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Managing Infections, Cytopenias, and Other AEs Related to Bispecific Antibodies

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Lonial:
This is CME on ReachMD, and I'm Dr. Sagar Lonial, and here with me today is Dr. Caitlin Costello.

In another episode of this series, we talked about CRS and neurotoxicity related to bispecific antibodies. Other treatment-emergent adverse events related to these agents include infections and cytopenias. Do you know best how to manage these side effects?

Dr. Costello, what can you tell us about the safety profile of these agents?

Dr. Costello:
Thank you, Dr. Lonial. New drugs, new toxicities. And much like some of these other CAR T programs and things we've seen, REMS programs are an important part of the bispecific T-cell engagers as well. It's an opportunity for physicians and all the supporting staff and nursing that go into taking care of these patients to recognize, be educated on, and be prepared to intervene on any of these side effects that we may see with some of these new T-cell engagers.

So let's just touch on a couple. Maybe I'll start briefly, talking about 2 of them: infections and cytopenias. Now in theory, these are 2 different side effects that we oncologists are very equipped with taking care of. We know that these patients are heavily pretreated. We know that means that their immune system may inherently be weakened from the get-go, before you even start these drugs. That can be because of high burden of disease or long-standing therapies where they're hypogammaglobulinemic; their CD4 counts are low. They may come into these treatments, which we know by themself cause weakened immune system, already in a weakened state. So it's important to recognize that prophylactic medications, antibiotics, antivirus medicines, sometimes antifungal medicines, these patients are at risk for so much, so you have to have a heightened awareness on what to look for.

As these patients are treated ongoing, we know that the T cells can be under such pressure to fight the myeloma that sometimes, let's just say, there isn't enough room in the inn in order to fight off the infections as well. So there are different opportunities for prevention and management that include vaccination if you can before you start these therapies, prophylactic antibiotics, antiviral medications. Sometimes monitoring CD4 counts can be a way for you to know when to intervene with some of your more intense anti-PJP [*Pneumocystis jirovecii* pneumonia] prophylaxis, for example. IVIG [intravenous immunoglobulin] is critical for these patients. It's not a question of whether you start it; it's really when you start it. And I think many of us start it really within the first month or so of receiving the first T-cell engager.

Now cytopenias, this can happen as a side effect of the drug, as mentioned; it can be a side effect of other drugs or even the disease itself. So you really need to recognize these patients and know that it may get worse. With these, you can use sometimes growth factors, TPO mimetics, whatever you need in order to help mitigate some of the higher-grade neutropenia or thrombocytopenia that you

may see. But also, there are opportunities for dose adjustments that may help to improve upon some of the cytopenias associated with the drugs.

What other side effects have you seen, Dr. Lonial?

Dr. Lonial:
Yeah, you know, when we talk about GPRC5D, for instance, we do see skin and oral toxicities that are sort of on-target, off-tumor effects, particularly with talquetamab. And that really is something that, unfortunately, is associated with response. So the more likely you are to have a good response, the more likely you are to have those toxicities. And I think from a practical perspective, loss of taste or dysgeusia, difficulty in swallowing, dry mouth, a skin rash, nail toxicities, noninfectious fever, and then anorexia, these are issues that one should be aware of when using a medicine like talquetamab. Now fortunately, there are some sort of supportive care measures that can be helpful. The use of emollient creams, salivary replacement sprays, rinses, those kinds of things. They can be helpful, but honestly, often, you'd end up having to hold doses or skip doses. And at least in my experience, reducing the dose and schedule really seems to make a big difference. It may take a couple of weeks for patients who get grade 2 skin or oral complications, for them to regress to a point that you can restart. But what I think we know, particularly from data presented at ASH [American Society of Hematology], that cutting the dose in half or cutting the frequency from either every week to every other week, or every other week sometimes to even once a month, those are highly effective and don't necessarily compromise the efficacy of the approach. So I think that's a really good approach for managing some of these unusual adverse events.

Well, this has been a brief but great discussion. I hope we gave you something to think about, and thanks for tuning in.

Announcer:
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