Autologous Hematopoietic Stem Cell Transplantation for Multiple Myeloma: Frequently Asked Questions

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Who are the best candidates for transplantation?

Multiple myeloma is the leading indication for autologous hematopoietic stem cell transplantation (AHSCT) in North America, which has become the standard of care for patients aged 65 years and younger (Gertz, Ghobrial, & Luc-Harousseau, 2009; Giralt et al., 2009; Moreau, Avet-Loiseau, Harousseau, & Attal, 2011; Palumbo & Anderson, 2011; Palumbo, Attal, & Roussel, 2011; Pasquini & Wang, 2012). Several randomized clinical trials demonstrated a superior survival outcome for patients who underwent high-dose melphalan and AHSCT when compared to those who received standard-dose chemotherapeutic agents (Attal et al., 1996; Matsui, Borrello, & Mitsiades, 2012; Palumbo, Attal, et al., 2011). Although most of those trials were conducted before newer agents such as lenalidomide, bortezomib, and thalidomide were available, more recent comparative trials using lenalidomide-containing initial regimens, with or without AHSCT, continue to demonstrate superiority of survival. One study stated that progression-free survival (PFS) at two years is 73% with transplantation compared to 43% without transplantation (Palumbo, Cavallo, et al., 2011). With that in mind, AHSCT should at least be considered for all patients with active multiple myeloma who have adequate organ function and performance status (Palumbo & Rajkumar, 2010).

AHSCT is not without risk and results in morbidity and mortality for 1%–2% of patients, usually from infection, bleeding, or organ toxicity (Hari & McCarthy, 2013). Patients with poor performance status are at a higher risk for these complications. Organ dysfunction, including compromised cardiac or liver function, as well as renal insufficiency, also predict a higher risk of toxicity and may lead to poor outcomes (Cavo et al., 2011; Palumbo & Anderson, 2011). Patients older than 70 years can undergo transplantation, but the incremental benefit of transplantation in this age group has not been demonstrated in randomized, prospective clinical trials. In addition, the standard dose of melphalan (200 mg/m²) has been shown to be of increased toxicity in patients older than 70 years with poor performance status and other comorbidities. A risk-adapted dosing of melphalan for patients older than aged 70 years (e.g., 140 mg/m²) and patients with renal insufficiency (100 mg/m²) has allowed patients to successfully undergo transplantation with acceptable toxicities (Gertz et al., 2009). Therefore, the use of AHSCT in these populations should be conducted cautiously and with risk-adapted dose modification of melphalan.
Patients with poor risk biology, defined by cytogenetic abnormalities such as t(4;14), del (17p), as well as high β₂ microglobulin, have shorter remission duration after AHSCT. Although this varies widely, median overall survival in the poor risk group can range from 18–36 months (Chang et al., 2004; Neben et al., 2010). This group of patients is the subject of clinical trials incorporating newer agents, including next-generation immunomodulatory medications and proteasome inhibitors that may improve overall results (Blađe, Rosiñol, Cibeira, Rovira, & Carreras, 2010; Palumbo & Rajkumar, 2010). Participation in clinical trials should be encouraged whenever possible.

What is the role of tandem transplantation?

Tandem autologous transplantation occurs when two autologous transplantations are performed within a period of no more than six months. For more than two decades, patients with multiple myeloma have successfully been treated with tandem stem cell transplantation using high-dose melphalan. One trial showed improved PFS and OS with tandem transplantation compared to single transplantation (Attal et al., 2003). That study suggests that patients who either progress after the first transplantation or are in complete remission are less likely to benefit from the second transplantation. Patients who achieve less than a very good partial response (VGPR) but are responding and have tolerated the first transplantation well may be the best candidates for a second transplantation (Blađe et al., 2010; Cavo et al., 2011; Moreau et al., 2011). A large national trial is underway to prospectively compare single AHSCT with tandem AHSCT, which should help clarify this issue (ClinicalTrials.gov, n.d.b.).

What is the role of salvage transplantation?

Mobilization techniques have improved and stem cells now can be stored for more than a decade. Salvage AHSCT has been used for patients who have relapsed after a prior stem cell transplantation, or who had stem cells harvested and did not initially proceed to stem cell transplantation. Response rates in the setting of relapsed and refractory myeloma are high, although the toxicity is increased (as high as 10% mortality versus 1%-2% mortality when AHSCT is conducted in the initial line of therapy) (Olin et al., 2009). Response durations also tend to be shorter (measured in months rather than years) with a second stem cell transplantation, or one conducted in the setting of refractory disease (Cook et al., 2011; Olin et al., 2009). Frequently, the remission induced by a stem cell transplantation acts as a bridge to another therapy for which the patient was not eligible because of rapid progression of disease or organ dysfunction. An intermediate dose of melphalan (100–140 mg/m²) usually is used in this setting, keeping in mind the patient’s performance status and organ function and implementing the same risk-adapted approaches used for initial therapy.

What is the role of consolidation therapy after stem cell transplantation?

Despite the success of high-dose melphalan and AHSCT, the regimen is not a curative treatment, and the majority of patients will relapse. Many strategies have been used to improve survival for patients with multiple myeloma who have undergone AHSCT, such as tandem transplantation, second transplantation, and using newer agents (e.g., lenalidomide, bortezomib, thalidomide) as consolidation therapy or maintenance therapy after stem cell transplantation.
of trials (Cavo et al., 2011; Hari & McCarthy, 2013) have demonstrated the feasibility of this approach, and regimens such as bortezomib, lenalidomide, and dexamethasone and bortezomib, thalidomide, and dexamethasone for two to four cycles following AHSCST and prior to initiation of maintenance therapy have been well tolerated with suggestion of improved duration of response. Preliminary results show increasing rates of complete remission following consolidation therapy. Once again, a number of clinical trials are prospectively analyzing the incorporation of these regimens after stem cell transplantation.

### What is the role of maintenance therapy after autologous hematopoietic stem cell transplantation?

Although AHSCST is associated with improved remission rates and PFS, relapse is inevitable for almost all patients. The goal of maintenance therapy is to prolong the duration of remission, extend OS, maintain quality of life, and reduce toxicities (Matsui et al., 2012; Moreau et al., 2011). Maintenance therapy has been investigated since the 1990s, and a number of approaches have been used. Alpha interferon given subcutaneously initially showed benefit, but prospective randomized trials demonstrated increased toxicity without a clear survival advantage (Attal et al., 1996; Cunningham et al., 1998). Oral thalidomide also has been used in the maintenance setting, with several randomized trials demonstrating improved remission rates, PFS, and OS. However, the use of thalidomide in this setting is limited because of cumulative toxicities including neurotoxicity and the development of resistance with prolonged exposure (Cavo et al., 2011; Gertz et al., 2009). Pulse doses of corticosteroids (prednisone or dexamethasone) also have been used after stem cell transplantation, showing improved PFS and tolerability with intermittent administration (Berenson et al., 2002).

A number of prospective trials have assessed low-dose lenalidomide as a maintenance therapy after AHSCST. McCarthy et al. (2012) showed significant PFS benefit in patients who received low-dose lenalidomide (86%) versus those who did not (58%), in addition to an OS advantage at three years of 88% versus 80%, respectively. Attal et al. (2012) showed a PFS benefit for the lenalidomide maintenance group at four years of 43% compared to 22% for those who did not receive lenalidomide. In those trials, lenalidomide was given until either progression or toxicity precluded additional use. Maintenance lenalidomide was well tolerated with a low incidence of neurotoxicity. However, the risk of second cancers, including solid tumor and hematologic malignancies, increased (Attal et al., 2012; McCarthy et al., 2012). Second cancers have been observed in patients with multiple myeloma; however, the risk has been less than 5% in previous studies (McCarthy et al., 2012). Most recent analyses report that the incidence of second cancers increases to 8% for patients on lenalidomide (McCarthy et al., 2012). When compared to the risks of progressive myeloma, the consensus remains supportive of the use of lenalidomide as maintenance therapy. However, research is ongoing. Efforts are now underway to identify the mechanisms for secondary malignancies and to determine risk factors that might reduce the likelihood of carcinogenesis (Cavo et al., 2011).

Bortezomib as part of initial and maintenance therapy has been shown to improve outcomes when compared to a similar regimen containing thalidomide instead of bortezomib (PFS median survival = 13 months versus 30 months; median OS = 21 months versus 54 months, respectively) (Sonneveld et al., 2012). When given on a weekly or biweekly schedule, bortezomib is well tolerated, although neurotoxicity remains a potential side effect. The relative benefit of proteasome inhibitors to immunomodulatory agents as single-agent maintenance therapy as well as in combination continues to be an area of active investigation (Palumbo & Anderson, 2011; Sonneveld et al., 2012). The combination of thalidomide and bortezomib, for instance, has been shown to be well tolerated and may result in improved disease-free outcomes (Mateos et al., 2012).

Maintenance therapy prolongs duration of remission, particularly for those who have achieved less than a VGPR. The ultimate benefit of maintenance therapy for those who have achieved complete remission after transplantation remains to be determined. However, increasing knowledge suggests that continued exposure may be advantageous even for patients in complete remission by preventing proliferation of malignant plasma cells and by maintaining a hostile bone marrow microenvironment (Giralt, Landau, & Palumbo, 2012; Matsui et al., 2012; McCarthy et al., 2012). Additional evaluation may clarify the use of maintenance in the post-transplantation setting (ClinicalTrials.gov, n.d.b).

### What needs to be considered when choosing a transplantation center?

Healthcare insurance coverage should be considered when choosing a transplantation center. The cost of transplantation...
can be prohibitive and requires insurance approval. Patients without insurance will require assistance from resourceful social workers and financial counselors to successfully undergo transplantation. Insurance carriers frequently contract with a select group of “centers of excellence” or other transplantation networks that they direct their patients to for evaluation; these may or may not be geographically close to where the patient lives. If the third-party payer does not direct the patient to a particular transplantation center, the primary hematologist may refer the patient to a center with which he or she has had prior success. Geographic location and resources available within that community also are important factors in choice of centers. Fortunately, most regions of the country have one or more experienced centers within close proximity of the patient in need. Ultimately, patients and their primary oncologists need to feel comfortable with the treatment philosophy and care approach of their transplantation team. A listing of available transplantation centers by location, disease, and statistical review can be found at www.CIBMTR.org or www.HRSA.gov.

Summary

Since 1998, high-dose melphalan and AH SCT have been a standard of care for patients with multiple myeloma, particularly when administered early in the course of disease. The willingness of patients to participate in the randomized comparative trials has been essential to the development of successful treatment approaches. The current practice of combining an initial (or induction) course of chemotherapy to autologous stem cell harvest and one or two cycles of high-dose melphalan and AH SCT followed by maintenance therapy with lenalidomide or bortezomib has resulted in unprecedented survival for this disease. A number of questions concerning the optimal timing, best initial therapy, post-transplantation consolidation, and maintenance therapy still remain. Ongoing clinical trials of innovative approaches hold great promise that these questions will be answered soon. The ultimate result will be improved survival and quality of life for patients with multiple myeloma.

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References


