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Managing AE and Patient Intolerance With Combination Therapy in Early Relapse Multiple Myeloma

**Announcer:**
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**Dr. Mikhael:**
Hello, my name is Dr. Joseph Mikhael, and I want to chat with you a little bit today about Managing Adverse Events and Patient Intolerance in Combination Therapy in Early Relapse.

And I think sometimes this topic is not addressed fully, but is so important. As we know, when patients can remain on these therapies over the longer term, they're going to do better. So I'm going to share with you some of the pitfalls that I see, as we use these early relapse therapies and some tips to help along the way.

We know that we now have a wealth of choice when it comes to early relapse with multiple combinations with CD38 antibodies, carfilzomib, pomalidomide, and selinexor. And basically, all of the combinations and permutations of those different agents. And so when we use them, we want to use them most fully. And so of course, we can't cover every possible adverse event. But in high-level format, I want to talk a little bit about some of the things that I do to help me manage patients with pomalidomide, with carfilzomib, and indeed, with dexamethasone, and of course, the importance of communicating with our patients.

So when you first think about pomalidomide, you know, this does have a toxicity profile quite similar to lenalidomide, don't forget that patients need thromboprophylaxis. Typically when they have cytopenias, we want to make sure it's not just related to the drug, but often to the disease itself. And so, the use of growth factors and the appropriate dose delays and reductions can be helpful. I can tell you that I frequently use 2 mg instead of 4 mg in patients. The fatigue that we see, like with lenalidomide, can be improved with dose reduction. We see diarrhea less commonly, but also with supportive care and dose reduction, that can be helpful. As I mentioned, although the starting dose is typically 4 mg, I often use 2 mg. And we know that pom can overcome LEN-resistance, and hence, we use it in LEN-refractory patients.

In carfilzomib, often we get concerned about cardiac adverse events. But what really helps is to very carefully manage a patient's heart failure and blood pressure prior to starting. If those two things are optimized, more often than not, we're not going to see problems, but we do want to monitor them, especially in that first month. Cytopenias, like I mentioned with pomalidomide, growth factors and dose reduction can be of help. Like with all proteasome inhibitors, don't forget the viral prophylaxis. And very often now we can reduce some of the AEs and even the adherence of patients by sticking to just a once-a-week regimen. And there are lots of ways of being able to do that.

And I have to put my plug in for what I call down with dex, or down with dexamethasone. Dexamethasone really boosts the effect of almost every drug we use in myeloma. But I think it's important for us to recognize that, over time, it causes a plethora of challenges in blood pressure, blood sugar, insomnia, mood changes, skin changes, bone changes, cataracts, and the list goes on. So please choose the initial dose carefully, whether it's typically 20 or 40 mg. And I really try to keep that only for the first couple of months and then ramp

down with most of my patients coming off by 6 to 9 months.

But before I wrap up, I want to comment on the critical importance of shared decision-making. Because we don't just tell our patients, 'you'll take it and you'll like it.' It's so important that when two parties come together, that they share information, and they discuss together what the options are to build consensus, because when the patient is on our side, and we are on the side of the patient as it were, because it's a two-way street, that mutual agreement can be reached. And patients do benefit from this. We know that there are significant benefits, that there's greater confidence in their treatment decisions, they have more trust within us, we know that it can directly affect adherence both in the short-term in the long-term. And now we have longer-term studies showing us that it actually affects their quality of life, and even outcomes like disease remission by virtue of that shared decision-making model.

So hopefully, there are some key points that you can take away here. The right dosing of pomalidomide and carfilzomib, using dexamethasone appropriately, the critical importance of having a shared decision-making model as we talk to patients so that we can get the greatest efficacy out of these agents with the least amount of toxicity, that we can not only deal with adverse events as they come up, but even prevent them by using the right strategy with our patients. And I hope this will help you pragmatically in the clinic as you care for your patients.

Thanks very much for your attention.

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