Transplant or Targeted Therapy: What's the Mainstay for Treatment in Multiple Myeloma?

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Andrew Schorr:

Dr. Hofmeister, you saw the hands go up with people who have had transplant, but now you have more and more drugs. Where do you come out in the debate of whether transplant still remains a mainstay, or would a pill or an injection or an IV take the place of that?

Dr. Hofmeister:

We do more transplants at OSU than anywhere else in the Midwest for myeloma, and I went into myeloma because I hate transplants. I hate the idea of dumping in chemotherapy into a patient's body that is poison. That just boggles my mind. Because I think it's not where we want to be. We want to be using targeted therapy that doesn't hurt the patient's normal cells but is going right towards the cancer cells. This is where most of our research at OSU is heading, and this is what we think is the next best thing.

But beyond looking at the future, a lot of times you have to say, Well, what are the tools that I have now? Who is the patient? Will they benefit from putting their disease in remission? Will they have a better quality of life if we expose them to an autologous transplant and the high-dose IV melphalan (Alkeran) that goes along with that? Will we be able to prolong their life? And while I find the whole procedure distasteful, and many of my patients, I know you're here, you found the

procedure distasteful too, and you didn't like the nausea, the diarrhea and the fatigue that goes along with it, that's consequent to chemotherapy.

Know that we are desperate to try to make that procedure go out of style, but the goal always in the foremost is What can we do today? What is the best decision for that patient today to prolong their life. And still autologous transplant holds an important spot for many patients to put their disease in remission, prolong life.

Dr. Lonial:

And if I could just add a little bit to that because I think Craig's sentiment is an important one. If you look at data from centers around the world, for instance, that use what I consider—and I don't know where Craig falls on this, but I consider the combination of bortezomib (Velcade) with Revlimid (lenalidomide) and dex (dexamethasone) to be probably the most powerful regimen, RVD, for newly diagnosed patients. Those patients then move on to a transplant and then get maintenance therapy. We're seeing remission durations on average that we have never seen before. And I'm not just talking about you know living a year or two longer here. I'm talking about remissions and excess of five years, which on average in a large population has not been shown in many other large, randomized trials.

I think that perspective needs to be put in to context with what else we've done in myeloma. Yes, we've got lots of new drugs, we have lots of new treatments. If you look at patients in the US across the board, survival 10 years ago versus survival now, it's doubled. It's doubled. And if you look at academic centers where all they do is focus on myeloma therapy, it's probably tripled in terms of overall survival. That to me represents the concept of combinations, integrated therapies, using transplant, not using transplant at the right times. It's a package deal that I think is really important to pay attention to.