Nuclear DNA content of non-endemic Burkitt’s lymphoma

T LEHTINEN,* M LEHTINEN,† R AINE,† O P KALLIONIEMI,†† T LEINO,* T HAKALA,* P LEINIKKI,† M ALAVAIKKO**

From the Departments of *Oncology, †Pathology, and ††Clinical Chemistry, Tampere University Central Hospital, the Department of ††Biomedical Sciences, University of Tampere, and the **Department of Pathology, University of Oulu, Finland

SUMMARY The nuclear DNA content of 26 non-endemic Burkitt’s lymphomas was studied by flow cytometry. Eighteen of the tumours showed a pattern characteristic for diploid chromosome distribution, while eight of the tumours were aneuploid. Six of the aneuploid tumours showed an almost diploid, aneuploid DNA index, while two were tetraploid tumours. Patients with aneuploid tumours had a significantly worse prognosis (p < 0.005) than those with diploid tumours. One of the aneuploid tumours was positive for Epstein-Barr virus DNA.

Burkitt’s lymphoma is characterised by a typical cytogenetic abnormality—the translocation of an oncogene (c-myc) containing fragments of chromosome 8 to the sites of immunoglobulin heavy or light chain genes in chromosomes 14, 2, or 22.1 Besides the specific chromosomal translocations a proportion of Burkitt type tumours contain secondary chromosomal abnormalities2–5 that are also detectable by flow cytometric DNA analysis.6 In chronic lymphocytic leukaemia (CLL) and immunocytoma comparable chromosomal changes indicate a poor prognosis.7

The recently described analysis of nuclear DNA content of formalin fixed, paraffin embedded material8 has also been successfully used on non-Hodgkin lymphomas (NHL).9 We report the analysis by flow cytometry of 26 archival, non-endemic, Burkitt type tumours. The nuclear DNA content and proliferative activity of the tumours were correlated with histological and clinical follow up data.

Material and methods

Twenty six newly diagnosed cases of NHL classified as small non-cleaved Burkitt type lymphomas were studied.10 The biopsy material was collected during 1965–85 from the catchment area of Tampere University Central Hospital which had about 410 000 inhabitants before 1980, with an incidence of 15 cases of NHL.11 After boundary reorganisation the region expanded to about 1 000 000 people and an additional 11 cases were found during 1981–85. The mean age of the patients was 36 (range four to 69 years); nine patients were younger than 15 years; 13 were between 16 and 60 years; and four were over 61 years of age. None of the patients had previously been treated for malignant disease or had received immunosuppressive drugs. Because of the retrospective nature of the study, patients’ treatment varied considerably from no treatment to radiotherapy alone, or chemotherapy and radiotherapy with various combinations.

Diagnostic, formalin fixed tumour biopsy specimens were available from 25 patients. Fresh frozen tumour biopsy specimens were available from four patients.

Clinical staging was done according to the Ann Arbor system.12 Eleven patients were classified as having disease of stages I–II and 10, stages III–IV. Two patients (aged 8 and 19 years) had acute lymphoblastic leukaemia, which was shown by a bone marrow aspirate to have Burkitt type cell infiltration. Three patients had no staging reported in their medical records.

The histopathological analysis of the lymphoma biopsy specimens has already been described thoroughly.1 The tumours were classified according to their growth patterns into follicular, follicular and diffuse, and diffuse.13 A mitotic ratio of the tumours was determined by calculating the lymphoid cells and mitotic activity by using an ocular square and lens
1.32 at a magnification of 100. The presence or absence of aberrant mitoses was also recorded. Six hundred to 1200 cells from randomly selected fields in the diagnostic area of the biopsy specimen were counted. The mitotic activity of the tumour was considered to be high if the mitotic ratio exceeded 19 per thousand cells, a categorisation which has been used previously to divide high grade NHLs into those with low or high mitotic activity.  

Preparation of the paraffin embedded biopsy material was carried out by the method of Schutte et al., with a few modifications. Briefly, 30 μm sections were cut from the biopsy specimens for flow cytometry in addition to a 5 μm section, which was used for the confirmation of the previous histopathological diagnosis. Usually, one section yielded enough cells for flow cytometry analysis. Predominantly haemorrhagic and necrotic areas were excluded. The preparations were deparaffinised with two changes of xylene and rehydrated in a series of alcohol (100%, 95%, 70%, and 50%) into distilled water. The rehydrated tissues were trypsinised. We used an overnight incubation at room temperature in 0.25% trypsin supplemented with 1 mM ethidic acid, 0.3% non-ionic detergent NP-40 (Shell, The Netherlands) in a Tris-hydrochloric acid buffer (pH 7.4). The resulting cell suspension was pelleted at 500 g for seven minutes. The pellet was resuspended by vigorous syringing in the Tris-hydrochloric acid buffer containing 50 μg/ml of ethidium bromide (Merck, West Germany). The fresh-frozen samples were minced and stained for 15 minutes in the ice cold Tris-hydrochloric acid buffer supplemented with 0.3% NP-40 and 50 μg/ml of ethidium bromide. Thereafter, ribonuclease A1 (Sigma, USA) was added to a final concentration of 100 μg/ml for 15 minutes at room temperature. Before analysis by flow cytometry the cell suspension was filtered through a nylon net (pore size 55 μm) to remove aggregates.  

Analysis by flow cytometry was performed with EPICS-C (Coulter Electronics, Hialeah, USA) flow cytometer, which is equipped with a 5 W argon laser. An excitation wavelength of 488 nm and emission wavelength of over 610 nm (obtained by an absor-
**DNA content of Burkitt’s lymphomas**

The S-phase fraction could reliably be calculated from 24 tumours. The mean S-phase fraction of these 24 tumours was 15-5. Only two tumours, one aneuploid and one diploid, showed low S-phase fraction of 3-4 and 4-6, respectively. For the aneuploid tumours, the mean S-phase fraction was 14-1 (range 3-4–27-7) and for the diploid tumours it was 15-9 (range 4-6–26-3).

**Fig 1** Histograms of fresh frozen (a) and paraffin embedded (b) biopsy specimens of Burkitt’s lymphoma. Coefficient of variation of diploid peaks 3-3 (a) and 3-5 (b).

**Table 2** Correlation of DNA analysis and various clinical and histopathological variables in Burkitt’s lymphoma

<table>
<thead>
<tr>
<th>Mean age</th>
<th>Sex (M/F)</th>
<th>S-phase fraction* mean (SD)</th>
<th>High mitotic ratio (No/%)</th>
<th>Abnormal mitoses (No/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploid tumours</td>
<td>37</td>
<td>9/9</td>
<td>15-9 (5-4)</td>
<td>9/16 (65)</td>
</tr>
<tr>
<td>Aneuploid tumours</td>
<td>35</td>
<td>1/7</td>
<td>14-1 (4-8)</td>
<td>1/7 (29)</td>
</tr>
</tbody>
</table>

* = Proportion of cells in the S-phase fraction as determined from the DNA histograms of Baisch et al.**

**Table 3** Epstein-Barr virus carrier state* and secondary chromosomal abnormalities in Burkitt’s lymphoma

<table>
<thead>
<tr>
<th>Reference</th>
<th>Country</th>
<th>Endemic region</th>
<th>Karyotyping†</th>
<th>DNA analysis‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 4 6</td>
<td>Japan  France  USA</td>
<td>No  No  No</td>
<td>0/4 (0%) 3/13 (23%) 1/4 (25%)</td>
<td>Not done Not done Not done</td>
</tr>
<tr>
<td>This paper</td>
<td>Kenya  Ghana</td>
<td>Yes  Yes</td>
<td>5/7 (71%) 7/14 (50%)</td>
<td>Not done 8/26 (31%) Not done</td>
</tr>
</tbody>
</table>

*Endemic > 95%/non-endemic < 25%; †47 chromosomes or more; ‡DNA-aneuploidy.

**Fig 2** Histograms of two paraffin embedded biopsy specimens of Burkitt’s lymphoma. Both tumours show an aneuploid cell population with DNA indices of 1-10 (a) and 1-18 (b). Corresponding coefficient of variation are 4-7 and 4-5, respectively.

**Fig 3** Three year survival of patients with Burkitt’s lymphoma bearing diploid or aneuploid tumours. Diploid tumours (———) 18 cases, aneuploid tumours (---) 8 cases.

**BIOLOGICAL PROPERTIES OF THE ANEUPLOID TUMOURS**

We compared the survival of the eight patients with aneuploid with the 18 with diploid tumours to see whether the difference in the nuclear DNA content reflected any differences in the biological behaviour of the tumours. The eight cases of aneuploid tumours clearly had a more unfavourable prognosis (p < 0-005) than those with diploid tumours (fig 3). An analysis irrespective of staging of survival could not be performed, because of the small number of cases studied. The distribution, however, of different stages within the groups was equal (data not shown).

Neither the S-phase fraction of the aneuploid tumours nor the mitotic activity, as calculated by the
mitotic ratio correlated well with the aneuploidy. Aberrant mitoses were found in seven tumours, only one of which was aneuploid (not significant, Fisher's exact test, table 2). There was no difference in the age distribution of the two patient groups, either, but men predominated in the group with aneuploid tumours (seven of eight, 88%) compared with the group with diploid tumours (nine of 18, 50%, table 2).

The reported cases of endemic Burkitt's lymphoma are accompanied by secondary chromosomal abnormalities twice as often as the non-endemic cases (table 3). The most noticeable differences between cases of endemic and non-endemic Burkitt's lymphoma are age of the patients (children v young adults) and the presence of Epstein-Barr virus genome (95% v 10 to 20%) in the tumours. One of our four fresh-frozen biopsy specimens was positive for Epstein-Barr virus (table 4), containing about 15 Epstein-Barr virus genome copies per cell. Two tumour specimens were negative and one could not be evaluated. The Epstein-Barr virus positive case was an 8 year old boy who had an aneuploid tumour by flow cytometry analysis (DNA index 1-13); the remaining three adult patients all had a diploid tumour.

Discussion

The recently described methods for the flow cytometry DNA analysis of formalin fixed, paraffin embedded tumour samples have made it possible to evaluate the validity of the DNA content as a marker of tumour behaviour. Our retrospective NHL material comprised, overall, more than 300 cases. It was especially suitable for evaluation as follow up data of all patients were readily available. Flow cytometry analysis showed that 18 of the non-endemic Burkitt type tumours (lymphomas or leukaemias) consisted of two cell populations: those showing aneuploid or diploid cells.

The results of DNA analysis of NHLs were the same, irrespective of whether formalin fixed or fresh frozen material was used. The correlation between flow cytometric and cytogenetic analyses of lymphomas has been shown to be good in triploid-tetraploid tumours. In the almost diploid aneuploid tumours the concordance was not as good (because of differences in DNA in the tumour cells which were in the G1-phase) as that of the resting normal cells. Thus the actual difference between chromosome numbers of the diploid and aneuploid tumours in our material is probably somewhat smaller than what would be expected from the mean DNA index (1-14).

According to the findings of cytogenetic studies on endemic and non-endemic Burkitt's lymphoma it is not uncommon to find that these tumours have chromosome numbers of 47-49 resulting from secondary chromosomal changes. Our results with the almost diploid aneuploid tumours approximate the chromosome numbers within the above mentioned range.

The impact of secondary chromosomal abnormalities on tumour biology has recently been questioned. In our material, however, the patients with aneuploid tumours had a much less favourable prognosis than those with diploid tumours. This agrees with the recent reports on CLL and immunocytoma in which an increased number of secondary chromosomal abnormalities were associated with a poor prognosis.

The aneuploid tumours did not show enhanced proliferative or mitotic activity, the common characteristics of tumours, including NHL, indicating poor prognosis. Abnormal mitotic activity has been suggested to be one of the possible mechanisms through which aneuploidy evolves. In our material it was the diploid tumours that showed aberrant mitoses, whereas only one such case was found in the group with aneuploid tumours. Our findings do not exclude the possibility that increased mitotic activity or abnormal mitoses have a role in inducing aneuploidy in Burkitt's lymphoma type tumours but this is a less plausible alternative.

Cases of endemic Burkitt's lymphoma that are consistently positive for Epstein-Barr virus show secondary chromosomal abnormalities twice as often as non-endemic tumours, which show Epstein-Barr virus in less than 25% of the cases. This was also the case for the one patient in this series whose tumour was positive for Epstein-Barr virus and aneuploidy by flow cytometry analysis. In vitro infection of lymphoblastoid cells with Epstein-Barr virus does not cause chromosomal aberrations. Whether the virus causes secondary chromosomal changes in the later stages of the clinical disease remains unclear.

Table 4  Epstein-Barr virus carrier state and aneuploidy in non-endemic Burkitt's lymphoma

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age (years)/sex</th>
<th>Epstein-Barr virus</th>
<th>DNA index</th>
<th>Abnormal mitoses</th>
<th>Mitotic ratio</th>
<th>S-phase fraction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8, male</td>
<td>15 genome copies/cell</td>
<td>1-13</td>
<td>Negative</td>
<td>Not done</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>19, male</td>
<td>Not available</td>
<td>1-0</td>
<td>Not done</td>
<td>Not done</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>31, male</td>
<td>Negative</td>
<td>1-0</td>
<td>Negative</td>
<td>High</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>41, male</td>
<td>Negative</td>
<td>1-0</td>
<td>Negative</td>
<td>High</td>
<td>26</td>
</tr>
</tbody>
</table>

*DNA index 1-0 corresponds to diploid cells.
DNA content of Burkitt’s lymphomas

The financial aid of Finnish Cancer Organisations and Pirkanmaa Cancer Fund is gratefully acknowledged.

References