MAYO CLINIC

Targeting the Un-targetable

Initial Treatment of Acute Myeloid Leukemia without Targetable Mutations

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Pharmacy Grand Rounds
January 19th, 2021

LEARNING OBJECTIVES

1. Describe epidemiology, pathophysiology, and prognosis of acute myeloid leukemia (AML)
2. Review literature supporting induction regimens for patients with AML without targetable mutations
3. Discuss how to select between AML induction regimens based on patient-specific factors

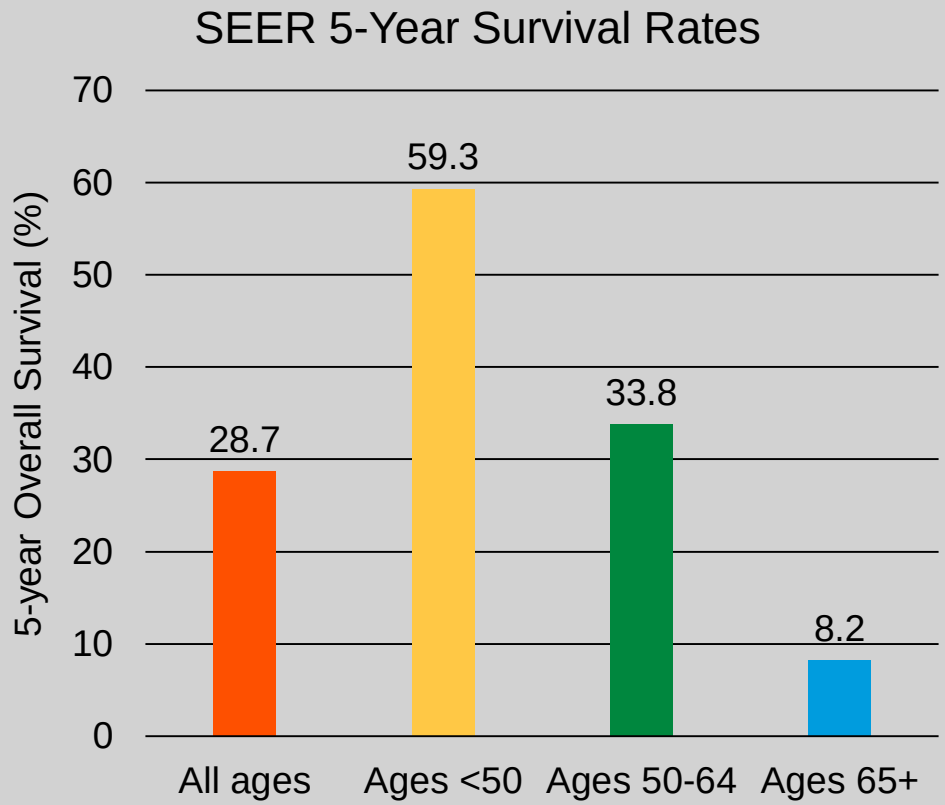
1 AML Background

Epidemiology, Pathophysiology, and Prognosis

Epidemiology

Acute Myeloid Leukemia in the United States

- Estimated 19,940 new cases in 2020
  - 1.1% of all new cancer cases
- Estimated 11,180 deaths in 2020
  - 1.8% of all cancer deaths
- Lifetime risk is ~0.5%
- More common:
  - Older adults
    - Median age at diagnosis is 68
  - 1.4:1 ratio of men to women



SEER Cancer Database. 2020.

Risk Factors

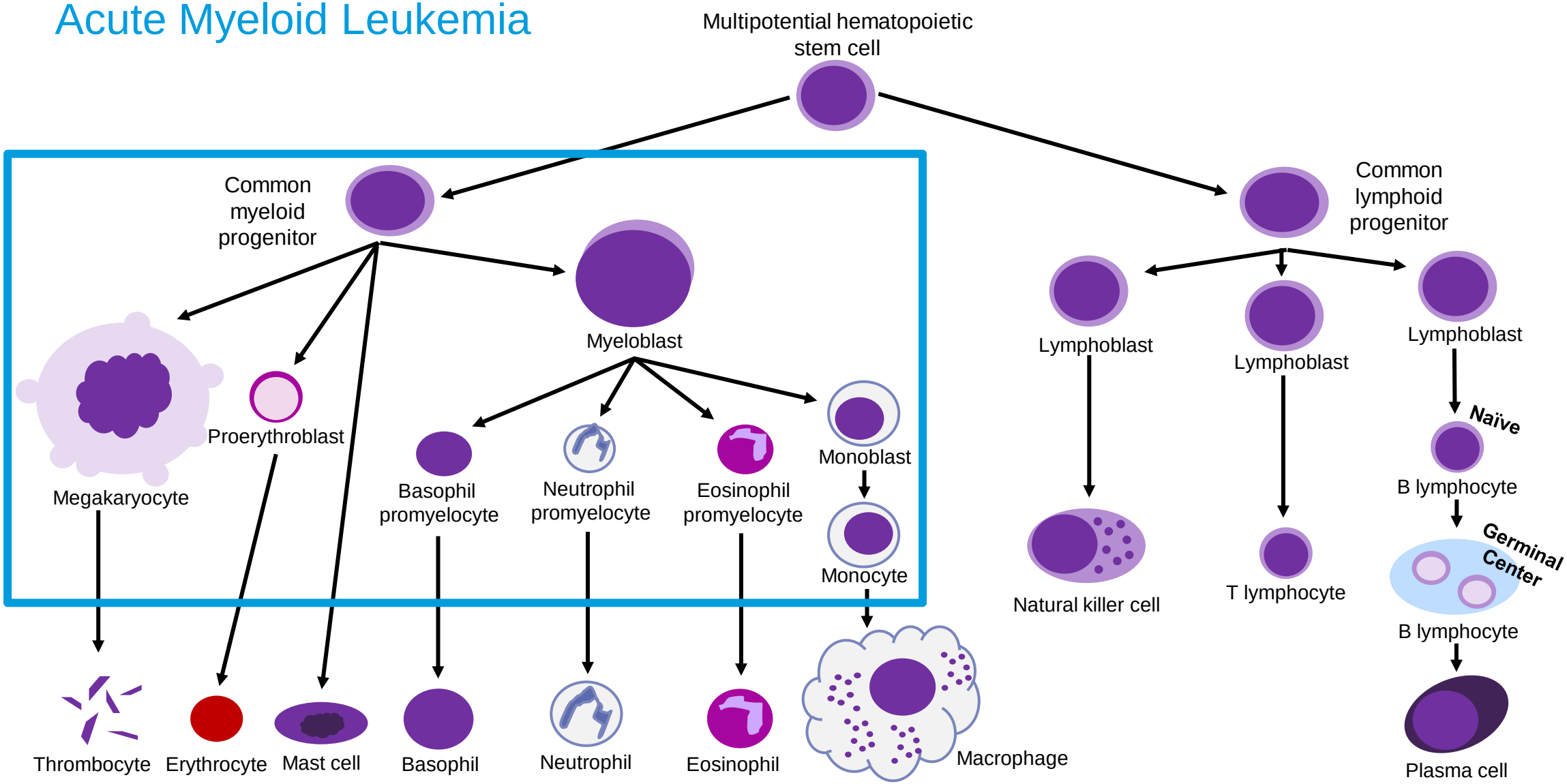
Acute Myeloid Leukemia

- Germline mutations in hematopoietic cells
- Prior chemotherapy
  - Topoisomerase II inhibitors – latency 1-5 years
    - Examples: doxorubicin, etoposide
  - Alkylating agents – latency 5-10 years
    - Examples: cyclophosphamide, cisplatin
- Radiation therapy
- Inherited bone marrow failure syndromes, genetic disorders, myelodysplastic disorders and myeloproliferative neoplasms

Warren JT and Link DC. Blood. 2020; 136(14):1599-1605.

Pathogenesis

Acute Myeloid Leukemia



Clinical Presentation

Signs/Symptoms

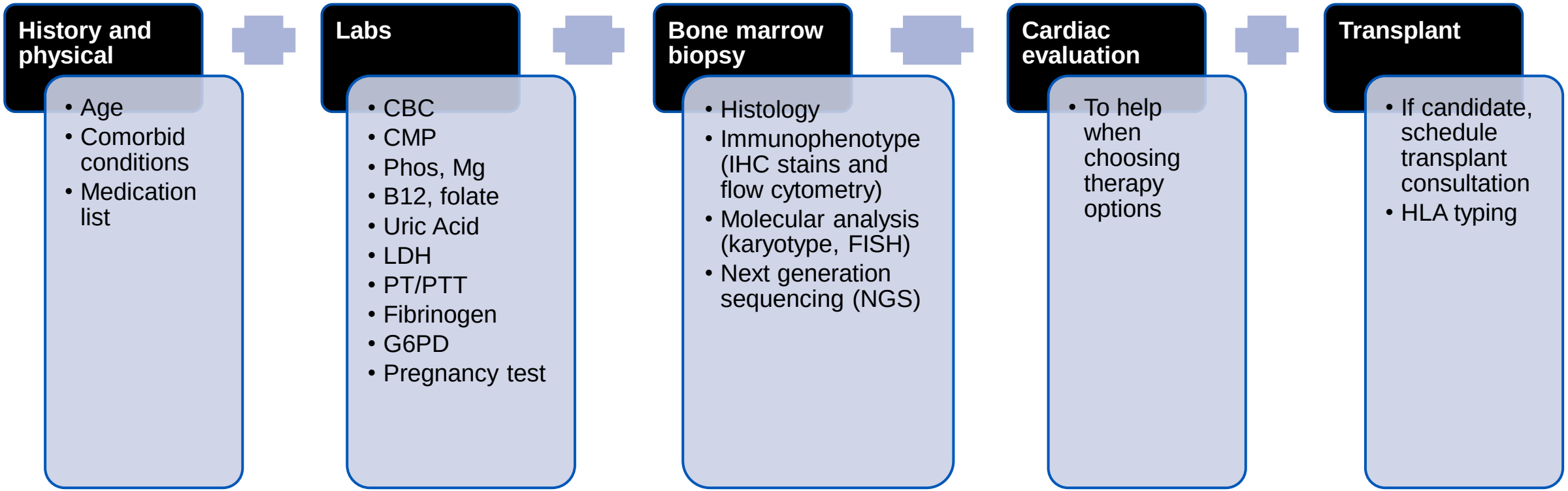
Neutropenia	Thrombocytopenia	Anemia

• Fever
• Infection
	• Bruising
	• Bleeding
	  • Gums
	  • Epistaxis
	  • Heavy menstruation
		• Fatigue
		• Feeling cold
		• Dyspnea on exertion
		• Dizziness
		• Chest pain
		• Pale skin

Other	bone/joint pain, hepatosplenomegaly, leukemia cutis, myeloid sarcoma, blood clots

Diagnostic Workup

NCCN Recommendations



Acute Myeloid Leukemia. NCCN Guidelines, Version 1.2021.

CBC: complete blood count, CMP: complete metabolic panel, LDH: lactate dehydrogenase, PT: prothrombin time, PTT: partial thromboplastin time, IHC: immunohistochemistry, FISH: fluorescence in situ hybridization, HLA: human leukocyte antigen

Diagnostic Workup

NCCN Recommendations

History and physical

- Age
- Comorbid conditions
- Medication list

Labs

- CBC
- CMP
- Phos, Mg
- B12, folate
- Uric Acid
- LDH
- PT/PTT
- Fibrinogen
- G6PD
- Pregnancy test

Bone mar biopsy

- Histol
- Immu (IHC s flow c
- Molec (karyo
- Next g seque

- **Histology**: how cells look under the microscope
- **Flow cytometry**: cell surface markers (i.e. CD33)
- **FISH**: large chromosomal changes (i.e. deletions, translocations)
- **NGS**: *FLT3, IDH1/2*, point mutations
- **Cytogenetics**: evaluation including information from FISH and NGS

Acute Myeloid Leukemia. NCCN Guidelines, Version 1.2021.

CBC: complete blood count, CMP: complete metabolic panel, LDH: lactate dehydrogenase, PT: prothrombin time, PTT: partial thromboplastin time, IHC: immunohistochemistry, FISH: fluorescence in situ hybridization, HLA: human leukocyte antigen

World Health Organization Classification

Acute myeloid leukemia and related neoplasms

≥20% blasts in marrow or blood OR <20% blasts with certain cytogenetic abnormalities*

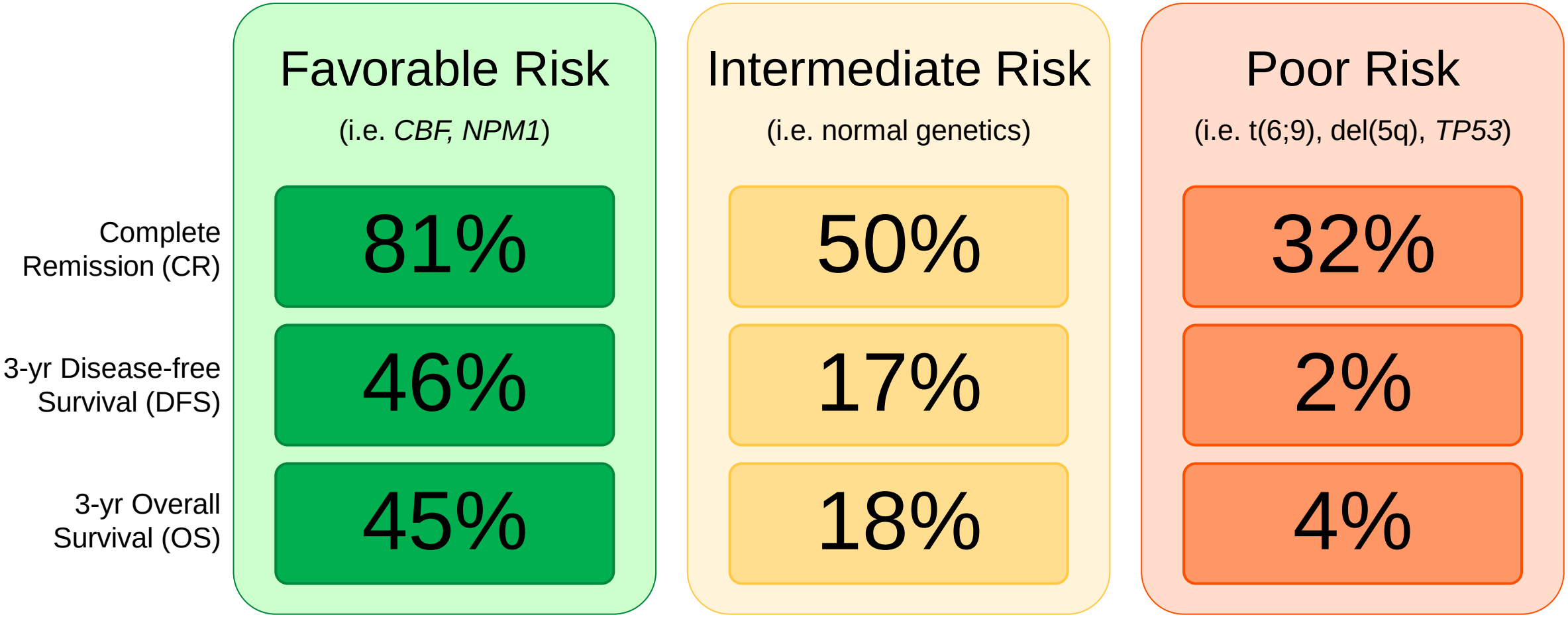
- AML with recurrent genetic abnormalities
- Therapy-related myeloid neoplasms
- Myeloid sarcoma
- AML with myelodysplasia-related changes
- Myeloid proliferations related to Down Syndrome
- AML, NOS
  - Acute myelomonocytic leukemia
  - Acute monoblastic/ monocytic leukemia
- Acute leukemias of ambiguous lineage

Blood. 2016;127(20):2391-2405.

*t(8;21)(q22;q22.1); *RUNX1-RUNX1T1*
*inv(16)(p13.1q22) or t(16;16)(p13.1;q22);*CBFB-MYH11*
*APL with *PML-RARA*

Prognosis Based on Cytogenetics

Outcomes with standard chemotherapy



Leukemia. 2018;32:1338-1348.

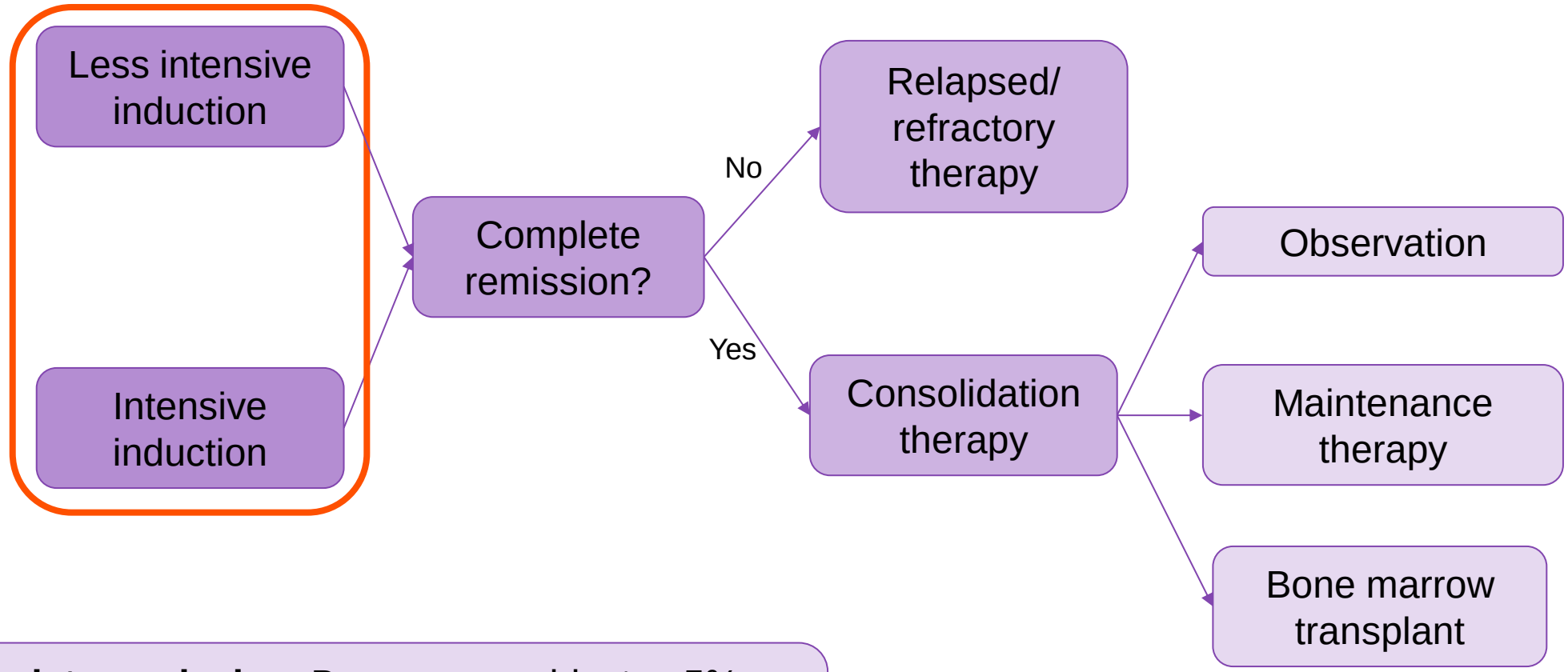
Question #1

- Which of the following is true about acute myeloid leukemia (AML)?
  - A. Cytogenetics play a key role in AML prognosis
  - B. Pathogenesis of AML begins with the common lymphoid progenitor
  - C. 5-year overall survival in AML is >80%
  - D. All patients with AML should receive intensive induction chemotherapy

2 AML Induction Treatment

Literature Review

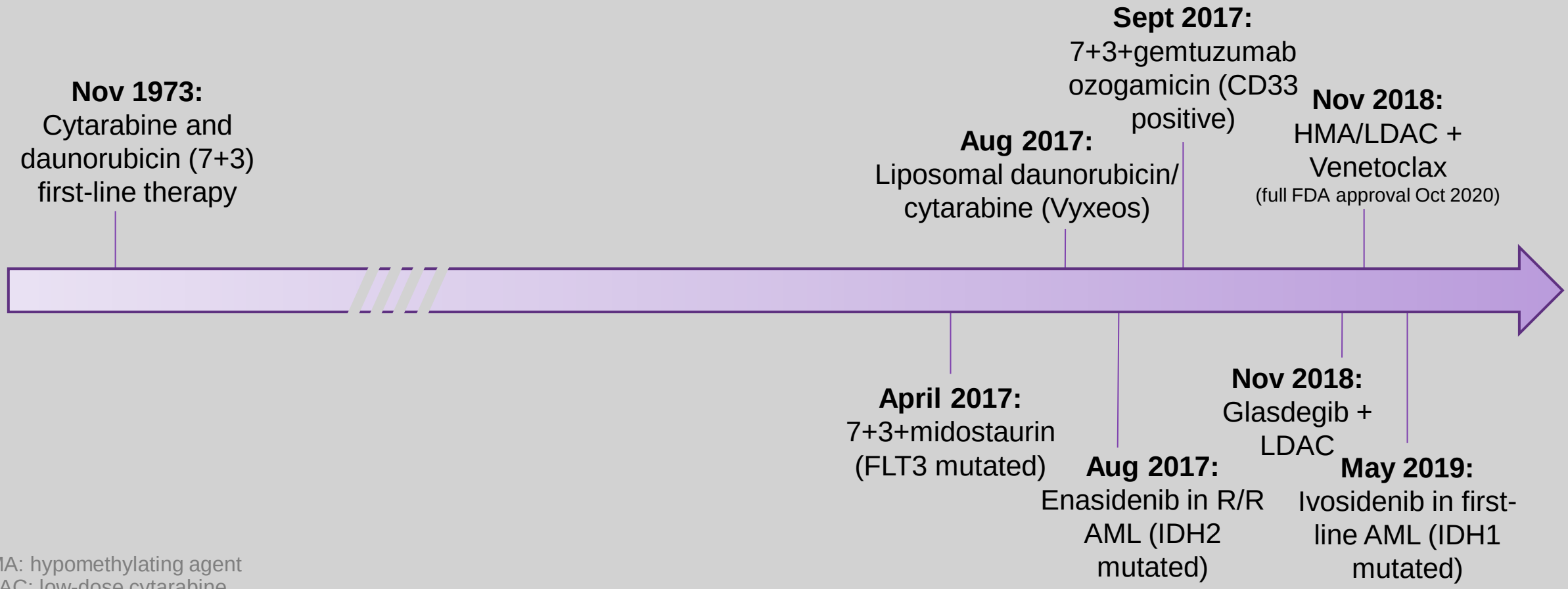
General AML Outline of Treatment



Complete remission: Bone marrow blasts <5%, no circulating blasts, absence of extramedullary disease; ANC ≥1.0 x10^9/L; platelets ≥100 x10^9/L

AML Induction Timeline

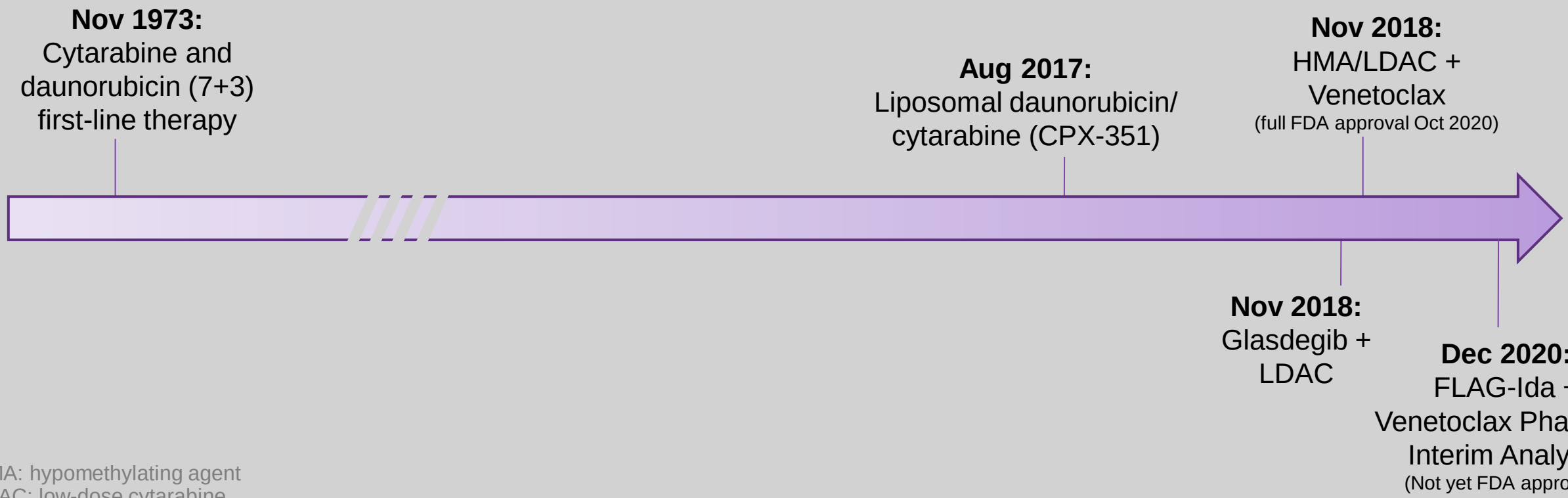
AML Induction Therapy Breakthroughs



HMA: hypomethylating agent
LDAC: low-dose cytarabine

AML Induction Timeline

AML Induction Therapy Breakthroughs

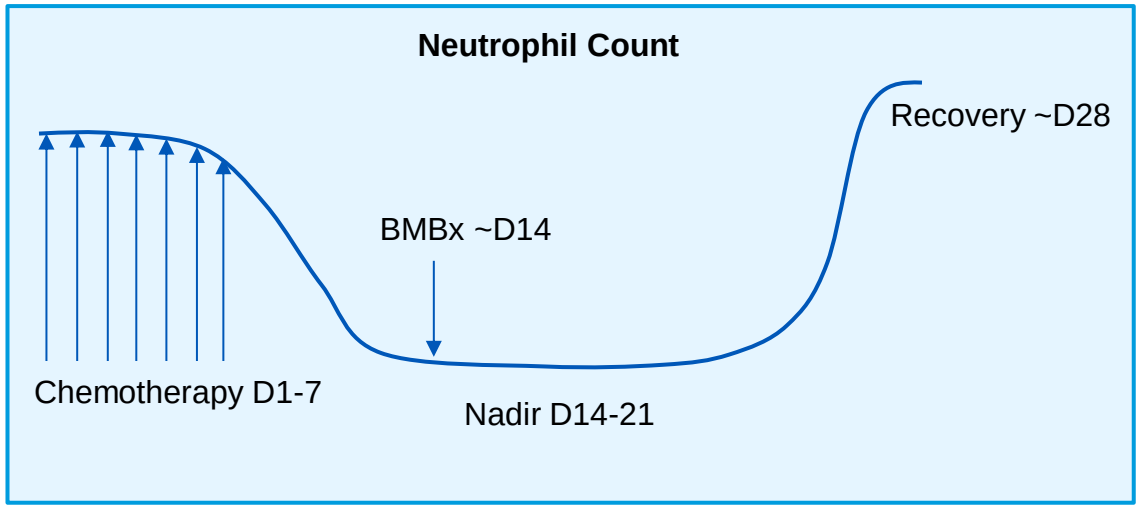


HMA: hypomethylating agent
LDAC: low-dose cytarabine
FLAG-Ida: fludaraine, cytarabine, idarubicin, growth colony stimulating factor

Cytarabine and Daunorubicin (7+3)

Regimen Pearls

- **Major adverse effects:**
  - Myelosuppression
  - Cardiomyopathy (daunorubicin)
  - Hepatotoxicity
  - Mucositis
  - Exanthematous pustulosis (cytarabine)
- **Recommended prophylaxis:**
  - Antiviral
  - Antibacterial with antipseudomonal coverage
  - Antifungal with antimold coverage



BMBx: bone marrow biopsy

Cytarabine + Daunorubicin (7+3)

Study Design

Inclusion/Exclusion

- All adult patients with acute nonlymphocytic leukemia at a single institution
- No previous treatment with daunorubicin
- Not in remission

Methods/Intervention

- Induction with cytarabine100mg/m^2/day via continuous infusion x7 days and daunorubicin 45mg/m^2 given on days 1, 2, and 3

Outcomes/Results (n=17)

- 5 of 8 previously untreated patients achieved CR
- 2 CR and 3 PR among 8 previously treated patients

Yates JW, et al. Cancer Chemother Rep. 1973 (57):485-488.

CR: complete remission, PR: partial remission

Cytarabine + Daunorubicin (7+3)

Daunorubicin 60mg/m2 vs. 90mg/m2

Study Objective

- Compare overall effectiveness of daunorubicin 90mg/m^2 vs. 60mg/m^2 for AML induction
- Given in combination with cytarabine 100mg/m^2

Included Patients

- 1206 patients were randomized to 60mg/m^2 vs. 90mg/m^2
- Majority <60 years old

Efficacy Results

- No difference in CR rate (73% vs. 75%, OR 1.07 [0.83-1.39]; P=0.6)

Safety Results

- 60-day mortality increased in 90mg/m^2 (10% vs. 5%, HR 1.98 [1.30-3.02]; P=0.001)
- No difference in 2-year OS

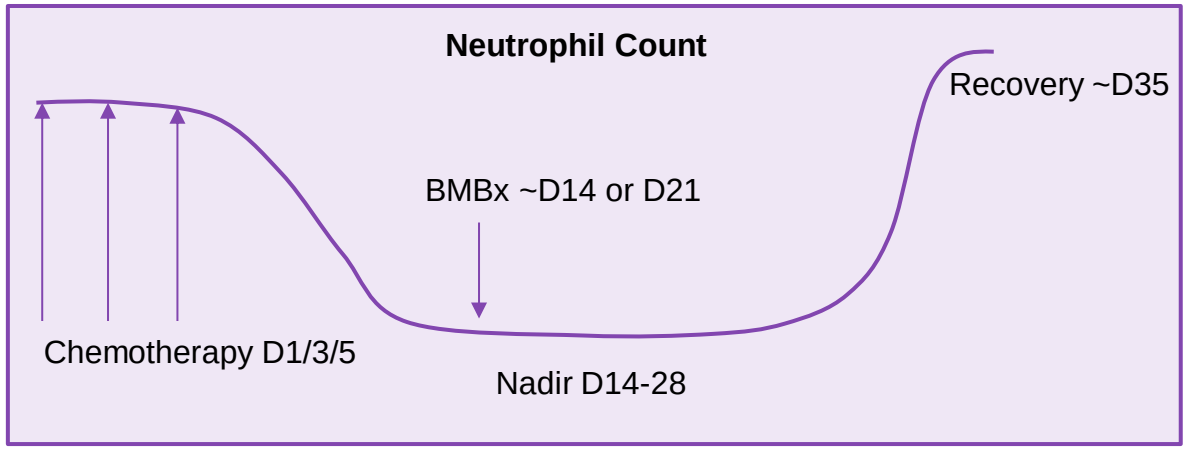
Burnett AK, et al. Blood. 2015; 125(25):3878-3885.

AML: acute myeloid leukemia, CR: complete remission, OR: odds ratio, OS: overall survival

Liposomal Daunorubicin/Cytarabine (CPX-351)

Drug Pearls

- ***Not interchangeable with other daunorubicin or cytarabine formulations***
  - Fixed 1:5 (daunorubicin : cytarabine) molar ratio
  - Enhanced uptake liposomal uptake by leukemia cells
- **Major adverse effects:**
  - Prolonged myelosuppression
  - Febrile neutropenia
  - GI toxicities
  - Skin rash
  - Cardiotoxicity
- **Recommended prophylaxis:**
  - Same as 7+3



BMBx: bone marrow biopsy

CPX-351 in Newly Diagnosed sAML

Study Design

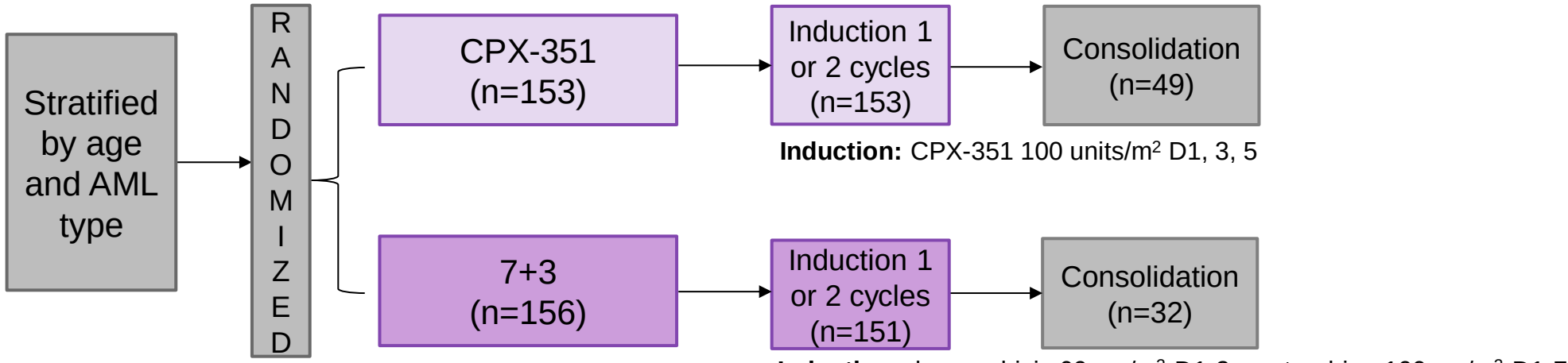
Inclusion/Exclusion

- Patients age 60-75 years old with newly diagnosed high-risk/secondary-AML per WHO 2008 criteria

Methods

- Multicenter, phase III, randomized, open-label study

Intervention



Lancet JE, et al. J Clin Oncol 2018;36(26):2684-2692.

sAML: secondary acute myeloid leukemia, WHO: World Health Organization

CPX-351 in Newly Diagnosed sAML

Results

- n=309, median age 68 years old
- Median follow up was 20.7 months

	CPX-351	7+3	Group comparison
OS	9.56 months	5.95 months	HR 0.69, 95% CI, 0.52 to 0.90; P=0.003
Overall Remission Rate (CR/CRi)	47.7%	33.3%	P=0.16
CR	37.3%	25.6%	P=0.040
EFS	2.53 months	1.31 months	HR 0.74; 95% CI, 0.58 to 0.96; P=0.021
Remission duration	6.93 months	6.11 months	P=0.291

OS: overall survival, CR: complete remission, CRi: complete remission with incomplete hematologic recovery, EFS: event-free survival

Lancet JE, et al. J Clin Oncol 2018;36(26):2684-2692.
Lancet JE, et al. Abstract 635 in ASH Annual Meeting; Dec 5-8, 2020.

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Overall Remission (CR/CRi)			
CR			
EFS			
Remission duration	6.93 months	6.11 months	P=0.291

5-year follow up data:
Median OS 9.33 months vs. 5.95 months
(HR 0.70; 95% CI, 0.55 to 0.91)

OS: overall survival, CR: complete remission, CRi: complete remission with incomplete hematologic recovery, EFS: event-free survival

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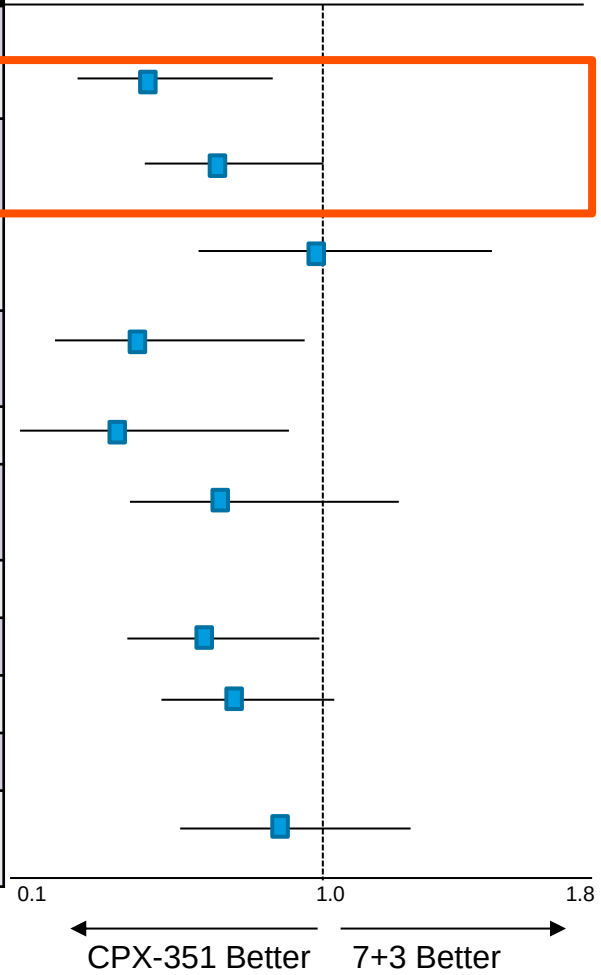
CPX-351 in Newly Diagnosed sAML

Subgroup Analysis Results

Subgroup	CPX-351 Median OS, mos	7+3 Median OS, mos	HR (95% CI) for Death
Type of AML			
Therapy-related AML	12.17	5.95	0.48 (0.26 to 0.86)
AML with antecedent MDS or CMML	7.38	5.95	0.70 (0.50 to 0.99)
MDS with prior HMA exposure	5.56	7.43	0.98 (0.64 to 1.51)
MDS without prior HMA exposure	15.74	5.13	0.46 (0.21 to 0.97)
CMML	9.33	2.28	0.37 (0.14 to 0.95)
De novo AML with MDS karyotype	10.09	7.36	0.71 (0.42 to 1.20)
Cytogenetic risk at screening			
Favorable/intermediate	14.72	8.41	0.64 (0.41 to 0.99)
Unfavorable	6.60	5.16	0.73 (0.51 to 1.06)
Overall HMA experience			
All patients with prior HMA exposure	5.56	5.90	0.86 (0.59 to 1.26)



MDS: myelodysplastic syndrome, CMML: chronic myelomonocytic leukemia, HMA: hypomethylating agent, OS: overall survival

Lancet JE, et al. J Clin Oncol 2018;36(26):2684-2692.
Prebet T, et al. Abstract 2844 in ASH Annual Meeting; Dec 5-8. 2020.

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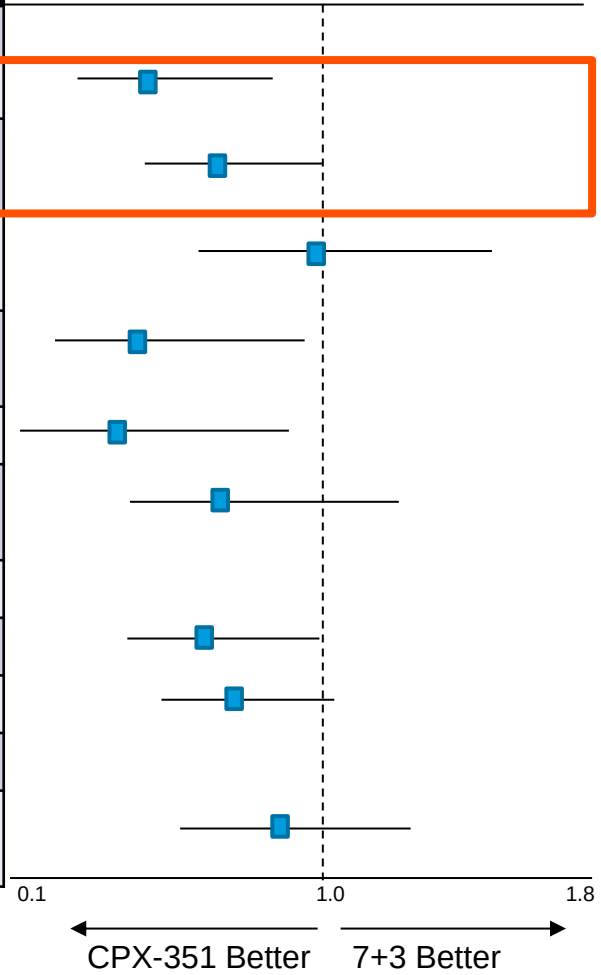


***TP53* mutations in the adverse-risk group**

Median OS was 5.7 months with CPX-351 (n = 24/99) vs. 5.1 months with 7+3 (n = 31/100)

HR = 1.00 [95% CI: 0.57, 1.75]

Without *TP53* mutations in the adverse-risk group

Median OS was 9.6 vs 5.6 months

HR = 0.55 [95% CI: 0.38, 0.81]

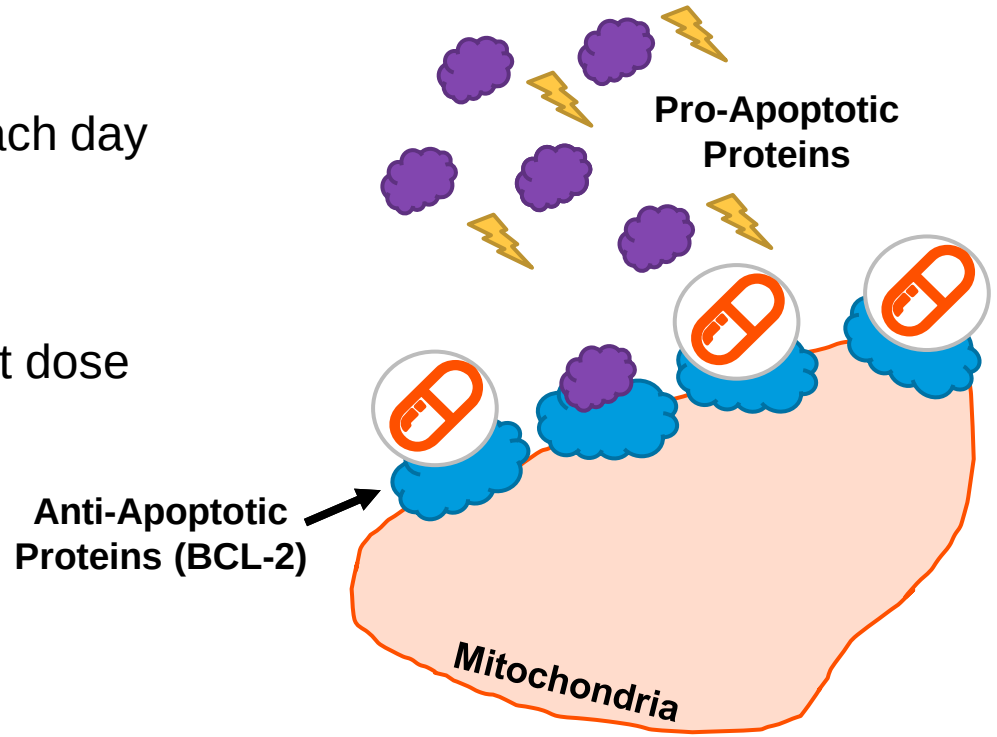
MDS: myelodysplastic syndrome, CMML: chronic myelomonocytic leukemia, HMA: hypomethylating agent, OS: overall survival

Lancet JE, et al. J Clin Oncol 2018;36(26):2684-2692.
Prebet T, et al. Abstract 2844 in ASH Annual Meeting; Dec 5-8. 2020.e-25

Venetoclax

Drug Pearls

- **Mechanism**: BCL2 inhibitor
- Administer with a meal and water at the same time each day
- **Tumor lysis syndrome risk:**
  - Hydroxyurea for WBC ≥ 25 x10^9/L
  - Prophylactic hydration and allopurinol prior to first dose
  - Utilize ramp up schedule based on target dose
  - Adjust dose based on antifungal prophylaxis
- **Caution:**
  - CYP3A4 substrate (major)
  - P-glycoprotein substrate (minor)



VIALE-A: Azacitidine + Venetoclax

Study Design

Inclusion/Exclusion

- Patients ≥18 years old with previously untreated AML who were ineligible for standard induction therapy
  - Due to comorbid conditions or being ≥75 years old
  - Excluded patients with favorable genetics

Methods

- Phase III, multicenter, randomized, double-blind, placebo-controlled trial

Intervention

- Randomized 2:1 to receive azacitidine 75mg/m^2 on days 1-7 + venetoclax daily (target dose 400mg) or placebo

Outcomes

- Primary: overall survival
- Secondary: multiple efficacy and safety outcomes, patient-reported quality of life

DiNardo CD, et al. N Engl J Med 2020.383:617-629.

VIALE-A: Azacitidine + Venetoclax

Results

- n=431, median age 76 years old
- Median duration of follow-up was 20.5 months (range <0.1 to 30.7)

	Azacitidine-Venetoclax N=286	Azacitidine-Placebo N=145	Comparison
Median OS, months	14.7	9.6	HR death, 0.66 95% CI, 0.52 to 0.85; p<0.001
Composite CR	66.4%	28.3%	P<0.001
Median time to first response, months	1.3	2.8	
Median duration of response, months	17.5	13.4	
CR	36.7%	17.9%	P<0.001

- Rates of adverse effects were consistent with each agent used and population treated

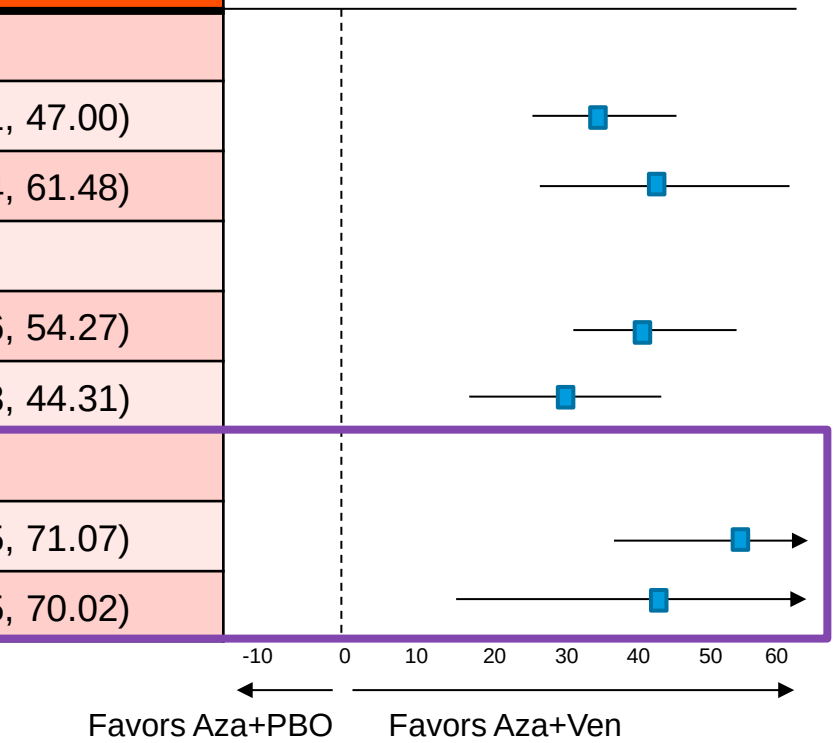
DiNardo CD, et al. N Engl J Med 2020.383:617-629.

OS: overall survival, CR: complete response

VIALE-A: Azacitidine + Venetoclax

Subgroup Analysis

Subgroup	Aza+Ven n/N (%)	Aza+PBO n/N (%)	Risk Difference (95% CI) for CR/CRi
Type of AML			
De novo	142/214 (66.4)	33/110 (30.0)	36.36 (25.71, 47.00)
Secondary	48/72 (66.7)	8/35 (22.9)	43.81 (26.14, 61.48)
Cytogenetic risk			
Intermediate	135/182 (74.2)	28/89 (31.5)	42.72 (31.16, 54.27)
Poor	55/104 (52.9)	13/56 (23.2)	29.67 (15.03, 44.31)
Molecular marker			
TP53	21/38 (55.3)	0/14	55.26 (39.45, 71.07)
NPM1	18/27 (66.7)	4/17 (23.5)	43.14 (16.25, 70.02)



DiNardo CD, et al. N Engl J Med 2020.383:617-629.

Aza: azacitidine, Ven: venetoclax, PBO: placebo, OS: overall survival, CR: complete response, CRi: complete response with incomplete blood count recovery

VIALE-C: Low-dose Cytarabine + Venetoclax

Study Design

Inclusion/Exclusion

- Adult patients with AML ineligible for intensive chemotherapy

Methods

- International, phase 3, randomized, double-blind, placebo-controlled trial

Intervention

- Randomized 2:1 to receive venetoclax or placebo in 28 day cycles + low-dose cytarabine D1-10

Outcomes

- Primary: overall survival
- Secondary: response rate, transfusion independence, event-free survival

Wei AH, et al. Blood 2020; 135(24): 2137-2145.

VIALE-C: Low-dose Cytarabine + Venetoclax

Results

- n=211, median age 76 years old
- Median duration of follow-up was 12.0 months (range 0.1-17.6 months)

	LDAC-Venetoclax N=143	LDAC-placebo N=68	Comparison
Median OS, months (at pre-planned analysis)	7.2	4.1	HR 0.75 (95% CI, 0.52-1.07) P=0.11
Median OS, months (additional 6 mo. follow-up)	8.4	4.1	HR 0.70 (95% CI, 0.50-0.99) P=0.04
Composite CR by initiation of cycle 2	48%	13%	P<0.001
CR	27%	7%	P<0.001

- Rates of adverse effects were consistent with each agent used and population treated

Wei AH, et al. Blood 2020; 135(24): 2137-2145.

CR: complete remission, LDAC: low-dose cytarabine, OS: overall survival

VIALE-C: Low-dose Cytarabine + Venetoclax

Subgroup Analysis

Subgroup Response Rates (CR/CRi)	LDAC+Ven n/N (%)	LDAC+PBO n/N (%)
Type of AML		
De novo	47/85 (55)	8/45 (18)
Secondary	21/58 (36)	1/23 (4)
Cytogenetic risk		
Intermediate	50/90 (56)	7/43 (16)
Poor	13/47 (28)	2/20 (10)
Molecular markers		
TP53	4/22 (18)	0/9
NPM1	14/18 (78)	4/7 (57)

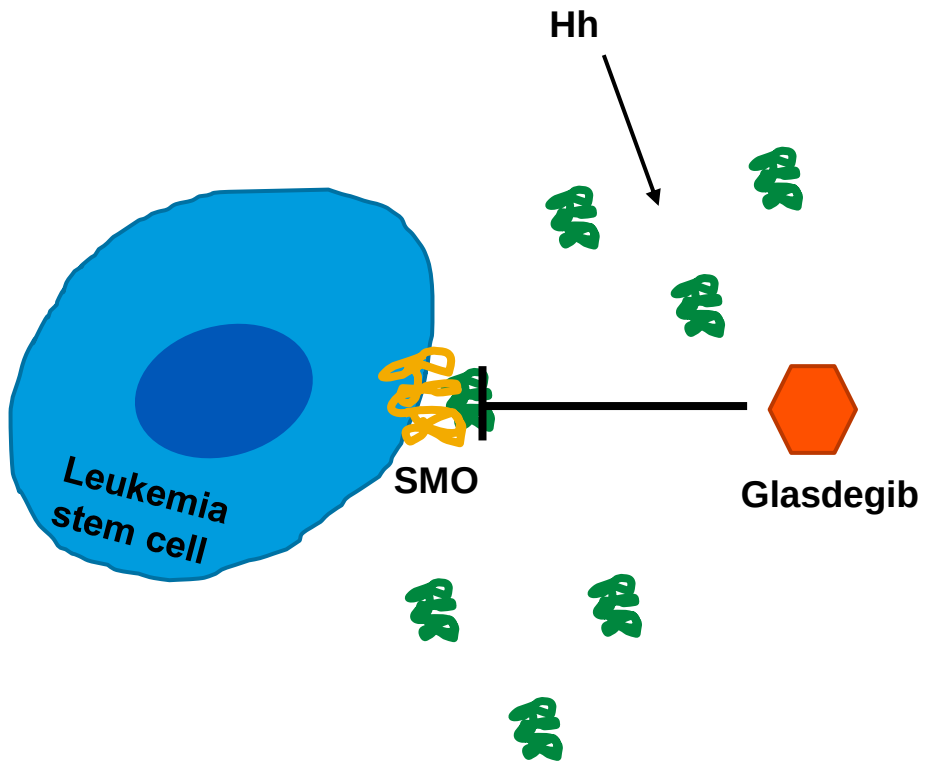
Wei AH, et al. Blood 2020; 135(24): 2137-2145.

LDAC: low dose cytarabine, Ven: venetoclax, PBO: placebo, CR: complete response, CRi: complete response with incomplete blood count recovery

Glasdegib

Drug Pearls

- **Mechanism**: hedgehog inhibitor
- Take at the same time each day with or without food
- **Adverse effects:**
  - Electrolyte abnormalities
  - GI upset
  - Transaminitis, increased serum creatinine
  - Muscle pain
  - QTc prolongation
- **Other considerations:**
  - Major CYP3A4 substrate
  - Treat for minimum 6 cycles to allow time for clinical response



BRIGHT AML 1003: Low-dose Cytarabine + Glasdegib

Study Design

Inclusion/Exclusion

- Adult patients with AML or high-risk MDS ineligible for intensive chemotherapy
  - Age ≥ 75 years
  - ECOG performance status 2+
  - Serum creatinine >1.3 mg/dL
  - Severe cardiac disease

Methods

- Phase II, open-label, multicenter trial

Intervention

- Randomized 2:1 to received cytarabine 20mg SQ BID x10 days +/- glasdegib 100mg PO daily in 28 day cycles

Outcomes

- Primary: overall survival

Cortes JE, et al. Leukemia 2019; 33:379-389.

LDAC: low-dose cytarabine, MDS: myelodysplastic syndrome

BRIGHT AML 1003: Low-dose Cytarabine + Glasdegib

Results

- n=132, median age 76 years old
- Median duration of follow-up was 20.1-21.7 months

	LDAC-Glasdegib N=88	LDAC N=44	Comparison
Median OS, months	8.8	4.9	HR 0.51 (80% CI, 0.39-0.67) P=0.0004
CR	17.0%	2.3%	P<0.05
Duration of treatment, months	2.7	1.5	
Duration of response, months	9.9	NR	

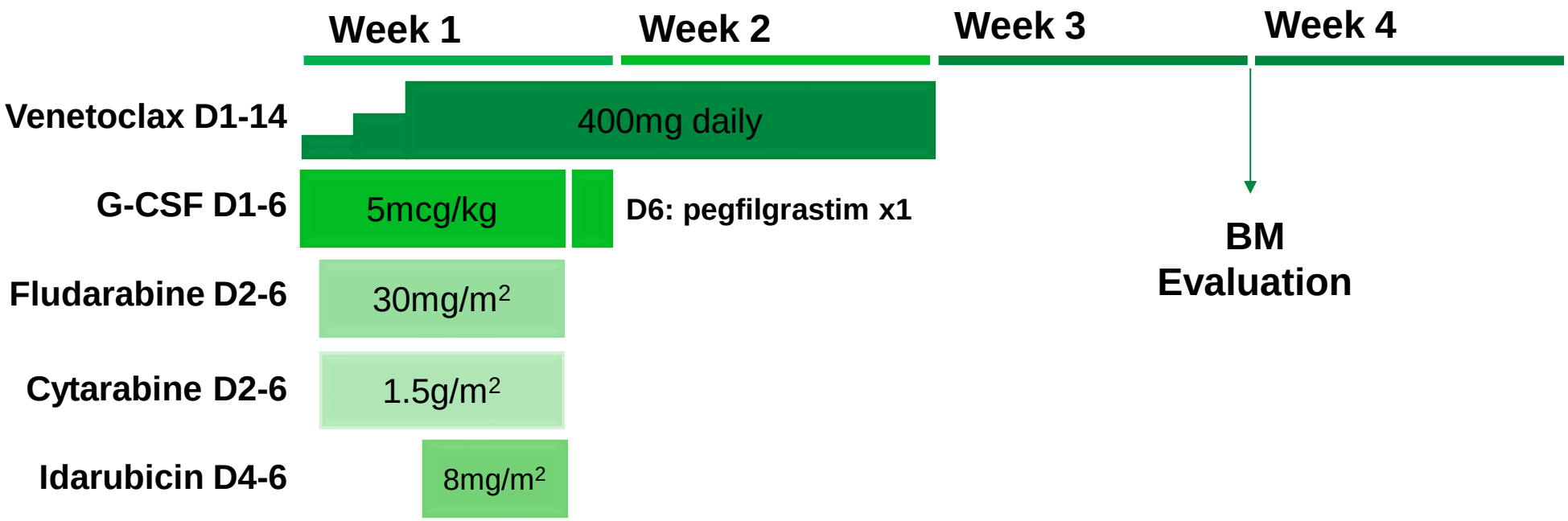
- 56.0% of patients in the LDAC/glasdegib vs. 31.7% of the LDAC group temporarily discontinued treatment due to adverse effects

Cortes JE, et al. Leukemia 2019; 33:379-389.

CR: complete remission, LDAC: low-dose cytarabine,
NR: not reported, OS: overall survival

FLAG-Ida-Venetoclax

Regimen Schema



G-CSF: growth-colony stimulating factor, ND: new diagnosis, R/R: relapsed/refractory, BM: bone marrow

FLAG-Ida-Venetoclax

Study Design

Inclusion/Exclusion

- Adult patients with newly diagnosed (ND) or relapsed/refractory (R/R) AML

Methods

- Phase Ib dose escalation included R/R AML
- Phase II dose expansion included 2 arms (ND and R/R)

Outcomes

- Primary: assessment of safety and tolerability, determination of dose limiting toxicities, maximal tolerated dose
- Secondary: ORR, OS, EFS, duration of response, biomarkers predictive of response

Lachowiez C, et al. ASH Abstract 332. 2020.

FLAG-Ida: fludarabine, cytarabine, growth-colony stimulating factor, idarubicin; R/R: relapsed/refractory, ORR: overall response rate, OS: overall survival, EFS: event free survival

FLAG-Ida-Venetoclax

Results

FLAG-Ida CR Comparison:
de novo **85%**
R/R **21%**

	All patients (n=62)	Phase 2A (ND AML; N=27)	Phase Ib & Phase 2B (R/R AML; n=35)
ORR	84%	89%	66%
MRD negative CR	83%	96%	70%
1-yr OS		92%	52%
Median OS	NR	NR	11 months
EFS	16 months		

- Grade 3/4 ADRs: febrile neutropenia (37%), bacteremia (29%), hypophosphatemia (24%), pneumonia (21%), SSTI (16%), increased ALT (11%)
- 30-day mortality = 0%, 60-day mortality = 4.8%
  - Only R/R AML patients to date

Lachowiez C, et al. Abstract 332 in ASH Annual Meeting; Dec 5-8, 2020.

ORR: overall response rate, CR: complete response, MRD: minimal residual disease, OS: overall survival, EFS: event free survival, ND: newly diagnosed, NR: not reported, R/R: relapsed/refractory, SSTI: skin/soft tissue infection

FLAG-Ida-Venetoclax

TP53 Mutated AML

TP53 Outcomes	All patients (n=10)	ND AML (n=3)	R/R AML (n=7)
ORR	6 (60%)	3 (100%)	3 (43%)
CRc	6 (60%)	3 (100%)	3 (43%)
DOR (months, 95% CI)	3.3 (1.9 – NE)	3.4 (1.9 – NE)	3.2 (1.8 – NE)
Deceased	5 (50%)	1 (33%)	4 (57%)

Lachowiez C, et al. Abstract 332 in ASH Annual Meeting; Dec 5-8, 2020.

ORR: overall response rate, CRc: composite complete response, DOR: duration of response, ND: newly diagnosed, R/R: relapsed/refractory

3 Selecting AML Induction Regimen

Based on Patient-Specific Factors

Factors to Consider

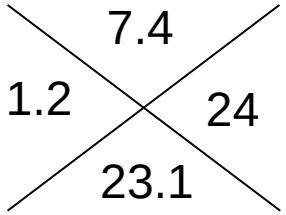
When Choosing Induction Regimens

7+3	CPX-351	Flag-Ida-Ven	Aza/Ven	LDAC/Ven	Glasdegib/ LDAC
Fit Younger	Fit 60-75 years old	Fit Younger	Unfit ≥75 years old	Unfit ≥75 years old	Unfit ≥75 years old
Anthracycline eligible	Anthracycline eligible tAML, AML-MRC Negative *TP53* mutated data	Need more data to determine place in therapy	Positive *TP53* mutated data	Less favorable *TP53* mutated data	Poor overall response rate *TP53* data unavailable

tAML: treatment-related acute myeloid leukemia, AML-MRC: acute myeloid leukemia with myelodysplastic changes, 7+3: cytarabine + daunorubicin, Aza: azacytidine, Ven: venetoclax, LDAC: low-dose cytarabine

Patient Case, 39 YO/M

- 39 YO/M presents to ED with complaints of SOB on exertion, fatigue, easy bruising
- PMH: HLD
- Labs:
  - ANC 0.4 cells/µL
  - 34% circulating blasts
  - SCr 0.7 mg/dL
  - LFTs, T. bili WNL

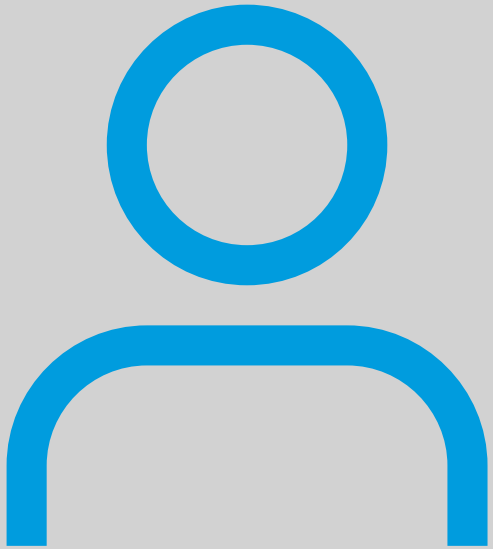


- Bone marrow biopsy: consistent with AML
  - Hypercellular marrow, 60% blasts
  - Cytogenetics: t(6;9), *FLT3* negative

Young, otherwise healthy

Good renal and hepatic function

Poor risk cytogenetics, no actionable mutations



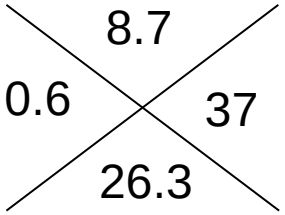
SOB: shortness of breath, HLD: hyperlipidemia, ANC: absolute neutrophil count, WNL: within normal limits

Question #2

- Given this patient case, what AML induction regimen would you choose for this patient?
  A. Liposomal daunorubicin/cytarabine (CPX-351)
  B. Cytarabine + daunorubicin (7+3)
  C. Azacitidine/Venetoclax
  D. Low-dose cytarabine/glasdegib

Patient Case, 74 YO/F

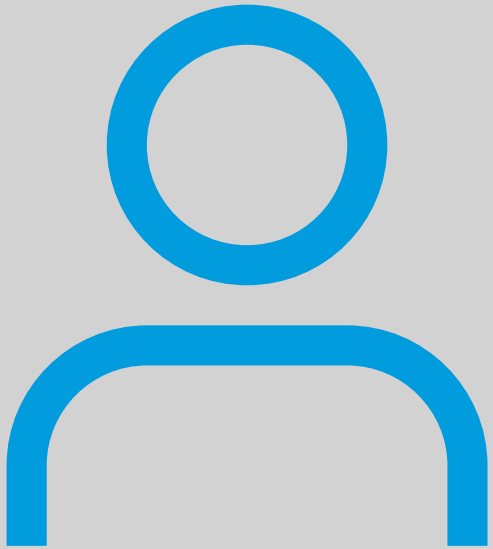
- 74 YO/F presents to ED with fevers, chest pain, and dyspnea on exertion
- PMH: hx breast cancer s/p dose-dense AC x4 cycles and bilateral mastectomy (2015), HTN, CHF with LVEF 40%, hx MI (2018), CKD stage 3
- Labs:
  - ANC 0.2 cells/µL
  - 5% circulating blasts
  - SCr 1.8 mg/dL
  - LFTs, T. bili WNL



- Bone marrow biopsy: consistent with therapy-related AML
  - Hypercellular marrow, 27% blasts
  - Cytogenetics: *TP53* mutated, *FLT3* negative

Older, multiple comorbidities

Impaired renal function



Poor risk cytogenetics, no actionable mutations, treatment-related AML

AC: doxorubicin and cyclophosphamide, HTN: hypertension, CHF: chronic heart failure, LVEF: left ventricular ejection fraction, MI: myocardial infarction, CKD: chronic kidney disease, WNL: within normal limits

Question #3

- Given this patient case, what AML induction regimen would you choose for this patient?
  A. Liposomal daunorubicin/cytarabine (CPX-351)
  B. Cytarabine + daunorubicin (7+3)
  C. Azacitidine/Venetoclax
  D. Low-dose cytarabine/glasdegib

SUMMARY

- AML accounts for approximately 1.1% of all new cancer cases per year
- Recent advances in AML treatment have expanded options beyond 7+3 for patients without targetable mutations
- Considering patient-specific factors is important when choosing an AML induction regimen

QUESTIONS & DISCUSSION