IWMF NEWSLETTER

# TORCH

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## INSIDE THIS ISSUE

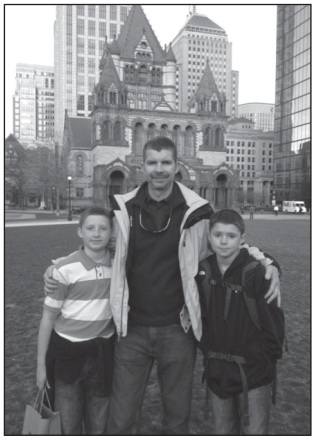


# LIFE INSIDE THE TRIAL THE CAREGIVER'S PERSPECTIVE

BY SUE DRAKE

I couldn't pronounce it, much less spell it. When the oncologist called at 9 pm on May 9, 2012, to explain the diagnosis of Waldenstrom's macroglobulinemia, I just could not process that my 43-year-old husband had a very rare, incurable lymphoma. What I did understand is that I finally had a name for the thief that had stolen my best friend over four months previously. To reclaim him, the oncologist scheduled Jeff for the best frontline treatments currently available. When Velcade and Rituxan failed to slow his rapidly escalating IgM, bendamustine was next in line. It too failed to produce any positive results, and Jeff had to rely on plasmapheresis as a treatment while the oncologist stepped back in the war room to plot another course. Fludaribine seemed a bit scary to us, and the oncologist asked if we would consider a clinical trial instead. That rather simple inquiry was the beginning to the clinical trial journey that quite literally saved Jeff's life.

Jeff has now been part of the Dana-Farber ibrutinib (Imbruvica) trial since November 2012. While I don't want to take anything away from the drug that handcuffed the thief, it is the clinical trial itself that provided the framework for us to receive ibrutinib. Perhaps you are a caregiver who is curious about what a trial entails, or perhaps you are like my husband, wondering if a trial is a viable option for you. Or maybe you are just a sucker for a happy ending. Regardless, I'll try to give you a good picture of trial life from a caregiver's perspective and tell you in advance that the hero *lives*. Nicholas Sparks, eat your heart out.



*Jeff Drake and sons in Copley Square, Boston. A participant in the clinical trial of Imbruvica (ibrutinib) at Dana-Farber Cancer Institute, Jeff travels periodically to Boston. While Sue Drake regularly accompanies her husband to his appointments, occasionally the whole family comes along and makes a day of it sightseeing in Boston and enjoying favorite eateries for a snack or a meal.*

I won't lie to you. A certain element of doubt and fear enters the mind when considering an unproven course of treatment. Side effects, efficacy, future toxicities – all of these unknowns cause understandable trepidation. However, there is also the possibility that this experimental treatment just might work, and that possibility brings blessed hope. Either emotional spectrum taken to an extreme could be dangerous to both patient and caregiver; thus, fear and hope become awkward partners who often switch leads. The dance can be tiresome at times, but there is also a sense of peace that comes from knowing the patient is under the close scrutiny of a top-notch team for the length of the trial. Being on the radar screen of a premier cancer facility certainly has its appeal.

Participating in a trial also comes with some extra demands on schedules and freedom. When you sign your name on the dotted line, you are agreeing to the trial protocols which determine how often a participant will visit the trial facility, as well as the frequency and types of tests that are run. Clinical visits and tests are usually more frequent at the beginning of the trial, and then even out as the trial progresses. Jeff now visits Dana-Farber every three months as opposed to monthly visits. These visits become the driving force of the family calendar; vacations, the

*Life Inside the Trial, cont. on page 2*

*Life Inside the Trial, cont. from page 1*

*The Drake family, March 2015, flew in from Charlotte and was obviously prepared for the long and cold winter of this year in Boston.*

activities of our two adolescent boys, and responsibilities at work all take a back seat to the timing of his Boston visits. Any long-range planning must include the trial calendar. No exceptions.

As for the tests, extra CT scans, bone marrow biopsies, and lab work are part of the schedule and sometimes require that we stay overnight in Boston because of the amount of time spent at the trial facility in one day. The extra procedures do cause anxiety for both of us as the BMBs are not on our fun-list, and the CT scans *are* radiation regardless of how safe I believe they are. Like I said before, when agreeing to a trial, you agree to the protocols. The decisions that you would make in partnership with your primary oncologist become decisions that have been pre-determined for the time period of the trial. While control addicts may be a bit uneasy, the highly regulated and monitored progress is both interesting and comforting.

Depending on where the trial is, travel can be an issue – both with time and expenses. Because we must fly from Charlotte to Boston for each visit, travel planning and budgeting is both time-consuming and critical. Flights, ground transport, and hotels are not covered for the patient so these must be absorbed by the family budget. As we have chosen for me to attend each visit, the cost increases and over half of my annual personal leave is allotted in advance to Boston trips. We try to mitigate the costs by utilizing public transportation instead of taxis, staying in hotels that offer discounted rates for hospital patients (clinical trials count), and making use of a credit card that allows us to earn frequent flyer miles.

Whether we stay overnight depends on the visit requirements. Most are easy visits that require lab work and a clinical check only. For these, we fly up to Boston early, ride the "T" (Boston's subway) to Longwood Medical area, walk a half mile to Dana-Farber, and check in for lab work on the second floor of the Yawkey building. Then it's up to the seventh floor to the Bing Center for Waldenstrom's Macroglobulinemia. A nurse records his vitals and we wait to see the trial representatives, usually a nurse practitioner and a research assistant. The NP goes over any lab work that has returned, an updated medication list, and we discuss any issues, questions, or concerns that have come up

*Life Inside the Trial, cont. on page 3*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since the last visit. Jeff turns in his trial diary, which is a daily record of time, dose, and any symptoms from visit to visit, and the NP gives Jeff a physical exam. The research assistant gives Jeff a new trial diary, we leave the exam room to make the next appointment, and then it's off to the pharmacy to pick up the next supply of the drug. By this time, it is usually around 2 or 3 pm. We have time for a late meal, and then catch the 7 pm flight out of Boston to Charlotte. A long, but do-able, experience that includes a great meal. Not a bad way to spend the day.

The other types of visits are those that require CT scans and a bone marrow biopsy in addition to the lab work and the office visit. The order of the procedures varies according to availability and timing, but usually lab work is still first with the addition of an IV for the CT scans. The scans and the BMB are all done at Dana-Farber so we are simply traveling to separate sections of the facility for each procedure. Wait time between procedures varies, but everything still takes only one day. These days are understandably tiring for Jeff, but he is mobile and usually able to walk to one of our favorite restaurants. We have found that light walking after all of these procedures is actually helpful in easing the achiness and fatigue.

There are other trial considerations, of course, such as dietary restrictions and when to take the medication. These can be a bit disruptive to meal times and choices, but we simply flex the family menu and stay alert to when we eat so that we can still have meals together. The real adjustment for our family has been in how we choose to perceive the clinical trial. Is it an inconvenient budget buster, or is it an adventure full of possibilities? As a family, we have trended towards the latter. To the degree that we can, we try to make each trip a mini-vacation, or even just a date that lasts all day. We always, at the very least, go to one of our favorite restaurants and make a visit to Mike's Pastry in the North End of Boston before coming home. It's all we can do to keep the TSA from our box of cannoli, but having a few "treats" built in to the experience lightens the mood and decreases the clinical tone of our trip. We've brought the children twice and have been able to experience Boston's museums, history, food, and activities such as Blue Man Group and whale watching. I know not all trials are conducted in such an event-rich location, but exploring the area could at least yield your new favorite burger joint or Italian restaurant. For us, being at a premier cancer facility like Dana-Farber is comforting, but it is also a larger-than-life reminder of the disease we battle daily. Being able to think about fish tacos at the Legal Seafood Test Kitchen and falafel sandwiches at Moby Dick's mitigates the clinical focus and makes us feel more like people and less like patients.

Looking back to November 2012 when Jeff and I spent a week in Boston in order to get him into the trial, I remember distinctly something that Dr. Treon told us (he was still seeing patients then). He said, "Conducting clinical trials is like dancing in a mine field." As he elaborated about the rigorous standards, cost, and time involved, my respect and appreciation for those that conduct, support, and participate in trials grew exponentially. I was overwhelmed by the enormity of it all. How desperate I was to grasp on to something that spoke life and hope when all seemed very dark for us. I thank God that we have been privileged to participate in the trial that brought approval of ibrutinib for WM. I thank God that this drug has returned a husband and father to my family. And I thank God for the doctors and researchers who dance in the mine fields daily to bring hope, life, and eventually a cure for those of us who live with WM. Truth be told, I think we could host our own version of "Dancing with the Stars."

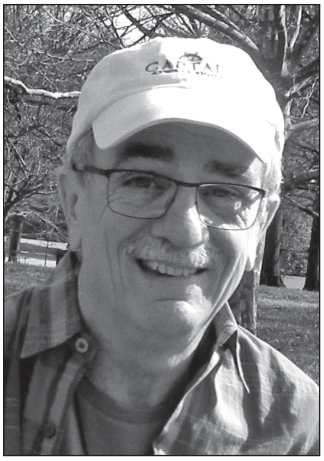
*Caregiver Sue Drake introduced her family to the* Torch *readership with her article "Caring Beyond Survival,"* Torch 15.1 (January 2014) *pp. 17, 20.*

## We Get E-Mails

I have been reflecting on Lisa Wise's column in the last *Torch*, "My Red Badge of Courage." She chronicles how she was reluctant to leave the last Ed Forum in Dallas. My wife and I also left with good feelings after attending the conference. What made so many of us feel that way? We were impressed with the friendliness and openness of so many. If there was a sourpuss at the conference, I never met her or him. And I saw so many smiles – even from those who had been through many kinds of treatments. It was so easy to visit and chat with people. And the doctors – they were amazing. I didn't sense that any of them were prima donnas. I saw them chatting with people at meals or just visiting. I am sure they took many of the same questions, but I sensed a down-to-earth attitude in those I observed more closely. I am not sure I have ever seen anything like this as I attended conferences throughout my career. So thank you, Lisa, for capturing in a small way the feel of the conference.

Paul Kubricht

# PRESIDENT'S CORNER: ROADMAP TO PROVIDENCE



Providence, Rhode Island, is one of my favorite cities in the world. Its attractions include WaterFire Providence, the historic Federal Hill district, and the Rhode Island School of Design (RISD) Museum of Art. On a personal level, and most importantly, Providence is where I met my wife, Elly, way back in 1972 when we were both attending a Masters in Arts of Teaching program at Brown University.

Providence is also where we'll hold the 2016 IWMF Educational Forum from June 10-12, 2016. To prepare for the next Ed Forum, the IWMF Board of Trustees recently met at the Omni Hotel, and we can confidently predict that you're going to love both the hotel and Providence. Mark June 10-12, 2016, on your calendar now and plan on joining us!

Providence – which literally refers to 'looking ahead and preparing in advance for future (and unknown) eventualities' – has another special meaning for us. To be provident includes making provision for the future and being very careful about planning for the future and saving for the future. At the recent meeting in Providence, the Board agreed to provident measures in the three following important areas:

First, we are improving IWMF-Talk, otherwise known as our Talk-List. IWMF-Talk is an invaluable on-line discussion group with over 1,888 members worldwide. Members use it to learn from each other's experience with WM. However, IWMF-Talk has become a bit cumbersome to use as we haven't updated the technology or rethought its organization since it was first set up years ago. A committee of Talk-List users has been hard at work on these issues. By November expect to see changes in IWMF-Talk that will make it easier to use. If you're not a member, you'll want to join!

Second, we're improving the way we get important news out to you. We've been posting news on our website, on our Facebook page, on IWMF-Talk, and tweeting it. But we can do better. We need another way to announce important news and lead you to the website for more details. In September we inaugurated a new e-mail service to make sure that important news reaches more people, for example when PowerPoint presentations and videos from the Educational Forum are available or how to access financial support from PAN or LLS. Have a look at *iwmf.com/NEWS-AND-EVENTS/NEWS* to see the all the news we've posted this year.

By far the most important way that we are moving ahead is the progress to date in developing the IWMF-LLS Strategic Research Roadmap. As you may remember, in May the IWMF-LLS Strategic Research Roadmap Conference was held in New York City. (See the July issue of the *Torch (16.3)* for full details, pages 1-4.) At that meeting, Dr. Steven Treon and Dr. Stephen Ansell were designated to define the areas where more research was needed. Furthermore, the attendees requested yearly meetings instead of every two years, as originally planned.

At the Board meeting in Providence, the IWMF Board agreed to three critical next steps regarding the Research Roadmap:

- We agreed to fund a second Strategic Research Roadmap Conference in May of 2016 in New York City. We will be able to report results from that meeting to you at the June 2016 Educational Forum.
- We approved the Strategic Research Roadmap provided by Drs. Treon and Ansell.
- We identified the new funding that we will need to fully implement the IWMF's share in the IWMF-LLS Strategic Research Roadmap, and we empowered our Fundraising Committee to solicit your support.

We will be soliciting research proposals for four target areas of the Research Roadmap. The areas are:

- *Signaling:* What are the pathways WM cells use to communicate with each other and surrounding cells? Once we understand this, we can devise ways to interfere with and prevent this communication. Ibrutinib, for example, is a drug that interferes with communication on the BTK pathway.
- *Tumor microenvironment:* WM cells are influenced by the environment of the bone marrow where they develop. If we can better understand the environment or "neighborhood" our WM cells live in, then we can change the environment so it no longer helps WM cells live and thrive.
- *Immunology/Immunotherapy:* How can we improve our own immune system to fight WM? WM is a wily foe. WM cells often "hide" in their environment and are not recognized as a threat by our immune system. If we are able to understand the immune checkpoints – proteins that prevent the immune system from attacking – we may be able to devise antibodies that inhibit these checkpoints

*President's Corner, cont. on page 5*

and unleash the immune system to kill cancer cells. This approach has proven effective in other cancers.

- *Omics:* What can we learn about genomics, epigenomics, and WM mutations? Using an analogy drawn from computers, you can think about genomics as our computer hardware (your PC, Mac, or whatever) and epigenomics as our software. Through research sponsored by the IWMF, we've already learned about two key mutations: the MYD88 mutation and the CXCR4 mutation. Identifying the MYD88 mutation in a majority of WMers led to the realization that ibrutinib (Imbruvica) would likely be effective in controlling WM, while the presence or absence of the CXCR4 mutation is thought to determine which drugs are more likely to be effective in the case of a specific patient. We need to leverage these discoveries and learn more about the "omics" of WM.

For more information on the Research Roadmap and a summary of all of our current research, see the articles in this issue on pages 6 and 7.

Moving ahead, the next steps in the IWMF-LLS Strategic Research Roadmap are:

1. The development of requests for proposals (RFPs). RFPs will be issued globally to researchers in mid-October.
2. Proposals will come to us in January and will be sent out by Dr. Robert Kyle for review by the IWMF Scientific Advisory Committee and the IWMF Research Committee, to be completed by March.
3. Based on this review, the IWMF Board of Trustees will select the projects we want to fund (and can afford to fund) in late April or early May and announce them before the mid-May IWMF-LLS Strategic Research Roadmap meeting.
4. In June we will finalize the contracts with the researchers.
5. By July 2016 Roadmap research should be underway.

What can you do to help? Donate as generously as you can. We need to raise at least $1,000,000 a year to fund the new research.

Please think about making a pledge to the *Imagine a Cure* campaign or increasing your pledge. See our website at *www.iwmf.com/how-you-can-help/ways-give.* If you can make a major contribution, contact Dave Benson at *Dave@dbenson.com* or 952-837-9980.

So, that's our Roadmap to Providence. By the way, although I met Elly in Providence in 1972, whenever someone asks me how long we've been together, my answer is always "Not nearly long enough." Whenever someone asks how long I've had WM, my answer is always "Way too long."

I hope you'll join the Board in supporting the Strategic Research Roadmap to help us reach a cure for our disease.

Stay well,
Carl

PS: What is WaterfireProvidence? A mystical aura pervading the middle of Providence on two Saturday evenings each summer month that is created by 100 bonfires blazing right above the surfaces of the three rivers that flow through the downtown area. Music from all over the world accompanies those who stroll along the river walks. If we are lucky, the Saturday evening of the Ed Forum will offer us this extraordinary experience.

## THE WEBSITE WANTS YOUR PHOTOS

The vibrancy of the IWMF website depends upon not only maintaining content that's fresh and up-to-date, but also by utilizing images of real WM patients going about their daily lives. We're always looking for fresh, new photos, so please, feel free to submit your own personal photos (send your photos to *webmaster@iwmf.com*). To ensure the highest quality presentation on the website, please submit photos with as high a resolution as possible (the more pixels the better). Also, while any aspect ratio will be gladly accepted (1:1/square, etc), we do have a dire need for photos that might fit a 6:1 aspect ratio for use on banners at the top of some of the web pages.

# THE IWMF-LLS STRATEGIC RESEARCH ROADMAP
## A LAYMAN'S SUMMARY WRITTEN FOR THE IWMF *TORCH*

BY GUY SHERWOOD, MD, IWMF VICE PRESIDENT FOR RESEARCH
SUE HERMS, IWMF TRUSTEE AND RESEARCH COMMITTEE MEMBER

As you may have already read in President Carl Harrington's column on pages 4-5 of this *Torch* issue, the IWMF is making plans to implement the new Strategic Research Roadmap initiative that resulted from a joint meeting in May of prominent WM researchers and clinicians along with representatives from the IWMF and the Leukemia & Lymphoma Society (LLS).

Based on discussions during the conference, the Scientific Co-Chairs, Dr. Stephen Ansell of Mayo Clinic in Rochester and Dr. Steven Treon of Dana-Farber Cancer Institute, defined in more detail the four priority areas where additional research is needed to advance our knowledge of WM. Dr. Ansell and Dr. Treon wrote (and graciously provided to the IWMF) a summary of these priority areas. The IWMF believes it is important for its members to understand and support the Roadmap initiative and, with that in mind, is offering below a layman's summary of the written report by Drs. Ansell and Treon.

**Signaling**

As we now know, mutations in the MYD88 gene are present in 90-95% of WM patients, and these mutations permit WM cells to grow by stimulating important survival pathways. Much of the knowledge about MYD88 has been generated for the native (unmutated or "wild-type") MYD88 gene. But what is known about native MYD88 is still limited, as is knowledge of the mutated Myddosome, a cell surface signaling protein complex that is a key part of the innate immune response and is made up of a ring of six MYD88 proteins and four associated kinase proteins. The creation of 3D models of the crystal structure of the mutated Myddosome can provide critical information for medicinal chemistry research aimed at disrupting Myddosome assembly and signaling. Studies to identify signaling pathways and downstream proteins associated with mutated MYD88 are needed in order to advance future WM treatments.

Other important mutations, including those affecting the CXCR4 gene, are present in approximately 30-40% of WM patients and impact disease presentation, usually leading to a worse prognosis as well as impacting response to ibrutinib treatment. Relatively little is known about the nature of CXCR4 mutations. Detailed studies aimed at clarifying CXCR4 dysregulated signaling and its impact on downstream growth and survival signaling of WM cells may help advance our understanding of the disease and exploit another avenue for treatment.

**Genomics**

Genomics (or simply "omics") is the study of genes, their functions, and their inter-relationships, all of which exert enormous influence on the growth and development of an organism.

Native MYD88 disease represents 5-10% of all cases of WM. Patients with native MYD88 have differences in their clinical presentation, including lower serum IgM, low bone marrow disease burden, CD27+ expressing disease, and lymphocytosis (high lymphocyte count), in contrast to mutated MYD88 patients. Native MYD88 patients also show poor responses to ibrutinib and an increased risk of death compared to those with mutated MYD88. The genetic basis for native MYD88 disease remains unknown, and one important priority should be the use of improved laboratory genetic sequencing techniques to identify this basis. Such knowledge may help to better clarify the disease classifications for these patients (WM vs. related lymphomas), trigger additional signaling studies, and identify targets for new therapies.

The epigenome (a subset of genes whose function is controlled by specific biochemical factors as well as by their DNA sequence) has undergone extensive study in many B-cell malignancies. Mutations or copy number alterations in the epigenome exist for WM, although their impact on specific gene dysregulation remains unclear. A comprehensive analysis of the epigenome of WM cells whose MYD88 and CXCR4 status are known will provide critical insights into cell signaling and potential therapeutic targets.

**Immunology/Immunotherapy**

The mechanism whereby a WM patient's own immune system could be manipulated or triggered to recognize and subsequently attack the offending WM cells remains unknown. Research to understand the biology of the immune response in WM is vitally important. Drs. Ansell and Treon recommend support for research to characterize the immune environment in WM and to understand immune cell migration, which is a key aspect in the development of the immune system and in effecting an immune response. There is extensive and continual redistribution of immune cells to different sites throughout the body. These distribution patterns control immune function, tissue regeneration, and the body's responses to insult. Specific knowledge gaps include: understanding T-effector cell exhaustion, determining the effect of immune checkpoint inhibitors, and defining the role of other immune cells including natural killer (NK) cells and mast cells. Drs. Ansell and Treon recommend studies to identify high-risk WM patients who would benefit the most from immune therapies such as CAR T-cell treatment. They

*The IWMF-LLS Strategic Research, cont. on page 7*

*The IWMF-LLS Strategic Research, cont. from page 6*

also support clinical trials that explore the role of immune-directed therapies such as monoclonal antibodies to CD38, CD70, and PD1/L1.

**Bone Marrow/Tumor Microenvironment**

Focused research is needed into the role of the bone marrow and tumor microenvironment (the "neighborhood" around WM cells) in supporting malignant cell growth in WM. Studies are required to better characterize the components of the microenvironment, as well as its contribution to disease progression and resistance to treatment. An evaluation of the nature of the cellular communications between WM cells and their associated microenvironment is needed. This will require the development of a better model system to understand these interactions.

**Next Steps**

As Carl outlines in his column, the IWMF is preparing to request proposals from researchers for projects that address the recommendations made in this list of priorities. These project proposals will go through our Scientific Advisory Committee (SAC) review process, and the most promising proposals will be selected for funding. Our goal is to have contracts signed and projects started by early 2016.

It is obvious that the Roadmap will represent a significant expansion in funding and effort by the IWMF. It will be a challenge, but one that we can meet successfully with your help.

# IWMF RESEARCH UPDATE

BY GUY SHERWOOD, MD, IWMF VICE PRESIDENT FOR RESEARCH
SUE HERMS, IWMF TRUSTEE AND RESEARCH COMMITTEE MEMBER

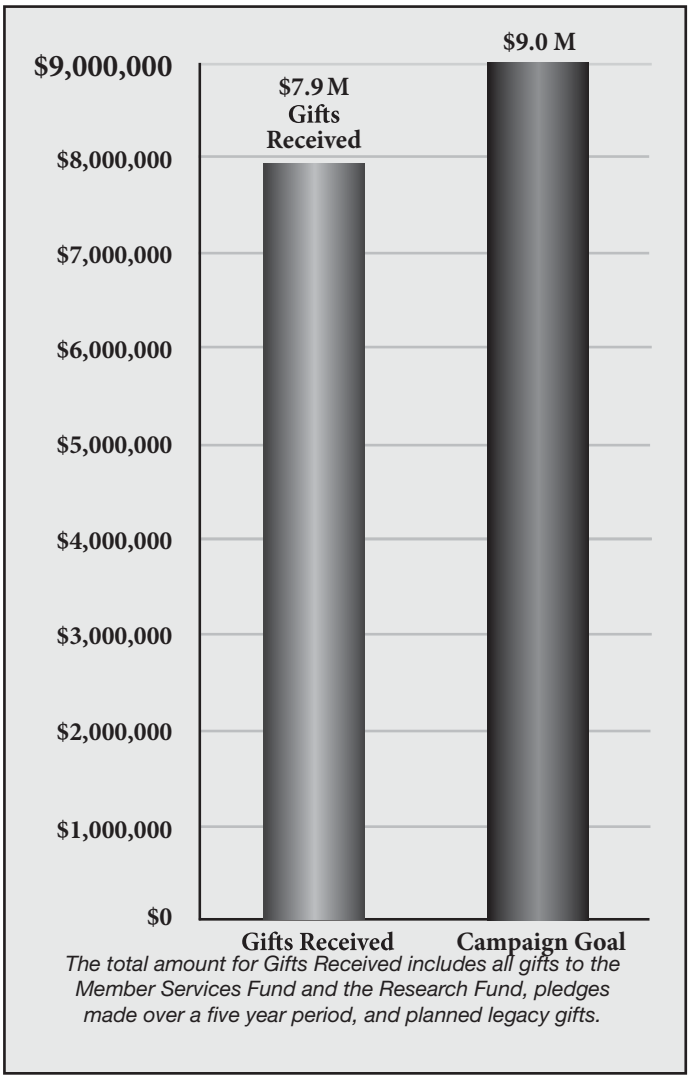
The IWMF has been fortunate (and busy!) to manage several research projects this year, indicating a heightened interest in the biology and pathogenesis of WM and the availability of new and rapidly improving technology in the medical research world. The following is a summary of ongoing and just-completed projects.

**Development of Targeted Therapies for Waldenstrom's Macroglobulinemia (Duration 2013-2015):**

This is a continuation of a previous project proposed by Dr. Steven Treon at Dana-Farber Cancer Institute to define the oncogenic signaling of the MYD88 L265P mutation found in 90-95% of WM patients, to identify and validate inhibitors of this signaling, and to characterize these inhibitors in the setting of early phase clinical trials in WM patients. The Final Progress Report was delivered in July and identified several potential inhibitors of MYD88 signaling. This project and the earlier work also supported discoveries made during the seminal Phase II trial of Imbruvica that led to its approval for WM by the US Food and Drug Administration and the European Medicines Agency. Dr. Treon is soon to publish detailed findings of his most recent work in the *New England Journal of Medicine*.

**Development of a Mouse Genetic Model of Waldenstrom's Macroglobulinemia (Duration 2012-2015):**

This study, jointly funded by the Leukemia & Lymphoma Society (LLS) and the Waldenstrom's Macroglobulinemia Foundation of Canada, aims to generate a mouse model of WM by engineering the MYD88 L265P mutation into mice in order to better define the role of the mutation in disease development. This project has been slow to yield results – while the mutation has been successfully engineered, only one mouse appears to have developed symptoms of lymphoma




*The total amount for Gifts Received includes all gifts to the Member Services Fund and the Research Fund, pledges made over a five year period, and planned legacy gifts.*

*IWMF Research Update, cont. on page 8*

and is still being evaluated. The project ends in December, but the principal investigator, Dr. Ruben Carrasco of Dana-Farber Cancer Institute, has suggested additional ideas to try to get the project back on track and intends to submit a proposal for an extension.

**Factors Regulating Immunoglobulin-Producing B-Cells in Patients with Waldenstrom's Macroglobulinemia (Duration 2015-2018):**

This is a continuation of previous projects proposed and completed by Dr. Stephen Ansell of Mayo Clinic in Rochester. The current study began in September and will continue his work of determining the role of the bone marrow microenvironment in the regulation of IgM production and the promotion of malignant B-cell growth. In particular, this project will focus on the role of PD-1, an immune checkpoint inhibitor that is upregulated by IL-21 and IL-6 via STAT5, which are important cytokines identified in his previous work.

**Large Scale Genomic and Proteomic Profiling in Waldenstrom's Macroglobulinemia (Duration 2010-2016):**

This project is popularly referred to as "The WM Tissue Bank Project" by those who have attended the past several IWMF Ed Forums. The lead investigator is Dr. Irene Ghobrial at Dana-Farber Cancer Institute, and her goals are to develop a tissue bank of WM specimens linked to clinical characteristics of patients in different stages of the disease, to characterize the biology of WM cells during disease progression, and to develop biomarkers that evaluate the activity of therapeutic agents in clinical trials. An epidemiological questionnaire for patients was developed in conjunction with this project, and information collected from it has been published. Specimens are still being collected and analyzed, with the next Progress Report due in November.

**Targeting the Tumor Microenvironment in Waldenstrom's Macroglobulinemia (Duration 2013-2016):**

This study, led by Dr. Sherine Elsawa at Northern Illinois University, will attempt to determine the significance of targeting a novel pathway that regulates the crosstalk between the malignant WM cells and the bone marrow microenvironment, with the goal of facilitating the development of new targeted therapies for WM patients. Her research, just recently published in the prestigious *Journal of Immunology*, discusses the oncogenic transcription factor GL12, which binds to a downstream target called the IL-6Rα promoter and modulates IgM secretion in WM cells.

**Further Genomic Characterization of Waldenstrom's Macroglobulinemia: Unveiling the Role of CXCR4 Somatic Mutation, a Crucial Regulator of Pathogenesis and Importance for Therapy (Duration 2014-2016):**

Mutations in the gene CXCR4 are found in approximately 30% of WM patients. Dr. Aldo Roccaro of Dana-Farber Cancer Institute is studying these mutations, which may lead to disease progression and dissemination of WM cells to distant organs. He has also validated the activity of a novel monoclonal antibody to CXCR4 in CXCR4-mutated WM cells, and this may represent a potential new targeted therapy.

**Mutant MYD88: A Target for Adoptive T-Cell Therapy of WM (Duration 2014-2016):**

A T-cell receptor that recognizes the MYD88 L265P mutation was recently identified. This receptor can be used to engineer a patient's own T-cells with the capacity to recognize and destroy his or her tumor cells. The patient can then be infused with larger numbers of these engineered T-cells, in the hope of improved cancer control and, potentially, a cure. Dr. Brad Nelson and Dr. Julie Nielsen of the BC Cancer Agency in Canada are pursuing this new treatment strategy. The study is also funded by the Waldenstrom's Macroglobulinemia Foundation of Canada.

**Identification of Germline and Somatic Variants Associated with Predisposition of Waldenstrom Macroglobulinemia (Duration 2014-2016):**

This is the latest project by Dr. Treon, who is sharing the investigator role with Dr. Zachary Hunter at Dana-Farber Cancer Institute. Although the MYD88 L265P mutation is significant in WM, it does not appear to be sufficient to cause the disease by itself. This study will sequence the regions of DNA that have been identified as associated with WM predisposition in 1,000 WM patients and their family members to see which inherited DNA variants are found in familial WM cases, as well as which variants occur in the general WM population.

**The UCLH WM Biobank: From Biology to Treatment (Duration 2015-2017):**

Principal investigator Dr. Shirley D'Sa of the University College London Hospitals is spearheading an effort to systematically examine the clinical and biological characteristics of patients with WM, IgM MGUS, and related conditions by setting up a Serum and Tissue Bank of samples to contribute to the international effort to understand WM. Samples will be obtained from patients in a dedicated WM clinic. This study is jointly funded by the WMUK, an Affiliate of the IWMF.

**For the Future:**

This next year promises to be another busy one for the IWMF Research Program. Plans are underway to carry out the research priorities recently articulated as a result of the Strategic Research Roadmap Conference jointly organized by the IWMF and LLS. See President's Corner on page 4 and a layman's summary of the IWMF-LLS Strategic Research Roadmap on page 6 for details.

Donate and Participate!

# TREASURER'S REPORT

BY CYNTHIA RUHL, IWMF TREASURER

The finances of the IWMF are accounted for through two separate funds. The Research Fund is used solely to fund research grants for projects that our Research Committee has reviewed and recommended. Our Member Services Fund provides for all of our outstanding services for members, including the Educational Forum, the website, and the *Torch*. Both funds are critically important to the work of the IWMF.

The audited financial statements for 2014 have been completed and are posted on the IWMF website at *iwmf.com/sites/default/files/docs/2014AuditedFinancials.pdf* We are pleased to have the results of the audit available at an earlier time this year.

So far for 2015, income in the Member Services Fund is well above budget and the prior year due to a large estate gift, corporate support for the Ed Forum, and honor and memory gifts. Income in the Research Fund is also well above budget and the prior year due to two large donations and an estate gift. Expenses for both Funds have been well managed and are below budget.

I can assure you that the Board of Trustees does its very best to make certain that every dollar given is wisely spent on serving you, our members. Thank you for your continued support.

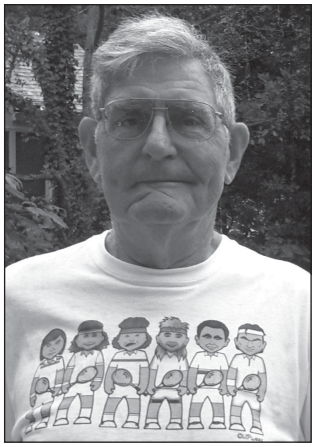
## Financial Assistance for WM Patients

The IWMF is aware that the potential cost of novel oral medications such as IMBRUVICA® (ibrutinib) is a recent and growing concern to the WM community. The Johnson & Johnson Patient Assistance Foundation provides assistance to uninsured patients who lack the financial resources to pay for certain medicines, including IMBRUVICA®. To see if you qualify, call the Johnson & Johnson Patient Assistance Foundation at 1-800-652-6227 or visit its website at *www.jjpaf.org*.

Patients with limited financial resources taking medications marketed by other pharmaceutical companies are encouraged to contact the financial assistance programs of those respective pharmaceutical companies – in many cases, some form of help is available for those in need. Assistance is also provided by non-profit foundations for WM patients who are insured but need help with drug co-pays. Visit the IWMF website at *www.iwmf.com/get-support/financial-assistance* for more information.

# ARNO'S MEDICAL ODYSSEY

BY ARNO MULLER, 31-YEAR WM SURVIVOR



*Arno Muller, 31-year survivor and tennis enthusiast, at home in Virginia Beach.*

*This tennis-playing octogenarian from Virginia Beach, Virginia, is familiar to long-time followers of IWMF-Talk. The title Arno chose for his account of "life for 31 years with Waldenstrom's and other cancers" makes appropriate reference to a legendary survivor known for his wits and a determination that empowered him to "survive the storms of life." Arno's life is indeed long and marked by challenges of many sorts. And, as a survivor, he has lots of advice to share.*

Today I am alive and well and, unless you hear otherwise from your *Torch* editor, I am still alive as you read this! What are the odds of survival for somebody with three cancers? I am 83, that is phenomenal! But am I exceptional? Not really – you may do even better!

It all began in 1931 when a pair of German emigrants had their first son, unaware that they likely passed on the genes that would predispose me to cancer. I was lucky to grow up in Chile during the Great Depression and World War II, blissfully ignorant then that it was my good fortune to go through the school of hard knocks in an underdeveloped country. Although well fed, I was raised as a child to accept delayed gratification as natural – for example, to endure long walks of up to 4 or 5 miles without food or water in order to reach a beach or mountain cabin. I had childhood diseases without the benefit of doctoring, including jaundice from contaminated water.

*Arno's Medical Odyssey, cont. on page 10*

Playing soccer on fields of plain dirt ground, I had eye injuries and a broken arm bone. I slept with mosquitoes through the summers and with chilblains in my fingers during the winter. I was lucky to live in an environment perfect for building resistance to an incredibly rich assortment of germs. I also built up body strength in college and trained for endurance, rowing on the Chilean team in the South American and Pan-American championship regattas (silver medals in both!).

*Arno takes great pride in his flourishing family.*

Fast forward: I immigrated to the USA in 1957, married in 1960, and by 1966 we had four children. In 1959 I began work in Connecticut and then took evening courses at the University of Connecticut for a Master's in Electrical Engineering. I was busy. Life was good.

The first portent of problems to come: throughout my life I had frequent nosebleeds. The earliest medical record I have shows that in 1983 my hemoglobin (Hg) was 13. In 1984 blood test results were Hg 13.4 and IgM 5820. I was referred to an oncologist. A bone marrow biopsy found WM! By then Hg was 11.8 and SV 3.6. I felt fine, healthy, no symptoms, and luckily the oncologist recommended 'watch and wait' (W&W). I had no idea what it all meant and felt so well that I literally did not believe the oncologist's diagnosis. I thought I was the healthiest person on the planet.

The oncologist told me that the median survival for WM was 5 years from diagnosis. Since two of our children were in their last years of college, I did not want to upset the family. I kept the diagnosis secret. It worked. The truth only came out when I got meningitis in 2003. By then it had been proven that statistics do not apply to me. This just goes to show the individual differences in how WM presents itself and treats us. I believe that my very active life up to that point was paying off.

The years between diagnosis in 1984 and the outbreak of meningitis in 2003, which was clearly a result of my lowered immunity, were not without health-related problems. In 1986 I had surgery for cataract removal and lens implants in both eyes. Lightning struck again the next year, 1987, when one centimeter of my lower lip had to be removed because of a squamous cell carcinoma. Wow, the surgeon did a great job and I got a free face-lift! Then in 1990 my 25-year old son, a recent college graduate, was diagnosed with rhabdomyosarcoma and died within a year. In retrospect it is amazing how completely life was suspended for the family. It required a couple of years to resume.

In the W&W years from 1984 to 2003 my Hg bounced from 11.8 to 13.1 to 9.4; IgM from 5820 to 3600 to 6300; and SV reached 4.3. I continued my normal active life – working full time, seeing my children through college – and thought myself a very healthy person. I managed to put my name on 45 US patents and a European and Japanese patent designing integrated circuits.

In 1999, after 40 years of employment with Pitney Bowes Inc., I chose retirement at age 68 and moved to Virginia Beach. At this time I also made a mistake: to ignore my disease and not seek a doctor in Virginia to monitor my condition while I continued on W&W.

I got bacterial meningitis in 2003 while skiing in Vermont. Doctors told me that the meningitis was the result of my totally "inadequate and neglected immune system." Luckily I was admitted to the well-known Hitchcock Medical School in Dartmouth, New Hampshire, where I spent a week in the intensive care unit (unconscious for the first two days). Treatment included plasmapheresis which reduced IgM to 2960 and SV to 1.8. I went home with a portable infusion pump supplying antibiotics for three additional weeks.

My WM now moved onward with a vengeance. From March to November of 2003, IgM and SV rose to 8500 and 3.9, respectively. For the first time (age 72), I felt the physical symptoms of anemia; I struggled walking uphill and my legs felt like they were loaded down with lead. My new local oncologist wanted to start treatment with chlorambucil. But in the meantime I had found the IWMF and had learned that a newer treatment called rituximab or Rituxan was available and less toxic.

My local oncologist sent me for a second opinion to Dr. Michael E. Williams, Professor of Medicine and Chief, Division of Hematology and Oncology, University of Virginia. Located in Charlottesville, Dr. Williams was only a three-hour drive away from home.

Dr. Williams recommended a cycle of 4 weekly Rituxan infusions preceded by plasmapheresis, and I was very pleased. This was the treatment I preferred. However, when the time came to start treatment, the local oncologist wanted to have a port installed. The previous plasmapheresis done earlier that year in New Hampshire only used my arm veins. I now refused the port. And the doctor "fired me" as a patient!

Consequently, I had to drive three hours each way once a week to have the Rituxan treatment done by Dr. Williams in Charlottesville. Still I considered this a *much* better option. I am a strong believer in patients being informed and taking part in treatment decisions.

Time for my *first* cancer treatment. I was *scared*! Before the end of 2003 I had plasmapheresis twice (this knocked IgM

*Arno's Medical Odyssey, cont. on page 11*

down to 1760), followed by 4 rounds of Rituxan. One month after the fourth Rituxan infusion, my IgM peaked at 6490 (remember the flare?) and SV at 3. Eventually, however, my response to Rituxan was excellent (IgM went to a low of 1300, Hg rose to 15.7), and it was 6 years before treatment was again required in 2010.

For a second time solo rituximab was recommended for 4 cycles. This second time IgM went no lower than 3050 and Hg peaked at 13.9. Good results, but not as good as the first treatment, and lasting only 2 years. We tried solo Rituxan one more time in October of 2012 when IgM was at 4930 and Hg down to 11.1. It was clear that solo Rituxan no longer was effective for me when by March of 2013 the numbers were worse than prior to treatment (IgM 6600 and Hg 9.6). It was time for combination therapy.

Let me add that during the 9 years that Rituxan kept my WM in check, other health-related issues continued to offer challenges. In 2007 lightning struck a third time, while I was on vacation to relatives in Italy. I suddenly was unable to urinate. A catheter was installed and I flew home with it in me. A biopsy showed prostate cancer, and I was treated with brachytherapy followed by 5 weeks of external beam radiation. In 2011 I had Mohs surgery on my nose to remove cancerous tissue. Luckily a good surgeon successfully removed skin from my back and got my nose to look normal!

Treatment for WM moved on to a combination of drugs. Dr. Thomas A. Alberico, the best oncologist in Virginia, chose 6 cycles of monthly rituximab and bendamustine starting in March of 2013. As of August 5, 2015, I am living with the results: Hg 15.0 and IgM 1336. I am happy!

**ARNO'S REFLECTIONS ON SURVIVORSHIP**

I would like to bring a couple of things to the attention of newly diagnosed readers. A word of caution: we are all different. But I firmly believe it is to your advantage to experiment and find how sensitive you are to the impact of *your* disease on *your* body.

Consider that I remained on W&W from 1984 to 2003, when meningitis struck. Who knows? Had I not had meningitis would I have gone longer on W&W? As it is, I was 19 years with Hg ranging from 9.4 to 13.1 and IgM 3600 to 5800. Of course, living with WM you will feel some change in your physical make-up, but if you can live with the symptoms *do not rush to treatment.*

Another thing: do not worry about numbers. Go by how you feel! All through my life (that is, my life as a WM patient) IgA and IgG have been abysmally low and IgM never lower than 1300, mostly higher than 3000.

Finally, rituximab is a monoclonal antibody targeting B-lymphocytes only and therefore does not harm other cells. It is one of the mildest treatments available at this time. Rituxan gave me 9 years, 6 years from the first series alone. WM is a slowly progressing disease. Try *solo Rituxan* first to see if it helps you. If 6 months after 4 cycles of rituximab there is no result, then go ahead and try something more toxic.

I probably have spent too much space writing about my early life and the numbers during treatments, but I just want to make sure that you understand why I think it is really up to each one of us to be proactive in taking care of our health.

There is the saying that, "The Lord helps those who help themselves." Here is how I helped myself:

**ARNO'S TIPS FOR HEALTHY LIVING**

Now, this is not medical advice. I take no responsibility for the consequences of following the advice of this 83-year-old WM survivor.

- Exercise daily. No excuses! I assure you that even if you are immobilized by something like peripheral neuropathy, your primary care physician will provide the name of a medical professional who can get the cardiovascular system of even a bed-ridden invalid pumping! My regimen includes two hours of tennis doubles twice a week and 2.7 miles of walking on the other days.
- Eat a green salad dish every day, plenty of fruits, vegetables, and whatever strikes your fancy in the fresh produce aisle of the supermarket.
- Eat fish at least twice a week. Stick to white meat. (I am not fanatic and admit to enjoying a bloody steak occasionally.) Eat a handful of nuts and *one* square of dark chocolate daily.
- My lunch is a bowl of "My Mix" of yogurt (not the factory-produced fruit yogurt cups with their "tastes like" label) and cottage cheese with *fresh* fruits like berries and/or diced seasonal fruit. I wash it down with a tall glass of V8 juice. I think the V8 juice is very important.
- For superstitious people (like me) who believe in alternative meds and/or the placebo effect, I add what follows. Although I am no longer anemic, once a week I take super B complex (an assortment of key B vitamins) plus vitamin C, 400 mg vitamin D, and a low dose aspirin (81 mg). This primes the bone marrow. The next day I take the once-a-week 65 mg *iron* pill to feed the bone marrow!
- I fortify my daily tall glass of V8 juice with green tea extract and turmeric.

Let peace flow and envelop you and your caregivers!

(That is an invitation to include meditation in your life)

# MEDICAL NEWS ROUNDUP

BY SUE HERMS, IWMF TRUSTEE AND RESEARCH COMMITTEE MEMBER

**Novel BTK Inhibitor for B-Cell Lymphomas Enters Clinical Trials** – A Phase I trial is beginning for the new oral BTK inhibitor called BGB-3111. Developed by BeiGene Co., Ltd. of China, the drug will be assessed for safety and efficacy in patients with relapsed/refractory B-cell lymphomas.

**Phase I Trial of Novel Spleen Tyrosine Kinase Inhibitor (SYK) Begins in CLL and NHL** – Patients with relapsed or refractory chronic lymphocytic leukemia (CLL) and B-cell non-Hodgkin's lymphoma (NHL) may be eligible to participate in a Phase I trial of HMPL-523. The trial will evaluate the safety and establish the maximum tolerated dosage of this oral drug that targets spleen tyrosine kinase (SYK), an essential enzyme involved in the B-cell receptor signaling pathway. HMPL-523 was developed by Hutchison Medipharma Ltd.

**New Study at Weill Cornell Will Combine a BTK Inhibitor with a PI3K Inhibitor for B-Cell Malignancies** – A Phase I/II study of the combination of ACP-196 and ACP-319 for previously treated B-cell malignancies will be opening at Weill Cornell Medical Center. ACP-196 is a second generation BTK inhibitor, and ACP-319 is a second generation PI3K inhibitor. Both drugs are administered orally twice daily and were developed by Acerta Pharmaceuticals.

**Phase II Trial of Indolent NHL Seeks to Enhance Effectiveness of Rituximab** – Biothera announced that patient dosing has begun in a Phase II trial of its investigational cancer immunotherapy drug, Imprime PGG, in combination with rituximab for relapsed indolent non-Hodgkin's lymphoma (NHL). The trial is being conducted at Dana-Farber Cancer Institute. An earlier trial of Imprime PGG with rituximab and alemtuzumab (Campath) in chronic lymphocytic lymphoma (CLL) patients achieved responses in 93%, including 64% complete responses. The most common adverse events were anemia, rash, and neutropenia (reduced neutrophils). Imprime PGG recruits neutrophils to attack the malignant B-cells, thus offering an additional mechanism for anti-tumor activity.

**Prognostic Importance of Extramedullary Disease in WM Discussed** – An article in the *Journal of Hematology & Oncology* discussed the prognostic importance of extramedullary (outside the bone marrow) involvement in WM patients at diagnosis and potential treatment options for these patients. Clinical data from 312 WM patients at the University of Texas MD Anderson Cancer Center from 1994-2014 were examined. Characteristics associated with extramedullary involvement included male sex, age younger than 65 years, presence of "B" symptoms (fever, fatigue, night sweats, weight loss), high serum beta-2 microglobulin, low serum albumin, and cytogenetic abnormalities. Analysis showed that patients with extramedullary involvement had a significantly shorter median overall survival and progression-free survival than those with bone marrow involvement only. Also, chemotherapy combined with targeted therapy and initial treatment with rituximab were not as effective; however, treatment with nucleoside analogs significantly improved progression-free survival in patients with extramedullary involvement.

**IWMF-Funded Study Discusses Novel Pathway for IgM Secretion in WM Patients** – An article in the *Journal of Immunology* outlined a novel pathway that modulates IgM secretion by WM cells. The study, led by principal investigator Dr. Sherine Elsawa at Northern Illinois University, is supported by IWMF funding. The researchers reported that the oncogenic transcription factor GL12 binds to a downstream target of IL-6Rα and regulates its activity and expression. Inhibition of GL12 resulted in a reduction in IgM secretion, leading the researchers to suggest that this signaling pathway could be a promising target for therapeutic agents to reduce elevated IgM.

**French Researchers Establish Maximum Tolerated Dose of Lenalidomide in WM** – A multi-center Phase I/II trial in France, published in the *American Journal of Hematology*, aimed to determine the maximum tolerated dose (MTD) of lenalidomide (Revlimid) in patients with relapsed/refractory WM. This trial was undertaken because lenalidomide is effective in multiple myeloma, but an earlier study of 25 mg daily dosing in combination with rituximab produced clinically significant anemia in WM patients. In this newest study, the MTD was established at 15 mg/day for 21 days in a 28-day cycle. The overall response rate was 29%. With a median follow-up of 36 months, the median time to progression was 16 months, and the 5-year overall survival was 91%. The most frequent grade 3 or more adverse events were anemia in 14% of patients and neutropenia (reduced neutrophils) in 43% of patients.

**New CAR T-Cell Therapy for NHL Receives Approval for Investigational New Drug Application** – Juno Therapeutics announced that the US Food and Drug Administration accepted its Investigational New Drug Application for JCAR017 for patients with relapsed/refractory B-cell non-Hodgkin's lymphoma (NHL). JCAR017 is a chimeric antigen receptor (CAR) T-cell product targeting CD19, a protein expressed on the surface of most B-cell leukemias and lymphomas. The acceptance enables the company to initiate a Phase I trial to begin in 2015. CAR T-cell technology uses genetically engineered T-cells to recognize specific antigens on cancer cells so that the cancer cells can be targeted and killed.

*Medical News Roundup, cont. on page 13*

**Results Released for Ibrutinib and Ofatumumab Combination Therapy in CLL** – Researchers at The Ohio State University studied the safety and activity of ibrutinib (Imbruvica) combined with ofatumumab (Arzerra) in a Phase Ib/2 trial of chronic lymphocytic leukemia (CLL). Patients received ibrutinib 420 mg daily and 12 doses of ofatumumab in three schedules: ibrutinib lead-in, concurrent start of both drugs, or ofatumumab lead-in. Of the 66 patients evaluated, the overall response rates on the three schedules were 100%, 79%, and 71%, respectively. The most frequent adverse events were diarrhea, infusion-related reactions, and peripheral neuropathy.

**Combination of Idelalisib, Lenalidomide, and Rituximab Proves Unacceptably Toxic in Indolent Lymphoma Study** – Researchers at The University of Texas MD Anderson Cancer Center reported results for relapsed/refractory indolent lymphoma patients who were treated in a small Phase I study with the combination of idelalisib, lenalidomide (Revlimid), and rituximab. Of the seven patients enrolled, six developed liver function test abnormalities, and two of those patients developed additional complications and died. The researchers concluded that this particular combination is unacceptably toxic and should be avoided.

**Phase I Trial of Novel 3-Drug Combination Reports Results in CLL and NHL** – TG Therapeutics announced data from a Phase I study of the 3-drug combination TG-1101 (ublituximab), an engineered anti-CD20 monoclonal antibody; TGR-1202, an oral PI3K delta inhibitor; and ibrutinib (Imbruvica). The trial was administered to 16 patients with relapsed or refractory high-risk chronic lymphocytic leukemia (CLL) and advanced non-Hodgkin's lymphoma (NHL). Minimal adverse events were reported, with Grade 3 or 4 events seen in 6% of patients. The most common adverse event was infusion-related on Day 1. Clinical activity was seen in 13 evaluated patients – 100% of CLL patients achieved an objective response, and 75% of patients with follicular lymphoma or marginal zone lymphoma achieved an objective response.

**Novel Dual Signaling Pathway Inhibitor Tested in CLL and Follicular Lymphoma** – Portola Pharmaceuticals announced safety and efficacy data from the Phase I part of its ongoing Phase I/IIa study of cerdulatinib in patients with hematologic cancers who have failed multiple therapies. Cerdulatinib is an oral inhibitor of two key signaling pathways that promote cancer cell growth: the B-cell receptor pathway via the tyrosine kinase SYK and key cytokine receptors via JAK. Partial responses were observed and tumor reductions were seen; the drug was well tolerated in these heavily pretreated patients. Grade 3 or 4 adverse events included fatigue. Dose escalation is ongoing to determine the maximum tolerated dose. The Phase IIa part of the study will evaluate the safety and efficacy of cerdulatinib in chronic lymphocytic leukemia (CLL) and follicular lymphoma.

**Phase II Kyprolis Trial in Multiple Myeloma Reports Improved Results Versus Velcade** – In Phase III clinical trial results published in the *Journal of Clinical Oncology*, progression-free survival doubled among relapsed multiple myeloma patients treated with carfilzomib (Kyprolis) rather than bortezomib (Velcade), in combination with dexamethasone. The carfilzomib regimen, administered at a higher dose than currently approved, led to a median progression-free survival of 18.7 months vs 9.4 months with the bortezomib regimen. The objective response rate was significantly higher with carfilzomib, and twice as many patients achieved complete responses and very good partial responses compared to bortezomib. Adverse events were comparable between the two groups and included diarrhea, fatigue, shortness of breath, fever, constipation, and insomnia. Peripheral neuropathy occurred in 5% of patients treated with bortezomib and 1.3% of those in the carfilzomib arm.

**Novel BCL-2 Inhibitor/Rituximab Combination Tested in CLL** – The pharmaceutical company AbbVie, which purchased Pharmacyclics earlier this year, announced updated results of a Phase Ib study of patients with relapsed/refractory chronic lymphocytic leukemia (CLL) who were treated with venetoclax, an investigational inhibitor of BCL-2, in combination with rituximab. The overall response rate was 84%, with 41% of patients achieving a complete response. The most common adverse events were neutropenia (reduced neutrophils), diarrhea and nausea, upper respiratory tract infections, fever, fatigue, headache, and cough. The BCL-2 protein prevents apoptosis (cell death) and can be over-expressed in certain cancers.

**Single-Dose Treatment Produces Improved Peripheral Stem Cell Collections** – Phase I results were presented at the 20th Annual Congress of the European Hematology Association on BL-8040, a novel approach for the collection of stem cells from the peripheral blood circulation. A single-dose injection of BL-8040 led to robust stem cell mobilization in all treated participants two to four hours after administration. BioLineRX, the company that developed BL-8040, intends to meet with the US Food and Drug Administration in order to discuss the next steps in clinical development, including the design of a planned follow-up Phase II study.

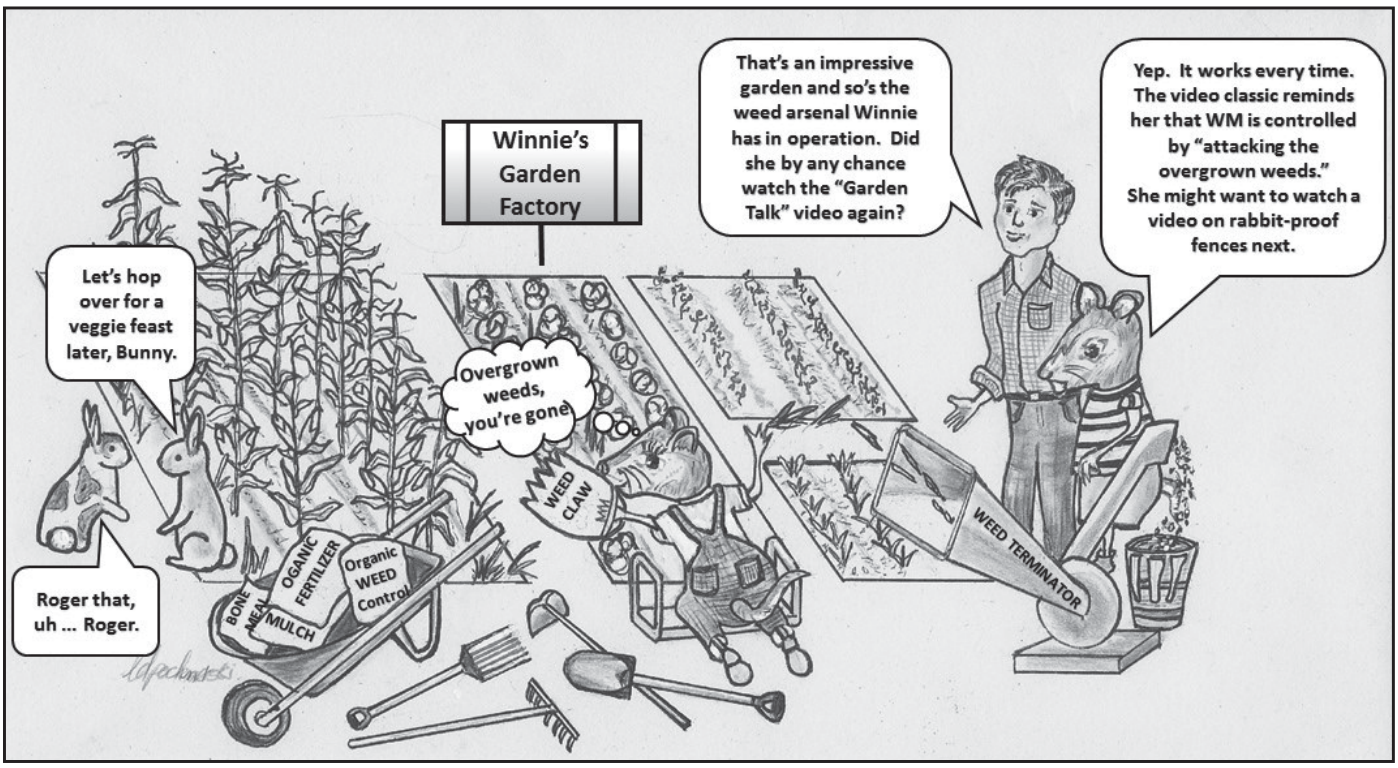
**Legislation Introduced in US to Speed New Drug Development** – In May, the 21st Century Cures Act was introduced in the US House of Representatives, with the goal of promoting the development and speeding the approval of new drugs and devices. The legislation calls for annual increases in the stagnating budget of the National Institutes of Health (NIH), amounting to about 3% per year for 3 years. It would also provide an additional $2 billion per year for 5 years to create an "NIH Innovation Fund." Another provision could make de-identified data from NIH-funded clinical trials more available to researchers.

*Medical News Roundup, cont. on page 14*

*Medical News Roundup, cont. from page 13*

*The author gratefully acknowledges the efforts of Peter DeNardis, Charles Schafer, John Paasch, Wanda Huskins, Colin Perrott, and others in disseminating news of interest to the IWMF-Talk community.* *The author can be contacted at* suenchas@bellsouth.net *for questions or additional information.*

**WALLY AND WINNIE, WM MODEL MICE by Linda Pochmerski**




*Dr. Morie Gertz's "The Garden Talk" video, available through IWMF, explains the scientific and medical concepts about WM in a clever way to help people to understand them. The video reminds Winnie that, when the WM weeds in her bone marrow interfere with her well-being, she must take strong measures to eradicate those weeds. And she will be rewarded with a more productive garden.*

# IN THE TORCHLIGHT: DAVELL HAYS

*Davell today gets a great kick out of touring with Wallie.*

The Torchlight is beaming on Davell Hays, a legendary figure in the history of our Foundation. Back in the "days of Smokler" Davell was one of the founding leaders passionately involved in the establishment of an organization directed to answering the needs of those affected by Waldenstrom's macroglobulinemia, an organization that would endure and expand. That organization was the IWMF.

Davell's lively account of the "Smokler days" has been previously published in the *Torch*, as has her report of her personal struggle to survive, see below.

Diagnosed in 1986, Davell was on "watch and wait" until 1999 when she underwent a double stem cell transplant. A long reprieve followed during which she was asymptomatic. Over the past 3 years, however, Davell's drive, not merely to survive but to do so with *elan*, was again tested, first with interstitial lung disease, leading to a coma and placement on a lung machine, and then, when this scare was behind her, Davell moved on to 6 months of Velcade and Rituxan. And now, the most recent twist in her 29-year survival of WM, the prospect of treatment is on the horizon once again.

*In the Torchlight, cont. on page 15*

*In the Torchlight, cont. from page 14*

Davell picks up the story here and reveals the life-style she has fashioned as her own way to face the vicissitudes of WM: "Every two months I am tested and convince the doctors to wait longer. Part of my self-treatment was the purchase of a trike, part car part motorcycle. I named him Wally, which is a nickname for our cancer. I am convinced that my happiness (in part helped by Wally) keeps me healthy and free of symptoms. That coupled with a great diet and nutritional supplementation, working in my gardens and winery, kayaking, bi-weekly massages, an active dating life and many friends. I have been truly lucky to always feel wonderful, and my heart goes out to those in pain and discomfort from our disease. I am watching with great interest all the new developments in WM and share these with my doctor. This Foundation is at the heart of most research occurring to help us. This week I got another two-month reprieve."

Placing Davell in the Torchlight, we celebrate her resilience and her joie de vivre.

May Davell and Wally go on cruising for a long, long time!

In the Torchlight *is a column for sharing the personal stories of Wallies of all ages to illustrate spirit and strength in the face of adversity. Our pages are full of stories of awards, accomplishments, successful treatments, new adventures, strength of character. Won't you share yours with the* Torch*? Let us hear from you at:* ariginos@me.com

# FROM IWMF-TALK

BY JACOB WEINTRAUB, MD

As summer winds down, and with the approach of fall, the IWMF-Talk discussions continue to be as heated as ever. Articles-multiple and timely-are referenced from a variety of sources below. Discussion topics range from neuropathy, skin rashes, treatment for cramps, as well as continuing reports about Imbruvica. More and more of us are being treated with this new medication, not only in tertiary centers but also in our communities. Questions continue to arise. We eagerly anticipate a Doctor on Call article by Dr. Richard Furman of Weill-Cornell in the January 2016 issue of the Torch for an expert's discussion of many of the questions that we all have as use of Imbruvica spreads.

**HUMAN INTEREST ITEMS**

IWMF-Talk Manager and Trustee **Peter DeNardis** posted several items of general interest for all readers.

Pete cited a book by Tom Brokaw, noted US national TV news anchorman. Brokaw's book speaks about his recent diagnosis of and treatment for multiple myeloma. It provides a perspective on how the disease affected him and his family. Some of his experiences mirror the experiences of WM patients. One of the first experts he saw, and continues to see, was Dr. Morie Gertz of Mayo Clinic. Mr. Brokaw also saw an expert at the Dana-Farber Cancer Institute. Peter indicated that this book is a quick read, well written, and informative from a patient's perspective.

Pete referenced an article published on the Fred Hutchinson Cancer Center website. It presents information about the beneficial impact of humor and laughter for cancer patients. The article discusses various types of humor and asks the question: "Is it OK to laugh?"
*https://www.fredhutch.org/en/news/center-news/2015/08/cancer-humor-eases-stress.html*

**Betsy M** also posted a link to an article about laughter. This article, from the *International Journal of Molecular Medicine*, is called "the elevation of natural killer cell activity induced by laughter." The abstract notes that positive emotion is believed to be favorable to health. This study looked at natural killer cell activity and showed an elevation of these cells in people who were watching a comic film. The elevation correlated with self-rated pleasantness of the comic film, but no correlation with the magnitude of laughter.
*http://www.ncbi.nlm.nih.gov/pubmed/11712080*

**Pete** also posted an article from the July 9, 2015, *New York Times* "Well" section by Mikkael Sekeres, MD, director of the leukemia program at Cleveland Clinic. This article is in the spirit of "how to live life with cancer." It presents a discussion of religion and how it may influence a person's attitude toward disease and treatment.
*http://well.blogs.nytimes.com/2015/07/09/seeing-god-through-my-patients/*

**Wanda H** posted an article about Oliver Sacks, noted neurologist, educator, and author. His books include *Awakenings* and *The Man Who Mistook his Wife for a Hat*. Dr. Sacks offers much wisdom to all. In this article the author writes about Dr. Sacks as he acknowledges his own mortality due to his diagnosis of metastatic melanoma.
*http://www.theguardian.com/commentisfree/2015/jul/25/oliver-sacks-who-has-taught-us-somuch-now-teaches-us-the-art-of'-dying*

**Ginger H** posted a link to the piece that Dr. Sacks wrote in the *New York Times*, July 24, 2015: *http://www.nytimes.com/2015/07 /26/opinion/my-periodic-table.html*
Ginger felt that Dr. Sacks is a most amazing man and an inspiration for how to approach death with dignity and

*From IWMF-Talk, cont. on page 16*

*From IWMF-Talk, cont. from page 15*

meaning. She recently read his autobiography and wants to read more of his work.

**Wanda** also posted a link to an article reporting an interview with a radiologist at Memorial Sloan Kettering Cancer Center who was diagnosed with stage IV lymphoma. The doctor discussed her feelings about being a physician working at a cancer center who was diagnosed with cancer herself. This is a slightly different perspective from what most of us experience but definitely is worth reading.
*http://blogs.webmd.com/cancer/2015/05/the-indignity-of-cancer-treatment.html*

**IBRUTINIB/IMBRUVICA**

This certainly was the most prominent topic in discussions all year. There have been multiple concerns and questions posed both by people who have started this treatment and by people who are considering Imbruvica. Atrial fibrillation, bleeding, dosing, urinary tract infections, various aches and pains – all have been discussed.

**Marcia K** reported that musculoskeletal pain is a common side effect. Six months after starting Imbruvica, she noticed a pain in one foot. MRI showed lesions in her foot and ankle. A bone biopsy report showed fibrosis in bone tissue, possibly drug related. Marcia stopped the medication for a week and the pain almost completely resolved. When Imbruvica was resumed, it was at a reduced dose. She now takes only one pill a day. The pain generally is tolerable with use of Tylenol at night, and Imbruvica seems still to be working well.

**Joseph D** said that he has been taking Imbruvica for almost 5 years. He recently developed inflammation in the little toe which was diagnosed as gout after an x-ray showed characteristic lesions. He now is on treatment for gout.

**Mitch O** started Imbruvica and developed "ricocheting" joint pain that was excruciating. All of his joints ached. He finally resorted to the steroid prednisone and the pain improved significantly. There never was any diagnosis of this, though Mitch is relieved to have improvement.

The question of whether urinary tract infections can be an adverse effect of Imbruvica brought several affirmative responses.

**Jan W** noted that, since starting Imbruvica in July, she has had 2 urinary tract infections (UTI). Her primary care physician looked up information on Imbruvica and found UTIs are listed as a common side effect.

**Sue B** reported that since she began taking ibrutinib in July 2014, she also has had frequent UTIs. Her oncologist sent her to a urologist to rule out other causes. No other cause has been found, and Jan was started on a prophylactic antibiotic for a few weeks.

There was considerable discussion about dosing protocols for Imbruvica. I will include only a small part of this interesting exchange with the hope that, at one of the upcoming Ed Forum sessions, one of the WM experts will address the issue of standard dosing, how the standard was selected, and also the issue of efficacy of reduced dosing for people who do not tolerate a full dose.

**Steve K** reported that after only 30 days on 2 pills a day, his IgM dropped from 1788 to 318, a number he has not been even remotely near since diagnosis. His hemoglobin also is normal for the first time since diagnosis, now at 14.2, up from 10.9.

**Liane C** commented that she wishes her hemoglobin would respond to Imbruvica. Her hemoglobin has not gone above 11.0 since she was diagnosed. She has been taking Imbruvica for over a year and has yet to see improvement in her hemoglobin. It was 10.6 at the start, 10.3 now, and occasionally has been below 10. However, Liane also reports that she has frequent nosebleeds and bruises easily although her platelets are at a normal level. She is currently taking one pill a day with her oncologist' s approval.

An informal poll was conducted of people taking Imbruvica to gauge range of response to treatment. As expected, the responses suggested a wide range of results. Some people reported excellent results in a short time, even within a couple of weeks, some did not show significant response for at least a few months, and others showed very little response.

**Sharon T** reported Imbruvica was working “fantastic” but she developed atrial fibrillation and the med was temporarily discontinued. This theme was repeated by a number of people. The discussion of atrial fibrillation was included in the April *Torch*, and the discussion is ongoing.

**TEMPORAL ARTERITIS**

**Cindy L** asked how many WM patients have been suspected of, or diagnosed with, autoimmune disorders, for example

*From IWMF-Talk, cont. on page 17*

## HOW TO JOIN IWMF-TALK

**Here are two ways to join:**

1. Send a blank e-mail to: *iwmf-talk-subscribe-request@lists.psu.edu*

   Make sure to enter the word “subscribe” as your subject, and do not sign or put anything in the message area (make sure you do not have any signature information in there). Also, do not put a “period” after “edu” or it will reject. Once approved you can post by sending e-mail to *iwmf-talk@lists.psu.edu*
2. Contact Peter DeNardis at *pdenardis@comcast.net* and provide your full name

*From IWMF-Talk, cont. from page 16*

temporal arteritis. Many of us have a very high sedimentation rate. Cindy's oncologist told her that a high sed rate is common with WM and not to worry about it. She subsequently went to her primary care physician with an earache and sinus headache, and the primary care physician put Cindy on steroids and was sending her for a temporal artery biopsy, primarily because of her elevated sedimentation rate.

**Dr. Jacob Weintraub** responded that in WM patients the sed rate is almost always artificially elevated because of how the test is done: blood is placed into a tube and after an hour the lab tech measures how far the red cells settle. With the elevated IgM in WM, the very large IgM molecules cause the red cells to fall further than they normally would fall. The test result is abnormal, suggesting inflammation, but this in fact may not be the case. Of course as WM patients we can have other diseases with inflammation producing a high sed rate, but we should be cautious about diagnoses that are based solely on an elevated sed rate.

**Sylvia A** reported she has the diagnosis of temporal arteritis based on biopsies of both temporal arteries. She was on steroids for a very long time. Her sed rate has held steady at a very elevated level in the low 100s despite the steroid treatment, but none of her physicians seems to be worried about that lab result.

**Maureen H** reported that she has autoimmune conditions and takes prednisone. She has polymyalgia rheumatica and a high sed rate. Sometimes giant cell arteritis may accompany polymyalgia rheumatica. Because there is a danger of visual impairment with temporal arteritis, she sees an ophthalmologist regularly. Maureen has not had a biopsy but monitors her conditions with multiple specialists and tries to keep up with all the latest information on those conditions as well as her WM.

**CRAMPS**

**Sandra A** posed a question about muscle cramps. She was going to her grandson's wedding and had a full day of activity before her on the day before the wedding. She awoke with severe cramping in her legs, feet, and toes. She is taking Imbruvica, and was wondering if anyone has had such a side effect and if anyone has a remedy.

**Hank S** offered a remedy that has worked for him. He drinks 2 ounces of dill pickle juice as often as needed when cramps set in, and it brings him relief, though he does not know what is in the pickle juice that has that effect. Hank keeps a jar of pickle juice in his refrigerator for this purpose.

**Dr. Tom Hoffmann** was doubtful at first but then found an interesting study that supported pickle juice as an effective remedy for cramps. In a study of healthy volunteers, monitored by athletic trainers, pickle juice was used to stop exercise-induced cramps and was quite effective.
*http://well.blogs.nytimes.com/201006/09/phys-ed-can-pickle-juice-stop-muscle-cramps/*

**Betty M** reported that she has recently started using straight vinegar to stop leg cramps at night. It stops the cramps in about a minute. She dilutes the vinegar in water, making it easier to swallow.

The discussion on each of these subjects was much more extensive than can be covered here. Everyone is welcome to join IWMF-Talk, if only to "lurk and listen," although opinions and shared experiences are always encouraged.

# COOKS' HAPPY HOUR

BY PENNI WISNER

**FAUX GRAS**

Adapted from David Lebovitz who adapted it from Rebecca Leffler, *Tres Green, Tres Green, Tres Chic: Eat (and Live!) the New French Way with Plant-Based, Gluten-Free Recipes for Every Season, (theexperimentpublishing.com* 2015). (Can you tell I believe in attribution?)

One of the things I love about writing this column is that I get to share my newest food discoveries. This one just blew me away. And I hope you like it, too.

It was the title that caught my attention: Faux Gras. I love foie gras but it remains illegal in California and so we make do with duck liver pate (tough, I know). For those who have given up organ meats and perhaps all meat, the rich, exotic, unctuous flavor of foie gras has become a creature of memory or imagination only.

Normally, I'm a' gin faux meat products. But this is not that. Instead, it is a vegetarian spread (and can be vegan, if you prefer) with a deliciously savory, meaty flavor. If you make it in a powerful blender such as a Blendtec or Vitamix, you can achieve a superior, light, and very creamy spread. Not supple and velvety like foie gras but what is?

Enough with the mystery! What am I talking about? This solution to all (at least some, I hope) of your entertaining needs for this upcoming holiday season is based on cooked lentils. Yes, the lowly lentil. Read on to learn the secret of its transformation.

Begin with 160 grams (1 cup) dried lentils. Cook them in plenty of boiling salted water and until they are very tender. Drain them well, transfer them to a bowl, and let cool.

*Cooks' Happy Hour, cont. on page 18*

*Cooks' Happy Hour, cont. from page 17*

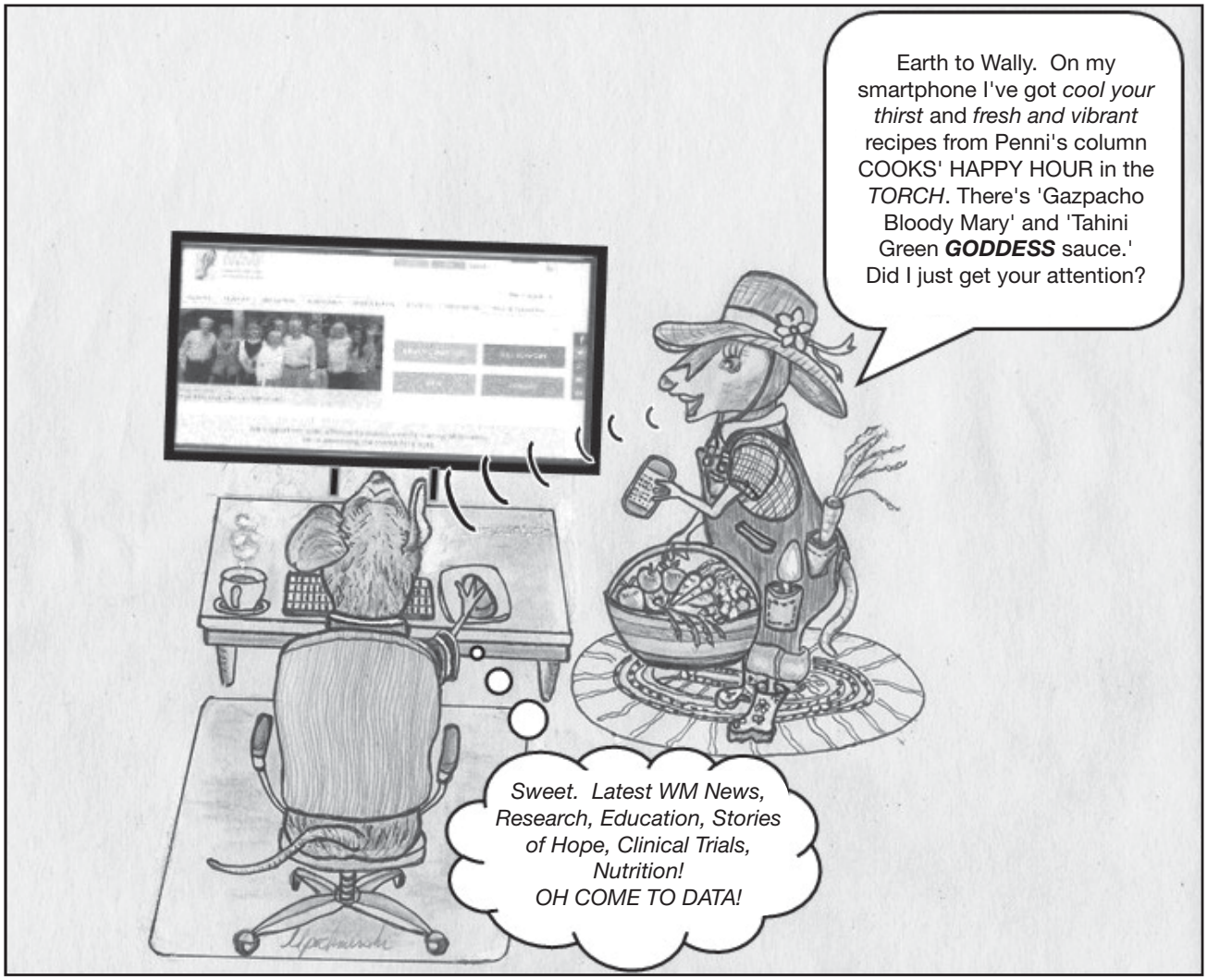
Meanwhile, slice (thickness doesn't really matter) 225 g button mushrooms (white or brown) and saute them in a large skillet over medium-high heat in 1 tablespoon each unsalted butter and olive oil. (If you want to go vegan, use all olive oil.) Cook them until they have nicely browned. When done, scrape them into the bowl with the lentils. Heat another tablespoon each butter and oil in the same pan over medium-high heat. Add 1 medium (about 140 g) yellow or white onion, thinly sliced, and cook until very soft and slightly browned about the edges. Add 2 cloves garlic, thinly sliced, for the last few minutes of cooking. Transfer the onions and garlic to the bowl with the lentils.

Now transfer your lentil mixture into a powerful blender or food processor and blend until you have as fine a puree as possible. Add 140 g (about 1 1/2 cups) toasted walnuts or pecans ( or a mixture of both) along with 2 tablespoons freshly squeezed lemon juice, 1 tablespoon soy sauce, 2 tablespoons each chopped fresh sage and flat-leaf parsley, 2 teaspoons each chopped rosemary and thyme, 1 tablespoon brandy, a large pinch dark brown sugar, a pinch cayenne. Bmrr it all up again, scraping down the sides occasionally, and pureeing until you have as smooth a mixture as you can get.

Now taste the Faux Gras and adjust the flavors to your liking with salt, freshly ground black pepper, brandy, lemon juice, and soy. The Faux Gras is rich so serve it on crunchy toasts or crackers with some chopped cornichons. These amounts will yield about 4 cups. You can halve or double the recipe and the Faux Gras freezes well, too. And yes, I know, I don't usually give such a specific list of ingredients, nor such a long one. But persevere and I would be so interested to know how you like the result.

*Our motto: Eat Well to Stay Well*

**WALLY AND WINNIE, WM MODEL MICE by Linda Pochmerski**




*The IWMF has successfully launched a new website specifically designed to provide worldwide support to WM patients and caregivers using the device of their choice. While Wally absorbs new data at* iwmf.com*, Winnie has priorities of her own. She immediately uses the improved technology to access back issues of the* Torch*, searching for inspirational recipes from the garden while harvesting her healthy home-grown veggies.*

# SUPPORT GROUP NEWS

EDITED BY PENNI WISNER

***Please Note:*** Contact information for all support groups and IWMF affiliates is found on *iwmf.com* under GET SUPPORT. Details of support group meetings and other upcoming events are posted on *iwmf.com* under EVENTS.

*The Illinois support group, 38 strong, gathered for fun, fellowship, and food at the home of Kathy Coyner.*

## CALIFORNIA

*Sacramento and Bay Area*

The group met at one of its satellite locations, the Kaiser Roseville Medical Center, at the end of September. The theme, taken from Dr. Joseph Mikhael's presentation, *I've Been Diagnosed with WM, What Happens Next?* gave rise to many stories of the sometimes long march to a correct diagnosis and much lively discussion. Dr. Mikhael is with the Mayo Clinic in Scottsdale and gave the talk at the IWMF Forum in May 2015. *Video from the 2015 Ed Forum is available at iwmf.com*

## IDAHO

Just five individuals – two patients, two husbands and the widow of a patient – comprise the Idaho support group. Because of its intimate size, the kitchen table approach has served us best, with informal gatherings scheduled with a quick telephone call to fit all five schedules. The co-leaders, **Janet Corson-Stanton** and **Barbara Britschgi,** live just 100 yards apart and both worked for the Regional Health Department. With her training (graduate degrees plus special training) in public health, Barbara worked for various Federal agencies as a Health Consultant (focusing primarily on dental health). She covered much of the United States including Alaska, auditing health education for Headstart Programs. Janet and Barbara each have another support group: their families. Barbara and her husband Jerry were blessed with six children. Alas, the oldest daughter is deceased but Theresa remains always in their memories. Together they have 14 grandchildren and 6 great-grandchildren (both biological, adopted, and step 'great-grands.'). All are loved equally. Other than a granddaughter located about 50 miles from their home, the children are scattered. A weekly Internet newsletter chronicling adventures, good and bad, keeps the family a close-knit unit. Each has the opportunity to start the week by naming the newsletter. For instance, this week is Panama de Je Vue. Barb strongly believes that support for WMers is available when shared with family.

*Barb Britschgi, the support group leader of a group numbering only 5 members, looks to her close-knit family for support. Pictured are husband Jerry and all five of their adult children. Front row: Jerry, Cathy, Barbara; in the second row, l. to r., are Andy, Mary, and John. In the far back: Bill. Missing are the 14 grandchildren and the 6 'great-grands.'*

## ILLINOIS

*Chicago Area/SE Wisconsin*

For the second year in a row, **Kathy Coyner** hosted the much-anticipated annual picnic (our seventh!) on August 8. Her home is located in a scenic wooded area of St. Charles, Illinois, on the west side of Chicago. Thirty-eight members attended, including three first-timer families and a couple from Milwaukee, Wisconsin. Special thanks to Kathy for

*Support Group News, cont. on page 20*

*Support Group News, cont. from page 19*

*WM veterans and newcomers alike gathered in Charleston for an informative meeting.*

hosting and to **Carol Kowaleski** for organizing the food. Many stories were shared during this time of fellowship. All appreciated the presence of Dr. Christine Winter, a local oncologist, who retired in 2014 after many years of treating WM patients.

## NEW YORK

*New York City*

Fewer members than usual attended the July meeting, and those who did were the old-timers who came to check in with their long-time comrades. The wide-ranging discussion included anecdotal reports on new treatments. While not exactly a newsworthy meeting, the participants took this as a good sign about the general good health of the group as a whole.

*Eastern NY/Western New England*

For the June meeting at the Hope Club, **Leslie Neustadt** arranged for her oncologist, Dr. Courtney Bellomo, to speak and answer members' questions submitted ahead of time. Dr. Bellomo joined the New York Oncology Hematology staff almost two years ago with specialties in hematology and stem-cell transplant.

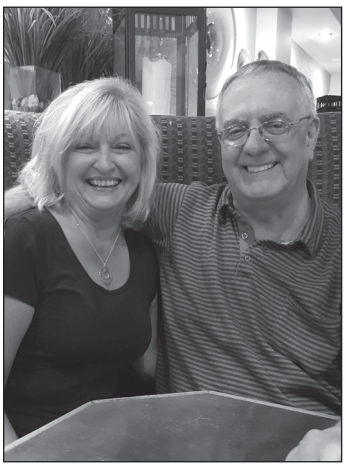
*Photograph of coneflowers in the garden of Thomas Rousher. Tom notes that the flower (coneflower or Echinacea) came from seeds he brought from the 2014 Tampa Ed Forum. "The photo," adds Tom, "is symbolic of the theme for the Forum – 'Imagine a Cure: Seeds of Hope.'"*

## EASTERN OHIO, WESTERN PENNSYLVANIA, & WEST VIRGINIA

The Hilton Garden Inn, Akron, Ohio, was a lovely venue for an early summer meeting. Several newcomers and many long-time members had a chance to socialize and share personal WM experiences during lunch, a delicious buffet provided through the hotel affiliation of one of our members, **Tom Rousher**. Following lunch, our attention turned to encouraging IWMF news and WM advances in a discussion of recent Ed Forum highlights by members who were present. **Shari Hall**, who attended both the first and the most recent Ed Forum, reflected on her special memories and impressions of the remarkable progress of the IWMF. Group members openly shared thoughts about treatment decisions and side effects, coping with the "watch and wait" situation, the ongoing dilemma of maintenance therapy, and the cost of drugs. There are always lots of issues to stimulate discussion! The mutual support in navigating WM challenges illustrates the caring spirit of our group.

## SOUTH CAROLINA

At the end of July twelve people attended the meeting held in Charleston at the American Cancer Society's Hope Lodge. WM veterans and newcomers enjoyed hearing each other's status and experiences with WM and various treatments, including ibrutinib. One had experience with the new treatment and another was about to start treatment with it. A newly diagnosed patient received a lot of information and support from the rest of the group.



*Bill Paul also had the opportunity to visit Arlene Hinchcliffe, the president of the WM Foundation in Canada during a trip to Toronto in August. Bill and Connie Paul were able to "compare notes" with the WMFC President during a pleasant lunch in Oakville, Ontario.*

## TENNESSEE

*W. Tennessee, E. Arkansas, N. Mississippi*

The Memphis Area group had two summer meetings, on June 20 and August 29. After some issues with meeting space, a permanent spot has hopefully been found at the St. Francis Hospital in Memphis. Many thanks to

*Support Group News, cont. on page 21*

the hospital for the assist! Seven patients and caregivers came to the June meeting. Three members who could not attend nonetheless sent along notes which group leader **Bill Paul** shared. The main topic centered around the latest approved WM therapy, Imbruvica, and the success a few members have had with it. All were encouraged and hope it works as well for others. Bill also had the opportunity to visit the president of the WM Foundation in Canada during a trip to Toronto in August. Bill and wife Connie were able to "compare notes" with WMFC President Arlene Hinchcliffe during a pleasant lunch in Oakville, Ontario. Bill then shared some thoughts and insights from that visit at the August 29 support meeting. It's always good to know what's happening with our neighbors "Up North"!

*Jim Reed, support group leader, Delaware; Elly Levie (Carl's wife); Tony Sabló (Lu's husband); Lu Kleppinger, support group leader, Northern Virginia; IWMF President Carl Harrington; Michele Grossman (Arnie Smokler's granddaughter); and Dr. Mary L. McMaster, NIH National Cancer institute).*

### NORTHERN VIRGINIA / WASHINGTON DC / WESTERN MARYLAND

At the group's early summer meeting, IWMF President **Carl Harrington** gave a superb presentation detailing the joint IWMF and Leukemia & Lymphoma Society Strategic Research Roadmap Conference. Held in New York City in May, the Research Roadmap Conference was attended by a "who's who of Waldenstrom" including scientific co-chairs Dr. Stephen Ansell, Mayo Clinic, and Dr. Steven Treon, Dana-Farber Cancer Institute. Carl stated that, "The purpose of the Research Roadmap was to identify gaps in our knowledge of WM and to strategize our research priorities. Then we can fill those gaps, leading to the development of better treatments and ultimately a cure. Fourteen of the leading minds in WM participated." (See pages 6-7 of this issue for further details.) The support group was very happy to have direct access to Carl and he was, as always, very engaging. He was a hit! Several special guests also attended, mingling with the 46 participants, including **Elly Levie** (Carl's wife) and **Dr. Mary L. McMaster** of the National Cancer Institute who gave our group's inaugural address in the fall of 2014. (Dr. McMaster's talk is available on iwmf.com, see NEWS January 28, 2015) Also attending was IWMF founder **Arnie Smokler**'s granddaughter, **Michele Grossman**. Michele is a member of the group and remembers at six years of age her grandfather's "big list" which he kept in his basement. She believes it was the beginning of IWMF's membership list. **Jim Reed**, support group leader from Delaware, drove a distance to assist. At the request of our President Emerita, **Judith May**, volunteers were invited to participate in her IWMF Advocacy Program. Several well-qualified applicants, all from the DC area, raised their hands. Dr. McMaster described an NIH-based Waldenstrom macroglobulinemia natural history study that will include WM patients irrespective of family history of WM (WM family history is the area that is of special interest to Dr. McMaster). "The overall goals of the study are to understand WM biology and to investigate factors that may be important in causing WM patients to progress from being asymptomatic to needing treatments," explained Dr. McMaster. Data collection began right there and then – dates of diagnosis, dates of treatment, and treatment protocols – collected and provided to the principal investigators, Dr. Adrian Wiestner and Dr. Clare Sun of the NIH National Heart, Lung, and Blood Institute. Eight group members kindly volunteered to help organize this meeting and to provide refreshments. **Lu Kleppinger**, support group leader, welcomed guests to the expanded group which now includes Northern Virginia, Washington DC, and Western Maryland.

### PACIFIC NORTHWEST/WASHINGTON

The Pacific Northwest WM Support Group has started up again in the greater Seattle area with **Shirley Ganse** as leader. The first meeting in March saw six attendees and the second, in June, had fifteen. The September meeting was held in Bellevue. Future meetings are planned for venues further afield to accommodate people who live further from Seattle. Building on this momentum, Shirley intends to hold meetings about every three months, presenting both formal educational programs and plenty of time to discuss and share attendees' concerns and questions.

## Have Your Say

The *Torch* welcomes letters, articles, or suggestions for articles. If you have something you'd like to share with your fellow WMers, please contact *Torch* editor Alice Riginos at *ariginos@me.com*

# INTERNATIONAL SCENE

EDITED BY ANNETTE ABURDENE

*Attendees at the very successful Toulouse Conference. Note: standing beside the white column are Patrice Ostermann on the right and Dr. Ysebaert on the left.*

## FRANCE

The annual Patient Education Conference of Waldenström France was held in Toulouse on May 23. Participants began arriving at the hotel "Le Clocher de Rodez" at 10 in the morning. We began with coffee and sweets at the hotel café, the occasion of an emotional reunion of returning patients and a welcoming of newly diagnosed. About 60 patients and caregivers participated in the conference.


*Patrice Ostermann, president of Waldenström France, with his wife Martine at the Patient Education Conference held in Toulouse.*

The first presenter was Dr. Philippe Paux, a general practitioner with an interest in Waldenstrom's macroglobulinemia. Dr. Paux gave a useful overview of WM's impact on caregivers and family and also covered the price of drugs and overall cost of the illness. The morning passed by quickly and then it was time for lunch. Patrice had made the arrangements for lunch, and we all sat in small groups to share news of the past months.

After lunch Dr. Loïc Ysebaert of the Center for Research in Cancer in Toulouse arrived. A passionate hematologist, he captivated the audience by popularizing "Wald" and by making his presentation comprehensible to all. Dr. Ysebaert's talk was a great success. Next was the turn of Dr. Pierre Morel. Dr. Morel, a clinician well known in the WM community and recipient of the Robert A. Kyle Award for contributions to Waldenstrom's macroglobulinemia presented at the International Workshop on Waldenstrom's Macroglobulinemia, August 2012, brought us up to date on the range of research projects currently under investigation.

During the afternoon snack break, gifts were presented to Nicole Bastin and Jean Claude Fayer to thank them for translating the *Torch* from English into French for so many years.

Dr. Loïc Ysebaert resumed the program by outlining new treatments envisioned for Waldenstrom. A question and answer session followed with Francois Soulié presiding. The conference concluded at 7 pm. Some of the participants enjoyed dinner together before everyone went on their separate ways.

This was a gathering rich with emotions and with human warmth and one filled with much new information. Everyone was left with one question: "When and where would the next meeting be?" Warm thanks were expressed for Denis and Annette Beaugeard, Martine and Patrice Ostermann, and all those who helped to put in place this magnificent day.

**Paulette Tribondeau, Secretary, Waldenström France, and Patrice Ostermann, President, reporting from Brittany.**

## GERMANY

There will be a workshop/discussion on Waldenström macroglobulinemia as part of the 11/21/2015 Cancer Patient and Family Support Day in Freiburg, Breisgau, Germany. The event is being hosted by the Comprehensive Cancer Center Freiburg (CCCF) and Leukaemiehilfe Rhein-Main (LHRM) and will be held at Max Weber Schule, Fehrenbuchallee 14, Freiburg, Breisgau, Germany.

More details at *http://www.leukaemiehilfe-rhein-main.de/files/pdf/veranstaltungen/2015-patiententag.pdf.*

*International Scene, cont. on page 23*

*A wonderful turn-out for Dr. Treon at the Ca 'Granda Niguarda Hospital in Milan. Dr. Treon stands in the front row, fourth from the left. To the right of Dr. Treon are Dr. Beatrice Colombo and Dr. Enrica Morra (in their white lab coats). And at the far left, front row, is Dr. Alessandra Trojni of the Department of Hematology.*

## ITALY

WM-IT, the Waldenstrom's macroglobulinemia patient support group of Italy, held a meeting on June 16 at the Department of Hematology, Ca 'Granda Niguarda Hospital in Milan. Dr. Steven Treon of the Dana-Farber Cancer Institute in Boston, whose recent research in the genetics of WM has led to new hope for control of the disease, was our speaker of the day.

The meeting was divided into two sessions, the first for Italian Waldenstrom patients held at the hospital, and the second directed to doctors and technicians.

**Meeting with Patients**

Dr. Treon met with WM patients and spoke with them about the therapeutic approaches currently in use and new approaches in trials and, above all, about the hope aroused by the enormous progress in clinical research targeting this disease.

Initially, Dr. Treon thanked Dr. Enrica Morra, President of the Italian Association "Malattie del Sangue" Onlus, for the substantial contribution that her work has provided to scientific progress in the study of disease. Dr. Treon reminded us that for this work Dr. Morra received the Waldenström Award at the Eighth International Workshop on Waldenstrom's Macroglobulinemia in 2014.

Dr. Treon's presentation focused mainly on recent advances in genetics leading to the discovery of the MYD88 and CXCR4 mutations in WM patients and the development mechanisms, activated by these mutations, of the resulting diseased cells. Based on these studies, the decision was made to test WM patients with the new drug ibrutinib (Imbruvica) which has proved to be very effective in fighting the disease. Imbruvica is the first drug approved by the FDA in the US for Waldenstrom's macroglobulinemia. Recently ibrutinib was approved by the EMA in Europe as a drug to be used within controlled therapeutic protocols. During the presentation Dr. Treon highlighted the contribution to genetic studies made by the Italian researcher Dr. Marzia Varittoni of Pavia, and he presented the team of scientists who have contributed to genetic research and are currently engaged in the study of another drug (ABT 199) that has a targeted action against the specific protein BCL-2.

The presentation raised much interest, and many questions followed from attending patients. Reassuring answers to their concerns were provided by Dr. Treon, thanks to the encouraging prospects seen in the new treatments resulting from clinical research.

**Meeting with Doctors and Technicians**

Dr. Treon also met with doctors and members of the technical staff from Ca 'Granda Niguarda Hospital and discussed the state of WM research, particularly the genetic aspects, and the active mechanisms of various drugs, both currently in use and under study.

Special emphasis was given to the therapeutic approach recommended for the various manifestations of the disease and to the differences of approach for similar diseases such as myeloma and MGUS. The meeting was organized in an informal and engaging way, which aimed to encourage direct contact between participants and speaker. Numerous questions and answers followed.

Many thanks are owed to Dr. Treon for inaugurating the lecture program of WM-IT.

International Scene, cont. on page 24

*International Scene, cont. from page 23*

**Recordings**

Recordings from both sessions are available online:

Dr. Treon Meets with WM Patients. Recording (with simultaneous translation into Italian) is available at the following link: *https://www.youtube.com/watch?v=-5E7URYjD3c*

Dr. Treon meets with Doctors and Technicians. Recording is available at the following link: *https://www.youtube.com/watch?v=MomJ-Pbf-oU&feature=youtu.be*

**Ermanno Chiavaroli, reporting from Abruzzo.**

## UNITED KINGDOM

The Rory Morrison WM Clinical Registry went live on August 14. Originally it was intended to let doctors slowly fill it with data on current patients, but with the assistance from Janssen UK at University College Hospital, London, and with resources locally at Bournemouth, it should now be possible to input historic treatment data. WMUK is fundraising to try to extend this to other centres so the registry will rapidly grow. There has been much interest from other countries, and those interested are welcome to contact WMUK if they would like to be included. The doctor group are now working on including patient-reported data to add to records directly from PCs and smartphones.

The WMUK Doctor Forum made a successful application to join the UK's Genomics England Clinical Interpretation Partnership (GECIP) with its own WM sub-domain. Essentially this should fund DNA sequencing of WM patients with the aim in the future of using the results to improve the effectiveness of treatments with new drugs.

Following the approval by the European Medicines Agency of ibrutinib (Imbruvica) in July, UK health regulators the National Institute for Health and Care Excellence (NICE) and the Cancer Drugs Fund will be considering its approval for relapsed WM in late 2015. It is already approved by the Cancer Drugs Fund for mantle cell lymphoma and chronic lymphocytic leukemia (CLL). Approval usually depends on a combination of unmet need, cost, and efficacy.

Following the note about UK trials in the last *Torch*, a number are now underway, and WMUK has added a trials page on its website to encourage patients to consider taking them up.

**Roger Brown, reporting from the Oztal Valley and Bregenz on the shore of Lake Constance, Austria.**

## AUSTRALIA

**Leukaemia Foundation's Annual Blood Cancer Education Conference**

Dr. Constantine Tam held a separate breakout session for WM patients at the Leukaemia Foundation's Annual Blood Cancer Education conference in Parramatta, Sydney, on May 23. Dr. Tam presented an overview of WM covering

*Dr. Constantine Tam*

diagnosis and treatment. Many questions followed in relation to his presentation. Dr. Tam was asked about his many WM-specific roles and experiences. Highlights involved work as principal investigator of the ibrutinib trial for WM patients in Melbourne and the ABT-199 clinical trial involving a WMozzies patient.

WMozzies and the Leukaemia Foundation have combined forces to increase education and support for people living with Waldenström's.

*Dr. Guy Sherwood, Vice President for Research, IWMF, shares a quiet moment with Dr. Peter Diamond, Leukaemia Foundation Blood Cancer Support Manager, attending his first IWMF Ed Forum.*

**IWMF Ed Forum**

At the IWMF Ed Forum held in Dallas, Texas, in May, WMozzies was represented by Dr. Peter Diamond, Leukaemia Foundation Blood Cancer Support Manager. At the Forum he also represented Australia at Marcia Klepac's workshop for IWMF US and International Support Group leaders.

Dr. Diamond reported on the Forum:

"This was my first opportunity to meet and start to get to know this amazing, eclectic, and passionate group of people from all over the USA, Canada, and Finland who had been brought together by this common bond – Waldenström's Macroglobulinemia.

"My name badge, with *first timer* written in fluoro orange on it, was a beacon, as I straight away noticed, for a steady progression of people coming up and introducing themselves and welcoming me to my first Educational Forum.

"Before coming to the conference I had spoken to Andrew Warden, WMozzies Leader in Australia, who told me about the sense of community at this Forum, and I was starting

*International Scene, cont. on page 25*

to understand what he was talking about. Carl Harrington, IWMF President, set the theme for the whole conference. The theme was simple: HOPE. Waldenström's wasn't a death sentence anymore, which was evident by those individuals who were there proudly displaying their 20-year survivor ribbons on their name tags.

"As someone who spent 20 years working in a research laboratory, I was particularly interested in hearing from the scientists to understand what was the frontier of WM research and where were things heading. Dr. Guy Sherwood, IWMF Vice President for Research, spoke about IWMF's current and future directions for medical research into WM, Dr. Julie Nielsen spoke of the revolution in cancer treatment that is harnessing the body's own immune system to fight cancer, and Dr. Zachary Hunter highlighted the complexities of the human genome and how advanced sequencing is helping scientists identify critical pathways in the disease.

"A rare and special treat was for me to listen to and have dinner with Dr. Robert Kyle, an individual whose work has paved the way in understanding and treatment of blood cancers.

"As one who runs support programs for people living with blood cancers, I left this meeting with enthusiasm, drive, and, above all, hope that we will find a cure not only for WM but all blood cancers."

**WMozzies Website**

The new WMozzies website is live and undergoing final user testing before its official launch. The site has been migrated to an Australian domain *www.wmozzies.com.au*

The development of the new site was made possible with the support of many, freely given. The starting point was the original WMozzies site created by Colin Perrott in 2011 on a US domain. Following advice from Peter DeNardis, Chair, IWMF Information Technology Committee and then IWMF Webmaster, it was decided to develop a new site with the domain in Australia using a WordPress platform. Again IWMF gave critical support to the development by allowing WMozzies to model our site using the IWMF menu structure and colour scheme. Direct links to a rich repository of IWMF educational material have been incorporated to allow WMozzies direct access to world best WM patient material. Peter Carr and Andrew Warden, who were leading the Australian development, realised that necessary expertise and funding were lacking. The WMozzies Talk-list was used to request expressions of interest in developing the WMozzies website. Long-time South Australian WMozzies Chris Doe and Michael van Ewijk (Michael is, by the way, the first Australian on the ibrutinib WM clinical trial) responded. Chris has provided his expertise as a professional WordPress site manager to set up the menu structure for the site. Michael, a professional photographer and graphic designer, created the vital photo-composition for the home page and other key visuals. Peter Carr had a pivotal role in the development. He undertook personally the initial trials to confirm that WordPress was suitable for WMozzies to develop and maintain the site, and he identified areas where specific IT support was needed, and he enlisted the IT support of the Leukaemia Foundation through Adrian Collins, Chief Executive Officer, and Anna Williamson, Head of Research & Advocacy. Peter worked with Charles Munchow, Leukaemia Foundation IT Head, to establish the Australian domain for the site and for its hosting by the Leukaemia Foundation.

**Australian Story of Hope**

The 20-year WM survival story of hope continues for Colin Parrish in a new clinical trial. Colin in August started a phase 1 trial at the Peter MacCallum Cancer Centre in Melbourne, Australia, of a new drug called BGB-3111 which targets the same Bruton's tyrosine kinase protein that ibrutinib does. At present there are 30 patients enrolled worldwide, with 4 WM patients amongst them. Colin naturally is feeling excited and privileged to have been enrolled in this new trial.

**Clinical Trials**

Two WMozzies are in the international WM ibrutinib clinical trial at Concord Cancer Centre at the Concord Repatriation General Hospital. The Principal Investigator is Associate Professor Judith Trotman. Michael van Ewijk is the first Australian to be in the trial. His results after four months are good, enabling him to be back on his bike and doing 150 km per week. Andrew Warden started on the trial in August and is in the randomized arm. Andrew is receiving either a placebo or ibrutinib along with MabThera (Rituxan) infusions.

**WMozzies CART-WHEEL Database**

The CART-WHEEL project is progressing to provide Principal Investigators Dr. Constantine Tam and Associate Professor Judith Trotman with a tool for research analysis of patient-submitted details in Waldenström's macroglobulinemia. The project feasibility study has been completed, confirming that the CART-WHEEL BioGrid database is fit for purpose. CART-WHEEL has been confirmed to be operationally proven, ethically approved, easy to use, with flexibility to meet ongoing and changing research requirements. It covers patient personal and disease history, treatments and types, dosage, treatment outcome in terms of the key measures of disease progression, and adverse events.

The database content has been confirmed by the Principal Investigators. Further development requires modifications to the existing CART-WHEEL system. This is currently being assessed by CART-WHEEL BioGrid Principal Investigator Associate Professor Clare Scott at Royal Melbourne Hospital. Expressions of interest in funding the system development have been received.

**Andrew Warden reporting.**

# INTRODUCING JONAS PALUDO, MD YOUNG INVESTIGATOR AWARDEE

AS TOLD TO PENNI WISNER

*Jonas Paludo, MD*

Dr. Jonas Paludo is one of four researchers granted a Young Investigator Award (YIA) to attend the International Workshop on Waldenstrom's Macroglobulinemia (IWWM8) held in London, August 2014. He presented a poster and made an oral presentation of the first installment of his clinical research project at the Mayo Clinic: *Clinical Features and Survival Outcome of Young Patients with Waldenstrom Macroglobulinemia*. The accompanying article is the third in a planned series to introduce young cancer researchers to IWMF members. Their cutting-edge and innovative work may well culminate in a new understanding of Waldenstrom's macroglobulinemia and potential new therapeutic regimens.

Like other young investigator awardees for 2014, Jonas Paludo, MD, knew he liked science as early as high school. He also knew he liked working with people, especially intelligent people. And he thought being a physician would give him the best opportunity to help more people. And that was important to him.

His father is a dentist and Dr. Paludo is the first physician in the family. When he told his parents of his career choice, they were delighted, "especially my mom," said Dr. Paludo. "My parents never wanted to influence me as to my career. They never told me what they wanted me to do."

*Dr. Paludo and his wife, Dr. Alice Gallo de Moraes, celebrate his graduation from medical school.*

After earning his medical degree in Brazil (Universidade Federal de Ciencias da Saude de Porto Alegre Brazil from 2004 to 2009), Dr. Paludo began searching for the best possible training for his residency and fellowship. "In my mind the best training was in the US. During medical school, I came to the US a few times to do clerkships, for instance, I came to the Miller School of Medicine at the University of Miami for a clerkship in internal medicine. And then I stayed for a preliminary year of residency in general surgery at the Jackson Memorial Hospital at the University of Miami."

But being a surgeon did not allow enough time for Dr. Paludo to be with patients. He decided that specializing in internal medicine would give him the most time with patients. He then switched to internal medicine, applied to the Mayo Clinic, Rochester, and was accepted. "I came to the Mayo for the first time as a med student. I liked the mentorship system they have; it was the main reason I wanted to come back. People are very open and approachable here, and the environment is very good for doctors to learn and for education and for patient care as well."

Dr. Paludo came to the US with his wife, Dr. Alice Gallo de Moraes, who is also a physician at the Mayo Clinic. "We are from the same city in Brazil. We both went to Miami for our residencies after medical school. She spent three years there in internal medicine. We had to spend about a year apart as I came to Rochester before her. Then she came here for her fellowship. It was not the best situation to be apart for a year but we handled it. Initially, her fellowship was in critical care, and now she is doing a pulmonary fellowship while I do my fellowship in hematology/oncology." A fellowship is at least three years and the Drs. Paludo have the option of doing a fourth year. Since, when we spoke, Dr. Paludo was just in his second month of his fellowship, he and his wife have a few years before they need to plan next steps.

In the limited time available outside of work, Dr. Paludo and his wife both like to hike. And Dr. Paludo also enjoys photography, especially landscape photography. He was fortunate that his last year of residency included enough spare time to allow travel to some national parks. "Over the last two years I went to Yosemite, which so far is the most beautiful of the parks I have visited. We went to the top of Yosemite Falls, a steep, hard climb but worth it for the view. We could only go half way up the Half Dome trail, as far as you can go without a permit. Some day I will go back. I also went to Big Sur in CA, which is amazing, and to Zion, Bryce Canyon, and Monument Valley. It was so beautiful. Recently biking is how I enjoy getting exercise – while the weather permits. In Minnesota, summer is amazing but winter is a different story."

Cooking together, especially on weekends, is another favorite leisure activity. While they cook dishes from all sorts of cuisines, if they can find the ingredients or have received a care package from relatives at home, they will cook Brazilian food. "Our

*Introducing Jonas Paludo, MD, cont. on page 27*

families send us the ingredients and bring them with when they visit." The Paludos visit their families in Brazil about once every other year and their parents visit them in the US maybe every six months. "My parents were just here," said Dr. Paludo. "It was my dad's dream to go to Yellowstone. We were able to take a few days vacation and go there all together."

One of his first rotations in his internal medicine residency at Mayo was in hematology/oncology. "I fell in love with the field. It was so rewarding to help and care for patients with cancer. And I liked all the physiology and the research coming out of hematology/oncology. My research focus shifted to reflect this new interest."

Of the three YIAs we have spoken with so far, Dr. Paludo is the first to focus on clinical research. Clinical research is when hypotheses developed by basic research (in the laboratory working, for example, with animal models or with genetic analysis and manipulation) are applied to patients, perhaps studying a new drug in patients to see how they respond. It is also part of clinical research to follow patients over time to see how they do. Conducting research is part of a hemotology/oncology fellowship (usually spread over the second and third years) and is encouraged in an internal medicine residency as well.

Despite it being early in his first year of his fellowship, Dr. Paludo has already had several articles published in peer-reviewed journals, including a review of WM entitled, "Waldenstrom Macroglobulinemia: What a Hematologist Needs to Know." This WM overview was suggested by Dr. Paludo's primary research mentor at Mayo, Dr. Prashant Kapoor. Together they have worked on both Waldenstrom and multiple myeloma projects. "I did the studies on Waldenstrom and multiple myeloma during those months of my residency as well as many nights and weekends. We have a lot of support here at Mayo; it's impressive how much support there is, to complete our research."

Some of the research started in his residency will carry over into this first fellowship year, especially the work on young WM patients. The 'pilot' study for a larger clinical research project was what Dr. Paludo presented at the IWWM8 in London. "It all began with the WM overview I wrote," said Dr. Paludo. "Once I started working with Dr. Kapoor, I began studying and reviewing Waldenstrom in order to write the Waldenstrom review paper. That led us to realize that we did not have much data, especially on young patients. So we thought: Okay, let's look at our experience at Mayo of young WM patients (diagnosed at or before age 50). That first look at the survival outcomes of our patients between 2000 and 2013 is the study I presented at the Workshop." The abstract of this study was published in May 2015 in the *Journal of Clinical Oncology.*

Because of what he found in those patients, Dr. Paludo decided to go further back, all the way to 1960, and to compare survival outcomes of all these young patients with older WM patients (diagnosed after age 50). The patient data sets include only young patients who have undergone treatment. This means that those with "smoldering WM", who do not need treatment, are not included in the data. He is now preparing the manuscript of that larger study for publication.

"WM is usually a disease of the elderly so they often have other health issues that can affect overall survival," explained Dr. Paludo. "Most of these elderly patients die from those diseases and not from WM. Younger patients with WM generally do not have these other problems. By following them, we can better understand the natural history of Waldenstrom. When we use the term 'natural history', we mean how a disease behaves (its common presenting symptoms and subsequent complications, time for symptoms to progress, effect of disease on other organs) without interference from other sources such as treatment or other competing diseases. Since younger WM patients are apt to have no interference from other comorbidities such as heart disease, they make a fascinating group to study and that is why we think we can learn so much from them.

"Overall, for younger and older WM patients taken together, survival has been improving since 1960. This is not just from our experience at Mayo but from data published by other authors at other institutions as well. In our experience at Mayo, for these younger patients, survival has improved slightly, but the improvement is not statistically significant. It is important to keep in mind that this is a retrospective study. We went back 50 years and, as you can imagine, there is a lot of missing information. The information we have gives suggestions but not final answers. So ideally, we can study patients diagnosed now and follow them over time to see how they do. But, as you can imagine, a study like this will take 20 years. That's why we have to work with retrospective studies."

Drugs such as ibrutinib, which gives very impressive results in WM, are not yet included in any data sets. The hope is that for patients followed from now on, survival outcomes will skew upwards. But this data does not yet exist since ibrutinib was so recently approved by the FDA for WM.

Eventually, patient information may be coordinated across various cancer centers. "But," cautions Dr. Paludo, "we are in an earlier phase; we are still trying to finalize our data for our patients here at Mayo. Once we have those results, it will be easier to coordinate with others, to know what questions to ask. And then further research studies will come next."

# IWMF LIFELINE

## Treatment

| Treatment | Contact | E-mail | Telephone |
|---|---|---|---|
| 2-CDA (Cladribine with Rituxan) | Bernard Swichkow | *bswichkow@braae.com* | 305-670-1984 |
| Bendamustine | Leslie Neustadt | *lesbn96317@aol.com* | 518-374-8607 |
| Bendamustine & Rituxan | Vicki Marino | *Vlm4588@yahoo.com* | 330-393-4588 |
| Bortezomib, Dexamethasone, & Rituxan (BDR) | Ron Linford | *Rongl@aol.com* | 865-657-9895 |
| CaRD (Carfilzomib, Rituxan, & Dexamethasone | Mindy Caplan | *mindycap@yahoo.com* | 504-309-2247 |
| Chlorambucil | Jack Cadigan | *ceco@alaskan.com* | 907-321-3466 |
| Oral Cytoxan | Lou Birenbaum | *lbirenbaum@aol.com* | 314-961-5591 |
| DRC (Dexamethasone, Rituxan, & Cytoxan | Alice Riginos | *ariginos@me.com* | 202-342-1069 |
| Everolimus (RAD001) | Larry Adam | *admiralsiker@hotmail.com* | 608-774-3949<br>608-872-2263<br>608-754-3949 |
| Fludarabine & Rituxan | Jerry Block | *jblock35@comcast.net* | 301-460-9799 |
| Ibrutinib (Imbruvica) | Mitch Orfuss<br>Hank Stupi | *morfuss@aol.com*<br>*hstupi@hotmail.com* | 646-352-4476<br>804-758-4096 |
| Ofatumumab | Rob Clark | | 518-298-2611 |
| R-CVP | Allen Weinert | *anweinert@gmail.com* | 760-704-1344 |
| Lenalidomide | Chris Patterson | *Christopher_patterson@dfci.harvard.edu* | 617-632-6285 |
| Rituxan | Allen Weinert<br>Mel Horowitz | *anweinert@gmail.com*<br>*wmcure@yahoo.com* | 760-704-1344<br>518-449-8817 |
| Rituxan Maintenance | Sue Herms | *suenchas@bellsouth.net* | 843-801-0989 |
| Thalidomide | Mel Horowitz | *wmcure@yahoo.com* | 518-449-8817 |
| Velcade subcutaneous | Allen Weinert | *anweinert@gmail.com* | 760-704-1344 |
| Allogenic stem cell transplant | Eileen Sullivan<br>Melissa Sawyer | *Ebsullivan27@gmail.com*<br>*sawyerirish@aol.com* | 617-625-6957<br>303-979-1765 |
| Autologous stem cell transplant | Scott Blazek | *mandsblazek@aol.com* | 651-730-0061 |
| IVIg | Ron Linford<br>Peter DeNardis | *rongl@aol.com*<br>*pdenardis@comcast.net* | 865-657-9895<br>724-462-9458<br>412-624-1092 |
| Plasmapheresis | Fred Bickle<br>Fay Langer | *Flb134@msn.com*<br>*Fhlanger@gmail.com* | 805-492-4927<br>904-625-3135 |
| Splenectomy | Kathleen Ugenti | *Vugentil@optonline.net* | 631-470-0971 |

## Other WM Issues

| Issue | Contact | E-mail | Telephone |
|---|---|---|---|
| Amyloidosis | Leslie Neustadt | *lesbn96317@aol.com* | 518-374-8607 |
| Anemia due to WM | Marcia Klepac | *marciaklep@hotmail.com* | 412-421-2437 |
| Cryoglobulinemia | Fay Langer | *fhlanger@gmail.com* | 904-625-3135 |
| Emotional aspects of dealing with WM | Wanda Huskins<br>Naomi Schechter | *wmnmzl@gmail.com*<br>*schechtern@earthlink.net* | 845-664-3077<br>212-666-7136 |
| MGUS | Mary Beth Nivens | *mbnev@sbcglobal.net* | 203-375-7748 |
| Newly diagnosed | Guy Sherwood | *foxfiremedic@gmail.com* | |
| Peripheral neuropathy | Gayle Backmeyer<br>Tom Hoffman | *divagayle@comcast.net*<br>*thh97@msn.com* | 765-962-3746<br>501-868-8305 |
| Watch & wait | Mel Horowitz<br>Renee Paley-Bain<br>Joel Rosenblit | *wmcure@yahoo.com*<br>*paleybain@aol.com*<br>*rosenblitj@gmail.com* | 518-449-8817<br>203-744-7851<br>503-365-7074 |
| Young WM | Ryan Scofield<br>Bob Bailey<br>Scott Blazek | *ryanscofield@gmail.com*<br>*Bbailey@rune2e.com*<br>*Laurabailey64@gmail.com*<br>*mandsblazek@aol.com* | 312-576-9429<br>770-633-3536<br>770-361-4859<br>651-730-0061 |

**US LIFELINE Specialty Topics**

| Topic | Contact | E-mail | Telephone |
|---|---|---|---|
| Affordable Care Act | Leukemia & LymphomaSociety | | 800-955-4572 |
| Caregiving | Lynn Bickle | *Flb134@msn.com* | 805-492-4927 |
| Clinical Trials | Tom Hoffman | *thh97@msn.com* | 501-868-8305 |
| Hearing impaired<br>TTY Facility | Betty McPhee | *bjmcphee@hotmail.com* | 647-348-7440 |
| Military Veterans | Daniel Costigan<br>Glenn Ross | *dancostigan@hotmail.com*<br>*GSR060647@aol.com* | 952-841-0174<br>305-808-4170<br>214-317-9494 |
| Social Security Disability | Howard Prestwich | *prestwichh@gmail.com* | 815-233-0915 |

**International LIFELINE**

| Country | Contact | E-mail | Telephone |
|---|---|---|---|
| Arabic speaker | Sherine Elsawa | *selsawa@niu.edu* | 815-753-7839 |
| Australia | Peter Carr<br>Andrew Warden | *petercarr@iprimus.com.au*<br>*andrew.warden@bigpond.com* | +61 75 552 90518<br>+61 29 974 2277 |
| Belgian speaker | Joanna Van Reyn | *Joanna.vanreyn@comp-vlaanderen.be* | +32 93 354660 |
| Canada LIFELINE | *http://wmfc.ca/local-support/canadian-lifeline-contacts/* | | |
| Dutch speaker | Paul Theuns | *pjtheuns@planet.nl* | |
| Finnish speaker | Veikko Hoikkala | *veikko.hoikkala@dnainternet.net* | +35 85 500484864 |
| French speaker | Patrice Ostermann | *Pat.ostermann@orange.fr* | +33 62 2347426<br>+33561712525 |
| German speaker | | | |
| Japanese speaker | Tony Undo Otani<br>(U.S.) | *adyna@msn.com* | 562-924-0150 |
| Spanish speakers<br>(all in U.S.) | Peter Mitro<br>Betty Beazley<br>Leon Maya<br>Brad Smith | *stonehill@earthlink.net*<br>*betsybeazley@gmail.com*<br>*leonmaya55@gmail.com*<br>*becandbrad@gmail.com* | 216-591-1004<br>561-495-4299<br>865-694-9581<br>808-594-8914 |
| Sweden/Norway | Anne Odmark | *Ag.odmark@gmail.com* | +46 18 140513 |
| UK LIFELINE | *http://www.wmuk.org.uk/about-wm/links* | | |

# PROGRESS IN THE TREATMENT OF WALDENSTROM'S MACROGLOBULINEMIA THE IWMF & CANCER*CARE* TELECONFERENCE

On September 2 the Cancer*Care* Education Department and the IWMF joined in presenting a teleconference devoted to Waldenstrom's macroglobulinemia that drew the attention of over 800 listeners, many of whom were international.

The scientific co-presenters were Dr. Stephen Ansell of Mayo Clinic and Dr. Steven Treon of Dana-Farber Cancer Institute whose remarks covered an overview of the disease and the current and fast-developing options for treatment. IWMF President Carl Harrington spoke briefly to enumerate the various ways that the IWMF serves and supports its members. A brisk question and answer session followed.

The warm words spoken at the conclusion of the teleconference by Carolyn Messner, Director of Education and Training for Cancer*Care*, opened the way for future collaboration between Cancer*Care* and the IWMF.

This workshop will be on Telephone replay for 24 hours a day, 7 days a week, for the next year and will also be available as a Podcast on Cancer*Care's* website: *http://www.cancercare.org/connect_workshops/475-progress_treatment_waldenstroms_macroglobulinemia_2015-09-02*

It will also remain for one year on our website, *iwmf.com.*

*A personal observation by your editor:* So familiar were the voices of Dr. Treon and Dr. Ansell to me while listening to the Teleconference that it led to the realization that this sense of familiarity grew from the many years in the past when

*Progress in the Treatment, cont. on back cover*

## SINCE MAY 2015, THE FOLLOWING CONTRIBUTIONS TO THE INTERNATIONAL WALDENSTROM'S MACROGLOBULINEMIA FOUNDATION AND SINCE FEBRUARY 2015, THE FOLLOWING CONTRIBUTIONS TO THE WALDENSTROM'S MACROGLOBULINEMIA FOUNDATION OF CANADA WERE MADE IN MEMORY OF:

**Gary Beauchemin**
Gary and Sharon Dionne

**John Bernloehr**
Jim and Ann Lipkowitz
TLC Eyecare & Laser Centers

**Therese Boudreau**
Linda Vaughan

**Nick Carrick**
Arlene Hinchcliffe

**June Carson**
Audrey Thompson

**William Cohagan**
Charles and Christine Aubrey
Andy Barclay
John and Dolly Barclay
Mike Benedum
Jack and Nancy Collins
Laurel Daniel
Sam and Valerie Dunnam
The Dure Family
Karl Edgerton
W.C. Enmon
Maura Farver
Robert Green
Walter Hall
Bill and Linda Holtkamp
Jack Kidd
Marsha Lanehart
Roy and Kitty Materanek
Margaret Meek
Christopher Mondini and Martin Skea
Duncan Elliott Osborne
Don and Pat Oxley
Mike and Eileen Pestorius
Bob Pohler
Dave and Kathy Roberts
Charles and Carole Sikes
Brooks Slaughter
Joyce Statz
Suzanne Stege
John and Laurel Suchyta

**Robert Coulbourn III**
Bennett Wethered

**Donald Crothers**
Margaret Crothers

**Jeffrey Davidson**
Charles and Marilyn Cuffari
Jan Jones
Barrie Leach
David and M.A. Sabourin
Andre Vallee

**Marjorie Dellinger**
Larry and Patti Leininger

**Walter Dere**
Laura Dere

**Lloyd Eichel**
Charles and Joan Carlson

**George Farrier**
Margaret Farrier

**Jerry Fleming**
Vince and Susan Santa Maria

**Eleanor Harrington**
Morry, Dawn and Micah Edwards

**Oleander Harrison Jr.**
Janie Harrison

**Paul Hendricks Jr.**
Tom and Eloise Cathcart

**Erik Herholz**
Cathy Crumbaugh

**Nancy Lee Kerr**
Michael and Jennifer Scott
Bette Harris
Robert and Katherine Hord Jr.
William and Jeannine Kent

**William Kinzer**
Ann Marie Kinzer

**Bonnie Koch**
Charles Koch

**Jan Koke**
Joan D. Bagg
John and Barbara Barta
Gloria Bedore
William and Claudette Brock
Beverly Brown
Canterbury Common Residence Assoc.
Joan Cicci
George Clapham and Regina Fowler
Lisa Clements
Henrica Dickson-Conklin
Emmy Dirken
Vern and Joan Dutrisac
The Farewell Family
Melinda Garritano
Arlene Hinchcliffe
Dorothy Imperial
Kerry and Yuen Lau
Pauline Leitch
Elizabeth Lightfoot
Fred MacMillan

**Jan Koke (cont.)**
Lauren and Lee Maher
Debra Mason
Dennis Mason
Michael Kim McQuay
Wayne and Jean Mouland
Barbara Park
Barry Philip
Paola Poletto
Margaret and William Puchalski
Arthur Rowan
Rocco Saverino
Laurie Senyk
Bruce and Betty Smith
David Sparling
John and Marjorie Stephenson
Ruth Stounton
Rosemary Swanston
John and Lois Taylor
Jana Tennison
Gerry and Deb Thistle
Barbara Willis
Margaret Wirth
Rita and Bruno Wrubel
Jenny Yorgason

**William Koontz**
Pamela Jones
Eileen Thornton

**Don Lindemann**
Ellen Smith

**Beatrice MacGillivray**
Audrey Thompson

**Maxine Masek**
John and Genevieve Lucas

**George and Rita McDonnell**
Anne Marie Vale

**Dugger McNeil**
Lea and Bill Hardman

**Kenny Wayne Miller**
Bonnie Bricklin
Barrie and Mike Grobstein
Eleanor Kravitz
Mary McCoy
Paul Meshekow
Charles and Catherine Nissen

**Alan Morrow**
Charles and Joan Carlson

**Antonia Murenbeeld**
Ann Alexander

**Antonia Murenbeeld (cont.)**
David Brayley
Scott Campbell
Alain Courville
Debbie Girard
Wes Govenlock
Arlene Hinchcliffe
Freek Hooning
James Lorne and Rita Mann
Patricia McEvoy
Walter Murenbeeld
Elizabeth Nunan
Charmaine Soutar

**Robert Murenbeeld**
G. Morgan
Walter Murenbeeld
Elizabeth Nunan

**John Osborne**
Jean Osborne

**Dr. David Precious**
Lea and Bill Hardman

**Elsie Ann Rashford**
Jim and Cinda Spavins

**Roberta Reed**
Connie Reed

**Percy Rich**
Rose Crownover and Raymond Valadez

**Mark Sadows**
Cindy Sadows

**Judy Shaffner**
Greg Shaffner

**Dan Singer**
Rose Crownover and Raymond Valadez

**Ian Singer**
Rose Crownover and Raymond Valadez

**Joanne Thompson**
Charles and Joan Carlson

**Henry Vaughan**
Linda Vaughan

**John E. Wheeler Jr.**
Bryan and Mary Gosselin

**Harold Zfaney**
June Zfaney

**Jan Zimmerman**
Antoinette Zimmerman
Chalmers and Judy Zimmerman

## SINCE MAY 2015, THE FOLLOWING CONTRIBUTIONS TO THE INTERNATIONAL WALDENSTROM'S MACROGLOBULINEMIA FOUNDATION AND SINCE FEBRUARY 2015, THE FOLLOWING CONTRIBUTIONS TO THE WALDENSTROM'S MACROGLOBULINEMIA FOUNDATION OF CANADA WERE MADE IN HONOR OF:

**Lisa Abbott**
Edward Goldberg and Linda Trytek

**John Albert**
Lori Tullis

**Dr. Stephen Ansell**
Carl Harrington and Eleanor Levie

**The Marriage of Tonya Antonucci and Tasha Cupp**
Keith and Sharon Rowe

**Gail Arcari**
June Kingsbury
Marjorie Marshall
Gregory Slover

**Thomas Baker**
Ted and Almie Baker

**Dave Benson**
Edward Goldberg and Linda Trytek

**Dennis Bischoff**
Theodore Bischoff

**Peg Bohanon**
Elaine Bohanon

**Towney Brewster**
Cate Lux

**Don Brown**
Erik Brown

**Gail Burroughs**
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# SAVE THE DATE

The 2016 IWMF Educational Forum
will be held in

## Providence, Rhode Island
## June 10-12, 2016

Registration materials and more information will
be available at *iwmf.com* and in the January 2016 *Torch*.

*Progress in the Treatment, cont. from page 29*

these two outstanding researchers in WM have made room in their busy schedules to speak at IWMF Ed Forums. Voice recognition of the Teleconference's speakers surely comes from the warmth and familiarity that result between IWMF members and WM physicians and that are, perhaps, unique.

In the world of cancer organizations, the IWMF may be small – but it is special.

*On behalf of the IWMF membership:* Many thanks are due to Drs. Ansell and Treon for articulating so clearly the current status of Waldenstrom's macroglobulinemia for the Teleconference and, looking ahead, for all the time they will spend on our behalf as the Scientific Co-Chairs for the IWMF-LLS Strategic Research Roadmap. Their commitment is truly enormous.