SPEAKER: Acute graft versus host disease and chronic graft versus host disease are different diseases. And for that reason, I'm going to address their treatment differently.

The standard therapy for acute graft versus host disease is corticosteroids. And the initial dose of corticosteroids used in this disease is 2 milligrams per kilogram of methylprednisolone or prednisone equivalent. And this really is what everyone has done.

As far as the addition of other therapies, well, so far we know that nothing has really added benefit to steroids alone. It is important to emphasize that if the patient is on calcineurin inhibitors, such as cyclosporine or tacrolimus, whatever is used in your or the institution, This can actually benefit the patient from a steroid-sparing perspective. In other words, it may help get the patients off of steroids faster. Although we think that it does not impact the efficacy of the steroids in treating acute graft versus host disease.

A positive response to steroids, either in the form of a complete response or a partial response, occurs in approximately 50% of cases. So again, it is not optimal. But it is the single most effective treatment for both acute and chronic graft versus host disease. So this is what we should be doing if there is no clinical trial that the patient qualifies for.

In other words, because of the not so great results with corticosteroids, if there is a clinical trial available. These people should be accrued into clinical trials. But the standard of care is still corticosteroids.

So I said that there is a 50% response rate to corticosteroids. So that means that there is another half of the patients that will fall under the category of steroid refractory. Some people also define another subcategory of steroid dependent for those patients that will flare under a certain dose of corticosteroids, which varies for the patient.

In either case, the patient is in trouble if he or she did not respond initially. Usually, there is literature that supports the notion that a response within the first five to seven days of initiation of corticosteroids is associated with favorable outcome. So if people don't respond within the first week, they are considered to be steroid resistant, steroid refractory, or steroid dependent later on if they flare with the taper of the corticosteroids.

So in those cases, we need a second line of therapy. And that second line of therapy varies according to the center and according to the physician too.