Chromosomal abnormalities of intravascular large B-cell lymphoma (IVLBCL), a rare form of extranodal diffuse large B-cell lymphoma, have been described in only a small number of cases. A 59-year-old female presented with pancytopenia and splenomegaly. Bone marrow was normocellular with 30.4% abnormal large lymphoid cells that were positive for CD5, CD19, CD20, HLA-DR and \( l \)-chain. Bone marrow biopsy showed intrasinusoidal infiltration of large lymphoid cells. G-banding and spectral karyotyping of the bone marrow cells demonstrated a complex karyotype as follows: \( 48,XX,-8,+r(11),+12,\text{del}(12)(p?) \times 2,+18,\text{der}(19)(19?:p13\rightarrow qter),\text{der}(21)(8;21)(q11.2;p11.2) \). Fluorescence in situ hybridization on interphase nuclei revealed three signals of \( CCND1 \) at 11q13, but two signals of \( BIRC3 \) at 11q22 and \( MLL \) at 11q23, indicating that \( r(11) \) contained \( CCND1 \). Together with other reported cases, our results indicate that the gain of 11q as well as trisomy 18 may be among the recurrent chromosomal aberrations in IVLBCL. Furthermore, an additional ring chromosome 11 could be a novel mechanism leading to the gain of 11q. (J Clin Exp Hematop 53(2) : 161-165, 2013)

Keywords: intravascular large B-cell lymphoma, chromosomal abnormalities, ring chromosome, gain of 11q, trisomy 18

INTRODUCTION

Intravascular large B-cell lymphoma (IVLBCL) is a rare form of extranodal diffuse large B-cell lymphoma (DLBCL) characterized by the selective growth of lymphoma cells within the lumina of vessels, particularly capillaries. Compared with intensive histopathologic and immunophenotypic analyses, chromosomal abnormalities of IVLBCL have been described in only a small number of cases, possibly due to the difficulty of early diagnosis and poor material for cytogenetic analyses. Most of the IVLBCL cases cytogenetically analyzed showed complex karyotypes with multiple numerical and structural changes, and gains of 11q and trisomy 18 were included in these abnormalities. Unlike other B-cell lymphomas, rearrangements of immunoglobulin heavy locus (\( IGH@ \)) at 14q32 are uncommon. However, specific chromosome aberrations remain to be completely elucidated in IVLBCL. Here, we describe a new case of IVLBCL, which revealed a gain of 11q by an additional ring chromosome 11 and trisomy 18.

CASE REPORT

A 59-year-old woman was admitted to our hospital because of petechiae. Computed tomography scans of the whole body showed splenomegaly but no lymphadenopathy. Peripheral blood values were hemoglobin 96 g/L, platelets \( 30 \times 10^9/L \) and leukocytes \( 2.4 \times 10^9/L \) with 41% neutrophils, 16% monocytes, 1% basophils, 23% lymphocytes and 19% abnormal lymphoid cells. Serum levels of lactate dehydrogenase and soluble interleukin-2 receptor were elevated to 1,324 U/L (normal range, 115～217) and 9,975 U/mL (124～466), respectively.

Bone marrow was normocellular with 30.4% abnormal large lymphoid cells (Fig. 1a). Immunophenotyping by three-color flow cytometry revealed that these lymphoid cells were positive for CD5, CD19, CD20, HLA-DR and \( l \)-chain, but negative for CD10 and CD23. Pathological examination showed intrasinusoidal infiltration of atypical large lymphoid...
cells (Fig. 1b & 1c). There was no evidence of hemophagocytosis. Immunohistochemistry confirmed that these lymphoid cells were positive for CD20 and CD79a, but negative for cyclin D1 and myeloperoxidase (Fig. 1d). Lymphoid cells were also positive for MUM1 but negative for CD10 and BCL6, indicating the non-germinal center B-cell phenotype. The MIB-1 index was about 80%. We made a diagnosis of IVLBCL in accordance with the World Health Organization classification.1

The patient received systemic chemotherapy with R-CHOP regimen (rituximab 375 mg/m² day 1, cyclophosphamide 750 mg/m² day 2, doxorubicin 50 mg/m² day 2, vincristine 1.4 mg/m² day 2 and prednisolone 100 mg/body days 2-6) followed by prophylactic intrathecal injection (15 mg of methotrexate, 40 mg of cytarabine and 3.3 mg of dexamethasone) because the central nervous system is frequently involved in IVLBCL.3 She achieved complete remission (CR), and received a further seven courses of R-CHOP and three courses of intrathecal injections. She has been in CR for more than 21 months.

G-banding analysis of the bone marrow cells at diagnosis showed 48,XX,−8,+12,del(12)(p?)×2,+18,add(19)(p13),der(21)t(8;21)(q11.2;p11.2),+r1[8]/46,XX[12] (Fig. 2a). Spectral karyotyping (SKY) revised the karyotype as follows: 48,XX,−8,+r(11),+12,del(12)(p?)×2,+18,der(19)(qter;19p13→qter),der(21)t(8;21)(q11.2;p11.2)[3]/46,XX[2] (Fig. 2b). That is, an additional ring chromosome was shown to be derived from chromosome 11.

For further characterization of the ring chromosome 11, we next performed fluorescence in situ hybridization (FISH) with commercially available chromosome 11- and B-cell lymphoma-associated probes for CCND1 at 11q13, BIRC3 at 11q22 and MLL at 11q23 on interphase nuclei.11 FISH with IGH@/CCND1 showed two IGH@ and three CCND1 signals in 9 of 100 cells (Fig. 2c). On the other hand, FISH with BIRC3/MALT1 showed two BIRC3 and three MALT1 signals due to trisomy 18 in 8 of 100 cells (Fig. 2d). Furthermore, FISH confirmed two normal MLL signals in all 100 cells (data not shown). These results indicate that the ring chromosome 11 contained CCND1 at 11q13, resulting in the gain of 11q.
but that it did not include \textit{BIRC3} and \textit{MLL}.

**DISCUSSION**

We have detected a gain of 11q by an additional ring chromosome 11 and trisomy 18 in a patient with IVLBCl by G-banding, SKY and FISH analyses. Khoury \textit{et al.} reviewed cytogenetic findings of 17 published IVLBCl cases, and clarified that the most frequent alterations were $\sim 6/\text{del(6q)}$ and $+18/\text{dup(18q)}$, which were observed in 59% and 41% of cases, respectively.\textsuperscript{9} In addition, commonly duplicated regions that were apparent in > 20% of the karyotypes included all of chromosome 18 (+18) and the 11q13–qter region. Then, we summarized the reported IVLBCl cases with gains of 11q (Table 1): two cases with an additional whole chromosome 11 (cases 3 and 4) and three cases with duplication or triplication of 11q (cases 5 to 7).\textsuperscript{6,7,9,11} Duplicated regions on chromosome 11 seemed to be heterogeneous, and the 11q13 region was involved in case 6.\textsuperscript{9} There were also two reported IVLBCl cases with ring chromosomes (cases 1 and 2),\textsuperscript{5,8} but their origins were unclear. Thus, our results indicate that the gain of 11q as well as trisomy 18 may be among the
recurrent chromosome abnormalities in IVLBCL. Furthermore, an additional ring chromosome 11 could be a novel mechanism leading to the gain of 11q.

Ring chromosomes occur when two ends of a chromosome fuse together and form a circular structure. Ring chromosomes occur when two ends of a chromosome fuse together and form a circular structure. They are usually a part of complex karyotypes. Ring chromosome 11 has been reported in 19 cases of acute myeloid leukemia, but not in any of the 78 cases of DLBCL. Interestingly, as shown in Table 1, all three cases of IVLBCL with ring chromosomes (cases 1, 2 and 8) had the ring chromosome 11, indicating that this chromosome might be specifically associated with trisomy 11.

Table 1. Reported cases of intravascular large B-cell lymphoma with ring chromosomes or gains of 11q

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age/ Sex</th>
<th>Subtypes</th>
<th>Karyotypes</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>63/F</td>
<td>Western</td>
<td>52.X,i(X)(q10)+;i(X)(q10)+3.del(1)(q42q44),add(6)(q11),del(6)(p11q27),del(9)(q11q34),+15,+18,=mar [3]46.XX[27]</td>
<td>Davey et al., 1990 (5)</td>
</tr>
<tr>
<td>3</td>
<td>76/M</td>
<td>Western</td>
<td>53.XY,+X,(3;22)add(3)(q?),del(5)(q?),i(6)(p10),+7,add(8)(p?),-10,+11,+12,del(12)(p?)x2,+18,mar1,+mar2[8]53,sl,-X,-,+mar[3]2</td>
<td>Molina et al., 1990 (6)</td>
</tr>
<tr>
<td>5</td>
<td>61/F</td>
<td>Asian</td>
<td>47.XX,inv(1)q13q21→25,del(4)(q31),del(5)(q13q33),add(6)(q21),add(8)(p11),-9,=up<a href="q22">1</a>(q11q25),del (17)(p11),=mar1,=mar2,inc[1]48,sl,add(10)(q22→q24),inc[1]46.XX[18]</td>
<td>Murae et al., 2000 (7)</td>
</tr>
<tr>
<td>6</td>
<td>66/M</td>
<td>Asian</td>
<td>47.XY,dup(1)q32(q21),inv(3)(p5?q?),del(3)(q21q24),del(8)(p11),del(10)(q11q25),del<a href="q13q21,21">11</a>(i11q14),(p5q32),=der(4)(i11q14),=der(11)(i11q14)</td>
<td>Khoury et al., 2005 (9)</td>
</tr>
<tr>
<td>7</td>
<td>47/M</td>
<td>Asian</td>
<td>47.XY,add(1)(p36.1),add(1)(q32),add(2)(q31),add(4)(p14),add(9)(p22),trp(11)(q22q25),del(14)(q31q32),add(19p13.1),der(7 ?11q21q22)</td>
<td>Deisch et al., 2009 (11)</td>
</tr>
</tbody>
</table>

M, male; F, female; Western, Western form; Asian, Asian variant, Ring chromosomes, gains of 11q, and trisomy 18 are described in bold letters.

IVLBCL shows immunophenotypic heterogeneity: CD5+ or CD5-CD10+. This heterogeneity was associated with a higher prevalence of marrow/blood involvement and thrombocytopenia and a lower frequency of neurologic abnormalities among patients with CD10-IVLBCL. These findings were also applicable to the present case with CD5+CD10+ phenotype. Currently, the association between immunophenotypic heterogeneity and chromosome abnormalities remains unclear. A detailed and extensive cytogenetic study for more cases would contribute to understanding the pathogenesis of IVLBCL.

REFERENCES


Gain of 11q and trisomy 18 in IVLBCL