Bone marrow culture in aplastic anaemia

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SUMMARY Blood and bone marrow granulocyte colony forming units (CFUc) were assayed in 46
patients with aplastic anaemia, and the serum was examined for its inhibitory action on normal
CFUc growth. All patients showed a gross reduction in colonies and clusters in incidence and
absolute number in the bone marrow and blood. Two proliferative abnormalities of CFUc in
aplastic anaemia were identified: a significantly higher than normal cluster to colony ratio
(p < 0.05) and a higher than normal ratio of granulocytes to total aggregates in the bone marrow.

Eleven out of 34 patients tested had serum inhibitory to normal CFUc. These patients were
indistinguishable from the rest on haematological and CFUc culture characteristics, and no correlation
between the results of CFUc assay and haematological severity was found.

The results suggest that the CFUc is abnormal in aplastic anaemia, the reduction in pool size
being related to a failure of self-renewal, but an immunological role in the pathogenesis of aplastic
anaemia remains unproven.

The close relationship of CFUc incidence to the percentage of granulocyte precursors in the
marrow, together with the failure of the CFUc assay to predict clinical severity, limits the practical
use of the assay to the confirmation of diagnosis in aplastic anaemia.

The assay of granulocyte progenitor cells (CFUc) by the soft agar colony forming technique has
demonstrated that patients with aplastic anaemia have grossly reduced numbers of granulocyte
precursors in the bone marrow and blood (Greenberg and Schrier, 1973; Kern et al., 1977). The evidence
from clinical bone marrow transplantation suggests that there is primary stem cell failure in aplastic
anaemia (Storb et al., 1974; Singer et al., 1978). However, some data support a bone marrow
microenvironmental defect (Knospe and Crosby, 1971; Fernbach and Trentin, 1977) and, at least in
some patients, an autoimmune process in the disease (Ascensão et al., 1976; Kagan et al., 1976; Speck et al.,
1977; Te Velde and Haak, 1977; Gluckman et al., 1978).

We studied a large group of patients with aplastic anaemia to look for clues to the aetiopathogenesis of
this condition:
1 comparing the relationship of CFUc to blood and bone marrow findings in normal subjects and
aplastic anaemia patients in an attempt to define

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Received for publication 14 December 1978

subgroups of patients with particular CFUc characteristics; and
2 determining the CFUc and haematological characteristics of patients found to have serum
inhibitory to normal bone marrow CFUc.

In addition, we examined the practical contribution of bone marrow culture to establishing the
diagnosis and severity of aplastic anaemia.

Patients and methods

Patients
Forty-six patients with aplastic anaemia (27 male
and 19 female; mean ages 25 and 22) referred to the
Hôpital Saint Louis between April 1976 and
October 1977 were studied. In five patients a toxic
cause for the aplastic anaemia was suspected, three
had aplasia following hepatitis, and in the rest no
aetiological cause was identified. The diagnosis of
aplastic anaemia was made on repeated blood counts
showing pancytopenia and greatly reduced bone
marrow cellularity on biopsy. There was a bias
towards referral of patients fulfilling the diagnostic
criteria of severe aplasia: 30 patients had a reticulo-
cyte count of less than 20 x 10⁹/l, a neutrophil
count of less than 0.5 x 10⁹/l, and a platelet count
of less than 20 x 10⁹/l.
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Colony assays
These were performed soon after admission to the unit before specific treatment had begun, but most patients had already received androgen treatment before referral, and all had received blood transfusions.

Serum
Serum for inhibitor studies was taken at the same time as the marrow sample and stored at −80°C until tested.

Normal bone marrow and blood samples
Samples were obtained from bone marrow transplant donors and from patients undergoing diagnostic bone marrow aspiration for non-haematological disorders. Blood samples for colony assays were obtained from healthy laboratory workers and blood donors.

CFUc Culture
The technique of Pike and Robinson (1970) was used. In particular, triplicate cultures were prepared for each sample, and feeder layers of 10⁶ normal buffy coat leucocytes were used as a source of colony stimulating factor. Marrow and blood samples were separated on Lymphoprep (Nygaard), and the washed separated mononuclear cells were cultured in McCoy's 5A medium in 0·3% agar at a concentration of 2 × 10⁶ cells/culture plate for marrow and 5 × 10⁶ cells/culture plate for blood. Cultures were incubated for 10 days in 5% CO₂ and high humidity. Colonies (groups of 50 or more cells) and clusters (groups of 5-49 cells) were counted using an inverted objective microscope, and results were expressed as the mean of triplicate cultures.

Serum
Serum was assayed for its inhibitory effect by pre-incubating 8 × 10⁶ normal bone marrow mononuclear cells in the presence of 10% test serum and 10% rabbit complement for 1½ hours at 37°C. The marrow cells were washed, suspended in agar and medium, and plated in triplicate at a final concentration of 2 × 10⁶ cells/culture plate. Colony inhibition was expressed as the index:

<table>
<thead>
<tr>
<th></th>
<th>mean colony number after exposure to test serum</th>
<th>mean colony number after exposure to autologous serum</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Normal serum gave a range of 1·03 ± 0·28 (2SD) (Barrett et al., 1978).</td>
<td></td>
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</table>

Statistical Analysis
The results were analysed using the Student's t test and the Wilcoxon Rank sum test.

Results
Figure 1 shows the haematological characteristics of the patients studied together with the colony assay results. Bone marrow and blood colony and cluster growth were grossly reduced in all patients, six patients having no detectable growth in marrow or blood. Table 1 compares these results with those of 40 normal bone marrow cultures. Blood and bone marrow colony and cluster numbers in aplastic anaemia patients were significantly lower either when expressed as growth in relation to cell concentration plated or as absolute colony or cluster numbers per millilitre of blood or marrow aspirate. In addition, the ratio of clusters to colonies in the bone marrow was significantly higher in patients with aplastic anaemia (Table 1).

Sera from 34 patients were tested for ability to inhibit CFUc growth of normal bone marrow (Fig. 2).

Patients with aplastic anaemia showed a wide scatter of results between an index of +1·2 to 0·0 (that is, total inhibition). Eleven patients had indices of 0·55 or less, and, for the purpose of analysis, these patients were designated as a group showing CFUc inhibition.

Comparison of Culture Results with Bone Marrow Findings
Figure 3 shows the relationship between total aggregate incidence and percentage of bone marrow granulocytes (myeloblasts plus promyelocytes plus myelocytes plus metamyelocytes). There was a positive correlation of CFUc with the bone marrow granulocyte percentage (r = 0·42, P = 0·4 (normals)

<table>
<thead>
<tr>
<th></th>
<th>Colonies/2 × 10⁶ cells</th>
<th>Total aggregates/2 × 10⁶ cells</th>
<th>Colonies/ml</th>
<th>Total aggregates/ml</th>
<th>Cluster: colony ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>&lt;0·01</td>
<td>&lt;0·01</td>
<td>&lt;0·01</td>
<td>&lt;0·01</td>
<td></td>
</tr>
<tr>
<td>Marrow</td>
<td>&lt;0·01</td>
<td>&lt;0·001</td>
<td>&lt;0·001</td>
<td>&lt;0·001</td>
<td>&lt;0·05</td>
</tr>
</tbody>
</table>

Bone marrow CFUc—46 patients with aplastic anaemia; 40 normal subjects
Blood CFUc—15 patients with aplasia; 29 normal subjects
Fig. 1 Haematological and granulocyte culture characteristics of patients with aplastic anaemia compared with normal (normal ranges for haematological indices taken from Dacie and Lewis (1975)). Twenty-nine normal blood samples and 40 haematologically normal bone marrows cultured in the same laboratory under identical conditions were used as controls for CFUc results. Shaded area represents ± one standard deviation of normal range.

and $r = 0.42$, $p = 0.01$ (aplastic anaemia). The slope of the regression lines differed, patients with aplastic anaemia having significantly lower ratios of total aggregate to granulocytes ($t = 2.2$, $p = 0.05$).

Figure 4 shows the relationship between total aggregate incidence and percentage of bone marrow lymphocytes. In aplastic anaemia there was an inverse correlation between the lymphocyte percentage and the total aggregates per $2 \times 10^5$ cells plated. The data best fitted an exponential distribution ($r = 0.48$, $p = 0.001$), but normal subjects showed no significant relationship of lymphocytes to total aggregates. There was no obvious segregation of data from patients with serum inhibitory to CFUc.

**RELATIONSHIP OF COLONY COUNTS TO HAEMATOLOGICAL SEVERITY**

Table 2 shows that there was no significant difference
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Fig. 3 Relationship of bone marrow granulocyte percentage to incidence of total aggregates in aplastic anaemia patients and 15 normal subjects: ● aplastic anaemia patients; ○ normal subjects.

Fig. 4 Relationship of marrow lymphocyte and plasma cell percentage to incidence of total aggregates in aplastic anaemia patients and 15 normal subjects: ● aplastic anaemia patients; ○ normal subjects; ® patients with serum inhibitors to CFUc.

Table 2 Comparison of severe aplasia v less severe aplasia CFUc characteristics

<table>
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<th>Colonies/2 × 10⁶ cells</th>
<th>Total aggregates/2 × 10⁶ cells ml</th>
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<td>Severe aplasia</td>
<td>4.7 ± 1.1 (0-27)</td>
<td>14 ± 3.3 (0-84)</td>
</tr>
<tr>
<td>Mean ± SEM (range)</td>
<td>(33 patients)</td>
<td>200 ± 63 (0-1347)</td>
</tr>
<tr>
<td>Less severe aplasia</td>
<td>4.3 ± 1.2 (0-14)</td>
<td>18 ± 3.6 (0-81)</td>
</tr>
<tr>
<td>Mean ± SEM (range)</td>
<td>(13 patients)</td>
<td>476 ± 181 (0-2970)</td>
</tr>
</tbody>
</table>

Table 4 shows that no significant difference was found between the proportion of bone marrow lymphocytes, the blood lymphocytes, and the CFUc characteristics of patients with inhibitors compared with those without.

Table 2

<table>
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<th>Colonies/2 × 10⁶ cells</th>
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P > 0.1 for: colonies/2 × 10⁶ cells, total aggregates/2 × 10⁶ cells, and total aggregates/ml using Wilcoxon Rank sum tests.

Discussion

Our results confirm in a large series of patients the characteristic paucity of colony and cluster growth in aplastic anaemia (Greenberg and Schrier, 1973; Kern et al., 1977).
Table 3  Haematological variation according to CFUc culture characteristics

<table>
<thead>
<tr>
<th></th>
<th>No growth (6)</th>
<th>Cluster growth only (17)</th>
<th>Colony and cluster growth (23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutrophils × 10⁹/l</td>
<td>0-39</td>
<td>0-38</td>
<td>0-5</td>
</tr>
<tr>
<td>Mean and (range)</td>
<td>(0-22-0-58)</td>
<td>(0-02-0-9)</td>
<td>(0-1-6)</td>
</tr>
<tr>
<td>Platelets × 10⁹/l</td>
<td>8</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Mean and (range)</td>
<td>(5-15)</td>
<td>(5-20)</td>
<td>(5-50)</td>
</tr>
<tr>
<td>Reticulocytes × 10⁹/l</td>
<td>11</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Mean and (range)</td>
<td>(0-27)</td>
<td>(0-14-5)</td>
<td>(0-69)</td>
</tr>
<tr>
<td>Median survival</td>
<td>910</td>
<td>794</td>
<td>580</td>
</tr>
</tbody>
</table>

No significant difference was found on Wilcoxon Rank sum tests between: no growth v cluster growth only; cluster growth only v colony and cluster growth; and no growth v colony and cluster growth (p > 0.1 for each test).

In addition, we have also identified qualitative abnormalities that distinguish CFUc in aplastic anaemia from normal. The ratio of clusters to colonies was higher in aplastic anaemia, as was the ratio of bone marrow granulocytes to the incidence of total aggregates.

These features could be interpreted as indicating stem cell damage which impairs their capacity both for proliferation (hence greater numbers of clusters than colonies) and for self-renewal (hence a small stem cell pool and the increased ratio of mature cells to CFUc).

We also found inhibitors of normal bone marrow CFUc in about one-third of the patients. While serum inhibitors of CFUc are found in polytransfused patients with other disorders (Barrett et al., 1978) we have shown that they are associated with a beneficial response of aplastic anaemia patients to ALG treatment (Faille et al., 1979), and one report (Gordon, 1978) of inhibition by the patient’s serum of bone marrow CFUc from an identical twin suggests that, at least in some instances, serum inhibitors in aplastic anaemia are directly related to the aplastic process and not to sensitisation by blood transfusion.

We were unable to distinguish the 11 patients with serum inhibitors from the rest of the group by either haematological severity or culture characteristics. This suggests that although serum inhibitors may possibly represent a marker of an immunological cause for the aplastic anaemia, the subsequent marrow failure is indistinguishable in nature and severity from the aplasia induced by other processes.

There are several possible interpretations for the inverse relationship between bone marrow CFUc incidence and marrow lymphocyte percentage in aplastic anaemia. The severity of the aplasia has been related to the degree of lymphocyte infiltration on marrow histology (Te Velde and Haak, 1977) but marrow lymphocytosis may simply reflect the absence of normal myeloid precursor cells. It has been claimed that lymphocytes from patients with aplastic anaemia can inhibit normal CFUc in co-culture (Kagan et al., 1976; Haak and Goslinc, 1977), but the validity of the co-culture technique to demonstrate specific abnormalities in aplastic anaemia has been challenged (Singer et al., 1978).

Further studies are required to demonstrate any association between the in vitro findings of lymphocyte inhibitors and the characteristics of the bone marrow lymphocytosis and CFUc content.

Lastly, from a practical viewpoint, while colony assay may confirm the diagnosis of aplastic anaemia, the technique does not identify different degrees of severity of the condition. Furthermore, since CFUc correlated directly with the percentage of bone marrow granulocytes, little additional information is obtained from bone marrow culture that cannot be obtained from examination of the bone marrow aspirate.

This work was carried out during tenure of a Leukaemia Research Fund/INSERM Anglo-French Exchange Fellowship by A. J. Barrett.

We thank Angela Tasker for typing the manuscript.

References

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