To the editor:

Autoantibodies neutralizing thrombopoietin in a patient with amegakaryocytic thrombocytopenic purpura

Amegakaryocytic thrombocytopenic purpura (AMTP), first reported by Korn,1 is a rare disease characterized by severe thrombocytopenia associated with a total absence or a selective decrease in bone marrow megakaryocytes. Previous studies suggest a variety of pathogenetic mechanisms for AMTP, such as the intrinsic defect at the megakaryocyte progenitor cell level and humoral and cellular suppression of megakaryocytic differentiation.2 Thrombopoietin (TPO), recently isolated, is the hematopoietic factor that potently stimulates megakaryocytopoiesis and platelet production.2 Since TPO is the principal regulator of platelet production, a decreased availability or function of TPO might lead to a form of AMTP. There was a recent report of a patient with pure red-cell aplasia who had a circulating autoantibody against erythropoietin, the primary regulator of red blood cell production.2 These findings suggest that a similar mechanism may be responsible for some cases of AMTP, that is, an autoantibody that blocks the action of endogenous TPO formation was able to be overcome by increasing the concentration normal human bone marrow mononuclear cells (Figure 2). The IgG response to the elevation in endogenous TPO levels (Figure 1). In an effort to characterize the patient’s anti-TPO antibody, we examined the effect of the IgG fractions from the patient’s serum on the growth of megakaryocyte colonies from adherent cell-depleted normal human bone marrow mononuclear cells (Figure 2). The IgG fraction before cyA therapy or during therapy (October 14, 1997) completely or partially reduced the number of megakaryocyte colonies stimulated with 0.2 ng/mL of glycosylated recombinant human TPO, respectively. This inhibition of megakaryocyte colony formation was able to be overcome by increasing the concentration of human TPO in the cultures to 10 ng/mL. The IgG fractions,

References

The preferential expression of CD7 and CD34 in myeloid blast crisis in chronic myeloid leukemia

Chronic myeloid leukemia (CML) is a myeloproliferative disorder that results from the clonal expansion of a pluripotent stem cell, characterized by the Philadelphia chromosome (Ph). The clinical course of CML is generally biphasic, representing an initial chronic phase (CP) and a subsequent blast crisis (BC), which is an inevitably terminal event. Although almost all the hematopoietic lineages may be involved in this event, two main forms are recognized as lymphoid and myeloid crisis, and herein the latter includes typical myeloid, erythroid, as well as megakaryocytic phenotype. CML is hypothesized to evolve in a multistep fashion from the preleukemialike CP into the most malignant BC. From this viewpoint, a certain fraction of Ph-positive stem/progenitor cells in CP might acquire additional genetic abnormalities and represent maturation arrest at a given stage of differentiation program. Then, the immunophenotype of blast cells in BC might reflect the antigenic profile of such a fraction of stem/progenitor cells in CP. In this sense, some notice should be given to the 2 recent papers in which it was described that the populations in 52 consecutive, well-characterized cases of CML-BC diagnosed in our institute, using multicolor flow cytometric analysis. According to the morphological, conventional cytochemical reactions and the lineage-specific immunological markers such as CD3, CD10, CD13, CD19, CD33, and CD41a, these cases were classified as follows: lymphoid (n = 10; 19.2%), myeloid (n = 39; 75.0%), and undifferentiated (n = 3; 5.7%). Myeloid crisis contains myelomonocytic (n = 1) and megakaryocytic (n = 6) as defined by the expression of CD41a. Flow cytometric analysis was performed in a significant part of our cases according to the method as previously described. In brief, diluted bone...
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