Survivorship – Indolent B-Cell Lymphomas[1]

ELIGIBILITY

Indolent B-Cell Lymphoma, 5 years post treatment and NED **or** co-management with oncologist at any time post treatment

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

- Annual history and physical examination with full nodal survey
- Annual CBC with differential, CMP, lipid panel, and vitamin D 25-OH
- Imaging: Consider CT[2] chest, abdomen, and/or pelvis (see Appendix A for recommended schedule)

New primary or recurrent disease?

- Yes → Return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[3]
- No → Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

Consider:

- Annual cardiovascular screening (see Survivorship – Adult Cardiovascular Screening algorithm)
- Women who received radiation to the chest should receive annual breast cancer surveillance at age 25, or 8 years after radiation, whichever occurs later, with annual mammogram and breast MRI (bilateral) with contrast (see Breast Cancer Screening algorithm)
- Annual thyroid-stimulating hormone (TSH) and free T4 if prior radiation to the neck or the chest
- Annual skin examination
- Colorectal cancer screening (see Colorectal Cancer Screening algorithm)
- Bone health education and screening via DEXA scan starting at age 40
- Monitor for neuropathy symptoms
- Check immunoglobulin levels as clinically indicated
  - Annually for patients whose prior levels showed continued persistent deficiencies post treatment
  - Every 6 months for patients with a history of recurrent infections

→ Refer or consult as indicated

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

→ See Page 2

NED = no evidence of disease
CMP = complete metabolic panel
DEXA = dual-energy x-ray absorptiometry

[1] This algorithm contains the following subtypes: follicular, marginal zone, small lymphocytic, lymphoplasmacytic, nodular lymphocyte predominant (NLP) Hodgkin lymphomas, Castleman's disease, Rosai-Dorfman Syndrome
[2] Consider surveillance CT scans with contrast, if not contraindicated, and CT scans without and with contrast only for the initial CT study
[3] 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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Survivorship – Indolent B-Cell Lymphomas

ELIGIBILITY

Indolent B-Cell Lymphoma, 5 years post treatment and NED **or** co-management with oncologist at any time post treatment

CONCURRENT COMPONENTS OF VISIT

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[1]
- Cancer screening[2]
- Vaccinations[3] as appropriate
  - Annual influenza vaccination, COVID complete vaccination and boosters, Tdap, shingles vaccine (if not already given), and other adult vaccines based on age and immune status (see NCCN Guidelines: Survivorship: Immunizations and Infections)
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Sleep disorder and consider referral to Sleep Clinic
- Access to primary health care
- Relationship issues
- Employment status/financial issues
- Patient related outcomes

CHRONIC HEALTH MAINTENANCE

- Confirm primary care provider (PCP) or recommend establishing care with a local PCP
- PCP responsible for assessment and management of non-cancer chronic health conditions (hyperlipidemia, diabetes, hypertension, *etc.*) or refer as indicated

DISPOSITION

Refer or consult as indicated

[1] 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
[2] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[3] Based on American Society of Clinical Oncology (ASCO) guidelines. For COVID information, see CDC COVID vaccination guidelines.

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Survivorship – Indolent B-Cell Lymphomas

APPENDIX A: Schedule for Surveillance of Relapse with CT Scans[1]

Low risk for relapse: limited stage disease, low tumor burden any stage
- Every 6 months for 2 years then yearly until year 5 **and**
- As indicated by new signs or symptoms suggesting relapse

High risk for relapse: high tumor burden meeting Group d'Etude des Lymphomes Folliculaires (GELF) criteria[2]
- Every 4 months for 2 years then yearly until year 10 **and**
- As indicated by new signs or symptoms suggesting relapse

[1] Consider surveillance CT scans with contrast, if not contraindicated, and CT scans without and with contrast only for the initial CT study

[2] High tumor burden defined as meeting one of the following GELF criteria:
- Any nodal or extranodal tumor mass > 7 cm in diameter
- Involvement of at least 3 nodal sites, each with a diameter > 3 cm
- Presence of any systemic or B symptoms
- Splenic enlargement with inferior margin below the umbilical line
- Compression syndrome (ureteral, orbital, gastrointestinal)
- Pleural or peritoneal serous effusion (irrespective of cell content)
- Leukemic phase (> 5.0 x 109/L circulating malignant cells)
- Cytopenia (granulocyte count < 1.0 x 109/L and/or platelets < 100 x 109/L)
- Serum lactate dehydrogenase or beta2-microglobulin level above normal values

SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

Continued on next page

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