FAQs From the American Society of Clinical Oncology Annual Meeting

July 20, 2022

Transcript

Mary DeRome (MMRF): Welcome everyone, and thank you for joining us for today's session on frequently asked questions from the American Society of Clinical Oncology annual meeting. I'm Mary DeRome, senior director of medical communications and education at the Multiple Myeloma Research Foundation. I am joined today by our good friends, Dr. Ravi Vij and Ms. Angela Vickroy from the Washington University School of Medicine in St. Louis, Missouri. Thank you so much for joining us today.

We've invited them here today to answer questions from patients and caregivers about recent multiple myeloma clinical study data that was seen at this year's American Society of Clinical Oncology meeting or ASCO.

Let's get to your questions. I'm going to start with you, Dr. Vij: At ASCO this year, the long-awaited results of the DETERMINATION trial were presented. This trial tackled the question of whether patients would benefit more from having a transplant directly after induction therapy, or if it's okay for them to wait until they relapse. In your opinion, do the results of this study answer this question once and for all? Did the study tell us which patients have a better outcome?

Ravi Vij, MD: That was not the primary question that this trial set out to answer. Though there were some leads, I don't think that it conclusively gives us any answers to that question. What it does tell us is that patients who undergo a transplant compared to those who don't have a much better period of disease control—about 21 months extra compared to those that did not get a transplant.

Second, this trial tells us is that giving lenalidomide, if possible, through progression rather than for a finite period of time at the moment is still the standard of care. If minimal residual disease (MRD)-based or other test-based technology can tell us which patients to abbreviate therapy for, we may have a different answer. But for now, if possible, we should give it till time of progression.

The fact is that transplant still remains part of the treatment algorithm for patients who can undergo it, whether that's early or late. It has always been thought to provide the same benefit in terms of years of life gained. I don't think that has changed, but it does provide a greater period of disease control. Whom to do a transplant early versus late is more dependent on patient social factors and patients' preferences.

As transplanters, we usually recommend early transplant, because the duration of benefit does matter. If you get a long period in this trial, more than 5 years, 5 and a half years without need for any treatment, that leads to better quality of life, both physically and mentally. Some people have talked about using MRD as a decision-making point to decide whether to do an early transplant or not. That is not a question that this trial conclusively answered, though it did tell us that if you got to MRD negativity, your outcomes were fairly similar with transplant versus standard-of-care therapy.

Mary DeRome (MMRF): What did this study show for patients who have high-risk multiple myeloma in this scenario?

Ravi Vij, MD: Once again, the study did show that patients with high-risk disease did have benefit with transplant. In fact, the benefit was fairly substantial, with patients who underwent a transplant having about a four-plus year period of disease control compared to only about 18 months for those who did not. Now when you start parsing high-risk disease into its cytogenetic subsets, the numbers get too small to draw any conclusions, but it appeared that the patients who had t(4;14) did derive much more benefit than those who had a 17p deletion. But I would caution you that because the numbers are so small, we can't draw any definitive conclusions.

Mary DeRome (MMRF): Angela, some patients are concerned about toxicity from transplant, and they wonder if they can delay transplant if they're found to be MRD negative after induction therapy, which Dr. Vij was just talking about. Did the results of the DETERMINATION trial change the way you educate and guide patients about whether to proceed with a transplant as part of their initial treatment?

Angela Vickroy, ANP-BC, OCN: I do feel that the results of the DETERMINATION trial have continued to shape our education, so we're able to talk to patients and give them the data as a part of the decision-making process. Being someone that is more on the pro transplant side, I do work with Dr. Vij, so that shapes my opinion on the data, as well.

We do a lot of transplants in our center, and I can't deny that the initial toxicities are there. However, I also see that most patients recover within a 3-month time point, and setting that expectation up front and giving that expectation to patients—that they will have some normalcy and get back to really good quality of life after that 3-month time point—is really important. We know that the overall survival from this study was similar between the two arms, but that progression-free survival (PFS)—that time that we get without the need for more toxic or time-invasive therapies—is also present when you do have a transplant. So, having that maintenance period or that PFS period is really important in quality of life for our patients. That's an important part to talk about with our patients.

Mary DeRome (MMRF): Dr. Vij, in the oral abstract session that you moderated, there were a couple of presentations on the use of a four-drug regimen, specifically adding the monoclonal antibody Darzalex to either Revlimid/Velcade/dexamethasone or Revlimid/Kyprolis/dexamethasone.

One of the interesting problems with the DETERMINATION trial was that it was set up before four-drug regimens became more commonplace as first-line therapy. It makes the data harder to interpret based on today's common therapy. Are four-drug regimens as induction now considered to be a standard of care for all newly diagnosed myeloma patients, and does this change how you would interpret the results of the DETERMINATION trial?

Ravi Vij, MD: The use of four-drug regimens for transplant patients is an evolving standard of care.

A lot of patients are still getting three-drug induction. But as we talk more to our colleagues in the community, we are seeing that they, too, are shifting to four-drug regimens for transplant-eligible patients. The use of four-drug regimens is driven by data that is early, but coming from a number of trials— the GRIFFIN study of Revlimid, Velcade, Decadron with daratumumab; to other trials that have been combining Kyprolis, Revlimid, and Decadron with daratumumab; the MASTER study; and there have been some French data that was presented at the meeting, as well.

There is also data from other studies that seems to suggest that the depth of response—the number of patients achieving a complete remission, those achieving MRD-negative remission—is much higher when you're using four-drug regimens in conjunction with transplant.

The preponderance of the data suggests that this usually, with longer-term follow-up, leads to better long-term outcomes, PFS, and possibly survival, as well. Because those end points can take years to demonstrate, most academic physicians are of the opinion that the data is sound enough and that the demonstrated depth of response advantage does justify changing our standard of care for these patients to four-drug regimens.

Now, in the very near future, four-drug regimens may also evolve to be a possible standard of care for a lot of non–transplant eligible patients, as well, as more than one clinical trial is looking at a similar combination of drugs in non–transplant eligible patients. The standard is certainly changing.

Mary DeRome (MMRF): It'll be interesting to see how long that takes to filter down to, for example, the National Comprehensive Cancer Network (NCCN) guidelines.

Ravi Vij, MD: Well, four-drug regimens have already got what we call two-way level of evidence now on NCCN, which allows for these regimens to be reimbursed by Medicare and by most insurances. We're not seeing any pushback there. In fact, we've seen a 66-, 67-month period of disease control in mainly people who got three-drug induction. That can only be improved upon with four-drug regimens. It'll be quite a long time before we see what actual PFS figure will result from this approach. But we are already at more than 5 and a half years. If it gets to 7 or 8 years, it wouldn't be surprising.

Mary DeRome (MMRF): Let's talk about maintenance.

There was a study presented at ASCO called the Atlas study that looked at the use of maintenance therapy with either a triplet regimen of Kyprolis, Revlimid, and dexamethasone or a single-agent maintenance with just Revlimid, which is much more common. This trial that used a drug combination for maintenance sparked a lot of questions.

Dr. Vij, for patients who are currently taking Revlimid only as maintenance, would there ever be a time when they should consider adding on other agents? For example, if they begin to relapse?

Ravi Vij, MD: The Atlas study was certainly something that we saw the first data from at the ASCO meeting. This was a Polish study built on data that was initially generated by Dr. Andrzej Jakubowiak through the Multiple Myeloma Research Consortium. We had taken part in some of those initial studies of carfilzomib-lenalidomide-dexamethasone (KRd).

This is obviously building on that and adding daratumumab to the mix. Then, in maintenance, keeping the Kyprolis going like was done in the earlier studies. The use of more than lenalidomide for maintenance—we're already doing that for patients who have high-risk disease using a proteasome inhibitor. Most people still use bortezomib or Velcade in that scenario. So, that is something that could potentially be bettered by the use of Kyprolis. But the fact is that it is a drug that has to be given intravenously on a somewhat more inconvenient schedule. That's why adoption of that has been limited. Also, it is often not reimbursed by insurance.

However, the data was very encouraging. For certain patients—especially those with high-risk disease or those who have a substantial disease burden for transplant who haven't achieved a certain level of response, like a very good partial response—it is perfectly rational to give them more than one drug in maintenance.

Which of the maintenance combination strategies is going to be best? It remains an open question. We have trials that are looking at even daratumumab in combination with lenalidomide as maintenance. But in the data for high-risk disease, proteasome inhibitors certainly seem to be a better class of drugs for those patients.

Mary DeRome (MMRF): Angela, many patients struggle with side effects from Revlimid maintenance therapy. Considering that maintenance has to be taken almost indefinitely until relapse, what can you suggest to help patients with their quality of life? Also, many patients are concerned that reducing the dose of Revlimid to reduce side effects might cause them to relapse faster.

What can you tell us about those two things?

Angela Vickroy, ANP-BC, OCN: That's a frequent question that I receive from patients post-transplant receiving maintenance therapy. As with any treatment, the most important thing patients can do is discuss their side effects with their care team. We can't do anything about what we don't know about. There are options and ways to improve overall quality of life while on maintenance therapy. There are medications and interventions to help with symptoms such as Revlimid-induced diarrhea, chemotherapy-induced neutropenia, or peripheral neuropathy. Lifestyle modifications can be made to combat fatigue.

All of these things can be addressed, and we can make alterations in their maintenance regimen to help it be more tolerated, but we have to know about their symptoms to make that happen.

Dose reductions based on side effects are often necessary. I agree that dose reductions are really scary or concerning for patients, due to the fear that their myeloma may come back if they aren't given the original recommended dose. I empathize with patients regarding this; however, the data show that Revlimid is an important part of treatment, and I believe that some maintenance is better than no maintenance.

I educate patients that dose reduction allows us to keep them on therapy, whereas if we didn't reduce the dose, a patient may have to come completely off of therapy.

Mary DeRome (MMRF): Would you expect a patient who was on multiple drugs for a long period of time during maintenance that have an increased risk of side effects?

Angela Vickroy, ANP-BC, OCN: As Dr. Vij said, we often give dual maintenance therapy to many of our patients that have high-risk disease. Any time you add a drug, there is the risk for additional side effects. Additional agents could either change the side effect profile or even enhance the current effects of Revlimid.

In particular, I would say that I am most concerned with a patient's counts and monitoring those counts closely, because the risk of infection related to those counts and those risks with additional agents are higher. That is a concern and something that has to be monitored closely.

Mary DeRome (MMRF): Let's move on and talk about CAR T-cell therapies and bispecific antibodies, which were talked about quite frequently at ASCO. There were several updates. Dr. Vij, what can you tell us about the investigational CAR T-cell therapies discussed at the meeting? What are these other agents that were discussed but not yet approved? What should patients be aware of regarding them? Is there any new data presented on the two CAR Ts that were already approved, Abecma and Carvykti?

Ravi Vij, MD: As far as the new data goes, we have been hearing about a number of CAR T products in development over the years. At ASCO, there was certainly more data on some of the ones that had already been presented and some data was there for the first time. The target for CAR T therapy, the autologous CAR Ts, predominantly remains BCMA.

We have been seeing several companies trying to improve on the results of BCMA-based treatments. One group is looking at trying to use humanized CAR T to reduce the possible rejection of CAR Ts by the body. Again, the data from that trial showed close to 100% response rate, which is what Carvykti also has been showing. I can't say it has at the moment shown superiority to that data set, but the data is very preliminary and we'll have to follow it on a longer time span.

We've also seen data from a Chinese group that was looking at adding another target to BCMA in the same CAR T to try to have greater efficacy by going after two antigens on the cancer cell. Once again, very impressive results, with close to 100% response rates.

The other thing about that CAR T construct was that the time to production of the CAR T was cut down substantially. The commercialized CAR Ts–from time of collection of T cells to the infusion of T cells or the CAR T cells–is often close to a month, sometimes even longer if there were production problems.

With this, they were attempting to cut it down to a week. Anything that can be done to reduce the time frame would be important, because a lot of patients, especially in later lines of therapy, can't wait the several weeks it takes to get these CAR Ts. There is certainly hope there. Another CAR T that was presented, which is directed at another antigen, has advanced a lot of interest, and that is GPRC5D. We have bispecifics in development.

We've actually seen CAR T to GPRC5D presented by a US group at Memorial Sloan Kettering at more than one meeting. This was a Chinese group that presented about 10 patients, once again with very impressive response rates. However, again, the data is very preliminary. It is, however, very exciting that we have targets beyond BCMA that patients can benefit by even when BCMA therapies fail; we have other options that are now in development for our patients.

As regards the currently commercialized CAR T, yes, we had new data on those. We had data on using the Carvykti in early lines of treatment for patients who had less than optimal response to frontline therapy and for those who relapsed early. Once again, high rates of the response and depth of response were seen, but the data is too early to conclusively say how long a benefit will last when given to these earlier line patients; we will see in the long run.

We also saw real-world data on the use of commercial ide-cel or Abecma. That data set had close to 150 patients. One of the highlights of that data set was that the response rates and the data in terms of durability seemed to be holding up compared to what the clinical trials had demonstrated. But for the unique data, that was also a very small number of patients. What

starts to emerge with that presentation is how CAR T cells to BCMA fare in people who have been exposed to prior BCMA-based treatments.

We saw that about 25 patients had received Blenrep, and the responses were lower in patients who had a prior exposure to antibody-drug conjugate like Blenrep. There were only, I think, five patients who had a bispecific to BCMA on clinical trials. Those patients, again, did not seem to do very well with the use of CAR T. Again, small numbers of patients, so we shouldn't be reading too much into this data set, but it brings up the vital question of how to sequence these therapies when all of these are commercially available.

I don't claim to have an answer to that, but these data sets will help inform our decision-making in the future.

Mary DeRome (MMRF): Sequencing is on everybody's mind right now, because there are now so many therapies that target BCMA. Which ones to give first, and then will they actually respond, are questions for many patients. Patients also ask about being able to receive CAR T in an earlier line of therapy.

Angela, are you seeing more patients that are able to receive Abecma and Carvykti? Is the availability okay?

Angela Vickroy, ANP-BC, OCN: Access to CAR T continues to be very limited. There are restrictions on manufacturing from the companies themselves. We're allotted so many slots each month to start. In addition, we're fighting with insurance constantly to get approval for these really expensive therapies. We are continuing to work with our institution, also with insurance companies and the drug companies, to try to obtain approval quickly. But I will say that it is somewhat limited.

Mary DeRome (MMRF): Do you think it's easier for patients to get on a CAR T therapy if they actually go in through a clinical trial, as opposed to trying to get the commercially available version?

Angela Vickroy, ANP-BC, OCN: On occasion, yes, if we have a clinical trial available.

Mary DeRome (MMRF): What can you tell us about the side effects that people face when they're on bispecifics? Are they similar to what you see with patients who are on CAR T or do you have to manage them differently?

Angela Vickroy, ANP-BC, OCN: The initial complications from bispecific antibodies are really managed as an inpatient currently. As with monoclonal antibodies, patients can have reactions to the initial infusion. In the case of bispecific antibodies, this usually is a concern for cytokine release syndrome. But patients are admitted during this time, so swift interventions can be completed to help improve those symptoms.

As outpatient treatment continues on bispecific antibodies, the most significant side effect that we're experiencing is infection related. We're seeing a lot of infections and infections that are requiring hospitalizations or delays in treatment. We are adjusting how we approach this and manage patients on bispecific antibodies.

We give prophylactic antibiotics and antivirals. We're checking patients' IgG and placing patients on IVIG, which helps boost immune function.

Infection prevention is something that we are constantly discussing, similar to post-transplant. For patients on any therapy we are giving prophylactic medications and also talking about giving COVID vaccines, antibody prophylaxis, and urging those interventions amongst our patients. One of the bispecific antibodies that we have on clinical trial, it's not currently approved, is talquetamab. This also has stressed the importance of nutrition in addressing nutritional needs amongst our patients with this specific therapy.

Mary DeRome (MMRF): Why that specific one for nutrition?

Angela Vickroy, ANP-BC, OCN: Patients have a side effect where they have difficulty eating. The taste is off. It's called dysgeusia, and it can cause patients to really need a focus on nutritional care to help them through the therapy.

Mary DeRome (MMRF): Are there any other specific side effects for talquetamab? Something having to do with like skin and nail toxicity?

Angela Vickroy, ANP-BC, OCN: Talquetamab also has skin and nail toxicity. I have not seen as much of that as I have with the decreased taste issue. Although I don't believe that has been seen or mentioned a lot in the data.

You asked also if patients that are getting CAR T-cell therapy are managed similarly, and that is true. We are managing these patients similarly to those that are on bispecific antibodies by using prophylactic antibiotics and antivirals, and IVIG has really been a common intervention that we're using with patients to help boost their own immune system. We are recommending COVID vaccines and Evusheld or antibody prophylaxis as well.

Mary DeRome (MMRF): We've talked about Blenrep,* which is an antibody–drug conjugate. Dr. Vij, can you remind us what Blenrep is, how it works, what it's approved for, and tell us something about the combination studies that we saw at ASCO and about which ones seemed to be the most helpful.

Ravi Vij, MD: Blenrep is a drug that's been on the market for now nearly a year and a half or longer. It has activity in patients who are triple-class refractory whose disease has progressed on proteasome inhibitors, immunomodulatory drugs, and C38 antibodies. Roughly about 25% to 30% of patients have responded as a single agent. The downside of the drug has been the ocular toxicity, which is keratitis, and that leads in some patients to blurring of vision.

The good thing is that it is always transient and can be restored by holding or dose reducing the drug. That is not a permanent problem, but people can have a fair amount of quality-of-life deficits by not being able to read, watch television, or drive. We have made several attempts in clinical trials to reduce the toxicity. Several of them are ongoing.

Giving the drug less frequently may help. We'll have to see. One of the reasons to go into combinations has been both to increase the efficacy and to potentially reduce the toxicity by lowering the dose of the drug, but making up for the efficacy by a combination therapy approach.

*Blenrep was withdrawn from the US market in November 2022. Health care providers can continue to enroll patients in Blenrep clinical trials.

There were several trials presented at this meeting and even at earlier meetings combining Blenrep with a variety of different molecules. The one that got pressed at this meeting, which was presented for the first time, was using it in combination with gamma secretase inhibitor (GSI). That is theoretically likely to improve the efficacy, because it reduces the chances that the BCMA molecule on the cancer cell breaks off from the cancer cell and goes into circulation. By keeping more of the target on the cancer cell, you can be potentially more efficacious. Doing so hopefully can reduce the dose of the Blenrep than is currently used as a single agent.

What we saw was, yes, we were able, with the lower dose, to reduce the toxicity, so that in some way was a successful experience. But it also, with the reduction in toxicity, seemed to reduce the efficacy and didn't seem to be any more effective than single-agent Blenrep. Going forward, it is hoped that adding a third drug to that combination may provide the efficacy boost and the lower toxicity that has been seen with the combination, because a Blenrep dose that has been reduced may be an advantage.

Other combinations of Blenrep that have been studied are combinations with immunomodulatory drugs. In the Algonquin study, which has been presented before, they combined it with pomalidomide with very encouraging results, up to 90% response rates in a highly refractory population.

We saw data in combination with lenalidomide at this meeting, which was also very encouraging. There are other combinations that have been studied in combination with bortezomib. We have seen some preliminary data for that combination. There was a data set combining Blenrep with pembrolizumab, which is a drug that is not approved for myeloma but is used extensively in solid tumors.

That data set, again, I can't say conclusively was something that is going to lead to the combination potentially becoming clinically utilized in the future. But as you indicated, there are several of these combinations that are being explored with Blenrep to hopefully provide greater efficacy and some to actually reduce the toxicity.

Mary DeRome (MMRF): Angela, what should patients know about the ocular toxicity that's associated with Blenrep?

Angela Vickroy, ANP-BC, OCN: Dr. Vij touched on this. Ocular toxicity is very common, and one thing patients should be aware of is that they will have lots of visits with ophthalmology. Setting that expectation right away is important. Patients have to see ophthalmology before each cycle. The cycles traditionally should be given every 3 weeks. So, that's an additional visit to the institution for the ophthalmology appointment. We have given this at less-frequent intervals due to the side effect of ocular toxicity.

Something patients should expect is holds or delays in therapy due to the toxicity, because it is so common. But despite those holds and delays, patients can often sustain their response if they are able to go back to get another dose. That is somewhat encouraging, although we'll probably need a combination, as you just discussed.

Mary DeRome (MMRF): I want to go back to bispecifics. Dr. Vij, we had a number of talks on the three main bispecifics that are in trials right now, teclistamab, elranatamab, and talquetamab. What are the differences between these agents, and what can you tell us about if and when any of these are going to be approved?

Ravi Vij, MD: Bispecifics are a very exciting group of drugs and are at the moment highly talked about. Bispecifics target more than one different protein on the cancer cell. The vast majority of the bispecifics, nearly six, are being used to target BCMA, the same antigen on the cancer cell that Blenrep and the currently commercialized CAR Ts target.
In that regard, data was presented on teclistamab, which showed—like all the other bispecifics to BCMA—that approximately two thirds or more patients respond and about one third of patients achieve a complete response in a highly refractory population. To put that in context, a few years ago, if we could get that response in patients who had newly diagnosed myeloma, we would've been happy.

Here we are talking about people who've been through nearly 10 years of therapy often having the same response. This is really exciting. The data also seems to suggest that these responses can be long-lived. We don't have mature data, but data from the teclistamab experience suggested that, after nearly a year and a half on average, patients are not progressing.

That is the first data set we've had on a bispecific regarding durability. A subset of those patients had already received CAR T cells, and some of them had Blenrep. Though the responses were lower, they still were fairly respectable and durable for patients who got BCMA-directed bispecific teclistamab after having high prior exposure to a BCMA-based treatment. There are others in development. The drug that we just talked about, teclistamab, if all goes well may be FDA approved as early as August this year, which would be very exciting for our patients. The other one that you mentioned, elranatamab, is also directed to BCMA. That one has not yet received FDA approval—it hasn't even, I don't think, been filed yet. We don't know when it will come. I hope that it will be available sometime next year.

All of these BCMA-directed therapies, the bispecifics namely, have fairly similar response rates. They have fairly similar toxicity profiles. As Angela said, they have to at the moment be given in the hospital for the first few doses when CRS occurs. But we will have to see post-marketing, whether that requirement persists.

We still don't know how easily these can be administered for the first few doses in the community, whether the first few doses may have to be given in a larger academic center because the management of CRS—usually grade 1 or 2—still requires expertise, with special drugs like tocilizumab needing to be administered.

The other one that you mentioned, talquetamab, is to a slightly different antigen, as Angela alluded to. This is one that is directed to GPRC5D. This is an antigen, again, that is present on the myeloma cell, but also present on the tongue. Therefore, the issue with this dysgeusia that she described, which has become more noticeable as higher doses of the drug have been now studied in a larger number of patients. Earlier, the focus had been on nail and the skin toxicity. That still remains a focus. But more and more people are focused on the fact that patients lose their sense of taste, and there have been patients who have had fairly significant weight loss. The good thing seems to be that this drug does have a fairly robust activity like we've seen with the BCMA bispecifics, with two thirds of patients responding.

Perhaps, if you can back off the drug after the initial period of response with the lower dose or treatment breaks, we can keep the dysgeusia issue under good control. We'll have to see. It's too early in its development to be sure about how the story will unfold, but it's clearly an active drug.

We also have another agent that targets FCRH5, cevostamab, that was the subject of a couple of posters at this meeting. That target, too, FCRH5, has shown robust activity in clinical trials—again, about two thirds of patients responding and, like with talquetamab, even patients who have had BCMA-based treatments have responded similarly. It is very exciting.
This era of bispecifics also will allow for more prompt initiation of treatment, because they're what we call off-the-shelf treatments that don't require waiting for several weeks to get the product prepared. As Angela was alluding to, insurance companies are increasingly denying access to these drugs. It's sad, but because of the cost, there are greater barriers that are being put up by insurance carriers to be able to access these.

Mary DeRome (MMRF): My final question to you both is, what, if anything, will you do differently based on what you've heard from the data that was presented at ASCO this year? What study data will you be hanging on the edge of your seat to see at the International Myeloma Society meeting at the end of August?

Dr. Vij, I'll let you answer first.

Ravi Vij, MD: As far as what we'll be doing differently, we will be certainly using the data set that we have to first see if we can sequence our therapies better. We have started to see data on multiple modalities of tackling BCMA and how these may impact treatment outcomes.
With BCMA-based treatments, if we can avoid it for a BCMA CAR T–eligible patient, we would like to see if we can avoid exposure to another BCMA-based treatment before getting CAR T. But, again, we know that because of the short supply, that doesn't mean that we should not use these drugs. These drugs, even the non–CAR T-cell therapies, especially when bispecifics, become available are going to be very active drugs. That is one takeaway.

The data from the plenary session, from the DETERMINATION study that we discussed, will once again reaffirm that transplant is part of the treatment paradigm, but that in certain patients delaying it to first progression may be an acceptable alternative if there are mitigating factors that prevent you from exercising it during your first line of therapy. Obviously, we will be utilizing the data when these newer drugs get commercialized to be able to manage our patients with bispecifics. In perhaps just a few weeks' time, we'll be utilizing this data in patient management.
What are we going to be waiting to see in International Myeloma Society? The International Myeloma Society is a very exciting forum with not only emphasis on clinical data, which ASCO is mainly focused on, but also a lot of discussion on the science of myeloma, why certain drugs work, why they don't work. There is going to be a robust discussion of new mechanisms of resistance and hopefully new ways to overcome resistance. The meeting is something that will, not perhaps have anything that we haven't known before, but we will have, I think, updates on some of the abstracts, and the meeting will give us longer-term follow up on some of these studies that we have seen before. It's going to be an exciting meeting.

Mary DeRome (MMRF): Angela, can you tell us if your day-to-day has changed from what you've heard coming out of ASCO?

Angela Vickroy, ANP-BC, OCN: As always, I usually come away from these meetings and the data from this meeting or these meetings with a lot of hope. I'm definitely the more touchy-feely one in the practice, and I find valuable anything that I can use to help educate my patients regarding the outcomes of the trials or hope for treatments that are soon to be available. I definitely think that I'll be using a lot of this data and having a lot of these discussions in clinic.

As for what I'm excited about in the future, I won't be at the meeting, but I am excited to see more data and hopefully more about bispecific antibodies, because they are very exciting and going to be huge game changers for our patients. Along with hopefully more access to CAR T, as well.

Mary DeRome (MMRF): We can leave with that thought. Thank you so much for your work on behalf of our patients. Thank you for joining me today.