Terminal Deoxynucleotidyl Transferase Positivity in Neuroblastoma

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Since the discovery of the enzyme terminal deoxynucleotidyl transferase (TdT) in calf thymus [1] this ‘marker’ has come to play a major role in the interpretation and classification of the leukaemias [2]. We would like, however, to report strong TdT positivity in marrow aspirate of a child with a non-haematological malignancy. A 5-year-old girl was admitted with a 3-week history of lethargy and flitting aches. Physical examination revealed obvious pallor and a low grade fever. There were no other abnormal physical findings. Haematological investigations included HB 9.6 g/dl, WCC 3.9 × 10⁹/1 of which 42% were neutrophils, 54% lymphocytes, 2% monocytes and 2% eosinophils; platelet count was 177×10⁹/1. May-Grünwald-Giemsa staining of initial marrow aspirate showed reduction in erythroid and megakaryocytic cell lines, but no evidence of a malignant process. Repeat marrow aspirate demonstrated malignant cells distributed both singly and in clumps permeating and replacing normal marrow elements. The cell morphology was consistent with acute lymphatic leukaemia (ALL) of L2 type using the FAB classification. Periodic acid Schiff and Sudan black stains were negative and the acid phosphatase stain revealed an atypical diffuse granular positivity. Immunophenotyping of the marrow cells with a panel of monoclonal antibodies gave the following result: UCHT-1 (P. Beverly), Ia”, cALLA (J5), OKT6, VIM-D5 and VIB-C5 (W. Knapp), My7 and My9 (J. Griffin) anti-monocyte-, slg-. A TdT immunofluorescence (IF) assay (Bethesda Research Laboratories) of bone marrow smear revealed greater than 90% positivity of bone marrow cells. A tentative diagnosis of ALL was made, probably of early T cell lineage. Subsequent clinical investigation, however, proved this not to be the case. A skeletal survey was normal apart from multiple lucent areas in the skull vault and there was downward and lateral displacement of the left kidney on IVP. CT scan of abdomen confirmed a small calcified mass (not seen on plain film) in the upper left quadrant extending medially and downward. 24-hour urinary estimation of VMA was normal. A repeat marrow aspirate reacted strongly with monoclonal antibody UJ13A [3], indicating presence in the marrow of cells of neuroectodermal origin. A diagnosis of stage IV neuroblastoma was thus confirmed. The child was commenced on three weekly courses of vin-cristine, cyclophosphamide, cisplatinum and VM26. After two courses, the marrow was free of neuroblastoma cells and removal of the primary tumour was carried out after a further four courses. Histology of the tumour confirmed a
well-differentiated neuroblastoma which did not demonstrate TdT positivity using the IF technique. The enzyme TdT catalyzes the addition of deoxynucleoside triphosphates to the 3'-OH of oligo- or polydeoxynucleoside initiators without template instruction [4]. The enzyme is normally present in high levels only in the thymus, but low levels are also found in bone marrow [5] and brain [6]. Some authors have demonstrated low levels of TdT activity in neuroblastoma cell lines while others have reported negative results in neuroblastoma tissue and marrow infiltrated with neuroblastoma [7]. Human brain TdT has been reported to have the same physical and molecular properties and to be antigenically identical with TdT of human leukaemia cells and calf thymus [6]. Presence of TdT is detectable by straightforward enzyme analysis or by monospe-cific antibody prepared against a homogeneous protein antigen [5]. Since the quantitative test for TdT did not aid in the classification of ALL and is costly and complicated to perform, it is no longer used routinely in many centres. TdT by IF assay, on the other hand, is a convenient and rapid technique that enables easy-

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er access to TdT determinations than enzymatic assay [5]. Most authors report complete concurrence between both assays though others [8] have highlighted a small number of exceptions to this rule in ALL. They proposed that the discrepancies between percentage of IF cells and quantitative enzymatic activity suggest heterogeneity among cells in content of TdT as well as the possibility of antigenically reactive enzyme that is enzymatically inactive. It is concluded that immunocytochemical techniques are the methods of choice in terms of both specificity and sensitivity [9]. Our observations demonstrate that TdT is not necessarily haemopoietic precursor cell-specific. The observation in this patient of TdT positivity in marrow which was subsequently negative in the primary tumour could indicate either: (a) chemotherapy altered the antigenic city of the tumour or (b) neuroblasts infiltrating marrow may be phenotypically different from the tumour of origin. Since the differential diagnosis of acute leu-
9 kaemia in childhood often includes neuroblastoma, these findings suggest that TdT positivity alone is insufficient immunologically to distinguish between these malignancies.

References
