Positive Quality Intervention: Advanced Systemic Mastocytosis Patient Diagnostic Algorithm

**Description:** The purpose of this PQI is to assist in the diagnosis of the advanced systemic mastocytosis (AdvSM) patient by providing a diagnostic algorithm.

**Background:** Systemic mastocytosis (SM) is a myeloid neoplasm driven in ~95% of cases by an activating mutation, D816V, affecting exon 17 of the KIT gene, and characterized by the accumulation of neoplastic mast cells in a variety of extra-cutaneous organs (as opposed to cutaneous mastocytosis, which generally affects children and is limited to the skin).\(^1\) The bone marrow is almost always involved, and patients can exhibit an array of symptoms involving multiple organ systems, such as spots, itching, flushing, fatigue, headache, dizziness, brain fog, nausea, vomiting, diarrhea and abdominal pain, among many others. Osteopenia and osteoporosis are common. Patients may report a wide range of triggers, stress being the most common, for their symptoms, believed to be a result of mast cell degranulation and mediator release. Anaphylaxis can occur and it is essential that patients have an epinephrine auto-injector in hand. SM is rare, with an annual incidence of 0.89/100,000.\(^2\) The diagnosis of SM is a pathologic one, typically based on examination of the bone marrow.\(^3\) Serum tryptase testing and peripheral blood testing for the KIT D816V mutation using a sensitive technique such as digital droplet or allele-specific oligonucleotide polymerase chain reaction can provide extremely helpful clues to the diagnosis in the appropriate setting, and serve as the basis for referral to a hematologist for bone marrow biopsy. Importantly, myeloid mutation panels utilizing next-generation sequencing platforms, may miss low (ex. <2-5%) mutant allele frequency KIT mutations.\(^4\) Well-differentiated SM, characterized by rounded, instead of spindled, mast cells is very rare but important to recognize because of the usual absence of KIT D816 mutations and hence, responsiveness to imatinib (imatinib is ineffective against the D816V and related mutations).\(^5\) A recent, single-institution study estimated the annual incidence and prevalence of AdvSM to be 0.8 and 5.2 per million inhabitants in the region, respectively.\(^6\) Survival in AdvSM has historically been poor; median survival was 5.7 years for patients with aggressive SM (ASM), 2.9 years for those with SM with an associated hematologic neoplasm (AHN), and 1.9 years for those with mast cell leukemia (MCL).\(^7\)

**PQI Process:**
- **Diagnosis of SM:** major criterion and ≥1 minor criteria or ≥3 minor criteria required for diagnosis\(^8\)
  - **Major criterion**
    - Multifocal dense infiltrates of mast cells (≥15 mast cells in aggregates) in bone marrow biopsies and/or in sections of other extracutaneous organ(s)
  - **Minor criteria**
    - >25% of all mast cells are immature or atypical on bone marrow aspirate smears or are spindle-shaped or atypical in mast cell infiltrates detected on biopsy sections of bone marrow or other extra-cutaneous organs
    - Activating c-KIT point mutation at codon 816 in bone marrow, blood or another extracutaneous organ
    - Mast cells in bone marrow or blood or another extracutaneous organ express CD25 and/or CD2, in addition to normal mast cell markers
    - Serum tryptase >20 ng/ml in the absence of an associated myeloid neoplasm
- **SM Subclassification**\(^8\)
  - Indolent SM (ISM): 0-1 B finding and no C findings - life expectancy near-normal, with a 5-10% risk of progression to more advanced forms

**IMPORTANT NOTICE:** NCODA has developed this Positive Quality Intervention platform. This platform is intended as an educational aid, does not provide individual medical advice, and does not substitute for the advice of a qualified healthcare professional. This platform does not cover all existing information related to the possible uses, directions, doses, precautions, warning, interactions, adverse effects, or risks associated with the medication. The materials contained in this platform do not constitute or imply endorsement, recommendation, or favoring of this medication by NCODA. NCODA does not ensure the accuracy of the information presented and assumes no liability relating to its accuracy. All decisions related to taking this medication should be made with the guidance and under the direction of a qualified healthcare professional. It is the individual’s sole responsibility to seek guidance from a qualified healthcare professional. **Updated 3.22.24**
Smoldering SM (SSM): ≥2 B findings and no C findings - a condition with relatively high mast cell burden but without organ damage from infiltrating neoplastic mast cells

AdvSM: ≥1 C findings - organ damage attributable to mast cell infiltration

AdvSM Subtypes

- ASM
- SM-AHN *most common*
  - Usually myeloid, the most frequent being myelodysplastic/myeloproliferative overlap syndromes (chronic myelomonocytic leukemia)
  - Finding of KIT D816V with another myeloid neoplasm should prompt a search for an occult SM that may have been obscured on histopathology by the AHN
  - MCL: presence of ≥20% mast cells on the bone marrow aspirate smear; in contrast, circulating mast cells are usually <10% (“aleukemic” MCL)
  - Rarely a “chronic” variant of MCL, without C findings, may be encountered

B and C Findings

- B findings (high mast cell burden but no organ damage)
  - >30% infiltration of bone marrow by mast cells and serum total tryptase >200 ng/mL
  - Signs of dysplasia/myeloproliferation in non-mast cell lineage, but criteria not met for diagnosis of AHN with normal/slightly abnormal counts
  - Hepatomegaly without impairment of liver function
  - Palpable splenomegaly without hypersplenism
  - Lymphadenopathy on palpation or imaging

- C findings (organ damage caused by mast cell infiltration)
  - Bone marrow dysfunction caused by neoplastic mast cell infiltration manifested by ≥1 cytopenia: ANC <1.0 × 10^9/L, Hgb level <10 g/dL, and/or platelet count <100 × 10^9/L
  - Palpable hepatomegaly with impaired liver function, ascites, and/or portal hypertension
  - Skeletal involvement, with large osteolytic lesions with or without pathological fractures
  - Palpable splenomegaly with hypersplenism
  - Malabsorption with weight loss due to gastrointestinal mast cell infiltrates

Patient-Centered Activities:

- Discuss the importance of testing for KIT and other mutations in the context of other diagnostic criteria
- Ensure patient has prescription for epinephrine auto-injector and proper knowledge of how to use
- Ensure bone health is not ignored/overlooked and patients are treated for osteopenia/osteoporosis
- Discuss diagnostic findings and counsel patients regarding treatment options (symptom-directed therapies for non-advanced SM, KIT-targeted and other cytoreductive therapies for AdvSM)
- Patient Assistance: NCODA Financial Assistance Tool

References:
4. NCCN Clinical Practice Guidelines Systemic Mastocytosis.