

3. RELAPSED/REFRACTORY MULTIPLE MYELOMA

SELINEXOR, MEZIGDOMIDE, AND DEXAMETHASONE IN PATIENTS WITH RELAPSED/REFRACTORY MULTIPLE MYELOMA WHO RELAPSED OR ARE INELIGIBLE FOR T-CELL–REDIRECTING THERAPY: STOMP PHASE 1 PRELIMINARY RESULTS

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Introduction. CAR T and bispecific antibody treatment for RRMM show promising clinical activity, but most pts relapse. Clinical data indicate that serial and/or prolonged TCRT promotes T-cell exhaustion, which is associated with inferior clinical outcomes. There is an unmet need to maintain anti-tumor activity between TCRT while promoting a tumor microenvironment facilitating T-cell recovery. Selinexor (S), an oral exportin 1 inhibitor, and mezigdomide (M), a novel and potent cereblon E3 ubiquitin ligase modulator (under investigation in RRMM), have shown T-cell preservation/stimulatory activity. We present preliminary results from Arm 12 of the Phase 1b/2 STOMP trial (NCT02343042), investigating SMd in pts with RRMM for whom TCRT has failed or cannot receive TCRT.

Methods. Arm 12 followed a 3+3 design evaluating 3 dose levels: cohort 1 received S 40 mg/M 0.6 mg/d 40 mg, cohort 2 S 60 mg/M 0.6 mg/d 40 mg, and cohort 3 S 60 mg/M 1.0 mg/d 40 mg. Prophylaxis for nausea (dual anti-emetics) for at least the first 2 months and thromboembolism (all cycles) were required. Objectives were to determine MTD and RP2D and assess safety (per CTCAE V5.0) and efficacy (per IMWG criteria) of SMd.

Results. Thirteen pts were enrolled: 3 in cohort 1, 3 in cohort 2, 7 in cohort 3. Overall, 69.2% were male, with median age 66 years and median of 5 prior lines of therapy. All pts were triple-class exposed to IMiD, PI, and anti-CD38 monoclonal antibody. Three pts (23.1%) relapsed after TCRT (3 cilta-cel; 2 talquetamab; 1 IGM-2644) and 4 after belantamab mafodotin, with 3 pts (30.8%) refractory to B-cell maturation antigen–targeted therapy. As of July 8, 2025, no DLTs were encountered in cohorts 1 and 2, and 2 occurred in cohort 3. One pt experienced Grade (G) 2 constipation and proctitis considered possibly related despite being pre-existing and withdrew consent prior to cycle 1 completion, qualifying as DLT. Another pt experienced G4 neutropenia on C1D15 not resolved within 7 days of holding study medication; G4 neutropenia recovered by C2D15 after 2 filgrastim doses (C1D15 and C1D22), and pt continued with S reduced to 40 mg and M 0.6 mg. Two pts in cohort 3 were not evaluable for DLT, due to protocol dosing deviations in C1, but continued therapy based on clinical benefit and are included in analyses. Most common treatment-emergent adverse events (TEAEs) were neutropenia (69.2%), thrombocytopenia (69.2%), constipation (46.2%), and leukopenia (46.2%). Most common G3/4 TEAEs were neutropenia (38.5%), thrombocytopenia (15.4%), and leukopenia (15.4%). As of July 25, 2025, 10 pts had ≥1 response assessment; disease control (≥SD) was reported in all 10 pts. Overall response rate was 40% (4/10); 4 pts achieved VGPR. In cohort 2, 2/3 pts had VGPR. Treatment with SMd led to an increase in proliferating (Ki-67+), activated (HLA-DR+), and effector memory (CD45RA-/CCR7-) T cells, with a decrease in TIGIT+ T cells by C2D15.

Conclusions. For the SMd all-oral combination, TEAEs were consistent with AE profiles for S and M, and no new safety signals were detected; DLT of G4 neutropenia reported but manageable with filgrastim and dose reduction. Across all dose levels, SMd showed efficacy in pts with heavily pretreated RRMM in whom TCRT had failed or who could not receive TCRT. Initial analysis of primary pt samples demonstrated presence of proliferating cytotoxic T--cells, with decrease in exhaustion markers. Results support continued investigation of SMd in pts with RRMM.

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