Survival of Multiple Myeloma Patients Aged 65–70 Years in the Era of Novel Agents and Autologous Stem Cell Transplantation

A Multicenter Retrospective Collaborative Study of the Japanese Society of Myeloma and the European Myeloma Network

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From January 1, 2004, to December 31, 2009, 318 newly diagnosed patients aged 65–70 years were treated with conventional chemotherapy, novel agent-containing regimens, conventional chemotherapy plus auto-SCT, or novel agents plus auto-SCT. The median progression-free survival was 19.1, 24.5, 26.8, and 35.2 months, respectively, and the 5-year overall survival (OS) was 40, 62, 63, and 87%, respectively. Initial therapy with novel agents (p < 0.001) or auto-SCT (p < 0.02) significantly improved OS compared with the group without these treatment modalities. Salvage therapy with novel agents also significantly improved survival after relapse compared with conventional chemotherapy alone (p < 0.04). In a multivari-
ate analysis, the use of novel agents was an independent prognostic factor significantly associated with extended OS (p < 0.003). These results indicate that novel agents and auto-SCT had a major impact on OS in eligible patients in this subgroup of MM.

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Introduction

Multiple myeloma (MM) is a plasma cell neoplasm characterized by the production of monoclonal immunoglobulin (Ig) and various clinical features such as hypercalcemia, renal failure, anemia and osteolytic bone lesions, as well as immunodeficiency [1]. MM remains incurable; however, the response rate, progression-free survival (PFS) and overall survival (OS) have significantly improved due to the introduction of initial treatment incorporating novel agents such as thalidomide, lenalidomide and bortezomib, and autologous stem cell transplantation (auto-SCT) [2–4]. Based on the results from randomized phase III studies, the National Comprehensive Cancer Network guidelines recommended the use of thalidomide, lenalidomide and bortezomib in the treatment of both transplant-eligible and noneligible patients [5, 6]. Thus, novel agents have become the standard of care for symptomatic MM as primary therapy and salvage therapy.

Auto-SCT is the standard front-line consolidation therapy, especially for younger patients less than 65 years of age. In elderly patients more than 65 years old, the efficacy and feasibility of an intermediate dose of melphalan (100–140 mg/m²) as a conditioning regimen have been reported previously [7–9]. However, it is not clear whether the combined use of novel agents with auto-SCT translates into better outcome in elderly patients.

To clarify this issue, we retrospectively analyzed the clinical features and treatment outcome of unselected MM patients aged 65–70 years in the facilities of the Japanese Society of Myeloma and the European Myeloma Network.

Methods

Patients

Between January 1, 2004, and December 31, 2009, a total of 318 newly diagnosed MM patients aged 65–70 years were treated in 39 facilities of the Japanese Society of Myeloma and the European Myeloma Network. The diagnosis and clinical staging of MM were based on the Durie-Salmon staging system and the International Staging System (ISS) [10, 11]. Baseline demographics, clinical and laboratory data at diagnosis and information concerning treatment and response were collected retrospectively during January 2012 and May 2012. This survey covered unselected patients treated at the participating facilities, including several patients who had been enrolled in clinical trials, but most patients had been treated in routine practice. This retrospective study was approved by the Ethics Committee/Institutional Review Board of Tokushima Prefectural Central Hospital.

Treatment

The primary objective was to assess the outcome of patients treated with different initial therapy. Treatment for each patient was determined by the corresponding physician. The short-term use of dexamethasone for emergent disease control was not considered conventional chemotherapy. Novel agents included thalidomide, lenalidomide and bortezomib in combination with dexamethasone and/or chemotherapeutic agents. Auto-SCT was performed as up-front therapy after induction therapy by using a high or intermediate dose of melphalan followed by peripheral blood SCT according to the institutional protocol. The transplantation-related mortality was defined as death due to any cause other than disease progression or relapse within 100 days after transplantation. Clinical response was evaluated according to the international uniform response criteria for MM [12].

Statistical Analysis

PFS and OS curves were calculated using the Kaplan-Meier estimate, and differences between the curves were evaluated with the log-rank test. The Cox proportional hazards model was used to determine independent predictors associated with extended OS. Variables included baseline patient factors, prognostic factors and treatment-related factors.

Results

Patients

A total of 318 patients were studied. There were 167 males and 151 females. The median age was 67 years (range 65–70). The type of monoclonal Ig was IgG in 169 patients, IgA in 80, light chain in 56, IgD in 7 and others in 6. Performance status of 0, 1 and ≥2 were found in 88, 96 and 93 patients, respectively. Twenty-two patients were classified as Durie-Salmon stage I, 73 as stage II, 216 as stage III and 7 as unknown. With regard to the ISS, 86 patients were stage I, 107 stage II and 102 stage III. Unfortunately, data on cytogenetic abnormalities were not available for most patients.

As initial therapy, 192 patients were treated with conventional chemotherapy, as follows: melphalan + prednisone in 83, vincristine + adriamycin + dexamethasone in 56, high-dose dexamethasone in 25 and other regimens in 28, including ranimustine + vindesine + mel-
phalan + prednisone, vincristine + melphalan + dexamethasone ± ranimustine, and methyl prednisone + vincristine + melphalan + prednisone. Another 88 patients were treated with novel agent-containing regimens composed of bortezomib + dexamethasone; BAD = bortezomib + adriamycin + dexamethasone; MPB = melphalan + prednisolone + bortezomib; MPL = melphalan + prednisolone + lenalidomide; TD = thalidomide + dexamethasone; MPT = melphalan + prednisolone + thalidomide; sHDM = single high-dose melphalan; tHDM = tandem high-dose melphalan; SD = stable disease; PD = progressive disease.

Table 1. Patient characteristics according to initial therapy

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Conventional chemotherapy</th>
<th>Novel agent</th>
<th>Chemotherapy + auto-SCT</th>
<th>Novel agent + auto-SCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>192</td>
<td>88</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Males/females</td>
<td>102/90</td>
<td>47/41</td>
<td>9/12</td>
<td>9/8</td>
</tr>
<tr>
<td>Mean age ± SD, years</td>
<td>67±1</td>
<td>67±1</td>
<td>66±1</td>
<td>67±1</td>
</tr>
<tr>
<td>Type of M protein: IgG/IgA/IgD/BJP/other</td>
<td>104/47/5/31/5</td>
<td>45/24/2/16/1</td>
<td>10/4/0/7/0</td>
<td>10/5/0/2/0</td>
</tr>
<tr>
<td>Performance status: 0/1/≥2</td>
<td>46/65/76</td>
<td>29/16/9</td>
<td>6/10/3</td>
<td>7/5/5</td>
</tr>
<tr>
<td>Durie-Salmon stage: I/II/III</td>
<td>14/39/139</td>
<td>6/23/52</td>
<td>0/9/12</td>
<td>2/2/13</td>
</tr>
<tr>
<td>ISS: I/II/III</td>
<td>45/62/72</td>
<td>23/29/27</td>
<td>8/10/2</td>
<td>10/6/1</td>
</tr>
</tbody>
</table>

Best response

<table>
<thead>
<tr>
<th>CR</th>
<th>VGPR</th>
<th>PR</th>
<th>SD</th>
<th>PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>10</td>
<td>21</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>2%</td>
<td>11%</td>
<td>24%</td>
<td>24%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Values represent numbers of patients, except where indicated otherwise. MP = Melphalan + prednisolone; VAD = vincristine + adriamycin + dexamethasone; HDD = high-dose dexamethasone; BD = bortezomib + dexamethasone; BAD = bortezomib + adriamycin + dexamethasone; MPB = melphalan + prednisolone + bortezomib; MPL = melphalan + prednisolone + lenalidomide; TD = thalidomide + dexamethasone; MPT = melphalan + prednisolone + thalidomide; sHDM = single high-dose melphalan; tHDM = tandem high-dose melphalan; SD = stable disease; PD = progressive disease.

Outcome according to Clinical Stage

We first assessed PFS and OS according to clinical stage. The median PFS for Durie-Salmon stage I, II and III was 40.5, 25.6 and 20.9 months, respectively, and a significant difference was found between stages I and III (p < 0.02; fig. 1a). The median OS was 55.2 months for stage III but was not reached in either stage I or II.

As for ISS stage I, II and III, the median PFS was 31.1, 25.0 and 14.2 months, respectively, and significant differences were found between stages I and III (p < 0.00001), and stages II and III (p < 0.0003; fig. 1b). The median OS was 36.8 months for stage III but was not
reached in stages I and II. OS was significantly shorter for ISS stage III compared with that for stage I or II (p < 0.00001).

**Outcome according to Initial Therapy**

We next compared PFS and OS according to initial therapy. The median PFS of the 4 different treatment groups, i.e. conventional chemotherapy, novel agents, conventional chemotherapy plus auto-SCT and novel agents plus auto-SCT, was 19.1, 24.5, 26.8 and 35.2 months, respectively (fig. 2a). PFS was significantly improved in patients treated with a novel agent-containing regimen (p < 0.01) and in those treated with novel agents plus SCT (p < 0.04) compared with that of the patients treated with the conventional chemotherapy alone. The median OS of the conventional chemotherapy group was 46.0 months, while it was not reached in the other groups. When we compared the outcome of the conventional chemotherapy group, there was a significant improvement in OS in the following treatment groups: novel agent-containing regimen (p < 0.001), chemotherapy plus SCT (p < 0.02) and novel agents plus SCT (p < 0.02). In terms of auto-SCT or novel agents as the front-line treatment, the median OS was significantly improved in the auto-SCT group compared with the non-SCT group (not reached vs. 57.9 months, p < 0.02) and more so in the novel agents group compared with the non-novel agents group (not reached vs. 49.3 months, p < 0.001; fig. 2b). No transplantation-related mortality was observed.

**Fig. 1.** Outcome according to clinical stage. **a** PFS and OS according to Durie-Salmon stage. **b** PFS and OS according to the ISS.
Efficacy of Novel Agents on OS

Because the induction therapy with novel agents had a significant impact on OS, we further evaluated the impact of novel agents as salvage therapy. When we analyzed OS in terms of the use of novel agents, the median OS was significantly improved in the group of patients treated with novel agents either as first-line or salvage therapy (second- and third-line) compared with those treated with conventional chemotherapy alone [86.7 months (n = 232) vs. 38.0 months (n = 86), p < 0.0001; fig. 3a]. Among 168 relapsed patients who received either conventional chemotherapy, novel agents or auto-SCT as ini-
tial therapy, 148 patients were treated with novel agent-containing regimens and the remaining 20 patients with conventional chemotherapy alone as salvage therapy. The median survival from the time of relapse was significantly extended in the novel agent group (45.5 months) compared with the chemotherapy group (15.0 months, \( p < 0.04 \); fig. 3b). No patient was treated with auto-SCT as salvage therapy.

**Outcome according to Response**

The best response to treatment in the 318 patients was a complete response (CR) in 26 patients (8.2%), very good partial response (VGPR) in 56 (17.6%), partial response (PR) in 127 (39.9%), stable disease in 92 (28.9%) and disease progression in 17 (5.3%). Achievement of CR or VGPR was mostly observed in patients treated with auto-SCT (table 1). A significant difference in OS was found between the CR and PR groups \( p < 0.003 \) and between the VGPR and PR groups \( p < 0.05 \); fig. 4).

**Multivariate Analysis**

Finally, we performed a multivariate analysis to identify predictors independently associated with OS by using the Cox proportional hazards model. Variables included in the analysis were baseline patient factors (age, gender and type of M protein), prognostic factors (albumin, \( \beta_2 \)-microglobulin and ISS stage) and treatment-related factors (the use of novel agents and auto-SCT). In this analysis, serum albumin \( p < 0.00005 \) and \( \beta_2 \)-microglobulin \( p < 0.02 \) were important prognostic factors for OS (table 2). As for the type of M protein, the BJ type \( p < 0.01 \) was found to be a significant prognostic factor associated with poor OS. Among treatment-relat-
Extended Survival of Elderly Myeloma Patients

Table 2. Multivariate analysis for OS

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
<th>SE (β)</th>
<th>Z</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.10093</td>
<td>0.07053</td>
<td>1.43112</td>
<td>0.1524</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.0239</td>
<td>0.19621</td>
<td>0.12176</td>
<td>0.9031</td>
</tr>
<tr>
<td>Type of M protein</td>
<td>-0.7012</td>
<td>0.26077</td>
<td>2.68887</td>
<td>0.0072</td>
</tr>
<tr>
<td>Albumin</td>
<td>-0.7308</td>
<td>0.15411</td>
<td>4.74216</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>β2-Microglobulin</td>
<td>0.02670</td>
<td>0.01110</td>
<td>2.40455</td>
<td>0.0162</td>
</tr>
<tr>
<td>ISS stage</td>
<td>0.17161</td>
<td>0.15183</td>
<td>1.13021</td>
<td>0.2584</td>
</tr>
<tr>
<td>Novel agent</td>
<td>-0.6770</td>
<td>0.22269</td>
<td>3.04012</td>
<td>0.0024</td>
</tr>
<tr>
<td>Auto-SCT</td>
<td>-0.5614</td>
<td>0.38184</td>
<td>1.47022</td>
<td>0.1415</td>
</tr>
</tbody>
</table>

Novel agents included thalidomide, lenalidomide and bortezomib.

ed factors, the use of novel agents (p < 0.003) was an independent favorable predictor significantly associated with extended OS.

Discussion

In this study, we performed a retrospective analysis of the prognosis of newly diagnosed MM patients aged 65–70 years. We evaluated an unselected group of patients who had been treated between January 1, 2004, and December 31, 2009. During this period, novel agents such as thalidomide, lenalidomide and bortezomib were available in clinical trials and routine practice. Therefore, this survey allowed us to compare the difference in outcome in terms of the use of novel agents.

Our data have shown that front-line therapy with novel agents or auto-SCT significantly prolonged OS when compared with conventional chemotherapy alone and that the use of novel agents followed by auto-SCT consolidation further improved OS. The additional use of novel agents as salvage therapy also prolonged the survival period after relapse. These findings suggest that treatment with novel agents and auto-SCT were effective approaches in this subgroup of MM patients.

In the current study, treatment for each patient was determined by the corresponding physician, and the baseline patient characteristics were different between each treatment group according to initial therapy. Therefore, the results cannot be compared equally across the groups. At that time, novel agents, especially bortezomib, were not used in vulnerable patients with performance status ≥3 because of the possibility of severe adverse events such as interstitial pneumonitis [13]. Thus, there was a bias in the patient background; that is, the conventional chemotherapy group included more fragile patients compared with the novel agent-containing regimen group or the auto-SCT group. Nevertheless, the median PFS in the conventional chemotherapy group was 19.1 months, which is similar to the previous data observed in clinical trials of melphalan + prednisone or other conventional chemotherapy (approximately 18 months) [14]. This suggests that the treatment outcome in the conventional chemotherapy group was not inferior to that in the historical standard chemotherapy group. Taken together, our results rather indicate a possible survival benefit of novel agents and auto-SCT in particular eligible patients.

We also found that the median OS in the conventional chemotherapy group (46.0 months) was longer than that in previous clinical trials (29 months) [14]. This is most likely due to the improvement of salvage therapy with novel agents. In fact, the survival after relapse was significantly improved by novel agent-containing regimens compared with conventional chemotherapy alone regardless of the use of novel agents as initial therapy. These findings also support the efficacy of novel agents as salvage therapy in MM.

Auto-SCT has been mostly applied to younger patients aged 65 or younger. Nevertheless, in this survey, 38 of 318 patients (12%) aged 65–70 years had been successfully managed with auto-SCT without transplantation-related mortality. Our results suggest that auto-SCT is a safe and effective approach for eligible patients with a good health condition, and this transplant eligibility in the elderly population is another prognostic factor for extended OS. Thus, auto-SCT is still an important strategy for so-called transplant-ineligible patients, as was reported previously [7, 9].

Recent treatment strategies with novel agents have significantly improved response rates in both younger and elderly patients with MM [15–18]. The achievement of CR and VGPR has been shown to be associated with prolonged PFS and OS in both transplant-eligible and -ineligible patients [3, 4]. In this study, CR and VGPR were mostly observed in the groups of patients treated with novel agents and/or auto-SCT, and these patients exhibited significantly longer OS compared with those achieving PR or inferior responses. Thus, the achievement of CR or VGPR was another favorable factor associated with extended OS, regardless of initial therapy.

By multivariate analysis, we confirmed that serum albumin and β2-microglobulin were independent prognostic factors for OS. Among the types of M protein, the BJP type was related to a poor prognosis. The reason is probably because most patients with BJP type had the compli-

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calation of renal damage. As for the treatment, the use of novel agents was an independent favorable prognostic factor associated with extended OS. Treatment with auto-SCT was not a significant prognostic factor, probably due to the small number of patients treated with auto-SCT.

In conclusion, our results indicate that treatment with novel agents and auto-SCT had a major impact on OS in eligible patients aged 65–70 years. We should evaluate the possible clinical indications of using novel agents plus auto-SCT even in this subgroup of elderly patients with MM.

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References


