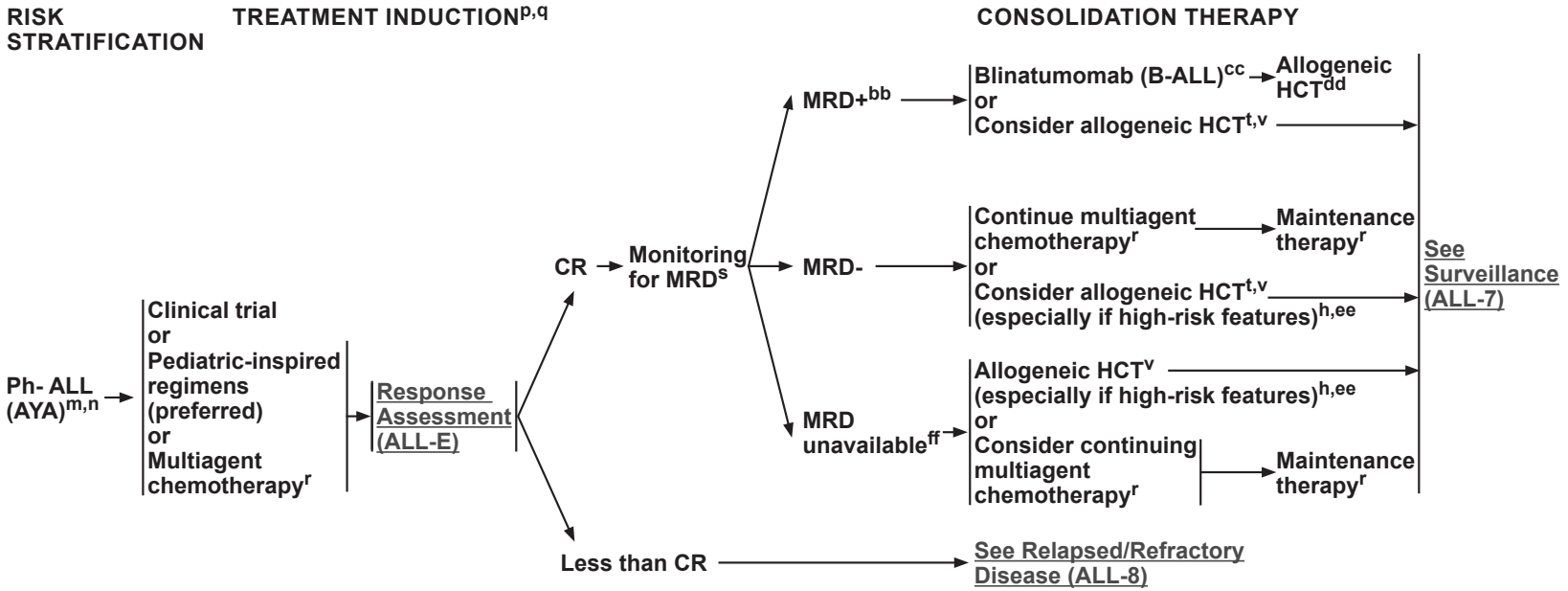
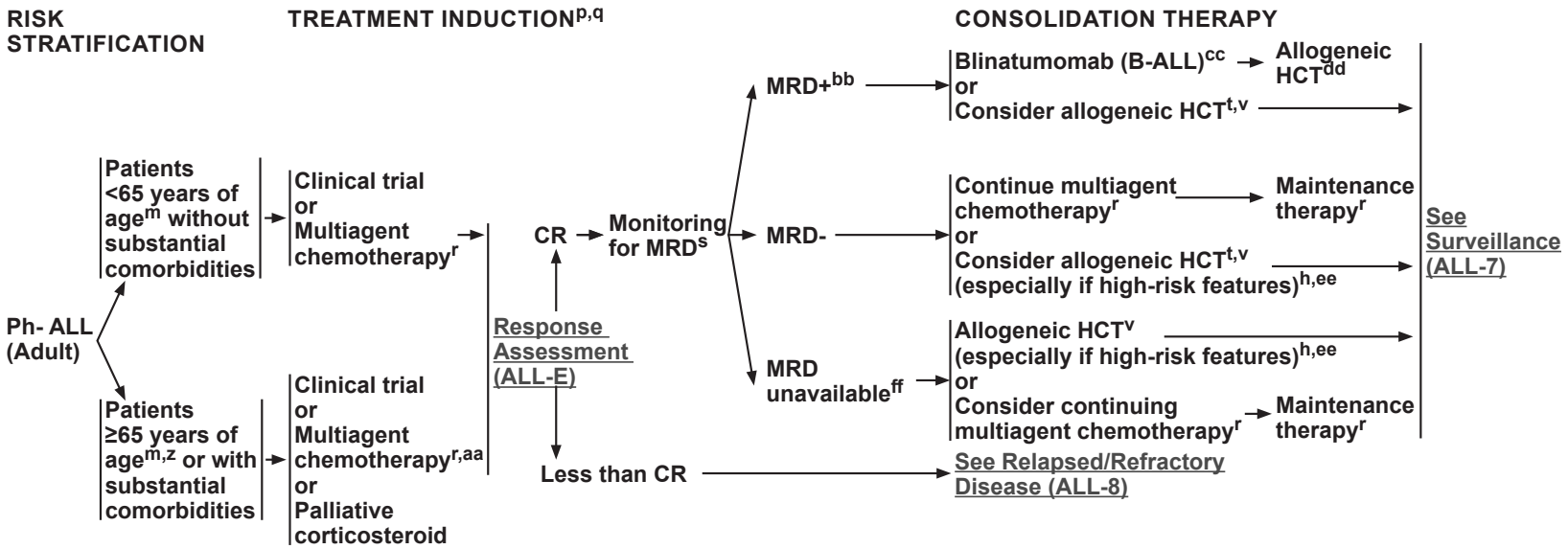


[h] See Cytogenetic Risk Groups for B-ALL (ALL-A).
[m] Chronological age is a poor surrogate for fitness for therapy. Patients should be evaluated on an individual basis, including for the following factors: end-organ reserve, end-organ dysfunction, and performance status.
[n] For additional considerations in the management of AYA patients with ALL, see the NCCN Guidelines for Adolescent and Young Adult (AYA) Oncology.
[p] All ALL treatment regimens include CNS prophylaxis.
[q] See Principles of Supportive Care (ALL-C).
[r] See Principles of Systemic Therapy (ALL-D).
[s] See Minimal/Measurable Residual Disease Assessment (ALL-F).
[t] Optimal timing of HCT is not clear. For fit patients, additional therapy may be considered to eliminate MRD prior to transplant.
[v] Many variables determine eligibility for allogeneic HCT including donor availabiltiy, depth of remission, comorbidities, and social support.
[bb] The prognostic significance of MRD positivity may be regimen-, ALL subtype-, and/or ALL risk-dependent. MRD timepoints and levels prompting allogeneic HCT should be guided by the specific treatment protocol being used. In general, MRD positivity at the end of induction predicts high relapse rates and should prompt evalution for allogeneic HCT. Therapy aimed at eliminating MRD prior to allogeneic HCT is preferred when possible. (See Discussion)
[cc] See Supportive Care: Toxicity Management (ALL-C 2 of 4).
[dd] Although long-term remission after blinatumomab treatment is possible, allogeneic HCT should be considered as consolidative therapy.
[ee] High WBC count (≥30 x 10^9/L for B lineage or ≥100 x 10^9/L for T lineage) is considered a high-risk factor based on some studies in ALL. Data demonstrating the effect of WBC counts on prognosis are less firmly established for adults than for the pediatric population and likely superseded by MRD quantification after treatment.
[ff] Consider retesting for MRD at first available opportunity.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



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[v] Many variables determine eligibility for allogeneic HCT including donor availabiltiy, depth of remission, comorbidities, and social support.
[z] For additional considerations in the management of older adult patients with ALL, see the NCCN Guidelines for Older Adult Oncology.
[aa] Consider dose modifications appropriate for patient age and performance status. See Principles of Systemic Therapy - Treatment of Older Adults with ALL (ALL-D 7 of 8).
[bb] The prognostic significance of MRD positivity may be regimen-, ALL subtype-, and/or ALL risk-dependent. MRD timepoints and levels prompting allogeneic HCT should be guided by the specific treatment protocol being used. In general, MRD positivity at the end of induction predicts high relapse rates and should prompt evalution for allogeneic HCT. Therapy aimed at eliminating MRD prior to allogeneic HCT is preferred when possible. (See Discussion)
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