IDH1 Mutation in Gliomas in Mosul City - Iraq

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Abstract

BACKGROUND: IDH1 (isocitrate dehydrogenase 1) mutation might be encounter in the low grade glioma and directs the progression of the tumor to a higher grade.

OBJECTIVE: To assess the frequency of IDH1 mutations in gliomas and to correlate the IDH1 positivity with the type and grade of tumors, the age and sex of the patients.

MATERIAL AND METHODS: A retro- and prospective case series study. One hundred and nine cases of intracranial gliomas were collected between 2008 and 2014 from Mosul Private Laboratories and Al-Jamboree Teaching Hospitals in Mosul. IDH1 mutations were assessed immunohistochemically using anti-IDH1 R132H mouse monoclonal antibody.

RESULTS: IDH1 mutation was perceived in 34.86% of gliomas. In adult gliomas, the secondary glioblastoma and the low-grade astrocytoma had the greatest values of IDH1 positivity (88.88% and 62.5% respectively), followed by oligoastrocytoma/oligodendroglioma (50.0%), and anaplastic astrocytoma (47.36%). The primary glioblastoma showed 17.64% IDH1 positivity. Males and females expressed the IDH1 equally. While, there was no role of IDH1 in pediatric gliomas.

CONCLUSION: IDH1 mutation is commonly present in adult gliomas particularly in low-grade gliomas, and secondary glioblastoma, with equal sex distribution, but it has no role in pediatric gliomas.

Introduction

Glial tumors (or gliomas) account for 40%–45% of all primary intracranial tumors. Therefore, they are considered the most common type of primary brain tumors. Gliomas are classified as grade I to grade IV according to histopathological and clinical criteria established by the WHO [1]. This group of tumors includes specific histologic subtypes, the most common of which are astrocytomas, oligodendrogliomas, and ependymomas [1]. WHO grade I gliomas, has an indolent growth, often considered to be benign, and rarely, if ever, evolve into higher-grade lesions. By contrast, gliomas of WHO grade II or III are aggressive tumors, usually invasive, progress to higher-grade lesions, and have a poor outcome [1].

Progression of glioma to a higher grade tumor is multistep process involving many genes and characterized by genetic alterations and mutation accumulation, these include TP53, PTEN, CDKN2A, and EGFR [2]. Recent studies suggested that mutations in the gene encoding for cytosolic NADP+ dependant IDH1 (isocitrate dehydrogenase 1) might occur after the formation of a low-grade glioma and direct the progression of the tumor to a glioblastoma [3, 4].

IDH1 is a member of IDH gene family, located on chromosome 2q33.3 and encodes for the cytosolic NADP+ dependant isocitrate dehydrogenase enzyme. The product protein catalyze the cytosolic oxidative decarboxylation of isocitrate to alpha-ketoglutarate, and resulting in the production of reduced form of NADPH (NADP+) which is play an important role in the cellular control of oxidative damage [5-7]. Gene
mutation alters the enzymatic property of IDH1 and leads to increase conversion of alpha-ketoglutarate to 2-hydroxyglutarate (2HG) metabolite and decreased production of NADPH, and accordingly reduced glutathione. These alterations may raise the oxidative stress level in mutant IDH1 cells and acting as an oncosens [8-10].

IDH1 mutation has been observed as an early evidence and in high frequency (50%-93%) among astrocytomas, oligodendrogiomas, oligodendrogliomas and secondary glioblastomas, while rarely occurs in primary glioblastoma [2-6,11,12].

Mutant IDH1 anaplastic astrocytomas, glioblastomas and oligodendroglial tumors have independent favorable prognostic factor particularly for grade III gliomas, and usually associated with increased progression-free survival and overall survival and may exceed other genetic markers. Interestingly, the few primary glioblastomas with IDH1 mutations also have a significantly better prognosis [5, 13-16].

The aim of this study was to validate the frequency of IDH1 mutation in gliomas in the Mosul city and to correlate the IDH1 positivity with the type and grades of gliomas, and with age and sex of the patients.

Material and Methods

This is a retro- and prospective case series study. In a period extended between 2008 and 2014, all types of intracranial gliomas of both sex and all age groups in the Mosul city were included in this study. Study carried out in Mosul Private Laboratory and in Al-Jamboore Teaching Hospital. The biopsies were processed histopathologically and paraffin-embedded blocks were sectioned on 4 micron thickness. Tumors proved to be gliomas were taken and were classified and graded according to last WHO Classification of the Central Nervous System Tumors [1]. Hereupon, 109 biopsies of adult, male and female, and pediatrics intracranial gliomas were collected with their clinical data including age and sex, MRI findings of site and side of affection and the provisional clinical diagnosis.

Ethical Approval was obtained from both Health Office and Medical College Ethical Review Committees.

Immunohistochemical technique

Four micron thickness slides were deparaffinized and rehydrated. Antigen retrieval was carried out by autoclaving at 95-99°C, for 20 minutes using retrieval solution (citrate puffer 10 mmol/L, pH 6.0). Sections then allowed cooling to a room temperature, followed by washing 3 times, each for 3 minutes, in phosphate buffered saline (PBS). Endogenous peroxidase activity was blocked by dipping sections in 3% hydrogen peroxidase blocker (Dako) for 10 minutes and washed in 3 changes of PBS. Sections were incubated with 1:20 diluted primary antibodies; anti-human IDH1 R132H (Dianova, GmbH, Hamburg, Germany, Mouse Monoclonal Antibody Clone H09) for 60 minutes, followed by washing twice for 3 minutes changes of PBS. Detection system using 2-steps polymer of HRP MR-2C, Polymer Detection Kit (Dianova Anti-Mouse, Rabbit, Universal Ms/Rb, PHA-70844) applied for 35 minutes for each step. Sections were washed twice by PBS and visualized using 3,3-diaminobenzidine (DAB) for 5-10 minutes. Finally, the sections were lightly counterstained with hematoxylin, dehydrated and mounted. Negative control sections were treated in the same way, but by the substitution of primary antibody with PBS. Positive control sections were taken from positive cases and were performed in each batch of staining.

Positive result show strong cytoplasmic staining which appears only in the tumor cells. Expression of IDH1 was determined by visual semiquantitative assessment of the proportion of the positively stained tumor cells. Cases with ≥10% cells as positive, and cases with <10% cells were rated as negative [2, 13].

Statistic analysis

Data were interpreted in form of frequencies and percentage. A chi square (χ²) test was used to associate the IDH1 status and different study variables. Statistical significance was achieved when the p-value was less than or equal to 0.05.

Statistic analysis were performed using computer program Microsoft Excel Window 7 (Microsoft Corporation, NY, USA) and SPSS statistic program (SPSS Inc, Chicago, IL, USA).

Results

Clinical findings

In a period of 5 years, 109 cases of intracranial gliomas were collected. The patients’ age range from 1.5 to 73 years with a mean age of 31.19 ± 15.36 years and a median of 32 years, most of the patients were in the third and fourth decades. There were 31 (28.44%) pediatric patients and 77 (71.55%) adults. Fifty eight (53.21%) were males and 51 (46.78%) were females and the male to female ratio was 1.13:1 (Figure 1).
The 10% cells positivity were the cornerstone point of IDH1 mutation [2, 13]. Positive IDH1 staining was observed in 38 (34.86%) cases of glioma. The secondary glioblastoma and the low-grade diffuse astrocytoma represent the largest groups of IDH1 positivity, followed by oligoastrocytoma/oligodendroglioma in 50.0% of cases, and anaplastic astrocytoma in 47.36%. However, the p-value between the frequency of different types of gliomas ad the IDH1 positivity failed to reach a statistical significance value (p-value = 0.056) (Table 2). IDH1 was evenly expressed in both sexes,

Concerning the grades of gliomas, no significant relationship was identified between the IDH1 positivity and the different grades of the tumors (Table 3).

Regarding the variants of glioblastoma, 4 were giant cell type, 1 of which was IDH1 positive positivity for IDH1. Two were gliosarcomas, both were positive; also the 2 glioblastomas with primitive neuroectodermal tumor (PNET) components were positive for IDH1 with granular rather than diffuse cytoplasmic staining. Lastly 1 out of 2 glioblastomas with oligodendroglioma component showed IDH1 cytoplasmic positivity.

In regarding pediatric gliomas, apart from a single recurrent pilocytic astrocytoma and a primary glioblastoma which were IDH1 positive, all others were IDH1 negative. No oligodendrogliomas/oligoastrocytomas or gangliogliomas were encountered below 15 years of age. Difference in age distribution of IDH1 positivity between adult and pediatric gliomas

**Histopathological findings**

Astrocytic tumors were the predominant types of glioma and those were 34 (31.19%) primary glioblastomas, 9 (8.25%) secondary glioblastoma, 19 (17.43%) anaplastic astrocytomas, 16 (14.67%) low-grade diffused fibillary and gemistocytic astrocytomas, 7 (6.42%) pilocytic astrocytomas and 1 (0.91%) subependymal giant cell astrocytoma. Whereas only 6 (5.50%) cases were oligodendrogliomas/oligodastrocytomas. Twelve (11.0%) were conventional ependymomas, 3 (2.75%) were anaplastic ependymomas. There was 1 (0.91%) desmoplastic infantile ganglioglioma, and 1 (0.91%) ganglioglioma.

**Grading System**

Tumors were graded according to the criteria established by WHO 2007 [1]. There were 10 (9.17%) cases grade I, 33 (30.27%) cases grade II, 23 (21.1%) cases grade III and the predominant grade was grade IV which was present in 43 (39.44%) cases as primary and secondary glioblastomas (Table 1).

**Table 1: The Grades and Types of Gliomas.**

| Grade of Gliomas | No of cases | Type of Gliomas               | Total |
|------------------|-------------|--------------------------------|-------|
| Grade-I          |             | Pilocytic astrocytoma          | 10    |
| Grade-II         |             | Subependymal giant cell astrocytoma | 10 (9.17%) |
|                  |             | Desmoplastic infantile ganglioglioma | 1     |
|                  |             | Ganglioglioma                   | 1     |
| Grade-III        |             | Low grade diffuse astrocytoma   | 50    |
|                  |             | Oligodendroglioma/oligodastrocytoma | 33 (30.27%) |
|                  |             | Epidermoidoma                   | 12    |
| Grade-IV         |             | Anaplastic astrocytoma          | 23    |
|                  |             | Anaplastic oligodendroglioma    | 9     |
|                  |             | Anaplastic ependymoma           | 3     |
|                  |             | Secondary glioblastoma          | 9     |
| Total            |             |                                | 109   |

**Table 2: IDH1 Status and the Types of Gliomas.**

| Types of Glioma | Total No case | IDH1 positivity | IDH1 Negativity | P-value |
|-----------------|---------------|-----------------|-----------------|---------|
| Diffuse astrocytoma | 16 (100.0%) | 10 (62.5%) | 6 (37.5%) |         |
| Anaplastic astrocytoma | 19 (100.0%) | 9 (47.36%) | 10 (52.63%) |         |
| Primary glioblastoma | 34 (100.0%) | 3 (8.82%) | 31 (91.18%) |         |
| Secondary glioblastoma | 9 (100.0%) | 0 (0.0%) | 9 (100.0%) |         |
| Oligodendroglioma/oligodastrocytoma | 6 (100.0%) | 0 (0.0%) | 6 (100.0%) | 0.056*  |
| Pilocytic astrocytoma | 7 (100.0%) | 7 (100.0%) | 0 (0.0%) |         |
| Epidermoma | 15 (100.0%) | 1 (6.66%) | 14 (93.33%) |         |
| Subependymal giant cell astrocytoma | 1 (100.0%) | 0 (0.0%) | 1 (100.0%) |         |
| Desmoplastic infantile ganglioglioma | 1 (100.0%) | 0 (0.0%) | 1 (100.0%) |         |
| Ganglioglioma | 1 (100.0%) | 0 (0.0%) | 1 (100.0%) |         |
| Total | 109 (100.0%) | 38 (34.86%) | 71 (65.13%) |         |

* Chi squared was used.

Gliomas were predominantly supratentorial in 80 (73.39%) cases, mainly on the right hemisphere especially in temproparietal lobe and commonly in adult patients. In contrary 29 (26.60%) gliomas were infratentorial commonly in the 4th ventricle, majority were ependymomas and pilocytic astrocytomas, and seen mostly in children.

**Table 3: Correlation of IDH1 Positivity and the Grades of Gliomas.**

| Grade of Gliomas | Total No case with IDH1 Positivity | No of cases with IDH1 Positivity | Type of Gliomas |
|------------------|-----------------------------------|----------------------------------|-----------------|
| Grade-I          | 1                                 | 1                               | Pilocytic astrocytoma |
| Grade-II         | 12                                | 10                              | Low grade diffuse astrocytoma |
|                  |                                    | 2                               | Oligodendroglioma/Oligodastrocytoma |
| Grade-III        | 11                                | 9                               | Anaplastic astrocytoma |
|                  |                                    | 1                               | Anaplastic oligodendroglioma |
|                  |                                    | 1                               | Anaplastic ependymoma |
| Grade-IV         | 16                                | 6                               | Primary glioblastoma |
|                  |                                    | 8                               | Secondary glioblastoma |
| Total            | 38                                | 36                              |                  |

Regarding the variants of glioblastoma, 4 were giant cell type, 1 of which was IDH1 positive positivity for IDH1. Two were gliosarcomas, both were positive; also the 2 glioblastomas with primitive neuroectodermal tumor (PNET) components were positive for IDH1 with granular rather than diffuse cytoplasmic staining. Lastly 1 out of 2 glioblastomas with oligodendroglioma component showed IDH1 cytoplasmic positivity.

In regarding pediatric gliomas, apart from a single recurrent pilocytic astrocytoma and a primary glioblastoma which were IDH1 positive, all others were IDH1 negative. No oligodendrogliomas/oligoastrocytomas or gangliogliomas were encountered below 15 years of age. Difference in age distribution of IDH1 positivity between adult and pediatric gliomas.

**Figure 1: Age and sex distribution of the intracranial gliomas.**
is statistically highly significant ($p<0.001$) (Table 4).

### Table 4: Distribution of IDH1 Reactivity and the Age-related Gliomas.

| Age-related Gliomas       | Total No | IDH1 Positivity No. | IDH1 Positivity % | IDH1 Negativity No. | IDH1 Negativity % | P-value* |
|---------------------------|----------|---------------------|-------------------|---------------------|-------------------|----------|
| Adult-related             | 78       | 42                  | (53.84%)          | 36                  | (46.15%)          |          |
| Pediatric-related         | 31       | 2                   | (6.45)            | 29                  | (93.54)           | $<0.001$ |
| Total                     | 109      | 38                  | (34.86%)          | 67                  | (61.46%)          |          |

*Chi squared was used.

**Discussion**

IDH1 mutation has become as a main diagnostic and prognostic biomarker for gliomas [13, 17]. IDH1 mutations occur in a vast majority of diffuse astrocytomas, oligodendrogliomas, and mixed oligoastrocytomas of WHO grades II and III and an earlier important findings in a fraction of secondary and primary glioblastomas [13,14,17,18].

![Figure 2: A- Low-grade diffuse astrocytoma (IDH1 x100). B- Anaplastic astrocytoma (IDH1 x400). C- Glioblastoma (IDH1 x100). D- Gliosarcoma (IDH1 x400). E- Glioblastoma with PNET-like component (IDH1 x400). F- Glioblastoma with Oligodendroglioma component (IDH1 x400). G- Oligodendroglioma (IDH1 x100). H- Pilocytic astrocytoma (IDH1 x100).](image)
The present work was the first study in Iraq to assess the immunohistochemical status of \textit{IDH1} mutant in various types and grades of gliomas. In line with many previous studies [3-5,12,15,19-22], that reported a higher frequency of \textit{IDH1} mutations in grade II gliomas compared with grades III and primary glioblastoma, the current study showed highest \textit{IDH1} mutations among low-grade diffused astrocytomas (62.5\%), and in secondary glioblastoma (88.88\%), between other grades and types of gliomas. However, in contrast to majority of the previous studies [2, 3, 5,18, 19, 23-27], the present study clarified a relatively higher degree of expression of the \textit{IDH1} in primary glioblastoma (17.64\%). This may be due to vague presentation, delay diagnosis and treatment of some of low grade gliomas that presented initially as primary glioblastomas. Nobusawa proposed that these primary glioblastomas with \textit{IDH1} mutation actually represent secondary glioblastomas with an unusually short clinical presentation [15], (Table 5).

Table 5: The positivity of \textit{IDH1} in primary glioblastomas in different studies.

| Study               | Region     | Year | No. of cases | \textit{IDH1} positivity |
|---------------------|------------|------|--------------|-------------------------|
| Current study       | Iraq       | 2014 | 109          | 17.64\%                 |
| Leibetseder [23]    | Austria    | 2013 | 70           | 39.3\%                  |
| Takano et al [19]   | Japan      | 2012 | 164          | 7.3\%                   |
| Pollack et al [24]  | USA        | 2011 | 106          | 16.3\%                  |
| Tocci et al [25]    | Germany    | 2011 | 131          | 8.0\%                   |
| Jha et al [26]      | India      | 2011 | 100          | 4.4\%                   |
| Labussiere et al [27]| France    | 2010 | 1320       | 6.0\%                   |
| Capper et al [5]    | Germany    | 2009 | 345          | 4.0\%                   |
| Yan et al [18]      | U.K        | 2009 | 445          | 4.87\%                  |
| Ichimura et al [3]  | Sweden     | 2009 | 305          | 3.0\%                   |
| Balsis et al [2]    | Germany    | 2008 | 685          | 7.0\%                   |

The presence of \textit{IDH1} mutation in the majority of low grade astrocytomas confirms the neoplastic nature of the lesion and helps to differentiate the lesser cellular infiltrative tumor and /or tumor margin from gliosis particularly in a stereotactic biopsy [10, 14, 28, 29]. In the current study \textit{IDH1} positivity was helpful in confirming the clinical diagnosis of the neoplastic nature of the lesion.

Concerning the 2 glioblastomas variant with PNET component, both were \textit{IDH1} positive, which suggest the possibility of secondary glioblastoma originated from this tumor or the different histogenetic origin of this tumor from the primary Glioblastoma. In contrast other similar study showed reactivity of \textit{IDH1} in a minority of glioblastoma with PNET component and argue against the sole of secondary glioblastoma [30]. Therefore, large-scale studies are necessary to conclude the facts.

In contrary to adult gliomas, pediatric low and high-grade gliomas did not express IDH1. There was only one pediatric primary glioblastoma and a recurrent case of pilocytic astrocytoma which expressed the \textit{IDH1} mutation. This is in agreement with other related studies [2, 4, 14, 24, 31-33], which concluded no role of \textit{IDH1} mutation in pediatric gliomas. This can be explained by the frequency, pathological spectrum and the anatomical location of gliomas in this age group. So this may highlight the differences in the pathogenesis between pediatrics and adult gliomas.

The prognostic role of \textit{IDH1} in gliomas: \textit{IDH1} mutation demonstrated by many studies as associated with prolonged survival. Furthermore, patients with IDH mutant glioblastomas showed longer survival than patients with glioblastomas, or even anaplastic astrocytomas, without \textit{IDH} mutations [18, 21, 22, 34, 35]

In conclusion, \textit{IDH1} mutation is commonly present in adult gliomas particularly low-grade gliomas, and secondary glioblastoma, with no sex predilection, but it has no role in pediatric gliomas.

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