The Latest Multiple Myeloma News
Convention Connection: American Society of Hematology Meeting
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Andrew Schorr:
Andrew Schorr on location in Orlando, Florida at the 52nd Annual meeting of the American Society of Hematology. There are doctors from around the world and one of the discussions that is predominate here is about multiple myeloma. There is a lot of new research being presented here. Happily we have a number of very effective therapies now and it looks like there are more coming. We wanted to understand what does all this mean for someone newly diagnosed with myeloma; someone who may now be in treatment; and someone who has gone through a number of the therapies and wondering what could be next for them. We pose those questions to Dr. Keith Stewart from the Mayo Clinic.

Dr. Stewart, I’m here with Jack Aiello who had had three transplants for multiple myeloma in medical therapy; radiation as well; doing well. How many years now Jack?

Jack:
Doing well, I was diagnosed 16 years ago in 1995 and my third transplant was a full allogeneic back in ’98 so I’ve been, I’ve not had any treatment for the last nine years.

Andrew Schorr:
Great news! So Jack blogs and is a volunteer with several organizations so we have a number of questions for you. First of all where are we now using this ASH meeting as sort of a benchmark with treatment for myeloma? I know there is more news every year. What is significant now?

Dr. Stewart:
Well the most significant thing is we have better treatments and people like Jack are living longer and I think there is a great deal of hope for patients who are diagnosed today that they are going to have a long life span. We have new drugs; less toxic drugs. We are defining the role of transplant more clearly. We have got advances in genetic understanding of the disease. So I think the main message is there’s hope and we are making progress.

Andrew Schorr:
So there is always questions about combining drugs; which drug with which drug, tell us about that; where we are; and sort of the state of the art combinations.
Dr. Stewart:
Yeah I think the bottom line message is combinations are better. In most trials we have done and in most instances and most measures of success. Which exact combination is the best? We don’t know. They each, there are many different cocktails. They each have different side effect profiles. They have different economic costs and there will be some presentations at this meeting where some of these regiments are compared and the bottom line for at least one of the trials that will be described is all three cocktails that we dreamed up were pretty much equivalent. And it didn’t matter whether you used Velcade, Revlimid, Dexamethasone; Velcade, Cyclophosphamide, Dexamethasone; or all four drugs together, they all worked great and it was very hard to distinguish anything between them except very subtle changes; and probably the major differentiator would be cost.

Andrew Schorr:
Jack, I know people ask you when they are newly diagnosed where should we start, right?

Dr. Stewart:
Sure they do. I’m thinking about that study you just mentioned. I guess the question is do all three of those combinations work the same on all patients? How do you know which of those three to try on a given patient?

Dr. Stewart:
That’s a very good question. Of course at the Mayo Clinic, we believe very much that we should use genetic risk as a determinate of what kind of treatment you should get but the first stratification we always make myeloma is whether you are fit enough and young enough to have a transplant like you did or you are elderly and you are not going to go for a transplant. That traditionally has changed how we approach the disease but what we are seeing at this meeting is a blurring of those edges; a blurring of the distinction in the two populations that the treatments are good in both. They are probably tolerable in both; and I think we are going to see a move to a one size fits all type approach to therapy.

Now that is with respect to the choice of drugs; the second element there however is patient preference; how far they live from the hospital; whether they have got renal failure or kidney failure or not; can they get the drugs in their country, in their insurance plan? So we really have to individualize therapy. There is the sort of this is the ideal regiment or mix of drugs that we could approach you with but then we have to deal with you as an individual and decide what is right for you. Where do you live? Who is your doctor? Do you like oral versus IV? Do you have diabetes? All of those things have to be taken into consideration.

Andrew Schorr:
Dr. Stewart, there are people who have more aggressive or less aggressive forms of the disease. Some have been described sometimes as smoldering; where you say “should we start now?” What is your view about how aggressively to treat myeloma in those cases when to start?
Dr. Stewart:
Well myeloma is a linear, sequential stage of disease; it is from monoclonal gammopathy into smoldering which is really asymptomatic myeloma to symptomatic disease. Now traditionally we have not treated asymptomatic myeloma and the reason we don’t treat it is that one in four patients with smoldering myeloma needs no treatment for 15 years. We are making such fast progress; I think treating those patients too early may do more harm than good. There are some studies now addressing whether drugs like Revlimid Lenalidomide used earlier in patients with smoldering disease are very likely to be going to get myeloma within a few years, might slow down progression.

I think that really needs to be reserved for the clinical trial situation where there is close follow up; close understanding of who those patients are. Overall we don’t treat patients until they are symptomatic for the reasons I just explained.

Andrew Schorr:
Okay, two classes of drugs that have made a big difference: IMiDs and proteasome inhibitors and not surprisingly, there are what could be newer generations in both those areas. What is the data on those?

Dr. Stewart:
We have a series of new proteasome inhibitor which are similar to Velcade or bortezomib which are in clinical trials. The one that is most advanced is Carfilzomib. Carfilzomib is now owned by Onyx Pharmaceuticals. It looks to be a drug with potency about the same as, at least the same as bortezomib. It has a different side affect profile. Most importantly, no patients on the studies had to stop the drug because of damage to the nerves, the peripheral neuropathy. So that would be its major selling feature. In terms of it’s, and we think that will go to the FDA next year. We hope the FDA approves it as an unmet medical need drug because it does work in about twenty four percent of patients who have already had and failed bortezomib and what we call the immune modulators, thalidomide and Revlimid.

In that class we have another member of the family too which is pomalidomide. Pomalidomide is also a very active drug and just like carfilzomib is quite interested in it is it seems to work when both of those drugs have failed; when thalidomide has failed and bortezomib has failed when Lenalidomide has failed. Pomalidomide seems to still have activity and we’ve been fortunate at Mayo Clinic to treat many hundreds of patients with it now. It’s well tolerated and it seems to be effective. When it goes to the FDA I don’t know. That one is a little bit less certain when that will happen and whether it will happen in myeloma or another disease initially.

Andrew Schorr:
Jack as you listen it sounds very encouraging that there is a new crop of drugs that may be offering improvement coming along.
Jack:
I think, I always think it is so important for patients to be involved with clinical trials. The first one I was in was thalidomide and while it didn’t work for me, it worked for about a third of the patients and I always feel like, you had a small part in moving myeloma treatment forward.

I think it’s really exciting with the carfilzomib, Proteasome Inhibitor working when a patient is no longer responsive to Velcade or pomalidomide potentially working when a patient is no longer responsive to thalidomide and Revlimid. So that’s really exciting and benefits the patient a lot.

Andrew Schorr:
So Dr. Stewart, you spend your days researching and treating this disease. How would you mark this time now as far as hope for someone diagnosed with myeloma? Many people who are diagnosed with it, they have never heard of it before or they have been treated for it a number of years and it takes a downturn and they say “is there any other line of treatment for me?” What encouragement could you give them?

Dr. Stewart:
Well as I started saying earlier, people are living longer. We have patients who have taken seven, eight, nine, ten lines of chemotherapy and by the time they run out, we have come up with a new one like you have just heard. So I think there is great promise for people who have the disease now that their life will be long. I don’t think we can tell people yet that we can make the myeloma go away and never come back. We can tell them that they will live a long time but there will be periods in their life they need treatment; and there will be periods of their life where they don’t. For a patient newly diagnosed today with all the new drugs; the better understanding of how to use them I fully expect that some of those patients will be cured of their disease moving forward. We are very close I think.

Andrew Schorr:
As you’ve been hearing, the landscape of myeloma treatments continues to change and that change is accelerating so now more than ever before, it is important for you to get smart about multiple myeloma and then consider your options; discuss them with your doctor; and I would say, get a second opinion from a myeloma specialist. So that you make sure that you get the treatment that is right for you. In Orlando, I’m Andrew Schorr.

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