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Introdução: Mieloma Múltiplo (MM) é uma neoplasia hematológica caracterizada pela proliferação de clone de plasmócitos que encontram microambiente favorável na medula óssea com síntese de proteína monoclonal e danos a órgãos-alvo. O estadiamento é feito por meio do International Staging System (ISS), que tem relação indireta com a sobrevida. **Objetivos:** Estudar a correlação do estadiamento do MM de acordo com ISS e características clínicas ao diagnóstico com sobrevida global e sobrevida livre de progressão em um centro de referência em Feira de Santana-BA (UNACON). **Material e métodos:** Estudo de coorte retrospectiva, por análise de 80 prontuários, selecionados ao acaso em um total de 247, no período de 2018 a 2025, da UNACON. Dados coletados foram: sexo, cidade de origem, idade, estadiamento ISS e grau de doença baseado nas características da doença ao diagnóstico (lesão óssea, anemia e disfunção renal) que foram caracterizados como doença leve, moderada e grave na presença de uma, duas ou três alterações. Os cálculos estatísticos foram realizados pelo software SPSS (versão 8) considerando o valor de significância ($p < 0,05$). A relação entre ISS e sobrevida foi avaliada por meio de ANOVA e coeficiente de correlação de Pearson. **Resultados:** Dos 80 pacientes, 59% eram do sexo masculino e 41% do sexo feminino, com idade média ao diagnóstico de 64,5 anos para homens e 66,6 anos para mulheres. A cidade com maior número de casos foi Feira de Santana, com 53%, seguido de 5% de Amélia Rodrigues. Quanto ao estadiamento ISS 51% dos pacientes tinham esse dado no prontuário, 9% eram ISS 1, 14% ISS 2 e 29% ISS 3; em 49% dos casos, essa informação não fora disponibilizada em prontuário mostrando a dificuldade de acesso aos exames ao diagnóstico especialmente tratando-se de um serviço público. A análise de Pearson demonstrou uma correlação forte e negativa entre ISS e tempo de sobrevida ($r=-0.75$), indicando uma proporcionalidade inversa. Além disso, a análise de Pearson entre ISS e sobrevida livre de progressão (SLP) apresentou correlação moderada e negativa ($r = -0,48$), o que demonstra que quanto maior o ISS, menor a SLP. Em relação ao grau de doença e sobrevida, a análise por ANOVA mostrou diferença significativa quando comparados o grupo com grau de doença 1 e o grupo com grau 3 ($p = 0,04$), demonstrando que quanto maior o grau de doença pior é a evolução clínica. **Discussão e conclusão:** Os dados deste estudo reforçam o ISS como importante preditor prognóstico no MM, evidenciado pela correlação com tempo de sobrevida e SLP. Estágios mais avançados associam-se a piores desfechos, em concordância com os achados de Palumbo et al. (2015). A idade observada nesta pesquisa seguiu o padrão encontrado na literatura, de 65 a 70 anos, com predomínio masculino (55-60%) (Kyle & Rajkumar, 2008; Fonseca et al. 2004). A diferença significativa entre pacientes com doença em grau 1 e 3 ($p = 0,04$) foram destacados também no estudode D'Agostinho et al. 2022. A ausência de registro em 49% dos prontuários é uma limitação para este estudo, mas a análise em grupos de risco está em concordância com o que temos na literatura e no cenário de dificuldade para realização do ISS pode ser uma ferramenta de avaliação de risco. A análise reforça que uma documentação clínica completa é essencial para uma melhor estratificação de risco e que, mesmo sem o ISS, marcadores clínicos no diagnóstico podem ajudar a prever o desfecho do paciente.

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IMPROVING THROMBOTIC EVENT PROPHYLAXIS IN MULTIPLE MYELOMA THROUGH PHARMACEUTICAL CARE: EXPERIENCE WITH IMPEDE-VTE IN A BRAZILIAN COHORT

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Introduction: Multiple myeloma (MM) patients face elevated venous thromboembolism (VTE) risks, particularly with immunomodulatory drugs (IMiDs). In the Myeloma XI trial, 11.8% of IMiD-treated patients developed VTE despite 87.7% receiving thromboprophylaxis at the time of the event (Leclerc et al., 2022). Given this context, risk assessment strategies are crucial for selecting patiets that would benefit for prophylaxis. In a 10-year retrospective cohort of Brazilian patients, IMPEDE-VTE was found accurate for assessing VTE risk during IMiD therapy, but nearly 98% of the cohort received thalidomide-based regimens (da Costa et al., 2023). **Objectives:** This study evaluates IMPEDE-VTE's application and documented thrombotic events in a Brazilian lenalidomide-treated MM cohort. **Material and methods:** We conducted a prospective analysis of all first-line MM patients at a private cancer center between February 2024 and July 2025. A clinical pharmacist calculated IMPEDE-VTE at treatment initiation, and proceeded with interventions with the prescriber for implementation or adjustment of prophylactic therapies if necessary, per institutional protocol. Although IMPEDE-VTE was not designed to measure specific myeloma-driven thrombosis, as it considers IMiD use and VTE prophylaxis on its calculus, a score disregarding the newly prescribed medications was also obtained to explore correlations with pretreatment thrombotic events. Statistical analysis employed Pearson's χ^2 tests for categorical variables and Welch's t-tests for continuous variables (α=0.05). **Results:** Sixty patients (mean age 71.8 years) were included in this preliminary analysis. The median follow-up duration was 26.42. Most patients were treated with VRd (80.0%), followed by IsaVRd (10.0%), DRd (3.3%), Rd (3.3%), and DVRd (3.3%). Following treatment, 45.0% of patients were classified as intermediate, 43.3% as low (due to proper use of prophylaxis) and 11.7% as high risk.

In total, 3 patients (5.0%) presented thrombotic events during active treatment (grade 2-5). Five other events were documented <90 days prior to treatment initiation (8.3%). A total of 20 pharmaceutical interventions were performed. Of these, 12 interventions were accepted by prescribers (60%), extending the adherence to recommended prophylaxis from 66.7% to 86.7% of the population. Most patients received ASA 100 mg (38.3%) or rivaroxaban 10 mg (28.3%). 13.3% of patients received no VTE prophylaxis. There was a significant association (χ^2 = 6.91, p = 0.032) between pre-treatment IMPEDE risk category and the occurrence of pre- treatment thrombosis, but not for the post-treatment risk category (χ^2 = 1.35, p = 0.509). **Discussion and conclusion:** In 18 months, pharmacist-led interventions optimized prophylaxis adherence amongst the hematology team. Yet, 13.3% of patients remained unprotected, underscoring persistent gaps in implementation. VTE incidence is consistent with literature data on this population, but further follow up is needed due to the small sample size.

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MAPPING AL AMYLOIDOSIS CHALLENGES IN BRAZIL: A BASIS FOR THE BRAZILIAN CONSENSUS RECOMMENDATIONS

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Introduction: AL amyloidosis is a systemic disease characterized by light chain deposition leading to multiple organ disfunction, representing a medical challenge. Many countries have recommendations for management of AL amyloidosis, but none exist for Brazil. **Objectives:** A national survey on AL amyloidosis was conducted, with diverse institutions across regions and funding models. Here, we describe the main challenges identified and provide expert-guided practical guidance and recommendations for optimal diagnosis, evaluation, classification, and treatment of AL amyloidosis in Brazil. **Material and methods:** A questionnaire to map diagnostic and therapeutic challenges in AL amyloidosis was answered by 96 institutions (50 private; 46 public) in Brazil. Expert recommendations were formulated following a virtual structured advisory exchange in May 2025. **Discussion and conclusion:** 1) Early detection: AL amyloidosis is rare (80.2% of centers perform 0–5 diagnoses/year) and patients experience delayed time to diagnosis after symptom onset (only 7.5% centers diagnose in <6 mo, 50.5% in 7–12 mo and 15.1% >24 mo). Early diagnosis of AL is critical to improve outcomes and prevent irreversible organ damage. Educational initiatives among patients and various specialties, and establishment of multidisciplinary specialized centers are needed in Brazil (only 70.8% of centers reported access to a multidisciplinary approach) to improve the time to diagnosis and subsequent prognosis for patients. 2) Accurate diagnosis: Diagnosis is based on 4 pillars: clinical syndrome, detection of monoclonal component, identification of amyloid deposits, and typing of the amyloidogenic protein. 20.9% of the 96 institutions did not have access to all 3 tests for detecting the monoclonal component. Patients in Brazil often require ≥2 biopsies for diagnosis. Clear guidance on which tissues to biopsy, techniques to use, and the appropriate timepoints is essential to improve diagnostic accuracy. Regarding availability of tissues for amyloid detection, 100% of centers reported performing bone marrow biopsy, 86.5% abdominal fat biopsy, 65.6% kidney biopsy, 36.5% salivary gland biopsy, and 16.7% endomyocardial biopsy. Additional training of pathology centers, plus availability and proper technique of Congo red staining and polarized light microscopy, are crucial for accurate diagnosis. These techniques were available in 97.9% and 42.7% of centers, respectively. 3) Evaluation and classification: cardiac involvement in AL amyloidosis is associated with worst outcomes. Biomarker testing should be used at all stages: diagnosis, prognostic evaluation, patient follow-up, and assessing suitability for transplant. Most centers have access to tests to assess cardiac involvement (NT- proBNP, 98.6%; troponin 91.7%, echocardiography test, 83.3%). 4) Optimal management and treatment: a multidisciplinary approach is crucial to manage the challenges patients experience. Only 54.2% of centers have access to daratumumab. Most centers have bortezomib (97.9%), cyclophosphamide (94.8%), melphalan (90.6%) and dexamethasone. Addition of daratumumab is recommended, if available. Bone marrow transplant should be indicated cautiously, considering patient fitness and center experience (82.3% had access). These expert-guided recommendations aim to educate and serve as a reference for HCPs involved in diagnosis and treatment of patients with AL amyloidosis in Brazil.

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