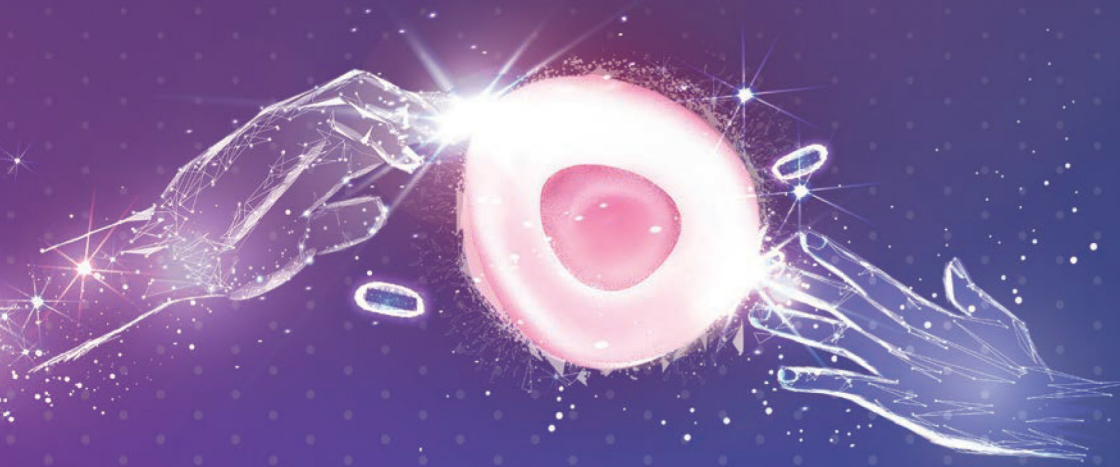
HKSOM
HONG KONG SOCIETY OF MYELOMA
香港骨髓瘤學會

Hong Kong Society of Myeloma

Annual Scientific Meeting 2022

Program Book



DATE 5 Nov 2022 (Sat)
TIME 14:00 – 20:30
VENUE Grand Ballroom, Conrad Hong Kong

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Welcome Message

Prof. James CS Chim

Founding & Current Chairman,
Hong Kong Society of Myeloma

We would like to welcome you to the 12th Annual Scientific Meeting of the Hong Kong Society of Myeloma. In recent years, the field of myeloma is rapidly evolving. Despite the ongoing COVID epidemic, research in myeloma has not ceased, and new data is being generated and continue to refine the way forward in myeloma treatment.

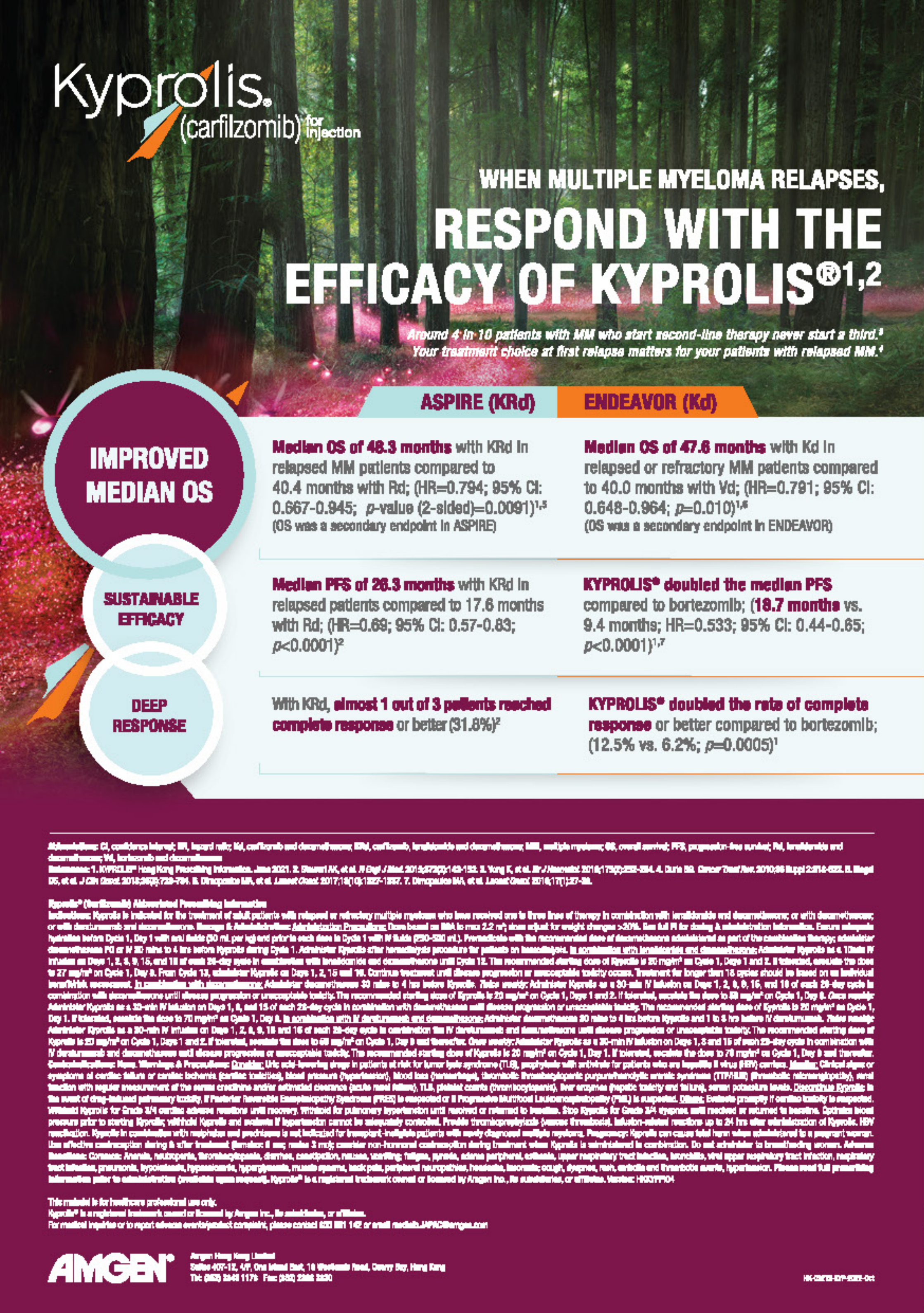
Recent advances in myeloma has resulted in remarkable improvement in outcomes and quality of life. The advent of CAR-T cell, therapeutic antibodies, Exportin-1 inhibitor and next generation novel agents have reshaped the treatment landscape of myeloma with ground-breaking success. Moreover, whether high-risk myeloma should be treated differently from standard-risk has remained controversial.

In this meeting, we are delighted to have internationally renowned myeloma experts to talk about the cutting edge advances in the management of high-risk myeloma, management of triple-class refractory advanced myeloma relapse, and the sequencing of novel agents for relapsed & refractory myeloma will be discussed.

Therefore, on behalf of the Society, I would like to extend to you our warmest welcome, and hope that you will enjoy these inspiring presentations.

Sincerely yours,

James Chim



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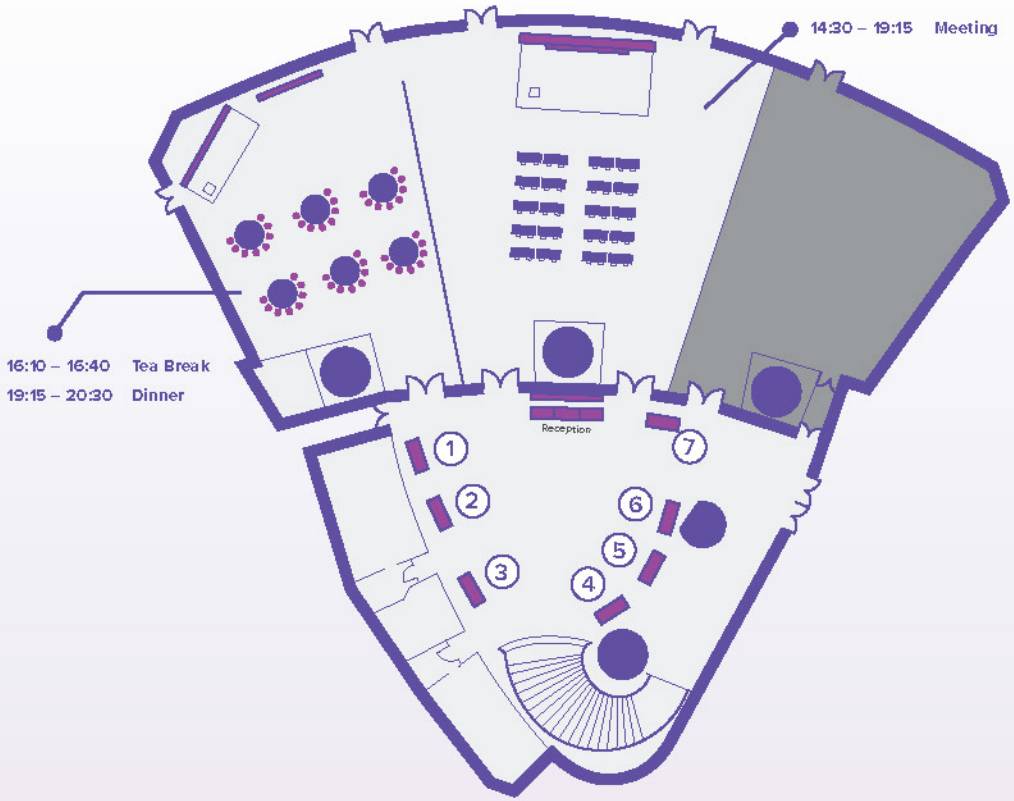
Agenda

Time	Program
14:00 – 14:30	Registration
14:30 – 14:40	Opening Ceremony *Prof. James CS Chim*
14:40 – 15:25	Lecture 1 High-risk diseases in multiple myeloma: R2-ISS and beyond *Prof. Thomas G. Martin (CA, USA)*
15:25 – 16:10	Lecture 2 The evolving role of IMiD-based strategy for RRMM *Prof. Katja Weisel (Hamburg, Germany)*
16:10 – 16:40	Tea Break
16:40 – 17:25	Lecture 3 Contemporary treatment paradigm of triple-class refractory multiple myeloma *Dr. Elena Zamagni (Bologna, Italy)*
17:25 – 18:10	Lecture 4 Optimizing treatment selection and sequencing for patients with RRMM *Dr. Rafael Fonseca (AZ, USA)*
18:10 – 18:30	Break
18:30 – 19:15	Lecture 5 Targeting XPO1 in relapsed/refractory multiple myeloma *Dr. Shambavi Richard (NY, USA)*
19:15 – 20:30	Dinner Closing Ceremony Certificate of Appreciation Presentation *Dr. Harold Lee*

Floor Plan

Conrad Hong Kong
Grand Ballroom



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Lecture 1

High-risk diseases in multiple myeloma: R2-ISS and beyond

Prof. Thomas G. Martin
University of California San Francisco, USA

Patients with multiple myeloma show heterogeneous outcomes. Approximately 60% of newly diagnosed myeloma patients are at intermediate-risk according to the Revised International Staging system (R-ISS), the standard-of-care risk stratification model. Moreover, chromosome 1q gain/amplification (+1q) recently proved to be a poor prognostic factor. The R2-ISS published by the ASCO group in May this year have introduced a weighted scoring system, with the inclusion of +1q in the risk stratification for myeloma.

This presentation will begin with a brief introduction of the R2-ISS as well as other relevant international guidelines or scoring updates. It will highlight the current evidence and clinical advancement on high-risk diseases, including del 17p), t(4,14), +1q. Insightful discussion will also focus beyond R2-ISS to other high-risk group and the latest scientific development regarding the cytogenetics of multiple myeloma, as well as case sharing on the latest available monoclonal antibodies regarding high-risk group.

Lecture 2

The evolving role of IMiD-based strategy for RRMM

Prof. Katja Weisel
University Medical Center Hamburg-Eppendorf, Germany

Immunomodulatory drug (IMiD) is a class of treatment which is well-proven in providing long-term improvement in survival and quality of life for relapsed/refractory multiple myeloma (RRMM) patients. It has been used as one of the treatment foundations for RRMM patients in Hong Kong and across other countries. However, with different choices of treatment combinations as well as practical constraints, optimising the use of IMiD could be difficult in clinical practice.

In this lecture, Prof. Katja Weisel would lead us through the journey of the past, present and future development of RRMM treatments and IMiD-based combinations. She would share her valuable clinical perspectives in managing IMiD-based treatment, particularly in the sequential use of treatment, safety management and treatment individualization. Looking forward, Prof. Weisel would highlight the innovation on the next-generation IMiD.

We are incredibly honored to invite Prof. Katja Weisel from Hamburg, Germany to speak for this lecture. Prof. Katja Weisel is the Deputy Director and associate professor of Hematology/Oncology in the Department of Oncology, Hematology and Bone Marrow Transplantation with Department of Pneumonology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany. Prof. Weisel's myeloma research interests focus on treatment optimisation for high-risk myeloma, renally-impaired myeloma patients, refractory myeloma patients and radiographic methods for disease monitoring of myeloma. She is a member of the German Speaking Myeloma Multicentre Group (GMMG) steering committee. Professor Weisel is co-investigator in all GMMG trials and is the lead investigator of three GMMG trials. Furthermore, she was the principal investigator in several national and international phase I-III clinical trials. She has contributed to more than 100 publications on multiple myeloma treatment and biology.

Lecture 3

Contemporary treatment paradigm of triple-class refractory multiple myeloma

Dr. Elena Zamagni

University of Bologna, Italy

The traditional approaches to the treatment of triple-class refractory multiple myeloma are limited and they include conventional chemotherapy and recycling use of previous regimens.

Based on a recent MAMMOTH study, patients with relapsed or refractory myeloma have a poorer OS in their outcome. Patients who are triple and quad refractory have a median OS of 9.2 months, and patients who are penta-refractory have a median OS of 5.6 months. The unmet need for triple refractory myeloma patients is huge.

With different novel agents launched in recent years, more options are available for relapsed refractory multiple myeloma patients. In the presentation, Dr. Zamagni will share the current available treatment options for triple-class refractory myeloma and their clinical data. Dr. Zamagni will share the role of anti-BCMA therapy which will be likely to be a core pillar in myeloma and cover the topic of anti-BCMA treatment sequencing.

Lecture 4

Optimizing treatment selection and sequencing for patients with RRMM

Dr. Rafael Fonseca

Mayo Clinic, USA

The use of anti-CD38 antibody daratumumab has become increasingly prominent in the treatment of relapsed/refractory myeloma in recent years. Longer follow-up updates of pivotal trials, e.g. Castor and Pollux, have demonstrated consistent and substantial clinical and survival benefits to patients, including prolonged PFS and deepened responses. Importantly, increased rates of sustained MRD-negativity have been observed with the use of daratumumab combinations.

In the real-world setting, attrition, in which patients fail to receive the next line of treatment, has been observed in each line of therapy. As such, with each increasing line of therapy, there is a decreasing number of available patients. This points to the significance of treatment sequencing that produces the longest progression-free survival duration while allowing the overall maximum number of patients to enjoy the benefit.

In this presentation, we will focus on the application of clinical data into real-world setting by exploring the impact of treatment attrition and the importance of treatment sequencing on patient management.

Targeting XPO1 in relapsed/refractory multiple myeloma

Dr. Shambavi Richard
Icahn School of Medicine at Mount Sinai, USA

Despite recent advances, there remains an unmet need for novel therapies to improve outcomes in patients with relapsed or refractory multiple myeloma (RRMM).

Exportin 1 (XPO1), an oncoprotein overexpressed in various hematologic and solid tumor malignancies, transports certain proteins and RNAs from the nucleus to the cytoplasm. In addition to correlating with more aggressive MM, elevated levels of XPO1 have been shown to correlate with resistance to proteasome inhibitors and to immunomodulatory drugs. In cancer cells, overexpression of XPO1 leads to the nuclear export of tumor suppressor proteins and the glucocorticoid receptor, culminating in their functional inactivation. High XPO1 also facilitates the nuclear export and translation of several oncoprotein mRNAs (e.g., cyclin D1, c-myc) leading to elevated oncoprotein levels.

Selinexor is a first-in-class, orally administered, selective inhibitor of nuclear export (SINE) compound with an innovative mechanism of action that triggers apoptosis in malignant cells by inducing nuclear retention of oncogene messenger RNAs and reactivation of tumor suppressor proteins. In RRMM clinical studies, selinexor has demonstrated both promising efficacy and manageable safety profile.

We are honored to have Dr. Shambavi Richard to provide an overview of selinexor and shed light on the latest emerging data. With appropriate combination drug choice and supportive care measures, patients now have multiple potential regimens to control their disease.

Acknowledgment

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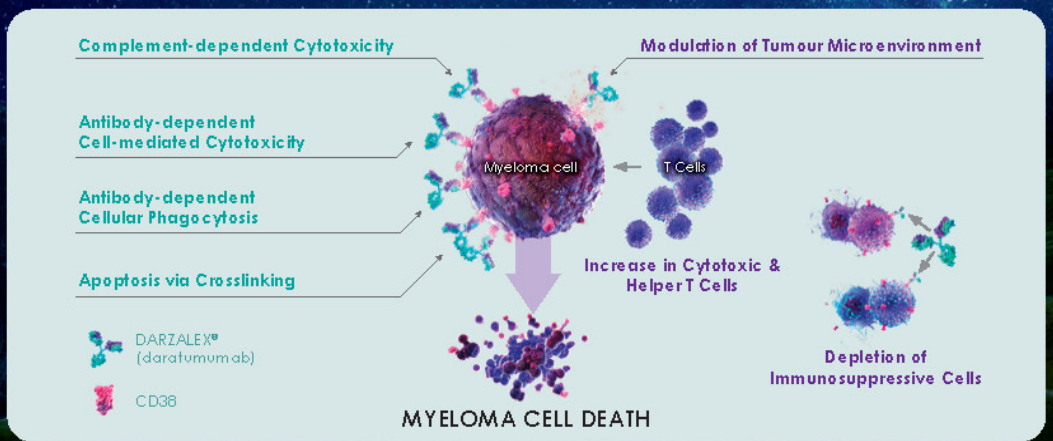
OPEN A NEW DIMENSION
IN MULTIPLE MYELOMA

DARZALEX®: The first human monoclonal IgG1κ antibody targeting CD38 antigen which induces myeloma cell death through direct on-tumour and immunomodulatory actions[1-5]

Direct ON-TUMOUR Actions

IMMUNOMODULATORY Actions



DARZALEX® (daratumumab) is indicated[2]:

- in combination with lenalidomide and dexamethasone or with bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- in combination with bortezomib, thalidomide and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma who are eligible for autologous stem cell transplant.
- in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.
- as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.

See **DARZALEX®** prescribing information for full indication, including its use as a monotherapy[2].

References:
1. Sanchez L, Wang Y, Siegel DS, and Wang ML. Daratumumab: a first-in-class CD38 monoclonal antibody for the treatment of multiple myeloma. J Hematol Oncol. 2016;9:51. 2. DARZALEX® Hong Kong prescribing information PI06. 3. de Weers M, Tai YT, van der Veer MS, et al. Daratumumab, a novel therapeutic human CD38 monoclonal antibody, induces killing of multiple myeloma and other hematological tumors. J Immunol. 2011;186:1840-1848. 4. Overdijk MB, Verploegen S, Bögels M, et al. Antibody-mediated phagocytosis contributes to the anti-tumor activity of the therapeutic antibody daratumumab in lymphoma and multiple myeloma. MAbs. 2015;7:311-321. 5. Krejcik J, Casneuf T, Nijhof IS, et al. Daratumumab depletes CD38+ immune regulatory cells, promotes T-cell expansion, and skews T-cell repertoire in multiple myeloma. Blood. 2016;128:384-394.

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DARZALEX® daratumumab concentrate for solution for infusion

WE FORM THE
Backbone of Regimens in Multiple Myeloma[1,2]

Revlimid® (lenalidomide) Pomalyst® (pomalidomide)

Recommended by **NCCN & EHA-ESMO Guidelines** as preferred regimens[1,2]

REVLIMID® is indicated:
- As monotherapy for the maintenance treatment of adult patients newly diagnosed MM who have undergone autologous stem cell transplantation.
- As combination therapy for the treatment of adult patients with previously untreated MM who are not eligible for transplant.
- In combination with DEX for the treatment of MM in adult patients who have received at least one prior therapy.

POMALYST® is indicated:
- In combination with BORT and DEX for the treatment of adult patients with MM who have received at least one prior treatment regimen including REVLIMID®.
- In combination with DEX for the treatment of adult patients with RRMM who have received at least two prior treatment regimens, including both REVLIMID® and BORT, and have demonstrated disease progression on the last therapy.

BORT: bortezomib. DEX: dexamethasone. EHA: European Hematology Association. ESMO: European Society for Medical Oncology. MM: multiple myeloma. NCCN: National Comprehensive Cancer Network. RRMM: relapsed and refractory multiple myeloma.

References:
1. National Comprehensive Cancer Network. NCCN Guidelines: Multiple Myeloma, Version 7.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf (accessed on 6 May 2021).
2. Dimopoulos MA, et al. Ann Oncol. 2021;32:309-322.

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IN THE TREATMENT OF **RELAPSED REFRACTORY MULTIPLE MYELOMA**

SARCLISA®
(isatuximab)

ACHIEVE **GREATER OUTCOMES** FOR **YOUR PATIENTS**

IKEMA[2,4]: SARCLISA + Kd vs Kd (N=302)		ICARIA[3]: SARCLISA + Pd vs Pd (N=307)
mPFS 35.7 mo* vs 19.2 mo with Kd alone **HR=0.58** (95.4% CI: 0.42–0.79)	**Superior PFS[1]**	**mPFS 11.53 mo** vs 6.47 mo with Pd alone **HR=0.596** (95% CI: 0.44–0.81; *P*=0.001)

IKEMA trial: SARCLISA + Kd[1,2]

IKEMA (EFC15246) was a multicentre, multinational, randomised, open-label, 2-arm, phase 3 study that evaluated the efficacy and safety of SARCLISA in 302 patients with relapsed and/or refractory multiple myeloma who had received 1 to 3 prior lines of therapy. Patients received either SARCLISA 10 mg/kg administered as an IV infusion in combination with Kd (n=179) or Kd alone (n=123), administered in 28-day cycles until disease progression or unacceptable toxicity. PFS was the primary endpoint; secondary endpoints included ORR, CR, ≥VGPR, MRD–, and OS. Median follow-up for the first interim analysis was 20.7 months.

ICARIA trial: SARCLISA + Pd[1,3]

ICARIA (EFC14335) was a multicentre, multinational, randomised, open-label, 2-arm, phase 3 study that evaluated the efficacy and safety of SARCLISA in 307 patients with relapsed and refractory multiple myeloma who had received at least 2 prior lines of therapy, including lenalidomide and a PI. Patients received either SARCLISA 10 mg/kg administered as an IV infusion in combination with Pd (n=154) or Pd alone (n=153), administered in 28-day cycles until disease progression or unacceptable toxicity. PFS was the primary endpoint; ORR was one of the secondary endpoints. Median follow-up for the first interim analysis was 11.6 months.

Most common adverse reactions[1,2,4]

- In ICARIA, the most frequent adverse reactions (≥20%) were neutropenia (47%), infusion reactions (38%), pneumonia (31%), upper respiratory tract infection (28%), diarrhoea (26%), and bronchitis (24%)
- In IKEMA, the most frequent adverse reactions (≥20%) were infusion reactions (46%), hypertension (37%), diarrhoea (36%), upper respiratory tract infection (36%), pneumonia (29%), fatigue (28%), dyspnoea (28%), insomnia (24%), bronchitis (23%), and back pain (22%).

SARCLISA is indicated:

- In combination with pomalidomide and dexamethasone, for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on the last therapy
- In combination with carfilzomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy

*Assessed by masked independent response committee (IRC)

References: 1. Sanofi Hong Kong prescribing information based on EU SmPC 29 July 2021. 2. Moreau P, et al. Lancet 2021; 397:2361–71. 3. Attal M, et al. Lancet. 2019;394(10214):2096-2107. 4. Moreau P, et al. Presented at EHA Virtual Plenaries, 2022 and 8th COMy World Congress. 20th May, 2022.

Presentation: SARCLISA 20 mg/mL concentrate for solution for infusion. [illegible]

Cycles	Dosing schedule
Cycle 1	Days 1, 8, 15, and 22 (weekly)
Cycle 2 and beyond	Days 1, 15 (every 2 weeks)

Premedication should be used prior to SARCLISA infusion with the following medicinal products: [illegible]

[illegible]

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