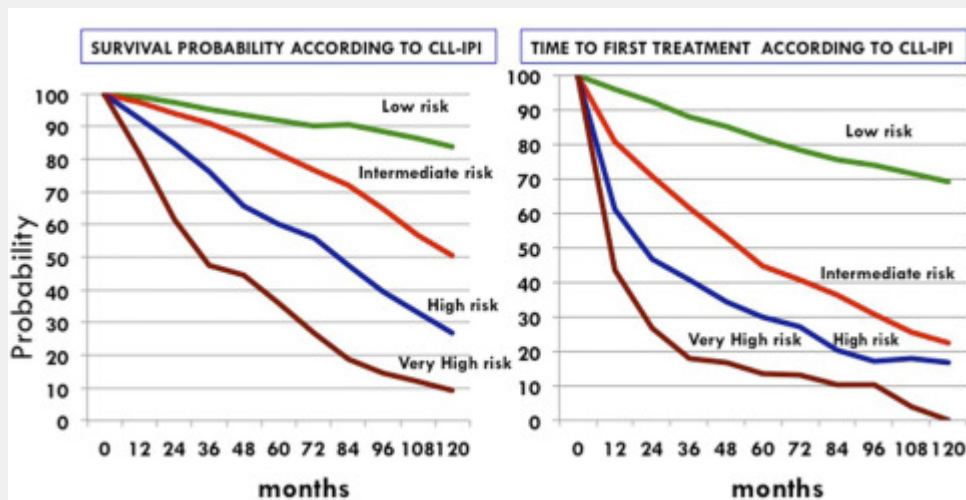
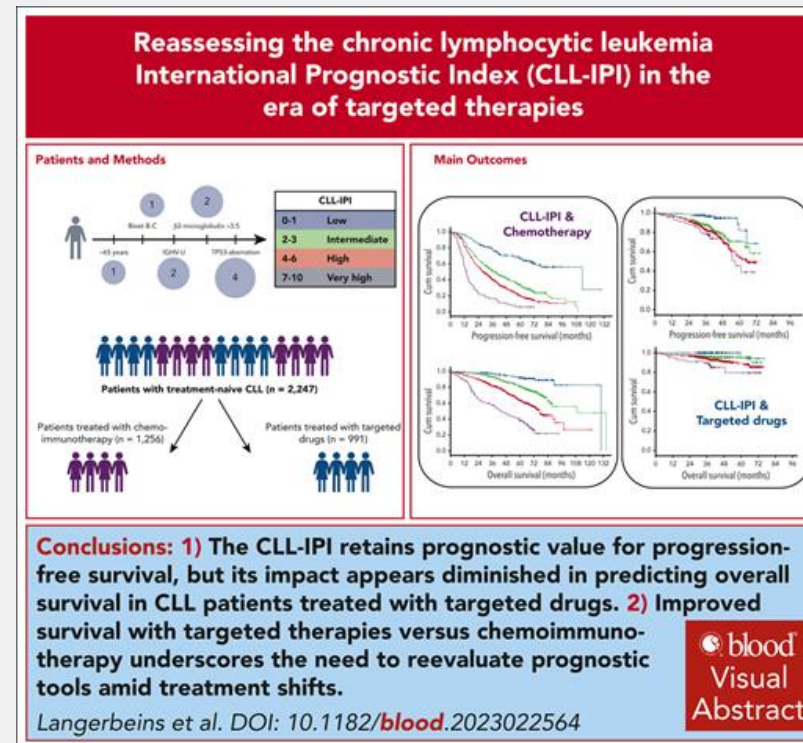
Catherine Coombs MD

Associate Clinical Professor
University of California Irvine



Newly diagnosed CLL

- CLL-IPI risk score: Prognostic tests including TP53 status (FISH + molecular testing needed), IGHV status, B2 macroglobulin, in addition to clinical factors (age, clinical stage) can inform time to first treatment and OS (in CIT era)
- In modern agent era, CLL-IPI can predict PFS but not OS



Molica S et al, Blood, Volume 130, Supplement 1, 2017

TP53 status	- Deleted or mutated	1-434	4-2 (3-2-5-5)	<0.0001	4
IGHV mutational status	- Unmutated	0-950	2-6 (2-1-3-2)	<0.0001	2
β_2 -microglobulin concentration	- >3.5 mg/L	0-678	2-0 (1-6-2-4)	<0.0001	2
Clinical stage	- Rai I-VI or Binet B-C	0-464	1-6 (1-3-1-9)	<0.0001	1
Age	- >65 years	0-555	1-7 (1-4-2-1)	<0.0001	1

- Progressive marrow failure (Hb<10, Plt<100^a)
- Autoimmune cytopenias poorly responsive to steroids or other treatments
- Massive or progressive or symptomatic SM (>6 cm below costal margin)
- Massive or progressive or symptomatic LAD (>10 cm)
- Progressive lymphocytosis (>50% increase over 2 months or LDT <6 months)
- Constitutional symptoms due to CLL

^aMany pts with platelets<100 can have prolonged stability for years and so this situation does not warrant immediate therapeutic intervention

Outside of clinical trial setting, there is **STILL** no role for “early treatment” of asymptomatic CLL

Level setting: What do the guidelines say? US perspective

SUGGESTED TREATMENT REGIMENS^{a,b,c,d}

CLL/SLL without del(17p)/TP53 Mutation (alphabetical by category)

FIRST-LINE THERAPY ^{e,f,g}		
Preferred	Other Recommended	Useful in Certain Circumstances
<ul style="list-style-type: none"> • BCL2i-containing regimens <ul style="list-style-type: none"> ▶ Venetoclax/Acalabrutinib^j ± Obinutuzumab (fixed duration)^h (category 1) ▶ Venetoclax + Obinutuzumab (fixed duration) (category 1) • cBTKi-based regimens^{i,j} <ul style="list-style-type: none"> ▶ Acalabrutinib (continuous) ± Obinutuzumab (category 1) ▶ Zanubrutinib (continuous) (category 1) 	<ul style="list-style-type: none"> • BCL2i-containing regimen <ul style="list-style-type: none"> ▶ Venetoclax/Ibrutinib^j (category 1; fixed duration)^k ▶ Venetoclax/Ibrutinib^j (category 1; MRD-guided)^l 	<ul style="list-style-type: none"> • BCL2i-containing regimen <ul style="list-style-type: none"> ▶ Venetoclax/Zanubrutinib^j (MRD-guided)^m • cBTKi-based regimens^{i,j} <ul style="list-style-type: none"> ▶ Ibrutinibⁿ (continuous) (category 1) ▶ Ibrutinib (continuous) + anti-CD20 mAb (category 2B)^o • High-dose methylprednisolone (HDMP) + anti-CD20 mAb^o (category 2B; category 3 for patients <65 y without significant comorbidities) • Consider only when cBTKi and BCL2i are not available or not feasible <ul style="list-style-type: none"> ▶ Bendamustine^p + anti-CD20 mAb^{o,q} ▶ FC (Fludarabine/Cyclophosphamide)^{r,s,t} + Rituximab ▶ Chlorambucil^u + Obinutuzumab ▶ Obinutuzumab

CLL/SLL with del(17p)/TP53 Mutation (alphabetical by category)

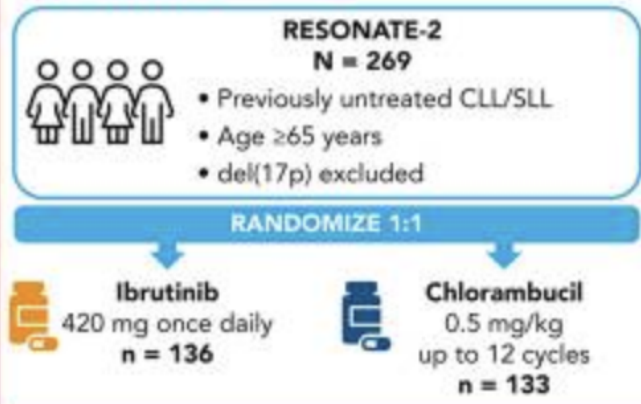
FIRST-LINE THERAPY ^{e,f,g}		
Preferred	Other Recommended	Useful in Certain Circumstances
<ul style="list-style-type: none"> • BCL2i-containing regimens <ul style="list-style-type: none"> ▶ Venetoclax + Obinutuzumab (fixed duration) ▶ Venetoclax/Acalabrutinib + Obinutuzumab (MRD-guided)^v ▶ Venetoclax/Zanubrutinib^j (MRD-guided)^m • cBTKi-based regimens^{i,j} <ul style="list-style-type: none"> ▶ Acalabrutinib (continuous) ± Obinutuzumab ▶ Zanubrutinib (continuous) 	<ul style="list-style-type: none"> • BCL2i-containing regimen <ul style="list-style-type: none"> ▶ Venetoclax/Ibrutinib^{j,w} (fixed duration) 	<ul style="list-style-type: none"> • cBTKi-based regimen^{i,j} <ul style="list-style-type: none"> ▶ Ibrutinibⁿ (continuous) • HDMP + anti-CD20 mAb^o • Consider only when cBTKi and BCL2i are not available or not feasible <ul style="list-style-type: none"> ▶ Obinutuzumab

Up to 10 Years of Follow-Up for Ibrutinib Treatment of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) in RESONATE-2

Context of Research

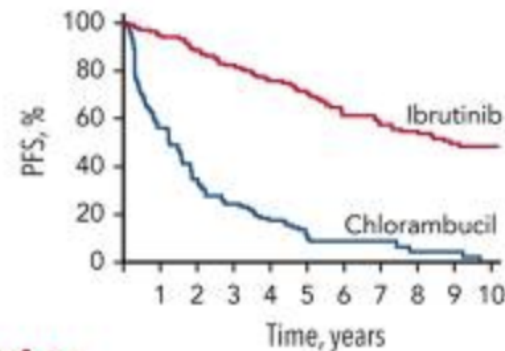
- Ibrutinib has demonstrated both a significant progression-free survival (PFS) and overall survival (OS) benefit over chemotherapy in CLL/SLL
- The RESONATE-2 study of ibrutinib versus chlorambucil treatment evaluated long-term efficacy and safety of ibrutinib. Final analysis with up to 10 years of follow-up is reported

Patients and Methods



Main Findings

Efficacy



- Median PFS for ibrutinib was 8.9 years
- PFS was not significantly associated with uIGHV, del(11q), serum β 2-macroglobulin, or mutated TP53/complex karyotype
- 9-year OS rate was 68% in the ibrutinib arm

Safety

- Ibrutinib's safety profile has been manageable and consistent across 10 years of follow-up
- Active dose management (holds and/or reductions) allowed continued ibrutinib benefit



Patient Disposition

- 27% of patients remained on ibrutinib treatment at 10 years



ELEVATE-TN: Frontline acalabrutinib +/- obinutuzumab

Treatment-naive CLL (N=535)

Age ≥65 or <65 years with coexisting conditions:

- CIRS score >6, or
- Creatinine Clearance <70 mL/min

Stratification

- del(17p), y vs n
- ECOG PS 0-1 vs 2
- Geographic region (N America, W Europe, or other)

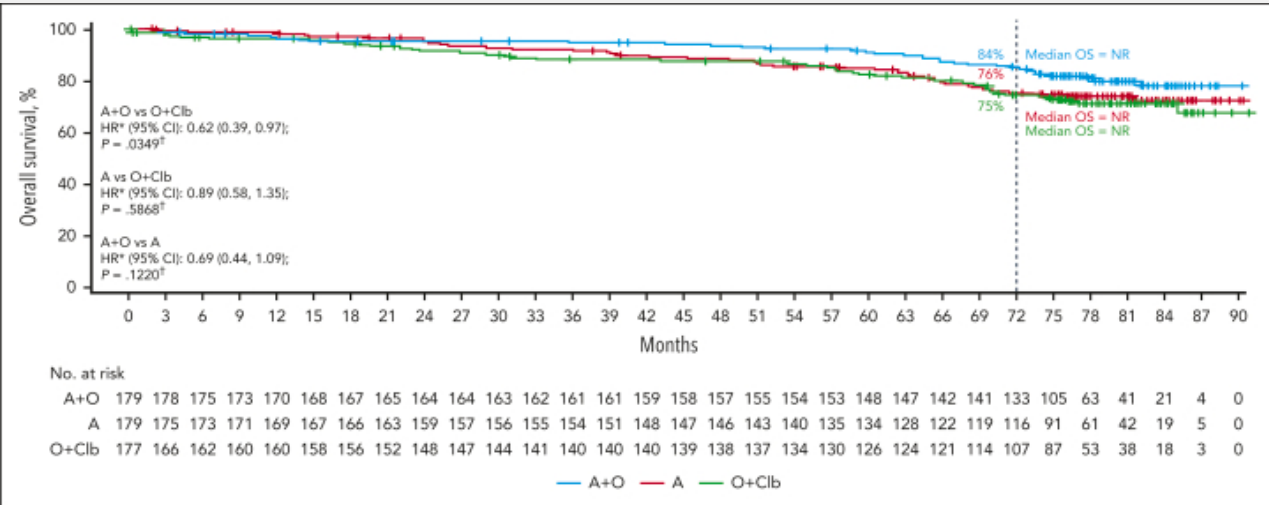
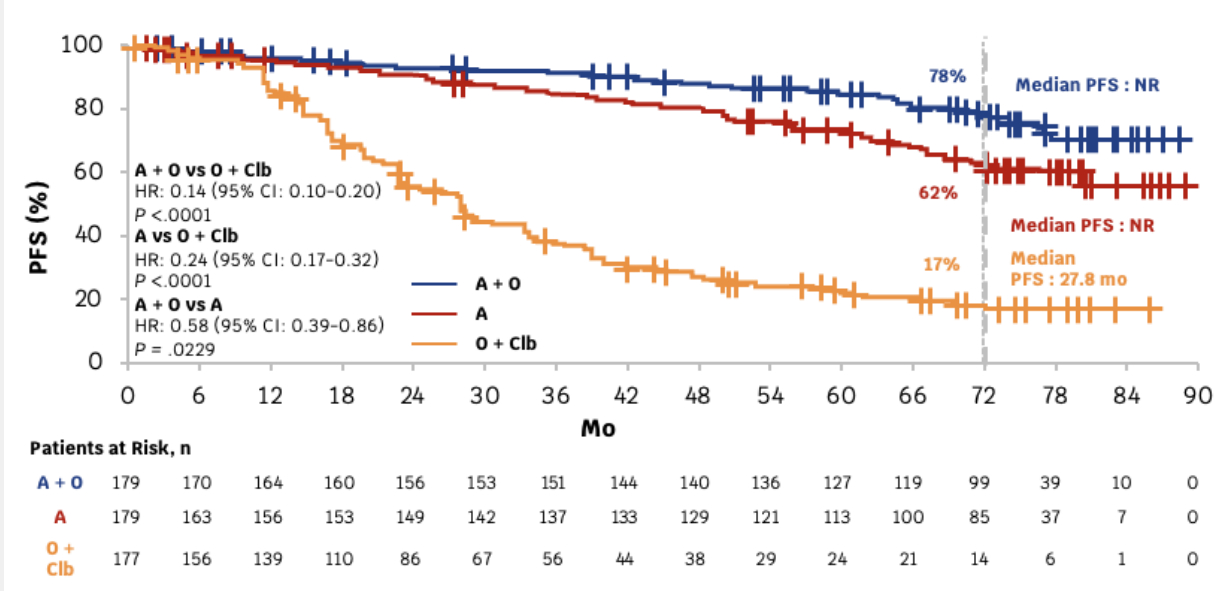
RANDOMIZE 1:1:1

Acalabrutinib + Obinutuzumab (G)
100 mg PO BID
1000 mg IV on D1, 2, 8, and 15 of C2, + D1 of subsequent 28-day cycles for a total of 6 cycles

Acalabrutinib
100 mg PO BID

Obinutuzumab (G) + Chlorambucil
1000 mg IV on D1, 2, 8, and 15 of C1, + D1 of subsequent 28-day cycles for a total of 6 cycles 0.5 mg/kg PO on D1 + 15 of each 28-day cycle for 6 cycles

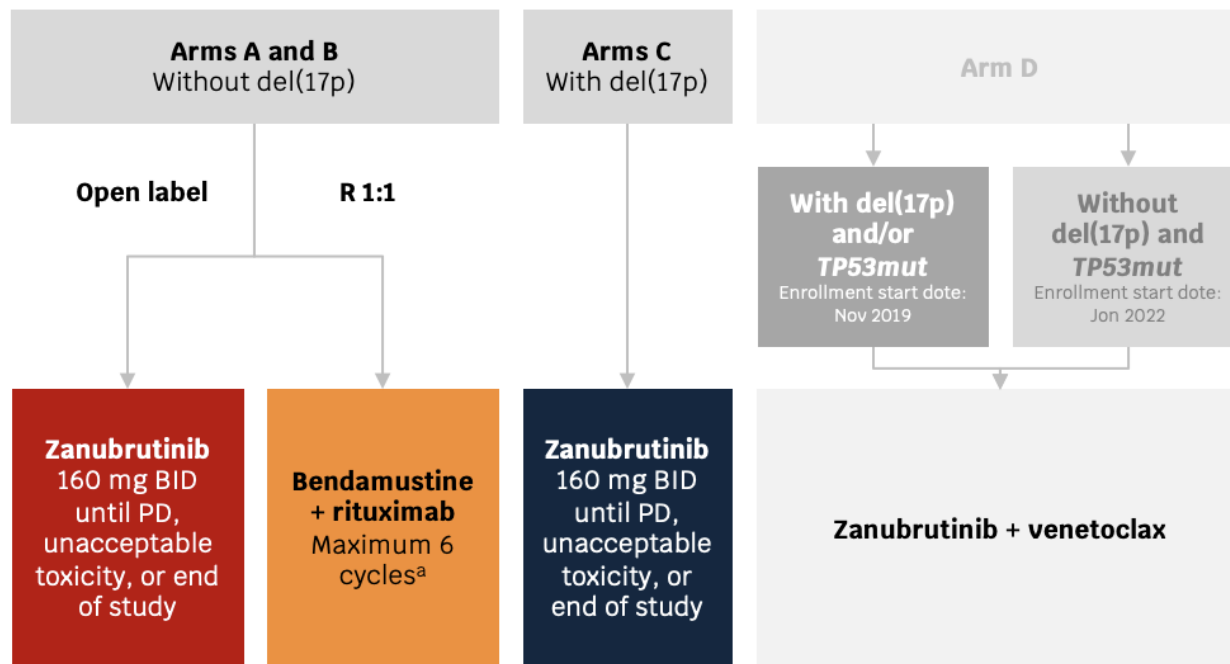
Primary endpoint: PFS (assessed by IRC), Acala-G vs G-Clb
Key secondary endpoints: PFS acalabrutinib vs G-Clb, ORR (assessed by IRC and investigator), TTNT, OS, Safety
 Crossover from G-Clb to acalabrutinib was allowed after IRC confirmed progression



SEQUOIA long-term follow up: Frontline zanubrutinib

Key eligibility criteria

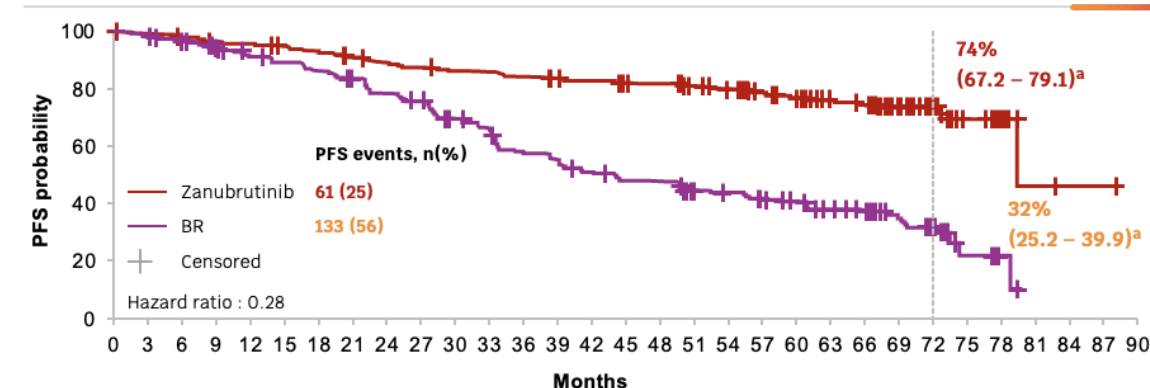
- Untreated CLL/SLL
- Measurable disease by CT / MRI
- Met iwCLL criteria for treatment
- Unsuitable for FCR



Key endpoints in Arms A, B, and C

- PFS (inv)
- OS
- ORR (inv)^b
- Safety per CTCAE

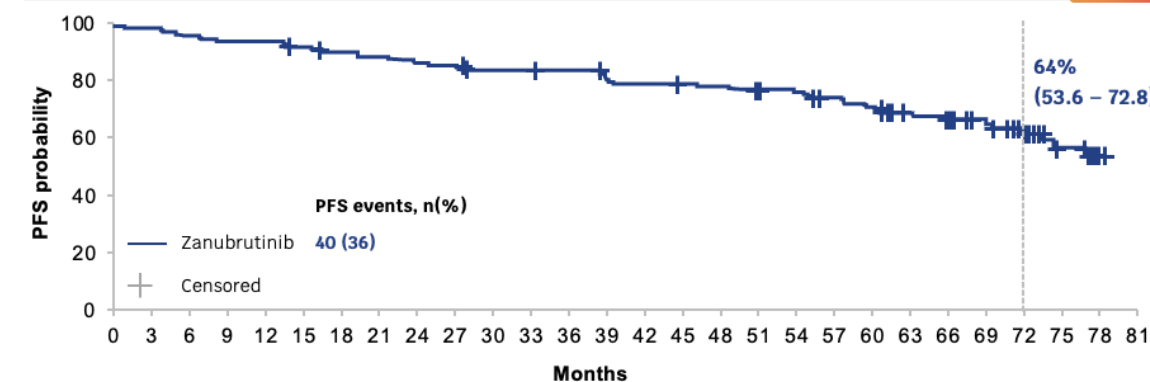
PFS in Arms A and B (w/o del 17p)



No. at Risk

Zanubrutinib	241	238	234	230	228	224	220	214	208	205	201	200	196	193	191	188	186	175	169	154	148	128	124	95	60	28	7	2	1	1	0
BR	238	218	212	201	192	187	180	174	163	157	142	135	117	111	102	95	94	80	78	66	61	53	49	33	25	5	2	0	0	0	0

PFS in Arm C (w/del 17p)

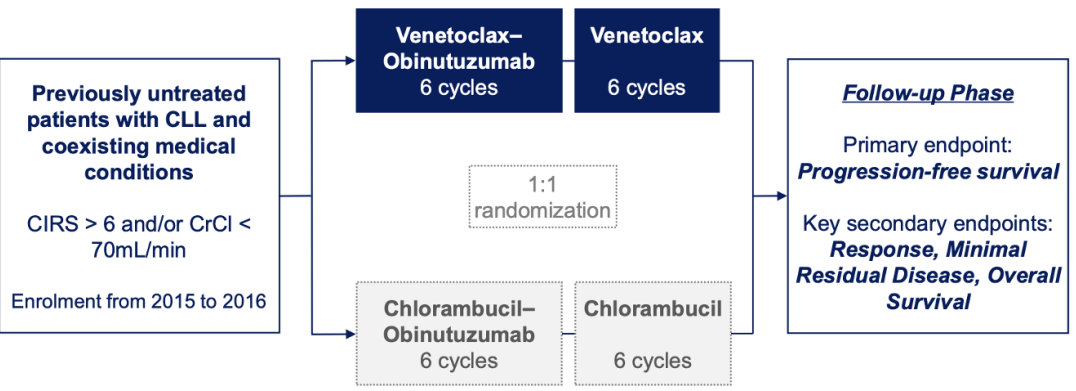


No. at Risk

Zanubrutinib	110	109	106	104	104	101	98	96	94	93	89	89	88	85	82	81	80	78	77	71	68	60	58	46	35	21	3	0	0	0
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CLL-14

TRIAL DESIGN



Current median observation time: 76.4 months

D

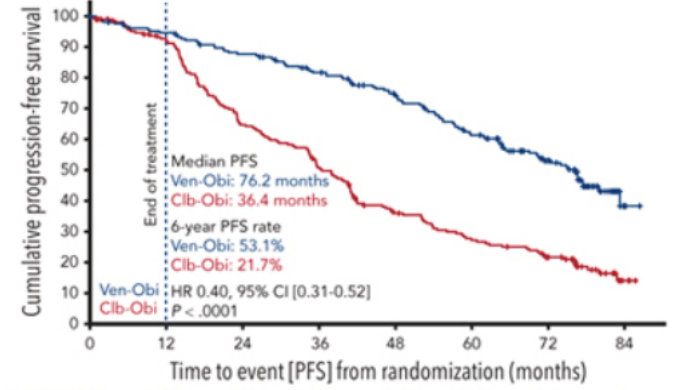
Cox regression PFS		Ven-Obi		
		Hazard ratio	95% Wald CI	
IGHV mutational status				
unmutated	vs. mutated	2.310	1.300-4.105	Worse prognosis
Deletion 17p				
del(17p)	vs. no del(17p)	2.941	1.532-5.646	Worse prognosis
Lymph node size				
≥ 5 cm	vs. < 5 cm	1.768	1.114-2.808	Worse prognosis

0,1 1,0 10,0
Better prognosis Worse prognosis

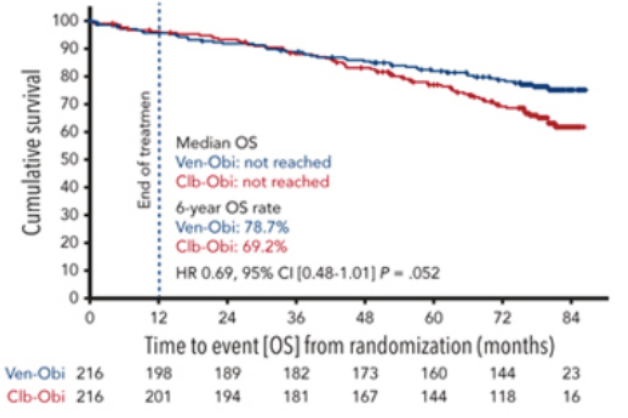
- Median PFS is 76.2 months
- Median PFS for TP53 aberrant pts: 51.9 months
- Median PFS for unmut IGHV pts: 64.8 months

Main Findings

• Progression-free survival



• Overall survival



CLL13: Venetoclax and obinutuzumab +/- ibrutinib

Eligibility

Treatment-naïve, fit patients with CLL, **no TP53** aberrations (centrally screened)

CIT FCR ≤65y, BR >65y

RV rituximab, venetoclax | FD 12 months

GV obinutuzumab, venetoclax | FD 12 months

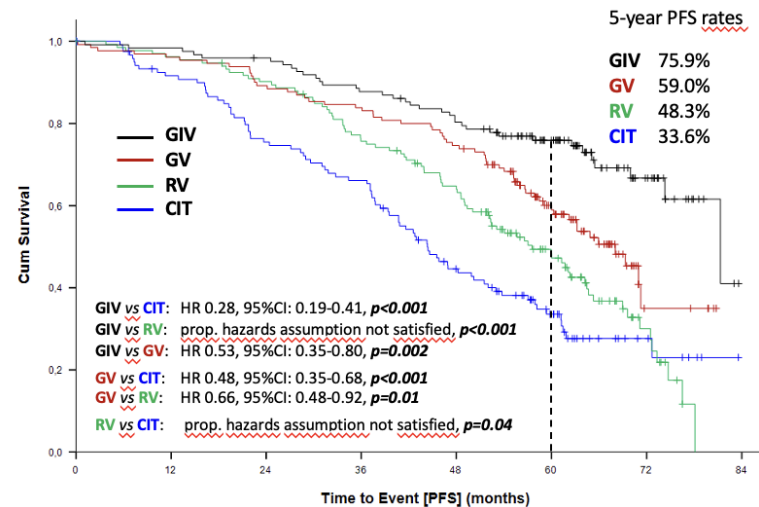
GIV obinutuzumab, ibrutinib, venetoclax | 12-36 months

Primary Endpoints

1. **uMRD** rate at MO15
2. **Progression-free survival**



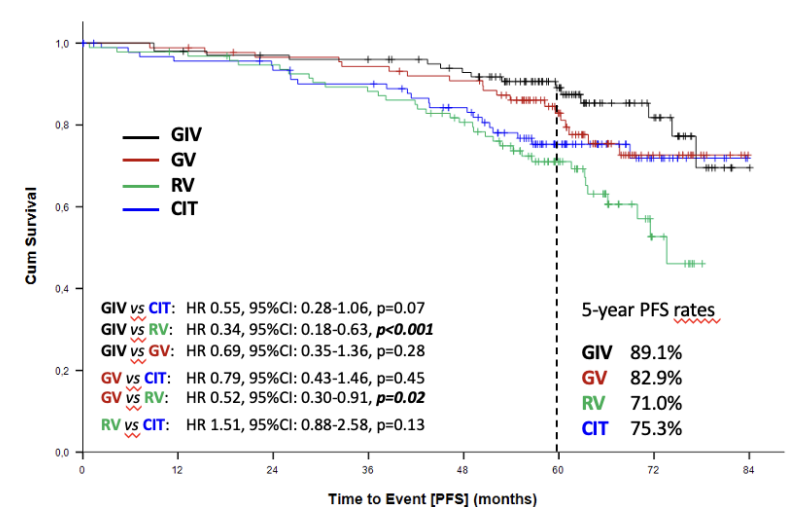
PFS – unmutated IGHV



Patients at risk

CIT	131	108	89	78	49	27	7
RV	134	128	119	99	82	44	11
GV	130	125	116	109	97	54	5
GIV	123	121	117	107	97	67	21

PFS – mutated IGHV



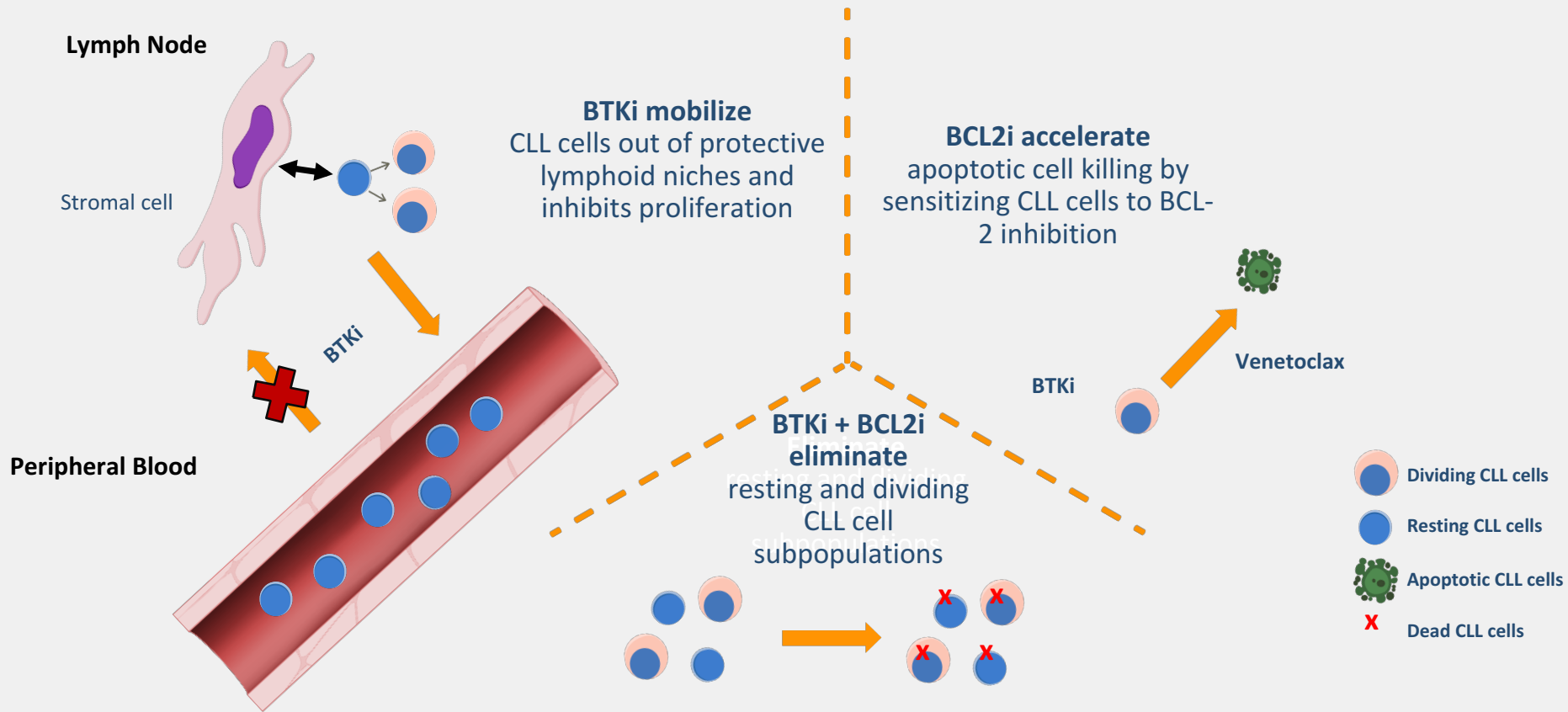
Patients at risk

CIT	95	87	84	80	70	40	14
RV	95	92	88	82	72	42	9
GV	89	88	84	82	78	49	15
GIV	101	99	96	94	87	57	23

“Newer” treatment approaches

- **Fixed-duration acalabrutinib + venetoclax (AMPLIFY trial)**
- **MRD-guided therapies**
 - **Acalabrutinib + venetoclax + obinutuzumab (AVO)**
 - **Zanubrutinib + venetoclax (SEQUOIA arm D)**
 - **Ibrutinib + venetoclax (FLAIR trial)**

Rationale to combine BTKi + BCL2i



1. Lu P et al. *Blood Cancer J.* 2021; 11:39; 2. Deng J et al. *Leukemia.* 2017; 31:2075-2084; 3. Herman ES et al. *Clin Cancer Res.* 2015; 21:4642-4651; 4. Burger JA et al. *Leukemia.* 2020;34:787-798; 5. Shanafelt T et al. *N Engl J Med.* 2019;381:432-443; 6. Cervantes-Gomez, F. et al. *Clin. Cancer Res.* 2015; 21:3705–3715; 7. Slinger E, et al. *Blood.* 2017; 130: 3018-3018; 8. Haselager MV, et al. *Blood.* 2020 ;136:2918-2926; 9. Slinger E et al. *Leukemia.* 2017 Dec;31(12):2601-2607.

AMPLIFY

Treatment-naive CLL

- Age ≥ 18y/o
- ECOG: 0-2
- Active disease per IWCLL 2018 criteria

Exclusion

- del(17p), TP53

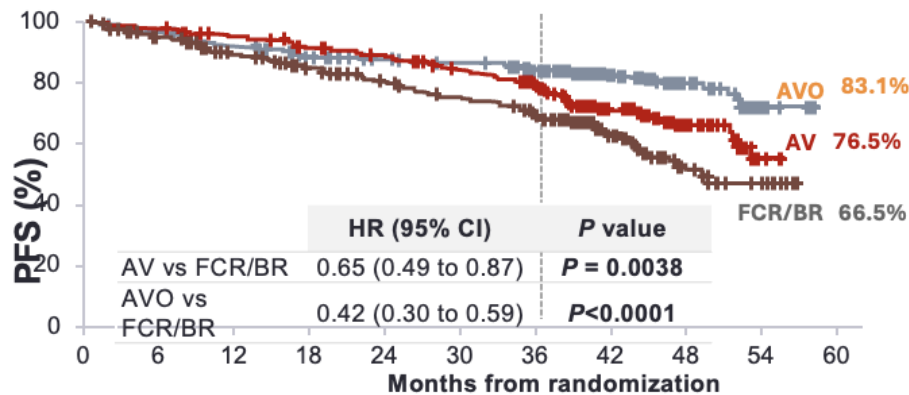
RANDOMIZE
1:1:1

Acalabrutinib + Venetoclax

Acalabrutinib + Venetoclax + Obinutuzumab

Chemo/IO (FCR or BR)

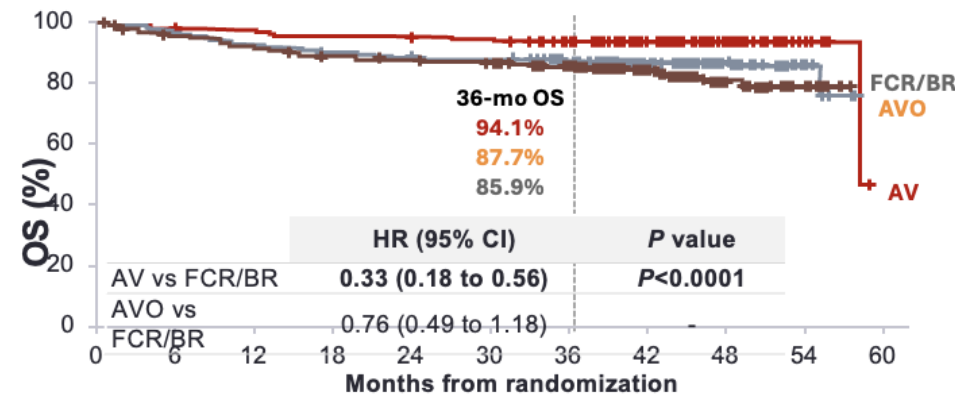
Primary endpoint: PFS (assessed by IRC)



Patients at Risk

	0	6	12	18	24	30	36	42	48	54	60
AV	291	282	269	251	237	219	177	102	35	3	0
AVO	286	272	258	237	225	219	191	116	51	7	0
FCR/BR	290	236	208	189	170	154	127	66	28	6	0

Median PFS was NR for AV and AVO, and was 47.6 mo for FCR/BR



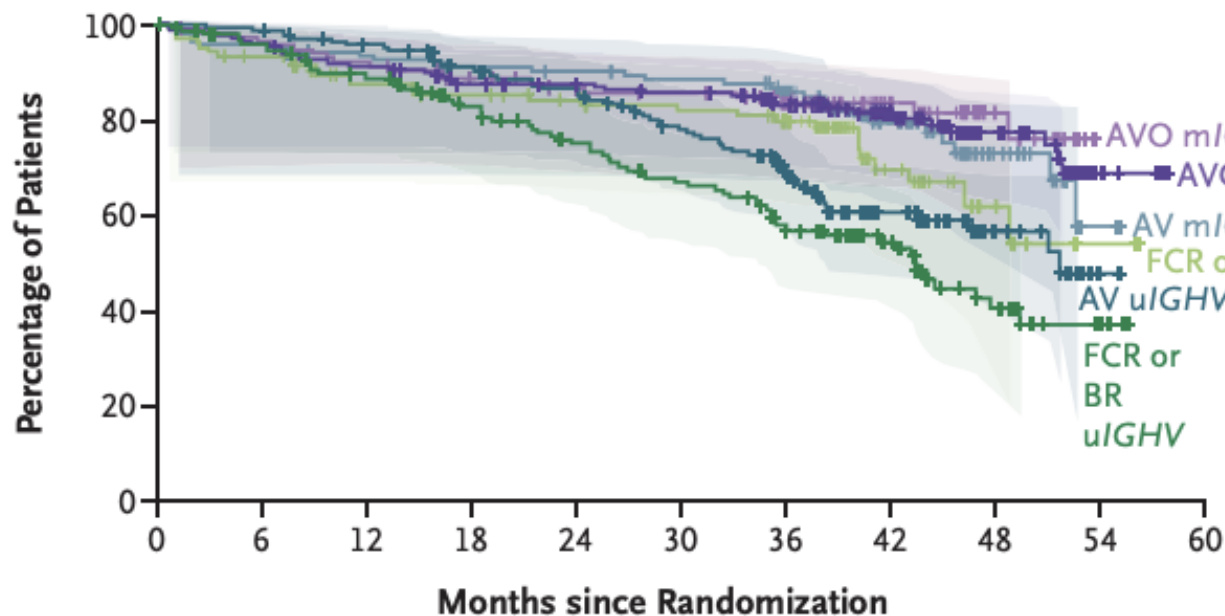
Patients at Risk

	0	6	12	18	24	30	36	42	48	54	60
AV	291	286	281	277	275	270	233	142	58	10	0
AVO	286	276	265	257	252	250	223	143	64	10	0
FCR/BR	290	247	236	228	223	217	182	98	45	13	0

Difference in overall survival is primarily due to imbalance in COVID-19 related deaths (AVO > FCR/BR >> AV)

IGHV status *matters* in patients getting fixed-duration acala + ven

B Progression-free Survival According to IGHV Mutation Status, Assessed by Blinded Independent Central Review



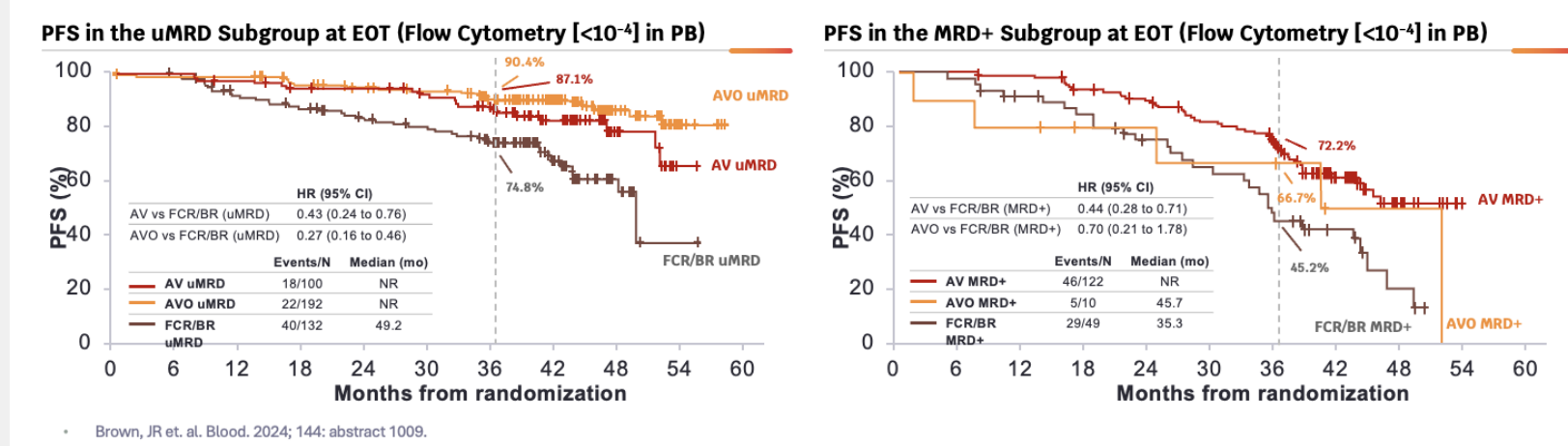
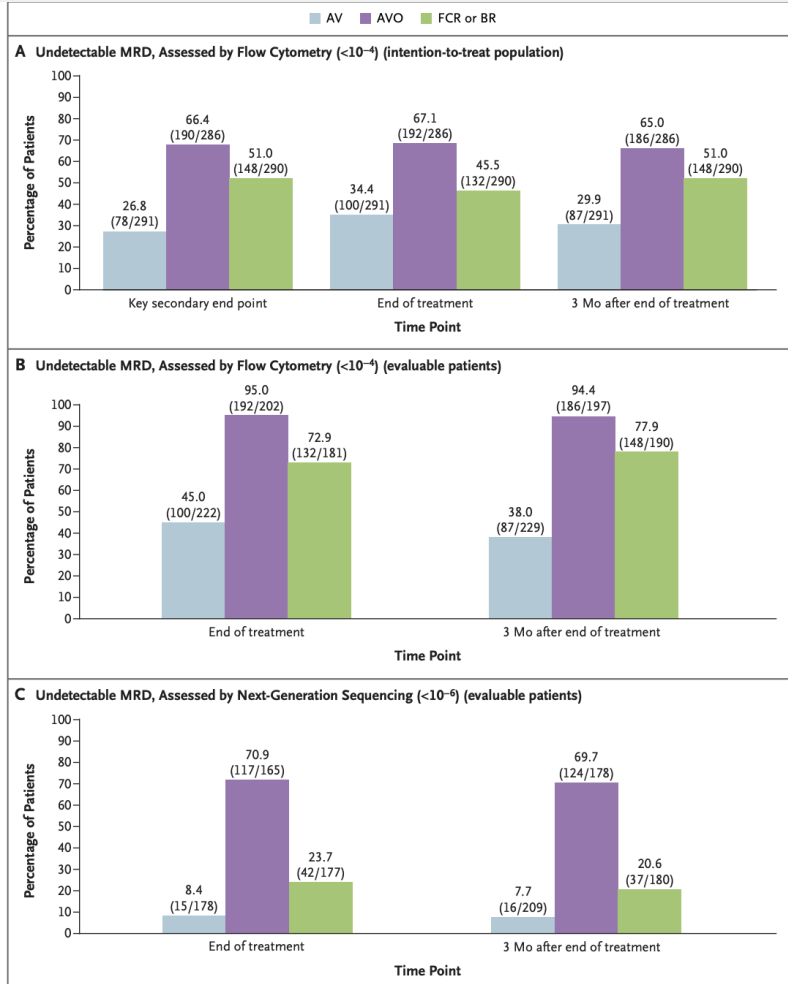
	No. of Events/ Total No. of Patients	Median Progression- free Survival <i>mo</i>	Progression- free Survival at 36 Months %
AV mIGHV	28/124	NC	86.0
AV uIGHV	61/167	51.5	68.9
AVO mIGHV	20/117	NC	83.6
AVO uIGHV	36/169	NC	82.8
FCR or BR mIGHV	28/118	NC	79.9
FCR or BR uIGHV	67/172	43.3	56.8

No. at Risk

	0	6	12	18	24	30	36	42	48	54	60
AV mIGHV	124	119	114	110	108	105	91	54	18	2	0
AV uIGHV	167	163	155	141	129	114	86	48	17	1	0
AVO mIGHV	117	111	106	96	89	86	73	41	15	0	
AVO uIGHV	169	161	152	141	136	133	118	75	36	7	0
FCR or BR mIGHV	118	99	86	81	76	72	65	28	9	2	0
FCR or BR uIGHV	172	137	122	108	94	82	62	38	19	4	0

	Hazard Ratio for Disease Progression or Death (95% CI)
AV vs. FCR or BR (mIGHV)	0.67 (0.39–1.14)
AV vs. FCR or BR (uIGHV)	0.69 (0.48–0.97)
AVO vs. FCR or BR (mIGHV)	0.58 (0.32–1.02)
AVO vs. FCR or BR (uIGHV)	–

Rates of uMRD in AMPLIFY trial



Safety considerations when using AV vs AVO

Table 2. Adverse Events and Selected Events of Clinical Interest (Safety Population).*

Adverse Events	Acalabrutinib–Venetoclax (N = 291)		Acalabrutinib–Venetoclax– Obinutuzumab (N = 284)		Chemoimmunotherapy (N = 259)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3	Any Grade	Grade ≥3
<i>number of patients (percent)</i>						
Events						
Any adverse event	270 (92.8)	156 (53.6)	269 (94.7)	197 (69.4)	236 (91.1)	157 (60.6)
Any serious adverse event	72 (24.7)		109 (38.4)		71 (27.4)	
Serious adverse event leading to death						
Any	10 (3.4)		17 (6.0)		9 (3.5)	
Due to Covid-19	8 (2.7)		15 (5.3)		7 (2.7)	
Adverse event leading to treatment discontinuation	23 (7.9)		57 (20.1)		28 (10.8)	
Selected events of clinical interest						
Any event of clinical interest	222 (76.3)	136 (46.7)	242 (85.2)	188 (66.2)	185 (71.4)	141 (54.4)
Cardiac event						
Any	27 (9.3)	5 (1.7)	34 (12.0)	7 (2.5)	9 (3.5)	3 (1.2)
Atrial fibrillation or flutter	2 (0.7)	1 (0.3)	6 (2.1)	2 (0.7)	2 (0.8)	2 (0.8)
Ventricular tachyarrhythmia†	2 (0.7)	0	3 (1.1)	0	0	0
Hypertension	12 (4.1)	8 (2.7)	11 (3.9)	6 (2.1)	7 (2.7)	2 (0.8)
Hemorrhage						
Any	94 (32.3)	3 (1.0)	86 (30.3)	6 (2.1)	11 (4.2)	1 (0.4)
Major	3 (1.0)	3 (1.0)	8 (2.8)	6 (2.1)	2 (0.8)	1 (0.4)
Neutropenia‡	108 (37.1)	94 (32.3)	143 (50.4)	131 (46.1)	132 (51.0)	112 (43.2)
Infection	148 (50.9)	36 (12.4)	153 (53.9)	67 (23.6)	82 (31.7)	26 (10.0)
Second primary cancer						
Any	15 (5.2)	5 (1.7)	12 (4.2)	5 (1.8)	2 (0.8)	0
Excluding nonmelanoma skin cancer	8 (2.7)	5 (1.7)	7 (2.5)	4 (1.4)	1 (0.4)	0
Tumor lysis syndrome	1 (0.3)	1 (0.3)	1 (0.4)	1 (0.4)	8 (3.1)	8 (3.1)

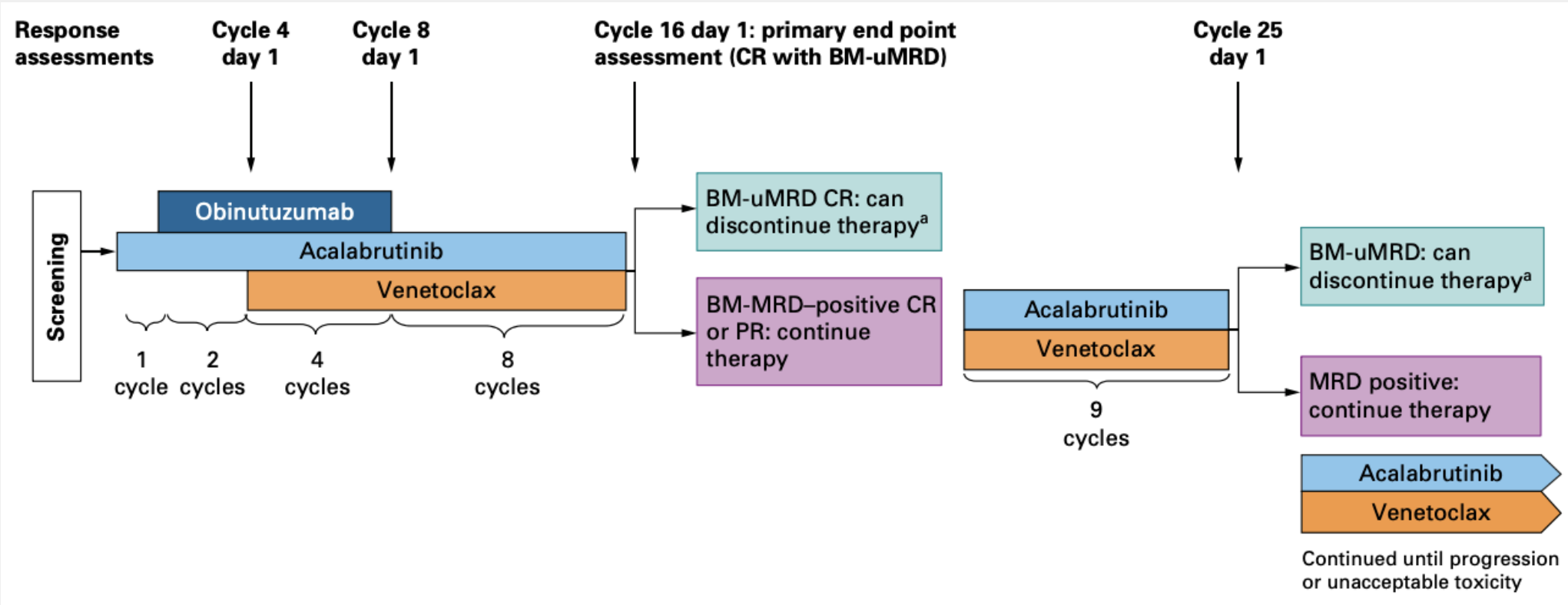
Total number of deaths due to COVID-10

AV: 10 (3.4%)

AVO: 25 (8.7%)

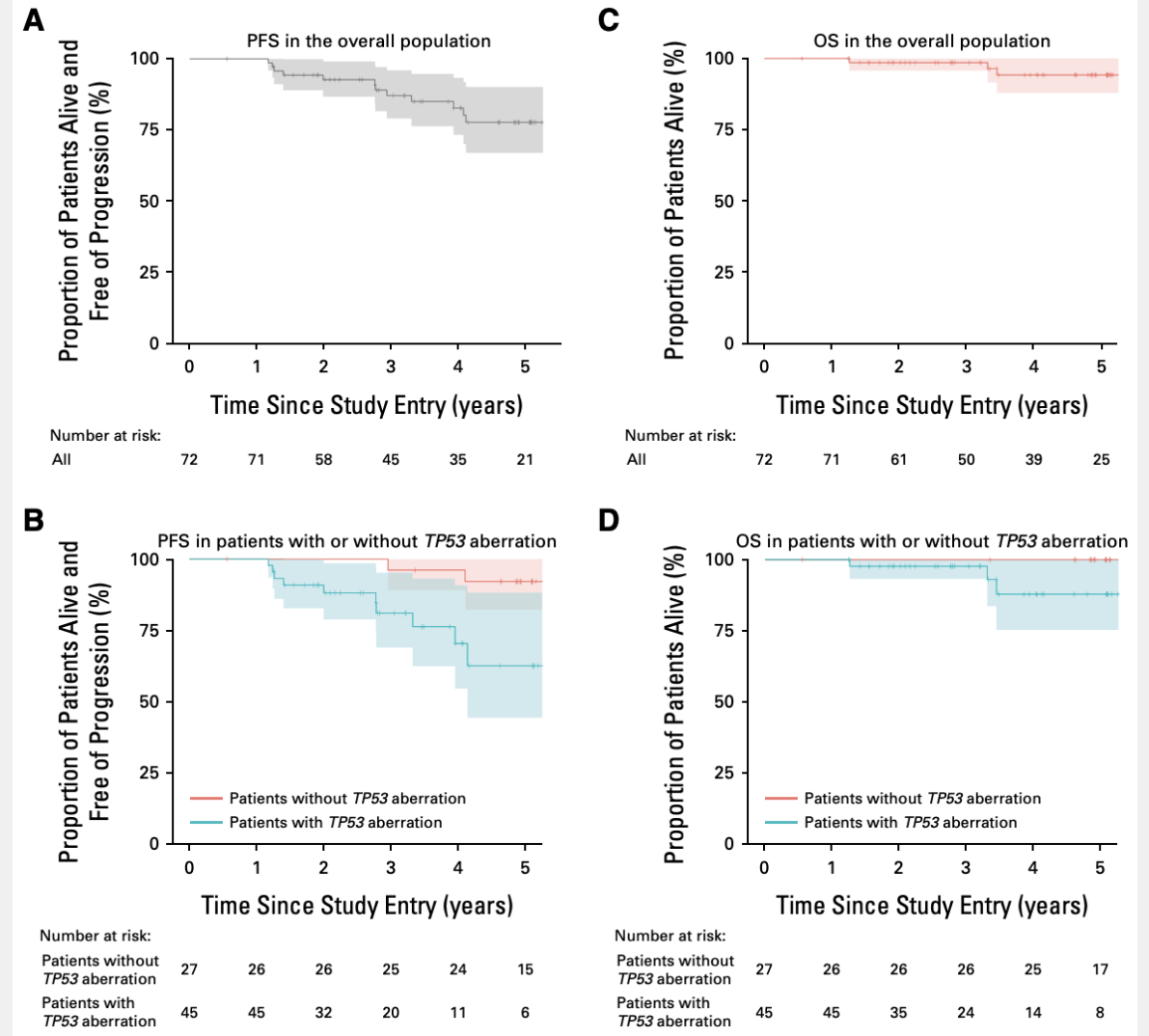
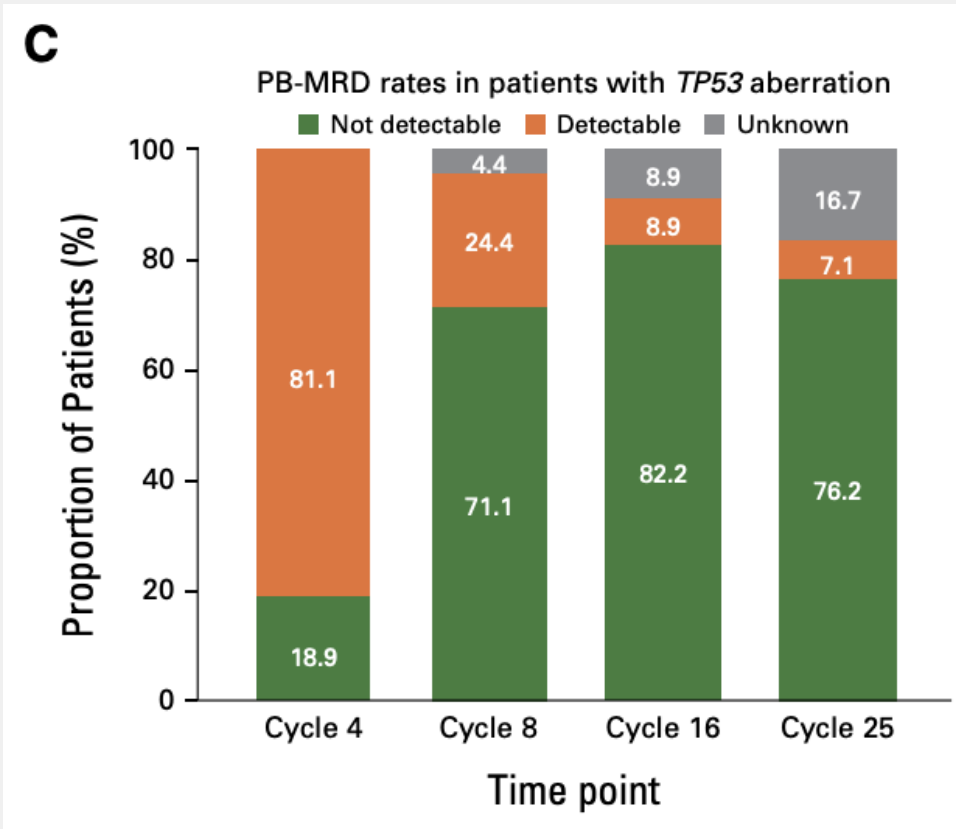
FCR/BR: 21 (7.2%)

AVO triplet regimen: MRD-guided duration of therapy



Seventy-two patients were accrued, including 45 patients with TP53 aberration

Efficacy of AVO regimen



Zanubrutinib + venetoclax, MRD guided (SEQUOIA arm D)

- Pts received zanubrutinib 160 mg BID and venetoclax from cycle 4-28 followed by zanubrutinib monotherapy
- Pts meeting uMRD-guided stopping criteria were eligible for early discontinuation of venetoclax after receiving a minimum of 12 cycles or for discontinuation of zanubrutinib after receiving a minimum of 27 cycles

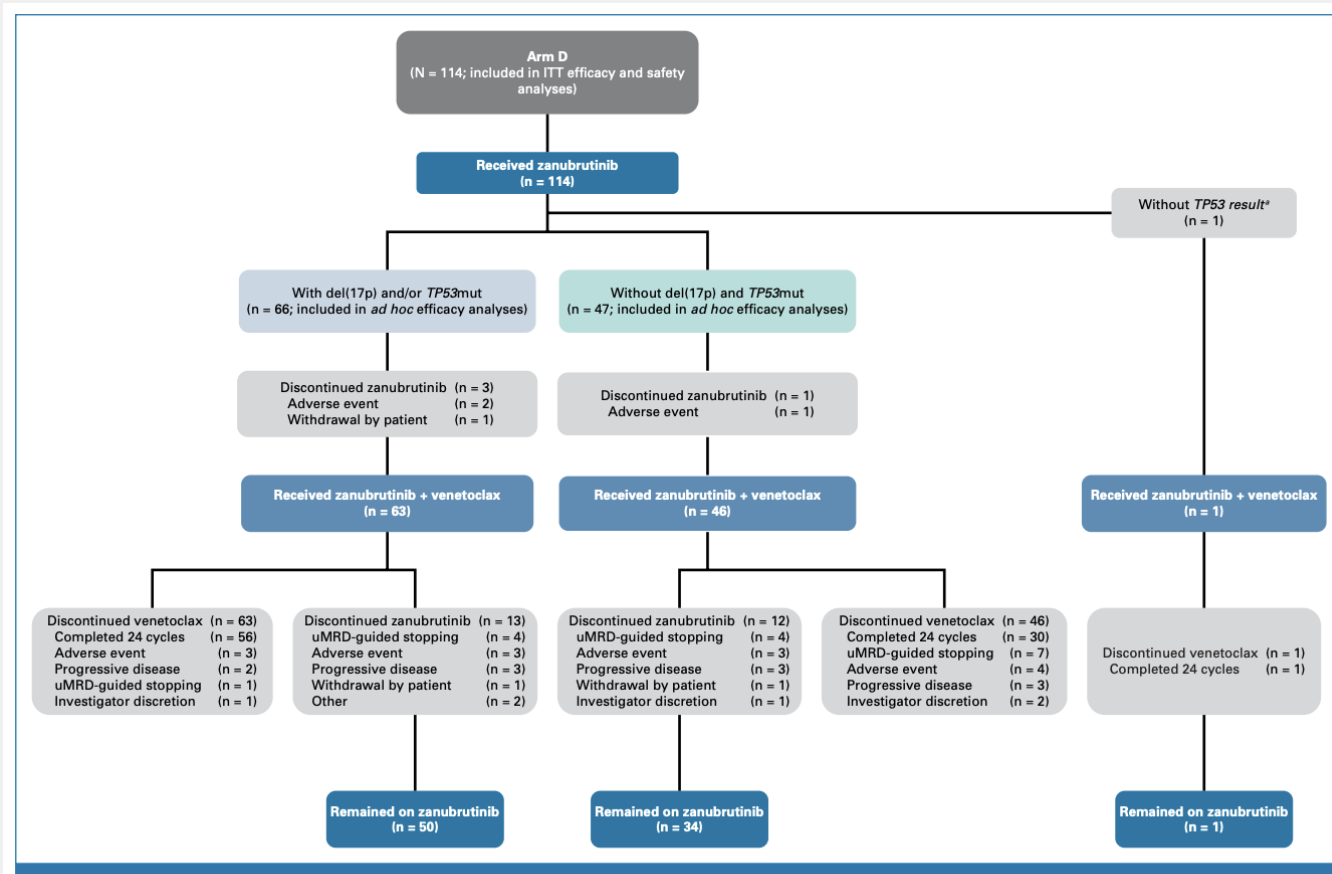


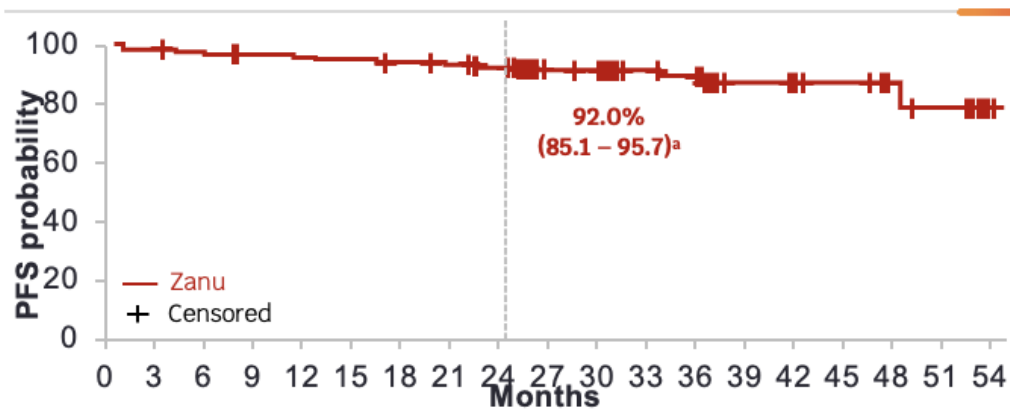
FIG 1. Flow diagram. *Via central laboratory. ITT, intention-to-treat; uMRD, undetectable minimal residual disease.

uMRD-guided stopping criteria All conditions must be met:

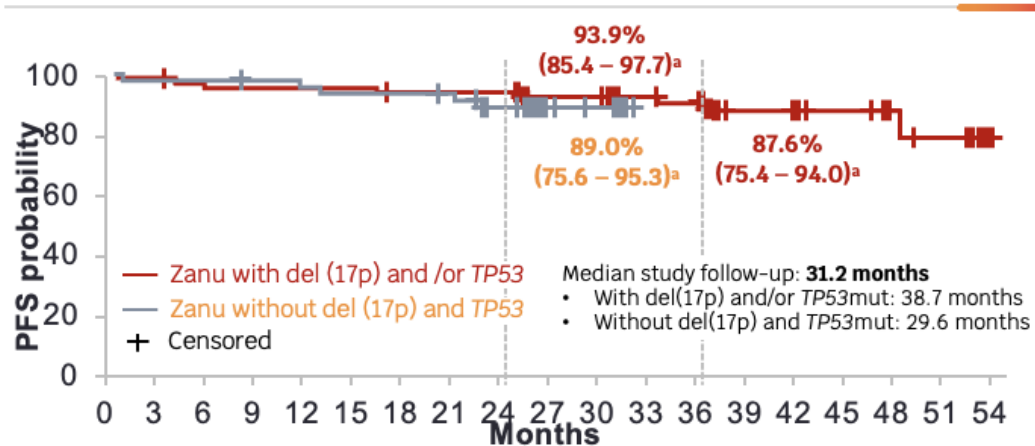
1. Response assessed as CR or CRi confirmed by a BM biopsy
2. uMRD $<1 \times 10^{-4}$ (uMRD4) achieved in 2 consecutive peripheral blood MRD tests conducted ≥ 12 weeks apart
3. uMRD4 achieved in 2 consecutive BM aspirate MRD tests conducted ≥ 12 weeks apart.
4. Minimum 12 venetoclax cycles; 27 cycles of zanubrutinib

5 year follow up for SEQUOIA arm D

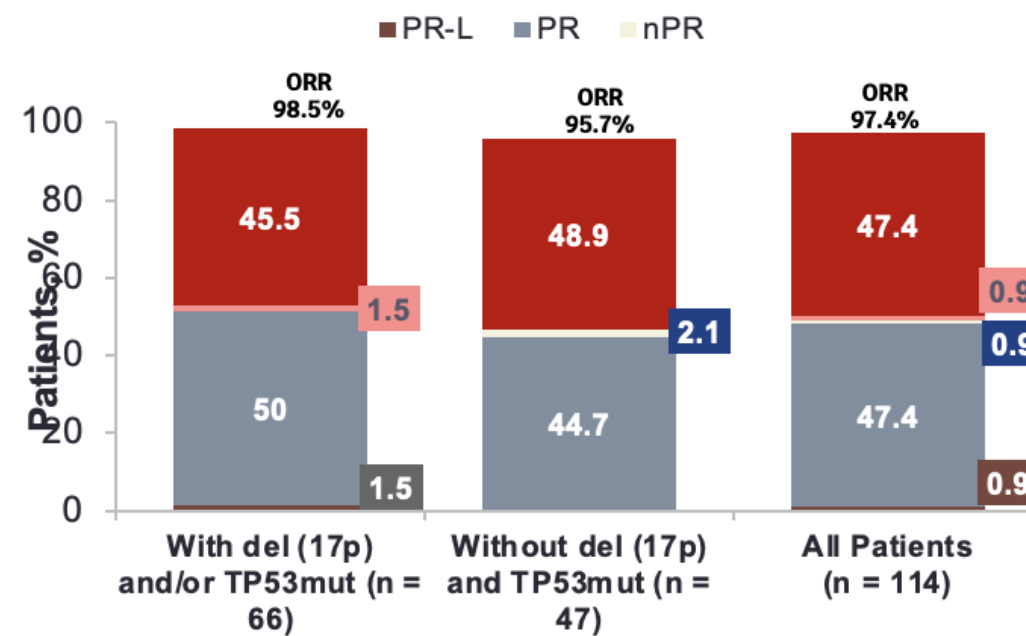
All Patients



With and without del (17p) and / or TP53 mutation



ORR and rates of CR / CRi were high regardless of mutational status



Median study follow-up

Months (range)

38.7

(0.4 – 58.0)

29.6

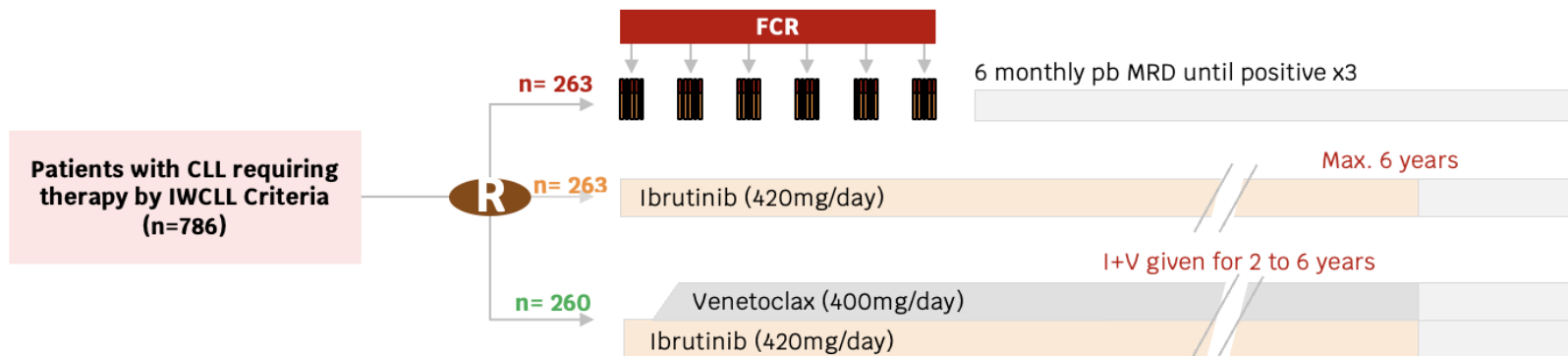
(0.6 – 31.9)

31.2

(0.4 – 58.0)

CR, complete response; CRi, complete response with incomplete hematopoietic recovery; ORR, overall response rate; nPR, nodular partial response; PR, partial response; PR-L, partial response with lymphocytosis

UK FLAIR Study: MRD-Guided Ibrutinib + Ven vs Ibrutinib



Primary objectives

PFS: To assess whether I+V is superior to FCR
MRD negativity: To assess whether I+V is superior to I

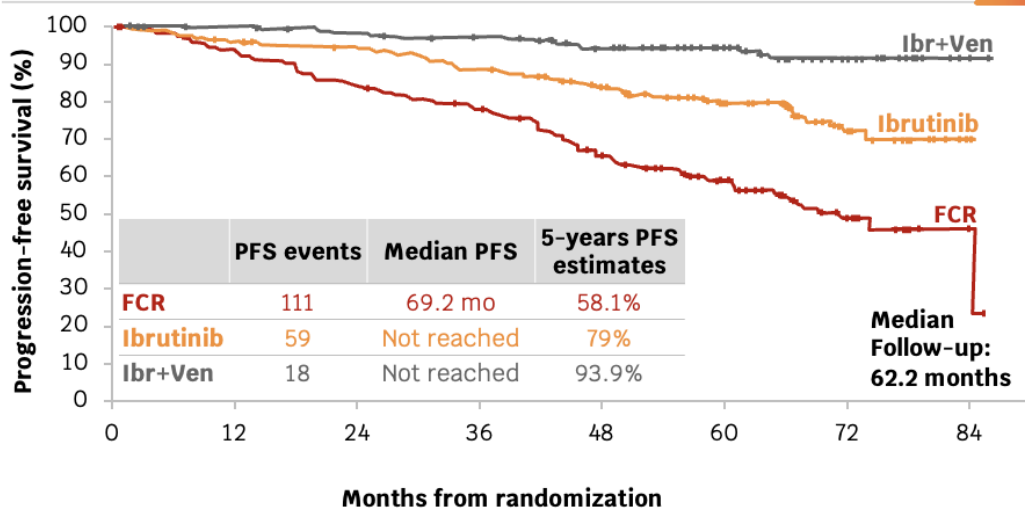
Key Secondary objectives

PFS of I+V in comparison with I
PFS of I in comparison with FCR
Overall survival

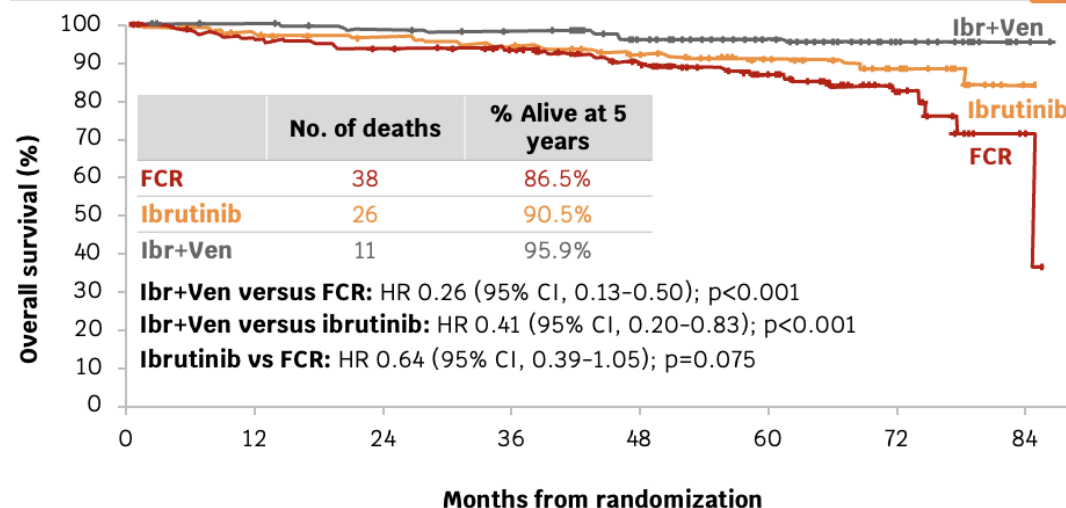
Proportion of participants obtaining undetectable MRD
IWCLL Response to therapy
Safety and toxicity
Health-related quality of life
Cost-effectiveness

In ibrutinib and ibrutinib+venetoclax arms: PB MRD every 6 months. If PB MRD negative repeat after 3 months and then PB and BM at 6 months – if all MRD negative then first PB MRD negative result is time to MRD negativity. **Duration of therapy – double time to MRD negativity (minimum 2 years; maximum 6 years)**

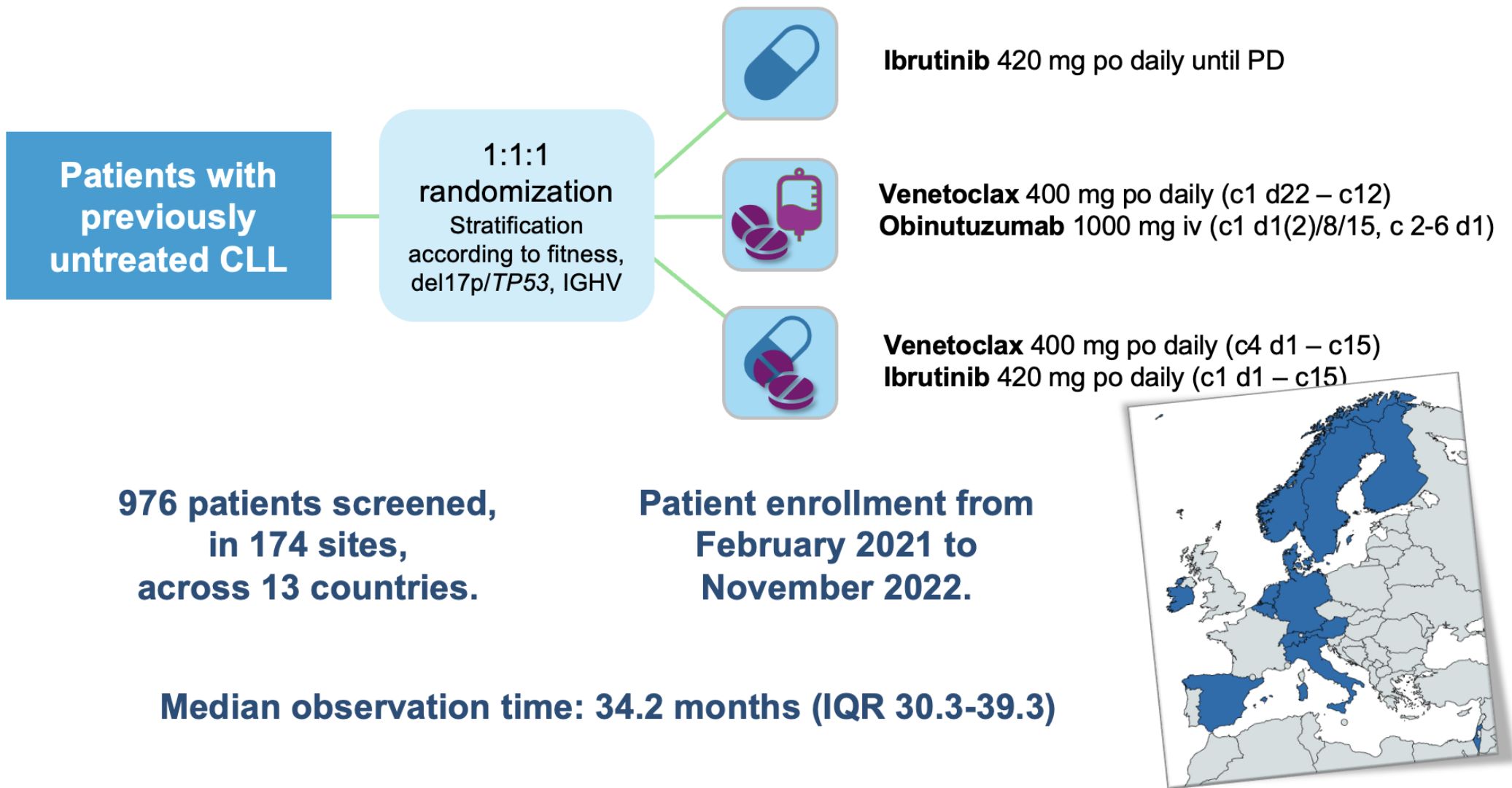
Progression Free Survival



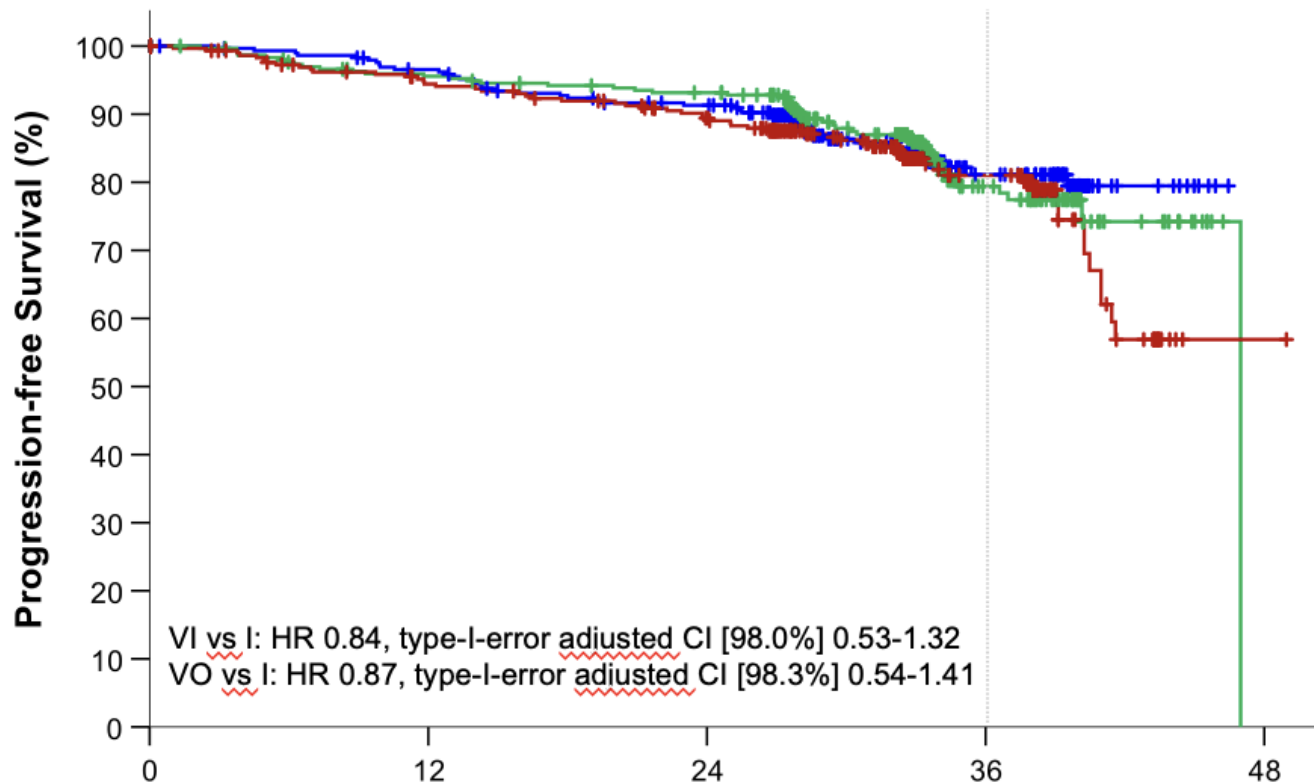
Overall Survival



So many options – how to choose? What does CLL17 trial tell us?



PROGRESSION-FREE SURVIVAL



Patients at risk

Months from date of randomization

	0	12	24	36	48
VO	303	278	256	77	0
VI	305	278	267	82	0
I	301	267	243	94	1

3-year-PFS

I 81.0%
VI 79.4%
VO 81.1%

	PD	Death
I	46	11
VI	37	13
VO	25	21

3-year-PFS

I, uIGHV 79.7%
I, mIGHV 83.5%

VI, uIGHV 78.9%
VI, mIGHV 80.0%

VO, uIGHV 75.8%
VO, mIGHV 87.6%

3-year-PFS

I, TP53del/mut 79.4%
I, TP53-WT 81.0%

VI, TP53del/mut 69.0%
VI, TP53-WT 80.1%

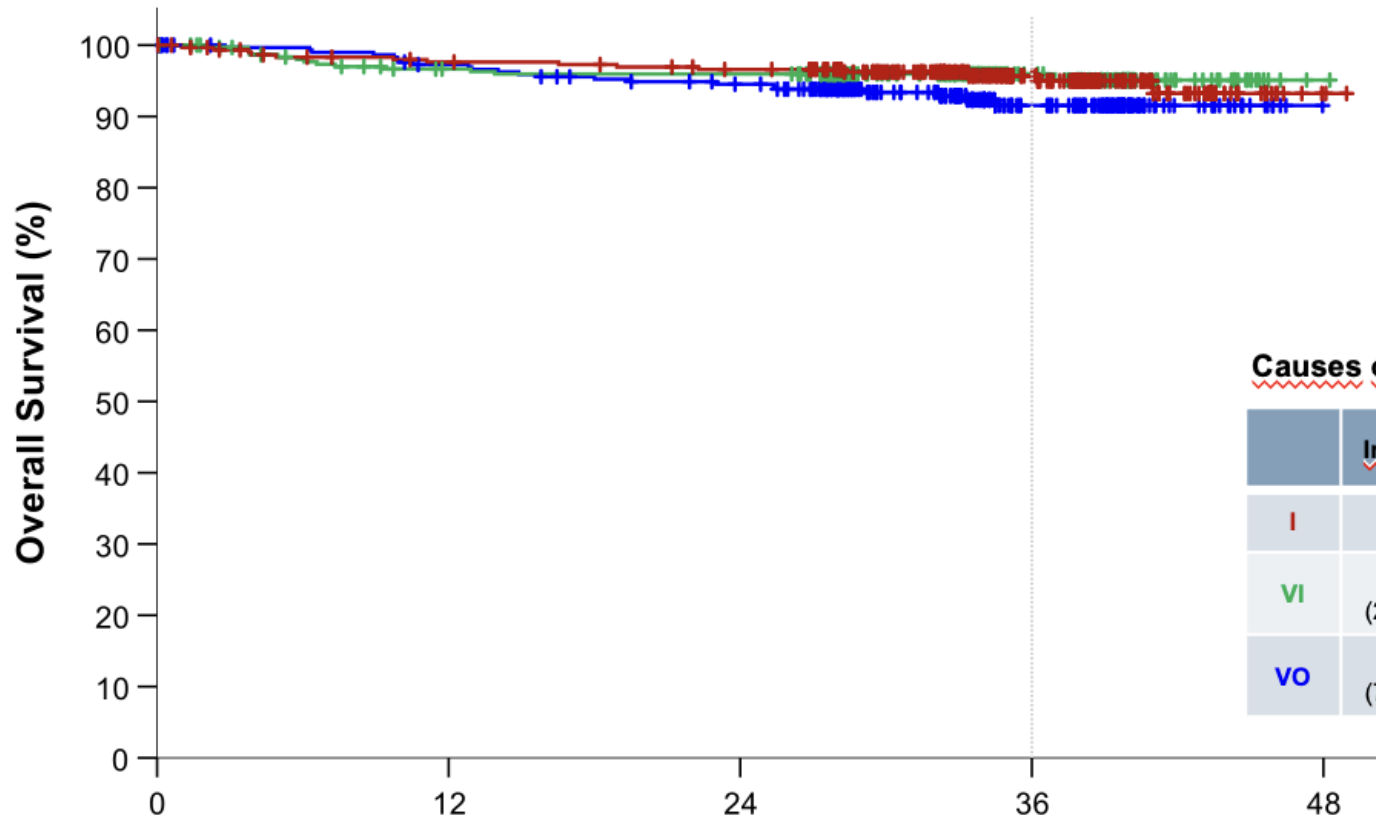
VO, TP53del/mut 62.0%
VO, TP53-WT 82.7%

TP53 del/mut:

VI vs I: HR 0.70, 95% CI 0.22-2.16

VO vs I: HR 1.20, 95% CI 0.40-3.59

OVERALL SURVIVAL



3-year-OS

I 95.7%
VI 96.0%
VO 91.5%

Causes of death

	Infection	Cardio-vascular	PD/RT	SPM	Other	Total
I	3	5	0	2	4	14
VI	7 (2 Covid)	3	0	2	1	13
VO	12 (7 Covid)	5	1	4	0	22

Patients at risk

	0	12	24	36	48
VO	303	284	269	102	0
VI	305	281	279	114	1
I	301	284	276	141	2

Months from date of randomization

VI vs I: HR 0.96, 95% CI 0.45-2.05
VO vs I: HR 1.67, 95% CI 0.86-3.28

Important phase 3 trials awaiting readouts

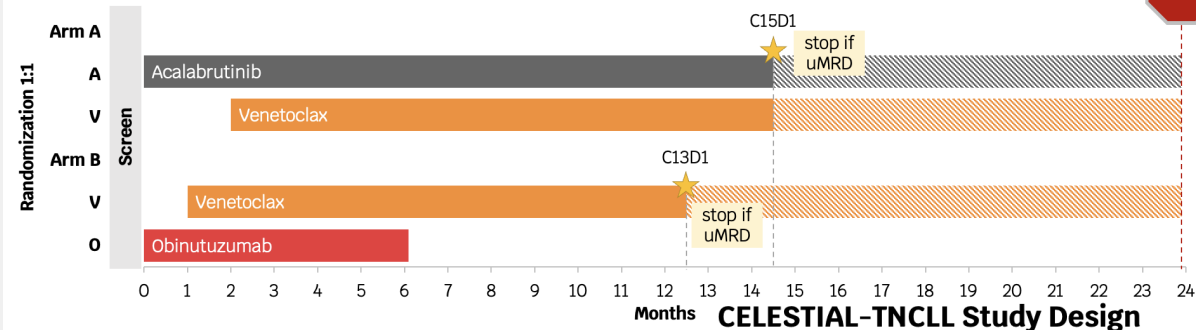
MAJIC Study Design



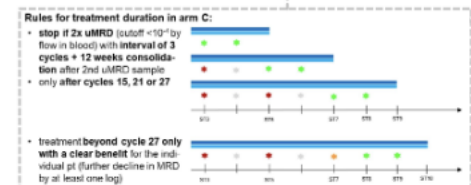
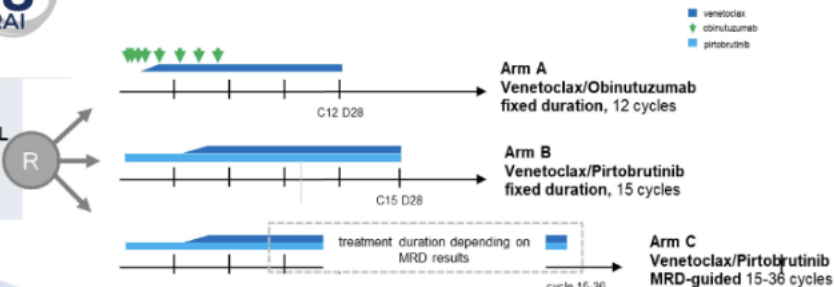
Arm A
Acalabrutinib (A) 100 mg po BID,
Venetoclax (V) 400 mg po daily (C3D1-C14), including 5 week ramp up
STOP if uMRD and at least PR. If MRD+ continue AV to 24 months

Arm B
Venetoclax (V) 400 mg po daily (C1D22-C12), including 5 week ramp up
Obinutuzumab (O) 1000 mg iv. (C1D1-2/8/15, C2-6 D1)
STOP if uMRD and at least PR. If MRD+ continue V to 24 months

★ PB MRD (clonoSEQ & flow)
BM MRD (flow)



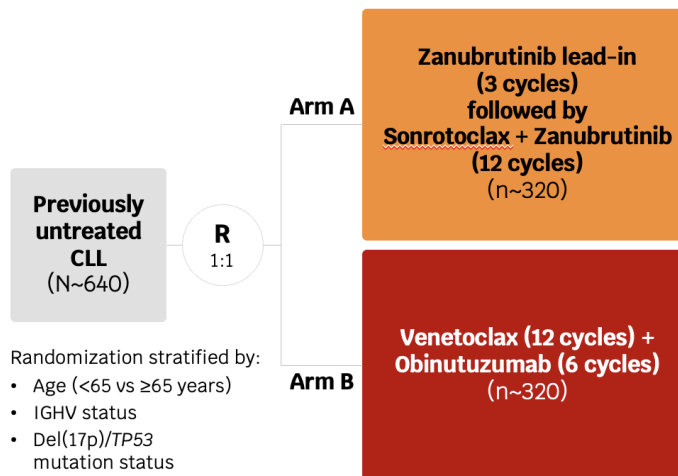
Treatment naive, all comor CLL/SLL (irrespective of fitness, comorbidity and risk factors)



Key Eligibility Criteria

- Age 18 years and above
- Confirmed CLL diagnosis, no previous treatment
- Measurable disease by CT/MRI
- ECOG PS of 0-2
- Adequate BM and organ function
- No history of, or currently suspected, Richter's transformation

Study Design



Endpoints

- Primary**
- PFS (IRC; iwCLL 2018^[5])
- Secondary**
- CRR^[a] (IRC and INV)
 - Rates of uMRD⁴ (BM and PB)^b
 - OS
 - PFS (INV)
 - ORR (IRC and INV)
 - DOR (IRC and INV)
 - Patient-reported outcomes
 - Safety and tolerability

Patient is a 62 year-old man who was diagnosed with CLL 6 years ago, who had been on “watch and wait.” Due to progressive fatigue and recent onset of night sweats (without any infections), we discuss frontline therapy options.

Labs: WBC ct 57, with ALC 52, Hb is 11.2, Plt 155, kidney/liver function normal

Prognostic markers: IGHV indeterminate (tested twice), FISH/karyotype with del(13q) as sole abnormality

PMH/social hx: Patient’s only comorbidity is GERD, he enjoys long-distance cycling and camping trips

Patient #1 undergoes treatment with venetoclax and obinutuzumab
Tolerates well aside from mild neutropenia not warranting medical intervention

Attains MRD negative remission (tested in peripheral blood only)

Still in remission 2 years following completion of therapy

Patient is a 59 year-old man who was diagnosed with CLL 1 year ago, while incarcerated. He was offered ibrutinib but he declined to start therapy. He is worried about side effects from treatment and says he is not afraid of dying from the CLL.

Presents for second opinion. Exam shows marked tonsillar enlargement (tonsils nearly touching) and diffuse LAD (largest node 4 cm)

Labs: WBC ct 88, with ALC 86 (ANC 1.2), Hb is 12, Plt 185, kidney/liver function normal

Prognostic markers: IGHV mutated, FISH/karyotype with del(11q) as sole abnormality

PMH/social hx: Incarcerated recently, methamphetamine use but clean past 5 months, intermittently unhoused

Patient #2 begins treatment with acalabrutinib + venetoclax – had a URI between month 1-2 of acalabrutinib but otherwise he has tolerated well

ALC still >25 at time of venetoclax initiation in cycle 3 but proceeded with outpatient TLS monitoring (risk for TLS was “medium” as nodes <5cm). No TLS seen.

Remains on combination therapy with plan to complete after 12 cycles of combination.

Thank you!

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