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Case Discussion: What JAK Inhibitor Should I Use in a Transfusion-Dependent Patient With MF With Platelets > 50 × 10^9/L?

Announcer:
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Dr. Mascarenhas:
Hi. This is CME on ReachMD, and I'm Dr. John Mascarenhas. It's a pleasure to be here today with Dr. Gabriela Hobbs to discuss this common situation we encounter when using ruxolitinib to treat our patients with myelofibrosis.

Gaby, thanks for joining us.

Dr. Hobbs:
Hi John, happy to be here.

Dr. Mascarenhas:
So the case we're talking about today is an older woman who's not a transplant candidate, with systemic symptoms and a large spleen, and counts that are borderline: white count 9,000, hemoglobin 7.5, platelets 90,000, has a marrow that's consistent with myelofibrosis that's JAK2 mutated, comes to you. What would you do in a patient like this that clearly needs treatment?

Dr. Hobbs:
So this is a patient, as you said, that clearly needs treatment because she has systemic symptoms and an enlarged spleen, and unfortunately, is not a transplant candidate, so she definitely needs a JAK inhibitor. Not so long ago, I would have said that the JAK inhibitor to use was the only one available, and that would be ruxolitinib, but I would be hesitant to make her transfusion dependent. So my answer to that has probably changed in the last couple of years, and I would be more likely to start her on momelotinib because of her anemia or pacritinib because of her thrombocytopenia and also ability to improve hemoglobin.

Dr. Mascarenhas:
All right. In this case, this woman was started on ruxolitinib, had improvement in spleen and symptom burden, but continues to have anemia and transfusion dependence and thrombocytopenia. So it really leads to this situation we see with ruxolitinib, where you can have spleen and symptom control but still have anemia versus having spleen and symptom that's not well controlled and anemia. And how do you make that decision? And at what point do you make it with ruxolitinib? When do you make a decision about switching therapy or adding on?

Dr. Hobbs:
Yeah, that's a great question. So if I have a patient like this one who came in with a lot of symptoms and an enlarged spleen, and her symptoms and splenomegaly have clearly almost resolved with ruxolitinib, then I would be hesitant to take her off of the ruxolitinib and put her on another JAK inhibitor. And so then I would favor starting another agent on top of the ruxolitinib, such as an erythropoietin-

stimulating agent, danazol, or luspatercept.

Now, if I have a patient where her symptoms haven't been well controlled, or her spleen is not well controlled, or she's having any other issues where ruxolitinib maybe is not well tolerated, or I feel like I would like to increase the dose of ruxolitinib but can't because of the cytopenias, then I would be much more inclined to switch her off of the ruxolitinib to one of the newer JAK inhibitors, like pacritinib and momelotinib, that have the ability of improving hemoglobin.

Dr. Mascarenhas:
And maybe just for the listeners, what's the shortest amount of time on rux till you make that decision to switch?

Dr. Hobbs:
Yeah, so I think that has also evolved now that we have different treatment options. And so after being on ruxolitinib for a couple of months, I would say, you know, 3 to 4 months, you know that you've gotten to the maximum dose with that patient, it's important to allow that hemoglobin to drop in the first month and then see if it improves, because we do see that dip with ruxolitinib initially, and then some patients recover. So I think that before a month is too soon, before 2 months is too soon, but I would give it a couple of months, like 3 to 4 months.

Dr. Mascarenhas:
Perfect. So with that, our time is up. I want to thank Dr. Hobbs for joining us for this discussion, and thanks for all the input.

Dr. Hobbs:
Thank you so much.

Announcer:
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