incidence of ONJ; median duration of zoledronic acid therapy (10 months; range, 4-35 months, in the whole patient population) was significantly longer among patients experiencing ONJ compared with patients who did not show this complication (17 versus 10 months, respectively; \( P < .01 \)) (Figure 1). ONJ occurred in the mandible in 6 cases (66.6%); symptoms of pain, swelling, or purulent discharge were present in all but one patient who was diagnosed as having exposed bone at routine dentistry examination. Four patients had a complete response to minimally invasive treatment and 3 patients showed a partial improvement, while no improvement was observed in the last 2 patients in whom a monoclonal plasma cell infiltrate of the mandible was detected.

Although patients’ follow-up was shorter than in other studies, possibly accounting for the lower incidence of ONJ compared with that reported by others,4-6 the rate of ONJ after 24 months of zoledronic acid exposure was 6.6%, a value comparable with those previously reported by others4-6 the rate of ONJ after 24 months of zoledronic acid exposure was 6.6%, a value comparable with those previously reported by others.

To the editor:

Use of the International System for Human Cytogenetic Nomenclature (ISCN)

One of the aims of the International System for Human Cytogenetic Nomenclature (ISCN)1 is to prevent confusion in reporting research cytogenetics results. In this context, Massey et al2 apparently overlooked the ISCN recommendations and their cytogenetic results were reported out of the proper form.

In concrete, the authors omitted the use of commas and slant lines in the description of karyotypes in Table 6 (footnotes) and Table 7. Moreover, the order of chromosome abnormalities in some karyotypes is not correct. There are also some mistakes in Table 7: sex chromosomes in patient 1 are described as XX and XY; because case 6 corresponds to a mosaic, the +21 has to be marked as a constitutional abnormality as exemplified by Hu et al3; patient 7 has an i(7)(q10), which should be indicated as i(7)(q10), not as “isochromosome 7(q10)”; the description in patient 9 of the der(7) as originated from a t(1;17), probably means der(7) from a t(1;17) because chromosome 7 has q36 band but chromosome 17 has not; also in this patient the single colon “isochrome 7(q10)” should be indicated as i(7)(q10), not as “isochrome 7(q10)”; the description in patient 10 of the der(7) as originated from a t(1;17), probably means der(7) from a t(1;17) because chromosome 7 has q36 band but chromosome 17 has not; also in this patient the single colon “isochrome 7(q10)” should be indicated as i(7)(q10), not as “isochrome 7(q10).”

There are other errors in Table 6 (footnotes); the total of individuals is 43 not 42; one karyotype from the 7 boys is missing; a t(1;7) is misused. There are other errors in Table 6 (footnotes); the total of individuals is 43 not 42; one karyotype from the 7 boys is missing; a t(1;7) is misused.

The authors declare no competing financial interests.

Correspondence: Patrizia Tosi, Istituto di Ematologia e Oncologia Medica “Statale,” Policlinico S. Orsola, Via Massarenti, 9, 40138, Bologna, Italy; e-mail: ptosi@med.unibo.it.

References

it is impossible to locate in Table 7 the 4 of 7 boys who evolved to leukemia (patients 2, 3, 9, and presumably 1 or 8).

In conclusion, the proper use of the ISCN by the authors would help to avoid this confusion.

Juan Ramon Gonzalez Garcia and Juan Pablo Meza-Espinoza
The authors declare no competing financial interests.
Correspondence: Juan Ramon Gonzalez Garcia, Division de Genetica CIBO-IMSS, Sierra Mojada # 800, colonia Independencia, Guadalajara, Jalisco, Mexico; e-mail: jrgg_gene@hotmail.com.

Response:

Use of the ISCN

Drs Garcia and Meza-Espinoza make an excellent point about the usefulness of the International System for Human Cytogenetic Nomenclature (ISCN 2005) in preventing confusion in reporting research cytogenetic results. The cytogenetic data reported in our study1 were derived from multiple institutional clinical reports and were reported as submitted by the participating Children’s Oncology Group (COG) institutions. All of the study patients were enrolled between 1994 and 1999 and thus predated the ISCN 2005 system. Obtaining cytogenetics on the leukemia cells was encouraged but was not a study requirement. Thus, there was no central reference laboratory that reviewed all of these studies. In analyzing the data, however, it appeared that the presence of cytogenetic abnormalities in addition to trisomy 21 was a potential risk factor for recurrent disease, and therefore this important finding was reported in our results.

We concur that in Table 7 for patient 1, the sex chromosomes should have been reported as “XX,” and we apologize for and regret this typographic error.1 Similarly, as exemplified by Hu et al,2 the correct nomenclature for Table 7 patient 6 would be “+21c.”

As for the total number of patients represented in Table 6, the number is indeed 42 and not 43. The one male mosaic is included in 2 columns (“Mosaic” and “Other”). All 7 karyotypes are represented in the footnote of the same table. There were 2 patients with trisomy 11 (as indicated by the 2 in parentheses), 1 mosaic, and 4 additional abnormal karyotypes. In Table 7, the 4 of 7 boys who evolved to leukemia are patients 2, 3, 6, and 9. The other 3 males had no consistent cytogenetic abnormality associated with their transient leukemia other than trisomy 21.1

We acknowledge that the results we reported need to be reproduced and verified by additional multi-institutional studies. For consistency and scientific accuracy, these studies should include more rigorous review of cytogenetics (through either a central review or, at the minimum, review through COG-certified cytogenetic laboratories) and reported using the ISCN 2005 nomenclature. Such a follow-up study is already ongoing in COG. Despite the nonstandardized nomenclature, we still feel that our data indicate that the presence of abnormal clonal cytogenetics in addition to trisomy 21 in neonates with transient leukemia is a risk factor for development of subsequent leukemia, and thus that these children require closer follow-up and possibly earlier intervention.

Gita Vasers Massey, Howard J. Weinstein, and Alvin Zipursky
The authors declare no competing financial interests.
Correspondence: Gita Vasers Massey, Pediatric Hematology-Oncology, PO Box 980121, Richmond, VA 23298-0121; e-mail: gvmassey@hs.vcu.edu.

References


To the editor:

**PASD1 is a potential multiple myeloma–associated antigen**

Immunotherapy is an important treatment option in multiple myeloma (MM), with allotransplantation demonstrating an inducible graft-versus-myeloma effect.1 This could be potentiated by vaccination, first requiring knowledge of tumor-associated antigens. The cancer testis antigens (CTAs) are exemplary, as normal expression is restricted to testis, an immune-privileged site. CTAs are being identified in a number of malignancies. In lymphoma, serologic analysis of recombinant cDNA expression (SEREX) analysis has revealed PASD1, a gene encoding the CT antigen OX-TES-1, spliced alternatively to PASD1_v1 and PASD1_v2.2 PASD1 appears to map to chromosome band Xq28 (Unigene Hs.160594), also flanked by the cluster of MAGE gene families.3 With MAGE antigens of importance as immunotherapeutic targets in MM, additional CTA genes at this locus may be significant. Here, we report on PASD1 expression in MM as one such antigen.

We observed PASD1 expression in 5 of 11 MM cell lines by reverse-transcription–polymerase chain reaction (RT-PCR), and in 8 of 11 by increasing sensitivity (Figure 1A). In primary MM, PASD1 expression was found in 14 of 16 samples using quantitative PCR (Q-PCR), both in presentation (MM1-9) and pretreated cases (MM10-16) (Figure 1B). Protein expression was tracked immunohistochemically, using a novel monoclonal antibody

References

Use of the International System for Human Cytogenetic Nomenclature (ISCN)

Juan Ramon Gonzalez Garcia and Juan Pablo Meza-Espinoza