Case report

Osteolytic Bone Lesions – A Rare Presentation of AML M6

N. Geetha¹, K.P. Sreelesh¹, M. J. Priy¹, V.S. Lali¹ and N. Rekha²

¹ Department of Medical Oncology, Regional Cancer Centre. Trivandrum 695011, India
² Department of Pathology. Regional Cancer Centre. Trivandrum 695011, India

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Abstract. Acute myeloid leukemia (AML) M6 is a rare form of AML accounting for < 5 % of all AML. Extramedullary involvement is very rarely seen in this entity. Skeletal lesion has not been described in AML M6 before. We discuss the case of a 17 year old boy with AML M6, who presented with osteolytic lesion of right humerus. He was treated with induction and consolidation chemotherapy. The present case is the first report in literature of AML M6 presenting with skeletal lesions.

Introduction. Acute erythroid leukemia or Acute myeloid leukemia (AML) M6 is a rare form of AML. It accounts for < 5 % of all AML.¹ AML M6 is otherwise known as Di Gugliemo syndrome, and it is a disease of adults. Extramedullary involvement is very rarely seen in this entity, and bone involvement is extremely rare. We present the case of a 17 year old boy with AML M6, who presented with predominant skeletal disease.

Case Report. A 17 year old boy presented with progressively increasing pain in right shoulder since 6 months, pain in right chest wall and gluteal region since 3 months. He gave history of intermittent fever and general weakness. A radiograph of right shoulder showed an irregular permeative type of lytic lesion involving proximal metadiaphyseal region of right humerus. Cortical breaks and interrupted periosteal reactions were present (Figure 1). He had undergone a biopsy from the humeral lesion prior to presenting to us. Examination showed a sick boy with a performance status of 4, he had pallor, tenderness of right shoulder and hepatomegaly. His hemoglobin was 7.4gm%, total leucocyte count 3800/mm³, platelet was 1,67,000/mm³ and peripheral smear showed 6% abnormal cells. Serum chemistries were normal, and LDH was 532 IU/L (Normal 313-618U/L). Magnetic resonance imaging showed focal cortical lytic lesion in the head of right humerus and greater tubercosity, glenoid and...
Figure 2. Magnetic resonance imaging showed focal cortical lytic lesion in the head of right humerus and greater tuberocity

Figure 3. CT both shoulder axial view (bone window) showing irregular destructive lytic lesions of right upper humerus.

coracoid process and right clavicle with moderate periosteal reaction (Figure 2). A computed tomogram showed permeative destruction of both shoulder joints and pelvic bones (Figure 3).

A Tc99 bone scan showed hot spots over upper end of both humeri, trochanter of both femur, shaft of right femur (Figure 4). A bone marrow study showed 64% myeloperoxidase-negative blasts with scanty cytoplasm, blebbing, round nuclei and immature chromatin. The remaining cells in marrow showed a Myeloid, erythroid ratio of 1:2. Erythroid population showed dyserythropoiesis. Non erythroid population showed 4% blasts. Megakaryocytes were absent. These blasts were myeloperoxidase negative and showed PAS block positivity. (Figure 5 and 6). Flow cytometry from marrow showed the blasts to be negative for CD13, CD33, CD64, CD117, cy MPO, cyCD61, CD10, CD19, CD2, CD3, CD4, CD5, CD5, CD8, cyCD3, CD34, and HLA DR. The blasts were positive for glycophorin A (Figure 7). Correlating the morphology, differential count and immunophenotype of blasts, a diagnosis of AML M6 (Pure erythroid leukaemia) was made. The biopsy from the humerus shows spicules of bone with intervening neoplasm showing tumor cells in sheets (Figure 8). Cells were negative for LCA, MIC2 (Figure 9 and 10). The picture was compatible with AML M6 involving the bone. Bone marrow cytogenetics was normal, and Bcr Abl was negative. He was treated with induction chemotherapy with cytosine arabinoside and daunorubicin 7/3. He achieved remission and symptom relief from bone pain. He received further chemotherapy with FLAG for 3 cycles. His bone pain

Figure 4. Bone scan showing increased uptake over both humeri, trochanters and shaft of right femur

Figure 5. PAS X1000. Blasts show PAS block positivity
Figure 6. Myeloperoxidase x 1000. Blasts are myeloperoxidase negative

Figure 7. Flowcytometry dot plot scan showing blast cells with negative uptake for CD13, CD33, CD34, CD68, CD10, CD117, MPO and positive uptake for anti glycophorin A (70%)

Figure 8. H&E x 400. Section from bone shows infiltration by blasts.

Discussion. Although leukemia usually presents with pallor, bleeding tendencies, lymphadenopathy, and infections, rarely they present with skeletal manifestations. Such bone manifestations are more often found in lymphoid leukemias than myeloid. Osteolytic lesions of the skeleton associated with AML is uncommon. There are only few cases of AML associated with skeletal disease reported in literature (Table 1). Skeletal lesion has not been described in AML M6. The present case is the first report in literature of AML M6 presenting with skeletal lesions.

The radiological findings described in leukemias include metaphyseal lucent bands, bone erosions, periosteal reactions, lytic bone lesions, reduced bone density, periative destruction and vertebral collapse. Bone lesions are more prevalent in children than in adults since growing skeleton is an important site for dissappeared and there were healing changes in the humerus. However, he relapsed 4 months later and was put on supportive care. He died of progressive disease at 10 months.
leukemic cell proliferation. Presence of bone lesions however donot give a worse outcome compared to those without bone involvement. Bone pain in acute leukemia is due to proliferation of bone marrow, pressure effect, compression fractures and osteoporosis. The pathogenesis of bone destruction in leukemia remain poorly defined. Abnormal production of parathyroid hormone by malignant cells has been demonstrated.

The hematologic malignancies often presenting with osteolytic lesions are multiple myeloma, non Hodgkin’s lymphoma such as adult Tcell lymphoma/leukemia, anaplastic large cell lymphoma.

Bone involvement can also rarely occur in acute lymphoblastic leukemia and blast crisis of chronic myeloid leukemia. Other tumor presenting with predominant bone destruction at this age is Ewing’s sarcoma. In the present case, the bone was negative for LCA and MIC2, thus ruling out the possibility of a lymphoid malignancy and Ewing’s sarcoma.

The expression of glycoporphin A on blast cells confirmed the diagnosis of erythroid leukemia. The present case demonstrates the importance of evaluation of skeleton in patients with AML presenting with bone pain.

References:


Table 1. Patients with AML presenting with bone involvement reported in literature

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age &amp; Sex</th>
<th>Bony Sites Involved</th>
<th>AML Subtype</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson JL</td>
<td>58 M</td>
<td>Multiple lytic lesions of L5, skull, femur</td>
<td>AML M1</td>
<td>Relapsed at 10 months and died</td>
</tr>
<tr>
<td>Lima CS</td>
<td>17M</td>
<td>Loin pain and lytic lesion</td>
<td>AML</td>
<td>Relapsed after 12 months</td>
</tr>
<tr>
<td>Muler JH</td>
<td>32 M</td>
<td>Hypercalcemia and lytic lesion in skull, acetabulum, L1 and L5 vertebra</td>
<td>AML M7</td>
<td>Achieved remission and resolution of hypercalcemia</td>
</tr>
<tr>
<td>Fisher D</td>
<td>20 months F</td>
<td>Long bones, skull, jaw, short bones of hands</td>
<td>AML M7</td>
<td>Died 2 at 2 weeks</td>
</tr>
<tr>
<td>Franco A</td>
<td>8 months</td>
<td>Orbital wall fracture, periosteal reaction, mixed lytic and sclerotic lesion</td>
<td>MDS transformed to AML</td>
<td>NA</td>
</tr>
<tr>
<td>Dharmasena F</td>
<td>27M</td>
<td>Scapula, skull, pelvis, femur</td>
<td>AML M7</td>
<td>Relapsed 13 mths after diagnosis, underwent autologous transplant, died in posttransplant period</td>
</tr>
<tr>
<td>Seifi S</td>
<td>21F</td>
<td>L3 vertebra, humerus</td>
<td>AML M2</td>
<td>Died</td>
</tr>
</tbody>
</table>

Note: Table 1 describes the patients with acute myeloid leukemia (AML) who presented with bone involvement. The table includes patient demographics, bony sites involved, AML subtype, and outcome details.

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