causas infecciosas e reumatológicas. Foi inclusive realizado painel de alterações genéticas para síndromes febris, sem se chegar a um diagnóstico. Como paciente apresentava quadro febril, sem etiologia, associado a gamopatia monoclonal, o diagnóstico de variante de Síndrome de Schnitzler foi feito, mesmo sem acometimento cutâneo. Prova terapêutica foi iniciada com prednisona 20 mg ao dia, sendo associado a Colchicina na dose de 4 mg. Paciente apresentou remissão com tratamento não sendo necessário uso de anticorpo monoclonal. **Discussão:** Terré et al. discute o caso de cinco pacientes com clínica muito semelhante a do paciente de nosso caso: febre recorrente de origem obscura associado a gamopatia monoclonal sem fechar critérios para Sindrome de Schnitzler. Ele sugere tratar-se de uma nova síndrome, denominada por eles de síndrome MGARF (gamopatia monoclonal, artralgias e febre recorrente) que, assim como a SS, estaria incluído no grupo das gamopatias monoclonais de significado inflamatório (MGIS). O tratamento em casos sem grande impacto na qualidade de vida dos pacientes e com provas inflamatórias não muito elevadas incluem colchicina, anti-inflamatórios não esteroidais e corticóides. Casos mais severos se beneficiam do uso de anticorpo monoclonal anti-IL1. A menor parte dos pacientes atingem remissão a longo prazo, com reicidivas ao se tentar suspender as medicações. Nosso paciente apresentou boa remissão com uso de colchicina e corticóide em doses baixas. **Conclusão:** Apresentamos o caso de um paciente com clínica sugestiva de síndrome MGARF conforme descrito por Terré et al. Por ser uma doença pouco descrita devido a sua raridade, mais estudos e relatos de caso são necessários para melhor entendimento de sua fisiopatologia e tratamento.

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## HEALTH-RELATED QUALITY OF LIFE OUTCOMES FROM THE PHASE 3 CANDOR STUDY COMPARING CARFILZOMIB, DEXAMETHASONE, AND DARATUMUMAB TO CARFILZOMIB AND DEXAMETHASONE IN PATIENTS WITH RELAPSED OR REFRACTORY MULTIPLE MYELOMA

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**Objectives:** In the phase 3 CANDOR study (n = 466) of patients with relapsed or refractory multiple myeloma (RRMM), a statistically significant improvement in progression-free survival (hazard ratio = 0.63; 95% confidence interval [CI]: 0.46, 0.85; p = 0.0014) was observed in the carfilzomib, dexamethasone, and daratumumab (KdD) arm vs the carfilzomib and dexamethasone (Kd) arm. Here, we report a secondary endpoint of CANDOR, evaluating health-related quality of life (HRQoL). **Material and methods:** HRQoL was assessed using the Global Health status (GHS)/Quality of Life (QoL) domain of the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30), which was completed on day 1 of cycle 1 and every 28 ± 7 days through the first follow-up visit. The GHS/QoL was scored from 0 to 100, with higher scores indicating better QoL. The scores were compared between the KdD and Kd arms using a restricted maximum likelihood–based mixed-effects model for repeated measures under the assumption of missing data at random. A minimally important difference of 5 points between arms was prespecified. An exploratory time-by-time sensitivity analysis of covariance (ANCOVA) was used to evaluate the treatment effect on the GHS/QoL score among patients who remained on treatment until the specified visit (cycle 3 and every 3 cycles thereafter). **Results:** GHS/QoL completion rates from baseline to cycle 26 (study ongoing) for randomized patients who remained on treatment were >81% for both the KdD and Kd arms; the median extent of missing GHS/QoL data was 5.3% for the KdD arm and 12.1% for the Kd arm. KdD was associated with higher GHS/QoL scores relative to Kd, starting at cycle 7, and this was maintained until cycle 26 (by mixed-effects model; overall least squares mean estimate difference [95% CI], 0.06 [–2.39, 2.50]; p = 0.96). At cycle 18, the mean difference between arms approached the prespecified clinically meaningful difference of 5 points (by ANCOVA; difference [standard error], KdD – Kd: 4.06 [2.45]). In an exploratory analysis of patients who remained on treatment at each cycle, a higher number of patients reported an improvement of ≥10 points in GHS/QoL score from baseline in the KdD vs Kd arm, with the greatest difference observed at cycle 7 (odds ratio for KdD/Kd [95% CI], 2.37 [1.29,4.34]), cycle 9 (2.96 [1.46, 6.03]), cycle 13 (2.44 [1.15, 5.17]), and cycle 16 (2.77 [1.27,6.07]). **Discussion:** Higher GHS/QoL scores were reported for patients in the KdD vs Kd arm, suggesting that this treatment can potentially offer both clinical benefit and improved QoL for RRMM patients with complex disease management needs. **Conclusion:** In addition to the superior clinical benefit observed with KdD vs Kd, HRQoL was maintained with the KdD triplet regimen. A higher number of patients treated with KdD vs Kd reported an improvement of ≥10 points in baseline GHS/QoL score. Clinicaltrials.gov: NCT03158688.

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