Paris staging system for primary gastrointestinal lymphomas

Currently, much effort is put into the development of specific therapeutic approaches that are tailored to specific lymphoma entities. As a consequence, more specific information needs to be collected to support the choice of therapy. In gastric marginal zone B cell lymphoma of MALT-type, the need for specialized documentation of tumour extent in the organ wall has been stressed by the high predictive value for failure of response after eradication of infiltration beyond the mucosa, a predictive parameter irrespective of the presence of the t(11;18) translocation. With new techniques such as endosonography, this infiltration depth can be assessed with improving accuracy. However, the information cannot be translated into the current staging systems. The dissemination patterns of extranodal lymphomas are also essentially different from primary nodal lymphomas. As tumour stage is one of the most important guidelines in the choice of local therapy (surgery, radiotherapy) and chemotherapy, adequate documentation of tumour localisation in the organ related lymph nodes and beyond is essential.

The Ann Arbor staging system, developed for and routinely used in nodal non-Hodgkin's lymphoma, is not optimal for documentation of the specific relevant features of primary extranodal lymphoma in the gastrointestinal tract. Several modifications and alternatives have been proposed. However, neither differentiation of stage I, (confined to mucosa and submucosa) from stage I (tumour extension beyond the submucosa according to Radaszkiewicz and colleagues') nor discrimination of stage II, (nodal involvement beyond the regional area, as assessed in the Musshoff modification) is sufficiently serving the demand for documenting all features of lymphoma. To meet these shortcomings, the Lugano classification was constructed by Roitman and colleagues' introducing stage IIIE for "serosa penetration" without lymph node involvement into the Ann Arbor system. This represents a change in meaning of stage II that originally indicated lymph node involvement. Therefore, the Lugano system is causing more confusion than benefit.

TNM staging for tumours of epithelial origin has also been proposed as an alternative in gastrointestinal lymphoma to describe localised disease. The "T" part of this system pertains to the anatomical structure of the organs and sufficiently fulfills the requirements for staging of local extent of the disease. The European Gastro-Intestinal Lymphoma Study Group (EGILS) is a multidisciplinary group of investigators, including clinical investigators such as gastroenterologists, medical oncologists, radiotherapists, and pathologists, as well as basic researchers such as cellular and molecular biologists. Several groups from the UK, France, Germany, the Netherlands, Spain, and Austria now take part and have come together regularly since 1999 to discuss and study subjects in epidemiology and molecular and cell biology of gastrointestinal lymphoma. Clinical protocols and trials have been developed and performed as a collaborative effort. As a result of discussions on staging protocols and reporting systems over the past years, we would like to propose a modified TNM staging system, named after the first venue of the group in Paris. The staging system adequately records: (1) depth of tumour infiltration; (2) extent of nodal involvement; as well as (3) specific lymphoma spreading (table 1). It is adjusted to the gastrointestinal origin of the lymphoma, considering histopathological characteristics of extranodal B and T cell lymphomas. The use of this system in future studies will permit accurate comparison of the reported cohorts and should allow rapid accumulation of good data for proper stratification of patients for risk assessment and treatment options.

**Table 1 Paris staging system for primary gastrointestinal lymphomas**

<table>
<thead>
<tr>
<th>Code</th>
<th>TNM Clinical staging: status of tumour, node, metastasis, bone marrow</th>
<th>pTNM Histopathological staging: status of tumour, node, metastasis, bone marrow</th>
<th>pN The histological examination will ordinarily include 6 or more lymph nodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Lymphoma extent not specified</td>
<td>Clinical staging: status of tumour, node, metastasis, bone marrow</td>
<td>The histological examination will ordinarily include 6 or more lymph nodes</td>
</tr>
<tr>
<td>TO</td>
<td>No evidence of lymphoma</td>
<td>Histopathological staging: status of tumour, node, metastasis, bone marrow</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Lymphoma confined to the mucosa/submucosa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1m</td>
<td>Lymphoma confined to mucosa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1sm</td>
<td>Lymphoma confined to submucosa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Lymphoma infiltrates muscularia propria or subserosa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Lymphoma penetrates serosa (visceral peritoneum) without invasion of adjacent structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Lymphoma invades adjacent structures or organs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Involvement of lymph nodes not assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>No evidence of lymph node involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Involvement of regional lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Involvement of intra-abdominal lymph nodes beyond the regional area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Spread to extra-abdominal lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MX</td>
<td>Dissemination of lymphoma not assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MO</td>
<td>No evidence of extranodal dissemination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Non-continuous involvement of separate site in gastrointestinal tract (eg, stomach and rectum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Non-continuous involvement of other tissues (eg, peritoneum, pleura) or organs (eg, tonsils, parotid gland, ocular adnexa, lung, liver, spleen, kidney, breast etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BX</td>
<td>Involvement of bone marrow not assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BO</td>
<td>No evidence of bone marrow involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BI</td>
<td>Lymphomatous infiltration of bone marrow</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Valid for lymphomas originating from the gastro-oesophageal junction to the anus (as defined by identical histopathological structure).

†In case of more than one visible lesion synchronously originating in the gastrointestinal tract, give the characteristics of the more advanced lesion.
A new cause for CA19.9 elevation: heavy tea consumption

Serum carbohydrate associated antigen (CA19.9) is a reliable tumour marker of biliopancreatic malignancies. A number of benign diseases are also known to be related to CA19.9 elevation. Here we report a case of markedly raised levels of CA19.9 associated with heavy tea consumption.

Case report

A 52 year old woman was referred to our unit for epigastric pain and anorexia of two months’ duration. She also complained of nausea and a 2 kg weight loss. Her past medical history was unremarkable. She was a non-smoker and denied alcohol abuse or medication intake but remarked on overconsumption of warm black tea for several months (1.5–2 litres/day). Physical examination was normal. Laboratory data demonstrated normal ranges for electrolytes, liver function tests, blood count, urea, creatinin, C reactive protein, amylase, and lipase. Fasting blood glucose, triglycerides, cholesterol, and thyroid function tests were normal. Autoantibodies were negative. Serum CA19.9 was 1432 IU/ml (normal <37), and CEA was 2 ng/ml (normal <5).

Upper endoscopy, colonoscopy, and barium study of the small bowel showed normal results. Abdominal ultrasonography and computed tomography scan found mild enlargement of the body of the pancreas without hepatobiliary abnormalities. Endoscopic ultrasonography showed no pancreatic malignancy or biliary abnormalities. The pancreas was homogenous and mildly enlarged in the body without pathological significance.

Sputum, chest x ray, bronchoscopy, and bronchoalveolar lavage fluid examination were normal. The patient was advised to stop tea consumption. Four weeks later she became symptom free and gained the 2 kg weight loss. Another serum CA19.9 assay showed a considerable drop in levels to 42 IU/ml. A rechallenge test was then attempted. The patient restarted tea consumption as previously. Four weeks later CA19.9 increased to 745 IU/ml followed by a fall to 25 IU/ml one month after withdrawal. Follow up one year later revealed no clinical abnormalities. Abdominal and chest computed tomography scan were normal.

Discussion

CA 19.9 (sialyl lewis-a) is a monosialoganglioside with small increases in a number of benign diseases, with highest levels in pancreatic adenocarcinoma, hepatocellular, and cholangiocellular cancer, and also in gastric, colorectal, and occasionally other cancers.1 Physiologically elevated concentrations are present in many secretions of healthy individuals with the Lewis a positive phenotype in contrast with low serum levels of CA19.9 in Lewis a negative individuals (7–10%).1

Among non-malignant causes, obstructive jaundice is frequently associated with increases in CA19.9. Relief of jaundice is often associated with a fall in CA19.9 in benign cases and mostly in patients with malignancy.2 Normal biliary epithelial cells secrete mucins carrying the epitope of CA 19.9. Unspecific elevation of CA 19.9 in serum reflects both inflammatory hypersecretion and leakage of biliary mucins into serum.3

In addition, there is a strong correlation between serum CA19.9 concentration and standard parameters of cholestasis; alkaline phosphatase and bilirubin during acute liver failure, acute hepatitis, and chronic liver diseases of any aetiology.4

Other benign causes of CA19.9 increases are shown in Table 1. The common underlying mechanism for each is probably inflammatory hypersecretion of CA19.9 by normal epithelial cells.5 The constituent flavonoids of tea beverage are known to be potent antioxidants. It appears the flavonoids in tea overuse have a wide range of molecular targets that influence cell growth and pathways of angiogenesis.6

In this case, the usual causes of CA19.9 elevation were ruled out before a link with the tea beverage was suspected. After tea consumption withdrawal, a dramatic improvement occurred and the patient became symptom free, suggesting the diagnosis of tea intoxication. At the same time, serum CA19.9 levels dropped and a positive rechallenge test proved the relationship between tea overconsumption and raised levels of CA19.9.

To our knowledge, this is the first reported case of markedly raised levels of CA19.9 associated with heavy tea consumption. The mechanism of this relation remains unclear. In addition, the epithelial tissue target involved in CA19.9 secretion by tea overuse is unknown. Individual susceptibility to abnormal CA19.9 secretion triggered by tea overconsumption could not be excluded.

References


Table 1 Non-malignant causes of CA19.9 elevation (median values)
Non-alcoholic steatohepatitis and hepatic steatosis in patients with adult onset growth hormone deficiency

Adult onset growth hormone (GH) deficiency closely resembles syndrome X. Patients with syndrome X often suffer from obesity, dyslipidemia, insulin resistance, and hypertension, and hepatic steatosis and non-alcoholic steatohepatitis (NASH) have also been characterized as symptoms of syndrome X. However, the relationship of GH deficiency to hepatic steatosis and NASH remains unclear.

We looked for the presence of hepatic steatosis using computer tomography (CT) in a study of 18 patients with adult onset anterior lobe pituitary hormone deficiency, with or without GH deficiency. We also performed a liver biopsy in one patient with adult onset GH deficiency. None of the patients was positive for hepatitis B surface antigen, hepatitis C virus antibody, antinuclear antibody, or antimitochondrial antibody. The criterion used for diagnosing hepatic steatosis was a ratio for liver/spleen CT value of less than 0.9. In 13 patients with GH deficiency, seven showed hepatic steatosis (53.8%) while in five patients without GH deficiency no hepatic steatosis was present (p = 0.035). Body mass index (BMI kg/m²), serum triglyceride level (TG mg/dl), and serum total cholesterol (T-ch mg/dl) were similar in patients with or without GH deficiency.

| Table 1 |
|------------------|------------------|------------------|------------------|
|                  | Without GH       | With GH           | p Value          |
| Hepatic steatosis (+/-) | 0/5              | 7/6              | 0.035            |
| BMI (kg/m²)       | 21.29 (1.2)      | 23.54 (2.21)     | 0.35             |
| TG (mg/dl)        | 135.8 (25)       | 95.4 (10)        | 0.30             |
| T-ch (mg/dl)      | 202.5 (18)       | 180 (6.0)        | 0.44             |

Values are mean (SD). BMI, body mass index; TG, serum triglyceride level; T-ch, serum total cholesterol.

Figure 1: Histology of the liver biopsy. Macrovesicular steatosis, pericellular and centrilobular fibrosis, and ballooned hepatocytes are all observed in this section. (Method: needle biopsy; haematoxylin-eosin staining.)

References

Expression of thioipurine methyltransferase in South Asians

Azathioprine and its metabolite 6-mercaptopurine (6-MP) are widely used in the treatment of Crohn’s disease, ulcerative colitis, autoimmune hepatitis, and a range of other inflammatory and autoimmune diseases, as well as for prevention of transplant rejection. Thioipurine methyltransferase (TPMT) converts 6-MP to 6-thioguanine nucleotides. Previous reports in Caucasians have shown that approximately 0.3% are homozygously and 10% heterozygously deficient in TPMT. One study

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suggests that the frequency of individuals with the mutant TPMT allele, TPMT*3A, is lower in Southwest Asians than in Caucasians; the allele causes reduced enzyme activity in vitro. However, there are no data on the phenotypic expression of TPMT in South Asian populations.

We have compared expression of TPMT in South Asian and Caucasian patients attending gastroenterology, renal, rheumatology, and dermatology clinics who were being considered for treatment with thiopurines. TPMT activity was assayed by tandem mass spectrometry for 6-mercaptopurine (6-MP) (assays kindly provided by Purine Research Laboratory, Guy’s Hospital, London SE1 9RT, UK). Homozygous deficiency of TPMT was defined as a level <10, heterozygous as 10–25, and normal as >25 pmol/h/mg haemoglobin.

Of 83 Caucasian patients, one (1.3%) was homozygously deficient, 10 (12%) were heterozygous, and 72 (86.7%) had normal expression of TPMT. The corresponding values in 77 South Asian patients were 0.7 (9%), and 70 (91%), respectively.

The prevalence of deficiency of expression of TPMT in South Asian patients resembles that in Caucasians. Use and monitoring of azathioprine and 6-MP should therefore follow similar principles in both ethnic groups.

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References

Fatigue is associated with high circulating leptin levels in chronic hepatitis C

We read with great interest the recent paper from Piche and colleagues (Gut 2002;51:434–9) relating leptin levels to fatigue in chronic hepatitis C patients. On the surface, their observation that serum leptin levels correlate with the fatigue impact scale are very intriguing. However, leptin shows a gender based with the fatigue impact scale are very intriguing. Indeed, in the study by Piche et al the fatigue impact scale was found to be significantly higher in females than in males, even when matched for body fat mass. 1 This sex needs to be considered when investigating any association with leptin levels, and multivariate analysis is necessary to reduce the bias caused by this confounding variable. Indeed, in the study by Piche et al the fatigue impact scale was found to be significantly higher in females than in males, even when matched for body fat mass. However, the authors do not say whether each postoperative serum mutation which they detected corresponded with the genotype of the primary tumour. While a number of studies have suggested that occasional somatic mutations may carry a different mutational load to the primary, this is very uncommon. If the mutation is not the same as the primary tumour, this raises many issues, not least that despite the very careful use of controls, nested polymerase chain reaction techniques may be too sensitive for clinical practice.

For an individual with colorectal cancer, a multiplicity of factors may shape the clinical course. To improve our knowledge, we must seek to study the most subtle variation in molecular profiles possible, as small differences may be very important. While rigorous small prognostic clinical studies may be intriguing, they may have significant limitations. Some of us have argued previously that there is only one way forward. All bodies funding prospective therapeutic studies in colorectal cancer should insist that a panel of molecular markers are measured and recorded in all patients using a standardised technique, even if they are not included as an end point, and make these results readily available for subsequent analysis. Studies in which groups and methods are performed prospectively carry the least risk of methodological flaws.

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Reference

Mutant K-ras2 in serum

Ryan and colleagues’ careful and well conducted study (Gut 2003;52:101–8) raises once again the interesting issue of whether molecular analysis and knowledge of mutations of the Kirsten ras gene in particular, have a role in the management of patients with colorectal cancer.

The two RASCAL (Kirsten Ras in Colorectal Cancer Collaborative group) studies1,2 which eventually enrolled data from 4266 patients from 42 centres in 21 countries showed that although the frequency of Kirsten ras mutations at codons 12 and 13 may vary a little between populations, overall they are only present in just over one third of patients. This is significantly less frequent than quoted by Ryan et al. In addition, the RASCAL study also showed that Kirsten ras mutations are not associated with sex, age, tumour site, or Duke’s stage.

Much more importantly, however, they also showed that of the 12 different possible specific point mutations at codons 12 or 13, only a guanine to thymidine mutation, which are found in less than 10% of all patients, is an independent variable for relapse and death. Indeed, the most common mutation, guanine to adenine, exerted an effect on survival barely different from wild-type ras. Others have shown there is a reasonable biological basis for these findings.

As a collaborative group, therefore, we felt it was generally unhelpful to consider Kirsten ras mutations collectively, rather than the effect of each individual mutation separately when considering the prognosis of patients with colorectal cancer. With this in mind, we believe that two crucial questions are left unanswered by the study of Ryan et al. Without definitive answers to these, it is unlikely that serum detection of mutated Kirsten ras gene will ever be clinically useful.

Firstly, firstly of any new mutation in the serum of a patient who has had colorectal cancer raises the possibility of tumour recurrence, although the presence of a Kirsten ras mutation is not colon specific. However, more than one third of patients in Ryan’s study did not clinically relapse despite the presence of a serum mutation for very long periods. Others have also detected tumour DNA in patients for long periods without evidence of overt clinical recurrence.3 Therefore, screening for the presence of Kirsten ras mutations per se is unlikely to be clinically helpful very often. However, it would have been very interesting to know whether the patients who did not relapse in this study were those who had the RASCAL allele or those who had not.

Secondly, the authors do not say whether each postoperative serum mutation which
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References

BOOK REVIEW
Radiological Imaging of the Small Intestine

Springer Verlag are producing an extensive range of Medical Radiology books under the general editorship of Professor AL Baert, and this volume on the small intestine is the latest in the line. Professor NC Gourtsoyiannis is its distinguished editor. This is no more than a very well established series with topics which vary from organ based (that is, pancreas) to more established series with topics which vary from organ based (that is, pancreas) to most likely to be due to the inclusion of 141 beautiful colour illustrations of both endoscopic views and pathology specimens in Radiological Imaging. This is also the most recent publication (2002 versus 1999) and in areas where there is rapid technical change—typically MR imaging—the reader can appreciate the difference. It has to be said that both books fulfil their remit extremely well but there remains more of a deductive radiological process where observations need to be carefully integrated with the clinical abnormality of the patient before a reasoned differential can be given. This coupled with the multitude of imaging techniques, from good old fashioned barium to ultrasound, CT, and magnetic resonance (MR), etc, still means that it provides a diagnostic challenge.