IMMUNOLOGICAL PHENOTYPING OF ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) IN UNIVERSITY AFFILIATED HOSPITALS:
A PRELIMINARY REPORT ON 50 PATIENTS

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ABSTRACT

The peripheral blood and bone marrow samples from 50 patients with ALL were investigated by indirect immunofluorescent technique. The most common type of ALL was common-ALL (82%) and the least common was T-ALL (2%). Other subtypes of ALL were unclassified by our technique (8%), B-ALL (4%), and pre B-ALL (4%). The correlation between immunophenotype, clinical condition and hematological profile is discussed.

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INTRODUCTION

After skin cancer, leukemias and lymphomas are the most common malignancies in the southern parts of Iran. Among the leukemia group, the incidence of the lymphocytic type slightly higher than the granulocytic type and acute lymphoblastic leukemia (ALL) is the most common type of malignancies in children.

Recent advances in immunology have led to important insights into lymphocyte differentiation and the cellular origin of ALL. Now, it is well recognized that the identification of the lymphoblast’s surface markers, or immunological phenotyping of ALL has provided important information in the diagnosis, prognosis and treatment of these patients.

The purpose of this study is to report the immunological subtypes in 50 patients obtained from hospitals in Shiraz. The samples were analysed by indirect immunofluorescent technique, using specific monoclonal antibodies that define cell surface antigens. The monoclonal antibodies used were anti HLA-DR, Anti-B lymphocyte antigen, anti-T lymphocyte antigen, antimm SOC monocytic antigen and anti-cALLA. These were combined with more traditional cell markers such as surface membrane immunoglobulins (SmIg), and sheep erythrocyte receptors on T lymphocytes, and also cytochemical stains such as PAS and Sudan black B.

RESULTS

The data from this study show that common-ALL is the most common phenotype of ALL at the present time in this area. About 82% of all cases and 88.6% of childhood-ALL are classified as common-ALL. 8% of cases were unclassified, 4% were B-ALL, 4% were pre B-ALL and 2% were of T-cell origin. The relative incidence of immunological subtypes of ALL are presented in Table I.

The majority of patients with C-ALL (84.6%) were
Table I. The relative incidence of immunological subtypes of ALL.

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>Subtype</th>
<th>No. patients</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALLA+, Dr+, B.Ag+, Sml.g+, T.Ag-, ER-, myelo/monocytic Ag-</td>
<td>Common-ALL</td>
<td>41</td>
<td>82</td>
</tr>
<tr>
<td>CALLA-, Dr+, B.Ag+, Sml.g-, T.Ag-, ER+, myelo/monocytic Ag-</td>
<td>Pre B-ALL</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CALLA-, Dr+, B.Ag+, Sml.g-, T.Ag+, ER-, myelo/monocytic Ag-</td>
<td>B-ALL</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CALLA-, Dr+, B.Ag+, Sml.g-, T.Ag-, ER-, myelo/monocytic Ag-</td>
<td>T-ALL</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CALLA+, Dr+, B.Ag+, Sml.g+, ER-, myelo/monocytic Ag-</td>
<td>Unclassified</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Total: 50 patients, 100%

cALLA: Common acute lymphoblastic leukemia antigen; Ag: Antigen; Sml.g: surface membrane immunoglobulin; ER: E-Rossette.

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Table II. Clinical presentations of ALL.

<table>
<thead>
<tr>
<th>Clinical Findings</th>
<th>Total %</th>
<th>C-ALL %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mediastinal mass</td>
<td>7.1</td>
<td>5.8</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>60.4</td>
<td>57.5</td>
</tr>
<tr>
<td>Splenomegaly</td>
<td>70.8</td>
<td>70</td>
</tr>
<tr>
<td>Hepatomegaly</td>
<td>66</td>
<td>64.1</td>
</tr>
<tr>
<td>CNS Involvement</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>WBC &gt; 50,000/mm³</td>
<td>18.7</td>
<td>12.8</td>
</tr>
<tr>
<td>Platelet &lt; 50,000/mm³</td>
<td>34.7</td>
<td>42.5</td>
</tr>
<tr>
<td>Hb &lt; 8g/dL</td>
<td>60.9</td>
<td>63.1</td>
</tr>
</tbody>
</table>

DISCUSSION

The common classification of ALL is based on the FAB system, which defines three categories of ALL with regard to the morphology of the blast cells. This classification has a limited value for significant diagnosis, prognosis, and treatment of patients with ALL. Even cytochemical stainings are not very valuable.

The most useful method of classification of subtypes of ALL depends on cell membrane markers. In this method we can divide ALL into 4 subtypes. First, common-ALL, which is the largest group and the blast cells in this category are cALLA-positive. Second, B-ALL, in which cells are of mature B-cell origin and have surface membrane immunoglobulins. Third, T-ALL, in which cells are of T-cell origin, and the fourth group, Null-ALL or unclassified in which cells are Smlg, E-Rosette, and cALLA-negative. Recent advances in monoclonal antibody production and gene rearrangement have indicated that all cases of Null-ALL are of B-cell origin. Thus new classifications of ALL have been suggested. In our study we had five groups of patients. Three groups were patients with
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C-ALL, B-ALL and T-ALL, which we could recognize easily by monoclonal antibodies against cALLA, B-Ag, and T-Ag. However we had some difficulties with other groups: 8% of cases were negative for all of the monoclonal antibodies which we used, so we called them an unclassified group. Also, in 4% of cases, cALLA and SmIg were negative but B antigen was positive. We could not classify them as B-ALL (because of absence of SmIg) and C-ALL (because of absence of cALLA), so we classified them as pre-B-ALL. Our study shows that common-ALL is the most common type of ALL, and T-ALL is the least common especially in children. Only one of 50 patients had T-ALL (2%).

In contrast with foreign reports, the majority of patients with C-ALL (84.6%) were reported to have the L2 morphologic form, whereas only 10.2% had the L1 type. Although all cases of ALL were Sudan black-B negative, about half of all the cases and 51.2% of the C-ALL group were PAS-positive. This matter shows that these stainings are not very significant for the diagnosis of ALL. In comparison with foreign reports with a high incidence of mediastinal mass in patients with ALL, only about 7.1% of all patients had mediastinal mass in this study. This may be because of the very low incidence of T-ALL in this area, as mediastinal mass is very common in T-ALL.2

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REFERENCES

1. Iranian Cancer Society Reports, Fars Province Cancer Registry. 1978-1981.