Epithelial cells disseminate into the bone marrow of colorectal adenoma patients

Although the skeleton is not a preferred site of overt metastasis in colorectal cancer, demonstration of tumour cells in bone marrow has to be seen as evidence of the general disseminative capability of an individual tumour. Other observations such as involuntary transmission of tumour by organ grafts directly supports the notion that very few quiescent cells lodging at improbable sites, such as the kidney or heart, suffice to generate de novo metastatic disease in the organ recipient. The TNM classification recommends mention of the presence of disseminated tumour cells as a facultative factor for metastasis (M0 (i.e) or M0 (mol+)) according to the immunological or molecular detection technique.

However, the results of the one and only meta-analysis available to date show that the prognostic impact of epithelial cells in the bone marrow of colorectal cancer patients has to be substantiated by further studies under standardised conditions. To further investigate this question, bilateral crest aspiration is performed routinely in our institution for neoplastic diseases. From September 1997 until July 2000, we investigated 233 patients using this method: approximately 2 million mononuclear cells were analysed from each sample and divided into 10 cytospins. One half was stained with the A45-B/B3 antibody (supplied by U Karstens, PhD, Berlin, Germany) and the other half with Ber-EP4 (supplied by U Karstens, PhD, Berlin, Germany) and the corresponding large (60x45 mm) tubulovillous adenomas of the right colon, with low grade intraepithelial neoplasia (haematoxylin-eosin staining, magnification 40x). In a previous study, we examined the clonality of disseminated tumour cells in the bone marrow of 51 colorectal cancer patients by determining the mutational pattern in codons 12 and 13 of the K-ras gene. Our results demonstrated that, at least for K-ras mutations, disseminated epithelial cells are not always clonal with the primary tumour. The type of mutations suggested also that cell dissemination might be an early event in the development of colorectal neoplasms as most bone marrow K-ras mutations were found in codon 13, a codon rarely mutated in invasive colorectal cancer but frequently mutated in aberrant crypt foci.

Obviously, epithelial cells can already disseminate in the polyp stage, in particular when so-called intraepithelial neoplasia is diagnosed. Indeed, dissemination of epithelial cells into the bone marrow in a stage defined as non-cancerous questions the carcinomatos nature of these cells, and in particular their micrometastatic nature. In contrast, should these cells be cancer cells—which we cannot exclude on the basis of our previous and present observations—then the benign nature of intraepithelial neoplasia should in turn be challenged.

We would be delighted to receive feedback from other researchers that would help us to interpret the present observation.

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Conflict of interest: None declared.

References


Table 1 Patients, tumours, and results of bone marrow immunohistochemistry

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age (y)</th>
<th>Localisation</th>
<th>Histopathology</th>
<th>A45-B/B3</th>
<th>BerEP4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>63</td>
<td>Rectum</td>
<td>Tubular adenoma with high grade intraepithelial neoplasia</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>F</td>
<td>41</td>
<td>Colon sigmoidum</td>
<td>Tubulovillous adenoma with high grade intraepithelial neoplasia</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>F</td>
<td>56</td>
<td>Colon ascends</td>
<td>Tubular adenoma with low grade intraepithelial neoplasia</td>
<td>Positive</td>
<td>Positive</td>
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<tr>
<td>M</td>
<td>57</td>
<td>Colon sigmoidum</td>
<td>3 tubulovillous adenoma with high grade intraepithelial neoplasia</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>F</td>
<td>67</td>
<td>Rectum</td>
<td>Tubulovillous adenoma with high grade intraepithelial neoplasia</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>M</td>
<td>79</td>
<td>Rectum</td>
<td>Tubular adenoma with high grade intraepithelial neoplasia</td>
<td>Positive</td>
<td>Positive</td>
</tr>
<tr>
<td>M</td>
<td>74</td>
<td>Colon sigmoidum</td>
<td>Tubulovillous adenoma with high grade intraepithelial neoplasia</td>
<td>2/7 positive</td>
<td>3/7 positive</td>
</tr>
</tbody>
</table>
Genetic evidence that juvenile nasopharyngeal angiofibroma is an integral FAP tumour

Juvenile nasopharyngeal angiofibroma (JNA) is a rare locally invasive neoplasm composed of cavernous vascular channels set in an abundant myxoid stroma of fibroblasts and focal mononuclear cell infiltrates (A, ×125; B, ×400).

Figure 1 Histopathological appearance of the nasopharyngeal angiofibroma described in this study. The tumour is composed of dilated vascular channels set in an abundant myxoid stroma containing fusiform fibroblasts and focal mononuclear cell infiltrates (A, ×125; B, ×400).

References


Evaluation of vascular signal in pancreatic ductal carcinoma using contrast enhanced ultrasonography: effect of systemic chemotherapy

Evaluation of the effect of chemotherapy for pancreatic ductal cancer (PC) is generally conducted based on changes in tumour diameter using imaging modalities; however, exact measurement is often difficult because of local inflammation, fibrotic change, and desmoplastic reaction to treatment, leading to an unreliable evaluation. PC is considered a hypovascular tumour. However, recently developed high sensitive ultrasonic equipment has enabled the detection of vascular signals in PC; vascular signals were detected in 20–67% of cases. We focused on changes in tumour vascularity of PC associated with chemotherapy, and attempted to apply it to evaluation of the effect of treatment and usefulness in relation to prognosis. In this study, we assessed vascular images of the tumour based on the Doppler signal (using contrast enhanced ultrasonography (CEUS)).

Thirty one histopathologically confirmed consecutive patients with PC who had distant metastasis were included in the study. Informed consent was obtained from all patients and the study was approved by the ethical committee. The tumour was located in the head of the pancreas in 16 patients and in the body or tail in 15. All patients were treated with a combination of S-1, an oral fluorinated pyrimidine derivative, and gemcitabine. Chemotherapy was performed every three weeks as one cycle. CEUS was performed before and after one and two cycles of treatment using a SSA-770A (Toshiba Co. Ltd, Tokyo, Japan) and a 3.75 MHz convex probe. CEUS images were obtained by Advanced Dynamic Flow mode, which is a wideband Doppler sonography with a high sensitivity and resolution. The contrast agent was Levovist (SHU 508 A; Schering AG, Berlin, Germany), which was administered at a concentration of 300 mg/ml by intravenous injection of 8 ml at 1 ml/s. After injection, v signals in the tumour of the pancreas were continuously observed for 120 seconds. CEUS images showing the high-intensity of the vascular signal were selected and classified into five categories according to intensity: no signal (grade 0), hypo-intensity (grade 1), linear signals between grades 1 and 3 (grade 2), mosaic pattern signals (grade 3), and diffuse pattern signals (grade 4). Dynamic computed tomography (CT) was performed with a helical CT scanner (Light Speed Ultra, GE Medical Systems) which was performed every two cycles. In this study, treatment effect after two cycles of chemotherapy was examined. The response to treatment, as determined by dynamic CT after two cycles of treatment, was as follows: partial response (PR) in five patients (16%), stable disease (SD) in 17 patients (55%), and progressive disease (PD) in nine (29%). A significant decrease in the v signal score was observed in PR compared with SD or PD after one cycle of treatment (p = 0.0009 and p = 0.0017, respectively). After two cycles of treatment, the decrease was conspicuous in PR (p = 0.0022 and p = 0.0021, respectively) whereas in PD a significant increase in the signal score was observed compared with SD (p = 0.0168). In a multivariate analysis, the increase in v signal (before the second cycle) was a significant prognostic factor (p = 0.0319). Median survival time of patients in the non-increased v signal group (n = 22) after two cycles of treatment was 382 days (71–484) and for those in the increased group (n = 9), 176 days (68–257). Thus patients in the increased group had a significantly shorter survival than those in the non-increased group (p = 0.0094) (fig 1).

In conclusion, analysis of tumour vascularity by CEUS evaluated the effect of treatment much earlier than dynamic CT, and predicted prognosis in patients with PC.

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References

Smoking status in therapeutic trials in Crohn’s disease

We were interested to hear the results of a number of trials of novel therapies for Crohn’s disease (CD) that were presented at the 12th UEGW and reported in abstract form in GUT. Many of the studies were randomised controlled trials in which the active and control groups were reported to have identical baseline characteristics. However, in all of the studies that were reported there was no mention of the smoking status of the participants, consistent with recent therapeutic trials in CD published in high profile journals. Smoking is a well documented and universally recognised risk factor for increased CD severity as smokers are more likely to relapse and require corticosteroids, immunosuppressants, and surgery. Furthermore, smokers are more likely to have a less favourable response to infliximab. Smoking status is therefore a potential confounding factor in therapeutic trials in Crohn’s disease. We urge investigators to include smoking status in the abstract, text, and analyses of all therapeutic trials of CD. Furthermore, we believe that stratification for smoking should be included at the planning stage for all randomised controlled trials in CD. Investigators may wish to reanalyse published data to ensure that results have not been confounded by smoking.

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Conflict of interest: None declared.

References
Serum ferritin concentration was 3500 μg/l with a transferrin saturation (TS) of 29%.

The study was approved by and performed in accordance with the ethical standards of the Helsinki Declaration of 1975, as revised in 1983. Informed and written consent was obtained from the patient and family members.

The subject was referred for further evaluation after complaining of ongoing lethargy and malaise. He had no risk factors for viral hepatitis, consumed minimal alcohol (20 g/week), and was married with two children.

Liver biopsy was performed and revealed significant Kupffer cell iron loading with minimal staining in hepatocytes, as detected by Perls’ Prussian blue staining. No fibrosis was detected. Hepatic iron concentration was 96 μmol/g dry weight (normal 5–35 μmol/g dry weight) with a hepatic iron index of 2.1 (normal <1.1). No other secondary cause for iron loading (for example, thalassemia, porphyria cutanea tarda, or chronic liver disease) was detected.

Liver histology and biochemistry were suggestive of ferroportin disease. The entire coding region and splice sites of the ferroportin gene from the proband were polymerase chain reaction amplified and sequenced, as previously described. Other family members were subsequently evaluated.

The presence of a cytokine to adenosine change at nucleotide 230 of ferroportin, which results in mutation of an alanine to aspartic acid at amino acid 77 (A77D), was identified in the proband. Subsequently, this change was also identified in the proband’s father, sister, and daughter (fig 1). This is the same mutation which was identified in Italy by Montosi and colleagues.1 There is no known ancestral link between the family reported here and that in Italy. Thus it is likely that the A77D mutation has occurred in the two populations separately, as appears to be the case with the V162del mutation, which has so far been reported in five geographic locations.

As knowledge about ferroportin disease is uncommon in the community, unlike HFE associated haemochromatosis, it is possible that some cases of this disorder are not recognised and thus remain undiagnosed. This particular case was not diagnosed until liver biopsy was performed. The raised serum ferritin level was initially attributed to viral illness. Because transferrin saturation and HFE genotype were normal, a diagnosis of iron overload was not initially considered.

In conclusion, we report the first identification of ferroportin disease caused by the A77D mutation in a region outside of Italy. This particular case was not diagnosed until liver biopsy was performed. The raised serum ferritin level was initially attributed to viral illness. Because transferrin saturation and HFE genotype were normal, a diagnosis of iron overload was not initially considered.

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In conclusion, we report the first identification of ferroportin disease caused by the A77D mutation in a region outside of Italy. This suggests that the A77D mutation may be more widespread than initially thought. This report also suggests that some cases of ferroportin disease may go undiagnosed.

Ferroportin disease should thus be considered when a patient presents with a high serum ferritin, even when transferrin saturation and HFE genotype are normal.

Acknowledgements

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Conflict of interest: None declared.

References


Ferroportin disease due to the A77D mutation in Australia

Ferroportin disease or type 4 haemochromatosis is an autosomal dominant iron overload disorder caused by mutations in the iron exporter ferroportin. Numerous mutations in ferroportin (SLC40A1) have been identified (see review by Pierrand et al). The A77D mutation of ferroportin has thus far only been reported in Italy. We report the first A77D mutation of ferroportin which resulted in haemochromatosis in an Australian family. The study was approved by and performed in accordance with the ethical standards of the Queensland Institute of Medical Research Human Ethics Committee and the Helsinki Declaration of 1975, as revised in 1983. Informed and written consent was obtained from the patient and family members.

The subject, a 45 year old Caucasian male, presented with complaints of lethargy and malaise. He had no risk factors for viral hepatitis, consumed minimal alcohol (20 g/week), and was married with two children. Physical examination was normal, including a normal body mass index.

Initial investigations revealed a haemoglobin level of 12.2 g/dl, white blood cell count of 3.8×10^3, and platelet count of 135×10^3. Serum ferritin concentration was 3500 μg/l with a transferrin saturation (TS) of 29%. Molecular analysis did not reveal the presence of the C282Y, H63D, or S65C mutations of HFE.

The subject was referred for further evaluation after complaining of ongoing lethargy and fatigue, myalgias, and arthralgia. On further clinical investigation he was found to have a mild lymphopenia, an alanine aminotransferase level of 63 IU/l, a serum ferritin concentration of 3340 μg/l, and a TS of 29%. He was non-reactive for hepatitis B surface antigen and negative for anti-hepatitis C virus IgG. Random blood sugar level and lipid profile were normal. HFE analysis was repeated, and again the absence of common mutations was confirmed.

Liver biopsy was performed and revealed significant Kupffer cell iron loading with minimal staining in hepatocytes, as detected by Perls’ Prussian blue staining. No fibrosis was detected. Hepatic iron concentration was 96 μmol/g dry weight (normal 5–35 μmol/g dry weight) with a hepatic iron index of 2.1 (normal <1.1). No other secondary cause for iron loading (for example, thalassemia, porphyria cutanea tarda, or chronic liver disease) was detected.

Liver histology and biochemistry were suggestive of ferroportin disease. The entire coding region and splicing sites of the ferroportin gene from the proband were polymerase chain reaction amplified and sequenced, as previously described. Other family members were subsequently evaluated.

The presence of a cytokine to adenosine change at nucleotide 230 of ferroportin, which results in mutation of an alanine to aspartic acid at amino acid 77 (A77D), was identified in the proband. Subsequently, this change was also identified in the proband’s father, sister, and daughter (fig 1). This is the same mutation which was identified in Italy by Montosi and colleagues. There is no known ancestral link between the family reported here and that in Italy. Thus it is likely that the A77D mutation has occurred in the two populations separately, as appears to be the case with the V162del mutation, which has so far been reported in five geographic locations.

As knowledge about ferroportin disease is uncommon in the community, unlike HFE associated haemochromatosis, it is possible that some cases of this disorder are not recognised and thus remain undiagnosed. This particular case was not diagnosed until liver biopsy was performed. The raised serum ferritin level was initially attributed to viral illness. Because transferrin saturation and HFE genotype were normal, a diagnosis of iron overload was not initially considered.

In conclusion, we report the first identification of ferroportin disease caused by the A77D mutation in a region outside of Italy. This suggests that the A77D mutation may be more widespread than initially thought. This report also suggests that some cases of ferroportin disease may go undiagnosed. Ferroportin disease should thus be considered when a patient presents with a high serum ferritin, even when transferrin saturation and HFE genotype are normal.
There are four clinical variants of KS: classic, endemic, acquired immunodeficiency syndrome (AIDS) associated, and iatrogenic. Excessive use of immunosuppressive drugs in the second part of the 20th century has been associated with a higher prevalence of iatrogenic KS. Start of the disease, after administration of the triggering drug in previously reported studies, ranged from less than one month to more than 20 years. The dose of steroid ranged from 5 to 125 mg/day. There was no evident correlation between the development of KS and dose or duration of steroid therapy. Our patient had been treated with 12-125 mg methylprednisolone daily for about four months when his skin lesions appeared. Reduction or discontinuation of immunosuppressive drugs often leads to considerable improvement in KS lesions. 

In accordance with these data, after withdrawal of steroid therapy the skin symptoms of our patient regressed spontaneously. Visceral KS is quite frequent in AIDS patients and can affect virtually all viscera, but colonic KS is rare. These patients are often asymptomatic or have aspecific symptoms. As KS affects the submucosa more often, superficial bowel biopsies frequently miss it, as happened in our case. A link between HHV-8, a gamma herpesvirus, and KS was first reported more than 10 years ago. The virus was found in more than 90% of KS samples from HIV seropositive patients but has low prevalence in healthy controls. HHV-8 DNA persists in endothelial cells and spindle cells of KS. According to the literature, the HHV-8 virus alone is not sufficient to form KS but it may be an important cofactor in the development of the disease. In our case, we detected HHV-8 genome in native samples from skin lesions but failed to do so in paraffin embedded colonic samples. The occurrence of colonic KS and UC together is rare. We found eight similar cases in the English literature (table 1).

Our patient was the fourth who was HIV negative and developed KS in association with UC. To our knowledge he was the first proven HHV-8 positive case who developed disseminated KS during immunosuppressive treatment for UC. Our treatment policy was successful. The patient, in spite of his poor condition, tolerated the surgical therapy well. After cessation of his steroid therapy KS regressed spontaneously. He remains well 35 months after surgery.

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Table 1 Main data from previously published articles on the coexistence of colonic Kaposi’s sarcoma (KS) and ulcerative colitis (UC)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year of publication</th>
<th>HIV status</th>
<th>Pathology of the colon</th>
<th>Skin lesion</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gordon et al.</td>
<td>1966</td>
<td>No information</td>
<td>UC</td>
<td>No</td>
<td>Colectomy</td>
</tr>
<tr>
<td>Adlersberg et al.</td>
<td>1970</td>
<td>No information</td>
<td>Non-specific colitis</td>
<td>No</td>
<td>Colectomy</td>
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<tr>
<td>Roth</td>
<td>1978</td>
<td>No information</td>
<td>Segmental non-specific colitis</td>
<td>Yes</td>
<td>Subtotal colectomy</td>
</tr>
<tr>
<td>Weber et al.</td>
<td>1985</td>
<td>Positive</td>
<td>Non-specific colitis of the rectosigmoid colon, separate lesion in the caecum</td>
<td>Yes</td>
<td>Alpha interferon-radiotherapy of rectal KS</td>
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<tr>
<td>Biggs et al.</td>
<td>1987</td>
<td>Negative</td>
<td>UC</td>
<td>Yes</td>
<td>Urgent colectomy for toxic megacolon and later abdominal perineal excision for rectal KS</td>
</tr>
<tr>
<td>Meltzer et al.</td>
<td>1987</td>
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<td>UC distal to the descending colon</td>
<td>Yes</td>
<td>Proctocolectomy with ileostomy</td>
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<tr>
<td>Thompson et al.</td>
<td>1989</td>
<td>Negative</td>
<td>UC</td>
<td>No</td>
<td>Restorative proctocolectomy</td>
</tr>
<tr>
<td>Tedsøe et al.</td>
<td>1999</td>
<td>Negative</td>
<td>UC</td>
<td>No</td>
<td>Restorative proctocolectomy</td>
</tr>
</tbody>
</table>
A 100 mm segment of the proximal jejunum had an irregular relation to the fastened seat belt. Direct trauma to the gut. The duodenum and jejunum are scarring she sustained seems to have been the result of mesenteric structures were normal on laparotomy, the superior and inferior mesenteric arteries. As Miss M’s secondary to mesenteric injury, with involvement of the bowel obstruction after blunt abdominal injury: direct and indirect. The direct theory postulates that viscera get under the shearing force of the fastened seat belt. In the compressed between the abdominal wall and spinal column indirect. The direct theory postulates that viscera get ischaemia from ischaemia secondary to mesenteric injury, with involvement of the superior and inferior mesenteric arteries. As Miss M’s mesenteric structures were normal on laparotomy, the scarring she sustained seems to have been the result of direct trauma to the gut. The duodenum and jejunum are particularly vulnerable in the seat belt syndrome because of their proximity to the vertebral column, as well as their relation to the fastened seat belt.

The diagnosis was seat belt injury. Two proposed mechanisms explain the occurrence of small bowel obstruction after blunt abdominal injury: direct and indirect. The direct theory postulates that viscera get compressed between the abdominal wall and spinal column under the shearing force of the fastened seat belt. In the healing process, fibrosis causes strictures that may result in partial or complete obstruction.

In the indirect mechanism, viscera suffer from ischaemia to mesenteric injury, with involvement of the superior and inferior mesenteric arteries. As Miss M’s mesenteric structures were normal on laparotomy, the scarring she sustained seems to have been the result of direct trauma to the gut. The duodenum and jejunum are particularly vulnerable in the seat belt syndrome because of their proximity to the vertebral column, as well as their relation to the fastened seat belt.

The affected segment was excised and this patient was discharged, totally recovered, nine days after surgery.