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on multiple myeloma

Teclistamab plus daratumumab in relapsed or refractory multiple myeloma

The New England Journal of Medicine, 2026 February 19; 394(8):739–52

Venetoclax-dexamethasone versus pomalidomide-dexamethasone in t(11;14)-positive relapsed/refractory multiple myeloma: primary results of the randomized, phase III CANOVA study

Journal of Clinical Oncology, 2026 January 20; 44(3):164–75

Prevention and treatment of venous thromboembolism in patients with multiple myeloma: clinical practice guidelines on behalf of the European Myeloma Network

HemaSphere, 2025 August 26; 9(8):e70177

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Clinical Lymphoma, Myeloma and Leukemia, 2026 April; 26(4):e502–10

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TECLISTAMAB PLUS DARATUMUMAB IN RELAPSED OR REFRACTORY MULTIPLE MYELOMA

The New England Journal of Medicine, 2026 February 19; 394(8):739–52

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BACKGROUND & AIM: There is a need for more effective and more easily accessible therapy options for patients with relapsed or refractory multiple myeloma (RRMM). Teclistamab is a bispecific antibody that showed deep and durable responses in heavily pretreated patients with RRMM in the phase 1/2 MajesTEC-1 trial. The aim of this trial (MajesTEC-3) was to evaluate the efficacy and safety of teclistamab combined with daratumumab (which has synergistic effects with teclistamab) versus investigator's choice of a daratumumab-based regimen in patients with RRMM.

STUDY DESIGN: International, open-label, randomized, phase 3 trial.

ENDPOINTS: Primary: progression-free survival. Secondary: complete response rate; overall response; minimal residual disease-negativity (10^{-5}); overall survival; safety.

METHOD: Adults with RRMM following one to three previous lines of therapy were randomized to receive teclistamab plus daratumumab (n=291) or daratumumab, dexamethasone and the investigator's choice of either pomalidomide (DPd) or bortezomib (DVd) (n=296). This paper reports on the first planned interim analysis.

RESULTS: At a median follow-up of 34.5 months (range 0.03–45.3 months), the teclistamab group had a significantly higher estimated 36-month progression-free survival rate than the DPd/DVd group, at 83.4% versus 29.7% (hazard ratio 0.17, 95% confidence interval 0.12–0.23; p<0.001). The overall response rate was also significantly higher in the teclistamab group (89.0% versus 75.3%; risk ratio 1.18, 95% CI 1.09–1.27), and more patients had a complete response or better (81.8% versus 32.1%; RR 2.55, 95% CI 2.14–3.03). Furthermore, a significantly higher proportion of teclistamab-treated patients had minimal residual disease-negativity versus those receiving DPd/DVd (58.4% versus 17.1%; RR 3.43, 95% CI 2.58–4.55). The estimated 36-month overall survival rate was 83.3% with teclistamab and 65.0% with DPd/DVd. Neutropenia was the most common grade 3/4 adverse event, occurring in 75.6% and 78.6% of the teclistamab and DPd/DVd groups, respectively; serious adverse events occurred in 70.7% and 62.4%, most commonly pneumonia (16.6% and 13.1%). Cytokine release syndrome occurred in 60.1% of teclistamab-treated patients; all events were grade 1/2 and transient, with a median duration of 2 days (range 1–22 days).

CONCLUSIONS: Compared with DPd/DVd, significant progression-free and overall survival benefits were seen with teclistamab plus daratumumab in patients with RRMM. Teclistamab had a predictable and manageable safety profile.

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VENETOCLAX-DEXAMETHASONE VERSUS POMALIDOMIDE-DEXAMETHASONE IN T(11;14)-POSITIVE RELAPSED/REFRACTORY MULTIPLE MYELOMA:

PRIMARY RESULTS OF THE RANDOMIZED, PHASE III CANOVA STUDY

Journal of Clinical Oncology, 2026 January 20; 44(3):164–75

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BACKGROUND & AIM: Venetoclax is a highly selective BCL-2 inhibitor that has shown promising efficacy and tolerability in patients with relapsed or refractory multiple myeloma (RRMM) with t(11;14)-positive cells, particularly in combination with dexamethasone, which enhances BCL-2 dependency. The aim of this study was to investigate the efficacy and safety of venetoclax plus dexamethasone compared with pomalidomide plus dexamethasone in patients with t(11;14)-positive RRMM.

STUDY DESIGN: International, randomized, open-label, phase 3 study.

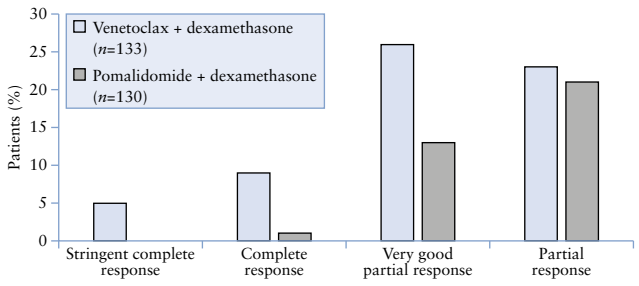
ENDPOINTS: Primary: progression-free survival (PFS). Secondary endpoints included the overall response rate, overall survival, the minimal residual disease (MRD)-negativity rate ($<10^{-5}$) and safety.

METHOD: Adults with t(11;14)-positive RRMM who had received at least two previous lines of therapy were randomized to receive oral venetoclax (800 mg; *n*=133) or pomalidomide (4 mg; *n*=130) once daily on days 1–21 in 28-day cycles. All patients also received oral dexamethasone. Treatment was continued until disease progression or unacceptable toxicity.

RESULTS: After a median follow-up of 24.9 months (range 1 day–54.9 months), median PFS was non-significantly longer in the venetoclax group versus the pomalidomide group (9.9 versus 5.8 months; hazard ratio 0.823, 95% confidence interval 0.596–1.136; *p*=0.24). Compared with the pomalidomide group, the venetoclax group had higher rates of overall response (62% versus 35%; Figure) and MRD-negativity (8% versus 0%), and longer median overall survival (32.4 versus 26.9 months; HR 0.856, 95% CI 0.612–1.197). Dose reductions and interruptions were similar between the two treatment groups. Grade 3 or worse treatment-emergent adverse event rates were lower with venetoclax versus pomalidomide (67% versus 83%), while serious treatment-emergent adverse event rates were similar (38% versus 40%).

CONCLUSIONS: Although the primary endpoint of a significant difference in PFS was not met, venetoclax plus dexamethasone resulted in numerically longer PFS and overall survival as well as higher response and MRD-negativity rates in patients with t(11;14)-positive RRMM. There were no new safety signals.

Responses among patients with a partial response or better



https://doi.org/10.1200/JCO-25-00924

PREVENTION AND TREATMENT OF VENOUS THROMBOEMBOLISM IN PATIENTS WITH MULTIPLE MYELOMA:

CLINICAL PRACTICE GUIDELINES ON BEHALF OF THE EUROPEAN MYELOMA NETWORK

HemaSphere, 2025 August 26; 9(8):e70177

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BACKGROUND & AIM: In patients with multiple myeloma, venous thromboembolism (VTE) is a frequent and life-threatening complication that can decrease life expectancy, interfere with scheduled treatment and negatively impact a patient's quality of life. Effective prevention and management of VTE in this population would improve patient outcomes. On behalf of the European Myeloma Network, the aim of this article was to provide evidence-based recommendations for VTE prevention and treatment in patients with multiple myeloma.

ARTICLE TYPE: Evidence-based recommendations.

FINDINGS: Patients with multiple myeloma should be informed about VTE risk and educated about modifiable risk factors, clinical signs and symptoms, and how to access pathways for prompt diagnosis and treatment. VTE risk should be regularly assessed using validated risk assessment scores. Patients with an intermediate or high risk of VTE should be treated with prophylactic low-molecular-weight heparin (LMWH) or factor Xa inhibitors such as rivaroxaban or apixaban. This is also recommended for all patients initiating carfilzomib- or immunomodulatory-based therapy. Patients classified as having a low risk of VTE should be treated with low-dose aspirin. Pharmacological prophylaxis should be administered for at least 6 months, followed by re-evaluation and consideration of downgrading thromboprophylaxis on a case-by-case basis.

Patients diagnosed with VTE should promptly receive therapeutic doses of LMWH or factor Xa inhibitors for at least 6 months, with both initial and regular evaluation of bleeding risk. In patients eligible for long-term secondary prevention of VTE at 6 months after the index event, low-dose apixaban 2.5 mg twice daily is preferred over the full-dose of 5 mg twice daily. Long-term anticoagulation requires a personalized strategy, taking into consideration a patient's haematological response, disease status and bleeding risks, as well as patient preference, drug-to-drug interactions and impact on quality of life.

The prompt diagnosis and treatment of VTE in ambulatory patients with multiple myeloma is essential, and it is strongly recommended that specialized outpatient thrombosis consultations are established, especially considering the complexity of managing patients with multiple myeloma. More effective and updated VTE risk assessment tools are also needed for this population, as well as further randomized trial data to determine optimal thromboprophylaxis treatment and duration.

CONCLUSION: These guidelines provide healthcare workers with recommendations to improve the prevention and treatment of VTE in patients with multiple myeloma, which should improve both clinical outcomes and patient quality of life.

https://doi.org/10.1002/hem3.70177

REAL-WORLD OUTCOMES OF HIGH DOSE MELPHALAN AND AUTOLOGOUS STEM CELL TRANSPLANTATION IN PATIENTS WITH MULTIPLE MYELOMA OLDER AND YOUNGER THAN 65 YEARS

Clinical Lymphoma, Myeloma and Leukemia, 2026 April; 26(4):e502–10

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BACKGROUND & AIM: The treatment of multiple myeloma using high-dose chemotherapy and autologous stem-cell transplantation (HDT/ASCT) as induction therapy is a standard approach in patients younger than 65 years, but its feasibility and efficacy in older patients is less certain. The aim of this study was to compare outcomes following HDT/ASCT treatment in patients with multiple myeloma aged ≤65 versus >65 years.

STUDY DESIGN: Retrospective single-centre study.

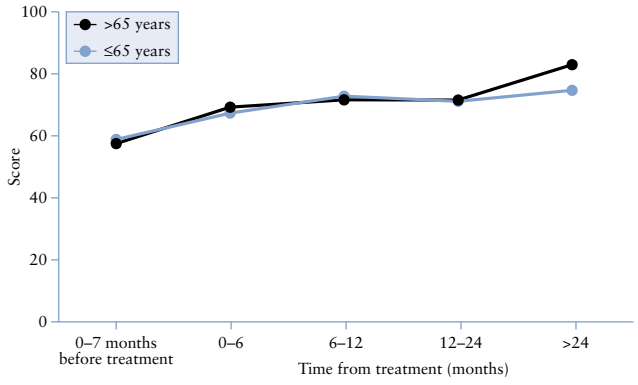
ENDPOINTS: Coprimary: overall survival; time to next treatment or death. Secondary outcomes included complications and quality of life (QoL).

METHOD: Data were retrieved on all patients with multiple myeloma who received a first HDT/ASCT at a single centre between 2013 and 2022 (285 aged ≤65 years and 109 aged >65 years). QoL data on patients with multiple myeloma treated with HDT/ASCT (n=108) were obtained from the OncoLifeS data-biobank for oncology, for which patients are asked to complete the EORTC QLQ-C30 questionnaire at inclusion and 6, 12, 18 and 24 months later.

RESULTS: There were no significant differences in baseline characteristics between the two groups. Both the ≤65 and >65 years groups had similar median overall survival (116 versus 101 months; p=0.56) and median time to next treatment or death (38 versus 41 months; p=0.65). Incidences of complications were low and comparable between age groups, except for a higher incidence of fever in older patients (77% versus 64%; p=0.02). There were five cases of transplantation-related mortality (>65 years: 1%, ≤65 years: 2%). No significant differences between the age groups were seen in QoL scores in the course of HDT/ASCT treatment, and scores in both groups seemed to improve over time (Figure).

CONCLUSION: No clinically significant differences in efficacy, toxicity or QoL were seen between patients aged ≤65 versus >65 years following HDT/ASCT treatment for multiple myeloma, supporting its use in fit older patients.

Global health status scores for patients aged ≤65 or >65 years treated with HDT/ASCT



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