UK Expert Delphi Consensus on Managing Talquetamab-Associated Oral Side Effects and Weight Loss in Patients With Multiple Myeloma

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https://www.congresshub.com/Oncology/IMS2026/Talquetamab/Mehrjou

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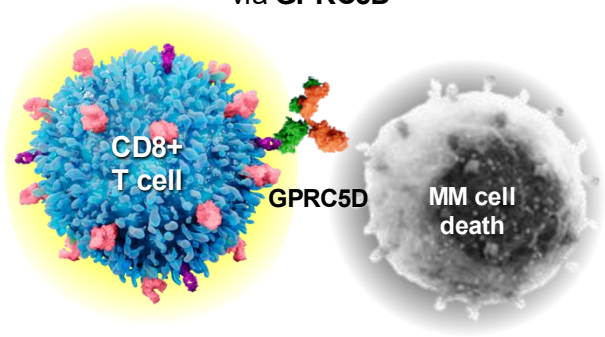
Talquetamab background

Talquetamab monotherapy

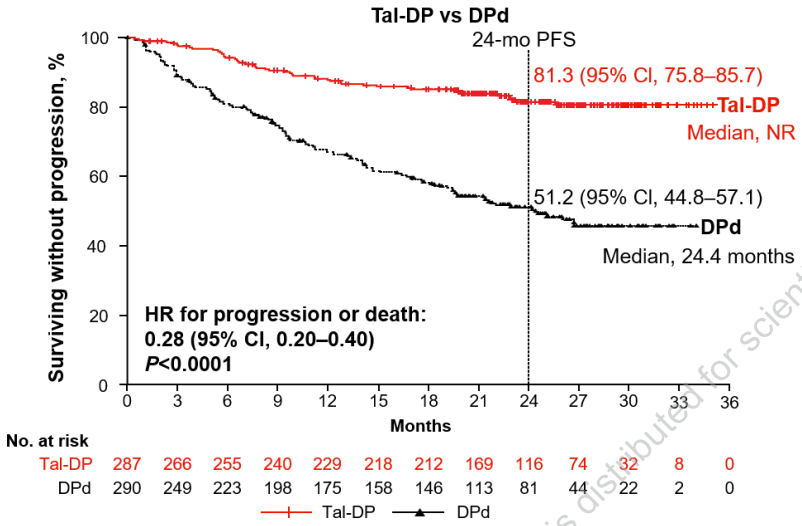
- Talquetamab is the first GPRC5D-targeting bispecific antibody approved for relapsed/refractory multiple myeloma (RRMM), eliciting high response rates and a 3-year overall survival rate of 60.8% as a monotherapy,[1] with meaningful improvements in quality of life[2]

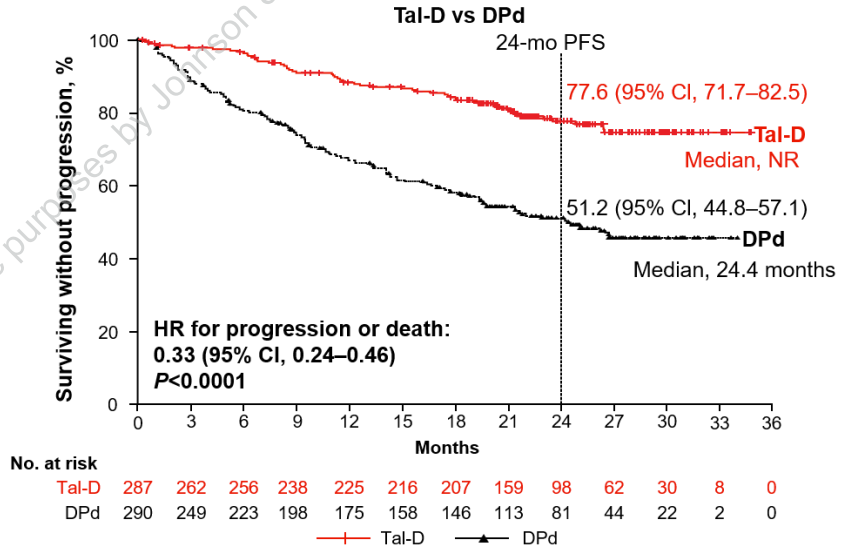
activates T cells and **redirects** them to MM cells via **GPRC5D**



Talquetamab combination therapy

- In MonumenTAL-3 Tal-DP and Tal-D significantly improved PFS vs DPd[3]





Clinical cut-off: November 3, 2025. Median follow-up of 24.6 months. The O'Brien-Fleming stopping boundary for superiority was crossed for Tal-DP and Tal-D (*P*<0.0001 both arms; Tal-DP boundary, *P*=0.0069; Tal-D boundary, *P*=0.0145). HR, hazard ratio.

1. Rasche L, et al. ASCO 2025. Poster presentation P96; 2. Schinke C, et al. Blood. 2023;142(suppl 1):6711; 3. Mina R, et al. N Engl J Med 2026; doi: 10.1056/NEJMoa2604657. Adapted with permission © The *New England Journal of Medicine* (2026).

Talquetamab background: MonumenTAL-3: Most Common AEs[1]

- Higher rate of neutropenia with Tal-DP and DPd vs Tal-D, consistent with known profile of Pom[2-3]
- With Tal-DP and Tal-D, CRS mostly grade 1 (55.8%, 48.9%), with 11.2% and 8.8% grade 2
  - All but 1 event resolved
- ICANS: 2.9% (Tal-DP), 1.8% (Tal-D); all resolved

	TEAE, n (%)	Tal-DP (n=276)		Tal-D (n=274)		DPd (n=283)	
		Any Grade	Grade 3/4	Any Grade	Grade 3/4	Any Grade	Grade 3/4
Hematologic	Neutropenia	232 (84.1)	211 (76.4)	112 (40.9)	80 (29.2)	255 (90.1)	244 (86.2)
	Anemia	136 (49.3)	66 (23.9)	107 (39.1)	41 (15.0)	117 (41.3)	45 (15.9)
	Thrombocytopenia	136 (49.3)	66 (23.9)	93 (33.9)	36 (13.1)	108 (38.2)	39 (13.8)
	Lymphopenia	99 (35.9)	86 (31.2)	82 (29.9)	68 (24.8)	72 (25.4)	50 (17.7)
Non-hematologic	Infections	241 (87.3)	104 (37.7)	231 (84.3)	80 (29.2)	235 (83.0)	120 (42.2)
	Taste changes[b]	201 (72.8)	–	205 (74.8)	–	11 (3.9)	–
	Non-rash skin AE[c]	191 (69.2)	6 (2.2)	177 (64.6)	7 (2.6)	24 (8.5)	0
	CRS	187 (67.8)	2 (0.7)	160 (58.4)	2 (0.7)	–	–
	Nail-related AE[d]	155 (56.2)	1 (0.4)	157 (57.3)	1 (0.4)	1 (0.4)	0
	Pyrexia	127 (46.0)	8 (2.9)	112 (40.9)	3 (1.1)	35 (12.4)	2 (0.7)
	Decreased weight	126 (45.7)	21 (7.6)	105 (38.3)	13 (4.7)	21 (7.4)	1 (0.4)
	Rash AE[e]	105 (38.0)	5 (1.8)	107 (39.1)	7 (2.6)	43 (15.2)	1 (0.4)
	Fatigue	83 (30.1)	14 (5.1)	60 (21.9)	8 (2.9)	69 (24.4)	9 (3.2)

The safety profiles of Tal-DP and Tal-D were consistent with known effects of each agent

[a]>30% of patients in any treatment arm. [b]Taste changes included dysgeusia, ageusia, hypogeusia, and taste disorder. Per the Common Terminology Criteria for Adverse Events, the maximum severity for taste changes is grade 2. [c]Non-rash skin adverse events included skin exfoliation, dry skin, palmar plantar erythrodysesthesia and pruritus. [d]Nail-related adverse events included nail discoloration, nail disorder, onycholysis, onychomadesis, onychoclasis, and nail ridging. [e]Rash adverse events included rash, maculopapular rash, erythematous rash, and erythema. AE, adverse event; CRS, cytokine release syndrome; ICANS, immune effector cell–associated neurotoxicity syndrome.

1. Mina R, et al. N Engl J Med 2026; doi: 10.1056/NEJMoa2604657. Adapted with permission © The *New England Journal of Medicine* (2026). 2. Dimopoulos MA, et al. *Lancet Oncol* 2021;22:801-12. 3. Richardson PG, et al. *Lancet Oncol* 2019;20:781-94.

Talquetamab associated oral side effects and weight loss are common and clinically meaningful

~70%[1]	~30%[1]	~15%[1]	~46%[2]
taste disturbance	xerostomia	stomatitis	weight decreased

Oral Side Effects

- These symptoms can substantially affect patients' quality of life, resulting in reduced enjoyment of food and drink, impaired oral intake, reduced appetite and subsequent weight loss[3]
- Discontinuation due to oral adverse events is infrequent[2,4]
- Severe dysgeusia and dry mouth tend to stabilize or improve by 4-6 cycles[5]
- Prophylactic dexamethasone or pregabalin does not improve the onset, incidence or severity or oral side effects[6]

Weight Loss

- Weight recovery may lag behind improvement in oral symptoms[3]
- Weight loss is greatest in the first 6 months then stabilizes with a smaller magnitude of loss in healthy or underweight patients[5]

1. Chari A, et al. Lancet Haematol. 2025;12(4):e269-e; 2. Mina R, et al. N Engl J Med 2026; doi: 10.1056/NEJMoa2604657 3. Naqvi S et al. EJHaem. 2024;5(4):789-92; 4. Popat R, et al Blood. 2025;146(Supplement 1):4573; 5. Mina R, et al. N Engl J Med 2026; doi: 10.1056/NEJMoa2604657; 6. NWCJ van de Donk et al, (EHA) 2026 Congress; June 11–14, 2026; Stockholm, Sweden

Study Objective

To generate multidisciplinary consensus recommendations for:

Diagnosis, monitoring and management of talquetamab-associated oral side effects and weight loss

Delphi Methods

A modified 2-round Delphi panel

Evidence review
HTA and literature inputs

Steering Committee
4 UK experts; statement review

Round 1
41 statements + 1 opened ended question

Controlled feedback
Aggregate results and comments

Round 2
14 revised statements

Final synthesis
Consensus recommendations

Multidisciplinary UK Expert Panel

- The expert panel met pre-defined eligibility, participants were prioritised according to standardised expertise grading and geography
- 29 HCPs completed ≥1 round including:

10 Haematologists (34.5%), 8 Clinical Nurse Specialists (27.6%), 8 Specialist Dietitians (27.6%) and 3 Haematology Pharmacists (10.3%)

- All worked in teaching hospitals; most based in tertiary centres across the four UK nations

Consensus was pre-defined and graded

≥75%
agreement or disagreement required for consensus

U	A	B	C
100%	91–99%	81–90%	75–80%

Results: Three quarters of statements reached consensus

41 / 55

statements reached consensus overall

Round 1

29/41 (71%) reached consensus

Round 2

12/14 (86%) reached consensus

75% consensus achieved

Controlled feedback increased agreement while important uncertainties remained

Results: Risk assessment should start before talquetamab

96% agree (A)

Baseline weight assessment

81% agree (B)

Identification of higher risk of morbidity associated with treatment related weight loss

75% agree (C)

Where dietitian referral was not possible, provision of simple dietary advice and signposting to educational resources

High Risk Factors

- Previous bodyweight loss of 10% or more
- Baseline BMI of <20 kg/m^2
- History of significant loss of appetite on previous treatment
- And / or active eating disorder

High-risk patients: consider dietitian referral where feasible — 93% agree

Results: Monitor early, repeatedly and beyond the clinic visit

Initiation	First 4 weeks	Every administration	Every ~4 weeks	Between visits
baseline symptoms and weight. Refer increased risk patients to dietitian	highest vigilance for early oral toxicity	targeted symptom review	ongoing weight monitoring	clear reporting and escalation route

- Prioritise dysgeusia, xerostomia, mucositis and dysphagia - 100% agree (U)
- Assess for alternative or contributory causes, including thrush/candidiasis - 100% agree (U)
- Clear escalation pathways - 96% agree (A)
- Shared multidisciplinary team responsibility - 89% agree (B)

Careful monitoring for oral toxicity for all patients (100% agree), from initiation and at every subsequent administration, continuing throughout treatment (89% agree)

Results: Patient-reported assessment should complement clinical review

Open conversation

Foundational for detecting changes in taste, oral comfort, eating and quality of life – 100% agree (U)

Clinical grading

CTCAE[1] alone was considered insufficient to describe severity — 78% agree (C)

Selected PRO-CTCAE[2] items

May support consistent detection, particularly for less experienced teams — 96% agree (A)

In the last 7 days,

- what was the SEVERITY of your DRY MOUTH at its WORST?
- what was the SEVERITY of your DIFFICULTY SWALLOWING at its WORST?
- what was the SEVERITY of your MOUTH OR THROAT SORES at their WORST?
- how much did MOUTH OR THROAT SORES INTERFERE with your usual or daily activities?
- what was the SEVERITY of your PROBLEMS WITH TASTING FOOD OR DRINK at their WORST?

Targeted symptom review should be supplemented, where possible, by patient-reported outcome measures (PROMs) for detection and monitoring of oral toxicities and weight loss (79% agree)

1. CTCAE, Common Terminology Criteria for Adverse Events; 2. Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events

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Results: Education is the preferred pre-emptive strategy

93%

agreed patient and carer education is the best current pre-emptive approach

- Explain possible symptoms and risk during consent with reassurance that side effects typically resolve over time and provide clear patient instruction for reporting and escalation - 96% agree (A)
- Signpost to high quality, accessible self-management and nutrition resources - 82% agree (B)
- Clinical teams should have access to a centralized repository of key resources - 89% agree (B)

Effectiveness of medical prophylaxis remains an evidence gap

Results: Early dietetic input and MDT ownership are central

Refer early

Appetite loss due to dysgeusia - 89% agree (B) for dietitian referral at the earliest opportunity.

Weight loss triggers for dietitian referral

>5% since talquetamab, >10% from usual weight, or BMI <20 kg/m² should prompt dietitian referral - 79% agree (C)

Plan for limited access

Where dietitian support is unavailable upskill the myeloma MDT - 79% agree (C)

Without access to dietitian support, patients meeting any of the following criteria should be prescribed nutritional supplements in accordance with local pathways:

- Experience weight loss of 10% or more from usual weight, OR
- Experience weight loss of 5% or more from usual weight AND whose BMI falls below 20 kg/m^2, OR
- Experience weight loss of 5% or more since starting talquetamab

81% agree (B)

Results: Individualised supportive strategies reached consensus

Dysgeusia

Smaller meals every 2–3 hours; oral hydration; tailor foods to preference 85% (B)

Dry mouth / swallowing difficulty

Avoid dry food 96% (B); sip liquid between bites 93% (B); regular small sips 78 (C); small bites 85% (B); smaller meals every 2–3 hours 89% (B), sit upright 78% (C)

Xerostomia

Regular sips of water; consider sugar-free gum or boiled sweets 78% (C)

Reduced appetite

Maximise protein and calorie intake; consider high-calorie supplements 79% (C)

Results: Where consensus was not reached

Prophylactic medical interventions

Evidence is evolving; no definitive consensus on the role of prophylaxis.

Taste severity tools

Routine STTA use did not reach consensus.

Reactive management

The proposition that management should primarily be reactive did not reach consensus. Highlighting the need for proactive management.

Specific dietary options

Several individual options failed initially but broader preference-based advice gained support in Round 2.

Consensus wasn't reached due to uncertainty rather than strong disagreement

Implications for Clinical Practice

1	**Before treatment**	Record weight and nutritional history; identify vulnerability; educate patient and carer.
2	**During treatment**	Ask proactively at each contact; use selected PRO prompts; document weight regularly.
3	**When symptoms emerge**	Exclude alternative causes; start supportive care; enable rapid escalation.
4	**When intake or weight declines**	Refer early to dietetics; use MDT/local pathways when specialist access is limited.

Note Limitations include:

- Expert opinion rather than prospective outcome evidence
- UK-only panel, predominantly tertiary/teaching centres

Conclusions

Oral side effects and weight loss warrant proactive supportive care

Baseline risk assessment and early, ongoing monitoring are recommended

Patient/carer education is the preferred current pre-emptive strategy

Open communication and selected PRO items can improve detection

Early dietetic referral and coordinated MDT escalation are central

Acknowledgements

With thanks to all 29 Expert Panel participants and the multidisciplinary Steering Committee