Responses Achieved With Belantamab Mafodotin in Relapsed or Refractory Myeloma

by CAROLINE HELWICK

The antibody-drug conjugate belantamab mafodotin yielded responses as a single agent and in combination with bortezomib and dexamethasone in the treatment of relapsed or refractory multiple myeloma, according to two reports from the DREAMM team at the ASCO20 Virtual Scientific Program.1,2

In the phase I/II DREAMM-6 trial, belantamab mafodotin plus bortezomib/dexamethasone led to responses in 78% of patients, with a median of three prior regimens.1 “This aligns with other triplet combinations using the bortezomib and dexamethasone backbone. Of note, 50% of patients achieved a deep response, greater than a very good partial response,” said lead author Ajay Nooka, MD, MPH, Associate Professor, Division of Bone Marrow Transplant, Winship Cancer Institute of Emory University, Atlanta. Belantamab mafodotin is a first-in-class antibody-drug conjugate that targets the B-cell maturation antigen (BCMA) expressed on malignant plasma cells. Its effect is multimodal: Upon binding to the myeloma cell surface via the BCMA receptor, belantamab mafodotin is internalized, and the active microtubule inhibitor is released into the cell, leading to apoptosis. This antibody-drug conjugate exerts tumoricidal effects on myeloma cells through

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IMMUNOTHERAPY

IMbrave150 Trial: Atezolizumab Plus Bevacizumab Improves Survival in Unresectable Hepatocellular Carcinoma

by MATTHEW STENGER

As reported in The New England Journal of Medicine by Richard S. Finn, MD, of Jonsson Comprehensive Cancer Center, Geffen School of Medicine at the University of California, Los Angeles, and colleagues, the phase III IMbrave150 trial has shown that anti-programmed cell death ligand 1 (PD-L1) plus anti-VEGF therapy with atezolizumab plus bevacizumab improved progression-free and overall survival vs sorafenib in patients with unresectable hepatocellular carcinoma who had received no prior systemic therapy and had well-compensated liver disease.1

Study Details

IN THE OPEN-LABEL TRIAL , 501 patients from 11 sites in 17 countries with unresectable hepatocellular carcinoma were randomly assigned

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“These data highlight the negative impact of socioeconomic background on access to state-of-the-art therapy in clinical trials and in the real world.”

—ANTONI RIBAS, MD, P. 48

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cancer has been available for decades. It needed the hard work and dedication of a few geriatric oncology investigators over the years to bring together the studies confirming what we had thought was possible. During this year’s ASCO meeting, four prospective randomized trials all showed that some type of geriatric assessment can reduce toxicity and improve various outcomes. I repeat—four prospective randomized trials.

If this were a drug, we would be seeing stories on the national news, interviews on television, and the stock shooting up. But we will have none of those things, because this therapy is ultimately simple and basic, not sexy. These results cannot be ignored.

How Did We Get Here?

We must start now. 
—STUART M. LICHTMAN, MD, FACP, FASCO

A true visionary in the field, Dr. Arti Hurria came on the scene in the early 2000s (unfortunately, she passed away in 2018). Dr. Hurria had a great influence on clinical trial development, patient evaluation, quality of life, and mentoring. One of her great achievements was the development of the Cancer and Aging Research Group (CARG), which is still very active in the professional development of young investigators and research. The development of a chemotherapy risk assessment tool has also been influential.

Making a Clinically Significant Difference

SO, WHAT WAS presented at ASCO20? The INTEGRATE study, from Australia, which included integrated oncogeriatric management, also showed an increase in quality of life (its primary endpoint) and a reduction in unplanned hospitalizations. The GAIN study, from City of Hope, which explored multidisciplinary team recommendations implemented by the primary team, showed an increase in the completion of advanced directives. The study by Mohile et al, conducted in private oncology practices, included an initial geriatric assessment, with recommendations sent to the primary oncologist. It resulted in treatment modifications and reduced toxicity. The final study was of perioperative oncogeriatric management. The intervention group showed a better Edmonton Symptom Assessment Scale score and fewer depressive symptoms. It also resulted in decreased length of stay and ICU admissions.

“Older patients need to become the focus of our endeavors. We must start now.”

—STUART M. LICHTMAN, MD, FACP, FASCO

Although each of these trials has slightly different methodologies and endpoints, the message is the same: Some type of geriatric assessment makes a clinically significant difference.

The pushback to geriatric evaluation has been it is time-consuming, expensive, not educated on this, etc. This is not the case. Also, even if a few extra minutes are required, the benefit is worth the effort. As Dr. Hamaker noted: “Geriatric assessment is not too time-consuming; it is time well spent.” ASCO, SIOG, the European Society for Medical Oncology, and others have websites to help guide and simplify these evaluations. An ASCO guideline publication offers guidance to determine the most important evaluations.

There is no expectation that a busy oncologist will do a comprehensive assessment; that is probably not necessary. Various components can be introduced gradually. It is a way for clinicians to begin to feel comfortable with geriatric evaluation and to make a tangible impact on patient care. Evaluation of polypharmacy and the ability to take medications correctly is a part of routine drug reconciliation. It also is a part of the instrumental activities of daily living (IADL; organizing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, managing medications, and overseeing a household).
Deficiencies in components of IADL have consistently been associated with increased therapy-related toxicities and poor outcomes. It takes seconds to ask about falls and to test memory. Other aspects of geriatric evaluation can be gradually introduced into a physician’s practice so the value of each component can be appreciated. Polypharmacy, one of the geriatric syndromes, can be evaluated during routine drug reconciliation. Technologies are already available to streamline this process.10,11

A Call to Action

FORTY YEARS of dedication and research have led to this point. These four trials, along with some others, have shown that some type of geriatric-specific evaluation for older patients has value.12,13 It improves outcomes and quality of life. Isn’t that what we want for our patients? Why wouldn’t we do this? There are no barriers, no toxicity, and proven benefit. Many evaluations can be done by office staff or self-assessment. Physician time is devoted to acting on the results. These results may be more important than those of a molecular study or a scan. This is personalized medicine in its highest form. This is evidence-based medicine. The COVID-19 epidemic has dramatically demonstrated the vulnerability of older patients. The number of older patients we treat is rising rapidly and will be the majority of patients we must start to prioritize. So, what are you waiting for?

DISCLOSURE: Dr. Lichtman has served as a consultant or advisor to Magellan Health and Remedy One.

REFERENCES

Dr. Lichtman is an attending physician at Memorial Sloan Kettering Cancer Center, Professor of Medicine at Weill Cornell Medical College, and Past President of the International Society of Geriatric Oncology.

ASCO20 Virtual Education Program
Saturday, August 8 - Monday, August 10

The ASCO20 Education Program will be available in an all-virtual format—on-demand videos, slides, and meeting materials, scheduled broadcast sessions, virtual networking, and exhibits—starting Saturday, August 8. Tune into a diverse lineup of 38 scheduled broadcast sessions on Saturday, Sunday, and Monday. Watch with fellow attendees and participate in live chats during the broadcast sessions.

Broadcast Session Highlights include:
• Opening Session With the David A. Karnofsky Memorial Award and Lecture
• ASCO Voices
• Seven ASCO Award Lectures
• ASCO Book Club: In Shock by Rana Awdish, MD
• COVID-19 Registry Roundtable
• Ethical Issues in Oncology Raised during the COVID-19 Pandemic
• Program Directors Roundtable: The Impact of COVID-19 on Fellowship Training

Broadcast sessions will air according to the Broadcast Session Schedule and can be accessed by registered attendees from the “Broadcasting Now” section on the ASCO20 Virtual homepage. Visit https://meetings.asco.org/am/virtual-welcome. All sessions included in the scheduled broadcast will also be available to watch on-demand two hours after the close of the broadcast.