What drug regimens are recommended for asymptomatic biochemical relapse with slow rise M-protein?

Robert Z. Orlowski, MD, PhD
Professor, Chair Ad Interim
Department of Lymphoma/Myeloma
Division of Cancer Medicine
The University of Texas MD Anderson Cancer Center
Houston, Texas

Welcome to *Managing Myeloma.* My name is Dr. Robert Orlowski, and I am the Director of the Myeloma Section and also the acting Chair of the Department of Lymphoma and Myeloma at the University of Texas MD Anderson Cancer Center in Houston, Texas. One of the questions that I frequently am asked is, “What drug regimen would I recommend in treating a patient with asymptomatic biochemical relapse who has a slow rise in their monoclonal protein level as opposed to a rapid rise?” I think this is an important question, especially for people on maintenance therapy (whether that maintenance is thalidomide or lenalidomide or bortezomib or other options). Oftentimes, when patients do relapse, they will have a slow increase either in their serum monoclonal protein or their serum-free light chains or their Bence-Jones proteinuria, but they will not have CRAB criteria. This means that they do not have hypercalcemia, renal insufficiency, worsening anemia, or new or enlarging bone lesions. In such cases, it may actually be reasonable in some patients to watch and wait and not necessarily immediately make a change, because an asymptomatic patient can often stay asymptomatic for a long period of time.

Now, if such a patient is already on maintenance, let’s say lenalidomide, one option would be to consider increasing the dose of lenalidomide and maybe adding a little bit of dexamethasone, or even adding elotuzumab on the standard dose and schedule. These often can be very helpful. In my practice, I found such approaches to be effective, and they often will result in first, stabilization of the disease level, and then in a reduction. Sometimes the reduction can be sufficient to bring the patient back down to a complete remission. The advantage of using these lower dose approaches, or of adding antibodies that are very well tolerated, is that you are likely to have a great clinical benefit but a low likelihood of any toxicity. Now, if your patient has a more aggressive relapse, then I think a more aggressive approach would be needed, and that is going to be the topic for a different *Managing Myeloma* discussion. I hope that this one will be of help in managing your myeloma patients, and thank you for viewing this activity.