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Effect of Body Composition and Renal Function on the Pharmacokinetics of High-Dose Melphalan for Multiple Myeloma

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**EFFECT OF BODY COMPOSITION AND RENAL FUNCTION ON THE PHARMACOKINETICS OF HIGH-DOSE MELPHALAN FOR MULTIPLE MYELOMA**

Vogl, D.T.1, Mick, R.2, Stouples, E., Darco, L.E.1, Paul, T.M.1, Salezian, G.1, Raguza-Lopez, M.1, Porter, D.L.1, Lugr, S.M.1, Stadtmueller, E.A.1,3, Abramson Cancer Center, University of Pennsylvania, Philadelphia; 2 University of Pennsylvania School of Dental Medicine, Philadelphia; 3 University of Pennsylvania School of Dental Medicine, Philadelphia; 4 University of the Sciences, Philadelphia; 5 University of Puerto Rico, San Juan

**Background:** High dose melphalan is the most common regimen for autologous stem cell transplantation (ASCT) for multiple myeloma (MM), but toxicity and efficacy are variable. We hypothesized that variation in body size, body composition, and renal function would explain differences in melphalan pharmacokinetics and therefore in outcomes after transplant.

**Methods:** We evaluated 41 patients who received melphalan 200 mg/m² on day -2 (one patient with poor renal function received 180 mg/m²). We calculated melphalan doses using ideal body weight (IBW), using adjusted IBW (ABW) for patients weighing >120% of IBW. We measured body composition using dual x-ray absorptiometry (DEXA), renal function with both iohexol clearance (ClIohexol) and the Cockroft-Gault formula (CrClCG), and plasma melphalan concentrations using HPLC/tandem mass spectrometry. We used non-compartmental analysis to estimate melphalan clearance (ClMEL) and area under the curve (AUCMEL) and linear regression modeling to identify factors associated with melphalan pharmacokinetics.

**Results:** Patients’ mean BSA using actual weight was 1.93 m² (range 1.44-2.48). By DEXA scan, the mean lean body weight was 53.3 kg (SD 11.0) and mean fat percentage 31% (SD 9.5%). Mean iohexol clearance was 109 mL/min (range 28-163), AUCMEL varied significantly, with a range of 7.6-26.6 mg•h/L (mean 13.6, SD 3.8); ClMEL was similarly variable (mean 27.9 mL/min, SD 8.1). In univariate analyses, ClMEL was inversely related to age and directly related to weight, BSA, lean body weight, bone mineral content, ClIohexol, CrClCG, and MEL dose. ClMEL was not associated with body fat percentage, body fat weight, or body lean percentage, or with other measurements, such as hemoglobin, albumin, immunoglobulins, or M-spire. The strongest correlation with ClMEL was for CrClCG, and multivariable models showed no improved prediction of ClMEL with the addition of other factors to CrClCG. The best model for predicting AUCMEL was dose/CrClCG (see table). These models consistently under-predicted AUCMEL (mean prediction error -3.3% to -2.6%).

**Table. Performance of linear models predicting AUCMEL**

<table>
<thead>
<tr>
<th>Model</th>
<th>R²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>dose/CrClCG</td>
<td>0.26</td>
<td>0.001</td>
</tr>
<tr>
<td>dose/ClIohexol</td>
<td>0.11</td>
<td>0.04</td>
</tr>
<tr>
<td>dose/weight</td>
<td>0.10</td>
<td>0.04</td>
</tr>
<tr>
<td>dose/lean weight</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>dose/BSAIBW</td>
<td>0.06</td>
<td>0.11</td>
</tr>
<tr>
<td>dose/BSAABW</td>
<td>0.04</td>
<td>0.23</td>
</tr>
</tbody>
</table>

**Conclusion:** A composite calculation incorporating age, weight, and serum creatinine, like CrClCG, may be the best way to choose melphalan doses but only explains 26% of drug exposure variability. Other measures of body composition were poor predictors of exposure. Further research is needed to better address the remaining variability in drug clearance and exposure.

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**COMPARATIVE COST UTILITY ANALYSIS OF PLERIXAFOR PLUS GCSF VERSUS CYCLOPHOSPHAMIDE PLUS GCSF AS SALVAGE MOBILIZATION REGIMENS IN MULTIPLE MYELOMA PATIENTS**

Taffaha, H.W.1,2, Husein, A.A.1, Abdel-Rahman, F.A.1,3 King Hussein Cancer Center, Amman, Jordan; 2 King Hussein Cancer Center, Amman, Jordan

**Introduction:** Plerixafor is a novel agent that enhances the mobilization of peripheral blood stem cells (PBSCs) in lymphoma and multiple myeloma (MM) patients whose cells mobilize poorly. Due to the substantial cost associated with its use, a cost utility analysis was performed to evaluate the economics of salvage Plerixafor in MM patients who failed previous mobilization.

**Methods:** A decision model was developed to analyze the cost utility for two salvage regimens: Plerixafor + GCSF (PG) versus Cyclophosphamide + GCSF (CG). This model assumes that patients undergained mobilization with one of the regimens, followed by apheresis and subsequent autologous transplant if CD34+ cell count is ≥ 2 x 10⁶ cells/kg, or Bortezomib plus Dexamethasone if insufficient CD34+ cells are collected. Patients included in the model will eventually progress and die from their disease. A structured literature review was performed to collect data on the successful mobilization rate, life year gained and quality of life associated with the mobilized options. The analysis was from the perspective of Jordanian Ministry of Health; the costs were based on its list prices and included the costs of medications, apheresis, autologous transplant and adverse effects management. The willingness to pay threshold was $30,000 per quality adjusted life year (QALY). Incremental cost effectiveness ratio (ICER) was calculated by dividing the incremental average cost by the incremental QALY gained. One-way sensitivity analysis was performed to explore the impact of the uncertainty in efficacy data on the results.

**Results:** The model showed that PG was associated with higher probability of achieving successful re-mobilization and subsequent transplant. The average total costs associated with CG and PG were $41,500 and $58,400 respectively. The estimated ICER was $52,813/QALY. (Table 1) The sensitivity analysis revealed that the ICERs ranged from $86,500 to $40,488 per QALY gained when the probability of PG success ranged from 60% to 95%.

**Conclusion:** This analysis showed that the use of Plerixafor plus GCSF as salvage mobilization regimen in MM patients was not cost effective compared to Cyclophosphamide plus GCSF from the perspective of our health care system. To our knowledge, this is the first study to describe a cost utility analysis of Plerixafor use in this indication.

**Table 1. Analysis of Plerixafor plus GCSF (PG) versus Cyclophosphamide plus GCSF (CG)**

<table>
<thead>
<tr>
<th>Regimen</th>
<th>PG</th>
<th>CG</th>
<th>Incremental results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of successful mobilization</td>
<td>0.80</td>
<td>0.27</td>
<td>0.53</td>
</tr>
<tr>
<td>Average total costs</td>
<td>$58,400</td>
<td>$41,500</td>
<td>$16,900</td>
</tr>
<tr>
<td>Life year gained</td>
<td>4.3</td>
<td>3.8</td>
<td>0.50</td>
</tr>
<tr>
<td>QALY</td>
<td>2.58</td>
<td>2.26</td>
<td>0.32</td>
</tr>
<tr>
<td>ICER ($/QALY gained) for PG</td>
<td>$52,813</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**OUTCOME OF PATIENTS WITH NONSECRETORY MULTIPLE MYELOMA AFTER AUTOLOGOUS HEMATOPOIETIC STEM CELL TRANSPLANTATION**

Farban, S., Lin, H., Baladandayuthapani, V., Shah, N., Bashir, Q., Hsuin, C., Popat, U., Parmar, S., Dinh, Y., Qureshi, S., Rundon, G., Giralt, S., Champlin, R., Qazi-Bashir, M. The University of Texas MD Anderson Cancer Center, Houston, TX

**Background:** More than 95% of patients with multiple myeloma have a detectable monoclonal protein either in the serum or urine. Less than 5% of patients have non-secretory myeloma (NSM), characterized by the absence of a monoclonal protein. There are limited available data on the successful mobilization rate, life year gained and quality of life associated with the mobilized options. The analysis was from the perspective of Jordanian Ministry of Health; the costs were based on its list prices and included the costs of medications, apheresis, autologous transplant and adverse effects management. The willingness to pay threshold was $30,000 per quality adjusted life year (QALY). Incremental cost effectiveness ratio (ICER) was calculated by dividing the incremental average cost by the incremental QALY gained. One-way sensitivity analysis was performed to explore the impact of the uncertainty in efficacy data on the results.

**Methods:** A decision model was developed to analyze the cost utility for two salvage regimens: Plerixafor + GCSF (PG) versus Cyclophosphamide + GCSF (CG). This model assumes that patients undergained mobilization with one of the regimens, followed by apheresis and subsequent autologous transplant if CD34+ cell count is ≥ 2 x 10⁶ cells/kg, or Bortezomib plus Dexamethasone if insufficient CD34+ cells are collected. Patients included in the model will eventually progress and die from their disease. A structured literature review was performed to collect data on the successful mobilization rate, life year gained and quality of life associated with the mobilized options. The analysis was from the perspective of Jordanian Ministry of Health; the costs were based on its list prices and included the costs of medications, apheresis, autologous transplant and adverse effects management. The willingness to pay threshold was $30,000 per quality adjusted life year (QALY). Incremental cost effectiveness ratio (ICER) was calculated by dividing the incremental average cost by the incremental QALY gained. One-way sensitivity analysis was performed to explore the impact of the uncertainty in efficacy data on the results.

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