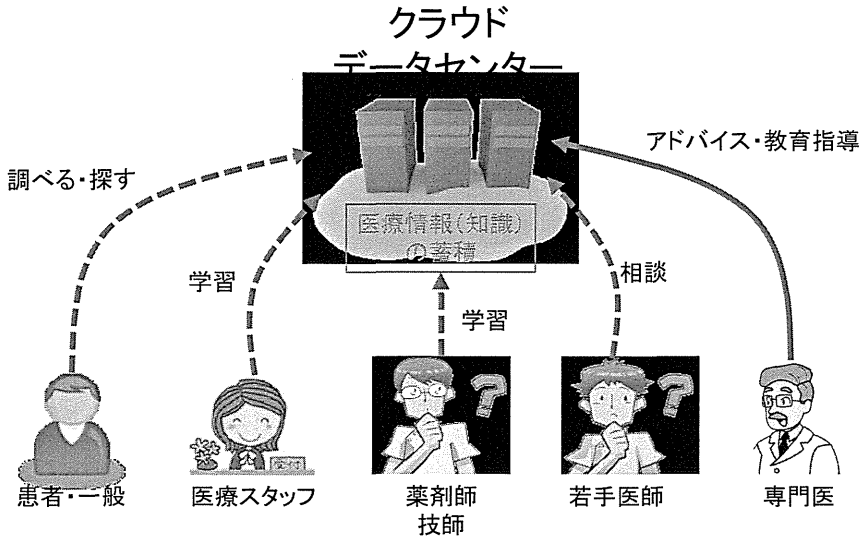
我々が考えるクラウドサービス



eSiteの2本柱

- コンテンツサービス
  - –2012年4月24日
    神田塾(症例コンテンツ勉強会)開始

医療画像を中心に据えた医療スタッフ
＆一般向け教育コンテンツ

コンテンツサービス実績

2012年4月　MS.CHEST神田塾　開校

- MS.CHEST神田塾：若手向け「胸部レントゲン」読影指南
- GUR神田塾：「婦人科・泌尿器科」読影指南
- H&N神田塾：「頭頸部領域」読影指南

2013年6月　研究会　支援開始

•阪神胸部疾患研究会、浜松びまん研究会、大阪びまん研究会、九州びまん研究会、南九州びまん研究会

•中之島X線セミナー（大阪大学放射線科）

•消化器画像診断研究会

MS.CHEST神田塾

塾長　佐藤 雅史　東邦大学医療センター大橋病院放射線科客員教授
講師　栗原 泰之　聖路加国際病院放射線科部長　他2名
門下生　東京医科歯科大学　2名
聖マリアンナ医科大学　2名
聖路加国際病院　2名
土浦協同病院　1名
帝京大学医学部付属病院　1
東京女子医科大学　1
越谷市立病院（順天堂大学）　1
東京慈恵会医科大学　1
東京北医療センター　1名
東京警察病院　1名
国立精神・神経医療研究センター　1名
NTT東日本関東病院　1名


佐藤雅史


栗原泰之

2012年4月　開講　月1回開催　毎回約10症例　31開催　393症例

GUR　神田塾

講師　陣崎 雅弘　慶應義塾大学医学部放射線科 教授
北井 里実　東京慈恵会医科大学放射線科 助教
田村 綾子　東京北医療センター病院放射線科 医長
松尾 義朋　イーサイトヘルスケア代表

門下生　帝京大学医学部付属病院　1名
東京慈恵会医科大学　1
聖マリアンナ医科大学　1名
日本医科大学　1名
聖路加国際病院　4名
済生会中央病院　1名
越谷市立病院(順天堂大学)　1名
慶應義塾大学放射線診断科　1名
東京逓信病院放射線科　1名
昭和大学横浜市北部病院　1名
東京女子医大病院　1名
板橋中央総合病院　1名


陣崎 雅弘


北井 里実


田村 綾子

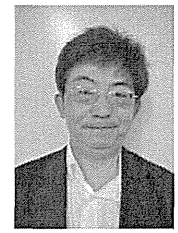

松尾 義朋

2013年7月　開講　年6回開催　毎回約4症例　8回開催　30症例

GUR　神田塾

講師　辰野 聡　八重洲クリニック放射線科

門下生　順天堂大学　1名
聖マリアンナ医科大学　2名
聖路加国際病院　4名
済生会中央病院　1名
東海大学医学部　1名
板橋中央病院　1名
東京歯科大学市川総合病院　1名


辰野 聡

2014年6月　開講　月1回開催　毎回約5症例　4回開催　20症例

eSiteの学会・研究会支援

- コンテンツサービス：医療画像を中心に据えた医療スタッフ＆一般向け教育コンテンツ
  - 2013年6月　研究会　支援開始
    - 阪神胸部疾患研究会
    - 浜松びまん研究会
    - 大阪びまん研究会
    - 九州びまん研究会
    - 南九州びまん研究会
    - 中之島X線セミナー（大阪大学放射線科）
    - 消化器画像診断研究会

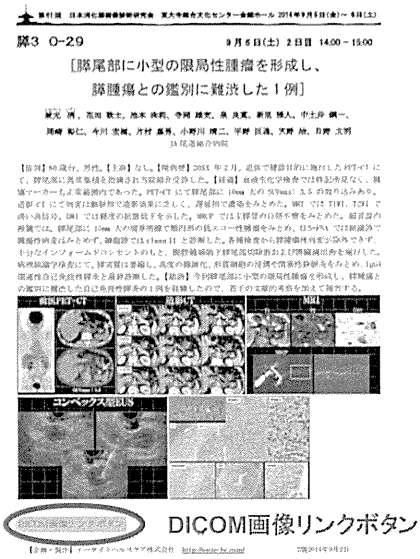
研究会支援

・クラウド環境を利用した画像供覧環境の提供

びまん性肺疾患研究会(大阪)

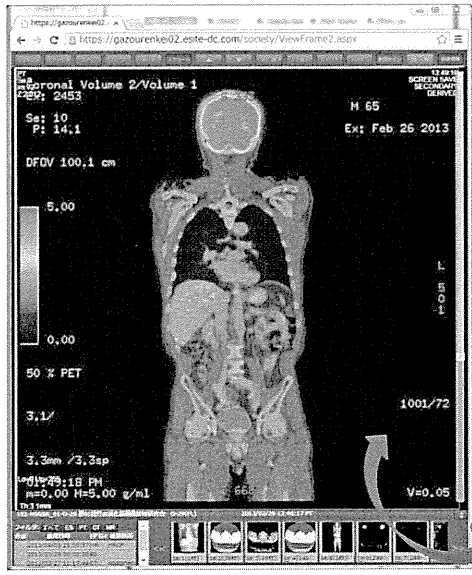
中之島胸部X線セミナー

第61回 消化器画像診断研究会



2014年11月30日 eSiteの取組説明 19

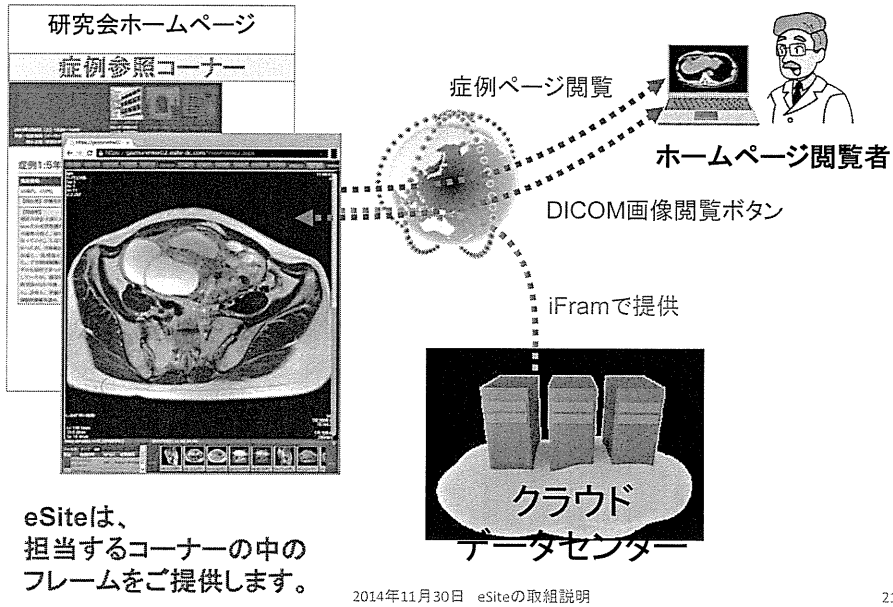
第61回 消化器画像診断研究会



②DICOM画像WebViewer起動

2014年11月30日 eSiteの取組説明 20

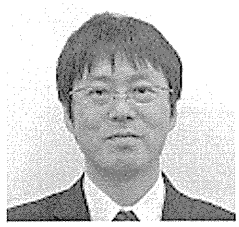
画像データ閲覧サービス



eSiteは、
担当するコーナーの中の
フレームをご提供します。

eSiteの取組のまとめ

- プロフェッショナル技術
  - 最新技術の早期導入
    - 国内初のクラウド型遠隔読影環境提供の専業会社
  - 読影（放射線科）
    - 読影組織　　:51組織
    - 登録読影医　:300人超
  - 研究支援
    - 研究会
    - 厚生労働省「難治性疾患克服研究事業」:血管腫・血管奇形
    - 経済産業省「平成22年度課題解決型医療機器の開発・改良に向けた病院・企業間の連携支援事業」:CIRCUS+（東京大学）



大野　孝

・星座　かに座（7月生まれ）
・趣味　楽器演奏（ギター、ウクレレ、フルート）
　　史跡めぐり
　　機械修理（コンピュータ、家電）

- 昭和42年　岐阜県岐阜市　生まれ
- 昭和61年　岐阜県立岐阜高等学校　卒業
- 平成6年　東京電機大学大学院　大学院　卒業
- 平成7年　国立循環器病センター研究所　人工臓器部　技官
- 平成11年　東京電機大学大学院　博士課程　満期退学
- 平成11年～ 国内PACSベンダー　開発職、SE職、営業職を経験
- 平成20年　㈱ジェイマックシステム　新規事業推進部　部長
- 平成22年　イーサイトヘルスケア㈱　取締役
- 平成25年　イーサイトヘルスケア㈱　副社長

III. 学会等発表実績

様式第１９

学 会 等 発 表 実 績

委託業務題目「転移性肝芽腫に対する薬剤開発戦略としての国際共同臨床試験 」
機関名 国立大学法人広島大学

１．学会等における口頭・ポスター発表

発表した成果（発表題目、口頭・ポスター発表の別）	発表者氏名	発表した場所（学会等名）	発表した時期	国内・外の別
肝芽腫の縦隔再発に対してICG蛍光法を使用した経験(口頭)	栗原 将，鬼武美幸，小倉 薫，檜山英三	岡山市（第55回日本中国四国小児がん研究会）	2014/4/26	国内
Detection of Cancer Stem Cells in Childhood Cancers(口頭)	Hiyama E	Dailen, China (BIT' S 4th Annual World Congress of Molegular &	2014/4/27	国外
JPLT(肝芽腫)(口頭)	檜山 英三	大阪市（第51回日本小児外科学会）	2014/5/9	国内
小児がん(口頭)	檜山英三	東京都（がん政策サミット）	2014/5/17	国内
Telomere Biology in Neuroblastoma: Focusing on ATRX/DAXX Genes and Alternative-Strengthening of Telomere(ALT)（ポスター）	Hiyama E	Cologne, Germany (ANR Congress 2014)	2014/5/13-16	国外
Central venous catheter-related complications in children with malignancy（ポスター）	Kurihara S, Hiyama E, Onitake Y, Miki M, Nakamura K, Kawaguchi H, Kobayashi M	Calgary, Canada (PAPS2014)	2014/5/25-29	国外
Clinical feature of ATRX or DAXX mutated neuroblastoma（ポスター）	Hiyama E, Kurihara S, Onitake Y, Yamaoka E, Fukuba I, Hiyama K	Calgary, Canada (PAPS2014)	2014/5/25-29	国外
Surgical managements for refractory neuroblastoma in young children（ポスター）	Hiyama E, Kurihara S, Onitake Y, Ueda Y, Miki M, Kawaguchi H, Nakamura K, Kobayashi M	Edinburgh, Scotland. (BAPS61st Annual Congress)	2014/6/22-25	国外
DNAメチル化解析による肝芽腫の新規予後予測マーカーの確立（口頭）	本多昌平，湊 雅嗣，鈴木 拓，春田雅之，金子安比古，檜山英三，武冨紹信	横浜市（第73回日本癌学会学術集会）	2014/9/25	国内
小児固形腫瘍における循環遊離DNAと循環がん細胞のがん診断への応用（口頭）	檜山英三，檜山桂子，林 陽子，森原なぎさ，平野尚子，福場郁子，山岡絵美，栗原 将	横浜市（第73回日本癌学会学術集会）	2014/9/27	国内
Outcome and morbidity of primary resection of hepatoblastoma in JPLT-1 and 2 protocols（ポスター）	Hiyama E, Hishiki T, Watanabe K, Ida K, yano M, Oue T, Iehara T, Hoshino K, Koh K, Tanaka Y, Kurihara S	Toronto, Canada (SIOP2014)	2014/10/22-25	国外
Molecular diagnosis of lung cancer	Hiyama E	Bali. Indonesia (APSR2014)	2014/11/13	国外
肺転移を有した肝芽腫6例の外科的検討（口頭）	栗原 将，鬼武美幸，三木瑞香，中村和洋，小林正夫，檜山英三	岡山市（第56回日本小児血液・がん学会学術集会）	2014/11/28-30	国内
マウス皮膚腫瘍特異的DNAメチル化領域を用いた新規ヒト神経芽腫関連遺伝子の探索（口頭）	星 玲奈，杉藤 公信，石塚 悦昭昭，渡邉 揚介，吉澤 信輔，植草 省太，川島 弘之，大橋 研介，池田 太郎，越永 従道道，藤原 恭子，永瀬 浩喜	岡山市（第56回日本小児血液・がん学会学術集会）	2014/11/28-30	国内
Sotos症候群に合併した肝芽腫におけるNSD1遺伝子のDNAメチル化検討（口頭）	渡邉 揚介，杉藤 公信，川島 弘之，石塚 悦昭，星 玲奈，吉澤 信輔，植草 省太，古屋 武史，藤原 恭子，谷ヶ崎 博，越永 従道	岡山市（第56回日本小児血液・がん学会学術集会）	2014/11/28-30	国内
肝動脈化学塞栓療法を施行した肝芽腫の2例（口頭）	星 玲奈，杉藤 公信，渡邉 揚介，吉澤 信輔，植草 省太，川島 弘之，大橋 研介，池田 太郎，越永 従道	大阪市（第51回日本小児外科学会学術集会）	2014/5/8-10	国内
A combination chemotherapy, temozolomide (TMZ) with etoposide (VP) in relapsed or refractory pediatric solid cancer: Preliminary report of randomized phase II study of two different outpatient setting regimens (rPII)（ポスター）	Ogawa A, Kawamoto H, Saito Oba M, Hosono A, Kosaka Y, Hara J, Ishida Y, Yamada K, Koh K, Okamoto Y, Mugishima H, Kikuta A, Takashi Taga	Chicago, USA (ASCO Annual Meeting 2014)	2014/6/2	国外

Outcome and morbidity of primary resection of hepatoblastoma in JPLT-1 and 2 protocols (ポスター)	Hiyama E, Hishiki T, Watanabe K, Ida K, Yano M, Oue T, Iehara T, Hoshino K, Koh K, Tanaka Y, Kurihara S	Toronto, Canada (46th Congress of the International Society of Paediatric Oncology)	2014/10/23	国外
当科における術中リアルタイムナビゲーションの導入 (口頭)	宗崎良太，家入里志，木下義晶，植村宗則，橋爪　誠，田口智章	大阪市 (第51回 日本小児外科学会学術集会)	2014/8/10	国外
日齢11の極低出生体重児に発症した新生児脾破裂の1例 (ポスター)	宗崎良太，木下義晶，安岡和昭，楠田　剛，松本隼人，原　寿郎，橋爪　誠，田口智章	横浜市 (第28回小児救急医学会)	2014/6/6-7	国外
極低出生体重児に発症した新生児脾破裂の1例 (ポスター)	宗崎良太，木下義晶，安岡和昭，楠田　剛，松本隼人，原　寿郎，橋爪　誠，田口智章	千葉市 (第50回日本州周産期・新生児医学会)	2014/7/13-15	国外
新生児副腎部嚢胞性腫瘤の4例 (口頭)	宗崎良太，木下義晶，林田真，橋爪　誠，田口智章	横浜市 (第23回日本小児泌尿器科学会)	2014/7/9-11	国外
プローチの工夫よる根治性・整容性の向上を目指した小児腫瘍性病変に対する内視鏡外科手術 (口頭)	宗崎良太，家入里志，和田桃子，神保教広，小幡　聡，木下義晶，橋爪　誠，田口智章	岩手県盛岡市 (27回日本内視鏡外科学会総会)	2014/10/2-4	国外
術前CT画像に基づく3Dプリンター作成立体モデルを用いた腹腔鏡下副腎摘出術シミュレーションを行った神経芽腫の1例 (口頭)	宗崎良太，家入里志，木下義晶，小幡　聡，神保教広，福原雅弘，古賀友紀，三好きな，小田義直，原　寿郎、橋爪　誠	兵庫県淡路市 (第34回日本小児内視鏡外科・手術手技研究会)	2014/10/30-31	国外
新生児副腎嚢胞性病変の4例 (口頭)	宗崎良太，川久保尚徳，代居良太，家入里志，木下義晶，橋爪　誠，田口智章	岡山市 (第56回日本小児血液・がん学会学術集会)	2014/11/28-30	国外

2．学会誌・雑誌等における論文掲載

掲載した論文（発表題目）	発表者氏名	発表した場所 （学会誌・雑誌等名）	発表した時期	国内・外の別
Pediatric hepatoblastoma: diagnosis and treatment	Hiyama E	Translational Pediatrics	2014年	国外
Clinical features of ATRX or DAXX mutated neuroblastoma	Kurihara S, Hiyama E, Onitake Y, Yamaoka E, Hiyama K	J Pediatr Surg	2014年	国外
FAST-id system for enrichment of cells with TALEN-induced mutations and large deletions	Tokumasu D, Sakuma T, Hayashi Y, Hosoi S, Hiyama E, Yamamoto T	Genes Cells	2014年	国外
Hepatoblastoma state of the art: pathology, genetics, risk stratification, and chemotherapy	Czauderna P, Lopez-Terrada D, Hiyama E, Häberle B, Malogolowkin MH, Meyers RL	Curr Opin Pediatr	2014年	国外
肝芽腫の診断と治療	上條　岳彦、檜山　英三	「最新肝癌学」、日本臨牀社	2014年	国内
肝動脈化学塞栓療法を施行した肝芽腫の2例	星 玲奈，杉藤 公信，渡邉 揚介，吉澤 信輔，植草 省太，川島 弘之，後藤 俊平，大橋 研介，池田 太郎，越永 従道	日本小児外科学会雑誌	2014年	国内
Glypican 3 Expression in Pediatric Malignant Solid Tumors	Kinoshita Y, Tanaka S, Souzaki R, Miyoshi K, Kohashi K, Oda Y, Nakatsura T, Taguchi T	Eur J Pediatr Surg	2014年	国外
Testicular sex cord-stromal tumor in a boy with 2q37 deletion syndrome.	Sakai Y, Souzaki R, Yamamoto H, Matsushita Y, Nagata H, Ishizaki Y, Torisu H, Oda Y, Taguchi T, Shaw CA, Hara T	BMC Med Genomics	2014年	国外
Development and testing of an endoscopic pseudo-viewpoint alternating system	Koreeda Y, Obata S, Nishio Y, Miura S, Kobayashi Y, Kawamura K, Souzaki R, Ieiri S, Hashizume M, Fujie MG	nt J Comput Assist Radiol Surg	in press	国外

Review Article

Pediatric hepatoblastoma: diagnosis and treatment

Eiso Hiyama

Department of Pediatric Surgery, Hiroshima University Hospital; and the Natural Science Center for Basic Research and Development (N-BARD), Hiroshima University, Hiroshima, Japan

Correspondence to: Eiso Hiyama, MD, PhD. Natural Science Center for Basic Research and Development, Hiroshima University, 1-2-3, Kasumi, Minami-ku, Hiroshima, 734-8551, Japan. Email: eiso@hiroshima-u.ac.jp.

Abstract: Hepatoblastoma (HBL) is the most common primary liver tumor in children, and is usually diagnosed during the first 3 years of life. Collaborative multicenter studies have led to improved diagnostic and treatment strategies. The pretreatment extent of disease (PRETEXT) staging system has become a consensus classification, and an international pathological classification system has also been developed. Clinical trials examining multimodal therapy, which consists of complete surgical resection plus liver transplantation and chemotherapy, have led to improved outcomes for children with HBL. Recently, the Children's Hepatic Tumors International Collaboration (CHIC), which includes major multicenter study groups, created a shared database that merges data on all children underwent therapy in the clinical trials of these groups until 2008. CHIC has developed a global approach to risk stratification of pediatric HBL for use in future global clinical trials. The aim of this review is to report the recent developments on the diagnosis and treatment of pediatric HBL.

Keywords: Hepatoblastoma (HBL); diagnosis; treatment; risk stratification; clinical trial

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doi: 10.3978/j.issn.2224-4336.2014.09.01
View this article at: http://dx.doi.org/10.3978/j.issn.2224-4336.2014.09.01

Introduction

Hepatoblastoma (HBL) is the most common primary liver tumor in children and is usually diagnosed during the first 3 years of life. Most HBLs are sporadic, but some are associated with constitutional genetic abnormalities and malformations, such as the Beckwith-Wiedemann syndrome and familial adenomatous polyposis (1,2). Over the last three decades, the annual incidence of HBL in children has gradually increased (3). Extremely premature babies with a birth weight of less than 1 kilo have been reported to have a greatly increased risk of developing HBL. The increased survival rates of these premature babies might account for the increased annual incidence of HBL.

Diagnosis of HBL

The most common sign is abdominal distension or abdominal mass. Some children present with abdominal discomfort, generalized fatigue, and loss of appetite, due to tumor distension or secondary anemia. Children with a ruptured tumor usually present with vomiting, symptoms of peritoneal irritation, and severe anemia. Rare cases manifest precocious puberty/virilization due to β-human chorionic gonadotropin (hCG) secretion by the tumor. Serum alpha-fetoprotein (AFP) is the most important clinical marker for HBL, and remains the key clinical marker of malignant change, response to the treatment, and relapse. However, there are some variants of both HBL and hepatocellular carcinoma (HCC) that have low or normal AFP levels (4,5). These variants, such as rhabdoid tumor, may have distinct histological features and worse prognosis.

Abdominal ultrasonography usually reveals a large mass in liver, sometimes with satellite lesions and areas of hemorrhage within the tumor. The most useful diagnostic modality is multiphase computed tomography (CT) or magnetic resonance imaging (MRI). Helical CT findings of hypervascular lesions in the liver with delayed contrast excretion are highly suggestive of a malignant liver tumor. Histological diagnosis of a tumor specimen is essential,

Table 1 CHIC proposed—Hepatoblastoma Risk Stratification (CHICS)

PRETEXT	Standard risk (SR)		High risk (HR)	Very high risk (VHR)
	Low risk (LR) (primary resection at diagnosis)	Intermediate risk (IR)		
Any M+	–	–	–	M+
I M–	VPERF–(any AFP, any age)	–	VPERF + AND age <8 years (any AFP)	VPERF + AND age ≥8 years
II M–	VPERF–AND Age <3 AND AFP >1,000 ng/mL	VPERF–AND Age <3 AND AFP 100-1,000 ng/mL	Age 3-7 AND/OR VPERF +	AFP <100 ng/mL, AND/OR age ≥8 years
III M–	–	VPERF–AND Age<3 AND AFP >1,000 ng/mL	Age 3-7 AND/OR VPERF + AND/OR AFP 100-1,000 ng/mL	AFP <100 ng/mL, AND/OR age ≥8 years
IV M–	–	–	AFP >100 ng/mL	AFP <100 ng/mL, AND/OR age ≥8 years

M+, distant metastases; VEPRF+, one or more of the following criteria; V, hepatic vein/cava involvement; P, portal vein involvement; E, contiguous extrahepatic tumor; R, rupture at diagnosis; F, multifocality; AFP, α-fetoprotein (ng/mL); PRETEXT, pretreatment extent of disease.

although some investigators believe that biopsy may not be necessary for young children (6 months to 3 years) with a very high AFP level (6); in addition, avoiding a biopsy theoretically reduces the risks of tumor seeding or dissemination. The Japanese Study Group for Pediatric Liver Tumors (JPLT) strongly recommends that liver tumors of children should be treated after definitive diagnosis of a biopsy specimen, except in urgent life-threatening circumstances such as tumor invasion of the right atrium or tumor rupture (7).

Segmental assessment of the extent of the tumor and its relationship to the main hepatic vessels is of utmost importance when planning the intensity of chemotherapy and eventual surgery. In Europe, the Childhood Liver Tumor Study Group of the International Society of Pediatric Oncology (SIOPEL) has developed the preoperative evaluation of the tumor extent (PRETEXT) staging system, which appears to be a valuable tool for risk stratification (8); although the system has not been formally evaluated for prognostic accuracy. Formal staging of the tumor should include chest and brain CT. The risk stratification system proposed by the Children's Hepatic Tumors International Collaboration (CHIC), which will be described later, is shown in *Table 1*.

In childhood hepatic tumors, clinically relevant histologic subtypes are also being incorporated into risk stratification systems as well as into the PRETEXT staging system and distant metastasis. The common HBL subtypes are as follows: epithelial, mesenchymal, fetal, and embryonal. Some HBL variants include cholangioblastic or teratoid components or a macrotrabecular growth pattern (9). Fibrolamellar HCC is a distinct clinical and histological variant of pediatric HCC. The histopathological subtypes are the major prognostic factors of pediatric liver tumors, including HCC. The Children's Oncology Group (COG) has found that patients with completely resected tumors (stage I) with pure fetal histology have an excellent outcome (10), while both the SIOPEL and the COG investigators found that HBL patients presenting with low AFP levels (<100 ng/mL) and/or with small cell undifferentiated (SCUD) histology had a poor outcome, regardless of the PRETEXT staging system (4,5). The SCUD histology has not been reported by Japanese investigators. Rhabdoid tumors, which show loss of SMARCB1/INI1 expression on immunohistochemistry, should be included in the differential diagnosis of patients with tumors and low AFP levels (11). In 2011, an International Pathology Symposium was held to perform a collaborative histopathological review of pediatric liver tumors to work towards a consensus classification, with the eventual aim of developing a common treatment-stratification system. This symposium proposed the current standardized, histopathological meaningful classification of pediatric liver tumors (12).

Treatments for HBL

Before 1980, children with malignant hepatic tumors could only be cured by complete surgical resection of tumors. At present, complete tumor resection remains the cornerstone of definitive cure for HBL and offers the only realistic chance of long-term disease-free survival (13-15). The introduction of effective chemotherapeutic regimens in the 1980s resulted in an increased number of patients who could ultimately undergo tumor resection and also reduced the postoperative recurrence rate. Moreover, modern surgical techniques based on the segmental anatomy of the liver and whole hepatectomy plus liver transplantation have also led to increased numbers of resectable patients and have markedly improved the prognosis of these patients. Therefore, the combination of surgery and chemotherapy is an essential therapeutic strategy for HBL. The COG and JPLT studies have approved primary resection for children with resectable tumors, especially PRETEXT I or II cases. However, SIOPEL studies have not permitted the used of primary resection.

Recently, international collaboration study should be required for prompt clinical trials. CHIC was formed to focus on international global cooperation for investigations of pediatric malignant hepatic tumors, including HBL. The leading multicenter groups in CHIC are JPLT, SIOPEL, GPOH (German Paediatric Oncology and Haematology Society) and COG. Risk stratification in these trials was based on individual special classification of stage, metastasis, and histology in each trial (16). These CHIC members have incorporated their unique data into a common database, which now includes the retrospective data of all children treated in eight separate multicenter HBL trials performed between 1985 and 2008 (1,605 patients) (13-15,17-23).

The identification and development of new prognostic stratifications has led to novel treatments for high-risk patients and treatment reduction for low-risk patients, who do not need therapy intensification but need to avoid the delayed effects and unnecessary toxicities associated with treatment (24). Since childhood cancers are leading the way in the use of risk-adapted therapeutic strategies (25,26), collaborative research based on common risk adaptations and chemoprotective therapy for toxicity will have many benefits throughout the field of pediatric oncology. Although the analysis of CHIC database is still being debated, the therapeutic strategies used in global studies will be proposed using the risk stratification system proposed by CHIC (*Table 1*).

Standard-/low-risk patients

Patients with a single localized tumor involving at most three segments of the liver (PRETEXT I, II, III) can safely undergo complete surgical resection because of recently developed surgical instruments and anatomical evaluation using imaging modalities. Standard-risk patients are those patients with PRETEXT I, II, and III tumors and no extrahepatic features [hepatic vein/cava involvement (V), portal vein involvement (P), contiguous extrahepatic tumor (E), rupture at diagnosis (R), and multifocality (F)] or distant metastasis (M) (*Table 1*).

The treatment algorithm is shown in *Figure 1*. JPLT and COG have permitted primary hepatectomy for patients with PRETEXT I and II tumors, but SIOPEL has recommended preoperative chemotherapy for every patient, which is followed by tumor resection (19,27-29) or liver transplantation (27), and a short course of postoperative chemotherapy for most cases. The current consensus based on CIHC analysis is that an initial resection can be performed for PRETEXT I or II tumors if the tumor is located at least 1 cm from the middle hepatic vein and the bifurcation of the portal vein. Preoperative chemotherapy should be performed for other situations. Cisplatin-and-anthracycline-based chemotherapy was used as the first-line regimen in European (SIOPEL) and Japanese (JPLT) studies. This regimen improved the survival rates of patients with resectable tumors (15,17). The SIOPEL-1 study (PLADO) used four triweekly preoperative and two postoperative cycles of cisplatin (CDDP) and doxorubicin (DOXO), and resulted in an overall response rate of 82% and 5-year event-free survival (EFS) of 66% (28). The JPLT studies, using the same four preoperative and two postoperative cycles of CDDP and pirarubicin (THP-ADM), and the COG studies, using the same cycles of CDDP, fluorouracil (5-FU), and vincristine, resulted in almost similar survival rates. CDDP monotherapy recently achieved similar rates of complete resection and survival among children with resectable tumors (15). Therefore, CDDP monotherapy will be first-line chemotherapy for these standard HBLs. A trial is underway that evaluates combination therapy using CDDP and sodium thiosulphate to reduce the late effects of CDDP, especially ototoxicity.

High-risk (HR) patients

These patients are those with unresectable tumor at diagnosis and/or associated with so-called "combi

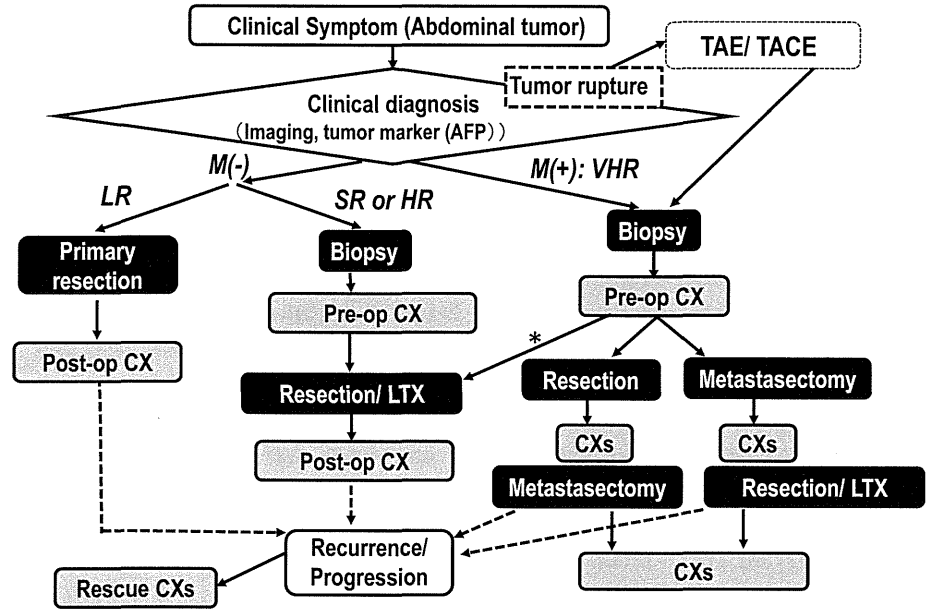

Figure 1 Diagnosis and treatment algorithm for hepatoblastoma. Hepatoblastoma is usually diagnosed from clinical signs, imaging findings, and elevation of serum α-fetoprotein (AFP) levels. In some patients whose tumor is ruptured, transarterial embolization (TAE) or transarterial chemoembolization (TACE) is needed for control of intraperitoneal bleeding. After bleeding is controlled, these patients should be treated according to the following risk stratification. Among the patients without distant metastasis [M(-)], low-risk (LR) patients are treated by primary resection followed by postoperative chemotherapy (Post-op CX). Standard-risk (SR) [intermediate-risk (IR) in *Table 1*] or high-risk (HR) patients receive preoperative chemotherapy (Pre-op CX) and then undergo primary tumor resection by hepatectomy or liver transplantation (LTX). The very high-risk (VHR) patients with distant metastasis [M(+)] receive Pre-op CX. Then, a patient whose distant metastasis is diminished by CX undergoes primary tumor resection by hepatectomy or LTX followed by Post-op CX; a patient whose distant metastasis remains undergoes metastasectomy or hepatectomy. LTX is usually indicated for the patient without distant metastasis or whose distant metastasis has clearly disappeared. Patients with recurrence or tumor progression should undergo rescue chemotherapy. Consolidation therapy has not been established as additional treatment for these HR and VHR patients who have undergone these multimodal therapies.

factors" without distant metastasis. The combi factor is a combination of the cross sectional imaging components including macrovascular involvement retrohepatic vena cava or all three hepatic veins (V); macrovascular involvement portal bifurcation or both right and left portal veins (P); contiguous extrahepatic tumor (E); multifocal disease (F); and spontaneous rupture (R) at diagnosis. V, P, E, F and R where a patient is categorized as positive when at least 1 of the components is present in HR. In addition, CHIC analysis found that older patients (≥3 years old at diagnosis) and patients with ruptured or multifocal tumors at diagnosis had unfavorable outcomes. Therefore, these patients were included as high-risk patients, even if their tumor was resectable (30,31). Conventional preoperative chemotherapy used in the PLADO, CITA, and C5V trials for patients with PRETEXT IV unresectable tumors resulted in tumors that could be resected by hepatectomy in some patients; but the outcome of patients with unresectable tumors at diagnosis remained unsatisfactory. Therefore, in SIOEPL studies, chemotherapy for HR-HBL was gradually intensified by the addition of carboplatin (SuperPLADO study) or high-dose CDDP (SIOPEL-4 study) with shortened intervals between chemotherapy cycles (31,32). In COG studies, the HR-HBL regimen was also intensified by addition of DOXO and high-dose CDDP (C5VD) (33). The SIOPEL-4 and COG approaches, based on CDDP intensification, improved the survival of children with HR-HBL, including those with lung metastases. Therefore, at present, CDDP intensification protocols are being evaluated for patients with HR-HBL, although the toxicity and late complications of these treatment protocols remain unclear.

In addition, orthotropic liver transplantation has

improved the outcome for some patients with unresectable tumors (PRETEXT IV tumors or tumors with portal or hepatic vein involvement) (34). Although the timing of liver transplantation and the role of rescue transplantation therapy remain controversial, consultation for liver transplantation should be performed for high-risk patients during the early stages of preoperative chemotherapy.

Very high-risk patients (metastatic HBL)

There is strong agreement that patients who present with lung metastases have a poor prognosis. In addition, CHIC analysis revealed that older patients (≥8 years old at diagnosis) and patients with low AFP levels (<100 ng/mL) have unfavorable outcomes. Therefore, these patients were included as very high-risk patients even if their tumor had not metastasized (35,36).

Conventional chemotherapy was usually ineffective for these very high-risk patients, with survival rates under 40% in the previous SIOPEL-1 and JPLT-1 studies (8,18). Moreover, resection of lung metastases has been effective for some patients with metastatic tumors. The surgical guideline for lung metasectomy should be necessary to improve outcome of the patient with lung metastasis in future. CDDP intensification therapy such as that used in the SIOPEL-4 protocol seems to be effective for these patients. The 3-year survival of metastatic HBL cases who underwent the SIOPEL-4 protocol was approximately 80% (31). To decrease recurrence, a consolidation regimen should be considered for these very high-risk patients. In addition, new molecular targeting therapy using vincristine and irinotecan will be investigated by COG.

For some of these metastatic patients whose metastatic lesions respond to these approaches, liver transplantation may be an indication. Therefore, carefully planned combination therapy using dose-intensified chemotherapy and surgical approaches that include metastasectomy and liver transplantation should be required to treat the very high-risk HBL patient.

Other therapies

Transarterial embolization (TAE) is used to control peritoneal hemorrhage in patients with ruptured tumors. Since primary resection for such rupture cases results in poor outcome, interventional control for hemorrhage is required for more successful treatment of these HBL patients.

It is well known that the normal liver receives blood from two sources, the hepatic artery and portal vein. Malignant liver tumors, including HBL, are mainly fed by the hepatic artery. Therefore, transarterial chemoembolization (TACE) is tumor selective. JPLT has used TACE instead of systemic chemotherapy as a clinical trial (17). CDDP and anthracycline have infused with particles that are used for embolization. The effect of TACE for HBL seemed to be equivalent to that of the patients who were treated by systemic chemotherapy and might be less toxic in comparison with systemic chemotherapy. Therefore, TACE is one of the effective procedures for pediatric liver tumors. However, administering TACE to children is somewhat difficult and requires general anesthesia. Verification of the efficacy of TACE for patients with standard-risk HBL requires additional clinical trials.

Future plans

To obtain consensus for universal risk stratification and treatment of pediatric HBL, CHIC has created the largest database to date of patients with this rare cancer. The CHIC based classification system described in this review is being incorporated into a new risk-based cooperative international trial, the Pediatric Hepatoblastoma International Therapeutic Trial (PHITT), a joint venture of global collaboration that includes SIOPEL, COG, and JPLT.

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Clinical features of *ATRX* or *DAXX* mutated neuroblastoma

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ABSTRACT

Purpose: Previously, we reported that alternative lengthening of telomere (ALT) may be a biomarker for chemosensitivity and late recurrence in neuroblastoma (NBL). In this study, alterations of *ATRX* or *DAXX*, which both encode chromatin remodeling proteins in telomeric region, and their relationship to ALT were examined in NBLs.
Methods: Our previous report on 121 NBLs revealed 11 NBLs with elongated telomeres by ALT. In these NBLs, *ATRX* or *DAXX* gene alterations were identified using next-generation sequencing and compared to clinical and other biological factors.
Results: In 11 ALT cases, *DAXX* mutations were detected in one case, and *ATRX* alterations were detected in 10 cases. Except for one case, no *DAXX* or *ATRX* alterations were detected in 110 tumors with normal or shortened telomeres. *MYCN* amplification was not detected in *ATRX* altered tumors. In ALT cases, three infants showed *ATRX* deletions, and all seven cases detected after 18 months of age showed poor prognosis.
Conclusions: In NBLs, ALT was caused by *ATRX* or *DAXX* alterations. *ATRX* altered cases without *MYCN* amplification detected at greater than 18 months showed poor prognosis, suggesting that *ATRX* or *DAXX* alterations are a particular NBL subtype. Since these tumors showed chemo-resistance and late recurrence, complete resection in a surgical approach should be performed to improve patient prognosis.

More than 90% of neuroblastomas (NBLs) are diagnosed within the first five years of age and exhibit different clinical behaviors such as life-threatening progression, and spontaneous regression or maturation. Since most NBLs produce catecholamines, vanillylmandelic acid (VMA) and homovanillic acid (HVA) are detectable in urine. In Japan, mass-screening of catecholamine metabolites to detect earlier stage NBLs in infants showed that the annual incidence increased more than two-fold prior to screening implementation, whereas both incidence of advanced NBLs in older children and cumulative mortality rate of NBLs were reduced significantly [1]. Therefore, NBLs consist of heterogeneous subtypes and the unfavorable subtypes increase in the older children.

Molecular and biological analyses revealed several distinguishable NBL subtypes with alterations in *MYCN*, *ALK*, *PHOX2*, *PTPN11*, *ATRX*, and *NRAS*[2,3]. *MYCN* amplification and hemizygous deletions of chromosomes 1p and 11q are highly recurrent and associated with poor prognosis in NBLs [4]. Heritable mutations in *ALK* or *PHOX2B* account for the majority of familial NBLs [5,6]. One distinguishable NBL characteristic, ALT (Alternative Lengthening of Telomere), was associated with unfavorable NBLs in older children without *MYCN* amplification [7–9]. Cheung et al. found *ATRX* loss-of-function mutations and deletions associated with NBLs in adolescents and young adults [10]. In this paper, we focused on *ATRX* and *DRXX* alterations in association with ALT activated tumors.

1. Materials and methods

1.1. Samples

Approximately 500 NBL cases, whose tumors were obtained prior to any treatment, were diagnosed at Hiroshima University Hospital or affiliated hospitals in Japan over the past two decades. As shown in our previous study [9], 121 cases that were followed for more than 2 years and had high quality isolated DNA and RNA were selected for further study. Mean age at initial diagnosis was 22.2 months (range, 0-168 months). Among these cases, 67 were detected by mass-screening in Japan at 6 months of age [1]. Clinical stages and histological findings were determined according to the International Neuroblastoma Staging System (INSS) [11] and the International Neuroblastoma Pathological Classification (INPC) [12]. Written informed consent was obtained from all subjects or from their parents before surgery and this study was approved by the Institutional Review Board of Hiroshima University (I-RINRI-Hi-No.20). NBLs were routinely examined for *MYCN* amplification using fluorescent *in situ* hybridization or qualitative PCR analysis, and DNA ploidy using flow-cytometry analysis.

Patients of any age with INSS 1 or 2 disease, and those less than 12 months old with INSS 3 or 4S disease were treated with either surgery or both surgery and chemotherapy. Patients 12 months or older with INSS 3 and 4 disease were typically treated according to the

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Japanese Neuroblastoma Study Group protocols [13]. In the cases with INSS 4 tumor or INSS 3 *MYCN* amplified tumor, most patients, except for some infants, underwent myeloablative chemotherapy followed by bone marrow transplantation.

1.2. Affymetrix platform

Array experiments were done according to standard protocols for Affymetrix GeneChip Mapping SNP 6.0 arrays (Affymetrix, Inc., Santa Clara, CA), which can detect genomic gains or deletions leading to LOH [14]. These arrays were scanned with the Affymetrix GeneChip Scanner 3000 using GeneChip Operating System 1.2 (Affymetrix). Genotype calls and intensity of the single nucleotide polymorphisms (SNP) were processed by GeneChip DNA Analysis Software. Individual SNP copy intensity and regions in the *ATRX* gene were evaluated with the Affymetrix Genotyping Console Workflow.

1.3. ATRX and DAXX mutation analysis

Target genes including *ATRX* and *DAXX* were chosen for next-generation sequencing. Primers for each gene were designed using DesignStudio (Illumina Inc., San Diego, CA). Using the Nextera Custom Enrichment system (Illumina), sample libraries were generated from 50 ng of DNA. Using a paired-end sequencing approach, 112 target genes were sequenced. Single nucleotide variations and deletions were identified using previously described methods [15].

To validate the identified *ATRX* and *DAXX* mutations by Sanger sequencing, PCR primers were designed for each exon of these genes according to previous reports [16] and each exon was amplified from genomic DNA using exon-specific primers. Sequencing products were purified using Centri-Sep Spin Columns (Princeton Separations, USA) and then prepared for analysis on the ABI 3100-Avant Genetic Analyzer (Applied Biosystems, USA) according to the manufacturer's instructions.

1.4. Telomere analysis

Telomere length was estimated as the length of terminal restriction fragments (TRFs) by Southern as previously described [17]. Briefly, genomic DNA was digested with *HinfI*, separated by electrophoresis on 0.8% agarose, and hybridized with a 5'-end [^{32}P]-labeled $(TTAGGG)_4$ probe. Signal peaks were estimated as the TRF length. Length of 3'-overhang (3'-OH), single strand of the telomere end, was measured by a telomere-oligonucleotide ligation assay (T-OLA) [18,19]. Normalized 3'-OH intensity was then calculated in comparison with that of HeLa cells (defined as 1.0), which were run on each gel.

1.5. Quantification of telomerase activity

Extraction of telomerase protein and evaluation of activity were done by the TRAP (telomeric repeat amplification protocol) assay as described [20,21]. Levels of telomerase activity, expressed as Total Product Generated (TPG) units, were quantified by examining the ratio of the fluorescein intensity of the entire TRAP ladder. Since telomerase activity levels in fetal adrenal gland tissue were under 10.0 TPG, telomerase activity levels were divided into four categories: undetectable (TPG < 1.0), low ($1.0 \leq$ TPG < 10.0), moderate ($10.0 \leq$ TPG < 100.0), and high (TPG > 100.0).

1.6. Statistical analysis

Chi-square test or Mann–Whitney's U test was used to examine the significance of the comparisons of telomerase activity, telomere length, and clinicopathological factors. A log rank test was used to evaluate survival rates. Statistical significance was defined as $p < 0.05$.

2. Results

2.1. Single nucleotide polymorphism (SNP) analysis data using Affymetrix platform

SNP signals around *ATRX* and *DAXX* regions were analyzed by the SNP 6.0 array in 121 tumors including 11 tumors with elongated telomeres. Large deletions in *ATRX* were detected in 8 tumors (6.6%) (Fig. 1) and no deletions in *DAXX* were identified. The *ATRX*-deleted cases included 5 males and 3 females and 7 of these cases had elongated telomeres. The minimum overlapping deleted region contained exon 5 to exon 10, which encodes a predicted nuclear localization signal (Fig. 1).

2.2. ATRX and DAXX sequencing

We performed on discovery of the *ATRX* and *DAXX* gene alterations on the cohort of the remaining 114 cases without deleted *ATRX* gene using the next-generation sequencing and/or Sanger method. A *DAXX* mutation was detected in only one case with elongated telomere. This mutation results in a frame-shift of *DAXX* (A470 indel). *ATRX* mutations were also detected in three cases with elongated telomeres. Two were missense mutations (Q929E and A1690D) and the remaining one was a nonsense mutation (E555*). Neither *DAXX* nor *ATRX* mutations were detected in the cases without elongated telomeres.

2.3. Telomere length, 3'-OH length, and telomerase activity in NBLs

We previously reported no correlation between telomere length and telomerase activity, but did find a significant correlation between telomere length and 3'-OH length [10]. In this study, we identified *DAXX* or *ATRX* alterations (4 mutations and 7 deletions) in all NBLs with elongated telomeres (>15 kb) and a long length of 3'-OHs (>1.5). On the other hand, no alterations of *DAXX* or *ATRX* were detected in the remaining 110 cases, except for one case. Therefore, *DAXX* or *ATRX* alterations might contribute to ALT activation in NBLs. The *ATRX* deleted case without elongated telomeres also had elongated 3'-OH (Table 1).

2.4. Clinical and biological features of cases with ATRX and DAXX alterations

For patients detected either clinically or in large scale screens, clinical features of all cases with detected *ATRX* and *DAXX* mutations are shown in Table 1. Survival rate for patients with high telomerase activity had already been shown to be less than for those with other tumors ($P < 0.0001$) (Fig. 2) [9]. However, tumors without high telomerase activity did not usually show good prognosis. In this study, we analyzed the correlation between patient outcome and *ATRX* alterations of the tumor. Since high telomerase activity is well known as a poor prognostic marker, we analyzed prognosis of patients with tumors that did not have high telomerase activity (Fig. 2). The *ATRX* altered cases showed significantly worse prognosis.

Among the *ATRX or DAXX* altered cases, 8 INSS 4 tumors showed poor outcomes except for one infant case (Table 1). In these deceased cases, survival periods were more than 2 years and relatively long as compared with the deceased cases without *ATRX* or *DAXX* alterations. These cases with these aberrations, except for one, responded poorly to myeloablative chemotherapy. Moreover, the patient with complete remission also relapsed soon afterwards, and died of the disease. *ATRX* or *DAXX* altered NBLs diagnosed at older ages did not have high proliferative capacities, but showed poor outcomes due to chemoresistance. Although these alterations were very rare in tumors without elongated telomeres, one screening-detected case showed the *ATRX* deletion. Clinical feature of this *ATRX* deletion case without elongated telomeres included a ranking of INSS1, complete resection by surgery, but death by recurrence 25 months after initial diagnosis.

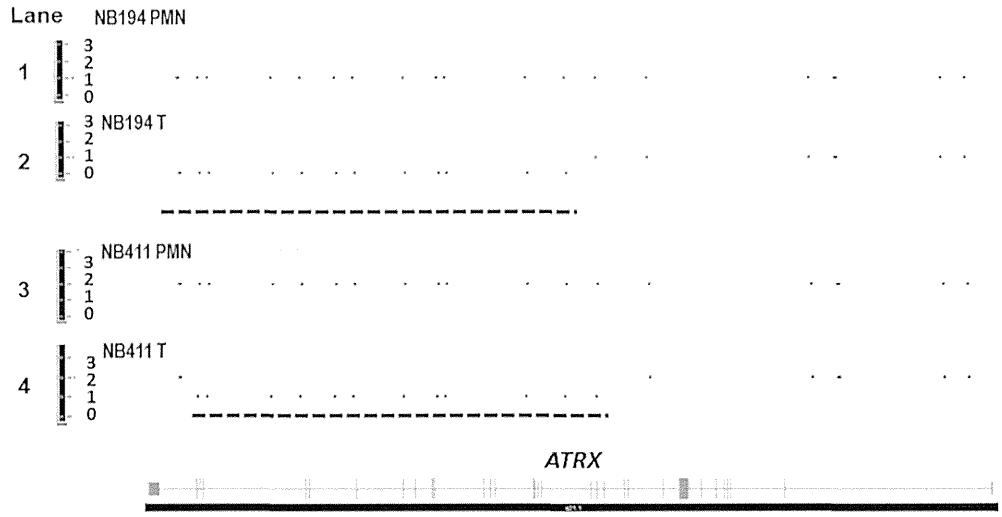

Fig. 1. Intensity of single nucleotide polymorphism (SNP) probes located in *ATRX* in neuroblastoma samples. Each dot indicates signal intensity of single nucleotide polymorphisms (SNPs) located in *ATRX* from an Affymetrix SNP 6.0 array. Since *ATRX* is located in chromosome X, male and female samples usually showed 1 and 2 copies in each SNP, respectively (lanes 1 and 3). Deleted loci were indicated by 0 and 1 copy in males and females, respectively (lanes 2 and 4). Solid lines show the prospective deleted lesions. A schematic of the intron–exon structure of *ATRX* is shown below, indicating the locations of exons are vertical lines.

3. Discussion

For immortalization in human tumor cells, telomerase is usually activated to maintain telomere length, which is shortened by cell division. However, in some tumor cells, a homologous recombination-based mechanism of telomere maintenance and elongation is activated [22] and this alternative lengthening of telomeres (ALT) is usually indicated by long telomeres [7,17]. High expression of telomerase activity correlates with advanced stages of disease and with tumor biological features that predict poor prognosis [7,23–25]. Indeed, tumors without detectable telomerase activity showed favorable outcomes except for some cases with elongated telomeres, suggesting the existence of ALT in NBLs [9].

Telomere maintenance by ALT also exists in unfavorable NBLs that were clinically suspected as chemo-resistant tumors without rapid growth [9]. Recently, identified *ATRX* or *DAXX* mutations in pancreatic neuroendocrine tumors and NBLs appeared to be loss-of-function mutations and thus, these mutations could lead to ALT activation [16].

In this study, we examined *ATRX* and *DAXX* alterations in the same cohort already analyzed for telomere biology [9]. Interestingly, all ALT activated NBLs had these alterations. Therefore, loss of function due to *ATRX* or *DAXX* alterations may contribute to ALT activation in NBLs, and it is possible that this is a direct effect of defects of histone H3.3 deposition at telomeres [26,27]. Although *ATRX* is located in chromosome X, both males and females were found to have *ATRX* mutations, consistent with previous work [10]. Additional studies will be required to determine the mechanism of ATRX function loss in both genders. Interestingly, an *ATRX* deleted infant case without long telomeres showed late recurrence regardless this case had been detected by screening. Although such cases are rare, NBLs with *ATRX* or *DAXX* alterations are a subgroup with high risk of late recurrence.

In our previous study for telomere biology in NBLs, clinical features of ALT-activating NBLs seemed to be markedly different from other NBLs [9]. These NBLs were clinically characterized as chemo-resistant tumors without rapid growth. Long telomeres in tumor cells might be disadvantageous for rapid growth. Therefore, cytotoxic therapy such as megachemotherapy with blood stem cell transplantation might be less effective in such NBLs. In such tumors with activated ALT due to *ATRX* or *DAXX* alterations, complete resection by surgery and careful attention for late recurrence should be performed to improve prognosis of these NBLs patients.

Recent advances in our understanding of NBL genetics and biology will greatly improve the outcome for patients with this complex heterogeneous disease [3,28]. Indeed, *MYCN* amplified NBLs [29], familial NBLs [30], *ALK* activated NBLs [31], and telomerase activated NBLs [7,32] have been identified and targeted molecular therapy for each of these NBLs

Table 1
Neuroblastoma cases with *ATRX* or *DAXX* aberrations.

	Age at diagnosis (mo.)/gender	Origin	INSS	*MYCN* (copies)	*DAXX/ATRX*	TRF (kb)	3'-OH	TRAP (TPG)	After CTx	Outcome
NBL003	73/M	retroperitoneal	4	1	Deletion	40	3.71	126.7	PR → PD	DOD (26 mo.)
NBL027	100/F	pelvic	4	200	Mut. (*DAXX*)	16	1.54	230.1	PD	DOD (27 mo.)
NBL094	23/M	adrenal	4	1	Mut. (*ATRX*)	26.1	2.96	9.28	SD → PD	DOD (52 mo.)
NBL194	129/M	adrenal	4	1	Deletion	28	3.85	6.16	PR → PD	DOD (42 mo.)
NBL225	42/M	adrenal	4	1	Deletion	31	1.71	4.6	PR → PD	DOD (53 mo.)
NBL292	40/F	retroperitoneal	4	1	Mut. (*ATRX*)	23	3.49	0.41	PR → PD	DOD (37 mo.)
NBL402	14/F	mediastinal	1	1	Mut. (*ATRX*)	15.6	3.31	7.31	-	NED (36 mo.)
NBL411	65/F	adrenal	4	1	Deletion	40	2.20	0.78	CR → PD	DOD (56 mo.)
NBL415	3/M	adrenal	4	1	Deletion	20.5	2.70	23.1	-	NED (127 mo.)
NBL418	8/F	adrenal	1	1	Deletion	20	3.05	5.22	-	NED (72 mo.)
NBL423	3/M	adrenal	2A	1	Deletion	17	2.39	42.3	-	NED (48 mo.)
NBL157*	8/M	adrenal	1	1	Deletion	12	1.72	11.12	CR → PD	DOD (25 mo.)

M: male, F: female, mo.: months of age, INSS: International Neuroblastoma Staging System, TRF: terminal restriction fragments, 3'-OH: 3'-overhang, TPG: Total Product Generated, Deletion: *ATRX* deletion, Mut: mutation, CTx: myeloablative chemotherapy, CR: complete remission, PR: partial remission, SD: stable disease, PD: progression of disease, DOD: dead of disease, NED: no evidence of disease.

* NB157 had *ATRX* deletion without elongated telomeres.