Absence of Granzyme B positive tumour-infiltrating lymphocytes in primary melanoma excisional biopsies is strongly associated with the presence of sentinel lymph node metastasis

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Abstract. Background: Sentinel Lymph Node (SLN) status is strongly related to clinical outcome in melanoma patients. In this study we investigated the possible association between the presence of activated and/or suppressive Tumour Infiltrating Lymphocytes (TILs) and SLN status in clinically stage I/II melanoma patients.

Methods: Diagnostic primary melanoma samples from 20 patients with a sentinel lymph node metastasis were compared to melanoma samples from 20 patients with a negative sentinel lymph node, who were matched for gender, age and Breslow thickness. Presence of activated Granzyme B positive (GrB+TILs, presence of suppressive (FoxP3+TILs and MHC class I antigen expression on tumour cells were analysed by immunohistochemistry.

Results: FoxP3 and MHC-I expression had no direct bearing on the presence of melanoma metastases in the SLN. Whereas the presence of activated GrB+TILs in the primary melanoma had no predictive value for SLN status either, their absence was strongly associated with the presence of metastasis in the SLN (p = 0.001). While both GrB+ and FoxP3+ TILs could be detected in SLN metastases, a majority did not display MHC-I expression.

Conclusion: These data support a role for cytotoxic T cells in the prevention of early metastasis of melanoma to the draining lymph nodes.

Keywords: Melanoma, CTL, Tregs, FoxP3, Granzyme B, sentinel lymph node

1. Introduction

Fatal outcome in melanoma patients mostly results from occurrence of distant metastases, which are usually preceded by lymph node metastases [23,29]. Lymph node metastases develop in the first-line tumour-draining lymph node, the sentinel lymph node (SLN). The prognostic value of the SLN status has been shown in several large studies [3] and the SLN status is used as a tool for selecting patients for trials on adjuvant (immune) therapy [20]. The SLN status and clinical outcome in melanoma patients is known to be associated with a number of variables, including Bres-
low thickness, ulceration, location of primary tumour, lymphatic invasion, gender and age [6,2,4,21].

It has previously been shown that melanomas can elicit an immune response [15,17] and that tumour cells can effectively be eradicated in vivo by cytotoxic activity of MHC class I restricted CD8\(^+\) Granzyme B\(^+\) (GrB\(^+\)) T-cells [1]. Proper activation of a CD8\(^+\) T-cell mediated immune response requires antigen to be presented in the context of the appropriate MHC class I molecules. When a cell loses expression of MHC class I molecules, it can no longer be recognized by CD8\(^+\) lymphocytes, but it might become susceptible to natural killer (NK) cell recognition [14]. Loss of MHC class I antigen expression has been shown to be involved in immune escape and tumour progression [1,18,19] and has been associated with poor clinical outcome [8,11]. In addition, target cell killing by cytotoxic T-cells (CTLs) requires the help of CD4\(^+\) T-helper (Th) cells [4,12] and is negatively regulated by suppressive regulatory T-lymphocytes. These suppressive T-lymphocytes express the FoxP3 transcription factor, which we used in this study as a marker for detection of suppressive T-lymphocytes [9,30]. FoxP3 is an X-chromosome-linked factor that controls development and function of regulatory T-lymphocytes (Treg). While high expression levels are indeed found in this specialized CD4\(^+\)CD25\(^+\) T cell subset, FoxP3 expression may also specify immune-suppressive activities in activated conventional T cells [9,10].

In a previous study of patients with stage I/II melanoma we showed that the presence of activated (i.e. GrB\(^+\) and CD8\(^+\)) Tumour Infiltrating Lymphocytes (TILs) predicted favourable outcome. Presence of these TILs was significantly correlated with expression of MHC class I antigen on tumour cells [26,27]. These data suggest that the cellular immune response, although apparently not sufficient to prevent primary tumour growth, is nevertheless able to prevent the occurrence of lymph node and/or distant metastases.

On the basis of these previous observations, we set out to determine if MHC class I status and the presence of GrB\(^+\) or FoxP3\(^+\) T cells in the immune infiltrate of early-stage primary melanomas might be associated with the absence or presence of SLN metastases.

2. Materials and methods

2.1. Patient characteristics

Two groups of patients were selected from the melanoma database of the department of Surgical On-
performed scoring of immunohistochemically stained slides based on at least ten high power fields. A high power field references the area visible using a 400× magnification level. Lymphocytes surrounding the tumour served as an internal control for interpretation of GrB, FoxP3, and MHC class I antigen expression. The difference between melanoma cells and lymphocytes was based on morphological examination. GrB was used as a marker for activated TILs with cytolitic ability and FoxP3 was used as a marker for suppressive TILs [16]. GrB+ and FoxP3+ TILs were scored as either positive (>1 positive TIL per high power field) or negative (<1 TIL per high power field). Expression of HLA-A, HLA-B/C and β2m on melanoma cells was scored semi-quantitatively in steps of 10% from 0% to 100%. The median percentage of tumour cells expressing HLA-A, HLA-B/C and β2m was determined. MHC class I expression was considered preserved if expression of both HLA-A, HLA-B/C and β2m was detected on a higher number of the tumour cells than the median percentage. Cases in which one of the MHC class I antigen markers was expressed below the median percentage, were categorized as “lost MHC class I antigen expression”.

2.4. Statistical analysis

All analyses were performed using the SPSS statistical software (version 12 SPSS, Inc., Chicago, IL). Differences between the groups were analysed using Pearson’s χ2 test or Fisher exact test when appropriate. The Mann–Whitney U-test was used to compare group means. All p values were based on two-tailed statistical analysis. p values ≤0.05 were considered significant.

3. Results

3.1. Patients and clinical characteristics

Clinical characteristics are listed in Table 1. The 20 patients with a SLN metastasis had a median follow-up period of 83 (range: 24–147) months and the 20 patients without a SLN metastasis had a median follow-up period of 102 (range: 65–137) months. Thirty-five patients were free of disease at the time of last follow-up, while one patient in the SLN-positive group died of a disease-unrelated cause and four patients had developed distant metastases resulting in death in two of these patients.

3.2. Presence of sentinel lymph node metastasis correlates with absence of GrB+ TILs in primary melanoma excisional biopsies

In 19 out of the 20 patients selected for negative SLN status, GrB+ TILs (Fig. 1A) were present in the

<table>
<thead>
<tr>
<th>Table 1: Clinical and primary melanoma characteristics of SLN− and SLN+ patients*</th>
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<tr>
<td>Sentinel lymph node</td>
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<tr>
<td><strong>Patients</strong></td>
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<td>Gender (male/female)</td>
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<td><strong>Primary melanoma excisional biopsies</strong></td>
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<td>GrB+ TILs</td>
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<td>MHC class I antigen expression</td>
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<td>Loss**</td>
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*SLN = Sentinel lymph node.

**Defined as <70% (i.e. median) HLA-A/B/C expression (p9).

***Defined as ≥70% HLA-A/B/C expression (p9).
primary tumour. Primary melanomas of 9 patients from the SLN positive group, however, also contained GrB$^+$ TILs. Thus, a direct association with presence of GrB$^+$ TILs and a negative SLN status was not observed. In contrast, absence of GrB$^+$ TILs in the primary tumour was strongly associated with SLN metastasis: primary melanoma excisional biopsies of 12 patients did not contain any GrB$^+$ TILs and for 11 of these 12 patients a metastasis was detected in the SLN ($p = 0.001$, see Table 1). While an inverse correlation between suppressive FoxP3$^+$ T cells and GrB$^+$ effector T cells might a priori have been expected, the opposite was actually found: primary melanomas with GrB$^+$ TILs most often also harbourred FoxP3$^+$ TILs (Fig. 1B and Table 2). The expected correlation between the presence of FoxP3$^+$ TILs in primary tumours and the presence of metastases in SLN was also not observed (Table 1).

3.3. Presence of MHC class I antigen expression on primary tumour cells does not correlate with SLN status

Complete loss of MHC class I antigen expression in the primary melanoma was observed in one case. All other patients showed expression of the three different MHC-I markers ranging from 10% to 100%. Based on the median percentages of positive cells, MHC class I antigen expression was considered preserved if expression of HLA-A/B/C and β2m was detected on $\geq70\%$ of the melanoma cells. No correlation was observed between preserved MHC class I antigen expression and either GrB$^+$ T cell infiltration or SLN status (Table 1).

3.4. Both FoxP3$^+$ and GrB$^+$ TILs are frequently detected in SLN metastases

Paraffin-embedded tissue of the melanoma positive SLN was available from 12 out of 20 patients with
**Table 2**

Expression of MHC class I and presence of GrB\(^+\) and FoxP3\(^+\) TILs in primary melanoma excisional biopsies and SLN metastasis

<table>
<thead>
<tr>
<th></th>
<th>GrB(^+) TILs absent</th>
<th>GrB(^+) TILs present</th>
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<tr>
<td>Primary melanoma biopsy</td>
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<td>FoxP3(^+) TILs</td>
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<td>Absent</td>
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<td>11</td>
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<td>Present</td>
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<td>MHC class I antigen expression</td>
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<tr>
<td>Loss(^*)</td>
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<td>16</td>
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<td>Preserved(**)</td>
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<td>12</td>
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<tr>
<td>SLN metastasis</td>
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<tr>
<td>FoxP3(^+) TILs</td>
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<td>Present</td>
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<tr>
<td>MHC class I antigen expression</td>
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<tr>
<td>Loss(^*)</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Preserved(**)</td>
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</table>

\(^*\) Defined as \(<70\%\) (i.e. median) HLA-A/B/C expression (\(p9\)).

\(^{**}\) Defined as \(\geq70\%\) HLA-A/B/C expression (\(p9\)).

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A SLN metastasis. In most cases both GrB\(^+\) TILs (Fig. 1C) and FoxP3\(^+\) TILs (Fig. 1D) were detected in the metastatic melanoma area (Table 2). In 7 of these 12 patients MHC class I expression was determined, while in the remaining five not enough tumour tissue was left in the tissue blocks after diagnostic examination to make a reliable assessment. Of note, in 6 of the 7 evaluable patients a loss of MHC class I expression was observed. However, no correlation was found between preserved MHC class I expression and presence of GrB\(^+\) TILs.

**4. Discussion**

In this study we demonstrate that absence of GrB\(^+\) TILs in primary melanoma excisional biopsies is strongly associated with SLN metastasis, as GrB\(^+\) TILs were nearly always (19/20 cases) present in primary melanoma excisional biopsies of patients with a negative SLN.

The two groups of patients, either with or without a SLN metastasis, were stratified for relevant covariables, i.e. selected for comparable prognostic factors (Breslow thickness, gender and age). Therefore, the differences in the cellular immune response as we describe in this report, are more likely to be associated with differences in SLN status than with other confounding clinical factors. These results are in line with our previous studies, demonstrating that the presence of activated GrB\(^+\) TILs is strongly associated with a favourable outcome in clinically stage I/II patients [27] and may also have a favourable impact on survival in patients with more advanced melanoma [26]. Furthermore, our data are in accordance with a recent study demonstrating that absence of CD3\(^+\) TILs predicts SLN metastasis in cutaneous melanoma patients [25].

We hypothesize that when GrB\(^+\) TILs are present in the primary tumour, they are capable of inhibiting or delaying the occurrence of melanoma lymph node metastasis. The cellular immune response, however, is apparently not able to clear the primary tumour itself. In a substantial number of cases (9 out of 20) GrB\(^+\) TILs were also observed in the primary tumour of patients with a SLN metastasis. Although absence of GrB\(^+\) TILs in the primary tumour is associated with the presence of SLN metastasis, the reverse is therefore not true. Apparently, an active cellular immune response is not sufficient for prohibiting the spread of melanoma cells to lymph nodes. In 6 of these 9 patients the occurrence of a positive SLN status despite presence of GrB\(^+\) TILs in the primary tumour, might be explained by presence of FoxP3\(^+\) suppressive TILs in the primary tumour. Although it is now accepted that in humans FoxP3 is not an exclusive marker for naturally occurring regulatory T cells (nTregs) as it can be expressed by other effector T cells upon activation, FoxP3\(^+\) T-lymphocytes are considered to be generally suppressive and may be involved in the induction of immunotolerance in lymph node metastases [28,31].
While a novel model for the role of GrB in FoxP3+ Treg-mediated suppression of anti-tumour CD8+ T cells has recently been proposed [7], the actual effector function of GrB in Tregs remains poorly understood. We were unable to detect GrB and FoxP3 co-localization in TILs in the primary tumour (unpublished data) and found no correlation between FoxP3+ TILs and GrB+ TILs, which supports the assumption that the detected GrB+ TILs are likely not Tregs. We hypothesize that presence of FoxP3+ suppressive TILs in the primary tumour, next to GrB+ effector TILs (both markers of possible activation), might result in active suppression of the latter and thus facilitate tumour escape, despite the presence of immune effector cells with a GrB-mediated cytolytic potential. Such local immune suppression might also explain the presence of apparently ineffective GrB+ TILs in SLN metastases, since most of these harboured FoxP3+ TILs as well.

Loss (either partial or total) of MHC class I antigen expression was observed in a significant number of melanomas as described before [8], and is in accordance with our previous results. Loss of MHC class I antigen expression on melanoma cells was nearly always associated with a lack of GrB+ TILs (Table 2). Although no correlation was present between MHC class I antigen expression and SLN status, a trend for association with clinical outcome was observed, because all patients with recurrence of disease (n = 4) showed loss of MHC class I antigen expression. Moreover, the finding of MHC class I loss in 6 out of 7 SLN metastases is highly suggestive of a role for MHC class I down-regulation in early immune escape of melanoma and regional spread to the draining lymph nodes.

In conclusion, absence of GrB+ TILs in primary melanoma excisional biopsies is strongly associated with the presence of SLN metastasis. These data underscore the notion that an activated cellular immune response is important in preventing melanoma cells to disseminate to lymph nodes. In addition, absence of GrB+ TILs in primary melanoma excisional biopsies in immunohistochemistry might be used to predict presence of SLN metastasis. Although confirmation in a larger number of patients is clearly needed, the absence of GrB+ TILs might prove a useful diagnostic tool to distinguish patients with invasive melanoma that might benefit from immediate full regional lymph node dissection.

Acknowledgements

The diagnostic melanoma excisional biopsies we obtained from either our own pathology department or were kindly provided by the pathology departments of the hospitals in which the primary biopsy was taken: MCA (Alkmaar), Gelderse vallei Hospital (Ede), PA laboratory East Netherlands (Enschede), SPALK (Haarlem), Leids cytology laboratory (Leiden), IJsselmeer Hospital (Lelystad), Waterland Hospital (Purmerend), IJzakia Hospital (Rotterdam), Academic Medisch Centrum (Amsterdam), Antoni van Leeuwenhoek Hospital (Amsterdam), St. Lucas-Andreas Hospital (Amsterdam), BovenIJ Hospital (Amsterdam) and Slotervaart Hospital (Amsterdam), all in the Netherlands. Antibodies HCA2 and HC10 to detect MHC class I molecules were kindly provided by Prof. Dr. J. Neefjes, Netherlands Cancer Institute, Amsterdam, The Netherlands.

Financial support: Grant of the VU University medical center. Supported by the Vivax foundation.

References


