Somatic Mutations of Calreticulin in Myeloproliferative Neoplasms


ABSTRACT

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BACKGROUND

Approximately 50 to 60% of patients with essential thrombocythemia or primary myelofibrosis carry a mutation in the Janus kinase 2 gene (JAK2), and an additional 5 to 10% have activating mutations in the thrombopoietin receptor gene (MPL). So far, no specific molecular marker has been identified in the remaining 30 to 45% of patients.

METHODS

We performed whole-exome sequencing to identify somatically acquired mutations in six patients who had primary myelofibrosis without mutations in JAK2 or MPL. Resequencing of CALR, encoding calreticulin, was then performed in cohorts of patients with myeloid neoplasms.

RESULTS

Somatic insertions or deletions in exon 9 of CALR were detected in all patients who underwent whole-exome sequencing. Resequencing in 1107 samples from patients with myeloproliferative neoplasms showed that CALR mutations were absent in polycythemia vera. In essential thrombocythemia and primary myelofibrosis, CALR mutations and JAK2 and MPL mutations were mutually exclusive. Among patients with essential thrombocythemia or primary myelofibrosis with nonmutated JAK2 or MPL, CALR mutations were detected in 67% of those with essential thrombocythemia and 88% of those with primary myelofibrosis. A total of 36 types of insertions or deletions were identified that all cause a frameshift to the same alternative reading frame and generate a novel C-terminal peptide in the mutant calreticulin. Overexpression of the most frequent CALR deletion caused cytokine-independent growth in vitro owing to the activation of signal transducer and activator of transcription 5 (STAT5) by means of an unknown mechanism. Patients with mutated CALR had a lower risk of thrombosis and longer overall survival than patients with mutated JAK2.

CONCLUSIONS

Most patients with essential thrombocythemia or primary myelofibrosis that was not associated with a JAK2 or MPL alteration carried a somatic mutation in CALR. The clinical course in these patients was more indolent than that in patients with the JAK2 V617F mutation. (Funded by the MPN Research Foundation and Associazione Italiana per la Ricerca sul Cancro.)
PHILADELPHIA CHROMOSOME–NEGATIVE myeloproliferative neoplasms include polycythemia vera, essential thrombocythemia, and primary myelofibrosis. A unique gain-of-function mutation in the Janus kinase 2 gene (JAK2) is found in about three quarters of patients in whom these disease entities have been diagnosed. The valine-to-phenylalanine (V617F) alteration constitutively activates JAK2, resulting in increased phosphorylation of its substrates and leading to increased cytokine responsiveness of myeloid cells. The JAK2 V617F mutation is present in approximately 95% of patients with polycythemia vera and in 50 to 60% of those with essential thrombocythemia or primary myelofibrosis. In addition, somatic mutations of JAK2 exon 12 are found in polycythemia vera, and activating mutations of the thrombopoietin receptor gene MPL are present in 5 to 10% of patients with essential thrombocythemia or primary myelofibrosis with nonmutated JAK2. Thus, whereas somatic JAK2 mutations are found in nearly all patients with polycythemia vera, approximately one third of patients with essential thrombocythemia or primary myelofibrosis do not carry any mutation in JAK2 or MPL. Somatic mutations in other genes, such as TET2, CBL, EZH2, DNMT3A, and ASXL1, are present in a proportion of cases of myeloproliferative neoplasms, but these can co-occur with JAK2 and MPL mutations and are found in all types of myeloid cancers.

The natural history of Philadelphia chromosome–negative myeloproliferative neoplasms is characterized not only by the occurrence of thromboembolic complications but also by a tendency toward progression to more aggressive disease, including post-polycythemia vera myelofibrosis or post–essential thrombocythemia myelofibrosis and acute myeloid leukemia or blast-phase disease. Progression of the disease is typically associated with the acquisition of somatic mutations in driver genes responsible for subclonal evolution. However, these mutated genes do not have a primary role in the pathogenesis of essential thrombocythemia or primary myelofibrosis associated with nonmutated JAK2 and MPL. We performed whole-exome sequencing to identify somatic mutations responsible for the initiation of disease in these subsets of myeloproliferative neoplasms.

METHODS

PATIENTS AND SAMPLES

We studied patients with Philadelphia chromosome–negative myeloproliferative neoplasms who were followed at the Medical University of Vienna in Austria, and Fondazione Istituto di Ricerche e Cura a Carattere Scientifico Policlinico San Matteo in Pavia, Italy. The study was approved by the ethics committee at each institution, and all the patients provided written informed consent.

Genomic DNA was obtained from bone marrow mononuclear cells, peripheral-blood granulocytes, or whole-blood samples. Germline control DNA was obtained from immunomagnetically purified circulating T cells.

WHOLE-EXOME SEQUENCING

Whole-exome sequencing was performed in six patients with primary myelofibrosis who did not have mutations in JAK2 or MPL. Genomic DNA libraries were generated from peripheral-blood granulocyte DNA (tumor samples) and matched CD3+ T-lymphocyte DNA (control samples) with the use of the NEBNext DNA Sample Prep Reagent set (New England BioLabs). Whole-exome enrichment was performed with the use of the SureSelect Human All Exon kit (Agilent Technologies) according to the manufacturer’s instructions. The libraries were sequenced with the use of a HiSeq 2000 sequencing system (Illumina). The data analysis is described in the Supplementary Appendix, available with the full text of this article at NEJM.org.

TARGETED RESEQUENCING AND MUTATION SCREENING

Genomic regions of interest were amplified by means of polymerase chain reaction (PCR). PCR products were purified, and a sequencing reaction was set up with the use of the BigDye Terminator, version 3.1, Cycle Sequencing Kit (Life Technologies). Sequencing products were analyzed with the use of a 3130xl Genetic Analyzer (Applied Biosystems). To screen for insertion and deletion mutations in CALR exon 9, we designed PCR primers spanning exon 9 and labeled the forward primer with 6-carboxyfluorescein. After PCR, the products were sized on a 3130xl Genetic Analyzer. Details of the methods and analysis are provided in the Supplementary Appendix.
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RESULTS

WHOLE-EXOME SEQUENCING IN PRIMARY MYELOFIBROSIS

Using whole-exome sequencing, we analyzed genomic DNA from granulocytes (tumor samples) and CD3+ T cells (control samples) obtained from six patients with primary myelofibrosis. Independent validation of the detected variants with the use of classic Sanger sequencing confirmed the presence of 2 to 12 somatic mutations per patient (Table S3 in the Supplementary Appendix). The only recurrently affected gene was CALR, encoding calreticulin.

Two patients had somatic deletions in exon 9 of CALR. PCR-product subcloning and sequencing revealed that Patient H_0191 had a 52-bp deletion and Patient H_0296 had a 1-bp deletion (Fig. S1 in the Supplementary Appendix). Because the 52-bp deletion in Patient H_0191 was incorrectly annotated as a 1-bp deletion coupled with a single nucleotide variant by our variant-calling analysis pipeline (Table S3 in the Supplementary Appendix), we manually reviewed the sequence alignment for this patient. We observed a misalignment of the sequence reads covering the site of mutation, owing to a repetitive element in the affected genomic region (Fig. S2 in the Supplementary Appendix).

Following up on this finding, we investigated the alignments for the remaining four patients and detected a recurrent 5-bp insertion in all four (Fig. S3 in the Supplementary Appendix). The mutations in CALR that were found by means of whole-exome sequencing were confirmed and shown to be somatic by means of Sanger sequencing of the granulocyte and matched T-lymphocyte DNA samples from all six patients.

CALR EXON 9 MUTATIONS IN MYELOPROLIFERATIVE NEOPLASMS

To estimate the prevalence of CALR mutations in myeloproliferative neoplasms, we screened a cohort of 896 patients for insertion or deletion mutations in CALR exon 9 (Fig. S4 in the Supplementary Appendix), using high-resolution sizing of fluorescent dye–labeled PCR products (Fig. S5 in the Supplementary Appendix). This cohort included 382 patients with polycythemia vera, 311 with essential thrombocytopenia, and 203 with primary myelofibrosis (Table S4 in the Supplementary Appendix).

We identified 150 samples (17% of the patients) with insertions or deletions in CALR that were independently validated by means of Sanger sequencing. We did not observe CALR mutations in patients with polycythemia vera. A total of 78 patients with essential thrombocytopenia (25%) and 72 with primary myelofibrosis (35%) had mutations in CALR.

All the patients were genotyped for the JAK2 V617F mutation. Patients with polycythemia vera who were negative for the JAK2 V617F mutation were tested for mutations in JAK2 exon 12. Patients with essential thrombocytopenia or primary myelofibrosis who had nonmutated JAK2 were tested for mutations in MPL exon 10. The distribution of the JAK2, MPL, and CALR mutations in the three disease entities is shown in Figure 1A. All patients with mutated CALR had nonmutated JAK2 and MPL. A total of 67 patients had nonmutated JAK2 and MPL as well as nonmutated CALR exon 9. Of these 67 patients with triple-negative findings, 19 underwent Sanger sequencing for mutations in all nine exons of CALR, but no mutations were detected (data not shown).

Because CALR mutations were strongly associated with essential thrombocytopenia or primary myelofibrosis with nonmutated JAK2 and MPL, we analyzed samples from an additional 211 patients in these disease categories. In the combined cohort of 1107 patients with analyzed samples, we studied 289 patients with essential thrombocytopenia and nonmutated JAK2 and MPL, of whom 195 had mutated CALR (67%). Of the combined 120 patients with primary myelofibrosis and nonmutated JAK2 and MPL, 105 had a mutation in CALR (88%). In 150 patients with mutated CALR for whom we had matched T-lymphocyte DNA available, the mutations were somatic.

CALR EXON 9 MUTATIONS IN OTHER MYELOID NEOPLASMS

To investigate whether CALR mutations are present in other myeloid neoplasms, we screened 254 patients with acute myeloid leukemia, 45 with chronic myeloid leukemia, 73 with the myelodysplastic syndrome, 64 with chronic myelomonocytic leukemia, and 24 with refractory anemia with ring sideroblasts associated with marked thrombocytosis (RARS-T) for mutations in CALR exon 9.
A Frequency/uni0020of/uni0020CALR/uni0020Mutations/uni0020in/uni0020Myeloid/uni0020Cancers

Polycythemia Vera
(N=382)

Nonmutated JAK2, MPL, and CALR

JAK2 mutation

MPL mutation

Essential Thrombocytopenia
(N=311)

Nonmutated JAK2, MPL, and CALR

CALR mutation

JAK2 mutation

Primary Myelofibrosis
(N=203)

Nonmutated JAK2, MPL, and CALR

CALR mutation

JAK2 mutation

B Frequency of CALR Mutations in Myeloid Cancers

Patients with CALR Mutation(%) 100 90 80 70 60 50 40 30 20 10 0

Polycythemia Vera (N=382)
Essential Thrombocytopenia (N=311)
Primary Myelofibrosis (N=203)
AML (N=254)
CML (N=45)
MDS (N=73)
CMML (N=64)
RARS-T (N=24)
Healthy Controls (N=524)

C Distribution of JAK2, MPL, CALR, and SF3B1 Mutations in RARS-T

JAK2

MPL

CALR

SF3B1

Figure 1. Frequency of CALR Mutations in Myeloid Neoplasms.

Panel A shows the distribution of JAK2, MPL, and CALR mutations in the three classical entities of myeloproliferative neoplasms. Panel B shows the frequency of CALR mutations in various myeloid cancers. The total numbers of patients included in the analysis for a specific disease entity are shown. Panel C shows the distribution of mutations in JAK2, MPL, CALR, and SF3B1 among 24 patients with refractory anemia with ring sideroblasts associated with marked thrombocytosis (RARS-T). AML denotes acute myeloid leukemia, CML chronic myeloid leukemia, CMML chronic myelomonoerythocytic leukemia, and MDS myelodysplastic syndrome.
Although most of these patients had nonmutated CALR exon 9, a total of 3 patients with RARS-T had mutations in CALR (Fig. 1B), all with nonmutated JAK2 and MPL (Fig. 1C). Mutations in the gene encoding splicing factor 3B, subunit 1 (SF3B1) co-occurred with mutations in all three genes. Of 524 healthy study participants, 1 had a 3-bp in-frame deletion in CALR.

**CALR MUTATIONS AND A NOVEL C-TERMINAL PEPTIDE IN MUTANT CALR**

We detected a total of 36 types of somatic mutations in CALR (insertions and deletions) that caused a frameshift (Fig. 2A, and Table S5 in the Supplementary Appendix). Furthermore, two patients who were positive for the JAK2 V617F mutation had in-frame germline mutations (type G1 and G2) (Table S5 in the Supplementary Appendix). All 36 types of somatic insertions or deletions resulted in a frameshift to the alternative reading frame 1 (Fig. 2B). Mutations of type 1 (52-bp deletion; c.1092_1143del) and mutations of type 2 (5-bp insertion; c.1154_1155insTTGTC) accounted for 53.0% and 31.7% of all the cases with mutated CALR, respectively (Fig. 2C and 2D). The other mutation types were observed at much lower frequencies, and many were detected only in a single patient (Fig. 2D, and Table S5 in the Supplementary Appendix).

Because all 36 mutation types caused a frameshift to alternative reading frame 1, the resulting mutant CALR proteins share a novel amino acid sequence at the C-terminal (Table S6 in the Supplementary Appendix). The C-terminal peptide derived from alternative reading frame 1 contains a number of positively charged amino acids, whereas the nonmutant CALR C-terminal is largely negatively charged (Fig. 2B).
In addition, the nonmutant calreticulin contains the endoplasmic reticulum–retention motif at the C-terminal end (lysine, aspartic acid, glutamic acid, and leucine (KDEL) amino acid sequence). The C-terminal KDEL motif is lost in all mutant variants (Table S6 in the Supplementary Appendix). Depending on the type of mutation, the mutant proteins retain varying amounts of the negatively charged amino acids of nonmutant calreticulin. The 52-bp deletions (type 1) eliminate almost all negatively charged amino acids, whereas the 5-bp insertions (type 2) retain approximately half the negatively charged amino acids (Fig. 2C).

Given these differences, we hypothesized that type 1 and type 2 mutations may be associated with qualitatively different phenotypes. Accordingly, we found that the type 1 deletions were significantly more frequent in primary myelofibrosis than in essential thrombocythemia (P<0.001). In addition, we found that only three patients were homozygous for CALR mutations associated with uniparental disomy of chromosome 19p, and all three had a 5-bp insertion of type 2 (Fig. 2C).

**EARLY ACQUISITION OF CALR MUTATIONS AND STABLE MUTANT CLONES**

To investigate whether mutations in CALR are acquired early or late in the clonal history of a patient, we analyzed hematopoietic-progenitor colonies from 2 patients for whom we had mutational profiles based on whole-exome sequencing. The clonal hierarchies for Patients H_0191 and H_0296 are shown in Figure 3B. We concluded that for these 2 patients, the mutations in CALR were acquired early in the major clones. We had follow-up samples available for 24 patients with mutated CALR; all these follow-up samples tested positive for the mutation as well.

**CLINICAL SIGNIFICANCE OF CALR MUTATIONS**

Overall, we studied 1215 patients with essential thrombocythemia or primary myelofibrosis (Fig. S4 and Table S7 in the Supplementary Appendix). Of these patients, 63.4% carried the JAK2 V617F mutation, 4.4% carried activating mutations of MPL exon 10, 23.5% carried mutations of CALR exon 9, and only 8.8% had none of these clonal markers. Most of the patients with no clonal markers were clustered in the subgroup of patients with essential thrombocythemia.

We used the Wilcoxon rank-sum test to compare hematologic values in patients carrying different mutated genes. Among patients with essential thrombocythemia, those with a CALR mutation had a lower hemoglobin level, lower white-cell count, and higher platelet count at diagnosis than patients with mutated JAK2 (P<0.001 for all comparisons). Among patients
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**A**

**CALR Exon 9 Sizing**

**B**

**Patient H_0191**

- CALR del 52 bp: + + -
- GAB2: + + -
- METTL11B: + + -
- PHF16: - + -
- CALR del 1 bp: - - +

**Patient H_0296**

- CALR del 1 bp: + +
- C10orf71: + +
- PIK3R1: + +
- CALR del 18 bp: - +

**Time to Sample**

**Relative Clone Size (%)**
with primary myelofibrosis, those with a CALR mutation had a lower white-cell count (P=0.03) and a higher platelet count (P<0.001) than patients with mutated JAK2.

Overall survival and the risk of thrombosis were analyzed only among patients carrying a mutation in JAK2, MPL, or CALR (i.e., patients with a clonal marker). Assuming that mutation status did not change with time, we performed survival analyses using the date of the initial diagnosis as the start of follow-up. Because 6 patients were excluded owing to inadequate follow-up, a total of 1102 patients were examined. The median follow-up for the entire cohort of patients with any of the three mutated genes was 5.7 years (range, 0 to 31).

As shown in Figure 4A, there was a significant difference in overall survival among the three subgroups of patients with primary myelofibrosis (P<0.001). Patients with a somatic mutation of CALR had longer overall survival than those with a JAK2 or MPL mutation (P<0.001 for both comparisons), whereas no significant difference was observed between the latter two subgroups. Among patients with essential thrombocythemia, who had much longer overall survival than those with primary myelofibrosis, there was a significant difference only between patients with a CALR mutation and those with a JAK2 mutation (P=0.04) (Fig. 4B).

In a multivariate Cox regression analysis of overall survival that included type of myeloid neoplasm (essential thrombocythemia vs. primary myelofibrosis), type of mutated gene, and patient cohort (Pavia vs. Vienna) as covariates, the first two variables were found to be independent prognostic factors. As expected, primary myelofibrosis was associated with shorter overall survival, as compared with essential thrombocythemia (hazard ratio for death, 7.1; 95% confidence interval [CI], 4.9 to 10.2; P<0.001). In addition, the type of mutated gene had an independent effect on survival. As compared with patients with a CALR mutation, patients with a JAK2 mutation had a higher risk of death (hazard ratio, 3.1; 95% CI, 2.0 to 4.7; P<0.001), as did those with an MPL mutation (hazard ratio, 3.5; 95% CI, 1.8 to 6.7; P<0.001).

The cumulative incidence of thrombosis in essential thrombocythemia was calculated with a competing-risk approach,24 with death from any cause as a competing event; the curves are shown in Figure 4C, and the data are provided in Table S8 in the Supplementary Appendix. Among patients with essential thrombocythemia, those with a CALR mutation had a lower risk of thrombosis than did those with a JAK2 mutation (P=0.003); no significant differences were found between the other subgroups. It should be noted that the subgroup of patients with an MPL mutation was small.

FUNCTIONAL ANALYSIS OF THE TYPE 1 CALR MUTATION

To study the functional effects of mutated CALR, we cloned the complementary DNA (cDNA) of the nonmutated CALR and the type 1 mutation (52-bp deletion) into a retroviral expression vector based on the murine stem-cell virus, with an internal ribosome entry site and green fluorescent protein (GFP). After retroviral production and transfection of the CALR cDNAs into the interleukin-3–dependent murine cell line Ba/F3, we sorted the transgene-positive cells by means of flow cytometry for GFP (Fig. S6 in the Supplementary Appendix). We then measured the interleukin-3–dependent proliferation of cells. Cells expressing the type 1 CALR mutation showed growth that was independent of interleukin-3 and also showed hypersensitivity to interleukin-3 (Fig. 5A). When we measured the proliferation of cells in the absence of interleukin-3, only the CALR type 1 mutation showed a significant accumulation of cells (Fig. 5B).

To investigate whether the interleukin-3 independence in the CALR type 1–mutated cells was caused by the activation of JAK–signal transducer and activator of transcription (JAK-STAT) signaling, we determined the sensitivity of cells to the JAK2 kinase inhibitor SAR302503. Cells expressing the nonmutated CALR or the type 1 mutation of CALR showed similar sensitivity to SAR302503, suggesting that the interleukin-3–independent growth of the mutated CALR cells depends on JAK2 or a JAK family kinase targeted by SAR302503 (Fig. S7 in the Supplementary Appendix).

To confirm this hypothesis, we examined the phosphorylation of STAT5 in the presence and absence of interleukin-3 in the control and CALR-transfected cell lines. We detected increased phosphorylation of STAT5 in the absence of interleukin-3 in the type 1 mutation of CALR and at an interleukin-3 concentration of 0.1 ng per milliliter (Fig. 5C). Thus, increased activation of JAK-STAT signaling is probably responsible for
We identified somatic mutations in CALR in patients with primary myelofibrosis or essential thrombocythemia. CALR mutations are mutually exclusive with mutations in both JAK2 and MPL.

**DISCUSSION**

We identified somatic mutations in CALR in patients with primary myelofibrosis or essential thrombocythemia. CALR mutations are mutually exclusive with mutations in both JAK2 and MPL.
No CALR mutations were found in patients with polycythemia vera, a myeloproliferative neoplasm that is specifically associated with JAK2 mutations. CALR mutations are the second most frequent mutation after JAK2 in myeloproliferative neoplasms. We also studied patients with other myeloid neoplasms and found CALR mutations only in a few patients with RARS-T, a myeloid neoplasm with both myelodysplastic and myeloproliferative features. These observations strong-
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ly support a causal relationship between CALR mutations and excessive platelet production.

Because CALR mutations are found in approximately 73% of patients who do not have mutations of JAK2 and MPL, we believe they fill in the current molecular diagnostic gap in myeloproliferative neoplasms. Altogether, less than 10% of our patients with essential thrombocythemia or primary myelofibrosis did not have a somatic mutation of JAK2, MPL, or CALR. In some of these patients, the mutatated clone might have been too small to be detected with the current approaches. Rare mutated driver genes may play a role in some patients, whereas other patients might not have a clonal disease at all. This is particularly true for patients with a clinical diagnosis of essential thrombocythemia, because the differential diagnosis between clonal and reactive thrombocytosis may be difficult without a clonal marker.26 Assessment for CALR mutations markedly improves the current diagnostic approach for essential thrombocythemia and primary myelofibrosis and may be a useful addition to the World Health Organization criteria for these disorders.1

All the mutations of CALR we identified are insertion or deletion mutations in the last exon encoding the C-terminal amino acids of the protein. Most of these mutations are present in a heterozygous state and cause a frameshift to a specific alternative reading frame. This frameshift results in the replacement of the C-terminal negatively charged amino acids of calreticulin by a positively charged polypeptide rich in arginine and methionine. The last four amino acids of calreticulin (KDEL) contain the endoplasmic reticulum–retention signal. This signal is absent in mutant calreticulin. Consequently, mutant calreticulin has an altered subcellular localization. Because the negatively charged C-terminal domain of calreticulin is the low-affinity, high-capacity, Ca\(^{2+}\)-binding domain, the Ca\(^{2+}\)-binding function of the mutant protein may be impaired. The presence of the peptide sequence derived from the alternative reading frame at the C-terminal domain of mutated CALR offers an opportunity for immunologic targeting because it represents a cancer-specific epitope.

To analyze the oncogenic capability of the mutant calreticulin, we generated Ba/F3 cells with overexpression of the nonmutant and the type 1 mutant CALR (52-bp deletion). The Ba/F3 cells expressing the 52-bp deletion showed cytokine-independent proliferation. However, the growth of Ba/F3 cells expressing nonmutant and mutant calreticulin was suppressed equally on treatment with a JAK2 kinase inhibitor, suggesting that the JAK-STAT pathway is required for cytokine-independent proliferation induced by mutant calreticulin.

In accordance with this finding, we detected increased phosphorylation of STAT5 in the Ba/F3 cells with the 52-bp deletion, both in the absence and in the presence of stimulation by interleukin-3. Calreticulin, Ca\(^{2+}\), and calmodulin have previously been shown to modulate the activity of Stats. The calreticulin complex with endoplasmic reticulum protein 57, in the endoplasmic reticulum, suppresses the phosphorylation and transcriptional activity of Stat3 in mouse embryonic fibroblasts.27 Moreover, inhibition of the calcium-calmodulin-dependent protein kinase II \(\gamma\) results in reduced levels of phosphorylated Stat1, Stat3, and Stat5.28 Overexpression of calreticulin attenuates interferon \(\alpha\)-induced Stat1 phosphorylation, resulting in interferon resistance.29

Studies are required to elucidate the mechanism for activation of the JAK-STAT pathway by the mutant calreticulin in myeloid cells. The involvement of the JAK-STAT signaling pathway in patients who are positive for a CALR mutation may also explain the effectiveness of JAK2-inhibitor therapy for primary myelofibrosis. However, our results indicate that the JAK2 inhibitors may not be selective for cells expressing the mutated CALR, as compared with the CALR nonmutated cells.

Although our analyses of clinical outcome are retrospective, they strongly suggest that CALR-positive myeloproliferative neoplasms have a more benign clinical course than the corresponding disorders associated with JAK2 or MPL mutations. Owing to the small number of patients with an MPL mutation, the more reliable comparisons are those between patients with a JAK2 mutation and those with a CALR mutation. Our results clearly show that patients with a CALR mutation have a lower risk of thrombosis and have longer overall survival than those with a JAK2 mutation. The lower incidence of thromboembolic complications might be related to our observation that patients with a CALR mutation had lower hemoglobin levels and lower white-cell counts than those with the JAK2 mutation. Longer overall survival was observed among patients with pri-
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From a practical point of view, the different effects of mutated genes might be incorporated into existing prognostic scoring systems for primary myelofibrosis and essential thrombocytopenia and might also guide therapeutic decision making. CALR molecular characterization may become a key component of the clinical management of essential thrombocytopenia and primary myelofibrosis.

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