**Protocol for the Examination of Myeloid and Mixed / Ambiguous Lineage Neoplasms**

**Version:** 1.1.0.0

**Protocol Posting Date:** June 2024

The use of this protocol is recommended for clinical care purposes but is not required for accreditation purposes.

This protocol applies to Myeloid and Mixed / Ambiguous Lineage Neoplasms involving bone marrow, blood, cutaneous, extranodal / mucosal, or any other anatomic site.

**The following tumor types should be reported using this protocol:**

|  |
| --- |
| **Tumor Type** |
| Myeloid precursor lesions   |
| Myeloproliferative neoplasms |
| Mastocytosis |
| Myelodysplastic neoplasms with defining genetic abnormalities   |
| Myelodysplastic neoplasms, morphologically defined |
| Myelodysplastic neoplasms of childhood   |
| Myelodysplastic / myeloproliferative neoplasms |
| Acute myeloid leukemias with defining genetic abnormalities   |
| Acute myeloid leukemias, defined by differentiation   |
| Myeloid sarcoma   |
| Myeloid / lymphoid neoplasms with eosinophilia and defining gene rearrangement   |
| Acute leukemias of mixed or ambiguous lineage |
| Plasmacytoid dendritic cell neoplasms   |

**The following tumor types should NOT be reported using this protocol:**

|  |
| --- |
| **Tumor Type** |
| Precursor lymphoid malignancies including B-lymphoblastic leukemia/lymphoma and precursor T-cell neoplasms (use Precursor and Mature Lymphoid Malignancies protocol) |
| Langerhans cells neoplasms |
| Indeterminate dendritic cell tumor |
| Interdigitating dendritic cell sarcoma |
| Histiocytic neoplasms including Juvenile xanthogranuloma, Erdheim-Chester disease, Rosai-Dorfman disease, ALK-positive histiocytosis, Histiocytic sarcoma |
| Follicular dendritic cell neoplasms |
| Myofibroblastic tumor |
| Splenic vascular stromal tumors |

**Authors**

Robert W. Allan, MD\*; L. Jeffrey Medeiros, MD; Robert Seifert, MD; Claudio A. Mosse, MD, PhD; Samer Z. Al-Quran, MD; Joseph D. Khoury, MD.

With guidance from the CAP Cancer and CAP Pathology Electronic Reporting Committees.

\* Denotes primary author.

**Accreditation Requirements**

The use of this case summary is recommended for clinical care purposes but is not required for accreditation purposes. The core and conditional data elements are routinely reported. Non-core data elements are indicated with a plus sign (+) to allow for reporting information that may be of clinical value.

**Summary of Changes**

**v 1.1.0.0**

* Typographical correction of mutation under Molecular Alterations Detected question in SPECIAL STUDIES section from "interim" to "internal"

**Reporting Template**

**Protocol Posting Date: June 2024**

**Select a single response unless otherwise indicated.**

**CASE SUMMARY: (MYELOID AND MIXED / AMBIGUOUS LINEAGE NEOPLASMS)**

**TUMOR (Note** [**A**](#N13968)**)**

**Site of Tumor Involvement in Sample (select most involved site)**

\_\_\_ Bone marrow

**Specify Percent Blasts / Blast Equivalents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ %**

**Specify Percent Marrow Cellularity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ %**

\_\_\_ Blood

**Specify Percent Blasts / Blast Equivalents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ %**

\_\_\_ Anterior mediastinum

\_\_\_ Lymph node

\_\_\_ Cutaneous

\_\_\_ Extranodal / mucosal site

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Final Integrated Diagnosis (Note** [**B**](#N13967)**)**

*# The Myeloid and Mixed / Ambiguous Lineage Neoplasms Cancer Case Summary is not required to be completed for Myeloid precursor lesions.*

+\_\_\_ Myeloid precursor lesions#

\_\_\_ Clonal hematopoiesis of indeterminate potential (CHIP)

\_\_\_ Clonal cytopenias of undetermined significance (CCUS)

\_\_\_ Other myeloid precursor lesion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Myeloproliferative neoplasms

\_\_\_ Chronic myeloid leukemia, chronic phase

\_\_\_ Chronic myeloid leukemia, blast phase

\_\_\_ Chronic neutrophilic leukemia

\_\_\_ Chronic eosinophilic leukemia

\_\_\_ Polycythemia vera

\_\_\_ Essential thrombocythemia

\_\_\_ Primary myelofibrosis, pre-fibrotic

\_\_\_ Primary myelofibrosis, fibrotic

\_\_\_ Juvenile myelomonocytic leukemia

\_\_\_ Myeloproliferative neoplasm, NOS

\_\_\_ Other myeloproliferative neoplasm (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Mastocytosis

\_\_\_ Bone marrow mastocytosis

\_\_\_ Indolent systemic mastocytosis

\_\_\_ Smoldering systemic mastocytosis

\_\_\_ Aggressive systemic mastocytosis

\_\_\_ Systemic mastocytosis with an associated hematologic neoplasm

\_\_\_ Mast cell leukemia

\_\_\_ Mast cell sarcoma

\_\_\_ Other mastocytosis (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Myelodysplastic neoplasms

*Myelodysplastic neoplasms with defining genetic abnormalities*

\_\_\_ Myelodysplastic neoplasm with low blasts and 5q deletion

\_\_\_ Myelodysplastic neoplasm with low blasts and SF3B1 mutation

\_\_\_ Myelodysplastic neoplasm with biallelic TP53 inactivation

*Myelodysplastic neoplasms, morphologically defined*

\_\_\_ Myelodysplastic neoplasm with low blasts

\_\_\_ Myelodysplastic neoplasm, hypoplastic

\_\_\_ Myelodysplastic neoplasm with increased blasts-1 (MDS-IB1)

\_\_\_ Myelodysplastic neoplasm with increased blasts-2 (MDS-IB2)

\_\_\_ Myelodysplastic neoplasm with increased blasts and fibrosis (MDS-F)

\_\_\_ Other myelodysplastic neoplasm (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Myelodysplastic neoplasms of childhood*

\_\_\_ Childhood myelodysplastic neoplasm with low blasts

\_\_\_ Childhood myelodysplastic neoplasm with increased blasts

\_\_\_ Other myelodysplastic neoplasm of childhood (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Myelodysplastic / myeloproliferative neoplasms*

\_\_\_ Myelodysplastic chronic myelomonocytic leukemia (MD-CMML), CMML-1

\_\_\_ Myelodysplastic chronic myelomonocytic leukemia (MD-CMML), CMML-2

\_\_\_ Myeloproliferative chronic myelomonocytic leukemia (MP-CMML), CMML-1

\_\_\_ Myeloproliferative chronic myelomonocytic leukemia (MP-CMML), CMML-2

\_\_\_ Myelodysplastic neoplasm with neutrophilia

\_\_\_ Myelodysplastic neoplasm with SF3B1 mutation and thrombocytosis

\_\_\_ Myelodysplastic neoplasm, NOS

\_\_\_ Other myelodysplastic / myeloproliferative neoplasm (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Acute myeloid leukemias

*Acute myeloid leukemias with defining genetic abnormalities*

\_\_\_ Acute promyelocytic leukemia with PML::RARA fusion

\_\_\_ Acute myeloid leukemia with RUNX1::RUNX1T1 fusion

\_\_\_ Acute myeloid leukemia with CBFB::MYH11 fusion

\_\_\_ Acute myeloid leukemia with DEK::NUP214 fusion

\_\_\_ Acute myeloid leukemia with RBM15::MRTFA fusion

\_\_\_ Acute myeloid leukemia with BCR::ABL1 fusion

\_\_\_ Acute myeloid leukemia with KMT2A rearrangement

\_\_\_ Acute myeloid leukemia with MECOM rearrangement

\_\_\_ Acute myeloid leukemia with NUP98 rearrangement

\_\_\_ Acute myeloid leukemia with NPM1 mutation

\_\_\_ Acute myeloid leukemia with CEBPA mutation

\_\_\_ Acute myeloid leukemia, myelodysplasia-related

\_\_\_ Acute myeloid leukemia with other defined genetic alterations (specify, if possible):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Acute myeloid leukemias, defined by differentiation*

\_\_\_ Acute myeloid leukemia with minimal differentiation

\_\_\_ Acute myeloid leukemia without maturation

\_\_\_ Acute myeloid leukemia with maturation

\_\_\_ Acute basophilic leukemia

\_\_\_ Acute myelomonocytic leukemia

\_\_\_ Acute monocytic leukemia

\_\_\_ Pure erythroid leukemia

\_\_\_ Acute megakaryoblastic leukemia

\_\_\_ Other acute myeloid leukemia (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Myeloid sarcoma*

\_\_\_ Myeloid sarcoma (specify myeloid neoplasm): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Myeloid neoplasms and proliferations associated with antecedent or predisposing conditions

\_\_\_ Myeloid neoplasm post cytotoxic therapy (specify neoplasm and cytotoxic therapy, if possible):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Myeloid neoplasm associated with germline predisposition (specify neoplasm and germline

 predisposition, if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Transient abnormal myelopoiesis associated with Down syndrome

\_\_\_ Myeloid leukemia associated with Down syndrome

\_\_\_ Other myeloid neoplasm and / or proliferation associated with antecedent or predisposing

 condition (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Myeloid / lymphoid neoplasms

*Myeloid / lymphoid neoplasms with eosinophilia and defining gene rearrangement*

\_\_\_ Myeloid / lymphoid neoplasm with PDGFRA rearrangement

\_\_\_ Myeloid / lymphoid neoplasm with PDGFRB rearrangement

\_\_\_ Myeloid / lymphoid neoplasm with FGFR1 rearrangement

\_\_\_ Myeloid / lymphoid neoplasm with JAK2 rearrangement

\_\_\_ Myeloid / lymphoid neoplasm with FLT3 rearrangement

\_\_\_ Myeloid / lymphoid neoplasm with ETV6::ABL1 fusion

\_\_\_ Myeloid / lymphoid neoplasms with other tyrosine kinase fusion genes

\_\_\_ Other myeloid / lymphoid neoplasm (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Acute leukemias of mixed or ambiguous lineage

\_\_\_ Mixed-phenotype acute leukemia with BCR::ABL1 fusion

\_\_\_ Mixed-phenotype acute leukemia with KMT2A rearrangement

\_\_\_ Acute leukemia of ambiguous lineage with other defined genetic alterations

\_\_\_ Mixed-phenotype acute leukemia, B / myeloid

\_\_\_ Mixed-phenotype acute leukemia, T / myeloid

\_\_\_ Mixed-phenotype acute leukemia, rare types

\_\_\_ Acute leukemia of ambiguous lineage, NOS

\_\_\_ Acute undifferentiated leukemia

\_\_\_ Other acute leukemia of mixed or ambiguous lineage (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Plasmacytoid dendritic cell neoplasms

\_\_\_ Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

\_\_\_ Other plasmacytoid dendritic cell neoplasm (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dysplasia# (select all that apply)**

*# Applicable only for myeloid malignancies*

\_\_\_ Not applicable

\_\_\_ Absent

\_\_\_ Erythroid

\_\_\_ Granulocytic

\_\_\_ Megakaryocytic

\_\_\_ Cannot be determined (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIAL STUDIES (Note** [**C**](#N13969)**)**

**Ring Sideroblasts / Iron Stain**

\_\_\_ Not applicable / not performed

\_\_\_ Not evaluable

\_\_\_ No ring sideroblasts seen on iron stain

\_\_\_ Positive for ring sideroblasts on iron stain (less than 15%)

\_\_\_ Positive for ring sideroblasts on iron stain (greater than or equal to 15%)

**Bone Marrow Fibrosis Grade**

\_\_\_ Not applicable / not performed

\_\_\_ MF-0

\_\_\_ MF-1

\_\_\_ MF-2

\_\_\_ MF-3

**Flow Cytometry**

\_\_\_ Not performed

\_\_\_ No aberrancy detected at level of sensitivity of assay

\_\_\_ Abnormal population (specify immunophenotype, if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pending

**Conventional Cytogenetics**

\_\_\_ Not performed

\_\_\_ Normal diploid karyotype

\_\_\_ Abnormal karyotype (specify, if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pending

**Fluorescence in situ Hybridization (select all that apply)**

\_\_\_ Not performed

\_\_\_ Normal probes (specify loci tested): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Abnormal probes (specify loci tested): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pending

**Molecular Alterations Detected# (select all that apply)**

*# Select all those with significant mutations*

\_\_\_ ASXL1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BCOR mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BCORL1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BCR::ABL1 p190 fusion transcript (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BCR::ABL1 p210 fusion transcript (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BCR::ABL1, unspecified transcript (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ BRAF mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CALR mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CBFB::MYH11 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CEBPA (mono-allelic) mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CBL mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CTCF mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ CSF3R mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ DEK::NUP214 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ DNMT3A mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ ETV6 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ ETV6::RUNX1 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ EZH2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ FGFR1 rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ FLT3 internal tandem duplication (ITD) (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ FLT3 p.D865 tyrosine kinase domain (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ GATA2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ GNAS mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ HRAS mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ IDH1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ IDH2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ IGH::IL3 rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ IKZF1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ JAK2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ JAK3 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ KIT mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ KMT2A rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ KRAS mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ MECOM rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ MPL mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ MYD88 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ NF1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ NOTCH1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ NPM1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ NRAS mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ NUP98 rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PDGFRA rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PDGFRB rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PCM1::JAK2 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PHF6 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PML::RARA fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PTEN mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PTPN11 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ PRPF8 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ RB1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ RBM15::MKL1 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ RUNX1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ RUNX1::RUNX1T1 fusion (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ SETBP1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ SH2B3 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ SF3B1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ SRSF2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ STAG2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ TET2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ TCF3::PBX1 rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ TCF3::HLF fusion rearrangement (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ TP53 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ U2AF1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ WT1 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ ZRSR2 mutation (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Other alterations detected (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**+Specify Molecular Alterations Assayed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMMENTS**

**Comment(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Explanatory Notes**

**A. Site of Involvement in Sample**

Select the most significantly involved site of involvement in the sample as a single select choice. If both bone marrow and blood are involved, as is often the case, select bone marrow and report the bone marrow blast/blast equivalent percentage and the bone marrow cellularity. If the sample is blood or if the percentage of blasts is higher in the blood compared to bone marrow (i.e., more significant), select the option of blood and specify the blasts/blast equivalents.

For bone marrow samples, bone marrow aspirate smears stained with Wright-Giemsa or May-Grunwald-Giemsa should be used to perform a cell differential count to enumerate blasts and other nucleated cells in the bone marrow sample. While a 500-cell differential count is the traditional number used; studies indicate that 300-cell differential counts give similar results.[1](#R64368) It is important to avoid hemodiluted areas that may not reflect bone marrow cellularity when performing the differential count. In those instances where the sample adequacy does not permit an adequate manual count, the best estimate of blasts can be given based on ancillary studies, typically immunohistochemistry for CD34 or other appropriate blast marker based on the known phenotype of the blast cells.

In addition, the overall bone marrow cellularity should be reported based on the area of hematopoietic bone marrow relative to the area of adipose tissue. This may be estimated on the bone marrow core biopsy specimen or intact areas of the bone marrow clot section. Bone marrow cellularity varies with age, but it is also important to note that cellularity may be lower in subcortical areas of bone marrow or may show significant heterogeneity and thus not be accurate in small samples.

References

1. Ahmed A Abdulrahman, MD, Kirtesh H Patel, MD, Tong Yang, MD, David D Koch, PhD, Sarah M Sivers, MLS (ASCP)CM, Geoffrey H Smith, MD, David L Jaye, MD, Is a 500-Cell Count Necessary for Bone Marrow Differentials? A Proposed Analytical Method for Validating a Lower Cutoff, American Journal of Clinical Pathology, Volume 150, Issue 1, July 2018, Pages 84–91, <https://doi.org/10.1093/ajcp/aqy034>.

**B. Final Integrated Diagnosis**

The final integrated diagnoses for the myeloid neoplasms are derived from the WHO 5th edition of Haematolymphoid Tumors.[1](#R64351) This represents an update since the last revision of the WHO 4th edition in 2017 and reflects updates in the diagnostic criteria and increasing reliance of ancillary studies such as conventional karyotyping, fluorescence in-situ hybridization (FISH), and molecular genetic profiling- the latter increasingly utilizing large multigene interrogations utilizing next-generation sequencing with abilities to detect point mutations, insertions, deletions, copy number alterations, and gene rearrangements.

The final integrated diagnosis is categorized into the major subsections of the WHO 5th edition, including myeloid precursor lesions, myeloproliferative neoplasms, mastocytosis, myelodysplastic neoplasms, myelodysplastic/myeloproliferative neoplasms, acute myeloid leukemia, myeloid neoplasms, secondary, myeloid/lymphoid neoplasms, acute leukemias of mixed or ambiguous lineage and blastic plasmacytoid dendritic cell neoplasm. Leukemias of mixed lineage and ambiguous lineage are included in the myeloid neoplasm cancer case summary for ease of reporting, as these neoplasms will share more elements with myeloid neoplasms and more frequently contain a myeloid component in addition to a lymphoid component.

Histiocytic/dendritic cell neoplasms with the exception of blastic plasmacytoid dendritic cell neoplasm, are excluded from the protocol due to infrequent involvement of blood and bone marrow and distinct clinicopathologic features; these include neoplasms of Langerhans cells (Langerhans cell histiocytosis, Langerhans cell sarcoma), indeterminate dendritic cell tumor, interdigitating dendritic cell sarcoma and histiocytic neoplasms (Juvenile xanthogranuloma, Erdheim-Chester disease, Rosai-Dorfman disease, ALK-positive histiocytosis, and histiocytic sarcoma).

Precursor myeloid lesions, clonal hematopoiesis of indeterminate potential (CHIP), and clonal cytopenia of undetermined significance (CCUS) are included as optional elements. These may have utility for some institutions for longitudinal tracking and documentation of pre-neoplastic states.

This cancer case summary contains certain common subtypes as the initial reporting option and includes staging/phase information as the primary diagnostic selection to emphasize its importance for these conditions and to ease reporting by minimizing additional deprecated selections. For example, chronic myeloid leukemia, chronic phase, and chronic myeloid leukemia, blast phase are listed as diagnostic choices instead of chronic myeloid leukemia with the option to further select chronic or blast phase (deprecated selections). Chronic myelomonocytic leukemia (CMML) includes both the subtype (myelodysplastic subtype vs. myeloproliferative subtype) and grading information (CMML-1 vs. CMML-2) as the primary choice (Myelodysplastic chronic myelomonocytic leukemia (MD-CMML), CMML-1).

This cancer case summary is designed to be used when a complete, integrated diagnosis can be rendered, including ancillary immunophenotypic, cytogenetic, and molecular results that are increasingly utilized to refine the diagnostic category. There may be some who wish to use this cancer summary to render a preliminary diagnosis prior to receipt of all pending ancillary studies; ideally, this approach would be used when a cancer case summary can be updated/addended/amended, or a new complete cancer protocol can be issued. To accommodate that use, one can use the “Other” category included as a diagnostic choice in each of the major sections of the cancer case summary. If using the “Other” option for cases pending further ancillary studies, it is strongly recommended to update the cancer case summary.

The full diagnostic criteria for the diagnostic categories in the WHO 5th edition are well summarized in the WHO monograph and beyond the scope of the explanatory notes. Essential diagnostic information is included in the explanatory notes to serve as a quick reference. Specific categories that may benefit from additional explanation, particularly regarding use of the cancer case summary, are discussed.

**Myeloid precursor lesions**

The WHO 5th edition introduces clonal hematopoiesis (CH)/clonal hematopoiesis of indeterminate potential (CHIP) and clonal cytopenias of undetermined significance (CCUS) as putative myeloid precursor lesions. Clonal hematopoiesis (CH) refers to the clonal expansion of a mutated hematopoietic progenitor cells. Clonal hematopoiesis of indeterminate potential (CHIP) is defined as CH that harbors myeloid malignancy associated genes detected in blood or bone marrow at variant allele frequency (VAF) ≥2% (≥4% for X-linked gene mutations in males) in individuals without cytopenia or other diagnosed hematologic disorder. Clonal hematopoiesis of undetermined significance (CCUS) is diagnosed when CHIP criteria are accompanied by clinical cytopenia (Hgb <13g/dL males, <12g/dL females, absolute neutrophil count <1.8x109/L, platelet count <150x109/L) without evidence of diagnostic myeloid neoplasm. Reporting of CHIP or CCUS using the cancer case summary is optional.

**Myeloid neoplasms, chronic**

**Myeloproliferative neoplasms**

Myeloproliferative neoplasms represent a group of myeloid neoplasms characterized by the abnormal proliferation of one or more terminally differentiated myeloid cell lines, sometimes with increased bone marrow reticulin or collagen fibrosis. The WHO 5th edition retains the framework of the revised WHO 4th edition for diagnostic entities with minor changes. Chronic myeloid leukemia (CML) accelerated phase (AP) has been removed as its relevance in the era of highly effective targeted tyrosine kinase inhibitors makes determination of ABL1 kinase resistance mutations, cytogenetic progression, and overt blast phase drive treatment decisions.[2](#R64352)

The diagnostic criteria for chronic eosinophilic leukemia have been updated as follows: (1) the time interval required to define sustained hypereosinophilia is reduced from 6 months to 4 weeks; (2) addition of requirement for both clonality and abnormal bone marrow morphology (e.g., megakaryocytic, or erythroid dysplasia); and (3) elimination of increased blasts (≥2% in blood or 5-19% in bone marrow) as an alternative to clonality.[1](#R64351) Diagnostic criteria for chronic myeloproliferative neoplasms are summarized in Table 1.

**Table 1. SUMMARY OF DIAGNOSTIC FEATURES FOR CATEGORY OF CHRONIC MYELOPROLIFERATIVE NEOPLASMS**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **Essential Diagnostic Features** | **Post-fibrotic diagnostic features** |
| Chronic myeloid leukemia (CML) | CML (chronic phase) criteria:1. Blood leukocytosis
2. Detection of Ph chromosome and/or BCR::ABL1 by cytogenetic and/or appropriate molecular genetic techniques
3. Do not meet criteria for blast phase

 CML (blast phase) criteria:1. ≥20% blasts in the blood or bone marrow

Or1. Presence of an extramedullary proliferation of blasts

or 1. Presence of bona fide lymphoblasts in the blood or bone marrow (even if <10%)
 |   |
| Chronic neutrophilic leukemia (CNL)  | The diagnosis requires exclusion of reactive neutrophilia and other myeloproliferative and myelodysplastic/​myeloproliferative neoplasms:1. Blood white blood cell count ≥25×109/ L-  Segmented neutrophils plus banded neutrophils constitute ≥ 80% of the white blood cells-  Neutrophil precursors (promyelocytes, myelocytes, and metamyelocytes) constitute <10% of the white blood cells- Myeloblasts rarely observed-  Monocytes constitute <10% of blood leukocytes; absolute monocytosis not  meeting criteria for CMML- No dysgranulopoiesis
2. Hypercellular bone marrow- Neutrophil granulocytes increased in percentage and number- Neutrophil maturation appears normal- Myeloblasts constitute < 5% of the nucleated cells
3. Not meeting WHO criteria for BCR::ABL1–positive chronic myeloid leukemia, polycythemia vera, essential thrombocythemia, or primary myelofibrosis
4. No evidence of disease-defining gene rearrangements such as PDGFRA, PDGFRB, or FGFR1, and no PCM1::JAK2 fusion
5. Presence of CSF3R p.T618I or another activating CSF3R mutation, OR Persistent neutrophilia (≥3 months), splenomegaly, and no identifiable cause of reactive neutrophilia including absence of a plasma cell neoplasm or, if a plasma cell neoplasm is present, demonstration of clonality of myeloid cells by cytogenetic or molecular studies
 |   |
| Chronic eosinophilic leukemia (CEL) | 1. Hypereosinophilia, defined as blood eosinophilia >1.5x109/L on at least 2 occasions over an interval of at least 4 weeks
2. Evidence of clonality, excluding the possibility of clonal hematopoiesis of indeterminate potential (CHIP)
3. Abnormal bone marrow morphology typically hypercellularity with dysplastic megakaryocytes, increased eosinophils
4. WHO criteria for other myeloid or lymphoid neoplasms not met, including MPN, MDS/MPN, MDS, MLN-eo, mastocytosis, AML
 |   |
| Polycythemia vera (PV) | Diagnostic criteria of polycythemia veraThe diagnosis of polycythemia vera requires either all 3 major criteria or the first 2 major criteria plus the minor criterion.Major criteria:1. Elevated hemoglobin concentration (>16.5 g/dL in men; >16.0 g/dL in women) or elevated hematocrit (>49% in men; >48% in women)
2. Bone marrow biopsy showing age-adjusted hypercellularity with trilineage growth (panmyelosis), including prominent erythroid, granulocytic, and megakaryocytic proliferation with pleomorphic, mature megakaryocytes (differences in size)
3. Presence of JAK2 V617F or JAK2 exon 12 mutation

Minor criterion:1. Subnormal serum erythropoietin level
 | Diagnostic criteria for post–polycythemia vera (PV) myelofibrosis Required criteria:Documentation of a previous diagnosis of WHO-defined PV Bone marrow fibrosis of grade 2-3 on a 0–3 scale Additional criteria (2 are required):1. Anemia (i.e., below the reference range given age, sex, and altitude considerations) or sustained loss of requirement of either phlebotomy (in the absence of cytoreductive therapy) or cytoreductive treatment for erythrocytosis
2. Leukoerythroblastosis
3. Increasing splenomegaly, defined as either an increase in palpable splenomegaly of >5 cm from baseline (distance from the left costal margin) or the development of a newly palpable splenomegaly
4. Development of any 2 (or all 3) of the following constitutional symptoms: >10% weight loss in 6 months, night sweats, unexplained fever (>37.5 °C)
 |
| Essential thrombocythemia | Diagnostic criteria for essential thrombocythemiaThe diagnosis of essential thrombocythemia requires that either all major criteria or the first 3 major criteria plus the minor criterion are met. Major criteria:1. Platelet count ≥ 450×109/ L
2. Bone marrow biopsy showing proliferation mainly of the megakaryocytic lineage, with increased numbers of enlarged, mature megakaryocytes with hyperlobated nuclei; no significant increase or left shift in neutrophil granulopoiesis or erythropoiesis; very rarely a minor (grade 1) increase in reticulin fibers
3. WHO criteria for BCR::ABL1–positive chronic myeloid leukemia, polycythemia vera, primary myelofibrosis, or other myeloid neoplasms are not met
4. JAK2, CALR, or MPL mutation

Minor criterion:1. Presence of a clonal marker or
2. Exclusion of reactive thrombocytosis
 | Diagnostic criteria for post–essential thrombocythemia (ET) myelofibrosis Required criteria:1. Documentation of a previous diagnosis of WHO-defined ET
2. Bone marrow fibrosis of grade 2–3 on a 0–3 scale

 Additional criteria (2 are required):1. Anemia (i.e., below the reference range given age, sex, and altitude considerations) and a >2g/dL decrease from baseline hemoglobin concentration
2. Leukoerythroblastosis
3. Increasing splenomegaly, defined as either an increase in palpable splenomegaly of >50 mm from baseline (distance from the left costal margin, or on imaging) or the development of a newly palpable splenomegaly
4. Elevated lactate dehydrogenase level (above the reference range)
5. Development of any 2 (or all 3) of the following constitutional symptoms: >10% weight loss in 6 months, night sweats, unexplained fever (>37.5°C)
 |
| Primary myelofibrosis | Diagnostic criteria for primary myelofibrosis, prefibroticThe diagnosis of pre-fibrotic primary myelofibrosis requires that all 3 major criteria and at least 1 minor criterion are met. Major criteria:1. Megakaryocytic proliferation and atypia, without reticulin fibrosis grade >1, accompanied by increased age-adjusted bone marrow cellularity, granulocytic proliferation, and (often) decreased erythropoiesis
2. WHO criteria for BCR-ABL1–positive chronic myeloid leukemia, polycythemia vera, essential thrombocythemia, myelodysplastic syndromes, or other myeloid neoplasms are not met
3. JAK2, CALR, or MPL mutation OR

Presence of another clonal marker ORAbsence of minor reactive bone marrow reticulin fibrosisMinor criteriaPresence of at least one of the following, confirmed in 2 consecutive determinations:1. Anemia not attributed to a comorbid condition
2. Leukocytosis ≥11×109/ L
3. Splenomegaly detected clinically and/or by imaging
4. Lactate dehydrogenase level above the upper limit of the institutional reference range
5. Leukoerythroblastic
 | Diagnostic criteria for primary myelofibrosis, fibrotic stageThe diagnosis of overt primary myelofibrosis requires that all 3 major criteria and at least 1 minor criterion are met. Major criteria:1. Megakaryocytic proliferation and atypia, accompanied by reticulin and/or collagen fibrosis grades 2 or 3
2. WHO criteria for essential thrombocythemia, polycythemia vera, BCR-ABL1–positive chronic, myeloid leukemia, myelodysplastic syndrome, or other myeloid neoplasms are not met
3. JAK2, CALR, or MPL mutation OR

Presence of another clonal marker OR Absence of reactive myelofibrosis Minor criteria:Presence of at least one of the following, confirmed in 2 consecutive determinations:1. Anemia not attributed to a comorbid condition
2. Leukocytosis ≥ 11×109/ L
3. Splenomegaly detected clinically and/or by imaging
4. Lactate dehydrogenase level above the upper limit of the institutional reference range
5. Leukoerythroblastosis
 |
| Juvenile myelomonocytic leukemia (JMML) | Clinical, hematological, and laboratory criteria (all 5 criteria are required):1. Blood monocyte count ≥1x109/L
2. Blast and promonocyte percentage in blood and bone marrow of <20%
3. Clinical evidence of organ infiltration, most commonly splenomegaly
4. No Philadelphia (Ph) chromosome or BCR-ABL1 fusion
5. No KMT2A (MLL1) gene rearrangement

Genetic criteria (any 1 criterion is sufficient):1. Mutation in a component or a regulator of the canonical RAS pathway:
* Clonal somatic mutation in PTPN11, KRAS, or NRAS
* Clonal somatic or germline NF1 mutation and loss of heterozygosity or compound heterozygosity of NF1
* Clonal somatic or germline CBL mutation and loss of heterozygosity of CBL
1. Non-canonical clonal RAS pathway pathogenic variant or fusions causing activation of genes upstream of the RAS pathway, such as ALK, PDGFR-B, ROS1, among others

Other criteriaCases that do not meet any of the genetic criteria listed above (or in conditions where genetic testing is not available) must meet the following criteria in addition to the aforementioned clinical, hematological, and laboratory criteria above:* ≥2 of the following:
* Increased hemoglobin F for age
* Myeloid (promyelocytes, myelocytes, metamyelocytes) and erythroid precursors on blood smear
* Thrombocytopenia with hypercellular marrow often showing decreased number of megakaryocytes. Dysplastic features may or may not be evident
* Hypersensitivity of myeloid progenitors to GM-CSF as tested in clonogenic assays in methylcellulose or by measuring STAT5 phosphorylation in the absence or with low dose of exogenous GM-CSF
 |  |
| Myeloproliferative neoplasm, NOS | Most cases of MPN-NOS fall into one of these groups:* Early presentations where the characteristic features of specific subtypes are not yet fully developed
* A proportion of cases presenting with a portal or splanchnic vein thrombosis that fail to meet the diagnostic criteria for any of the specific MPN entities may also be considered to belong in this group
* Advanced-stage MPN, in which pronounced myelofibrosis, osteosclerosis, or transformation to a more aggressive stage with increased blast counts and/or myelodysplastic changes obscures the underlying disorder
* Cases with convincing evidence of an MPN in which a coexisting neoplastic or inflammatory disorder obscures some of the usual diagnostic clinical and/or morphological features
 |  |

**Mastocytosis**

Mastocytosis is an uncommon neoplasm with varying clinical presentation that is characterized by the abnormal accumulation of mast cells in various tissues, typically associated with mutations in KIT receptor that lead to constitutive activation. There have been updates to the minor diagnostic criteria of systemic mastocytosis in the WHO 5th edition including the expression of CD30 and any KIT mutation being a minor criterion. The subtype of systemic mastocytosis, bone marrow mastocytosis, has been added along with updates to the B- (burden of disease) criteria for subtyping systemic mastocytosis.

The cancer case summary lists the subtypes of systemic mastocytosis as the diagnostic choices. The approach to subtyping requires first the establishment of the diagnosis of systemic mastocytosis (see Table 2 for diagnostic criteria), followed by the application of the criteria (see Table 3 for B- and C-findings required for subtypes) for each of the subtypes shown in Table 4. A rare morphologic pattern that is worth noting, but not a defined subtype, is well-differentiated systemic mastocytosis (WDSM) which is characterized by round and well-granulated mast cells that are usually negative for KIT codon 816 mutation (15% positive, may possess KIT mutations outside TK2 domain) and negative for CD2 and CD25, but positive for CD30.[3](#R64354)

Mast cell sarcoma is a very rare clinically aggressive form of mastocytosis characterized by the presence of atypical mast cells that results in a locally destructive lesion that typically express, similarly to systemic mastocytosis, CD2, CD25 and/or CD30. Unlike systemic mastocytosis, KIT p. D816V mutations are uncommon in de novo/classical mast cell sarcoma, suggesting a distinct origin from systemic mastocytosis. Mast cell sarcoma may exist as a transformation of a systemic mastocytosis.[4](#R64355)

Cutaneous mastocytosis (CM), a form of mastocytosis primarily affecting the skin is not included in the cancer case summary due to typically indolent behavior and need for correlation with clinical and pathologic signs for systemic mastocytosis that are often not available at time of evaluation of skin biopsy samples.

**TABLE 2. SUMMARY OF ESSENTIAL DIAGNOSTIC FEATURES FOR SYSTEMIC MASTOCYTOSIS**[1](#R64351)

|  |  |
| --- | --- |
| **Diagnosis** | **Essential Diagnostic Features** |
| Systemic Mastocytosis (SM) | The diagnosis is SM if at least 1 major and 1 minor or 3 minor criteria are fulfilled. Major criterion:Multifocal dense infiltrates of mast cells (≥15 mast cells in aggregates) detected in sections of bone marrow and/or other extracutaneous organ(s). Minor criteria:1. >25% of all mast cells are atypical cells on bone marrow smears or are spindle-shaped in dense and diffuse mast cell infiltrates in sections of BM or other extracutaneous organ(s)
2. Activating KIT point mutation(s) at codon 816 or in other critical regions of KIT in bone marrow or another extracutaneous organ(s)
3. Mast cells in bone marrow, blood, or another extracutaneous organ(s) aberrantly express one or more of the following antigens (flow cytometry or immunohistochemistry): CD2, CD25, CD30
4. Baseline serum tryptase concentration >20ng/mL in the absence of a myeloid associated hematologic neoplasm (AHN). In the case of a known hereditary alpha-tryptasemia (HαT), the tryptase level could be adjusted[5](#R64353)
 |

**TABLE 3. SYSTEMIC MASTOCYTOSIS B-FINDINGS (BURDEN OF DISEASE) AND C-FINDINGS (CYTOREDUCTION-REQUIRING**)[1](#R64351)

|  |  |
| --- | --- |
| **Diagnosis** | **Essential Diagnostic Features** |
| B-findings | 1. High MC burden: infiltration grade (MC) in BM ≥30% in histology (IHC) and/or serum tryptase ≥200 ng/mL and/or KIT p.D816V VAF ≥10% in BM or PB leukocytes
2. Signs of myeloproliferation and/or myelodysplasia: hypercellular BM with loss of fat cells and prominent myelopoiesis ± left shift and eosinophilia ± leukocytosis and eosinophilia and/or discrete signs of myelodysplasia (<10% neutrophils, erythrocytes, and megakaryocytes)
3. Organomegaly: Palpable (or documented by US, CT, or MRI) hepatomegaly without ascites or other signs of organ damage or/and palpable splenomegaly without hypersplenism and without weight loss or/and lymphadenopathy palpable or visceral LN-enlargement found in ULS or CT (>20 mm)
 |
| C-findings | 1. Cytopenia/s (one or more found):
* ANC <1x109/L
* Hb <10 g/dL
* PLT <1.0x109/L
1. Hepatopathy: ascites and elevated liver enzymes ± hepatomegaly or cirrhotic liver ± portal hypertension
2. Spleen: palpable splenomegaly with hypersplenism ± weight loss ± hypalbuminemia
3. GI tract: malabsorption with hypoalbuminemia ± weight loss
4. Bone: large-sized osteolysis (≥20 mm) ± pathologic fracture ± bone pain
 |

**TABLE 4. SUMMARY OF SUBTYPES OF SYSTEMIC MASTOCYTOSIS**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Diagnostic criteria** | **Morphologic features** |
| Bone marrow mastocytosis (BMM) | * SM criteria fulfilled
* No skin lesions
* No B-finding(s)
* Basal serum tryptase <125ng/mL
* No dense SM infiltrates in an extramedullary organ
 | * Low to very low MC burden in the BM
* Compact MC infiltrates >70% of cases
* Morphologic features otherwise as in ISM
* WD morphology rarely observed
 |
| Indolent Systemic Mastocytosis (ISM) | * SM criteria fulfilled
* Typical skin lesions
* ≤1 B-finding
* ISM without skin lesions: ≤1 B finding and/or basal serum tryptase ≥125 ng/mL and/or dense SM infiltrates in an extramedullary organ
 | * Low MC burden in the BM (usually <5-10% of section area)
* Compact MC infiltrates >70% of cases, typically of mixed morphology, containing numerous eosinophils, lymphocytes, fibroblasts and histiocytes in addition to neoplastic MC
* Usually >25% spindle-shaped MC
* Hemopoiesis usually normal, mild reactive changes possible
* Paratrabecular compact MC infiltrates often with prominent reticulin or collagen fibrosis and osteosclerotic changes in adjacent trabeculae
* In BM smears atypical MC (usually type I)
* WD morphology possible
 |
| Smoldering systemic mastocytosis (SSM) | * SM criteria fulfilled
* ≥2 B-findings
* No C-finding
 | * High MC burden in the BM (usually >30% of section area)
* Diffuse-compact MC infiltration pattern
* Usually spindle-shaped MC embedded in a dense fibrotic stroma with pronounced osteosclerosis
* Hemopoiesis often with mild dysplastic changes (not fulfilling WHO criteria for AHN)
* WD morphology rarely observed
 |
| Aggressive systemic mastocytosis (ASM) | * SM criteria fulfilled
* ≥1 C-finding
 | * High to very high MC burden in the BM (up to 80% of the section area)
* Diffuse-compact MC infiltration pattern
* Usually spindle-shaped MC embedded in a dense fibrotic stroma with pronounced osteosclerosis
* Pure ASM less frequent than ASM-AHN
* MCs in BM smears between >5% and <20% indicating ASM in transformation (ASM-t)
* Hemopoiesis often with mild dysplastic changes (not fulfilling WHO criteria for AHN)
* WD morphology possible

  |
| Systemic mastocytosis with an associated hematologic neoplasm (SM-AHN) | * SM criteria fulfilled
* Criteria for a WHO-defined hematologic neoplasm. Both disease compartments are classified according to WHO-definitions, e.g., BMM-ET, or MCL-CMML-1, etc
 | * Any subtype of SM and any type of WHO-defined myeloid and lymphoid neoplasm can occur; CMML or other MDS/MPN overlap neoplasms are most frequently found
* In most cases, AHN obscures SM
* In ASM or MCL, an AHN may be difficult to detect
* In every case of suspected SM-AHN, not only immunostains for neoplastic MC (tryptase, CD117/KIT, CD25, CD30), but also for myeloid neoplasms (including CD14, CD34, CD42b, and CD71) should be applied
* WD morphology possible

  |
| Mast cell leukemia (MCL) | * SM criteria fulfilled
* ≥20% MCs in BM smears
* In classic MCL ≥10% MCs, in aleukaemic MCL <10% MCs in blood smears
* In acute MCL C-findings are detectable; chronic MCL (no C-findings with much better prognosis
 | * High MC burden in the BM (usually >50% of section area)
* Diffuse-compact MC infiltration pattern
* Predominantly round and hypogranulated MCs in most cases
* Rarely highly pleomorphic MCs with hypogranulation and cytoplasmatic vacuolization
* Reticulin content usually much lower than in SSM/ASM
* Pure MCL is a diagnosis of exclusion of AHN
* WD morphology rarely observed (chronic MCL)
 |

**Myelodysplastic Neoplasms**

Myelodysplastic syndromes are now referred to as myelodysplastic neoplasms (MDS) in the WHO 5th edition to emphasize the clonal, neoplastic nature and to be consistent with diagnostic terminology for myeloproliferative neoplasms. The new classification groups MDS into two broad categories; those that are defined by genetic abnormalities and those that are morphologically defined. This approach is analogous to the groupings of acute myeloid leukemia and will enhance diagnostic consistency and highlight the importance of certain genetic alterations to MDS. The threshold for presence of dysplasia is set at 10% of cells of that lineage (erythroid, myeloid, megakaryocytic). Furthermore, diagnostic categories are appended with low blasts or increased blasts for additional clarity.

The major diagnostic criteria for MDS with defining genetic abnormalities are shown in Table 5. Myelodysplastic neoplasm with low blasts and 5q deletion (MDS-5q) may possess SF3B1 mutations and non-biallelic TP53 alterations (niTP53) if present. Myelodysplastic neoplasm with low blasts and SF3B1 mutation (MDS-SF3B1) was introduced to capture the high association between the presence of SF3B1 mutation and ring sideroblasts (>90% of cases of MDS with ≥5% ring sideroblasts). If ring sideroblasts are identified and SF3B1 mutation is absent, after exclusion of secondary causes of ring sideroblasts, it is acceptable to diagnose these cases as MDS with low blasts and ring sideroblasts in the narrative report. These can be reported as MDS with low blasts as the diagnostic category and denote the presence of ring sideroblasts. Biallelic TP53 (biTP53) alterations are a poor prognosis category of MDS characterized by alterations in TP53 that result in no functional/wild-type TP53.[6](#R64356) The presence of one or more TP53 mutations with copy number loss or evidence of copy neutral loss of heterozygosity (LOH) are considered sufficient for demonstration of biTP53/loss of wild type TP53. TP53 with >49% variant allele frequency (VAF) may be regarded as presumptive evidence of allelic loss or copy neutral LOH if a constitutional TP53 variant can be excluded.[7](#R64357)

**TABLE 5. SUMMARY OF SUBTYPES OF MYELODYSPLASTIC NEOPLASMS WITH DEFINING GENETIC ABNORMALITIES**[1](#R64351)

|  |  |
| --- | --- |
| **Subtype** | **Essential diagnostic criteria** |
| Myelodysplastic neoplasm with low blasts and 5q deletion (MDS-5q) | * Anemia, with or without other cytopenias and/or thrombocytosis
* Dysplasia involving megakaryocytes, often micromegakaryocytes with or without dysplasia involving other lineages
* Blasts <5% in the bone marrow and <2% in the blood
* Detection of 5q deletion, isolated or with one other cytogenetic aberration other than monosomy 7 or 7q deletion
* Not fulfilling diagnostic criteria of AML, MDS with biallelic TP53 inactivation, MDS with increased blasts, or MDS/MPN

  |
| Myelodysplastic neoplasm with low blasts and SF3B1 mutation (MDS-SF3B1) | * Cytopenia involving one or more lineages, without thrombocytosis
* Erythroid lineage dysplasia
* Blasts <5% in the bone marrow and <2% in the blood
* Detection of SF3B1 mutation. If SF3B1 mutation analysis is not available, demonstration of ring sideroblasts comprising ≥15% of erythroid precursors
* Absence of 5q deletion, monosomy 7/7q deletion, or complex karyotype
* Not fulfilling diagnostic criteria of AML, MDS with low blasts and 5q deletion, MDS with biallelic TP53 inactivation, MDS with increased blasts or any MDS/MPN type

  |
| Myelodysplastic neoplasm with biallelic (or multi-hit) TP53 alterations (MDS-biTP53) | * Myeloid neoplasm fulfilling diagnostic criteria of MDS
* Detection of one or more TP53 mutations
* In the presence of one TP53 mutation, evidence of TP53 copy loss or copy neutral LOH
 |

Myelodysplastic neoplasms morphologically defined is a new category in the WHO 5th edition. The new diagnostic category of hypoplastic myelodysplastic neoplasm (MDS-h) is recognized to capture this distinctive type of MDS characterized by bone marrow hypocellularity, cytopenias, and dysplastic changes. It is important to exclude secondary causes of hypocellularity with dysplastic changes such as drug or toxin exposure and exclude aplastic anemia (AA) or paroxysmal nocturnal hemoglobinuria (PNH). In addition, exclusion of a genetic predisposition to bone marrow failure, particularly in younger patients, should be considered.

The distinction of single- and multilineage dysplasia in the classification of MDS has been removed to reflect the absence of a well-defined category and fluidity of lineage dysplasia over the disease course of MDS. MDS with increased blasts is now the preferred terminology to capture those cases with 5-19% bone marrow or 2-19% blood blasts. For the cancer case summary, select the appropriate subtype of MDS-IB- either MDS-IB-1, MDS-IB-2, or MDS-F based on the criteria shown in Table 6.

**Table 6. SUMMARY OF MYELODYSPLASTIC NEOPLASMS, MORPHOLOGICALLY DEFINED WITH SUBTYPES OF MDS-IB**[1](#R64351)

|  |  |
| --- | --- |
| **Subtype** | **Essential diagnostic criteria** |
| Myelodysplastic neoplasm with low blasts (MDS-LB) | * Cytopenia involving one or more lineages
* Dysplastic changes in one or more lineages involving at least 10% of cells
* <5% bone marrow blasts and <2% blood blasts
* Exclusion of folate and vitamin B12 deficiency
* No fulfilling diagnostic criteria of MDS with defining genetic alterations or hypoplastic MDS
 |
| Hypoplastic MDS (h-MDS) | * Cytopenia involving one or more lineages
* Hypocellular bone marrow (assessed on a trephine core biopsy, adjusted for age of the patient) not explained by drug/toxin exposure or pertinent nutritional deficiency
* Dysplasia involving myeloid and/or megakaryocytic lineages
* <5% blasts in bone marrow and <2% blasts in blood
* Not meeting criteria for MDS with defining genetic abnormalities or MDS with increased blasts

  |
| Myelodysplastic neoplasm with increased blasts (MDS-IB) | * Cytopenia involving one or more lineages
* Dysplastic changes in one or more lineages, involving at least 10% of cells
* ≥5% blasts in the bone marrow and/or ≥2% blasts in blood
* No fulfilling diagnostic criteria of MDS with biallelic TP53 inactivation or AML

Subtypes of MDS-IB* MDS with increased blasts-1 (MDS-IB1): 5-9% blasts in the bone marrow and/or 2-4% blasts in the blood, without significant reticulin fibrosis
* MDS with increased blasts-2 (MDS-IB2):10-19% blasts in the bone marrow and/or 5-19% blasts in the blood, without significant reticulin fibrosis; or, with presence of Auer rods
* MDS with increased blasts and fibrosis (MDS-F): 5-19% blasts in the bone marrow and/or 2-19% blasts in the blood, with significant fibrosis (defined as grade 2 or 3)
 |

**Myelodysplastic neoplasms of childhood**

Myelodysplastic neoplasms of childhood are distinct clinicopathologic and biologic syndromes characterized by ineffective hematopoiesis, resultant cytopenias, and increased risk of developing acute myeloid leukemia. Like adults, the WHO 5th edition divides these into the morphologically defined categories of cMDS with low blasts (cMDS-LB) and cMDS with increased blasts (cMDS-IB). cMDS-LB replaces refractory cytopenia of childhood (RCC) from the revised WHO 4th edition. Bone marrow hypocellularity is particularly common in cMDS-LB, and it is important to exclude secondary causes of hypocellularity (infection, toxin, nutritional deficiency, severe aplastic anemia, PNH).[8](#R64358) The diagnostic criteria for cMDS are summarized in Table 7.

**TABLE 7. SUMMARY OF SUBTYPES OF MYELODYSPLASTIC NEOPLASMS OF CHILDHOOD**[1](#R64351)

|  |  |
| --- | --- |
| **Subtype** | **Essential diagnostic criteria** |
| Childhood myelodysplastic neoplasm with low blasts (cMDS-LB) | * Cytopenia involving one or more lineages
* Dysplastic changes in one or more lineages, involving at least 10% of cells
* <5% bone marrow blasts and <2% blood blasts
* Meeting at least one of the following criteria:
1. Detection of clonal cytogenetic and/or molecular abnormality
2. Exclusion of other causes of cytopenia (non-neoplastic and some germline mutations)

  |
| Childhood myelodysplastic neoplasm with increased blasts (cMDS-IB) | * Cytopenia involving one or more lineages
* Dysplastic changes in one or more lineages, involving at least 10% of cells
* 5-19% bone marrow blasts and/or 2-19% blood blasts
* Exclusion of Down syndrome, juvenile myelomonocytic leukemia, and AML with defining genetic abnormalities
 |

**Myelodysplastic/myeloproliferative neoplasms**

The criteria for the diagnosis of chronic myelomonocytic leukemia (CMML) were revised in the WHO 5th edition to include prerequisite and supporting criteria. The initial prerequisite criteria include persistent absolute (≥0.5x109/L) and relative monocytosis (≥10%) in the blood. Of note, the absolute monocyte count in the blood was lowered from the 1.0x109/L cutoff in the revised WHO 4th edition. Another new criterion introduced was the abnormal partitioning of monocytes (>94%) into classical monocytes CD14+, CD16- compared to those with more variable levels of intensity of CD14 and CD16.[9](#R64359) In addition, the presence of a NPM1 mutation supersedes the diagnosis of CMML. In the current WHO 5th edition, these cases meet the criteria for AML with NPM1 mutation.[10](#R64360)

Supporting criteria are required after meeting the prerequisite criteria, with a higher absolute monocyte count (>1x109/L) requiring one additional supporting, and lower absolute monocyte count (>0.5x109/L) requiring 2 supporting criteria. CMML is further subtyped into myelodysplastic CMML (WBC <13x109/L) and myeloproliferative CMML (WBC ≥13x109/L) based on the white blood cell count (WBC). Furthermore, it is subgrouped based on the percentage of blasts and promonocytes in the blood and bone marrow (CMML-1: < 5% blasts and promonocytes in blood and < 10% in bone marrow; CMML-2: 6-19% blasts and promonocytes in blood and 10-19% in bone marrow). The cancer case summary removes choice deprecation and allows for reporting of the four options for the final subtype to make reporting easier and more straightforward.

Atypical chronic myeloid leukemia was renamed MDS/MPN with neutrophilia in the WHO 5th edition to avoid potential confusion with chronic myeloid leukemia (CML); diagnostic criteria are unchanged. A summary of the diagnostic features for myelodysplastic/myeloproliferative neoplasms and subtypes/subgroups of CMML are shown in Table 8.

**TABLE 8. SUMMARY OF MYELODYSPLASTIC/ MYELOPROLIFERATIVE NEOPLASMS INCLUDING SUBTYPES AND SUBGROUPS OF CHRONIC MYELOMONOCYTIC LEUKEMIA (CMML)**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/Notes** |
| Chronic myelomonocytic leukemia (CMML) | Prerequisite criteria:1. Persistent absolute (≥0.5 × 109/ L) and relative (≥10%) blood monocytosis
2. Blasts and equivalents\* constitute <20% of the cells in the blood and bone marrow. (\*= myeloblasts, monoblasts, and promonocytes)
3. Not meeting diagnostic criteria of chronic myeloid leukemia or other myeloproliferative neoplasms
4. Not meeting diagnostic criteria of myeloid/lymphoid neoplasms with eosinophilia and defining gene rearrangements (e.g., PDGFRA, PDGFRB, FGFR1, or JAK2)

Pre-requisite criteria must be present in all cases:* If monocytosis is ≥1 × 109/ L: one or more supporting criteria must be met
* If monocytosis is <1 × 109/ L: supporting criteria 1 and 2 must be met

  | Supporting criteria:1. Dysplasia involving ≥1 myeloid lineage (morphologic dysplasia ≥10% of cells in lineage)
2. Acquired clonal cytogenetic or molecular abnormality
3. Abnormal partitioning of blood monocyte subsets (Based on detection of increased classical monocytes (>94%) in the absence of known active autoimmune diseases and/or systemic inflammatory syndromes)

Subtyping criteria:* Myelodysplastic CMML (MD-CMML): WBC count <13 × 109/L
* Myeloproliferative CMML (MP-CMML): WBC count ≥13 × 109/L

Subgrouping criteria:* CMML-1: < 5% blasts and promonocytes in blood and < 10% in bone marrow
* CMML-2: 6-19% blasts and promonocytes in blood and 10-19% in bone marrow
 |
| Myelodysplastic/myeloproliferative neoplasm with neutrophilia (MDS/MPN-N) | * Blood leukocytosis ≥13 × 109/  L, with neutrophilia and ≥10% circulating immature myeloid cells (promyelocytes, myelocytes and metamyelocytes), as well as neutrophilic dysplasia
* Hypercellular bone marrow with granulocytic predominance and granulocytic dysplasia, with or without dysplasia in the megakaryocytic and erythroid lineages
* <20% blasts in blood and bone marrow
* Not meeting diagnostic criteria for myeloproliferative neoplasms (specifically, exclusion of BCR::ABL1 fusion), myeloid neoplasms with eosinophilia and defining gene rearrangement, chronic myelomonocytic leukemia, or myelodysplastic/myeloproliferative neoplasm with SF3B1 mutation and thrombocytosis
 | * Detection of SETBP1 and/or ETNK1 mutations
* Absence of mutations in JAK2, CALR, MPL, and CSF3R
* Previously referred to as “Atypical CML”
 |
| Myelodysplastic/​myeloproliferative neoplasm with SF3B1 mutation and thrombocytosis (MDS/MPN-SF3B1-T) | * Anemia associated with dysplastic erythropoiesis and ≥15% ring sideroblasts, with or without dysplasia in the megakaryocytic and erythroid lineages
* Persistent thrombocytosis, with platelet count ≥450 × 109/L
* SF3B1 mutation and concurrent JAK2 p.V617F, or, in the absence of these mutations, concurrent biologically similar mutations involving spliceosome factors and cell signaling (e.g., MPL or CBL)
* Not meeting diagnostic criteria for myelodysplastic neoplasms, myeloproliferative neoplasms, chronic myelomonocytic leukemia, acute myeloid leukemia with MECOM rearrangement, or myeloid/lymphoid neoplasms with eosinophilia
 |   |
| Myelodysplastic/​myeloproliferative neoplasm, NOS (MDS/MPN-NOS) | * Blood with combination of cytopenia(s) and proliferative features
* Bone marrow with both dysplasia and proliferative features
* Molecular alterations seen in proliferative and dysplastic myeloid malignancies
* Exclusion of: Therapy-related myeloid neoplasms, disease-defining gene fusions, exclusion of other specific MDS/MPN such as CMML, MDS/MPN with neutrophilia (MDS/MPN-N), MDS/MPN with SF3B1 mutation and thrombocytosis
 |   |

**Acute myeloid leukemia**

The classification of acute myeloid leukemia (AML) was reorganized and made into two major categories; those with defining genetic abnormalities and those defined by differentiation. A major change was the elimination of the 20% blast requirement for all AML types with defining genetic abnormalities except for acute myeloid leukemia (AML) with BCR::ABL1 fusion and acute myeloid leukemia (AML) with CEBPA mutation.

The entity designated AML with myelodysplasia-related changes in the revised WHO 4th edition classification has been renamed AML, myelodysplasia-related, and new diagnostic criteria have been implemented. In the WHO 5th edition, in addition to the morphologic requirements, both defining cytogenetic criteria and mutational-based criteria have been introduced. See Table 9 for a summary of the diagnostic criteria for AML with defining genetic abnormalities.

**TABLE 9. SUMMARY OF ACUTE MYELOID LEUKEMIA WITH DEFINING GENETIC ABNORMALITIES**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/ Notes** |
| Acute promyelocytic leukemia (APL) with PML::RARA fusion | * Myeloid neoplasm with increased blood and/or bone marrow atypical promyelocytes showing characteristic abnormal hypergranular promyelocytes or microgranular blasts (may be <20%)

 | * Detection of t(15;17)(q24;q21)
 |
| Acute myeloid leukemia (AML) with RUNX1::RUNX1T1 fusion | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Detection of RUNX1::RUNX1T1
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy

  | * Detection of t(8;21)(q22;q22.1)
 |
| Acute myeloid leukemia with CBFB::MYH11 fusion | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Detection of CBFB::MYH11
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy

  | * Detection of inv(16)(p13.1q22.1) or t(16;16)(p13.1;q22.1)
 |
| Acute myeloid leukemia with DEK::NUP214 fusion | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Presence of DEK::NUP214 fusion
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 | * Detection of t(6;9)(p22.3;q34.1)
 |
| Acute myeloid leukemia (AML) with RBM15::MRTFA fusion | * Detection of RBM15::MRTFA fusion by fluorescence in situ hybridization and/or RT-PCR or similar molecular technique
* Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
 | * Detection of t(1;22)(p13.3;q13.1) by karyotype analysis
* Demonstration of megakaryocytic differentiation
 |
| Acute myeloid leukemia (AML) with BCR::ABL1 fusion | * Myeloid neoplasm with >20% blasts expressing a myeloid immunophenotype in the bone marrow and/or blood
* Detection of BCR::ABL1 at initial diagnosis
* Lack of features of CML prior to or at diagnosis or after therapy
 | * Presence of t(9;22)(q34.1;q11.2) on conventional karyotyping
* Determination of the BCR::ABL1 transcript subtype and establishing a baseline level of BCR::ABL1 transcript for monitoring treatment response
 |
| Acute myeloid leukemia with KMT2A rearrangement | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%), or presence of a myeloid sarcoma
* Blasts express myeloid immunophenotype, not fulfilling immunophenotypic criteria for mixed-phenotype acute leukemia
* Presence of a KMT2A rearrangement.
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 | * Identification of the KMT2A fusion partner
 |
| Acute myeloid leukemia with MECOM rearrangement | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Detection of MECOM rearrangement
* No history of myeloproliferative neoplasm
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 | * Detection of inv(3)(q21.3q26.2), t(3;3)(q21;q26), t(3;21)(q26.2;q22) or t(3;12)(q26.2;p13)
 |
| Acute myeloid leukemia (AML) with NUP98 rearrangement | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Detection of the NUP98 rearrangement and/or specific fusion products such as NUP98::NSD1
 | * Dentification of the NUP98 fusion partner at diagnosis is desirable to enable PCR-based disease monitoring
 |
| Acute myeloid leukemia with NPM1 mutation | * Myeloid neoplasm with increased blood and/or bone marrow blasts (may be <20%)
* Detection of NPM1 mutation
* No history of exposure to cytotoxic therapy
 |   |
| Acute myeloid leukemia (AML) with CEBPA mutation | * ≥20% blasts with myeloid immunophenotype in bone marrow or blood
* Presence of biallelic mutations in CEBPA, or a single mutation located in the bZIP region
* Absence of criteria allowing for classification into other AML with defining genetic abnormalities
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |   |
| Acute myeloid leukemia, myelodysplasia-related (AML-MR) | * ≥20% blasts with myeloid immunophenotype in bone marrow or blood
* History of MDS or MDS/MPN and/or detection of one or more chromosomal or molecular aberrations
* Criteria for other AML types with defined genetic alterations are not met.
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 | Defining cytogenetic abnormalities:* Complex karyotype (≥ 3 abnormalities)
* 5q deletion or loss of 5q due to unbalanced translocation
* Monosomy 7, 7q deletion, or loss of 7q due to unbalanced translocation
* 11q deletion
* 12p deletion or loss of 12p due to unbalanced translocation
* Monosomy 13 or 13q deletion
* 17p deletion or loss of 17p due to unbalanced translocation
* Isochromosome 17q
* idic(X)(q13)

 Defining somatic mutations:* ASXL1
* BCOR
* EZH2
* SF3B1
* SRSF2
* STAG2
* U2AF
* ZRSR2
 |
| Acute myeloid leukemia (AML) with other defined genetic alterations | * ≥20% blasts with myeloid immunophenotype in bone marrow and/or blood
* Detection of one or more cytogenetic or molecular aberrations listed in adjacent column
* Not fulfilling diagnostic criteria for AML with defining genetic abnormalities, AML-MR, AML-pCT or MPAL
 | Other defined genetic alterations:* CBFA2T3::GLIS2
* KAT6A::CREBBP
* FUS::ERG
* MNX1::ETV6
* NPM1::MLF1
 |

The WHO 5th edition classification maintains the traditional categories of AML defined by differentiation that lack defining genetic abnormalities. As advances in our understanding of AML and improvements in molecular genetic techniques occur, it is likely that the number of cases falling into this category will diminish. Acute erythroid leukemia (AEL) is distinctive in that it requires >30% pronormoblasts (proerythroblasts), typically with marked background erythroid predominance (≥80%) and maturation arrest in the erythroid lineage. Biallelic TP53 alterations are present in most cases.[11](#R64361) AEL would supersede the diagnoses of MDS with biallelic TP53 alterations due to lake of blasts (pronormoblasts and myeloid blasts) and AML, myelodysplasia related due to the lack of sufficient myeloid blasts. Criteria for acute myeloid leukemia (AML), defined by differentiation is shown in Table 10,

Myeloid sarcoma describes the presence of a tumor mass arising at a site other than bone marrow (extramedullary) that effaces the tissue architecture and is composed of myeloid blasts or blast equivalents with or without accompanying myeloid maturation. Myeloid sarcoma may occur prior to, coincident with, or following treatment for bone marrow myeloid leukemia. Non-effacing or non-tumor forming extramedullary blastic proliferations can occur in AML, MPN, MDS, or MDS/MPN and are not to be diagnosed as myeloid sarcoma.  When selecting myeloid sarcoma on the cancer case summary, specify the associated myeloid neoplasm that it is associated with, if possible. For example:

**Myeloid sarcoma**

\_X\_ Myeloid sarcoma, specify myeloid neoplasm: Acute myeloid leukemia (AML) with RUNX1::RUNX1T1 fusion

**Table 10. SUMMARY OF DIAGNOSTIC FEATURES OF ACUTE MYELOID LEUKEMIA, DEFINED BY DIFFERENTIATION**[1](#R64351)

|  |  |
| --- | --- |
| **Subtype** | **Diagnostic criteria** |
| Acute myeloid leukemia (AML) with minimal differentiation | * ≥20% blasts in bone marrow and/or blood lacking morphological and cytochemical evidence of myeloid differentiation
* Positive for ≥2 myeloid-associated markers (e.g., CD13, CD33, CD117)
* Criteria for AML types with defined genetic alterations are not met
* Criteria for mixed-phenotype acute leukemia are not met
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |
| Acute myeloid leukemia (AML) without maturation | * ≥20% blasts in bone marrow and/or blood with cytochemical evidence of myeloid differentiation and limited (<10%) morphologic features of granulocytic maturation
* Positive for ≥2 myeloid-associated markers (e.g., myeloperoxidase, CD13, CD33, CD117)
* Criteria for AML types with defined genetic alterations are not met.
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |
| Acute myeloid leukemia (AML) with maturation | * ≥20% blasts in bone marrow and/or blood with cytochemical evidence of myeloid differentiation and morphologic features of granulocytic maturation in ≥10% of bone marrow cells
* Positive for ≥2 myeloid-associated markers (e.g., myeloperoxidase, CD13, CD33, CD117)
* Monocyte lineage cells constitute <20% of bone marrow cells
* Criteria for AML types with defined genetic alterations are not met
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |
| Acute basophilic leukemia (ABL) | * ≥20% of blasts with increased immature and mature basophils
* Blasts/basophils with metachromasia on toluidine blue staining and negative for myeloperoxidase, or SBB, and NSE
* Blasts positive for ≥2 myeloid-associated markers (e.g., myeloperoxidase, CD13, CD33, CD117)
* Criteria for AML types with defined genetic alterations are not met
* Not fulfilling diagnostic criteria for myeloid neoplasm post cytotoxic therapy

Desirable diagnostic criteria: Blasts positive for CD123, CD11b, CD9, and/or CD203c, and negative for HLA-DR. |
| Acute myelomonocytic leukemia | * ≥20% blasts and blast equivalents (promonocytes) in bone marrow and/or blood
* Positive for myeloid-associated markers (e.g., myeloperoxidase, CD13, CD33, CD117)
* Maturing granulocytes constitute ≥20% of bone marrow cells
* Monocyte lineage cells constitute ≥20% of bone marrow cells
* Criteria for AML types with defined genetic alterations are not met
* No fulfillment of diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |
| Acute monocytic leukemia | * ≥20% blasts and blast equivalents (promonocytes) in bone marrow and/or blood
* ≥80% of the leukemic cells are monocytes and their precursors, including monoblasts and promonocytes
* <20% maturing granulocytic cells
* Criteria for AML types with defining genetic abnormalities are not met
* No fulfillment of diagnostic criteria for myeloid neoplasm post cytotoxic therapy
 |
| Acute erythroid leukemia (AEL) | * Erythroid predominance, usually ≥80% of bone marrow elements, of which ≥30% are erythroblasts.

Desirable diagnostic criteria: Evidence of TP53 mutation |
| Acute megakaryoblastic leukemia (AMKL) | * ≥20% blasts with megakaryocytic differentiation in bone marrow and/or blood.
* Blasts express at least one or more of the platelet glycoproteins: CD41, CD61, or CD42b
* Does not meet criteria for other defined AML types
* No history of myeloproliferative neoplasm
* Recommend evaluation for possible Down syndrome
 |

**Myeloid neoplasms and proliferations associated with antecedent or predisposing conditions**

Myeloid neoplasms post cytotoxic therapy (MN-pCT) includes AML, MDS, and MDS/MPN that arises in patients with antecedent exposure to cytotoxic/DNA-damaging chemotherapy or large field radiation therapy for an unrelated neoplasm. Recognition of prior cytotoxic therapy is important as the prognosis of matched therapy-related compared to primary/de-novo myeloid neoplasms is worse[12](#R64362); lists of causative cytotoxic chemotherapy is provided in the WHO 5th edition Classification of Tumors of Hematopoietic and Lymphoid Tissue.[1](#R64351) The reporting of therapy-related, and predisposing conditions are required to be added as qualifiers to the AML, MDS, and MDS/MPN diagnosis rendered. In the cancer case summary, this is accomplished by selecting the diagnostic category of Myeloid neoplasm, post cytotoxic therapy, or Myeloid neoplasm and further specifying the neoplasm and therapy or germline predisposition. Examples are shown below.

Example of post cytotoxic therapy:

Myeloid neoplasms and proliferations associated with antecedent or predisposing conditions

\_X\_ Myeloid neoplasm post cytotoxic therapy

specify neoplasm: AML with KMT2A rearrangement, post cytotoxic therapy

Example of post-germline predisposition:

Myeloid neoplasms and proliferations associated with antecedent or predisposing conditions

\_X\_ Myeloid neoplasms associated with germline predisposition

specify neoplasm: MDS-LB

specify germline predisposition: germline RUNX1 variant

**Table 11. SUMMARY OF MYELOID NEOPLASMS AND PROLIFERATIONS ASSOCIATED WITH ANTECEDENT OR PREDISPOSING CONDITIONS**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/ Notes** |
| Myeloid neoplasms post cytotoxic therapy (MN-pCT) | * Myeloid neoplasm meeting diagnostic criteria of any myelodysplastic neoplasm, myelodysplastic/myeloproliferative neoplasm, or acute myeloid leukemia
* History of prior exposure to cytotoxic therapy and/or large-field radiation therapy for an unrelated disorder
* Not meeting diagnostic criteria of myeloproliferative neoplasms
 |   |
| Myeloid neoplasms associated with germline predisposition | * Detection of germline mutation
* Changes consistent with myeloid neoplasm with features of MDS, or with ≥20% blasts in blood and/or bone marrow
 | * Clonal molecular and/or cytogenetic abnormalities in addition to the germline mutation
* Positive family history as determined by formal genetic counseling
 |
| Myeloid proliferations associated with Down syndrome (DS) | Transient abnormal myelopoiesis associated with Down syndrome:* Confirmation of constitutional trisomy 21
* Blood leukocytosis with increased blasts
* Detection of exon 2/3 GATA1 mutation (GATA1 exon 2/3 sequencing should be performed in all cases with blood blasts >10%)

 Myeloid leukemia associated with Down syndrome:* Confirmation of constitutional trisomy 21
* Myeloid neoplasm with persistent increased blood and/or bone marrow blasts (may be <20%)
* Detection of exon 2/3 GATA1 mutation
 | * Mutation profiling and detection of mutations in other genes, e.g., cohesin complex, EZH2, KANSL1, and/or JAK3
 |

**Myeloid/lymphoid neoplasms with eosinophilia and defining gene rearrangements**

Myeloid/lymphoid neoplasms with eosinophilia and defining gene rearrangements are myeloid or lymphoid neoplasms that are driven by gene fusions resulting in constitutively active tyrosine kinase domains and resultant cell proliferation and survival. Clinical presentation is similar to myeloproliferative neoplasms with elevated white blood cells counts, bone marrow hypercellularity, and extramedullary involvement being common.[13](#R64363) Unlike many of the AML with defining genetic alterations above, these neoplasms are classified as blast phase/acute myeloid leukemia only when blasts are ≥20% in blood or bone marrow. A summary table of salient diagnostic features is shown in Table 12. Several diagnostic points are worth emphasizing. First, eosinophilia is common in these disorders but not invariably present, so a high index of suspicion is warranted when some, but not all features are present. This is important as the FIP1L1::PDGFRA is not detected on routine karyotype and requires FISH or molecular studies to demonstrate the rearrangement. Second, many of the neoplasms in myeloid/lymphoid with eosinophilia and defining gene rearrangements may present with atypical mast cell infiltrates both morphologically (spindled, clustered) and by immunophenotype (CD25+), and therefore these should be excluded when considering the diagnosis of mast cell neoplasms.[14,](#R64364)[15](#R64365)

**TABLE 12. SUMMARY OF MYELOID/ LYMPHOID NEOPLASMS WITH EOSINOPHILIA AND DEFINING GENE REARRANGEMENT**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/ Notes** |
| Myeloid/lymphoid neoplasm with PDGFRA rearrangement | * A myeloid (more frequent) or lymphoid neoplasm, usually with prominent and/or tissue eosinophilia
* Presence of a PDGFRA fusion gene, usually with FIP1L1
 | * In the absence of molecular demonstration of the fusion gene, the diagnosis should be suspected if there is a BCR::ABL1-negative myeloproliferative neoplasm with prominent eosinophilia associated with splenomegaly.
* Marked elevation of serum vitamin B12, increased serum tryptase, and increased bone marrow mast cells
 |
| Myeloid/lymphoid neoplasm with PDGFRB rearrangement | * A myeloid or lymphoid neoplasm, often with prominent eosinophilia with varying degrees of neutrophilia or monocytosis associated with the formation of a PDGFRB fusion gene
* Cases of BCR::ABL1-like B-ALL without evidence of an associated myeloid neoplasm are excluded from this category
 | * Cytogenetic and molecular identification of the partner gene, e.g., t(5;12)(q32;p13.2) with ETV6::PDGFRB or other partner genes
 |
| Myeloid/lymphoid neoplasm with FGFR1 rearrangement | * Demonstration of t(8;13)(p11.2;q12.1) or a different translocation leading to formation of an FGFR1 fusion gene is required
* Phenotypically the disease may present as a myeloproliferative or myelodysplastic/myeloproliferative neoplasm with prominent eosinophilia, +/- neutrophilia or monocytosis or with increased blasts of myeloid, T-cell or B-cell lineage, or mixed phenotype, usually with eosinophilia

  | * Molecular identification of the partner gene of FGFR1
 |
| Myeloid/lymphoid neoplasm with JAK2 rearrangement | * A myeloid or lymphoid neoplasm, often with prominent eosinophilia and the presence of a JAK2 fusion gene
* Cases of BCR::ABL1-like B-ALL without evidence of an associated myeloid neoplasm are excluded from this category
 | * Cytogenetic identification of the translocation. Molecular identification of the fusion gene, e.g., PCM1::JAK2
* May have prominent erythroblastic islands in bone marrow and extramedullary locations
 |
| Myeloid/lymphoid neoplasms with FLT3 rearrangement | * A myeloid or lymphoid neoplasm, with or without associated eosinophilia with chromosomal rearrangements leading to the formation of a FLT3 fusion gene

  |   |
| Myeloid/lymphoid neoplasm with ETV6::ABL1 fusion | * A hematopoietic (myeloid or lymphoid) neoplasm in chronic phase associated with ETV6::ABL1
 | * Cytogenetics: t(9;12)(q34;p13) or complex aberrations involving other chromosomes
 |
| Myeloid/lymphoid neoplasms with other tyrosine kinase gene fusions | * A myeloid and/or lymphoid neoplasm
* Detection of a tyrosine kinase fusion gene, other than those specifically defined as distinct entities (i.e., PDGFRA, PDGFRB, FGFR1, JAK2, FLT3, ETV6::ABL1, etc.)
 | * Eosinophilia
* Cytogenetic identification of a translocation, suggesting the involvement of a tyrosine kinase gene and prompting the selection of appropriate break apart FISH probes or other molecular investigation
* Reported alterations include but are not limited to: ETV6::FGFR2; ETV6::LYN; ETV6::NTRK3; RANBP2::ALK; BCR::RET; FGFR1OP::RET
 |

**Acute leukemias of mixed or ambiguous lineage**

Acute leukemias of ambiguous lineage are neoplasms composed of ≥20% blasts in the blood or bone marrow that do not show differentiation along a single lineage (mixed phenotype acute leukemia/MPAL) or fail to demonstrate lineage differentiation (acute undifferentiated leukemia/AUL). MPAL may consist of a single, well-defined blast population that expresses lineage-defining antigens (see Table 13) of two or more lineages (termed biphenotypic), multiple distinct blast populations that each express lineage-defining antigens (bilineal/ bilineage) or a combination of these two. To clarify, in cases of bilineal/bilineage acute leukemia, the aggregate count of the two distinct abnormal blasts populations is used to define the total blast count and meet criteria for ≥20% blasts.

The assessment of antigen expression to determine lineage assignment is best performed by flow cytometry due to its ability to identify discrete populations based on multiparametric analysis and ability to quantify antigen expression. The criteria for the assignment of B-, T-, and myeloid lineage is shown in Table 13. Briefly, B-lineage is defined using CD19 expression coupled with additional antigens based on the intensity of CD19. T-lineage is defined by cytoplasmic or surface CD3 expression. Myeloid lineage by myeloperoxidase expression or expression of more than one marker of monocytic differentiation. Leukemias that have a well-defined single lineage assignment that express antigens associated with another lineage but not lineage-defining should be considered acute leukemia with aberrant antigen expression and not defined as MPAL.

Leukemias that can more accurately be assigned to another well-defined entity but meeting the criteria for MPAL or AUL should be assigned to that category; common examples include acute myeloid leukemia (AML) with RUNX1::RUNX1T1 fusion, acute myeloid/lymphoid neoplasms with eosinophilia and blast phase chronic myeloid leukemia. A summary of the diagnostic features of leukemias with ambiguous lineage with defining genetic abnormalities and acute leukemias with ambiguous lineage, immunophenotypically defined as shown in Tables 14 and 15, respectively.

**TABLE 13. LINEAGE ASSIGNMENT CRITERIA FOR MIXED PHENOTYPE ACUTE LEUKEMIA- B-LINEAGE, T-LINEAGE AND MYELOID LINEAGE**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Lineage**  | **Criterion** | **Notes** |
| B lineage | * CD19 strong

and* 1 or more also strongly expressed: CD10, CD22, or CD79a
 | * CD19 strong= intensity in part exceeds 50% of normal B cell progenitor by flow cytometry
* CD19 weak= intensity does not exceed 50% of normal B cell progenitor by flow cytometry
* If mixed T lineage is under consideration, CD79a cannot be used for B lineage assignment
 |
| * CD19 weak

and* 2 or more also strongly expressed: CD10, CD22, or CD79a
 |
| T lineage | * Cytoplasmic CD3 or surface
* Cytoplasmic CD3 or surface expression flow cytometry (CD3 epsilon chain antibodies); intensity exceeds 50% of mature T cells by flow cytometry
* Cytoplasmic CD3 by immunohistochemistry using non-zeta chain antibody
 | * Surface CD3 expression rare in mixed phenotype/ ambiguous acute leukemia
 |
| Myeloid lineage | * Myeloperoxidase (MPO)
* Intensity in population of interest exceeds 50% of mature neutrophil level
 |   |
| * Monocytic differentiation
* 2 or more expressed:  CD11c, CD14, CD36, CD64, diffuse non-specific esterase, lysozyme
 |

**TABLE 14. SUMMARY OF ACUTE LEUKEMIA OF AMBIGOUS LINEAGE WITH DEFINING GENETIC ABNORMALITIES**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/ Notes** |
| Mixed-phenotype acute leukemia with BCR::ABL1 fusion | * ≥20% blasts in bone marrow and/or blood with an immunophenotype that meets the diagnostic criteria for MPAL
* BCR::ABL1 and/or t(9;22)(q34;q11.2) detected at initial diagnosis
* No prior or subsequent evidence of chronic myeloid leukemia
* No history of exposure to cytotoxic therapy
 | Determination of the BCR::ABL1 transcript subtype and establishment of a quantitative baseline for monitoring treatment response |
| Mixed-phenotype acute leukemia (MPAL) with KMT2A rearrangement | * ≥20% blasts in bone marrow and/or blood with an immunophenotype that meets the diagnostic criteria for MPAL
* Presence of a KMT2A rearrangement
* No history of exposure to cytotoxic therapy
 | Identification of the KMT2A fusion partner |
| Acute leukemia of ambiguous lineage with other defined genetic alterations | * ≥20% blasts in bone marrow and/or blood expressing mixed-lineage or ambiguous immunophenotype.
* Detection of ZNF386 or BCL11B rearrangement
 |   |

**TABLE 15. SUMMARY OF ACUTE LEUKEMIA WITH AMBIGUOUS LINEAGE, IMMUNOPHENOTYPICALLY DEFINED**[1](#R64351)

|  |  |  |
| --- | --- | --- |
| **Subtype** | **Essential diagnostic criteria** | **Desirable diagnostic criteria/ Notes** |
| Mixed phenotype acute leukemia, B/Myeloid (MPAL-B/M) | * ≥20% blasts in bone marrow and/or blood expressing B lineage and myeloid lineage antigens
* Not fulfilling diagnostic criteria of MPAL with defined genetic alterations
* No history of exposure to cytotoxic therapy
 |   |
| Mixed phenotype acute leukemia, T/Myeloid (MPAL-T/M) | * ≥20% blasts in bone marrow and/or blood expressing T lineage and myeloid lineage antigens
* Not fulfilling diagnostic criteria of MPAL with defined genetic alterations
* No history of exposure to cytotoxic therapy
 |   |
| Mixed-phenotype acute leukemia (MPAL), rare types | * ≥20% blasts in bone marrow and/or blood expressing combinations of B, T, myeloid and megakaryocytic (Mk) lineage markers
* Not fulfilling diagnostic criteria of MPAL with defined genetic alterations, MPAL B/Myeloid, or MPAL T/Myeloid
* No history of exposure to cytotoxic therapy
* No history of myeloid neoplasms
 | Subtypes:* Mixed-phenotype acute leukemia, B/T (MPAL-B/T)
* Mixed-phenotype acute leukemia, B/T/Myeloid (MPAL-B/T/M)
* Mixed-phenotype acute leukemia, T/Megakaryocytic (MPAL-T/Mk)
 |
| Acute leukemia of ambiguous lineage, not otherwise specified (ALAL-NOS) | * ≥20% blasts in bone marrow and/or blood expressing combinations of immunophenotypic lineage markers that do not permit definitive lineage assignments
* Not fulfilling diagnostic criteria of MPAL with defined genetic alterations
 |   |

**Blastic plasmacytoid dendritic cell neoplasm**

Blastic plasmacytoid dendritic cell neoplasm (BPDCN) is a hematological neoplasm consisting of immature cells with plasmacytoid dendritic cell differentiation. While plasmacytoid dendritic cells can be derived from both myeloid and lymphoid cells, the predominant cell of origin is myeloid.[16](#R64366) In addition, the frequent leukemic presentation and possible blastic transformation event of underlying myeloid neoplasm, typically MDS or MDS/MPN in 20-30% of cases make inclusion in this cancer case summary more apt. Diagnostic characteristics include immature cells with blast/blastoid features and immunophenotypic evidence of plasmacytoid dendritic cell differentiation including the expected expression of CD123, CD4, CD56, TCF4, TCL1, CD303, CD304 with typical absence of expression of other antigens such as CD3, CD14, CD19, CD34, Lysozyme, Myeloperoxidase.[17](#R64367)

**Dysplasia**
The presence or absence of significant dysplasia (defined as 10% or greater of cells in each lineage) should be noted for each of the major cell lineages present in the sample- erythroid, myeloid, and megakaryocytes. If dysplasia cannot reliably be assessed due to the nature of the sample select- Cannot be determined and specify the reason. For blood, report dysplasia that you can evaluate- typically granulocytic. If dysplasia is not applicable, for example in myeloid sarcoma or blastic plasmacytoid dendritic cell neoplasm, report as not applicable.

References

1. WHO Classification of Tumours Editorial Board. Haematolymphoid tumours. Lyon (France): International Agency for Research on Cancer; forthcoming. (WHO classification of tumours series, 5th ed.; vol. 11). <https://publications.iarc.fr>.
2. Wang W, Cortes JE, Tang G, Khoury JD, Wang S, Bueso-Ramos CE, et al. Risk stratification of chromosomal abnormalities in chronic myelogenous leukemia in the era of tyrosine kinase inhibitor therapy. Blood. 2016;127:2742–50.
3. Álvarez-Twose I, Jara-Acevedo M, Morgado JM, García-Montero A, Sánchez-Muñoz L, Teodósio C, Matito A, Mayado A, Caldas C, Mollejo M, Orfao A, Escribano L. Clinical, immunophenotypic, and molecular characteristics of well-differentiated systemic mastocytosis. J Allergy Clin Immunol. 2016 Jan;137(1):168-178.e1. doi: 10.1016/j.jaci.2015.05.008. Epub 2015 Jun 19. PMID: 26100086.
4. Raymond LM, Funk T, Braziel RM, Fan G, Gatter K, Loriaux M, Dunlap J, Raess PW. Mast cell sarcoma with concurrent mast cell leukaemia. Br J Haematol. 2020 May;189(4):e160-e164. doi: 10.1111/bjh.16581. Epub 2020 Apr 3. PMID: 32242922.
5. Valent P, Akin C, Hartmann K, Alvarez-Twose I, Brockow K, Hermine O, Niedoszytko M, Schwaab J, Lyons JJ, Carter MC, Elberink HO, Butterfield JH, George TI, Greiner G, Ustun C, Bonadonna P, Sotlar K, Nilsson G, Jawhar M, Siebenhaar F, Broesby-Olsen S, Yavuz S, Zanotti R, Lange M, Nedoszytko B, Hoermann G, Castells M, Radia DH, Muñoz-Gonzalez JI, Sperr WR, Triggiani M, Kluin-Nelemans HC, Galli SJ, Schwartz LB, Reiter A, Orfao A, Gotlib J, Arock M, Horny HP, Metcalfe DD. Updated Diagnostic Criteria and Classification of Mast Cell Disorders: A Consensus Proposal. Hemsphere. 2021 Oct 13;5(11):e646. doi: 10.1097/HS9.0000000000000646. PMID: 34901755; PMCID: PMC8659997.
6. Yoshizato T, Nannya Y, Atsuta Y, Shiozawa Y, Iijima-Yamashita Y, Yoshida K, Shiraishi Y, Suzuki H, Nagata Y, Sato Y, Kakiuchi N, Matsuo K, Onizuka M, Kataoka K, Chiba K, Tanaka H, Ueno H, Nakagawa MM, Przychodzen B, Haferlach C, Kern W, Aoki K, Itonaga H, Kanda Y, Sekeres MA, Maciejewski JP, Haferlach T, Miyazaki Y, Horibe K, Sanada M, Miyano S, Makishima H, Ogawa S. Genetic abnormalities in myelodysplasia and secondary acute myeloid leukemia: impact on outcome of stem cell transplantation. Blood. 2017 Apr 27;129(17):2347-2358. doi: 10.1182/blood-2016-12-754796. Epub 2017 Feb 21. PMID: 28223278; PMCID: PMC5409449.
7. Bernard E, Nannya Y, Hasserjian RP, Devlin SM, Tuechler H, Medina-Martinez JS, Yoshizato T, Shiozawa Y, Saiki R, Malcovati L, Levine MF, Arango JE, Zhou Y, Solé F, Cargo CA, Haase D, Creignou M, Germing U, Zhang Y, Gundem G, Sarian A, van de Loosdrecht AA, Jädersten M, Tobiasson M, Kosmider O, Follo MY, Thol F, Pinheiro RF, Santini V, Kotsianidis I, Boultwood J, Santos FPS, Schanz J, Kasahara S, Ishikawa T, Tsurumi H, Takaori-Kondo A, Kiguchi T, Polprasert C, Bennett JM, Klimek VM, Savona MR, Belickova M, Ganster C, Palomo L, Sanz G, Ades L, Della Porta MG, Elias HK, Smith AG, Werner Y, Patel M, Viale A, Vanness K, Neuberg DS, Stevenson KE, Menghrajani K, Bolton KL, Fenaux P, Pellagatti A, Platzbecker U, Heuser M, Valent P, Chiba S, Miyazaki Y, Finelli C, Voso MT, Shih LY, Fontenay M, Jansen JH, Cervera J, Atsuta Y, Gattermann N, Ebert BL, Bejar R, Greenberg PL, Cazzola M, Hellström-Lindberg E, Ogawa S, Papaemmanuil E. Implications of TP53 allelic state for genome stability, clinical presentation and outcomes in myelodysplastic syndromes. Nat Med. 2020 Oct;26(10):1549-1556. doi: 10.1038/s41591-020-1008-z. Epub 2020 Aug 3. Erratum in: Nat Med. 2021 Mar;27(3):562. Erratum in: Nat Med. 2021 May;27(5):927. PMID: 32747829; PMCID: PMC8381722.
8. Baumann I, Führer M, Behrendt S, Campr V, Csomor J, Furlan I, de Haas V, Kerndrup G, Leguit RJ, De Paepe P, Noellke P, Niemeyer C, Schwarz S. Morphological differentiation of severe aplastic anaemia from hypocellular refractory cytopenia of childhood: reproducibility of histopathological diagnostic criteria. Histopathology. 2012 Jul;61(1):10-7. doi: 10.1111/j.1365-2559.2011.04156.x. Epub 2012 Mar 28. PMID: 22458667.
9. Selimoglu-Buet D, Wagner-Ballon O, Saada V, Bardet V, Itzykson R, Bencheikh L, Morabito M, Met E, Debord C, Benayoun E, Nloga AM, Fenaux P, Braun T, Willekens C, Quesnel B, Adès L, Fontenay M, Rameau P, Droin N, Koscielny S, Solary E; Francophone Myelodysplasia Group. Characteristic repartition of monocyte subsets as a diagnostic signature of chronic myelomonocytic leukemia. Blood. 2015 Jun 4;125(23):3618-26. doi: 10.1182/blood-2015-01-620781. Epub 2015 Apr 7. PMID: 25852055; PMCID: PMC4497970.
10. Peng J, Zuo Z, Fu B, Oki Y, Tang G, Goswami M, Priyanka P, Muzzafar T, Medeiros LJ, Luthra R, Wang SA. Chronic myelomonocytic leukemia with nucleophosmin (NPM1) mutation. Eur J Haematol. 2016 Jan;96(1):65-71. doi: 10.1111/ejh.12549. Epub 2015 Apr 21. PMID: 25809997.
11. Montalban-Bravo G, Benton CB, Wang SA, Ravandi F, Kadia T, Cortes J, Daver N, Takahashi K, DiNardo C, Jabbour E, Borthakur G, Konopleva M, Pierce S, Bueso-Ramos C, Patel K, Kornblau S, Kantarjian H, Young KH, Garcia-Manero G, Andreeff M. More than 1 TP53 abnormality is a dominant characteristic of pure erythroid leukemia. Blood. 2017 May 4;129(18):2584-2587. doi: 10.1182/blood-2016-11-749903. Epub 2017 Feb 28. PMID: 28246192; PMCID: PMC5418636.
12. Kuendgen A, Nomdedeu M, Tuechler H, Garcia-Manero G, Komrokji RS, Sekeres MA, Della Porta MG, Cazzola M, DeZern AE, Roboz GJ, Steensma DP, Van de Loosdrecht AA, Schlenk RF, Grau J, Calvo X, Blum S, Pereira A, Valent P, Costa D, Giagounidis A, Xicoy B, Döhner H, Platzbecker U, Pedro C, Lübbert M, Oiartzabal I, Díez-Campelo M, Cedena MT, Machherndl-Spandl S, López-Pavía M, Baldus CD, Martinez-de-Sola M, Stauder R, Merchan B, List A, Ganster C, Schroeder T, Voso MT, Pfeilstöcker M, Sill H, Hildebrandt B, Esteve J, Nomdedeu B, Cobo F, Haas R, Sole F, Germing U, Greenberg PL, Haase D, Sanz G. Therapy-related myelodysplastic syndromes deserve specific diagnostic sub-classification and risk-stratification-an approach to classification of patients with t-MDS. Leukemia. 2021 Mar;35(3):835-849. doi: 10.1038/s41375-020-0917-7. Epub 2020 Jun 29. PMID: 32595214; PMCID: PMC7932916.
13. Olga Pozdnyakova, MD, PhD, Attilio Orazi, MD, PhD, Katalin Kelemen, MD, PhD, Rebecca King, MD, Kaaren K Reichard, MD, Fiona E Craig, MD, Leticia Quintanilla-Martinez, MD, Lisa Rimsza, MD, Tracy I George, MD, Hans-Peter Horny, MD, Sa A Wang, MD, Myeloid/Lymphoid Neoplasms Associated With Eosinophilia and Rearrangements of PDGFRA, PDGFRB, or FGFR1 or With PCM1-JAK2, American Journal of Clinical Pathology, Volume 155, Issue 2, February 2021, Pages 160–178, <https://doi.org/10.1093/ajcp/aqaa208>.
14. Klion AD, Noel P, Akin C, Law MA, Gilliland DG, Cools J, Metcalfe DD, Nutman TB. Elevated serum tryptase levels identify a subset of patients with a myeloproliferative variant of idiopathic hypereosinophilic syndrome associated with tissue fibrosis, poor prognosis, and imatinib responsiveness. Blood. 2003 Jun 15;101(12):4660-6. doi: 10.1182/blood-2003-01-0006. Epub 2003 Apr 3. PMID: 12676775.
15. Fang H, Tang G, Loghavi S, Greipp P, Wang W, Verstovsek S, Medeiros LJ, Reichard KK, Miranda RN, Wang SA. Systematic use of fluorescence in-situ hybridisation and clinicopathological features in the screening of PDGFRB rearrangements of patients with myeloid/lymphoid neoplasms. Histopathology. 2020 Jun;76(7):1042-1054. doi: 10.1111/his.14097. Epub 2020 May 17. PMID: 32083752.
16. Musumeci A, Lutz K, Winheim E and Krug AB (2019) What Makes a pDC: Recent Advances in Understanding Plasmacytoid DC Development and Heterogeneity. Front. Immunol. 10:1222. doi: 10.3389/fimmu.2019.01222.
17. Francine Garnache-Ottou, Chrystelle Vidal, Sabeha Biichlé, Florian Renosi, Eve Poret, Maïder Pagadoy, Maxime Desmarets, Anne Roggy, Estelle Seilles, Lou Soret, Françoise Schillinger, Sandrine Puyraimond, Tony Petrella, Claude Preudhomme, Christophe Roumier, Elisabeth A. MacIntyre, Véronique Harrivel, Yohan Desbrosses, Bérengère Gruson, Franck Geneviève, Sylvain Thepot, Yuriy Drebit, Thibaut Leguay, François-Xavier Gros, Nicolas Lechevalier, Pascale Saussoy, Véronique Salaun, Edouard Cornet, Zehaira Benseddik, Richard Veyrat-Masson, Orianne Wagner-Ballon, Célia Salanoubat, Marc Maynadié, Julien Guy, Denis Caillot, Marie-Christine Jacob, Jean-Yves Cahn, Rémy Gressin, Johann Rose, Bruno Quesnel, Estelle Guerin, Franck Trimoreau, Jean Feuillard, Marie-Pierre Gourin, Adriana Plesa, Lucile Baseggio, Isabelle Arnoux, Norbert Vey, Didier Blaise, Romaric Lacroix, Christine Arnoulet, Blandine Benet, Véronique Dorvaux, Caroline Bret, Bernard Drenou, Agathe Debliquis, Véronique Latger-Cannard, Caroline Bonmati, Marie-Christine Bene, Pierre Peterlin, Michel Ticchioni, Pierre-Simon Rohrlich, Anne Arnaud, Stefan Wickenhauser, Valérie Bardet, Sabine Brechignac, Benjamin Papoular, Victoria Raggueneau, Jacques Vargaftig, Rémi Letestu, Daniel Lusina, Thorsten Braun, Vincent Foissaud, Jérôme Tamburini, Hind Bennani, Nicolas Freynet, Catherine Cordonnier, Magali Le Garff-Tavernier, Nathalie Jacques, Karim Maloum, Damien Roos-Weil, Didier Bouscary, Vahid Asnafi, Ludovic Lhermitte, Felipe Suarez, Etienne Lengline, Frédéric Féger, Giorgia Battipaglia, Mohamad Mohty, Sabrina Bouyer, Ouda Ghoual, Elodie Dindinaud, Caroline Basle, Mathieu Puyade, Carinne Lafon, Thierry Fest, Mikael Roussel, Xavier Cahu, Elsa Bera, Sylvie Daliphard, Fabrice Jardin, Lydia Campos, Françoise Solly, Denis Guyotat, Anne-Cécile Galoisy, Alice Eischen, Caroline Mayeur-Rousse, Blandine Guffroy, Christian Recher, Marie Loosveld, Alice Garnier, Vincent Barlogis, Maria Alessandra Rosenthal, Sophie Brun, Nathalie Contentin, Sébastien Maury, Mary Callanan, Christine Lefebvre, Natacha Maillard, Patricia Okamba, Christophe Ferrand, Olivier Adotevi, Philippe Saas, Fanny Angelot-Delettre, Delphine Binda, Eric Deconinck; How should we diagnose and treat blastic plasmacytoid dendritic cell neoplasm patients?. Blood Adv 2019; 3 (24): 4238–4251. doi: <https://doi.org/10.1182/bloodadvances.2019000647>.

**C. Special Studies**

**Ring sideroblasts/iron stain**

An iron stain (Prussian blue) is necessary to evaluate for the presence of stainable iron and to identify ring sideroblasts.[1](#R64369) Stainable iron is best evaluated on bone marrow aspirate smears or touch preparations of the core biopsy. Evaluation of the bone marrow core biopsy or clot section may hinder the visualization of the ring sideroblasts and decalcification diminishes stainable iron. For specimens other than bone marrow, select not applicable/not performed/not evaluated.

**Bone marrow fibrosis grade**

Bone marrow fibrosis is assessed using a semi-quantitative grade (MF-0 to MF-3) based on reticulin stains and, depending on the degree of fibrosis (MF-2 or MF-3), trichrome stain. The fiber density should only be assessed in areas of hematopoiesis; if there is variability the grade should be assigned based on the highest grade that is present in at least 30% of the bone marrow. The bone marrow fibrosis grading system is shown in Table 1.[2,](#R64370)[3](#R64371)

**Table 1. Semi-quantitative grading of bone marrow fibrosis**

|  |  |
| --- | --- |
| **Myelofibrosis grade** | **Description** |
| MF-0 | * Scattered linear reticulin with no intersections (crossovers) corresponding to normal BM
 |
| MF-1 | * Loose network of reticulin with many intersections, especially in perivascular areas
 |
| MF-2 | * Diffuse and dense increase in reticulin with extensive intersections, occasionally with focal bundles of thick fibers mostly consistent with collagen, and/or focal osteosclerosis. (Trichrome stain recommended)
 |
| MF-3 | * Diffuse and dense increase in reticulin with extensive intersections and coarse bundles of thick fibers consistent with collagen, usually associated with osteosclerosis. (Trichrome stain recommended)
 |

**Flow cytometry**

Flow cytometry is a quantitative method for rapid, multiparametric evaluation of the expression of cell surface and cytoplasmic antigens of a large number of cells. If flow cytometry is performed, report if there was no aberrancy detected in the sample at the level of sensitivity of the assay or specify what specific alterations were detected. As there is substantial variability in the reporting of results the cancer case summary does not require a specific method. It is recommended to report the result on the tumor cell population in a semi-quantitative method that would allow those reviewing the report to determine if there is heterogenous expression (not all tumor cells are positive) and the level of expression on the population. Examples of this reporting include: CD34 dim+ (low-level expression of CD34), CD34+ (moderate level of expression of CD34), CD34++ (bright expression of CD34), CD34-/+ het (variable heterogeneous expression of CD34).

**Cytogenetics**

Report if conventional/karyotype cytogenetic analysis was performed on the sample, and if performed, the result. For those samples with abnormal karyotypes, specify the result.

**Fluorescence in-situ hybridization**

Report the results of any fluorescence in-situ hybridization performed by listing probes that were tested with normal results and those that showed an abnormal signal pattern.

**Molecular alterations detected**

With the advent of increasingly sophisticated molecular genetic techniques such as next-generation sequencing (NGS), chromosomal microarrays, and large fluorescence in-situ hybridization panels reporting all of these results in a synoptic format is a challenge. As many of these alterations are diagnostically, prognostically, or therapeutically significant- reporting in a succinct manner is necessary. To make reporting easier for the pathologist and highlight what is most important for the treating clinician, this cancer case summary requires the reporting of any positive/abnormal alterations that were detected followed by an optional listing of all the alterations that were tested. The cancer case summary lists some of the most common genetic alterations that occur in myeloid neoplasms, but it is in no way comprehensive. The option exists to provide the molecular alterations not specifically listed under “Other alterations listed (specify),” where the user would enter what molecular alteration was detected.

After each alteration, there is a specific field where users can delineate, if desired, specific alterations, methodology (NGS, for example), or additional information (variant allele frequency VAF) that would be useful for that institution. While preferable to include specific information, this could also reference a separate report with this information (separate molecular pathology report). An example of how to use this section is as follows:

**Molecular alterations detected (select all those with significant mutations)**

\_X\_ DNMT3A mutation, (specify): DNMT3A R882H, VAF 47%, NGS

\_X\_   FLT3 interim tandem duplication (ITD), (specify): (PCR)/Capillary Electrophoresis, signal ratio 9.5

\_X\_   NPM1 mutation, (specify): c.578A>G→p.K193R, VAF 40%, NGS

Molecular alterations assayed:

(List): ABL1, ANKRD26, APC, ARAF, ASXL1, ATM, ATRX, BCOR, BCORL1, BLM, BRAF, BRCA1, BRCA2, BRIP1, CALR, CBL, CBLB, CBLC, CDKN2A, CEBPA, CHEK2, CSF3R, CTC1, CUX1, CXCR4, DDX41, DKC1, DNMT3A, ELANE, EPCAM, ERCC4, ETNK1, ETV6, EZH2, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FBXW7, FLT3, G6PC3, GATA1, GATA2, GFI1, GNAS, GNB1, HAX1, HRAS, IDH1, IDH2, IKZF1, IKZF3, ITPKB, JAK2, JAK3, KDM6A, KIT, KMT2A, KRAS, MAP2K1, MET, MLH1, MPL, MSH2, MSH6, MYD88, NF1, NHP2, NOP10, NOTCH1, NPM1, NRAS, PALB2, PDGFRA, PHF6, PIGA, PML, PMS2, PPM1D, PTEN, PTPN11, RAD21, RAD51C, RB1, RPL11, RPL35A, RPL5, RPS10, RPS17, RPS26, RPS7, RTEL1, RUNX1, SAMD9, SAMD9L, SBDS, SETBP1, SETD2, SF3B1, SH2B3, SLX4, SMC1A, SMC3, SRP72, SRSF2, STAG2, STAT3, STAT5B, SUZ12, TERC, TERT, TET2, TINF2, TP53, U2AF1, VHL, WAS, WRAP53, WT1, ZRSR2

This method can simplify the reporting of large numbers of genes to highlight only those with alterations identified. It also provides a means of listing what was assayed- such lists can be typically obtained from the laboratory performing the molecular studies. This is less labor-intensive than listing all the negative results.

References

1. Della Porta MG, Travaglino E, Boveri E, et al. Minimal morphological criteria for defining bone marrow dysplasia: a basis for clinical implementation of WHO classification of myelodysplastic syndromes. Leukemia 2015;29: 66–75.
2. Thiele J, Kvasnicka HM, Facchetti F, Franco V, van der Walt J, Orazi A. European consensus on grading bone marrow fibrosis and assessment of cellularity. Haematologica. 2005 Aug;90(8):1128-32. PMID: 16079113.
3. Kvasnicka HM, Beham-Schmid C, Bob R, Dirnhofer S, Hussein K, Kreipe H, Kremer M, Schmitt-Graeff A, Schwarz S, Thiele J, Werner M, Stein H. Problems and pitfalls in grading of bone marrow fibrosis, collagen deposition and osteosclerosis - a consensus-based study. Histopathology. 2016 May;68(6):905-15. doi: 10.1111/his.12871. Epub 2015 Nov 20. PMID: 26402166.