Chemo-immunotherapy — The Role of Monoclonal Antibodies for the Treatment of Chronic Lymphocytic Leukaemia

A report by
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Introduction

The last 15 years have seen a dynamic development of new agents for the treatment of chronic lymphocytic leukaemia (CLL). Fludarabine and a monoclonal antibody, alemtuzumab, have been approved, and additional antibodies (anti-CD20, anti-CD23, rituximab; anti-MHC II) are currently tested in clinical trials.1,2 In particular, the combined use of chemotherapy with monoclonal antibodies (commonly called chemo-immunotherapy) has given very promising results in CLL.

Combination Chemotherapy with Purine Analogues

Fludarabine has been evaluated in a variety of combination regimens. One of the most promising and most thoroughly studied combinations is fludarabine plus cyclophosphamide (FC).3

In preliminary, non-comparative trials, the overall response rates did not appear to be better than with fludarabine alone, but the addition of cyclophosphamide appeared to improve the quality of the responses. This combination, with or without mitoxantrone, has achieved response rates of 64% to 100%, with complete remission (CR) rates of up to 50%.5

In a prospective trial of the German CLL study group (GCLLSG) comparing fludarabine versus FC, results for 375 patients showed superior response rate for the combination.4 The FC combination chemotherapy resulted in a significantly higher CR rate (16%) and overall response rate (94%) compared with fludarabine alone (5% and 83%; p=0.004 and 0.001, respectively).

The FC treatment also resulted in a longer median duration of response (48 vs 20 months; p=0.001), and a longer event-free survival (49 vs 33 months; p=0.001). So far, no difference in the median overall survival could be observed within a median observation period of 22 months. FC caused significantly more thrombocytopenia and neutropenia, but less anaemia than fludarabine. FC did not increase the number of severe infections.4

Rituximab-based Chemo-immunotherapy

Rituximab, an anti-CD20 monoclonal antibody, has only recently provoked interest for the treatment of CLL. As a single agent, rituximab is less active than in follicular lymphoma, unless very high doses are used.5,6 Somewhat surprisingly, combinations of rituximab with chemotherapy have proven to be very efficacious therapies for CLL.

There is preclinical evidence for synergy between rituximab and fludarabine.7 The majority of rituximab combination studies in CLL have focused on combinations with fludarabine or fludarabine-based regimens.

A multicentre phase II study of GCLLSG has evaluated the efficacy and safety of rituximab plus fludarabine in patients with previously treated or untreated CLL.8 Of 31 patients treated, 27 (87%) responded, with 10 patients (32%) achieving a complete response.

Byrd and colleagues combined rituximab with fludarabine in either a sequential or concurrent regimen in a randomized study (Cancer and Leukemia Group B (CALGB) 9712 protocol).9 Patients (n=104) with previously untreated CLL received six cycles of fludarabine, with or without rituximab, followed by four once-weekly doses of rituximab.

Overall and complete response rates were higher in the concurrent group (90% and 47% vs 77% and 28%). Similarly, in a large phase II trial conducted at the MD Anderson Cancer Center on 224 patients with previously untreated CLL, rituximab plus FC achieved a response rate of 95%, with 71% complete responses.10

Median overall survival was not reached in patients treated with rituximab plus FC, and was significantly longer than in patients treated with FC alone in a historical comparison.
Alemtuzumab-based Chemo-immunotherapy

Alemtuzumab is a recombinant, fully humanised, monoclonal antibody against the CD52 antigen. Monotherapy with alemtuzumab has produced response rates of 33–53%, with a median duration of response ranging from 8.7 to 15.4 months, in patients with advanced CLL who were previously treated with alkylating agents and had failed or relapsed after second-line fludarabine therapy.11-13 In addition, alemtuzumab has proven effective even in patients with poor prognostic factors, including high-risk genetic markers such as deletions of chromosome 11 or 17 and p53 mutations.14,15 If these results are confirmed in larger, prospective trials, alemtuzumab might be a rational choice for first-line treatment of patients with these poor prognostic factors.

Alemtuzumab consolidation therapy after fludarabine-based chemotherapy also improved the quality of responses, achieved molecular remissions in a substantial proportion of patients and increased progression-free survival (PFS) compared with patients who had no further treatment.16-18 Results of a phase III trial by GCLLSG showed improved PFS with alemtuzumab consolidation therapy compared with the observation arm (no progression vs 24.7 months, p=0.036) when calculated from the start of fludarabine-based treatment.19 When PFS was calculated from the date of alemtuzumab administration, the same benefit was apparent, with no progression compared with 17.8 months (p=0.036).

O’Brien and colleagues reported an overall response rate of 53%, comprised of nine out of 23 (39%) at a 10mg dose and 17 of 26 (65%) at a 30mg dose (p=0.066).18 Residual disease was cleared from the bone marrow in most patients, and 11 (38%) of the 29 patients with available data achieved a molecular remission. Median time to disease progression had not yet been reached for patients who achieved minimal residual disease (MRD) negativity, compared with 15 months for patients who still had residual disease after alemtuzumab consolidation treatment.19 While the GCLLSG trial was halted early because of infectious adverse events, the study by O’Brien et al. had no such issue, perhaps due to a longer time interval between induction therapy and consolidation with alemtuzumab (six months vs three months in the GCLLSG study).

Perhaps the most potent regimen for CLL is the combination of the most effective single chemotherapeutic agent with the most effective monoclonal antibody-fludarabine plus alemtuzumab. The synergistic activity of these two agents was initially suggested by the induction of responses, including one CR, in five of six patients who were refractory to each agent alone.19 The combination of fludarabine and alemtuzumab was investigated in a phase II trial enrolling patients with relapsed CLL.20 Using a four-weekly dosing protocol, this combination has proven feasible, safe and very effective. Among the 36 patients, the objective response rate (ORR) was 83% (30/36 patients), which included 11 CRs (30%) and 19 partial remission (PRs) (53%); in addition, one patient achieved stable disease. Sixteen of 31 (53%) evaluated patients achieved MRD negativity in the peripheral blood by three months of follow-up, and resolution of disease was observed in all disease sites, particularly in the blood, bone marrow and spleen. Overall, the fludarabine/alemtuzumab combination therapy was fairly well tolerated.

Conclusion

In the last decade, impressive progress has been made in the therapy of CLL by using novel chemo-
MabCampath® is the first monoclonal antibody for CLL. It can offer substantial improvements in duration of response in all refractory CLL where alkylating agents and fludarabine have failed.

Prescribing information: Name of the medicinal product MabCampath® 10 mg/2 ml concentrate for solution for infusion. MabCampath® 30 mg/6 ml concentrate for solution for infusion. Qualitative and quantitative composition: Each ampoule contains 30 mg alemtuzumab. Each vial contains 60 mg alemtuzumab. Alemtuzumab is a genetically engineered humanized IgG1 kappa monoclonal antibody specific for a 21-26 kD lymphocyte cell surface glycoprotein (CD52). The antibody is produced in mammalian cell (Chinese Hamster ovary) suspension culture in a nutrient medium. Therapeutic indications: MabCampath® is indicated for the treatment of patients with CLL, lymphocytic leukemia (CML) who have been treated with alkylating agents and who have failed to achieve a complete or partial response or achieved only a short remission (less than 6 months) following fludarabine phosphate therapy. Contraindications: Hypersensitivity or anaphylactic reactions to alemtuzumab, to murine proteins or to any of the excipients. MabCampath® is contraindicated in patients with active systemic infections, in patients infected with HIV, in patients with active secondary malignancies, pregnancy and breast-feeding. Undesirable effects: More than 80% patients may be expected to experience adverse reactions; the most commonly reported reactions usually occur during the first week of therapy. The frequencies of the adverse reactions reported below (very common >10%, common 1-10%) are based on clinical trial data in CLL patients and post-marketing data. Application site: commonly injection site reaction. Body a whole: very common – fever, cough, hypotension, vomiting, diarrhea; very common – abdominal pain, gastrointestinal haemorrhage, stomatitis, mucositis; musculoskeletal: very common – back pain, hypocalcaemia, thirst; urogenital: urinary: very common – dysuria, renal impairment; gastrointestinal: very common – nausea, vomiting, diarrhea; very common – abdominal pain, gastrointestinal haemorrhage, stomatitis, mucositis; musculoskeletal: common – bone pain; central and peripheral nervous system including vision: very common – headache; very common – dizziness, hyperkinesia, conjunctivitis, paraesthesia, flushing, palpitation. Cardiovascular: very common – chest pain, pain, oedema mouth, asthenia, malaise, influenza-like symptoms, oedema, temperature change sensation. Hematopoietic: very common – panleucopenia, leuopenia, lymphopenia, purpura. Dermatological & nutritional: very common – hypocalcaemia, thirst, Musculo-skeletal: common – skeletal pain, arthralgia, myalgia. Psychiatric: common – anxiety, somnolence, depression, insomnia; Reactions occurring usually within 24 hours of MabCampath® infusion during dose escalation and as clinically indicated. The median time to reach a level of 200 cells/µl may be prolonged. CD4 counts are not obtainable, then patients should remain on anti-herpes prophylaxis for 6 months or longer to approximate pretreatment levels. This may predispose patients to opportunistic infections. It is highly recommended that anti-herpes prophylaxis (e.g. trimethoprim/sulfamethoxazole 1 tablet twice daily, 3 times weekly, or other prophylaxis against Pneumocystis carinii pneumonia [PCP] and an effective oral anti-herpes agent, such as famciclovir, 250 mg twice daily) should be initiated while on therapy and continued following the completion of treatment with MabCampath® until the CD4+ count has recovered to 200 cells/µl or greater. If CD4 counts are not obtainable, then patients should remain on anti-herpes prophylaxis for 6 months. Patients may have allergic or hypersensitivity reactions to MabCampath® and to murine or chimeric monoclonal antibodies, and female patients of childbearing potential should use effective contraceptive measures during treatment and for 6 months following MabCampath® therapy. Prescribing information refer to the package insert and/or contact your local Schering organisation.
immunotherapies, that combine monoclonal antibodies with purine analogue-based chemotherapy. This approach has led to an increased response rate and prolonged treatment-free survival, from complete remissions about 4% with chlorambucil up to 70% with the novel chemoinmunotherapies (see Table 1). So far, it has not been formally proven by prospective, randomised trials that this approach prolongs overall survival of CLL patients. The current protocols such as the CLL8 protocol of the GCLLSG, which compares the FC versus FC+R combination, will contribute to further define the future value of chemoinmunotherapy for CLL.

References