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What is the role of consolidation therapy in multiple myeloma and is there a best approach?

My name is Dr. Paul Richardson and I am the clinical director of the Jerome Lipper Multiple Myeloma Center. It is my pleasure to discuss with you today the role of consolidation therapy in multiple myeloma and is there a current best approach? What consolidation therapy typically means is that after successful induction treatment, a patient undergoes transplant, and then after transplant, consolidation is utilized to further improve their response in the duration of disease control. In that context then, what data do we have to support this approach? We have a number of trials in fact that have shown that the use of three drugs as part of consolidation have dramatically improved the quality and depth of response that are seen after transplant and seemingly have had an impact on progression-free survival. Probably the best and most mature example of this is the study led by Dr. Michele Cavo which looks at the role of bortezomib, thalidomide, and dexamethasone after transplant compared to thalidomide and dexamethasone alone in patients who have successfully undergone transplant. And what he shows very nicely is not only is there a much higher quality and depth of response to the three drugs, but also this translates into an impressive difference in progression-free survival. Built upon that, a number of consolidation strategies have been further developed. One includes bortezomib alone led by the Nordic study group in which, again, response rate benefit is seen as well as progression-free survival advantage as well. In the same context, the combination of bortezomib with lenalidomide in the paradigm of RVD has been used as consolidation in a number of trials. This setting has been associated with improvements in the quality and depth of response. Very encouragingly, this is now being explored in the setting of randomized studies that are ongoing. One is the CTN study, a very important randomized trial looking at after-transplant, either lenalidomide maintenance alone or RVD, consolidation or in fact the use of a second transplant followed then by lenalidomide. Now for the RVD consolidation arm, not only did they get RVD consolidation, but they then get lenalidomide for at least 3 years as maintenance. So this will be a very important study, about 80% full accrued now, so another several months to go. When that study is now complete, we will then have very important answers to a key question. One other vital study that is ongoing is looking at the combination of RVD with cyclophosphamide for stem cell mobilization followed then either by RVD and then lenalidomide maintenance or the use a single transplant after stem cell mobilization for RVD consolidation and then lenalidomide maintenance. This study is ongoing, and is now multi-center across the United States and will be joined by both the clinical trials network and the alliance in the coming months as the study enlarges to involve 60 sites across the country. There is a very important question that is being tested here. Where is transplant best suited, early or late? Most importantly, it is done in a way that is designed to maximize the efficacy of both approaches, minimize toxicity, and provide patients with an excellent supply of excellent medications going forward, not a small consideration in the setting, and that trial is currently ongoing as I have mentioned.