Consensus recommendations for the uniform reporting of clinical trials: report of the International Myeloma Workshop Consensus Panel 1

S. Vincent Rajkumar,1 Jean-Luc Harousseau,2 Brian Durie,3 Kenneth C. Anderson,4 Meletios Dimopoulos,5 Robert Kyle,1 Joan Blade,6 Paul Richardson,4 Robert Orlowski,7 David Siegel,8 Sundar Jagannath,9 Thierry Facon,10 Hervé Avet-Loiseau,2 Sagar Lonial,11 Antonio Palumbo,12 Jeffrey Zonder,13 Heinz Ludwig,14 David Vesole,8 Orhan Sezer,15 Nikhil C. Munshi,4,16 and Jesus San Miguel,17 on behalf of the International Myeloma Workshop Consensus Panel 1

1Mayo Clinic, Rochester, MN; 2Université de Nantes, Nantes, France; 3Cedars-Sinai Medical Center, Los Angeles, CA; 4Dana-Farber Cancer Institute, Boston, MA; 5University of Athens, Athens, Greece; 6Hospital Clinic in Barcelona, Barcelona, Spain; 7M. D. Anderson Cancer Center, Houston, TX; 8John Theurer Cancer Center, Hackensack, NJ; 9Mt Sinai Medical Center, New York, NY; 10Université de Lille, Lille, France; 11Winship Cancer Institute/Emory Clinic, Atlanta, GA; 12University of Turin, Turin, Italy; 13Karmanos Cancer Center, Detroit, MI; 14Wilhelminen Hospital, Vienna, Austria; 15University Medical Center, Hamburg, Germany; 16Boston Veterans Administration Healthcare System, West Roxbury, MA; and 17Hospital Universitario, Instituto de Biología Molecular y Celular del Cáncer, Centro de Investigación del Cáncer, Salamanca, Spain

It is essential that there be consistency in the conduct, analysis, and reporting of clinical trial results in myeloma. The goal of the International Myeloma Workshop Consensus Panel 1 was to develop a set of guidelines for the uniform reporting of clinical trial results in myeloma. This paper provides a summary of the current response criteria in myeloma, detailed definitions for patient populations, lines of therapy, and specific endpoints. We propose that future clinical trials in myeloma follow the guidelines for reporting results proposed in this manuscript. (Blood. 2011;117(18):4691-4695)

Introduction

The treatment of myeloma has evolved rapidly in the last decade.1 The introduction of several active new drugs and novel targeted investigational agents has resulted in numerous active clinical trials in every stage of the disease. Studies are being conducted worldwide, including an increasing number of multicenter, international trials.2,3 It is essential that there be consistency in the conduct, analysis, and reporting of clinical trial results. Unless uniform reporting requirements are adhered to, it will be impossible to compare results across trials or to accurately determine whether reported results are valid and reliable. The goal of the International Myeloma Workshop Consensus Panel 1 was to develop a set of guidelines for the uniform reporting of clinical trial results in myeloma. We recognize that some compromises have to be made to ensure that this guidance meets requirements that are practical in most countries, academic and community practices, and various groups conducting clinical trials in myeloma. We propose that future clinical trials in myeloma follow the guidelines proposed in this manuscript.

Definition of patient populations

The terms used to define patient populations studied should be standardized. The terms “relapsed,” and “refractory,” when used to describe patient populations tested in clinical trials, should adhere to the definitions listed in this section. These definitions are based on a recent American Society of Hematology–Food and Drug Administration panel on endpoints in myeloma.5 We also propose that, when new clinical trials are initiated, these definitions be used in eligibility criteria to ensure uniformity across trials.

Rerfractory myeloma

Rerfractory myeloma is defined as disease that is nonresponsive while on primary or salvage therapy, or progresses within 60 days of last therapy. Nonresponsive disease is defined as either failure to achieve minimal response or development of progressive disease (PD) while on therapy. There are 2 categories of refractory myeloma: “relapsed-and-refractory myeloma” and “primary refractory myeloma.”

Relapsed and refractory myeloma. Relapsed and refractory myeloma is defined as disease that is nonresponsive while on salvage therapy, or progresses within 60 days of last therapy in patients who have achieved minimal response (MR) or better at some point previously before then progressing in their disease course.5,6
Primary refractory myeloma. Primary refractory myeloma is defined as disease that is nonresponsive in patients who have never achieved a minimal response or better with any therapy. It includes patients who never achieve MR or better in whom there is no significant change in M protein and no evidence of clinical progression as well as primary refractory, PD where patients meet criteria for true PD. On reporting treatment efficacy for primary refractory patients, the efficacy in these 2 subgroups (“nonresponding-nonprogressive” and “progressive”) should be separately specified.

Relapsed myeloma

Relapsed myeloma is defined as previously treated myeloma that progresses and requires the initiation of salvage therapy but does not meet criteria for either “primary refractory myeloma” or “relapsed-and-refractory myeloma” categories.

Additional qualifiers

When possible, if a clinical trial is targeted to a specific population, it would be best to provide additional qualifiers that describe more precisely the population being studied, for example, “relapsed and refractory to immunomodulatory therapy” or “relapsed and refractory to bortezomib.” Prognostic factors, such as stage and cytogenetic information, should be considered as stratification factors at trial entry.

Response criteria

The International Myeloma Working Group (IMWG) uniform response criteria should be used in future clinical trials, with additional clarifications as listed in this section. The IMWG uniform response criteria were developed from the European Group for Blood and Bone Marrow Transplant/International Bone Marrow Transplant Registry/American Bone Marrow Transplant Registry published criteria, commonly referred to as the Blade criteria or the European Group for Blood and Bone Marrow Transplant criteria, with revisions and improvements that aid uniform reporting. These include the addition of free light chain (FLC) response and progression criteria for patients without measurable disease, modification of the definition for disease progression for patients in complete response (CR), and addition of very good partial response (VGPR) and stringent response categories.

The panel endorsed the definitions of partial response (PR), VGPR, CR, PD, and stable disease according to IMWG. Of note, there was unanimous consensus that PD for patients in CR should be defined as per the IMWG criteria. CR patients will need to progress to the same level as VGPR and PR patients to be considered PD. A positive immunofixation alone is therefore not sufficient.9,10

The need for bone marrow confirmation of CR was discussed in detail, but new data showed that up to 14% of patients with immunofixation-negative CR may have more than or equal to 5% plasma cells in the marrow.11 Bone marrow confirmation is required for coding CR, and the panel recommends no change to the CR definition in this regard.

The clarifications and additions to the IMWG criteria discussed in this section were recommended and approved by the panel. The IMWG criteria for response and progression incorporating published errata and clarifications, updated definition of stringent CR, and additional clarifications are listed in Tables 1 and 2.

Immunophenotypic CR

The panel approved a definition of immunophenotypic CR to be incorporated into the IMWG criteria (Table 2). This requires absence of phenotypically aberrant plasma cells (clonal) in bone marrow with a minimum of 1 million total bone marrow cells analyzed by multiparametric flow cytometry (with ≥ 4 colors).14

Molecular CR

The panel approved a definition of molecular CR to be incorporated into the IMWG criteria. Molecular CR is defined as CR plus negative allele-specific oligonucleotide polymerase chain reaction (sensitivity 10−4; Table 2).

Minimal response

The following clarifications to IMWG criteria were made for coding CR in patients in whom the only measurable disease is by serum FLC levels (Table 1). In these patients, CR requires negative serum and urine immunofixation plus a normal FLC ratio of 0.26 to 1.65, on 2 consecutive assessments. Similarly, to code VGPR in such patients, a more than 90% decrease in the difference between serum and urine immunofixation plus a normal FLC ratio of 0.26 to 1.65. In these situations, it is appropriate to define normal FLC ratio using those used in the given laboratory.

The panel clarified that bone marrow criteria for PD are to be used only in patients without “measurable disease” as defined in the IMWG criteria7 by M protein and by FLC levels. The “lowest response value” in determining the nadir for PD assessment does not need to be a confirmed value.

The third panel recommended that, if a patient has more than one M protein spike in the serum (or urine), the M protein to be followed for assessing response is only the one that meets IMWG criteria for “measurable” M protein level IMWG criteria. If more than one M protein spikes meet the criteria for measurable disease, then both need to be followed for response.

Fourth, the panel agreed that magnetic resonance imaging and positron emission tomography-computed tomography findings will not be incorporated formally into the response criteria for purposes of assessing depth of response, but additional single-center studies are encouraged.15 Further validation of new aspects of the IMWG criteria will also be needed as agreed at the recent American Society of Hematology-Food and Drug Administration panel.

Finally, it is recommended that the time at which response assessment was conducted should be reported. In addition, the time to best response should also be reported.

Reporting of efficacy results

All efficacy results for primary endpoints should be reported only on an intent-to-treat basis. In the case of secondary endpoints, in
<table>
<thead>
<tr>
<th>CR’</th>
<th>Stringent complete response (sCR)†</th>
<th>VGPR’</th>
<th>PR</th>
<th>SD</th>
<th>PD†</th>
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| Negative immunofixation of serum and urine, and  
CR as defined, plus  
M-component detectable by immunofixation but not on electrophoresis, or  
Serum and urine M-component  
< 100 mg/24 h  
Serum and urine M-component by 90% or to < 200 mg/24 hours  
Not meeting criteria for CR, VGPR, PR, or PD  
Increase of 25% from lowest response value in any of the following:  
Serum M-component (absolute increase must be ≥ 0.5 g/dL), and/or  
Urine M-component (absolute increase must be ≥ 200 mg/24 h), and/or  
In addition to the above criteria, if present at baseline, ≥ 50% reduction in the size of soft tissue plasmacytomas is also required  
Only in patients without measurable serum and urine M-protein levels: the difference between involved and uninvolved FLC levels (absolute increase must be > 10 mg/dL)  
Definite development of new bone lesions or soft tissue plasmacytomas or definite increase in the size of existing bone lesions or soft tissue plasmacytomas  
Development of hypercalcemia (corrected serum calcium > 11.5 mg/dL) that can be attributed solely to the PC proliferative disorder |
| Disappearance of any soft tissue plasmacytomas, and  
Normal FLC ratio and  
≥ 90% reduction in serum M-component plus urine M-component  
If the serum and urine M-protein are not measurable, a decrease ≥ 50% in the difference between involved and uninvolved FLC levels is required in place of the M-protein criteria  
Serum M-component (absolute increase must be ≥ 0.5 g/dL), and/or  
Urinary M-component (absolute increase must be ≥ 200 mg/24 h), and/or  
If serum and urine M-protein are not measurable, and serum free light assay is also not measurable, ≥ 50% reduction in bone marrow PCs is required in place of M-protein, provided baseline percentage was ≥ 30% |
| ≤ 5% PCs in bone marrow  
Absence of clonal PCs by immunohistochemistry or 2- to 4-color flow cytometry  
If serum and urine M-protein are not measurable, and serum free light assay is also not measurable, ≥ 50% reduction in bone marrow PCs is required in place of M-protein, provided baseline percentage was ≥ 30%  
Only in patients without measurable serum and urine M-protein levels and without measurable disease by FLC levels, bone marrow PC percentage (absolute percentage must be ≥ 10%)  
Definite development of new bone lesions or soft tissue plasmacytomas or definite increase in the size of existing bone lesions or soft tissue plasmacytomas  
Development of hypercalcemia (corrected serum calcium > 11.5 mg/dL) that can be attributed solely to the PC proliferative disorder |

Adapted from Durie et al7 and Kyle et al13 with permission. All response categories (CR, sCR, VGPR, PR, and PD) require 2 consecutive assessments made at any time before the institution of any new therapy; CR, sCR, VGPR, PR, and SD categories also require no known evidence of progressive or new bone lesions if radiographic studies were performed. VGPR and CR categories require serum and urine studies regardless of whether disease at baseline was measurable on serum, urine, both, or neither. Radiographic studies are not required to satisfy these response requirements. Bone marrow assessments need not be confirmed. For PD, serum M-component increases of more than or equal to 1 g/dL are sufficient to define relapse if starting M-component is ≥ 5 g/dL. PCs indicate plasma cells.

*Clarifications to IMWG criteria for coding CR and VGPR in patients in whom the only measurable disease is by serum FLC levels: CR in such patients indicates a normal FLC ratio of 0.26 to 1.65 in addition to CR criteria listed above. VGPR in such patients requires a > 90% decrease in the difference between involved and uninvolved FLC levels.

†Clarifications to IMWG criteria for coding PD: Bone marrow criteria for PD are to be used only in patients without measurable disease by M protein and by FLC levels; “25% increase” refers to M protein, FLC, and bone marrow results, and does not refer to bone lesions, soft tissue plasmacytomas, or hypercalcemia and the “lowest response value” does not need to be a confirmed value.
addition to intent-to-treat results, results based on actual treatment received can also be reported. The reporting of results in subsets of patients restricted to those who completed certain duration of therapy should be avoided. All patients who were registered and met eligibility criteria regardless of whether they actually received therapy for a meaningful period (or not at all) should be in the denominator for all efficacy calculations. Response assessments should be performed before the next therapy is initiated.

In all clinical trials, patients should be followed every 1 to 2 months until PD to enable accurate calculation of time to progression (TTP) and progression-free survival (PFS).

### Essential efficacy measures in phase 3 trials

Regardless of the primary endpoint studies, all phase 3 studies should report overall survival, TTP, PFS, duration of response (DOR), and if possible, time to next treatment (TNT), 5-year overall survival rate, and 10-year overall survival rate. The definitions of TTP, PFS, and DOR are listed in Table 3.7 It is particularly important that both TTP and PFS be reported. Where possible, details of any crossover should be provided.

### TNT

TNT is difficult to accurately compare, except in double-blind studies, but it is clearly important to report TNT in future phase 3 trials. TNT is defined time from registration on trial to next treatment or death of any cause, whichever comes first. To accurately define TNT, next treatment should start uniformly in clinical practice. The consensus is that the next treatment should start when there is either clinical relapse or a significant paraprotein relapse.

Clinical relapse is defined using the definition of clinical relapse in the IMWG criteria.7 In the IMWG criteria, clinical relapse is defined as requiring one or more of the following direct indicators of increasing disease and/or end-organ dysfunction that are considered related to the underlying plasma cell proliferative disorder:

1. Development of new soft tissue plasmacytomas or bone lesions on skeletal survey, magnetic resonance imaging, or other imaging
2. Increase in the size of existing plasmacytomas or bone lesions. A definite increase is defined as a 50% (and at least 1 cm) increase as measured serially by the sum of the products of the cross-diameters of the measurable lesion
3. Hypercalcemia (≥ 11.5 mg/dL; > 2.875mM/L)
4. Decrease in hemoglobin of more than 2 g/dL (1.25mM) or to less than 10 g/dL
5. Rise in serum creatinine by more than or equal to 2 mg/dL (≥ 177mM/L)
6. Hyperviscosity

In some patients, bone pain may be the initial symptom of relapse in the absence of any of the features listed in “TNT.” However, bone pain without imaging confirmation is not adequate to meet these criteria in trials.

In patients who do not have clinical relapse, a significant paraprotein relapse is defined as doubling of the M-component in 2 consecutive measurements separated by less than or equal to 2 months; or an increase in the absolute levels of serum M protein by more than or equal to 1 g/dL, or urine M protein by more than or equal to 500 mg/24 hours, or involved FLC level by more than or equal to 20 mg/dL (plus an abnormal FLC ratio) in 2 consecutive measurements separated by less than or equal to 2 months. This definition of “paraprotein relapse” represents the rate of rise or absolute level of increase in M protein at which the panel considered that myeloma therapy should be restarted in relapsing...
patients in clinical practice, even if signs and symptoms of new end-organ damage are not yet apparent.

**Summary and future directions**

This paper summarizes, clarifies, and updates current response criteria in myeloma. We have provided detailed definitions for patient populations, lines of therapy, and specific endpoints. We propose that future clinical trials in myeloma follow the guidelines for monitoring patients and reporting results proposed in this manuscript. These criteria will most probably change with time as the technology improves and more sensitive tests become available. We also need to develop criteria to assess the efficacy of therapy for earlier stages of the disease, such as smoldering multiple myeloma given the interest in preventive clinical trials. Finally, we need to quickly develop and validate response criteria that incorporate gene expression profiling and imaging techniques, such as positron emission tomography.

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**Authorship**

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Correspondence: S. Vincent Rajkumar, Mayo Clinic, 200 First St SW, Rochester, MN 55905; e-mail: rajks@mayo.edu; Nikhil C. Munshi, Dana-Farber Cancer Institute, 44 Binney St, Boston, MA 02115; e-mail: nikhil_munshi@dhh.harvard.edu; and Jesús San Miguel, Hospital Clinic of Universitario Universidad de Salamanca Salamanca, Spain; e-mail: sanmigiz@usal.es.

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