Patient Case: GT

60M with relapsed IgG lambda multiple myeloma (dx 2021, del13q, +circulating plasma cells at diagnosis <5%) s/p multiple lines including ASCT and most recently cilta-cel (best response VGPR), labs now show increase in M-protein 6 months post-cilta-cel (0.6 -> 3.4 in 1 month). Also concern for CNS involvement in setting of LUE weakness, LP showing 1.8% lambda-restricted population s/p IT MTX and hydrocort with subsequent negative LP.

Planned for initiation of talquetamab.

PMH: asthma, right testicular cancer s/p radiation and orchiectomy, chemo-induced neuropathy

Patient Case: GT

Prior lines:

1. CyBorD -> VRd
2. KRd -> ASCT -> KR maintenance (9-month remission)
3. HyperCD
4. Dara-pom-vel-dex
5. Bridging hyperCD -> cilta-cel

Labs:

M-spike 3.4, lambda 718.7, kappa <1.0

CBC – WBC 3.3, Hb 8.9, Plt 177

Cr – 0.73

Ferritin – 9758, CRP 96.1

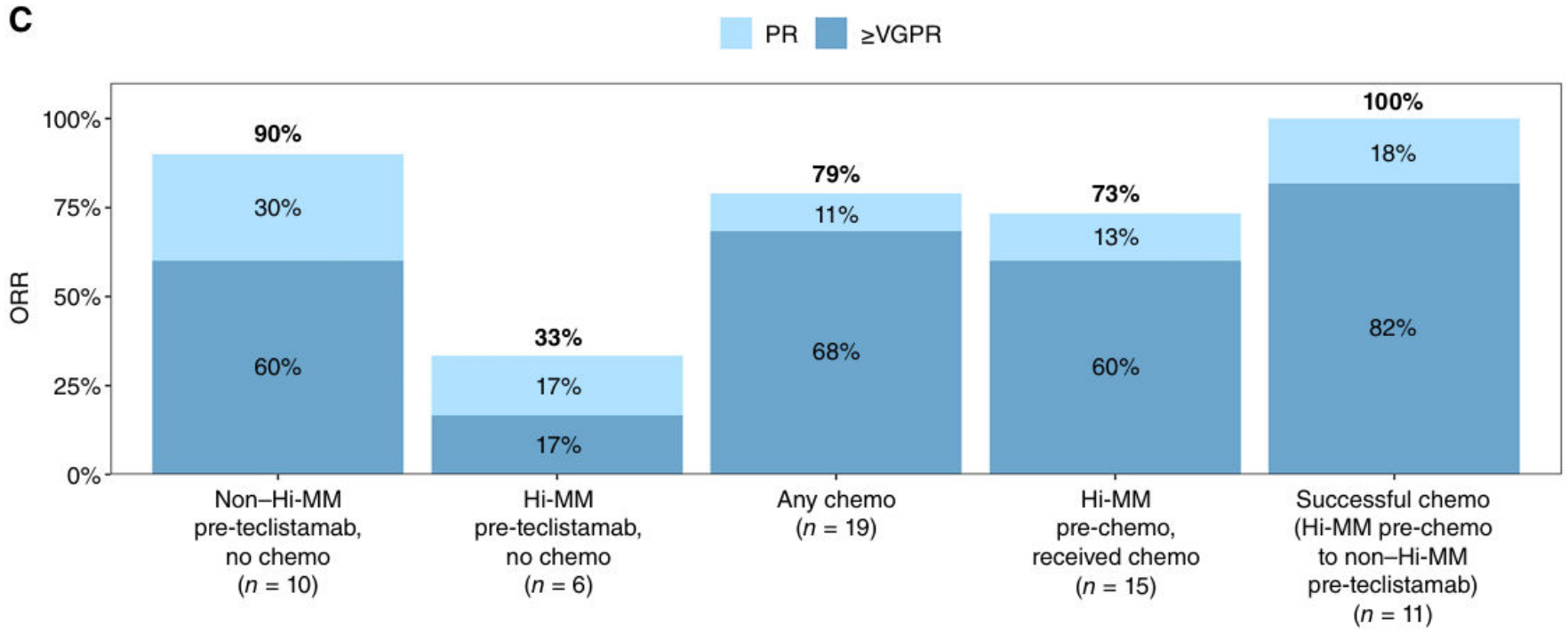
No recent BMBx available

Panel Questions

- What proportion of bispecifics do you initiate inpatient versus outpatient?
  - What are your considerations when choosing between the two?
  - Do you use prophylactic tocilizumab?
- Do you debulk patients prior to starting bispecifics?
- How do you coordinate with community oncologists who are unable to step-up bispecifics themselves? When do you transition patients back to their local center?

Debulking Chemotherapy

- Sharma et al evaluated the effect of debulking chemotherapy prior to starting teclistamab
- Patients with high-risk features (EMD, PCL, >50% PCs, or transfusion within 30 days) had ORR of 20-40% compared to 80% in patients without
- 4 of 4 patients who were primary refractory to a BCMA bispecific later responded to teclistamab after debulking chemo



Sharma, Rintu, et al. *Blood Cancer Discovery* (2026)

Patient Case Conclusion

Patient was admitted for tal step-up with a target dose of 0.8 mg/m2. He developed grade 1 CRS after SUD1 for which tocilizumab was given with resolution. He was discharged on day 9 following completion of step-up.

On day 12, he was seen in clinic complaining of diarrhea, temp 39.1 C with labs showing ferritin >40,000, CRP 61.1 (at discharge, 9394 and 10.8, respectively), ALT 1418, AST 1008, Tbili 2.5 (previously normal). WBC 7.4, Hb 9.9, Plt 114. He was readmitted with workup positive for blood and urine cultures showing Citrobacter frendii and salmonella on GI panel. He was treated with a 2-week course of cefepime and discharged with resolving ferritin and LFTs.

M-spike decreased progressively and was undetectable by month 5.