Survivorship – Acute Lymphoblastic Leukemia (ALL)

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.

ELIGIBILITY

ALL patients 5 years post diagnosis and in remission

CONCURRENT COMPONENTS OF VISIT

Year 5-9, every 6 months. Then starting year 10, annually:
- History and physical examination
- CBC with differential
- Chemistries (CMP, LDH, and uric acid)

MONITORING FOR LATE EFFECTS

Consider:
- Pulmonary toxicity and monitor pulmonary function tests (PFT) if patient is symptomatic
- Cardiovascular screening 1 annually
- Lipid panel annually
- Immunoglobulin levels annually

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

See Page 2

DISPOSITION

New primary or relapsed disease?

Yes
- Return to primary treating physician

No
- Continue survivorship monitoring

Consider:
- CD4 count annually if not recovered
- Bone Health (see Breast Cancer Survivorship: Bone Health algorithm)
- Neuropathy screening
- Avascular necrosis as clinically indicated
- Assess for diabetes and glucose intolerance if indicated (late onset)

Refer or consult as indicated

CMP = complete metabolic panel
LDH = lactate dehydrogenase

1 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health
Patient education, counseling and screening:
- Lifestyle risk assessment\(^1\)
- Cancer screening\(^2\)
- 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 algorithm)
- Vaccinations\(^3\) as appropriate
  - Pneumococcal vaccines PCV13 followed by PPSV23 at least 8 weeks apart. Thereafter, only PPSV23 every 5 years.
  - 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 whose last chemotherapy treatment is greater than 6 months, has a shared patient-provider conversation regarding the vaccine, and meets ACIP criteria\(^4\)
- Patients should inform their providers about plans to travel outside of the US at least one month in advance for appropriate counseling and vaccinations
- Recommendations for vaccination of household members

Assess for the following as clinically indicated:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Access to primary health care
- Vision/cataract screening (see Cataract Screening algorithm)
- Financial stressors
- Relationship issues
- Infertility

\(^1\) See Physical Activity, Nutrition, and Tobacco Cessation 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

ACIP = Advisory Committee on Immunization Practices
**SUGGESTED READINGS**


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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