ATLANTA AREA MULTIPLE MYELOMA SUPPORT GROUP, INC.

Meeting Minutes

Northside Virtual MM Support Group

February 3, 2024

Next Meeting: Northside meeting on Saturday, March 2, will be an open discussion about the myeloma journey. After a brief business meeting, members will break into smaller groups to continue the discussion with other patients on suggested topics.

Please note that Northside will not meet on the first Saturday in April. The IMF is hosting a Regional Community Workshop on Saturday, April 13, that will take the place of our usual meeting. The workshop last year was a very informative and amazing experience. More details to follow.

Business and News

Thank you to **Nancy B**. for hosting the virtual meeting with approximately 35 attendees. In this meeting, important information and Multiple Myeloma news from the ASH 2023 recap session with the Emory MM team was reviewed and discussed in detail.

ASH Recap Discussion

Nancy B. highlighted the ASH recap meeting sessions presented by the Emory MM team members.

Charise Gleason and Bryan Burton discussed Clinical Trials (CTs). Emory is once again fully staffed and offers many and varied CTs for MM patients and is doing a lot of research. The latest approved drugs have gone through CTs at Emory and patients have access to all of the new drugs and treatments that are being approved.

There are four CT phases. In *Phase 1* drug dosage is determined. In *Phase 2* its effectiveness against MM is assessed. CT *Phases* evaluate the side effects using a 4-level grading system. *Grades 1 and 2* are low level side effects that may be temporary or be resolved easily with medication. *Grades 3 and 4* are more severe and may cause patients to stop treatment. In *Phase 3* the drug being studied is compared with the MM standard of care (SOC). *Phase 4* is post-FDA approval studies with various goals. Participation in clinical trials is voluntary and you can stop the CT at any time. You will not receive a placebo in CTs for myeloma, and your health, safety, and care that you receive is always a top priority.

Dr. Gupta reported on MGUS and smoldering myeloma (SMM). In the Iceland (iSTOPMM) study over 75,000 blood samples were tested. This is a very important clinical trial with global recognition. The risks in SMM vary a lot and the challenge is to understand the disease to find the right treatment. Researchers are monitoring iSTOPMM participants annually to determine the rate of progression when SMM is present. Questions such as is the disease remaining stable, progressing slowly, progressing rapidly, etc. can be answered through patient monitoring. Patients found with SMM are being treated. Understanding progression rates will lead to better treatments and knowing when and how intense to treat.

Dr. Joseph reported on newly diagnosed MM patients. She discussed her research on real-world data, which has no limitations versus data collected from CTs that some patients are not accepted to participate in. Data analysis collected from several years of real-world data is compared to several years of CT data and the findings are very similar in outcomes. One of the CTs studies compared current induction therapy RVd (Revlimid/Velcade/Dex versus RVd + Dara (Daratumumab) added. The results concluded that RVD + Dara used in induction provided a deeper and longer lasting progression free survival (PFS) than the standard of care 3- drug combo RVD treatment. After 4 years, the PFS rates for patients receiving the SOC RVD was 67% compared to the PFS rate of 84% for patients who received 4-drug combo of RVD + Dara. These CT studies will ultimately change the treatment protocols.

Dr. Nooka spoke about relapsed MM and subsequent lines of therapy. For relapsed patients, there are 7 different drug classes for myeloma and 15 new

drugs that FDA recently approved, resulting in several new drug combinations that are available. It is very important to discuss with your doctor what drugs would be best for you based upon your medical history and expected side effects for any drugs being considered. There is a lot of collaboration with all of the Emory MM doctors on this topic, and the team works together to help with multiple treatment options for relapsed patients. Although you may interact with one doctor, there are many additional doctors behind the scenes who are working together to help you as well.

Dr. Dhodapkar discussed new research in immunology and pre-clinical trials related to MM. Myeloma cells grow in clusters in various locations of the bone marrow. Now researchers can use artificial intelligence (AI) to understand these clusters and patterns. This will help to gain insights into individual patients who present these cluster patterns, providing breakthroughs in treatments and outcomes. Also important is to understand the progression of tumors from monoclonal gammopathy of unknown significance (MGUS) to MM. As this happens, the immune system weakens. Researchers are trying to understand the degree of weakening of the immune system in different sets of patients to determine their "immune fitness" which is very important. They are trying to understand the difference between patients with really good immune systems and those with weakened immunity, as well as why some patients live long with MM and others do not. What causes the discrepancies in these extreme cases? Researchers are also analyzing T cells which are key to immune therapy and understanding that there is a limiting number of times to activate T cells before they become weakened and no longer function effectively. Researchers are trying to find additional or new cell targets and Bispecifics that use T-cells less often. With so many mutations and alterations in MM, there is a need for treatments using T cells with different targets to be able to reach all types of MM in the immune system.

Dr. Kaufman reviewed CAR-T treatments and how they are working well overall, even for those patients who have received several prior lines of treatment. As more patients receive different types of CAR-T therapy, doctors are learning how to control the side effects. Dr. Kaufman discussed the response rates of CAR-T being 70% or higher, compared to SOC treatment response of about 40% for relapsed patients. There is a new Bispecific that

uses the GPRC5D target to treat myeloma as well as a CAR-T study that is also using that target.

Sara Scott, Clinical Pharmacy Specialist, talked about Bispecific treatments. Bispecifics are immunotherapies that utilize T cells to attack and kill the MM cells. For Bispecifics, as with CAR-T, there is a CRS (cytokine release syndrome) side effect. Doctors have learned how to prevent serious side effects and now monitor and treat CRS much earlier during step up dosing levels of Bispecifics. This allows patients to recover at home while going through treatment. Sara also noted that new Bispecific drugs with different target markers are in CTs with positive patient response. CAR-T treatments were once considered 'one and done' with no additional drugs or maintenance given. Now POM (Pomalidomide) is being added to post treatment in an attempt to extend the effectiveness of CAR-T to try to get it to work as well as a stem cell transplant (SCT). Also being researched are trispecific (3 targets) drugs, along with further research on bispecific (2 targets) drugs.

Dr. Lonial stated that Emory Winship expects to treat approximately 4,500 myeloma patients this year, making Emory one of the largest MM programs in the world. In the last 20 years, there has not been a MM drug FDA approved that was not available at Emory first.

Nancy B. commented about other positive aspects leading to better outcomes for MM patients. The amount of real-world and CT data that has been collected for years along with the vast research being conducted using the data, and collaboration of the data results to draw conclusions is incredible. The other advancement that is rapidly growing is the number of Myeloma Centers of Excellence.

Patient Updates & Group Discussion

Nancy Y. reported that she is doing well after being diagnosed with MM in 2007 and having two tandem SCTs in 2009. She has had no treatment in six years. Nancy stays very active and is strict about her nutrition. She has a bountiful vegetable garden and grows turmeric which she uses in marinades.

She walks 3 miles every day in hilly terrain and enjoys fast-paced line dancing classes. Nancy mentioned that her kappa ratio fluctuates without explanation, but all of her other numbers are good, and she feels great. **Wendy R.** reported that her husband, **Rick D**., is doing well. Rick was diagnosed in 2005, had 4 rounds of Velcade induction followed by a SCT. He has not taken any maintenance drugs. Rick was diagnosed with osteonecrosis of the jaw (ONJ) in 2022. His doctors believe it is due to receiving Zometa 8 years early in his treatment. There was some discussion about using bisphosphonates and how it can lead to developing ONJ. Doctors are using less bisphosphonates for shorter periods of time now. **Jeff W.** reported that he has been on a Venetoclax CT for five years as of this month and it is still controlling the myeloma for him. **Sandy W.** noted that she was on Phase 1 CT (Mezigdomide CELMod, Dara, Dex) that Dr. Nooka discussed at ASH that has an 82% success rate, but the treatment did not work for her. She and Dr. Hofmeister discussed drug eligibility which restricted many CTs due to not receiving 3 or more prior lines of therapy. Her option was another CT with a brand-new drug or receive SOC combo KPd (Kyprolis, Pomalyst, Dex). Sandy opted for KPd since she had never taken Kyprolis or Pomalyst before and many CTs required use of these drugs in prior lines of therapy for CT eligibility. The treatment is working very well for her with few side effects. Sandy confirmed that it is essential to understand all of your options and keep updated on treatment plans for the next lines of therapy even when your current drug regimen is working.

Sandy B. was diagnosed 34 years ago. She had taken two drugs and was treatment free for 12 years. She relapsed in 2016, which she attributes to stress induced, and is now on Revlimid daily and Dex weekly, which continues to control her myeloma. Sandy recently caught COVID for the first time and thinks that she got it from physical therapists coming to her home and not wearing N95 masks. Her case was mild, which Sandy attributes to being fully vaccinated (for COVID, Flu, and RSV) and the Paxlovid drug for COVID which she took for 5 days. She looks forward to the support group sessions and enjoys hearing about the newest treatments and meeting new people and hearing their stories. We are grateful to Sandy B., for being the AAMMSG Outreach contact member who keeps in touch with people that we have not

heard from in a while to help us stay connected. There was discussion about how stress can cause relapse, as others have had this experience as well. Stress affects the immune system and our immune response. Others commented on experiencing relapse after having COVID. **Kyle W**. was diagnosed in 2005. In January 2023, he tried an experimental drug and went into heart failure. This led him to starting Ninlaro in May 2023, which is one pill/week, 3 weeks on/one week off. Ninlaro is working very well for him with no side effects. He is an Oncology nurse at Piedmont Hospital and a patient at Emory. Kyle has experienced stress taking him out of remission and relapsed twice after having COVID and had to start on new MM regimens. Kyle expressed that as a nurse and a MM patient, you should always wear a N95 mask. Many in the group agreed that they continue to mask when they go out, especially in crowds despite being fully vaccinated. Reminder MM is a cancer of the immune system which causes a weakened immune system with limited ability to fight infections.

Karen C. was diagnosed in December 2022 with high-risk MM. She had a SCT and also enrolled in a CT in August 2023 using Blenrep. Within a couple of weeks, she developed micro cysts on her corneas, had tingling fingertips, and swollen ankles. It turned out she also had developed clots in her left leg, so she stopped the CT and is now on Revlimid. Karen has developed neuropathy after a short time from drugs, so she is leery of starting new drugs due to potential side effects. As a high-risk MM patient her doctor has advised to remain on maintenance drugs. Karen is finding it hard to know what to pay attention to with treatment options to ensure she is receiving the best treatment for the best outcomes. **Nancy B.** recommended an IMF-sponsored high risk MM support group and specialized interest support groups to join myeloma.org where several doctors discuss high risk MM and help to explain it.

Marilyn M. had a question regarding intravenous immunoglobulin (IVIG) therapy. Her IgG numbers are high and asked if anyone received IVIG with a high IgG number and had it help them? Marilyn added that she has been getting frequent (every 6 weeks) infections and must go to urgent care within 24 hours to start on antibiotics to avoid a hospital stay with pneumonia. Although antibiotics are helping her for now, she wants to be proactive and

prevent infections by trying IVIG, but her doctor will not approve IVIG due to her high IgG numbers. She also has concerns about becoming resistant to frequent use of antibiotics. Marilyn's MM doctor suspects that even though her IgG numbers are high, they might not be functioning and helping her due to having SMM. She and her MM doctor are tracking her infections and hope that given her history, her MM doctor will be able to get IVIG approved with her insurance company. **Jeff** noted that IVIG helped him with sinus and upper respiratory infections, his numbers were low enough to get the therapy approved.

Nancy B. talked about the similarities and differences between CAR-T and Bispecific drugs which was also discussed at the January 27, 2024, Southside meeting. Both treatments engage T cells that attach to a protein called *B cell maturation antigen* (BCMA) then wait for the T cell to find and kill MM. CAR-T treatment is administered in a hospital and is considered 'one and done' with no maintenance until relapse. Bispecific drugs are administered (injected) every week or two weeks while you are on treatment. Bispecific drugs can be attained *off-the-shelf* and started quickly, whereas CAR-T therapy requires a longer ramp up time of collecting patient T-cells, followed by 4-6 weeks in a lab for re-engineering the T-cells, then returning cells to the patient. Side effects for both treatments include cytokine release syndrome (CRS). **Glenn** asked if a patient could go from one treatment to another and someone else had asked their doctor about this and was told that after CAR-T therapy could later try Bispecific drugs. You can also try different Bispecific drugs after being treated with the first Bispecific therapy.
Gail V. has created a colorful timeline of her myeloma journey. Check it out. *It's in My Blood.*

Submitted by Wendy R.

Meeting Minutes

Southside Virtual MM Support Group

February 24, 2024

Next Meeting

Saturday, March 23 @ 10 AM. Patient and Caregiver Voices; *How did you spread the word MM in Myeloma Awareness/Action Month?* This meeting will be

hybrid. The in-person location is the Evelyn Lowery Library at Cascade. 3665 Cascade Rd, Atlanta, GA.
For Men Only: Tuesday, March 26 @ 6:00 PM. *What are your challenges and successes?*

Business and News

Thank you to **Gail M** for hosting the meeting with 25+ attendees. The meeting opened with a moment of silence led by **Doris**, followed by focused breathing and quiet centering to clear the mind led by Gail.
The meeting started with the introduction of our new members. A sorority member referred **Jean W.** to learn all she could about myeloma. Her friend was diagnosed about eight years ago and is in the watchful waiting stage. **Steven N.** went through surgery in Chesterfield, VA to remove a mass found on his hip at L5. After testing the mass, the doctor informed him that he had multiple myeloma. Steven did not realize that MM was cancer until later, which shook him. He recently had a SCT. The unknown has caused him considerable anxiety and depression. The medication Steven takes makes him "out of it" for almost 12 hours. **Rosalyn G.** was diagnosed with myeloma in January 2019, after initially being MGUS since February 2012. She is a veteran who was exposed to many toxins (agent orange, agent blue, toxic water, and other chemicals) in Fort McCullen, AL, and Fort Meade in Maryland. Rosalyn is a part of a Veteran's Cancer Support Group, but no other members in that group have myeloma. She goes to Northside – Georgia Cancer Specialists and Emory Winship. Her myeloma is considered environmental, not genetic. Note: *Veterans among our Support Groups may have an interest in getting together to discuss exposure possibilities.*
An update was reported from the *"For Men Only"* Group. **Ted** gave some words of encouragement to Steve. He invited Steve and other men to join the "For Men's Only Group" on Tuesday, February 27th at 6 PM. **Dr. Brandon Blue** from Moffitt Cancer Center in Tampa was the guest speaker. Men with myeloma from across the country were invited to join this month's meeting. The men discussed ways to talk about and navigate myeloma and treatment issues.

Guest Speaker Presentation

Our guest speaker was **Kim Burney, RN, MSN ed**, an educational representative from Johnson & Johnson (JNJ) Innovative Medicine/Pharmaceuticals formerly Janssen Pharmaceuticals. Kim's focus was on three JNJ's myeloma drugs*, Darzalex, Teclistamab, and Talquetamab*. She has been an oncology nurse for 36 years.

Darzalex (also known as Daratumumab) is a *monoclonal antibody* treatment that has been around for over nine years. **Carolyn H.** has been on Darzalex for that long and has considered changing to another therapy. Kim's response: *If a therapy is working, stay with it.*

How Darzalex works. On the surface of the myeloma cell is a protein called CD38. Darzalex seeks out this protein and destroys the diseased myeloma cell. This is a targeted therapy, and as such, there is much less "collateral damage" or killing off healthy cells and has **fewer side effects** than other therapies. *To be eligible for Darzalex*, patients must have gone through at least three prior lines of therapy. Clinical trials have shown that Darzalex added to the traditional Revlimid-Velcade-dexamethasone (RVd) combination during traditional first line therapy the response rates increased by almost 20%. Darzalex has been a "game-changer" in myeloma treatment regimens to enhance the effectiveness of other proven conventional therapies (e.g., Revlimid, Velcade, Kyprolis, etc.) alone and in drug combinations.

Darzalex has undergone continuous improvement. Since 2020, it has been approved for subcutaneous (SubQ) delivery versus its original infusion method that took 8-9 hours to administer. This SubQ version of Darzalex is called *Darzalex Fastpro* for its quick delivery time delivered over 3-5 minutes with fewer side effects which is much better for the patient/caregiver.

There are current trials to determine if Darzalex can move up to frontline treatment for newly diagnosed myeloma patients. Some myeloma treatment centers, like Emory Winship, are already using it as a frontline treatment based on positive results from the GRIFFIN clinical trial. Some research has shown that a *'quad' therapy* (taking 4 drugs to fight myeloma) that includes Dara may be even more effective than the traditional *triple drug therapy*, with a high 90s percent response rate. Darzalex can also be used as a single agent.

Bispecific Antibodies. Where drugs like Dara have only one target, CD38 protein, to destroy the myeloma cell, **Bi**specifics engage a protein on the myeloma cell and the T-cell – two separate targets to destroy the myeloma

cell. *Therapy criteria*: Patients must have had at least four prior therapies that included the following drug treatments: a (PI) proteasome inhibitor (Velcade, Kyprolis, Ninlaro); an (IMid) immunomodulatory agent (Revlimid, Pomalyst, thalidomide); and a CD-38 monoclonal antibody (includes Darzalex, Sarclisa, Isatuximab).

Teclistamab/TECVALI®. Is considered *salvage therapy* for those who have been treated with at least four prior lines of therapy. It was the first drug approved in the Bispecific class. Darzalex travels to CD38 proteins on the myeloma cell, then attaches to the patient's own immune system to target the myeloma. TECVALI® **binds** to the BCMA (B-cell maturation antigen) on the myeloma cell while simultaneously engaging the patient's T-cells to combat and restrict the BCMA protein to continue to grow. This chemical battle in the myeloma cells leads to cytokine release syndrome (CRS) where fevers and other side effects are common. The drug was so effective that it was fast-tracked by the FDA and continues to undergo clinical trials to determine whether it can be moved up as an earlier line of therapy.

Adverse side effects (AE) include CRS and other neurological issues. Infections are a common side effect as white blood cells generally drop (neutropenia) during treatment. TECVALI® is administered as an in-patient treatment but is becoming commonplace to administer as an outpatient treatment. Bispecific therapy is performed in specialized treatment facilities using step-up drug dosing to manage the AEs. Locally, facilities are Northside Hospital and Emory Winship; nationally, they include Mayo Clinic and Moffitt Cancer Center in Tampa. Step-up dosages begin at a very low level based on your bodyweight. Step 1 for example, would start at 0.3 mg day1, increase 0.6mg/kg of weight Step 2, then several days later Step 3 is about 1.5 mg/kg. Each step is given at a minimum of 48 hours apart during which you will likely be hospitalized. Patients are closely monitored for AEs during each step of the dosing process. Signs of CRS include fevers of 100.4 or greater, shortness of breath, and mental confusion may delay the next step up until symptoms are under control. If CRS is not caught and controlled early, it may lead to a visit to the ER and hospital admission. It can make one very sick. The liver can also be affected by the drug. Keep an eye out for darker urine, abdominal pain or anything that is different in your physical or mental status since starting TECVALI®. JNJ has created warning "wallet

cards" available to alert others medical personnel of your potential for CRS. Patients are advised **to ask for** and carry these cards on them at all times. The **top three AEs** for CRS are fever, shortness of breath, and drop in blood pressure.

Difficulty speaking and a change in handwriting are signs concerning neurological issues. Since neuropathy is already an issue in many myeloma patients it can be complicated by the TECVALI®**.**

REMS **program (Risk Evaluation Mitigation Strategies).** Prescribers of the drug must take REMS training. Patients are not surveyed as they once were with Revlimid and Pomalyst. Kim trains nurses in facilities to monitor and manage SEs from TECVALI®. JNJ offered prescription wallet cards that can be used in case of emergency. If you have a CRS event and cannot get to your usual doctor, use the wallet card of prescriptions you take.

Jannsen Compass – a patient navigator program staffed by oncology nurses. It is a Free program for up to a year after patients are on any JNJ drugs, including Darzalex. In some cases, patients pay only $25 out of pocket, up to $26,000.

Talquetamab/TALVEY™ called the "little sister" of Teclistamab, is very similar to TECVALI®. It has been available for about six months and was also fast-tracked by the FDA. It has similar indicators, but binds to a different protein, GPRC5D, on the myeloma cell. Dosage is given once per week or every other week. It is also delivered sub-Q. **TALVEY™** side effects/Adverse Events are also similar. CSR and neurological problems are present, but AE is often less intense than with Teclistamab. Protein binding is GPRC5D protein, the same protein found on epithelial cells. Side effects include mouth problems (change in **taste,** sore throat, dry mouth), fingernails (crack, peeling), skin (rashes, redness) and weight loss (get nutritional consult). JNJ provides patient kits with a recommended cream/lotion and lozenges to each patient. If you are going on this drug, please ask Northside and Emory for wallet cards to carry in case some AE occurs outside of your usual provider. JNJ also has a CAR-T cell therapy called CARVYKTI® (cilta cartagene autoleucel; Cilta-cel). This is a BCMA CAR-T which was not the focus of this presentation.

Geraldine shared that she was just released from the hospital and is taking TALVEY™. She is experiencing AEs – mouth, pins & needles like neuropathy. One of the biggest problems is being unable to swallow as well

as problems with taste and smell. Geraldine was advised to cut pills in half, or to crush them and take them with applesauce. It was also recommended that she go to a Speech Therapist. Kim noted difficulty swallowing is a known AE with TALVEY™. She encouraged Geraldine to have a conversation with her physician about holding the drug before her next STEP or dosage. There can be some connection between the patient and the prescribing information. Doctors must make decisions based on the person in front of them and the situation. *After the meeting, Alma shared that she had also had problems swallowing and lost a significant amount of weight. She was referred to an Ear, Nose, and Throat (ENT) to help with the problem. She offered to speak with Geraldine about her experience.* **Bernard**, do these medications cause neuropathy? **Response:** There are some neurological side effects. Close monitoring will hopefully minimize potential neuropathy. **Steve:** During SCT, my BP went up very high. Do these drugs have hypertension as a Side Effect? **Response:** What we have seen as a problem is low blood pressure (hypotension) along with the CRS, but we have not seen hypertension. Remember though, the drugs are relatively new to the market, so research is ongoing. Please continue to report any changes that you notice when undergoing treatment.

Kim's final words:

Have conversations with your doctor. You are your own first line of defense. Treatment is becoming so personalized that you must learn as much as you can, so you can be your own best advocate.

From this meeting we have learned about new medications and how they work. We learned more about potential side effects that are not always addressed by health care providers. This is not necessarily due to intentional omission, but there is often so much information to be discussed during a medical appointment. We have to ask more informed questions pertaining to our needs.

Group Discussion

Transportation: a very generous donation of some funds for transportation that we plan to use on a case-by-case basis. Continue to apply for available funds from LLS and other agencies. We will use these limited funds in emergencies or special situations.

Fulton County: Bridgette and Nancy conducted research for Fulton County Services. There is a contract with Lyft to provide transport to medical appointments for senior adults in Fulton County. You must pay $15 to register for this service. Then all rides are $1.00 charged to your credit card on file. Contact phone number and other details under a separate email. MARTA can schedule appointments to take you where you need to go. You provide MARTA with a time for both pick up and return trips. Doris has used both services and never had a problem.

Fayette County: Alma researched this and reported that Fayette County has two kinds of transportation; *non-emergency medical transportation* and *voucher transportation*. The non-emergency service no longer goes as far as Atlanta/Emory Winship or Northside. Pick-up and delivery pharmacy services are included. Schedule appointments at least two days in advance if there are specialized services, like wheelchair lift, etc. Voucher transportation can be used for going to grocery stores, shopping, or other transportation for senior adults. Purchase vouchers in advance. You **must register in advance,** and your fee is based on a sliding scale. Most will pay about $4.00 each way. *For Fayette Senior Services - Call 770-461-0813 ext.130* to get more info. Get more information at the website: https://fayss.org/transportation/

Other counties may have similar services for medical, disabled, and/or senior services. Please search for resources in your own county or community, especially in more metropolitan areas.

Financing myeloma. Some agencies and organizations are reducing the amounts they award to each applicant. LLS has already announced reduced funding. In part, this is related to the changes coming to Medicare in 2025. e, Medicare Part D will have an annual limit, capping out-of-pocket prescription drug costs at $2,000. This cap does not apply to out-of-pocket spending on Part B drugs. Please see the guide in the February issue of Conquer Magazine – the link is below.

For your information, there is an FDA warning on CAR-T cell therapy. There is evidence of secondary cancers connected to the T-cell. Dr. Joe (IMF) says that so far, the numbers are very small, less than 1%. This is not to minimize the importance of the occurrence, but we should be aware when making decisions about our treatment. Here is a short video about the FDA statement. **Recent FDA Warnings about CAR-T therapy** – Expert

opinion. - Video - ~ 1:27 min. MM.CAR-T cell therapy-FDA warning-secondary cancers.2024

March is Myeloma Action/Awareness Month. Tell at least one new person about MM. Go to the website and see some additional ways you can celebrate MAM. Action can include a letter to your physician to remind them to discuss possible symptoms with their patients.

Respectfully submitted,
Gail

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