

### Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/project-oncology/managing-multiple-myeloma-patients-providing-better-care/15046/>

### ReachMD

www.reachmd.com  
info@reachmd.com  
(866) 423-7849

---

## Managing Multiple Myeloma Patients: Providing Better Care

### Announcer:

You're listening to *Project Oncology* on ReachMD. Here's your host, Dr. Charles Turck.

### Dr. Turck:

Welcome to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss best practices for managing patients with multiple myeloma are Drs. Shaji Kumar and Noopur Raje. Dr. Kumar is a Professor of Medicine in the Division of Hematology and Department of Internal Medicine at the College of Medicine at the Mayo Clinic in Rochester, Minnesota. Dr. Kumar, welcome to the program.

### Dr. Kumar:

Thank you.

### Dr. Turck:

And Dr. Raje is a Professor of Medicine at the Harvard Medical School, as well as the Director at the Center for Multiple Myeloma at the Massachusetts General Hospital in Boston. Dr. Raje, thanks for being here today.

### Dr. Raje:

Thanks for having me, Dr. Turck.

### Dr. Turck:

Let's dive right in, starting with you, Dr. Kumar. What do the current National Comprehensive Cancer Network guidelines for managing patients with multiple myeloma tell us?

### Dr. Kumar:

So the guidelines from the NCCN, that is on various aspects of multiple myeloma therapy. The guidelines are organized in terms of the stage of multiple myeloma and dives into the initial work-up, the testing that needs to be done, and also the treatments that are applied at various stages of the disease, including newly diagnosed and relapsed multiple myeloma. For patients with newly diagnosed multiple myeloma, the current recommendation for patients eligible for stem cell transplant would be to use a combination of a proteasome inhibitor and an immunomodulatory drug along with dexamethasone, the most commonly used triplet regimen being bortezomib, lenalidomide, and dexamethasone. There is emerging data with four-drug combinations, which can also be used, though the data from phase 3 trials for the four-drug combinations are currently lacking. In patients who are ineligible to go through a stem cell transplant, three-drug combinations, such as bortezomib, lenalidomide, dexamethasone, or daratumumab, lenalidomide, and dexamethasone can both be used based on results from phase 3 trials.

In both these settings, treatments often continue until disease progression. Patients who are eligible for an autologous stem cell transplant typically goes through a stem cell transplant after completing four to six cycles of injection therapy, followed by a single autologous stem cell transplant, and then maintained on lenalidomide, at least for two years and often until progression if it is well tolerated. In patients with high-risk disease, there are some variations to the treatment pattern, and these patients are preferred to be treated with four-drug combinations before transplant for injection therapy, and then maintained on two-drug combinations, typically bortezomib and lenalidomide after their autologous stem cell transplantation, and treatments continue until disease progression. For patients who are ineligible for an autologous stem cell transplant, the treatment is often started with the VRd or DRd, which is often continued until disease progression, with the dexamethasone being discontinued after the first nine to 12 months, and bortezomib also discontinued if VRd is considered to be, or is used for the initial treatment. In patients with high-risk disease who are transplant ineligible

continuing the treatment with the two-drug combination, either daratumumab and lenalidomide or bortezomib and lenalidomide based on what initial therapy was started is important.

**Dr. Turck**

And turning to you, Dr. Raje, could you point out a few key takeaways from the European Society for Medical Oncology and the American Society of Clinical Oncology guidelines as well?

**Dr. Raje:**

Sure. So as Dr. Kumar has already pointed out, for the U.S., we follow the NCCN guidelines, but ESMO and ASCO are pretty much aligned to what you see with the NCCN guidelines. In general, we divide patients with multiple myeloma and think about whether or not they should be getting a transplant versus not. If they are going to be getting a transplant, we would recommend a triplet induction regimen, slight differences between ESMO and ASCO because of what is available in Europe versus what we have access to in the United States. But in general, the combination of lenalidomide, bortezomib, and dexamethasone as an induction treatment is an accepted regimen. In the United States, we're using more quadruplets, and that's been included in the NCCN as well.

For the non-transplant eligible patients, we are looking, as Dr. Kumar has already pointed out, at combinations including a monoclonal antibody, such as daratumumab in combination with lenalidomide and dexamethasone. There are certain other combinations, which are also included in the ESMO guidelines based on what's accessible in Europe.

**Dr. Turck:**

For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Shaji Kumar and Noopur Raje about the current guidelines for multiple myeloma.

Now coming back to you, Dr. Raje, let's switch gears now to discuss interdisciplinary collaboration. Who are the key specialists who make up a multiple myeloma care team?

**Dr. Raje:**

This is a really important point, Dr. Turck. I'm glad you brought this up because care of multiple myeloma patient is truly, truly multidisciplinary. We do reach out to a whole host of specialists. The ones who come to mind right away is because multiple myeloma is associated with bone disease, involving the orthopedic surgeons at specific time points in the care of a myeloma patient is quite important. We do use radiation occasionally in the care of myeloma patients, so having radiation oncology available to you. There are certain other supportive care strategies, mostly to do with bone disease where we have to reach out to interventional radiology for things like kyphoplasties. I think what's happened over the last several years is the fact that we're using novel immunotherapeutic approaches, infection and infection prophylaxis is a really important component of how we take care of myeloma, and therefore, having an infectious disease specialist available, as and when required, is important.

Lastly, it's not just the specialists. Taking care of myeloma patients, it requires a team; we have our nurse practitioners, our practice nurses. Our pharmacist, at least in my practice, is becoming incredibly important in the care of our myeloma patients because the landscape of myeloma therapy is becoming more complicated, and having the expertise of the pharmacist is critical to the care of myeloma patients.

We do include social workers because this is treatment over prolonged periods of time, some of them requiring very expensive medications. So having the social support infrastructure is critical, and not just the patient, but providing the support to the caregivers of that myeloma patient is also critically important.

**Dr. Turck:**

With that in mind, Dr. Kumar, how could the members of the care team better collaborate to enhance their patients' multiple myeloma treatment journey?

**Dr. Kumar:**

It is very important that we approach the management of multiple myeloma in a multidisciplinary fashion as you just heard, and there are several key members of the team that play very, very important roles in the management. Now patients with multiple myeloma can present with complications like renal failure, which will require, again, help from a nephrologist and who might need to continue to watch the patient if there is persistent renal dysfunction. Some patients might present with neurological complications that can lead to cord compression for example, and these patients might need urgent surgery that would involve a neurosurgeon, and also a neurologist. Patients can present with significant bone pain, which can require the help of a pain specialist in terms of its management, and also a bone specialist in terms of the appropriate treatments for bone disease and prophylaxis against myeloma-related bone disease. Infections are fairly common in these patients, and close collaboration with an infectious disease specialist can be quite helpful in terms of managing the infection prophylaxis and particularly, when patients present with uncommon infections, which is increasingly being

observed in late-stage disease when patients are getting immunotherapeutic approaches, like bispecific T-cell engagers and CAR T cells. Now in addition to these specialties, patients with myeloma can sometimes have other manifestations of plasma cell disorders, including amyloidosis, and these patients can again, present with significant peripheral neuropathy or the neurological complications that may need us to consult with a neurologist.

Patients with amyloidosis can also present with significant cardiac involvement, and even patients with myeloma can sometimes get therapies like carfilzomib that may have impact on their cardiac function, which may require the help of a cardio-oncologist. Now in addition to the physician providers, the team clearly includes a pharmacist who will and can help us with the management of the drugs that are used for not only treating multiple myeloma but also the various infectious disease prophylaxis and management of side effects and complications related to myeloma itself. Now as the number of treatment options increase and especially, given that we are talking about a patient population that is older who are already on multiple medications for comorbidities, significant attention needs to be paid to drug-drug interactions, and that's where a pharmacist working collaboratively and closely with the myeloma care team can make a significant difference for the patient, and particularly, in the context of renal dysfunction, which is fairly common in patients with multiple myeloma. Modifications of drug dose is important and should be employed early on.

Now clearly, there's a lot of education that needs to go into management of myeloma for the patients and the caregivers. Clearly, we need to make sure that patients are aware of side effects related to the therapies, particularly, those like neuropathy related to bortezomib, which should be caught on very early, and having nurses working very closely with the patients will allow us to not only detect some of these adverse events early on but also provides a very easily accessible source for patients when they need to get taken care of or get in touch with the care team. Obviously, both nurses and nurse practitioners form an important part of this larger team of care providers or medical providers for patients with multiple myeloma.

**Dr. Turck**

And as we come to a close, Dr. Raje, would you like to leave our audience with any key takeaways?

**Dr. Raje:**

Sure. I think it's been a really exciting time in the care of multiple myeloma patients. We've made tremendous advances. We have lots and lots of different treatments. But because of all of those different treatments, sometimes picking and choosing different treatments can, in fact, be a challenge. I would highly recommend that people reach out to folks with myeloma expertise.

The other really important thing in my mind is we are where we are in the care of myeloma patients because of rapid accrual to clinical trials and approval of drugs. So if there is a clinical trial close to you which you're eligible for, think about it and consider trying to enroll on this clinical trial, and really reach out to expertise in this area so that you can have access to cutting-edge treatment in myeloma.

**Dr. Turck:**

Thanks, Dr. Raje.

And, Dr. Kumar, I'll give you the final word as we end our discussion.

**Dr. Kumar:**

It is an exciting time for multiple myeloma for not only for the patients but also for providers taking care of the patients. We have a lot more options that we can provide for the patients that are more and more customizable to the individual patient characteristics. We are hopeful that these advances will translate to converting multiple myeloma into a chronic disease if not a curable disease.

**Dr. Turck:**

And with those key thoughts in mind, I want to thank my guests, Drs. Shaji Kumar and Noopur Raje, for joining me to discuss management strategies for multiple myeloma. Dr. Kumar, Dr. Raje, it was great having you both on the program.

**Dr. Raje:**

Thank you.

**Dr. Kumar:**

Thank you for having me as part of this program.

**Announcer:**

You have been listening to *Project Oncology*. To access this and other episodes in this series, visit [ReachMD.com/Project Oncology](https://ReachMD.com/ProjectOncology), where you can Be Part of the Knowledge. Thanks for listening!