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Volhenni diagnose 2017
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ndaongalaiyan, givan vpd, again remision till august 2023, in the add a second relapse,
did we dara tomo map plus karfil zomi plus dexamitazom, received a total of 24 doses of dara till august 2024.
Third relapse in august 2024, while on dara tomo map, at that time bonaro was done, at 35% plasma cells, fish had a new clone in the form of deletion 17p and again of 1Q.
Pets can show multiple bonilisions, organ functions ok, performance status good, treated with karfil zomi, cyclophosphamide, which was converted by a fungal pneumonia,
treated with poriconazole and the fungal pneumonia improved.
So, question number 1, anyone can take up.
He is relapse refractory myloma, post auto etc and dara exposed, has a new clone in the form of 17p and 1Q.
So, what are the treatment options available? Nikita?
Alright sir, so islands.
Yeah, Girish, no problem.
So, yeah, he has been treated with multiple lines of, three lines of therapy and has received monoclonal antibody as well.
So, probably we have an option of giving something like VTD paste because it has been aggressive disease and there is clonal evolution as well.
Along with that, we can consider him for carticel therapy and a tectlis temab, probably can be an option.
So, right, so we have huge options.
We have two antibodies, we have ADC, we have two cars, we have tectlis temab, elrun temab, talquet temab, we have bendermostine, wired, VTD paste, we have oral drugs, we have MPT, we have selenix or and there is an option again for an second auto etc.
Because it is more than three years after the first auto etc.
So, huge number of options.
So, things are becoming difficult to decide which is the best available option.
So, Nikita, what will you do?
How do you choose a treatment?
So, of course, so can you go back about two slides, I am sure, previously I am sorry.
So, the first relapse was about three, four years later and the second...
Five years later, first, the debris relapse one, one year down the line.
Okay.
The shorter and shorter remission periods.
So, refractory to dara to mumble also.
On dara, auto, boat, car, cyclol, lenn, decks.
And the performance stage is...
Oh, my lennies are very good.
Good performance status.
Even though it is 67 is quite okay.
Organ functions are good.
The ulcerative colitis is okay.

BP is okay.
Absolutely fine.
It doesn't have peripheral blood plasma cells.
No other organs involved.
No external disease.
Only in the bones and marrow.
Okay.
So, of course, of all the options that you showed, what is practical?
Orel melphalan, I am not sure.
I mean, yes, you could give that as well because the patient has had a transplant and is done well.
But we do use some bendermostene.
And we have had some patients who have responded for a brief duration.
Again, these are anecdotes.
They are not lots of patients who have responded well.
But because of its dual anti-cancer activity,
it possibly has some immunomodulate re-roll.
So, bendermostene is something that we shouldn't forget.
Aside from that, a transplant, we actually have a couple of patients at Cancer Institute WI,
where patients with refractory disease have been transplanted.
We wanted to ideally take them up for two transplants.
That is a tandem transplants, but we were not able to get funds for them.
And they've done all right.
So, practically in our center, I mean, in our country with limited resources, etc., that can always be an option.
And again, this is something, this published data on actually giving a smaller dose international data
on giving a smaller dose of IV melphalan.
You don't even have to give 200 milligrams per meter square.
Sometimes stem cells, storing stem cells, we won't be able to yield enough stem cells.
You can give smaller doses.
Those are the only practical options.
No, not actually as all the money on earth.
Take a list of them up.
Money is not a...
Here, we are not the economics.
This is all money on earth available.
No problem.
Then, what will you suggest?
Absolutely well.
He has come to you with some hope.
No melphalan, Selenex, or VTDs and all out.
So, what will you consider for this with a new clone which is 17 p and 1 q gain and pentary factory?
No, of course, sir, if Kati is available, if you could...
if we could refer the patient to your center for Kati, we would...
Vizha, achieved.
Mr. Nachiv, for today, absolutely right.
So, there are antibodies, there are ADCs and there are cars.
If you have everything on earth available, currently these are the three options available.
If you can go to any center which will offer car and we are offering cars,
plus antibody or ADC, whatever we are offering, you can have a clinical study or you can use others.
But this is money unlimited.
Lakshmi, I see, Khaadi Rani Chaya.
Mutti Ban, Neh Chal.

But that is available.
You have lot of patients.
So, don't underestimate the money power in India.
The way we are investing in SIPs, you should understand.
25,000 crores a month, that much money we easily have, right.
So, these are the five BCMA approved therapies into three classes.
CARTs, T cell, Engagers and ADCs.
And probably if you look at the literature, cars are the best currently available.
Even though the data are from single center, the Mayo data, 350 patients,
long term survivors, less toxicity, less cost, less infections,
CART do the best.
See this.
This is about cars.
This is about monoclonal antibody.
These are about ADCs.
And the blue ones are the stingant and the CRs.
See the number of CRs in cars.
So, probably if I have one crore and I cannot afford more than that,
instead of going to anything else, I would prefer a car.
That is the current message which I got eight days of reading literature.
So, thanks Vijay.
I could read some literature.
See the infection rates.
CART has the minimal infection rates.
And that tore a long period of time.
Five, fifty days, two years.
Monoclonal antibodies, even you continue to give the infection rates,
continue to increase.
But CART infection rates dropped out.
These are the survival.
Across the board, extra middle disease, plasma cell leukemia,
spentar, refractory, high risk.
On all cases, CARS do better than monoclonal antibodies or ADCs.
Right?
Right.
So, Jain, is there a patient population, even though he has a lot of money,
you will say don't do CARE.
Do you have any such data available or information available?
Or anybody can answer.
Everything I have available, do you say Namaskar, Kuchman, Kaurav?
Patient is not fit.
Absolutely.
Fitness, most important.
Rapidly progressive disease.
Very, very tough.
Girish, will you say some Namaskar to any patient go home, dip peacefully?
Even if your money, donate to some patient.
If the patient is not fit, one thing.
The second thing is, if the probability, the expression of BCMA is not good,
where we see that there is, it is going to not helpful for this patient,
then there is no point in offering this treatment for this patient.
So, still at the till the last moment, you have the option of saying no or go home.
Otherwise, more or less, probably we should go ahead with some T cell therapy
and probably CARE, if it is easily available available, affordable and understood.
I thank a lot.
As I have finished in 10 minutes.
Sir, can I add one last point?
Absolutely.
Very quickly.

So, this is a publication by Samir Hadid from, I think he is from Kansas, US.
And they basically presented or published data on the patients who were enrolled on clinical trials for CARE,
but actually did not make it.
And they talked about that profile and how many patients died during the weight period.
So, if it can be manufactured quickly and given great, there are some.
And for that patients, bridge with the antibody or ADC, if manageable.
And then you do the harvest, it takes one month, you do something in between,
that something is challenging, but do something and then give a car.
But probably if you want to give one, probably currently CARE is the best available.
And just want to say, because you were, we discussed that DCMA,
the expression probably goes down when they are treated with different lines of therapy.
I came across a study where ATRA can be used to increase the DCMA expression,
which can be on the plasma cells.
And then we can subject them to BCMA.
Right.
Bhau say, bar you online?
Bhau say, doctor, doctor Shruti, you are online?
Am I audible?
Okay.
I thank the audience.
I thank the panelists also for inviting me.