What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Acute Myeloid Leukemia

A CME/MOC-Accredited Virtual Event

Wednesday, December 14, 2022
5:00 PM – 6:00 PM ET

Faculty

Courtney D DiNardo, MD, MSCE
Mark Levis, MD, PhD

Moderator

Neil Love, MD

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Faculty

Courtney D DiNardo, MD, MSCE
Associate Professor, Department of Leukemia
Division of Cancer Medicine
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MD Anderson Cancer Center
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Andrew H Wei, MBBS, PhD
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Peter MacCallum Cancer Centre and
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University of Melbourne
Walter and Eliza Hall Institute of Medical Research
Melbourne, Australia

Mark Levis, MD, PhD
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Co-Division Director, Hematologic Malignancies
Professor of Oncology
The Sidney Kimmel Comprehensive Cancer Center
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Baltimore, Maryland

MODERATOR
Neil Love, MD
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Dr Love — Disclosures

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Prof Wei — Disclosures

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Nonrelevant Financial Relationship	Prof Wei is an employee of the Walter and Eliza Hall Institute (WEHI). WEHI receives milestone and royalty payments related to the development of venetoclax. Current and past employees of WEHI may be eligible for financial benefits related to these payments. Prof Wei receives such a financial benefit.

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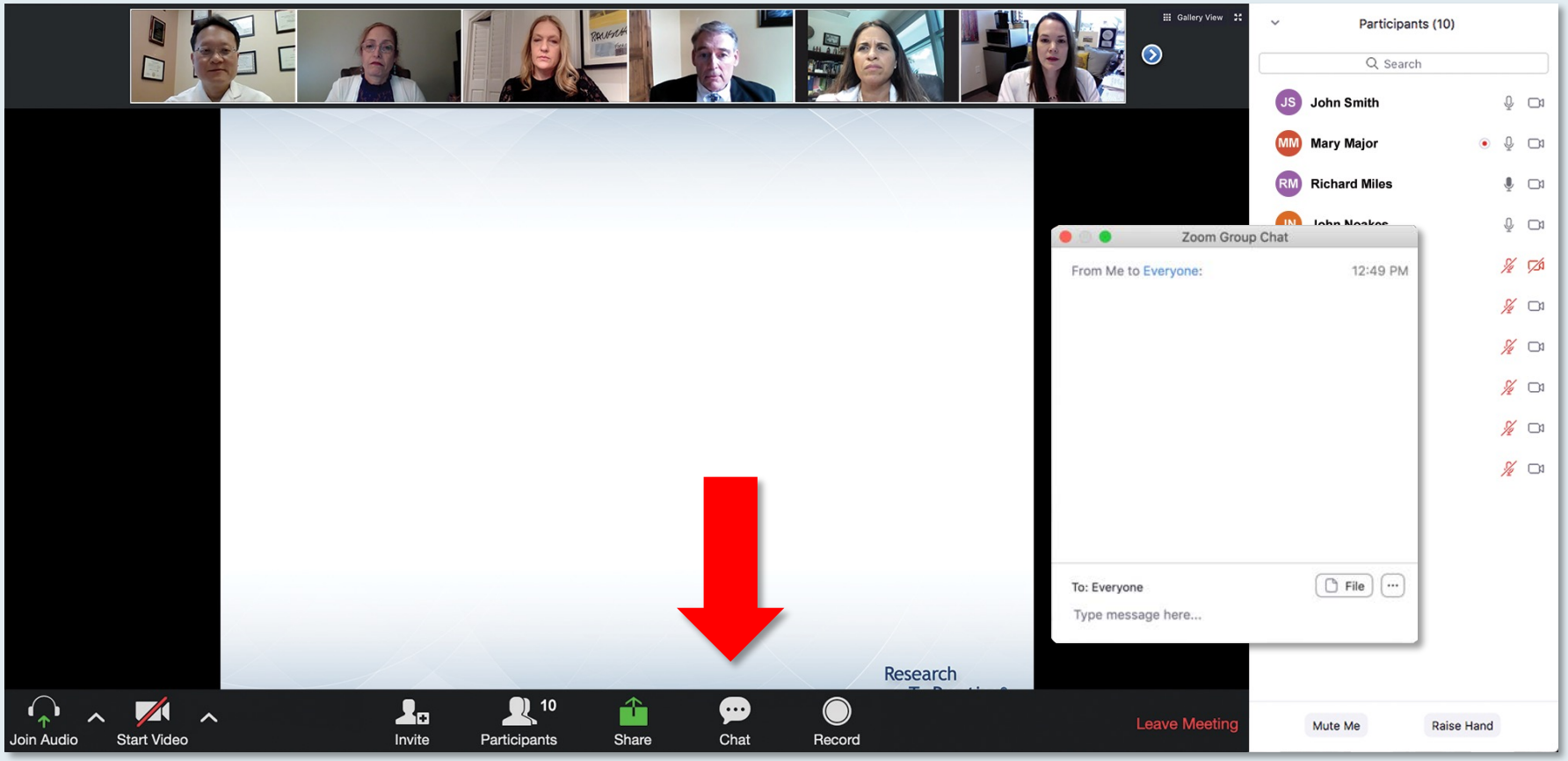

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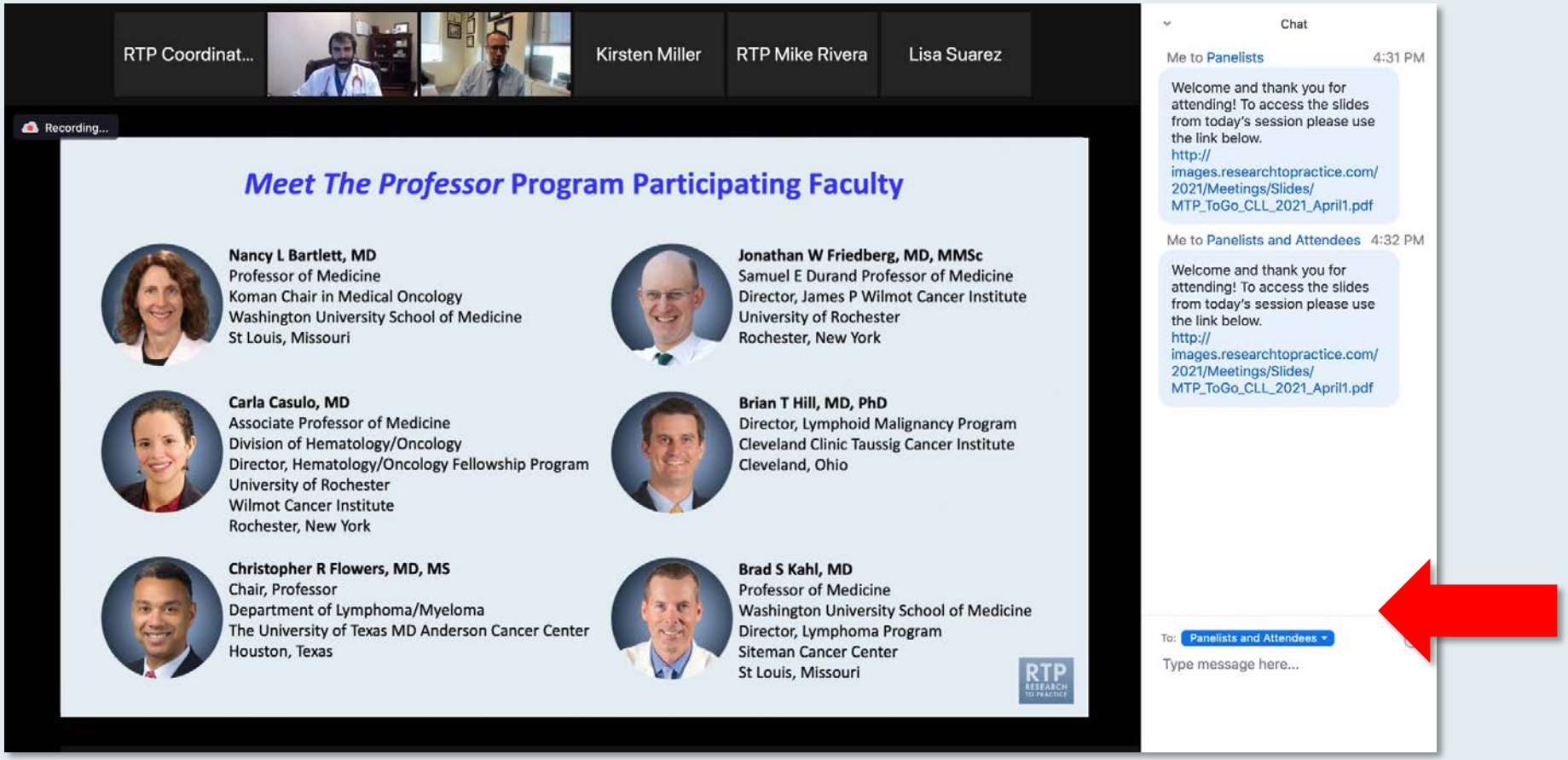
Expand chat submission box



Drag the white line above the submission box up to create more space for your message.

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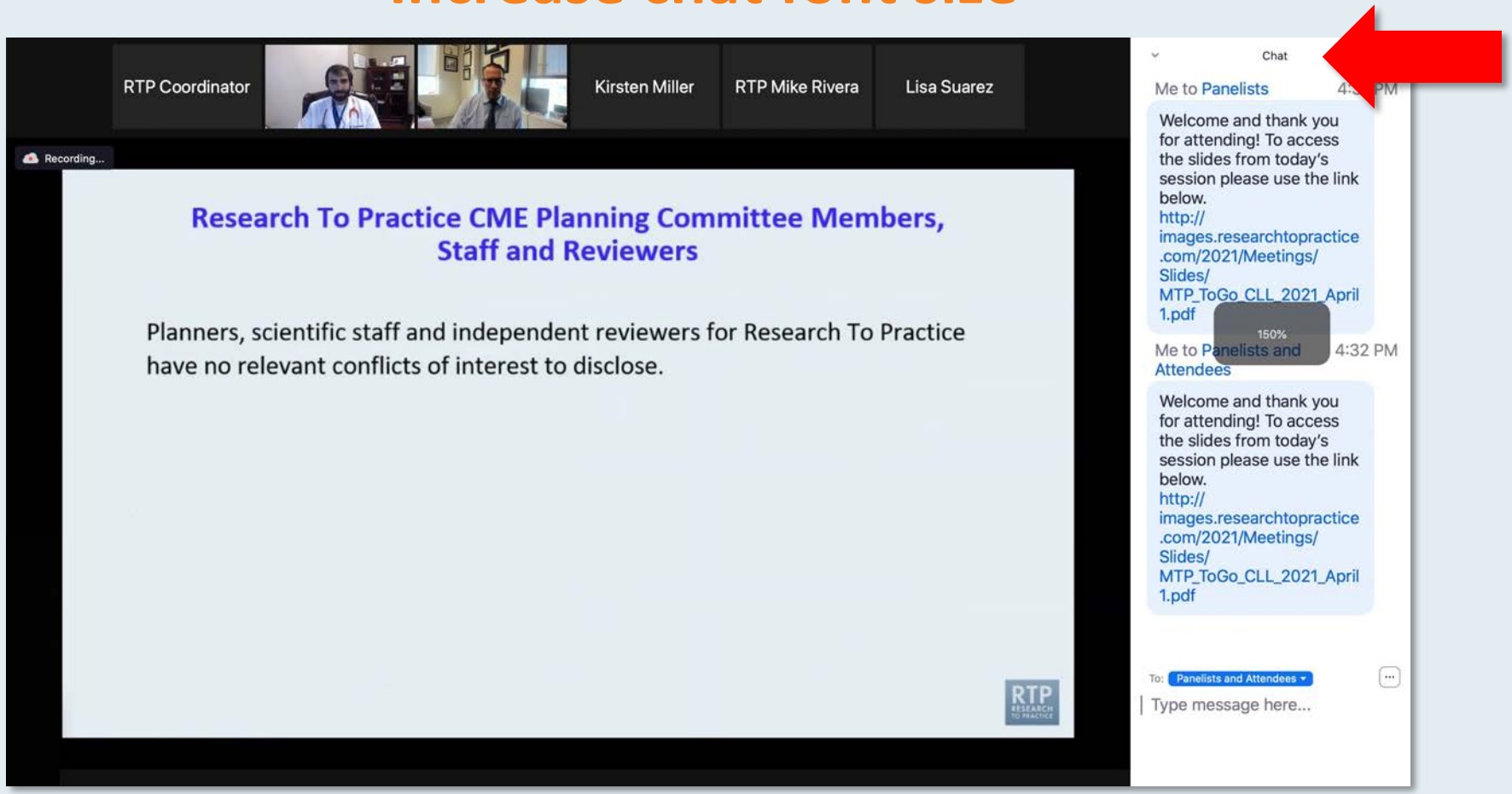

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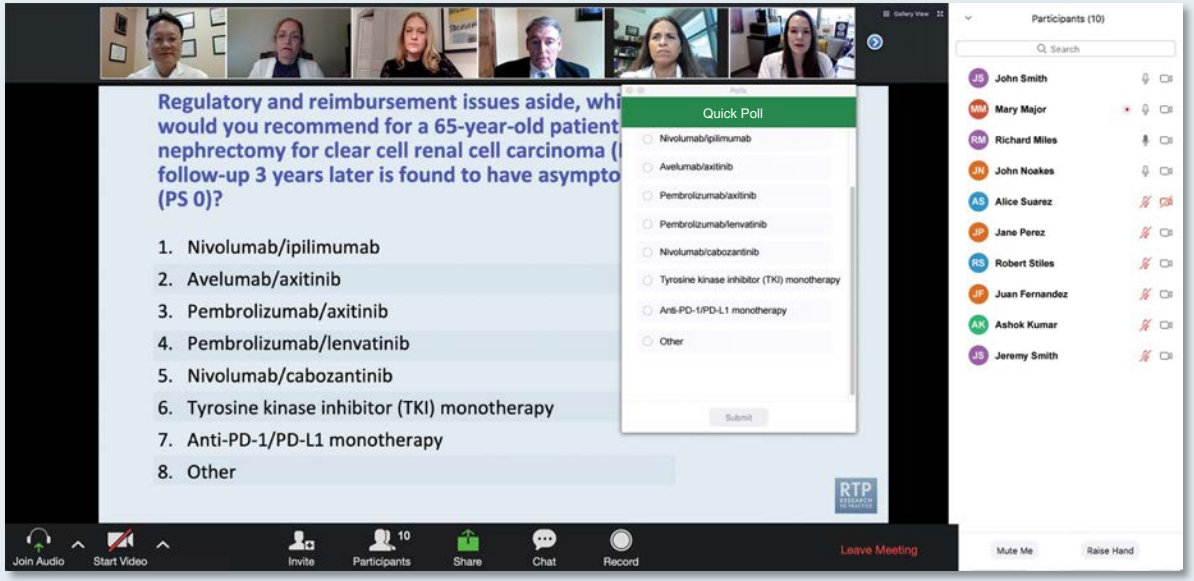

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WITH DR NEIL LOVE

Novel Agents and Strategies in AML

DR EYTAN STEIN
MEMORIAL SLOAN KETTERING CANCER CENTER

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Meet The Professor

Optimizing the Management of Multiple Myeloma

Thursday, December 15, 2022
5:00 PM – 6:00 PM ET

Faculty

Shaji K Kumar, MD

Moderator

Neil Love, MD

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

Breast Cancer

A Multitumor CME/MOC-Accredited Live Webinar Series

Wednesday, January 4, 2023
5:00 PM – 6:00 PM ET

Faculty

Joyce O'Shaughnessy, MD
Professor Peter Schmid, FRCP, MD, PhD

Moderator

Neil Love, MD

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

Chronic Lymphocytic Leukemia

A Multitumor CME/MOC-Accredited Live Webinar Series

Thursday, January 5, 2023
5:00 PM – 6:00 PM ET

Faculty

Jennifer R Brown, MD, PhD
Deborah Stephens, DO

Moderator

Neil Love, MD

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

Multiple Myeloma

A Multitumor CME/MOC-Accredited Live Webinar Series

Tuesday, January 10, 2023
5:00 PM – 6:00 PM ET

Faculty

Joseph Mikhael, MD, MEd
Ajay K Nooka, MD, MPH

Moderator

Neil Love, MD

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

Targeted Therapy for Non-Small Cell Lung Cancer

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Wednesday, January 11, 2023
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Cases from the Community: Investigators Discuss Available Research Guiding the Care of Patients with Gastrointestinal Cancers

A 3-Part CME Symposium Series Held in Conjunction with the 2023 ASCO Gastrointestinal Cancers Symposium

Colorectal Cancer

Wednesday, January 18, 2023

7:15 PM – 9:15 PM PT
(10:15 PM – 12:15 AM ET)

Gastroesophageal Cancers

Thursday, January 19, 2023

6:15 PM – 7:45 PM PT
(9:15 PM – 10:45 PM ET)

Hepatobiliary Cancers

Friday, January 20, 2023

6:00 PM – 7:30 PM PT
(9:00 PM – 10:30 PM ET)

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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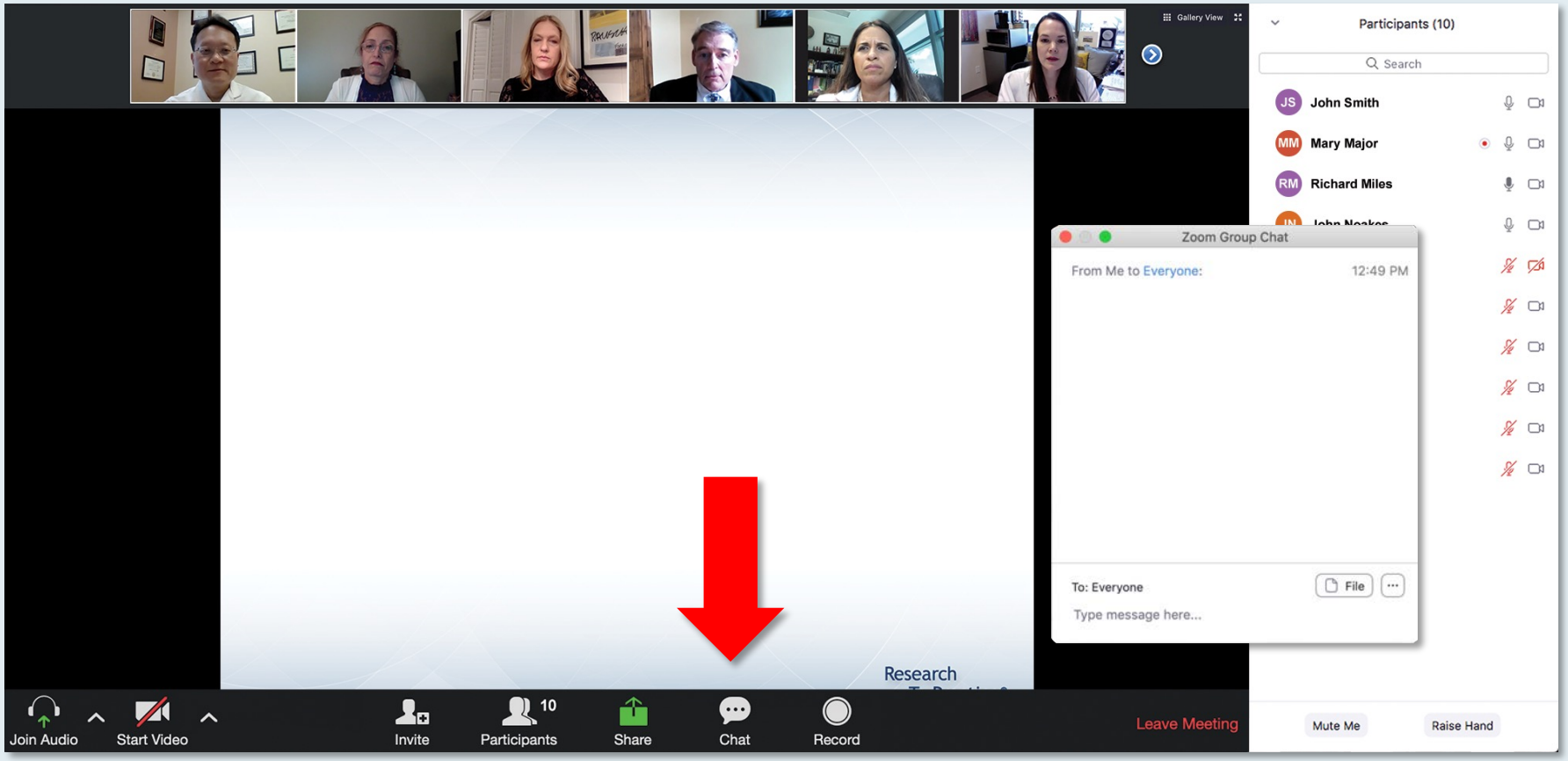

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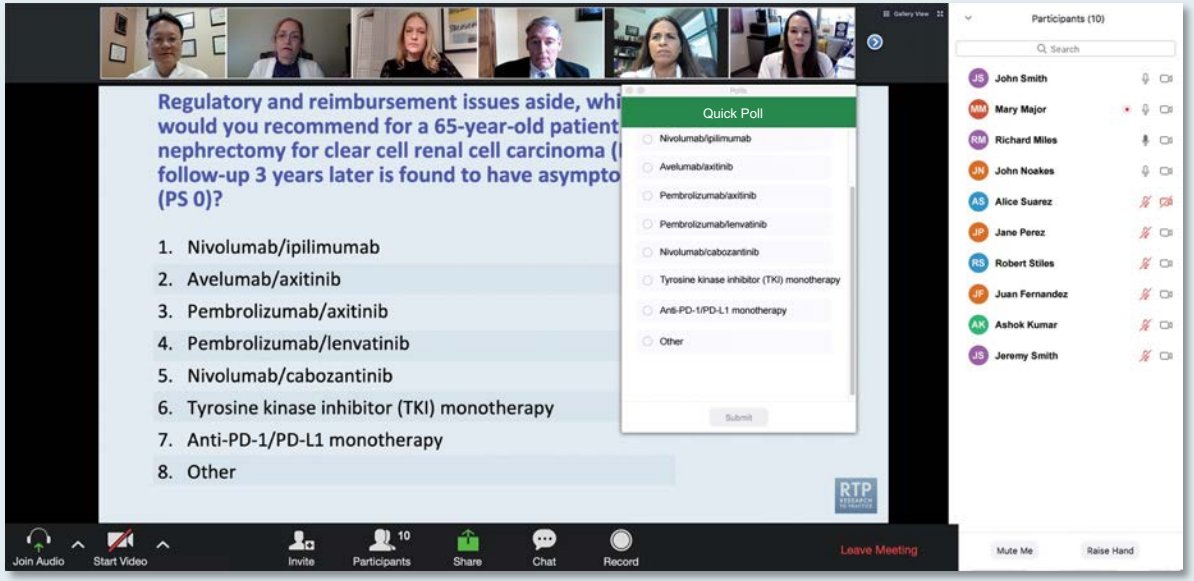

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Spencer H Bachow, MD
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Boca Raton, Florida

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Lehigh Valley Topper Cancer Institute
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Wheeling, West Virginia

Anna Halpern, MD
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Georgia Cancer Specialists
Athens, Georgia

Rebecca L Olin, MD, MSCE
University of California, San Francisco
San Francisco, California

Rajni Sinha, MD, MRCP
Piedmont Cancer Institute
Atlanta, Georgia

Selection of Therapy for Patients with AML

Courtney DiNardo
Dept of Leukemia
MD Anderson Cancer Center

Agenda

MODULE 1: Case Presentations – Part 1

MODULE 2: Selection of Therapy for Patients with AML

MODULE 3: Case Presentations – Part 2

MODULE 4: Treatment of AML with Targetable Mutations

Agenda

MODULE 1: Case Presentations – Part 1

- Dr Olin: 80-year-old man with newly diagnosed AML with significant comorbidities is treated with decitabine/venetoclax
- Dr Bachow: 54-year-old man s/p 7 + 3 → allogeneic SCT presents with myeloid sarcoma
- Dr Gupta: 78-year-old man s/p 7 + 3 → allogeneic SCT presents with myeloid sarcoma
- Dr Halpern: 39-year-old man with core binding factor AML s/p induction CLAG-M + gemtuzumab ozogamicin (GO) → high-dose cytarabine x 4
- Dr Bhatnager: 64-year-old woman with newly diagnosed del(5q) AML with monocytic differentiation and multiple mutations (GATA2, BCOR, NF1 and RUNX1) receives azacitidine and venetoclax

MODULE 2: Selection of Therapy for Patients with AML

MODULE 3: Case Presentations – Part 2

MODULE 4: Treatment of AML with Targetable Mutations

Case Presentation: 80-year-old man with newly diagnosed AML with significant comorbidities is treated with decitabine/venetoclax

Dr Rebecca Olin (San Francisco, California)

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Dr Spencer Bachow
(Boca Raton, Florida)

Case Presentation: 54-year-old man s/p 7 + 3 → allogeneic SCT presents with myeloid sarcoma

Dr Ranju Gupta
(Bethlehem, Pennsylvania)

Case Presentation: 78-year-old man s/p 7 + 3 → allogeneic SCT presents with myeloid sarcoma

Case Presentation: 39-year-old man with core binding factor AML s/p induction CLAG-M + gemtuzumab ozogamicin (GO) → high-dose cytarabine x 4

Dr Anna Halpern (Seattle, Washington)

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Questions and Comments: De-escalation of therapy

Prof Andrew Wei (Melbourne, Australia)

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Case Presentation: 64-year-old woman with newly diagnosed del(5q) AML with monocytic differentiation and multiple mutations (GATA2, BCOR, NF1 and RUNX1) receives azacitidine and venetoclax

Dr Tina Bhatnagar (Wheeling, West Virginia)

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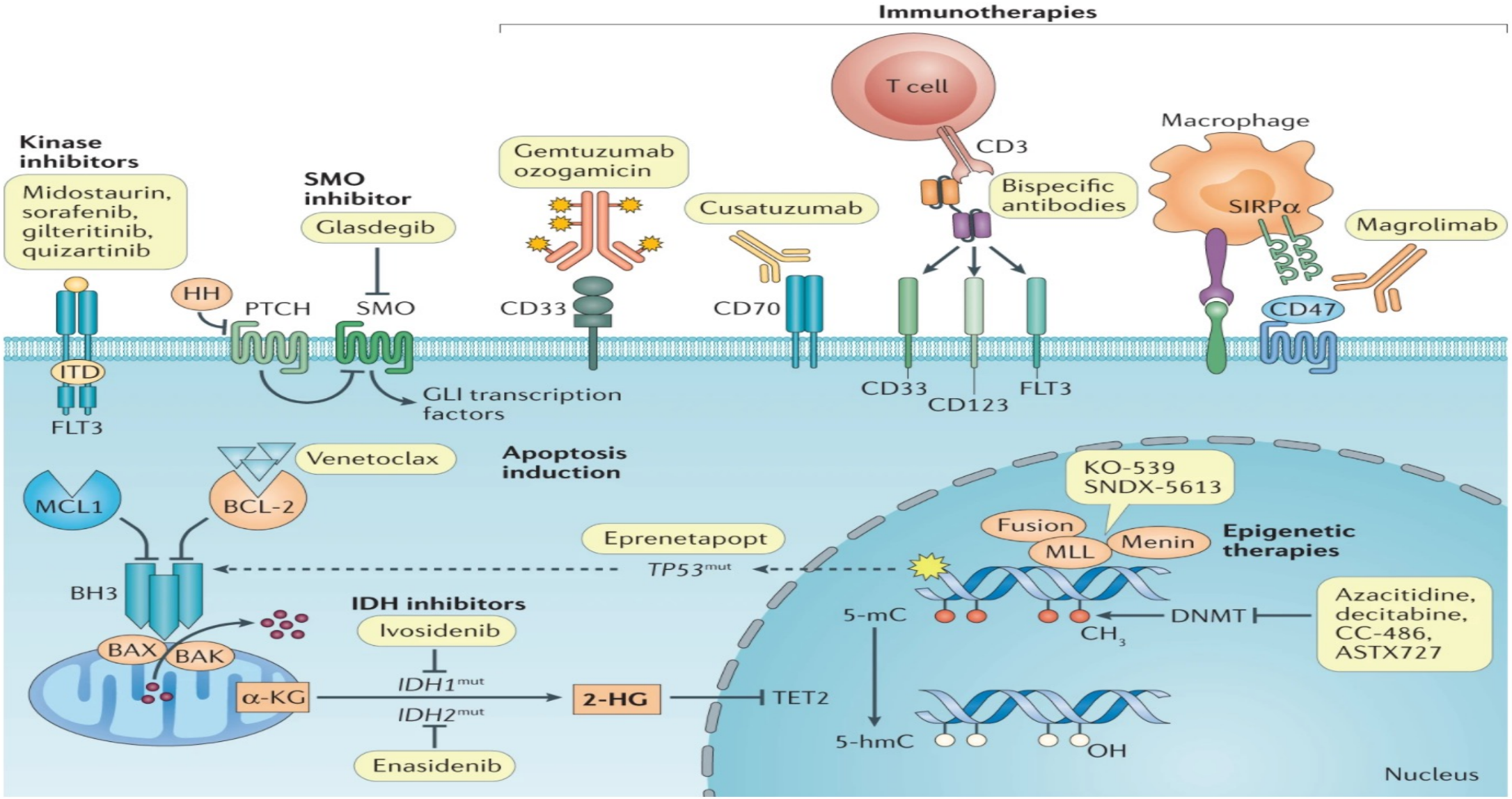
Selection of Therapy for Patients with AML

Courtney DiNardo

Dept of Leukemia

MD Anderson Cancer Center

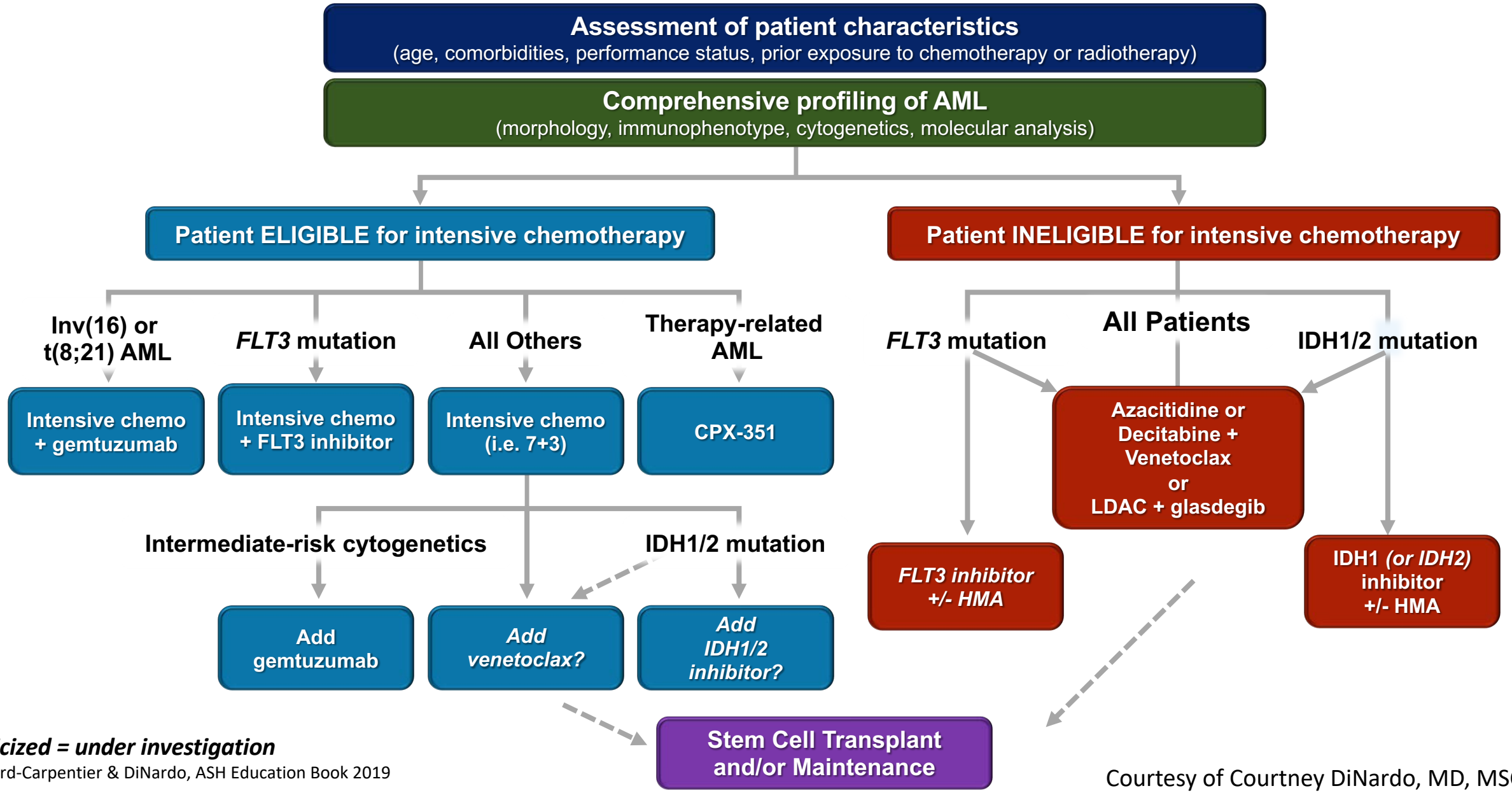
Novel targets for precision medicine in AML



Courtesy of Courtney DiNardo, MD, MSCE

Döhner H, Wei AH, Löwenberg B. Nat Rev Clin Oncol. 2021;18(9):577-590.

Evolving diagnostic and treatment paradigm for Newly Dx AML



Italicized = under investigation

Richard-Carpentier & DiNardo, ASH Education Book 2019

Courtesy of Courtney DiNardo, MD, MSCE

Young/Fit Newly Dx AML:
role for addition of venetoclax to IC?

Courtesy of Courtney DiNardo, MD, MSCE

VEN+IC in AML:

Venetoclax added to intensive chemotherapy in ND-AML:

- **Improved MRD-negative CRc (86% vs 61%)**
  - Most prominent in TP53-wild type ELN adverse-risk AML
- **Enabled more patients to transition to HSCT in CR (72% vs 58%)**
  - HSCT associated with improved EFS in ELN intermediate and adverse-risk AML
- **Improved EFS compared to our historical cohort treated with IC**
  - OS benefit also observed in ELN intermediate or adverse-risk AML
- ***TP53 mutated-AML demonstrates inferior outcomes compared to patients with wild-type TP53***

Lachowiez C et al, Lancet Hemaetol 2022

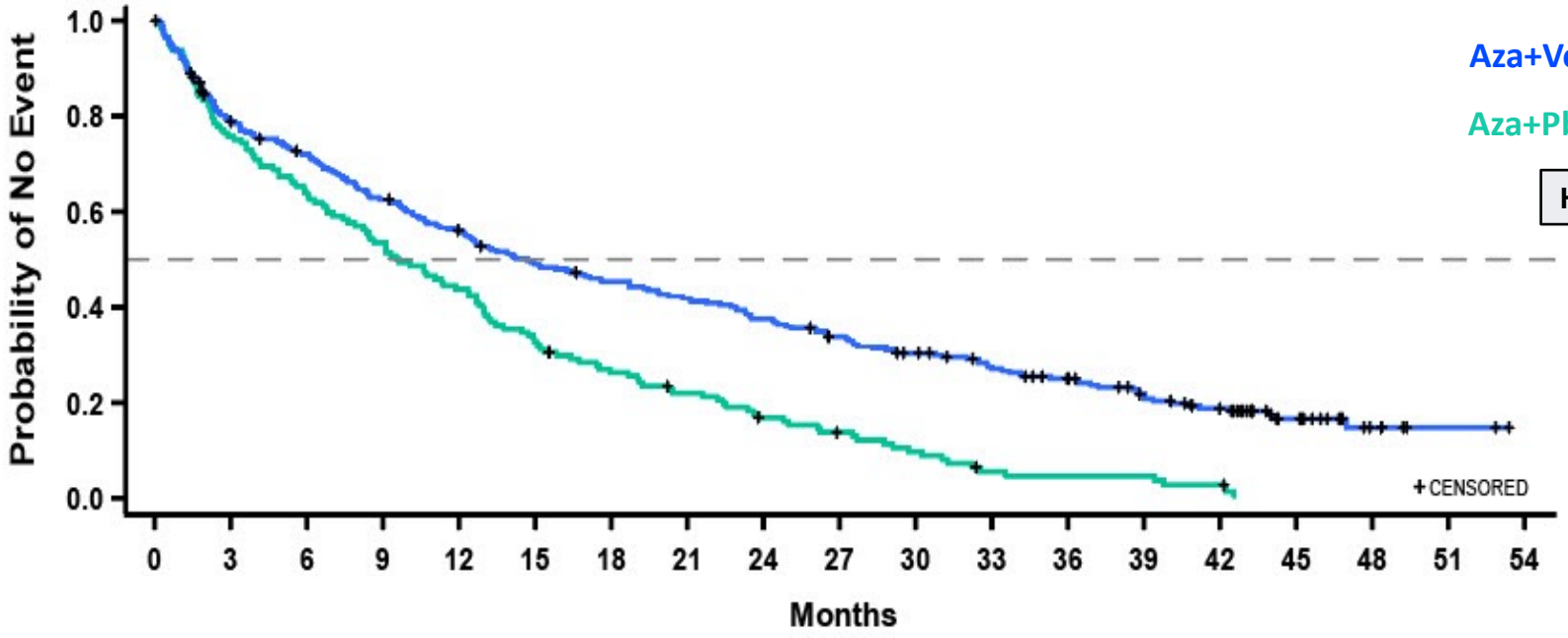
Courtesy of Courtney DiNardo, MD, MSCE

Older AML

Courtesy of Courtney DiNardo, MD, MSCE

Long Term Results of VIALE-A : Azacitidine ± venetoclax

Median follow-up time: 43.2 months (range: 0.0 - 53.4)



	No. of events/No. of patients (%)	Median overall survival, months (95% CI)
Aza+Ven	222/286 (77.6)	14.7 (12.1–18.7)
Aza+Pbo	138/145 (95.2)	9.6 (7.4-12.7)

Hazard ratio: 0.58 (95% CI: 0.465 - 0.723), p<0.001

Patients at Risk

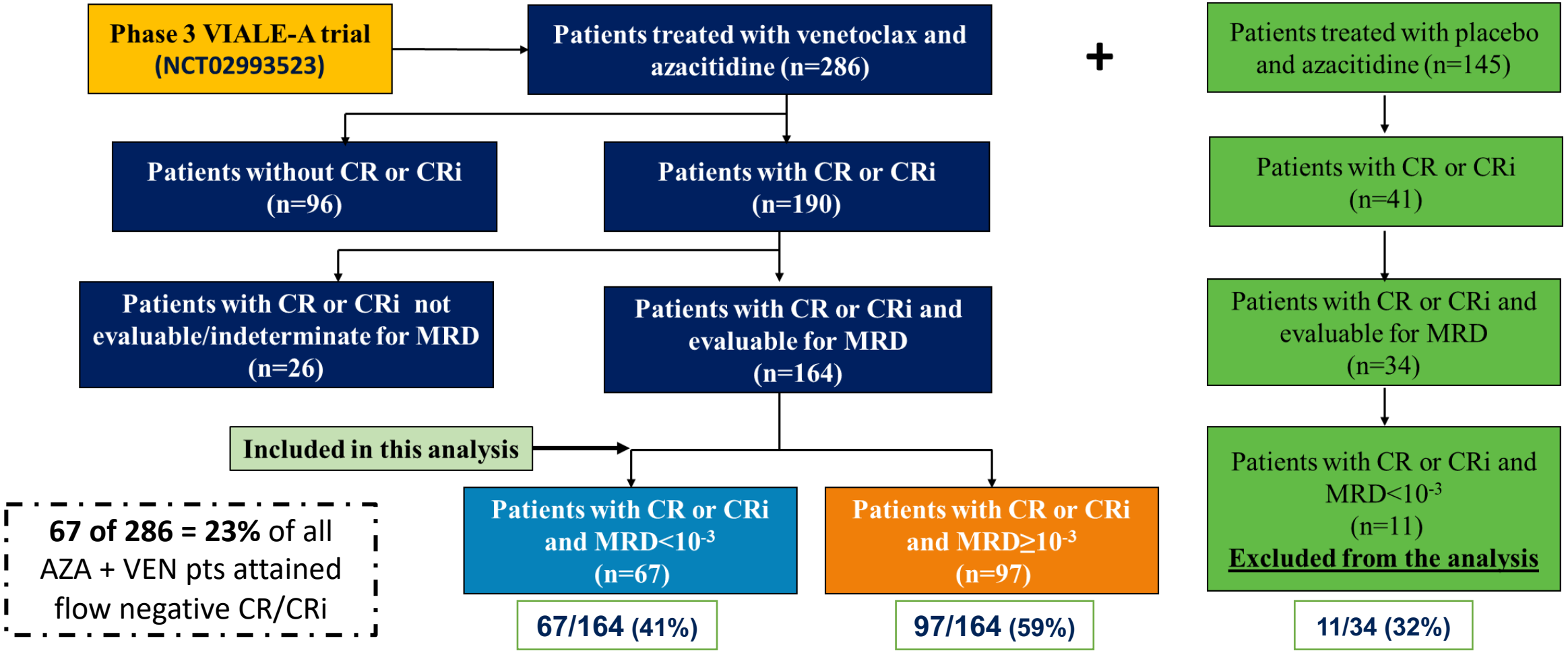
Azacitidine plus placebo	145	109	92	77	63	47	37	30	22	17	12	6	5	5	3	0			
Azacitidine plus venetoclax	286	220	199	173	153	133	122	113	101	89	78	67	57	45	34	18	6	2	0

Pratz K et al, ASH 2022;Abstract 219.

Courtesy of Courtney DiNardo, MD, MSCE

VIALE-A: Flow cytometry MRD: Response and Prognosis

Analyzed patient population



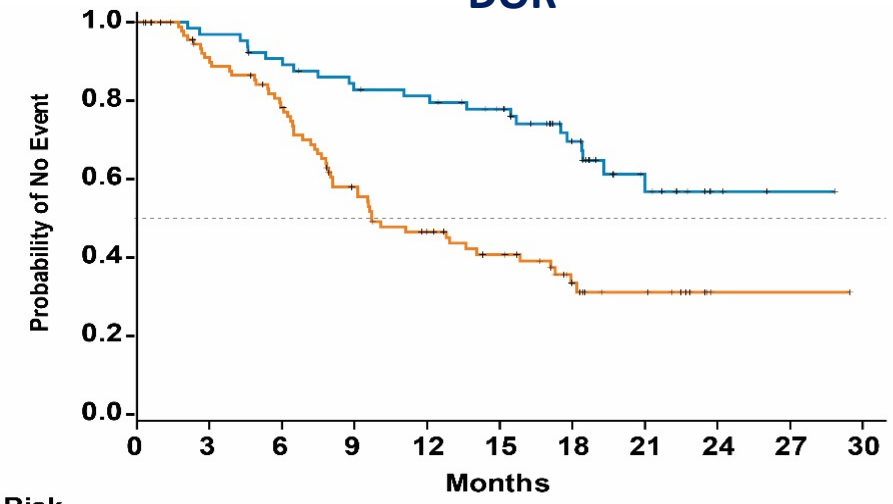
Data cutoff: Jan 04, 2020
CR: Complete remissions, CRi: CR with incomplete hematological recovery; MRD: Minimal residual disease
Patients were indeterminate if the BM samples had less than a hundred thousand CD45+ leukocytes

Courtesy of Courtney DiNardo, MD, MSCE

Pratz KW, et al. JCO 2022.

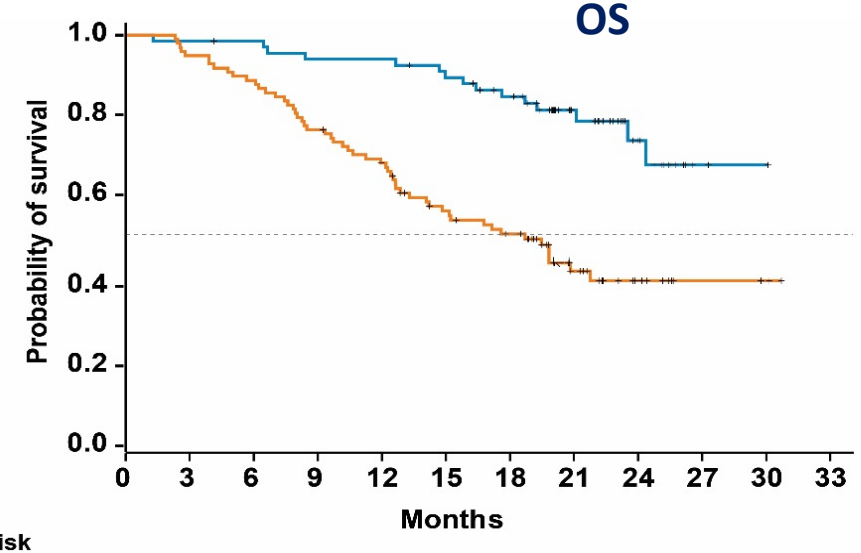
DOR and OS in CR/CRi patients treated with AZA + VEN by MRD Status

DOR



Patients at Risk											
CR+CRi+MRD<10^{-3}	67	63	58	52	50	44	30	14	3	1	0
CR+CRi+MRD≥10^{-3}	97	80	67	46	34	27	14	9	1	1	0

OS



Patients at Risk												
CR+CRi+MRD<10^{-3}	67	66	65	62	62	58	52	30	13	2	1	0
CR+CRi+MRD≥10^{-3}	97	92	86	74	64	49	42	21	10	3	2	0

Duration of remission	# of events	12-month, % (95% CI)	18-month % (95% CI)	Median DoR, months (95% CI)
CR+CRi+MRD<10^{-3}	22	81.2 (69.3, 88.9)	69.6 (55.9, 79.8)	NR (19.3 – NR)
CR+CRi+MRD≥10^{-3}	54	46.6 (35.6, 56.8)	33.5 (22.9, 44.5)	9.7 (8.0 – 15.8)

Overall survival	# of events	12-month, % (95% CI)	18-month % (95% CI)	Median OS, months (95% CI)
CR+CRi+MRD<10^{-3}	15	94.0 (84.7, 97.7)	84.6 (73.3, 91.4)	NR (24.4 – NR)
CR+CRi+MRD≥10^{-3}	52	67.9 (57.6, 76.2)	50.1 (39.6, 59.8)	18.7 (12.9 – NR)

Patients who attained an MRD response at any time received a median of 16·0 (range: 1·0 — 28·0) cycles of treatment with Ven+Aza; patients with MRD≥10^{-3} received a median of 9·0 (range: 2·0 — 30·0) cycles .
The median follow-up was 22·1 (range: 1·3— 30·1) months in patients with MRD<10^{-3} and 20·8 (range: 2·3 — 30·7) months in patients with MRD ≥10^{-3}.
Duration of remission for CRc was defined as the number of days from the date of first response (CR or CRi) per the modified IWG criteria for AML to the earliest evidence of confirmed morphologic relapse, confirmed progressive disease, or death due to disease progression.
OS was defined as the time from randomization to the date of death from any cause.

Courtesy of Courtney DiNardo, MD, MSCE

Pratz KW, et al. JCO 2022.

Practical Considerations

Courtesy of Courtney DiNardo, MD, MSCE

G-CSF Use with VEN Combinations

- In VIALE-A, 190/286 patients **(66%)** treated with Ven+Aza achieved CR/CRi; **49%** received G-CSF after achieving remission
- In VIALE-C, 69/143 patients **(48%)** treated with Ven+LDAC achieved CR/CRi; **43%** received G-CSF after achieving remission
- Baseline Grade ≥3 neutropenia was similar between patients who went on to receive G-CSF and those who did not

In both VIALE-A and VIALE-C, duration of post-remission Grade ≥3 neutropenia or febrile neutropenia was generally **shorter with G-CSF use than without G-CSF use**

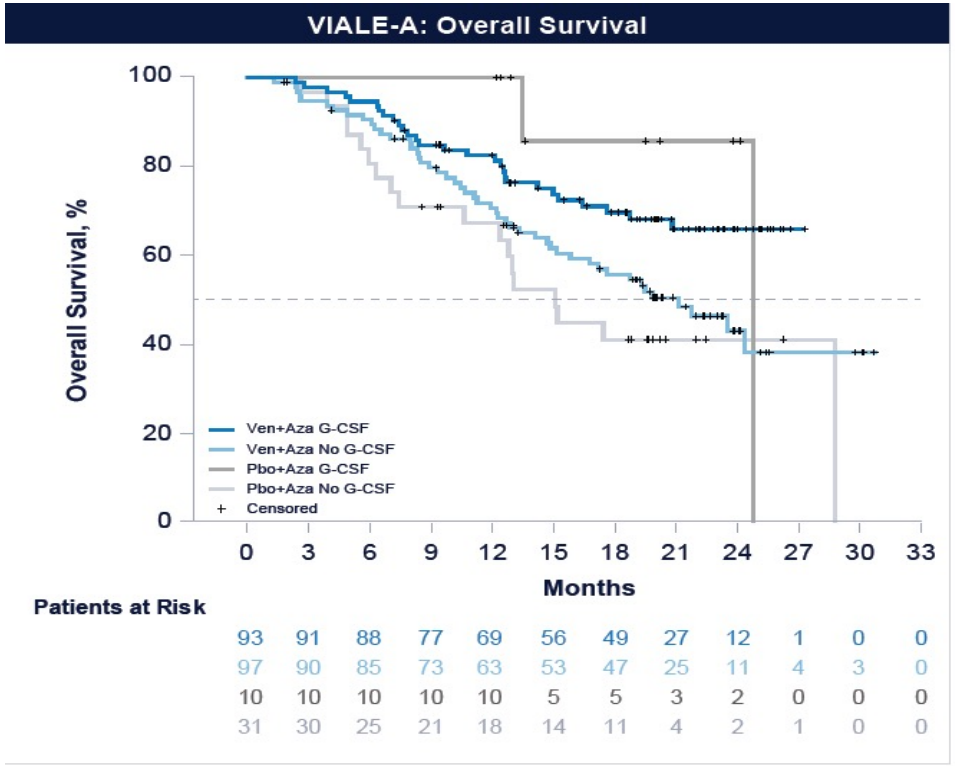
	VIALE-A		VIALE-C	
Duration of Post-Remission Neutropenia	**Ven+Aza G-CSF (n=93)**	**Ven+Aza No G-CSF (n=97)**	**Ven+LDAC G-CSF (n=30)**	**Ven+LDAC No G-CSF (n=39)**
Median duration of post-remission Gr ≥3 neutropenia (range), days	12.5 (1–696)	16 (1–648)	15 (2–419)	12.5 (5–367)
Median duration of post-remission Gr ≥3 febrile neutropenia (range), days	8 (1–320)	10.5 (2–22)	6 (3–411)	29 (1–30)

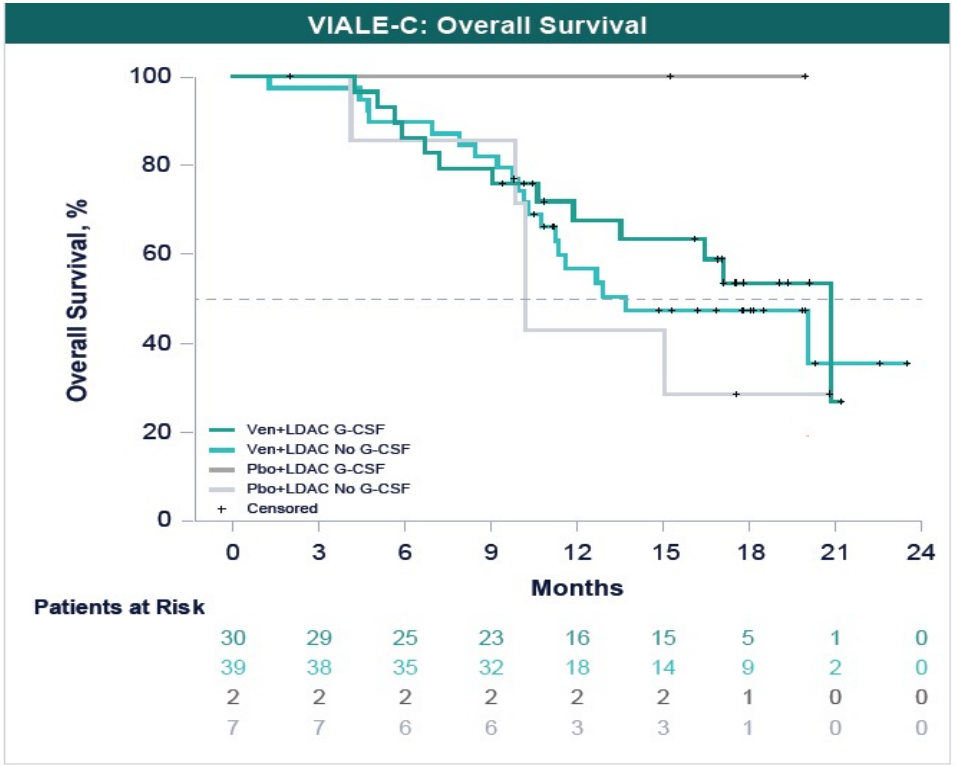
DiNardo CD, et al. Presented at: 2022 EHA Congress; June 9-12, 2022. Vienna, Austria. Poster P510.

Courtesy of Courtney DiNardo, MD, MSCE

Outcome of G-CSF After VEN Combinations

Post-remission G-CSF use was NOT associated with inferior OS (or DOR) among VEN-treated patients





	VIALE-A		VIALE-C	
Overall Survival	**Ven+Aza G-CSF (n=93)**	**Ven+Aza No G-CSF (n=97)**	**Ven+LDAC G-CSF (n=30)**	**Ven+LDAC No G-CSF (n=39)**
Median (95% CI), mo	NR (NR–NR)	21.1 (15.2–NR)	20.8 (11.9–NR)	13.7 (10.8–NR)
12-mo rate (95% CI), %	83 (73–89)	71 (60–79)	68 (47–82)	57 (39–71)
18-mo rate (95% CI), %	70 (59–78)	56 (45–65)	54 (32–71)	47 (30–63)
24-mo rate (95% CI), %	66 (54–75)	43 (31–55)	NA	NA

DiNardo CD, et al. Presented at: 2022 EHA Congress; June 9-12, 2022. Vienna, Austria. Poster P510.

Courtesy of Courtney DiNardo, MD, MSCE

Anti-infectious Prophylaxis With Venetoclax: Recommended Venetoclax Dose Reductions in the VIALE Studies and US and European Labels

Venetoclax dose reductions with VEN + AZA and VEN + LDAC VIALE-A and VIALE-C[1,2]

Standard venetoclax dose	Moderate CYP3Ai/P-gpi (eg, isavuconazole, ciprofloxacin)	Strong CYP3Ai (eg, posaconazole, voriconazole)
100 mg	50 mg	10 mg
200 mg	100 mg	20 mg
400 mg	≤200 mg	50 mg
600 mg*	≤300 mg	50 mg

- Consider antibacterial, antiviral, antifungal prophylaxis
- Note that azoles interact with venetoclax
- Real-world data show efficacy of venetoclax dosed with antifungal agents[5]

Venetoclax dose reductions USPI[3]

Day	Moderate CYP3Ai/P-gpi	Strong CYP3Ai	Posaconazole
Day 1	Reduce the dose by at least 50%	10 mg	10 mg
Day 2		20 mg	20 mg
Day 3		50 mg	50 mg
Day 4		100 mg	70 mg

Venetoclax dose reductions EMA SmPC[4]

Day	Moderate CYP3Ai/P-gpi	Strong CYP3Ai
Day 1	Reduce the dose by at least 50%	10 mg
Day 2		20 mg
Day 3		50 mg
Day 4		100 mg or less

*For VEN + LDAC only.

Aza, azacitidine; CYP3Ai, CYP3A inhibitor; LDAC, low-dose cytarabine; P-gpi, P-glycoprotein inhibitor; Ven, venetoclax.

1. Wei AH, et al. *Blood.* 2020;135(24):2137-2145 (incl. suppl); 2. DiNardo CD, et al. *N Engl J Med.* 2020;383(7):617-629 (incl. suppl); 3. Venclexta (venetoclax tablets) [prescribing information]. North Chicago, IL: AbbVie Inc; 2022; 4. Venclyxto [summary of product characteristics]. Ludwigshafen, Germany: AbbVie Deutschland GmbH & Co. KG; 2018; 5. Rausch CR, et al. *Blood*. 2019;134(suppl 1): abstract 2640.

Courtesy of Courtney DiNardo, MD, MSCE

Practical Take-Homes on VEN + AZA Therapy in AML

- VEN/AZA remains the optimal approach for newly diagnosed AML not suitable for intensive therapy, irrespective of cytogenetic or molecular features at this time
  - Generally well tolerated, with 30-day mortality of 6% to 7%
  - Prolonged neutropenia compared with AZA alone
  - Early bone marrow assessment (EOC1) with VEN interruption and shortened VEN duration for count recovery is recommended

- Responses are quick, with a median time to response of 1 month
  - Therapy is indefinite
  - Flow MRD negative status predicts for improved DOR and OS

Pratz. JCO. 2022;40:855. Pratz. ASH 2020. Abstr 1944.

Courtesy of Courtney DiNardo, MD, MSCE

Agenda

MODULE 1: Case Presentations – Part 1

MODULE 2: Selection of Therapy for Patients with AML

MODULE 3: Case Presentations – Part 2

- Dr Keruakous: 50-year-old man with therapy-related AML with an MLL mutation treated with CPX-351
- Dr Rudolph: 72-year-old man with secondary IDH-mutant AML
- Dr Sinha: 81-year-old woman with IDH2-mutant AML
- Dr Halpern: 70-year-old man with recurrent IDH2-mutant AML receives enasidenib and develops differentiation syndrome/disease progression
- Dr Olin: 44-year-old woman with NPM1, FLT3-TKD-mutant AML

MODULE 4: Treatment of AML with Targetable Mutations

Dr Amany Keruakous
(Augusta, Georgia)

Case Presentation: 50-year-old man with therapy-related AML with an MLL mutation treated with CPX-351

Dr Priya Rudolph
(Athens, Georgia)

Case Presentation: 72-year-old man with secondary IDH-mutant AML

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Case Presentation: 81-year-old woman with IDH2-mutant AML

Dr Rajni Sinha (Atlanta, Georgia)

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Case Presentation: 70-year-old man with recurrent IDH2-mutant AML receives enasidenib and develops differentiation syndrome/disease progression

Dr Anna Halpern (Seattle, Washington)

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Questions and Comments: Selection and sequencing of targeted therapies

Prof Andrew Wei (Melbourne, Australia)

Case Presentation: 44-year-old woman with NPM1, FLT3-TKD-mutant AML

Dr Rebecca Olin (San Francisco, California)

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Agenda

MODULE 1: Case Presentations – Part 1

MODULE 2: Selection of Therapy for Patients with AML

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MODULE 4: Treatment of AML with Targetable Mutations

Treatment of AML with Targetable Mutations

Andrew Wei

Peter MacCallum Cancer Centre
Royal Melbourne Hospital
Melbourne, Australia

Current landscape in AML

First line

Fit for intensive chemo

FLT3^{MUT}	*7+3 + Midostaurin*	*Post-remission therapy* *HCT* *IDAC* *oral AZA*
FLT3-ITD	*7+3 + Quizartinib*	
AML MRC, tAML	*CPX-351*	
Non-adverse CG	*7+3 + GO*	
Adverse CG	*7+3*	

Unfit for chemo

IDH1 mut	*IVO + AZA*
Other	*VEN + AZA* *VEN + LDAC*

Salvage

Fit for intensive chemo

FLT3 mut	*Gilteritinib*
Non-targeted	*IDAC +/- anthracycline*
	FLAG-IDA
	MEC
	CLAG-M
	Allogeneic HCT

Unfit for chemo

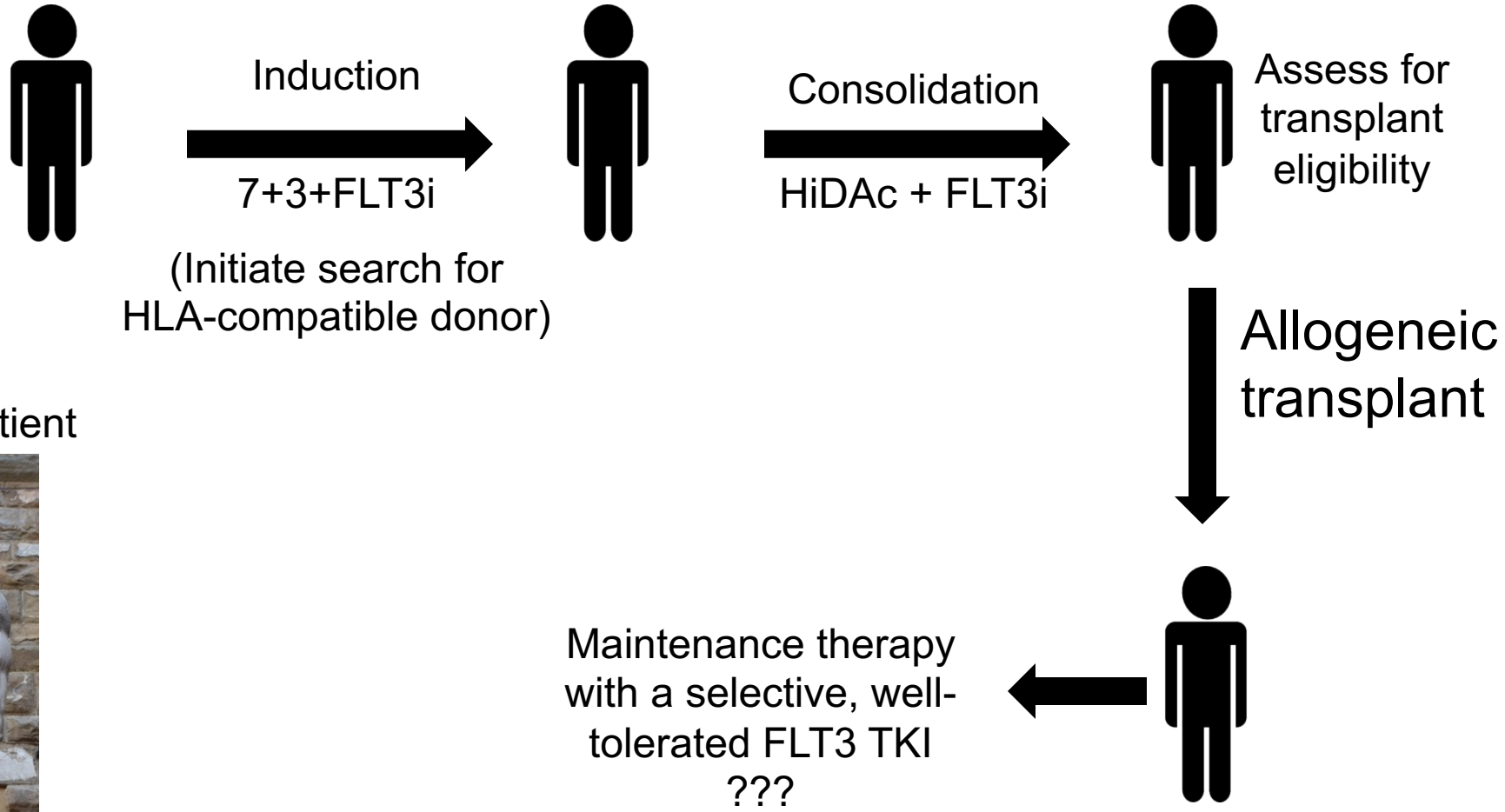
IDH1 mut	*Ivosidenib*
IDH2 mut	*Enasidenib*
FLT3 mut	*Gilteritinib*

Courtesy of Andrew Wei, MBBS, PhD

FLT3-ITD AML

Courtesy of Mark Levis, MD, PhD

Current treatment scheme for the “fit” patient with newly-diagnosed FLT3/ITD AML



The fit AML patient

Courtesy of Mark Levis, MD, PhD

Controversies

- Which FLT3 inhibitor for 1L therapy?
- FLT3 TKI or oral AZA as maintenance for patients with *FLT3* mutation?
- IVO-AZA or VEN-AZA for IDH1 mut AML?
- When to use gilteritinib in relapsed/refractory AML?
- 7+3 or VEN-AZA for adverse CG risk AML?

Courtesy of Andrew Wei, MBBS, PhD

Targeted options for 1L therapy of *FLT3*-ITD AML

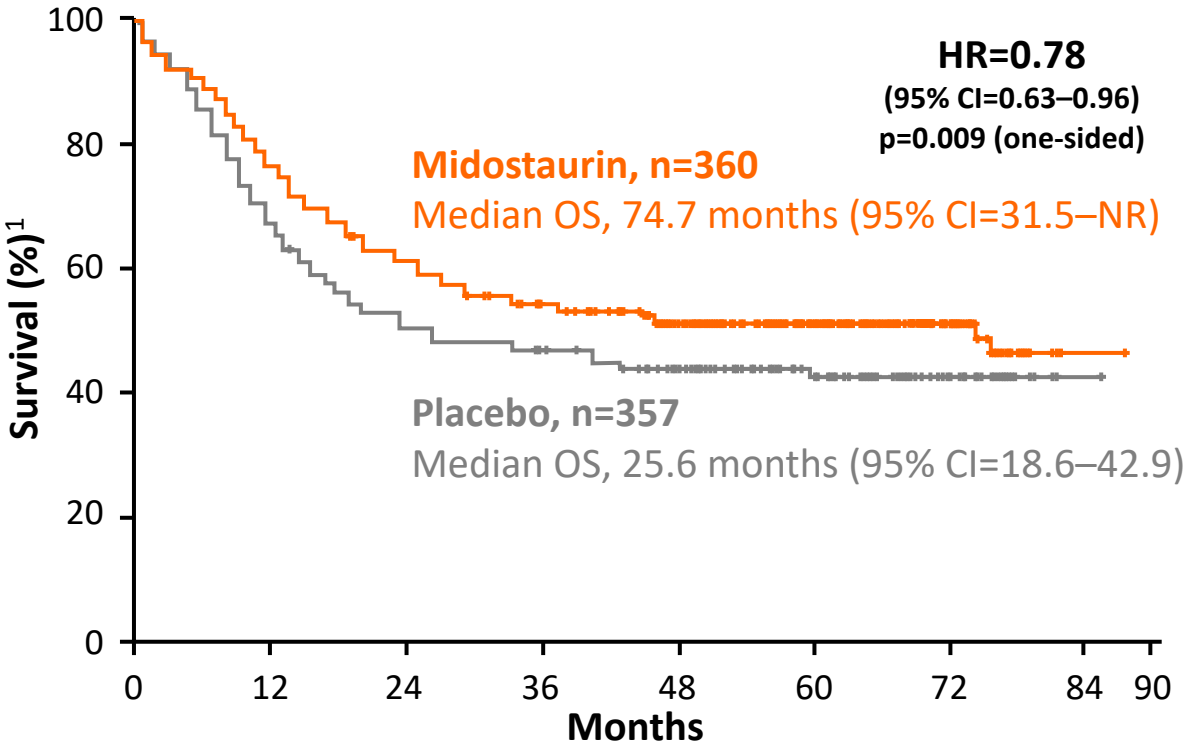
	RATIFY	QuANTUM-First
Median Age	47	56
≥ 60 y	0%	40%
FLT3-ITD	78%	100%
CR	59%	55%
Duration of CR	27m	39m
30-day death (vs PBO)	4.5% (3.1%)	5.7% (3.4%)

Maint 12 m

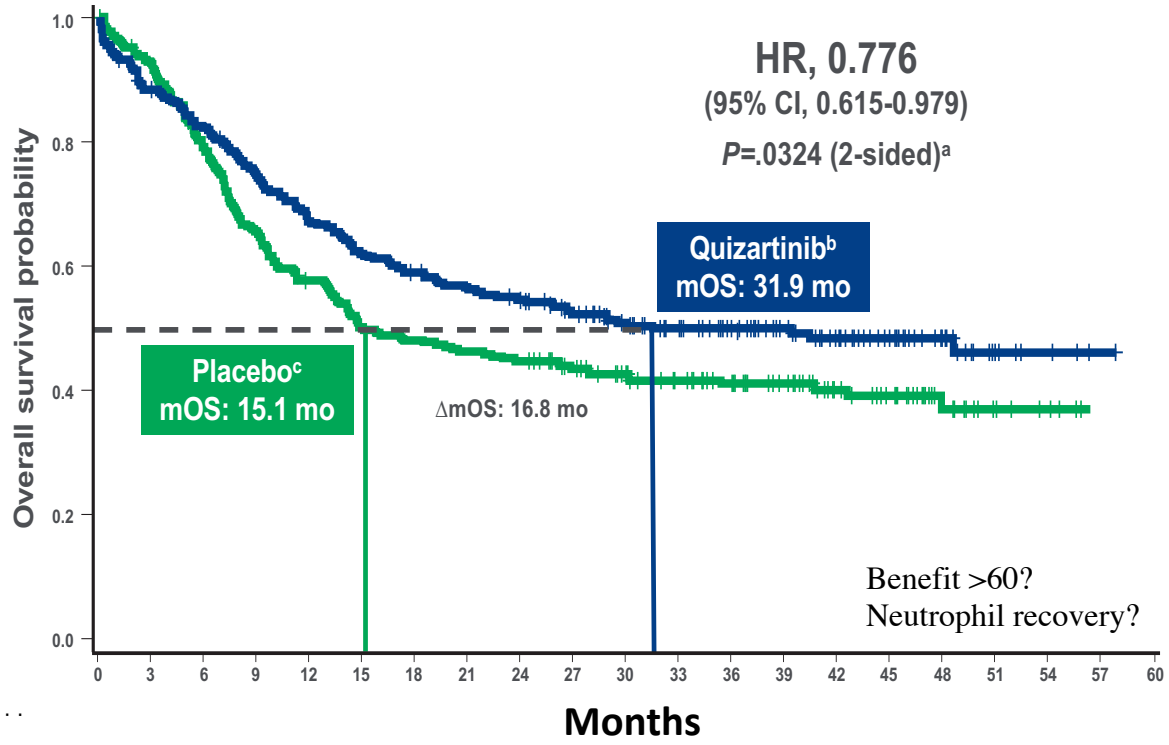
Gr 3+ Rash 14%

Maint 36 m + post HCT Quiz

Gr 3+ QTc inc 13.6%



Stone RM, *et al*. *N Engl J Med* 2017; **377**:454–464



Courtesy of Andrew Wei, MBBS, PhD

Harry Erba, EHA 2022

Controversies

- Which FLT3 inhibitor for 1L therapy?
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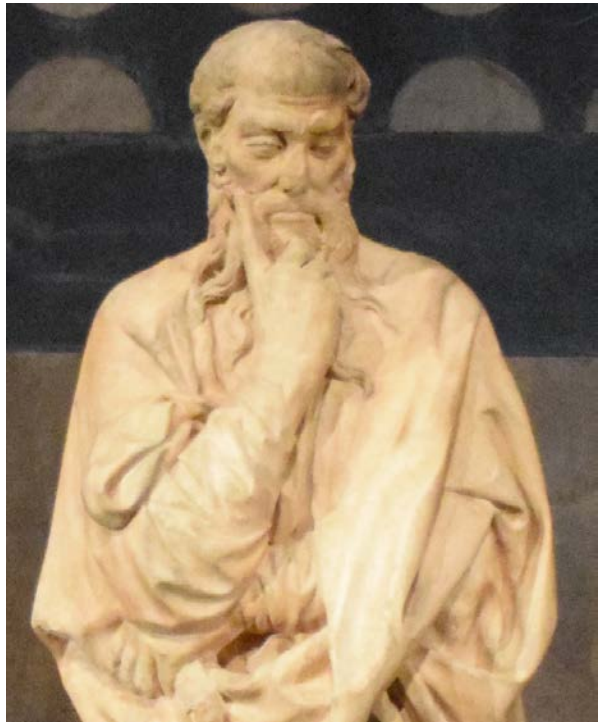
Courtesy of Andrew Wei, MBBS, PhD



What would happen if we combined venetoclax and gilteritinib…or even used a triplet of aza/ven/gilt?

Courtesy of Mark Levis, MD, PhD

FLT3 tyrosine kinase inhibitors synergize with BCL-2 inhibition to eliminate FLT3/ITD acute leukemia cells through BIM activation

Ruiqi Zhu[1,2], Li Li[1], Bao Nguyen[1], Jaesung Seo[1], Min Wu[1], Tessa Seale[1], Mark Levis[1], Amy Duffield[1,3], Yu Hu[2] and Donald Small[1,4]

Signal Transduction and Targeted Therapy (2021)6:186

In vitro rationale for combining venetoclax and gilteritinib

Courtesy of Mark Levis, MD, PhD

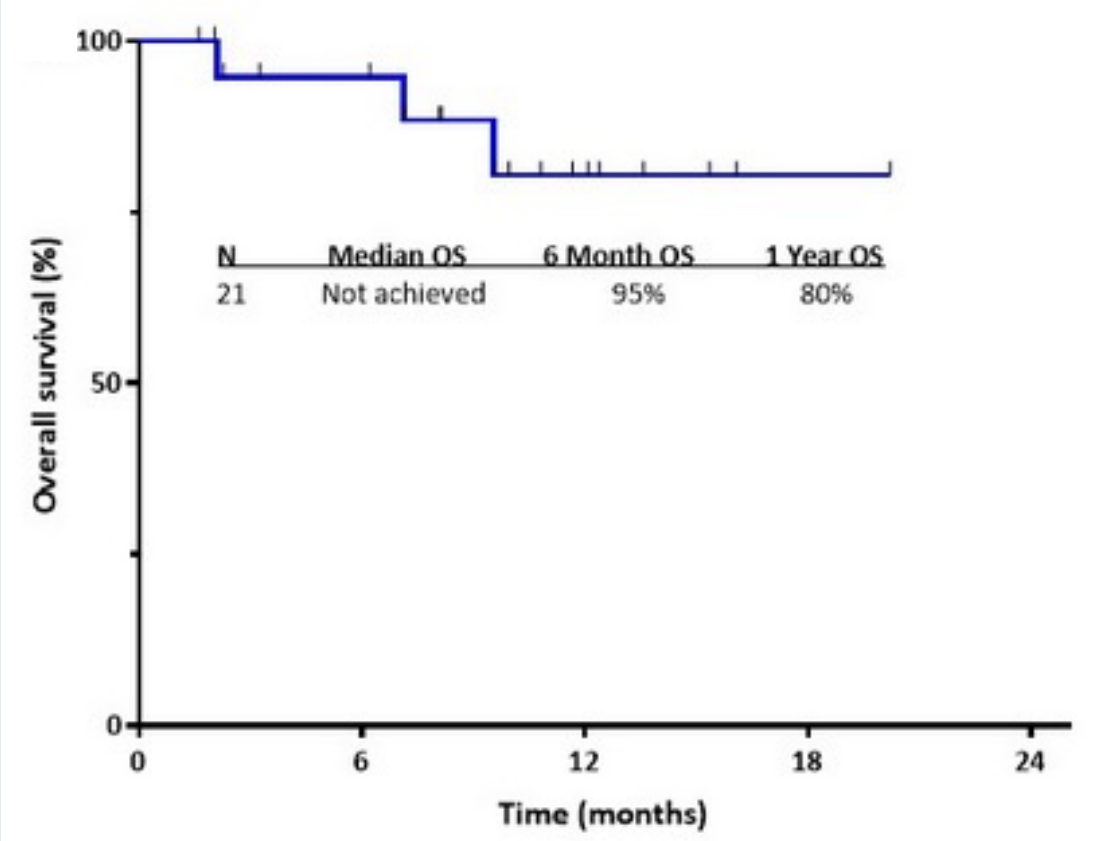
Updated Results from a Phase I/II Study of the Triplet Combination of Azacitidine, Venetoclax and Gilteritinib for Patients with FLT3-Mutated Acute Myeloid Leukemia

Short N et al.

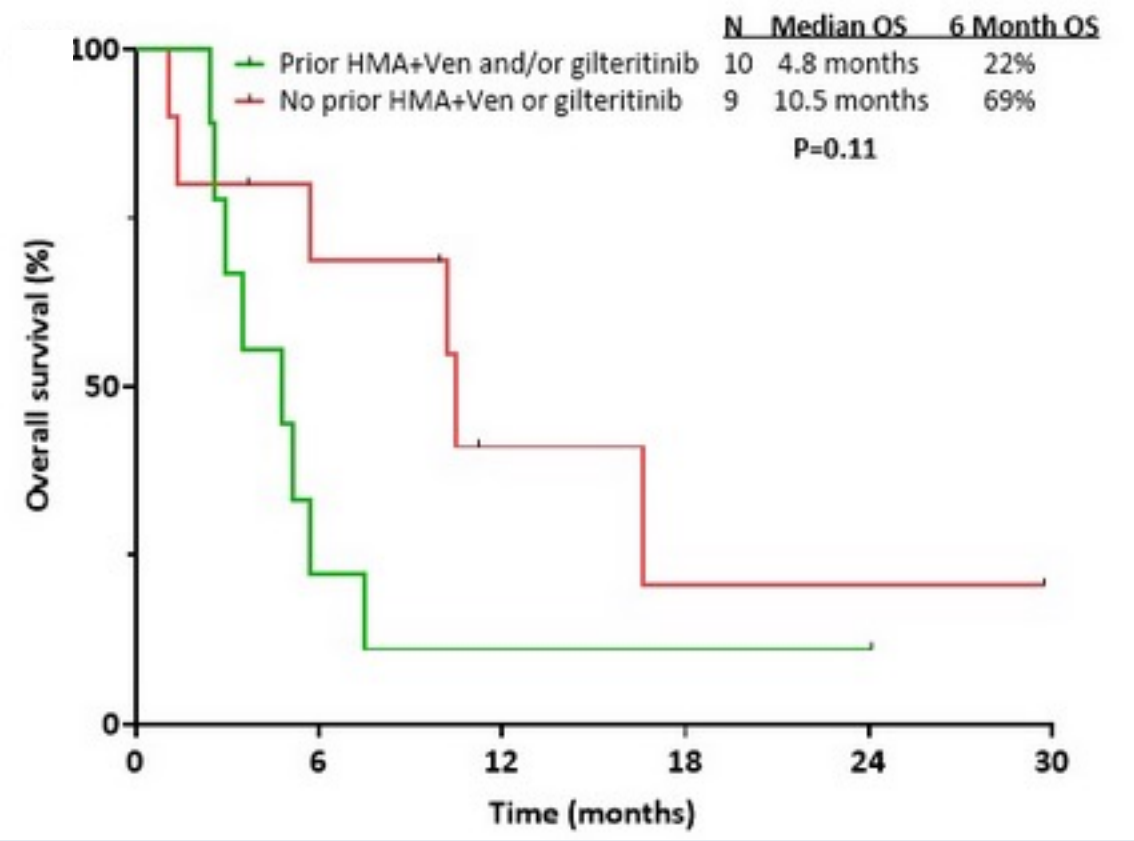
ASH 2022;Abstract 831.

Overall Survival with the Triplet of Azacitidine, Venetoclax and Gilteritinib in the Newly Diagnosed Cohort and in the Relapsed/Refractory Cohort Stratified by Prior Therapy

Newly Diagnosed



Relapsed/Refractory



Short N et al. ASH 2022;Abstract 831.

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APPENDIX

ASH 2022 – Select Additional Abstracts

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Long-Term Survival of Acute Myeloid Leukemia Responding Patients Who Stopped Azacytidine and/or Venetoclax Because of Poor Tolerance or Physician Choice: A Retrospective Multicenter Study from the French Innovative Leukemia Organization (FILO)

Garciaz S et al.

ASH 2022;Abstract 2737 (Poster).

Phase I/II Study of Azacitidine (AZA) with Venetoclax (VEN) and Magrolimab (Magro) in Patients (Pts) with Newly Diagnosed (ND) Older/Unfit or High-Risk Acute Myeloid Leukemia (AML) and Relapsed/Refractory (R/R) AML

Daver N et al.

ASH 2022;Abstract 61 (Oral).

Single versus Double Induction with “7 + 3” Containing 60 versus 90 mg Daunorubicin for Newly Diagnosed AML: Results from the Randomized Controlled SAL Dauno-Double Trial

Röllig C et al.

ASH 2022;Abstract 217 (Oral).

The Menin Inhibitor SNDX-5613 (Revumenib) Leads to Durable Responses in Patients (Pts) with KMT2A-Rearranged or NPM1 Mutant AML: Updated Results of a Phase (Ph) 1 Study

Issa GC et al.

ASH 2022;Abstract 63 (Oral).

Update on a Phase 1/2 First-in-Human Study of the Menin-KMT2A (MLL) Inhibitor Ziftomenib (KO-539) in Patients with Relapsed or Refractory Acute Myeloid Leukemia

Erba HP et al.

ASH 2022;Abstract 64 (Oral).

FLAG-IDA Combined with Gemtuzumab Ozogamicin (GO) Improves Event Free Survival in Younger Patients with Newly Diagnosed Acute Myeloid Leukaemia (AML) and Shows an Overall Survival Benefit in NPM1 and FLT3 Mutated Subgroups. Results from the UK NCRI AML19 Trial

Russell NH et al.

ASH 2022;Abstract 218 (Oral).

Meet The Professor

Optimizing the Management of Multiple Myeloma

Thursday, December 15, 2022
5:00 PM – 6:00 PM ET

Faculty

Shaji K Kumar, MD

Moderator

Neil Love, MD

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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