Ethics committee approval

This research was approved by the Ethics Committee of Chiba Cancer Center (nos. 20-21 and 21-10). Written consent was obtained from all patients. All samples were coded and managed independently.

Statistical analysis

For clinical characteristics and genetic factors, frequency analysis was performed with Fisher's exact test (dichotomous factors) and χ^2 test (multinomial factors). Mann-Whitney *U* test was applied to continuous data. General data analysis was conducted with StatView 5.0 (SAS Institute, Inc.). All *P* values were based on a two-sided hypothesis, $P < 0.05$ was considered to have statistical significance.

Results

Patient characteristics

The clinical characteristics of all 109 patients are listed in Table 1; 82 patients (75.2%) were male. The median age was 64.4 years (range, 38–90 y). Histologic examination was performed in all cases, leading to a diagnosis of adenocarcinoma (Fig. 1B) in 82 cases (75.2%), squamous cell carcinoma in 18 cases, and "other" in 9 cases. With respect to smoking status, 22 cases (20.4%) were never-smokers, 15 (13.9%) were light smokers (defined as a smoking index score <400), and 72 were heavy smokers (smoking index score ≥400). A total of 191 mediastinal lymph nodes and 84 hilar lymph nodes (2.52 lymph nodes/patient) were detected with EBUS, and 158 mediastinal lymph nodes and 71 hilar lymph nodes (2.10 lymph nodes/patient) were sampled. The median size of the sampled lymph nodes was 12.1 mm (range, 3.0–33.4 mm) in the short axis on ultrasound. According to criteria from the International Union Against Cancer, there were 9 stage II cases, 49 stage III cases, and 45 stage IV cases; the remaining 6 cases were defined as having recurrent lung cancer. *EGFR* gene mutations were detected in 25 cases (22.9%), which included 9 cases with in-frame deletions at exon 19, 9 cases with a point mutation at exon 21, 3 cases with a point mutation at exon 18, 2 cases with point mutations at exons 18 and 21, 1 case with a point mutation at exon 20, and 1 case with point mutations in exons 20 and 21.

Table 1. Clinical characteristics of patients with NSCLC

Parameter	Number of cases (%)
	109
Age	
Mean (y)	64.4 (range, 38–90)
Gender	
Male	82 (75.2%)
Female	27 (24.8%)
Pathology	
Adenocarcinoma	82 (75.2%)
Squamous cell	18 (16.5%)
Other histology	9 (8.3%)
Clinical stage	
II	9 (8.3%)
III	49 (45.0%)
IV	45 (41.3%)
Recurrence	6 (5.5%)
Bone metastasis	
Yes	22 (20.2%)
No	87 (79.8%)
Brain metastasis	
Yes	16 (14.7%)
No	93 (85.3%)
Smoking	
Never (SI = 0)	22 (20.4%)
Light (SI < 400)	15 (13.9%)
Heavy (SI ≥ 400)	70 (64.8%)
EGFR mutation status	25 (22.9%)
Exon 18	3
Exon 19	9
Exon 20	1
Exon 21	9
Exons 18 + 21	2
Exons 20 + 21	1

Abbreviation: SI, smoking index.

ALK fusion gene assessment

Out of 109 cases examined by immunohistochemistry using the iAEP method, 6 *ALK*-positive cases and 17 suspicious cases (1 probably positive and 16 probably negative) cases were detected. The staining of the small histologic core did not show any heterogeneity.

FISH confirmed the existence of an *ALK* fusion gene in all six *ALK*-positive cases (Figs. 1D, 2A and B), and there were no false-positive cases for immunohistochemistry. Sixteen probably negative cases were determined to be negative for the *ALK* fusion gene by re-testing with immunohistochemistry and FISH. One probably positive case had too few tumor cells to be used for FISH analysis; however, RT-PCR assessment confirmed the presence of *EML4-ALK* fusion cDNA. *EML4*, *ALK*, and fusion signals (arrows in Fig. 2A) are presented in the green, red, and merged image and a pair of split signals (arrow in Fig. 2B, downstream) shows rearrangement of *ALK*. In Fig. 2C, unique bands in each *ALK*-positive case reveal variant 1 and variant 3 *EML4-ALK* fusion genes. Thus, the *ALK* fusion gene was detected in a total of seven cases (6.4%). Direct sequencing of the PCR products revealed that four cases carried *EML4-ALK* variant 1, whereas three cases had variant 3. The fusion point of *ALK* and *EML4* is observed in the cDNA sequence (arrow in Fig. 2D).

Clinicopathologic characteristics of lung cancers possessing _ALK_ fusion genes

Clinicopathologic characteristics were compared between the 7 *ALK*-positive cases and the 102 *ALK*-negative

cases (Table 2). All *ALK*-positive cases had an adenocarcinoma histology and lacked *EGFR* gene mutations. With respect to smoking habits, six out of the seven *ALK*-positive cases were either never-smokers or light smokers (smoking index score <400). No significant difference in gender was observed between *ALK*-positive and *ALK*-negative patients; however, *ALK*-positive patients were significantly younger than *ALK*-negative patients (55.4 versus 65.0 years; $P = 0.0408$). No significant differences in the incidence of bone metastasis (9.1% versus 5.7%; $P = 0.64$) or brain metastasis (12.5% versus 5.4%; $P = 0.30$) were observed. Overall, the mean primary tumor diameter was 40.4 mm; interestingly, the mean primary tumor diameter of *ALK*-positive cases was 28.6 mm, which was significantly smaller than that of *ALK*-negative cases (41.9 mm; $P < 0.05$). Mucin production was significantly more frequently observed in *ALK*-positive cases as shown by Alcian blue staining (Fig. 1C; $P < 0.01$). Finally, among the 84 cases expressing wild-type *EGFR*, 8.3% (7 of 84) were *ALK*-positive.

Discussion

This is the first attempt and report about using EBUS-TBNA samples in the detection of *ALK* fusion genes, and is expected to have a major effect on the management of patients with lung cancer. EBUS-TBNA is an established procedure for the evaluation of mediastinal and hilar adenopathy in patients with lung cancer. It is as safe, as highly diagnostic, and less invasive than other diagnostic modalities (9–11). Biopsy samples obtained with EBUS-TBNA can be subjected to histologic as well as cytologic evaluation. Nonsurgical modalities for obtaining tumor specimens are particularly critical in lung cancer because many patients have advanced disease at the time of first presentation, and are therefore not eligible for radical surgery. In addition to histologic diagnosis and stage definition, EBUS-TBNA enables molecular analysis of biopsy samples, the clinical significance of which is growing as molecularly targeted strategies for NSCLC are becoming increasingly important. We have previously reported that metastatic lymph node samples obtained by EBUS-TBNA can be applied to multidisciplinary analyses (5), and the present study is the first report of successful analysis of *ALK* fusion genes, a newly identified genetic abnormality in NSCLC, with such specimens (2). However, the small size of the paraffin-embedded biopsy samples obtained from EBUS-TBNA might limit the utility of this methodology; thus, multidirectional analysis will be critical for microsampling methods such as EBUS-TBNA.

The reliability of the newly developed immunohistochemistry (iAEP) method for the detection of *ALK* fusion

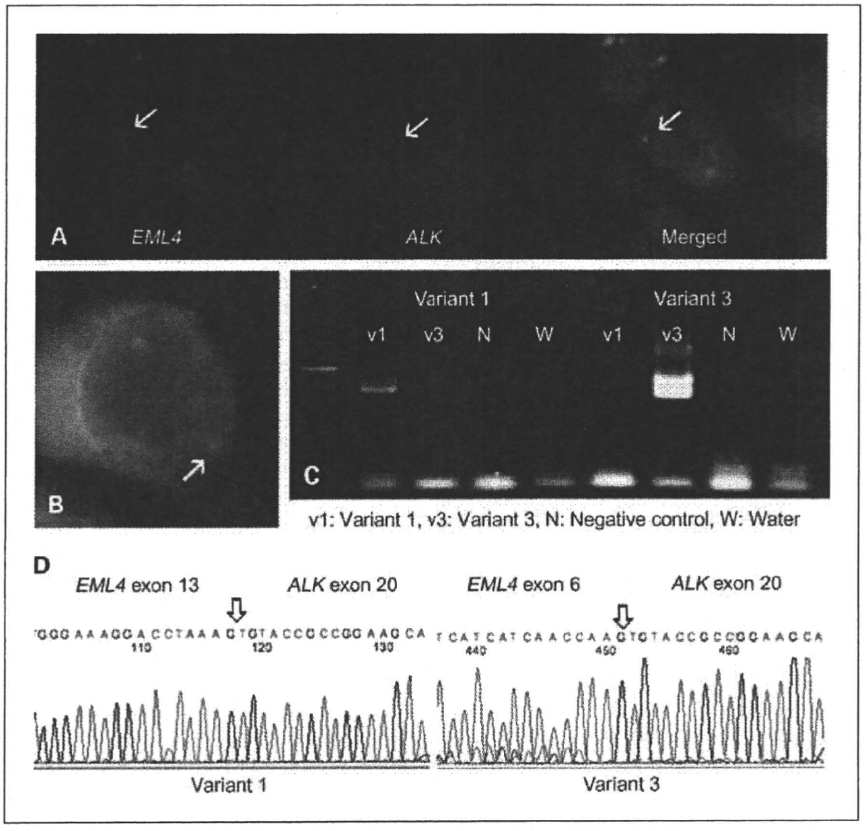

Fig. 2. Molecular analysis of *ALK* fusion genes. A, FISH *EML4-ALK* fusion assay with labeled probes for *EML4* (green, arrow) or *ALK* (red, arrow). The *EML4-ALK* fusion gene is observed (yellow, arrow). B, *EML4-ALK* split assay with labeled probes for the upstream (red) or downstream (green, arrow) region of the *ALK* locus. C, RT-PCR detection of the *EML4-ALK* fusion gene. D, direct cDNA sequence of *EML4-ALK* variants 1 and 3.

Table 2. Clinical, pathologic, and genetic analysis of *ALK*-positive NSCLC

Characteristic	*EML4-ALK* fusion			*P*
	NSCLC	+	−	
Female gender	27	4	23	0.062
Mean age (y)	64.4	55.4	65.0	0.0408
<60	29	5	24	0.0139
Bone metastasis	22	2	20	0.6396
Brain metastasis	16	2	14	0.2973
Mean tumor diameter (mm)	40.4	28.6	41.9	0.0478
Smoking index (n = 107)	784	161	827	0.0071
Never/light smoker	37	6	31	0.0056
Adenocarcinoma	82	7	75	0.1896
Mucin production	17	5	12	0.0009
EGFR wild-type	84	7	77	0.3317
ALK variant 1		4		
ALK variant 3		3		

NOTE: Two cases without primary tumors and six cases of recurrence were excluded from the tumor diameter analysis. Smoking history was recorded in 107 patients.

genes is very precise (4). This method is expected to be more practical for the detection of *ALK* fusion genes compared with FISH because FISH can sometimes be very difficult to perform for *ALK* fusion genes due to the close proximity of the two fusion gene components. We performed both fusion and split assays for FISH, and FISH was performed to confirm the immunohistochemical results. In addition, the *ALK* fusion genes are novel oncogenes in lung cancer. There is a possibility of existing unknown fusion pattern which cannot be detected by FISH or RT-PCR. Immunohistochemistry has an advantage of detecting novel unknown fusion patterns (4). In this study, we performed immunohistochemistry using the iAEP methodology and an Autostainer instrument. This technique is convenient, highly reproducible, and enables accurate diagnosis even if only a small amount of specimen is available. These features are well-suited for the screening of *ALK*-positive lung cancers using small biopsy samples. The Autostainer instrument also allows uniform immunohistochemical analysis, which may lead to consistent results among different institutions/hospitals; such uniformity is essential for the standardization of diagnostic procedures that assess the presence of *ALK* fusion genes. Recently, a highly sensitive antibody directed against *ALK* fusion products that can possibly be used for immunohistochemistry has been reported, therefore representing a novel candidate for *ALK* fusion detection (12).

The median age of *ALK*-positive cases in the present study was 55.4 years. Patients <60 years represent approximately 10% of all lung cancer deaths (6,655 of 63,255 deaths) according to the Japanese National Cancer Center Cancer Information Service Statistics published in 2008 (13). In the present study, a significant number of *ALK*-positive cases were <60 years of age (17.2%, 5 of 29; $P < 0.05$). *ALK*-positive cancer may therefore be more common in patients with early-onset NSCLC. However, it should be noted that two *ALK*-positive cases were >70 years of age (71 and 73 years); therefore, although patient age may become a predictor of *ALK* fusion gene positivity, *ALK* screening must also be performed in elderly individuals. The median diameter of primary lung tumors was significantly smaller in *ALK*-positive cases (28.6 versus 41.9 mm; $P < 0.05$), further emphasizing the importance of EBUS-TBNA because this technique does not require a large primary lesion. An additional advantage of EBUS-TBNA is that it can be used for lymph node sampling, which is relevant to the majority of advanced lung cancer cases. Although lung cancer is generally more common in smokers, most of the *ALK*-positive cases in this study (37 cases; 34.3%) were never-smokers or light smokers. The smoking index scores in the *ALK*-positive cohort were significantly lower than that of *ALK*-negative patients (161 versus 827; $P < 0.01$). Hence, being a never-smoker or light smoker seems to be a strong predictor of *ALK* positivity ($P < 0.01$).

Evaluation of the clinicopathologic characteristics of patients in our cohort indicated that *ALK*-positive lung cancer tends to have an adenocarcinoma histology, expresses wild-type *EGFR*, has an early age of onset (<60 y), manifests as a relatively small primary lesion, more frequently occurs in never-smokers or light smokers (smoking index score <400), and has a mucin-producing histology. However, as EBUS-TBNA samples are obtained from metastatic lymph nodes rather than the primary tumor, these clinical features are nearly compatible with previously reported features (14). Patients harboring one or more of these predictive factors may therefore derive the most benefit from *ALK* fusion gene screening.

Recently, *ALK*-positive NSCLC was reported to be a signet ring cell type adenocarcinoma (15, 16). We assume that this description also includes mucin production, i.e., mucin-producing tumors or tumors with >10% Alcian blue staining in the cytoplasm. Herein, we performed Alcian blue staining on suspected mucin-producing tumors as part of the histologic diagnosis. By this classification, 17 (15.6%) NSCLC cases were determined to be mucin-producing cancers. These cases were all adenocarcinomas and included five *ALK*-positive cases; thus, approximately 30% of the mucin-producing adenocarcinomas showed *ALK* positivity. This is a significantly high frequency compared with that of other NSCLCs ($P < 0.01$). This histologic feature, which can be assessed in cytologic samples, therefore seems to be useful for the prediction of *ALK* positivity.

The standard therapy for patients with advanced lung cancer at the time of presentation is chemotherapy and/or radiotherapy. However, standard platinum-based combined chemotherapy is not sufficient for disease eradication (17). Recently, lung cancer treatment strategies have become refined through the development of molecular markers and molecularly targeted agents. *ALK* inhibitors

have a high potential to become a definitive treatment for *ALK*-positive lung cancer, in a manner parallel to the exceptional therapeutic response of *EGFR*-positive lung cancers to *EGFR* tyrosine kinase inhibitors (18, 19). The efficacy of *ALK* inhibitors has been confirmed in cell lines (20, 21), and phase I clinical development of an oral *ALK* inhibitor for patients with lung cancer is currently under way (PF-02341066); two of the seven *ALK*-positive NSCLC cases from the present series have been enrolled in this trial (22, 23). As the background of *ALK*-positive lung cancer is similar to that of *EGFR*-positive lung cancer, and *ALK* tyrosine kinase inhibition is fundamentally similar to *EGFR* tyrosine kinase inhibition, *ALK* inhibitors might experience a similar progression of drug development and clinical and pathologic prediction of *ALK* positivity in lung cancer patients as *EGFR* tyrosine kinase inhibitors have for patients with *EGFR*-positive lung cancer. In this study, all *ALK*-positive lung cancers possessed wild-type *EGFR* and were therefore ineligible for *EGFR* tyrosine kinase inhibitor therapy (24). Therefore, *ALK* fusion gene assessment and administration of *ALK* inhibitors may become important for patients with *EGFR*-negative lung cancers.

Although some *ALK* inhibitors have already been developed and are currently being evaluated in clinical trials, it is important to establish a method for determining the existence of *ALK* fusion genes prior to the administration of *ALK* inhibitors. Both the presence of *ALK* fusion genes as well as *EGFR* gene mutations were successfully evaluated using histologic samples obtained by EBUS-TBNA of lung cancer regional lymph nodes. This diagnostic strategy allowed both pretreatment staging and evaluation of critical molecular markers to be definitively determined in a less invasive manner. There are some publications related with the genomic difference between primary tumor and metastatic site (25–29). EBUS-TBNA is a minimally invasive modality that allows the sampling of tumor cells from metastatic lymph node with a very low morbidity. The possibility of genetic differences should be considered whenever the biomarker information is used for the selection of patients for molecular target therapies. EBUS-TBNA is an ideal approach in this aspect.

In conclusion, EBUS-TBNA sampling is feasible for *ALK* fusion gene assessment by immunohistochemistry, FISH, and RT-PCR, as well as for pathologic diagnosis. The development of a safe and highly precise modality that enables the acquisition of a sufficient amount of high-quality tissue without surgery will become increasingly important in the molecularly targeted therapy era. EBUS-TBNA is one of the best candidates for such a methodology.

Disclosure of Potential Conflicts of Interest

K. Yasufuku, recipent of an unrestricted grant from Olympus Medical Corporation for Continuing Medical Education; H. Mano, member of the scientific advisory board, Pfizer Inc.

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Lymphomatoid gastropathy: a distinct clinicopathologic entity of self-limited pseudomalignant NK-cell proliferation

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Diagnostic errors in distinguishing between malignant and reactive processes can cause serious clinical consequences. We report 10 cases of unrecognized self-limited natural killer–cell proliferation in the stomach, designated as lymphomatoid gastropathy (LyGa). This study included 5 men and 5 women (age, 46-75 years) without any gastric symptoms. Gastroscopy showed elevated lesion(s) (diameter, ~ 1 cm). Histologically, medium-sized to large atypical cells diffusely infiltrated the lamina propria and, occasionally, the glandular epithelium. The cells were $CD2^{+/-}$, $sCD3^{-}$, $cCD3^{+}$, $CD4^{-}$, $CD5^{-}$, $CD7^{+}$, $CD8^{-}$, $CD16^{-}$, $CD20^{-}$, $CD45^{+}$, $CD56^{+}$, $CD117^{-}$, $CD158a^{-}$, $CD161^{-}$, T cell–restricted intracellular antigen-1^{+}, granzyme B^{+}, perforin^{+}, Epstein-Barr early RNA^{-}, T-cell receptor $\alpha\beta^{-}$, and T-cell receptor $\gamma\delta^{-}$. Analysis of the 16 specimens biopsied from 10 patients led to a diagnosis of lymphoma or suspected lymphoma in 11 specimens, gastritis for 1 specimen, adenocarcinoma for 1 specimen, and LyGa or suspected LyGa for 3 specimens. Most lesions underwent self-regression. Three cases relapsed, but none of the patients died. According to conventional histopathologic criteria, LyGa is probably diagnosed as lymphoma, especially as extranodal natural killer/T-cell lymphoma, nasal type. However, LyGa is recognized as a pseudomalignant process because of its clinical characteristics. The concept of LyGa should be well recognized. (*Blood.* 2010;116(25):5631-5637)

Introduction

The World Health Organization classification of tumors of hematopoietic and lymphoid tissues lists > 60 types of lymphomas.[1] Several reactive or borderline lesions related to these overt lymphomas are well known. Some benign lymphoproliferative disorders, including infectious mononucleosis, drug-induced lymphadenitis especially related to anticonvulsants, and histiocytic/subacute necrotizing lymphadenitis (Kikuchi-Fujimoto disease),[2,3] are occasionally misdiagnosed as malignancy because these lesions histopathologically mimic lymphoma.[4] They are basically self-limited and require no cytoreductive therapies. Lymphomatoid papulosis, lymphomatoid granulomatosis, and methotrexate-associated lymphoproliferative disorder[5] are listed as borderline lesions with uncertain malignant potential according to the World Health Organization. These disorders may also be diagnosed as overt lymphoma. Moreover, even if they are properly diagnosed, selection of a treatment strategy is then a matter of discussion because some of these cases undergo spontaneous regression. Therefore, conservative therapies are primarily favored in such cases, and these lesions should be treated as lymphoma only if they are clinically malignant. In any case, at the time these lesions are evaluated with biopsy specimens, the possibility of being benign should be well considered, and overtreatment must be carefully avoided.

Here, we report 10 cases of a pseudomalignant disorder caused by an unrecognized atypical natural killer (NK)–cell proliferation in the stomach; we have designated this disorder as lymphomatoid gastropathy (LyGa). According to conventional histopathologic criteria, such lesions are diagnosed as lymphoma, especially as extranodal NK/T-cell lymphoma, nasal type. However, considering its clinical characteristics, LyGa is recognized as a pseudomalignant process because it spontaneously regresses without any treatment.

Methods

Patients

During the 11-year period between 1998 and 2009, there were 10 cases of CD56-positive atypical lymphoid cell proliferation in the stomach (patients 1-3 presented at the Cancer Institute and patients 4-10 were referred to K.T. for consultation). The clinical records and pathology materials of the cases were reviewed.

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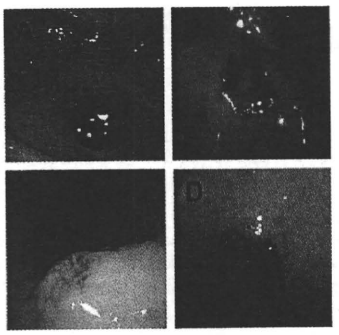

Figure 1. Gross appearance of LyGa. Cases 3 (A), 3 (B), 4 (C), and 10 (D) are shown.

Immunophenotyping and Epstein-Barr virus detection

Immunohistochemical examination was performed with Autostainer (Dako); dextran-polymer method (EnVision+; Dako); and antibodies against CD2, CD3, CD4, CD5, CD7, CD8, CD20, CD30, CD45, CD56, CD68 (KP1 or PGM1), T cell–restricted intracellular antigen-1 (TIA1), granzyme B, anaplastic lymphoma kinase, myeloperoxidase, Ki67, and T-cell receptor βF1 (TCRβF1). For flow cytometry, the following antibodies were used: CD2, CD3, CD7, CD56, TCRαβ, TCRγδ, TCRVa24, CD158a, and CD161. The presence of Epstein-Barr virus (EBV) was assessed by in situ hybridization for Epstein-Barr early RNA (EBER).

Polymerase chain reaction analysis for TCRγ gene rearrangement

DNA was extracted from the paraffin sections with the use of Recover All Total Nucleic Acid Isolation according to the manufacturer's instructions (Ambion). A seminested protocol involving 2 rounds of polymerase chain reaction (PCR) was used for the amplification of the rearranged TCRγ gene with the use of the primers TVγ, 5′-AGGGTTGTGTTGGAATCAGG-3′; TJγ-out, 5′-CGTCGACAACAAGTGTTGTTCCAC-3′; and TJγ-in, 5′-GGATCCACTGCCAAAGAGTTTCTT-3′. The 5′ end of TJγ-I was labeled by cyanine 5 for fragment analysis. In all the experiments, monoclonal (Jurkat cells) and polyclonal (placental tissue from a healthy person) controls were run in parallel with the samples. The PCR products were analyzed with CEQ8000 (Beckman Coulter Inc). DNA from each sample was amplified ≥ 6 times.

Results

Clinical history

Of the 10 patients in this study, 5 were men and 5 were women. The age of these patients ranged from 46 to 75 years Three patients had a history of gastric cancer, of whom 1 had previously undergone endoscopic mucosal resection 2 times (case 1) and the other 2 had previously undergone partial gastrectomy (cases 3 and 8). At the time of the study, 3 patients had diabetes mellitus (cases 1, 2, and 9) and 4 had hypertension (cases 2, 7, 9, and 10). Blood cell counts and chemistry, including lactic dehydrogenase levels, were within the normal limits in all patients. There were no gastric symptoms at the time of gastroscopy. The 3 patients with history of gastric cancer underwent gastroscopy during a follow-up study for gastric cancer, and the procedure was performed on the other patients as a secondary checkup because gastric x-ray screening for cancer in these patients showed the presence of abnormal shadows. Gastroscopy showed ulcerative or elevated lesion(s) ~ 1 cm in diameter in the stomach (Figure 1A-D). The pathologists of the institutions where the biopsies of the patients with LyGa were first performed diagnosed the patients' conditions as lymphoma or suspected lymphoma (cases 1, 2, 5-8, and 10), gastritis with histiocytic infiltration (case 3), and poorly differentiated adenocarcinoma (case 4). In case 3, the specimen was biopsied again 11 months later, and the patient's condition was then diagnosed as NK/T-cell lymphoma. Cases 5 and 9 were suspected of having lymphoma, and the pathologist consulted with one of the authors (K.T.), leading to the diagnosis of LyGa. In case 5, another biopsy was performed 3 weeks after the first biopsy for flow cytometry.

An extensive workup, including ultrasonography (cases 1-4 and 9), computed tomographic (cases 1-4 and 6-9), and 2-[fluorine-18]fluoro-2-deoxy-D-glucose positron emission tomographic scans (cases 2, 4, 6, and 8); colonoscopy (cases 2, 4-6, and 9); and bone marrow biopsy (cases 1-4 and 7-9), was performed. The results showed no evidence of lymphoma in sites other than the stomach. Multiple serologic studies for celiac disease showed no evidence of high titers of anti–gliadin immunoglobulin A and immunoglobulin G antibodies in cases 2 and 4. Gastroscopy and biopsy were performed 1-4 months after the biopsies, which showed no evidence of lymphoma (cases 1, 2, 5, 7 and 10). Cases 4 and 6 underwent partial gastrectomy 1 month after the initial biopsy diagnosis, resulting in no evidence of carcinoma or lymphoma. All the patients were carefully watched and followed up without chemotherapy. Except in the case of patients 3, 8, and 9, none of the other patients had any recurrences. In case 3, the patient developed 3 lesions; on follow-up examination 11 months later, the lesions had regressed, and a new lesion was detected. The new lesion also regressed in 1 month from the second biopsy. In case 8, the patient developed another lesion 7 months after self-regression of the first lesion; this new lesion also regressed in 3 months without any treatment. In case 9, the first lesion could not be detected 4 months from the first biopsy; however, 2 new lesions were detected. After another 4 months, these 2 lesions could also not be detected, and 2 new lesions were identified. The consequence of the 2 lesions last detected is unknown because the patient refused further gastroscopic examination.

Morphology

Grossly, the lesions were flat elevations with or without a shallow depression and were approximately 1 cm in diameter (Figure 1A-D). The atypical cells diffusely infiltrated the lamina propria and occasionally into the glandular epithelium (Figure 2A), simulating the lymphoepithelial lesion seen in extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue lymphoma, which was designated as lymphoepithelial-like lesion by NK cells (Figure 2B). In some cases, necrosis was present, but there were no angiocentric or angiodestructive growth patterns or apoptotic bodies. Mitotic figures were occasionally present. The atypical cells were medium to large with moderate to abundant clear or slightly eosinophilic cytoplasm. The nuclei were generally round to oval, but some were irregular and indented, with fine chromatin and a few inconspicuous nucleoli. These cytomorphologic features somewhat give a histiocyte-like impression. Interestingly, specimens for all the patients contained a variable proportion of cells (20%-90%) with eosinophilic granules in the cytoplasm (Figure 2C-D). In some cases, atypical cells with a prominent nucleolus were observed (Figure 2D). Small reactive lymphocyte aggregates and neutrophils may be occasionally found. Nine of the patients had *Helicobacter pylori* infection.

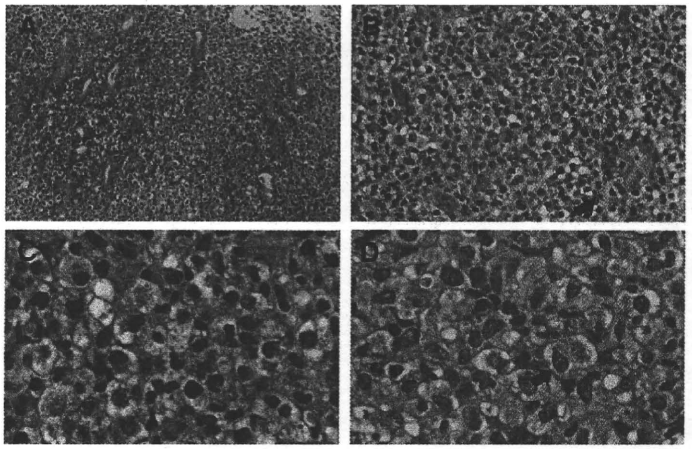

Figure 2. Histopathology of LyGa. The pattern of infiltration is diffuse (A; case 1; 20× objective). Atypical NK cells occasionally infiltrate the glandular epithelium (arrow), showing lymphoepithelial-like lesions by NK cells (B; case 10; 40× objective). Some atypical cells harbor large eosinophilic granules in the cytoplasm (C; case 3; 100× objective). In some cases, the nucleoli are prominent (arrow; D; case 5; 100× objective). Figures were taken with a microscope (BX51; Olympus) and a digital camera (KY-F75; Victor). Microsoft PowerPoint 2007 was used for image processing. Numeric apertures: 20×/0.40 (A), 40×/0.75 (B), 40×/0.95 (C), 60×/0.90 (D).

Immunophenotype and EBER in situ hybridization

The atypical cells were strongly positive for CD7, CD56, and cytotoxic molecule-associated proteins (TIA1, granzyme B, and perforin; Figure 3A-C). CD2 and CD45 were variably positive. CD3ε was positive in the cytoplasm, but a membrane-staining pattern was not observed (Figure 3D). Anaplastic large cell lymphoma-associated markers (CD30 and anaplastic lymphoma kinase) were negative. Other common lineage markers, including B-cell (CD20), T-cell (CD4, CD5, and CD8), and myelomonocytic (CD68 and myeloperoxidase) markers, were all negative. EBER in situ hybridization was negative. The results of immunohistochemistry for individual cases are listed in Table 1. For case 5, flow cytometric analysis was performed with the second specimen, which was obtained from a biopsy performed 3 weeks after the first biopsy (Figure 4). Grossly, although the lesion was regressing, it remained present. The atypical cells of this case expressed CD7 and CD56 (both aberrantly bright) and CD2 (negative or dim). Other T or NK cell–related markers were negative (CD3, CD16, TCRαβ, TCRγδ, TCRVa24, CD158a, and CD161).

PCR analysis for TCRγ gene rearrangement

PCR analysis for TCRγ gene rearrangement was performed 6 times per case for cases 1-4 and 8. No reproducible rearranged bands were observed (data not shown).

Discussion

Here, we report 10 cases of self-limited lymphoma-like lesions in the stomach, which we designated as LyGa. These cases were almost identical to each other in morphology and immunophenotype of atypical cells. Gross examination showed that the lesions were ulcers or flat elevations with a shallow depression, measuring approximately 1 cm in diameter. Microscopic observation showed that they were composed of sheets of large peculiar cells that showed indented nuclei and clear cytoplasm with eosinophilic granules. Immunohistochemical analysis of the atypical cells of LyGa showed that they were $CD2^-$ or variably $CD2^+$, $CD3^+$ (cytoplasmic), $CD4^-$, $CD5^-$, $CD7^+$, $CD8^-$, $CD16^-$, $CD20^-$,

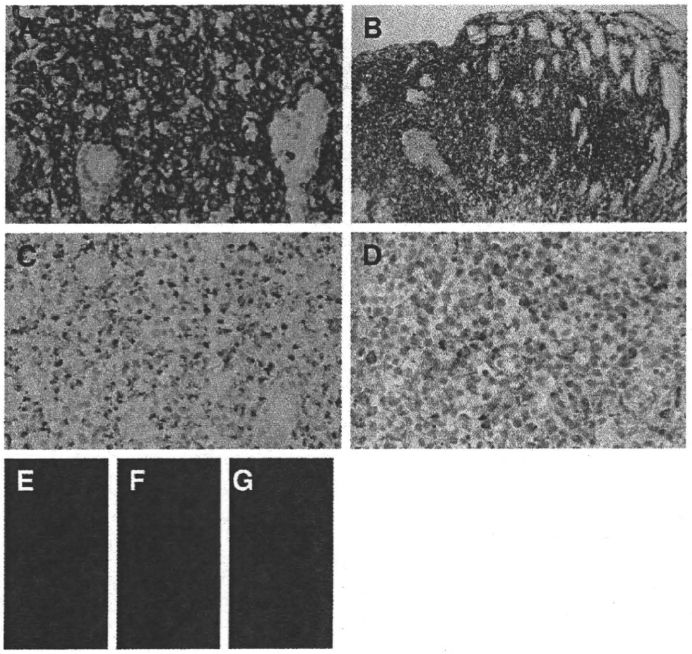

Figure 3. Immunophenotype of LyGa by immunohistochemistry. The atypical cells are positive for CD7 (A; case 5), CD56 (B; case 3), granzyme B (C; case 4), and cytoplasmic CD3ε (D; case 2). To confirm the cytoplasmic localization of CD3ε, fluorescein double immunohistochemistry for CD3ε (E) and CD56 (F) was performed (case 10). In the merged figure (G), the cytoplasmic localization of CD3ε is clearly shown, indicating that the atypical cells are of NK lineage. Figures were taken with a microscope (BX51; Olympus) and a digital camera (KY-F75; Victor). Microsoft PowerPoint 2007 was used for image processing. Numeric apertures: 40× (A,C,D), 10× (B), 60× (E-G).

Table 1. Patient characteristics and immunologic markers

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10
Age, y	52	58	51	50	55	46	65	56	59	75
Sex	Male	Male	Male	Female	Male	Male	Female	Female	Female	Female
Past history	Two individual early gastric cancers at the ages of 48 and 51 y	NP	Advanced gastric cancer at the age of 47 y	NP	NP	NP	NP	Advanced gastric cancer at the age of 52	NP	NP
H pylori	–	+	+	+	+	+	+	+	+	+
Original pathologic diagnosis	NK/T-cell lymphoma	NK/T-cell lymphoma	Gastritis with histiocytosis. NK/T-cell lymphoma*	Adenocarcinoma	Lymphoma, s/o LyGa*	NK/T-cell lymphoma; NK/T-cell lymphoma*	T-cell lymphoma	T-cell lymphoma; NK/T-cell lymphoma*	Lymphoma, s/o LyGa, s/o LyGa*	T-cell lymphoma
Follow-up examinations, days from the initial biopsy	45, 73, 276, 577, 1165	55, 239, 442, 675, 896, 1121, 1497	336,† 365, 484, 701, 1065, 1429, 1793	41,‡ 167, 1360	13,† 132	50,† 56‡	38, 81, 137, 207, 361, 515, 742, 1029, 1281, 1515	98, 154, 236,† 256, 333, 452, 585, 790	113,† 232†	30, 59, 143, 232, 354
Patient status	Well at 145 mo	Well at 50 mo	Well at 60 mo	Well at 46 mo	Well at 33 mo	Well at 60 mo	Well at 56 mo	Well at 29 mo	Well at 18 mo	Well at 12 mo
Treatment	Observation	Observation	Observation	Subtotal gastrectomy	Observation	Total gastrectomy	Observation	Observation	Observation	Observation
CD2	–	+w	+w	+w	–	+	+w	–	+	+
CD3	+	+	+	+	+	+	+	+	+	+
CD4	ND	–	–	–	–	–	–	–	–	–
CD5	–	–	–	–	–	–	–	–	–	–
CD7	+	+	+	+	+	+	+	+	+	+
CD8	ND	–	–	ND	–	–	–	–	–	–
CD20	–	–	–	–	–	–	–	–	–	–
CD56	+	+	+	+	+	+	+	+	+	+
Cytotoxic molecules	TIA1+	TIA1+, granzyme B+, perforin+	TIA1+, granzyme B+, perforin+	TIA1+, granzyme B+, perforin+	Granzyme B+	TIA1+, Perforin+	Perforin+	TIA1+	Granzyme B+	Granzyme B+
EBER	–	–	–	–	–	–	–	–	–	–
Other markers	CD16−, betaF1−	CD16−, CD30−, CD45+w, CD57−, CD68−, CD123−, betaF1−, ALK−, MPO−, MIB1 index 10%	CD16−, CD30−, CD45+w, CD57−, CD68−, CD123−, betaF1−, ALK−, TdT−, MIB1 index 30%	CD16−, CD45+, CD68−, CD123−, betaF1−, CD43+	TCRαβ−, TCRγδ−, CD161−, TCRVα24−, CD16−, CD158a−				CD10−, CD21−, BCL2−, CD45RO+, CD68−, MIB1 index 20%	MIB1 index 20%, CD21−

NP indicates nothing in particular; s/o, suspected of; ND, not done; and +w, weakly positive.

*In case 3, 5, 6, 8 and 9, multiple biopsies showed the presence of LyGa.

†LyGa is present on follow-up examination.

‡In follow-up examinations, days of gastrectomy or gastroscopy with or without biopsy from the initial biopsy are described.

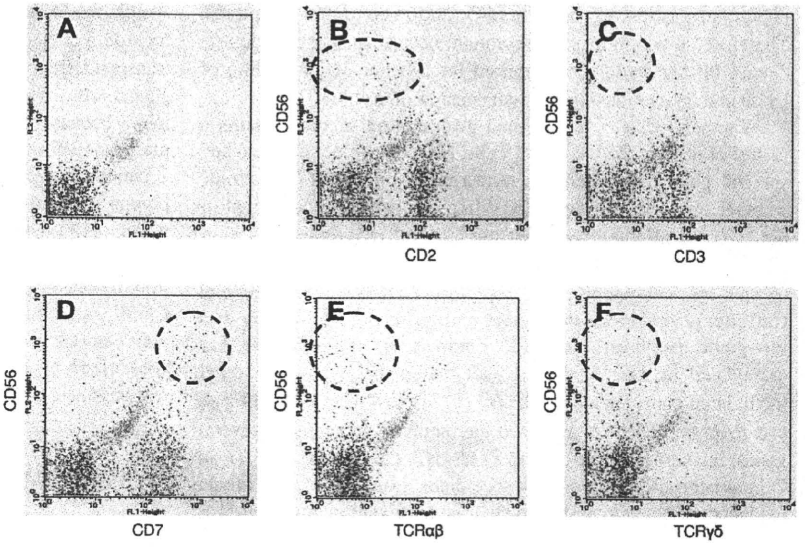

Figure 4. Immunophenotype of LyGa by flow cytometry. Flow cytometry was performed for case 5. The atypical cells were $CD56^{bright}$, $CD2^{dim}$ (B), $CD3^-$ (C), $CD7^{bright}$ (D), $TCR\alpha\beta^-$ (E), and $TCR\gamma\delta^-$ (F). (A) Negative control.

$CD45^+$, $CD56^+$, $CD117^-$ and positive for cytotoxic molecule-related proteins ($TIA1^+$, granzyme B^+, and $perforin^+$). This immunophenotype is highly suggestive of extranodal NK/T-cell lymphoma of the nasal type, which usually arises in extranodal sites, especially in the nasal cavity.[1,6,7]

Extranodal NK/T-cell lymphoma of the nasal type is rarely seen in Western countries and is more common in Asia and in Central and South American countries.[1,6,7] It accounts for ~ 2%,[8] 6%,[9] 8%,[10] and 5%[11] of all newly diagnosed lymphoma cases in Japan, Hong Kong, Korea, and Taiwan, respectively. Histologically, the lymphoma often has an angiocentric and angiodestructive infiltrate of atypical lymphocytes of various sizes leading to extensive necrosis.[1] The immunophenotype of neoplastic cells usually indicates that they are of NK-cell lineage (surface $CD3^-$, cytoplasmic $CD3^+$, $CD5^-$, and $CD56^+$) but are occasionally of T-cell lineage by definition.[1] In previous studies, neoplastic cells in almost all the cases were found to be infected by EBV.[12,13] In localized diseases, the survival rate has recently improved with a combination of upfront radiotherapy and chemotherapy, whereas almost all patients with extensive disease die within a year after diagnosis.[14-16]

Of the 16 biopsied specimens in this study, 11 were diagnosed with lymphoma or suspected lymphoma. Fortunately, however, LyGa has several characteristic features that are not consistent with extranodal NK/T-cell lymphoma. First, the stomach is not a common site of origin in the case of NK/T-cell lymphoma. To the best of our knowledge, there are 10 reported cases of extranodal NK/T-cell lymphoma involving the stomach, and the lesions were not limited to the stomach in any of these cases.[17-21] Second, although some of the cases of LyGa showed necrosis, but angiocentric or angiodestructive growth patterns, and prominent apoptotic bodies, which are common features of extranodal NK/T-cell lymphoma,[1] were not observed. Third, LyGa may show epithelial invasion, that is, lymphoepithelial-like lesion by NK cells. Fourth, the cytomorphology of LyGa is atypical for extranodal NK/T-cell lymphoma. Although the cytologic spectrum of extranodal NK/T-cell lymphoma is broad,[1] to the best of our knowledge, large eosinophilic cytoplasmic granules seen in the atypical cells of LyGa have never been observed in the histopathology section of extranodal NK/T-cell lymphoma although finer granules can often be seen in Giemsa-stained cytologic preparations. Finally, EBER in situ hybridization, which is almost always positive in NK/T-cell lymphoma of the nasal type,[1,12,13] is consistently negative in LyGa. In addition, a differential diagnosis of $CD56^+$ T-cell neoplasm with extensive loss of T-cell markers may be considered. In particular, the immunophenotype of LyGa overlaps the immunophenotype observed in some cases of enteropathy-associated T-cell lymphoma (type II).[22] However, the negative PCR results for the TCRγ gene rearrangement (performed in cases 1-4 and 8; data not shown) were inconsistent with results obtained for T-cell lymphomas.

Vega et al[23] reported a similar case of atypical NK-cell proliferation probably related to gluten sensitivity mimicking NK-cell lymphoma. In that study, the 32-year-old male patient was positive for anti–gliadin antibody and had persistent multiple lesions in the stomach, small bowel, and large bowel for 3 years.[23] Two of our 10 patients were tested and found to be negative for anti–gliadin antibodies. Actually, gluten intolerance and celiac disease are extremely rare in Japan. However, the immunophenotype and morphology of the atypical cells of our patients were similar to those observed in the case of the 32-year-old man reported by Vega et al.[23] In addition, our cases shared a significant clinical feature with the case reported by Vega et al,[23] that is, "self regression." The lesions of the 32-year-old man persisted for 3 years until he was placed on a gluten- and lactose-free diet, whereas the lesions of our patients did not seem to persist for such an extended period of time. Furthermore, none of our patients were found to have intestinal lesions. These differences might be due to the different stimulants, if any, although we were unable to identify any stimulant(s) in our cases.

Two types of gastric malignant neoplasms, namely, adenocarcinoma and mucosa-associated lymphoid tissue lymphoma, are related to *H pylori* infection. Nine of the 10 cases were positive for *H pylori* infection, and 3 of the patients had a history of gastric adenocarcinoma. Normal NK cells were present in both *H pylori*–infected and uninfected gastric mucosa at approximately 6% and 15% of the infiltrating lymphocytes, respectively.[24] Several of our patients received *H pylori* eradication therapy, and their LyGa was observed to regress. There may be a pathogenetic relationship between *H pylori* and LyGa. However, ~ 82% of the Japanese population is infected with *H pylori*.[25] Moreover, even patients who did not undergo eradication therapy exhibited regression of LyGa. In terms of the relation of LyGa with adenocarcinoma, LyGa is more likely to be found in persons who have frequently

undergone gastroscopy because LyGa shows no gastric symptoms. Therefore, although these concomitant occurrences appear coincidental, further studies are required for a better understanding of LyGa and its relationship with adenocarcinoma.

Whether LyGa is monoclonal proliferation or not remains a matter of debate. Unlike B or T cells, NK cells do not undergo any specific gene rearrangement, rendering it difficult to determine whether the proliferation of EBV-free NK cells is monoclonal or not. Vega et al[23] indicated that the NK-cell proliferation in their study appeared polyclonal because of the heterogeneous expression of the immunoglobulin-like receptors CD158a, CD158b, and CD158e; nevertheless, they could not exclude the possibility of a low-grade neoplasm. Siu et al[26] reported that the p73 gene was methylated in 94% of the NK-cell malignancies and that other methylated genes included *hMLH1* (63%), *p16* (63%), *p15* (48%), and *RAR* β (47%). We analyzed the methylation status of several genes, including *p16*, *p73*, *DAPK*, *MGMT*, *CDH1*, and *hMLH1*, in 2 heterochronically biopsied specimens from case 3 to obtain evidence of monoclonality. No aberrant methylation, however, was found in the examined genes (data not shown). These results reconfirmed that LyGa is different from extranodal NK/T-cell lymphoma, but the results did not serve as evidence for the monoclonality of LyGa. Further investigation with a larger sample size is required to clarify this distinction. Cytogenetic analyses and studies involving the identification of genetic loss/gain (eg, studies involving single nucleotide polymorphism microarray analysis) or point mutations (eg, studies involving next-generation genome sequencing) may be helpful to clarify the biologic natures of LyGa, especially whether LyGa is monoclonal proliferation or not. Procurement of fresh materials for these studies is impeded by spontaneous regression of lesions after the index biopsy; the biopsy specimen is usually fixed in formalin and embedded in paraffin for routine pathologic diagnosis.

LyGa should be regarded as a distinctive clinicopathologic entity and be observed without treatment. However, if not well recognized, LyGa is probably to be histopathologically misdiagnosed as lymphoma. For example, Kikuchi-Fujimoto disease, a self-limiting disorder of unknown cause, is still often mistakenly diagnosed as lymphoma,[4] although > 30 years have passed since it was first described in 1972. If LyGa is misdiagnosed as NK/T-cell lymphoma, it might be treated with radical therapeutic procedures, including chemotherapy, radiotherapy, gastrectomy, and stem cell transplantation. In fact, 2 patients of the present series underwent gastrectomy. The remaining 8 patients did not receive any treatment because the staging procedures followed by the initial diagnosis showed that the lesions regressed spontaneously. For 1 patient, however, the first biopsy specimen diagnosed as lymphoma was suspected to have been mistakenly identified to the patient. Fortunately, LyGa shows highly conserved and characteristic features in terms of clinical presentation, morphology, and immunophenotype (immunohistochemistry for CD3, CD5, CD7, CD56, and cytotoxic molecule(s) and EBER in situ hybridization are required to diagnose LyGa). Therefore, as long as LyGa is recognized as a distinct disease concept, there is no scope of misdiagnosis as malignancy.

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Authorship

Contribution: K.T. and K.O. conceived the study, collected and analyzed the data, and drafted the paper; M.Y., Y.T., K. Marutsuka, M.N., N.F., T.Y., H.N., F.A., K. Hoshi, K. Matsue, and K. Hatake contributed patient materials and analyzed the data; and S.I. and K.N. performed special studies and analyzed the data.

Conflict-of-interest disclosure: The authors declare no competing financial interests.

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Sorafenib-induced erythema multiforme for metastatic renal cell carcinoma

Sorafenib is an active agent for cytokine-refractory renal cell carcinoma (RCC) patients [1]. Skin toxicity such as hand–foot syndrome (HFS) is one of the frequent adverse events of sorafenib. In the phase II study conducted in Japan, grade 3 skin toxicity occurred in 13.7% of 131 patients with RCC, but all of those skin toxic effects were HFS or rash/desquamation [2]. We here report three cases of erythema multiforme (EM) associated with sorafenib therapy. EM, Stevens–Johnson syndrome, and toxic epidermal necrolysis are mucocutaneous diseases associated with significant morbidity and mortality. The term 'Stevens–Johnson syndrome' has been widely accepted as a synonym for EM major [3].

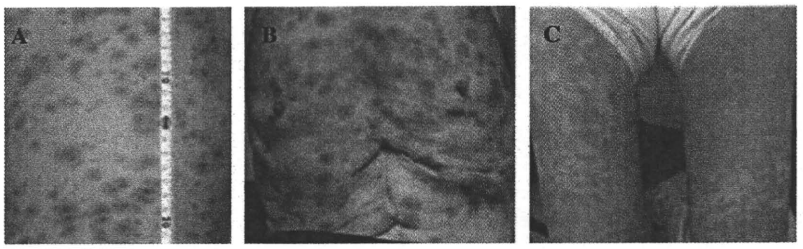

Figure 1. Erhythema multiforme of three cases. Target-like erythematous skin rash of left femoral lesion of case 1 (A), case 2 (B), and case 3 (C).

case 1

A 25-year-old female with pulmonary metastases of papillary RCC received sorafenib 800 mg/day. At day 8, erythema appeared on lower legs and spread over 50% of body surface area in 2 days (Figure 1A) with HFS. She also suffered intermittent fever up to 39.5°C from day 8. Serum examination excluded the viral infection, including measles, herpes simplex, or herpes zoster. Skin biopsy of femoral region at day 12 revealed superficial and perivascular lymphocyte infiltration and necrotic keratinocytes, compatible with EM. Skin rash disappeared within days after discontinuation of sorafenib without steroid treatment or antimicrobial treatment.

case 2

An 80-year-old man with multiple pulmonary metastases of papillary RCC was treated with sorafenib 800 mg/day. From the 8th to 12th day of sorafenib, erythema spread over his whole body (Figure 1B) with grade 2 HFS, mild stomatitis, and grade 3 fatigue. EM and HFS disappeared within 2 weeks after discontinuation of sorafenib and oral predonisolone 10 mg/day. When sorafenib (400 mg/day) was rechallenged, EM with high fever reappeared within 24 h and the sorafenib was discontinued at once.

case 3

A 70-year-old female with metastatic clear cell RCC developed erythema spread to whole body 15 days after starting sorafenib 800 mg/day (Figure 1C). Eruption disappeared within 2 weeks after discontinuation of sorafenib and topical treatment without steroid. She was treated with sunitinib 50 mg/day and EM has not appeared.

Rash, desquamation, and HFS are most frequent skin symptoms with sorafenib. They are dose dependent and disappear with discontinuation of sorafenib. In most cases, restart with the same dose is possible and the symptoms may resolve without dose modification. MacGregor et al. [4] reported sorafenib-induced EM in malignant melanoma patient. They carried out skin biopsy and showed the same findings with that of our case. In that report, the patient was rechallenged with the reduced dose of sorafenib (100 mg) but developed the same eruption within 24 h, and they discontinued sorafenib. There have been only two other reports about sorafenib-induced EM [5, 6], but we experienced three EM patients, one of which was confirmed by biopsy, of 16 RCC patients we have treated with sorafenib in a year.

Furthermore, postmarketing surveillance of sorafenib-treated patients in Japan reported that 108 cases of so-called EM occurred in 2889 cases from February 2008 to October 2009, so occurrence rate of EM might be different between Japanese and Caucasians. A recent study suggests that polymorphisms in specific genes encoding for metabolizing enzymes, efflux transporters, and drug targets are associated with toxic effects of sunitinib, another angiogenesis inhibitor [7]. In addition, the population-related pharmacogenomics might contribute to differences in adverse events and responses of antitumor agents between patients in Japan and those in the United States [8]. Further study is necessary to elucidate this discrepancy of EM occurrence rate between Japanese and Caucasians.

In clinical practice, it is very difficult to diagnose whether the drug-induced skin rash is caused by allergic or toxic mechanisms. To use sorafenib safely, restarting of sorafenib needs careful monitoring because the possibility of an allergic mechanism cannot be ruled out. Patients with skin lesions due to allergic mechanisms may not have benefits from sorafenib treatment because of early treatment failure. At present, we cannot recommend the rechallenge of sorafenifb for these patients as two of three patients including our case recurred EM.

Sorafenib is now one of few standard agents for metastatic RCC. Molecular mechanism of this type of toxicity remains unknown. Further investigation is necessary to disclose the mechanism and establish the effective therapy for sorafenib-induced EM, which might not be a rare adverse event in Japanese patients.

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disclosure

None of the authors declare conflicts of interest.

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CORRESPONDENCE

Is Statin Use Really Associated With Efficacy of Rituximab?

TO THE EDITOR: We would like to raise several issues regarding the recent article in *Journal of Clinical Oncology* by Nowakowski et al,[1] "Statin Use and Prognosis in Patients With Diffuse Large B-Cell Lymphoma and Follicular Lymphoma in the Rituximab Era."

This report focused on the clinical impact of statin use on outcomes of patients with diffuse large B-cell lymphoma (DLBCL) or follicular lymphoma (FL) receiving rituximab treatment based on the experimental results that statins impair the efficacy of rituximab. However, we do not think it can be concluded with certainty that statin use was associated with the efficacy of rituximab.

First, the authors have mentioned the limitation of medication compliance, the timing of the opening for statin use, and the type of statin, which was collected retrospectively using medical records; however, they do not provide any information about the serum cholesterol level. In a laboratory study, statins were found to significantly decrease rituximab-mediated complement-dependent cytotoxicity and antibody-dependent cellular cytotoxicity against B-cell lymphoma cells.[2] This study suggested that statins, through the depletion of serum cholesterol, induce conformational changes in CD20 molecules that result in impaired binding of rituximab.[2] Thus, we think the difference in serum cholesterol levels in the statin group versus no statin group should be compared. If the statin use group had an advantage for higher total cholesterol level despite statin use, it would be difficult to know whether statin use with lowered cholesterol levels may have a different impact. Our recent analysis showed that statin use was not correlated with the prognosis of patients with DLBCL receiving rituximab plus cyclophosphamide, doxorubicin, vincristine and prednisone therapy by adjusting serum cholesterol level.[3]

Second, although the authors have analyzed event-free survival in all patients with FL as a whole group, regardless of whether or not they received rituximab, there are still heterogeneous groups of patients as a result of the disparate approaches to the initial care. Because rituximab significantly improved the outcomes of patients with FL,[4-8] we think the authors should analyze outcomes separately according to statin use, with or without the addition of rituximab.

Third, previous studies have shown that statin use reduces the risk of cardiovascular disease[9] and cerebral vascular attack, and the influence of death from these diseases should be ruled out to evaluate the correlation between statin use and prognosis of lymphoma. Detailed information about death or the evaluation of progression-free survival is encouraged.

Fourth, in patients treated on phase III adjuvant colon clinical trials, disease-free survival (DFS) and overall survival are highly correlated, both within patients and across trials. Although the correlation between DFS and overall survival in patients with FL treated with rituximab-containing chemotherapy has still not been proven, these results suggest that DFS after 3 years of median follow-up is an appropriate end point for adjuvant colon cancer clinical trials of fluorouracil-based regimens.[10]

The influence of statin use on rituximab efficacy is a significant clinical problem. Further studies and follow-up are warranted to confirm the prognostic significance of statins for patients with DLBCL and FL receiving rituximab-containing chemotherapy.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST
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Implications for Differential Diagnosis of Lung Cancer–Associated Lymphadenopathy in Lymphoepithelioid Cell Lymphoma (Lennert's Lymphoma) Arising Simultaneously with Lung Cancer

A Case Report

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Background

Lymphoepithelioid cell lymphoma (LCL) is a rare morphologic variant of peripheral T-cell lymphoma, and its cytologic features have not been well characterized. We describe details from fine needle aspiration cytology (FNAC) of LCL in a patient simultaneously suffering from lung cancer, in whom extensive lymph node metastasis was suspected clinically.

Case

A 54-year-old man had a lung nodule diagnosed as an adenocarcinoma by biopsy. 18F-fluoro-deoxyglucose positron emission tomography showed high uptake in the lung nodule as well as interlobar, supraclavicular and axillary lymph nodes. FNAC from interlobar and supraclavicular lymph nodes revealed abundant lymphoid cells intermingled with epithelioid cell clusters. Most lymphoid cells were small, with teardrop-shaped nuclei. Occasionally, large lymphoid cells with hyperconvoluted nuclei and prominent nucleoli were observed. An extensive sarcoid reaction was suspected on cytology, and lobectomy was performed. LCL with lung adenocarcinoma was diagnosed on the immunohistochemical findings.

Conclusion

Detailed observation of lymphoid cells with FNAC is important even in patients with lung cancer and massive regional lymphadenopathy. Presence of a teardrop nuclear shape and nuclear irregularities of lymphoid cells provides important information for cytologic diagnosis of LCL when epithelioid cell clusters are evident. (Acta Cytol 2010;54:197–201)

It is important to carefully examine the morphology of lymphoid cells on FNAC even if metastasis from a malignant tumor such as lung cancer is highly suspected.

Keywords: aspiration cytology, fine-needle; lung cancer; lymph node metastasis; lymphoepithelioid cell lymphoma; sarcoid reaction.

Lymphoepithelioid cell lymphoma (LCL) considered to be a rare variant of peripheral T-cell lymphoma, unspecified, in the World Health Organization (WHO) classification.[1,2] Its major cytologic feature is the presence of epithelioid cell clusters intermingled with atypical lymphoid cells.[3-17] Although several case reports of LCL have appeared in the literature, detailed cytologic features have yet to be established.[11-17]

The frequency of synchronous nodal lymphomas and lung cancer is in the range of 0.13% to ~0.43% of all lung cancers in Japan.[18] To our knowledge, however, simultaneous LCL with lung cancer has never been reported. Many nodal lesions seen in patients with lung cancer are sarcoid reactions and nodal reactive changes, including granulomatous lymphadenitis,[13,19] and need to be distin-

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guished from LCL cytologically.[3-17]

We describe a rare case of simultaneous LCL with lung cancer. Extensive lymph node metastasis was suspected on imaging, but a sarcoid reaction was indicated by fine needle aspiration cytology (FNAC). We discuss cytologic pitfalls and detailed characteristics of LCL.

Case Report

A 54-year-old Japanese man was referred to our hospital for further examination of a right lung nodule found on chest radiography at a regular health check-up. Chest computed tomography (CT) showed a 24-mm nodule with spiculation and pleural indentation in the right upper lung field and lymphadenopathy involving the mediastinal, subcarinal, interlobar and left axillary lymph nodes. Transbronchial FNA (TBAC) and biopsy from the nodule revealed a primary lung adenocarcinoma. FNAC from interlobar and subcarinal lymph nodes was then performed for diagnosis of the apparent metastasis. Cytology for interlobar lymph nodes revealed a few atypical cells, but no unequivocal malignancy. Whole-body positron emission tomography revealed increased 18F-fluoro-deoxyglucose uptake in the right lung nodule and interlobar, right supraclavicular and left axillary lymph nodes; FNAC and biopsy of a supraclavicular lymph node were performed. This revealed atypical lymphoid cells, again with uncertainty as to whether they were malignant or reactive in nature. Examination of biopsy material from interlobar, subcarinal and supraclavicular lymph nodes resulted in a diagnosis of sarcoid reactions in all cases.

The presence of teardrop-shaped nuclei and nuclear irregularity of small lymphoid cells admixed with epithelioid cell clusters could be helpful for cytologic diagnosis of LCL.

With the clinical diagnosis of stage I disease, the patient underwent right upper lobectomy with mediastinal lymph node dissection. The interlobar lymph node was diagnosed as demonstrating granulomatous lymphadenitis from examination of intraoperative frozen sections. Finally, the pulmonary nodule was diagnosed as a stage I poorly differentiated adenocarcinoma. Based on further immunohistochemical studies, the interlobar lymph node was diagnosed as LCL. Thus we reviewed the biopsy material obtained from a supraclavicular lymph node and added immunohistochemical investigation. The final diagnosis was LCL. As a result of 6 cycles of chemotherapy with Adriamycin, cyclophosphamide, vincristine and prednisone, he is now in complete remission after 10 months of follow-up. Unfortunately, he had lung cancer recurrence locoregionally 2 years after the surgery, but is now alive after 3 years of follow-up.

Right Upper Lobe Lung Cancer

Cytologic Findings. The smears of TBAC were moderately cellular, with cohesive clusters of large tumor cells on a necrotic background (Figure 1). The tumor cells were polygonal to cuboidal, with abundant homogenously staining cytoplasm, hyperconvoluted nuclei with a finely reticular chromatin pattern, thickened nuclear membranes and a single to several and prominent nucleoli. There was no evidence of glandular structures.

Histopathologic Findings. Grossly, the resected pulmonary tumor was a solid, gray-white, firm nodule, 21 mm in diameter, located in the peripheral portion of the right upper lobe. Microscopically, the tumor consisted of sheets of large polygonal cells with occasional mucin vacuoles (Figure 2). The tumor cells had hyperconvoluted nuclei, and markedly cellular pleomorphism was evident. Papillary structures were observed within the lesion focally.

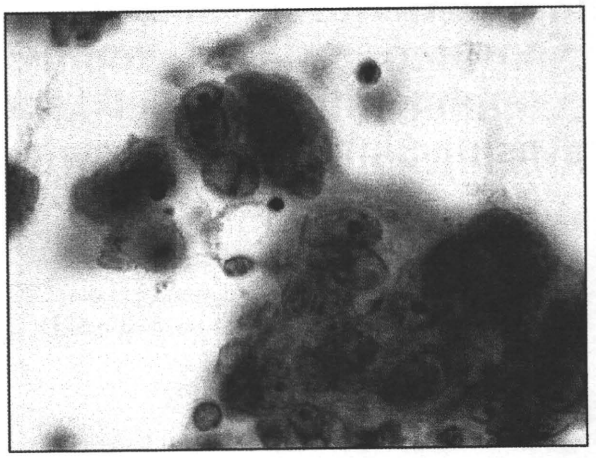

Figure 1 TBAC smear from the lung cancer. The cohesive clusters of polygonal to cuboidal tumor cells (Papanicolaou stain, × 1,000).

Lymphoepithelioid Cell Lymphoma

Cytologic Findings. The smears of TBAC from an interlobar lymph node and FNAC from a supraclavicular lymph node were highly cellular, with numerous lymphoid cells and occasional dispersed epithelioid cell clusters (Figure 3). Most of the lymphoid cells were small, with frequent teardrop-shaped nuclei (Figure 4). Occasionally, isolated and large lymphoid cells were evident (Figure 5) with a round shape and pale or clear cytoplasm. These cells had hyperconvoluted nuclei with a finely granular chromatin pattern and thin nuclear membranes. Single to several large, round to irregularly shaped nucleoli were seen.

The epithelioid cell clusters consisted of small, monolayered and loose aggregates of 10–20 spindle cells with abundant, pale-staining

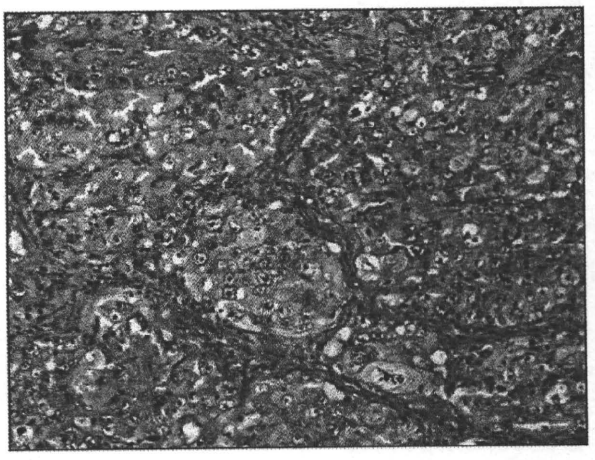

Figure 2 Histologic findings of the resected lung cancer. Sheets of large and polygonal cells with marked cellular pleomorphism (hematoxylin-eosin, × 200).

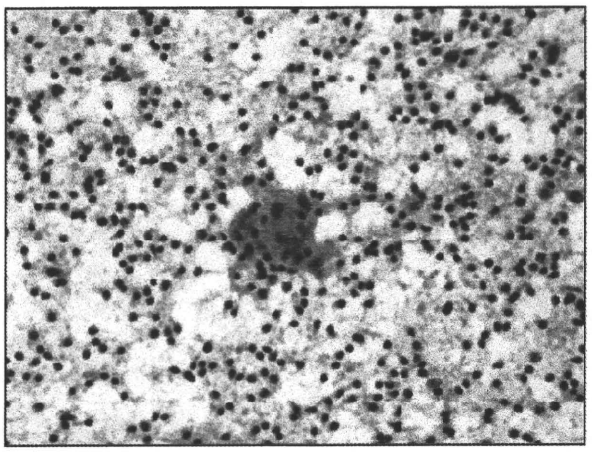

Figure 3 TBAC smear of LCL. The cohesive clusters of epithelioid cells with many atypical lymphoid cells (Papanicolaou stain, ×400).

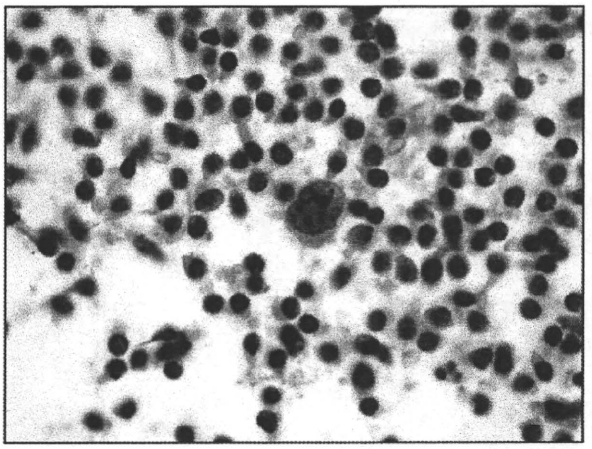

Figure 5 TBAC smear of LCL. Occasional atypical large lymphoid cells with hyperconvoluted nuclei and prominent nucleoli (Papanicolaou stain, × 1,000).

and homogeneous cytoplasm. Oval to elongated nuclei with single small nucleoli were evident.

Histopathologic Findings. Dissected interlobar, hilar and mediastinal lymph nodes were all enlarged. Microscopically, nodal structures in the obtained materials were precluded by the presence of epithelioid histiocytes usually grouped in small clusters (Figure 6A). The lymphoid component was heterogeneous in population, including small and medium-sized to large cells, eosinophils and plasma cells. Most of the lymphoid cells had irregularly shaped nuclei, granular chromatin and prominent nucleoli. Occasionally, large cells resembling Reed-Sternberg cells were observed. Immunohistochemical studies of the lymph nodes were performed with a labeled streptavidin-biotin staining kit (Dako, Carpinteria, California, U.S.A.) according to the manufacturer's instructions. The results were classified as follows: negative—the absence of positive-stained tumor cells; weakly positive—the presence of tumor cells expressing the antigen more weakly than normal T-cells of positive controls; and positive—the presence of tumor cells expressing the antigen as strongly as normal T-cells of positive controls. Immunohistochemically, the lymphoid cells were positive for CD8 (Nichirei, Tokyo, Japan) (Figure 6B) and weakly positive for CD3 (Dako, Glostrup, Denmark), CD7 (Novocastra, Newcastle upon Tyne, U.K.) and CD30 (Dako). Immunostaining for CD4 (Nichirei), CD5 (Novocastra), CD15 (Becton-Dickinson, Mountain View, California, U.S.A.), CD20 (Dako), perforin (Novocastra) and Granzyme B (Dako) was negative (Table I). These findings indicate a T-cell lineage. Because large cells resembling Reed-Sternberg cells showed positivity for CD8, as did small and medium-sized lymphoid cells, Hodgkin's disease was excluded. In situ hybridization using a fluorescein-conjugated oligonucleotide probe for Epstein-Barr virus–encoded RNA was performed with paraffin-embedded specimens.[20,21] As a result, the Epstein-Barr virus–encoded RNA probe detected no evident Epstein-Barr virus infection. The histologic features of biopsy material obtained from a supraclavicular lymph node were similar to those described earlier. Finally, these lymph nodes were diagnosed as LCL by the WHO classification.[1]

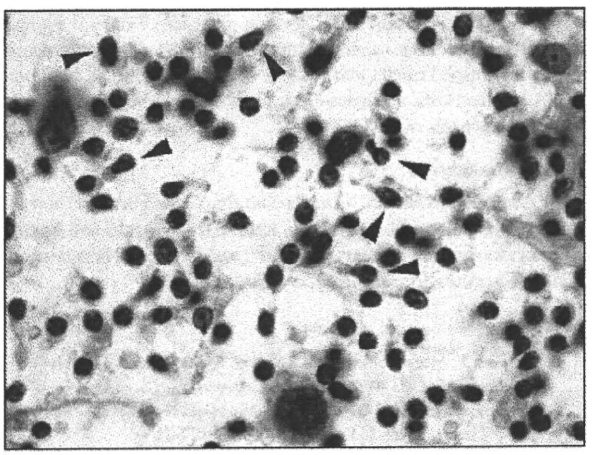

Figure 4 TBAC smear of LCL. Atypical small lymphoid cells with teardrop-shaped nuclei (arrowheads) (Papanicolaou stain, × 1,000).

Discussion

Complete and accurate mediastinal staging of patients with lung cancer is essential for determining prognosis and guiding optimal treatment strategies. Therefore, for patients with lung cancer accompanied by lymphadenopathy, it is important to indicate whether the cause of the lymphadenopathy is metastasis. For differential diagnosis of lymphadenopathy in patients with lung cancer, several reports have indicated that sarcoid reactions require particular attention in this regard.[22,23] For staging lung cancer, FNAC has demonstrated a sensitivity of 76.0–95.7%, a specificity of 100% and a diagnostic accuracy of 98.0%, with fewer false positive results than with CT and PET.[24,25] In our case, because extensive lymphadenopathy was apparent, FNAC was performed and a sarcoid reaction was diagnosed cytologically. On pathologic examination and immunohistochemical analysis of resected materials, however, lymph nodes were diagnosed as LCL.

LCL is now included in the category of peripheral T-cell lymphomas, unspecified, by the WHO classification.[1] Atypical lymphoid cells express variable T-lineage markers, such as CD2, CD3, CD4, CD5, CD7, CD8, CD43 and CD45RO, and lack expression of B-lineage markers.[9-17,26,27] Previously the immunocytochemical characteristics of LCL cells were thought to be CD4-positive and CD8-negative. In some cases of LCL, however, the neoplastic cells were CD8-positive and CD4-negative, a well-known variant of LCL.[28] Moreover, Epstein-Barr virus infection is occasionally