CD34 immunoperoxidase staining for the diagnosis of myelodysplastic syndromes and chronic myeloid leukaemia

Horany et al recently reported that immunoperoxidase staining of bone marrow biopsy specimens with the CD34/QBEND10 monoclonal antibody can be used to separate the myelodysplastic syndromes RAEB and RAEB-T from the RA and RARS subtypes. This report has now confirmed our previous findings that CD34/QBEND10 is a useful reagent for the detection of conventionally processed, paraffin wax embedded bone marrow biopsy specimens.1 We have recently studied bone marrow biopsy specimens from 50 cases of primary myelodysplastic syndromes addressing the diagnostic value of CD34 staining in these conditions.2 We found that CD34 immunostaining can help in the detection of the increased number of blasts associated with the RAEB and RAEB-T subtypes. In addition, our study showed that QBEND10 represents a powerful prognostic tool for predicting survival and outcome in myelodysplastic syndromes. In primary RAEB cases median survival was 41 months in those with less than 1% CD34+ cells, and 29 months in those with more than 1% CD34+ cells (p<0.05).3 Similar results were obtained in cases of therapy related myelodysplastic syndromes: CD34+ cases had a mean survival of 10 months compared with 43 months for the CD34- cases (p<0.0005).4 The authors also suggest the potential usefulness of CD34 staining for identifying patients in the accelerated phase of chronic myeloid leukaemia. Our recently published study of 59 bone marrow biopsy specimens representing the three phases (stable, accelerated and blastic) of chronic myeloid leukaemia has confirmed the finding of a statistically higher CD34 value in the two aggressive phases of this disease compared with the stable phase.5 Taken together, these data and those from Horany et al show that QBEND10 is a very useful reagent for the study of routinely processed bone marrow biopsy specimens and may provide useful diagnostic and prognostic information in myelodysplastic syndromes and myeloproliferative disorders. This type of approach may be especially valuable when a paraffin wax embedded specimen is the only material available for immunohistochemical examination.

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Lung pathology course
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M adame A Alcaraz, Laboratoire de Biochimie C, CHURG, B.P. 217, F-38043 Grenoble Cedex 9, France (tel: (33) 76 76 54 84; fax: (33) 76 76 56 64).

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Correction
Microscopic thymoma and myasthenia gravis (JClin Pathol 1995;48:682–683). The authors apologise for the errors which appeared in the Pathological findings section of their report. In the last line of the first paragraph, 272 x 71 mm should read 272 x 71 μm. In the first paragraph, 107 mm (range 41–237 mm) should read 107 μm (range 41–237 μm).
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