Immunotherapy for Smoldering Myeloma

Clinical trials test PD-1, CD38 inhibitors to delay progression from premalignant disease to multiple myeloma

By Bryan Tutt

Until recently, patients with smoldering myeloma had no option but to watch and wait for the inevitable progression to malignancy. But now, two clinical trials of immunotherapy drugs offer patients with the precancerous condition a chance to delay disease progression and perhaps add years to their lives.

Smoldering myeloma has no symptoms and is diagnosed chiefly by levels of myeloma-produced proteins (e.g., monoclonal protein, free light chain proteins) in the serum and clonal plasma cells in the bone marrow. These levels help clinicians classify patients’ disease as low, intermediate, or high risk.

Because smoldering myeloma is expected to progress to multiple myeloma, a patient’s risk level indicates how soon this progression is likely to occur. Intermediate-risk smoldering myeloma, for example, indicates a 50%–74% chance of progression to multiple myeloma within 5 years. Patients’ risk levels help determine the frequency of clinic visits to monitor their disease.

Although observation is the standard management strategy for smoldering myeloma, several clinical trials have evaluated the use of approved multiple myeloma chemotherapy regimens to delay the progression of smoldering myeloma. One recent study, a multicenter phase II trial, evaluated a regimen of carfilzomib, lenalidomide, and dexamethasone in patients with high-risk smoldering myeloma. The results were...
promising; however, the regimen was arduous for patients.

“Patients in that trial had two infusions a week for 8 months, plus stem cell collection for transplant-eligible patients,” said Elisabet Manasanch, M.D., an assistant professor in the Department of Lymphoma and Myeloma at The University of Texas MD Anderson Cancer Center and a co-investigator of that trial. “Patients who have smoldering myeloma usually are not feeling sick, so it’s difficult for them to accept a disruptive treatment.”

In search of less invasive treatments to delay the progression of smoldering myeloma, Dr. Manasanch and her colleagues turned to immunotherapy. She is the principal investigator of two ongoing clinical trials of different immunotherapy approaches.

PD-1 inhibition

Pembrolizumab, which inhibits the immune checkpoint protein PD-1 (programmed cell death protein 1), is approved by the U.S. Food and Drug Administration (FDA) for the treatment of several advanced cancers and has been studied against multiple myeloma. Promising results from an early trial of pembrolizumab plus low-dose chemotherapies in patients with relapsed/refractory multiple myeloma led to a similar phase III trial (No. 2015-1037), which is ongoing but no longer recruiting patients. To see if the drug can slow the progression of smoldering myeloma, Dr. Manasanch is leading a phase I trial (No. 2015-0371) of pembrolizumab.

The phase I trial began enrolling patients with intermediate- or high-risk smoldering myeloma in 2016 and has nearly completed enrollment. Patients receive one intravenous infusion of pembrolizumab per 3-week cycle for up to 24 cycles. The trial’s primary outcome measure is the response rate; response is defined as decreased levels of myeloma-produced proteins in the serum and urine and/or decreased levels of clonal plasma cells in the bone marrow.

Dr. Manasanch is encouraged by the early results seen in the 12 patients who have begun treatment, and she plans to present these findings at the American Society of Hematology annual meeting in December 2017. “These results are a breakthrough,” she said.

CD38 inhibition

CD38 is a glycoprotein that is found on the surface of many lymphocytes and overexpressed on myeloma cells. One drug that inhibits CD38, daratumumab, is approved by the FDA for the treatment of relapsed/refractory multiple myeloma. A phase II clinical trial (No. 2015-0148) of another CD38 inhibitor, isatuximab, is currently enrolling patients who have high-risk smoldering myeloma.

Patients in the trial receive isatuximab intravenously every week for the first 28-day cycle, then every other week for five cycles, and finally every 4 weeks for up to 24 more cycles. The
primary outcome measure is the response rate. The safety and feasibility of the treatment will also be evaluated.

“Our goal is to achieve a 70% response rate after 6 months of treatment,” Dr. Manasanch said. She added that she hopes to have preliminary results ready to present in 2018.

“‘We’re making major steps toward treating this disease.’”
– Dr. Elisabet Manasanch

Expanding options

For patients with intermediate- or high-risk smoldering myeloma who wish to pursue treatment, immunotherapy drugs—with their lower toxicity profiles—are an attractive alternative to traditional chemotherapy regimens. Dr. Manasanch believes her research will help determine not only which immunotherapy drugs can best delay the progression of smoldering myeloma but also when patients need to be treated (See “Observational Study May Uncover Indicators of Smoldering Myeloma Progression,” p. 2).

“These are important studies, and we’re finding out important things already,” Dr. Manasanch said. “We’re making major steps toward treating this disease.”

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Malignant Pheochromocytoma and Sympathetic Paraganglioma Research

Studies may expand treatment options for patients with rare neuroendocrine tumors

By Sarah Bronson

Malignant pheochromocytoma and sympathetic paraganglioma affect only about 100–200 people per year in the United States, but those who do develop these neuroendocrine cancers have only a 60% 5-year overall survival rate and limited options for effective treatment. Researchers at The University of Texas MD Anderson Cancer Center are conducting clinical trials of new treatments and studying the survival benefits of surgery to improve outcomes for patients with malignant pheochromocytoma and sympathetic paraganglioma.

Historically, response rates to standard treatment with chemotherapy or radiopharmaceuticals have been around 30% in patients with these cancers.

Surgery is another treatment for these patients; but it is not always feasible, and its impact on survival was unclear until recently.

Unfortunately, the small number of patients affected by these cancers has hindered progress. “We are the only institution that currently has multiple clinical trials devoted exclusively to patients with malignant pheochromocytoma and paraganglioma,” said Camilo Jimenez, M.D., an associate professor in the Department of Endocrine Neoplasia and Hormonal Disorders. Dr. Jimenez and his colleagues hope their efforts will improve the outlook for patients with these rare neuroendocrine tumors.

Drug trials

Ultratrace iobenguane I 131

Introduced into clinical practice 30 years ago, the targeted radiopharmaceutical agent iobenguane I 131 enters cancer cells via the cell membrane norepinephrine transporter and has been used to both visualize and treat pheochromocytoma and paraganglioma. As an imaging aid, iobenguane I 131 shows where the cancer is and whether the cancer is taking up the agent. Patients whose tumors are

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Malignant Pheochromocytoma and Paraganglioma

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Iobenguane avid on imaging may be given a higher, therapeutic dose to kill the cancer cells.

However, the original version of iobenguane I 131 is limited by the absence of radioactivity in most of its molecules. “Conventional iobenguane has an abundance of carrier molecules that are not radioactive but are bioactive, meaning they will cause side effects,” said Aaron Jessop, M.D., until recently an assistant professor in the Department of Nuclear Medicine at MD Anderson and now at another institution. “We want to make sure we’re treating the patient as aggressively as we can but without causing undue collateral damage.”

Ultratrace iobenguane I 131 overcomes the inefficiency of the original agent through a production process that minimizes the number of molecules without radioactivity. “Compared with conventional iobenguane, this version is highly specific,” Dr. Jimenez said. “Therefore, the delivery of radioactivity to the tumor per dose is much higher.”

Dr. Jimenez is the principal investigator of a phase II trial of Ultratrace in patients with iobenguane-avid metastatic or recurrent pheochromocytoma or paraganglioma. So far, Ultratrace has been well tolerated by patients and has demonstrated significant activity, as measured by tumor shrinkage and reduced need for antihypertensive drugs.

These promising preliminary results led to the opening of an expanded access trial (No. 2009-0210) of Ultratrace in patients with malignant relapsed or refractory pheochromocytoma or paraganglioma. This trial is ongoing at MD Anderson and other institutions and will provide access to the radiopharmaceutical prior to its anticipated approval by the U.S. Food and Drug Administration (FDA).

**Cabozantinib**

Another phase II trial at MD Anderson (No. 2014-0081) for patients with malignant pheochromocytoma and paraganglioma is testing cabozantinib, a tyrosine kinase inhibitor that has been approved by the FDA for the treatment of medullary thyroid cancer and kidney cancer. “This drug blocks the cMET receptor, which is important for the spread, growth, and survival of tumors and is upregulated when the tumors become resistant to other medications,” said Dr. Jimenez, the trial’s principal investigator. “So this is a drug that could be used to prevent resistance.”

The trial is enrolling patients with unresectable metastatic pheochromocytoma or paraganglioma. Because cabozantinib also may benefit bone health, the trial includes an exploratory cohort of patients whose metastases are solely or predominantly in the bone—a group excluded from many trials.

So far, about 90% of patients treated in the trial have experienced a decrease in tumor size. Symptomatic improvement has been observed as well. Dr. Jimenez said, “It’s a drug that we believe can make a difference for many of these patients.”

**Pembrolizumab**

A third approach being studied for this disease is immunotherapy. A phase II trial (No. 2015-0948) of the PD-1 (programmed cell death protein 1) inhibitor pembrolizumab is currently open to patients with any of several rare, advanced tumors, including malignant pheochromocytoma and paraganglioma.

“This study will add crucial information about the efficacy of pembrolizumab in patients with malignant pheochromocytoma and paraganglioma,” said Mouhammed Habra, M.D., an associate professor in the Department of Endocrine Neoplasia and Hormonal Disorders. “The results could establish the foundations for future immunotherapy-based trials in these diseases.”

**Expanding the use of surgery**

Although novel drug treatments are not yet widely available, surgery may be used for treating malignant pheochromocytoma and paraganglioma in appropriately selected patients. As with other cancers, the use of surgery for these tumors depends on the extent of the disease. For patients whose disease is localized, Dr. Habra said, “Surgery is often our best hope for long-term survival.”

However, “If a patient has distant disease on initial evaluation or if the tumor is locally very invasive or aggres-

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**“For the first time, we have options that seem to be less toxic than traditional chemotherapy.”**

– Dr. Camilo Jimenez
Genetic Testing

An important consideration in
the management of malignant or
benign pheochromocytoma and symp-
thetic paraganglioma is their genetic
basis. “Genetic counseling and
consideration of genetic testing are
indicated for all patients with pheo-
chromocytoma or paraganglioma
regardless of their family history, per-
sonal history, age, or disease charac-
teristics because 30%–40% of these
patients have an underlying heredi-
tary predisposition,” said Samuel
Hyde, M.M.Sc., a genetic counselor
in the Department of Clinical Cancer
Genetics.

If a patient with pheochromocy-
toma or paraganglioma tests positive
for a hereditary condition associated
with his or her disease, the patient’s
long-term surveillance becomes
more intensive because the patient
could be at risk for other tumors.
“Patients with these hereditary con-
ditions need to come back and see
us more often,” Mr. Hyde said. “They
need to be screened for tumors in
other parts of their body and have
other blood tests.” The presence
of such a hereditary condition also
means that family members should
be tested for the same mutations.

The number of patients with
pheochromocytoma, paraganglioma,
and other neuroendocrine tumors
seen at MD Anderson has enabled
Mr. Hyde to build expertise in ge-
netic testing for these patients while
keeping up with advances in the
field. “There are often subtleties to
family histories or personal histories
that can make us more suspicious of
one condition over another,” he said.

Hereditary conditions associated
with pheochromocytoma and para-
ganglioma include mutations in
SDHB, SDHC, SDHD, and SDHAF2,
each of which predisposes patients
to a distinct disease phenotype.

These and other mutations associ-
ated with pheochromocytoma and
paraganglioma are becoming better
understood, and the tools for detect-
ing them are becoming capable of
evaluating more genes at once.

Patients seeking genetic coun-
seling or testing at MD Anderson
can fill out a self-referral form at
https://my.mdanderson.org/Request
Appointment or call the Clinical Can-
cer Genetics Program at 855-711-
9908.

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To learn more about the ongoing
clinical trials for patients with
pheochromocytoma or paraganglioma,
visit www.clinicaltrials.org and select
study No. 2009-0210, 2014-0081, or
2015-0948.
Partial-breast irradiation is an effective strategy to prevent breast cancer recurrence after breast-conserving surgery. However, brachytherapy, the most-studied method of delivery, is invasive and not widely available; and accelerated partial-breast external-beam radiation therapy has had unacceptable levels of toxicity in some studies. In search of a less invasive and less toxic but still rapid adjuvant radiation therapy technique, researchers at The University of Texas MD Anderson Cancer Center are conducting a clinical trial of hypofractionated partial-breast external-beam irradiation for early-stage breast cancer patients.

Hypofractionated dosing, in which external-beam radiation is delivered at higher doses in fewer fractions than in standard fractionated dosing, has been proven safe and effective for whole-breast irradiation following lumpectomy and is more convenient and less expensive for patients (see “Shorter Course of Whole-Breast Irradiation for Breast Cancer,” OncoLog, January 2015). In fact, hypofractionated whole-breast irradiation is now standard practice at MD Anderson for patients who have undergone lumpectomy for early-stage breast cancer.

“Our trial of hypofractionated partial-breast irradiation is the next natural step: taking some of the advantages of partial-breast irradiation and some of the advantages of hypofractionated whole-breast irradiation and making those two concepts meet in the middle,” said Benjamin Smith, M.D., an associate professor in the Department of Radiation Oncology.

“We want to find the most convenient and least toxic way to deliver partial-breast irradiation,” added Elizabeth Bloom, M.D., a professor in the Department of Radiation Oncology.

Benefits and limitations of standard partial-breast irradiation

Compared with whole-breast irradiation, partial-breast irradiation has a smaller radiation field, which translates into fewer radiation-related toxic effects. For example, whole-breast irradiation sometimes causes cosmetic alterations or scar tissue in the breast or underlying muscles. Such damage could potentially be avoided with partial-breast irradiation because a smaller volume of tissue is treated.

Partial-breast irradiation using brachytherapy is safe and effective, but it has some drawbacks. First, the catheters used to deliver the radioactive beads can be uncomfortable for patients and must remain in place for the duration of treatment. Second, the catheters carry a risk of infection. Finally, because placement of the catheters requires specialized training, the treatment is not widely available. “Brachytherapy works very well,” Dr. Bloom said, “but a limited number of people in the country know how to do it well.”

In contrast to brachytherapy, external-beam radiation therapy is widely available but is not commonly used for partial-breast irradiation owing to its reputation for having undesirable side effects. “Several studies have shown that partial-breast external-beam irradiation has higher risks of breast tissue scarring and poor cosmetic outcomes than expected with brachytherapy,” Dr. Smith said. However, he added that those studies treated patients twice a day for 5 days because such an accelerated dosing schedule had worked for brachytherapy.

“External-beam radiation given in twice-daily fractions doesn’t provide enough time between treatments for the normal breast tissue to repair itself,” Dr. Smith said. And standard fractionation (i.e., given over 6 weeks) for partial-breast external-beam irradiation would have the same disadvantages of inconvenience and expense that it has for whole-breast irradiation.

Drs. Smith and Bloom and their co-investigators hypothesized that once-daily
Support for Cancer Patients

Patients, caregivers find many types of support from various organizations

Even when they are surrounded by friends and family, cancer patients can feel isolated because no one around them understands what they are going through. Likewise, caregivers sometimes need help coping with the changes brought about by a loved one’s cancer. Fortunately, support services such as support groups, educational programs, social events, or one-on-one mentoring from a fellow cancer survivor are available.

Many patients benefit from support services, especially one-on-one mentoring. “Evidenced-based research shows that trained cancer peer mentors can reduce patients’ anxiety and can hasten patients’ recovery,” said Debbie Schultz, a director in the Department of Volunteer Services and Merchandising at The University of Texas MD Anderson Cancer Center. Ms. Schultz is responsible for leading myCancerConnection, a collection of psychosocial support programs for cancer patients.

Choosing a support organization

Although many organizations and Web sites offer various support services, patients and caregivers should be careful to choose trusted, credible organizations. “If you go to a support Web site you’re not familiar with and talk to someone online, you don’t know whether they’ve been trained and whether your information will be kept confidential,” Ms. Schultz said.

When support services are sponsored by large nonprofit organizations such as the American Cancer Society or hospitals such as MD Anderson, patients and caregivers have some assurance that the volunteers have been vetted and trained. Many smaller organizations also provide excellent services, but patients and caregivers should do a little research before contacting these organizations. The Better Business Bureau (www.bbb.org), GuideStar (www.guidestar.org), Charity Navigator (www.charitynavigator.org), and other watchdog groups can provide information about nonprofit support organizations.

Available resources

Below are a few nonprofit support organizations and the services they provide.

The American Cancer Society (www.cancer.org) maintains a nationwide database that can be searched by location and cancer type to find in-person support groups. In addition to supplying information on treatment and financial aid, the organization provides a live chat tool on its Web site and a toll-free help line.

CancerCare (www.cancercare.org) offers educational resources, counseling by social workers, and support groups. Some of these support groups meet in person in New York City, Long Island, New Jersey, and Connecticut; others meet online or by teleconference. Some support groups are specific to a certain cancer type, some are for young adults, and some are for caregivers or bereaved family members.

Cancer Support Community (www.cancersupportcommunity.org) offers information on cancer-related topics and online support groups led by licensed counselors. In-person education and support programs are available at more than 150 locations in the United States, Canada, Israel, and Japan.

Caregiver Action Network (www.caregiveraction.org), formerly known as the National Family Caregivers Association, provides online discussion forums and educational resources for caregivers of patients with chronic illnesses or disabilities. The organization’s Caregiver Community Action Network is a group of more than 100 volunteers, all current or former caregivers, who provide one-on-one support or counseling to caregivers.

Cancer180 (www.cancer180.org) hosts support groups, social events, conferences, and educational offerings for young adults with cancer. The MD Anderson–sponsored program is open to all cancer patients in their 20s and 30s.

myCancerConnection (www.mdanderson.org/mycancerconnection) offers a variety of support and education programs for patients treated at MD Anderson and elsewhere. An annual Survivorship Conference is held in September and is open to all cancer survivors. Also available to all cancer patients is one-on-one peer mentoring. myCancerConnection has a cadre of more than 2,300 trained volunteers who are current or former cancer patients. When someone requests a peer mentor, myCancerConnection staff search their database for a mentor who has had a similar diagnosis.

“Being able to talk to someone who’s been there, had the same diagnosis, and taken the same treatments is helpful to patients,” Ms. Schultz said.

Recently, myCancerConnection worked with other peer mentoring organizations, including Cancer Hope Network (www.cancerhopenetwork.org) and Imerman Angels (www.imermanangels.org), to pool their resources into a nationwide peer mentoring group. If one organization cannot find a peer mentor to match a particular patient, it can find one through one of the other organizations. “Together,” Ms. Schultz said, “we can help anybody, anywhere.”

FOR MORE INFORMATION

• Ask your physician
• Call askMDAnderson at 877-632-6789
• To request a myCancerConnection peer mentor, call 713-792-2553 or 800-345-6324
Hypofractionated Partial-Breast Irradiation

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hypofractionated dosing could avoid the side effects seen in the previous studies of partial-breast external-beam irradiation. In March, they began enrolling patients in a clinical trial of hypofractionated partial-breast external-beam irradiation at MD Anderson clinics in the Texas Medical Center, The Woodlands, Sugar Land, the Bay Area, and Katy—all of which are in the Houston area.

Clinical trial

The phase II trial, called OPAL (No. 2016-1035), is currently enrolling women 50 years and older who have ductal carcinoma in situ or early-stage (T1 or T2, N0, M0) invasive breast cancer. Invasive tumors must be smaller than 3 cm and estrogen receptor-positive.

After undergoing breast-conserving surgery and, if desired, immediate oncoplastic reconstruction, patients receive hypofractionated partial-breast external-beam radiation therapy. A total dose of 35 Gy is delivered in once-daily fractions on 10 consecutive treatment days (excluding weekends and holidays). Patients whose tumors had resection margins narrower than 2 mm receive an additional 9-Gy boost in three fractions. The regimen was evaluated by radiobiologist Howard Thomas, Jr., Ph.D., a professor in the Department of Biostatistics, to ensure that the dose was equivalent to the standard regimen used for whole-breast irradiation.

The trial’s primary outcome measure is the rate of grade 2 or higher toxic effects from the start of radiation therapy through the 6-month follow-up visit. “Our goal is for this rate to be lower than the lowest rate from our most recent study of hypofractionated whole-breast irradiation,” Dr. Smith said, “because the patients in our current trial, like almost any patient who’s had a lumpectomy, would also be candidates for that treatment.”

The secondary outcome measure is patient-reported cosmetic results. Patients complete questionnaires about how their breast looks and feels at baseline, at the 6-month follow-up visit, and at five yearly follow-up visits afterward. These results will be compared with data from the recent study of hypofractionated whole-breast irradiation.

If the outcomes of the OPAL trial are satisfactory, Drs. Smith and Bloom and their co-investigators may propose a randomized trial to directly compare outcomes from hypofractionated partial-breast irradiation and hypofractionated whole-breast irradiation. Dr. Bloom said, “Why treat more healthy tissue if you don’t have to?”

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For more information about the OPAL trial, visit www.clinicaltrials.org and select study No. 2016-1035.

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