Study of nuclear sizes in the centres of malignant and benign lymphoid follicles

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SUMMARY The sizes of follicle centre cells in 15 specimens of follicular (centroblastic-centrocytic) non-Hodgkin’s lymphoma and 15 specimens of reactive follicular hyperplasia have been measured. The findings differ from previous studies, where nuclei of cells from follicle centres and interfollicular areas were measured and revealed no significant difference between follicular lymphoma and reactive follicular hyperplasia. In the current study, by measuring only follicle centre cell nuclei, it has been found that, in reactive follicular hyperplasia, the mean nuclear maximum diameter (Dmax) and area are significantly greater than in centroblastic-centrocytic follicular lymphoma. In addition, the standard deviation of these data is greater for reactive follicular hyperplasia than follicular lymphoma, implying greater “scatter” or heterogeneity of the nuclear sizes in the follicle centre cells of the former than the latter. Thus, the size of these cells appears to be of value as an histological discriminator between these benign and malignant conditions.

Various criteria have been suggested in the past as aids to the histological distinction between follicular non-Hodgkin lymphomas and reactive follicular hyperplasia.1−4 Quantitative studies, such as enumeration of the macrophage content of follicular lymphoma and reactive follicular hyperplasia specimens5 and the measurement of mean nuclear maximum diameter (Dmax), area and form factor6 7 have not proved useful in distinguishing between these two types of specimen. In these latter studies, however, nuclei of cells within the follicle centres, marginal zones and in areas between the follicles were measured which may have led to falsely-low data with respect to reactive follicular hyperplasia. In addition in follicular lymphoma, the interfollicular cells may or may not be malignant. To investigate the possibility of differentiating follicular lymphoma from reactive follicular hyperplasia by virtue of nuclear size, the mean nuclear Dmax and area have been measured in a series of such specimens. However, in an attempt to measure only (or principally) malignant cells in follicular lymphoma, nuclei in the follicle centres have been specifically selected. Similarly, only nuclei in the centres of follicles in reactive follicular hyperplasia have been measured.

Material and methods

LYMPH NODES
Thirty lymph nodes were examined, from the same number of patients. The 15 specimens of follicular lymphoma were morphologically all of the follicular-centroblastic-centrocytic type and the other 15 specimens were cases of reactive follicular hyperplasia. To ensure that the pathological nature of the specimens of follicular lymphoma was truly malignant, specimens which had relentlessly disseminated, caused death of the patient or occurred in extranodal sites were chosen. Similarly, reactive nodes were selected whose aetiology was serologically or otherwise established (Tables 1 and 2).

FIXATION AND STAINING
The nodes were processed as described before.6−8 They were cut into 2 mm thick slices after surgical excision, and the slices fixed for 24 h in 10% formol-saline, processed to paraffin wax, sectioned at 4 μm and stained by Harris’s haematoxylin and eosin. The sections were dehydrated, cleared and mounted in balsam prior to the measurement procedure.

MEASUREMENT OF NUCLEI
The use of the MOP-AMO1 has been described in detail previously.5−8 As before, the machine was used in conjunction with a light microscope with a camera lucida drawing tube. The images of 500 nuclei were outlined and for each specimen the histogram and mean values for Dmax and area were given by the microprocessor. Sections were viewed under a ×100 oil-immersion lens. Unlike previous
Table 1  Mean nuclear dimensions in specimens of reactive follicular hyperplasia (follicle centres)

<table>
<thead>
<tr>
<th>Diagnosis or serologically/ clinically demonstrable infective agent</th>
<th>Mean nuclear Dmax (μm)</th>
<th>Mean nuclear area (μm²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>11-8 (5-4)</td>
<td>110 (26)</td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td>11-9 (5-2)</td>
<td>104 (24)</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>12-4 (5-6)</td>
<td>104 (26)</td>
</tr>
<tr>
<td>Draining carcinoma of colon</td>
<td>12-5 (5-4)</td>
<td>102 (28)</td>
</tr>
<tr>
<td>Draining carcinoma of colon</td>
<td>12-7 (4-9)</td>
<td>103 (31)</td>
</tr>
<tr>
<td>Yersinia pseudotuberculosis</td>
<td>12-9 (5-2)</td>
<td>110 (27)</td>
</tr>
<tr>
<td>Draining carcinoma of breast</td>
<td>13-1 (4-9)</td>
<td>111 (28)</td>
</tr>
<tr>
<td>Draining carcinoma of larynx</td>
<td>13-4 (5-6)</td>
<td>107 (34)</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>13-6 (6-3)</td>
<td>122 (36)</td>
</tr>
<tr>
<td>Draining carcinoma of breast</td>
<td>13-6 (4-8)</td>
<td>117 (28)</td>
</tr>
<tr>
<td>Draining carcinoma of colon</td>
<td>13-8 (5-9)</td>
<td>119 (22)</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>13-9 (5-8)</td>
<td>109 (37)</td>
</tr>
<tr>
<td>Cat-scratch disease</td>
<td>14-0 (4-9)</td>
<td>126 (38)</td>
</tr>
<tr>
<td>Draining carcinoma of breast</td>
<td>14-2 (6-1)</td>
<td>127 (34)</td>
</tr>
</tbody>
</table>

Standard deviations for each mean measurement are given in parentheses.

Studies, where nuclei of cells in both the follicles and interfollicular areas were measured, only those in the follicle centres were outlined. This was facilitated by initial examination of lower-power (×10) fields and the interposition of a simple eyepiece grid in the follicle centre areas, excluding the small lymphocyte “mantle zone” or interfollicular regions. Follicles were selected at random.

As before, the MOP-AMO₂ was programmed to exclude nuclei with a Dmax of < 5 μm or area of < 50 μm². Section thickness corrections were applied using the method of Weibel.

Statistical differences between pooled groups of data were determined by means of the Student’s paired t test.

Results

Tables 1 and 2 show the mean nuclear Dmax and area for follicle centre cells in reactive and malignant follicles, respectively. The mean nuclear Dmax for cells in reactive follicles ranges from 11-8–14-2 μm whereas the mean nuclear Dmax has values of 10-1–12-4 μm in the case of malignant follicles. The corresponding standard deviations for reactive follicles are 4-8–6-3 μm and 2-3–3-8 μm for their malignant counterparts.

The mean nuclear area of follicle centre cells in reactive lymphoid ranges from 102–139 μm², in malignant follicles the values extend from 75–101 μm². The SDs for reactive follicle centre cells are from 22–39 μm² and for malignant follicle centre cells range from 13–23 μm².

The range of values for mean Dmax for follicle centre cells in reactive nodes is significantly greater than those in malignant follicles (p < 0·001). The same is true for the SD of Dmax (p < 0·001). Similarly, the mean nuclear area of follicle centre cells in reactive nodes is significantly (p < 0·001) greater than that of follicle centre cells in centroblastic-centrocytic lymphoma, as is the SD of nuclear area (p < 0·001).

Discussion

The histological distinction between florid “reactive” follicular hyperplasia and follicular lymphoma often presents diagnostic problems. Accordingly, several authors have proposed criteria to aid in this problem:¹⁻⁴ features such as nuclear pleomorphism, mitotic frequency, the presence of a marginal “mantle zone” or of tingible body macrophages have been proposed. However, these features are all based on subjective assessment.

Previously, we have investigated the usefulness of an objective approach based on quantitative measurements as means of differentiating between reactive follicular hyperplasia and follicular lymphoma. Mean nuclear Dmax and area measurements were not helpful,¹ reactive follicular hyperplasia and follicular lymphoma having similar ranges. However, in this study, the nuclei of both follicle centre, “mantle zone” and interfollicular cells were measured. Thus in follicular lymphoma both malignant (follicular) and reactive (interfollicular) cells were included. In an attempt to arrive at a better, measurable comparative cell population, it was later felt that follicle centre cells alone should be measured. This technique should give a direct comparison between malignant (follicular lymphoma) and reactive, benign (reactive follicular hyperplasia) cells.

In this study, as before,⁶ specimens were selected which were, in the case of reactive follicular hyperplasia, of known aetiology or in the case of follicular lymphoma had a relentless disseminating course or were tumours in extranodal sites. Thus tautological comparisons have been avoided, the natural history
of both groups being confirmed.

The use of a simple squared eyepiece graticule readily enables the selection of follicle centre area and the results show that the mean nuclear \(D_{max}\) and SD of mean \(D_{max}\) for cells here are greater in reactive follicular hyperplasia than in (centroblastic-centrocytic) follicular lymphoma. The same is true for mean nuclear area and SD of nuclear area. Thus not only is the mean nuclear size greater in reactive follicular hyperplasia than follicular lymphoma but so also is the SD of the measured values, implying a wider scatter and heterogeneity of nuclear dimensions in the former. This concurs with subjective impressions. Indeed, the reactive follicle centre includes centrocytes, centroblasts, macrophages (and related cells) whereas centrocytes greatly predominate over centroblasts in centroblastic-centrocytic lymphoma.\(^{10}\) The latter feature no doubt also accounts for the lower mean nuclear size in centroblastic-centrocytic follicular lymphoma than in reactive follicular hyperplasia.

Other quantitative techniques which we have applied to lymphoid tissue, partly in an attempt to distinguish between reactive follicular hyperplasia and follicular lymphoma, have included the enumeration of macrophages (by virtue of their content of alpha-naphthyl acetate esterase)\(^2\) and the measurement of shape (form factor) of these same cells.\(^{11}\) It was shown that both low-grade non-Hodgkin’s lymphoma and specimens of reactive follicular hyperplasia contained up to 4-1 and 3.2% of esterase-positive cells respectively (other than T \(\mu\) lymphocytes); thus the contribution of these cells, in haematoxylin-eosin preparations, should make little significant difference to the values for nuclear \(D_{max}\) and area of follicle centre cells in the current study. The mean form factor of the esterase-positive cells in both low-grade non-Hodgkin’s lymphoma and in reactive follicular hyperplasia was similarly low (in contrast to high-grade non Hodgkin’s lymphoma), implying that irregular or branching forms predominate.\(^{11}\) A study of macrophage numbers, by virtue of their content of alpha-naphthyl acetate or acid phosphatase content, in follicle centres in reactive follicular hyperplasia and follicular lymphoma, also showed no difference between these two conditions.\(^{12}\)

Follicle size and the contribution of the “mantle zone” have also recently been measured, using the MOP-AMO\(_3\).\(^3\) It was found that mean follicle area was greater in reactive follicular hyperplasia than in centroblastic-centrocytic follicular lymphoma; the standard error of mean of the values was also greater in reactive follicular hyperplasia implying a greater heterogeneity of follicle sizes than in follicular lymphoma. Although the mean form factor was the same in reactive follicular hyperplasia and follicular lymphoma, the standard error of mean was greater in reactive follicular hyperplasia than follicular lymphoma, again suggesting greater heterogeneity of follicle shape in the former than in the latter. A “mantle zone” was present in all of the reactive follicles measured but only rarely observed in the specimens of follicular lymphoma.

It appears, therefore, that morphometric techniques help the pathologist to distinguish between reactive follicular hyperplasia and follicular lymphoma. The most useful measurements are those of follicle size\(^4\) and of mean nuclear \(D_{max}\) and area of follicle centre cells. The presence of a “mantle zone” of small lymphocytes points towards a diagnosis of reactive follicular hyperplasia.

We are grateful to Miss Angela Wright for typing the manuscript. The camera lucida was kindly donated by The Royal Society.

References


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