Perforin gene mutations in 77 Chinese patients with lymphomas

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INTRODUCTION

Lymphoma is a panel of diseases characterized by uncontrolled clonal proliferation of mature or immature B cells, T cells or natural killer (NK) cells. Because of the various maturities of the malignant cells, lymphoma can be classified based on their corresponding differential stage. Lymphoma is a group of bewildering diseases in their limited effective therapy and untoward prognosis. Various approaches have been applied to clarify the pathogenesis of lymphoma, such as mRNA transcriptome,¹ miRNA targetome,² cell signaling,³ gene translocation,⁴ and Epstein-Barr virus infection,⁵ etc. However, our understanding in development of neoplastic lymphoid cells is largely insufficient.

Perforin is a membrane-disruptive protein secreted by cytotoxic T lymphocytes (CTLs) and NK cells, which is essential for killing virus-infected and transformed cells through the granule exocytosis pathway.⁷ One outstanding finding in perforin gene (PRF1) knockout mice is the predisposition of spontaneous malignancy from distinct lymphoid cell lineages.⁸ In addition to familial hemophagocytic lymphohistiocytosis due to PRF1 mutations, human lymphomas were also found to harbor PRF1 mutations in some cases.⁹,¹⁰ The presence of PRF1 gene mutations may be different in different geographic regions and ethnic groups,¹¹,¹² and little is known about the mutations in Chinese populations. Here we report our findings of mutations in the PRF1 gene and the association with EBV infection in Chinese patients with lymphoma.
METHODS

Patients
We recruited 77 unrelated Chinese patients with lymphomas (43 males and 34 females; their age ranged from 2 to 73 years) treated in the two hospitals during the period of 2007–2010. They were sporadic cases with complete clinical data and confirmative diagnosis complying with the WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues, 2008. Six cases were Hodgkin's lymphoma, including nodular lymphocyte predominant type 2 cases, mixed cellularity classical type 2 cases, and nodular sclerosis classical type 2 cases; and 71 cases were non-Hodgkin lymphoma, including diffusion large B cell lymphoma (DLBCL) 30 cases, follicular lymphoma (FL) 15 cases, anaplastic large cell lymphoma (ALCL) 10 cases, T lymphoblastic lymphoma 6 cases, NK/T lymphoma 3 cases, splenic marginal zone lymphoma (SMZL) 2 cases, mucosa-associated lymphoid lymphoma 2 cases, B lymphoblastic lymphoma 2 cases, and transformation of FL to DLBCL 1 case. Genomic DNA samples from 63 healthy medical students were used as controls. Informed consent was obtained from all participants or their guardians. The Medical Ethics Committee of Peking University First Hospital and the Institutional Review Board of General Hospital of Armed Police approved the research proposal.

Sample preparation
Peripheral blood obtained from the patients was centrifuged and separated into plasma and cell fractions. Mononuclear cells from the cell fraction were separated by Ficoll-Paque density gradient method (Pharmacia, Piscataway, NJ, USA). Genomic DNA was extracted from (2–3) ×10^6 mononuclear cells using the QIAamp Blood Kit (Qiagen, Hilden, Germany) and re-suspended in 50 μL elution buffer. DNA sample from nails or hair follicles was extracted by using the QIAamp DNA Investigator Kit (Qiagen).

PRF1 mutation analysis
The coding region of the PRF1 gene (exon 2 and exon 3) was amplified from genomic DNA using polymerase chain reaction (PCR). The primers 2F (5'-CCTTCCATGTGCCCTGATAA) and 2R (5'-GCCAGGATTGCATTTC) were used for the amplification of exon 2, the primers 3aF (5 '- CCCCTGGGTTCCAGTTCC TAGT ) and 3aR (5'-GCCCTGTCCGTCAGGTACT) were used for the amplification of 5' part of exon 3, and the primers 3bF (5'-GTGGACTACACCCCTGGAACC) and 3bR (5'-CTGGTCCTTTCCAAGCTCAC) were used for the amplification of 3' part of exon 3. PCR was performed in a 50 μL mixture containing 2 × PCR mixture 25 μL, primers 10 pmol/each, and genomic DNA 125 ng, with the thermal cycle condition of 95 °C 5 minutes for pre-denaturation, 35 cycles at 95 °C 30 seconds, 60 °C 30 seconds and 72 °C 45 seconds, followed by extension at 72 °C for 7 minutes. PCR products were sequenced from both directions using the same primers for PCR.

Evaluation of serum EBV copy number by quantitative real-time PCR and EBV infection in lymphoma by in situ hybridization
A primer set to amplify a DNA fragment in EBV genome and a fluorogenic TaqMan probe was used to measure serum EBV DNA (EBV quantification kit, Da-An, Guangzhou, China). The amount of EBV DNA was expressed as EBV copies/mL of serum. A fluorescein-conjugated RNA probe was used to detect EBER1 RNA in lymphoma sections by in situ hybridization, and the signals were examined under a microscope.

Statistical analysis
Allele frequency of a SNP = (cases of homozygote ×2 + cases of heterozygotes)/total cases ×2. Genotype and allele frequencies of a SNP in lymphoma and normal controls were assayed for Hardy-Weinberg equilibrium. The Chi-square test or Fisher's exact test was used for the comparisons of genotype and allele frequencies of a SNP between patients and controls, patients with and without PRF1 mutation, and EBV infection positive and negative patients.

RESULTS
Eleven novel mutations identified in 8 of the 77 Chinese patients with lymphoma
Table 1 summarizes the results of PRF1 mutation detection in the 77 lymphoma patients. We found 11 novel mutations in 8 lymphoma patients (Table 1), and none of them were detected in healthy controls. Three patients had one or two biallelic missense mutations (cases 2 and 7), or two monoallelic missense mutations (case 8), indicating that their perforin function was severely impaired. Three patients had one monoallelic missense mutation (cases 1, 3 and 4), suggesting that their perforin function may be partially impaired. We found 3 synonymous mutations in 3 patients (cases 5, 6 and 7), of which case 7 also had two biallelic
Table 1. Eleven novel missense and/or synonymous mutations in the \textit{PRF1} gene identified in 8 Chinese patients with lymphoma

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex/age</th>
<th>Mutation</th>
<th>Lymphoma immunohistotchemistry</th>
<th>Primary involvement site</th>
<th>Diagnosis</th>
<th>Bone marrow infiltration</th>
<th>Hemophagocytosis</th>
<th>EBER 1 in lymphoma</th>
<th>Therapy</th>
<th>Survival period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M/10</td>
<td>c.177T&gt;C, ([L6P][m])</td>
<td>CD3+, CD43+, Ki-67+, CD15-, CD20+, CD79a-</td>
<td>Neck lymph node</td>
<td>Hodgkin, mixed cellularity type</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Chemo + radio</td>
<td>4 y</td>
</tr>
<tr>
<td>2</td>
<td>M/53</td>
<td>c.374T&gt;A, ([1125N][b])</td>
<td>CD3+, CD10+, CD45 RO+, CD79a+, CD57+, CD20-</td>
<td>Spleen</td>
<td>T cell lymphoma</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Chemo</td>
<td>6 m</td>
</tr>
<tr>
<td>3</td>
<td>M/39</td>
<td>c.563C&gt;T, ([P188L][m])</td>
<td>CD30+, CD43+, ALK-, CD57-, CD20-</td>
<td>Submandibular lymph node</td>
<td>ALCL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Auto-HSCT</td>
<td>&gt;3 y</td>
</tr>
<tr>
<td>4</td>
<td>M/72</td>
<td>c.1153C&gt;T, ([R85W][m])</td>
<td>CD22+, CD19+, CD10+, CD45 RO+, CD79a-, CD57-</td>
<td>Submandibular lymph node</td>
<td>Transformation of FL to DLBCL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Chemo + radio</td>
<td>9 y</td>
</tr>
<tr>
<td>5</td>
<td>F/60</td>
<td>c.9C&gt;T, ([A3A][b])</td>
<td>CD20+, CD10+, Bel-6+, MUM-1+, CD3+, CD68-</td>
<td>Submandibular lymph node</td>
<td>DLBCL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Chemo</td>
<td>&gt;1 y</td>
</tr>
<tr>
<td>6</td>
<td>F/60</td>
<td>c.180A&gt;G, ([P60P][m])</td>
<td>CD3+, CD56+, Grz+, Ki-67+, CD20+, CD5-</td>
<td>Left eye</td>
<td>NK/T</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>Chemo + radio</td>
<td>5 m</td>
</tr>
<tr>
<td>7</td>
<td>M/59</td>
<td>c.32T&gt;C, ([L11P][b]), c.216C&gt;A, ([T72T][b]), c.491A&gt;T, ([Q164L][b])</td>
<td>CD5+, CD20+, CD79a+, CD43+, CD13+, CD20+, CD79a+, CD57+</td>
<td>Spleen</td>
<td>SMZL</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>Chemo</td>
<td>1.5 y</td>
</tr>
<tr>
<td>8</td>
<td>F/02</td>
<td>c.326G&gt;C, ([A109G][m]), c.506T&gt;C, ([F169S][m])</td>
<td>CD19+, CD10+, c.506T&gt;C, ([F169S][m])</td>
<td>Right eye</td>
<td>DLBCL</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>Chemo</td>
<td>3 m</td>
</tr>
</tbody>
</table>

[m]: monoallelic mutation; [b]: biallelic mutation; Chemo: chemotherapy; radio: radiotherapy; auto-HSCT: auto hematopoietic stem cell transplantation

No significant difference in EBV infection between lymphoma patients with \textit{PRF1} mutation and those without the mutation

We measured serum EBV copy number and detected EBER1 RNA in lymphomas by \textit{in situ} hybridization in the 8 lymphoma patients with \textit{PRF1} mutations. One of the 8 patients (case 2) was found to have positive serum EBV DNA (5×10^2 copies/mL) and positive EBER1 RNA in lymphoma sections, indicating EBV infection in lymphoma. We also measured serum EBV copy number in 25 lymphoma patients without \textit{PRF1} mutations. Three patients were found to have positive serum EBV (2.3×10^3– 2.7×10^4 copies/mL). Subsequently, the prevalence of EBV infection seems to be similar between lymphoma patients with \textit{PRF1} mutation and those without mutation.

DISCUSSION

To date, there are about 60 mutations in \textit{PRF1} documented in several clinical diseases, such as in familial hemophagocytic lymphohistiocytosis and lymphoma.\cite{13} The prevalence and characteristics of \textit{PRF1} mutation may be different in different populations.\cite{11,12} In this study, we found 11 novel mutations in 8 of 77 Chinese patients with lymphoma. We collected nails and/or hair follicles from 4 patients with \textit{PRF1} mutations. The 6 mutations (4 missense mutations and two synonymous mutation) detected in

No differences in the 4 SNPs in the \textit{PRF1} gene between lymphoma patients and healthy controls

The genotypes of SNPs rs885821 (in exon 3), rs885822 (in exon 3), rs10999427 (in intron 2), and rs10999426 (in exon 2, closely linked to rs10999427) were also identified during the mutation detection. There were no differences in genotype and allele frequencies in the 4 SNPs between lymphoma patients and controls (data not shown).

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Peripheral blood in the 4 patients were also found in their nails and/or hair follicles, suggesting the germ-line origin of the 6 mutations. Consequently, genomic mutations in the PRF1 gene may be important factors in the pathogenesis of lymphoma in some lymphoma patients. Nine of the 11 novel mutations were located in exon 2. Of the 8 missense mutations in 6 patients, 5 were located in the first low homology domain of perforin protein (cases 2, 3, 7 and 8), 2 were located in the signal peptide region (cases 1 and 7), and 1 in the EGF-like domain (case 4). Therefore, mutations in exon 2 and in the first low homology domain of PRF1 protein may be the hotspots for PRF1 mutations in Chinese lymphoma patients. We did not find mutations in the amphipathic alpha helix and the second low homology domain, which were frequently reported in lymphoma patients in western countries.\cite{9,10,13,14}

Functional perforin plays a critical role in immune surveillance of viral infected cells and abnormal transformed cells.\cite{15,16,17} Perforin mutations resulting in the decrease or absence of the protein or its activity cause the uncontrolled cellular proliferation or lymphoproliferative disorders.\cite{7,18} EBV infection is closely correlated to lymphoma in some cases.\cite{19} To evaluate whether uncontrolled EBV infection due to PRF1 mutations is correlated to the emerging of lymphoma in patients with PRF1 mutations, we assayed serum EBV DNA and EBER1 expression in lymphoma in the 8 lymphoma patients with PRF1 mutation and 25 patients without PRF1 mutation. The prevalence of EBV infection was similar in lymphoma patients with PRF1 mutation and those without the mutation, suggesting that the uncontrolled EBV infection may not be the leading cause of lymphoma in patients with PRF1 mutation. Moreover, PRF1 mutation may not be associated with the higher prevalence of EBV infection.\cite{11,20,21}

In summary, 11 novel PRF1 mutations were found in 8 of the 77 lymphoma patients. These mutations may be of germ-line origin, and may therefore be inherited from their parents. Three patients (cases 2, 7 and 8) had biallelic or compound monoallelic missense mutations, which may be the direct cause of lymphoma. Another 3 patients (cases 1, 3 and 4) carried monoallelic missense mutation. Monoallelic PRF1 mutation usually has normal phenotype, but may contribute a genetic predisposition factor to develop malignant diseases, and may become one of the pathogenesis factors in the presence of other detrimental factors or gene variations. Three patients had monoallelic (case 6) or biallelic (cases 5 and 7) synonymous mutations in PRF1 exon 1, of which the significance is yet unknown.

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**Conflicts of interest:** The authors declare that there is no conflict of interest.

**Contributors:** Ding Q proposed the study, analyzed the data and wrote the first draft. All authors contributed to the design and interpretation of the study and to further drafts.

**REFERENCES**


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