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CASES

Insights Into Multidisciplinary Team Management of Veno-Occlusive Disease/Sinusoidal Obstructive Syndrome (VOD/SOS)

October 25, 2023

Co-Chairs: Kris Michael Mahadeo, MD

Sarah Featherston, RN, CPN, BMTCN

How to Navigate This Report

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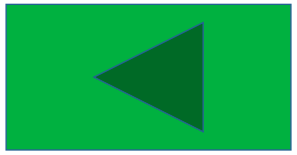

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Report Objectives

STUDY OBJECTIVE
Gain advisors' perspectives on a multidisciplinary approach to care in acute leukemia and the management of VOD/SOS

Report Snapshot: Session Overview

A moderated roundtable discussion was held with 13 healthcare providers on **October 25, 2023**

Disease state and data presentations were co-chaired by **Kris Michael Mahadeo, MD,** Duke University Medical Center, Durham, NC, and **Sarah Featherston, RN, CPN, BMTCN,** MD Anderson Cancer Center, Houston, TX, with content developed in conjunction with the Aptitude Health clinical team

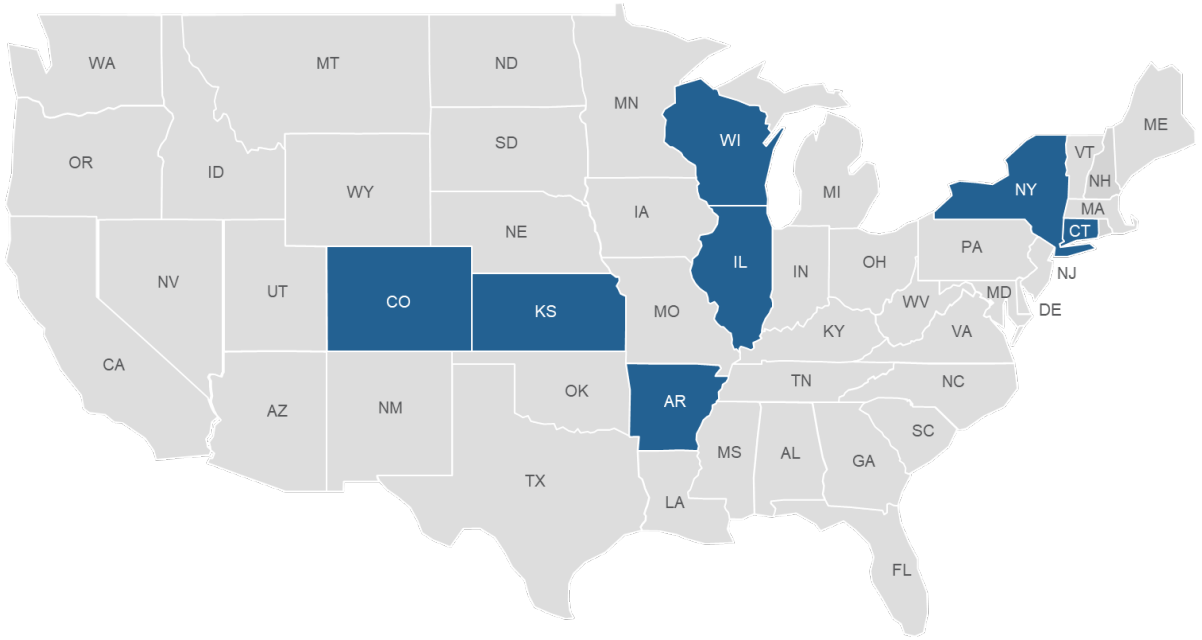
Insights were obtained on the multidisciplinary approach to care in acute leukemia and the management of VOD/SOS

Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

Report Snapshot: Attendee Overview

> The group of advisors comprised 13 healthcare providers from Illinois, Colorado, Wisconsin, Connecticut, Kansas, Arkansas, and New York

Institution	Specialty	City	State
Ann & Robert H. Lurie Children's Hospital of Chicago	Pediatric Oncologist	Chicago	IL
Children's Hospital Colorado*	Pediatric Pharmacist, Pediatric Oncologist, Pediatric APP	Aurora	CO
Memorial Sloan Kettering Cancer Center*	Pediatric Oncologist, Pharmacist	New York	NY
Clinical Cancer Center, Froedtert Hospital	Hematologist/Oncologist	Milwaukee	WI
Smilow Cancer Hospital	Hematologist/Oncologist	Waterford	CT
Maria Fareri Children's Hospital at Westchester Medical Center*	APP	Valhalla	NY
University of Kansas Health System	Adult Pharmacist	Kansas City	KS
Milwaukee Campus – Children's Wisconsin	Pediatric Oncologist	Milwaukee	WI
University of Arkansas for Medical Sciences	Hematologist/Oncologist	Little Rock	AR



*More than 1 advisor from this institution attended.

Participant Demographics (1/2)

How many pediatric patients with acute leukemia have you treated/helped manage care for in the past 12 months? (N = 13)

Of the pediatric patients with acute leukemia whom you have seen in the past 12 months, how many have gone on to receive HSCT? (n = 12*)

*One physician did not respond.

Participant Demographics (2/2)

How many adult patients with acute leukemia have you treated/helped manage care for in the past 12 months? (N = 13)

Of the adult patients with acute leukemia whom you have seen in the past 12 months, how many have gone on to receive HSCT? (N = 13)

Report Snapshot: Agenda

Time (CT)	Topic
6.00 PM – 6.15 PM (15 min)	**Introduction**
6.15 PM – 7.10 PM (55 min)	**HSCT and VOD/SOS** • Overview of current data • Reaction and discussion
7.10 PM – 7.20 PM (10 min)	**BREAK**
7.20 PM – 8.45 PM (95 min)	**Multidisciplinary Approach to Care** • Patient case-based discussion
8.45 PM – 9.00 PM (15 min)	**Key Takeaways and Meeting Evaluation**

Report Snapshot: Patient Cases Discussed

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Ph-Negative ALL (Cindy)

- 19-year-old previously healthy woman

Pre–B-Cell ALL (William)

- 10-year-old male patient diagnosed in 2016

Relapsed AML (Aliyah)

- Female patient s/p HSCT

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Patient Case 1: Ph-Negative ALL

Cindy

Discussion: Ph-Negative ALL (Cindy) (1/3)

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INSIGHTS

AYA patient with Ph-negative ALL treated with pediatric asparaginase-based regimen followed by inotuzumab

- Treatment success in frontline DLBCL

"It's overall survival, that's what we need. This is not metastatic disease, this is curable disease, so we need overall survival."
"... cure without any significant long-term toxicity. ... I think when I define success, I would rather use a landmark endpoint rather than using OS or PFS, and I would say what's the disease-free rate at 2 years. I definitely do think OS is important if there is significant toxicity with the treatment, and people dying from competing comorbidities."

- Data needed to switch from SOC in frontline

"First of all, a lot of things have been tried, nothing is better than R-CHOP, and frankly, I'm pretty happy with how R-CHOP performs for my patients."
"I would be a late adopter. I would not be one of the first ones to move based on PFS or anything like that. I want something that's tried and true and we know how well it works."
"If the toxicities are not very severe, I think a hazard ratio of 0.85 or better would be something that I would be looking at."
"Overall survival data, that's ideal, but in this disease state OS is hard to come by, so you do have to use some surrogates of efficacy. So, I do think that a 2- or 3-year event-free survival kind of story is likely what's going to start driving my use of any regimen. ... PFS is NOT sufficient."

Discussion: Ph-Negative ALL (Cindy) (2/3)

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INSIGHTS

Approach to transplant in AYA patient recently exposed to inotuzumab

- Treatment success in frontline DLBCL

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Discussion: Ph-Negative ALL (Cindy) (3/3)

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INSIGHTS

"So it's usually the BMT team that determines that [the approach to HSCT, based on risk factors]. The leukemia

- Treatment success in frontline DLBCL

- Data needed to switch from BCNU in frontline

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Patient Case 2: Pre–B-Cell ALL

William

Discussion: Pre–B-Cell ALL (William) (1/2)

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INSIGHTS

Pediatric patient with pre-B cell ALL who underwent second HSCT presents with abdominal pain, puffy eyes, fluid retention, hepatomegaly, and abnormal laboratory values on day +10

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: Pre–B-Cell ALL (William) (2/2)

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INSIGHTS

Patient presents with worsening abdominal pain, pedal edema, progressively increasing fluid retention, diminished

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

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Patient Case 3: Relapsed AML

Aliyah

Discussion: Relapsed AML (Aliyah)

INSIGHTS

Discussion of whether to hold defibrotide in a patient with relapsed AML on transplant 3 with severe SOS and

- Treatment success in frontline DLBCL

- Data needed to switch from 3C3C in frontline

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Advisor Key Takeaways

Advisor Key Takeaways (1/3)

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ADVISOR		ADVISOR	
1	> The first thing was earlier administration of defibrotide and the [illegible]	6	> I'm glad to hear that the earlier you see it, the earlier you treat it. [illegible]
2	[illegible]	8	[illegible]
3	[illegible]	7	[illegible]
4	[illegible]	5	[illegible]

Advisor Key Takeaways (2/3)

ADVISOR		ADVISOR	
1	> I hope that we give enough attention to ensuring that we > I have a better understanding of sequencing therapies > I really wasn't that familiar with [illegible] and [illegible] but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> It was great to hear the discussion that some of the risk factors > For relapsed/refractory patients it's nice to have different options besides R-CE and auto or going to CAR T
2	> I have a better understanding of some of my relapse options > I'm particularly interested in the [illegible]s and hope that tafa and Rev would be tolerated for a second-line option for my very elderly patients > There's a bit more enthusiasm for targeted therapy and for things like [illegible]s that may offer lesser side effects	6	> I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
3	> It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory	7	> Very interesting to learn about all these relapsed/refractory treatments, specifically the bispecific antibodies > A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
4	> There's a lot of good options for second line than just CAR T and transplant with decent side effect profile and good response rates > Sequencing is an issue	8	> Still R-CHOP is the standard

Advisor Key Takeaways (3/3)

ADVISOR		ADVISOR	
1	> I'm interested to learn more about the peritoneal drains. Like I [illegible]	5	> I'm glad we kind of touched upon prophylaxis. We're an institution [illegible]
2	[illegible]	6	[illegible]
3	[illegible]	7	[illegible]
4	[illegible]	8	[illegible]

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Insights Into Multidisciplinary Team Management of VOD/SOS

ARS Results

The Majority of Advisors (77%) Use MAC Regimens for Their Adult Patients Receiving HSCT; None Use NMA Regimens

Which conditioning regimen do you most commonly use for adult patients

All Advisors Use MAC Regimens for Their Pediatric Patients Receiving HSCT

Which conditioning regimen do you most commonly use for pediatric patients

*One advisor did not respond.

One-Third of Advisors Had 1–2 Adult HSCT Patients Who Developed VOD/SOS in the Past Year

Of the adult patients who received HSCT, how many have had VOD/SOS as a post-HSCT

*One advisor did not respond.

33% of Advisors Had 3–4 Pediatric HSCT Patients Who Developed VOD/SOS in the Past 12 Months

Of the pediatric patients who received HSCT, how many have had VOD/SOS as a post-

*One advisor did not respond.

76% of Advisors Indicated That Patients Were Diagnosed With VOD/SOS ~13–16 Days Post-HSCT

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Of the patients who have had VOD/SOS as a post-HSCT complication, about how long

Although Most Advisors (50%) Use EBMT/Modified Pediatric EBMT Criteria to Diagnose VOD/SOS, One-Third Use Baltimore Criteria

What diagnostic criteria does your institution use to diagnose VOD/SOS? (n = 12*)

*One advisor did not respond.

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