The Effect of α-Interferon on Bone Marrow Megakaryocytes and Platelet Production Rate in Essential Thrombocythemia

By Hans Wadenvik, Jack Kutti, Börje Ridell, Peter Revesz, Stefan Jacobsson, Bengt Magnusson, Jan Westin, and Lars Vilén

In 10 patients with previously untreated essential thrombocythemia (ET), by using 111In-labeled platelets and megakaryocyte morphometry, the relation between platelet production rate and bone marrow megakaryocytes was evaluated before and during α2b-interferon (IFN) therapy. A highly significant decrease in platelet count occurred during IFN therapy; the platelet counts, at baseline and after 2 and 6 months of IFN therapy, were 1,102 ± 345 x 10^9/L, 524 ± 169 x 10^9/L (P < .0001), and 476 ± 139 x 10^9/L (P < .0001), respectively. The decrement in platelet count was mainly a result of diminished platelet production rate, which at baseline and after 2 and 6 months of IFN therapy were 89 ± 30 x 10^9 platelets/d, 53 ± 18 x 10^9 platelets/d (P = .0033), and 45 ± 20 x 10^9 platelets/d (P < .0001), respectively. Also, a slight shortening of platelet mean life-span (MLS) was observed in response to IFN treatment; platelet MLS was 7.96 ± 0.69 days at baseline and 6.68 ± 1.30 days (P = .012) after 6 months of IFN therapy. IFN induced a significant decrease in bone marrow megakaryocyte volume; both megakaryocyte nuclear and cytoplasmic volumes were affected. The mean megakaryocyte volume was 372 ± 128 ± 10^9 pL/μL at baseline and 278 ± 147 ± 10^9 pL/μL (P = .049) after 6 months of IFN therapy. However, the number of megakaryocytes did not show any significant change in response to IFN. It is concluded that α-IFN reduces platelet production rate and the peripheral platelet count in ET mainly through an anti-proliferative action on the megakaryocytes and to a considerably lesser degree by a shortening of platelet MLS.

Essential thrombocythemia (ET) is a chronic myeloproliferative disorder (MPD) in which an excessive number of morphologically and functionally abnormal platelets are produced.1-2 The clonal nature of the disorder has been well established.3 In ET, as well as in other chronic MPD, human α-interferon (α-IFN) is known to be effective in controlling thrombocytopoiesis.4-6 Although α-IFNs are recognized for their anti-viral, immunomodulatory, and anti-proliferative properties,7-11 the mechanisms by which they reduce platelet counts in patients with chronic MPD are poorly understood. Recently, it has been demonstrated that α-IFN inhibits the in vitro growth of normal bone marrow (BM) megakaryocyte colony-forming units (CFU-MK).12-14 Also, α-IFN has been shown to decrease the number and size of BM CFU-MK-derived colonies in ET patients; α-IFN exerted this effect both in vitro and in vivo.15 However, the effect of α-IFN on platelet production rate in vivo and its relation to BM megakaryocyte morphometry has thus far not been evaluated in ET patients.

Three methods are available for the estimation of platelet production: (1) morphologic estimation of megakaryocyte frequency, (2) indirect calculation of production from direct measurement of platelet destruction, and (3) direct measurement of platelet production using tracers of the megakaryocyte line. Presently, the indirect method using determination of the platelet mean life-span (MLS) from randomly labeled platelets is the most reliable.16

The aim of the present report was to describe, in terms of platelet kinetics, the decrease in platelet count following α-IFN treatment of patients with ET. Thus, by using 111In-labeled platelets and megakaryocyte morphometry of BM biopsies, the platelet production rate was determined, before and during α-IFN treatment, in a well-defined group of previously untreated ET patients.

MATERIALS AND METHODS

Ten ET patients, three men and seven women, aged 40 to 75 (mean 57) years, were studied. All subjects but one were newly diagnosed and otherwise healthy; none of them had previously received any myelosuppressive treatment. Their platelet counts ranged from 646 to 1,512, average 1,102 ± 345 x 10^9/L. The spleen was not palpable in any subject; gamma camera imaging (see below) showed slight splenic enlargement in some patients (posterior projections ranged from 47 to 115, average 76 ± 21 cm²; left lateral projections ranged from 55 to 115, average 91 ± 19 cm²). Before study only one patient had experienced deep venous thrombosis and severe pulmonary embolism; none of them had suffered from major hemorrhagic complications. One of them had suffered from wide-spread thrombophlebitis of the leg. Five subjects had experienced mild/moderate disturbances from the central nervous system including dizziness, paresthesias, headaches, and visual phenomena. One of them had suffered from digital ischemia, whereas two patients had not experienced any symptoms related to thrombocytopoiesis. In sections of paraffin-embedded iliac crest biopsies the BM of all subjects showed moderate to marked hypercellularity together with abundant large megakaryocytes. The BM reticulin was normal in three subjects, and there was a slight, moderate, or marked increase in two, and two subjects, respectively. No patient demonstrated fibrosis of the BM. In smears, the average erythrocytosis was 15.2% ± 9.3%, the average myelopoiesis was 65.0% ± 6.3% and other cell types constituted 19.6% ± 6.4% of the BM cells. No signs of myelodysplasia were observed. The diagnostic criteria for ET were those established by the Polycythemia Vera Study Group.17 For inclusion into the study a venous platelet count in excess of 1,000 x 10^9/L and/or symptoms related to thrombocytosis were required. In-

From the Department of Medicine, Östra Hospital; Hematology section, Department of Medicine II, and Department of Pathology, Sahlgrens' Hospital, Gothenburg University, Gothenburg, Sweden. Submitted April 9, 1990; accepted January 9, 1991.

Supported by grants from the Swedish Cancer Society, project 432-B90-09XB, the Göteborg Medical Society, and from Cancer-och Trafikskadades Riksförebynd.

Address reprint requests to Jack Kutti, MD, Department of Medicine, Östra Hospital, S-416 85 Gothenburg, Sweden.

The publication costs of this article were defrayed in part by page charge payment. This article must therefore be hereby marked "advertisement" in accordance with 18 U.S.C. section 1734 solely to indicate this fact.

© 1991 by The American Society of Hematology.
formed written consent was obtained from all subjects participating in the study. Induction therapy consisted of daily doses of 5 × 10^4 IU α-2b-IFN (Intron-a; Schering-Plough Int, USA) and was administered subcutaneously (SC) over 4 weeks. Thereafter, maintenance therapy with IFN was administered three times weekly at a dose of 5 × 10^4 IU SC. The treatment with IFN was initiated while the patients were admitted to hospital over 2 to 4 days. Thereafter, they were managed on an out-patient basis.

The venous blood cell counts were determined weekly during the first month of therapy and subsequently with 2- to 4-week intervals. Platelet kinetics were determined immediately before the start of IFN treatment and the platelet production rate was calculated. The platelet kinetic studies were repeated after 2 and 6 months of IFN treatment. The spleen size was measured and megakaryocyte morphology of BM biopsies was performed before and after 6 months of IFN therapy.

**In-labeling.** The method for 111In-labeling of autologous platelets and calculation of platelet MLS has been described in detail elsewhere. Briefly, 17 mL of venous blood were anticoagulated with 3 mL ACD-A and spun at 260g for 15 minutes. The supernatant platelet-rich plasma (PRP) was removed, acidified to pH 6.5 by addition of ACD-A, and then centrifuged at 800g for 10 minutes to obtain a platelet button. The platelet-poor plasma (PPP) was saved in a sterile syringe and the platelet button and tube walls were carefully washed with 5 mL Modified Tyrode's Solution. The platelet button was resuspended in 1 mL of the same solution and the required amount of 111In-oxine (Amersham Radiochemical Centre, UK) added. After incubation for 2 minutes at 37°C, 2 mL of PPP were added and the suspension centrifuged at 800g for 10 minutes. The supernatant plasma was removed and the labeled platelet button was resuspended in 5 to 6 mL PPP. The radioactivity associated with the supernatant and platelet button was measured in a dose calibrator and the labeling efficiency calculated. Finally, to remove contaminating red blood cells (RBCs), the labeled platelet suspension was spun at 100g for 3 minutes and then aspirated into a disposable syringe. The labeled platelet suspension was injected to the donor through a 19-gauge butterfly infusion set. The syringe was weighed before and after injection, and the injected weight was divided by 1.027 to obtain the injected volume. Standards consisted of duplicate aliquots of the final labeled platelet suspension and were prepared as follows: (1) 100 μL platelet suspension, (2) 100 μL platelet suspension incubated with 2 mL 0.9% NaCl for 10 minutes, centrifuged at 2,000g for 20 minutes, supernatant discarded, and the platelet button saved, (3) 100 μL platelet suspension incubated with 2 mL 1% ammonium oxalate for 10 minutes, centrifuged at 2,000g for 20 minutes, supernatant discarded, and the platelet button saved, (4) 100 μL platelet suspension incubated with 2 mL 1% ammonium oxalate for 10 minutes, centrifuged at 2,000g for 20 minutes, supernatant discarded, and the platelet button resuspended in 3 mL water. The difference between the unwashed and NaCl-washed standards was taken as the plasma-bound radioactivity, and the difference between the NaCl-washed and ammonium oxalate-washed standards was taken as the RBC-bound radioactivity. The ammonium oxalate-washed standards were used for calculation of in vivo recovery of platelet-bound radioactivity, and the total blood volume was calculated after measurement of body weight and height.

**Intrasplenic platelet kinetics.** For measurements of intrasplenic platelet kinetics, a compartmental analysis of the initial distribution of platelets between systemic blood and splenic pool was used. For this purpose a large field of view gamma camera (MaxiCamette FT; General Electric), fitted with a medium energy parallel hole collimator (max 370 keV) and interfaced to a computer (PDP 11; Digital Equipment) with a nuclear imaging system (Gamma-11; Digital Equipment), was used. The patient was placed in the supine position under the gamma camera so that the liver, spleen, and cardiac blood pool could be monitored. Both gamma photons of 111In (173 and 240 keV) were collected with a 15% energy window setting. After 15 minutes of rest in this position, the 111In-labeled platelet suspension was injected through a 19-gauge butterfly infusion set and the radioactivity over liver, spleen, and cardiac blood pool was followed for 30 minutes using a frame time of 30 seconds. The injected dose was 6 MBq. The images were stored in the computer using a 64 × 64 matrix system. Time activity curves for different regions of interest (liver, spleen, and heart) were constructed with the computer. Splenic blood flow, intrasplenic platelet transit time, and the size of the exchangeable splenic platelet pool were calculated after fitting monoexponential functions to the experimental data of the spleen and cardiac blood pool time activity curves.

**Platelet survival.** Venous blood (30 mL) was collected into 0.34 mol/L K3-EDTA at 2, 3, and 4 hours after infusion of radiolabeled platelets, and subsequently at 24-hour intervals over 7 consecutive days. All blood samples were drawn after 15 minutes of rest in the supine position and avoiding venous occlusion. The packed RBC volume was determined in an impedence cell counter (Coulter Counter Model S-Plus VI; Coulter Electronics, UK). Determination of platelet count was performed by phase contrast microscopy. For determination of radioactivity, duplicate samples of 3 mL whole blood, lysed with saponin, and 3 mL PPP (obtained by centrifugation at 2,000g for 20 minutes) were prepared in association with each sampling. Also, two platelet buttons were obtained from duplicate aliquots of 5 mL whole blood by differential centrifugation. Whole blood (5 mL) was mixed with 2.5 mL 0.9% NaCl, centrifuged at 1,500g for 1 minute, and the supernatant was discarded. The platelet button was resuspended in 6 mL PPP. The platelet button was counted in a hole-type crystal scintillation counter (Packard Model PGD PRIAS; Packard Instrument Company, Inc, USA) to a counting error of 1% or less, and with a spectrometer setting including both photo peaks and the summation peak of 111In.

The platelet MLS was calculated by least square computer fitting of a multiple hit gamma function model to the experimental data. The 2-hour value constituted the first experimental point used for calculation of platelet MLS, and the initial recovery of platelet-bound radioactivity was obtained by extrapolating the gamma function fitted survival curve to zero time. The computer program for these calculations was obtained from the office of ICSH. The platelet MLS was calculated using the platelet buttons as well as the whole blood samples corrected for plasma-bound radioactivity. Platelet production rate (platelet destruction rate in steady state conditions) was estimated by dividing the circulating platelet mass by platelet MLS and correcting for platelets residing in the splenic platelet pool (SPP), calculated from compartmental analysis: PLC × TBV × MLS⁻¹ × (1 − SPP). In the formula PLC denotes the platelet count and TBV the total blood volume. The platelet MLS obtained using whole blood samples was used for this calculation.

**Spleen size.** The spleen size was determined using a gamma camera fitted with a high resolution parallel hole collimator (max 200 keV), and interfaced to a computer with a nuclear imaging system. Ten minutes after intravenous injection of 200 MBq
counts were collected with the gamma camera in the left lateral and posterior projections, and the images were stored in the computer using a 64 × 64 matrix system. The spleen areas in the lateral and posterior projections were calculated after weighted background subtraction and edge detection with an automatic computer program. The measured area in number of pixels was converted to square centimeters with the help of an enlargement computer program. The measured area in number of pixels was

Megakaryocyte morphometry. A Jamshidi needle was used to obtain BM. After local anesthesia, the biopsy needle was introduced into the posterior iliac crest and the biopsy was taken. The specimens were fixed in 3% glutaraldehyde in 0.1 mol/L sodium cacodylate buffer at pH 7.4 for 24 hours, dehydrated in alcohol, and embedded in hydroxyethylmethacrylat (Hostoresin) without decalcification. Sections of a thickness of 2 μm were cut and stained with May-Grünwald-Giemsa, hematoxylin-eosin, and PAS-reaction, accordingly. The results were calculated. Using a Zeiss Integration Eye Piece IV at a magnification of 1,000× the total area (Aₚ) of at least 50 megakaryocytes and their nuclei (Aₙ) was determined by the point counting method and their mean areas were determined (Aₚ and Aₙ, respectively). The standard error of a single determination was calculated from 10 duplicate determinations according to the formula \( \sqrt{\frac{S^2}{n}} \) and were 2.8% and 5.8%, respectively, for the measurements of Aₚ and Aₙ. The megakaryocyte area fraction per square millimeter BM, ie, the megakaryocyte volume per microliter BM (Vₚ), was calculated as Nₚ × Aₚ. In a similar fashion, the volume fraction (Vₚ) occupied by nuclei in the megakaryocytes was calculated as Aₙ/Aₚ × Vₚ and the volume fraction of cytoplasm (Vₑ) was calculated as Vₑ = Vₚ - Vₚ. These volumes are expressed as picoliter per microliter BM. The number of megakaryocytes per microliter BM (Nₚ) was calculated as described by others as \( Nₚ = K/β \sqrt{Nₙ/Vₑ} \) thereby considering the cells to have a spherical form (ie, \( β = 1.382 \)) and a size variation coefficient of 20% (ie, K = 1.06). From the data on volume and number of megakaryocytes per microliter BM the average cell and nuclear volumes were determined as \( Vₚ/Nₚ \) and \( Vₑ/Nₚ \), respectively.

Standard statistical methods were used. Unless otherwise stated, mean values ± SD are given. The differences between means were tested with the Student's t-test for paired data, and a P value < .05 was considered statistically significant.

The present study was approved by the local ethical committee and by the Swedish National Board of Health and Welfare.

RESULTS

Before start of IFN treatment, the mean platelet count was 1,102 ± 345 × 10⁹/L. A highly significant decrease in platelet count occurred during IFN therapy (Fig 1); the average platelet counts after 2 and 6 months of IFN therapy were 524 ± 169 (P < .0001) and 476 ± 139 × 10⁹/L (P < .0001), respectively. A concomitant reduction in white blood cell count and hemoglobin concentration was also observed. The hemoglobin concentration was reduced from a pretreatment value of 145 ± 19 to 132 ± 18 (P = .019) and 134 ± 18 g/L (P = .056) after 2 and 6 months of IFN therapy, respectively. Likewise, there was a statistically significant but clinically negligible lowering of the granulocyte and leukocyte counts.

Table 1 gives the results for the platelet kinetics. IFN induced a shortening of the platelet MLS. The mean pretreatment platelet MLS was 7.96 ± 0.69 days, using whole blood samples, and decreased to 6.95 ± 1.25 days (P = .035) and 6.68 ± 1.30 days (P = .012) after 2 and 6 months of IFN therapy, respectively. There was no change as to the SPP size, irrespective of whether it was measured indirectly, using the in vivo recovery of “platelet-bound radioactivity,” or directly, using compartmental analysis. However, a statistically significant increase in splenic blood flow was present after 2 months of IFN therapy, as compared with the pretreatment value (7.3 ± 2.0 vs 5.7 ± 2.3 %TBV/min; P = .041). The intrasplenic platelet transit time decreased slightly but not significantly so. Furthermore, the calculated platelet production rate showed a

| Table 1. Results for the Platelet Kinetics and Spleen Size in 10 ET Patients Treated With α-2b-IFN for Six Months (mean ± SD) |
|---|---|---|
| | Pre-treatment | 2 mo | 6 mo |
| Platelet count (× 10⁹/L) | 1,102 ± 345 | 524 ± 169* | 476 ± 139* |
| Platelet MLS (whole blood) (d) | 7.96 ± 0.69 | 6.95 ± 1.25* | 6.68 ± 1.30* |
| Initial recovery of platelet bound radioactivity (whole blood) (%) | 48 ± 8 | 45 ± 7 | 49 ± 9 |
| Platelet MLS (platelet button) (d) | 7.84 ± 0.88 | 6.89 ± 1.17* | 6.56 ± 1.22* |
| Initial recovery of platelet-bound radioactivity (platelet button) (%) | 53 ± 11 | 48 ± 5 | 52 ± 10 |
| SPP size (%) | 36 ± 8 | 41 ± 7 | 37 ± 8 |
| Splenic blood flow (% TBV/min) | 5.7 ± 2.3 | 7.3 ± 2.0* | 6.5 ± 2.1 |
| Intrasplenic platelet transit time (min) | 10.4 ± 1.7 | 9.9 ± 1.8 | 9.8 ± 1.6 |
| Platelet production rate (× 10⁹/d) | 88.9 ± 29.8 | 53.1 ± 17.5* | 45.4 ± 20.5* |
| Spleen area (cm²) | 66.8 | 56.1 | 45.4 |

*P < .05.
†P < .01.
‡P < .0001.
marked decline following IFN treatment. The pretreatment platelet production rate, $89 \pm 30 \times 10^9$ platelets/d, diminished to $53 \pm 18 \times 10^9$ platelets/d after 2 months ($P = .0033$), and was $45 \pm 20 \times 10^9$ platelets/d after 6 months ($P < .0001$) of IFN therapy (Fig 2).

The mean labeling efficiency was $87 \pm 4\%$. The radioactivity bound to plasma constituted $3.4\% \pm 1.8\%$ of the total radioactivity in the final labeled platelet suspension, and $1.0\% \pm 1.2\%$ was bound to the erythrocytes.

The spleen showed no statistically significant changes in response to IFN treatment in either the left lateral or in the posterior projections (Table 1).

Due to technical reasons, in two of the study subjects BM specimens were not satisfactorily evaluable on one of the two biopsy occasions. The mean BM cellularity showed no changes in response to IFN. The pretreatment mean BM cellularity was $71\% \pm 10\%$ as compared with $74\% \pm 8\%$ after 6 months of IFN treatment. There was a nonsignificant decrease of the number of megakaryocytes per microliter BM; the megakaryocyte numbers at baseline and after 6 months of IFN therapy were $1,324 \pm 554$ and $1,227 \pm 703$ ($P = .486$), respectively. The pretreatment average megakaryocyte volume was $372 \pm 126 \times 10^2$ pL/$\mu$L BM as compared with $278 \pm 147 \times 10^2$ pL/$\mu$L BM at 6 months ($P = .049$). This decline in BM megakaryocyte volume was a result of reduced megakaryocyte cytoplasmatic as well as reduced megakaryocyte nuclear volumes. The mean megakaryocyte cytoplasmatic and nuclear volumes, at baseline and at 6 months, were $320 \pm 110$ versus $239 \pm 127 \times 10^2$ pL/$\mu$L BM ($P = .058$), and $54 \pm 19$ versus $39 \pm 21 \times 10^2$ pL/$\mu$L BM ($P = .007$), respectively (Fig 3). The calculated average cell and nuclear volumes were $29.4 \pm 7.9$ versus $23.1 \pm 4.0$ pL ($P = .026$) and $4.2 \pm 0.7$ versus $3.2 \pm 0.6$ pL ($P = .001$), respectively, at start and after 6 months of IFN treatment.

IFN therapy, as administered in the present work, was well tolerated and caused a minimum of side effects. Mild flu-like symptoms over the very first days of treatment were easily controlled by the intake of 500 mg paracetamol approximately 30 minutes before the injections; further, most patients experienced mild hair loss, and over the first few months there were complaints of slight fatigue and loss of appetite.

**DISCUSSION**

The present study describes a homogeneous group of previously untreated ET patients in all of whom recombinant human $\alpha$-2b-IFN given over 6 months was shown to dramatically lower the peripheral platelet count; the predominant therapeutic response occurred within the first weeks of treatment.

In 1983, Talpaz et al reported that partly purified human leukocyte IFN reduced the thrombocytosis associated with Philadelphia chromosome positive chronic granulocytic leukemia. These results were confirmed by other investigators, and the capacity of $\alpha$-IFN to reduce the thrombocytosis was found to be valid for all chronic MPD.

The mechanisms by which $\alpha$-IFN exerts this effect are still unresolved. However, several studies have ascribed human IFNs, derived from different sources, antiproliferative activity against normal hematopoietic progenitor cells; suppression of in vitro colony formation has been seen in human and mouse multipotential (CFU-GEMM, CFU-leukocyte), human and mouse megakaryocyte (CFU-MK), erythroid (erythroid burst-forming unit [BFU-E]) and mouse megakaryocyte (CFU-MK) progenitor cells. Moreover, IFN has been shown to exert an antiproliferative activity against chronic granulocytic leukemia progenitor cells, and to inhibit the growth, size, and number of CFU-MK from patients with ET. Indeed, an antiproliferative effect of $\alpha$-IFN in ET patients is clearly demonstrated by the present results; both the platelet production rate and the BM megakaryocyte volume were...
significantly reduced in our ET patients treated with α-IFN. Other workers have reported a decrease in the number of BM megakaryocytes in response to IFN treatment of ET.3,7,20

In accordance with the present results in a recent study comprising two patients with ET, a decrease of the megakaryocyte area and the megakaryocyte nuclear area was observed after IFN therapy.38 By using various methods, several investigators have demonstrated a significant correlation between nuclear as well as cell size and DNA content of megakaryocytes.39,40 The present finding of significant decrease of nuclear and cell volumes in response to IFN treatment would therefore imply a decrease of the average ploidization and size of megakaryocytes. Such a decrease might explain the decreased megakaryocyte volume and would ultimately explain the observed reduction in platelet production rate.

An IFN-induced reduction of the platelet half-life was suggested as the mechanism by which IFN decreases the peripheral platelet count.41-43 However, our results do not support this view; the pretreatment mean platelet MLS was 7.97 days and diminished to 6.68 after 6 months of IFN therapy. Thus, platelet MLS was reduced by only 16%, whereas the mean peripheral platelet count decreased by 57%. Hence, the reduction of platelet MLS can only account for about 28% of the peripheral platelet count decrement. Moreover, because the exchangeable SPP size was unaffected by IFN therapy, the IFN-induced change in platelet production rate is responsible for more than 70% of the reduction in venous platelet concentration. However, it could be argued that this shortening in platelet MLS may to some extent explain the initial and rather instant lowering of platelet counts.29

As described by others,46 we also found that α-IFN caused a slight decrease in hemoglobin concentration and leukocyte count. In our study, these changes did lack clinical relevance.

The results for the determination of SPP size and spleen size did not show any significant changes in response to IFN treatment. According to the closed two-compartmental model,18,22 the size of the SPP is dependent on only two variables, i.e., the splenic blood flow and the intrasplenic platelet transit time. The SPP size and the splenic blood flow are known to increase concomitantly with increasing spleen size, and the splenic blood flow can be modulated by adrenaline and isoprenaline infusions.47 The intrasplenic platelet transit time is a variable that until recently had not been investigated.21 Unlike the splenic blood flow, the intrasplenic platelet transit time appears to be unrelated to spleen size but shows an inverse relationship to splenic perfusion.46,48 Other factors that are expected to influence platelet transit time through the spleen include platelet size, platelet antibody coating, intrinsic platelet abnormalities, and splenic macrophage function.50,51 In the present study, IFN treatment was followed by a slight increase in splenic blood flow, which was shown to be statistically significant at 2 months after start of IFN therapy. This increase in splenic blood flow was counteracted by a slight shortening of the intrasplenic platelet transit time, leaving the SPP size mainly unchanged.

It can be concluded that the present results clearly demonstrate that α-IFN reduces the platelet count in ET mainly through an anti-proliferative action on the BM megakaryocytes and to a considerably lesser extent by inducing a shortened platelet MLS.

REFERENCES
Blood Cells in Nuclear Medicine, Part I. The Hague, The Netherlands, Martinus Nijhoff, 1984, p 86
28. Cullen WC, McDonald TP: Comparison of stereologic techniques for the quantification of megakaryocyte size and number. Exp Hematol 14:782, 1986
The effect of alpha-interferon on bone marrow megakaryocytes and platelet production rate in essential thrombocythemia

H Wadenvik, J Kutti, B Ridell, P Revesz, S Jacobsson, B Magnusson, J Westin and L Vilen