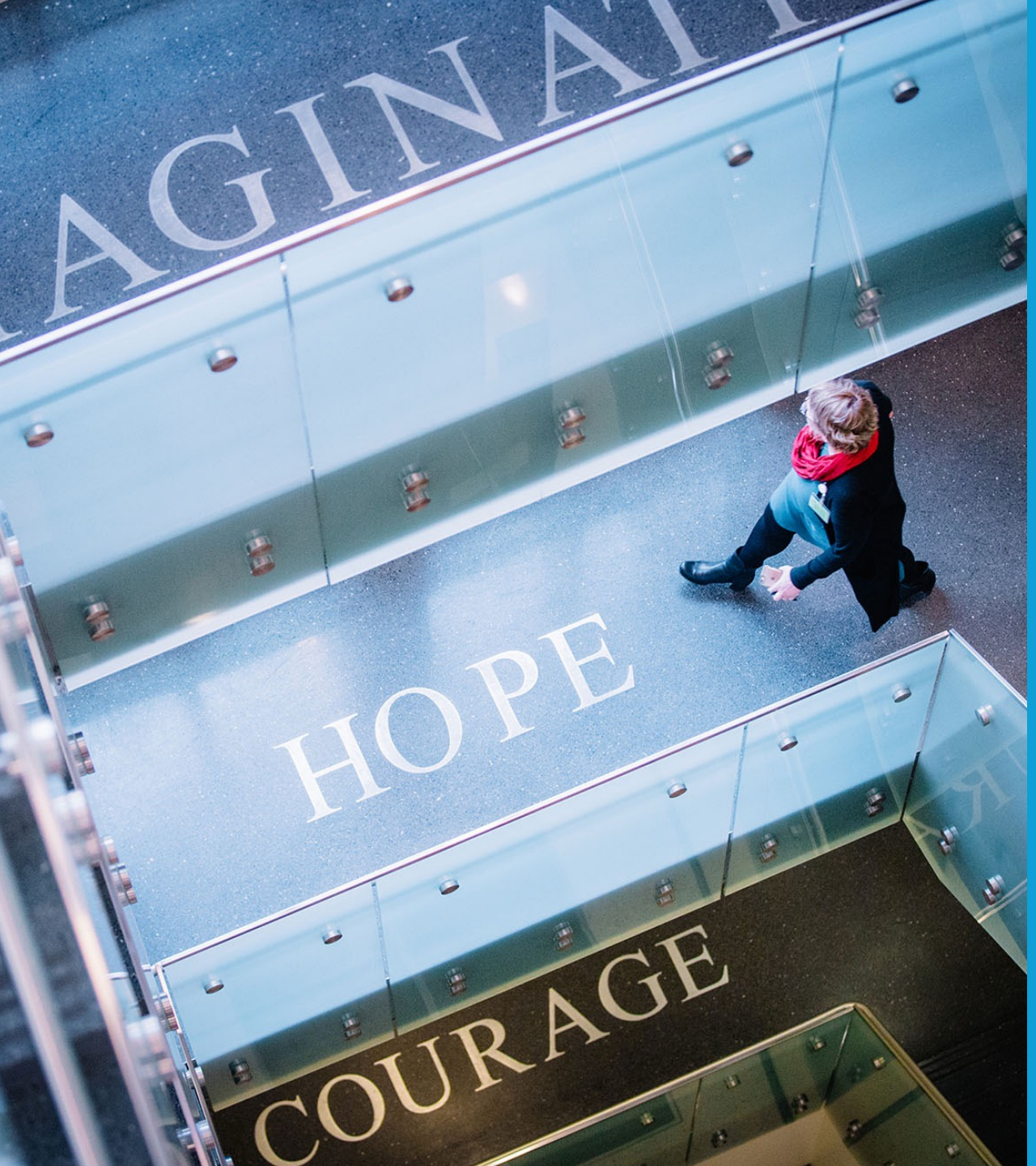

Patient-Based Panel Discussion Leukemic Malignancies

All Speakers: Drs. Frank, Vale, Langston, Hunter, Arellano, Hochman& Kantarjian

Case presented by Emory University Hematology Fellow: Abraham Attah, MD

July 24th, 2025

EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute-Designated Comprehensive Cancer Center

NCI Designated Comprehensive Cancer Center

Case Summary

HPI: 62YOF with PMH of HTN, iron deficiency anemia, presented to PCP in Sept 2024 with fatigue, malaise, weight loss and recurrent COVID-19 infection.

Labs 9/30/24: WBC of 1.8 (ANC 310), Hb 8.5 (MCV 73.7), Plt of 30. Diff showed 2+ polychromasia with no circulating blasts noted

Case Summary

Bone Marrow Biopsy 10/7/24:

- Morphology: 70% cellularity with trilineage hematopoiesis, left shifted erythroid hyperplasia, **megakaryocytic hyperplasia with marked atypia. Overall, 1 lineage with atypia/dysplasia**
- Flow Cytometry Aspirate: 10% myeloblasts, phenotypically aberrant granulocytes/monocytes
- IHC Core: 6% of cells CD34+, +CD117
- MDS FISH: WNL (5, 7, 8, 20)
- Karyotype: 46, XX [20]
- Molecular Analysis: No significant variant

Diagnosis

Diagnosis: MDS-IB1 WHO 2022/ MDS-EB ICC 2022

Risk Stratification: IPSS-R (high risks), IPSS-M (mod-high risks)

PS: ECOG1

Panel Discussion

1. Should IPSS-M completely replace IPSS-R as the standard risk stratification tool for MDS in 2025?

2. How would you manage patient at this time? If treatment is indicated, what regimen will you consider?

Treatment

- Started on single agent Azacitidine on 10/28/24 and completed 3 cycles with rhino virus infection slightly delaying C2.

Panel Discussion

1. Following updates from phase 3 VERONA trial at EHA 2025 would you continue Aza monotherapy or add venetoclax to Aza?
2. In fit patients with higher-risk MDS and available donors, should intensive induction chemotherapy precede transplant or proceed directly to transplant? Would you consider allogenic transplant in this patient?