

# Identification of A Novel $inv(2)(p13;q14)$ in Essential Thrombocythemia

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
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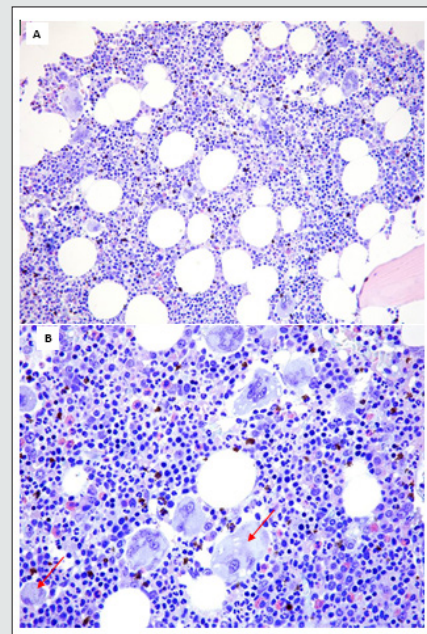
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## Introduction

A 69-year-old man came at our observation for thrombocytosis. Peripheral blood counts showed: PLT,  $805 \times 10^9/L$ ; hemoglobin 14.4 g/dl; WBC,  $7 \times 10^9/L$  (with 58% neutrophils, 27% lymphocytes, 12% monocytes, 2% eosinophils, and 1% basophils). Bone marrow examination at trephine biopsy showed a hypercellular marrow with an obvious megakaryocytopoiesis increase (Figure 1). Some of the megakaryocytes were small, with a reduced ploidy. The karyotype, assessed as previously described [8,9] showed an isolated  $inv(2)(p13;q14)$ . The patient did not record any previous thrombosis or hemorrhage. Clinically, the disease remained stable, the PLT count being  $750 \times 10^9/L$ , at the time of writing after 6 years of hydroxyurea treatment, at the daily dosage of 1000 mg p.o. No thrombotic or hemorrhagic event was reported during the follow-up. Some episodes of tinnitus were retained after a period of 11 months since the date of diagnosis. This is the first time, to the best of our knowledge, that  $inv(2)(p13;q14)$  was recorded in ET. In anaplastic large cell lymphomas (ALCL) is rarely observed the  $inv(2)(p23q35)$ . It involves ALK and ATIC genes, and the fusion protein has a cytoplasmic localization [10]. No other genetic aberrations involving the same chromosomal region are reported in hematological malignancies. Interestingly, however, the loci 2p13 and 2q14 do contain genes known to be involved in the pathogenesis of human cancer, such as MERTK (c-mer proto-oncogene tyrosine kinase), TGFA (transforming growth factor alpha), IL1A (interleukin-1 alpha), and, intriguingly, IL1B (interleukin-1 beta), known to enhance the megakaryocyte proliferation in vitro [11]. In conclusion, though we cannot exclude that  $inv(2)$  was not strictly related to the neoplastic clone, we hypothesize that the herein

described aberration is a newly acquired chromosomal abnormality in ET. Further studies are warranted to better define the exact prevalence and to definitively characterize the phenotypic and molecular features associated with this chromosomal aberration.



**Figure 1:** Bone marrow trephine biopsy. A) Hypercellular bone marrow with regular erythropoiesis and granulopoiesis. B) Megakaryocytes are increased in number and mature, with some evidence of dystrophy, and reduced size/ploidy (arrows).

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