Multiple Myeloma: Increased Circulating Lymphocytes Carrying Plasma Cell-Associated Antigens as an Indicator of Poor Survival

By Paola Omedé, Mario Boccadoro, Gabriele Gallone, Roberto Frieri, Silvano Battaglio, Valter Redoglia, and Alessandro Pileri

In multiple myeloma (MM) an increase in circulating lymphocytes expressing plasma cell-associated antigens (PCAA) has been described. Its prognostic significance was evaluated in this study. The immunologic phenotype of peripheral blood lymphocytes was analyzed with a panel of monoclonal antibodies specific for B, T, natural killer lymphocytes, and PCAA (CD38, PCA1) in 52 MM patients at diagnosis, remission, and during relapse, 18 monoclonal gammopathy of undetermined significance (MGUS), and 25 normal controls. No significant phenotypic alteration was observed in MGUS. In MM, the number of B lymphocytes was in the normal range at diagnosis and during the subsequent phases. A CD4/CD8 ratio decrease, during relapse, was due to both a CD4+ reduction and to an expansion of a subset of CD8+ activated suppressor lymphocytes. CD38- and PCA1- lymphocytes at diagnosis were significantly higher than in MGUS, and a further increase was observed during relapse, suggesting a correlation between PCAA expression and disease activity. The prognostic significance of increased PCAA was confirmed by a survival analysis of 32 patients evaluated at diagnosis using a CD38 cutoff of 0.45 \times 10^9/L positive lymphocytes. Median survival for patients with high values was only 14 months, whereas it was not reached at 32 months by those with low values (P < .0007).

MATERIALS AND METHODS

Patients. Seventy patients with monoclonal gammopathies entered this study from February 1986 to June 1989. Eighteen had MGUS and 52 MM (33 men, 19 women, aged 58.5 ± 8.9 years). MGUS showed a stable M component for at least 2 years and a bone marrow labeling index less than 1%.15 MM was diagnosed according to the Southwest Oncology Group (SWOG) criteria.16 Remission was defined as an M component decrease greater than 50% lasting for at least 6 months without treatment (unmaintained remission phase),17 and relapse as an increase greater than 50% from the lowest value. According to the Durie and Salmon staging system,18 5 were stage I, 20 stage II, and 27 stage III; 6 were sub-stage B. Twenty-six patients were IgG, 17 IgA, 8 Bence Jones myeloma, and 1 IgD. Thirty-two MM patients were evaluated at diagnosis. Median follow-up for censored patients was 13 months (range 1 to 38).

Patients were treated with 12 courses of melphalan and prednisone or alternating VMCP/VBAP in a previous report we showed that these regimens were equally effective even in high-risk patients.19 The 25 normal controls were healthy subjects comparable for mean age and sex distribution with our patient population, and screened for platelet aggregation.

Phenotypic analysis. A total of 135 phenotypic analyses of peripheral blood lymphocytes (PBL) were performed. In the 32 MM patients evaluated at diagnosis the analysis was also performed in remission and relapse (Table 1).

PBL were separated on Lymphoprep (Nyegaard, Oslo, Norway) gradient, and monocytes were removed by adherence on plastic culture flasks (Falcon, Becton Dickinson, Mountain View, CA) at 37°C for 60 minutes. In double-layer staining, lymphocytes were...
incubated for 30 minutes at 4°C with 5 μL of monoclonal antibody (MoAb), washed twice, and then incubated for 30 minutes with 2.5 μL of FITC-conjugated goat antimouse IgGs. At least 5,000 cells were scored using a Facscan (Becton Dickinson).

### Table 1. Number of Phenotypic Analysis Performed in Different Patient Subgroups

<table>
<thead>
<tr>
<th>Phenotypic Analysis</th>
<th>Diagnosis</th>
<th>MM</th>
<th>MGUS</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>95</td>
<td>52</td>
<td>18</td>
<td>25</td>
</tr>
</tbody>
</table>

RESULTS

PBL immunologic phenotypes of the 52 MM, 18 MGUS patients, and the 25 controls are shown in Table 2.

In MGUS patients no phenotypic alteration was detected. In MM patients, no significant phenotypic variation was present in the B-cell compartment (CD19, CD20) both at diagnosis or during remission and relapse. The number of T cells detected by the expression of CD3 was in the normal range, whereas the CD4/CD8 ratio decreased during the course of the disease due to both a progressive increase in CD8+ and a constant low value in CD4+ lymphocytes. These data, together with the high expression of CD11b+ and CD74+ lymphocytes, point to the elevation of activated suppressor cells, as previously demonstrated. The transferrin receptor (CD71), another activation marker, was also higher in MM at diagnosis than in MGUS and normal controls, normal during remission, and high during relapse. CD10+ lymphocytes sharply increased during relapse in four patients only, suggesting an intrinsic individual patient characteristic rather than a general feature. The natural killer subset, identified by the CD57, showed no significant variation at diagnosis and during follow-up.

In the 32 MM patients evaluated at diagnosis, a significant increase of CD38+ lymphocytes was detected in comparison with MGUS (Table 2). Among MM patients, CD38+ lymphocytes were significantly increased during relapse. Similar variations were observed for PCA1 expression, but they did not reach the statistical significance using Bonferroni’s correction (Table 2). A statistically significant correlation was detected between the number of CD38+ and PCA1+ lymphocytes (r = .71; P < .0001), suggesting their partial coexpression by the same cell; this was confirmed by a two-color analysis in five patients (data not shown). Figure 1 shows the distribution of CD38+ lymphocytes in normal controls, in MGUS, and in MM during different phases of the disease.

To assess the prognostic value of PCAA expression, a survival analysis was performed in 32 MM patients evaluating...
INCREASED CD38' LYMPHOCYTES IN MYELOMA

In different phases of the disease. Box plot legend: dashed horizontal line, median; plus sign, mean; box, middle 50% of values; vertical lines, up to 95% of distribution.

Fig 1. Distribution of CD38' lymphocytes in normal controls, MGUS, and MM patients in different phases of the disease.

Clinical characteristics of the two groups of patients separated according to this CD38 cutoff are described in Table 3. Median survival of patients with CD38' lymphocytes greater than 0.45 x 10^9/L was 14 months, whereas patients with lower values did not reach the median survival at 32 months (P < .0007) (Fig 2).

It may be stressed that all data are presented as the absolute number of circulating lymphocytes. Even more significant results were obtained on considering the percentage of positive lymphocytes, particularly in the case of CD38 and PCAl expression. MM patients displayed a significant lymphocytopenia in comparison with normal controls (median 1,561 v 2,073; P < .0001). An increase in the percentage of lymphocytes carrying PCAl resulted in subset unbalance and was frequently not evident when absolute numbers were considered.

Table 3. Clinical Characteristics of MM Patients at Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>CD38' &lt;0.45 x 10^9/L (19 pts)</th>
<th>CD38' ≥0.45 x 10^9/L (13 pts)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>M</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Stage</td>
<td>I</td>
<td>2</td>
<td>2</td>
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<tr>
<td></td>
<td>II</td>
<td>8</td>
<td>4</td>
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<tr>
<td></td>
<td>III</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>M-Comp IgG</td>
<td></td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>IgA</td>
<td></td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>IgD</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>BJ</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Age</td>
<td>57.7 ± 9.9</td>
<td>57.4 ± 10</td>
<td>NS</td>
</tr>
<tr>
<td>LI%</td>
<td>1.0 ± 0.7</td>
<td>1.1 ± 0.9</td>
<td>NS</td>
</tr>
</tbody>
</table>

Abbreviations: NS, not significant; LI, labeling index.

DISCUSSION

Alterations of the immunologic phenotype of virtually all PBL subsets have been reported in MM. This report shows that the number of circulating lymphocytes carrying PCAl is related to the course of the disease: values were higher during relapse. Moreover, a survival analysis showed that the number of PCAl' lymphocytes at diagnosis is a useful prognostic parameter because median survival for patients with a high number was significantly reduced.

The immunologic phenotype of 52 MM patients and 18 MGUS was evaluated with a panel of MoAbs. No significant variation in the B-lymphocyte compartment was shown by the B4 (CD19) and B1 (CD20) MoAbs. A reduction in CD4' and an increase in CD8' lymphocytes were particularly evident during relapse, leading to the previously described reduction of the CD4/CD8 ratio. Investigation of
the T-cell compartment confirmed the expansion of activated suppressor cells carrying CD8, CD11b, and CD74 (HLA-DR) antigens. Moreover, they coexpress PCAA, react against the related patient M component Ig idiotype,9 and may be considered specifically directed against the tumor clone. The nature and possible function of these T cells is still undetermined. As a first hypothesis, they may be regarded as an attempt by the immune system to suppress the tumor clone when an expansion occurs. The transferrin receptor (CD71), another activation marker, was increased in MM at diagnosis, returned to normal values during remission phase, and increased again during relapse.

An increase in PCAA+ PBL, unaccompanied by circulating plasma cells, has been previously reported.12,13,26 These cells have been regarded as neoplastic precursor cells. Their malignant origin is suggested by immunologic studies using anti-idiotypic antibodies14 and molecular analysis of the Ig genes showing the same rearrangement as that present in the bone marrow myeloma cells.5,6 Moreover, a B clonal excess detected by the unbalance of the K/X Ig light chain ratio has been described in several MM patients.15 However, PCAA are also expressed by T-cell blasts, and we have already demonstrated that they significantly contribute to the increase of positive PCAA cells.12

Phenotypic analysis of PBL performed with PCAA takes into account the presence of neoplastic precursors and activated T cells, which both expand during relapse.16 We now confirm the expansion of PCAA positive lymphocytes during this phase. In our patient series, PCAA values were highly dispersed at diagnosis, suggesting that they do not just increase during the course of the disease, but may already indicate a poor prognosis at diagnosis. Therefore, we performed a survival analysis according to the PCAA expression: median survival for patients with more than 0.45 × 10^9/L CD38+ lymphocytes was only 14 months. This feature definitely confirms its prognostic significance. From a clinical point of view, a high CD38 value may be relevant to: (1) discriminate between MM and MGUS; (2) determine whether the disease is stable or progressing; or (3) evaluate the prognosis at diagnosis.

Because phenotypic analysis of PBL with MoAbs is a routine practice in several hematologic centers, it may be regarded as a simple alternative to more complex analyses requiring bone marrow samples, such as plasma cell labeling index,17 in the evaluation of MM prognosis.

In conclusion, PCAA phenotypic analysis in combination with other prognostic factors, such as serum β-2 microglobulin,18 can be used to select poor prognosis patients as potential candidates for the newly proposed aggressive chemotherapy regimens.24

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