Kompetenznetz Maligne Lymphome

Lymphom Kompetenz KOMPAKT

KML KONGRESSE

Expert:innen berichten zu Lymphomen & Leukämien

EHA 2025

MAILAND, ITALIEN

12. – 15. Juni 2025

Kompetenznetz Maligne Lymphome

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Expert:innen berichten zu Lymphomen & Leukämien

Prof. Dr. med. Katja Weisel
Universitätsklinikum Hamburg-Eppendorf

Multiples Myelom

Offenlegung potentieller Interessenskonflikte

LymphomKompetenz KOMPAKT – EHA 2025 Mailand, Italien wird in Kooperation mit fünf unterstützenden Firmen durchgeführt.
Meine persönlichen Disclosures betreffen:

Anstellungsverhältnis, Führungsposition	
Beratungs-/ Gutachtertätigkeit	Abbvie, Adaptive, Amgen, Bristol Myers Squibb, Celgene, Janssen, GSK, Karyopharm, Novartis, Oncopeptides, Pfizer, Roche Pharma, Takeda, Sanofi, Stemline, Cellcentric
Besitz von Geschäftsanteilen, Aktien oder Fonds	
Patent, Urheberrecht, Verkaufslizenz	
Honorare	Abbvie, Adaptive, Amgen, Bristol Myers Squibb, Celgene, Janssen, GSK, Karyopharm, Novartis, Oncopeptides, Pfizer, Roche Pharma, Takeda, Sanofi, Stemline
Finanzierung wissenschaftlicher Untersuchungen	Amgen, BMS/Celgene, Janssen, Sanofi; GSK, Abbvie (alle an die Institution)
Andere finanzielle Beziehungen	
Immaterielle Interessenkonflikte	

State of the Art - Erstbehandlung

- Die Primärtherapie des Myeloms hat sich in 2024 erneut geändert:
- D-VRd – HD-MEL – D-VRd – DR (PERSEUS) Regime ist SOC für alle transplantierbaren Patient:innen
- Für Patient:innen, die sich nicht für eine Transplantation eignen, stehen die Quadruplet Behandlungen Isa-VRd und D-VRd (IMROZ- und CEPHEUS-Regime) zur Verfügung
- Es gibt neue Klassifikationen und Leitlinien parallel zum EHA!

NEU!

International Myeloma Society/International Myeloma Working Group Consensus Recommendations on the Definition of High-Risk Multiple Myeloma

Hervé Avet-Loiseau, MD, PhD[1]; Faith E. Davies, MD[2]; Mehmet K. Samur, PhD[3]; Jill Corre, PharmD, PhD[1]; Mattia D'Agostino, MD[4,5]; Martin F. Kaiser, MD[6,7]; Marc S. Raab, MD[8]; Niels Weinhold, PhD[8]; Norma C. Gutierrez, MD, PhD[9]; S. Bruno Paiva, PhD[10]; Paola Neri, MD[11]; Katja Weisel, MD[12]; Francesco Maura, MD[13]; Brian A. Walker, PhD[14]; Mark Bustoros, MD[15]; A. Keith Stewart, MB, CHB[16]; Saad Z. Usmani, MD[17]; Jens Hillengass, MD, PhD[18]; Wee Joo Chng, MD[19]; Jonathan J. Keats, PhD[20]; Joaquin Martinez-Lopez, MD[21]; Adam S. Sperling, MD, PhD[22]; Cyrille Touzeau, MD[23]; Fenghuang Zhan, PhD[24]; Noopur S. Raje, MD[25]; Michele Cavo, MD[26]; Niccolò Bolli, MD, PhD[27]; Irene M. Ghobrial, MD[28]; Madhav V. Dhodapkar, MD[29]; Sundar Jagannath, MD[30]; Andrew Spencer, MD[31]; Samir Parekh, MD[32]; Nizar J. Bahlis, MD[11]; Sagar Lonial, MD[33]; Pieter Sonneveld, MD, PhD[34]; Leif Bergsagel, MD[35]; Robert Z. Orlowski, MD, PhD[36]; Gareth Morgan, MD[2]; María Victoria Mateos, MD[9]; S. Vincent Rajkumar, MD[37]; Jesus F. San Miguel, MD[38]; Kenneth C. Anderson, MD[39]; Philippe Moreau, MD[23]; Shaji Kumar, MD[37]; Felipe Prósper, MD[40]; and Nikhil C. Munshi, MD[41]

Multiple Myeloma: EHA-EMN Clinical Practice Guidelines for Diagnosis, Treatment and Follow-up

by Evangelos Terpos, Meletios Dimopoulos, Mario Boccadoro, Philippe Moreau, Maria Victoria Mateos Manteca, Sonja Zweegman, Gordon Cook, Monika Engelhardt, Michel Delforge, Roman Hajek, Fredrik Schjesvold, Francesca Gay, Salomon Manier, Katja Weisel, Martin Kaiser, Niels van de Donk, Elena Zamagni, Paula Rodriguez-Otero, Aurore Perrot, Christoph Driessen, Jelena Bila, Edward Laane, Dominik Dytfeld, Cyrille Touzeau, Meral Beksac, Marc Raab, Michele Cavo, Mohamad Mohty, Andrew Spencer, Heinz Ludwig, Hermann Einsele, Jesus San Miguel, and P Sonneveld [NRCO-25-016V1B], for which you are listed as a contributing author, *has been Accepted for publication in Nature Reviews Clinical Oncology*

Kapitel 1

Primärtherapie des Multiplen Myelom –

Warum Isa-KRd?

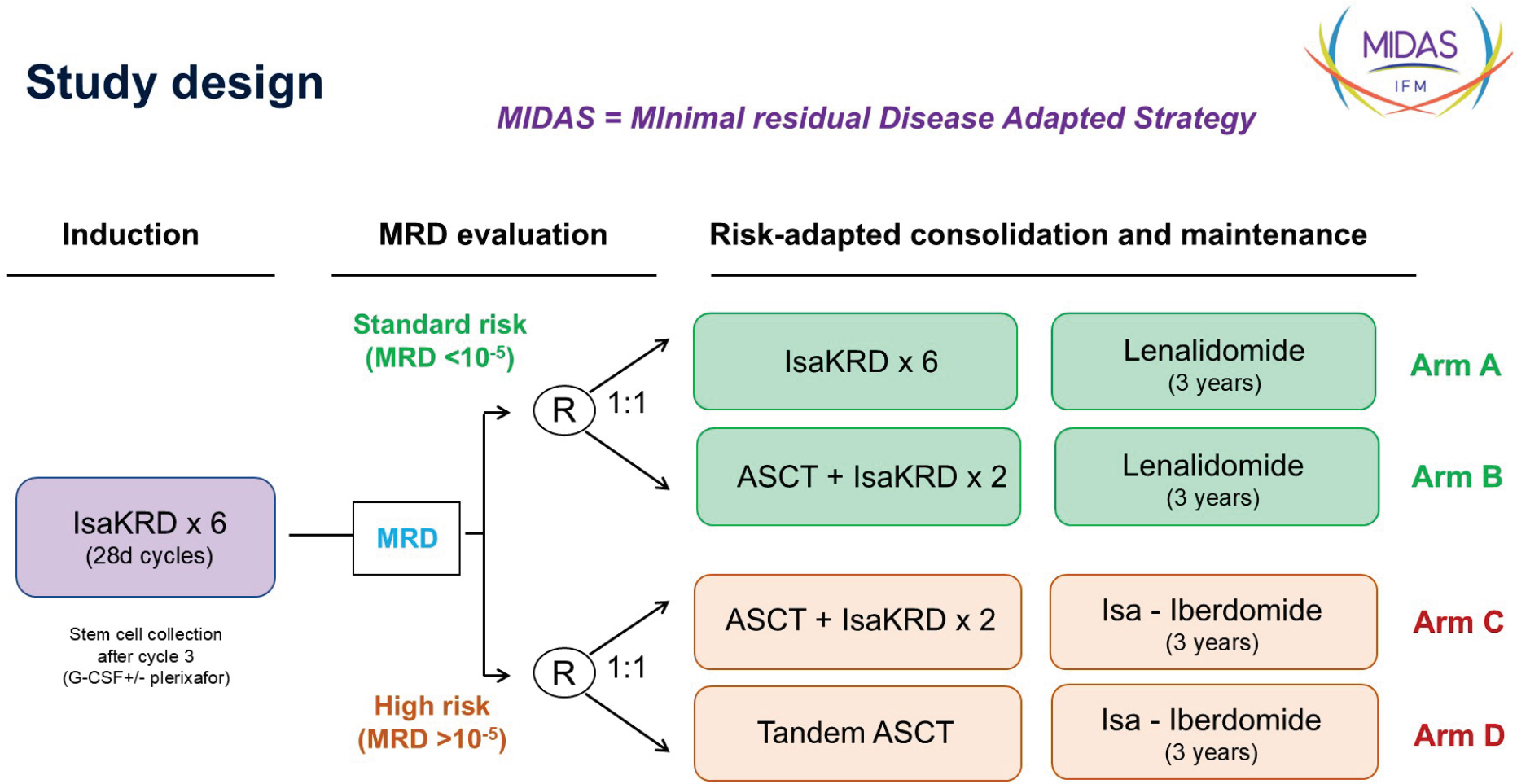
MIDAS-Studie

S205: **MINIMAL RESIDUAL DISEASE-DRIVEN STRATEGY FOLLOWING ISATUXIMAB-CARFILZOMIB-LENALIDOMIDE-DEXAMETHASONE INDUCTION IN TRANSPLANT-ELIGIBLE NEWLY DIAGNOSED MULTIPLE MYELOMA: PRIMARY ENDPOINTS OF THE PHASE 3 MIDAS TRIAL**

Aurore Perrot (Toulouse, France)

MIDAS-Studie

S205: **MINIMAL RESIDUAL DISEASE-DRIVEN STRATEGY FOLLOWING ISATUXIMAB-CARFILZOMIB-LENALIDOMIDE-DEXAMETHASONE INDUCTION IN TRANSPLANT-ELIGIBLE NEWLY DIAGNOSED MULTIPLE MYELOMA: PRIMARY ENDPOINTS OF THE PHASE 3 MIDAS TRIAL**



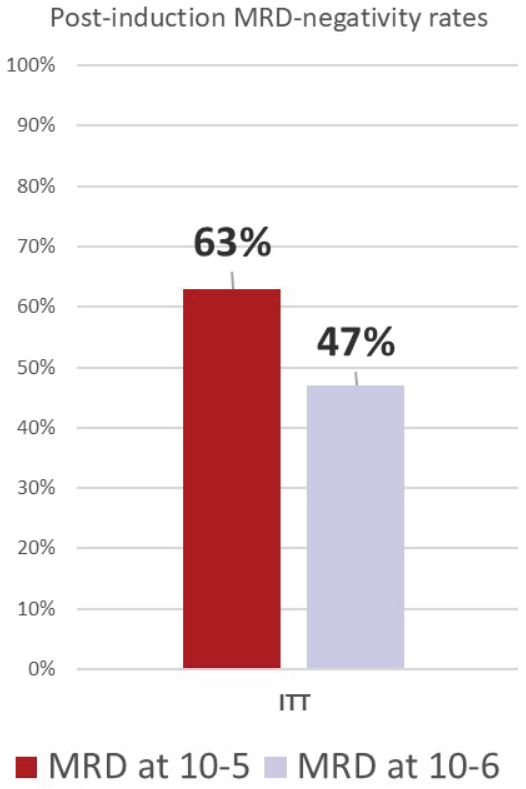
MIDAS-Studie

S205: **MINIMAL RESIDUAL DISEASE-DRIVEN STRATEGY FOLLOWING ISATUXIMAB-CARFILZOMIB-LENALIDOMIDE-DEXAMETHASONE INDUCTION IN TRANSPLANT-ELIGIBLE NEWLY DIAGNOSED MULTIPLE MYELOMA: PRIMARY ENDPOINTS OF THE PHASE 3 MIDAS TRIAL**

Induction

IsaKRD x 6
(28d cycles)

Stem cell collection
after cycle 3
(G-CSF+/- plerixafor)



	Arm A	Arm B	Arm C	Arm D
N	243	242	109	124
Age				
Median age	59.8 [36 - 66]	57.8 [25 - 66]	57.5 [36 - 65]	58.3 [33 - 65]
> 60y	118 (49%)	92 (38%)	35 (32%)	47 (38%)
Gender Male	143 (59%)	142 (59%)	58 (53%)	75 (60%)
Female	100 (41%)	100 (41%)	51 (47%)	49 (40%)
Performans status				
ECOG 0-1	206 (85 %)	216 (89 %)	100 (91 %)	111 (90%)
ECOG 2	37 (15 %)	26 (11 %)	9 (8 %)	12 (10%)
ISS				
I / II	96 / 114 (87%)	104 / 106 (87%)	52 / 48 (92%)	70 / 43 (91%)
III	33 (13 %)	32 (13 %)	9 (8 %)	11 (9%)
Cytogenetic abnormalities				
t(4;14)	29 (13%)	20 (9%)	3 (3%)	8 (7%)
t(11;14)	32 (14%)	46 (20%)	43 (41%)	59 (49%)
t(14;16)	1 (<1%)	5 (2%)	2 (2%)	5 (4%)
del(17p)	10 (4%)	10 (4%)	6 (6%)	12 (10%)
***TP53* mutation**	7 (3%)	9 (4%)	3 (3%)	5 (4%)
1q gain	55 (24%)	60 (26%)	27 (26%)	33 (27%)
del(1p32)	18 (8%)	23 (10%)	2 (2%)	7 (6%)
double del(1p32)	2 (1%)	4 (2%)	0 (0%)	1 (1%)
High-risk cytogenetics				
IFM LP >1	19 (8%)	18 (7%)	5 (5%)	13 (10%)
IMS/IMWG definition	58 (24%)	55 (23%)	18 (17%)	29 (23%)
Post-induction efficacy				
MRD < 10^{-6}	185 (76%)	177 (73%)	0	0
At least VGPR	229 (94%)	230 (95%)	96 (88%)	113 (91%)

MIDAS-Studie

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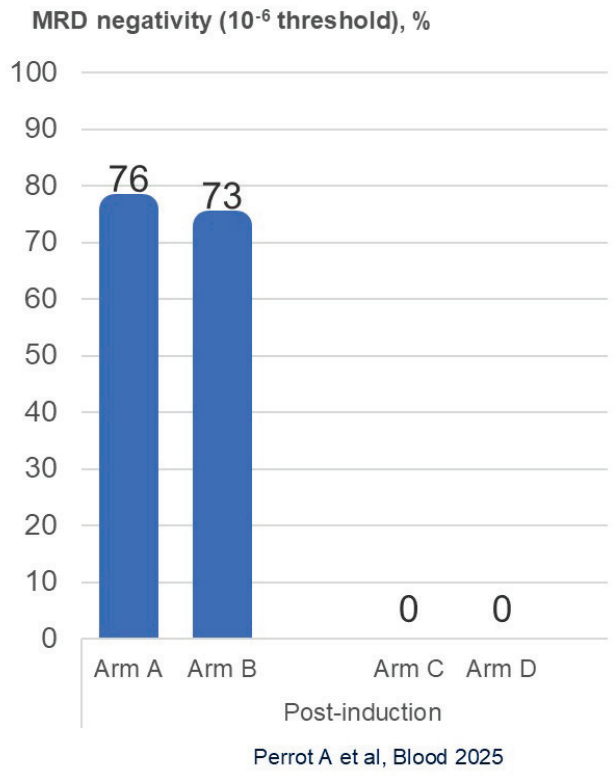

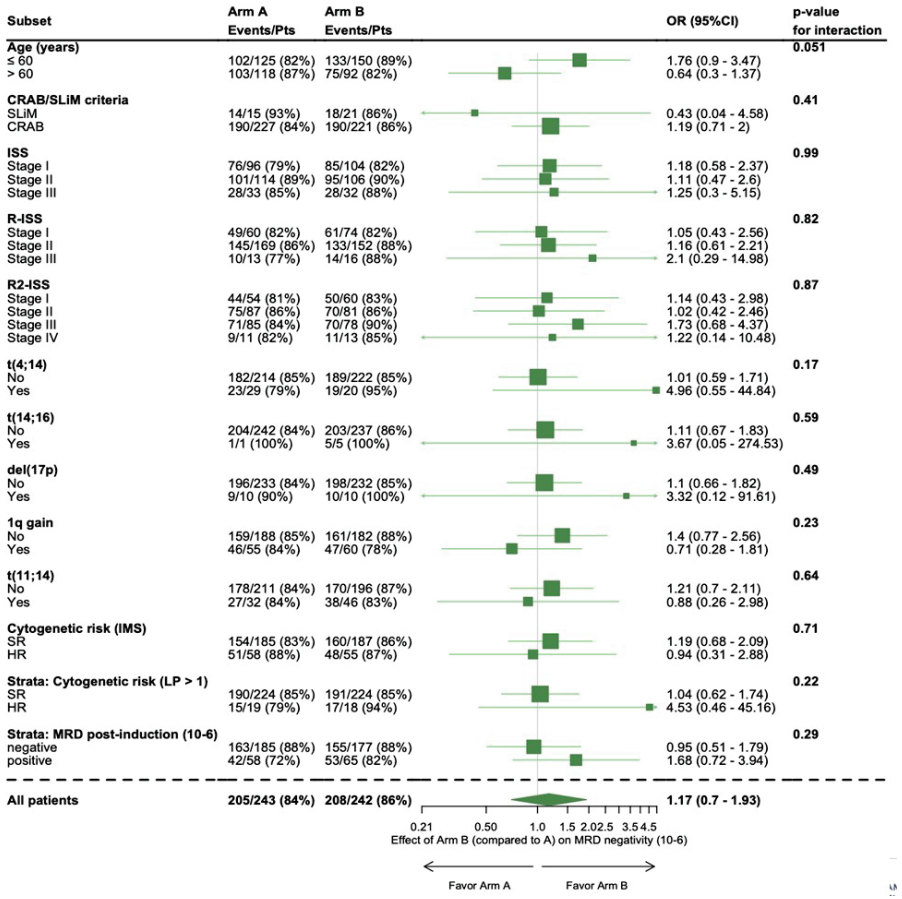

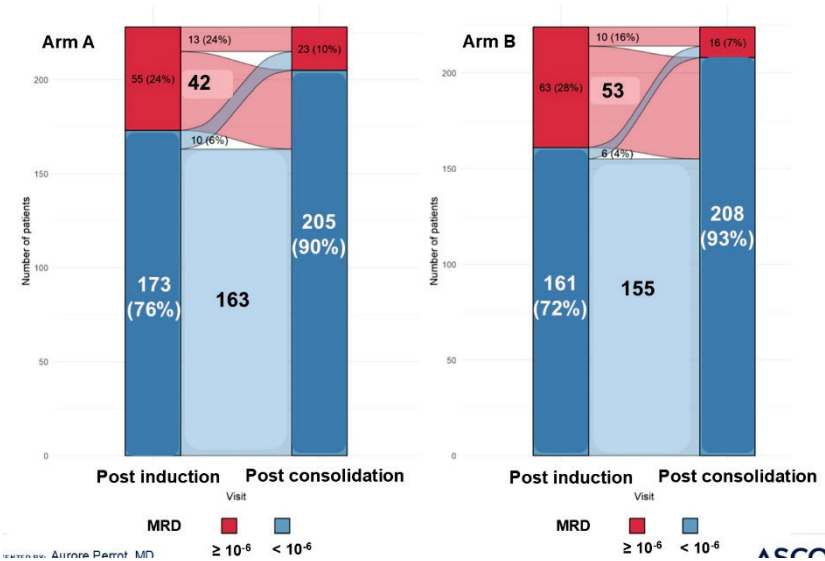

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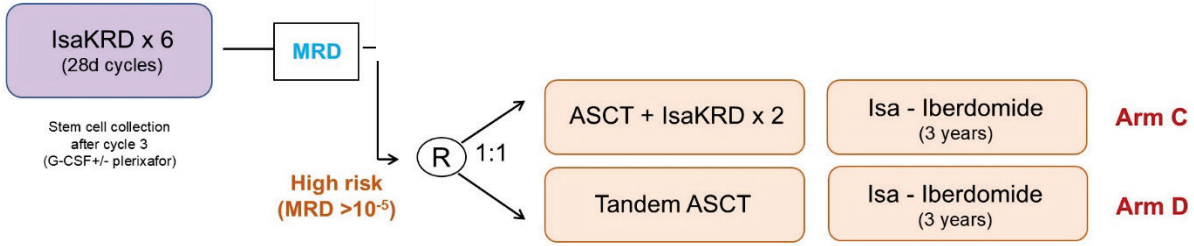

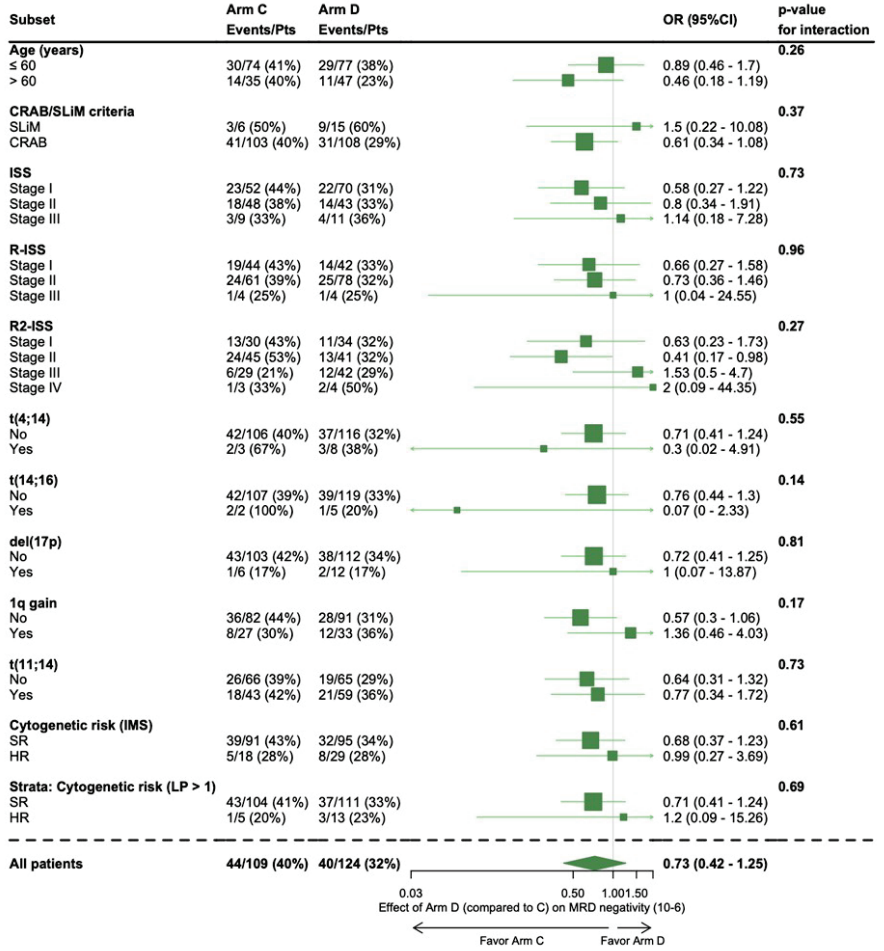

MIDAS-Studie

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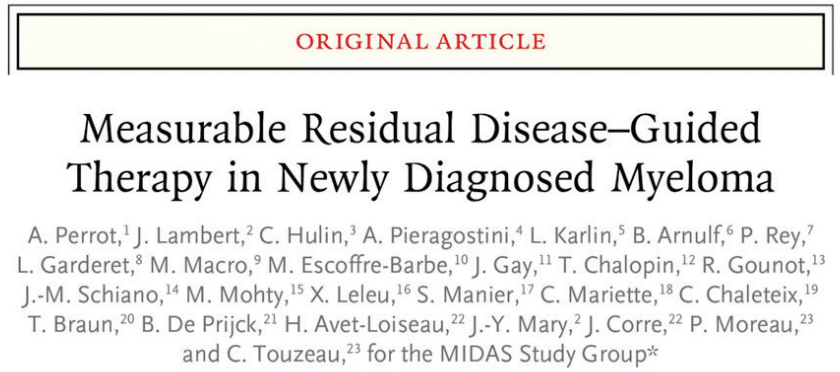
The academic MIDAS trial is the first phase 3 study to randomize a MRD-guided consolidation strategy in NDMM patients following six cycles of a quadruplet induction with IsaKRD

- **In MRD-negative patients, ASCT consolidation did not improve MRD outcomes compared to continued IsaKRD**
- **In MRD-positive patients, tandem ASCT offered no added MRD benefit over single transplant.**



ORIGINAL ARTICLE

Measurable Residual Disease–Guided Therapy in Newly Diagnosed Myeloma

A. Perrot,[1] J. Lambert,[2] C. Hulin,[3] A. Pieragostini,[4] L. Karlin,[5] B. Arnulf,[6] P. Rey,[7] L. Garderet,[8] M. Macro,[9] M. Escoffre-Barbe,[10] J. Gay,[11] T. Chalopin,[12] R. Gounot,[13] J.-M. Schiano,[14] M. Mohty,[15] X. Leleu,[16] S. Manier,[17] C. Mariette,[18] C. Chaleteix,[19] T. Braun,[20] B. De Prijck,[21] H. Avet-Loiseau,[22] J.-Y. Mary,[2] J. Corre,[22] P. Moreau,[23] and C. Touzeau,[23] for the MIDAS Study Group*

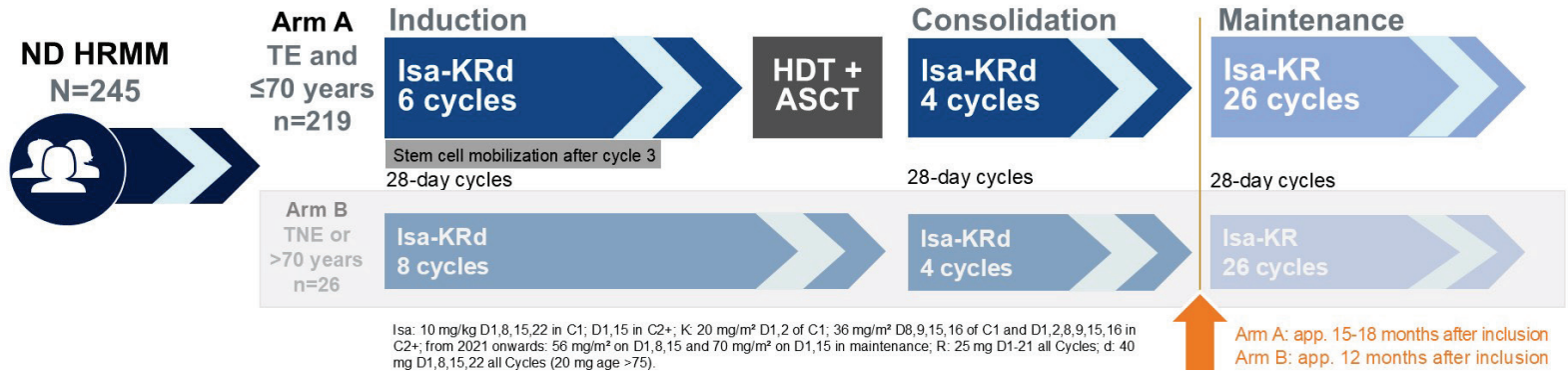
CONCEPT-Studie

S209: **ISATUXIMAB, CARFILZOMIB, LENALIDOMIDE, AND DEXAMETHASONE (ISA-KRD) FOR HIGH-RISK (HR) NEWLY DIAGNOSED MULTIPLE MYELOMA (NDMM): FIRST-TIME REPORT OF THE FULL COHORT OF TRANSPLANT-ELIGIBLE (TE) PATIENTS IN THE GMMG-CONCEPT TRIAL**

Lisa Leypoldt (Hamburg, Germany)

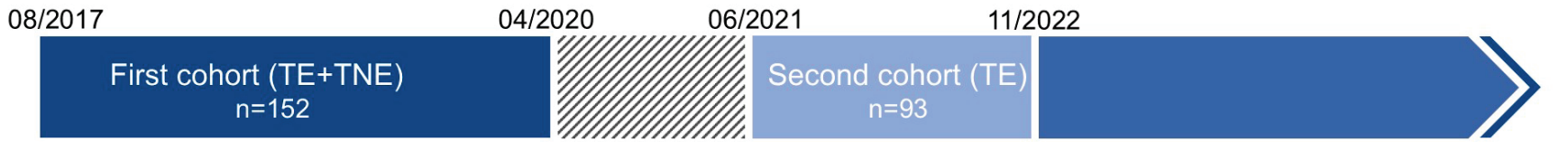
CONCEPT-Studie

S209: ISATUXIMAB, CARFILZOMIB, LENALIDOMIDE, AND DEXAMETHASONE (ISA-KRD) FOR HIGH-RISK (HR) NEWLY DIAGNOSED MULTIPLE MYELOMA (NDMM): FIRST-TIME REPORT OF THE FULL COHORT OF TRANSPLANT-ELIGIBLE (TE) PATIENTS IN THE GMMG-CONCEPT TRIAL



HRMM criteria: ISS stage II or III **PLUS** ≥1 of: del(17p), t(4;14), t(14;16) and/or ≥3 copies 1q21 (amp1q21)
Primary objective: MRD negativity after consolidation (NGF, 10^{-5})
Secondary objective: PFS; Selected tertiary objectives: ORR, OS

Recruitment



- Carfilzomib **BIW**
- ISS II/III plus ≥1 of del(17p), t(4;14), t(14;16), or **>** 3 copies 1q21

- Carfilzomib **QW**
- ISS II/III plus ≥1 of del(17p), t(4;14), t(14;16), or **≥** 3 copies 1q21

50 patients still on drug
Expected LPLV Q3/2026

CONCEPT-Studie

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		TE (n=219)	TNE (n=26)
Age	Years, median (range)	60 (31-73)	74 (64-87)
Sex	Female sex, No. (%)	99 (45.2)	14 (53.8)
ECOG	ECOG 0–1, No. (%)	189 (86.3)	18 (69.2)
	ECOG 2–3, No. (%)	27 (12.3)	7 (26.9)
ISS	II, No. (%)	119 (54.3)	13 (50.0)
	III, No. (%)	100 (45.7)	13 (50.0)
R2-ISS	Low/intermediate risk (I/II), No. (%)	2 (0.9)	1 (3.8)
	Intermediate/high risk (III/IV), No. (%)	217 (99.1)	25 (96.2)
HRCA	del(17p), No. (%)	89 (40.6)	11 (42.3)
	t(4;14), No. (%)	80 (36.5)	6 (23.1)
	t(14;16), No. (%)	36 (16.4)	2 (7.7)
	gain1q21 (≥3 copies), No. (%)	102 (46.6)	14 (53.8)
	≥2 HRCAs, No. (%)	78 (35.6)	7 (26.9)
LDH	Elevated LDH (>ULN), No. (%)	57 (26.0)	8 (30.8)
BM infiltration	Plasma cell infiltration %, median (range)	60 (0-100)	50 (5.5-100)

CONCEPT-Studie

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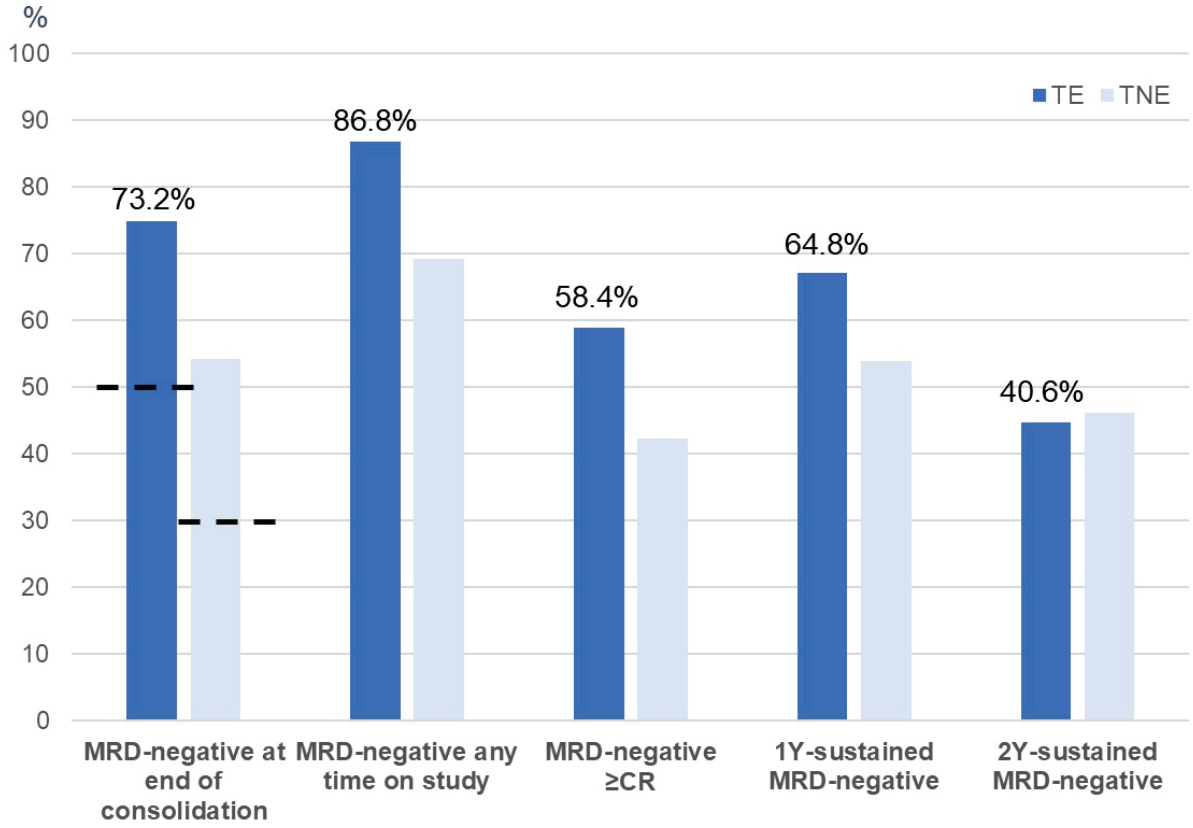
- Primary endpoint met with an MRD-negativity rate after consolidation of 73.2% (153/209), p= 1.91 x 10^{-13}
- Overall, 86.8% reached MRD-negativity at any time
- 58.4% reached MRD-negative ≥CR
- 64.8% and 40.6% retained ≥1-year- and ≥2-year-sustained MRD-negativity



CONCEPT-Studie

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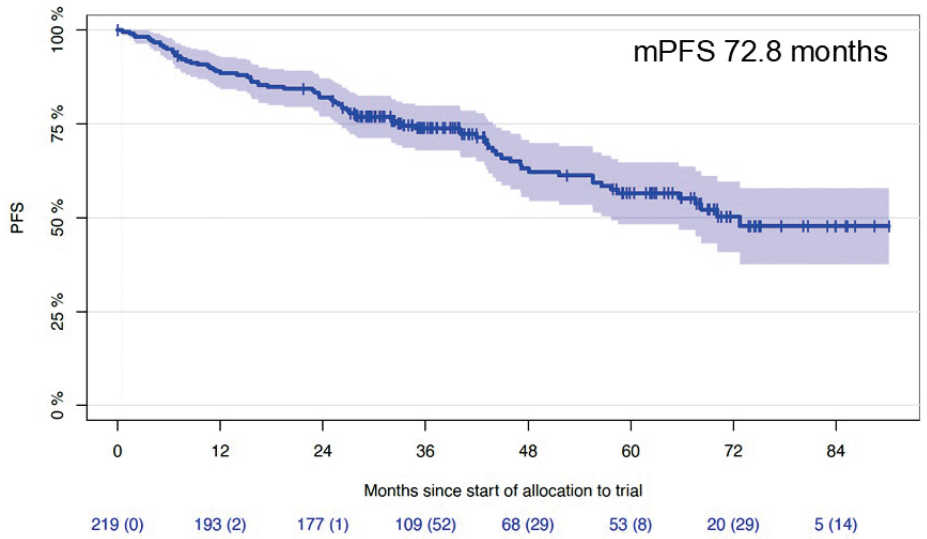
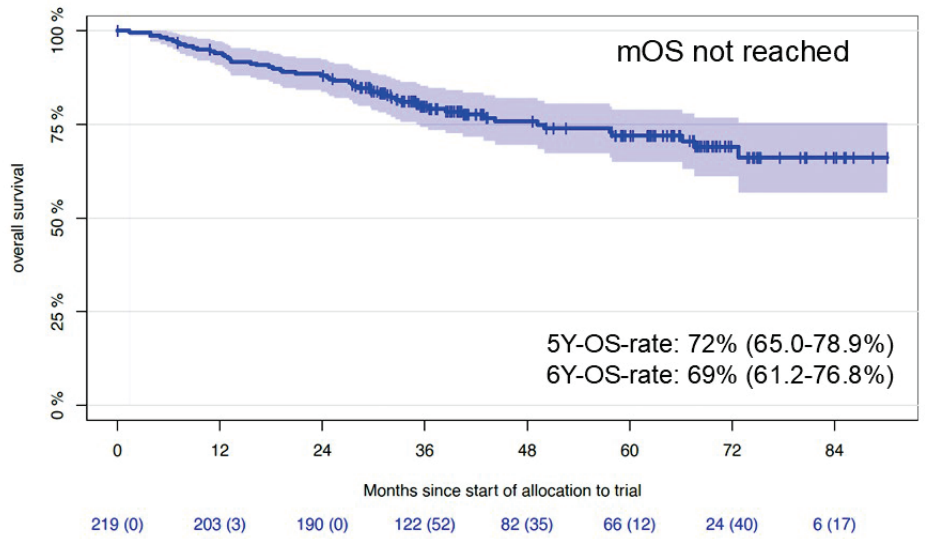
- Median follow-up of 43 months (0-90.2 months)
  - 1st cohort: 69 months (0-90.2 months)
  - 2nd cohort: 33 months (5.5-43.3 months)





TE, transplant-eligible; mOS, median Overall Survival; mPFS, median Progression-free Survival. Results for TE patients. Clinical data cut-off: April 28, 2025.

CONCEPT-Studie

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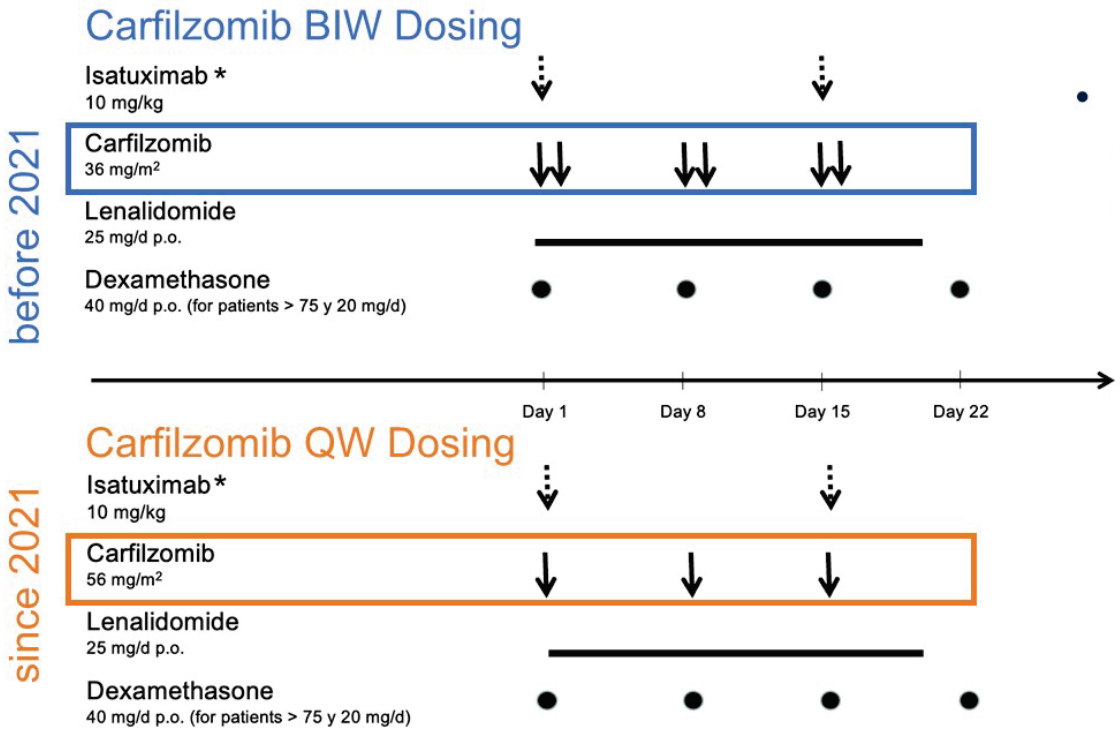
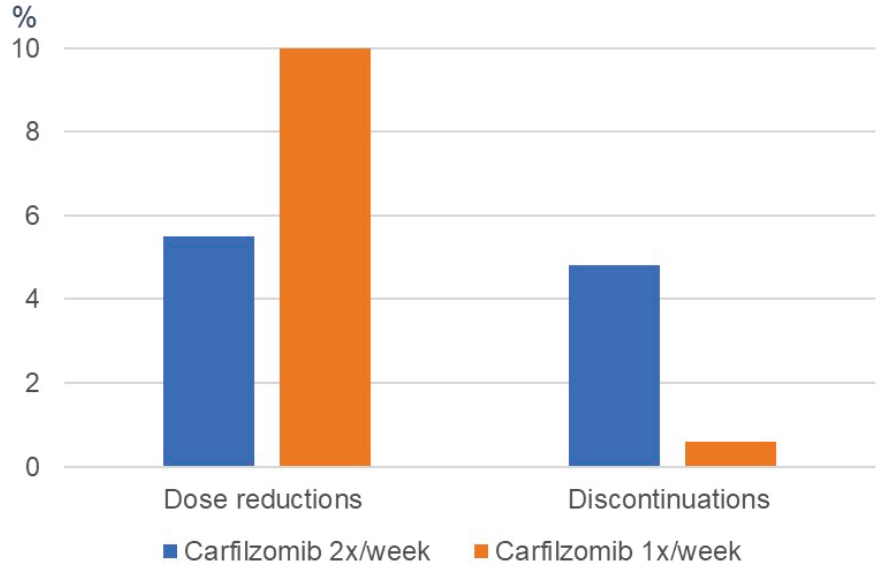


- Median relative dose intensity of carfilzomib was 78.8%
- More carfilzomib dose reductions but less carfilzomib discontinuations were observed with once weekly dosing



Primärtherapie des Multiplen Myeloms

MIDAS und CONCEPT Studie

- Isa-KRd zeigt sehr hohe Raten an MRD negativen Remissionen
- In diesem Kontext keine Überlegenheit hinsichtlich Remissionsvertiefung der Hochdosistherapie bei MRD negativen und der Tandem Hochdosistherapie bei MRD positiven Patient:innen
- Bislang keine PFS Daten vorliegend, Isa-KRd ist nicht zugelassen
- Für Hochrisikopatient:innen zeigt Isa-KRd im Kontext der Hochdosistherapie in der bislang größten prospektiv untersuchten Kohorte bilang unerreichte MRD negative Remissionen und PFS Daten

Kapitel 2

Rezidivtherapie:

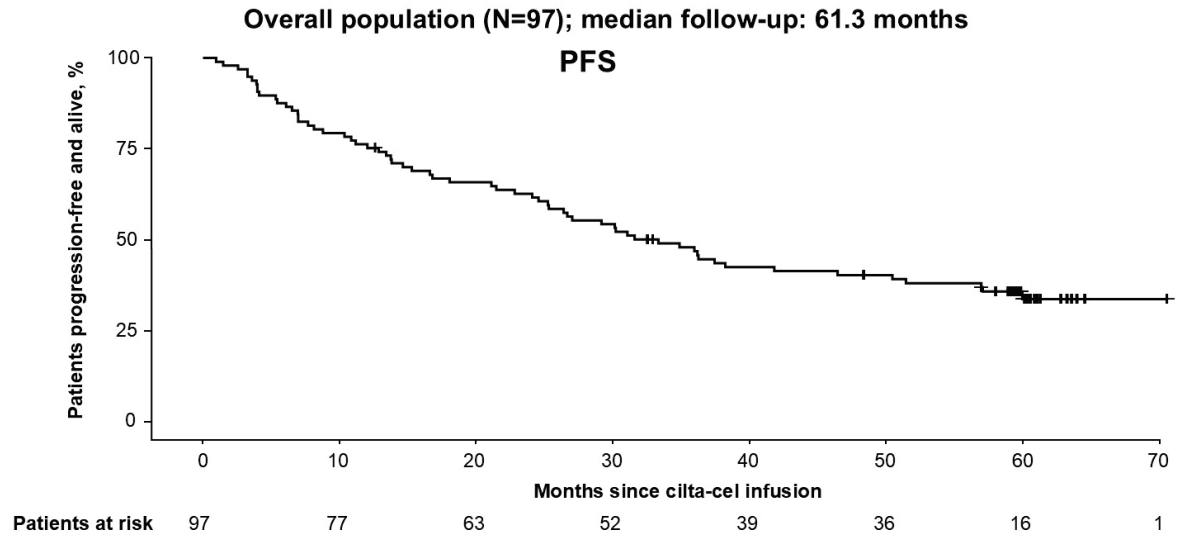
Was bleibt, was kommt?

IMMER WIEDER BEEINDRUCKEND!

- Cilta cel: Langzeitdaten aus CARTITUDE-1

Eligibility criteria

- Progressive MM per IMWG criteria
- ECOG PS ≤1
- Measurable disease
- ≥3 prior LOT or double refractory to a PI and an IMiD
- Prior PI, IMiD, and anti-CD38 mAb exposure

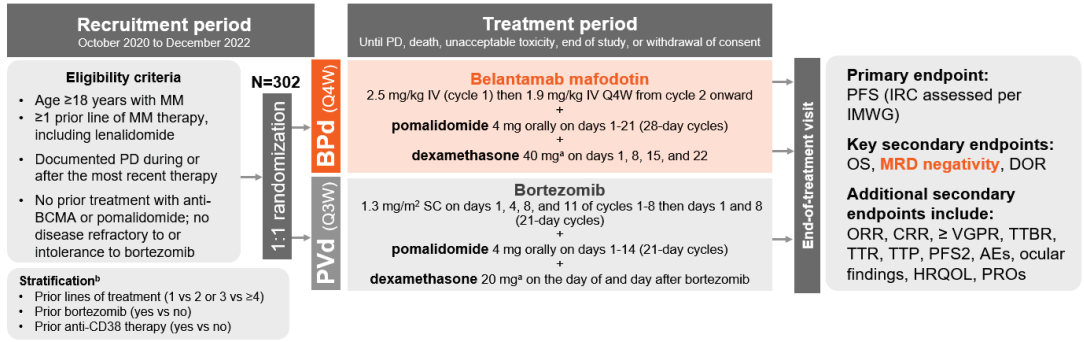


32 of 97 (33%) patients were treatment- and progression-free at ≥5 years

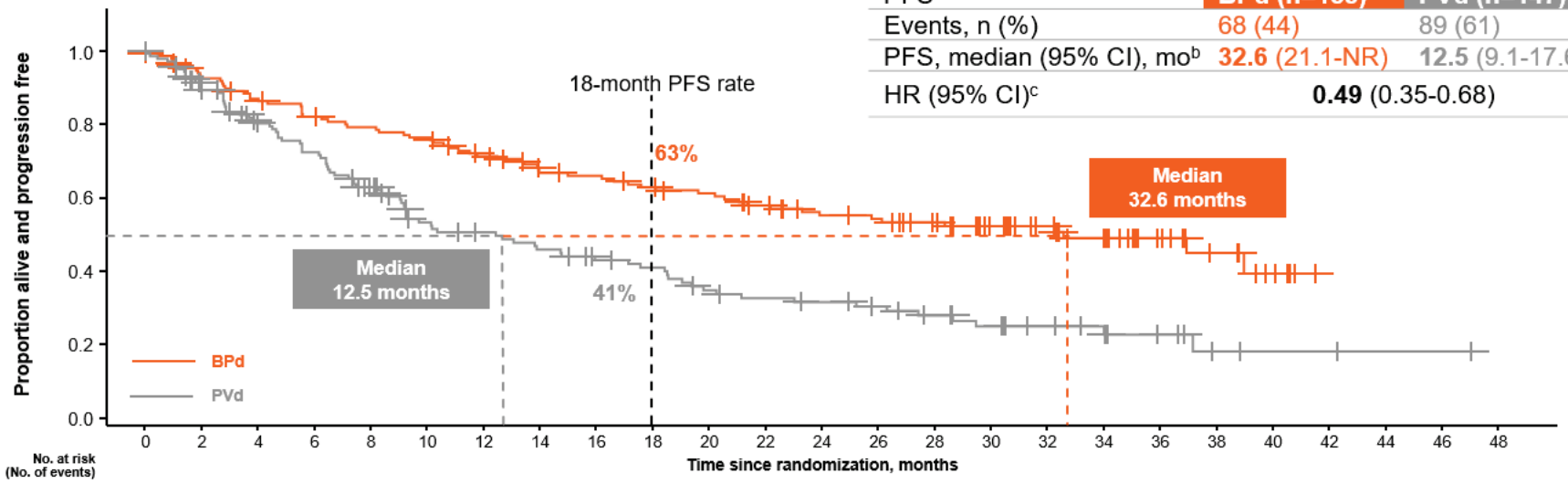
Patients with high-risk cytogenetics and extramedullary plasmacytomas were equally likely to be progression-free. Of note, the percentage of patients with high tumor burden was numerically lower among patients who were progression-free

ZURÜCK!

- Eine Substanz kommt zurück: Belantamab mafodotin Triplets



PFS[a]	BPd (n=155)	PVd (n=147)
Events, n (%)	68 (44)	89 (61)
PFS, median (95% CI), mo[b]	**32.6** (21.1-NR)	**12.5** (9.1-17.6)
HR (95% CI)[c]	**0.49** (0.35-0.68)	



TRIMM-3 Studie

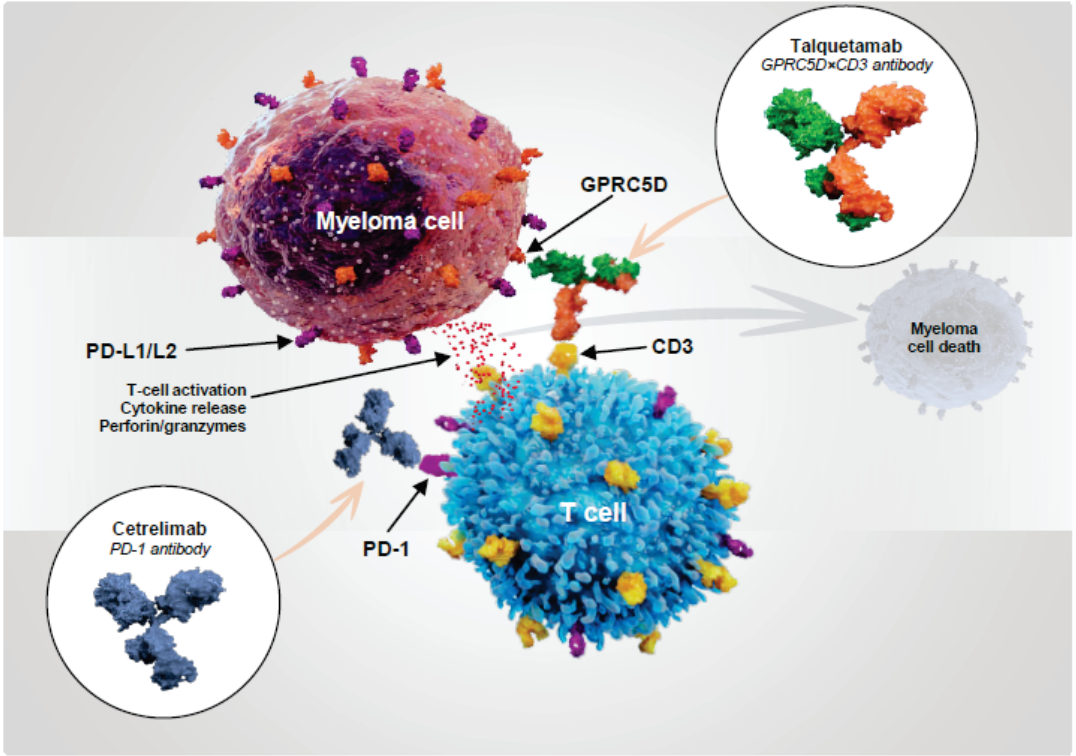
Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

Aurore Perrot et al., Centre Hospitalier Universitaire de Toulouse, Oncopole, Toulouse, France

TRIMM-3 Studie

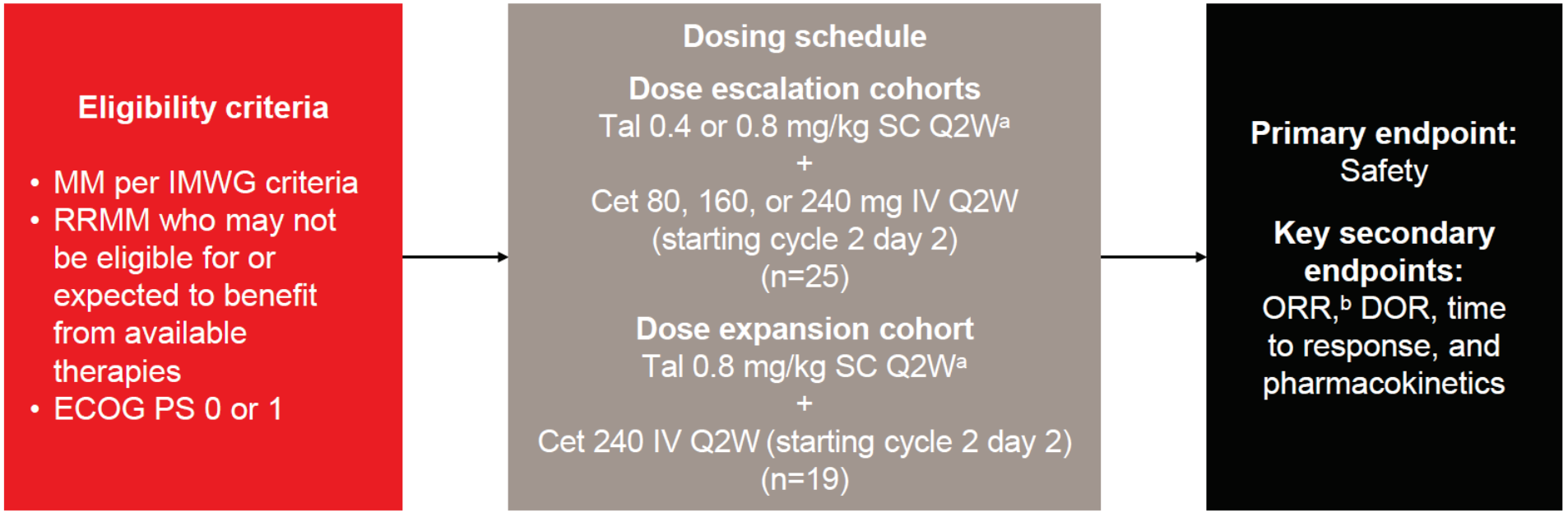
Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

- Tal is the first approved GPRC5D-targeting bispecific antibody for RRMM[1-3]
  - Patients with prior exposure to BsAb therapy is a newly emerging patient population with a high unmet need
- Cet is a monoclonal antibody that inhibits PD-1 to enhance T-cell activity and antitumor immunity[4]
- Combining Cet with T-cell redirection therapy may lead to additive antimyeloma effects by reinvigorating T cells



TRIMM-3 Studie

Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study



- Tal and Cet dosing regimens were escalated to their respective RP2Ds (Tal 0.8 mg/kg Q2W; Cet 240 mg Q2W)
- All patients in the dose expansion cohort had prior exposure to BsAb therapy[c]

TRIMM-3 Studie

Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

Characteristic	All patients (Tal + Cet) (N=44)
Age (years), median (range)	64 (45–87)
Male, n (%)	24 (54.5)
Race, n (%)	
White	22 (50.0)
Black/African American	2 (4.5)
Asian	1 (2.3)
Not reported	15 (34.1)
High cytogenetic risk,[a] n (%)	17 (43.6)
ISS stage, n (%)	
I	27 (61.4)
II	11 (25.0)
III	6 (13.6)
Time since diagnosis (years), median (range)	6.8 (1.0–16.8)

Characteristic	All patients (Tal + Cet) (N=44)
Prior LOT (n), median (range)	5 (2–11)
Prior stem cell transplantation, n (%)	34 (77.3)
Prior therapies, n (%)	
Triple class[b]	44 (100.0)
Penta drug[c]	29 (65.9)
BCMA-targeted therapy	31 (70.5)
CAR-T	9 (20.5)
Bispecific antibody	22 (50.0)
ADC	4 (9.1)
Refractory status, n (%)	
Triple class[b]	37 (84.1)
Penta drug[c]	15 (34.1)
Any prior BCMA	24 (54.5)
To last LOT	35 (79.5)

TRIMM-3 Studie

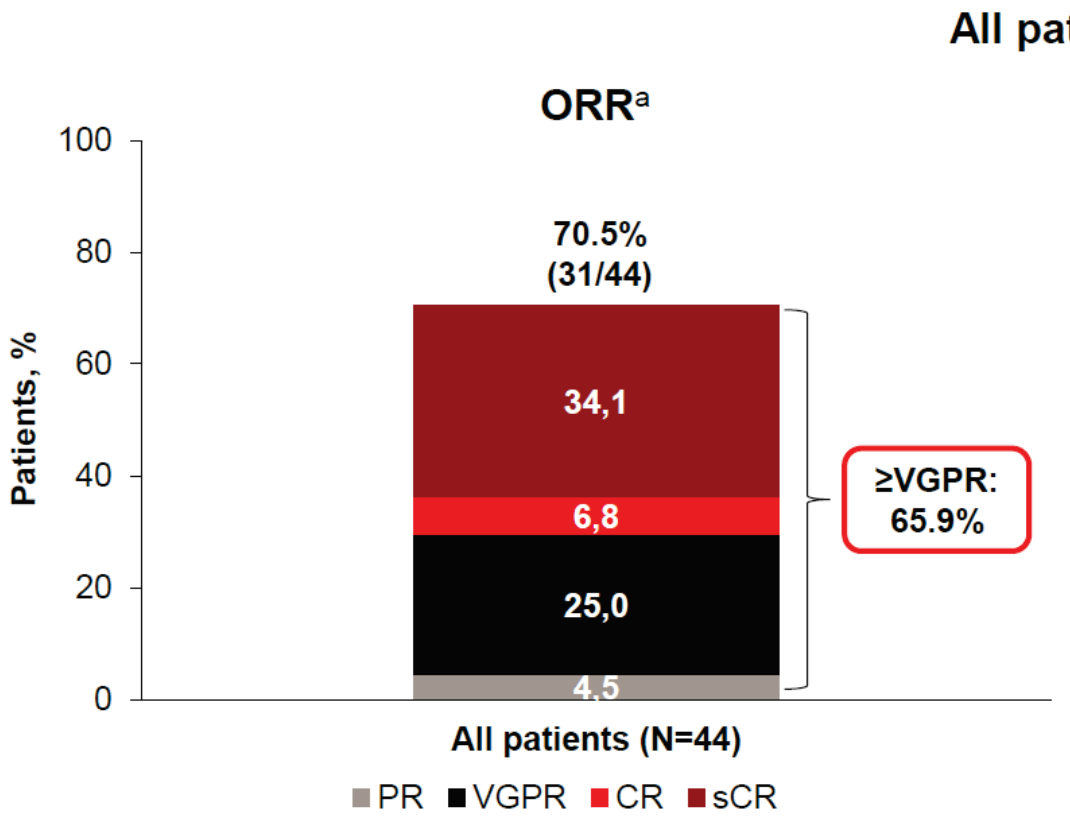
Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

AEs (≥25%),[a] n (%)	All patients (N=44)	
	Any Grade	Grade 3/4
Taste events[b]	36 (81.8)	0 (0)
Infections	36 (81.8)	13 (29.5)
Nail events[c]	33 (75.0)	0 (0)
Nonrash skin events[d]	31 (70.5)	0 (0)
CRS	27 (61.4)	0 (0)
Dry mouth	21 (47.7)	0 (0)
Weight decreased	15 (34.1)	1 (2.3)
Diarrhea	14 (31.8)	1 (2.3)
Rash events[e]	14 (31.8)	1 (2.3)
PD-1 immune-mediated events[f]	13 (29.5)[g]	3 (6.8)
Pyrexia	13 (29.5)	0 (0)

- CRS mostly confined to step-up and cycle 1 dosing (prior to the addition of Cet)
  - No grade ≥3 CRS
  - All events recovered
- ICANS[a] in 2 patients (both grade 1)

TRIMM-3 Studie

Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study



	All patients (N=44)
Median (range) follow-up, months	11.5 (1.5–32.3)
Median (range) time to first response, months	1.9 (0.8–17.5)
Median (range) time to best response, months	4.0 (1.1–22.8)
Median (range) DOR, months	16.8 (10.6–NE)
9-month DOR, %	72.6
6-month PFS, %	69.9

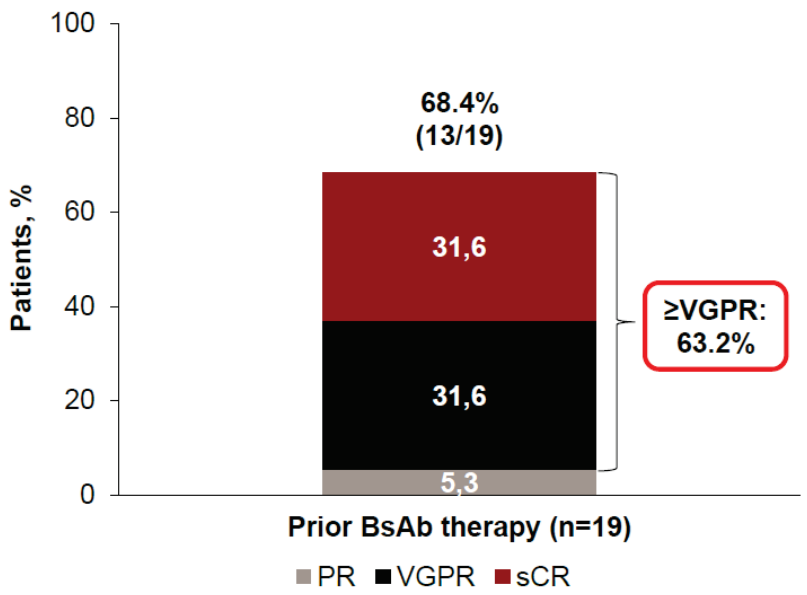
TRIMM-3 Studie

Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

TRIMM-3 (Tal + Cet): Deep and Durable Responses in Patients With Prior BsAb Therapy

Dose expansion cohort

ORR[a]



Data cut-off: April 2, 2025.

	Patients with prior BsAb therapy (n=19)
Median (range) follow-up, months	10.9 (1.5–17.5)
Median (range) time to first response, months	1.9 (0.8–3.7)
Median (range) time to best response, months	3.7 (1.8–7.4)
Median (range) DOR, months	12.0 (8.9–NE)
9-month DOR, %	65.9
6-month PFS, %	61.5

- 18 patients with BCMA-targeted BsAb therapy[b]
- 95% of patients with BsAb therapy as their immediate prior LOT
- Median of 39 days since prior exposure

TRIMM-3 Studie

Talquetamab + Cetrelimab in Patients With Relapsed/Refractory Multiple Myeloma: Initial Safety and Efficacy Results From the Phase 1b TRIMM-3 Study

- **Tal + Cet elicited deep and durable responses in patients with RRMM and prior BsAb therapy, similar to results with Tal + Dara[1]**
  - ORR was 68% (≥VGPR 63%) in patients with prior BsAb therapy
  - Median DOR of 12 months and 9-month DOR rate of 66% in patients with prior BsAb therapy
- **Safety profile was generally consistent with each individual agent,[2-4] supporting combinability of Tal**
  - Taste, skin, rash, and nail AEs were low grade, with no discontinuations of Tal
  - Grade 3/4 infections were comparable with Tal monotherapy in patients with prior CAR-T/BsAb therapy[1]
- **Higher induction of CD27 and lower expression of CD57 on CD8 T cells suggest greater T-cell reinvigoration potential, which may lead to improved outcomes in patients with prior BsAb therapy**
- **Together, in patients with prior BsAb therapy who may have altered T-cell function following treatment, Cet may potentiate Tal by reinvigorating T cells**

These data support Tal as a versatile combination partner and suggest potential activity of PD-1 inhibitors in RRMM

Trispezifischer Antikörper in der Myelomtherapie

First-in-human study of JNJ-79635322 (JNJ-5322), a novel, next-generation trispecific antibody (TsAb), in patients (pts) with relapsed/refractory multiple myeloma (RRMM): Initial phase 1 results.

Niels van de Donk et al., Amsterdam University Medical Center, Vrije Universiteit Amsterdam, Department of Hematology, Amsterdam, Netherlands

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First-in-human study of JNJ-79635322 (JNJ-5322), a novel, next-generation trispecific antibody (TsAb), in patients (pts) with relapsed/refractory multiple myeloma (RRMM): Initial phase 1 results.

Molecule	Implications
Dual-Targeted Molecule to Bind Both BCMA and GPRC5D	• Enhanced myeloma cell targeting due to **"double lock-down"** effect of binding 2 myeloma antigens • **More comprehensive targeting of myeloma cells** • BCMA-/GPRC5D+, BCMA+/GPRC5D-, and dual BCMA+/GPRC5D+ • **Prevention of antigen escape** • **Potential to improve GPRC5D-related safety profile** • **Manageable CRS profile with only 1 step-up dose needed**
Novel CD3, BCMA, and GPRC5D Binding Domains	

Key eligibility criteria
- Triple-class exposed RRMM[a]

Key objectives
- Identify RP2D
- Safety, including DLTs
- Preliminary efficacy assessment

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Characteristic	RP2D (n=36)	All doses (N=147)
Median prior LOT, n (range)	4.0 (2–11)	4.0 (1–11)
Exposure status, n (%)		
Triple-class[e]	36 (100.0)	147 (100.0)
Penta-drug[f]	15 (41.7)	72 (49.0)
BCMA/GPRC5D exposed	9 (25.0)	29 (19.7)
Prior BCMA	8 (22.2)	26 (17.7)
Prior GPRC5D	1 (2.8)	5 (3.4)
BCMA/GPRC5D naive	27 (75.0)	118 (80.3)
Antibody-drug conjugate	2 (5.6)	7 (4.8)
CAR-T therapy	4 (11.1)	12 (8.2)
Bispecific antibody	6 (16.7)	16 (10.9)
Refractory status, n (%)		
PI	19 (52.8)	86 (58.5)
IMiD	36 (100.0)	136 (92.5)
Anti-CD38	36 (100.0)	138 (93.9)
Triple-class[e]	19 (52.8)	79 (53.7)
Penta-drug[f]	2 (5.6)	10 (6.8)
To last LOT	34 (94.4)	132 (89.8)

Most common TEAEs,[a] n (%)	RP2D (n=36)	
	Any Grade	Grade 3/4
Hematologic TEAEs (≥10% of total)		
Neutropenia	15 (41.7)	11 (30.6)
Lymphopenia	16 (44.4)	15 (41.7)
Anemia	6 (16.7)	3 (8.3)
Thrombocytopenia	8 (22.2)	3 (8.3)
Leukopenia	5 (13.9)	3 (8.3)
Nonhematologic TEAEs (≥30% of total)		
Infections	29 (80.6)	12 (33.3)
Taste related[b]	21 (58.3)	NA
CRS	19 (52.8)	0
Nail related[c]	22 (61.1)	0
Skin (non-rash)[d]	23 (63.9)	0
Hypogammaglobulinemia[e]	10 (27.8)	1 (2.8)
Diarrhea	11 (30.6)	1 (2.8)
Fatigue	13 (36.1)	3 (8.3)

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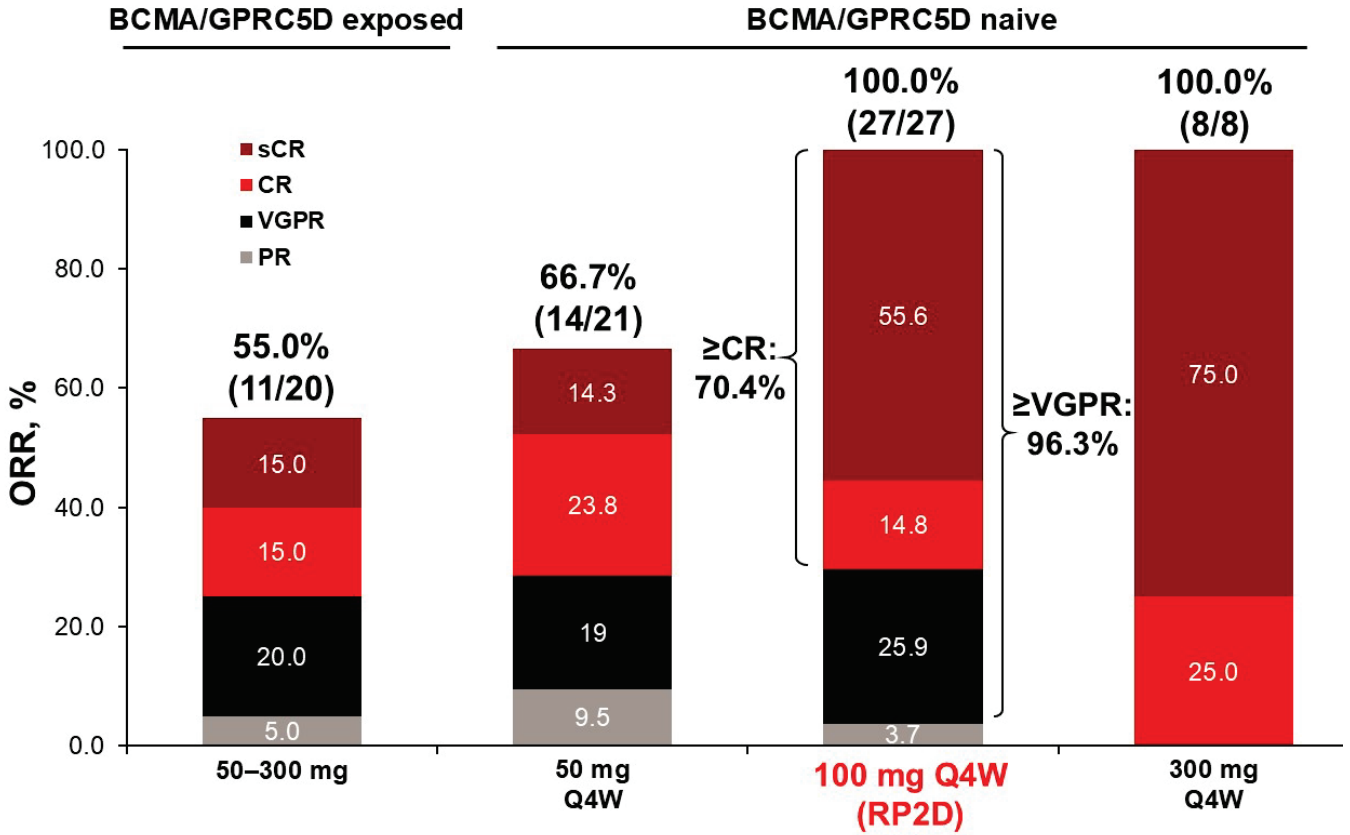

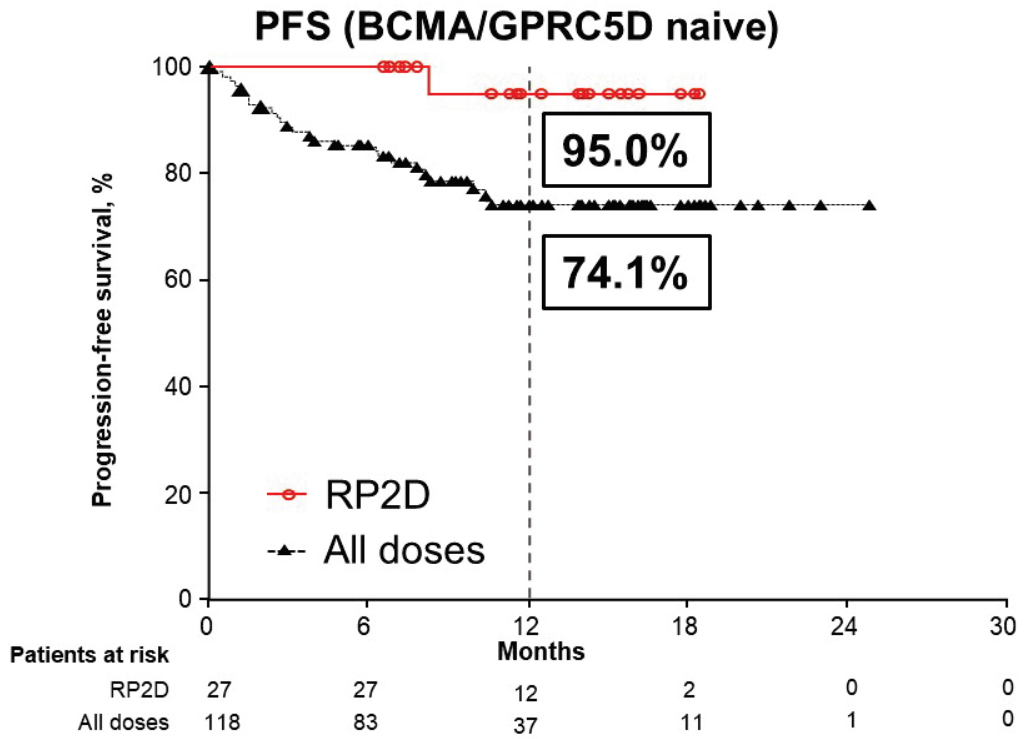

Trispezifischer Antikörper in der Myelomtherapie

First-in-human study of JNJ-79635322 (JNJ-5322), a novel, next-generation trispecific antibody (TsAb), in patients (pts) with relapsed/refractory multiple myeloma (RRMM): Initial phase 1 results.

- **JNJ-5322 100 mg Q4W SC with 1 SUD (2–8 days before first full dose) of 5 mg was selected as the RP2D**
- **JNJ-5322 appeared to have an improved or similar safety profile compared with bispecific antibodies targeting BCMA/GPRC5D**
  - Grade 3/4 infection rate of 28.6% with appropriate infection management
  - Improved oral TEAE profile, with minimal to no weight loss
  - CRS events were low grade with only 1 SUD; prophylactic tocilizumab data support option for outpatient dosing
- **ORR at the RP2D in patients naive to BCMA/GPRC5D of 100% (≥CR, 70.4%)**
  - 12-month PFS of 95.0% at the RP2D in BCMA/GPRC5D-naive patients

JNJ-5322, a BCMA×GPRC5D T-cell engaging trispecific antibody, demonstrated manageable safety and an ORR comparable to CAR-T, with convenient, off-the-shelf, Q4W dosing with 1 SUD to facilitate outpatient dosing

Zusammenfassung | Take-Home-Messages

- Quadruplet-Therapie ist Standard in der ersten Linie (quasi) altersunabhängig
- Induktionsregime wie Isa-KRd mit noch höherer Effektivität wie D-VRd beginnen die Transplantation bei MRD negativen Patient:innen in Frage zu stellen.
- Isa-KRd im CONCEPT Regime zeigt die höchsten Effektivitätsraten zur Behandlung des Hochrisikomyeloms
- CAR-T Zelltherapien im Rezidiv erzielen relavante Raten an Langzeitremissionen
- Belantamab mafodotin kommt in 2 Triplets zurück
- Checkpointinhibition bleibt ein interessantes Thema beim Myelom+
- Trispezifische Antikörper gehen in die klinische Prüfung, auch in Deutschland, auch in der ersten Therapielinie

Alle Kurzpräsentationen sind online unter

www.lymphome.de/eha2025

Für den Inhalt verantwortlich:

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Universitätsklinikum Hamburg-Eppendorf

Lymphom Kompetenz KOMPAKT

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EHA 2025

MAILAND, ITALIEN

12. – 15. Juni 2025

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