

SINTOMA 2026

Flash Clinical Cases

CML & Myeloproliferative Neoplasms

Day 1 · Thursday May 14, 2026

CML · TFR · PV · ET · Myelofibrosis

5 Cases · 3–5 min discussion each

PATIENT

- 48F, CML × 8 years on imatinib
- Planning embryo transfer (last frozen embryo)
- MR4.5 sustained × 38 months; ECOG PS 0

DIAGNOSTICS

- BCR-ABL1 IS <0.001% (MR4.5) × 38 consecutive months
- Normal karyotype; no residual Ph+
- 1 prior TFR attempt: molecular relapse at 6 mo, re-achieved MR4.5 at 18 mo

PRIOR THERAPY

- Imatinib 400mg × 8 years — no dose reductions
- No 2G-TKI; prior failed TFR at year 5
- Currently at TFR decision point

CLINICAL DILEMMA

38 months sustained MR4.5 with one prior failed TFR. Patient requests 2nd TFR attempt before embryo transfer. Safe to proceed — and what is the optimal strategy if both TFR and pregnancy are goals?

MANAGEMENT OPTIONS — no single correct answer

- A. Approve 2nd TFR attempt — 38-mo MR4.5 meets criteria
- B. Nilotinib → deeper MR5 → then TFR attempt
- C. Continue imatinib through IVF; switch to IFN- α before transfer
- D. IFN- α now as TKI-free bridge for pregnancy planning
- E. TFR concurrent with embryo transfer — monthly PCR monitoring

PATIENT

- 67M, primary MF, newly diagnosed; significant fatigue, early satiety
- ECOG PS 1; transfusion-dependent (2u RBC/month × 3 months)
- Splenomegaly 18cm; symptomatic; no prior JAK inhibitor

DIAGNOSTICS

- DIPSS-Plus: Intermediate-2; JAK2 V617F (VAF 62%)
- Hgb 8.4 g/dL; Plt 180; BM: MF grade 2; LDH 2.1× ULN
- CALR/MPL negative; no complex karyotype

PRIOR THERAPY

- Treatment-naïve; transfusion-dependent × 3 months
- Discussed with patient: ruxolitinib · momelotinib · clinical monitoring
- Transplant evaluation deferred pending symptom control

CLINICAL DILEMMA

Newly diagnosed intermediate-2 MF with symptomatic splenomegaly and transfusion dependence. Momelotinib now approved in Brazil. Is it the preferred frontline JAKi over ruxolitinib — or is ruxolitinib still the standard?

MANAGEMENT OPTIONS — no single correct answer

- Momelotinib frontline — SIMPLIFY-1/MOMENTUM: anemia benefit; transfusion independence; approved in Brazil
- Ruxolitinib frontline — COMFORT-I/II: established spleen + symptom standard; most experience
- Ruxolitinib + danazol — add danazol upfront for anemia; practical combination
- Fedratinib frontline — alternative JAKi; comparable spleen response; not available in Brazil
- Pacritinib frontline — thrombocytopenia-specific JAKi; Plt 180 does not require it

PATIENT

- 69M, primary MF × 4 years; ECOG PS 2
- Massive splenomegaly (22cm), transfusion-dependent
- Severe fatigue, night sweats, early satiety

DIAGNOSTICS

- DIPSS-Plus: High; SPLF score 4/4
- JAK2 V617F (VAF 58%), ASXL1 (VAF 42%)
- BM: MF grade 3, 8% blasts, del(20q); LDH 3× ULN
- Platelets: $68 \times 10^9/L$ (low)

PRIOR THERAPY

- Ruxolitinib 20mg BID × 28 mo → progressive spleen/anemia → d/c
- Off ruxolitinib × 2 months; symptomatic
- Transfusion-dependent (2u/month); transplant deferred

CLINICAL DILEMMA

High-risk MF after ruxolitinib failure. Transfusion-dependent, low platelets, massive splenomegaly, ECOG PS 2. Momelotinib is now available in Brazil. Is it the right next step — and what does it realistically offer this patient?

MANAGEMENT OPTIONS — no single correct answer

- A. Momelotinib — newly approved in Brazil
- B. Ruxolitinib re-challenge at lower dose — some patients re-respond after treatment holiday
- C. Ruxolitinib re-challenge + danazol — address anemia while maintaining JAK inhibition
- D. Hydroxyurea + best supportive care — symptom management; realistic goals in PS 2
- E. Allogeneic SCT evaluation — high-risk MF post-ruxolitinib: only curative option; assess fitness

PATIENT

- 64M, MF × 6 years; ECOG PS 2–3
- Weight loss, fever, weekly transfusions
- Recent neutropenic fever hospitalization

DIAGNOSTICS

- BM: 16% blasts (8% × 4 months ago); MF grade 3
- New karyotype: +8, inv(3)
- EZH2 new (VAF 18%), TP53 subclone (VAF 6%)
- LDH 5× ULN

PRIOR THERAPY

- Ruxolitinib × 48 months for symptom/spleen control
- Blast count: 4% (yr 1) → 8% (yr 4) → 16% (now)
- Karyotype evolved: normal → +8 → +8 + inv(3)
- No azacitidine, no chemotherapy

CLINICAL DILEMMA

16% blasts in MF with cytogenetic evolution and emerging TP53 subclone. Is this accelerated MF or early AML? Does the treatment approach differ — and is transplant still achievable?

MANAGEMENT OPTIONS — no single correct answer

- Azacitidine + ruxolitinib — treat as accelerated MF; bridge to transplant
- Intensive induction (7+3 or CPX-351) — blastoid biology, cytogenetic evolution
- Venetoclax + azacitidine — low-intensity for PS 2–3; address blast excess
- Urgent transplant now — <20% blasts still allows SCT
- Palliative intent — inv(3)