SPEAKER 1: Someday using markers that are surrogate markers of disease activity, we will be able to personalize the treatment regimen for each individual patient and for each individual patient's disease course. The reason for the two treatments back to back at monthly intervals as a standard beginning in CTCL is because that's the way we started, and in the first group of patients, got responses. It has become the standard and hasn't really changed from the beginning, in part because of ethical practicalities.

It's hard to titrate this without extremely expensive and extensive studies. So right now, in the functional way, we start all patients at two treatments on two successive days at monthly intervals. If a patient is not responding after three months, we consider moving on to another therapy, completely separate from ECP. But an alternative, if we're seeing partial responses or we have a sense that we have at least stopped disease augmented activity, perhaps in its tracks, what we will then do is go to two treatments on two successive days, back to back every two weeks.

In those cases, we would give that another three months of trial, and empirically, if that is not working, we would stop the therapy. The question then comes, what do you do when a patient responds, which is quite common, with a substantial response, but not a complete response. In those cases, we wait to be certain that we have reached a therapeutic plateau, again over a three month period. And we then start to decrease the frequency of treatments.

Instead of being two treatments back to back on two successive days on a monthly basis, we might go to every six weeks. And we tend to move, because we respect the delayed disease response or lack of response. If we at least hold that line on three months or three cycles of every six weeks, we would then go to three cycles of every two months.

And we have taken it down to as little as two cycles back to back every four months. Some patients continue to get treatment to hold that line, and other patients we try to wean off. But other disease activity in a patient specific way may not be controllable by weaning off. And so again, we try to modify the treatment regimen along those lines for every patient.