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POSTER ABSTRACTS

652.MULTIPLE MYELOMA: CLINICAL AND EPIDEMIOLOGICAL

Teclistamab in Relapsed Refractory Multiple Myeloma Patients on Dialysis: A French Experience

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Background
Up to 50% of patients with multiple myeloma (MM) have renal impairment at diagnosis; about 5% require dialysis. Prognosis of these patients remains significantly worse and associated with early death. Teclistamab is a humanized immunoglobulin bispecific antibody directed against the BCMA and CD3 receptors and demonstrated clinical benefit as monotherapy for the treatment of patients with relapsed/refractory MM (RRMM) who have received at least 3 prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody. However, data in patients with dialysis-dependent renal failure are missing. Here, we report safety and efficacy data from RRMM patients treated with teclistamab in a dialysis setting.
Methods
This retrospective study included RRMM patients with end-stage renal failure requiring dialysis treated with teclistamab in French Acces Précoce program. Teclistamab was given every week at dose of 1.5 mg/kg subcutaneously after step-doses of 0.06 and 0.3 mg/kg. Premedication (including dexamethasone for step up doses and first full dose) were administered before teclistamab administration according the FDA and EMA recommendations. Teclistamab was administered after dialysis, but precise schedules vary slightly according to the rhythm of dialysis of each patient.
Results
To date, 13 patients with end-stage renal failure requiring dialysis have been treated with teclistamab in French hospitals. The median age was 67 years [59-83]. Median time since diagnosis was 6 years [2-9]. The median number of previous lines of therapy was 4 [3-9]. Most of the patients had a myeloma-related end-stage renal failure. Isotype of myeloma was free light chains in 75% of cases.
Step-up dosing modalities were similar to the patients with normal renal function with the only difference being that teclistamab is administered within 1-2 days after dialysis. Half of the patients developed cytokine release syndrome grade 1 or 2, treated with tocilizumab, and addition of dexamethasone for one patient. No ICANS was reported. The infection rate seems not to be superior to non-dialysis patients with only grade < 3 events, except for one patient who presented a severe Covid infection and a pseudomonas aeruginosa bacteriemia, both resolved after short break of teclistamab and specific treatments.

Taking precautions when interpreting such a small cohort, all evaluable patients responded and obtained a VGPR or better. With a median follow-up of 4 months, no progression or deaths were reported. Updated data will be presented during the meeting.

Conclusion

These first results suggest that teclistamab is a feasible, effective and safe option for patients with RRMM who need dialysis. These data are very important for such subgroup of patients typically excluded from clinical trials and for CAR T cell therapies that usually requires fludarabine-based lymphodepletion.

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