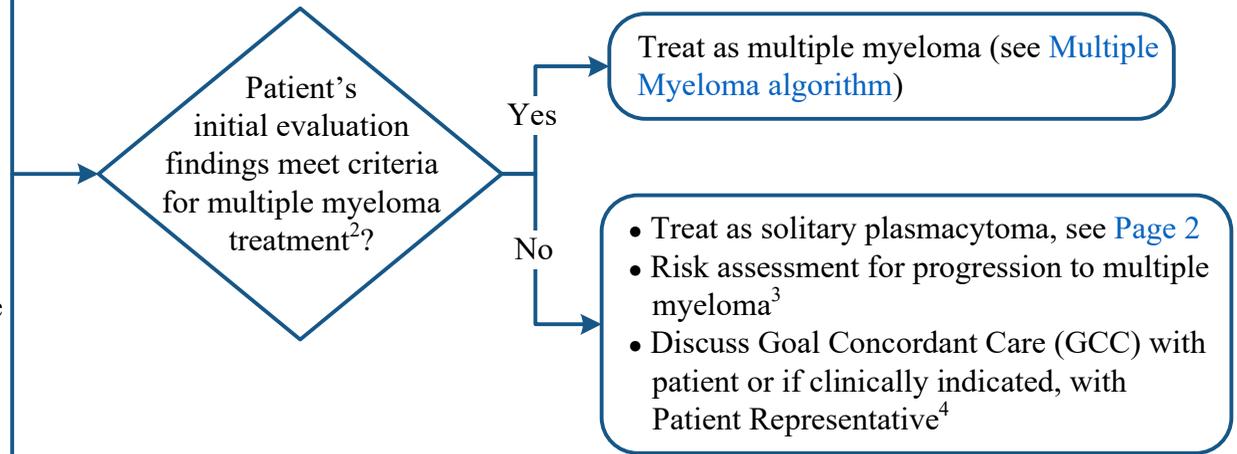


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**Note:** Consider Clinical Trials as treatment options for eligible patients.

## INITIAL EVALUATION

- History and physical (if palpable upon physical examination, document the size of mass)
- CBC with differential, CMP, LDH, beta-2-microglobulin, serum quantitative immunoglobulins, serum protein electrophoresis, serum immunofixation, serum free light chains (kappa and lambda), and quantitative immunoglobulins (IgG, IgM, IgA)
- 24-hour urine protein electrophoresis and urine immunofixation
- Bone marrow biopsy and aspirate (immunohistochemistry, flow cytometry, cytogenetics, and FISH; molecular diagnostics if available and indicated)
- Tissue biopsy (immunohistochemistry, flow cytometry, cytogenetics, and FISH; molecular diagnostics if available and indicated)
  - Touch imprints for additional FISH testing as clinically indicated
- PET/CT of whole body **or** non-contrast MRI of whole body
- If PET/CT of whole body or MRI of whole body is unavailable, then perform MRI of the cervical, thoracic, lumbar spine with and without contrast
- Consider CT with contrast or MRI with and without contrast of the affected area, if clinically indicated
- Lifestyle risk assessment<sup>1</sup>



## TREATMENT

CMP = comprehensive metabolic panel  
 FISH = fluorescence in situ hybridization

<sup>1</sup> See [Physical Activity, Nutrition, Obesity Screening and Management](#) and [Tobacco Cessation Treatment](#) algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

<sup>2</sup> Criteria for multiple myeloma treatment:

- Anemia, hypercalcemia, renal failure due to multiple myeloma **and/or**
- Bony lytic lesions due to multiple myeloma in a skeletal survey **and/or** MRI of whole body and/or PET/CT of whole body **and/or**
- Serum free light chains involved:uninvolved ratio  $\geq 100$  **and/or**
- Greater than one focal lesions on MRI (each focal lesion must be 5 mm or more in size) **and/or**
- Percentage of clonal plasma cells is  $\geq 60\%$  in the core biopsy by CD138 immunohistochemistry

**Note:** Treatment may be considered if percentage of clonal plasma cells is  $\geq 10\%$  in the core biopsy by CD138 immunohistochemistry

<sup>3</sup> Risk assessment:

- Plasmacytoma size  $\geq 5$  cm at diagnosis
- Persistent presence of serum paraprotein 1 year after treatment

Rates of progression to multiple myeloma for patients with 1 or 2 risk factors:

- 3 years from diagnosis – 65%
- 5 years from diagnosis – 70%
- 10 years from diagnosis – 82%

<sup>4</sup> GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

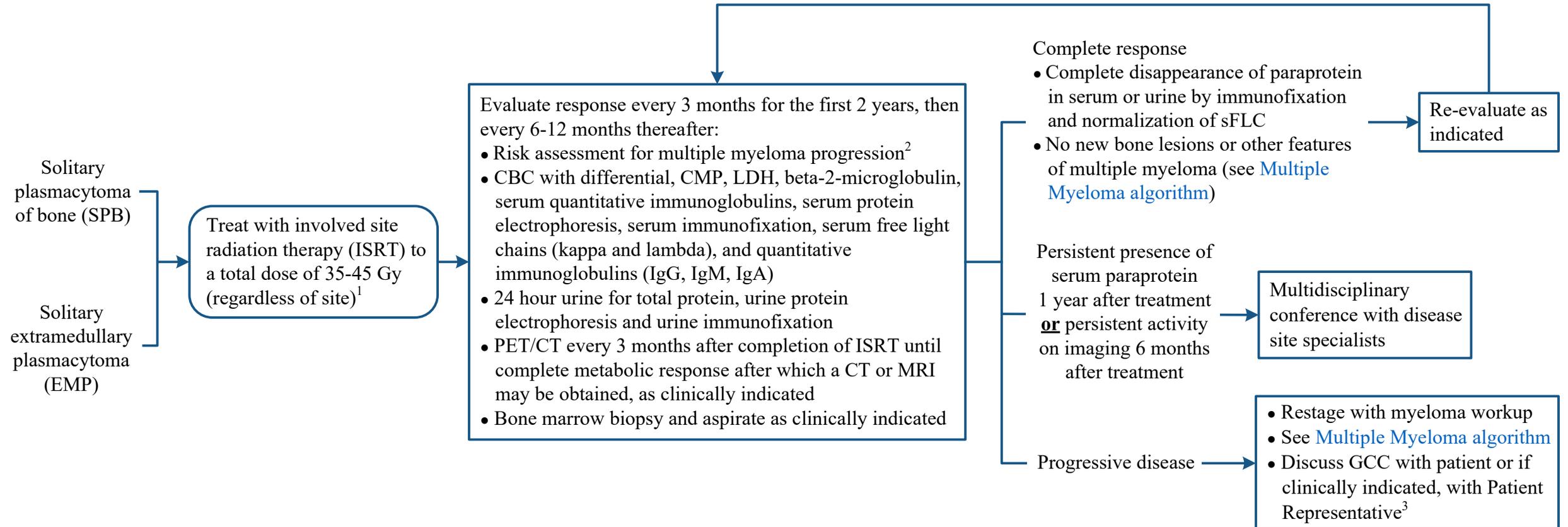
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**Note:** Consider Clinical Trials as treatment options for eligible patients.

## CLINICAL PRESENTATION

## PRIMARY TREATMENT

## FOLLOW-UP SURVEILLANCE



<sup>1</sup> Although historically the recommended dose has been 40-50 Gy, more recent data suggests that lower doses may be sufficient (35 Gy for lesions < 5 cm). Refer to suggested readings for data regarding ISRT dose.

<sup>2</sup> Risk assessment:  
 • Plasmacytoma size ≥ 5 cm at diagnosis  
 • Persistent presence of serum paraprotein 1 year after treatment

Rates of progression to multiple myeloma for patients with 1 or 2 risk factors:  
 • 3 years from diagnosis – 65%  
 • 5 years from diagnosis – 70%  
 • 10 years from diagnosis – 82%

<sup>3</sup> GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

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## DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Myeloma Center providers at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

### Core Development Team Leads

Christine Ye, MD (Lymphoma/Myeloma)

### Workgroup Members

Behrang Amini, MD (Musculoskeletal Imaging)

Melody Becnel, MD (Lymphoma/Myeloma)

Bouthaina Dabaja, MD (Radiation Oncology)

Penny Fang, MD (Radiation Oncology)

Wendy Garcia, BS♦

Andres Quesada, MD (Hematopathology Administration)

Claudio Tatsui, MD (Neurosurgery)

Mary Lou Warren, DNP, APRN, CNS-CC♦

♦ Clinical Effectiveness Development Team