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M-Power Facebook Live

Studies on disparities in myeloma presented at ASH

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The 63rd Annual Meeting & Exposition of the American Society of Hematology (ASH), held in December 2021, was an extraordinary platform for presentations of groundbreaking research in myeloma: impressive screening programs, quadruplet therapies in frontline therapy, and several new agents in relapsed disease. In addition to this great research, there were more than 20 abstracts devoted to disparities in myeloma.

On December 15, the IMF hosted a Facebook Live event to present an overview of the key ASH 2021 abstracts devoted to disparities in myeloma, and you can listen to the recording at **mpower.myeloma.org**. As we shine a spotlight on health equity in the United States and beyond, I would like to highlight for you some of the key themes that emerged from this important work.

Myeloma patients of African descent

Myeloma is twice as common in patients of African descent. Furthermore, despite great advances in the treatment of myeloma and improvements in overall survival, outcomes in African Americans remain inferior to myeloma patients who are white. However, we know that survival in African American patients can be superior when given equal access to therapies.

Understanding the reasons for this disparity is one of the key areas of work presented at ASH. Indeed, most of this research has focused on "diagnosing" the problem. Thus far, only a few studies propose a solution.

Difference in biology

Previous studies have shown that African Americans have differences in the biology of myeloma. They are diagnosed on average 5 years younger, are more likely to have the standard-risk cytogenetic feature of t(11;14), and are less likely to have the high-risk cytogenetic feature of deletion 17p.

The PROMISE clinical trial (**ASH abstract 152**) was a large screening study that showed us that 10% of African Americans over the age of 40 have monoclonal gammopathy of undetermined significance (MGUS), and the percentage may be even higher with more sophisticated testing techniques. **Abstract 402** added to our understanding by noting differences in mutation profiles in African Americans. Interestingly, in **abstract 4121** they propose that historical risk stratification with cytogenetics may not be as influential in African American patients.

Socioeconomic status

Several studies identified the link between socioeconomic status and outcomes in myeloma. The concept of financial toxicity was presented in **abstract 4027**. Another study noted the differences between patients who had access to WiFi to conduct video visits with their doctors during the pandemic versus those who held phone visits. African Americans are less likely to be able to have video visits, and this "digital divide" further exacerbates issues of structural racism and health inequity.

Access to testing and treatment

A plethora of studies identified the challenge in access to healthcare in myeloma. Blacks are less likely to have the full testing needed (**abstract 4116**) and less likely to have access to novel treatments (**abstract 4118**).

Minority enrollment in clinical trials remains a major issue, especially in "pivotal" studies that often lead to drug approval by the FDA (**abstract 846**). Another study demonstrated reduced access to CAR T-cell therapy in African Americans (**abstract 566**). An important Canadian study noted that although Blacks had the same benefit from the use of Darzalex® (daratumumab), they were more likely to receive it later in their disease course than white patients (**abstract 1965**).

Strategies for testing and therapy

A minority of studies proposed solutions to the above problems, such as using a more inclusive prognostic score (**abstract 3789**) or using real-world data to identify communities where studies should take place to enhance access to clinical trials in minority populations (**abstract 3008**).

I applaud this work. To drive solutions, we need to understand the disparity more fully. Part of the solution may involve genuinely rethinking our approach to the diagnosis of myeloma, its therapy, and where and how we conduct clinical trials. It will also involve a partnership between all stakeholders, including policymakers, communities, healthcare providers, and regulators. The IMF is deeply committed to this issue. We have implemented our M-Power program, designed to empower patients and their communities to change the course of myeloma – a course, confirmed by the research above, that remains unacceptable.

More than 150,000 people have engaged in our program at **mpower.myeloma.org** and accessed the resources we make available to all. Join us. If we work together, we can make a difference in reducing the disparity in myeloma. **MT**

Please contact the IMF InfoLine for help with your myeloma-related questions and concerns. Phone lines are open 9 a.m. to 4 p.m. (Pacific) Monday through Friday at **800.452.CURE** *in the US and Canada or* **818.487.7455** *worldwide. You can also email* **InfoLine@myeloma.org** *to submit your query electronically.*