جامعة الملك سعود
King Saud University
1957

Polycythemia

Dr. Mansour Aljabry MD,MSHA,KSUF

Chairman of Pathology Department

Head of Academic guidance Unit

Associate Professor & Consultant Hematologist

Objectives

1. To understand the physiological mechanisms that regulate erythropoiesis
2. To recognize the secondary and primary causes of polycythemia
3. To understand the clinicopathological features of polycythemia vera
4. To recognize the importance of genetic studies in diagnosis and management of polycythemia vera
5. To understand the general aspects of essential thrombocythemia and primary myelofibrosis

Myeloproliferative Neoplasms

1. Myeloproliferative neoplasms (MPN)

1.1. Chronic myelogenous leukemia, *BCR-ABL1*–positive (CML)
1.2. Polycythemia vera (PV)
1.3. Essential thrombocythemia (ET)
1.4. Primary myelofibrosis (PMF)
1.5. Chronic neutrophilic leukemia (CNL)
1.6. Chronic eosinophilic leukemia, not otherwise specified (CEL-NOS)
1.7. Mast cell disease (MCD)
1.8. MPN, unclassifiable

MPN features

- Cytosis
- Organomegaly (mainly splenomgaly)
- High uric acid
- Hypercellular bone marrow
- Progression to acute leukaemia (mainly AML)

Table 1. Classification of Myeloid Neoplasms According to the 2008 World Health Organization Classification Scheme

1. Myeloproliferative neoplasms (MPN)
- 1.1. Chronic myelogenous leukemia, *BCR-ABL1*–positive (CML)
- 1.2. Polycythemia vera (PV)
- 1.3. Essential thrombocythemia
- 1.4. Primary myelofibrosis (PMF)
- 1.5. Chronic neutrophilic leukemia
- 1.6. Chronic eosinophilic leukemia
- 1.7. Mast cell disease (MCD)
- 1.8. MPN, unclassifiable

BCR-ABL must be negative

2. Myeloid and lymphoid neoplasms with eosinophilia and abnormalities of *PDGFRA*, *PDGFRB*, and *FGFR1*

3. MDS/MPN
- 3.1. Chronic myelomonocytic leukemia (CMML)
- 3.2. Juvenile myelomonocytic leukemia (JMML)
- 3.3. Atypical chronic myeloid leukemia, *BCR-ABL*–negative (aCML)
- 3.4. MDS/MPN, unclassifiable

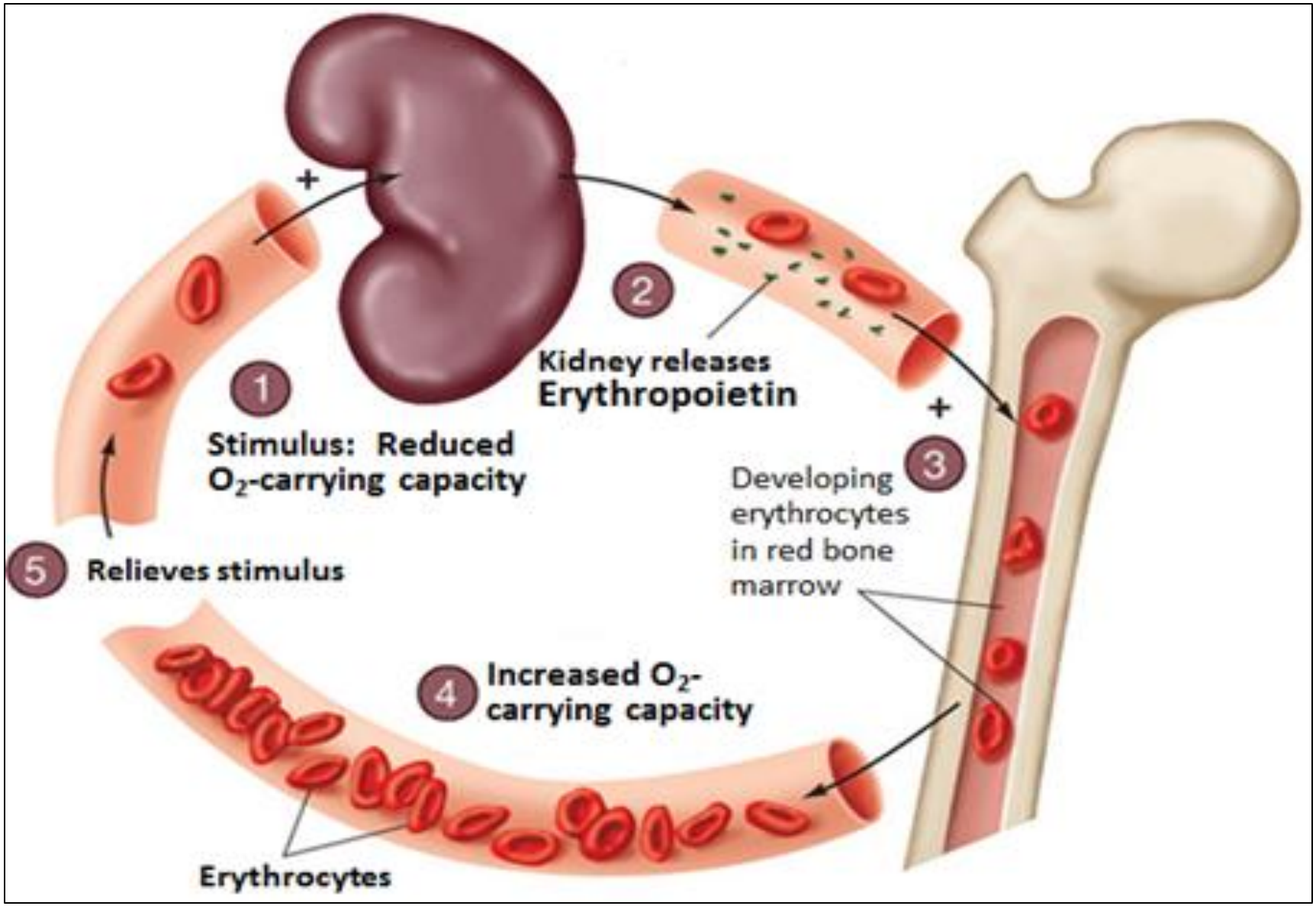
4. Myelodysplastic syndromes (MDS)

5. Acute myeloid leukemia (AML)

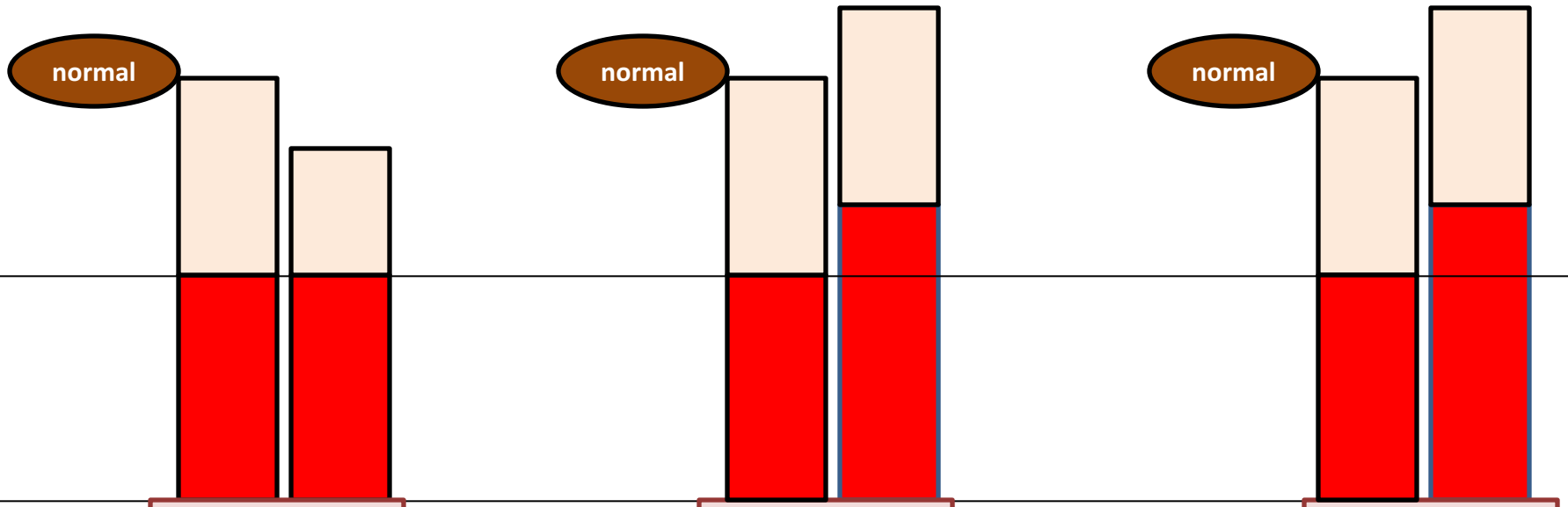
Polycythemia

- In Greek “too many cells in the blood.”.
- Absolute increase in total body red cell volume (or mass)
- Manifests itself as a raised Hb or packed cell volume (PCV)
- Hb is >16.5or 18.5 g/dl in women and men, respectively.

Regulation of Erythropoiesis



Classification of Polycythemia



Relative Polycythemia

Decreased plasma volume due to severe dehydration

2nd Polycythemia

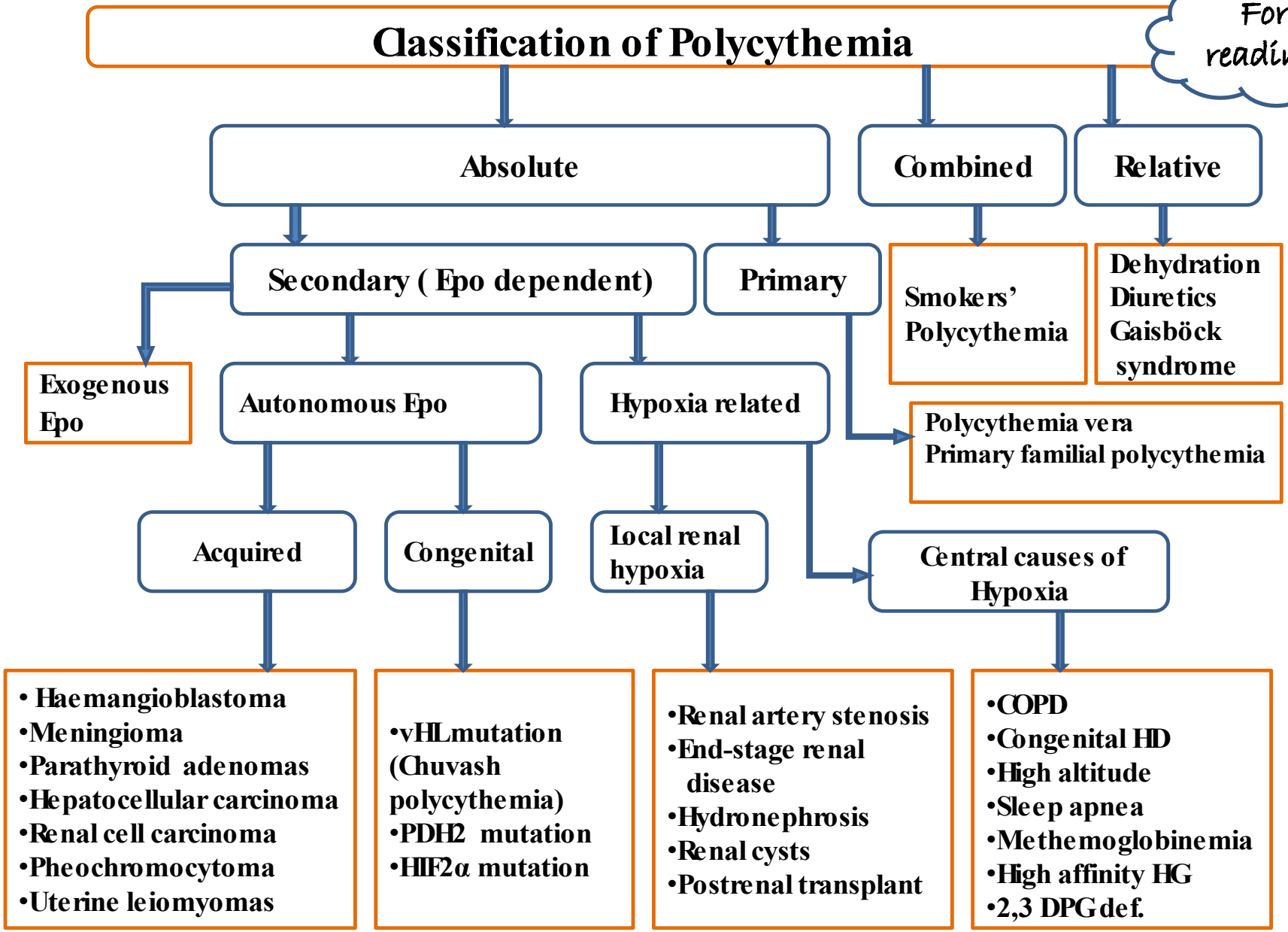
Increased RBC mass due to high EPO:
1-COPD, Sleep apnea, smoking..
2-High altitude
3-High affinity HB
4-Renal disease
5-Epo secreating tumor (Parathyroid adenoma …)

Polycythemia vera

Increased RBC mass due to malignant proliferation

Classification of Polycythemia

For reading



Polycythemia Vera

- MPN characterized by increased red blood cell production independent of the mechanisms that normally regulate erythropoiesis.

Diagnostic Features:

- HB >18.5g/dl in men ,16.5g/dl in women
- Hypercellular bone marrow
- JAK2 mutation in >95% of cases
- Low Serum erythropoietin level

Clinical features of PV

1-Increased blood viscosity

- **Hypertension**
- **Headache, dizziness, visual disturbances & paresthesia**

2- Thrombosis

- **Deep vein thrombosis**
- **Myocardial infarction**
- **Mesenteric, portal or splenic vein thrombosis**

3-Splenomegaly in 70%

4-Hepatomegaly in 40%

Investigations

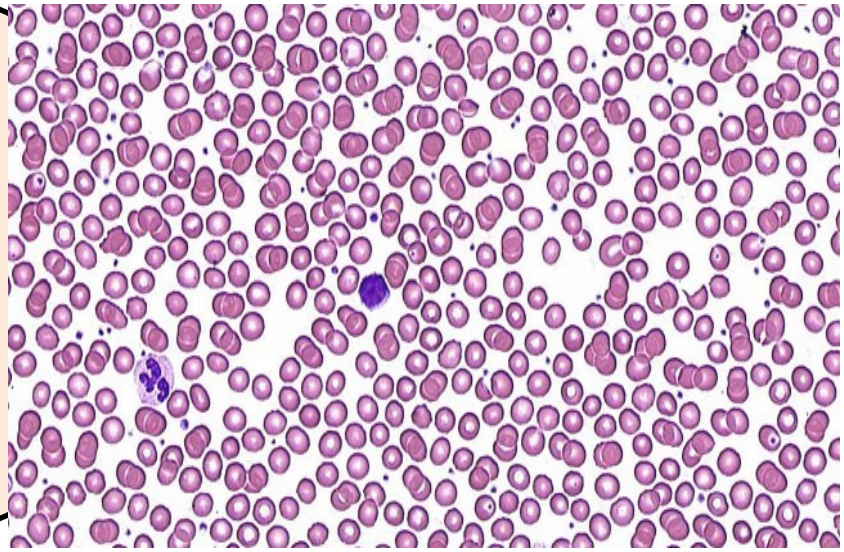
CBC:

*RBC: increased *Hb: increased

*WBC & PLT :mildly increased (usually)

Blood smear:

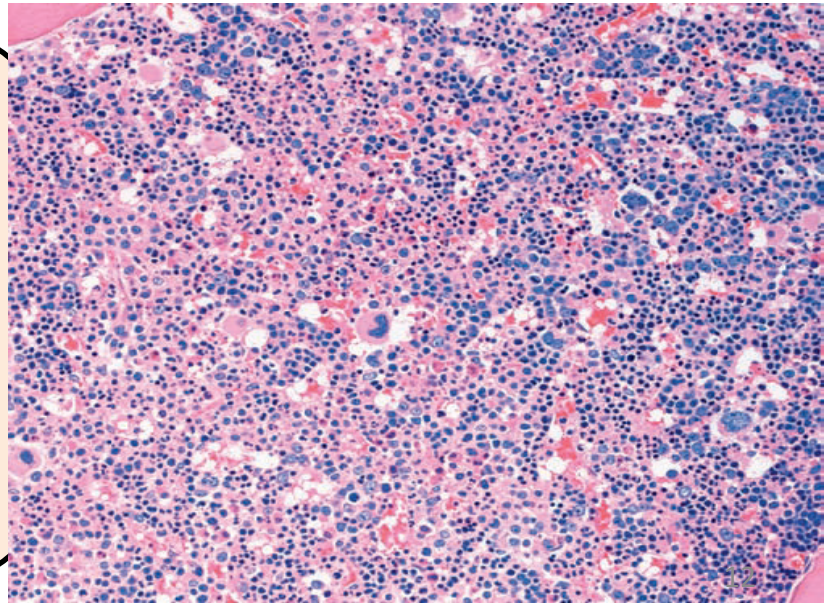
- Excess of normocytic normochromic RBC
- ±Leukocytosis &thrombocytosis



Bone marrow

- Hypercellular
- Predominant erythroid precursors
- ± Increased megakaryocytes &Myeloid precursors.

↑ Blasts ⟶ AL transformation



Complication &treatment

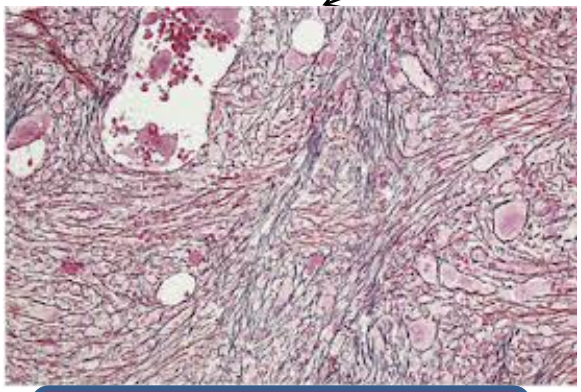
Diagnosis of Polycythemia Vera

Treatment:

- Venesection + Aspirin
- ± Myelosuppressive drugs (hydroxyuria)

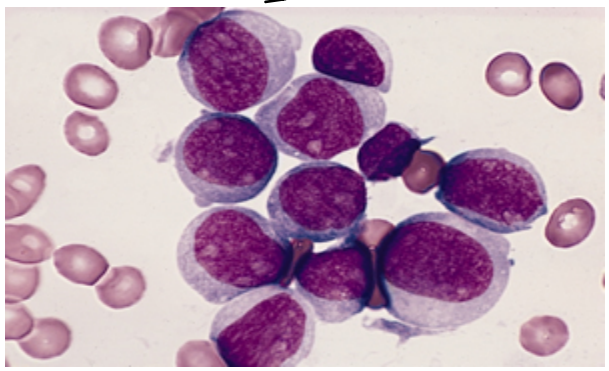
10-15 years

20%



Myelofibrosis

10%



Acute leukemia

Primary Myelofibrosis

1. Myeloproliferative neoplasms (MPN)

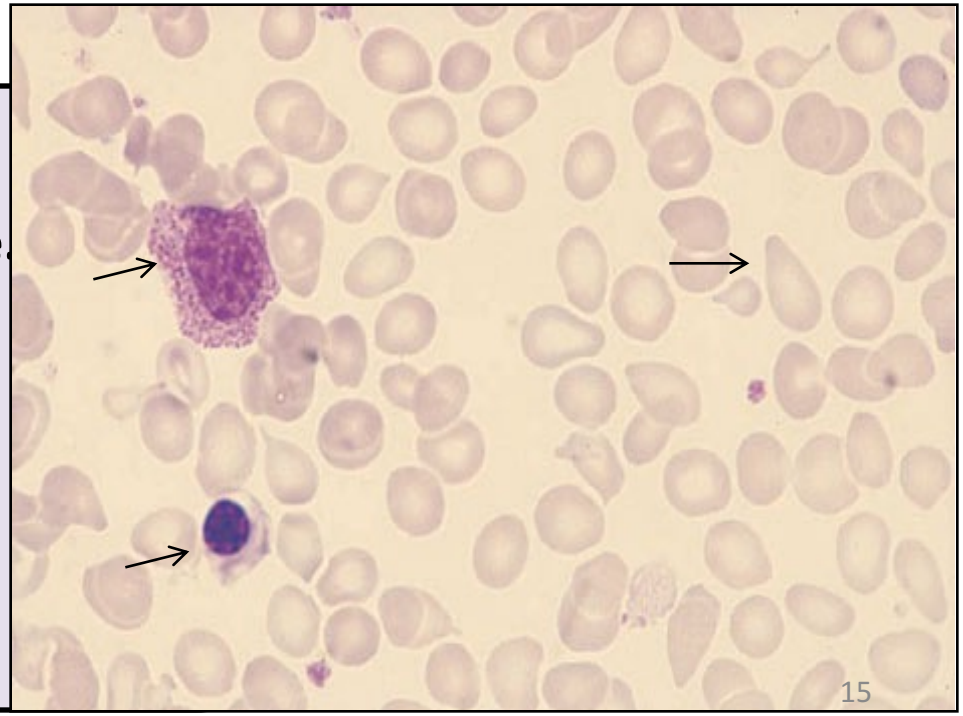
1.1. Chronic myelogenous leukemia, *BCR-ABL1*–positive (CML)
1.2. Polycythemia vera (PV)
1.3. Essential thrombocythemia (ET)
1.4. Primary myelofibrosis (PMF)
1.5. Chronic neutrophilic leukemia (CNL)
1.6. Chronic eosinophilic leukemia, not otherwise specified (CEL-NOS)
1.7. Mast cell disease (MCD)
1.8. MPN, unclassifiable

Primary Myelofibrosis

Clonal MPN characterized by a proliferation of megakaryocytes & granulocytes in the bone marrow that associated with deposition of fibrous connective tissue and extramedullary haematopoiesis

Clinical features

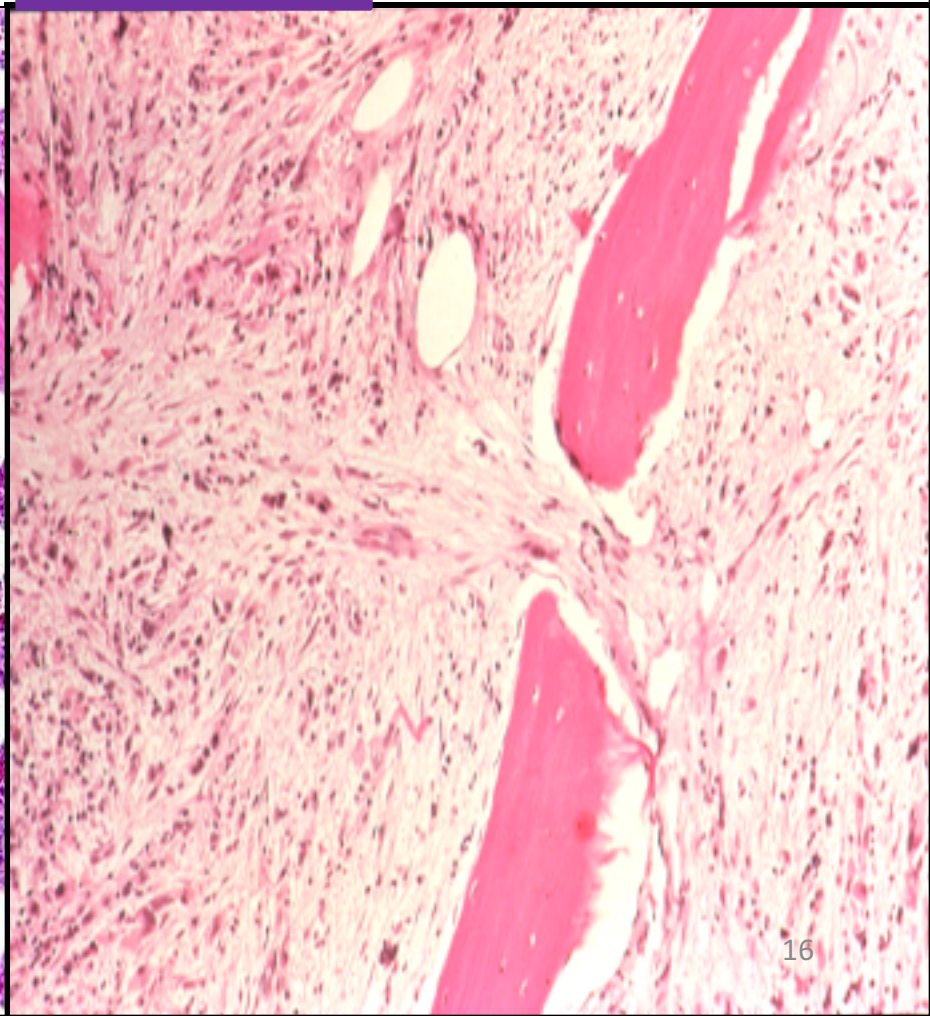
- Anemia
- Leukoerythroblastic blood picture.
- Massive splenomegaly
- Fibrotic bone marrow
- JAK2 mutation (50%)
- Risk of AML transformation (20%)



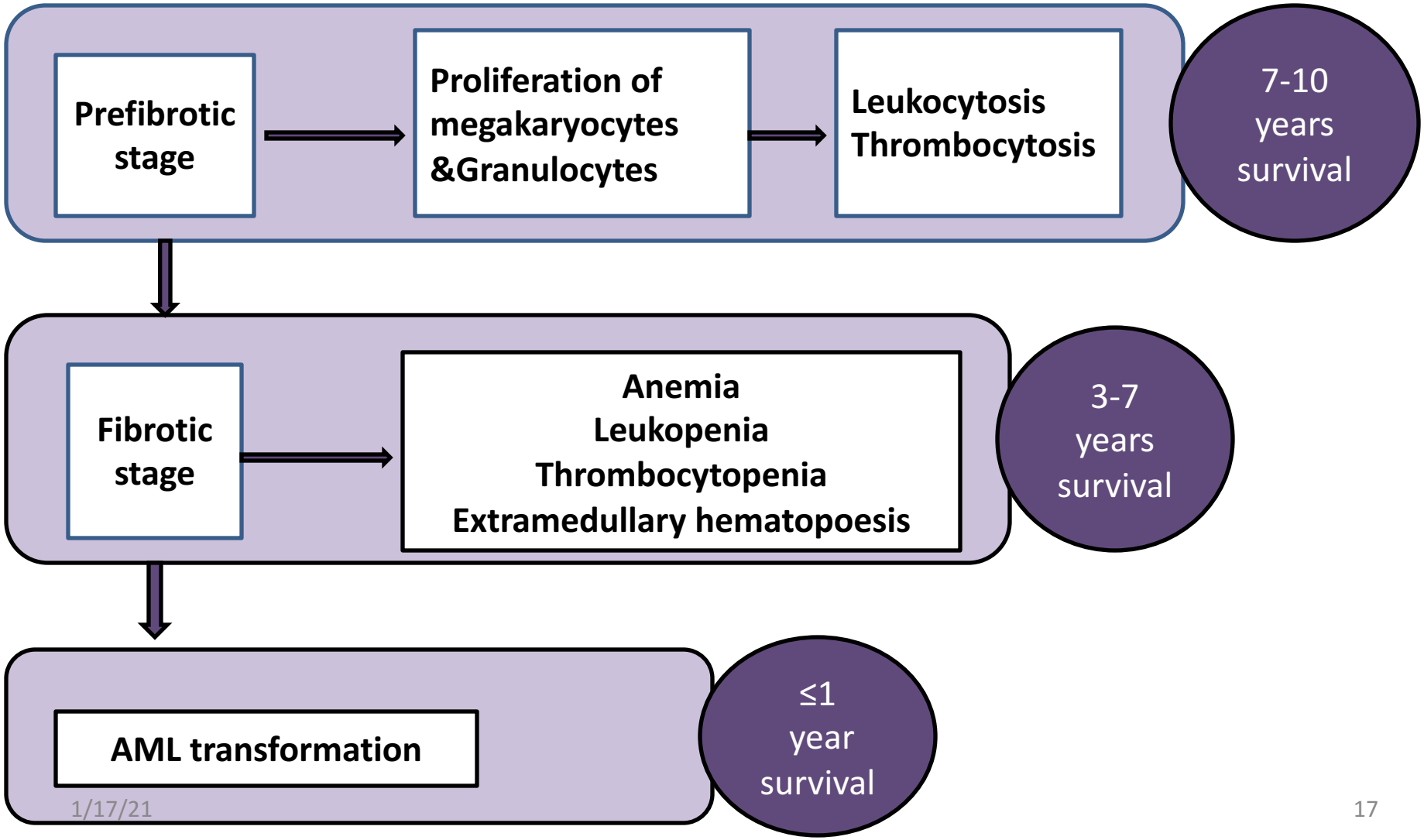
Bone marrow in Myelofibrosis

Normal BM

Fibrotic BM



Stages of PMF



Essential Thrombocythemia

1. **Myeloproliferative neoplasms (MPN)**
   - 1.1. Chronic myelogenous leukemia, *BCR-ABL1*–positive (CML)
   - 1.2. Polycythemia vera (PV)
   - 1.3. Essential thrombocythemia (ET)
   - 1.4. Primary myelofibrosis (PMF)
   - 1.5. Chronic neutrophilic leukemia (CNL)
   - 1.6. Chronic eosinophilic leukemia, not otherwise specified (CEL-NOS)
   - 1.7. Mast cell disease (MCD)
   - 1.8. MPN, unclassifiable

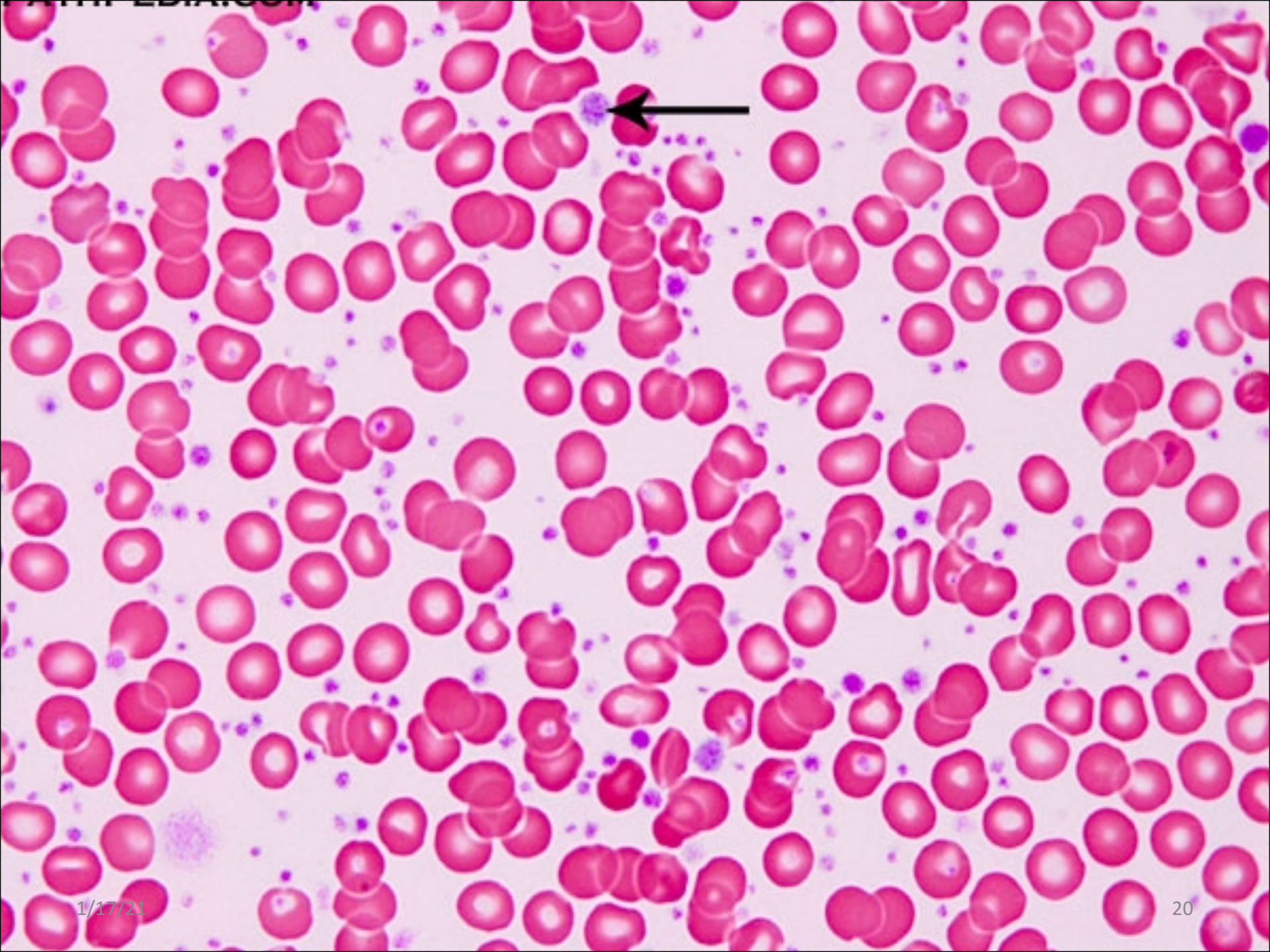
Essential Thrombocythemia

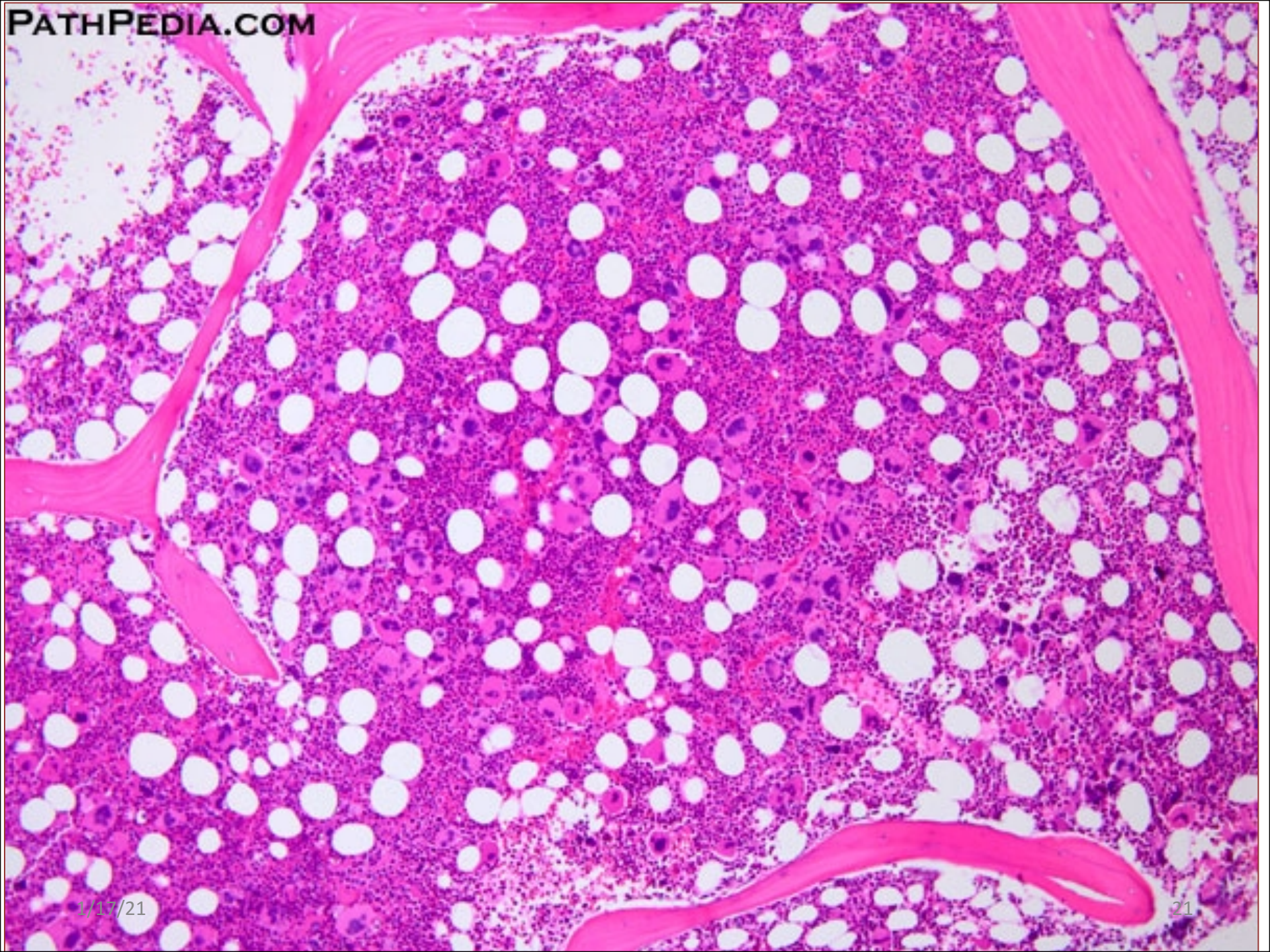
ET is MPN that involves primarily the megakaryocytic lineage. & characterized by sustained thrombocytosis .

Diagnostic Features

- **Sustained thrombocytosis ≥45O×10^9.**
- **Hypercellular BM with megakaryocytic proliferation**
- **Exclusion of: CML, MDS,PV &Primary Myelofibrosis**
- **JAK2 mutation (60%),If negative ;no evidence of reactive thrombocytosis:**

Iron def. ,splenoctomy, surgery, infection ,autoimmune disease….




PATHPEDIA.COM

Essential Thrombocythemia

Clinical Presentation

- Asymptomatic (50%)
- Thrombosis
- Bleeding
- Mild splenomegaly (50%)
- Mild hepatomegaly (20%)

Very indolent
(5% risk of AML transformation)

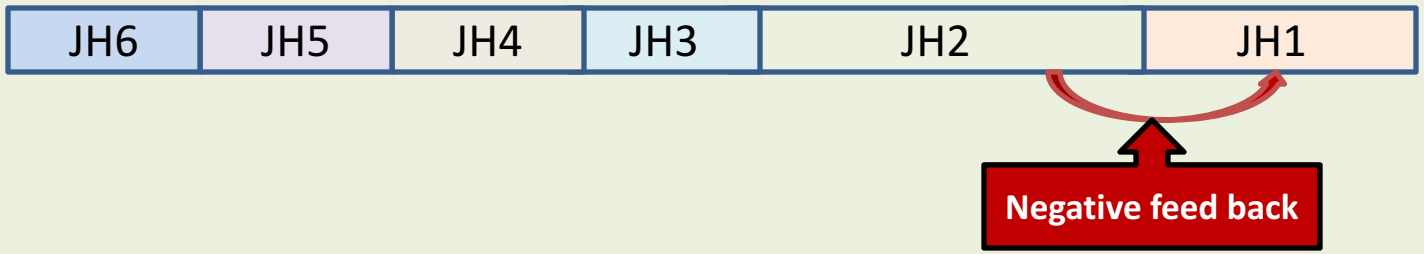
Treatment

Aspirin ±Hydroxyuria

JAK2 Mutation

JAK2: Non receptor protein tyrosine kinase involved in signal transduction pathway

JAK2 kinase domains structure

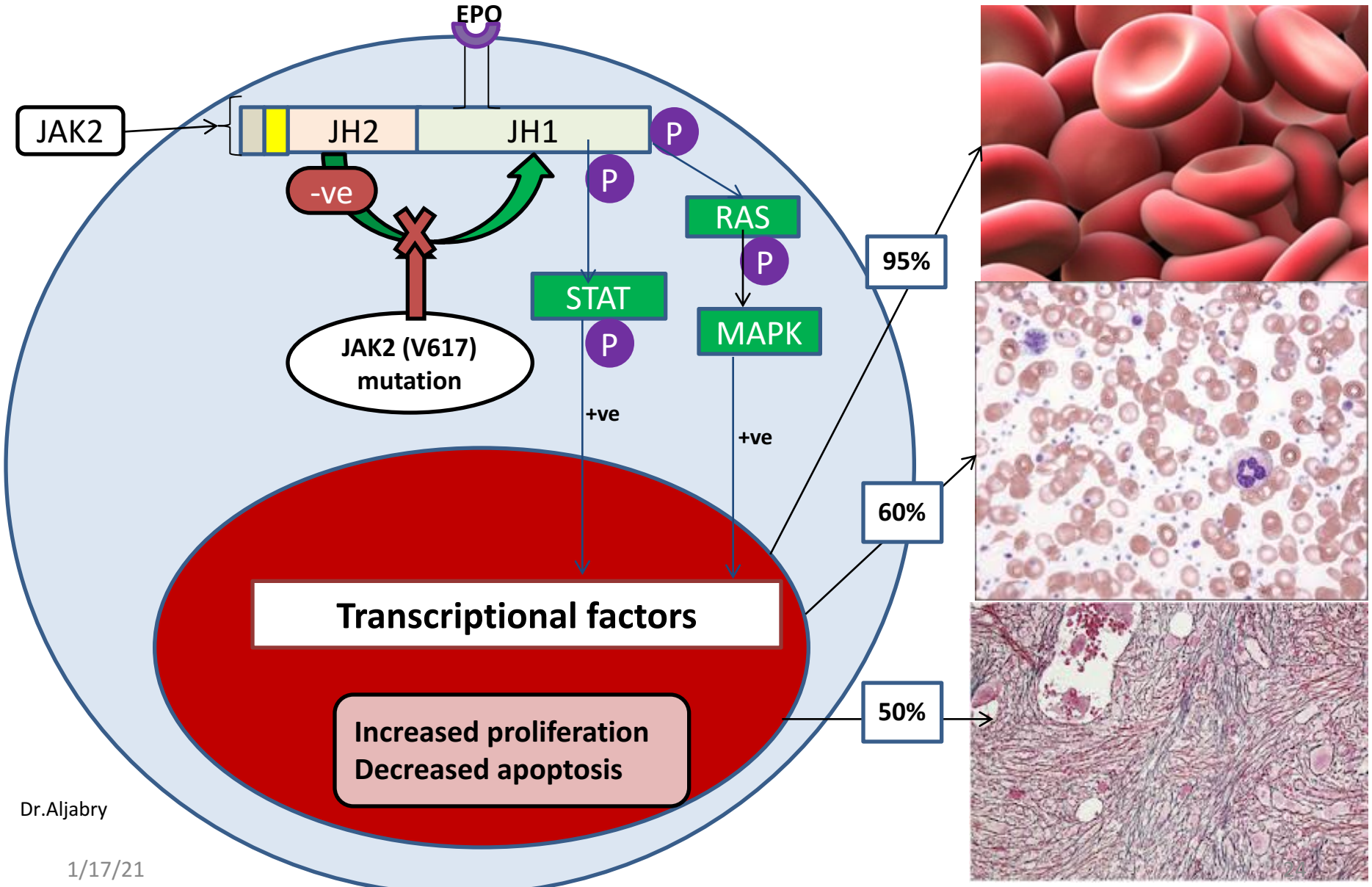


JAK2 mutation :

Point mutation (at codon 617 in JH2) leads to loss of auto inhibitory control over JAK2.

The mutated JAK2 is in a constitutively active state,

JAK2 Mutation



Dr.Aljabry