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Association of HLA Class II Allele and Haplotype Frequencies with Chronic Myelogenous Leukemia and Age-at-Onset of the Disease

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Chronic myelogenous leukemia (CML) is characterized by the presence of Philadelphia chromosome resulting from *bcr/abl* translocation. To clarify the association between HLA class II allele and haplotype frequencies in CML, 50 patients referred to Hematology Oncology and Bone Marrow Transplantation (BMT) center, Shariaty Hospital, Tehran, Iran, were randomly selected and compared with a group of 80 unrelated healthy blood donor subjects. HLA class II alleles were determined by PCR-SSP method. The results showed that the frequencies of DQB1*03011 (P=0.01) and DQA1*0505 (P=0.05) were

higher, while that of DQB1*03032 (P=0.04) was lower in patients than in the controls. Regarding age-at-onset, the frequency of HLA-DRB1*07 (P=0.03) and -DQA1*0201 (P=0.03) alleles were higher in patients younger than 35 years. The most frequent haplotypes in our CML patients were HLA-DRB1*11/-DQB1*03011/-DQA1*0505 (P=0.01) and HLA-DRB1*04/-DQB1*0302/-DQA1*03011 (P=0.02). In conclusion, it is suggested that positive and negative association in certain HLA alleles and haplotypes exist in Iranian patients with CML. (Pathology Oncology Research Vol 13, No 1, 47–51)

Key words: chronic myelogenous leukemia, genetic susceptibility, HLA-DRB, HLA-DQA1, HLA-DQB1

Introduction

Chronic myelogenous leukemia (CML) is a malignant hematological disorder that occurs mostly in the fourth and fifth decades of life. In 90% of the patients a translocation exists and can be readily diagnosed by karyotyping. This alteration t(9;22)(q34;q11) results in Philadelphia chromosome formation. Two genes fused together (*bcr* and *abl*) encode the P210 fusion protein with a tyrosine kinase activity.^{7,15} P210 fusion protein as a novel protein to the immune system should be presented to T cells in association with HLA molecules. In this case HLA molecules play an important role in the response of the immune system to tumor cells.^{13,16} In a case-control study designed by Mund-

hada et al to assess the association of HLA alleles with CML in 163 patients and 376 control subjects, a significant positive association was observed between CML and some alleles.⁹ In two other studies HLA-A3, -B8, -DR4¹³ and -Aw19² have been reported as protective markers against CML. In Chinese patients, HLA-DPB1*1301 and -DPB1*20011 frequencies were higher in patients compared to controls.¹⁴ HLA-DRw6 frequency was significantly lower in Sicilian patients than in controls.⁴ Dorak et al studied the frequency of HLA alleles and haplotypes in 169 patients of different ages, and their results indicate a role of HLA-DRB3 and -DRB4 homozygosity as a protective and as a risk factor, respectively.⁵ Moreover, HLA-DRB4 homozygosity frequency was highest in the early age patients, while these patients had the lowest frequency of HLA-DRB3.¹³ In the present study we have analyzed the frequency of HLA-DRB, -DQA1 and -DQB1 alleles and haplotypes in Iranian patients with CML and in a healthy control group. In addition, we have compared the frequency of these alleles in patients of different ages.

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Materials and methods

Sampling and DNA extraction

A total of 50 patients with CML (age 18-69 years, mean 44.6 years, 24 males and 26 females), referred to Hematology Oncology and BMT center at Shariaty Hospital (Iranian referral center for Hematological and Leukemic disorders in Tehran), have been selected for this study. As a control group, 80 unrelated healthy subjects (mean age 32±10 years, 40 males and 40 females) were randomly selected from healthy blood donors admitted to Iranian Blood Transfusion Organization (IBTO). Patients were diagnosed on the basis of cytogenetic studies by the G-banding method and all of them were positive for Philadelphia (Ph) chromosome. Informed consent had been taken from all patients and control subjects participating in this study.

Genomic DNA was extracted from 10 ml peripheral blood in EDTA vacutainers by modified salting-out method.⁸ HLA-DRB1, -DQA1 and -DQB1 typing was performed by polymerase chain reaction based on sequence-specific primers (PCR-SSP), following the method of Olerup and Zetterquist.¹¹ HLA-DRB1, -DQA1 and -DQB1 PCR-SSP kits were supplied by Biotest (Heidelberg, Germany). Taq DNA polymerase was purchased from Roche (Basel, Switzerland). The PCR reactions were carried out in 10 µl volumes. Samples were amplified in Techne genius thermal cyclers, after initial denaturation at 94°C for 2 minutes, fol-

lowed by 10 cycles of 94°C denaturation for 10 seconds, 65°C annealing and extension for 60 seconds, and finally 20 cycles of 94°C denaturation for 10 seconds, 61°C annealing for 50 seconds and 72°C extension for 30 seconds. After amplification, PCR products were run on an agarose gel, and then the gel was interpreted for specific bands using a UV trans-illuminator. The haplotypes were calculated according to Iranian population specific linkage disequilibrium pattern among HLA-DRB, -DQA, and -DQB alleles.¹

Statistical analysis

The differences in allele and haplotype frequencies of HLA alleles in the studied groups were analyzed using the Chi-square test for two by two tables after Yates' correction.⁶ Fisher's exact 2-tailed correction test was used when necessary. Each allele frequency in CML patients was compared to the same allele in controls. The odds ratio (OR) and its 95% confidence intervals (CI) were calculated using the InStat version 3.06 (GraphPad Software, 2003, San Diego, CA, USA), and a P value of 0.05 or less was considered to be significant.

Results

This study included 50 patients with CML and 80 healthy blood donor volunteers as a control group. All of the HLA loci in patients and controls were consistent with Hardy-Weinberg equilibrium. The frequency of each allele and haplotype are shown in Tables 1-4. HLA-DQA1*0505 (P=0.05) and HLA-DQB1*03011 (P=0.01) allele frequencies were significantly increased in our patients compared to controls. Haplotypes more frequent in patients than in controls were HLA-DRB1*11/-DQB1*03011/-DQA1*0505 (33% vs. 19.37%, P=0.01), HLA-DRB1*04/-DQB1*0302/-DQA1*03011 (12% vs. 4.37%, P=0.02) and HLA-DRB1*0101/-DQB1*0501/-DQA1*0104 (3% vs. 0%, P=0.05). On the other hand, three alleles were associated with a reduced risk of developing CML. The frequency of HLA-DRB1*1302 (0% vs. 3.75%, P=0.08), HLA-DQB1*0604 (0% vs. 3.75%, P=0.08) and HLA-DQB1*03032 (0% vs. 4.37%, P=0.04) alleles were decreased in the CML patients.

Homozygosity frequencies were examined for each HLA locus,

Table 1. HLA-DRB1 allele frequencies in Iranian CML patients and controls

DRB1	CML (n=50) (100 alleles)		Control (n=80) (160 alleles)		Odds ratio (95% CI)	P value
	n	%	n	%		
0101	7	7	13	8.12	0.85 (0.33-2.21)	0.81
15	11	11	23	14.37	0.74 (0.34-1.58)	0.55
16	0	0	3	1.87	0.22 (0.01-4.38)	0.29
0301	9	9	12	7.5	1.22 (0.49-3.009)	0.65
0302	1	1	0	0	4.84 (0.19-120.05)	0.38
04	12	12	12	7.5	1.68 (0.72-3.90)	0.27
07	10	10	23	14.37	0.66 (0.30-1.45)	0.34
08	0	0	5	3.12	0.14 (0.007-2.57)	0.16
0901	0	0	1	0.62	0.53 (0.02-13.12)	1.0
1001	1	1	4	2.5	0.39 (0.04-3.58)	0.65
11	33	33	39	24.37	1.53 (0.88-2.65)	0.15
12	1	1	0	0	4.84 (0.19-120.05)	0.38
1301	6	6	12	7.5	0.78 (0.28-2.17)	0.80
1302	0	0	6	3.75	0.11 (0.006-2.12)	0.08
1303	2	2	0	0	8.15 (0.39-171.6)	0.15
1401	6	6	7	4.37	1.40 (0.45-4.28)	0.57
1402	1	1	0	0	4.84 (0.19-120.05)	0.38
DRB3	58	58	76	47.5	1.53 (0.92-2.53)	0.12
DRB4	22	22	36	22.5	0.97 (0.53-1.77)	1.0
DRB5	12	12	25	15.62	0.74 (0.35-1.54)	0.46

showing statistically not significant tendencies for higher prevalence in patients compared to controls in the case of HLA-DR11 (10% vs. 5.43%, $P=0.28$), HLA-DRB3 (34% vs. 21.1%, $P=0.14$) and HLA-DRB4 (4% vs. 2.2%, $P=0.61$).

Regarding age-at-onset in 27 of our patients with available age information, patients were divided into two subgroups, one with patients aged less than 35 and the other with those aged more than 35 years at the disease onset. The remarkable differences between allele frequencies are shown in Table 5. The frequencies of HLA-DRB1*07 (21.87% vs. 0%, $P=0.03$) and HLA-DQA1*0201 (21.87% vs. 0%, $P=0.03$) alleles were higher in patients younger than 35 years. It is interesting in our study that all HLA-DRB1*07-positive patients with information concerning age of disease onset were younger than 35 years, and out of these patients two subjects were homozygous for HLA-DRB4, suggesting that HLA-DRB1*07 is a strong risk factor for early onset of CML in Iranian patients. Homozygosity for HLA-DRB4 reported previously by Dorak et al was not confirmed in this study; for confirmation, however, a larger sample size would be necessary.

Discussion

The P210 fusion protein encoded by $t(9;22)(q34;q11)$ genetic alteration should be recognized by the immune system as an endogenous protein. Although originally it was thought that endogenous intracellular proteins, like P210, would only be presented by HLA class I molecules and exogenous proteins by HLA class II molecules, more recent evidence illustrates that HLA class II molecules also carry fragments of endogenous proteins. Reports have been published on both negative and positive associations of *bcr-abl* transcripts with HLA class I and class II alleles. Recently it has been reported that HLA class II alleles such as HLA-DR1, -DR2, -DR3, -DR4 and -DR11 can present endogenous proteins like synthetic *bcr-abl* peptides and induce the generation of T cell responses.^{3,12} Accordingly, we have investigated HLA-DRB1, -DQA1 and -DQB1

allele and haplotype frequencies in Iranian CML patients and controls.

The results of our study showed that, although statistically not significant, HLA-DRB1*11 was more frequent in patients than in the control group (33% vs. 24.37%, $P=0.15$). In contrast, in a Turkish population, HLA-DR11 was considered as a protective marker.⁵ These population differences may be attributable to ethnicity. Posthuma et al claimed that HLA-DR4 diminishes the risk of CML.¹³ However, our study did not support such a role of HLA-DR4, since it showed a statistically not significant trend to be more frequent in patients than in the control group (12% vs. 7.5%, $P=0.27$). In our patients, HLA-DRB1*1302 could not be detected, while it was found in 3.75% of controls ($P=0.08$). Similar results were observed in Japanese patients.¹⁵

Table 2. HLA-DQA1 allele frequencies in Iranian CML patients and controls

DQA1	CML (n=50) (100 alleles)		Control (n=80) (160 alleles)		Odds ratio (95% CI)	P value
	n	%	n	%		
0101	4	4	13	8.12	0.47 (0.15-1.49)	0.30
01021	7	7	20	12.5	0.53 (0.21-1.29)	0.21
0103	11	11	22	13.75	0.77 (0.36-1.67)	0.57
0104	10	10	15	9.37	1.07 (0.46-2.49)	1.0
0201	9	9	21	13.12	0.65 (0.28-1.49)	0.43
03011	13	13	12	7.5	1.84 (0.80-4.22)	0.19
0401	0	0	5	3.12	0.14 (0.007-2.57)	0.16
0505	35	35	37	23.12	1.79 (1.03-3.11)	0.05
05011	11	11	15	9.37	1.19 (0.53-2.72)	0.68

Table 3. HLA-DQB1 allele frequencies in Iranian CML patients and controls

DQB1	CML (n=50) (100 alleles)		Control (n=80) (160 alleles)		Odds ratio (95% CI)	P value
	n	%	n	%		
0201	18	18	30	18.75	0.95 (0.49-1.81)	1.0
0203	0	0	1	0.62	0.53 (0.02-13.12)	1.0
03011	38	38	37	23.12	2.03 (1.18-3.51)	0.01
03012	0	0	3	1.87	0.22 (0.01-4.38)	0.29
0302	10	10	7	4.37	2.43 (0.89-6.60)	0.12
03032	0	0	7	4.37	0.10 (0.005-1.80)	0.04
0305	1	1	2	1.25	0.80 (0.07-8.92)	0.67
0306	0	0	1	0.62	0.53 (0.02-13.12)	1.0
0401	1	1	4	2.5	0.39 (0.04-3.58)	0.65
0501	13	13	22	13.75	0.94 (0.45-1.96)	1.0
05031	4	4	9	5.62	0.69 (0.21-2.33)	0.77
06011	5	5	11	6.87	0.71 (0.24-2.12)	0.61
0602	10	10	20	12.5	0.78 (0.35-1.74)	0.69
0604	0	0	6	3.75	0.12 (0.006-2.12)	0.08

Table 4. HLA class II haplotype frequencies in Iranian CML patients and controls

HLA-DRB1/ -DQB1/-DQA1	CML (n=50) (100 alleles)		Control (n=80) (160 alleles)		Odds ratio (95% CI)	P value
	n	%	n	%		
Haplotypes						
0101/0501/0101	4	4	9	5.62	0.69 (0.20-2.33)	0.77
0101/0501/0104	3	3	0	0	11.52 (0.58-225.6)	0.05
15/0602/01021	7	7	9	5.62	1.26 (0.45-3.50)	0.79
15/06011/0103	4	4	9	5.62	0.69 (0.20-2.33)	0.77
0301/0201/05011	9	9	12	7.5	1.22 (0.49-3.009)	0.65
04/0302/03011	12	12	7	4.37	2.98 (1.13-7.85)	0.02
07/0201/0201	10	10	17	10.62	0.93 (0.41-2.13)	1.0
11/03011/0505	33	33	31	19.37	2.05 (1.15-3.63)	0.01
1301/0602/0103	6	6	8	5	1.21 (0.41-3.60)	0.78
1302/0604/0104	0	0	6	3.75	0.12 (0.006-2.12)	0.08
1401/05031/0104	6	6	7	4.37	1.39 (0.46-4.28)	0.57

Table 5. HLA class II allele frequencies in CML patients aged more vs. less than 35 years

HLA alleles	< 35 years (n=16) (32 alleles)		> 35 years (n=11) (22 alleles)		Odds ratio (95% CI)	P value
	n	%	n	%		
	-DRB1*07	7	21.87	0		
-DRB1*1401	0	0	2	9.09	0.12 (0.00-2.76)	0.16
-DRB4	12	40	3	15.78	3.8 (0.92-15.6)	0.07
-DQA1*0101	0	0	2	9.09	0.12 (0.00-2.76)	0.16
-DQA1*0104	2	6.25	4	18.18	0.30 (0.05-1.8)	0.21
-DQA1*0201	7	21.87	0	0	13.23 (0.71-245.16)	0.03
-DQB1*0201	8	25	2	9.09	3.33 (0.63-17.52)	0.17
-DQB1*0501	3	9.37	5	22.72	0.35 (0.07-1.66)	0.24
-DQB1*05031	0	0	2	9.09	0.12 (0.00-2.76)	0.16

In our population, HLA-DQA1*0505 (35% vs. 23.12%, P=0.05) and HLA-DQB1*03011 (38% vs. 23%, P=0.01) alleles were shown to have positive association with CML. In another study by Mundhada et al a significant positive association was observed with HLA-DQB1*0402, -DQB1*0609 and -DQB1*0201 for b2a2, with HLA-DQB1*0609 for b3a2 and with HLA-DQB1*0502 for e1a2 transcripts. HLA-DQB1*0604 showed a negative association in our patients (0% vs. 3.75%, P=0.08), whereas Mundhada et al reported negative association of HLA-DQB1*0303 and -DQB1*0603 with b2a2 and of HLA-DQB1*0303 with b3a2 transcripts.⁹ As a result it is suggested that HLA-DQB1 alleles have different capabilities to present the P210 fusion protein.

We examined homozygosity at each HLA locus in patients and controls. Homozygosity associations for HLA-DR11 (10% vs. 5.43%, P=0.28), HLA-DRB3 (34%

vs. 21.1%, P=0.14) and HLA-DRB4 (4% vs. 2.2%, P=0.61) were not statistically significant.

HLA-DRB1, -DQA1 and -DQB1 allele frequencies were analyzed in two groups of our patients, divided according to age at onset, as higher or lower than 35 years. We obtained a significant positive association of HLA-DRB1*07 and -DQA1*0201 with early age of disease onset. It seems that HLA-DRB1*07 is preferentially expressed in cases with early age-at-onset of disease in Iranian patients, because seven out of ten HLA-DRB1*07-positive patients aged less than 35 years whereas the frequency of this allele among 11 patients older than 35 years was zero. Since we did not have sufficient age data, we could not examine the age-specific distribution of homozygous genotypes for DRB3 and DRB4 to replicate previous findings.^{5,10} It is suggested that more studies are needed in different ethnic groups to show the homozygosity at different HLA loci and to investigate the risk of CML in individuals with a certain allele or genotype. Knowledge of HLA association with different bcr-abl transcripts would have diagnostic and prognostic implications. It would also help to improve strategies of immunization with bcr-abl peptides against t(9;22) (q34;q11) leukemia.

In conclusion, HLA allele and haplotype associations in our population show some differences from previously published studies on CML. Differences in ethnic background could be behind such controversies.

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