What Does Maintenance Therapy After Transplant Look Like for Myeloma Patients?

Robert Orlowski, MD, PhD
Director of Myeloma and Professor in the Departments of Lymphoma/Myeloma and Experimental Therapeutics
The University of Texas MD Anderson Cancer Center

Noopur Raje, MD
Director, Center for Multiple Myeloma
Massachusetts General Hospital Cancer Center

Jack Aiello:
When I was diagnosed and I originally had transplants, one of the benefits of transplants versus continuing treatment was that for transplants, they said, well, I don't have to go on any more treatment. These days however, it's often recommended that you shortly afterwards start some maintenance treatment. So, Dr. Orlowski, can you—and that becomes part of your life then. So can you talk about what you prescribe in terms of maintenance treatment for myeloma patients these days?

Dr. Orlowski:
Yeah, definitely. One of the problems after transplant is that there can still be some myeloma cells left over. And if you don't do maintenance, we have been able—in a number of randomized studies—to show that you will relapse sooner without maintenance than with. And lenalidomide (Revlimid) is the most common drug which is used. On average, it adds somewhere between 18 to 20 months in remission on top of what the transplant already does. And in general—with dose adjustments—it can be relatively well tolerated. And there was one that—there were two large studies. Both showed longer time in remission. One showed also a longer survival for the patients who got lenalidomide.

The major complications are blood count issues which may require some dose adjustment. We talked earlier about diarrhea from lenalidomide.

And it is important to note that both of those studies did suggest that there might be a small increase in the risk of second cancers. Fortunately, that increase is small, and the benefit is still felt to outweigh the risk. But we do have to do a better job of maybe understanding why some people develop those. And maybe if we could identify those in advance, we might not give maintenance—at least not with lenalidomide—to those patients.

Jack Aiello:
And, Dr. Raje? For how long do you keep patients on maintenance treatment?

Dr. Raje:
Great question. And I don't think we have a good answer to that just yet but hopefully soon, because you have Jay out here who's been on two drugs as maintenance. And the other drug in addition to lenalidomide—as Dr. Orlowski's pointed out—is ixazomib (Ninlaro), which is an older [protostome]. And I bet it would be a perfect maintenance drug, which Jay is on.

And the other case is where you have stopped maintenance. So I don't think we know what the duration of maintenance is. But with tests such as MRD now, what we are beginning to see is if you are MRD negative at whatever time point—maybe

two years down the line—can we stop maintenance? We don't have that data just as yet, Jack. But those are the kinds of studies which we plan for the future so that we can deescalate treatment. Because being on treatment for such a long time does impact your quality of life for sure.

Jack Aiello:
So what do you tell patients today?

Dr. Raje:
As of right now, the majority of my patients will stay on maintenance. The time that I take them off maintenance is if they have troubles with continuing on maintenance. There are certain patients who absolutely can't tolerate it. And if they've been on it for two or three years, then I have stopped it. But by default, I do continue maintenance up until disease comes back again.