MDedge | Hematology & Oncology
Keeping you informed. Saving you time.

CONFERENCE COVERAGE

Ibrutinib dons new anti-GVHD hat

Publish date: June 24, 2017

By Neil Osterweil

AT EHA 2017

MADRID – Talk about versatility: Ibrutinib (Imbruvica), a drug with marked activity against B-cell malignancies, also appears to be a safe and acceptable option for the treatment of patients with chronic graft vs. host disease (cGVHD) for whom frontline therapies have failed.

Among 42 patients in a phase II study with steroid-refractory cGVHD, the overall response rate with ibrutinib was 67%, with one-third of responders having a complete response, reported Iskra Pusic, MD, from Washington University School of Medicine in St. Louis.

Neil Osterweil/Frontline Medical News

Dr. Iskra Pusic

"Ibrutinib resulted in clinically meaningful and sustained responses in patients who have failed at least one prior treatment. They were able to taper steroids, and it's important to underline here that we saw responses even in the setting of tapering steroids," she said at a briefing at the annual congress of the European Hematology Association.

Corticosteroids are the most commonly used therapy for cGVHD in the United States, but for those patients for whom corticosteroids are a bust, there is no established second-line therapy, and patients with refractory cGVHD are usually recommended for clinical trials, Dr. Pusic said.

The therapeutic rationale underpinning the use of ibrutinib in cGVHD, a condition marked by extensive immune dysregulation, is that the agent is an irreversible inhibitor of Bruton's tyrosine kinase and interleukin-2 inducible T-cell kinase, and thus has wide-ranging immune-dampening activity, Dr. Pusic said.

She and colleagues in a multicenter study enrolled 42 patients with cGVHD that corticosteroids had failed to treat adequately, and treated them with oral ibrutinib 420 mg daily until cGVHD progression or unacceptable toxicity.

At a median follow-up of 13.9 months, a total of 28 patients (67%) had a response according to 2005 National Institutes of Health (NIH) criteria, including nine with a complete response, and 19 with partial responses.

Of the patients with responses, 79% had a response at the time of the first assessment for response, and 71% of responders had responses lasting at least 5 months.

Among patients with multiorgan involvement, responses were seen in two or more organs.

Grade 3 or greater adverse events included fatigue, diarrhea, muscles spasms, pneumonia, pyrexia, and headache. Two patients died on study, one from multilobular pneumonia and one from bronchopulmonary aspergillosis.

In general, the safety profile of ibrutinib was similar to that seen in studies of the drug in B-cell malignancies and to that seen with corticosteroid therapy for patients with cGVHD, Dr. Pusic said.

Investigators are currently enrolling patients in a double-blind clinical trial comparing ibrutinib or placebo in combination with corticosteroids in patients with newly diagnosed cGVHD, she noted.

The study was supported by Pharmacyclics. Dr. Pusic did not report disclosures.