Patterns of Hematopoietic Lineage Involvement in Children With Neurofibromatosis Type 1 and Malignant Myeloid Disorders

By Darryl K. Miles, Melvin H. Freedman, Karen Stephens, Maria Pallavicini, Eric L. Sievers, Molly Weaver, Tom Grunberger, Patricia Thompson, and Kevin M. Shannon

Children with neurofibromatosis type 1 (NF1) are at increased risk of developing malignant myeloid disorders, particularly juvenile chronic myelogenous leukemia/juvenile myelomonocytic leukemia (JCML/JMML). We investigated bone marrows from 11 such patients (8 boys and 3 girls) and detected allelic losses at the NF1 locus in 4 of them and probable losses in 2 others. To determine which hematopoietic cell lineages were derived from the abnormal clones, Epstein-Barr virus (EBV)-transformed cell lines and CD34+ cells were analyzed from 3 children with JCML with allelic losses in unfraccionated marrow. CD34 cells from these 3 patients lacked the normal NF1 allele, whereas EBV cell lines retained it. Erythroblasts plucked from the burst-forming unit-erythroid colonies of one of these children lacked the normal NF1 allele. We also studied a 10-month-old boy with NF1 who developed an unusual myeloproliferative syndrome. His bone marrow and EBV cell line both showed loss of the normal NF1 allele. In our series and in the literature, male sex and maternal transmission of NF1 were associated with the highest risk of myeloid leukemia. These data (1) provide strong genetic evidence that NF1 functions as a tumor-suppressor in early myelopoiesis, (2) confirm the clonal nature of JCML/JMML, (3) suggest that the elevation in fetal hemoglobin seen in JCML/JMML is a result of primary involvement of erythroid progenitors in the malignant clone, (4) show consistent loss of NF1 in the CD34 cells of affected children and show that the malignant clone may also give rise to pre-B cells in some cases, and (5) implicate epigenetic factors in the development of leukemia in children with NF1.

© 1996 by The American Society of Hematology.

From the Departments of Pediatrics and Laboratory Medicine, University of California, San Francisco, CA; the Division of Hematology, Hospital for Sick Children, Toronto, Ontario, Canada; and the Departments of Pediatrics and Medicine, University of Washington, Seattle, WA.

Submitted April 9, 1996; accepted August 1, 1996.

K.M.S. is supported in part by National Institutes of Health (NIH) Grant No. 3M01 RR02171-1351, by an American Cancer Society Junior Faculty Research Award (JFRA-471), by grants from the US Army Medical Research and Development Command (Grant No. DAMD17-93-J-3075), by the Concern 2 Foundation, and by an award to Tom Grunberger, Patricia Thompson, and Kevin M. Shannon from the Children’s Cancer Group (Study No. B24). D.K.M. received Grant No. CA60417 to M.P. and was facilitated by a collaboration with the Children’s Cancer Group (Study No. B24). D.K.M. received additional support from the UCSF School of Medicine and from the UCSF Pediatric Clinical Research Center.

Address reprint requests to Kevin M. Shannon, MD, Department of Pediatrics, University of California, Room HSE-302, Box 0519, San Francisco, CA 94143-0519.

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.

© 1996 by The American Society of Hematology.


4314

NF1 who developed an unusual myeloproliferative syndrome. His bone marrow and EBV cell line both showed loss of the normal NF1 allele. In our series and in the literature, male sex and maternal transmission of NF1 were associated with the highest risk of myeloid leukemia. These data (1) provide strong genetic evidence that NF1 functions as a tumor-suppressor in early myelopoiesis, (2) confirm the clonal nature of JCML/JMML, (3) suggest that the elevation in fetal hemoglobin seen in JCML/JMML is a result of primary involvement of erythroid progenitors in the malignant clone, (4) show consistent loss of NF1 in the CD34 cells of affected children and show that the malignant clone may also give rise to pre-B cells in some cases, and (5) implicate epigenetic factors in the development of leukemia in children with NF1.

© 1996 by The American Society of Hematology.


4314
that is committed to myeloid differentiation. However, we surprisingly found loss of the normal NF1 allele in both EBV-transformed and untransformed bone marrow cells from 1 child with an atypical clinical presentation. These new cases also extend previous observations that boys who inherit NF1 from their mothers are at the highest risk of developing myeloid disorders.2

MATERIALS AND METHODS

**Patient population and diagnostic criteria.** The 11 patients included in this study were referred for study by pediatric oncologists throughout the world between 1992 and 1995. The experimental procedures were approved by the Institutional Review Board of the University of California, San Francisco. An International Working Group has suggested that JCM be renamed JMML because the latter provides a more accurate description of the underlying malignant myeloid disorder and eliminates potential confusion with Philadelphia chromosome-positive chronic myelogenous leukemia (CML; RR Castelberry et al, personal communication, April 1996). Accordingly, the term JMML is used in the succeeding sections of this report. Children diagnosed with JMML were diagnosed by pediatric hematologists at the referring institutions using a combination of clinical and laboratory criteria26 including (1) leukocytosis with an elevated absolute monocyte count, (2) the presence of immature myeloid precursors in the peripheral blood, (3) less than 50% blasts in bone marrow aspirates, and (4) the absence of the Philadelphia chromosome. Most of the patients had associated findings, including hepatosplenomegaly, thrombocytopenia, an elevated percentage of heptocytes in bone marrow aspirates, and (4) the absence of the Philadelphia chromosome. Most of the patients had associated findings, including hepatosplenomegaly, thrombocytopenia, an elevated percentage of heptocytes in bone marrow aspirates, and (4) the absence of the Philadelphia chromosome.

**Polymeric markers in the NF1 region.** Investigating these leukemic samples for allclic loss was complicated by the fact that normal nonhematopoietic tissues from the same patients were not available to determine if their bone marrow showed loss of constitutional heterozygosity (LOH) in the NF1 region. We therefore extracted parental DNA and studied it in parallel with DNA from the bone patient marrows and, in some cases, from EBV-transformed lymphoblastoid cell lines. We routinely used 3 sequence polymorphisms within NF1 and 1 marker located centromeric of the gene to screen for allclic loss. The intragenic markers are EVI-20,27 an Alu repeat described by Xu et al,27 and a complex repeat described by Andersen et al20; the flanking marker is UT-172.21 Some patient bone marrows showed a single allele at all 4 loci, but allclic loss could not be ascertained with certainty because DNA from one or both parents was not available. In these cases, we also investigated two new intragenic repeat polymorphisms described by Lazaro et al.26 All of the polymorphic loci were scored by amplifying DNA segments that contain a variable number of short nucleotide repeats with flanking oligonucleotide primers. DNA samples were amplified in a DNA Thermocycle Machine (Perkin-Elmer Applied Biosystems Inc, Foster City, CA). Polymerase chain reaction (PCR) was performed in reaction mixtures that include 10 pmol of respective 3' and 5' primers, 100 ng of target genomic DNA, 1 U of Taq polymerase (Perkin-Elmer Applied Biosystems Inc), and 100 mmol/L final concentrations of deoxyribonucleotides in a final reaction volume of 25 µL.52P deoxy-adenosine triphosphate (ATP) was incorporated into the DNA fragments generated in the PCR procedure by adding 1 µCi (0.0037 MBq) of 32P deoxy-ATP per 25 µL of the reaction mixtures and decreased the concentrations of cold deoxy-ATP to 50 mmol/L. Labeled PCR products were separated on (6 mol/L urea, 8% polyacrylamide) sequencing-type gels and run at 60 to 80 W constant power for 2 to 4 hours. The gels were placed in Saran wrap and exposed to x-ray film for 1 to 36 hours at -70°C. The thermocycle parameters and experimental procedures for each primer pair were as described previously.23,26

**Preparation of EBV-transformed lymphoblastoid cell lines.** In most patients, mononuclear cells were isolated from patient peripheral blood samples by ficoll-histopaque (specific gravity, 1.077) density gradient centrifugation. The cells were washed three times in calcium and magnesium-free phosphate-buffered saline (CMF/PBS) and resuspended in 1 mL of RPMI 1640 medium supplemented with 20% fetal bovine serum, L-glutamine, and antibiotics. The number of viable lymphocytes was then determined by trypan blue exclusion. The cells were then resuspended in 4 mL of CMF/PBS supplemented with 0.5% human gamma globulin and transferred to T25 tissue culture flasks coated with anti-CD3 antibody (Applied Immune Sciences Inc, Santa Clara, CA) that had been prepared by washing four times with CMF/PBS. Mononuclear cells were incubated in the T25 anti-CD3 flasks for 1 hour at room temperature on a level surface without agitation. The nonadherent cells were then recovered by gently rocking the flask and removing the cell suspension. The cells were washed and resuspended at 1 × 10⁶ cells/mL. A total of 0.1 mL of EBV supernatant from cell line B95-8 was added per 1 × 10⁶ cells with thorough mixing. Cells were cultured at 1 to 2 × 10⁶ cells per well in a 24-well tissue culture plate. After 5 days, 1 mL of fresh media was added to each well. The cultures were fed twice weekly with 20% fetal bovine serum in RPMI 1640 supplemented with 25 mmol/L HEPES, L-glutamine, and antibiotics. Transformation was ascertained by the appearance of tightly formed cell clusters and usually occurred within 3 to 6 weeks. The EBV cell line from the patient shown in Fig 2 was prepared using a modification of the method of Netzel26 (the exact protocol is available from K. Stephens, University of Washington, Seattle).

**Isolation of CD34** cells. Frozen cells were thawed gradually and washed once in Iscove's modified Dulbecco's medium supplemented with 10% fetal calf serum prewarmed to 37°C. Nucleated cells were labeled with 7.5 µmol/L Hoechst 33342 (HO) at 37°C for 60 minutes, washed in Hank's balanced salt solution containing 0.02% azide, and incubated at 4°C for 45 minutes with fluorescein isothiocyanate (FITC)-conjugated anti-CD34 antibody (Becton Dickinson [BD], San Jose CA). After antibody labeling, the cells were washed once with PBS. Dead cells were stained with 1 µg/mL propidium iodide (PI, Calbiochem, Santa Clara, CA) for 5 minutes at 20°C. Flow cytometric analysis was performed using a FACStar PLUS (BD) equipped with 2 argon lasers tuned to 488 nm and 351 to 364 nm (UV wavelength). Forward light scatter, perpendicular light scatter, and fluorescence signals were measured for each cell. Cell doublets and aggregates were excluded using forward light scatter processing. HO and PI fluorescence emissions (UV excitation) were collected through a 425-nm (±50-nm) bandpass and a 620-nm long pass filter, respectively. PI**+/HO-positive events were considered to be viable nucleated cells. FITC emission (488 nm excitation) was collected through a 530-nm (±30-nm) bandpass filter. An isotype-matched antibody (Stimultest; BD) was used to define the immunofluorescence intensity above which cells were considered labeled. PI**+/HO-positive CD34** cells were sorted into a test tube containing RPMI medium and DNA was extracted as described previously.2 The small numbers of bone marrow mononuclear cells available from these young children precluded using the cell sorter to purify additional hematopoietic subpopulations for DNA extraction and polymorphism analysis.

RESULTS

Clinical data on the 11 patients are presented in Table 1. The study group included 8 boys and 3 girls with a median age at disease onset of 22 ± 15 months. Eight children had JMML and 1 patient each had Mo 7, AML, or a myeloprolif-
Table 1. Features of Study Population

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age at Onset</th>
<th>Diagnosis</th>
<th>Parent With NF1</th>
<th>Results With NF1 Markers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1M</td>
<td>24 mo</td>
<td>Mo 7</td>
<td>Unknown</td>
<td>LOH</td>
</tr>
<tr>
<td>2M</td>
<td>6 mo</td>
<td>JMML</td>
<td>Neither</td>
<td>HZ</td>
</tr>
<tr>
<td>3M</td>
<td>14 mo</td>
<td>JMML</td>
<td>Mother</td>
<td>LOH</td>
</tr>
<tr>
<td>4M</td>
<td>6 mo</td>
<td>JMML</td>
<td>Mother</td>
<td>HZ</td>
</tr>
<tr>
<td>5M</td>
<td>22 mo</td>
<td>AMMoL</td>
<td>Neither</td>
<td>HZ</td>
</tr>
<tr>
<td>6M</td>
<td>30 mo</td>
<td>JMML</td>
<td>Mother</td>
<td>LOH</td>
</tr>
<tr>
<td>7M</td>
<td>5 yr</td>
<td>JMML</td>
<td>Mother</td>
<td>LOH</td>
</tr>
<tr>
<td>8F</td>
<td>30 mo</td>
<td>JMML</td>
<td>Mother</td>
<td>Probable LOH</td>
</tr>
<tr>
<td>9M</td>
<td>19 mo</td>
<td>MPS</td>
<td>Mother</td>
<td>HZ</td>
</tr>
<tr>
<td>10F</td>
<td>12 mo</td>
<td>JMML</td>
<td>Neither</td>
<td>HZ</td>
</tr>
<tr>
<td>11F</td>
<td>18 mo</td>
<td>JMML</td>
<td>Unknown</td>
<td>Probable LOH</td>
</tr>
</tbody>
</table>

Abbreviations: HZ, retains heterozygosity; AMMoL, acute myelomonocytic leukemia.

CD34+ cells from the frozen bone marrow mononuclear cells of patients no. 3, 7, and 8; and plucked erythroblasts from BFU-E colonies grown from the bone marrow of patient no. 3. As shown in Fig 1, the EBV cell lines of these 3 patients retained both NF1 alleles, whereas the CD34+ cells consistently showed LOH. DNA extracted from the BFU-E colonies of patient no. 3 also showed LOH. Because patients no. 3, 7, and 8 had JMML, these data provide evidence that leukemic transformation in this disorder occurs at the level of an immature progenitor that is committed to myeloid differentiation and shows involvement of erythroid progenitors in the abnormal clone.

An EBV line was also available from a child with an MPS reported previously (patient no. 8 in Shannon et al23). In contrast to the 3 JMML patients, we detected absence of the normal maternal NF1 allele and of flanking polymorphic markers in both his EBV line and bone marrow (Fig 2).

Fig 1. Analysis of bone marrow and EBV cell line DNA from patients no. 3, 7, and 8 and DNA extracted from the blood of their parents. The mother is affected with NF1 in all three families. Lanes 1 through 11 were analyzed with the marker described by Xu et al27 and lanes 12 through 16 were analyzed with UT172. Lanes 1, 7, and 12 show maternal DNA; lanes 2, 8, and 13 show paternal DNA; lanes 3, 9, and 14 show EBV line DNA; and lanes 4, 10, and 15 show DNA extracted from leukemic bone marrow. Lanes 5, 11, and 16 represent DNA isolated from CD34+ cells in patient marrow and lane 6 shows analysis of BFU-E from 1 affected child. In all 3 cases, polymorphic NF1 markers show that the EBV lines have retained both parental alleles, whereas the affected bone marrow samples have deleted the normal paternal NF1 allele.
Fig 2. Analysis of bone marrow and EBV cell line DNA from a child who developed an unusual MPS with the polymorphic markers UT172 (lanes 1 through 5) and D17S787 (lanes 6 through 9). Different alleles are designated in order of size, beginning with the letter “A.” DNA from the following sources were amplified and resolved: lanes 1 and 6, mother; lanes 2 and 7, father; lane 3, patient blood; lanes 4 and 8, patient EBV cell line; lanes 5 and 9, unfractionated patient bone marrow. UT172 and D17S787 are located centromeric and telomeric of NFI, respectively. The EBV cell line and bone marrow also showed LOH with the intragenic NFI marker described by Andersen et al.28

DISCUSSION

Although substantial progress has been made in characterizing the genes that are altered during leukemogenesis and in understanding how these somatic mutations perturb hematopoietic growth, most of this work has focused on dominant genetic changes such as translocations that activate putative proto-oncogenes. Much less is known about the role of tumor-suppressor gene alterations in leukemic transformation and progression. General features of tumor-suppressor genes include (1) that germline mutations are associated with an increased risk of specific cancers; (2) that the single normal allele is inactivated by deletion, gene conversion, or point mutation during tumorigenesis; and (3) that the proteins encoded by tumor-suppressor genes normally function to negatively regulate cell growth.32,33 NFI fulfills all of these criteria in myeloid leukemia. First, children with NFI are at a markedly increased risk of developing malignant myeloid disorders, particularly JMML.3-5 Second, when data from the patients included in this study are combined with cases in a previous report,23 leukemic bone marrows from 9 of 18 children have definitely shown allelic losses and samples from 2 other patients have probable deletions. Similarly, mice that are heterozygous for a targeted disruption of Nfi are predisposed to myeloid leukemia, and these bone marrows delete the wild-type allele.32,34 When LOH has been detected in leukemic cells from children with familial NFI, the NFI allele inherited from the unaffected parent has been deleted in every case studied to date. It is likely that the bone marrows that retained both copies of NFI sustained subtle alterations such as point mutations in the normal allele that caused loss of function without allelic loss. Third, the identification of neurofibromin as a GAP for Ras, the conspicuous absence of RAS mutations in the leukemic bone marrows of children with NFI22 and direct evidence that the Ras signaling pathway is activated in leukemic cells from children with NFI and in murine Nfi−/− hematopoietic cells24,25 provide strong evidence that neurofibromin normally restrains the growth of myeloid cells by negatively regulating Ras.

JMML is the most common leukemia that arises in children with NFI.24,25 The clonal nature of this disorder is supported by studies of rare patients with a marker cytogenetic alteration in the bone marrow35 and, more recently, by showing a clonal pattern of hematopoiesis by the criteria of a nonrandom pattern of X chromosome inactivation in girls with JMML.36 Loss of the normal allele of NFI in some patients provides a third independent line of evidence that supports the clonal nature of JMML. The existence of this genetic marker of the leukemic clone allowed us to ascertain patterns of hematopoietic lineage involvement in 3 children with NFI who developed JMML. We consistently found loss of the normal NFI allele in unfractionated bone marrow samples and in CD34+ cells, but retention of the normal allele in cell lines derived from pre-B lymphocytes. Our data suggest that JMML is not a true stem cell disorder but that malignant transformation occurs in a hematopoietic cell that is restricted to myeloid differentiation. This is in contrast to Philadelphia-positive CML and a number of other malignant myeloid disorders in which involvement of both B lymphocytes and myeloid cells has been shown by a number of approaches.37-46 The myelodysplasias associated with monosomy 7 or del(5q) are similar to JMML in that the cytogenetic abnormality is apparently restricted to myeloid cells.41,42 The observation that CD34+ cells have deleted the normal parental NFI allele is consistent with the aberrant pattern of myeloid progenitor colony growth in response to GM-CSF that is a laboratory feature of JMML.33,45 In addition, JMML bone marrows contain a higher percentage of CD34+ cells than normal samples (mean, 4.9%; range, 3.8% to 5.8% in JMML v mean, 1.8%; range, 0.6% to 2.9% in normal marrows; Freedman and Grunberger, unpublished data). These findings are consistent with data from mice reconstituted with Nfi-deficient hematopoietic cells that develop a JMML-like syndrome that is associated with a marked increase in the percentage of immature Mac-1+, Gr-1+ myeloid progenitor cells in the marrow.22 Although all of these data show a myeloid/erythroid pattern of involvement in JMML, it is possible that this disorder arises from

Table 2. Parental Transmission of Familial NFI in Children With Myeloid Disorders

<table>
<thead>
<tr>
<th>Sex of Parent With NFI</th>
<th>Sex of Affected Child</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>19</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Includes the patients in this study; cases described previously as reviewed in Shannon et al3 and cases in Shannon et al.23

From www.bloodjournal.org by guest on October 3, 2017. For personal use only.
a more primitive cell that only achieves clonal dominance in these lineages.

JMML is characterized by elevated levels of fetal hemoglobin in vivo and by qualitatively abnormal growth of BFU-E colonies in vitro. A previous report that described a marker cyogenetic abnormality in the BFU-E colonies of a child with JMML suggested that the erythroid lineage is derived, at least in part, from differentiation of the malignant clone. Papayannopoulou et al observed an embryonic pattern of γ- and ε-globin synthesis in JMML erythroid colonies and more recent work has shown constitutive expression of the erythroid-lineage genes GATA-1, EPOR, α-globin, and γ-globin in myeloid progenitor colonies grown from JMML patients. These qualitative abnormalities of in vitro hematopoiesis are consistent with the idea that the disordered pattern of erythropoiesis is an intrinsic characteristic of progenitors derived from the malignant clone. Our data showing loss of the normal NF1 allele in erythroblasts harvested from the BFU-E colonies of a JMML patient confirm this hypothesis.

Although EBV-transformed cells from patients with JMML consistently retained both NF1 alleles, we observed allelic loss in both unfractionated bone marrow and EBV-transformed cells from a child with an atypical MPS. This case shows that loss of NF1 can occur in an immature hematopoietic precursor that is capable of giving rise to both lymphoid and myeloid progeny. It is intriguing that the clinical course of this child was suggestive of Philadelphia-positive CML, because CML is associated with activation of the Ras signaling pathway through binding of Bcr-Abl to the Grb2 adapter protein. Transfection of BCR-ABL into hematopoietic and nonhematopoietic cell lines results in phosphorylation of other proteins in the Ras signaling pathway, including p120GAP, MAP kinase, and Jun N-terminal kinase. Recent data implicate Ras activation as essential for BCR-ABL-induced transformation. Additional experiments are required to characterize the full spectrum of hematopoietic lineage involvement in the myeloid disorders associated with NF1 and to ascertain whether the level at which transformation occurs correlates with clinical behavior.

Leukemic transformation is much less common in children with NF1 than in patients who inherit germline mutations that predispose to retinoblastoma or Wilms’ tumor. This suggests that loss of the normal NF1 allele occurs very infrequently in hematopoietic cells or, alternatively, that inactivation of NF1 must cooperate with other somatic and inherited genetic alterations to produce full leukemic transformation. It is not yet possible to distinguish between these possibilities. On the one hand, the fact that mice transplanted with NF1–/– fetal liver cells consistently develop a JMML-like disorder shows that inactivation of NF1 is sufficient to deregulate myeloid growth. However, two lines of evidence suggest that loss of NF1 function interacts with other genetic factors in human leukemogenesis. First, some NF1 patient bone marrows show cyogenetic abnormalities, particularly monosomy 7. Second, epidemiologic data implicate epigenetic factors in the development of myeloid disorders in children with NF1. According to the Knudson model, inheriting a germline NF1 mutation should predispose to cancer in a manner that is independent of the sex of either the transmitting parent or the affected child. This is not true in children with NF1 as boys who inherit NF1 from their mothers are at especially high risk of developing myeloid disorders. Although the male predilection seen among children with NF1 is similar to the distribution of cases of JMML and Mo7 in the general population, it is striking that this ratio is retained even in the context of a strong inherited cancer predisposition. In addition, the fact that leukemia is much more common among children who inherit NF1 from their mothers is unexpected and is not easily explained. The proposal that the maternal NF1 allele might be imprinted in hematopoietic cells (reviewed in HalJ and Sapienza) is not supported by our finding that mutant NF1 alleles of both maternal (6 cases) and paternal (3 cases) origin have been retained in patient bone marrows (Shannon et al and these data).

The results of this study firmly establish NF1 as a tumor-suppressor gene in immature hematopoietic cells and raise a number of questions with respect to the role of NF1 inactivation in leukemogenesis. The reason children with NF1 are strongly predisposed to myeloid disorders whereas adults are not is unknown. It is interesting that the MPS that develops in mice that are heterozygous for a targeted deletions of the murine NF1 gene have only been observed in adult animals. In addition, although we have shown that the CD34+ compartment in JMML bone marrows consists largely of cells derived from the malignant clone, it is not clear if transformation occurs at this level of differentiation or if a subpopulation of more primitive stem cells is also affected. Our data in the child with atypical MPS provide direct evidence that his malignant clone included some cells that are capable of both myeloid and lymphoid differentiation. Finally, the role of epigenetic factors in the pathogenesis of JMML and Mo7 in children with and without NF1 and the nature of the genetic events that cooperate in leukemogenesis requires further study.

ACKNOWLEDGMENT

We are indebted to Dr Daniel Beck (Center Hospitalier Universitaire Vaudois, Lausanne, France), Drs Roger Berkow and Peter Emanuel (University of Alabama, Birmingham, AL), Dr Bruce Bostrom (Minneapolis Children’s Hospital, Minneapolis, MN), Dr Paul Bowman (Cook-Ft. Worth Children’s Medical Center, Fort Worth, TX), Dr L.C. Chan (University of Hong Kong, Hong Kong, China), Dr Patricia Dinndorf (Children’s National Medical Center, Washington, DC), Dr Lawrence Ettinger and Joan Rubin (University of Medicine and Dentistry of New Jersey, New Brunswick), Dr Maxine Hetherington (Children’s Mercy Hospital, Kansas City, MO), Dr Beverly J. Lange (University of Pennsylvania, Philadelphia, PA), Dr Wing Leung (Johns Hopkins University, Baltimore, MD), and Dr Virginia Sybert (University of Washington, Seattle) for referring families to us for study. We are grateful to Vivian Weinberg, PhD, for performing the statistical analysis.

REFERENCES

22. Kalra R, Paderanga D, Olson K, Shannon KM: Genetic analysis is consistent with the hypothesis that NF1 limits myeloid cell growth through p210 ras. Blood 84:3435, 1994
but not lymphoid cells carry the 5q deletion: Polymerase chain reaction analysis of loss of heterozygosity using mini-repeat sequences on highly purified cell fractions. Blood 81:1849, 1993


47. Pendergast AM, Quilliam LA, Cripe LD, Bassing CH, Zonghan D, Nanxin L, Baizer A, Rabun KM, Der CJ, Schlessinger D, Gishizky ML: BCR-ABL-Induced oncogenesis is mediated by direct interaction with the SH2 domain of the GRB-2 adaptor protein. Cell 75:175, 1993


Patterns of hematopoietic lineage involvement in children with neurofibromatosis type 1 and malignant myeloid disorders

DK Miles, MH Freedman, K Stephens, M Pallavicini, EL Sievers, M Weaver, T Grunberger, P Thompson and KM Shannon

Updated information and services can be found at:
http://www.bloodjournal.org/content/88/11/4314.full.html

Articles on similar topics can be found in the following Blood collections

Information about reproducing this article in parts or in its entirety may be found online at:
http://www.bloodjournal.org/site/misc/rights.xhtml#repub_requests

Information about ordering reprints may be found online at:
http://www.bloodjournal.org/site/misc/rights.xhtml#reprints

Information about subscriptions and ASH membership may be found online at:
http://www.bloodjournal.org/site/subscriptions/index.xhtml