Monoclonal Gammopathy of Undetermined Significance (MGUS): Diagnosis, Predictors of Progression, and Monitoring
A Pocket Guide for the Clinician

Brea C. Lipe, MD
University of Rochester Medical Center

Robert A. Kyle, MD
Mayo Clinic, Rochester, MN

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Recommendations in this guide are based on Monoclonal gammopathy of undetermined significance (MGUS) and smoldering (asymptomatic) multiple myeloma: International Myeloma Working Group consensus perspectives risk factors for progression and guidelines for monitoring and management and additional sources.
Disease Definition

Monoclonal Gammapathy of Undetermined Significance (MGUS) is an asymptomatic condition that is included in a spectrum of monoclonal plasma cell disorders (dyscrasias). MGUS is characterized by a monoclonal protein (M protein) < 3 g/dL (30 g/L) in the serum and < 10% monoclonal plasma cells in the bone marrow and no evidence of end-organ damage (“CRAB”: hypercalcemia, renal insufficiency, anemia or bone lesions), lymphoma, Waldenström macroglobulinemia, or light chain amyloidosis (AL). Smoldering multiple myeloma (SMM) also lies along this spectrum of plasma cell disorders, is also asymptomatic and is defined as having an M protein ≥ 3 g/dL (30 g/L) and/or ≥ 10% monoclonal plasma cells in the bone marrow and no CRAB features. Patients with high risk SMM may be candidates for clinical trials. It is important to follow patients with MGUS and SMM for disease progression.

Baseline Evaluation

A diagnosis of MGUS is relatively common, affecting 3.2% of the Caucasian population over the age of 50 years, and approximately 6% of the African American population. In patients with an M protein, the following baseline evaluation is recommended to either confirm a diagnosis of MGUS or rule out other more serious diagnoses:

Patient History

The following may suggest a diagnosis other than MGUS:

- Fatigue, easy bruising, or abnormal bleeding may indicate active multiple myeloma with cytopenias
- Bone pain or fractures may indicate active multiple myeloma
- Symptoms suggesting amyloidosis including weight loss, nephrotic syndrome with peripheral edema, or unexplained dyspnea (congestive heart failure)
- Neurologic symptoms, including sensory neuropathy associated with plasma cell dyscrasias (including amyloidosis, POEMS syndrome, multiple myeloma, or Waldenström macroglobulinemia) or symptoms of hyperviscosity
- Left upper quadrant discomfort or early satiety (splenomegaly can be a presenting sign of lymphoplasmacytic lymphoma)

Physical Exam

The following may indicate an underlying non-MGUS plasma cell dyscrasia or lymphoproiferative disease:

- Lymphadenopathy
- Hepatosplenomegaly
- Localized bone pain
- Periorbital purpura
- Macroglossia
- Peripheral neuropathy

Laboratory Evaluation

Table 1

<table>
<thead>
<tr>
<th>Test</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>For a diagnosis of MGUS, results are within normal limits. Abnormal results may be indicative of an alternate diagnosis (see Table 3).</td>
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<tr>
<td>Calcium</td>
<td></td>
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<tr>
<td>Creatinine</td>
<td></td>
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<tr>
<td>LDH (lactate dehydrogenase)</td>
<td></td>
</tr>
<tr>
<td>LFTs (liver function tests)</td>
<td></td>
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<tr>
<td>Quantitative test for urine protein</td>
<td></td>
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<tr>
<td>Serum and urine protein electrophoresis (UPE) with immunofixation (IFE)</td>
<td>May be diagnostic for a clonal plasma cell disorder. If the above qualitative test for urine protein is abnormal, check 24 hour urine collection for UPE and IFE.</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Test</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative (IgG, IgA and IgM) immunoglobulins</td>
<td>May be suggestive of a plasma cell disorder</td>
</tr>
<tr>
<td>Serum immunoglobulin free light chains (including the ratio)</td>
<td></td>
</tr>
</tbody>
</table>

Secondary Evaluation

Patients should undergo bone marrow aspiration and biopsy, including FISH and skeletal survey in the presence of an M-protein with any of the following:

- End-organ damage with “CRAB” features including hypercalcemia (Ca > 11 mg/dL or 2.75 mmol/L), renal insufficiency (creatinine > 2 mg/dL or 177 µmol/L or creatinine clearance < 40 mL/min), anemia (hgb < 10 g/dL (100 g/L) or > 2 g/dL (20 g/L) below the lower limit of normal) and bone lesions (lytic lesions, severe osteopenia, or pathologic fracture).
- Non-IgG M-protein (IgA or IgM protein)
- IgG M-protein > 1.5 g/dL (15 g/L)
- Abnormal free light chain (FLC) ratio (FLC ratio < 0.26 or > 1.65)

Patients with an M-protein and suspected amyloidosis should undergo bone marrow aspirate and biopsy, and either a fat pad biopsy, rectal biopsy or biopsy of organ with suspected involvement by amyloidosis. The tissue should be stained with Congo Red and examined by mass spectroscopy or immunohistochemical stains. Decisions regarding which tissue to biopsy should take into consideration diagnostic yield and the invasiveness of the procedure.

Diagnostic Criteria

Plasma cell dyscrasias include a spectrum of diseases.
Key Predictors of Risk Progression

Prediction of MGUS patients who will remain stable compared with those who progress is very difficult at the time of recognition of MGUS. However, Table 3 describes predictors associated with a higher risk of progression. To obtain a risk classification, one point is given for each risk factor to determine the cumulative risk as in Table 4.

Table 3

<table>
<thead>
<tr>
<th>Risk factors for progression per Mayo criteria*</th>
<th>Monitoring and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-protein &gt; 1.5 g/dL (15 g/L)</td>
<td>Repeat serum protein electrophoresis in 6 months and every 2–3 years thereafter if stable</td>
</tr>
<tr>
<td>Non-IgG isotype (IgA or IgM)</td>
<td>No need for bone marrow biopsy or skeletal survey</td>
</tr>
<tr>
<td>FLC Ratio &lt; 0.26 or &gt; 1.65</td>
<td></td>
</tr>
</tbody>
</table>

Classification of MGUS and Recommendations for Monitoring and Evaluation

Recommendations for monitoring and evaluation of a confirmed diagnoses of MGUS vary based on risk stratification. Table 4 lists the criteria that determine the likelihood of a patient with MGUS progressing to smoldering multiple myeloma or multiple myeloma.

Table 4

<table>
<thead>
<tr>
<th>Associated Lab Values (from table 3)</th>
<th>Classification</th>
<th>Monitoring and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk factors present</td>
<td>Low-risk MGUS (5% absolute risk of progression at 20 years)*</td>
<td>Repeat serum protein electrophoresis in 6 months and every 2–3 years thereafter if stable</td>
</tr>
<tr>
<td>1 risk factor present</td>
<td>Low-intermediate-risk MGUS (21% absolute risk of progression at 20 years)*</td>
<td>BM biopsy with FISH</td>
</tr>
<tr>
<td>2 risk factors present</td>
<td>High-intermediate-risk MGUS (37% absolute risk of progression at 20 years)*</td>
<td>LDH, β2 microglobulin, CRP</td>
</tr>
<tr>
<td>3 risk factors present</td>
<td>High-risk MGUS (58% absolute risk of progression at 20 years)*</td>
<td>If all above are unremarkable, follow CBC serum protein electrophoresis, creatinine in 6 months, and then annually for life</td>
</tr>
</tbody>
</table>

Factors Unrelated to Risk Progression

The following diagnostic factors are not useful for predicting risk of progression:

- Age
- Sex
- Presence of hepatosplenomegaly
- Hemoglobin
- Serum creatinine
- Serum albumin
- Presence or amount of a monoclonal urinary light chain

References


How to Use This Pocket Guide

ASH pocket guides are primarily intended to help clinicians make decisions about diagnostic and treatment alternatives. These guidelines are not intended to serve or be construed as a standard of care. Clinicians must make decisions on the basis of the unique clinical presentation of an individual patient, ideally through a shared process that considers the patient’s values and preferences with respect to all options and their possible outcomes. Decisions may be constrained by realities of a specific clinical setting, including but not limited to institutional policies, time limitations, or unavailability of treatments. ASH pocket guides may not include all appropriate methods of care for the clinical scenarios described. As science advances and new evidence becomes available, these pocket guides may become obsolete. Following these guidelines cannot guarantee successful outcomes. ASH does not warrant or guarantee any products described in these guidelines.

Drs. Lipe and Kyle declare no competing financial interests.

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