



Measurable Residual Disease by Next-Generation Flow Cytometry in Multiple Myeloma

Bruno Paiva, PhD¹; Noemi Puig, MD, PhD²; Maria-Teresa Cedena, MD³; Laura Rosiñol, MD, PhD⁴; Lourdes Cordón, PhD⁵; María-Belén Vidriales, MD, PhD²; Leire Burgos, PhD¹; Juan Flores-Montero, MD, PhD^{6,7}; Luzalba Sanoja-Flores, MSc^{6,7}; Lucia Lopez-Anglada, MD, PhD³; Roberto Maldonado, MSc³; Javier de la Cruz, MD³; Norma C. Gutierrez, MD, PhD²; Maria-Jose Calasanz, PhD¹; Maria-Luisa Martin-Ramos, PhD³; Ramón Garcia-Sanz, MD, PhD²; Joaquin Martinez-Lopez, MD³; Albert Oriol, MD⁸; María-Jesús Blanchard, MD⁹; Rafael Rios, MD¹⁰; Jesus Martin, MD¹¹; Rafael Martinez-Martinez, PhD¹²; Anna Sureda, MD, PhD¹³; Miguel-Teodoro Hernandez, MD, PhD¹⁴; Javier de la Rubia, MD^{5,15}; Isabel Krsnik, MD, PhD¹⁶; Jose-Maria Moraleda, MD¹⁷; Luis Palomera, MD, PhD¹⁸; Joan Bargay, MD, PhD¹⁹; Jacques J.M. Van Dongen, MD, PhD²⁰; Alberto Orfao, MD, PhD^{6,7}; Maria-Victoria Mateos, MD, PhD²; Joan Blade, MD, PhD⁴; Jesús F. San-Miguel, MD, PhD¹; and Juan-José Lahuerta, MD³; on behalf of the GEM (Grupo Español de Mieloma)/PETHEMA (Programa Para el Estudio de la Terapéutica en Hemopatías Malignas) Cooperative Study Group

PURPOSE Assessing measurable residual disease (MRD) has become standard with many tumors, but the clinical meaning of MRD in multiple myeloma (MM) remains uncertain, particularly when assessed by next-generation flow (NGF) cytometry. Thus, we aimed to determine the applicability and sensitivity of the flow MRD-negative criterion defined by the International Myeloma Working Group (IMWG).

PATIENTS AND METHODS In the PETHEMA/GEM2012MENOS65 trial, 458 patients with newly diagnosed MM had longitudinal assessment of MRD after six induction cycles with bortezomib, lenalidomide, and dexamethasone (VRD), autologous transplantation, and two consolidation courses with VRD. MRD was assessed in 1,100 bone marrow samples from 397 patients; the 61 patients without MRD data discontinued treatment during induction and were considered MRD positive for intent-to-treat analysis. The median limit of detection achieved by NGF was 2.9×10^{-6} . Patients received maintenance (lenalidomide \pm ixazomib) according to the companion PETHEMA/GEM2014MAIN trial.

RESULTS Overall, 205 (45%) of 458 patients had undetectable MRD after consolidation, and only 14 of them (7%) have experienced progression thus far; seven of these 14 displayed extraosseous plasmacytomas at diagnosis and/or relapse. Using time-dependent analysis, patients with undetectable MRD had an 82% reduction in the risk of progression or death (hazard ratio, 0.18; 95% CI, 0.11 to 0.30; $P < .001$) and an 88% reduction in the risk of death (hazard ratio, 0.12; 95% CI, 0.05 to 0.29; $P < .001$). Timing of undetectable MRD (after induction v intensification) had no impact on patient survival. Attaining undetectable MRD overcame poor prognostic features at diagnosis, including high-risk cytogenetics. By contrast, patients with Revised International Staging System III status and positive MRD had dismal progression-free and overall survivals (median, 14 and 17 months, respectively). Maintenance increased the rate of undetectable MRD by 17%.

CONCLUSION The IMWG flow MRD-negative response criterion is highly applicable and sensitive to evaluate treatment efficacy in MM.

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ASSOCIATED CONTENT

Appendix

Protocol

Author affiliations and support information (if applicable) appear at the end of this article.

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INTRODUCTION

Assessing measurable residual disease (MRD) has become a standard procedure in many hematologic malignancies,¹⁻⁴ but the lack of effective therapies for multiple myeloma (MM) delayed the interest to perform MRD studies in this disease until the past decade. Although initial data were obtained using low-sensitive and nonstandardized methods⁵⁻¹⁹ or with next-generation sequencing (NGS) applied in retrospective series of patients treated with older regimens,^{20,21} depth of response based on MRD emerged as one of the most relevant prognostic factors in MM.^{15,22,23}

Thus, the International Myeloma Working Group (IMWG) updated the response criteria in 2016 to foster standardized assessment of MRD in prospective trials, which should incorporate MRD-negative definitions based on NGS, next-generation flow cytometry (NGF), and positron-emission tomography/computerized tomography (PET/CT).²⁴ Thus far, a few studies have investigated the utility of PET/CT²⁵⁻³⁰ and NGS^{27,31-34} in patients treated with novel regimens, and the impressive results obtained with NGS in five trials³¹⁻³⁵ validated the new IMWG sequencing MRD-negative response criterion. By contrast, no prospective studies

using NGF in trials have validated the encouraging preliminary results reported by EuroFlow,³⁶ and many questions about the utility of MRD in patients with MM remain unanswered.³⁷

PATIENTS AND METHODS

Study Design

Assessment of MRD was a secondary end point in the PETHEMA/GEM2012MENOS65 clinical trial (Appendix, online only). This open-label, phase III study included 458 patients receiving six induction cycles of bortezomib, lenalidomide, and dexamethasone (VRD), autologous stem-cell transplantation (ASCT) conditioned with busulfan and melphalan (ie, Bu-Mel) or melphalan (ie, Mel-200) high-dose therapy (HDT), and two consolidation cycles of VRD (Appendix Fig A1, online only).³⁸ The primary end point was progression-free survival (PFS) after Bu-Mel versus Mel-200, and it has not been met yet. Afterward, patients were enrolled in the PETHEMA/GEM2014MAIN clinical trial that randomly assigned them to maintenance with lenalidomide and low-dose dexamethasone (Rd) or Rd plus ixazomib for 2 years, after which patients continued with Rd for an additional 3 years if MRD positive or stopped therapy if MRD negative. Each study site's independent ethics committee approved the protocol, and informed consent forms were required prior to patient enrollment. Studies were registered at www.clinicaltrials.gov (ClinicalTrials.gov identifiers: NCT01916252, NCT02406144) and EudraCT (EudraCT identifiers: 2012-005683-10, 2014-000554-10), and the studies were conducted per the ethical principles of the Declaration of Helsinki.

MRD Assessment

MRD was predefined to be assessed at the time of suspected complete remission (CR), after induction, at day 100 after HDT/ASCT, and after consolidation. Of the 458 patients enrolled, 397 had at least one assessment of MRD performed after one or more of these defined treatment phases. The 61 patients without assessment of MRD discontinued therapy during induction. Another 26 patients discontinued therapy during intensification. Other reasons for missing MRD data ($n = 52$ [4.5%] of 1,152) are described in Figure 1. Overall, 377, 352, and 357 patients had MRD evaluable after induction, HDT/ASCT, and consolidation, respectively. MRD continued to be assessed every year during maintenance (PETHEMA/GEM2014MAIN), and data from the first 2 years were analyzed.

MRD was evaluated using NGF developed by EuroFlow (Appendix, online only).³⁶ The number of viable nucleated cells was systematically registered, and the limit of detection (LOD) achieved by NGF was determined in each sample according to the following formula: $(20/\text{number of viable nucleated cells}) \times 100$. Patients had detectable MRD whenever the percentage of phenotypically aberrant clonal plasma cells (PCs) was equal to or greater than the

LOD achieved in the corresponding sample. To determine the impact of detectable MRD levels on survival, patients were grouped according to the following MRD logarithmic levels: $\geq 2 \times 10^{-6}$ to $< 10^{-5}$, $\geq 10^{-5}$ to $< 10^{-4}$, and $\geq 10^{-4}$. Conversely, patients had undetectable MRD when phenotypically aberrant clonal PCs were either absent or present at percentages lower than the LOD achieved in the corresponding sample.

Statistical Analyses

To avoid narrowing the study by considering only those patients who experienced a response to treatment (ie, favorable disease course), MRD results were analyzed on the intent-to-treat population ($n = 458$) unless otherwise specified. Thus, patients with active disease who discontinued treatment were considered to have detectable MRD at that moment and thereafter. As expected, these patients had poor PFS (median, 13 months). Patients without an assessment of MRD at a specific timepoint for reasons other than discontinuing treatment also were considered to have detectable MRD at that timepoint.

The effect of an MRD response was evaluated using Cox proportional hazards models that considered MRD as a time-dependent covariable; all patients had disease at diagnosis (time = 0), and their MRD statuses were updated after induction (time = 1), HDT/ASCT (time = 2), and consolidation (time = 3). The effect of MRD conversions during maintenance was not included because of short follow-up. Cox regression models for PFS and overall survival (OS) were adjusted for sex, age, International Staging System (ISS), serum lactate dehydrogenase (LDH) levels, and fluorescence in situ hybridization cytogenetics; high-risk cytogenetics was defined by the presence of $t(4;14)$, $t(14;16)$ and/or $del(17p)$ alterations. The regression models were performed by entering an interaction term between patient subgroup and MRD status.

Survival probabilities according to persistent versus undetectable MRD after consolidation were estimated using the Kaplan-Meier method. Briefly, differences were tested for statistical significance with the (two-sided) log-rank test, and hazard ratios (HRs; with two-sided 95% CIs) were estimated with a Cox regression model. PFS was defined as the time from MRD assessment until disease progression or death of any cause, and OS was defined as the time from MRD assessment until death. To estimate survival probabilities in all patients stratified at diagnosis by the Revised ISS (R-ISS; $n = 404$), PFS was defined as the time from study entrance until disease progression or death of any cause, and OS was defined as the time from study entrance until death. Multivariable Cox regression models with forward selection were performed to evaluate, at each step, the prognostic value of risk stratification at diagnosis based on the R-ISS and after treatment based on MRD status. Variables were introduced in the models if P was $< .05$. Statistical analyses were conducted using SAS (SAS

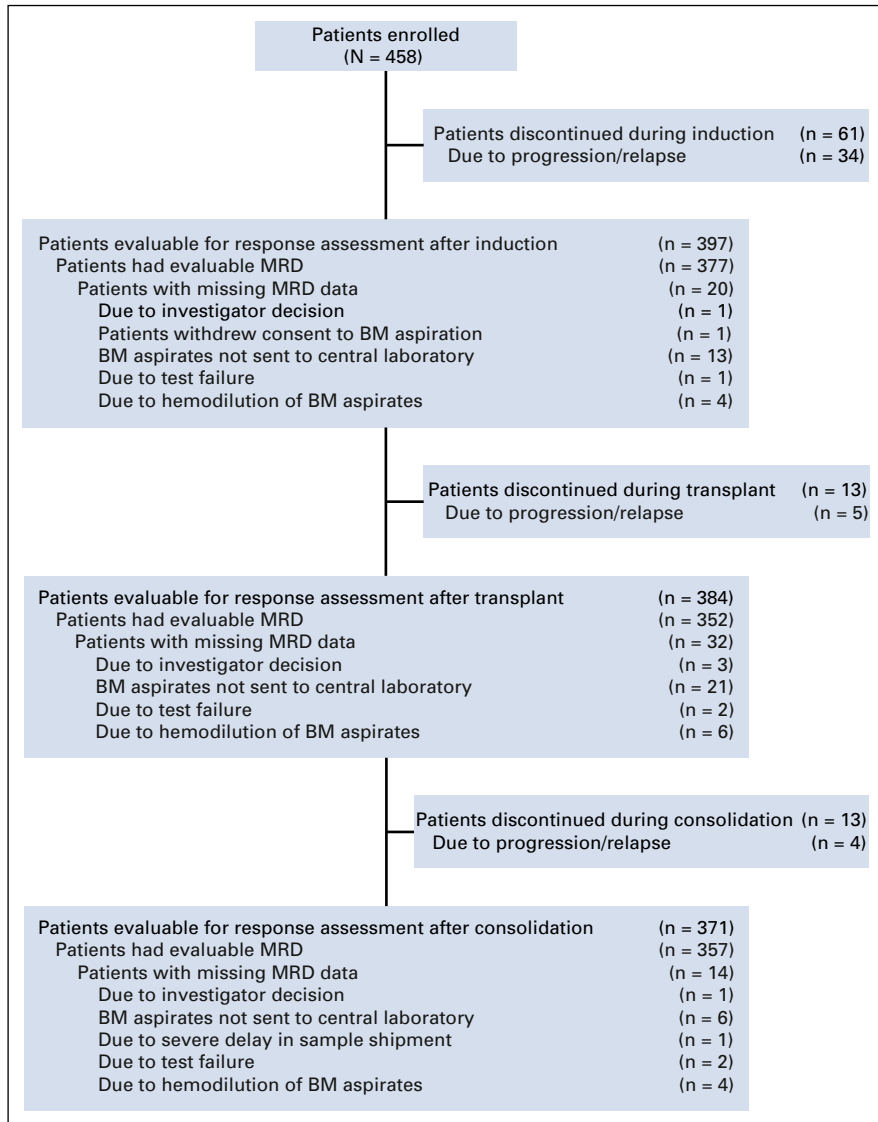


FIG 1. Patient disposition and measurable residual disease (MRD) assessments in the GEM2012MENOS65 clinical trial. BM, bone marrow.

Institute, Cary, NC), STATA (version 15.0; StataCorp, College Station, TX), and Statistical Package for Social Sciences (version 20.0; SPSS, Chicago, IL).

RESULTS

Applicability and Sensitivity of NGF

A total of 1,119 bone marrow (BM) aspirates were tested after induction, HDT/ASCT, or consolidation, and evaluable data were obtained from 1,114 aspirates (99.6%). NGF was unsuccessful in five samples (0.4%) because of inadequate specimen processing and/or instrument setup. The percentages of B-cell precursors, nucleated red blood cells, and mast cells were evaluated in each sample to determine the extent of hemodilution. Samples with $< 0.01\%$ BM PCs, B-cell precursors, nucleated red blood cells, and mast cells ($n = 14$ of 1,114) were considered severely hemodiluted and inadequate for MRD assessment. The median LOD achieved by NGF in the 1,100 BM

aspirates evaluable for MRD was 2.9×10^{-6} (range, 1×10^{-6} to 1.14×10^{-4}). The logarithmic ranges of $< 2 \times 10^{-6}$, 2×10^{-6} to $< 10^{-5}$, $\geq 10^{-5}$ to $< 10^{-4}$, and $\geq 10^{-4}$ were achieved in 11 (1%), 965 (88%), 1,099 (99.9%), and 1,100 samples (100%), respectively.

Rates of Undetectable MRD With VRD Induction, HDT/ASCT, and VRD Consolidation

In the intent-to-treat population ($n = 458$), 129 (28%), 194 (42%), and 208 (45%) patients had undetectable MRD after induction, HDT/ASCT, and consolidation, respectively. After consolidation, 34% of patients had MRD levels $\geq 10^{-4}$, 10% had levels of $\geq 10^{-5}$ to $< 10^{-4}$, and 11% had levels of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$.

Despite similar rates of undetectable MRD after HDT/ASCT and consolidation, a detailed analysis of MRD log levels among patients with persistent MRD showed that 8% had MRD levels in the logarithmic range of 2×10^{-6} to $< 10^{-5}$ after HDT/ASCT, but subsequent consolidation reduced

MRD levels to a range of 2×10^{-6} to $< 10^{-5}$ in 19% of MRD-positive patient cases (Appendix Table A1, online only).

Patient MRD statuses according to conventional response criteria are listed in Appendix Table A2 (online only). Of note, all patients in partial response or less and undetectable MRD after induction remained MRD negative in subsequent timepoints, and all but two reached CR. Similarly, 32 of the 33 patients with very good partial response and undetectable MRD after induction remained MRD negative, and 18 reached CR.

Characteristics of Patients Who Experienced Disease Progression Despite Undetectable MRD

With a median follow-up of 40 months, disease progression occurred in 14 patients (7%) with undetectable MRD versus 101 patients (40%) with persistent MRD after consolidation ($P < .001$). Appendix Table A3 (online only) lists the characteristics of patients who experienced progression despite an undetectable MRD: five of 14 displayed ISS-III status, four of 14 had high LDH levels, and only two of 14 had high-risk cytogenetic abnormalities. More than half of the patients were early responders with negative MRD after induction (eight of 14). Interestingly, many patients experienced relapse without detectable M-protein (nine of 14) or BM infiltration (seven of 14) and with extraosseous plasmacytomas (six of 14); in fact, these traits were already observed in five of these patients at diagnosis.

Risk of Disease Progression in Patients With Persistent Versus Undetectable MRD

Using a Cox proportional hazards model in which the patient's MRD status was treated as a continuous time-dependent variable, we found that achieving undetectable MRD before maintenance was associated with an 82%

reduction in the risk of progression or death (HR, 0.18; 95% CI, 0.11 to 0.30; $P < .001$) and an 88% reduction in the risk of death (HR, 0.12; 95% CI, 0.05 to 0.29; $P < .001$).

Using MRD as a fixed covariable, the Kaplan-Meier estimate of the 36-month PFS rate was 87% versus 50% in patients with undetectable versus persistent MRD after consolidation (Fig 2A). The 36-month OS rate was 96% versus 88% in patients with undetectable versus persistent MRD (Fig 2B). Data on time to progression and cumulative incidence of relapse are shown in Appendix Fig A2 (online only). The HRs for PFS and OS according to patient MRD statuses after consolidation were 0.21 (95% CI, 0.12 to 0.36; $P < .001$) and 0.26 (95% CI, 0.10 to 0.67; $P = .005$), respectively. The effect of MRD in reducing the risk of progression or death was independent of treatment arm (Appendix Tables A4 and A5, online only) and of whether patients were in CR (Appendix Fig A3, online only) or in less than CR (HR, 0.10; 95% CI, 0.01 to 0.72; $P = .02$). By contrast, there were no significant differences in PFS ($P = .21$) and OS ($P = .60$) in patients with positive MRD in CR versus less than CR after consolidation.

Positive MRD in the Logarithmic Range of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$ Is Clinically Relevant

Among patients with persistent MRD, there were no significant differences in PFS according to the logarithmic range of MRD levels (ie, $\geq 2 \times 10^{-6}$ to $< 10^{-5}$, $\geq 10^{-5}$ to $< 10^{-4}$, and $\geq 10^{-4}$). Thus, even patients who had very low but positive MRD levels in the logarithmic range of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$ displayed significantly inferior PFS ($P < .001$) and a trend for inferior OS ($P = .07$) compared with patients who had undetectable MRD (Appendix Fig A4, online only).

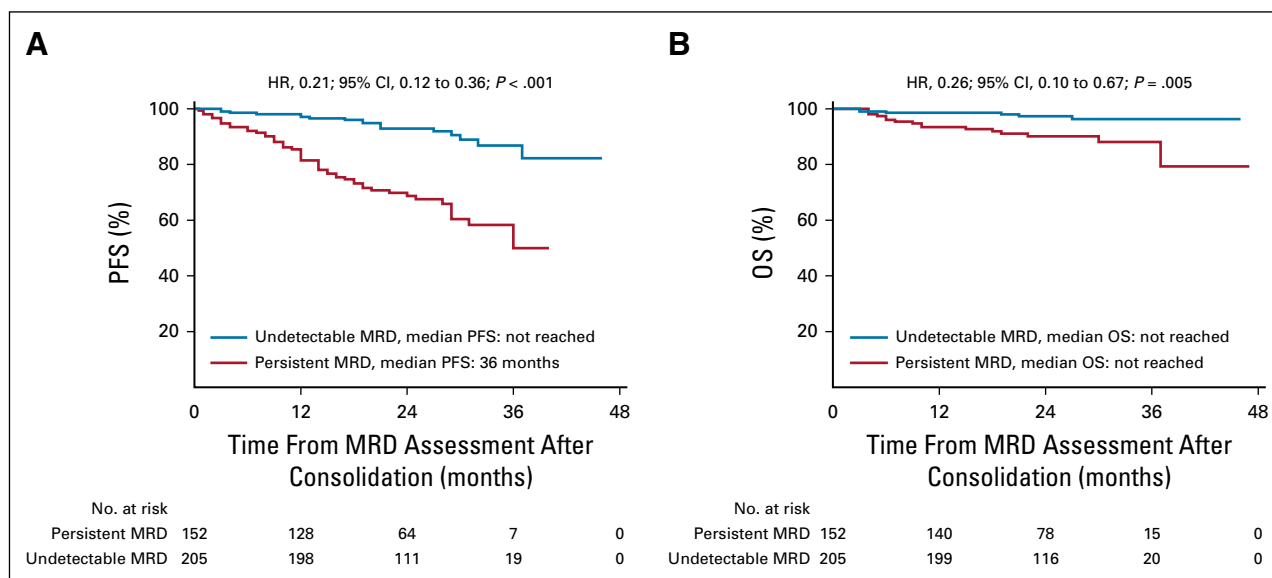


FIG 2. Survival according to undetectable v persistent measurable residual disease (MRD). The Kaplan-Meier estimates of (A) progression-free survival (PFS) and (B) overall survival (OS) after MRD assessment after consolidation ($n = 357$). HR, hazard ratio.

Undetectable MRD Is of Similar Significance at Distinct Timepoints

There were no significant differences in survival between patients with undetectable MRD achieved after induction or after treatment intensification (ie, HDT/ASCT and/or consolidation). The 36-month rates of PFS were 88% and 85% ($P = .38$), respectively, whereas the 36-month rates of OS were 94% and 99% ($P = .17$), respectively (Appendix Fig A5, online only).

MRD Responses Modulate Patients' Risks at Diagnosis

The observed reduction in the risk of progression or death observed in the intent-to-treat population with undetectable MRD was consistent across all patients, including those with high-risk cytogenetics (Fig 3; Appendix Table A6, online only). The reduction in the risk of progression or death also was evident in patients with elevated LDH levels; however, probably because of its association with extramedullary disease, the HR was higher when compared with patients who had normal LDH (0.47 v 0.18, respectively). Similar results were observed with regard to OS (Appendix Fig A6, online only).

When combining all risk parameters for the R-ISS according to the IMWG guidelines (prognostic value of the R-ISS is listed in Appendix Table A7, online only), there were no significant differences in the 36-month PFS rate for patients with R-ISS-I, R-ISS-II, or R-ISS-III statuses if MRD was undetectable after treatment (95%, 94%, and 88%, respectively; Fig 4A). Thus, patients with R-ISS-III status had their poor prognoses overcome through the achievement of undetectable MRD. By contrast, outcomes were

progressively poor for patients with R-ISS-I, R-ISS-II, and R-ISS-III statuses when MRD remained positive (36-month PFS rates of 62%, 53%, and 28%, respectively; Fig 4B). Similar results were observed when OS was considered (Appendix Fig A7, online only). In Cox regression models with forward selection, undetectable MRD was selected in the first regression as the variable with the highest predictive value for PFS (HR, 0.12; 95% CI, 0.07 to 0.21; $P < .001$) and OS (HR, 0.09; 95% CI, 0.04 to 0.23; $P < .001$). In a second regression, both the R-ISS and MRD statuses showed significant predictive values (Table 1).

Impact of Maintenance Therapy on Patients' MRD Statuses

Overall, patient MRD status after consolidation remained stable during the first 2 years of maintenance: approximately half of patients (103 [45%] of 190) had sustained undetectable MRD, and one fifth (40 [21%] of 190) had persistent MRD. Conversions from positive to negative MRD during maintenance were observed in 33 (17%) of 190 patients, whereas the remaining 14 (7%) of 190 patients lost the negative MRD status (Appendix Table A8, online only). Longitudinal analysis of patients with paired MRD assessment from consolidation into the first and second years of maintenance denoted that most conversions from MRD positive to negative status were achieved during the first year.

DISCUSSION

The triple combination of proteasome inhibitors, immunomodulatory agents, and corticosteroids is emerging as

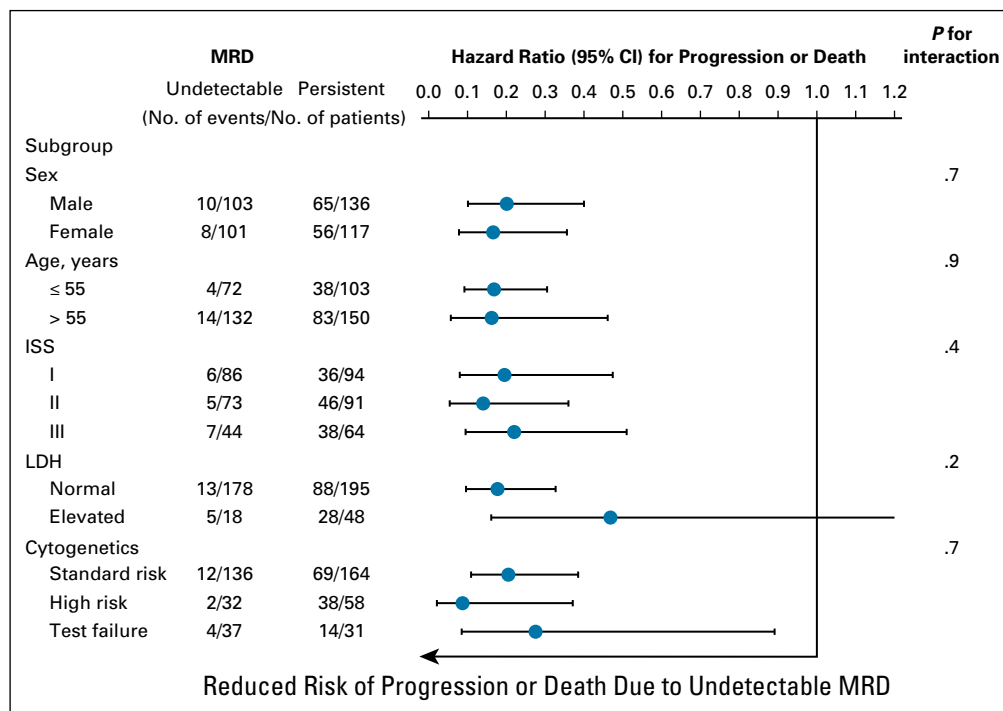


FIG 3. Subgroup analysis of progression-free survival according to patients' time-dependent measurable residual disease status. The intent-to-treat patient population was sub grouped according to sex, age, International Staging System (ISS), lactate dehydrogenase (LDH) levels, and cytogenetic abnormalities.

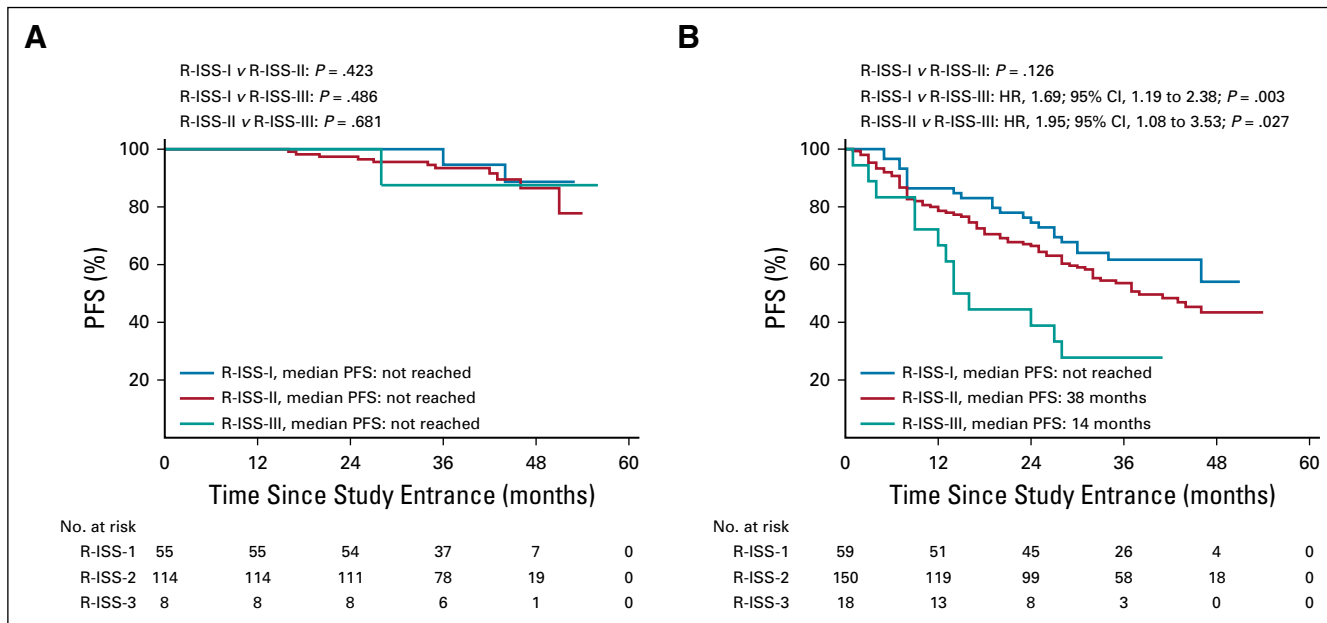


FIG 4. Modulating patients' risk at diagnosis according to depth of response after treatment, defined by measurable residual disease (MRD) status. Impact on progression-free survival of the Revised International Staging System (R-ISS) in patients with (A) undetectable v (B) persistent MRD. Of note, ISS was unavailable in six of 458 patient cases, lactate dehydrogenase in 19 of 458, and fluorescence in situ hybridization in 68 of 458. HR, hazard ratio.

a standard of care for patients with MM.³⁹⁻⁴¹ Based on Cassiopeia,⁴² the efficacy of this triplet can be increased by adding anti-CD38 monoclonal antibodies. Here, in a prospective study with limited missing MRD data, we report that a VRD/ASCT/VRD treatment scheme provides almost 50% MRD-negative rates; with a median follow-up of 40 months, patients with undetectable MRD after consolidation showed very low risk of disease progression (7%), with 3-year survival rates reaching 90%. These are unprecedented results that identify new outcomes for transplant-eligible patients and establish undetectable MRD as the new treatment end point for MM.

Despite the positive results accumulated in the past decade,^{22,23} MRD assessment has been considered in MM an exploratory test without clinical implications. Thus, MRD has been valuable to identify a false CR (ie, patients in CR

with similar outcome to those in partial response because of persistent MRD),¹⁵ but the achievement of undetectable MRD using low-sensitive methods was associated with a reduction in the risk of progression or death of only 60%.¹⁵ Here, we show that an MRD-negative response defined by NGF identifies a group of patients with significantly lower risk of progression when compared with previous studies using flow cytometry.^{5,6,12,13,15,16,18,40} Thus, our prospective analysis conducted in a large series of homogeneously treated patients validates the IMWG flow MRD-negative response criterion and supports its translation from trials into clinical practice. Of note, MRD assessment in trials typically is performed at predefined timepoints and irrespective of depth of response to prevent missing data. Accordingly, some patients in less than CR had undetectable MRD at a given timepoint, but most achieved CR later. This result reinforces that, in clinical

TABLE 1. Multivariable Analyses of PFS and OS, Incorporating Risk Stratification at Baseline According to the Revised International Staging System and Response Assessment After Treatment According to MRD status

Model	PFS			OS		
	HR	95% CI	P	HR	95% CI	P
First regression						
Undetectable v persistent MRD	0.12	0.07 to 0.21	< .001	0.09	0.04 to 0.23	< .001
Second regression						
Undetectable v persistent MRD	0.12	0.07 to 0.21	< .001	0.09	0.04 to 0.23	< .001
R-ISS I/II v III	0.46	0.26 to 0.80	.006	0.29	0.15 to 0.55	< .001

Abbreviations: HR, hazard ratio; MRD, measurable residual disease; OS, overall survival; PFS, progression-free survival; R-ISS, Revised International Staging System.

practice, MRD should be performed whenever patients achieve CR.

Despite the increased sensitivity of next-generation techniques, some patients with undetectable MRD develop early progression.^{20,27,34,36} Here, we show that approximately half of these patients, some of them with extraosseous plasmacytomas at diagnosis, presented new plasmacytomas as an isolated criterion of disease progression without detectable M-protein or BM infiltration. Thus, it appears that these were true false-negative MRD results, reinforcing the need to combine NGF or NGS with PET/CT to monitor treatment efficacy,^{25,30} particularly in patients presenting with extramedullary or macrofocal disease as well as elevated LDH levels.

After the promising results reported by Martinez-Lopez et al,²⁰ subsequent studies^{21,27,31-34} confirmed the prognostic value of NGS-based MRD assessment in MM and established it as the gold standard among molecular methods to evaluate treatment efficacy in this disease. Because the clinical meaning of persistent MRD $< 10^{-5}$ remained uncertain, some studies used an LOD of 10^{-5} to define negative MRD,^{20,31-33} while others adopted an LOD of 10^{-6} .^{21,34} Although, for prognostic purposes, the IMWG threshold of $< 10^{-5}$ is adequate, our study extends the findings by Perrot et al³⁴ and Flores-Montero et al³⁶ and supports a negative MRD defined with an LOD of 10^{-6} .

Based on low-sensitive flow cytometry, we and others reported that patients who achieved MRD negativity after induction had superior outcomes compared with patients who achieved this response after HDT/ASCT,^{5,16} probably because of the inability of these methods to detect MRD $< 0.01\%$.^{20,34,36} Here, we showed that, using sensitive NGF, patients with undetectable MRD before or after HDT/ASCT had virtually identical survival. These results, obtained with a sequential scheme, suggest that persistent MRD after induction may be used as an indication for early intensification. Whether patients with undetectable MRD after induction are candidates to harvest stem cells for a late ASCT after disease progression (or, eg, MRD

reappearance) should be investigated in randomized clinical trials. In addition, 17% of patients converted from detectable to undetectable MRD during maintenance, most of them in the first year. This rate is lower than in other trials (eg, Myeloma XI, EMN02, BMT CTN 0702), which could be related to exposure to lenalidomide during induction/consolidation, which would render patients less sensitive during maintenance, and/or to the higher sensitivity of NGF versus less-sensitive flow cytometry assays used in those studies. Of note, none of the patients converting from detectable to undetectable MRD during maintenance have experienced progression thus far, which strengthens the clinical value of maintenance therapy.

In 2015, the IMWG developed the R-ISS to effectively risk stratify patients on the basis of three diagnostic parameters.⁴³ Here, we show that achieving undetectable MRD by NGF overcame the poor prognosis of adverse factors identified at diagnosis, including high-risk cytogenetics. This unveils that risk is dynamic, because patients with adverse prognoses may shift into a favorable one upon achieving deep responses to treatment. The opposite also holds true; patients with R-ISS-I or R-ISS-II statuses and detectable MRD have a PFS closer to that of patients with R-ISS-III status and persistent MRD, rather than the other patients with R-ISS-I or R-ISS-II statuses with undetectable MRD. These results underline that MRD assessment helps resolve the variability in patient survival predicted by the R-ISS and highlight the value of the R-ISS to predict early versus late disease progression in patients with detectable MRD. Accordingly, patients with R-ISS-III status and persistent MRD showed median PFS and OS times of only 14 and 17 months, respectively. This observation is clinically meaningful, because these patients should be offered alternative treatment strategies before insurmountable disease progression occurs. In conclusion, the IMWG flow MRD-negative response criterion assessed in the BM is highly applicable and sensitive to evaluate treatment efficacy in MM.

AFFILIATIONS

¹Clinica Universidad de Navarra, Centro de Investigación Médica Aplicada Instituto de Investigación Sanitaria de Navarra, Pamplona, Spain

²Hospital Universitario de Salamanca, Instituto de Investigación Biomédica de Salamanca, Salamanca, Spain

³Hospital 12 de Octubre, Madrid, Spain

⁴Hospital Clínic Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Spain

⁵Hospital Universitario y Politécnico La Fe, Valencia, Spain

⁶Centro de Investigación Biomédica en Red de Cáncer, Instituto Carlos III, Madrid, Spain

⁷University of Salamanca, Salamanca, Spain

⁸Institut Català d'Oncologia i Institut Josep Carreras, Badalona, Spain

⁹Hospital Ramón y Cajal, Madrid, Spain

¹⁰Hospital Virgen de las Nieves, Granada, Spain

¹¹Hospital Universitario Virgen del Rocío, Instituto de Biomedicina de Sevilla, Sevilla, Spain

¹²Hospital Universitario San Carlos, Madrid, Spain

¹³Institut Català d'Oncologia L'Hospitalet, Barcelona, Spain

¹⁴Hospital Universitario de Canarias, Santa Cruz de Tenerife, Spain

¹⁵Catholic University of Valencia, Valencia, Spain

¹⁶Hospital Puerta de Hierro, Madrid, Spain

¹⁷Hospital Virgen de la Arrixaca, Murcia, Spain

¹⁸Hospital Clínico Lozano Blesa, Zaragoza, Spain

¹⁹Hospital Son Llatzer, Palma de Mallorca, Spain

²⁰Leiden University Medical Center, Leiden, the Netherlands

CORRESPONDING AUTHOR

Jesús F. San-Miguel, MD, PhD, Clínica Universidad de Navarra; Centro de Investigación Médica Aplicada, Av Pio XII 36, 31008 Pamplona, Spain; e-mail: sanmiguel@unav.es.

EQUAL CONTRIBUTION

B.P., N.P., M.-T.C., and L.R. contributed equally to this study as first authors. J.F.S.-M. and J.-J.L. contributed equally to this study as last authors.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST AND DATA AVAILABILITY STATEMENT

Disclosures provided by the authors and data availability statement (if applicable) are available with this article at DOI <https://doi.org/10.1200/JCO.19.01231>.

AUTHOR CONTRIBUTIONS

Conception and design: Bruno Paiva, Juan Flores-Montero, Luzalba Sanoja-Flores, Jesus Martin, Rafael Martinez-Martinez, Joan Bargay, Jacques J.M. Van Dongen, Alberto Orfao, Joan Blade, Jesús F. San-Miguel, Juan-José Lahuerta

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Administrative support: Roberto Maldonado, Jesus Martin, Jacques J.M. Van Dongen, Jesús F. San-Miguel, Juan-José Lahuerta

Provision of study material or patients: Bruno Paiva, Laura Rosiñol, Lourdes Cordón, María-Belén Vidriales, María-Jose Calasanz, Ramón García-Sanz, Joaquín Martínez-Lopez, Albert Oriol, Rafael Rios, Jesus Martin, Rafael Martínez-Martinez, Anna Sureda, Javier de la Rubia, Luis Palomera, Jacques J.M. Van Dongen, María-Victoria Mateos, Joan Blade, Jesús F. San-Miguel, Juan-José Lahuerta

Collection and assembly of data: Bruno Paiva, Noemi Puig, María-Teresa Cedena, Lourdes Cordón, María-Belén Vidriales, Lucía Lopez-Anglada, Roberto Maldonado, Norma C. Gutierrez, María-Jose Calasanz, María-Luisa Martín-Ramos, Ramón García-Sanz, Joaquín Martínez-Lopez, Albert Oriol, María-Jesús Blanchard, Rafael Rios, Jesus Martin, Rafael Martínez-Martinez, Miguel-Teodoro Hernandez, Isabel Krsnik, Jose-Maria Moraleda, Luis Palomera, Joan Bargay, Jacques J.M. Van Dongen, María-Victoria Mateos, Jesús F. San-Miguel, Juan-José Lahuerta

Data analysis and interpretation: Bruno Paiva, Noemi Puig, María-Teresa Cedena, Laura Rosiñol, María-Belén Vidriales, Leire Burgos, Javier de la Cruz, Ramón García-Sanz, Albert Oriol, Rafael Rios, Jesus Martin, Rafael Martínez-Martinez, Anna Sureda, Javier de la Rubia, Jose-Maria Moraleda, Joan Bargay, Jacques J.M. Van Dongen, Joan Blade, Jesús F. San-Miguel, Juan-José Lahuerta

Manuscript writing: All authors

Final approval of manuscript: All authors

Accountable for all aspects of the work: All authors

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST**Measurable Residual Disease by Next-Generation Flow Cytometry in Multiple Myeloma**

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Bruno Paiva

Honoraria: Amgen, Bristol-Myers Squibb, Celgene, Janssen-Cilag, Takeda
Consulting or Advisory Role: Celgene, Janssen-Cilag, Sanofi, Takeda
Speakers' Bureau: Celgene
Research Funding: Celgene, Janssen-Cilag, Sanofi, Takeda

Noemi Puig

Honoraria: Amgen, Celgene, Janssen, Takeda, The Binding Site
Consulting or Advisory Role: Amgen, Celgene, Janssen, Takeda
Speakers' Bureau: Celgene
Research Funding: Celgene, Janssen, Amgen, Takeda
Travel, Accommodations, Expenses: Amgen, Celgene, Janssen, Takeda

Laura Rosiñol

Honoraria: Janssen-Cilag, Celgene, Amgen, Takeda
Consulting or Advisory Role: Janssen-Cilag, Celgene, Amgen

Juan Flores-Montero

Patents, Royalties, Other Intellectual Property: Methods, reagents and kits for detecting minimal residual disease: Patent number: PCT/NL/2013/050420US 62/072.498 (Inst); methods, reagents and kits for flow cytometry immunophenotyping: Patent number: PCT/NL2010/050332US2012/0165213 (Inst)
Travel, Accommodations, Expenses: Janssen Scientific Affairs

Norma C. Gutiérrez

Honoraria: Janssen-Cilag
Travel, Accommodations, Expenses: Kite/Gilead

Ramón García-Sanz

Honoraria: Janssen, Takeda, Amgen
Consulting or Advisory Role: Janssen
Research Funding: Gilead (Inst), Incyte (Inst)
Patents, Royalties, Other Intellectual Property: BIOMED 2 primers (Inst)
Travel, Accommodations, Expenses: Janssen, Takeda (I)

Joaquín Martínez-Lopez

Speakers' Bureau: Novartis, Janssen-Cilag, Celgene, Bristol-Myers Squibb, Incyte
Research Funding: Bristol-Myers Squibb

Albert Oriol

Consulting or Advisory Role: Celgene, Janssen, Amgen
Speakers' Bureau: Amgen, Celgene

María-Jesús Blanchard

Consulting or Advisory Role: Janssen-Cilag, Amgen
Speakers' Bureau: Celgene

Rafael Rios

Consulting or Advisory Role: Janssen, Celgene

Jesus Martin

Travel, Accommodations, Expenses: Amgen

Rafael Martínez-Martinez

Travel, Accommodations, Expenses: Celgene

Anna Sureda

Honoraria: Takeda, Bristol-Myers Squibb, Merck Sharp & Dohme, Celgene, Janssen, Sanofi, Roche, Novartis, Gilead Sciences
Consulting or Advisory Role: Takeda, Bristol-Myers Squibb, Gilead Sciences, Celgene, Janssen, Novartis
Speakers' Bureau: Takeda
Other Relationship: Sanofi, Takeda, Roche, Celgene, Gilead Sciences

Miguel-Teodoro Hernandez

Consulting or Advisory Role: Celgene, Janssen, Amgen, Takeda
Speakers' Bureau: Janssen, Celgene, Amgen, Roche Pharma AG, Novartis
Research Funding: Celgene (Inst)

Javier de la Rubia

Expert Testimony: Amgen, Celgene, Janssen
Travel, Accommodations, Expenses: Amgen, Janssen

Isabel Krsnik

Honoraria: Celgene, Janssen, Takeda, Amgen
Consulting or Advisory Role: Celgene
Research Funding: Janssen, Prothena

Jose-Maria Moraleda

Consulting or Advisory Role: Gilead Sciences, Celgene
Research Funding: Pfizer (Inst)

Luis Palomera

Honoraria: Janssen-Cilag
Consulting or Advisory Role: Celgene, Janssen-Cilag, Amgen

Jacques J.M. Van Dongen

Honoraria: BD Biosciences (Inst)
Consulting or Advisory Role: Cytognos (Inst)
Research Funding: GlaxoSmithKline (Inst)
Patents, Royalties, Other Intellectual Property: Patents concerning methods for diagnosis of lymphoproliferative disorders (Inst)

Alberto Orfao

Consulting or Advisory Role: Cytognos
Speakers' Bureau: Novartis, Pfizer, AbbVie, BD Biosciences, Alexion Pharmaceuticals

Maria-Victoria Mateos

Honoraria: Janssen-Cilag, Celgene, Amgen, Takeda
Consulting or Advisory Role: Takeda, Janssen-Cilag, Celgene, Amgen, AbbVie, GlaxoSmithKline, Pharmamar-zeltia

Joan Blade

Honoraria: Janssen, Celgene, Amgen, Takeda

Jesús F. San-Miguel

Consulting or Advisory Role: Amgen (Inst), Celgene (Inst), Takeda (Inst), Bristol-Myers Squibb (Inst), MSD (Inst), Novartis (Inst), Sanofi (Inst), Janssen (Inst), Roche (Inst), AbbVie (Inst)

Juan-José Lahuerta

Consulting or Advisory Role: Celgene, Takeda, Amgen, Janssen-Cilag
Travel, Accommodations, Expenses: Celgene

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List of Investigators in the GEM (Grupo Español de Mieloma)/PETHEMA (Programa para el Estudio de la Terapéutica en Hemopatías Malignas) Cooperative Study Group

The following are study group investigators and locations: Dr. María Casanova Espinosa, Complejo Hospitalario Costa del Sol; Dr. José Luis Guzman Zamudio, H. Especialidades de Jerez de la Frontera; Dr. Eduardo Ríos Herranz, H. Nuestra Señora de Valme; Dr. Rafael Rios Tamayo, H. Universitario Virgen de las Nieves; Dr. Jesús Martín Sánchez, Complejo Hospitalario Regional Virgen del Rocío; Dr. Luis Palomera Bernal, H. Clínico Universitario Lozano Blesa; Dr. Ana Pilar González Rodríguez, H. Universitario Central de Asturias; Dr. María Esther González García, H. Cabueñes; Dr. Antonia Sampol Mayol, Complejo Asistencial Son Espases; Dr. Joan Bargay Lleona, H. Son Llàtzer; Dr. Alexia Suárez, H. de Gran Canaria Dr. Negrín; Dr. Miguel Teodoro Hernández García, H. Universitario de Canarias; Dr. Carmen Montes Gaisán, H. Universitario Marqués de Valdecilla; Dr. Belén Hernández Ruiz, H. General de Ciudad Real; Dr. Felipe Casado Montero, Complejo Hospitalario de Toledo; Dr. Dunia de Miguel Llorente, H. Universitario de Guadalajara; Dr. Fernando Solano Ramos, H. Nuestra Señora del Prado (Talavera); Dr. Ángela Ibañez García, H. General de Albacete; Dr. Mariví Mateos Manteca, H. Clínico de Salamanca; Dr. José Mariano Hernández Martín, Complejo Hospitalario H. General de Segovia; Dr. Fernando Escalante Barrigón, H. de León; Dr. Javier García Frade, H. Universitario Río Hortega; Dr. Alfonso García de Coca, H. Clínico Universitario de Valladolid; Dr. Carlos Aguilar Franco, H. Santa Bárbara; Dr. Jorge Labrador Gómez, Hospital Universitario de Burgos; Dr. Elena Cabezudo Pérez, H. Althaia, Xarxa Asistencial de Manresa (Sant Joan de Deu); Dr. Joan Bladé Creixent, H. CLINIC; Dr. Ana M^a Sureda Balari, H. Durán i Reynals—ICO L'Hospitalet; Dr. Yolanda González Montes, ICO Girona, H. Universitario de Girona Dr. Josep Trueta; Dr. Lourdes Escoda Teigell, H. Universitario Joan XXII de Tarragona; Dr. Antonio García Guiñón, Hospital Universitari Arnau de Vilanova de Lleida; Dr. Eugenia Abella Monreal, H. del Mar; Dr. Juan Alfonso Soler Campos, H. de Sabadell (Parc Taulí); Dr. Josep M^a Martí Tutusaus, Hospital Universitari Mútua de Terrassa; Dr. Albert Oriol Rocafiguera, H. Germans Trias i Pujol; Dr. Miquel Granell Gorrochategui, H. de la Santa Creu i Sant Pau; Dr. Mercedes Gironella Mesa, H. Vall d'Hebrón; Dr. Carmen Cabrera Silva, H. San Pedro de Alcántara (Complejo Hospitalario de Cáceres); Dr. Marta Sonia González Pérez, Complejo Hospitalario Universitario de Santiago; Dr. Ana Dios Loureiro, Complejo Hospitalario de Pontevedra; José Ángel Méndez Sánchez, Complejo Hospitalario de Ourense; Dr. María Josefa Nájera Irazu, H. San Pedro; Dr. Francisco Javier Peñalver Párraga, H. Universitario Fundación de Alcorcón; Dr. Juan José Lahuerta Palacios, H. Universitario 12 de Octubre; Dr. Pilar Bravo Barahona, H. de Fuenlabrada; Dr. Cristina Encinas Rodríguez, H. General Universitario Gregorio Marañón; Dr. José Ángel Hernández Rivas, H. Infanta Leonor; Dr. Jaime Pérez de Oteya, H. Universitario Madrid—Sanchinarro; Dr. Rebeca Iglesias del Barrio, Centro Oncológico MD Anderson; Dr. Ana López de la Guía, H. Universitario La Paz; Dr. Adrián Alegre Amor, H. Universitario de la Princesa; Dr. Elena Prieto Pareja, Fundación Jiménez Díaz—UTE; Dr. Isabel Krsnik Castelló, Hospital Universitario Puerta de Hierro—Majadahonda; Dr. M^a Jesús Blanchard Rodríguez, H. Ramón y Cajal; Dr. Rafael Martínez, H. Universitario de San Carlos; Dr. Rosalía Ríaza Grau, H. Severo Ochoa; Dr. Eugenio Giménez Mesa, H. Infanta Sofía; Dr. Elena Ruiz Sainz, Hospital del Tajo; Dr. Felipe de Arriba, H. Morales

Meseguer; Dr. Jose María Moraleda Jiménez, H. Universitario Virgen de la Arrixaca; Dr. Marta Romera, H. General Universitario Santa Lucía; Dr. Felipe Prósper Cardoso, Clínica Universidad de Navarra; Dr. José M^a Arguñano Pérez, Complejo Hospitalario de Navarra; Dr. María Puente Pomposo, H. de Cruces; Dr. Ernesto Pérez Persona, H. de Txagorritxu; Dr. Ana Isabel Teruel Casasús, H. Clínico Universitario de Valencia; Dr. Paz Ribas García, H. Universitario Dr. Peset; Dr. Isidro Jarque Ramos, H. Universitario La Fe; Dr. María Blanca Villarrubia Lor, H. General Universitario de Alicante; Dr. Pedro Luis Fernández García, H. Torre Vieja Salud UTE; and Dr. Pedro Luis Fernández García, H. del Vinalopo.

Supplementary Methods

Secondary end points of the PETHEMA/GEM2012MENOS65 clinical trial.

- The following were secondary end points:
- Complete response (CR) rates with negative immunofixation after each phase of treatment (induction, autologous stem-cell transplantation [ASCT] and consolidation);
 - Measurable residual disease (MRD) in patients with immunofixation-negative CR and after each phase of treatment (induction, autologous stem-cell transplantation, and consolidation);
 - Overall survival after ASCT with busulfan + melphalan versus melphalan; and
 - Safety and tolerability of induction and consolidation treatments.

Next-generation flow. MRD was assessed using the next-generation flow (NGF) method developed by EuroFlow for highly sensitive and standardized MRD detection in multiple myeloma (Sanoja-Flores L, et al: *Blood Cancer J* 8:117, 2018).³⁶ In brief, the method is based on a (standardized) lyse-wash-and-stain protocol and an optimized eight-color, two-tube antibody panel for accurate identification of phenotypically aberrant, clonal plasma cells (PCs): Tube 1 includes CD138-BV421, CD27-BV510, CD38-FITC, CD56-PE, CD45-PerCPy5.5, CD19-PECy7, CD117-APC, and CD81-APCH7; tube 2 includes CD138-BV421, CD27-BV510, CD38-FITC, CD56-PE, CD45-PerCPy5.5, CD19-PECy7, cyKAPPA-APC, and cyLAMBDA-APCH7 (Arana P, et al: *Leukemia* 32:971-978, 2018).³⁶ The two-tube strategy allows detection of MRD with specific confirmation of light-chain (mono)clonality on phenotypically aberrant PCs, identified by antigen underexpression (CD19, CD27, CD38, CD45, CD81) or overexpression (CD56, CD117, CD138) compared with normal PCs (Arana P, et al: *Leukemia* 32:971-978, 2018).³⁶ Data acquisition was performed in a FACSCanto II flow cytometer (BD, San Jose, CA) using the FACSDiva 6.1 software (BD). Data analysis was performed by experienced operators using the Infinicyt software (Cytognos SL, Salamanca, Spain). MRD assessments were performed blinded for clinical outcomes in three PETHEMA/GEM laboratories and data were centralized for MRD analyses.

Cytogenetic characterization. Fluorescence in-situ hybridization was performed at diagnosis in the same three PETHEMA/GEM laboratories that perform MRD monitoring. Immunomagnetically enriched PCs from 390 of 458 patients were tested for chromosome 1 alterations, *IGH* translocations and del(17p13). Patients with t(4;14), t(14;16), and/or del(17p13) were classified as high risk (n = 90); others were classified as standard risk (n = 300).

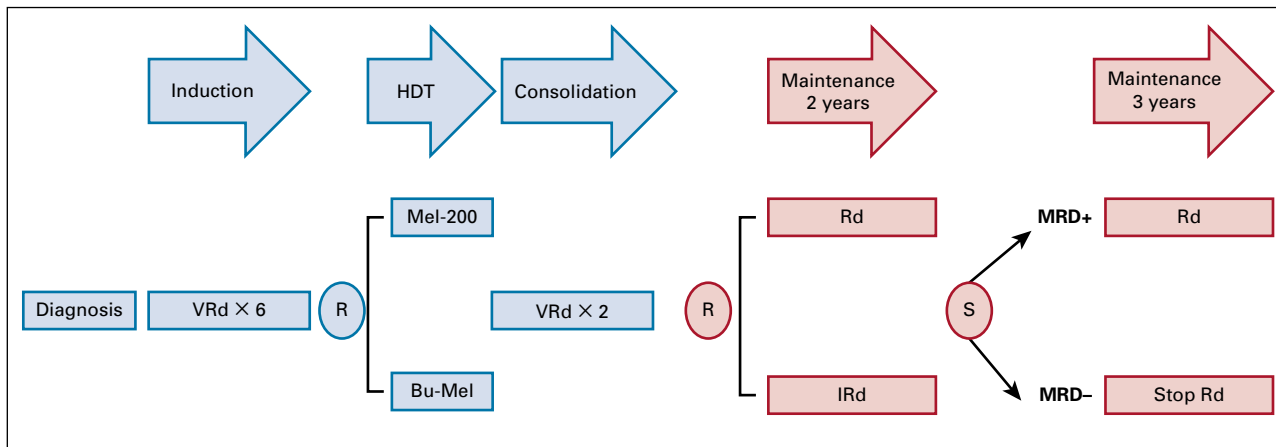


FIG A1. Schema of the PETHEMA GEM2012MENOS65 (in light blue) and GEM2014MAIN trials (in light red). Bu-Mel, busulfan + melphalan; d, low-dose dexamethasone; HDT, high-dose therapy; I, ixazomib; Mel, melphalan; MRD, measurable residual disease; R, lenalidomide; V, bortezomib.

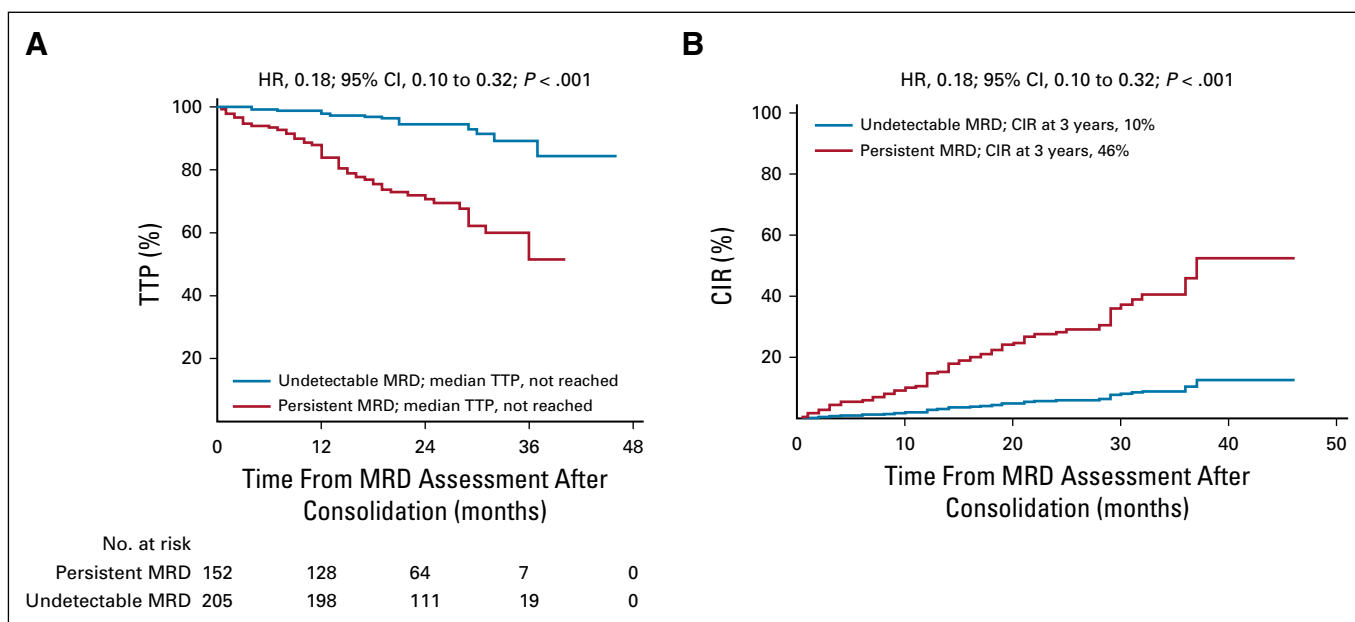


FIG A2. (A) Kaplan-Meier estimates of time-to progression (TTP), defined as the time from measurable residual disease (MRD) assessment until disease progression, according to patients' MRD statuses after consolidation ($n = 357$). Data from patients who died in the absence of progression were thus censored. The 3-year TTP rates were 89% v51% for patients with undetectable v persistent MRD, respectively. (B) The cumulative incidence of relapse (CIR) was calculated from the time from MRD assessment to the date of disease progression, considering death without disease progression as a competing event. HR, hazard ratio.

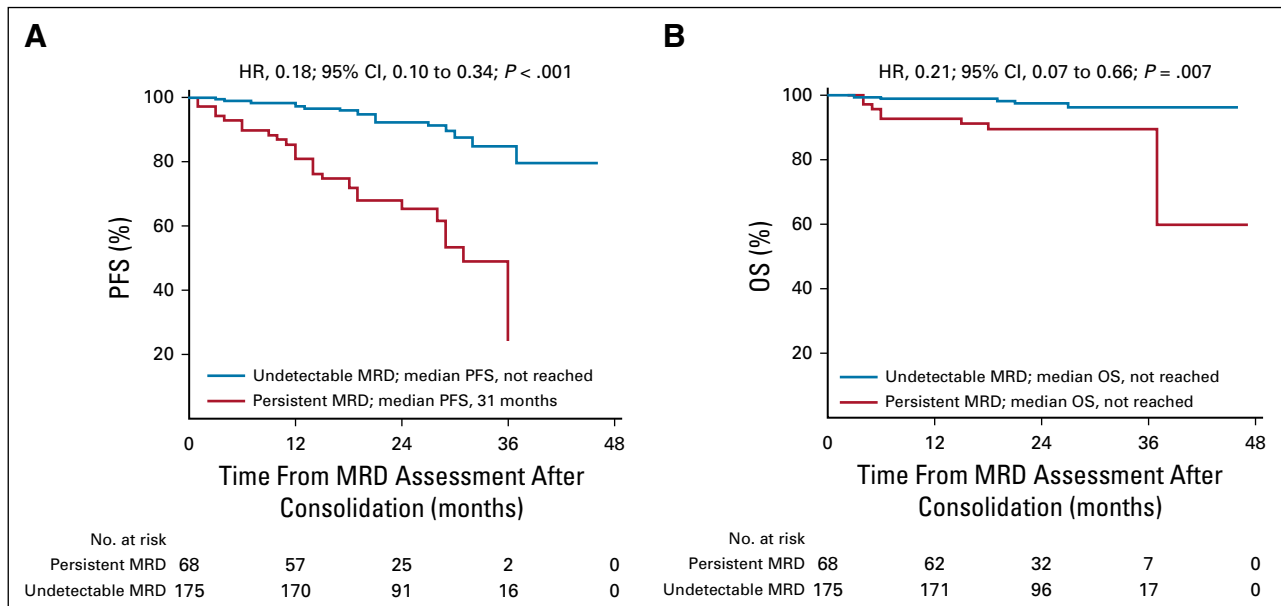


FIG A3. Survival according to undetectable v persistent measurable residual disease (MRD) in patients in complete remission (CR) after consolidation. (A) The Kaplan-Meier estimate of the 36-month progression-free survival (PFS) rate was 85% v 24% in patients with undetectable v persistent MRD. (B) The 36-month overall survival (OS) rate was 96% v 89% in patients with undetectable v persistent MRD. HR, hazard ratio.

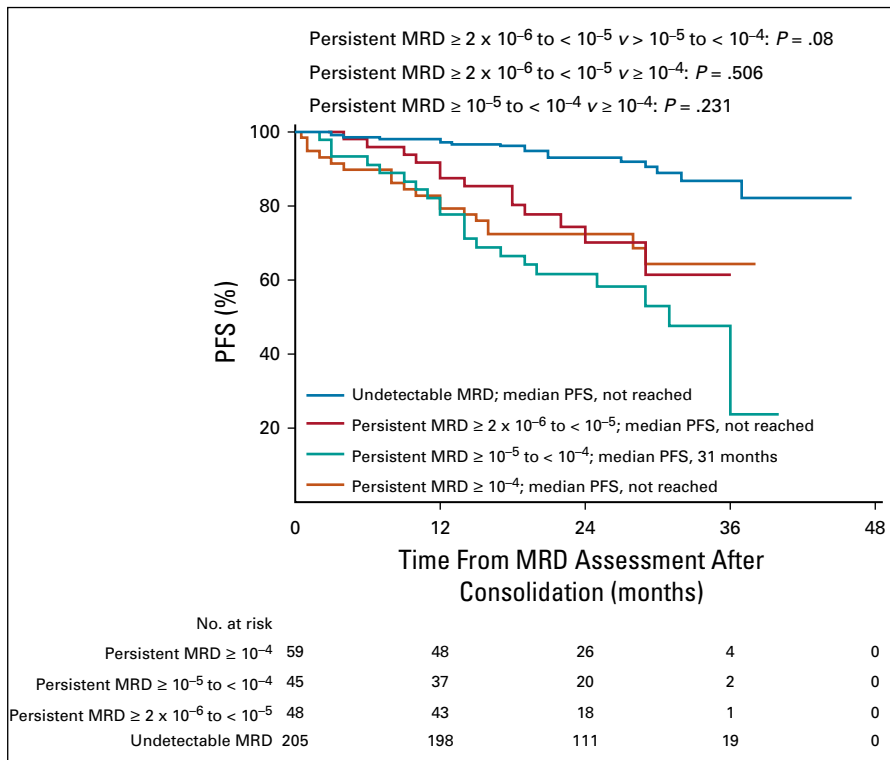


FIG A4. Progression-free survival (PFS) according to the presence of undetectable v persistent measurable residual disease (MRD) in the logarithmic ranges of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$, $\geq 10^{-5}$ to $< 10^{-4}$ and $\geq 10^{-4}$ after consolidation ($n = 357$). All pairwise comparisons between patients with negative v positive MRD in the logarithmic ranges of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$, $\geq 10^{-5}$ to $< 10^{-4}$ and $\geq 10^{-4}$ were statistically significant ($P < .001$). By contrast, there were no statistically significant differences in PFS of patients with positive MRD in the logarithmic range of $\geq 2 \times 10^{-6}$ to $< 10^{-5}$ v those with MRD levels of $\geq 10^{-5}$ to $< 10^{-4}$ or v those with MRD $\geq 10^{-4}$. There were also no statistically significant differences when comparing the PFS of patients with MRD in the logarithmic range of $\geq 10^{-5}$ to $< 10^{-4}$ v those with MRD $\geq 10^{-4}$.

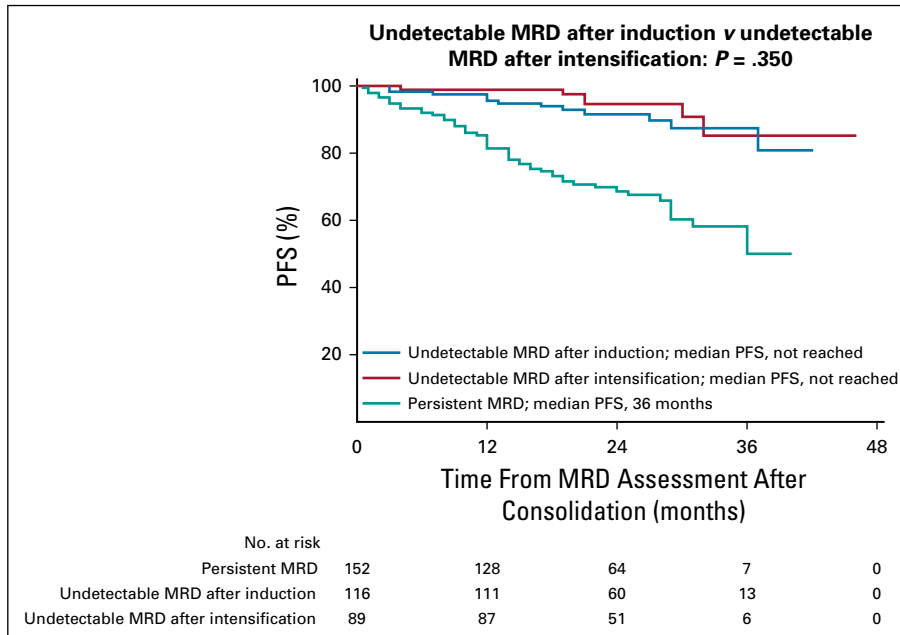


FIG A5. Progression-free survival (PFS) after consolidation (n = 357) according to the moment at which measurable residual disease (MRD) is undetectable: after induction v after intensification (either after high-dose therapy or consolidation). Data from patients with persistent MRD across the entire duration of the study were also plotted. Of note, 16 patients achieved negative MRD after induction (n = 1) or after high-dose therapy/autologous stem-cell transplantation (n = 15) but lost their MRD-negative status at the end of consolidation; five of the 16 experienced disease progression.

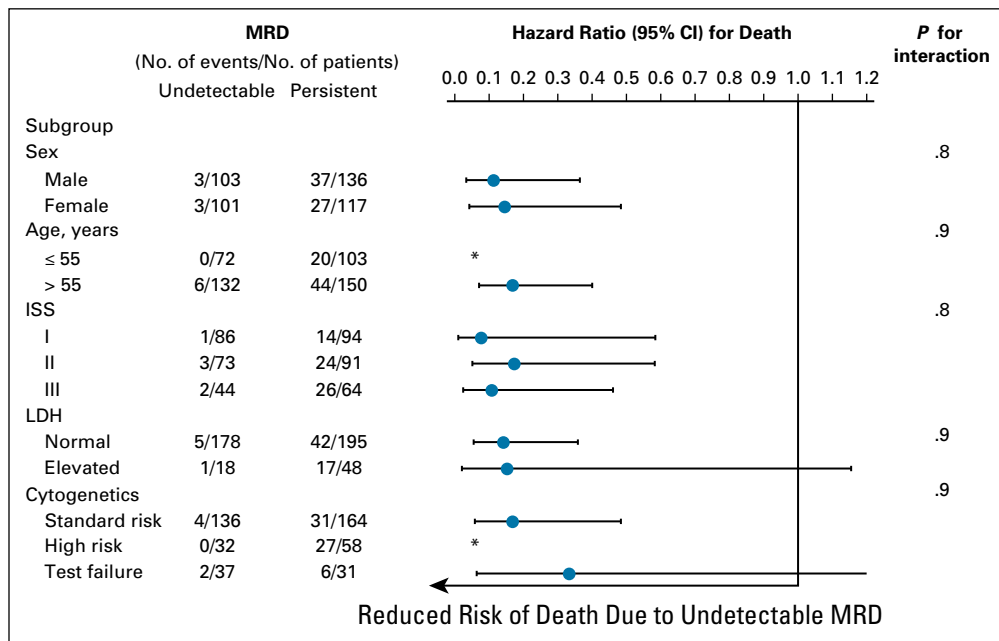


FIG A6. Subgroup analysis of overall survival according to patients' time-dependent measurable residual disease status. The intent-to-treat patient population was subgrouped according to sex, age, International Staging System (ISS), lactate dehydrogenase (LDH) levels, and cytogenetic alterations. (*) No events in this subgroup category.

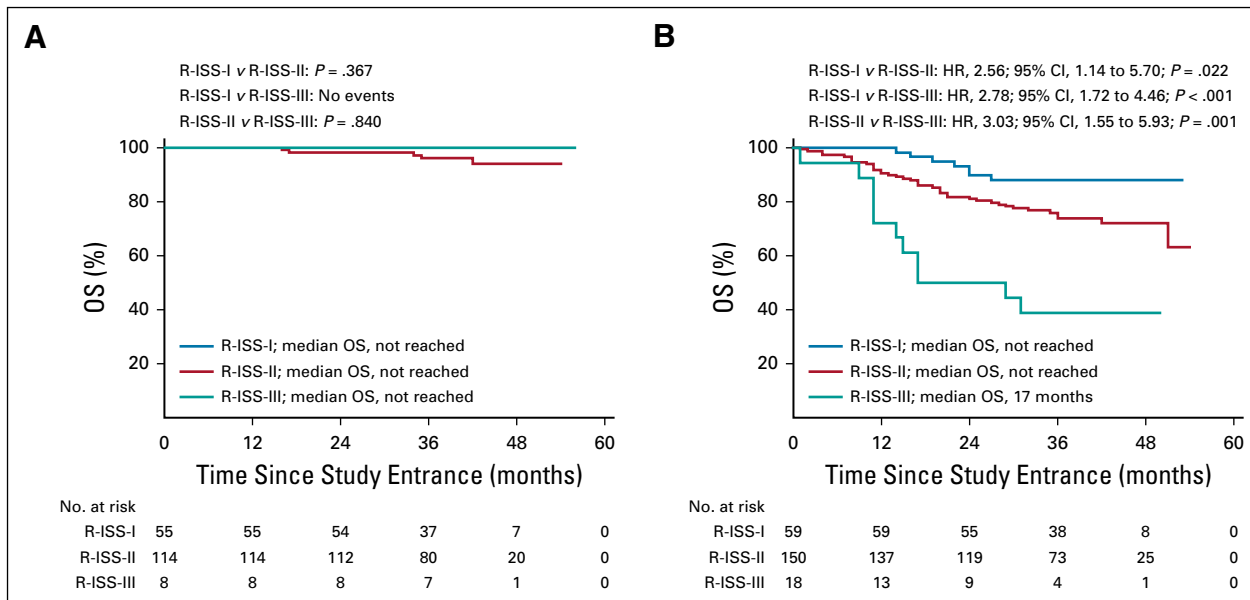


FIG A7. Modulating patients' risks at diagnosis according to depth of response after treatment, defined by measurable residual disease (MRD) status. Impact on overall survival (OS) of the Revised International Staging System (R-ISS) in patients with (A) undetectable v (B) persistent measurable residual disease. The Kaplan-Meier OS curves of patients with R-ISS-I and -III are superimposed, because no events were observed in either patient subgroup. HR, hazard ratio.

TABLE A1. Longitudinal MRD Response Rates After Induction, HDT/ASCT, and Consolidation in the Intent-to-Treat Patient Population Enrolled in the GEM2012MENOS65 Clinical Trial

MRD Status	No. (%) of Occurrences by Phase of Therapy (N = 458)		
	VRD × 6	HDT/ASCT	VRD × 2
On intent-to-treat protocol (n = 458)			
Undetectable MRD	129 (28)	194 (42)	208 (45)
Persistent MRD	329 (72)	264 (58)	250 (55)
MRD log levels $\geq 10^{-4}$	244 (74)	170 (64)	156 (63)
MRD log levels $\geq 10^{-5}$ and $< 10^{-4}$	66 (20)	73 (28)	46 (18)
MRD log levels $\geq 2 \times 10^{-6}$ and 10^{-5}	19 (6)	21 (8)	48 (19)
Longitudinally (n = 317)			
Undetectable MRD	110 (35)	173 (55)	185 (58)
Persistent MRD	207 (65)	144 (45)	132 (42)
MRD log levels $\geq 10^{-4}$	139 (67)	61 (42)	47 (36)
MRD log levels $\geq 10^{-5}$ and $< 10^{-4}$	52 (25)	65 (45)	42 (32)
MRD log levels $\geq 2 \times 10^{-6}$ and 10^{-5}	16 (8)	18 (13)	43 (32)

NOTE. Three hundred seventeen patients had MRD assessed at all three timepoints, and results for this cohort are shown in the lower part of the Table. Patients with MRD-positive statuses were subgrouped according to detectable MRD log levels to evaluate the impact of different treatment stages in persistent MRD.

Abbreviations: HDT/ASCT, high-dose therapy followed by autologous stem-cell transplantation; MRD, measurable residual disease; VRD × 2, consolidation therapy; VRD × 6, induction therapy.

TABLE A2. MRD Status Assessed After Induction, HDT/ASCT, and Consolidation in the GEM2012MENOS65 Clinical Trial According to Conventional Response Criteria

MRD Status	No. (%) of Occurrences by Treatment Stage								
	Induction (n = 377)			HDT/ASCT (n = 352)			Consolidation (n = 357)		
	CR (n = 160)	VGPR (n = 130)	≤ PR (n = 87)	CR (n = 200)	VGPR (n = 121)	≤ PR (n = 31)	CR (n = 243)	VGPR (n = 89)	≤ PR (n = 19)
Undetectable MRD	87 (54)	33 (25)	9 (10)	143 (71.5)	43 (35.5)	4 (13)	175 (72)	28 (31.5)	0 (0)
Persistent MRD	73 (46)	97 (75)	78 (90)	57 (28.5)	78 (64.5)	27 (87)	68 (28)	61 (68.5)	19 (100)

NOTE. Conventional response criteria used: CR, VGPR, and ≤ PR. The numbers of patients in CR, VGPR, and ≤ PR after induction, HDT/ASCT, and consolidation are reported for the cohort of patients with MRD assessment at that specific treatment stage.

Abbreviations: CR, complete remission; HDT/ASCT, high-dose therapy followed by autologous stem-cell transplantation; MRD, measurable residual disease; ≤ PR, partial response or less; VGPR, very good partial response.

TABLE A3. Characteristics of Patients Who Experienced Progression Despite Undetectable MRD

Patient	Diagnosis				Response				Relapse			
	ISS	LDH	FISH	Bone-Related Plasmacytomas (imaging)	Depth	Moment of Undetectable MRD	LOD	Time Since Diagnosis (months)	M-Protein	BM PCs (%)	Clonal PCs (%)	Extrasosseous Plasmacytomas (imaging)
1	III	Normal	SR	No (PET/CT)	sCR	IND	10 ⁻⁶	51	Yes	40	100	No (PET/CT)
2	I	Elevated	HR	No (CT, MRI)	sCR	CONS	10 ⁻⁶	46	Yes	2	0	No (CT, MRI)
3	II	Normal	SR	Yes (PET/CT)	VGPR	IND	10 ⁻⁶	20	No	4	0	Yes (PET/CT)
4	I	Normal	SR	No (WB-MRI)	sCR	HDT	10 ⁻⁶	44	Yes	36	28	No (WB-MRI)
5	III	Elevated	HR	Yes (PET/CT)	sCR	IND	10 ⁻⁶	28	No	3	0	Yes (PET/CT)
6	II	Normal	SR	No (WB-MRI)	sCR	IND	10 ⁻⁶	43	No	0.2	0	Yes (PET/CT)
7	I	Normal	SR	Yes (PET/CT)	sCR	IND	10 ⁻⁵	36	No	2	0	Yes (PET/CT)
8	II	Normal	SR	No (PET/CT)	CR	CONS	10 ⁻⁶	34	Yes	NE	NE	NE
9	III	Normal	TF	No (x-rays, CT)	sCR	HDT	10 ⁻⁶	35	Yes	17	100	NE
10	I	Normal	SR	No (CT)	sCR	CONS	10 ⁻⁶	36	No	2	86	Yes (CT)
11	III	Elevated	SR	Yes (PET/CT)	sCR	IND	10 ⁻⁶	25	No	1	0	Yes (PET/CT)
12	I	Normal	TF	No (PET/CT)	sCR	IND	10 ⁻⁶	33	No	5	50	No (PET/CT)
13	I	Normal	TF	NE (x-rays)	CR	CONS	10 ⁻⁶	20	No	58	100	NE
14	III	Elevated	SR	Yes (PET/CT)	sCR	IND	10 ⁻⁶	27	No	1	0	No* (PET/CT)

NOTE. The incidence of +1q (7/14) was higher than that typically observed in newly-diagnosed multiple myeloma (approximately 30%).

Abbreviations: BM PCs, bone marrow plasma cells; CONS, consolidation; CR, complete response; CT, computed tomography; FISH, fluorescence in situ hybridization; HDT, high-dose therapy; HR, high risk [t(4;14), t(14;16) and/or del(17p)]; IND, induction; ISS, International Staging System; LDH, lactate dehydrogenase; LOD, limit of detection achieved at the time of the latest MRD assessment; MRD, measurable residual disease; MRI, magnetic resonance imaging; NE, not evaluated; PCs, plasma cells; PET, positron emission tomography; sCR, stringent CR; SR, standard risk; TF, test failure; VGPR, very good partial response; WB-MRI, whole-body MRI.

*Multifocal disease.

TABLE A4. PFS and OS of Patients With Undetectable MRD Conditioned With Bu-Mel or Mel-200 High-Dose Therapy

Survival Type	Survival Rate (%) by Conditioning Regimen		P
	Bu-Mel (n = 180)	Mel-200 (n = 177)	
36-month PFS	88	86	.61
36-month OS	98	95	.38

NOTE. Achieving undetectable MRD before maintenance was associated with a 77% reduction in the risk of progression or death (HR, 0.23; $P < .001$) in patients treated with Bu-Mel and an 81% reduction (HR, 0.19; $P < .001$) in patients treated with Mel-200 high-dose therapy.

Abbreviations: Bu-Mel, busulfan + melphalan; HR, hazard ratio; Mel, melphalan; MRD, measurable residual disease; OS, overall survival; PFS, progression-free survival.

TABLE A5. PFS and OS of Patients With Undetectable MRD Receiving Maintenance With RD or IRD

Survival Type	Survival Rate (%) by Maintenance Regimen		P
	IRD (n = 163)	RD (n = 150)	
36-month PFS	86	90	.50
36-month OS	98	94	.18

NOTE. Achieving undetectable MRD before maintenance was associated with a 77% reduction in the risk of progression or death (HR, 0.23; $P < .001$) in patients treated with IRD and an 80% reduction (HR, 0.20; $P = .001$) in patients treated with RD.

Abbreviations: HR, hazard ratio; IRD, RD + ixazomib; MRD, measurable residual disease; OS, overall survival; PFS, progression-free survival; RD, lenalidomide + dexamethasone.

TABLE A6. Subgroup Analysis of Disease Progression Rates According to Patients' Time-Dependent MRD Statuses

Subgroup	No. of Patients	No. (%) of Progressions/No. of Patients by MRD Status	
		Undetectable	Persistent
Sex			
Male	239	8 (8)/103	55 (40)/136
Female	218	6 (6)/101	46 (39)/117
<i>P</i>		.78	.90
Age, years			
≤ 55	175	4 (6)/72	35 (35)/103
> 55	282	10 (8)/132	66 (44)/150
<i>P</i>		.77	.12
ISS			
I	179	6 (7)/85	29 (31)/94
II	164	2 (3)/73	41 (45)/91
III	108	6 (14)/44	30 (47)/64
<i>P</i>		.08	.06
LDH			
Normal	373	10 (6)/178	75 (39)/195
Elevated	70	4 (22)/18	23 (48)/48
<i>P</i>		.03	.25
Cytogenetics			
Standard risk	300	9 (7)/136	56 (34)/164
High risk	90	2 (6)/32	34 (59)/58
Test failure	69	3 (8)/37	11 (36)/31
<i>P</i>		.94	.004

NOTE. The intent-to-treat patient population was subgrouped according to sex, age, ISS, LDH levels, and cytogenetic abnormalities.

Abbreviations: ISS, International Staging System; LDH, lactate dehydrogenase; MRD, measurable residual disease.

TABLE A7. Multivariable Analyses of PFS and OS According to the R-ISS

R-ISS Subgroup	PFS			OS		
	Median (months)	36-Month Rate (%)	<i>P</i>	Median (months)	36-Month Rate (%)	<i>P</i>
I	NR	77		NR	94	
II	NR	70	.002	NR	83	< .001
III	28	46		NR	58	

Abbreviations: NR, not reached; OS, overall survival; PFS, progression-free survival; R-ISS, Revised International Staging System.

TABLE A8. Impact of Maintenance Therapy on Patients' MRD Statuses

MRD Status	No. (%) of Patients		
	CONS→M1 (n = 190)	M1→M2 (n = 190)	CONS→M1→M2 (n = 190)
MRD- → MRD-	107 (56.3)	123 (64.7)	103 (54.2)
MRD+ → MRD-	33 (17.4)	13 (6.8)	33 (17.4)
MRD- → MRD+	10 (5.3)	17 (8.9)	14 (7.4)
MRD+ → MRD+	40 (21.1)	37 (19.5)	40 (21.1)

NOTE. According to the GEM2014MAIN study design, MRD was assessed every year during maintenance. The longitudinal comparison from CONS into M1 and M2 was performed in the 190 patients with MRD assessment at all three timepoints. Results also are reported for the paired comparison between CONS and M1 (CONS→M1) and the paired comparison between M1 and M2 (M1→M2). Patients were categorized into sustained MRD negativity from consolidation to maintenance (MRD- → MRD-), conversion from MRD+ into MRD- during maintenance (MRD+ → MRD-), loss of MRD negativity during maintenance (MRD- → MRD+), and persistent MRD from consolidation to maintenance (MRD+ → MRD+). Of note, none of the patients who converted from MRD+ into MRD- during maintenance or who lost their MRD negativity during maintenance have experienced disease progression thus far.

Abbreviations: +, positive; -, negative; CONS, consolidation; M1, first year of maintenance; M2, second year of maintenance; MRD, measurable residual disease.