Comprehensive genetic analyses of childhood acute leukemia in Iraq using next-generation sequencing

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Background: Molecular analyses in hematological malignancies provide insights about genetic makeup. Probable etiological factors in leukemogenesis could also be disclosed. Since genetic analyses are still primitive in Iraq, a country of repeated wars, we conceived of performing next-generation sequencing (NGS), to disclose the genomic landscape of acute lymphoblastic leukemia (ALL) and acute myeloid leukemia (AML) among a cohort of Iraqi children.

Methods: Dried blood samples were collected from Iraqi children with ALL (n=55), or AML (n=11), and transferred to Japan where NGS was done. Whole-exome, whole-genome, and targeted gene sequencings were performed.

Results: Somatic point mutations and the copy number variations among Iraqi children with acute leukemia were comparable with those in other countries, and cytosine-to-thymine nucleotide alterations were dominant. Strikingly, *TCF3-PBX1* was the most recurrent fusion gene (22.4%) in B-cell precursor ALL (B-ALL), and acute promyelocytic leukemia (AML-M3) was subtyped in 5 AML cases. Additionally, a high frequency of *RAS* signaling pathway mutations was detected in children with B-ALL (38.8%), along with 3 AML cases that carried oncogenic *RAS*.

Conclusions: Apart from disclosing the high frequency of *TCF3-PBX1*, NGS confirmed our previous finding of recurrent *RAS* mutations in Iraqi childhood acute leukemia. Our results suggest that the biology of

Iraqi childhood acute leukemia is in part characteristic, where the war-aftermath environment or geography might play a role.

Introduction

Childhood acute leukemia has heterogeneous biological and multifactorial etiology mechanisms linked with genetic susceptibility factors and subsequently acquired somatic mutations (1-3). Differences in the incidences, risk factors, and survival of pediatric acute leukemia along with the different frequencies of molecular markers have been reported across various countries (4,5). Such differences could be attributed to the interaction between genomic drivers, which are associated with race and ethnicity, and environmental factors (2,3,6-8).

Over the last four decades of wars and their aftermath in Iraq, the health system underwent a serious regression. No genetic analysis is yet available for diagnosing pediatric acute lymphoblastic leukemia (ALL) and acute myeloid leukemia (AML) in Iraq. Limited diagnostic facilities have

a negative impact on disease understanding, management, and consequently its outcome. Meanwhile, childhood leukemia rates doubled over 15 years (1993–2007) according to a study from Basra in Southern Iraq, and the trend was deemed significant when compared to neighboring countries like Kuwait and Oman, as well as the United States (9). Notably, Basra was the nearest spot that experienced repeated gulf wars and was exposed to repeated bombing and by-products of the petroleum fires.

Despite the improved 5-year survival rate of pediatric ALL outcome of more than 90% in developed countries, Iraqi pediatric oncologists struggle to achieve around 70% (10,11). The international collaboration from Japan was, therefore, established aiming to scale up the diagnosis of Iraqi children with acute leukemia by performing molecular analysis using the dried blood spot (DBS) samples; concomitantly, Italy had settled a telemedicine program in the main pediatric oncology center in Baghdad to support in protocol guidance for acute leukemia cases. Through our collaboration studies, the prevalence of *RAS* mutations was previously noted to be higher among Iraqi childhood ALL and AML than in other countries (12,13). Likewise, acute promyelocytic leukemia (APL) was unusually frequent among Iraqi children with AML in our study (14) and in a report by the Italian team (15).

Next-generation sequencing (NGS) technology with its characteristic high throughput and high sensitivity and specificity provides a good platform for acute leukemia diagnosis and research to improve the understanding of molecular alterations in patients with such diseases. Thus, it aids in refining their treatment plans accordingly. NGS when compared to conventional genetic sequencing, has several advantages such as comprehensive genomic coverage, higher capacity with sample multiplexing, and the ability to sequence hundreds to thousands of genes or gene regions simultaneously (16).

In this new collaborative study, NGS was utilized for the first time for illustrating the landscape of genetic mutations

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Highlight box

Key findings
- Among Iraqi children with acute leukemia, we disclosed a high frequency of *TCF3-PBX1* in ALL, and a frequent AML-M3 subtype, along with recurrent RAS mutations in ALL/AML.

What is known, and what is new?
- Molecular analyses in hematological malignancies provide insights about genetic makeup. Probable etiological factors in leukemogenesis could be disclosed.
- For the first time in Iraq, NGS was performed to disclose the molecular landscape of a cohort of childhood ALL/AML from Iraq in Japan using dried blood spot samples. Our results suggest that the biology of Iraqi childhood acute leukemia is, in part, characteristic, where the war-aftermath environment or geography might play a role.

What is the implication, and what should change now?
- Understanding the biology of acute leukemia in Iraq could help doctors there in modifying the management protocols or arranging the plan for required and applicable analysis in their locations for achieving better results.

in a series of Iraqi children with ALL and AML, and the DBS-extracted DNA was used for the NGS analysis. We aimed to perform a more comprehensive genetic analysis using NGS and to assess the possible differences in the biology of pediatric acute leukemia in Iraq in association with genetic or non-genetic factors with the consideration of environmental factors. We present this article in accordance with the MDAR reporting checklist (available at https://tp.amegroups.com/article/view/10.21037/tp-22-512/rc).

Methods

General information about the study

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The research work was approved by the Ethical Committee of Shinshu University School of Medicine (No. 622/2020), Nagoya University Graduate School of Medicine (No. 18185/2020), and by the Ministry of Health in Iraq (No. 2553/2018). All methods were carried out in accordance with relevant guidelines and regulations and a written informed consent was obtained from all subjects and/or their legal guardian(s).

Five main pediatric oncology centers from Iraq have participated in this study, including Children Welfare Teaching Hospital (CWTH) in Baghdad (the major referral center for childhood cancers in the country), Basra Children's Specialty Hospital (BCSH) in Basra, Ibn Al-Atheer Hospital for Children (IAH) in Mosul, Hiwa Cancer Hospital (HCH) in Sulaymaniah, and Jin Pediatric Hematology-Oncology Centre (JPHOC) in Duhok. CWTH, BCSH, and IAH are in Arab provinces, whereas HCH and JPHOC are in Kurdistan, the area inhabited mostly by the Kurdish ethnicity in the north of Iraq. HCH in Sulaymaniah is the only oncology center in Iraq, which is equipped with hematopoietic stem cell transplantation unit under the supervision of an Italian team, and they are performing the minimal residual disease detection using flow cytometry. Patients in the mentioned centers were treated according to the United Kingdom-Medical Research Council (UK-MRC) protocols for pediatric acute leukemia, including the modified UKALL 2011 for ALL, and AML-MRC15 for AML, described elsewhere (10,17).

Sample collection

In the form of DBS, paired bone marrow (BM) samples were collected at diagnosis (day 0, tumor status), and at (day 30 or 60, remission status), from Iraqi patients aged ≤16 years, who were newly diagnosed with ALL or AML, from June 2016 to December 2019. Providing that no molecular data are available in Iraq upon diagnosis and the samples were received sequentially within the first few weeks of diagnosis, selection bias are not expected. In total, 101 cases were recruited from Iraq, 53 from CWTH, 25 from BCSH, 15 from HCH, and 8 from JPHOC. However, 66 (55 ALL and 11 AML) cases who had paired BM samples (at diagnosis and remission) were eligible for NGS, including 36, 17, 8, and 5, from CWTH, BCSH, HCH, and JPHOC, respectively. The remaining 35 cases were either missing one sample (n=15), died before reaching remission (n=9), insufficient in terms of DNA concentration (n=5), transferred to be treated outside Iraq (n=3), or abandoned therapy (n=3).

Flinders Technology Associates (FTA) paper processing

A few drops of blood from BM aspirate at initial diagnosis and at remission status were applied to the FTA classic card's filter paper (Cat No. WB120205, GE Healthcare, Buckinghamshire, UK Limited) (18) at the five Iraqi hospitals. After the blood spots were dried for 1 hour at room temperature, the FTA card was kept in a special FTA envelope in a refrigerator for up to several weeks and was then transported by airplane to Japan. Two mm disks (eight disks) were punched out from the DBS on FTA cards using a sterile hole puncher (Harris Micro-Punch, Shunderson Communications Inc., Ottawa, Canada). For the matched remission status samples especially those with hypoplastic BM samples, more DBS disks (up to 40) were consumed to increase the DNA yield. DNA was extracted from the DBS from the samples of FTA cards and was purified using the QIA amp DNA Blood Mini Kit (Cat No. 56304, Qiagen, Ltd., Tokyo, Japan) as per the manufacturer's instructions. After the extraction, DNA was measured using Qubit® 2.0 Fluorometer (Thermo Fisher Scientific, Life Technologies, MA, USA) as per the manufacturer's instructions.

Whole-exome sequencing (WES)

NGS analyses have been performed essentially as described (19). Briefly, WES libraries starting from 50–200 ng of DNA have been prepared using a SureSelect Human All Exon V5 bait and SureSelect Reagents (Agilent, Santa Clara, CA, USA) as per the manufacturer's

instructions. The libraries were run on a HiSeq X next-generation sequencer (Illumina, San Diego, CA, USA), with a 2×150-bp paired end-reads option. The sequence reads were aligned to the hg19 reference genome using the Burrows-Wheeler Aligner (http://bio-bwa.sourceforge.net/) with default parameters and a "–mem" option. Polymerase chain reaction (PCR) duplicates were removed from constructed BAM files using the Picard tools (https://broadinstitute.github.io/picard/).

To identify somatic point mutations, paired tumor-normal data were analyzed using VarScan2. We then called candidate variants in the coding region that have variant allele frequencies (VAF) of >0.1 (in tumor) and <0.05 (in normal), 10 or more reads with the variant, and minor allele frequencies (MAF) of <0.001 in single nucleotide polymorphism (SNP) databases (ESP6500, 1000 genomes, ExAC, and Kaviar). A candidate variant was considered as an artifact and was filtered out if the identical variant was present in 12 irrelevant germline samples with an average VAF of >0.01. The variants were then annotated using ANNOVAR (https://annovar.openbioinformatics.org/).

In total, 50 candidates were randomly selected, and PCR-based deep sequencing was performed. Briefly, a *Not*I-tagged PCR primers (having 5'-AAGCGGCCGC-3' tag on their 5'- side) were designed to cover 100–200 bp regions including candidates. PCR products were digested using *Not*I (New England Biolabs, Ipswich, MA, USA) and concatenated using T4 DNA Ligase (TaKaRa Bio, Otsu, Japan). The concatemers were fragmented to an average length of 400 bp by Covaris M220 (Covaris, Wobam, MA, USA) and were prepared for sequencing using an NEBNext Ultra DNA Prep Kit for Illumina (New England Biolabs) as per the manufacturer's instructions. BAM files have been assembled, and VAF of candidates has been measured. The candidate is considered present if the VAF in tumor was three times more than that in normal. As a result, (48/50, 96%) were confirmed to be present as somatic mutations.

To identify germline variants, variants with VAF >0.25 in normal data have been picked up using VarScan2. The variants were annotated using ANNOVAR. Genetic diagnoses were considered only when germline variants fulfilled the criteria of "pathogenic" or "likely pathogenic" as provided by the American College of Medical Genetics guideline, as described (20). The zygosity of a variant was considered homozygous when the VAF of the variant exceeded 0.85.

To identify copy number alterations (CNAs), a read count of an exon in a tumor sample was normalized for the total coverage of the sample and was compared with 12 irrelevant germline samples. The exon was considered a candidate of CNAs if the standard deviation of the tumor sample's read count was >3. If three or more continuous exons are the candidates, the exons are considered affected by amplifications or deletions.

Run of homozygosity (ROH) was identified by detecting a run of homozygous common (>1% MAF in SNP databases) SNPs in normal samples. ROH was classified by simply counting the number of continuous SNPs (10–50 SNPs; short ROH, and >50 SNPs; long ROH). A total of 60 germline samples of Japanese origin were used as control.

Targeted gene sequencing (TGS)

A custom SureSelect bait was designed targeting the whole gene body of 31 genes associated with fusion genes or deletions in B-ALL (Table S1). To detect chromosomal structural variations (SVs), soft-clipped bases were realigned to the hg19 using BLAT (https://hgwdev.gi.ucsc.edu/~kent/src/). A candidate SV supported by five or more reads with the identical breakpoint was visually interrogated using the Integrative Genomics Viewer (https://software.broadinstitute.org/software/igv/).

Whole-genome sequencing (WGS)

A total of 13 cases were analyzed using WGS. WGS libraries were prepared starting from 50–100 ng of DNA using an NEBNext Ultra II DNA Prep Kit for Illumina (New England Biolabs), according to the manufacturer's instructions. Somatic and germline variants and SVs were detected using the approaches used in WES and TGS. A copy number estimate of 10 kb bin was made simply from the number of reads within the bin divided by the mean coverage of the sample.

Co-occurrence simulation

The probability of co-occurrence of two kinds of genetic alterations was calculated using a Monte-Carlo simulation approach, based on the number of total patients, the number of patients with either of the mutations, and the number of patients with both mutations, as described (21).

Statistics

Statistical analyses were performed using SPSS program

Table 1 Clinical characteristics of 66 Iraqi children with ALL and AML

Acute leukemia type	Variable	Number of patients (%)
ALL (n=55)	Sex	
	Male	36 (65.5)
	Female	19 (34.5)
	Age (years)	
	1–<5	29 (52.7)
	5–<10	19 (34.6)
	≥10	7 (12.7)
	WBC (×10⁹/L)	
	<20	27 (49.1)
	20–<50	9 (16.4)
	≥50	19 (34.5)
	ALL subtypes	
	B-ALL	49 (89.1)
	T-ALL	6 (10.9)
AML (n=11)	Sex	
	Male	8 (72.7)
	Female	3 (27.3)
	Age (years)	
	1–<5	5 (45.5)
	5–<10	1 (9.0)
	≥10	5 (45.5)
	AML subtypes	
	M2	4 (36.3)
	M3 (APL)	5 (45.5)
	M5	1 (9.1)
	M6	1 (9.1)

ALL, acute lymphoblastic leukemia; AML, acute myeloid leukemia; WBC, white blood cell; APL, acute promyelocytic leukemia.

v. 28 (SPSS, IBM Corporation, Armonk, NY, USA). The unpaired Student's t-test was used in determining the significance of differences between two independent groups, and the Mann-Whitney U-test was used for data that were not normally distributed. Chi-square test or Fisher's exact test was used to compare the frequencies of genetic mutations between our cases and those from other countries.

Statistical significance was defined as a P value of <0.05.

Results

Study cohort and design

This study included 49, 6, and 11 cases of B-cell precursor ALL (B-ALL), T-cell precursor ALL (T-ALL), and AML, respectively (*Table 1*). The median age among B-ALL was 4.2 (1–13) years, with a male to female ratio (M/F) of 1.7, meanwhile, the median age among T-ALL cases was 9.3 (3.5–12.8) years, and 5/6 of them were males. The median white blood cell (WBC) count in B-ALL and T-ALL was 16.4 (2.4–181) ×10⁹/L and 280.5 (4.2–700) ×10⁹/L, respectively. The average age and WBC were significantly higher in T-ALL compared to B-ALL, with P values of 0.007 and <0.001, respectively. The 3-year event-free survival (EFS) was 70.9%, and the 3-year overall survival (OS) was 74.5%. In AML, a higher frequency of APL or French-American-British (FAB) AML-M3 morphology (5/11, 45%) was observed, followed by FAB-M2 (4/11, 36%), and one case of M5 and M6. A case of AML-M2 (UPN49) was found to be secondary to chemotherapy or therapy-related AML (s-AML), for a previously cured germ cell tumor.

Either WES (53 cases), or WGS (13 cases) for each patient was performed. Paired tumor (BM specimen at diagnosis) and germline (BM at remission) samples were analyzed for each patient to identify somatic and germline mutations. Additionally, for patients with B-ALL analyzed by WES (40 cases), targeted sequencing was performed to identify fusion genes (Table S1).

Quality assessment of DBS-derived DNA

Since using DBS-derived DNA was unusual for NGS, the performance of our analysis was checked. As a result, an average of 81.0× and 30.3× coverage was obtained in WES and WGS analyses, respectively. The coverage resulted in 97.7% and 97.3% of the coding region covered by 10 or more unique reads, suggesting that DBS-derived DNA can be utilized for NGS.

Somatic mutations

A comprehensive detection of point mutations, small insertions/deletions (indels), copy number variants, and chromosomal SVs was performed in 66 patients with acute
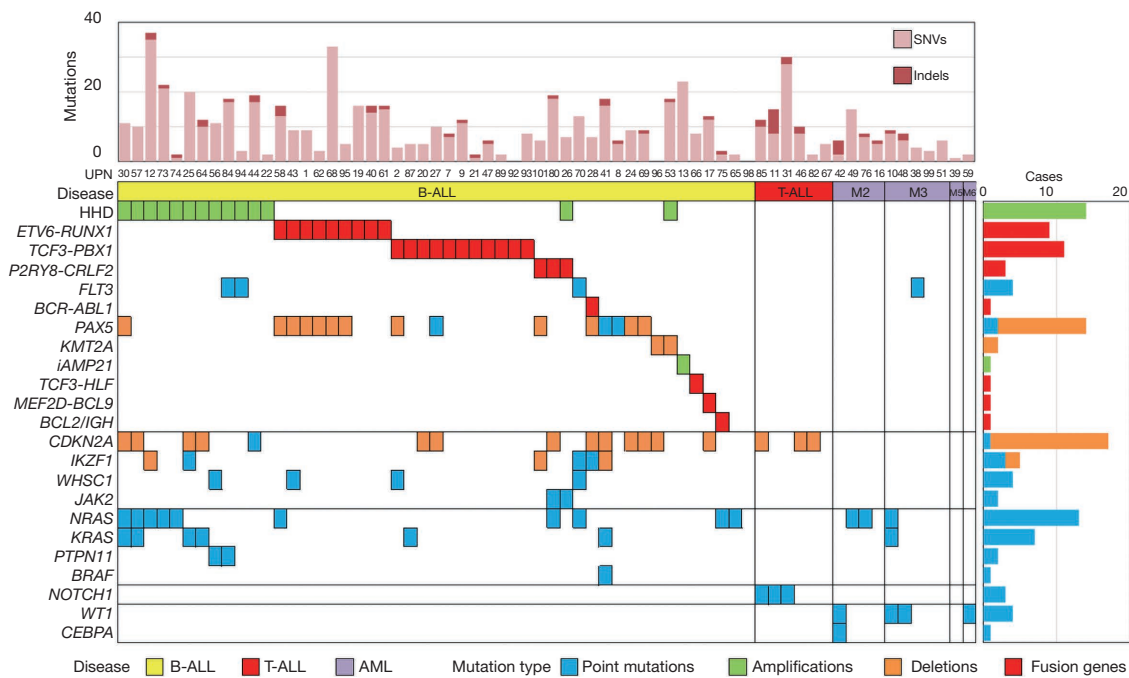
Figure 1 Mutational landscape of childhood acute leukemia in Iraq. Mutational landscape of B-ALL; n=49, T-ALL; n=6, and AML (M2, M3, M5, and M6); n=11. Each column indicates a patient, while each row indicates the kind of mutation. Boxes indicate mutations (blue, point mutations; green, chromosomal amplifications; orange, deletions; red, fusion genes). The bar chart on the top indicates the number of mutations in the coding region. The bars on the right indicate the number of cases with the indicated mutations. SNVs, single nucleotide variants; indels, insertions and deletions; UPN, unique patient number; HHD, high hyperdiploidy; iAmp21, intrachromosomal amplification of chromosome 21; B-ALL, B-cell precursor acute lymphoblastic leukemia; T-ALL, T-cell precursor ALL; AML, acute myeloid leukemia.

leukemia in Iraq (*Figure 1*, Tables S2,S3).

At least one driver mutation in 48 (95%) cases with B-ALL was identified, and accordingly B-ALL cases were classified. In 21 (42%) cases, 2 major subsets of B-ALL, including, high hyperdiploid (HHD) (>50 chromosomes), and *ETV6-RUNX1*, were identified representing 12, and 9 cases, respectively. The pattern of chromosomal amplification in HHD cases and the positions of chromosomal recombination in *ETV6-RUNX1* cases were found to be typical (*Figure 2A,2B*). Surprisingly, *TCF3-PBX1*, which usually constitutes 3–5% of a B-ALL cohort, explained 11 (22.4%) cases. This observation was not caused by cross-contamination of samples, because each patient carried a unique chromosomal breakpoint (*Figure 2C*). Moreover, the fusion gene was frequently associated with the amplification and deletion of chromosomes 1 and 19, respectively (*Figure 2D*). Four Ph-like ALL cases (3 with *P2RY8-CRLF2* and a case with *FLT3*-tyrosine kinase domain mutation) were identified (22), in addition to a Ph-ALL case

with *BCR-ABL1*. Two of the 3 cases with *P2RY8-CRLF2* carried concomitant *JAK2* p.Arg683Gly point mutations. Other classifications were *PAX5* alterations (four cases) (22), *KMT2A* (*MLL*) deletion (two cases), intrachromosomal amplification of chromosome 21 (iAMP21), one case (*Figure 2E*), *TCF3-HLF* fusion (one), *MEF2D-BCL9* fusion (one), and *BCL2-IGH* fusion (one case).

Two cases (UPN65 and UPN98) did not carry any mutation associated with B-ALL classification and thus were classified with B-other ALL. The contamination of tumor in the germline sample or the scarcity of tumor cells in the tumor specimen was considered to explain the absence of classification in these two patients (Table S4).

Some mutations showed co-occurrence within a patient. Both HHD and RAS pathway mutations (*NRAS*, *KRAS*, *PTPN11*, and *BRAF* mutations) were detected in nine patients (P=0.0058) (Table S5). Also, 6/9 patients with *ETV6-RUNX1* carried *PAX5* mutations (P=0.0066).

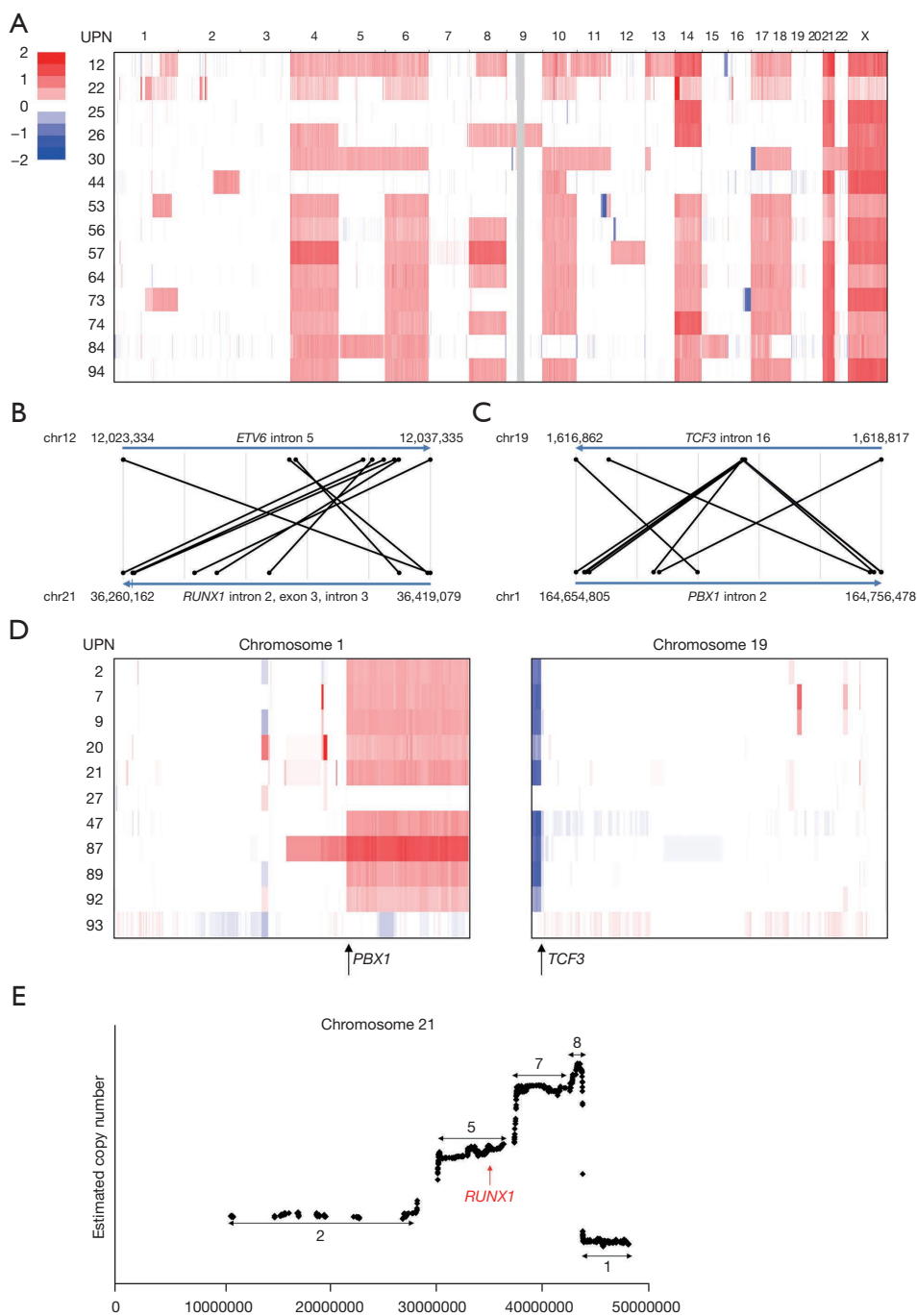In patients with T-ALL or AML, several mutations that

Figure 2 Copy number aberrations and fusion genes in B-ALL in Iraq. (A) Chromosomal copy number alterations in B-ALL patients with HHD. Numbers on the top indicate chromosome numbers. Red and blue indicate amplified and deleted regions, respectively, while grey indicates regions where the copy number could not be determined. (B) Chromosomal breakpoints of B-ALL patients with *ETV6-RUNX1*. Each black line indicates a patient's breakpoints. Numbers indicate the hg19 genomic coordinate. (C) Chromosomal breakpoints of *TCF3-PBX1*. (D) Chromosomal amplification and deletion in chromosomes 1 and 19 in patients with *TCF3-PBX1*, using the same color codes as in (A). The positions of *TCF3* and *PBX1* are indicated by arrows. (E) Intrachromosomal amplification of 21 identified in UPN13. The X- and Y-axes indicate the genomic coordinate and the estimated copy number, respectively. Numbers and arrows also indicate the estimated copy numbers. UPN, unique patient number; B-ALL, B-cell precursor acute lymphoblastic leukemia; HHD, high hyperdiploidy.

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are characteristic of these diseases have been identified. T-ALL carried *NOTCH1*, *PTEN*, *ETV6*, *IL7R*, *RUNX1*, *RPL10*, and *SUZ12* mutations and *CDKN2A* deletions. AML carried *WT1*, *CEBPA*, *FLT3*, *MYC*, *KRAS*, and *NRAS* mutations. Because fusion gene detection was not performed in patients who had these diseases and were analyzed by WES, characteristic fusion genes were mostly not identified in these patients; but at least, *PML-RARA* was detected by WGS in UPN99 with AML-M3 and thus confirmed the PCR result of that patient in Iraq.

The number of somatic point mutations in the coding region was 0–37 (9.9 on average) and was considered comparable with similar diseases in other countries. B-ALL and T-ALL were noted to significantly differ in terms of the number of indels (0.81 *vs.* 2.66 on average, P=0.002), while the small number of T-ALL cases defies its interpretation. The number of indels looked high in several patients (including UPN11 who carried seven indels); however, the number was not statistically significant.

The type of nucleotide alterations of somatic mutations was biased toward C-to-T transitions (40%), suggesting that most somatic point mutations were acquired because of cell division (*Figure 3A*). Indels accounted for 7.5% of the somatic mutations.

The RAS pathway mutations were present in (16/49, 32.7%) of B-ALL cases and (3/11, 27.3%) of AML cases. Thus, in line with our previous reports, *RAS* mutations are prevalent among Iraqi children with acute leukemia compared with that of other countries (23-28). Three patients carried 2 *RAS* pathway mutations in ALL (*NRAS* and *KRAS* in both UPN30 and UPN57, *KRAS* and *BRAF* in UPN41), and one AML case (UPN10) had *NRAS* and *KRAS* mutations.

Germline variations

Germline mutations were analyzed; however, those related to the known inherited diseases were not identified. We also could not point out any pathogenic variants associated with leukemia predisposition. Meanwhile, several drug metabolism-associated SNPs were disclosed for 6-mercaptopurine (6-MP) and methotrexate (MTX) (29-31) (*Figure 3B*). Two SNPs (*ITPA* rs1127354 and *NUDT15* rs116855232) associated with 6-MP toxicity were present with MAF of 0.038, and 0.015, respectively. *MTHFR* rs1801131 (MTHFR-A or c.1298A>C) and rs1801133 (MTHFR-C or c.677C>T), which affect MTX metabolism, were frequent (MAF of 0.409 and 0.265, respectively). As

a result, (23/66, 34.8%) cases of our cohort were affected by 2 or more MTHFR-A/C risk alleles. *SLCO1B1*, another MTX catalyzer, carried several drug metabolism-associated SNPs including rs11045819 (MAF =0.144) and rs4149056 (MAF =0.197). Additionally, it may be notable that *SLCO1B1* was also affected by rare nonsense mutations including rs7158941 (p.Arg580Ter, three patients, MAF =0.023) and p.Trp171Ter (one patient).

ROH was frequently observed in the germline of children with acute leukemia in Iraq, possibly because of consanguinity (*Figure 3C*). In total, (29/66, 43.9%) patients carried at least 1 ROH that had a length of >10 Mb. However, a significant accumulation of ROH could not be identified. At the very least, the lengths of ROH were significantly longer compared with those of Japanese samples [Iraq: 0–392,289,752 bp (70,539,478 bp on average); Japan: 0–148,869,110 bp (8,397,369 bp on average), P=2.6×10^{-6}].

Genetic findings and clinical presentations

Several fusion genes were associated with clinical parameters; 9 patients with *ETV6-RUNX1* fusion gene had a median age of 4 (3–4.75) years, with M/F ratio of 3.5, and a median WBC of 11.7 (4.5–72) ×10^9/L (*Table 2*). The average WBC associated with *ETV6-RUNX1* cases was lower than those B-ALL cases without *ETV6-RUNX1*; however, it was of no significance (22.5 *vs.* 42) ×10^9/L, respectively (P=0.237). Eleven patients with *TCF3-PBX1* fusion gene had a median age of 5.7 (2–12) years, M/F ratio of 4.5, and a median WBC of 52.5 (4.6–152) ×10^9/L. The average WBC in patients with *TCF3-PBX1* was significantly higher than those *TCF3-PBX1*-negative B-ALL cases (63.4 *vs.* 31.2) ×10^9/L, respectively (P=0.033), whereas the average number of somatic mutations per patient associated with *TCF3-PBX1* was significantly lower than those B-ALL cases without *TCF3-PBX1* (5.6 *vs.* 11.9), respectively (P=0.023).

Several drug metabolism-associated SNPs were found to be correlated with adverse effects of chemotherapy (*Table 3*); UPN93, who carried three *MTHFR* risk alleles (heterozygous MTHFR-A and homozygous MTHFR-C), had experienced frequent interruptions in chemotherapy protocol owing to neutropenia or elevated liver function test. Likewise, UPN25, who carried heterozygous NUDT15 and MTHFR-C risk alleles, had recurrent febrile neutropenia and abnormal liver function test, resulting in relapse, and eventually died. Additionally, UPN87, who carried homozygous MTHFR-C, suffered from frequent neutropenia. Finally, UPN80 with heterozygous
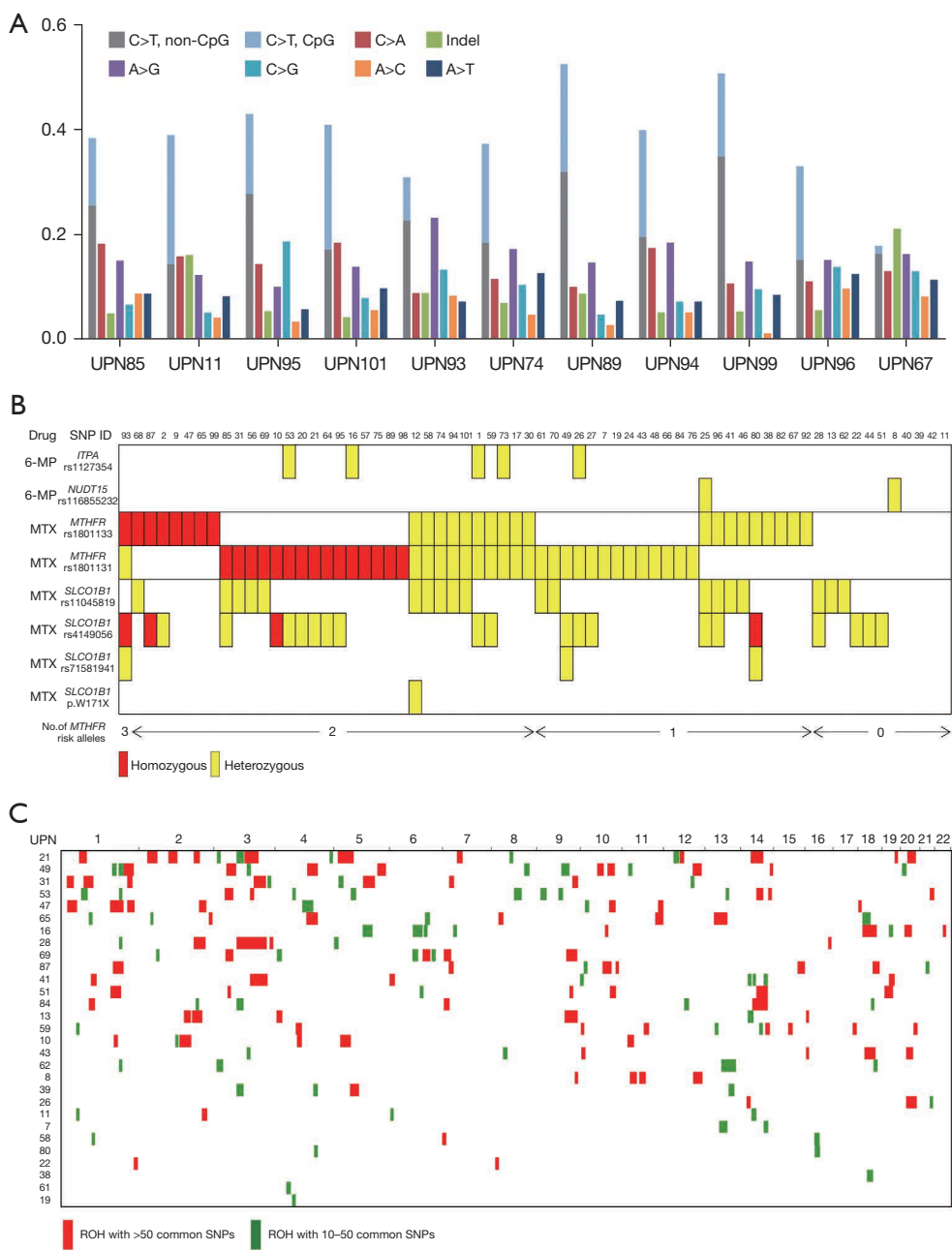
Figure 3 Other genetic findings. (A) Nucleotide alteration patterns of somatic mutations identified using whole-genome sequencing. The result of 11 patients who carried >50 somatic point mutations is presented, sorted in the descending order of total number of mutations. C-to-T transitions were separated into those in the CpG context and those in the non-CpG context. (B) Germline variants associated with drug metabolism. Each column and row indicate a patient and a SNP, respectively. Red and yellow indicate homozygous and heterozygous variants, respectively. The sum of the MTHFR alleles for each patient is also indicated. (C) ROH map. Red and green indicate ROH with >50 and 10–50 common SNPs, respectively. Only patients who carried one or more ROH regions in whole-exome sequencing are visualized. SNP, single nucleotide polymorphism; 6-MP, 6-mercaptopurine; MTX, methotrexate; UPN, unique patient number; ROH, run of homozygosity.

Table 2 Clinical criteria, important genetic aberrations results, and the outcome of 55 Iraqi childhood ALL cases

	Modified UKALL-2011 clinical-based risk factors classification						Genetic aberrations		Notes and outcome****		
UPN/sex	Age (years)	Initial WBC ×10⁹/L	Initial CSF (CNS status)*	Pre-phase steroid response**	Post-induction BMA status	Protocol regimen	ALL classification	Potentially deleterious somatic point mutation	Relapse, site/time in weeks	Death, time of death in weeks/cause	Cured, in continuous CR and others
1/M	4.20	34.07	–	Good	CR by Morph***	A	ETV6-RUNX1		CNS/54		Follow-up
19/M	3.50	11.6	–	Good	CR by Morph	A	ETV6-RUNX1				Follow-up
43/M	4.10	22.4	–	Good	CR by Morph	A	ETV6-RUNX1	WHSC1			On therapy
58/M	4.00	5.1	–	Good	CR by Morph	A	ETV6-RUNX1	NRAS			On therapy
61/F	3.00	11.4	–	Good	CR by Morph	A	ETV6-RUNX1				Follow-up
62/M	3.00	29.8	–	NU	Flow-MRD: 0.005%	A	ETV6-RUNX1				On therapy
68/M	4.00	4.5	–	NU	Flow-MRD: 0.001%	A	ETV6-RUNX1				On therapy
95/F	4.75	11.7	–	Good	CR by Morph	A	ETV6-RUNX1				On therapy
40/F	3.75	72	–	Good	CR by Morph	B	ETV6-RUNX1	U2AF1			Follow-up
44/F	6.10	5.2	–	Good	CR by Morph	A	HHD	CDKN2A, CDKN2A, CHD4			Follow-up
64/F	4.00	7.4	–	NU	Flow-MRD: 0.003%	A	HHD	KRAS			Follow-up
56/F	6.00	2.4	–	Good	CR by Morph	A	HHD	PTPN11, WHSC1			Follow-up
57/M	2.50	11.1	–	Good	CR by Morph	A	HHD	KRAS, NRAS			On therapy
73/M	4.70	5.94	–	Good	CR by Morph	A	HHD	NRAS, IKZF3			On therapy
74/F	6.50	8.32	–	Good	CR by Morph	A	HHD	NRAS			Follow-up
84/F	5.10	16.4	–	NU	CR by Morph	A	HHD	PTPN11, FLT3, ARID5B			Follow-up
94/F	2.75	12.63	–	Good	CR by Morph	A	HHD	FLT3			On therapy
22/F	1.10	9.6	–	Good	CR by Morph	A	HHD			84/infection	
25/F	5.60	5.7	–	Good	CR by Morph	A	HHD	IKZF1, KRAS	BM/111	114/PD	
30/M	7.00	71.5	CNS3	Good	CR by Morph	B	HHD	KRAS, NRAS	BM/166	170/PD	
12/M	10.70	15.8	–	Poor	CR by Morph	B	HHD	NRAS, KMT2D, KMT2D			Follow-up
2/M	5.70	33.7	–	Good	CR by Morph	A	TCF3-PBX1	WHSC1			Follow-up
21/F	7.60	16.6	–	Good	CR by Morph	A	TCF3-PBX1	SETD2			Abandon/12 weeks

Table 2 (*continued*)

Table 2 (*continued*)

| UPN/sex | Modified UKALL-2011 clinical-based risk factors classification | | | | | | Genetic aberrations | | Notes and outcome**** | | |
	Age (years)	Initial WBC ×10⁹/L	Initial CSF (CNS status)*	Pre-phase steroid response**	Post-induction BMA status	Protocol regimen	ALL classification	Potentially deleterious somatic point mutation	Relapse, site/time in weeks	Death, time of death in weeks/cause	Cured, in continuous CR and others
92/M	2.00	4.6	–	Good	CR by Morph	A	TCF3-PBX1		CNS/37		On palliative therapy
7/M	7.00	40.7	–	Poor	CR by Morph	B	TCF3-PBX1				Follow-up
87/M	12.00	6.21	–	Good	CR by Morph	B	TCF3-PBX1	KRAS			On therapy
9/M	4.20	134	–	Good	Not in CR by Morph	C	TCF3-PBX1				Follow-up
89/F	10.00	65.75	–	Good	CR by Morph	B	TCF3-PBX1				Follow-up
93/M	9.90	52.5	–	Poor	CR by Morph	B	TCF3-PBX1				On therapy
20/M	3.40	125	–	Good	CR by Morph	B	TCF3-PBX1				Follow-up
27/M	2.20	152	–	Good	CR by Morph	B	TCF3-PBX1	PAX5			Follow-up
47/M	3.00	66.14	–	Good	CR by Morph	B	TCF3-PBX1	IKZF3	CNS/63	77/infection	
24/M	2.20	14.6	–	Good	CR by Morph	A	PAX5alt	TP53			On therapy
69/M	3.90	89.19	–	Good	CR by Morph	B	PAX5alt				On therapy
41/F	13.00	11.8	–	Good	CR by Morph	B	PAX5alt	KRAS, BRAF, PAX5, XBP1		45/infection	
26/M	2.00	14.4	–	Good	CR by Morph	A	P2RY8-CRLF2	JAK2			On therapy
80/M	3.00	47.4	–	NU	Flow-MRD: 0.001%	A	P2RY8-CRLF2	NRAS, JAK2			On therapy
101/M	4.20	85.07	–	Good	CR by Morph	B	P2RY8-CRLF2				On therapy
70/M	7.40	46.5	–	Good	CR by Morph	A	Ph-like (FLT3)	NRAS, IKZF1, FLT3, WHSC1	BM + CNS/61	92/PD	
53/F	2.90	3.8	–	Good	CR by Morph	A	del(11)(q23)				Follow-up
96/M	3.25	23	–	Poor	CR by Morph	B	del(11)(q23)				On therapy
28/M	6.80	144	CNS3	Good	CR by Morph	B	BCR-ABL1	IKZF1			Follow-up
75/F	7.75	3.7	–	Good	CR by Morph	A	BCL2-IGH	NRAS	CNS/111	112/PD	
66/F	13.00	4	–	NU	Flow-MRD: 0.009%	B	TCF3-HLF		BM/101	102/PD	
13/M	3.60	58.3	–	Good	CR by Morph	B	iAMP21	BCORL1, CSF3R	BM/118	149/PD	

Table 2 (*continued*)

Table 2 (*continued*)

UPN/sex	Modified UKALL-2011 clinical-based risk factors classification						Genetic aberrations		Notes and outcome****		
	Age (years)	Initial WBC ×10⁹/L	Initial CSF (CNS status)*	Pre-phase steroid response**	Post-induction BMA status	Protocol regimen	ALL classification	Potentially deleterious somatic point mutation	Relapse, site/time in weeks	Death, time of death in weeks/cause	Cured, in continuous CR and others
17/M	7.40	30.15	–	Good	CR by Morph	A	MEF2D-BCL9	ARID1A	BM + CNS/47	113/PD	
8/F	7.11	181	CNS3	Good	CR by Morph	B	B-other ALL	PAX5			Follow-up
65/M	1.00	51	–	NU	Flow-MRD: 0.02%	B	B-other ALL	NRAS			On therapy
98/M	8.00	3.16	–	Poor	Not in CR by Morph	C	B-other ALL			24/PD	
11/M	9.20	73	–	Poor	CR by Morph	B	T-ALL	NOTCH1, ETV6, IL7R			Follow-up
46/M	3.50	563	–	Poor	CR by Morph	B	T-ALL	PTEN		43/infection	
67/F	8.00	4.2	–	NU	Flow-MRD: 0.001%	B	T-ALL				Follow-up
82/M	10.60	700	CNS3	NU	CR by Morph	B	T-ALL		CNS/45	53/PD	
85/M	12.80	111	–	Good	CR by Morph	B	T-ALL	NOTCH1, RPL10			Follow-up
31/M	9.40	450	–	Good	CR by Morph	B	T-ALL	NOTCH1, RUNX1, SUZ12, SUZ12			On therapy

*, CNS status, CNS3 defined as CSF of >5 WBC/µL and cytospin positive for blasts; **, a seven-day pre-phase steroid response defined as a drop in peripheral blasts count of <1.0×10⁹/L at day 8; ***, CR by Morph, BM blasts <5% with normal hematopoietic recovery; ****, no patient had testicular involvement at initial diagnosis, and no case in our cohort had Down syndrome. ALL, acute lymphoblastic leukemia; UPN, unique patient number; WBC, white blood cells; CSF, cerebrospinal fluid; CNS, central nervous system; BMA, bone marrow aspirate; CR, complete remission; M, male; Morph, morphology; F, female; NU, not used; Flow-MRD, flow cytometry based-minimal residual disease; HHD, high hyperdiploidy; BM, bone marrow; PD, progressive disease.

Table 3 Drug metabolism-associated SNPs of 55 Iraqi childhood ALL cases and related clinical notes

UPN/ sex	Age (years)	Drug metabolism-associated SNPs								Clinical notes of drug toxicity
		Methotrexate						6-mercaptopurine		
		SLCO1B1				*MTHFR*		*ITPA*	*NUDT15*	
		rs4149056	*rs11045819*	*rs71581941*	*p.W171X*	*rs1801131*	*rs1801133*	*rs1127354*	*rs116855232*	
1/M	4.20	het	–	–	–	het	het	het	–	
19/M	3.50	–	–	–	–	het	–	–	–	
43/M	4.10	–	–	–	–	het	–	–	–	
58/M	4.00	–	het	–	–	het	het	–	–	
61/F	3.00	–	het	–	–	het	–	–	–	
62/M	3.00	–	het	–	–	–	–	–	–	
68/M	4.00	–	het	–	–	–	hom	–	–	
95/F	4.75	het	–	–	–	hom	–	–	–	
40/F	3.75	–	–	–	–	–	–	–	–	
44/F	6.10	het	–	–	–	–	–	–	–	
64/F	4.00	het	–	–	–	hom	–	–	–	MTX toxicity
56/F	6.00	–	het	–	–	hom	–	–	–	
57/M	2.50	–	–	–	–	hom	–	–	–	
73/M	4.70	–	–	–	–	het	het	het	–	
74/F	6.50	–	het	–	–	het	het	–	–	
84/F	5.10	–	–	–	–	het	–	–	–	
94/F	2.75	–	het	–	–	het	het	–	–	
22/F	1.10	het	–	–	–	–	–	–	–	
25/F	5.60	het	het	–	–	–	het	–	het	Frequent FN, abnormal LFT and jaundice
30/M	7.00	–	–	–	–	het	het	–	–	
12/M	10.70	–	het	–	het	het	het	–	–	
2/M	5.70	het	–	–	–	–	hom	–	–	
21/F	7.60	het	–	–	–	hom	–	–	–	
92/M	2.00	–	–	–	–	–	het	–	–	
7/M	7.00	–	–	–	–	het	–	–	–	
87/M	12.00	hom	–	–	–	–	hom	–	–	Recurrent neutropenia
9/M	4.20	–	–	–	–	–	hom	–	–	
89/F	10.00	–	–	–	–	hom	–	–	–	
93/M	9.90	hom	–	het	–	het	hom	–	–	Recurrent neutropenia/and elevated LFT

Table 3 (*continued*)

Table 3 (*continued*)

UPN/ sex	Age (years)	Drug metabolism-associated SNPs								Clinical notes of drug toxicity
		Methotrexate						6-mercaptopurine		
		SLCO1B1				*MTHFR*		*ITPA*	*NUDT15*	
		rs4149056	*rs11045819*	*rs71581941*	*p.W171X*	*rs1801131*	*rs1801133*	*rs1127354*	*rs116855232*	
20/M	3.40	het	–	–	–	hom	–	–	–	
27/M	2.20	het	–	–	–	het	–	–	–	
47/M	3.00	–	–	–	–	–	hom	–	–	
24/M	2.20	–	–	–	–	het	–	–	–	
69/M	3.90	–	het	–	–	hom	–	–	–	
41/F	13.00	–	het	–	–	–	het	–	–	
26/M	2.00	het	–	–	–	het	–	het	–	
80/M	3.00	hom	–	het	–	–	het	–	–	MTX toxicity
101/M	4.20	–	het	–	–	het	het	–	–	
70/M	7.40	–	het	–	–	het	–	–	–	
53/F	2.90	het	–	–	–	hom	–	het	–	
96/M	3.25	het	het	–	–	–	het	–	–	
28/M	6.80	het	het	–	–	–	–	–	–	
75/F	7.75	–	–	–	–	hom	–	–	–	
66/F	13.00	–	–	–	–	het	–	–	–	MTX toxicity? Frequent neutropenia
13/M	3.60	–	het	–	–	–	–	–	–	
17/M	7.40	–	–	–	–	het	het	–	–	
8/F	7.11	–	–	–	–	–	–	–	het	
65/M	1.00	–	–	–	–	–	hom	–	–	
98/M	8.00	–	–	–	–	hom	–	–	–	
11/M	9.20	–	–	–	–	–	–	–	–	
46/M	3.50	–	het	–	–	–	het	–	–	
67/F	8.00	–	–	–	–	–	het	–	–	
82/M	10.60	–	–	–	–	–	het	–	–	
85/M	12.80	het	het	–	–	hom	–	–	–	
31/M	9.40	–	het	–	–	hom	–	–	–	

SNPs, single nucleotide polymorphism; ALL, acute lymphoblastic leukemia; UPN, unique patient number; M, male; het, heterozygous; F, female; hom, homozygous; MTX, methotrexate; FN, febrile neutropenia; LFT, liver function test.

MTHFR-C and UPN64 with homozygous MTHFR-A had been complaining from MTX toxicity, with delay in their treatment progress.

Discussion

The use of FTA cards for conventional molecular analysis including PCR and Sanger sequencing for Iraqi pediatric acute leukemia was previously reported (12-14,18). Whereas in this study, and for the first time NGS was utilized for illustrating the landscape of genetic mutations in a series of Iraqi children with acute leukemia.

Our results disclosed apparent differences in some genetic aberrations, including the unusually high frequency of *TCF3-PBX1* fusion gene in ALL (22.4%) and the prevalent APL in AML (45.5%), along with the high frequency of *RAS* signaling pathway mutations in both ALL (38.8%) and AML (36.4%). Less frequent, however, still comparable results were detected with *ETV6-RUNX1* (18.4%), *PAX5alt* (6.1%), and Ph-like ALL (8.2%) compared to those in the developed world. While HHD (24.5%), *BCR-ABL1* (2%), *iAMP21* (2%), *KMT2A* (*MLL*) deletion (2%), *MEF2D-BCL9* (2%), and *TCF3-HLF* (2%), were similar to those in other studies (19,22,32).

Risk stratification of our cohort according to the clinical characteristics set in the modified UKALL-11 protocol (10) assigned (28/55, 51%) as good risk group eligible for regimen-A treatment plan. Although a total of (32/55, 58.2%) cases carried the favorable risk according to genetic subsets made of *ETV6-RUNX1*, HHD, and *TCF3-PBX1*, the stepwise risk refinements, by combining the data, had recognized only (20/55, 36.4%), with the favorable prognostic criteria. Among them, (18/20, 90%) were in continuous complete remission, whether finished or still under treatment, albeit 1 died from infection before completing the therapy. As a result, the 3-year EFS was 70.9%, and the 3-year OS was 74.5%.

One of the striking observations of this study is the unprecedented high frequency of B-ALL cases possessing *TCF3-PBX1* fusion gene associated with the translocation t(1;19)(q23;p13), (11/49, 22.4%). Abundance of *TCF3-PBX1* in the current cohort is significantly higher than several studies from different ethnicities and countries, ranging from 3% to 7.2% (33-37), including our previous report of (11/264, 4.2%) in pediatric ALL in Iraq (18). Arguably, there might be an underestimation of the frequency of *TCF3-PBX1* using the DBS-derived RNA in our previous study compared to DNA. Also, in the previous study the cases were not defined whether

of B or T-ALL subtype. Notably, although the number of cases in this study is fewer, our current results are supported both by the chromosomal breakpoints and copy number changes of chromosomes (1 and 19). In fact, our frequency was significantly higher than neighboring Arab countries; Saudi Arabia of 3.4% (38), and Palestine of 7.3% (39), as well as than the Middle Eastern countries of 6.2% (40). Remarkably, *TCF3-PBX1* incidence in this report is higher even than that of the African-American B-ALL cases of 16.3% and the Mexican of 14.6% (4,33).

Among AML cases, APL subtype was recurrent (5/11, 45.5%) representing about half of our AML cohort. Of note, frequencies of (9/26, 35%) and (24/134, 18%) of APL among Iraqi children with AML were reported by Testi *et al.*, and Al-Kzayer *et al.* (based on molecular diagnosis), respectively (14,15). Interestingly, APL seems to be a prevalent AML subtype in Iraq, and records from adolescents and adults in locally published study over 5-year period in a single center at Sulaymaniyah province by Tawfiq *et al.* (41) showed that APL represented 25.5% of the total AML cases. Indeed, compared to nearby Middle Eastern countries, our frequency is yet higher than that in Saudi Arabia, Israel, Oman, and Iran, which is 3.4%, 8%, 13%, and 16%, respectively (5). Our incidence was also higher than Japan (9%) and other international registries including the United States (5–10%) and Switzerland (2%) (5).

In agreement with our previous work (12,13), in B-ALL, the most frequent somatic mutations were those in the RAS signaling pathway made up of 10 *NRAS*, 6 *KRAS*, 2 *PTPN11*, and 1 *BRAF*, which were detected in (16/49, 32.7%), including 3 with double mutations. Compared to literature, the overall somatic *RAS* signaling pathway mutations of around 39% in Iraqi children with ALL are among the highest reported frequencies. Our incidence was comparable to that reported by Case *et al.* (42) with overall mutations of (26/86, 30%) of childhood ALL cases, provided that *FLT3* mutations were excluded from their results. Moreover, our frequency was higher than those reported by Liang *et al.* (24), with overall *RAS* mutations of (122/530, 23%) of B-ALL Taiwanese pediatric cohort (P=0.16), and by Zhang *et al.* (23), with overall mutations of (24/114, 21.1%) in 23 Chinese children with B-ALL (P=0.1). *RAS* mutations were reported in less frequency of 15–20% in previous studies among childhood ALL (25-28). Wiemels *et al.* elucidated that *RAS* mutation frequency among Hispanics was > twice compared to non-Hispanic whites, of 28%, and 13%, respectively, in their cohort, and that HHD-associated *RAS* mutations were 30%; while, in

our series, the latter was 75% (28).

Numerous researchers had investigated the role of environmental exposure to chemicals, including hydrocarbons, and the risk factors behind childhood acute leukemia. Moreover, *RAS* oncogene was linked to hydrocarbons and other environmental insults. However, whether such association is causal in fact or not remains unclear (7,12,25,28,43).

Iraq was exposed to environmental and chemical hazards that carried potential health risks during repeated wars. Furthermore, the chaotic situation that characterized Iraq, as a consequence of repeated wars, and the damaged infrastructures had resulted in an ongoing process of undifferentiated water and air pollution, with a negative impact on several health aspects in Iraq, including cancer (9,11,12,25,44).

Although racial, ethnic, and geographic differences in the frequency of molecular markers of childhood ALL are widely of concern, the distinct biological difference in the genetics of Iraqi childhood acute leukemia, which varies even with the surrounding countries and sometimes in a significant manner, despite the ethnic similarity, may emphasize the concept of the environmental impact, especially considering Iraq has a war zone environment.

Conclusions

Apart from disclosing the high frequency of *TCF3-PBX1*, NGS confirmed our previous finding of recurrent *RAS* mutations in Iraqi childhood acute leukemia. Our results suggest that the biology of Iraqi childhood acute leukemia is in part characteristic, where the war-aftermath environment or geography might play a role. Given the environmental differences in respect to the above complicated status of Iraq, our findings maybe of special interest to encourage more studies enrolling more ALL/AML cases from Iraq to focus on this issue.

Acknowledgments

Footnote

Reporting Checklist: The authors have completed the MDAR reporting checklist. Available at https://tp.amegroups.com/article/view/10.21037/tp-22-512/rc

Data Sharing Statement: Available at https://tp.amegroups.com/article/view/10.21037/tp-22-512/dss

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at https://tp.amegroups.com/article/view/10.21037/tp-22-512/coif). The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The research work was approved by the Ethical Committee of Shinshu University School of Medicine (No. 622/2020), Nagoya University Graduate School of Medicine (No. 18185/2020), and by the Ministry of Health in Iraq (No. 2553/2018). All methods were carried out in accordance with relevant guidelines and regulations and informed consent was obtained from all subjects and/or their legal guardian(s).

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