ATLANTA AREA MULTIPLE MYELOMA SUPPORT GROUP, INC.

Meeting Minutes

Northside MM Support Group

January 4, 2025

2024 ASH Review

The ASH (*American Society of Hematology*) review from the Emory Winship team returned to where we used to meet before Covid. There were about thirty people onsite and around sixty online along with seven members of the Winship team onsite. Pizza and desserts were provided for the onsite attendees prior to the start of the meeting.

Dr. Lonial welcomed everyone with recognition of both Atlanta support groups and the close partnership between the groups and Winship. He noted that Emory has the most MM patients of any medical center in the US. They also have so many exciting clinical trials underway.

Dr. Hofmeister started the program with an overview of MGUS, SMM and MM. MGUS, Monoclonal Gammopathy of Undetermined Significance, is an abnormal protein that may lead to myeloma. All myeloma starts as MGUS, but not all MGUS becomes myeloma. Smoldering Myeloma, SMM, is an early stage of myeloma. Understanding the early stages of MM may lead to prevention. The CRAB criteria are a method to measure myeloma, and that method was enhanced as SLiM CRAB to predict likelihood of MM more accurately:

S – Sixty percent plasma cells in bone marrow biopsy = 95% chance of MM in 2 years

Li – Light chain ratio ≥ 100 = 70% chance of MM in 2 years

M – MRI abnormalities in 2+ sites = 75% chance of MM in 2 years

CRAB defines active myeloma:

C – Calcium elevation in the blood

R – Renal damage (kidney issues)

A – Anemia

B – Bone holes

The IMWG Smoldering Myeloma SMM 2020 Guideline applies points for certain levels of test results from Free Light Chains ratio, FISH chromosome test, and bone marrow plasma cell percentages. These ratings help determine low risk vs. high risk of progressing to myeloma from SMM.

The AQUILA clinical trial included 390 patients with SMM less than five years. They were divided into two groups: one group was treated with Darzalex for up to 36 months and the other group was actively monitored with imaging every six months for three years then yearly. The endpoint was how long the MM remained quiet and the patient alive. The results showed that the median survival without MM for the monitored was 18 months and the median for the treated group was about 45 months. Treating SMM improves disease-free survival at a financial and physical cost. This should be discussed with your doctor.

Dr. Joseph spoke next about updates on treatment for newly diagnosed myeloma. She noted that Emory will be participating in the Nutrivention-3 study on the impact of nutrition on MGUS and

SMM patients. This study is from Memorial Sloan Kettering in New York.

First line of treatment is the most important to get the maximum depth and duration of response with minimal overlapping toxicities. This must take into account risk status and comorbidities (other health issues). For standard risk, the first line includes: induction (4-6 cycles); transplant; and risk-based maintenance. Maximum response from the frontline treatment is associated with better disease control and longer survival, particularly for younger, fit patients. A less aggressive approach would be used for older, frail patients. Emory looked back at one thousand patients who were on VRd as the first line to measure outcomes. The median progression free survival (PFS) of standard risk patients was 6.7 years and high-risk patients was 3.5 years. The median overall survival (OS) for standard risk was not reached in ten years and the median survival of high risk was 7.25 years.

Dr. Joseph also reviewed the PERSEUS study where Dara-VRd was compared to VRd for frontline treatment. After 48 months, PFS for D-VRd was 84.3% and VRd was 67.7%. Comparing four drugs to three drugs was also done with Sarclisa (Isatuximab) with VRd compared to just VRd. MRD-negative was used to compare and the ISA-VRd was 50.1% vs. 35.6% for VRd. This GMMG-HD7 trial will continue to track the participants through maintenance to see if the frontline difference continues to impact outcomes.

Dr. Joseph continued with the AURIGA study on maintenance comparison – Dara-Rev vs. Rev alone. The participants were analyzed by age, race, stage, and risk levels. The D-R maintenance demonstrated a PFS benefit versus R across various high-risk areas as well as patients with standard risk. She then looked at transplant ineligible patients in the DREAMM-9 study using Blenrep with VRd

as frontline therapy, using various doses of Blenrep and a treatment schedule of every 4 to 12 weeks. The rates of eye problems were lower in those patients given lower doses with a longer time between doses. The overall response rates (ORR) ranged from 71% to 100%. Time to achieve VGPR+ (very good partial response) was 2-3 months with response deepened over time. Higher Blenrep starting doses are associated with deeper and faster MRD-neg rates.

Dr. Gupta presented a clinical trial CC-92480 with minidome (MEZI) plus Dex and Velcade or Kyprolis in patients with relapsed /refractory multiple myeloma (RRMM). MEZI is an oral CELMoD agent that induces immune-modulatory (IMiD) effects, causing tumor cell death. In patients with triple-class RRMM, MEZI + Dex had manageable side effects and an ORR (overall response rate) of 41%. Triple-class RRMM means that the patient was refractory (myeloma increased while on a treatment) or patient relapsed (myeloma increased when off treatment). The primary classes of myeloma drugs are:

- **immune modulators (Thalidomide, Revlimid, and Pomalyst)**
- **proteasome inhibitors (Velcade, Kyprolis, and Ninlaro)**
- **monoclonal antibodies (Darzalex, Empliciti, and Sarclisa)**
- **CAR-T (Abecma and Carvykti)**
- **bispecific T-cell engagers (Tecvayli, Talvey, and Elrexfio)**

There are other classes of drugs that are added in, like steroids, but these are the primary myeloma classes as of now. There were over 100 participants in the trial, and most were refractory to IMiDs and PIs. For the group of patients with three prior lines of therapy, the PFS was 12.3 months. The group with only one prior therapy, the median PFS was 17.5 months. Summary: MEZI is a newer version of Revlimid and Pomalyst. It can be safely combined with Velcade and

Kyprolis. Common side effects were low blood counts, infection, fatigue, and GI issues. The drug may work even in patients who became resistant to Revlimid or Pomalyst.

How does MM become resistant to treatment? **Dr. Gupta talked about the P300 protein that makes myeloma resistant to Rev and Pom. This new research is being done in the UK in a clinical trial of a novel "First-In-Class" oral agent, Inobrodib (CCS1477). Think about it: a whole new class of treatment that works differently than anything we have now! Phase I with RRMM and Inobrodib (INO) as a single agent shows a 25% response rate. New trials will start with INO in combination with Pom and dex. Note that when Velcade was in trial as monotherapy, the response rate was 29%. The combos hold great promise. Most common side effects are low blood counts and fatigue. These side effects did not impact patients continuing the treatment. Response rate of Ino/Pom/dex was 49%. Emory plans to open a trial combining Inobrodib and Pom later this year.**

Dr. Kaufman talked about amyloidosis, which is a plasma cell disorder where the light chain proteins deposit on organs, mainly heart and kidney. The Andromeda study compares Velcade/Cytoxan/dex (VCd) versus Dara-VCd. ORR are 50% (with Dara) vs. 18%. PFS after five years is 60% (with Dara) vs. 33%. Amyloidosis has both CD38 and BCMA targets on the cells. CD38 is the target for Dara and Sarclisa while BCMA is the target for CAR-T and bispecifics. The first trial with CAR-T for amyloidosis showed good results but was more difficult due to organ damage. The trial included fourteen patients with heart damage who had an average of four prior lines of therapy and were running out of options. 75% had a complete response and the MRD-neg rate at five years was 50%. MRD testing is important in amyloidosis. There are open trials at Emory for Dara-VCd and looking for underrepresented patients.

Emory is also looking for amyloidosis candidates for CAR-T and bispecifics.

Dr. Nooka reviewed the approved bispecifics: teclistamab (Tecvayli); talquetamab (Talvey); and elranatamab (Elrexfio). The conditional approvals from the FDA for these treatments required that the patient have four prior lines of therapy. The dates of approval: Tecvayli – 10/22; Talvey – 8/23; and Elrexfio – 8/23. The longest approval is just over two years, so we need more time to determine long-term outcomes. Both Tecvayli and Elrexfio use BCMA as the target on the MM cell and Talvey uses the GPRC5D target. New targets are important when the BCMA targets decrease. There are more bispecifics with new targets in clinical trials. Bispecifics are off-the-shelf treatments similar to CAR-T but without the 4-6 week wait for the T-cells to be engineered. Common side effects are similar to CAR-T: cytokine release syndrome (CRS), neurologic toxicities, infections, and other issues. CRS can be controlled or prevented with tocilizumab (toci) used earlier in the process. This has just been approved as a standard of care. There are many more bispecifics in trials that were reported at ASH, including combinations with Dara, Pom, or Rev and another trial with both Tecvayli and Talvey given together. These combinations show very high response rates (94%), and more time is needed to determine the PFS.

Dr. Dhodapkar talked about a new CAR-T, Anitocel, that has a new binding process which delivers longer survival and lower toxicity. In Phase I trials for Anitocel where patients had at least three lines of therapy, the ORR was 97% with high levels of MRD-neg. The CRS reaction was low grade levels and neurotoxicity was also low levels. Further trials will be coming to Emory soon. In Cartitude-4 trials with Carvykti versus the standard of care, the PFS and OS were

better with Carvykti. This included MRD-neg of 90% versus 35% in the standard of care, across all subgroups. Another new development was using Talvey as bridging therapy for CAR-T. Bridging is used to control myeloma while the patient waits 4-6 weeks for the T-cells to be engineered in a lab. Too much disease reduces the effectiveness of CAR-T and results in higher toxicity. CAR-T uses BCMA as a target on the MM cells, so Talvey is used for bridging since it goes to the GPRC5D target and spares the BCMA target for the super T-cells. As a result, the CAR-T response increased from 62% to 95% with no additional toxicity.

Dr. Dhodapkar explained how the immune system is impacted by treatment and certain immune cells can estimate outcomes from CAR-T treatment. "Immune Score" is a way to determine the aging of immune systems compared to chronological age. IMiDs improve immune score. Biome microbes impact cancer. Just a few thoughts on some of the research to come.

Sara Scott, PharmD, discussed the importance of supportive care. Since infections are so risky for MM patients, there is a trial on flu vaccines. The trial is comparing three flu vaccines versus a single vaccine per season. The three vaccines are given two months apart starting early in the season. At the end of the trial, 69% of the triple vaccine patients were protected against the flu versus 31% of the single vaccine participants. She also talked about the risk of infection with bispecifics. Infection rates are high and 25% of patients have infections higher than Grade 3 and end up in the hospital. CMV virus can be dormant and cause no problems for those with healthy immune systems, but bispecific treatment can wake up this virus and the patient may be hospitalized if not caught early. It is important to notify your healthcare of any symptoms of fever, chills, rash, etc.

Infections are more common with BCMA targeted treatment, but myeloma and its treatment weaken the immune system. Stay alert and make the call if there are any changes.

Submitted by Nancy B

Meeting Minutes

Southside MM Support Group

January 25, 2025

Next Meeting:

Southside group will meet on Saturday, February 22. Meetings will begin at ***10:30 a.m***. The hybrid format will continue each month unless otherwise indicated. The in-person meeting and lunch will be at Evelyn Lowery Library at 3665 Cascade Rd, Atlanta. Lunch will be provided for in-person participants. Look for the Southside meeting email for RSVP and additional details. The zoom link for the virtual participants will also be sent out.

News & Business

Gail opened the meeting with a moment of silence and "centering" exercise of deep breathing concentration**. Nancy Bruno** is retiring from her position as Regional Support Group Coordinator after 12+ years of dedicated service for the IMF. Her retirement begins at the end of March 2025. Nancy will continue her leadership role with the Northside Atlanta Area Multiple Myeloma Support Group (AAMMSG). In addition, **Doris M.** announced her retirement as Co-Leader of the Southside Atlanta MM SG in December. Doris founded the Southside

group 18 years ago when she was diagnosed with myeloma. We will surely miss the active engagement of Doris but appreciate all she has done to spread the word about myeloma, especially in Black communities. We thank these two dynamic SG leaders for their enduring dedication and commitment to myeloma in the Atlanta community.

Atlanta will host the IMF In-person **Regional Community Workshop** on **April 5**. The location will be at the Galleria Cumberland Mall located at 2844 Cobb Pkwy-SE, Atlanta, GA 30339. For more info and to register, go to **2025 RCW Atlanta - April 5**

"For Men Only" Group update

Anderson and Ted shared their thoughts on how the group is one of helping each other from a male perspective and are finding ways to make this even more successful. They held a great meeting on December 24 and were pleasantly surprised how many members showed up on Christmas eve. The group is building a great comradery over time and even reaching out to each other between meetings. They consider this a "transformative" meeting and learning about each other in ways that have nothing to do with myeloma. The Group includes a Baseball Hall of Famer!

They asked the question for discussion, *"What do you do to balance your life and forget about your diagnosis?"*

There are competing medical conditions with myeloma – pacemakers, knees (arthritis), Afib, and aging in general. *Rejoicing in life* was a common response. Group members enthusiastically invite other men to join them each 4th Tuesday of the month for one hour, starting at 6:00 PM.

Patient/Care Partner Updates and Voices

Joe S. spoke with the group about several issues he has with his treatment. His diagnosis, treatment, medical costs, decision-making and communication with medical staff are some of the issues he is facing at Emory Winship. Group members gave him some helpful suggestions including taking someone with him to his appointments. Requesting support services of a Social Worker from Emory were also discussed. Funding grants from LLS might be an option, though he shared that his income might be too high for assistance. Gail will reach out to him and try to help with resources.

Andala is a new member**,** diagnosed with myeloma in 2016. She had a bone marrow transplant – and is allergic to the additives in Revlimid. She spoke about her issues with being able to afford Revlimid through her insurance in January. Alf and others in the group had similar concerns. With the help of Dr. Lonial and Kedan's (Fayetteville) staff, she was able to get the medication covered. She also found the grants from LLS to be helpful. We will invite LLS to come to our February meeting to discuss the different funding programs available to myeloma patients. Andala asked others on Revlimid medication to share about side effects. Rashes, diarrhea, and fatigue are common. Bernard was on Revlimid for 10 years without negative side effects. **Karen** is on Revlimid and experiencing a rash on her shoulder. Talk with your providers on how to deal with side effects. Also communicate with non-physician providers, well-trained medical professionals who can offer tips on how to manage side effects.

Alma shared she was on clinical trial of Iberdomide (CC-220) for 2 years. It may never have been approved. **Doris** is now on Pomalyst and Ninlaro, both oral medications. **Gail** was on this combination in 2016

for about 2 years. This combination provided Gail with 7 years of remission. **Barbara** has been dealing with bronchitis. **Garth** had CAR-T in November 2024 and is doing well. Doris mentioned that one of the members, **Pat**, had fallen and is now in rehab and asked for our prayers. We offered to send a card from the Support Group.

Thyra asked about any other members with experience with ***Talvey*****. Alf N.** shared experience with the bispecific, Talvey since February 2024. He is on a clinical trial with Talvey. Early symptoms are loss of fingernails, rashes, loss of taste. Jannsen should provide a cream to help with skin and nails and potential of Cytokine Release Syndrome (CRS)*. He is now in remission, tested MRD negative (no sign of myeloma), and is pleased with his outcome. In the time that Alf has been on Talvey, doctors have learned that starting at a lower dosage and increasing the dosage is better for Talvey versus starting at the higher dosage. Nancy offered that doctors are giving their patients Toci** to reduce effects of CRS. Gail suggested looking at videos on Talvey. She will send a list of resources on Bispecifics to the Support Group. Nancy also suggested using the IMF community, Smart Patients. **Geraldine** is also on Talvey and developed side effects, such as loss of fingernails/toenails and difficulty swallowing. She was not pre-warned about these side effects, nor given ways to deal with them, which made the journey more frightening.

*CRS – Cytokine Release Syndrome – side effects that can occur as a response to immunotherapy -- fever, chills, difficulty in breathing, fast heartbeat, nausea

**Tocilizumab – Toci – used to reduce effects of CRS

Doris shared that **Joyce J.** and **Veronica** have volunteered to take on responsibilities in the library – and all in-person roles. Joyce will help with being in contact with membership and help with any requests for

Health Fairs to help spread the word about myeloma. Joyce will be the contact for the library. **Wanda P.** has also volunteered to help with the group. Veronica will be the technological point of contact. Nancy and Dirk will help with backup for Veronica. **Portia** has also agreed to lend assistance where possible.

Respectfully submitted, Gail.