BCR/ABL positive thrombocythemia: a diagnostic dilemma

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Introduction

The Philadelphia (Ph) chromosome is a disease-specific marker for chronic myeloid leukemia (CML), which is a myeloproliferative neoplasm and accounts for 15% of newly diagnosed cases of leukemia in adults [1]. The disease is characterized by a balanced genetic translocation, t(9;22)(q34;q11.2), leading to BCR-ABL1 gene rearrangement, the product of which is a constitutively active tyrosine kinase. The Hannover Bone marrow classification has distinguished three phenotypes of BCR-ABL1+ CML - CML of common type (CML.CT), CML with megakaryocyte increase (CML.MI), and CML with megakaryocyte predominance (CML.MP) - on the basis of clinical features, peripheral blood smear, and bone marrow (BM) examination [2]. We discuss here a case of a 45-year-old man who was BCR-ABL1+ with marked thrombocythemia without evidence of CML in peripheral blood smear.

Case report

A 45-year-old man presented to our outpatient department with complaints of fatigue and malaise for previous 2 months. He was a nonsmoker and was not having any chronic disease. His previous medical history was insignificant, but treatment history revealed that he was on hypouricemic agents for last 3 months. His previous medical history was insignificant, but treatment history revealed that he was on hypouricemic agents for last 3 months. His clinical examination was normal with no evidence of splenomegaly, and the patient was not having any thrombotic or bleeding manifestations. The complete blood count revealed a hemoglobin level of 12.2 g/dl, hematocrit level of 37.6%, white blood cells count of 23.8×10^3/μl (differential count: neutrophils 80%, lymphocytes 14%, eosinophils 2%, basophils 4%, and monocytes 0%), and platelet count of 589×10^3/μl. Peripheral blood smear showed marked thrombocythemia without any underlying etiology, and also there were no immature cells present. BM aspiration yielded small megakaryocytes with hypolobulated nuclei (Figures 1, 2). His serum biochemistry was as follows: aspartate aminotransferase 28 IU/l; alanine aminotransferase 37 IU/l; total bilirubin 0.4 mg/dl; blood urea nitrogen 10 mg/dl; creatinine 1.0 mg/dl; random blood glucose 119 mg/dl; and serum uric acid 8.7 mg/dl. Ultrasonography of abdomen was normal with no evidence of splenomegaly or hepatomegaly. He was negative for JAK2V617F mutation. On the basis of thrombocythemia and BM features, the patient was investigated for BCR-ABL rearrangement, which turned out to be positive. Quantitative PCR for BCR/ABL rearrangement showed major translocation, that is, e13a2 and e14a2. Finally, the patient was diagnosed as BCR-ABL1+ essential thrombocythemia (ET) and was advised imatinib 400 mg/day, and he subsequently responded to treatment (Figure 3).

Discussion

The criteria for diagnosis of CML and ET has been given by Polycythemia Vera Study Group and WHO [3,4]. ET is considered to lack BCR-ABL rearrangement whereas its expression is considered diagnostic of CML. However, a gray zone exists between the two entities, as observed in our patient who was BCR-ABL1+ with marked thrombocythemia, without any evidence of CML in the peripheral blood smear. Michiels et al. [5] evaluated cases with similar presentation and concluded that the presence of peripheral blood thrombocythemia, normal hemoglobin, normal white blood cell differential...
count, and presence of small megakaryocytes with round or slightly lobulated nuclei in normocellular BM should be diagnosed as Ph+ ET.

Ph+ ET is a myeloproliferative disorder and a separate entity from both Ph+ CML and Ph− ET. Ph+ ET is characterized by small hypolobated megakaryocytes in BM caused by BCR-ABL-induced maturation defect of hematopoietic stem cells, in contrast to clustered and enlarged mature megakaryocytes with hyperploid nuclei because of growth advantage caused by constitutively activated JAK2V617F or MPL515 mutation in Ph− ET [6]. The small and indolent platelets in BCR-ABL+ ET are nonreactive, that is, they do not have platelet-mediated erythromelalgic microvascular events or bleeding complications similar to BCR-ABL+ CML [7,8]. These complications are due to platelet-mediated inflammation and thrombus in end arteries [8–11]. These erythromelalgic thrombotic manifestations are present in BCR-ABL+ ET due to the presence of platelets that are large and hypersensitive [10,11].

Ph+ ET also differs from CML. These include the predilection of Ph+ ET for women, the absence of splenomegaly, and no features of CML in the peripheral blood or BM [5]. The BM in BCR-ABL+ ET is featured by predominant and pronounced mononucleated megakaryopoiesis with initial none, minor, or overt granulocytic hypertrophy consistent with CML.MP [6]. Although the risk for thrombotic or hemorrhagic events is low, the prognosis of BCR-ABL+ ET is poor. It may develop features of classic Ph+ CML with a high risk for blast transformation and progression to myelofibrosis after a follow-up of a few to several years [5,12].

The BCR-ABL fusion gene produces protein that has a tyrosine kinase activity. Imatinib mesylate (tyrosine kinase inhibitor) by binding to BCR-ABL protein tyrosine kinase and inhibiting the BCR-ABL pathway reduces selective proliferation of BCR-ABL+ cells and also induces apoptosis of these cells [13]. As TKI are targeting cells that are BCR-ABL+, their use as treatment agents in BCR/ABL+ ET is justified.
Conclusion
This is perhaps the first documented case of a man diagnosed as BCR-ABL+ ET, which is a neoplastic disorder with specific peripheral blood and BM features and should be confirmed by using karyotyping. This demands a heightened suspicion in any case of thrombocythemia for early diagnosis and prompt treatment.

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Conflicts of interest
There are no conflicts of interest.

References