

# SINTOMA 2026

Pre-Symposium · São Paulo · May 13, 2026

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## Flash Clinical Cases

Expert Panel Discussions

### Panel I — Diagnosis

16:18–16:38 · Cases 1–3

Cançado · Sallman · Zacchi

Moderator: Phillip Scheinberg

*5–7 min per case · Audience poll → Expert debate*

### Panel II — Treatment

18:36–19:06 · Cases 4–7

Helman · Garcia-Manero · Osorio · Fonseca

Moderator: Phillip Scheinberg

*7–10 min per case · Audience poll → Expert debate*

# PANEL I

## DIAGNOSIS

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16:18 – 16:38 · Cases 1–3 · 5–7 minutes per case

Cançado · Sallman · Zacchi · Moderator: Phillip Scheinberg

# CHIP, CCUS, or MDS?

## Navigating Clonal Cytopenia in 2026

### PATIENT

- 73M · incidental macrocytic anemia
- Hb 9.6 g/dL · VCM 104 fL · isolated cytopenia
- No cytotoxic exposure · ECOG 0 · asymptomatic
- No transfusion requirement

### DIAGNOSTIC DATA

- BM biopsy: 40% cellularity · erythroid dysplasia 8% · no excess blasts
- Karyotype: normal (46,XY)
- NGS: TET2 VAF 34% · DNMT3A VAF 29% · no SF3B1/TP53/splicing
- EPO 68 mU/mL · Ferritin 340 ng/mL

### PRIOR THERAPY

- No prior therapy
- Referral for unexplained macrocytic anemia ×5 months

### CLINICAL DILEMMA

#### WHO 2022: CHIP vs CCUS vs MDS-SLD?

Dual high-VAF mutations, borderline dysplasia, isolated cytopenia — is this actionable?

### DISCUSSION OPTIONS

A

CCUS: watchful waiting q6 months · no treatment · reassess if cytopenia worsens

B

MDS-SLD: cytopenia + dysplasia + clonal mutations → initiate ESA (EPO 68 favorable)

C

Repeat BM in 3 months + flow cytometry + serial NGS to establish clonal trajectory

D

Treat anemia empirically with ESA regardless of classification — EPO 68 mU/mL is favorable; separate the therapeutic decision from the diagnostic label

# MDS/MPN Overlap Syndrome: How Do You Get to the Right Diagnosis?

## PATIENT

- 67F · anemia + thrombocytosis ×12 months
- Hb 9.0 g/dL · PLT 640K · mild splenomegaly
- Referring diagnosis: Essential Thrombocythemia + iron deficiency anemia
- No prior cytotoxic exposure · ECOG 1

## DIAGNOSTIC DATA

- BM aspirate: erythroid dysplasia · megakaryocytic dysplasia · 23% ring sideroblasts
- BM biopsy: hypercellular · no fibrosis · del(20q) on cytogenetics
- NGS: SF3B1 VAF 42% · JAK2 V617F VAF 18% · no TP53/ASXL1/EZH2
- Serum EPO: 82 mU/mL · Iron studies: normal · LDH mildly elevated

## PRIOR THERAPY

- No prior therapy
- Treated 6 months as ET + iron deficiency — no hematologic improvement

## CLINICAL DILEMMA

**The referring diagnosis is ET + iron deficiency anemia — clearly incorrect.**

**What is the precise WHO 2022 diagnosis, and what additional workup, if any, is needed to confirm it?**

**What diagnostic pitfalls led to a 6-month delay?**

## DISCUSSION OPTIONS

**A** MDS/MPN-RS-T (WHO 2022): SF3B1 + RS ≥15% + PLT ≥450K + multilineage dysplasia — diagnosis established; no further workup needed

**B** MDS with SF3B1 mutation — JAK2 VAF 18% is a concomitant CHIP finding, insufficient for MPN overlap

**C** Diagnosis requires repeat BM with flow cytometry + JAK2 allele burden quantification before classification

**D** MDS/MPN unclassifiable — insufficient criteria without confirming PLT sustained ≥450K over time

## CASE 3 Clonal Evolution or New Disease? Reclassifying MDS at Progression

### PATIENT

- 68F · MDS-SLD diagnosed 18 months ago (IPSS-R 2.0 at diagnosis)
- Hb now 7.2 g/dL (was 9.8) · new thrombocytopenia (PLT 62K) · blast count 4%
- Worsening cytopenias over 3 months · no prior treatment
- ECOG 1 · referred for 'progression workup'

### DIAGNOSTIC DATA

- Original BM (18 mo ago): SF3B1 VAF 38% · del(20q) · dysplasia single lineage · 2% blasts · IPSS-R 2.0
- Current BM: multilineage dysplasia · 4% blasts · new RUNX1 mutation VAF 22%
- Current cytogenetics: del(20q) + new complex karyotype (3 abnormalities) · no del(17p) · no monosomy 7
- Flow cytometry: aberrant CD34+ population 3.8% · no monocytic excess

### PRIOR THERAPY

- No prior MDS-directed therapy
- Observed with q3-month CBC monitoring since diagnosis

### CLINICAL DILEMMA

**At diagnosis: MDS-SLD, IPSS-R 2.0 (low risk).**

**Now: multilineage dysplasia, complex karyotype, new RUNX1 mutation, blast count 4%.**

**How do you reclassify this patient under WHO 2022 — and does the new molecular/cytogenetic data change the diagnosis category, the IPSS-R, and the urgency of intervention?**

### DISCUSSION OPTIONS

- A** MDS with multilineage dysplasia (MDS-MLD) · complex karyotype upgrades IPSS-R to high risk · new workup complete
- B** MDS with increased blasts-1 (MDS-IB1) · 4% blasts meets threshold · IPSS-R recalculation required
- C** MDS with biallelic RUNX1 mutation (MDS-biRUNX1, WHO 2022 new entity) — requires confirmation of second RUNX1 hit
- D** Clonal evolution toward AML — complex karyotype + new RUNX1 + rising blasts warrants re-biopsy in 4–6 weeks before reclassifying