ASH 2026 Guidelines on Diagnosis of Light Chain Amyloidosis
Quality Metrics Assessment Tool

Use this set of metrics to assess quality of care using the 2026 American Society of Hematology (ASH) Clinical Practice Guidelines on Diagnosis of Light Chain Amyloidosis. Results may be used to identify quality gaps and target quality improvement efforts.

1. Time to Diagnosis

Quality Priority	Minimize time between symptom onset and diagnosis of amyloidosis
Denominator	Patients diagnosed with amyloidosis
Numerator	Time between first symptom onset to diagnosis
Quality Metric 1	**Median time (in days) between initial symptom onset and confirmed diagnosis**
Implementation Comments	Symptoms can be vague at initial presentation and missed across disciplines (e.g., cardiology, nephrology, neurology, general internal medicine and hematology)
Suggested Areas of Focus	1. Patients with heart failure with a preserved ejection fraction (HFPEF) – investigations are done to rule out/in light chain amyloidosis – complete paraprotein assessments (SIFE, UIFE, sFLC) to start with - suggest >90% of patients have this testing done 2. Patients with nephrotic range proteinuria – investigations are done to rule out/in light chain amyloidosis – complete paraprotein assessments to start with (SIFE, UIFE, sFLC) – suggest >90% of patients have this testing done

2. Paraprotein Testing

Recommendation	ASH guideline panel recommends serum and urine immunofixation and serum free light chain assay (SIFE, UIFE, sFLC) to increase clinical suspicion of cardiac AL amyloidosis
Denominator	Individuals with suspected cardiac amyloidosis defined (see “Red Flag Signs and Symptoms for Cardiac Amyloidosis”)
Numerator	Test patients with suspected cardiac amyloidosis with serum and urine immunofixation and serum free light chain assay (SIFE, UIFE, sFLC)
Quality Metric 2	**% of patients with suspected cardiac amyloidosis tested with all three assays (SIFE, UIFE, sFLC)**

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Red Flag Signs and Symptoms for Cardiac Amyloidosis

- HFpEF (heart failure with preserved ejection fraction)
- Moderate or Severe LVH in absence of a significant history of untreated hypertension on imaging
- Echocardiogram: Severe left ventricular wall thickening, advanced diastolic dysfunction, reduced left ventricular global longitudinal strain with an apical sparing pattern
- EKG/Arrhythmia: Low voltage and/or discordance between voltage on EKG and left ventricular wall thickness on imaging, pseudo-infarct pattern, and arrhythmias including atrial fibrillation, heart block, and ventricular tachycardia/ventricular fibrillation
- Elevated biomarkers (Troponin and NT-Pro BNP) in absence of CAD
- Constellation of symptoms suggesting cardiac, renal, and peripheral nervous system disease
- Low Flow, Low Gradient Aortic Stenosis

3. Cardiac Magnetic Resonance

Recommendation	ASH guideline panel suggests performing cardiac magnetic resonance (CMR) rather than not performing CMR to increase clinical suspicion of cardiac amyloidosis
Denominator	Individuals with suspected cardiac amyloidosis and positivity in any of the following studies: SIFE, UIFE, or sFLC + abnormal cardiac biomarkers, + non-diagnostic echocardiography
Numerator	Perform CMR in patients with suspected cardiac amyloidosis and positivity in any of the following studies: SIFE, UIFE, or sFLC + abnormal cardiac biomarkers, + non-diagnostic echocardiography
Quality Metric 3	**% of patients with positive SIFE, UIFE, or sFLC + abnormal cardiac biomarkers, + non-diagnostic echocardiography who receive CMR**

Definitions

- **Abnormal cardiac biomarker:** Any one or combination of the NT pro-BNP, BNP, troponin (hs, I, or T) above the reference range for that laboratory test
- **Diagnostic echocardiography**: Diagnostic echocardiographic findings that increase clinical suspicion for cardiac amyloidosis include unexplained left ventricular wall thickening, reduced left ventricular global longitudinal strain (especially when accompanied by an apical sparing pattern), myocardium with a sparkling appearance, worsening degrees of diastolic dysfunction, elevation in left ventricular filling pressures, elevations in right heart pressures, and presence of varying degrees of pericardial effusion

4. Bone Scintigraphy for AL Amyloidosis

Recommendation	ASH guideline panel recommends against the use of bone scintigraphy (PYP, DPD, HMDP) for the diagnosis of AL cardiac amyloidosis

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Denominator	Individuals with a suspicion of light chain amyloidosis cardiomyopathy and serum or urine monoclonal protein or abnormal serum free light chains)
Numerator	Not testing with bone scintigraphy in individuals with suspicion of light chain amyloidosis
Quality Metric 4	**% of patients with concern for light chain amyloidosis who are tested with bone scintigraphy**
Remarks	Immunological assays (SIFE, UIFE, sFLC) must be completed and confirmed negative before a bone scintigraphy test is done for cardiac amyloidosis

5. Bone Scintigraphy for ATTR Amyloidosis

Recommendation	ASH guideline panel recommends the use of bone scintigraphy (PYP, DPD, HMDP) for the diagnosis of ATTR cardiac amyloidosis
Denominator	Individuals with suspicion of cardiac amyloidosis without evidence of a plasma cell disorder (normal serum free light chain levels and absence of monoclonal protein on serum and urine immunofixation electrophoresis
Numerator	Testing with bone scintigraphy in patients with suspicion of cardiac amyloidosis and no evidence of plasma cell disorder
Quality Metric 5	**% of patients tested with bone scintigraphy in patients with suspicion of cardiac amyloidosis and no evidence of plasma cell disorder**
Remarks	Immunological assays (SIFE, UIFE, sFLC) should be done and confirmed as negative before a bone scintigraphy test is done for cardiac amyloidosis If bone scintigraphy is positive (Grade 2–3 uptake) in the absence of monoclonal protein, the diagnosis of ATTR cardiac amyloidosis is confirmed

6. Time to Bone Marrow Biopsy

Quality Priority	Limit the time between abdominal fat pad sampling and bone marrow biopsy
Denominator	Patients with abdominal fat pad sampling
Numerator	Time (in days) between abdominal fat pad and bone marrow biopsy
Quality Metric 6	**Median time interval between abdominal fat pad sampling and bone marrow biopsy**
Remarks	Both procedures for surrogate sites biopsy should be performed promptly to ensure adequate diagnostic sensitivity for AL amyloidosis - *optimally within 14 days*

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Save a copy of this tool to your local files and save your work as you go.

Amyloidosis Diagnosis Guideline Quality Metrics Assessment Tool

Instructions:

1. Identify your institution and, if relevant, unit.
2. Determine the date range for which you will collect data and enter it into the tool.
3. Collect denominator data for each relevant metric and enter it into the Denominator fields
4. Collect numerator data for each metric and enter it into the Numerator field. The Rate field will automatically calculate as the numerator divided by the denominator entered.
5. Based on the calculated metric rates, determine where you have opportunities for quality
6. improvement; you may wish to include QI targets and potential change strategies.
7. Identify who completed this tool.
8. Share the completed tool with quality stakeholders at your institution.
9. Consider repeating this tool after implementing a process change to assess changes in quality.

Institution:

Date range of data:

Metric #	Quality Metric	Denominator	Numerator	Rate
1	**Median time interval (in days) between initial symptom onset and confirmed diagnosis**			
2	**% of patients with suspected cardiac amyloidosis tested with all three assays (SIFE, UIFE, sFLC)**			
3	**% of patients with positive SIFE, UIFE, or sFLC + abnormal cardiac biomarkers, + non-diagnostic echocardiography who receive CMR**			
4	**% of patients with concern for light chain amyloidosis who are tested with bone scintigraphy**			
5	**% of patients tested with bone scintigraphy in patients with suspicion of cardiac amyloidosis and no evidence of plasma cell disorder**			
6	**Median time interval (in days) between abdominal fat pad sampling and bone marrow biopsy**			

Identified areas for improvement:

Completed by: