Expression profile of human herpesvirus 8 (HHV-8) in pyothorax associated lymphoma and in effusion lymphoma

M O'Donovan, I Silva, V Uhlmann, N Bermingham, K Luttich, C Martin, O Sheils, A Killalea, C Kenny, S Pileri, J J O'Leary

Abstract

Aims—Pyothorax associated lymphoma (PAL) occurs in a clinical setting of longstanding pyothorax or chronic inflammation of the pleura. Like primary effusion lymphoma, it has an association with Epstein-Barr virus (EBV), and is confined to the pleural cavity, but has differing morphological and phenotypic features. Human herpesvirus 8 (HHV-8) has been consistently reported in primary effusion lymphoma. This study examines the immunophenotype of two European cases of PAL, investigates the presence of HHV-8 and its expression profile, and assesses whether PAL is similar to other effusion lymphomas.

Methods—Material was obtained from two European cases of PAL. Immunocytochemical analysis was performed using antibodies against CD45, CD20, CD79a, CD45RAA, CD3, CD43, CD45RO (UCHL1), CD30, BCL-2, CD68, epithelial membrane antigen (EMA), BCL-6, p53, Ki-67, Kappa light chain, Lambda light chain, and the EBV antigens latent membrane protein 1 (LMP-1) and EBV encoded nuclear antigen 2 (EBNA-2). The cases were examined for HHV-8 by means of polymerase chain reaction in situ hybridisation (PCR-ISH), solution phase PCR, in situ hybridisation (ISH), and real time quantitative TaqMan PCR. v-IL-6 was high in PAL and in BC-1 and BC-3 cells. v-IL-6 was high in PAL and in BC-1 and BC-3 cells. v-IL-6 was high in PAL and in BC-1 and BC-3 cells.

Conclusion—The presence of HHV-8 in one of two patients with PAL raises interesting questions in relation to the pathobiology of the condition. Clearly, the results indicate that HHV-8 is not an obligate pathogen, necessary for the effusion phenotype, but might contribute to it by its secretion of specific cytokines.

Keywords: pyothorax associated lymphoma; human herpesvirus 8; primary effusion lymphoma

Pyothorax associated lymphoma (PAL) is a relatively recently described entity, occurring most frequently in Japanese populations,4 with occasional cases reported in Western countries.5–11 Patients have a clinical history of longstanding pyothorax or chronic inflammation of the pleura, resulting from the artificial induction of pneumothorax for the treatment of tuberculosis or tuberculous pleuritis. PAL occurs between 22 and 55 years after the onset of pulmonary tuberculosis. Patients present with chest pain, pleural effusion, and/or a mass with infiltration of the visceral or parietal pleura. Histologically, tumours have a diffuse large cell morphology with many showing immunoblastic differentiation. Tumour cells are B cells or null cells, are CD30 negative, and exhibit monoclonal immunoglobulin gene rearrangements. Most cases show Epstein-Barr virus (EBV) infectivity, with EBV encoded early RNA 1 (EBER1) and EBER2 positivity, strong expression of EBV encoded nuclear antigen 2 (EBNA-2) and weak expression of latent membrane protein 1 (LMP-1).5,10–12,14

Although PALs and primary effusion lymphomas have a similar pleural location and association with EBV, they have different morphological and phenotypic features. Human herpesvirus 8 (HHV-8) has recently been reported in association with primary effusion lymphomas (body cavity based lymphomas), and this has led to speculation regarding its
HHV-8 expression in PAL and effusion lymphoma

Involvement in PALs. To date, Ascani et al have been the only group to identify HHV-8 in their small series of pyothorax associated lymphomas. Here, we analyse two European cases of PAL for HHV-8 using the highly sensitive TaqMan technique. The objective of our study was to examine the immunophenotypic profile of European cases of PAL, to examine the expression patterns of EBV infection in these cases, and to assess whether HHV-8 is associated with PAL as it is with other effusion lymphomas.

Materials and methods

Material from two patients with PAL was obtained from the files of the Department of Haematology, University of Bologna, Italy.

Patient 1 was a 70 year old man who had a history of artificial pneumothorax for pulmonary tuberculosis 50 years previously. A computed tomography scan showed a pallor mass continuous with the pleura and invading the chest wall. Biopsy histology showed this to be a diffuse peripheral large B cell lymphoma, immunoblastic type (REAL classification).

Patient 2 was a 75 year old man with a history of artificial pneumothorax for pulmonary tuberculosis; 45 years previously he presented with a 15 cm mass in the left anterior hemithorax. Biopsy histology showed this to be a saccular peripheral large B cell lymphoma, immunoblastic type.

Immunocytochemical analysis was performed using the APAAP technique. Antibodies were used against CD45 (Dako, Glostrup, Denmark), CD20, CD79a (Dr DY Mason, Oxford, UK), CD55RA (Dako), κ light chain (polyclonal; Dako), λ light chain (polyclonal; Dako), CD3, CD43 (Dako), CD45RO (UCHL1) (Dako), CD30, BCL-2, p53 (Dako), BCL-6 (Professor B, Falini, Perugia, Italy), Ki-67 (Professor J Gerdes, Borstel, Germany), CD68 (Professor Falini), EMA (Dako), and the EBV antigens LMP-1 and EBNA-2 (Dako).

Immunocytochemical detection was achieved using the manufacturers' recommendations.

EBV was detected using EBER-ISH (Dako) and solution phase PCR.14

Immunoglobulin gene rearrangement was assessed. DNA was extracted from paraffin wax embedded tissue blocks and amplified by the PCR based method for the detection of rearranged immunoglobulin heavy chain genes described by Ramasamy et al.15 Primers homologous to the conserved sequences of the framework II and III regions, as well as the LJH and VLJH regions, were used.

HHV-8 was detected using non-isotopic in situ hybridisation, PCR-ISH, solution phase PCR, and TaqMan quantitative PCR.

HHV-8 detection by PCR ISH

Sections (5 µm thick) were cut on to silane coated in situ PCR glass slides (PE Biosystems, Warrington, UK). BC-1 and BC-3 cells established from patients with effusion lymphomas (containing 50–80 HHV-8 genome equivalents) were used as positive controls. Tissue sections were dewaxed with xylene for 15 minutes, and 100% ethanol for 10 minutes, followed by incubation in 0.02 N HCl for 10 minutes and digestion with 0.4 mg/ml proteinase K at 37°C for 15 minutes. Proteinase K was removed by washing the sections in cold phosphate buffered saline (PBS). Endogenous peroxidase activity was blocked with a 3% hydrogen peroxide solution in 0.1% sodium azide.

PCR amplification was carried out using the Gene Amp in situ PCR 1000 system (PE Biosystems). The following reaction conditions were used: 1 µM of each HHV-8 primer (KS1 open reading frame 26 (ORF-26): 5'-AGCGAAGATTCCACCAT-3' and KS2 ORF-26: 5'-TCCGTGGTGTCTACGTCCAG-3'), 200 µM dNTPs, 4–5 mM MgCl2, 1x PCR buffer II (PE Biosystems), and 10 U Taq IS (PE Biosystems) in a total reaction volume of 50 µl. Slides were assembled on the in situ PCR 1000 slide assembly unit (PE Biosystems), which was held at 70°C to perform “hot start” PCR. An aliquot of 50 µl of the PCR mix was placed directly on to the tissue sections and the reaction mix was covered with AmpliCover discs and clips (PE Biosystems). The slides were transferred to the heating block and the following cycles applied: 94°C for 55 seconds (cycle 1), followed by 94°C for 50 seconds and 55°C for 90 seconds for a total of 30 cycles. Control sections from each sample were used for PCRISH, without Taq polymerase and/or without primers. After amplification, AmpliCover discs and clips were removed and slides were fixed in 100% ethanol for five minutes. For HHV-8 detection, a 5'-end biotin labelled 30 mer oligoprobe (5'-TGGTTGTGGTACCCACATCTACTCCAAAATAT-3'; Oswell, Edinburgh, UK), which hybridises internally to the PCR amplicon, was applied at a concentration of 5–10 pmol/100 µl hybridisation buffer (5% dextran sulphate, 2× SSC at 55°C for 15 minutes), followed by a final wash in TBT (100 nM NaCl, 40 mM Tris (pH 7.2), 3% bovine serum albumin (BSA), and 0.05% Triton X-100) for 10 minutes. Target specific signals were seen with washing stringencies of 2× SSC at 37°C and 2× SSC at 53°C. Only occasionally were signals seen at 1× SSC at 55°C, and fewer signals were seen at 0.1–0.2× SSC at this temperature. These conditions are appropriate for 30 mer oligoprobes. A further control included amplification with HHV-8 primers and the use of a human papillomavirus type 16 (HPV-16) 30 mer probe (5'-GACTCCTGAGGAGAAGTCTGCCGTTACTG-3').

For detection, the slides were incubated with avidin-horseradish peroxidase (1/100 in TBT with 5% skimmed dried milk (Cow and Gate)). Unbound conjugate was removed by washing twice in Tris buffered saline (TBS) for five minutes each. The slides were then incubated with AEC development reagent (Histostain-SP...
Table 1  Primers and probes for TaqMan PCR of HHV-8 ORF-26 and v-cyclin encoding regions

<table>
<thead>
<tr>
<th>Primer</th>
<th>Sequence</th>
</tr>
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<tbody>
<tr>
<td>KS1 ORF-26</td>
<td>5'-AGC GCA AAG GAT TCC ACC AT-3'</td>
</tr>
<tr>
<td>KS2 ORF-26</td>
<td>5'-TCC GTG TTT TCT ACG TCC AG-3'</td>
</tr>
<tr>
<td>v-Cyclin 1</td>
<td>5'-ACC AGT TCA CTT TGC TAT GCC-3'</td>
</tr>
<tr>
<td>v-Cyclin 2</td>
<td>5'-GCT TTT GTA ATG GTG TTT AC-3'</td>
</tr>
<tr>
<td>v-Cyclin reverse</td>
<td>5'-TCA CCC ACA CTG TCG CCA ATG A-3'</td>
</tr>
<tr>
<td>β-Actin forward</td>
<td>5'-CAG CGG AAC CGC TCA TTG CCA ATG G-3'</td>
</tr>
<tr>
<td>β-Actin reverse</td>
<td>5'-F-ATG CCC TCC CCC ATG TCC TGC GTT-3'</td>
</tr>
</tbody>
</table>

Fl, FAM; HHV-8, human herpesvirus 8; ORF, open reading frame; TAMRA; v-cyclin, viral cyclin.

Table 2  Primers and probes used for HHV-8 ORF-26, v-cyclin, and GPCR PCR

<table>
<thead>
<tr>
<th>Primer/probe</th>
<th>Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>v-Cyclin forward</td>
<td>5'-GCC GGC TGT AGA AGC GAA A-3'</td>
</tr>
<tr>
<td>v-Cyclin reverse</td>
<td>5'-F-GAG CAA CCA ACA GGC CAC GGC C-3'</td>
</tr>
<tr>
<td>v-IL-6 forward</td>
<td>5'-CTC TTG GTG CTG TTC GGT TCA-3'</td>
</tr>
<tr>
<td>v-IL-6 reverse</td>
<td>5'-TCC CGG TAC GGT AGA AGA GG-3'</td>
</tr>
<tr>
<td>GAPDH forward</td>
<td>5'-GAA GGT AGA CAG AGT CCA G-3'</td>
</tr>
<tr>
<td>GAPDH reverse</td>
<td>5'-F-CTT GGT GGG TTA GCA CCA ACG ATG C-3'</td>
</tr>
<tr>
<td>β-Actin forward</td>
<td>5'-F-CGG CCC ACC CCC ATG TTT AAA A-3'</td>
</tr>
<tr>
<td>β-Actin reverse</td>
<td>5'-F-ATG CCC TCC CCC ATG TCC TGC GTT-3'</td>
</tr>
</tbody>
</table>

Fl, FAM; GAPDH, glyceraldehyde-3-phosphate dehydrogenase; GPCR, G protein coupled receptor; HHV-8, human herpesvirus 8; T, TAMRA; V, VIC; v-IL-6, viral interleukin 6.

Hybridisation efficiency was assessed using a biotin labelled alu repeat probe (blur 8).

HHV-8 DETECTION BY SOLUTION PHASE PCR

DNA was extracted from three to four 5 µm sections of paraffin wax embedded biopsies by treatment with xylene, digestion with proteinase K, extraction with phenol/chloroform, and alcohol precipitation. The quality of the extracted DNA was controlled by PCR amplification of an β-actin gene fragment using the following primers: forward primer, 5'-TCA CCA CACT GTG GCC CAC TCT ACGA-3' and reverse primer, 5'-CAC GGG AAAG GCT GTT CAC CAG-3'. For HHV-8 detection, KS4 primer (5'-AG CACTCAGGGGAGCAGTACG-3') and KS5 primer (5'-GACTCTTCCGCTGATG AACTGG-3'), derived from the putative minor capsid protein (homologue of ORF-26 of herpesvirus saimiri) were used and 100 ng of starting DNA template was amplified for 25 cycles. To increase the sensitivity and verify the specificity of the amplicon obtained with these primers, 2 µl of amplified product was re-amplified (for 25 cycles) using internal primers KS1 (5'-AG CCCAAGAGGATTCCACCAT-3') and KS2 (5'-TCCGTGTTGTCATGTC AGC-3').

All positive cases were confirmed by amplification with non-overlapping primers derived from the major capsid protein of HHV-8 (ORF-25) using outer primers (5'-AGG CAGCTCAGATGCCATGC-3' and 5'-GAA TTA CCCC CAG GAT CCG GGC ATT C-3') and inner primers (5'-GATGGACTAGTACGTA C-3' and 5'-GAA ACCAAGCATGGTGAG-3').

QUANTITATION OF HHV-8 VIRAL LOAD IN PAL BY TaqMan PCR

HHV-8 viral load in PAL biopsies was assessed by real time TaqMan PCR using the 7700 sequence detector (Perkin Elmer Applied Biosystems) and amplifying segments within the ORF-26 and the v-cyclin encoding region of the HHV-8 genome. This technique uses the 5′→3′ endonucleolytic activity of AmpliTaq DNA polymerase,16–18 which enables the direct detection of the PCR product by the specific release of a fluorescent reporter molecule during the PCR reaction.19 The sensitivity of the TaqMan PCR is 1–2.5 viral copies in 106 contaminating human DNA sequences. For the detection of HHV-8, triplicate samples containing 100 ng of starting DNA template were used. Magnesium chloride titration assays were performed initially to identify the optimal MgCl2 concentration for the reaction. Primers and the TaqMan probe were designed using “Primer Express”, which determines the optimal annealing temperature (Ta_opt).20 The amplification mix consisted of 1× PCR buffer II (PE Biosystems), 4 mM MgCl2, 200 µM dNTPs (dCTP, dATP, dGTP), 400 µM dUTP, 300 nM forward and reverse primers, 200 nM ‘TaqMan probe, 0.025 U/µl AmpliTaq Gold DNA polymerase, and 0.01 U/µl AmpErase UNG (to prevent PCR cross contamination), using the primer and probe sets detailed below.
The quality of amplifiable DNA was assessed by β-actin TaqMan PCR. Controls containing no template were also performed in triplicate for the ORF-26, v-cyclin, and actin amplifications.

The following thermocycling conditions were applied: 50°C for two minutes (activation of UNG), 95°C for 10 minutes (activation of AmpliTaq Gold), 95°C for 15 seconds (denaturation), and 60°C for one minute (combined annealing and denaturation) for 40 cycles.

Specific product was detected using the Perkin Elmer 7700 sequence detector for real-time PCR.

RNA TaqMan PCR
HHV-8 v-IL-6, v-cyclin, and GPCR PCR was carried out using the TaqMan PCR kit (PE Biosystems) using 0.1 U/µl ReTh polymerase, 1× 5X EZ buffer, 300 µM dNTPs (dCTP, dATP, dGTP, dUTP), 0.1 U/µl UNG, 200 nM forward and reverse primers, 96.7 µM GPCR and v-IL6 TaqMan probes, 5 µM v-cyclin probe, and 3.5 mM Mn(OA)2.

Copy RNA (cRNA) standards were used for RNA quantitation. This was achieved using cloned HHV-8 v-IL6, GPCR, and v-cyclin fragments, which were then in vitro transcribed using T7 or T3 to give bidirectional cRNA isolates.

Controls with no template DNA were also performed in triplicate for the v-IL6, v-cyclin, GPCR, and GAPDH amplifications.

The following thermocycling conditions were applied: 50°C for two minutes (activation of UNG), 60°C for 30 minutes (reverse transcription), 95°C for five minutes (initial denaturation), and 94°C for 15 seconds and 60°C for one minute (denaturation and combined annealing), for 45 cycles.

Specific product was detected using the PE Biosystems 7700 sequence detector for reverse transcription real time PCR.

Results
In patient 1, CD45, CD79a, CD20, CD45RA, CD43, κ light chain, and BCL-2 were all positive in 75–80% of the cells. The Ki-67 index was high (identified in 70–80% of cells).

In patient 2, CD45, CD79a, CD20, κ light chain, p53, and BCL-2 were positive in 70% of the cells. The Ki-67 index was high (identified in 90% of the cells).

EBER-ISH revealed hybridisation signals in approximately 30–40% of the cells (on serial section) (fig 1).

In patient 2, HHV-8 was not identified by solution phase PCR, but was identified using TaqMan PCR analysis, which yielded approximately 50–100 HHV-8 copies/2000 cell genome equivalents. Approximately 35% of cells were positive by PCR-ISH (fig 1), showing discrete punctate signals in the cytoplasm of lymphomatous cells. Diffuse signals were also seen in a few cells (< 1%), indicating possible lytic infection. The sensitivity of the TaqMan PCR assay is 1 viral genome copy/106 contaminating sequences; the sensitivity of single round HHV-8 ORF-26 PCR is 1 copy/104 contaminating DNA sequences, with the nested format achieving sensitivities of 1 viral genome copy/105 contaminating sequences. The sensitivity of PCR-ISH is 1 viral genome copy/cell. Control reactions yielded appropriate results (fig 2), with the blur
8 alu repeat probe giving 100% signal in tissue sections, indicating 100% hybridisation efficiency. BC-1 and BC-3 cell lines (containing 50–100 HHV-8 genome copies/cell) yielded positive signals on ISH and PCR-ISH.

In patient 2, HHV-8 v-IL-6, GPCR, and v-cyclin encoded transcripts could be identified using RNA TaqMan PCR. Results are compared with the expression of these regions in BC-1 and BC-3 cells (fig 3). v-IL6 expression was high in BC-1 cells, BC-3 cells, and in PALs, ranging from 2700 to 4000 cRNA equivalents/2000 cell. Constitutive expression of GPCR and v-cyclin was lower, at around 1000 cRNA transcript equivalents. All results were gene dosage corrected using GAPDH.

Discussion

PAL occurs in approximately 2% of patients with chronic pyothorax, 22–55 years after artificial pneumothorax to control lung tuberculosis or tuberculous pleuritis. Epidemiological studies in Japan suggest that the risk of lymphoma in these patients is 3000 times higher than in the general population. Although rare cases of anaplastic large cell and T cell rich B cell morphology have been described, our cases were representative of the more usual diffuse large B cell immunoblastic phenotype, and both demonstrated clonal rearrangements (κ and λ light chain restriction), as documented previously. The Ki-67 index was high (80–90% of cells positive), indicating high cell turnover.

Viral studies suggest a causal association with EBV. Our results also confirmed the presence of latent type III EBV infection. HHV-8 has been reported recently in association with primary effusion lymphomas (body cavity based lymphomas) and this has led to speculation regarding its involvement in PALs. HHV-8 is the well described first member of the Rhadinovirus family of γ herpesviruses. It is also described in all types of Kaposi’s sarcoma,
HHV-8 expression in PAL and effusion lymphoma

Castleman’s disease, AIDS central nervous system lymphoma, and multiple myeloma. To date, at least 14 reading frames of HHV-8 are clearly homologous to cellular genes known to encode proteins involved in inflammation and tumour development: v-IL-6, v-cyclin, GPCR, BCL-2, the IL-8 receptor, macrophage immunoprotein 1 (MIP-1), and MIP-2.

An association between PAL and HHV-8 remains controversial. Ascani et al reported an association with HHV-8,11 but Cesarian et al did not detect the virus in 12 Japanese and two French cases of PAL.27 We investigated the presence of HHV-8 using solution phase PCR and in situ PCR, confirming and quantifying our previous results using the highly sensitive real time quantitative TaqMan PCR technique. We identified the virus in one of two cases of PAL (50–100 viral copies/2000 DNA cell equivalents). We recognise that our sample number is very small, but feel that these results are relevant given the sensitivity (detects 1 copy of viral genome/107 DNA cell extract equivalents) and specificity of the TaqMan reaction. We suggest that earlier studies not identifying HHV-8 suffer from a lack of sensitivity.

The examination of the expression patterns of HHV-8 encoded genes (v-IL-6, GPCR, and v-cyclin) demonstrated similar degree of expression in both PALs and primary effusion lymphoma cell lines (BC-1 and BC-3), suggesting that there is a similar mechanism of induction and conservation of the effusion phenotype in both of these entities. Although both entities are pleural cavity based, are associated with EBV, show immunoglobulin restriction, and express CD45 antigen, they have many differing features—primary effusion lymphomas show diffuse large cell morphology (with features intermediate between immunoblastic or anaplastic large cell lymphoma morphology) and have a B cell genotype, with evidence of immunoglobulin gene rearrangements. CD45, CD30, CD38, CD71, and human major histocompatibility complex DR antigen (HLA-DR) are expressed in the absence of other B or T cell lineage restricted antigens, whereas PALs have a diffuse large cell (predominantly immunoblastic) morphology. Tumour cells are B cell or null in type and negative for CD30.12–22 Of interest, the B-3 cell line is not infected by EBV, whereas the BC-1 cell line and PALs are, suggesting that EBV is not the agent responsible for the effusion phenotype.

The presence of HHV-8 in one of two cases of PAL raises interesting questions in relation to the pathobiology of the condition. Clearly, the results indicate that HHV-8 is not an obligate pathogen, necessary for the effusion phenotype, but might contribute to it by its secretion of specific cytokines. The HHV-8 encoded cytokine pattern in BC-1 and BC-3 cells is similar, suggesting a common pathogenic mechanism in these lesions. Further studies involving larger numbers of patients should delineate the relationship between HHV-8, PALs, and the effusion phenotype.

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