# AML Relapsed / Refractory / High Risk Multidisciplinary Team (MDT)

Terms of Reference

## 1. Definition

The AML Relapsed/Refractory/High Risk Multidisciplinary Team (MDT) comprises clinicians with a specialist interest in Acute Myeloid Leukaemia (AML), with expertise in its diagnosis and management. Drawing on their collective knowledge and experience, the team considers all relevant treatment options and develops individualised recommendations for each patient.

## 2. Aim

The overall aim of the expert advisory panel is to provide a formal mechanism for specialist input into the treatment planning and ongoing management of patients with relapsed, refractory, and high-risk AML — including those with Measurable Residual Disease (MRD) relapse.

The panel provides advice to the referring clinician. Treatment decisions remain the responsibility of the primary clinician and should be subsequently ratified through the patient's local or regional MDT.

## 3. Objectives

i. Ensure up-to-date, evidence-based treatment recommendations are made with respect to patient management as clinical circumstances dictate.
ii. Facilitate discussion of complex AML cases in the relapsed, refractory, or high-risk setting, including those with MRD relapse (defined per ELN criteria).
iii. Maintain documentation of treatment recommendations for each patient and communicate these to relevant team members, including the referring physician. Data will be anonymised and referrers will be provided a unique identifier for each case.
iv. Provide an opportunity to discuss enrolment of patients in clinical trials and research activities, where available.
v. Promote an educational environment for referring clinicians, trainees and core members, ensuring consistent, evidence-based provision of therapy for complex patients throughout the UK.
vi. Contribute to a database of complex AML cases.

## 4. Operational Guidelines

### 4.1 Membership

Membership of the AML Relapsed/Refractory/High Risk MDT comprises members of the UKAML RN and referring treating clinicians.

## 4.2 Quorum

Four members of the MDT must be present for the meeting to be considered quorate. At least one transplant physician and one physician with knowledge of the current relapse trials portfolio must be present.

## 4.3 Patients to be Discussed

The MDT will discuss the following patient groups:

- Patients with relapsed or refractory AML who are considered eligible for treatment.
- Patients with MRD-positive disease — either relapse from a previously negative timepoint, or persistence following therapy (ELN defined).
- High-risk AML, including cases with TP53 mutations or MECOM rearrangements, where upfront standard-of-care options result in suboptimal outcomes.
- Unusual and rare myeloid malignancies where there is limited consensus on the best treatment approach — including, but not limited to, blastic plasmacytoid dendritic cell neoplasm and bi-phenotypic leukaemias.

The referring clinician must submit all referral details via the online referral form no later than three days prior to the meeting, to allow prioritisation of cases and to ensure adequate time for any further information to be obtained. Late additions to the agenda are acceptable but must be agreed with the Chair in advance. If referrers experience any issues with the form or problems referring, they should contact kch-tr.nationalamlmdt@nhs.net. The referring clinician is responsible for ensuring all patients are made aware that their case will be discussed with the expert advisory panel.

## 4.4 Chair And Co-Chairs

The Chair and Co-Chairs will be appointed from the UK AML RN. The responsibilities of the Chair/Co-Chair include:

- Keeping meetings to the agenda and managing timekeeping.
- Ensuring all members are appropriate to the meeting and are encouraged to participate.
- Ensuring there is appropriate representation to enable comprehensive recommendations.
- Commencing and facilitating discussions.
- Summarising the discussion and inviting further comment before moving to the next case.
- Promoting mutual professional respect among all team members.
- Ensuring a member of the MDT is allocated to document discussion and recommendations for each session.

## 4.5 Meeting Time & Venue

Meetings will be held remotely via Microsoft Teams on a fortnightly basis on Friday at 1200-1300.

### 4.6 Referral Pathway

The referral pathway is detailed in the Appendix below.

### 4.7 Meeting Agenda

Case discussion will be determined and prioritised by the Chair following review of referrals and/or discussion with the referrer.

The referring clinician should present each case, ensuring all details on the referral proforma have been completed in advance to facilitate full and informed discussion. The agenda will be circulated prior to the meeting. During the meeting, the Chair will summarise the recommendations from each discussion before moving to the next case. Outcomes will be shared with those in attendance and recorded in the shared Excel sheet.

### 4.8 Confidentiality

All patient information presented remains confidential and is to be used solely for the purpose of clinical management. All healthcare professionals are subject to confidentiality agreements through their regular employment.

### 4.9 Meeting Documentation

Referral documentation will be maintained by the Chair and MDT members. Outcomes will be circulated by email following each meeting. Recommendations should be recorded in accordance with local policy at the referring clinician's site.

The referring clinician is responsible for discussing the meeting recommendations with the patient, family, and/or carer, and for developing a treatment plan that reflects patient preferences. All recommendations should be ratified by the relevant local or regional MDT to ensure agreement is reached.

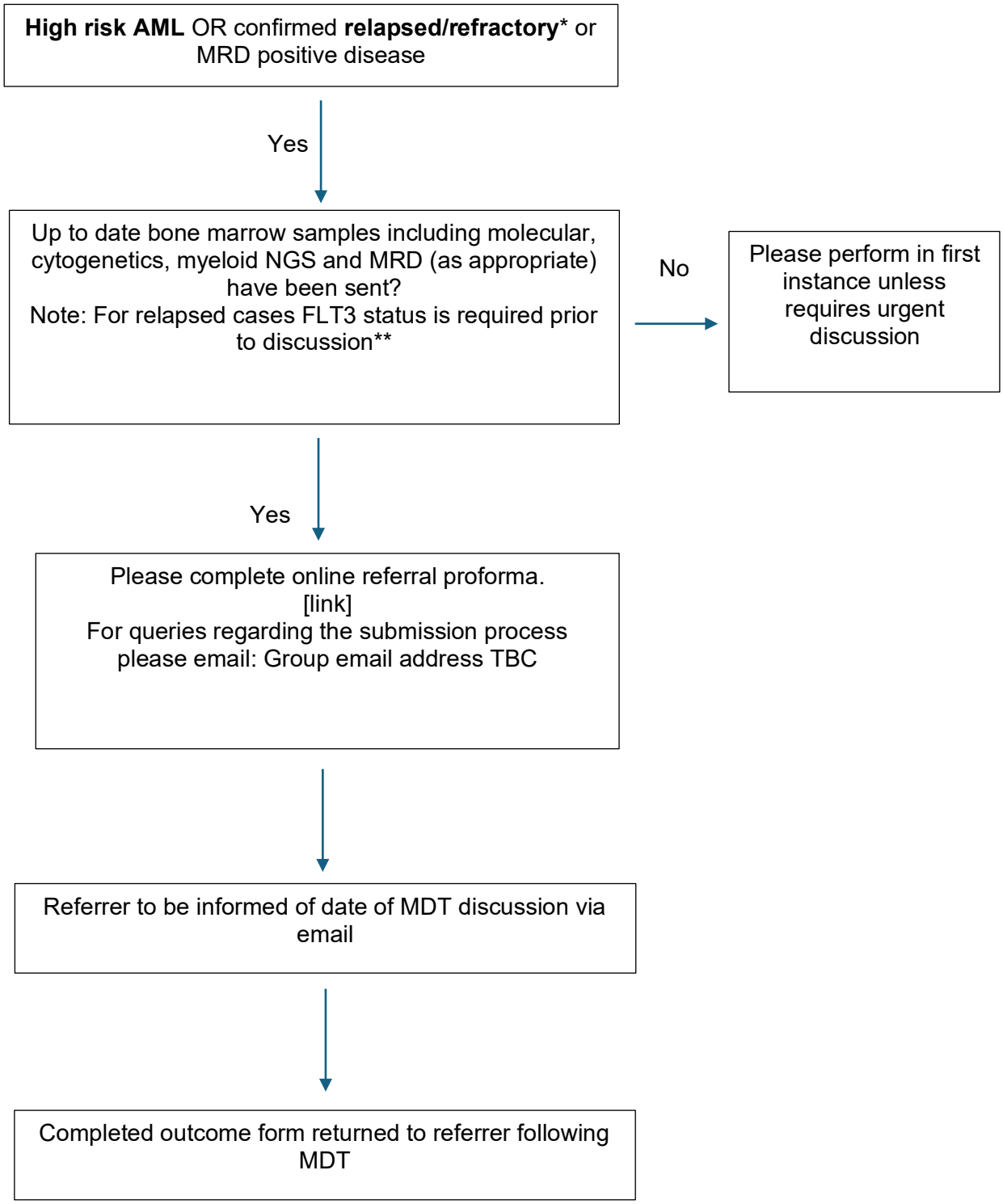
For any concerns regarding the accuracy or completeness of documentation please contact kch-tr.nationalamlmdt@nhs.net.

## 5. Adoption of Terms of Reference

All members of the expert advisory panel will be provided with these terms of reference. The Chair is responsible for ensuring that members adhere to them; members are individually responsible for compliance. The terms of reference require annual review, and additionally whenever core membership changes.

## Appendix: Referral Pathway for AML Relapsed/Refractory MDT

**Appendix: Pathway for AML Relapsed/Refractory MDT**




* As per ELN 2022 Criteria
Relapsed disease: ≥5% leukaemic blasts in the bone marrow, reappearance of leukaemic blasts in peripheral blood (PB) in at least 2 PB samples at least 1 week apart, or development of new extramedullary disease.
Refractory disease: Specified response has not been achieved by a defined landmark (ie, failure to achieve response after 2 cycles of intensive chemotherapy).
** In FLT3 positive relapsed AML Gilteritinib would be the usual first line approach