

## IMF HOTLINE COORDINATORS ANSWER YOUR QUESTIONS

The IMF Hotline 800-452-CURE (2873) is staffed by Debbie Birns, Paul Hewitt, Nancy Baxter, Missy Klepetar. The phone lines are open Monday through Friday, 8am to 4pm (Pacific Time). To submit your question online, please email [TheIMF@myeloma.org](mailto:TheIMF@myeloma.org).

**I had a stem cell transplant about four months ago and just got word that my myeloma is in remission. My bone marrow biopsy was normal and the doctor can't find the myeloma protein in my blood. I had hoped to enjoy my remission, but my doctor wants me to consider taking thalidomide as an "insurance policy" to keep the myeloma from coming back. What is your take on maintenance therapy?**

Two caveats are in order. First, we are defining "maintenance therapy" narrowly to signify treatment given following stem cell transplant to "maintain" the gains made with high-dose therapy. The issue of maintenance therapy following induction or "frontline" therapy is a thorny and unresolved one, and there is simply not enough clinical trial data available to establish guidelines. Second, it is important to note that even in the context of ongoing therapy after autologous stem cell transplant, maintenance therapy is a controversial and much-discussed topic in myeloma, and we are far from having a definitive answer.

The first and simplest statement that can be made concerning maintenance therapy post transplant is: **for patients who are in complete remission (CR) or very good partial response (VGPR, or  $\geq 90\%$  reduction in monoclonal protein) after an autologous transplant, there are no data to indicate that further therapy is necessary and/or beneficial.**

If the response to auto transplant is less than VGPR, then we must turn to the results of a significant clinical trial conducted by the Intergroupe Francophone du Myelome (IFM), a large clinical trials consortium in France with a long history of expertise in autologous stem cell transplantation. The trial results were published in *Blood* in November 2006, with Dr. Michel Attal as chief author. The article is entitled "Maintenance therapy with thalidomide improves survival in patients with myeloma." Patients were randomized two months after stem cell transplant to receive no maintenance, pamidronate only, or thalidomide plus pamidronate,



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*"...because responses may occur with doses of 50 to 100 mg/day, maintenance therapy with these low doses should be proposed... thalidomide could benefit patients who do not have a very good partial response (VGPR) at time of randomization, but has a limited effect among patients already in VGPR at time of randomization. Thus, thalidomide may improve the survival by reducing the tumor mass after high-dose therapy rather than by a pure maintenance effect. This result also suggests that stopping thalidomide as soon as VGPR has been reached could be an effective strategy to reduce the side effects and to avoid thalidomide resistance at time of relapse."*

and were followed for four years. The authors' two major conclusions were: "Thalidomide is an effective maintenance therapy in patients with multiple myeloma," and "Maintenance treatment with pamidronate does not decrease the incidence of bone events."

However, examining more closely the conclusion that thalidomide is an effective maintenance therapy, one must look at the subset of patients for whom this statement was true. The authors summarized their findings as follows: It was true for patients who failed to achieve at least a VGPR. In other words, thalidomide was beneficial for the active treatment of residual disease ( $\geq 10\%$  residual) after transplant.

The authors, thus, do not recommend ongoing thalidomide treatment for patients who are already in complete remission (i.e. those in whom no monoclonal protein can be measured). Much more research needs to be done on the issue of maintenance therapy both post transplant and in the non-transplant setting. Below are some of the areas that are under investigation:

- the role of corticosteroids added to thalidomide maintenance;
- the role of maintenance therapy in patients with high-risk myeloma;
- the role of Velcade® (bortezomib), Revlimid® (lenalidomide), and experimental agents that target cell-signaling cascades or surface receptors as maintenance therapy.

We encourage all myeloma patients to discuss the pros and cons of maintenance therapy in their own particular case with their oncologists and to consider participating in clinical trials that will help answer these important questions. **MT**

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**Is there one simple recommendation you can make that would help patients better tend to their overall health?**

If you wouldn't want your internist treating your myeloma, why would you want your myeloma specialist treating your hypertension or diabetes? Doctors who keep up-to-date in their area of specialty may not be as current in new drugs or guidelines in other areas of medicine. Many patients travel long distances to see myeloma specialists but, to improve or maintain coordination of their overall health, they should also have a local internist looking after them. **MT**

### GASTROINTESTINAL SIDE EFFECTS — continued from page 13

healthcare team. We understand that some patients feel embarrassed to talk about constipation and diarrhea. We understand that nausea and vomiting are sometimes not reported immediately because patients believe this is part of the treatment and they try to cope on their own. "I did not want to bother you," they say. But we are here to help our patients, and adequate management of side effects ensures a better outcome for them. **MT**