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The Impact and Management of Solid Tumors Developing Before or Within the First 6 Months of a Diagnosis with Multiple Myeloma

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INTRODUCTION & METHODS

Multiple myeloma accounts for approximately 1% of all malignant tumors and about 10% of hematologic malignancies. In the course of hematologic malignancies—particularly considering the long-term use of maintenance therapy with immunomodulatory agents—the risk of developing second primary tumors increases significantly. However, there is a notable lack of data in the literature regarding the management of patients who are either already diagnosed with myeloma or are undergoing diagnostic and staging procedures for myeloma and are found to have solid organ tumors during the initial post-diagnosis treatment phase or before. The available literature on this subject is extremely limited.

The diagnostic and treatment details of patients who developed solid organ tumors either prior to or within the first six months following the diagnosis of multiple myeloma were retrospectively collected and analyzed. Special attention was given to how key treatment phases of myeloma—such as high-dose chemotherapy supported by autologous stem cell transplantation and maintenance therapies—were guided, particularly from the perspective of the treating physicians. The perceptions influencing these treatment decisions were also assessed. Non-melanoma skin cancers were excluded from the study.

RESULTS

A total of 31 patients from 7 different centers were included in the study. Of these, 61.3% were male and 38.7% were female, with a median age at diagnosis of 65 years (range: 42–76). IgG kappa monoclonal gammopathy was observed in 58.1% of patients, while the distribution of other subtypes showed similar percentages. Among patients with available data, the Revised International Staging System (R-ISS) scores were distributed as follows: 30% in stage I, 45% in stage II, and 25% in stage III. Extramedullary disease (EMD) was present in 13% of patients. High cytogenetic risk was identified in 9.7% of cases. Regarding solid tumors, 25.9% of patients had breast cancer, 19.4% had lung cancer, 9.7% had colon cancer, 9.7% had prostate cancer, and 6.5% had rectal cancer. Additionally, each of the following cancers was observed in 3.2% of patients: gastric, nasopharyngeal, ovarian, cervical, and thyroid cancers, as well as hepatocellular carcinoma, malignant melanoma, and pleomorphic sarcoma. Of the patients, 45.2% were diagnosed with a solid organ tumor prior to the diagnosis of multiple myeloma, 42% within the first six months following the diagnosis, and 12.8% concurrently with the multiple myeloma diagnosis. Regarding initial treatment regimens for multiple myeloma, 54.8% of patients received bortezomib, cyclophosphamide, and dexamethasone (VCd); 16.1% received bortezomib, lenalidomide, and dexamethasone (VRd); and 16.1% received vincristine, doxorubicin (adriamycin), and dexamethasone (VAD). The remaining patients each received one of the following regimens at a frequency of 3.2%: bortezomib and dexamethasone (Vd), lenalidomide and dexamethasone (Rd), daratumumab with bortezomib, lenalidomide, and dexamethasone (Dara-VRd), and daratumumab with lenalidomide and dexamethasone (Dara-Rd). Among patients diagnosed with another primary malignancy either concurrently with or within six months after the diagnosis of multiple myeloma—and who required treatment for both conditions—34.6% received simultaneous treatment for both multiple myeloma and the other malignancy. In the remaining 65.4% of cases, priority was given to the treatment of the non-myeloma malignancy. Although its use is more limited in the initial treatment phase, lenalidomide was administered as maintenance therapy in 38.7% of patients. Notably, 48.4% of the hematologists following these patients reported no hesitation in using lenalidomide despite the presence of an additional malignancy. In 19.4% of patients who were eligible for autologous stem cell transplantation, the procedure was not pursued due to concerns related to the coexisting malignancy. Among the patients who proceeded to autologous stem cell transplantation, progression of the secondary malignancy at any point post-transplant was observed in only 36.4% of cases. Death related to the non-myeloma malignancy occurred in just 16.1% of patients, while 12.9% of patients died due to myeloma progression. The median overall survival for the entire cohort was calculated as 60 months (range: 44.4–75.6 months).

CONCLUSION

The existing literature has predominantly focused on second primary malignancies that develop after the diagnosis of multiple myeloma, particularly those associated with the use of alkylating agents and immunomodulatory drugs. However, it remains limited and lacks guidance regarding the clinical course and management of patients who have a pre-existing malignancy at the time of myeloma diagnosis or who are diagnosed with an additional malignancy shortly thereafter. The findings of our study support and encourage the continuation of concurrent myeloma treatment in patients with a newly identified malignancy either prior to or shortly after the diagnosis of myeloma. Furthermore, if eligible, proceeding with autologous stem cell transplantation and the use of lenalidomide as maintenance therapy—provided the other malignancy is in remission—appear to yield overall survival and myeloma-related mortality outcomes comparable to those reported in the existing Turkish literature.

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