

WJG 20th Anniversary Special Issues (6): *Helicobacter pylori****Helicobacter pylori* and gastric mucosa-associated lymphoid tissue lymphoma: Recent progress in pathogenesis and management**

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Abstract

Recent progress in the research regarding the molecular pathogenesis and management of gastric mucosa-associated lymphoid tissue (MALT) lymphoma is reviewed. In approximately 90% of cases, *Helicobacter pylori* (*H. pylori*) infection plays the causative role in the pathogenesis, and *H. pylori* eradication is nowadays the first-line treatment for this disease, which leads to complete disease remission in 50%-90% of cases. In *H. pylori*-dependent cases, microbe-generated immune responses, including interaction between B and T cells involving CD40 and CD40L co-stimulatory molecules, are considered to induce the development of MALT lymphoma. In *H. pylori*-independent cases, activation of the nuclear factor- κ B pathway by oncogenic products of specific chromosomal translocations such as t(11;18)/*API2-MALT1*, or inactivation of tumor necrosis

factor alpha-induced protein 3 (A20) are considered to contribute to the lymphomagenesis. Recently, a large-scale Japanese multicenter study confirmed that the long-term clinical outcome of gastric MALT lymphoma after *H. pylori* eradication is excellent. Treatment modalities for patients not responding to *H. pylori* eradication include a "watch and wait" strategy, radiotherapy, chemotherapy, rituximab immunotherapy, and a combination of these. Because of the indolent behavior of MALT lymphoma, second-line treatment should be tailored in consideration of the clinical stage and extent of the disease in each patient.

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Key words: Gastric lymphoma; Mucosa-associated lymphoid tissue lymphoma; *Helicobacter pylori*; Nuclear factor κ B

Core tip: Recent progress in the research regarding the molecular pathogenesis and management of gastric mucosa-associated lymphoid tissue (MALT) lymphoma is reviewed. *Helicobacter pylori* (*H. pylori*) eradication leads to complete disease remission in 50%-90% of cases. In *H. pylori*-independent cases, activation of nuclear factor κ B pathway by chromosomal translocations such as t(11;18)/*API2-MALT1*, or inactivation of A20 are considered to contribute to the lymphomagenesis. A recent Japanese multicenter study confirmed the excellent long-term outcome of gastric MALT lymphoma after *H. pylori* eradication. Strategies for patients not responding to *H. pylori* eradication should be tailored in consideration of clinical stage and the disease extent in each patient.

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INTRODUCTION

Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT) lymphoma is an indolent non-Hodgkin lymphoma derived from marginal zone B-cells, which occurs in a number of extranodal organs, including the gastrointestinal tract, lung, salivary gland, thyroid, ocular adnexa, liver or skin^[1]. Among these, the stomach is the most frequent site for MALT lymphoma. Gastric MALT lymphoma comprises 40%-50% of primary gastric lymphomas, 20%-40% of all extranodal lymphomas, 4%-9% of all non-Hodgkin lymphomas, and 1%-6% of all gastric malignancies^[2-5]. *Helicobacter pylori* (*H. pylori*) plays a causative role in the development of gastric MALT lymphoma, and the eradication of *H. pylori* leads to a complete disease remission (CR) in 50%-90% of cases^[6,7].

In the present paper, we review the current knowledge on the etiology, diagnosis and optimal management strategies for patients with gastric MALT lymphoma, with special reference to its association with *H. pylori* infection and efficacy of the eradication therapy.

PATHOGENESIS OF GASTRIC MALT LYMPHOMA

H. pylori

A link of *H. pylori* with gastric MALT lymphoma was first suggested in 1991 by identification of the bacteria in the vast majority of patients^[8]. This association was supported by subsequent epidemiological and histopathological studies^[9,10]. Approximately 90% of patients with gastric MALT lymphoma are infected with *H. pylori*^[7,11,12], and about 70% of the cases respond to *H. pylori* eradication^[6,7]. In such responders, survival of the lymphoma cells depends critically upon the microbe-generated immune responses^[13]. Laboratory studies demonstrated that the growth of neoplastic B cells is stimulated by tumor-infiltrating *H. pylori*-specific T-cells, which require interaction between B and T cells involving CD40 and CD40L co-stimulatory molecules^[14-19]. Thus, the genesis of *H. pylori*-dependent gastric MALT lymphoma is now considered as follows: an *H. pylori* infection results in T cell-dependent responses through the classic germinal center reaction, and thus generates reactive B and T cells. The *H. pylori*-specific T cells raised in the reactive component then migrate to the marginal zone/tumor area and provide non-cognate help to autoreactive neoplastic B cells, which may involve stimulation of CD40 and other surface receptors by soluble ligands and cytokines^[13,19].

Recently, Munari *et al.*^[20] reported that high levels of a proliferation-inducing ligand (APRIL) were produced

exclusively by tumor-infiltrating macrophages in *H. pylori*-dependent gastric MALT lymphoma cases, and that macrophages produced APRIL on direct stimulation with both *H. pylori* and *H. pylori*-specific T cells. APRIL is a tumor necrosis factor (TNF) superfamily member known to be important for B-cell development, maturation and survival. It should be noted that APRIL-producing macrophages were dramatically reduced on lymphoma regression induced by *H. pylori* eradication^[20]. These findings suggest that APRIL may also play some important role in the *H. pylori*-dependent lymphomagenesis.

Genetic abnormalities

Genetic abnormalities are common in gastric MALT lymphomas. To date, a number of chromosomal translocations have been described in MALT lymphomas. Among these, t(11;18) (q21;q21)/*API2-MALT1*, t(1;14) (p22;q32)/*BCL10-IGH*, t(14;18) (q32;q21)/*IGH-MALT1* and t(3;14) (p13;q32)/*FOXP1-IGH* are replicable^[1,13,21]. MALT1 and BCL10 proteins are involved in surface immune receptor-mediated activation of the nuclear factor kappa B (NF- κ B) transcription factor; the chromosomal translocations involving these genes are believed to exert their oncogenic activities through constitutive activation of the NF- κ B pathway, leading to expression of a number of genes important for cell survival and proliferation^[21].

In gastric MALT lymphoma, t(11;18)/*API2-MALT1* is the most frequent translocation, which is detected in 15%-24% of cases. The translocation fuses the N-terminal region of *API2* to the C-terminal region of *MALT1* and generates a functional chimeric fusion, which gains the ability to activate the NF- κ B pathway^[13,21]. Clinically, t(11;18) is more frequently associated with absence of *H. pylori* infection, and the majority of the translocation-positive cases do not respond to *H. pylori* eradication therapy^[7,11,21,22]. Interestingly, t(11;18)-positive cases rarely transform to diffuse large B-cell lymphoma (DLBCL)^[23].

Recently, the TNF-alpha-induced protein 3 gene (*TNFAIP3*, *A20*), a negative regulator of NF- κ B, was identified as the target of 6q23 deletion in many cases of MALT lymphoma^[13,24,25]. *A20* mutation and deletion, which lead to A20 inactivation, are preferentially found in MALT lymphoma of the ocular adnexa, salivary glands, thyroid and liver. It is considered that A20-mediated oncogenic activities in MALT lymphoma depend on the NF- κ B activation triggered by TNF or other unidentified molecules^[13]. In gastric MALT lymphomas, however, *A20* deletion was detected only in 2 of 29 (7%) cases examined^[25]. Thus, further investigations are needed to determine to what extent A20 inactivation contributes to the genesis of gastric MALT lymphoma.

DIAGNOSIS OF GASTRIC MALT LYMPHOMA

Histopathological diagnosis

The diagnosis of gastric MALT lymphoma should be

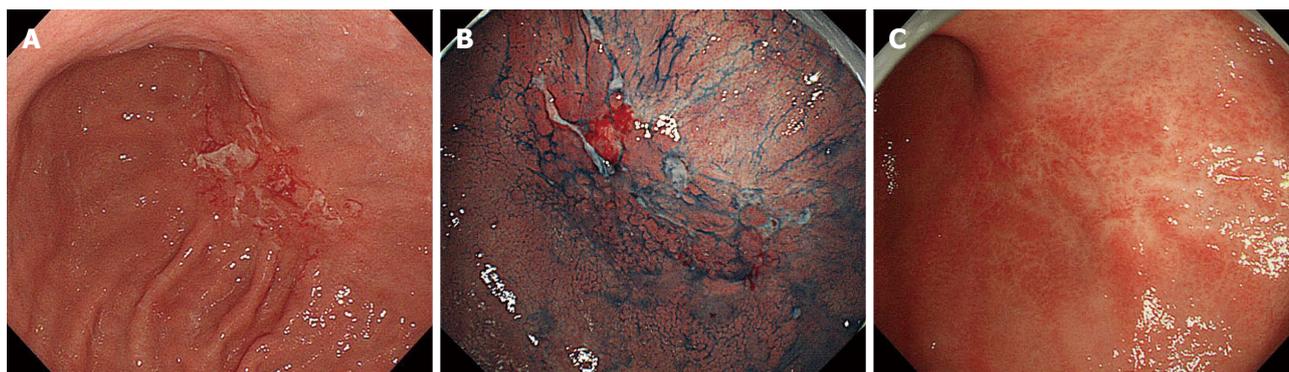


Figure 1 Endoscopic images of gastric mucosa-associated lymphoid tissue lymphoma, superficial type. A, B: Pretreatment images; a superficially depressed lesion with multiple erosions and small ulcers with reddish granular mucosa can be seen on the posterior wall of the angularis; C: Follow-up image 6 mo after *H. pylori* eradication showing regression of the initial lesion.

Table 1 Lugano staging system for gastrointestinal lymphomas

Stage	Definition	Description
Stage I	Tumor confined to gastrointestinal tract	Single primary site or multiple, non contiguous lesions
Stage II	Tumor extending into abdomen from primary gastrointestinal site	
	Nodal involvement	
	II ₁ local	Paragastric (gastric cases) or paraintestinal (intestinal cases) nodal involvement
	II ₂ distant	Mesenteric, paraaortic, paracaval, pelvic or inguinal nodal involvement
Stage II E	Penetration of serosa to involve adjacent organs or tissues	Gastrointestinal lesion extending to involve adjacent organs, <i>i.e.</i> , penetration, direct invasion, perforation or peritonitis by lymphoma
Stage IV	Disseminated extranodal involvement, or supra-diaphragmatic nodal involvement	Cases with Ann-Arbor stage III disease should be included

Rohatiner *et al*^[31] with modification.

based on the histopathological criteria according to the World Health Organization classification, using tissue specimens appropriately obtained by biopsy or surgery^[1,3,26]. Histologically, the small to medium-sized neoplastic lymphoid cells (centrocyte-like cells) infiltrate around reactive follicles showing marginal zone growth pattern, which often infiltrate into gastric glands causing destruction of the epithelial cells (lymphoepithelial lesions)^[1,26]. Immunohistochemically, the neoplastic cells of MALT lymphoma are usually CD20⁺, CD79a⁺, CD5⁺, CD10⁺, CD23⁺, CD43^{+/−}, cyclin D1[−]. Staining for Ki-67 may help in identifying components of DLBCL. Cytogenetic analyses using G-banding, reverse transcription-polymerase chain reaction and/or fluorescence *in situ* hybridization for t(11;18)/*API2-MALT1* or other chromosomal translocations are also useful for confirming the diagnosis^[1,21,26].

Macroscopic diagnosis

The standard macroscopic classifications for gastric lymphomas have not been established. In Western countries, gastric B-cell lymphomas have been endoscopically classified either as ulcerative (34%-69%), mass/polypoid (26%-35%), diffusely infiltrating (15%-40%), or other types^[27-29]. We previously reported that 197 Japanese cases of primary gastric B-cell lymphoma (MALT lymphomas

and DLBCLs) were macroscopically classified as superficial-spreading (46%), mass-forming (41%), diffuse-infiltrating (6%), or other types (8%)^[30]. Importantly, the most frequent macroscopic type in gastric MALT lymphomas is superficial type (Figure 1), while that in gastric DLBCLs is mass/polypoid type^[29,30].

Clinical staging

An appropriate clinical staging is mandatory in order to determine the optimal management for malignant lymphomas. For the staging classification in patients with gastric MALT lymphoma, the Ann Arbor staging system with its modifications by Musschoff and Radaszkiewicz (I₁E, I₂E, II₁E, II₂E, III E, or IV) was recommended in the consensus report of the EGILS (European Gastro-Intestinal Lymphoma Study) group^[26]. To date, however, the Lugano International Conference (Blackledge) classification (I, II₁, II₂, II E, or IV) has been widely applied for the clinical staging in gastrointestinal lymphomas (Table 1)^[31]. In addition to esophagogastroduodenoscopy, the following are recommended for the initial staging workup: physical examination (including peripheral lymph nodes and Waldeyer's ring), complete hematological biochemical examinations (including LDH and β 2-microglobulin), computerized tomography of abdomen and pelvis, and endoscopic ultrasonography^[26].

Table 2 Groupe d'Etude des Lymphomes de l'Adulte histological grading system for post-treatment evaluation of gastric mucosa-associated lymphoid tissue lymphoma

Score	Lymphoid infiltrate	LEL	Stromal changes	Clinical significance
CR	Absent or scattered plasma cells and small lymphoid cells in the LP	Absent	Normal or empty LP and/or fibrosis	Complete remission
pMRP	Aggregates of lymphoid cells or lymphoid nodules in LP/MM and/or SM	Absent	Empty LP and/or fibrosis	Complete remission
rRD	Dense, diffuse or nodular extending around glands in the LP	Focal LEL or absent	Focal empty LP and/or fibrosis	Partial remission
NC	Dense, diffuse or nodular	Present, "may be absent"	No changes	Stable disease or progressive disease

Copie-Bergman *et al.*^[34] with modification^[26]. LEL: Lymphoepithelial lesions; LP: Lamina propria; MM: Muscularis propria; SM: Submucosa; CR: Complete histological response; pMRP: Probable minimal residual disease; rRD: Responding residual disease; NC: No change.

In our opinion, however, ileocolonoscopy, bone marrow aspiration or biopsy, and fluorine-18 fluorodeoxyglucose positron emission tomography should also be included. In addition, endoscopic examinations of the small bowel (balloon-assisted endoscopy or capsule endoscopy) can be considered^[32].

TREATMENT FOR GASTRIC MALT LYMPHOMA

H. pylori eradication

The first-line treatment of all gastric MALT lymphomas is *H. pylori* eradication therapy^[1,26,33]. In patients with stage I / II₁ disease, CR is achieved in 50%-90% of cases only by *H. pylori* eradication^[6,7]. Histological evaluation of post-treatment biopsies should be performed according to the Groupe d'Etude des Lymphomes de l'Adulte (GELA) grading system (Table 2)^[26,34]. Various predictive factors for resistance to *H. pylori* eradication therapy have been described, including absence of *H. pylori* infection, advanced stage, proximal location in the stomach, endoscopic non-superficial type, deep tumor invasion in the gastric wall, and t(11;18)/API2-MALT1 translocation^[6,7,21,22,26].

In a systematic review of the data from 32 published studies that included 1408 patients with gastric MALT lymphoma, the CR rate after *H. pylori* eradication was 78%^[6]. Recently, we confirmed excellent long-term outcomes of the disease after *H. pylori* eradication by a large-scale multicenter study of 420 Japanese patients with gastric MALT lymphoma^[7]. In the study, CR was achieved by *H. pylori* eradication in 77% of patients. During the follow-up periods of up to 14.6 years (mean 6.5 years, median 6.04 years), treatment failure was observed in 9% of patients (37 patients; 10 relapse, 27 progression). Probabilities of freedom from treatment failure, overall survival and event-free survival after 10 years were 90%, 95% and 86%, respectively. Table 3 summarizes 28 previously published studies that included more than 20 patients initially treated by *H. pylori* eradication^[7]. In the 28 studies, CR was achieved in 1361 of 1877 patients (73%), Progressive disease (PD) was observed in 17 of 1576 patients (1.1%), relapse was recorded in 60 of 1203 CR

patients (4.9%), and treatment failure (PD or relapse) was found in 118 of all 1877 patients (6.3%). These data are almost similar to those in our multicenter study^[7], except for PD rate (1.1% *vs* 6.4%).

As for the regimen for *H. pylori* eradication therapy, proton pump inhibitor (PPI) + clarithromycin-based triple therapy composed of a double dose of a PPI plus clarithromycin and amoxicillin or metronidazole for 7 or 14 d is recommended^[26,35]. In the areas where the clarithromycin resistance rate exceeds 15%, use of this drug should be avoided without prior susceptibility testing^[35]. A pooled data analysis in 1271 patients with gastric MALT lymphoma from 34 studies showed a successful eradication was achieved in 91% of cases after the first-line treatment, and the eradication rate was extended to 98% after the second-line treatment or more attempts^[36].

Several studies have demonstrated that *H. pylori* eradication therapy is also effective even in cases with gastric DLBCL^[37,38]. In those reports, 27%-60% of *H. pylori*-positive patients with DLBCL in stage I / II₁ achieved CR after *H. pylori* eradication. Not only cases with MALT lymphoma component, but also cases without any evidence of MALT lymphoma responded to eradication therapy^[37,38]. Therefore, *H. pylori* eradication should be tried in *H. pylori*-positive patients with gastric DLBCL.

Treatments for patients not responding to *H. pylori* eradication

The management strategy for the patient with gastric MALT lymphoma who does not respond to *H. pylori* eradication still remains to be elucidated. While patients with PD or clinically evident relapse should undergo oncological treatment, for patients with persistent histological lymphoma without PD (responding residual disease or no change), a "watch and wait" strategy was recommended up to 24 mo after *H. pylori* eradication in the EGILS consensus report^[26].

As for the second-line oncological treatment, radiotherapy is highly effective in localized cases (stage I / II₁)^[7,26,33]. While chemotherapy and immunotherapy with rituximab are also effective, these systemic treatments are suitable for cases with an advanced stage^[26,33]. Recently, the combination of rituximab and chlorambucil^[39] or fluda-

Table 3 Review of literature on efficacy of *Helicobacter pylori* eradication for gastric mucosa-associated lymphoid tissue lymphoma n (%)

Author, yr	Patients	CR cases	Median FW (yr)	PD	Relapse	Treatment failure ¹
Hancock et al, 2009	199	92 (46)	ND	ND	ND	25 (13)
Wündisch et al, 2006	193	146 (76)	2.3	0	5 (3.1)	5 (2.6)
Wündisch et al, 2005	120	96 (80)	6.3	0	3 (3.1)	3 (2.5)
Stathis et al, 2009	102	66 (65)	6.3	ND	ND	16 (16)
Kim et al, 2007	99	84 (85)	3.4	0	5 (5.9)	5 (5.1)
Nakamura et al, 2005	96	62 (65)	3.2	7 (7.3)	4 (6.4)	11 (11)
Hong et al, 2006	90	85 (94)	3.8	0	8 (9.4)	8 (8.9)
Fischbach et al, 2004	88	73 (83)	3.8	2 (2.3)	4 (5.5)	6 (6.8)
Nakamura et al, 2008	87	57 (66)	3.5	1 (1.1)	1 (1.8)	2 (2.3)
Savio et al, 2000	76	71 (93)	2.3	0	6 (8.5)	6 (7.9)
Terai et al, 2008	74	66 (89)	3.9	0	3 (4.5)	3 (4.1)
Sumida et al, 2009	66	47 (71)	3.3	0	0	0
Weston et al, 1999	58	40 (69)	1.8	0	0	0
Ono et al, 2010	58	48 (83)	6.3	2 (3.4)	1 (2.1)	3 (5.2)
Andriani et al, 2009	53	42 (79)	5.4	0	9 (21)	9 (17)
Akamatsu et al, 2006	47	30 (64)	3.1	1 (2.1)	1 (3.4)	2 (4.3)
Pinotti et al, 1997	44	30 (68)	1.8	0	2 (6.7)	2 (4.6)
Urakami et al, 2000	44	42 (95)	1.7	0	0	0
Ruskoné-Fourmestraux et al, 2001	44	19 (43)	2.9	1 (2.3)	2 (11)	3 (6.8)
Steinbach et al, 1999	34	14 (41)	3.4	2 (5.9)	0	2 (5.9)
Takenaka et al, 2004	33	26 (79)	ND	0	0	0
Chen et al, 2005	32	24 (75)	5.8	0	3 (13)	3 (9.4)
Lee et al, 2004	28	24 (86)	2.0	0	1 (4.2)	1 (3.6)
Montalban et al, 2005	24	22 (92)	4.6	0	1 (4.5)	1 (4.2)
de Jong et al, 2001	23	13 (57)	3.1	1 (4.3)	0	1 (4.4)
Raderer et al, 2001	22	15 (68)	2.1	0	1 (6.7)	1 (4.6)
Dong et al, 2008	22	13 (59)	1.5	0	0	0
Yamashita et al, 2000	21	14 (67)	0.8	0	0	0
Total of above	1877	1361 (73)	3.3	17 (1.1 ²)	60 (4.9 ³)	118 (6.3)
Nakamura et al ^[7] , 2012	420	323 (77)	6.04	27 (6.4)	10 (3.1)	37 (8.8)

¹Progressive disease (PD) or relapse; ²17/1576 patients; ³60/1203 complete remission (CR) patients (Nakamura et al^[7] with modification). FW: Follow-up; ND: Not described.

rabine^[40] provided excellent responses in patients with MALT lymphoma of variable organs, including gastric cases. Surgical resection is nowadays restricted to the management of cases with perforation or bleeding that cannot be controlled endoscopically^[26].

CONCLUSION

While a large amount of clinical evidence has confirmed the validity of *H. pylori* eradication as the first-line treatment for gastric MALT lymphoma, there are many choices for the second-line treatments. Because of the indolent behavior of MALT lymphoma, the strategy for patients not responding to *H. pylori* eradication should be tailored in consideration of the clinical stage and extent of the disease. Despite the recent advances in our understanding of the pathogenesis of gastric MALT lymphoma, there still exist many questions to be answered. Further basic and clinical research is needed to clarify the molecular mechanisms in the development of the disease.

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