Original Article

Thymidine phosphorylase expression and stromal vascularity in ductal carcinoma in situ of the breast

N B Teo, B S Shoker, C Jarvis, J P Sloane, C Holcombe

Aims: Periductal angiogenesis in ductal carcinoma in situ is associated with an increased risk of subsequently developing a recurrence. This study aimed to (1) identify the relation between periductal and stromal vascularity and recurrence and (2) determine whether thymidine phosphorylase (TP) is associated with angiogenesis or recurrence in ductal carcinoma in situ (DCIS).

Methods: Twenty cases of DCIS that did not subsequently recur, 20 that developed a subsequent in situ recurrence, and 12 that developed a subsequent invasive recurrence were investigated. Periductal and stromal (hotspot) microvessel density were determined quantitatively using antibodies to CD34 and von Willebrandt factor (vWF). TP expression by DCIS was assessed semiquantitatively using the H score method.

Results: Stromal and periductal microvessel density assessed by anti-vWF gave similar mean values, and showed a strong positive correlation. When angiogenesis was assessed with anti-CD34 this association was lost. Not only were the mean values for both types of microvessel density higher than those obtained with anti-vWF, but the periductal microvessel density was significantly greater than the stromal microvessel density. TP expression was associated with stromal microvessel density assessed with anti-vWF, but not with anti-CD34. TP expression was not related to recurrence. No significant difference was identified in TP expression or stromal vascularity in DCIS between cases that recurred as DCIS and those that recurred as invasive carcinoma.

Conclusions: Recurrent in situ or invasive disease after excision of DCIS does not appear to be related to stromal microvessel density or to TP expression by DCIS cells.

Materials and Methods

Patients and tumours (table 1) Records from 355 patients with DCIS in the Merseyside region were examined. Thirty two patients were identified who were known to have subsequently developed recurrent disease, 20 as recurrent DCIS and 12 as recurrent invasive carcinoma. In addition, 20 cases of DCIS with no history of recurrence after initial treatment were retrieved. These 20 cases had similar clinical and histological features, in addition to initial treatment. Histological features included nuclear grade, pathological grade, tumour size, and excision margin (table 1). We used the same cases in our previous study. The original haematoxylin and eosin stained sections were reviewed by two pathologists (BSS and JPS) for classification following the guidelines of the European Commission and the UK National Breast Screening Programme. A representative block for each patient was selected for subsequent immunostaining.

Immunohistochemistry Sections were stained using monoclonal anti-CD34 (Qbend/10; Dako, Glostrup, Denmark) and polyclonal antihuman von Willebrandt factor (anti-vWF; Dako). These two antibodies were chosen because in a previous study they had been shown to detect different subpopulations of blood vessels.

Abbreviations: BSA, bovine serum albumin; DCIS, ductal carcinoma in situ; IMS, industrial methylated spirits; MVD, microvessel density; TBS, Tris buffered saline; TP, thymidine phosphorylase; VEGF, vascular endothelial growth factor; VEGFR, vascular endothelial growth factor receptor; vWF, von Willebrandt factor
An antibody to TP was also used (Clone P-GF.44C; NeoMarkers, Freemont, California, USA). Sections were dewaxed through two changes of xylene and industrial methylated spirits (IMS). Endogenous peroxidase activity was blocked with a mixture of H₂O₂/methanol (12 ml H₂O₂ in 400 ml methanol) for 12 minutes. Antigen retrieval was performed for the endothelial markers by treating the sections with 0.2 g of trypsin and 0.4 g of calcium chloride in 440 ml Tris buffered saline (TBS; 50mM Tris/HCL, 150mM NaCl, pH 7.4) at 37˚C for 20 minutes. A pretreatment was not required for the TP antibody. Before staining with the polyclonal antiserum, sections were treated with a mixture of 5% bovine serum albumin (BSA)/TBS for 10 minutes. The antibodies were diluted 1/20 for anti-CD34, 1/100 for anti-TP, and 1/1000 for anti-vWF in 5% BSA/TBS. The sections were incubated with the primary antibodies at room temperature for 40 minutes. Secondary antibodies were incubated for 40 minutes using EnVision labelled polymer (mouse or rabbit as appropriate). Sections were washed with TBS between incubation steps. 3,3-Diaminobenzidine was used as a chromogen. The last two steps were carried out using a commercial kit (EnVision™ System; Dako, Carpenteria, California, USA).

The nuclei were counterstained with haematoxylin solution. The sections were dehydrated through four changes of IMS and three changes of xylene before being mounted in resinous mountant (DPX; BDH Laboratory Supplies, Poole, Dorset, UK). Omission of the primary antibody was used as a negative control and a case of DCIS with known endothelial and TP staining was used as a positive control for each batch of immunohistochemistry.

### Assessment of tumour periductal vascularity

Periductal vascular density evaluation required the assessment of completely transected ducts involved by DCIS. Counting started from the upper right of all stained sections, moving downwards and to the left. All or the first 50 foci encountered were assessed on each section. The area of each individual focus of DCIS was measured at ×200 magnification using an image analysis system (Zeiss Axiohome with software version 3.0; Germany). In addition, the area with a circumference 100 µm from the edge of an individual focus of DCIS was measured. The area required for MVD assessment was thus calculated by subtracting the first measurement from the second. The microvessels within the appropriate area around each DCIS focus were then counted at high magnification (×400). Eligible microvessels included any immunostained endothelial cell or cluster of cells around a visible lumen clearly separated from adjacent microvessels, tumour cells, and other connective tissue components. The presence of red blood cells was not required. It was not possible to distinguish blood and lymphatic vessels. Where vessels were in clusters, each was counted as separate if it met the above criteria. The highest periductal MVD around a single duct and the mean periductal MVD for the section were then calculated.

### Assessment of tumour stromal vascularity

Microvessel counts were determined as described by Weidner et al. Areas with high vascularisation were identified by scanning the sections at low power (×40 magnification). Only those stromal areas at least 1 mm from the edge of the nearest tumour were assessed. Up to 30 high power fields (magnification, ×200; field size, 0.32 mm²) were examined. The five highest counts were recorded and the hotspot (highest) MVD, the mean of the three highest counts, and the mean of the five highest counts were calculated. However, the results obtained with the three different counts were similar.

### Assessment of TP expression

Sections were examined at ×40 and ×100 magnification. TP expression in DCIS cells was both cytoplasmic and nuclear, with the cytoplasmic form predominating. Nuclear and

| Table 1 | Clinical and pathological data from the three groups of patients with ductal carcinoma in situ |
|-----------------------------------------------|
| Non-recurrence | In situ recurrence | Invasive recurrence |
| Number of patients | 20 | 20 | 12 |
| Age (years) | | | |
| Range | 49–87 | 45–78 | 43–82 |
| Mean | 66.2 | 65.6 | 63.3 |
| Follow up (months) | | | |
| Range | 29–138 | 9–98 | 7–52 |
| Mean | 94 | 43 | 48 |
| Death | 2 (both not related to breast cancer) | 0 | 1 (died of breast cancer) |
| Surgery | | | |
| Wide local excision | 18 | 20 | 10 |
| Mastectomy | 2 | 0 | 2 |
| Adjuvant treatment | | | |
| None | 9 | 9 | 5 |
| Hormone | 11 | 11 | 7 |
| Radiotherapy | 0 | 0 | 0 |
| Others | 0 | 0 | 0 |
| Nuclear grade | | | |
| Low | 4 | 3 | 4 |
| Intermediate | 4 | 6 | 2 |
| High | 12 | 11 | 6 |
| Size (mm) | | | |
| Range | 1–65 | 5–20 | 1–22 |
| Mean | 17 | 13 | 12 |
| No of cases not assessable | 0 | 9 | 3 |
| Excision margin (mm) | | | |
| <1 | 7 | 5 | 3 |
| 1< to 10 | 4 | 4 | 0 |
| >10 | 5 | 4 | 3 |
| No of cases not assessable | 4 | 8 | 6 |
cytoplasmic staining were both counted as evidence of positive staining. An H score for each section was then calculated. This was produced by multiplying the percentage of cells staining with each individual intensity score (0, negative; 1, weak; 2, intermediate; and 3, strong) and then adding the numbers together to produce a score ranging from 0 to 300.

The data were analysed by means of the non-parametric Mann Whitney and Kruskal Wallis tests and Spearman’s and Pearson’s correlation coefficients using SPSS Version 10.0 software for Windows 97/NT.

RESULTS
Table 1 summarises the clinical and histological details of the 52 cases of DCIS studied. All the cases studied are retrospective cases and thus the size or excision status could not be evaluated in all the cases.

Comparison of periductal and stromal MVD vWF
The mean stromal MVD and the mean periductal MVD were both 160 vessels/mm². A strong positive correlation was identified between stromal and periductal density, regardless of how measured (for example, hotspot, mean of three highest stromal counts, mean of five highest stromal counts, highest periductal density, or mean periductal density). The weakest correlation was between hotspot and mean periductal MVD (Pearson: lowest r = 0.464; highest p < 0.001).

There was no significant correlation between nuclear grade and stromal or periductal MVD in the entire group of DCIS cases (Spearman: lowest p = 0.3). No significant difference was identified in stromal vascularity between DCIS cases that did and did not subsequently recur, either as DCIS or as invasive carcinoma (Mann-Whitney: lowest p = 0.9).

CD34 (figs 1 and 2)
The mean stromal MVD was 182 vessels/mm² and was higher than that seen for vWF (Mann-Whitney: p = 0.037). The mean periductal density was 210 vessels/mm² and was again higher than that seen for vWF (Mann-Whitney: p < 0.001). Furthermore, in contrast to that seen for vWF, the periductal MVD was significantly higher than the stromal MVD, regardless of how measured (Mann-Whitney: highest p = 0.037). Unlike staining with the anti-vWF antibody, there was no significant correlation noted between stromal and periductal vascularity when the anti-CD34 antibody was used (Pearson: lowest p = 0.1).

There was also no significant correlation between nuclear grade and periductal or stromal vascularity (Spearman: lowest p = 0.4). This finding was again similar to that seen with the anti-vWF antibody. In addition, there was no significant difference in stromal vascularity between DCIS cases that did and did not recur, either as DCIS or invasive carcinoma, after initial treatment (Mann-Whitney: lowest p = 0.5).

TP staining in DCIS (figs 3 4, and 5)
When the H scores for TP staining were compared between cases of DCIS that subsequently recurred or did not recur, either as DCIS or invasive carcinoma, no difference was identified (Mann-Whitney: p = 0.181). A negative correlation was seen between the TP H score and DCIS nuclear grade (Spearman: r = 0.292; p = 0.049). The TP H score correlated with stromal (Pearson: highest p = 0.033) but not periductal (Pearson: lowest p = 0.091) vWF MVD. In contrast, for CD34, no significant correlation was identified between the TP H score and stromal or periductal vascularity (Pearson: lowest p = 0.598).

DISCUSSION
Angiogenesis is thought to play an important role in the progression of invasive cancer. Angiogenesis is also thought to play a role in the development of hyperplastic and other precancerous lesions. Two vascular patterns have been described in DCIS, a diffuse stromal increase and an increase in periductal blood vessels. An increase in periductal MVD is seen in 23–62% of DCIS cases. Our previous study showed that an increase in periductal MVD around DCIS predicts the development of a recurrence, particularly an invasive
and nuclear grade in all cases of ductal carcinoma in situ. HNG, high nuclear grade; ING, intermediate nuclear grade.

Figure 4 Relation between thymidine phosphorylase (TP) expression and nuclear grade in all cases of ductal carcinoma in situ. HNG, high nuclear grade; ING, intermediate nuclear grade.

Figure 5 Relation between thymidine phosphorylase (TP) expression and clinical outcome.

Although thymidine phosphorylase expression may play a role in the development and progression of invasive breast cancer, it does not appear to be important in the development of disease recurrence following treatment for ductal carcinoma in situ.

There is some evidence to suggest that TP expression in invasive breast cancer correlates with MVD and may have prognostic value, although other studies have not found this to be the case. TP has also been shown to correlate with the relapse rate in DCIS, although the same study did not show a significant correlation between relapse-free survival and TP expression. In our present study, when the H scores for TP expression were compared between patients who did or did not subsequently develop a recurrence, no difference was seen. Although TP expression may play a role in the development and progression of invasive breast cancer, it does not appear to be important in the development of disease recurrence following treatment for DCIS.

TP can also be induced by hypoxia and low pH. Although two patterns of vascularity have been described in DCIS, the relation between these two patterns is unclear. Guidi et al found increased stromal vascularity in 25% of cases and the presence of a periductal vascular cuff in 35%. However, they could not show an association between stromal and perivascular density. In contrast, when measuring vWF expression, we found a strong correlation between stromal and periductal vascularity, with similar values for each. When measuring vascular density by means of CD34 expression, the values were higher than those seen for vWF. There was also a difference between stromal and periductal vascularity, with the highest values being seen for...
Take home messages

- An increase in microvessel density around ductal carcinoma in situ (DCIS) did not predict the development of a recurrence, whether in situ or invasive, in contrast to our earlier study.
- In addition, thymidine phosphorylase expression by DCIS cells did not appear to be related to recurrent in situ or invasive disease after excision of DCIS.

Periductal vascularity. The difference between the stromal and periductal counts probably results from an increase in CD34+/vWF blood vessels, and it may be that this phenotype of blood vessel is most important in angiogenesis and disease progression.

Acknowledgements

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References

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