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ASH 2009 - A PATIENT'S PERSPECTIVE

By Jack Aiello

The 2009 meeting of the American Society of Hematology (ASH) was the fourth year I've attended this important annual gathering. The 25,000 attendees from all over the world included clinicians practicing in the field of hematology/oncology, lab researchers, scientists, and representatives from pharmaceutical companies. Many results are presented from a broad range of clinical trials and research centers.

As I tried to gather my notes in order to share my impressions of ASH with fellow patients and caregivers who read Myeloma Today and/or visit the IMF website, I found myself looking at a veritable alphabet soup of combination treatments that comprise the current approach to myeloma therapy. VTD, RTD, VCDx, VRDx, VPM, and more! While there is still no "best" treatment for all patients, what we currently have are options for many. If myeloma experts are still debating treatment approaches of sequential "more gentle" (low-dose) therapies as opposed to the "kitchen sink" (three- and four-drug combinations) mentality, it's no wonder that the overall treatment picture is so difficult for most of us patients to truly understand. And with so many treatment choices, it now appears that the role of transplantation in myeloma has evolved as a treatment option rather than the gold standard it once was.

And questions extend beyond treatment combinations to issues of dosage levels and maintenance. A few years ago, we saw the recommended dosage level of dexamethasone get reduced from 40mg on days 1-4 to 40mg just once per week. Today, other "standard" dosage levels are being tested (e.g. bortezomib being given just once/week instead of twice). "Maintenance" (not a great word because it may well be treatments that continue to improve response) has become a more important topic as patients are living longer with myeloma. Also, on the front end of the myeloma process, treatments for MGUS and "smoldering" myeloma that may potentially delay the onset of disease are being evaluated.

New drugs in development continue to produce good trials results. Personally, I'm always grateful to see toxicity results, both hematologic (e.g. pulmunary embolism, neutropenia) and non-hematalogic (e.g. peripheral neuropathy), presented as part of every trial and dose-escalation results. And high-risk myeloma, which accounts for about 25% of patients, now appears to be successfully overcome in some patients with the use of novel agents and/or transplantation.

I appreciated having the opportunity to listen to myeloma experts presenting their findings at ASH, and found the following remarks most interesting:

- I can't really tell you which triple regimen [VTD, RTD, VCDx, or VRDx] is better than the other.

And do these justify that the ‘kitchen sink' or ‘sequential' treatment approach is better?” - Ann Morbacher (USA)

- “The goal for treating a young patient (< 65-70yo) should be long-term survival (10-20 yrs) with good quality of life.”- Jesus San-Miguel (Spain)
- “Consider dose-reduction as the patient ages.” - Mario Boccadoro (Italy)

For someone like myself, diagnosed with Stage III multiple myeloma 15 years ago, the myeloma world has made incredible strides, especially since about 2000. While there continue to be many unanswered questions, the bottom line is that there are now many more effective treatments (perhaps with maintenance) for myeloma, providing patients with better opportunities to manage their disease. For me personally, even though I've been in complete remission for the last eight years without treatment, I know enough to expect my myeloma to return one day. As such, I'm grateful for the enormous progress that continues to be made developing new myeloma treatments, both for the newly diagnosed patients and for those like me. MT