

25th March 2020

UK Myeloma Forum guidance to support medical decision-making in the management of myeloma patients during the COVID-19 (Coronavirus) outbreak

It is clear that the current outbreak is going to impact the ability to deliver healthcare for some months to come. This is especially the case for systemic anti-cancer therapy.

To try and mitigate the impact of changing capacity, and to minimise the risk that the immunosuppressive effects of myeloma therapy has, the following guidance has been compiled to help support myeloma doctors in their decision-making and treatment planning. It is by no means a comprehensive guide, but lays out principles with some examples. It is expected practice to ratify decisions at the MDT, and to discuss with colleagues any urgent or difficult decisions in between MDTs. All such conversations should be documented in the patient record. NHSE announcements should be checked over the coming weeks for possible announcements of increased access to oral regimens

Who/when to treat

Newly Diagnosed Patients

Patients fulfilling the CRAB criteria (hypercalcaemia, renal impairment or bone disease) should be offered primary treatment (*rationale: untreated newly diagnosed myeloma in these groups is likely to be fatal in 3 months or less and delay may adversely affect disease-related morbidity, quality of life and survivalship*)

Patients who fulfil the SLiM part only of the SLiM-CRAB criteria or who only have anaemia should be monitored (*rationale: SLiM criteria patients have an 80% chance of needing treatment in the 2 years after diagnosis- spreading this population across the 2 years reduces demand and infection risk*).

First-line treatment

Transplant eligible patients.

Bortezomib/dexamethasone with either thalidomide (VTD) or cyclophosphamide (VCD).

Use once weekly bortezomib for the full 6 cycles. If twice a week is needed for rapid response, de-escalate to weekly as soon as response achieved. Use 20mg of dexamethasone weekly or lower.

Transplant ineligible patients.

Lenalidomide/dexamethasone for 9 cycles then single agent Lenalidomide (*rationale- Larocca et al 2019*). For those patients already on Len/dex, consider de-escalating steroid after cycle 9.

Relapsed patients

Those patients with clinically significant relapse should be offered second/third etc line therapy if the benefit (e.g. reversal of renal impairment, new bone disease) outweighs the risk. For those with biochemical relapse, deferment of treatment should be considered but this should be based on clinical concern or the rate of disease progression.

For patients who would ordinarily be candidates for second transplant, then Daratumumab/bortezomib/dexamethasone (weekly) should be initiated unless contra-indicated (under present NHSE guidance this would negate a second transplant at this line of therapy).

If there is an option, then consider using an oral rather than IV/SC regimen to reduce hospital attendances (such as Rd based regimens) including less commonly used regimens such as alkylator or thalidomide-based especially if not previously exposed.

Other chemotherapies of note

DT-PACE

Only to be used if no other likely effective options available or rapid disease control is critical (e.g. plasma cell leukaemia) due to capacity constraints and immunosuppressive effect. The all oral regimen, TIDE (thalidomide, idarubicin, dexamethasone and etoposide) is an alternative that could offer clinical benefit.

Pomalidomide-Isatuximab

Use with caution- requires frequent daycase trips to start with and has a significant infectious complication rate. Levofloxacin interacts with Pomalidomide, so alternative prophylaxis may be required.

Stem cell harvest

It is, at this time, still reasonable to proceed with stem cell harvest at end of induction with a plan for deferred transplant according to local capacity.

Consider switch to GCSF-only priming to reduce the immunosuppression and myelosuppression associated with high dose cyclophosphamide. It is more likely that salvage plerixafor will be needed and an additional day of apheresis.

Stem Cell Transplant

Autologous stem cell transplant is not a curative process in myeloma. It renders the patient immunocompromised for 3-6 months afterwards. Thus at present, we are recommending not to proceed with autologous transplant except in clinical high risk disease (genetically defined high risk; clinically aggressive disease, Extra-Medullary Disease) patients where a judgement should be made about the risk of progression without transplant.

Most patients will be stable for a few months. To increase the chances of stability, ensure full number of cycles of treatment (VTD, VCD for example) have been given. For Myeloma XII patients, ensure they have had 6 cycles of ITd.

Allogeneic transplant should be deferred and the patient placed on/resume continuous therapy if possible (*rationale, cure fraction low infectious burden very high*).

Supportive care

Bisphosphonates

Consider either extending the dosing interval or switching from intravenous bisphosphonates to oral clodronate- consider giving patients a 3 month supply of oral medications to reduce hospital attendance.

Antibiotic prophylaxis

All patients on treatment should receive cotrimoxazole prophylaxis if tolerated.

Ensure Levofloxacin prophylaxis for 12 weeks is offered to all patient starting induction therapy.

ESAs

Consider erythropoiesis stimulating agents (ESAs) to prevent the need for blood transfusions where indicated and reduce visits to hospital

GCSF

Consider GCSF to reduce the need for additional monitoring blood tests and to reduce additional visits in those patients on myelosuppressive regimens