Long-Term Treatment Planning for Multiple Myeloma

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Andrew Schorr:

Talk about the road map. When you sit down with somebody, how do you think of the road map of care.

Dr. Lonial:

I think that that actually is a really important point to bring up, and I think it begins with the story that Craig told us at the very beginning. About 10, 15 years ago where if you had myeloma it was, Here, we can try one of these two things, try it, see me back in six months. If it works, that's great, if it doesn't, we'll move on. And you didn't really have a lot of choices.

Now there are lots of choices, and I think it's important that we not just be happy with patients having a response, which is what we were happy with 10 years ago. Oh, great, you're end protein dropped by 50 percent, that's great news. Well, that's not all we want to know anymore. We want to know how low can we get it, what's the best treatment approach.

And I think what major centers really do is chart out not what we're doing today and tomorrow but what we're doing six months and 12 months and 18 months and 24 months and five years and eight years from now. How are we charting out your road map down the road, whether that involves medicines that we don't even know about today, we want to know that we're maximizing the benefit from the medicines we have, and that is a unique function that you'll probably really only get at a major myeloma center like the one you guys have in town.

Andrew Schorr:

It would be a terrible tragedy, people in the audience would say, if they were given something early on that wouldn't let them be in the trial. Oh, you had this, sorry, you know. That's a worry that people have. How do we cover that off?

Dr. Hofmeister:

I think with older drugs, especially you read on the internet that people would be concerned that if you were a transplant candidate you shouldn't get X drug or Y drug, and because I think we have better supportive meds and ways to get stem cells available for patients, should they want to move on to autologous transplants, the idea that one therapy is going to preclude another is often a concept of the past. And in general when we see patients, we see newly diagnosed, we see relapsed, we see their tenth line of therapy.

Really, the way we think about it is always the same. What is the next best thing? What is the next best thing for that particular patient that particular day? And we look through what's available on clinical protocols, what's available off trial and what's best for them and what fits their life. That doesn't change, that changes based on what they've had, but very little planning necessarily for what might come up in the future because probably wouldn't have predicted a lot of clinical trial results that happened in the last 12 months. Lord knows we can't predict the ones in the next five years, so I think very much we want to personalize it to what's the next best thing today.