Survivorship – Plasma Cell Dyscrasias

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Survivorship – Multiple Myeloma

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ELIGIBILITY

Patients with multiple myeloma:
- On maintenance therapy
  or
- Maintenance therapy has been discontinued
  or
- 6 months post-CAR T-cell therapy

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Every 1 - 3 months[1]:
- History and physical exam
- CBC with differential
- Comprehensive metabolic panel (CMP)
- Serum protein electrophoresis
- Free kappa light chain
- Free lambda light chain
- Serum immunoglobulins - IgG, IgA, IgM (obtain IgD or IgE as indicated)
- Serum protein electrophoresis with immunofixation electrophoresis (IFE)

Annually or as clinically indicated:
- Imaging: PET/CT whole body or MRI whole body - bone marrow
- Mini-Cog©

Consider as clinically indicated:
- Lactate dehydrogenase (LDH)
- Uric acid
- Beta-2 microglobulin
- Neurological exam (CAR-T patients only)
- Urine protein electrophoresis with IFE

MONITORING FOR LATE EFFECTS

RISK REDUCTION/ EARLY DETECTION

→ See Page 3

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

→ See Page 4

DISPOSITION

Suspected new concern for new amyloidosis diagnosis, 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[2]

No → Continue survivorship monitoring

CAR = chimeric antigen receptor

[1] Follow up every 6 months may be considered for long-term survivors (≥ 3 years) post-CAR T-cell therapy if MRD (minimal residual disease) negative and received ciltacabtagene autoleucel

[2] 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 – Multiple Myeloma

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ELIGIBILITY

Patients with multiple myeloma:
- On maintenance therapy
  or
- Maintenance therapy has been discontinued
  or
- 6 months post-CAR T-cell therapy

(continued from previous page)

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Consider:
- Cardiovascular screening for patients on carfilzomib **or** who have received radiation to chest (see Survivorship - Adult Cardiovascular Screening algorithm)
- Pulmonary function test **and** chest x-ray for patients with history of radiation to chest wall
- Neuropathy assessment, including:
  - Copper level
  - Vitamin B12 level
  - Methylmalonic acid (MMA) quantitative, serum
  - Vitamin B6 level
- Bone health monitoring as clinically indicated:
  - Vitamin D 25-OH
  - Bone density screening
- Pain management evaluation
- Neurotoxicity assessment
- Lipid panel
- Hemoglobin A1c
- Patients who received radiation to head/neck:
  - TSH
  - T4
- CAR-T patients:
  - Evaluate persistent diarrhea/colitis
  - Evaluate persistent neurological symptoms
- Integrative Medicine service consult for lifestyle change, mind-body therapies, acupuncture/massage, supplement consultation, etc.

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[1]
- Cancer screening[2]
- 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
  - For patients who are post-SCT, follow institutional vaccine guidelines (refer to Stem Cell Transplantation and Cellular Therapy page, for internal use only)
  - For patients who are post-CAR T-cell therapy, follow institutional vaccine guidelines (refer to CARTOX page, for internal use only)
  - For patients who are **not** post-CAR T-cell therapy or post-SCT, follow American Society of Clinical Oncology (ASCO) guidelines and Centers for Disease Control and Prevention (CDC) guidelines
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
  - For patients who receive ≥ 50% splenic irradiation, see Management of Adult Asplenic/Hyposplenic Patients algorithm

DISPOSITION

Refer or consult as indicated

CAR = chimeric antigen receptor
SCT = stem cell transplant

[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

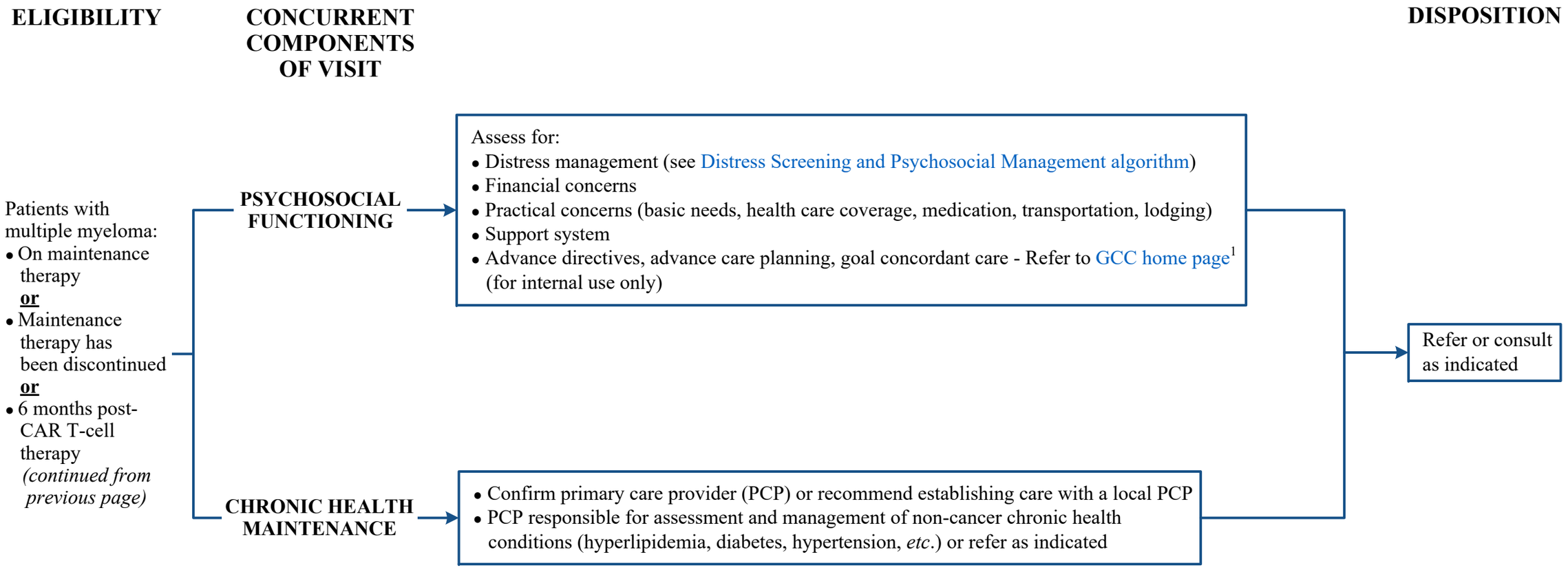
[2] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

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Survivorship – Multiple Myeloma

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CAR = chimeric antigen receptor

[1] Goal concordant care (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 – MGUS

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ELIGIBILITY

Patients with:

High-intermediate risk[1] MGUS (any two of the following)

or

High-risk[1] MGUS (all three of the following):

- Serum monoclonal protein ≥ 1.5 grams/dL
- Non-IgG subtype (IgA or IgM)
- Abnormal light chain ratio of involved light chain to uninvolved

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Every 3 - 6 months:

- History and physical exam, including neurological exam and Mini-Cog©
- CBC with differential
- Comprehensive metabolic panel (CMP)
- Serum protein electrophoresis
- Free lambda light chain
- Free kappa light chain
- Serum immunoglobulins - IgG, IgA, IgM (obtain IgD or IgE as indicated)
- Serum protein electrophoresis with immunofixation electrophoresis (IFE)

Annually or as clinically indicated:

- Imaging: MRI whole body - bone marrow
- Urine protein electrophoresis with IFE

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

See Page 6

Suspected new concern for new amyloidosis diagnosis, new primary, or recurrent disease?

DISPOSITION

Yes

Return to primary treating physician

- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[2]

No

Continue survivorship monitoring

MGUS = monoclonal gammopathy of undetermined significance

[1] Risk factor guidelines are according to International Myeloma Working Group (IMWG) criteria

[2] 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 – MGUS

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ELIGIBILITY

Patients with:

High-intermediate risk[1] MGUS (any two of the following)
or
High-risk[1] MGUS (all three of the following):

- Serum monoclonal protein ≥ 1.5 grams/dL
- Non-IgG subtype (IgA or IgM)
- Abnormal light chain ratio of involved light chain to uninvolved

(continued from previous page)

CONCURRENT COMPONENTS OF VISIT

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[2]
- Cancer screening[3]
- 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[4] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Bone health monitoring, as clinically indicated:
  - Vitamin D 25-OH
  - Bone density screening
- Integrative Medicine consult for lifestyle change, mind-body therapies, acupuncture/massage, supplement consultation, etc.
- Lipid panel
- Hemoglobin A1c
- TSH, as clinically indicated
- T4, as clinically indicated

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Financial concerns
- Practical concerns (basic needs, health care coverage, medication, transportation, lodging)
- Support system

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

MGUS = monoclonal gammopathy of undetermined significance

[1] Risk factor guidelines are according to International Myeloma Working Group (IMWG) criteria
[2] 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
[3] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[4] Based on American Society of Clinical Oncology (ASCO) guidelines and Centers for Disease Control and Prevention (CDC) guidelines

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Survivorship – Solitary Plasmacytoma

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ELIGIBILITY

Patients with solitary plasmacytoma, ≥ 5 years post radiation with curative intent

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Every 6 - 12 months:
- History and physical exam, including neurological exam and Mini-Cog©
- CBC with differential
- Comprehensive metabolic panel (CMP)
- Serum protein electrophoresis
- Free lambda light chain
- Free kappa light chain
- Serum immunoglobulins - IgG, IgA, IgM (obtain IgD or IgE as indicated)
- Serum protein electrophoresis with immunofixation electrophoresis (IFE)

Annually or as clinically indicated:
- Imaging: PET/CT whole body or MRI whole body - bone marrow

Consider as clinically indicated:
- Lactate dehydrogenase (LDH)
- Uric acid
- Beta-2 microglobulin
- Urine protein electrophoresis with IFE

MONITORING FOR LATE EFFECTS

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

→ See Page 8

DISPOSITION

Suspected 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[1]

No → Continue survivorship monitoring

[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).

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Survivorship – Solitary Plasmacytoma

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ELIGIBILITY

Patients with solitary plasmacytoma, ≥ 5 years post radiation with curative intent *(continued from previous page)*

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Consider:
- Cardiovascular screening for patients who have received radiation to chest (see Survivorship – Adult Cardiovascular Screening algorithm)
- Pulmonary function test **and** chest x-ray for patients with history of radiation to chest wall
- Integrative Medicine consult for lifestyle change, mind-body therapies, acupuncture/massage, supplement consultation, etc.
- Neuropathy assessment, including:
  - Copper level
  - Vitamin B12 level
  - Methylmalonic acid (MMA) quantitative, serum
  - Vitamin B6 level
- Bone health monitoring as clinically indicated:
  - Vitamin D 25-OH
  - Bone density screening
- Lipid panel
- Hemoglobin A1c
- Patients who received radiation to head/neck:
  - TSH
  - T4
- Pain management evaluation

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[1]
- Cancer screening[2]
- 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[3] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Financial concerns
- Practical concerns (basic needs, health care coverage, medication, transportation, lodging)
- Support system

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 and Centers for Disease Control and Prevention (CDC) guidelines

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Survivorship – Waldenström's Macroglobulinemia (Lymphoplasmacytic Lymphoma)

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ELIGIBILITY

Patients with Waldenström's, **not** on active treatment or status post-treatment

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Every 1 - 3 months:
- History and physical exam, including neurological exam and Mini-Cog©
- CBC with differential
- Comprehensive metabolic panel (CMP)
- Serum protein electrophoresis
- Free lambda light chain
- Free kappa light chain
- Serum immunoglobulins - IgG, IgA, IgM (obtain IgD or IgE as indicated)
- Serum protein electrophoresis with immunofixation electrophoresis (IFE)

Consider as clinically indicated:
- Cold agglutinins
- Cryocrit
- Urine protein electrophoresis with IFE
- Viscosity
- MAG antibody with reflex EIA

Suspected new primary or recurrent disease?

DISPOSITION

Yes → Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[1]

No → Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

Consider:
- Bone health monitoring, as indicated:
  - Vitamin D 25-OH
  - Bone density screening
- Pain management evaluation
- Lipid panel
- Hemoglobin A1c
- Integrative Medicine consult for lifestyle change, mind-body therapies, acupuncture/massage, supplement consultation, etc.

→ Refer or consult as indicated

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

→ See Page 10

EIA = enzyme immunoassay
MAG = myelin-associated glycoprotein

[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).

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Survivorship – Waldenström's Macroglobulinemia (Lymphoplasmacytic Lymphoma)

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ELIGIBILITY

Patients with Waldenström's, **not** on active treatment or status post-treatment *(continued from previous page)*

CONCURRENT COMPONENTS OF VISIT

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[1]
- Cancer screening[2]
- 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[3] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Financial concerns
- Practical concerns (basic needs, health care coverage, medication, transportation, lodging)
- Support system

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
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DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Plasma Cell Dyscrasias 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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