INTRODUCTION

Wilms Tumor (WT) is the most common malignant renal tumor of children, accounting for approximately 14% of pediatric cancers (1). Although survival rates in WT have been improved in the past decades due to a multidisciplinary therapeutic approach, a certain population of the patients continue to experience poor survival and increased rates of relapse (2). Mutations and abnormal expressions of the 6 WT genes basically contribute to tumorigenesis of WT but other genes also participate in its development. Recent studies have revealed that several genetic abnormalities are associated with a worse prognosis in WT, even in those with localized stage and favorable histology (3, 4).

Neutrophil gelatinase-associated lipocalin (NGAL), a member of the lipocalin superfamily, was first isolated as a 25 kDA glycoprotein covalently bound to matrix metalloprotease 9 (MMP9) in human neutrophils (5). Although initially in neutrophils, it was later found to be expressed in most epithelial cells and to participate in the diverse processes of growth, development, differentiation and tumorigenesis of many tissues (6, 7).

Kidney injury molecule-1 (KIM-1) was first reported as a sensitive and specific biomarker in detecting injury of the proximal tubules in 1998 by Ichimura (8). KIM-1 is a type 1 membrane protein that contains a novel six-cysteine immunoglobulin-like domain and a mucin domain. Structurally, KIM-1 is a member of the immunoglobulin gene superfamily most reminiscent of mucosal addressin cell adhesion molecule 1 (MAdCAM-1). Human KIM-1 is also homologous to the monkey hepatitis A virus cell receptor 1 (HAVcr-1) (9). KIM-1 is expressed at a low level in the normal kidney but is increased dramatically in the post-ischemic kidney (8-10).

Hitherto, many parameters have been suggested as relevant markers for assessing the proliferative activity and tumor cell dynamics of WT (11-13). However, the presence
of NGAL and KIM-1 expressions in WT has not been investigated widely (10). The aim of this study was to explore the importance of these two markers in Wilms tumor and also to investigate the correlations between them, and some clinical prognostic factors such as tumor weight, stage and histological features.

MATERIAL and METHODS

WT resection specimens of 50 cases diagnosed and treated in Dr. Behçet Uz Children’s Education and Research Hospital between 1999 and 2014 were included in this study. The study was approved by the Local Ethics Committee of Tepecik Education and Research Hospital. The staging system developed by the National Wilms Tumor Study Group (NWTS) was used to describe the extent of spread of these tumors (14, 15).

For immunohistochemistry (IHC), hematoxylin and eosin (H&E) staining was used to select appropriate paraffin blocks and to identify the viable tumor areas. IHC was performed by the streptavidin biotin peroxidase method (Invitrogen, Camarillo, 85-9043). Serial 5-µm sections were obtained and these slides were baked over-night at 60°C, dewaxed in xylene, and hydrated with distilled water through decreasing concentrations of alcohol. All slides were treated with heat-induced epitope retrieval in the microwave (in 10mM/L citrate buffer, pH 6.0, for 20 minutes, followed by cooling at room temperature for 20 minutes) and blocked for endogenous peroxidase and biotin. An affinity purified monoclonal mouse antibodies against NGAL (Novus Biologicals, Littleton, USA, NDP1-90331) and KIM-1 (Bioss, Philadelphia, USA, HAVCR1) were used at a dilution of 1: 300. Renal tissue with acute tubular necrosis was used as positive control for KIM-1 and splenic tissue for NGAL (Figure 1). The evaluation was blinded to any of the clinical features and staining patterns were classified according to the severity of staining. For KIM-1, cytoplasmic staining similar to the proximal tubules in control tissues was considered as positive (Figure 2). Focal staining occupying less than 5 % of the field or diffuse weak staining were considered as negative. In previous studies, it was reported that NGAL showed both cytoplasmic and membranous expression in most tissues. Contrary to the other studies, there was no expression of NGAL in tumor cells. We counted the neutrophils that infiltrated the tumors. If there were up to five cells in every high power fields, we evaluated this as negative for NGAL. Spearman Correlation analysis, Mann-Whitney U test, Chi square test and Kaplan-Meier survival analyses were performed for statistical analysis with SPSS 15.0. P values less than 0.05 was considered to be statistically significant.

RESULTS

Surgery, chemotherapy and radiotherapy were the treatment modalities that were applied alone or in combination to the total of 50 patients according to their individual features. We used the NWTS protocol with surgery approach first for patients with unilateral tumor, but pre-operative chemotherapy was added and the combination of drugs was changed for patients with bilateral tumors. In addition, unfavorable histology required radiation therapy, even in some localized diseases. Therefore we classified the histology of all tumors as favorable or unfavorable. Thirty-nine (78%) cases had triphasic tumors, while 11 (22%) were biphasic and the blastemal component was predominant.
These latter 11 cases were evaluated as showing unfavorable histology. In the whole series, 11 patients died at follow-up; 3 of these died because of bilateral tumor, and 4 from conditions apparently unrelated to WT such as pneumonia, sepsis, hepatic insufficiency and veno-occlusive disease.

Twenty-three (46%) of the cases were male while 27 (54%) were female. The mean age was found to be 3.26±2 years (ranging from 5 months to 8 years). The tumor was right-sided in 25 (50%) cases, left-sided in 19 (38%) cases and 6 (12%) cases had bilateral tumors (stage V). The average tumor size was 9.16 ± 2.9 cm in diameter and the average weight of the kidney was 478±312 gr (15). Thirteen (26%) cases were stage I, 18 (36%) cases were stage II, 7 (14%) cases were stage III, 6 (12%) cases were stage IV. Thirty-nine cases were alive (78%), while 11 cases (22%) were deceased. Mean overall survival time was 68.2±39.5 (3-148) months.

The frequency of KIM-1 expression varied between different components in the same tumor. KIM-1 was negative in 13 (26%) cases. Expression was limited in the epithelial component in 19 (38%) cases (Figure 3), while it was limited in the blastemal in 7 (14%) cases (Figure 4) and in mesenchymal areas in 3 (6%) cases. In 8 cases (16%), diffuse KIM-1 expressions were determined (Figure 5). NGAL expressions were determined in only NGAL-positive inflammatory cells within the WTs (Figure 6). In most tumors, less than 5 NGAL-positive neutrophils per high-power field were determined. Therefore NGAL was considered as negative in all WTs.

Figure 3: Cytoplasmic KIM-1 expression in epithelial component in WT (KIM-1; x200).

Figure 4: Cytoplasmic KIM-1 expression in blastemal component in WT (KIM-1; x100).

Figure 5: Diffuse KIM-1 expression in a triphasic WT (KIM-1; x200).

Figure 6: Note the NGAL-positive inflammatory cell within a WT (NGAL; x200).
Most prognostic parameters such as kidney weight (p=0.127), tumor diameter (p=0.271), patient age (p=0.340) and therapy response (p=0.407) were not found to be associated with KIM-1 expression using the Mann-Whitney U and Chi-square Analyses. The overall survival was 61.5±11.7 months in patients with KIM-1 positive tumors while it was 70.8±6.3 months in KIM-1 negative tumors. There were no relationship between the KIM-1 expression and the survival (Log Rank, p=0.932) by Kaplan-Meier Survival Analysis (Figure 7).

KIM-1 expression was positive in all stage I tumors and most stage II and III tumors. In contrast, KIM-1 was determined as negative in most stage IV tumors (Figure 8). While 67.5% of KIM-1 positive tumors were in the early-stage, 46.2% of KIM-1 negative tumors were in the early stage, excluding the bilateral tumors. The Chi square test revealed a relationship between KIM-1 expression and stage that was statistically significant (p= 0.027).

DISCUSSION

NGAL was initially defined as a useful bacteriostatic agent, and was found to be over-expressed in many types of cancers including breast, pancreatic and ovarian cancers (5, 6). The reported effects of NGAL in tumors are contradictory. For example, it was shown to have protumoral effects in breast (16), stomach (17) and esophageal cancers (18). In contrast, some studies showed that NGAL demonstrates antitumor and antimetastatic effect in anaplastic thyroid carcinoma cells (19), prostate cancer (20) and cholangiocarcinoma (21). Recently Wang et al. (22) reported that both NGAL gene and NGAL expression in tumor tissue was down-regulated in head and neck squamous cell carcinoma (HNSCC) and this down-regulation may correlate with tumorigenesis in HNSCC. It was also reported that NGAL could form a complex with MMP-9 to prevent its degradation and increase MMP-9 activity. Moreover, NGAL is bound to siderophores and participates in iron metabolism in mammalians. Thus, iron homeostasis was speculated to be involved with NGAL in promoting cancer. Based on these studies, NGAL was speculated to be a new kind of metastasis biomarker. However, the detailed mechanism has not been totally understood yet (16-22). In the present study, we evaluated the NGAL expression in WT. However, we did not determine NGAL expression in tumor cells or renal tissue. Therefore, we think that NGAL may not have any role in tumorigenesis in WTs.

Clinical investigations have revealed that the prognosis of WT correlates with stage and favorable histology, which is characterized by the presence of all three histological elements and the absence of diffuse anaplasia (12,14,15). These three histological components of WT have different proliferation potentials and different responses to therapy. Hitherto, many studies have revealed these differences. In most reports, the lowest proliferative capacity was determined in the mesenchymal component and this component generally survived after chemotherapy (14,15). In the present study, KIM-1 expression was determined in the early stage tumors. In addition, we determined KIM-1 expressions confined to the epithelial and blastemal components in the most cases. Our results have two important implications. Firstly, the relationship between the KIM-1 expression and stage suggests that KIM-1
may be used an important indicator of localized disease. Secondly, KIM-1 expression is potentially relevant in WT differentiation. However, further research is required to define how KIM-1 expression status can be used to clinical advantage in WT.

As in several body fluids, the urine is a rich reservoir of various substances and extracellular vesicles, directly originating from cells facing the urinary lumen. These substances are secreted by all types of cells under both physiological and pathological conditions. Some of them are accepted as markers of glomerular and tubular damage, as well as of renal regeneration. In addition, some substances appear to be involved in the cell-to-cell communication along the nephron and to emerge as potential amplifying or limiting factors in renal damage. Substances secreted from injured cells may favor the demonstration of fibrosis or disease progression. KIM-1 is one of these substances in the urine and it has been identified as representing an incredible source of information for diagnostic purposes (23). Several studies revealed that KIM-1 is expressed in both proliferating and dedifferentiated epithelial cells in regenerating proximal tubules. In addition, it is an epithelial cell adhesion molecule up-regulated in the cells, which are dedifferentiated and undergoing replication. KIM-1 may play an important role in the restoration of the morphological integrity and function to the post-ischemic kidney. KIM-1 is a sensitive and specific biomarker in detecting injury of proximal tubules in humans and other animals (10,23,24). Recent studies indicate that KIM-1 may play an important role in the tumorigenesis of renal cell carcinomas (10,24). Kidney development is a complex process regulated by transcription factors, proto-oncogenes, and several growth factors that act as signaling molecules and their receptors. WT can be considered as a failure of this transition (11). In this study, we determined KIM-1 expression in most WTs. This finding indicates that urinary KIM-1 may also be a marker in WTs. KIM-1, a marker of tubular damage, may possibly be useful to gain information about tissue damage, regeneration and even tumorigenesis in WTs.

In summary, the preliminary data indicates that KIM-1 is frequently expressed in WT and this expression is negatively associated with stage in WTs. However, further studies are needed to validate these pilot observations and to clarify the functional and physiopathologic significance of this relevance. Contrary to the other studies, we did not determine any association with NGAL protein and tumorigenesis in WT.

CONFLICT OF INTEREST
The authors declared no conflict of interest

REFERENCES


