ASCO 2021
Jack Aiello – Terse Notes

Key Takeaways:

1) High Risk MM is still an unmet need. We need more HR-only trials. [8000, 8001, 8002, 8042]
2) Sustained (1 yr, 2yrs?) MRD is a very important endpoint.
3) Teclistimab may be the first Bi-Specfic (BiTE) approved and just received FDA Breakthrough Therapy designation. One new (at least for me) BiTE was introduced: Eranantamab from Pfizer. These Bi-specifics continue to show high response rate. [8007, 8006]
4) After 24 and 18 mos follow-up, Abecma/Ide-cel and Cilte-cel CAR-T shows durable responses respectively. [8016, 8005]
5) Whole-body MRI is more effective than PET/CT as detecting focal lesions and diffuse MM. [8012]

ASCO URL: https://meetinglibrary.asco.org/results?meetingView=2021%20ASCO%20Annual%20Meeting
Theme: Equity – Every patient, every day, everywhere.

Color Key Codes
Oral: 8000-8008, 10507; Posters: 8010-; TSP: Trials in Progress
Green = CART, BiTE; Purple = CD38/Dara; Red-Not on Dr. Thompson List; High Risk

---

8000 (CARDAMON): KCd induction (4 cycles) –> (R)SCT vs KCd consolidation (4 cycles) -> K maintenance (18 cycles) (N=197 maintenance) for NDMM pts (N=281). Although MRD- 10^{-5} rates were higher for SCT arm (53% vs 36%), after 37 mos follow-up other measures ORR, PFS, and OS were similar for this non-Rev treatment. For HR pts (N=41), MRD- rates were higher for SCT arm (67% vs 32%) but HR pt numbers were small. Overall SCT arm did not show significant benefit. K Yong

8001 (UK OPTIMUM): Pts (107) take Dara-CVRd (6 cycles) in ND ultra-high-risk (>= 2 of t(4;14), 6(14;16), t(14;20), 1q+, 1p-, 1p- or certain gene expression) MM and pts w pPCL (circulating plasmablasts > 20%) followed by SCT followed by Dara-VRd (18 but "d" dropped after 6 cycles) and Dara-R maint. MRD- by 10^{-5} after induction and D100 post SCT were 41% and 64% resp, and ORR was 94% and 83% for the same periods. ORR at D100 post SCT for PCL was lower at 75%. M Kaiser

8002 (FORTE): KRd induction/consolidation w/wo SCT followed by Rev or KR maintenance efficacy in HR NDMM (N=243). KRd-SCT and KR maintenance is highly effective in HR and Double-hit pts, with 4-yr PFS at 62% and 55% respectively and 3-yr PFS from maintenance 69% and 67% respectively. 1 yr MRD- rate was 50% and showed similar results for all types of HR [t(4;14, t(14;16), del(17p), gain(1q), and del(1p)] except amp(1q) (>= 4 copies). F Gay

8003 (ANDROMEDA), Ph3: SubQ Dara-VCd + Dara maint (2 yrs) vs VCd-only in ND Amyloidosis (N=388). CR (59% vs 19%), >= VGPR (79% vs 50%). Cardiac responses higher at both 6 mos (42% vs 22%) and 12 mos (57% vs 28%) as well as renal responses were doubled (57% vs 27%) at 12 mos in the Dara arm. E Kastritis

8004 (CASSIOPEIA Part 2): Dara maint or Observation after VTd +/- Dara and SCT for 886 pts NDMM. Med PFS NR with Dara but 47 mos with Obs although this benefit was seen primarily in VTd without Dara arm. MRD at 10^{-5} was 59% vs 47%. P Moreau

8005 (CARTITUDE-1): Cilta-cel updated (18 mos follow-up) results for 97 pts w 6 prior mLOT. ORR 98% (sCR 80%), 92% MRD- at 10^{-5}, 18-mos PFS and OS were 66% and 81% respectively. CRS occurred in 92% (4% grade 3/4). S Usmani

8006 (MagnetisMM-1) Elranatamab BCMA-CD3 BiTE from Pfizer: IV and now Subq for RRMM pts, who were allowed prior BCMA therapy. Subq ORR for doses >= 215 microg/kg was 70% (N=14/20) although RP2D of 1000 microg/kg (73 mg) ORR was 83% (67% >= VGPR). CRS 73% but all grade 1/2. N Bahlis

8007 (MajesTEC): Updated Ph1 Teclistamab BCMA x CD3; 156 pts (84 IV, 72 SC), 40 pts treated at RP2D and had 5 mLOT. 100% triple class refractory. At RP2D, CRS 70% but gr3 0%, ORR 65% (58% >= VGPR). A Krishman

8008 (Monumental): Updated Ph1 Talquetamab GPRC5D x CD3; 174 pts (102 IV, 72 SC), 30 pts treated at RP2D and had 6 mLOT. Most triple class refractory. At RP2D, CRS 73% but gr3/4 only 1 pt, 75% skin-related AEs, ORR 70% (60% >= VGPR) at RP2D. J Berdeja

8010 (GEM2012MENOS65): Analysis of MRD in bone marrow by NGF and in peripheral blood by mass spectrometry for NDMM (N=187). Results showed significant concordance of 80% and are associated with similar prognostic value. N Puig

8011 Ph 2: MRD adaptive trial of Elo-KRd (12 cycles) induction for NDMM (N=39), then MRD- pts proceed to Elo-Rd till progression whereas MRD+ are given more Elo-KRd before converting to Elo-Rd (actually schema is a bit more complex). Results are early but ORR was 97% 2yr PFS was 87% (100% for std risk) and sCR/MRD- as 10^{-5} was 58% after 8 cycles. B Derman

8012 (iTIMM): Comparison of whole-body MRI and PET/CT for MM detection and disease burden for N=60 pts. WB MRI is more sensitive detecting focal lesions and diffuse disease. M Kaiser

8013: CARTITUDE-2 (cilta-cel) after 1-3 prior LOT and Rev-refractory. 20 pts ORR 95%, 75% CR. CRS in 85% pts, 10% G3/4. M Agha

8014 (FasT CAR-T GC012F): Dual BCMA/CD19 for RRMM (avg 5 prior mLOT) N=19 (18 were HR). ORR 95% (all >=VGPR), mDOR not reached after 14 mos follow-up, CRS 95% (2 pts Grade 3). CAR-T persistence up to 60 weeks, H Jiang

8016 (KarMMA, ide-cel, bb2121): Updated results (2-yr follow-up): MM pts >= 3 LOT and refractory to last regimen. For N=54 at std dose 450 x 10^6 cells, ORR 81%, CR 39%, mPFS 12 mos, mDOR 11 mos but 22 mos for CR pts. L Anderson

8017 (ICARIA-MM) Ph 3: Isatuximab + Pomdex vs PD in RRMM pts (N=307) but not prior Dara. Isa-PD arm favored mPFS (11 mos vs 6 mos), mTTNT (16 vs 9 mos), mPFS2 (18 vs 13 mos) and mOS (25 vs 18 mos). P Richardson

8018 (STOMP) Ph 2: All-oral RP2D of Selinexor (60 mg weekly)-Pom-d in RRMM 4 prior mLOT (N=20). ORR 65%, mPFS not yet reached for pts on RP2D. In those POM -refractory and had prior dara, ORR was 44% and 58% respectively. D White

8019 (BOSTON): Selinexor-Vel-d vs Vel-d survival in older (>=65yo) RRMM pts (N=241). mPFS longer (21 mos vs 10 mos), ORR improved 76% vs 64%, med OS NR vs 29 mos. No Grade 3 AE differences although Most AE's higher but reversible in the Sel arm. However lower Neuropathy since Vel only given weekly vs twice weekly. T Facon

8020 (Ph 2): Ixa-dex vs Pom-dex for Rev-refractory RRMM pts (N=122). Ixa-d arm prolonged mPFS by 2 mos (7 vs 5), had lower G>=3 AE rates, and comparable QoL but otherwise similar results. Ixa arm had more diarrhea, thrombocytopenia, and neuropathy but less anemia, neutropenia, and pneumonia. M Dimopoulos

8023: Ph2 data for 15 of planned 25 pts reporting MGTA-145 + plerixafor for rapid stem cell harvest…same day mobilization and collection. 100% of pts harvest >=2M cells, 80% >= 4M cells. 100 pts fully engrafted, avg 12 days. MGTA-145 could replace GCSF. S Sidana (Stanford)

8024 (Boston): For Rev-refractory MM pts (N=106), SelVd vs Vd, mPFS 10 vs 7 mos, TTNT 13 vs 8 mos, ORR 68% vs 47%. X Leleu

8030: Cilta-cel (N=97) vs conventional treatment using MAMMOTH study pts (N=190) refractory to anti-cd38 mAb. Cilta-cel benefits were ORR (96% vs 30%), 12mosPFS (79% vs 15%) and 12mosOS (88% vs 35%). L Costa

8035 (LYRA): Ph 2 (N=101) Dara + CyBorD induction w/wo SCT followed by Dara maintenance 12 mos. SCT offered some benefit: >= VGPR 82% vs 70%, 3yr PFS 69% vs 73%, 3yr OS 95% vs 84%. R Rifkin

8037 (ANCHOR OP-104): Melflufen + Vel +dex in RRMM pts (N=13). Optimal Mel dose is 30mg, with ORR 57%. R Hajek

8038: Weekly selinexor, carfilzomib, dex (XKd) for carfilzomib nonrefractory MM. 32 pts w avg 4 prior LOT. ORR 78% (>=VGPR 48%), mPFS 15 mos. In 9 pts refractory to Vel, Rev, Pom and Dara, ORR was 67%. C Gasparetto

8042 (IKEMA) Ph 3: Isa-Kd vs Kd in High Risk RRMM pts (N=73). Isa arm showed PFS benefit and trend towards improved responses in all HR, including Amp(1q). I Spicka

8044: ISB 1342 CD38-CD3 BiTE from Glenmark Pharma appears more efficient than Dara in vivo/vitro. Ph 1 dose escalation is on-going. M-A Doucey

8045 (Cilta-cel vs Real World): RW treatment patterns (N=196) vs Cilta-cel CAR-T (N=97) for triple-class refractory RRMM. Cilta-cel pts had improved PFS and OS and a reduction in risk of progression and death by 82% and 75% respectively. T Martin

e18152: Health disparities experienced by Black Americans with Myeloma in the US…a population-based study. Black Americans with MM had the slowest improvement and highest inpatient mortality in recent years. Data suggests higher disease burden, more frequent hospitalizations, delay in accessing care and lower utilization of supportive care measures compared with White MM patients. S A Hadidi

e20025: HealthTree report of distress among MM pts during Covid-19 Acute (1,070 pts Apr-Jun'2020) and Chronic (246 pts Jan-Feb'21) phases of pandemic. Eating and Nutrition (71%, 74%), Sleep, Pain, etc. J Ahlstrom

TPS8051 (LIGHTHOUSE): Ph 3, N=240 planned RRMM compares Melflufen (30mg, IV)-dex-Dara vs Dara-only. M-V Mateos

TPS8052 (EQUATE EAA181): Ph 3 1450 pts NDMM not intended for early SCT, DRd 9 cycles, MRD, Random DRVd (18)-> DR maint vs DRd (18) -> DR maint till progression. S Kumar

TPS8053 (KarMMa-4): Ide-cel in HR NDMM pts. 12 pts will be enrolled at optimum target. S Usmani

TPS8054 (AURIGA): Ph 3, N=214 planned Dara SC – Rev vs Rev-only for maintenance for NDMM who are MRD+ after SCT. N Shah

TPS8055: Ph 3 290 pts get low-dose Selinexor (40mg weekly) and Rev (10mg d1-21) vs Rev-only maintenance post SCT for NDMM. H Quach

10507: Second Primary Cancers (SPM) in AA and white pts with MM in the VA system. Pts followed for SPM's 7.5 yrs after MM diagnosis. N=419 (5% of 8467 pts) developed SPM's, 244 white pts and 125 AA pts. 12% hematological SPM's (34% of these being lymphoma, 32% MDS), 88% Solid Tumor (31% of these being prostate). 5% of both transplant and non-transplant pts developed SPMs. The development of prostate cancer was the most significant difference among race: 3 in 1000 for white; 6 in 1000 for AA. S Premji