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PB2016 COMPARISON BETWEEN DRD VS KRD AS SALVAGE THERAPY FOR MULTIPLE MYELOMA PATIENTS IN FIRST RELAPSE: THE REAL LIFE EXPERIENCE OF RETE EMATOLOGICA PUGLIESE (REP)

Topic: 14. Myeloma and other monoclonal gammopathies - Clinical

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Background: Daratumumab (DRD) and Carfilzomib (KRD), in combination with lenalidomide and dexamethasone, performed well in patients with relapsed or relapsed/refractory multiple myeloma (RRMM). The lack of randomized and/or real-life trials comparing the two triplets prompted us to assess their effectiveness and safety in RRMM in first relapse.

Aims: To analyzed effectinness and safety of Drd and Krd in first line relapse Multiple Myeloma

Methods:

176 RRMM patients, including 107 DRD and 69 KRD, entered this non-randomized comparison.

Results:

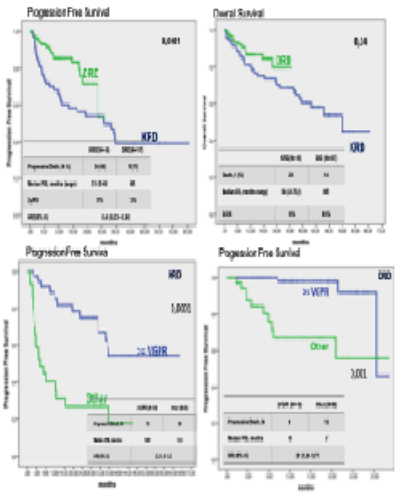
Baseline characteristics and details of the previous therapies are analyzed (Table 1). KRD cohort accounted for a higher incidence of III Durie-Salmon staging (71 vs 23%, p 0,001). Instead, a higher number of patients with refractory disease were treated with DRD (29 vs 13%, p 0,01). Moreover, median age of patients, elevated LDH, III ISS stage, cytogenetic risk categories, type of previous therapy, were equally distributed between the two therapy arms. Half of them (43%) relapsed after a previous ASCT, without differences in KRD and DRD group of patients.

The overall response rate (ORR) was 78% (n=83), with 31% complete response (CR; n= 33) in DRD. In patients treated with KRD, the ORR was 74% (n=51), with 42 % CR (n=29),p 0,31. Median time to best response was shorter in KRD patients (2,8 vs 4,3 months, p 0,03). The probability of CR+VGPR response was significantly higher in patients with normal LDH and treated with DRD (41 vs 22%, p 0,02). Elevated LDH didn't influenced the probability of response in KRD cohort (45 vs 42%, p 0,89). Response was better in late relapse (64 vs 21%, p 0.001) and in patients relapsed after a prior autologous transplant (61 vs 33%, p 0,02) in KRD arm. After a median follow-up of 18 months, median PFS was NR in DRD and 31 months in KRD, p 0,0001. The 2y-PFS was 72% and 57% in DRD and KRd, respectively. PFS was longer in patients achieving a Very good partial response (VGPR) with median PFS of 28 months and NR, in DRD and KRD, respectively (p 0,001). Better PFS was obtained in patients with normal LDH treated with DRD as KRD. The treatment discontinuation rate due to adverse events (AEs) was 13% and 22% in DRD and KRD, respectively (p 0,12). No differences in hematologic and non-hematologic AEs were observed between the two triplets.

Image:

Table 1. Patients' characteristics at enrolment and details of the previous therapies

	All	KRD	DRD	
	N= 176	N=69	N= 107	p
Median age, years (range)	66 (34-85)	62 (34-79)	69 (42-85)	0,01
Age ≥70 years, n (%)	67 (38)	15 (22)	52 (49)	
Type of Myeloma, n (%)				
IgG	97 (56)	32 (46)	65 (62)	
IgA/IgC	53 (23)/2(1)	23 (33)/1 (1)	27 (25)/1 (1)	0,16
Detected in urine only	25 (14)	13 (19)	12 (11)	
III Durie Salmon staging, n (%)	64 (44)	46 (71)	18 (23)	0,001
III ISS disease staging, n (%)	45 (31)	26 (40)	19 (24)	0,11
Cytogenetic profile, n (%)				
Standard Risk	53 (33)	21 (31)	36 (34)	0,55
High Risk	9 (5)	5 (8)	4 (3)	
Elevated LDH, n (%)	51 (30)	26 (44)	25 (30)	0,15
Median Time since initial therapy, months (range)	28 (3-165)	29 (30-137)	26 (3-165)	0,43
≤18 months	61 (53)	26 (39)	35 (33)	
Previous autologous transplant, n (%)	75 (43)	34 (49)	42 (40)	0,20
Previous therapy, n (%)				
Bortezomib	170 (97)	67 (97)	103 (96)	0,74
Lenalidomide	9 (5)	4 (6)	5 (5)	0,74
Bortezomib and IMIDs	80 (46)	40 (58)	40 (37)	0,01
Refractory disease, n (%)	40 (23)	9 (13)	31 (29)	0,01



Summary/Conclusion:

With limitations characteristic to any retrospective analysis, this real-life study demonstrated similar ORR in patients treated in first relapse with DRD or KRD,shorter time to best response with KRD but longer PFS with DRD. PFS was longer in patients achieving a VGPR after DRD as KRD. Patients who had relapsed after a previous transplant appeared to benefit more from KRD than DRD. Unfortunately, high LDH values at the first relapse had a negative impact on PFS beyond the treatment used. These observations may help the daily clinical practice.