outstanding efficacy of the type II reagent. We are currently exploring alternative mechanisms that explain such activity.

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To the editor:

Congenital JAK2V617F polycythemia vera: where does the genotype-phenotype diversity end?

A previously healthy 7-month-old girl was admitted to her local hospital with tonsillitis. Full blood count showed polycythemia (Hb 190 g/L) along with an elevated platelet (946 × 109/L) and white cell count (19.7 × 109/L). Oxygen saturations, arterial blood gases, chest x-ray, abdominal ultrasound, and P50 were normal. Serum erythropoietin was low. No mutations were identified in genes, chest x-ray, abdominal ultrasound, and P50 were normal.

JAK2V617F mutation was identified in her family with PV showed the presence of JAK2V617F mutation. Inheritance of as yet unknown germline mutations may have predisposed toward the acquisition in utero of the somatic JAK2V617F mutation. In affected family members but not in an obligate carrier. This suggests that other genetic abnormalities, possibly inherited, precede the acquisition of the JAK2V617F mutation. Inheritance of as yet unknown germline mutations may have predisposed toward the acquisition in utero of the somatic JAK2V617F mutation in our particular case, but such events also may have influenced the relatively rapid evolution to the polycythemic phenotype in this infant compared with the estimated time it takes for a JAK2V617F mutation to develop into clinical PV in adult patients.

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To the editor:

Hepatitis C virus (HCV) infection, monoclonal immunoglobulin specific for HCV core protein, and plasma-cell malignancy

Hepatitis C virus (HCV) infection can lead to B-cell malignancy via direct infection and transformation of B lymphocytes, or via indirect transformation by chronic antigen-driven stimulation. Both mechanisms may occur simultaneously, as we previously reported in a case of HCV infection followed by plasma-cell leukemia (PCL), where blasts were infected with HCV and the monoclonal immunoglobulin (Ig) they produced was directed against the core protein of the virus. Approximately 10% of HCV-positive patients responding to viral infection with poly-Ig, the horseradish peroxidase conjugates used were anti-α, anti-μ, or anti-κ chains. Typical results are shown for Mc Ig specific for HCV core protein (Pt 21).

Over a period of 13 months beginning in January 2002, all sera from patients consulting or hospitalized at the Centre Hospitalier Universitaire de Nantes that the Biochemistry Laboratory declared positive for monoclonal Ig were systematically tested for the presence of HCV RNA and anti-HCV Ig. Among the 700 patients studied, 10 (1.4%) were found positive for HCV; 2 of these 10 patients were also positive for human immunodeficiency virus. Only 3 of 10 patients were infected with HCV genotype 1, the predominant genotype in western France; 7 of 10 patients were infected with genotypes 2 (5 patients), 3, or 5 (Table 1), suggesting contamination from blood products before 1980. Purification of the monoclonal Ig was achieved for 7 of 10 patients. Using immunoblotting, the purified monoclonal Ig (2 IgG, 1 IgA, 1 IgM) of 4 patients, all with genotype 2, recognized the C22-3 fragment of HCV-core protein; 2 (IgG) recognized NS-4 and I did not recognize HCV (Table 1, Figure 1). Among the 4 patients with anti-HCV core monoclonal Ig, 2 presented with mixed (type II) cryoglobulinemia (patients 12 and 20) and one was diagnosed with multiple myeloma (patient 21). Anti-HCV treatment resulted in the disappearance of the monoclonal Ig (patients 8, 9, and 10).

Altogether, for all but one patient presenting with monoclonal Ig in the context of HCV infection, the monoclonal Ig was directed against the virus. Taking into account the first reported case, 2 of 5 patients who responded to HCV infection with anti-HCV core monoclonal Ig developed multiple myeloma or PCL, implying that a monoclonal Ig response directed against HCV core may distinguish patients with increased risk of plasma-cell malignancy. Efforts should be made to identify such patients, as associated antiviral therapy should help eradicate the malignant, HCV-driven plasma-cell clone.

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