January 2019

Northside Multiple Myeloma Support Group Meeting
January 5, 2019

Dr. Lonial welcomed 70 people to the conference center. He reported that the Winship team is growing and they were at ASH reporting on the great things happening at Emory.
Charise Gleason announced that the Phase I clinical trials will be moving to the new Emory Tower, which will provide double the space of the current area. She reviewed the phases of clinical trials.

Phase I -- First step in transforming laboratory research to clinical care – "bench to bedside"
Goals of Phase I trials

- Find a safe dosage
- Decide how the agent should be given
- Observe how the agent affects the human body
- Evaluate pharmacokinetics
- Average number of participants 15 – 30

Phase I Trial Endpoints

- DLT – Dose Limiting Toxicity
- Unacceptable toxic effects presumed to be related to the investigational drug
- Typically assessed during the 1st cycle
- Accurate grading of toxicities very important
- MTD – Maximum Tolerated Dose
- Highest dose level at which ≤ 1/6 of patients experience DLT.

Phase II Trials

- Designed to test the effectiveness of a drug in a larger population (usually < 100)
- Use the dose determined to be safe in Phase I trials
- Typically narrow the focus to people with diagnoses that are most likely to respond to therapy
- The treatment is assessed for effectiveness as well as additional safety data.

Phase III Trials

- Enroll more patients (hundreds - thousands)
- Compare an investigational treatment to the current standard
- Participants are usually randomized to the investigational or control group
- Conducted at multiple institutions around the country, including community settings

Charise noted that in 2018 Emory had 49 active clinical trials in myeloma, including 13 new trials opened that year. In 2018, 108 patients were enrolled in clinical trials, bringing the total participants to 443 for 2018. She thanked the expanding myeloma team at Emory and a special thanks to the patients.

Dr Nooka talked next about newly diagnosed myeloma. He has looked at the data from 1000 patients at Emory over the last ten years, both high risk and standard risk. Emory began using RVd (Revlimid, Velcade, and Dex) combination earlier than most centers and has data on PFS (progression free survival) and OS (overall survival). For standard risk myeloma, his chart shows over 50% of patients on RVd did not relapse after five years and over 80% survival rate at five years. The Emory team knows that three drugs are better than two, but what about four drugs? There are several clinical trials adding Daratumumab (Darzalex, aka Dara) to standard treatment with three other drugs (VMP or RVd). Some trials are using Isatuximab, the newest monoclonal antibody. Dara's direct on-tumor actions may contribute to rapid response, and Dara's immunomodulatory actions may contribute to deep and durable responses when added to all lines of therapy. It is approved as single therapy and in combinations with standard-of-care regimens in many countries for relapsed myeloma or transplant-ineligible newly diagnosed patients. The ALCYONE study showed 57% reduction in the risk of progression or death in patients receiving Dara with VMP (Velcade, Melphalan, and Prednisone). In MAIA study, comparing D-Rd vs. Rd in transplant ineligible patients, there was a 44% reduction in the risk of progression or death in patients receiving D-Rd. Both D-VMP and D-Rd induced significantly deeper responses with greater that 3-fold higher MRD negative rate. HOVON study showed 70% response rate with Ixazomib (Ninlaro), Dara, and dex after four cycles in patients over 75 years of

age. In a trial adding Isatuximab (new antibody) to RVd for new patients ineligible for transplant, there was a 100% overall response rate (ORR).Responses were quick and well tolerated among frail patients. The conclusion is that adding Dara to standard treatment was associated with rapid and deep responses for new patients. The toxicity was manageable and did not affect stem cell collection. The standard practice could be changed after review of longer-term data from new patients and should be considered for transplant ineligible patients.
Questions to Dr. Nooka:
Many studies are looking at the potential use of daratumumab in initial myeloma treatment. What would be the downside of adding daratumumab to first-line therapy in every patient? There are many factors to consider. It helps most patients, but some have no benefit. Daratumumab can increase the risk of infections. There is also the additional cost to consider. Moreover, we don't yet know the long-term effects of targeting CD38 as daratumumab does, especially on other cells in the immune system. Finally, we also haven't determined the implications on later lines of therapy (meaning, when is the best time to use daratumumab and can it be used again?) Q- How is PFS measured? A- The IMWG says that it is a 0.5 mg increase in monoclonal protein over the starting baseline.

Dr. Heffner talked about some of the transplant studies reported at ASH. Although transplants are now the standard of care, not all patients are eligible. There was nothing new at ASH, but data was reported. He observed that a transplant is complex: induction therapy; harvest of stem cells; transplant; then determine consolidation; maintenance, etc. The purpose is to improve depth and duration of response. Mayo Clinic reported on 30 years of transplants by decade. The age and counts have increased. PFS and OS have increased. 100 day TRM (treatment related mortality) has dropped. 1990-1999 – median age = 55, number of transplants = 144, percent >1 regimen of treatment = 67%, novel agents <1%, PFS median 12 months, OS median 26 months, 100 day TRM 7.6%; 2000-2009 – median age = 59, number of transplants = 909, percent >1 regimen = 27%, novel agents 59%, PFS median 18 months, OS median 63

months, 100 day TRM 1.8%; 2010-2015 (less years) – median age = 61, transplants = 972, percent >1 regimen = 34%, novel agents 100%, PFS median 33 months, OS median 83 months, 100 day TRM 0.7%. No significant difference in OS for patients > 65 years old vs. patients <65 years old. The median PFS for > age 65 is 37 months vs 49 months for < age 65.
The stats on allogeneic transplant (ASCT) show it as much more toxic, but better outcomes if Complete Response (CR) is achieved: OS of 64% at ten years (from Hackensack Hospital). en-year follow-up of double vs. single ASCT in Europe showed upfront double transplant was associated with significant improvement in PFS and OS in comparison with single transplant. This is not the case in US studies, although double transplant does show benefit for high-risk patients and advanced ISS stage. He pointed out that there are many variables that impact the transplant decision.
Q – How many patients refuse transplant or are ineligible and what are their outcomes? A- Patients are not referred to Emory if they refuse to have a transplant. Most Emory patients get a transplant since there are lower risks from transplant these days.

Dr. Kaufman talked about CAR T therapy and new antibodies. T-cells are our own immune cells that fight cancer and infections. He noted that this is new territory and there are new team members at Winship working on this research. Part of the process is to test the patient and follow procedures to evaluate health level: CT scan, heart evaluation, full blood work-up, and other tests. Dr. Kaufman explained how the CAR T process works. 1- Extract T-cells from patient's blood, similar to stem cell harvest. Apheresis harvest takes about 3-6 hours. 2- T-cells are shipped to a special lab to re-engineered to detect tumor and reprogrammed to be super-killers. 3- Grow and army of cancer killing T-cells. The reprogramming and growing takes about four weeks. During that time, the patient is given "bridging therapy". 4- Patient receives lymphodepleting chemotherapy to make room for the new cells. Then infuse cancer killing T-cells back into the patient's body and watch for engraftment. 5- Best-in-class T-cells target and destroy cancer cells. Patient is in the hospital for two weeks and closely monitored. Winship has two studies open and more trials coming.

The CAR T therapies are evolving quickly through the clinical trials. Researchers are working to find the most effective dose and how to get longer living T cells. There are also multiple companies developing and testing CAR T therapy in the US and China. One clinical trial of next-generation CAR T Cell therapy is working to enrich the T cells to improve their memory so they may persist and function longer than non-enriched CAR T cells. This could improve the duration of response. As reported at ASH 2017, the median PFS for CAR T therapy was 11.8 months. This trial was on patients who had many lines of therapy (median 7-9 different therapies) and had tried all the novel treatments. This small number of patients had serious side effects. Cytokine release syndrome (CRS) is like the worst flu ever. The next generation of CAR T-cell therapy is getting higher response rates (86%), but longer-term follow-up is needed to determine sustained response. CAR T therapy is extremely expense, takes a month to engineer the cells, and is not yet producing sustained remissions. Watch for updates at ASCO in June and the next ASH. Q- Might there be a role for CAR-T to replace ASCT? A- This is currently being explored in clinical trials. Both CAR-T and ASCT have significant potential side effects and there is not yet enough data to compare the two approaches. Q - Could CAR-T be used early in therapy? A- It is currently reserved for patients with multiple prior lines of therapy. There are two major serious side effects associated with CAR-T therapy. One is CRS (cytokine release syndrome) and the other is neurotoxicity, which can be serious in rare cases. Another issue is that we don't yet understand how long responses to CAR-T therapy will last.
Q- What kinds of patients might be eligible for CAR-T therapy? A- Patients have to be in pretty good general health but must meet certain myeloma criteria. Responses have been seen in patients up to 81 years of age. Q- Are CAR T patients post-transplant? A- Yes, for now.

BiTE, Bispecific T-cell Engager, is a new type of monoclonal antibody. AMG 420 is a phase I clinical trial in Europe. BCMA (B-Cell Maturation Antigen) is on the surface of myeloma cells and plasma cells. This drug activates T-cells and binds them to the BCMA on the

surface of the myeloma cells. This trial is showing results but has some serious side effects. Next generation BiTE treatments are in development that have longer activity time-spans. The dosage is continuous IV for four weeks then two weeks off for several cycles. The toxicity is similar to CRS from CAR T and symptoms are resolved after drug is discontinued. A clinical trial is open at Emory. Watch for more information.

The next presenter was Dr. Timothy Schmidt on the study of Ixazomib in maintenance after transplant. Maintenance is intended to maintain and deepen the response from transplant to extend remission. The goal is to help patients live longer and better, but the downsides are side effects from medicine and cost. Current practice is to use Revlimid for maintenance. Ixazomib (Ninlaro) is also in pill form but is a drug similar to Velcade. It is approved for relapsed myeloma and is currently being tested for use earlier in the disease cycle as maintenance. Early results are showing that Ixazomib is extending PFS from 21.5 months to 26.5 months. Side effects were increased infection and GI issues. The bottom line is that the trial was generally a success, but not enough evidence to change the standard of care for most patients. It might be enough for FDA approval and could serve as an alternative to patients who do not tolerate Revlimid.
Q- Could you discuss the risk of second cancers with Revlimid (lenalidomide)? A- Second primary cancers occur in about 2.5-3% of patients receiving lenalidomide on a 21-days-on/7-days-off schedule. These can include second blood cancers or solid tumors like lung cancer or colorectal cancer. This translates to about a doubling of second cancer risk with lenalidomide. Second cancers are particularly seen in patients who also receive melphalan as part of a stem cell transplant. However, it is important to keep in mind that lenalidomide is still associated with a survival benefit despite the increased risk of second cancers. Q- I hear Revlimid is associated with an increased risk of blood clots. How can you tell you have a clot? A- Yes, venous thromboembolism (VTE) is not uncommon in patients receiving Revlimid or the other myeloma drugs ending in ‘ide” (thalidomide, pomalidomide). Clots often develop in the lower legs and can cause redness, swelling, and pain upon touch. They can also occur in

patients with central lines. Immobility is an important risk factor. Q- Is there a comparison of Rev maintenance to Ninlaro maintenance? A- Not yet, but a new study is underway. Q- Was MRD testing done on patients with Ninlaro maintenance? A- Emory does MRD testing on all patients, but it does not change treatment decision. Some patients achieved MRD negative on Ninlaro maintenance. Q- Does Ninlaro maintenance cause second cancers? A- No data on second cancers, which have low occurrence compared with the risk of myeloma progressing. Q- Is Pomalyst being considered for maintenance? A- Yes, we are looking at it.

Sara DiCamillo, PA, talked about older and frail patients with myeloma. Age is not the single factor in treatment planning. The patient's healthcare team will assess frailty to predict survival, impact of drug toxicity, transplant decision, and guide treatment. The IMWG has developed a myeloma frailty score calculator based on age, comorbidities, cognitive and physical conditions. Comorbidities includes heart disease, leukemia, dementia, diabetes, liver or kidney disease. The ability to perform basic daily activities is evaluated: bathing, dressing, toileting, feeding, and transferring out of bed or chair without assistance. The activities of daily living are also scored: use telephone, shopping, cooking, laundry, housekeeping, transportation, handle medications and finances. Evaluations could also consider: current MM length of survival, medication side effects, if patient has had falls, walking speed, and timed on getting up from chair and walking. Emory is discussing which score and factors to use that may alter treatment and improve outcomes.

Dr. Ben Barwick spoke next about genetics in myeloma. Dr. Lonial pointed out that the money designated to myeloma from the Emory 5K help to support Dr. Barwick's research. Dr. Barwidk noted that B cells provide adaptive immunology. B cells are activated and become plasma cells. Researchers are looking for a virus or bacteria that may cause the plasma cells to rapidly proliferate and become myeloma cells. Mistakes happen with the cells are growing so fast and it causes genetic alterations. The MMRF CoMMpass study collected genetics from 1000 newly diagnosed MM patients for analysis. They

are finding parts of chromosomes that are added on to other chromosomes and some that are missing. As patients know, not all myeloma is the same. There are known high-risk markers that impact treatment decisions. Attention to these factors can spare unnecessary treatment and improve outcomes. There are known high-risk markers: t(4;14), t(4;16), del(17p), and researchers are finding new markers. Participating in clinical trials and research programs is invaluable. He thanked all the myeloma patients who grant permission for research on bone marrow biopsies. Q- Are all chromosome abnormalities on the FISH test? A- This information is from sequencing the entire genome, which is more expensive and takes longer. When clearly identified, then the FISH test may get updated. Q- What other translocations affect therapy? A- t(1;14) does better on Venetoclax.

Dr. Hofmeister had two short stories from ASH 18. First, 3,254 African-American veterans and 8,845 Caucasian veterans identified with MM and treated at VA hospitals showed that after adjusting for age, AA's lived longer when treated similarly, despite making less money and more of them living in cities. Access to treatment is the key. Second, split dose Daratumumab has identical serum concentrations (levels in the blood) except for just the first day you receive the drug. This means that the very long first day is not required. Splitting the dose over two days is an option but coming back to the infusion center two days in a row is no picnic, either. Dr. Hofmeister went on to discuss Selinexor, which slows down the myeloma cell from making more myeloma cells and may increase usefulness of dex. A phase 1 trial determined dose when given alone at 80 mg + dex 20 mg twice weekly. At this dose, half of patients responded. In the STORM trial, phase 2, patients were enrolled who had failed in four or five lines of therapy. Overall response rate was 21%. For those with high-risk myeloma, the overall response rate was 43%. Selinexor has shown similar responses in aggressive lymphoma and this new type of drug may have a bright future. More information in future medical meetings.

Nancy

Southside Multiple Myeloma Support Group Meeting
January 26, 2019

The meeting opened with a moment of silence and a moment of guided breathing and stretching with **Gail**. In February, our focus will be on member patient/caregiver discussions. The topics will be **"Members' Choice."**

Doris shared that several of our members are having health challenges and we should keep them in our thoughts and prayers. They include **Selena, Pat. C, Harold P., and Mary E.**

In 2019, we want to place emphasis on patients and caregivers having a more working knowledge of their individual myeloma – what kind of myeloma do you have (kappa, lambda, IgG, IgA, genetic testing in clinical trials for African Americans and all, etc.,). This first month of the year we started with "What do your lab results say about your health" led by Group Volunteer member and retired nurse practitioner, Vermell Sanford, RN, BSN, MSN, ANP-BC.

Vermell provided three handouts, including the Patient Handbook (from IMF) as a resource. She used a redacted (name blacked out) laboratory report from an actual patient to walk the group through the presentation. Each member was asked in advance to bring at least two copies of their own lab results to better follow the presentation. **What kind of Myeloma do you have?**

Vermell started with a brief overview of Multiple Myeloma (MM). Some highlights of MM for review included: *MM is a cancer of the plasma cells.*

Plasma cells can become cancer cells, called myeloma cells. The cells can be in all parts of the body, and often set up in the larger bones of the body -- the spine, skull, pelvis, rib cage, shoulders, and hips. MM can appear as tumors or areas of bone loss (called lytic lesions). A solid plasmacytoma is a single myeloma tumor inside or outside of the bone marrow. Healthy plasma cells are part of the immune system. They produce immunoglobins – complex proteins called antibodies. Myeloma cells grow in an uncontrolled way and start to crowd out the healthy plasma cells. This increase in myeloma reduces the production of normal blood cells and antibodies in the bone marrow. The monoclonal protein is like a "bully" – chasing out all the good guys. All cells – platelets, white blood cells, red blood cells – are made in the bone marrow. The myeloma cells produce an abnormal, nonfunctional antibody, called monoclonal protein, or M-spike, or paraprotein. This increase in myeloma cells results in a reduced ability to fight infections.

To diagnose MM, the criteria includes looking for biomarkers, referred to as **SLiM**. This stands for **S**ixty percent or higher monoclonal plasma cells in the bone marrow, Serum Free **Li**ght chain ratio of 100 or greater (kappa and lambda free light chains). Two or more lesions shown on an **M**RI. This is newer criteria (2014) added to the CRAB criteria, which focuses on end organ damage. In the past, the practice was to watch and wait until one of the CRAB end organ damage symptoms was present. **CRAB** – too much **C**alcium in the blood; kidney (**R**enal) problems; unexplained **A**nemia; and **B**one damage. You will see SLiM CRAB in articles and presentations when talking about signs and symptoms of MM. There are excellent Tip Cards from the IMF (myeloma.org) on the *Early Warning Signs of Myeloma and*

important questions to Ask Your Doctor. Myeloma starts with MGUS (Monoclonal Gammopathy of Undetermined Significance) and Smoldering Myeloma. The diagnosis of active disease and treatment is determined by SLiM – CRAB.

Question: Does everyone who has MGUS go on to active Myeloma?

*Answer: No, a*n antibody, also known as an immunoglobulin, is a large, Y-shaped protein produced mainly by plasma cells that is used by the immune system to control disease. There are five types of normal heavy chain immunoglobulins. In our bodies, two heavy chain immunoglobulins are bound to two light chain immunoglobulins. Your myeloma is defined by one heavy chain – IgG, IgA, IgD, IgE, and IgM. And one Light Chain – kappa or lambda – immunoglobulins. ***Do you see this on your lab test? What type do you have?*** When you are typing MM, an immunofixation electrophoresis test identifies heavy and light chain protein types. Different types of MM are based on the kind of immunoglobulin you produce -- IgG, IgA, IgD, IgE, or IgM. The most common type of heavy chain in MM patients is IgG (65%) with either kappa or lambda Light Chain. The second most common is IgA, with either kappa or lambda. IgD, IgE, and IgM are rare. One third of MM patients produce Free Light Chains (bound to heavy chains). There is also a myeloma called Bence-Jones myeloma (15-20 %), where these patients produce only Light Chain – no heavy chain. According to MMRF, there are at least 12 different types of MM.

Why is it important to know your myeloma type?

It is important to know your type, because much of the research for

effective treatment will be more targeted – or personalized for a specific type of MM. You can better understand and follow your lab test results over your journey and can participate more fully with your doctor and other health care providers (HCP) about your status. On your lab results, for example, the **SPEP** (**s**erum **p**rotein **e**lectro**p**horesis) and free light assay are used to monitor the level of monoclonal protein, assess your response to treatment, the activity of the cancer, and the status during remission. You are advised to keep ongoing records of your test results to compare from visit to visit. You might note a change in some results that your HCP misses. (Resource: Understanding your Multiple Myeloma Lab Tests – Takeda and Patient Handbook- IMF). *Suggestion: At each visit, get a hard copy of your lab test printed so that the normal ranges appear on the document. Be sure to look at each important test value with your provider. Sometimes it's good to have your previous lab results to compare the difference. Also, view all your results and appointments through the patient portal. You should be the person most familiar with your lab results.*

Baseline Testing

Bone Marrow Biopsy can assess the disease status – chromosomes, and immune typing). It can determine the presence and percentage of myeloma cells in the bone marrow. Blood tests include the **CBC** (Complete Blood Count) which can assess anemia, low white cell count, and low platelet counts during your treatment. The chemistry panel can assess the function of different organs, like kidney function (creatinine, BUN), liver function, albumin/protein, calcium level, and LDH. The lactate dehydrogenase (***LDH) test*** looks for signs of damage to the body's tissues. LDH is an enzyme

found in almost every cell of your body, including your blood, muscles, brain, kidneys, and pancreas. The ***LDH test*** measures the amount of LDH in your blood or other body fluid. *Have you checked your levels?*

Blood Tests

· Serum protein testing – show the presence of monoclonal “Spike”

· Serum protein electrophoresis (SPEP) – amount of abnormal myeloma heavy chain protein

· Immunofixation electrophoresis (IFE) – shows heavy chain Ig (G,A,D,E,and M) and light chain, kappa or lambda types of protein

· Freelite assay* - used to measure the amount of free kappa or lambda light chains if no SPEP or UPEP abnormality is discovered.

· Hevylite* assay – used to measure normal and abnormal levels of intact immunoglobulins

Urine Tests

· Special protein testing similar to serum (blood) testing

· UPEP (Urine protein electrophoresis) - Shows the presence or amount of abnormal myeloma protein in the urine

Bone Tests

· X-rays, MRI, CT, Nuclear Medicine Scans, PET/CT Scans, and Bone Density Testing - These tests assess the severity, amount, location of any areas of bone damage

What some of the other tests tell you…

· Serum Beta 2 microglobulin – the higher the level the more advanced the disease

· Serum albumin -the lower the level, the more advanced the disease

· C-reactive protein – increases with active disease

· Serum lactate dehydrogenase – increases with active disease – highly predictive of aggressive disease.

Genetic Studies of Disease Risk

· Cytogenetics is an assessment of chromosomes in dividing myeloma cells

· Fluorescence in situ hybridization (FISH test) – assesses the chromosomes of all myeloma cells in a bone marrow sample

· About half of MM patients have part of one chromosome has switched with part of another chromosome in the myeloma cells. High risk abnormalities in MM include the **translocation** of some of our 22 chromosomes t(4;14).t(14;16), t(14;20), and the loss of a particular chromosome -17p **deletion**, and 1q+. Data show that newly diagnosed myeloma patients with the chromosome 14 translocation t(14;16) are more likely to have kidney damage, while patients with extra chromosomes are more likely to have bone disease or anemia (Source: Myeloma Beacon, N Raneesh, October 2013).

· *All patients should request a copy of their cytogenetics. The test can only be conducted during a bone marrow biopsy. The type of treatment regimen decisions is in part dependent on the type of MM.*

Question: Why can't lab tests give an earlier warning of MM.

Answer: They actually can – if patients go for regular doctor's visits, and if primary care providers are reminded of what to look for. SLiM CRAB is one way – increase protein or calcium in the blood or urine. The IMF Myeloma

Awareness Month has provided letters for primary doctors each year for the past three years to help with this. We have that letter for 2019 as well. About 70% of patients have symptoms that can be red flags for MM: persistent, recurrent, unexplained back pain, fever or history of infections, unexplained fatigue, shortness of breath, unusual bleeding, or a rash (shingles).

There are several genetic studies that are ongoing to further define MM and determine the best ways to treat it. This is called Personalized Medicine, targeted therapy, or ***Precision Medicine****. All persons over the age of 40 in the country of Ireland are eligible for a genetic study of MM – from MGUS to active disease as part of the Black Swan Initiative® to find a cure for MM. There are several studies going on to help determine why MM occurs in African Americans at more than twice the rate as whites. We have many treatment decisions to make along the MM journey – and they should be informed decisions.*

At the end of her presentation, Vermell held one-on-one counseling services with patients and caregivers who needed more personal information. This was such an unexpected gift to the group. Thank you, Vermell!

Announcements/Upcoming Events

· Doris shared a flyer from an MM meeting in Columbus. Perhaps we should sponsor members to attend some of the meetings.

· **Health Fair. April 6** at West End Mall – Public Health Program, Morehouse School of Medicine.

· We should limit ourselves to **2-4 Health Fairs** each year to raise awareness. We have very few volunteers who we do not want to burnout. We must order materials for Health Fair through Nancy. 3-4 pieces of information plus LLS Cancer and Finances publication. We should keep Deborah's Delta/Greenbriar Health Fair as one of the Awareness opportunities.

· **Topics suggested for 2019**" Palliative Care; Alternative Pain Control; Managing Side Effects; Finances – Co-Pay assistance – LLS and more; Estate Planning -end of life planning; Social Security; Nutrition – Dr. Rooke; How to find Clinical trials and more information about other agencies, e.g., Jackson and Associates who recruit through email; play topics from Ask. Dr. Durie.

· **LLS.** New publication. Tips for managing stress and communicating with your healthcare team.

· **IMF.** When you shop Amazon, remember to choose IMF as your preferred charity. Go to smile.amazon.com, choose the International Myeloma Foundation as your charity, and 0.5% of your purchase is donated to IMF – no added cost to you.

· **New resource. Fulton County Senior Services**. Soaring Through Aging Resources (STAR Line) is offered through the Department of Senior Services (404-613-6000). Food delivery, light housecleaning, legal services, and more.

· **LLS.** Patients and Caregivers may get one FREE Nutrition Consult. (800) 955-4572 or provide your name for email.

· **Free rides for cancer patients. Lyft** partnering with American Cancer Society through its Road to Recovery Program. Call

1.877.277.2345. Must call at least three days before appointment.

Respectfully submitted, Gail

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Southside Multiple Myeloma Support Group – Southside group meets at 10:00 on the fourth Saturday of each month in second floor Meeting Room at the Macy's on Greenbriar Pkwy. Doris Morgan 404-346-1372; dorismorgana@aol.com , Gail McCray 770-996-4964; mccrayg@aol.com
web site: ssatlanta.support.myeloma.org
Southside Meetings: 2/23/2019, 3/23/2019
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Northside Meetings 4/6/2019
Meets 11:00 AM on the 1st Saturday of each month
Shallowford Presbyterian Church
2375 Shallowford Rd.
Atlanta, GA 30345
mmsg.org, email: aammsg-2@comcast.net
For additional information, contact:
Nancy Bruno 404-374-9020;
Sandy Brown 470-514-5330
Please Note: Meeting notes are anecdotal only and not intended to replace advice from your doctor. Feel free to review the discussion topics with your healthcare team.

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