

CONVEGNO INTERREGIONALE SIE

Delegazioni Umbria e Marche

Società Italiana di Ematologia

NOVITÀ TERAPEUTICHE NEI LINFOMI NON-HODGKIN E MIELOMA MULTIPLO: FOCUS SU ANTICORPI BISPECIFICI E CAR-T

Assisi, Sala Conciliazione, Comune di Assisi
4 Novembre 2026

Relazione

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Disclosures of Name Surname

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
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53 aa ♀

APR *Gozzo multinodulare in eutiroidismo*

Novembre 2022. Diagnosi Mieloma Multiplo IgA lambda stadio I ISS, R-ISS II, evoluzione da MGUS
BOM PC 40%
FISH t(14:16), ampl 1q21
Laboratorio. IFS CM IgA lambda 14 g/l, BJ lambda 60 mg/24h, IgG 243 mg/dl, IgA 2124 mg/dl, IgM 25 mg/dl, B2m 2.3 mg/l, sFLC kappa 2.6 mg/l, lambda 114 mg/l, sK/L 0.02, Hb 12.2 g/dl, creatinina 0,65 mg/dl. Ca 9.4 mg/dl, LDH 122 UI/L
PET-TC. *Disomogenea distribuzione del tracciante glicometabolico in ambito scheletrico, Lesione litica VII costa sn*

➢ *Arruolamento protocollo EMN18 TERAPIA I linea*
03/2022 – 06/2023. VTD x 4 (PR) + ASCT x 2 + VTD x 2 >>> VGPR, MRD 10.6 pos
07/2023 – 05/2024. Mantenimento Dararumumab - Ixazomib x 6 cicli
Trattamento interrotto PD

Giugno 2024
PD

PET-TC. Diffusa attività ipermetabolica in ambito midollare, focalità lesioni litiche D4, L5, VII costa sn, ischio dx

Laboratorio. Hb 10.7 g/dL, creatinina 0.96 mg/dL, ca 10.7 mg/dl, LDH 186 UI/l, IFS CM IgA lambda 21.9 g/L, IgG 250 mg/dl, IgA 2944 mg/dl, IgM < 25 mg/dl, B2m 6.35 mg/l, BJ lambda 1185 mg/24h, proteinuria 1401mg/24 ore

06/2024 >> 04/2025. Terapia di II linea KRD X 10
Migliore risposta RC

Aprile 2025
PD

PET-TC. Numerose, patologiche, focalità in ambito scheletrico «bilateralmente archi costali emitoraci, teste omerali, scapole, somi rachide D/L L5, D2, multiple focalità sacro, ossa iliache, ischio dx, femori, nodulo inframuscolare loggia post coscia dx

Laboratorio. Hb 10. g/dL, creatinina 1 mg/dL, ca 10.7 mg/dl, LDH 200 UI/l, IFS CM IgA lambda 20 g/L, IgG 400 mg/dl, IgA 3000 mg/dl, IgM < 25 mg/dl, B2m 6 mg/l, BJ lambda 985 mg/24h, proteinuria 1201 mg/24 ore

04/25 – 06/25. Terapia III linea EloPD x 3
Migliore risposta SD

Agosto 2025

Laboratorio. Hb 6.5 g/dL, PLT 141.000/mmc, creatinina 5.83 mg/dL (0.73 mg/dl), azotemia 158 mg/dl, acido urico 11 mg/dl, ca 11 mg/dl, LDH 488 ui/l, IFS CM IgA lambda 18.7 g/L, B2m 3.63 mg/l, BJ lambda 1000 mg/24h, proteinuria 1300 mg/24 ore, sFLC lambda 3990 mg/L, K 3.6 mg/L, sK/L
Eco addome. Reni in sede nella norma per dimensioni ed ecostruttura
Consulenza nefrologica. IRA acuta da interessamento renale in corso MM

04/08 Dexa 20 mg ev x 4 giorni
12/08 Terapia IV linea dose incrementale Teclistamab 0.06 mg/kg g1, 0.3 mg/kg g2, 1.5 mg/kg g7, g16, g23

- *sFLC lambda 3990 >> 1810 mg/L*
- *Normalizzazione della funzionalità renale*

Teclistamab efficacy and safety in pts with and without renal impairment in MajesTEC-1

- Renal impairment (RI) **common complication** of MM occurring in up to 50% of pts
- Pts with MM and RI experience **poorer outcomes**, **excluded** from MM **clinical trials**, resulting in **limited treatment options** and a need for real-world (RW) data and expert recommendations to guide treatment strategies for these pts
- In the phase 1/2 **MajesTEC-1 trial**, the efficacy and safety of teclistamab, were generally **comparable in patients with and without RI**
- Population pharmacokinetic (PK) analysis based on data from MajesTEC-1 showed **no clinically significant differences in teclistamab PK** for patients with mild-to-moderate RI
- Limited RW data in pts with moderate-to-severe-RI, including those on **dialysis**, support the potential benefits of teclistamab in this population

Outcome	CrCl < 60 mL/min/1.73 m^2 ($n = 44$)	CrCl ≥60 mL/min/1.73 m^2 ($n = 121$)
Median follow-up, mo (range)	29.9 (0.5–38.0)	30.9 (0.3–41.5)
Efficacy		
ORR, n (%)	27 (61.4)	77 (63.6)
≥CR	17 (38.6)	59 (48.8)
VGPR	8 (18.2)	14 (11.6)
PR	2 (4.5)	4 (3.3)
Median DOR, mo (95% CI)	21.6 (9.0–NE)	24.0 (16.2–NE)
Median PFS, mo (95% CI)	9.9 (4.8–22.8)	13.1 (8.0–17.6)
Median OS, mo (95% CI)	20.0 (9.8–NE)	22.5 (16.0–30.7)
Safety		
Any grade TEAEs, n (%)	44 (100)	121 (100)
Grade 3/4 TEAEs	41 (93.2)	115 (95.0)
Discontinuations due to TEAEs, n (%)	1 (2.3)	7 (5.8)
Deaths, n (%)	24 (54.5)	70 (57.9)
Due to AEs	6 (13.6)	20 (16.5)
Due to disease progression	12 (27.3)	44 (36.4)

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REALiTEC-2: Patient Characteristics

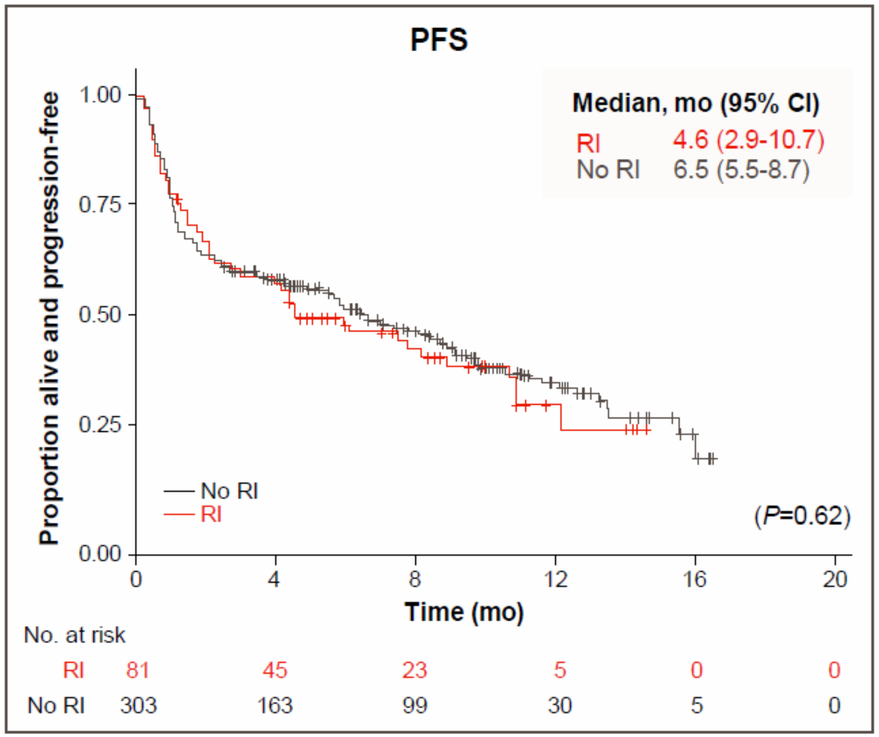
Table 1. Patient baseline characteristics

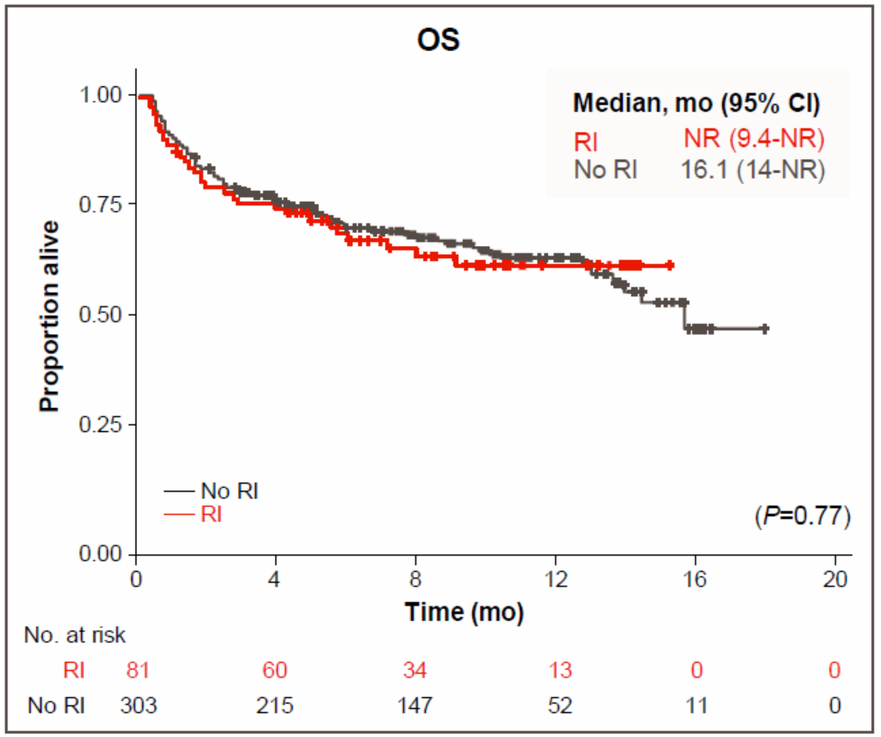
Characteristic	N=260[a]
Age, years, median (range)	68 (40–100)
<65 years, n (%)	100 (38.5)
≥65 to <75 years, n (%)	89 (34.2)
≥75 years, n (%)	71 (27.3)
Male, n (%)	142 (54.6)
ECOG PS ≥1, n (%)	82/121 (67.8)
ISS stage, n (%)	97
I	23/97 (23.7)
II	30/97 (30.9)
III	44/97 (45.4)
High-risk cytogenetics,[b] n (%)	94/139 (67.6)
Extramedullary plasmacytoma, n (%)	29/152 (19.1)
Bone-related soft tissue plasmacytoma, n (%)	43/152 (28.3)
Creatinine clearance ≥30–<40	17/251 (6.5)
Creatinine clearance <30	40/251 (15.4)

Characteristic	N=260[a]
Patients' ineligible for MajesTEC-1, n (%)	156 (60.0)
pLOT, median (range)	4 (2–14)
≤3 pLOT, n (%)	82 (31.5)
4 pLOT, n (%)	66 (25.4)
≥5 pLOT, n (%)	112 (43.1)
Triple-class exposed, n (%)	257 (98.8)
Penta-class exposed, n (%)	195 (75.0)
Triple-refractory, n (%)	64 (24.6)
Penta-refractory, n (%)	19 (7.3)
Refractory to the last LOT, n (%)	114 (43.8)
Patients receiving prior BCMA, n (%)	41 (15.8)
Prior anti-BCMA therapy, n (%)	
CAR-T	14 (5.4)
ADC	26 (10)
BsAb	2 (0.8)
Prior talquetamab, n (%)	22 (8.5%)

[a]Data available added as denominators if some were missing and not available in the clinical chart for the whole cohort. [b]High risk defined as having presence of t(4;14), t(14;16), del17p13, and amp1q21. ADC, antibody-drug conjugate; BCMA, B-cell maturation antigen; BsAb, bispecific antibody; CAR, chimeric antigen receptor; ECOG PS, Eastern Cooperative Oncology Group performance status; ISS, International Staging System; LDH, lactate dehydrogenase; (p)LOT, (prior) lines of therapy; HRCA, high-risk cytogenetic abnormalities.

Teclistamab is feasible in RRMM pts with RI with efficacy and safety comparable to patients with normal





Some patients experienced an **improvement in their renal function** after teclistamab initiation, and **renal function did not deteriorate** outside of the context of disease progression[1]

A case series of 15 patients on dialysis from France reported an ORR of >90% and a median PFS of NR after 5.4 months of median follow-up **effective option** for patients with RRMM and **end-stage renal failure requiring dialysis**, with a **safety profile consistent with MajesTEC-1**[2]

mPFS and mOS were comparable in patients with and without renal impairment

G1 to G2 CRS occurred in 73.3% of pts with no G3 to 4 CRS

9 pts developed G≥2 infections;
1 pt stopped hemodialysis following 5 months of teclistamab

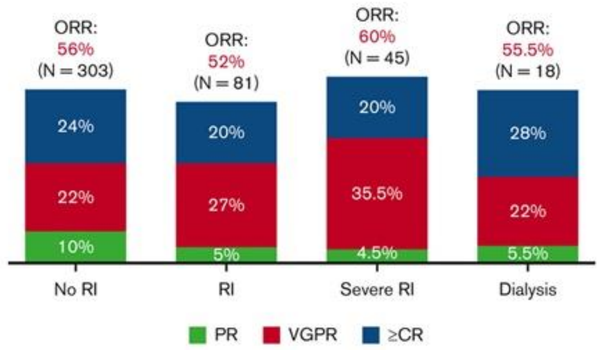
1) Dima D, et al. *Blood Adv* 2025; 9: 3408–3417; 2. Lebreton P, et al. *Br J Haematol* 2024.DOI: 10.1111/bjh.19772;3.Moreau P, et al. *N Engl JMed* 2022;387:495–505;4. Garfall AL, et al. ASCO2024.Poster 7540.

Outcomes With Teclistamab for Heavily Pretreated Relapsed/Refractory Multiple Myeloma (RRMM) and Renal Impairment (RI)

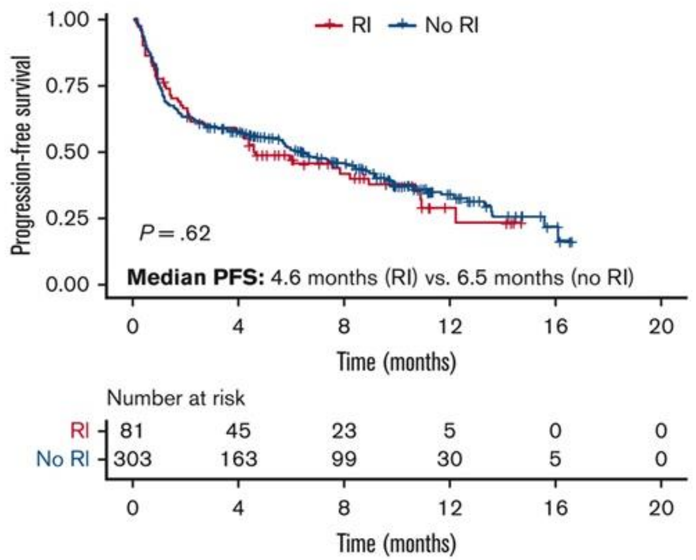
384 patients with RRMM across 13 U.S. centers received standard-of-care teclistamab

81 had RI (CrCl < 40 ml/min), including 45 (12%) with severe RI (CrCl < 30 ml/min), and 18 (5%) on dialysis

Response Rates & Depth of Response



Median follow-up: 9.9 months



Adverse Events	RI group N = 81	No RI group N = 303	*P* value
Any grade CRS	41 (51%)	178 (59%)	.23
• Grade ≥ 3 CRS	1 (1.2%)	3 (1%)	.9
Any grade ICANS	13 (16%)	41 (13%)	.6
• Grade ≥ 3 ICANS	2 (2.5%)	8 (2.6%)	.9
Infections	27 (33%)	139 (46%)	.06
• Severe infections	16 (20%)	58 (19%)	.9

DIMA et al Blood advances 22 JULY 2025 • VOLUME 9, NUMBER 14

Teclistamab seems to be a feasible, effective and safe option for patients with RI, including those on dialysis

Table 2. Simplified algorithm for the treatment and management of patients with MM and renal impairment.

No teclistamab dose adjustment recommended for patients with mild, moderate, or severe RI	
General considerations:	
• Consistent monitoring to evaluate treatment response • Monitor risks (ie, volume management, CRS, ICANS, infection, tumor lysis syndrome, renal function) • Manage comorbidities (ie, cardiovascular disorders, diabetes, hypertension, myeloma-related AL amyloidosis) • Adjust concomitant medication as needed for RI	
Specific recommendations:	
CRS	• Monitor closely, as CRS is a renal risk factor for MM therapy • Supportive care with steroids (ie, dexamethasone) • Consider use of tocilizumab for treating CRS
IVIg	• No contraindications • Monitor kidney function, infection, and fluid dynamics during IVIg therapy in patients with RI • Avoid sucrose-stabilized IVIg if possible • Administer IVIg the day of and every 3–4 weeks post-dialysis; separate teclistamab and IVIg administration by ≥ 2–3 days • Consider SCIg if available
Infection prophylaxis	• Antibacterial and antiviral prophylaxis strongly recommended • Adjust dosing as necessary to account for reduced renal clearance • Preference for dapsone/atovaquone over Bactrim for PJP prophylaxis
G-CSF	• No contraindications

Abbreviations: AL, amyloid light-chain; CRS, cytokine release syndrome; G-CSF, granulocyte colony-stimulating factor; ICANS, immune effector cell-associated neurotoxicity syndrome; Ig, immunoglobulin; IV, intravenous; MM, multiple myeloma; PJP, Pneumocystis jirovecii pneumonia; RI, renal impairment; SC, subcutaneous.

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Complicanze:

- **Tossicità ematologica** PLT 26.000/mmc Gb 1860/mmc N 820/mmc, Hb 8 g/dl
  Supporto trasfusionale GRC e PLT, somministrazione G-CSF

- **Viremia da CMV** 4957copie svp e febbrilcola trattamento con ganciclovir fino a negativiazzazione

- **Episodio febbrile (+ 8 giorni)** Incremento IL6, PCT, terapia empirica Pip/taz poi sostituito con Meropenem per positività emocolture E. Coli ESBL

Teclistamab somministrazione settimanale
Supporto con Ig
Migliore risposta ottenuta: CR

Dicembre 2025. Complicanza Infettiva, polmonite con insufficienza respiratoria acuta