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Pacritinib for Myelofibrosis Across the Cytopenic Spectrum

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Mascarenhas:
This is CME on ReachMD, and I'm Dr. John Mascarenhas. Today, I'm reviewing the efficacy of pacritinib in reducing both spleen volume and symptoms in patients with myelofibrosis and low platelet counts.

So from the PERSIST-2 study, which was the randomized phase 3 study evaluating pacritinib versus best available therapy [BAT] in patients with platelet counts less than 100,000, we saw that there was significant spleen volume response with pacritinib at 200 mg twice daily in the intention-to-treat population in 22% of patients, versus 3% in the BAT, which also included half the patients received low-dose ruxolitinib. I should point out that these patients were, in half the cases, rux-treated previously. The symptom improvement was also statistically significantly better with pacritinib at 200 mg twice daily, 35% versus 14% with BAT. And that was in the total population of less than 100,000 patients, a cytopenic profile. But even if you looked at patients with less than 50,000, the results still remained robust in favor of pacritinib with 29% versus 3%, SVR 35%. And from a symptom perspective, 26% versus 9%. So a drug that can offer both spleen and symptom benefit across the cytopenic platelet spectrum.

Now what we hadn't originally appreciated, which became more obvious over time and with more evaluation, is the ability for pacritinib to afford anemia improvement. So transfusion reduction by 50% or greater was attained at 50% of patients treated with pacritinib at 200 mg twice daily versus 9%. And that was irrespective of whether the patient was rux naïve, had platelet count less than 50,000, or had a high or low JAK2 V617F allele burden. In fact, even in the BAT arm, where 11 patients received erythropoiesis stimulating agents, pacritinib still had a benefit in terms of reduction in transfusion requirements.

If one looks at the Gale criteria for transfusion independence, so 12 weeks of not needing a red cell transfusion at any hemoglobin, pacritinib had a response rate of 37% versus 7% in BAT. Again, irrespective of whether the patients were rux naïve, had low platelets less than 50,000, or had a high or low JAK2 allele burden.

If one looks at the time to transfusion conversion, transfusion dependence to independence conversion, that can happen within the first several months, but there are some patients that require longer treatment. So the learning point here is to be patient because those responses can take, in some cases, over 6 months to see that transfusion independence.

So in summary, pacritinib is a drug, a JAK2 inhibitor, that can be given to patients with low platelets, irrespective of the platelet count, that can afford both spleen and symptom benefit and is associated with anemia responses both from a transfusion reduction standpoint, but also a transfusion independence, conversion from dependence. And that can happen either within the first couple of months, or in some cases, longer. So one needs to be patient when expecting that anemia response in those patients.

Well, my time is up. I hope I've given you something to think about. And thank you again for listening.

Announcer:
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