Fifteen-minute consultation: Initial management of suspected acute leukaemia by non-specialists

Sam Behjati,1,2 Amy Ruffle,2,3 Anne Kelly,2 Emmy Dickens2

ABSTRACT
Leukaemia is the most common cancer of childhood. Most children with a new diagnosis of leukaemia are clinically stable at initial presentation. However, there are a number of life-threatening complications that have to be considered and monitored for. These complications include sepsis, tumour lysis syndrome, mediastinal masses, bleeding and pain. The aim of this article is to equip the general paediatrician with a framework for managing children with suspected leukaemia, prior to transfer to the primary treatment centre. The presentation, diagnosis and definitive treatment of acute leukaemia is not in the remit of this article.

INTRODUCTION
All paediatricians will at some point care for a child who presents with suspected leukaemia. A typical-sized district general hospital (DGH) can expect approximately three children to be diagnosed with leukaemia each year, with around 420 new cases diagnosed annually in England.1

INVESTIGATIONS
While most children presenting with a new diagnosis of acute leukaemia remain clinically stable, occasionally children can become critically unwell. Early death in leukaemia is rare, although young age, particularly those under 2 years, high white cell count (more than 100×10⁹ cells/L) and acute myeloid leukaemia (AML) are established risk factors.

It is important to discuss suspected cases of new leukaemia with the primary treatment centre (PTC) early while arranging investigations (table 1) and starting appropriate treatment (table 2). The overall aim of the initial management is to anticipate and, where required, manage complications prior to transfer.
Best practice and Fifteen-minute consultations

Table 1  Initial mandatory investigations

<table>
<thead>
<tr>
<th>Test</th>
<th>Indication</th>
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<tbody>
<tr>
<td>Chest X-ray</td>
<td>To identify a mediastinal mass, consolidation due to infection or alveolar infiltrates suggestive of leucostasis.</td>
</tr>
<tr>
<td>Serial full blood counts</td>
<td>Assessment of white cell count and rate of change, anaemia and thrombocytopenia.</td>
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<tr>
<td>Serial urea, electrolytes, creatinine, bone profile and uric acid</td>
<td>Tumour lysis syndrome is characterised by hyperuricaemia hyperphosphataemia, hyperkalaemia and hypocalcaemia leading to renal injury.</td>
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<tr>
<td>Blood cultures (if indicated)</td>
<td>Prior to starting intravenous antibiotics, blood cultures should be taken.</td>
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<tr>
<td>Group and save</td>
<td>In anticipation of potential need for blood products.</td>
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<tr>
<td>Clotting (prothrombin time, activated partial thromboplastin time and fibrinogen)</td>
<td>Disseminated intravascular coagulation is occasionally seen in association with acute leukaemia.</td>
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<tr>
<td>Blood film</td>
<td>Can usually be examined by the on-call haematologist at the referring hospital, with a second film made and sent with the child to the PTC.</td>
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<tr>
<td>Additional EDTA sample</td>
<td>Peripheral blood can be sent to the PTC for immunophenotyping, which may be sufficient to confirm or refute the diagnosis of leukaemia.</td>
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<tr>
<td>Viral serology</td>
<td>Pretransfusion viral serological tests (especially VZV) are required for every child with a new diagnosis of cancer. Typically a virology screen includes VZV, HSV1, HSV2, EBV, measles, hepatitis B and hepatitis C.</td>
</tr>
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PTC, primary treatment centre.

according to local policies. If there is clinical evidence of sepsis, manage this as you would in any child, aggressively within ‘the golden hour’.4

Tumour lysis syndrome (TLS)

TLS is a metabolic disturbance resulting from the breakdown of tumour cells. Cellular lysis causes the release and degradation of intracellular contents including nucleic acids, which have the potential to overwhelm the body’s normal homeostatic mechanisms.5 The resulting biochemical abnormalities include hyperuricaemia, hyperkalaemia and hyperphosphataemia with secondary hypocalcaemia. Uric acid precipitates within renal tubules; phosphate crystallises with calcium within soft tissues, including the kidney. Together these can result in acute kidney injury, reducing the body’s ability to excrete electrolytes, which sets up a spiral of worsening metabolic derangement and kidney failure.

It therefore follows that children at greater risk of TLS are those with a large volume of disease. These are children with a high white cell count (more than 50×10⁹ cells/L) or ‘bulky’ disease such as significant hepatosplenomegaly, lymphadenopathy or a mediastinal mass. In addition, pre-existing impaired renal function puts children at higher risk of TLS. Although TLS is most frequently seen following administration of steroids and chemotherapy agents, it can occur spontaneously.

Management of TLS is largely anticipatory to prevent its development. In acute leukaemia, some children with low count disease and without bulky disease can be managed with maintenance fluids, which can be oral or intravenous. Others at higher risk will require hyperhydration even prior to starting chemotherapy, with intravenous fluids of at least 2.5 L/m²/day.6 With the guidance of the PTC, the fluid rate may be increased if there is any evidence or significant risk of TLS. Potassium should not be added to fluids due to the risk of hyperkalaemia, even if potassium levels are very low. Children should be monitored for fluid overload, particularly children with severe anaemia and infants. In addition to records of fluid input and output, daily

Table 2  Management points to consider

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Indications</th>
</tr>
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<tbody>
<tr>
<td>Oxygen</td>
<td>Hypoxia and/or respiratory distress that might indicate severe anaemia, infection, leucostasis within the lung vasculature or a mediastinal mass.</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Broad-spectrum antibiotics following local guidelines for neutropaenic sepsis should be started if there are any concerns regarding infection irrespective of neutrophil count.</td>
</tr>
<tr>
<td>Analgesia</td>
<td>Paracetamol±oral morphine. Non-steroidal anti-inflammatory drugs are best avoided in thrombocytopenia.</td>
</tr>
<tr>
<td>Hyperhydration</td>
<td>For prevention of tumour lysis syndrome following discussion with the PTC. However, transfer to the PTC should not be delayed if there is difficulty in obtaining these drugs.</td>
</tr>
<tr>
<td>Allopurinol or rasburicase</td>
<td>Platelets, fresh frozen plasma and/or cryoprecipitate transfusion may be required to treat bleeding. Red cell transfusion should be considered carefully particularly in the context of a high or rising white cell count because the further increase in viscosity from packed red cell transfusion can precipitate complications of hyperleucostasis.</td>
</tr>
</tbody>
</table>

PTC, primary treatment centre.

or twice daily weight measurements are very useful in assessing fluid balance, especially in infants. Frusemide can be used to maintain diuresis although it should be used with caution if there is risk of leucostasis.

Allopurinol should be started in children where the clinical suspicion of acute leukaemia is high.6 It is a xanthine oxidase inhibitor, which prevents the formation of uric acid. In children either at high risk of developing TLS or with biochemical signs of the syndrome, rasburicase may be used as an alternative to allopurinol. This recombinant urate oxidase actively degrades uric acid and is a more potent therapy against TLS. However, it should be avoided in children with glucose-6-phosphate dehydrogenase deficiency as this can precipitate a haemolytic crisis. Recommended doses for allopurinol and rasburicase may differ between leukaemia treatment protocols (e.g., UKALL 20116) and pharmacopoeias such as the British National Formulary (BNF). Therefore, seek advice from your PCT on current drug doses and treatment schedules for both drugs.

Initially, TLS is an asymptomatic biochemical abnormality and your PCT will guide how frequently monitoring bloods should be taken, but this may be as often as every 4 hours in high-risk cases. Note that in very high count leukaemia, cells may haemolysed in the specimen bottle en route to the laboratory, leading to false electrolyte readings. It is therefore advisable to perform paired gas machine and laboratory electrolyte measurement when the white cell count is high. It is important to discuss any abnormalities, including both elevated and low electrolytes, early and before making corrections as these may show an evolving picture. Very occasionally, children with severe TLS will require haemofiltration.

**Box 1 The first cannula**

Children undergoing cancer treatment often become needle phobic. For the first few days, and in many cases, the first month, treatment will be given through peripheral intravenous access. Therefore, it is important to aim to minimise trauma from the very first episode of cannulation. If your patient is stable enough, take your time, use a local anaesthetic cream and distraction techniques. Get all the blood bottles ready and calculate the total volume of blood required. If possible, insert a 22G or 20G cannula with the aim of using it to bleed back for regular tumour lysis blood tests. Try to avoid dorsal hand and foot veins, which may later be needed for vincristine administration. It is also preferable for the practitioner doing the cannulation to be the person most likely to be successful on the first attempt.

**Mediastinal mass**

Children with leukaemia, particularly with T cell disease, may have mediastinal lymphadenopathy, which can cause airway obstruction. Signs and symptoms of an obstructive mediastinal mass include wheezing, stridor, orthopnoea (specifically ask about this) and signs of superior vena cava obstruction (facial swelling and prominent veins). Should a child have any symptoms or signs of a mediastinal mass, it is important to consider an early anaesthetic assessment and organise urgent transfer to the PTC. Children should be nursed sitting upright. Lying flat, even for the short duration of a CT chest, may precipitate airway obstruction.

General anaesthetic and sedation with drugs such as chloral hydrate or midazolam should be avoided if there is any suspicion of a mediastinal mass, due to the risk of precipitating airway compromise and cardiovascular instability, even in a previously asymptomatic child. This is because these drugs cause a reduction in tone in both airway and vascular structures.

**Hyperleucocytosis and leucostasis**

Hyperleucocytosis is defined as a white cell count greater than 50×10⁹ cells/L. However, this threshold is arbitrary and complications from hyperleucocytosis can be seen at lower counts, especially in AML.8 Hyperleucocytosis significantly increases the risk of morbidity and mortality. For instance, a recent case series reported a 30% mortality within 2 weeks of diagnosis in children with AML who had a white cell count of greater than 200×10⁹ cells/L. Seeking the opinion of your local consultant haematologist on the blood film appearance may help you to identify AML early and thus identify the increased risk of complications from hyperleucocytosis.

Leucostasis is the process of increased blood viscosity, poorly deformable blasts and cytokine-induced activation of the endothelium resulting in vascular obstruction and tissue hypoxia. If this process occurs in the lungs, shortness of breath, coughing and hypoxia may ensue. A plain chest radiograph may show diffuse interstitial or alveolar infiltrates. Leucostasis can also affect cerebral vessels and cause haemorrhagic or ischaemic events leading to symptoms of confusion, dizziness, tinnitus and headaches, as well as focal neurological deficits. Other manifestations of leucostasis include priapism, limb ischaemia, renal vein thrombosis and retinal haemorrhage.8

Management includes oxygen, hyperhydration and urgent discussion and transfer to the PTC. Definitive treatment is that of the underlying leukaemia, and it is important this is not delayed by other interventions. However, within an intensive care setting, apheresis or an exchange transfusion may occasionally be instigated.

**Coagulopathy**

Serious bleeding in acute leukaemia is rare with only 3% of children showing evidence of coagulopathy at diagnosis.10 There is a greater risk of serious bleeding at presentation in some children, including those with acute myeloid leukaemia (AML) and hyperleucocytosis. There is a rare subtype of myeloid leukaemia,
acute promyelocytic leukaemia, which requires aggressive correction of coagulopathy to prevent life-threatening bleeds at presentation. The Nordic group reported eight deaths (14%) from intracranial haemorrhage and/or disseminated intravascular coagulation, out of a total of 57 patients with AML and a WCC more than 200×10^9 cells/L. By contrast, significant coagulopathy is extremely uncommon in acute lymphoblastic leukaemia (ALL) with only two cases of intracranial haemorrhage seen in over 2500 children in the UKALL 2003 trial.11

Coagulation should always be checked at diagnosis, although the correlation between serious haemorrhage, coagulopathy or the use of prophylactic plasma is questionable.13 When considering correction of abnormal clotting results in the absence of bleeding, it is important to consider the potential risks of administering plasma components. Discuss any abnormal results with your PTC who will provide patient-specific guidance.

Blood product support
Although serious bleeding is rare, minor bleeding is much more common, affecting 38% of children with ALL at diagnosis.14 This is related to thrombocytopenia and therefore affects predominantly the mucosa and skin. National guidelines would advise transfusing platelets if platelet counts are less than 10×10^9 platelets/L. Raising this threshold to 20×10^9 platelets/L in febrile children routinely is no longer recommended.15 In the presence of significant bleeding transfusion should be based on the clinical situation rather than the platelet count.

At presentation, many children will be anaemic, but red cell transfusions may not be required. In hyperleucocytosis, red cell transfusion should be avoided due to the risk of complications of leucostasis such as TLS or stroke. Therefore, the conventional transfusion thresholds for children undergoing chemotherapy (below 70–80 g/L15), do not necessarily apply at presentation, and discussion with the PCT is advised before giving red cells. When transfusion is required due to severe anaemia, in the context of hyperleucocytosis, smaller volumes are often used, such as 5 mL/kg over 4 hours, in parallel with hyperhydration.

At diagnosis, UK national guidelines16 do not recommend any special blood product requirements as all blood products are now hepatitis E negative and leucodepleted. However, your own PTC may have local guidelines regarding cytomegalovirus-screened blood products and also suggest viral serology testing before transfusion. There is no specific evidence to guide the optimum haemoglobin transfusion threshold, although current practice would suggest that a threshold between 70 g/L and 80 g/L may be reasonable.

Pain
Pain is surprisingly common at presentation in leukaemia with 43% of children having limb pain at presentation14 and this may be under-recognised. Surrogate markers of pain can be useful, such as not using limbs and being clingy or unsettled. Non-steroidal anti-inflammatory drugs are best avoided due to their effects on platelet function in a child who is already at risk of thrombocytopenia due to their underlying disease. In this context, oral morphine sulphate may be useful. Attempts should also be made to minimise procedural pain (box 1).

COMMUNICATION
It is essential to tell the family that a diagnosis of leukaemia is suspected prior to transfer to the PTC. Families need to be prepared that they will be transferred to an oncology ward, which can identified as such from signs, posters and patients. Similarly, children should be given age appropriate information. While a detailed discussion of how to break bad news is beyond the scope of this article, there are some specific points we would like to highlight about communicating a diagnosis of suspected leukaemia (box 2).

Clinical bottom line

- Communicate early with your primary treatment centre.
- Most children presenting with acute leukaemia are clinically stable yet have the potential to deteriorate and require intensive clinical care.
- Monitoring for complications should include infection, tumour lysis syndrome, hyperleucocytosis and coagulopathy.
- Ensure appropriate analgesia; some children will require oral morphine for adequate pain relief.
- Parents should be aware that you suspect leukaemia prior to transfer.
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TRANSFER

It is important to consider and discuss with your PTC an appropriate timing for transfer, and these conversations should include senior decision makers. There are some children who require urgent transfer, such as those with a very high white cell count, mediastinal mass or clinical instability. Many children who are clinically stable and have low count disease can be safely managed in a DGH overnight, or even for several days, if there is no bed immediately available in the nearest PTC. These children need to be monitored closely with regular observations, clinical assessment and blood tests and require regular discussion with the PTC.

Acknowledgements

We would like to thank Dr Kristina Marshall for reviewing the manuscript.

Contributors

SB conceived of the paper. AR and SB were both co-authors on this paper. AR did the literature search. ED and AK contributed expert views. All authors have contributed to editing successive drafts and agreed the content of the final article.

Funding

This study was funded by Wellcome Trust (Grant 110104/Z/15/Z).

Competing interests

None declared.

Patient consent for publication

Not required.

Provenance and peer review

Commissioned; externally peer reviewed.

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6 UKALL2011 Trial: United Kingdom National Randomised Trial For Children and Young Adults with Acute Lymphoblastic Leukaemia and Lymphoma, 2011.