lymphadenopathy

A

1

associated

Hypercalcaemia

was

1

Centor Dickinson, Mountain View, California, USA). The following antibodies were analysed: T3, T4, T8, J5, B4, B1 (Coulter Clone); Leu-M5, Leu-15, Leu-4, IL-2, Leu-17 and Leu-8 (Becton Dickenson); anti-LFA 1 and anti-β-LFA 1B (Janssen); Cris 1 (Dr R Viella, Hospital Clinic Provincial, Barcelona); FMC7 (Sera-Lab); 10B8 (Immunotech); and surface immunoglobulins (Kallestad). Mouse rosettes were also sought. Detailed results are shown in the table.

B cell chronic lymphoid leukaemias comprise a broad spectrum of lymphoid proliferations classified according to the cytological and phenotypic features of the leukaemic cells.1 Our case was a mantle zone lymphoma in leukaemic phase, which is a rare form of B cell chronic lymphoid leukaemia (B-CLL). Cytologically, the leukaemic cells had pronounced heterogeneity of size and a fairly pleomorphic appearance. The surface marker analysis of the leukaemic cells (table) showed a monoclonal B cell proliferation that was CD5+, CD23-, CD25+, and CD19+. Surface immunoglobulin was strong, FMC7 was positive, and there was no formation of mouse rosettes. All these features differ from typical B-CLL leukaemia but resemble the surface phenotype of prolymphocytic leukaemia and that of follicular lymphoma in leukaemic phase. Overall, it seems that the characteristic phenotypic profile of mantle zone lymphoma in the leukaemic phase includes strong surface immunoglobulin and positivity for FMC7 and CD5. Reactivity with CD10 and mouse rosette formation is variable. Data on the antibodies Leu6, CD11, CD22, CD23, CD25 and CD38 are scarce. Further studies are needed to clarify precisely the phenotype of this particular lymphoid leukaemia.

| SOLAR |
| FORTINO |
| RUBIOL |

Serveis d’Hematologia Hospital de la Santa Creu i Sant Pau Avinguda S. A. M. Claret 167 08025 Barcelona Spain


Hypercalcaemia and osteolytic lesions associated with chronic lymphocytic leukaemia (CLL)

Case 1

A 72 year old man had cervical and axillary lymphadenopathy and an enlarged spleen palpable 1 cm below the left costal margin. A blood count showed that his haemoglobin concentration was 11.5 g/dl (normal range: 12.5-16 g/dl), his white cell count was 1.14 x 10^9/l (normal range 4.0-10.0 x 10^9/l), his lymphocytes were 105 x 10^9/l and his platelet count 250 x 10^9/l (normal range 150-400 x 10^9/l). A biochemical screen, including that for serum calcium concentration, was normal. A bone marrow aspirate and trephine biopsy specimen showed diffuse infiltration with small mature lymphocytes, and chronic lymphatic leukaemia (CLL) was diagnosed. The disease was easily controlled by short, intermittent courses of chlorambucil.

Three years from diagnosis and while not receiving treatment, the patient was admitted with a two week history of thirst, malaise, and vomiting. Examination showed that he was dehydrated, had enlarged cervical lymph nodes, an enlarged liver palpable 3 cm below the right costal margin and an enlarged spleen palpable 4 cm below the left costal margin. The haemoglobin concentration was 9.1 g/dl, the white cell count 14.8 (small mature lymphocytes 9.1 x 10^9/l, prolymphocytes 3.9 x 10^9/l), and the platelet count 142 x 10^9/l. Serum calcium was 3.66 mmol/l (normal range 2.15-2.60 mmol/l), serum phosphorus 0.9 mmol/l (normal range 0.70-1.30 mmol/ml), and alkaline phosphate activity 101 IU/l (normal range 28-142 IU/l). Serum albumin was 34 g/l (normal range 35-45 g/l). The increased serum calcium and alkaline phosphatase concentrations were normal. The serum parathormone concentration was <0.1 µg/l (normal range is 0.5-5 µg/l) and vitamin D concentration was 10 µmol/l (normal range 15-100 µmol/l). A bone scan showed increased uptake in several ribs, vertebrae, clavicles and several long bones. Treatment with chlorambucil 6 mg/day, prednisolone 40 mg/day and intravenous fluids was begun, and after three days the calcium had fallen to 2.0 mmol/l. Intravenous mithramycin (25 µg/kg/day) for three days was given, after which the calcium concentration was 2.05 mmol/l. Two weeks later a further course of mithramycin was necessary as the calcium concentration had risen to 3.7 mmol/l. A further short-lived response was achieved but three weeks later the patient fell, fractured his femur and pelvis, and died shortly afterwards from bronchopneumonia.

Thoracic aortitis due to salmonella

Case report

A 62 year old college lecturer was admitted with a six month history of night sweats, arthralgia, and lethargy. Two weeks before admission he developed haemoptysis, hoarseness, and continuous left shoulder pain. There was no history of recent foreign travel, nor diarrhoeal illness in the patient or family, nor a notable medical history. On examination he had fluctuating fever up to 38.5°C. His blood pressure was 110/80 mm Hg in both arms with a systolic murmur at the left sternal edge and a pericardial rub. An X-ray of the chest and left main bronchus, Culture of bronchial washings was negative. A computed tomogram of the thorax (figure) showed azygous dilatation of the thoracic aorta; this was confirmed at

Hypercalcemia and osteolytic lesions associated with chronic lymphatic leukemia (CLL)

T J Littlewood, A P Lydon and C J Barton

_J Clin Pathol_ 1990 43: 877
doi: 10.1136/jcp.43.10.877-a

Updated information and services can be found at:
_http://jcp.bmj.com/content/43/10/877.1.citation_

These include:

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
_http://group.bmj.com/group/rights-licensing/permissions_

To order reprints go to:
_http://journals.bmj.com/cgi/reprintform_

To subscribe to BMJ go to:
_http://group.bmj.com/subscribe/_