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RESPONSE

To the Editor:

As pointed out by H.G. Drexler, the term proliferation is indeed misused in our discussion.1 We used DNA synthesis (which may not necessarily be followed by cell growth) to assess the effect of B-cell growth factor and interleukin-2 (IL-2). We obtained positive results with cells from some (but not all) B-chronic lymphocytic leukemia (B-CLL) patients, which fits with results from other studies2-5 not quoted in H.G. Drexler's letter. The real growth of (normal as well as monoclonal) B cells under the influence of these factors is still a matter of controversy.

As suggested by H.G. Drexler, we performed double staining on our cell preparations and found 93% of the cells positive for both CD5 and CD19 markers. Thus, our preparations contain essentially B-CLL cells. Moreover, a role for residual normal B cells in our results seems improbable on the following arguments: (a) By using identical experimental conditions, we could obtain terminal B-cell differentiation in B-CLL cultures; and only IgM was produced in contrast to normal B-cell cultures, which produce both IgM and IgG.3 (b) In our hands, B-CLL cells display patterns of responsiveness to interferon-γ4 and to IL-45 that are clearly different from that of normal B or T cells.

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REFERENCES


INTERFERON GAMMA IN CHRONIC MYELOID LEUKEMIA: DOSE AND SIDE EFFECTS

To the Editor:

We have attempted to treat 14 patients with Ph positive chronic myeloid leukemia (CML) by recombinant human gamma interferon (IFN-γ) (kindly supplied by Boehringer Ingelheim) administered intramuscularly (IM) at a schedule similar to that described by Kurzrock et al6: 0.10 mg/m² daily during the first week, 0.25 mg/m² daily during the second week, and 0.50 mg/m² daily from the third week onward. Fever, night sweats, chills, myalgias, and headaches were observed as in Kurzrock's experience (ie, in 100% to 64% of cases). However, in spite of a constant use of paracetamole (1 to 2 g daily), the intensity of the side effects did not decrease after the first weeks of treatment, and this led to a progressive deterioration of the performance status of our patients, with a Karnofsky's index ≤60 in 21% of cases and ≤70 in 57% of cases. From the fourth to the twentieth week of treatment, the median maximum tolerated dose was 0.25 mg/m²/day, but only two of 14 patients were able to tolerate 0.50 mg/m²/day. Therefore, we agree with Kurzrock et al7 that side effects of IFN-γ are qualitatively similar to those experienced with IFN-α, but we do not agree that tachyphylaxis often occurs after the first week of treatment as it usually does with IFN-α. Kurzrock et al7 reported that most patients were able to tolerate 0.25 to 0.50 mg/m²/day of IM IFN-γ, but they did not specify how many of them did actually tolerate 0.25 or 0.50 mg, and how many patients received <0.25 mg.

In our experience, the maximum tolerated dose was always <0.25 mg in two cases, equal and sometimes <0.25 in eight cases, 0.35 mg in two cases, and 0.50 mg in two cases only. Also at these doses the Karnofsky's index remained ≤80 in 78% of the cases throughout the study.
Interferon gamma in chronic myeloid leukemia: dose and side effects [letter]

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