To the editor:

Does the FLIPI apply to grade 3 follicular lymphoma?

We welcome the publication of a score (Follicular Lymphoma International Prognostic Index [FLIPI]) assisting in the choice of treatment for patients with newly diagnosed follicular lymphoma (FL),1 As the authors state, treatment options for this disease range from “watch and wait” to allogeneic bone marrow transplantation, and the selection of the best available option will be favored by a realistic estimation of the expected survival for each particular patient.

The 5 independent prognostic factors retained in the FLIPI reflect important characteristics of the patient (age), of the disease extension and clinical aggressiveness (stage and number of nodal sites involved, lactose dehydrogenase [LDH]), and of the tumor-host interaction (hemoglobin level). Surprisingly enough, histology grade, a disease characteristic considered by many clinicians to be of paramount importance for prognosis and choice of treatment, is missing from the index and was not even significant in the univariate analysis.

The absence of this parameter from the index and the omission of any discussion about this fact in the paper could suggest that histologic grade is indeed not relevant to patient survival and should therefore not be taken as an important information.

We believe that this misunderstanding results from a bias that is not sufficiently covered in the article and that should be clarified.

It was long recognized that an important proportion of large cells (centroblasts) at histologic examination (an observation referred to as grade 3 in the current World Health Organization [WHO] classification) does confer to FL a worse prognosis, despite apparently favorable clinical prognostic features.2,3 Nevertheless, the outcome of these cases can be similar to the forms with less centroblasts when they are treated with an anthracycline-containing regimen.3,5 This information was known in 19856 (the year of the start of data collection for the FLIPI) and, although details on treatment are not given in the paper, it is probable that the majority of grade 3 FLs of this data set were treated with anthracyclines, thus influencing the prognosis.

Even though the article states that “none of the treatments given during the period of inclusion has significantly changed the natural history of the disease,”1(p1264) this only applies to cases with histologic grades 1 and 2, while for WHO grade 3 we have reason to think that treatment did indeed influence survival, and therefore interacted with other prognostic factors.

The FLIPI could have been a more reliable index if grade 3 FLs were not included in the analysis. We believe that for grades 1 and 2 FL, treatment should be selected based on a number of factors, including the FLIPI score, but an anthracycline-containing regimen should still be favored for patients with grade 3 FL, independent of their FLIPI index.

Michele Ghielmini and Oreste Mora

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Response:

FLIPI in grade 3 follicular lymphoma

We agree with Prof Ghielmini that grade 3 follicular lymphoma is in many cases a more aggressive disease than other follicular lymphomas, although this is an area of ongoing controversy.1 Grade 3b follicular lymphoma especially shares the prognosis of and requires treatment approaches similar to that of diffuse large B-cell lymphoma.2 We welcome the opportunity to comment further on the Follicular Lymphoma International Prognostic Index (FLIPI) observations about grade 3 follicular lymphoma.

First, a central pathology review was not realistic for the 5000 FLIPI cases. Since there are known interobserver variations in the assignment of histologic grade,3,4 we felt we would introduce a bias if we excluded these cases arbitrarily. Moreover, they represented only 9% of the entire FLIPI population.

Second, the IPI appears to have one of the same shortcomings for grade 3 follicular lymphoma as it does for all follicular lymphomas, namely the identification of only a small (15%-20%) fraction of cases with high risk.5,6 Thus the inclusion of grade 3 cases in the FLIPI, and the applicability of the FLIPI to grade 3 follicular lymphoma, represents a potential benefit to patient management.

But we completely agree with Prof Ghielmini’s observation that an anthracycline-containing regimen is favored for patients with grade 3 follicular lymphoma. It was beyond the scope of the initial FLIPI project to analyze in any detail the various treatment modalities used. Moreover, such a retrospective analysis would be open to valid criticism. But we agree that the literature supporting the inclusion of anthracyclines in grade 3 follicular lymphoma6,8 is

References

less controversial than the comparable literature in other follicular lymphomas.7 We thank him for drawing attention to this important topic. The F2 study (coordinated by M. Federico) is ongoing to determine the influence of grade and the impact of diffuse areas on prognosis.

Peter McLaughlin and Philippe Solal-Céлингы, on behalf of the Scientific Committee of the FLIPI

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References


To the editor:

Analysis of total phosphotyrosine levels in CD34+ cells from CML patients to predict the response to imatinib mesylate treatment

The achievement of partial or complete cytogenetic remission (CCR) in response to imatinib mesylate in chronic myeloid leukemia (CML) is an indicator of favorable response to the drug.1 The current assays for prediction of response rely on immunoblot analyses of Bcr-Abl or its substrates Crkl2 or Stat5.3 However, these require large numbers of primary cells and are technically demanding. We previously showed that the inhibition of total phosphotyrosine was a reliable indicator of the effect of imatinib mesylate on BCR-ABL+ cell lines.4 We now have further developed this flow cytometric test to assess the response of primary cells to in vitro imatinib treatment.

We analyzed cryopreserved mononuclear cells from 23 patients with CML in chronic phase, 16 of whom had responded to imatinib mesylate, reaching at least a partial cytogenetic response within the first year of therapy. There was no significant difference in the interval between diagnosis and the initiation of imatinib mesylate treatment between the 2 groups. After thawing, CD34+ cells were isolated by immunomagnetic separation, kept overnight in culture, and subsequently exposed for 2 hours to doses of imatinib mesylate ranging from 0.1 to 50 μM, and intracellularly stained as described in Figure 1. The overall tyrosine phosphorylation was determined by flow cytometry and expressed as a percentage of the level of phosphorylation of the nonexposed control cells.

The results showed a significant difference between patients who achieved a complete or partial cytogenetic remission and those who did not (Figure 1). For the most discriminatory concentration of 20 μM imatinib mesylate, the median level of tyrosine phosphorylation inhibition in cells from the responders was 46%, as opposed to only 32% in the nonresponders (P = .034, Mann-Whitney test). None of the nonresponders had more than 45% inhibition of their total cellular phosphotyrosine content, whereas this was achieved in half of the responding patients. The molecular response to imatinib mesylate also correlated with its capacity to inhibit tyrosine phosphorylation in vitro: in none of the patients who failed to exhibit a greater than 2-log reduction in the number of BCR-ABL transcripts or a BCR-ABL/ABL ratio less than 2% was imatinib able to reduce the cellular phosphotyrosine content below 55% of the pretreatment levels, whereas 75% (6/8) of those with at

1. Bosga-Bouwer AG, van Imhoff GW, Boonstra R, et al. Follicular lymphoma grade 3b includes 3 cytogenetically defined subgroups with primary t(14;18) or other translocations: t(14;18) and t(9;22) are mutually exclusive. Blood. 2003;101:1145-1154.


5. Riely GJ, Engert A, Corcoran RD, et al. Kinase tyrosine-phosphorylation inhibition in vitro: in none of the patients responding to imatinib mesylate the tyrosine phosphorylation levels upon in vitro exposure to the inhibitor fell below 55% (dotted line) of that in the nonexposed cells, whereas this level of reduction was not achieved in any of the nonresponders. (B) Illustrative flow cytometric profile of 1 responder (top) and 1 nonresponder (bottom). Cells stained with the isotype control antibody (gray line) are used to adjust the flow cytometer settings, whereas cells not exposed to imatinib mesylate serve as a phosphorysine staining baseline for all measurements (black line). Imatinib mesylate–treated cells (shaded curve) from patients who eventually responded to imatinib mesylate show a clearly visible shift to the left, while the shift is not as clear for cells from nonresponders. (D) Comparison of CD34 cells used fresh or after 1 round of freezing for the assessment of total phosphotyrosine phosphorylation. From 7 extra patients, CD34+ cells from freshly collected blood were divided into 2 aliquots: 1 was placed in culture for the assay on "fresh" cells, and the second was cryopreserved and thawed later on for the same test. Each line depicts 1 paired sample of cells.
least 45% inhibition of phosphotyrosine levels achieved those degrees of molecular remission. No association was found between the Sokal and Hasford scores and the level of decrease in tyrosine phosphorylation.

The test is able to generate reproducible data from as little as $5 \times 10^4$ CD34$^+$ cells, can be completed within 1 day from the receipt of the sample in the laboratory, and yields similar results on fresh or cryopreserved cells (Figure 1D). In order to confirm the results of this pilot study, we initiated a prospective analysis on a larger patient group where additional clinical and molecular parameters will be assessed. If validated, this assay may facilitate decisions on whether to opt for imatinib mesylate treatment as opposed to allogeneic stem cell transplantation in the first place.

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References


To the editor:

The interleukin-10 gene promoter polymorphism (−1082) does not correlate with clinical outcome in diffuse large B-cell lymphoma

Interleukin-10 (IL-10) is a cytokine important in suppressing the immune response by inhibiting proinflammatory cells. However, this cytokine is multifunctional and can also stimulate proliferation as has been shown both in normal and tumor B cells. IL-10 has been implicated to play a role in lymphoma development, especially considering the finding of an association between increased IL-10 levels and poor outcome in some lymphoma entities. Furthermore, IL-10 gene promoter polymorphisms have been shown to affect the levels of IL-10 expression, for example, the IL-10−1082A allele was not significantly different in our patients with DLBCL versus the control group (0.43 vs 0.46; $P = .38$). Thus, the increased IL-10−1082G allele frequency could not be verified in our analysis of DLBCL (Table 1). Furthermore, we did not find any difference in overall survival between the 174 patients with IL-10−1082G (174 cases) or IL-10−1082A (70 cases) genotype.

We thank Efthymios Fidanis for technical assistance, Dr David Marin and Linda Fung for providing clinical information on the patients, Dr Giuseppe Saglio for cells from 1 patient, and Dr Elisabeth Buchdunger for donation of imatinib mesylate.

This work was funded by the Hammersmith Hospital Trust Research Committee and the Leukaemia Research Fund (United Kingdom).

Table 1. Allele and genotype frequency of the IL-10−1082 polymorphism in 244 DLBCLs and 195 control subjects

<table>
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<th>Controls</th>
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<table>
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<th>Genotype frequency (%)</th>
<th>DBCL cases</th>
<th>Controls</th>
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<td>IL-10−1082AA</td>
<td>70 (29)</td>
<td>60 (31)</td>
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</table>

$P$ values were calculated using $\chi^2$ test. The $P$ value for the genotype frequency is calculated for IL-10−1082G/GG versus IL-10−1082A.

Figure 1. Overall survival for the 244 patients with DLBCL with the IL-10−1082G/GG (174 cases) or IL-10−1082A (70 cases) genotype.

We thank Efthymios Fidanis for technical assistance, Dr David Marin and Linda Fung for providing clinical information on the patients, Dr Giuseppe Saglio for cells from 1 patient, and Dr Elisabeth Buchdunger for donation of imatinib mesylate.

This work was funded by the Hammersmith Hospital Trust Research Committee and the Leukaemia Research Fund (United Kingdom).

References

when patients with or without B symptoms or elevated S-LDH levels were analyzed separately. Moreover, no difference in outcome was evident for patients with or without the IL-10-1082G allele when separately analyzing de novo DLBCL and cases with previous history of low-grade lymphoma. In conclusion, we could not confirm the findings in the report by Lech-Maranda et al of increased frequency of the IL-10-1082G allele and its association with superior outcome in our analysis of patients with DLBCL. We therefore believe that the clinical relevance of the IL-10-1082G promoter polymorphism may be limited in DLBCL, although larger studies have to be performed to conclude this properly.

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Response:

Different patients, different results: the need for prospective controlled studies

In this issue, Berglund and colleagues report their analysis of the IL-10 gene polymorphism (IL10-1082) in a series of 244 lymphoma patients. This series included 168 de novo diffuse large B-cell lymphomas whereas other cases had a previous history of low-grade lymphoma and should probably be considered as transformed lymphoma. The authors did not find a different distribution in IL10-1082 alleles between the patient and the control populations. Of note, the IL10-1082G allele disequilibrium frequency that we previously described only applies to diffuse large B-cell lymphoma. The single nucleotide polymorphism (SNP) genotyping was performed by the Wallenberg Consortium North (WCN) SNP platform, Department of Medical Sciences, Uppsala University.

The authors are grateful to Drs Lars Klareskog and Leond Padyukov and to the Epidemiologic investigation of rheumatoid arthritis (EIRA) group for help with the collection of the healthy control material and to Dr Thomas Axelsson for technical assistance. The single nucleotide polymorphism (SNP) genotyping was performed by the Wallenberg Consortium North (WCN) SNP platform.

References


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To the editor:

The bone marrow microenvironment influences the differential chemokine receptor expression of normal and neoplastic plasma cells

A number of mechanisms may explain the clinical and biologic differences in behavior between monoclonal gammopathy of undetermined significance (MGUS) and myeloma plasma cells (PCs). These include inherent differences in PC programming, immortalization of PCs at different stages of differentiation, different cells of origin, and potentially the influence of the normal/neoplastic bone marrow (BM) microenvironment. Chemokines and their receptors are known to be paramount to normal cell differentiation and homing. As B cells differentiate into PCs they undergo a coordinated change in chemokine receptor expression and chemokine responsiveness. We therefore hypothesized that the expression of chemokine receptors on myeloma PCs would be altered compared with normal PCs and may explain some of the differences in behavior between normal and malignant populations.

As our previous studies have demonstrated that 2 populations of PCs (normal and neoplastic) can be identified in myeloma and MGUS cases based on expression of CD19 expression1-3 and that MGUS cases with a predominantly neoplastic phenotype have a higher chance of progressing to myeloma than those with a mixed normal and malignant phenotype,3 we also hypothesized that by examining both normal and neoplastic PCs from the same BM in MGUS patients we could determine whether any variation in chemokine receptor profile was due to the marrow microenvironment or to neoplastic transformation.

Normal (CD38+CD138+CD19+CD56-) and neoplastic PCs (CD38+CD138+CD19-CD56+/-) were distinguished from other leukocytes using 4-color flow cytometry with CELLQuest version 3.1 on a FACSort (BD Biosciences, Oxford, United Kingdom) as
Chemokine receptor expression was assessed on PCs from 20 normal and 19 myeloma BMs. CCR3, CCR5, CXCR2, and CXCR3 were not expressed on PCs (<3-fold difference in expression with control). In contrast, CCR1, CCR2, CCR6, CXCR1, CXCR4, and CXCR5 were expressed on both types of PCs, in keeping with data from other groups. The differences in chemokine receptor expression between normal and myeloma PCs were small (Figure 1A). CCR1 and CXCR5 showed no difference in expression between the 2 cell types. CCR2, CXCR6, and CXCR1 showed increased expression on myeloma PCs compared with normal PCs (average 3.3, 1.5, and 1.8 fold, respectively). In contrast, CXCR4 was up-regulated on myeloma PCs in comparison to normal PCs (average 2.2 fold). This suggests that PCs have a specific chemokine receptor expression profile; however, differences in the level of expression of some receptors, particularly CCR2 and CXCR1, may explain the abnormal localization of myeloma PCs.

These differences were studied further by assessing normal and neoplastic PCs from the same BM in 20 MGUS patients. CCR6, CXCR1, and CXCR4 showed no significant difference in expression between the 2 cell types, suggesting that feedback loops between neoplastic PCs and BM stroma also influence normal PC chemokine receptor expression. In contrast, CCR2 expression on CD19+ PCs was on average 1.6-fold lower than on their CD19+ counterparts (range, 1.1-6.8 fold), suggesting that a key feature of neoplastic PCs is the down-regulation of CCR2 (Figure 1B). This reduced expression is therefore not a consequence of differences in BM microenvironment but rather a function of the neoplastic process or of the stage of differentiation of the originating neoplastic cell. Interfering with chemokines and their receptors that are related to malignant transformation may prove useful as adjunct to chemotherapy approaches.

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References


To the editor:

Patients with thalassemia in the United States

Thalassemia is one of the most common monogenic diseases of man, prevalent in tropical and subtropical regions of the world. Population migration during the past decades has led to increasing numbers of these patients being encountered in all parts of the world, including in the United States. A clinical research network, supported by National Institutes of Health (NIH), was established to study β-thalassemia major/intermedia. A report on disease complications was published in July 2004, based on 342 patients (222 in the United States and 120 in Toronto).1

Our laboratory was established in 2003 to provide molecular diagnosis of hemoglobinopathies and thalassemias. In the past 18 months, we have genotype.d 40 β-thalassemia major/intermedia patients of all ethnic backgrounds (Table 1). Only 4 cases are of Mediterranean ancestry, hitherto the source of most β-thalassemia patients in our country. Seventy percent of the cases are 15 years of age or younger. They reside in Massachusetts (18), Rhode Island (3), West Virginia (4), New York (1), Maryland (3), and Georgia (11). Surprisingly, only one patient in this recently diagnosed cohort has the β-thalassemia mutation genotype [IVS1-1 (T>C) / IVS1-110 (G>A)] that corresponds to 1 of the 5 genotypes reported to be most commonly found in the United States.1

These findings highlight the fact that β-thalassemia is more

Figure 1. Flow-cytometric analysis of chemokine receptor expression. (A) Chemokine receptor expression on normal and myeloma PCs. The mean expression level and range is shown. (B) CCR2 expression is significantly lower on CD19+ PCs from MGUS patients than that on CD19+ PCs from the same bone marrow. The figure shows 5th, 25th, 50th, 75th, and 95th percentiles for expression, measured as mean fluorescence intensity.
Additionally, our laboratory has diagnosed 11 cases of clinically for this disease (12 of our patients are 5 years of age or younger). Screening and genetic counseling may not be used optimally Mediterranean ancestry any more. They also suggest that carrier common and diverse than generally thought of in the United States; many of the recently diagnosed patients are not of the Mediterranean ancestry any more. They also suggest that carrier screening and genetic counseling may not be used optimally for this disease (12 of our patients are 5 years of age or younger). Additionally, our laboratory has diagnosed 11 cases of clinically significant hemoglobin (Hb) H disease from Massachusetts, New York, and Georgia: 1 ($-\alpha^\text{MED}$); 5 ($-\alpha^\text{SEA}$), including 1 Hb E heterozygote; and 5 ($-\alpha^\text{Constant Spring}$), including 2 Hb E homozygotes. Efforts devoted to community public education appropriately adapted to different cultures and languages, continuous education for health care providers, and research in disease pathophysiology and treatment for $\alpha$- and $\beta$-thalassemias are needed.

### Table 1. Forty recently diagnosed $\beta$-thalassemia major/intermedia patients and their $\beta$-thalassemia mutations

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age, y</th>
<th>Sex</th>
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<td>9</td>
<td>M</td>
<td>Cuban</td>
<td>IVSI-6 ([T-C)</td>
<td>Codon 39 (CAG&gt;TAG)</td>
</tr>
<tr>
<td>34</td>
<td>29</td>
<td>F</td>
<td>Italian</td>
<td>IVSI-6 ([T-C)</td>
<td>IVSI-1 ([G-A)</td>
</tr>
<tr>
<td>35</td>
<td>3</td>
<td>F</td>
<td>Irish</td>
<td>Codon 91 ([T]²</td>
<td>No mutation</td>
</tr>
<tr>
<td>36†</td>
<td>25</td>
<td>F</td>
<td>Irish</td>
<td>Codon 91 ([T]²</td>
<td>No mutation</td>
</tr>
<tr>
<td>37</td>
<td>51</td>
<td>F</td>
<td>Irish</td>
<td>Codon 91 ([T]²</td>
<td>No mutation</td>
</tr>
<tr>
<td>38</td>
<td>51</td>
<td>F</td>
<td>Irish</td>
<td>Codon 91 ([T]²</td>
<td>No mutation</td>
</tr>
<tr>
<td>39†</td>
<td>&lt; 1</td>
<td>F</td>
<td>Egyptian</td>
<td>IVS-II-745 ([G-C)</td>
<td>Hb Lepore Boston-Washington</td>
</tr>
<tr>
<td>40†</td>
<td>15</td>
<td>M</td>
<td>Egyptian</td>
<td>IVS-II-745 ([G-C)</td>
<td>Hb Lepore Boston-Washington</td>
</tr>
</tbody>
</table>

NI indicates nucleotide; IVS, intron; and HPFH-3, hereditary persistance of fetal hemoglobin 3.

*Patients are the same kindred.
†Patients are siblings.
‡Patients are twins.
§Patients are siblings.
Dominant $\beta$-thalassemia in the same kindred.
¶Patients are siblings.

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References

To the editor:

The Marburg I polymorphism of factor VII–activating protease is not associated with venous thrombosis

Table 1. Marburg I polymorphism and the risk of venous thrombosis

<table>
<thead>
<tr>
<th>FSAP nt 1601</th>
<th>Patients, no. (%)</th>
<th>Controls, no. (%)</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG</td>
<td>444 (94.3)</td>
<td>441 (93.6)</td>
<td>1*</td>
<td>NA</td>
</tr>
<tr>
<td>GA</td>
<td>26 (5.5)</td>
<td>28 (6.0)</td>
<td>0.9</td>
<td>0.5-1.6</td>
</tr>
<tr>
<td>AA</td>
<td>1 (0.2)</td>
<td>2 (0.4)</td>
<td>0.5</td>
<td>0.05-5.5</td>
</tr>
<tr>
<td>GA + AA</td>
<td>27 (5.7)</td>
<td>30 (6.4)</td>
<td>0.9</td>
<td>0.5-1.5</td>
</tr>
</tbody>
</table>

*Reference category.

In a recently published paper in Blood, Hoppe et al1 showed in 213 patients and 213 controls that carriers of the Marburg I polymorphism of the factor VII–activating protease (FSAP)2 had an increased risk of venous thrombosis (odds ratio [OR], 3.5; 95% confidence interval [CI], 1.2-10.0).

FSAP is a serine protease that has 2 functions in hemostasis. It activates factor VII, thereby promoting coagulation, but it can also activate single-chain plasminogen activators, thus promoting fibrinolysis.4 Recently, a single nucleotide polymorphism (1601G>A) was discovered in the gene coding for FSAP, which results in the substitution of glycine 511 by glutamic acid (FSAP Marburg I) and which is present in 2% to 9% of the white population.1,5,6 The Marburg I variant has an impaired prourokinase activating potency, whereas it can still activate factor VII normally.7

If true, the finding of Hoppe et al1 would support the hypothesis that reduced fibrinolysis contributes to the risk of venous thrombosis. However, the authors indicated that their control group might be biased due to the exclusive inclusion of healthy blood donors, or because the control group was relatively selected on health, or because the control group was relatively small. On the other hand we cannot exclude small geographic differences in the Marburg I frequency.

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Supported by grant 912-02-036 from the Netherlands Organization for Scientific Research (NWO). The LETS study was supported by grant 89-063 from the Netherlands Heart Foundation.

References


Response:

Association of Marburg I polymorphism of factor VII–activating protease with venous thromboembolism is limited to idiopathic events

In this issue, van Minkelen et al report on venous thrombosis and the Marburg I variant of factor VII–activating protease (FSAP), commenting on a study published recently by our group in the journal. They essentially describe 2 findings that appear to be in contrast to our study: (1) the frequency of carriers of FSAP Marburg I in the controls of van Minkelen et al was considerably higher (6.4%) than that of our control group (2.3%); and (2) an association of FSAP Marburg I with deep vein thrombosis (DVT) could not be confirmed.

In reply to these comments we want to remark the following. (1) Indeed, the frequency of carriers of FSAP Marburg I in our controls (5/213; 2.3%) comprising healthy blood donors was lower than that of the Bruneck study cohort (37/810; 4.6%). The controls of van Minkelen et al (30/471; 6.4%), and the Northwick Park Heart Study cohort (176/2066; 8.5%). Different frequencies in the described study populations could be due to low sample size, selection bias, and different geographic distributions. To exclude the possibility that our controls might be biased by negative selection of FSAP Marburg I due to its association with atherosclerosis, we analyzed a larger, independent control group consisting of consecutive patients admitted to our institution for reasons other than venous thromboembolism (non-VTE patients). Main diagnoses of these patients included transient ischemic attack/stroke, myocardial infarction. Considering the positive association of FSAP Marburg I with progression of atherosclerosis and assuming at least no negative association of this variant with VTE (Hoppe et al and van Minkelen et al), the frequency of FSAP Marburg I carriers in these non-VTE patients (15/327; 4.6%) will presumably overestimate the normal frequency of this variant in our geographic region.

(2) The data presented by van Minkelen et al included patients with DVT, making no distinction between idiopathic and secondary events. As we described in the initial report, the association of FSAP Marburg I with VTE (including DVT and/or pulmonary embolism) was nearly exclusively attributable to idiopathic events (Table 1; “Comparison vs controls I”). Secondary VTE due to acquired risk factors (immobilization, surgery, trauma, pregnancy, puerperium, malignancy) was not associated with this variant. To avoid possible biases by the control group (blood donors), we performed a statistical analysis based on the second, independent control group (non-VTE patients; Table 1; “Comparison vs controls II”). Again, FSAP Marburg I was significantly associated with idiopathic but not secondary VTE (odds ratio, 2.7; 95% confidence interval [CI], 1.2-6.1).

The FSAP genotypes have no influence on its capacity to activate factor VII in vitro. Moreover, the physiologic role of FSAP and the site where its action takes place remains unclear. Thus, the absence of a detectable difference in circulating factor VII activities with both FSAP genotypes as described by van Minkelen et al is not surprising. Based on the additional data described here and as stated in our initial report, FSAP Marburg I is associated with idiopathic VTE.

Table 1. Association of FSAP Marburg I with VTE

<table>
<thead>
<tr>
<th></th>
<th>Carriers of FSAP Marburg I, no. (%)</th>
<th>Comparison vs controls I, odds ratio (95% CI)</th>
<th>Comparison vs controls II, odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic VTE</td>
<td>103 (12.7)</td>
<td>5.5 (1.9, 16.0) †</td>
<td>2.7 (1.2, 6.1) ‡</td>
</tr>
<tr>
<td>Secondary VTE</td>
<td>110 (5.4)</td>
<td>2.0 (0.56, 7.0) *</td>
<td>0.99 (0.35, 2.8)</td>
</tr>
<tr>
<td>VTE</td>
<td>213 (17.0)</td>
<td>3.6 (1.3, 10.0) †</td>
<td>1.8 (0.88, 3.7)</td>
</tr>
<tr>
<td>Controls I</td>
<td>213 (5.2)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Controls II</td>
<td>327 (15.4)</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*The data presented here (univariate analyses) differ slightly from those of our initial report (logistic regression analyses; independent variables: factor V Leiden, prothrombin 20210G→A, and FSAP Marburg I).†P = .001 (Fisher exact test).‡P < .05 (Fisher exact test).

References

Does the FLIPI apply to grade 3 follicular lymphoma?

Michele Ghielmini and Oreste Mora