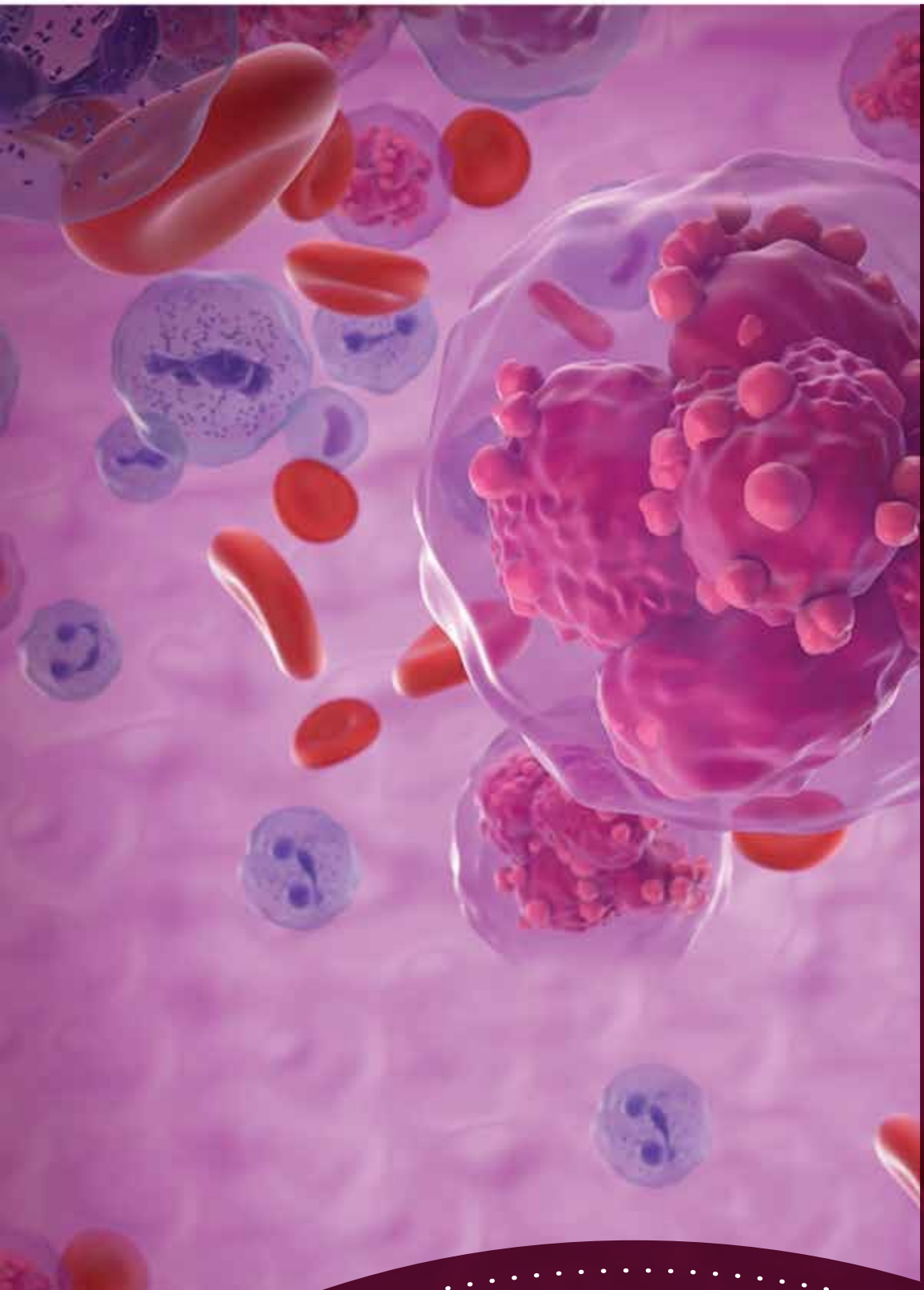
NEWSLETTER

Issue No-04 | Year-2024

An Indian Myeloma Academic Groupe Publication (IMAGe)



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Preface

*This newsletter was born out of sincere efforts of the **IMAGE Groupe** to serve a quarterly academic feast to all myeloma connoisseurs and novitiates with a platter of translational research work update, neuron tickling trivia, cherishable accomplishments of our members and highlights of past and upcoming academic events in the realm of myeloma. A blitzkrieg of brainstorming zoom sessions followed by pounding and grinding of intellect and prose by five geeks over weeks led to fruition of the first edition on new year eve and a greater hard work to bring forth this snippet on myeloma activities across country as second edition.*

- From Editorial Team

This bulletin will be a ready reckoner for those grappling to keep up with the progress on myeloma. As it summarizes journal clubs that paved the way for the holy grail of truth based on evidence, the eagle eye gives the synopsis of the critical thinking prowess shown by the myeloma prodigies. The rest of the sections gives us a glance at what is happening around us. The team has done a spectacular job in putting this together. Of course, not to mention the turbocharger, Dr. Uday.

- Newsletter Committee

"Inshorts-Through expert's lens" Journal Club

Dr. Annie Kanchan Baa
MD, DM

Assistant Professor, Department of Medical Oncology, St. John's Medical College & Hospital, Bangalore

San-Miguel J, Dhakal B et al; Cilta-cel or Standard Care in Lenalidomide-RefractoryMultiple Myeloma.N Engl J Med. 2023 Jul 27;389(4):335-347. doi:10.1056/NEJMoa2303379. Epub 2023 Jun 5. PMID: 37272512.

Summary: The CARTITUDE-4 study was the first phase 3, open-label, randomized trial, evaluating the ciltacabtagene autoleucel (cilta-cel) in relapsed/refractory multiple myeloma. The efficacy and safety of cilta-cel, a CAR T-cell therapy targeting BCMA was compared to the physician's choice of standard therapy (pomalidomide, bortezomib, and dexamethasone or daratumumab, pomalidomide, and dexamethasone); in patients who were refractory to lenalidomide and had received 1-3 prior lines of therapy. Cilta-cel demonstrated superior progression-free survival (PFS) rates when compared with SoC (PFS at 12 months: 76% vs 49%), thus fulfilling the study's primary endpoint. The median PFS was not reached in the cilta-cel arm while it was 11.8 months in the standard arm (HR: 0.26; 95% CI: 0.18-0.38; P <.0001). The PFS benefit was observed across all patient subgroups. The overall response rates also significantly improved with cilta-cel(84.6% vs 67.3%, odds ratio-3; range:1.8-5; p<0.0001); with impressive complete response (CR) rates (72% vs 22%). The MRD negativity rates were higher with the CAR T cell therapy (60.6% vs 15.6%; odds ratio-8.7; p<0.0001).The haematological toxicities were the most common adverse events encountered in the cilta-cel group (grade ¾: 94.2% vs 86.1%). The cytokine release syndrome(CRS) was seen in 76% of the CAR-T cell therapy cohort with grade ¾ observed in 1.1%. There were no fatal neurotoxicities (any grade 20%; grade ¾ -1.1%) documented, with cranial nerve palsy, ICANS and MNTs seen in 8%, 4.5% and 0.6% respectively.

Commentaries: Lenalidomide-refractory multiple myeloma often portends a poor prognosis with less than 12 months of median progression-free survival in real-world studies. This is a clear unmet need and is commonly seen in clinical practice. Cilta-cel therapy targeting BCMA was evaluated in this phase-3 study after promising results of CARTITUDE-1which explored cilta-cel in a heavily pretreated population (median 6 lines). Cilta-cel demonstrated superiority in numerous key outcomes. The hazard ratio for disease progression or death was 0.26, indicating a significant reduction in risk. The depth of response (ORRs and MRD negativity) was significantly higher with cilta-cel. The CAR T-cell-associated adverse events (CRS/ICANS/MNTs) were well managed with supportive care, as the majority were grade 3 or lower. The incidence and severity of the toxicities were lesser when compared with CARTITUDE-1. This suggests improved tolerability when used in earlier lines, making cilta-cel the "potential" new standard of care for patients with lenalidomide-refractory MM after first relapse. However, the ORR reported in CARTITUDE-1 was higher than that seen in CARTITUDE-4 (98% vs 84.6%). Long-term follow-up and PFS updates would shed light on the durability of response and help in the appropriate sequencing of available therapies.

"Inshorts- Through expert's lens" Journal Club

Dr. Nikhil M. Kumar
MD, DM

Associate Consultant, Department of Hematology & BMT, Fortis Memorial Research Institute, Gurugram

Nørgaard, J.N., Abildgaard, N., Lysén, A. et al. Intensifying treatment in PET-positive multiple myeloma patients after upfront autologous stem cell transplantation. Leukemia 37, 2107–2114 (2023).https://doi.org/10.1038/s41375-023-01998-7

Summary: Multiple myeloma is a plasma cell dyscrasia with heterogenous treatment outcomes. Induction chemotherapy followed by autologous stem cell transplant remains the standard of care. PET-CT scan is highly sensitive in detecting residual disease in myeloma patients post autologous stem cell transplant (ASCT) and is complimentary to bone marrow MRD assessment. PET positivity after autologous transplant is strongly correlated with inferior PFS and OS. Additional treatment in PET positive patients post-transplant may improve outcomes. This phase 2 study enrolled 159 patients who had a VGPR or better post ASCT and screened them with PET-CT scan. A total of 53 patients (33%) were PET positive and 57% of PET-positive patients were MRD negative, demonstrating that these response assessments are complementary. PET-positive patients received four 28-day cycles of carfilzomib-lenalidomide-dexamethasone (KRd). Flow cytometry-based MRD analysis was performed before and after treatment. Around one third (33%) of the PET positive patients turned PET negative after KRd consolidation and MRD negative patients were more likely to convert than MRD positive patients.

Thus, combining PET-CT scan and MRD assessment by bone marrow is a sensitive technique to detect residual disease post-transplant. KRd consolidation in PET positive patients could improve outcomes.

Critical Appraisal

This study has looked at whether intensifying treatment in PET positive patients post-transplant improves outcomes. Induction chemotherapy pre-transplant is not uniform in this study. Neither is the timing of PET-CT scan post-transplant standardised. Also, its unclear whether patients have received any additional treatment after ASCT prior to getting a PET-CT done. Baseline PET-CT scan for comparison was also lacking. This is a single arm study with short duration of follow-up. A randomised control trial with longer duration of follow up is warranted to ascertain whether intensifying treatment in PET positive patients post-transplant would improve outcomes.

“Inshorts- Through expert's lens” Journal Club

23rd November 2023

Birtamimab plus standard of care in light-chain amyloidosis: the phase 3 randomized placebo-controlled VITAL trial

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MD, DM

Associate Professor & Consultant Hemato-oncologist, Department of Hematology. United Institute of Medical Sciences, Prayagraj

Summary: AL amyloidosis is a rare progressive,and fatal disease caused by amyloid deposition leading to organ dysfunction and failure. Clonal plasma cells produces immunoglobulin lightchain that misfolds, forms toxic aggregates and deposits as amyloid in vital organs, most commonly the heart Current therapies available target the clonal plasma cells but not the pre formed amyloid fibrils and has not significantly improved survival in patients with stage 4 AL amyloidosis. Birtamimab is the first drug to produced survival benefit in these patients with risk of early mortality. It is a form of amyloid depleter therapy that promotes clearance of amyloid deposits via phagocytosis. VITAL trial is a the first randomized, placebo-controlled phase 3 trial of an amyloid-depleter therapy combined with SOC chemotherapy in patients with AL amyloidosiswith cardiac involvement. The trial was stopped early after the results of a futility analysis that suggested the primary end point was unlikely to be met. But post hoc efficacy analyses showed that in patients with Mayo stage IV AL amyloidosis, significant improvement in survival with birtamimab + SOC was observed at 9months.

Critical Appraisal:

- Though this is the first trial that has demonstrated a survival benefit in patients with Mayo stage IV AL amyloidosis with a favourable risk benefit profile, the statistical analysis must be viewed with great caution, as the VITAL trial was not designed for this analysis and that post-hoc data analyses conform to neither the population nor the randomization model of statistical inference, so the promising data could be nothing more than simple coincidence. The survival curves separating the lines way early either shows that birtamimab is a game changing treatment or just a mere chance and hence we need more number of patients and longer duration to ascertain its efficacy.
- But on the positive side, this post HOC analysis suggesting survival benefit in Mayo stage IV Al amyloidosis has led to the AFFIRM-AL study is designed to confirm the survival benefit observed in the VITAL study in these high risk patients.

“Inshorts- Through expert's lens” Journal Club

28th December 2023

Impact of cytogenetic abnormalities on treatment outcomes in patients with amyloid light-chain amyloidosis: subanalyses from the ANDROMEDA study

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Summary: This study is a post hoc analysis of the ANDROMEDA study,which is a randomized, open-label, active-controlled, multicenter, phase-3 study in newly diagnosed patients of AL amyloidosis. 388 patients were randomised 1:1 to D-VCd or VCd, of whom 321 had cytogenetic testing available. Assessment of cytogenetic abnormalities was based on fluorescence in situ hybridisation (FISH) and/or karyotyping. Clinical outcomes in patients with t(11;14), del17p13, del13q14, and amp1q21 was evaluated. t(11;14) was the most common cytogenetic abnormality. Rates of hematologic CR and organ responses were higher in D-VCd across all cytogenetic sub- groups. In the VCd group the rates of hematologic CR was numerically lower in presence of amp1q21 and t(11;14). This study validated the results of previous studies which showed poor deep responses with VCd therapy in AL amyloidosis patients with cytogenetic abnormalities and further strengthening the role of cytogenetic evaluation in AL amyloidosis patients.

Critical Appraisal: The study evaluated the role of cytogenetic abnormalities in AL amyloidosis patients receiving D-VCd vs VCd therapy. The superiority of daratumumab based regimen in AL amyloidosis irrespective of cytogenetic abnormalities was highlighted. The study results have provided an insight to a cytogenetic testing-based treatment approach in amyloidosis patients.

The sub-group analysis had small sample sizes. Particularly del17p13 had only 9 cases in each treatment arm. Cytogenetic analysis was performed locally and not centrally which may lead to analyses biases. Karyotyping was also used to detect abnormalities which may not be an optimal test and may have affected sensitivity too owing to patchy nature of the disease and presence of small number of plasma cells. Another limitation of the study is a short median follow-up of 20.3 months.

"Inshorts- Through expert's lens" Journal Club

Dr. Hamza Dalal

Consultant Hematologist, Fortis Institute of Blood Disorders, Mumbai.

Bortezomib-Dexamethasone, Rituximab and Cyclophosphamide as First-Line Treatment for Waldenstrom's Macroglobulinemia - A Prospectively Randomized Trial of the European Consortium for Waldenstrom's Macroglobulinemia

(ECWM – 1 study)

Summary:

The European consortium for Waldenstroms Macroglobulinemia (EWCM) conducted a two-armed randomised prospective trial to evaluate Bortezomib-Dexa-Cyclophosphamide-Rituximab (V-DRC) regimen versus DRC regimen for newly diagnosed treatment naïve patients with WM/LPL. This study was published in the Journal of Clinical Oncology on 10th February 2023.

The Rationale for the study was to identify a fixed duration CIT regimen with high rates of response and acceptable toxicity profile. 202 patients were randomized in 1:1 manner. Arm 1 (DRC arm) included subcutaneous rituximab (1400mg SC on day 1), dexamethasone (20mg on day 1) and cyclophosphamide (100mg/m2) from day 1-5 in each 28 day cycle. Arm 2 had Bortezomib (1.6mg/m2 SC) x 3 weekly doses in addition to DRC Backbone.

Primary end point was PFS and secondary end points included response depth, response kinetics and OS. Median age in both age groups was 68 years with 80% patients above the age of 65 years although majority had good ECOG score. About half the patients belonged to high risk ISSWM group with median IGM level of 3.1gm/dl. As the study was initiated prior to routine MYD88 testing, a drawback of the study was incomplete availability of mutation data.

V-DRC showed a statistically non-significant PFS benefit as compared to DRC (80.6% vs 72.6%). Improvement in ORR, VGPR and CR rates were also seen in V-DRC arm but OS benefit could not be demonstrated due to short follow-up. Main adverse events were manageable but incidence of infection and neuropathy in V-DRC group was twice that in DRC group. The authors concluded that V-DRC was an effective option in this subset of patients with acceptable toxicity profile.

Critical Appraisal:

The ECWM-1 study was initiated at a time when management options for WM/LPL included chemo-immunotherapy regimens like BR, DRC and CyBorD. These regimens achieved good Overall response but did not improve OS. Unlike Follicular lymphoma, addition of maintenance rituximab was a failure in improving PFS in patients with LPL .

The objective of this study was to understand if addition of Bortezomib could improve and deepen the response rates to available therapy without undue toxicity. The study accrual although initially fast paced, slowed down considerably after approval for Ibrutinib in the management of elderly patients with WM/LPL. This goes to show the difficulties in conducting trials for rare diseases like WM. Another major drawback of this study was that the trial was initiated when routine MYD88 / CXCR4 testing was not practised. Hence only patchy mutation data is available precluding meaningful results on the basis of this stratification. Further studies will be need to elucidate the impact on MYD88 and CXCR4 mutation on outcomes with V-DRC regimen.

Although primary end point was achieved, it was not statistically significant. Whether this regimen will hold up against powerful targeted therapy drugs like BCL2 and BTK inhibitors need to be seen. The Non-availability of SC rituximab in India is a hindrance to adoption of study protocol for use in India. Lastly, incidence of neuropathy amongst study participants was significant and did lead to substantial treatment discontinuations.

“Inshorts- Through expert's lens” Journal Club

22nd February 2024

Ibrutinib and venetoclax as primary therapy in symptomatic, treatment-naïve Waldenström macroglobulinemia Castillo et al

Dr. Aishwarya Muralidharan

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Summary:

A multicentre, single-arm, prospective phase 2 trial held in Dana-Farber Cancer Institute (DFCI), Massachusetts General Hospital, and Beth Israel Deaconess Medical Centre in Boston, Massachusetts studied the efficacy of ibrutinib with venetoclax in WM in an upfront setting. patients were enrolled from July 2020 to January 2022 and Data was collected till 31 may 2023. Previously untreated WM meeting the IWWM2 criteria for therapy were enrolled. Primary endpoint was assessment of VGPR(a surrogate marker for OS). 45 patients were enrolled and therapy was given in an OPD setting comprising of 28 day cycles. First cycle was ibrutinib monotherapy and subsequently venetoclax was added from cycle two with TLS prophylaxis. At best response 19 participants (42%) attained a VGPR, 24 (53%) a PR, and 2 (4%) a minor response. CXCR4 mutations were associated with a numerically, but not statistically significant, lower VGPR rate (29% vs 50%; P = .15. Grade ≥3 adverse events observed in more than 1 participant were neutropenia, mucositis, diarrhea, laboratory tumor lysis syndrome, and atrial fibrillation Two grade 5 and 1 grade 4 ventricular arrhythmia lead to early termination of study.

Commentary:

MYD88 mutation is seen in 90% of Waldenström macroglobulinemia . This mutation leads to its constitutive dimerization this causes downstream activation of NFkB, which leads to proliferation and cell survival. This also causes BTK activation via an B cell receptor independent pathway. The efficacy of ibrutinib has been established in previous studies in both relapsed refractory and now in front line settings in WM. There is a significant difference in response with CXCR4 mutated patients performing poorly as compared to unmutated. Bcl2(antiapoptotic marker) is overexpressed in lymphoplasmacytic cells with MYD88 irrespective of CXCR4 mutation status. Hence the efficacy of this combination theray. It’s an all oral and fixed duration and chemotherapy free and the VGPR rate reported is higher than that for both Ibrutinib monotherapy in the frontline setting and venetoclax monotherapy in the relapsed setting. Provides fast response with effective bone marrow clearence. The cost considerations and safety profile are yet to be established. Trials with newer noncovalent BTKi are ongoing which in studies have shown a better safety profile.

"Inshorts-Through expert's lens" Journal Club

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Oubari S, Hegenbart U, Schoder R, Steinhardt M, Papathanasiou M, Rassaf T, Thimm A, Hagenacker T, Naser E, Duhrsen U, Reinhardt HC, Kortum M, Agis H, Schonland S, Carpinteiro A. Daratumumab in first-line treatment of patients with light chain amyloidosis and Mayo stage IIIb improves treatment response and overall survival. Haematologica. 2024 Jan 1;109(1):220-230. doi: 10.3324/haematol.2023.283325. PMID: 37439344; PMCID: PMC10772504.

Summary:

The prognosis of patients with Mayo stage IIIb light chain amyloidosis remains very poor and treating this subset of patients is definitely challenging. The ANDROMEDA trial that led to approval of Daratumumab in combination with bortezomib-cyclophosphamide dexamethasone, had excluded Mayo Stage IIIb light chain (AL) amyloidosis patients. A post-hoc analysis showed that patients with cardiac involvement (up to Mayo stage IIIa) were the ones who benefited most from the addition of daratumumab to standard chemotherapy. This retrospective, multicentre study enrolled 119 patients with histologically diagnosed AL Amyloidosis and Mayo stage IIIb, presenting between 2016 to 2022 at four different sites in Germany and Austria, to evaluate the addition of daratumumab to the first line therapy. Twenty seven patients received an upfront treatment including daratumumab, 63 a bortezomib based regimen without daratumumab, eight received therapies other than daratumumab or bortezomib and 21 pre-treated patients or deceased prior to treatment were excluded. In the daratumumab group, median overall survival was not reached after a median follow-up time of 14.5 months, while it was significantly worse in the bortezomib- and the otherwise treated group (6.6 and 2.2 months, respectively) (P=0.002). Overall hematologic response rate at 2 and 6 months was better in the daratumumab group compared to the bortezomib group (59% vs. 37%, P=0.12, 67% vs. 41%, P=0.04, respectively). Landmark survival analyses revealed a significantly improved overall survival in patients with partial hematologic response or better, compared to non-responders. Cardiac response at 6 months was 46%, 21%, 0% in the daratumumab-, bortezomib- and otherwise treated groups, respectively (P=0.04). A landmark survival analysis revealed markedly improved overall survival in patients with cardiac very good partial response vs. cardiac non-responders (P=0.002).

Commentaries:

This study demonstrates for the first time the superiority of an upfront treatment with daratumumab over standard-of-care in stage IIIb AL amyloidosis. Daratumumab-containing regimens seem to be an effective and tolerable treatment option for patients with Mayo stage IIIb in the first-line setting, potentially representing a step forward in the treatment of this group of patients. Being a retrospective study, the unavailability of a few clinical parameters or response data in some patients seemed to be a limitation. Therapy-associated side effects were not systematically recorded as well. The better survival rates in the group treated with daratumumab suggests its efficacy and safety profile in this vulnerable patient population. Further randomized trials should be conducted to confirm the data and to define the best sequence of daratumumab combination therapies.

MYELOMA QUIZ : OCT 2023 - MAR 2024

Q1. Identify the incorrect statement wnt to myeloma bone disease

A. Bone disease is the most frequent disease-defining clinical feature of multiple myeloma (MM), with 90% of patients developing bone lesions over the course of their disease

B. Approximately half of patients with myeloma bone disease will experience skeletal-related events (SREs), such as spinal cord compression and pathologic fractures, which increase the risk of mortality by 20-40%

C. For a lytic lesion to become apparent, it requires losing more than 30% of trabecular bone.

D. Wnt signaling pathway inhibitor Dickkopf1 (DKK1) secreted directly from tumor PCs inhibits osteoclasts.

E. Pamidronate was the first BP to show a clinical benefit in MM

Q2. In the Phase 2 Magnetism MM-3 trial, after six cycles, persistent responders were switched to a dosing interval of once every 2 weeks (Q2W). Which one of the following best defines a persistent responder as per trial design ?

A. Partial response (PR) or better lasting at least 2 months

B. ≥ VGPR lasting atleast 3 months

C. Partial response (PR) or better lasting at least 3 months

D. ≥ VGPR lasting atleast 2 months

Q3. In the Phase 2 Magnetism MM-3 trial which of the following was the most common primary reason for permanent treatment discontinuation ?

A. Progressive disease

B. Infectious complications

C. Death

D. Patient request

Q4. Which of these options is incorrect with regards to the design of CONPET study ?

A. Only patients who had achieved at least VGPR, were eligible for inclusion

B. PET was done at a uniform time point of D + 90 post ASCT in all patients.

C. PET was considered positive if the Deauville score was 4 or higher.

D. Two experienced nuclear medicine radiologists at two centers evaluated all the PET examinations centrally

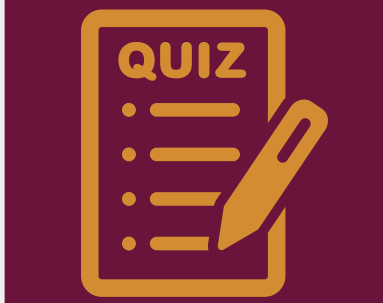
Q5. Which of these options is incorrect with regards to the findings of the CONPET study assessing the impact of PET adapted treatment in MM ?

A. Almost 60 percent of PET positive patients were MRD negative by FCM.

B. KRd consolidation converted 33% of PET-positive patients into PET negativity.

C. MRD negative patients were more likely to convert to PET negative state post KRD consolidation than MRD-positive patients.

D. Numerically, more patients with previous VCd induction than VRd induction converted from PET Positive to PET negative.



Oct 2023

WINNER

Dr. Sumeet Mirgh

Asst Professor, TMH, ACTREC, Mumbai

Q6. Diagnosis of Systemic AL Amyloidosis as per IMWG criteria includes all of the following except

A. Presence of an amyloid-related systemic syndrome

B. Positive amyloid staining by Congo red in any tissue

C. Evidence that amyloid is light-chain-related established by direct examination of the amyloid using mass spectrometry-based proteomic analysis, or immunoelectron microscopy

D. Evidence of a monoclonal plasma cell proliferative disorder

E. All the above criteria are mandatory as per IMWG criteria (so no exceptions)

Q7. A patient with systemic amyloidosis (including GI) has these waxy-raised hemorrhagic lesions below the nose, around the lips, and eyes. What is the diagnosis ?

A. Herpes Zoster

B. Herpes Simplex

C. Amyloid deposits

D. Vitamin deficiency due to Amyloid Gastropathy

E. Molluscum contagiosum

Q8. All the following are the used in Mayo 2012 staging for AL Amyloidosis except ?

A. Troponin

B. BNP

C. dFLC

D. SFLC ratio

E. All are components of staging (so no exception)

Q9. Clinical trials may be stopped for futility if there is little or no chance of demonstrating the hoped-for effect. Reasons include all except:

A. Evidence of no treatment effect by scheduled interim analysis

B. Substantial missing data that would unacceptably undermine trial conclusions

C. Event rates too low to support meaningful comparisons

D. Lack of funding/ finances for continuing the trial

E. All of the above are part of the futility analyses; thus no exceptions from the above options

Q10. VITAL trial on the role of Birtamimab has shown benefit in post-hoc analysis in which patients?

A. Benefit in the percentage of all-cause mortality (ACM) in Stage IV AL amyloidosis

B. Benefit in time to ACM in stage IV AL amyloidosis

C. Benefit in time to ACM in all stages of AL amyloidosis

D. Benefit in the primary composite endpoint (time to ACM or centrally adjudicated cardiac hospitalization ≥91 days) in Stage IV AL amyloidosis

E. Benefit in the primary composite endpoint (time to ACM or centrally adjudicated cardiac hospitalization ≥91 days) in all stages of AL amyloidosis

QUIZ

MYELOMA QUIZ

Nov 2023

WINNER

Dr. Bipin Francis

Jubilee Mission Medical College, Thrissur, Kerala

MYELOMA QUIZ : OCT 2023 - MAR 2024

Q11. The term “Amyloid” was brought into the scientific literature by :

A. German botanist Matthias Schleiden
B. German pathologist Rudolf Virchow
C. German chemist Herman Bennhold
D. German psychiatrist Aloysius (Alois) Alzheimer

Q12. Identify the incorrect statement wrt to the protocol of the study by Buske et al evaluating B+ DRC in WM :

A. Rituximab 375mg/m2 IV was used in both arms for all 6 cycles
B. Subjects with ≥ Grade 2 neuropathy were excluded from study population.
C. An effect size of 15 % improvement in PFS was assumed to calculate the sample size.
D. Only WM patients with ECOG performance status 0 to 2 were included in the study.
E. All are correct statements.

Q13. Which of these statements is incorrect wrt to findings of study by Buske et al evaluating B+ DRC in WM ?

A. At the end of treatment, B-DRC and DRC induced major responses in 80.6% versus 69.9%.
B. The median time to first response was shorter for B-DRC with 3.0 vs 5.5 m for DRC
C. ≥ Grade 3 adverse events occurred more commonly in the B-DRC arm and neuropathy was the most common reason for drug discontinuation.
D. One patient in the B-DRC arm achieved a CR while none achieved CR in DRC arm

Q14. Which of these statements is incorrect wrt to WM ?

A. Extramedullary infiltration is commonly seen involving liver, spleen and lymph nodes.
B. Bulky lymphadenopathy and massive hepatosplenomegaly are rare findings.
C. Paratrabecular infiltration by lymphoplasmacytic cells is the hallmark of WM in bone marrow biopsy specimens.
D. All are correct statements.

Q15. Which of the following statement regarding response rates to Talquetamab in specific myeloma subgroups is incorrect wrt to findings of the MonumenTAL trial ?

A. Unlike IgM myeloma ; plasma cells in WM are positive for CD 19 and CD 45 and negative for CD56 and CD 117.
B. CXCR4 mutation is associated with aggressive disease and poorer response ot therapy.
C. The most common cytogenetic abnormality seen in WM is 6q deletion and is associated with reduced PFS.
D. Cold agglutinins develop in ~ 5% cases of WM and hemolytic anemia is evident in ~ 1 % cases

QUIZ

MYELOMA QUIZ

Jan 2024

WINNER

Dr. Swapnil Tripathi

Senior Resident, Hematology, AIIMS, New Delhi

MYELOMA QUIZ : OCT 2023 - MAR 2024

Q16. Which of the following is an incorrect statement regarding the Swedish physician Jan Waldenstrom?

A. Waldenström studied organic chemistry with Hans Fischer at the Technical University of Munich

B. In 1937, he defended a landmark PhD thesis on acute intermittent porphyria.

C. He initially desribed cases of WM as 'purpura hyperglobulinemica'

D. He described the first case of carcinoid syndrome and chronic active hepatitis in medical literature

Q17. Identify the incorrect statement wrt to the protocol of the study by Castillo et al evaluating Ibrutinb + Ven in WM :

A. All treatments were administered orally in an outpatient setting

B. Venetoclax was introduced from cycle 2 only

C. G CSF support was permitted only when absolute neutrophil count < 500µl

D. BM aspiration and biopsies were obtained at baseline and at 6, 12, and 24 months

E. All are correct statements.

Q18. Which of these statements is incorrect wrt to the trial results by Castillo et al evaluating Ibrutinb + Ven in WM ?

A. The most common Grade 3 adverse event in the study arm was neutropenia.

B. Two Grade 5 adverse events were reported in the trial

C. he responses were fast, with a median time to minor and major response of 0.9 and 1.8 months, respectively.

D. 3 cases of clinical TLS were seen in the trial and none required RRT

Q19. MYD88 mutation L265P is not a common association with which of these disorders

A. Splenic Marginal Zone Lymphoma

B. IgM Myeloma

C. MALT Lymphoma

D. IgM amyloidosis

Q20. Which of these statements is incorrect wrt International Prognostic Scoring System for Waldenström Macroglobulinemia ?

A. IPSS to be used only for patients who require treatment for WM

B. Serial measurements of β2 microglobulin are not useful in monitoring therapy.

C. Age is the most powerful predictor of outcome

D. LDH and IgM levels > 5000mg/dl are predictors of early mortality in WM as per IPSS

QUIZ

MYELOMA QUIZ

Feb 2024

WINNER

Dr. Harish Chandra Yadav

NSC Government Medical College, Khandhawa

MYELOMA QUIZ : OCT 2023 - MAR 2024

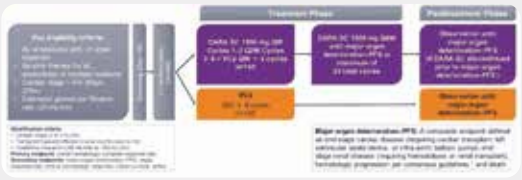
Q21. Which of the following was not an exclusion criteria in the trial which used the study protocol shown ?

A. A. Previous or current diagnosis of symptomatic multiple myeloma

B. Planned stem cell transplant during the first 6 cycles of protocol therapy

C. Grade 1 painful peripheral neuropathy

D. Supine systolic blood pressure < 100 mmHg



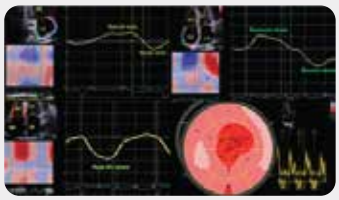
Q22. Identify the diagnostic modality being shown in the image which is a good value addition in assessing organ dysfunction in amyloidosis.

A. Four-chamber strain imaging using speckle-tracking echocardiography

B. Tc 99m pyrophosphate map

C. Cardiac MRI T1 mapping

D. Cardiac SPECT tracing



Q23. Which of these statements is incorrect wrt to the OS results by Sara et al evaluating role of Daratumumab in Mayo stage IIIB AL amyloidosis ?

A. OS was calculated from the date of treatment initiation to death or loss of follow-up or to the date of heart transplantation.

B. The median OS was 6.6 m in the bortezomib group, 2.2 m in the group treated with other regimens, but was not reached in the daratumumab group

C. The 6- m OS in the daratumumab group, bortezomib group, and the group treated with other regimens was 70%, 51% and 25%, respectively

D. In regression analysis, dFLC ≥500 mg/L or NTproBNP ≥16,000 pg/mL predicted OS in the Mayo IIIb cohort

Q24. Which of these statements is incorrect wrt to the response rates results by Sara et al evaluating role of Daratumumab in Mayo stage IIIB AL amyloidosis ?

A. None of the patients achieved a cardiac CR in any of the treatment arms

B. Patients in the daratumumab group were more likely to have a cardiac VGPR than those in the bortezomib group

C. The 12-m OS was 100% in patients who achieved a cardiac VPGR or cardiac PR, compared to 73% in cardiac non-responders

D. The benefit of adding daratumumab to first-line therapy appeared to increase relatively with increasing NTproBNP across all levels

Q25. Subgroup analysis of overall survival in patients with AL amyloidosis and Mayo stage IIIb favoured Daratumumab in all subsets except ?

A. NT proBNP ≥ 25000pg/ml

B. dFLC ≥ 180 mg/l

C. GFR ≥ 30 ml/min/1.73m2

D. Proteinuria > 5g/24h

QUIZ

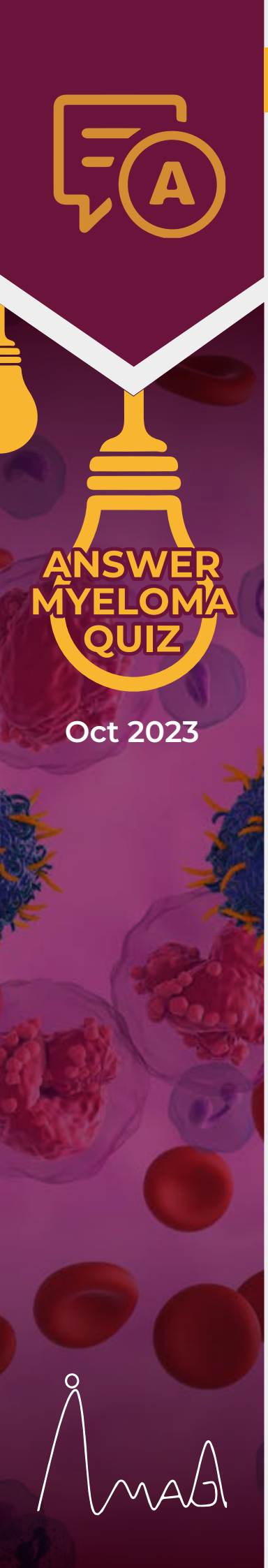
MYELOMA QUIZ

Mar 2024

WINNER

Dr. Ramesh B.

Meenakshi Mission Hospital, Madurai, Tamil Nadu



ANSWER MYELOMA QUIZ : OCT 2023 - MAR 2024

Q1 & Answer

Identify the incorrect statement wnt to myeloma bone disease

Wnt signaling pathway inhibitor Dickkopf1 (DKK1) secreted directly from tumor PCs inhibits osteoclasts.

Explanation : Wnt signaling pathway inhibitor Dickkopf1 (DKK1) secreted directly from tumor PCs inhibits osteoblasts and not osteoclasts. Malignant plasma cells in MM severely disturb this system by secretion of Wnt antagonists in the BM microenvironment. This skews the balance toward osteogenic bone resorption and results in development of the characteristic osteolytic bone lesions.

Q2 & Answer

In the Phase 2 Magnetism MM-3 trial, after six cycles, persistent responders were switched to a dosing interval of once every 2 weeks (Q2W). Which one of the following best defines a persistent responder as per trial design ?

Partial response (PR) or better lasting at least 2 months

Explanation : Ref : Lesokhin AM et al. Elranatamab in relapsed or refractory multiple myeloma: phase 2 MagnetisMM-3 trial results. Nat Med. 2023 Sep;29(9):2259-2267. doi: 10.1038/s41591-023-02528-9.

Q3 & Answer

In the Phase 2 Magnetism MM-3 trial which of the following was the most common primary reason for permanent treatment discontinuation ?

Progressive disease

Explanation : About 95 percent of trial participants discontinued treatment on trial due to disease progression and not adverse events.

Q4 & Answer

Which of these options is incorrect with regards to the design of CONPET study ?

PET was done at a uniform time point of D + 90 post ASCT in all patients.

Explanation : No unfoitrm time point for PET in this prospective study. The median time from transplant to screening with PET was 146 days (IQR : 103- 186d)

Q5 & Answer

Which of these options is incorrect with regards to the findings of the CONPET study assessing the impact of PET adapted treatment in MM ?

Numerically, more patients with previous VCd induction than VRd induction converted from PET Positive to PET negative.

Explanation : More patients with previous VRd induction than VCd induction converted from PET positive to PET negative disease

ANSWER MYELOMA QUIZ

Nov 2023

ANSWER MYELOMA QUIZ : OCT 2023 - MAR 2024

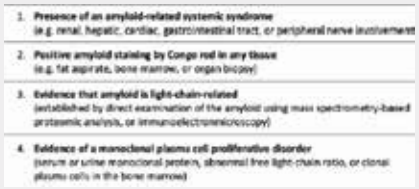
Q6 & Answer

Diagnosis of Systemic AL Amyloidosis as per IMWG criteria includes all of the following except

All the above criteria are mandatory as per IMWG criteria (so no exceptions)

Explanation : Rajkumar SV, Dimopoulos MA, Palumbo A, et al. International Myeloma Working Group updated criteria for the diagnosis of multiple myeloma. The Lancet Oncology. 2014

IMWG diagnostic criteria for Systemic AL Amyloidosis



Q7 & Answer

A patient with systemic amyloidosis (including GI) has these waxy-raised hemorrhagic lesions below the nose, around the lips, and eyes. What is the diagnosis?

Amyloid deposits

Explanation : Cutaneous manifestation in AL amyloidosis depends upon the site of amyloid deposition.Superficial dermal deposition of amyloid produces shiny waxy translucent papules. Flexural areas are sites of predilection, including the eyelids, retroauricular region, neck, axillae, inframammary area, umbilicus, inguinal and anogenital regions. Lesions may also be found on the central face, lips, tongue and buccal mucosa.

Q8 & Answer

All the following are the used in Mayo 2012 staging for AL Amyloidosis except ?

SFLC ratio

Explanation : Two validated cardiac staging systems, Mayo 2012 (stage I-IV) and the European modification of the standard Mayo 2004 staging system (stage I-IIIb), stratify patients according to different thresholds of biomarkers of disease involvement. The Mayo 2012 model divides patients based on three biomarkers: high-sensitivity troponin T <40 ng/L, NT-proBNP <1,800 pg/mL, and difference between involved and uninvolved serum free light chain (dFLC) <180 mg/L. The European modification of Mayo 2004 stratifies patients based on two biomarkers: high-sensitivity troponin T <50 ng/L and NT-proBNP <332 ng/L with stage III sub-classified into two sub-stages using NT-proBNP at 8,500 ng/L cutoff.

Q9 & Answer

Clinical trials may be stopped for futility if there is little or no chance of demonstrating the hoped-for effect. Reasons include all except :

Lack of funding/ finances for continuing the trial

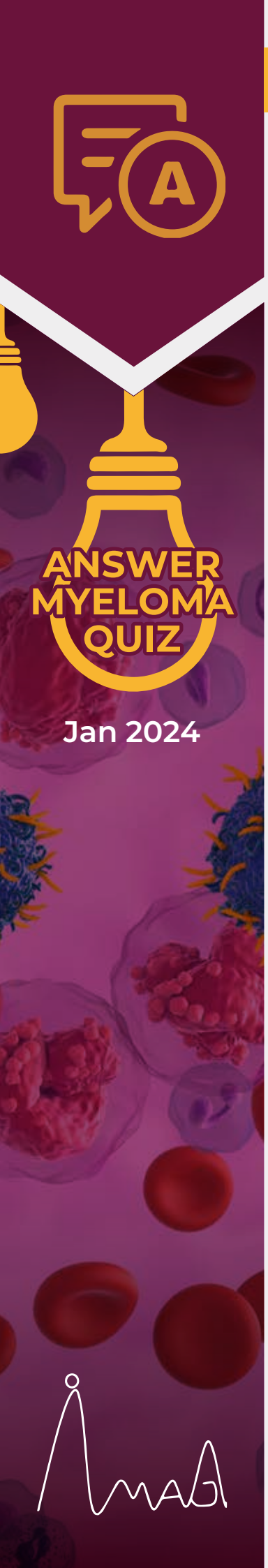
Explanation : No unfoitrm time point for PET in this prospective study. The median time from transplant to screening with PET was 146 days (IQR : 103- 186d)

Q10 & Answer

VITAL trial showed benefit of Birtamimab in post-hoc analysis in which patients ?

Benefit in time to ACM in stage IV AL amyloidosis

Explanation : Gertz MA, Cohen AD, et al. Birtamimab plus standard of care in light-chain amyloidosis: the phase 3 randomized placebo-controlled VITAL trial. Blood. 2023 Oct 5;142(14):1208-1218. doi: 10.1182/blood.2022019406



ANSWER MYELOMA QUIZ : OCT 2023 - MAR 2024

Q11 & Answer

The term “amyloid” was brought into the scientific literature by :

German botanist Matthias Schleiden

Explanation : The term “amyloid” was brought in the scientific literature by the German botanist Matthias Schleiden. Schleiden oriented to botany, microscopy and anatomy, with a special interest in the chemical and anatomical composition of plant cell, and received his second PhD in 1839. One of Schleiden’s major ideas was to apply the iodine-sulphuric acid test for starch in plants. Schleiden describes “amyloid” to represent “a normal amylaceous constituent in plants

Q12 & Answer

Identify the incorrect statement wrt to the protocol of the study by Buske et al evaluating B+ DRC in WM :

Rituximab 375mg/m2 IV was used in both arms for all 6 cycles

Explanation : ROnly during first cycle was Rituximab 375mg/m2 IV used but for subsequent cycles SC Rituximab 1200mg was used.

Q13 & Answer

Which of these statements is incorrect wrt to findings of study by Buske et al evaluating B+ DRC in WM ?

≥ Grade 3 adverse events occurred more commonly in the B-DRC arm and neuropathy was the most common reason for drug discontinuation

Explanation : ≥ Grade 3 adverse events were equivalent in both experimental arm and control arm; Ref : Buske C, Dimopoulos MA,et al; Bortezomib-Dexamethasone, Rituximab, and Cyclophosphamide as First-Line Treatment for Waldenström's Macroglobulinemia: A Prospectively Randomized Trial of the European Consortium for Waldenström's Macroglobulinemia. J Clin Oncol. 2023 May 10;41(14):2607-2616. doi: 10.1200/JCO.22.01805

Q14 & Answer

Which of these statements is incorrect wrt to WM ?

Paratrabecular infiltration by lymphoplasmacytic cells is the hallmark of WM in bone marrow biopsy specimens.

Explanation : The common patterns of BM infiltration mentioned in the literature are diffuse, nodular interstitial, mixed paratrabecular nodular, and paratrabecular patterns. Interstitial infiltration by lymphoplasmacytic cells is the hallmark of WM and paratrabecular pattern is rare

Q15 & Answer

Which of the following statement regarding response rates to Talquetamab in specific myeloma subgroups is incorrect wrt to findings of the MonumenTAL trial ?

The most common cytogenetic abnormality seen in WM is 6q deletion and is associated with reduced PFS.

Explanation : 22–46% of WM patients have a 6q deletion. WM patients with 6q deletion have higher levels of β2M, lower albumin, and anemia. Nonetheless; the association between 6q deletion and disease progression or prognosis is controversial

ANSWER MYELOMA QUIZ

Feb 2024

ANSWER MYELOMA QUIZ : OCT 2023 - MAR 2024

Q16 & Answer

Which of the following is an incorrect statement regarding the Swedish physician Jan Waldenstrom?

He initially desribed cases of WM as “Purpura hyperglobulinemica”

Explanation : Although he coined the term “purpura hyperglobulinaemica,” this entity is now recognized as benign hypergammaglobulinemic purpura of Waldenström (BHPW). Subsequent studies have shown that rheumatoid factor was present in all and intermediate complexes ranging from 7 S to 19 S were found on ultracentrifugation. The purpura can be precipitated by increases in hydrostatic pressure. Moreover, we now know that BHPW occurs frequently in autoimmune diseases and rarely with multiple myeloma.

Q17 & Answer

Identify the incorrect statement wrt to the protocol of the study by Castillo et al evaluating Ibrutinb + Ven in WM :

G CSF support was permitted only when absolute neutrophil count < 500µl

Explanation : G CSF support was permitted only when absolute neutrophil count < 1000µl

Q18 & Answer

Which of these statements is incorrect wrt to the trial results by Castillo et al evaluating Ibrutinb + Ven in WM ?

3 cases of clinical TLS were seen in the trial and none required RRT

Explanation : No single case of clinical TLS in the trial

Q19 & Answer

MYD88 mutation L265P is not a common association with which of these disorders

IgM Myeloma

Explanation : Upto 10 percent of SMZL and MALT oma and 80 percent of IgM amyloidosis have MYD88 mutation L265P but IgM myeloma lack the same.

Q20 & Answer

Which of these statements is incorrect wrt International Prognostic Scoring System for Waldenström Macroglobulinemia ?

LDH and IgM levels > 5000mg/dl are predictors of early mortality in WM as per IPSS

Explanation : IPSS WM

Risk group	Stage 1 (low risk)	Stage 2 (intermediate risk)	Stage 3 (high risk)
Risk factors present*	0 or 1 (except age)	Age or 2	≥ 3
5-year OS (%)	87	60	36

*Risk factors for IPSSWM include: age ≥ 65 years, Hb ≤ 11.5 g/dL, platelets ≤ 100 × 10⁹/L, B2M > 3 mg/L and IgM > 70 g/L. Other risk factors not included in IPSSWM include elevated serum LDH and low serum albumin.

B2M, β2 microglobulin; Hb, haemoglobin; IgM, immunoglobulin M; IPSSWM, International Prognostic Scoring System for Waldenström's macroglobulinaemia; LDH, lactate dehydrogenase; OS, overall survival; WM, Waldenström's macroglobulinaemia.

ANSWER MYELOMA QUIZ

Mar 2024

ANSWER MYELOMA QUIZ : OCT 2023 - MAR 2024

Q21 & Answer

Which of the following was not an exclusion criteria in the trial which used the study protocol shown ?

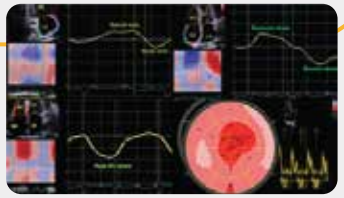
Supine systolic blood pressure < 100 mmHg

Explanation : Supine systolic blood pressure < 90 mmHg was used as exclusion trial

Q22 & Answer

Identify the diagnostic modality being shown in the image which is a good value addition in assessing organ dysfunction in amyloidosis.

Four-chamber strain imaging using speckle-tracking echocardiography



Q23 & Answer

Which of these statements is incorrect wrt to the OS results by Sara et al evaluating role of Daratumumab in Mayo stage IIIB AL amyloidosis ?

In regression analysis, dFLC ≥500 mg/L or NTproBNP ≥16,000 pg/mL predicted OS in the Mayo IIIb cohort

Explanation : Ref Oubari S,et al; A. Daratumumab in first-line treatment of patients with light chain amyloidosis and Mayo stage IIIb improves treatment response and overall survival. Haematologica. 2024 Jan 1;109(1):220-230. doi: 10.3324/haematol.2023.283325

Q24 & Answer

Which of these statements is incorrect wrt to the response rates results by Sara et al evaluating role of Daratumumab in Mayo stage IIIB AL amyloidosis ?

The benefit of adding daratumumab to first-line therapy appeared to increase relatively with increasing NT pro BNP across all levels

Explanation : The benefit of adding daratumumab to first-line therapy appeared to increase relatively with increasing NT pro BNP up to 25,000 pg/ml.. However, this advantage appeared to decrease with further increases in NT pro BNP.

Q25 & Answer

Subgroup analysis of overall survival in patients with AL amyloidosis and Mayo stage IIIb favoured Daratumumab in all subsets except ?

Proteinuria > 5g/24h

Explanation : Advanced kidney disease, i.e., renal stages II and III and especially proteinuria >5 g/24 h, reduced the benefit of adding daratumumab, confirming data from Kimmich et al. who showed that the antibody is excreted in the urine in the context of proteinuria and thus loses efficacy.

"Original research publications from India"

- Kathrotiya M, Radhakrishnan V, Bhave SJ, et al. Bortezomib-based induction therapy followed by autologous hematopoietic cell transplantation in newly diagnosed multiple myeloma patients: A single-center experience and review of Indian literature. Indian J Cancer. 2023;60(4):486-492. doi:10.4103/ijc.ijc_78_22
- Khan AN, Asija S, Pendhari J, Purwar R. CAR-T cell therapy in hematological malignancies: Where are we now and where are we heading for? Eur J Haematol. 2024 Jan;112(1):6-18. doi: 10.1111/ejh.14076. Epub 2023 Aug 7. PMID: 37545253.
- Ganju P, Kalaiyarasi JP, Karunakaran P, Veeraiah S, Mehra N. COVID-19 Vaccine Uptake in Patients with Multiple Myeloma and AL Amyloidosis: A Cross-Sectional Observational Study from India. Indian J Hematol Blood Transfus. 2024;40(1):30-35. doi:10.1007/s12288-023-01680-z
- Sundaresan D, Bhagat S, Sreedharanunni S, Sachdeva MUS, Malhotra P, Sharma P. Relapsed Multiple Myeloma with Anaplastic Transformation. Indian J Hematol Blood Transfus. 2024 Jan;40(1):179-180. doi: 10.1007/s12288-023-01672-z. Epub 2023 Jun 3. PMID: 38312170; PMCID: PMC10830952.
- Kumar A, Kumar KV, Kundal K, Sengupta A, Sharma S, R K, Kumar R. MyeloDB: a multi-omics resource for multiple myeloma. Funct Integr Genomics. 2024 Jan 20;24(1):17. doi: 10.1007/s10142-023-01280-0. PMID: 38244111.
- Thareja J, Minj A, Samal P, Panigrahi PK. Ophthalmic manifestations in hematological malignancies: An observational study from a tertiary care health center in Eastern India. Indian J Ophthalmol. Published online January 8, 2024. doi:10.4103/IJO.IJO_815_23
- Gaba M, Kumar N, Pandey A, Dewan A. An interesting case of AL amyloidosis and MM: a complex scenario with cardiac involvement. BMJ Case Rep. 2024 Jan 24;17(1):e256012. doi: 10.1136/bcr-2023-256012. PMID: 38272507; PMCID: PMC10826505.
- Saijpaul R, Khurana V, Verma R, Kaushik S. Single monoclonal spike characterized as double monoclonal gammopathy in a patient with multiple myeloma: A rare finding. Indian J Pathol Microbiol. 2024 Jan-Mar;67(1):192-194. doi: 10.4103/ijpm.ijpm_904_21. PMID: 38358220.
- Sharma NS, Choudhary B. Good Cop, Bad Cop: Profiling the Immune Landscape in Multiple Myeloma. Biomolecules. 2023;13(11):1629. Published 2023 Nov 7. doi:10.3390/biom13111629
- Mishra UP, Verma AK, Chaurasia JK. Solitary Extramedullary Plasmacytoma of Nasal Cavity. Indian J Otolaryngol Head Neck Surg. 2023;75(4):4060-4065. doi:10.1007/s12070-023-04061-0
- Kumar R, Kapoor R, Sharma S, et al. Bone marrow transplant: A two-decade single centre hematology experience. Med J Armed Forces India. 2023;79(6):657-664. doi:10.1016/j.mjafi.2023.09.005
- Sundaresan D, Bhagat S, Sreedharanunni S, Sachdeva MUS, Malhotra P, Sharma P. Relapsed Multiple Myeloma with Anaplastic Transformation. Indian J Hematol Blood Transfus. 2024;40(1):179-180. doi:10.1007/s12288-023-01672-z
- Danalakshmi S. Monoclonal Light Chains with alpha 2 mobility on Serum Protein Electrophoresis. EJIFCC. 2023;34(3):250-257. Published 2023 Oct 16.
- Kapur K, Sharma M, Puj K, Bande V, Pandya S. Solitary endobronchial plasmacytoma-a rare differential of an endobronchial mass. Indian J Thorac Cardiovasc Surg. 2023;39(6):629-631. doi:10.1007/s12055-023-01557-w
- Bagade S, Anjum A. Bisalbuminemia: A Rare Incidental Finding in Monoclonal Gammopathy. EJIFCC. 2023;34(4):325-329. Published 2023 Dec 21.
- Shankar M, Anandh U, Guditi S. PARAKID: Navigating the relation between paraproteins and kidney lesions: A multi-center retrospective observational study. Clin Nephrol. 2023;100(6):269-274. doi:10.5414/CN111123
- Shruthi S, Kishan Prasad HL, Kanthaje A, Rajendra VKJ. Ovarian Plasmablastic Lymphoma Posing Diagnostic Dilemma: A Rare Case Report. J Obstet Gynaecol India. 2023;73(Suppl 2):298-300. doi:10.1007/s13224-023-01802-7
- Basha FKM, Reddy VT, Sharma P, Vaishnav B. An interesting case of systemic lupus erythematosus with multiple myeloma. J Family Med Prim Care. 2023;12(11):2970-2972. doi:10.4103/jfmpc.jfmpc_178_22

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"Original research publications from India"

- Nayak HK, Chaudhary M, Panigrahi C, Mishra P, Das P, Panigrahi MK. Plasma cell myeloma associated with mediastinal plasmacytoma causing dysphagia. Indian J Gastroenterol. 2023;42(6):849-851. doi:10.1007/s12664-023-01368-2
- Misra S, Singh A, Kumar V. Plasma cell myeloma with double M bands on Serum protein electrophoresis: A diagnostic conundrum?. J Cancer Res Ther. Published online December 15, 2023. doi:10.4103/jcrt.JCRT_1362_20
- Muniswari U, Panigrahi C, Mishra SK, Padhi S. Hypergranular multiple myeloma with crystalline inclusions in young with 13q deletion. Indian J Pathol Microbiol. Published online November 9, 2023. doi:10.4103/ijpm.ijpm_345_23
- Marwah V, Rajput AK, Kumar K, Singh S, Sengupta P. Pulmonary diffuse alveolar-septal amyloidosis in association with multiple myeloma: It is not always tuberculosis. Med J Armed Forces India. 2023;79(6):732-733. doi:10.1016/j.mjafi.2021.05.016
- Agarwal M, Vijayaraghavan M, Muthuvel B, Narayanasamy A. Biochemical Analysis of Aqueous Humor in an Elderly Patient with Multiple Myeloma Presenting First as Bilateral Chronic Uveitis. Ocul Immunol Inflamm. Published online July 10, 2023. doi:10.1080/09273948.2023.2229416
- Kannan N, Dass J, Dangudubiyyam S, et al. Clinico-pathological profile of patients with plasma cell neoplasms with special reference to bone marrow fibrosis and amyloid deposition. J Clin Exp Hematop. 2023;63(4):214-218. doi:10.3960/jslrt.23029
- Yanamandra U, Reddy Gorla AK, Agrawal K, et al. Prognostic significance of extramedullary disease (EMD) detected on pre-transplant 18F-FDG PET/CT in patients with multiple myeloma: Results of PIPET-M trial. Med J Armed Forces India. 2023;79(6):672-678. doi:10.1016/j.mjafi.2023.08.007
- Kar R, Ramamoorthy S, Sathya P, et al. Plasma cell leukemia mimicking erstwhile hairy cell leukemia variant: A case with an intriguing immunophenotype. Int J Lab Hematol. 2023;45(5):806-809. doi:10.1111/ijlh.14085
- Gupta L, Suku P, Dash A, et al. Detection of circulating normal and tumor plasma cells in newly diagnosed patients of multiple myeloma and their associations with clinical and laboratory parameters. Curr Probl Cancer. 2024;48:101025. doi:10.1016/j.currproblcancer.2023.101025
- Kumar L, Melinkeri S, Ganesan P, et al. Daratumumab in Indian patients with relapsed and refractory multiple myeloma: a prospective, multicenter, phase IV study. Future Oncol. 2024;20(4):191-205. doi:10.2217/fon-2023-0842
- Jha K, Saha S, Bhattacharyya M. Cytogenetic Alterations and Correlation with Age and Gender in Patients of Multiple Myeloma: A Study from a Tertiary Care Center in Eastern India. South Asian J Cancer. 2024;13(2):126-131. Published 2024 Feb 12. doi:10.1055/s-0043-1761441
- Ganju P, Kalaiyarasi JP, Karunakaran P, Veeraiah S, Mehra N. COVID-19 Vaccine Uptake in Patients with Multiple Myeloma and AL Amyloidosis: A Cross-Sectional Observational Study from India. Indian J Hematol Blood Transfus. 2024;40(1):30-35. doi:10.1007/s12288-023-01680-z
- Bhowmik D, Kumar L. Seven-year Follow-up of India's First Sequential Hematopoietic Stem Cell and Kidney Transplant for Multiple Myeloma. Indian J Nephrol. 2024;34(2):205. doi:10.4103/ijn.ijn_234_23
- Dash S, Pandalanghat S, Kumar Y. An Unusual Case of Hoarseness of Voice and Dysphagia in Multiple Myeloma with Amyloidosis. Indian J Crit Care Med. 2024;28(2):175-176. doi:10.5005/jp-journals-10071-24613
- Sundaresan D, Bhagat S, Sreedharanunni S, Sachdeva MUS, Malhotra P, Sharma P. Relapsed Multiple Myeloma with Anaplastic Transformation. Indian J Hematol Blood Transfus. 2024;40(1):179-180. doi:10.1007/s12288-023-01672-z
- Aravind N, Krishnappa N, Shafiq N, Malhotra P. Possible case of bortezomib-induced ileus paralytic. BMJ Case Rep. 2024;17(2):e257592. Published 2024 Feb 21. doi:10.1136/bcr-2023-257592

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- Shankar M, Anandh U, Guditi S. Multiple Facets of Multiple Myeloma in Kidney Biopsy: A Multicenter Retrospective Study. Indian J Nephrol. 2024;34(1):31-36. doi:10.4103/ijn.ijn_362_22
- Sood N, Hamide A, Dubashi B, et al. Impact of Genetic Polymorphisms in NF-κB2 and TRAF3 Genes on Response to Bortezomib-Based Therapy in Multiple Myeloma Patients. Asian Pac J Cancer Prev. 2024;25(3):829-837. Published 2024 Mar 1. doi:10.31557/APJCP.2024.25.3.829
- Gupta R, Jevremovic D, Mathew SJ, Kumar S. Multiparametric Flow Cytometry in the Evaluation of Plasma Cell Proliferative Disorders: Current Paradigms for Clinical Practice. Clin Lymphoma Myeloma Leuk. 2024;24(3):e88-e95. doi:10.1016/j.clml.2023.11.006
- Kumar A, Kumar KV, Kundal K, et al. MyeloDB: a multi-omics resource for multiple myeloma. Funct Integr Genomics. 2024;24(1):17. Published 2024 Jan 20. doi:10.1007/s10142-023-01280-0
- Pradeep IY, Mayuri RK, Sourabh SP, Nirali MP. Myelomatous pleural effusion in multiple myeloma- A rare presentation. J Cancer Res Ther. 2024;20(1):476-478. doi:10.4103/jcrt.jcrt_1772_22
- Shinde S, Guntiboina VA, Nag A, et al. Melphalan-associated encephalopathy following autologous stem cell transplant: a transplanter's nightmare!. Blood Cell Ther. 2024;7(2):33-36. Published 2024 Mar 15. doi:10.31547/bct-2023-025
- Gupte A, Sasidharan A, Dutta D, Anoop R. Extramedullary plasmacytoma of the larynx - Case report. J Cancer Res Ther. 2024;20(1):493-495. doi:10.4103/jcrt.JCRT_1640_20
- Goel L, Gupta P, Kumar L, et al. Effect of CYP2C19 polymorphism on response to bortezomib-based therapy in multiple myeloma patients. Am J Med Sci. 2024;368(1):18-24. doi:10.1016/j.amjms.2024.03.022
- Dixit J, Gupta N, Kataki A, et al. Health-related quality of life and its determinants among cancer patients: evidence from 12,148 patients of Indian database. Health Qual Life Outcomes. 2024;22(1):26. Published 2024 Mar 13. doi:10.1186/s12955-024-02227-0
- Hegde PJ, Ramesh M, Shetty VV, Kumar S. Multiple myeloma as a mandibular primary - Dilemma in diagnosing rare tumours of the mandible. J Oral Maxillofac Pathol. 2024;28(1):138-141. doi:10.4103/jomfp.jomfp_297_23
- Gaba M, Kumar N, Pandey A, Dewan A. An interesting case of AL amyloidosis and MM: a complex scenario with cardiac involvement. BMJ Case Rep. 2024;17(1):e256012. Published 2024 Jan 24. doi:10.1136/bcr-2023-256012
- Saijpaul R, Khurana V, Verma R, Kaushik S. Single monoclonal spike characterized as double monoclonal gammopathy in a patient with multiple myeloma: A rare finding. Indian J Pathol Microbiol. 2024;67(1):192-194. doi:10.4103/ijpm.ijpm_904_21
- Mangla M, Sivakoti S, Palo S, Kumar N. Russell Body Cervicitis in a Human Immunodeficiency Virus-positive Female: An Unusual Presentation of Prolonged Cervical Inflammation. J Midlife Health. 2024;15(1):48-52. doi:10.4103/jmh.jmh_255_23
- Jain H, Reddy MMRK, Dey RC, et al. Exploring Transthyretin Amyloid Cardiomyopathy: A Comprehensive Review of the Disease and Upcoming Treatments. Curr Probl Cardiol. 2024;49(1 Pt B):102057. doi:10.1016/j.cpcardiol.2023.102057
- John S, Subba P, Aramugam A, Gupta S, Khanna R. A serious warning: A case report on localized amyloidosis of the oral cavity. Indian J Pathol Microbiol. Published online February 19, 2024. doi:10.4103/ijpm.ijpm_720_23
- Sinha P, Tripathi A, Gopal Madakshira M, Gb P, Sampoorna Raj C. Scratch amyloidosis over nose: A rare site of cutaneous amyloidosis. Indian J Dermatol Venereol Leprol. Published online January 6, 2024. doi:10.25259/IJDVL_448_2023
- Padmanabhan P, P J, Mampilly N, et al. Monoclonal Gammopathy of Renal Significance (MGRS) - Case Series from a Tertiary Center in Kerala. Indian J Nephrol. 2024;34(1):59-63. doi:10.4103/ijn.ijn_329_22
- Bagai S, Sanjeevani S, Khullar D, Duggal R, Prasad P, Saxena V. An Intriguing Case of Amyloidosis Leading to PAGE Kidney in a Post Renal Transplant Recipient: A Case Report. Indian J Clin Biochem. 2024;39(1):146-150. doi:10.1007/s12291-022-01072-6

"In case of any additional publication in the last 3 months - please contact the editorial team at **secretary@imagesociety.co.in***"*

"Original research publications from India"

Indian abstracts in plasma cell dyscrasias at ASH 2023

- Jeevan Kumar, Rajat Pincha, Vivek S Radhakrishnan, et al. Safety and Efficacy of Bortezomib-Pomalidomide-Dexamethasone (VPD) As Novel Induction Therapy in Newly-Diagnosed Multiple Myeloma: Updated Data from an Ongoing Single Arm Phase-II Investigator- Initiated Clinical Trial (PRIME Study). Blood 2023; 142 (Supplement 1): 6713. doi: https://doi.org/10.1182/blood-2023-186903
- Rashmi Yawalkar, Mrudula E.V., Reshmy GS, et al. Fluorescent in Situ Hybridization Analysis in Multiple Myeloma: Enhancing Risk Stratification, Autologous Transplant Utilization and Treatment Decisions in Limited-Resource Settings. Blood 2023; 142 (Supplement 1): 2420. doi: https://doi.org/10.1182/blood-2023-186857
- Sumeet Mirgh, Bhausaheb Bagal, Sachin Punatar, et al. Comparison of Various Stem Cell Mobilization Regimens for Multiple Myeloma - a 15-Year Retrospective Institutional Analysis from India. Blood 2023; 142 (Supplement 1): 2225. doi: https://doi.org/10.1182/blood-2023-182563

“Autologous HSCT – Data from Eastern India – The data strengthens”

Kathrotiya M, Radhakrishnan V, Bhave SJ, et al. Bortezomib-based induction therapy followed by autologous hematopoietic cell transplantation in newly diagnosed multiple myeloma patients: A single-center experience and review of Indian literature. Indian J Cancer. 2023;60(4):486-492. doi:10.4103/ijc.ijc_78_22

This is a retrospective study of Newly Diagnosed Multiple Myeloma patients who underwent Autologous stem-cell transplant (ASCT) at Tata Medical Centre, Kolkata from 2011 to 2018. A total of 1169 patients with newly diagnosed myeloma were registered in the above time period. Ten percent (n=78) of the transplant eligible patients (n=764) from their centre underwent ASCT. Median age was 59 years (range: 22–66 years); 51 (65%) were males, and 55% patients had an ISS-stage III disease. Most common isotype was IgG kappa, found in 34 (44%) patients. Light chain MM was found in 19 (23.5%) patients. FISH test reports were available in 37 (47%) patients. Of these, 30 were standard risk, and 7 were high-risk. The most common induction regimen given was VTD in 62 (79%) patients, followed by VCD in 13 (17%) patients. The median number of cycles received before AHCT was 6 (range: 5–7 cycles). Median cost of ASCT was INR 4.5 lacs (US$ 5800). Pre-transplant, 90% patients were in ≥VGPR (It should be borne in mind that bone marrow examination was not done routinely to assess response in all patients). Median follow-up of their entire cohort was 57.2 months. The entire cohort’s 5 year overall survival (OS) and progression free survival (PFS) were 89.1% and 41.8%, respectively.

TATA MEDICAL CENTER

"Pre-transplant PET-CT – To do or Not to do?"

Yanamandra U, Reddy Gorla AK, Agrawal K, et al. Prognostic significance of extramedullary disease (EMD) detected on pre-transplant 18F-FDG PET/CT in patients with multiple myeloma: Results of PIPET-M trial. Med J Armed Forces India. 2023;79(6):672-678. doi:10.1016/j.mjafi.2023.08.007

This is a single centre prospective study from Northern India during a study period of 2014-2022. Median follow-up of their cohort was 6 years. All patients planned for autologous stem-cell transplant (ASCT) underwent 18F-FDG-PET/CT as part of pre-transplant workup. The conditioning and treatment protocols were not modified based on PET/CT findings. Extramedullary disease (EMD) on PET/CT was correlated with pre-transplant biochemical markers and post-ASCT survival/ progression (as defined by revised IMWG criteria). Statistical analysis was done using SPSS ver. 20. Patients with pre-ASCT EMD had a hazard-ratio for post-transplant all-cause mortality of 5.46 (p-0.045). Pre-transplant β2M and LDH were significantly higher in patients with EMD (p-0.036). The 6-year median OS in patients with and without EMD were 57.1%, and 80.6% respectively. There was no significant difference in clinical or biochemical EFS among patients with EMD. EMD detected on 18F-FDG-PET/CT has a higher hazard for mortality and is significantly correlated with pre-transplant higher β2M and LDH levels. Thus, it seems worthwhile to do a pre-transplant 18F-FDG-PET/CT for prognostication.

“Bone marrow fibrosis and Amyloidosis in patients with plasma cell neoplasms – A Less Explored Entity”

Kannan N, Dass J, Dangudubiyyam S, et al. Clinico-pathological profile of patients with plasma cell neoplasms with special reference to bone marrow fibrosis and amyloid deposition. J Clin Exp Hematop. 2023;63(4):214-218. doi:10.3960/jslrt.23029

This was a retrospective single-centre analysis from Department of Hematology, AIIMS, Delhi. Authors sought to study the incidence of bone marrow fibrosis and amyloid deposition at diagnosis in plasma cell neoplasms at diagnosis. A total of 273 bone marrow aspirates and biopsies of patients with suspected plasma cell neoplasms were analysed. Of these, there were 181 male patients and 92 female patients (Male: Female = 1.96: 1). Amongst 273 diagnostic samples, there were 245 cases of multiple myeloma (89.7%), 8 cases of primary amyloidosis (2.9%), 6 cases of monoclonal gammopathy of undetermined significance (MGUS) (2.1%), 5 cases of plasmacytoma (1.8%), 4 cases of smouldering myeloma (1.4%), and 5 cases of POEMS syndrome (1.8%). Interestingly, bone marrow fibrosis was noted in 12 patients at diagnosis (4.3%). Importantly, all 12 of them were diagnosed as multiple myeloma with an incidence of fibrosis in this cohort being 4.9% (12/245). Patients with bone marrow fibrosis had significantly lower hemoglobin at presentation as compared to those without (6.25 vs 9.6 gm/dl; p=0.001). Concomitant amyloid deposition in any organ (bone marrow, liver, kidney) was noted in 6.2% patients (n=17) at diagnosis. Of these 17 patients, 9 had concomitant myeloma, and 8 had primary amyloidosis. This study highlights the incidence of bone marrow fibrosis in approximately 5% patients of myeloma at diagnosis, and the presence of amyloidosis in 6% patients who have a suspected plasma cell neoplasm.

“Cytogenetics Alterations in Patients with Multiple Myeloma in Eastern India”

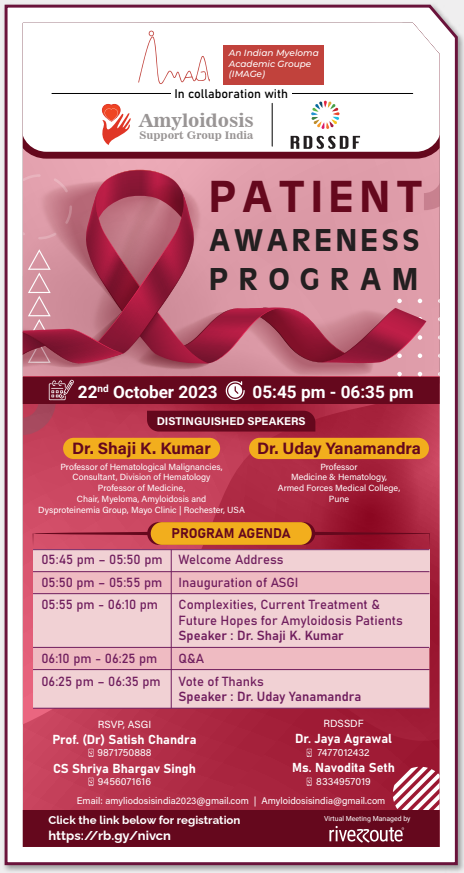
Jha K, Saha S, Bhattacharyya M, et al. Cytogenetic Alterations and Correlation with Age and Gender in Patients of Multiple Myeloma: A Study from a Tertiary Care Center in Eastern India. South Asian J Cancer. 2024;13(2):126–131.

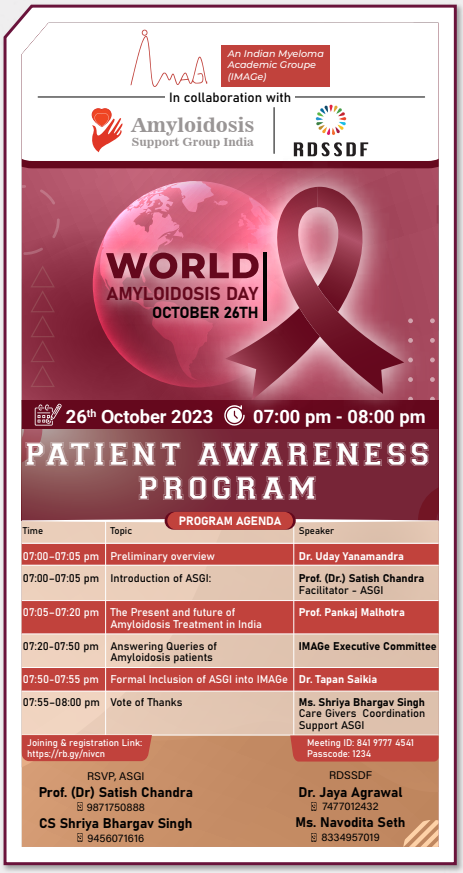
Multiple myeloma is a cytogenetically heterogeneous, evolving, and incurable disease. Differences in prevalence of myeloma already exist in Indian subcontinent as compared with Western world countries. This study attempts to investigate differences in incidence of cytogenetic abnormalities (CA) in Eastern Indian patients and study differences in incidence with respect to age and gender. iFISH was applied on purified plasma cells in patients of newly diagnosed multiple myeloma (NDMM). Probes used for all patients included del13q, del17p, t(4;14), t(14;16). A separate set of 100 NDMM patients were studied for 1q gain by iFISH. The cutoff threshold used was 5% for all the probes. 51.07% patients had iFISH positivity. Del13q was the most common CA. Del13q was commonly associated with t(4;14), del17p, and 1q gain. Higher number of cases were positive by FISH in 41-50 years age group ($p<0.05$). Those in 61-70 years age group had lower FISH positivity ($p<0.05$). Del17p had higher number of cases in age group 41 to 50 years and 51 to 60 years as compared with other age groups. Incidence of t(11;14) was in 5th to 7th decade, while del13q and t(4;14) had the widest range of age at presentation. Gender disparities with female predominance were seen in high-risk CAs like del17p and 1q gain. Important drawbacks of this study include – not specified whether iFISH was done in-house or outsourced, absence of corelation with treatment outcomes and survival, and absence of detection CAs like t(14;20) and del1p in their cohort. Nonetheless, it illustrates the heterogeneity in CAs in NDMM in Eastern India patients.

PATIENT AWARENESS PROGRAM

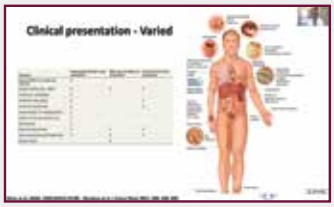
PARTICIPANTS

48



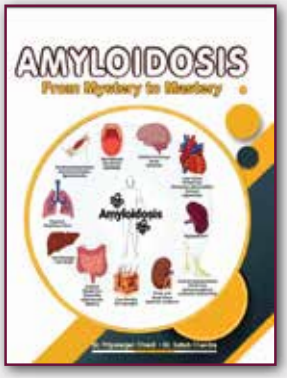


Glimpse of Event



Link for the event video: https://imagesociety.co.in

Partnership with ASGI



"A Book on various aspects of Amyloidosis was edited by Mr Satish Chandra, ASGI Chairperson which was released by the IMAGe"

Indian Myeloma Academic Groupe (IMAGe)

Caregivers ASHA Society

Jodhpur Society of Pathologists & Microbiologists

Updates in the Treatment of Waldenstrom Macroglobulinemia

29th March 2024

Venue: **Council Hall**, Dr. S N Medical College, Jodhpur

30th March 2024

Venue: **M D M Hospital,** Dr. S N Medical College, Jodhpur

Program Coordinator

Dr. R C Purohit

Senior Pathologist
Jodhpur

Contact Person

Dr. Arvind Mathur
Ex-Principal, Dr S N Medical College, Jodhpur
Mob: +919829024569
Email: arvindmathur@caregiversashasociety.com

Click here to register
https://forms.gle/fBD2mBDF4QWaL7Fy8

Event Organised under the ageis of
The Indian Myeloma Academic Groupe (IMAGe)

Glimpse of Event

Updates in the Treatment of "**Waldenstrom Macroglobulinemia"** held at Dr. S N Medical College, Jodhpur as on **29th & 30th March 2024.**

रक्त कैंसर के असामान्य प्रकारों के बारे में बताया

दो दिवसीय संगोष्ठी का समापन

वॉल्डेस्ट्रोम मैक्रोग्लोब्यूलिनेमिना ब्लड कैंसर असाधारण बीमारी, इसमें शरीर का रक्षक प्रोटीन ही भक्षक बन लील लेता है जिंदगी : डॉ. उदय

वाल्डनस्ट्रोम मैक्रोग्लोब्यूलिनेमिया के प्रबंधन पर हुई चर्चा

Glimpse of Event

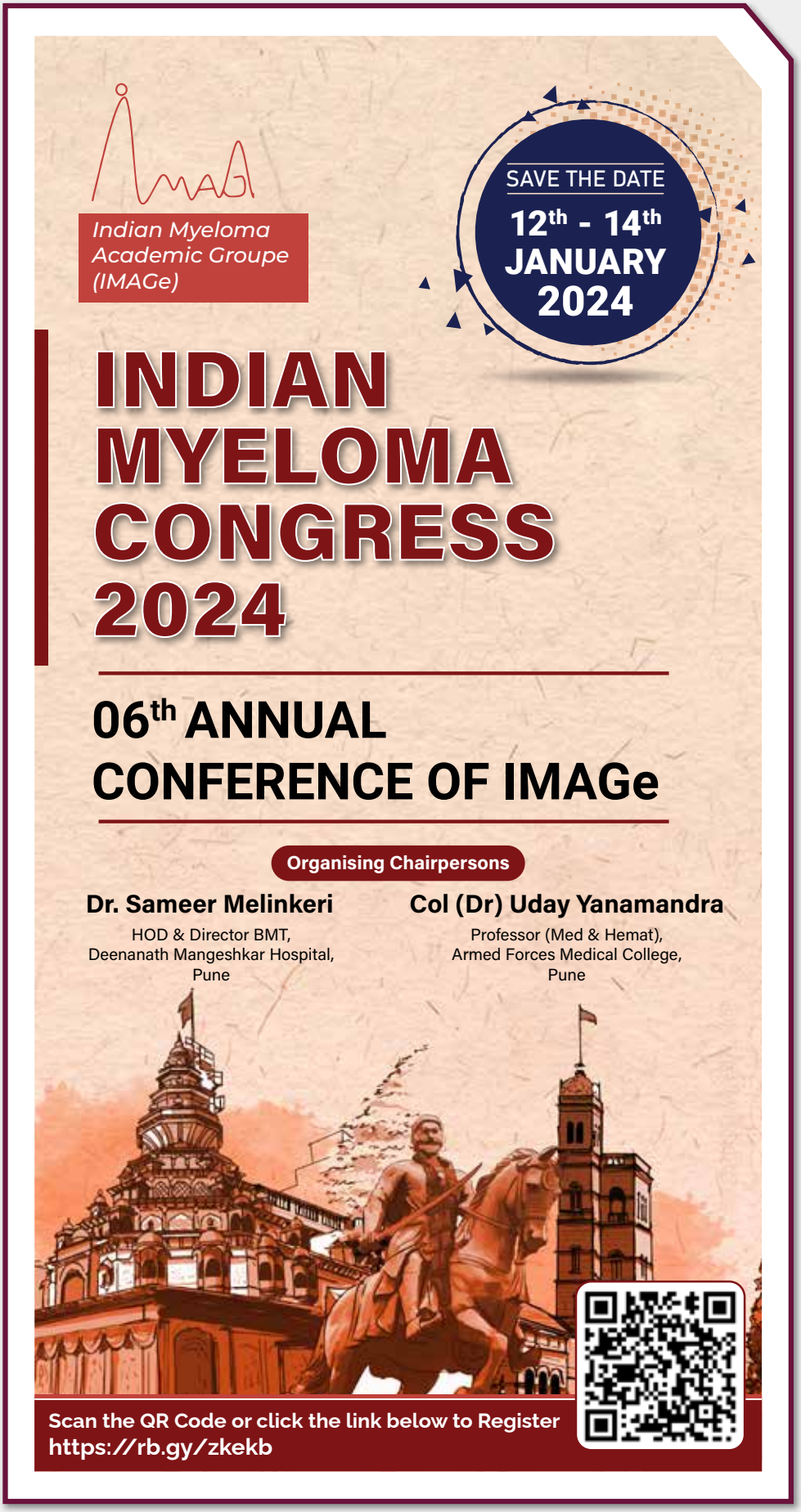
“Amyloidosis and the Waldenstrom chapter”

INDIAN MYELOMA CONGRESS 2024

PARTICIPANTS

184

The 6th annual Conference of Indian Myeloma Academic Groupe **"IMC 2024"** held at Symbiosis Medical College for Women, Pune from **12th to 14th January 2024.**



INDIAN MYELOMA CONGRESS 2024

INTERNATIONAL FACULTY

Dr. Nikhil Munshi
Dr. Priya Sampathkumar
Dr. Dipti Talaulikar
Dr. Ashutosh Wechalekar
Dr. Prashant Kapoor
Dr. Vincent Rajkumar
Dr. Amit Khot
Dr. Chandramauli

NATIONAL FACULTY

Dr. Kannan S.
Dr. Vijay Ramanan
Dr. Nikhil Munshi
Dr. Ashish Dixit
Dr. Manoj Toshniwal
Dr. Vishvdeep Khushoo
Dr. Varun Bafna
Dr. Amrita Ramaswami
Dr. Sweta Kothari
Brig. Dr. J. Muthukrishnan
Dr. Bhausaheb Bagal
Dr. Venkatesh Ekbote
Dr. Ketan Modak
Dr. Sanket Shah
Dr. Seema Bhatwadekar
Dr. Rayaz Ahmed
Dr. Sameer Tulpule
Dr. Pankaj Malhotra
Dr. Sameer Melinkeri
Dr. Sharat Damodar
Dr. Jeevan Kumar
Dr. Faheema Hasan
Dr. Revanth
Dr. Renu Mishra
Dr. Shubprakash Sanyal
Dr. Sandip Bartakke
Dr. Subhash Varma
Dr. Prashant Kapoor
Dr. Stalin Balachoudhary
Dr. Ganesh Kumar
Dr. Ganesh Jaishetwar
Dr. Shrinath Kshirsagar
Dr. Hari Menon
Dr. Urmi Sheth
Dr. Gurleen Oberai
Dr. Harshini Sriram
Dr. Mugdha Sathe
Dr. Ritu Gupta
Dr. Pratibha Suku
Dr. Sanjeev
Dr. Gurpreet Kaur
Dr. Reetu Jain
Dr. Mukul Aggarwal
Dr. Abhijeet Ganpule
Dr. R Manchanda
Dr. Kiruthiga
Dr. Amit Janu
Prof. Ritu Gupta
Dr. Dinesh Bhurani
Dr. Anil Handoo
Dr. Nidhi Jain
Dr. Nishant Jindal
Dr. Aniket Mohite
Dr. Ajay Jha
Dr. Venkatesan S
Dr. Sandip Shah
Dr. Nitin Yashas
Lt. Col. Renjith Verghese
Dr. Ankur Ahuja
Dr. Tapan Saikia
Col (Dr.) Uday Yanamandra
Dr. Priyanka Moule
Dr. Sarthak Wadhera
Dr. Anupam Brahma
Dr. Arjin Philips
Dr. Saswat Saha
Dr. Karthik Ambalavana
Dr. Vaikhari M. G.
Dr. Rajat Pincha
Dr. Gurvinder Kaur
Dr. Devyani Surange
Dr. Mahima Choudhari
Dr. Ajay Kumar Jha
Dr. Joydeb Singha
Dr. Deep Gala
Dr. Souvik Saha
Dr. Shubh Purohit
Dr. Nirali Chandan
Dr Chinnu Jomi
Dr. Jhansi J.
Dr. Abhijeet Baheti
Dr. Rahul Naithani
Dr. Rajendra Pol
Dr. Sumeet Mirgh
Dr. Saurabh Bhave
Dr. Abhay Bhave
Dr. Anusree Prabhakaran
Brig. Ajay Sharma (Retd.)
Dr. Charanpreet Singh
Dr. Neelam Varma
Brig. Dr. S Das (Retd.)
Dr. Rithambhara Nada
Brig. Ranjith Nair

INDIAN MYELOMA CONGRESS 2024

06th ANNUAL CONFERENCE OF IMAGe

12th - 14th JANUARY 2024

INTERNATIONAL FACULTY

Dr. Amit Khot
Australia

Dr. Ashutosh Wechalekar
UK

Dr. Chandra Mouli
Singapore

Dr. Dipti Talaulikar
Australia

Dr. Nikhil Munshi
USA

Dr. Prashant Kapoor
USA

Dr. Priya Sampathkumar
USA

Dr. Vincent Rajkumar
USA

INDIAN MYELOMA CONGRESS 2024

Glimpse of Event

The 6th annual Conference of Indian Myeloma Academic Groupe **"IMC 2024"** held at Symbiosis Medical College for Women, Pune from **12th to 14th January 2024.**

INDIAN MYELOMA CONGRESS 2024

HBCH Varanasi patients helped by IMAGe for Medicines

PATIENTS HELPED FOR TRANSPLANT

₹10 Lakhs

Thanks to **Oswal Industries** for the Donation

Patient: 1

File No. - KE/51733
Date of transplant - 11.08.2023
Male / 48 yrs

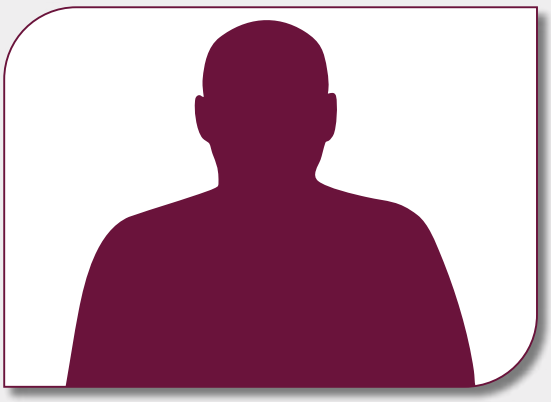
मैं [redacted] वर्ष का पुरुष जौनपुर, जिला का रहनेवाला हूँ. मैं हरा कैंसर हॉस्पीटल वाराणसी से अपना इलाज करा रहा हूँ. मुझे मल्टीपल मायलोमा नाम के बिमारी से ग्रसित रहा हूँ. मेरा इलाज हरा कैंसर हॉस्पीटल द्वारा हो रहा है. मुझे IMAGE GROUP द्वारा बहुत से औषधो की मदद मिली है, जिसका मैं अपने दिल से धन्यवाद करता हूँ.

Patient: 2

File No. - KE/51977
Date of transplant - 07.06.2023
Male / 55 yrs

Patient: 3

File No. - KD/51358
Date of transplant - 10.02.2024
Male / 32 yrs



Patient: 4

File No. - CV/39654
Date of transplant - 14.09.2023
Male / 50 yrs

DR. REENA NAIR SCHOLARSHIP

EDUCATION GRANT DURING IMC 2024

₹2,00,000

Winner of Dr Reena Nair Scholarship for participating in **The Indian Myeloma Congress 2024.**

DR. TAPAN SAIKIA TRAVELING FELLOWSHIP

TRAVELLING FELLOWSHIP DURING IMC 2024

₹2,35,796

Indian Myeloma Academic Groupe (IMAGe)

12th - 14th JANUARY 2024

INDIAN MYELOMA CONGRESS 2024

06th ANNUAL CONFERENCE OF IMAGe

Winners of Dr. Tapan Saikia

Travelling Fellowship for participating in the Conference

Harshini Sriram	Reshmy Gs	Souvik Saha
Mugdha Sathe	Mrudula E.v	Punit Jain
Pratibha Suku	T Jemima Evangelyn	Joydeb Singha
Priyanka Moule	Subhiksha Sundaram	Venkata Madhavi Koka
Anupam Brahma	Sarthak Wadhera	Aekta Gupta
Bhavani Mandava	Deepalakshmi Putchen	Manasi Gupta
Sandeep Abhijit Pattnaik	Somanath Padhi	Rajat Pincha
Soujanya M	E. Nithye Parvathy	Sushma Meenugu
Rashmi Yawalkar	Aravind Radhakrishnan	Rizwan Athar
Karthik Ambalavana	Wesley Joyal	Gurvinder Kaur
Aakash Chozakade	Deepa Subramanian	Mayank Soni
Deep Gala	Vaikhari M G	Tharageswari Srinivasan
Arjin Philips	Sreedhar Jayakrishnan	Sharanya Sathish
Abhishek Das	George John	Mohammed A. R. Basalathullah
Disha Jain	Saswat Saha	Nidhi R
Gourav Bain	Gayathri J	Devyani Surange
Sudip Roy	Suvir Singh	Rupjyoti Sarma
Soudamini Mahapatra	Samyukta Shyam	Ajmat Khan

Winner of Dr. Tapan Saikia Traveling Fellowship for participating in **The Indian Myeloma Congress 2024.**

"Annual Myeloma Quiz during IMC 2024"

AWARDS & ACCOLADES

1st PRIZE

INR 1,00,000

DR. DEEP GALA
SGPGIMS, Lucknow

DR. SOUVIK SAHA
SGPGIMS, Lucknow

2nd PRIZE

INR 50,000

DR. SHUBH PUROHIT
Sahyadri Superspeciality Hospital, Pune

DR. NIRALI CHANDAN
Sahyadri Superspeciality Hospital, Pune

3rd PRIZE

INR 20,000

DR. CHINNU JOMI
Manipal Hospital, Banglore

DR. JHANSI J
Manipal Hospital, Banglore

"Annual Myeloma Quiz during IMC 2024"

AWARDS & ACCOLADES

ORAL PRESENTATION

1st PRIZE INR 1,00,000

DR. RITU GUPTA
AIIMS, New Delhi

2nd PRIZE INR 50,000

MS. PRATIBHA SUKU
PGIMER, Chandigarh

3rd PRIZE INR 20,000

DR. HARSHINI SRIRAM
ACTREC, TMC, Mumbai

"Annual Myeloma Quiz during IMC 2024"

AWARDS & ACCOLADES

MINI ORAL PRESENTATION

DR. PRIYANKA MOULE
SGRH, New Delhi

DR. SANJEEV
SGPGI, Lucknow

DR. SARTHAK WADHERA
PGIMER, Chandigarh

DR. ANUPAM BRAHMA
TMC, Kolkata

DR. ARJIN PHILIPS
Apollo Hospital, Kolkata

DR. SASWATA SAHA
TMC, Mumbai

DR. KARTHIK AMBALAVANA
Madras Medical College, Chennai

DR. VAIKHARI M G
Government Medical College, Kozhikode

"Annual Myeloma Quiz during IMC 2024"

AWARDS & ACCOLADES

E-POSTER PRESENTATION

1st PRIZE INR 10,000

DR. RAJAT PINCHA
TMC, Kolkata

1st PRIZE INR 10,000

DR. GURVINDER KAUR
AIIMS, New Delhi

2nd PRIZE INR 10,000

DR. DEVYANI SURANGE
Army Hospital, New Delhi

2nd PRIZE INR 10,000

DR. MAHIMA CHOUDHARI
AFMC, Pune

3rd PRIZE INR 10,000

DR. AJAY KUMAR JHA
Vayodha Hospital, Nepal

3rd PRIZE INR 10,000

DR. JOYDEB SINGHA
Apollo Hospital, Kolkata

3rd PRIZE INR 10,000

DR. TAPAN SAIKIA
Jaslok Hospital, Mumbai

Armed Forces Medical College, Pune

ILLUMINATI RESONATE 2024

A total of

₹1.5 Lakhs

were sponsored for the event

ILLUMINATI RESONATE

WINNER

01st

Dr. Ayush Amlan
AIIMS Bibinagar, Hyderabad

02nd

Dr. Sana Thimmoji
Jawaharlal Nehru Medical College , Belagavi , Karnataka (KLE University)

A total of 29 colleges participated in the "Resonate" held as part of Illuminati 2024, a UG medical conference organized by the Student's Scientific Society AFMC co-sponsored by IMAGe, wherein the students were asked to prepare patient educational material for patients suffering from "Amyloidosis" to make understanding of the disease easy.

Recent Partnerships

Indian Myeloma Academic Groupe (IMAGe)

with

Amyloidosis Support Group India

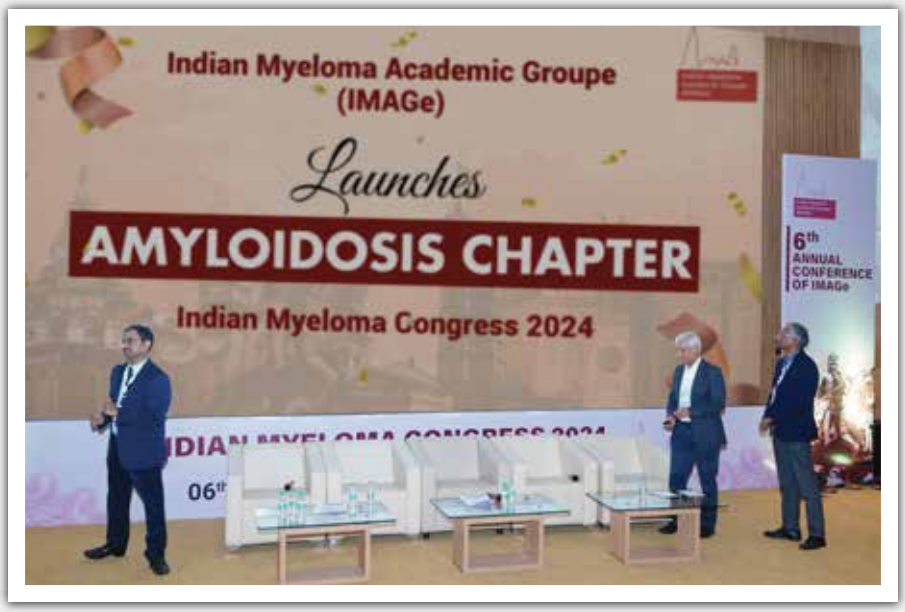


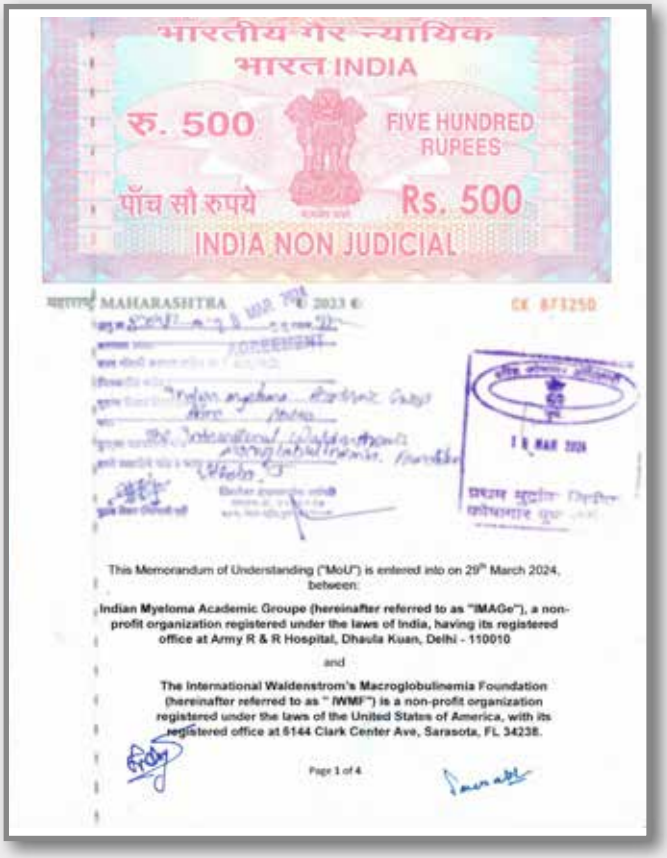
IMAGe partenered with ASGI. The Amyloidosis Support Group India is a compassionate and dedicated community formed to provide essential support, information, and resources to individuals suffering from Amyloidosis.

Recent Partnerships

Indian Myeloma Academic Groupe (IMAGe)

with

IWMF
International Waldenstrom's Macroglobulinemia Foundation



भारतीय गैर न्यायिक
भारत INDIA
रु. 500 FIVE HUNDRED RUPEES
पाँच सौ रुपये Rs. 500
INDIA NON JUDICIAL

MAHARASHTRA

This Memorandum of Understanding ("MoU") is entered into on 29th March 2024, between:

Indian Myeloma Academic Groupe (hereinafter referred to as "IMAGe"), a non-profit organization registered under the laws of India, having its registered office at Army R & R Hospital, Dhaula Kuan, Delhi - 110010

and

The International Waldenstrom's Macroglobulinemia Foundation (hereinafter referred to as " IWMF") is a non-profit organization registered under the laws of the United States of America, with its registered office at 6144 Clark Center Ave, Sarasota, FL 34238.

Page 1 of 4

IMAGe signed an MoU with The International Waldenstrom's Macroglobulinemia Foundation (IWMF). IWMF is a patient-funded and patient-driven, nonprofit organization that is dedicated to patients suffering from Waldenstrom macroglobulinemia.

Recent Partnerships

Indian Myeloma Academic Groupe (IMAGe)

with

Caregivers ASHA Society


भारतीय गैर न्यायिक
भारत INDIA
रु. 500 FIVE HUNDRED RUPEES
पाँच सौ रुपये Rs. 500
INDIA NON JUDICIAL
MAHARASHTRA
AGREEMENT
This Memorandum of Understanding ("MoU") is entered into on 29th March, 2024, between:
Indian Myeloma Academic Groupe (herein after referred to as "IMAGe"), a non-profit organization registered under the laws of India, having its registered office at Army R & R Hospital, DhaulaKuan, Delhi - 110010
and
Caregivers Asha Society, a non-profit organization registered under the laws of India, having its registered office at A-79, Shastri Nagar, Jodhpur 342003 (India).

IMAGe signed an MoU with the Caregivers Asha Society. This society aims to support caregivers at local and state levels through evidence-based research, educational programs, and practical assistance.

The Geeks - Editorial Team

Dr. Uday Yanamandra

Dr. Sumeet Mirgh

Dr. Gurleen Oberoi

Dr. Arun V A

OUR FACULTY TEAM

Dr. Tapan Saikia

Dr. Velu Nair

Dr. Reena Nair

Dr. Hari Menon

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