

# GLOBAL JOURNAL

OF MEDICAL RESEARCH: C

## Microbiology & Pathology

Catenin Role and Expression

Intractable Nausea and Vomiting

### Highlights

Case of Systemic Amyloidosis

Spectrum of Disorders Diagnosed

Discovering Thoughts, Inventing Future

VOLUME 15

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MICROBIOLOGY AND PATHOLOGY

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## A Diagnostic Challenge in a Patient with Intractable Nausea and Vomiting: A Case of Systemic Amyloidosis

By Naveed Ali, Ali Ghani, Apurva Gandhi, Ritesh Rampure & Herbert E. Auerbach

**Abstract-** Amyloidosis is a rare disorder caused by deposition of amyloid fibrils in various tissues causing structural and functional defects. Depending upon organs involved, it may be categorized as localized or systemic. Systemic amyloidosis involves multiple organs where some organs are affected more commonly than others. Diagnosis is often challenging as in a 76-years-old female described here who presented with intractable nausea and vomiting. Clinical course was complicated because of simultaneous presence of peptic ulcer disease and hypothyroidism. Involvement of multiple systems including gastrointestinal tract, thyroid, liver, heart and kidneys was seen, and diagnosis was achieved after renal biopsy showing Congo red staining and apple green birefringence. Gastric and thyroid infiltration by amyloidosis are extremely rare occurrences described very infrequently in the literature. However, to our knowledge, involvement of both organs in a single patient has not been reported in the literature.

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AD IAGNOSTIC CHALLENGE IN A PATIENT WITH INTRACTABLE NAUSEA AND VOMITING AS A CASE OF SYSTEMIC AMYLOIDOSIS

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# A Diagnostic Challenge in a Patient with Intractable Nausea and Vomiting: A Case of Systemic Amyloidosis

Naveed Ali <sup>α</sup>, Ali Ghani <sup>σ</sup>, Apurva Gandhi <sup>ρ</sup>, Ritesh Rampure <sup>ω</sup> & Herbert E. Auerbach <sup>¥</sup>

**Abstract-** Amyloidosis is a rare disorder caused by deposition of amyloid fibrils in various tissues causing structural and functional defects. Depending upon organs involved, it may be categorized as localized or systemic. Systemic amyloidosis involves multiple organs where some organs are affected more commonly than others. Diagnosis is often challenging as in a 76-years-old female described here who presented with intractable nausea and vomiting. Clinical course was complicated because of simultaneous presence of peptic ulcer disease and hypothyroidism. Involvement of multiple systems including gastrointestinal tract, thyroid, liver, heart and kidneys was seen, and diagnosis was achieved after renal biopsy showing Congo red staining and apple green birefringence. Gastric and thyroid infiltration by amyloidosis are extremely rare occurrences described very infrequently in the literature. However, to our knowledge, involvement of both organs in a single patient has not been reported in the literature.

## I. INTRODUCTION

Nausea and vomiting are universal symptoms encountered in daily clinical practice, mostly as a part of medical illnesses involving the gastrointestinal tract with causes ranging from relatively benign to at times serious pathology. In either case, these symptoms are very distressing to patients. Therefore, a systematic approach is warranted to determine the cause particularly in cases of intractable nausea and vomiting. We report a 76-years-old female with intractable nausea and vomiting where diagnosis of systemic amyloidosis was made after an extensive workup. Being a systemic disease, amyloidosis affected multiple systems including extremely rarely involved organs.

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## II. CASE PRESENTATION

A 76 years old non-alcoholic female with history of coronary artery disease (CAD) developed intractable nausea and vomiting lasting two months with repeated admissions to various hospitals. An upper endoscopy (EGD) was done which showed duodenal ulcer and *Helicobacter pylori* was identified on biopsy. She was subsequently treated with triple therapy. At the same time, she was diagnosed with severe primary hypothyroidism and was started on levothyroxine supplementation. Despite completing triple therapy for *Helicobacter pylori* infection, she had persistent nausea and vomiting, and presented to our hospital. Furthermore, she had developed generalized body swelling and a skin rash.

On examination, she was noted to have bilateral feet and leg swelling, epigastric tenderness and a faint maculopapular rash was evident on the abdomen. Laboratory investigations were noteworthy of the following: BUN 26 mg/dl, Cr. 1.30 mg/dl, Na 129 mEq/l, K 5.2 mEq/l, HCO<sup>3</sup> 16 mEq/l, AST 169 U/l, ALT 86 U/l, ALP 2390 U/l, total bilirubin 0.6 mg/dl, albumin 1.2 gm/dl and  $\gamma$ -glutamyl transpeptidase (GGTP) 849 U/l. Hemogram showed a WBC count of  $10.2 \times 10^3$  per  $\mu$ l, hemoglobin level of 18.7 gm/dl and platelet count of  $238 \times 10^3$  per  $\mu$ l. Thyroid function tests showed elevated TSH at 51 IU/ml (which was markedly elevated at  $> 200$  per  $\mu$ U/ml on previous admission to another hospital), decreased free T4 at 0.59 ng/dl and decreased free T3 at 1.13 pg/dl. Her troponin level was also found to be elevated at 0.47 ng/ml.

Renal function abnormalities were presumed to be secondary to pre-renal etiology from dehydration consequent to vomiting. Electrolyte derangements were corrected and therapy was instituted for severe hypothyroidism as intravenous levothyroxine. Deranged hepatic enzymes were evaluated for hepatobiliary pathology with a computerized tomography (CT) scan of the abdomen which showed bilateral pleural effusions and findings compatible with hepatic cirrhosis and ascites (Figure 1). Further evaluation of hepatic cirrhosis was negative for infectious or autoimmune causes. The elevation in liver and biliary tract enzymes in particular

markedly elevated alkaline phosphatase was presumed to be due to severe hypothyroidism.



Figure 1 : CT scan showing mildly nodular liver contour, hepatomegaly, ascites

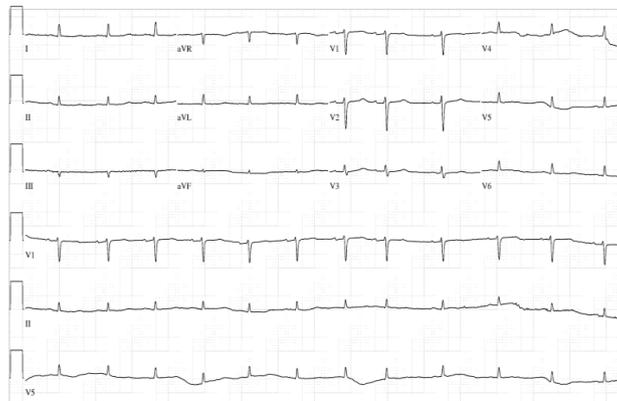


Figure 2 : EKG showing low voltages QRS complexes

Elevated troponin level in the setting of CAD history was evaluated by an echocardiogram which showed moderate asymmetrical left ventricular hypertrophy (Figure 3a) without left ventricular outflow tract obstruction (Figure 3b), which along with low voltage EKG QRS complexes (Figure 2) suggested an

underlying systemic infiltrative disease such as hemochromatosis and amyloidosis. Hence, iron studies were done which showed a ferritin level of 581 ng/dl, iron (Fe) of 86 µg/dl, transferrin (TIBC) of 109 µg/dl and iron saturation of 79%, findings not compatible with hemochromatosis.

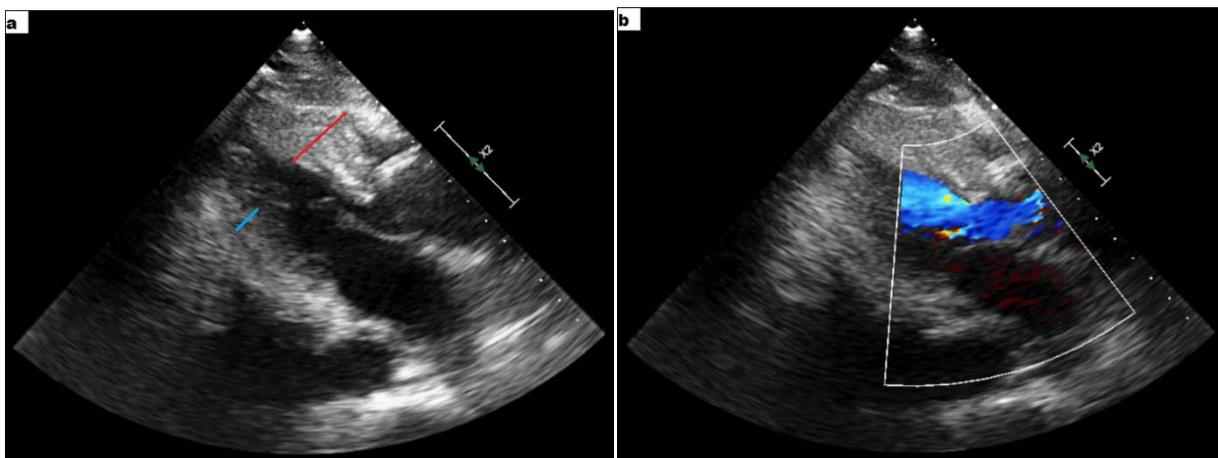
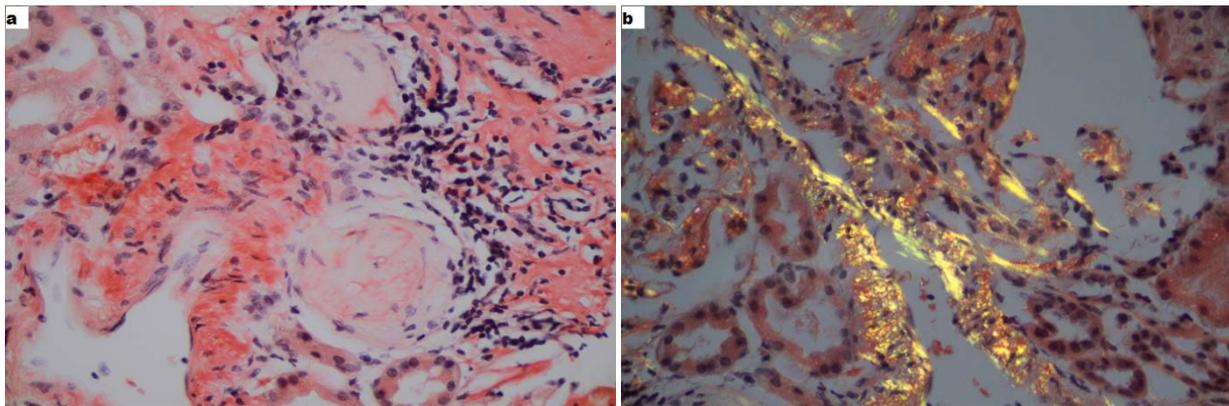


Figure 3 : a) parasternal long axis view showing asymmetrical septal hypertrophy (red line – septum, blue line – left ventricular free wall) b) parasternal long axis view with color doppler showing laminar flow (blue) across left ventricular outflow tract

During the course of her treatment, she developed worsening anasarca and severe hypoalbuminemia raising suspicion of nephrotic syndrome. Therefore, a 24 hour urinary protein quantification demonstrated proteinuria of 4 grams. As part of nephrotic syndrome workup, she was noted to have IgA lambda monoclonal gammopathy on serum protein immunofixation, however, serum protein electrophoresis did not show any abnormal monoclonal spike. Serum immunoglobulin analysis revealed elevated immunoglobulin A level at 544 mg/dl and decreased IgG level at 442 mg/dl. Serum kappa free light chains were 30 mg/l, lambda free light chains were 148 mg/l and kappa/lambda ratio was decreased to < 0.2. Ultimately, a kidney biopsy was done to find

out the exact cause of nephrotic syndrome which stained positive for Congo red and birefringence (*Figure 4a & 4b*). PAS, Jones and trichrome stain were compatible with amyloidosis. She was diagnosed with type AL systemic amyloidosis with gastric, cardiac, thyroid, liver and kidney involvement. The morbilliform skin rash was thought to be secondary to amoxicillin which she received as part of H. pylori treatment and it improved over the course of her hospital stay. She was given diuretics, albumin infusions and steroids. After stabilization in the hospitalization, she was discharged. Unfortunately, bone marrow biopsy could not be performed as patient was readmitted to another hospital and passed away.



*Figure 4* : a) renal biopsy staining with Congo red stain b) apple green birefringence under polarized light

### III. DISCUSSION

Amyloidosis is characterized by deposition of misfolded fibrillar proteins in the extracellular space, leading to multiple organ and tissue derangements [1]. The primary pathogenetic mechanism involves antiparallel beta-pleated sheet conformation of polypeptide molecules resulting in insoluble protein aggregates that get deposited in tissues as amyloid. This abnormal folding of native proteins occurs due to various factors including intrinsic amyloidogenic propensity, increased serum concentrations, aging, genetics and proteolytic remodeling [2]. Amyloidosis is classified according to the precursor protein. Primary or AL amyloidosis is caused by deposition of monoclonal immunoglobulin light chains and occurs in association with plasma cell dyscrasias. Secondary or AA amyloidosis is derived from serum amyloid A protein and occurs in association with chronic underlying inflammatory disorders. Several familial forms of amyloidosis have been identified such as transthyretin, apolipoprotein A-1 and fibrinogen A. Long term dialysis also results in amyloidosis derived from  $\beta$ -2 microglobulin [1, 3, 4].

Gastrointestinal disease is present in as many as 60 percent of patients with amyloidosis which can occur as an isolated entity or as part of multiorgan

involvement [5, 6]. GI involvement is more common in AL type rather than AA type amyloidosis [7, 8]. Gastrointestinal disease in amyloidosis results from either mucosal or neuromuscular infiltration. In addition, an extrinsic autonomic neuropathy may also affect gut function [5]. Infiltration may occur anywhere along the GI tract presenting as GI bleeding, malabsorption, protein losing enteropathy and chronic GI dysmotility. GI dysmotility presenting as nausea, vomiting and pseudo obstruction is a rare presentation that occurs in 1% of patients with GI amyloidosis [5, 6, 7, 9]. There have been rare cases reported with systemic amyloidosis presenting solely as a gastrointestinal obstruction or pseudo obstruction [10, 11, 12, 13]. Even though there were multiple systems involved in this patient, but amyloid gastropathy presenting as nausea and vomiting was most predominant.

Being a systemic disease, amyloid can infiltrate the thyroid gland. Thyroid infiltration can present as progressively enlarging goiter and can be confused with rapidly enlarging thyroid cancer. The majority of amyloidosis affected patients develop infiltration of the thyroid gland; yet thyroid dysfunction in the form of hypothyroidism rarely occurs [14]. Literature search reveals only a few case reports of severe hypothyroidism as manifestation of systemic amyloidosis and most of these cases were diagnosed at

autopsy [15, 16]. Severe hypothyroidism in this case was presumed to be due to amyloidosis involving thyroid gland. Interestingly, we did not see goiter in our patient which is a more common manifestation of thyroid infiltration.

Because amyloidosis is a systemic disease, we find involvement of multiple systems in our case besides GI tract and thyroid gland. Firstly, involvement of liver was noted when CT scan of the abdomen was done. Although hepatic involvement is very common in patients with amyloidosis, the clinical manifestations of hepatic involvement are usually mild [17, 18]. Liver infiltration is more common in AL amyloidosis than AA amyloidosis [6]. Hepatomegaly is present in up to 81-92% of patients in amyloidosis [6, 20]. Contrast-enhanced CT scan, although not diagnostic, may show an enlarged liver with heterogeneous decreased attenuation or rarely a mass [18, 19]. The patients are often misdiagnosed with hepatic cirrhosis based on imaging features. In this patient, cirrhosis was thought to be secondary to amyloidosis because all causes of hepatic cirrhosis (HBV, HCV, autoimmune, alcohol, hemochromatosis) were excluded. Elevated alkaline phosphatase, usually along with elevated GGTP, is the most common laboratory abnormality in systemic amyloidosis [17, 20]. In our patient, markedly elevated alkaline phosphatase and CT scan findings strongly suggested amyloid infiltration of liver.

Secondly, cardiac involvement occurs in up to 50 percent of patients with AL amyloidosis compared to less than 5 percent with AA amyloidosis [21, 22]. The heart is considered involved if either an endomyocardial biopsy demonstrates amyloidosis in the presence of clinical or laboratory evidence of involvement or echocardiographic evidence of amyloidosis is found in a patient with a positive result of noncardiac biopsy [23]. Besides EKG which shows low voltage QRS complexes, echocardiography is particularly useful in diagnosis especially if there are not significant cardiac symptoms [22]. In our patient, asymmetrical septal hypertrophy and lack of outflow tract obstruction favored an infiltrative disease. It is of great importance to pay particular attention to details such as low voltage QRS complexes, as it may be a clue towards a rare yet significant disease.

Thirdly, severe hypoalbuminemia and nephrotic range proteinuria were secondary to renal involvement of amyloidosis, which was confirmed by renal biopsy. The kidney is affected in 50% to 80% of patients with AL amyloidosis and is the most common cause of mortality in these patients along with cardiac manifestations [24]. Diagnosis is made by renal biopsy demonstrating Congo red staining and apple-green birefringence upon polarization [24, 25]. Renal manifestations in amyloidosis are characterized by nephrotic syndrome with heavy proteinuria and impaired renal functions [26].

Our patient exhibited both nephrotic syndrome and impairment of renal functions.

The present case is very unique in presentation as there were two exceedingly rare manifestations of systemic amyloidosis: amyloid gastropathy and severe hypothyroidism. The diagnosis in the patient was confounded by recent diagnosis of *H. pylori* related duodenal ulcer. However, the symptoms persisted even after undergoing therapy leading to repeated admissions in various hospitals. Moreover, the diagnosis was challenging in the presence of another systemic disease, hypothyroidism. Although recurrent nausea and vomiting is relatively uncommon in hypothyroidism, its concomitant presence in this case complicated the diagnosis. After extensive investigations, the clue towards a systemic infiltrating disease (amyloidosis) was provided by EKG which showed low voltage complexes, underscoring the importance of even basic investigations. Ultimately, diagnosis of systemic amyloidosis was reached after renal biopsy.

Amyloidosis, being a great masquerader, is one of the unusual diseases that physicians encounter and often presents a diagnostic challenge as in our patient. Suspicion of GI involvement may be very low if other organs are unaffected. However, unexplained nausea and vomiting and lack of resolution of these symptoms should raise possibility of such rare yet significant disease as amyloidosis. It becomes more crucial to consider amyloidosis in the differential if there is multiorgan involvement. Lastly, early diagnosis is important to initiate timely therapy as the response to treatment could be very different, and ultimately affects patient morbidity and mortality.

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## $\alpha$ -Catenin Role and Expression in Oral Squamous Cell Carcinoma

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**Abstract-** This study aimed to reveal the role and altered immunohistochemical expression of  $\alpha$ -catenin in oral squamous cell carcinoma progression in its three histopathological differentiations. Immunohistochemical method was used to stain 81 biopsy taken from 81 patients and 15 control sample from normal oral mucosa.  $\alpha$ -catenin was detected with homogenous strong staining in 56.6%, 40%, 15% of well, moderately, poorly differentiated squamous cell carcinomas, respectively with  $p < 0.05$ . the heterogenous slight staining appeared in 40%, 52%, 61.5% respectively with  $p < 0.05$ . the loss of  $\alpha$ -catenin is observed in oral squamous cell carcinoma progression. The appearance of  $\alpha$ -catenin oral SCC and invasive carcinomas might suggest its role in tumor progression by influencing on APC to control  $\beta$ -catenin dissolution and transcriptional suppression of Wnt pathway in this type of carcinogenesis.

**Keywords:** oral squamous cell carcinoma,  $\alpha$ -catenin, immunohistochemical expression.

**GJMR-C Classification :** NLMC Code: WP 460



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## I. INTRODUCTION

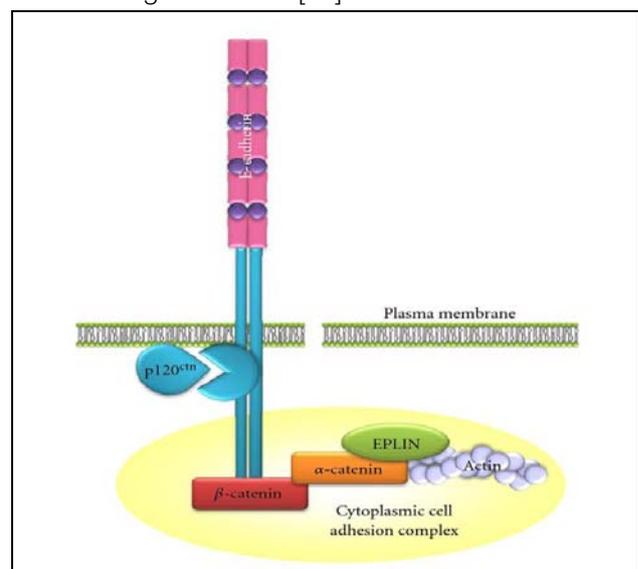
Catenin present as  $\alpha$ -catenin (102 kDa),  $\beta$ -catenin (88 kDa), and  $\gamma$ -catenin (80 kDa) are anchoring proteins present in cytoplasm and very essential in maintaining the normal functions of E-cadherin protein in the cross-linkage action between actin filament and the intracellular membranous proteins, Na<sup>+</sup>/K<sup>+</sup> adenosine triphosphatase and E-cadherin [1].

$\alpha$ -catenin or alpha-1-catenin (also called alpha-E-catenin) binding protein, is effectively coordinating the cortical actin networks of adjacent cells [2], Roles for  $\alpha$ -cat are best understood at cell junctions, where its essential for cell cohesion and tissue organization[3-5]. As a homodimer,  $\alpha$ -cat directly interacts with filamentous (F) actin [6] but  $\alpha$ -cat can also indirectly associate with the cytoskeleton through other actin-binding proteins, such as epithelial protein lost in neoplasm (EPLIN) (figure 1)[7][8], vinculin [9], afadin [10],  $\alpha$ -actinin [11], and zonula occludens-1 (ZO-1) [12]. In addition,  $\alpha$ -cat can impact F-actin remodeling by directly inhibiting Arp2/3-mediated actin polymerization in vitro [13], lamellipodial dynamics in cells [14], and by promoting F-actin bundling in vitro [15].

$\alpha$ -Catenin might serve as an invasion suppressor molecule, and reduced expression of  $\alpha$ -catenin has been related to poor differentiation of tumours, infiltrative growth, and lymph node metastasis [16-18]. Furthermore, the disappearance of membranous  $\alpha$ -catenin is predictive of an unfavourable

outcome in prostate, ovarian, and colorectal cancer [19-21]. many studies have shown that  $\alpha$ -catenin represses the transcriptional activities by segregating the YAP1/TAZ transcriptional coactivator in inactive complexes within the cytoplasm[22]

According to World Health Organization, carcinoma of oral cavity in males in developing countries, is the sixth commonest cancer after lung, prostate, colorectal, stomach and bladder cancer, while in females, it is the tenth commonest site of cancer after breast, colorectal, lung, stomach, uterus, cervix, ovary, bladder and liver[23]. More than 90% of all oral cancers are squamous cell carcinomas (SCC) [1] and this type of cancers composes About 95% of oral cancers in India [24]. This malignancy constitute a major health problem in developing countries, representing a leading cause of death. The survival index continues to be small (50%), as compared to the progress in diagnosis and treatment of other malignant tumors[25].



**Figure 1 :** Cell adhesion Complex. E-cadherin is stabilised at the cell surface by its link to the actin cytoskeleton via  $\beta$ -catenin,  $\alpha$ -catenin, and, possibly, Epithelial Protein Lost in Neoplasm (EPLIN). [7]

This study aimed to show the relation between altered expression of  $\alpha$ -catenin and the histopathological differentiations of oral squamous cell carcinoma.

## II. MATERIALS AND METHODS

81 Formalin-fixed, paraffin embedded representative tissue sections 3 $\mu$ m in thickness of 30 well

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differentiated oral scc (WDOSCC), 25 moderately differentiated oral scc (MDOSCC), 26 poorly differentiated oral scc, sections were retrieved from the archive of Pathology an Histology Department, faculty of dentistry, Damascus University, in addition to 15 normal oral tissues as a control group were harvested during surgical extraction of third impacted molars.

Sections were dewaxed, rehydrated in graded alcohols, and immunostained using a standard streptavidin-biotin immuno-peroxidase method. Monoclonal antibodies against α-Catenin (RB-089-P, 1:5 dilution, Neomarkers, USA) were used.

Normal oral epithelium was used as a positive control and sections incubated with a negative control serum (Dako, Denmark) were used as negative controls. Immunostaining was evaluated according to the intensity (slight/ strong) and the distribution of staining pattern (homogenous-membranous; heterogenouscytoplasmic and/or membranous).

Immunostaining pattern was scored as follows: 0= nostaining, +1= heterogenous slight staining, +2= homogenous strong staining with respect to the control positive tissue. The intensity and the staining pattern in normal oral squamous epithelium were regarded as +2 homogenous strong staining.

a) *Statistical analysis*

The chi-square test was used to assess the statistical significance of α -Catenin expression in relation to histopathological grade.

III. RESULTS

a) *Normal epethelium*

α-catenin staining was cytoplasmic with a clearly strong intensity and showed homogenous strong membranous staining in basal, parabasal and intermediate layers of squamous epithelium of the normal tissues (figure 2 ).

b) *study sample*

homogenous strong positivity appeared in 56.6% of the WDOSCC sections in the epithelium and the tumoral islands, 40% revealed +1 and in one section we noticed that there was no staining (figure 3). MDOSCCC revealed 40%(+2) immunostaining, 52% (+1) and two showed no staining (figure 4). PDOSCC had only 4 (15%) strong immunostaining (figure 5) (p=0.0001). Aberrant nuclear staining of α-catenin was observed in a few cells of PDOSCC. (table 1) (figure 6)

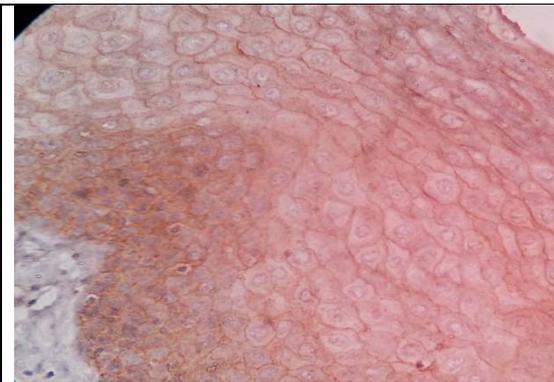


Figure 2 : Expression of α-catenin in normal oral epethelium .40X



Figure 3 : Expression of α-catenin in well differentiated OSCC .40X

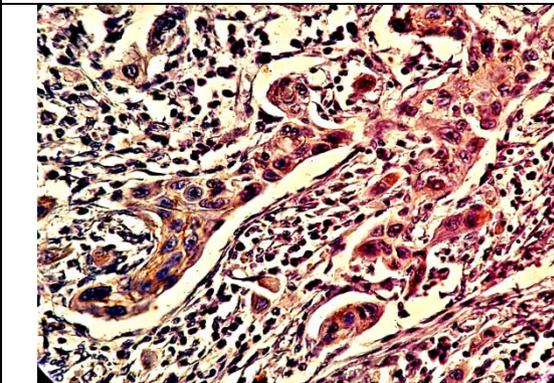


Figure 4 : Expression of α-catenin in moderately differentiated OSCC .40X

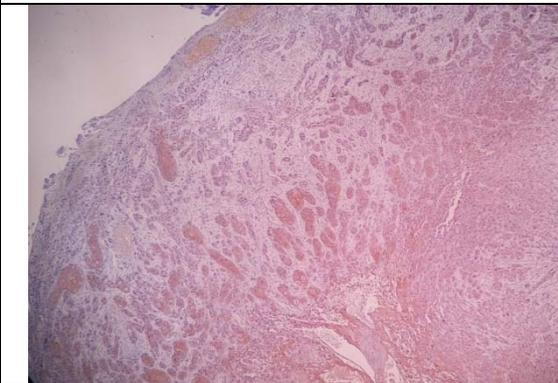
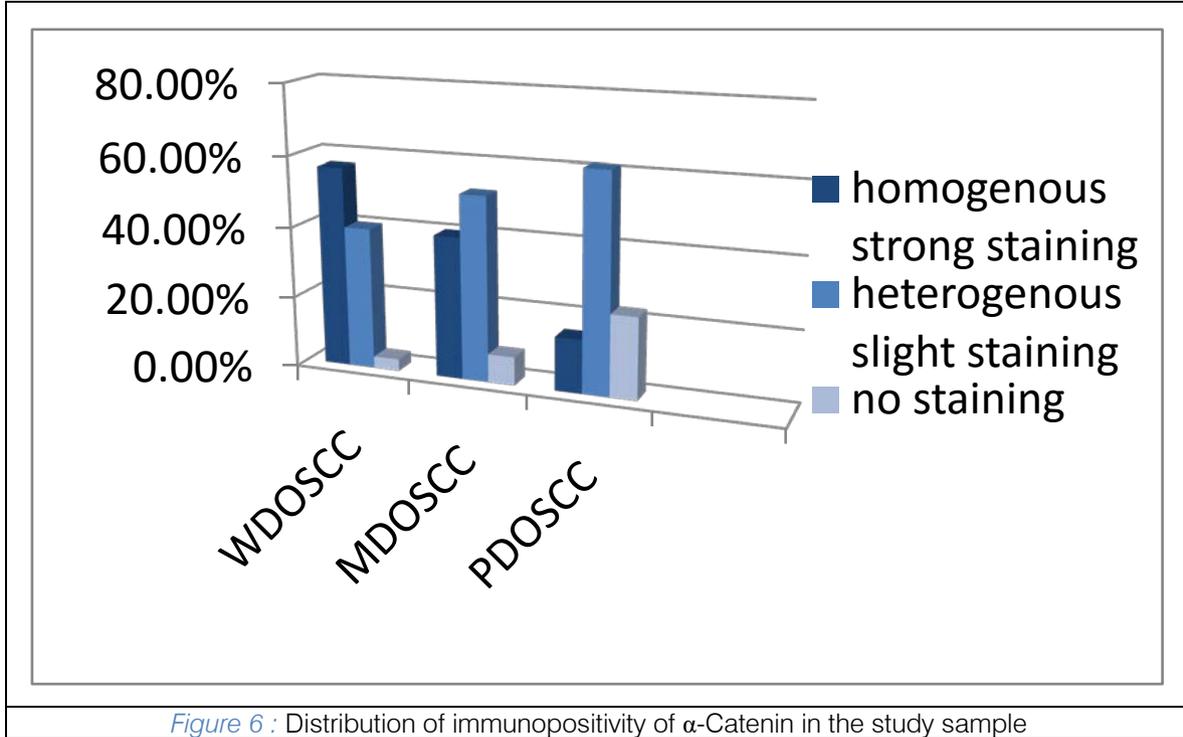


Figure 5 : Expression of α-catenin in moderately differentiated OSCC .10X

*Table (1)*

Distribution of immunopositivity of α-Catenin

	+2	+1	0
	positivity% (n)	positivity% (n)	% (n)
WDOSCC	56.6% (17)	40% (12)	3.3% (1)
MDOSCC	40% (10)	52% (13)	8% (2)
PDOSCC	15% (4)	61.5% (16)	23% (6)



#### IV. DISCUSSION

Loss of cell adhesion molecules or altered expression of these molecules plays an essential role in tumor progression in epithelial tissues [26]. E-cadherin and its associated cytoplasmic protein α-catenin are of the main parts of cell adhesion complex in squamous epithelial tissues [27].

We investigated the expression α-catenin in oral squamous cell carcinoma progression from the well differentiated stage to the poorly differentiated.

Though we revealed α-catenin expression loss in the progression of squamous cell carcinoma, this reduced expression was clearly associated with the histopathological differentiation (p<0.05). revealed such loss of α-catenin in the cases of oral squamous cell carcinomas [28, 29]

Unlike β-catenin, which has a role as an oncogene [30], α-catenin is considered a potent suppressor in many tumors, and its loss or down-regulation in many aggressive cancers is clearly correlated with metastasis [31, 32]. In addition to its well-known role in cell-cell adhesion, α-catenin represses signaling through the Wnt, Ras, NF-kB, and Hedgehog pathways [33] which controls organs sizes

and cell contact inhibition by way of the Yes-associated protein YAP1. YAP1 is a potent coactivator in many signaling pathways and also interacts with β-catenin in TBX5 complexes to regulate anti-apoptotic genes in colon cancer [34]

At high cell density, phosphorylated YAP1 accumulates in the cytoplasm, where it is sequestered by α-catenin and inhibits Wnt signaling [22]. The YAP1 homolog TAZ is degraded by the APC complex and is required for expression of many Wnt target genes [35]

Mechanistic studies of YAP1 function in TGFβ/SMAD signaling further reveal that it both stimulates transcription and promotes the exchange of coactivator and corepressor complexes at target genes [36]

Thus, α-catenin links cell adhesion signals to YAP1 inactivation and the inhibition of cell proliferation.

α-catenin may potentially control TAZ functions directly at Wnt target genes or guide it to the cytoplasm for degradation by the APC complex. Because α-catenin and APC are recruited with β-catenin to target genes, their transcriptional activities must be under control to prevent premature termination of transcription. [37, 38]. One interesting possibility is that Y177 phosphorylation

of  $\alpha$ -catenin could prevent docking of APC prior to activation of the RNAPII elongation complex [39]

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## Spectrum of Disorders Diagnosed by Bone Marrow Aspiration

By Dr. Aparajita Tomar, Dr. Vibha Trichal & Dr. RPS Chauhan

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**Abstract- Aims and Objectives:** To identify and analyse the most common hematological disorders diagnosed by doing bone marrow aspiration in a particular group of patients.

**Material and Method:** Bone marrow aspiration was done from Manubrium of the Sternum after injecting 2% xylocaine to the part. Bone marrow smears were prepared and stained with Leishman stain along with the simultaneous staining of the peripheral smears. A complete hemogram including Hb%, PCV, Red cell indices, platelet count, total leucocyte count and differential leucocyte count was also done by Automated cell counter. Finally, the bone marrow and peripheral smears were examined manually under oil immersion.

**Conclusion:** In this study it was found that the most frequently diagnosed hematological disorders on bone marrow aspiration are Megaloblastic and Dimorphic anemias followed by Acute Myeloid and Acute Lymphoblastic Leukemias. Hematological disorders are more common in early adulthood. commonest leukemia in adults and children is Acute Myeloid Leukemia, AML and Acute Lymphoblastic Leukemia, ALL respectively with overall prevalence of leukemias being more in adults.

**Keywords:** bone marrow aspiration, anemia, leukemia.

**GJMR-C Classification :** NLMC Code: WH 380, WH 175



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# Spectrum of Disorders Diagnosed by Bone Marrow Aspiration

Dr. Aparajita Tomar <sup>α</sup>, Dr. Vibha Trichal <sup>σ</sup> & Dr. RPS Chauhan <sup>ρ</sup>

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**Keywords:** bone marrow aspiration, anemia, leukemia.

## I. MATERIAL AND METHOD

**Study area and design:** The present study was done in the Department of pathology, Gandhi Medical College and associated Hamidia hospital, Bhopal M.P. A total of 135 consecutive prospective cases were studied during a span of one year.

**Ethical consideration:** Bone marrow aspiration was done under all aseptic precautions and samples were processed according to the established laboratory protocol before generating final report to the patient. Informed consent regarding the procedure was taken prior to the aspiration. It was told to the patients that the information shared by them and the results thereafter will be used for medical research.

**Patient's Selection criteria:** Our study included all the patients admitted in Hamidia hospital with a clinical suspicion of hematological disorder and demonstrating

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some abnormality in the peripheral blood smears. OPD patients on clinical suspicion of a hematological disorder by the consultant incharge were also included in the study group after obtaining the detailed history, clinical examination and all relevant investigations. Patients with highly increased bleeding time and clotting time were deterred.

## II. PROCEDURE

### a) Bone Marrow Aspiration

Patient and his attendants were told about the entire procedure and a written consent was taken. Complete patient preparation (xylocaine sensitivity testing, cleaning and draping) was done prior to the bone marrow aspiration. The skin over the sternum was cleaned with 70% ethyl alcohol. The skin, subcutaneous tissue and the periosteum overlying the manubrium was infiltrated with 1-1.5 ml of 2% xylocaine. Two minutes were given to achieve the effect of anaesthesia. In case of small children and uncooperative patients, sedation with diazepam was used. The site of puncture of the manubrium was opposite to the second intercostal space and slightly to one side of the midline.

The guard on the aspiration needle was adjusted and with the boring movement, needle (salah needle) was passed perpendicularly into the cavity. After piercing the skin and the subcutaneous tissue when the needle point reached the periosteum, the needle was pushed with a boring motion into the cavity and the termination point was achieved when there was loss of resistance. Stilette was removed and a 10 ml disposable syringe was attached to the needle to suck the marrow contents. Not more than 0.3 ml of marrow fluid was sucked in a single aspiration. Immediately, 6-8 good marrow smears were made and dried quickly with the help of a hair drier. Simultaneously, 2-3 peripheral blood smears were also made. The slides were numbered with a diamond pencil. Two marrow smears and one peripheral blood smear were taken for leishman staining while the rest of the unstained smears, after being fixed in methanol were wrapped in an aluminium foil and kept in a dry place for future use.

### b) Leishman Staining of Slides

Bone marrow smears and the peripheral blood smear were placed on a staining rack and leishman stain was put drop by drop on the film so as to cover it completely. After 2 minutes, double the volume of

buffered water was added and the two were mixed together with the help of a dropper. After 20 minutes, slides of peripheral smear were washed under the running tap water and the scum was drained off while bone marrow smears were washed after 30 minutes. Back side of the slides was wiped off with a clean and dry filter paper. The slides were kept in a vertical position to drain and dry. The slides were now ready for the microscopic examination.

### c) Reporting of Bone Marrow Smears

Bone marrow as well as peripheral smears were first scanned with scanner (4X lens) followed by the examination under low power(10X), high power(40X) and oil immersion lenses(100X) respectively. The final reports were dispatched in the prescribed format only.

## III. OBSERVATION AND DISCUSSION

Table no. 1 : Indications for Bone Marrow Examination

INDICATION	CASES	
	No.	%
Anemia Under Evaluation	62	46.0
Pancytopenia Under evaluation	28	20.7
Suspected Leukemia	14	10.4
Thrombocytopenia	12	8.9
Hepatosplenomegaly Under evaluation	04	3.0
Pyrexia Under Evaluation	02	1.5
Others	13	10.0
Total	135	100.0

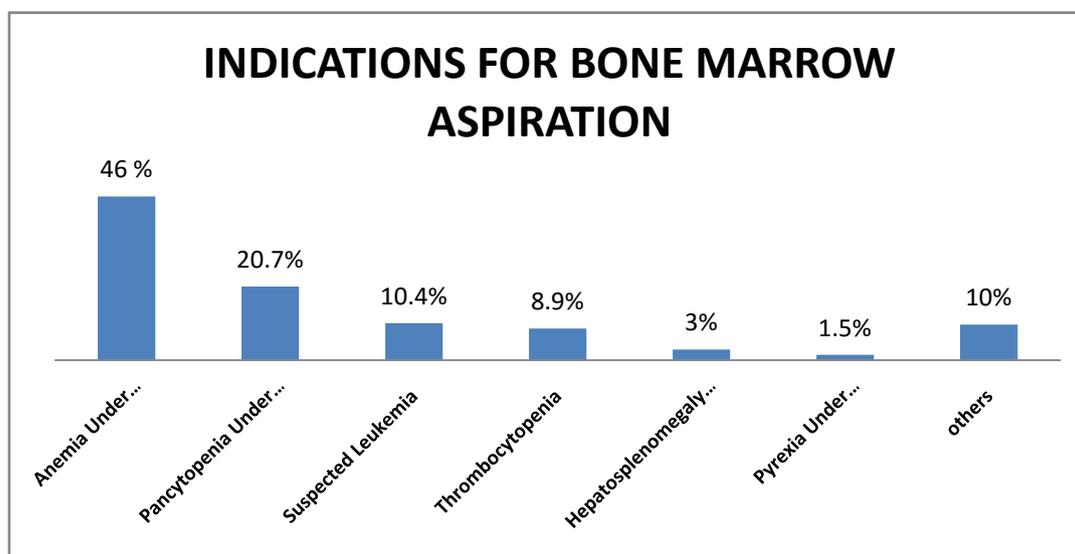


Table no. 2 : Spectrum of Disorders

S.No	Disorder	Total	Percentage (%)
1	Megaloblastic Anemia	59	43.7
2	Dimorphic Anemia	18	13.3
3	Acute Myeloid Leukemia	13	9.6
4	Idiopathic Thrombocytopenic Purpura	13	9.6
5	Hypoplastic Marrow	11	8.1
6	Acute Lymphoblastic Leukemia	09	6.6
7	Plasma Cell Disorder	03	2.2
8	Myeloproliferative Disorder	03	2.2
9	Lymphoproliferative Disorder	02	1.5
10	Chronic Lymphocytic Leukemia	01	0.74
11	Myelodysplastic Syndrome	01	0.74
12	Leishmaniasis	01	0.74
13	Hypersplenism	01	0.74
Total		135	100.0

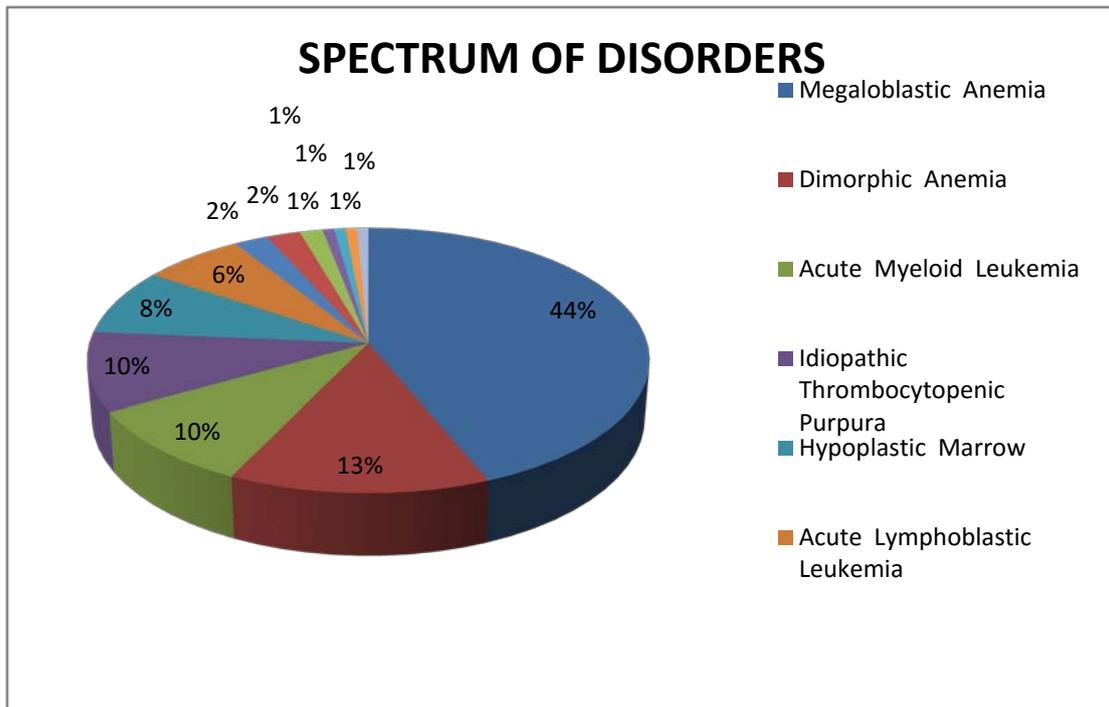


Table no. 3 : Percentage of Cases in Each Age Group

Age (Yrs)	Percentage
0-20	41.5
21-40	33.3
41-60	22.2
>60	3.0

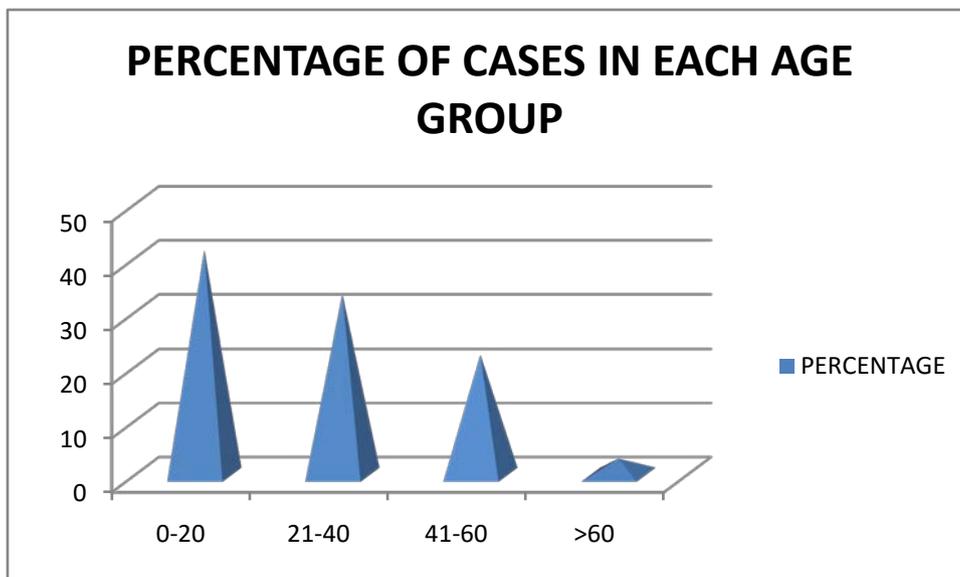
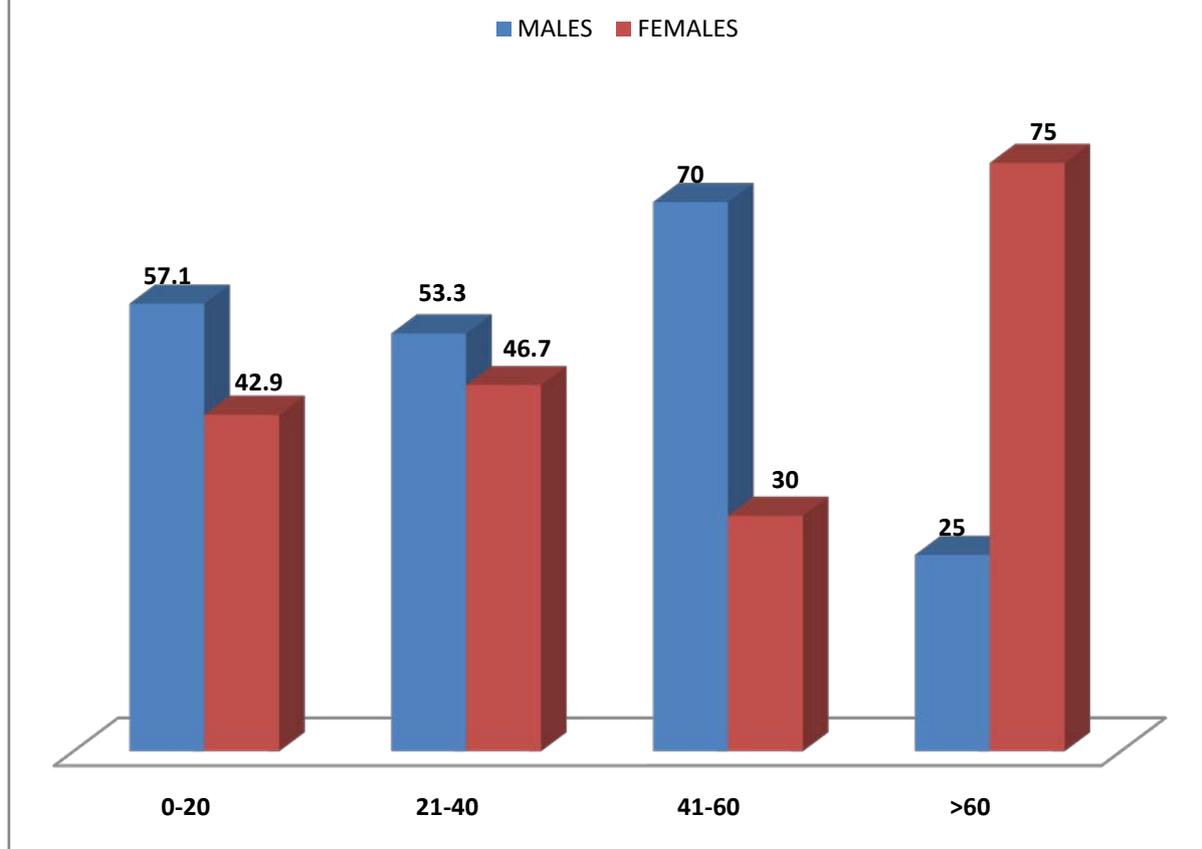


Table no. 4 : Age and Sex Distribution of Cases

Age (Yrs)	Males (%)	Females (%)
0-20	57.1	42.9
21-40	53.3	46.7
41-60	70	30
>60	25	75

## AGE(Yrs) AND SEX(%) DISTRIBUTION OF CASES



### IV. CONCLUSION

In this study, we found that on bone marrow aspiration the most frequently diagnosed haematological disorders<sup>1</sup> are Anemias<sup>9</sup>. Amongst the anemias, the commonest one are the Megaloblastic anemias<sup>4,6,10</sup> and those showing Dimorphic blood picture. Acute Leukemias<sup>2,3,5,7,8</sup> occupy the second position in the list including the Acute Myeloid Leukemias and Acute Lymphoblastic Leukemias with overall prevalence of leukemias being more in adults as compared to children. Hematological disorders are more common during childhood period and in the early adulthood. Commonest Leukemia in adults is Acute Myeloid Leukemia. The most common clinical presentation of Acute Leukemias is Pallor and Fever while Anemias present clinically with Pallor and Fatigue.

### V. ACKNOWLEDGEMENT

Smt. Annapurna Tomar, Dr. R.K Nigam and the entire staff of the department of pathology, Gandhi Medical College, Bhopal, M.P.

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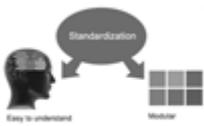
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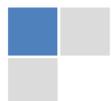
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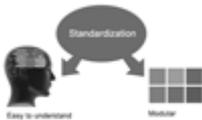
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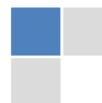
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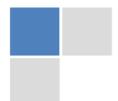
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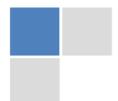
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