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A Review of the Multiple Myeloma Treatment Journey

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 strategies for overcoming challenges in the multiple myeloma treatment journey are doctors Morie Gertz and Aaron Rosenberg. Dr. Gertz is a hematologist at the Mayo Clinic Comprehensive Cancer Center in Rochester, Minnesota. Dr. Gertz, thanks for being here today.

Dr. Gertz:

Pleasure to be here. Thank you.

Dr. Turck:

And Dr. Rosenberg is an Associate Professor in the Hematology and Oncology department at the UC Davis Comprehensive Cancer Center in Sacramento, California. Dr. Rosenberg, it's great to have you with us.

Dr. Rosenberg:

Thanks for having me.

Dr. Turck:

To get us started, Dr. Gertz, would you give us an overview of the challenges multiple myeloma patients and their care teams face during the clinical evaluation stage?

Dr. Gertz:

Certainly, thank you. It's an important question, indeed. A lot of it depends on the tempo of the disease. So most patients present to a primary care provider. If they present because of anemia and no other symptoms, typically, it's okay for the evaluation to take six to eight weeks. But let's say a patient presents with unrecognized cast nephropathy, they go to the primary care provider because their creatinine is 1.8, and it's unclear what the cause is. While some of these patients are going to meander, being referred first to a nephrologist, then the nephrologist has to figure out that this is light chain cast nephropathy. And of course, these types of referral delays can result in permanent loss of kidney function. And so one of the issues with myeloma is that it's a multidisciplinary disorder. And our healthcare systems not well designed for someone to necessarily see their primary care provider, nephrologist, hematologist in a very timely fashion.

The same challenge in patients who have an acute bone fracture or spinal cord compression, it isn't really something that you can take two to three weeks. Some institutions have challenges. For example, let's say you want to image with a PET scan, it's not so easy necessarily to get a PET scan the next day. And so those delays in accessing some of the diagnostic techniques can be a real barrier to a timely diagnosis of myeloma, which for patients with anemia, not such a big deal, but patients with progressive bony disease or worse, renal failure, it's a big deal not to be able to get this taken care of in 48 hours.

Dr. Turck:

Now coming over to you, Dr. Rosenberg, what challenges might occur when considering treatment options and while monitoring patients?

Dr. Rosenberg:

Yeah, this is a pretty complicated treatment space at this point with lots and lots of options for patients in both the newly diagnosed

setting and the relapsed refractory setting. I think even in the newly diagnosed setting, though, where we probably have the best data for what is our current standard procedures, we're still in the midst of an evolving landscape where patients are being offered three now, even four-drug combinations as part of their newly diagnosed treatment.

A lot of the challenges that we're having in the field, though, is that we have some heterogeneity in how it is that studies are being run and how risk factors for progression and relapse are being defined within different clinical trials. And this leads to some challenges in picking the right treatment for a given patient. And for patients to try to evaluate this data, which is so complex even for the physicians who spend their lives immersed in it, is overwhelming, I think, for most patients.

The other challenges that patients have, I think are really trying to wrap their brains around, what does this diagnosis mean? And what are the expectations moving forward for recovery from some of those potentially catastrophic events that Dr. Gertz just outlined? And the coming to grips with the fact that they may be on long-term treatment, and potentially, indefinite treatment, depending on their disease and their disease response. And working with patients through these issues can be very emotionally, challenging, as well as physically challenging, depending on their underlying comorbidities, how robust a response they're having, how quickly, and how well they're able to recover from some of those initial events, such as renal insufficiency and particularly, the bone fractures, which can leave patients with chronic pain syndromes.

Dr. Turck:

So with all that in mind, Dr. Gertz, how might these issues come up when transitioning care teams in the inpatient setting versus the outpatient setting?

Dr. Gertz:

And so this really transcends the knowledge of how to manage multiple myeloma. There are real system issues. One of the most common ones that I've seen is when the inpatient and outpatient teams don't share a common medical record. It's quite common for the hospital team to have some form of an electronic environment, which may or may not synchronize with the outpatient. So when the patient leaves the hospital, you end up with a hospital discharge summary, which doesn't always reflect the entire episode of care when they move to the outpatient.

And there are issues with regard to treating multiple myeloma patients in the inpatient setting. In the United States, it's next to impossible to get an immunomodulatory drug, such as lenalidomide, administered to an inpatient, you just can't register them and get it delivered to the hospital. And so patients often start with a cyclophosphamide-based regimen but need a change, a transition to an outpatient setting where a lenalidomide or an immunomodulatory was added.

In addition, reimbursement comes into play. So there are many hospitals that are financially stressed, where the idea of giving daratumumab as part of initial therapy if it's decided to give that for a myeloma patient in patients with fixed reimbursement, can be a challenge, and many hospital pharmacies refuse to administer, so that has to start after hospital discharge. And that raises some serious communication issues between them, if there's no commonality and no common thread between the outpatient team and the inpatient team, both in terms of communication, as well as which specific medicines, and finally, the diagnostics.

In the inpatient setting, most hospital laboratories are set up for a diagnostic myeloma evaluation, serum protein electrophoresis, quantitative immunoglobulins, and immunoglobulin-free light chains. In some outpatient practices, those might be mailed out to a reference laboratory, rather than using the hospital laboratory.

So there's a lot of disjunction that occurs when a patient is discharged that has nothing to do with the care plan, but there are barriers to implementation based on systems and based on reimbursement.

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 doctors Morie Gertz and Aaron Rosenberg about the challenges multiple myeloma patients and their care teams often face.

So now that we have a better understanding of these challenges, let's look at some potential solutions. Dr. Rosenberg, how could multidisciplinary teams better coordinate to optimize their patient's care journeys?

Dr. Rosenberg:

Yeah, I think this is a great question and really gets to the heart of the multiple myeloma patient experience with this disease, kind of from soup to nuts, from presenting with, maybe a bone pain or a sudden change in laboratories that can lead to inpatient hospitalization, all the way through their initial therapy, potentially, stem cell transplant, maintenance therapy, and then again, relapse and reinduction and further maintenance.

I'm really quite fortunate to work with a couple of skilled nurses and nurse practitioners. And I think what I've learned from working with

them is how important it is to have a team that has a different viewpoint on patient care, but that can come together and really surround the patient and support them and their family through this journey.

And to hit on one of the things that Dr. Gertz was pointing out about the challenges with reimbursement, in particular, on immunomodulatory agents in the United States, one of the big things that we cope with here, is dealing with copay assistance and the share of costs that some patients are really saddled with, with these drugs, even in the outpatient setting. And being upfront with them and working with our pharmacy colleagues to really try to make sure that patients understand what these costs could be and how we can defray costs if need be. But it's really quite heartbreaking when I meet a patient who has been treated for nine months already, and they're transferring their care to me for one reason or another, or they're coming for a second opinion, and I hear that they had to mortgage their house to afford their medications because we couldn't find them in appropriate copay assistance, and we couldn't find an alternate treatment that we thought was going to be good enough for them to keep the disease at bay while we came up with some other treatment strategies for them.

Dr. Turck:

And from your vantage point, Dr. Gertz, would you share some tips on how multidisciplinary teams could better engage patients in the treatment decision-making process?

Dr. Gertz:

Thank you. There are actually a couple of issues. First, the multidisciplinary teams have to communicate with each other. And in myeloma, that's orthopedic, oncology, neurology, nephrology, oncology, pharmacy, and nursing. And so having a common medical record in the inpatient as well as outpatient settings, so that each member of the team is really tuned in to the thought processes that we're all engaged in is step one.

And obviously, this is an incurable, invariably fatal disease. And so having patients engaged in the decision-making process is at least theoretically important. But as Dr. Rosenberg mentioned, these are very, very complex issues. And for many patients and families, it's really beyond. I mean, a discussion with a patient about bone prophylaxis with zoledronic acid versus denosumab, I don't know how patients can deal with that. A 70-year-old, is it daratumumab/len/dex or daratumumab/bortezomib/len/dex? Those normally aren't unilateral decisions, but engaging patients to participate in that can be challenging. Transplant, early transplant, immediate, late transplant, cryopreserve stem cells, all of those become really clinically relevant and might vary from patient to patient that we try very hard to educate with our nursing teams. But it's really a complex problem. And most people want to have some control and want to share in the decision-making process, but the truth is the data is so hard to interpret and is so controversial, that sometimes the physician does their best to make their recommendations for the patients without the patients having a large input on what happens. I mean, even just this question of—do you want to participate in a clinical trial of multiple myeloma? For newly diagnosed cancer patients, that can really be overwhelming and the Fed being what it is, the consent forms are rarely under 17 pages long, and expecting patients to digest that and be an active participant in the decision can be really challenging.

Dr. Turck:

Well, as our discussion comes to an end, Dr. Rosenberg, are there any final takeaways you'd like to leave with our audience today?

Dr. Rosenberg:

Yeah, I think we've talked a lot about what the challenges are for patients and for providers and building up care teams, but I think the other thing that's important to remember is how rewarding it is to take care of these patients, especially in the modern era where we have such a plethora of really good treatment options for patients. We could do a lot of good for these patients. We can help them maintain a good quality of life while helping them to live longer, see those really important milestones in their and their family's lives that maybe 20 years ago just wasn't going to be a realistic option for them. And so it's really a privilege to take care of these patients and despite the challenges and maybe because of some of the challenges it is really a rewarding practice.

Dr. Turck:

Thank you, Dr. Rosenberg. And, Dr. Gertz, I'll give you the final word.

Dr. Gertz:

Thank you very much. When I started in this field, melphalan and prednisone was all we had, and that was my practice for 17 years manipulating, starting, and stopping melphalan and prednisone. And the survival in this disease was 30 months. Today, patients surviving 10 years is extremely common. And in our transplant database, we have 20 patients surviving 20 years. And so the future for patients is extremely bright. And of course, when I say 20 patients, that's retrospective back to 2000. And of course, with the introduction of widespread use of immunotherapies, like CAR T and bispecific antibodies, the explosion of antibody use, the future looks so bright for our multiple myeloma patients. There's real room for optimism.

Dr. Turck:

With those key takeaways in mind, I want to thank my guests, doctors Morie Gertz and Aaron Rosenberg, for joining me to share their perspectives on how we can address challenges in the multiple myeloma care journey. Dr. Gertz, Dr. Rosenberg, it was great having you both on the program.

Dr. Gertz:

Thank you.

Dr. Rosenberg:

Thank you so much.

Announcer:

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