years. The cause of a low absolute neutrophil count (ANC) was autoimmune neutropenia in 37 patients, 31 had chronic idiopathic neutropenia, 27 had infectious neutropenia, 3 had cyclic neutropenia, while 2 were diagnosed with alloimmune neonatal neutropenia. The mean value of ANC at presentation was 732/mm$^3$, and the mean lowest ANC detected during disease course was 600/mm$^3$. Among the 5 diagnostic subgroups, both values were the lowest in patients with cyclic neutropenia in which mean ANC at presentation was 420/mm$^3$ and mean lowest ANC detected during disease course was 180/mm$^3$.

Granulocyte colony-stimulating factor (GCS-F) was given to only 3 patients, whose mean ANC at presentation was 140/mm$^3$. Besides the laboratory finding of persistent severe neutropenia, all 3 patients were prone to recurrent infections. Twenty-three patients had additional cytopenia, out of which 4 had pancytopenia, 13 had anaemia and 6 patients had thrombocytopenia. Among patients with additional cytopenia, 5 had positive anti-granulocyte antibodies (21.7%). The mean time to disease resolution was 10.2 months, being the longest in the cyclic neutropenia subgroup, while patients with infectious neutropenia mainly recovered after 21.3 days. The mean follow-up time was 1.6 years.

According to data from our Department, neutropenia is most commonly diagnosed in pre-school children, boys being more frequently affected than girls. More than one third of patients have positive anti-granulocyte antibodies. However, the condition is usually benign, it resolves mainly spontaneously in less than a year, and patients generally do not require G-CSF.

We report our center experience in immunotherapy of high risk neuroblastoma, in particular concerning the most common side effects and their management.

Multidisciplinary team approach will be discussed as well, as it is especially important in care for these patients.

Retrospective review of hospital medical data basis High risk neuroblastoma patients receive intensive multimodal therapy that includes induction, consolidation, and postconsolidation phases. The postconsolidation or maintenance phase implies immunotherapy with anti-GD2 monoclonal antibody dinutuximab beta, applied with the purpose of eliminating any residual tumor cells that may exist after induction and consolidation treatment (multiagent chemotherapy, surgery, high-dose chemotherapy and autologous stem cell transplant).

During the 3-year period (2017 – 2019) 8 high risk neuroblastoma patients received immunotherapy with dinutuximab beta in our center. Patients were in remission confirmed by different methods of investigation. Dinutuximab beta was applied in hospital conditions, as a 10-day continuous infusion, with premedication and concomitant medications that included crystalloid fluids, various pain medications, antihistamines, antiemetics and antipyretics, requiring double lumen central venous catheter and continuous monitoring of vital functions.

Most of our patients achieved adequate pain control with gabapentin and titrated doses of opioids. Fever was a common side effect easily managed by NSAIDs. In case of allergic reaction the rate of dinutuximab beta was decreased by half and restored to its full rate after resolution of symptoms. In the meantime additional doses of antihistamines, oxygen, salbutamol and racemic epinephrine were applied depending on the clinical condition.

Special care was dedicated to fluid balance supervision due to the risk of capillary leak syndrome. Although 5 of our patients had some degree of capillary leak, only one patient developed significant hypotension which was recognized and treated in timely manner with fluid boluses and epinephrine titrated to effect. Upon resolution of hypotension, the drug infusion was restarted at 50% rate during 2 hours and after that in the absence of recurrent hypotension increased to the full rate.

Postconsolidation immunotherapy with dinutuximab beta has become the standard of care for high-risk neuroblastoma patients. The benefits of this kind of therapy do not come without risks. Having front-line providers who are familiar with immunotherapy and its associated toxicities is critical to the safe and consistent administration of this complex therapy. The team includes physicians of different specialities, nurse practitioners, physician assistants and bedside nurses.
The diagnosis of thrombocytopenia in newborns and infants is relatively difficult and it should be diagnosis by exclusion. The most important causes of thrombocytopenia that need to be considered in this group are infections, including sepsis as well as CMV infection, fetal hypoxia, chromosomal abnormalities, bone marrow proliferative diseases and neonatal immune thrombocytopenia.

A rare cause of infant thrombocytopenia is genetically determined, most often X-linked, primary immunodeficiency – Wiskott-Aldrich syndrome (WAS).

Depending on the type of mutation in the WAS gene, encoding the WAS protein, there is a wide spectrum of clinical phenotypes: X-linked thrombocytopenia, X-linked neutropenia and classic WAS. The last one is characterized by a triad of symptoms: thrombocytopenia, usually with small platelets, recurrent infections, and eczema.

This case – report presents the case of a 4-month-old boy with thrombocytopenia resistant to treatment found from the second day of his life, who was diagnosed with full-blown Wiskott–Aldrich syndrome in the following weeks. An additional difficulty in the differential diagnosis in this case was the boy’s negative family history and the normal size of the platelets in the tests, which is atypical for WAS. The diagnosis was confirmed by a molecular test which revealed a new mutation, not registered in the ClinVar and HGMD database. The boy’s severe course of disease has been brought under control thanks to a bone marrow transplant from his mother in the age of 12 months.