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903.HEALTH SERVICES AND QUALITY IMPROVEMENT -MYELOID MALIGNANCIES

Impact of Ethnicity in Treatment Choice for Multiple Myeloma in the 3 First Lines of Therapy: Data from Observational Retrospective Real-World Study in the USA

Nicolas Blin, MD[1], *Christine Mai, MD*[2], *Siegfried Ertl, MBA*[3], *Elodie Schneider, MBA*[2], *Marine Leberre, MBA*[2], *Melissa Yilmaz, MSc*[2]

[1] Hematology Department, Nantes University Hospital, Nantes, France
[2] AplusA, Lyon, France
[3] AplusA, London, United Kingdom

Background
In Multiple myeloma (MM) patient ethnic origin appears to be associated with significant disparities including access to care and treatment patterns in some western countries, including the USA (3).

Aims
Identify impact of ethnicity in real world setting on choice of treatment regimens and new combinations for MM in 1st line and relapsed/refractory (R/R) setting among patients (pts) treated recently in the USA.

Methods
A total of 1,209 anonymous patient charts were reported by onco-hematologists in the USA, in 2022 - 2023.
The analysis focused on first 3 lines of therapy for MM: 397 first line (1L) pts, 89 receiving induction treatment prior to autologous stem cell transplantation (SCT), 101 receiving maintenance therapy after SCT and 207 pts non eligible for intensive treatment, + 457 second line (2L) and 355 third line (3L) pts.
D= daratumumab; V=bortezomib; T=thalidomide; d= dexamethasone; R=lenalidomide; M= melphalan; p= prednisone; K=carfilzomib

Results
39% of pts were female and 61% were male.
49% were white/Caucasians vs. non-white race, (9% Asians, 25% black/African Americans, 15% Hispanic/Latinos and 2% American Indians/native Hawaiians/other pacific islanders).
In 1st line induction prior to SCT, the most frequently used regimens were VRd (33 pts), D-VRd (17 pts) and DRd (6 pts), in line with NCCN and IMWG clinical practice guidelines.
Black/African Americans and Hispanic/Latinos were underrepresented in the D-VRd group, with these 2 groups corresponding 6% of pts as compared to 88% for white/Caucasian pts. No significant discrepancy in the VRd and DRd groups among different ethnic origins.
In 1st line maintenance post SCT, treatment with R alone or Rd were the most frequently used (44 and 13 pts, respectively), with no difference between different ethnic subgroups.
In 1st line non SCT eligible pts, the 3 major regimens used were VRd (73 pts), DRd (38 pts) and D-VRd (15 pts) and in accordance with international IMWG guidelines, except for D-VRd which is not yet recommended for this subset of pts.
Breakdown between different ethnic groups was in line with the sample population, except in the VRd group where black/African Americans were slightly overrepresented compared to overall population (36% vs. 25%).
In the R/R setting, there was more heterogeneity and the most frequently used regimens in 2nd line treatments were DRd (35 pts), DPd (38 pts), DKd (37 pts), Dd (30 pts) and KRd (21 pts). In this subset, black/African Americans were underrepresented in the DKd group (14% of all pts vs. 56% for white and 19% for Hispanic/Latinos). Conversely, black pts more commonly received Dd combination despite this not being included in international guidelines and considered suboptimal as a second line treatment.
Few pts received doublets with no anti-CD38 antibody in 2nd line, mainly Rd (14 pts) and Vd (16 pts) but no discrepancy was identified among different ethnic subgroups.
In the 3rd line setting, the 3 most used combinations were DPd (21 pts), Dd (21 pts) and Kd (18 pts). Black/African Americans were overrepresented in the DPd and, in particular in the Kd group where they represented 50% of all pts.

Conclusion

Those results show that regimens recommended in the last NCCN and IMWG clinical practice guidelines are the most frequently used regardless patient's ethnic origin in 1st, 2nd and 3rd line MM.
However, racial disparities are noted in treatment choices with lower usage of next generation combinations for black/African Americans in first line SCT eligible pts (D-VRd) and 2nd line (DKd) when compared with white/Caucasian population.
Conversely, some regimens, such as Dd in 2nd line and Kd in 3rd line tend to be more regularly considered in black/African Americans even if they may be suboptimal.

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