



POST-ASH Issue 1, 2015

Brentuximab Vedotin Combined with ABVD or AVD for Newly Diagnosed Advanced-Stage Hodgkin Lymphoma

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CME INFORMATION

OVERVIEW OF ACTIVITY

Each year, thousands of clinicians, basic scientists and other industry professionals sojourn to major international oncology conferences, like the American Society of Hematology (ASH) annual meeting, to hone their skills, network with colleagues and learn about recent advances altering state-of-the-art management in hematologic oncology. As such, these events have become global stages where exciting science, cutting-edge concepts and practice-changing data emerge on a truly grand scale. This massive outpouring of information has enormous benefits for the hematologic oncology community, but the truth is it also creates a major challenge for practicing oncologists and hematologists.

Although original data are consistently being presented and published, the flood of information unveiled during a major academic conference is unprecedented and leaves in its wake an enormous volume of new knowledge that practicing oncologists must try to sift through, evaluate and consider applying. Unfortunately and quite commonly, time constraints and an inability to access these data sets leave many oncologists struggling to ensure that they're aware of crucial practice-altering findings. This creates an almost insurmountable obstacle for clinicians in community practice because they are not only confronted almost overnight with thousands of new presentations and data sets to consider but they are also severely restricted in their ability to review and interrogate the raw findings.

To bridge the gap between research and patient care, this CME activity will deliver a serial review of the most important emerging data sets on the use of brentuximab vedotin and novel immune checkpoint inhibitors in the treatment of Hodgkin lymphoma (HL) from the latest ASH meeting, including expert perspectives on how these new evidence-based concepts may be applied to routine clinical care. This activity will assist medical oncologists, hematologists, hematology-oncology fellows and other healthcare professionals in the formulation of optimal clinical management strategies and the timely application of new research findings to best-practice patient care.

LEARNING OBJECTIVES

- Assess the efficacy and safety of brentuximab vedotin in investigational settings, such as in combination with AVD for patients with newly diagnosed HL, as consolidation after autologous stem cell transplant or as first-line salvage therapy alone or in combination with bendamustine prior to stem cell transplant.
- Appraise recent clinical trial data on the use of immune checkpoint inhibition for patients with relapsed or refractory HL.

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FACULTY — The following faculty (and their spouses/partners) reported real or apparent conflicts of interest, which have been resolved through a conflict of interest resolution process:

Stephen M Ansell, MD, PhD
Professor of Medicine
Division of Hematology
Mayo Clinic
Rochester, Minnesota

Research Funding: Bristol-Myers Squibb Company, Celldex Therapeutics.

Craig Moskowitz, MD
Clinical Director, Division of Hematologic Oncology
Attending Physician, Lymphoma and Adult BMT Services
Member, Memorial Sloan Kettering Cancer Center
Professor of Medicine, Weill Medical College of Cornell University
New York, New York

Advisory Committee: Genentech BioOncology, Seattle Genetics;
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This activity is supported by educational grants from Bristol-Myers Squibb Company, Celgene Corporation, Incyte Corporation, Onyx Pharmaceuticals, an Amgen subsidiary, Seattle Genetics and Takeda Oncology.

Hardware/Software Requirements:

A high-speed Internet connection
A monitor set to 1280 x 1024 pixels or more
Internet Explorer 7 or later, Firefox 3.0 or later, Chrome, Safari 3.0 or later
Adobe Flash Player 10.2 plug-in or later
Adobe Acrobat Reader
(Optional) Sound card and speakers for audio

Last review date: February 2015

Expiration date: February 2016

To go directly to slides and commentary for this issue, [click here](#).

Last fall, I received a set of slides submitted by Memorial Sloan Kettering's "tell it like it is" lymphoma maven Dr Craig Moskowitz for a presentation we'd asked him to give at our Year in Review regional CME meeting in Orlando, and it became instantly clear that the year's top story at ASH would be Hodgkin lymphoma (HL). What immediately grabbed my attention was a reference to 2 presentations that Craig would be giving at the upcoming Annual Meeting in San Francisco. The first focused on the initial results of the much anticipated Phase III randomized

AETHERA trial evaluating the antibody-drug conjugate brentuximab vedotin (BV) as maintenance treatment after autologous stem cell transplant (ASCT) for relapsed HL, while the second was one of a pair of very much *un*anticipated parallel presentations of Phase I studies of the anti-PD-1 monoclonal antibodies nivolumab and pembrolizumab, both of which are now approved by the FDA for metastatic melanoma.

Investigators who are about to present landmark clinical trials usually have embargoes up the wazoo, and while I couldn't squeeze many details out of Craig a month or so before ASH, there was no mistaking the enthusiasm in his voice as he told us what he could. Several weeks later when the abstracts became available it was evident why this often skeptical and conservative researcher was so genuinely excited: The 19-month jump in progression-free survival on the BV arm of AETHERA and the off-the-charts waterfall plots in the anti-PD-1 papers pretty much spoke for themselves.

After spending the last couple of months chatting with investigators (Craig among them) and general oncologists about what happened in San Francisco, we chose to profile HL on this first issue of our ASH review series, and it is interesting that the cancer that in many ways became the prototype for oncologic therapy for a generation has suddenly become the focal point of 2 of the most important innovations in the field. Unlike MOPP and its descendants, however, these newer modalities often lead to striking clinical outcomes not only in efficacy but also in tolerability. Here in a nutshell is what the justifiable fuss is all about.



Craig Moskowitz, MD

Maintenance BV after ASCT for relapsed/refractory HL

When I met with Dr Moskowitz not long after ASH he glowed about the previously mentioned AETHERA trial, noting that it was the first ever placebo-controlled, randomized study reported in HL. Over the last few years we have learned that CD30, a transmembrane glycoprotein receptor in the tumor necrosis factor receptor superfamily, is expressed on virtually all Reed-Sternberg cells in classical HL and at notably low levels in normal cells. Thus the anti-CD30 antibody-drug conjugate BV has proved to be among the most effective agents for the disease, and this study brings that into full focus.

Patients on the trial were randomly assigned to receive 16 cycles of maintenance BV or placebo every 3 weeks, and one of the most striking outcomes was that the risk of relapse at 2 years was reduced from 55% to 35%. From Craig's perspective this is likely to translate into improved cure rates because relapse after 24 to 30 months is uncommon. The bottom line is pretty much an instant change in standard of care.

BV up front in newly diagnosed HL

As many as 25% of patients with advanced-stage HL are not cured by chemotherapy regimens such as ABVD, and many others experience long-term toxicities, particularly bleomycin-induced pulmonary damage. For these reasons there has been great interest in evaluating alternative up-front regimens, and at ASH we saw more encouraging follow-up from a **Phase I trial** that initially combined BV with ABVD but then removed the bleomycin because of unacceptable pulmonary toxicity. The findings include a 3-year failure-free survival of 92% and seem compelling enough to lead any eligible patient with newly diagnosed, advanced-stage HL to consider entering the Phase III ECHELON-1 trial comparing ABVD to AVD-BV.

More on BV

Other key ASH BV data sets included a **Phase II trial** investigating the use of up to 4 cycles of the drug prior to ASCT in 36 patients with relapsed disease. This study demonstrated a 36% complete response rate and a 33% partial response rate, and 52% of the patients were able to proceed to transplant without additional chemotherapy.

In another **Phase II study** also evaluating patients at first relapse prior to ASCT, bendamustine was added to BV, producing outstanding efficacy outcomes, with 83% complete and 13% partial responses among 48 evaluable patients. Investigators initially observed a high rate of infusion reactions with the combination, but this problem was reportedly solved with more intensive premedication regimens.

Anti-PD-1 antibodies in HL

The biologic story here is fascinating. It has long been known that HL tumor masses are occupied mainly by inflammatory cells with only rare cancer (Reed-Sternberg)

cells. Analyses have shown that classical HL frequently harbors amplification of genetic material at the 9p24.1 locus and that these genes lead to overexpression of the PD-L1 and PD-L2 ligands. The Epstein-Barr virus — signs of which are observed in about half of patients with classical HL — is also thought to cause overexpression of PD-L1 and PD-L2, and for these and perhaps other reasons, these ligands are almost uniformly expressed on the surface of Reed-Sternberg cells. This had led to the rational hypothesis that classical HL is a tumor with a genetically determined vulnerability to PD-1 blockade.

At ASH we saw confirmation of this theory as the very busy Dr Moskowitz unveiled results from the **[Phase IB study \(KEYNOTE-013\)](#)** of pembrolizumab. Among the 31 patients with relapsed or refractory HL, all demonstrated PD-L1 expression on tumors and 66% achieved objective responses. Craig noted that as has been observed with solid tumors, responses often occur early, usually in the first 12 weeks. Although more follow-up is needed, it is intriguing that to this point almost 70% of patients remain on treatment.

The other major ASH anti-PD-1 HL paper came from a **[Phase I trial](#)** evaluating nivolumab for a variety of hematologic cancers. The HL cohort included 23 patients, and objective responses were observed in 87%. Analysis of pretreatment tumor specimens from 10 individuals demonstrated increased expression of both PD-L1 and PD-L2, and all 10 tumors had a genetic abnormality at 9p24.1. Note that the FDA recently bestowed breakthrough therapy designation on nivolumab in HL, although as in other tumors, including melanoma, investigators at this point can't really distinguish major differences in efficacy or tolerability of the 2 anti-PD-1 antibodies.

[A related ASH data set](#) from the same study included findings from patients with B-cell and T-cell lymphomas in addition to patients with multiple myeloma. The results were mixed: More than a third of patients with follicular and diffuse large B-cell lymphoma experienced objective responses, and the decision has been made to continue investigation of nivolumab in these diseases, either alone or combined with other therapies, including anti-CTLA4 antibodies such as ipilimumab. Fewer responses (17%) were observed in 23 patients with T-cell lymphoma and none were reported in 27 patients with multiple myeloma or 2 patients with primary mediastinal B-cell lymphoma, and for this reason this agent will not be further evaluated in these tumors.

As in prior trials of anti-PD-1 antibodies in other cancers, both nivolumab and pembrolizumab were generally well tolerated in patients with HL, with few Grade 3 or 4 adverse events. However, the spectrum of autoimmune complications with these and other checkpoint inhibitors is specific and quite different from the side effects seen with traditional anticancer systemic therapies, such as cytotoxic and targeted treatment. In this regard Dr Moskowitz noted that while autoimmune toxicities like pneumonitis and thyroid or adrenal dysfunction are uncommon, oncologists must be vigilant in identifying and managing such complications. Similarly, during a recent interview for our audio series, lung cancer investigator Dr Julie Brahmer noted that she tells patients that "anything that ends in an 'itis'" might be observed.

BV has been around long enough for oncologists to have integrated it into their practices relatively effectively, but while checkpoint inhibitors have been used for a while in melanoma, it seems entirely possible that as early as this summer anti-PD-1 agents could be approved and used widely in non-small cell lung cancer. This development will transform the practice of oncology perhaps more than any other event in the history of the field as chemotherapy infusion rooms become, to a great extent, immunotherapy centers. Even more, this revolution will likely not be limited to melanoma and lung cancer because it seems plausible that many other, less common diseases, including HL but also bladder cancer and renal cell carcinoma, will soon incorporate checkpoint inhibitors into standard treatment algorithms and offer patients running out of options a novel approach that appears to be unique and very promising. Next on this series we chat about multiple myeloma and a major new Phase III study (ASPIRE) that exemplifies how far we have come with this difficult disease.

Neil Love, MD

Research To Practice

Miami, Florida

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Brentuximab Vedotin Combined with ABVD or AVD for Newly Diagnosed Advanced-Stage Hodgkin Lymphoma

Presentation discussed in this issue

Connors JM et al. **Brentuximab vedotin combined with ABVD or AVD for patients with newly diagnosed advanced stage Hodgkin lymphoma: Long term outcomes.** *Proc ASH 2014*; **Abstract 292.**

Slides from a presentation at ASH 2014 and transcribed comments from a recent interview with Craig Moskowitz, MD (1/6/15)

Brentuximab Vedotin Combined with ABVD or AVD for Patients with Newly Diagnosed Advanced Stage Hodgkin Lymphoma: Long Term Outcomes

Connors JM et al.

Proc ASH 2014; Abstract 292.

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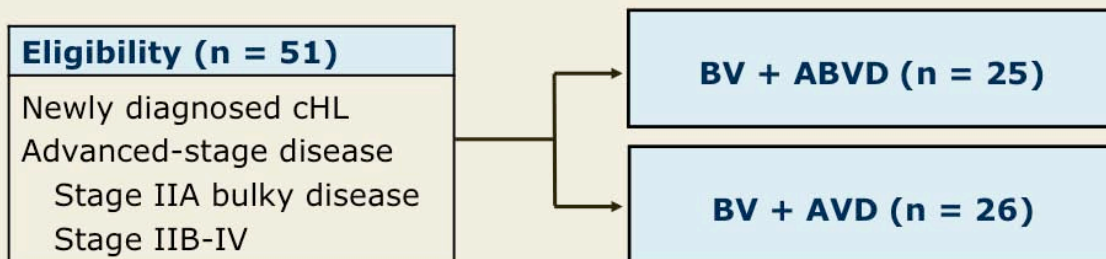
Background

- The ABVD (doxorubicin/bleomycin/vinblastine/dacarbazine) regimen is a common standard therapy for the front-line treatment of advanced-stage Hodgkin lymphoma (HL).
 - It is curative for most patients (*JCO* 2003;21(4):607).
- Hodgkin Reed-Sternberg cells of classical HL (cHL) typically express CD30.
- In a pivotal Phase II trial, brentuximab vedotin (BV), an anti-CD30 antibody-drug conjugate, induced an objective response rate (ORR) of 75% and complete response rate (CR) of 34% in patients with relapsed/refractory cHL (*JCO* 2012;30(18):2183).
- **Study objective:** To provide long-term safety and efficacy results of a Phase I trial of BV in combination with ABVD or AVD for patients with newly diagnosed advanced-stage HL.

Connors JM et al. *Proc ASH* 2014;Abstract 292.

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Open-Label Phase I Trial Design



- Patients on the BV + ABVD arm received 0.6, 0.9 or 1.2 mg/kg of BV + standard doses of ABVD on days 1 and 15 of each 28-day cycle for up to 6 cycles.
- Patients on the BV + AVD arm received 1.2 mg/kg of BV with standard doses of AVD on days 1 and 15 of each 28-day cycle for up to 6 cycles.
- 80% of patients on the study had Stage III or IV disease.

Connors JM et al. *Proc ASH* 2014;Abstract 292.

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Preliminary Results from the Phase I Trial

- CR rate
 - BV + ABVD: 21/22 (95%)
 - BV + AVD: 24/25 (96%)
- Adverse events were generally Grade 1 or 2.
- Pulmonary toxicity
 - An unacceptable number of patients in the BV + ABVD arm experienced pulmonary toxicity: 11/25 (44%).
 - 2 patients died of pulmonary toxicity.
 - No patient experienced pulmonary toxicity on the BV + AVD arm.
- Hence, the objective of the long-term study is to assess the durability of response and to examine the time distribution of relapses experienced by the patients.

Younes A et al. *Lancet Oncol* 2013;14(13):1348-56.

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Treatment Outcomes

- Patients who have experienced relapse: n = 5
 - BV + ABVD (n = 3): At 9, 22 and 23 months from diagnosis
 - BV + AVD (n = 2): At 7 and 22 months from diagnosis
- Follow-up for the 22 patients who received BV + ABVD and are still alive: >32 months.
- Follow-up for the 25 patients who received BV + AVD: >22 months.

Connors JM et al. *Proc ASH* 2014;Abstract 292.

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Survival Outcomes

Outcome	BV + ABVD (n = 24)*	BV + AVD (n = 26)
3-year failure-free survival (FFS)	79%	92%
3-year overall survival (OS)	92%	100%

* One patient declined continued follow-up and so is not included.

- Number of patients alive: BV + ABVD (n = 22); AV + AVD (n = 26)
- Median follow-up: ABVD arm 45 months, AVD arm 36 months
- All 5 patients with relapsed disease have undergone autologous stem cell transplant

Connors JM et al. *Proc ASH* 2014;Abstract 292.

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Author Conclusions

- Brentuximab vedotin cannot safely be combined with bleomycin.
- With the BV + AVD regimen a 92% 3-year FFS, 100% 3-year OS and a 96% CR rate were observed.
 - No major unexpected toxicity was noted.
- The results strongly support the need for the currently ongoing, large, international Phase III ECHELON-1 trial comparing BV + AVD (AVD in combination with 1.2 mg/kg of brentuximab vedotin) versus standard ABVD (NCT01712490).
 - This trial may identify a new, less toxic gold standard for the treatment of advanced-stage cHL.

Connors JM et al. *Proc ASH* 2014;Abstract 292.

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Investigator Commentary: Long-Term Results from a Phase I Study of BV in Combination with ABVD or AVD in Newly Diagnosed Advanced-Stage HL

The preliminary results of this study have been published (*Lancet Oncology* 2013; 14(13):1348-56). Originally, patients received ABVD and BV, and that was found to be toxic. Two patients died of pulmonary toxicity. At that point, bleomycin was stopped and the treatment was modified to AVD and BV.

The bottom line is that if you exclude the 2 patients who had pulmonary toxicity, which was unfortunate, then the majority of patients have fared extremely well. Even if you count those 2 cases as events, the 3-year FFS is 79% (BV + ABVD) and 92% (BV + AVD). However, the follow-up is shorter in the group of patients who did not receive bleomycin. I believe that community physicians should be comfortable with participating if the randomized study is made available to them evaluating BV with AVD versus ABVD. The results are potentially practice changing. However, BV is quite expensive, and it is not clear how much better its addition to chemotherapy has to be for oncologists to recommend its use.

Interview with Craig Moskowitz, MD, January 6, 2015

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