Likewise, no significant difference regarding viral titers of HCV were observed between SENV-H viremic and nonviremic patients.

**References**


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**To the editor:**

**Efficacy of a low dose of thalidomide in advanced multiple myeloma**

Barlogie and his group have demonstrated the efficacy of thalidomide (THAL) in the treatment of advanced multiple myeloma.¹ In a more recent expanded follow-up study of 169 patients, the same authors reported that patients receiving more than 42 g THAL in 3 months had higher response and 2-year survival rates and therefore supported the hypothesis of a dose-dependent effect of THAL in advanced myeloma.² The authors also observed a 58% incidence of THAL-related toxicity greater than grade II, which was related to both intensity and cumulative dose of THAL. In a retrospective study of 83 patients treated with THAL for advanced myeloma,³ we also observed that a high cumulative dose of at least 34.4 g in the first 90 days was associated with significantly higher response and overall survival (OS) rates. However, the mean daily-received dose of THAL in the initial 90-day treatment period was not found to influence the response rate, the OS, or the event-free survival.³ We now have addressed the issue of the minimal effective THAL dose, given the high incidence of troubling side effects, and report preliminary experience regarding the efficacy and lack of toxicity of a low THAL dose (50 mg/d) in patients with advanced multiple myeloma.

Between May 2000 and November 2000, 16 consecutive patients with relapsed advanced multiple myeloma were considered for low-dose THAL. During the consent and protocol initiation process, 2 patients with fulminant progression were started with a dosage of 200 mg/d THAL and experienced rapid death at 32 days and 68 days. The 14 patients without life-threatening myeloma-related complications were begun on THAL at 50 mg/d (Laplah, Allauch, France), along with bisphosphonates. Patients who progressed on this dose of THAL received salvage therapy decided on by their primary physician.

The median age at the onset of THAL was 62 years (range, 43-79 years). Of the patients, 10 were male. The median time from disease diagnosis to the onset of THAL treatment was 57 months (range, 13-127 months), and the median number of prior lines of therapy was 2 (range, 1-5 lines). M-component isotype was IgG in 6 patients, IgA in 7 patients, and light chain in only 1 patient. The light chain was kappa in 8 patients and lambda in 6 patients. A chromosome 13 deletion at band 13q14 in bone marrow plasma cells was found in 6 patients, and the median value for the serum β2 microglobulin at the start of the THAL treatment was 3.5 mg/L (1.5-6.9 mg/L). The prior treatment consisted of conventional chemotherapy alone (n = 2), single autotransplant (n = 8), tandem autotransplant (n = 3), and allogeneic bone marrow transplant (n = 1).

The analysis was performed on the reference date of October 15, 2001, and 10 patients (71%) were still alive 230+ to 529+ days (median, 483 days) after protocol entry. Despite THAL dose escalation, 3 patients died at 27, 119, and 133 days, respectively, after the onset of treatment, and 3 patients were still receiving THAL 50 mg/d with a follow-up ranging from 384+ to 521+ days. They have had a reduction of at least 25%, 75%, and 75%, respectively, of the serum M-component. The 5 patients who failed at the 50 mg/d dose level have experienced response after salvage treatment, which consisted of an increased THAL dose alone or in combination with another drug (usually dexamethasone). One of the patients relapsed 244 days after the onset of THAL and died despite further salvage treatments. Despite an increase in THAL dose and further switch to dexamethasone or melphalan in 2 of them, 3 patients were still alive with stable disease. Overall, response was recorded in 8 patients (57%) as at least 25% (n = 1), at least 50% (n = 1), and at least 75% (n = 6). At the dose levels of blood-borne diseases.⁶ This would lead to the assumption that no protective immunity is established after SENV-H infection. Although SENV-H has been assigned a possible causative agent of postransfusion hepatitis, no clinical impact or biochemical differences caused by SENV-H could be observed in this study.

**References**

200 mg/d and 400 mg/d, a dose reduction was required in 4 patients because of toxicity of at least grade II (neurological in 2 patients and digestive in the 2 remaining patients). In contrast, the tolerance at the 50-mg/d dose level was good, with only one patient suffering from mild nausea.

These results suggest that some patients with advanced myeloma may respond to doses of THAL as low as 50 mg/d. This was the case in 3 of our 14 patients (21%), with a follow-up now exceeding 12 months. Toxicities appeared less; thus, for patients intolerant to THAL 200 mg/d or more, a dose reduction to 50 mg/d may be tried before drug discontinuation. Patients who fail low-dose THAL may be salvaged with increasing THAL doses alone or in combination with dexamethasone. To confirm the hypothesis that low-dose THAL, particularly in combination with dexamethasone, might be nontoxic and efficacious, the Intergroupe Francophone du Myélome (IFM) group is currently conducting a prospective randomized trial comparing low and conventional doses of THAL in patients with advanced myeloma.

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