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Delivering Change: Mechanisms to Address Racial Healthcare Disparities in Multiple Myeloma

Announcer:

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Dr. Mikhael:

Multiple myeloma is the most common hematologic malignancy in African Americans. Are you aware of the fact that there are tremendous disparities between Black and White Americans with multiple myeloma? Are you aware of the strategies that we are taking to try and reduce these disparities?

This is CME on ReachMD, and my name is Dr. Joseph Mikhael.

Dr. Blue:

And I'm Dr. Brandon Blue.

Dr. Hartley-Brown:

And I'm Dr. Monique Hartley-Brown.

Dr. Mikhael:

To start things off, and to level set a little bit, let's think about some of the key facts that are guiding us as we deal with these health disparities in multiple myeloma in the African American population. First of all, it's important for us to recognize not only did I note that it is the most common hematologic malignancy in patients of African descent, but the incidence is actually twice as high in African Americans when compared to White Americans. So the incidence is higher.

The second important fact is that the diagnosis is made at a considerably younger age, roughly 4 to 5 years younger than White Americans. Indeed, Hispanic Americans actually are diagnosed at even yet approximately a year younger than African Americans.

The third important fact is that there is a difference in biology between patients of African American descent and those who are not. Typically patients of African American descent have less aggressive myeloma overall, meaning they have a greater incidence of translocation t(11;14), which we know to be a lower-risk feature, and they have a reduced incidence of the p53 deletion or mutations in the p53 gene, which we know is a higher-risk phenomenon.

The fourth and perhaps most dramatic fact I want to share with you is that a Black man with myeloma will have half the survival of a White man with myeloma. And the same is true of a Black woman with myeloma will have half the survival of a White woman with myeloma. That is, sadly, the greatest disparity in survival and outcomes. However, fact number 5 gives us hope. And that fact is that when given equal access to therapies, as we've witnessed in things like the VA system, we know that African Americans can have as good if not superior survival with multiple myeloma. So to me, this even widens the disparity all the more, because survival should be better, let alone half that of White patients.

So as we think a little bit about these facts, I wonder, Monique, if you have something else to add, as we think through these health disparities together.

Dr. Hartley-Brown:

I do. I would like to add that the precursor conditions are also much more prevalent in the African American population. And we really want to think about the fact that not only is, as you mentioned, the disease, the active disease outcomes poorer, but the early onset, the age of onset, the precursor conditions that lead up to multiple myeloma are much more prevalent.

Dr. Mikhael:

Dr. Blue, let's turn now and think a bit about the disparity itself and how many things, as we indicated, guide this disparity and are sadly what we see in real life. And I wonder if you can share with us, Brandon, a little bit about that disparity.

Dr. Blue:

Yeah, so typically, when I think about the disparity, I kind of break it up into multiple ways, 2 different kind of buckets of problems that we have. The number one problem is, is that there is a disparity for all people with multiple myeloma when it comes to actually getting the diagnosis correct. There's some literature that shows that a lot of people who actually have multiple myeloma actually go to their primary care or family doctor 2 to 3 times before the diagnosis is actually even made. So there's multiple opportunities to actually detect the disease, but because symptoms of multiple myeloma are things that, unfortunately, are so common that, unfortunately, the delay in diagnosis is there. So that's, I would say, the number one thing that does happen. But again, that is universal. However, I will say that in the African American community, this delay in diagnosis is exacerbated. Because unfortunately, in the African American community, we have what they call comorbidities. And what that means is that we just have extra diagnoses that could make the diagnosis a little bit trickier. Things such as high blood pressure, things such as diabetes, all these things can affect some of the same organs that multiple myeloma can affect. So unfortunately, that just leads to us having a delay in diagnosis that's even more exacerbated because of those comorbidities.

The second thing that I'll say is that when it comes to the actual treatment, meaning that once you actually have the diagnosis, there is some disparities that we can find out that actually can happen with the treatment. Meaning that, typically, when we try to kill cancer, we try to kill it multiple different ways, meaning each drug has a different mechanism of action. And so because we try to use multiple different drugs, unfortunately, we do see that there is some literature that shows that African Americans are less likely to get these extra drugs, what we call triplet therapy, when it comes to multiple myeloma. Also, the good thing about myeloma is that we can get the disease under control with those therapies. However, what we like to do is to keep it that way; we like to put a lid on the cancer. And one of the ways that we do that is through stem cell or bone marrow transplant. And unfortunately, we also find out that with African Americans compared to others, unfortunately, there's a disparity in not only getting to the transplant, but actually receiving that treatment as well. There's a new emerging therapy that I would be remiss to not talk about, something called CAR T-cells. But actually, with CAR T, we're actually going to fight off cancer cells, and in this case, multiple myeloma. There's some recent data that basically shows that, unfortunately, when it comes to African Americans, the access to this novel therapy is different than other counterparts. And so just know that we have a lot of work to do. There's some literature and data that shows there are differences within these groups, but hopefully, we can make some change.

Dr. Mikhael:

Oh, that's fantastic, Brandon.

For those just tuning in, you're listening to CME on ReachMD. My name is Dr. Joseph Mikhael, and here with me today are Dr. Brandon Blue and Dr. Monique Hartley-Brown. We're discussing the mechanisms to address racial healthcare disparities in multiple myeloma.

And, Dr. Hartley-Brown, Monique, maybe I can ask you to comment a little bit as to why it is so important that we have appropriate representation of all people in clinical trials.

Dr. Hartley-Brown:

I really think that's an important point. I think, you know, clinical trials, are extremely important to allow for all our patients to receive the newest and the most impactful therapy. That's how we actually advance the treatment outcomes for our patients. Several years ago, multiple myeloma was essentially a 3-year survival disease. And through clinical trials, we've had the opportunity to advance survival outcomes for all patients. If we have clinical trials showing about 2% to 8% of the clinical trial population being of African American descent, then we're not truly mirroring what we're seeing in the communities, which is 20% of the population. And so that is where it is extremely important. How can we really say that these side effects and outcomes and all these benefits are applicable to the entire population if we don't really have a true representation of that population in our clinical trials?

Dr. Mikhael:

We heard earlier, Dr. Hartley-Brown, that one of the major pieces of disparity was the delayed diagnosis that Dr. Blue explained, and I wonder if you can talk to us a little bit about strategies that we can have in reducing that disparity to catch this disease earlier and its precursors earlier.

Dr. Hartley-Brown:

Thank you, Dr. Mikhael. I think that's extremely important. So looking at our African American patients, we recognize the fact that they also have a higher incidence of the precursor conditions to multiple myeloma. And we do have things in place that are trying to look at screening earlier on, especially in high-risk populations. There is a nationwide PROMISE study, which is looking into this, and patients who are of African American descent are considered eligible. Patients who have a first-degree relative with a diagnosis of multiple myeloma or MGUS [monoclonal gammopathy of undetermined significance] or other plasma cell dyscrasia are highly considered eligible for this trial. And I think that's going to answer some questions, if we can probably get to screen some of these higher-risk populations sooner and identify people who would be at risk for developing active multiple myeloma.

On the other hand, when we're talking about patients who are in the community, what we're doing now, our primary care physicians, we can partner very well with them to identify the fact that African Americans do have a higher risk of hypertension and diabetes. And those are the leading cause of causing kidney failure or renal insufficiency in our patients. And so we should start to look at some of these patients and identify the fact that it's not only hypertension and diabetes that can contribute to some of the criteria that we see in our patients with multiple myeloma, which is high calcium, kidney problems, anemia, and bone pain. So if we have patients with any 2 of those symptoms, even one of those symptoms, we might want to look a little bit deeper into the possibility of them having multiple myeloma, and we can screen them with a total protein on the metabolic panel, as well as a serum protein electrophoresis, which can be done by the primary care provider.

In addition, we need to partner with our community primary care physicians so that a multiple myeloma specialists can be contacted early on when the patient is diagnosed or a suspected diagnosis is made so that that patient's journey throughout the treatment can be optimal, given that they would have a multiple myeloma specialist on their team who has access to clinical trials, access to autologous stem cell transplantation, and access to CAR T therapy.

Dr. Mikhael:

Dr. Blue, as we think about how we overcome these disparities, you know, Dr. Hartley-Brown has beautifully described what we do in the clinic. But even if we step back and look at the bigger picture, you know, we think of the disparity, sadly, has been here hundreds of years based on issues of systemic racism, of the design and the carry out of the healthcare system, the social determinants of health, mistrust within the system.

Dr. Blue:

Yeah, I would say that there's 2 things that I want to say about community engagement and trust that I think are very important. Number one, I would say that it's important for people to know that not all people of any race are what they call monolithic, meaning that, like, there are things that will be true for one African American that will be completely different for the next, okay? And that is true, really, within all races and ethnicities, okay?

But I will say that in certain communities, it's important, as a number 2 thing to recognize, is that the words "clinical trial" can be a negative connotation, meaning that there's some groups of people who look at that word and say, "Sign me up; I'm all for it," and their outlook is very positive. But there's other groups that say, "Oh, no, not me," and, "I'll stay away," and, "No, thank you."

And so we have to just remember that not all patients are the same, okay, and that while we try to do patients in what we call equality, I think something even better is what we call equity. And knowing that sometimes we have to do a little bit more for those who have the least. Just know that, unfortunately, trust is one of those things that only comes when you have a good patient and doctor relationship. How do we build trust? And again, what we're trying to do is just move the needle. Even if we can't erase hundreds of years of mistrust and issues, we, with every step, can move one foot forward.

Dr. Mikhael:

Beautifully said, Brandon. I just really appreciate how you said that.

I mean, this has been a fantastic conversation today. We've thought about the biology of the disease.

I know that some of the work that I have the privilege of being involved with in the M-Power program, which stands for myeloma power, you can read more about it at mpower.myeloma.org. We are seeking to do this very thing, to engage the community, to educate the primary care world, and to support myeloma providers so that they can provide the best care for our patients.

Well, that's all the time we have today. I want to thank our audience for listening. I want to thank these 2 incredible physicians who are

also friends of mine, Drs. Brandon Blue and Monique Hartley-Brown, who are just wonderful individuals and really appreciate your insights today. It was great chatting with you both.

Dr. Hartley-Brown:

It was wonderful chatting with you both as well. And I hope our patients gain a lot of insight from this conversation.

Dr. Blue:

Yeah, I think this is something that, again, we're going to change the world, and I think this conversation starts here.

Announcer:

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