The relation between bone marrow angiogenesis and the proliferation index Ki-67 in multiple myeloma

M G Alexandrakis, F H Passam, C Dambaki, C A Pappa, E N Stathopoulos

A ngiogenesis has been shown to play an important role in solid tumour invasion and metastasis.1–3 In some types of cancer, the degree of angiogenesis has been shown to have an adverse effect on prognosis.4–6 Although initial studies were performed with solid tumours, several recent studies have shown that angiogenesis also plays an important role in haematological malignancies.7–11 Increased angiogenesis, measured as bone marrow microvessel density (MVD), and increased serum angiogenic factors have been measured in patients with acute and chronic leukaemia, non-Hodgkin lymphomas, myelodysplastic syndromes, and multiple myeloma (MM).12–19 More specifically, for MM, histomorphometric studies have shown that the number of arterioles and arterial capillaries is significantly increased compared with osteoporosis4 and monoclonal gammopathy of undetermined significance.20 It has also been reported that bone marrow angiogenesis is a predictive factor of poor survival in newly diagnosed myeloma.11 17 18

Although initial studies were performed with solid tumours, several recent studies have shown that angiogenesis also plays an important role in haematological malignancies.

Aim: Angiogenesis correlates with disease progression in various haematological malignancies. This study investigated the association between microvascular density (MVD) and the Ki-67 proliferation index (Ki-67 PI), bone marrow infiltration, and C reactive protein (CRP) in patients with multiple myeloma.

Methods: Bone marrow MVD was examined in 44 biopsies at diagnosis and 15 in plateau phase by immunostaining the endothelial cells with a monoclonal antibody to CD34. The Ki-67 PI was evaluated by a double immunostaining technique using the monoclonal antibodies MIB-1 and CD34.

Results: MVD, Ki-67 PI, bone marrow infiltration, and CRP were significantly higher in pretreatment patients than in controls and decreased in patients achieving plateau phase. MVD significantly correlated with Ki-67 PI and infiltration, and Ki-67 correlated with infiltration.

Conclusion: In multiple myeloma, apart from being a marker of proliferative activity, Ki-67 is also associated with bone marrow angiogenesis and tumour burden.
Table 1  Mean (SD) values of the measured parameters in the groups of patients with different disease stage before treatment

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Stage I (N = 12)</th>
<th>Stage II (N = 15)</th>
<th>Stage III (N = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ki-67 (%)</td>
<td>3.67 (1.97)**</td>
<td>8.07 (10.73)**</td>
<td>15.2 (8.0)</td>
</tr>
<tr>
<td>Infiltration (%)</td>
<td>25.8 (14.4)**</td>
<td>36.5 (20.1)**</td>
<td>53.2 (22.3)</td>
</tr>
<tr>
<td>CRP (mg/l)</td>
<td>6.42 (3.15)*</td>
<td>10.27 (6.57)</td>
<td>13.12 (8.70)</td>
</tr>
<tr>
<td>MVD (/0.0625 mm²)</td>
<td>6.18 (1.72)*</td>
<td>8.53 (6.23)</td>
<td>11.4 (5.9)</td>
</tr>
</tbody>
</table>

*p<0.05 v stage II; **p<0.01 v stage III.
CRP, C reactive protein; MVD, microvascular density.

Double immunostaining for CD38 and Ki-67 expression by neoplastic plasma cells

After dewaxing and gradual rehydration in alcohols of decreasing strength down to tap water, 3 µm thick tissue sections were heated at 500 W in 0.01M citrate buffer pH 6.2 for 3.5 minutes, three times; after cooling at room temperature, they were blocked with 3% H₂O₂ in distilled water for 10 minutes. Next, the sections were incubated with the primary monoclonal antibody antihuman Ki-67/MIB1 antibody (code M7077; Dako, Glostrup, Denmark) using an alkaline–antialkaline phosphatase (APAAP) method. Monoclonality and percentages of κ/λ neoplastic cells in the bone marrow were assessed by in situ hybridisation (SS ISH detection system, catalogue number DA030-SS; Biogenex, San Ramon, California, USA; κ/λ, mRNA peptide nucleic acid probes/fluorescein isothiocyanate; catalogue number Y5202; Dako).

Immunostaining and counting of microvessels

Blood vessels were highlighted by immunostaining endothelial cells with a monoclonal antibody to CD34κ (catalogue number 0786; Immunotech, Marseille, France) and the same APAAP method used above. Known positive controls and negative controls were included in every run of the immunostaining. MVD was assessed by two independent observers (ENS, KD) using a standard 16 Zeiss microscope equipped with plan objectives and Kpl/W10x/18 eyepieces.

In a supplemental evaluation, the percentage of Ki-67 positive plasma cells was examined in hot spot versus containing the highest number of microvessels (capillaries and venules) representing the most intense microvasculature (hot spots) were examined. Initially, the sections were scanned at low magnification (×100) and the hot spots located before counting. Microvessels in close proximity to the trabeculae and those in sclerotic areas were not considered when counting. After the hot spots were identified, individual microvessels were counted at ×400 magnification. For systematic examination of the specimens, a squared and numbered (with 100 indexed squares of equal dimension) eyepiece graticule (micrometer, grid), 1 x 1 cm in dimension (NE35 mm; Graticules Ltd, Kent, UK), was introduced into one of the eyepieces and calibrated against a calibration 1 mm stage micrometer for transmitted light (Zeiss, 5+100/100 mm) with 100 divisions of 1/100 mm each, mounted on a 76 x 76 mm slide. The measurements were performed on the part of the field corresponding to the projection of the eyepiece graticule, covering a 0.0625 mm² surface area. During microvessel counting, the stage of the microscope was moved in such a way that the whole area of each of the hot spots was examined. An effort was made to ensure that each counting square was full of tissue. Any red staining cells morphologically compatible with endothelial cells and any cluster of endothelial cells with or without a rudimentary or well formed lumen were considered to be microvessels and were counted. Finally, the mean microvessel count of the three hot spots was calculated and expressed as vessels/0.0625 mm² (fig 2).

In a supplemental evaluation, the percentage of Ki-67 positive plasma cells was examined in hot spot versus
non-hot spot areas. To achieve this measurement, additional sections were stained in patients with sufficient histological specimens. The sections were double stained as previously described for Ki-67 and CD34. The areas of increased microvasculature were identified and plasma cells in the vicinity were identified based on morphological criteria. The percentage of Ki-67 positive plasma cells was counted in the hot spot areas and expressed as the mean for three hot spots in the same patient. The same procedure was followed in three areas with very sparse or no microvasculature (termed non-hot spot areas) and the mean number of Ki-67 positive plasma cells was calculated. This comparative measurement was performed in 26 patients before treatment. In the rest of the cases, a lack of histological material did not allow this measurement to be carried out.

STATISTICAL ANALYSIS
Data analysis was carried out using SYSTAT 8.0 statistical software (SPSS Inc, Chicago, Illinois, USA). Results were expressed as mean (SD), unless otherwise indicated. ANOVA was used to test the differences in the studied parameters between the various stages of the disease. The Wilcoxon test was used to compare pretreatment, post-treatment, and control parameter values. The Spearman’s rank correlation coefficient was used to determine the correlation between pretreatment values of the various studied parameters. A p value < 0.05 was considered to be significant.

RESULTS
Table 1 shows the mean (SD) values for each of the variables measured in the pretreatment group of patients. The proportion of Ki-67 positive plasma cells was significantly higher in stage III of the disease than in stages I and II (p < 0.01). There were also significant differences in the proportion of Ki-67 positive plasma cells among the untreated patients and those in plateau phase after chemotherapy (p < 0.01). Of note, the double staining of normal control bone marrows revealed no Ki-67 positive plasma cells. The single Ki-67 staining performed on these bone marrows (which depicts the proliferative activity in the bone marrow progenitors) was 2.42 (SD, 2.4). The small numbers of plasma cells (≤ 2%) seen on the initial standard staining were resting, non-proliferating cells.

MVD was significantly higher in stage III than in stage I of MM disease (p < 0.05; table 1). Significant differences were also found regarding the MVD value in the pretreatment and post-treatment groups (p < 0.01; table 2), and between untreated patients with MM and controls (p < 0.0001; table 3). Significant differences were also found regarding MVD values between post-treatment and control groups (p < 0.05).

Plasma cell infiltration and CRP values increased significantly with increasing stage of disease in untreated patients with MM (p < 0.01 and p < 0.05, respectively). Comparisons between pretreatment and post-treatment values indicated that bone marrow infiltration and CRP concentrations decreased significantly (p < 0.01 and p < 0.05, respectively).

In the pretreatment group of patients, a correlation between bone marrow MVD and plasma cell infiltration was found (r = 0.325; p < 0.05). We also found a significant relation between Ki-67 PI, bone marrow MVD (r = 0.474; p < 0.01), and plasma cell infiltration (r = 0.630; p < 0.0001). Bone marrow MVD and Ki-67 PI did not correlate with CRP.

With regard to the comparative analysis of plasma cell Ki-67 positivity in hot spot versus non-hot spot areas, the results from Mann Whitney and Wilcoxon testing showed that the percentage of Ki-67 positive plasma cells was significantly higher in areas of increased microvasculature than in areas with decreased vasculature. Specifically, the mean (SD) of Ki-67 positive plasma cells was found to be 15.0 (13.3 %) in hot spot areas and 4.7 (4.8%) in non-hot spot areas (p < 0.001).

DISCUSSION
In myeloma disease, prognostic factors are useful for distinguishing stable or slowly progressive disease from the more aggressive forms.26,27 Of the various factors reported, Ki-67 expression and angiogenesis have been shown to be of prognostic importance.4,11,18,20,26 The results of our study link plasma cell proliferation to angiogenic activity in MM because the Ki-67 index correlated closely to MVD. This association has also been investigated in another study,18 although a different methodology was used: immunostaining for von Willebrand factor to estimate MVD and the plasma cell labelling index as a plasma cell proliferation marker. These authors also found that proliferative activity (expressed by the plasma cell labelling index) correlated with MVD; however, in contrast to our study, they did not find an association between MVD and plasma cell infiltration. The method of CD34 staining used in our study has been advocated as a more accurate method than factor VIII or CD31 staining for the estimation of microvessels in the bone marrow.26 Furthermore, ours is the first study that directly supports a relation between the proliferative activity of malignant cells and the development of microvessels.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Mean (SD) values for Ki-67/CD38 positivity and infiltration</th>
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<tr>
<td></td>
<td>Pre-T (N = 15)</td>
</tr>
<tr>
<td>Ki-67+CD38+ (%)</td>
<td>14.6 (13.0)</td>
</tr>
<tr>
<td>Infiltration (%)</td>
<td>44.3 (24.8)</td>
</tr>
</tbody>
</table>

Pre-T, pretreatment; post-T, posttreatment.
Although in a limited number of samples. Thus, in the vicinity of the increased microvasculature, the percentage of proliferating plasma cells is significantly higher than in areas of decreased vasculature, suggesting that angiogenesis is one of the major determinants of tumour growth in MM. The importance of bone marrow angiogenesis for the proliferation of neoplastic plasma cells has been investigated in several studies by separate groups.17–19 There is evidence to support the cytotoxic effect of certain chemotherapeutic agents on endothelial cells, leading to a reduction in the release of angiogenic factors from the myeloma cells.10–12

The observed decrease in Ki-67 and MVD after chemotherapy is probably a result of the direct cytotoxic effect of the drugs on both plasma cells and endothelial cells, leading to a reduction in the release of angiogenic factors from the myeloma cells.10–12 In vitro and in vivo studies have been performed that support the cytotoxic effect of certain chemotherapeutic agents on endothelial cell function and proliferation of microvessels in solid tumours and MM.10–12

"Ours is the first study that directly supports a relation between the proliferative activity of malignant cells and the development of microvessels, although in a limited number of samples"11

However, it should be noted that although the proliferative activity of plasma cells was almost normalised after effective treatment, MVD was decreased, but still remained higher than normal. This has also been noted by others,13 and suggests that a pathological angiogenic process still remains, which may contribute to myeloma relapse and renders clinical studies using a combination of antineoplastic and antiangiogenic agents extremely useful.

With regard to the role of Ki-67 expression in MM, in an earlier study Ki-67 values did not differ significantly between patients with MM at diagnosis and those in plateau phase, but were found to be significantly higher in patients with relapsing MM.14–17 On the contrary, our data are in accordance with another study demonstrating a significant decrease in Ki-67 in patients who entered plateau phase whereas those in plateau phase experience a reduction of these factors. Thus, the assessment of bone marrow MVD and Ki-67 expression in bone marrow plasma cells may be considered important indicators of disease activity. However, although the Ki-67 proliferative activity was almost normalised after treatment, MVD remained higher than normal. The role of this in future MM relapse and the value of adjacent antiangiogenic drugs in standard treatment need to be evaluated further.

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### REFERENCES

### Table 3

| Table 3 Mean (SD) values for CRP and MVD before and after treatment and in controls |
| CRP (mg/l) | MVD (vessels/0.0625 mm²) | Pre-T (N=15) | Post-T (N=15) | Controls (N=15) | Pre-T v post-T controls | Pre-T v controls | Post-T v controls |
| 10.20 (7.34) | 4.93 (2.18) | 3.8 (0.9) | p<0.05 | p<0.0001 | NS |
| 10.14 (6.29) | 4.107 (2.285) | 2.77 (0.88) | p<0.01 | p<0.0001 | p<0.05 |

CRP, C reactive protein; MVD, microvascular density; NS, not significant.

### Take home messages
- Microvessel density (MVD) and Ki-67 index are significantly higher in pretreatment patients than in controls and decreased in patients achieving plateau phase.
- MVD significantly correlated with the Ki-67 index and plasma cell infiltration, and Ki-67 correlated with plasma cell infiltration.
- The assessment of bone marrow MVD and Ki-67 expression in bone marrow plasma cells are important indicators of disease activity.
- However, MVD remained higher than normal after chemotherapy and the role of this in future MM relapse and the value of adjacent antiangiogenic drugs in standard treatment need to be evaluated further.

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*J Clin Pathol* 2004 57: 856-860
doi: 10.1136/jcp.2003.013110

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