

Discussions with Dr. Brian Durie (IMF Chairman)  
Jack Aiello July 21-22, 2017

Recently I had the privilege of attending a meeting with other Myeloma support group leaders, and we were fortunate to listen and ask Dr. Durie a number of questions. Here is a summary beginning with his presentation on various topics.

- 1) Best Induction: Today we have VRd (Velcade-Revlimid-dex) where V may be substituted with K (Kyprolis) and Daratumumab might also be added. Long-term, we'll be looking at a) bi-specific mAb's, b) precision meds for MCL-1/Venetoclax, and c) CAR-T therapy.

"Today 10+ yrs OS (Overall Survival) is a reasonable expectation for a newly diagnosed non-HR MM pt."

"Cure = MM pt has the same OS and QOL as a non-MM pt."

"CAR-T will probably be approved for MM R/R (Relapsed/Refractory) pts in 1-1.5 yrs." It will be expensive \$300-500K and comes with risks Cytokine Storm Release (CSR) and damaged immune systems.

- 2) For Rev-resistant pts, consider DaraVd, DaraPomd or KPd (Pom, P = Pomalidomide)
- 3) For Vel-resistant pts, consider DaraRd, KRd, or KPd
- 4) What about SCT? Longer remissions but similar OS (since we have other treatments). IMWG still universally recommends SCT up front.

"I believe it's still best to do the SCT up front and get that durable remission."

#### SQL Questions

- 1) *I'm in remission, so why am I still on maintenance?* "We don't know the right length of maintenance for a specific patient." There was discussion about a future trial where MRD (Minimum Residual Disease) might be able to provide a better guideline.
- 2) *If 4 drugs (including Dara) becomes a standard, that leads to even higher costs. Can anything be done?* "This was a huge topic of discussion at the recent IMWG and GMAN meetings." See my notes at:  
<https://static1.squarespace.com/static/52c36017e4b077a7b031529a/t/5968e60629687fcb35f1381e/1500046854982/GMAN-IMWG+2017.pdf>
- 3) *Do doctors remember about QOL?* "Pts need to be their own best advocate."
- 4) *Are HR pts more susceptible to a poor (sic) relapse after an SCT than std risk pts?* "For HR pts, it is particularly important to knock down their MM as low as possible."
- 5) *When should treatment begin after an SCT?* "The standard waiting time is 100 days because you don't know the full results of the SCT."
- 6) *What's the best plan for monitoring during Rev maintenance?* "Monitor for your markers as well as for bone lesions (but you need an initial baseline)."

Finally Dr Durie discussed the importance of having MRD (either NGF or NGS  $10^{-5}$ ) as an FDA surrogate for OS in clinical trials as well as the curative (?) CESAR and ASCENT trials for HR SMM pts.