Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Diagnostic and Therapeutic Services
LABORATORY MEDICINE DIRECTORATE

Recommendations for monitoring of monoclonal proteins in the primary care setting and when to refer for specialist haematological assessment.

Monoclonal proteins are relatively common and when discovered should prompt other investigations to exclude myeloma or other lymphoproliferative disorders.

These should routinely include

- FBC - a full blood count to look for anaemia or other cytopaenias
- U&E's – urea and electrolytes to look for renal impairment
- Ca – calcium levels to look for hypercalcaemia

Clinical features to assess include

- Pain – does the patient present with unexplained bone pain?
- Infections – does the patient present with an increased incidence of infections?
- Lymphadenopathy and hepatosplenomegaly
- Heart failure, oedema or proteinuria suggestive of AL amyloidosis

If a patient has a monoclonal protein and any of the above features, urgent referral to a Consultant Haematologist, for specialist assessment should be made.

If a patient has a stable (ie measured at least twice two months apart) low level monoclone eg IgG M-protein <15g/l or IgA M-protein <10g/l, is not anaemic, renally impaired, hypercalcaemic and does not complain of bone pain and has no hepatosplenomegaly or lymphadenopathy or increased incidence of infections, or features suggestive of AL amyloidosis, the likely diagnosis is monoclonal gammopathy of undetermined significance (MGUS) and referral for specialist haematological assessment is not required. The risk of progression from MGUS to myeloma is estimated at 1% per year

When a diagnosis of MGUS has been made, these patients can be monitored in the primary care setting and monitoring of the monoclonal protein along with periodic FBC, U&Es, Ca and a clinical check for new features including unexplained bone pain may be made. Once stability of the monoclonal protein is established, parameters may be measured at six months and then at yearly intervals with earlier re-assessment if new clinical features emerge. If patients remain stable according to their blood results and clinical state, on going monitoring in the community is reasonable. If any of these features become deranged, urgent referral for specialist assessment is recommended.

If in doubt, referral for specialist assessment is welcomed.

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See algorithm below: