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Acute cerebellar syndrome after high dose cytosine arabinoside treatment: case report

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Objective: Cytosine Arabinoside (cytarabine, ARA-C) discovered in the early 1950s from crptathetia crpta which is a type of sponge. It is a chemotherapeutic agent that is an analogue of primidine from the group of antimetabolites and it is used in AML (acute myeloid leukemia), ALL (acute lymphoblastic leukemia), CML (chronic myeloid leukemia), relapse or refractory hodgkin lymphoma, non-hodgkin lymphoma, primary central nervous system lymphoma treatment. The most common side effect is cytopenias due to the bone marrow suppression. In addition; side effects may occur such as nausea, vomiting, diarrhea, abdominal pain, hepatic dysfunction, neurological side effects. Beside many neurological side effects such as peripheral neuropaty, convulsion, cerebral dysfunction can be seen in systemic and intrathecal treatments, classical cytarabine neurotoxicity is acute cerebellar syndrome caused by high-dose systemic therapy.

Case report: A 61 year-old man who had lung cancer history and not suitable for allogeneic stem cell transplantation; was planned HyperCVAD A/B chemotherapy protocol with the diagnosis of B-ALL. Dysarthria and impaired coordination of hand and foot movements occurred on the sixth days of second cycle of HyperCVAD-B chemotherapy. In neurologic examination, dysarthric speech, measured and sequential motion tests for cerebral examination was failed and no motor deficits. No mass or vascular pathology were detected in imaging examinations that could explain the patient's complaint. As a result, the patient was evaluated acute cerebellar syndrome caused by high dose cytosine arabinoside side effect by neurology department. From the eleventh day of treatment patient's complaints was regressed and come back to normal at fifteenth days of treatment.

Conclusion: Acute cerebellar syndrome begins 3–8 days after the start of drug administration. Cerebellar symptoms such as dysarthria, dysdiadokokinesia, dysmetry and ataxia greatly improved after stopping the drug however these symptoms may not full recover in approximately 1/3 of patients. Therefore there is not any treatment for neurological side effects, it should be kept in mind in chemoterapy treatment planning. While planning treatment, dose adjustment considering side effects as performance and age of patient. Nearly monitored is most important for early diagnosed of neurological symptoms.

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PP 03

An unusual case report: myeloid sarcoma presented with appendicitis

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Objective: Myeloid sarcomas (MS) also called as granulocytic sarcomas, myeloblastoma or chloromas are the representatives of extramedullary infiltrates of immatur myeloid cells. According to 2016 revısıon to the World Health Organization classification of myeloid neoplasms and acute leukemia; it is classified a subgroup of Acute myeloid leukemia (AML) and related neoplasms. MS has more aggressive clinical course than AML. MS may present simultaneously with or precede bone marrow disease or may be seen in relapse. Isolated myeloid sarcoma involvement is most frequently detected in the bone, periosteum, soft tissues and lymph nodes. Herein we reported an unusual case of a 44 year old man who presented to appendicitis and diagnosed with MS with appendicitis pathology report.

Case report: A 44 year-old man who had no history of smoking, alcohol or any chronic disease, was admitted to the hospital with sudden abdominal pain, nause and vomiting. The patient, who was diagnosed with appendicitis and was underwent appendectomy. The patient's appendectomy result was reported as MS. In the blood test examination; white blood cells (WBC): $43.2 \times 10^3/\mu L$; neutrophil: $36.3 \times 10^3/\mu L$; monocyte: $2 \times 10^3/\mu L$, hemoglobin:11.5 g/dL, and plateletes:$100 \times 10^3/\mu L$ were detected. Peripheral smear was applied to the patient due to leukocytosis. Blastic cell infiltration was detected in peripheral smear and the patient underwent bone marrow biopsy. More than 20% monoblasts were observed in bone marrow aspiration. Flowcytometric examination was performed and immunfenotypic finding MS of the patient were interpreted of AML M5. Remission induction chemotherapy (daunorubucin 60 mg/m^2 110 mg/daily throughout 3 days and ARA-C 100 mg/m^2 180 mg/daily, throughout 7 days) was planned.

Conclusion: Hematological malignancies could involve extramedullary soft tissue in relatively rare cases. MSs are rare extramedullary tumors, most commonly occur in patient with acute or chronic myeloid leukemia (1–3). De novo MS may represent the first sign of systemic disease. Untreated MS usually progress to AML in about 1 year. The clinical presentation of MS depends on location, size of mass. In the current case a sudden right lower abdominal pain, nause and vomiting due to blastic infiltraion and obstruction of appendix were initial symptoms. Total excision of the mass is to gold standard for diagnosis. In the current case, appendix patology results showed that monoblastic and localize inflitration of cell form of monocytoid with large nucleolus, prominent nucleoli, wide cytoplasm, Ki 67 proliferative activity >. There is no consensus of MS treatment. Recommended treatment regimen for isolated MS or MS with AML is conventional AML protocols. In conclusion, MS is a subgroup of AML present with myeloblastic