

Epstein-Barr virus in oral proliferative verrucous leukoplakia and squamous cell carcinoma: A preliminary study

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Summary

The aim of this study was to analyze proliferative verrucous leukoplakia (PVL) and oral squamous cell carcinoma (OSCC) for the possible presence of Epstein-Barr virus (EBV).

We studied three groups: Sub-Group 1 was composed of 10 patients with PVL, (6 of whom had developed OSCC); Sub-Group 2 comprised 5 patients with OSCC but no preceding PVL; and Sub-Group 3 were 5 controls with clinically normal oral mucosa. Oral biopsies from all cases were examined for Epstein-Barr virus (EBV) by nested PCR. EBV was detected in 60% of Sub-Group 1 patients (PVL) and in 40% of Sub-Group 2 (OSCC), but in 0% of Sub-Group 3 (controls).

Key words: Proliferative verrucous leukoplakia, carcinoma, Epstein-Barr virus.

Introduction

Proliferative verrucous leukoplakia (PVL), first described by Hansen, (1985), (1) has a high risk of malignant transformation to carcinoma – especially to oral squamous cell carcinoma (OSCC) (2-5). The aetiology of PVL is unclear but the aetiology of OSCC may involve tobacco, alcohol, and viruses including human papillomavirus (HPV) (6). An association has also been reported between HPV and PVL (7-11), particularly HPV16 and HPV18, but HPV were found in only a small number of cases, and other authors have been unable to find any such association (12-14). For example, Campisi et al. (13) using nested polymerase chain reaction (PCR) – a sensitive technique- studied 58 cases of PVL compared with 90 cases of other oral leukoplakias and concluded that PVL is not more likely to be associated with HPV infection than is

conventional leukoplakia. Using PCR we also could not find an association (14).

Epstein-Barr virus (EBV) has been implicated in a range of malignant neoplasms, including in some studies, in the aetiology of OSCC (15-18) though not in all (19) but we have not found any study which examined the possible role of EBV in PVL.

The aim of this preliminary study was to analyze the possible implication of EBV in a series of patients with proliferative verrucous leukoplakia (PVL).

Material and Methods

The study group consisted of 20 adult subjects, with local ethical committee authorisation, examining oral biopsies by nested polymerase chain reaction (PCR). The clinical data of the patients are summarized in Table 1. The study

Table 1. Clinical, histological and nested PCR results for EBV in Sub-Groups 1 (PVL); 2 (OSCC) and 3 (controls).

Case	Sub-Group	Age	Gender	Oral locations of the lesions	Histology	EBV
1	1	75	Female	Gingiva, Palate	OSCC	+
2	1	74	Female	Gingiva, Palate, Tongue, Buccal mucosa	OSCC	+
3	1	90	Female	Gingiva, Palate, Tongue, Buccal mucosa	OSCC	+
4	1	84	Female	Gingiva, Tongue, Buccal mucosa	Verrucous carcinoma	+
5	1	81	Female	Gingiva, Tongue, Buccal mucosa	Hyperkeratosis Dysplasia	+
6	1	68	Female	Gingiva, Tongue	Hyperkeratosis Dysplasia	+
7	1	57	Female	Gingiva, Buccal mucosa	OSCC	-
8	1	79	Female	Gingiva, Tongue	OSCC	-
9	1	78	Female	Gingiva, Tongue	Hyperkeratosis Dysplasia	-
10	1	53	Female	Gingiva, Tongue, Palate, Buccal mucosa	Hyperkeratosis Dysplasia	-
11	2	66	Male	Sof palate	OSCC	+
12	2	69	Male	Buccal mucosa	OSCC	+
13	2	65	Female	Gingiva	OSCC	-
14	2	69	Male	Tongue	OSCC	-
15	2	37	Male	Gingiva	OSCC	-
16	3	35	Male	-	No lesions	-
17	3	21	Female	-	No lesions	-
18	3	48	Female	-	No lesions	-
19	3	45	Male	-	No lesions	-
20	3	18	Male	-	No lesions	-

Sub-Group 1: PVL

Sub-Group 2: OSCC without a background of PVL

Sub-Group 3: Control – no lesions

EBV: PCR results positive for Epstein-Barr Virus.

Table 2. Primer sequences employed for qualitative detection of Epstein-Barr Virus [EBV] DNA.

Primer	Sequence [5'-3']
EBV outerF	GAGACCGAAGTGAAGGCCCT
EBV outerR	GGTGCCTTCTTAGGAGCTGT
EBV innerF	GCCAGAGGTAAGTGGACTTTAAT
EBV innerR	GAGGGGACCCTGAGACGGGT

group comprised 3 sub-groups; in all three sub-groups we took a biopsy under local anaesthesia and divided it in two fragments, one for conventional histopathological analysis and the rest for the biomolecular study after freezing the sample at -80°C .

Sub-Group 1 were 10 patients with PVL diagnosed according to the criteria of Hansen et al. (1), 6 of whom had developed oral squamous cell carcinoma (OSCC) and the remaining 4 had some degree of hyperkeratosis with dysplasia but did not show histological signs of OSCC. The main age of Sub-Group 1 was 71.9 years, and all were females. Lesional biopsy was used.

Sub-Group 2 comprised 5 patients with OSCC but without any background of PVL. Lesional biopsy was used.

Sub-Group 3 came from a randomly selected healthy control group - 5 patients who came for third molar removal. We took an incisional biopsy of the oral mucosa in a clinically normal area from the third molar flap site.

All cases were examined by nested PCR for biomarkers of EBV, in the following way:

DNA Extraction

DNA from frozen tissue was extracted using the High Pure PCR Template Preparation Extraction Kit (Roche), following the instructions of the manufacturer: the tissue was incubated at 55°C with a Roche lysis buffer and $40\ \mu\text{l}$ of Roche proteinase K. DNA was eluted in $200\ \mu\text{l}$ of H_2O .

DNA from oral rinse samples was extracted, after transferring the sample into a 15ml sterile tube and centrifuging for 2 minutes at 4000 rpm in order to obtain a cellular precipitate.

The precipitate was resuspended in $200\ \mu\text{l}$ of PBS buffer. The extractions were carried out using the QIAamp DNA blood Midi Extraction Kit (QIAGEN), following the instructions of the manufacturer. The DNA was eluted in $200\ \mu\text{l}$ of H_2O .

Qualitative Detection of Epstein Barr Virus (EBV) DNA by PCR

Detection of EBV was carried out by nested PCR. Primary PCR amplifications of the processed samples were performed in a reaction volume of $25\ \mu\text{l}$, containing $2.5\ \mu\text{l}$ of 10X PCR buffer (100 mM Tris-HCl, 500 mM KCl), $2.5\ \mu\text{l}$ of

MgCl_2 25 mM, $0.5\ \mu\text{l}$ of 10mM dNTPs, $0.5\ \mu\text{l}$ of each 20 μM forward and reverse EBV outer primers (Table 2), 0.5 U of Taq DNA polymerase GOLD (Applied Biosystems) and $5\ \mu\text{l}$ of the DNA extracted from the processed samples. Secondary PCR amplifications were carried out under the same buffer conditions described for primary PCR amplification in a reaction volume of $50\ \mu\text{l}$ containing forward and reverse EBV inner primers instead of outer ones and $1\ \mu\text{l}$ of the primary PCR. As a positive control for each PCR reaction, we used quantitated viral DNA from B95-8 strain of Epstein Barr Virus (Advanced Biotechnologies, Inc.). Our limit of detection was 10 copies of virus per amplification. As a negative control, we used the same components described previously but without DNA.

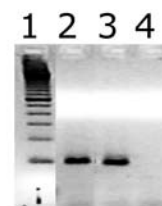
All PCR reactions were performed in a Biometra T3 or in a T1 thermocycler at the same conditions: an initial denaturing step of 2 min at 94°C followed by 35 cycles of 30 sec at 94°C , 30 sec at 55°C and 30 sec at 72°C and a final elongation step of 5 min at 72°C .

Presence of PCR-amplifiable DNA as well as absence of PCR inhibitors were tested by amplification of human β -globin gene as previously described (14).

The products of amplification were visualized by electrophoresis in 2% agarose gel, stained with ethidium bromide.

Results

The results of the study are shown in table 1. We have highlighted the fact that we detected EBV by nested PCR in 60% of Sub-Group 1 patients (PVL) but if we consider only those patients with OSCC in Sub-Group 1, the EBV positivity was slightly higher at 66,6%. (Fig. 1); in 40% of Sub-Group 2 (OSCC); and in 0% of Sub-Group 3 (controls).

Fig. 1. Electrophoretic analysis of PCR products.

Lane1: 100 pb DNA Ladder [GibcoBRL]; Lane 2: EBV detection PCR reaction from a positive sample; Lane 3: positive control for EBV amplification; Lane 4: negative PCR control reaction.

Discussion

Proliferative verrucous leukoplakia (PVL) is a slow growing lesion which typically affects several areas (5), has a high tendency to recur after treatment, and has a high rate of malignant transformation and a recognized field cancerization (20,21) which makes it possible to study the implications of some viruses in this disease. In the present study we identified EBV in PVL and OSCC. However, although we detected EBV in PVL and in a higher percentage of patients with PVL when compared with the OSCC cases without PVL we have no evidence of any direct role of it in the aetiology as it might be a simple associated infection in the context of an epithelium with severe multiple alterations over a long period. We recognize that we are reporting only a small sample of cases to support any role of EBV in PVL or OSCC, but our positive results may encourage other investigations with a greater number of patients.

After initial infection, it is known that EBV persists in oral epithelial cells and often replicates in them (17). EBV is the proven aetiological agent of nasopharyngeal carcinoma and is also associated with oral hairy leukoplakia, lymphoproliferative disease, B-cell lymphomas and lymphoepithelial carcinoma (22). Several authors have previously studied the possible implication of EBV in OSCC, but with controversial results (15-19). In particular, Anwar et al. (23), Goldenberg et al. (24), Yang et al. (25) were unable to implicate EBV in OSCC. In contrast, Higa et al. (15) found a large number of EBV infections in their OSCC. EBV type B was detected in 36% of EBV-related OSCC in Japan but other authors such as Shimakage et al. (17) using mRNA in situ hybridization, immunofluorescence staining, reverse transcriptase-polymerase chain reaction (RT-PCR) and polymerase chain reaction (PCR) did not find EBV. This is a preliminary study about the possible presence of EBV within PVL, and the method used cannot distinguish EBV in epithelium from EBV in infiltrating B cells.

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