Expression profile of apoptosis-related genes in childhood adrenocortical tumors: low level of expression of BCL2 and TNF genes suggests a poor prognosis

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Abstract

Background: Impaired apoptosis has been implicated in the development of childhood adrenocortical tumors (ACT), although the expression of apoptosis-related gene expression in such tumors has not been reported.

Methods: The mRNA expression levels of the genes CASP3, CASP8, CASP9, FAS, TNF, NFKB, and BCL2 were analyzed by quantitative real-time PCR in consecutive tumor samples obtained at diagnosis from 60 children with a diagnosis of ACT and in 11 non-neoplastic adrenal samples. BCL2 and TNF protein expression was analyzed by immunohistochemistry.

Results: A significant association was observed between tumor size ≥ 100 g and lower expression levels of the BCL2 (P=0.03) and TNF (P=0.05) genes; between stage IV and lower expression levels of CASP3 (P=0.008), CASP9 (P=0.02), BCL2 (P=0.002), TNF (P=0.05), and NFKB (P=0.03); Weiss score ≥ 3 and lower expression of TNF (P=0.01); unfavorable event and higher expression values of CASP9 (P=0.01) and lower values of TNF (P=0.02); and death and lower expression of BCL2 (P=0.04). Underexpression of TNF was associated with lower event-free survival in uni- and multivariate analyses (P<0.01). Similar results were observed when patients with Weiss score < 3 were excluded.

Conclusion: This study supports the participation of apoptosis-related genes in the biology and prognosis of childhood ACT and suggests the complex role of these genes in the pathogenesis of this tumor.

Introduction

Adrenocortical tumors (ACT) are rare childhood neoplasias with a very low incidence in children, corresponding to only 0.2% of pediatric cancers (1, 2, 3). However, in Southern Brazil, an inherited germline TP53 mutation (p.R 337H) greatly increases the predisposition to the development of childhood ACT, estimated to be 10–15 times higher than the worldwide incidence, and this mutation has been found in over 80% of Brazilian patients with childhood ACT (4, 5, 6).

In children, ACT appear more often during the first 5 years of life and normally cause endocrine disorders, the most common being virilization alone or in combination with hypercortisolism (2, 3). The differentiation of malignant and benign forms of childhood ACT is difficult and, to date, there are no histological or molecular markers that can reliably distinguish between them (1, 2).

It has been speculated that malignant transformation could originate from abnormal persistence and/or defective apoptosis of the fetal adrenal cortex (7, 8, 9), and although some studies have been conducted on cell lines (10), the role of apoptosis-related genes in childhood ACT has not been evaluated.

The study of apoptosis-related genes in ACT could be important not only to promote new insights into the biology of ACT but also to determine potential prognostic and therapeutic markers. On this basis, the aim of this study was to evaluate the gene expression profile of key genes related to apoptosis (CASP3, CASP8, CASP9, FAS, BCL2, TNF, and NFKB) by
Materials and methods

Subjects

Sixty consecutive pediatric patients with ACT diagnosed between October 1991 and July 2009 at two reference centers in Southeast Brazil (Faculty of Medicine of Ribeirao Preto, University of Sao Paulo, and Centro Infantil Boldrini, Campinas) were enrolled in the study. All patients underwent appropriate clinical and hormonal investigation. Following the biochemical tests, abdominal computed tomography (CT) and/or magnetic resonance imaging (MRI) were performed. Additionally, chest CT and bone scintigraphy were performed for the detection of metastases. Disease stage was classified according to the Sandrini classification (11) and the histological diagnosis was based on the criteria of Weiss (12). Eleven non-neoplastic adrenal cortex samples from children aged 2–6 years were used as control. Samples were obtained during nephrectomy due to Wilms’ tumor before any chemotherapy. Adrenal invasion was excluded by conventional microscopy. The study was approved by the local ethics committees (protocol numbers 9374/2003 and 8380/2010), and a signed statement of informed consent was obtained from the parents of the pediatric patients and control subjects.

We evaluated 46 girls and 14 boys with a mean age at diagnosis of 40.5 months (range: 5–187 months). Hormone-secreting tumors were diagnosed in 57 patients: 37 were androgen-secreting tumors, 18 mixed cortisol- and androgen-secreting tumors, and two cortisol-secreting tumors. Two patients had non-secreting tumors and one had no available data. Thirty-five patients were classified as stage I, ten as stage II, eight as stage III, and seven as stage IV according to Sandrini’s classification. The TP53- p.R337H mutation was evaluated by direct DNA sequencing and was found in 52/60 (86.6%) patients with ACT. Forty-six patients (76.6%) had Weiss classification scores ≥3, 13 had scores <3, and one had an undetermined score. Clinical and pathological features including gender, age, histology according to Weiss classification, clinical presentation, tumor size, stage, TP53-p.R337H mutation, and follow-up status are described in Supplementary Table 1, see section on supplementary data given at the end of this article.

Analysis of overall survival (OS) revealed a higher 5-year OS for patients younger than 4 years (90.6 vs 53.8%; P=0.004), with tumor size <100 g (97.2 vs 48.5, P<0.0001), which was marginally significant compared with patients classified as Weiss criteria <3 (100 vs 74.8%, P=0.05). When we analyzed survival according to Sandrini’s classification, the 5-year OS was 96.9, 68.6, 68.6, and 33.3% for stages I, II, III, and IV respectively (P=0.001). OS did not differ regarding TP53 R337H status (P=0.16). Follow-up ranged from 8 to 168 months (median: 68.3 months) and three patients were lost to follow-up. These data are shown in Table 1.

The characteristics of our sample regarding clinical data such as age, sex, stage, clinical symptoms, survival, and prognostic factors were similar to those described by the International Pediatric Adrenocortical Tumor Registry (IPACTR) (1) and the frequency of the TP53-p.R337H mutation was also similar to that observed in other Brazilian childhood ACT series (4, 5, 6).

mRNA quantification by real-time PCR (RT-PCR)

The frozen tumor tissue and control adrenal cortex samples were microdissected by an experienced pathologist for exclusion of tissue areas presenting necrosis or not matching ACT diagnostic before RNA extraction. For tumor microdissection, tumor samples were placed on a cooled platform and immediately positioned on the cutting base of the cryostat under Tissue Tek (Fisher Scientific, Pittsburg, PA, USA). After rapid freezing in liquid nitrogen, the sample was cut and immediately

Table 1 Five-year event-free survival (EFS) and overall survival (OS) according to clinical features and Sandrini’s classification.

<table>
<thead>
<tr>
<th>Genes</th>
<th>5-year EFS</th>
<th>P</th>
<th>5-year OS</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;4 years (n: 46)</td>
<td>81.2±6.0</td>
<td>0.002*</td>
<td>90.6±4.5</td>
<td>0.004*</td>
</tr>
<tr>
<td>≥4 years (n: 14)</td>
<td>36.9±13.8</td>
<td></td>
<td>53.8±13.8</td>
<td></td>
</tr>
<tr>
<td>Tumor size</td>
<td></td>
<td></td>
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<tr>
<td>&lt;100 g (n: 40)</td>
<td>88.3±5.5</td>
<td>&lt;0.001*</td>
<td>97.2±2.7</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>≥100 g (n: 20)</td>
<td>36.7±11.6</td>
<td></td>
<td>48.5±12.1</td>
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<tr>
<td>&lt;200 cm³ (n: 44)</td>
<td>84.4±5.9</td>
<td>&lt;0.001*</td>
<td>92.5±4.2</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>≥200 cm³ (n: 16)</td>
<td>35.2±12.4</td>
<td></td>
<td>47.6±13.8</td>
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<tr>
<td>Pathology</td>
<td></td>
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<tr>
<td>Weiss criteria &lt;3 (n: 13)</td>
<td>100.0±0.0</td>
<td>0.01*</td>
<td>100.0±0.0</td>
<td>0.05*</td>
</tr>
<tr>
<td>Weiss criteria ≥3 (n: 46)</td>
<td>60.7±7.9</td>
<td></td>
<td>74.8±7.0</td>
<td></td>
</tr>
<tr>
<td>TP53 R337H status</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Negative (n: 8)</td>
<td>85.7±13.2</td>
<td>0.24</td>
<td>100.0±0.0</td>
<td>0.16</td>
</tr>
<tr>
<td>Positive (n: 52)</td>
<td>68.0±6.9</td>
<td></td>
<td>78.1±6.1</td>
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</tr>
<tr>
<td>Classification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Sandrini)</td>
<td></td>
<td></td>
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<tr>
<td>Stage I (n: 35)</td>
<td>86.8±6.2</td>
<td>0.003*</td>
<td>96.9±3.1</td>
<td>0.001*</td>
</tr>
<tr>
<td>Stage II (n: 10)</td>
<td>54.9±17.2</td>
<td></td>
<td>68.6±15.1</td>
<td></td>
</tr>
<tr>
<td>Stage III (n: 8)</td>
<td>62.5±17.1</td>
<td></td>
<td>68.6±18.6</td>
<td></td>
</tr>
<tr>
<td>Stage IV (n: 7)</td>
<td>28.6±17.1</td>
<td></td>
<td>33.3±19.2</td>
<td></td>
</tr>
</tbody>
</table>

*Statistically significant (P≤0.05) values are in bold.
*One patient with an indeterminate score.
The relative mRNA expression levels of the genes analyzed were quantified using real-time PCR analysis with the ABI PRISM 7700 Sequence Detection System (Applied Biosystems, Inc.). All samples were analyzed in triplicate using GUSB as the reference gene. Each run was completed with a melting curve analysis to confirm the specificity of amplification and the lack of primer dimers. The efficiency (E) of each primer set was tested on dilutions of control cDNA samples and ranged from 1.9 to 2.1. The 2\(^{-\Delta\Delta C_t}\) equation was applied to calculate the relative gene expression (13). The same sample of non-neoplastic adrenal tissue was used as calibrator in all reactions. The median gene expression values of all non-neoplastic adrenal tissues were used as reference and defined as 1. The primers for the CASP3 (sense (S): GGTATCCATGGAGACACTGAA, antisense (AS): GAGTCCATTGATCCGTTC, CASP9 (S: CTGTTCAGGCCCATATGAT, AS: CTGGCCTGTGTCCTCTAAGG), BCL2 (S: ATGTTGTTGGAGACCTGCAA, AS: GCCGATACTTCACAAA), NFKB (S: CTGCAGGCTGCTGCTGCACT, AS: GCCAGGGCTGATTAGAGA), and GUSB (S: GAAAATATGTTGGTGAGAGCGTCAA, AS: GCCGTAACCCCATATGAT) genes were designed in different exons using the Primer 3 program (http://frodo.wi.mit.edu/primer3/) and synthesized by Invitrogen.

**Immunohistochemical analysis**

Immunohistochemical (IHC) studies were performed on a subset of 28 tumor tissue samples. Briefly, 3 µm-thick sections cut from paraffin blocks containing representative tumor samples were mounted on poly-L-lysine-coated slides, deparaffinized, rehydrated, immersed in 10 mmol/l citrate buffer, pH 6.0, and submitted to heat-induced epitope retrieval using a vapor lock for 45 min. The slides were rinsed with PBS and immersed in 3% hydrogen peroxide for 20 min to block endogenous peroxidase. Non-specific protein binding was blocked with normal serum (Vectastain Elite ABC Kit, Universal, Vector Laboratories, Inc., Burlingame, CA, USA) for 30 min. The sections were then incubated with monoclonal primary antibodies specific for BCL2 (dilution 1:100; Dako, Carpenteria, CA, USA or Millipore, Temecula, CA, USA) and TNF (dilution 1:100; Millipore) for 2 h at room temperature (25°C) in a humid chamber. Following washes in PBS, a biotinylated pan-specific universal secondary antibody (Vectastain Elite ABC Kit, Universal, Vector Laboratories, Inc.) was applied for 30 min. Next, the slides were incubated with the avidin–biotin–peroxidase complex (Vectastain Elite ABC Kit, Universal, Vector Laboratories, Inc.) for 30 min and developed with the DAB Peroxidase Substrate Kit, 3,3′-diaminobenzidine + Nyquil (Vector Laboratories, Inc.) for 5 min. The slides were counterstained with Harris hematoxylin, dehydrated, and mounted with Permount (Biomed, Foster City, CA, USA). Normal skin was used as the positive control for all antibodies. As negative controls, all specimens were incubated with an isotype-matched control antibody under identical conditions. Each sample was defined on the basis of percentage of stained cells: negative (< 1%), weak (1–10%), moderate (10–50%), and strong (> 50%).
Table 2 Median (range) relative gene expression values of the genes CASP3, CASP8, CASP9, FAS, BCL2, TNF, and NFκB according to the clinical/biological features of childhood ACT.

<table>
<thead>
<tr>
<th>Feature</th>
<th>CASP3</th>
<th>CASP8</th>
<th>CASP9</th>
<th>FAS</th>
<th>BCL2</th>
<th>TNF</th>
<th>NFκB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>P: 0.46</td>
<td>P: 0.14</td>
<td>P: 0.12</td>
<td>P: 0.43</td>
<td>P: 0.03*</td>
<td>P: 0.05*</td>
<td>P: 0.72</td>
</tr>
<tr>
<td>&lt; 100 g (n: 40)</td>
<td>0.52 (0.00–13.12)</td>
<td>1.38 (0.00–47.65)</td>
<td>0.45 (0.00–1.85)</td>
<td>0.21 (0.00–7.06)</td>
<td>0.41 (0.00–52.37)</td>
<td>2.91 (0.00–1366.2)</td>
<td>0.39 (0.01–2.49)</td>
</tr>
<tr>
<td>≥ 100 g (n: 20)</td>
<td>0.44 (0.00–2.57)</td>
<td>2.42 (0.00–14.54)</td>
<td>0.69 (0.01–2.15)</td>
<td>0.27 (0.04–4.24)</td>
<td>0.05 (0.00–21.67)</td>
<td>0.98 (0.00–93.11)</td>
<td>0.34 (0.08–1.52)</td>
</tr>
<tr>
<td>Pathologya</td>
<td>P: 0.25</td>
<td>P: 0.94</td>
<td>P: 0.29</td>
<td>P: 0.57</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Weiss &lt;3 (n: 13)</td>
<td>0.24 (0.02–13.12)</td>
<td>2.03 (0.00–13.77)</td>
<td>0.39 (0.11–1.48)</td>
<td>0.25 (0.00–7.06)</td>
<td>0.36 (0.00–52.32)</td>
<td>2.69 (0.00–1366.2)</td>
<td>0.39 (0.10–2.49)</td>
</tr>
<tr>
<td>Weiss ≥3 (n: 46)</td>
<td>0.55 (0.00–4.87)</td>
<td>1.97 (0.00–47.65)</td>
<td>0.53 (0.00–2.15)</td>
<td>0.24 (0.00–4.24)</td>
<td>0.04 (0.00–21.67)</td>
<td>0.98 (0.00–93.11)</td>
<td>0.31 (0.01–1.52)</td>
</tr>
<tr>
<td>TP53 R337H</td>
<td>P: 0.44</td>
<td>P: 0.35</td>
<td>P: 0.68</td>
<td>P: 0.92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (n: 8)</td>
<td>0.24 (0.12–0.98)</td>
<td>2.23 (0.00–9.92)</td>
<td>0.51 (0.12–1.86)</td>
<td>0.34 (0.17–7.06)</td>
<td>0.01 (0.00–6.89)</td>
<td>1.49 (0.00–319.77)</td>
<td>0.44 (0.05–1.46)</td>
</tr>
<tr>
<td>Positive (n: 52)</td>
<td>0.52 (0.00–13.12)</td>
<td>2.00 (0.00–47.65)</td>
<td>0.49 (0.00–2.15)</td>
<td>0.20 (0.00–4.45)</td>
<td>0.29 (0.00–52.32)</td>
<td>2.15 (0.00–1366.2)</td>
<td>0.34 (0.01–2.49)</td>
</tr>
<tr>
<td>Stage</td>
<td>P: 0.008*</td>
<td>P: 0.61</td>
<td>P: 0.03*</td>
<td>P: 0.06</td>
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</tr>
<tr>
<td>IV (n: 7)</td>
<td>0.09 (0.00–0.44)</td>
<td>1.96 (0.00–14.54)</td>
<td>0.22 (0.01–0.65)</td>
<td>0.11 (0.00–4.24)</td>
<td>0.01 (0.00–0.08)</td>
<td>0.45 (0.00–49.91)</td>
<td>0.09 (0.05–0.74)</td>
</tr>
<tr>
<td>Other (n: 53)</td>
<td>0.56 (0.00–13.12)</td>
<td>2.01 (0.00–47.65)</td>
<td>0.50 (0.00–2.15)</td>
<td>0.25 (0.00–7.06)</td>
<td>0.72 (0.00–52.32)</td>
<td>2.16 (0.00–1366.2)</td>
<td>0.39 (0.01–2.49)</td>
</tr>
<tr>
<td>I (n: 35)</td>
<td>0.53 (0.00–13.12)</td>
<td>1.38 (0.00–47.65)</td>
<td>0.47 (0.00–1.85)</td>
<td>0.21 (0.00–7.06)</td>
<td>0.56 (0.00–52.32)</td>
<td>3.54 (0.00–578.40)</td>
<td>0.44 (0.01–2.49)</td>
</tr>
<tr>
<td>Other (n: 25)</td>
<td>0.44 (0.00–2.27)</td>
<td>2.31 (0.00–14.54)</td>
<td>0.67 (0.01–2.15)</td>
<td>0.25 (0.00–4.24)</td>
<td>0.04 (0.00–21.67)</td>
<td>1.22 (0.00–1366.2)</td>
<td>0.27 (0.05–1.52)</td>
</tr>
<tr>
<td>Eventb</td>
<td>P: 0.09</td>
<td>P: 0.68</td>
<td>P: 0.01*</td>
<td>P: 0.74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remission (n: 42)</td>
<td>0.58 (0.01–13.12)</td>
<td>2.00 (0.00–13.77)</td>
<td>0.44 (0.00–1.85)</td>
<td>0.22 (0.00–7.06)</td>
<td>0.34 (0.00–52.32)</td>
<td>2.48 (0.00–1366.2)</td>
<td>0.35 (0.01–2.49)</td>
</tr>
<tr>
<td>Death/relapse (n: 17)</td>
<td>0.39 (0.00–2.28)</td>
<td>1.96 (0.00–47.65)</td>
<td>0.82 (0.01–2.15)</td>
<td>0.32 (0.00–4.24)</td>
<td>0.07 (0.00–21.67)</td>
<td>0.58 (0.00–93.11)</td>
<td>0.40 (0.05–1.52)</td>
</tr>
<tr>
<td>Follow-upc</td>
<td>P: 0.09</td>
<td>P: 0.09</td>
<td>P: 0.09*</td>
<td>P: 0.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alive (n: 47)</td>
<td>0.57 (0.00–13.12)</td>
<td>2.00 (0.00–47.65)</td>
<td>0.47 (0.00–1.86)</td>
<td>0.22 (0.16–7.06)</td>
<td>0.36 (0.00–52.32)</td>
<td>2.17 (0.01–1366.2)</td>
<td>0.35 (0.01–2.49)</td>
</tr>
<tr>
<td>Death (n: 10)</td>
<td>0.43 (0.00–13.12)</td>
<td>1.92 (0.00–14.54)</td>
<td>0.69 (0.01–1.60)</td>
<td>0.37 (0.04–4.24)</td>
<td>0.01 (0.00–0.87)</td>
<td>0.58 (0.00–49.91)</td>
<td>0.20 (0.05–2.49)</td>
</tr>
</tbody>
</table>

*Statistically significant (P ≤ 0.05) by Mann–Whitney U test are presented in bold.
*One patient with indeterminate histology was not analyzed.
*One patient with no data available.
*Three patients were lost from follow-up.
### Statistical analysis

The association of the variables age (< vs ≥ 4 years), tumor weight (< vs ≥100 g), tumor size (< vs ≥ 200 cm³), TP53-p.R377H mutation (positive vs negative), pathology (Weiss criteria < 3 vs Weiss criteria ≥ 3), disease stage according to Sandrini’s classification at diagnosis (stage IV vs other and stage I vs other), event-free survival (EFS) (death/relapse vs complete remission), OS (death vs alive) and the expression levels of each gene analyzed was determined by the Mann–Whitney U test. Survival analysis was carried out based on Kaplan–Meier curves, using −2-fold of the gene expression observed in the control samples as cutoff points for EFS, with relapse and/or death due to any cause considered as unfavorable events, and for OS, with death considered as an unfavorable event. Curves for different groups were compared by the log-rank test. The Cox proportional regression model was used for multivariable analysis of prognostic factors and also to estimate the association between lower or higher −2-fold expression values and risk of an unfavorable event or death, with calculation of the hazard ratio and 95% confidence interval. Three patients were lost to follow-up after relapse and were analyzed only for EFS and censored at the time of relapse. One patient had no information about the relapse date and was excluded from the EFS analysis. The correlation between the expression values of the genes studied was determined by the Spearman correlation coefficient. The level of significance was set at P ≤ 0.05 in all analyses. Data were analyzed using the SPSS Graduate Pack 15.0 software (SPSS, Inc., Chicago, IL, USA).

### Results

#### Expression of apoptosis-related genes in ACT and non-neoplastic controls

Compared with non-neoplastic adrenal samples, ACT presented significantly lower expression levels of genes EAS (−4.2-fold, P = 0.004) and NFKB (−2.9-fold, P = 0.02) (Fig. 1). Patients classified as having carcinomas (Weiss score ≥ 3) had significantly lower expression of genes EAS (P = 0.003), BCL2 (P = 0.03), and NFKB.

![Figure 2](https://viafreeaccess.org)
Expression of apoptosis-related genes and clinical and biological characteristics

A positive correlation was observed by the Spearman test between the FAS gene and genes CASP3 (correlation coefficient 0.48, \( P < 0.001 \)), CASP8 (correlation coefficient 0.30, \( P = 0.01 \)), and CASP9 (correlation coefficient 0.32, \( P = 0.007 \)). A positive correlation was also observed between BCL2 and TNF (correlation coefficient 0.32, \( P = 0.007 \)) and NFKB (correlation coefficient 0.49, \( P < 0.001 \)), indicating a common and uniform activation of these two groups of genes, regardless of the heterogeneity of the clinical stage of the sample studied.

TNF underexpression was more pronounced in ACT with \( \geq 100 \) g, Weiss scores \( \geq 3 \), classified as stage IV, and presence of unfavorable event (relapse or death). BCL2 underexpression was found in ACT with \( \geq 100 \) g, \( \geq 200 \text{ cm}^3 \), stage IV, and in association with death event. Underexpression of CASP3, CASP9, and NFKB was also associated with stage IV classification. Overexpression of CASP9 was associated with unfavorable events. These data are shown in Table 2 and Fig. 2. It is interesting to point out that in our study, the mean BCL2 gene expression was significantly higher in patients with mitotic index \( \leq 5/50 \text{ HPF} \) (8.84 vs 0.42, \( P = 0.002 \)).

In order to analyze a possible correlation between the expression levels of apoptosis-related genes and 5-year EFS and OS, the patients were divided into two groups using \(-2\)-fold decreased expression values of non-neoplastic adrenal samples to define low expression. Lower expression of the TNF gene was associated with a lower EFS (34.6 vs 83.0\%, \( P = 0.001 \)) and lower expression of CASP9 with a higher 5-year EFS (84.1 vs 57.4\%, \( P = 0.03 \)) (Fig. 3).

Low expression of TNF was also an independent unfavorable prognostic factor (\( P = 0.001 \)) when analyzed in combination with age (\( P = 1.00 \)) and tumor size \( \geq 100 \text{ g} \) (\( P = 0.002 \)). No significant differences were observed in EFS or OS for the other genes. When we analyzed only patients classified as having carcinomas, similar results were observed with several of the genes analyzed, showing a significant association with clinical and biological features, as illustrated in Fig. 4.

A lower 5-year EFS was observed for patients with low expression of the TNF gene (24.2 vs 76.6\%, \( P = 0.002 \)) and CASP3 (41.9 vs 78.8\%, \( P = 0.03 \)) (Fig. 5). Multivariable analysis showed that TNF expression below \(-2\)-fold was an independent unfavorable prognostic factor (\( P = 0.01 \)) when analyzed in combination with age \( \geq 4 \text{ years} \) (\( P = 0.97 \)) and tumor size \( \geq 100 \text{ g} \) (\( P = 0.04 \)).

Expression of BCL2 and TNF determined by IHC and survival

The BCL2 and TNF protein expression was evaluated by IHC, and the results were similar to those observed by RQ-PCR. Of the 28 ACT samples analyzed for BCL2 protein, ten (35.7\%) presented strong cytoplasmic immunoreactivity (> 50\% of the cells), while immunoreactivity was moderate (10–50\% of the cells) in six (21.4\%) and negative or weak (<10\%) in 12 (42.9\%). In the group with strong/moderate immunoreactivity for BCL2 protein, the median relative mRNA expression detected by RQ-PCR was 0.375, and in the group with expression <10\%, the median mRNA expression was 0.007. Regarding TNF, cytoplasmic immunoreactivity was strong in ten (35.7\%), moderate in four (14.3\%), and negative or weak (<10\%) in 14 (50\%). In the group with strong/moderate immunoreactivity for TNF protein, the median of relative mRNA expression detected by RQ-PCR was 1.896, and in the group with expression <10\%, the median mRNA expression was 0.056.

The 5-year EFS was higher in patients with strong/moderate BCL2 immunoreactivity (92.9 vs 33.3\%, \( P = 0.002 \)), as also was the 5-year OS (100 vs 54.5\%, \( P = 0.05 \)). Regarding TNF, patients with strong/moderate immunoreactivity had a higher 5-year EFS (83.3 vs 48.6\%, \( P = 0.10 \)) as well as a higher 5-year OS (100 vs 66.7\%, \( P = 0.04 \)). A representative BCL2 and TNF IHC staining is shown in Fig. 6.

Discussion

During the embryologic period, the fetal cortex corresponds to 85% of the adrenal cortex and disappears rapidly after birth due to a massive apoptosis process (7, 14, 15). Similarities exist between normal
Apoptosis-related genes in ACT

The study of apoptosis-related genes in a tumor so closely related to the control of this pathway (16, 17) has been little studied until now. It is interesting to point out that in the only study using gene expression analysis in childhood ACT by microarray (15), which analyzed 24 ACT (five adenomas, 18 adenocarcinomas, and one undetermined tumor) and seven non-neoplastic samples obtained by Wilms tumor surgery, no difference was observed in the genes analyzed in this study. The small number of cases analyzed by West et al. (15) and the different approaches used (RQ-PCR vs microarray) could be responsible for these differences. Despite the wide range of gene expression values, some of them such as CASP9, CASP3, NFKB, TNF, and BCL2 showed a significant association with clinical and prognostic features.

CASP9 is an apoptosis-related cysteine protease that plays a central role in intrinsic and mitochondrial apoptosis pathways. Once activated, caspase 9 cleaves and activates the effector caspases 3 and 7, which target key proteins for proteolysis to induce cell death (18). The association of higher CASP9 expression with a higher chance of unfavorable events in ACT detected in this study may be surprising. Very few reports on a prognostic influence of CASP9 expression in cancer have been published until now, with conflicting results. In large B-cell lymphomas, inhibition of CASP9 was strongly associated with a poor response to chemotherapy (19). However, as described here, other studies have...
associated higher expression levels of \( \text{CASP9} \) with poor survival in colon carcinomas (21) and with the metastatic potential of non-small-cell lung cancer (21). The real significance of this association remains to be determined.

Lower expression of \( \text{CASP3} \) was observed in patients classified as stage IV and was also associated with a higher risk of unfavorable events (relapse/death) in patients with Weiss criteria \( \geq 3 \). In agreement with our findings, the association of lower levels of \( \text{CASP3} \) with a poor prognosis has been described in several human cancers including gastric carcinomas (22), ovarian carcinomas (23), hepatocellular carcinomas (24), childhood acute lymphoblastic leukemia (25), and esophageal cancer (26).

\( \text{NFkB} \) is a member of inflammation-related transcription factors that is activated in several human cancers and can promote or oppose tumor development. Its activation elevates the expression of several cell cycle, antiapoptotic, and inflammation-related genes, including \( \text{BCL2} \) and \( \text{TNF} \) (27, 28). The activation of \( \text{NFkB} \) has been classically described as capable of inducing antiapoptotic proteins resulting in an increase in proliferation, inhibition of apoptosis, and stimulation of angiogenesis (27, 28, 29). There is also strong evidence of inhibitory effects on tumor development in models of chemically induced skin and liver cancers (29, 30). This evidence that \( \text{NFkB} \) has an inhibitory effect on some kinds of cancers could explain its low expression levels in more advanced stages of childhood ACT as observed in this study.

\( \text{TNF} \), a major inflammatory cytokine, is being reported to exert both positive and negative effects on human neoplasias (31). In this study, a lower level of mRNA expression of this gene was significantly associated with poor prognostic factors. Similar associations were also observed at the protein level when analyzed by IHC. In agreement with our results, in adrenocortical cell lines, \( \text{TNF} \) was able to regulate steroidogenesis, apoptosis, and cell viability (32, 33). In these cells, \( \text{TNF} \) increased apoptosis and consequently decreased cell viability (32). This property of apoptosis induction by \( \text{TNF} \) has also been observed in other human cancers (31).

The \( \text{BCL2} \) gene codes an external mitochondrial membrane protein that acts as an antiapoptotic factor. In this study, lower levels of mRNA expression of this gene were significantly associated with poor prognostic factors. The same associations were also observed at the protein level when analyzed by IHC. Contradictory results about \( \text{BCL2} \) expression have been described in cancer cell lines from different human tumors (34). In breast cancer patients, higher expression of \( \text{BCL2} \) has been associated with a good prognosis (35). Similar results have also been reported for esophageal, cervical and head, and neck carcinomas and colorectal adenocarcinomas (36, 37, 38). In Hodgkin’s lymphoma, association of prostate carcinomas, testicular carcinomas, and acute myelogenous leukemia has been described to have opposite effects, with higher expression values being associated with a dismal prognosis (39, 40, 41, 42). The antiapoptotic role of \( \text{BCL2} \) has been well characterized but the exact mechanism by which \( \text{BCL2} \) might exert its protective effect on some kinds of cancers is still unclear. It has been suggested that in some cancers, the antiproliferative effect of \( \text{BCL2} \) could translate into tumor suppression (34, 43). \( \text{BCL2} \) expression prolongs G0, delaying G1 progression and G1-S transition and being able to inhibit cell growth (43). In colon cancer cell lines, \( \text{BCL2} \) inhibited proliferation to the same extent as TP53 (34, 43). This cell growth inhibition by \( \text{BCL2} \) was also observed in lung adenocarcinomas, glioblastoma cell lines, and multi-stage liver carcinogenesis models (34, 43). In this study, the mean \( \text{BCL2} \) gene expression was significantly higher in patients with lower mitotic

![Figure 5](www.eje-online.org)

**Figure 5** Kaplan–Meier plots of cumulative event-free survival (EFS) and cumulative incidence of events according to relative gene expression values below or twofold above the non-neoplastic adrenal samples for \( \text{CASP3} \) (A) and \( \text{TNF} \) (B) in the group of ACT patients with adrenocortical carcinomas (Weiss score \( \geq 3 \)).
index, reinforcing an antiproliferative effect of BCL2 in pediatric ACT.

Despite the wide range of expression values of the genes analyzed, the association of lower mRNA and protein expression values of BCL2 and TNF with classical unfavorable prognostic factors such as age, size, stage, and lower survival in both uni- and multivariate analyses suggests that these genes could be potential prognostic markers in childhood ACT.

Due to the high prevalence of the p.R337H mutation in this patient cohort, the results could not be generalizable to other pediatric ACT cohorts without this mutation. In this way, the prognostic significance of TNF and BCL2 expression must be viewed with caution, remaining somewhat a matter of discussion, and need to be validated in an independent cohort.

Conclusion

In conclusion, this study demonstrated for the first time abnormal expression of apoptosis-related genes in childhood ACT and its association with the biology and prognosis, suggesting a potential role of these genes in the pathogenesis of these tumors. The data presented here show that genes such as TNF and BCL2 have prognostic potential and might be used to improve stratification of childhood ACT.

Supplementary data

This is linked to the online version of the paper at http://dx.doi.org/10.1530/EJE-12-0183.

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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