MM-691

Phase 3 AQUILA Study of Daratumumab Monotherapy Versus Active Monitoring in Patients With High-Risk Smoldering Multiple Myeloma

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Introduction

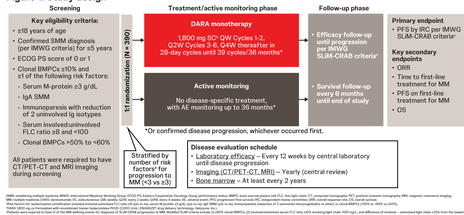
- Smoldering multiple myeloma (SMM) is an asymptomatic precursor disease of multiple myeloma (MM) and includes a subset of patients who are at high risk of progressing to MM and developing end-organ damage[1]
  - Currently, the standard of care for patients with high-risk SMM is observation, with treatment initiation at the time of progression to MM[2]
  - However, therapeutic intervention before MM diagnosis, and especially before occurrence of end-organ damage, could be beneficial for these patients to delay or avoid end-organ damage and progression to MM[1,3]
- Daratumumab (DARA), a human IgGκ monoclonal antibody targeting CD38, demonstrated clinical activity and was well tolerated in the phase 2 CENTAURUS study of patients with intermediate- and high-risk SMM[4]
  - Additionally, DARA combination regimens demonstrated significant improvements in progression-free survival (PFS), overall survival (OS), and minimal residual disease negativity in several phase 3 studies in patients with MM[5-9]
- Here we report the efficacy and safety outcomes from the phase 3 AQUILA study, which evaluated whether treatment with DARA monotherapy could delay or avoid progression to MM in a well-defined population with high-risk SMM

Methods

Study design

- AQUILA (ClinicalTrials.gov Identifier: NCT03301220) was a randomized, open-label, multicenter, phase 3 study comparing the efficacy and safety of DARA versus standard-of-care active monitoring in adults with high-risk SMM (**Figure 1**)
- Eligible patients were ≥18 years of age with a diagnosis of high-risk SMM per the study eligibility criteria shown in **Figure 1**; all patients were required to have thorough imaging during screening to exclude individuals with active MM, which was also confirmed by an independent review committee (IRC) via a central read of the imaging
- Patients were randomized 1:1 to active monitoring or subcutaneous DARA monotherapy in 28-day cycles until 39 cycles, 36 months, or disease progression, whichever came first
- The primary endpoint was PFS, defined as the duration from randomization to initial documented progression to active MM, per IRC assessment according to International Myeloma Working Group SLiM-CRAB diagnostic criteria for MM,[10] or death

Figure 1: Study design



SMM, smoldering multiple myeloma; IMWG, International Myeloma Working Group; ECOG PS, Eastern Cooperative Oncology Group performance status; BMPC, bone marrow plasma cell; FLC, free light chain; CT, computed tomography; PET, positron emission tomography; MRI, magnetic resonance imaging; QW, once weekly; Q2W, once every 2 weeks; Q4W, once every 4 weeks; SC, subcutaneous; AE, adverse event; ORR, overall response rate.
*See factors for combination stratification (central review) and protocol for full criteria. DARA 1,800 mg was co-formulated with recombinant human hyaluronidase PH20 (rHuPH20) and administered SC over ~3 to ~5 min. Active monitoring: Laboratory assessments (serum protein electrophoresis with immunofixation, serum FLC ratio, 24-h urine protein electrophoresis with immunofixation) every 3 months; skeletal survey every 12 months; bone marrow aspiration and biopsy every 12 months or as clinically indicated.
†Patients were required to have ≥1 of the MM-defining events for diagnosis of SLiM-CRAB progression in MM: Modified SLiM criteria include (1) ≥60% clonal BMPCs; (2) involved:uninvolved serum FLC ratio ≥100; involving light chain +60 mg/L; and difference of involved – uninvolved light chain ≥200; from the lowest documented value; (3) >1 lesion on MRI; and (4) hemoglobin level ≥2 g/dL below the lower limit of normal or ≥10 g/dL; involving light chain the upper limit of normal or ≥12 mg/dL; (2) creatinine clearance <40 mL/min or serum creatinine >177 µmol/L (>2 mg/dL); (3) hemoglobin value <8 g/dL below the lower limit of normal or a hemoglobin value <10 g/dL; and (4) ≥1 osteolytic lesion on skeletal radiography, CT, or PET-CT.

Key Takeaway

Results from the phase 3 AQUILA study strongly support early intervention with subcutaneous DARA monotherapy for a fixed duration in patients with high-risk SMM, representing an opportunity to delay or avoid end-organ damage and progression to MM while preserving quality of life and extending survival

Conclusions

Treatment with DARA monotherapy for 36 months led to a statistically significant 51% reduction in the risk of disease progression or death compared with active monitoring (HR, 0.49 [95% CI, 0.36-0.67]; *P* <0.001)

The most notable PFS benefit was seen in patients retrospectively identified as high risk per the Mayo 2018 criteria (HR, 0.36), although a benefit was also observed among patients with low- and intermediate-risk SMM per the Mayo 2018 criteria

DARA also extended OS (HR, 0.52) and PFS on first-line treatment for MM (HR, 0.58)

DARA demonstrated a favorable safety profile, with a low rate (5.7%) of treatment discontinuation due to TEAEs

Patients maintained their health-related quality of life during DARA treatment compared with active monitoring

Acknowledgments

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Disclosure

MAD received honoraria for participation on advisory boards from Amgen, Astra, BioGene, Bristol Myers Squibb, GSK, Johnson & Johnson, Menarini, Regeneron, Sanofi, Swixx BioPharma, and Takeda; and received travel support from Amgen, Bristol Myers Squibb, Johnson & Johnson, and Takeda.

Results

Patients

- In total, 390 patients were randomized to receive DARA (n = 194) or active monitoring (n = 196)
- Demographic and baseline disease characteristics were generally well balanced between groups (**Table 1**)
- The median (range) duration of DARA treatment was 38 (1-39) cycles, which equated to 35.0 (0-36.1) months; patients remained on active monitoring for 25.9 (0.1-36.0) months
- The rate of discontinuation of treatment/monitoring was lower with DARA (24.2%) versus active monitoring (59.2%)
  - The most frequent reasons for discontinuation of DARA and active monitoring, respectively, were progressive disease (21.8% vs 41.8%), adverse events (AEs; 6.7% vs 0.5%), and patient refusal of further treatment/monitoring (2.6% vs 11.2%)

Table 1: Baseline demographic and disease characteristics (ITT population)

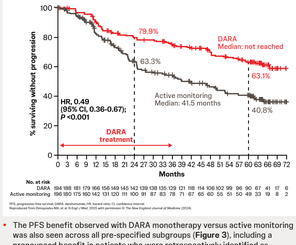
Characteristic	DARA (n = 194)	Active monitoring (n = 196)
Median age (range), years	63.0 (31-86)	64.5 (36-83)
Female, n (%)	99 (51.0)	103 (52.6)
ECOG PS score, n (%)		
0	165 (85.1)	160 (81.6)
1	29 (14.9)	36 (18.4)
Median time from diagnosis of SMM to randomization (range), years	0.80 (0-4.7)	0.67 (0-5.0)
Type of SMM, n (%)	20.0 (8.0-59.5)	20.0 (10.0-55.0)
IgG	127 (65.5)	138 (70.4)
IgA	55 (28.4)	42 (21.4)
Other	12 (6.2)	16 (8.2)
AQUILA risk factors for progression to MM, n (%)*		
<3	154 (79.4)	156 (79.6)
≥3	40 (20.6)	40 (20.4)
Cytogenetic risk profile†	n = 167	n = 170
≥1 of del(17p), t(4;14), and/or t(14;16), n (%)	29 (17.4)	22 (12.9)
Mayo 2018 risk criteria, n (%)‡		
Low	45 (23.2)	34 (17.3)
Intermediate	77 (39.7)	76 (38.8)
High	72 (37.1)	86 (43.9)

ITT, intent-to-treat; DARA, daratumumab; ECOG PS, Eastern Cooperative Oncology Group performance status; SMM, smoldering multiple myeloma; BMPC, bone marrow plasma cell.
*Risk factors: serum M-protein ≥3 g/dL; IgA SMM; immunoparesis with reduction of 2 uninvolved immunoglobulin isotypes; serum involved:uninvolved FLC ratio ≥8 and <100; or clonal BMPCs >50% to <60%.
†Cytogenetic risk was assessed by fluorescence in situ hybridization.
‡Patients were retrospectively categorized according to the Mayo 2018 risk criteria[11]: serum M-protein <3 g/dL, involved:uninvolved FLC ratio <20, and clonal BMPCs <30%. Patients with ≥1 factors = low risk; 1 factor = intermediate risk; ≥2 factors = high risk.

PFS

- After a median follow-up of 65.2 months, there was a 51% reduction in the risk of disease progression or death in patients who received DARA versus active monitoring (hazard ratio [HR], 0.49 [95% confidence interval (CI), 0.36-0.67]; *P* <0.001; **Figure 2**)
- SLiM criteria–based progression to MM[10] was observed in 25.8% (n = 50/194) of patients in the DARA group and 33.2% (n = 65/196) in the active monitoring group (elevation of clonal bone marrow plasma cells [≥60%], abnormal serum free light chain ratio [17.0%; 16.8%], or the presence of >1 focal lesion [6.2%; 8.2%])
- CRAB criteria–based progression to MM[10] was observed in 6.2% (n = 12/194) of patients in the DARA group and 17.3% (n = 34/196) in the active monitoring group (calcium elevation [0%; 1.0%], renal insufficiency [0%; 0%], anemia [1.0%; 7.1%], or bone disease [5.2%; 9.2%])

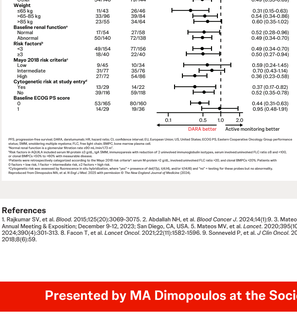
Figure 2: PFS



PFS, progression-free survival; DARA, daratumumab; CI, confidence interval.
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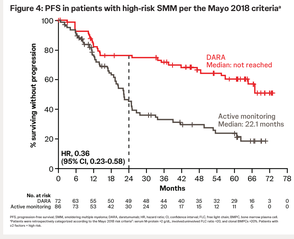
- The PFS benefit observed with DARA monotherapy versus active monitoring was also seen across all pre-specified subgroups (**Figure 3**), including a pronounced benefit in patients who were retrospectively identified as high risk per the Mayo 2018 criteria[11] (**Figure 4**)

Figure 3: PFS in subgroups



PFS, progression-free survival; DARA, daratumumab; HR, hazard ratio; CI, confidence interval; EU, European Union; US, United States; ECOG PS, Eastern Cooperative Oncology Group performance status; SMM, smoldering multiple myeloma; FLC, free light chain; BMPC, bone marrow plasma cell.
*Normal renal function is a glomerular filtration rate ≥60 mL/min/1.73 m².
†Risk factors: serum M-protein ≥3 g/dL; IgA SMM; immunoparesis with reduction of 2 uninvolved immunoglobulin isotypes; serum involved:uninvolved FLC ratio ≥8 and <100; or clonal BMPCs >50% to <60%, with reasonable doubt.
‡Patients were retrospectively categorized according to the Mayo 2018 risk criteria[11]: serum M-protein <3 g/dL, involved:uninvolved FLC ratio <20, and clonal BMPCs <30%. Patients with ≥1 factors = low risk; 1 factor = intermediate risk; ≥2 factors = high risk.
§Cytogenetic risk was assessed by fluorescence in situ hybridization; where "yes" = presence of del(17p), t(4;14), and/or t(14;16) and "no" = testing for these protocol-mi or abnormality.
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Figure 4: PFS in patients with high-risk SMM per the Mayo 2018 criteria[a]



PFS, progression-free survival; SMM, smoldering multiple myeloma; DARA, daratumumab; HR, hazard ratio; CI, confidence interval; FLC, free light chain; BMPC, bone marrow plasma cell.
[a]Patients were retrospectively categorized according to the Mayo 2018 risk criteria[11]: serum M-protein <3 g/dL, involved:uninvolved FLC ratio <20, and clonal BMPCs <30%. Patients with ≥1 factors = high risk.
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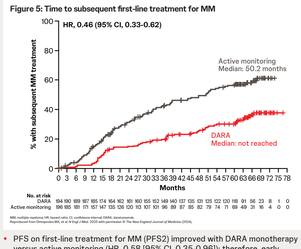
Response rates

- Overall response rate (partial response or better) was 63.4% with DARA versus 2.0% with active monitoring (odds ratio, 83.80 [95% CI, 29.69-236.54]; *P* <0.001)
- In the DARA group, 29.9% of patients achieved a very good partial response or better and 8.8% achieved a complete response or better

Subsequent antimyeloma treatment

- As of the primary analysis clinical cutoff, 64 (33.2%) patients in the DARA group and 105 (53.6%) in the active monitoring group had initiated subsequent treatment for MM
  - Bortezomib/lenalidomide/dexamethasone was the most commonly initiated first-line treatment for MM, received by 19/64 (29.7%) patients in the DARA group and 29/105 (27.6%) in the active monitoring group
  - Anti-CD38 antibody–based therapy was received as subsequent treatment for MM by 16/64 (25.0%) patients in the DARA group and 35/105 (33.3%) in the active monitoring group
- The median time to initiation of subsequent first-line treatment for MM was not reached for the DARA group versus 50.2 months for the active monitoring group (HR, 0.46 [95% CI, 0.33-0.62]; **Figure 5**)

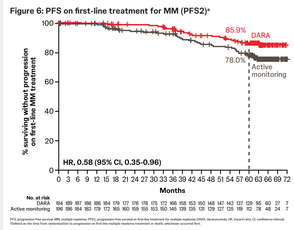
Figure 5: Time to subsequent first-line treatment for MM



MM, multiple myeloma; HR, hazard ratio; CI, confidence interval; DARA, daratumumab.
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- PFS on first-line treatment for MM (PFS2) improved with DARA monotherapy versus active monitoring (HR, 0.58 [95% CI, 0.35-0.96]); therefore, early treatment with DARA did not appear to impair later treatment for MM (**Figure 6**)

Figure 6: PFS on first-line treatment for MM (PFS2)*

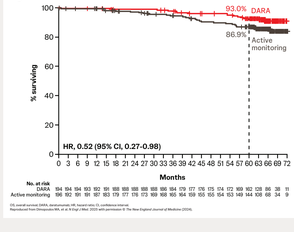


PFS, progression-free survival; MM, multiple myeloma; PFS2, progression-free survival on first-line treatment for multiple myeloma; DARA, daratumumab; HR, hazard ratio; CI, confidence interval.
*Defined as the time from randomization to progression on first-line multiple myeloma treatment or death, whichever occurred first.

OS

- Early intervention with DARA for a fixed duration (36 months) led to a strong positive trend toward prolonged OS (HR, 0.52 [95% CI, 0.27-0.98]; **Figure 7**)
  - A total of 41 deaths were observed, including 15 in the DARA group and 26 in the active monitoring group; key reasons included disease progression (n = 3 vs n = 9) and AEs (n = 2 vs n = 4)

Figure 7: OS



OS, overall survival; DARA, daratumumab; HR, hazard ratio; CI, confidence interval.
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Safety and tolerability

- Overall, no new safety concerns were identified in patients who received DARA (**Table 2**)
- DARA treatment was associated with a higher frequency of grade 3/4 treatment-emergent AEs (TEAEs), with hypertension being the most frequently reported (5.7% vs 4.6% with active monitoring)
- Although the frequency of serious TEAEs was also higher in the DARA group, the rate of discontinuation of DARA due to TEAEs was low (5.7%)
- Grade 3/4 infections were typically of short duration, and the majority of infections resolved or recovered
- The frequency of second primary malignancies was similar for the DARA (n = 18 [9.3%]) and active monitoring (n = 20 [10.2%]) groups
- Systemic infusion-related reactions were reported in 32 (16.6%) patients in the DARA group, including 2 (1.0%) with grade 3/4 reactions; local injection-site reactions were reported in 53 (27.5%) patients, all of which were grade 1/2 in severity

Table 2: Safety overview

Event, n (%)	DARA (n = 193)	Active monitoring (n = 196)
Median duration of AE reporting, months*	35	26
Any grade TEAEs	187 (96.9)	162 (82.7)
Grade 3/4 TEAEs	78 (40.4)	59 (30.1)
Hypertension†	11 (5.7)	9 (4.6)
Serious TEAEs	56 (29.0)	38 (19.4)
Pneumonia‡	7 (3.6)	1 (0.5)
Grade 5 TEAEs#	2 (1.0)	4 (2.0)
Treatment discontinuations due to a TEAE^	11 (5.7)	–
Dose modifications due to a TEAE†	90 (46.6)	–
Cytopenias (all grades)	23 (11.9)	24 (12.2)
Neutropenia	13 (6.7)	5 (2.6)
Anemia	9 (4.7)	19 (9.7)
Thrombocytopenia	4 (2.1)	3 (1.5)
Lymphopenia	3 (1.6)	1 (0.5)
Grade 3/4 infections	31 (16.1)	9 (4.6)
Number of grade 3/4 infections	37	11
Recovered or resolved	35 (94.6)	8 (72.7)
Median duration of infection, days	9	5
COVID-19 TEAEs	17 (8.8)	10 (5.1)
Serious COVID-19 TEAEs	5 (2.6)	1 (0.5)
Deaths due to COVID-19	2 (1.0)	0

AE, adverse event; TEAE, treatment-emergent adverse event; MM, multiple myeloma.
*TEAEs include all AEs that occurred during the 30 month treatment or monitoring phase or for 30 days after discontinuation of DARA or active monitoring, or until the start of subsequent MM therapy.
†Grade 3/4 TEAEs in ≥1% of patients in either group.
‡Grade 3/4 TEAEs in ≥2 patients in either group.
§Grade 3 TEAEs included COVID-19 infection and COVID-19 pneumonia in the DARA group and pulmonary edema, cardiac arrest, pulmonary embolism, and cardiac failure in the active monitoring group.
¶Dose modifications mainly reported TEAEs leading to DARA discontinuation were fatigue, dyspnea, and anemia (n = 2 each).
#These modifications included dose delays within a cycle, cycle delays, and skipped doses.

Patient-reported quality of life

- In an expanded assessment of patient-reported outcomes, health-related quality of life was maintained with DARA across multiple measures and domains, with similar mean changes from baseline reported at Week 112 for both groups (**Figure 8** and **Table 3**)

Figure 8: Patient-reported quality of life*

EORTC QLQ-C30, European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; LS, least squares; SE, standard error; DARA, daratumumab.
EORTC QLQ-MY20, European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Multiple Myeloma Module; EQ-5D-5L, EuroQol 5-Dimension 5-Level.
*See Table 3.
The EORTC QLQ-C30 global health status score is a patient-reported measure of health-related quality of life. The EORTC QLQ-MY20 is a disease-specific module administered alongside the EORTC QLQ-C30 to assess multiple myeloma–specific symptoms and functioning. The EQ-5D-5L is a generic measure of health status that comprises a 5-domain, 5-item questionnaire plus a visual analog scale. Mean changes from baseline in key EORTC QLQ-C30, EORTC QLQ-MY20, and EQ-5D-5L domains are presented in Figure 8. All scores are transformed from raw scores initially ranging from 1 to 4. The EQ-5D-5L is a generic measure of health status that comprises a 5-domain, 5-item questionnaire plus a visual analog scale. All scores are transformed from raw scores initially ranging from 1 to 5. For EORTC QLQ-C30 and EORTC QLQ-MY20 scales, higher scores represent a "better" level of health-related quality of life.

Table 3: Change from baseline in key EORTC QLQ-C30 scores at Week 112

LS mean (95% CI) change from baseline at Week 112	DARA	Active monitoring	Interpretation
Physical functioning	−1.6 (−3.9 to 0.6)	−2.2 (−5.1 to 0.7)	A negative change indicates decreased physical functioning
Emotional functioning	3.6 (0.7 to 6.5)	1.4 (−2.4 to 5.2)	A positive change indicates improved emotional functioning
Role functioning	−0.5 (−3.8 to 2.8)	−4.0 (−8.2 to 0.2)	A negative change indicates decreased role functioning
Pain score	−2.0 (−5.4 to 1.4)	−1.2 (−5.8 to 3.3)	A negative change indicates reduced pain
Fatigue score	−2.4 (−5.9 to 1.1)	−0.1 (−4.6 to 4.4)	A negative change indicates reduced fatigue

EORTC QLQ-C30, European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; LS, least squares; CI, confidence interval; DARA, daratumumab.
All scores are presented on a scale from 0 to 100 after linear transformation from raw scores initially ranging from 1 to 4.

References

1. Rajkumar SV, et al. *Blood*. 2015;125(20):3069-3075. 2. Abdallah NH, et al. *Blood Cancer J*. 2024;14(1):9. 3. Mateos MV, et al. *Blood Cancer J*. 2020;10(10):102. 4. Landgren O, et al. Presented at: American Society of Hematology (ASH) Annual Meeting & Exposition; December 9-12, 2023; San Diego, CA, USA. 5. Mateos MV, et al. *Lancet*. 2020;395(10232):1821-1831. 6. Dimopoulos MA, et al. *N Engl J Med*. 2024;390(4):301-313. 8. Facon T, et al. *Lancet Oncol*. 2021;22(11):1582-1596. 9. Sonneveld P, et al. *J Clin Oncol*. 2023;41(8):1600-1609. 10. Rajkumar SV, et al. *Lancet Oncol*. 2014;15(12):e538-e548. 11. Lakshman A, et al. *Blood Cancer J*. 2018;8(6):59.

Multiple Myeloma

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