

## FAQS from Dr. Brunner's Webinar

**Any suggestions for older MDS patients with high-risk MDS with diabetes and thyroid issues?**

I don't think that would preclude any of our typical chemotherapies; as MDS is mostly in 70-year-old or older, we can generally administer treatment even to patients in their late 80s/early 90s, albeit often with dose modification. Functional status - what you do on your own day-to-day - seems to be as if not more important.

**Is full cytogenetic analysis and molecular diagnostics done via a blood test or bone marrow biopsy?** Each test can be attempted on the blood but tends not to be as good as the bone marrow. Particularly cytogenetics, that test typically does not culture correctly with just a blood sample unless a patient has frank AML. So generally, I prefer a marrow for these particularly at diagnosis. Molecular testing may be a little more amenable to blood, but still the marrow is probably a better sample for baseline assessments.

**I have already had a stem cell transplant for AML. Now that I have high-risk MDS, would a second transplant be considered and if yes under what circumstances?** This is a question unfortunately with a lot of nuances, depending on your exact situation, and whether the donor is the source of the MDS or if this represents relapse of your prior myeloid malignancy. So, it is worth asking your transplant and leukemia team directly. But in general, yes, in certain circumstances we do consider a second transplant, or some other cell therapy like a DLI or GCSF-stimulated DLI.

**For a patient on azacitidine every 5 weeks and doing well (over 5 years transfusion free with 12 hgb) what are the risks halting treatment after 3 days due to Covid and resuming the 5-week schedule?** For this exact scenario it is hard to know, but in general what we have seen is that lowering the amount of chemotherapy or stopping chemotherapy tends to be associated with a faster rate of disease relapse/recurrence. This obviously varies patient to patient, but in general if someone is tolerating therapy and their counts are good, I try to maintain full dosing as much as possible. If it is an issue around schedule, one consideration is to discuss oral options such as oral decitabine.

**I am low-risk with sideroblasts. I am consistently (daily) challenged to maintain a blood sodium count of 130-134. My doctors (PC and Kidney specialist) have not been able determine the cause. I am not sure that the MDS would directly relate to a low sodium level, generally that would not be related.**

**I have recently been diagnosed with MDS-RS. Can the treatments, transfusions or transplant exacerbate my asymptomatic Crohn's disease?** There can be a number of interactions between MDS, treatment, and autoimmune disease. It is hard to know specifically the impact. Indeed, since it is a new immune system, sometimes a transplant can resolve both the MDS and any pre-existing autoimmune disorder. But I don't think we can reliably say what will happen person to person; in general, however, I don't limit my MDS treatment in the setting of other autoimmune processes, and if the latter do worsen, I treat them alongside my colleagues in rheumatology (or GI, etc).