Simultaneous occurrence of Epstein-Barr virus associated Hodgkin’s disease and HHV-8 related multicentric Castleman’s disease: a fortuitous event?

E Caussinus, F Meggetto, G Delsol, P Brousset

Abstract

Previous serological or molecular studies by means of the polymerase chain reaction have failed to show an association between classic Hodgkin’s disease (HD) and human herpesvirus 8 (HHV-8). Using immunohistochemistry, this study re-examines (with anti-LNA1 antibody) the possible association of HHV-8 with HD, particularly in human immunodeficiency virus (HIV) infected patients. HHV-8 was not detected in the Reed Sternberg cells of the cases examined (33 HIV negative and 17 HIV positive), thus confirming the lack of involvement of HHV-8 in HD. Interestingly, a case of HHV-8 positive multicentric Castleman’s disease was associated with Epstein-Barr virus positive HD in the same lymph node, which was probably a fortuitous occurrence.

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Human herpesvirus 8 (HHV-8), also referred to as Kaposi’s sarcoma herpesvirus, is a human herpesvirus recently identified by representational difference analysis that isolated genomic differences between Kaposi’s sarcoma (KS) cells and normal skin tissue. HHV-8 sequences have been detected by Southern blot or the polymerase chain (PCR) reaction in more than 90% of patients with KS, both those with and those without human immunodeficiency virus (HIV) infection (see Dupin et al and references therein). HHV-8 sequences have also been detected in AIDS related, body cavity based lymphomas (also designated as primary effusion lymphoma) and multicentric Castleman’s disease (see Dupin et al and references therein). Despite some cases of post transplant lymphomas or plasmablastic lymphomas associated with multicentric Castleman’s disease, it has not been possible to show a clear association between HHV-8 and other lymphoid tumours.

In immunocompetent patients, classic Hodgkin’s disease (HD) is associated with Epstein-Barr virus (EBV) in approximately 50% of cases, whereas the incidence of EBV infection is close to 100% in HIV positive patients with HD. Previous serological or molecular studies (using PCR) have failed to show an association between HHV-8 and HD, and to our knowledge, immunohistochemistry has not been used for this purpose.

Thus, using immunohistochemistry with a monoclonal antibody against LNA1 (a latent nuclear antigen of HHV-8 encoded by viral open reading frame 73) we have re-examined the possibility that HHV-8 is associated with HD, at least in a small subset of cases. LNA1 appears to be a reliable marker for HHV-8 latent or lytic infection because it is constitutively expressed in vitro and in vivo and detectable by immunohistochemistry in all HHV-8 infected cells. We investigated 50 cases of classic HIV positive and HIV negative HD. We included a case of HHV-8 positive multicentric Castleman’s disease associated with EBV positive HD in an HIV infected patient, which provides additional information to the case reports of an association between Castleman’s and Hodgkin’s disease (Abdel-Reheim et al and references therein).

Material and methods

Lymph node biopsy specimens from 50 patients with classic HD were examined. The specimens were fixed in Dubosq Brasil liquid (acetic acid, 6.6%; 80% ethyl alcohol, 65.8%; 40% formol, 26.3%; picric acid, 0.4%; distilled water to 100%) or in 4% formol saline, and then routinely embedded in paraffin wax. The histopathological diagnosis of HD and HD subtype, and the EBV status of Reed Sternberg (RS) cells were based on immunomorphological criteria using anti-CD15 (clone C3D-1), anti-CD30 (clone Ber-H2), anti-epithelial membrane antigen (clone-EMA; clone E29), anti-latent membrand protein 1 (anti-LMP1; clone CS 1-4), anti-CD20 (clone L26), and anti-CD3 (clone T3) antibodies (Dako, Trappes, France).

The first series of lymph node biopsies came from 33 HIV negative patients: 17 cases of mixed cellularity HD (MCHD), 16 cases of nodular sclerosing HD (NSHD); age range, 21–82 years; male to female ratio, 14 : 19; 14 of these 33 cases were EBV positive.

The second series of lymph node biopsies came from 17 HIV infected patients: 15 cases of MCHD, two cases of HD difficult to subtype; age range, 10–45 years; male to female ratio, 16 : 1; 15 of these 17 cases were EBV associated. One of these patients presented with features of both HD and multicentric Castleman’s disease in the same lymph node.

The presence of HHV-8 was investigated in all cases by standard immunohistochemical
The biopsy from the patient with monoclonal antibody anti-LNA1 (clone LN53).23 The biopsy from the patient with monoclonal antibody anti-LNA1 (clone LN53), peroxidase (brown); original magnification, ×1000.

**Results and discussion**

We could not detect HHV-8 LNA1 protein in RS cells in the cases examined, thus confirming by immunohistochemistry the lack of involvement of HHV-8 in HD, irrespective of the patient's viral status. The lack of HHV-8 in EBV negative HD in HIV negative patients is well documented.4 The lack of association of EBV and HHV-8 in HIV positive patients indicates the involvement of different mechanisms of lymphomagenesis from that seen in AIDS related body cavity based lymphomas, the only known pathology involving both EBV and HHV-8 (see Dupin et al and references therein4). Furthermore, the lack of an association of HHV-8 in rare EBV negative HD seen in HIV positive patients (two cases in our study) reinforces the findings of our study.

To our knowledge, HHV-8 positive multicentric Castleman's disease associated with EBV-positive HD in an HIV infected patient has not been documented. Our study includes one such case; the patient was a 27 year old homosexual man with asymptomatic HIV infection diagnosed in 1992. He presented in 1995 with a six month history of fever. Physical examination revealed enlarged cervical lymph nodes; the spleen tip was palpable 4 cm below the costal margin. Computer tomography showed retroperitoneal lymphadenopathy. EBV positive HD (stage IIIb) and multicentric Castleman's disease were diagnosed on examination of an enlarged cervical lymph node. Treatment with eight cycles of ABVD (doxorubicin, bleomycin, vinblastine, and dacarbazine) and adjuvant irradiation could not control the progression of his HD and the patient died in 1997 from his lymphoma.

Morphologically, the cell populations infected with HHV-8 and with EBV were distinct and localised in different areas of the same lymph node. One area showed features of Castleman's disease with follicular hyperplasia associated with an “onion bulb” aspect of reticular dendritic cells and an interfollicular vascular proliferation. The periphery of the follicle contained a population of plasma cell-like elements infected by HHV-8 (LNA1+, LMP1−), some of which are close to the follicle (with many binucleated and multinucleated atypical cells and diagnostic Reed Sternberg cells). No such lymphoma cell was infected by HHV-8 (LNA1−) (fig 1). This result appears to be specific because LNA1, which is detectable using immunohistochemistry with high sensitivity,9 is a specific marker of HHV-8 latent or lytic infection. Conversely, no HHV-8 infected cell was seen to be infected by EBV (fig 1). It is probable that, in our case, both multicentric Castleman's disease and HD are related to the underlying immunodeficiency. However, these results imply that the association of multicentric Castleman's disease and HD was merely fortuitous.

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