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Multiple Myeloma Care: Translating Evolving Practices to Oncology Nurses in Community Settings

Announcer:
Welcome to CME on ReachMD. This replay of a live broadcast titled, "Multiple Myeloma Care: Translating Evolving Practices to Oncology Nurses in Community Settings," is provided by the American Academy of CME Incorporated and is supported through an educational grant from Sanofi Legend Biotech and Janssen Biotech incorporated. Administered by Janssen Scientific Affairs LLC.

Here's your host, Dr., Jennifer Caudle.

Dr. Caudle:
Welcome to a CME Live Broadcast on ReachMD. I'm your host, Dr. Jennifer Caudle, and joining me to share her clinical experience and insights on multiple myeloma care is Tricia Mangan. Tricia is a Nurse Practitioner in Hematology and Oncology at the Abramson Cancer Center at the University of Pennsylvania in Philelphia, PA. Here are her faculty disclosures, disclosures for this program, and learning objectives.

Tricia, welcome to the program.

Tricia:
Well, happy to be here.

Dr. Caudle:
Well, I'd like to now turn our attention to a few housekeeping notes before we get started today. To submit questions during the presentation, please type them into the chat on the right side throughout the program or in your comment box through Facebook Live. We'll try to answer as many as we can during the time allotted. And, you know, with the number of novel agents being approved within the last 5 years, the treatment landscape for patients with multiple myeloma is evolving very rapidly. Now, this is good news for patients who previously only had a few options. About 60% of multiple myeloma patients are living more than 5 years after their diagnosis.

So, let's move on to our first question. Tricia, can you talk about how the landscape of multiple myeloma treatments has expanded and how the multiple classes, such as several novel therapies that are especially important and the RRMM setting could impact multiple myeloma care?

Tricia:
Well, yeah, no, its such an exciting time, and this slide here really highlights since 2000 the advances with FDA-approved therapies for our patients, and honestly, particularly even in the last 5 years, the remarkable advances in a relapse refractory setting, many of these were brought to market in that realm, and honestly, we just have people living longer, as you mentioned. When I started in nursing many years ago, we didn't really know our myeloma patients. They had such a short life expectancy. Now, you know, we grow old with them. So, and I think that as newer agents and classes of drugs are being utilized, as you can see in the last few years, they are even starting to move earlier in lines of therapy because of their success, and also in various combinations. And so, we just have such an arsenal of therapies now for our patients.

I'd like to highlight the initial frontline therapies that many years ago would be one or two agents, more recently triple-therapy, three different classes of drugs, have been very helpful. But more and more now, even in the non-high-risk setting, utilizing 4-combination of classes of drugs, or quad-therapies, including the exciting addition of the anti CD38 monoclonal antibodies. And that includes the PERSEUS trial that looked at patients in the upfront setting with a 4-drug combination, those that we're moving on to transplant had much greater benefit. And then, isatuximab, another agent, CD38 monoclonal antibody, also showed benefit, and just recently published and presented this month at ASCO and publication. And so, it's really exciting to see.

We then move on to our maintenance therapies that have been very helpful in maintaining remission that the initial therapy would provide a patient. But we do still consider myeloma an incurable cancer, so it is very likely that our patients do relapse and being prepared for that. But as you can see listed here in this box, this is really where I would like to highlight many of the advances that we're experiencing now, all the various different modalities of therapy, including CAR-T therapies and bispecific antibodies. And as mentioned, really even these are now being utilized in combination. So, it's a really exciting time.

Dr. Caudle:
Absolutely. You know, this is a great review of those therapies. I appreciate that. You know, and how important is supportive care beyond the newly diagnosed setting and initial therapy?

Tricia:
Well, I think a supportive care is very essential. You know, myeloma has a lot of classic organ toxicities that can develop in patients just from the disease itself, they are immune compromised. So, infection not only from the disease but also from the treatments that we provide our patients can render our patients' immune compromised, and so utilizing all the therapies listed on this particular slide, that's the NCCN recommendations, is very helpful, and it's also something to refer to in the resource section of this as well.

Bone disease. We know our patients certainly have the issue of developing bone related events. Seventy percent of our patients sometime during their life will develop a lytic bone lesion or many times can be painful, so utilizing therapies like bisphosphonates and denosumab that pushes the calcium back into bone, has been really very helpful in quality of life of our patients over time.

And then listed here, renal dysfunction. We're always concerned by potential toxicities. Drugs that we take or give may cause some renal insufficiency. Blood clots can happen in our patients, so they're hypercoagulable. Just the disease itself of myeloma, but also the therapies we give can increase the risk of clots. So, being on anticoagulation is a very important thing. So, it is always something that we're monitoring and watching for, and adding to all the therapies that we have in the arsenal treatment.

Dr. Caudle:
Understandable. Thank you so much for giving us those key points to keep in mind. And now could you give us a brief overview of T-cell directed therapies in multiple myeloma?

Tricia:
Yes. So, you know, we know that our T-cells are such play such a vital role in our surveillance for not only infection, but also for cell cancer development, or abnormal cell development. And why do people get cancer? Sometimes their T-cells are just not competent enough to see a malignant cell being developed or circulating in the system, or their T-cells are just not adequate to fight or destroy this abnormal cell development, and so T-cell directed therapy is really – the other term we use is immunotherapy, to really – how can we really grab those T-cells and really make them function in the way they should is a very exciting new phase of treatment in myeloma.

And depicted on this slide are the antigens or the protein globs that basically are expressed on the myeloma cell. And there's certain targets, just BCMA, you hear about. B-cell maturation antigen is now approved for the two CAR-T products we have and two of the bispecific products that we have now available for our patients. The nice thing about the antigens that we develop therapies too is that the antigen is just expressed on the myeloma cell. In most cases, you don't want to have it expressed on other healthy tissue or you're targeting that as well. Fortunately, in myeloma, we have a couple of very active targets. BCMAs, I mentioned. GPRC5D is another target that is often expressed on myeloma and also now has a new bispecific antibody that just got approved for targeting that particular antigen. There is some expression of that on the follicle of the skin as well as mild expression on nail hardening cells, and so some of the toxicities can reflect that mild expression on them as well. We also have a SLAMF7 is a target that is highly expressed on myeloma cells, and we do have a monoclonal antibody that directs therapy towards that.

And finally, the CD38, anti-CD38 antibodies. So, CD38 very common on myeloma cells and a great target for many of the monoclonal antibodies that we have in practice.

Dr. Caudle:
Excellent. And since we now have so many types of agents, can you highlight the important differences among monoclonal antibodies

bispecifics and CAR-T agents?

Tricia:
Yes. Yeah, because it is – everything, even though they are immunotherapies, they all have a different mechanism of action and even just design of the particular molecule. So, on the left-hand side of the screen, you'll see conventional monoclonal antibodies, and these are proteins antibodies that are produced with high affinity to that antigen target that I highlighted in the last slide. So, daratumumab is what's highlighted here, and that is an anti-CD38 monoclonal antibody. So, there is the Y-shaped protein that we see here on the screen. There is the veritable aspect to it, the upper part of the Y that opens, and then the long arm that we call the constant region, or FC region, and that circulates. Once it's infused into the body it circulates and attaches onto anti-CD38 antigen on that myeloma cell and causes cell death. The way that we try to utilize and recruit those T-cells is the constant region. I always think it kind of wags its tail as that gets attached and it recruits T-cells, natural killer cells that can aid in the destruction of that myeloma cell.

Now bispecific is even more potent in cell death because it has a different structure where – there is – it's bispecific. So, one of the parts of the antibody looks in structure very similar to a conventional monoclonal antibody, but it, one, targets in the veritable the antigen BCMA on the myeloma cell, while the other aspect of that region grabs the T-cell at an antigen that's expressed on the T-cell called CD3. And so, it really actively brings those two, the myeloma cell and the T-cell together, and has a much more robust death or destruction of the myeloma cells.

And then finally, CAR-T is a little different in structure. What we know about the CAR-T is it is a personalized immunotherapy where we actually, a patient has their T-cells removed and then manufactured, genetically altered, to express a new T-cell receptor. So, it's actually the T-cells being actually, genetically modified with a great affinity to BCMA antigen on the myeloma cell. This is a, as I said, a personalized therapy. It's a one-time therapy and it is just given to that particular patient using their own T-cells.

And then, this is a nice, highlighted overview of the FDA T-cell directed therapy approvals based on the registration trials. And so, highlighting the top two rows is ide-cel and Cilta-cel that are the CAR-T products that we now have available for our patients. They both are directed towards BCMA. And I always look at the prior lines of treatment these people have had on these trials, and you can see the average median line of treatment was 6, but if you look, there were people that had up to 16, 20 ,22 lines of therapy, and despite that, with this refractory disease, they've had such an amazing overall response rate and the duration of response are very impressive too. To the point where both of those products, as I mentioned earlier, moving earlier in lines of treatment where ide-cel is now indicated after one prior line of treatment, and Cilta-cel after two. Listed below are the three FDA-approved bispecific antibodies. Teclisatamab and elranatamab are both BCMA-directed targets, and talquetamab is the GPRC5D target. So, of note, one other thing in CAR-T, there was some evolving information about the T-cell therapies. Might potentially increase risk of other T-cell tumors, as it's now black box warning for CAR-T products. But it's a nice highlight and –

Dr. Caudle:
Absolutely. No, it's very helpful to know. And you know, if we zero in on CAR-T therapies for a moment, can you speak more about nursing considerations when it comes to these therapies?

Tricia:
Yeah. Well, so, yes, I think this is a nice overview of CAR-T therapy, that it is a process, and so nurses are vital in every aspect of the care, not only the physical care but also the education and the preparation, and even just coordinating getting people to the sites and home to their community settings. And so, a patient who is identified as a potential CAR-T patient undergoes leukapheresis, where their T-cells are removed from their body. They then are sent to a manufacturing facility where they're genetically modified to express this new chimeric T-cell receptor on its surface and that can take a period of time, this manufacturing from the harvesting until it's ready to be sent back to the facility can take weeks to even up to two months of time. And so, that with it, has some challenges that I'd like to address in a second. But once the T-cells are ready to go and passed all the manufacturing restrictions, or approvals, they then get sent back to the institution. Patient then, is prepared with what we call lympho-depleting chemotherapy just prior to the infusion to allow the lymphocytes that are circulating in the patient to be somewhat reduced so that when the T-cells are infused they have a much more robust ability to get to those targets and to proliferate and persist over time.

And so, the other therapy during the manufacturing time, as I mentioned, can be a prolonged period of time, and so bridging therapy is a very important aspect to this.

So, these are therapies. There isn't any standard therapy that we use for bridging. It depends on what patients have had in the past. But the goal of bridging therapy is to keep the person in their disease state as healthy as they can be without infection, you know, try to control the disease as best we can. Remember, many of these patients, at least in these earlier trials, had a very refractory disease, and so this can be a challenge. Fortunately, now as it moves earlier, we identify people that may be needing a CAR-T. We can sometimes

even utilize the treatments that they're currently on, but they're having some progression. So, there's various options of therapy, and this is where we work very closely with our community centers to communicate with their local oncologists that are currently treating the patient, to come up with a good therapy that they can remain on, and healthy on, until the CAR-T is ready.

And so, we do know the other thing is, the bridging therapy can be very helpful in mitigating the potential toxicities of the CAR-T. And so, the lower the bulk of the disease, maybe that is beneficial as well. And then, finally, I mentioned the lymphodepletion chemotherapy, that's administered right before the CAR-T is infused. The typical regimen we give is fludarabine/cytotoxin and it's given over 3 days just prior to the infusion of the CAR-T cells. This can be administered in the hospital, or most often, it's right in the CAR-T Center outpatient prior to the admission for the infusion of CAR-T.

So, of course, when we're giving CAR-T, we're always looking at how do we premedicate a patient. And it is important that this can cause a chill, a fever, when we infuse the T-cell, the CAR-T cell back, so we do give Tylenol/Benadryl. However, the one thing of note that is important is that we do not give steroids as a premedication for this, because although we often give it in other therapies, we know that having circulating steroid or dexamethasone, one of them, in the system at the time we are infusing T-cells, it may actually kill the T-cells because we know steroids kill lymphocytes. And that's what we just created, these souped-up lymphocytes. So, avoiding steroids is an important aspect.

One thing also is we do initiate prophylactic antibiotics to avoid any reactivation of viruses, the development of fungal or bacterial infections. That's an important aspect because these are immunosuppressive therapies that we're giving. And then finally, one of the toxicities of a CAR-T can be a neurotoxicity and there is an increased risk of seizures, so some centers may consider antiseizure prophylaxis just to avoid that issue.

Dr. Caudle:
You know, it makes sense. And you know, turning to unique adverse events with CAR-T therapy, can you explain what they are and their relationship to initial administration?

Tricia:
Yeah. Well, we do have two very unique toxicities. I like this timeline, it's helpful just to see where these unique toxicities. The first one is called CRS, cytokine release syndrome, and neurotoxicity. They occur very soon after the infusion of T-cells. It can happen the day of the infusion. CRS, we'll talk about in a second, but during the CRS and neurotoxicity phase, it's usually, as I said, early in the first week or two and that's why many patients are usually, excuse me, admitted and being observed very closely for the emergence of these toxicities. Some centers might actually initiate the therapy outpatient, but the first sign of any hint of these toxicities, they're getting admitted for further management of that.

In a CAR-T therapy, because of these potential toxicities, there could even be delayed neurotoxicity up in that first month of therapy, so CAR-T approvals usually require patients to stay close to the CAR-T Center for that first month to watch very closely for emerging toxicity. They may be in the hospital for that first week or two, but then discharged, but stay close to home. And that's an important aspect for education for families and patients, that they need to stay close by.

The other toxicities can happen a little longer out, after that month, although can also happen during that first month of therapy. Can be low blood count, cytopenias, risk of infection, and certainly B-cell aplasia is on-target toxicity because we're targeting the lymphocytes, and so we're bringing that B-cell level down because of the activity of this treatment.

So, just to kind of separate out, there's the acute toxicities that we have in the first month of therapy, and that's typically managed by the CAR-T Centers that are rent-certified. And then there is, once patients get through that initial month and they're feeling well, doing well, they are referred back to their community setting. But still, to be watching for B-cell aplasia, the administration potentially IVIG is something because they are hypogammaglobulinemic after this. And monitoring labs for cytopenias or late infections, some of them could even be opportunistic infections. So, I think it's an important aspect of the acute versus delayed adverse events.

Dr. Caudle:
You know, those are great points. And now, how do you monitor a patient who has received CAR-T therapy for potential adverse events? For example, CRS, neurotoxicity and infections in your practice?

Tricia:
Yeah. Well, we are, you know, we know that CRS is cytokine release syndrome, and it is an immune response to the T-cells being infused and expanding in the system, and it is associated with more bulky disease. So, we are very mindful of the early nature of this and monitoring with vital signs and just observation, blood tests looking at – there's two unique labs that we order to get a sense of whether there's an emerging CRS. CRS usually is hurled with a high fever and then there can be lowering of the blood pressure, and

also oxygen-requiring nature to this as the grading system goes up. And just to highlight that all these grading systems are in your resource in the back of this program. But I do think that the two unique labs are the ferritin and c-reactive proteins. It turns out, they are markers for acute inflammatory events, and so they'll shoot up. And if you're suspicious for this, we do monitor ferritin and CRS. But we also look for, is there renal insufficiency developing, liver function abnormalities? And so, the nurses do play a very important role in that, and that's why they're monitored in the hospital for that week or two.

The other aspect to this is that we actually have an antidote to it. Because it is a cytokine-driven phenomenon, it turns out interleukin 6 is the major cytokine that's causing this reaction in our patients, and we now have an anti-interleukin 6 monoclonal antibody that we can administer to a patient that can really turn this process off relatively quickly. And it turns out that it is so helpful because this can be life threatening if it left unchecked and the grading system increases. It is required by the REMS risk eval program that the center needs to be participating in, and anyone that cares for someone undergoing CAR-T needs to have a REMS program associated with it, and that we have two doses of tocilizumab on hand at the time that we administer the T-cell, just to have close access to it. And that's been very helpful at a quicker treatment for this emerging toxicity.

The other toxicity we talked about is that neurotoxicity, or ICANS, immune effector cell in toxicities, and that is a little unclear why that happens. It is thought to be a T-cell mediated phenomenon as well. It can happen with CRS, but it can also happen alone. And so, the thought is that it may happen a little later in the therapy within the first 5 to 10 days. It's usually self-limiting, but when it progresses to a higher grade, it does require treatment and close observation. So, we do find steroids can be very helpful to turn this process off if it's associated with CRS, tocilizumab can be utilized as well. And certainly, utilizing antiseizure therapy if the grading system increases over time.

Now, the other early therapy risk of infection is highlighted here with the various bacterial infections we see, viral, fungal. These are some of the treatments that are available for our patients, and they are very helpful at reducing risk in these patient populations. So, we do utilize prophylactic and continued therapies and monitor for this risk of infection for long-term. We do give immunoglobulins for low IgG levels and monitoring them for a long period of time is an important aspect of this. And certainly, monitoring neutrophil counts and administering growth factor if need-be, and that can be very helpful at avoiding risk, or risk of infection I should say.

Dr. Caudle:
Sure, no, thank you. Thank you for this. As a quick reminder for those of you who are listening or just tuning in, you're able to submit questions for our Q&A session at the end of this program by typing them into the chat on the right side of your screen or in your comment box through Facebook LIVE.

So, Tricia, is there a difference in the timeline of adverse events with bispecifics compared to the CAR-T adverse events that we just talked about?

Tricia:
Well, yeah. So, bispecifics is a little different. Where CAR-T is a one-time treatment, this bispecifics are administered subcutaneously weekly or every other week. And this is a nice timeline for the administration. And how we prepare someone for bispecifics, in the red box, these are the things that we do prior to the therapy in the Community setting. We're screening and evaluating patients, referring them to the center that will be administering the bispecific therapies. But more and more recently bispecifics are even being started in the Community setting. But there is still the associated CRS, because you're, remember, you're grabbing the T-cell and the myeloma cell and bringing them together in with this monoclonal bispecific antibody, so it is very important to be mindful of that. And CRS and neurotoxicities do occur with bispecifics. But the treatment itself is usually initiated in the restricted or approved site or center. There is mitigating administration. To avoid CRS and neurotoxicity, we actually give step-up dosing. So, the first week, instead of just getting one full shot each week, we give a very small dose on day 1, we wait 48 hours watching for any emerging toxicity of CRS or neurotoxicity. Once 48 hours goes by, we give a little higher dose, and then 48 hours observation followed by the first full dose of a bispecific is given at that point if there is no emerging issue. Just to be mindful, it's usually, if there is a CRS or neurotoxicity, it often occurs in that early week, in that first week of therapy, and that's why many centers actually admit patients for that observation time. But that's something to be mindful of.

We then, once they go home on the full dose, although we do monitor for CRS neurotoxicity less common, but still infection, cytopenias, those things can occur and very quickly soon after that we are coordinating with the Community Center to initiate that therapy in their local community setting if it is available. So, the toxicity profile, this is the first FDA-approved bispecific antibody against BCMA target, is Teclisatamab. And this was the very exciting clinical trial that showed great response rates, but there are certainly some toxicities of neutropenia, CRS. Although it was seen, 70% approximately, of the patients did have some CRS. It was very low-grade. And I think that's something to highlight the difference between CAR-T and bispecific. Although CRS neurotoxicities do occur, it's a little lower-grade that occurred. And so, I think that's a helpful thing to look at.

And again, just to highlight the difference in how we administer it, that step-up dosing is very helpful, the premedication. But we can give, actually, steroids in the premedication with bispecifics, where we cannot prior to a CAR-T infusion. And tocilizumab is certainly indicated for CAR-T and can be utilized as well in bispecific CRS-like syndromes.

Dr. Caudle:
Excellent. Now, it looks like the infection risk is different for these two bispecifics. You know, why do you think that is? And are these on-target events?

Tricia:
Yeah. So, the two targets, BCMA and GPRC5D, so Teclisatamab and erlotinib are the two BCMA-direct therapies. But I just like to highlight that Teclisatamab infection rates were 80%, and hypogammaglobulinemia occurred in close to 75% of the patients. This was the first trial for bispecifics, and the peak of the trial was done during the peak activity of COVID. And you'll see here, there were COVID deaths, unfortunately. And so, the other thing we learned with that trial is the use of prophylactic antibacterial antiviral, anti PJP prophylaxis, and that. So, when talquetamab was done, there was definitely less infection, as you mentioned. But there was still development of hypogammaglobulinemia. But I think we've learned. And all bispecifics going forward, we're utilizing prophylactic antibiotics and antivirals, et cetera, and monitoring for infection because it can be a part of the toxicity profile of this, of course.

And listed here, just again, are those various prophylactic things that we do, and I really do want to highlight the use benefit of the inner infusional IVIG. We don't give it to everyone. We monitor the level of IgG and if it's dropping below 400, certainly below 300, we're starting to administer that and that has been very helpful. The other thing is consideration, if there is an infection, is spreading out the schedule a little bit. Moving to an every-other-week if they're responding or achieving a nice remission. These are things that we're looking at to hopefully benefit our patients to avoid infection.

Dr. Caudle:
That's helpful. And, you know, what about the new target, GPRC5D? Is there anything different with this bispecific versus the BCMA-directed bispecific class?

Tricia:
Yeah, there are particular toxicities that are unique to this. And as I mentioned earlier, there is some mild expression on the hair follicle skin cells, as well as in the, I guess, really also, in the hair – the nail, that's what it's called, the nail hardening aspects. So, you'll see that there are some oral changes that are unique to this. Patients can have dry mouth, altered taste. We prepare our patients for this, because it can happen early, these toxicities, and so, monitor.

We just had a young patient come in who last week, we said you're going to lose your appetite, and he must have gained like 5 pounds in the time, because he was like, I told them I might. Yeah. But it turns out that it can be a serious issue. For him, not so yet, but it's early in his treatment course. But we do utilize nutritionist to help our patients with this. Mouths can be very dry. We do suggest some artificial saliva, sucking on lemon drops can be very helpful. Utilizing liquids to help. Some people can have difficulty swallowing. So, that's an important aspect to this. And weight loss is associated with all this. So, some people with swallowing, and they may even have thrush, and so, monitoring for that, treating for that, can be very helpful as well.

The other toxicity is skin-related. So, dry skin, rashes can develop. So, utilizing creams and moisturizing creams can be very helpful for our patients. There is nail thinning and even nails can pull from the nail bed and so, utilizing ointments to keep that moist can be very helpful as well. I think, as I really do think seeing these toxicities and pictures can be very helpful for us as we're starting to utilize this drug. And so, you can see these nail changes can be dry, they can – nails are very brittle, and so we use moisturizing creams. We keep the nail short. Nail strengthening polish can be sometimes helpful in our patients.

And then finally, the last picture is just the rash that can often develop on the palms and soles, and can be somewhat painful when it can, as you can see in some of these pictures. And so, utilizing moisturizing cream. Holding treatment can be very helpful if it's higher grade, until it resolves to a lower grade, and then reinitiating it. Many of these are self-limiting and overtime, they do improve.

Dr. Caudle:
Well, this has been very helpful and a fantastic review of multiple myeloma care. You know, before we close, would you like to leave our audience today with any key take-home messages?

Tricia:
Well, I think the comparison of the various T-cell directed therapies, or immunotherapies, are listed here. We have the monoclonal antibody bispecifics, or what we call off-the-shelf. If someone cannot wait for manufacturing to occur, these are great options for therapy. As we know, monoclonal antibodies are even being utilized in upfront use. The CAR-Ts are moving earlier, as well. CAR-T and

bispecifics do have those unique toxicities related to the robust T-cell reactions that we can see, which benefit our patients for killing myeloma, but can also cause these toxicities of CRS neurotoxicity. So, I think monitoring is essential in any of these. However, the one aspect to the CAR-T, it does require lymphodepleting chemotherapy, where the others do not. And then, finally, I think, really just to conclude, I think we've just – hopefully you've seen that we've made such significant advances in the last few years with these highly effective immunotherapies that, really, people are getting wonderful responses to with maintained remission.

They do require observation and long-term management in most cases, and we're just happy to report that patients have such great access to these and are really just surviving longer, so that's exciting.

Dr. Caudle:
It is very exciting. No, that's, that's very well put. You know, for now we're gonna actually move on to our Q&A session. If you have not submitted a question yet, feel free to do so through the chat on the right hand side of your screen.

Okay. So let's start with our questions. We have a number of them here. The first question says, can you elaborate on the latest clinical trial data for emerging treatment options in relapsed refractory multiple myeloma?

Tricia:
Well, I think in the relapse setting, we have great advances as we talked about that we highlighted in the CAR-T therapies, as well as bispecifics, to the point where now they're moving earlier in lines of treatment. And so, it's just been remarkable how that has greatly, significantly improved our patients in that heavily treated relapsed setting.

Dr. Caudle:
Absolutely. Absolutely. We have another question here. How do the evolving treatment options impact patient selection criteria and treatment algorithms for RRMM, and/or change approaches and treatment sequencing?

Tricia:
Yeah, well, that's the big challenge now is, how do we, you know, how do we sequence these therapies? What's best for that patient at that time? And it's all individual. There isn't a one-answer-for-all of that, and it does require longer visit times to figure out what is the best approach for that patient at that time. Utilizing the community settings, as well as the tertiary care settings to really come up with a plan for that particular patient. And so, it is evolving, and as we continue to have these treatments available, we'll learn more of how best to sequence them. But for now, it is one of the important aspects that we're figuring out.

Dr. Caudle:
No, that makes sense. We have another question here. The question reads, especially for academic and tertiary care centers, what are common challenges when integrating newer treatments for RRMM into your practice, and what recommendations do you have to overcome them?

Tricia:
It's true. One aspect we found in the tertiary care setting, where, you know, this is myeloma. All of these immunotherapies, every patient that has myeloma, potentially, could be a candidate for these. And so, then you're dealing with all the other things you're doing, CAR-Ts and other diseases and things, so finding the right space. Removing therapies to maybe, in many cases, to an outpatient setting, to initiate some of the bispecifics or CAR-T. And so, utilizing the resources that you have is one of the challenges that I found we had. But I think we're learning from that, and anticipating toxicities and things can be very helpful. But that's one aspect I think of when you ask that question.

Dr. Caudle:
No, that makes sense. Another question, how can clinicians effectively mitigate and manage chronic adverse events in patients undergoing long-term RRMM treatment, including additional support strategies?

Tricia:
Well, I think long-term toxicities, particularly infection. So, there is required monitoring. You know, once someone has been on these therapies, you still can develop toxicities, and so utilizing prophylactic antibiotics, monitoring lab values and things, is very helpful. Utilizing just the community setting in general, you know, just educating them to these potential toxicities, can all be very helpful to prevent long-term issues and things.

Dr. Caudle:
Absolutely. And the next question is about multidisciplinary care. So, they ask what approaches are recommended to improve a multidisciplinary patient-centered care?

Tricia:

Well, we definitely utilize multidisciplinary aspects. We know that patients do require sometimes, you know, these people are on these therapies ID, we have cardio-oncologists that are utilized, and we have social support that is such an essential aspect to this, not only to the patient but to the family. Utilizing nurse navigators to help coordinate some of the care and communication within the community and outpatient. Social workers, we owe a debt of gratitude to our social workers that, you know, can help as simple as, like, traveling to the site to get these ongoing treatments can be very important and essential.

Dr. Caudle:
That's excellent. Can you elaborate on the evolving role of nurse navigators and ensuring optimal access and adherence to new treatments for RRMM patients?

Tricia:
Yeah. Well, there is a network of nurse navigators, and they all know one another, which is good. Yes. And it's growing. And I think utilizing them to help facilitate entry into a setting that requires for a CAR-T or the bispecific therapy, a REMS training center but also communicating back to the community can be so, so helpful and is so I, I see great help that, that has already provided for us.

Dr. Caudle:
The question says, as a nurse in the community setting, what issues should I be most prepared to watch out for when a patient of mine returns for follow-up after CAR-T or bispecifics?

Tricia:
Great question. And I think that, to assure you, we wouldn't send someone to the community until we're pretty confident that, particularly in CAR-T, because we do require them staying close by this CAR-T center for that month. There may be some emerging CRS or neurotoxicity. Not so much CRS, but neurotoxicity may be a little later. So, monitoring for that, being aware that that is a potential thing. We still do monitor our patients from afar too, and they do come back to the center as needed. But I think really for the community setting, it's the monitoring of blood counts, the administration of growth factor as needed, the administration of IVIG, are really essential. And managing the prophylactic antibiotics that are important now. Bispecifics, you're actually administering the drug in the community setting at this point, and so, again, monitoring for infection. And important, if there is an emerging issue, holding the therapy until infection resolves and things like that is an important aspect.

Dr. Caudle:
Excellent. Thank you for that answer. We have a number of other questions. The next question says, can you share best practices for integrating new RRMM therapies into a busy clinical setting?

Tricia:
Yeah. Well, I think our patients wait longer in the waiting room because every discussion with every patient has so many options of therapy, and so it is an exciting time, but it does create a lot of – there's a lot more education of patients and family members and how best to sequence the therapies is a challenge. But we look forward to this challenge because it benefits our patients in the end. Absolutely, absolutely.

Dr. Caudle:
We have another question. The question says have you found that bispecifics are moving into the community setting?

Tricia:
Yeah. Well, I think there is a hesitancy when you hear about CRS neurotoxicity. And like, woah, do I want to handle this? And I think that what I want to stress with bispecifics is, yes, these toxicities do occur. They tend to be lower-grades, grade 1 and 2. Many patients don't even require tocilizumab therapy. So, I think that it's usually early on in that first week or two there could be some delay activity, but I do think as we get more comfortable with this, as it's being introduced into the arsenal therapies for our patients with myeloma, it is moving out to the community and very successfully so. And so, I think I do see this definitely evolving and moving out there very quickly.

Dr. Caudle:
Excellent. We have another question. This question asker says, where does the community oncology practice fit when managing patients with multiple myeloma, who were initially treated at a tertiary care center?

Tricia:
Yeah. So, I work at a tertiary care center and often, we love to partner with the community setting for any therapies that can be given in the community setting. Unfortunately, CAR-T is required to be in a REMS certified center, but we will work very closely with the community centers. Many of our patients do have them, but I think it's our responsibility to try to really educate the community, try to do outreach with them, to really make them comfortable and feel part of it because it is a really important aspect to our patient care.

Dr. Caudle:
Understandably. Another question: How do nurses, advanced practice providers, APPs, and nurse navigators play a role in educating patients about newer RRMM treatment options?

Tricia:
Well, I think doing programs like this is helpful to know the potential toxicities, how do we mitigate those toxicities. And I think – but nurses are always willing to learn that stuff and they're always the first-line of defense. Patients are always very comfortable asking them questions, and I think, as I mentioned, having APP-run units that are ministering these bispecifics or monitoring post-CAR-T is essential. So, I think nurses play an essential role in all this, and I see it continuing to grow.

Dr. Caudle:
Absolutely, absolutely. What patient education and counseling strategies have been the most effective for addressing common patient concerns on safety, efficacy, especially adverse events, to improve adherence?

Tricia:
Well, I think making sure patients are aware that, you know, we want to take the potential CRS neurotoxicity very serious, and infection, because it can be life-threatening. So, you don't want to scare your patients, but you want them and family members to understand you don't ignore symptoms, you reach out to your provider. We have patients on prophylactic antibiotics, but sometimes that's not enough. And so, we do need the assurance of a patient and their caregivers to be aware, and to at least know how to reach us, day or night. Another aspect of this, if they do get sick and they're not near a center that has been giving the CAR-T, we do have information cards they keep in their wallet. We had a patient just last week who did present that to a local emergency room with a fever a month after receiving a bispecific antibody, and it was very helpful.

Dr. Caudle:
Yes, I can only imagine how helpful that would be. That's excellent. It looks like we have one more question. Can you elaborate on the evolving role of nurse navigators in ensuring optimal access and adherence to new treatments for RRMM in patients?

Tricia:
No, I think nurse navigators are very important in this, and I think, you know, we're seeing an increase in the number of nurse navigators, which is important. Sometimes there's lack of nurse navigators, but they are very essential to communicate with. Our nurse navigator in our institution, really reviews that new patient consult for CAR-T or bispecific, or just treatment in relapsed myeloma, and can help get people in quicker, communicate very closely with the community setting. Also, be essential to be in the communication as we refer people back. They also are very essential in other modalities or specialties that we may require, radiation therapy, infectious disease, cardiology. They're very essential in linking our patients to those other specialties.

Dr. Caudle:
Yes. No, that’s great and very helpful. So, thank you very much.

So, this was a great way to round out our discussion on nursing considerations when managing patients with relapsed and refractory multiple myeloma. I'd like to thank my guest, Tricia Mangan, for helping us better understand how advances in treatment are impacting clinical care.

Tricia, it was so great speaking with you today.

Tricia:
It's wonderful to speak with you. Absolutely.

Announcer:
Thank you for joining our replay of a live broadcast titled, "Multiple Myeloma Care: Translating Evolving Practices to Oncology Nurses in Community Settings," provided by the American Academy of CME Incorporated, and is supported through an educational grant from Sanofi Legend Biotech and Janssen Biotech Incorporated, administered by Janssen Scientific Affairs LLC.

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