UNDERSTANDING
CHRONIC LYMPHOCYTIC LEUKEMIA

ABOUT CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

CLL IS ONE OF THE MOST COMMON TYPES OF LEUKEMIA IN ADULTS.[1]

CLL makes up 25% to 30% of leukemias in the U.S.[2]

CLL is a type of cancer in which too many blood stem cells become abnormal lymphocytes, also called leukemia cells, which are not able to fight infection very well. The increase of leukemia cells in the blood and bone marrow leaves less room for healthy white blood cells, red blood cells, and platelets, which may lead to infection, anemia, and easy bleeding.[1]

Autoimmunity in some CLL patients:

- The immune system cells make abnormal antibodies that attack normal blood cells, which can lead to low blood counts.[3]
- If the antibodies attack red blood cells, it's called autoimmune hemolytic anemia.[4]
- Less often, the antibodies attack platelets and the cells that make them, leading to low platelet counts.[2,5]

Many patients with CLL do not have obvious symptoms of the disease, so CLL is often detected during routine blood tests and physical exams. If a patient does have symptoms, they can include swollen lymph nodes, weakness and fatigue, unintentional weight loss, unexplained fevers, and night sweats.[1]

ABOUT SMALL LYMPHOCYTIC LYMPHOMA (SLL)[6]

- **SLL is a related cancer that shares many key similarities with CLL.**
- **CLL and SLL are essentially different forms of the same disease, often referred to as CLL/SLL. The main difference between CLL and SLL is the location of the cancer cells. When the cancer cells are mainly in the blood and bone marrow, though possibly in certain organs, it is CLL. When the cancer cells are mainly in the lymph nodes and rarely in the blood, it is SLL.**

In 2020 there were **207,000 people** estimated to be living with CLL in the U.S.[7]

There have been **approximately 19,000** new cases of CLL in the U.S. in 2023[7]

The likelihood that the average person will get CLL in their lifetime is **1 in 175 or ~0.6%**[8]

The risk of diagnosis is slightly higher in men than women

Median survival of CLL is **10 years**[2]

Average age at diagnosis is **70 years**[6]

CLL STAGING[9]

The staging of CLL upon diagnosis is determined by the abnormal increase in number of lymphocytes (lymphocytosis), presence of enlarged lymph nodes, presence of enlarged spleen and/or liver, presence of anemia, and presence of thrombocytopenia (abnormal decrease in the number of platelets).

In the U.S., the Rai staging system defines CLL in the following stages upon diagnosis:

LOW RISK
STAGE 0:

Abnormal increase in the number of lymphocytes in the blood and marrow

INTERMEDIATE RISK
STAGES 1&2:

Abnormal increase in the number of lymphocytes in the circulating blood and the marrow

Enlarged lymph nodes

OR

Abnormal increase in the number of lymphocytes in the circulating blood and the marrow

Enlarged spleen and/or liver

HIGH RISK
STAGES 3&4:

Abnormal increase in the number of lymphocytes in the circulating blood and the marrow

Anemia (low red blood cell count)

OR

Abnormal increase in the number of lymphocytes in the circulating blood and the marrow

Thrombocytopenia (low platelet count)

TREATING CLL

A CLL treatment plan is affected by certain factors, including the age and other health conditions of the patient at the time of diagnosis, among other considerations.[1]

Current approaches to help manage CLL/SLL include:

Active surveillance strategy, an approach that involves closely **monitoring a patient's condition, but not initiating treatment until symptoms arise or change.**[1]

Approved drug therapies: Targeted therapies such as Bruton's tyrosine kinase (BTK) inhibitors, B-cell lymphoma 2 (BCL-2) inhibitors, monoclonal antibodies, and phosphatidylinositol 3-kinase (PI3K) inhibitors. Chemotherapy can also be used.[1,3]

Rarely used options include **radiation therapy and splenectomy** based on the location of cancer cells.[1]

In relapsed or refractory CLL or in high-risk cases, doctors might use **allogeneic stem cell transplantation.**[1]

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