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# Neues vom amerikanischen Hämatologenkongress Multiples Myelom

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Medical Clinic V

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**Disclosures**

- Honoraria
  - Amgen, BMS, Celgene, Chugai, GSK, Janssen, Novartis, Sanofi
- Consulting or advisory role
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- Travel, accommodations, expenses
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# PERSEUS

## Phase 3 Randomized Study of Daratumumab + Bortezomib, Lenalidomide, and Dexamethasone (VRd) Versus VRd Alone in Patients With Newly Diagnosed Multiple Myeloma Who Are Eligible for Autologous Stem Cell Transplantation: Primary Results of the PERSEUS Trial*

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EMN

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## PERSEUS: Baseline Demographic and Clinical Characteristics

| | D-VRd (n = 355) | VRd (n = 354) |
|---|---|---|
| Age | | |
| Median (range), years | 61.0 (32-70) | 59.0 (31-70) |
| Category, n (%) | | |
| <50 years | 54 (15.2) | 54 (15.3) |
| ≥50 and <65 years | 207 (58.3) | 213 (60.2) |
| ≥65 years | 94 (26.5) | 87 (24.6) |
| Male, n (%) | 211 (59.4) | 205 (57.9) |
| ECOG PS,[a] n (%) | | |
| 0 | 221 (62.3) | 230 (65.0) |
| 1 | 114 (32.1) | 108 (30.5) |
| 2 | 19 (5.4) | 16 (4.5) |
| 3 | 1 (0.3) | 0 |
| MM diagnosis, n (%) | | |
| N | 354 | 352 |
| CRAB criteria only[b] | 125 (35.3) | 113 (32.1) |
| Biomarkers of malignancy only | 52 (14.7) | 65 (18.5) |
| CRAB criteria and biomarkers of malignancy | 177 (50.0) | 174 (49.4) |

| | D-VRd (n = 355) | VRd (n = 354) |
|---|---|---|
| ISS stage,[c] n (%) | | |
| N | 355 | 353 |
| I | 186 (52.4) | 178 (50.4) |
| II | 114 (32.1) | 125 (35.4) |
| III | 55 (15.5) | 50 (14.2) |
| Number of extramedullary plasmacytomas, n (%) | | |
| 0 | 340 (95.8) | 338 (95.5) |
| ≥1 | 15 (4.2) | 16 (4.5) |
| Cytogenetic profile,[d] n (%) | | |
| Standard risk | 264 (74.4) | 266 (75.1) |
| High risk | 76 (21.4) | 78 (22.0) |
| Indeterminate | 15 (4.2) | 10 (2.8) |

- **D-VRd and VRd treatment arms were well balanced**

MM, multiple myeloma; CRAB, calcium, renal, anemia, bone. [a]ECOG PS is scored on a scale from 0 to 5, with 0 indicating no symptoms and higher scores indicating increasing disability. One patient had an ECOG PS score of 0 at randomization that worsened to a score of 3 at baseline. [b]≥1 of the CRAB criteria. [c]Based on the combination of serum β2-microglobulin and albumin levels. Higher stages indicate more advanced disease. [d]Based on fluorescence in situ hybridization; high risk was defined as the presence of del(17p), t(4;14), and/or t(14;16).

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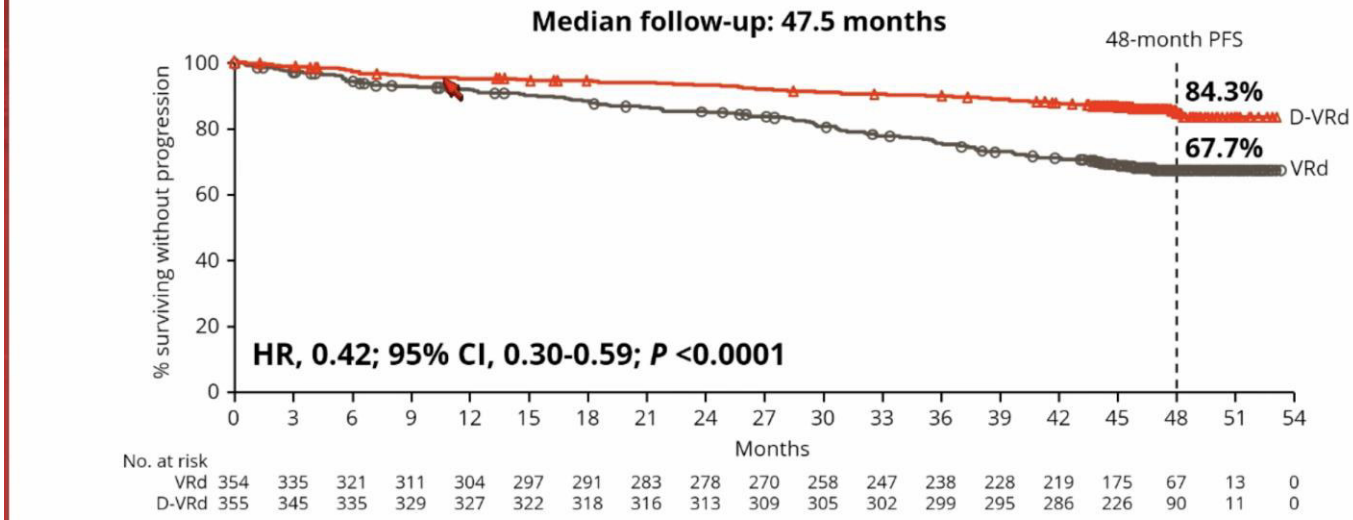
## PERSEUS: Progression-free Survival




- **58% reduction in the risk of progression or death in patients receiving D-VRd**

HR, hazard ratio; CI, confidence interval.

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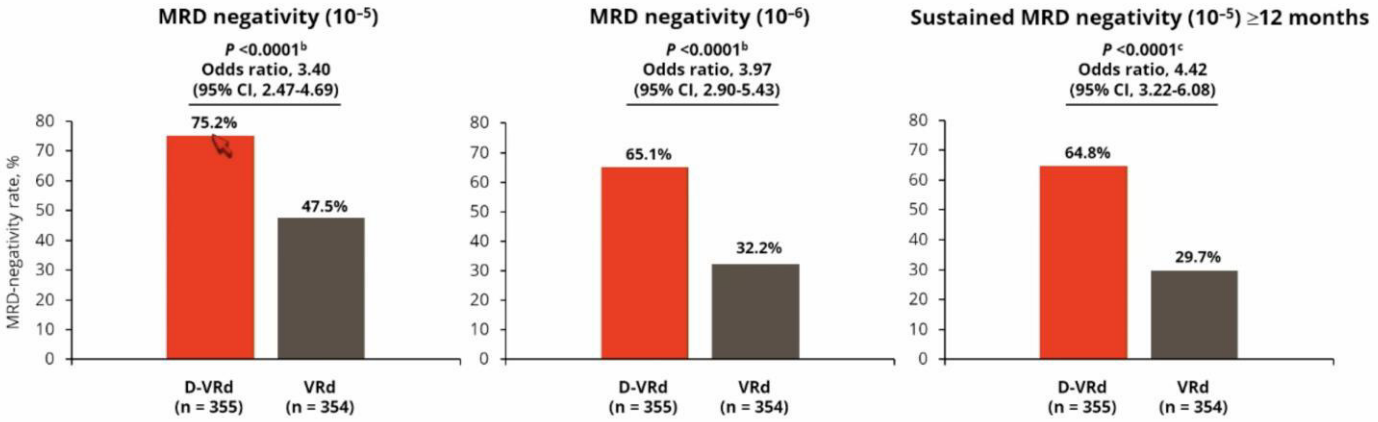
## PERSEUS: Overall and Sustained MRD-negativity Rates[a]




- **Deep and durable MRD negativity was achieved with D-VRd**
- **64% (207/322) of patients receiving maintenance in the D-VRd group discontinued DARA after achieving sustained MRD negativity per protocol[d]**

[a]MRD-negativity rate was defined as the proportion of patients who achieved both MRD negativity and ≥CR. MRD was assessed using bone marrow aspirates and evaluated via next-generation sequencing (clonoSEQ assay, version 2.0; Adaptive Biotechnologies, Seattle, WA). [b]*P* values were calculated with the use of the stratified Cochran–Mantel–Haenszel chi-squared test. [c]*P* value was calculated with the use of Fisher's exact test. [d]After ≥24 months of maintenance therapy, DARA was discontinued in patients who achieved ≥CR and sustained MRD negativity ($10^{-5}$) for ≥12 months.

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## PERSEUS: Safety

| Event, n (%)[a] | D-VRd (n = 351) | | VRd (n = 347) | |
|---|---|---|---|---|
| | Any grade | Grade 3 or 4 | Any grade | Grade 3 or 4 |
| HEMATOLOGIC | | | | |
| **Neutropenia** | **243 (69.2)** | **218 (62.1)** | **204 (58.8)** | **177 (51.0)** |
| **Thrombocytopenia** | **170 (48.4)** | **102 (29.1)** | **119 (34.3)** | **60 (17.3)** |
| Anemia | 78 (22.2) | 21 (6.0) | 72 (20.7) | 22 (6.3) |
| Febrile neutropenia | 34 (9.7) | 33 (9.4) | 38 (11.0) | 35 (10.1) |
| NON-HEMATOLOGIC | | | | |
| Diarrhea | 214 (61.0) | 37 (10.5) | 188 (54.2) | 27 (7.8) |
| **Peripheral sensory neuropathy** | **188 (53.6)** | **15 (4.3)** | **179 (51.6)** | **14 (4.0)** |
| Constipation | 119 (33.9) | 8 (2.3) | 118 (34.0) | 6 (1.7) |
| Pyrexia | 111 (31.6) | 8 (2.3) | 109 (31.4) | 9 (2.6) |
| Insomnia | 95 (27.1) | 8 (2.3) | 61 (17.6) | 6 (1.7) |
| Asthenia | 94 (26.8) | 12 (3.4) | 89 (25.6) | 9 (2.6) |
| Cough | 85 (24.2) | 1 (0.3) | 51 (14.7) | 0 |
| Fatigue | 84 (23.9) | 10 (2.8) | 92 (26.5) | 18 (5.2) |
| Rash | 82 (23.4) | 9 (2.6) | 94 (27.1) | 17 (4.9) |
| Back pain | 80 (22.8) | 2 (0.6) | 66 (19.0) | 1 (0.3) |
| Peripheral edema | 72 (20.5) | 4 (1.1) | 74 (21.3) | 1 (0.3) |
| Nausea | 71 (20.2) | 2 (0.6) | 58 (16.7) | 2 (0.6) |
| **Infections** | **305 (86.9)** | **124 (35.3)** | **266 (76.7)** | **95 (27.4)** |
| COVID-19 | 123 (35.0) | 12 (3.4) | 83 (23.9) | 4 (1.2) |
| Upper respiratory tract infection | 111 (31.6) | 2 (0.6) | 87 (25.1) | 6 (1.7) |
| Pneumonia | 64 (18.2) | 37 (10.5) | 38 (11.0) | 21 (6.1) |

TEAE, treatment-emergent adverse event. [a]TEAEs of any grade reported in ≥20% of patients in either treatment group and grade 3 or 4 TEAEs reported in ≥10% of patients in either treatment group.

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## PERSEUS Primary Analysis: Conclusions

- D-VRd (DARA SC) induction followed by ASCT, D-VRd consolidation, and D-R maintenance significantly improved PFS versus VRd induction followed by ASCT, VRd consolidation, and R maintenance in transplant-eligible patients with NDMM (HR, 0.42; *P* <0.0001)
  - 48-month PFS rates: 84.3% versus 67.7%
- D-VRd regimen significantly improved depth of response versus VRd regimen
  - Overall ≥CR rates: 87.9% versus 70.1%
  - Overall MRD-negativity rates: 75.2% versus 47.5%
  - 64% of patients receiving D-R maintenance for at least 2 years were able to stop DARA after achieving sustained MRD negativity
- Observed safety profile was consistent with the known safety profiles for DARA SC and VRd

- **These randomized phase 3 results support D-VRd followed by D-R maintenance as a new standard of care for transplant-eligible patients with NDMM**

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# The Phase 2 CARTITUDE-2 Trial: Updated Efficacy and Safety of Ciltacabtagene Autoleucel in Patients With Multiple Myeloma and 1–3 Prior Lines of Therapy (Cohort A) and With Early Relapse After First Line Treatment (Cohort B)

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* At the time of the study

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# CARTITUDE-2 Cohorts A & B: Introduction

- In CARTITUDE-1, a single cilta-cel infusion yielded deep and durable responses in heavily pretreated patients with RRMM[1,2]
  - Basis for approval in patients with RRMM with ≥3 and ≥4 prior LOT in Europe and the US, respectively[3,4]
- CARTITUDE-2 is a multicohort study of cilta-cel use in patients as early as after 1 prior LOT[5-7]
  - Cohorts A and B have the potential to yield insight into cilta-cel outcomes in patients in early LOT RRMM, a high unmet need

**Cohort A: Len-refractory MM after 1–3 prior LOT, including a PI and IMiD**

ORR, 95% (90% ≥CR) as previously reported[5]

**Cohort B: 1 prior LOT, including a PI and IMiD, and PD ≤12 months after ASCT or from the start of antimyeloma therapy**

ORR, 100% (90% ≥CR) as previously reported[6]

**Objective: To report updated efficacy and safety data from CARTITUDE-2 cohorts A and B after a median follow-up of ~29 months**

ASCT, autologous stem cell transplant; cilta-cel, ciltacabtagene autoleucel; CR, complete response; IMiD, immunomodulatory drug; len, lenalidomide; LOT, line of therapy; MM, multiple myeloma; ORR, overall response rate; PD, progressive disease; PI, proteasome inhibitor; RRMM, relapsed/refractory MM.

1. Berdeja JG, et al. *Lancet* 2021;398:314-24. 2. Martin, T et al. *J Clin Oncol* 2023;41:1265-74. 3. CARVYKTI® (ciltacabtagene autoleucel). Prescribing information. Janssen Biotech, Inc.; 2023. 4. CARVYKTI® (ciltacabtagene autoleucel). European Medicines Agency. Orphan maintenance assessment report. June 7, 2022. Accessed November 27, 2023. 5. Einsele H, et al. *J Clin Oncol* 2022;40(suppl 16):8020. 6. van de Donk NWCJ, et al. *Blood* 2022;140(suppl 1):7536-7. 7. ClinicalTrials.gov, NCT04133636.



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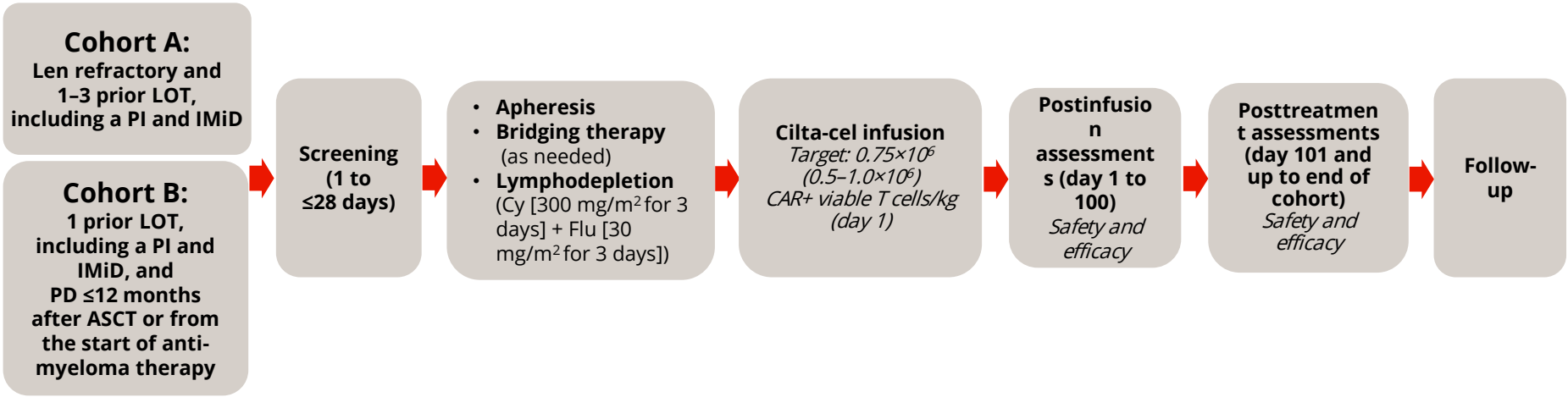
# CARTITUDE-2 Cohorts A & B: Study Design and Methods




- **Primary endpoint:** MRD negativity[a] ($10^{-5}$ threshold) assessed by NGS or NGF
- **Secondary endpoints included:** ORR,[a] DOR, time to response, incidence and severity of AEs,[b] including CRS and ICANS[1,c]
- **Exploratory endpoints included:** PFS and OS

[a]Assessed per IMWG criteria. [b]Assessed per CTCAE version 5.0. [c]Graded per ASTCT criteria. AE, adverse event; ASCT, autologous stem cell transplant; ASTCT, American Society of Transplantation and Cellular Therapy; CAR, chimeric antigen receptor; cilta-cel, ciltacabtagene autoleucel; CRS, cytokine release syndrome; CTCAE, Common Terminology Criteria for Adverse Events; Cy, cyclophosphamide; DOR, duration of response; Flu, fludarabine; ICANS, immune effector cell–associated neurotoxicity syndrome; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; len, lenalidomide; LOT, line of therapy; MRD, minimal residual disease; NGF, next-generation flow; NGS, next-generation sequencing; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PI, proteasome inhibitor.

1. Lee DW, et al. *Biol Blood Marrow Transplant* 2019;25:625-38.



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# CARTITUDE-2 Cohorts A & B: Patient Demographic and Baseline Characteristics

| Characteristic | Cohort A (N=20) | Cohort B (N=19) |
|---|---|---|
| Age, median (range), y | 60 (38–75) | 58 (44–67) |
| Male, n (%) | 13 (65.0) | 14 (73.7) |
| Race, n (%) | | |
| White | 18 (90.0) | 14 (73.7) |
| Black/African American | 2 (10.0) | 2 (10.5) |
| Asian | 0 | 1 (5.3) |
| Not reported | 0 | 2 (10.5) |
| Bone marrow plasma cells[a] ≥60%, n (%) | 3 (15.0) | 4 (21.1) |
| Extramedullary plasmacytomas, n (%) | 3 (15.0) | 3 (15.8) |
| Cytogenetic high risk,[b] n (%) | 7 (35.0)[c] | 3 (15.8)[d] |
| del17p | 3 (15.0) | 3 (15.8) |
| t(14;16) | 5 (25.0) | 0 |
| t(4;14) | 0 | 0 |
| 1q | 0 | 0 |

| Characteristic | Cohort A (N=20) | Cohort B (N=19) |
|---|---|---|
| Years since initial diagnosis to enrollment, median (range) | 3.5 (0.7–8.0) | 1.15 (0.5–1.9) |
| Prior LOT, median (range) | 2 (1–3) | 1 (1–1) |
| Previous stem cell transplantation,[e] n (%) | | |
| Autologous | 17 (85.0) | 15 (78.9) |
| Exposure status, n (%) | | |
| Triple-class[f] | 13 (65.0) | 4 (21.1) |
| Penta-drug exposed[g] | 4 (20.0) | 0 |
| Refractory status, n (%) | | |
| Triple-class[f] | 8 (40.0) | 3 (15.8) |
| Penta-drug refractory[g] | 1 (5.0) | 0 |
| To last line of prior therapy | 19 (95.0) | 15 (78.9) |

- As of April 2023, median follow-up of patients who received cilta-cel infusion was 29.9 months (range, 3.3[h]–35.6) in cohort A and 27.9 months (range, 5.2[h]–32.1) in cohort B

[a]Maximum value from bone marrow biopsy and bone marrow aspirate is selected if both results are available. [b]Any of the following 4 cytogenetic features abnormal: del17p, t(14;16), t(4;14), or 1q. [c]1 patient had both del17p and t(14;16); 6 (30.0%) patients had unknown cytogenetics. [d]3 (15.8%) patients had unknown cytogenetics. [e]17 patients in cohort A and 15 patients in cohort B received prior stem cell transplantation and all were autologous. [f]PI, IMiD, and anti-CD38 antibody. [g]≥2 PIs, ≥2 IMiDs, and 1 anti-CD38 antibody. [h]Includes patients who died. cilta-cel, ciltacabtagene autoleucel; IMiD, immunomodulatory drug; LOT, line of therapy; PI, proteasome inhibitor.



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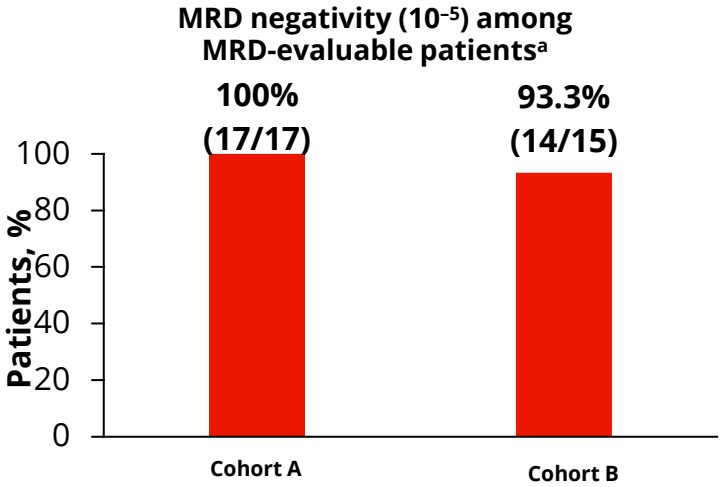
# CARTITUDE-2 Cohorts A & B: MRD Negativity (Primary Endpoint)

(~29-month median follow-up)

## Most patients achieved MRD negativity at a threshold of $10^{-5}$




| Sustained MRD negativity[b] | Cohort A | Cohort B |
|---|---|---|
| **Patients evaluable for sustained MRD negativity ≥6 mo[c]** | **n=11** | **n=13** |
| Sustained MRD negativity ($10^{-5}$) ≥6 mo,[d] n (%) | 8 (72.7) | 10 (76.9) |
| **Patients evaluable for sustained MRD negativity ≥12 mo[e]** | **n=14** | **n=13** |
| Sustained MRD negativity ($10^{-5}$) ≥12 mo,[f] n (%) | 7 (50.0) | 8 (61.5) |

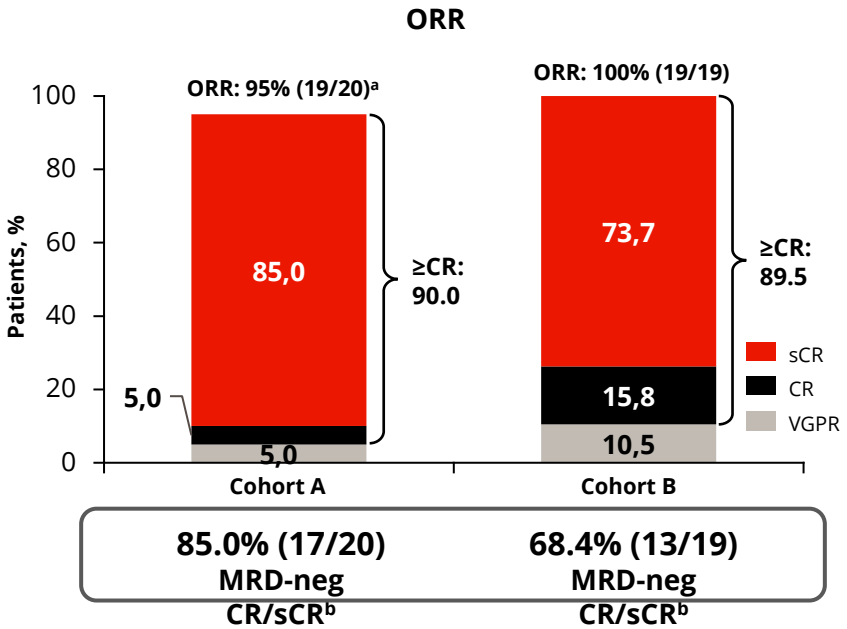
Per protocol, bone marrow aspirate samples for MRD evaluation were collected at time of suspected CR/sCR; for all dosed patients at months 2, 6, 12, 18, and 24; and yearly thereafter for patients in CR/sCR.

[a]Patients who were MRD evaluable had a clone identified and had at least 1 postbaseline MRD sample that included sufficient cells for evaluation at the $10^{-5}$ testing threshold (for NGS) or patients who had at least 1 postbaseline sample with the result of either positive or negative (for NGF). [b]Post hoc analysis. [c]Patients who achieved overall MRD negativity and had at least an evaluable MRD sample at the $10^{-5}$ testing threshold on or after 6 months after their first MRD negativity or progressed, started subsequent therapy, or died due to progressive disease within 6 months after their first MRD negativity. [d]MRD negative confirmed by at least 6 months apart without MRD positive in between. Percentage is calculated with number of patients evaluable for sustained MRD negativity ≥6 months as denominator. [e]Patients who achieved overall MRD negativity and had at least an evaluable MRD sample at the $10^{-5}$ testing threshold on or after 12 months after their first MRD negativity or progressed, started subsequent therapy, or died due to progressive disease within 12 months after their first MRD negativity. [f]MRD negative confirmed by at least 12 months apart without MRD positive in between. Percentage is calculated with number of patients evaluable for sustained MRD negativity ≥12 months as denominator. CR, complete response; MRD, minimal residual disease; NGF, next-generation flow; NGS, next-generation sequencing; sCR, stringent CR.

# CARTITUDE-2 Cohorts A & B: Response (Secondary Endpoints)

(~29-month median follow-up)

## Cilta-cel led to deep and durable responses




| Treatment response among responders | Cohort A (N=19) | Cohort B (N=19) |
|---|---|---|
| Time (mo) to first response,[c] median (range) | 0.99 (0.7–3.3) | 0.95 (0.9–9.7) |
| Time (mo) to best response, median (range) | 3.25 (0.9–13.6) | 5.1 (0.9–11.8) |
| **Duration of response** | | |
| 24-mo DOR rate, % (95% CI) | 73.3 (47.2–87.9) | 70.5 (42.5–86.7) |

[a]1 patient had a minimal response. [b]Only MRD assessments ($10^{-5}$ testing threshold) within 3 months of achieving CR/sCR until death/progression/subsequent therapy (exclusive) are considered. [c]≥PR.
cilta-cel, ciltacabtagene autoleucel; CR, complete response; DOR, duration of response; MRD, minimal residual disease; ORR, overall response rate; PR, partial response; sCR, stringent CR; VGPR, very good partial response.

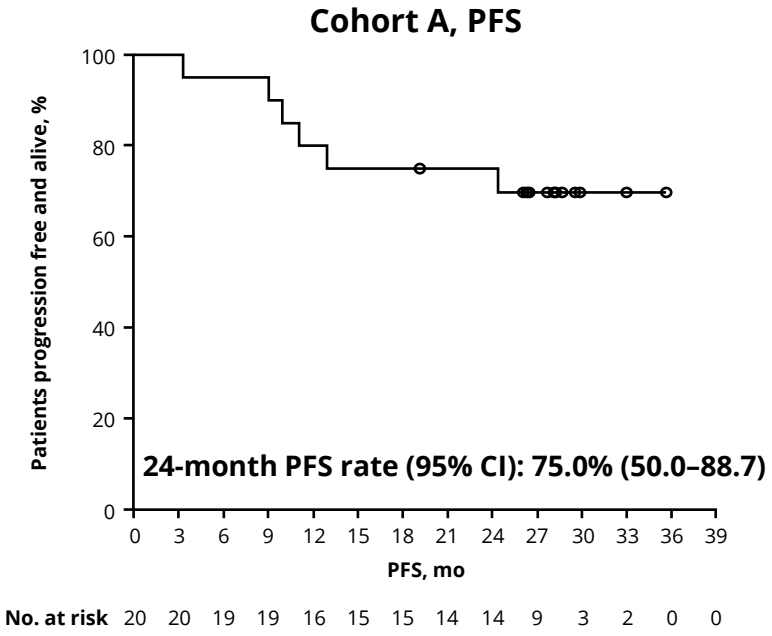


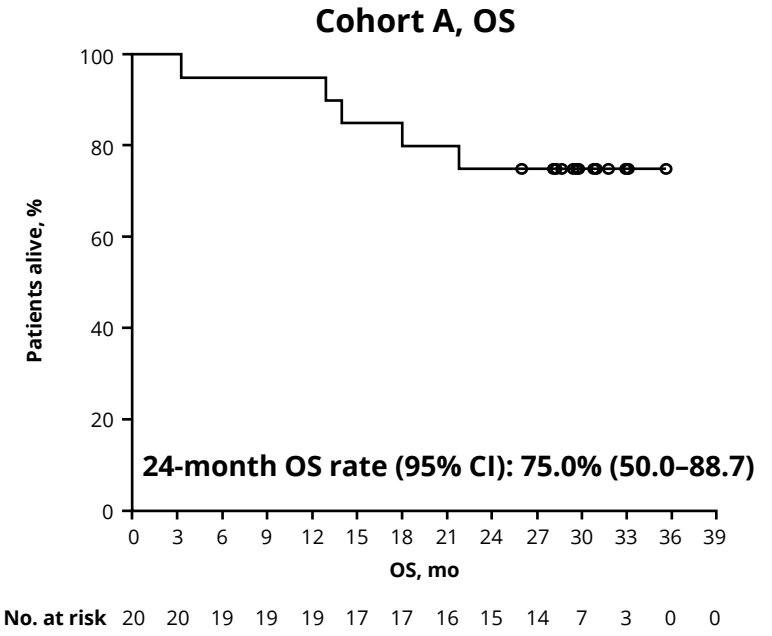
Presented by J Hillengass at the 65th American Society of Hematology (ASH) Annual Meeting; December 9–12, 2023; San Diego, CA, USA

# CARTITUDE-2 Cohort A: PFS and OS (Exploratory Endpoints)

(~29-month median follow-up)

## PFS and OS maintained with additional follow-up




OS, overall survival; PFS, progression-free survival.



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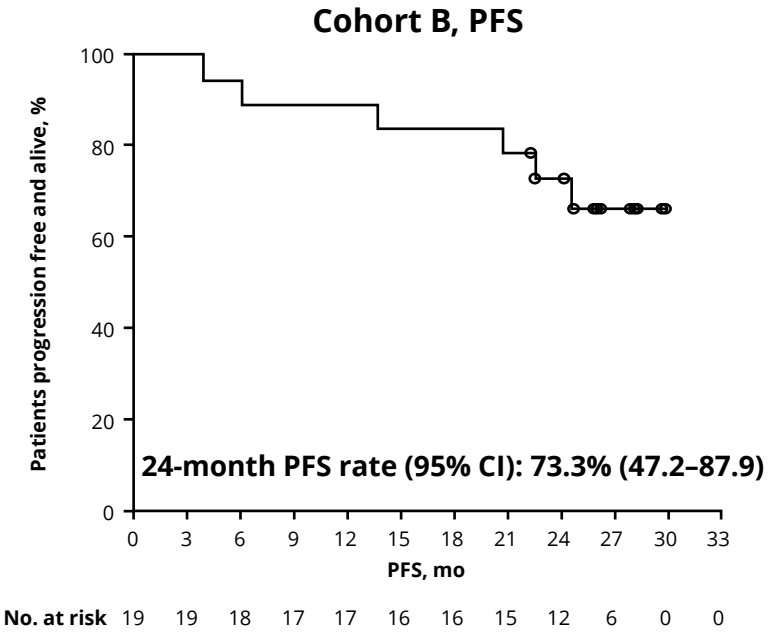
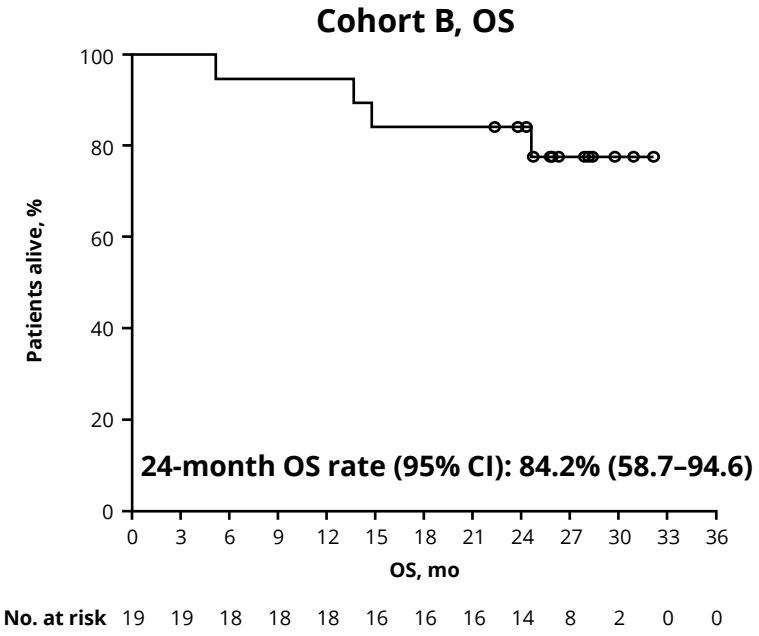
# CARTITUDE-2 Cohort B: PFS and OS (Exploratory Endpoints)

(~29-month median follow-up)

## PFS and OS maintained with additional follow-up




OS, overall survival; PFS, progression-free survival.



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# CARTITUDE-2 Cohorts A & B: AEs (Secondary Endpoint)

(~29-month median follow-up)

## AEs were predictable and consistent with the known safety profile of cilta-cel

### Cohort A

- **Hematologic TEAEs[a] were most common**
  - 95.0% neutropenia, all grade 3/4
- **Second primary malignancies[b]:**
  - Grade 3 mucoepidermoid carcinoma, n=1
- **Deaths:** PD, n=3[c]; sepsis, n=1[b]; pneumonia, n=1[d,e]

### Cohort B

- **Hematologic TEAEs[f] were most common**
  - 94.7% neutropenia, almost all grade 3/4
- **Second primary malignancies[b]:**
  - Grade 2 prostate cancer, n=1
  - Grade 4 choroid melanoma, n=1[g]
- **Deaths:** PD, n=3; 1 cardiac arrest, n=1[b,g]

| Select TEAEs, n (%) | Cohort A (N=20) | | Cohort B (N=19) | |
|---|---|---|---|---|
| | Any Grade | Grade 3/4 | Any Grade | Grade 3/4 |
| Any TEAE | 20 (100.0) | 19 (95.0) | 19 (100.0) | 18 (94.7) |
| Serious TEAE | 10 (50.0) | – | 7 (36.8) | – |
| **Hematologic** | | | | |
| Neutropenia | 19 (95.0) | 19 (95.0) | 18 (94.7) | 17 (89.5) |
| Lymphopenia | 16 (80.0) | 16 (80.0) | 9 (47.4) | 9 (47.4) |
| Thrombocytopenia | 16 (80.0) | 8 (40.0) | 11 (57.9) | 5 (26.3) |
| Anemia | 15 (75.0) | 9 (45.0) | 11 (57.9) | 9 (47.4) |
| Leukopenia | 12 (60.0) | 12 (60.0) | 6 (31.6) | 6 (31.6) |

[a]Between a median follow-up of 17.1–29.9 months, new grade 3/4 cases of leukopenia (n=1), lymphopenia (n=2), and thrombocytopenia (n=1). [b]Not treatment related. [c]1 new death on day 666 since last data cut-off. [d]Patient also had an AE of sepsis in addition to COVID-19 pneumonia. [e]Treatment related. [f]No change since previous data cut-off. [g]New event since last data cut-off. AE, adverse event; cilta-cel, ciltacabtagene autoleucel; PD, progressive disease; TEAE, treatment-emergent AE.



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# CARTITUDE-2 Cohorts A & B: Conclusions

(~29-month median follow-up)

### Cohort A: Len-refractory 1–3 prior LOT RRMM

- 100% of evaluable patients were MRD negative at $10^{-5}$
- 85% sCR rate with 73% of responders remaining in response for ≥24 months
- 24-month PFS and OS rates were both 75%
- No new CAR-T–related safety signals were observed

### Cohort B: Progressed ≤12 months after 1L therapy

- 93% of evaluable patients were MRD negative at $10^{-5}$
- 74% sCR rate with 71% of responders remaining in response for ≥24 months
- 24-month PFS and OS rates were 73% and 84%, respectively
- No new CAR-T–related safety signals were observed

- A similar patient population to CARTITUDE-2 Cohort A was evaluated in the phase 3 CARTITUDE-4 trial[1]

**Longer-term results from CARTITUDE-2 cohorts A and B showed deep and durable responses in patients with MM, including in a len-refractory population as early as after first relapse, and in a functionally high-risk population who progressed on frontline therapy within 12 months**

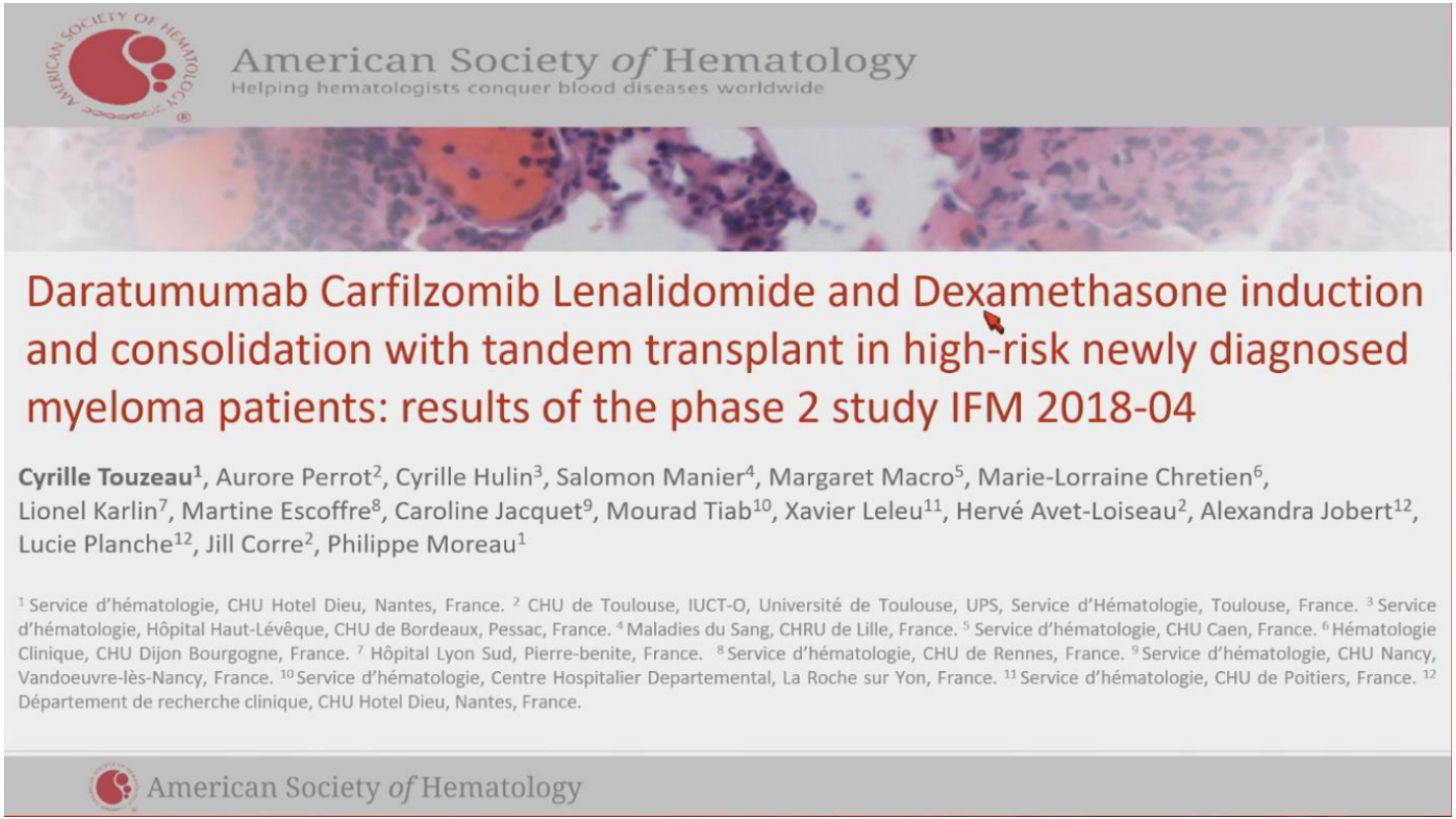
1L, first line; CAR, chimeric antigen receptor; len, lenalidomide; LOT, line of therapy; MM, multiple myeloma; MRD, minimal residual disease; OS, overall survival; PFS, progression-free survival; RRMM, relapsed/refractory multiple myeloma; sCR, stringent complete response.

1. San-Miguel J, et al. *New Engl J Med* 2023;389:335-47.



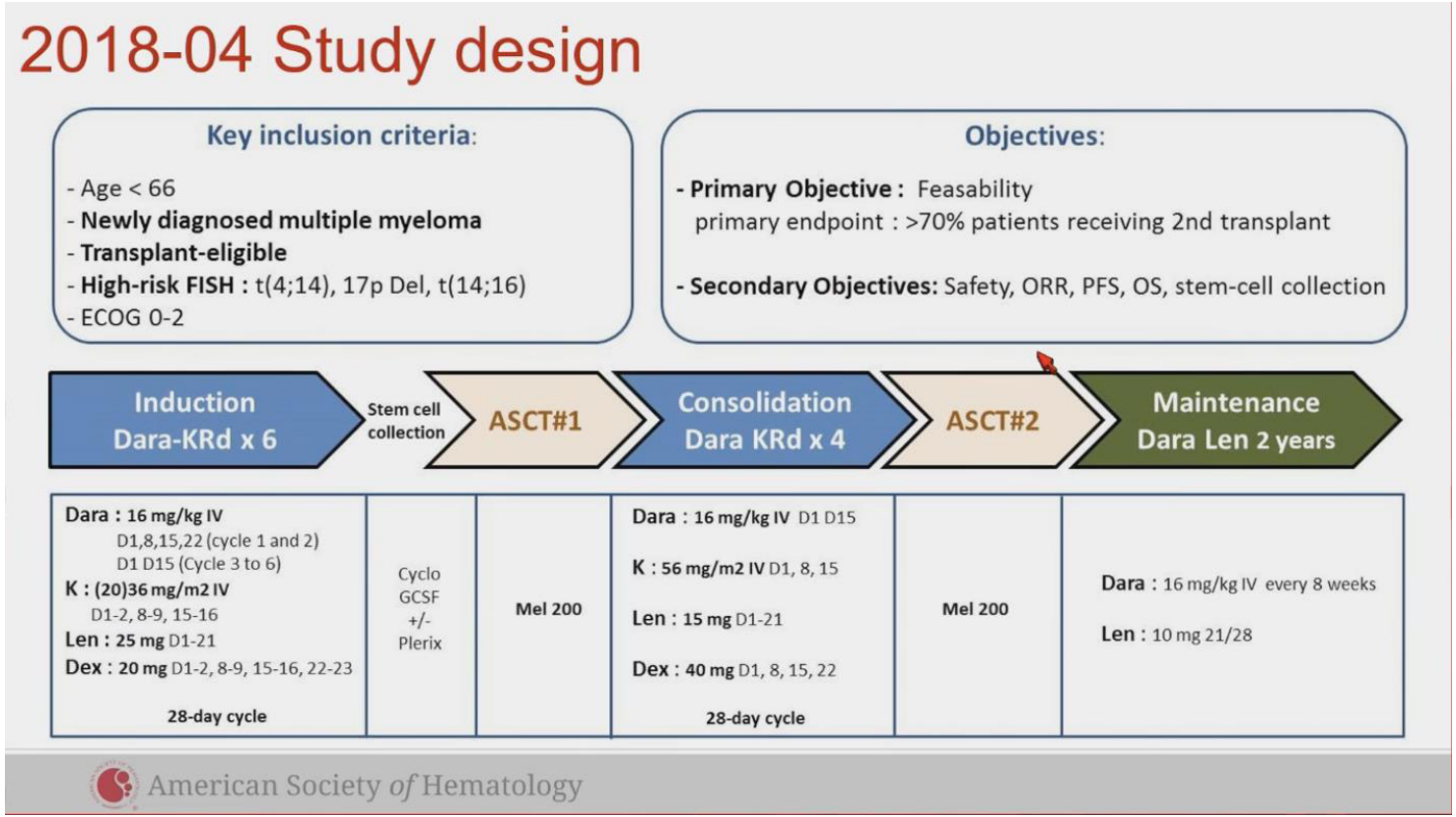
Presented by J Hillengass at the 65th American Society of Hematology (ASH) Annual Meeting; December 9–12, 2023; San Diego, CA, USA

# IFM2018-04




Touzeau C. et al.

# IFM2018-04




Touzeau C. et al.

# IFM2018-04

## Baseline characteristics

| | N=50 |
|---|---|
| **Median age (range), years** | 57 (38-65) |
| **ECOG PS** | |
| 0-1 | 47 (94%) |
| 2 | 3 (6%) |
| **ISS score** | |
| stage 1 | 21 (42%) |
| stage 2 | 17 (34%) |
| stage 3 | 12 (24%) |
| **R-ISS score** | |
| stage 2 | 38 (76%) |
| stage 3 | 12 (24%) |

| | N=50 |
|---|---|
| **Extramedullary disease** | 4 (8%) |
| primary PCL | 3 (6%) |
| **High-risk (HR) cytogenetics** | 50 (100%) |
| del(17p) | 20 (40%) |
| t(4;14) | 26 (52%) |
| t(14;16) | 10 (20%) |
| gain(1q) | 25 (50%) |
| del(1p) | 6 (12%) |
| ≥2 HR cytogenetic abnormalities * | 30 (60%) |

* defined by the presence of 2 HR abnormalities among del(17p), t(4;14), t(14;16), gain(1q), del(1p)

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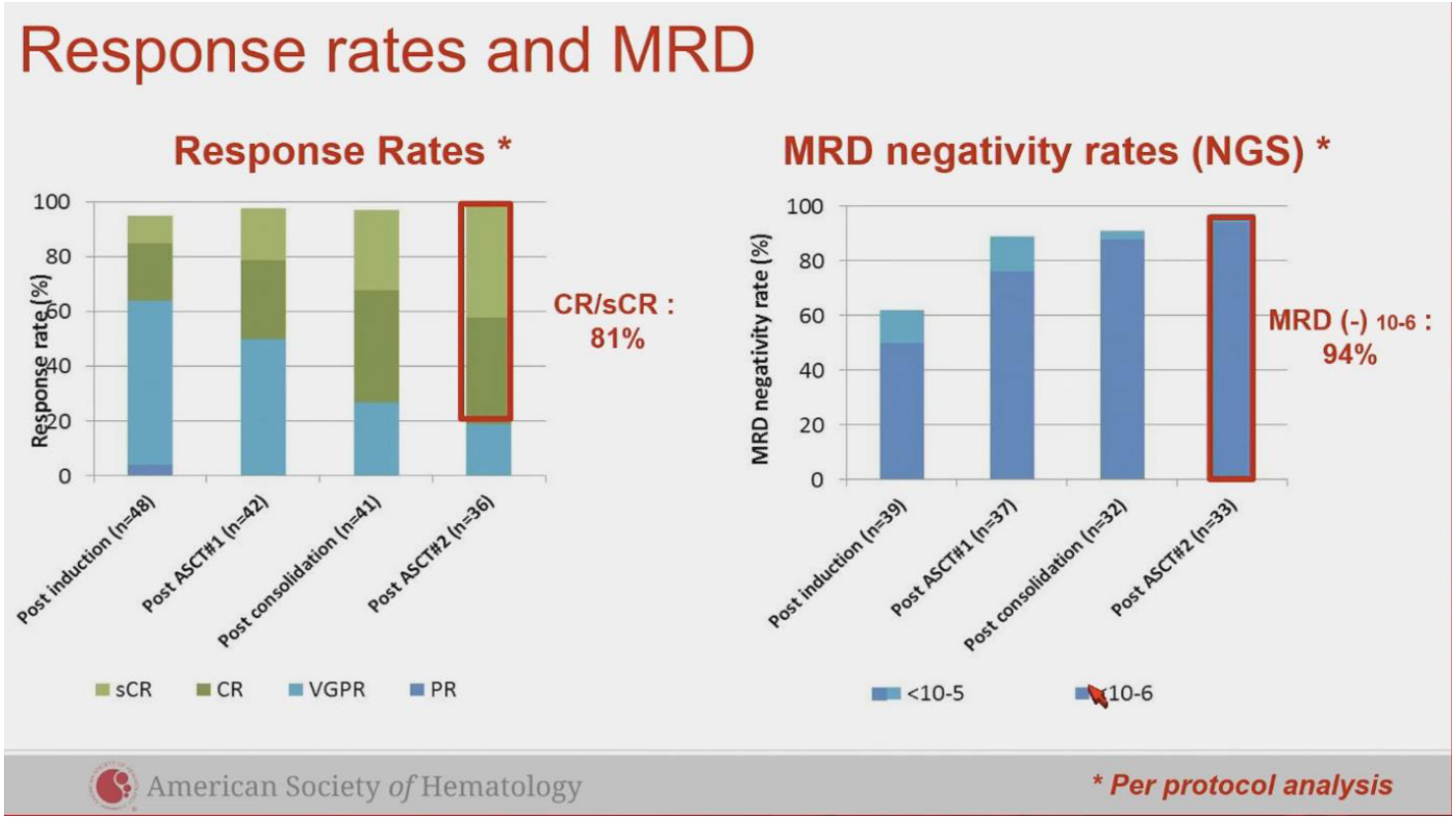
# IFM2018-04

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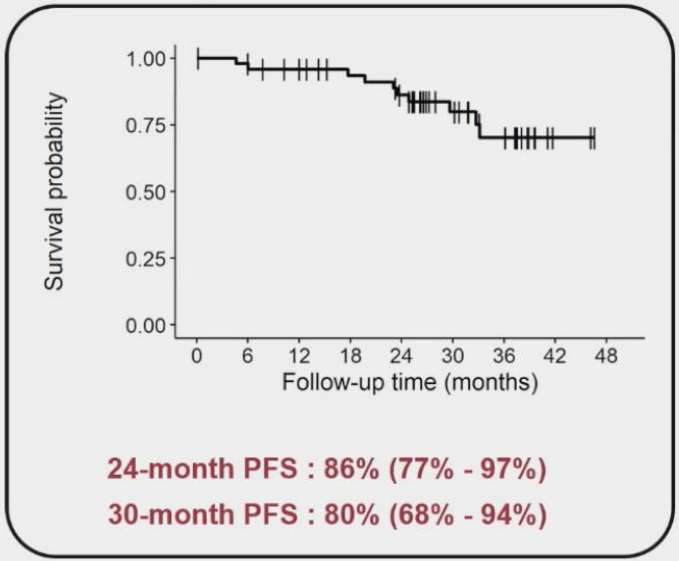
# IFM2018-04

## Progression-free and Overall Survival

### Progression-free survival

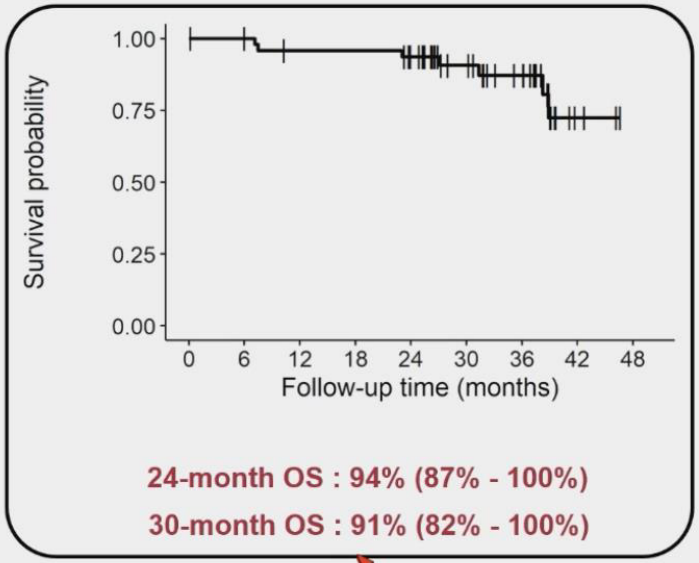



**24-month PFS : 86% (77% - 97%)**

**30-month PFS : 80% (68% - 94%)**

8 patients had disease progression

### Overall Survival




**24-month OS : 94% (87% - 100%)**

**30-month OS : 91% (82% - 100%)**

7 patients died : disease prog (n=5) ; SAE (n=2)

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*Median follow-up : 32 months*

*Data cut-off: may 2023*



Touzeau C. et al.

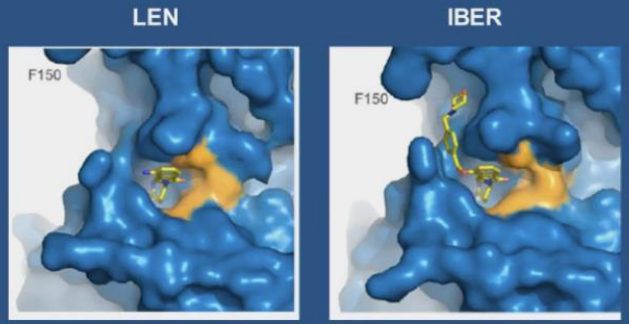
# EMN26

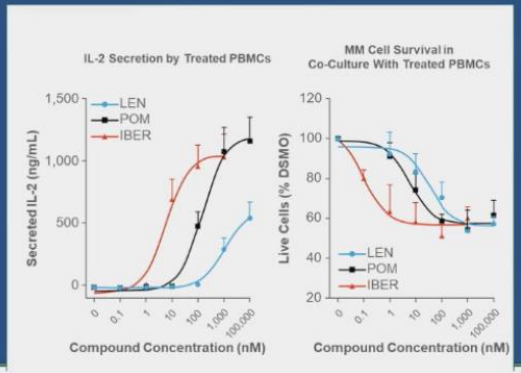

van de Donk N. et al.

# EMN26

## EMN26: Introduction (2)

- Iberdomide (IBER) is a novel, potent, oral cereblon (CRBN) E3 ligase modulator (CELMoD™) with greater tumoricidal and immune-modulatory effects compared with IMiDs[1-3]
- Unlike lenalidomide, Iberdomide is administered as a single enantiomer (S isomer), maintained in vivo. This can help to avoid side effects such as sedation and fatigue attributed to the R isomer.
- IBER safety, efficacy, and pharmacodynamic data from the ongoing CC-220-MM-001 trial justify further investigation of this agent in the maintenance setting[4]
- **We present the initial results from the** ongoing EMN26 phase 2 study with IBER maintenance after ASCT in patients with NDMM (NCT04564703)

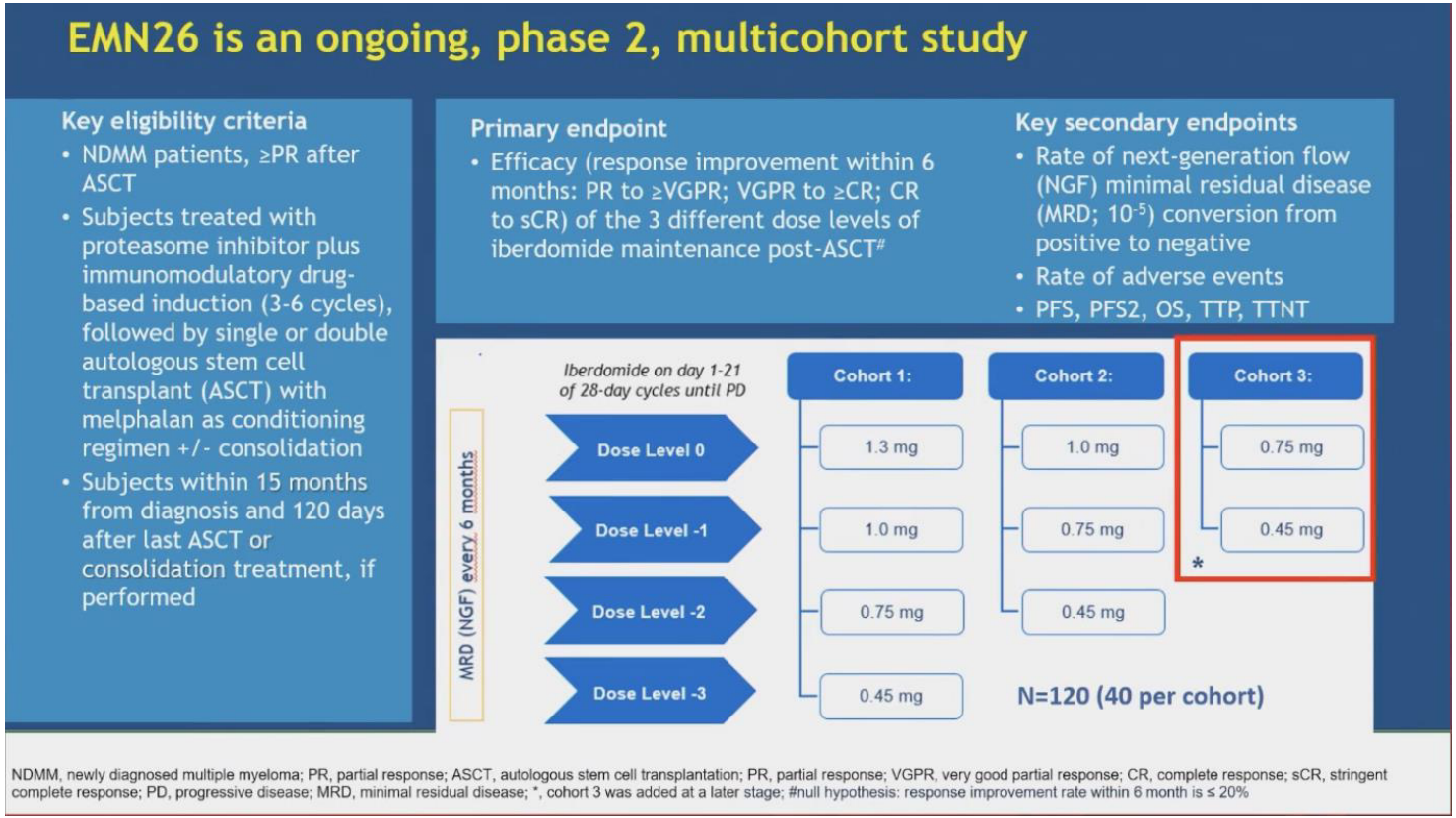



[1]Matyskiela ME, et al. *J Med Chem* 2018;61:535–542; [2]Amatangelo M, et al. *Blood* 2019;134(suppl 1). Abstract 1775; [3]Bjorklund CC, et al. *Leukemia* 2020;34:1197–1201; [4]Lonial S, et al. *Lancet Haematol* 2022;9:e822–e832.

van de Donk N. et al.

# EMN26




van de Donk N. et al.

# EMN26

## EMN26: Baseline demographics and Disease Characteristics (1)

| Characteristic | IBER 1.3 mg PO (n=40) | IBER 1.0 mg PO (n=40) | IBER 0.75 mg PO (n=40) |
|---|---|---|---|
| Median (IQR) age, years | 59 (51-66) | 59 (55-64) | 60 (52-65) |
| Male sex, n (%) | 26 (65) | 17 (42) | 22 (55) |
| Type of myeloma at initial diagnosis, n (%) | | | |
| IgG | 20 (50) | 20 (50) | 20 (50) |
| IgA | 12 (30) | 9 (22) | 7 (17) |
| Light chain | 7 (17) | 10 (25) | 13 (33) |
| Other | 1 (3) | 1 (3) | 0 |
| ≥1 extramedullary plasmacytomas, n (%) | 0 | 1 (3) | 1 (3) |
| High-risk cytogenetics,[a] n (%) | 7 (17) | 8 (20) | 10 (25) |
| ISS stage at diagnosis, n (%) | | | |
| I | 14/40 (35) | 16/39 (41) | 21/38 (55) |
| II | 14/40 (35) | 13/39 (33) | 11/38 (29) |
| III | 12/40 (30) | 10/39 (26) | 6/38 (16) |

| Characteristic | IBER 1.3 mg PO (n=40) | IBER 1.0 mg PO (n=40) | IBER 0.75 mg PO (n=40) |
|---|---|---|---|
| R-ISS stage at diagnosis, n (%) | | | |
| I | 9/40 (22) | 12/39 (31) | 15/37 (41) |
| II | 25/40 (62) | 22/39 (56) | 19/37 (51) |
| III | 6/40 (15) | 5/39 (13) | 3/37 (8) |
| ECOG performance status at study entry, n (%) | | | |
| 0 | 28 (70) | 23 (58) | 27 (68) |
| 1 | 12 (30) | 17 (42) | 13 (32) |
| Median (IQR) creatinine, mg/dL | 0.81 (0.71/0.91) | 0.79 (0.65/0.91) | 0.78 (0.72/1.01) |

Data cut-off November 8, 2023. [a]Cytogenetic risk is based on FISH and is defined as ≥1 of the following: del(17p), t(4;14), or t(14;16).
FISH, fluorescence in situ hybridization; ISS, International Staging System; PO, oral.

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van de Donk N. et al.

# EMN26

## EMN26: Baseline demographics and Disease Characteristics (2)

| Characteristic | IBER 1.3 mg PO (n=40) | IBER 1.0 mg PO (n=40) | IBER 0.75 mg PO (n=40) |
|---|---|---|---|
| Induction type* | | | |
| VTD | 12 (30) | 19 (48) | 2 (5) |
| VRD | 13 (33) | 7 (18) | 3 (8) |
| D-VTD | 12 (30) | 13 (33) | 33 (83) |
| D-VRD | 3 (8) | 1 (3) | 2 (5) |
| Auto-SCT | | | |
| Single | 34 (85) | 30 (75) | 36 (90) |
| Double | 6 (15) | 10 (25) | 4 (10) |
| Consolidation | | | |
| No | 35 (88) | 36 (90) | 22 (55) |
| Yes | 5 (13) | 4 (10) | 18 (45) |
| Response at study entry | | | |
| sCR | 7 (17) | 6 (15) | 8 (20) |
| CR | 4 (10) | 4 (10) | 5 (12) |
| VGPR | 26 (65) | 25 (62) | 22 (55) |
| PR | 3 (7) | 5 (12) | 5 (12) |

| Characteristic | IBER 1.3 mg PO (n=40) | IBER 1.0 mg PO (n=40) | IBER 0.75 mg PO (n=40) |
|---|---|---|---|
| MRD status at study entry | | | |
| Negative | 20 (50) | 19 (48) | 26 (65) |
| Positive | 15 (38) | 19 (48) | 10 (25) |
| Not evaluable | 5 (13) | 2 (5) | 4 (10) |
| Time from diagnosis to first maintenance dose (months) | 10 (9-11) | 10 (9-12) | 12 (11-14) |
| Time from last ASCT to first maintenance dose (months) | 4 (3-4) | 3 (3-4) | 4 (3-6) |

Data cut-off November 8, 2023. ᵃCytogenetic risk is based on FISH and is defined as ≥1 of the following: del(17p), t(4;14), or t(14;16). *Some patients exchanged one drug for another drug after initiation of induction treatment (most frequently exchange of thalidomide for cyclophosphamide in case of neuropathy)
FISH, fluorescence in situ hybridization; ISS, International Staging System; PO, oral.

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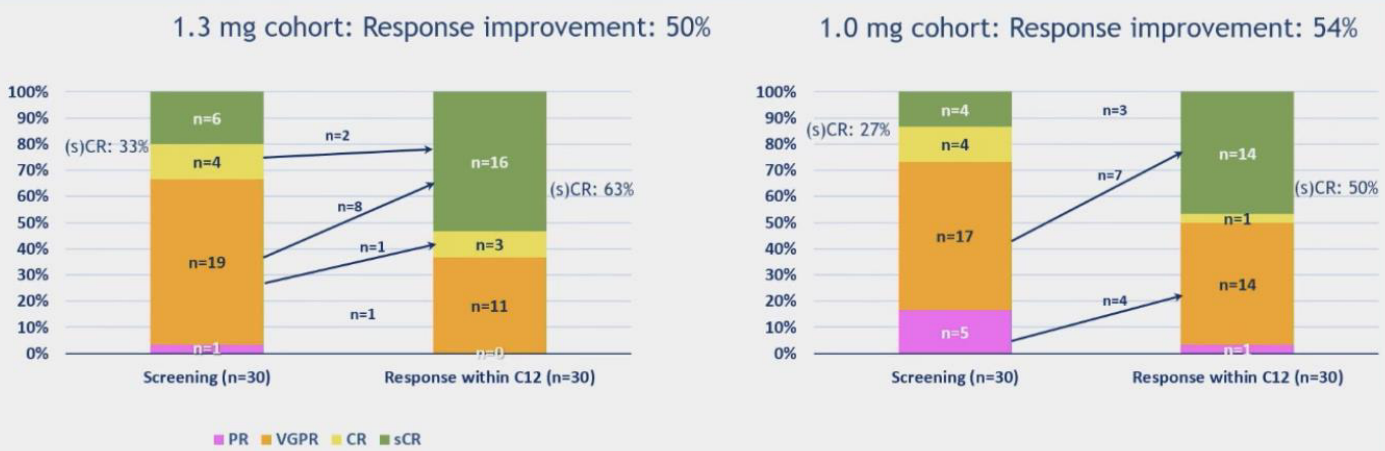
van de Donk N. et al.

# EMN26

## EMN26: Response improvement during first 12 cycles

→ responses improve over time




MRD conversion*: 7/12 patients (58%) in 1.3 mg cohort and 5/17 patients (29%) in 1.0 mg cohort

* MRD evaluated with next-generation flow cytometry with a sensitivity of $10^{-5}$; Conversion of MRD-positive to MRD-negative; calculated in patients who were MRD-positive at the time of screening and for whom a repeat bone marrow was done as scheduled at 12 months; patients who experienced earlier study discontinuation in the absence of MRD evaluation at 12 months were included in denominator

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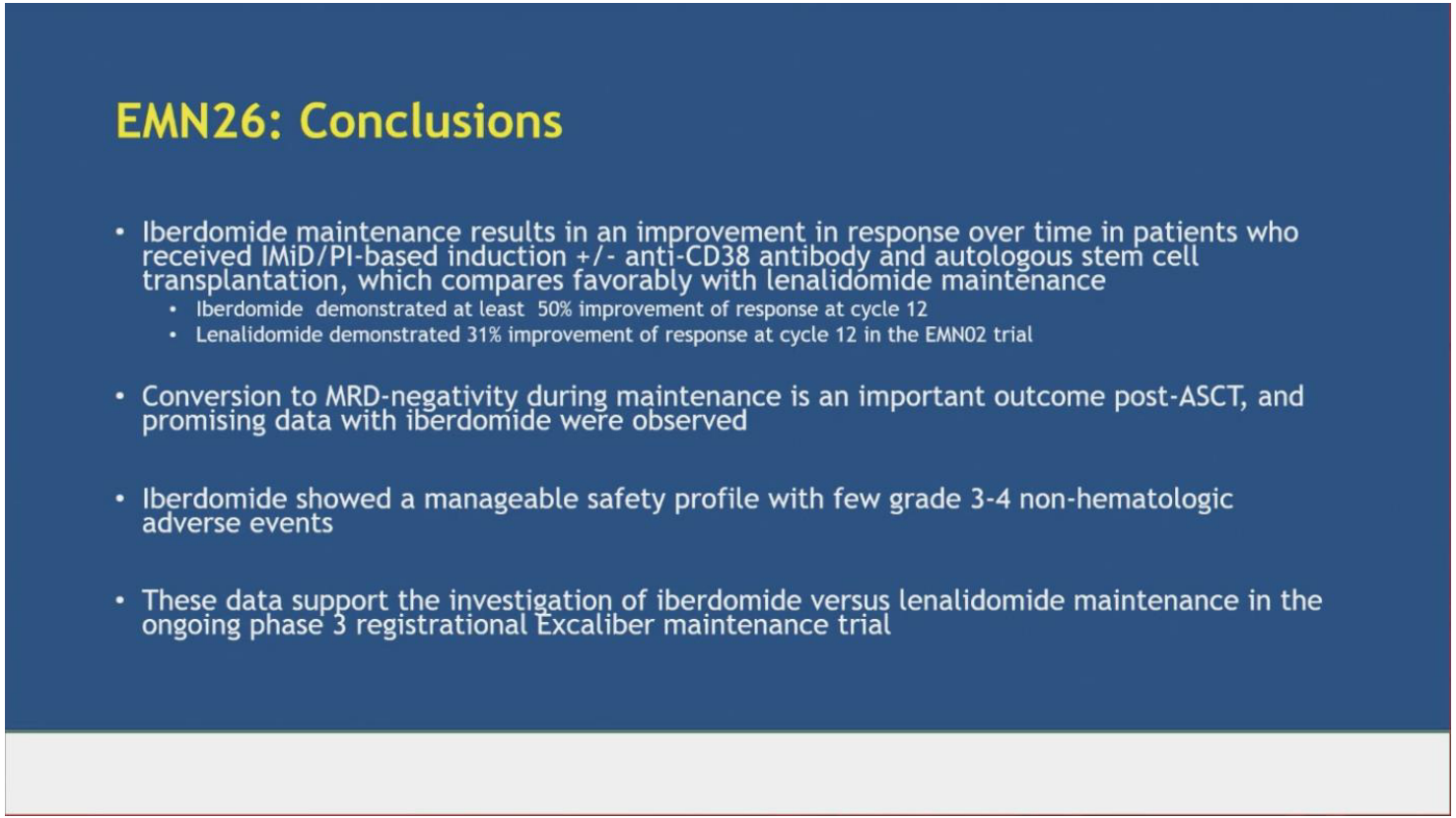
# EMN26

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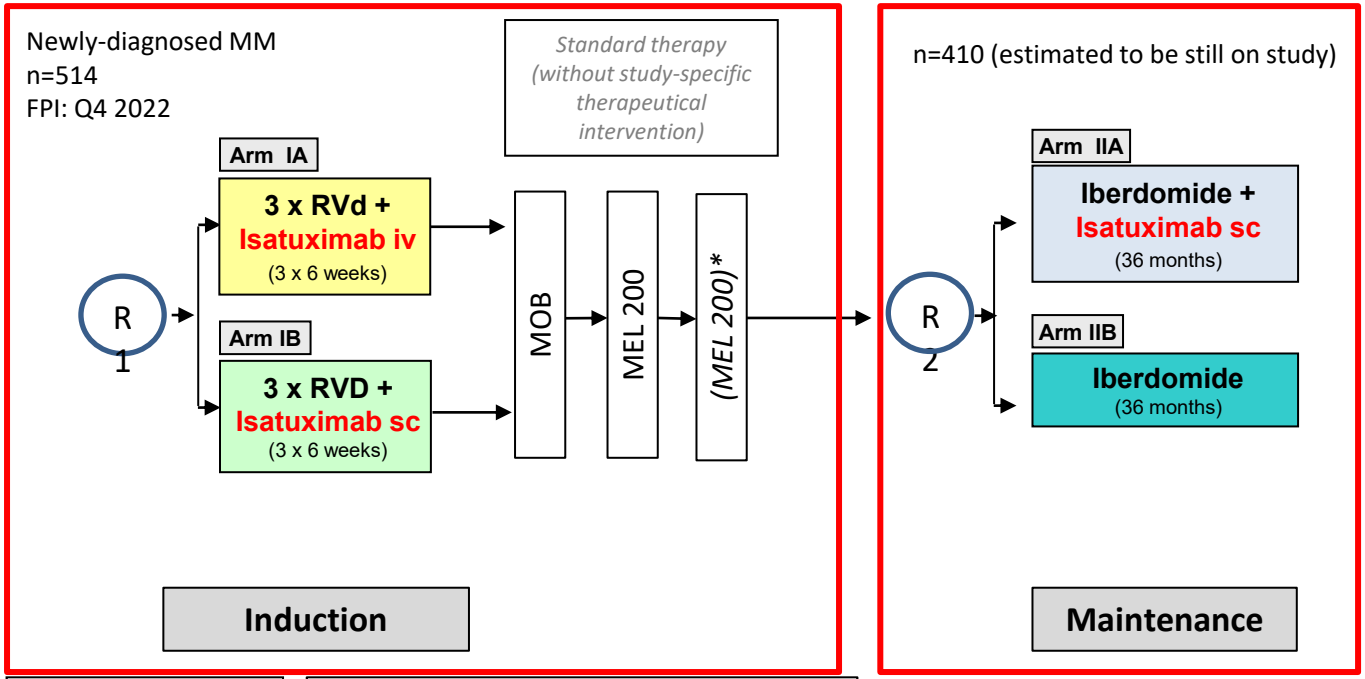
## GMMG-HD8/DSMM XIX

## GMMG-HD9/DSMM XVIII




**Primary Endpoint:**
Rates of VGPR or better

**Key Secondary Endpoints:**
Patient Reported Outcome (isatuximab application)
MRD negativity (NGS) after induction

deutsche studiengruppe multiples myelom
dsmm
doing studies on multiple myeloma

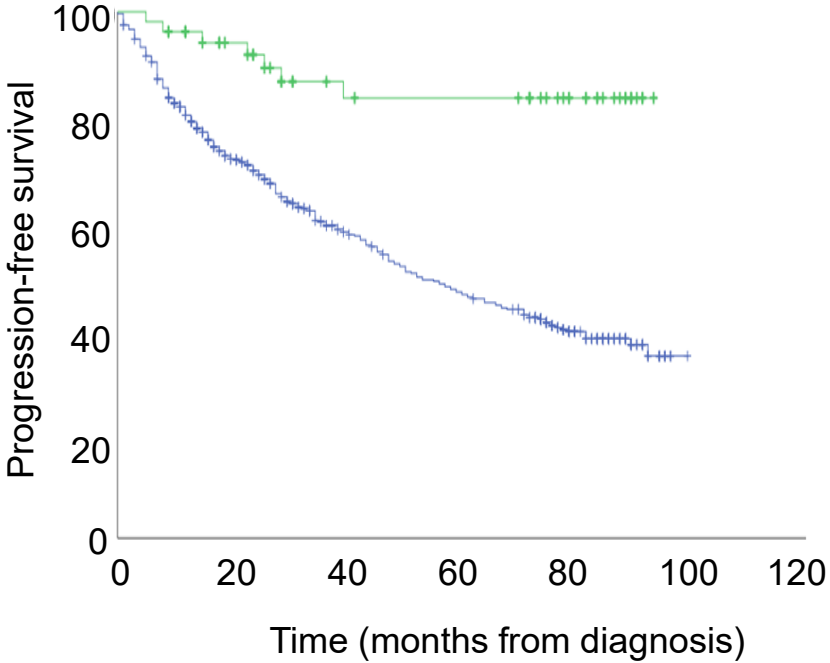
# Kinetics and Biology of Circulating Tumor Cells (CTCs) and Measurable Residual Disease (MRD): Two Dynamic High-Risk Clones in Multiple Myeloma (MM)

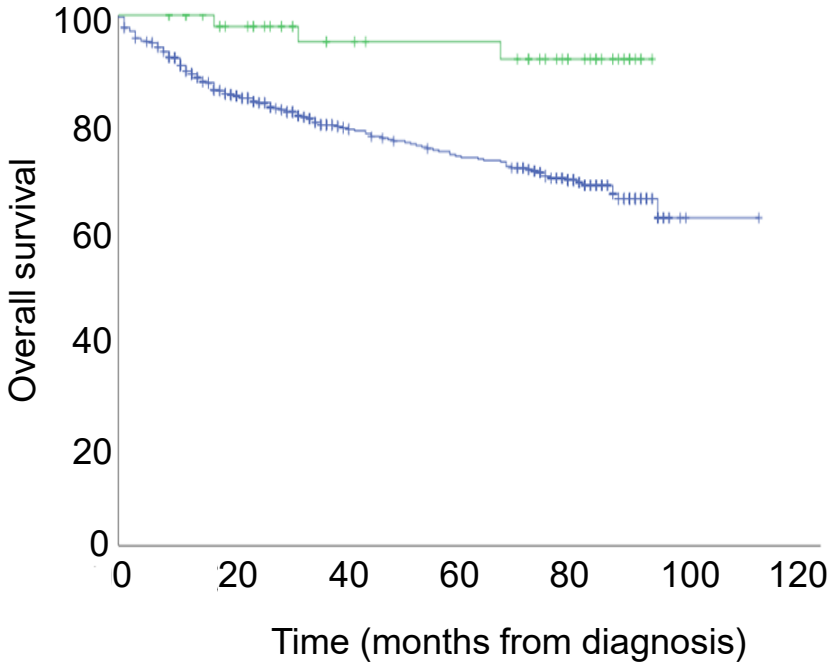
651, 339

**Camila Guerrero, MSc1***, Rosalinda Termini2*, Juan-José Garcés, PhD3*, Maria Jose Calasanz, PhD4*, Rafael Ríos, MD, PhD5*, Elena Cabezudo6*, Laura Rosiñol, MD, PhD7*, Bargay Joan8*, Albert Pérez-Montaña, MD9*, Albert Oriol Rocafiguera, MD10*, Valentin Cabanas Perianes, MD11*, Maria-Josefa Najera12*, Esther Gonzalez Garcia, MD13*, Enrique M Ocio, MD, PhD14, Anna Maria Sureda Balari, MD, PhD15, Felipe De Arriba, MD, PhD16*, Miguel Teodoro Hernández Garcia, MD, PhD17*, Antonio Garcia18*, Joaquin Martinez-Lopez, MD, PhD19*, María-Jesús Blanchard20*, Marta Sonia Gonzalez Perez21*, Rebeca Iglesias22*, Alberto Orfao, MD, PhD23*, Maria Victoria Mateos, MD, PhD24, Juan Jose Lahuerta Palacios25*, Joan Bladé, MD, PhD26*, Jesus San-Miguel, MD, PhD27, María T Cedena28*, Noemi Puig, MD, PhD29 and Bruno Paiva30*

# Absence of CTCs in NDMM is associated with longer survival

## 80% reduction in the risk of progression and/or death



# Salvage Autologous Transplant and Lenalidomide Maintenance Versus Continuous Lenalidomide/Dexamethasone for Relapsed Multiple Myeloma: Long term follow Up results of the Randomized GMMG Phase III Multicenter Trial ReLApsE

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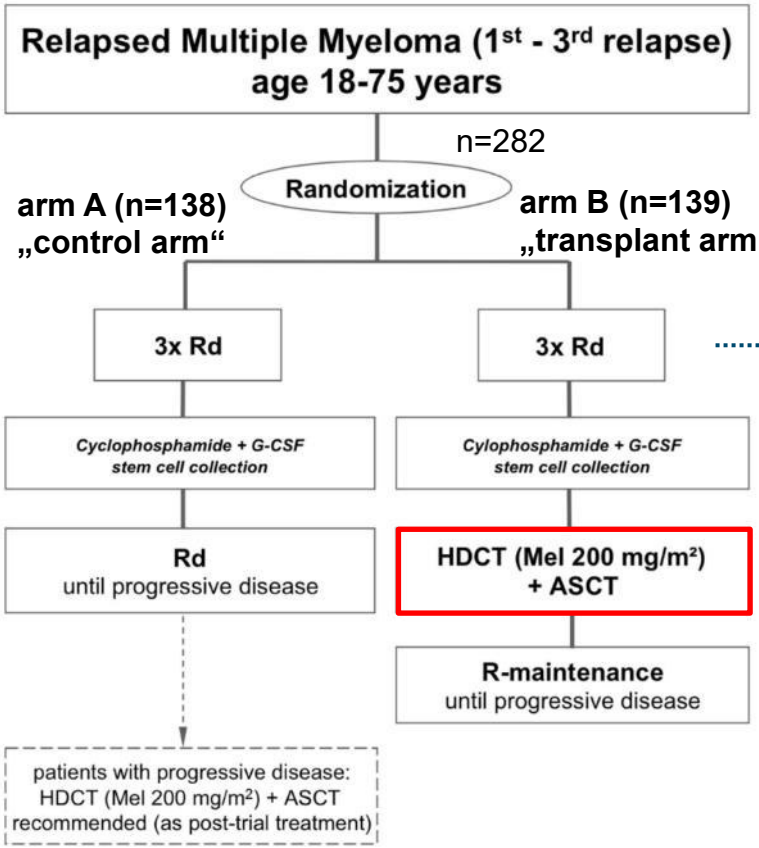
**Marc-Andrea Baertsch**, MD1,2, Jana Schlenzka, MD1, Thomas Hielscher3, Marc-Steffen Raab, MD1,2,4, Sandra Sauer1, MD, Maximilian Merz, MD5, Elias Karl Mai, MD1, Carsten Müller-Tidow, MD1,4, Steffen Luntz, MD6, Anna Jauch, PhD7, Peter Brossart, MD8, Martin Goerner, MD9, Stefan Klein, MD10, Bertram Glass, MD11, Peter Reimer, MD12, Ullrich Graeven, MD13, Roland Fenk, MD PhD14, Mathias Haenel, MD15, Ivana von Metzler, MD16, Hans W. Lindemann, MD17, Christof Scheid, MD18, Axel Nogai, MD19, Hans Salwender, MD20, Richard Noppeney, MD21, Britta Besemer, MD22, Katja Weisel, MD23, Hartmut Goldschmidt, MD1,4

# GMMG ReLApsE trial - Flow chart




**Rd** (arm A+B)

- **Lenalidomide** 25 mg, d1-21
- **Dexamethasone** 40 mg, d1,8,15,22
- 4 week cycles

**R-maintenance** (arm B)

- **Lenalidomide** 10 mg daily

Goldschmidt H*, Baertsch MA* et al., Leukemia, 2021

# ReLApsE - Baseline characteristics

| | arm A (n=138) n (%) | arm B (n=139) n (%) |
|---|---|---|
| Age [years] | 62.2 (41.9; 74.5) | 61.3 (29.9; 74.7) |
| Sex | | |
| Female | 54 (39) | 60 (43) |
| WHO PS | | |
| 0 | 105 (76) | 96 (69) |
| 1 | 32 (23) | 43 (31) |
| 2 | 1 (1) | 0 |
| ISS stage | | |
| I | 77/129 (60) | 82/131 (63) |
| II | 40/129 (31) | 32/131 (24) |
| III | 12/129 (9) | 17/131 (13) |
| Cytogenetics | | |
| t(4;14) | 10/99 (10) | 19/94 (20) |
| t(14;16) | 0/97 (0) | 2/90 (2) |
| del13q14 | 45/104 (43) | 59/97 (61) |
| del17p13 | 15/107 (14) | 14/98 (14) |
| gain1q (>3 copies) | 12/105 (11) | 11/97 (11) |
| High risk* | 31/98 (32) | 39/91 (43) |

| | arm A (n=138) n (%) | arm B (n=139) n (%) |
|---|---|---|
| Interval diagnosis to randomization [years] | 4.1 (0.7-16.5) | 3.9 (0.2-19.4) |
| Prior lines of therapy | | |
| 1 | 129 (94) | 131 (94) |
| 2 | 8 (6) | 5 (4) |
| 3 | 1 (1) | 3 (2) |
| Frontline HDCT/ASCT | 130 (94) | 129 (93) |
| Single | 71 (55) | 83 (64) |
| Tandem | 59 (45) | 46 (36) |
| Prior therapy | | |
| Bortezomib | 106 (77) | 107 (77) |
| Thalidomide | 25 (18) | 31 (22) |
| Lenalidomide | 18 (13) | 12 (9) |
| Interferone | 9 (7) | 9 (6) |
| Chemoth. only | 10 (7) | 14 (10) |

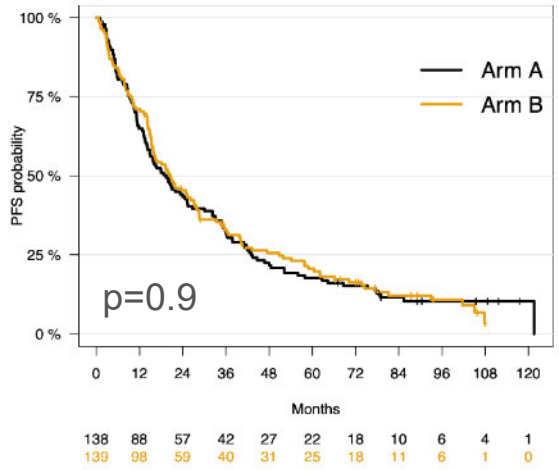
*High risk cytogenetic aberrations: t(4;14), t(14;16), del17p13, gain1q (>3 copies)



Goldschmidt H*, Baertsch MA* et al., Leukemia, 2021

# ReLApsE - Survival - LTFU analysis

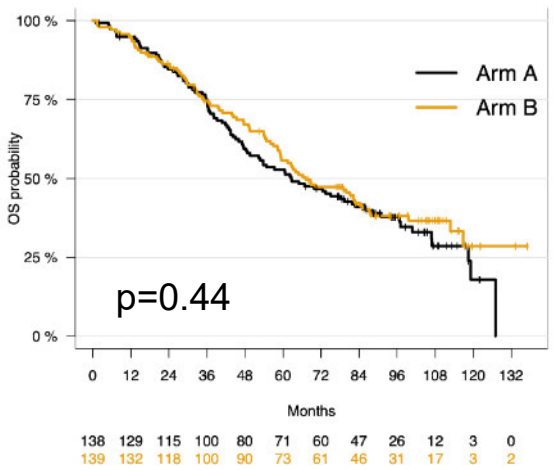
## PFS




**Median PFS**

- Arm A: 19.3 months
- Arm B: 20.5 months
- HR 0.98

## OS




**Median OS**

- Arm A: 62.7 months
- Arm B: 67.1 months
- HR 0.89

**No survival benefit in long term follow up analysis from randomization**

# Take Home Message

- Vierer Kombinationen (CD38 Antikörper, Proteasominhibitor, Imid und Dexametason) sind der neue Standard vor und nach Hochdosistherapie
- Dauer der Therapie unklar
- MRD Knochenmark weiter gefestigt
- MRD Blut wichtiger in der Zukunft
- MassSpect Daten zeigen prognostische Bedeutung
- Auto-TPX im Rezidiv des MM Wirkung?
- Viele Präsentationen Bispez. AK und CART-Zelltherapie

# *Danke!*

## Addition of isatuximab to lenalidomide, bortezomib, and dexamethasone as induction therapy for newly diagnosed, transplantation-eligible patients with multiple myeloma (GMMG-HD7): part 1 of an open-label, multicentre, randomised, active-controlled, phase 3 trial

Lancet Haematol. 2022 Nov;9(11):e810-e82

*Hartmut Goldschmidt*, Elias K Mai*, Uta Bertsch, Roland Fenk, Eva Nievergall, Diana Tichy, Britta Besemer, Jan Dürig, Roland Schroers, Ivana von Metzler, Mathias Hänel, Christoph Mann, Anne M Asemissen, Bernhard Heilmeier, Niels Weinhold, Stefanie Huhn, Katharina Kriegsmann, Steffen P Luntz, Tobias A W Holderried, Karolin Trautmann-Grill, Deniz Gezer, Maika Klaiber-Hakimi, Martin Müller, Cyrus Khandanpour, Wolfgang Knauf, Christof Scheid, Markus Munder, Thomas Geer, Hendrik Riesenberg, Jörg Thomalla, Martin Hoffmann, Marc S Raab, Hans J Salwender, Katja C Weisel, for the German-Speaking Myeloma Multicenter Group (GMMG) HD7 investigators†*

Prof. Dr. Rudolf Weide; Dr. Christoph van Roye, PD Dr. Dr. Geothy Chakupurakal, PD Dr. Christoph Lutz; PD Dr. Andreas Günther
Praxis für Hämatologie und Onkologie Koblenz

# *Danke!*

## Elotuzumab, lenalidomide, bortezomib, dexamethasone, and autologous haematopoietic stem-cell transplantation for newly diagnosed multiple myeloma (GMMG-HD6): results from a randomised, phase 3 trial

Lancet Haematol. 2024 Feb;11(2):e101-e113

Elias K Mai*, Hartmut Goldschmidt*, Kaya Miah, Uta Bertsch, Britta Besemer, Mathias Hänel, Julia Krzykalla, Roland Fenk, Jana Schlenzka, Markus Munder, Jan Dürig, Igor W Blau, Stefanie Huhn, Dirk Hose, Anna Jauch, Christina Kunz, Christoph Mann, Niels Weinhold, Christof Scheid, Roland Schroers, Ivana von Metzler, Aneta Schieferdecker, Jörg Thomalla, Peter Reimer, Rolf Mahlberg, Ullrich Graeven, Stephan Kremers, Uwe M Martens, Christian Kunz, Manfred Hensel, Axel Benner, Andrea Seidel-Glätzer, Katja C Weisel, Marc S Raab, Hans J Salwender, for the German-speaking Myeloma Multicenter Group (GMMG) HD6 investigators†

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# Danke an Prof. Dr. med. Jens Chemnitz und Team Hämatologie/Onkologie, Palliativmedizin; Klinikum Mittelrhein

**GMMG Studiengruppe**

| | Site # | Trial site | PI | Status | Affiliation |
|---|---|---|---|---|---|
| 1 | 8001 | Aachen UK | Dr. Deniz Gezer | recruiting | GMMG |
| 2 | 8008 | Bad Saarow Helios | Dr. Daniel Schönbude | recruiting | GMMG |
| 3 | 8021 | Berlin Charité | Dr. Axel Nogai | recruiting | GMMG |
| 4 | 8022 | Berlin Vivantes Neukölln | Prof. Dr.Maike De Witt | recruiting | GMMG |
| 5 | 8026 | Bielefeld Praxis | Dr. Hendrik Riesenberg | initiated | GMMG |
| 6 | 8023 | Bochum UK | Prof. Dr. Schroers | | GMMG |
| 7 | 8031 | Bonn Johanniter | Prof. Dr. Yon-Dschun Ko | recruiting | GMMG |
| 8 | 8028 | Bonn UK | Dr. Tobias Holderried | recruiting | GMMG |
| 9 | 8033 | Chemnitz | PD Dr. Matthias Hänel | recruiting | GMMG |
| 10 | 8035 | Cottbus Carl-Thiem-Klinikum | PD Dr. Martin Schmidt- | recruiting | GMMG |
| 11 | 8036 | Darmstadt Klinikum | Prof. Dr.Helga Bernhard | recruiting | GMMG |
| 12 | 8041 | Duisburg Helios St. Johannes | Dr. Michael Heinsch | recruiting | GMMG |
| 13 | 8040 | Düsseldorf Marien-Hospital | Dr. Maika Klaiber-Hakimi | recruiting | GMMG |
| 14 | 8067 | Düsseldorf UK | Prof.Dr. Roland Fenk | recruiting | GMMG |
| 15 | 8042 | Eschweiler St. Antonius Hospital | PD Dr. Peter Staib | recruiting | GMMG |
| 16 | 8034 | Essen UK | Dr. Christine Hanoun | | GMMG |
| 17 | 8038 | Essen-Werden Evang. Kliniken | Prof. Dr. Peter Reimer | recruiting | GMMG |
| 18 | 8044 | Franfkurt am Main Praxis Knauf | Prof.Dr. Wolfgang Knauf | | GMMG |
| 19 | 8045 | Frankfurt UK | Dr. Ivana von Metzler | initiated | GMMG |
| 20 | 8047 | Gießen UK | Dr. Tobias Arnold | initiated | GMMG |
| 21 | 8054 | Hagen | Prof. Dr. Doris Kraemer | activated | GMMG |
| 22 | 8046 | Hamburg Altona Asklepios | Dr. Hans-Jürgen Salwender | activated | GMMG |
| 23 | 8068 | Hamburg UKE | Prof.Dr.med. Katja Weisel | recruiting | GMMG |
| 24 | 8052 | Heidelberg Praxis Fuxius/Debatin | Dr. med Stefan Fuxius | recruiting | GMMG |
| 25 | 8051 | Heidelberg UK | Prof.Dr. Goldschmidt | recruiting | GMMG |
| 26 | 8057 | Heilbronn SLK Kiniken | Prof. Martens | recruiting | GMMG |
| 27 | 8053 | Homburg | Dr. Jörg Bittenbring | recruiting | GMMG |
| 28 | 8060 | Kaiserslautern Westpfalz Klinikum | Prof.Dr. Gerhard Held | | GMMG |
| 30 | 8063 | Köln UK | Prof.Dr. Christoph Scheid | | GMMG |
| 31 | 8066 | Ludwigshafen Klinikum | Dr.Martin Hoffmann | activated | GMMG |
| 32 | 8077 | Mainz UK | Prof. Markus Munder | activated | GMMG |
| 33 | 8074 | Mannheim Onkol. | Prof.Dr. Manfred Hensel | activated | GMMG |
| 34 | 8073 | Marburg Philipps-Universität | Dr. Christoph Mann | recruiting | GMMG |
| 35 | 8081 | Meschede | Dr. Mohammed Wattad | activated | GMMG |
| 36 | 8079 | Mönchengladbach | Prof. Dr. Ullrich Graeven | recruiting | GMMG |
| 37 | 8082 | Osnabrück | PD Dr. Martin Kropff | initiated | GMMG |
| 38 | 8083 | Paderborn | Dr. Tobias Gaska | recruiting | GMMG |
| 39 | 8084 | Regensburg Barmherzige Brüder | Dr. Bernhard Heilmeier | activated | GMMG |
| 40 | 8088 | Lebach | PD Dr. Stefan Bauer | activated | GMMG |
| 41 | 8087 | Saarbrücken | PD Dr. Topaly | | GMMG |
| 42 | 8086 | Schwäbisch Hall Diakonie | Dr.Thomas Geer | activated | GMMG |
| 43 | 8085 | Siegburg ZAHO | Dr. Stefan Fronhoffs | activated | GMMG |
| 44 | 8089 | Speyer Onkol. Schwerpunktpraxis | Dr. Lars Scheuer | activated | GMMG |
| 45 | 8091 | Trier Mutterhaus | Dr. Rolf Mahlberg | | GMMG |
| 46 | 8092 | Tübingen UK | Dr. Britta Besemer | recruiting | GMMG |
| 47 | 8096 | Villingen-Schwenningen SBK | Prof. Dr. Paul La Rosée | activated | GMMG |
| 48 | 8094 | Wiesbaden | Dr. Wolfgang Blau | | GMMG |
| 49 | 8099 | Wuppertal | Dr. Blasius Liss | | GMMG |

**DSMM Studiengruppe inkl. AGMT-Zentren (Österreich)**

| Site # | Trial site | PI | Status | Affiliation |
|---|---|---|---|---|
| 8101 | Augsburg | Prof. Dr. Björn Hackanson | recruiting | DSMM |
| 8104 | Bayreuth | Dr. Carla Dorn | activated | DSMM |
| 8105 | Berlin-Buch | Dr. Snjezana Janjetovic | recruiting | DSMM |
| 8106 | Berlin Spandau | Dr. Annegret Kunitz | | DSMM |
| 8108 | Bremen | Dr. Matthias Bormann | | DSMM |
| 8107 | Bielefeld Klinikum | Prof. Dr. Florian Weißinger | recruiting | DSMM |
| 8102 | Dessau | Prof. Dr. Bernhard Gehre | | DSMM |
| 8109 | Dortmund | Dr. Ralf Meyer | activated | DSMM |
| 8110 | Dresden UK | Dr. Katrin Trautmann-Grill | activated | DSMM |
| 8111 | Flensburg Malteser | Dr. Petra Drewniok | activated | DSMM |
| 8112 | Freiburg | Prof. Dr. Ralph Wäsch | | DSMM |
| 8113 | Göttingen | Dr. Wolfram Jung | | DSMM |
| 8114 | Greifswald | Dr. Annamaria Brioli | recruiting | DSMM |
| 8115 | Halle-Wittenberg | Dr. Franziska Brunner | | DSMM |
| 8117 | Jena UK | Dr Olaposi Yomade | recruiting | DSMM |
| 8118 | Karlsruhe | Dr. Lukas Kündgen | initiated | DSMM |
| 8119 | Kempten | Prof. Dr. Christian Langer | recruiting | DSMM |
| 8120 | Kiel UK | Dr. Natalie Schub | | DSMM |
| **8121** | **Koblenz GK** | **Dr. Christian Breitbarth-Girmscheid** | **recruiting** | **DSMM** |
| 8122 | Leipzig UK | Dr. Merz | | DSMM |
| 8123 | Lübeck UK | Prof. Dr. Cyrus Khanandpour | initiated | DSMM |
| 8124 | Magdeburg | Dr. Denise Wolleschak | | DSMM |
| 8125 | Mannheim UK | Dr. Stefan Klein | recruiting | DSMM |
| 8128 | München Rotkreuz | Prof. Dr. med. Marcus Hentrich | recruiting | DSMM |
| 8129 | TUM München | Prof. Dr. Florian Bassermann | recruiting | DSMM |
| 8130 | Münster | Dr. Evgenii Shumilov | recruiting | DSMM |
| 8131 | Mutlangen | Prof. Dr. med. Holger Hebart | activated | DSMM |
| 8132 | Nürnberg | Dr. Knut Wendelin | | DSMM |
| 8133 | Oldenburg | Dr. Christoph Kimmich | recruiting | DSMM |
| 8135 | Regensburg UK | Dr. Matthias Grube | recruiting | DSMM |
| 8138 | Stuttgart Robert Bosch KH | PD Dr. Nicola Giesen | | DSMM |
| 8139 | Stuttgart Diakonie | Prof. Dr. Jochen Greiner | | DSMM |
| 8141 | Ulm UK | Dr. Miriam Kull | | DSMM |
| 8142 | Würzburg UK | Prof. Dr. Kortüm | recruiting | DSMM |
| 8140 | Stuttgart Katharienenhospital | Dr. Ulrike Krohn | recruiting | DSMM |
| 8150 | Graz (Austria) | Prof. Dr. Sigfried Sormann | | DSMM |
| 8151 | Krems (Austria) | PD Dr. Klaus Podar | | DSMM |
| 8152 | Linz Ordensklinikum | Dr. Irene Strassl | | DSMM |
| 8153 | Linz Kepler UK (Austria) | Univ.-Prof. Dr. Clemens Schmitt | | DSMM |
| 8154 | Rankweil_Feldkrich (Austria) | Dr. Bernd Hartmann | activated | DSMM |
| 8155 | Salzburg (Austria) | Prim. Univ.-Prof. Dr. Richard Greil | recruiting | DSMM |
| 8156 | St. Poelten (Austria) | Dr. Petra Pichler | | DSMM |
| 8157 | Steyr (Austria) | Dr. Hanns Hauser | | DSMM |
| 8158 | Wels-Grieskirchen (Austria) | Dr. Sonja Heibl | | DSMM |
| 8160 | Wien Ottakring (Austria) | Dr. Martin Schreder | | DSMM |

# Danke!

# Heidelberg, Germany