Acute Lymphoblastic Leukemia and Lymphoblastic Lymphoma (ALL) – Adult[1]

Disclaimer: *This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.*

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[1] Age ≥ 18 years old

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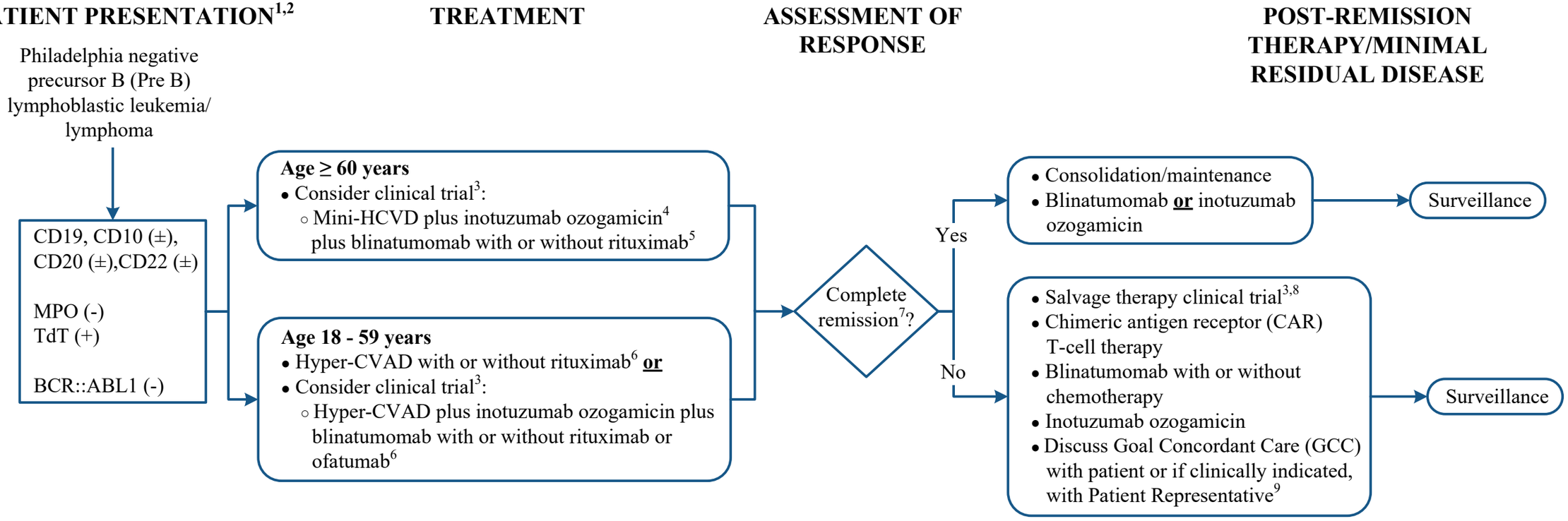
Note: Consider clinical trials as treatment options for eligible patients. Stem Cell Transplant (SCT) guidelines are not included with this algorithm. Leukemia patients should be referred and treated at a Comprehensive Cancer Center.



[1] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[2] Consider MD Anderson approved biomarkers
[3] See Leukemia Clinical Trials
[4] Mini-HCVD (cyclophosphamide and dexamethasone at 50% dose reduction, no anthracycline, methotrexate at 75% dose reduction, cytarabine at 0.5 g/m^2 for 4 doses) plus inotuzumab ozogamicin
[5] Rituximab if CD20 ≥ 20%
[6] Hyper-CVAD (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, dexamethasone); rituximab if CD20 ≥ 20%
Hyper-CVAD (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, dexamethasone); ofatumumab if CD20 ≥ 1%
[7] Failure after induction with hyper-CVAD based regimen means no response after 2 cycles of chemotherapy
[8] For late relapses (relapse > 3 years from initial diagnosis), the same induction regimen may be considered for salvage therapy
[9] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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Approved by the Executive Committee of the Medical Staff on 05/16/2023

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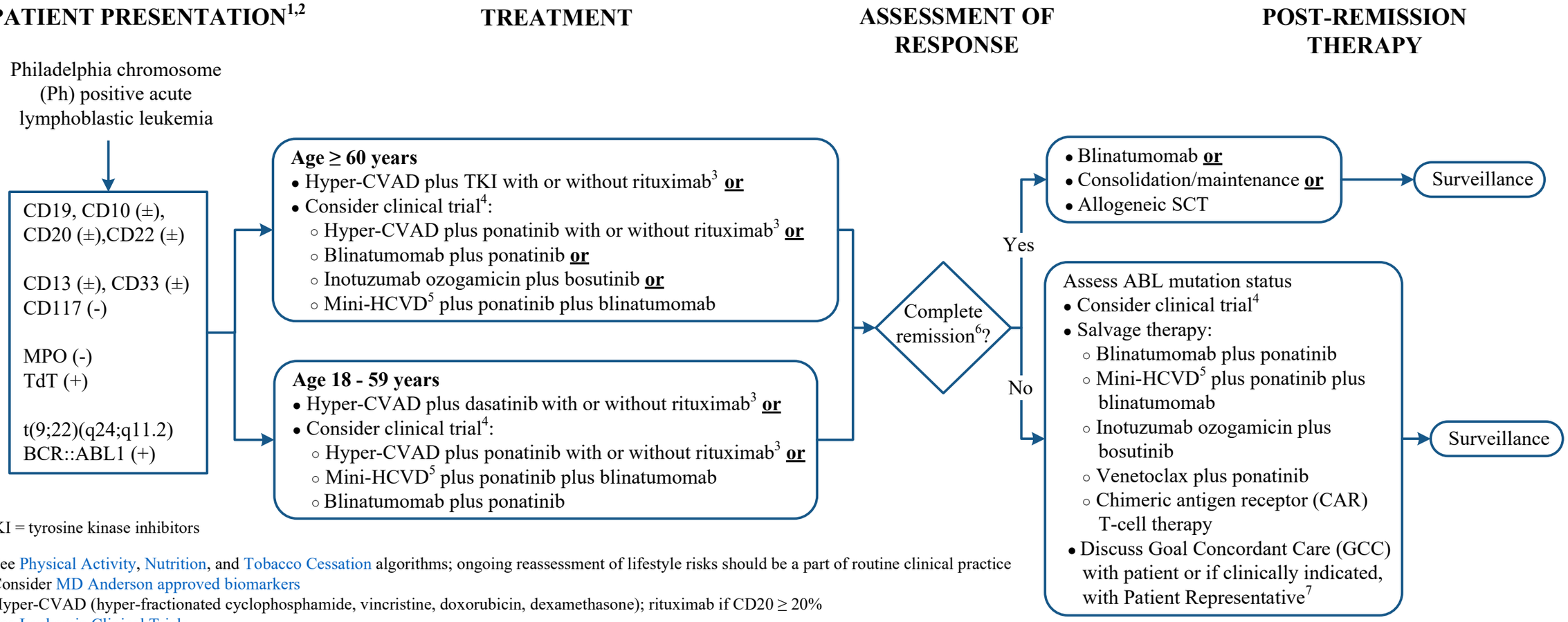

TKI = tyrosine kinase inhibitors

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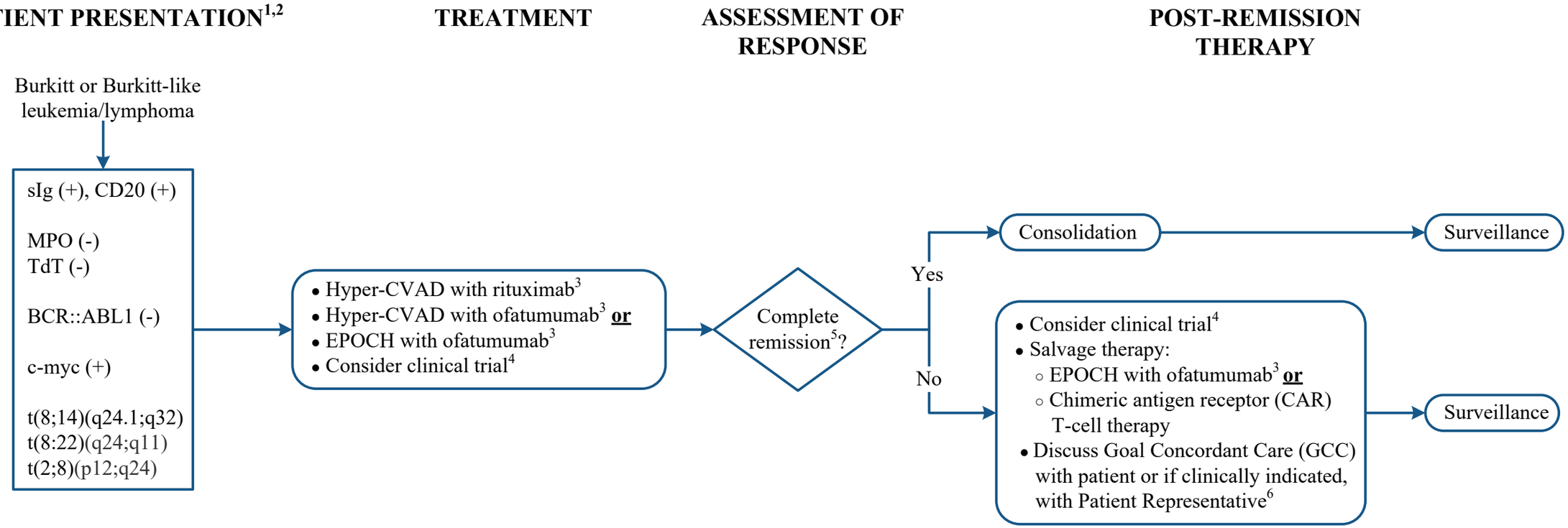

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[3] Hyper-CVAD (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, dexamethasone) plus rituximab
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EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) plus ofatumumab
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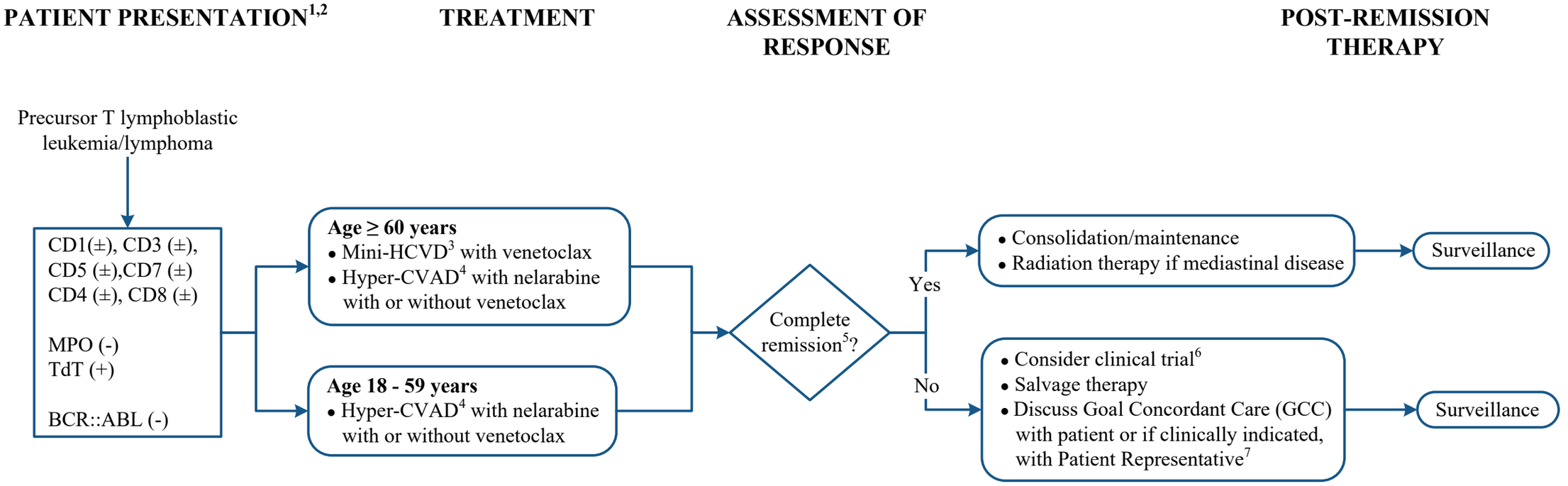

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Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Leukemia Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Core Development Team Leads

Alessandra Ferrajoli, MD (Leukemia)
Elias Jabbour, MD (Leukemia)
Hagop Kantarjian, MD (Leukemia)

Workgroup Members

Yesid Alvarado, MD (Leukemia)
Michael Andreeff, PhD, MD (Leukemia)
Kapil Bhalla, MD (Leukemia)
Gautam Borthakur, MBBS (Leukemia)
Prithviraj Bose, MD (Leukemia)
Jan Burger, MD (Leukemia)
Naval Daver, MD (Leukemia)
Courtney DiNardo, MD (Leukemia)
Wendy Garcia, BS♦
Guillermo Garcia-Manero, MD (Leukemia)
Ghayas Issa, MD (Leukemia)
Nitin Jain, MBBS (Leukemia)
Tapan Kadia, MD (Leukemia)
Michael Keating, MD (Leukemia)
Marina Konopleva, PhD, MD (Leukemia)
Steven Kornblau, MD (Leukemia)
Lucia Masarova, MD (Leukemia)
Deborah McCue, PharmD (Pharmacy Clinical Programs)
Guillermo Montalban-Bravo, MD (Leukemia)
Maro Ohanian, DO (Leukemia)
Naveen Pemmaraju, MD (Leukemia)
Farhad Ravandi-Kashani, MD (Leukemia)
Koji Sasaki, MD (Leukemia)
Nicholas Short, MD (Leukemia)
Koichi Takahashi, MD (Leukemia)
Philip Thompson, MBBS (Leukemia)
Srdan Verstovsek, MD (Leukemia)
Mary Lou Warren, DNP, APRN, CNS-CC♦
William Wierda, PhD, MD (Leukemia)
Musa Yilmaz, MD (Leukemia)

♦ Clinical Effectiveness Development Team