Trisomy 4 Identifies a Subset of Acute Nonlymphocytic Leukemias

By Cristina Mecucci, Angeline Van Orshoven, Guido Tricot, Jean-Louis Michaux, André Delannoy, and Herman Van Den Berghe

We present four patients with acute nonlymphocytic leukemia, one M2 and three M4 French-American-British (FAB) types and one patient with refractory anemia with excess blasts in transformation who at diagnosis had trisomy of chromosome 4 as the primary karyotypic anomaly. This chromosome anomaly probably defines a previously undescribed subset of acute nonlymphoid leukemias. Hematologic characteristics commonly found in these patients were dysplastic features of all bone marrow lineages, suggesting that trisomy 4-associated disorders involve the early myeloid hematopoietic stem cell.

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<table>
<thead>
<tr>
<th>Patient</th>
<th>Age/Sex</th>
<th>Date</th>
<th>FAB Type</th>
<th>HB (g/dL)</th>
<th>Platelets (x 10^9/L)</th>
<th>WBC (x 10^9/L)</th>
<th>Sample</th>
<th>Blasts (%)</th>
<th>Promyelocytes (%)</th>
<th>PAS</th>
<th>POX</th>
<th>SBB</th>
<th>ANBE</th>
<th>ANAE</th>
<th>Immunophenotype†</th>
<th>Therapy</th>
<th>Survival From Diagnosis (mo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.V.C.</td>
<td>17/F</td>
<td>April 1974</td>
<td>M2</td>
<td>10.4</td>
<td>90</td>
<td>33.7</td>
<td>BM</td>
<td>43</td>
<td>55</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>—</td>
<td>ARA-C</td>
<td>7, died</td>
</tr>
<tr>
<td>H.B.</td>
<td>64/F</td>
<td>June 1984</td>
<td>M4</td>
<td>11.7</td>
<td>54</td>
<td>18.7</td>
<td>BM</td>
<td>51</td>
<td>4</td>
<td>ND</td>
<td>40</td>
<td>50</td>
<td>ND</td>
<td>30</td>
<td>TdT-neg, BA-2-pos, OKT10-pos, OKT3-neg, Slg-neg</td>
<td>ARA-C</td>
<td>12. + Dauno</td>
</tr>
<tr>
<td>A.Z.</td>
<td>56/F</td>
<td>June 1978</td>
<td>M4</td>
<td>9</td>
<td>17</td>
<td>248</td>
<td>BM</td>
<td>89</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>49</td>
<td>ND</td>
<td>—</td>
<td>ARA-C</td>
<td>1.5, died Dauno</td>
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<tr>
<td>J.M.</td>
<td>15/M</td>
<td>Oct 1984</td>
<td>M4</td>
<td>7.6</td>
<td>31</td>
<td>4.7</td>
<td>BM</td>
<td>87</td>
<td>2</td>
<td>0</td>
<td>40</td>
<td>ND</td>
<td>30</td>
<td>ND</td>
<td>TdT-neg, OKla1-pos, OKMs-pos</td>
<td>Adria</td>
<td>6, died Dauno</td>
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<tr>
<td>P.B.</td>
<td>58/F</td>
<td>Oct 1984</td>
<td>RAEBt</td>
<td>8</td>
<td>199</td>
<td>15.8</td>
<td>PB</td>
<td>22</td>
<td>—</td>
<td>0</td>
<td>ND</td>
<td>8</td>
<td>ND</td>
<td>2</td>
<td>TdT neg, BA-1–neg, B1-neg, J5-neg, OKT3-neg, OKla1-pos, OKT9-pos, OKT10-pos</td>
<td>ARA-C</td>
<td>6-MP 22, + Dauno</td>
</tr>
</tbody>
</table>

Abbreviations: BM, bone marrow; PB, peripheral blood, RAEBt; refractory anemia with excess of blasts in transformation; ARA-C, cytosine arabinoside; 6-TG, 6 thioguanine; Adria, Adriamycin; Dauno, daunomycin; 6-MP, 6-mercaptopurine; ND, not determined.

*Numbers indicate positive cells among blast cells.

†Reactivity of monoclonal antibodies: TdT, lymphoid progenitor cells; BA-1, pre-B cells, B cells, granulocytes; BA-2, pre-B and B cells; TdT; vast majority of non-T acute lymphocytic leukemia (ALL), some cases of nonlymphoid leukemias; B1, pre-B, B cells; J5, common ALL antigen; OKla1, HLA-DR antigens, B cells, macrophages, activated T cells; OKT3, mature T cells; OKT9, transferrin receptor, proliferating cells, including stem cells and activated lymphocytes; OKT10, early stem cells, activated lymphocytes; OKMs, monocytes and platelets.
hemoglobin, 157 x 10^9/L platelets, and 9.4 x 10^9/L WBC with 19% blast cells.

**Morphologic and cytochemical studies.** May-Grünewald-Giemsa (MGG)-stained slides of bone marrow and peripheral blood were reviewed retrospectively in all the cases using the criteria of the French-American-British (FAB) classification for acute leukemias and myelodysplastic syndromes.45 Cytochemical studies included assays for periodic acid-Schiff stain (PAS), Sudan black B (SSB), peroxidase (POX), alpha-naphthyl-acetate-esterase (ANAE), and alpha-naphthyl-butyrate esterase (ANBE) and were performed following the usual criteria.7

**Immunologic marker studies.** Surface markers were detected by an indirect immunofluorescence technique using fluorescein isothiocyanate (FITC)-conjugated goat antiserum IgG (Ortho Pharmaceutical Corp, Raritan, NJ) as the second antibody. Cell surface immunoglobulins were tested by direct fluorescence with FITC-conjugated antibodies.

Monoclonal antibodies OKTla, OKT3, OKT9, OKT10, OKM5 (Ortho Pharmaceuticals), BA-1, BA-2 (Hybritech, San Diego), B1, and J5 (Coulter Immunology, Hialeah, Fl) were obtained commercially. Reactivity is reported in Table I. Terminal deoxynucleotidyl transferase (TdT) activity was determined by immunofluorescence using rabbit antialphatdT serum and FITC-conjugated goat antirabbit serum (Bethesda Research Laboratories, Md).

**Cytogenetic studies.** Chromosome analysis was performed at diagnosis on all patients. Metaphase chromosome preparations were obtained from bone marrow and/or peripheral blood cells after 48-hour unstimulated cultures. A reverse banding with acridine orange was used. Karyotypes were arranged according to the International System for Human Cytogenetic Nomenclature.18

**RESULTS**

**Morphologic, cytochemical, and immunologic studies.** The age, sex, presenting symptoms, WBC count, hemoglobin level, platelet count, cytochemical properties and immunophenotype of blast cells, type of treatment, and survival from diagnosis of the five patients with trisomy 4 are listed in Table I.

Patient N.C.V. was classified as FAB M2 on the basis of the presence of maturation of the bone marrow cells, including granulated myeloblasts, Auer’s rods, and a high number of promyelocytes. Pelger-Huët–like anomaly, megaloblastic features of the red cell series, and a very few, abnormal megakaryocytes were noted.

Patient H.B. was classified at diagnosis as M4. MGG-stained slides of bone marrow showed maturation of the myeloid blasts and a few elements with single Auer’s rods. Nuclear abnormalities with bilobated or clover nuclei were prominent in the blast elements. Bone marrow smears showed 30% of the blast cells positive for ANAE. The more differentiated granulocytic forms showed a Pelger-Huët–like anomaly as well as hypersegmentation. A few eosinobasophilic elements were also observed. The red cell series was megaloblastic, and several bincleated forms were present. Megakaryocytes were abnormal with mononucleated nuclei and cytoplasmic basophilia. Blast cells in this case reacted with the BA-2 monoclonal antibody. All other lymphoid markers, however, were negative, including TdT, T3 antigen, and surface immunoglobulins.

In patient A.Z., bone marrow was classified as M4 and showed abnormal maturation of the myeloid series with hypogranulation. Pelger-Huët–like anomaly was present. Several blast cells showed scanty cytoplasm and sometimes folded nuclei. Most of these elements (49%) showed ANBE activity partially inhibited by NaF. Megaloblastosis of red cell series, hypolobulation of megakaryocytes, and a few eosinobasophils were associated morphologic anomalies.

Patient J.M. showed a typical FAB M4. ANBE activity was present in 30% of the immature elements. Morphologic anomalies, ie, megaloblastosis of the red cell series, dysmegakaryopoiesis, Pelger-Huët–like anomalies, and eosinobasophilic elements were consistently present in this case.

In patient P.B., the diagnosis was RAEB in Oct 1984 when cytogenetic studies were performed. Morphologically, two types of blast cells were identified: small blast elements with scanty cytoplasm, diffuse nuclear chromatin, and one or sometimes two nucleoli; and blasts with folded monocytoid nuclei. There was abnormal maturation of the myeloid series with a Pelger-Huët–like anomaly. Dysmegakaryopoiesis was present with both mononucleated and apparently polynucleated forms. The red cell series was megaloblastic. Iron staining did not show ringed sideroblasts. Plasma cells and eosinobasophils were noted. The myeloid nature of the disorder in this patient was confirmed by positivity of the SBB stain in more than 5% of the blast cells. Moreover, immunophenotype studies revealed a negativity of the antibodies reacting with lymphoid antigens, ie, TdT, BA-1, B1, J5, and OKT3.

**Cytogenetic studies.** The karyotypic investigations of the five patients at diagnosis and during the course of the disease are summarized in Table 2. Figure 1 shows the trisomy 4 in a partial karyotype of the five patients. In patients 1, 2, and 4, the predominant clone with trisomy 4 was associated with normal karyotypes at the time of diagnosis. In patient 1, no mitoses were obtained at the time of a possible hematologic remission, but trisomy 4 was again present in 80% of the bone marrow metaphases during the terminal phase of the disease. Patient 3 showed trisomy 4 as sole anomaly in 23 out of 25 metaphases. In this patient, however, also one subclone with an additional trisomy 7 was identified. All five metaphases obtained from the peripheral blood of patient 5 showed a 47, XX, +4 karyotype.

**DISCUSSION**

To the best of our knowledge, trisomy 4 as the primary karyotypic anomaly has never been described in human hematologic malignancies. A few cases of ANLL, namely, one M2 and five M5 FAB types have been described in which trisomy 4 was part of a complex abnormal karyotype with both numerical and structural anomalies of other chromosomes.19-22

The present study documents for the first time the existence of a unique hematologic disorder associated with a trisomy of chromosome 4. This hematologic disorder is nonlymphoid in nature as demonstrated on the basis of morphology, cytochemistry, and monoclonal antibody reactivity of the blast cells. Furthermore, the fact that the acute leukemias in this study showed either granulocytic or monocytic differentiation, ie, M2 and M4 FAB types, indicates
Figures in parentheses are the number of karyotypes over the total number of metaphases studied.

The significance of a trisomy of chromosome 4 for the biology of the malignant clone is unclear at present. Trisomy may be associated with quantitative changes in the production of specific gene products. A gene dosage effect has been described in some disorders associated with trisomy 8 and increased levels of the enzyme glutathione reductase, the gene of which is located on the short arm of chromosome 8.28-29 A similar example was recently given by Koprowski et al30 who demonstrated that the epidermal growth factor receptor, coded for by chromosome 7, was expressed by only melanoma cells with a trisomy 7. Therefore, one may speculate that trisomy 4 is involved in the abnormal proliferation of the neoplastic clone through an increased production of one or more factor(s) that are controlled by genes on this chromosome. Two genes involved in the proliferation and self-perpetuation of malignant cells31 have been mapped on chromosome 4, one coding for the T cell growth factor,32 the other for the epidermal growth factor.33 It remains to be tested whether trisomy 4 confers a proliferating advantage to the malignant cells by amplification of one or more of these growth factor(s).
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