Abstract: PB2703

Title: ISA-KD IN NOT TRANSPLANT CANDIDATES RRMM. EXPERIENCE IN REAL LIFE.

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Background:

Isatuximab+pomalidomide+dexamethasone (Isa-Pd) or Isa+carfilzomib+dexamethasone (Isa-Kd), respectively, are approved for patients with relapsed and/or refractory multiple myeloma (RRMM). Limited real-world evidence (RWE) exists for patients treated with Isa-Pd/Isa-Kd.

Aims:

Describe baseline characteristics, treatment exposure, and treatment-emergent adverse events (TEAEs) for Isa-treated RRMM patients in a real-world setting.

Methods:

We reported patients with relapsed MM with 1–3 prior lines of therapy. Patients were excluded if they had primary refractory MM, had received prior carfilzomib treatment, were refractory to anti-CD38 antibody therapy, or presented with left ventricular ejection fraction <40%. Patients with a baseline estimated glomerular filtration rate (eGFR) as low as 15 mL/min/1.73m^2 were and prior pulmonary comorbidities, including chronic obstructive pulmonary disease, were eligible. Patients received Isa intravenously at 10 mg/kg on days 1, 8, 15, and 22 in the first 28-day cycle; and days 1 and 15 in subsequent cycles. In both arms, carfilzomib was administered intravenously at 20 mg/m[^[2]{.underline}^](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9152981/#ref2) on days 1 and 2; 56 mg/m[^[2]{.underline}^](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9152981/#ref2) on days 8, 9, 15, and 16 of cycle 1; and then 56 mg/m[^[2]{.underline}^] (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9152981/#ref2) on days 1, 2, 8, 9, 15, and 16 of subsequent cycles. Dexamethasone 20 mg was administered intravenously or orally on days 1, 2, 8, 9, 15, 16, 22, and 23. The patients received acyclovir in prophylaxis treatment. Treatment continued until unacceptable adverse event (AE), disease progression, or other discontinuation criteria.

Results:

Between May-2022 and Feb-2023, 6 patients received ≥1 dose of Isa-Kd. Compared with baseline characteristics in Phase 3 Isa studies, a higher proportion of patients in our report 66% were ≥75 years old (median 75, range age 64-83) and ISS stage III, 50% of Isa-Kd patients had high-risk cytogenetics, and 66%, 17% and 17% of Isa-Kd patients received 1, 2 and ≥5 prior lines of therapy, respectively. 100%, 83%, 17% of patients were exposure to bortezomib, lenalidomida and pomalidomide. Everybody was naïve to antiCd38 therapy. At data cutoff, median (min–max) duration of Isa exposure was 3 (1-4) months, with 83.3% of patients still receiving Isa-Kd. For Isa-Kd, AEs occurred during treatment in 2 patients (2 (11.7%; pneumonia); and TEAEs leading to discontinuation in 0 patients. We don't reported any infusion reactions. Response data are 40% CR, 60% VGBP.

Summary/Conclusion:

Isa-Kd has manageable safety profiles in routine clinical practice. These data provide RWE to support Isa use in RRMM outside clinical trials and in wider populations.

We reported fast response , and well tolerated regimen in elderly patients. We don't need to use G-CSF.

Keywords: Multiple myeloma, Langerhans Cell Histiocytosis