Myeloma-Supportive Care
Mayo Consensus

Scottsdale, Arizona
Rochester, Minnesota
Jacksonville, Florida
Multiple Myeloma with Anemia

Anemia: Hb > 2 g/dL below lower limit of normal
Transfuse PRBC if symptomatic
Initiate myeloma directed therapy

Persistent Anemia (Hb < 9 g/dL) after 1 to 2 cycles of therapy in responsive disease

Rule out other causes of anemia
- Folate and B12 deficiency
- Iron deficiency
- Impaired Erythropoietin production

Replacement therapy for deficiencies
- If no response start EPO

Anemia of chronic disease/chemotherapy induced

Trial of Erythropoietin stimulating Agents
Hold drug if Hb >10 g/dL
Infection Prophylaxis

- **Bacterial Prophylaxis**
  - All patients should receive levofloxacin prophylaxis during induction for 2-3 months

- **PJP Prophylaxis**
  - Sulfamethoxazole/Trimethoprim SS daily (or equivalent) while on dexamethasone

- **Viral Prophylaxis**
  - Acyclovir or Valacyclovir prophylaxis for herpes zoster in patients receiving proteasome inhibitor or daratumumab containing regimens
Multiple Myeloma with Renal Failure

Suspected Myeloma with Renal Failure

- Initiate Bortezomib base chemotherapy†
- Identify and treat reversible factors*
- Initiate Standard Renal supportive Care

Serum FLC

- > 150 mg/dL
  - Most likely cast nephropathy; **
  - Consider renal biopsy only if inadequate response

Serum FLC

- < 150 mg/dL
  - Consider kidney biopsy
  - Treat based on Biopsy

*Hypovolemia, Hypercalcemia, Drugs, infections

**Use of plasma exchange is controversial, and may be considered in some patients

† Bortezomib Based regimen: eg., VCD, VTD

v2 //last reviewed Nov 2019