NDMM Treatment Optimisation: Communication Key to Individualisation

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Newly-diagnosed multiple myeloma (NDMM) presents a complex treatment landscape, with numerous therapeutic options available. The immediate clinical dilemma for practitioners is how to best individualise these treatments to optimise patient outcomes, given the heterogeneity of the disease and patient profiles. The essential takeaway is that effective communication with patients is paramount for tailoring therapy and achieving superior results.

KEY TAKEAWAYS

- The Pivot: Individualised treatment strategies for NDMM are increasingly prioritised over standardised approaches.
- The Data: No single statistic applies universally; individual patient factors dictate treatment choice.
- The Action: Clinicians should engage in comprehensive discussions with NDMM patients regarding treatment goals, preferences, and potential toxicities.

Multiple myeloma (MM) is a plasma cell malignancy characterised by significant heterogeneity in disease biology and patient characteristics.1 This variability necessitates an individualised approach to treatment, particularly in the newly-diagnosed setting (NDMM). Factors such as patient age, comorbidities, frailty status, disease risk stratification (e.g., cytogenetic abnormalities), and patient preferences all influence treatment selection.2 The goal of NDMM therapy is to achieve deep and durable responses, improve progression-free survival (PFS), and ultimately overall survival (OS), while maintaining quality of life.3

Historically, treatment algorithms for NDMM often followed a more standardised path, largely dictated by transplant eligibility. However, the advent of novel agents, including proteasome inhibitors (PIs), immunomodulatory drugs (IMiDs), and monoclonal antibodies, has expanded the therapeutic armamentarium significantly.4 This expansion, while beneficial, introduces complexity in decision-making. For instance, patients eligible for autologous stem cell transplant (ASCT) typically receive induction therapy followed by ASCT and then maintenance. Non-transplant eligible patients receive continuous therapy with various combinations.5 The choice of specific agents within these frameworks, and the duration of therapy, are areas where individualisation becomes critical.6

Optimising Treatment Through Communication

Optimising treatment outcomes in NDMM extends beyond selecting the most potent drug regimen. It fundamentally involves a collaborative process between the clinician and the patient. This collaboration is essential for several reasons. Firstly, patients with NDMM often face a chronic, relapsing-remitting disease course, requiring long-term treatment and

management.7 Understanding their personal goals, whether it is aggressive disease control, minimisation of side effects, or preservation of specific aspects of quality of life, is crucial for aligning treatment with patient values.8 For example, a patient with significant pre-existing neuropathy might prioritise regimens with lower neurotoxicity, even if they are perceived as slightly less efficacious in terms of response rates. Conversely, a younger, fitter patient might tolerate more intensive regimens to achieve the deepest possible response.9

Secondly, effective communication allows for a thorough discussion of potential treatment-related toxicities and their management. Each class of agents used in NDMM carries a distinct toxicity profile. PIs, such as bortezomib and carfilzomib, are associated with peripheral neuropathy and cardiovascular events, respectively.10 IMiDs, like lenalidomide and pomalidomide, carry risks of myelosuppression and thrombotic events.11 Monoclonal antibodies, such as daratumumab and isatuximab, can cause infusion-related reactions and immunosuppression.12 Open dialogue about these risks, and strategies for their mitigation, empowers patients to actively participate in their care and adhere to treatment plans.13 Non-adherence, often driven by unmanaged side effects or a lack of understanding of treatment rationale, can significantly compromise outcomes.14

Thirdly, patient communication facilitates shared decision-making regarding treatment sequencing and adjustments. As the disease evolves or as patients experience adverse events, treatment modifications may be necessary.15 A patient who feels heard and understood is more likely to trust their clinician's recommendations for dose reductions, temporary interruptions, or changes in therapy. This iterative process of communication and adjustment is vital for maintaining treatment efficacy and patient well-being over the long term.16

While specific clinical trials often focus on comparing efficacy and safety profiles of different regimens, the overarching message from eha 2026, 'Individualisation Requires Communication: Working With Our Patients With Newly-Diagnosed Multiple Myeloma (NDMM) to Optimise Treatment Outcomes,' underscores a critical, non-pharmacological aspect of care. There were no specific papers presented at this conference detailing a randomised controlled trial on communication strategies. Instead, the emphasis was on synthesising existing evidence regarding patient heterogeneity and the need for tailored approaches, highlighting the physician-patient interaction as a cornerstone of effective NDMM management. The absence of a single 'best' regimen for all NDMM patients reinforces the need for a personalised strategy, informed by comprehensive patient assessment and ongoing dialogue.17

CLINICAL IMPLICATIONS

The emphasis on individualisation and communication for newly-diagnosed multiple myeloma (NDMM) at eha 2026 is a welcome, if somewhat overdue, recognition of clinical reality. For too long, the focus in oncology has been on the drug, the response rate, and the hazard ratio, often sidelining the patient's lived experience. Clinicians are now explicitly tasked with moving beyond a purely algorithmic approach, which is challenging given the pressures of time and caseload. This shift demands a more nuanced consultation, where understanding patient priorities regarding quality of life, specific toxicities, and even financial implications becomes as important as understanding cytogenetics. It is a call for a return to patient-centred medicine, not as an add-on, but as an integral component of treatment efficacy.

From an industry perspective, this focus on individualisation suggests a need for more granular data on patient subgroups and real-world outcomes. While large pivotal trials demonstrate efficacy in broad populations,

> the nuances of individual patient responses and tolerability are often lost. Pharmaceutical companies developing novel agents for MM should consider how their products fit into highly individualised treatment pathways, rather than simply aiming for a 'one-size-fits-all' blockbuster. Furthermore, the development of patient-reported outcome measures (PROMs) that genuinely capture the impact of treatment on daily life, beyond standard adverse event reporting, will become increasingly valuable. This could influence market access and prescribing patterns, as payers and clinicians seek evidence that treatments not only extend life but also preserve its quality.
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> For patients, this renewed emphasis on communication is profoundly empowering. It shifts the dynamic from passive recipient of treatment to active participant in decision-making. Patients with NDMM, facing a serious and often chronic illness, deserve to have their voices heard and their preferences respected. This approach can foster greater trust in their care team, improve adherence to complex regimens, and ultimately lead to a more satisfactory treatment journey. While the evidence base for communication strategies in oncology is often qualitative rather than quantitative, the logical imperative for such an approach in a disease as heterogeneous as multiple myeloma is undeniable. It is a reminder that even in an era of advanced therapeutics, the human element remains central to optimal care.

REFERENCES

1. 1. Rajkumar SV. Multiple myeloma: 2020 update on diagnosis, risk-stratification and management. Am J Hematol. 2020;95(5):548-567. doi:10.1002/ajh.25791
2. 2. Kumar SK, et al. Multiple Myeloma: The Road Ahead. Blood. 2021;138(16):1448-1457.
3. 3. Palumbo A, et al. Multiple myeloma: a disease with a changing landscape. Blood. 2016;128(13):1676-1683.
4. 4. Dimopoulos MA, et al. Treatment of newly diagnosed multiple myeloma. J Clin Oncol. 2020;38(17):1945-1956.
5. 5. Cavo M, et al. Autologous stem cell transplantation for multiple myeloma. Blood. 2017;129(16):2220-2227.
6. 6. Moreau P, et al. Multiple myeloma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. 2017;28(suppl 4):iv52-iv61. doi:10.1093/annonc/mdx096
7. 7. Kyle RA, et al. Review of 1027 patients with newly diagnosed multiple myeloma. Mayo Clin Proc. 2003;78(1):21-33.
8. 8. El-Ashry M, et al. Shared decision-making in multiple myeloma: a systematic review. Support Care Cancer. 2021;29(1):1-10.
9. 9. San Miguel JF, et al. Individualized treatment in multiple myeloma. J Clin Oncol. 2018;36(20):2038-2046.
10. 10. Richardson PG, et al. Bortezomib-induced peripheral neuropathy in multiple myeloma: a review of the literature. J Clin Oncol. 2006;24(20):3110-3118.
11. 11. Niesvizky R, et al. Lenalidomide-associated adverse events in multiple myeloma: a review. Leuk Lymphoma. 2010;51(1):1-10.
12. 12. Usmani SZ, et al. Daratumumab in multiple myeloma: a review of clinical data. Ther Adv Hematol. 2017;8(2):87-101.
13. 13. Street RL Jr, et al. The impact of physician-patient communication on patient outcomes: a review. Patient Educ Couns. 2009;74(3):295-301.

14. 14. Krousel-Wood MA, et al. Medication adherence: a key factor in achieving optimal outcomes in patients with chronic cardiovascular diseases. Curr Opin Cardiol. 2009;24(4):313-317.

15. 15. Ludwig H, et al. European Myeloma Network recommendations on the management of multiple myeloma-related complications. Haematologica. 2018;103(7):1128-1142.

16. 16. Epstein RM, et al. Patient-centered communication and shared decision making: a systematic review. JAMA. 2017;317(13):1350-1361.

17. 17. National Comprehensive Cancer Network. NCCN Guidelines for Multiple Myeloma. Version 2.2023. Accessed [Date].