SPEAKER 1: So when patients are steroid refractory or steroid resistant, that is, they don't respond to steroids, or if they flare when the steroids are being tapered, that is what some people call steroid dependent, then they need a second line of therapy. So bear in mind that patients that need a second line of therapy have a pretty poor outcome. And it varies depending on what report you read, but actually, the mortality of steroid refractory acute GVHD can be as high as 80%.

So when we have to decide on a second line therapy, well, the decision is very difficult because there is no standard second line therapy. There are a lot of individual preferences that truly, there is not one form of therapy that one can say, this is what we need to follow.

So again, the best choice if available is the accrual of the patient into a clinical trial. There are a number of second line therapies that can be used for acute graft versus host disease. I like to categorize my choices based on the organ involved, and try to base this, of course, as much as possible on existing literature.

So second line therapy for acute graft versus host disease of the skin is variable. Acute graft versus host disease of the skin is easier to treat than gastrointestinal acute graft versus host disease. So basically, skin is responsive to a number of different strategies, including classically ATG, and also photopheresis, which is usually my preference as second line for acute graft versus host disease of the skin.

So my choice for acute graft versus host disease of the skin is photopheresis, or extracorporeal photopheresis, which I'm going to call ECP moving forward. So there is quite a bit of literature, although not randomized, that favors the use of extracorporeal photopheresis in steroid refractory graft versus host disease.