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**Executives:**

Jennifer Gillette - Staff Social Worker at the National Bone Marrow Transplant Link

Dr. Hong De Sa - Northside Hospital Cancer Institute in Atlanta

Eva Podstata - Multiple Myeloma Survivor

**Operator:**

Thank you for standing by. My name is Jordan, and I'll be your conference operator today. At this time, I'd like to welcome everyone to the National Bone Marrow Transplant LINK - Multiple Myeloma Updates.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there'll be a question-and-answer session. If you'd like to ask a question during this time, simply press star followed by the number one on your telephone keypad. If you'd like to withdraw your question, press star one again. Thank you.

I would now like to turn the call over to Jennifer Gillette. Please go ahead.

**Jennifer Gillette:**

Thank you so much, Jordan. We appreciate you helping us with this call today. Yes, my name is Jennifer Gillette, and I'm the Staff Social Worker at the National Bone Marrow Transplant LINK. I'd like to warmly welcome you to our Lunch & Learn with the LINK program.

Today's program will focus on Multiple Myeloma, Immunotherapy, Sequencing, and Treatment Updates.

We'd like to extend a special thanks to our generous sponsors: Blood Cancer United, Incyte, and Sanofi. We also sincerely thank our esteemed LINK partners for their continued support.

Today's program will include a brief introduction to the National Bone Marrow Transplant LINK, our featured presentation with Dr. Hong De Sa from Northside Hospital Cancer Institute in Atlanta. We will have a survivor perspective from Eva Podstata, a multiple myeloma survivor. And then we'll have a question-and-answer session.



For those who may not be familiar with the LINK, the National Bone Marrow Transplant LINK is dedicated to helping individuals and families navigate the transplant and cellular therapy journey from diagnosis through survivorship by providing education, emotional support, and trusted resources. Some of the resources we provide include a content-rich Facebook community featuring daily inspiration, educational updates, and survivor tips. We have our educational books, referrals, and emotional support from a licensed social worker. We have our last Wednesdays of the month program, where you can connect and support fellow survivors through writing workshops, meditation, exercises, and crafting. We have our healing arts program. Our Lunch & Learn programs, like you're on today, which are monthly toll-free educational programs featuring healthcare professionals alongside patient and caregiver voices discussing things related to transplant, CAR-T cell therapy, survivorship and related topics. We have our Marrow Masters podcast program covering chronic graft-versus-host disease, survivorship, new treatments, caregiving topics, and more. We've had over 42,000 downloads with those programs. They're very popular. We have our educational webinars on topics a couple of times a year as well. Our Coffee Klatch support group, and that is an interactive Zoom gathering with other patients and led by a social worker. We have our peer support program, where you can connect with trained peer support volunteers who understand the transplant and survivorship journey firsthand. Our Celebrating Second Birthday program, where you're recognized on your transplant anniversary with a personalized birthday postcard honoring your survivorship milestone. And our Survivors Thrive Book Club, which is an interactive group discussion centered around books related to healing, resilience, and survivorship, and there is much more. So, please feel free to reach out to us if you're interested in any of these programs.

A couple of housekeeping items before we begin today. One, please try to keep your questions concise so we can answer as many as possible during our call today. If you have more than one question, we ask you to return to the queue and get back in line so we can answer as many as possible. And while we do our best to address as many questions as we can today, we do have time constraints which may prevent us from answering all submitted. Please remember that the information shared in today's program is intended for educational purposes and to encourage discussion with your healthcare team. It is not intended to replace your individualized medical advice or your personal treatment plan.

So now it is my pleasure to introduce our featured speaker, Dr. Hong De Sa. Dr. Hong is board-certified in hematology, oncology, internal medicine, and pediatrics, with fellowship training in hematology and oncology. She serves as a physician with the Northside Hospital Blood and Marrow Transplant, Leukemia, and Immunotherapy Program.



Her clinical and research interests include blood and marrow transplants, CAR-T cell therapy, TIL therapy, acute leukemia, and other blood-related cancers.

Please join me in welcoming Dr. Hong De Sa.

**Dr. Hong De Sa:**

Hi. Thank you so much. Good afternoon, everyone. I'm honored and excited to talk with you all, and I'm really thankful to the NBMT LINK for inviting me to participate in the Lunch & Learn.

So as mentioned, my name is Hong De Sa, and I'm a physician with the Blood and Marrow Transplant Group of Georgia at Northside, where we specialize in hematologic malignancy, cellular therapies, and stem cell transplantation.

So today I'll talk about multiple myeloma, specifically looking at CAR T-cell therapy, new immune therapies, and treatment sequencing.

Before I do that, I'll introduce what myeloma is and some of the standard of care options that we approach first before going to the newer immune therapies. And so the goals of today's talk:

- First, I'll talk about the basics of multiple myeloma
- Then we'll move on to how CAR T-cell therapy works. Talk about other exciting new immune therapies that are developing, and explain how we as physicians choose and sequence these treatments based on individualized patients
- And then help you all understand where the field is heading and what new developments are upcoming in clinical trials

So, multiple myeloma is a cancer of plasma cells, and plasma cells are part of the immune system that normally helps to fight infections by making antibodies. Antibodies are proteins, and in multiple myeloma, the cancer cells produce abnormal proteins. When plasma cells grow uncontrollably in the bone marrow, they can crowd out healthy blood-forming cells. And this can lead to low red blood cells, causing anemia, low platelets, leading to bleeding, compromise of the immune system, and multiple myeloma can also damage bones and cause kidney damage. So, common symptoms of people who are newly diagnosed with myeloma are bone pain, fatigue, anemia, kidney problems, infections, and also we can see high calcium in the blood as it's released from bone that has been destroyed. So, an important point that I want to emphasize through this talk is that myeloma is generally considered treatable, but not yet curable. And treatments today are dramatically better than they were even 10 years ago. So, there are a lot of promising treatments that we are using and that we're looking at in trials.



Why has myeloma treatment improved so much? One of the reasons over the last decade is because of the era of immunotherapy. So rather than only using chemotherapy traditionally to attack cancer cells directly, there are treatments that harness the patient's immune system to attack the cancer in a more targeted way. And some of these major advances that I'll go into more detail later include monoclonal antibodies (mAbs), bispecific antibodies, antibody-drug conjugates (ADCs), and CAR T-cell therapy. Also, we've improved some strategies for stem cell transplantation, and we've gotten better at supporting patients through. So, that's something we call supportive care. So, because of these advancements, people are living longer with multiple myeloma and achieving deeper remissions. So, many patients now have deep remissions with years without any signs of progression. There's improved quality of life. And then also, there are more options in the outpatient setting so that there's fewer hospitalization stays.

For the definition of what relapsed/refractory multiple myeloma (RRMM) is, it just means that the myeloma has not responded to treatment initially, or maybe it responded and then it's come back. So, most patients with myeloma will require multiple lines of treatment over time. And this is why the idea of sequencing therapy is so important, so that we can figure out the right strategy for patients on an individual basis. And today, myeloma treatment is increasingly viewed as a long-term strategy rather than just a single time point treatment decision.

So, before I go into the new immune therapy space, I'll talk about what the traditional building blocks of myeloma therapy look like, which is the standard of care in new diagnosed myeloma. So, there are several different drug classes that you might be familiar with already. One is called the IMiDs (Immunomodulatory drugs), and some examples of this are lenalidomide and pomalidomide. There are proteasome inhibitors such as bortezomib and carfilzomib. Steroids are frequently added to the backbone regimen, such as dexamethasone, and then some new anti-CD38 antibodies have been incorporated into the upfront setting, and these are daratumumab and isatuximab, for example. So, the upfront treatment of myeloma is usually a four-drug combination, including one of those anti-CD38 antibodies. And if patients achieve a remission, either partial or complete, we then recommend what we call a consolidative autologous stem cell transplantation (ASCT), which is essentially to consolidate that remission and to deepen the remission so that it lasts for a longer time.

So, when do we do a stem cell transplant? It's usually after four to six cycles of that upfront therapy. And as I mentioned, the goal is to give chemotherapy that will deepen the remission and hopefully keep the remission going for several years. But even with that very effective upfront therapy, many patients do become resistant to these treatments, and this has then led to the development of newer immune-based therapies.



And so immunotherapy is very exciting because the immune system, it already knows how to recognize abnormal cells, and essentially, we're just harnessing the immune system and augmenting its effects. So, with modern immune therapy, the immune system can help to find cancer cells, recognize them, activate other immune components to attack the cancer cells, and some of these are considered living drugs, such as CAR T-cell therapy, which can sustain long-term control of the disease. And specifically in multiple myeloma, one of the most important targets of immune therapies is called BCMA (B-cell maturation antigen). And this is a protein that's found on almost all myeloma cells and much less on normal tissues. So, this makes it an ideal target for therapies like CAR T-cell therapy, bispecific antibodies, and antibody drug conjugates (ADCs).

So, I'll talk first about CAR T-cell therapy. It stands for chimeric antigen receptor (CAR) T-cell therapy. And T cells are a part of our immune system. They're kind of considered the attacked cells of the immune system that can find cancer cells and kill them, but also activate other parts of the immune system. And so, in a very simplified explanation, what we do is we remove T cells from the patient through a process called Apheresis, and send those T cells off to a manufacturing laboratory that then genetically modifies the T cells so that they express a receptor that can target one of the proteins on the myeloma cells, and the FDA-approved product targets that BCMA antigen that I talked about. Once those CAR T-cells are manufactured in the lab to express that receptor, they're then expanded into the millions of cells and then shipped back to the institution where the patient's being treated at for reinfusion. Prior to reinfusion, we do administer low-dose or what we call Lymphodepletion (LD) chemotherapy, and this prepares the patient's body to accept those T cells back so that they're not fighting against the patient's own pre-existing T cells. So, the T cells are then re-infused into the patient, and then that's when they get to work and seek out the myeloma cells, killing them directly, but also expanding in the patient and hopefully recruiting other parts of the immune system to fight off the cancer.

So I mentioned some of the steps of CAR T. The first step, as I mentioned, is T cell collection, and we do this through a process called leukapheresis that's usually over one day. Then manufacturing by the company, when the cells are sent off to the laboratory. For the FDA-approved products, this manufacturing process takes between four to six weeks. And during those four to six weeks when we're waiting for the product to be made, some patients may need bridging therapy, which is a temporary therapy to maintain remission before the CAR T-cells are ready. After the CAR T-cells are made, then, like I mentioned, we administer lymphodepletion (LD) chemotherapy, which is short-course chemo, preparing the body to receive the CAR T-cells, then the CAR T infusion is infused through an IV line, usually a central line, and that happens on what we call day zero. After day zero, we then count up day plus one, plus two, plus three, etc.



And that's when we look for the side effects of the treatment, monitor for response, and hopefully see good remissions that last a long time.

So there are two major BCMA-directed CAR T-cell therapies that have changed the field and that are FDA-approved right now. The first one is called Idecabtagene vicleucel, the commercial name is Abecma. The second one is Ciltacabtagene autoleucel, the commercial name is CARVYKTI. And both of these therapies have shown remarkable responses in patients who are heavily pretreated, meaning they've had multiple lines of therapy before they received the CAR T. And even after this heavy pretreatment, in those clinical trials, the patients were seen to have deep remissions with what we call MRD negativity or measurable residual disease negativity. So the highest sensitivity that we can test to see if the cancer is there, and very long progression-free survivals, meaning that we don't see the cancer come back for long periods of time. Some of these remissions last for many years.

And so just to talk very briefly about the landmark CAR T clinical trials, there were two that I'll mention specifically for CARVYKTI, which is what we offer very frequently at our center at Northside. So the first one was the CARTITUDE-1 trial, which looked at patients who were treated after four or more lines of therapy. And even in their follow-up, more than five years out, about a third of patients were still in remission. And then more recently, the CARTITUDE-IV trial looked at using CAR T after one to three lines of therapy, so earlier in treatment. And the response rates are very impressive, about 85% overall response rate with about a 75% complete remission rate. And of the patients who achieved that negative MRD status, so undetectable cancer with our highest sensitivity test, the progression-free survival or the remission rate at several years approached 100%. So, if patients achieve a deep remission following CAR T, it can last for many, many years without further therapy. This is considered a one-time infusion, and then we just watch for side effects and response.

So, regarding CAR T side effects, it is a very powerful therapy. It has very unique side effects that are different from standard chemotherapy. The most common side effect is called Cytokine Release Syndrome (CRS), and this presents with a fever. Sometimes, if it's more advanced, it can lead to low blood pressure or low oxygen levels. We're very good at recognizing and treating CRS these days, and it's much more rare that it progresses to the later stages. And if CRS occurs, it is reversible. There are neurologic side effects. One of them is called ICANS (Immune Effector Cell-Associated Neurotoxicity Syndrome), and what that can look like is sometimes confusion or word-finding difficulty, difficulty handwriting.



Very rarely it can lead to more severe stages such as seizure or coma. And because, again, we're so good at recognizing these side effects, we catch them early and treat them early to prevent the further stages. Because of the lymphodepletion chemotherapy, even though it is low-dose, it does cause immune suppression for a period of time and an alteration of the immune system. So, infection risk is a concern following CAR T, and that can persist for several months after CAR T. But we watch closely, and we place patients on prophylactic antibiotics, antivirals, antifungals while their immune system is very weak. So those are the highlights of CAR T-cell therapy.

Just speaking briefly about other immune therapies, there are bispecific antibodies, which act essentially as a bridge between a T cell and the myeloma cancer cell. So there is no genetic modification of the T cells, but it does bring them into close proximity with the myeloma cell so that they can directly kill the cell. The advantages of this compared to CAR T are that they're off the shelf, so there's no manufacturing delay, we can start patients on bispecific pretty quickly, and they're often done outpatient and can be done locally by a lot of oncologists. So, some examples of this are teclistamab and talquetamab.

Just highlighting the differences between CAR T and bispecific, again, CAR T is more personalized. It's a one-time infusion. There is a manufacturing process required, but there are high, high response rates for durable remissions. For bispecific antibodies (BsAbs), they're ready off-the-shelf. But they do require repeated dosing, sometimes continuously every couple of weeks. They do have very good activity after many prior lines of therapy, but they often require continuous treatment. And so, one of the challenges that our field is having is how to sequence these therapies. And what I will say is our recommendation, and I believe the field as a whole, is that if a patient is eligible for CAR T-cell therapy, they should receive that prior to bispecific antibodies, specifically if they're both targeting the same antigen, such as BCMA. We don't want to use bispecific antibodies that target BCMA before CAR T because it could exhaust the receptor and also the T cells.

So, you know, the field is moving extremely fast. Those are FDA-approved therapies. There are also many in clinical trials that I'll mention briefly. At our center, we have some clinical trials for CAR T. There's a CAR T that targets a different antigen called GPRC5D that myeloma cancer cells also express. There, at other centers, are also clinical trials looking at CELMoDs, which are oral drugs. Some of these examples are mezigdomide and iberdomide, and these look very promising for patients who have [inaudible] after the standard immunomodulatory agents. There are also, at our center, there's a trial for off-the-shelf CAR T, so having the CAR T-cells manufactured from patients who are healthy donors. So, these are "off-the-shelf" CAR T that allows patients to move forward with the therapy more quickly and not have to wait for the product to be made.



So in terms of the last thing that I'll talk about is how do we sequence therapy besides considering the target and making sure that we do CAR T before bispecific? If we can, we take into consideration the age and fitness of the patient. Myeloma is a marathon, not a sprint. This is a chronic disease. It's considered a chronic disease these days. And we really want to maximize therapies without burning you all out or making it too hard for you. We also take into consideration prior therapies, what has worked in the past, what hasn't, trying to surprise the cancer cells with something they haven't seen before. We take into account the chromosomes of the cancer, the speed of relapse, if it comes back quickly or not quickly, the function of the bone marrow, and other organ systems such as kidneys. And then, of course, just what your goals are, what your lifestyle looks like. And access to therapy where you live, what's convenient for you, and caregiver support is very important because we can't do any of these intense immune therapies without the support of family and friends.

So I think that's bringing me up on 20 minutes, and I could talk much more about myeloma, but I'll pass it over to Eva, and I look forward to the questions at the end.

**Jennifer Gillette:**

Thank you so much, Dr. De Sa. We really appreciate you making the time today and sharing your expertise.

And yes, we want to bring Eva Podstata on. Eva was diagnosed with multiple myeloma four years ago at the age of 59. She has been a registered nurse for more than 40 years and currently serves as a supervisor in Employee Health. In addition, she volunteers at guest services at WCC, serves as a chaplain for the RU Women's Softball team, and leads a women's small group at WCC.

We're grateful for her willingness to share her personal experience and insights today. Welcome, Eva.

**Eva Podstata:**

Thank you so much. I appreciate that. It's good to be here, and thank you for this opportunity.

I just wanted to share my story because I had never been sick a day in my life. And so having this diagnosis was shocking to me. I had moved all three of my girls, and I thought I'd just pulled a muscle. I went to Northside Orthopedic Institute, which was two floors below me, and I was given the anti-inflammatories and the muscle relaxers, and I did the exercises, and they did make me feel better, but I just wasn't getting better. And so after the MRI, I was diagnosed by Dr. Matthew Simmons, and he told me I had multiple myeloma. And he said, I have an appointment with you with Georgia Cancer to be seen and evaluated. And he had that all set up before I left the office. So that was shocking, and I was not expecting to hear all of that.



And after all the scans, and it was confirmed, I was a candidate for the bone marrow transplant, and I did that in tandem times two with Dr. Lawrence Morris in Atlanta at the bone marrow transplant team. I did that in tandem, and I did get two years from that, before my multiple myeloma came back. Then I was placed on Velcade, Revlimid. My pain got better with the effects of the medicine, everything. I had improved; my walking had improved, and I couldn't feel my feet. And then, you know, they would juggle the medications around, and then one of the PAs for Dr. Lozinski mentioned the CAR T-cell was on the horizon. And I said, I want to do that. I want to learn more about that. Tell me more about it. And I talked to Dr. Lozinski, and I talked to Dr. Morris, and he wasn't really familiar with it. It didn't sound like to me, and he, you know, told me all the side effects, and it scared me. And he said, but under his breath, he said, and this is so important to listen because there are some words that are triggering and you just shut down. But he said, "But none of these side effects are different than the bone marrow transplant." And they're all, like Dr. Sasine said, they're all reversible and treatable. So I had taken my son-in-law with me, and he was scared after he listened to what all Dr. Morris said, and I said. Dr. Morris also said I needed to fail for treatments before they would allow me to do that. And I wanted that second opinion, and I went to Dr. Nuka at Emory, and he spoke my language. I'm from Alabama, so football's a big deal, and he said, "Why are you putting your fourth-string quarterback in your first quarter?" he said, "You need to really consider this." And the next week, I was pondering the cost of the two different hospitals because I worked for Northside. And that week, my Velcade failed me. So that was my fourth treatment that I had failed. So, Dr. Morris called me back in the office and said, "We can do this." And again, he reassured me that all of the side effects, I didn't really have a choice at this time, and I was glad to do it because all of the side effects that just spoke to me, they're all treatable, they're all reversible. So, I clung onto that and went into the CAR T-cell very optimistic. And I didn't have the neurotoxicity that Dr. De Sa talked about, but I did have the CRS, the Cytokine Release Syndrome, in all three, the bone marrow transplants and the CAR T-cell.

So I had gone to the ICU and was placed on some like inotropic medications to support my blood pressure. But during the CAR T, you know, as a nurse, I said, you have one job to do. Please don't send me back to the ICU. So they gave me a lot of fluids, and I had gained 15 pounds in 36 hours because of all the fluids, and I was guppy breathing. So I thought, I need to back down. I'm not the expert here; they are. And listen to them and allow them to treat me the way they know to treat me. And that was probably the hardest part, but we did. I didn't go back to the ICU, and it was treatable in reverse. And I am currently in remission and happy to be here and happy to share my story with everyone, and I look forward to your questions as well. I hope that was a long story short.



**Jennifer Gillette:** You know, Eva, we won. We are so thankful that you are in remission, and we appreciate you sharing your story. I have a question for you. As far as with everything you've gone through, what kinds of things have helped you cope on the most difficult days with this journey?

**Eva Podstata:** My family, my friends. I lost my husband to cancer. And honestly, I was ready to tap out when they told me everything, like, I needed a caregiver, and they were telling me it was very overwhelming. And I thought, I am not going to do this again, because we battled, we went to battle for three years with him, and I thought, I cannot put my girls through this again. But my girls didn't see it that way. They thought, we've lost one parent, we're not going to lose another. So I think my family, the people that I work with, my community, my church, my faith, that's all been huge. And my care team, like when a case manager knocked on the door, and she came in, and she told me, " It's my job to make sure all this happens." And I said, "I'm so glad you walked in the door when you did because I was tapping out." So everybody, just so much support staff. Does that answer the question?

**Jennifer Gillette:** It sure does. And I'm glad you didn't tap out. It sounds like you've got a great team. And thank you for sharing that. Jordan, I am sure. I'm sorry. Go ahead.

**Eva Podstata:** No, I'm glad I didn't either. I'm back at work and fully functioning and have been for 18 months. So this is exciting to be a part of this.

**Jennifer Gillette:** Absolutely. And it looks like the grass does not grow under your feet with all you're doing. But we also are very sorry about the loss that you experienced with your husband, too. But we are very thankful that you're here helping everyone today and sharing your story.

Jordan, can you tell our callers how they can ask questions to this lovely panel?

**Operator:** Certainly, if you'd like to ask a question in today's call, you may simply press star followed by the number one on your telephone keypad. You'll be limited to one question, but if you'd like to ask another question, you may simply re-queue by pressing star one. We'll take a brief moment to compile a Q&A roster.

Your first question comes from the line of Kathleen Fitzsimmons. Your line is now live.

**Kathleen:** Hello. Thank you for this wonderful presentation. My question is regarding high-risk patients. I am a high-risk patient. I'm wondering what kind of information you have on the new treatments for high-risk patients.

**Dr. Hong De Sa:** Hi, Ms. Fitzsimmons. Thank you for calling in. So, high-risk patients, just to define it for some people who might not be familiar, we look at the chromosomes specifically in myeloma as part of the new IMWG staging. So, if there are high-risk chromosome changes, then that can predict maybe a more aggressive disease, biology that it might come back earlier or faster, essentially the same thing. So, that's one way that we can define high risk. And then we also can look at other biomarkers, which are blood tests, to determine how aggressive the myeloma might be. So, for the upfront setting, if we identify that you're high risk, then we usually recommend what we call a tandem stem cell transplant. We recommend the same for drug induction for everyone, but then for the consolidation transplant, we would do two back-to-back to really get you into the best remission for as long as possible. So that's our standard at Northside.

For the CAR T therapies and the immune therapies, we're still seeing very high success rates with the high-risk patients. And so we definitely try to offer in earlier lines of therapy. If we have a patient who's high risk, maybe offering CAR T after one to two failed lines of therapy, rather than waiting for more treatment lines to go by. And clinical trials, I can't emphasize that enough because all of the data that we have and all of these advancements have come because of patients participating in clinical trials and really helping us figure out how promising these drugs are. So, if we have concerns that, you know, the treatment options we have aren't going to be adequate, then we'll offer you the best treatment that we think we have. And maybe that'll be a clinical trial.

**Operator:** Your next question comes from the line of Sabrina Williams. Your line is now live.

**Sabrina:** Yes. My question is, I am a multiple myeloma, high-risk, low, excuse me, high lambda cells. And my doctor is suggesting the CAR T-cell, but I have extremely low white cells. As a matter of fact, it's been low off and on. I was originally a stem cell transplant patient in 2015. It did not work. He continued doing chemo drugs, Revlimid, and then that stopped working. He did Pomalyst and Darzalex. White cells kept going low, pulled me off the Pomalyst, been on Darzalex, and the Darzalex is not working. So at this present time, he wants to do a T cell transplant. My question is, can I be a candidate for that with extremely low blood cells, like 3.1?

**Dr. Hong De Sa:** Hi, Miss Williams. Yes, absolutely. You can be a candidate for CAR T. And one of the potential side effects of CAR T is that there will be low blood counts, not just in the immediate period, but what we call prolonged cytopenia. So after 30 days, maybe the blood count will still be low. And one way that we help to get around that is to have stem cells as backup, just in case the blood count remains low after CAR T-cell therapy, and then we can boost your bone marrow that way. But definitely, low white blood cell count, and you said 3.1, is not a contraindication to CAR T, and I encourage you to have a consultation and see if there are other reasons why you can't get it. But I think you should investigate that more.



**Sabrina:** Okay. Thank you.

**Operator:** There are no further questions. I'd now like to turn the call back... correction. There is a question from Mary Perkins. Your line is now live.

**Mary:** Hello.

**Jennifer Gillette:** Hi, Mary. Welcome.

**Mary:** Hi. So my husband was diagnosed back in October of 2022, and he's been through a stem cell transplant, and he's been through a myriad of other treatments. So we were introduced to mezigomide. And I was asking about what that treatment is all about?

**Dr. Hong De Sa:** Hi, Ms. Perkins. Good question. So, mezigomide is one of those new areas of development. It's an oral drug. The class of it is called CELMoD. It can modulate the immune system by working on a group of transcription factors. You don't have to remember all of that, but it's being studied in spaces where there's refractoriness to... like Revlimid and Pomalyst. Is he on a clinical trial? Because they're in clinical trials right now.

**Mary:** Oh, they are? Okay. I didn't know that.

**Dr. Hong De Sa:** Yes, we don't have FDA approved for standard care at this point.

**Mary:** And who is we?

**Dr. Hong De Sa:** The nation as a whole, the United States.

**Mary:** Okay. Yes, thank you.

**Dr. Hong De Sa:** They're under study, and they are showing promising results in the clinical trials that I've been following so far. So hopefully in the early, I guess, near future they'll be approved.

**Mary:** Okay, very good. Thank you very much.

**Dr. Hong De Sa:** Thank you.

**Jennifer Gillette:** Jordan, do we have anyone? Thank you.

**Operator:** The next question comes from the line of Shannon Ridenour. Your line is live.

**Shannon:** Hello, thanks for having me. I've been enjoying listening to your story from a survivor. And much like myself, or much like her, I have been a picture of health my whole life and never any disorders, even broken bones. And just all of a sudden, I started experiencing some lower back pain.

And really, aside from that, I had some pain in my upper leg. To make a long story short, I kind of ignored it, being stubborn, and my upper femur broke. Had to be whisked off to the ER, and they wanted to do some further imaging and came back into the room, and that's when they disclosed to me what my prognosis was. It is a horrifying experience when you are told that you have cancer. And at that point in time, I had no idea what myeloma was. I didn't. And they told me that I was in bad shape. I had a 95% cancer rate for my oncologist after all the tests were run. So after hip replacement, I underwent treatment with Velcade and Darzalex Faspro and Revlimid, much like your survivor mentioned. And I sought remission really quickly. I was surprised at how fast, even though it was a horrifying experience with pain, not just from the cancer, but the side effects from the drugs and the nerve damage.

My question is, once I achieved remission, I was informed by my oncologist that I had an MRD-negative status. And at that time, I did not comprehend, because I was so scared to research and read on it, because I did not want to bear the... I did not want to read the bad news, and I knew I was going to be faced with that if I Googled stuff. And at that time, I did not realize how significant that MRD-negative status was, and how promising it seemed to be with the stories that I had read after I found out. My question to you is, how significant of a difference or promising is the MRD negative as opposed to the MRD positive, which I understand is still remission, but the cancer cells are still traceable? I know that at that time, when I underwent the testing, it was new. It was new technology. I have been in remission for about 3 1/2 years now. I underwent a transplant and made it out in record time. There's a hangover period when you survive something like this, where you don't just turn the page and jump back in life. There's a fear. It's like a hangover. So my question to you is how significant are the differences, the contrast between these two statuses, and what is the prognosis for negative versus a positive, so to speak? Thanks for yielding my question.

**Dr. Hong De Sa:**

Yes, thank you so much for sharing your experience, and I am so sorry. I know it must be such a gutting experience to get a cancer diagnosis. So, you are asking a million-dollar question. As you mentioned, MRD is relatively new, not only just for myeloma, but for other diseases. And so, what we know with patients who achieve MRD negativity in myeloma is that there's longer, what we call progression-free survival, so longer remission periods compared to patients who are MRD-positive. There may be a plateau over many, many years, which some people postulate might, you know, indicate a cure down the road. But right now, like I said, we don't believe that myeloma is curable at this time. But having an MRD-negative state is definitely a very, very good thing in terms of prognosticating.

In terms of what to do with MRD, if it becomes positive or if it's low-level positive, but we don't detect the myeloma on our standard tests, such as the protein in the blood or PET scans, or bone marrow biopsy.



That's a really difficult question that we're still trying to figure out in terms of would we start treatment on a patient who just has MRD positivity, but no other evidence of disease? Because, as you know, every treatment we start comes with side effects, toxicities, inconveniences, and anxiety. There's a lot of work going into following these MRD tests and how they affect treatment decisions and patient outcomes. But I think you're asking exactly the right question. I'm very happy that you're in an MRD-negative state. But a lot of the questions haven't been answered yet.

**Jennifer Gillette:** Thank you, Doctor. Jordan?

**Operator:** Next question comes from the line of Dave Duffy. Your line is live.

**Dave:** I'm sorry. Yes, I muted myself. My question is around CAR T therapy, and maybe, can you state a typical remission period following that treatment?

**Dr. Hong De Sa:** Sure. Yes. So for patients who go into CAR T with not a lot of disease or who, I guess, achieve a complete remission following CAR T, the remission period is going to be longer. And so what we're seeing from that clinical trial that looked at CAR T in earlier lines of therapy, so after one to three lines of therapy, patients who had standard-risk myeloma, so not the high-risk patients, at about three years. I think about 80%. Yes, about 80% of them were still in remission. And so we're just waiting for a longer-term follow-up. But for patients who have a response and who achieve a remission, it can be on the order of years. So it's looking about three-plus years for those patients.

**Operator:** The next question comes from the line of May Montgomery. Your line is now live. May Montgomery, your line is now live.

**May:** Hi. Thank you for the talk. It was very informative. My question is, I was diagnosed with multiple myeloma in 2024. At that time, it was a standard. And then recently, I was getting ready, actually, for CAR T therapy, and my collection date is June 22<sup>nd</sup> of next month. And the bone marrow that I recently had done indicated now that I have moved from standard to high risk with 17p deletion. And I also have a problem with my kidneys. I'm still at stage 3b, and I was diagnosed as stage 5 when I was first diagnosed in 2024. So the question I have is, with the CAR T therapy, I know they're going to pump you with a lot of drugs. How is that going to affect my kidneys? And how would you maintain your kidney function to prevent further damage?

**Dr. Hong De Sa:** That's also a very good question. So, as we know, a lot of patients with myeloma have kidney damage because of the myeloma, and thankfully, that wasn't the case for you, but you do have another reason that your kidneys could become damaged. So, for a stem cell transplant, for example, we know that we can do a stem cell transplant safely for patients who are even on dialysis.



For CAR T, because it's a newer therapy, we don't have as much data or experience, but at Northside, we do have a clinical trial for patients with myeloma who are undergoing CAR T and have baseline chronic kidney disease. And we're trying to see what modulations we have to make to the lymphodepletion chemo or other aspects of CAR T that could help patients do it. So always, if you're in the area, you can always have... well, I guess you're getting your CAR T collection next month. So things are moving forward. But I think, you know, they'll keep a close eye on your kidneys, and the pharmacist will just make sure that all of your drugs are appropriately dosed for your kidney function. And it's still an area of research as a whole for seeing how we can do CAR T with people who have chronic kidney disease.

**May:** Thank you.

**Operator:** The next question comes from the line of Mary Perkins. Your line is now live.

**Mary:** Hello. So you mentioned another drug, Iberdomide.

**Jennifer Gillette:** Are you here, Mary?

**Mary:** Yes, I can hear you. I can hear you now. Another drug that you mentioned for breakthrough patients, which my husband is, Iberdomide?

**Jennifer Gillette:** Yes. Was there a question?

**Mary:** All right. So again.

**Jennifer Gillette:** I'm sorry, go ahead.

**Mary:** Iberdomide.

**Dr. Hong De Sa:** Yes, I don't know if there's a specific question you have regarding that drug.

**Mary:** Yes, I'm not familiar.

**Dr. Hong De Sa:** Okay. It's also in that class of CELMoD. When we talked about Mezigdomide, there's a similar drug, Iberdomide, and so it's in clinical trials right now.

**Mary:** Same thing.

**Dr. Hong De Sa:** Yes.

**Mary:** All right. And we've been going up to once a quarter of the University of Pennsylvania. So we'll inquire. Thank you.

**Jennifer Gillette:** We wish you the best.



**Operator:** Your next question comes from the line of Robin Freenfeld. Your line is now live.

**Robin:** Hello. Thank you. Thank you for providing us with this information. I'm 75 years old. I was diagnosed about a year and a half ago with multiple myeloma, and I did six months of immunotherapy. And the past year I've been on maintenance, and I have a 0.01, whatever that means, of what they find that I still have, but I'm apparently doing very well. From what I gather, I have two questions. From what I gather from listening to a number of these lectures, is that they're starting to feel that doing the CAR T-cell while one is still doing really well, as opposed to at the end of a series of attempts to make them better, that they do better with the CAR T-cell when they're in good shape, as opposed to down the line. But my doctor have all said, " You're doing so well, we don't advise this." And the other question I have is that I was a kidney donor about 15 years ago, and so I have one kidney, and I'm wondering what effect that has on all of this?

**Dr. Hong De Sa:** Well, thank you for donating your kidney. That's really nice of you. So in terms of... I'm glad that you're doing very well. So you mentioned 0.01. That's probably what we call the M spike, the protein that we detect in your blood.

**Robin:** Yes.

**Dr. Hong De Sa:** And the way that we determine response, it really does a ratio of like where you started to where you are now. So I don't know your responses based on that, but that's very good that you're doing very well. You know, for CAR T in the earlier lines of therapy, yes, we do recommend earlier is better. You do have to fail a therapy, and so it sounds like you're still in remission with one therapy. So I think insurance approval would be one hurdle there, but also, CAR T right now is one of many options for you, thankfully, because you're in your 70s, and we still offer different therapies for that. Maybe a transplant, maybe CAR T, but I think your doctor's right in saying it's okay to wait right now and see how things go on this maintenance therapy because you're doing so well.

And then in terms of your one kidney, similar to what I was talking to you before with Mary Perkins, is that we don't yet know exactly how CAR T and kidney function go together, but we know that a lot of the other myeloma therapies are safe with decreased kidney function.

**Robin:** Okay, I don't really have decreased kidney function; I just have only one kidney. I just wondered if it makes it more difficult.

**Dr. Hong De Sa:** No, I think just keeping a closer eye when you go through therapies. But you should still have all the things that...



**Robin:** Okay, thank you.

**Operator:** If there are no further questions, I'd like to turn the call over to Jennifer Gillette for closing remarks.

**Jennifer Gillette:** Thank you so much, Jordan. I appreciate you helping us with that. And again, I just want to thank our speakers, our sponsors, and our partners, and all of you for joining us today. Just wrapping up a couple of loose ends as I look at some of the other questions that were submitted.

One, we had people asking about financial assistance. We know the cancer journey can be very expensive, and it can be difficult to figure that out. One, I want to let you know that if you go to [nbmtlink.org](http://nbmtlink.org), we have a guide that is a free download to help you with that. But in addition, I want to tell you about a website called [needymeds.org](http://needymeds.org), and that is a site that you can go on and look at different assistance programs with different drug companies if you're struggling to keep up with those copays. As well as I saw some legal questions about navigating the cancer journey, and I wanted to let our callers know about a site called Triage Cancer, T-R-I-A-G-E. It is a site that gives you all kinds of information about navigating insurance and legal issues regarding cancer.

And then there is a question regarding whether this program was recorded or not. It is indeed recorded, and it will be on our website within a couple of days. I also want to let you know we'll be sending out a survey. So if there's anything we can do to provide programs you're interested in, or things we can do to improve our programs, or things you like, we want to hear it all. So thank you so much for that.

We hope today's discussion provided helpful education, encouragement, and practical insight as you navigate the multiple myeloma journey. And as a reminder, you can go to our website to look for additional resources and support. Thank you for being a part of our community, and we will see you next month for Thriving After Transplant: How Occupational Therapy Helps You Get Back to Life. We hope everyone has a wonderful afternoon, and thank you again to our wonderful speakers for making time to be here and help us all today. Have a great day.

**Eva Podstata:** Thank you, Jennifer.

**Operator:** This concludes today's meeting. You may now disconnect.