Citation for final published version:


Publishers page: http://dx.doi.org/10.1111/bjh.12985

Please note: Changes made as a result of publishing processes such as copy-editing, formatting and page numbers may not be reflected in this version. For the definitive version of this publication, please refer to the published source. You are advised to consult the publisher’s version if you wish to cite this paper.

This version is being made available in accordance with publisher policies. See http://orca.cf.ac.uk/policies.html for usage policies. Copyright and moral rights for publications made available in ORCA are retained by the copyright holders.
Use of JAK inhibitors in the management of myelofibrosis: a revision of the British Committee for Standards in Haematology Guidelines for Investigation and Management of Myelofibrosis 2012

The British Committee for Standards in Haematology (BCSH) Guidelines for myelofibrosis were produced in 2012 (Reilly et al, 2012), but since then Ruxolitinib, a JAK1/JAK2 inhibitor, has been approved for use in the European Union and highly prevalent mutations in the Calreticulin gene (CALR) have been described. We therefore wish to revise the existing guideline (Reilly et al, 2012) to accommodate this important data. Current diagnostic criteria should be modified to incorporate testing for the CALR mutations into major criteria A2 alongside JAK2 V617F, as shown in Table I (Evidence grade 1A). Patients with CALR mutations may have a better prognosis (Klampfl et al, 2013), but this has not formally been assessed and incorporated into prognostic scores.

Substantial data are now available concerning responses to JAK inhibitor therapies including beneficial effects upon survival (Verstovsek et al, 2012, 2013; Cervantes et al, 2013). For example, at 144 weeks in the COMFORT-II study the median of overall survival had not been reached in either arm. A total of 29 (19.9%) and 22 (30.1%) patients died during the study in the ruxolitinib and best available therapy (BAT) arms, respectively, of which deaths on treatment were reported for 13 (8.9%) in the ruxolitinib arm, and 5 (6.8%) in the BAT arm (one death occurred after crossover to ruxolitinib). There was a 52% reduction in risk of death in the ruxolitinib treatment arm compared to the BAT arm (Hazard Ratio = 0.48, 95% confidence interval 0.28–0.85). The estimated probability of being alive at 144 weeks was 81% in ruxolitinib arm and 61% in BAT arm. The P-value for the log-rank test stratified by the baseline risk category was 0.009, (Cervantes et al, 2013). Furthermore, data from these randomized studies suggest that standard therapies are comparable to placebo in terms of spleen and symptom responses. The previous guideline (Reilly et al, 2012) recommended consideration of JAK inhibitor therapy for patients who have failed hydroxyurea therapy and are not presently suitable for bone marrow transplantation, or for patients with severe constitutional symptoms. In view of new evidence we now formally recommend ruxolitinib as first line therapy for symptomatic splenomegaly and/or myelofibrosis-related constitutional symptoms regardless of JAK2 V617F mutation status (Evidence grade 1A) where the balance between need to resolve the latter outweighs risk of side effects and, in particular, we make the following recommendations:

**Indications:**

1 Symptomatic splenomegaly. (Evidence grade 1A)
2 Myelofibrosis-related symptoms that are impinging upon quality of life. (Evidence grade 1B)
3 Hepatomegaly and portal hypertension due to myelofibrosis are reduced by ruxolitinib (Verstovsek et al, 2010) and it can be considered for these indications. (Evidence grade 2B)

Whilst treatment with ruxolitinib is suggested to confer a survival advantage treatment with this agent in asymptomatic patients and/or those who lack bothersome splenomegaly is not currently recommended.

**Tolerance and side effects:**

1 Anaemia and thrombocytopenia are to be anticipated with this agent, anaemia usually peaking by weeks 12–16 and improving thereafter. In patients with pre-existing anaemia and thrombocytopenia (NB, those patients with

---

Table I. Diagnostic criteria for primary myelofibrosis.

| Diagnosis requires A1 + A2 and any two B criteria |
|-------------------------------------------------
| A1 | Bone marrow fibrosis ≥3 (on 0–4 scale) |
| A2 | Pathogenetic mutation (e.g. in JAK2, CALR or MPL), or absence of both BCR-ABL1 and reactive causes of bone marrow fibrosis |
| B1 | Palpable splenomegaly |
| B2 | Unexplained anaemia |
| B3 | Leuco-erythroblastosis |
| B4 | Tear-drop red cells |
| B5 | Constitutional symptoms* |
| B6 | Histological evidence of extramedullary haematopoiesis |

*Drenching night sweats, weight loss >10% over 6 months, unexplained fever (>37.5°C) or diffuse bone pains.
platelet counts below $50 \times 10^9/l$ are excluded from using this drug) a lower starting dose is recommended for example 5 mg BD (Harrison et al, 2013) (evidence grade 1B)

2 Anaemia may be ameliorated by lowering the dose of ruxolitinib or by concomitant use of erythropoietin-stimulating agents, and/or anabolic steroids, such as danazol (McMullin et al, 2011). (evidence grade 2B)

3 Given that there have been reports of reactivation of latent and atypical infections, such as hepatitis B and tuberculosis, the prescriber should actively screen for these and use appropriate prophylactic measures. Live vaccinations should be considered with caution. (evidence grade 1B)

How to stop

1 Disease symptoms and splenomegaly will recur on drug withdrawal, sometimes rapidly. A gradual dose tapering over 7–10 d and avoidance of sudden interruptions are recommended. Cover with systemic steroids (suggestion 20–30 mg of prednisolone) has also been used in these circumstances (Harrison et al, 2013). (evidence grade 1A)

For patients failing or intolerant of ruxolitinib, additional JAK inhibitors are being assessed in clinical trials and may be approved in the future.

Authorship statement

The content was reviewed and approved by all authors, the manuscript was written by CH.

Competing interests

John T. Reilly has acted as consultant or been paid on the speakers bureau for Novartis and Shire. Mary Frances McMullin has acted as a consultant or been on the speakers bureau for Novartis, Sanofi, Shire and Gilead Pharmaceuticals. Philip A. Beer, none. Nauman Butt has received sponsorship to attend educational meetings from Novartis and Shire Pharmaceuticals, and acted as a speaker for educational meeting sponsored by Novartis and Bristol-Myers Squibb. Eibhlin Conneally has acted as an advisory board member for Novartis, Bristol-Myers Squibb and Pfizer Pharmaceuticals. Andrew Duncombe has acted as an advisory board or speaker bureau member for Novartis, Bristol-Myers Squibb and Pfizer Pharmaceuticals. Anthony R. Green, none. N. George Mikhaeel, none. Marie H. Gilleece, none. Steven Knapper has acted as a consultant for Novartis and has received funding for overseas conference travel from Novartis, Shire. Adam Mead has received consultancy fees from Novartis and Sanofi Aventis and research
funding from Novartis. Ruben A. Mesa has received research support from Incyte, Genentech, Sanofi, Lilly, NS Pharma and Gilead and consultancy fees from Novartis. Mallika Sekhar has received research funding from Novartis. Claire Harrison has received research funding from Novartis pharmaceuticals, acted as a consultant or been on the speakers bureau for Novartis, Sanofi, Shire, Celgene, YMBioscience, SBio, CTI and Gilead pharmaceuticals.

John T. Reilly1
Mary Frances McMullin2
Philip A. Beer3
Nauman Butt4
Eibhlin Conneally5
Andrew S. Duncombe6
Anthony R. Green7
George Mikhaeel8
Anthony R. Green
Andrew S. Duncombe
Eibhlin Conneally

Ruben A. Mesa12
Mallika Sekhar13
Claire N. Harrison8
1Sheffield Teaching Hospitals NHS Trust, Sheffield, 2Queen’s University, Belfast, UK, 3Terry Fox Laboratory, BC Cancer Agency, Vancouver, BC, Canada, 4The Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool, UK, 5St. James’s Hospital, Dublin, Ireland, 6Department of Haematology, University Hospital Southampton, Southampton, 7University of Cambridge, Cambridge, 8Guy’s and St Thomas’ NHS Foundation Trust, London, 9St James University Hospital, Leeds, 10Cardiff University, Cardiff, 11University of Oxford, Oxford, UK, 12Mayo Clinic, Scottsdale, AZ, USA and 13Royal Free Hospital NHS Trust, London, E-mail: Claire.Harrison@gstt.nhs.uk

Keywords: myeloproliferative disease, CALR, JAK inhibition

First published online 25 Jun 2014
doi: 10.1111/bjh.12985

References


