How to Treat Multiple Myeloma: Thoughts on a Multicentre Survey in Germany

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Knauf et al. [1] report in the current issue of ONKOLOGIE the results of a multicenter survey study performed in order to learn on the changes in the management of multiple myeloma (MM) over time in Germany. For this purpose 386 patients diagnosed in a 3 months-period from 35 centres in Germany (14% university hospitals, 46% community hospitals and 40% office-based haematologists) were studied and the results were compared with similar surveys from 2004 and 2006. The authors concluded that: i) there were important deviations from international recommended guidelines [2], ii) a high proportion of patients in Durie and Salmon stage I were treated, iii) a minority of patients was considered for high-dose therapy/stem cell transplantation (HDT/SCT), and iv) a shift towards the incorporation of novel drugs in the treatment of MM. Although this study demonstrates an improvement when compared with the results from 2004 and 2006, there are issues that remain of concern in the general management of patients with MM.

First, from this study it seems evident that the baseline evaluation is still suboptimal. Thus, β_2 -microglobulin and serum albumin, two easily available parameters and which are required for the current International Staging System classification [3], were missing in almost 30% of the patients. Even more striking, FISH cytogenetics, the most important prognostic parameter, was studied in only 22% of the patients. Surprisingly (or not surprisingly) 'proteinuria' was only measured in 8% of the patients. A minimal baseline evaluation should include the basic haematological plus chemical values (including haemoglobin level plus serum creatinin, calcium, albumin and β_2 -microglobulin) plus total serum protein, 24-h urine protein excretion with serum and urine electrophoresis plus serum and urine immunofixation, skeletal survey and bone marrow aspirate with FISH analysis whenever possible. All myeloma treating physicians should keep in mind that the initial disease assessment, response evaluation and monitoring is not possible without the essential studies on serum and urine basic protein assays [2, 4, 5].

Second, in the PETHEMA studies the number of patients with Durie and Salmon Stage I myeloma is less than 5% [6]. The 16.9% in this study seems too high and the population appears to be heterogeneous. In all myeloma series there is a proportion of patients with symptomatic stage I MM who require systemic therapy from the beginning. However, one must be certain that the patient has not solitary bone plasmacytomas or smouldering (asymptomatic) MM (SMM). In the first case, surgery and/or radiation therapy should be the treatment of choice [2]. In case of SMM, no treatment should be administered until evident progressive or symptomatic myeloma develops [7]. Bisphosphonates are not recommended in SMM [8].

Third, it is concluded that only 35% of the patients were considered for HDT/SCT. Considering that in the study population only 40% of the patients were younger than 65 years, the number of patients considered eligible for HDT/SCT seems reasonable. While it is true that fit patients aged 65–70 years can be eligible for HDT/SCT, there are patients with MM younger than 65 years that are not candidates for HDT (i.e., patients with severe co-morbidities, with poor performance status or disease complications such as advanced renal failure as well as patients with initially unresponsive progressive disease) [9].

Fourth, the increased use of novel agents in the upfront as well as in the relapse/refractory settings in the more recent years is an expected finding and should be encouraged [10]. Fortunately, we are already in an era of improvement in quality of life and survival of patients with MM and we can foresee an improved long-term outcome for our patients with MM through a number of medical interventions: i) the possible use of a tailored front-line therapy for elderly patients optimising the use of MPT (melphalan, prednisone and thalidomide), MPV (melphalan, prednisone and bortezomib) or lenalidomide/dexamethasone according to age, co-morbidities, performance status and disease aggressiveness, ii) using more effective pre-transplant regimens for younger patients eligible

for HDT/SCT resulting in a high pre- and post-transplant complete response rate and this leading to a significantly longer survival, iii) selecting the more appropriate rescue regimens after relapse and exploiting the available drugs in a sequential manner according to previous drug exposure, depth and duration of response and previous toxicities, iv) careful baseline and response evaluation with an appropriate monitoring that allows the recognition of clinical progression ensuring a timely rescue therapy, v) adequate prophylaxis and management of toxicities, particularly peripheral neuropathy and thrombotic events, and vi) supportive care with optimal use of bisphosphonates, infectious prophylaxis in high-risk patients (renal failure, very high IgG levels with low back-

ground immunoglobulins and those with past history of recurrent bacterial infections, particularly pneumococcal pneumonia) appropriate use of erythropoietin as well as an adequate management of renal failure [11, 12].

Conflict of Interest

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