19th May 2020

Updated UK Myeloma Forum guidance to support medical decision-making in the management of myeloma patients during the COVID-19 (causative agent the SARS-CoV-2 virus) outbreak.

As the current pandemic continues, the impact both on the ability to deliver healthcare (especially systemic anti-cancer therapy (SACT)) and on specific patient groups becomes increasingly evident. A number of rapid guidance documents have been released to guide both the treatment of cancer and, more recently, specific details of changes to the myeloma treatment pathway and transplantation advice have been introduced. The original UKMF guidance remains active, however as service capacity concerns start to recede and social distancing policy evolves, there will be the potential to re-establish certain areas of the pre-existing treatment pathways.

Stem cell harvest

It is, at this time, still reasonable to proceed with stem cell harvest at the end of induction.

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. Patients should be Covid-19 tested prior to commencing G-CSF mobilisation, with the ability to proceed when a negative RNA result is obtained. https://www.nice.org.uk/guidance/ng164

Stem Cell Transplant

The development of COVID -19 negative sites for the delivery of more intensive treatments may allow some centres to safely re-establish autologous Stem Cell transplant (ASCT) activity in patients who are classified as clinically high risk. The definition of high risk is one that should be made on a case-by-case basis, ratified through the appropriate MDT and does not necessarily depend on molecular tumour aberrations. The ability to cautiously re-instigate ASCT will depend on circumstances at individual sites but should be managed at a regional level as part of a programme plan and will vary geographically across the home nations. Patients should be tested for COVID-19 ideally 96 hours before planned admission and then again within 24 hours of admission. Conditioning should be only initiated once a confirmed RNA negative result for COVID-19 is present, the ability to test within these timescales will vary between institutions http://www.bsbmtct.org/wp-content/uploads/2020/03/BSBMTCT-recommendations-for-COVID-Adult-BMT-27th-March-2020.pdf The current suspension of ambulatory transplant procedures should remain in place unless the risks of frequent hospital visits can be mitigated by patient benefit and the decision should be patient-focussed and ratified by the relevant MDT.

MM patients undergoing ASCT have practised social distancing prior to the COVID-19 pandemic and are familiar with this type of clinical advice. Our recommendation is that current shielding advice remains unchanged from that at present provided by Public Health England until June 2020. In addition we

recommend shielding for 12 weeks (3 months) from discharge after ASCT, after which we recommend that ongoing precautions to minimise any infective risks should continue for up to 6 months post-ASCT to allow immune recovery of the individual in keeping with updated NHSE guidance.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200402-FAQs-Patients-vFINAL.pdf

Given the risk/benefit ratio for Allogeneic SCT in MM, we recommend that this should be deferred, and the patient placed on/resume continuous therapy if possible (*rationale, cure fraction low infectious burden very high*).