

FramingHam

on multiple myeloma

Daratumumab in transplant-ineligible or -deferred
newly diagnosed multiple myeloma:
minimal residual disease in CEPHEUS

Blood Advances, 2026 August 25; 10(16):5594–606

Optimizing lenalidomide therapy in renal impairment:
analysis of renal response in the prospective REMNANT
study in transplant-eligible
newly diagnosed multiple myeloma

Blood Cancer Journal, 2025 December 22; 15(1):214

Teclistamab-based induction treatment
in transplant-eligible, newly diagnosed multiple myeloma:
a phase 2 trial

Nature Medicine, 2026 July; 32(7):2440–8

Sustained disease remission after a limited duration
of bispecific antibody therapy in patients
with multiple myeloma

HemaSphere, 2026 June 7; 10(6):e70396

ISSUE 4, 2026



CURRENT TITLES

Framingham *on atherosclerosis*
 Framingham *on chronic lymphocytic leukaemia*
 Framingham *on cystic fibrosis*
 Framingham *on dermatology*
 Framingham *on epilepsy*
 Framingham *on gastroenterology*
 Framingham *on HIV/AIDS*
 Framingham *on menopause*
 Framingham *on nephrology*
 Framingham *on neurology*
 Framingham *on non-Hodgkin lymphoma*
 Framingham *on ophthalmology*
 Framingham *on respiratory diseases / asthma*
 Framingham *on systemic fungal infections*
and many more...

OUR PURPOSE

The Framingham series of publications is designed to meet clinical specialists' need for a reliable guide to the most important articles appearing in their field. Each issue presents an authoritative selection from the recently published literature, with the emphasis on evidence-based medicine. Articles are recommended for inclusion by Framingham's editorial office and an advisory board headed by key opinion leaders in the relevant clinical area. Framingham's team of medical writers prepares original abstracts of these articles, in a structured format that presents the main points at a glance. Our aim is to convey the essence of each article in a concise but readable style. Issues are published every three to six months.

ADVISORY BOARD

Jo Caers, MD PhD
 Haematologist,
 Department of Haematology,
 Laboratory of Haematology,
 CHU of Liège,
 University of Liège,
 Liège, Belgium

Cecilie Hveding, MD PhD
 Associate Professor in
 Haematology,
 Department of Haematology
 and Coagulation,
 Sahlgrenska University Hospital,
 Gothenburg, Sweden

Thomas Lund, MD PhD
 Head of the Department of
 Haematology,
 Vejle Hospital, Vejle,
 And Senior Researcher,
 Centre for Innovative Medical
 Technology (CIMT),
 University of Southern Denmark,
 Odense, Denmark

Fredrik Schjesvold, MD PhD
 Head of Oslo Myeloma Center,
 Department of Haematology,
 Oslo University Hospital, and
 KG Jebsen Center for B Cell
 Malignancies,
 University of Oslo,
 Oslo, Norway

DISCLAIMER

The abstracts in this publication are prepared with care to reflect the views expressed by the author or authors of the original source material. These views are not necessarily those of the publisher. While every care is taken to avoid errors, these cannot always be avoided; readers are advised to independently validate any data and recommendations contained herein before acting on this information. The publisher disclaims any responsibility or liability for the accuracy of such information.

Framingham

Editor

Catherine Harris Booth

Consulting Editor

Niels van de Donk, MD PhD
 Professor of Haematology,
 Cancer Center Amsterdam,
 Amsterdam UMC,
 Location VU University Medical
 Center,
 Amsterdam, the Netherlands

Medical Writers (this issue)

Lorraine Law
 Kevin West

Art Design

Jan van Halm

Layout and Printing

Drukmeesters,
 Zwijndrecht, the Netherlands

Publishing Director

Evelien Enter

Publisher

Waldemar H.G. Dobrowolski

Framingham bv

Postbus 1593
 1200 BN Hilversum
 The Netherlands
www.framinghampublishers.com

Framingham *on multiple myeloma*
 is published with the support of
Sanofi AB
 Stockholm, Sweden

MAT-BE-2600456 (ver. 2) 10 2026

© 2026 Framingham bv



DARATUMUMAB IN TRANSPLANT-INELIGIBLE OR -DEFERRED NEWLY DIAGNOSED MULTIPLE MYELOMA: MINIMAL RESIDUAL DISEASE IN CEPHEUS

Blood Advances, 2026 August 25; 10(16):5594–606

AUTHORS: ZWEEGMAN S, FACON T, HUNGRIA V, ET AL., ON BEHALF OF THE CEPHEUS STUDY INVESTIGATORS
CENTRE FOR CORRESPONDENCE: DEPARTMENT OF HEMATOLOGY, AMSTERDAM UMC, VRIJE UNIVERSITEIT
AMSTERDAM, CANCER CENTER AMSTERDAM, AMSTERDAM, THE NETHERLANDS

BACKGROUND & AIM: The CEPHEUS study demonstrated that transplant-ineligible or transplant-deferred patients with newly diagnosed multiple myeloma (NDMM) treated with daratumumab, bortezomib, lenalidomide and dexamethasone (D-VRd) had higher rates of overall minimal residual disease (MRD)-negativity than those who received bortezomib, lenalidomide and dexamethasone (VRd). The aim of the present paper was to provide an expanded analysis of MRD from the CEPHEUS study.

STUDY DESIGN: Expanded analysis of a multicentre, randomized, open-label, phase 3 study.

ENDPOINT: Overall MRD-negativity rate.

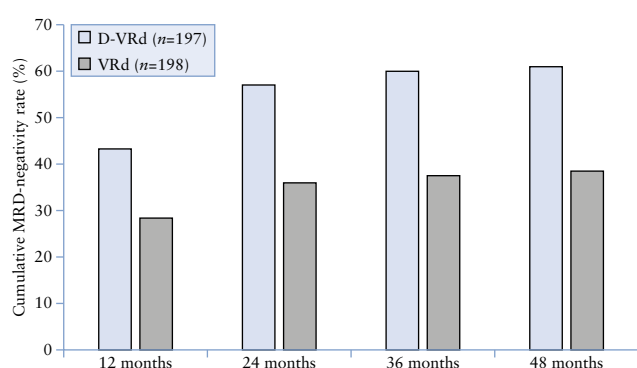
METHOD: In CEPHEUS, transplant-ineligible or -deferred patients with NDMM

were randomized to receive D-VRd ($n=197$) or VRd ($n=198$). The current post-hoc expanded analysis evaluated overall MRD-negativity at thresholds of 10^{-5} and 10^{-6} (intention-to-treat).

RESULTS: Over a median follow-up of 58.7 months, the overall MRD-negativity rate was 60.9% with D-VRd versus 39.4% with VRd at the 10^{-5} threshold (odds ratio 2.37, 95% confidence interval 1.58–3.55; $p<0.0001$) and 46.2% versus 27.3%, respectively, at the 10^{-6} threshold (OR 2.24, 95% CI 1.48–3.40; $p=0.0001$). Moreover, the rate of sustained MRD-negativity for ≥ 12 months was significantly higher with D-VRd versus VRd at both the 10^{-5} threshold (49.2% versus 27.3%; $p<0.0001$) and the 10^{-6} threshold (34.0% versus 16.2%; $p<0.0001$), with similar findings at ≥ 24 and ≥ 36 months. MRD-negativity rates were higher with D-VRd than VRd at all measured timepoints and cumulatively (Figure). Finally, participants with MRD-negativity trended towards more favourable progression-free survival with D-VRd versus VRd at both the 10^{-5} threshold (hazard ratio 0.61, 95% CI 0.35–1.06; $p=0.755$) and the 10^{-6} threshold (HR 0.66, 95% CI 0.31–1.41; $p=0.2811$).

CONCLUSION: Among 395 transplant-ineligible or -deferred patients with NDMM, D-VRd significantly increased overall and sustained MRD-negativity rates versus VRd.

Cumulative MRD-negativity rates at the 10^{-5} threshold



OPTIMIZING LENALIDOMIDE THERAPY IN RENAL IMPAIRMENT: ANALYSIS OF RENAL RESPONSE IN THE PROSPECTIVE REMNANT STUDY IN TRANSPLANT-ELIGIBLE NEWLY DIAGNOSED MULTIPLE MYELOMA

Blood Cancer Journal, 2025 December 22; 15(1):214

AUTHORS: ASKELAND FB, BUGGE VH, RASMUSSEN AM, LYSÉN A, HAUKÅS E, MOKSNES M, EILERTSEN AL, TSYKUNOVA G, EIKEN BD, LEKNES NM, ROLKE J, STAVSETH V, SAMSTAD E, HALLSTENSEN RF, SZATKOWSKI D, HANSEN AA, NILSEN AS, SLØRDAHL TS, ABDOLLAHI P, SCHJESVOLD F
CENTRE FOR CORRESPONDENCE: OSLO MYELOMA CENTER, DEPARTMENT OF HEMATOLOGY, OSLO UNIVERSITY HOSPITAL, OSLO, NORWAY

BACKGROUND & AIM: Renal impairment is a serious complication of newly diagnosed multiple myeloma (NDMM) that considerably reduces overall survival, and rapid renal recovery is therefore an important treatment goal. Because lenalidomide is renally excreted, current guidelines recommend that patients with transplant-eligible NDMM and renal impairment should receive a reduced dose of lenalidomide induction therapy (5–10 mg/day), but studies have challenged the need for such cautious dosing. The aim of this analysis was to evaluate the efficacy and safety of higher-dose lenalidomide induction therapy in transplant-eligible patients with NDMM and renal impairment.

STUDY DESIGN: Subanalysis of a prospective, observational, open-label phase 2/3 study.

ENDPOINTS: Safety; renal response rate; overall response rate.

METHOD: Transplant-eligible adults with NDMM, including those with renal impairment – defined as estimated glomerular filtration rate (eGFR) <50 mL/min/1.73 m² – received induction therapy with four 21-day cycles of bortezomib, lenalidomide and dexamethasone. Lenalidomide was adjusted for eGFR, with a dose of 25 mg/day for patients with eGFR ≥ 30 mL/min/1.73 m² and 15 mg/day for those with eGFR <30 mL/min/1.73 m².

Patients were grouped according to renal status: eGFR ≥ 50 mL/min/1.73 m² ($n=301$), 30–49 mL/min/1.73 m² ($n=37$) or <30 mL/min/1.73 m² ($n=44$; including seven patients on dialysis in cycle 1).

RESULTS: Worsening renal function was significantly more frequent in patients with versus without renal impairment (5% versus 0%; $p<0.005$). Two grade 4 renal events occurred in patients with renal impairment, of which one was possibly related to lenalidomide. Adverse event rates were generally comparable between patients with and without renal impairment, with the exceptions of anaemia (12% versus 2%; $p<0.001$) and thrombocytopenia (7% versus 0.3%; $p<0.001$). There were no treatment-related deaths. Overall, 77% of patients with baseline renal impairment had a renal response and 57% had a complete renal response during induction. Median eGFR improved from 39 to 66 mL/min/1.73 m² in patients with baseline eGFR 30–49 mL/min/1.73 m² and from 18 to 58 mL/min/1.73 m² in those with eGFR <30 mL/min/1.73 m². Overall response rates were similar across patients with and without renal impairment (82–95%).

CONCLUSION: In transplant-eligible patients with NDMM and renal impairment, the use of lenalidomide at a full or moderately reduced dose during induction therapy was found to be both safe and effective.



TECLISTAMAB-BASED INDUCTION TREATMENT IN TRANSPLANT-ELIGIBLE, NEWLY DIAGNOSED MULTIPLE MYELOMA: A PHASE 2 TRIAL

Nature Medicine, 2026 July; 32(7):2440–8

AUTHORS: RAAB MS, WEINHOLD N, KORTÜM KM, ET AL., ON BEHALF OF THE GMMG-HD10/DSMM-XX (MAJESTEC-5) STUDY INVESTIGATORS

CENTRE FOR CORRESPONDENCE: HEIDELBERG MYELOMA CENTER AND GMMG STUDY GROUP, DEPARTMENT OF MEDICINE V, HEIDELBERG UNIVERSITY HOSPITAL AND MEDICAL FACULTY HEIDELBERG, HEIDELBERG, GERMANY

BACKGROUND & AIM: The combination of teclistamab (a bispecific antibody targeting B-cell maturation antigen and CD3) and daratumumab has been shown to have strong efficacy as early as first relapse among patients with relapsed or refractory multiple myeloma. The aim of this study was to evaluate the safety and efficacy of teclistamab-based regimens in patients with newly diagnosed multiple myeloma (NDMM).

STUDY DESIGN: Prespecified pooled analysis of a multicentre, open-label, non-randomized, multicohort phase 2 study.

ENDPOINTS: Primary: safety. Secondary endpoints included rates of overall response, minimal residual disease (MRD)-negativity and MRD-negative complete response.

METHOD: Across three cohorts, 49 patients with transplant-eligible NDMM received at least one dose of teclistamab combined with either daratumumab and lenalidomide ($n=30$) or with daratumumab, lenalidomide and bortezomib ($n=19$). Endpoints

were evaluated overall across the cohorts. This analysis focused on the induction and autologous stem-cell transplantation phases, up to the premaintenance phase.

RESULTS: Overall, 45 patients (91.8%) had grade 3/4 treatment-emergent adverse events, mostly lymphopenia (59.2%), neutropenia (59.2%) and leukopenia (18.4%); there were no grade 5 treatment-emergent adverse events. A total of 27 patients (55.1%) had serious adverse events, mostly pyrexia (12.2%), and 40 patients (81.6%) experienced any-grade infections (grade 3/4 in 36.7%; Table). Additionally, 33 patients developed cytokine release syndrome (all grade 1/2, all resolved and none leading to treatment discontinuation). No patient experienced treatment-related immune effector cell-associated neurotoxicity syndrome. In terms of efficacy, all 49 patients had an overall response. MRD-negativity (at 1×10^{-5} and/or 1×10^{-6} sensitivity) was seen in all 46 evaluable patients at postinduction cycles 3 and 6, and in all 40 evaluable samples at premaintenance. By the premaintenance timepoint, 45 patients (91.8%) had an MRD-negative complete response. The pooled overall total median stem cell yield was $8.1 \times 10^6/\text{kg}$.

CONCLUSION: Among patients with transplant-eligible NDMM, frontline induction treatment with teclistamab-based regimens was generally well tolerated and associated with excellent response rates.

Most common treatment-emergent infections ($n=49$)

Patients, %	Any grade	Grade 3/4
Upper respiratory tract infection	40.8	2.0
COVID-19	20.4	6.1
Nasopharyngitis	14.3	0
Pneumonia	8.2	6.1
Viral upper respiratory tract infection	8.2	2.0
Infection	6.1	4.1
Respiratory tract infection	6.1	0
Bronchitis	4.1	0



SUSTAINED DISEASE REMISSION AFTER A LIMITED DURATION OF BISPECIFIC ANTIBODY THERAPY IN PATIENTS WITH MULTIPLE MYELOMA

HemaSphere, 2026 June 7; 10(6):e70396

AUTHORS: VEGA G, MORILLO D, RIEDHAMMER C, SMITS F, BAG A, JULIAN K, GOMIS NT, GAISAN CM, BERMUDEZ MA, SHAH MR, MOHYUDDIN GR, DHAKAL B, RASCHE L, SCHINKE C, D'SOUZA A, SZABO A, VAN DE DONK NW, CHAKRABORTY R, MOHAN M

CENTRE FOR CORRESPONDENCE: DIVISION OF HEMATOLOGY/ONCOLOGY, DEPARTMENT OF MEDICINE, MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE, WISCONSIN, USA

BACKGROUND & AIM: Patients with relapsed or refractory multiple myeloma (RRMM) usually receive bispecific antibody (BsAb) therapy indefinitely until disease progression or intolerable side effects, but some patients have been reported to have sustained remission after just a limited duration of BsAb therapy. The aim of this study was to report on sustained remission, immune reconstitution and infection risk off-treatment in a larger cohort of patients with RRMM treated with a finite duration of BsAb therapy.

STUDY DESIGN: Multicentre, prospective observational study.

ENDPOINTS: Relapse-free survival (RFS); mortality; cumulative risk of grade 3 or worse infection; use of intravenous immunoglobulin (IVIg) replacement.

METHOD: Data were retrieved on adults with RRMM who had discontinued BsAb therapy for reasons other than disease progression or death, and who had at least 3 months of ongoing remission off-therapy.

RESULTS: A total of 81 patients were included in the analysis. The median duration of BsAb therapy was 7 months (range 1–40 months) and all patients had responded to therapy. Median follow-up after discontinuing BsAbs was 19 months

(range 4–61 months). The 36-month RFS rate was 62% and estimated median RFS was 43 months. Seven patients had sustained remission of at least 3 years after BsAb discontinuation. On multivariate analysis, worse RFS was associated with extramedullary disease (hazard ratio 7.42, 95% confidence interval 2.29–24; $p \leq 0.001$) and a higher number of prior lines of therapy (HR 8.17, 95% CI 2.02–33; $p \leq 0.003$). The non-relapse and relapse mortality rates were 7.7% and 30%, respectively. There were 74 grade 3 or worse infections (of which three were grade 5) in 28 patients, with a cumulative incidence of 41%. Recurrent infection rates stabilized 6 months after discontinuation, dropping to zero after 900 days. Between discontinuation and follow-up, 404 IVIg treatments were given to 51 patients; 67.4% of these patients still had low IgG levels 180 days after discontinuation but almost 90% of patients had normalized levels after 900 days. Patients who received IVIg within 90 days after treatment discontinuation did not have significantly lower IgG levels than those who did not, suggesting that immune reconstitution eventually occurred regardless of IVIg necessity.

CONCLUSION: Patients with a finite duration of BsAb therapy were found to maintain durable responses, with an improving infection risk and immune reconstitution over time.

