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# Lymphoproliferative Disease After Intestinal Transplantation Under Primary FK 506 Immunosuppression

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**P**OSTTRANSPLANT lymphoproliferative disorder (PTLD) is a well-recognized complication after transplantation, and has been reported to occur in approximately 2% of organ transplant recipients both with cyclosporine and FK 506 immunosuppression.<sup>1-6</sup> The use of FK 506 in clinical small bowel transplantation has resulted in improved patient and graft survival.<sup>7</sup> This report describes the clinical and pathologic features of PTLT occurring in intestinal transplant recipients treated primarily with FK 506. This complication has been known to be a special risk of intestinal transplantation since the first reports of long survival of multivisceral recipients who were treated with cyclosporine.<sup>8,9</sup>

## MATERIALS AND METHODS

### Case Material

Between May 2, 1990 and August 7, 1993 54 patients received intestinal transplants with or without other abdominal organs using FK 506 as their primary immunosuppressive therapy. This group comprised 18 isolated intestine recipients (I), 26 liver/intestine recipients (L/I), and 10 multivisceral recipients (MV) (1 MV without the liver or modified multivisceral). Within this population 29 pediatric patients were transplanted, including 5 I, 20 L/I, and 4 MV recipients.

Immunosuppressive therapy (induction, and treatment of rejection) was as previously described and based on FK 506 as primary drug.<sup>7</sup>

### Pathologic Studies

All available surgical and autopsy specimens as well as Epstein-Barr virus (EBV) serologic data were reviewed. The evaluation of PTLT lesions included histopathology, analysis of clonal status, and demonstration of EBV (by in situ hybridization for EBER).

## RESULTS

### Patient Population and Tumor Incidence

Eight cases of PTLT were identified. Four occurred in males and 4 occurred in females (M:F ratio, 1/1). The age of these recipients at the time of transplantation ranged from 1.7 to 44 years. Six patients were children, with a mean age of 4.1 years. The time between the date of organ transplant and the date of disease presentation ranged between 24 days and 2.3 years; however, 6 patients presented after 10 months posttransplant (mean of 1.2 years). These 8 cases represent 14.8% of the total study population. The overall incidence in adult recipients was 8%, and the overall incidence in pediatric recipients was 20.6%. The distribution of cases relative to the graft type revealed 5 cases in L/I grafts, and 3 cases in MV grafts.

Interestingly, the 2 adult patients were recipients of MV grafts.

### Clinical Presentation and Location of PTLT

Symptoms of fever, weight loss, and malaise were common (4 patients), although nonspecific, initiating a work-up and a search for infection and/or rejection. One patient presented with hemolysis and diarrhea. A lymphadenopathic presentation was noted in 2 patients (22%) and localized to the head and neck region in 1 patient and generalized in the other. Six patients (66.6%) had involvement of the gastrointestinal tract presenting as nodular ulcerated tumors. The intestinal graft was involved with disease in 5 patients (55.5%) and generally presented with vomiting, diarrhea, and gastrointestinal bleeding. Of these, 2 patients developed complications related to their graft that included bleeding and intestinal perforation. One patient presented isolated right lung involvement. After resolution of this tumor she later presented spindle cell tumors in the native colon that were positive for EBV at in situ hybridization studies. One patient presented fulminant disseminated disease, a recipient of an MV graft who received intensive therapy for early exfoliative type rejection of the intestine. He developed early onset disease (involving all thoracic and abdominal organs) and died of fulminant PTLT and multisystem organ failure at 2 months posttransplant. Of note, PTLT was identified on routine endoscopy without associated symptoms in 2 patients.

### Pathologic Features of PTLT

The evaluation of PTLT in this series was hindered by sample size and necrosis (when ulcers were present). The range of histology was that of activated lymphocytes with a polymorphic appearance, which was seen in all patients. Clonal analysis was feasible in only 4 cases; the lesions were monoclonal in all cases studied. Evidence of EBV DNA was found in all specimens.

Serologic evidence of EBV infection was found in all

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patients, 7 were non primary infections, and 1 was primary.

#### Treatment

Treatment consisted of reduction of immunosuppression combined with intravenous acyclovir or gancyclovir for as long as there were lesions present. Alpha interferon and/or Foscarnet were used in selected cases where there seemed to be rapid progression of disease, extensive disease, recurrent disease, or there had been a history of severe rejection and immunosuppression could not be reduced. In 2 cases the immunosuppression was stopped entirely while there was evidence of clinical disease. In 1 patient immunosuppression was not reduced because of previous repetitive rejections. This patient had resolution of lesions on gancyclovir and alpha interferon. Lesions were followed by a combination of endoscopy, and radiologic studies (computed tomographic scans, plain and contrast films, etc).

#### Outcome

Five of the 8 patients diagnosed with PTLD have survived (mortality of 37.5%) with a mean follow-up of 20 months. Four of these surviving patients have had complete remission of their disease, whereas 1 patient continues to have lesions and is under therapy. Four surviving patients have retained their grafts. All of these patients are presently on maintenance immunosuppression using FK 506. Four patients developed rejection after resolution of their PTLD and required aggressive therapy. Three patients were treated successfully with resumption of maintenance FK 506 therapy and steroids; 1 patient was retransplanted.

The deaths in this series of PTLD occurred in recipients of L/I (n = 2) and MV (n = 1) grafts. The median time from transplant to death as a result of PTLD was 15 months. Of these 3 patients who died all were identified as having residual PTLD at autopsy. Two fatalities (66%) presented severe bacterial and fungal infection as well as multisystem organ failure. One of these patients presented perforation and bleeding of the PTLD lesions. Two of these patients who died had received OKT3 some time during their course. One patient died of iatrogenic administration of an excessive amount of enteral sodium after successful treatment of PTLD. He was found to have recurrent PTLD at autopsy.

#### DISCUSSION

Three identifiable factors could contribute to the higher incidence of PTLD (14.8%) in these intestinal transplant recipients: the lymphoid content of the graft, the aggressive immunotherapy required in these cases, and earlier diagnosis in 2 patients in whom the EBV was identified by in situ hybridization. One patient who was at the lower end

of the EBV infection spectrum before clonal expansion and tumor development was diagnosed after presentation with minimal enlargement of cervical lymph node and flulike symptoms. Hopefully, early diagnosis will improve treatment response.

The time of PTLD onset in these intestinal recipients was later (> 10 months) than in recipients of other kinds of organ transplants.<sup>1-5</sup> However, there were 3 examples of early aggressive disease, from which 2 patients died. The spectrum of lesions was peculiar in that histologically the PTLDs were all within the range of a polymorphic pattern. Also, monoclonality was found in the 4 patients studied, 2 patients with severe disease and 2 patients with a mononucleosis-like picture. The occurrence of spindle cell lesions in 2 patients reflects a significant, as of yet unexplained, deviation from the expected pattern. Complications of PTLD (infections, bleeding, perforation) and late diagnosis have been responsible for death in 2 patients.

Gastrointestinal involvement, of both native and transplanted gut, was the most common site of presentation. A lymphadenopathic presentation is amenable to a rapid and complete remission of their disease, with preservation of graft function.

The mainstay of therapy is above all reduction of immunosuppression to which intravenous acyclovir or gancyclovir is an adjuvant measure. The risk of complete discontinuation of treatment is rejection, which led to retransplantation in 1 patient and left another child with a marginal graft. PTLD was treated successfully in 1 child while maintaining base line immunosuppression.

The role of alpha interferon and foscarnet for the treatment of any PTLD in organ transplant recipients remains to be determined. These agents may be regarded as adjuvant to reduction of immunosuppression in patients with severe disease, or as primary treatment in selected patients for whom reduction of immunosuppression would carry a high risk of rejection.

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