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Clinical and biological characterization of patients with low (0.1-2%) *JAK2V617F* allele burden at diagnosis.

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Running title: Significance of low *JAK2V617F* allele burden

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To the Editor:

Detection of the *JAK2V617F* mutation is of major help for the diagnosis of Myeloproliferative Neoplasms (MPNs)^{1,2,3}. Techniques using allele-specific quantitative PCR (AS-qPCR) can reliably and consistently detect down to 0.001% mutated alleles⁴. Moreover, a study of healthy blood donors has shown that the maximum *JAK2V617F* value in 200 subjects was 0.035%⁵. In practice, a positivity threshold of 1% is commonly admitted⁷. The generalization of highly sensitive techniques revealed that the detection of very small clones (around and below 1% *JAK2V617F*) is far from exceptional and its interpretation is sometimes challenging. In particular, one may question the clinical interest of detecting such minor clones in untreated patients. Molecular biologists and clinicians involved in MPN management gathered in the MPN&MPNr-EuroNet (Myeloproliferative Neoplasms and related disorders - European Network) have collected and analysed clinical and biological data from 36 patients presenting with 0.1 to 2% *JAK2V617F* at diagnosis.

All patients had provided an informed written consent in accordance with the Declaration of Helsinki for the use of left DNA for investigational purposes. Local ethics committees approved the study. Eight molecular biology laboratories members of MPN&MPNr-EuroNet were sent DNA standards containing 0.1 % and 1% *JAK2V617F* prepared and provided by IPSOGEN (now Qiagen-Marseille, France) to calibrate local assays. With the help of these standards, 36 patients were selected who fulfilled the following criteria: *JAK2V617F* determined at least twice with at least two months between the two determinations, one determination found between 0.1 and 2% *JAK2V617F* in the absence of cytotoxic therapy; sufficient clinical and biological characterization to confirm or rule out the diagnosis of MPN; sufficient DNA for centralized assessment of *JAK2V617F* allele burden and search for additional mutations. Each center first used their own *JAK2V617F* quantification technique and sent DNA to CHU de Bordeaux where the allele burden was centrally determined using a "sense" and an "anti-sense" primer-based allele specific qPCR as described^{3,8} (figure 1). For patients with erythrocytosis, *JAK2* exon 12 mutations were screened by High Resolution Melting curve analysis

(HRM)⁹ followed by sequencing. For patients with thrombocytosis or suspicion of myelofibrosis, *MPL* exon 10 and *CALR* mutations were detected by HRM or fragment analysis and confirmed by sequencing.

Patients were subdivided into four groups depending on the reason for which they were submitted to *JAK2V617F* mutation detection: erythrocytosis (n=15), unusual thrombosis (n=3), thrombocytosis (n=11) or suspicion of myelofibrosis (circulating immature granulocytes, anemia and/or splenomegaly; n=7). The correlation between the allele burdens determined locally and in the central lab was not perfect, a few results being under-estimated in local laboratories (Table 1). However, all positive results were confirmed positive by central determination. This emphasizes the technical difficulty of precisely assessing low burdens and the usefulness of centralized quantification of low *JAK2V617F* quantification results.

Among the 15 patients explored for erythrocytosis, only three had a final diagnosis of polycythemia vera (PV) according to WHO criteria (omitting the *JAK2V617F* mutation). Of these, one (E4) had an additional mutation in exon 14, just upstream (5') of the G1849T (V617F) substitution, thus interfering with the annealing of the primer and resulting in an under-estimation of the *JAK2V617F* burden when assessed with a "sense" qPCR. These cases can be detected by using an "anti-sense" qPCR with the specific primer located 3' of the mutation (Figure 1). For patient E4, the alternative PCR revealed a significant mutated clone (10% *JAK2V617F*). The same phenomenon applies to patient M7: in this case, the "sense" qPCR indicated a *JAK2V617F* burden of 0.6% while the anti-sense revealed a high burden (73%). Thus, an unexpectedly low *JAK2V617F* burden should first prompt for a search of additional mutations hampering correct primer annealing. Another PV patient (E8) had a mutation in the exon 12 of *JAK2* in addition to the small (1.5%) *JAK2V617F* clone. The third patient with a PV phenotype (E14) did not fulfill WHO criteria of PV at the time of diagnosis because he had a normal EPO level and bone marrow histology was not consistent with PV. However, when *JAK2V617F* was later re-assessed, it was found to have slightly increased (from 0.6 to 1.5%) and the

EPO level was then found below the lower limit. Thus in this case, enough criteria were gathered to establish the diagnosis of PV based on the WHO recommendations. In the twelve remaining patients with erythrocytosis, none had sufficient criteria to confirm the diagnosis of PV. Three (E1, E2 and E10) had secondary erythrocytosis attributed to a respiratory condition (Chronic Obstructive Pulmonary Disease). Three others (E3, E9 and E13) had probable secondary erythrocytosis with high levels of EPO. Two (E11 and E15) had a false erythrocytosis diagnosed on the basis of a normal isotopic red cell mass and one (E12) had a transitory erythrocytosis that spontaneously resolved. Three others (E5, E6 and E7) had idiopathic erythrocytosis of whom two remained stable without treatment. Two of these patients did not have a bone marrow biopsy, so a diagnosis of MPN could not be definitively ruled out. None of the patients explored for erythrocytosis evolved towards myelofibrosis or leukemia.

For the 3 patients tested for unusual thromboses (which did not include splanchnic thromboses), no sign of MPN was found and blood counts remained normal.

For the 11 patients presenting with thrombocytosis, a clear diagnosis of MPN could be made in five, either because the bone marrow histology was in favor of MPN and/or because an additional mutation was found in the *MPL* (Tc3) or *CALR* (Tc5 and 11) genes. For the other patients, even though the bone marrow histology was not available (Tc6 and Tc9), or reported as normal (Tc1, Tc2, Tc7 and Tc8) the persistence of high platelet counts in the absence of any reactive cause of thrombocytosis made the diagnosis of essential thrombocythemia (ET) highly probable. For patients tested for suspicion of myelofibrosis, a hematological malignancy was always discovered: three primary myelofibroses (PMF), three myelodysplastic syndromes and an overlapping syndrome (atypical CML). The evolution of these patients was mostly pejorative.

These results indicate that when a low *JAK2V617F* burden is found, one should first eliminate the possibility that the %*JAK2V617F* is underestimated because of an additional mutation hampering correct primer or probe annealing. Secondly, the existence of another mutation should be searched

for, either in *JAK2* exon 12 for patients with erythrocytosis or in the *CALR* or *MPL* genes for other patients. These associations are rare but other cases have been reported^{11,12} and their finding is consistent with the observation that mutations which activate cytokine signaling pathways can be acquired several times in MPNs. In particular, the *JAK2V617F* mutation itself has been shown to be acquired at least twice in at least 2.8% of MPN patients¹³.

In the absence of other mutations in the *JAK2*, *CALR* or *MPL* genes, the interpretation varies according to the context: for patients with erythrocytosis, the diagnosis of PV cannot be established based on low *JAK2V617F* allele burdens since most of the patients in our cohort showed no evidence of PV and some had clear evidence of secondary erythrocytosis. In this context, the presence of a minor clone with acquired *JAK2V617F* is reminiscent of the mosaicisms of cancer-associated mutations found in healthy elderly people^{14,15}. Similarly, patients explored for thrombosis did not have any evidence of hematological malignancy.

In contrast, a diagnostic of hematological malignancy was either confirmed or very likely for patients with thrombocytosis or/and suspicion of myelofibrosis, possibly because the vast majority of patients explored for thrombocytosis or suspicion of myelofibrosis do suffer from hematological malignancy, irrespective of mutational status. Yet in our study, bone marrow histology was not in favour of MPN for all the patients presenting with thrombocytosis and a low *JAK2V617F* allele burden. This may be due to the fact that the patients were studied at early stages, had mild forms of disease and only minor histologic features, not sufficient to establish a neoplastic myeloproliferation.

For all patients, the size of the clones was mostly stable over time (Figure 2) except for two patients with a hematological malignancy: one presenting with erythrocytosis (patient E4) who was diagnosed with PV and whose allele burden reached 7% *JAK2V617F* and one patient with myelofibrosis (patient M2) whose allele burden increased 10 fold. Of note, patient E15 tripled his *JAK2V617F* burden although he was finally diagnosed with false erythrocytosis. These observations confirm that a *JAK2V617F*-mutated clone can be present and increase in individuals with no evidence of MPN.

In conclusion, finding a low allele burden of *JAK2*V617F should prompt the search for additional mutations, in the *JAK2* gene in case of erythrocytosis and in the *CALR* and *MPL* genes in other cases suspect of MPN. In the absence of additional mutations in *JAK2*, *MPL* or *CALR*, the significance of the *JAK2*V617F-mutated clone should not be considered as sufficient evidence to establish malignant myeloproliferation. Long term prospective studies should evaluate whether patients with minor *JAK2* (and possibly *MPL* or *CALR*) mutated clones and no overt MPN eventually develop full blown MPN and/or present complications, especially thrombotic events.

AUTHORS AND DISCLOSURES

EL designed the research and analysed the data; EL, OM, BD, AN, CR, LL, VU, AL, BB, JM, DN, NG and SH provided samples and clinical data; EL, OM, MM and NM performed experiments, EL and SH wrote the paper. All authors approved the manuscript.

NM is an employee of Qiagen-Marseille.

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Table1: Main characteristics of 36 patients with a low JAK2V617F allele burden. EPO: Erythropoietin. EEC: Endogenous Erythroid Colonies. EMC: Endogenous Megakaryocytic Colonies. PV: Polycythemia vera. ET: Essential Thrombocythemia. mds/mpn: mixed myelodysplastic/myeloproliferative neoplasm. ND: No Data available.

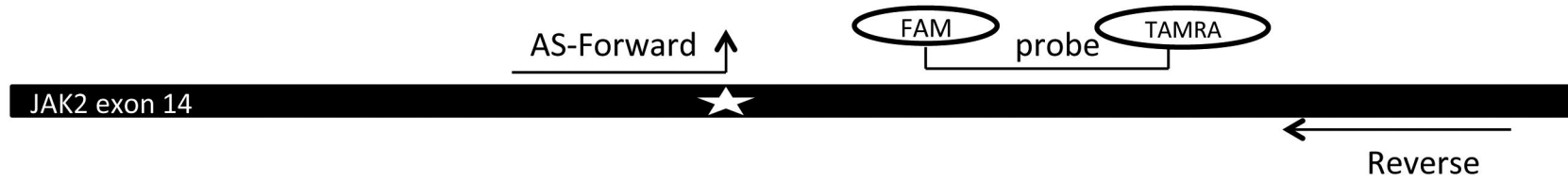
Patient Number	%JAK2V617F (local measurement)	%JAK2V617F (centralized)	Bone Marrow histology	EPO (mU/mL)	EEC/EMC	Other mutation	JAK2	MPL mutation	CALR mutation	Final diagnosis
E1	0.39	1.26	Erythroblastic hyperplasia	11.8	ND	None		ND	Neg	Pulmonary Disease
E2	0.70	0.91	Normal	3.4	ND	None		ND	Neg	Pulmonary Disease
E3	0.70	2.99	Normal	13.1	ND	None		ND	Neg	Secondary Erythrocytosis
E4	0.20	10.00	PV	ND	Pos/Pos	V615L		ND	Neg	Idiopathic Erythrocytosis
E5	1.40	1.40	ND	ND	Neg/Neg	None		ND	Neg	Idiopathic Erythrocytosis
E6	1.84	1.81	ND	3	Neg/Neg	None		ND	Neg	Idiopathic Erythrocytosis
E7	1.00	1.00	Normal	7.9	Neg/Neg	None		ND	Neg	Idiopathic Erythrocytosis
E8	1.50	1.50	ND	ND	Pos/Neg	F537I K539I		ND	Neg	Idiopathic Erythrocytosis
E9	0.70	0.40	ND	27.2	ND	None		ND	Neg	Secondary Erythrocytosis
E10	0.70	0.54	ND	11.6	ND	None		ND	Neg	Pulmonary Disease
E11	0.20	0.20	ND	ND	ND	None		ND	Neg	False Erythrocytosis
E12	0.40	0.40	No MPN	2.48	Neg/Neg	None		ND	Neg	Transitory Erythrocytosis
E13	0.45	0.90	Erythroblastic hyperplasia	16.7	Pos/Neg	None		ND	Neg	Secondary Erythrocytosis
E14	0.58	0.77	Normal	5.6	Pos/Neg	None		ND	Neg	Idiopathic Erythrocytosis/False Erythrocytosis
E15	1.00	1.00	ND	10	ND	None		ND	Neg	False Erythrocytosis
Ts1	0.84	1.07	Normal	ND	ND	ND		ND	Neg	No MPN
Ts2	0.50	2.87	ND	13	Neg/Neg	ND		ND	Neg	No MPN
Ts3	0.45	0.45	Normal	ND	ND	ND		ND	Neg	No MPN
Tc1	0.70	4.64	Normal	ND	ND	ND		Neg	Neg	Probable ET
Tc2	0.50	1.33	Normal	10.9	ND	ND		Neg	Neg	Probable ET
Tc3	0.27	0.28	ET	ND	ND	ND		W515L	Neg	ET
Tc4	1.38	1.20	ET	ND	ND	ND		Neg	Neg	ET
Tc5	0.10	0.30	ND	ND	Neg/Pos	ND		Neg	Type mutation ¹	ET
Tc6	0.70	1.40	ND	6	ND	ND		Neg	Neg	Probable ET
Tc7	1.66	5.78	Normal	ND	Pos/Pos	ND		Neg	Neg	Probable ET
Tc8	2.00	3.36	Normal	ND	Neg/Neg	ND		Neg	Neg	Probable ET
Tc9	0.60	1.50	ND	ND	ND	ND		Neg	Neg	Probable ET
Tc10	0.50	0.50	Primary Myelofibrosis	ND	ND	ND		Neg	Neg	Primary Myelofibrosis
Tc11	1.00	0.42	ND	6.76	ND	ND		Neg	Type mutation ¹	ET
M1	0.80	1.18	atypical CML	ND	ND	ND		Neg	Neg	Atypical CML
M2	0.74	0.64	mds/mpn	9.49	ND	ND		Neg	Neg	Myelodysplasia - Myelofibrosis
M3	0.69	0.93	Primary Myelofibrosis	ND	ND	ND		Neg	Neg	Primary Myelofibrosis
M4	0.93		MDS	ND	ND	ND		Neg	Neg	MDS
M5	2.00	0.80	MDS	ND	ND	ND		Neg	Neg	MDS
M6	0.80	0.80	Primary Myelofibrosis	ND	ND	ND		Neg	Neg	Primary Myelofibrosis
M7	0.60	73.00	Primary Myelofibrosis	ND	ND	c.1848_1849delinsCT		Neg	Neg	Primary Myelofibrosis

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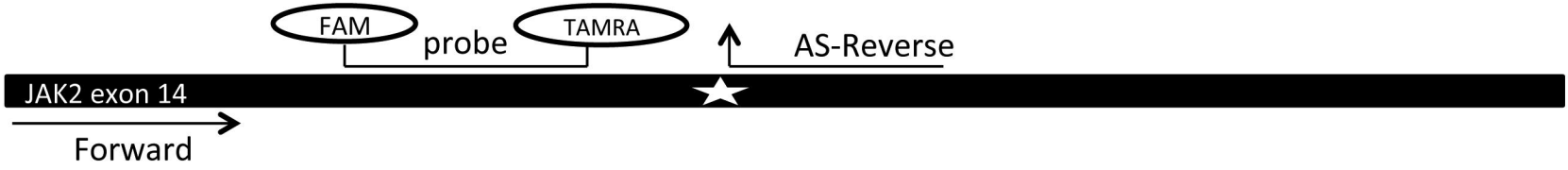
Figure1: Design of the « sense » and « anti-sense » JAK2V617F allele-specific qPCR. **A-** In the « sense » PCR, the forward primer is allele-specific whereas the reverse primer and the FAM-TAMRA probe are generic. **B-** In the antisense-PCR, allele specificity is based on the reverse primer. **C-** In the case of an additional mutation occurring 5' of the G1849T substitution, annealing of the forward allele-specific primer is impaired with the « sense » PCR, resulting in an under-estimation of the mutant allele burden. **D.** In the case of an additional mutation occurring 5' of the G1849T substitution, the « anti-sense » PCR is not affected.

Figure 2: Evolution over time of the JAK2V617F allele burden of patients presenting with erythrocytosis, thrombosis, thrombocytosis or suspicion of myelofibrosis. Data generated by each laboratory are shown.

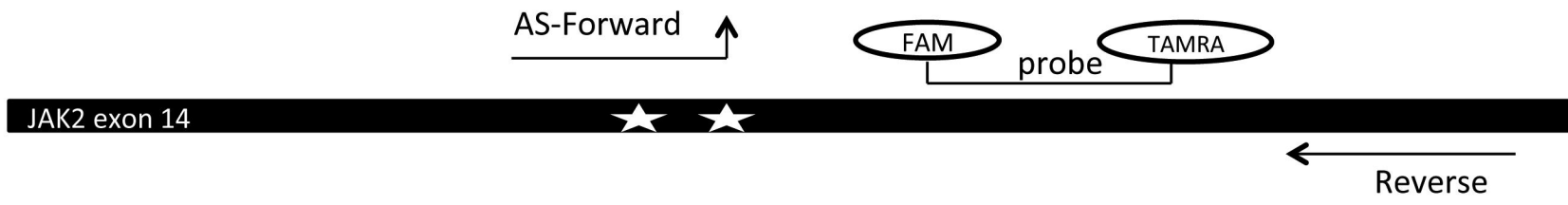
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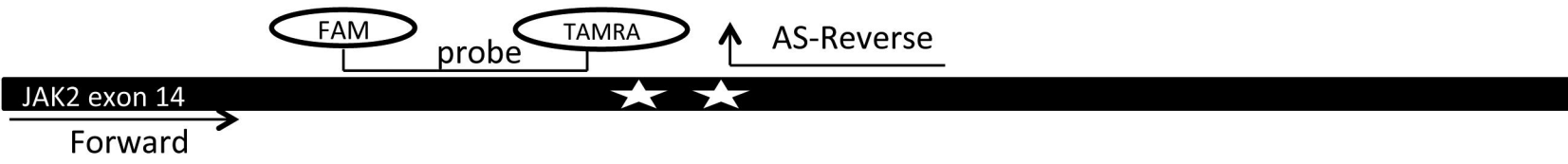
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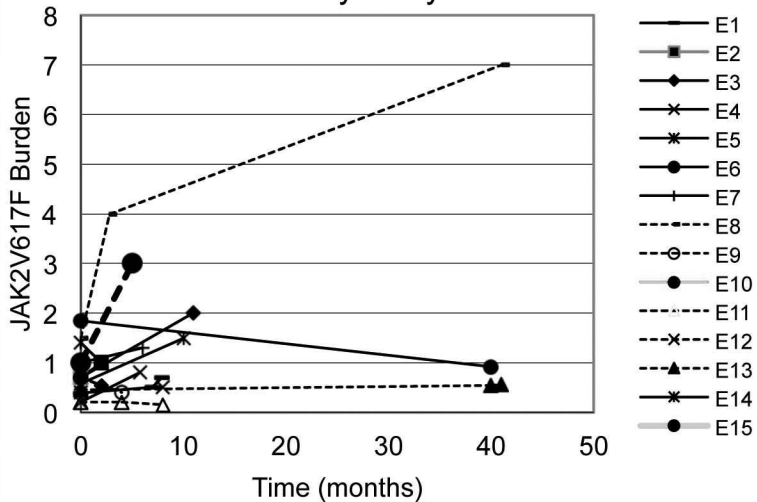
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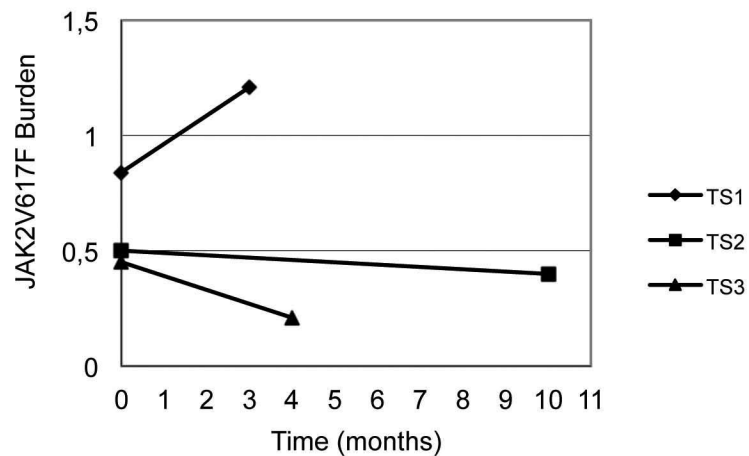
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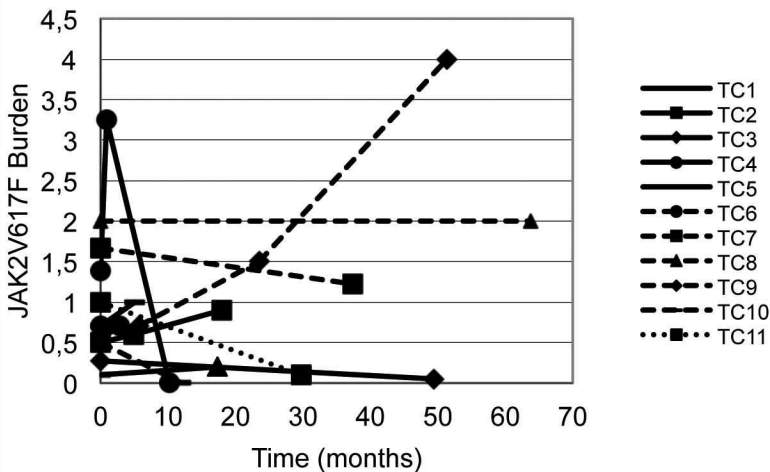
Erythrocytosis



Thrombosis



Thrombocytosis



Suspicion of myelofibrosis

