A variant of acute promyelocytic leukemia with t(4;17)(q12;q21) showed two different clinical symptoms

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Abstract

A 63-year-old man was diagnosed with a rare variant of acute promyelocytic leukemia (APL) with t(4;17)(q12; q21) that showed atypical morphological features and two different clinical symptoms. He was started on standard induction chemotherapy for acute myeloid leukemia, which decreased myeloblast numbers; however, APL-like blasts remained. He then received a salvage therapy that added all-trans retinoic acid (ATRA). After ATRA commenced, APL-like blasts disappeared and cytogenetic analysis became normal. However, myeloblasts subsequently increased, and he became resistant. In summary, this patient exhibited two different clinical courses of acute myeloid leukemia and APL.

Case Report

A 63-year-old man was admitted to our hospital because he had fever and thrombocytopenia. The initial laboratory evaluation of peripheral blood revealed that his white blood cell count was 31,500 cells/μL with 58.5% blast cells, hemoglobin was 10.1 g/dL, and platelet count was 1,100 cells/μL. Coagulopathy was absent. Bone marrow examination showed a total nucleated cell count of 168,000 cells/μL with 31.6% myeloblasts and 28.0% promyeloblasts. Most myeloblasts had regular nuclei, and a few promyeloblasts contained azurophilic granules and Auer rods; however, atypical APL cells were <1% of the total cells (Figure 1). Myeloperoxidase staining revealed that both myeloblasts and promyeloblasts were positive; however, the staining was not as strong as the typical APL pattern (Figure 2b). These morphological findings revealed features of both M2 and APL according to the French-American-British (FAB) Classification, and did not correlate with typical APL findings. Blasts were positive for CD13/34/HLA-DR, and negative for CD33 by flow cytometry. Wilms’ tumor gene 1 (WT1) mRNA levels in peripheral blood were 39×10^4 copies/μg RNA. Reverse transcription polymerase chain reaction (RT-PCR) analysis was negative for PML-RARA, AML1-MTG8, DEK-CAN, NUP98-HOXA9, CBFB-MYH11, MLL-AF9, MLL-AF6, MLL-ENL, minor-BCR, BCR-ABL, MLL-AF4, ETV6-AML1, E2A-PBX1, SIL-TAL1, FLT3-3, and C-KIT (multi-kinase screening exam). Thus, he was initially diagnosed with acute myeloid leukemia with maturation according to the World Health Organization classification from 2008 (M2 in FAB).

An induction chemotherapy regimen consisting of idarubicin (12 mg/m²/d; days 1-3) and cytarabine (100 mg/kg/d; days 1-7) was administered (Figure 1). During induction therapy, the karyotype analysis from diagnosis arrived and revealed an abnormality: 46, XY, t(4;17)(q12;q21) in 6/20 cells (Figure 2c). After induction therapy, blasts in peripheral blood disappeared; however, 3.7% of myeloblasts and 24.0% of promyeloblasts remained in bone marrow. Karyotype analysis revealed: 46, XY, t(4;17)(q12;q21) in 12/20 cells. An induction chemotherapy regimen including idarubicin and cytarabine (100 mg/kg/d; days 1-7) was administered (Figure 1). During induction therapy, the karyotype analysis from the initial treatment, blasts from the M2 origin decreased, while blasts of APL origin remained.

We then started a salvage treatment regimen to be effective for both M2 and APL: mitoxantrone (7 mg/m²/d; days 1-3) and cytarabine (200 mg/m²/d; days 1–5) were added to ATRA (25 mg/m²/). With the salvage therapy, he achieved hematological remission in peripheral examination, FISH for PML2:RAL3 was 0%, and karyotype analysis was normal in bone marrow. However, blasts in bone marrow remained at 19.5%, the morphological features of which were normal myeloblasts without azurophilic granules or Auer rods. WT1 mRNA levels in peripheral blood were 2.4×10^4 copies/μg RNA; thus, he was diagnosed with induction failure. From the morphological features and FISH results, we diagnosed him as an APL variant with t(4;17)(q12;q21). We assumed there were two kinds of blast stem cells of different origin, and that following initial treatment, blasts from the M2 origin decreased, while blasts of APL origin remained.

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Key words: acute promyelocytic leukemia, t(4;17)(q12;q21), PML-RARA, all-trans retinoic acid.

Acknowledgments: the authors would like to thank Ms. Nomura A for helpful discussions and technical assistance.

Contributions: Conception and design of the study, or acquisition of data, or analysis and interpretation of data: TN, AN, SF, AS, TN, YT, YA, AK, MH, HY, KI, TI. Drafting the article or revising it critically for important intellectual content: TN, AN, SN. Final approval of the version to be submitted: AN, SN.

Conflict of interest: the authors declare no potential conflict of interest.

Funding: none.

Received for publication: 14 December 2018. Accepted for publication: 5 July 2019.

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Hematology Reports 2019; 11:7971
doi:10.4081/hr.2019.7971
tive for CD13/34/HLA-DR by flow cytometry. Adding to them, CD71 and glycophorin-A were positive, those were not positive at the diagnosis. The second salvage treatment (high dose cytarabine: 4000 mg/m²/d; days 1–5) was started with continuous ATRA. After this treatment, 45% of blasts, whose morphology was typical myeloblast, remained in bone marrow, and WT1 mRNA levels in peripheral blood were 3.3×10⁴ copies/μg RNA. Thus, he was diagnosed as resistant to second salvage treatment. At this time, he became so weak that he could not continue aggressive chemotherapy; thus, we changed to palliative therapy. The patient died of pneumonia eight months after diagnosis.

Discussion and Conclusions

Variant fusion genes containing RARA are frequently associated with APL. The FIP1L1-RARA fusion gene was reported to result from t(4;17)(q12;q21).³,⁴ There are two APL cases with FIP1L1-RARA. Kondo et al.³ reported a case of a 90-year-old woman where they found split RARA signals without a PML-RARA fusion signal by FISH. They examined the effect of FIP1L1-RARA on ATRA response and found that FIP1L1-RARA was ATRA responsive, similar to patients with PML-RARA. Consistent with this result, the patient achieved a complete remission by oral ATRA alone (50 mg/d). Menezes et al.⁴ reported a case of a 77-year-old woman who was started on ATRA. The case revealed morphologically typical APL. Thus, they diagnosed her as PML-RARA-negative APL and started an APL protocol. Although we did not confirm the presence of a FIP1L1-RARA fusion gene in our case, the patient had the same karyotype abnormality as the two previous cases. Although the precise role of FIP1L1-RARA is unknown, the previous cases reported that patients with FIP1L1-RARA showed APL-like clinical symptoms. However, our case revealed atypical APL morphology at diagnosis and different clinical features. The most interesting point of our case is that it showed two different clinical characteristics. The induction therapy was standard regimen for acute myeloid leukemia and was effective for the M2 clone, as the number of blasts in bone marrow decreased. However, the APL clone remained, as the number of karyotype abnormalities increased and FISH remained positive. After ATRA was initiated, APL-like blasts disappeared, and karyotype and FISH analyses became normal. From these clinical responses, ATRA could be effective for APL clones with t(4;17)(q12;q21). However, it is uncertain whether the different clinical features happened accidentally or were related to cytogenetic abnormalities. We tried to use WT1 mRNA levels in peripheral blood as a biomarker. We expected it would reflect M2 clones, however, it did not. Our results showed that it responded in proportion to the number of bone marrow myeloblasts in induction therapy, however, it showed contradiction after salvage therapy. It decreased and remained low levels, although bone marrow myeloblasts increased (Figure 1).

In conclusion, we report a variant APL with t(4;17)(q12;q21) that demonstrated two different clinical symptoms. However, the relationship between genetic abnormalities and clinical symptoms for this patient is unclear. Further studies are required to elu-
citate the pathogenesis of variant APL with t(4;17)(q12;q21).

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