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Integrating Bispecific Antibodies Into Clinical Practice

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Lonial:
This is CME on ReachMD, and I'm Dr. Sagal Lonial, and here with me today is Dr. Caitlin Costello.

Let's find out how effectively you can integrate bispecific antibodies into your practice.

Dr. Costello, let's start off with a case that combines what we've learned in our previous episodes. What do you have for us?

Dr. Costello:
All right, let's start off with Marian. So she is your patient, Dr. Lonial. She's 76 years old. You've been taking care of her for 8 years and she was diagnosed with an IgG kappa myeloma. She's had 4 different lines of therapy that includes a stem cell transplant. She's had both of the proteasome inhibitors, including bortezomib and carfilzomib. She's had 2 immunomodulatory agents with pomalidomide and lenalidomide, and you treated her in various combinations also that included a CD38 monoclonal antibody. Well, she comes into clinic and says, “Dr. Lonial, I'm having back pain.” You order a PET scan because you've been noticing her M-spike’s been rising; you know that she has new bone lesions now, all consistent with clinical relapse. Now, Marian, she's a ripe 76, but she is a good, healthy woman. She has well-controlled blood pressure. Her ECOG performance is a 1, but she lives alone. She does have family, she has a daughter, and her daughter has 3 children. They're in the area, but they do live about 90 minutes away.

So you discuss different options. Initially, she leans towards going towards CAR T-cell therapy, but after further discussions with you in discussion, she says, “You know what, a bispecific T-cell engager may be better for me.”

So okay, she has chosen a bispecific antibody. What happens next?

Dr. Lonial:
Yeah, so I think in her case, likely given what we've done in the last few months to years, BCMA would likely be the target. And so she would get admitted for the first dosing of a BCMA bispecific that for us would likely include the first 3 doses, was what we would try and administer as an inpatient. She would be admitted, and then given the amount of disease that we've seen from a number of different parameters, we likely would start to do some tumor lysis prophylaxis, maybe just with a little bit of allopurinol to make sure we don't run into any renal complications. And then our nursing unit would be ready to manage her dosing with appropriate algorithms to help deal with CRS and neurotoxicity.

Before she gets admitted, she would likely get some education from our PharmD in the outpatient setting on what to expect, and just a further description to her family about what they can expect and what they need to be aware of so that should something happen after this step-up dosing and the hospitalization, they'll be prepared to manage whatever she might need in the coming weeks when the therapy is still relatively early and perhaps they haven't gotten comfortable with the dosing and the potential adverse events.

Dr. Costello:
Great. Okay. So let's say Marian comes into the hospital. She gets the BCMA T-cell engager that you both decided on and she gets her first step-up dose. 48 hours, she's doing fine. You've been evaluating her for signs of neurotoxicity with very specific ICE questionnaires. You have been checking her vital signs very frequently per your institutional standard. You give her the second step-up dose, and of course, it's, well, the middle of the night. Dr. Lonial, you are getting a phone call that says, “Dr. Lonial, Marian has developed a fever to 103. Her blood pressure seems a little lower now. It’s, let’s say, 95/65, and she feels a little more short of breath,” and the nurse noticed that she's suddenly needs a liter of oxygen. How do you manage this? What's happening here?

Dr. Lonial:
Yeah, I think this is a great example of grade 1 to likely grade 2 CRS. And I think from my perspective, the first thing I want to do is make sure we get good cultures and we give her some preemptive antibiotics just to make sure we've got her covered. But at the same time, gentle hydration because we know that older patients when they have a fever, they start to lose fluids. And then ultimately jump into a dose of tocilizumab. Tocilizumab I think it's key to give it early to prevent more severe CRS. There, again, is no real downside to giving a dose of tocilizumab other than the cost. And most patients who are getting a BCMA bispecific, the toxicity reverses relatively quickly and rarely proceeds beyond grade 2 CRS. So I think this is a reasonable strategy to try and mitigate side effects and maintain efficacy.

Dr. Costello:
Perfect. You gave her her dose; she was able to have her fevers go away; her oxygen is no longer required. She completed the step-up dosing and is now continuing on once a week as an outpatient.

You know, so I think this is a really nice example of some of the kind of nuances that we see with these T-cell engagers. New drugs mean new toxicities, which means we have much to learn. You know, each of the different 3 T-cell engagers that are available for relapsed/refractory myeloma each come with a REMS program that require that every institution or every center that is administering these basically have all of their physicians, their advanced practitioners, their nursing staff, the pharmacy all be taught, educated on what to expect and what the appropriate means of evaluating these patients and intervening is. And so in order to do that, we all have to go through these REMS programs.

Well, that is all the time we have today. Dr. Lonial, thank you for an excellent discussion, and thank you to all of our listeners for tuning in.

Announcer:
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