Do Myeloma Patients Still Need Transplant in First Remission?

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Dr. Anderson:
So one of the key questions these days, one of the most common questions these days is with all of these newer, good treatment options we have for myeloma like the IMDs and proteasome inhibitors and combinations, do we still need to do the transplant in first remission like we've always done? Because the studies where we saw the improved survival and outcomes were before we had IMDs and proteasome inhibitors. So there's a current study ongoing to help better address this question.

It started at the Dana Farber, and now it's opened up across the country, looking at the role of transplant comparing transplant in first remission versus collecting and storing stem cells after three cycles of triple induction therapy and then waiting for the transplant after relapse.

So our study in the U.S. is ongoing. But part of the study was also done in France, and that was presented at a recent American Society of Hematology meeting. In that study, they showed that the patients that had an early transplant had significantly prolonged remissions; so longer progression-free survival. And so right now, the current standard of care is still to do the transplant in first remission, based on this and a couple of other similar studies.

But what we can't say yet is that is it causing improved overall survival. So far, that trial hasn't proven improved overall survival. The data is still early. But at least we know that the remissions last significantly longer and don't have to go onto different therapies. One caveat is in that French part of the study, they only gave maintenance therapy for one year in both of the groups.

So all the patients in that study had triple therapy with a proteasome inhibitor, an IMD and a steroid followed by either transplant or further cycles of the triple therapy, and then a year of maintenance with an IMD. And the American study, we're actually continuing the maintenance therapy indefinitely as long as the patient is tolerating it and as long as it's working. And so we're hoping that maybe the prolonged maintenance could bring those progression-free survival curves together or change the outcomes to where they're more similar between the groups, but the jury's still out on that.

Andrew Schorr:
Any comment from you on that, Bob? There's a lot of debate about this.

Dr. Orlowski:
Yes, this is definitely a controversial area. I agree that transplant up front is very important. But just to provide a counterpoint to what Larry mentioned, the difference in progression-free survival in the French part of the study was about nine months.

Meaning that for the people who got their transplant, their time in remission was only longer by nine months. And for some people, it can take six to nine months for them to fully recover from a stem cell transplant. So that's point number one. Point number two was that there were more second cancers in the group that got the early transplant. Now, the numbers were low in both arms, and sometimes when the numbers are so low, the differences can be just because of random chance or bad luck.

So we don't know that yet for sure. But we do know that melphalan (Alkeran), which is the main drug which is used for transplant, can damage chromosomes not just in myeloma cells which is a good thing, but they can also damage chromosomes in normal cells which may be not a good thing.

I think that what we need to as a community look at is now that we have even better drugs available than the ones that are used in that study, can we pick out a patient population where maybe a delayed transplant is reasonable, and they don't necessarily need an upfront transplant. For example, if you get your initial therapy and you get into a complete remission with MRD negativity, and hopefully we'll talk about MRD a little bit later, and you have good risk disease, that's a group of patients that may be just harvesting and holding the stem cells and waiting until they relapse may be a reasonable approach. Although that's only a hypothesis, and we don't know that, yet.

Andrew Schorr:
It sounds complicated. Again, you want to check in with a myeloma specialist, because you can see there are studies going on, debates about whether to go this way or that way and when, and what's right for you.