EPSTEIN-BARR VIRUS DNA LOAD IN NASOPHARYNGEAL BRUSHINGS AND WHOLE BLOOD IN NASOPHARYNGEAL CARCINOMA PATIENTS BEFORE AND AFTER TREATMENT.

Marlinda Adham¹, Astrid E Greijer⁶, Sandra AWM Verkuijlen⁶, Hedy Juwana⁶, Sabine Fleig⁶, Lisnawati Rachmadi², Octavia Malik⁶, AN Kurniawan², Averdi Roezin¹, Soehartati Gondhowiardjo³, Djumhana Atmakusumah⁴, Servi JC Stevens⁶, Bambang Hermani¹, I Bing Tan⁵, Jaap M Middeldorp⁶

¹ENT Department, ²Anatomy Pathology Department, ³Radiotherapy Department, ⁴Division of Hematology-Medical Oncology, Department of Internal Medicine Medical Faculty, University of Indonesia, Dr. Cipto Mangunkusumo Hospital Jakarta, Indonesia, ⁵Antoni van Leeuwenhoek Hospital, Netherlands Cancer Institute, and ⁶Department Pathology, VU University Medical Center, Amsterdam, Netherlands

Running title: EBV DNA load in NPC patients before and after treatment

Keywords:

Nasopharyngeal Carcinoma (NPC), Epstein-Barr Virus (EBV), Nasopharyngeal brushing, Quantitative Real-Time Polymerase Chain Reaction

Corresponding author:

Prof. Dr. Jaap M. Middeldorp
Department of Pathology,
VU University Medical Center
De Boelelaan 1117,
1081 HV Amsterdam,
The Netherlands
Phone: +31-204442168
Fax: +31-204442964
Email: j.middeldorp@vumc.nl
ABSTRACT:

Purpose: Nasopharyngeal carcinoma (NPC) is consistently associated with Epstein-Barr virus (EBV) and highly prevalent in Indonesia. EBV-DNA load can be used for early diagnosis and may have prognostic value. In this study EBV-DNA load was evaluated in minimal invasive nasopharyngeal (NP) brushings and whole blood for initial diagnosis and therapy assessment against the standard of care diagnosis by biopsy with EBV-RISH and standard EBV-IgA serology.

Experimental Design: NP-brushings and blood samples were collected from 289 consecutive ENT patients suspected of NPC and 53 local healthy controls. EBV-DNA load was quantified by real-time PCR and serology by peptide-based EBV-IgA ELISA. Tissue biopsies were examined by routine histochemistry and by EBER RNA in situ hybridization.

Results: Repeated NP brushing was well tolerated by patients and revealed high viral load in the 228 NPC cases at diagnosis compared to 61 non-NPC cancer cases and healthy controls (p<0.001). The diagnostic value of EBV-DNA load in blood and EBV-IgA serology was inferior to the NP brush results. The level of EBV-DNA load in brushes of NPC patients was not related to T, N or M stage, whereas elevated EBV-DNA load in blood correlated with N and M stage. EBV DNA levels in brushings and whole blood showed a significant reduction at 2 month post-treatment (p=0.001 and p=0.005, respectively), which was not reflected in EBV-IgA serology.

Conclusions: NP brush sampling combined with EBV-DNA load analysis is a minimal invasive and well-tolerated diagnostic procedure, suited for initial diagnosis and follow-up monitoring of NPC.
TRANSLATIONAL RELEVANCE

Diagnosis and post-treatment monitoring of Epstein-Barr virus (EBV) associated nasopharyngeal carcinoma (NPC) is complicated and requires repeated painful biopsies and pathological examination. Early tumor detection and timely initiation of treatment are important for patient survival. The results from this study in 228 NPC patients reveal that simple non-invasive nasopharyngeal (NP) brushing plus EBV-DNA load as tumor marker gives excellent diagnostic and prognostic results compared to the biopsy. The NP-brush approach proved better than EBV-DNA load assessment in blood and EBV-IgA serology. The data suggests that NP-brush sampling may provide a useful instrument for direct in situ NPC tumor detection in populations with symptoms suspected of NPC and may replace repeated biopsies during follow-up. The NP-brush is not perceived as painful by patients, is suited for remote sampling in regional hospitals and allows parallel assessment of additional tumor markers. The NP-brush appears well suited for use in NPC screening in high incidence regions, like Indonesia.
INTRODUCTION.

Nasopharyngeal carcinoma (NPC) is a distinct head & neck cancer, occurring at high frequency in Southeast-Asian, North-African and Inuit populations [1]. In Indonesia, with an ethnically diverse population of 225 million people, NPC is the most common head and neck cancer with high prevalence among native populations and an overall incidence estimated at 6.2/100,000 [2]. In the Dr. Cipto Mangunkusumo Hospital, Jakarta, NPC is the 5th most frequent cancer overall after cervical carcinoma, breast cancer, colon and skin cancer with an incidence of 6.6% (cervical cancer 16.1%, breast cancer 14.5%, colorectal cancer 9.9%). NPC is the most common tumor in the head and neck, constituting 23.8% of all head and neck cancer cases [3].

Because NPC is highly radiosensitive the mainstay treatment is radiotherapy (RT), which can result in a 5-year overall survival of 90% for early stage disease I and in late stage disease (stage 3 and 4) the treatment outcome has a cure rate of less than 58% [4]. Thus, diagnosis at early stage of NPC is a clear medical need. Unfortunately more than 85% of NPC patients in Indonesia present in the clinic with advanced stage of disease and treatment outcome is poor [3].

NPC has a close association with Epstein Barr virus (EBV), a ubiquitous human herpesvirus infecting over 90% of the world population and viral gene products are expressed in all tumor cells. EBV is present in almost 100% of undifferentiated NPC cases (UCNT WHO type III), whereas its association with squamous cell carcinoma (WHO type I) and non-keratinizing carcinoma (WHO type II) is variable. In NPC endemic regions WHO type I and II tumors are also frequently associated with EBV [5], but in non-endemic regions these often result from tobacco and alcohol abuse [6]. Undifferentiated NPC represents 85% of all NPC cases in endemic regions and is
a major cause of cancer morbidity and mortality imposing a significant socio-economic burden to families and the population in general [7].

Currently, diagnosis of NPC requires a biopsy from the suspected tumor site with histopathological assessment and demonstration of EBV involvement by *in situ* hybridization for EBER1/2 RNA or immunohistochemistry for EBNA1 or LMP1 protein. The detection of EBER transcripts by *in situ* hybridization remains the standard of care for identifying latent EBV infection. A biopsy from the post-nasal space is an invasive and painful procedure that may lead to extensive bleeding and cannot be repeated easily without compromising the patient [8]. At early stage NPC often presents with minimal or nonspecific local symptoms and the nasopharynx is difficult to access for (repeated) routine examination making early diagnosis challenging. Thus the biopsy is crucial for defining NPC as cause of symptoms and subsequent medical handling. In addition, it is important to obtain biopsies of adequate depth as nasopharyngeal carcinoma may spread submucosally and are easily missed by endoscopic examination, even in patients with an obvious exophytic tumour, due to slough, necrotic tissue, and inflammatory tissue overlying the tumor. Therefore biopsy with a small endoscopic forceps may result in a high false negative rate. A representative biopsy can be difficult to obtain and requires the use of flexible and rigid endoscopes to allow good visualization of the nasopharynx. Local anesthesia, permit biopsies to be taken under direct vision and therefore anesthesia is recommended to avoid missing small or submucosal lesions yielding sensitivity of 95.1% and 95.6% respectively [9, 10]. When no obvious tumor is present a biopsy from the lateral pharyngeal recess can be performed because this is the most common site for early disease [11].
There is a clear need for more simple non-invasive diagnostic assays for early NPC detection, in particular in endemic regions, which can also be used in monitoring therapy requiring repeated sampling. Previous studies revealed nasopharyngeal (NP) brushing as a simple procedure with minor discomfort, being well tolerated and reflecting carcinoma-specific EBV involvement at the anatomical site of tumor development, thereby reducing the need for invasive biopsies [12-14]. This procedure has promise as confirmation test in serological NPC screening programs and has potential as prognostic tool for therapy assessment and follow-up monitoring. Furthermore, aberrant tumor-associated DNA methylation patterns can be analyzed in the same brush specimen [15, 16]. In addition to viral load in NP brushings, measuring the level of EBV DNA in whole blood, plasma or serum of NPC patients before and after treatment may be valuable for assessment of disease progression [17], since levels of EBV DNA in the circulation of NPC patients with recurrence were shown to be much higher than EBV DNA levels of those who remain in continuous clinical remission [18, 19]. These studies indicated that monitoring EBV DNA load may provide useful diagnostic information for NPC diagnosis and post-treatment management.

The present study evaluates the diagnostic and post-treatment value of viral DNA load measurement in minimal invasive NP brushings and in parallel in whole blood samples collected at diagnosis and 2 months after start of therapy in 228 patients with advanced NPC. The viral load was compared to standardized peptide-based EBV-IgA serology and clinical treatment response.
MATERIAL AND METHODS

Patients and controls.

Two hundred and eighty nine consecutive patients presenting to the ENT clinic of Dr. Cipto Mangunkusumo Hospital, Universitas Indonesia in Jakarta with suspected NPC during 2006-2009 were enrolled into this study. About 20% of the patients were referred by regional health centers where initial diagnosis was performed. Medical ethical approval for this study was obtained and all patients and controls signed for informed consent. TNM staging was done for all patients using the 2002 American Joint Committee on Cancer (AJCC)/International Union Against Cancer (UICC) staging system. Assessment for diagnosis included: medical history, particularly on NPC related symptoms, physical examination for enlarged neck node and examination of the suspected nasopharyngeal (NP) lesion by fiber-optic nasopharyngoscopy with photography and CT scans. In all patients a nasopharyngoscopy guided NP brushing was performed first, followed by biopsy from the same area of the suspected NPC. Endoscopic findings were classified as normal (no tumor), suspicious tumor, or clearly abnormal. Of the 289 patients at intake, 228 had biopsy proven NPC and 61 were proven to have a variety of malignant and non-malignant head and neck diseases and served as clinical controls in this study, as specified in Table 1. Unfortunately due to problems inherent to the Indonesian health care system (lack of medical facilities, low social economic status, insufficient insurance coverage and the often remote area’s where patients are living) detailed follow-up proved difficult. A total of 202 brushings, 149 whole blood and 174 serum samples at diagnosis and from follow-up 69 brushings, 65 whole blood and 68 serum samples were available for analysis (Table 2). Clinical characteristics and NPC stage information is given in Table 3. Diagnosis was based on routine pathological
assessment of paraffin-embedded tumor biopsy specimens and WHO typing of NPC was assessed by 2 independent pathologist. The presence of EBV was confirmed by EBER-RISH using the commercial PNA-based hybridization kit (Dakocytomation, Glostrup, Denmark) in 116 of 228 patients from whom an adequate biopsy specimen was available.

**Treatment**

In NPC cases radiotherapy was uniformly administered to the primary tumor and neck region. The total dose delivered was 66 to 70 Gy during 6 to 8 weeks by conventional fractionation or hyperfractionation accelerated radiotherapy. Neoadjuvant/adjuvant chemotherapy consisted of 5-FU (1000 mg/m² day 1-5) and cisplatin (100 mg/m² day 1) in 3 cycles every 3 weeks. Concurrent chemotherapy was delivered with cisplatin at 40 mg/m² weekly during radiotherapy courses. Due to under-capacity of radiotherapy and the poor financial situation of most patients optimal treatment, i.e. full chemoradiation, was not always feasible and different treatment protocols had to be implemented.

**Sampling procedures.**

NP brushing was performed under rigid or flexible endoscopic guidance by experienced ENT specialists and ENT resident trainees. Endoscope-guided NP brushings were performed under local anesthesia (1% Lidocaine spray, Astra Zeneca, Waltham, USA). An endoscope was used to evaluate the entire nasopharynx and photographs were taken routinely from the site of tumor involvement. Localization and appearance of the tumor was defined and graded into 3 groups (none, suspicious and clear abnormal). A Cytobrush Plus (Medscand, Malmo, Sweden) was employed in combination with a plastic catheter covering the entire brush to prevent contamination by cells from non-NP sites. The catheter
covering the cytobrush was inserted via the nose until the NP cavity was reached. Subsequently, the brush was released from the catheter and the cytobrush was rotated several times over the NP epithelium at the site of the suspected lesion, returned into the catheter and removed. Immediately after sampling the brush tip (1.5 cm) was cut and placed in 4 ml of NucliSens Lysis buffer (LB) (BioMerieux, Marcy l'Etoile, France) mixed well and stored in 1 ml aliquots at -80°C until use [14, 20]. In all NPC suspected patients NP brushings were obtained from the site of suspected tumor involvement before taking the biopsy at the same site. In 20 patients both sides of the NP wall were brushed at diagnosis or during follow-up under endoscopic guidance (twenty-five 2-sided samples were collected). To compare the level of discomfort between the brushing procedure and the biopsy, 57 patients at random answered a questioner-form based on visual analog scale 1-10. Furthermore we performed standard nasopharyngoscopy and brushings with informed consent in 53 healthy regional controls. At the same time 5 ml whole blood was taken of which 4.5 ml was used to make serum for serology and 0.5 ml was added to 4.5 ml LB for measuring EBV-DNA load, exactly as described before [21,22]. Frozen samples were shipped on dry-ice and analyzed blindly to the NPC status for EBV-DNA load at the department of Pathology, VU University Medical Centre, Amsterdam, the Netherlands.

**Quantification of EBV DNA load and cellular DNA by LightCycler-based real-time PCR assays.**

DNA was isolated from 1 ml NP brush samples in LB by silica-based nucleic acid extraction and eluted in 100 μl H₂O, exactly as described before [14,22]. Reagents for the isolation procedure were obtained from BioMerieux. EBV real-time PCR
described for NP-brush samples in this study was based on amplification of well-conserved 213-bp region of the BKRF1 gene encoding Epstein-Barr nuclear antigen-1 (EBNA-1), a single-copy gene of EBV and blood samples were analyzed by PCR using a 99-bp region from the same EBNA1 region in order to reliably detect fragmented EBV-DNA, as described before [21, 22]. Most brush samples were analyzed by both PCR assays, yielding no significant different result (Supplementary figure 1). Primers, probes and PCR conditions have been described in detail previously [14,22]. Cut-off value (COV) for EBV DNA load in NP brushings was defined at 2300 copies/brush, being the mean + 3xSD of brush EBV-DNA load in non-NPC case-controls as previously defined [14] and confirmed in the current group of healthy Jakarta EBV carriers, excluding 4 individuals with elevated EBV-DNA load also having aberrant EBV-serology, possibly relating to stress-induced EBV reactivation. The COV for EBV-DNA in blood was defined at 2000 copies/ml, based on prior studies [21, 22] These COVs were validated and confirmed in the healthy control group in this study used to determine sensitivity and specificity, positive and negative predictive values.

The amount of human diploid genome equivalent in NP brushing specimens was determined by quantitative LC-PCR targeting a 197 bp fragment of the human β-globin gene [23].

**EBV serology.**

Serum samples from NPC patients, control patients and healthy controls (Table 2) were analyzed for IgA antibodies to EBV-specific immunodominant epitopes of VCA-p18 and EBNA1 using individual synthetic peptide-based ELISA assays for each marker exactly as described previously [24].
Statistics:

One-way ANOVA was used for comparison of EBV-DNA load and EBV IgA antibody levels between NPC and non-NPC groups. In addition, one-way ANOVA was used for comparing EBV DNA load and antibody levels to TNM stage of NPC at intake. A p-value of <0.05 was considered to be significant.

Mann Whitney test: p<0.001 used for subjective evaluation for visual analog scale (VAS) between brushing and biopsy procedures to examine the median difference between two group (procedures) and for analysing the level of comfort of the performing a NP brush or biopsy.

The evaluation of viral DNA load of bilateral side nasopharyngeal brushing was performed by a Mann Whitney test. Testing the Viral DNA load decreases in NP brush and whole blood at diagnosis and after treatment of the paired samples was performed by a Wilcoxon test.
RESULTS

Patient characteristics

For this study 289 consecutive patients with suspected NPC were enrolled. In 228 cases NPC diagnosis was confirmed by pathological examination of the biopsy using routine histochemistry. Patient characteristics are summarized in Table 3. The non-NPC group consisted of patients diagnosed with EBV related malignancy, EBV negative non-NPC head and neck cancer, non-malignant ENT disorders and 53 healthy individuals (Table 1).

In the NPC group male-female ratio was 3:1 and 85% were classified as WHO type 3. Although the age of the majority of NPC patients (54%) was above 40 years, 11% was of juvenile (5-20 years) age. At presentation 99% of patients had advanced stage of disease, with 85 patients (37%) in stage IVB (AJCC-UICC staging system) and 18 patients (8%) had distant metastasis. The treatment of choice for these patients is a combination of chemotherapy and radiotherapy (Table 1). The patients with distant metastasis were treated with palliative chemotherapy For this study, 208 NP-brushes, 149 whole blood and 174 serology samples could be evaluated at diagnosis. Post-treatment NP brush samples of 69 patients were analyzed as well as 65 parallel whole blood (WB) and 68 serology samples.

Viral DNA load in nasopharyngeal (NP) brushings at diagnosis

An accurate well-validated real-time PCR procedure for EBV-DNA quantification, detecting a conserved region of the single copy EBNA1 (BKRF1) gene, was used for analyzing the EBV-DNA load in NP brushings taken at diagnosis. Clinical cut-off value (COV) for viral DNA load in NP brushings was previously defined at 2300 EBV DNA copies/NP brushing in healthy EBV seropositive individuals and non-NPC
patients with various head and neck complaints [14] and was here confirmed in the healthy controls in the Jakarta population (Figure 1A). This COV was used to determine sensitivity, specificity, positive and negative predictive values of 94%, 90%, 84% and 80% respectively, as indicated in Table 4.

Figure 1A shows that NP brushings from NPC patients showed significant higher levels of viral load compared to controls (median NPC 1.0x10^6, range 0-1.9x10^8 versus median 4.0x10^3, range 0-1.2x10^5, p<0.0001).

EBV-DNA was detected above COV in 95% of NPC cases, confirming NPC tumor cell presence. The higher EBV DNA values in NP brushings in the ‘other’ tumor group compared to the EBV related tumors may be explained by the location of the tumor in the ENT region which might associate with reactivating EBV. The non-NPC EBV associated tumors are not located in the ENT region. Frequently extreme EBV-DNA levels were reached in NPC cases, up to 100 million copies of EBV-DNA per brush. Ten cases (5%) had an EBV-DNA level below COV. Viral DNA load at diagnosis was not related to age or sex of NPC patients (data not shown).

Erroneous sampling was excluded by quantifying the cellular beta-globin DNA which showed similar host genomic levels (3-10 million copies/brush), indicating that brush sampling itself was done appropriately [14]. However, absence of EBV load may be caused by sampling outside the tumor field. Brush viral DNA load in NPC cases was higher than in patients with non-NPC head and neck cancers (p=0.059), other EBV related malignancies (p=0.001) and non-malignant ENT complaints (p<0.001). However, EBV-DNA load in NP-brushings of these patients with mainly advanced stage NPC did not correlate with T- N- or M- substage of the tumor at diagnosis, as shown in Figure 2A, C and E (p-values of 0.60, 0.071 and 0.092, respectively, as determined by one-way ANOVA). Some control individuals having no detectable NPC
tumor mass did show elevated EBV-DNA levels. In these cases EBV IgA serology was also elevated indicating EBV reactivation (data not shown), as recently found in defined NPC risk groups in Indonesia [25].

**Viral DNA load in whole blood at diagnosis**

The whole blood EBV-DNA load of NPC patients at diagnosis was significantly higher than the clinical COV of 2000 copies/ml whole blood [21] compared to the control groups and even compared to that in other EBV related malignancies (Figure 1B). However and importantly, a high number of NPC cases had low (<COV) or undetectable EBV-DNA levels in blood which was even observed in some patients with bulky disease (stage IVA and IVB), confirming our previous independent findings [21]. No correlation was found between EBV-DNA load in whole blood and T-stage of the tumor at presentation as shown in Figure 2B (p=0.25). However, considering the positive samples only, a correlation was found between whole blood EBV-DNA load and N and M stage, (p<0.001 and p=0.010, respectively, Figure 2D and F).

**Serology IgA VCA-p18 and IgA-EBNA1**

IgA VCA-p18 serology, reflecting viral replication at the mucosal surface, showed higher values in sera from NPC patients at primary intake (median 2.3, range 0.29-30), compared to healthy controls (p=0.001). Sera form 79.8% of the patients with NPC had IgA VCA-p18 values above the COV level. The sera obtained from all other patient groups including the EBV related malignancies and non-NPC head & neck cancer had lower antibody levels against VCA-p18 compared to NPC patients and did not reveal further statistically significant differences between the groups. (Figure 1C)
IgA EBNA1 serology, reflecting latent (tumor) antigen expression, revealed significant higher values in NPC cases compared to other groups resulting in 85.6% of the patients having IgA EBNA1 responses above the COV. NPC patients have higher median value (median 3.0, range 0.3-29) compared to EBV related malignancy (median 1.1, range 0.53-5.5), other malignant conditions (3.05, range 0.3-29), healthy controls, (median 1.1, range 0.5-4.1), and other ENT disorders (median 1.1, range 0.5-10), (p<0.05) (Figure 1D). No correlation was found between VCA-IgA or EBNA1-IgA antibody levels in ELISA and TNM staging of the NPC tumor at intake (data not shown).

**Diagnosis by biopsy versus brushing**

Biopsy was performed as standard of care diagnosis in all 228 NPC patients. We obtained information on the level of discomfort experienced during brushing and biopsy procedures in 57 patients, which were quantified by Visual Analogue Scale (VAS). The brush procedure was characterized by a median VAS score of 5 (range 3-6), which is significantly less compared to the biopsy with a median VAS of 9 (range 4-10; Kolmogorov Smirnov: p<0.001). Only 1 patient stated the biopsy was less painful than brushing.

In 11 patients repeated biopsies were required to obtain the diagnosis. One patient needed even three subsequent biopsies to obtain diagnostic evidence explaining the mass observed by CT Scan. In all 11 cases the viral DNA load in the initial brush was above COV allowing direct diagnosis.

In a selected group of 25 patients giving separate informed consent, we collected NP-brushings from both sides of the nasopharyngeal cavity, i.e. at and opposite to the suspected tumor site (defined by location of neck node in most cases). EBV DNA
load values in parallel brushings were higher at the tumor site (72% >COV; median 16.700 c/brush; mean 188.782 c/brush; range 414 - 4.7x10^6 copies/brush) compared to the opposite site (48% >COV; median 2.400 c/brush, mean 43.258 copies/brush; range 0 - 1.1x10^6 copies/brush) (Figure 3). These differences were not statistically different (p=0.13). However, in NPC cases both the median and mean EBV DNA level in brushings taken from the non-lesional side of the nasopharynx were still significantly higher that the EBV DNA load observed in non-NPC tumors and ENT-hyperplasia (p<0.001)

**Comparison of viral DNA load at diagnosis and two months post treatment.**

In 69 patients the effect of the therapy on the viral load was analyzed by comparing the viral DNA load in NP brush and whole blood at diagnosis and 2 months post-treatment. The median EBV-DNA load in NP-brushing at diagnosis was 9x10^5 copies/NP brush and decreased after two months post-treatment to a median of 3x10^3 copies/NP brush indicating a 300-fold reduction (Figure 4). Initially 96% of patients had a viral load > COV level in the NP brush, but after treatment this dramatically reduced to 39.4%. Similarly, the level of EBV-DNA in whole blood was significantly lower post-treatment with a reduction of 27-fold (p<0.001 for both), and the percentage of patients with a viral load >COV in the circulation dropped from 51% to 8.8%. Although the fold reduction in viral DNA load in both NP brush and blood samples reflected the treatment response, irrespective of the regimen used (see below), the level of EBV DNA at diagnosis did not have any predictive value for treatment outcome.

Patients treated with neoadjuvant plus hyperfractionated radiotherapy had a median value of 8.9x10^6 copies/brush at diagnosis which decreased after therapy to 1.7x10^5
copies/brush (p=0.006). Patients treated with concurrent chemoradiation had a median DNA viral load in brushings of 1.9x10^7 copies/brush at diagnosis decreasing to 5.8x10^4 copies/brush after therapy (p=0.049). Only one patient with neoadjuvant and radiotherapy had increased DNA viral load brush post-treatment (9.5x10^5 copies/brush) and one patient had increased viral load in whole blood at 2 months post-treatment, both linked to progressive disease.

Based on response to treatment 41 patients had a complete response at 2 months post-treatment as judged by clinical examination plus a negative CT-scan and negative biopsy. These patients had a post-treatment median viral DNA load in the NP brushing of 3.0 x10^3 copies/brush, a significant difference compared to the pre-treatment value of 1.7 x10^6 copies/brush in this group (p=0.013) (Figure 5). In 22 patients with partial response the median EBV-DNA load in NP brush pre-treatment was 1.3x10^6 and post treatment 3.2 x10^3 copies/brush (p = 0.14). For whole blood samples most cases with an initial positive DNA load, the EBV DNA load became undetectable after 2 months after start treatment for both complete and partial responses. Two of three patients with progressive disease post-treatment showed a median of EBV-DNA load in brush being below COV, whereas the post-treatment median level in blood was above COV in all 3. Two patients died within 2 months post-treatment and their DNA viral load brush was above COV, whereas the viral load in the whole blood was negative. No significant difference was observed for EBV-IgA serology levels at diagnosis compared to two month post-treatment, neither for VCA-p18 nor for EBNA1 antibody levels individually, nor for different treatment regimens (data not shown).
DISCUSSION

Pathological examination for diagnosis of NPC requires an invasive biopsy that is painful and cannot be repeated easily. A less invasive diagnostic procedure by using NP-brush sampling would be preferred, also for assessment of post-treatment tumor activity. This NP-brush procedure may also be combined with detection of aberrant EBV-IgA serology in screening approaches of patients at (family) risk or having symptoms suggestive of early-stage NPC [25]. In this study we evaluated minimal-invasive NP-brushing with quantification of EBV-DNA load for primary NPC diagnosis and assessment of treatment response relative to the standard biopsy taken in parallel [14]. We also measured EBV-DNA load in whole blood and VCA-p18 and EBNA1 specific EBV-IgA serology in simultaneous venous blood samples [21]. We demonstrated that measuring EBV DNA load in NP brushings provides a highly specific tool for primary NPC diagnosis with minimal patient discomfort, giving better sensitivity/specificity compared to EBV-IgA serology and EBV-DNA load in blood, as detailed in Table 4. Because most patients in this study presented with advanced stage NPC, the utility of NP brushing for detecting early stage NPC remains to be defined. In ongoing studies in patients with persistent head and neck complaints, non-responsive to antibiotic or anti-allergy therapy, we are currently validating this method for identification of early stage NPC. The diagnostic utility of NP brush may be further increased by assessing a combination of molecular carcinoma markers in the same brush material, including tumor-specific EBV-RNA transcripts [14], host genomic methylation patterns [15, 16] and other genetic abnormalities linked to NPC.

Although detection of NPC at early stage is important for the patient outcome, diagnosis is often difficult because of the non-specific nature of the clinical symptoms and difficulty in visualizing the nasopharynx [4]. Only 12.2% of our patients presented
with early T1-IIa stage, whereas 24.6% presented with TIIb with tumor already invading into the parapharyngeal area giving worse prognosis compared with localized disease limited to the nasopharynx. The majority (89%) of patients, however, already had parallel enlargement of the regional lymph node indicative of advanced (late) stage (Table 1), which is typical for most endemic regions [3]. This situation reflects the need for novel diagnostic procedures for regular testing of NPC risk populations, such as family members of NPC patients and patients with chronic head and neck complaints suggestive for early stage NPC [25, 26].

NP brushings from NPC patients frequently contain extremely high levels of EBV-DNA compared to other clinical conditions, including EBV-related non-NPC head & neck cancers (Figure 1), confirming previous studies [28, 29]. Over 95% of our NPC patients had a brush containing viral loads above COV. A negative result (5%) of DNA EBV viral load brush might be caused by absence of cancer cells or obscured by blood, by tumor detritus or due to improper sampling. Both primary and recurrent cancers may be located deep under the overlying mucosa and early lesions not invading the nasopharyngeal surface can be difficult to detect when biopsy or brushing is done too superficially [30]. Contrary, NPC tumor-derived EBV-DNA from submucosal locations may reach the surface (shedding) leading to detectable aberrant levels in the brush. Our data indicate that NP brushing combined with quantitative real-time PCR directly reflects carcinoma-specific EBV involvement at the anatomical site of tumor development. The NP brush may greatly reduce the number of invasive NP biopsies required when applied for diagnosis and follow-up monitoring. Since bilateral brushing might be necessary for EBV tumor detection Tune et al. originally recommend bilateral brushing as a routine to avoid missing small, localized tumors [13]. We performed brush and biopsy sampling under
endoscopic guidance for all patients, which may be a preferred procedure for accuracy of sampling. Our data on bilateral brushing (Figure 3) indicate that random brushing of the nasopharyngeal cavity may be adequate, supporting the general applicability of the brush technique for NPC diagnosis, without the need for endoscope guidance. Blind brushing may be done in the NP area on the side of the neck node at the lateral pharyngeal recess, because this is the most common site for early disease. However this needs to be further evaluated.

The level of discomfort and pain was analyzed between brushing and biopsy procedure in 57 suspected NPC patients. The NP brushing procedure was well tolerated and none of the patients or controls complained of negative effects like pain or bleeding etc. In contrast, the biopsy procedure frequently associated with excessive bleeding and pain. In 11 patients repeated biopsies were needed to pathologically verify the presence of tumor cells, whereas EBV-DNA load in the parallel brush was above COV at the first sample with 2 patients having very high viral loads. Overall, NP brushing proved to be a specific and minimal invasive diagnostic tool for NPC diagnosis. However the possibility remains that a deeply located tumor is missed by the NP bushing procedure, while a deep biopsy may be able to yield sufficient number of tumor cells for making a diagnosis [30]. This can only be confirmed in more extensive studies.

The sensitivity, specificity, PPV and NPV for detecting EBV-DNA load above the pre-determined clinical cut-off level in whole blood (WB), being 71%, 50%, 86% and 20%, respectively (Table 2), were low compared to the NP brush values. This confirms a previous independent study showing that many patients have only minimal (50%) or even negative (25%) EBV DNA levels in blood [21]. Circulating EBV-DNA does not reflect intact circulating tumor cells, because EBV-RNA transcripts from
either BART, LMP2 or BARF1 reading frames were not detectable in the whole blood samples. EBV-DNA in blood reflects apoptotic release of DNA fragments with an average size of 150 bp or less, which are rapidly cleared from the circulation [18, 28, 29]. High EBV-DNA blood levels therefore may reflect on going tumor apoptosis and necrosis rather than a growing tumor mass [21]. Our quantitative data on circulating EBV-DNA load differ from the initial studies by Lo et al. in Hong Kong [17, 18], as detailed elsewhere [22]. Pre-treatment level of circulating EBV-DNA is considered to be a prognostic factor for NPC [19, 28, 29, 31]. Others showed that circulating EBV-DNA levels may correlate with stage of disease [18], which was not observed in this study. However, percentage of NPC patients with elevated EBV-DNA levels in blood or plasma differ between studies and procedures are not well standardized. In this study elevated EBV DNA load in blood above the clinical COV of 2000 copies/ml was detected in only 50% of the NPC patients. Some patients with extensive clinical disease (Stage IVB) completely lacked circulating EBV DNA, despite having high EBV-DNA levels in the NP-brush collected at the same time. These observations confirm prior findings that EBV-DNA load in blood may not provide strong diagnostic information [21]. Tong et al found that T1 tumors had a significantly lower EBV DNA level as compared to cases with locally more advanced disease [32]. In this study only a tendency of increasing DNA viral load between early and advanced tumor stage was observed (Figure 2). In addition, we found no correlation between the level of EBV-DNA in blood or NP brushing at diagnosis and the clinical response at 2 months post-treatment. Therefore the initial EBV-DNA load values may not be taken as a prognostic marker.

At two months after treatment the level of EBV-DNA load in brush and whole blood showed a significant decrease in most cases, being clinically relevant and
reflecting reduced tumor activity. For viral DNA load in NP brushings there is a substantial reduction (43-fold), similar to whole blood (27-fold reduction). We did not find any correlation between type of treatment, treatment response and the fold reduction of viral DNA load. Two patients died before treatment was finished both having an initial high EBV-DNA load in whole blood and distant metastasis pointing to an initial poor prognosis. Post-treatment EBV-DNA levels have proven to be a strong predictor for relapse and survival in larger studies [17, 19, 31, 33-35]. The time point of 2 months follow-up chosen for this study may be too short to permit complete disappearance of treatment induced tumor-related EBV activity in complete responders. More long-term follow-up is needed to define the clinical relevance of persisting EBV-DNA levels in NP brush samples.

In summary, this study demonstrates that EBV-DNA quantification in NP brushings is a promising approach for NPC diagnosis and post-treatment monitoring and may reduce the number of invasive NP biopsies required. Although pathological examination for definite NPC diagnosis remains needed, molecular testing of NP brush material provides a promising and minimally invasive alternative requiring further validation. NP brush sampling is suitable for follow-up monitoring to measure EBV-DNA load dynamics during and after treatment aiming at detection of progressive or recurrent disease without significant discomfort for the patient.
Acknowledgments

The authors thank Dr. Alida Harahap from Eijkmann Institute, Jakarta for helpful discussions, Nur Ita and Denny Feriandika from Eijkmann Institute and Antonina Zahra from Radiotherapy research laboratory, RSCM, Jakarta for storage of samples and initial processing of samples and PCR. This study was supported by grant KWF-IN2006-21 from the Dutch Cancer Society.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed. JMM holds proprietary rights to the EBV peptides used in this study.

REFERENCES:


Legends to the figures.

Figure 1. EBV parameters at diagnosis.
A: Viral DNA load in NP brushings (log scale). The EBV-DNA levels observed were significantly different between NPC and healthy controls EBV-related malignancies (p<0.001), and other ENT disorders (p<0.001), whereas a near significant difference was found between NPC and non-NPC head & neck cancer (p=0.059). B: viral DNA load in whole blood (ilog scale). The mean EBV DNA load in blood was not significantly different between NPC and healthy controls (p=0.601), EBV-related malignancies (p=0.109), and other ENT disorders (p=0.401), whereas NPC and non-NPC head and neck cancer did show a significance difference (p<0.001). C: IgA VCA-p18 serology. EBV-specific VCA-p18 IgA serology was significantly higher in NPC versus healthy controls (p=0.011), but not between NPC and EBV-related malignancy (p=0.21), non-NPC head and neck cancer (p=0.75), and other ENT disorders (p=0.57). D: EBNA1-IgA serology. EBNA1-IgA serology was significantly higher in NPC versus healthy controls (p<0.001), and EBV-related malignancies (p=0.018), and was close to significance for NPC versus non-NPC head and neck cancer (p=0.20), and other ENT disorders (p=0.054). The dotted line in each graph represents the cut-off value for each assay, as defined in the methods section.

Figure 2. EBV markers in relation to tumor characteristics at intake
A: Correlation of EBV-DNA load in brush with T stage (DNA copies in log scale), showing no relation using Anova (p=0.597). B: Correlation of EBV-DNA load in whole blood (WB) with T stage (p=0.248), C: Correlation of EBV-DNA load in brush with N
D: Correlation of EBV-DNA load in WB with N stage (p<0.001), E: Correlation of EBV-DNA load in brush with M stage (p=0.092), F: Correlation of EBV-DNA load in WB with M stage (p=0.010).

**Figure 3. Viral DNA load of bilateral side nasopharyngeal brushing.** Bilateral brushing (n=20) was performed at the site of suspected tumor location and the non-tumor site. The mean viral DNA load was 3.4x10^5 vs 7.1x10^4 copies per brush, respectively (p=0.13), which indicates that single brushing at the site of enlarged neck node may be more representative for detecting NPC presence.

**Figure 4. Viral DNA load in NP brush and whole blood at diagnosis and after treatment.** A: EBV-DNA load in NP-brushings (copies/brush). B: EBV-DNA load in whole blood. There was a significant decrease in EBV-DNA load in both NP-brushings and whole blood at diagnosis compared to 2 months post-treatment for samples paired before and after treatment (p<0.001).

**Figure 5. Viral DNA load of NPC patient samples before and 2 months post treatment in relation with treatment response.** NPC patients treated with concurrent therapy are given in black and patients receiving neo-adjuvant therapy are presented in gray. Presented is EBV DNA load in A: in brushes of NPC patients with complete response, B: in brushes of NPC patients with partial response, C: in whole blood of NPC patients with complete response, D: in whole blood of NPC patients with partial response. Complete response is defined as complete disappearance of locoregional disease by physical examination or X-Ray and CT Scan and endoscopic examination and a negative biopsy at 2 months post treatment; partial response is defined by reduction of disease by 30% or more based on clinical
examination or X-Ray and CT-Scan. If the disease shows a slight increase in size or extends after treatment it is defined as progressive disease.
### Table 1: Numbers of patients and controls used for validation of viral load by NP brush.

<table>
<thead>
<tr>
<th>Patient description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NPC</td>
<td>228</td>
</tr>
<tr>
<td>EBV related malignancy</td>
<td></td>
</tr>
<tr>
<td>non-Hodgkin lymphoma</td>
<td>8</td>
</tr>
<tr>
<td>T/NK cell lymphoma</td>
<td>10</td>
</tr>
<tr>
<td>Burkitt's lymphoma</td>
<td>1</td>
</tr>
<tr>
<td>Non NPC head and neck carcinoma</td>
<td>25</td>
</tr>
<tr>
<td>Other ENT disorder</td>
<td>17</td>
</tr>
<tr>
<td>Healthy control</td>
<td>53</td>
</tr>
</tbody>
</table>

### Table 2: Numbers of samples of NPC patients at diagnosis and 2 month follow-up

<table>
<thead>
<tr>
<th>Patients with NPC</th>
<th>NP brushing</th>
<th>whole blood</th>
<th>serology</th>
</tr>
</thead>
<tbody>
<tr>
<td>At diagnosis</td>
<td>208</td>
<td>149</td>
<td>174</td>
</tr>
<tr>
<td>After 2 months follow-up</td>
<td>69</td>
<td>65</td>
<td>68</td>
</tr>
</tbody>
</table>
Table 3. Characteristics of NPC Patients (n= 228)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>164</td>
<td>71,9</td>
</tr>
<tr>
<td>Female</td>
<td>64</td>
<td>28,1</td>
</tr>
<tr>
<td><strong>Histopathology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO 1</td>
<td>28</td>
<td>12,3</td>
</tr>
<tr>
<td>WHO 2</td>
<td>5</td>
<td>2,2</td>
</tr>
<tr>
<td>WHO 3</td>
<td>195</td>
<td>85,5</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>5</td>
<td>2,2</td>
</tr>
<tr>
<td>10-20</td>
<td>19</td>
<td>8,3</td>
</tr>
<tr>
<td>21-40</td>
<td>81</td>
<td>35,5</td>
</tr>
<tr>
<td>&gt;=41</td>
<td>123</td>
<td>53,9</td>
</tr>
<tr>
<td><strong>T Stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>18</td>
<td>6,4</td>
</tr>
<tr>
<td>T2a</td>
<td>16</td>
<td>5,7</td>
</tr>
<tr>
<td>T2b</td>
<td>69</td>
<td>24,6</td>
</tr>
<tr>
<td>T3</td>
<td>53</td>
<td>18,9</td>
</tr>
<tr>
<td>T4</td>
<td>72</td>
<td>25,6</td>
</tr>
<tr>
<td><strong>N stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>N1</td>
<td>61</td>
<td>26,8</td>
</tr>
<tr>
<td>N2</td>
<td>48</td>
<td>21,1</td>
</tr>
<tr>
<td>N3a</td>
<td>77</td>
<td>33,8</td>
</tr>
<tr>
<td>N3b</td>
<td>17</td>
<td>7,5</td>
</tr>
<tr>
<td><strong>N Stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>N+</td>
<td>203</td>
<td>89</td>
</tr>
<tr>
<td><strong>M Stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M0</td>
<td>210</td>
<td>74,7</td>
</tr>
<tr>
<td>M+</td>
<td>18</td>
<td>6,4</td>
</tr>
<tr>
<td><strong>Stage AJCC-UICC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I</td>
<td>2</td>
<td>0,9</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>1</td>
<td>0,4</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>Stage III</td>
<td>55</td>
<td>24,1</td>
</tr>
<tr>
<td>Stage IVA</td>
<td>42</td>
<td>18,4</td>
</tr>
<tr>
<td>Stage IVB</td>
<td>85</td>
<td>37,3</td>
</tr>
<tr>
<td>Stage IVC</td>
<td>18</td>
<td>7,9</td>
</tr>
<tr>
<td><strong>Stage summary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>3</td>
<td>1,3</td>
</tr>
<tr>
<td>Advance</td>
<td>225</td>
<td>98,7</td>
</tr>
<tr>
<td><strong>Type treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neoajuven+ RT</td>
<td>81</td>
<td>35,5</td>
</tr>
<tr>
<td>Neoajuven+ HPF</td>
<td>40</td>
<td>17,5</td>
</tr>
<tr>
<td>Neoajuven + CRT</td>
<td>9</td>
<td>3,9</td>
</tr>
<tr>
<td>Concurrent CRT</td>
<td>87</td>
<td>38,2</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>1</td>
<td>0,4</td>
</tr>
<tr>
<td>Chemotherapy full dose</td>
<td>9</td>
<td>3,9</td>
</tr>
<tr>
<td>No treatment</td>
<td>1</td>
<td>0,4</td>
</tr>
<tr>
<td><strong>Clinical Response treatment at 2 months post treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete response</td>
<td>52</td>
<td>22,8</td>
</tr>
<tr>
<td>Partial responses</td>
<td>30</td>
<td>13,2</td>
</tr>
<tr>
<td>Progressive disease</td>
<td>2</td>
<td>0,9</td>
</tr>
<tr>
<td>Death</td>
<td>7</td>
<td>3,1</td>
</tr>
<tr>
<td>Loss to FU</td>
<td>137</td>
<td>0,9</td>
</tr>
</tbody>
</table>

RT: Radiotherapy, HPF: Hyperfractination, CRT: Chemoradiation, FU: Follow up.
Table 4: Sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of EBV markers.

<table>
<thead>
<tr>
<th></th>
<th>Brush</th>
<th>Whole Blood</th>
<th>IgA VCA P18</th>
<th>IgA EBNA 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>94.3</td>
<td>71.1</td>
<td>65.4</td>
<td>74.3</td>
</tr>
<tr>
<td>Specificity</td>
<td>90.0</td>
<td>50.0</td>
<td>60.0</td>
<td>72.0</td>
</tr>
<tr>
<td>PPV</td>
<td>84.4</td>
<td>85.7</td>
<td>84.7</td>
<td>89.8</td>
</tr>
<tr>
<td>NPV</td>
<td>80.0</td>
<td>20.0</td>
<td>33.3</td>
<td>44.6</td>
</tr>
</tbody>
</table>
Figure 2

A. Log DNA load/brush vs. T stage
   - T1: n = 17
   - T2: 82
   - T3: 46
   - T4: 63
   p = 0.597

B. Log DNA load/ml blood vs. T stage
   - T1: n = 11
   - T2: 59
   - T3: 36
   - T4: 43
   p = 0.248

C. Log DNA load/ml blood vs. N stage
   - N0: n = 25
   - N1: 55
   - N2: 42
   - N3: 86
   p = 0.056

D. Log DNA load/ml blood vs. N stage
   - N0: n = 21
   - N1: 39
   - N2: 32
   - N3: 57
   p < 0.001

E. Log DNA load/brush vs. M stage
   - M0: n = 191
   - M1: 17
   p = 0.092

F. Log DNA load/ml blood vs. M stage
   - M0: n = 137
   - M1: 12
   p = 0.010
Figure 3

Log DNA load/brush

p = 0.13

suspected tumor side

non tumor side
Figure 4

- Log DNA load/brush
- Log DNA load/ml blood

Comparison between at diagnosis and 2 months after start treatment:

- **Left panel:** n=208 (208), 69 (69)
  - p<0.001

- **Right panel:** n=149 (149), 65 (65)
  - p<0.001
Figure 5

Complete response

Partial response

Log viral DNA load/brush

A

B

At diagnosis  2 months post treatment

Log DNA load/ml whole blood

C

D

At diagnosis  2 months post treatment
Clinical Cancer Research

EPSTEIN-BARR VIRUS DNA LOAD IN NASOPHARYNGEAL BRUSHINGS AND WHOLE BLOOD IN NASOPHARYNGEAL CARCINOMA PATIENTS BEFORE AND AFTER TREATMENT

Marlinda Adham, Astrid E. Greijer, Sandra AWM Verkuijlen, et al.

Clin Cancer Res Published OnlineFirst March 14, 2013.

Updated version Access the most recent version of this article at:
doi:10.1158/1078-0432.CCR-12-2897

Supplementary Material Access the most recent supplemental material at:
http://clincancerres.aacrjournals.org/content/suppl/2013/03/14/1078-0432.CCR-12-2897.DC1

Author Manuscript Author manuscripts have been peer reviewed and accepted for publication but have not yet been edited.

E-mail alerts Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.