



A Comparison Between Daratumumab And Non-daratumumab-based Salvage Regimens At First Relapse Post-lenalidomide Maintenance In Multiple Myeloma

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Introduction

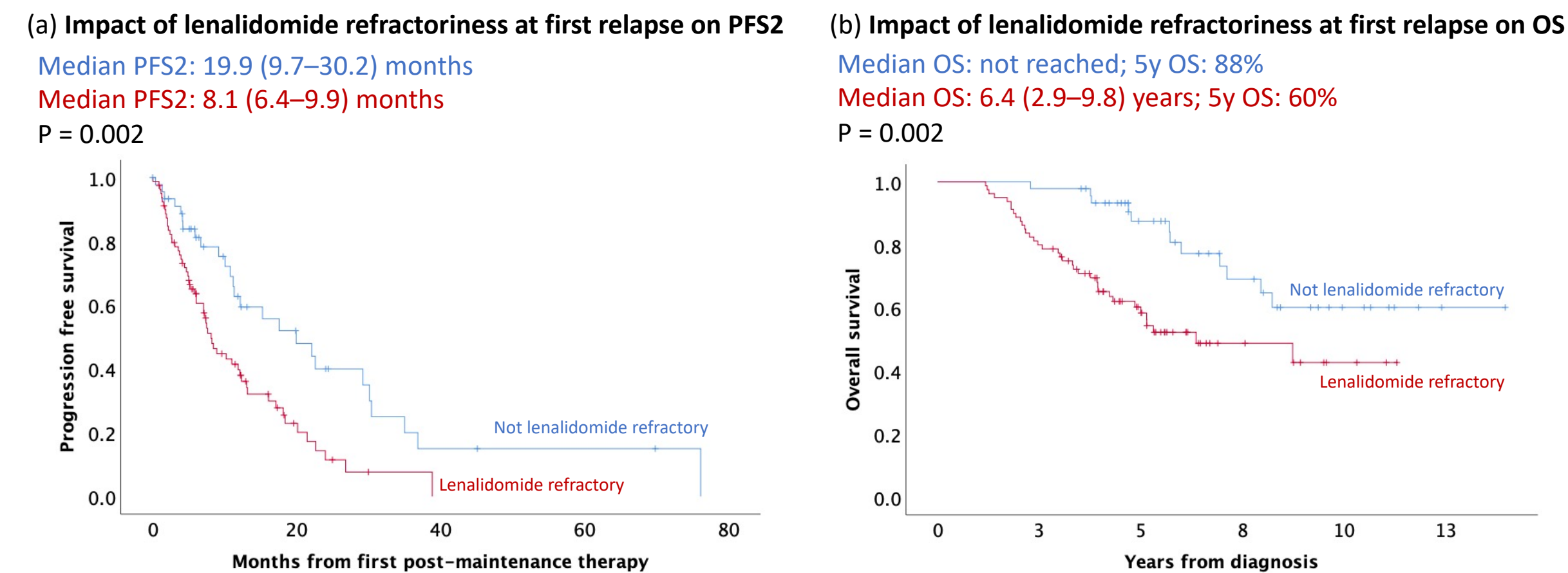
Lenalidomide maintenance after autologous stem cell transplantation (ASCT) is standard of care in multiple myeloma (MM). Randomized studies demonstrate a progression free survival (PFS) benefit and a recent meta-analysis of the CALGB, GEMIMA, and IFM trials showed improvement in overall survival (OS) as well. However, most patients relapse and the optimal choice of therapy at first-relapse post-lenalidomide maintenance is not established.

Patients/Methods

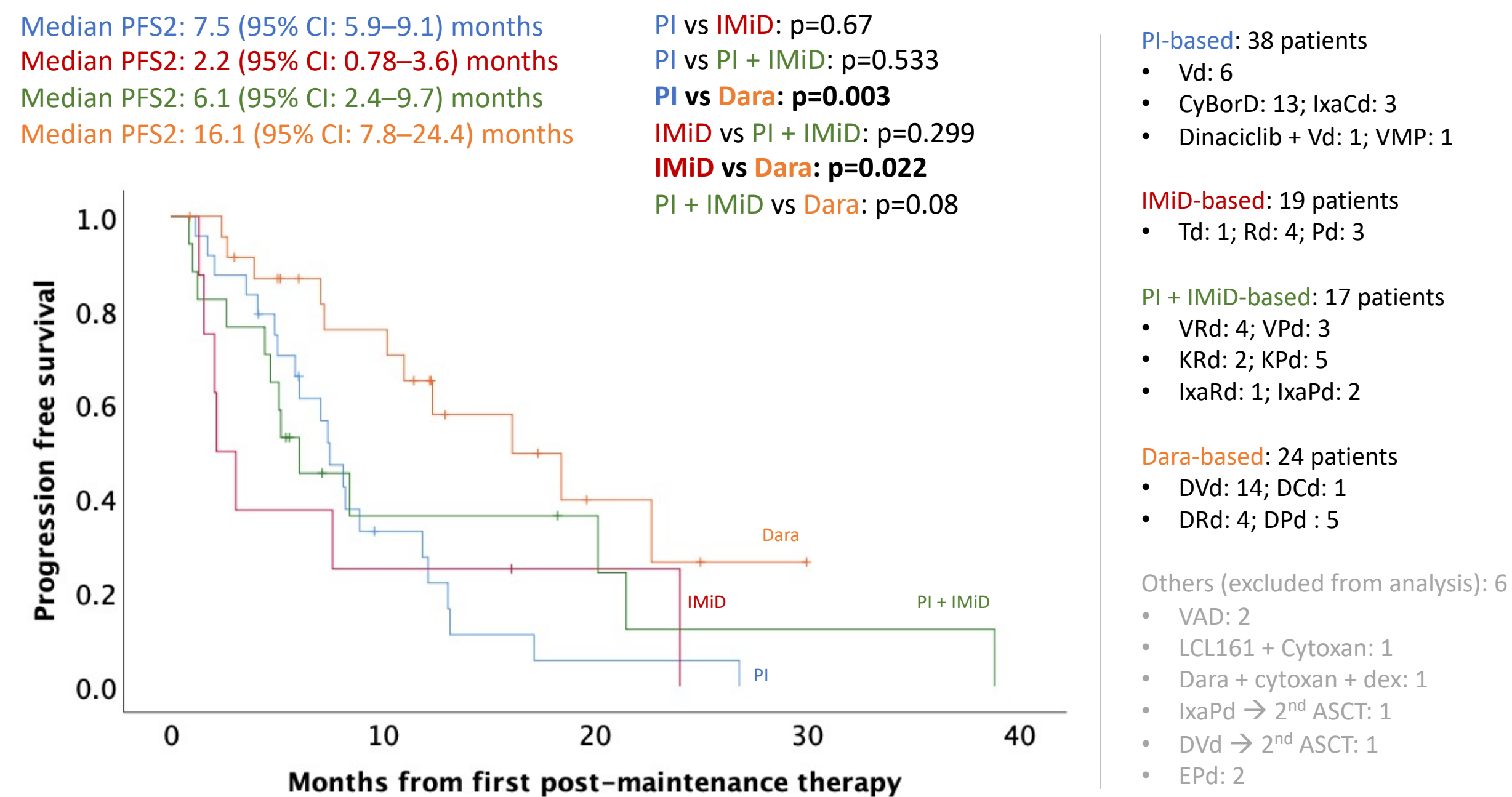
- Retrospective study
- N=213 patients seen at Mayo Clinic, Rochester between 1/1/2015–12/31/2016 who received lenalidomide maintenance post-early ASCT (i.e., frontline ASCT within 1 year of diagnosis)
- n=136 patients experienced first relapse and n=118 patients received salvage therapy were included.
- Main outcome measures were OS and PFS2 (i.e., start of post-maintenance salvage therapy until discontinuation due to progression)
- Kaplan Meier method used to estimate median OS and PFS2
- All statistical analyses were performed using SPSS (version 19; SPSS Inc., Chicago, IL, USA).

Results

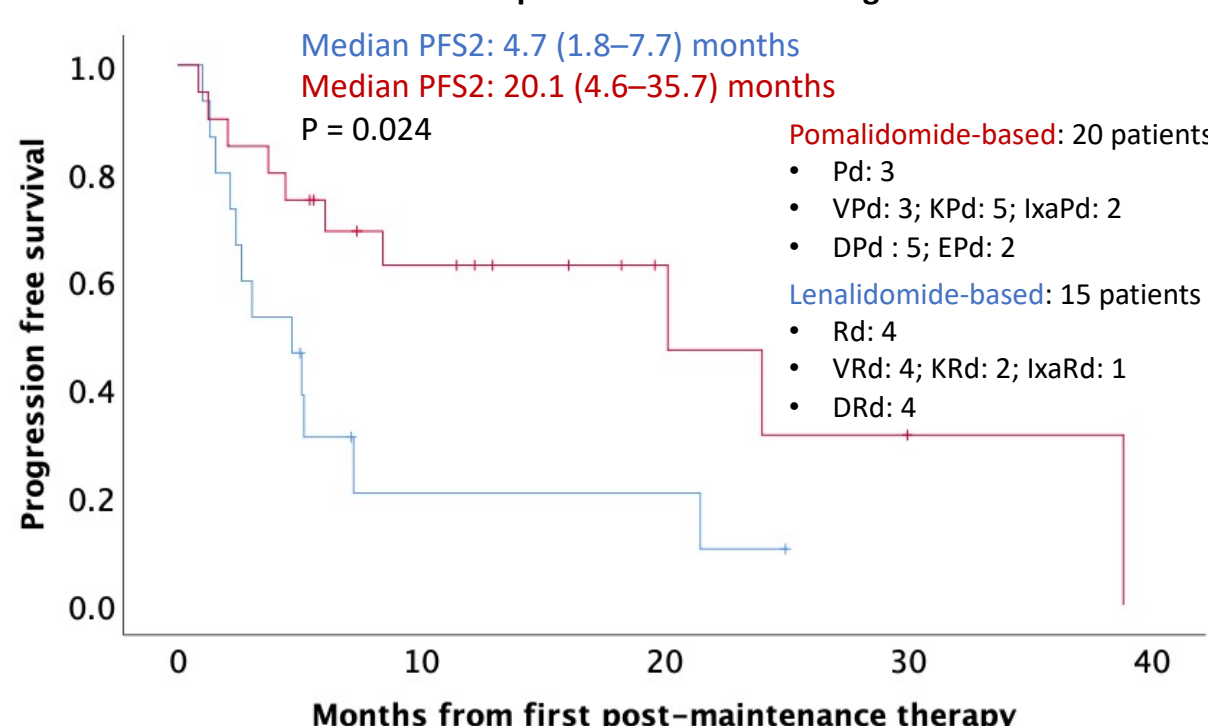
1. Lenalidomide refractoriness at relapse



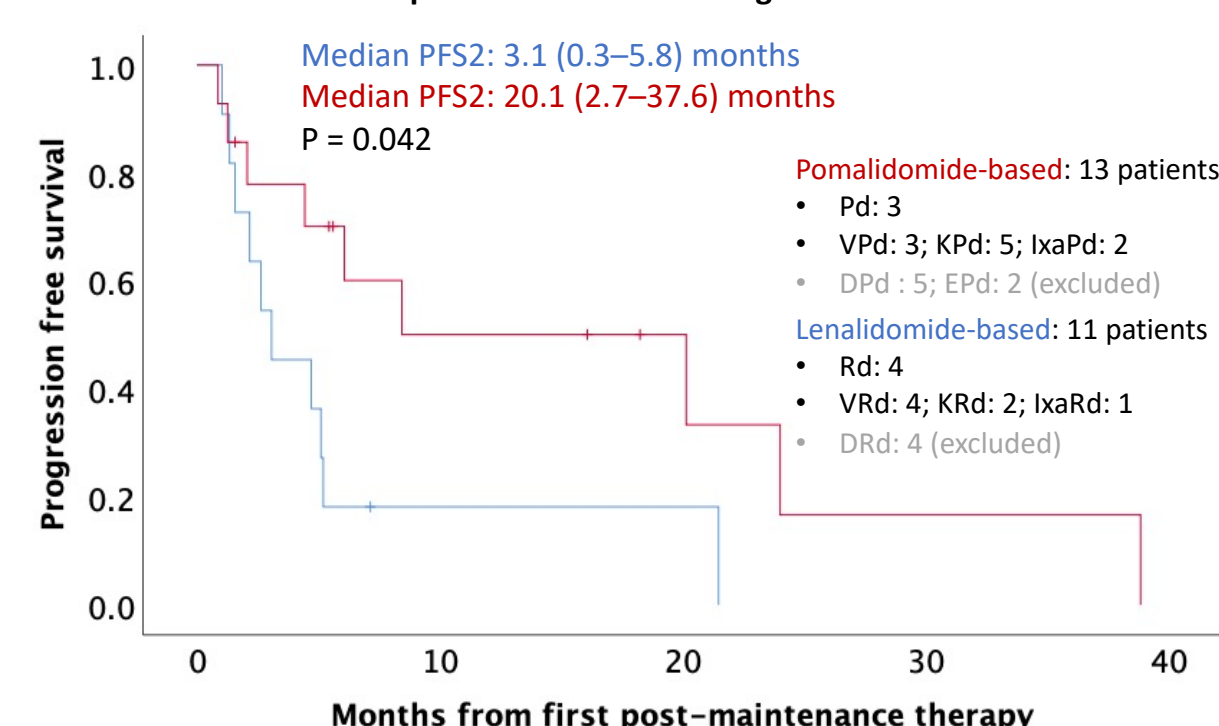
(c) PFS2 in patients who are lenalidomide refractory receiving PI, IMiD, or PI + IMiD as initial therapy at relapse post-maintenance



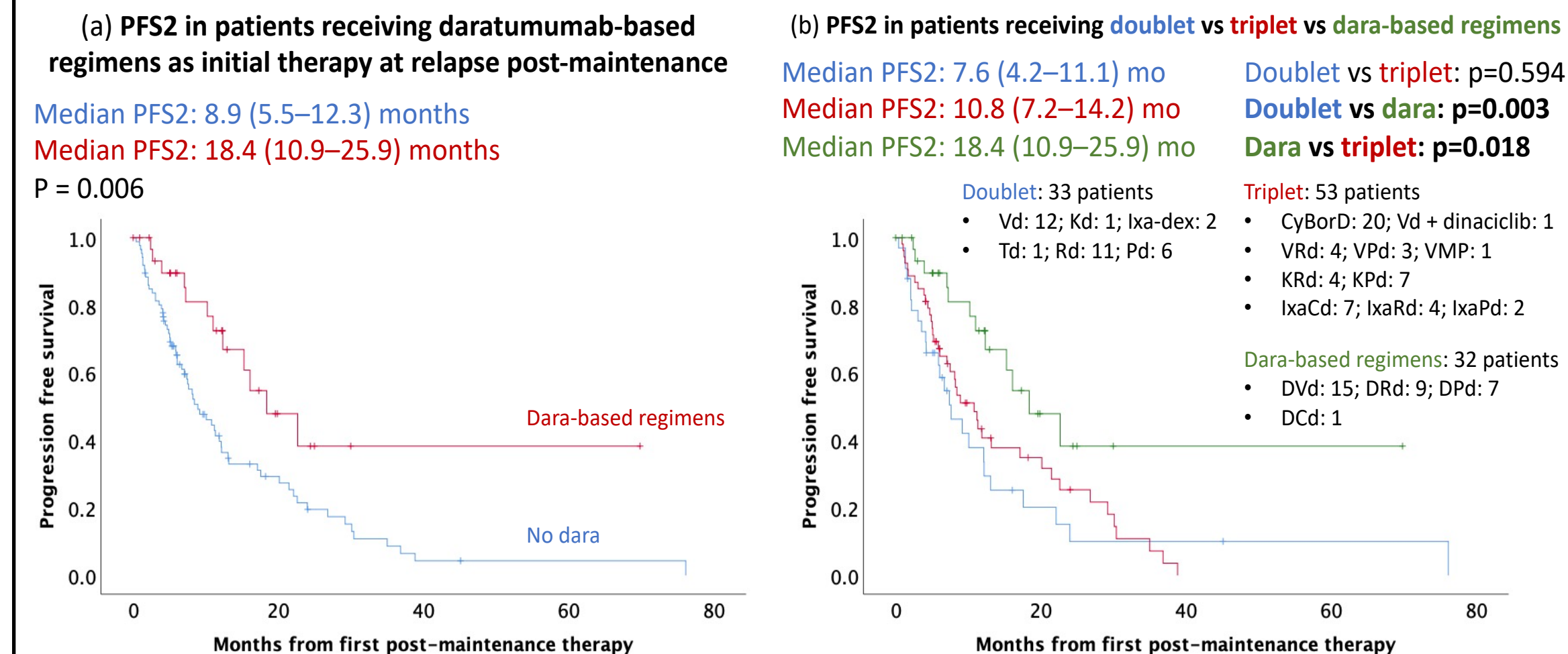
(d) PFS2 in patients who are lenalidomide refractory receiving lenalidomide- versus pomalidomide-based regimens



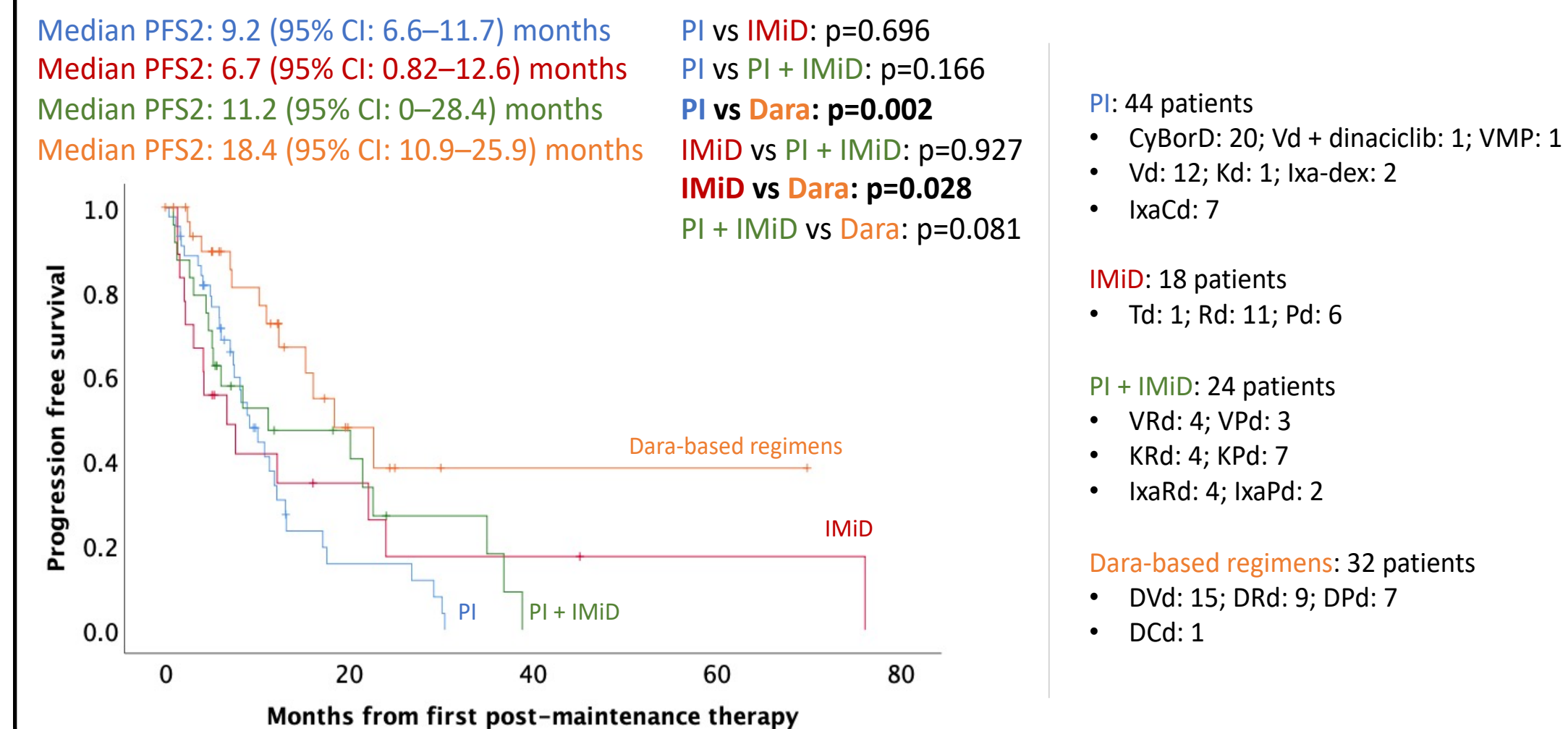
(e) PFS2 in patients who are lenalidomide refractory receiving lenalidomide- versus pomalidomide-based regimens without dara or elo



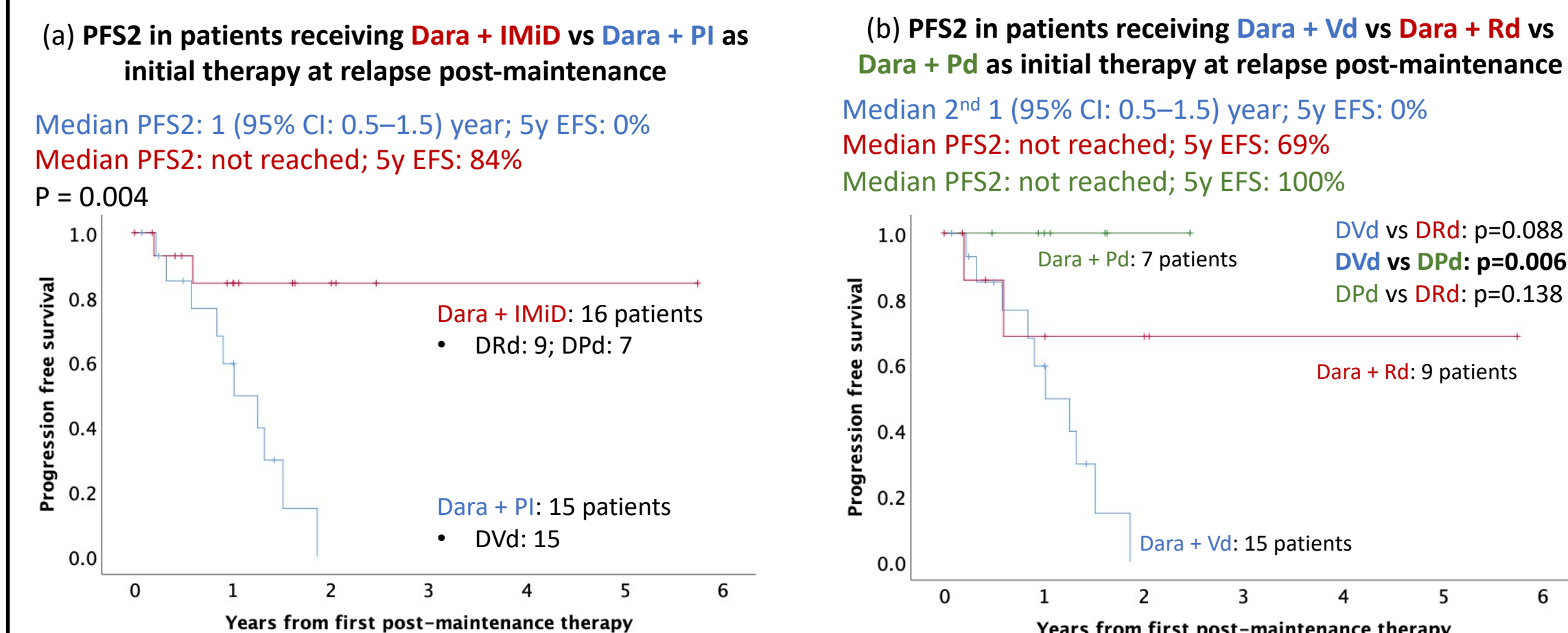
2. Daratumumab vs Non Daratumumab-Based Regimens



(c) PFS2 in patients receiving PI, IMiD, PI + IMiD, or Dara-based regimens as initial therapy at relapse post-maintenance



3. Dara + IMiD vs Dara + Bortezomib



CONCLUSION: FIGURE 1

- Lenalidomide refractoriness associated with inferior PFS2 even after adjusting for age, ISS III, cytogenetic risk [HR 1.9 (95% CI: 1.1, 3.2; p=0.017)]
- Pomalidomide-based regimens associated with superior median PFS2 compared to lenalidomide-based therapies in lenalidomide refractory patients.

CONCLUSION: FIGURE 2

- Dara-based regimens had better PFS2 versus regimens without dara even after adjusting for age, ISS III, cytogenetic risk, lenalidomide refractoriness, and date of maintenance (before or after 1/1/2014) [HR 0.35 (95% CI: 0.17, 0.68; p=0.002)].
- Without dara, no difference between doublet vs triplet, IMiD- vs PI, or lenalidomide vs pomalidomide

CONCLUSION: FIGURE 3

- Dara + IMiD superior to dara + bortezomib even after adjusting for age, cytogenetic risk, ISS III, and lenalidomide refractoriness [HR 0.1 (95% CI: 0.016, 0.58); p=0.011].
- Possibly due to synergism from IMiD-mediated of NK proliferation, cytotoxicity → improved dara-mediated ADCC