Nordic Guidelines for Germline Predisposition to Myeloid Neoplasms in Adults: Recommendations for Genetic Diagnosis, Clinical Management and Follow-up

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Abstract

Myeloid neoplasms (MNs) with germline predisposition have recently been recognized as novel entities in the latest World Health Organization (WHO) classification for MNs. Individuals with MNs due to germline predisposition exhibit increased risk for the development of MNs, mainly acute myeloid leukemia (AML) and myelodysplastic syndrome (MDS). Setting the diagnosis of MN with germline predisposition is of crucial clinical significance since it may tailor therapy, dictate the selection of donor for allogeneic hematopoietic stem cell transplantation (allo-HSCT), determine the conditioning regimen, enable relevant prophylactic measures and early intervention or contribute to avoid unnecessary or even harmful medication. Finally, it allows for genetic counseling and follow-up of at-risk family members. Identification of these patients in the clinical setting is challenging, as there is no consensus due to lack of evidence regarding the criteria defining the patients who should be tested for these conditions. In addition, even in cases with a strong suspicion of a MN with germline predisposition, no standard diagnostic algorithm is available. We present the first version of the Nordic recommendations for diagnostics, surveillance and management including considerations for allo-HSCT for patients and carriers of a germline mutation predisposing to the development of MNs.

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Introduction

Although the majority of myelodysplastic syndrome (MDS) and acute myeloid leukemia (AML) cases are sporadic, the introduction of next-generation sequencing (NGS) into the diagnostic work-up has revealed that hereditary MDS or AML are more common than previously thought. Estimates suggest that about 5% to 15% of adults and 4% to 13% of pediatric patients with MDS or AML carry germline pathogenic variants in cancer susceptibility genes.1–4 At the same time, several new genes associated with familial MDS or AML, with or without syndromic features, have been recently discovered, such as GATA2, ETV6, DDX41, SAMD9, and SAMD9L.5–20

In 2016, myeloid neoplasms with germline predisposition were included as a new dedicated entity in the revision of the WHO classification of myeloid neoplasms (Table 1), thus acknowledging the clinical importance of recognizing these disorders during the diagnostic work-up of patients with MN.21 Consideration of MDS or AML germline predisposition syndromes has also been integrated in the clinical management guidelines of patients with MDS or AML of the European Leukemia Net and the National Comprehensive Cancer Network.22,23 In addition, experts in this field have provided recommendations on which patients should be investigated for germline predisposition syndromes, and how such patients and families should be managed.24–31 For specific disorders such as Fanconi anaemia,32 Shwachman-Diamond syndrome,33 Diamond-Blackfan anaemia,34 and telomere biology disorders35 consensus guidelines already exist, but for the other rare disorders predisposing to MDS and AML, international recommendations and guidelines for adult patients have not yet been developed.36

Recognition of a specific germline predisposition in a patient with MDS or AML is important not only for psychological reasons providing an explanation for the disease, but also because of clinical implications as it may tailor therapy, dictate the selection of donor for allogeneic hematopoietic stem cell transplantation (allo-HSCT) and determine the conditioning regimen.37 For disorders with extra-hematopoietic manifestations, a molecular diagnosis may enable prophylactic measures, early intervention or contribute to avoid unnecessary or even harmful medication.38 Finally, it allows for genetic counseling and follow-up of at-risk family members.39

The rarity of hereditary MDS and AML combined with the heterogeneous clinical presentation makes identification of these patients challenging. For this reason, the Nordic MDS study group (NMDSG) decided to establish a working group with the purpose of creating and implementing common Nordic clinical guidelines to ensure uniformity in diagnostic procedures and management of patients and their family members at risk. The working group members are hematologists, pediatricians, and clinical/medical geneticists from Sweden, Norway, Finland, and Denmark. The initial focus of the working group was on the adult patients with MDS or AML and a germline predisposition, but hopefully these guidelines may also be of value in other settings.

This document is based on a review of the current literature and presents the first version of Nordic recommendations for diagnostics, surveillance and management including considerations for allo-HSCT for adult patients and carriers of a germline mutation predisposing to MDS or AML. It will be also posted on the NMDS website (NMDS.org) and updated regularly.

Which patients should be tested for germline conditions predisposing to myeloid neoplasms

Who should test patients suspected for germline disorders

Diagnostic genetic testing for germline variants in patients with MDS or AML may be performed by the clinical/medical geneticist as part of genetic counseling or requested by a specialized hematologist without prior referral to genetic counseling, depending on the legislation of each country. As the genetic investigation of suspected myeloid germline disorders is challenging, close collaboration between the hematologist who is more likely to identify these patients and the geneticist responsible for the actual testing, is mandatory. However, it is important that genetic counseling is offered to all patients investigated for potential germline conditions, even if no pathogenic variant is detected.

Genetic counseling is highly recommended prior to genetic testing of all apparently healthy relatives for germline predisposition for myeloid neoplasms (predictive and presymptomatic testing) including predictive testing of HLA-identical potential family donors.

Criteria for whom to test

For the development of the following criteria a number of factors have been considered, namely:

- Age
- Family history
- Personal medical history
- Clinical/physical findings
- Genetic characterization of the clonal cells
- Recommendations published in the recent literature
- Our clinical experience thus far.

A: Patients with positive family history or signs/symptoms indicative of a hereditary condition predisposing to myeloid neoplasms (MN) especially MDS and AML.

A1: Patient with MDS or AML and symptoms/signs of a hereditary condition predisposing to MN development1 diagnosed before the age of 50.

A2: Two individuals (first or second-degree relatives, FDR, and SDR, respectively) with MDS or AML or long-lasting thrombocytopenia or symptoms/signs indicative of a hereditary condition predisposing to MN development1, one of whom diagnosed before the age of 50.

A3: One individual with MDS or AML and two FDR or SDR with a diagnosis of solid tumor malignancy2 one of whom diagnosed before the age of 50.

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1 Excessive toxicities with chemotherapy or radiation, multiple cancer diagnoses, therapy-related leukaemia, poor stem cell mobilization of a sibling candidate donor (reported in rare cases related to TERC and RUNX1 germline variants)26–30, consanguinity, skin or nail abnormalities, unexplained liver disease, pulmonary fibrosis or alveolar proteinosis, short stature, microcephaly or characteristic skeletal abnormalities or other congenital abnormalities, Café au lait spots, hypopigmented macules, lymphedema, immune deficiencies, atypical infections, excessive warts (Table 1).

2 other haematological malignancies or cancer forms suggestive of constitutional mismatch repair deficiency syndrome, Li-Fraumeni syndrome, BRCA2 related syndromes (such as sarcomas, adenocortical carcinomas, brain tumours, gastrointestinal, genitourinary, breast, ovarian and pancreas cancer). It should be noted that a number of conditions included in criterion A may appear with atypical or no clinical stigmata, therefore a detailed personal and family history including various generations pedigrees is needed. In order to facilitate the acquisition of such a history a questionnaire proposed by Churpek et al.35 from the Chicago group could be used.
### Table 1
Overview of germline conditions predisposing for myeloid neoplasms (adapted from WHO 2016 book chapter and NCCN MDS v1.2019)

| Genetic syndrome with germline predisposition without a pre-existing disorder or organ dysfunction | Gene(s) | Inheritance pattern(s) | Characteristic haematological malignancies | Lifetime risk for myeloid malignancies | Other phenotypes and clinical features | Diagnostic testing |
|--------------------------------------------------------------------------------------------------|--------|------------------------|--------------------------------------------|---------------------------------------|--------------------------------------|--------------------|
| Acute myeloid leukemia with germline CEBPA mutation | CEBPA  | AD | AML | >80% | – | DNA sequencing including del/dup analysis |
| Myeloid neoplasms with germline DDX41 mutation | DDX41  | AD | MDS, AML | Unknown, probably high but mostly in older age | OML, OMML and lymphomas have also been reported | DNA sequencing |
| Chromosome 14q32 duplication syndrome | 14q32 genomic duplication | AD | AML, MPNs, OMML | High prevalence in the 5 families reported | – | Del/dup analysis |

| Myeloid neoplasms with germline predisposition and pre-existing platelet disorders | RUNX1  | AD | MDS, AML | ~45% | Thrombocytopenia and abnormal platelet function; clonal hematopoiesis; ALL | DNA sequencing including del/dup analysis |
|--------------------------------------------------------------------------------------------------|--------|------------------------|--------------------------------------------|---------------------------------------|--------------------------------------|--------------------|
| Myeloid neoplasms with germline ANKRD26 mutation | ANKRD26 | AD | AML, MDS, OML | 8% | – | DNA sequencing including del/dup analysis |
| Myeloid neoplasms with germline ETV6 mutation | ETV6   | AD | ALL, AML, MDS | Unknown | Thrombocytopenia and mild bleeding manifestation | DNA sequencing |

| Myeloid neoplasms with germline predisposition and other organ dysfunction | GATA2  | AD | MDS, AML | >80% | – | DNA sequencing including del/dup analysis |
|--------------------------------------------------------------------------------------------------|--------|------------------------|--------------------------------------------|---------------------------------------|--------------------------------------|--------------------|
| MRAGE syndrome | S4MD9  | AD | MDS, AML with monosomy 7 | High, spontaneous resolution through revertant mosaicism possible | – | DNA sequencing |
| Aplastic anemia syndrome | S4MD9L | AD | MDS, AML with monosomy 7 | High, spontaneous resolution through revertant mosaicism possible | – | DNA sequencing |
| Bone marrow failure syndrome 1 (BMM1/SP72) | SRP72  | AD | MDS | Unknown | Cytopenias and marrow failure; growth restriction, infection susceptibility, adenocarcinoma, general phenotypes, and enteropathy. | DNA sequencing |
| Fanci anemia | FANCA  | XLR | MDS, AML | ~10% | – | DNA sequencing including del/dup analysis |
| Severe congenital neutropenia | ELANE, CSF3R, GFI1, SRP54 | AD | MDS, AML | 21–40% | Severe neutropenia | DNA sequencing including del/dup analysis |
| Swashman-Diamond syndrome | HAX1, G6PC3, JAG1, UPS1 | AR | MDS, AML | 5–24% | Neutropenia, pancreatic insufficiency, short stature, skeletal abnormalities | DNA sequencing including del/dup analysis |
| Diamond-Blackfan anaemia | RPS19, RPS17, RPS24, RPL5A, RPL5, RPL11, RPL15, RPL26, RPS7, RPS10, RPS29 | AR | MDS, AML | <5% | Aplastic anemia and severe erythroid hypoplasia. Small stature, congenital anomalies (e.g. craniofacial, cardiac, skeletal, genitourinary) | DNA sequencing including del/dup analysis |
| GATA1 | XLR | – | – | – | Elevated erythrocyte adenosine deaminase | – |

(continued)
| Genetic syndrome | Gene(s) | Inheritance pattern(s) | Characteristic haematological malignancies | Lifetime risk for myeloid malignancies | Other phenotypes and clinical features | Diagnostic testing |
|------------------|--------|------------------------|--------------------------------------------|----------------------------------------|----------------------------------------|--------------------|
| **Telomere biology disorders** |
| DKC1 | XLR | MDS, AML | 2–30% | Bone marrow failure, nail dystrophy, abnormal skin and pigmentation, oral leukoplakia, early hair graying, pulmonary fibrosis, hepatic fibrosis, squamous cell carcinoma | DNA sequencing including del/dup analysis | Telomere length analysis |
| TERT, TERC, TINF2, RTEL1, PARN, ACD | AD | | | | |
| NOP10, NHP2, WRAP53, RTEL1, TERT, CTC1-PARN, | AR | | | | |
| **Down syndrome** |
| Trisomy 21 | 95% De novo, 5% translocation | Transient abnormal myelopoiesis/AML, Acute megakaryoblastic leukemia, ALL | 10% (transient abnormal myelopoiesis) | All, lymphomas, AML, MDS | Down syndrome: multiple congenital anomalies, dysmorphic features, intellectual disability | Karyotype |
| **RASopathies** |
| CBL, KRAS, NF1, PTPN11 | AD | | | | | DNA sequencing |
| **Constitutional mismatch repair deficiency** |
| MLH1, MSH2, MSH6, PMS2, EPCAM | AR | ALL, lymphomas, AML, MDS | Unknown, risk ~30% for lymphoma/ALL | | DNA sequencing including del/dup analysis |
| **Bloom syndrome** |
| BLM | AR | ALL, AML, MDS, lymphoma | 15% | | DNA sequencing including del/dup analysis |
| **LIG4 syndrome** |
| LIG4 | AR | MDS | Rare (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5000938/) | Short stature, microcephaly, Immunodeficiency combined, pancytopenia & myelodysplastic syndrome | DNA sequencing including del/dup analysis |
| **Li Fraumeni syndrome** |
| TP53 | AD | ALL, MDS, AML | 2–4% | High risk for cancer (50% by age 30 years and 90% by age 60 years) especially high risk for adenocortical carcinoma, brain cancer, breast cancer, chondroid plexus carcinoma, colon cancer, lung cancer, sarcoma, other tumors. | DNA sequencing including del/dup analysis |
| **Other bone marrow failure syndromes** |
| MECOM | AD | MDS, AML | Unknown | Skeletal/cardiac abnormalities, neurological defects | DNA sequencing |
| ERCC6L2 | AR | | | | |

AD = autosomal dominant; ALL = acute lymphoblastic leukemia; AML = acute myeloid leukemia; AR = autosomal recessive; CML = Chronic Myeloid leukemia; CMML = chronic myelomonocytic leukemia; JMML = juvenile myelomonocytic leukemia; MDS = myelodysplastic syndrome; XLR = X-linked recessive. Risks for development of myeloid malignancies have been based on: The 2016 revision to the World Health Organization classification of myeloid neoplasms and acute leukemia, McGar et al 2016, ASH educational book 2016/2017 and GeneReviews (https://www.ncbi.nlm.nih.gov).
A4: ≥3 FDR or SDR with MN or long-lasting thrombocytopenia or symptoms/signs indicative of a hereditary condition predisposing to MN development, independently of age.

B: Patients with MN where the diagnostic work-up for the determination of the somatic genomic background has detected gene variants suspected to be germline (near heterozygous or near homozygous).

A number of genes that causes hereditary MN can also be somatically mutated in sporadic cases. Classical examples are variants within the RUNX1, GATA2, TP53, ETV6 and CEBPA genes.40,41 Analysis of such variants with the advent of NGS panels is performed routinely as part of the diagnostic work-up for MDS and AML patients, especially in young individuals. The Variant Allele frequency (VAF) of a specific variant detected on the somatic NGS panel can suggest that the variant may be of germline origin, when the VAF is 40% – 60% [near-heterozygous] or >90% [near-homozygous].4,42 In such cases further testing of extra-hematological tissue for the respective variant is highly recommended after obtaining the patient’s consent. The detection of a pathogenic germline variant through a somatic gene panel is more likely in younger patients with MDS or AML (<50 years) but may also be identified in older age groups. Particularly, variants in the DDX41 gene are associated with MDS and AML between 55 and 65 years of age. Furthermore, the type of variant may be of importance, for example truncating variants in the DDX41 gene are usually of germline origin.12,13 It should be highlighted that the majority of the NGS panels used in the current clinical setting are designed for the detection of somatic variants, therefore a normal result does not preclude the possibility of a germline variant in regions not included in the actual analysis.

C: Patients not fulfilling the criteria A and B diagnosed with MDS or AML before the age of 50 carrying aberrations of chromosome 7 [monosomy 7/del(7q)/der(7)].

A family or personal history without any suspicion of a hereditary disorder does not exclude an underlying predisposing germline variant.43 De novo mutations, gonadal mosaicism, genetic reversion, variable penetrance and expressivity may explain the absence of distinctive clinical features. It is well explained that early cancer debut strongly implies heredity.4 Moreover, several reports in the literature favor genetic testing for hereditary conditions predisposing to MN for all young patients.5,47 That said and for the time being, our working group proposes that among young patients (<50 at diagnosis) without a family or personal history only those with aberrations of chromosome 7 (monosomy 7/del(7q) or other aberrations with loss of 7q material), which is particularly common in GATA2- and SAMD9/SAMD9L-related disorders,16,17,44–46 should be further referred for genetic counseling/testing.

Preliminary data suggest that specific somatic gene variants may be over-represented in some disorders predisposing to MN,10,47–49 They may in the future prove to be useful indicators to identify patients with MN who do not meet the standard criteria for genetic testing for a predisposing germline variant.49

We think that testing all young patients independently of family/personal history could be performed primarily in the context of clinical trials rather than in the clinical setting, at least for the time being. If, however, resources are available and national guidelines approve, genetic counseling/investigation for MDS or AML predisposing syndromes could be offered to all young patients.

Limitations of the proposed criteria to take into consideration

It is important to highlight that the current criteria are focused mainly on known genetic predisposition syndromes to MDS or AML. The proposed age threshold of 50 years at the time of diagnosis is arbitrary and conditions such as predisposition to MDS or AML due to germline DDX41 mutations15 or patients debuting at a later age than expected may be underrepresented. Moreover, a number of genetic aberrations predisposing to the development of myeloid neoplasms may have not yet been identified; therefore, some patients may not fit the aforementioned criteria. However, they may still be eligible for genetic counseling/investigation. In case of any clinical suspicion of a hereditary condition not included in the following criteria, a referral to an institution with expertise in the field is recommended.

How should patients with MN and suspicion of germline predisposition be genetically investigated

Different approaches to genetic testing exist between the Nordic countries and even within each country. This is primarily due to various organizational structures and access to funding. Genetic testing should be performed with the aim to detect both single nucleotide variants (SNVs) and copy-number variations (CNVs). Taking into consideration the number of the investigated genes, comprehensive genetic analysis for these rare diseases can be only performed with the advent of NGS, with the prerequisite that such a technology is available in the clinical setting. It is not our goal to provide guidelines on the actual method that should be used, as long as the genetic testing is performed following validated and accredited methodologies. Instead, we propose a number of genetic conditions that should be assessed in all patients fulfilling the abovementioned criteria (Table 1). As a suggestion and in order to provide solid and timely genetic testing for patients fulfilling criteria A and C we propose upfront the performance of either whole exome sequencing (WES), whole genome sequencing (WGS) or large NGS panels complemented with the in silico CNV calling and/or laboratory analysis for CNVs, such as microarrays testing or MLPA (multiplex ligation amplification). At the moment WGS is however, not widely established in the clinical setting, but is being investigated as an alternative method in the Nordic countries. For the diagnostic procedure of Fanconi anemia, telomere biology disorders, Shwachman-Diamond syndrome, and Diamond-Blackfan anemia we refer to the respective international guidelines.32–35

If a potential germline variant has been detected in a somatic gene panel as part of the diagnostic workup for MN (see Criteria B above), further testing of extra-hematological tissue for the respective variant is highly recommended after obtaining the patient’s consent. The patient may ideally be referred to genetic counseling for further information prior to testing of extra-hematological tissue.

Diagnostic algorithm

Please see Figure 1 for a proposal for a diagnostic algorithm. It should be highlighted that for specific syndromes such as GATA2-related disorders and ANKDR26 even noncoding regulatory regions should be covered. Functional analyses may
be of value in Fanconi anemia, telomere biology disorders, and Diamond-Blackfan anemia especially when a variant of uncertain significance is detected.

Tissue for genetic testing

Regarding the tissue that should be analyzed we recommend fibroblasts obtained after skin biopsy, especially in cases fulfilling criteria A and C. In selected cases other alternatives such as blood in remission may also be appropriate. In cases included in criterion B a stepwise procedure with targeted analysis of sorted T-cells isolated from blood may be the first step. In case of confirmation of the pathogenic variant in the T-cells, a skin biopsy should also be performed. For carrier testing of healthy family members DNA from a whole blood sample can be used. Carrier testing, presymptomatic and predictive testing of healthy relatives require genetic counseling before and after genetic testing.

Genetic counseling

All patients with germline predisposition to MN should be offered genetic counseling. This also includes patients with a positive family history where the genetic pathogenic variant has not been identified. If the patient has not already received genetic counseling as part of the diagnostic procedures, it is important to offer counseling to ensure identification of family members at risk.

Surveillance of individuals with a germline predisposition to MDS or AML

The overall goal of surveillance and monitoring of patients with a germline predisposition to MDS and AML is to ensure intervention prior to development of high-risk disease. However, uncertainty regarding penetrance and age-adjusted risk of MDS and AML transformation makes it highly challenging to time such intervention correctly. In addition, germline disorders presenting as cytopenia, inherited bone marrow failure syndromes (IBMFS) or MDS may benefit more from surveillance as opposed to germline predisposition disorders presenting primarily as overt AML, especially if they occur in the context of a cancer syndrome with more than one organ involvement.

As very little evidence-based data exist on the efficacy and benefit of surveillance in individuals with germline predisposition to MDS and AML, published recommendations for surveillance are solely based on expert opinion.\(^{26,28,38,44,50}\) For the classical IBMFS like Fanconi anemia, Shwachman-Diamond syndrome, Diamond-Blackfan anemia, and telomere biology disorders guidelines for surveillance already exist and should be followed when indicated in both children and adults.\(^{32-35,51}\)

For whom is surveillance indicated

These recommendations for surveillance are intended for:

- Individuals with a deleterious or likely deleterious genetic variant associated with a germline predisposition regardless of clinical presentation.
- Individuals who fulfill the clinical diagnostic criteria for a myeloid neoplasm with a germline predisposition even if the pathogenic genetic variant is undetermined.

The recommendations do in general not apply to individuals with a variant of uncertain significance (VUS) in whom clinical diagnostic criteria for a specific predisposition disorder are absent.

If presymptomatic testing is impossible due to an unidentified pathogenic variant, and the family history is highly suggestive of hereditary MDS and AML, first-degree relatives to an affected

Figure 1. Diagnostic algorithm for the detection of germline variants predisposing to myeloid neoplasms (NMs). The algorithm is adjusted depending on the criterion which is fulfilled and aims in the detection of both single nucleotide variants (SNVs) and copy-number variations (CNVs). AML = acute myeloid leukemia; MDS = myelodysplastic syndrome; VUS = variant of unknown significance; WES = whole exome sequencing; WGS = whole genome sequencing.
Bone marrow aspirate/biopsy

Bone marrow aspirate/biopsy should not be routinely repeated if the CBC values are stable and other indications of progressive disease are absent. American guidelines in children and adults recommend annual bone marrow aspirate/biopsy in high-risk disorders, \(^{38,50}\) because blood counts may not be sensitive enough as a marker for progression. However, it is the experience of the working group that asymptomatic carriers do not in general consent to annual bone marrow aspirate/biopsies and that the lack of compliance is not outweighed by the benefits of the procedure.

If deterioration of blood counts occurs on consecutive CBC, a bone marrow biopsy/aspirate is mandatory to examine for changes in bone marrow cellularity, dysplasia, blast percentage, clonal cytogenetic evolution, and somatic mutations.

Regarding clonal cytogenetic evolution it is important to note that some acquired aberrations like monosomy 7/del(7q)/der(1;7) and a complex karyotype are associated with high risk of malignant transformation, whereas others do not increase leukemic risk and can remain stable for long periods of time or even disappear. Isochromosome 7q and del(20q) in Shwachman-Diamond syndrome are examples of cytogenetic aberrations without associations to disease progression. \(^{58,59}\)

Testing of peripheral blood for somatic mutations

There was consensus in the working group about the potential value of annual blood testing for somatic gene mutations with an NGS gene panel targeting myeloid genes with high coverage and reading depth. This recommendation is based on recent reports which highlight the emergence of clonal hematopoiesis associated with increased risk for the development of MDS or AML in hereditary conditions, mainly those related to germline GATA2 and RUNX1 mutations. \(^{49,64,65}\) The frequency of testing for somatic mutations and the clinical implications are however, undefined in most other patients with germline predisposition to MDS or AML. Nevertheless, appearance in the blood of a new somatic mutation or a persistent or steep increase in variant allele frequency of an already existing clone should lead to further investigations including a bone marrow aspirate/biopsy in exactly the same way as emerging cytopenia (see “Complete blood count” above). The emergence of a clone should not solely be an indication for clinical action. \(^{6}\) The gene, the VAF, the number of pathogenic variants as well as the dynamics over time should be taken into account. It should also be noted that the above-mentioned myeloid NGS panels are designed to include the great majority of potential somatic genomic aberrations that occur at the MDS or AML transformation, however they are restricted in their targets and a normal result cannot exclude somatic variant in genes not included in the panel-design.

For an overview of baseline and follow-up investigation of individuals with a germline predisposition see Table 2.

Management and surveillance of other organ dysfunction

Patients with germline predisposition to MDS/AML with risk of other organ dysfunction must be referred by the hematologist or relevant medical disciplines/specialties to ensure screening for solid tumors and organ dysfunction depending on the specific risks and according to existing guidelines. \(^{10,32–35}\)

Work-up for patients with a germline predisposition to MDS or AML

Baseline

Initially all patients should have a diagnostic work-up for MN including a complete blood count (CBC) with manual differential, a bone marrow aspirate/biopsy with cytogenetic analysis and testing for somatic mutations using a myeloid gene panel according to the NMDSG guidelines. These investigations serve to exclude MDS or a manifest bone marrow failure disorder and as a baseline for subsequent comparison. It is important to recognize that asymptomatic carriers may present with varying blood counts ranging from normal CBC to mild or severe cytopenia. Also, carriers of RUNX1, ANKRD26 and ETV6 variants may have thrombocytopenia or bleeding tendency without thrombocytopenia at baseline. \(^{20,32–57}\)

Follow-up

At the moment it is debatable how often routine follow-up investigations should be performed to monitor for disease progression.

Complete blood counts

The working group agreed that CBC should be repeated every 6 months particularly in high-risk patients i.e. those with pathogenic variants in GATA2, RUNX1 or Fanconi complex genes.

If changes to abnormal values in blood counts develop, CBC should be repeated within a few weeks, other causes of cytopenia should be excluded, and a bone marrow biopsy/aspirate should be performed. Even a slight drop in thrombocytes just below normal range should warrant further investigations. See below.
Table 2

| Follow-up of individuals with a germline predisposition to MDS/AML | Baseline | Follow-up |
|---------------------------------------------------------------|----------|-----------|
| Complete blood count (CBC)                                    | YES      | Every 6 months |
| Bone marrow aspirate/biopsy                                    | YES      | Only in case of change in CBC |
| NGS-myeloid gene panel                                         | YES (bone marrow) | Once a year* (blood) |
| Control of other relevant organs                               | As indicated depending on the underlying condition | As indicated depending on the underlying condition |

CBC = complete blood count; NGS = Next-generation sequencing.

*The emergence of a clone should not solely be an indication for action. The gene, the variant allele frequency (VAF), the number of pathogenic variants as well as the dynamics over time should be taken into account.

Referral to genetic counseling when family planning is relevant

Patients with germline predisposition to MDS/AML should be referred to genetic counseling when family planning is ongoing and preferably before pregnancy. At genetic counseling the couple should be informed about the risk in their offspring of inheriting the predisposition and options, if any, for prenatal diagnostics.

Considerations for allo-HSCT

As the hereditary myeloid disorders are highly heterogeneous it is outside the scope of the present guidelines to provide fully comprehensive recommendations regarding allo-HSCT. Instead this section contains general suggestions regarding indication, timing, donor selection, conditioning and follow-up of allo-HSCT for patients with “myeloid neoplasms with germline predisposition”. Please note that especially the timing and the indication for allo-HSCT are based on expert-opinion due to the novelty and rarity of these syndromes.

Indication for allo-HSCT

All patients of a suitable age, who have developed MN on the basis of a genetic predisposition except those diagnosed with AML associated with germline variants in CEBPA, are potential candidates for allo-HSCT (see below). It should be highlighted that each case should be referred for discussion with an expert transplantation panel that may include international specialists in the field.

Timing of allo-HSCT

The exact diagnosis according to the WHO 2016 classification for myeloid neoplasms influences when allo-HSCT should be performed.

A: Myeloid neoplasm with germline predisposition without a pre-existing disorder or organ dysfunction

Patients with germline CEBPA mutations have no absolute indication for allo-HSCT in CR1 because they can experience long remissions after conventional chemotherapy, but the risk of new leukemic clones is still high, therefore allo-HSCT may be considered at some time point in these patients. AML patients with germline DDX41 mutations are often older and no specific recommendation regarding allo-HSCT can be made at the moment due to lack of data.

B: Myeloid neoplasm with germline predisposition and pre-existing platelet disorder

For the time being there is no indication for allo-HSCT until the development of a MN.

C: Myeloid neoplasm with germline predisposition and other organ dysfunction

These syndromes show high risk of developing MN with a relatively early onset. Therefore, allo-HSCT could be considered before transformation occurs to prevent mortality due to other manifestations (GATA2 related disorders). In some individuals, even organ dysfunctions or life-threatening immunodeficiency may represent an indication for allo-HSCT. Timing of allo-HSCT in patients in this subgroup must be discussed with an expert panel that may even include international experts.

Donor selection

It is crucial to refrain from using an affected family member or an asymptomatic known carrier as donor in order to avoid graft failure and/or donor derived leukemia. In families with an identified germline predisposing pathogenic variant we recommend genetic testing of any potential compatible donor in the absence of any signs/symptoms before HSCT. The genetic testing of a potential donor must be performed in respect of the individual’s integrity and right “not to know” his or her carrier status. Genetic counseling is strongly recommended before testing if feasible. This procedure may take time, and in such cases a well-matched unrelated donor may be first choice to avoid harmful delay of the transplantation.

In families with a positive family history where the underlying genetic cause has not been identified an unrelated donor may be preferred even in the presence of phenotypically “healthy” matching family donors. However, donor selection must depend on availability and match.

Conditioning regimen

Individuals with IBMFS, like Fanconi anemia and telomere biology disorders, show an increased sensitivity to chemotherapy and specific dose-reduced conditioning regimens are recommended (for more information please see the respective treatment recommendations). Reduced intensity conditioning transplantation can also be used for patients with GATA2 related syndromes before they have transformed because functional and numeric defects in the immune and hematopoietic stem cells will allow it.

Follow up after allo-HSCT

Allo-HSCT increases the risk for secondary tumors, but many patients within the category “myeloid neoplasm with genetic predisposition and other organ dysfunction” have a specifically high risk so they should be monitored even more closely after allo-HSCT (Table 1). See Table 1.
Concluding remarks
Germline predisposition to myeloid neoplasms is a new and rapidly emerging field, which significantly impacts therapy and care of involved patients and family members. Hence it is crucial that hematologists and clinical/medical geneticists have the basic knowledge to suspect a germline disorder. These Nordic guidelines are intended to support clinicians when dealing with patients with a potential germline predisposition to MDS or AML. The working group is aware that the criteria for genetic testing are conservative reflecting the fact that genetic testing is not widely available in all Nordic countries. However, this approach is aimed at identifying highly penetrant germline disorders, and as mentioned above the recommendations need to be updated and revised regularly.

At present we lack understanding on many biological and clinical aspects of the well-known and new germline disorders with increased risk of MDS or AML. Joint research projects and registries are urgently needed, and urgent need for large-scale genetic and clinical/medical geneticists with special interest and expertise in the field to actively take part in such research activities.

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