

ALL

B-cell 1-9 yrs
good prognosis.

T-cell >10 years peak
♂:♀ 4:1

Testicular
mediastinal
CNs

In infantile
poor prognosis
t(4,11)

↑WBC
massive H.Smegally.

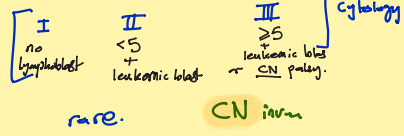
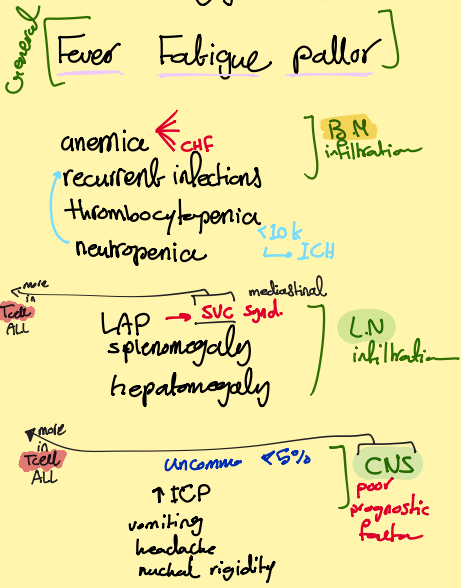
Philadelphia chr. tve. ✓ TKI imatinib
✓ HSCT.

Blast >5% of total BM cells.
peak 2-5 years
♂ > ♀

Leukemia

75% ← MC ped. malignancy → 20%

#Clinical features#



-Testicular involvement.
-Bone & joint.

AML

♀ = ♂

#Predisposing F: -

Down Good prognosis
Fanconi anemia
Kostman synd.
Bloom synd.
diamond blackfan anemia.

21q → ionizing Radiation
myelo dysplasti-pro lifer
drugs ⇒ cyclophosphamide Melphalan
Grapaside.

SC nodule / blueberry muffin. infant.
infiltr of gingiva M5
DIC M3 APL. t(15-18) J ATRA
mass = chloasma / Granulocytic sarcoma. M2
t(8:21)

M4 t(16,16) inv
Down's M7
Good

≥20% blast.

Most important chemotherapy agent in the treatment of AML is:
Anonymous Quiz
65% Cytrabine

① Induction of remission

BM aplasia = elimination of leukemic cells
[prednisone ... + cytotoxic agents]
4.5 weeks

② Consolidation
8-10 wks
↑MTX.

③ Maintenance

MTX 6 Mercaptopurine
prolong test. recur.
2.5 - 3 years.

HSCT Indications

hematopoietic stem cell Transplant:-

- Induction failure X

- Philadelphia +ve ALL

- Infantile ALL.

- hypodiploidy <45

- Early isolated CNS relapse

- Early B.M relapse.

- ▶ For prophylaxis of CNS leukemic disease intrathecal application of MHA before, during, and after remission has to be performed.
- ▶ The addition of preventive irradiation is probably necessary in children at high risk of ALL as determined in most studies