Indication: First line Multiple Myeloma, not suitable for intensive therapy.

Regimen details: Melphalan 7mg/m² orally D1 to 4
Prednisolone 60mg orally D1 to 4

Prednisolone is available as 5mg and 25mg tablets. Prednisolone should be taken with or after food.

Thalidomide 100mg od orally
After 2 to 4 weeks, increase to 200mg od orally
Continue to increase as tolerated, up to a maximum dose of 200mg od per day.

Administration: Orally
Thalidomide should be taken 2 hours before bedtime.

Premedication: Not applicable

Frequency: 28 days
Re-assess every cycle. Subsequent cycles may be delayed by up to a total of 6 weeks without dose reduction. Further delays greater than 6 weeks should result in dose reduction. Continue to ≥ PR (which is normally 3 to 6 cycles) plateau.

Extravasation: Not applicable

Anti-emetics: Mild emetogenicity, e.g. metoclopramide 20mg tds prn

Supportive medication: Thromboprophylaxis: All patients should receive thromboprophylaxis with aspirin 75mg od unless contraindicated. Patients with a previous VTE or who are at high risk of VTE (one other risk factor in addition to multiple myeloma) should receive LMWH e.g. enoxaparin 40mg sc od as per local protocol.

In addition for patients receiving prednisolone: PPI or H2-receptor antagonist e.g. omeprazole 20mg od or ranitidine 150mg bd

Allopurinol 100mg - 300mg od (dependent on renal function) until plateau

Antifungal prophylaxis as per local protocol

Prophylactic laxatives as per local protocol

Regular investigations: FBC D1 of each cycle
LFTs D1 of each cycle
U&Es D1 of each cycle
Bone profile D1 of each cycle
Serum paraprotein / serum free light chains at the start of each cycle
Blood pregnancy test for women of child bearing potential within 3 days of the prescription date for every cycle.

**Dose Modifications**

**Haematological Toxicity**

Prior to every cycle of MPT:

<table>
<thead>
<tr>
<th>Neutrophils (x 10⁹/L)</th>
<th>Platelets (x 10⁹/L)</th>
<th>MPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥1.0 x 10⁹/L &amp; ≥ 50 x 10⁹/L</td>
<td>100% dose</td>
<td></td>
</tr>
<tr>
<td>&lt;1.0 x 10⁹/L or &lt; 50 x 10⁹/L</td>
<td>Consider reducing melphalan dose by 2mg.</td>
<td></td>
</tr>
</tbody>
</table>

NB. In the presence of cytopenias due to marrow involvement with myeloma, it is possible that the first cycle will go ahead even if neutrophils <1.0 x 10⁹/L and platelets < 50 x 10⁹/L.

**Renal Impairment** No dose modification required

**Hepatic Impairment** No dose modification required

**Non-Haematological toxicities**

Consider reducing thalidomide dose depending on patient tolerability.

**Doses reduced for toxicity should not be re-escalated**

**Toxicities:** Thrombosis, somnolence, skin dryness, constipation, sensory peripheral neuropathy, uncommonly motor neuropathy, haematological.

Steroid related toxicities including mood changes, restlessness, withdrawal effects.

**Drug interactions:** Not applicable

**Comments:** Thalidomide must only be prescribed according to the Pregnancy Prevention Programme. Patients are required to complete an informed consent process.

**References:** Facon T et al on behalf of the Intergroupe Francophone du Myelome. Melphalan and prednisolone plus thalidomide versus melphalan and prednisolone alone or reduced-intensity autologous stem cell transplantation in elderly patients with multiple myeloma (IFM99-06: a randomised trial. Lancet 2007;370:1209-18