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Which patients benefit from a doublet vs. a triplet salvage regimen?

Hi, welcome to *Managing Myeloma.* My name is Bob Orlowski. I am the Director of the Myeloma Section and the acting Chair of the Department of Lymphoma/Myeloma at the University of Texas MD Anderson Cancer Center in sunny and humid Houston, Texas. One of the questions that referring physicians and patients often ask me is how do they decide between the benefits and the risks of using either a doublet or a triplet salvage regimen?

This is a very important question because we now have a variety of two-drug regimens: high-dose carfilzomib with dexamethasone, for example, as well as three-drug regimens such as ixazomib with lenalidomide and dexamethasone, or carfilzomib with lenalidomide and dexamethasone. Because we have multiple choices you really do have to pick between them. One method that I often use is to try and judge the aggressiveness of the myeloma. If you have a patient with relapsed disease, but their monoclonal protein is only slightly rising and they are not truly clinically symptomatic, a two-drug regimen would probably be sufficient. But, if you have somebody whose monoclonal protein is rising rapidly, they are becoming anemic, hypercalcemic, or their creatinine is rising and you get the sense that this a more aggressive myeloma, then I think a three-drug regimen is the best way to go in the salvage setting.

Another way to think about it is, what is your ultimate endpoint? If you're thinking about taking the patient to stem cell transplant, for example, either if the patient did not have a transplant before or if the patient is eligible for a second autologous transplant, then often the goal is to try to reduce the myeloma to as low a level as possible, as quickly as possible. In this case, I would probably prefer to use a three-drug regimen, because your goal is hopefully to use maybe 2 or 4 cycles and then take them on to transplant. Whereas, if you think your patient is not a candidate for either first or second transplant and you're thinking more about the long-term, then a two-drug regimen will probably be a little bit better tolerated, and would be the better way to go, with the hope that these patients will be able to stay on that two-drug regimen for a longer period of time.

These are some of the factors that I consider. In general, I try to use a three-drug regimen much more frequently than a two-drug combination, but certainly as I mentioned, if you have older patients with many comorbid medical features, or they are not transplant candidates and they have a relatively indolent form of myeloma, I think a two-drug regimen is great. For most others, I would do a three-drug regimen.

Thank you very much, and I hope that this helps the next time you have to make this decision for your patients.