Case Report

Pulmonary Complications of Azanucleoside Therapy in Patients with Myelodysplastic Syndrome and Acute Myelogenous Leukemia

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Our primary aim was to identify potential risk factors and clinical outcome of azanucleoside induced pulmonary complications in patients with myelodysplastic syndrome (MDS) and Acute Myelogenous Leukemia (AML). We present an 89-year-old female with MDS derived AML who developed fatigability, hypoxemia, and bilateral lung infiltrates indicating interstitial lung disease after 11 cycles of azanucleoside. In addition, we describe a cohort of six MDS patients with fever, cough, dyspnea, and pulmonary infiltrates at early time point during azanucleoside treatment. Early and late onset of pulmonary manifestations suggest different pathogenic mechanisms. Brief azanucleoside discontinuation and steroids led to rapid improvement in symptoms.

1. Introduction

Myelodysplastic syndrome (MDS) is an immunologically and epigenetically heterogeneous disease characterized by dysplastic hematopoiesis and propensity for AML transformation [1]. Deregulated immunity results in abnormal myelosuppressive cytokine milieu and marrow failure usually observed in low-risk MDS, whereas high-risk disease is associated with high rate of leukemia conversion and expansion of immunosuppressive T cells during progression. Autoimmunity is seen in about 10–20% of patients [2], with pulmonary manifestations representing unusual presentation. Mechanisms associated with autoimmunity and MDS pathogenesis are largely unknown. For patients with high-risk disease, hypomethylating agents such as azacitidine (AZA, Vidaza, Celgene) and decitabine (DAC, Dacogen, Janssen) provide survival benefit. Despite low incidence of side effects, azanucleosides induced lung complications represent a limiting factor for therapeutic optimization. Bronchiolitis obliterans organizing pneumonia (BOOP) and idiopathic pulmonary fibrosis (IPF) are rare noninfectious complications observed in patients treated with azanucleosides who present with fever, dyspnea, and cough. To gain insight into potential clinical, radiographic, and immunological mechanisms of azanucleoside induced lung injury, we present an 89-year-old female who developed IPF after 11 cycles of DAC and we reviewed the English literature on MDS and AML patients who developed noninfectious pulmonary complications while receiving epigenetic therapy.

2. Patient and Methods

In addition to our patient, we reviewed 15 MDS cases presenting with BOOP/IPF while on azanucleoside treatment. Cases with incomplete clinical features were excluded resulting in 6 additional patients [3–8]. In our 7 cases’ cohort, we evaluated time of symptom onset, age, sex, radiographic and histopathological findings, and cytogenetic and clinical outcome. When available, laboratory data including ANA, P-CANCA antibodies, erythrocyte sedimentation rate (ESR), and C-reactive protein (CRP) were recorded.
3. Case Report

An 89-year-old female presented with pancytopenia. Her WBC was 7800/μL, ANC 1750/μL, absolute lymphocyte count (ALC) 1250/μL, hemoglobin 7.8 g/dL, and platelet count 579000/μL. Peripheral smear showed 15% leukemic blast with high nuclear/cytoplasmatic ratio (Figures 1(a)-1(b)). Her bone marrow demonstrated 50% nucleated cells expressing myeloperoxidase (MPO), CD177, and CD33. Significant erythroid and granulocytic dysplasia suggested AML with myelodysplasia-related changes. Standard G-band karyotyping revealed 54,XX,+1, del(5)(q15q33), +6,+8, i(11)(q10), +13,+14,+20,+22 [17]/54, ide(5q) + del(5)t (5,19) (q15,q13.1) – i(11)(q10), del(19)(q13.1) [3] consistent with complex hyperdiploid karyotype. FISH analysis revealed 5q31, trisomy chromosome 8, deletion 20q, and trisomy 11 in 88%, 85%, 91%, and 10% of nuclei, respectively. Next generation sequencing showed TP53 c.817>C (p.R273G) mutation at exon 8. DAC at 20 mg/m² intravenously for 5 days every 28-day cycle was initiated. A pretreatment chest CT was normal (Figure 2(a)). Patient achieved progressive trilineage response by cycle 4. After cycle 11, she presented with shortness of breath, fatigability, and hypoxemia. Her auscultation revealed bibasilar crackles. A follow-up chest CT highlighted subpleural bilateral ground-glass opacities, subtle early honeycombing in posterior right lung base, and increased interstitial lung markings bilaterally (Figures 2(b) and 2(c)). In addition, increased bronchial wall thickness was observed (Figure 2(d)). Her blood cultures, urine legionella, and streptococcus antigens were negative. ESR and CRP were 63 mm/hr and 0.68 mg/dL, respectively. Her autoimmune panel showed ANA and p-ANCA antibodies positive at titers of 1: 40 and 1: 160. Her SCL-70 antibody was negative. Peripheral blood immunophenotypic analysis revealed normal absolute CD4+CD25highFOXP3+(Tregs), CD4+, and CD8+ T cells with reduced CD4 : CD8 ratio. Both CD4+ and CD8+ T cell compartments demonstrated an increase in activation state. Patient was initiated on prednisone at 20 mg orally daily. Her dyspnea, oxygen dependence, and pulmonary infiltrates gradually resolved after 8 weeks of treatment (Figure 2(e)). To date, 26 cycles of DAC have been delivered without additional complications.

4. Result

4.1. Patient Characteristics. As depicted in Table 1, median patient age was 71 years (range, 56–89). 5/7 (71%) of patients were males. All patients from the literature review were...
# Table I: Clinical and laboratory characteristics of MDS and AML patients with pulmonary complications treated with azanucleosides therapy.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age/sex</th>
<th>Symptoms</th>
<th>Cycles of AZA</th>
<th>Initiation of symptoms (days)</th>
<th>Radiographic findings</th>
<th>Lung pathology</th>
<th>CRP$^a$ (mg/dL)</th>
<th>MDS WHO 2008 classification</th>
<th>Cytogenetic</th>
<th>R-IPSS</th>
<th>ANC$^b$ (cell/µL)</th>
<th>ALC$^c$ (cell/µL)</th>
<th>Platelet count (µL)</th>
<th>Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>72/M</td>
<td>Fever, shortness of breath</td>
<td>1</td>
<td>3</td>
<td>Interstitial pneumonitis, ground-glass opacities</td>
<td>NA</td>
<td>10.2</td>
<td>RAEB-1</td>
<td>46, XY, der(1;7)(q10;p1) [17/20]</td>
<td>Very high</td>
<td>90</td>
<td>540</td>
<td>NA</td>
<td>18000</td>
</tr>
<tr>
<td>2</td>
<td>64/M</td>
<td>Dry cough, fever, and chills</td>
<td>2</td>
<td>2</td>
<td>Left lower lobe infiltrate</td>
<td>Fibrous and organizing pneumonia</td>
<td>NA</td>
<td>t-MDS$^d$</td>
<td>NA</td>
<td>NA</td>
<td>140</td>
<td>490</td>
<td>12000</td>
<td>[4]</td>
</tr>
<tr>
<td>3</td>
<td>74/M</td>
<td>Dry cough, shortness of breath</td>
<td>1</td>
<td>7</td>
<td>Nons-segmental consolidation/ground-glass opacities</td>
<td>NA</td>
<td>1.25</td>
<td>RAEB-1$^e$</td>
<td>Complex</td>
<td>Very high</td>
<td>630</td>
<td>1790</td>
<td>17000</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>56/M</td>
<td>Dry cough, fever</td>
<td>1</td>
<td>2</td>
<td>Nodular opacities, bilateral airspace disease</td>
<td>Intestinal lung disease, organizing pneumonia with bronchocentric granulomatous pattern</td>
<td>NA</td>
<td>RAEB-2</td>
<td>NA</td>
<td>NA</td>
<td>750</td>
<td>NA</td>
<td>12000</td>
<td>[6]</td>
</tr>
<tr>
<td>5</td>
<td>71/M</td>
<td>Fever, shortness of breath</td>
<td>1</td>
<td>14</td>
<td>Diffuse bilateral interstitial/alveolar infiltrates</td>
<td>Focal areas of intra-alveolar acute inflammation and necrosis</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>[7]</td>
</tr>
<tr>
<td>6</td>
<td>74/F</td>
<td>Fever, dry cough, and shortness of breath</td>
<td>2</td>
<td>5</td>
<td>Reticulonodular and ground-glass shadowing and small pleural effusions</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Complex</td>
<td>Very high</td>
<td>4300</td>
<td>NA</td>
<td>342000</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Case</td>
<td>Shortness of breath</td>
<td>II</td>
<td>330</td>
<td>Bilateral interstitial lung infiltrates</td>
<td>NA</td>
<td>0.68</td>
<td>MDS derived AML</td>
<td>Complex$^f$</td>
<td>Very high</td>
<td>1750</td>
<td>1250</td>
<td>579000</td>
<td></td>
</tr>
</tbody>
</table>

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$^a$CRP: C-reactive protein; $^b$ANC: absolute neutrophil count; $^c$ALC: absolute lymphocyte count; NA: not available; $^d$t-MDS: treatment-related MDS; $^e$RAEB: refractory anemia excess blast; $^f$karyotype included 10 chromosomal abnormalities.
diagnosed with MDS and developed radiographic suggestion of BOOP/IPF while on azanucleoside. After initiation of respiratory symptoms, broad-spectrum antibiotics were started; however, an infectious etiology was not detected leading to progressive antibiotic deescalation. Symptoms were available in all patients with combination of fever, dyspnea, and/or dry cough observed in 5/7 (71%) of patients. In all cases, treatment with steroids and azanucleoside discontinuation resulted in quick symptoms improvement.

4.2. Characteristics of Pulmonary Complication. Symptoms were observed within a median of 1 cycle of treatment. Radiographically, diffuse bilateral interstitial infiltrates were observed in 5/7 (71%) of cases. As shown in Table I, pathology was documented in 3/7 cases, revealing that diffuse alveolitis with honeycombing, bronchogenic granulomatous pattern, focal areas of intra-alveolar inflammation with necrosis, and fibrotic tissue were common findings in patients with available biopsies.

4.3. Characteristics of MDS. WHO 2008 classification was available in 5/7 cases representing RAEB-1 (2 cases), RAEB-2, MDS derived AML, and t-MDS, 1 case each (Table I). Karyotypic abnormalities were reported in 4/7 patients including 3 patients harboring complex cytogenetic. At the time of symptoms onset, neutrophils, lymphocyte, and platelet counts were 690 (range, 90–4300/μL), 895 (range, 490–1790/μL), and 175000 (range, 12000–617000/μL), respectively. For patients experiencing early onset of pulmonary complications, median ANC was 630 (range, 90–4300/μL).

5. Discussion

Therapeutic alternatives for elderly patients with high-risk MDS and AML are limited with treatment success compromised by drug-induced complications. The incidence of azanucleoside induced pulmonary complications is unknown. Our report is the first in describing a late onset of pulmonary complications. Median ANC was 630 (range, 90–4300/μL).

Conflict of Interests

Manuel Molina, Sarvari Yellapragada, Martha Mims, Effie Rahman, and Gustavo Rivero report no relevant conflict of interests.

References


