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Managing Myeloma **recently spoke with Dr. Sagar Lonial of the Winship Cancer Institute of Emory University in Atlanta, Georgia, regarding BD or KD as a standard of care in relapsed/refractory multiple myeloma.** *[Editor's note: Dr. Lonial's transcript has been edited to improve readability]*

Dr. Lonial: This question of whether BD or KD is the standard of care for relapsed/refractory multiple myeloma patients really stems from a recent trial, the ENDEAVOR trial, that compared bortezomib and dexamethasone (BD) at the standard 1.3 mg/m^2 dosing given twice a week either intravenously (IV) or subcutaneously, versus carfilzomib and dexamethasone (KD) with the carfilzomib given at 56 mg/m^2 twice a week, 3 weeks in a row with a 1-week break. This is a really important landmark trial in the field of myeloma, and the reason it is such an important trial is that it does appear at the higher dose of twice a week carfilzomib that the KD combination is, in fact, more effective and results in longer progression-free survival. In fact it improved overall survival compared to full-dose bortezomib and dexamethasone. This probably has to do with two factors:

1) It is easier to keep patients on full-dose carfilzomib without limitation such as peripheral neuropathy as we often see with full-dose bortezomib over an extended period of time.
2) Carfilzomib at the higher dose of 56 mg/m^2 is likely a more potent proteasome inhibitor than bortezomib and dexamethasone given at 1.3 mg/m^2, again likely because peripheral neuropathy is not a significant issue with carfilzomib and dexamethasone.

If one is trying to choose between a doublet using a proteasome inhibitor, then I think there is no question that the use of carfilzomib and dexamethasone at the higher dose versus standard-dose bortezomib is probably the better option. I think one of the main questions that is not answered by the study is how you want to address the higher dose of carfilzomib when looking at combination trials. When one thinks about convenience from a patient perspective, coming in six times a month versus the subcutaneous dosing for bortezomib, it certainly does become a patient preference issue. However, when one is comparing head-to-head, IV 56 mg/m^2 of carfilzomib versus subcutaneous bortezomib at 1.3 mg/m^2, there is no question that the higher dose carfilzomib is the more active agent.