inflammatory cytokines such as interleukin 1, tumour necrosis factor, and gamma interferon, T cell activation, 3 conversion T of lymphocytes from naive to memory cells 1 and viral infection. 1 One or more of these factors may be responsible for causing the increased expression of ICAM-1 that occurs during liver allograft rejection. The factors regulating ICAM-1 expression in normal hepatocytes remain uncertain.

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Dr’s Smith and Thomas comment:

We thank Hubscher and Adams for clarifying the ICAM-1 expression they found in normal liver and agree that the factors they mention may be responsible for the upregulation of ICAM-1 they detected in the rejecting liver allografts.

Thrombocytosis and follicular thyroid carcinoma

We report a rare case of thrombocytosis associated with thyroid follicular carcinoma. Thrombocytosis associated with malignant disease has been described in lung carcinoma, pleural mesothelioma, gastrointestinal tract carcinoma, lymphoma and acute leukaemia, hepatocarcinoma, neuroblastomas, hyperthyroidism and other epithelial cell origin tumours; it has not been described in association with thyroid carcinoma. 1-4

A 72 year old woman was diagnosed as having a follicular thyroid carcinoma because of progressive enlarging goitre. A fine needle aspiration biopsy specimen was consistent with follicular carcinoma, the diagnosis of which was confirmed when the excised thyroid was examined microscopically. Pre-operative tests had shown increased numbers of platelets (746 × 10¹²/l and 731 × 10¹²/l, respectively). The haemoglobin concentration was 14.4 g/l, the haematocrit 41.8%, while red blood cell count, white cell count, mean corpuscular volume, mean corpuscular haemoglobin concentration, and serum ferritin and serum transferrin concentrations were normal. Haemostatic evaluation showed normal prothrombin and partial thromboplastin times. FDP concentrations were within the normal range. Two months after surgical resection the platelet count returned to normal.

Most cases of thrombocytosis secondary to malignant disease have a platelet count from 4 to 6 × 10¹²/l. Iron deficiency may also contribute to an increased platelet count. 1,2 In other cases slow activation of clotting and disseminated intravascular coagulation have occurred and FDP was detectable. 3,4 It was not specified, however, whether these cases also had thrombocytosis. Although haemorrhagic and thrombotic episodes are characteristic of primary thrombocytosis, 4,5 in these patients platelet production probably occurs in the tumour or in the bone marrow by a protein produced by the neoplasm (thrombocyte stimulating factor) (TSF). 6,7 The occurrence of unexplained thrombocytosis precludes malignancy.

We suggest that clinicians should be aware of this rare sign in malignant diseases.

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