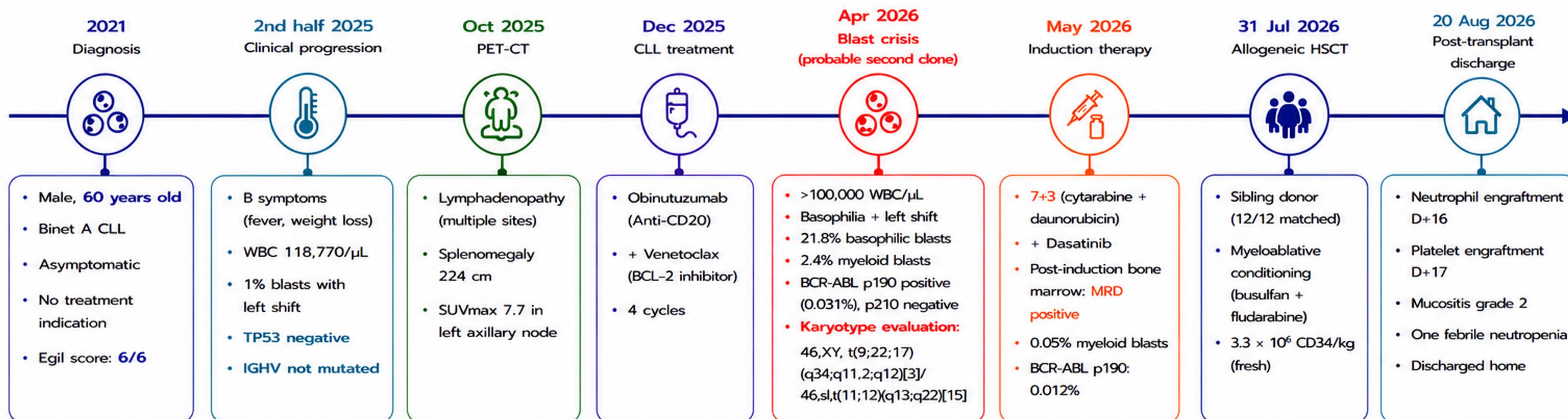


CLINICAL TIMELINE



DISCUSSION & KEY POINTS

- 1** This case presents a very rare scenario involving a **patient who initially had CLL and subsequently developed a second – CML blast crisis**, possibly associated with the presence of a second clone. Confirmation of a second clone would only be possible using a cell-sorting technique (separating the CD19+ lymphoid fraction from the myeloid fraction) followed by FISH or gene rearrangement analysis (JH for the B-cell lineage, BCR for the myeloid lineage), unfortunately unavailable at our center laboratory [1].
- 2** A GIMEMA review identified only 25 cases of CLL/CML coexistence in the literature; most studies involving cytogenetic and molecular analysis pointed to an **independent origin** for the two cell populations [2]. This patient presented the **BCR-ABL p190 transcript**, which is rare in CML—found in fewer than 5% (sometimes cited as ~1%) of patients—whereas p210 is the classic alteration [3].
- 3** Regarding the myeloid blast crisis, the literature highlights a strong association with the **acquisition of additional AML-type chromosomal alterations** (particularly at the EVI1 and RUNX1 loci) than with the specific transcript type (whether p210 or p190). After transplantation, this patient should continue **TKI therapy for at least 12–24 months, with molecular monitoring of BCR-ABL1 p190** performed monthly to quarterly.
- 4** **Monitoring for CLL** should also be performed during the patient the follow up, including a complete blood count (CBC), LDH, surveillance for splenomegaly or lymphadenopathy, and peripheral blood immunophenotyping [4].

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