Epstein-Barr virus-negative aggressive natural killer-cell leukaemia with high P-glycoprotein activity and phosphorylated extracellular signal-regulated protein kinases 1 and 2

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Abstract

Aggressive natural killer-cell leukaemia (ANKL) is a rare type of disease with fulminant course and poor outcome. The disease is more prevalent among Asians than in other ethnic groups and shows strong association with Epstein-Barr virus (EBV) and P-glycoprotein (P-gp) expression associated with multidrug resistance. Here we present a case of a 47-year-old Caucasian female with a prior medical history of azathioprine treated ulcerative colitis who developed EBV-negative form of ANKL. The patient presented with hepatosplenomegaly, fever and nausea with peripheraL blood and bone marrow infiltration with up to 70% of atypical lymphoid cells positive for CD3, CD2, CD7, CD56, CD38, CD45, TIA1 and granzyme B, and negative for CD3, CD4, CD5, CD8, CD34 and CD123 indicative of ANKL. Neoplastic CD56+ NK-cells showed high level of P-glycoprotein expression and activity, but also strong expression of phosphorylated extracellular signal-regulated protein kinases 1 and 2 (ERK1/2) MAP kinase. The patient was treated with an intensive polychemotherapy regimen designed for treatment of acute lymphoblastic leukaemia, but one month after admission developed sepsis, coma and died of cardiopulmonary arrest. We present additional evidence that, except for the immunophenotype, leukaemic NK-cells resemble normal NK-cells in terms of P-gp functional capacity and expression of phosphorylated ERK1/2 signalling molecule. In that sense drugs that block P-glycoprotein activity and activated signalling pathways might represent new means for targeted therapy.

Introduction

Mature natural killer (NK) malignancies, according to the World Health Organization classification, comprise extranodal NK/T-cell lymphoma, nasal type (ENKL) and aggressive NK-cell leukaemia (ANKL).1,2 These are rare types of neoplasms, particularly in Western countries, but with somewhat higher incidence rate in Asian and Central and South American population. Both entities have a highly aggressive clinical course with very poor survival rates.3 Fernandez et al4 and Koizumi et al5 were the first to report and give evidence of a new clinical entity named aggressive NK-cell leukaemia. Bone marrow and peripheral blood are common sites of involvement, with equal incidence in males and females. Median age of patients diagnosed with ANKL is between 30 and 40 years. Common symptoms comprise fever, anaemia, hepatosplenomegaly, disseminated intravascular coagulation and lymphadenopathy.1 Survival rates are extremely low, measuring in weeks and not exceeding 2 years (median 2 months).

Common immunophenotype of aggressive NK-cell leukaemia is surface CD3-negative (sCD3–), cytoplasmatic CD3-positive (cCD3+), CD2-negative (CD2–), CD7-positive (CD7+), CD56-positive (CD56+), CD5-negative (CD5–), CD4-negative (CD4–), CD8-negative (CD8–), with germline configuration of T-cell receptor.6 Frequent cytogenetic abnormalities are deletion 6q21-q25 and loss of 17p13.7 Also, mature NK neoplasms are highly associated with Epstein-Barr virus (EBV), implying a role of this virus in tumour pathogenesis.8 It is noteworthy to mention that NK cells have the highest level of P-glycoprotein (P-gp) (MDR-1) expression and activity of all lymphoid cells.9 Accordingly, malignancies arising from mature NK cells frequently express P-gp,10,11 a protein involved in multidrug resistance mechanism (MDR). This may be a partial answer to the question of why there is such a high chemotherapy failure rate in NK-cell derived neoplasms.

Case Report

A 47-year-old Caucasian female was admitted to the University Hospital Centre Zagreb, Croatia, in September 2010 with high fever, splenomegaly and urinary infection. She reported feeling nausea, fatigue and pain in the lower left abdominal quadrant. Medical history revealed a prior diagnosis of ulcerative colitis (UC) in 2002 after which she was on continuous treatment with topical and peroral aminosalicylates. She received interferon therapy was introduced. Due to progression of the disease in 2009, the patient was started on azathioprine and continued the treatment for 17 months. In May 2010 UC worsened and sideropaenic anaemia developed. She was admitted to hospital, treated with corticosteroids, antibiotics and erythrocyte transfusions with a good response. In 2005 Hashimoto’s thyreoiditis was diagnosed and thyroxine therapy initiated.

Upon admission, the patient’s laboratory findings were as follows: white blood cells 5.92×109/L, neutrophils 2.61×109/L, lymphocytes 1.43×109/L, monocytes 0.32×109/L, eosinophils 0.06×109/L, basophils 0.01×109/L and platelets 246×109/L. Hemoglobin was 9.4 g/dL with 23% hypochromic cells, while the mean corpuscular volume was 78.3 fl. Total cholesterol was 6.84 mmol/L and high density lipoprotein cholesterol was 1.11 mmol/L. C-reactive protein was 87 mg/L, while erythrocyte sedimentation rate was 40 mm/h. The patient’s albumin level was 35 g/L, while γ-glutamyl transpeptidase was 171 U/L. Procalcitonin and C-reactive protein were elevated to 0.57 ng/mL and 87 mg/L, respectively. Fibrinogen 920 mg/L, D-dimer 274 ng/mL, troponin I 0.004 ng/mL, creatinine 111 μmol/L, urea 28.5 mmol/L, glucose 4.4 mmol/L and aspartate transaminase 131 IU/L. Sodium was 136 mmol/L and potassium 3.9 mmol/L. Haemoglobin electrophoresis was normal. Chest X-ray and abdominal ultrasonography were normal.

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Peripheral blood and bone marrow smears revealed up to 70% of atypical lymphoid cells. The morphology (medium/large granular cells, round nucleus, intermediate condensed chromatin, pronounced nucleolus and basophilic cytoplasm) (Figure 1A) and cytochemical pattern (MPO+, SUDAN+, ANAE-, PAS-) of these cells was indicative of lymphoproliferative disease. Bone marrow biopsy revealed reduction of all three haematopoietic cell lineages and diffuse interstitial infiltrate of medium sized to large atypical lymphoid cells. Immunohistochemically, the cells were CD56+, TIA1+, CD34, HLA-DR, TdT and CD123. Karyotyping was negative for sCD3, CD4, CD5, CD8, CD13, CD117, CD45, cCD3, CD2, CD7, CD38, CD56, and negative in concordance with high membrane P-gp fluorescence intensity, RFI=16.54 which was indicative of a tumour necrotic cells, CD56+, TIA1+. Flow cytometry of bone marrow aspirate revealed relative homogenous population of cells (65%) positive for CD45, cCD3, CD2, CD7, CD38, CD56, and negative for sCD4, CD3, CD5, CD8, CD13, CD117, CD34, HLA-DR, TdT and CD123. Karyotyping showed no chromosomes abnormalities (46, XX). Considering all of the above, the patient was diagnosed with aggressive NK-cell leukaemia.

Further analysis concentrated on P-gp and phosphorylated signalling molecules in CD56+ neoplastic cells (Figure 2). P-gp activity was assessed using Rhodamine 123 and verapamil that P-gp acts as a protector of haematopoietic stem cells against toxins, its role in mature NK cells still needs to be elucidated. Case Report

Discussion

As mentioned above, aggressive NK-cell leukaemia is uncommon disease, but occurs with higher frequency in Asians and Central/South Americans than in other ethnic groups. The vast majority of such cases are associated with EBV which is found in clonal episomal form implying active aetiologic role in NK-cell-derived malignancy development. Here we emphasize the clinical and scientific importance of reporting much rarely EBV-negative form of ANKL in Caucasian patient. Namely, 13-15% of all ANKL cases are EBV-negative, raising certain suspicions in regards of proposed pathogenic mechanisms. Consequently, presumptions of different clinical course and outcomes of patients with EBV-positive and EBV-negative ANKL were made. The published reports on this issue show conflicting results: one group reported no significant prognostic value of EBV-positivity whereas the other presented evidence of significantly longer survival of EBV-negative ANKL patients in comparison to EBV-positive ones (11.5 vs. 1.5 months, respectively). Obviously, larger cohorts of patients will be more conclusive, since both reports include only two EBV-negative ANKL cases. The patient we are reporting had a very aggressive and rapid clinical course despite EBV-negative ANKL therapy protocols could be created in a way that they combine P-gp activity modulators and standard chemotherapy. Alternatively, they could avoid chemotherapeutics known to be P-gp substrates.

Furthermore, signalling pathways are very important in tumorigenesis. Utilisation and constitutive activation of certain signalling molecules enable malignant leukaemic cells to suppress normal haematopoiesis and continue disease.

Figure 1. Bone marrow aspirate (A). The blasts have large nuclei with fine chromatin, a single nucleolus, and a moderate amount of light blue cytoplasm (May-Grünwald Giemsa stain, 1000x). Bone marrow biopsy (B, C). Immunohistochemically, tumor cells are CD56+ (B) and show granular cytoplasmic reaction when stained for TIA1 (C) (40x).
ously proliferate. Peripheral blood NK cells and NK cell lines demonstrate ERK1/2 (p44/p42 mitogen-activated protein kinase) phosphorylation. This pathway plays critical role in NK-cell cytotoxicity; it drives lytic activity and mobilisation of granzyme B.16-18 However, it has been proposed that there are two different pathways responsible for ERK1/2 activation. Sky/Zap70 - PI3K - Rac - Pak - MEK - ERK cascade regulates human PB NK cell cytolysis, while Ras - Raf - MEK - ERK cascade regulates growth, survival and gene expression in human NK LDGL.19,20 Constitutive activation of ERK1/2 molecule was found in our patient’s ANKL cells, confirming previous statements, although it remained unclear which upstream mediators led to ERK1/2 activation. Thus, the use of signalling pathway inhibitors might prove to be useful in elucidation of upstream signalling pathway in ANKL.

Patient’s previous medical history revealed UC azathioprine therapy during the period of 17 months. It has been reported that patients who receive such treatment are at an increased risk of lymphoma in UC patients treated with azathioprine. Caution is necessary with interpretation of these results, since an increased risk could be a consequence of the severity of the disease itself, or combination of both.

### Conclusions

In conclusion, aggressive NK-cell leukaemia is chemotherapy resistant disease with extremely poor prognosis. However, leukaemic NK-cells resemble normal NK-cells in terms of P-gp functional capacity and expression of phosphorylated ERK1/2 signalling molecule. In this regard, drugs that block P-glycoprotein activity and activated signalling pathways might represent new means for targeted therapy.

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