**Survivorship – Acute Myelogenous Leukemia (AML)**

**ELIGIBILITY**
AML patients 4 years post diagnosis and in remission

**CONCURRENT COMPONENTS OF VISIT**
Year 4, every 6 months. Then starting year 5, annually:
- History and physical examination
- CBC with differential
- Chemistries (glucose, calcium, creatinine, sodium, potassium, bilirubin, ALT, LDH, uric acid)
- Coagulation profile
- Bone marrow aspiration if peripheral smear is abnormal or cytopenias develop

**SURVEILLANCE**

**MONITORING FOR LATE EFFECTS**
Consider:
- Cardiovascular screening\(^2\) annually and monitor cardiac function if patient is symptomatic
- Lipid panel annually
- Bone Health (see Survivorship – Breast Cancer: Bone Health algorithm)

**RISK REDUCTION/EARLY DETECTION**

**PSYCHOSOCIAL FUNCTIONING**
See Page 2

**DISPOSITION**

Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative\(^1\)
- Continue survivorship monitoring

**Suspected new primary or relapsed disease?**
- Yes
- No

\(^1\) 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).

\(^2\) Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health

ALT = alanine aminotransferase
LDH = lactate dehydrogenase

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

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Department of Clinical Effectiveness V5
Approved by the Executive Committee of the Medical Staff on 04/16/2024
Survivorship – Acute Myelogenous Leukemia (AML)

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ACIP = Advisory Committee on Immunization Practices

1 See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

2 Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate and skin cancer screening

3 Based on Centers for Disease Control and Prevention (CDC) guidelines

4 Adults age 50 years and older with a history of chickenpox or shingles

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**Eligibility**

- AML patients 4 years post diagnosis and in remission

**Concurrent Components of Visit**

- Patient education, counseling and screening:
  - Lifestyle risk assessment
  - Cancer screening
  - Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
  - Vaccinations as appropriate
    - Human papillomavirus (HPV) vaccination as clinically indicated (see HPV Vaccination algorithm)
    - For pneumococcal vaccine schedules, see Appendix A
    - Influenza vaccination yearly
    - Consider one dose of tetanus-diphtheria-pertussis (Tdap) vaccine as an adult if patient has not received Tdap previously and there are no contraindications. Thereafter tetanus-diphtheria (Td) vaccination every 10 years.
    - Zoster Vaccine Recombinant, Adjuvanted (Shingrix) can be considered for patients who have had a shared patient-provider conversation regarding the vaccine and meets ACIP criteria
    - Covid-19 vaccination as per CDC guideline
    - Hepatitis B vaccination as per CDC guideline
    - No live, attenuated vaccine
    - Recommendations for vaccination of household members
    - Patients should inform their providers about plans to travel outside of the US at least one month in advance for appropriate counseling and vaccinations

**Disposition**

- Refer or consult as indicated
# APPENDIX A: Pneumococcal Vaccine Schedules for Adults

<table>
<thead>
<tr>
<th>Prior Vaccines</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>None or Unknown</td>
<td>1 dose of PCV20</td>
</tr>
<tr>
<td>PPSV23 only</td>
<td>1 dose of PCV20 at least 1 year after the last PPSV23 dose</td>
</tr>
<tr>
<td>PCV13 only</td>
<td>1 dose of PCV20 at least 1 year after PCV13</td>
</tr>
<tr>
<td>PCV13 at any age and PPSV23 before 65 years</td>
<td>1 dose of PCV20 at least ≥ 5 years after the last pneumococcal vaccine</td>
</tr>
<tr>
<td>PCV13 at any age and PPSV23 at 65 years or older</td>
<td>The decision to administer 1 dose of PCV20 at least ≥ 5 years of last pneumococcal vaccine is a shared clinical decision between the patient and the provider</td>
</tr>
</tbody>
</table>

PCV13 = pneumococcal 13-valent conjugate vaccine  
PCV20 = pneumococcal 20-valent conjugate vaccine  
PPSV23 = pneumococcal polysaccharide 23-valent vaccine

1 Based on Centers for Disease Control and Prevention (CDC) guidelines  
2 Refer to the CDC pneumococcal vaccination summary or the CDC PneumoRecs VaxAdvisor clinical support tool for comprehensive pneumococcal vaccination recommendations
SUGGESTED READINGS


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy

Advance Care Planning (ACP) Conversation Workflow (ATT1925)


Survivorship – Acute Myelogenous Leukemia (AML)

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

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