TABLE 8. Hematologic Toxicities (continued)

8.4 Aplastic Anemia

Grading	Management
G1: mild: > 0.5 PMNs × 10^9/L hypocellular marrow, with marrow cellularity < 25%, Peripheral platelet count > 20,000, reticulocyte count > 20,000	Hold ICPi, provide growth factor support, and close clinical follow-up and laboratory evaluation. Supportive transfusions as per local guidelines.
G2: moderate: Hypocellular marrow < 25% and two of the following ANC < 500, peripheral platelet < 20,000 and reticulocyte < 20,000	Hold ICPi and provide growth factor support and close clinical laboratory evaluations daily. Hematology consult Administer horse ATG plus cyclosporine. Supportive transfusions as per local guidelines. All blood products should be irradiated and filtered. HLA typing and evaluation for bone marrow transplantation if patient is a candidate.
G3-4: severe: ANC < 200, platelet count < 20,000, reticulocyte count of < 20,000, plus hypocellular marrow < 25%.	As per G2 Hold ICPi and monitor weekly for improvement. If not resolved, discontinue treatment until AE has reverted to G1. If no response, repeat immunosuppression with rabbit ATG plus cyclosporine, and cyclophosphamide. For refractory patients, consider eltrombopag plus supportive care.

8.5. Lymphopenia

Workup and evaluation
- History (special attention to nutritional status and for lymphocyte depleting therapy such as fludarabine, ATG, steroids, cytotoxic CTX, and radiation exposure, as well as history of AD and family history of AD)
- Physical examination with special attention to spleen size
- CBC with differential, peripheral smear, and reticulocyte count
- CXR for evaluation of presence of thymoma
- Bacterial cultures and evaluation for infection (fungal, bacterial, and viral—specifically CMV or HIV)

Grading	Management
All grades	No specific action is required for lymphopenia G1-G3 and ICPi therapy should be continued. For G4 (< 250 PB lymphocyte count), continue ICPi therapy and initiate *Mycobacterium avium* complex prophylaxis and *Pneumocystis jirovecii* prophylaxis, CMV screening. HIV or hepatitis screening if not already done. May consider EBV testing if evidence of lymphadenopathy or hepatitis, fevers, and hemolysis occur c/w lymphoproliferative disease occurs.

8.6. ITP

Workup and evaluation
- History and physical examination (special attention for history of viral illness and lymphocyte depleting therapy such as fludarabine, ATG, steroids, and cytotoxic therapy)
- FH of autoimmunity or personal history of AD
- CBC, peripheral blood smear, and reticulocyte count
- Bone marrow evaluation only if abnormalities in the above testing results and further investigation is necessary for a diagnosis
- Patients with newly diagnosed ITP should undergo testing for HIV, HCV, HBV, and *H. pylori*
- Direct antigen test should be checked to rule out concurrent Evans' syndrome
- Nutritional evaluation
- BM evaluation if other cell lines affected and concern for aplastic anemia

Grading	Management
G1: Platelet count 75 to < 100/μL	Continue ICPi with close clinical follow-up and laboratory evaluation.
G2: Platelet count 50 to < 75/μL	Hold ICPi but monitor for improvement. If not resolved, interrupt treatment until AE has reverted to G1. Administer prednisone 1 mg/kg per day (dosage range, 0.5-2 mg/kg per day) orally for 4 weeks followed by taper over 4-6 weeks to the lowest effective dose. IVIG may be used in conjunction with corticosteroids if a more rapid increase in platelet count is required.

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