

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

- **Induction Phase**
 - **Bacterial Prophylaxis**
 - All patients should receive antibacteria prophylaxis during induction
 - Sulfamethoxazole/Trimethoprim SS daily for 4 months
 - If sulfa allergy or induction with Lenalidomide Quinolone or Penicillin can be used
 - **Viral Prophylaxis**
 - Prophylaxis for herpes zoster in Bortezomib containing Regimen
 - Acyclovir 400mg BID or Valacyclovir 500mg daily
 - **PCP Prophylaxis**
 - Sulfamethoxazole/Trimethoprim prophylaxis recommended if long term steroid therapy planned [Especially high dose/intensity steroid]
- **Re assess need for continued prophylaxis after completion of induction therapy**

Multiple Myeloma with Renal Failure

Suspected Myeloma with Renal Failure

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

*Hypovolemia,
Hypercalcemia,
Drugs,
infections

Serum FLC
> 150 mg/dL

Serum FLC
< 150 mg/dL

Consider kidney biopsy

Most likely cast nephropathy; **
Consider renal biopsy only
if inadequate response

Treat based on Biopsy

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

† Bortezomib Based regimen: VTD, PAD, VDD