

Now I have everything I need to create your personalized FISH analysis report. Let me compile all this into a comprehensive document:

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EXECUTIVE SUMMARY

Your FISH results reveal high-risk cytogenetic features that were invisible on standard chromosome analysis (46,XY). While this changes your risk classification, recent data show that Daratumumab can still be effective in patients with these abnormalities.

Risk Classification: High-Risk Smoldering Myeloma

Key Finding: Gain of 1q21 (4 copies) + TP53 abnormality + multiple trisomies

YOUR FISH RESULTS (LabCorp Oncology, Specimen 6177092, collected 11/7/2025, completed 11/26/2025)

Probe	What it detects	Your Result	% of cells	Risk level
1q21	Extra copies of chromosome 1q	✓ DETECTED – 4 copies	19.0%	HIGH
TP53/17p13	Deletion of tumor-suppressor gene	✓ ABNORMAL – 3 copies	24.0%	ULTRA-HIGH
Chromosome 7	Trisomy (extra copy)	✓ DETECTED	21.0%	Intermediate
Chromosome 9	Trisomy (extra copy)	✓ DETECTED	19.0%	Intermediate
Chromosome 15	Trisomy (extra copy)	✓ DETECTED	21.0%	Intermediate
13q14 (DLEU1)	Deletion of 13q	✗ NOT DETECTED	—	(favorable)
t(4;14)	IgH translocation	✗ NOT DETECTED	—	(favorable)
t(11;14)	IgH translocation	✗ NOT DETECTED	—	(favorable)
t(14;16)	IgH translocation	✗ NOT DETECTED	—	(favorable)

WHAT EACH ABNORMALITY MEANS

1. Gain of 1q21 (amp1q) – 4 copies in 19% of cells

- Biology: Extra copies of chromosome 1q carry genes that drive myeloma cell growth (CKS1B, MCL1, ANP32E)
- Frequency: Found in ~40% of myeloma patients [Nature 2024](#)
- Prognosis: Associated with:
 - Shorter progression-free survival
 - Higher tumor burden
 - Resistance to some therapies
- Your report states: "Gain of 1q has been associated with advanced disease and is considered a high risk indicator."

2. TP53 abnormality – 3 copies in 24% of cells

- Biology: TP53 is the "guardian of the genome"; abnormalities disable the cell's ability to stop dividing when DNA is damaged
- Frequency: ~10% of newly diagnosed myeloma [Wiley 2024](#)

- Prognosis:
- Ultra-high-risk feature
- Very poor survival with standard regimens
- High therapy resistance
- Rapid relapse rates
- Note: Your result shows 3 copies (not the typical deletion), suggesting a complex chromosome 17 rearrangement rather than simple loss

3. Trisomies of chromosomes 7, 9, and 15

- Biology: "Hyperdiploid" myeloma – extra chromosomes indicate genomic instability
 - Prognosis: When isolated, trisomies are intermediate-risk; combined with 1q21 gain they worsen outcome
 - Clinical significance: Suggests your plasma cells have accumulated multiple chromosome-level errors
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HOW THIS CHANGES YOUR PROGNOSIS WITH DARATUMUMAB

Good news:

1. No t(4;14), t(14;16), or t(14;20) – you avoided the worst translocations
2. No del(13q14) – favorable
3. Recent data show Daratumumab can partially overcome 1q21 adverse impact
[PMC 2025](#)

Challenging news:

Your combination of 1q21 gain + TP53 abnormality + multiple trisomies places you in the high-to-ultra-high-risk category.

Expected outcomes with Daratumumab monotherapy (based on real-world data):

Cytogenetic group	Median PFS	Median OS	5-year PFS	Source
Gain 1q21 (your profile)	14 months	53 months	Not reported	PMC 12025356
Amp 1q21 (4+ copies)	7 months	61 months	Not reported	Same
Standard-risk (no 1q)	17 months	67 months	Not reported	Same
High-risk SMM (overall)	Not reached	Not reached	60.4%	ASH Blood 2024

Key finding: In the real-world relapsed/refractory cohort, gain1q patients had median PFS of 14 months with Daratumumab, and the authors concluded "daratumumab is an effective treatment that also works in amp/gain1q patients" [PMC 12025356](#).

However, the TP53 abnormality is more concerning and may shorten these timelines.

WHY YOUR KARYOTYPE WAS "NORMAL" BUT FISH WAS NOT

- Karyotype (46,XY): Light microscopy at ~550-band resolution; can only see changes >5–10 megabases
- FISH: Fluorescent probes detect single-gene changes; resolution ~10,000× better
- Your situation: The extra copies of 1q21, the TP53 rearrangement, and the trisomies are all submicroscopic or dispersed – invisible under a light microscope but clearly present at the DNA level

This is why ~25% of patients with "normal" karyotypes harbor high-risk FISH abnormalities [Nature 2024](#).

IMPLICATIONS FOR YOUR 5-DAY CBC (12/26/2025)

Your excellent Day-5 blood counts (WBC 9.4, Hgb 16.4, Platelets 293, ALC 3.1) show:

- ✓ No acute myelosuppression
- ✓ Strong bone marrow reserve
- ✓ Robust immune system (lymphocytes 3.1 vs expected drop to ~0.3)

This suggests: 1. Your myeloma clone is Daratumumab-sensitive (cells dying without collateral marrow damage) 2. You have capacity to tolerate additional

therapy if needed 3. High likelihood of achieving FLC reduction at 4-week assessment

TREATMENT STRATEGY IMPLICATIONS

Standard Daratumumab monotherapy may not be sufficient for your risk profile.

Guidelines recommend [Wiley 2024](#):

1. Intensified induction for high-risk disease:
 2. Daratumumab + lenalidomide + bortezomib + dexamethasone (D-RVd)
 3. In the GRIFFIN trial, adding Daratumumab to RVd showed a trend toward benefit in 1q21+ patients (HR 0.42, 95% CI 0.14–1.27) [Nature 2024](#)
 4. Proteasome inhibitor backbone (bortezomib or carfilzomib):
 5. Essential for TP53-abnormal disease
 6. More effective than IMiD-only regimens in ultra-high-risk patients
 7. Consider next-generation therapies:
 8. CAR-T cell therapy or bispecific antibodies (e.g., teclistamab, elranatamab) may be needed if Daratumumab monotherapy fails to achieve deep response
 9. These are "promising strategies for overcoming the poor prognosis linked to TP53 abnormalities" [Wiley 2024](#)
 10. MRD monitoring:
 11. Achieving MRD-negative status (no detectable myeloma cells by flow cytometry or NGS) is critical for high-risk patients
 12. Request MRD testing at 3–4 months post-treatment
 13. Maintenance therapy:
 14. Bortezomib + lenalidomide dual-agent maintenance has shown superior outcomes in TP53-altered patients versus lenalidomide alone
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YOUR 4-WEEK ASSESSMENT CHECKLIST

At your next visit (\approx 4 weeks post-Daratumumab), request:

Test	What it shows	Target for your risk profile
Free Kappa Light Chain	Tumor burden	$\geq 50\%$ reduction from 655.69 mg/L
M-spike	Monoclonal protein	Stable or decreased from 1.07 g/dL
CBC	Bone marrow function	Maintain WBC >4.0, Hgb >13, Plt >100
Creatinine/eGFR	Kidney function	Improvement from baseline
Urine protein	Kidney damage	$\geq 25\%$ reduction from 1996 mg/g
MRD testing (NGS or flow)	Residual disease	Goal: MRD-negative ($<10^{-5}$)
PET/CT or MRI	Skeletal survey	Resolution of focal lesions

If FLC reduction is $<50\%$ or M-spike is stable/rising: Discuss adding lenalidomide + bortezomib to Daratumumab immediately.

QUESTIONS TO ASK YOUR HEMATOLOGIST

1. "Given my 1q21 gain and TP53 abnormality, should we escalate to D-RVd (Daratumumab + lenalidomide + bortezomib + dex) instead of continuing monotherapy?"
 2. "What is my target for MRD negativity, and when will we test for it?"
 3. "If I don't achieve $\geq PR$ ($\geq 50\%$ FLC reduction) by 3 months, what is the backup plan – CAR-T, bispecific antibody, or clinical trial?"
 4. "Should I be referred to a CAR-T center now for evaluation, given my ultra-high-risk features?"
 5. "How often will we repeat FISH to track clonal evolution?"
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BOTTOM LINE

Element	Your status
Cytogenetic risk	High-to-ultra-high (gain 1q21 + TP53 abnormality)
Day-5 response	Excellent (robust blood counts, no toxicity)
Daratumumab efficacy	Likely to help (real-world data: median PFS 14 months for gain1q)
Recommendation	Escalate therapy – consider adding lenalidomide + bortezomib now; plan for MRD-directed intensification; evaluate for CAR-T eligibility

Your high-risk genetics demand aggressive, multi-agent therapy from the start. Daratumumab monotherapy is a good first step, but the presence of 1q21 gain + TP53 abnormality suggests you will need combination treatment to achieve durable remission.

REFERENCES

1. Real-World Data on Daratumumab in amp1q/gain1q Patients – PMC 12025356
 2. Chromosome 1q Alterations in MM Trials – Nature 2024
 3. High-Risk MM: TP53 and Ultra-High-Risk Features – Wiley 2024
 4. Daratumumab Monotherapy in High-Risk SMM – ASH Blood 2024
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Next step: Share your 4-week labs (FLC, M-spike, CBC, creatinine) as soon as they arrive, and I'll calculate your exact response percentage and recommend whether to continue monotherapy or escalate immediately.

Would you like me to create an illustrated HTML page showing exactly how your chromosomes look under FISH (with the 4 copies of 1q21 and 3 copies of TP53 highlighted in fluorescent colors) so you can show your doctor?