The Association of Myeloproliferative and Lymphoproliferative Diseases

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We read with great interest the report by Harrison et al [1] dealing with a case of polycythemia vera (PV) following treatment for centroblastic lymphoma. This case appears to be of particular interest because the authors were able to find a chromosomal marker (20q-) in the bone marrow cells after the diagnosis of PV, although the bone marrow was not involved by the centroblastic lymphoma. Indeed, a karyotype anomaly has been found, to the best of our knowledge, in very few cases of coexistence of a myeloproliferative disease with a lymphoid neoplasm. Therefore we agree with the authors’ conclusions that such cases should be reported in the medical literature. In 1987, we reported on the case of a male patient who, in 1985, developed stage II (Rai classification) B cell chronic lymphocytic leukemia (B-CLL) in the course of PV (first diagnosed in 1983) [2]. We were able to detect an unusual karyotype anomaly (18p+) both in the unstimulated bone marrow cells and in the peripheral B lymphocytes. Our patient was subjected to a long follow-up until his death (1993) due to severe heart failure. During the period of follow-up, the karyotype was evaluated on two different occasions and 18p+ remained the only chromosomal aberration (kindly provided by Dr P. Simi, Azienda Ospedaliera Pisana, Pisa). The clinical evaluation of our patient showed the exhaustion of PV and a slow evolution of B-CLL, which was treated with intermittent courses of chlorambucil throughout the whole period of observation.

On the basis of the available data in the literature [reviewed in 2-4], it appears that B-CLL generally suppresses PV, but sufficient information is not available on the long-term events in cases of non-Hodgkin’s lymphoma associated with PV or other myeloproliferative diseases. In addition, it is not clear whether the peculiar karyotype anomalies found in some of the cases have an impact on the behavior of the two coexisting diseases and on the prognosis of the patients. In our case, the karyotype anomaly did not show a negative impact on survival according to the most recent analysis of prognosis of B-CLL [5].

We would also like to report that, very recently, a patient with the simultaneous appearance of bcl 2+ follicular center lymphoma (with bone marrow involvement) and essential thrombocytosis has been observed at our institution. In this patient, the karyotype was found to be normal. Similarly, a normal karyotype was found in another case of B-CLL associated with essential thrombocytosis [3].
In conclusion, we think that any case of lymphoid neoplasm associated with a myeloproliferative disease ought to be carefully investigated, and that karyotype analysis should be performed.

References