RGCIRC
Ethics, Empathy & Excellence

Dated: 02/04/25

CR. NO. : 363672
NAME : NEEL NAYYAR
DIAGNOSIS : ACUTE MYELOID LEUKEMIA WITH MONOCYTIC DIFFERENTIATION
CYTOGENETICS: COMPLEX KARYOTYPE
NGS: TP53(89%), PTPN11
POST FLAG CT (4 DAYS)+VENETOCLAX→BM: 79% BLASTS
FEBRILE NEUTROPENIA (CULTURE NEGATIVE)
POST DECITABINE+VENETOCLAX→BM: 32% BLASTS
ON VENETOCLAX+ATRA (14 DAYS)

Brief Summary of the Case

He is a 27yrs old normotensive, nondiabetic male who was incidentally detected atypical cells on peripheral smear on routine check-up, presented with mild pallor & weakness since 1 month. Patient was apparently well 1 week back when he got routine CBC and found to have few atypical cells seen in his smear. CBC (09/02/25): Hb: 10, TLC: 14000 with 15% atypical cells, Plt: 110000. He came to RGCI for further management. Patient was confirmed to have AML on the basis of **Bone Marrow Aspiration, Biopsy and Flow Cytometry Report**. Case was discussed with family members regarding disease, options of treatment and prognosis. Psychiatrist consultation was taken and advice was followed. ID physician consultation was taken and HRCT Chest was done showed no evidence of active pneumonitis. He was managed with Cap hydrea, posaconazole, IV fluid along with other supportive care. Patient was planned and given Day1-4 of 1st cycle of FLAG based chemotherapy from 17/02/25 to 20/02/25. During stay patient developed fever and loose stools. After collecting blood sample for culture he was started with IV antibiotics, IV fluid, antifungal, blood and blood products along with other supportive care. Blood culture showed no growth. Stool for C.Diff was sent and is was negative. Flu gene X-pert test was sent and was negative. Repeat ID physician consultation was taken and Respiratory Tract Panel was sent and was negative. Repeat HRCT Chest was done showed subpleural GGOs with reticulations, septal thickening in bilateral lower lobes-likely infective etiology. Patient had c/o abnormal movement and uprolling of eye and he was started on antiepiletics. CT head was done reveals, ill-defined hypodensities in bilateral cerebellar white matter. CEMRI Head (03/03/25) showed no demonstrable enhancing parenchymal/meningeal lesion in brain. During stay patient developed generalised ertymateous pressure. Dermatologist opinion was taken and advice followed.
Bone Marrow aspiration & biopsy (06/03/25) showed morphologically Consistent with relapse in a known case of Acute Myeloid Leukemia (79% blasts). Patient was planned & given Day1-10 of 1st cycle of Tab Decitabine + Venetoclax (14 days) from 08/03/25 to 17/03/25 followed by Cap Atra 50mg (M), 40mg (E) from 18/03/25 to 31/03/25. Ophthalmology opinion was taken in view of floaters in front of eyes from 2 days.

Current admission on 20/03/25: **Patient was re-admitted on same day and continued on supportive care with blood and blood products along with other supportive care. Repeat Infectious disease consultation was taken and advice was followed. Bone Marrow Aspiration was done on (21/03/25) showed marrow is not in morphological remission; Histiocytes are markedly increased in the background with few showing red cell and platelet phagocytosis. (Blast: 32%)**

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