reported 530 cases, with an ASR of 0.26, above both the global and South American (0.23) averages. **Discussion and conclusion:** EO-MM accounts for a small proportion of myeloma cases worldwide but displays marked geographic and socioeconomic disparities. Higher ASRs in very high HDI and high-income regions likely reflect better diagnostic capacity and cancer registration, as well as possible differences in population risk profiles. Lower rates in parts of Africa and Asia may result from underdiagnosis, limited diagnostic infrastructure, and competing health priorities, whereas elevated incidence in certain small island states could relate to genetic isolation and environmental exposures, warranting targeted investigation. Strengthening surveillance systems, improving access to early diagnosis, and expanding research into genetic and environmental determinants are fundamental to reducing the global burden of EO-MM and addressing disparities.

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EPIDEMIOLOGICAL PROFILE ANALYSIS OF MULTIPLE MYELOMA – PROSPECTIVE DATA FROM A POPULATION-BASED CANCER REGISTRY

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Introduction: The present study provides a prospective analysis of data collected by the Population-Based Cancer Registry (PBCR) of Campinas, São Paulo, covering the period from 2010 to 2019. By systematically gathering data on cancer incidence within a defined geographic region, PBCRs support public health planning, resource allocation, and scientific research. The PBCR of Campinas holds international recognition from the International Agency for Research on Cancer (IARC), affiliated with the World Health Organization, which establishes stringent standards to ensure data quality, comparability, and reliability. **Objectives:** The present study aims to characterize multiple myeloma cases by sex, age group, race/ethnicity, and geographic distribution within the municipality. **Material and methods:** The present study stratified data by sex and age group and in incidence, and examined geographic distribution across the six administrative health districts of Campinas. Researchers also considered socioeconomic indicators in each district. The PBCR compiled data from 29 reporting sources, including both public and private institutions, five hospital-based cancer registries, and the municipal mortality information system. **Discussion and conclusion:** Between 2010 and 2019, the PBCR recorded 526 cases of multiple myeloma, with 277 cases (52.7%) occurring in women and 249 (47.3%) in men. Temporal analysis revealed fluctuations in annual incidence, with the highest number of diagnoses in 2019 (73 cases) and the lowest in 2017 (37 cases). The age distribution showed a progressive increase in incidence with advancing age, particularly among individuals aged 80 and older, 45 cases (8.5%) in women and 40 (7.6%) in men. The 60–69 age group had the highest concentration of cases, with 86 (16.3%) in women and 93 (17.7%) in men. Most cases occurred among white individuals (363 cases; 69%), followed by Black individuals (94 cases; 18%). Geographic analysis according to the health districts of residence, revealed a higher concentration of cases in the Eastern District (171 cases; 32%), followed by the Southern District (136 cases; 26%). The Eastern District is characterized predominantly elderly population with low social vulnerability. In contrast, the Southern District encompasses areas with distinct socioeconomic profiles, including regions of high and low social vulnerability. Subsequently, there were 96 cases (18%) in the Northern District, 66 cases (12.5%) in the Southwest District and 57 cases (11%) in the Northwest District. In conclusion, the present study highlights the epidemiological profile of multiple myeloma within a socioeconomically diverse urban population. The findings underscore the importance of population-based cancer registries, such as the PBCR, in guiding cancer prevention strategies, diagnostic efforts, and treatment planning. In Campinas, the PBCR serves as a critical tool for informing public health policies and interventions grounded in local epidemiological evidence. **Funding:** Grant FAPESP #2021/10265-8, Cancer Theranostics Innovation Center; Multicenter Study Group in Oncohematology (HEMOH).

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ESQUEMA CTD NO TRATAMENTO DE MIELOMA MÚLTIPLO ELEGÍVEL AO TRANSPLANTE AUTÓLOGO DE CÉLULAS-TRONCO HEMATOPOIÉTICAS (TACTH) NO SUS

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Introdução: O mieloma múltiplo (MM) é uma neoplasia hematológica da medula óssea, causada pela proliferação clonal de

plasmócitos. Entre 2008 e 2017, a incidência no Brasil foi estimada em 1,24 casos por 100 mil habitantes. Clinicamente, o MM se manifesta por hipercalcemia, insuficiência renal, anemia ou lesões ósseas líticas; associadas à ≥ 10% de plasmócitos clonais na medula. No Sistema Único de Saúde (SUS), antes de 2022, o tratamento era baseado em agentes alquilantes, corticoides e imunomoduladores, com destaque para o esquema talidomida, ciclofosfamida e dexametasona (CTD). Para pacientes elegíveis, o TACTH é uma terapêutica consolidada. Em 2022, o bortezomibe foi implementado no SUS. **Objetivos:** Avaliar dados clínicos-laboratoriais e resposta ao tratamento com CTD seguidos de TACTH em pacientes com MM. **Material e métodos:** Estudo retrospectivo com análise de prontuários de pacientes tratados com CTD seguido de TACTH em um serviço do SUS, antes da implementação do bortezomibe. **Resultados:** Foram avaliados 23 pacientes no diagnóstico. A idade variou entre 42 e 74 anos (média de 61,17; mediana 62), com predomínio feminino (60,87%). O pico monoclonal foi detectado em 43,47% e em 65,22% casos, pela eletroforese de proteínas (EP) e imunofixação sérica (IFS), respectivamente. Quanto ao estadiamento ISS (International Scoring System): 47,83% estavam em estágio III, 17,39% em II e 34,78% em I. Em relação às manifestações: 30,43% apresentaram hipercalcemia (média cálcio iônico: 2,70; mediana 1,27); 9% insuficiência renal (média creatinina: 1,79 mg/dL; mediana: 0,9 mg/dL); anemia (hemoglobina média: 10,67 g/dL; mediana 9,9 g/dL); e 34,78% tinham ≥1 lesão osteolítica. A média de plaquetas foi de 243.957/mm^3 (mediana: 235.000/mm^3). Todos foram submetidos ao TACTH: 9% menos de 12 meses, 78,26% em 1 ano, e 13% após mais de 1 ano. Quanto à resposta: 26,09% alcançaram resposta completa (RC), 4,34% resposta parcial muito boa (RPMB), 30,43% resposta parcial (RP) e 39,13% resposta ausente (RA). O tempo de seguimento teve média de 5,17 anos (mediana: 4 anos). **Discussão:** A média etária (61,17 anos) está de acordo com a epidemiologia do MM, predominando após 60 anos. Apesar do leve predomínio masculino na literatura, observou-se maior proporção de mulheres (60,87%). A alta frequência de pacientes em ISS III (47,83%) sugere diagnóstico tardio, refletindo barreiras no acesso precoce. A anemia foi a manifestação mais comum (73,91%). A alta taxa de pico monoclonal na IFS (65,22%) reflete a elevada prevalência desse achado em pacientes com MM e reforça a maior sensibilidade da técnica em relação à EP. O tempo prolongado até o TACTH, maioria após 12 meses, pode comprometer os desfechos, sendo o ideal entre 4 e 6 meses após a indução. A taxa de RC (26,1%) é semelhante à de estudos com CTD em populações sem acesso ao bortezomibe. Apesar de inferior aos esquemas modernos, o CTD segue como opção viável e custo-efetiva no SUS diante das limitações de acesso a novas terapias. **Conclusão:** O regime CTD seguido de TACTH demonstrou eficácia em parte dos pacientes, mesmo com limitações. O diagnóstico tardio e longo intervalo até o TACTH revelam fragilidades no SUS. Estratégias para diagnóstico e tratamento precoce são fundamentais para melhorar os desfechos no MM.

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HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH TRANSPLANT-INELIGIBLE OR TRANSPLANT-DEFERRED NEWLY DIAGNOSED MULTIPLE MYELOMA (MM) IN THE PHASE 3 CEPHEUS TRIAL

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Introduction: Previous daratumumab clinical trials showed no detriment to health-related quality of life (HRQoL) with addition of daratumumab as part of a triplet or quadruplet treatment regimen. In the phase 3 CEPHEUS trial (NCT03652064), minimal residual disease negativity and progression-free survival improved with subcutaneous daratumumab plus bortezomib and Rd (DVRd) vs VRd in pts with newly diagnosed multiple myeloma (NDMM). **Objetives:** Evaluate HRQoL of DVRd vs VRd in CEPHEUS. **Material and methods:** Pts had transplant-ineligible (TIE) or transplant-deferred (TD) NDMM, ECOG performance status ≤2, and International Myeloma Working Group frailty score ≤1. Pts were randomized 1:1 to DVRd or VRd. Patient-reported outcomes (PROs) were evaluated at baseline (BL), once each cycle to C8D1, and every 3rd C from C9D1 until disease progression. PROs included the European Organization for Research and Treatment of Cancer quality of life questionnaire core 30 (EORTC QLQ-C30), EORTC QLQ multiple myeloma 20 (EORTC QLQ-MY20), and the EuroQol 5-Dimension 5-Level (EQ-5D-5L). **Results:** The intent-to-treat population had 395 pts (DVRd, n = 197; VRd, n = 198). Median follow-up was 58.7 months; 135 pts in the DVRd arm and 106 in the VRd arm were on study treatment at C36. Compliance was >85% at BL and >81% through C36 in both arms. For all questionnaires, BL means were comparable, and similar improvements in least square (LS) mean change from BL were seen across arms. At C36, the LS mean change from BL (95% CI) in EORTC QLQ-C30 global health status was 8.2 for DVRd and 8.5 for VRd with no apparent difference between arms. For EORTC QLQ-C30, the LS mean change from BL at C36 was 3.6 for DVRd and 5.1 for VRd (difference −1.5 [−6.4,