Optimizing the Selection of First-Line Therapy for Patients with Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Tuesday, July 1, 2025
5:00 PM – 6:00 PM ET

Faculty

Xavier Leleu, MD, PhD
Peter Voorhees, MD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Faculty

Xavier Leleu, MD, PhD
Professor, Head of Myeloma Clinic
Head of Department of Hematology
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MODERATOR
Neil Love, MD
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Miami, Florida

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Professor of Medicine
Wake Forest University School of Medicine
Chief, Plasma Cell Disorders Division
Atrium Health/Levine Cancer Institute
Associate Director of Clinical Research
Atrium Health Wake Forest Baptist Comprehensive Cancer Center
Charlotte, North Carolina

Commercial Support

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Dr Love — Disclosures

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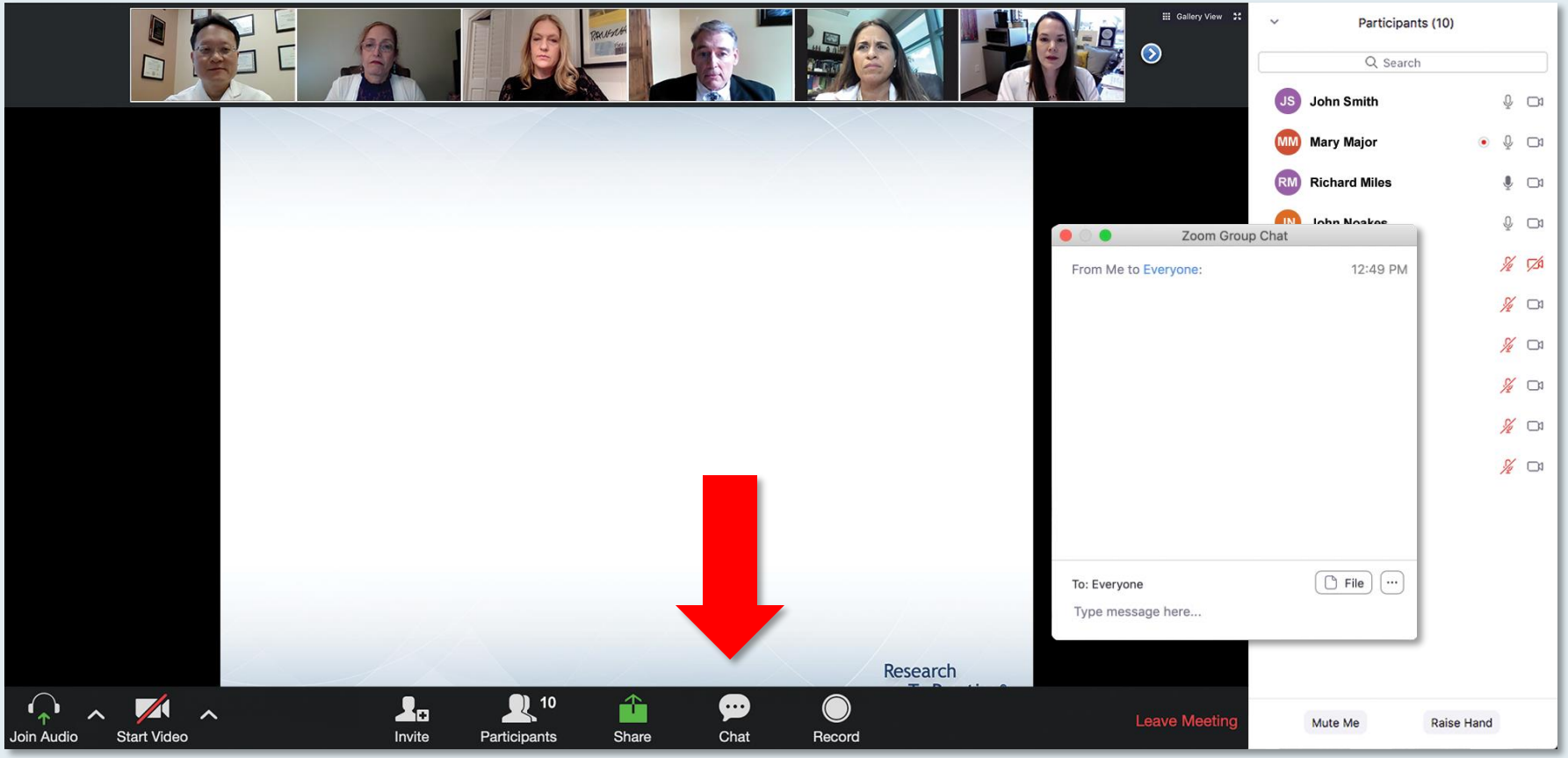

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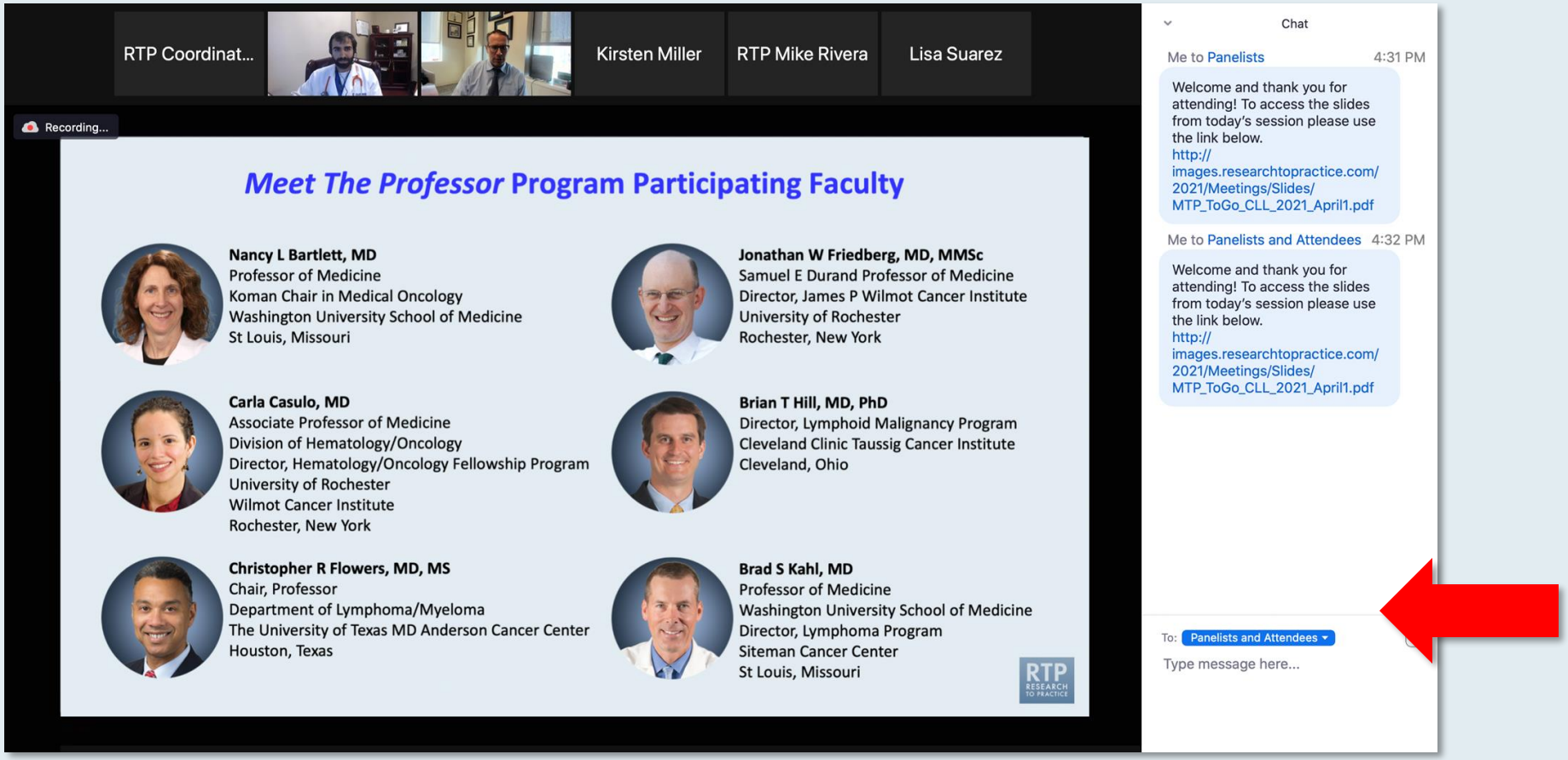

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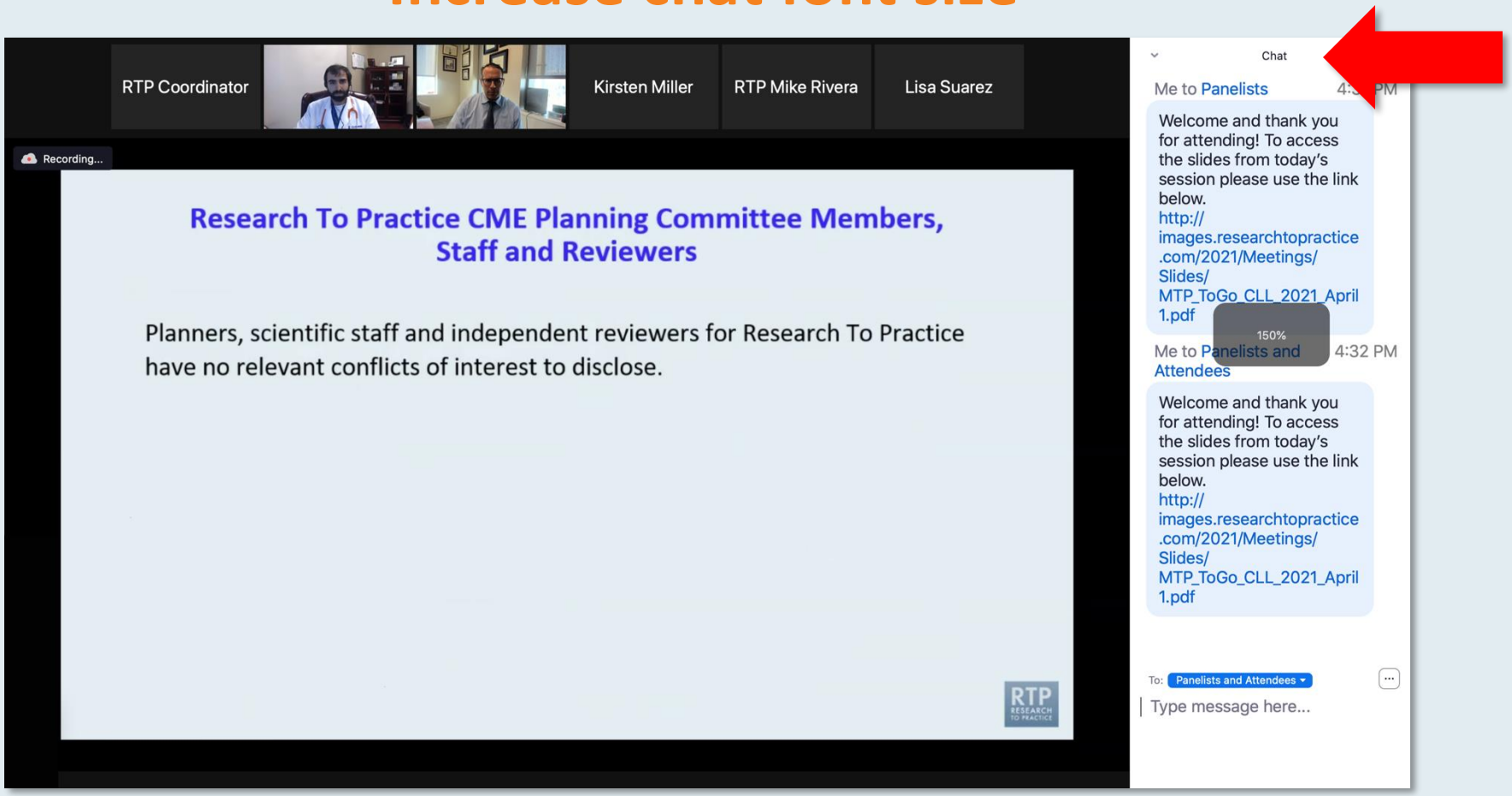

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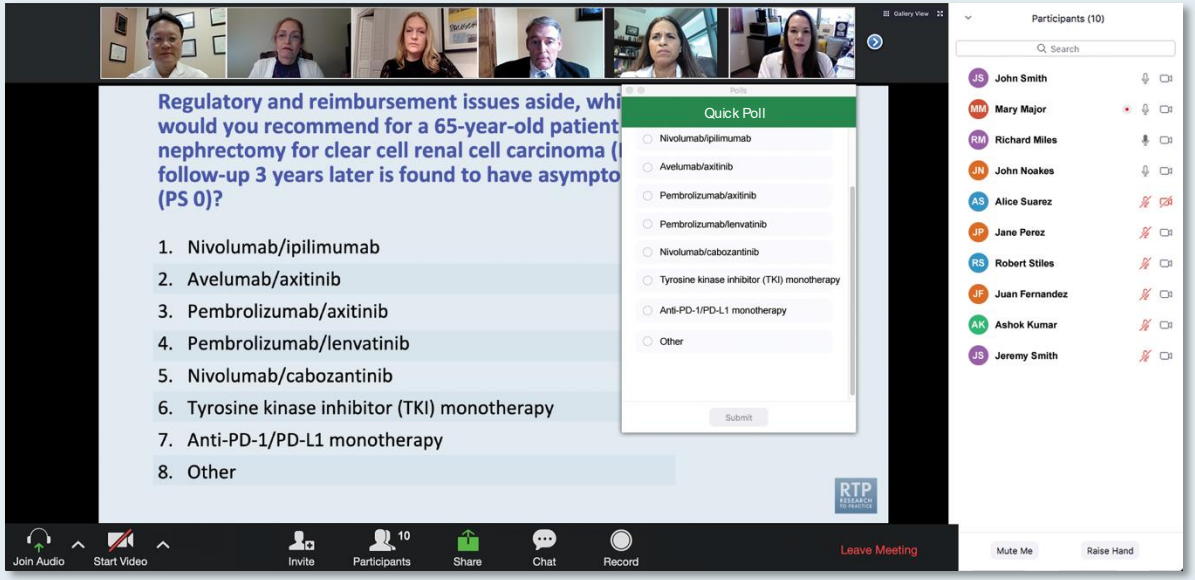

Multiple Myeloma — Year in Review Series on Relevant New Datasets and Advances

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NATIONAL AND KAPODISTRIAN UNIVERSITY OF ATHENS

DR ROBERT Z ORLOWSKI
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Practical Perspectives: Experts Review Actual Cases of Patients with Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 16, 2025
5:00 PM – 6:00 PM ET

Faculty

Stephen V Liu, MD
Charles Rudin, MD, PhD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Inside the Issue: Managing Ocular Toxicities Associated with Antibody-Drug Conjugates and Other Cancer Therapies

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Thursday, July 17, 2025
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Rebecca A Dent, MD, MSc
Hans Lee, MD
Neel Pasricha, MD
Tiffany A Richards, PhD, ANP-BC, AOCNP

Moderator

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RESEARCH TO PRACTICE

Cancer Q&A: Addressing Common Questions Posed by Patients with Relapsed/Refractory Multiple Myeloma

A Webinar Series for Clinicians and Patients,
Developed in Partnership with Cancer*Care*®

Patients	Clinicians
Wednesday, July 23, 2025	**Thursday, August 7, 2025**
6:00 PM – 7:00 PM ET	**5:00 PM – 6:00 PM ET**

Faculty

Natalie S Callander, MD
Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Addressing Current Knowledge and Practice Gaps in the Community — Optimizing the Use of Oral Selective Estrogen Receptor Degraders for Metastatic Breast Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, July 29, 2025

5:00 PM – 6:00 PM ET

Faculty

Komal Jhaveri, MD, FACP

Virginia Kaklamani, MD, DSc

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Neil Love, MD

RTP RESEARCH TO PRACTICE

Practical Perspectives: Experts Review
Actual Cases of Patients with Biliary Tract Cancers

A CME/MOC-Accredited Live Webinar

Wednesday, August 6, 2025
5:00 PM – 6:00 PM ET

Faculty

Haley Ellis, MD
James J Harding, MD

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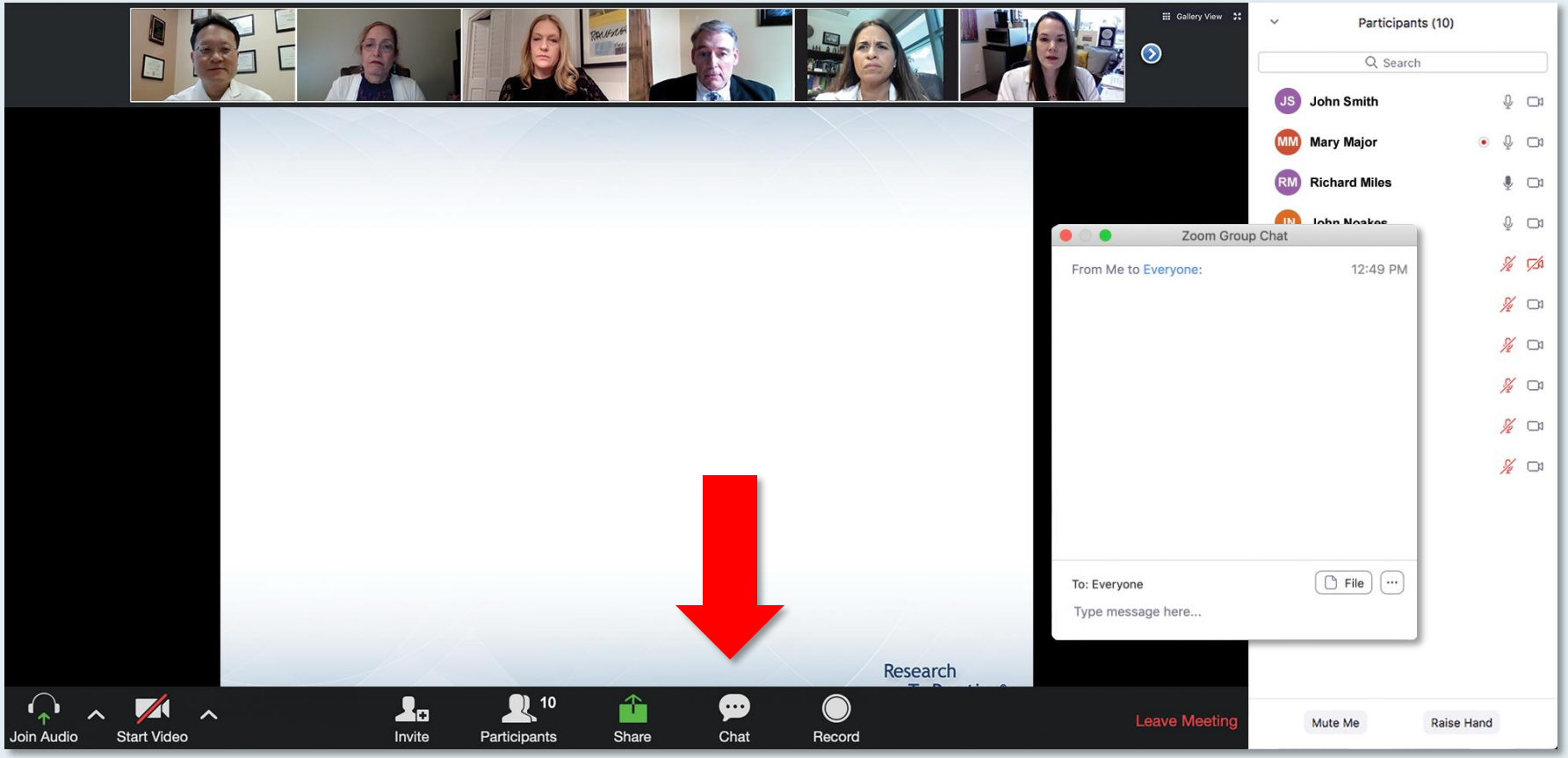

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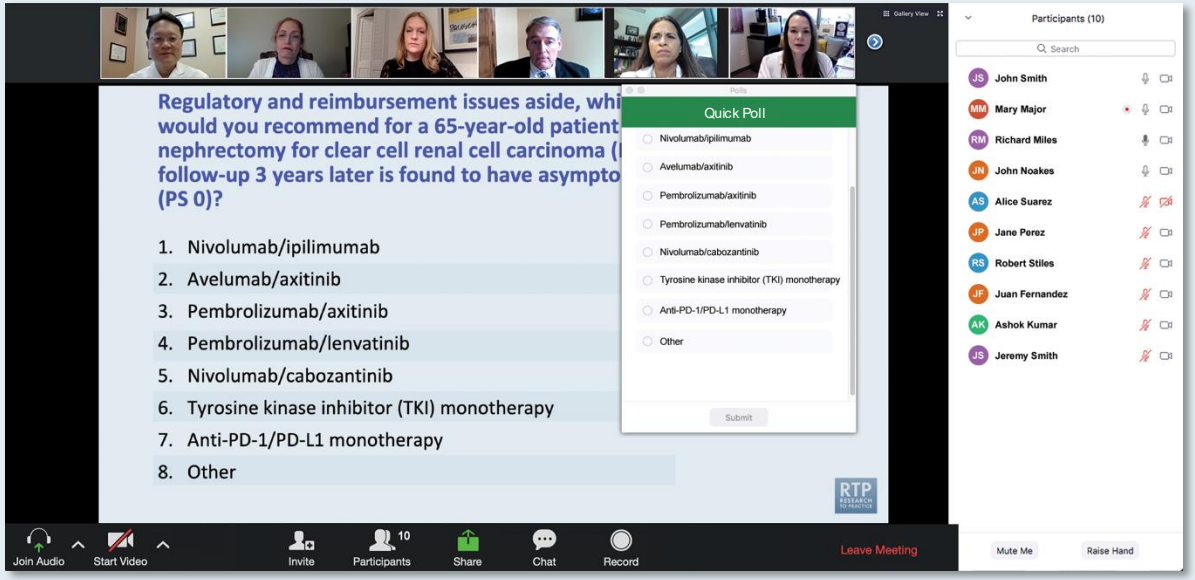

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Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

Module 3: ASCT Ineligible

Module 4: Subcutaneous Anti-CD38 Antibodies

Module 5: Special Considerations

Clinical Investigator Survey Participants

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RESEARCH TO PRACTICE

First Line Therapy for Multiple Myeloma

Peter Voorhees, M.D.

Professor of Medicine, Wake Forest University School of Medicine

Chief, Plasma Cell Disorders Division,
Atrium Health / Levine Cancer Institute

Associate Director of Clinical Research,
Atrium Health Wake Forest Baptist Comprehensive Cancer Center

Key Datasets

Peter Voorhees, MD

- Dimopoulos MA et al. Phase 3 randomized study of **daratumumab monotherapy versus active monitoring** in patients with high-risk smoldering multiple myeloma: Primary results of the **AQUILA study.** ASH 2024;Abstract 773.
- Dimopoulos et al. **Daratumumab or active monitoring** for high-risk smoldering multiple myeloma. *N Engl J Med* 2024;392(18):1777-88.
- Voorhees PM et al. Addition of **daratumumab to lenalidomide, bortezomib, and dexamethasone** for transplantation-eligible patients with newly diagnosed multiple myeloma (GRIFFIN): Final analysis of an open-label, **randomised, phase 2 trial**. *Lancet Haematol* 2023;10:e825-37.
- Sonneveld P et al. **Daratumumab, bortezomib, lenalidomide, and dexamethasone** for multiple myeloma. *New Engl J Med* 2024;390:132-47.
- Dimopoulos M et al. **Daratumumab (DARA)/bortezomib/lenalidomide/dexamethasone (D-VRd)** with D-R maintenance (Maint) in transplant-eligible (TE) newly diagnosed myeloma (NDMM): **PERSEUS cytogenetic risk analysis**. International Myeloma Society (IMS) 2024;Abstract OA-48.
- Goldschmidt H et al. Impact of minimal residual disease on progression-free survival in patients with newly diagnosed multiple myeloma treated with **isatuximab, lenalidomide, bortezomib and dexamethasone** induction therapy in the **Phase 3 GMMG-HD7 trial**. ASH 2024;Abstract 364.
- Gay F et al. Sustained MRD negativity in patients with newly diagnosed multiple myeloma treated with **carfilzomib-lenalidomide-dexamethasone with or without isatuximab (phase III IsKia trial).** ASCO 2025;Abstract 7502.

Key Datasets

Peter Voorhees, MD (continued)

- Gay F et al. Analysis of sustained MRD negativity in patients with newly diagnosed multiple myeloma treated with **carfilzomib-lenalidomide-dexamethasone with or without isatuximab (Phase III ISKIA trial).** EHA 2025;Abstract S208.
- Badros A et al. **Daratumumab with lenalidomide as maintenance after transplant** in newly diagnosed multiple myeloma: The **AURIGA study**. *Blood* 2025;145(3):300-10.
- Foster L et al. **Daratumumab plus lenalidomide (D-R) versus lenalidomide (R) alone as maintenance therapy** in newly diagnosed multiple myeloma (NDMM) after transplant: Analysis of the **phase 3 AURIGA study** among clinically relevant subgroups. ASH 2024;Abstract 675.
- Moreau P et al. **Daratumumab (DARA) + bortezomib/thalidomide/dexamethasone (D-VTD)** followed by DARA maintenance in transplant-eligible (TE) newly diagnosed multiple MYELOMA (NDMM): >6-year update of **CASSIOPEIA**. EHA 2024;Abstract S204.
- Moreau P et al. **Bortezomib, thalidomide, and dexamethasone with or without daratumumab** and followed by daratumumab maintenance or observation in transplant-eligible newly diagnosed multiple myeloma: Long-term follow-up of the **CASSIOPEIA randomised controlled phase 3 trial**. *Lancet Oncol* 2024;25(8):1003-14.
- Callander N et al. **Daratumumab-based quadruplet therapy** for transplant-eligible newly diagnosed multiple myeloma with **high cytogenetic risk**. *Blood Cancer J* 2024;14(1):69.
- Perrot A et al. MRD-driven strategy following **IsaKRD induction** in transplant-eligible NDMM: Primary endpoints of the **phase 3 MIDAS trial**. ASCO 2025;Abstract 7500.

Key Datasets

Peter Voorhees, MD (continued)

- Perrot A et al. Minimal residual disease-driven strategy following **isatuximab-carfilzomib-lenalidomide-dexamethasone** induction in transplant-eligible newly diagnosed multiple myeloma: Primary endpoints of the **phase 3 MIDAS trial**. EHA 2025;Abstract S205.
- Usmani S et al. **Daratumumab plus bortezomib, lenalidomide and dexamethasone** for transplant-ineligible or transplant-deferred newly diagnosed multiple myeloma: The randomized **phase 3 CEPHEUS trial**. *Nature Med* 2025;31(4):1195-202.
- Facon T et al. **Isatuximab, bortezomib, lenalidomide, and dexamethasone** for multiple myeloma. *New Engl J Med* 2024;391:1597-609.
- Leleu X et al. **Isatuximab, lenalidomide, dexamethasone and bortezomib** in transplant-ineligible multiple myeloma: The randomized **phase 3 BENEFIT trial**. *Nat Med* 2024;30:2235-41.
- Manier S et al. **Phase 3 study** results of **isatuximab, bortezomib, lenalidomide, and dexamethasone (Isa-VRd) versus VRd** for transplant-ineligible patients with newly diagnosed multiple myeloma **(IMROZ).** IMS 2024;Abstract OA-49.
- Ailawadhi S et al. **Isatuximab subcutaneous by on-body injector** versus isatuximab intravenous plus pomalidomide and dexamethasone in relapsed/refractory multiple myeloma: **Phase III IRAKLIA study**. *J Clin Oncol* 2025;[Online ahead of print].
- Leleu X et al. **Isatuximab subcutaneous via an on-body delivery system** versus isatuximab intravenous, plus pomalidomide and dexamethasone, in relapsed/refractory multiple myeloma: The randomized **phase 3 IRAKLIA study**. EHA 2025;Abstract S203.

RTP RESEARCH TO PRACTICE

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

Module 3: ASCT Ineligible

Module 4: Subcutaneous Anti-CD38 Antibodies

Module 5: Special Considerations

Case Presentation – Dr Voorhees: 78-year-old man with smoldering myeloma

- 78-year-old man who was screened for a clonal plasma cell disorder as part of a work-up of cardiac amyloidosis.
- CBC, Cr, Ca normal. SPEP/IFE: Monoclonal IgG kappa 2.2 g/dL, serum free kappa LCs 290 mg/L, FLC ratio 31.66.
- Bone marrow: 40% PCs. Myeloma FISH: + for gain 1q21 and +9.
- Endomyocardial biopsy + for wild type TTR amyloidosis.
- Imaging: PET-CT and MRI of the C/T/L spine with no lesions.
- Co-morbidities: Diastolic heart failure (compensated),atrial fibrillation, neuropathic pain in the distal lower extremities from lumbar spine stenosis.
- Repeat myeloma markers 1-year into active monitoring: SPEP/IFE: Monoclonal IgG kappa 2.5 g/dL, serum free kappa LCs 312 mg/L, FLC ratio 39.7.
- ECOG PS 1

To treat or not to treat?

Case Presentation – Dr Voorhees: 78-year-old man with smoldering myeloma (cont'd)

- After a discussion of the risks / benefits of treatment, we agreed to move forward with daratumumab monotherapy as treatment.
- The patient had some exacerbation of edema and dyspnea with exertion after the first 2 doses of daratumumab that we attributed to the corticosteroid premedication. After omission of dexamethasone from cycle 1, day 15 and beyond, the patient has had essentially no side effects. The M spike has achieved a partial response to therapy.
- We intend to stop treatment after 36 months.

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

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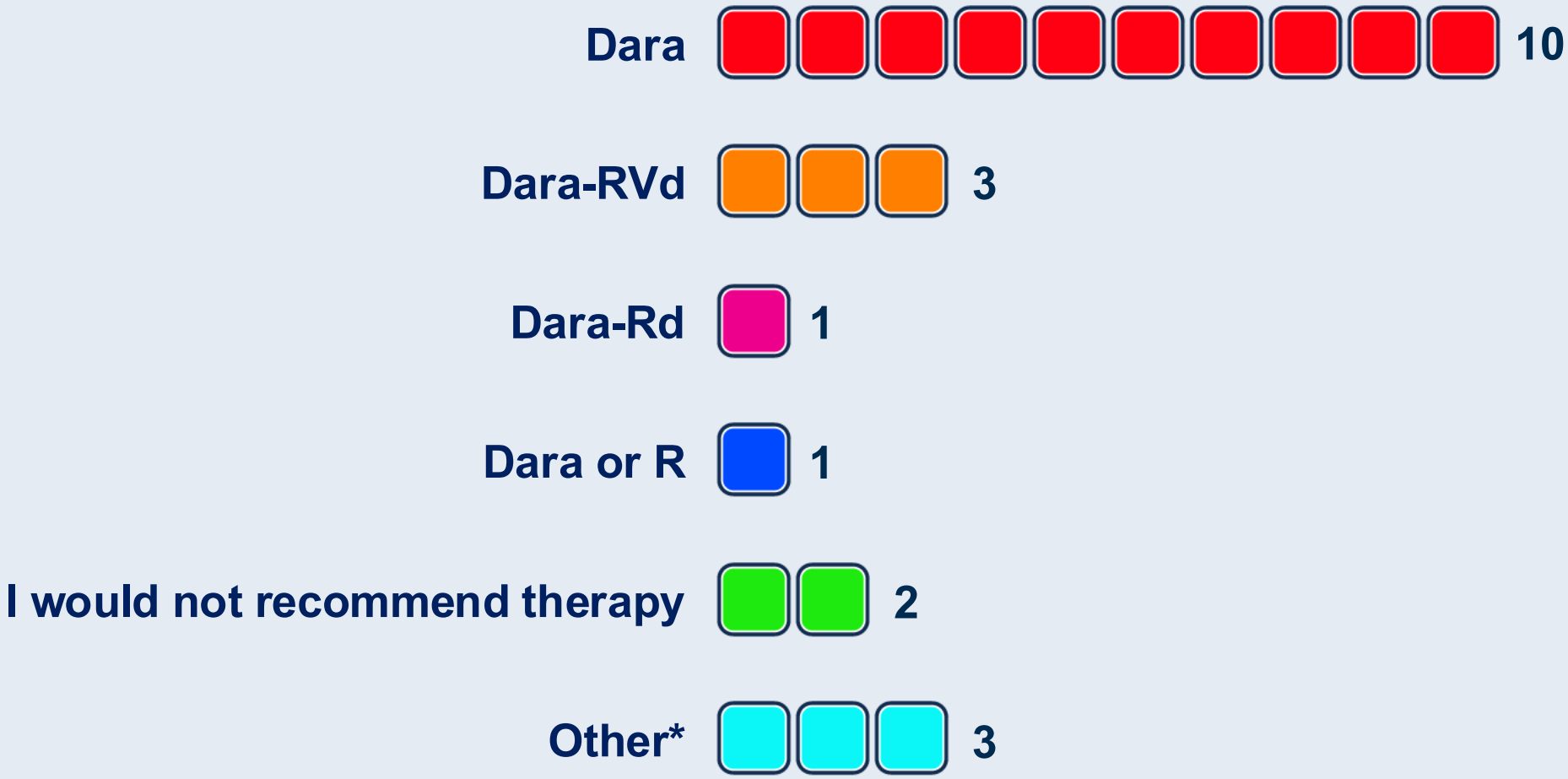
Regulatory and reimbursement issues aside, if you were going to offer systemic treatment to a 65-year-old patient with high-risk smoldering myeloma, what would you most likely recommend?



* Only on a clinical trial; full MM therapy; first-line therapy as in MM trials

Survey of 20 clinical investigators, June 2025

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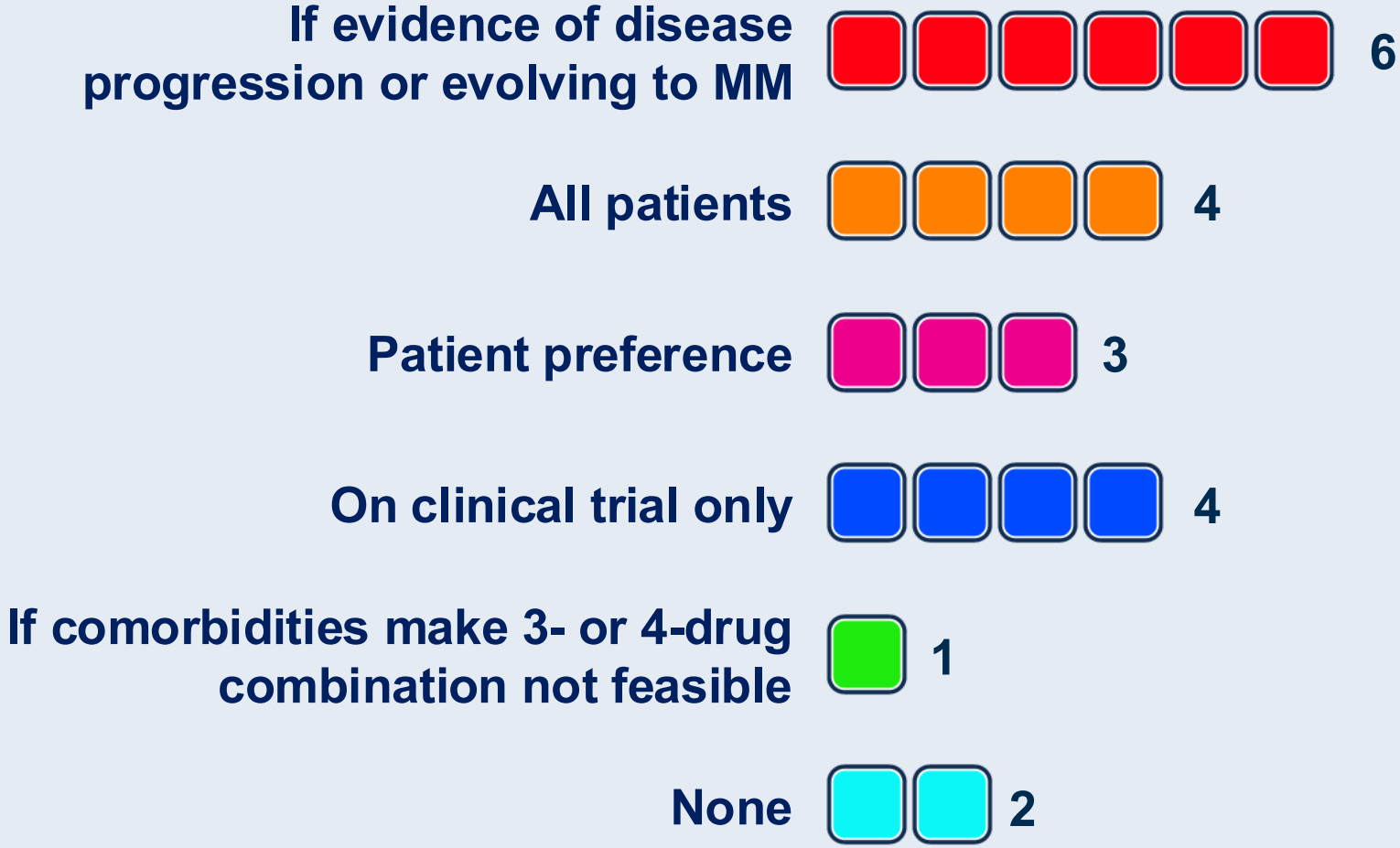
For which clinical situations, if any, would you offer systemic treatment to a 65-year-old patient with high-risk smoldering myeloma?



Survey of 20 clinical investigators, June 2025

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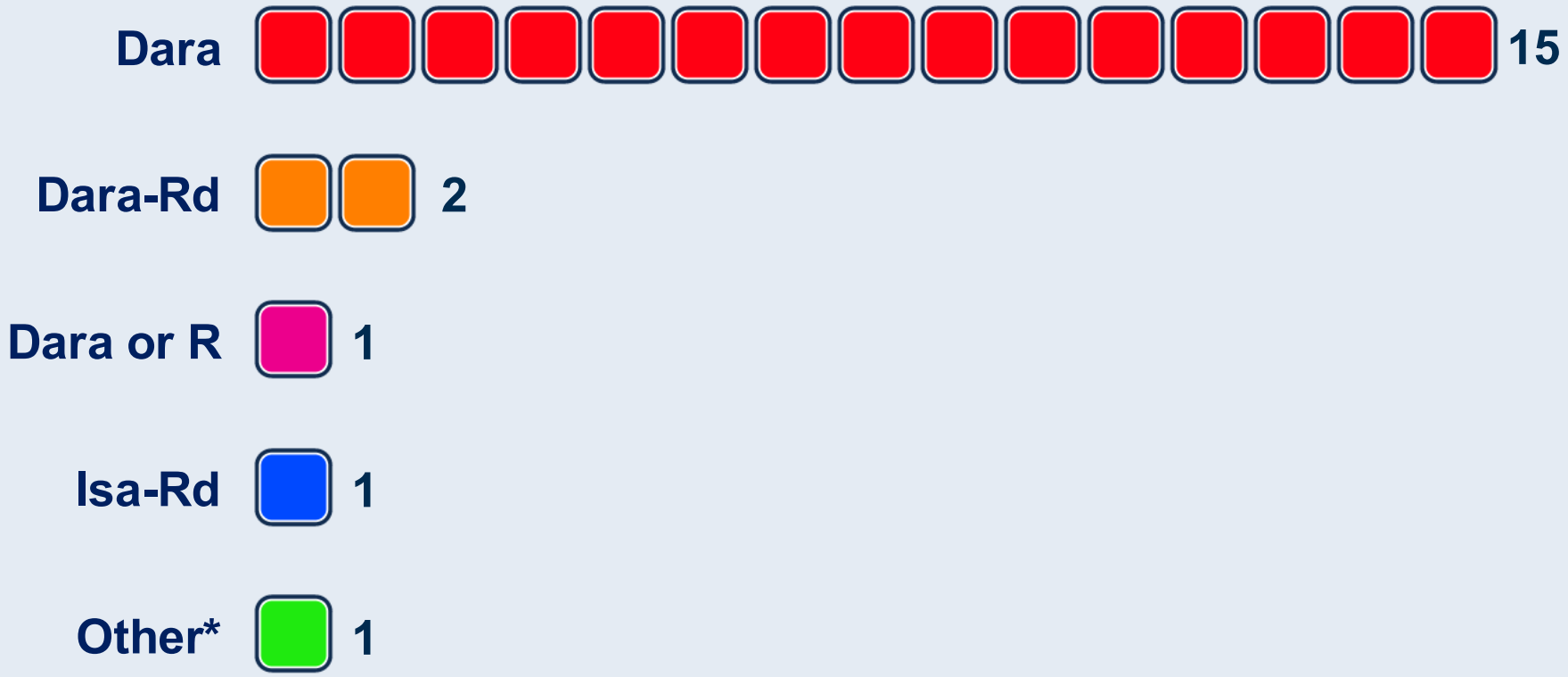
Regulatory and reimbursement issues aside, if you were going to offer systemic treatment to an 80-year-old patient with high-risk smoldering myeloma, what would you most likely recommend?



* Only on a clinical trial

Survey of 20 clinical investigators, June 2025

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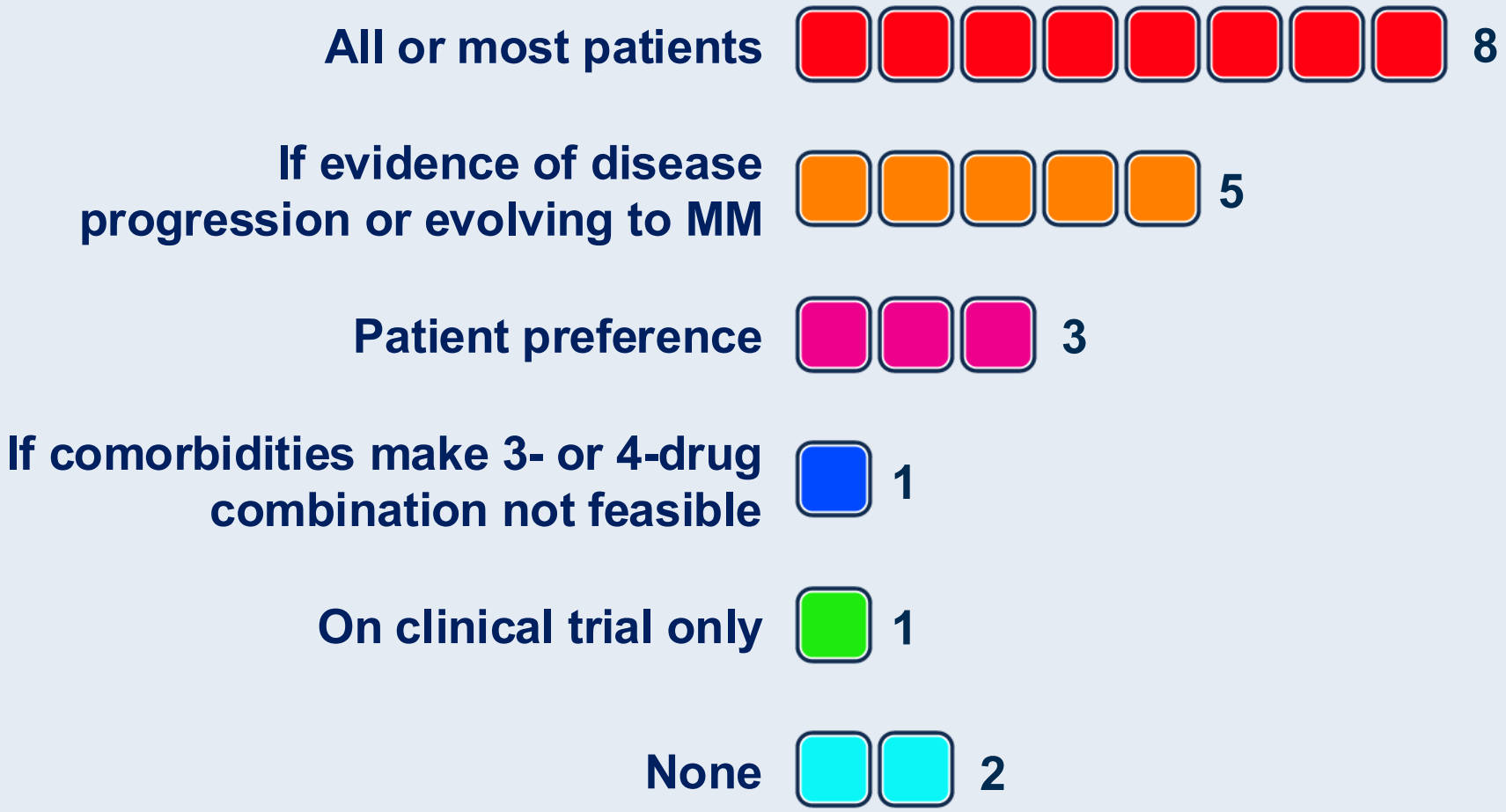

Survey of 20 clinical investigators, June 2025

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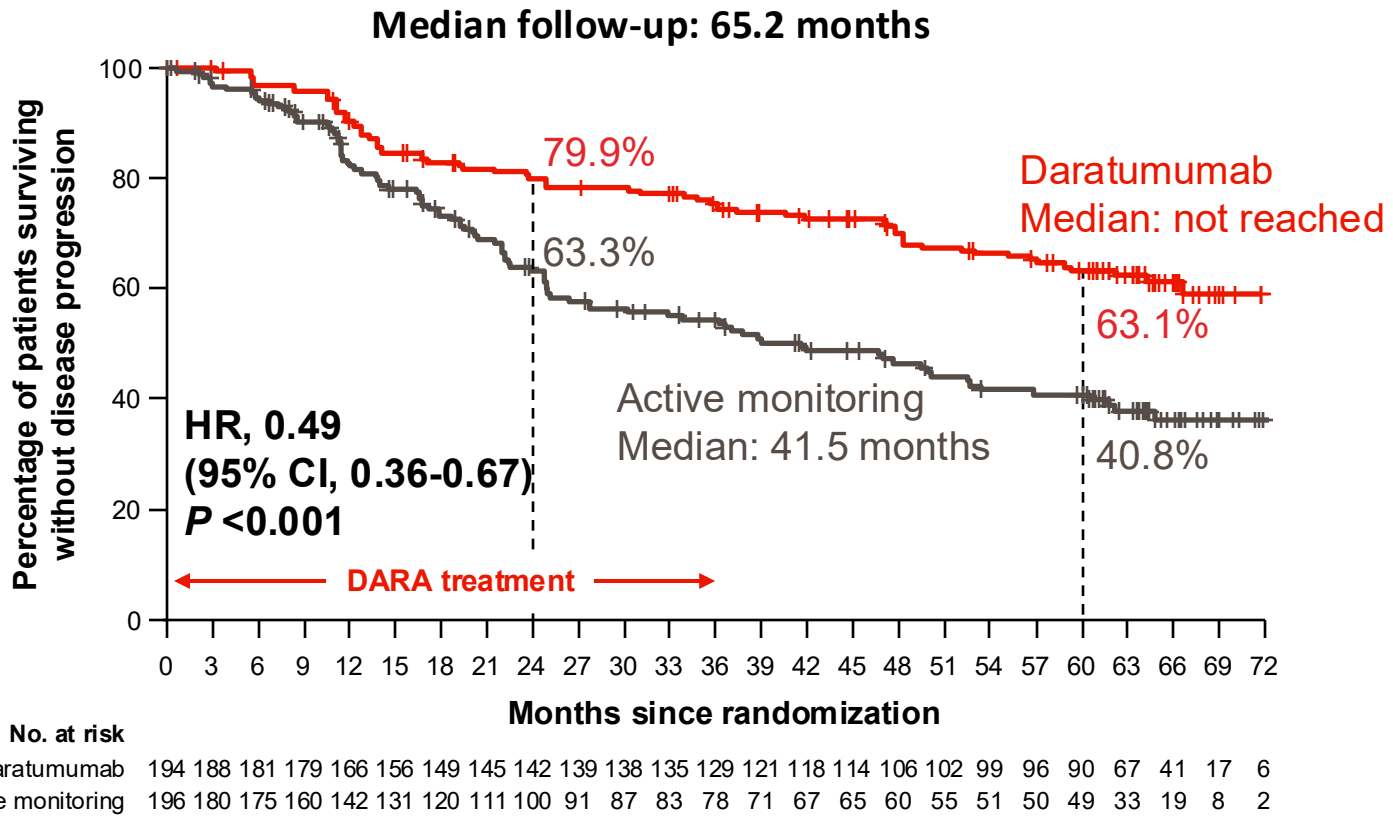
Daratumumab vs Observation for High-Risk Smoldering Myeloma: The Phase III AQUILA Trial

- 3 years of SC dara vs observation
- Clonal BMPCs ≥10% and ≥1 of the following risk factors: 1) Serum M-protein ≥30 g/L; 2) IgA SMM; 3) Immunoparesis with reduction of 2 uninvolved Ig isotypes; 4) Serum involved:uninvolved FLC ratio ≥8 and <100; 5) Clonal BMPCs >50% to <60%
- ECOG PS 0 - 1
- Primary Endpoint: Death or progression to active myeloma (SLiM / CRAB)



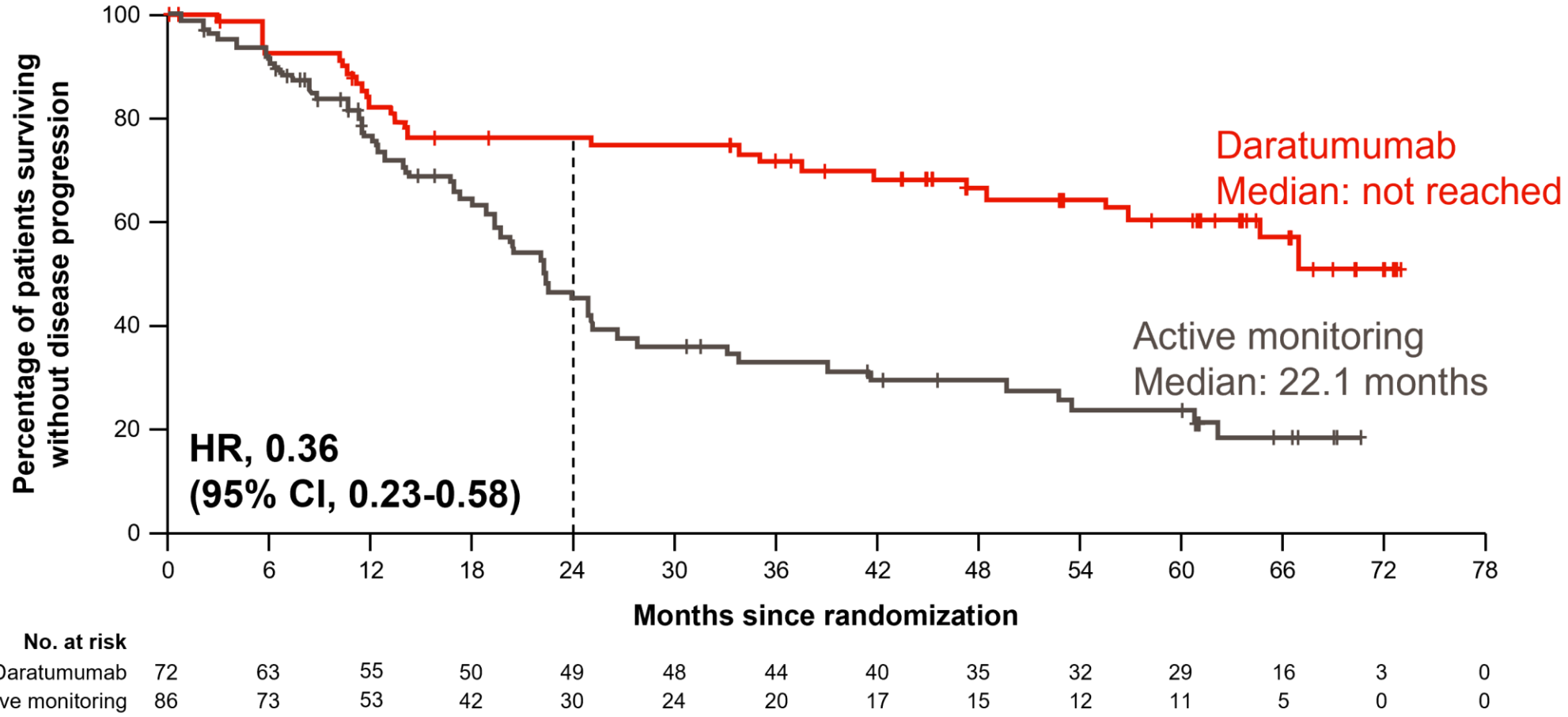
	DARA (n = 194)	Active monitoring (n = 196)
PFS event, n (%)	67 (34.5)	99 (50.5)
Death without disease progression	5 (2.6)	5 (2.6)
Disease progression[a]	62 (32.0)	94 (48.0)
CRAB criteria	12 (6.2)	34 (17.3)
Calcium elevation	0	2 (1.0)
Renal insufficiency[b]	0	0
Anemia	2 (1.0)	14 (7.1)
Bone disease	10 (5.2)	18 (9.2)
SLiM criteria	50 (25.8)	65 (33.2)
Clonal BMPCs	5 (2.6)	16 (8.2)
Serum FLC	33 (17.0)	33 (16.8)
Focal lesion by MRI	12 (6.2)	16 (8.2)

HR, hazard ratio; CI, confidence interval. [a]A patient may show disease progression based on ≥1 criterion. [b]Some patients met the CRAB criteria for renal insufficiency, but the investigator attributed this to a cause other than disease progression to MM. Adapted with permission © The *New England Journal of Medicine* (2024).

Dimopoulos MA et al. ASH 2024; Dimopoulos et al. N Engl J Med 2024.

Courtesy of Peter Voorhees, MD

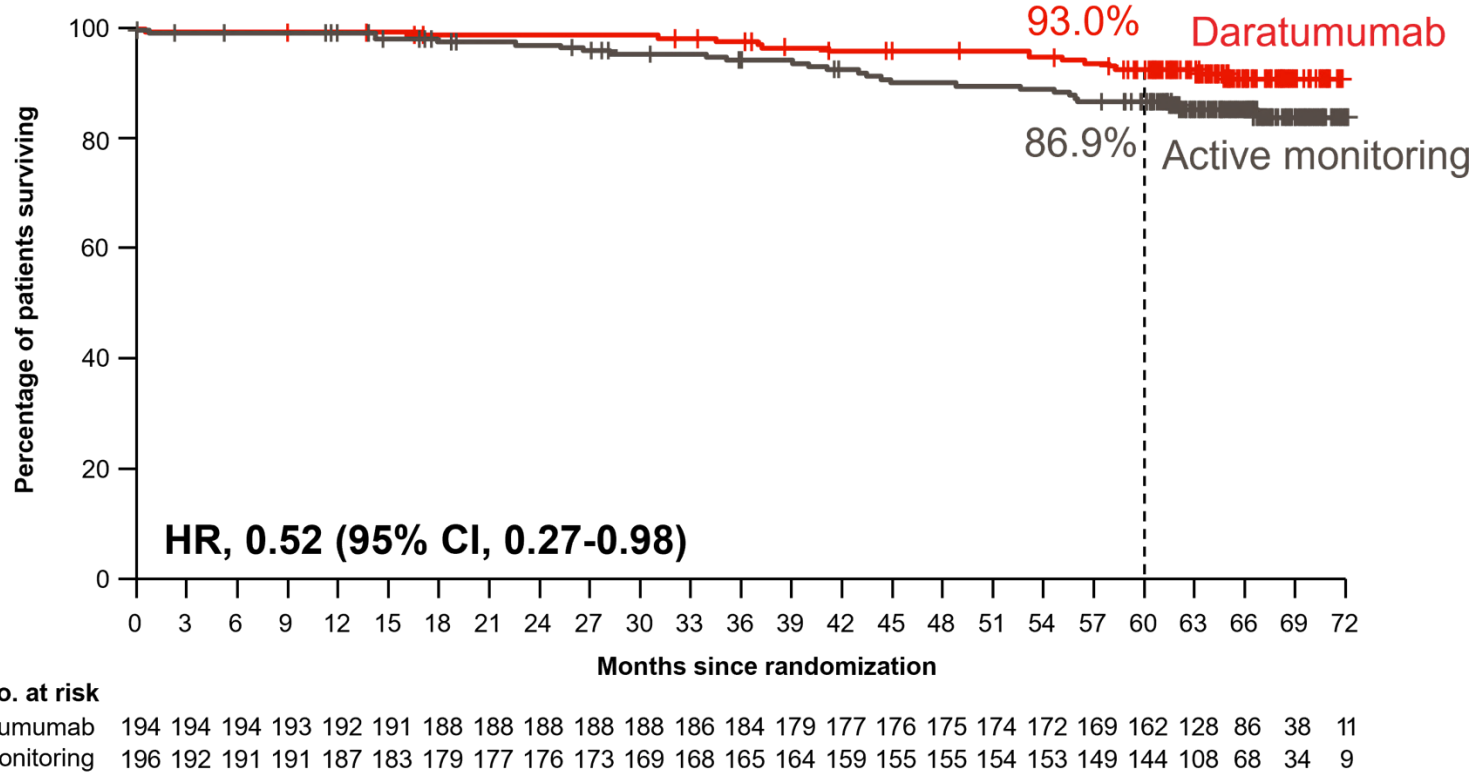
Daratumumab Monotherapy for High-Risk Smoldering Myeloma: The 20 / 2 / 20 Criteria



Dimopoulos MA et al. ASH 2024.

Courtesy of Peter Voorhees, MD

Overall Survival: AQUILA



	DARA (n = 194)	Active monitoring (n = 196)
Deaths, n (%)	15 (7.7)	26 (13.3)
Primary cause, n		
Disease progression	3	9
AE	2	4
Other*	10	13

*Deaths due to an event occurring after the AE reporting window (ie, events that happened after patient started subsequent therapy or >30 days after last dose) or deaths with unknown reason.

Dimopoulos MA et al. ASH 2024; Dimopoulos et al. N Engl J Med 2024.

Courtesy of Peter Voorhees, MD

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

Module 3: ASCT Ineligible

Module 4: Subcutaneous Anti-CD38 Antibodies

Module 5: Special Considerations

Case Presentation – Prof Leleu: 63-year-old transplant-eligible patient with multiple myeloma (MM)

Male, 63 years old, fit, doing sports on a regular basis.

Almost never has seen a physician in his adult life besides general practitioner for vaccinations. No regular medications.

Started having lower back pains a year ago approximately. Thought initially it was either related to sport or some gain of weight. The pain intensified moderately, and the patient asked for anti-inflammatory pain killers or a checkup for discal hernia. The general practitioner recommended a lumbar column radiography before any other imagery and some labs tests.

Radiography. Possible lytic lesion on L4 and L5.

Bio test. Hb 10.5 g/dL, WBC and Plat normal values. Clearance creatinine and calcium normal. Protidemia 110 g/L.

The biology lab added a serum protein electrophoresis given the hyperprotidemia. Showed hypergammaglobulinemia of monoclonal type. Then it was confirmed on immunofixation, IgG K isotype.

Urine test requested, that was normal. Serum calcium, ionogram, liver enzymes' values were in normal ranges.

Patient was sent over to Hematology for consultation as Myeloma is suspected.

Hematology department. Education on MM was done, and extra labs and imagery performed, including PET CT (multiple lytic lesions with hypermetabolisms, no PMD and EMD, careful L4 and L5 are very unstable), labs for prognostication, MM confirmation + NGS genomic. ISS 2. RISS 2. Serum LDH level normal. No plasmablastic features. No CTC on CBC.

Case Presentation – Prof Leleu: 63-year-old transplant-eligible patient with MM (cont'd)

As a conclusion. NDMM SLiM CRAB on bone and sFLC ratio (ratio 110). Non HR, patient hyperdiploid, isolated t11;14+. 63 fit TE. ECOG 1.

Line 1.

DVRd was given as the standard of care according to PERSEUS study

V twice weekly, R 25 mg 21/28, dexa 20 mg

+ supportive care, Bisphosphonate x 4 cycles, vaccination +++ (flu, covid, pneumonia)

x 3 cycles

Patient experienced grade 1 neuropathy

VGPR

Was collected for 1 transplantation

x 3 more cycles but with V weekly

Patient grade 1 neuropathy

sCR

Patient transplanted with HDM 200 mg/m2

Case Presentation – Prof Leleu: 63-year-old transplant-eligible patient with MM (cont'd)

3 months later (day 100 from graft infusion), patient started DR no dexa as maintenance.

Objective to try to give for a minimum of 2 years then see.

At 2 years, patient decided to stop TTT and was on watch and wait.

5 years from diagnosis = CR and doing great.

Neuropathy persists grade 1.

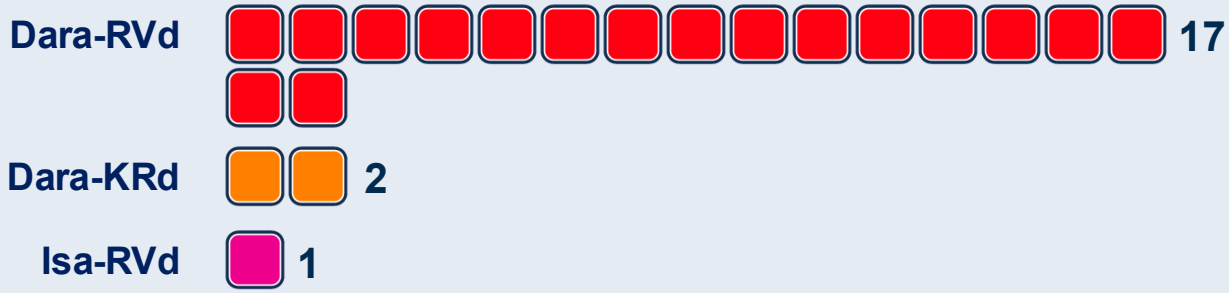
Case Presentation – Dr Voorhees: 57-year-old transplant-eligible patient with MM

- 57-year-old woman who presented with symptomatic bone disease, anemia, hypercalcemia and acute renal failure.
- Hgb 8.5 g/dL, Ca 14.8, albumin 3.2, Cr 1.56, LDH normal, B2M 9.7, SPEP/IFE: Monoclonal IgG kappa 4.8 g/dL, serum free kappa LCs 6749 mg/L, FLC ratio 2045.
- Bone marrow: 80% PCs. Myeloma FISH: + for del 1p32, -13 and loss of IgH.
- Imaging: PET-CT with innumerable FDG avid lytic bone lesions.
- Co-morbidities: Hyperlipidemia.
- ECOG PS 2 due to bone pain.

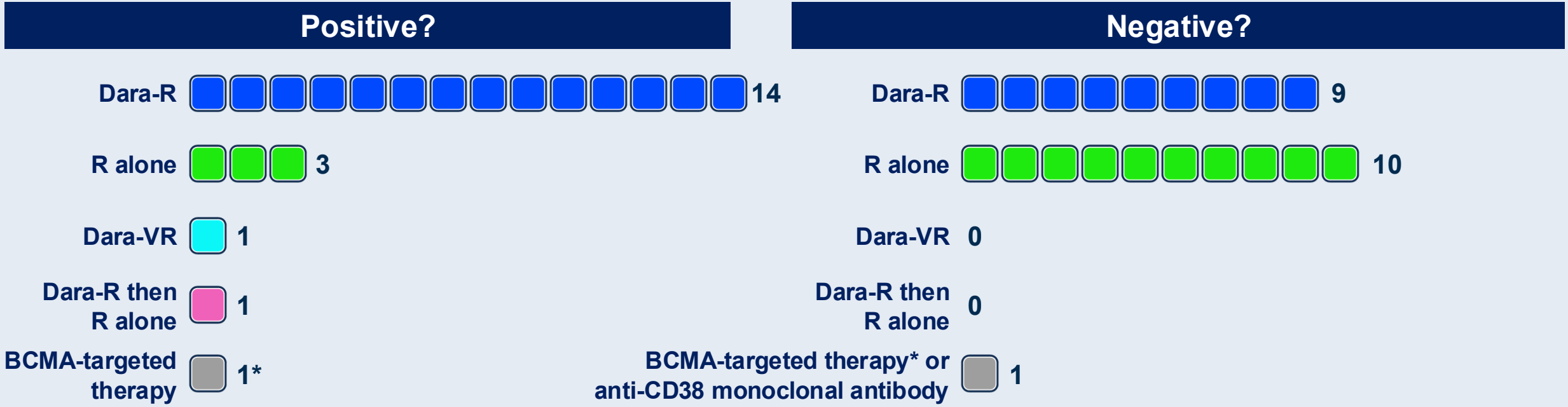
Case Presentation – Dr Voorhees: 57-year-old transplant-eligible patient with MM (cont'd)

- The patient was placed on D-VRd induction therapy. Due to the early emergence of symptomatic neuropathy, the bortezomib was replaced with carfilzomib during cycle 2. The patient received 4 cycles of induction therapy to which she achieved an MRD+ very good partial response followed by an upfront ASCT to which she achieved an MRD negative complete response. She has since received 2 cycles of post-ASCT consolidation with D-KRd and is now on lenalidomide and daratumumab maintenance.

Regulatory and reimbursement issues aside, what is your preferred induction regimen for a 65-year-old transplant-eligible patient with standard-risk MM?



What maintenance therapy would you recommend if the post-transplant measurable residual disease (MRD) status were …

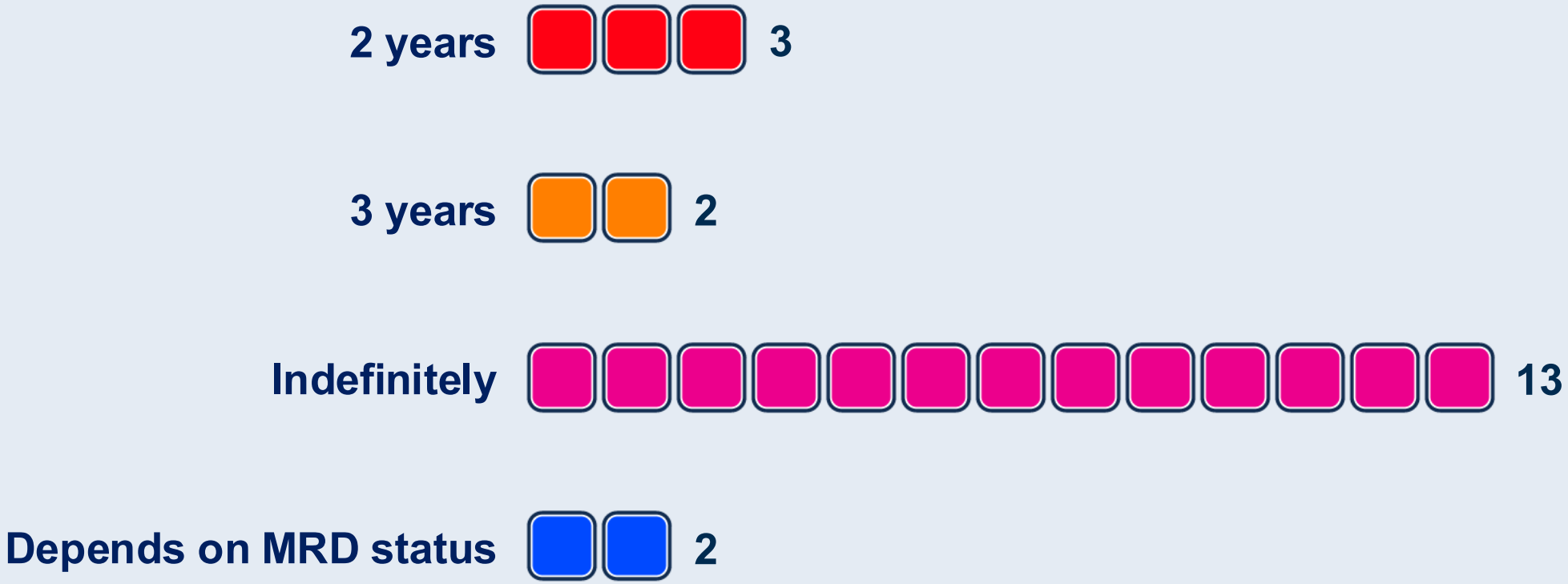


* Bispecific antibody or CAR T-cell therapy

Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

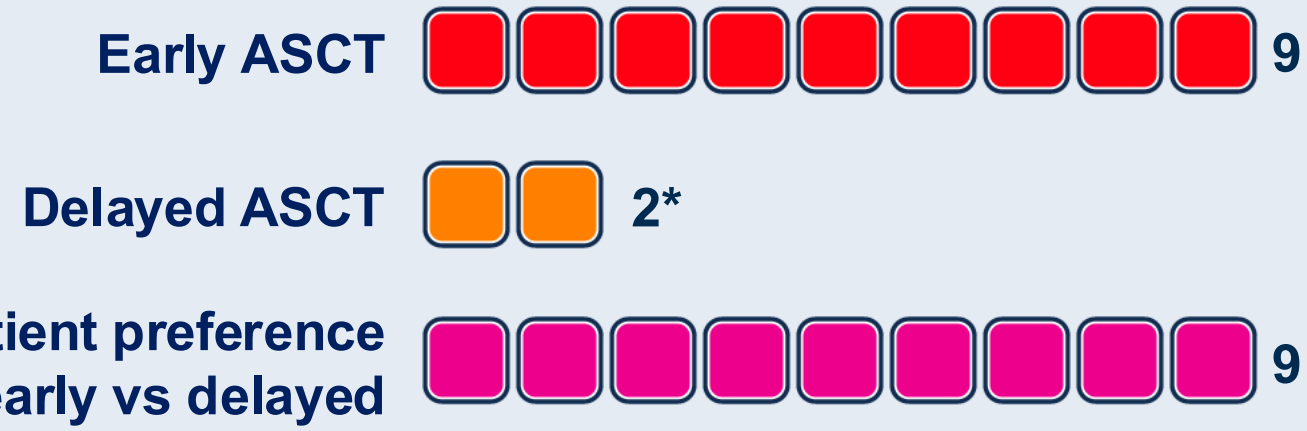
How long would you continue maintenance therapy for a 65-year-old transplant-eligible patient with standard-risk MM?



Survey of 20 clinical investigators, June 2025

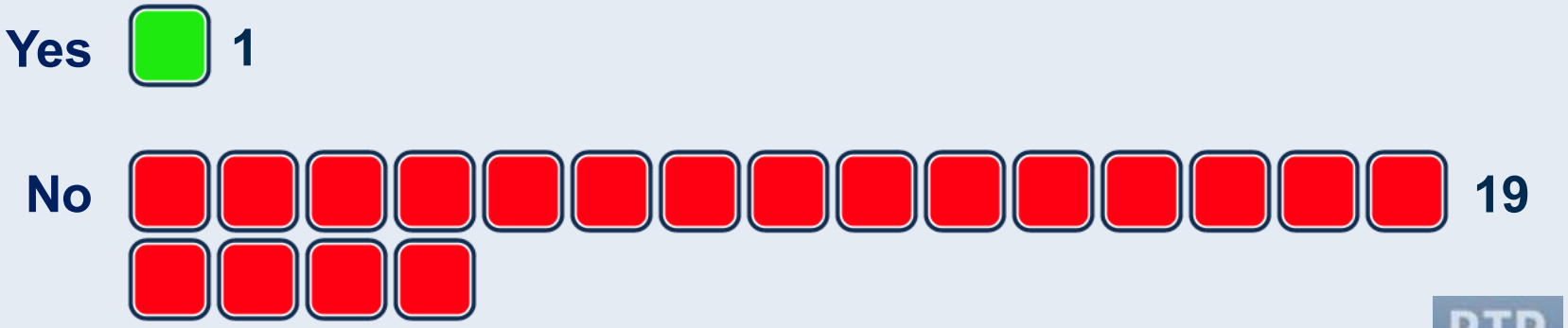
RTP RESEARCH TO PRACTICE

In general, what is your approach to autologous stem cell transplant (ASCT) for patients with standard-risk MM?



* If MRD-negative and not high risk

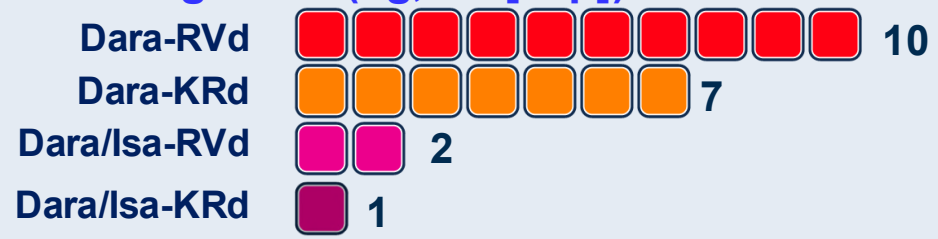
Does your approach to ASCT differ for African American patients with MM?



Survey of 20 clinical investigators, June 2025

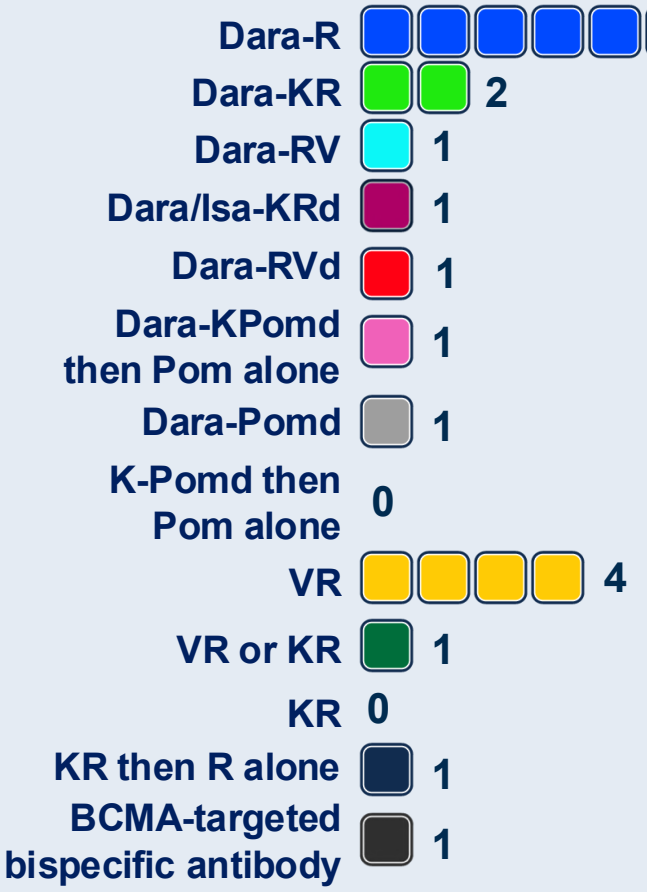
RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, what is your preferred induction regimen for a 65-year-old transplant-eligible patient with high-risk (eg, del[17p]) MM?

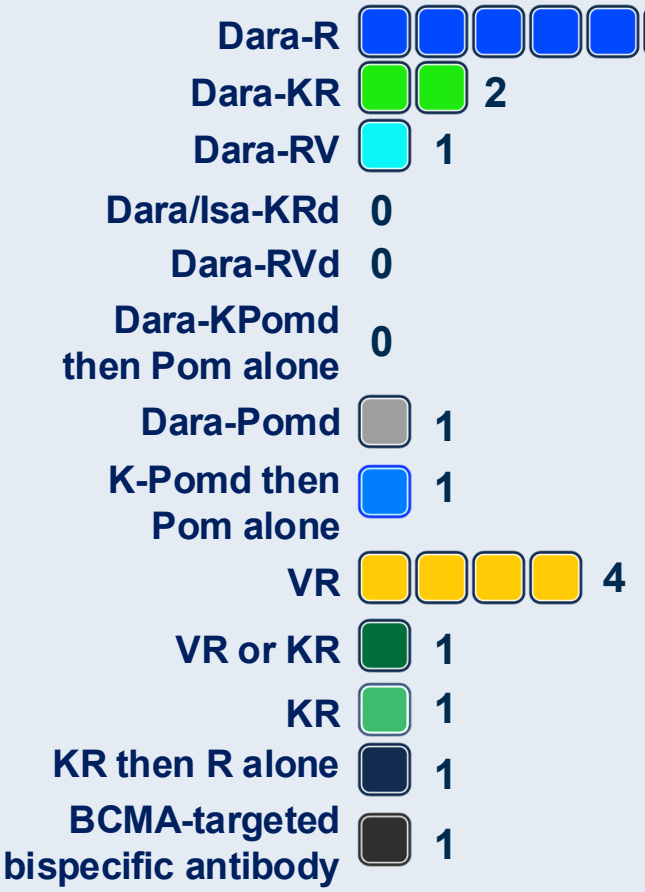


What maintenance therapy would you recommend if the post-transplant MRD status were …

Positive?



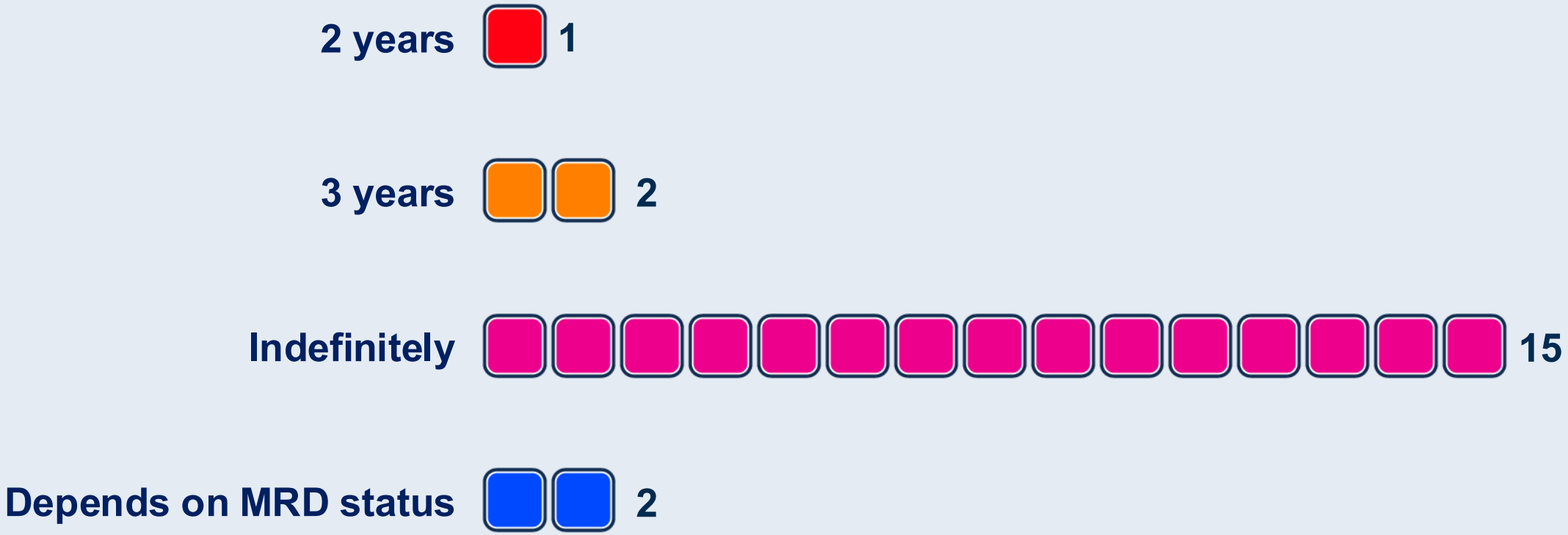
Negative?



Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

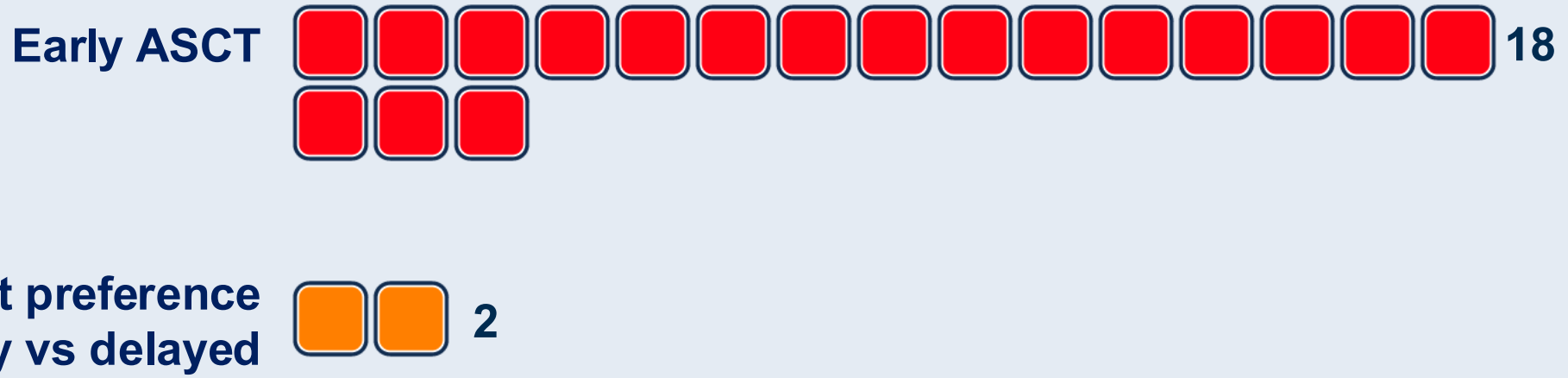
How long would you continue maintenance therapy for a 65-year-old transplant-eligible patient with high-risk (eg, del[17p]) MM?



Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

In general, what is your approach to ASCT for patients with high-risk (eg, del[17p]) MM?



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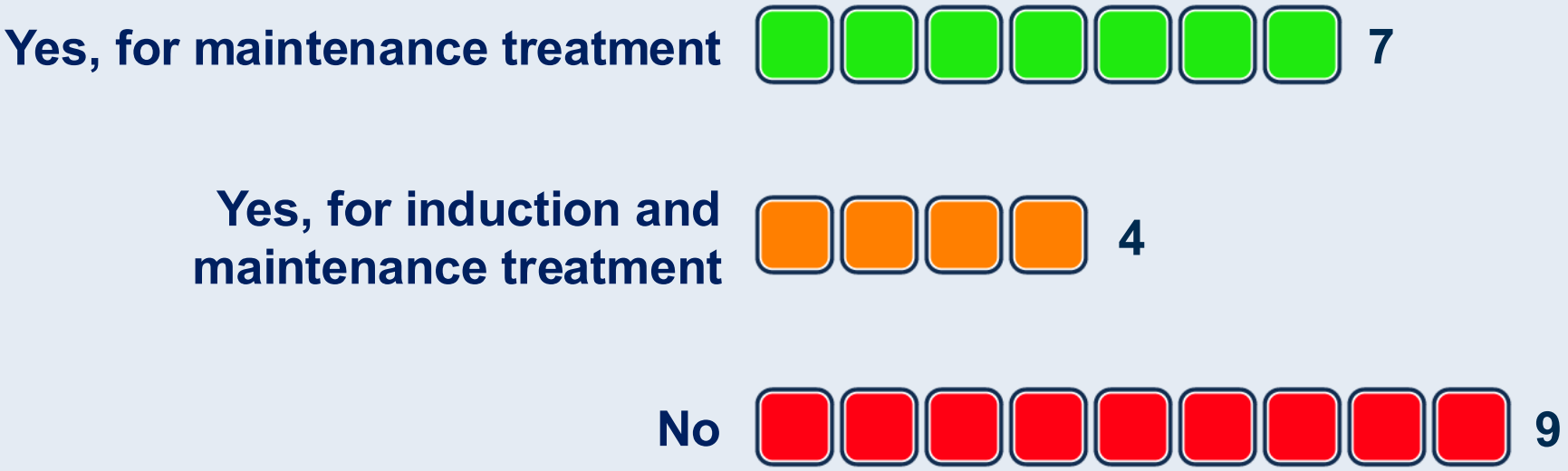
RTP RESEARCH TO PRACTICE

From your perspective, at this time should community-based general medical oncologists be assessing MRD to guide clinical decisions regarding induction and/or maintenance therapy?



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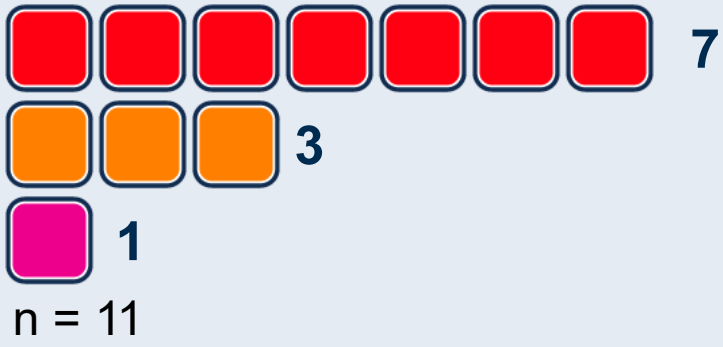
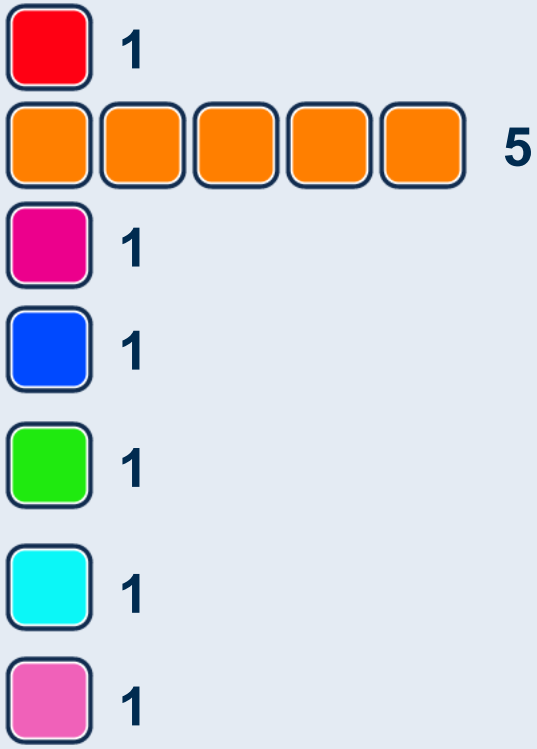
RTP RESEARCH TO PRACTICE

Which type or types of MRD assay should be ordered?



At what intervals during the treatment course should an MRD assay be ordered?



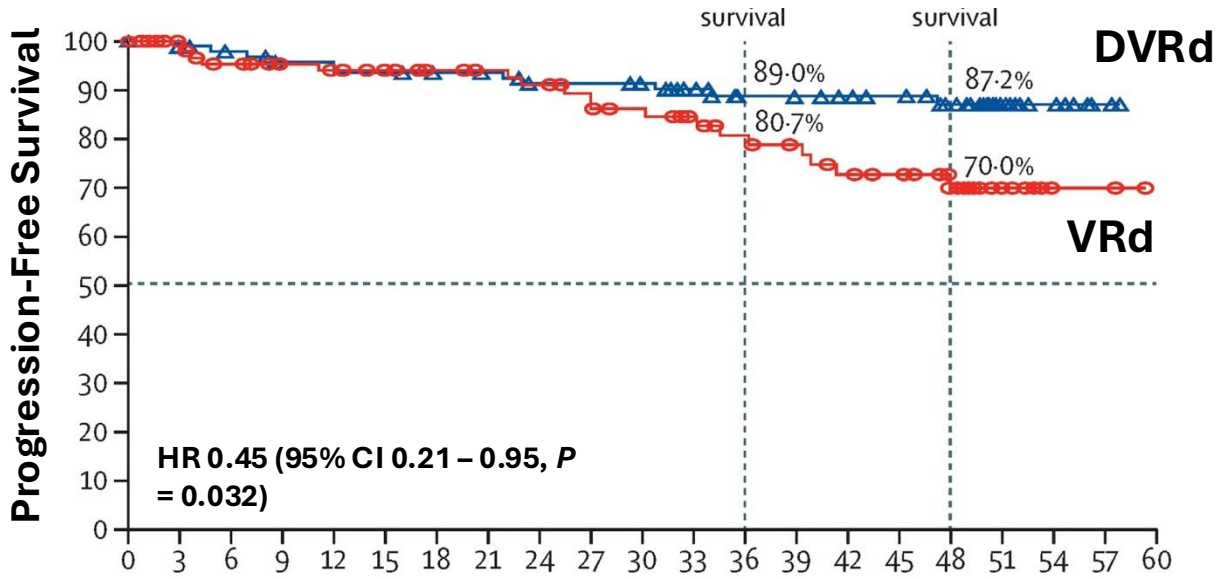
Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

Daratumumab / IMiD / PI Quadruplets + Upfront Autologous Stem Cell Transplantation in Newly Diagnosed Myeloma

Randomized phase II (GRIFFIN) and phase III (PERSEUS) studies of VRd ± daratumumab (4 cycles induction, 2 cycles post-transplant consolidation) → ASCT → lenalidomide ± daratumumab maintenance (GRIFFIN: 2 years of daratumumab maintenance; PERSEUS: 2 years of daratumumab maintenance if CR and MRD- for ≥1 year)

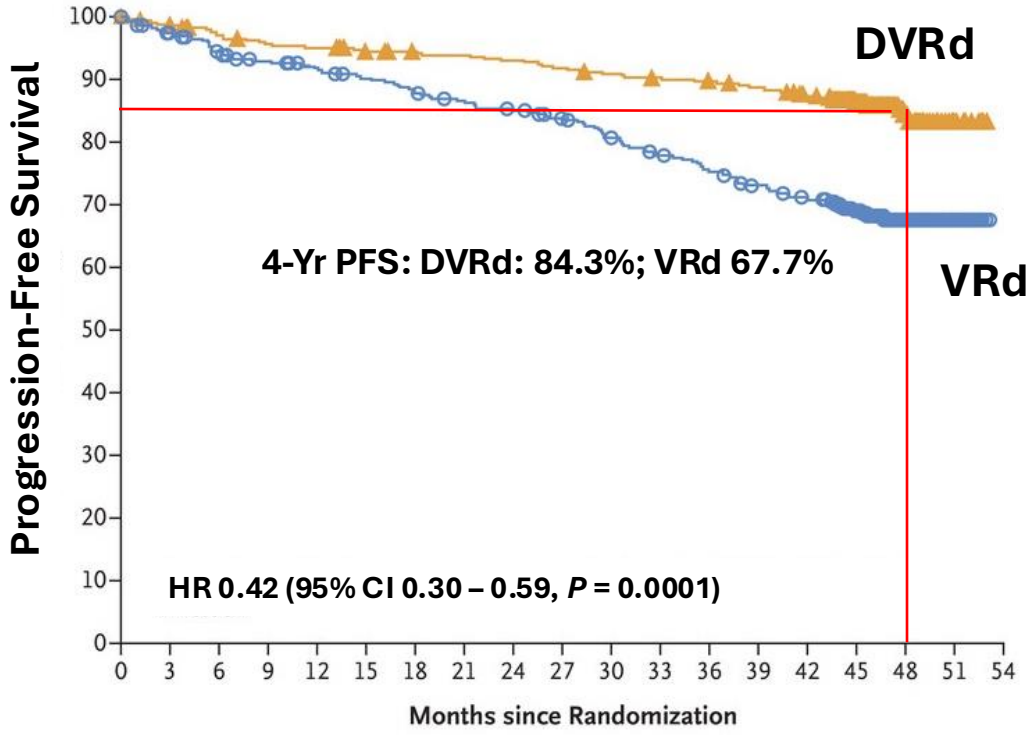
GRIFFIN



Number at risk (number censored)

RVd	103	93	77	72	70	68	63	61	59	53	51	46	42	39	35	33	25	12	3	3	0
	(0)	(9)	(22)	(27)	(28)	(30)	(35)	(37)	(37)	(40)	(42)	(46)	(48)	(50)	(51)	(53)	(60)	(73)	(82)	(82)	(85)
D-RVd	104	98	94	90	90	89	86	85	81	81	79	68	59	58	56	54	45	23	12	3	0
	(0)	(5)	(8)	(10)	(10)	(10)	(12)	(13)	(15)	(15)	(17)	(27)	(35)	(36)	(38)	(40)	(48)	(70)	(81)	(90)	(93)

PERSEUS



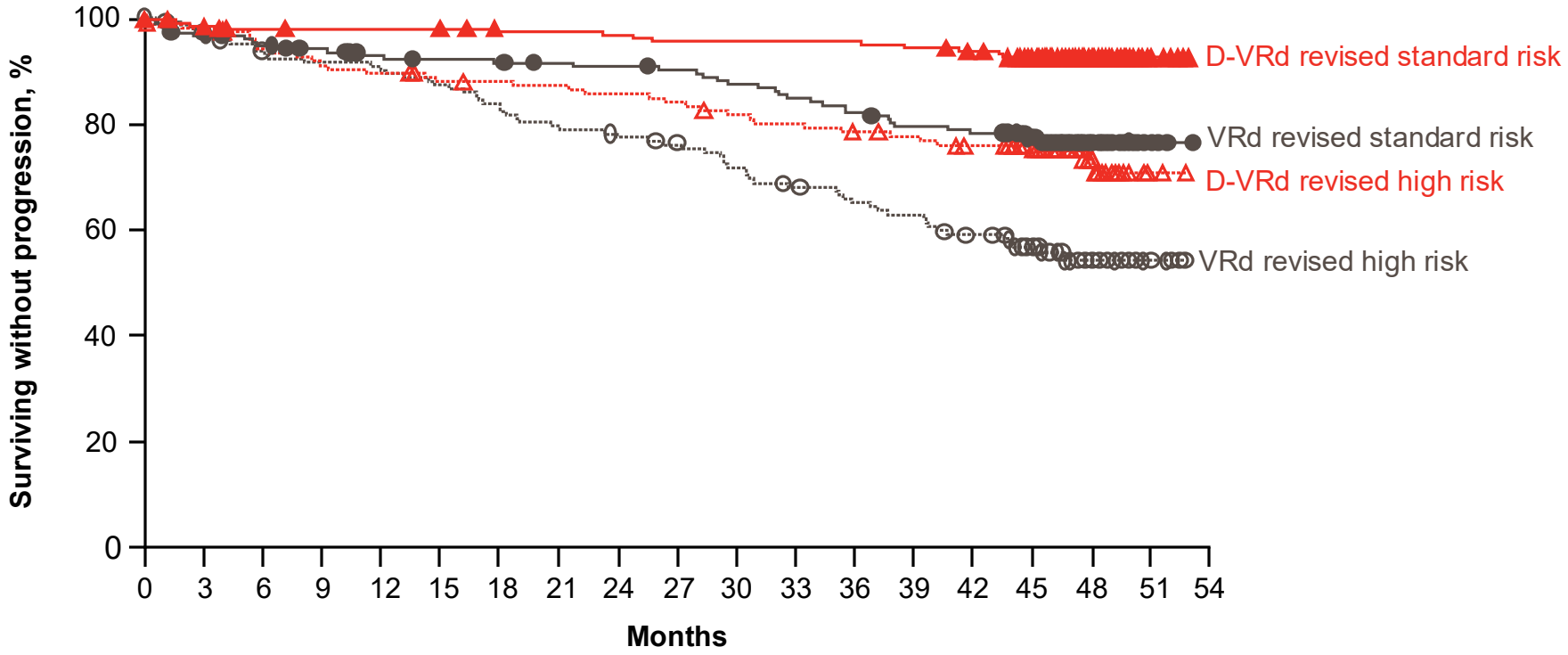
No. at Risk

D-VRd	355	345	335	329	327	322	318	316	313	309	305	302	299	295	286	226	90	11	0
VRd	354	335	321	311	304	297	291	283	278	270	258	247	238	228	219	175	67	13	0

Voorhees PM et al. Lancet Haematol 2023;10:e825-e837. Sonneveld P et al. New Engl J Med 2024;390:132-147

Courtesy of Peter Voorhees, MD

Daratumumab / IMiD / PI Quadruplets + Upfront Autologous Stem Cell Transplantation in High-Risk Patients: PERSEUS



No. at risk																			
VRd revised standard risk	167	157	152	148	143	141	140	138	137	135	131	127	123	118	116	96	36	6	0
D-VRd revised standard risk	174	167	163	162	162	162	159	158	157	155	155	155	155	153	149	124	52	7	0
VRd revised high risk	148	139	132	129	127	123	118	112	109	105	98	92	87	84	77	64	22	4	0
D-VRd revised high risk	130	127	121	117	115	111	110	109	107	105	101	99	96	94	90	76	31	2	0

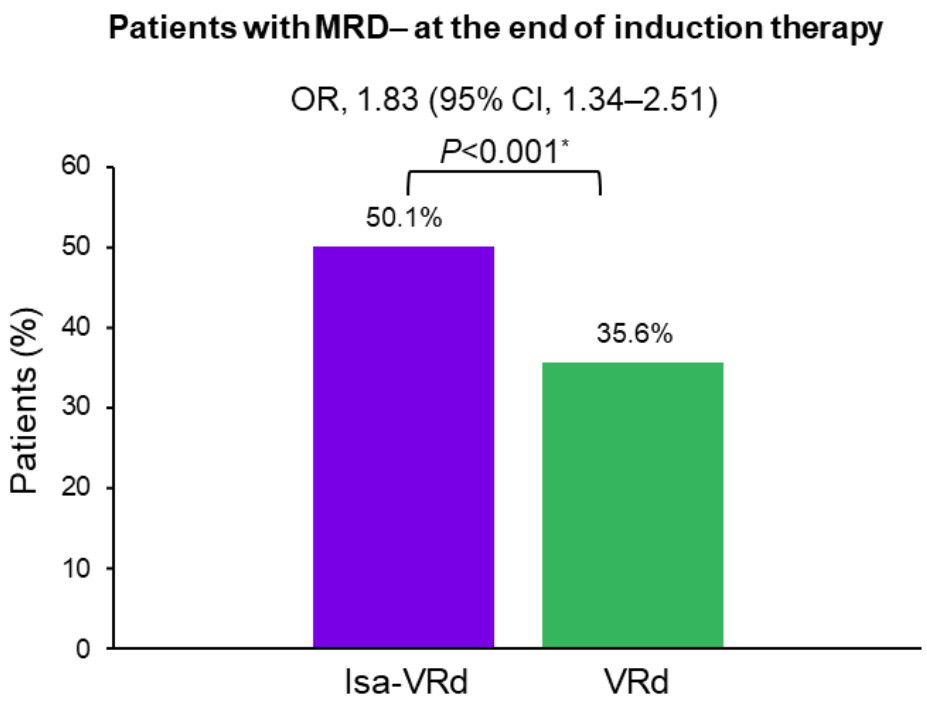
[a]Revised standard risk: none of del(17p), t(4;14), t(14;16), amp(1q21), or gain(1q21). Revised high risk: ≥1 of del(17p), t(4;14), t(14;16), amp(1q21), or gain(1q21).

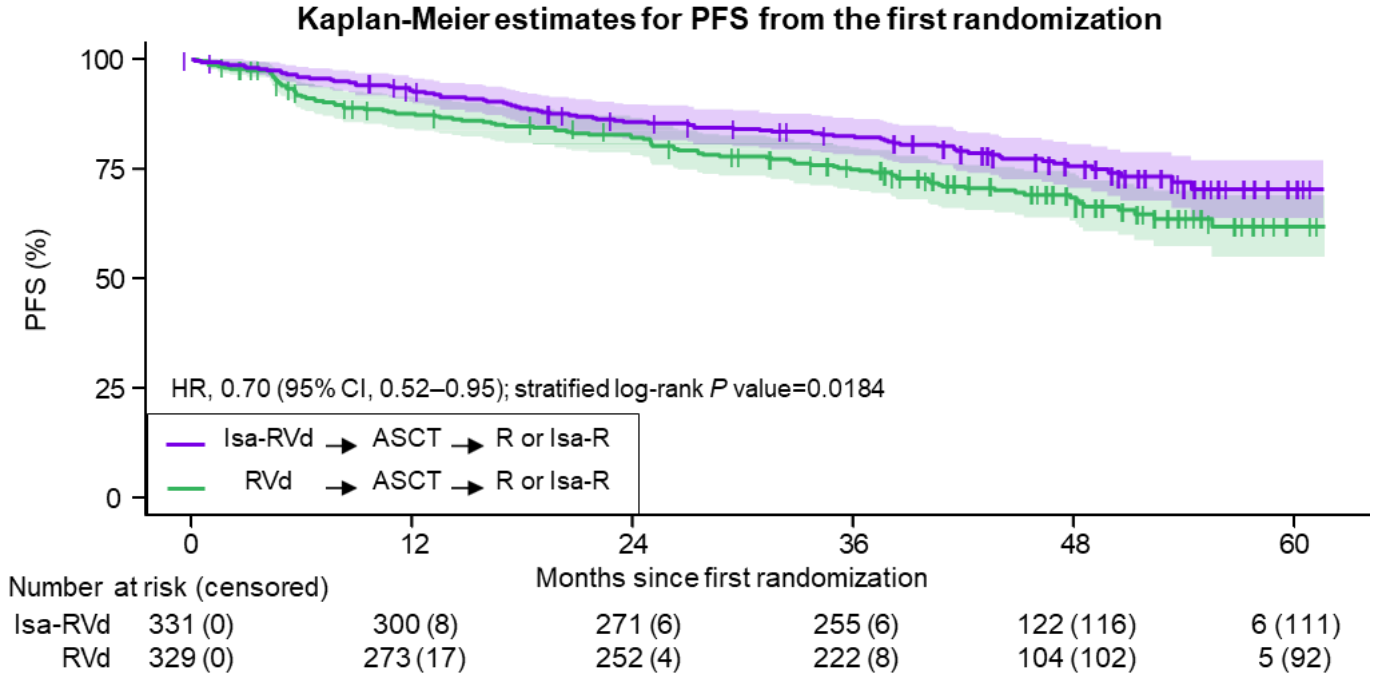
Dimopoulos MA et al. IMS 2024.

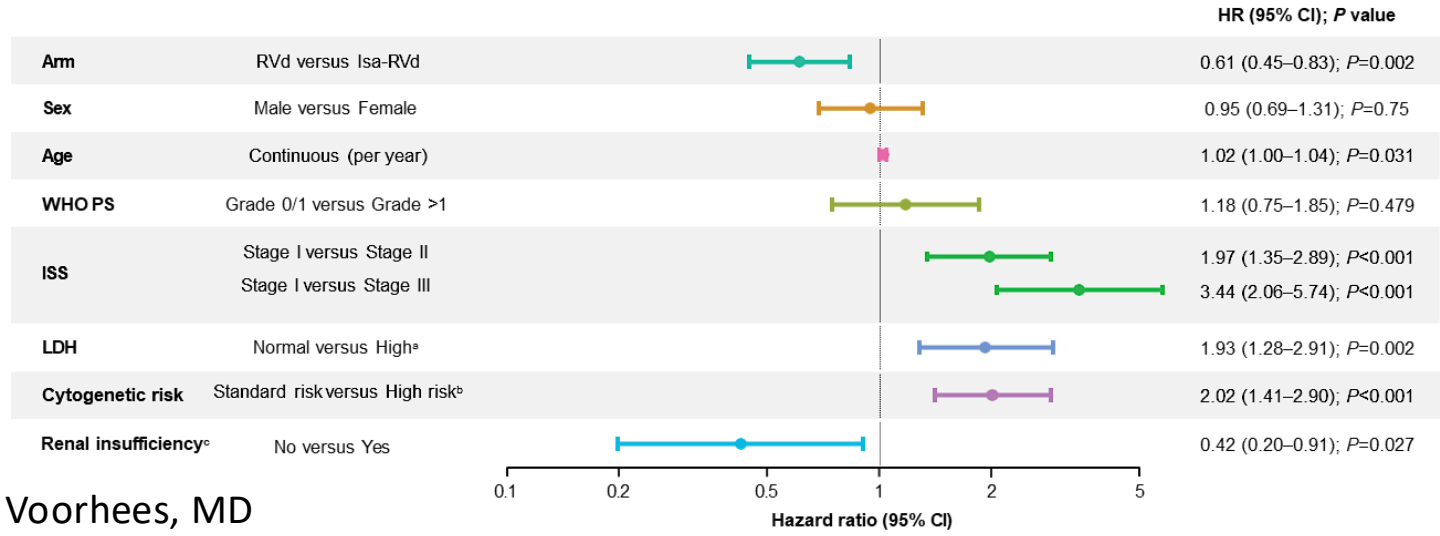
Courtesy of Peter Voorhees, MD

Isatuximab / IMiD / PI Quadruplets + Upfront Autologous Stem Cell Transplantation in Newly Diagnosed Myeloma: GMMG-HD7

- Phase III study of VRd ± Isa x 6 cycles → ASCT for patients with NDMM
- Randomization #1: VRd vs Isa-VRd
- Randomization #2: R vs Isa-R maintenance







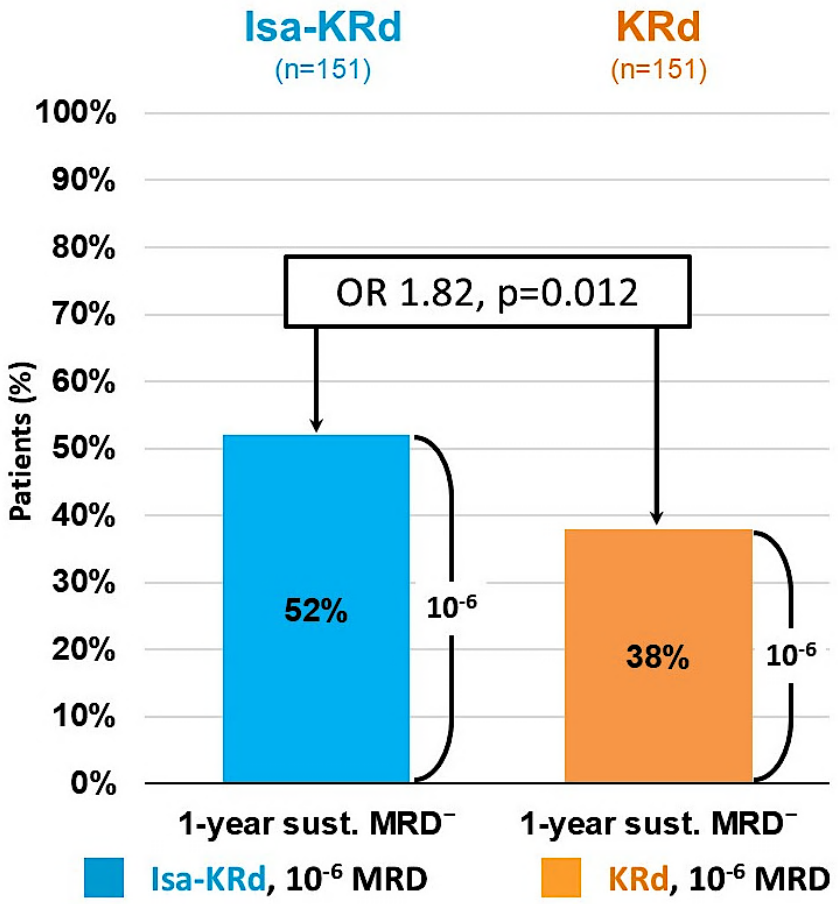
Goldschmidt H et al. ASH 2024.

Courtesy of Peter Voorhees, MD

Isatuximab / IMiD / PI Quadruplets + Upfront Autologous Stem Cell Transplantation in Newly Diagnosed Myeloma: IsKia

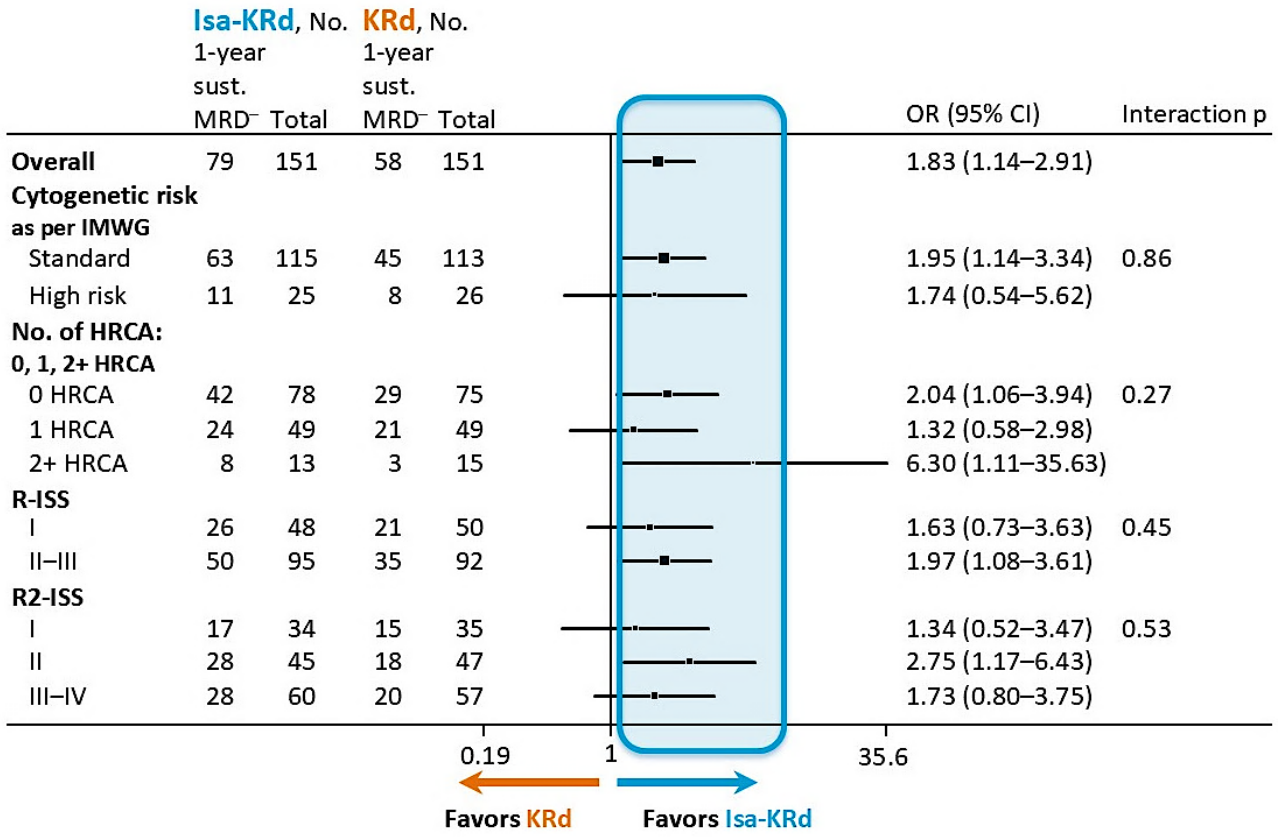
- Phase III study of KRd ±Isa x 4 cycles → ASCT → KRd ±Isa x 4 cycles → KRd-light ±Isa x 12 cycles

Sustained MRD Negativity ≥1 Year (10^{-6})



Subgroup analysis

10^{-6} cut-off

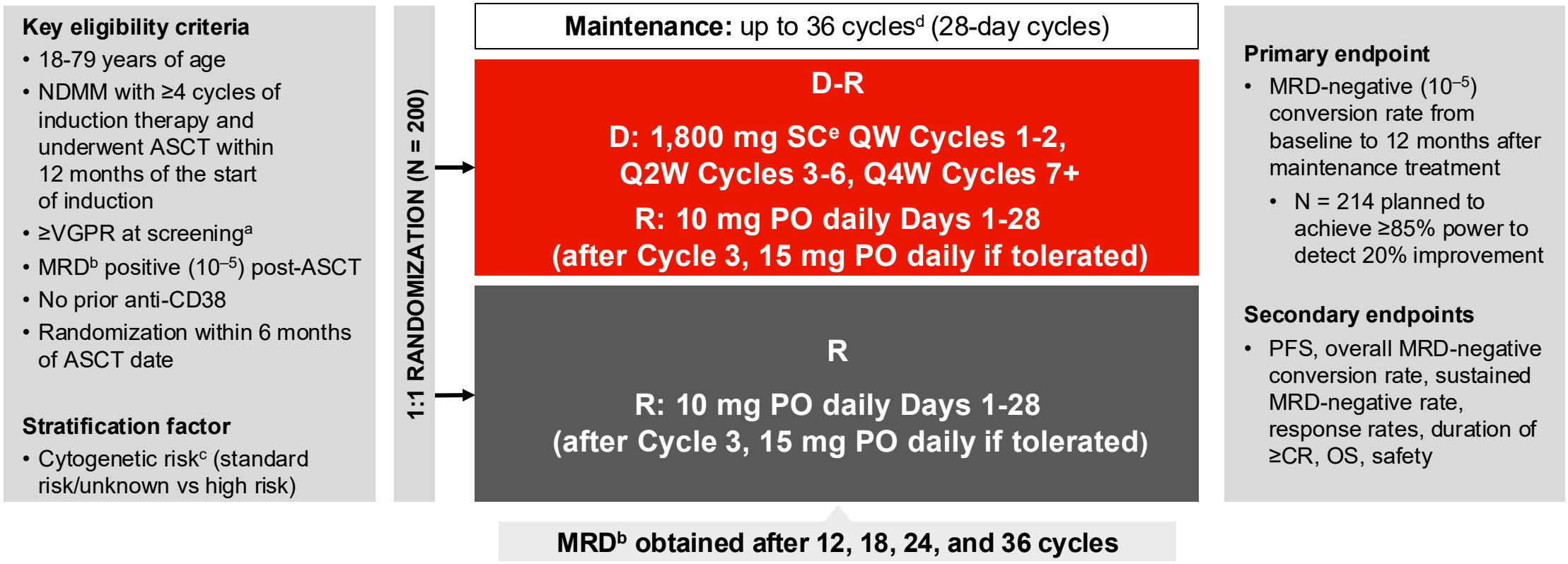


Gay F et al. ASCO 2025; Gay F et al. EHA 2025.

Courtesy of Peter Voorhees, MD

CD38 Monoclonal Antibody-Based Maintenance Therapy

Lenalidomide ± Daratumumab as Maintenance Therapy for MRD+ / CD38 mAb-Naïve Patients Post-ASCT: AURIGA

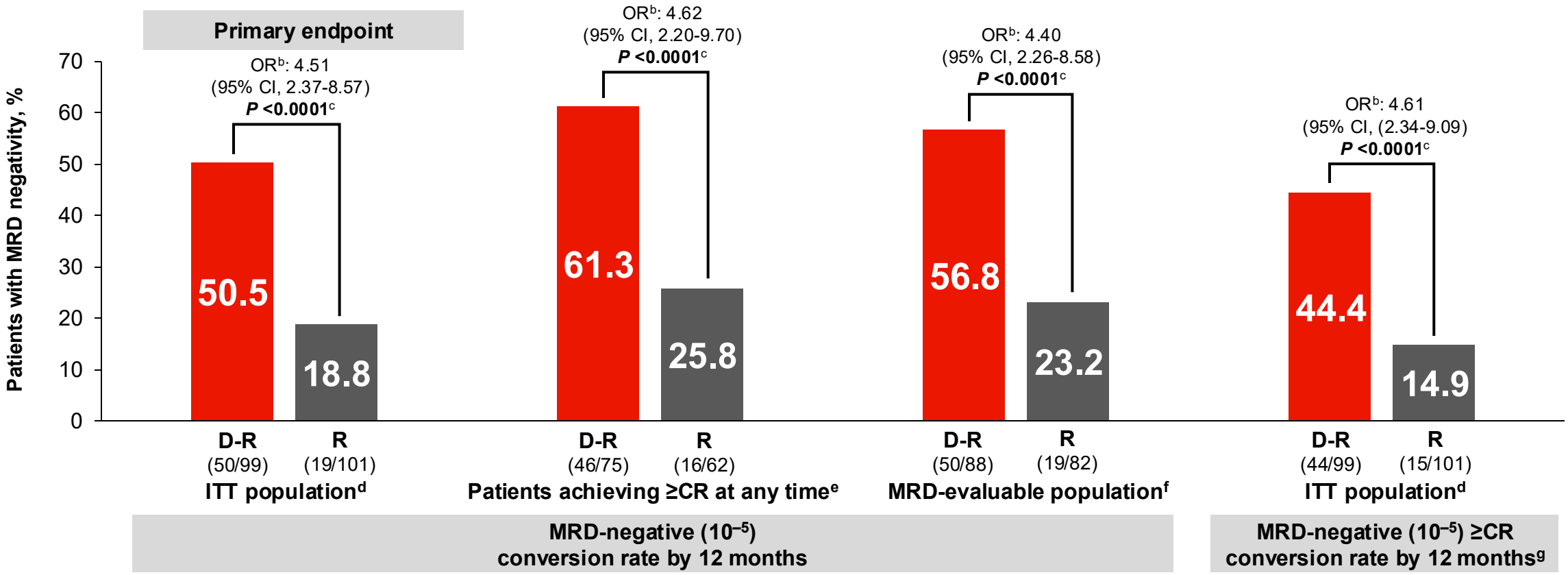


VGPR, very good partial response; D, daratumumab; SC, subcutaneous; QW, weekly; Q2W, every 2 weeks; Q4W, every 4 weeks; PO, orally; CR, complete response. [a]As assessed by International Myeloma Working Group 2016 criteria. [b]MRD based upon NGS (clonoSEQ®; Adaptive Biotechnologies). [c]For stratification, cytogenetic risk was evaluated per investigator assessment, in which high risk was defined as the presence of ≥1 of the following cytogenetic abnormalities: del[17p], t[4;14], or t[14;16]. [d]Study treatment continued for a planned maximum duration of 36 cycles or until progressive disease, unacceptable toxicity, or withdrawal of consent. After the end of the study treatment period of 36 months and after the end of the study, patients benefiting from treatment with DARA and/or R could continue receiving treatment per the investigator's discretion. [e]DARA SC (DARA 1,800 mg co-formulated with recombinant human hyaluronidase PH20 [rHuPH20; 2,000 U/mL; ENHANZE® drug delivery technology; Halozyme, Inc., San Diego, CA, USA]).

Badros A et al. IMS 2024.

Courtesy of Peter Voorhees, MD

MRD: AURIGA



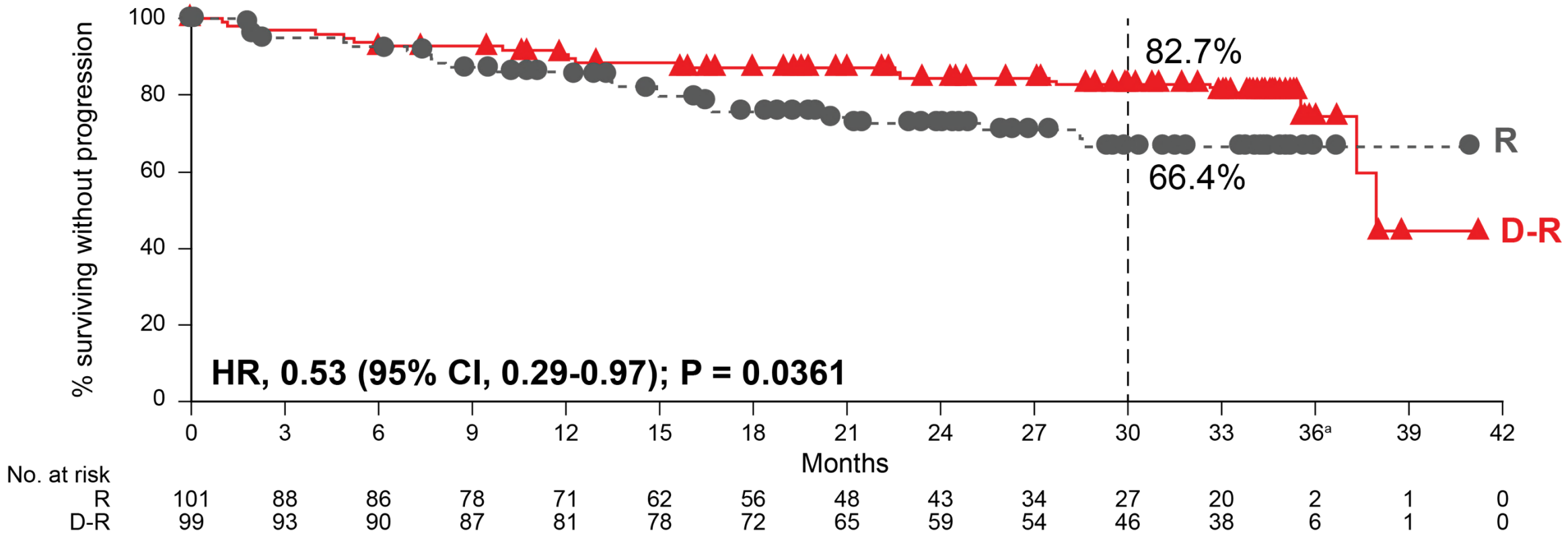
OR, odds ratio; CI, confidence interval. [a]Defined as the proportion of patients who achieved MRD-negative status (at 10^{-5}) by NGS by 12 months after maintenance treatment and prior to progressive disease or subsequent antimyeloma therapy. [b]Mantel–Haenszel estimate of the common OR for stratified tables was used. The stratification factor was baseline cytogenetic risk per investigator assessment (high vs standard/unknown), as used for randomization. An OR >1 indicates an advantage for D-R. [c]*P* <0.0001 from Fisher's exact test. [d]ITT analysis set is defined as all patients who were randomized to treatment. [e]Patients who achieved ≥CR at any time during the study per International Myeloma Working Group computerized algorithm. [f]MRD-evaluable analysis set included all randomized patients who had an MRD assessment at baseline and had ≥1 post-baseline MRD evaluation. [g]Defined as the proportion of patients who achieved ≥CR response and had MRD negative status (at 10^{-5}) by NGS by 12 months after maintenance and prior to progressive disease and subsequent anti-myeloma therapy.

Badros A et al. IMS 2024.

Courtesy of Peter Voorhees, MD

Progression-Free Survival: AURIGA

- Median follow-up: **32.3** months



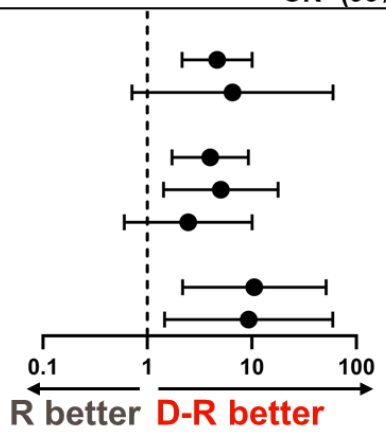
HR, hazard ratio. [a]Per study protocol, disease assessments stopped at the end of study treatment (Cycle 36), after which patients were only followed for survival. At the time of this analysis, the number of patients who reached end of study treatment was low, thus resulting in a low number of patients at risk.

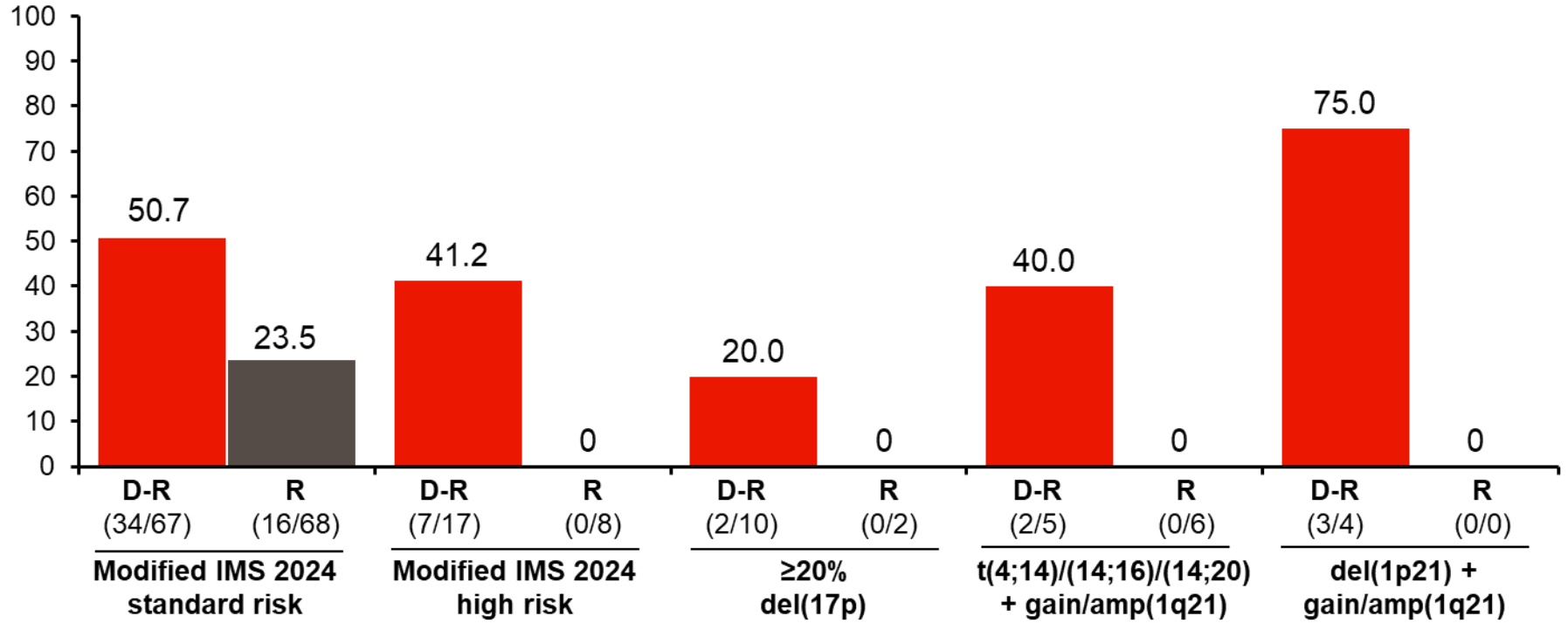
Badros A et al. IMS 2024; Badros A et al. Blood 2025.

Courtesy of Peter Voorhees, MD

AURIGA in Standard- vs High-Risk Patients

	MRD-negative (10^{-5}) conversion rate,[a] n/N (%)		OR[b] (95% CI)
	D-R	R	
Cytogenetic risk at diagnosis			
Standard risk	35/63 (55.6)	14/66 (21.2)	4.64 (2.15-10.04)
High risk[c]	7/22 (31.8)	1/15 (6.7)	6.53 (0.71-60.05)
Revised cytogenetic risk at diagnosis			
Revised standard risk (0 HRCAs)	28/52 (53.8)	12/53 (22.6)	3.99 (1.72-9.26)
Revised high risk[d] (≥1 HRCA)	14/32 (43.8)	4/30 (13.3)	5.06 (1.43-17.88)
1 HRCA	8/21 (38.1)	4/20 (20.0)	2.46 (0.60-10.04)
≥2 HRCAs	6/11 (54.5)	0/10 (0)	NE (NE-NE)[e]
Gain/amp(1q21)	10/16 (62.5)	3/22 (13.6)	10.56 (2.17-51.42)
Isolated gain/amp(1q21)	7/10 (70.0)	3/15 (20.0)	9.33 (1.46-59.48)

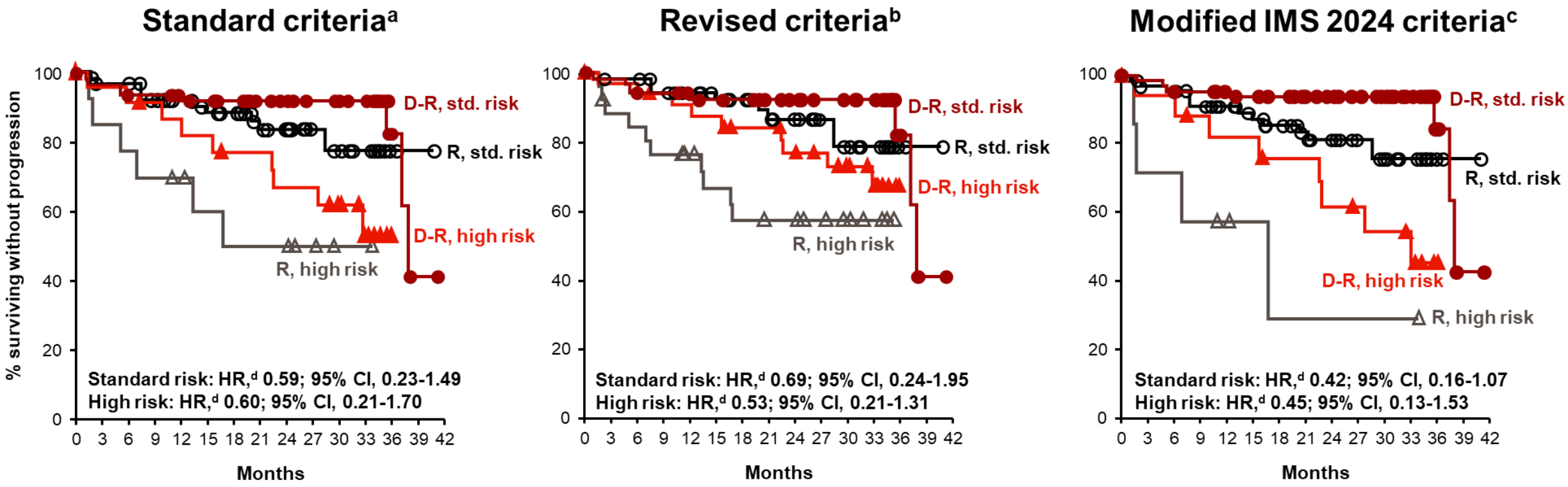




Courtesy of Peter Voorhees, MD

Foster L et al. ASH 2024.

Lenalidomide ± Daratumumab as Maintenance Therapy for High-Risk Myeloma: AURIGA



[a]High-risk cytogenetics per the standard definition are defined as ≥1 abnormality including del(17p), t(4;14), or t(14;16). [b]Revised high-risk cytogenetics per the revised definition are defined as ≥1 abnormality including del(17p), t(4;14), t(14;16), t(14;20), or gain/amp(1q21). [c]High risk per the modified IMS 2024 criteria is defined as the presence of ≥20% del(17p); or the association of ≥2 of the following: t(4;14) or t(14;16) or t(14;20); gain/amp(1q21); or del(1p32) [in the AURIGA study, data were not available on TP53 mutations, baseline ß2M, and creatinine levels and differentiation between monoallelic versus biallelic del(1p32)]. [d]HR and 95% CI from a Cox proportional hazards model with treatment as the sole explanatory variable. A HR <1 indicates an advantage for D-R.

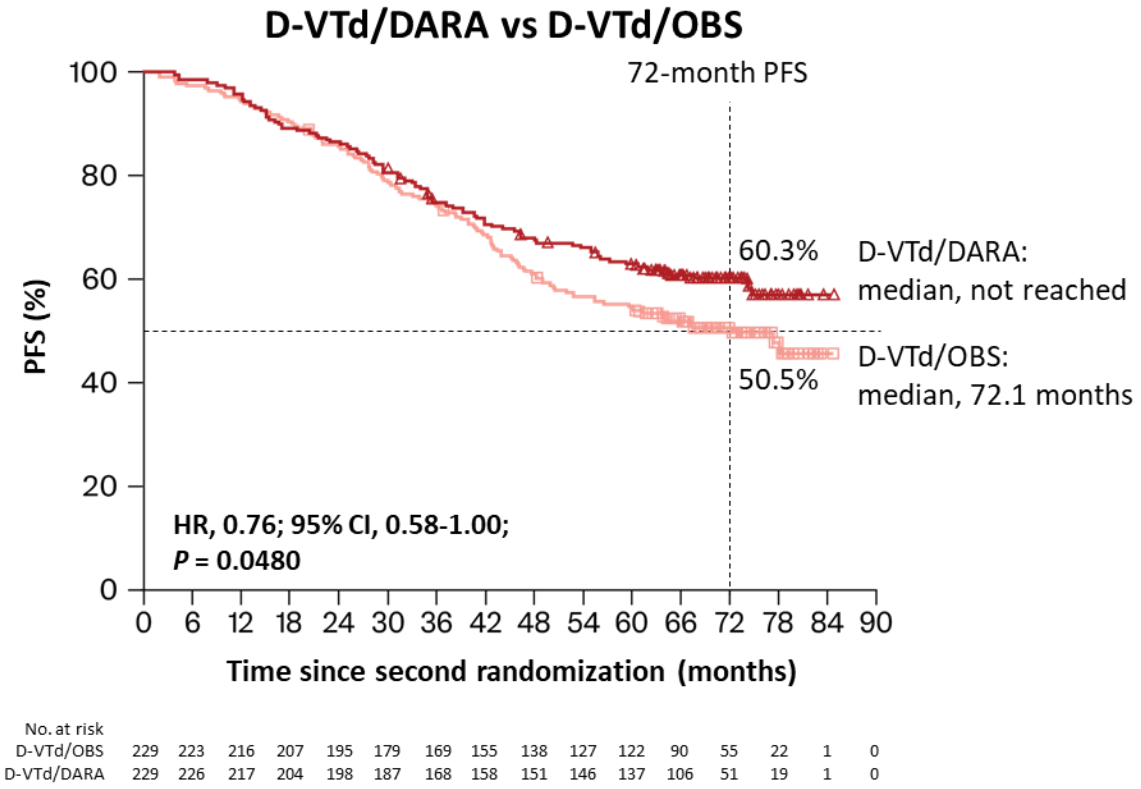
Foster L et al. ASH 2024.

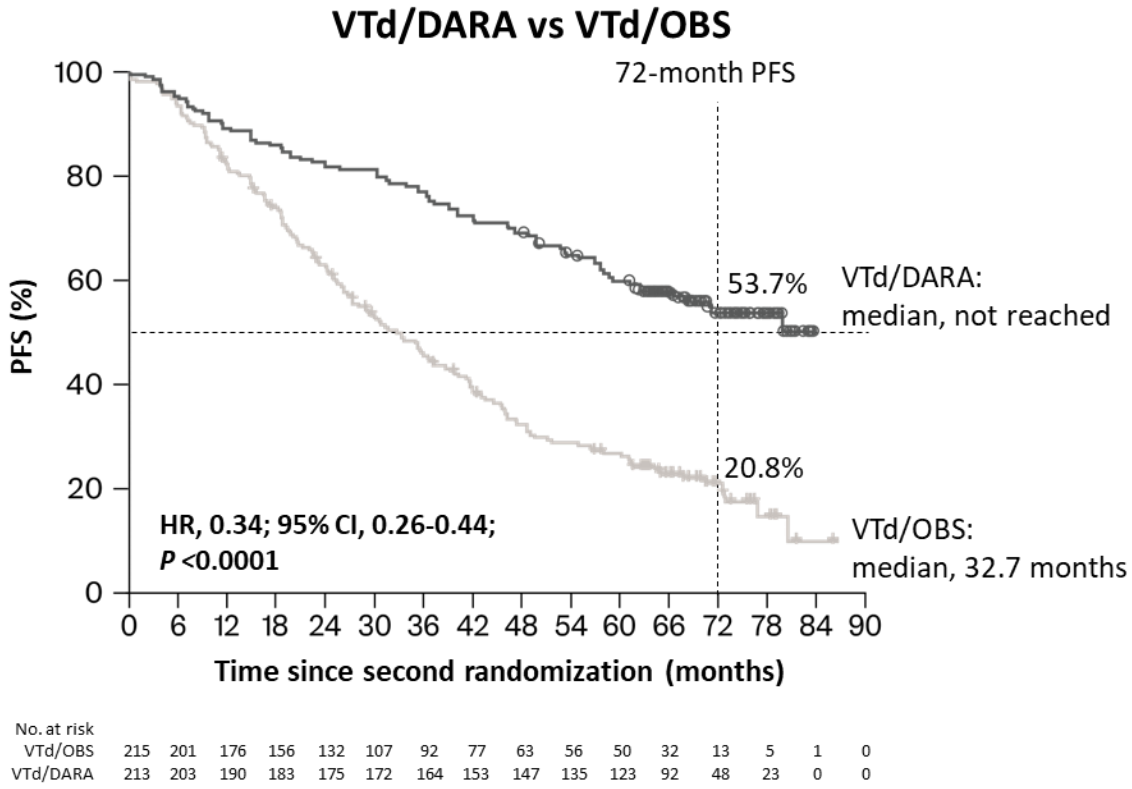
Courtesy of Peter Voorhees, MD

CD38 mAbs in Induction / Post-Transplant Consolidation vs Maintenance: CASSIOPEIA

Phase III study of randomization #1: VTd ± daratumumab (4 cycles induction, ASCT, 2 cycles post-transplant consolidation) → randomization #2: Observation vs daratumumab maintenance x 2 years

Median follow-up from second randomization: 70.6 months





Moreau P et al. EHA 2024; Moreau P et al. Lancet Oncol 2024.

Courtesy of Peter Voorhees, MD

MRD-Adapted Therapy

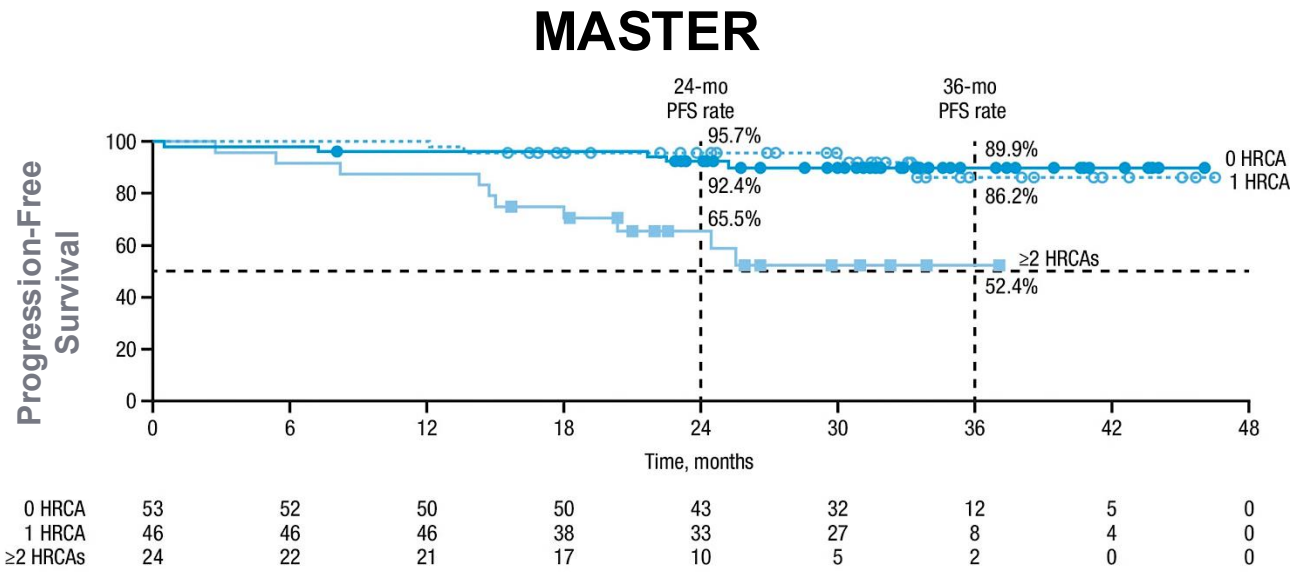
CD38 mAb / IMiD / PI Quadruplets in High-Risk Myeloma: A MASTER and GRIFFIN Subset Analysis

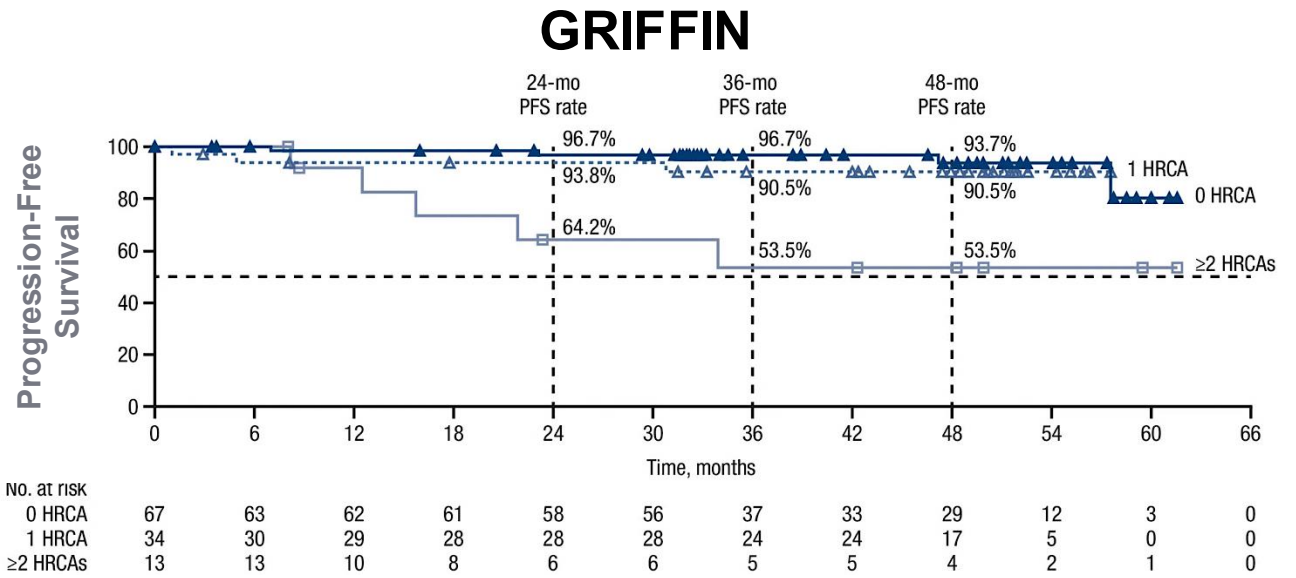
MASTER

- 4 cycles of Dara-KRd → ASCT → 4 cycles of Dara-KRd → 4 cycles of Dara-KRd → Len maintenance
- MRD assessment after completion of each cassette of therapy
- Transition to observation with 2 consecutive MRD negative readouts at 10^{-5}

GRIFFIN

- 4 cycles of Dara-VRd → ASCT → 2 cycles of Dara-VRd → 2 years of Dara-len maintenance → Len maintenance



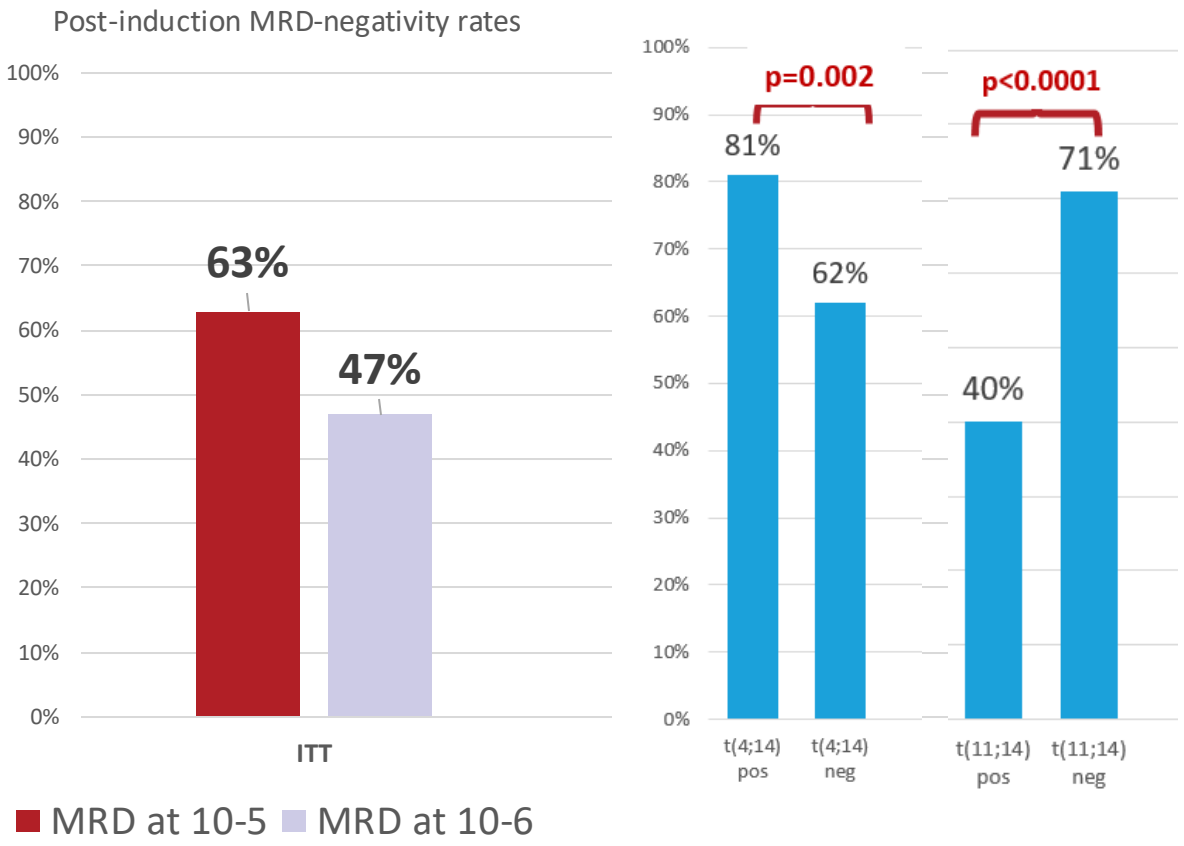


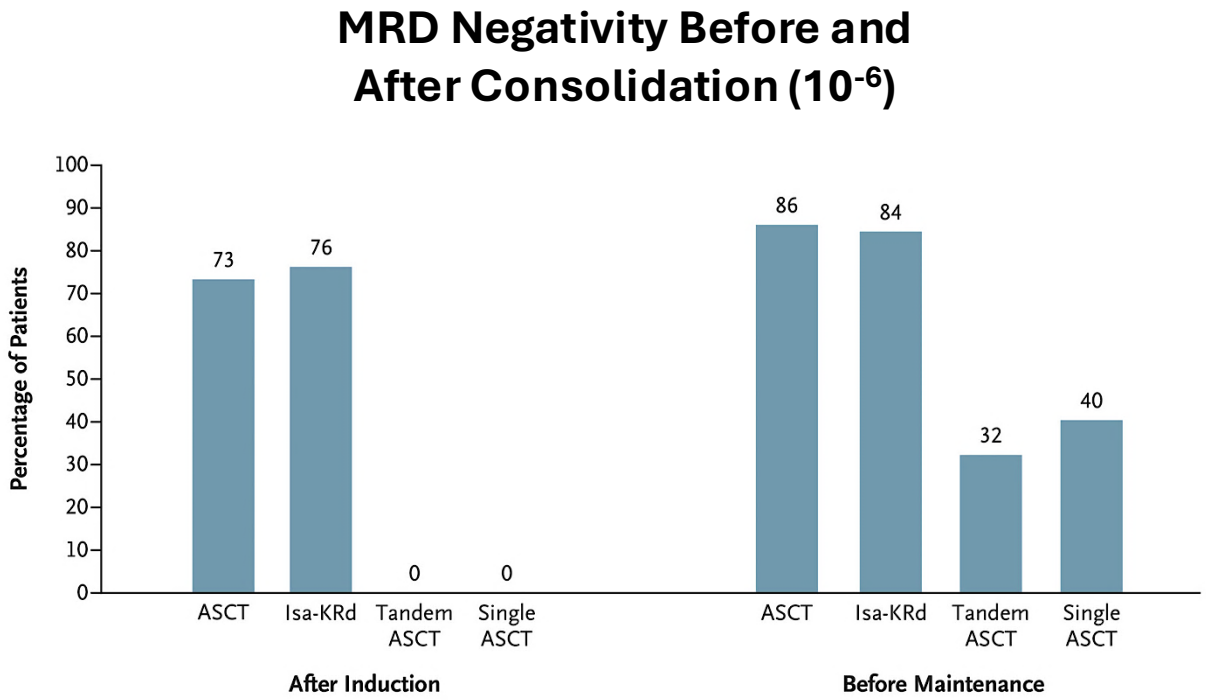
Callander N et al. Blood Cancer J 2024;22:69.

Courtesy of Peter Voorhees, MD

MRD-Adapted Consolidation after Isatuximab-KRd Induction: MIDAS

- Phase III study of MRD-adapted therapy after 6 cycles of Isa-KRd induction therapy
- MRD negative consolidation: Isa-KRd x 6 cycles vs ASCT + Isa-KRd x 2 cycles
- MRD positive consolidation : Tandem ASCT vs single ASCT + Isa-KRd x 2 cycles





Perrot A et al. ASCO 2025; Perrot A et al. EHA 2025.

Courtesy of Peter Voorhees, MD

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

Module 3: ASCT Ineligible

Module 4: Subcutaneous Anti-CD38 Antibodies

Module 5: Special Considerations

RTP
RESEARCH TO PRACTICE

Case Presentation – Prof Leleu: 75-year-old transplant-ineligible patient with MM

Male, 75 years old, fit.

Prior history of hypertension (treated and controlled), dyslipidemia (treated and controlled), doing sports on a regular basis.

Was admitted to infectious disease department for dyspnea severely worsening in the context of bronchopneumonia. The patient was diagnosed with pneumococcal infection having a bronchopneumonia with important pleuresis.

This unusual severe infection led the infectious disease department to seek for immunodepressive conditions, including multiple myeloma.

Bio test.

Hb 9.5 g/dL, WBC elevated for neutrophil count and Plat elevated values. Clearance creatinine at 50 mL/min, normally above 80 for the patient. Serum calcium, ionogram, liver enzymes' values were in normal ranges.

Patient had an important inflammatory syndrome that could be explained in the context of the infection. Protidemia 110 g/L. Serum protein electrophoresis showed hypergammaglobulinemia of IgA K monoclonal type. Urine was negative for proteinuria, including BJ. sFLC was kappa 3000 mg/L, lambda 2 mg/L, ratio 1500.

PET CT.

Multiple lytic lesions with hypermetabolisms, no PMD and EMD.

Case Presentation – Prof Leleu: 75-year-old transplant-ineligible patient with MM (cont'd)

BM aspiration and genomic.

35% plasma cells, dystrophic nucleus.

Genomic (NGS). No del17p, t(4;14)pos and gain 1q pos, no t(11;14), no del1p32, no mutations of special interest.

ISS 2. RISS 2. Serum LDH level normal. No plasmablastic features. No CTC on CBC.

Patient was sent over to Hematology for Myeloma. Education on MM was done.

As a conclusion. NDMM SLiM CRAB on sFLC ratio (ratio 110). HR, 75 fit TI. ECOG 2 at start.

Line 1.

Isa-VRd was given as the standard of care according to IMROZ/CEPHEUS/BENEFIT studies

V twice weekly, R 25 mg 21/28, dexa 20 mg

+ supportive care, Bisphosphonate x 4 cycles, vaccination +++ (flu, covid, pneumonia)

x 1 cycle

Patient experienced grade 1 neuropathy

PR

Case Presentation – Prof Leleu: 75-year-old transplant-ineligible patient with MM (cont'd)

Cycle 2 was done with V weekly

Cycle 4 = VGPR

Safety. Diarrhea ++++ = supportive care given

Cycle 6 = CR

Patient sick of diarrhea = Len is decreased to 10 mg

Dexa is stopped

Cycle 12 = CR

V is stopped, Isa and Len continued until PD

Cycle 24 = CR

Cycle 48 = IFS positive again while negative up to now, but no PD yet

==== pt wishes to stop the treatment ….

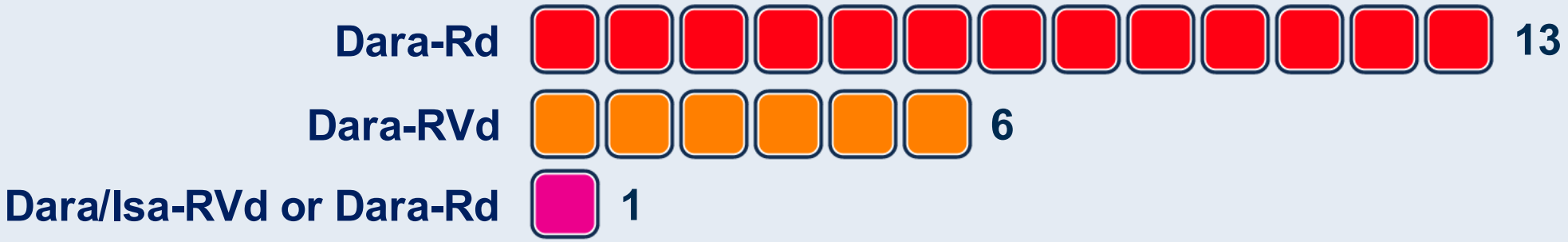
Case Presentation – Dr Voorhees: 73-year-old transplant-ineligible patient with MM

- 73-year-old man who presented with rapidly escalating thoracic back pain.
- Hgb 11.0 g/dL, Ca 9.6, albumin 3.3, Cr 1.11, LDH normal, B2M 3.0, SPEP/IFE: Monoclonal IgG kappa 2.3 g/dL, serum free kappa LCs 583 mg/L, FLC ratio 61.
- Bone marrow: 15% PCs. Myeloma FISH: + t(11;14) and del(13q).
- Imaging: PET-CT with innumerable FDG avid lytic bone lesions and compression deformities involving T5, T6, T8, T10 and T12.
- Co-morbidities: Parkinson disease, early-stage prostate cancer (active surveillance), hyperlipidemia.
- ECOG PS 3 due to debilitating back pain from numerous compression fractures.

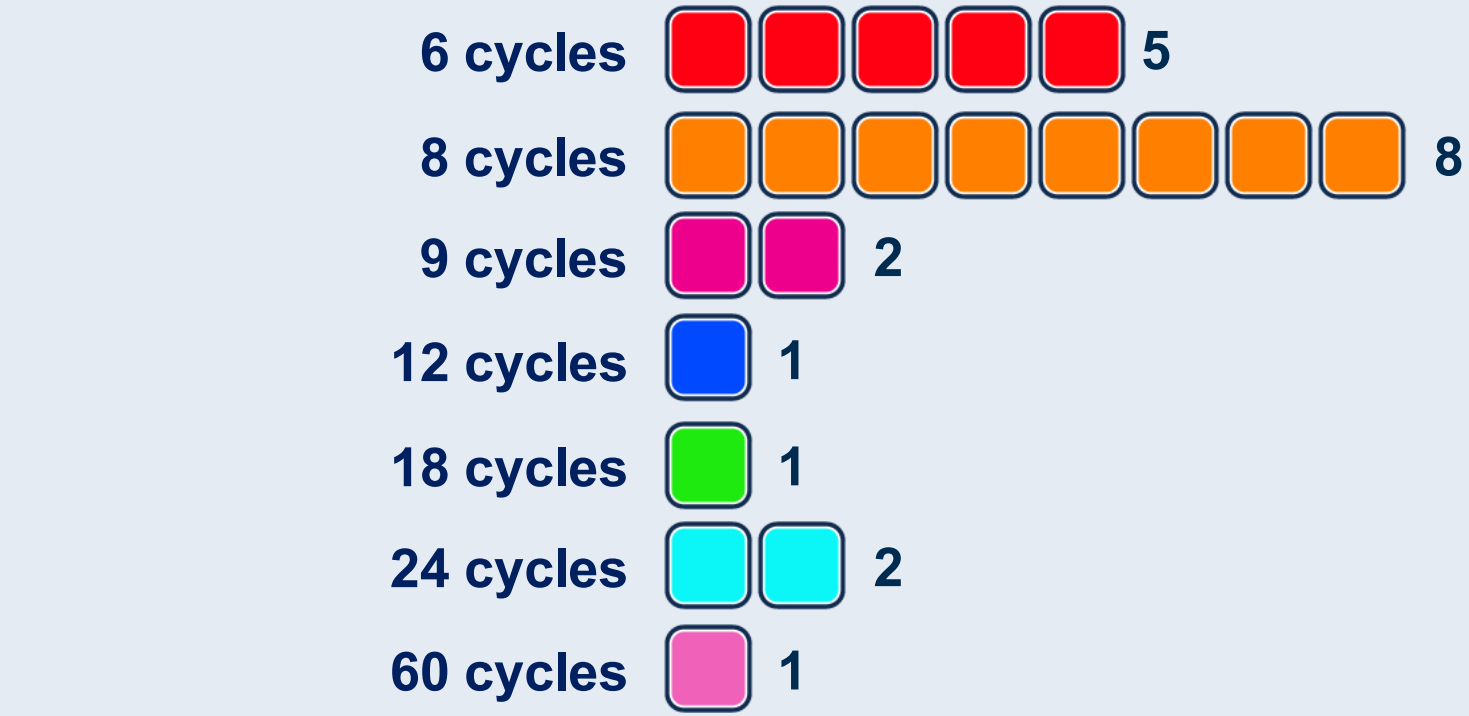
Case Presentation – Dr Voorhees: 73-year-old transplant-ineligible patient with MM (cont'd)

- The patient was placed on D-VRd induction therapy and is in a very good partial response after 4 cycles of therapy. His performance status has improved to the point that we have decided to collect stem cells for a potential future ASCT if his disease response does not hold for as long as we expect. We intend to treat the patient with 6 cycles of D-VRd followed by D-R maintenance until disease progression or the emergence of unacceptable side effects.

Regulatory and reimbursement issues aside, what is your preferred initial regimen for an 80-year-old patient with standard-risk MM who is not eligible for transplant?



How long would you continue induction treatment?



Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

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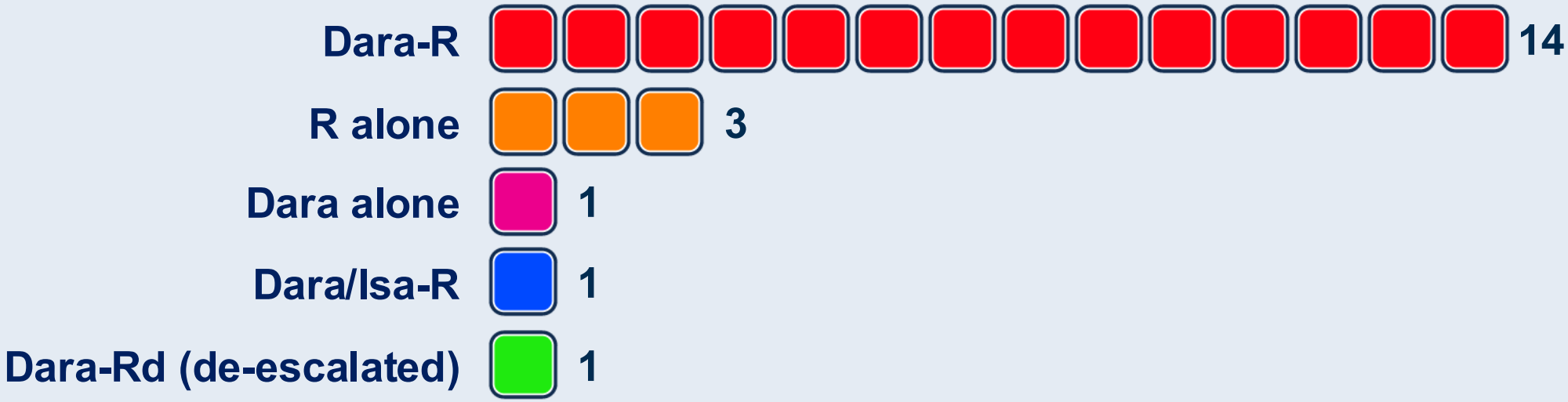

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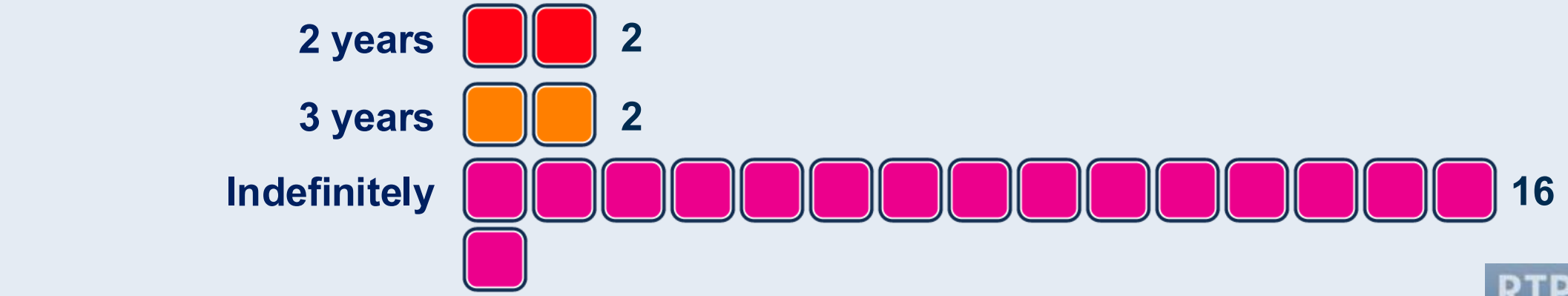
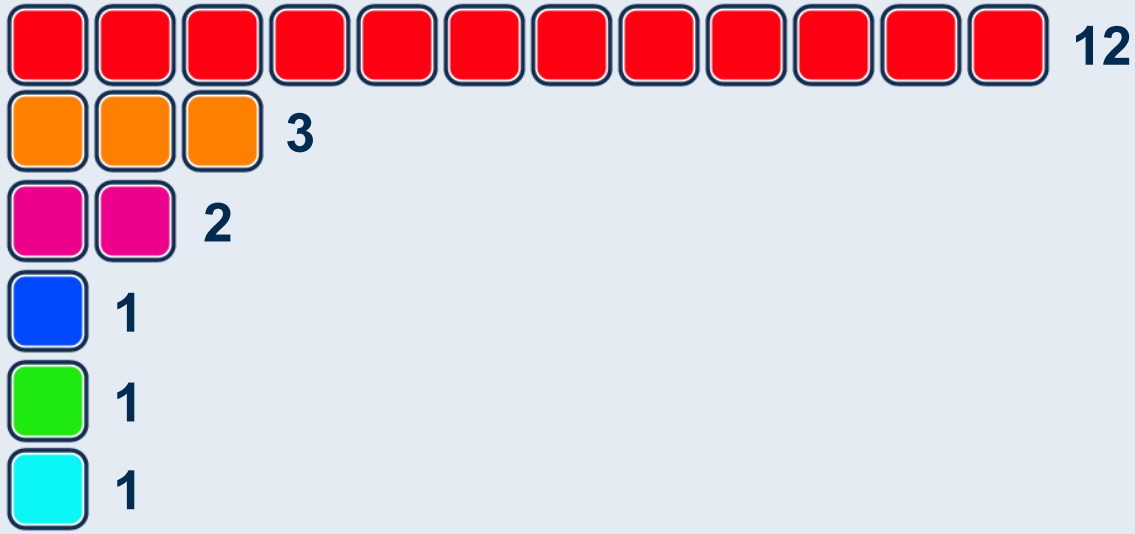


Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, what would be your preferred initial regimen for an 80-year-old patient with high-risk (eg, del[17p]) MM who was not eligible for transplant?



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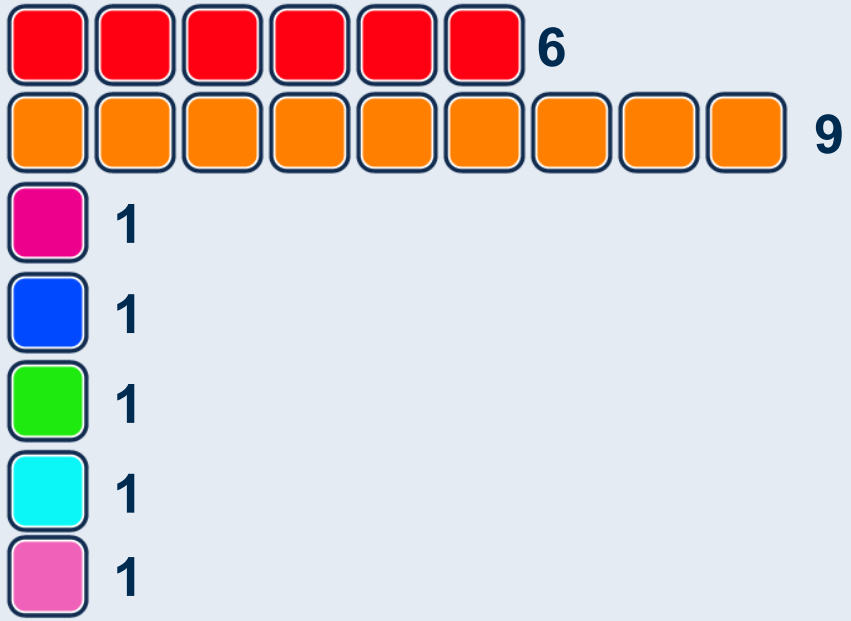

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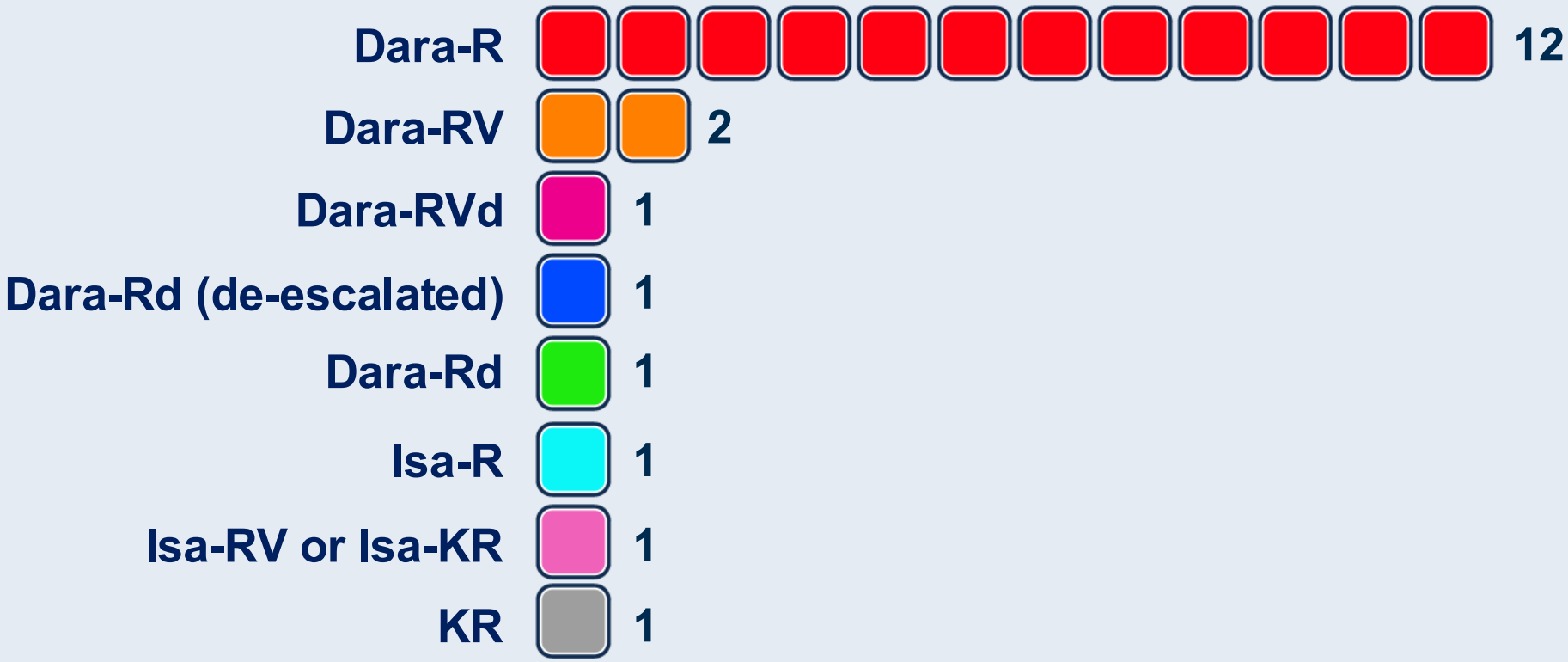

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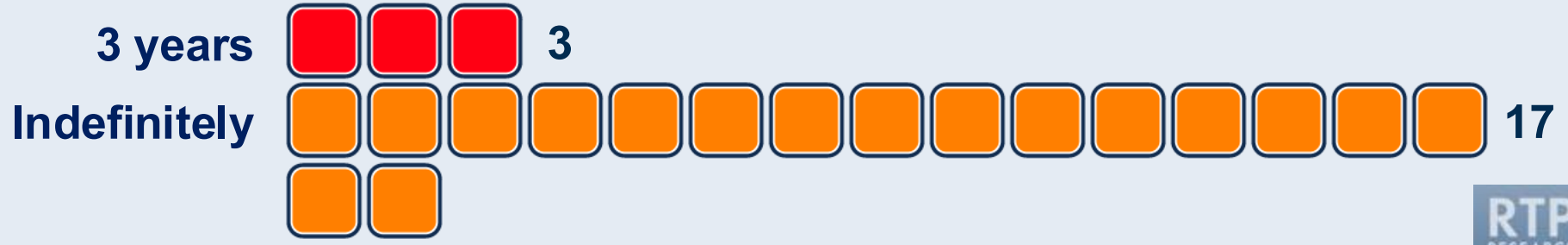

Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

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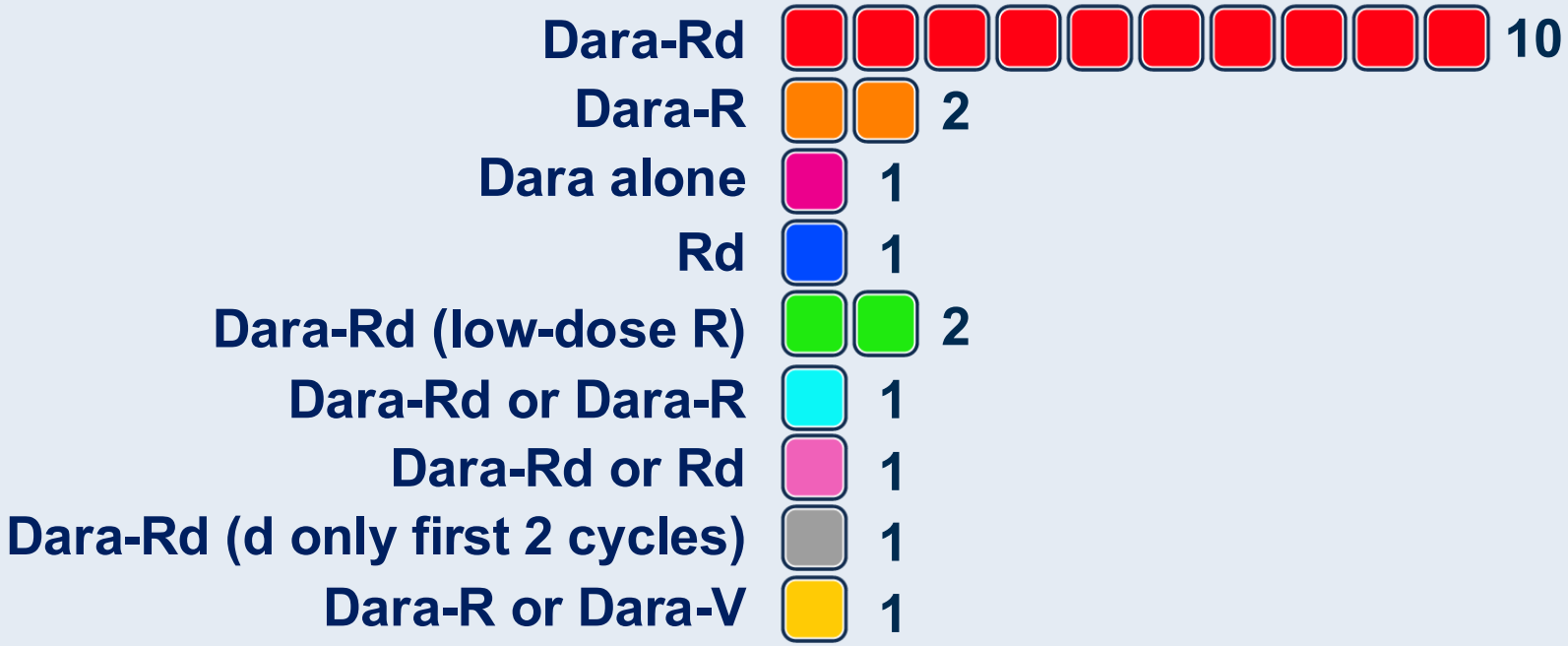

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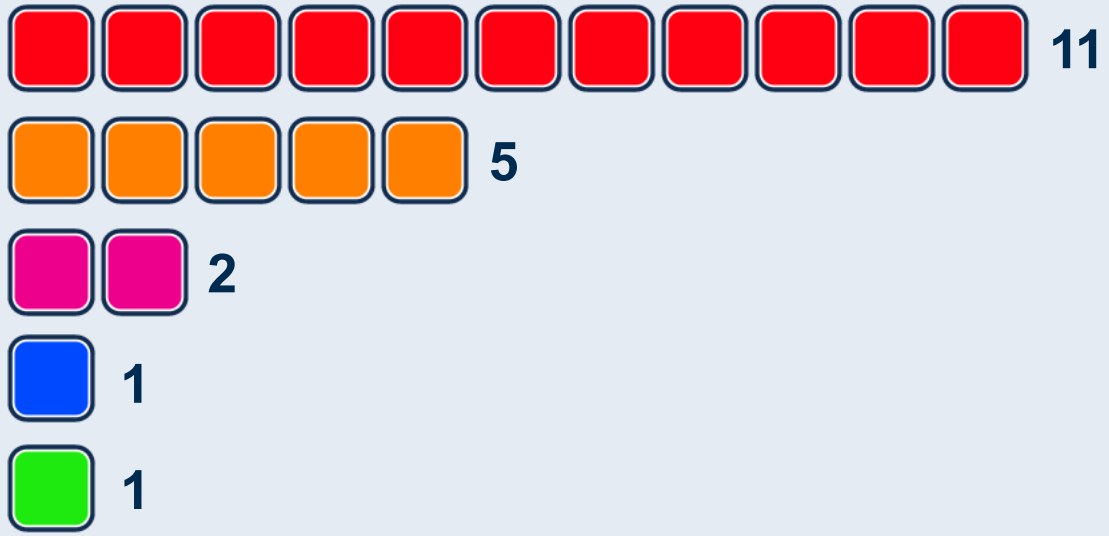

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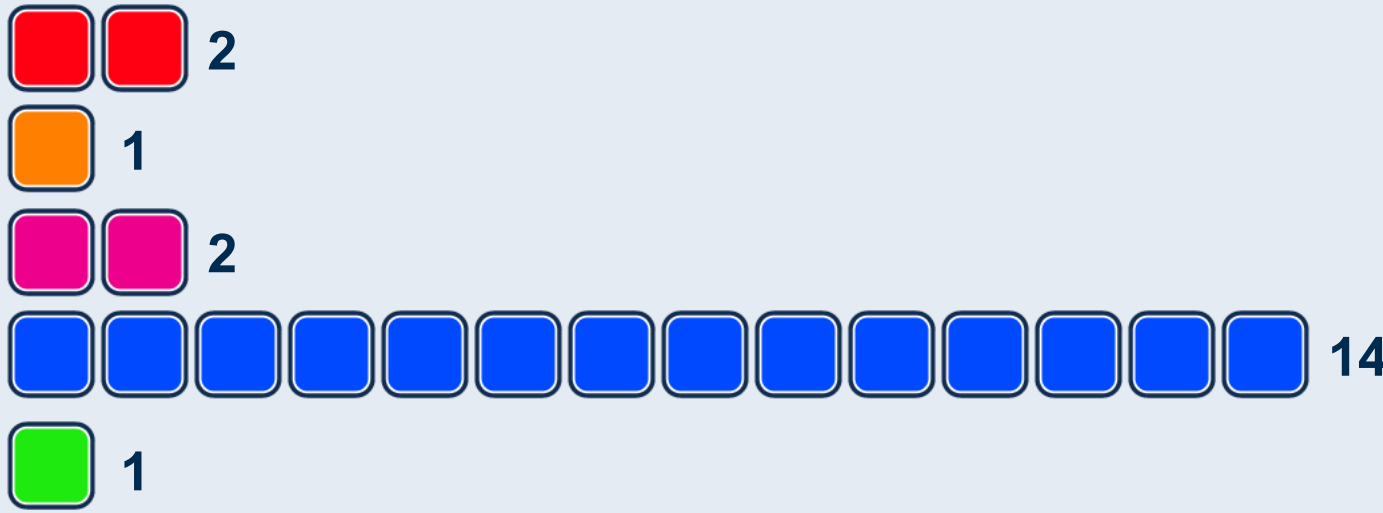

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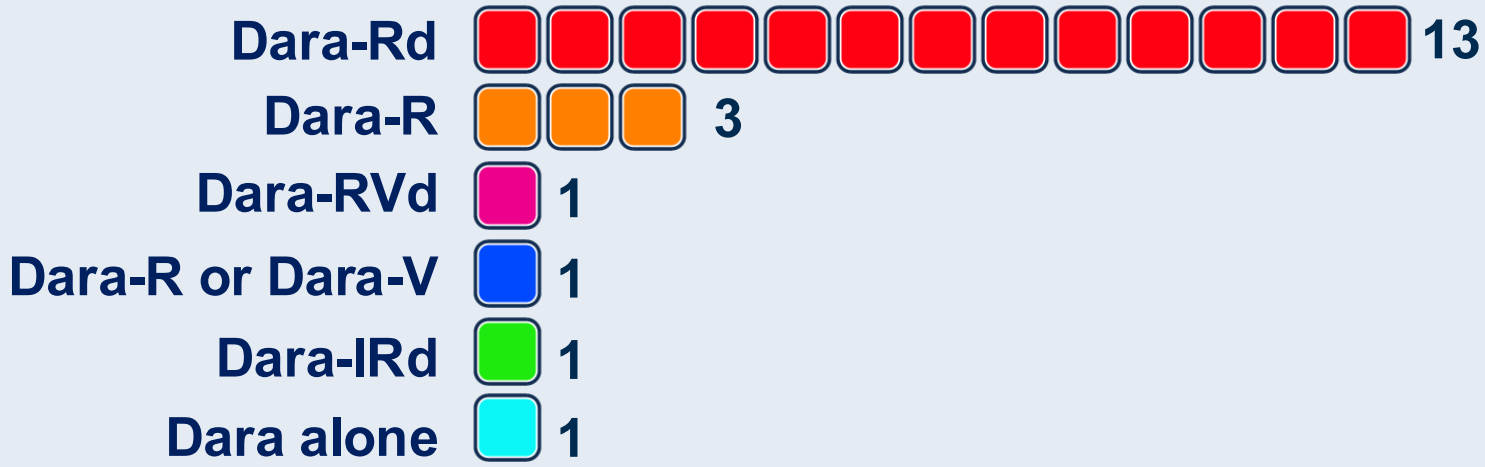

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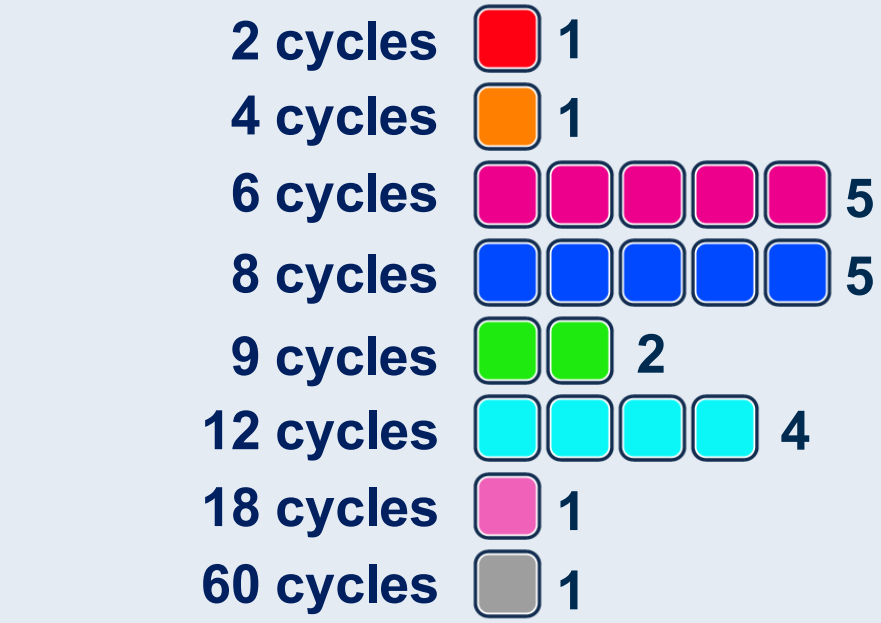

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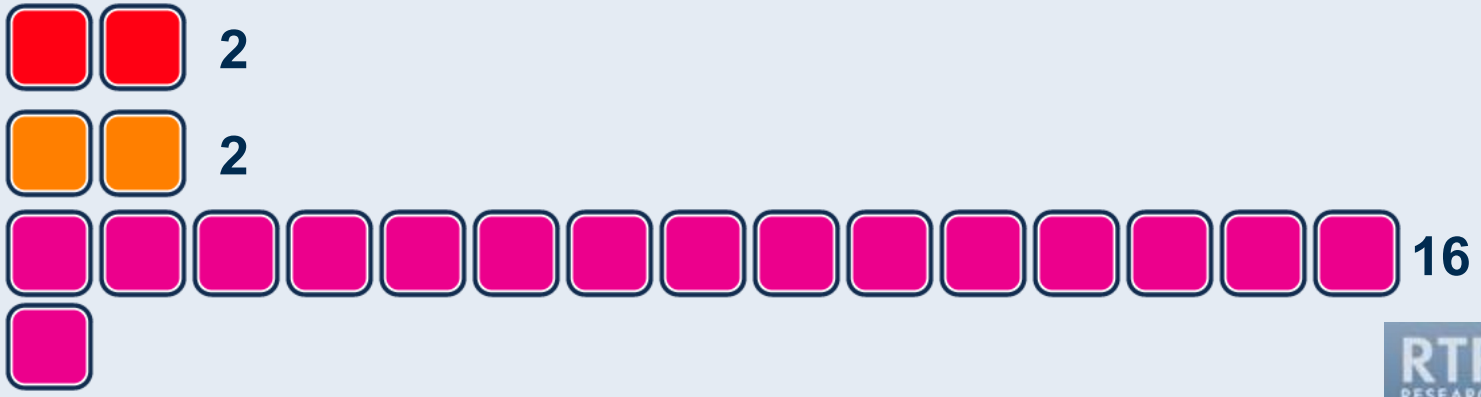
How long would you continue maintenance therapy?



Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

CD38 mAb / IMiD / PI Quadruplets in Newly-Diagnosed Myeloma: Transplant Deferred and Ineligible

Randomized phase III studies of VRd ± CD38 mAbs (CEPHEUS: Daratumumab; IMROZ: Isatuximab)

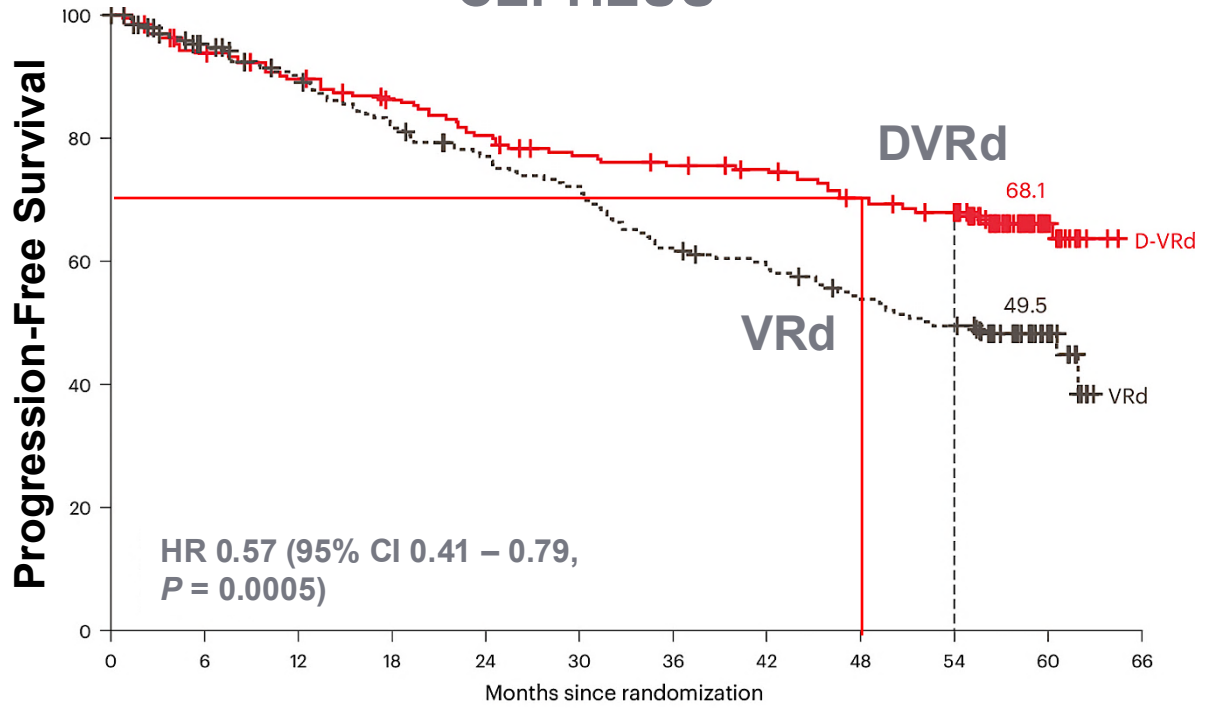
Key Eligibility Criteria
- ECOG PS 0 – 2; Frailty index <2
- Transplant ineligible: Age 70 – 80, <70 with comorbidities
- Transplant deferred allowed

DVRd vs VRd
- Median age: 70 (42 – 79) vs 70 (31 – 80)
- ≥70 y/o: 55.3% vs 55.6%
- Transplant deferred: 26.9% vs 26.8%

Key Eligibility Criteria
- ECOG PS 0 – 2, age ≤80
- Transplant ineligible: Age ≥65 or comorbidities precluding ASCT

Isa-VRd vs VRd
- Median age: 72 (60 – 80) vs 72 (55 – 80)
- ≥70 y/o: 69.4% vs 69.1%

CEPHEUS

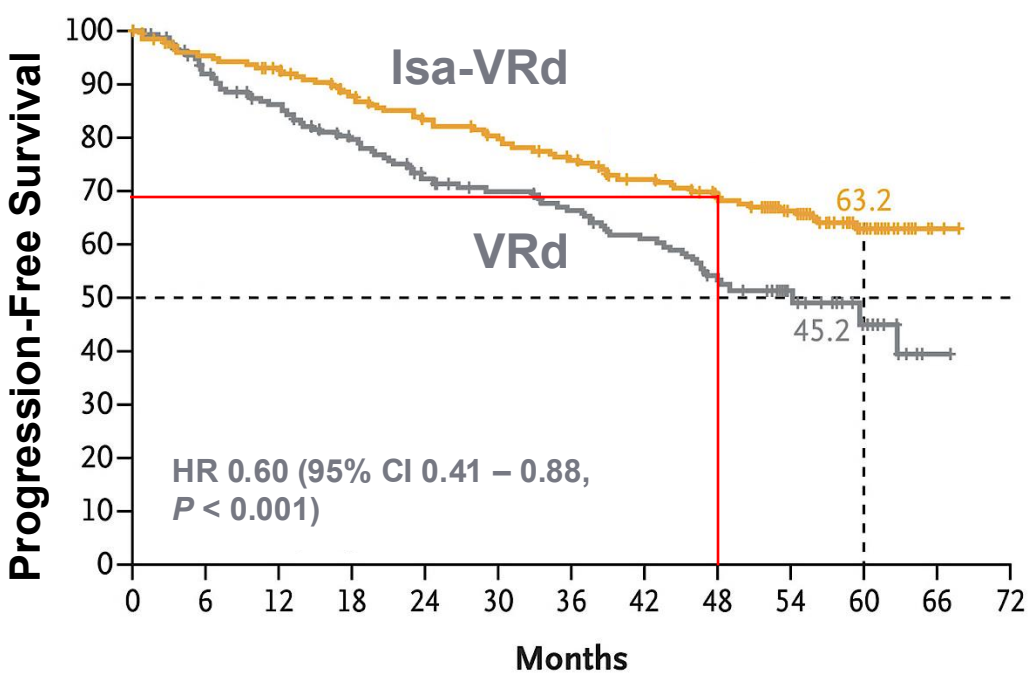


No. at risk

D-VRd	197	180	170	160	149	140	136	132	122	115	33	0
VRd	198	174	157	143	131	123	105	98	88	81	21	0

Usmani S et al. Nature Med 2025;ePub ahead of print.

IMROZ



No. at Risk

Isatuximab-VRd	265	243	234	217	201	190	177	164	153	104	43	2	0
VRd alone	181	155	141	121	104	96	89	81	70	51	20	2	0

Facon T et al. New Engl J Med 2024;391:1597-1609

Courtesy of Peter Voorhees, MD

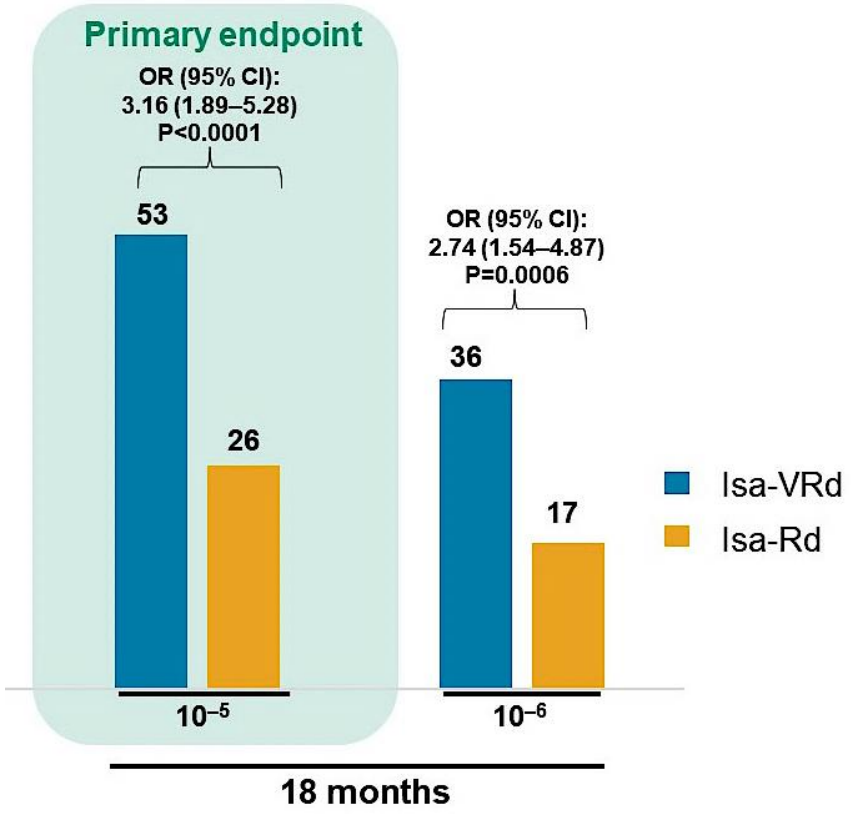
CD38 mAb / IMiD / PI Quadruplets in Transplant-Ineligible Patients with Newly-Diagnosed Myeloma: The BENEFIT of Bortezomib

Phase III study of Isa-Rd ± Bortezomib

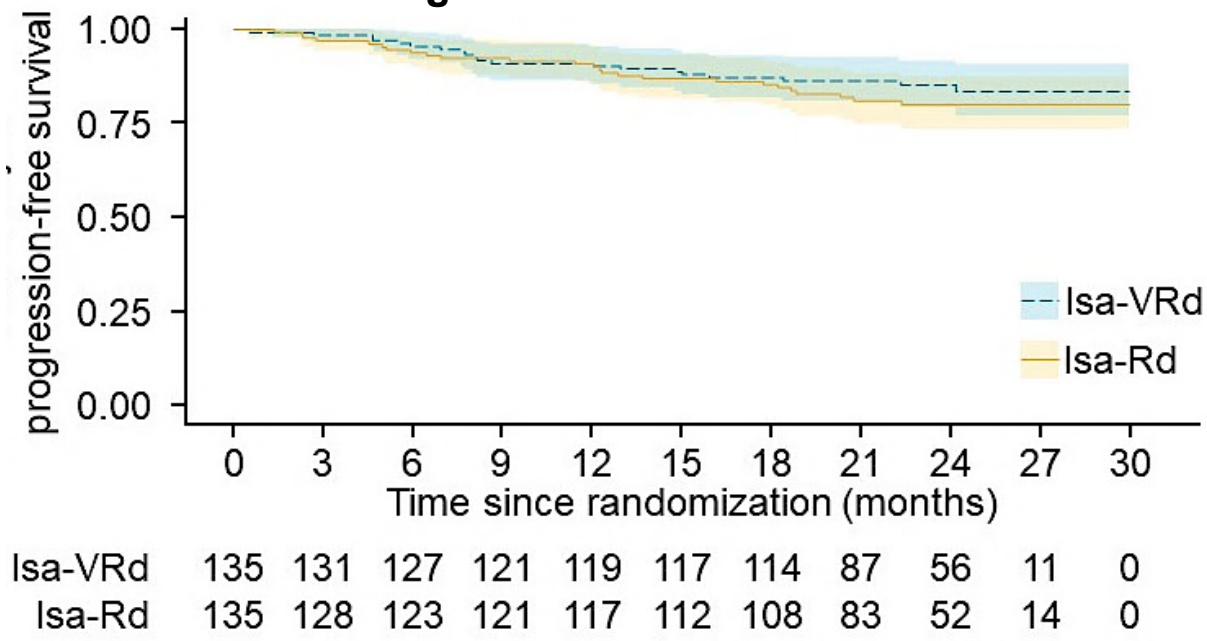
Study Design: Isa-Rd x 12 cycles → Isa-R cycles 13+. For the Isa-VRd arm, bortezomib on days 1, 8 and 15 of cycles 1 – 12 and days 1 and 15 of cycles 13 – 18 added.

Key Eligibility Criteria: Deemed not transplant eligible, ages ≥65 – 79 years, frailty score <2, ECOG PS 0 – 2

Measurable Residual Disease



Progression-Free Survival



Estimated 24 months PFS

85.2% (95%CI 79.2–91.7) for Isa-VRd

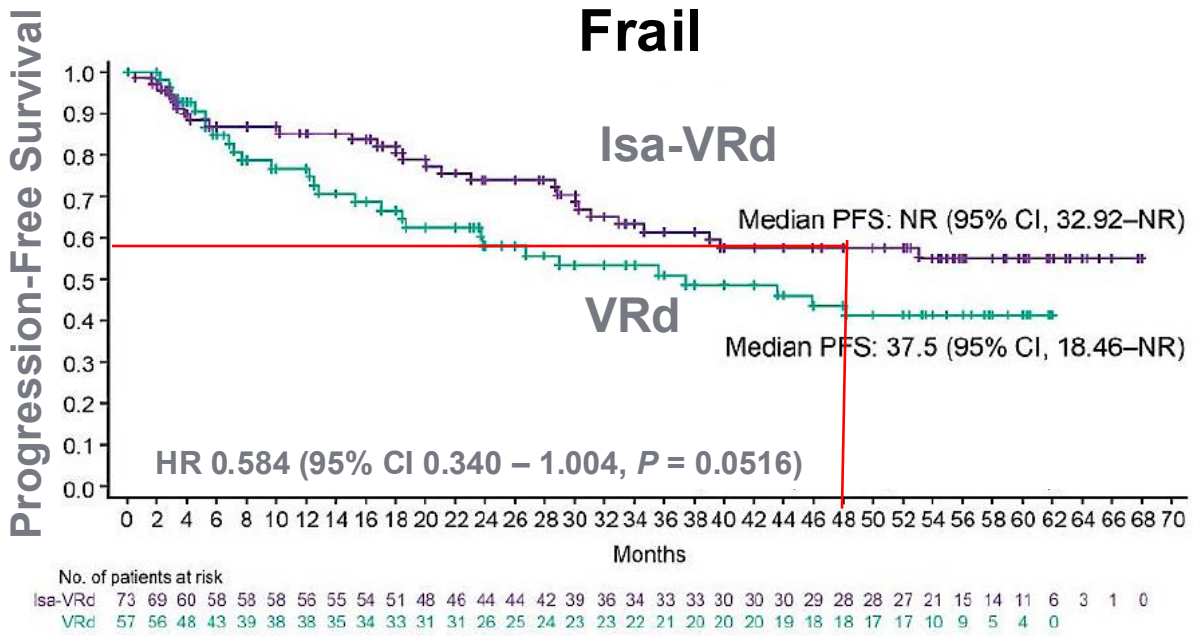
80.0% (95% CI 73.3–87.4) for Isa-Rd

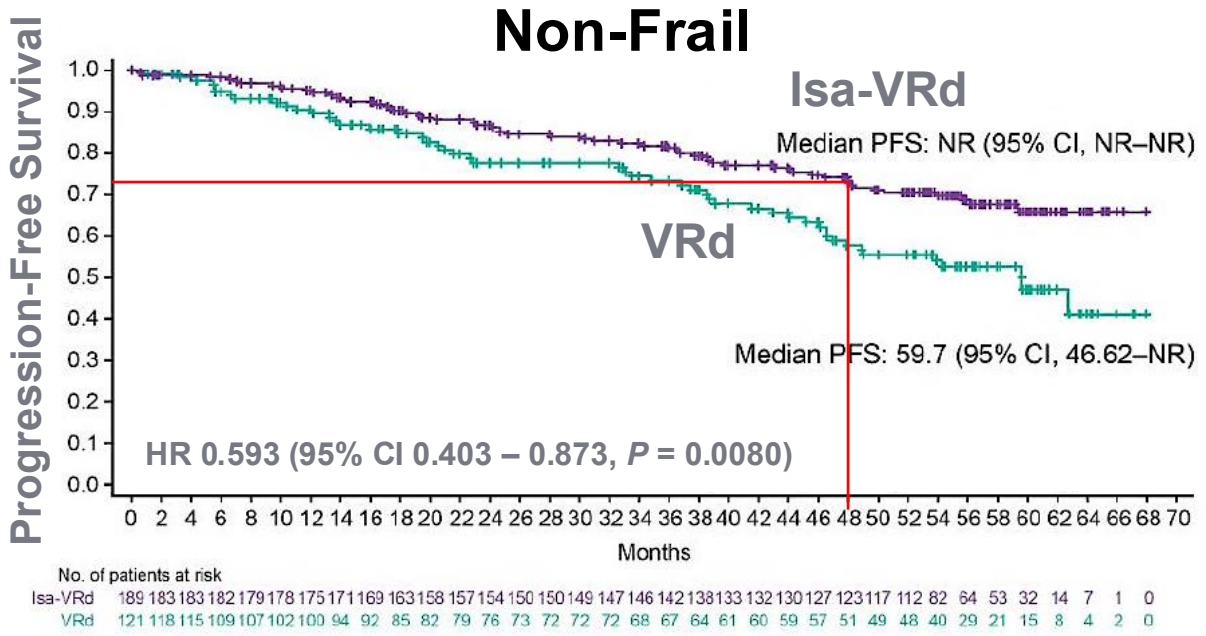
Leleu X et al. Nat Med 2024;30:2235-2241

Courtesy of Peter Voorhees, MD

CD38 mAb / IMiD / PI Quadruplets in Frail Patients with Newly-Diagnosed Myeloma: An IMROZ Subset Analysis

- Key Eligibility Criteria: ECOG PS 0 – 2, transplant ineligible (age 65 – 79 or any age with comorbidities precluding safe transplant)
- Modified IMWG Frailty Score: Based on age, modified Charlson Comorbidity Index, ECOG PS.
- Frailty score 0 or 1: Non-frail; ≥2: Frail.
- 29% of patients were deemed frail (Isa-VRd 28%; VRd 32%)
- Frail group enriched for patients with higher ECOG PS and ISS stage





- OS worse in frail vs non-frail patients
- No difference in OS between Isa-VRD vs VRd arms for frail (HR 0.826, 95% CI 0.490 – 1.392, *P* = 0.4720) and non-frail (HR 0.734, 95% CI 0.453 – 1.188, *P* = 0.2076) patients

Manier S et al. IMS 2024.

Courtesy of Peter Voorhees, MD

CD38 mAb / IMiD / PI Quadruplets in Frail Patients with Newly-Diagnosed Myeloma: An IMROZ Subset Analysis

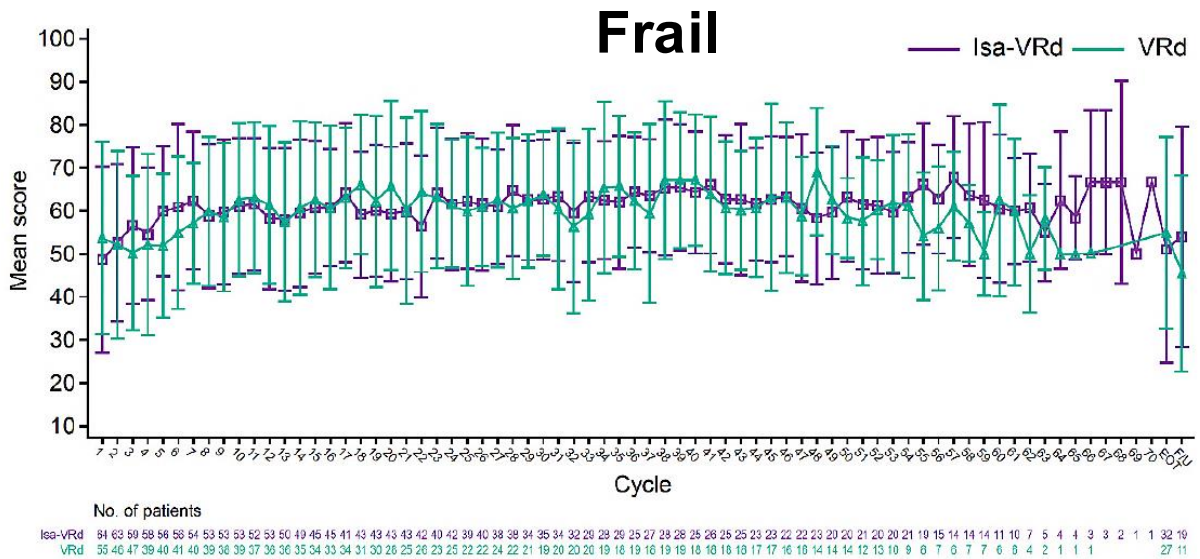
Median duration of treatment (Isa-VRd vs VRd)
- Frail: 31.5 vs 23.7 mos
- Non-Frail: 55.2 vs 36.6 mos

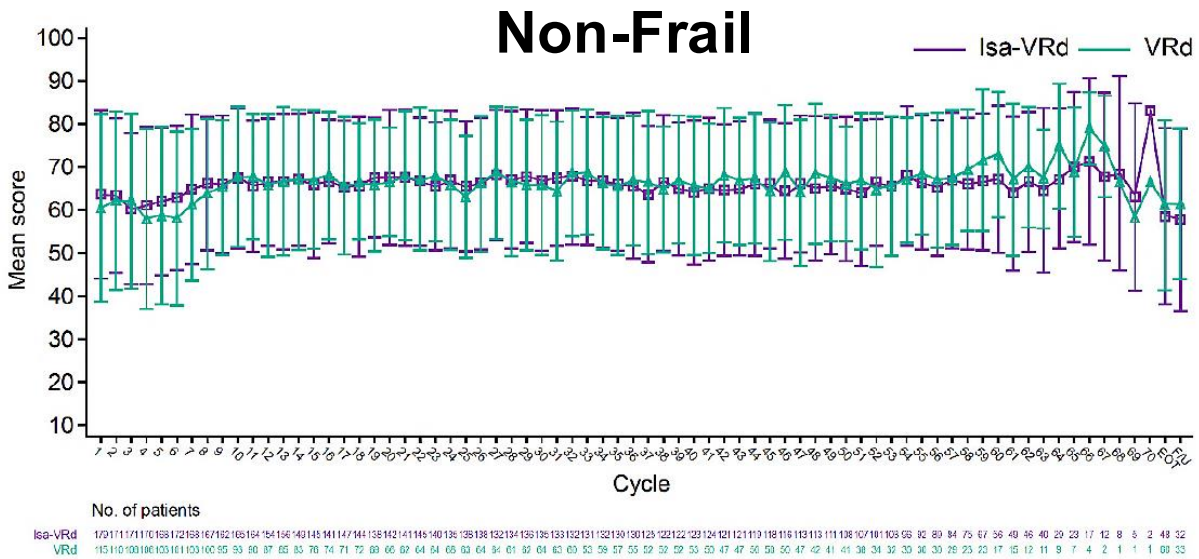
Median Relative Dose Intensity for Isa
- Frail vs Non-Frail: 92.1% vs 94.0%

Median Relative Dose Intensity for Bortezomib
- Frail: 90.3% vs 83.4%
- Non-Frail: 90.0% vs 87.5%

Safety Metric	Frail		Non-Frail	
	Isa-VRd	VRd	Isa-VRd	VRd
D/C for any reason	71.23%	82.46%	46.03%	72.73%
D/C 2/2 Adverse Events	30.14%	35.09%	20.11%	24.79%
Any ≥Grade 3 TEAE (event rate per year)	2.221	3.248	1.832	2.141
Any Grade 5 TEAE (event rate per year)	0.975	1.979	0.509	0.416
Any TE SAE (event rate per year)	1.051	1.340	0.989	1.296

QoL as measured by the EORTC-QLQ-C30





Manier S et al. IMS 2024.

Courtesy of Peter Voorhees, MD

Conclusions

- Quadruplets are a new standard of care for patients with newly diagnosed myeloma
  - Triplets remain an important standard of care: Age ≥80, frail patients defined more rigorously
- The best PFS outcomes are those with quadruplets and upfront transplant
- Impact of MRD-adapted consolidation on PFS and OS outcomes: TBD
- Daratumumab + lenalidomide maintenance is a new standard of care for patients who are MRD+ after non-CD38 mAb-containing induction → ASCT
- Optimal maintenance therapy for those treated with upfront quadruplets and transplant is unclear
  - GMMG-HD7, SWOG 1803

Courtesy of Peter Voorhees, MD

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

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Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

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RTP RESEARCH TO PRACTICE

Case Presentation – Prof Leleu: 53-year-old transplant-eligible patient with MM

Male, 53 years old, fit, working in a wine cellar.

Prior history of importance.

Severe trauma injury at 30 in the wine cellar. Long history of repeated surgery of both legs.

No regular medications.

The patient was admitted to nephrology department for acute renal insufficiency. Patient suffered from lower back pain for years that intensified months ago, patient thought it was related to history of trauma. Patient self-treated his back pain with anti-inflammatory drugs for months. The pain became acute a week ago and did not respond to AINS anymore, the patient went to his general practitioner to have “real pain killers”. CT of the back and basic lab tests were ordered.

Bio test.

Hb 9.5 g/dL, WBC and Plat normal values. Clearance creat at 20 mL/min, normally above 80 for the patient. Calcium was elevated above normal range. Protidemia 2 g/L. Serum protein electrophoresis showed hypogammaglobulinemia. SIF demonstrated kappa light chains. Urine was positive for proteinuria, 5g/24h 100% BJ. sFLC was kappa 30 000 mg/L, lambda 2 mg/L, ratio 15 000.

CT of the back confirmed multiple lytic lesions, and fracture of L4.

Patient was admitted immediately in Nephrology. The diagnosis of CAST nephropathy was made, and further checkup done in collaboration with the hematology department.

Case Presentation – Prof Leleu: 53-year-old transplant-eligible patient with MM (cont'd)

BM aspiration.

60% plasma cells, dystrophic nucleus.

Genomic (NGS). No del17p, no t(4;14), gain 1q pos, no t(11;14), no del1p32, no mutations of special interest.

ISS 3. RISS 2. Serum LDH level normal. No plasmablastic features. No CTC on CBC.

PET CT.

Multiple lytic lesions with hypermetabolisms, PMD from costal ribs right side K9 2x3 cm. No EMD.

Education on MM.

As a conclusion. NDMM SLiM CRAB on bone, PMD, sFLC ratio (ratio 110). Non HR, 53 fit TI. Acute RI but on AINS drugs. ECOG 2.

Immediately.

Hydration, correction of hypercalcemia, and DVd was started. Daratumumab, bortezomib and dexamethasone, special 40 mg x 4 days.

At end of cycle 1. Clearance creatinine had stabilized at 40 mL/min. sFLC dropped to K 5000, L2, ratio 2500.

Then Line 1.

Patient then started on D-VRd with objective to collect after 3 cycles, perform autologous transplantation after 6 cycles. V was given = twice weekly, R was given at 10 mg/day 21/28.

Case Presentation – Prof Leleu: 53-year-old transplant-eligible patient with MM (cont'd)

After cycle 2 patient developed neuropathy grade 1, grade 2 after injections decreasing to grade 1 after day 15. Patient experienced multiple episodes of diarrhea with difficulties to maintain clearance creatinine at 40 because of dehydration. Patient had severe local reactions on daratumumab.

D-VRd was maintained, but V was done on weekly basis at days 1/8/15.

After cycle 3. Apheresis was organized, but patient was not feeling good. Fatigue, neuropathy, diarrhea and local skin reaction grade 2. sFLC K 3000, L2, ratio 1500.

The medical team met with pharmacist, patient and family = decision was made to cancel apheresis, and to change the treatment to Isa-KRd for 1 cycle and see from there.

Isatuximab ss cut 1400 mg flat dose with OBI + K 20/56 mg/m^2 IV 30 minutes, R no change, dexa 20 mg on Isa or K days. Supportive care no change, lab monitoring no change.

At end of cycle 4. Clearance creatinine is stabilized at 40 mL/min. sFLC ratio is normalized. Local reactions have disappeared. Patient is feeling really great, fatigue grade 1 persists.

The patient had apheresis performed after cycle 4, it was successful for 2 grafts, as planned.

At end of cycle 6. Patient is back to ECOG 1.

sFLC ratio normalized. Clearance creatinine 45 mL/min. Neuropathy persists grade 1. No more local reactions.

The patient underwent ASCT, conditioned HDM 200 mg/m^2. One graft was reinjected, and the leftover was cryopreserved.

Case Presentation – Prof Leleu: 53-year-old transplant-eligible patient with MM (cont'd)

ASCT went smoothly enough.

After ASCT, the patient wished to resume work as it was August and the harvests were to be prepared… A post-transplant treatment was organized with Isa ss cut flat dose 1400 mg and K 56 on a monthly basis + R no dexa. This way, the patient was asked to come only once a month to the outpatient clinic. Tolerance was good, adhesion to treatment was good.

24 months later (3 years from diagnosis).

Clearance creatinine stabilized around 50 mL/min. sFLC ratio normalized. MRD test NGS was run upon patient request and was negative at 10^{-5} and 10^{-6}.

The K was stopped and patient continued on Isa ss cut flat dose 1400 OBI until PD.

At 5 years from ASCT. Same conclusion.

According to current clinical trial data and your personal experience, in which clinical situations, if any, does a difference in efficacy exist between daratumumab and isatuximab?

Survey of 20 clinical investigators, June 2025

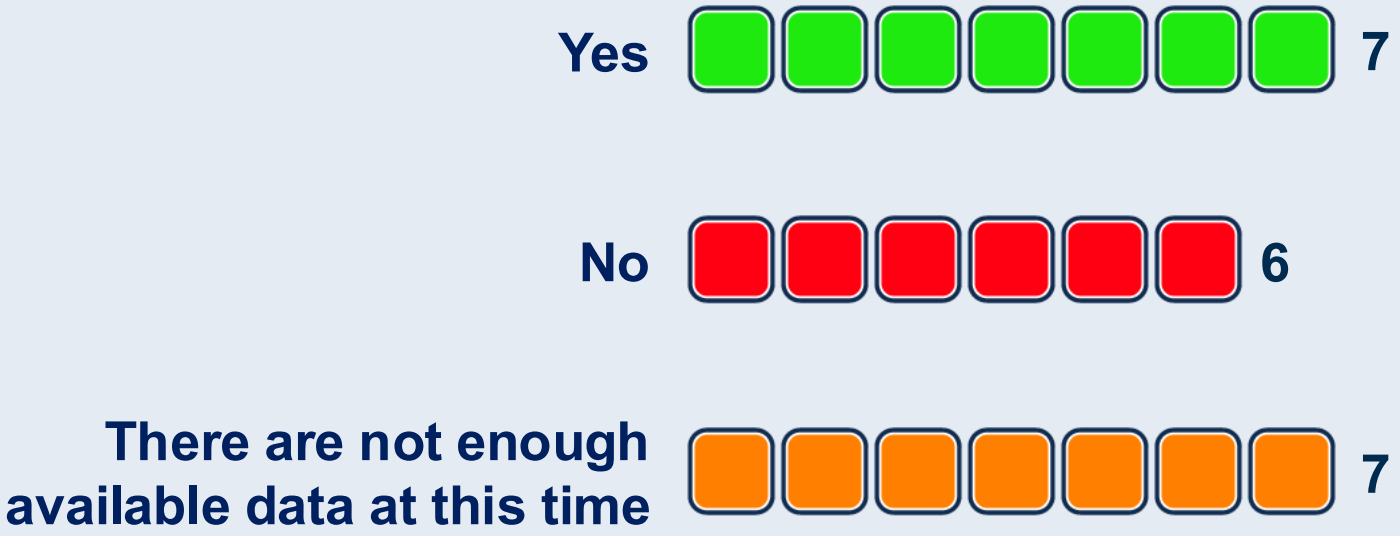
RTP RESEARCH TO PRACTICE

Assuming subcutaneous formulations of isatuximab and daratumumab were both FDA approved and available and the efficacy and tolerability were equal, would you prefer one over the other for your patients with MM?

Survey of 20 clinical investigators, June 2025

RTP RESEARCH TO PRACTICE

Based on current clinical trial data and your personal experience, do you believe that patients will prefer the on-body delivery system for subcutaneous isatuximab to the administration method of subcutaneous daratumumab?



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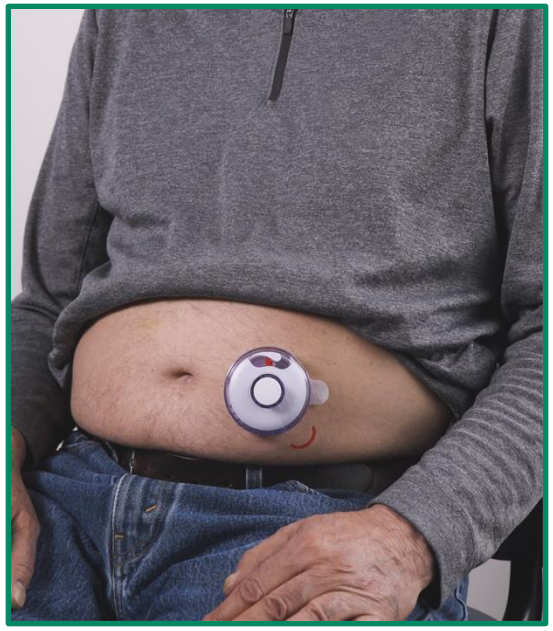
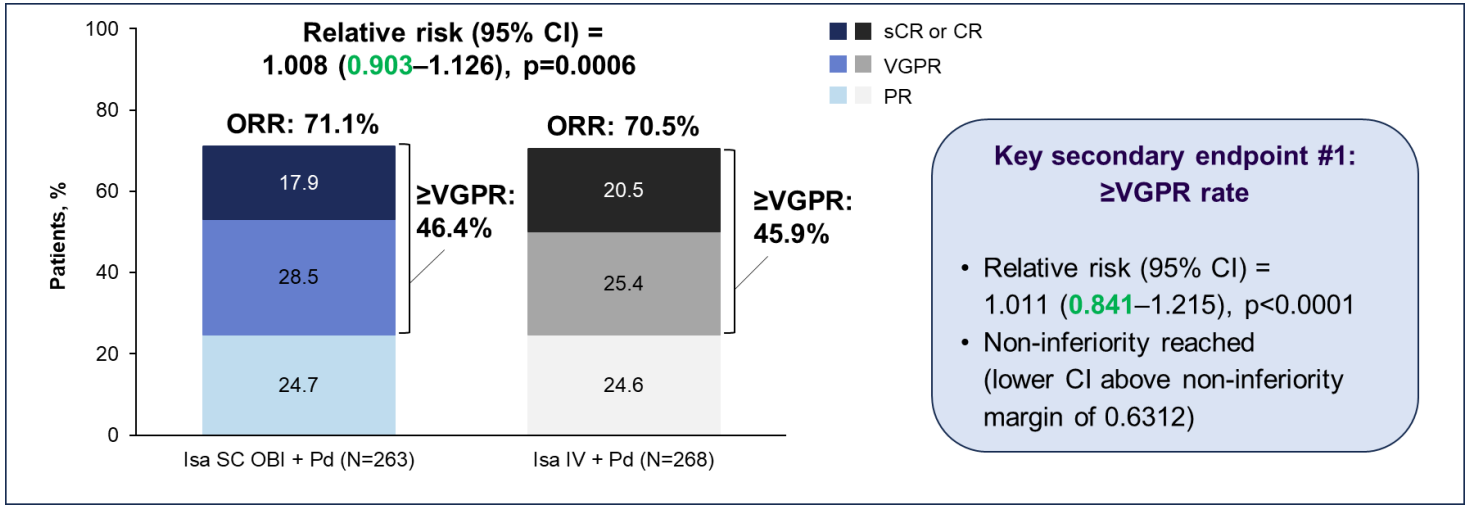
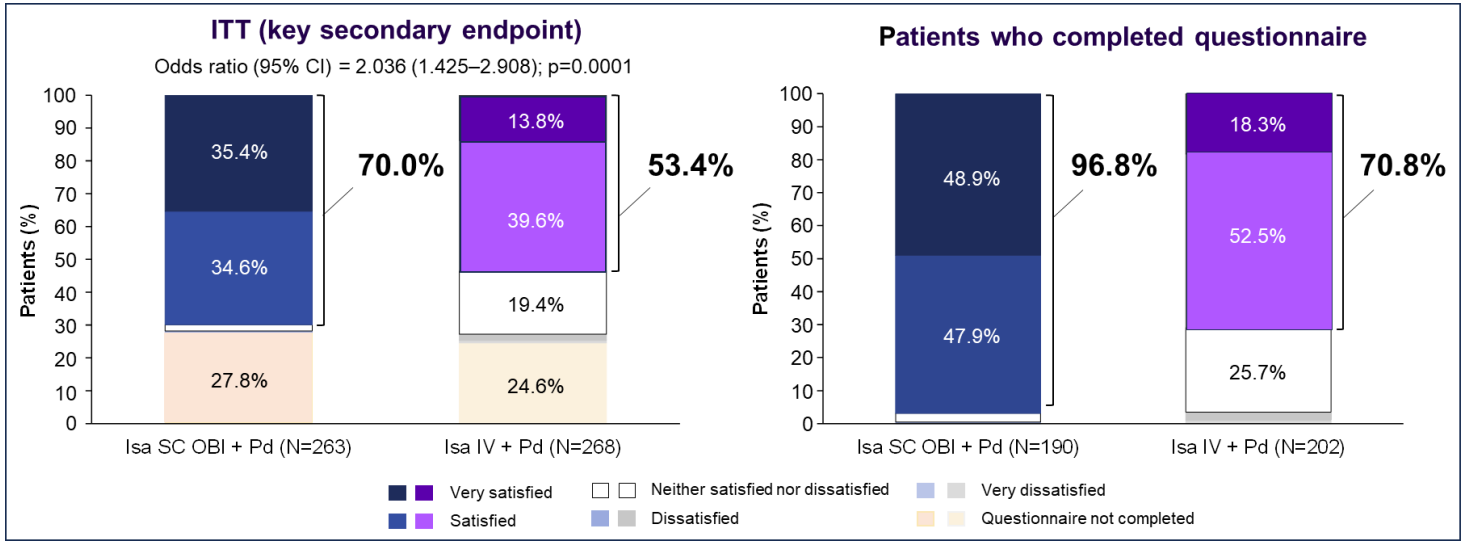
RTP RESEARCH TO PRACTICE

Subcutaneous Isatuximab for Relapsed Myeloma: IRAKLIA

- Phase III study of IV Isa-Pd vs SC Isa-Pd for pts with RRMM and ≥1 prior line of therapy
- IV Isa 10 mg/kg D1, 8, 15, and 22 with C1; D1, 15 with C2+
- SC Isa 1400 mg flat dose using the same dosing schedule as IV
- SC Isa delivered using an on-body delivery injector (OBI)







- Infusion Reactions (SC vs IV): 1.5% vs 25%
- ≥Grade 3 neutropenia (SC vs IV): 84.7% vs 74.3%

Ailawadhi S et al. J Clin Oncol 2025; Leleu X et al EHA 2025.

Courtesy of Peter Voorhees, MD

Selection of First-Line Therapy and Maintenance Treatment for Patients with Multiple Myeloma

Introduction: Myeloma Time Capsule

Module 1: Smoldering Myeloma

Module 2: Autologous Stem Cell Transplant (ASCT) Eligible

Module 3: ASCT Ineligible

Module 4: Subcutaneous Anti-CD38 Antibodies

Module 5: Special Considerations

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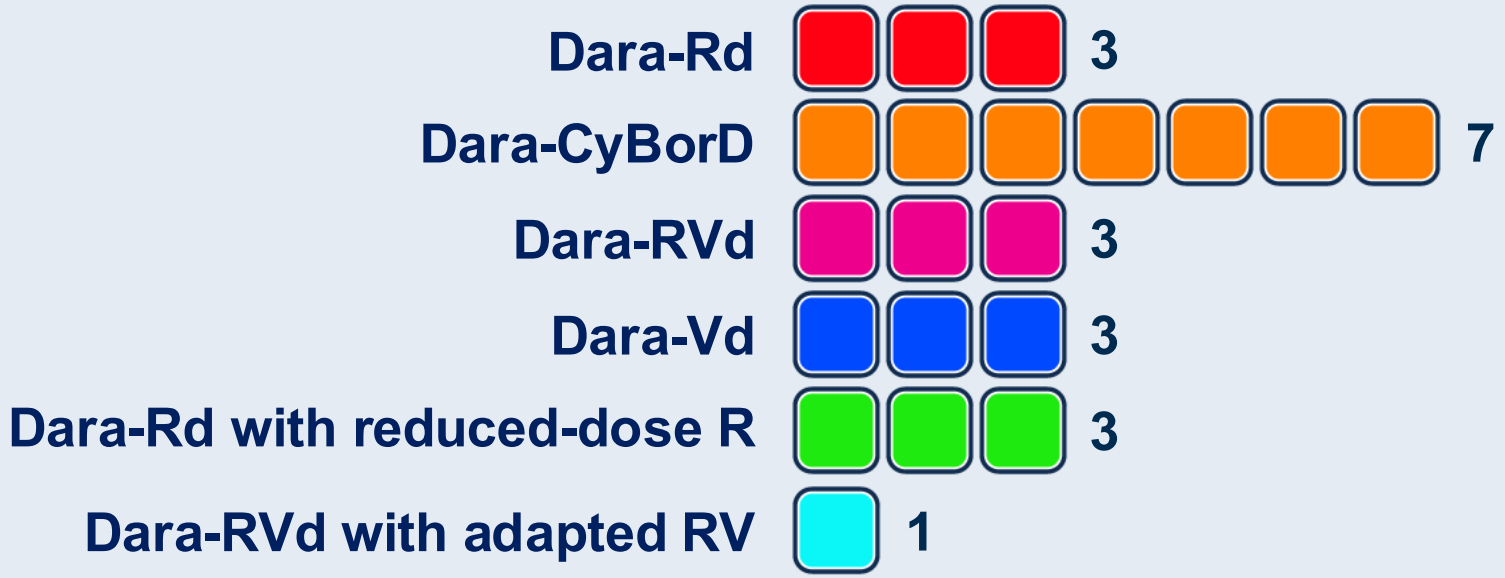
RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, what is your preferred initial regimen for an 80-year-old patient with standard-risk MM who is transplant ineligible with new-onset renal failure not requiring dialysis?



How long would you continue induction treatment?

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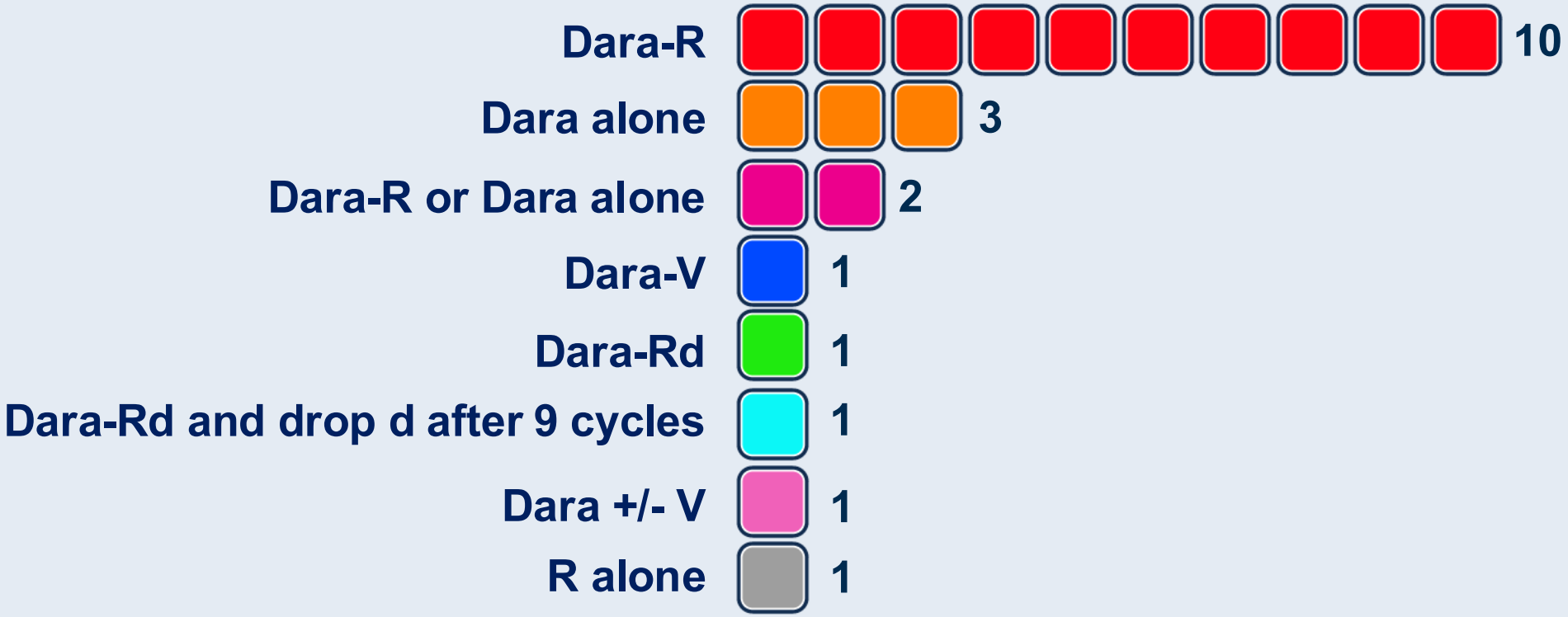
RTP RESEARCH TO PRACTICE

What maintenance therapy, if any, would you recommend, for an 80-year-old patient with standard-risk MM who was transplant ineligible with new-onset renal failure not requiring dialysis?



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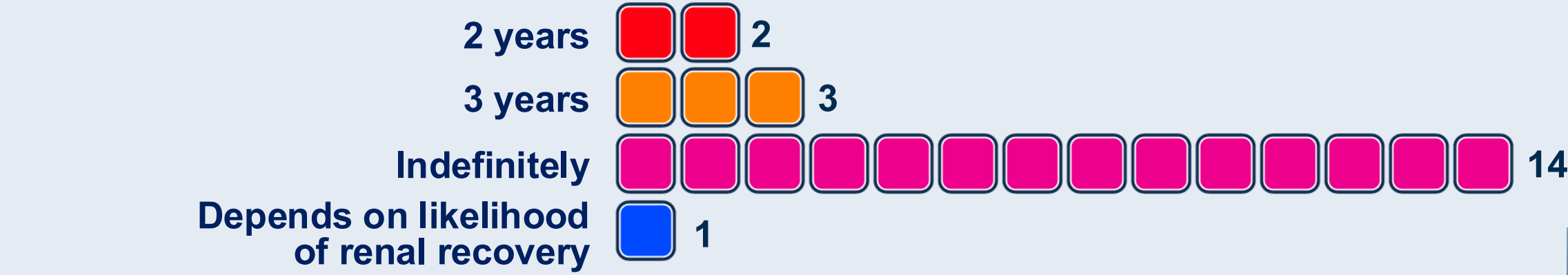

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RTP RESEARCH TO PRACTICE

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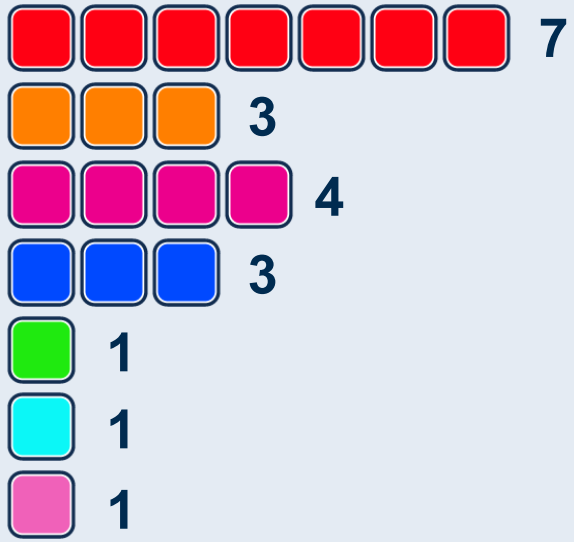

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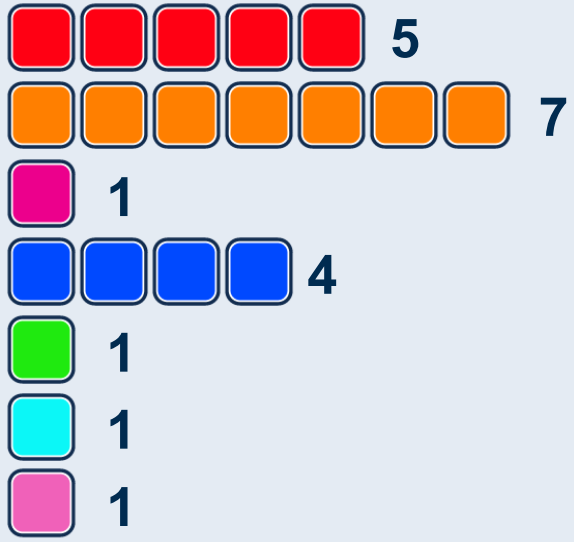

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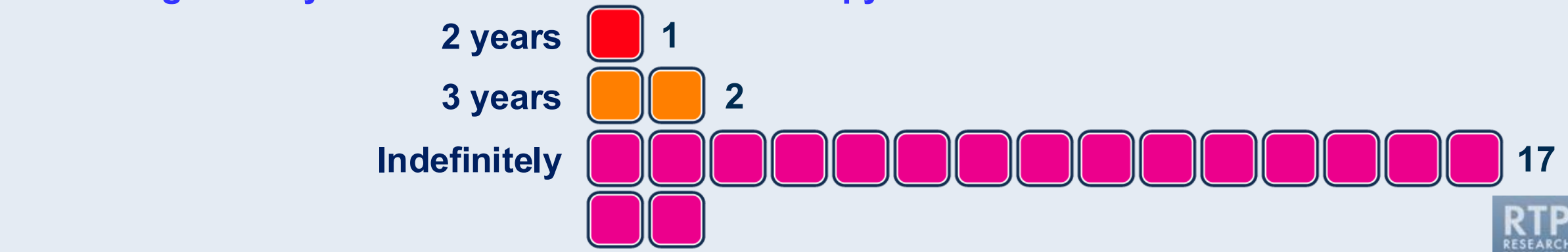

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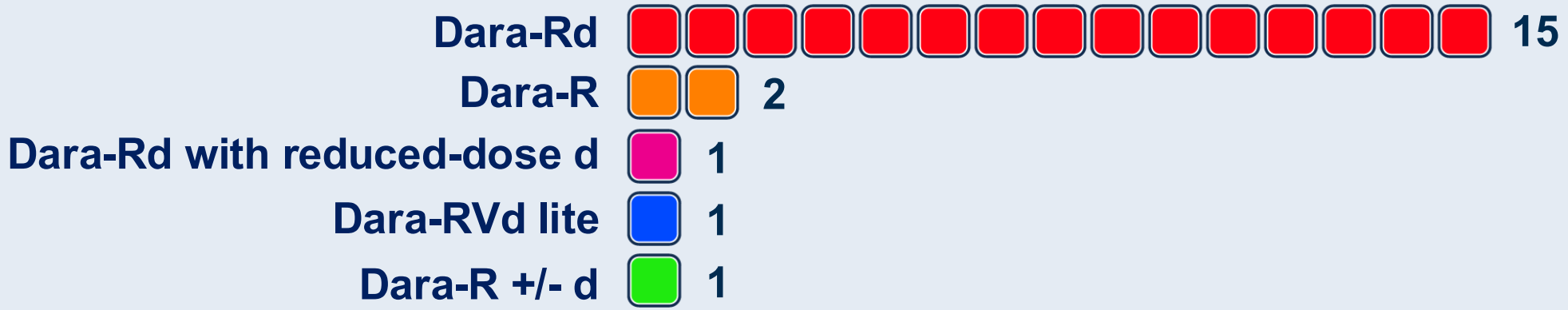

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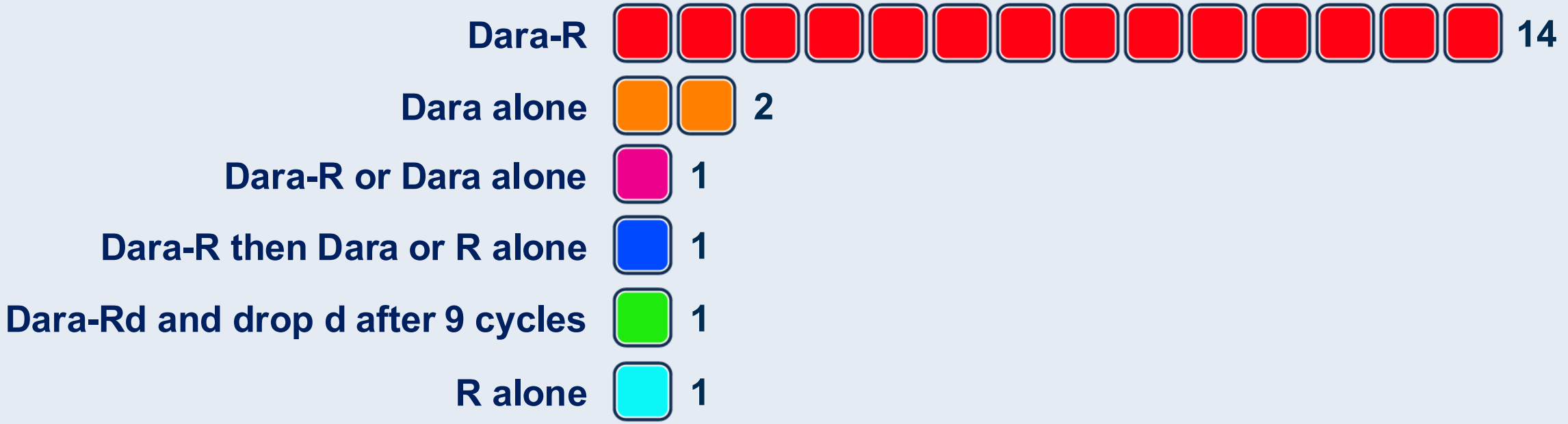

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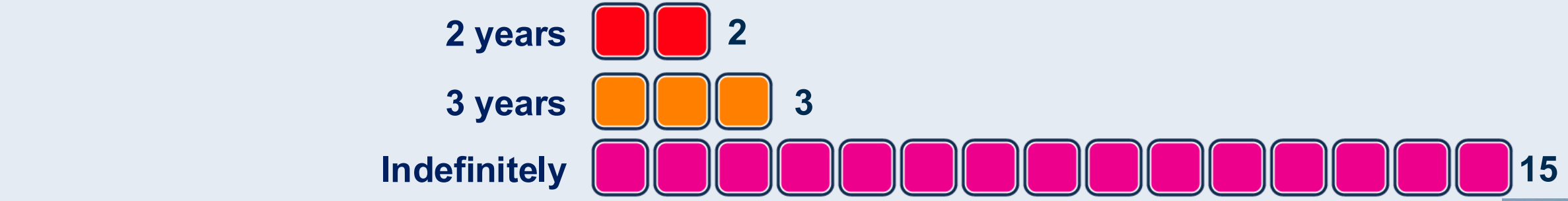

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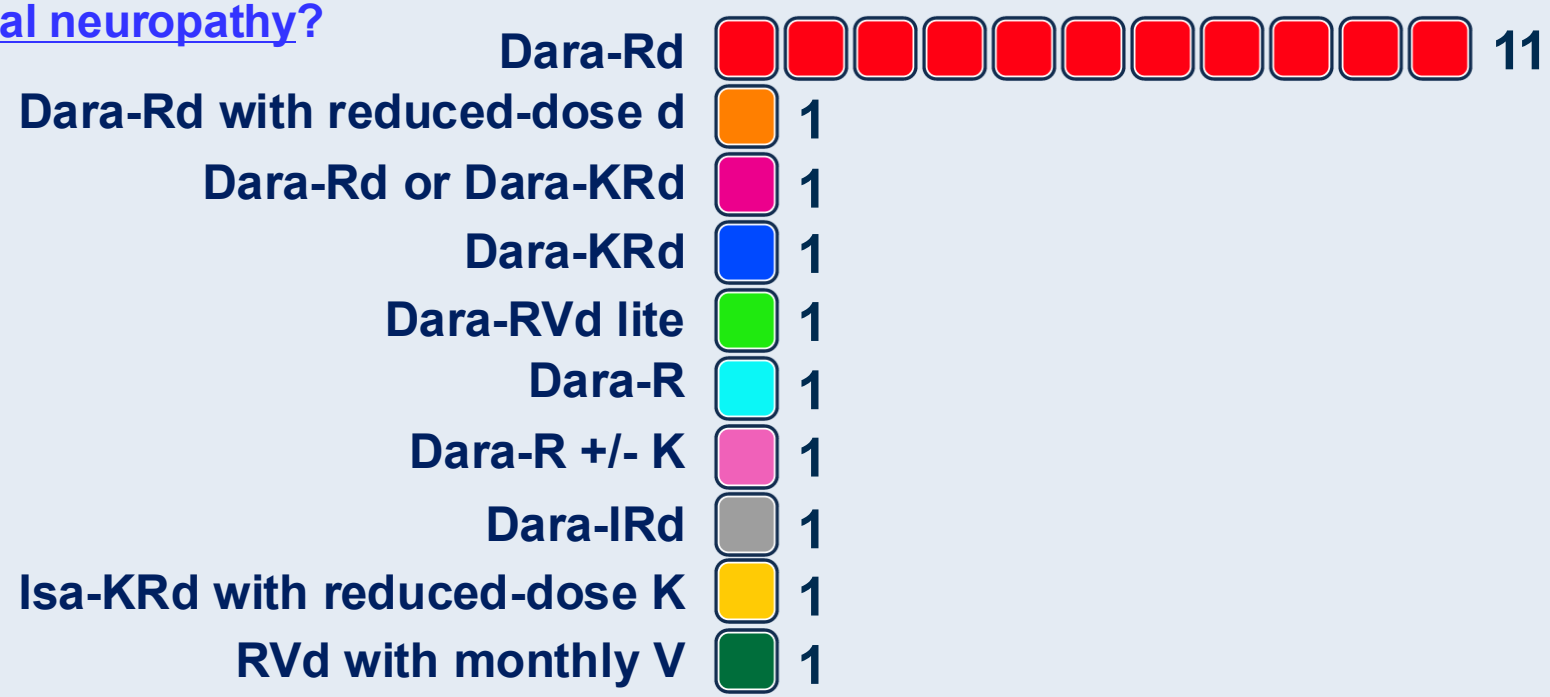

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Practical Perspectives: Experts Review Actual Cases of Patients with Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 16, 2025
5:00 PM – 6:00 PM ET

Faculty

Stephen V Liu, MD
Charles Rudin, MD, PhD

Moderator

Neil Love, MD

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Thank you for joining us!

Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us. The survey will remain open for 5 minutes after the meeting ends.

Information on how to obtain CME and ABIM MOC credit is provided in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

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