Enzyme and membrane markers in leukaemia: recent developments

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SUMMARY Terminal deoxynucleotidyl transferase (TdT) assay has proved a valuable test for distinguishing lymphoblastic from myeloblastic leukaemias, particularly in adults whose blast cells are often negative for the c-ALL antigen. The immunofluorescence assay, particularly when used in combination with antisera to surface membrane antigens, has proved a sensitive technique for detecting small numbers of lymphoblasts in extramedullary sites, for example, testis or cerebrospinal fluid, or of residual Thy-ALL blasts in the marrow, which might otherwise be difficult to recognise.

Differences in concentrations of several enzymes concerned in purine metabolism have been detected between the blast cells in the various acute leukaemias. Adenosine deaminase (ADA) concentrations tend to be higher in Thy-ALL than in other forms of leukaemia, but the wide overlap reduces the diagnostic value of this assay. Thy-ALL blasts, however, appear to be selectively and exquisitely susceptible to inhibition of ADA by the drug deoxycoformycin, which has now been used successfully in a number of otherwise resistant patients with Thy-ALL to obtain a complete remission.

The recently introduced technique for the production of monoclonal antibodies has substantially widened the reagents available for analysing the membrane characteristics of bone marrow stem cells and of cell lineages derived from them. These have revealed previously unsuspected heterogeneity among different cases of acute lymphoblastic leukaemia, for example, among Thy-ALL blasts from different patients, and they have also delineated minor populations of immature thymocytes from which these leukaemic cells are derived. The potential use of these antibodies to prevent graft-versus-host disease by selective removal of T-lymphocytes from donor bone marrow before allogeneic bone marrow transplantation, or to prevent recurrence of Thy-ALL and other lymphoblastic leukaemias or lymphomas by selective removal of leukaemic or lymphoma malignant cells before autologous transplantation, is reviewed.

During the last three years enzymatic and immunological assays have been used concomitantly in our laboratory for the characterisation of leukaemic cells and their normal counterparts. This study has evolved partly from our long-term interest in DNA metabolism of haemopoietic cells and has been initiated partly by the extensive characterisation of membrane structures (cALL antigen and Ia-like antigens) on leukaemic cells and their normal equivalent cells in Dr MF Greaves’ laboratory at the Imperial Cancer Research Fund. Both avenues were greatly facilitated by the fact that large numbers of leukaemic samples have been made available for diagnostic testing through the MRC UKALL trials organised by Dr HEM Kay. The aims of these studies have always been threefold: (1) accurate diagnosis; (2) elaboration of reagents and test systems for the study of normal cells from which the various forms of acute lymphoblastic leukaemia (ALL) originate; and (3) standardisation of new avenues for leukaemia treatment. An important advance in concomitant enzymatic and immunological analysis had taken place when Dr FJ Bollum developed a specific antibody to nuclear terminal deoxynucleotidyl transferase (TdT). By combining the analysis of nuclear TdT and membrane markers in double colour immunofluorescence tests, the immunoenzymatic analysis of individual single cells has become feasible. The method is both simple and important since these double marker assays prove useful in the efficient analysis of new specific ‘monoclonal’ antibodies (made by somatic cell hybridisation in mice) on even minute haemopoietic cell subpopulations, which helps to standardise anti-
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Panel of reagents for leukaemia diagnosis*

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<tr>
<th>Antibody to:</th>
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<th>References below and availability</th>
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<tr>
<td>Terminal deoxynucleotidyl transferase (TdT)</td>
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<td>1, 2; Bethesda Research Labs</td>
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<td>Ia-like (p28, 33)</td>
<td>Rabbit</td>
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<td>Common ALL (cALL) antigen</td>
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<td>Human thymocyte antigen</td>
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<tr>
<td>Human IgM</td>
<td>Goat†</td>
<td>2, 14; other laboratories</td>
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*Due to lack of space only some of the relevant references are shown.
†These reagents are pure antibodies eluted from the relevant immuno-adsorbent column.

1 Bollum FJ. Proc Natl Acad Sci USA 1975;72:4119
6 Charro D, et al. Blood 1979;54 Suppl. 1:82a
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Enzyme markers

A wide range of enzyme analyses is now available which may be used to distinguish different forms of leukaemia. These may be detected by cytochemical, biochemical, immunofluorescence, or electron microscopic techniques. In this section we wish to concentrate on terminal deoxynucleotidyl transferase (TdT, E.C. 2.7.7.31), which has proved particularly valuable in distinguishing lymphoblastic from myeloblastic leukaemias, and two enzymes in purine interconversion, adenosine deaminase (ADA, E.C. 3.5.4.4) and purine nucleoside phosphorylase (PNP, E.C. 2.4.2.1), which not only have diagnostic value but also have therapeutic implications, particularly for the treatment of thymic(Thy)-ALL.

Terminale deoxynucleotidyl transferase

Analysis of normal cells

Although the enzyme was detected in thymus by Bollum in 1962, it was only in 1973 that McCaffrey et al. reported a raised level in c-ALL blasts and aroused clinical interest (reviewed by Bollum10). Two normal human tissues, bone marrow and thymus, are now known to contain the enzyme. Immunofluorescent studies using a rabbit anti-TdT antibody8 have shown that a small fraction of normal bone marrow cells resembling normal lymphocytes are TdT positive. These cells are also usually positive for Ia-like and c-ALL antigens (Fig. 1). None of the TdT+ cells in the marrow show T-cell surface markers or surface membrane immunoglobulin (SmIg), that is, these cells are non-T, non-B.10 The number of TdT+ cells is increased in regenerating marrow, for example, after chemotherapy or bone marrow transplantation.

Fig. 1 The main leukaemic phenotypes and the corresponding normal precursor cell types. The reagents used are shown in the Table. Note that normal TdT+ pre-B cells (cytoplasmic immunoglobulin positive) are extremely rare while approximately 30% of common ALL cases are pre-B (TdT+, CySmIg+).

1 Common ALL and pre-B ALL: both are cALL antigen+, Ia+, TdT+, SmIg-, HuTLA-, My-. In addition, pre-B ALL blast cells have cytoplasmic IgM.
2 Two forms of thymic ALL: both are HuTLA+, TdT+, Ia+, SmIg-, My-. The rare 'early' forms are E- and weakly cALL+; the typical Thy-ALL is E+, cALL-.
3 B-ALL: SmIg+, Ia+, TdT-, E-, HuTLA-, My-, cALL-.
4 AML: My+, Ia+, TdT-, E-, HuTLA-, SmIg-, cALL-?

A few pre-B cells of TdT+, Cy (cytoplasmic) IgM+, Sm (surface membrane) Ig- phenotype can also be observed in normal child marrow but their number is extremely low: only 1% of the marrow TdT+
population. The vast majority of normal pre-B cells (Cy IgM+, Sm Ig-) in the marrow are TdT-. In spite of their rarity, the finding of a small proportion of cells with an intermediate phenotype between cALL+, TdT+, Sm Ig- cells (marrow precursors?) and the cALL-, TdT-, Sm Ig+ lymphocytes (bone marrow B cell) tentatively suggests that these cells could belong to the same differentiation lineage.

Cell separation studies have shown that the TdT+ cell is not in the fraction containing CFUc or BFUe, but whether the pluripotential stem cell (CFUs in mouse) is TdT+ is unknown. In the rat, a proportion of TdT+ cells develop T cell (thymocyte?) characteristics when treated with thymosin.15

In the human thymus, the TdT+ cells are predominantly localised in the cortex, while the majority of medullary thymocytes (which express characteristics of peripheral T lymphocytes) are TdT-. No TdT+ cells can be detected in circulating blood and peripheral lymphoid organs, apart from the transient appearance of a low proportion of TdT+ cells in young animals (eg, 1-4-week-old rats).17 The TdT+ thymic cell develops in rat, chicken, and human in late fetal life before TdT+ bone marrow cells can be detected. In the mouse, it can also be shown that the TdT+ bone marrow cell arises independently of the thymus, for example, in athymic 'nude' animals.18

In man, cortical thymocytes and peripheral T cells carry Hu TLA membrane antigens (detected by heterologous antisera) but do not express Ia-like antigens. Therefore cortical thymocytes are TdT+, Hu TLA+, Ia-, and peripheral T cells are TdT-, Hu TLA+, Ia-.

**Studies in leukaemia: Acute lymphoblastic leukaemia**

Approximately 95% of patients with cALL (positive with the antisera described by Greaves) have TdT+ blast cells.41319 The expression of the enzyme assessed by biochemical assay or by immunofluorescence is extremely variable, enzyme levels in positive cases ranging from 3-0 to > 200 units/10⁸ cells. In most but not all cases, cALL and Ia-like antigens are also expressed (Fig. 1). In older children and adults, however, cALL antigen is often negative and then TdT is a particularly valuable marker. Patients with cALL who are TdT- are usually young children and infants, but the response to therapy and prognosis does not appear to differ from that of the more usual TdT+ cases.

A subgroup of cALL exhibit TdT+ blasts with cytoplasmic IgM (Cy IgM; pre-B ALL).2021 We emphasise that in other respects these pre-B blast cells have the cALL phenotype (cALL+, Ia+, TdT+) and frequently contain mixtures of Cy IgM negative and positive blasts. These findings suggested that

leukaemic cells in some cases of cALL undergo at least a partial lymphocyte differentiation into pre-B cells. As these pre-B blasts do not express surface membrane immunoglobulin they are different from typical B-ALL leukaemic blasts or normal B cells which are cALL-, TdT-, Sm Ig+. (Interestingly, very few leukaemias, if any, contain mixtures of TdT+, Cy IgM+, Sm Ig-, pre-B and TdT-, Cy IgM-, Sm Ig+ B blasts.)

As the blast phenotype in cALL is similar to that of the normal marrow TdT+ cells (TdT+, Ia+, cALL+) individual residual or relapsing cALL blasts in the bone marrow suspension from treated patients can not yet be detected. The presence of TdT+ cells at extramedullary (and extrathymic) sites may, however, indicate leukaemia. Thus immunofluorescence studies with anti-TdT on cells in the cerebrospinal fluid can be used to detect blasts that might otherwise be missed,22 while both immunoperoxidase and immunofluorescence studies may be used to detect TdT+ testicular infiltration (Fig. 2).2324

Thy-ALL blasts are also usually TdT+ but this leukaemia is Hu TLA+, Ia-. In normal or regenerating bone marrow, no TdT+, Hu TLA+ cells can be detected, and in the marrow of patients treated for Thy-ALL even a single TdT+, Hu TLA+ cell indicates residual leukaemia. This assay is obviously more sensitive than conventional haematological methods.24

**Acute myeloblastic leukaemia**

Over 95% of cases are TdT-. The few TdT+ Ph-negative cases show mixtures of lymphoblastic and myeloblastic leukaemia, or there is aberrant expression of TdT on myeloblasts.25 In some studies, cases with a myelomonocytic pattern (M₄) appear to be more likely to be TdT+.26 Our own studies suggest that these TdT+ cases tend to be older and have a worse prognosis than is usual in AML and do not respond well to therapy for either ALL or AML. It is not yet clear whether these mixed cases consist of two separate clones or a single clone diverging along separate differentiation pathways.

These TdT+ cases of AML must be distinguished from cases of undifferentiated leukaemia in which the cells evade characterisation by morphological and cytochemical techniques. A positive TdT test in such cases implies, in our experience, a lymphoblastic origin and good response to vincristine and prednisone.

**Chronic granulocytic leukaemia**

TdT+ cells are not found in the peripheral blood or bone marrow in the chronic phase but about one-third of typical Ph'-positive cases of CGL in acute transformation show TdT+ blasts, and in some, but not all, these cases blasts show other typical morpho-
logical and cytochemical features of lymphoblasts. Ph⁻-negative cases may also show this TdT⁺ lymphoblastic transformation, and in some cases the blasts show pre-B features. TdT⁺ cases show a substantially better response to chemotherapy for ALL (vincristine and prednisone) and longer survival than those in myeloblastic transformation.

**CLL and lymphomas**

TdT is negative in chronic B and T cell disorders, including the tumour cells in CLL, Sézary’s syndrome, mycosis fungoides, Hodgkin’s disease, and most non-Hodgkin’s lymphomas. In a few histologically diffuse and poorly differentiated lymphomas, TdT is positive, and in these cases, where the appropriate tests have been carried out, the cells show T-cell markers.

**ADENOSINE DEAMINASE**

The importance of this enzyme in lymphoid development has been recognised since the observation that congenital ADA deficiency was a cause of T-cell deficiency. ADA is concerned in the degradation and recycling of purines, converting deoxyadenosine and adenosine to deoxyinosine and inosine, respectively (Fig. 3). Although the enzyme is present in most body cells, the highest concentration occurs in thymic cortical cells, and the concentration is higher in mature T than B cells. Thymocytes and T cells are more susceptible to deoxycadenosine toxicity because they have a lower ability to degrade deoxyadenosine triphosphate (dATP) than B cells or other tissues, the 5' nucleotidase level being particularly low while they have high levels of deoxynucleoside kinases. Taheri et al. have shown that Thy-ALL cells, unlike other cells, are unable to compartmentalise dATP into a degradative pool. Accumulation of dATP is thought to inhibit ribonucleotidase reductase in T cell precursors and thus switch off the supply of dTTP, dATP, and dCTP and so inhibit DNA synthesis. An alternative suggested mechanism of toxicity in ADA deficiency is the accumulation of S-adenosyl-homocysteine (SAH) due to inhibition of SAH hydrolase by adenosine with inhibition of S-adenosyl methionine (SAM) synthesis and thus reduced methylation of RNA, DNA, and proteins.

Recent studies in patients treated with the ADA inhibitor, deoxycoformycin (dCF), show that the rise in dATP rather than inhibition of SAH hydrolase correlates with cell killing.

**ADA in leukaemia**

Initial studies showed raised levels in acute leukaemia, whether myeloblastic or lymphoblastic, and levels in CLL lower than in normal peripheral blood. More recently, the incidence of raised
levels has been shown to be higher in ALL than in AML, the highest levels occurring in Thy-ALL blasts.\textsuperscript{43} An antibody to the enzyme may be used in a radioassay of enzyme in cells or serum, and this has confirmed enzyme assays showing particularly high levels in Thy-ALL blasts. The assay may have value in confirming remission or demonstrating early relapse since the serum level appears to relate to total body ADA level.\textsuperscript{45}

The diagnostic value of the enzyme assay is, however, limited. Although Thy-ALL blasts tend to show higher ADA and lower TdT concentrations than cALL blasts,\textsuperscript{43} the overlap is too great for reliable distinction. Similarly, although, in the chronic lymphoid proliferative disorders, ADA is higher in the T-cell tumours (Sézary’s syndrome, T-CLL or T-prolymphocytic leukaemia) than in B-cell disorders, the overlap is again substantial.\textsuperscript{46}

The observation that deoxycoformycin, an ADA inhibitor, inhibits T-cell proliferation\textsuperscript{47} and may be used to obtain full remission in patients with Thy-ALL resistant to other drugs,\textsuperscript{48} is of considerable importance. The action seems to be extremely selective, cALL blasts proving resistant to ADA inhibition.\textsuperscript{48} The drug is also of value in patients with the more chronic T-cell disorders in selectively killing tumour cells (Prentice \textit{et al.}, in preparation). It also has potential value for selective removal of Thy-ALL cells \textit{in vitro}, for example, before autologous transplantation.\textsuperscript{8}

**Purine nucleoside phosphorylase (PNP) (E.C. 2.4.2.1)**

This enzyme acts sequentially with ADA in purine degradation (Fig. 3), converting inosine or deoxyinosine hypoxanthine and guanosine or deoxyguanosine to guanine. Congenital deficiency of PNP, either complete or partial, due to the presence of a mutant enzyme causes immune deficiency with lack of T-cells but normal B-cell function\textsuperscript{50} which has been ascribed to the accumulation of deoxyguanosine and dGTP in T-cell precursors.\textsuperscript{51} Blatt \textit{et al.}\textsuperscript{52} found PNP to be significantly reduced in eight cases of Thy-ALL (range 10-100U, median 38) compared with 14 cases of non-T, non-B ALL (range 50-140U, median 79) or compared with normal peripheral blood mononuclear cells (range 10-230U, median 83).

On the other hand, cytochemical staining has suggested that it is the T-cells in peripheral blood that are PNP positive and B-cells negative with decreased activity in B-CLL compared to normal peripheral blood.\textsuperscript{53} 54

**Immunological markers in leukaemia**

It has been emphasised above that many of the new immunological reagents (anti-TdT, anti-ALL, anti-Ia-like, anti-HuTLA, and anti-myeloid antisera) play complementary roles in the differential diagnosis of leukaemias. The diagnostic accuracy can therefore be increased when the reagents to membrane antigens are used in combination with each other or with an antiserum detecting nuclear TdT enzyme (see above and ref. 10). An even more recent development has been the standardisation of new monoclonal antibodies (McAb-s). Many of these McAb-s react with the same molecules as the conventional reagents (cALL antigen, Ia-like antigens, sheep erythrocyte receptor on thymocytes and T-cells, etc). The great advantages of the McAb-s are that no absorptions are required during their preparation, and they can be made in large amounts for wide distribution and general use in many laboratories. It is therefore likely that the McAb-s will replace many of the conventional reagents in leukaemia analysis.

\begin{figure}[h]
\centering
\includegraphics[width=0.8\textwidth]{purine_degradationDiagram.png}
\caption{The role of adenosine deaminase (ADA) and purine nucleoside phosphorylase (PNP) in metabolism of purines. PNP also degrades deoxyguanosine and guanosine to guanine. Toxicity due to ADA deficiency (or inhibition) is thought to be due to accumulation of dATP with inhibition of ribonucleotide reductase and also to accumulation of S-adenosyl homocysteine, whereas PNP deficiency leads mainly to deoxyguanosine and dGTP accumulation (not shown): dA=deoxyadenosine; MP, DP, TP=mono-, di-, and tri-phosphate respectively.}
\end{figure}
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**Recent Developments in Membrane Marker Analysis**

As McAb-s can be distributed widely, the initial standardisation of the product frequently takes place in many different collaborating laboratories, some of which use functional assays for lymphocyte subsets and analysis on the cell sorter and cytofluorograph. In our laboratory, two groups of assays have been used for analysing the reactivity of McAb-s. The first group has been analysis of bone marrow precursor cells. This included (1) reactivity of TdT+ cells (putative lymphoid precursors) with McAb; (2) reactivity of recognisable myeloblasts (identified by morphology and staining for Ia-like antigens); and (3) the CFUc activity in vitro after separating the positive and negative populations on the cell sorter. The second group of tests has been the analysis of differentiating cells: thymocytes/T cells, B lymphoid cells, and myeloid/erythroid cells. For this, well-established known antisera (anti-HuTLA, anti-Ig, anti-myeloid, etc) were used in double combination with the new McAb, and the phase contrast morphology of the cells was also studied.

**Monoclonal Antibodies Reacting with Marrow Precursors**

Five interesting reagents fall into this group. The two most obvious ones are: the new McAb reacting with the CALL antigen, which labels only normal TdT+ marrow cells; and McAb-s to Ia-like antigens, which label TdT+ marrow cells and, in addition, myeloblasts, CFUc cells, and B lymphocytes but not thymocytes/T cells and differentiating myeloid/erythroid cells.

A new McAb (RFB-1, made by Dr M Bodger at the Royal Free Hospital) labels TdT+ marrow cells, myeloblasts, and CFUc (but not differentiating myeloid/erythroid cells) and TdT+ thymocytes (but not T cells). This reagent is unreactive with B lymphocytes. In contrast, the BA-2 (standardised by Dr J Kersey's group) labels only TdT+ marrow cells and B lymphocytes. Finally, the OKT10 reagent is an antibody made by Ortho Laboratories, which reacts with precursor cells of all haemopoietic lineages: TdT+ marrow cells, marrow B lymphocytes, myeloblasts, and CFUc and TdT+ thymocytes, but is unreactive with differentiating and mature cells of the marrow peripheral T and B lymphocytes.

In conclusion, a new range of McAb-s recognise abundantly expressed membrane structures (evidenced by bright immunofluorescence staining) which are present on marrow precursors and seem to be 'spreading down' on immature cells of the various differentiation pathways to a different degree. These essentially morphological observations have to be interpreted with caution. Clearly, cell separation techniques combined with cell culture and new functional assays are now required for the exact analysis of the reactivity of these new reagents. Using these principles in the rat, a remarkable purification of the various haemopoietic precursor cells could be achieved with the help of anti-Thy-1 antibody. This anti-rat antibody seems to have a reactivity pattern similar to that of the anti-human McAb OKT10. Nevertheless the group of assays used here already provides sufficient indications about the expected diagnostic and potential therapeutic uses of the reagents studied (see below).

**Monoclonal Antibodies Reacting with Differentiating Cells**

A wide range of McAb-s is now available which react with thymocytes and T lymphocytes. These studies confirm that Thy-ALL has a thymic origin. As the McAb-s have a finer analytical capacity than conventional antibodies, the new observations reveal more details: Thy-ALL blast cells closely parallel the phenotypic characteristics of a relatively minor, probably immature subpopulation of larger thymic blast cells. Thus only some of the McAb-s react with most Thy-ALL blast cells strongly, for example, pan-T reagents such as OKT11 made by Ortho, Lyt-3 made by Kamoun et al. and T101 prepared by Royston et al. Many other McAb-s (which are strongly reactive against normal cortical thymocytes); for example, NA1/34 made by McMichael et al. and OKT4, 5, 6, and 8 described by Reinherz et al. frequently detect only small proportions of Thy-ALL blasts present in the sample. It will therefore be interesting to see whether additional McAb-s can be made which react only with normal large thymic blast cells (and the majority or all of corresponding Thy-ALL blast cells). Particular attention has to be focused on the McAb-s reacting with peripheral T lymphocytes. These include OKT3 (which reacts with all TdT- HuTLA+ cells in the bone marrow, peripheral blood, and lymphoid organs), and pan-T reagents (OKT11, Lyt-3, see above, or UCHT1 standardised by Beverley and colleagues). The important point is that these antibodies are apparently unreactive with marrow precursors such as TdT+ cells and CFUc.

Other McAb-s reacting with differentiating cells of B cell, myeloid, erythroid, monocyte lineage have been described but are outside the scope of our study.

**Potential Use of McAb-s in Leukaemia Treatment**

The two main areas are (1) the removal of mature T lymphocytes from the allogeneic bone marrow...
before transplantation (prevention of graft versus host disease: GvHD) and (2) elimination of residual leukaemic cells from the autologous bone marrow without damaging marrow stem cells.

Since McAb-s reactive with T lymphocytes are available, and some of these are lytic in the presence of rabbit complement (eg, OKT3), it will be important to establish the best method to prevent GvHD (coating of T cells with antibody? lysis of T cells in vitro? removal of T cells on immunoadsorbents?). These studies are in progress.

Once the techniques of T-cell removal are perfected the elimination of residual leukaemic blasts can also be attempted. The obvious candidates are patients with Thy-ALL (eg, using antibody OKT11), B lymphoma, and perhaps cALL in second remission. The removal of TdT+ putative lymphoid precursors together with the residual cALL blasts may not have serious consequences although it remains to be seen whether the surviving patients develop hypogammaglobulinemia.

Conclusions

Chemotherapy alone dramatically improved survival in leukaemia. Remission induction is successful in most patients but many relapse. Additional therapy is required. This needs to be selective with no or only minimal additional myelotoxicity. A better understanding of the enzymatic and antigenic make-up of leukaemic cells may lead to selective treatment protocols. It is already clear that ADA inhibitors kill Thy-ALL blasts selectively, and it may be that during the course of marrow transplantation the antibodies used will remove T cells or residual Thy-ALL blasts specifically without damaging myeloid stem cells. These efforts should be used in combination with conventional therapy and with each other. Allogeneic bone marrow transplantation may already be the choice of therapy for AML, and the studies described here can only improve the prospect of patients with AML, ALL, and other leukaemias.

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