

Multiple Myeloma Relapse

A multiple myeloma relapse occurs when the cancer returns after a period of remission or becomes resistant to treatment. While relapse can be disheartening, remember that many effective treatment options are available, including innovative therapies that can extend remission and [improve your quality of life \(/node/12890/\)](#). By understanding the signs of relapse and working closely with your healthcare team, you can make informed decisions about your next steps.

Whether it involves returning to a previous treatment or exploring new options, there is hope for [continued management of myeloma \(/node/12891/\)](#). The International Myeloma Foundation (IMF) is here to provide the resources, education, and support you need to navigate all aspects of myeloma.

What Is a Multiple Myeloma Relapse?



Relapse is the reappearance of signs and symptoms of myeloma after a period of improvement. Patients with relapsed disease have been treated, then developed signs and symptoms of myeloma at least 60 days after this treatment ended. There can be multiple periods of response and remission following treatment. Fortunately, a growing number of effective treatment protocols has significantly expanded therapy options for relapsing patients

Relapse is a key time to discuss with a myeloma specialist the overall strategy that is most appropriate for you and your myeloma. Treatment at each relapse aims to achieve optimal response with the least toxicity. This is what leads to the best long-term outcome possible for each patient with myeloma. Therapy for relapsed disease should be based on underlying disease biology and patient characteristics.

If risk factors were [identified when you were newly diagnosed \(/node/984/\)](#) and the initial treatment choice was made, this knowledge will have an impact on th

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Time-to-progression (TTP) is the time from start of treatment until myeloma relapses.

Progressive disease is myeloma that is becoming worse or relapsing.

Duration and Depth of Initial Therapy

After achieving their first remission, myeloma patients experience their first relapse at variable intervals. The duration and depth of a patient's response to frontline therapy is often predictive of long-term efficacy in managing myeloma, and helps guide the selection of the next course of treatment. Patients who achieve MRD-negativity status tend to have better PFS.

Biochemical Relapse

Biochemical relapse means there is disease progression based on increase in M-protein levels, but no myeloma-related symptoms of organ dysfunction.

 Biochemical relapse requires monitoring of M-protein levels to catch disease progression if or when it occurs.

In high-risk myeloma, treatment should be initiated early after biochemical relapse is diagnosed to avoid progression to symptomatic disease. Treatment of biochemical relapse is indicated in cases where there is an abnormal ratio by 2 measurements taken 2 months apart: M-spike shows an absolute rise of 0.5 gm/dL or the light chains measured by sFLC show an increase of 10 mg/dL or more.

Clinical Relapse

Clinical relapse interventions vary depending upon the factors that are present. For example, if there are new soft-tissue plasmacytomas or bone lesions, your doctor may suggest radiation as a potentially satisfactory way to manage the relapse. Treatment of clinical relapse is indicated if there is any evidence of worsening CRAB criteria.

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immunomodulatory agents and proteasome inhibitors has demonstrated efficacy. Local radiation for local disease control and pain relief, as well as surgical intervention should be considered. PET/CT imaging is key to evaluating and monitoring extramedullary myeloma.

Sequence of Regimens After Relapse

There is no ideal sequence of treatment regimens for a relapsing patient.

Primarily, treatment options depend on the drugs to which the patient is no longer responsive. However, given the many new and emerging therapies, many patients have unexplored treatment options, including in the context of clinical trials.

Refractory myeloma

Myeloma is considered to be refractory in patients who have had progressive disease either during treatment or within 60 days following treatment. Patients who have short remissions or who become refractory to their initial therapy are considered to have high-risk disease.



A subset of patients may develop refractory disease that is no longer responsive to standard treatments, but myeloma that is refractory to one drug may be responsive to another drug in the same drug class or in a different class. The efficacy of a treatment protocol is dependent on the patient's prior exposure to a specific myeloma drug, as well as to other drugs in the same class.

Patients with refractory myeloma must select from a narrower range of FDA-approved therapy options. The number of regimens a patient has been exposed to and the length of time for a regimen to lose efficacy are predictive of the outcome of therapy. The development of drug resistance may emerge over time.

In late-stage relapse and with refractory disease, attaining stable disease can have clinical benefits for the patient. This is another key time to discuss with your doctor the risks and benefits of clinical trial participation, which may offer access to new drugs and new therapies not yet approved by the FDA.

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patient who is not undergoing therapy. The tests used to monitor a patient for relapse are the same as those used to establish a baseline at diagnosis. Repeating the baseline tests provides a means of comparison.

Explore Our Myeloma Resources

Stay informed with our expert-reviewed resources, including treatment guides, webinars, and the latest research updates. [Explore our myeloma resources \(/publications-videos\)](#) and navigate relapse with confidence.



Relapsed Refractory Multiple Myeloma (RRMM) Glossary

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Relapse of myeloma is defined as the reappearance of signs and symptoms after a period of improvement. Patients with relapsed disease have been treated, then developed signs and symptoms of myeloma at least 60 days after treatment ended. Please visit [myeloma.org/treatment/relapse-definition](https://www.myeloma.org/treatment/relapse-definition) for more information and contact the IMF InfoLine at 1-818-487-7455 or info@myeloma.org with your myeloma-related questions and concerns.

Administration-related reaction (ARR): Reaction to treatment administered via intravenous (IV) infusion or subcutaneous (SQ) injection. See "infusion-related reaction (IRR)" and "Cytokine."

Antibody: A protein produced by plasma cells in response to an antigen that enters the body. See "Antigen" and "Immunoglobulin (Ig)."

Antibody-drug conjugate (ADC): An anti-cancer therapy that links a monoclonal antibody directed at cancer cells with a drug that is toxic to cancer cells.

Antigen: Any foreign substance that causes the immune system to produce natural antibodies. Examples of antigens include bacteria, viruses, parasites, fungi, and toxins.

Apheresis: A procedure that uses a machine to separate whole blood so that one specific component can be collected while other components are immediately re-infused back into the bloodstream of the patient or donor.

B-cell maturation antigen (BCMA): A protein involved in myeloma cell growth and survival. BCMA is found on the surface of cells in all patients with myeloma. Also called "tumor necrosis factor receptor superfamily member 17 (TNFRSF17)."

B cells (B lymphocytes): White blood cells that are part of the natural immune system. Some B cells develop into plasma cells in the bone marrow and are the source of antibodies.

Bispecific antibody: An artificial monoclonal antibody that uses dual-binding ("b") action to kill the targeted cancer cells. Also called "bispecific therapy."

Chimeric antigen receptor (CAR) T-cell therapy: A treatment approach used for blood cancers in which a patient's T cells are collected and modified to attack the patient's tumor cells.

Chromosome: A strand of DNA and proteins in the nucleus of a cell. Chromosomes contain genes and function in the transmission of genetic information. Normally, human cells contain 46 chromosomes (23 pairs).

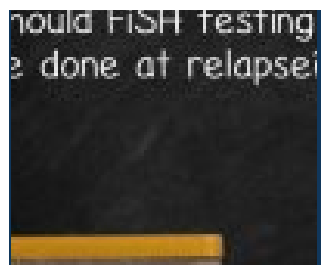
- **Chromosomal deletion** – Genetic mutation in which part or all of a chromosome become lost during DNA replication. Chromosomal deletions that occur in myeloma include loss of the long arm of chromosome 13 (written as 13q-) or loss of the short arm of chromosome 17 (written as 17p-).
- **Chromosomal translocation** – Genetic mutation in which parts of different chromosomes are rearranged. Written with a lowercase "t" followed by the numbers of the chromosomes with translocated genetic material. Translocations that occur in myeloma include t(4;14), t(11;14), and t(14;16), and t(14;20).

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The International Myeloma Foundation medical and editorial content team

Comprised of leading medical researchers, hematologists, oncologists, oncology-certified nurses, medical editors, and medical journalists, our team has extensive knowledge of the multiple myeloma treatment and care landscape.

Additionally, the content on this page is medically reviewed by myeloma physicians and healthcare professionals.

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