Liver transplant recipients (LTRs) are at an increased risk of developing de novo malignancies after orthotopic liver transplantation (LT; ref. 1). De novo malignancies include skin cancers, solid tumors, and lymphoproliferative disorders (2). The overall incidence of colorectal neoplasia in this population is controversial (3); however, most studies have identified an increased risk of colorectal neoplasia in this setting (2, 4, 5).

Other groups, such as patients with primary sclerosing cholangitis (PSC) and inflammatory bowel disease (IBD), are especially at increased risk for colorectal neoplasia, and screening colonoscopy is recommended before LT (3). Importantly, colorectal neoplasia in transplant recipients appears at an earlier age and is associated with a diminished 5-year survival, and the tumors have more aggressive clinical behaviors (6). In previous studies, asymptomatic LTRs were found to have a significant increase in risk of colorectal neoplasia compared with asymptomatic average risk cohorts (2, 4).

Risk factors for cancer in this cohort may include long-term exposure to alcohol, but the most important factor is the postransplantation immunosuppressive treatment regimens. Immunosuppressive medications decrease immune surveillance and enable the reactivation of potentially oncogenic viruses, such as human papillomavirus, EBV, and human herpes virus-8 (1). An oncogenic virus might also explain the earlier onset and higher risk for advanced colorectal neoplasia in LTRs.

JC virus (JCV) is a polyomavirus that infects most humans worldwide. We have previously provided evidence for the presence of JCV in the normal gastrointestinal tract and its involvement in colorectal cancer in humans (7–9). About 90% of the adult population carries antibodies to the virus, and it seems that in most people, the virus remains latent. However, in immunocompromised patients, JCV may become reactivated.
and can cause the lethal demyelinating disease, progressive multifocal leukoencephalopathy (10).

The suspicion that JCV might be oncogenic arose because studies showed that the virus causes anaplastic tumors after injection into the brain of rodents and primates (11) and the virus can be detected in high-grade human brain tumors (12). The oncogenic potential of the virus is a consequence of the potent transforming oncoprotein, T antigen (TAg). TAg is a multifunctional protein and is able to bind and inactivate the p53 and pRb, leading to dysregulation of the cell cycle, permitting replication of cells with damaged chromosomes, which is normally censored by the G1-S cell cycle checkpoint (13, 14). More importantly in the context of colorectal carcinogenesis, TAg interacts with β-catenin, which can dysregulate the WNT signaling pathway (15), and JCV can bind to p53 and β-catenin and induce chromosomal instability in the colon cancer cell line RKO (16). Finally, there is a strong association between JCV TAg expression and the methylator phenotype in colorectal cancer, suggesting that aberrant methylation in colorectal cancer may also be related to JCV infection (17). Because of the strong correlation between TAg expression and colorectal cancer, we proposed that the virus might be detectable more frequently in adenomatous polyps of patients who underwent LT and hypothesized that the use of immunosuppression leads to reactivation of the virus, resulting in accelerated adenoma development in LTRs. Our results support this conclusion.

### Materials and Methods

**Inclusion criteria and patients.** Between March 1979 and October 2000, 381 adult patients had a LT in the Department of Gastroenterology and Hepatology of the University Medical Center of Groningen (Groningen, the Netherlands). Patients surviving at least 5 y following LT were eligible for this study. In 147 of these patients, one or more colonoscopies had been done following LT. Data were collected on the age, gender, diagnosis of liver disease, diagnosis of pretransplant IBD, and the use of immunosuppressive medications after LT. The endoscopic and pathologic findings in a subset of those patients have been previously published (4). For this study, we included all neoplastic lesions found at least 3 y after LT, whether or not the patients were symptomatic.

We obtained formalin-fixed, paraffin-embedded samples of 15 normal colonic epithelial tissues and 26 adenomatous polyps from LTRs (Table 1). Samples were collected during colonoscopy done after LT. Posttransplant colonoscopy had been done at a mean interval of 3.2 y.

### Table 1. Clinical and histopathologic findings in the studied populations

<table>
<thead>
<tr>
<th>Characteristics of adenomatous polyps</th>
<th>LT (n = 41)</th>
<th>Controls (n = 61)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adenomas</td>
<td>Normal colon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 26)</td>
<td>(n = 15)</td>
<td></td>
</tr>
<tr>
<td>Male sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13 (50%)</td>
<td>6 (40%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age at colonoscopy, mean (range)</td>
<td>58 (48-71)</td>
<td>50.9 (31-66)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mean age at LT (range)</td>
<td>47 (27-61)</td>
<td>43.4 (21-63)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Reasons for transplant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSC 6</td>
<td>HCV 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PBC 10</td>
<td>PBC 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AIC 3</td>
<td>PSC 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALC 3</td>
<td>NRH 1</td>
<td></td>
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<tr>
<td></td>
<td>BCS 2</td>
<td>ALC 4</td>
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<tr>
<td></td>
<td>HCC 1</td>
<td>HBV 1</td>
<td></td>
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<tr>
<td></td>
<td>PCD 1</td>
<td>Wilson 1</td>
<td></td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubular growth</td>
<td>80.8%</td>
<td>72.5%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Villous growth</td>
<td>19.2%</td>
<td>27.5%</td>
<td>n.s.</td>
</tr>
<tr>
<td>HGD</td>
<td>19.2%</td>
<td>25%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Size (mm)</td>
<td>6 (mean)</td>
<td>9.8 (mean)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Proliferative activity, % (mean ± SE)</td>
<td>60.3 ± 3.2</td>
<td>42.7 ± 2.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Apoptotic index, % (mean ± SE)</td>
<td>0.29 ± 0.08</td>
<td>0.39 ± 0.06</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Abbreviations: PBC, primary biliary cirrhosis; AIC, autoimmune cirrhosis; ALC, alcoholic cirrhosis; HBC, hepatitis B cirrhosis; BCS, Budd-Chiari syndrome; HCC, hepatocellular carcinoma; HCV, hepatitis C cirrhosis; HGD, high-grade dysplasia; NRH, nodular regenerative hyperplasia; PCD, polycystic liver disease; n.s., not significant.
sequencing results were aligned with JCV sequences from GenBank using an ABI PRISM BigDye Terminator v1.1 Cycle Sequencing kit on an ABI PRISM 3100 Avant Genetic Analyzer (Applied Biosystems). The productswereanalyzedonanethidiumbromide–stained1%agarosegel. A region of JCV TAg, as previously described (21). Five microliters of the PCR was sectioned at a thickness of 5 μm and mounted onto positively charged slides. The sections were placed in an oven at 65 °C for 20 min and rinsing with PBS, endogenous enzymes were incubated with the hydrated tissue sections. In all cases, at least 1,000 epithelial cells were counted and morphologic apoptotic and M30-positive cells were expressed as a percentage of the total number of cells counted (apoptotic index). Apoptotic cells located in the lumen, assessed by morphologic criteria or M30 positivity, were excluded. For evaluation of MIB-1 staining, complete crypts were counted.

For M30 and MIB-1 staining, quantitative analyses were done on complete crypts from normal mucosa and adenomas. M30 positivity was identified as brown cytoplasmic staining. Morphologic characteristics, including the presence of apoptotic bodies, nuclear condensation, cytoplasmic shrinkage, and membrane blebbing, were assessed in H&E-stained tissue sections. In all cases, at least 1,000 epithelial cells were counted and morphologic apoptotic and M30-positive cells were expressed as a percentage of the total number of cells counted (apoptotic index). Apoptotic cells located in the lumen, assessed by either morphologic criteria or M30 positivity, were excluded.

Results

Clinical characteristics. Clinical features of the patients investigated in this study are summarized in Table 1. The mean age at LT was 45.6 years (SD ± 9.8; range, 21-61). Colonoscopy in the LTRs with adenomatous polyps was done later (128.2 ± 74.9 months after LT; mean ± SD) compared with the LTRs stained for 45 s with hematoxylin, dehydrated, dehydrated in xylene, and mounted. Slides were reviewed by two pathologists who were blinded to the other results.

For M30 and MIB-1 staining, quantitative analyses were done on complete crypts from normal mucosa and adenomas. M30 positivity was identified as brown cytoplasmic staining. Morphologic characteristics, including the presence of apoptotic bodies, nuclear condensation, cytoplasmic shrinkage, and membrane blebbing, were assessed in H&E-stained tissue sections. In all cases, at least 1,000 epithelial cells were counted and morphologic apoptotic and M30-positive cells were expressed as a percentage of the total number of cells counted (apoptotic index). Apoptotic cells located in the lumen, assessed by either morphologic criteria or M30 positivity, were excluded. For evaluation of MIB-1 staining, complete crypts were counted.

Statistical analysis. Mean M30 and MIB-1 counts were compared between LTRs and controls using the Mann-Whitney test. The Student’s t test, χ² test, and Fisher’s exact test were used to compare LTR adenomas with non-LTR adenomas. The confounding effect of age was further controlled using regression models that included a continuous term for age. Statistical analysis was done using Statistical Package for the Social Sciences software 11.0 (SPSS, Inc.). P values were considered significant when <0.05.

DNA extraction and detection of JCV genomic sequences. DNA was obtained from normal colonic and adenomatous polyps samples microdissected from 10-μm tissue slices. DNA isolation was done using the QiAmp DNA extraction kit (Qiagen) according to the manufacturer’s recommendations. The DNA extraction was done in a room completely isolated from any post-PCR samples to avoid contamination with PCR-amplified products. To avoid contamination with JCV genomes, we did not include any positive controls carrying JCV DNA sequences; rather, each positive sample was sequenced in both directions to verify the authenticity of the JCV TAg DNA.

All pathologic specimens of colorectal adenomas were reviewed by one pathologist for confirmation of diagnosis and assessment of the degree of dysplasia and the presence of villous architecture according to criteria established by WHO (20). An advanced adenoma was defined as an adenoma at least 1 cm in size, and/or (tubular) villous architecture, and/or high-grade dysplasia. Institutional Review Board approval was granted for this study and informed consent was given by the patients included in the study.

Immunohistochemical staining. Paraffin-embedded tissue specimens were sectioned at a thickness of 5 μm and mounted onto positively charged slides. The sections were placed in an oven at 65 °C to melt the paraffin, deparaffinized with xylene, and rehydrated through an alcohol gradient. Nonenzymatic antigen retrieval was done in 0.01 mol/L sodium citrate buffer (pH 6.0) at 102°C to 104°C for 15 min. After cooling for a period of 20 min and rinsing with PBS, endogenous enzyme blocking was done by incubating the slides in 5% normal goat serum for 1 h at room temperature. Primary antibodies against viral and cellular proteins were incubated with the hydrated tissue sections overnight at room temperature in a humidified chamber. The primary antibodies used to detect JCV proteins were a mouse monoclonal antibody against SV40 large TAg that cross-reacts with JCV TAg (clone PAb416, 1:100 dilution; Oncogene Research Products) and a mouse monoclonal antibody against JCV TAg (clone PAb2003, 1:100 dilution; kindly provided by Dr. Richard Frisque, Professor of Molecular Virology, Pennsylvania State University). Monoclonal antibodies against the caspase-cleaved portion of cytokeratin 18 (M30; Boehringer Mannheim GmbH) and Ki-67 (MIB-1; Immunotech) were used to determine apoptosis and proliferative activity at final concentrations of 1:50 and 1:400, respectively. After washing in PBS, incubation with Dako EnVision-labeled polymer (DakoCytomation, Glostrup, Denmark) was done for 1 h at room temperature. Staining was developed by a reaction with 3,3′-diaminobenzidine chromogen for 1 to 5 min and then counterstained with hematoxylin.

Clinical characteristics. Clinical features of the patients investigated in this study are summarized in Table 1. The mean age at LT was 45.6 years (SD ± 9.8; range, 21-61). Colonoscopy in the LTRs with adenomatous polyps was done later (128.2 ± 74.9 months after LT; mean ± SD) compared with the LTRs.
with normal endoscopic findings (89.5 ± 36.5 months after LT; mean ± SD). Most LTR patients had received immunosuppression consisting of cyclosporin A, prednisolone, and azathioprine (n = 28), whereas eight patients received prednisolone and tacrolimus and five patients received prednisolone plus azathioprine and tacrolimus. The adenomatous polyps in the LTR group were similar to those obtained from the control group. Interestingly, JCV TAg DNA was significantly more amplifiable in normal mucosa samples obtained from LTRs than controls. No differences in JCV TAg DNA amplification were found in adenomas among the two groups, whereas no JCV TAg expression was present in any of the normal mucosa samples. *, P = 0.0002; #, P = 0.025.

**Discussion**

In our study, we show that JCV TAg is frequently expressed in adenomatous polyps of patients who had undergone LT. Our results suggest that the expression of JCV TAg in premalignant lesions in concert with the use of immunosuppressive agents might be involved in the risk of colorectal neoplasia in LTRs.

The overall incidence of neoplasms in LTRs is reported to be higher compared with the general population (22). Moreover, several published studies describe an increased incidence of colorectal neoplasia in LTRs (3, 22). In certain high-risk patients, such as those with PSC and IBD, the incidence of colorectal cancer is substantially higher (23–26). However, our study cohort contained just two patients with PSC and ulcerative colitis. The increasing number of LTRs in both the United States and Europe, and the significant improvement in survival after transplant, have created a steadily increasing population of living LTRs who may be at increased risk for malignancies.7

The question remains whether the increased prevalence of colorectal neoplasia in LTRs is because liver transplant candidates have an intrinsically increased predisposition for developing colorectal neoplasia or whether tumorigenesis in these patients is triggered by factors associated with transplantation, such as the use of immunosuppressive medications. Studies done on renal, lung, and cardiac transplant recipients are not conclusive on the role played by immunosuppression in increasing the risk of colon cancer (27–32). However, the frequent finding of JCV DNA in nonneoplastic colonic tissue from LTRs opens the speculation that the immunosuppression facilitates reactivation of oncogenic viruses, such as JCV, accelerating adenoma formation. The finding that JCV TAg is highly expressed in adenomatous polyps from LTRs adds fuel to this discussion.

In our study, apoptotic rates were significantly lower in adenomatous polyps from LTRs compared with control adenomas. This is consistent with a recent study, which suggested that JCV infection promotes antiapoptotic mechanisms in immunosuppressed patients (33). Additionally, we found significantly increased proliferative activity in adenomas from LTRs compared with sporadic adenomas. It has been shown that JCV TAg can form a complex with ß-catenin, an integral component of the Wnt signaling pathway (15). JCV TAg could chaperone ß-catenin to the nucleus and directly stimulate the proliferative program in the colonic epithelial cell (15, 16).

In sporadic adenomatous polyps, JCV TAg expression was found in 2 of 40 adenomas in this study and in 16% in a previous series using different samples studied by different examiners (21). We have previously reported that JCV TAg DNA was detected in a substantially high proportion of normal polyps from LTRs showed positive nuclear staining for JCV TAg compared with 2 of 40 (5%) of the adenomas obtained from controls (P = 0.0002). Furthermore, all 15 TAg-positive samples harbored JCV DNA sequences. Positive staining for JCV TAg was restricted to the nuclei of the dysplastic areas in colorectal samples but was never present in the cytoplasm or adjacent nonneoplastic cells. No TAg protein expression was present in any of the normal colonic mucosa samples, whether a LTR or not.
colonic epithelium. The detection of JCV in tissues is quite sensitive to the techniques used, and in our previous study, we used fresh-frozen tissues, two rounds of (nested) PCR, and degenerate primers to increase sensitivity (9). In this study, DNA was extracted from formalin-fixed, paraffin-embedded tissues microdissected from neoplastic domains on glass slides, which would be expected to limit detection of JCV. The JCV copy number is quite low in normal colonic tissues.

Interestingly, although there was a significant difference in the prevalence of JCV DNA in the normal mucosa of LTRs compared with controls, there was no significant difference in the prevalence of JCV DNA sequences in the adenomas from either group. We believe that the best explanation for these results might be that low-level JCV infection is nearly universal among adults, and proliferating adenomatous cells with latent viral infection would make the virus easier to detect by PCR. The higher rate of finding amplifiable JCV DNA from the normal tissues of LTRs suggests that these patients may be experiencing reactivation of the virus and increased copy numbers of viral DNA in normal tissues. Another explanation for the higher rate of JCV DNA from the normal tissues of LTRs might be that low-level JCV infection is nearly universal in either group. We believe that the best explanation for these results is that active JCV infection, which might trigger or accelerate the adenoma-to-carcinoma sequence in this group of patients. Future studies will be required to determine the exact molecular and virological mechanisms of viral activation and viral-induced carcinogenesis in LTRs.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

References

JC Virus Infection in Colorectal Neoplasia That Develops after Liver Transplantation

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