CD34 selections from myeloma peripheral blood cell autografts contain residual tumour cells due to impurity, not to CD34⁺ myeloma cells

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Summary. Malignant cells in haemopoietic autografts can contribute to post-transplant relapse. Engraftment of myeloma patients with CD34⁺ peripheral blood progenitors selected from total autografts reduces the number of tumour cells infused by 2.7-4.5 logs. Residual tumour cells detected in CD34⁺ selected cells may be due to selection impurity or the existence of malignant CD34⁺ progenitors. In three patients we evaluated the CD34 purity and tumour load of total autografts, CD34⁺ progenitors selected with immunomagnetic beads and highly purified CD34⁺ progenitors obtained in two rounds of selection (combining magnetic with flow cytometry activated cell sorting) to determine the cause of residual tumour cells in CD34 selections.

Using allele-specific oligonucleotides (ASO) complementary to the unique Ig heavy chain sequence (CDRIII region) of the malignant clone, semi-quantitative ASO-PCR was capable of detecting one malignant cell in 10⁴-10⁵ normal white blood cells. Selection of CD34⁻ cells from bone marrow (BM) with approximately 20% malignant plasma cells resulted in a 1.4 log reduction of tumour burden. Using two-colour flow-cytometry we observed CD34⁺, BB4⁺ malignant plasma cells contaminating this CD34 selection. Prior to sorting, peripheral blood cell autografts (PBCA) contained approximately 0.1% malignant cells. Selection of >99% pure CD34⁺ cells using immunomagnetic beads (Dynal) resulted in an approximate 2 log reduction of malignant cells, but residual tumour cells were still detectable. ASO-PCR detected no malignant cells in >99.9% pure CD34⁺ peripheral blood progenitors obtained with two rounds of selection (combining magnetic with flow cytometry activated cell sorting). We conclude that CD34⁺ malignant cells are not detectable in myeloma PBCA and that residual tumour cells in CD34 selections are due to contaminating CD34-negative cells.

Keywords: PBCA, myeloma, CD34, immunoglobulin, ASO-PCR.
normal cells. Using these sensitive PCRs we show that multiple myeloma PBCA contain about 0.1% tumour cells and that immunomagnetic bead selection of CD34+ cells results in an approximate 2 log depletion of tumour cells. Residual tumour cells in CD34 selections were due to contaminating CD34-negative cells.

MATERIAL AND METHODS

Patients. All three patients (K, S and T) included in this study had stage III multiple myeloma according to Durie & Salmon (1975) and had been previously treated with alkylating agents and prednisone. Patients S and K subsequently received repeated courses of steroids with vincristine and doxorubicin administered by continuous infusion (VAD). Patients T and S achieved partial remission but patient K was refractory to prior treatment. For all three patients peripheral blood stem cells were harvested after high-dose cyclophosphamide (7 g/m²) and G- or GM-CSF (patients T and K). Stem cells were re-infused after high-dose melphalan (140 mg/m²) and TBI (9 Gy).

Cell isolations. Bone marrow cells were obtained by aspiration from the sternum of the patients after informed consent. PBCA were collected in four to six apheresis procedures with a continuous flow cell separator (Fenwal CS 3000, Baxter Healthcare, Deerfield, U.S.A.; Areman et al., 1990). Cytospin preparations of BM and PBCA were stained with May Grunwald Giemsa (MGG) and differential morphology of 200 nucleated cells was scored by two independent investigators. Cells were layered over Ficoll Hypaque and the mononuclear layer was collected after density centrifugation and washed in phosphate-buffered saline (PBS). These cells were cryopreserved at −196°C in small aliquots.

Cell sortings. The cryopreserved cells were thawed, washed and resuspended in RPMI 1640 supplemented with 10% FCS. More than 40 x 10⁶ thawed cells were washed and resuspended in PBS with 1% BSA (PBSB) to a concentration of 10⁷ cells/ml. CD34+ cells were selected according to the manufacturer's protocol with M450 beads directly coated with ‘561’ antibody (Dynal). Bead to cell ratio was 1:2. After 30 min incubation at 4°C with CD34 beads, a magnetic separation was performed. Selected cells were concentrated in 150 µl PBSB and detachment of beads was performed by adding 50 µl CD34 Detach-a-Bead (Dynal). After incubation for 1 h at room temperature, beads were magnetically separated from detached cells. Purity of CD34 selection was flow-cytometrically monitored. In brief, detached cells were washed twice and concentrated in 100 µl PBSB and incubated with a mixture of phycoerythrin (PE)-conjugated CD34 (HPCA-2, Becton Dickinson) and fluorescein isothiocyanate (FITC)-conjugated BB4 (ImmuNo Quality Products). As a control cells were labelled with IgGl-FITC/IgGl-PE. Flow cytometric analysis and FACS was performed with an

Fig 1(a). Outline of the method used to develop ASO-PCR. Schematic representation of the rearranged heavy chain locus amplified by CDR3 primers.
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DNA extraction. DNA was extracted by making whole-cell lysates. If present, erythrocytes were lysed with NH₄Cl. The NH₄Cl was then washed away with PBS. Cells in PBS were transferred to Eppendorf tubes and pelleted in an Eppendorf centrifuge (5 min, 400 g at 4°C). The supernatant was removed and the pellet loosened by vigorous rasping. The pellet of ≥ 10⁵ cells was resuspended in PCR buffer supplemented with 0-5% NP40 and 0-5% Tween 20 to a concentration of 10⁴ cells/μl. 1 μl of proteinase K (10 mg/ml) was added for every 100 μl cell lysate. The cell lysate was incubated at 55°C for 1 h, after which the proteinase K was inactivated by a 10 min incubation at 95°C. When ≤ 10⁴ cells were available, pelleted cells were resuspended to a concentration of 10 cells/μl. In those cases 1 μl of proteinase K (0-1 mg/ml) was added for every 100 μl. Whole-cell lysates were frozen at −70°C. 10 μl of cell lysate was used in each PCR.

Amplification of CDRIII using consensus primers. Whole-cell lysates were subjected to PCR in a 100 μl PCR solution containing: 31 μM dNTP, 0-2 μl [α-³²P]dCTP (Amersham International, Amersham, U.K.), 3000 Ci/mmol, 10 μCi/ml, 50 mM KCl, 10 mM Tris-HCl pH 8-4, 0-0001% gelatine, 2-5 Units Taq DNA polymerase (Life Technologies) and 30 pmol of each consensus primer (Fig 2). Primers were synthesized on a 391A DNA synthesizer (Applied Biosystems, Warrington, U.K.). PCR was performed for 35 cycles of 1 min 95°C, 1 min 55°C and 1 min 72°C, supplemented with a final 10 min extension at 72°C in a Perkin-Elmer Cetus™ thermocycler. Radioactive products were separated on a 6% non-denaturing polyacrylamide gel.

Analysis of CDRIII sequence. For direct sequencing double-stranded DNA was sequenced by the dideoxy chain termination method.
termination method (Innis et al, 1988) in a 10-cycle PCR using 5 pmol of one of the end-labelled CDRIII consensus primers (Fig 2) and 1 µl (10 ng) template. CDRIII sequences were searched for homology (Yamada et al, 1991) with published DIR (Dh gene containing irregular spacer signals), D gene segments (Ichihara et al, 1988; Matsuda et al, 1990; Buluwela et al, 1988) and Jh gene segments (Ravetch et al, 1981).

Tumour-specific PCR of patient samples. To achieve highest PCR specificity allele specific oligonucleotides (ASOs) were designed complementary to the CDRIII region with the highest variability amongst different B-cell clones (Fig 2). A non-radioactive amplification was performed essentially as described for CDRIII consensus PCR except for the use of 30 pmol 5′ASO primer instead of Vconsensus primer (Fig 2) and a dNTP concentration of 250 ‰. PCR products were separated on 2% agarose gel, transferred to nylon membranes (Hybond N+) and probed with end-labelled ASO probes under stringent conditions. Radioactive signals were visualized on X-ray film (Kodak) and quantified by densitometric scanning on a LKB laser densitometer. Allele-specific calibration curves were generated after serially diluting patient marrow DNA into PCR lysate buffer in 10-fold decrements, supplemented with normal white blood cell (NWBC) lysate to yield a concentration of 10⁴ cells per µl PCR lysate buffer and 10⁵ cells per PCR.

Statistical estimation of tumour load. Quantified PCR product is given in OD (optical density, arbitrary units). Least squares was used to fit a linear regression equation for ln (OD) as a function of ln (tumour fraction) for each patient. The number of tumour cells in patient samples and its 95% Scheffe's confidence interval was computed using this patient-specific linear regression equation (Billadeau et al, 1991).

β2m control PCR. PCR amplification was performed as for the ASO-PCR except for the use of 30 pmol β2m sense: 5′-CTCGGCTACTCTCTTTCT and 30 pmol β2m antisense: 5′-CTAAAATGTGCCGACCCTC primers. Size of the β2m PCR product was estimated on 2% agarose gels using a 100 bp ladder (Pharmacia) as a reference.

RESULTS

CDRIII sequencing

To determine the Ig heavy chain CDRIII sequence of the malignant clone we performed radioactive PCR using the consensus primers oJcon and Vcon flanking the Ig CDRIII

Fig 3. (a) ASO-PCR analysis of tumour cells in PBCA fractions of patient S. The dilutions of BM DNA samples used to obtain the calibration curve are shown on the left. CD34 pos columns represent duplicate PCRs of the same selection of CD34⁺ cells with immunomagnetic beads. An aliquot of this CD34⁺ selection was then subdivided by flow sorting. The columns CD34 pos, BB4 neg and CD34 pos, BB4 pos represent ASO-PCR results performed with DNA isolated from flow sorted CD34⁺, BB4⁻ and CD34⁺, BB4⁺ cells. (b) Ethidium bromide stained 2% agarose gel showing β2m control products of patient S DNA samples used in ASO-PCR.

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For each patient two allele-specific oligonucleotides (ASO) were synthesized (Fig 2). Using a 5' ASO and the αIhcon or αIh5i primer a PCR was developed that was specific for the malignant clone. ASO-PCR products were blotted and hybridized with a radiolabelled internal ASO-probe (Fig 1a). Quantification by densitometrical scanning shows that each tumour-specific PCR detects only malignant cells in one of the multiple myeloma patients but not in several NWBC preparations. Also ASO probes specifically designed for each patient never hybridized with ASO-PCR products of other multiple myeloma patients. By serially diluting the DNA derived from myeloma bone marrow samples (containing >30% plasma cells) in DNA derived from NWBC we were able to show that sensitivity of the ASO-PCRs ranged from detection of one tumour cell in $10^4$–$10^5$ normal white blood cells (Figs 3 and 4).

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Sensitivity of ASO-PCR to specifically detect malignant cells

For each patient two allele-specific oligonucleotides (ASO) were synthesized (Fig 2). Using a 5' ASO and the αIhcon or αIh5i primer a PCR was developed that was specific for the malignant clone. ASO-PCR products were blotted and hybridized with a radiolabelled internal ASO-probe (Fig 1a). Quantification by densitometrical scanning shows that each tumour-specific PCR detects only malignant cells in one of the multiple myeloma patients but not in several NWBC preparations. Also ASO probes specifically designed for each patient never hybridized with ASO-PCR products of other multiple myeloma patients. By serially diluting the DNA derived from myeloma bone marrow samples (containing >30% plasma cells) in DNA derived from NWBC we were able to show that sensitivity of the ASO-PCRs ranged from detection of one tumour cell in $10^4$–$10^5$ normal white blood cells (Figs 3 and 4).

Quantification of malignant cells in myeloma autografts

As a control we performed PCR with β2m primers on all samples tested in the tumour-specific PCRs. Only minor differences in signal intensity of the β2m PCR products were observed (Figs 3 and 4). We conclude that the DNA

Fig 4. (a) ASO-PCR analysis of myeloma tumour in BM fractions of patient S. The dilutions of BM DNA samples used to obtain the calibration curve are shown on the left. Sample description is as in Fig 3. The CD34 neg column represent ASO-PCR results performed with DNA isolated from bone marrow samples that were depleted of CD34-positive cells. (b) Ethidium bromide stained 2% agarose gel showing β2m control products of patient S DNA samples used in ASO-PCR.

Fig 5. Percentage tumour burden in peripheral blood cell autografts (A) and BM samples (B) of myeloma patients as detected by ASO-PCR. Values are given with statistically generated confidence intervals (see Material and Methods) and <0.001% tumour cells indicates that the number of tumour cells in the sample is below the detection limit of ASO-PCR. CD34+ samples were selected with CD34 immunomagnetic beads and the CD34-depleted fraction was called CD34-; CD34+, BB4- samples are cells sorted with CD34 immunomagnetic beads and subsequent flow cytometry. CD34- are samples depleted of CD34+ cells. Aliquots of these CD34+ selection were then subdivided by flow sorting into CD34- BB4- cells and CD34- BB4+ cells and their tumour burden was also assessed.

Fig 6. Flow cytometric analysis of cells obtained with CD34 immunomagnetic bead selection from bone marrow (a, b) and PBCA (c, d) of patient S. Analysis of forward and side scatter (a) and CD34 (PE) and BB4 (FITC) expression (b). For bone marrow as well as PBCA material CD34+, BB4- cells in gate F and CD34+, BB4+ cells in gate D were further purified by FACs. Purity of the CD34+, BB4+ cellsort was monitored by flow cytometric analysis of CD34 (PE) and BB4 (FITC) expression (d). The quadrant B indicates green and red fluorescence of IgG-PE/IgG-FITC control antibodies.
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Bone marrow CD34 selection

Gate: A

PBCA CD34 selection

Gate D: 0.9%
Gate F: 70.8%
quadrant B1: 73.7%
quadrant B2: 0.6%
quadrant B3: 24.5%
quadrant B4: 1.2%

gate D: 0.2%
gate F: 92.7%
quadrant B1: 99.0%
quadrant B2: 0.7%
quadrant B3: 0.3%
quadrant B4: 0.0%

gate D: 0.0%
gate F: 100%
quadrant B1: 100%
quadrant B2: 0.0%
quadrant B3: 0.0%
quadrant B4: 0.0%
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preparation was of sufficient quality to allow PCR amplification of each sample with comparable efficiency. ASO-PCR detected between 0.07% and 0.17% malignant cells in PBCA in three patients in duplicate PCR experiments (Fig 5). Plasma cells were never detected in cytospin preparations of PBCA whereas in cytospins of bone marrow aspirates 2-5% plasma cells were found (results not shown).

Isolation of CD34+ progenitors using immunomagnetic beads

CD34+ cells were selected from PBCA and BM using CD34+ immunomagnetic beads (Dynal). Flow-cytometric analysis of detached cells, stained with CD34 phycoerythrin showed that purity of CD34+ peripheral blood progenitor cells was always higher than 99% (Fig 6c). Using this procedure, PBCA or BM were depleted of 99% of the CD34+ cells and we consequently called these fractions CD34+. Tumour-specific ASO-PCR detected <0.002% malignant cells in CD34+ immunomagnetic bead preparations and 0.03-0.1% malignant cells in CD34+ PBCA fractions (Figs 3 and 5a). Thus the majority of malignant cells were not selected with CD34 immunomagnetic beads and CD34 selection from PBCA using immunomagnetic beads (Dynal) reduced malignant cells with approximately 2 logs. Selection of CD34+ cells from bone marrow of patient T resulted in a 2-6 log reduction in tumour cells (Fig 5b). We used BM of patient S (who had progressed to plasma cell leukaemia) to test if, in bone marrow heavily infiltrated with malignant cells, the same reduction of tumour cells could be accomplished with CD34 selection. Flow-cytometric analysis of this BM sample stained with the plasma cell (PC) marker BB4-FITC (Pellat-Deceunynck et al, 1994) revealed 20-7% PC. In MGG-stained cytospins 22% PC were detected (results not shown). When the selected CD34+ cells were stained with BB4 and CD34, purity was higher than 75%, BB4+ PC (1%) were, however, contaminating this selection (Fig 6b). Tumour-specific ASO-PCR detected 22-2% malignant cells in this BM aspirate of patient S and 25-7% in the CD34+ fraction. In the CD34+ fraction 0-8% malignant cells were detected (Figs 4 and 5b). We conclude that selection of CD34+ cells from highly contaminated BM results in a 1-4 log reduction of tumour cells.

Isolation of CD34+ progenitors using immunomagnetic beads followed by flow cytometrically activated cell sorting (FACS)

The selection of CD34+ progenitors from BM of patient S was contaminated with BB4+ PC (Fig 6b). Using FACS we sorted 10^5 BB4+ PC (Fig 6b, gate D) from CD34 immunomagnetic bead fractions. Cytospin preparations of sorted BB4+ cells showed only cells with typical plasma cell morphology (results not shown). ASO-PCR showed that BB4+ PC belong to the malignant clone (Fig 4). Over 90% of the BB4+ cells were CD34 negative, suggesting that most plasma cells contaminate the CD34 selections in a non-specific manner. If this were true it would mean that increasing the purity of CD34+ cells could further reduce the contamination of malignant cells. Highly purified CD34+ BM progenitors were obtained in two rounds of selection combining magnetic with flow cytometry activated cell sorting (Fig 6b, gate F).

Purity of these flow-sorted CD34+ cells was > 99-9%. ASO-PCR showed that a second round of purification with FACS results in a 2-3 log reduction of malignant cells (Figs 4 and 5b). Flow-cytometric analysis of CD34+ immunomagnetic bead selections from PBCA of patients S and T showed 0.1% CD34+, BB4+ cells but no CD34+, BB4+ PC. Using FACS, we sorted 10^5 CD34+, BB4+ and 10^5 CD34+, BB4- cells. Purity of flow sorted CD34+ peripheral blood progenitors was > 99-9% (Fig 6d). ASO-PCR could not detect tumour cells in either of these fractions (Fig 3 and 5a). Consequently malignant cells with a CD34+ progenitor phenotype were not detectable in PBCA of three patients and residual tumour cells detected in CD34 selections were due to contaminating CD34 negative myeloma cells.

DISCUSSION

In this study we showed that residual tumour cells in CD34 selections of myeloma autografts are due to impurity. We used tumour-specific PCR, capable of detecting one malignant cell in a background of 10^5 normal white blood cells. In accordance with other studies (Mariette et al, 1994; Bird et al, 1994) we found between 0.07% and 0.17% malignant cells in PBCA. CD34 selection using immunomagnetic beads resulted in an approximately 2 log depletion of malignant cells in myeloma PBCA of three patients. Even when highly contaminated BM (22% PC) was used for CD34 selection, a 1.4 log reduction in tumour cells was achieved. Assuming that most tumour cells do not express the CD34 marker, a 2 log reduction in malignant cells is in agreement with the 2 log increase of CD34+ cells achieved by CD34 selection. An additional advantage of autologous CD34+ transplants over total peripheral blood cell transplants is that fewer cells are needed, resulting in a 2.7-4.5 log reduction of malignant cells in clinical trials (Schiller et al, 1995).

Since the CD34 selection was not 100% pure we reasoned that positive ASO-PCR signals might result from contamination with CD34-negative cells. Starting with BM heavily infiltrated with plasma cells we showed that contaminating malignant plasma cells were the major cause of impurity in CD34 immunomagnetic beads selections. In those cases the purging of BB4+ PC in combination with CD34 selection using immunomagnetic beads should provide further tumour cell reduction. A contamination phenomenon was also reported by Vescio et al (1994). They found positive ASO-PCR signals when CD34 cells were collected from BM with one round of selection using a immunoadsorption column, whereas a second round of CD34 selection with FACS resulted in a negative ASO-PCR. Others have suggested that residual tumour cells in selections of CD34+ cells are malignant CD34+ progenitors (Takashita et al, 1994; Belch et al, 1994; Bersagel et al, 1994). Since no PCR data of preselected material are shown it cannot be excluded that the positive ASO-PCR signals Takashita et al (1994) report after having selected CD34 or CD20 cells from PB of myeloma patients with FACS arise from contamination. To prove that positive ASO-PCR signals in CD34 selections arise from contamination with CD34-negative tumour cells not from malignant CD34+ progenitors we

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performed a second round of CD34 selection with FACS resulting in >99-9% pure CD34+ cells. We found a clearcut reduction of malignant cells with ASO-PCR when we compared 10^5 CD34 immunomagnetic bead selected cells with 10^5 highly purified CD34+ cells (isolated with two rounds of CD34 selection) in patients S and T. In 10^5 highly purified CD34+ cells from PBCA we were not able to detect malignant cells with ASO-PCR. These experiments show that ASO-PCR signals in CD34 selections arise from contamination with CD34-negative tumour cells.

Our results argue against the presence of malignant CD34+ precursors. One could reason, however, that malignant CD34+ stem cells that have yet to undergo Ig gene rearrangement or malignant pre-B cells that could still undergo Vh replacements and somatic hypermutation could exist and escape detection by ASO-PCR. If such precursor cells exist, the plasma cell progeny should have an extremely diverse Ig gene sequence. However, after sequencing multiple clones in each patient, Bakkus et al (1992) and Vescio et al (1993) found no evidence of intraclonal diversity. They concluded there was no ongoing somatic hypermutation. In addition, others found no evidence for ongoing Vh replacements (Takishita et al, 1994). Therefore the scenario of a malignant pre-B-lymphocyte or stem cell as a precursor for malignant plasma cells is unlikely. It has been suggested that a change in the predominant tumour clone may occasionally occur in multiple myeloma (Bird et al, 1994), resulting in tumour cells that are not detected by ASO-PCR. We detected the same monoclonal tumour population before and after peripheral blood cell transplantation without major additional clones appearing. We conclude that there was no clonal evolution in our patients and tumour cells are thus adequately quantified.

In summary, residual tumour cells detected in CD34 selections are due to impurity. Removal of all tumour cells from the graft is not possible with CD34 selection protocols that are currently applied in clinical trials (Schiller et al, 1995). We and others (Vescio et al, 1994), however, consistently achieved negative ASO-PCR signals with two rounds of CD34 selection, or a combination of counterflow elutriation, treatment with phenylalanine methylester and flow sorting of CD34+, Lin-, Thy1+ stem cells (Gazitt et al, 1995). Since purity of CD34 selection seems the most essential parameter in obtaining tumour-free autografts, we are currently evaluating the purity of different CD34+ isolation methods and their applicability in the clinical setting of autologous transplantation.

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