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Citation for final published version:

McMullin, M. F., Harrison, C. N., Ali, S., Cargo, C., Chen, F., Ewing, J, Garg, M., Godfrey, A., Knapper, Steven, McLorcan, D., Nangalia, J., Sekhar, M., Wadelin, F. and Mead, A. J. 2019. A guideline for the diagnosis and management of polycythaemia vera. *British Journal of Haematology* 184 (2) , pp. 176-191. 10.1111/bjh.15648 file

Publishers page: <https://doi.org/10.1111/bjh.15648> <<https://doi.org/10.1111/bjh.15648>>

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1 **Title**

2 A guideline for the diagnosis and management of polycythaemia vera

3 A British Society for Haematology Guideline

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4 **Keywords:** Diagnosis, management, polycythaemia vera, risk stratification,
5 cytoreductive therapy

6 **Methodology**

7 This guideline was compiled according to the BSH process at b-s-h.org.uk. The
8 Grading of Recommendation Assessment, Development and Evaluation (GRADE)
9 nomenclature was used to evaluate levels of evidence and to assess the strength of
10 the recommendations. The GRADE criteria can be found at
11 <http://www.gradeworkinggroup.org>.

12 *Literature review details*

13 The literature review was conducted on 2nd March 2017. Databases searched
14 include MEDLINE(OVID), Embase (OVID) and CENTRAL(The Cochrane library)
15 using search terms (and relevant MESH terms) polycythaemia vera, erythrocytosis,
16 familial, high oxygen affinity haemoglobin, defects of oxygen sensing pathway,
17 diagnosis, investigation, molecular, mutation, *JAK2, MPL, CALR*, bone marrow, red
18 cell mass, erythropoietin, risk, management, treatment, cytoreduction, venesection,
19 hydroxyurea, interferon, busulfan, pipobroman, radioactive phosphorus, aspirin,
20 anagrelide, ruxolitinib, thrombosis, haemorrhage, pregnancy, pruritus, surgery and
21 management. The search covered the period from 2005 the date of last version of
22 the guideline, to February week 3 2017. Exclusions included articles not in English,
23 studies not in humans, single case reports and case series of under 5 cases. A total

1 of 6062 articles were identified which with exclusions and duplications resulted in
2 1215 articles which were reviewed.

3 *Review of manuscript*

4 Review of the manuscript was performed by the British Society for Haematology
5 (BSH) Guidelines Committee General Haematology Task Force, the BSH Guidelines
6 Committee and the General Haematology Sounding Board of BSH. It was also on
7 the members section of the BSH website for comment. A patient representative from
8 MPN-Voice (www.mpnvoice.org.uk) participated in the guideline writing meeting. The
9 guideline has been reviewed by MPN-Voice; this organisation does not necessarily
10 approve or endorse the contents.

11 **Introduction**

12 The previous guideline was published in 2005 (McMullin, Bareford et al. 2005) with
13 an amendment in 2007 (McMullin, Reilly et al. 2007) to update the diagnostic criteria
14 following the discovery of the *JAK2* mutation in patients with polycythaemia vera
15 (PV). Since that time there has been a considerable amount of research in the area
16 concerning diagnostics, risk stratification, new agents and reinvestigation of existing
17 agents. It was therefore decided to evaluate the literature to formulate guidance on
18 the diagnostic pathway for erythrocytosis, risk stratification of polycythaemia vera
19 (PV), management of PV including specific situations and the management of
20 secondary erythrocytosis. Here we provide evidence-based guidance on diagnosis,
21 risk stratification and management of PV. Our review of the evidence led us to some
22 differences in diagnostic criteria and risk stratification than have been proposed by
23 other international organisations. We discuss the reasons for this. An accompanying

1 guideline looks at management of specific situations in PV and management of
2 secondary erythrocytosis.

3 **The diagnostic pathway for investigation of an erythrocytosis**

4 Patients with a persistently raised venous haematocrit (Hct) (>0.52 males, >0.48
5 females) should be investigated. As suggested in our previous guideline and
6 confirmed in recent literature, Hct has been consistently shown to perform better in
7 identifying patients with a raised red cell mass than haemoglobin concentration
8 (Alvarez-Larrán, Pereira et al. 2012, Ancochea, Alvarez-Larrán et al. 2014).

9 Patients should be investigated according to the proposed algorithm (Fig. 1).

10 Investigation requires knowledge of diagnostic criteria for both PV and potential
11 secondary causes of erythrocytosis (Tables I and II). A detailed history, examination
12 and stage 1 investigations (listed below) should identify a potential cause in the
13 majority of patients, although a proportion will require more extensive testing and in
14 some a cause cannot be found (idiopathic erythrocytosis). The potential for dual
15 pathology should also be considered.

16 **Initial assessment**

17 *Clinical History and Examination*

18 A detailed clinical history and examination are essential and, in the absence of a
19 molecular marker of disease, will determine further investigations and management.
20 Particular attention should be paid to the drug history (prescribed and recreational),
21 smoking, alcohol consumption and body habitus. Systematic questioning should
22 elicit symptoms related to other potential secondary causes of erythrocytosis (see
23 Table II). A proportion of patients, who have a clear secondary cause for their
24 erythrocytosis, may not need any further investigations.

1 **Stage 1 Investigations**

2 *Full blood count / blood film*

3 The full blood count analysis will not only confirm a raised Hct but will also identify
4 neutrophilia and thrombocytosis, which are common in *JAK2* V617F-positive PV and
5 part of the criteria for *JAK2*-negative PV (Table 1). As smokers have a significantly
6 higher neutrophil count than non-smokers (Whitehead, Robinson et al. 1995) a
7 neutrophilia is defined as $>12.5 \times 10^9/l$ in this patient group.

8 A blood film should be reviewed in all patients to look for any atypical features. In
9 those with confirmed PV, abnormalities such as circulating blasts, leucoerythroblastic
10 features and monocytosis would be indications for bone marrow assessment.

11 *Renal and Liver Function*

12 A number of renal and hepatic diseases can cause erythrocytosis. Serum calcium
13 levels should also be determined to exclude a parathyroid adenoma/carcinoma,
14 which rarely causes secondary erythrocytosis.

15 *Arterial oxygen saturation (SaO₂) / carboxyhaemoglobin*

16 Identifying tissue hypoxia, a cause of secondary erythrocytosis, can be achieved
17 most simply by using pulse oximetry in the clinic. An SaO₂ of <92% has been
18 shown to be associated with an absolute erythrocytosis (Berlin 1975). Clinicians
19 should however be aware of three situations of hypoxic erythrocytosis where this
20 testing is unreliable and will give a normal result. These are carbon monoxide
21 poisoning, high oxygen affinity haemoglobins and sleep apnoea syndrome. Those
22 with suspected high oxygen affinity haemoglobins should undergo genetic testing as
23 described below. In those with suspected sleep apnoea (heavy snoring with daytime

1 somnolence or increased body mass index $>30 \text{ kg/m}^2$), referral should be made to a
2 respiratory or sleep physician.

3 Carboxyhaemoglobin (COHb) levels are significantly higher in smokers compared
4 with non-smokers and cigarette consumption has been shown to be directly related
5 to COHb levels (Castleden and Cole 1975). Testing can therefore be performed at
6 baseline where smoking is suspected.

7 *Serum Ferritin*

8 Low serum ferritin levels are common in PV patients and iron deficiency can mask
9 the presentation of PV giving a misleadingly low Hct because iron deficiency limits
10 erythropoiesis and hypochromic microcytosis develops.

11 *Serum Erythropoietin*

12 Erythrocyte production is controlled by the hormone erythropoietin (EPO).
13 Measurement of serum EPO can provide information on potential causes of
14 erythrocytosis and help stratify further testing (see Fig.1). EPO levels are commonly
15 high in hypoxic conditions or when erythrocytosis is secondary to exogenous
16 administration or endogenous overproduction. In contrast EPO levels are typically
17 low in PV, although their diagnostic utility in this setting is limited in the era of *JAK2*
18 mutation testing (Ancochea, Alvarez-Larrán et al. 2014).

19 *JAK2 V617F mutational analysis*

20 The identification of *JAK2* mutations in almost all PV patients has revolutionised the
21 diagnosis of PV. The *JAK2 V617F* mutation can be found in over 95% of PV
22 patients (James, Ugo et al. 2005) and an exon 12 mutation in most remaining
23 patients (Scott, Tong et al. 2007). Testing for *JAK2 V617F* in peripheral blood is

1 sensitive and bone marrow samples are not required to identify this (Takahashi,
2 Patel et al. 2013). Testing for *JAK2* V617F is advised as a stage 1 investigation and
3 should confirm the diagnosis the vast majority of PV patients. Separate guidance is
4 available for assays used for detection of *JAK2* mutations (Bench, White et al. 2013).

5 **Further Investigations in *JAK2* V617F-negative erythrocytosis**

6 Further investigations are warranted in those patients with a persistent, significant
7 erythrocytosis if *JAK2* V617F studies are negative and a secondary cause is not
8 immediately apparent (See Figure 1). Secondary causes must be considered since
9 PV is rare in the absence of a *JAK2* V617F mutation.

10 *Red Cell Mass studies*

11 Patients with Hct >0.60 (males) or >0.56 (females) can be assumed to have an
12 absolute erythrocytosis, but in others red cell mass (RCM) studies can be helpful to
13 confirm an absolute erythrocytosis. A RCM more than 25% above the mean
14 predicted value is diagnostic of an absolute erythrocytosis (Pearson, Guthrie et al.
15 1995). Those with a raised Hct but a RCM within the normal range have an apparent
16 erythrocytosis. A relative erythrocytosis, found in states of dehydration, can be
17 confirmed when the RCM is within the normal range and plasma volume is below
18 normal. Patients with a relative or apparent erythrocytosis require no further
19 investigation. It is noted however that due to the many drawbacks of this test
20 including cost and labour, access to RCM studies is variable nationally.

21 *Abdominal Ultrasound*

22 Radiological splenomegaly is a minor criterion for *JAK2* V617F-negative PV (Table
23 1) and ultrasound is the simplest method for detection. Abdominal ultrasound can

1 also exclude secondary causes of erythrocytosis, particularly renal and hepatic
2 pathology including hepatocellular carcinoma. .

3 Further testing can be stratified according to the EPO level measured during stage 1
4 investigations.

5 **Normal or low EPO level**

6 *JAK2 exon 12 analysis*

7 Compared with *JAK2* V617F, patients with exon 12 mutated- PV tend to be younger,
8 with higher haemoglobin concentrations, lower white blood cell (WBC) and platelet
9 counts, and isolated an isolated increase in erythropoiesis without granulocytic or
10 megakaryocytic morphological abnormalities (Scott, Tong et al. 2007, Passamonti,
11 Elena et al. 2011). In contrast to *JAK2* V617F testing, a discrepancy between exon
12 12 mutant allele burden in bone marrow and peripheral blood has occasionally been
13 described (Kjær, Westman et al. 2012).

14 *Bone marrow biopsy*

15 Bone marrow histology may be helpful in distinguishing PV from secondary
16 erythrocytosis (Thiele, Kvasnicka et al. 2005). Bone marrow aspiration in PV typically
17 reveals markedly increased erythropoiesis with moderate to marked increase in
18 granulopoiesis and megakaryopoiesis; widely variable megakaryocyte size, including
19 large forms with hyperlobated nuclei; and absent iron stores. The bone marrow
20 trephine biopsy sections show hypercellularity; trilineage expansion of haemopoiesis
21 (rarely preferentially erythroid) and normoblastic erythropoiesis. Granulocytic
22 maturation may be left-shifted and disorderly; megakaryocytes show increased
23 variation in size, often with a predominance of large forms with uneven or reduced

1 nuclear lobulation, and megakaryocyte clusters are common. Reticulin is increased
2 in a minority of patients (up to WHO grade 1 in most cases).

3 Presence of an acquired genetic abnormality is a major criterion for *JAK2*- negative
4 PV and the presence of an abnormal karyotype can therefore support this diagnosis.
5 An acquired *LNK* mutation would also support the diagnosis. More recently
6 mutations in a number of other genes, most commonly *TET2* and *DNMT3A*, have
7 been reported in PV (Delic, Rose et al. 2016) These gene mutations are not,
8 however, disease specific and have also been reported in healthy individuals
9 (Genovese, Kähler et al. 2014, Jaiswal, Fontanillas et al. 2014) limiting their
10 application in the diagnostic setting, particularly when found in isolation.

11 **High EPO level**

12 A raised EPO level should lead to a thorough search for secondary causes of
13 erythrocytosis (Table 2), which may require additional supplementary investigations
14 (Figure 1).

15 *Imaging*

16 Further imaging (e.g. CT head and neck) is indicated in this setting if a cause for the
17 high EPO has not been identified. Imaging should aim to exclude rare tumours such
18 as a cerebellar haemangioblastoma, pheochromocytoma, meningioma or a
19 parathyroid tumour, all of which can rarely cause erythrocytosis.

20 **Gene sequencing for congenital erythrocytosis**

21 A number of germline mutations in genes involved in oxygen sensing, erythropoiesis
22 and oxygen transport have now been implicated in patients with otherwise
23 unexplained erythrocytosis. These include mutations in the *EPO* receptor and genes

1 in the oxygen sensing pathway (*VHL*, *EGLN1*, *EPAS1*), high oxygen affinity
2 haemoglobinopathies caused by mutations in the globin genes *HBA1*, *HBA2*, *HBB*,
3 and 2,3-bisphosphoglycerate deficiency as a result of *BPGM* mutations (Bento,
4 Percy et al. 2014). These patients can present with low, normal or high EPO levels;
5 high affinity haemoglobins and 2,3-BPG deficiency also cause a left shift of the
6 oxygen dissociation curve. In the past this group of mutations were detected by
7 Sanger sequencing of individual genes, in an order directed by EPO levels and P50
8 analysis, but this approach is labour-intensive and time-consuming (Bento, Percy et
9 al. 2014). More recently next generation sequencing-based targeted panels have
10 been developed to assess established and novel genes implicated in erythrocytosis
11 (Camps, Petousi et al. 2016), negating the need for P50 testing. A targeted panel
12 should be performed in patients in whom congenital erythrocytosis is suspected,
13 particularly young patients or those with a family history.

14 **Diagnostic criteria for polycythaemia vera**

15 ***Presentation***

16 Polycythaemia vera (PV) presents at a median age of 60 years with a slight male
17 predominance. Patients can present with arterial or venous vascular occlusive
18 events, microvascular disturbances, or occasionally, haemorrhage. Splenic pain
19 and/or enlargement, pruritus, gout and constitutional symptoms such as fatigue may
20 be present. Alternatively, asymptomatic patients may be identified incidentally
21 following a full blood count. All patients who are newly diagnosed with PV should be
22 discussed in a multidisciplinary team setting.

23 The recommended diagnostic criteria for *JAK2*-positive and the very rare *JAK2*-
24 negative PV are given in full in table I.

1 **Role of the bone marrow biopsy in *JAK2* V617F-positive patients**

2 Although the WHO classification considers histology to be useful in distinguishing PV
3 from other myeloproliferative neoplasms (MPNs) (Arber, Orazi et al. 2016), several
4 studies have reported high rates of non-consensus or failure to reach a histological
5 diagnosis in patients with PV (Koopmans, Bot et al. 2011, Madelung, Bondo et al.
6 2013) (Alvarez-Larrán, Ancochea et al. 2014) Given the uncertain utility of bone
7 marrow histology in the diagnosis of uncomplicated PV, it is not mandatory in all
8 patients, but should be considered if there are atypical features such as marked
9 splenomegaly or a history of splanchnic vein thrombosis where it is necessary to
10 establish if there is an occult myeloproliferative neoplasm. The degree of baseline
11 fibrosis can also be ascertained, which as discussed below may have a prognostic
12 role. Bone marrow biopsy may nonetheless be useful in those patients likely to have
13 a long disease history, as a baseline sample for comparison in the event of
14 suspected disease transformation. Abnormal karyotype and other molecular
15 abnormalities (e.g. *TET2* mutations) have been reported in PV and some may have
16 prognostic value (Delic, Rose et al. 2016, Cerquozzi, Barraco et al. 2017) but these
17 tests are not required routinely at diagnosis.

18 **Differentiation of *JAK2* V617F-positive PV from other MPNs**

19 In patients with a *JAK2* V617F mutation, haemoglobin and/or Hct are currently used
20 as a surrogate for RCM to distinguish between PV and essential thrombocythaemia
21 (ET) (Arber, Orazi et al. 2016), but Hct has the better accuracy in predicting red cell
22 mass (Alvarez-Larrán, Pereira et al. 2012, Ancochea, Alvarez-Larrán et al. 2014).
23 Concerns have however been raised that distinguishing PV from ET based on blood

1 count thresholds alone may fail to identify a subgroup of patients with “masked” PV,
2 who may be better managed as PV rather than ET.

3 The definition of masked PV has been inconsistent across studies. When using a
4 raised RCM to define an erythrocytosis, studies have shown that a Hct threshold of
5 0.52 in males will fail to identify approximately 20% of male patients with a raised
6 RCM, whilst the threshold of 0.48 in women is more sensitive (Alvarez-Larrán,
7 Pereira et al. 2012). These “masked” PV patients were reported to have similar
8 outcomes to those with “overt” PV when managed equivalently (Alvarez-Larrán,
9 Angona et al. 2016).

10 By contrast, other studies have defined masked PV as those patients who did not
11 meet the haemoglobin-based thresholds for PV but did meet the other WHO criteria,
12 mainly bone marrow histology and JAK2 status. Patients meeting this definition had
13 poorer outcomes in terms of myelofibrotic or leukaemic transformation and survival,
14 but no difference in rate of thrombosis. Hct thresholds of 0.48/0.49 (females/males)
15 were subsequently proposed to discriminate ET from PV in the WHO 2016 revision
16 (Barosi, Tefferi et al. 2015).

17 The proposed BSH Hct-based thresholds have good specificity but will miss a
18 minority of patients with a raised RCM. By lowering the Hct threshold it may be
19 possible to identify patients with histology more typical of PV who may have certain
20 adverse outcomes, but these findings have not yet been reproduced independently.
21 It is unknown whether management of any of these patients using a strict Hct target
22 benefits their vascular risk. However, in patients with a *JAK2* V617F mutation and
23 borderline Hct levels (especially males with Hct 0.48-0.52), the possibility of true
24 erythrocytosis should be considered, especially if the patient is at high risk of

1 vascular events. Options in this group include performing a RCM study to clarify the
2 diagnosis or, pragmatically, managing the patient with a Hct target as for PV.

3 It should also be noted that Hct is a poor surrogate of red cell mass in patients who
4 have had splanchnic vein thrombosis (Lamy, Devillers et al. 1997), and these high-
5 risk patients are best managed with standard blood count targets regardless of blood
6 count parameters at diagnosis. Hct is also reduced by pregnancy and gestation-
7 specific ranges should be used when considering the distinction between PV and ET
8 in a patient presenting during pregnancy.

9 ***JAK2* V617F allele burden**

10 Quantitative assessments of the *JAK2* V617F allele burden in peripheral blood
11 granulocytes have shown that this parameter tends to be higher in PV than ET. A
12 higher mutant allele burden correlates with certain clinical features at presentation
13 including higher haemoglobin levels, higher WBCs, lower platelet counts, lower
14 mean cell volume (MCV), lower serum ferritin and EPO, more splenomegaly and
15 more pruritus (Dupont, Massé et al. 2007, Tefferi, Strand et al. 2007, Vannucchi,
16 Antonioli et al. 2007, Passamonti, Rumi et al. 2010). However, there is no validated
17 threshold at which *JAK2* V617F allele burden can confirm or refute a diagnosis of PV
18 and this investigation is not recommended routinely.

19 **Low level *JAK2* V617F allele burden**

20 A low level *JAK2* V617F mutation (allele burden <1-3%) should be interpreted in the
21 context of clinical, haematological and other laboratory findings (Bench, White et al.
22 2013). If the result is reproducible and does not represent a false positive, this
23 finding may provide support for a diagnosis of a PV in a patient with otherwise
24 unexplained, significant erythrocytosis (Perricone, Polverelli et al. 2017). However,

1 the *JAK2* V617F mutation has been identified in normal individuals, often at a low
2 allele burden, with a frequency that increases with age (Genovese, Kähler et al.
3 2014, Jaiswal, Fontanillas et al. 2014). Caution is therefore warranted and
4 comprehensive investigations should exclude an alternative secondary or congenital
5 cause of erythrocytosis. The test should preferably be repeated within 3-6 months,
6 and clinical assessment for other features of an MPN e.g. splenomegaly, bone
7 marrow histological features, and screening for an additional mutation in *JAK2* exon
8 12 may be helpful.

9 **Recommendations:**

- 10 • **In patients with persistent, significant and unexplained erythrocytosis,**
11 **testing for *JAK2* V617F is recommended, using a peripheral blood**
12 **sample and an assay sufficiently sensitive to detect a mutant allele**
13 **burden as low as 1-3%.**

14 **(GRADE 1B)**

15 **Risk stratification in PV**

16 The principal aims of risk stratification in PV are a) to select patients at higher risk of
17 thrombosis for consideration of cytoreductive therapy and b) to provide the most
18 accurate information to patients on the risks and implications of a diagnosis of PV.

19 **Thrombosis and Bleeding Risk**

20 At diagnosis, in the largest prospective study to date the European Collaboration on
21 Low-Dose Aspirin in Polycythaemia Vera (ECLAP), age \geq 65 years and a prior
22 history of thrombosis were found to be the most important predictors of
23 cardiovascular events (Marchioli, Finazzi et al. 2005). A baseline WBC of $>15.0 \times$

1 $10^9/l$ is a significant predictor of thrombosis, particularly an increased risk of
2 myocardial infarction (Landolfi, Di Gennaro et al. 2007); however, prognostic models
3 including leucocytosis have not been prospectively validated. Cardiovascular risk
4 factors (smoking, diabetes mellitus, arterial hypertension, hypercholesterolaemia)
5 also contribute to thrombotic risk in PV (Barbui, Vannucchi et al. 2017) (Landolfi, Di
6 Gennaro et al. 2007) (Gangat, Strand et al. 2007). Once treatment is initiated,
7 cardiovascular events occur more frequently in patients with less stringent Hct
8 control (Marchioli, Finazzi et al. 2013) and when the WBC remains elevated $>11 \times$
9 $10^9/l$ (Barbui, Masciulli et al. 2015). A relationship between thrombocytosis (either at
10 diagnosis or follow-up) and thrombotic risk has not been established in PV (Di Nisio,
11 Barbui et al. 2007), but extreme thrombocytosis ($\geq 1500 \times 10^9/l$) is associated with
12 increased risk of bleeding due to acquired von Willebrand disease and should be
13 considered an indication for initiation of cytoreductive therapy (Budde and van
14 Genderen 1997).

15 **Survival and Transformation Risk**

16 The impact of age, degree of leucocytosis and prior history of venous thrombosis on
17 long term prognosis are well-established. In the ECLAP study, age >65 years was
18 associated with inferior survival and age >70 years was associated with increased
19 incidence of leukaemia/myelodysplasia (Marchioli, Finazzi et al. 2005). In the IWG-
20 MRT study, age >61 years was associated with inferior overall and leukaemia-free
21 survival (Tefferi, Rumi et al. 2013). Longer disease duration has been associated
22 with increased risk of myelofibrotic (MF) transformation (Marchioli, Finazzi et al.
23 2005). Leucocytosis with $WBC \geq 15 \times 10^9/l$ is associated with an inferior leukaemia-
24 free survival. A prior history of venous thrombosis also impacts negatively on overall
25 survival. The IWG-MRT Prognostic Score uses these three parameters (age, WBC

1 and thrombotic history) to delineate distinct risk groups for overall survival (Tefferi,
2 Rumi et al. 2013), but this prognostic score has not been independently validated in
3 prospective studies.

4 Several other clinical and laboratory variables have been reported to influence
5 overall survival and/or risk of disease transformation. The presence of splenomegaly
6 in PV patients has been associated with shorter overall survival and increased risk of
7 transformation to both MF and AML (Abdulkarim, Ridell et al. 2011). The presence of
8 an abnormal karyotype adversely impacts overall and leukaemia-free survival
9 (Tefferi, Rumi et al. 2013). A raised lactate dehydrogenase (LDH) and the presence
10 of reticulin fibrosis at diagnosis predict a higher rate of transformation to
11 myelofibrosis (MF) but not to acute myeloid leukaemia (AML) (Alvarez-Larrán,
12 Bellosillo et al. 2009) (Barbui, Thiele et al. 2012). Prospective analysis indicates that
13 a *JAK2* mutant allele burden of >50% is also associated with increased risk of MF
14 (but not of AML or thrombosis) (Passamonti, Rumi et al. 2010) but the clinical utility
15 of this measurement is not yet well-established. Although *JAK2* exon12-mutated
16 disease has a subtly different clinical phenotype to *JAK2* V617F-driven PV (higher
17 haemoglobin concentration, lower WBC), there appears to be no difference in long-
18 term prognosis (Passamonti, Elena et al. 2011). Targeted gene sequencing is a
19 rapidly advancing area; approximately 15% of PV patients have mutations of ≥1 of
20 *ASXL1*, *SRSF2* and *IDH2* and these patients have a reduced rate overall survival in
21 univariate analysis (Tefferi, Lasho et al. 2016).

22 **Recommendations: Risk stratification**

- 23 • **Age and thrombotic history should be used to define risk groups for**
24 **thrombosis in PV (GRADE 1A).**

- 1 • **‘High risk’**: age ≥ 65 years and/or prior PV-associated arterial or venous
2 **thrombosis (GRADE1A)**
- 3 • **‘Low risk’**: age < 65 years and no PV-associated thrombotic history
4 **(GRADE 1A)**
- 5 • **Some ‘low risk patients’ may be to be considered at higher risk in the**
6 **presence of cardiovascular risk factors, elevated WBC, extreme**
7 **thrombocytosis or Hct uncontrolled with venesection (GRADE 1B)**
- 8 • **A number of variables including age, prior thrombosis, the presence of**
9 **splenomegaly, serum LDH level, degree of reticulin staining, presence of**
10 **an abnormal karyotype and *JAK2* mutant allele burden may be utilised**
11 **when counselling the patient on longer term prognosis including overall**
12 **survival and disease transformation risk (GRADE 2B).**
- 13 • **Deep sequencing for ‘high risk mutations’ e.g. *ASXL1*, *SRSF2*, *IDH1/2* is**
14 **not yet ‘standard of care’ but may be considered in selected cases**
15 **where their presence may influence management. (GRADE 2B).**

16 **Management of polycythaemia vera**

17 Patients with PV may present with thrombosis or cardiovascular disease. Disease-
18 related PV symptoms such as microvascular disturbance, pruritus (which may be
19 excruciating), migraine-type headache and fatigue may also be presenting features
20 which can significantly impact on quality of life (Harrison, Koschmieder et al. 2017).
21 However, patients may be asymptomatic at presentation.

22 The goals of treatment are to reduce complications and therefore improve survival.
23 (Table III). Mortality is chiefly related to thromboembolic events and the principal aim
24 of therapy is to reduce this risk. Targeted assessment and management of

1 cardiovascular risk factors such as hypertension, hypercholesterolaemia and
2 diabetes mellitus and smoking is essential. Reduction in symptom burden is also a
3 valid target for treatment. There is evidence that patients with inadequately
4 controlled PV as determined by hydroxycarbamide (HC) use, splenomegaly and
5 venesection requirements have a significantly higher symptom score measured by
6 the MPN-SAF (Geyer, Scherber et al. 2016). Frequent need for concurrent
7 venesection may indicate need for dose alteration and or change of treatment.

8 **Haematocrit target**

9 The target for Hct control in PV was originally based on data from assessment of
10 numbers of vascular events at different Hct levels and it was estimated that a target
11 below 0.45 should be maintained (Pearson and Wetherley-Mein 1978). This target
12 has now been validated in a randomised clinical trial by the investigators of the
13 CYTO-PV group who assessed the impact of stringent Hct reduction to <0.45
14 compared with a more liberal target range of 0.45-0.50. Patients with a Hct target of
15 < 0.45 had a significantly lower rate of cardiovascular death and major thrombosis
16 than those with a target of 0.45-0.50 (Marchioli, Finazzi et al. 2013). It was noted
17 that the median WBC was significantly lower in the low Hct group, which may have
18 been related to variation in the use of cytoreductive therapy between the groups. The
19 impact of this parameter on the difference in outcome between the groups has been
20 debated (McMullin, Harrison et al. 2013).

21 The European LeukemiaNet (ELN) has by consensus recommended response
22 criteria for PV . There is, however, little evidence that stringent achievement of these
23 contributes to improved outcomes apart from the Hct target. These are a valuable

1 set of measures to assess treatment outcome with consistency across clinical trials
2 but are not as useful in clinical practice (Barosi, Tefferi et al. 2015).

3 **Platelet and leucocyte target**

4 There is considerable published evidence that there is an association between
5 increased WBC and thrombosis risk in PV (Barbui, Carobbio et al. 2009,
6 Caramazza, Caracciolo et al. 2009) ((De Stefano, Za et al. 2010, Barbui, Masciulli et
7 al. 2015) (Cerquozzi, Barraco et al. 2017). In contrast, one prospective study did not
8 find such an association (Passamonti, Rumi et al. 2010). An analysis of long-term
9 outcome of patients enrolled into the ECLAP study demonstrated that in patients
10 with WBC $>15 \times 10^9/l$ there was increased incidence of thrombosis in comparison
11 with those with WBC $<10 \times 10^9/l$, largely related to an increase in myocardial
12 infarction (Landolfi, Di Gennaro et al. 2007). In a retrospective study of PV to
13 determine whether blood counts influenced the complication rate and survival, older
14 age and elevated lactate dehydrogenase at diagnosis were found to be risk factors
15 for vascular complications. When the vascular complication occurred, 41% of the
16 patients with a complication had elevated WBC compared with 20% of patients
17 without a complication (Enblom-Larsson, Girodon et al. 2017).The CYTO-PV study
18 treatment arms which showed a lower thrombotic risk in those intensively managed
19 to Hct <0.45 showed a comparatively lower WBC which may have contributed to the
20 lower rate of thrombotic events (Marchioli, Finazzi et al. 2013) (McMullin, Harrison et
21 al. 2013). There is no evidence from randomised trials to determine whether
22 treatment targeted at reducing leucocyte count impacts on overall outcome and
23 therefore no recommendation to target WBC as a treatment goal can be made.
24 Indeed, no evidence for improved survival or lower thrombosis risk was seen in

1 patients achieving complete or partial response according to ELN criteria in an
2 analysis of PV patients treated with HC whereas a better prognosis was seen when
3 there was a white cell and platelet response (Alvarez-Larrán, Pereira et al. 2012).
4 There is evidence that at extremes of platelet count there is a risk for bleeding and
5 haemorrhage which may necessitate cytoreductive treatment in those with high
6 counts.

7 **Allele burden reduction**

8 There is currently no indication to monitor allele burden sequentially outside the
9 clinical trial setting. Whilst many studies have used allele burden reduction to assess
10 impact of treatment there is currently no clear clinical impact of this as a target. Allele
11 burden over 50% may correlate with progression to myelofibrosis (Passamonti, Rumi
12 et al. 2010) but there is no evidence that this alters outcome and no evidence that
13 lowering allele burden alters outcome.

14 **Bone marrow response**

15 There is no indication that serial monitoring of bone marrow morphology or fibrosis
16 grade is of value but this should be undertaken if there is suspected progression
17 from blood counts or symptomatology.

18 **Venesection**

19 Randomised trial data supports venesection of 200 – 500 mls blood at intervals
20 suitable for patient size/tolerability should be used to achieve and maintain Hct of
21 <0.45 (Marchioli, Finazzi et al. 2013). In low risk patients this is usually adequate to
22 maintain target Hct. Where frequent venesection is needed to achieve this target
23 then an alternative approach using a cytoreductive agent may need to be
24 considered. High levels of venesection requirement have been reported to have an

1 association with higher thrombosis risk in patients on HC, specifically in those
2 patients requiring 3 or more venesections per year (Alvarez-Larrán, Pérez-Encinas
3 et al. 2017).

4 No study has explicitly defined a gender difference in Hct target. A different target
5 Hct in males and females is not recommended

6 Iron deficiency may result from venesection. Whilst generally this is asymptomatic,
7 restless legs, concentration problems, impaired cognitive function, dizziness, fatigue,
8 headaches and inactivity and other symptoms may warrant a different treatment
9 approach. Iron administration must be undertaken with extreme caution and with
10 close supervision and monitoring of blood counts. Severe symptoms may warrant an
11 alternative approach such as cytoreductive therapy.

12 **Aspirin**

13 The value of low-dose aspirin in patients with PV was demonstrated in the ECLAP
14 study. In this double blind, placebo-controlled randomised trial those randomised to
15 aspirin 100 mg daily had significantly fewer vascular events at 3 years compared to
16 placebo. There was a 60% decrease in the risk of the combined primary end-point
17 which was of thrombotic events and death from cardiovascular causes. Major
18 bleeding events were not significantly increased (Landolfi, Marchioli et al. 2004).

19 **Cytoreductive therapy**

20 High-risk patients should be considered for cytoreductive therapy. Low-risk patients
21 who may benefit from cytoreduction include those with progressive splenomegaly,
22 progressive leucocytosis (e.g. WBC $>15 \times 10^9/l$) thrombocytosis (e.g. platelets >1500
23 $\times 10^9/l$) and poor tolerance of venesection.

1 *Hydroxycarbamide*

2 Hydroxycarbamide is a cytoreductive agent, a non-alkylating antimetabolite which
3 acts through inhibition of ribonucleotide reductase thereby regulating the rate of DNA
4 synthesis. HC has a dose-dependent effect and needs to be individually titrated to
5 achieve optimal count control. The efficacy of HC in controlling blood counts and
6 preventing thrombosis has been extrapolated from the evidence in ET (Cortelazzo,
7 Finazzi et al. 1995) and HC has been used in the management of PV. A recent
8 retrospective study of PV demonstrated that patients treated with HC experienced
9 significantly fewer vascular complications (11%) than patients treated with
10 venesection only with a survival advantage for patients treated with HC when
11 adjusted for variables supporting the use of this agent in first-line treatment (Enblom-
12 Larsson, Girodon et al. 2017).

13 *Side effects*

14 HC is generally well tolerated. Macrocytosis is expected. Myelosuppression is seen
15 in some patients. Mucocutaneous side effects occur including ulceration in
16 perimalleolar areas, oral aphthous ulceration, actinic keratosis, squamous cell
17 cancer and other skin lesions. Gastrointestinal side effects have been reported.

18 *Leukaemogenic risk and risk of secondary malignancy*

19 There has been much debate and concern over the potential leukaemogenic risk of
20 treatments used for PV and also the potential for secondary malignancies. The
21 natural history of PV is that a proportion of patients will experience progression to
22 acute leukaemia and myelofibrosis. There is currently no conclusive evidence that
23 this risk is exacerbated by the use of HC alone. A recent large study European ET
24 trial, the EXELS study compared anagrelide treated patient versus those treated with

1 other cytoreductive therapies and found there was a higher incidence of leukaemia
2 and increased incidence of other cancers in those treated with other cytoreductive
3 therapies including HC alone (Besses, Kiladjian et al. 2013) (Birgegård, Besses et al.
4 2018). A Swedish population-based study with a nationwide MPN cohort, identified
5 those who developed AML/myelodysplastic (MDS) and matched controls,
6 retrospective case record analysis was undertaken. Whilst the risk of AML/MDS was
7 increased in patients exposed to high doses of ³²P and alkylators or 2 or more
8 cytoreductive agents, this was not seen in those patients treated exclusively with HC
9 (Björkholm, Derolf et al. 2011). A long-term assessment from the ECLAP study
10 showed no increased MDS/AML in those treated with HC alone (Finazzi, Caruso et
11 al. 2005) and a retrospective analysis showed no association between HC or
12 busulfan and AML (Tefferi, Rumi et al. 2013).

13 A higher incidence of second malignancies has been seen in a small cohort of
14 patients treated with HC compared to interferon (INF) alone (Hansen, Sørensen et
15 al. 2017), particularly non-melanoma skin cancers, and this has been seen in
16 population-based studies with increased risk of non-melanotic skin cancer in
17 patients treated with HC, especially in older patients of male sex (Gómez, Guillem et
18 al. 2016). Another study looked at treatment characteristics of a large number of
19 patients with ET, diagnosed and followed during a 30-year period. The different
20 therapies administered, comprising HC and alkylating agents, did not appear to have
21 any impact on the development of secondary malignancy with a similar rate of
22 secondary malignancies in untreated patients. Male gender and age >60 years were
23 the only factors that were correlated with higher risk (Santoro, Sperduti et al. 2017).

24 HC is recommended as a first line cytoreductive treatment option for all patients for
25 whom this is required. The risk benefit profiles need to be discussed with patients.

1 HC is not safe in pregnancy and it is recommended that it be stopped 3 months prior
2 to intended conception. Adequate contraception should be used by patients
3 receiving this medication.

4 *Hydroxycarbamide intolerance and resistance*

5 There has been an attempt to define the criteria to suggest failure of HC as first line
6 therapy for PV. The ELN have by consensus suggested a unified definition of
7 resistance to intolerance or hydroxycarbamide. This classification identifies a group
8 of patients who have a poorer prognosis who may require or benefit from a change
9 of treatment (Barosi, Birgegard et al. 2010) (Table IV). In retrospective studies
10 resistance is associated with worse survival, with development of anaemia or
11 cytopenias identifying a group with poorer outcome (Alvarez-Larrán, Pereira et al.
12 2012, Alvarez-Larrán, Pérez-Encinas et al. 2017).

13 *Interferons*

14 Numerous single centre studies have observed that interferon- α (IFN- α) can be
15 successfully to normalise blood counts, reduce splenomegaly and prevent
16 thrombosis in PV (Silver 2006) It is also effective in many patients in reducing
17 pruritus (Taylor, Dolan et al. 1996). This agent is of particular interest due to its anti-
18 clonal activity as demonstrated by molecular (as assessed by mutation burden of
19 *JAK2* V617F) and histological remissions (Larsen, Møller et al. 2009) (Stauffer
20 Larsen, Iversen et al. 2013). No leukaemogenic effect has been identified. However,
21 side effects often limit use and most commonly include flu-like symptoms and mood
22 changes. In a minority of patients, endocrine and autoimmune disorders also occur
23 warranting regular monitoring of thyroid function and additional investigations where

1 indicated. Treatment with IFN- α is usually continuous but occasionally it can be
2 stopped for prolonged periods of time.

3 Longer acting pegylated IFN- α -2a (PEG- α -2a) requires less frequent administration
4 and is generally better tolerated. Two Phase II studies of PEG- α -2a demonstrated
5 complete responses of 70-95% as well as complete molecular remissions of 14 –
6 24% with treatment discontinuation due to side-effects observed in 8-10% of
7 patients only (Kiladjian, Cassinat et al. 2006) (Quintás-Cardama, Kantarjian et al.
8 2009) Comparable results have been noted in single-centre studies (Crisà, Cerrano
9 et al. 2017, Gowin, Jain et al. 2017) A Phase III study of PEG- α -2a versus HC as
10 first-line treatment for high-risk PV is underway and interim analysis shows no
11 significant advantage for PEG- α -2a over HC (Mascarenhas, Prchal et al. 2016
12)

13 Pegylated interferon- α -2b (PEG- α -2b) has also been assessed in two studies which
14 included PV patients and whilst it has been shown to be effective in controlling
15 disease, clinical use has been limited by high discontinuation rates due to side
16 effects (Samuelsson, Hasselbalch et al. 2006) (Jabbour, Kantarjian et al. 2007).

17 Recently, interim analysis from a phase III study of proline-PEG- α -2b
18 (Ropeginterferon) has demonstrated complete haematological responses in 71% of
19 PV patients, sustained reductions in mutation burden of *JAK2* V617F, good
20 tolerability and confirmed non-inferiority (or no significant advantage) to HC as first
21 line treatment for patients with high risk PV (Gisslinger, Klade et al. 2017)

22 *Ruxolitinib*

23 Following early studies of the JAK1 and 2 inhibitor ruxolitinib in MF this agent was

1 tested in PV and ET, in patients resistant or intolerant to HC. The majority of PV
2 patients became phlebotomy-independent and had an improvement in symptoms
3 and splenomegaly (>50%) (Verstovsek, Passamonti et al. 2014).

4 Following this a phase III trial RESPONSE evaluated the efficacy and safety of
5 ruxolitinib in a specific subgroup of PV patients who were both refractory to, or
6 intolerant of HC and who required ongoing phlebotomy and had splenomegaly
7 (Vannucchi 2015). Patients were randomized between ruxolitinib and best available
8 therapy (BAT), which could include any therapy, and crossover was permitted.
9 Patients on ruxolitinib achieved good Hct control and spleen response, although only
10 21% of patients achieved both. Improvements in disease-related symptoms were
11 described. Anaemia and thrombocytopenia were the main haematological adverse
12 events. Herpes zoster infection was described in patients on ruxolitinib. Non-
13 melanoma skin cancer was reported in both arms. Thromboembolic events were
14 more frequent on BAT arm but this was not a pre-determined outcome. Data
15 published from this study also suggested that molecular responses can occur
16 perhaps to the same extent as with interferon (Pieri, Pancrazzi et al. 2015,
17 Vannucchi, Verstovsek et al. 2017) and that even profoundly iron deficient patients
18 can normalise their iron parameters with ruxolitinib therapy (Verstovsek, Harrison et
19 al. 2017). Disease transformation occurred and there is no information to suggest
20 that ruxolitinib therapy impacts these events.

21 However, the RESPONSE study had some inherent bias: first, the population of the
22 study is highly selected as they had to be venesection-dependent. Second, patients
23 on the BAT arm were allowed to receive HC and many did so reflecting the lack of
24 therapy options in this setting. Finally, as patients received other treatments before
25 ruxolitinib and crossed between the treatment arms it is difficult to establish if the

1 events such as skin cancer, or disease transformation could be an effect of the
2 ruxolitinib or occur as an accumulative effect of other cytoreductive therapies.

3 Following RESPONSE, a second randomized open label phase 3b study
4 (RESPONSE-2) was developed to determinate the efficacy of ruxolitinib versus BAT
5 in a similar population of PV patients as RESPONSE but the patients were not
6 required to have splenomegaly (Passamonti, Griesshammer et al. 2017). Here
7 ruxolitinib showed good responses in controlling Hct and PV-related symptoms.
8 However, the follow-up for the study is short, the majority of patients had received
9 HC previously and HC was part of BAT options.

10 RELIEF was a randomized study focusing on PV-related symptoms for patients on a
11 stable dose of HC (Mesa, Vannucchi et al. 2017) with crossover to ruxolitinib allowed
12 after week 16. The primary endpoint, the percentage of patients with $\geq 50\%$ reduction
13 in symptoms, was seen in significantly more patients in the ruxolitinib arm. A
14 statistically significant reduction in itching was also noted in the ruxolitinib. This study
15 was perhaps underpowered but showed that ruxolitinib improves symptoms in
16 patients with controlled PV.

17 The evidence from these trials suggests ruxolitinib has a role in the treatment of HC-
18 resistant or intolerant PV.

19 *Other treatments*

20 There are several cytotoxic agents that are effective in controlling blood counts but
21 which have been associated with increased rates of leukaemic transformation.

22 Busulfan, a cell cycle non-specific alkylating agent, has such an association.

23 However, retrospective studies show that it is an effective therapy for MPNs (Begna,
24 Abdelatif et al. 2016) although an actuarial probability of leukaemia transformation of

1 10% at 3 years was reported in one study (Alvarez-Larrán, Martínez-Avilés et al.
2 2014). Busulfan is useful in treating PV in those with limited life expectancy. It can be
3 given in dosing regimens of 2 – 4 mg daily until counts are controlled but patients
4 need to be seen frequently to check for neutropenia or thrombocytopenia so that
5 treatment can be interrupted. An alternative regimen is pulsed single 25 – 50 mg
6 doses at intervals of approximately 6 weeks.

7 ³²P is has a leukaemogenic potential but a single intravenous dose can be effective
8 for long term control. One retrospective study showed its efficacy with remission
9 rates of 90% (Lawless, McMullin et al. 2016). Doses can be repeated if the response
10 is lost but the leukaemogenic risk increases with the cumulative exposure. ³²P is a
11 suitable treatment for those with limited life expectancy who are self-caring (so that
12 there is no risk for carers).

13 Pipobroman a bromide derivative of piperazine similar to alkylating agents has been
14 compared to HC in randomised trials and shown to be effective but has continuing
15 leukaemogenic potential (Kiladjian, Chevret et al. 2011) and therefore should only be
16 used in those with limited life expectancy.

17 Anagrelide, a megakaryocyte differentiation inhibitor, is licensed as second line
18 therapy in ET. Retrospective reports of anagrelide used in combination with HC in
19 PV have shown that it is effective at lowering the platelet count and it may be useful
20 in combination when an elevated platelet count is an issue (Ahn, Natelson et al.
21 2013).

22 A number of other agents have been used for cytoreduction in PV with varying
23 efficacy. A small study investigated the use of imatinib. The complete response rate

1 was 30% with frequent side effects. This has not been studied further and is not
2 recommended for the treatment of PV (Silver, Bourla et al. 2012)

3 Histone-deacetylase inhibitors (HDACi) inhibit proliferation of cells with a *JAK2*
4 V617F mutation. Two HDACis have been tested in PV in phase 2 trials. Vorinostat in
5 a trial of PV and ET achieved a response rate of 35% but with a very high drop-out
6 rate because of adverse events (Andersen, McMullin et al. 2013). Givinostat was
7 assessed in a phase 2 study of PV unresponsive to HC monotherapy with response
8 rates in the order of 50% and with high rates of improvement in pruritus (Finazzi,
9 Vannucchi et al. 2013). HDACis need to be assessed further in trials before they can
10 be recommended for clinical use.

11

12 Following evaluation of all recent evidence it is recommended that all patients
13 including those stratified as low-risk should be venesected to a Hct target of 0.45 and
14 given low dose aspirin if there are no specific contraindications. High-risk patients
15 should be treated with cytoreductive therapy in addition. However, low-risk patients
16 with any of the criteria listed below, may also need to be considered for cytoreductive
17 therapy

18

19 **RECOMMENDATIONS: Management options for ALL PV including low-risk**
20 **patients**

- 21 • **Target haematocrit of <0.45 in all patients (GRADE 1A)**
- 22 • **Low dose aspirin (75 – 100 mg) in all patients (GRADE 1A)**
- 23 • **Targeted intervention to reduce cardiovascular risk factors**

1 **Consider cytoreductive therapy in low-risk patients with:**

- 2 • **History of treated arterial hypertension, ischaemia heart disease or**
- 3 **diabetes mellitus**
- 4 • **Persistent leucocytosis (e.g. WBC >15 × 10⁹/l)**
- 5 • **Uncontrolled haematocrit (or poor tolerability of venesection)**
- 6 • **Extreme / progressive thrombocytosis (e.g. ≥ 1500 × 10⁹/l) and/or**
- 7 **haemorrhagic symptoms**
- 8 • **Progressive / symptomatic splenomegaly**
- 9 • **Uncontrolled or progressive disease-related symptoms e.g. weight loss,**
- 10 **sweats**

11 **(GRADE 1B)**

12 **Recommendations: Management options in high-risk patients**

- 13 • **First Line: hydroxycarbamide or interferon (preferably pegylated**
- 14 **interferon)**
- 15 • **Second line: In patients treated with hydroxycarbamide 1st line**
- 16 **interferon as second line treatment or where treated with interferon 1st**
- 17 **line recommend hydroxycarbamide as second line treatment**
- 18 • **Consider pegylated interferon as second line in those patients who have**
- 19 **had non-pegylated interferon 1st line and could not tolerate it**
- 20 • **Ruxolitinib 2nd /3rd line in HC resistant or intolerant**

21 **(GRADE 1A)**

22 **Third-line or further treatment options**

- 1 • **Busulfan or ³²P or pipobroman in those with limited life expectancy**
- 2 **(GRADE 1B).**
- 3 • **Anagrelide in combination with hydroxycarbamide may be helpful in**
- 4 **those where platelet control is difficult (GRADE 2C)**

5 **Acknowledgements**

6 The authors would like to the BSH task forces and the BSH sounding boards for their
7 support in preparing this guideline. They also wish to thank Jacky Wilson for help in
8 undertaking the initial literature review. All authors reviewed the literature search,
9 formulated and agreed guidance and contributed to drafting writing and editing of the
10 manuscript.

11 **Declaration of Interest**

12 The BSH paid the expenses incurred during the writing of this guidance. All authors
13 have made a declaration of interests to the BSH and Task Force Chairs which may
14 be reviewed on request.

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