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.

References: da Costa IHF, Ribeiro DD, de Oliveira GB, Vieira ÉLM, Rocha NP, Teixeira AL, et al. Tissue factor pathway inhibitor and protein S plasma levels are associated with thrombosis in multiple myeloma. J Thromb Thrombolysis. 2023;56(1):147-55. doi:10.1007/s11239-023-02793-9. PMID: 37129132.

Leclerc V, Lode L, Eveillard M, Harousseau JL, Avet-Loiseau H, Magrangeas F, et al. Clinical relevance of clonal hematopoiesis in newly diagnosed multiple myeloma patients. J Cancer Res Clin Oncol. 2022;148(4):975-84. doi:10.1007/s00432-021-03721-w. PMID: 34595506.

https://doi.org/10.1016/j.htct.2025.104839

ID - 1072

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

PMM Garibaldi [a], JTDS Filho [b], RJPdM Filho [c], RS Szor [d], C Miguel [e], E Crusoe [f], CT Bueno [g], T Queiroz [g], V Hungriai [h]

[a] *Faculdade de Medicina de Ribeirão Preto (FMRP), Universidade de São Paulo (USP), Ribeirão Preto, Brazil*
[b] *Faculdade de Medicina de Campos (FMC), Campos dos Goytacazes, Brazil*
[c] *Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil*
[d] *Hospital Nove de Julho, São Paulo, Brazil*
[e] *Regional Medical School Foundation, São José do Rio Preto, Brazil*
[f] *Instituto D'or Oncologia; Federal University of Bahia, Salvador, Brazil*
[g] *Johnson & Johnson Innovative Medicine, São Paulo, Brazil*
[h] *Clínica São Germano, São Paulo, Brazil*

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.

https://doi.org/10.1016/j.htct.2025.104840