HSD66

Treatment Pathway and Unmet Needs of Waldenström Macroglobulinemia: An Exploratory Study from Portugal

Dimitrovová K[1,2], Reis A[1], Viana DS[3]

[1] MOAI Consulting, Lisbon, Portugal; [2] Comprehensive Health Research Center, CHRC, NOVA University Lisbon, Lisbon, Portugal; [3] Janssen-cilag Farmacêutica, Lda, Oeiras Portugal

INTRODUCTION

Waldenström Macroglobulinemia (WM) is a rare type of non-Hodgkin B lymphoma with indolent course, corresponding to ~1% of all cases of non-Hodgkin Lymphoma.[1] The most common mutations that characterize this disease diagnosis are $MYD88^{L265P}$ (~90% of cases) and CXCR4 (30%-40%). [2,3]

WM is more common in elderly men, with the median age at diagnosis being 63-75 years.[1] The reported age-adjusted incidence rate is 7.3 per million (male) and 4.2 per million (female) in the European standard population (with incidence increasing with age).[4] The median time to symptom development for patients with asymptomatic WM exceeds 5–10 years.[1] According to records of patients in ten European countries with symptomatic WM treated between 2000 and 2014, after front-line treatment, median progression-free survival (PFS) was 29 months and 10-year overall-survival (OS) was 69%.[5]

Although a general consensus exists on the diagnosis of WM and when to begin treatment, there is heterogeneity in the approaches and regimens used to treat patients, even in international guidelines.[2] This impacts physicians' treatment decision-making process in patients with an uncommon disease.[6] Chemoimmunotherapy combinations are the most commonly used regimens for WM treatment in Europe, however, the approval of ibrutinib monotherapy and in combination with rituximab has expanded the treatment options for WM, with highest responses in the $MYD88^{L265P}$/$CXCR4^{wildtype}$. [3]

OBJECTIVE

This study aimed to give a general overview of the treatment pathway and unmet needs of Waldenström Macroglobulinemia in Portugal.

METHODS

Two interviews with Hematologists (in September 2022) were conducted to ascertain the treatment pathway of WM patients in Portugal. Based on these qualitative findings, a quantitative script was developed. The script followed the treatment pathway, in order to quantify the percentage of patients with WM in each step, including *watch-and-wait*, and per line of treatment, according to patient *fitness*. An open-ended question was added to assess the main therapeutic unmet needs.

The survey was administered online, in November 2022, targeting Hematologists with experience in the treatment of WM patients. All anonymized data was self-reported and was based on the personal clinical experience of each Hematologist.

RESULTS

19 hematologists answered the survey. The majority of participants´ place of medical practice is within the Lisbon district (n=11, 50%), with the remaining participants practicing in other 5 (of 18) districts of mainland Portugal and one in Madeira Island. Additionally, the majority (n=12, 60%) practice in public health sector.

On average, each Hematologist diagnosed 6 new patients (min:1, max:20) in the last 12 months and had 5 patients undergoing treatment (min:1, max:10). The average age at diagnosis in 69 years. Approximately 61% of diagnosed patients with WM stay in a *watch-and-wait* period over three years (min:1, max:12). Several criteria are considered to determine patient *fitness*, including age, comorbidities, Cumulative Illness Rating Scale (CIRS) and Eastern Cooperative Oncology Group (ECOG) performance status scale, which has an influence on the treatment option.

1L therapy

55% are considered fit for intensive therapy when initiating treatment.

1L therapy consists essentially of immunochemotherapy, while only 6% are treated with targeted therapy. This percentage increases to 13% for unfit patients in 1L.

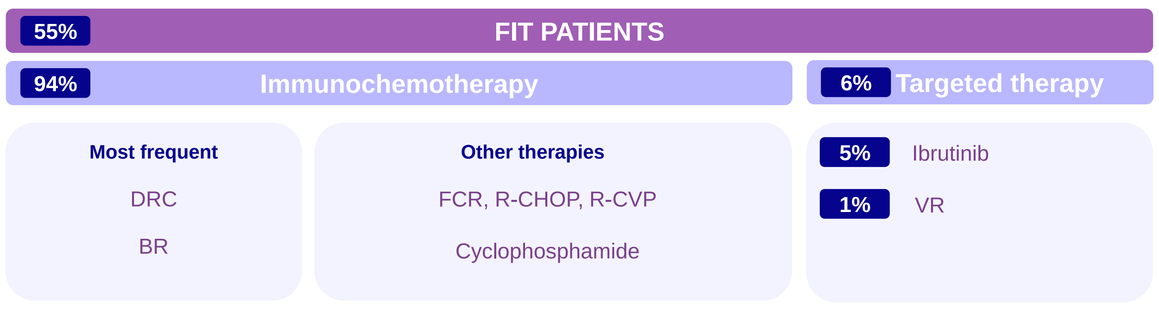

Fig.1– WM 1L assessed therapeutic algorithm

2L therapy

On average, 40% of patients are eligible for 2L treatment, approximately 22 months after 1L, of which 30% are considered fit.

In 2L, 24% and 26% of fit and unfit patients are treated with targeted therapy, respectively, being Ibrutinib the most common therapeutic choice.

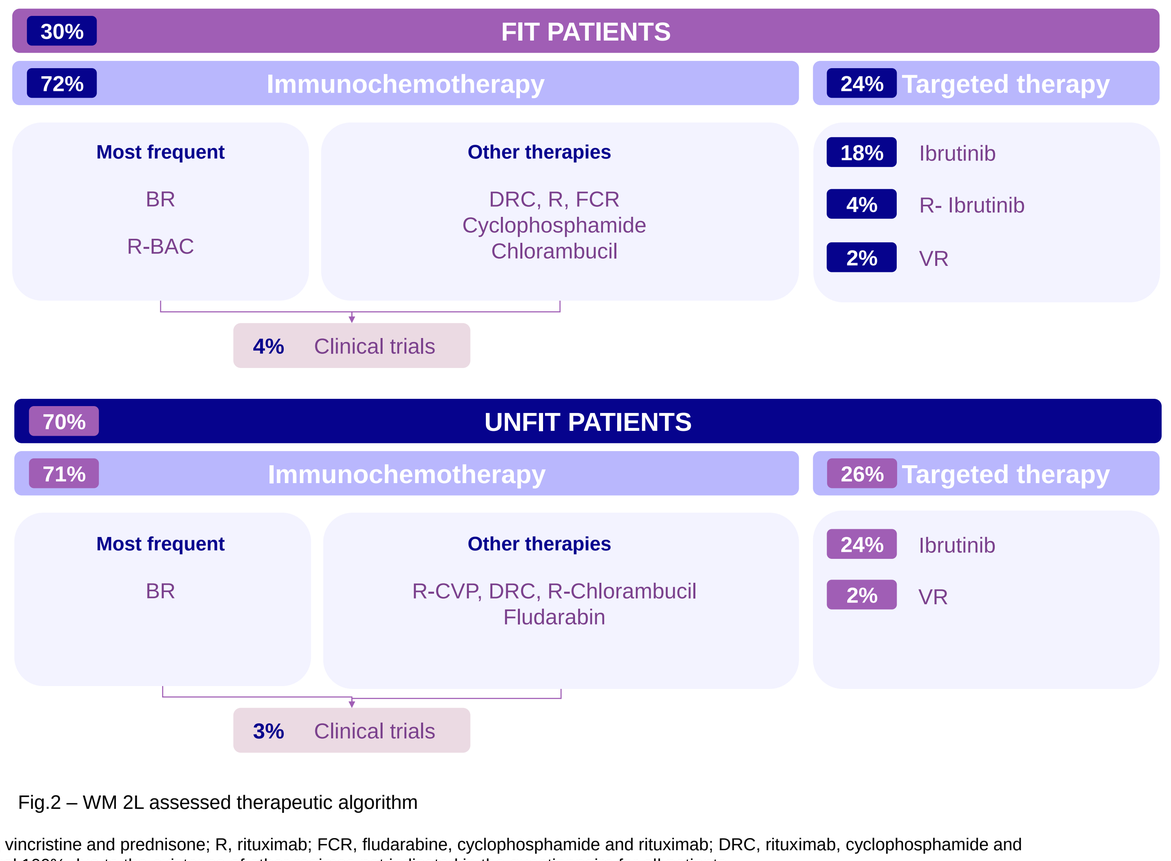

Fig.2 – WM 2L assessed therapeutic algorithm

Note: BAC, bendamustine and cytarabine; BR, bendamustine and rituximab; CTD, Cyclophosphamide, thalidomide and dexamethasone; CVP, cyclophosphamide, vincristine and prednisone; R, rituximab; FCR, fludarabine, cyclophosphamide and rituximab; DRC, rituximab, cyclophosphamide and dexamethasone, CHOP, cyclophosphamide, doxorubicin, vincristine and prednisolone; VR, Bortezomib, Rituximab. *Note*: The sum of the percentages may not equal 100% due to the existence of other regimes not indicated in the questionnaire for all patients.

UNMET NEEDS

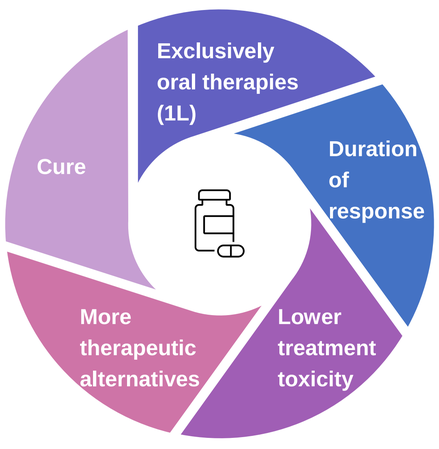

Fig.3 – Main therapeutic unmet needs identified

The main identified unmet needs were related with cure, duration of therapeutic response, lower treatment toxicity, more effective therapeutic alternatives specially for older and unfit patients and exclusively oral therapies for 1L.

Additionally, to better support patients needs, it is necessary to involve nutritionists, psychologists and social workers as well as ensuring other complementary needs and guarantee proximity of services (especially in rural areas).

LIMITATIONS

- This is an exploratory study, based on an online questionnaire with a small number of participants, and therefore results cannot be generalizable to the Portuguese clinical practice;
- Due to the quantitative nature of the survey, unmet needs were not fully explored.

TAKE HOME MESSAGE

Evidence about the treatment of WM in Portugal is limited. This exploratory study showed that immunochemotherapy is the most common treatment for WM patients in 1L of treatment, with the lack of therapeutic alternatives and treatment toxicity pointed as the main therapeutic unmet needs.

ISPOR Europe 2023, Copenhagen, Denmark

References

[1] Ghobrial et al (2003) DOI: 10.1016/s1470-2045(03)01246-4; [2]Guerrera et al (2018) DOI: 10.3324/haematol.2018.190181; [3]Kaiser et al (2021) DOI: 10.1038/s41375-020-01102-3; [4]Phekoo et al (2008) DOI: 10.1016/j.leukres.2007.02.002;
[5] Buske et al (2018) DOI: 10.1016/S2352-3026(18)30087-5; [6]Ansell et al (2010) DOI:10.1001/jamaoncol.2016.5763

Janssen Pharmaceutical Companies of Johnson & Johnson

MOAI Stepping Stone to knowledge