

National Comprehensive Cancer Network Fireside Chat

November 8, 2022

Transcript

Veronica Bohorquez: Thank you for joining us for today's Fireside Chat. I'm Veronica Bohorquez, manager of education at the Multiple Myeloma Research Foundation. Today, we are reviewing updates from the National Comprehensive Cancer Network's (NCCN's) Hematologic Malignancies 2022 Annual Conference. This meeting brings together nurses, pharmacists, and other oncology professionals from across the country along with world-renowned experts who present and discuss clinical topics on hematologic cancers including multiple myeloma. I'm very excited to be joined by our Patient Navigation Center nurses, Grace Allison and Erin Mensching, who attended many of the sessions and will summarize key points about myeloma that they've learned.

When patients are first diagnosed with multiple myeloma, there is a lot of information to take in and a lot of considerations when it comes to treatment. Dr. Raje presented on the various treatment options available for newly diagnosed multiple myeloma.

Erin, what was a key takeaway message for patients and their caregivers?

Erin Mensching: Dr. Kumar and Dr. Raje shared that it is important to use the best drugs first, to achieve a deep, durable response. The standard is typically to use a triplet or a quadruplet, a combination of three or four drugs. These combinations are usually made up of a proteasome inhibitor, an immunomodulator, and a steroid. These drugs work synergistically. Another point was to consider clinical trials. Whether or not this may be right for a newly diagnosed patient is up to a patient to discuss with their doctor.

Yet another point was that a doctor typically looks at a patient holistically. They look at whether the patient has impaired kidney function, whether their labs are very high, and what stage they are at. The doctor also considers what kind of symptoms the patient is having. It is important to consider all of these.

Grace Allison: That's a great point that you made, that there is no one size that fits all, that the doctor is treating the patient, not a disease. So, there's no way of saying there's an absolute approach.

But there is a standard, as you said. Initially, when somebody is diagnosed, they have a conversation about whether the patient is transplant eligible or not. That tends to inform their next steps. If a patient is transplant eligible, we generally see them use four to six cycles of therapy and then they move to harvesting stem cells. And then there is a discussion on the timing of the transplant.

And if a patient is not transplant eligible, they will use a drug induction, more medication, to induce a response. And then they will discuss what they will use going forward, once they've reached that maximum response.

They also talked about what makes a patient transplant eligible. The decision is not strictly age related. It's other conditions that the patient may be having. Maybe it's a cardiac condition, maybe renal disease, something like that. There's also the patient's preference to consider. Many things go into the decision about whether or not to move forward with stem cell transplant.

Veronica Bohorquez: What are some things that patients who are considering a transplant, or who have undergone transplant, need to consider?

Grace Allison: One of the sessions discussed revaccination for patients following transplant. This might be something that patients are not aware of. Following stem cell transplant, the patient's immune system has been reset.

They may have lost their prior protection from infection, including the protection that they got from childhood vaccinations. There is no standard approach, but the major stem cell transplant centers have their own individual protocols. Some places revaccinate with childhood vaccinations after six months. Some wait a year. They don't always draw levels to see if there's any residual immunity left from those vaccines; they just go ahead and revaccinate for safety. And the most common vaccine that patients go to, following transplant, is the COVID-19 vaccination.

Physicians want to get that protection in place as soon as possible. That might not be six months or a year; it might be closer to the transplant itself that they offer that vaccination.

Another session was talking about sepsis, and it reminded us that as we talk to our patients, it's really important to mention that there are basic things that we can do to protect ourselves from infection, including hand washing. This means washing with soap and water when you can and with alcohol when you can't. Using alcohol on the skin should be less common than washing with soap and water, because the skin is one of the major protections against infection for patients, and alcohol dries out the skin and increases the risk of it breaking. Keeping the skin intact and moisturized, avoiding large crowds of people, asking friends and relatives not to visit if they have a cold or flu, and wearing a mask (if instructed to) are important right after transplant or any cell therapy.

There was also a session that talked about the fact that some patients, after stem cell transplant, have no immunoglobulins. If the doctor finds that to be the case, they may recommend an infusion of immunoglobulins, especially during the winter months, when viral illness is more commonplace. That will be given, if needed, once a month.

Veronica Bohorquez: What side effects do newly diagnosed multiple myeloma patients need to consider?

Erin Mensching: One session talked about the cardiotoxic effects of some therapies. The main point was that any time a patient experiences something like shortness of breath, swelling of the lower extremities, dizziness, or blood pressure changes, they should report them right away and not wait even a day or two. These side effects need to be reported right away. Also, some therapies will require an EKG to be done beforehand.

For a newly diagnosed patient, it's a good idea to ask their doctor what kind of testing they want to do before starting these therapies.

Veronica Bohorquez: So, patients should be very aware of symptoms as they come up?

Erin Mensching: Yes.

Veronica Bohorquez: When we talk about side effects, should we discuss where palliative care fits in? Can you first discuss, perhaps, what it is and when multiple myeloma patients and caregivers should start to think about it?

Erin Mensching: Palliative care focuses on providing relief from pain and other symptoms like nausea or loss of appetite. These are the side effects that can come alongside a serious illness, and the palliative care approach looks at focusing on these medical aspects, but also looks at helping a patient from a social, emotional, and spiritual component as well.

And hospice is defined as having six months or less to live. If this discussion is had with a patient's doctor, they should try to get their affairs in order and to understand the differences between the two. One thing I should mention is that palliative care does include a period of treatment. So, treatment can continue, but it's more of a supportive method. And this is done by asking your doctor about a consult to a palliative care team.

Veronica Bohorquez: We've covered a bit of information already. Before we change topics, what are one or two questions that newly diagnosed patients should ask their doctor?

Erin Mensching: Two questions to ask are, "What type of myeloma do I have?" and "What did you learn from my lab values?" Because myeloma could look very different for everybody, and it is important to understand the heavy- and the light-chain aspects of the disease.

Another point is that any patient who is newly diagnosed will have had a bone marrow biopsy. From that, a doctor would learn about a patient's cytogenetics. So it's important to ask, "What did you learn from my cytogenetic report?" Another question to ask is,

“Am I high risk or standard risk?” Because this can change the treatment approach; instead of a three-drug therapy, it could possibly be a four-drug combination.

Veronica Bohorquez: Excellent. Thank you. Grace, do you have anything to add?

Grace Allison: Most patients know what they want to ask. But one thing we suggest that people ask is what kind of therapy is the physician suggesting and how long they’re going to be on that treatment. Generally, they’re given an idea of how long the physician is going to give them the treatment. Another question that’s good to ask is, “How will you measure my response to this treatment?”

Generally, we see physicians do complete blood counts (CBCs) and chemistry once a week, and generally, specialists will check the myeloma markers or myeloma labs once a month just to see how things are going and what kind of response they’re getting. Those are good questions that we suggest patients ask. And, of course, we encourage patients to ask, “What kind of side effects should I expect and how should I communicate with you if I am having side effects? How do I get in touch with you?”

There are different methods. Some patients are able to communicate with their physicians through their patient portal. But we hear that at most centers, a physician will give their dedicated phone line to their patients so that they can communicate with them about side effects and the patient does not think this is just something they have to put up with. A lot of times, if the physician is able to intervene earlier and manage those symptoms, potentially that will mean that the patient can stay on that therapy longer and get the benefit from it.

Veronica Bohorquez: Certainly, questions identifying what type of myeloma one may have, identifying if it is high risk or standard risk, and then asking about side effects as well and keeping those lines of communication open between the patient and their doctor.

Let’s shift gears to relapsed and refractory myeloma. For patients whose disease did not respond to treatment or whose disease came back after initially responding, the news may be overwhelming and treatment options change. Grace, what do we tell a patient who has had a relapse?

Grace Allison: Well, Veronica, what we heard them discuss was the various types of relapse and what these look like.

I’m sure it is nerve racking for patients and their family members to be watching. Say a patient has had their initial line of therapy, which may include stem cell transplant, and then they are on a maintenance medication. And those follow-up labs start to show some changes in the blood tests. There may be what they call a biochemical relapse, which is when markers will start to show that there’s some activity before a patient feels any symptoms. A physician mentioned, in one of the sessions, that it’s not always necessary to jump on that straight away. There can be a time when they’re just

watching things. And I'm sure that's very nerve racking for the patients, but they're just watching things to see when is the appropriate time to step in. So, always have that ongoing, open conversation.

So, a relapse can be like that, or a relapse can be more overt, more obvious. And the physician at that point will determine what their next steps will be, which would include what are the next drugs that they're going to use. Because we know that multiple myeloma is a disease of relapse and remission. It's a chronic condition. So we expect to see some relapse, but we also know that there are therapies that they can use, and they made that very clear. There are therapies that they can use to bring the patient back into a remission or a response phase.

In one session, Dr. Kumar also stated that one of the most relevant features to watch for in a patient with high-risk multiple myeloma is an early relapse following stem cell transplant. That could be anytime within the first year following the transplant.

Veronica Bohorquez: Erin, when the clinician does decide to change therapy for a relapsed or refractory patient, what are some things that the clinician may consider? And, do additional therapies get added to the mix for consideration?

Erin Mensching: That's a good question. First, I feel like it's important to define what refractory means. Because we get questions about this all the time: "Am I refractory to this drug? Or am I refractory to this line of therapy?" So, refractory means that your myeloma doesn't improve with treatment or that it's no longer responsive to the treatment. Dr. Kumar did state that it's important to look at the type of response from induction therapy, that initial line of therapy. Because they will often go back to one particular drug in that initial line of therapy or a similar drug in the class. So, like for an immunomodulatory drug (IMiD), there's Revlimid, but then also Pomalyst can be used later. It's the same drug class, but it may be effective in the second or third line of therapy.

Another point that Dr. Kumar made was that there are different lines of therapy, and so they will consider whether this is the second or third line of therapy and the type of drug class within that line of therapy.

Dr. Kumar also stated that it's important to think about clinical trials. For relapsed/refractory myeloma patients, there are many, many clinical trials available. So, this is a good time for a patient to ask their doctor, "Are there trials at this particular center? What trial is right for me?" And also understand that there are eligibility criteria for each trial, so they will look at the eligibility criteria. And they will do what's called a screening.

So, there are many treatment options that are available.

Most often, these immunotherapies are approved for patients who have had four lines of therapy or more, and these would be bispecific antibodies. There are many in clinical

trials, but there was one that was recently approved just last week. And then there is an antibody drug-conjugate that has been approved. And also, too, CAR T-cell therapies that have been approved just in the past year or more. And then clinical trials do have a variation of these different immunotherapies and more, so this is a good time for a patient to ask their doctor about which trial or which immunotherapy could be right for them if they have relapsed.

Veronica Bohorquez: Grace, treatment options have really expanded, which is good news for patients. Can you discuss the side effects or toxicities of some of these newer immunotherapies? What do patients need to know?

Grace Allison: That's a good question. As Erin said, there are two new CAR T-cell therapies available, approved for multiple myeloma, and a bispecific.

And those immunotherapies have some similarities in terms of side effects to watch out for. The most common one that we have heard discussed is cytokine release syndrome. That can present with fever, chills, shortness of breath, and low oxygen levels. And as with every side effect, physicians grade these. So, you can have a low grade: you may have just a little fever and nothing else. But it can go to grade four. The good news is that there are drugs that physicians have to manage cytokine release syndrome.

And there's also a type of neurotoxicity, where the patients could experience things like headache. That is on the "monitoring" end of the spectrum. It can go all the way through to confusion and patients having difficulty communicating.

And a lot of the times, with these therapies, these side effects can be short lived. But they have to be managed appropriately, and so the monitoring is ongoing. Also, we want to remind patients that they can be confident that they'll be well looked after, because the FDA has put in place "risk management strategies." So, there are protocols in place to guide the care team if a patient is having symptoms. But that's why, with these particular approaches, like CAR T-cell therapy, a caregiver is very important, because they may be able to recognize alterations in a patient's thought process before the patient would. You need that extra pair of eyes and a way of communicating with the physician afterwards.

So, those are the side effects that are most watched for. The other thing to mention is, after these therapies, a patient can have low blood counts for longer than they would, for example, after a stem cell transplant. Having a low white count, in particular, will put a patient at a high risk of contracting infections. So, again, the physician has ways to approach that; they may use what they call "prophylactic therapies," which are preventative. You could have an antibiotic, an antiviral medication, and an antifungal. Generally, you'll see physicians use all of those types of medications to protect the patient.

And then after the basics, they're going to be watching for any signs like fever. Any time a patient has a high fever, the physician is going to investigate that. They may do a workup to see if there is any infection present and intervene appropriately.

Veronica Bohorquez: Erin, with all the new treatment options, what are some take-away messages for patients about optimal combinations and treatment sequencing?

Erin Mensching: One reminder that we learned from Dr. Kumar is to use the most effective combinations of drugs up front. The earlier the patient can have a deep response, the better. He did mention that it was important to treat to the very maximum effect, rather than switching lines of therapy. It is a balance of side effects and effectiveness, but it really is important to treat to the very maximum effect before switching lines of therapy.

Also, it's important to note that the NCCN has really wonderful patient guidelines. They have a booklet that's approximately 70 pages long, but it's really helpful; it goes over all the different side effects and the treatment plans. They also have an immunotherapy side effects guideline, so I wanted to mention that.

Grace Allison: Yes, patients can ask for it to be sent to them, or they can download it online. But they are really useful resources, especially when someone's starting out on something such as a CAR T-cell therapy. We're glad to have those as the resource for our patients.

Veronica Bohorquez: Erin, my last question here is what are some questions that patients with relapsed/refractory myeloma should ask their doctor?

Erin Mensching: One question to ask would be, "What treatment options are available to me and why do you feel, as my doctor, that this particular option would be best for me?" It's always good to ask the question "Why?" so that there's a deeper understanding. Another question would be, "Should I consider clinical trials? Which would be most appropriate for me?"

And this again is a discussion just between the patient and the health care provider who understands the patient and the prior lines of therapy and their past medical history and their co-morbidities. So to ask if this is right for me and when to consider this.

Grace Allison: We'd like to mention, too, that we are happy that the MMRF has us here at the Patient Navigation Center. A lot of times, patients just want to talk out their options and get a deeper understanding of what these drugs are and what type of side effects to expect, so they can have that good, informed discussion with their physicians. So, we're very happy to be here and to be a sounding board.

Veronica Bohorquez: So, some concluding thoughts here, is there anything else you will be talking to patients about based on what you learned at the meeting?

Grace Allison: In our approach with myeloma patients, we use the NCCN and their resources quite a bit. They're very reputable, and they're very reliable, and they're up to date because they convene regularly and they update. What we're seeing in multiple myeloma care is that treatment options are expanding very rapidly, and you have to have an organization that's up to date. And that is what we rely on the NCCN to be. They are able to bring us the most up to date and reliable information that we can then use to guide our patients.

Veronica Bohorquez: Erin?

Erin Mensching: Just a reminder that we are here to empower patients. Not only patients, but also their caregivers. We are determined to provide the most reputable resources. So, whether it's the NCCN or the National Institutes of Health, we make sure that the information that we provide is the most empowering, the most up to date, and accurate.

Another point to add is that not everybody is ready to learn about this disease. So, just take it in stages. First, learn what myeloma is, maybe, and then, maybe a few weeks later, learn what treatment options. Because it's challenging to take it all in at one time.

Veronica Bohorquez: Thank you, Erin and Grace. In summary, it's important that patients are aware of being able to use the most effective drug combinations up front and to be hyperaware of side effects as they're ongoing with their therapies. And be aware that relapsed/refractory therapies are evolving over time, so it's important that patients can utilize the Patient Navigating Center for questions surrounding any of these pieces as they're navigating their disease. I'd like to thank Grace and Erin for joining me today to share their insights from this meeting.

I'd also like to thank Adaptive Biotechnologies, BMS, Janssen, and GSK for sponsoring these updates. If you have additional questions about what you heard today, you could speak directly with Grace or Erin by calling our MMRF Patient Navigation Center at 1-888-841-6673.