Original Article

A Clinical and Laboratory Profile of Multiple Myeloma

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Abstract

Background: Myeloma, the most common malignant disease of bone, is incurable and occurring with increasing frequency in elderly population. Typical clinical features are weakness, fatigability, bone pain, anemia, renal insufficiency and hypercalcemia. Incidental discovery on comprehensive laboratory panels is common. Serum or urine protein electrophoresis or immunofixation and bone marrow aspirate analysis help the diagnosis of multiple myeloma. Objective: The aim of this study was to define and evaluate the clinico-laboratory features of newly diagnosed adult multiple myeloma (MM) patients in the context of Bangladesh. Materials and Methods: This study was carried out in two centers, from October 2005 to January 2010 in Bangabandhu Sheikh Mujib Medical University (BSMMU) and July 2012 to June 2017 in Enam Medical College and Hospital (EMCH). Thirty two diagnosed valid cases of multiple myeloma were included in this study. Clinical history, physical and relevant laboratory findings were carefully recorded and analyzed. Results: In this study among 32 patients, 29 were males and 3 were females with mean age 51.94 ± 10.09 years. The common complaints were bone pain, weakness and fatigue. The common clinical findings were bone tenderness, pallor and high ESR (ESR of all the study patients was more than 100 mm in 1st hour). Hemoglobin level was <8.5 gm/dL in 13 patients, serum creatinine ≥2 mg/dL in seven patients, serum albumin <30 mg/L in 14 patients and serum β2 microglobulin >5.5 mg/L in 15 patients. Three patients were hypercalcemic. Lytic lesions were the most common radiological finding in the study. Conclusion: This study showed that multiple myeloma is a disease of the middle and elderly aged population with male preponderance, with high male female ratio. Multivenued studies are needed to view the real picture of multiple myeloma in the context of Bangladesh.

Key words: Multiple myeloma; Clinical profile; Laboratory profile; Bangladesh

Introduction

Multiple myeloma (plasma cell myeloma or plasmacytic myeloma or myelomatosis or Kahler disease) is a hematological neoplasm characterized by proliferation of a single clone of plasma cells derived from B cells. This clone of plasma cells proliferates in the bone marrow and frequently invades the adjacent bone, producing skeletal destruction that results in bone pain and fractures. Occasionally, plasma cells infiltrate multiple organs and produce other symptoms. The excessive production of a monoclonal protein (M-protein) may lead to renal failure from Bence Jones protein or hyperviscosity from excessive amounts of M-protein in the blood. The diagnosis depends on identification of abnormal monoclonal plasma cells in the bone marrow, M-protein in the serum or urine, osteolytic lesions, and a clinical picture consistent with multiple myeloma.1

Multiple myeloma accounts for approximately 1% of neoplastic diseases and 13% of hematologic cancers. In Western countries, the annual age-adjusted incidence is 5.6 cases per 100,000 persons. The median age at diagnosis is approximately 70 years; 37% of patients are younger than 65 years, 26% are...
between the ages of 65 and 74 years, and 37% are 75 years of age or older.²,³ In India, the incidence varies from 0.3−1.9/100000 for male and 0.04−1.3/100000 for female.⁴

In most patients with this disease no clear risk factor can be identified. Exposure to ionizing radiation, farming pesticides, or possibly petrochemicals increase the risk. There is an increased incidence of multiple myeloma in persons with rheumatoid arthritis or obesity (body mass index of more than 30 kg per m²).⁵

Myeloma arises from an asymptomatic premalignant proliferation of monoclonal plasma cells that are derived from post-germinal center B cells. Multistep genetic and microenvironmental changes lead to the transformation of these cells into a malignant neoplasm. Myeloma is thought to evolve most commonly from a monoclonal gammapathy of undetermined clinical significance (usually known as MGUS) that progresses to smoldering myeloma and, finally, to symptomatic myeloma. Several genetic abnormalities that occur in tumor plasma cells play major roles in the pathogenesis of myeloma.⁶,⁷ The adhesion of myeloma cells to hematopoietic and stromal cells induces the secretion of cytokines and growth factors, including interleukin-6, vascular endothelial growth factor (VEGF), insulin-like growth factor 1, members of the superfamily of tumor necrosis factor, transforming growth factor β1, and interleukin-10.⁸ These cytokines play an important role in myeloma cell proliferation.

Myeloma is classified as asymptomatic or symptomatic, depending on the absence or presence of myeloma-related organ or tissue dysfunction, including hypercalcemia, renal insufficiency, anemia, and bone disease.⁹ It is important to note that 34% of patients are asymptomatic at presentation with incidental abnormalities on total protein, creatinine, calcium or hemoglobin laboratory panels.¹⁰ Anemia, which is present in about 73% of patients at diagnosis, is generally related to myeloma marrow infiltration or renal dysfunction.¹¹ Bony lesions develop in almost 80% of patients with newly diagnosed disease; in one study, 58% of patients reported bone pain.¹¹ Renal impairment occurs in 20 to 40% of patients with newly diagnosed disease¹¹,¹² mainly as a result of direct tubular damage from excess protein load, dehydration, hypercalcemia, and the use of nephrotoxic medications.¹³ The risk of infection is increased with active disease but decreases with response to therapy.¹⁴ Hypercalcemia is uncommon.¹

Serum β2-microglobulin and albumin are two most important prognostic factors. The International Staging System defines three risk groups on the basis of these two.¹⁵ Myeloma is usually incurable. In recent years, the introduction of autologous stem-cell transplantation and the availability of agents such as thalidomide, lenalidomide, and bortezomib have changed the management of myeloma and extended overall survival. In patients presenting at an age under 60 years, 10-year survival is approximately 30%.¹⁶ Therefore, the purpose of this study which determines the spectrum of clinical, hematological and biochemical changes in the patients of multiple myeloma in the context of Bangladesh is obviously appropriate and timely as there was no such study conducted in our country previously.

Materials and Methods
This study was carried out in two centers — from October 2005 to January 2010 in Bangabandhu Sheikh Mujib Medical University and from July 2012 to June 2017 in Enam Medical College and Hospital. In this study the total number of cases was 32. Diagnosis was based on serum protein electrophoresis, bone marrow examination and FNAC from plasmacytoma. Relevant clinical history, physical findings, complete blood count and ESR, bio-chemical tests like serum albumin, serum calcium, serum creatinine, serum β2 microglobulin and radiological survey were recorded for further analyses.

Results
Total 32 patients diagnosed as multiple myeloma were included in this study. Out of them 29 (90.63%) were males and 3 (9.27%) were females with male female ratio 9.67:1. Age range of patients was 36−71 years with mean 51.94 ± 10.09 years and median 53 years. Table I shows the distribution of patients according to age.

Table I: Distribution of subjects according to age

<table>
<thead>
<tr>
<th>Age groups (years)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>40–60</td>
<td>20</td>
<td>62.50</td>
</tr>
<tr>
<td>≥60</td>
<td>7</td>
<td>21.87</td>
</tr>
</tbody>
</table>
Bone pain, weakness and fatigue were the most commonly presented complaints. Bone tenderness and anemia were the common clinical findings. No organomegaly or lymphadenopathy was found.

Table II: Clinical features of multiple myeloma subjects

<table>
<thead>
<tr>
<th>Clinical features</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness and fatigability</td>
<td>28</td>
<td>87.50</td>
</tr>
<tr>
<td>Bone pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>low back pain</td>
<td>23</td>
<td>71.88</td>
</tr>
<tr>
<td>shoulder pain</td>
<td>2</td>
<td>6.25</td>
</tr>
<tr>
<td>chest pain</td>
<td>3</td>
<td>9.38</td>
</tr>
<tr>
<td>generalized pain</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Fever</td>
<td>10</td>
<td>31.25</td>
</tr>
<tr>
<td>Impaired consciousness</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Headache</td>
<td>5</td>
<td>15.63</td>
</tr>
<tr>
<td>Anaemia</td>
<td>29</td>
<td>90.63</td>
</tr>
<tr>
<td>Bone tenderness</td>
<td>32</td>
<td>100</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>1</td>
<td>3.13</td>
</tr>
</tbody>
</table>

*Some subjects presented with more than one complaints

Investigations revealed that Hb level was <8.5 gm/dL in 13 (40.62%) patients, 8.5–10 gm/dL in 7 (21.88%) patients and >10 gm/dL in 12 (37.50%) patients. ESR was more than 100 mm in 1st hour in all patients. Total WBC count was <4000/cu mm in 5 (15.63%) patients, 4000–11000/cu mm in 23 (71.88%) patients and in 4 (12.5%) patients it was >11000/cu mm. Platelet count was <100000/cu mm in 6 (18.75%) patients and in 26 (81.25%) patients it was >100000/cu mm.

The calcium level was <11 mg/dL in 29 (90.62%) patients and in 3 (9.38%) patients it was ≥11 mg/dL. S. creatinine was <1.4 mg/dL in 5 (15.63%) patients, 1.5–1.9 mg/dL in 20 (62.5%) patients and in 7 (21.87%) patients it was ≥2 mg/dL.

S. albumin level was >30 gm/L in 18 (56.25%) patients and in 14 (43.75%) patients it was <30 gm/dL. None of the patients showed β2 microglobulin level <2 mg/L, in 5 (15.63%) patients the level was 2–3.4 mg/L, 3.5–5.5 mg/L in 12 (37.50%) patients and in 15 (46.87%) patients the level was ≥5.5 mg/L accordingly.

Radiography showed that 17 (53.12%) patients had lytic lesion, 7 (21.88%) had vertebral compression fracture and 4 (12.50%) patients had osteoporosis and 4 (12.50%) showed no skeletal changes.

According to the international prognostic index of multiple myeloma 3 (9.37%) patients were stratified as in the stage I, 14 (43.75%) patients in the stage II and 15 (46.88) patients in the stage III.

**Discussion**

Diagnostic criteria of multiple myeloma were fulfilled by all 32 patients in this study. Multiple myeloma, as this study shows, affects commonly the elderly and middle age groups of population and affects less the young age group. Kyle et al1 and Kaur P et al17 have observed that 2% and 3.58% patients were less than 40 years. We observed that 15.63% patients were younger than 40 years which is comparable with the study of Sultan et al18 who found it 13.1%. The mean age of patients was 55.4, 51, 58.8 and 56 years in the studies of Wadhwa et al19, Kaur et al17 and Sultan et al18. In our study the mean age was 52 years whereas in another study20 in Bangladesh it was 63 years.

In this study the male-female ratio was 9.67:1. But Chowdhury et al20 reported it 5:2 in Bangladesh. The variables that affect the ratio are to be considered with importance. As most of the females in our country are housewives, they are conservatives and have less exposure to the outside community. Moreover in our study the sample size was small.

In our study most of the patients presented with later stage of disease with various clinical presentations. Weakness and fatigability (87.50%) and low backache (71.88%) were the commonly presented complaints. Sultan et al18 observed fatigability in 81.9% and backache in 80.3% of the patients. Kaur et al17 observed weakness and fatigability in 46.4% cases and bone pain in 50% cases. Kyle et al1 observed weakness and fatigability in 32% and bone pain in 58% cases. In our observation this percentages were found higher possibly because of the advanced stage at presentation. In our study 31.25% of patients presented with fever but in the studies of Kyle et al1 and Kaushik et al20 only 0.7% and 16% presented with fever. But Diwan et al22 found that 35% presented with fever which is comparable with our study.

Pallor (90.63%) and bone tenderness (100%) were the
The most common physical findings in this study. In the study of Kaushik et al. pallor was seen in 94% of the patients which is similar to this study. But it was 44.2% patients in the study of Sultan et al. Bone tenderness was in 47% cases observed by Kaushik et al. It was lower than the findings in this study possibly due to late stage of presentation in our study.

Anemia in myeloma is caused due to replacement of marrow by myeloma cells and decreased production of erythropoietin due to accompanying renal involvement. In some cases it may be associated with cytokine mediated bone marrow suppression. Hemoglobin value ≤10 gm/dL was seen in 63.9% of the patients in Sultan et al study and in the study of Wadhwa it was in 59% of the patients. These are similar to the present study (62.5%). But these are less than Kaur et al study (92.8%) and more than Kyle et al study (35%). Moderate to severe anemia (<8.5 gm/dL) was seen in 40.62% of patients in the present study. It is lower in comparison to the studies of Kaur et al (75%) and Subramanian et al (71%) and higher than the studies of Kalita et al (33%) and Diwan et al (25%) studies. But it is nearly similar to studies of Gupta et al (40%) and Kaushik et al (45%) studies. The anemia was normochromic normocytic in most of our patients.

ESR is high in multiple myeloma due to increased paraproteins and anemia. ESR >100 mm in 1 hour was reported in different series from 33–100%. This is similar to the present study (100%).

Leukopenia and leucocytosis were found in 15.63% and 12.5% in patients of the present study. In the study of Kyle et al these were 20% and 8%. Low platelet count is uncommon in early phases of myeloma. Thrombocytopenia may be due to infiltration of the marrow by plasma cells or intravascular destruction of platelets or thrombopoietic activity of IL-6. In our study thrombocytopenia was in 18.75% cases, but in the study of Kaur et al it was higher (25%) and in the studies of Diwan et al and Kyle et al it was in 10% and 5% of the patients respectively.

In multiple myeloma, the main causes of renal failure are cast nephropathy due to light chain excretion and glomerular deposition of immunoglobulin. In the current study, raised serum creatinine was found in 84.38% of the patients, which is similar to the findings in the study of Kaur et al (86.4%), but it is higher than the studies of Kyle et al (55%) and Sultan et al (40.9%). In our study serum creatinine was ≥2mg/dL in 21.87% patients which is similar to Kyle et al (19%).

Hypercalcemia remains the most frequent metabolic complication of myeloma patients and excessive osteolysis plays a major contributory role in its pathogenesis. In our study 9.38% patients were hypercalcemic which is comparable to Kyle et al (13%) but it is lower than the findings in Sultan et al (47.5%) study.

Serum β2-microglobulin and albumin are two most important prognostic factors though raised β2-microglobulin level is a poor prognostic sign. In our study 84.37% patients had their serum β2-microglobulin ≥3.5 mg/dL. Kaur et al showed it higher in 71.4% subjects and Kyle et al showed it in 75% of their patients. Low serum albumin is also a poor prognostic factor. In 43.75% of our patients serum albumin level was <30 gm/dL, but in the study of Jacobson et al it was in 20% of patients. Our study shows a higher rate because of late stage of presentation and the enrollment of a limited number of patients.

Lytic lesions, compression fractures and osteoporosis are the most common bone lesions in multiple myeloma. In this study lytic lesions were seen in 53.12% of the patients. This is consistent with some other studies in the literature. In our study compression fracture was observed in 21.88% of the patients, which is similar to Kyle et al (22%) study. In our study osteoporosis was found in 12.5% cases. It was found in 23%, 20%, 52% patients in the studies of Kyle et al, Kaushik et al and Kalita et al respectively. In 12.5% of our patients radiological findings were normal, but in the study of Kyle et al radiological findings were found normal in 21% cases.

According to International Staging System (based on Serum β2 microglobulin and serum albumin), 9.37% patients were stratified in stage I, 43.75% patients in stage II and 46.88 patients in stage III. In the study of Rahman et al 22% patients were in the stage I, 26% patients were in the stage II and 52% in stage III. The International Staging System has better reliability, simplicity and predictability for survival of patients.
with multiple myeloma.

Multiple myeloma is a disease of middle age and elderly with male preponderance. The presentation of multiple myeloma can range from asymptomatic to severely symptomatic with complications. Our clinico-laboratory findings were comparable to other studies with some variations. It may be due to small number of patients included in this study. Our study can be considered as an important step towards studying multiple myeloma. Nonetheless, further such multicenter studies would enrich our views to determine the actual picture of multiple myeloma in the context of Bangladesh.

References


