


## Remission Possible: The Evolving Role of Post-Transplant Maintenance Therapy


Katie S. Gatwood, PharmD, BCOP  
Stem Cell Transplant Clinical Pharmacist  
Vanderbilt University Medical Center – Nashville, TN

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### Disclosures

- I am a member of a Speaker’s Bureau for Jazz Pharmaceuticals




### Objectives

- Discuss the rationale for use of maintenance therapy following hematopoietic stem cell transplantation (HCT)
- Summarize maintenance therapy strategies utilized following autologous HCT (MM, lymphoma)
- Summarize maintenance therapy strategies utilized following allogeneic HCT (AML HMAs/TKIs, ALL TKIs)
- Identify appropriate candidates for post-transplant maintenance therapy




### The Need for Maintenance Therapy

- Maintenance therapy following HCT is generally given for two different reasons:
  - Maintaining depth of response achieved using HCT in incurable disease states
  - Prevention of relapse in aggressive disease states or in patients with early detection of minimal residual disease (MRD) post-HCT
    - May be indefinite in duration or for a pre-defined period of time




Blood. 2016;128(6):763-73.



### Ideal Properties of Maintenance Therapy Agents

- Easy to administer
  - Oral medications
  - Ability for administration via home infusion
- Able to maintain disease response with minimal toxicity
  - Ability to tolerate long-term
  - Infrequent need for follow-up
  - Do not interfere with graft-versus-leukemia effect or increase graft-versus-host disease (allogeneic HCT)
- Low financial burden

Blood Cancer J. 2017;7(1):e545 | doi:10.1038/bcj.2017.23.



### Maintenance Therapy Post-Autologous HCT: Multiple Myeloma (MM)



### NCCN Maintenance Recommendations

- Historical (v3.2016)
  - Preferred
    - Thalidomide (category 1)
  - Other
    - Bortezomib with prednisone or thalidomide (category 2B)
    - Interferon (category 2B)
    - Dexamethasone or prednisone (category 2B)
    - Thalidomide with prednisone (category 2B)
- Current (v3.2017)
  - Preferred
    - Lenalidomide (category 1)
  - Other
    - Bortezomib (category 2A)

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NCCN Guidelines. Multiple Myeloma, v3.2017. Accessed August 23, 2017.

### Lenalidomide Maintenance - Key Trials

	IFM 2005-02 (2012)	CALGB 100104 (2012)	Gay et al. (2015)
<b>Population</b>	n=614 Age <65 yrs SD or better after HCT	n=460 Age <71 yrs SD or better after HCT	n=389 Age <65 yrs Newly diagnosed MM
<b>Start of Maintenance</b>	After 2 months of lenalidomide consolidation	100 days post-auto HCT	3 months post-auto HCT
<b>Treatment</b>	Lenalidomide 10 mg daily x 3 months then ↑ to 15 mg daily until relapse vs. placebo	Lenalidomide 5-15 mg daily vs. placebo	Lenalidomide 10 mg + pred 50 mg daily (LP) days 1-21 vs. lenalidomide (L) alone
<b>PFS/OS</b>	PFS: 41 vs. 23 mos (p<0.0001) 4-yr OS: 70%	PFS: 46 vs. 27 mos (p<0.001) OS: 88% vs. 80% (p=0.03)	PFS: 37.5 mos (LP) vs. 28.5 mos (L) (p=0.34)
<b>Adverse Effects</b>	Secondary malignancies: 3.1 vs. 1.2/100 patient years (p<0.002)	Secondary malignancies: 7.8% vs. 2.6%	No difference

SD: stable disease; PFS: progression-free survival; OS: overall survival Blood Cancer J. 2017;7(e545).doi:10.1038/bcj.2017.23.

### Lenalidomide Maintenance – GIMEMA Trial

Rd: lenalidomide, dexamethasone  
MPR: melphalan, prednisone, lenalidomide  
\*Dose: 10 mg daily days 1-21 of every 28 day cycle

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N Engl J Med. 2014;371:895-905.

### Lenalidomide Maintenance – GIMEMA Trial

- Median progression-free survival
  - Lenalidomide maintenance: 41.9 months
  - No maintenance: 21.6 months
  - p<0.001
  - No difference in PFS between auto SCT and MPR groups
- 3-year overall survival (%)
  - Lenalidomide maintenance: 88%
  - No maintenance: 79.2%
  - Not statistically significant

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N Engl J Med. 2014;371:895-905.

### Lenalidomide Maintenance – GIMEMA Trial

Grade 3-4 Adverse Events (%)	Lenalidomide Maintenance	No Maintenance	P-value
Neutropenia	23.3	0	<0.001
Infection	6	1.7	NS
Dermatologic	4.3	0	0.03
Venous thromboembolism	1.7	0	NS
Secondary malignancies	4.3	4.3	NS

- 14.7% of lenalidomide patients required dose reductions due to adverse events
- 5.2% of lenalidomide patients discontinued therapy due to adverse effects

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N Engl J Med. 2014;371:895-905.

### Secondary Malignancies with Lenalidomide

- Meta-analysis of all randomized, phase III trials in newly diagnosed multiple myeloma where at least one study group received lenalidomide
  - 7 trials included, n=3,254
  - 80.5% of patients received lenalidomide
    - Post-auto HCT: 30% received lenalidomide vs. 38% did not
- 5-year incidence of all cancers: 6.9% vs. 4.8% (p=0.037)
  - Hematologic: 3.1% vs. 1.4% (p=0.029)
  - Solid: 3.8% vs. 3.4% (p=0.72)
  - 1 death in each group due to secondary malignancy
  - Higher incidence in combination with PO melphalan (p<0.0001) but no difference with cyclophosphamide

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Lancet Oncol. 2014;15:333-42.

### Bortezomib Maintenance

	HOVON-65/GMMG-HD4 (2012)	PETHEMA-GEM (2012)
<b>Population</b>	n=827 Age <65 yrs	n=386 Age <65 yrs SD or better after HCT
<b>Start of Maintenance</b>	4 weeks post-auto HCT	3 months post-auto HCT
<b>Treatment</b>	Bortezomib 1.3 mg/m <sup>2</sup> q2 weeks vs. thalidomide 50 mg daily x 2 yrs	Thalidomide+bortezomib (TV) vs. IFN vs. thalidomide (T) x 3 yrs
<b>PFS/OS</b>	PFS: 35 vs. 28 mos (p=0.002) 5-yr OS: 61% vs. 55% (p=0.11) 5-yr PFS (del 17p): 22% vs. 5% 5-yr OS (del 17p): 65% vs. 18%	2-yr PFS: 78% vs. 63% vs. 49% (p=0.01) OS: No difference Increase in CR rate from 53 to 74% (TV) vs. 60% (T) (p=0.04)
<b>Adverse Effects</b>	30% discontinued treatment due to toxicity with thalidomide vs. 11% with bortezomib (p<0.001)	Increased thrombocytopenia (p=0.01) and peripheral neuropathy (NS) with TV vs. T

SD: stable disease IFN: interferon; PFS: progression-free survival; OS: overall survival  
Blood Cancer J. 2017;7(e545).doi:10.1038/bcj.2017.23.  
https://clinicaltrials.gov/ Accessed August 20, 2017.

### Ongoing MM Post-HCT Maintenance Trials

- Ixazomib
  - Phase I-III, single agent and in combination with lenalidomide
- Carfilzomib
  - Phase II-III, single agent and in combination with lenalidomide+dexamethasone
- Elotuzumab
  - Phase I-III, single agent and in combination with lenalidomide +/- bortezomib
- Daratumumab
  - Phase I, single agent
- Vorinostat
  - Phase I-III, in combination with lenalidomide or bortezomib
- Panobinostat
  - Phase I-II, single agent and in combination with lenalidomide

Blood Cancer J. 2017;7(e545).doi:10.1038/bcj.2017.23.  
https://clinicaltrials.gov/ Accessed August 20, 2017.

### Maintenance Therapy Post-Autologous HCT: Lymphoma

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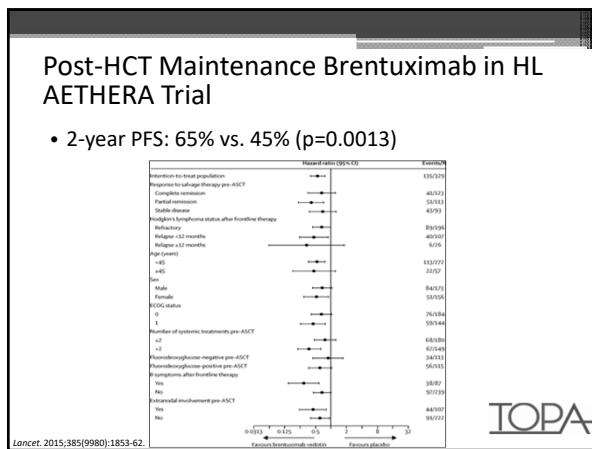
### Post-HCT Maintenance Brentuximab in Hodgkin Lymphoma (HL)

- AETHERA trial: Phase III multicenter, randomized double-blind, placebo-controlled trial of unfavorable-risk relapsed or refractory HL patients

\*Dose: 1.8 mg/kg q3 weeks for 16 cycles, starting 30-45 days post-HCT

Lancet. 2015;385(9980):1853-62.

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### Post-HCT Maintenance Brentuximab in HL AETHERA Trial

- Dose reductions due to adverse events required in 32% of brentuximab vs. 3% of placebo patients
  - Lead to delay in dosing in 9% of doses for brentuximab vs. 3% for placebo
- Most common adverse event in brentuximab group was peripheral neuropathy
  - Lead to discontinuation in 23% of patients
- Neutropenia and infections were other common adverse effects occurring more frequently with brentuximab
  - 25% of brentuximab patients required growth factor support vs. 11% of placebo patients

Lancet. 2015;385(9980):1853-62.

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### Post-HCT Maintenance Brentuximab in HL

- NCCN recommends maintenance brentuximab following autologous HCT in the following scenarios (category 2A):
  - Consider for Deauville 1-3 patients
  - Strongly consider for Deauville 4 patients
  - Only recommended for 1 year post-HCT
- Also states that the value of post-HCT maintenance brentuximab is unclear if patient received brentuximab pre-HCT as no OS benefit has been documented in the literature

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NCCN Guidelines. Hodgkin Lymphoma. v1.2017. Accessed August 23, 2017.

### Post-HCT Maintenance Rituximab in Mantle Cell Lymphoma (MCL)

- Single-center retrospective review of 157 MCL patients who underwent autologous HCT
  - 50 went on to receive maintenance rituximab
    - 375 mg/m<sup>2</sup> dose given according to a variety of dosing schedules
    - Initiated at a median of 77 days post-HCT
    - Median of 8 doses received
  - 107 went on to receive observation alone

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Ann Oncol. 2015;26(11):2323-28.

### Post-HCT Maintenance Rituximab in Mantle Cell Lymphoma (MCL)

- Results at median follow-up of 5 years
  - PFS: HR 0.44 (95% CI: 0.24-0.8, p=0.007)
  - OS: HR 0.46 (95% CI: 0.23-0.93, p=0.03)
    - Benefit retained after multivariate analysis
- Adverse events
  - Increased rate of grade 4 neutropenia with maintenance rituximab (34% vs. 18%, p=0.04)
  - No increase in non-relapse mortality observed with use of rituximab maintenance

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Ann Oncol. 2015;26(11):2323-28.

### Post-HCT Maintenance Rituximab in MCL – LyMA Trial

- Phase III international randomized trial of young (age <66 yrs), previously untreated >stage 1 MCL patients

```

    graph LR
      A["R-DHAP → auto HCT  
(n=240)"] --> B["Rituximab*  
maintenance  
(n=120)"]
      A --> C["No maintenance  
(n=120)"]
    
```

R-DHAP: rituximab, dexamethasone, cytarabine, cisplatin

\*Dose: 375 mg/m<sup>2</sup> q8 weeks x 3 years

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Hematol Oncol. 2017;35(52):doi: 10.1002/hon.2438. 74.

### Post-HCT Maintenance Rituximab in MCL – LyMA Trial

- Results
  - 4-year PFS: 82.2% vs. 64.6% (p=0.0005)
  - 4-year OS: 88.7% vs. 81.4% (p=0.0413)
  - 60% reduced risk of progression and 50% reduced risk of death with maintenance rituximab (p=0.0007, p=0.0454)
- Maintenance rituximab is now an NCCN category 1 recommendation following autologous HCT in patients with aggressive stage II (bulky) - stage IV disease

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Hematol Oncol. 2017;35(52):doi: 10.1002/hon.2438. 74.

### Post-HCT Maintenance Bortezomib in MCL CALGB 50403

```

    graph LR
      A["R-CHOP → auto HCT  
(n=151)"] --> B["Bortezomib*  
maintenance (BM)  
(n=34)"]
      A --> C["Bortezomib**  
consolidation (BC)  
(n=33)"]
    
```

R-CHOP: rituximab, cyclophosphamide, vincristine, prednisone

\*Dose: 1.6 mg/m<sup>2</sup> weekly 4/8 weeks x 18 months, starting 90 days post-HCT

\*\*Dose: 1.3 mg/m<sup>2</sup> days 1,4,8,11 of a 3 week cycle x 4 cycles, starting 90 days post-HCT

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Blood. 2015;126:337.

### Post-HCT Maintenance Bortezomib in MCL CALGB 50403

- Results
  - 5-year PFS: 70% (BM) vs. 69% (BC) compared to null (p<0.001)
- Treatment discontinuation due to adverse effects
  - 13% (BM) vs. 28% (BC)
  - Most common adverse events were cytopenias and peripheral neuropathy

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Blood. 2015;126:337.

### Post-HCT Maintenance Rituximab in Diffuse Large B-Cell Lymphoma (DLBCL)

- CORAL trial

R-ICE: rituximab, ifosfamide, carboplatin, etoposide  
 R-DHAP: rituximab, dexamethasone, cytarabine, cisplatin

\*Dose: 375 mg/m<sup>2</sup> q8 weeks x 1 year, starting 28 days post-HCT

CR: complete response; PR: partial response; SD: stable disease

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J Clin Oncol. 2012;30(36):4462-69.

### CORAL Trial Results

**4-Year Progression-Free Survival (%)**

Patient Group	Rituximab Maintenance	No Maintenance	P-value
All patients (n=242)	52	56	0.8
R-ICE (n=116)	50	49	0.5
R-DHAP (n=126)	55	63	0.4

**4-Year Event-Free Survival (%)**

Patient Group	Rituximab Maintenance	No Maintenance	P-value
All patients (n=242)	52	53	0.7
R-ICE (n=116)	50	47	0.4
R-DHAP (n=126)	55	59	0.7

J Clin Oncol. 2012;30(36):4462-69.

### CORAL Trial Results

- Adverse effects
  - Infection and neutropenia were most common
  - Pre-day 100 post-HCT:
    - 47% (rituximab) vs. 42% (no maintenance)
  - Post-day 100 post-HCT:
    - 30% (rituximab) vs. 17% (no maintenance)
- Death
  - Rituximab maintenance: 6
    - 2 secondary malignancies, 4 infections
  - No maintenance: 3
    - 2 secondary malignancies, 1 infection

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J Clin Oncol. 2012;30(36):4462-69.

### Ongoing Lymphoma Post-HCT Maintenance Trials

- Romidepsin (T-cell lymphoma - post-allo HCT)
  - Phase II
- Brentuximab (HL - post-allo HCT)
  - Terminated (slow accrual)
- Bortezomib
  - Phase II, single agent (MCL) and in combination with vorinostat (DLBCL, HL, MCL, T-cell lymphoma, follicular lymphoma)
- Lenalidomide
  - Phase III (MCL), phase I (HL)
- Ixazomib (MCL)
  - Phase I/II
- Panobinostat (HL)
  - Phase III
- Idelalisib (DLBCL, MCL, follicular lymphoma - post-allo HCT)
  - Phase I
- Ibrutinib (DLBCL)
- Pidilizumab (DLBCL)
- Nivolumab (HL)

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https://clinicaltrials.gov/. Accessed August 20, 2017.

### Maintenance Therapy Post-Allogeneic HCT: Acute Myeloid Leukemia (AML) and Myelodysplastic Syndromes (MDS)

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### Hypomethylating Agents - Key Trials

	Oshikawa <i>et al.</i> (2014)	Antar <i>et al.</i> (2014)
<b>Population</b>	n=10 AML	n=9 MDS, AML
<b>Start of Maintenance</b>	Median of 79 days post-HCT	Median of 100 days post-HCT
<b>Treatment</b>	Azacitidine 30 mg/m <sup>2</sup> x 7 days q4 weeks x 4 cycles	Azacitidine 32 mg/m <sup>2</sup> x 5 days q4 weeks x 12 cycles
<b>PFS/RFS/OS</b>	1-yr RFS: 60% 1-yr OS: 70%	1-yr PFS: 65% 1-yr OS: 90%
<b>Adverse Effects</b>	Infection and myelosuppression	Mild thrombocytopenia in 2 patients
<b>GVHD</b>	50% incidence of chronic GVHD	No GVHD exacerbations

PFS: progression-free survival; OS: overall survival; RFS: relapse-free survival;  
GVHD: graft-versus-host disease

Blood. 2016;128:763-73.

### Hypomethylating Agents - Key Trials

	Pusic <i>et al.</i> (2015)	Gill <i>et al.</i> (2015)
<b>Population</b>	n=22 AML	n=34 MDS, AML
<b>Start of Maintenance</b>	50-100 days post-HCT	
<b>Treatment</b>	Decitabine 5-15 mg/m <sup>2</sup> x 5 days q6 weeks x 8 cycles	Azacitidine 100 mg/m <sup>2</sup> x 3 days q4 weeks x 8 cycles (or progression)
<b>RFS/OS</b>	2-yr RFS: 48% 2-yr OS: 56%	2-yr PFS: 66.1% (1 <sup>st</sup> ), 25% (2 <sup>nd</sup> ) 2-yr OS: 73.2% (1 <sup>st</sup> ), 14% (2 <sup>nd</sup> ) Full donor chimerism achieved in all patients
<b>GVHD</b>	41% aGVHD; 63% cGVHD	31.8% aGVHD; 77% cGVHD (1 <sup>st</sup> ) 8.3% aGVHD; 41.7% cGVHD (2 <sup>nd</sup> )

PFS: progression-free survival; OS: overall survival; RFS: relapse-free survival;  
a/cGVHD: acute/chronic graft-versus-host disease

Blood. 2016;128:763-73.

### FLT3 Tyrosine Kinase Inhibitors – Key Trials

	Chen <i>et al.</i> (2014)	Pratz <i>et al.</i> (2015)
<b>Population</b>	Phase I dose-escalation trial n=22 FLT3-ITD AML	n=28 FLT3-ITD AML
<b>Start of Maintenance</b>	45-120 days post-HCT	30-120 days post-HCT
<b>Treatment</b>	Sorafenib 200-400 mg BID x 1 yr	Sorafenib 200 mg QOD-400 mg BID for median of 252 days post-HCT
<b>PFS/OS</b>	1-yr PFS: 85% 1-yr OS: 95%	6 deaths (3 relapse), 5 relapses
<b>Adverse Effects</b>	5 patients discontinued due to toxicity (weight loss, GI symptoms)	Not reported
<b>GVHD</b>	38% incidence	32% incidence of ≥grade II

PFS: progression-free survival; OS: overall survival; GVHD: graft-versus-host disease

Blood. 2016;128:763-73.

### Midostaurin Maintenance

- Prospective, phase II trial in newly diagnosed *FLT3*-ITD AML receiving midostaurin maintenance therapy post-allogeneic HCT
  - 50 mg daily for 1 year post-HCT (n=40)
- Results
  - Cumulative incidence of relapse: 12% (*FLT3* mutant:wildtype ratio <0.5), 5% (*FLT3* mutant:wildtype ratio ≥0.5)
  - Low incidence of adverse events (four grade 3-4 events)

Blood. 2015;126:322.

### Lenalidomide Maintenance – LENAMAINT Trial

- Prospective, single center, phase II trial in high-risk AML/MDS patients with del5q (n=10)
- Lenalidomide maintenance (10 mg daily days 1-21 q28 days) starting at a median of 2.5 months post-HCT for 12 cycles
- Trial stopped early due to increased incidence of acute graft-versus-host disease (GVHD)
  - 60% of patients developed grade III-IV GVHD within first 2 cycles of maintenance
  - GVHD resolved in 67% patients after lenalidomide discontinuation and steroid initiation

Hematologica. 2012;97(9):e34-5.

### Panobinostat Maintenance – Panobest Trial

- Phase I/II dose-escalation study in high-risk MDS/AML
  - N=42 (37 AML, 5 MDS)
- Panobinostat initiated between day 60-150 post-HCT and continued for up to 1 year
- Schedule A dosing:
  - 10 mg thrice weekly (TIW) escalated to 30 mg TIW
- Schedule B dosing:
  - 20 mg thrice weekly (TIW) escalated to 40 mg TIW

Blood. 2015;126:4344.

### Panobinostat Maintenance – Panobest Trial

- Results
  - Recommended phase II dosing:
    - 20 mg TIW weekly or 30 mg TIW every other week
  - 2-year OS: 88%
  - 2-year disease-free survival (DFS): 74%
  - 19 patients discontinued therapy early
    - 10 due to adverse effects, 6 due to relapse, 3 for other reasons
    - Most common adverse effects were hematologic and GI toxicity
  - Cumulative incidence of moderate or severe chronic GVHD was 24% at 1-year post-HCT

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Blood. 2015;126:4344.

### Conclusions Regarding Post-HCT Maintenance in AML

- Maintenance therapy post-allogeneic HCT is currently not recommended by any guidelines, including NCCN
- Very few published randomized trials assessing efficacy of maintenance therapy though results of available studies are promising
- Encourage patient participation in a maintenance therapy clinical trial

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### Ongoing AML/MDS Post-HCT Maintenance Trials

- Azacitidine
  - Phase II
- Decitabine
  - Phase II
- Sorafenib
  - Phase II
- Midostaurin
  - Phase II
- Quizartinib
  - Phase I
- Crenolanib
  - Phase II
- Panobinostat
  - Phase I/II

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https://clinicaltrials.gov/. Accessed August 20, 2017.

### Maintenance Therapy Post-Allogeneic HCT: Acute Lymphoblastic Leukemia (ALL)

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### BCR-ABL Tyrosine Kinase Inhibitors – Key Trials

	CSTIBES02 (2010)	Chen <i>et al.</i> (2012)
<b>Population</b>	n=13 Ph+ ALL (4 auto HCTs)	n=62 Ph+ ALL
<b>Start of Maintenance</b>	Engraftment	Engraftment
<b>Treatment</b>	Imatinib 400 mg daily for a median of 9 mos post-HCT	Imatinib 400 mg daily for median of 3 mos
<b>Outcomes</b>	Relapse rate: 33% 4-yr OS: 30%	5-yr relapse rate: 10.2% vs. 33.1% (p=0.016) 5-yr DFS: 81.5% vs. 33.5% (p<0.0001)
<b>Adverse Effects</b>	20% discontinued treatment (GVHD, hematologic and GI toxicity)	16% discontinued treatment (hematologic and GI toxicity)

Ph+: Philadelphia chromosome-positive; DFS: disease-free survival; OS: overall survival; GVHD: graft-versus-host-disease

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Cancer. 2016;122(19):2941-51.

### BCR-ABL Tyrosine Kinase Inhibitors – Pfeifer *et al.* (2013)

```

    graph LR
      A[Ph+ ALL post-allo HCT (n=55)] --> B[Imatinib* maintenance x 1 yr (n=26)]
      A --> C[MRD-triggered imatinib* (n=29)]
    
```

\*Target dose: 600 mg daily

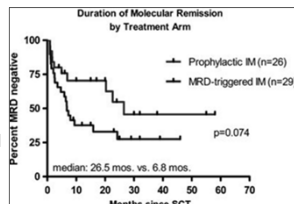
Ph+: Philadelphia chromosome-positive; MRD: minimal residual disease

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Leukemia. 2013;27:1254-62.

## BCR-ABL Tyrosine Kinase Inhibitors – Pfeifer *et al.* (2013)

- Results
  - Incidence of molecular recurrence
    - 40% vs. 69% (p=0.046)
  - 5-year OS:
    - 80% vs. 74.5% (NS)
  - Imatinib was discontinued in 67% of patients
    - GI intolerance was most common reason for discontinuation
    - GVHD incidence was not different between groups



Leukemia. 2013;271254-62.

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## Recommendations Regarding Post-HCT Maintenance Tyrosine Kinase Inhibitors in ALL

- NCCN:
  - Tyrosine kinase inhibitor (TKI) maintenance following allogeneic HCT in patients Philadelphia chromosome-positive (Ph+) ALL is a category 2A recommendation
  - Therapy should be initiated within 90 days post-HCT and continue for 1 year post-HCT
- European Society for Blood and Marrow Transplantation:
  - All Ph+ ALL patients are candidates for post-HCT TKI therapy to reduce relapse risk
  - A prophylactic (maintenance) or preemptive strategy can be used
  - Imatinib is first-choice TKI unless resistance is documented
  - Dasatinib is first-choice TKI in patients with a history of central nervous system involvement
  - Should be given for 12 months of continuous MRD negativity (if HCT in CR1) or indefinitely until unacceptable toxicity (if HCT in CR2)

NCCN Guidelines. Acute Lymphoblastic Leukemia. v2.2017. Accessed August 23, 2017. Cancer. 2016;122(19):2941-51.

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## Ongoing AML/MDS Post-HCT Maintenance Trials

- Blinatumomab
  - Phase II
- Lenalidomide
  - Phase I

<https://clinicaltrials.gov/>. Accessed August 20, 2017.

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## Summary

- Disease states with documented evidence supporting post-autologous HCT maintenance therapy include:
  - Multiple myeloma, Hodgkin lymphoma, mantle cell lymphoma
- Disease states with documented evidence supporting post-allogeneic HCT maintenance therapy include:
  - Acute myeloid leukemia/myelodysplastic syndromes, Philadelphia chromosome acute lymphoblastic leukemia
- Patients must be carefully selected and risks vs. benefits of further treatment must be assessed prior to initiation of maintenance therapy

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## Remission Possible: The Evolving Role of Post-Transplant Maintenance Therapy

### Questions?

katie.s.gatwood@vanderbilt.edu

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