



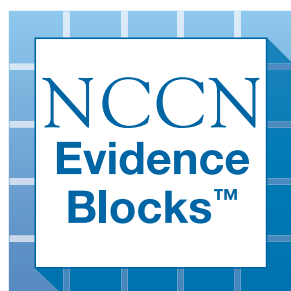
National Comprehensive
Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Systemic Light Chain Amyloidosis

NCCN Evidence Blocks™

Version 1.2020 — December 12, 2019



[NCCN.org](https://www.nccn.org)

[Continue](#)



National
Comprehensive
Cancer
Network®

NCCN Guidelines Version 1.2020

Systemic Light Chain Amyloidosis

NCCN Evidence Blocks™

[NCCN Guidelines Index](#)
[Table of Contents](#)
[Discussion](#)

***Shaji K. Kumar, MD/Chair ‡ ξ**
Mayo Clinic Cancer Center

***Natalie S. Callander, MD/Vice Chair ‡ ξ**
University of Wisconsin
Carbone Cancer Center

Muhamed Baljevic, MD † ‡ P ξ
Fred & Pamela Buffett Cancer Center

Erica Campagnaro, MD ‡
University of Michigan Rogel Cancer

Jorge J. Castillo, MD ‡
Dana-Farber/Brigham and Women's
Cancer Center | Massachusetts General
Hospital Cancer Center

Jason C. Chandler, MD †
St. Jude Children's Research Hospital/
The University of Tennessee
Health Science Center

Robert F. Cornell, MD, MPH ‡ P
Vanderbilt-Ingram Cancer Center

Caitlin Costello, MD † ‡ ξ
UC San Diego Moores Cancer Center

Yvonne Efebera, MD, MPH ‡
The Ohio State University Comprehensive
Cancer Center - James Cancer Hospital
and Solove Research Institute

Matthew Faiman, MD P
Case Comprehensive Cancer Center/
University Hospitals Seidman Cancer
Center and Cleveland Clinic
Taussig Cancer Institute

Alfred Garfall, MD ‡
Abramson Cancer Center
at the University of Pennsylvania

Kelly Godby, MD †
O'Neal Comprehensive
Cancer Center at UAB

Jens Hillengass, MD ‡
Roswell Park Comprehensive Cancer Center

Leona Holmberg, MD, PhD ξ ‡
Fred Hutchinson Cancer Research Center/
Seattle Cancer Care Alliance

Myo Htut, MD P ‡
City of Hope National Medical Center

Carol Ann Huff, MD † ‡
The Sidney Kimmel Comprehensive
Cancer Center at Johns Hopkins

Yubin Kang, MD ‡ † ξ
Duke Cancer Institute

Ola Landgren, MD, PhD † ‡
Memorial Sloan Kettering Cancer Center

Michaela Liedtke, MD ‡
Stanford Cancer Institute

Ehsan Malek, MD ‡
Case Comprehensive Cancer Center/University
Hospitals Seidman Cancer
Center and Cleveland Clinic Taussig
Cancer Institute

Thomas Martin, MD ‡
UCSF Helen Diller Family
Comprehensive Cancer Center

James Omel, MD ¥
Patient Advocate

Noopur Raje, MD † ‡
Dana-Farber/Brigham and Women's Cancer
Center | Massachusetts General Hospital
Cancer Center

Douglas Sborov, MD, MSc ‡ P
Huntsman Cancer Institute
at the University of Utah

Seema Singhal, MD ‡
Robert H. Lurie Comprehensive Cancer Center
of Northwestern University

Keith Stockerl-Goldstein, MD † ξ
Siteman Cancer Center at Barnes-
Jewish Hospital and Washington
University School of Medicine

Carlyn Tan, MD † ‡
Fox Chase Cancer Center

Donna Weber, MD † ‡ P
The University of Texas
MD Anderson Cancer Center

NCCN
Alyse Johnson-Chilla, MS
Jennifer Keller, MSS
Rashmi Kumar, PhD

[NCCN Guidelines Panel Disclosures](#)

Continue

ξ Bone marrow transplantation	¥ Patient advocacy
‡ Hematology	† Surgery/Surgical oncology
P Internal medicine	* Discussion section writing committee
† Medical oncology	



[NCCN Systemic Light Chain Amyloidosis Panel Members](#)
[NCCN Evidence Blocks Definitions \(EB-1\)](#)

[Initial Diagnostic Workup \(AMYL-1\)](#)
[Clinical Findings and Primary Treatment \(AMYL-2\)](#)

[Systemic Light Chain Amyloidosis Therapy \(AMYL-A\)](#)
[Definition of Organ Involvement Based on Amyloidosis Consensus Criteria \(AMYL-B\)](#)
[Prognostic Staging System for Light Chain Amyloidosis \(AMYL-C\)](#)
[Definition of Organ and Hematologic Response and Progression Criteria \(AMYL-D\)](#)

Clinical Trials: NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, [click here: nccn.org/clinical_trials/member_institutions.aspx](#).

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See [NCCN Categories of Evidence and Consensus](#).

NCCN Categories of Preference: All recommendations are considered appropriate.

See [NCCN Categories of Preference](#).

The NCCN Guidelines® are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way. The NCCN Evidence Blocks™ and NCCN Guidelines are copyrighted by National Comprehensive Cancer Network®. All rights reserved. The NCCN Evidence Blocks™, NCCN Guidelines, and the illustrations herein may not be reproduced in any form without the express written permission of NCCN. ©2019.

NCCN EVIDENCE BLOCKS CATEGORIES AND DEFINITIONS

5					
4					
3					
2					
1					

E = Efficacy of Regimen/Agent
S = Safety of Regimen/Agent
Q = Quality of Evidence
C = Consistency of Evidence
A = Affordability of Regimen/Agent

Example Evidence Block

5					
4	■	■		■	
3	■	■	■	■	■
2	■	■	■	■	■
1	■	■	■	■	■

E = 4
S = 4
Q = 3
C = 4
A = 3

Efficacy of Regimen/Agent

5	Highly effective: Cure likely and often provides long-term survival advantage
4	Very effective: Cure unlikely but sometimes provides long-term survival advantage
3	Moderately effective: Modest impact on survival, but often provides control of disease
2	Minimally effective: No, or unknown impact on survival, but sometimes provides control of disease
1	Palliative: Provides symptomatic benefit only

Safety of Regimen/Agent

5	Usually no meaningful toxicity: Uncommon or minimal toxicities; no interference with activities of daily living (ADLs)
4	Occasionally toxic: Rare significant toxicities or low-grade toxicities only; little interference with ADLs
3	Mildly toxic: Mild toxicity that interferes with ADLs
2	Moderately toxic: Significant toxicities often occur but life threatening/fatal toxicity is uncommon; interference with ADLs is frequent
1	Highly toxic: Significant toxicities or life threatening/fatal toxicity occurs often; interference with ADLs is usual and severe

Note: For significant chronic or long-term toxicities, score decreased by 1

Quality of Evidence

5	High quality: Multiple well-designed randomized trials and/or meta-analyses
4	Good quality: One or more well-designed randomized trials
3	Average quality: Low quality randomized trial(s) or well-designed non-randomized trial(s)
2	Low quality: Case reports or extensive clinical experience
1	Poor quality: Little or no evidence

Consistency of Evidence

5	Highly consistent: Multiple trials with similar outcomes
4	Mainly consistent: Multiple trials with some variability in outcome
3	May be consistent: Few trials or only trials with few patients, whether randomized or not, with some variability in outcome
2	Inconsistent: Meaningful differences in direction of outcome between quality trials
1	Anecdotal evidence only: Evidence in humans based upon anecdotal experience

Affordability of Regimen/Agent (includes drug cost, supportive care, infusions, toxicity monitoring, management of toxicity)

5	Very inexpensive
4	Inexpensive
3	Moderately expensive
2	Expensive
1	Very expensive

**INITIAL DIAGNOSTIC WORKUP^a****Clinical and amyloid-related assessment**

- History and physical
- Orthostatic vital signs
- Whole-body low-dose CT scan^b

Laboratory evaluation (directed toward commonly affected organ systems)

- CBC, differential, platelet count
- Peripheral blood smear
- Prothrombin time (PT), partial thromboplastin time (PTT), and Factor X (if indicated)
- Serum BUN/creatinine, electrolytes, albumin, calcium, serum uric acid, serum LDH, and beta-2 microglobulin
- Creatinine clearance (calculated or measured directly)
- Serum quantitative immunoglobulins, serum protein electrophoresis (SPEP), and serum immunofixation electrophoresis (SIFE)
- 24-h urine for total protein, urine protein electrophoresis (UPEP), and urine immunofixation electrophoresis (UIFE)
- Serum free light chain (FLC) assay
- NT-proBNP,^c troponin T
- Alkaline phosphatase, aspartate aminotransferase (AST), alanine aminotransferase (ALT), and bilirubin
- Coagulation studies as indicated

Pathologic evaluation^{d,e}

- Unilateral bone marrow aspirate + biopsy^f
- Plasma cell fluorescence in situ hybridization (FISH) on bone marrow
- Abdominal fat pad aspirate^g and/or involved organ biopsy as clinically indicated
- Amyloid tissue subtyping with mass spectrometry

Special testing based on organ system involvement

- Cardiac
 - ECG
 - Echocardiogram with strain assessment to examine longitudinal strain
 - Cardiac MRI (in certain circumstances)
- Liver and GI tract
 - Fecal occult blood test (FOBT)
 - Gastric emptying scan (if gastroparesis present)
 - Abdominal ultrasound or abdominal CT scan to document craniocaudal liver span as clinically indicated
- Peripheral nervous system
 - Electromyography (EMG) (if clinically significant peripheral neuropathy)/nerve conduction studies
- Other
 - Endocrine testing: Thyroid-stimulating hormone (TSH), cortisol
 - Pulmonary testing: Pulmonary function tests
 - Chest CT without contrast as indicated

→ [See Clinical Findings \(AMYL-2\)](#)

^a Frailty assessment should be considered in older adults. [See NCCN Guidelines for Older Adult Oncology.](#)

^b [Skeletal survey is acceptable in certain circumstances. However, it is significantly less sensitive than whole-body low-dose CT and FDG PET/CT. If FDG PET/CT or whole-body low-dose CT has been performed, then skeletal survey is not needed.](#)

^c If NT-proBNP is not available, BNP can be performed.

^d It is essential to confirm that patients have primary systemic light chain amyloidosis (AL) rather than hereditary amyloidosis, wild-type transthyretin-related (ATTR) cardiac amyloidosis, or secondary amyloidosis. The amyloid deposits should be confirmed to be composed of light chains using immunohistochemistry or mass spectrometry. Immunohistochemistry for transthyretin or serum amyloid A component should be performed if kappa and lambda stains are negative. ^{99m}Tc-pyrophosphate scan can help distinguish cardiac involvement with AL from ATTR.

^e Identification of light chains in the serum or urine without confirmation of the amyloid composition in tissue is not adequate, as patients with other forms of amyloidosis may have an unrelated MGUS. Lachmann HJ, Booth DR, Booth SE, et al. Misdiagnosis of hereditary amyloidosis as AL (primary) amyloidosis. *N Engl J Med* 2002;346:1786-1791.

^f Congo red staining for amyloid. Congo stain does not differentiate between types of amyloid.

^g Alternate sites could include rectal or minor salivary gland biopsy.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page EB-1.

All recommendations are category 2A unless otherwise indicated.

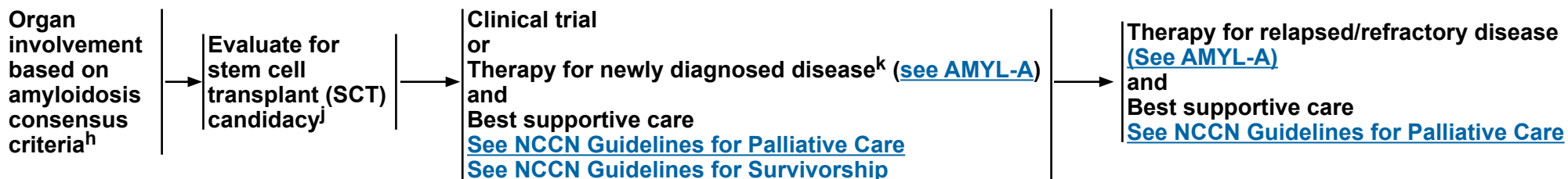
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



CLINICAL FINDINGS

TREATMENT OF NEWLY DIAGNOSED DISEASE^{a,h,i}

RELAPSED/REFRACTORY DISEASEⁱ



^a Frailty assessment should be considered in older adults. [See NCCN Guidelines for Older Adult Oncology.](#)

^h [See Definition of Organ Involvement and Response to Treatment Based on Amyloidosis Consensus Criteria \(AMYL-B\).](#)

ⁱ [See Definition of Organ and Hematologic Response and Progression Criteria \(AMYL-C\).](#)

^j In those patients with very low tumor burden induction therapy may not be required. If not a candidate for SCT at initial diagnosis, reassess after 2 cycles of systemic therapy.

^k Organ transplant, as clinically indicated.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page EB-1.

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



NCCN Guidelines Version 1.2020

Systemic Light Chain Amyloidosis

NCCN Evidence Blocks™

SYSTEMIC LIGHT CHAIN AMYLOIDOSIS THERAPY (Order of regimens is alphabetical and does not indicate preference)

PRIMARY THERAPY FOR TRANSPLANT CANDIDATES^{1,2,3}

Preferred Regimen:

- Bortezomib/cyclophosphamide/dexamethasone

Other Recommended Regimens:

- Bortezomib ± dexamethasone
- Bortezomib/melphalan/dexamethasone
- Lenalidomide/cyclophosphamide/dexamethasone
- Lenalidomide/dexamethasone
- Melphalan/dexamethasone

PRIMARY THERAPY FOR NON-TRANSPLANT CANDIDATES^{1,3} (if not a candidate for stem cell transplant at initial diagnosis, reassess after 2 cycles of systemic therapy)

Preferred Regimen:

- Bortezomib/cyclophosphamide/dexamethasone
- Melphalan/dexamethasone

Other Recommended Regimens:

- Bortezomib ± dexamethasone
- Bortezomib/melphalan/dexamethasone
- Lenalidomide/cyclophosphamide/dexamethasone
- Lenalidomide/dexamethasone

[See Evidence Blocks on AMYL-A \(EB-1\)](#)

¹ Consider oral doxycycline as adjuvant to standard systemic therapy.

² Patients eligible for stem cell transplant can elect to collect stem cells and delay transplant to a later line of therapy. The dose of melphalan as part of stem cell transplantation can be adjusted based on factors such as age, presence/absence of cardiac involvement, and number of organs involved. These risk-adapted approaches have not been evaluated in randomized studies. Skinner M, Sancharawala V, Seldin D, et al. High-dose melphalan and autologous stem-cell transplantation in patients with AL amyloidosis: an 8-year study. *Ann Intern Med* 2004;140:85-93.

Gertz MA, Lacy MQ, Dispenzieri A, et al. Risk-adjusted manipulation of melphalan dose before stem cell transplantation in patients with amyloidosis is associated with a lower response rate. *Bone Marrow Transplant* 2004;34:1025-1031.

Perfetti V, Siena S, Palladini G, et al. Long-term results of a risk-adapted approach to melphalan conditioning in autologous peripheral blood stem cell transplantation for primary (AL) amyloidosis. *Haematologica* 2006;91:1635-1643.

³ Recommend herpes zoster prophylaxis for patients treated with bortezomib.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued
References](#)

AMYL-A
1 OF 4



5					E = Efficacy of Regimen/Agent
4					S = Safety of Regimen/Agent
3					Q = Quality of Evidence
2					C = Consistency of Evidence
1					A = Affordability of Regimen/Agent
	E	S	Q	C	A

EVIDENCE BLOCKS FOR NEWLY DIAGNOSED SYSTEMIC LIGHT CHAIN AMYLOIDOSIS

Transplant eligible

Preferred Regimen	
Bortezomib/cyclophosphamide/dexamethasone	

Other Regimens	
Bortezomib	
Bortezomib/dexamethasone	
Bortezomib/melphalan/dexamethasone	
Lenalidomide/cyclophosphamide/dexamethasone	
Lenalidomide/dexamethasone	
Melphalan/dexamethasone	

Transplant ineligible

Preferred Regimens	
Bortezomib/cyclophosphamide/dexamethasone	
Melphalan/dexamethasone	

Other Regimens	
Bortezomib	
Bortezomib/dexamethasone	
Bortezomib/melphalan/dexamethasone	
Lenalidomide/cyclophosphamide/dexamethasone	
Lenalidomide/dexamethasone	

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).
All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



SYSTEMIC LIGHT CHAIN AMYLOIDOSIS THERAPY

THERAPY FOR PREVIOUSLY TREATED DISEASE^{1,3,4}

Consider repeating initial therapy, especially if relapse-free for several years

- **High-dose melphalan⁵ with stem cell transplant**
- **Bortezomib ± dexamethasone**
- **Bortezomib/melphalan/dexamethasone**
- **Daratumumab⁶**
- **Ixazomib ± dexamethasone**
- **Lenalidomide/cyclophosphamide/dexamethasone**
- **Lenalidomide/dexamethasone**
- **Melphalan/dexamethasone**
- **Pomalidomide/dexamethasone**

[See Evidence Blocks on AMYL-A \(EB-2\)](#)

¹ Consider oral doxycycline as adjuvant to standard systemic therapy.

³ Recommend herpes zoster prophylaxis for all patients treated with bortezomib.

⁴ Recommend herpes zoster prophylaxis for patients treated with proteasome inhibitors or daratumumab.

⁵ The dose of melphalan as part of stem cell transplantation can be adjusted based on factors such as age, presence/absence of cardiac involvement, and number of organs involved. These risk-adapted approaches have not been evaluated in randomized studies.

⁶ Daratumumab may interfere with serologic testing and cause false-positive indirect Coombs test. Type and screen should be performed before using daratumumab.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[References](#)

AMYL-A
2 OF 4



5						E = Efficacy of Regimen/Agent
4						S = Safety of Regimen/Agent
3						Q = Quality of Evidence
2						C = Consistency of Evidence
1						A = Affordability of Regimen/Agent
	E	S	Q	C	A	

EVIDENCE BLOCKS FOR RELAPSED REFRACTORY SYSTEMIC LIGHT CHAIN AMYLOIDOSIS

High-dose melphalan with stem cell transplant	
Bortezomib	
Bortezomib/dexamethasone	
Bortezomib/melphalan/dexamethasone	
Daratumumab	
Ixazomib	
Ixazomib ± dexamethasone	
Lenalidomide/cyclophosphamide/dexamethasone	
Lenalidomide/dexamethasone	
Melphalan/dexamethasone	
Pomalidomide/dexamethasone	

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

**SYSTEMIC LIGHT CHAIN AMYLOIDOSIS THERAPY****REFERENCES FOR TREATMENT OPTIONS****• Bortezomib/cyclophosphamide/dexamethasone**

- ▶ Venner CP, Lane T, Foard D, et al. Cyclophosphamide, bortezomib, and dexamethasone therapy in AL amyloidosis is associated with high clonal response rates and prolonged progression-free survival. *Blood* 2012;119:4387-4390.
- ▶ Mikhael JR, Schuster SR, Jimenez-Zepeda VH, et al. Cyclophosphamide-bortezomib-dexamethasone (CyBorD) produces rapid and complete hematologic response in patients with AL amyloidosis. *Blood* 2012;119:4391-4394.

• Bortezomib ± dexamethasone

- ▶ Reece DE, Hegenbart U, Santhorawala V, et al. Efficacy and safety of once-weekly and twice-weekly bortezomib in patients with relapsed systemic AL amyloidosis: results of a phase ½ study. *Blood* 2011;118:865-873.
- ▶ Kastritis E, Wechalekar AD, Dimopoulos MA, et al. Bortezomib with or without dexamethasone in primary systemic (light chain) amyloidosis. *J Clin Oncol* 2010;28:1031-1037.
- ▶ Singh V, Saad A, Palmer J, et al. Response to bortezomib based induction therapy in newly diagnosed light chain (AL) amyloidosis [abstract]. *Blood* 2009;114: Abstract 1867.
- ▶ Lamm W, Willenbacher W, Lang A, et al. Efficacy of the combination of bortezomib and dexamethasone in systemic AL amyloidosis. *Ann Hematol* 2011;90:201-206.
- ▶ Reece DE, Santhorawala V, Hegenbart U, et al. Weekly and twice-weekly bortezomib in patients with systemic AL amyloidosis: results of a phase 1 dose-escalation study. *Blood* 2009;114:1489-1497.

• Bortezomib/melphalan/dexamethasone

- ▶ Gasparetto C, Santhorawala V, Snyder RM, et al. Use of melphalan (M)/dexamethasone (D)/bortezomib in AL amyloidosis [abstract]. *J Clin Oncol* 2010;28:Abstract 8024.

• Daratumumab

- ▶ Kaufman GP, Schrier SL, Lafayette RA, et al. Daratumumab yields rapid and deep hematologic responses in patients with heavily pretreated AL amyloidosis. *Blood* 2017;130:900-902.

• High-dose melphalan with stem cell transplant

- ▶ Skinner M, Santhorawala V, Seldin D, et al. High-dose melphalan and autologous stem-cell transplantation in patients with AL amyloidosis: an 8-year study. *Ann Intern Med* 2004;140:85-93.
- ▶ Gertz MA, Lacy MQ, Dispenzieri A, et al. Risk-adjusted manipulation of melphalan dose before stem cell transplantation in patients with amyloidosis is associated with a lower response rate. *Bone Marrow Transplant* 2004;34:1025-1031.
- ▶ Perfetti V, Siena S, Palladini G, et al. Long-term results of a risk-adapted approach to melphalan conditioning in autologous peripheral blood stem cell transplantation for primary (AL) amyloidosis. *Haematologica* 2006;91:1635-1643.
- ▶ D'Souza A, Dispenzieri A, Wirk B, et al. Improved outcomes after autologous hematopoietic cell transplantation for light chain amyloidosis: A center for international blood and marrow transplant research study. *J Clin Oncol* 2015;33:3741-3749.
- ▶ Dispenzieri A, Seenithamby K, Lacy MQ, et al. Patients with immunoglobulin light chain amyloidosis undergoing autologous stem cell transplantation have superior outcomes compared with patients with multiple myeloma: a retrospective review from a tertiary referral center. *Bone Marrow Transplant* 2013;48:1302-1307.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)**AMYL-A**
3 OF 4

**SYSTEMIC LIGHT CHAIN AMYLOIDOSIS THERAPY****REFERENCES FOR TREATMENT OPTIONS****• Ixazomib ± dexamethasone**

- ▶ Sanchorawala V, Palladini G, Kukreti V, et al. A phase 1/2 study of the oral proteasome inhibitor ixazomib in relapsed or refractory AL amyloidosis. *Blood* 2017;130:597-605.

• Lenalidomide/cyclophosphamide/dexamethasone

- ▶ Kumar SK, Hayman SR, Buadi FK, et al. Lenalidomide, cyclophosphamide, and dexamethasone (CRd) for light-chain amyloidosis: long-term results from a phase 2 trial. *Blood* 2012;119:4860-4867.
- ▶ Palladini G, Russo P, Milani P, et al. A phase II trial of cyclophosphamide, lenalidomide and dexamethasone in previously treated patients with AL amyloidosis. *Haematologica* 2013;98(3):433-436.

• Lenalidomide/dexamethasone

- ▶ Sanchorawala V, Wright D, Rosenzweig M, et al. Lenalidomide and dexamethasone in the treatment of AL amyloidosis: results of a phase 2 trial. *Blood* 2007;109:492-496.
- ▶ Dispenzieri A, Lacy M, Zeldenrust S, et al. The activity of lenalidomide with or without dexamethasone in patients with primary systemic amyloidosis. *Blood* 2007;109:465-470.
- ▶ Dispenzieri A, Lacy M, Zeldenrust S, et al. Long term follow-up of patients with immunoglobulin light chain amyloidosis treated with lenalidomide and dexamethasone [abstract] *Blood* 2008;112: Abstract 1737.

• Oral melphalan/dexamethasone

- ▶ Palladini G, Russo P, Nuvolone M, et al. Treatment with oral melphalan plus dexamethasone produces long-term remissions in AL amyloidosis. *Blood* 2007;110:787-788.
- ▶ Jaccard A, Leblond V, Royer B, et al. Autologous stem cell transplantation (ASCT) versus oral melphalan and high-dose dexamethasone in patients with AL (primary) amyloidosis: long term follow-up of the French multicentric randomized trial [abstract]. *Blood* 2010;116: Abstract 1344.

• Pomalidomide/dexamethasone

- ▶ Dispenzieri A, Buadi F, Laumann K, et al. Activity of pomalidomide in patients with immunoglobulin light-chain amyloidosis. *Blood* 2012;119:5397-5404.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

**DEFINITION OF ORGAN INVOLVEMENT BASED ON AMYLOIDOSIS CONSENSUS CRITERIA¹****Organ Involvement**

Kidney	24-h urine protein >0.5 g/d, predominantly albumin
Heart	Echo: mean wall thickness >12 mm, no other cardiac cause or an elevated NT-proBNP (>332 ng/L) in the absence of renal failure or atrial fibrillation
Liver	Total liver span >15 cm in the absence of heart failure or alkaline phosphatase >1.5 times institutional upper limit of normal
Nerve	Peripheral: clinical; symmetric lower extremity sensorimotor peripheral neuropathy Autonomic: gastric-emptying disorder, pseudo-obstruction, voiding dysfunction not related to direct organ infiltration
Gastrointestinal tract	Direct biopsy verification with symptoms
Lung	Direct biopsy verification with symptoms Interstitial radiographic pattern
Soft tissue	Tongue enlargement, clinical Arthropathy Claudication, presumed vascular amyloid Skin Myopathy by biopsy or pseudohypertrophy Lymph node (may be localized) Carpal tunnel syndrome

Revised Consensus Criteria for amyloidosis involvement from XII International Symposium on Amyloidosis:

Gertz M and Merlini G. Definition of organ involvement and response to treatment in AL amyloidosis: an updated consensus opinion [abstract]. Amyloid 2010 17(Suppl 1):48-49. (Abstract CP-B).

¹ Adapted with permission from John Wiley and Sons, Inc. Gertz M, Comenzo R, Fermand JP, et al. Definition of organ involvement and treatment response in immunoglobulin light chain amyloidosis (AL): a consensus opinion from the 10th International Symposium on Amyloid and Amyloidosis, Tours, France, 18-22 April 2004. Am J Hematol 2005;79:319-328. Copyright (2005).

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

**PROGNOSTIC STAGING SYSTEM FOR LIGHT CHAIN AMYLOIDOSIS**

Prognostic Variables	Value	Assigned Prognostic Variable Score
cTnT	≥0.025 ng/mL (or hs-cTnT ≥40 pg/mL)	1
NT-ProBNP	≥1,800 pg/mL	1
FLC-diff	≥ 18 mg/dL	1

REVISED STAGING SYSTEM BASED ON THE ABOVE THREE PROGNOSTIC SCORES¹

Total Prognostic Score	Stage
0	Stage I
1	Stage II
2	Stage III
3	Stage IV

¹ Kumar S, Dispenzieri A, Lacy MQ, et al. Revised prognostic staging system for light chain amyloidosis incorporating cardiac biomarkers and serum free light chain measurements. J Clin Oncol 2012;30:989-995.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

**DEFINITION OF ORGAN AND HEMATOLOGIC RESPONSE AND PROGRESSION CRITERIA****Organ Response and Progression Criteria**

Organ	Response	Progression
Heart ¹	NT-proBNP response (>30% and >300 ng/L decrease in patients with baseline NT-proBNP ≥650 ng/L) or NYHA class response (≥2 class decrease in subjects with baseline NYHA class 3 or 4)	NT-proBNP progression (>30% and >300 ng/L increase) ^a or cTn progression (≥33% increase) or Ejection fraction progression (≥10% decrease)
Kidney ²	≥30% decrease in proteinuria or drop of proteinuria below 0.5 g/24 h in the absence of renal progression	≥25% decrease in eGFR
Liver ¹	50% decrease in abnormal alkaline phosphatase value Decrease in liver size radiographically at least 2 cm	50% increase of alkaline phosphatase above the lowest value
Peripheral nervous system ¹	Improvement in electromyogram nerve conduction velocity (rare)	Progressive neuropathy by electromyography or nerve conduction velocity

Abbreviations: NT-proBNP, N-terminal prohormone of brain natriuretic peptide; cTnT, cardiac troponin; eGFR, estimated glomerular filtration rate; NYHA, New York Heart Association.

^a Patients with progressively worsening renal function cannot be scored for NT-proBNP progression.

Hematologic Response and Progression Criteria¹

Response Category	Criteria
Complete	Normalization of the free light chain levels and ratio, negative serum and urine immunofixation
Very good partial	Reduction in the dFLC to <40 mg/L
Partial	A greater than 50% reduction in the dFLC
No response	Less than a PR
Progression	From CR, any detectable monoclonal protein or abnormal free light chain ratio (light chain must double) From PR, 50% increase in serum M protein to >0.5 g/dL or 50% increase in urine M protein to >200 mg/d (a visible peak must be present) Serum free light chain increase of 50% to >100 mg/L

Abbreviations: CR, complete response; dFLC, difference between involved FLC and uninvolved FLC; FLC, free light chain; PR, partial response.

¹ Reproduced with permission from Springer Nature: Comenzo RL, Reece D, Palladini G, et al. Consensus guidelines for the conduct and reporting of clinical trials in systemic light-chain amyloidosis. *Leukemia* 2012;26:2317-2325. Copyright (2012).

² Adapted with permission from the American Society of Hematology: Palladini G, Hegenbart U, Milani P, et al. A staging system for renal outcome and early markers of renal response to chemotherapy in AL amyloidosis. *Blood* 2014;124:2325-32.

Note: For more information regarding the categories and definitions used for the NCCN Evidence Blocks™, see page [EB-1](#).

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



NCCN Categories of Evidence and Consensus	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN Categories of Preference	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.



NCCN Guidelines Version 1.2020 Systemic Light Chain Amyloidosis

Discussion

This discussion is being updated to correspond with the newly updated algorithm. Last updated 08/14/15

Table of Contents

Overview	MS-2
Initial Diagnostic Workup	MS-2
Organ Involvement and Response to Treatment	MS-3
Primary Treatment.....	MS-3
References.....	MS-8



Overview

Primary systemic light chain amyloidosis is typically characterized by decreased numbers of monoclonal plasma cells in the bone marrow compared to multiple myeloma, however, the protein produced by these plasma cells has an affinity for visceral organs (such as kidney, heart, liver, and spleen), and this protein causes related end-organ dysfunction.¹ Even though patients with this disease typically have a low burden of monoclonal plasma cells their survival is often poor due to the end organ damage by the amyloid protein. The therapy of systemic light chain amyloidosis is directed to recovering the function of the target organs by targeting the abnormal plasma cell clone.

Initial Diagnostic Workup

The initial diagnostic workup includes a history and physical (H & P) examination and evaluation of orthostatic vital signs. The following biological assessments are carried out: complete blood counts (CBC) with differential including platelet counts, blood urea nitrogen (BUN) content, serum creatinine, coagulation studies and electrolytes. Patients with systemic light chain amyloidosis are at risk for developing acquired factor X deficiency due to binding of factor X to amyloid fibrils.^{2,3} This deficiency typically responds to treatment of the underlying amyloidosis.

Screening by serum electrophoresis alone may be inadequate, as it does not show a monoclonal spike in nearly 50% of cases. Therefore, all patients should undergo immunofixation electrophoresis of both serum and urine, which could detect a monoclonal (M) component. The work-up should also include quantification of proteinuria by 24 hour urine collection and measurement of creatinine clearance. The measurement of circulating serum free light chain (FLC) is a powerful diagnostic complement as the majority of patients with light chain amyloidosis will have abnormalities of the kappa or lambda chains or

the kappa/lambda ratio. Additionally the FLC analysis is necessary to determine the hematologic response to therapy.^{4,5} Free light chains are cleared by the kidney therefore renal insufficiency increases the concentrations of FLC. In that case, the kappa/lambda ratio or the difference between involved and uninvolved free light chains should be monitored.⁶

The diagnosis of amyloidosis requires the identification of amyloid deposits in tissues either by aspiration of abdominal subcutaneous fat and/or biopsy of the organs involved and the characterization of amyloidosis as a systemic light chain type requires the demonstration of the underlying plasma cell clone. Amyloid deposits are identified by bone marrow aspiration and biopsy followed by Congo red staining. Congo red staining of the subcutaneous fat aspirate is a reliable and noninvasive test reported to identify amyloid deposits in approximately 90% of patients.⁷ The monoclonal plasma cell population can be detected in bone marrow aspirates by immunohistochemical staining of kappa and lambda chains. Immunohistochemistry for transthyretin or the serum amyloid A component should be performed if kappa and lambda stains are negative. The stroma or blood vessels have been reported to be positive for amyloid in 60% of patients.⁸ Identification of light chains in the serum or urine without confirmation of the amyloid composition in tissue is not adequate as patients with other forms of amyloidosis may have an unrelated MGUS.⁹ Therefore it is essential to confirm that the amyloid deposits are composed of light chains by immunohistochemical methods, electron microscopy, or mass spectrometry.¹⁰⁻¹² The NCCN panel members recommend mass spectrometry only if clinically indicated such as in cases where two potential amyloid precursor proteins are present including patients with monoclonal gammopathies who are African-American or elderly men, or who have dominant peripheral or autonomic neuropathy, family histories

of amyloidosis, or coexisting inflammatory disorders. Since the treatment is different in the various types of amyloidosis, it is essential to confirm that patients have primary systemic amyloidosis rather than hereditary amyloidosis, senile amyloidosis, or secondary amyloidosis. Genetic testing especially for African-American and patients with peripheral neuropathy must be done to identify the specific mutation in the hereditary forms and avoid misdiagnosis.^{9,13}

Specialized tests based on organ involvement

Majority of the patients present with one or more organs affected by amyloidosis. The consensus criteria for organ involvement have been recently updated at the 12th International Symposium on Amyloidosis.¹⁴

Cardiac involvement is diagnosed by imaging techniques such as echocardiography (EKG), echocardiogram, chest x-ray, and cardiovascular MRI in certain circumstances. Cardiovascular MRI has been successfully used for the diagnosis and prognosis of amyloid cardiomyopathy.¹⁵ Cardiac biomarkers in the serum provide a quantitative assessment of cardiac dysfunction (troponin I or T) and cardiac stress (brain natriuretic peptide (BNP) or NT-proBNP) are important predictors of outcome in amyloidosis as well as part of the cardiac response criteria.^{16,17}

Liver and gastrointestinal (GI) involvement is diagnosed by elevated serum alkaline phosphatase levels and bilirubin; performing stool guaiac tests to detect fecal occult blood; gastric emptying scan if gastroparesis is present; and ultrasound or CT scan to determine craniocaudal liver span.

An electromyogram (EMG) or nerve conduction testing can be performed if the patient has significant peripheral neuropathy to confirm peripheral nervous system involvement.

Endocrine tests (thyroid stimulating hormone and cortisol levels) and pulmonary function tests may be performed if involvement of the endocrine system or lungs is suspected.

Organ Involvement and Response to Treatment

The first International consensus opinion for the definition of organ involvement and response to treatment for systemic light chain amyloidosis was published in 2005.¹⁸ These criteria has been recently updated^{14,19} and the tables with definition for hematologic and organ involvement and criteria for response to treatment are included in the NCCN algorithms.

Primary Treatment

All current strategies include systemic therapy to destroy the plasma cells responsible for the synthesis of immunoglobulin light chain. Several active regimens are now available for the treatment of systemic light chain amyloidosis. Most are those derived from the treatment of multiple myeloma. The goals of therapy include eliminating the misfolded amyloid light chains as promptly as possible, minimizing treatment toxicity, and supporting the function of the damaged organs. The consensus criteria for hematologic and organ response have been recently updated at the 12th International Symposium on Amyloidosis.¹⁴

High-dose melphalan followed by stem cell transplant

High-dose melphalan followed by stem cell transplant (SCT) is one of the therapeutic options listed by the NCCN panel. However, patients have to be carefully selected as this treatment modality is associated with significant treatment-related mortality.²⁰⁻²⁵ The extent of organ involvement is considered as predictor of outcome.^{23,26,27}

In eligible patients, high-dose chemotherapy along with stem cell support has been associated with higher response rates and improved

overall survival (OS) than standard chemotherapy.²⁶ The best outcomes following SCT have been reported in patients who achieve complete response (CR) to high-dose primary chemotherapy²⁸ including improvement of organ-related disease.²⁹ The most significant leading indicator of the durability of treatment benefits is the depth of the response to therapy measured by the lowest post-transplantation serum free light chain level.³⁰

There are a number of groups that have evaluated dose-adjustment of the high dose melphalan during a transplant based on factors such as age, number of organs involved and presence or absence of cardiac involvement.^{29,31,32} The reported toxicity of reduced-dose of melphalan is substantially less than high dose.³¹ However it should be noted that higher doses of melphalan are associated with a higher CR rate, and improved OS and event-free survival (EFS).³³ Long-term follow-up study of the 74 patients who underwent SCT found that 32 (43%) survived greater than 10 years. The baseline characteristics identified in the study as statistically and significantly different between those who survived long term versus those who did not are 1) the number of organs involved; 2) interventricular septal thickness; 3) total cholesterol; and 4) urine total protein.

Melphalan/Dexamethasone

Melphalan and dexamethasone regimen has also been used in the management of systemic light chain amyloidosis. It has shown promising results in patients with primary amyloidosis who are ineligible for SCT. A small study reported hematologic response in 67% (n = 31) and complete remission in 33% (n = 15) treated with melphalan and high-dose dexamethasone in a median of 4.5 months.³⁴ Improvement in organ function was seen in 48% (n = 22). The updated results reported that the CR induced by melphalan and high-dose dexamethasone was

maintained in 70% of the patients for up to 3 years, and survival at a median follow-up of 5 years was about 50%.³⁵

The French Myeloma Collaborative Group compared melphalan and dexamethasone to high-dose melphalan followed by SCT in a randomized trial and found no significant differences for hematologic or organ responses.³⁶ In a recent update, with a longer follow-up, the authors found that survival or remission duration were not statistically different between melphalan and dexamethasone versus high-dose melphalan followed by SCT even after eliminating treatment related mortality in from SCT arm.³⁷

Dexamethasone/Alpha-interferon

In a multicenter, cooperative group trial (n = 93), patients were treated with induction therapy with dexamethasone, followed by maintenance therapy with dexamethasone and alpha interferon. Complete hematologic response was seen in 24% and improvement of organ dysfunction in 45% of the evaluable patients; overall median survival was 31 months; and 2-year survival rate was 60%.³⁸

Thalidomide/Dexamethasone

Thalidomide in combination with dexamethasone was studied in a small group of patients.³⁹ Only 11 patients out of the 31 enrolled tolerated 400 mg/day of thalidomide for a median of 5.7 months; 20 patients experienced toxicity of grade 3 or more.³⁹ This combination although active is associated with substantial toxicity.

Cyclophosphamide/Thalidomide/Dexamethasone

Thalidomide has also been combined with cyclophosphamide, and dexamethasone. Wechalekar et al studied the use of oral regimen of cyclophosphamide, thalidomide, and dexamethasone (CTD) in phase II study involving 75 patients with advanced systemic light chain

amyloidosis, including 44 patients with clonal relapse after prior therapy.⁴⁰ Elderly patients (> 70 years), those with heart failures, and those with significant fluid overload received a risk attenuated CTD regimen (CTDa). The study reported overall hematologic response in 74% (48 out of 65 evaluable patients treated with either CTD or CTDa), including complete responses in 21% (n = 14) and partial responses in 53% (n = 34). About 8% (n = 6) discontinued treatment due to toxicities within 8 weeks of initiating therapy. Grade 2 toxicities were reported in 52% (n = 39) of patients and treatment related mortality was 4% (n = 3).⁴⁰ Among patients with complete and partial hematologic response, the three year estimated OS based on the data was 100% and 82% respectively.

Lenalidomide/Dexamethasone

Lenalidomide is an analogue of thalidomide. Phase II studies have shown lenalidomide in combination with dexamethasone is active in the treatment of patients with systemic light chain amyloidosis, including those with relapsed/refractory disease.⁴¹⁻⁴⁴ Common adverse effects reported in patients on the study included rash, cytopenia, and fatigue. The incidence of dermatologic adverse effects with combination of lenalidomide and dexamethasone was found to be higher in patients with amyloidosis compared to those with myeloma.⁴⁵ In addition, progressive azotemia and serious cardiac and renal toxicity has been reported in patients with amyloidosis, warranting careful monitoring of patients on this regimen.⁴⁶⁻⁴⁸

Lenalidomide/cyclophosphamide/dexamethasone

In phase II study, 35 patients of whom 24 were newly diagnosed with systemic amyloidosis, were treated with the combination of lenalidomide, cyclophosphamide, and dexamethasone.⁴⁹

About 63% of patients had cardiac involvement; 3% had stage III disease and 28% had ≥ 3 organs involved. The overall hematologic response rate to lenalidomide, cyclophosphamide and dexamethasone was 60%, including 40% with very-good partial response or better. Assessment of response using serum FLC assay, revealed 77% of patients had a hematologic response and 29% of these patients showed organ responses. The median hematologic progression-free survival reported in this trial was 28.3 months and the median overall survival was 37.8 months. Hematologic toxicity was the predominant adverse event reported in this study.⁴⁹

Pomalidomide/dexamethasone

Pomalidomide, like lenalidomide is an analogue of thalidomide. The safety and efficacy of pomalidomide and dexamethasone was studied in a prospective phase II study.⁵⁰ Patients with previously treated systemic light chain amyloidosis (n = 33) were enrolled in the trial and upon treatment with pomalidomide and dexamethasone, confirmed response was reported in 48% (n = 16) with a median time to response of 1.9 months. The median overall was 28 months and progression-free survival rates was 14 months; the overall and progression-free survival rate at one year were 76% and 59%, respectively.

Bortezomib

Bortezomib is rapidly active in systemic light chain amyloidosis with high rates of hematologic and organ responses. Clinical studies have reported bortezomib with or without dexamethasone to be active in untreated and relapsed amyloidosis.⁵¹⁻⁵⁵ The National Amyloidosis Center in Britain reported on 20 relapsed or refractory patients treated with bortezomib.⁵² A hematologic response was seen in 80% (n = 16) of patients, 15% (n = 3) achieved CR and 65% (n = 13) achieved a partial response.⁵² In a multicenter phase I/II dose-escalation study of

bortezomib, hematologic responses were seen in 15 % (15 out of 30 evaluable pretreated patients) with CR rate of 20% (n = 6).⁵⁶ Bortezomib was well tolerated at doses up to 1.6 mg/m² on a once-weekly schedule and 1.3 mg/m² on a twice-weekly schedule.⁵⁷ The median time to response was 1.2 months. Although once-weekly and twice-weekly bortezomib was seen to be generally well tolerated in the study, the once-weekly bortezomib regimen was associated with lower neurotoxicity.⁵⁷

Bortezomib/Dexamethasone

Efficacy of bortezomib in association with dexamethasone was also evaluated in small study of 18 patients included those who had relapsed or progressed on prior therapies. Out of 16 evaluable patients, hematologic response was seen in 94% (n = 14) including complete response in 44% (n = 7).⁵¹ A phase II clinical trial studied the bortezomib and dexamethasone adjuvant therapy in 21 patients not achieving a CR post-SCT. At 1 year post-SCT out of 12 evaluable patients, there was an overall response rate of 92% (n = 11), 67% (n = 8) achieved a CR and 50% (n = 6) had organ responses.⁵⁸ Data from three international centers from 94 patients (18 previously untreated) treated with bortezomib reported a 71% (67 out of 93 patients) overall response rate with CR in 25% (47% CR was in previously untreated patients).⁵³

Bortezomib/Melphalan/Dexamethasone

Combining weekly bortezomib with melphalan in small series of patients yielded hematologic response rates of 94%.⁵⁹ Bortezomib in combination with melphalan and dexamethasone was evaluated in a small phase II trial and results with a best-response rate of over 80% and a CR rate of 42%.⁶⁰ These encouraging preliminary results and the fact that bortezomib in combination oral melphalan and prednisone has improved survival in patients with myeloma had led to an ongoing phase

III trial is comparing bortezomib in combination with melphalan and dexamethasone to melphalan and dexamethasone as frontline therapy in patients with systemic amyloidosis.

A collaborative study at three large European amyloid centers analyzed the outcomes of 428 patients treated with oral CTD; oral melphalan/dexamethasone; bortezomib/dexamethasone with or without an alkylator; cyclophosphamide/lenalidomide/dexamethasone; or autologous SCT as first line treatment for systemic light chain amyloidosis. The organ and NT-proBNP responses were found highest in the group treated with bortezomib/dexamethasone (53% and 32%), followed by CTD (38% and 12%), autologous SCT (30%), melphalan/dexamethasone (23% and 19%) and cyclophosphamide/lenalidomide/dexamethasone (12% and 0%).⁶¹

Cyclophosphamide/Bortezomib/Dexamethasone

Recently, the combination of cyclophosphamide, bortezomib and dexamethasone (CyBORD) is reported with high hematologic response rates and CR in two independent studies.^{62,63} Mikhael et al reported analysis of 17 patients, 10 had no previous therapy. The patients were treated with weekly administration CyBORD before autologous transplantation, as an alternate to transplantation for transplant ineligible patients, or as salvage therapy for patients with relapsed disease. The hematological responses were seen in 94% and CR rate was 71%. The median duration of response was 22 months. Organ response was observed in 50% of the patients with renal involvement. Three patients originally ineligible for autologous SCT, became eligible after treatment with CyBORD.⁶²

In the study by Venner et al, 43 patients were treated with biweekly administration of CyBORD, Twenty out of the 43 patients were treatment naïve. The hematologic response rate was 81.4% with a CR



NCCN Guidelines Version 1.2020

Systemic Light Chain Amyloidosis

rate of 39.5%. Due to the biweekly administration, peripheral neuropathy was seen in 30% of the patients.^{62,63} A small retrospective study of patients newly diagnosed with systemic amyloidosis and multiple myeloma treated with the CyBORd regimen containing subcutaneous bortezomib reported a high response rate and minimal toxicity.⁶⁴ These results need to be validated in prospective trials.

NCCN Recommendations for Primary Treatment

The NCCN panel members recommend that treatment of systemic light chain amyloidosis should be in the context of a clinical trial when possible because data are insufficient to identify optimal treatment of the underlying plasma cell disorder.

Based on the evidence discussed above, the current NCCN Guidelines list the following as therapeutic considerations for management of patients with systemic light chain amyloidosis (all category 2A recommendation) along with best supportive care: high-dose melphalan followed by autologous SCT; oral melphalan and dexamethasone; dexamethasone in combination with alpha-interferon; thalidomide plus dexamethasone; lenalidomide and dexamethasone; Lenalidomide/cyclophosphamide/dexamethasone; pomalidomide and dexamethasone; bortezomib with or without dexamethasone; bortezomib with melphalan plus dexamethasone; cyclophosphamide, thalidomide, and dexamethasone; and cyclophosphamide, bortezomib, and dexamethasone.

The treatment options are listed alphabetically in the NCCN Guidelines and do not indicate or imply preference. As the optimal therapy for systemic light chain amyloidosis still remains unknown, the NCCN Panel Members strongly encourage treatment in the context of a clinical trial when possible.

Discussion
Update in
progress

References

- Falk RH, Comenzo RL, Skinner M. The systemic amyloidoses. *N Engl J Med* 1997;337:898-909. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/9302305>.
- Choufani EB, Sanchorawala V, Ernst T, et al. Acquired factor X deficiency in patients with amyloid light-chain amyloidosis: incidence, bleeding manifestations, and response to high-dose chemotherapy. *Blood* 2001;97:1885-1887. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11238135>.
- Thompson CA, Kyle R, Gertz M, et al. Systemic AL amyloidosis with acquired factor X deficiency: A study of perioperative bleeding risk and treatment outcomes in 60 patients. *Am J Hematol* 2010;85:171-173. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20052750>.
- Comenzo RL, Reece D, Palladini G, et al. Consensus guidelines for the conduct and reporting of clinical trials in systemic light-chain (AL) amyloidosis. *Leukemia* 2012. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22475872>.
- Lachmann HJ, Gallimore R, Gillmore JD, et al. Outcome in systemic AL amyloidosis in relation to changes in concentration of circulating free immunoglobulin light chains following chemotherapy. *Br J Haematol* 2003;122:78-84. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12823348>.
- Dispenzieri A, Kyle R, Merlini G, et al. International Myeloma Working Group guidelines for serum-free light chain analysis in multiple myeloma and related disorders. *Leukemia* 2009;23:215-224. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19020545>.
- van G, II, Hazenberg BP, Bijzet J, van Rijswijk MH. Diagnostic accuracy of subcutaneous abdominal fat tissue aspiration for detecting systemic amyloidosis and its utility in clinical practice. *Arthritis Rheum* 2006;54:2015-2021. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16732553>.
- Swan N, Skinner M, O'Hara CJ. Bone marrow core biopsy specimens in AL (primary) amyloidosis. A morphologic and immunohistochemical study of 100 cases. *Am J Clin Pathol* 2003;120:610-616. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14560572>.
- Lachmann HJ, Booth DR, Booth SE, et al. Misdiagnosis of hereditary amyloidosis as AL (primary) amyloidosis. *N Engl J Med* 2002;346:1786-1791. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12050338>.
- Lavatelli F, Perlman DH, Spencer B, et al. Amyloidogenic and associated proteins in systemic amyloidosis proteome of adipose tissue. *Mol Cell Proteomics* 2008;7:1570-1583. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18474516>.
- Vrana JA, Gamez JD, Madden BJ, et al. Classification of amyloidosis by laser microdissection and mass spectrometry-based proteomic analysis in clinical biopsy specimens. *Blood* 2009;114:4957-4959. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19797517>.
- Brambilla F, Lavatelli F, Di Silvestre D, et al. Reliable typing of systemic amyloidoses through proteomic analysis of subcutaneous adipose tissue. *Blood* 2012;119:1844-1847. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21917755>.
- Comenzo RL, Zhou P, Fleisher M, et al. Seeking confidence in the diagnosis of systemic AL (Ig light-chain) amyloidosis: patients can have both monoclonal gammopathies and hereditary amyloid proteins. *Blood* 2006;107:3489-3491. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16439680>.
- Gertz M, Merlini G. Definition of organ involvement and response to treatment in AL amyloidosis: an updated consensus opinion [abstract]. *Amyloid* 2010 17(Suppl 1):48-49. (Abstract CP-B). Available at:
- Maceira AM, Joshi J, Prasad SK, et al. Cardiovascular magnetic resonance in cardiac amyloidosis. *Circulation* 2005;111:186-193. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15630027>.

16. Dispenzieri A, Gertz MA, Kyle RA, et al. Serum cardiac troponins and N-terminal pro-brain natriuretic peptide: a staging system for primary systemic amyloidosis. *J Clin Oncol* 2004;22:3751-3757. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15365071>.
17. Palladini G, Campana C, Klersy C, et al. Serum N-terminal pro-brain natriuretic peptide is a sensitive marker of myocardial dysfunction in AL amyloidosis. *Circulation* 2003;107:2440-2445. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12719281>.
18. Gertz MA, Comenzo R, Falk RH, et al. Definition of organ involvement and treatment response in immunoglobulin light chain amyloidosis (AL): a consensus opinion from the 10th International Symposium on Amyloid and Amyloidosis. *Am J Hematol* 2005;79:319-328. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16044444>.
19. Palladini G, Dispenzieri A, Gertz MAA, et al. Validation of the criteria of response to treatment in AL amyloidosis [abstract]. *Blood* 2010;116:Abstract 1364. Available at: <http://abstracts.hematologylibrary.org/cgi/content/abstract/116/21/1364>.
20. Comenzo R, Gertz M. Autologous stem cell transplantation for primary systemic amyloidosis. *Blood* 2002;99:4276-4282. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12036853>.
21. Gertz MA, Lacy MQ, Dispenzieri A, et al. Stem cell transplantation for the management of primary systemic amyloidosis. *Am J Med* 2002;113:549-555. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12459400>.
22. Goodman HJ, Gillmore JD, Lachmann HJ, et al. Outcome of autologous stem cell transplantation for AL amyloidosis in the UK. *Br J Haematol* 2006;134:417-425. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16822290>.
23. Jimenez-Zepeda VH, Franke N, Delgado D, et al. High-dose melphalan for AL amyloidosis: The importance of case selection to improve clinical outcomes [abstract]. *Blood* 2010;116:Abstract 2403. Available at: <http://abstracts.hematologylibrary.org/cgi/content/abstract/116/21/2403>.
24. Santhorawala V. Role of high-dose melphalan and autologous peripheral blood stem cell transplantation in AL amyloidosis. *Am J Blood Res* 2012;2:9-17. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22432083>.
25. Cordes S, Dispenzieri A, Lacy MQ, et al. Ten-year survival after autologous stem cell transplantation for immunoglobulin light chain amyloidosis. *Cancer* 2012. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22707405>.
26. Dispenzieri A, Kyle RA, Lacy MQ, et al. Superior survival in primary systemic amyloidosis patients undergoing peripheral blood stem cell transplantation: a case-control study. *Blood* 2004;103:3960-3963. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14739213>.
27. Wechalekar AD, Schonland SO, Kastiris E, et al. A European collaborative study of treatment outcomes in 346 patients with cardiac stage III AL amyloidosis. *Blood* 2013;121:3420-3427. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23479568>.
28. Gertz MA, Lacy MQ, Dispenzieri A, et al. Effect of hematologic response on outcome of patients undergoing transplantation for primary amyloidosis: importance of achieving a complete response. *Haematologica* 2007;92:1415-1418. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17768110>.
29. Skinner M, Santhorawala V, Seldin D, et al. High-dose melphalan and autologous stem-cell transplantation in patients with AL amyloidosis: an 8-year study. *Ann Intern Med* 2004;140:85-93. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14734330>.
30. Kumar SK, Dispenzieri A, Lacy MQ, et al. Changes in serum-free light chain rather than intact monoclonal immunoglobulin levels predicts outcome following therapy in primary amyloidosis. *Am J Hematol*

2011;86:251-255. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/21328431>.

31. Gertz MA, Lacy MQ, Dispenzieri A, et al. Risk-adjusted manipulation of melphalan dose before stem cell transplantation in patients with amyloidosis is associated with a lower response rate. *Bone Marrow Transplant* 2004;34:1025-1031. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15516945>.

32. Perfetti V, Siena S, Palladini G, et al. Long-term results of a risk-adapted approach to melphalan conditioning in autologous peripheral blood stem cell transplantation for primary (AL) amyloidosis. *Haematologica* 2006;91:1635-1643. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17145600>.

33. Cibeira MT, Sanchorawala V, Seldin DC, et al. Outcome of AL amyloidosis after high-dose melphalan and autologous stem cell transplantation: long-term results in a series of 421 patients. *Blood* 2011. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21828140>.

34. Palladini G, Perfetti V, Obici L, et al. Association of melphalan and high-dose dexamethasone is effective and well tolerated in patients with AL (primary) amyloidosis who are ineligible for stem cell transplantation. *Blood* 2004;103:2936-2938. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15070667>.

35. Palladini G, Russo P, Nuvolone M, et al. Treatment with oral melphalan plus dexamethasone produces long-term remissions in AL amyloidosis. *Blood* 2007;110:787-788. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17606766>.

36. Jaccard A, Moreau P, Leblond V, et al. High-dose melphalan versus melphalan plus dexamethasone for AL amyloidosis. *N Engl J Med* 2007;357:1083-1093. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17855669>.

37. Jaccard A, Leblond V, Royer B, et al. Autologous stem cell transplantation (ASCT) versus oral melphalan and high-dose

dexamethasone in patients with AL (primary) amyloidosis: long term follow-up of the French multicentric randomized trial [abstract]. *Blood* 2010;116:Abstract 1344. Available at:

<http://abstracts.hematologylibrary.org/cgi/content/abstract/116/21/1344>.

38. Dhodapkar M, Hussein M, Rasmussen E, et al. Clinical efficacy of high-dose dexamethasone with maintenance dexamethasone/alpha interferon in patients with primary systemic amyloidosis: results of United States Intergroup Trial Southwest Oncology Group (SWOG) S9628. *Blood* 2004;104:3520-3526. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15308571>.

39. Palladini G, Perfetti V, Perlini S, et al. The combination of thalidomide and intermediate-dose dexamethasone is an effective but toxic treatment for patients with primary amyloidosis (AL). *Blood* 2005;105:2949-2951. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15572585>.

40. Wechalekar AD, Goodman HJ, Lachmann HJ, et al. Safety and efficacy of risk-adapted cyclophosphamide, thalidomide, and dexamethasone in systemic AL amyloidosis. *Blood* 2007;109:457-464. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16990593>.

41. Dispenzieri A, Lacy M, Zeldenrust S, et al. The activity of lenalidomide with or without dexamethasone in patients with primary systemic amyloidosis. *Blood* 2007;109:465-470. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17008538>.

42. Sanchorawala V, Wright D, Rosenzweig M, et al. Lenalidomide and dexamethasone in the treatment of AL amyloidosis: results of a phase 2 trial. *Blood* 2007;109:492-496. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/16960148>.

43. Sanchorawala V, Finn KT, Fennessey S, et al. Durable hematologic complete responses can be achieved with lenalidomide in AL amyloidosis. *Blood* 2010;116:1990-1991. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/20847211>.

44. Dispenzieri A, Lacy M, Zeldenrust S, et al. Long term follow-up of patients with immunoglobulin light chain amyloidosis treated with lenalidomide and dexamethasone [abstract] *Blood* 2008;112:Abstract 1737. Available at: <http://abstracts.hematologylibrary.org/cgi/content/abstract/112/11/1737>.
45. Sviggum HP, Davis MD, Rajkumar SV, Dispenzieri A. Dermatologic adverse effects of lenalidomide therapy for amyloidosis and multiple myeloma. *Arch Dermatol* 2006;142:1298-1302. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17043184>.
46. Batts ED, Sanchorawala V, Hegerfeldt Y, Lazarus HM. Azotemia associated with use of lenalidomide in plasma cell dyscrasias. *Leuk Lymphoma* 2008;49:1108-1115. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18452093>.
47. Specter R, Sanchorawala V, Seldin DC, et al. Kidney dysfunction during lenalidomide treatment for AL amyloidosis. *Nephrol Dial Transplant* 2011;26:881-886. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20693160>.
48. Tapan U, Seldin DC, Finn KT, et al. Increases in B-type natriuretic peptide (BNP) during treatment with lenalidomide in AL amyloidosis. *Blood* 2010;116:5071-5072. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21127185>.
49. Kumar SK, Hayman SR, Buadi FK, et al. Lenalidomide, cyclophosphamide, and dexamethasone (CRd) for light-chain amyloidosis: long-term results from a phase 2 trial. *Blood* 2012;119:4860-4867. Available at: <http://bloodjournal.hematologylibrary.org/content/119/21/4860.abstract>.
50. Dispenzieri A, Buadi F, Laumann K, et al. Activity of pomalidomide in patients with immunoglobulin light-chain amyloidosis. *Blood* 2012;119:5397-5404. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22493299>.
51. Kastritis E, Anagnostopoulos A, Roussou M, et al. Treatment of light chain (AL) amyloidosis with the combination of bortezomib and dexamethasone. *Haematologica* 2007;92:1351-1358. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18024372>.
52. Wechalekar AD, Lachmann HJ, Offer M, et al. Efficacy of bortezomib in systemic AL amyloidosis with relapsed/refractory clonal disease. *Haematologica* 2008;93:295-298. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18245653>.
53. Kastritis E, Wechalekar AD, Dimopoulos MA, et al. Bortezomib with or without dexamethasone in primary systemic (light chain) amyloidosis. *J Clin Oncol* 2010;28:1031-1037. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20085941>.
54. Lamm W, Willenbacher W, Lang A, et al. Efficacy of the combination of bortezomib and dexamethasone in systemic AL amyloidosis. *Ann Hematol* 2011;90:201-206. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20821326>.
55. Singh V, Saad A, Palmer J, et al. Response to bortezomib based induction therapy in newly diagnosed light chain (AL) amyloidosis [abstract]. *Blood* 2009;114:Abstract 1867. Available at: <http://abstracts.hematologylibrary.org/cgi/content/abstract/114/22/1867>.
56. Reece DE, Sanchorawala V, Hegenbart U, et al. Weekly and twice-weekly bortezomib in patients with systemic AL amyloidosis: results of a phase 1 dose-escalation study. *Blood* 2009;114:1489-1497. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19498019>.
57. Reece DE, Hegenbart U, Sanchorawala V, et al. Efficacy and safety of once-weekly and twice-weekly bortezomib in patients with relapsed systemic AL amyloidosis: results of a phase 1/2 study. *Blood* 2011;118:865-873. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21562045>.
58. Landau H, Hoffman J, Hassoun H, et al. Adjuvant bortezomib and dexamethasone following risk-adapted melphalan and stem cell

transplant in systemic AL amyloidosis [abstract]. J Clin Oncol 2009;27 (Suppl-15):Abstract 8540. Available at:
<http://meeting.ascopubs.org/cgi/content/abstract/27/15S/8540>.

59. Gasparetto C, Santhorawala V, Snyder RM, et al. Use of melphalan (M)/dexamethasone (D)/bortezomib in AL amyloidosis [abstract]. J Clin Oncol 2010;28:Abstract 8024. Available at:
http://meeting.ascopubs.org/cgi/content/abstract/28/15_suppl/8024.

60. Zonder J, Santhorawala V, Snyder R. Rapid hematologic and organ responses in patients with AL amyloid treated with bortezomib plus melphalan and dexamethasone [abstract]. Amyloid 2010;17(s1):86.

61. Wechalekar AD, Kastiris E, Merlini G, et al. A European Collaborative Study of Treatment Outcomes In 428 Patients with Systemic AL Amyloidosis [abstract] Blood 2010;116:Abstract 988. Available at:
<http://abstracts.hematologylibrary.org/cgi/content/abstract/116/21/988>.

62. Mikhael JR, Schuster SR, Jimenez-Zepeda VH, et al. Cyclophosphamide-bortezomib-dexamethasone (CyBORd) produces rapid and complete hematologic response in patients with AL amyloidosis. Blood 2012;119:4391-4394. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22331188>.

63. Venner CP, Lane T, Foard D, et al. Cyclophosphamide, bortezomib, and dexamethasone therapy in AL amyloidosis is associated with high clonal response rates and prolonged progression-free survival. Blood 2012;119:4387-4390. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22331187>.

64. Shah GL, Kaul E, Fallo S, et al. Subcutaneous Bortezomib in Combination Regimens in Newly Diagnosed Patients with Myeloma or Systemic AL Amyloidosis: High Response Rates and Minimal Toxicity. ASH Annual Meeting Abstracts 2012;120:2968-. Available at:
<http://abstracts.hematologylibrary.org/cgi/content/abstract/ashmtg;120/21/2968>.

Discussion
update in
progress