From the Editor

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In the December issue of *AJHO*, a timely review of a major branch-point decision in the treatment of multiple myeloma is presented. It is impressive enough that long-term remissions are being seen with autologous stem cell transplantation, now with over 20 years of experience, and some patients have achieved an apparent cure. The more surprising turn of events has been the evolution of biological therapies that have lower toxicities and longer disease control when used sequentially or in combinations. The decision to undergo transplant with acute toxicities and risk of death (albeit much lower than in earlier decades), or to proceed with non-curative, gentler therapy, is now more difficult but still uses the same metrics of age, comorbidities, and personal preferences. However, the terrain is definitely changing with the development of newer biological agents. While autologous stem cell transplant is still favored for transplant-eligible patients, the timing of this procedure – at diagnosis, or after induction with biological or other combinations – has yet to be settled. Also, the optimal agents and treatment lengths of consolidation and maintenance therapy remain unclear, even though, in general, they do improve the quality and duration of remission.

The optimal approach may pivot over time as more effective drugs for relapse/progression are approved. Just in the last month, the FDA granted accelerated approval for the anti-CD38 antibody daratumumab, the first monoclonal antibody approved for multiple myeloma, to treat patients who have received at least three prior treatments, including a proteasome inhibitor and an immunomodulatory agent. Also approved was the new proteasome inhibitor ixazomib in combination with lenalidomide and dexamethasone as second-line therapy, even more markedly superior in the setting of high-risk cytogenetics compared to the control arm of lenalidomide and dexamethasone alone. In this same period, the second antibody elotuzumab, against signaling lymphocytic activation molecule F7 (SLAMF7), was approved also in combination with lenalidomide and dexamethasone for multiple myeloma after progression to 1 - 3 prior therapies.

This flurry of activity in myeloma may be narrowing the gap between upfront or delayed transplant and the use of biological therapies for the whole course of the disease.