Transcript of Rai Interview Part 8: Splenomegaly Management

Gerald Marti: Well, another subject that I was just thinking that I brought up with Dr. Hallek when he was here, and it's somewhat of a pet project of my own, it's what is the optimal medical and surgical management of splenomegaly in CLL?[1] And I would maybe give the clinical example of a 50-year old male with Rai stage II isolated splenomegaly, splenomegalic CLL who becomes anemic and thrombocytopenic, marrow is packed, you don't know how much of it's due to marrow failure and how much it's due to secondary hypersplenism, but you treat this patient because they're symptomatic. And now they're starting to relapse and they're going to develop another episode of splenomegaly. What's the management of that spleen?

Kanti Rai: Well I assume that the previous therapy is whatever they were had shrunk the spleen.

Marti: Yes, definitely.

Rai: Now you are faced with a patient who has a recurrence of disease, relapse of disease in which the most prominent part is a large spleen but the lymph nodes clinically are not palpable and the patient has moderate to significant level of cytopenias in terms of anemia and platelet numbers. I would say that this person might benefit from a splenectomy. I have found that splenectomy in a relapsed person does not seem to be of great help when there are lymph nodes also significantly enlarged. But in your type of patient, isolated splenomegaly with cytopenias, I would think that you would offer a good chance of benefit by taking the spleen out.

I would expect that hemoglobulin and platelets would increase. I certainly do not for a moment suggest that this will cure the person, but it will buy him good quality life and today's day and age, a splenectomy can be done by laparoscopic approach. And then, when the patient does need chemoimmunotherapy, you might have—which may not happen for another two years or so—but when and if it does happen, then you have a better chance because the bulk of tumor, to some extent, you have been able to surgically excise. Although as you point out, the disease is still in the packed marrow so we are not fooling ourselves that we will cure this person, but we can buy good quality life and time and then approach whenever the relapse occurs.

Marti: How would you sketch out an NIH-type protocol that would evaluate the role, if any, of splenectomy in the CLL?

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[1] Dr. Rai's note: We don't see these cases anymore. This is before the targeted Rx era and before obinutuzumab.

Rai: Well in that case, I would certainly have to do a randomized trial and in that randomization, half the patients would have some Rituxan, rituximab-based chemotherapy, or you may say that if the patient has not had too much of rituximab in the past, I may use single-agent rituximab. Or if you have available ofatumumab, so that if I were to plan a prospective trial, then this group of patients, half the patients, will undergo a splenectomy and half the patients will undergo a relatively non-toxic immunotherapy. And you will know in the next three or four years whether splenectomy did benefit the patient because non-splenectomized patients who do not respond can still have splenectomy, and similarly, splenectomized patients if they are successful, then you can go two, three years without needing anything.

If they do fail and within a year or so after a splenectomy they need something, I may go with ofatumumab on protocol, and by five or six years, you would have hard, solid data to say that a splenectomy is of no benefit or if it is indeed.

Marti: Or if single-agent alemtuzumab might be just as good and have not the complicate—the risk of surgery.

Rai: Right, right.