Acute Lymphoblastic Leukemia – Pathophysiology and Epidemiology

Acute lymphoblastic leukemia (ALL) is a malignant disease which arises from the clonal uncontrolled proliferation of immature lymphoid cells. This uncontrolled proliferation causes normal cells to be displaced from the bone marrow and peripheral blood. It is a heterogeneous disease in terms of its pathology and the populations it affects.¹³

**Immunophenotype:**

ALL may be classified as B-cell precursor or T-cell lineage depending on the expression of lineage markers.¹

- B-ALL represents 85–90% of pediatric and roughly 75–80% of adult cases of ALL.⁴ ⁵
- T-ALL represents 10–15% of pediatric and approximately 20–25% of adult cases of ALL.¹ ¹³

Based on American Cancer Society estimates, there will be about 6,590 new cases of ALL and about 1,430 deaths due to ALL in the US in 2016 in both children and adults.⁶
Acute lymphoblastic leukemia (ALL) is the most common childhood cancer. While current 5-year event free survival exceeds 85%, children still suffer serious adverse effects from treatment.1,4

ALL is less common in adults and the treatment outcomes are significantly lower than in children with ALL, especially those with relapsed ALL.4 Some reasons for this difference include the higher incidence of poor prognostic cytogenetics and a lack of good cytogenetics in adults.9

### Specific Phenotypes

<table>
<thead>
<tr>
<th>Children</th>
<th>Adults*</th>
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<tbody>
<tr>
<td>Poor Prognostic</td>
<td></td>
</tr>
<tr>
<td>Philadelphia-positive (Ph+)</td>
<td>3%</td>
</tr>
<tr>
<td><strong>ALL</strong> rearrangements</td>
<td>2-8%</td>
</tr>
<tr>
<td>Good Prognostic</td>
<td></td>
</tr>
<tr>
<td>TEL-AML1</td>
<td>50%</td>
</tr>
<tr>
<td>Hyperdiploid</td>
<td>26–30%</td>
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</table>

*Adults have higher incidence of poor prognostic cytogenetics and lack good-risk cytogenetics

### Blood and Bone Marrow

<table>
<thead>
<tr>
<th>Location</th>
<th>Response Criteria</th>
<th>Features</th>
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<tbody>
<tr>
<td>CRi</td>
<td>&lt;5% BM blasts</td>
<td>No circulating blasts or extramedullary disease (No lymphadenopathy, splenomegaly, skin/gum infiltration/testicular mass/CNS involvement)</td>
</tr>
<tr>
<td>CRp</td>
<td>Complete remission; CRi remission with incomplete recovery of blood counts</td>
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<tr>
<td>CRf</td>
<td>Defined as the lack of MRD at a specific time point with polymerase chain reaction (PCR) assay sensitivity ≥10-4</td>
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<tr>
<td>Molecular CR</td>
<td>Defined as reappearance of MRD within the quantitative range (&gt;10-4) after prior achievement of molecular CR</td>
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</tr>
<tr>
<td>Molecular failure</td>
<td>Defined as the persistent quantifiable presence of MRD with a PCR assay sensitivity of ≥10-4</td>
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</tr>
<tr>
<td>Molecular relapse</td>
<td>Defined as marrow with &lt;5% blasts</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Defined as marrow with 5 to 24% blasts</td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Defined as marrow with ≥25% blasts</td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Defined as marrow with &gt;25% blasts</td>
<td></td>
</tr>
<tr>
<td>Refractory disease</td>
<td>Failure to achieve CR at the end of induction</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td>Increase of ≥25% in the absolute number of circulating or bone marrow blasts or development of extramedullary disease</td>
<td></td>
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</tbody>
</table>

Molecular relapse is defined as reappearance of MRD within the quantitative range (>10-4) after prior achievement of molecular CR.

MLL rearrangements

- Philadelphia-positive (Ph+)
- TEL-AML1
- Hyperdiploid
- Hyperdiploidy
- T-Cell ALL
- B-Cell ALL

### Hypodiploidy

- (45 chromosomes)
- 2% in T-Cell ALL
- 7% in B-Cell ALL

### Hyperdiploidy

- (>50 chromosomes)
- 7% in T-Cell ALL
- 11.5% in B-Cell ALL

### T-Lineage

- Hypodiploidy
- 2% in T-Cell ALL
- Hyperdiploidy
- 7% in T-Cell ALL

### B-Lineage

- Hypodiploidy
- 2% in B-Cell ALL
- Hyperdiploidy
- 11.5% in B-Cell ALL

### Other Phenotypes

- MLL rearrangements
- HOX11
- TAL1
- LYL1
- HOX11L2
- Others

### Treatment Outcomes

- Children: 85%
- Adults: <85%

Multiple myeloma (MM) is a B-cell malignancy in which abnormal, clonal plasma cells proliferate and accumulate in the bone marrow. These abnormal cells, referred to as myeloma cells, disrupt normal bone marrow function and invade bone. Myeloma cells produce and secrete significant quantities of monoclonal protein (M-protein) into the blood and/or urine.

The clinical features of MM include hypercalcemia, renal failure, anemia, osteolytic bone lesions, and increased susceptibility to infection. MM predominantly affects elderly people, and is most frequently diagnosed between the ages of 65–74 years. MM is more common in males and African Americans compared to females and Caucasians, respectively. Overall, the 5-year survival among adults with MM is 48.5%.

Globally, an estimated 114,251 new cases of MM are diagnosed annually, with 80,019 deaths per year attributable to the disease. MM is a genetically complex and heterogeneous disease. Nearly all MM cases are preceded by an asymptomatic, pre-malignant, condition known as monoclonal gammopathy of undetermined significance (MGUS) which may progress to a smoldering MM phase. The disease course to symptomatic MM is driven by multiple genomic events within myeloma cells and changes in the bone marrow microenvironment. Several chromosomal abnormalities have been identified in patients with MM and involve translocations, deletions, or amplifications.

MM is the second most common hematologic malignancy and accounts for approximately 13% of all hematologic cancers. MM is the second most common hematologic malignancy and accounts for approximately 13% of all hematologic cancers.

Emergence of Different Treatment Options Have Necessitated Revised Response Criteria

The evolution of MM response criteria has been driven by improvements in response with the availability of different agents and regimens.

ABMTR, Autologous Blood and Marrow Transplant Registry; CR, complete response; EBMT, European Group for Blood and Marrow Transplantation; ECOG, Eastern Cooperative Oncology Group; IFM, International Bone Marrow Transplant Registry; IMWG, International Myeloma Working Group; nCR, near complete response; sCR, stringent complete response; VGPR, very good partial response.
**Response Categories in MM**

<table>
<thead>
<tr>
<th>Response Categories</th>
<th>Response Criteria</th>
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<tbody>
<tr>
<td>sCR</td>
<td>CR plus normal FLC ratio and absence of clonal cells in bone marrow biopsy by immunohistochemistry (κ/λ ratio ≤ 1:2 for κ and λ patients, respectively, after counting ≥ 100 plasma cells).</td>
</tr>
<tr>
<td>CR</td>
<td>Negative immunofixation on the serum and urine and disappearance of any soft tissue plasmacytomas and &lt;5% plasma cells in bone marrow aspirates.</td>
</tr>
<tr>
<td>VGPR</td>
<td>Serum and urine M-protein detectable by immunofixation but not on electrophoresis or ≥ 90% reduction in serum M-protein plus urine M-protein level &lt;100 mg per 24 h.</td>
</tr>
<tr>
<td>PR</td>
<td>≥ 50% reduction of serum M-protein plus reduction in 24 h urinary M-protein by ≥ 90% or to &lt;200 mg per 24 h; If the serum and urine M-protein are unmeasurable, a ≥ 50% decrease in the difference between involved and uninvolved FLC levels is required in place of the M-protein criteria; If serum and urine M-protein are unmeasurable, and serum-free light assay is also unmeasurable, ≥50% reduction in plasma cells is required in place of M-protein, provided baseline bone marrow plasma-cell percentage was ≥30%. In addition to these criteria, if present at baseline, a ≥50% reduction in the size (SPD) of soft-tissue plasmacytomas is also required.</td>
</tr>
</tbody>
</table>

**Select Standard IMWG Response Criteria**

<table>
<thead>
<tr>
<th>IMWG MRD Criteria</th>
<th>MRD-negative</th>
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<tbody>
<tr>
<td>Response Criteria</td>
<td>Absence of aberrant clonal plasma cells on bone marrow aspirate, ruled out by an assay with a minimum sensitivity of 1 in 10^5 nucleated cells or higher (i.e. 10^-5 sensitivity)*</td>
</tr>
<tr>
<td>Imaging-positive MRD-negative</td>
<td>MRD negativity as defined by NGF or NGS plus disappearance of every area of increased tracer uptake found at baseline or a preceding PET/CT or decrease to less mediastinal blood pool SUV or decrease to less than that of surrounding normal tissue**</td>
</tr>
<tr>
<td>Sustained MRD-negative</td>
<td>MRD negativity in the marrow (NGF or NGS, or both) and by imaging as defined above, confirmed minimum of 1 year apart. Subsequent evaluations can be used to further specify the duration of negativity (eg, MRD-negative at 5 years)</td>
</tr>
</tbody>
</table>

**IMWG, International Myeloma Working Group; MRD, minimal residual disease; NGF next-generation flow; NGS, next-generation sequencing; PET, positron emission tomography; CT, computed tomography; SUV, standardized uptake values.**

**BM, bone marrow; CR, complete response; FLC, free light chain; IMWG, International Myeloma Working Group; M-protein, monoclonal protein; PC, plasma cells; PR, partial response; sCR, stringent complete response; SPD, sum of the products of the maximal perpendicular diameters of measured lesions; VGP, very good partial response.**

*Derived from international uniform response criteria for multiple myeloma. Minor response definition and clarifications derived from Palumbo and colleagues. When the only method to measure disease is by serum FLC levels, major response can be defined as a normal FLC ratio of 0.30 to 1.65 in addition to the complete response criteria listed previously. Very good partial response in such patients requires ≥ 90% decrease in the difference between involved and uninvolved FLC levels. All response categories require two consecutive assessments made at any time before the institution of any new therapy. All categories also require no known evidence of progression of new bone lesions or extramedullary plasmacytomas. If radiographic studies were performed, radiographic studies are not required. BM marrow assessments do not need to be confirmed. Each category will be considered unconfirmed until the confirmatory test is performed. The date of the initial test is considered as the date of response for evaluation of time dependent outcomes such as duration of response.

**Based on flow cytometry (EuroFlow) or next-generation sequencing (LymphoSIGHT platform or validated equivalent method).**

**Criteria used by Zanagni and colleagues, and expert panel (IMPetUs; Italian Myeloma criteria for PET Use). Baseline positive lesions were identified by presence of focal areas of increased uptake within bones, with or without any underlying lesion identified by CT and present on at least two consecutive slices. Alternatively, an SUVmax≥2.5 within osteolytic CT areas ≥1cm in size, or SUVmax≥1.5 within osteoblastic CT areas ≤1cm in size were considered positive. Imaging should be performed once MRD negativity is determined by FPC or NGS.**
The treatment of ALL and MM has improved significantly over the last decade, resulting in many patients achieving a complete response or remission (CR; <5% of morphologically identifiable malignant cells in the bone marrow samples) to frontline therapy.\textsuperscript{16, 33}

However, many patients may still relapse. Relapse is a result of the persistence of malignant cells in patients who achieve CR.\textsuperscript{33}

The presence of malignant cells below the limits of detection is referred to as minimal residual disease (MRD).\textsuperscript{6}

Remission & Relapse

33\% of patients with standard-risk ALL and 66\% of patients with high-risk ALL relapse after achieving CR.\textsuperscript{34}

In a retrospective analysis of three clinical trials, 40\% of patients with MM relapsed within 4 years after achieving CR.\textsuperscript{35}
Minimal residual disease (MRD) is the persistence of small numbers of residual malignant cells in patients during or following treatment, and may be a function of poor tumor cytoreduction or rapid regrowth of tumor clones with high proliferation potential. These residual malignant cells are clinically relevant, as they may lead to relapse and disease progression.

Morphologic examination can miss the detection of many residual malignant cells. As the technology changes and becomes more sensitive, the limit of detection gets lower. Some of the tools used to detect these residual cells are described in the following pages.

Introduction to MRD

Improvements in detection techniques can enable clinicians to identify MRD throughout the disease lifecycle, which may help to assess the potential risk of relapse early on and inform treatment decisions.

Adapted from:
Methods for Detection of MRD

Multiparametric flow cytometry (MFC)

Cells from bone marrow aspirates are labeled with fluorophore-conjugated antibodies against specific cell surface antigens, and labeled cells are subjected to light of different wavelengths.

Cells can then be counted and assessed according to their expression of cell surface antigens, providing quantitative information on the immunophenotype of the population of sampled cells. Flow cytometers commonly detect >4 colors, however, more sensitive >8 color flow cytometers are also available.

Real-time quantitative polymerase chain reaction (RQ-PCR)

Real-time quantitative PCR (RQ-PCR) is used to detect and quantify gene rearrangements in the variable region of the immunoglobulin (Ig) gene, as well as the T cell receptor (TCR) in patient blast cells.

For this method, patient-specific primers are required. Additionally, RQ-PCR can be used to analyze fusion transcripts such as BCR-ABL, or MLL gene fusions.

Gene fusions tend to occur in specific regions, not requiring primers to be generated for each patient.

Next-generation sequencing (NGS)

NGS uses high-throughput sequencing to detect clonal Ig VDJ/gene rearrangements. This technique offers the potential for increased sensitivity as well as MRD assessment from peripheral blood.

Clonal heterogeneity can be monitored and different clones tracked over time. NGS offers the potential for widespread applicability as data analysis is automated, however this technique still requires validation.

PET/CT imaging in MM

Fluorodeoxyglucose (FDG)-positron emission tomography (PET)/computed tomography (CT) imaging permits detection of lesions demonstrating metabolic activity together with morphologic information. An advantage of PET/CT imaging is its ability to detect extramedullary disease in MM.

However, since not all bone lesions attributable to MM acquire FDG, both false-negatives and false-positives are possible in the setting of MM. Further research is needed to clarify the use of PET/CT imaging in monitoring MRD in MM and its role in combination with other MRD-based techniques.
## Features of MRD Detection Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Applicability</th>
<th>Sensitivity</th>
<th>Important Considerations</th>
</tr>
</thead>
</table>
| MFC             | ALL: >90% MM: 100%                | 3- to 4-color: 10⁻⁴⁻¹¹⁻⁰\(^{1,2,3,4,5}\) 6- to 9-color: 10⁻⁴⁻¹⁻⁰\(^{1,2,3,4,5}\) Also depends on cell input. | Widely applicable and available  
Turnaround in hours  
Relatively inexpensive  
Does not require baseline sample  
Clonal heterogeneity undetectable  
Standardization ongoing (EuroFlow/IMF)  
Requires bone marrow aspirate  
Fresh sample necessary  
Widely applicable and available  
Turnaround in hours  
Relatively inexpensive  
Does not require baseline sample  
Clonal heterogeneity undetectable  
Standardization ongoing (EuroFlow/IMF)  
Requires bone marrow aspirate  
Fresh sample necessary  |
| RQ (real-time quantitative) – PCR | ALL: 90–95% MM: 66–70%            | 10⁻⁴⁻¹⁻⁰\(^{1,2,3,4,5}\) | Standardized (EuroMRD)  
Fresh sample not necessary  
Clonal heterogeneity undetectable  
Patient-specific primers necessary  
More expensive than MFC  
Requires bone marrow aspirate  
Requires baseline sample  
Time consuming |
| Fusion transcript PCR | BCP-ALL: 25–40% T-ALL: 10–15%  | 10⁻⁴⁻¹⁻⁰\(^{1,2,3,4,5}\) | Rapid  
Unequivocal link with leukemic/preleukemic clone  
Stable target throughout therapy  
Possible differences in expression levels (transcripts/cells) during the course of treatment  
RNA instability = false negative  
Risk of cross contamination = false positive  |
| NGS             | >95% all lymphoid malignancies MM – >90% | 10⁻¹⁰\(^{1,2,3,4,5}\) | Limited clonal heterogeneity detected  
Bone marrow aspirate or peripheral blood sample acceptable  
Fresh sample not necessary  
Not yet standardized  
Limited availability  
One week or more  
Expensive, but costs decreasing  
Requires baseline sample or stored sample from a time point with detectable disease |

ALL, acute lymphoblastic leukemia; BCP, B-cell precursor; IMF, International Myeloma Foundation; MFC, Multiparametric flow cytometry; MM, multiple myeloma; MRD, minimal residual disease; NGS, next-generation sequencing; PCR, polymerase chain reaction.

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### MRD in ALL Summary

Morphological assessment cannot detect very low numbers of cells representing minimal residual disease in patient samples. Consequently, techniques using flow cytometry, RQ-PCR and NGS have been developed, which allow for more sensitive detection as well as the quantification of those residual leukemic cells. These methods are highly sensitive with detection limits of 10⁻⁴ to 10⁻⁶.\(^{2,3,4,5}\) A number of studies have shown that the detection of MRD in patients with ALL, both children and adults, is an independent risk parameter of high clinical relevance.\(^ {2} \) This applies to patients with ALL undergoing stem cell transplant.\(^ {16} \) A consensus on the timing of assessment and the definitions of common MRD terminology is becoming increasingly important when evaluating patients. Also, the standardization of MRD methodologies is important to ensure comparability within an MRD treatment protocol, as well as to provide a solid basis for the comparison of MRD data between different treatment protocols.\(^{46}\)

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### Positron Emission tomography (PET)/Computed Tomography (CT) imaging

PET/CT imaging is applicable for detecting MM in 100% of patients, however sensitivity is variable. PET/CT imaging is able to detect extramedullary disease and takes a matter of hours to carry out. However, it is expensive and both false-negative and false-positive results have been seen when other coexisting infectious or inflammatory processes exist.\(^{19,20}\)
MRD in MM Summary

After induction therapy, post-autologous stem disease (e.g., after achieving a CR, during or continuum in monitoring the course of the disease), MRD may help mitigate bias in patient selection. However, identifying which patients should be assessed for extramedullary disease and may help determine the optimal risk stratification. Some patients who present with high-risk features at baseline may have persistent MRD despite achieving a CR, while patients with MGUS-like gene expression may experience better outcomes independent of CR status.

The 2016 IWGM consensus criteria proposed definitions for MRD-negativity and outcomes independent of CR status. Relapses in MM could potentially reflect whether treatment should be tailored for extramedullary disease and may help mitigate biopsy bias. Ongoing studies will continue to define and recommends evaluating MRD-negativity and outcomes.

Further clinical trials and meta-analyses are needed to determine how current CR criteria and MRD assessment in MM may inform treatment decision-making and to validate the relationship of sustained MRD-negativity and outcomes.

References