

# Immunohistochemical Expression of Stem Cell Marker Musashi 1(Msi-1) in Colorectal Carcinoma and Its Correlation With various pathologic Parameters

#### Thesis

Submitted for partial fulfillment of Master Degree in Pathology

Presented by

#### Rana Ahmed Mostafa EL-Ghondakly

M.B., B.Ch

Faculty of Medicine-Ain Shams University

Supervised by

#### **Prof. Dr. Nahed Samy Khamis**

Professor Of Pathology
Faculty of Medicine, Ain Shams University

#### Prof. Dr. Hala Sobhy Cousha

Professor Of Pathology
Faculty of Medicine, Ain Shams University

#### Ass. Prof. Dr. Amr Lotfy Farag

Assistant professor Of clinical oncology and nuclear medicine

Faculty of Medicine, Ain Shams University

Faculty of Medicine Ain Shams University 2017



# التعبير المناعى الهيستوكميائى موساشي ١ (Msi-1) في سرطان القولون والمستقيم وارتباطه بمختلف العوامل المرضية

رسالة

توطئة للحصول علي درجة الماجيستر في الباثولوجي مقدمة من

الطبيبة/ رنا أحمد مصطفي الغندقلي بكالوريوس الطب والجراحة العامة- جامعة عين شمس

تحت إشراف

أ.د/ ناهد سامي خميس

أستاذ الباثولوجي

كلية الطب- جامعة عين شمس

أ.د/ هالة صبحي قوشة

أستاذ الباثولوجي

كلية الطب- جامعة عين شمس

أ.م. د/ عمرو لطفى فرج

أستاذ مساعد علاج الأورام والطب النووى

كلية الطب- جامعة عين شمس

كلية الطب

جامعة عين شمس

7.17



سورة البقرة الآية: ٢١



First and foremost thanks to ALLAH, the Most Merciful.

Really I can hardly find the words to express my gratitude to **Prof. Dr. Nahed Samy Khamis**, Professor of pathology, faculty of medicine, Ain Shams University, for her supervision, continuous help, encouragement throughout this work and tremendous effort she has done in the revision of the whole work. It is a great honor to work under her guidance and supervision.

I would like also to express my sincere appreciation and gratitude to **Prof. Dr. Hala Sobhy Cousha**, Professor of pathology faculty of medicine, Ain Shams University, for her continuous directions, help, patience and support throughout the whole work.

I am so thankful to Ass. Prof. Dr. Amr Lotfy Farag, Assistant professor of clinical oncology and nuclear medicine, Faculty of Medicine, Ain Shams University for his helpful guidance and honest effort that assisted me to finish this scientific work.

Last but not least, I dedicate this work to my family, whom without their sincere emotional support, pushing me forward this work would not have ever been completed.

Rana Ahmed Mostafa

#### **Contents**

S	Subjects	Page
•	List of Abbreviations	I
•	List of tables	IV
•	List of Figures	VI
•	Introduction	1
•	Aim of the Work	4
•	Review of literature:	
	Chapter 1: The anatomy and histology of the colo	n 5
	Chapter 2: Colorectal Carcinoma	12
	Chapter 3: Intestinal Stem Cells	72
	Chapter 4: MUSASH I	86
•	Material and Methods	96
•	Results	106
•	Illustrative photos	137
•	Discussion	148
•	Summary	161
•	Conclusion	
•	Recommendations	166
•	References	167
•	Arabic Summary	

### List of Abbreviations

**ABC** : Avidin-biotin-enzyme complex

**ACF** : Aberrant crypt foci

**AJCC** : American Joint Committee of Cancer

**ANOVA** : Analysis of variance

**APC** : Adenomatous polyposis coli

**AS** : Additive score

**BAX** : Bcl-2–associated X protein

BE : Barrett's esophagus BMI : Body mass index

BMP Bone morphogenetic protein
CBCCs Crypt base columnar cells
CC-IC : Colon cancer initiating cell
CD : Cluster of differentiation
CEA : Carcinoembryonic antigen

**c-myc** Avian myelocytomatosis virus oncogene

cellular homolog

CRC : Colorectal carcinoma
CSCs : Cancer stem cells
DAB : Diaminobenzidine
DC Differentiated cell
Double -distilled water
DNA : Deoxy ribonucleic acid
EAC : Esophageal adenocarcinoma

EMT Epithelial mesenchymal transition epithelial cell adhesion molecule Eph/ephrin Erythropoietin–producing human

hepatocellular receptor/ Eph receptor-

interacting protiens

**FAP** : Familial adenomatous polyposis

**FOLFIRI** Combination of 5-fluorouracil, leucovorin,

and irinotecan

**FOLFOX** Combination of 5-fluorouracil, leucovorin,

and oxaliplatin

H&E : Hematoxylin and EosinH2O2 : Hydrogen peroxideHGF : Hepatocyte growth factor

hMLH1 : human mutL homolog 1

**HNPCC** : Hereditary non-polyposis colorectal cancer

**HPs** : Hyperplastic polyps

**IBD** : Inflammatory bowel disease

#### &List of Abbreviations

ICD : Intracellular domain
 IEN : Intraepithelial neoplasm
 IGF2 : Insulin-like growth factor

IL-6 : Interleukin 6

**ISCs** : Intestinal stem cells

ISEMFs
 IUCC
 K-ras
 Intestinal subepithelial myofibroblasts
 International Union for Cancer Control
 Kirsten rat sarcoma viral oncogene

Leucine rich repeat-containing G-protein

coupled receptor 5

MAC staging system : Modified Astler-Coller staging system

**MAP kinase** : Mitogen-activated protein kinase,

MMPsMSIMicrosatellite instability

Msi-1 : Musashi 1

**MyoD** : Myogenic determination factor

NCI : National cancer institute
NEC : Neuroendocrine carcinoma
NET : Neuroendocrine tumor
NICD : Notch Intracellular domain
P VALUE : Probability factor value

PC Progenitor r cell

**PCR** Polymerase chain reaction

**PPARs** : Peroxisome proliferator-activated receptors

RNA : Ribonucleic acid SA : Serrated adenoma

SAC : Serrated adenocarcinoma SCC : Squamous cell carcinoma

SCs : Stem cells

SD: Standard deviation
SHH: Sonic hedgehog

**SPSS** : Statistical Package for Social Sciences

SSA : Sessile serrated adenoma

TB : Tumor budding
TBS : Tris-buffered saline

**TDLU** : Terminal ductal lobular unit

**TDs** : Tumor deposits

**TGF-β** : Transforming growth factor beta

**TGF-β II** : Transforming growth factor beta receptor-II

TNF-α : Tumor necrosis factor α : Traditional serrated adenoma

**U.S** : United states

#### **EList of Abbreviations**

UK WCRF-AICR : United kingdom

The World Cancer Research Fund/American

: Institute for Cancer Research

WHO : W Wnt pathway : W

: World health organization wingless-related integration site

### **∠List of Tables**

# List of Tables

Tab. No.	Subject	Page
Table (1)	The large bowel and its mesentery.	6
Table (2)	Regional lymph node groups in anatomic subsites of the colorectum.	9
Table (3)	Histologic and Genetic Characteristics of Serrated Polyps.	34
Table (4)	The revised Vienna classification of gastrointestinal epithelial neoplasia.	36
Table (5)	Genes implicated in colorectal carcinogenesis.	40
Table (6)	WHO histological classification of tumors of the colon and rectum.	41
Table (7)	WHO Criteria for histologic grading of colorectal adenocarcinoma.	45
Table (8)	Dukes' classification and it's modifications.	57
Table (9)	Astler-Coller classification.	58
Table (10)	TNM staging classification for cancers of the colon and rectum 7 <sup>th</sup> edition, AJCC (2010).	59
Table (11)	Stage Grouping of colorectal cancers.	60
Table (12)	Modified Dukes' staging of colorectal cancer.	99
Table (13)	TNM staging classification for cancers of the colon and rectum 7 <sup>th</sup> edition, AJCC (2010).	100
Table (14)	Stage Grouping.	101
Table (15)	Age in the studied cases.	106
Table (16)	sex distribution of the studied cases.	107
Table (17)	Tumor site distribution in the studied cases.	108
Table (18)	Distribution of cases as regards the tumor size.	109
Table (19)	Distribution of cases as regards the depth of tumor invasion.	111
Table (20)	Distribution of cases as regards Lymph node metastasis.	113
<b>Table (21)</b>	Distribution of cases as regards distant metastasis	114
<b>Table (22)</b>	Stage grouping in studied cases.	116
<b>Table (23)</b>	Modified Dukes' classification in studied cases	117
Table (24)	perineural invasion in studied cases.	119
<b>Table (25)</b>	lympho-vascular emboli in studied cases.	120
<b>Table (26)</b>	recurrence in studied cases.	121
<b>Table (27)</b>	Response of metastasis to chemotherapy.	122
<b>Table (28)</b>	Msi-1 intenisty of staining in the studied cases.	124

## **∠**List of Tables

Table (29)	percentage of Msi-1 stained cells in each case of	125
Table (23)	the studied cases.	
Table (30)	Msi-1 additive score in the studied cases.	127
Table (21)	The relationship between Msi-1 expression and	128
<b>Table (31)</b>	patient's age group.	
<b>Table (32)</b>	The relationship between Msi-1 expression and	128
1 abie (32)	sex.	
Table (22)	The relationship between Msi-1 expression and	129
<b>Table (33)</b>	size.	
<b>Table (34)</b>	The relationship between Msi-1 expression and	129
Table (34)	site.	
Table (35)	The relationship between Msi-1 expression and	130
Table (33)	histologic type.	
<b>Table (36)</b>	The relationship between Msi-1 expression and	130
Table (36)	histologic grade.	
<b>Table (37)</b>	The relationship between Msi-1 expression and	131
Table (37)	depth of tumor invasion.	
Table (38)	The relationship between Msi-1 expression and	132
Table (36)	lymph node status.	
Table (39)	The relationship between Msi-1 expression and	132
Table (33)	distant metastasis.	
Table (40)	The relationship between Msi-1 expression and	133
Table (40)	recurrence.	
Table (41)	The relationship between Msi-1 expression and	134
Table (41)	perineural invasion.	
Table (42)	The relationship between Msi-1 expression and	134
142)	lymphovascular emboli.	
Table (43)	The relationship between Msi-1 expression and	135
Table (43)	TNM stage group.	
Table (44)	The relationship between Msi-1 expression and	135
14516 (44)	Duke`s stage.	
Table (45)	The relationship between Msi-1 expression and	136
1 abic (43)	response of metastasis to chemotherapy.	

# List of Figures

Fig. No.	Subject	Page
<b>Fig.</b> (1)	Macroscopic characteristics of the colon	5
<b>Fig.</b> (2)	vascular supply of the colon	7
<b>Fig.</b> (3)	Normal colonic mucosa.	10
Fig. (4)	Histologic features of hyperplastic polyps	31
Fig. (5)	Histologic features of Traditional serrated adenoma	32
Fig. (6)	Histologic features of sessile serrated adenomas.	33
<b>Fig.</b> (7)	Mixed serrated polyp with tubular adenoma.	34
<b>Fig.</b> (8)	Adenoma-Carcinoma Sequence	39
Fig. (9)	<ul><li>(A) Well-differentiated adenocarcinoma.</li><li>(B) Moderately differentiated adenocarcinoma.</li><li>(C) Poorly differentiated adenocarcinoma.</li></ul>	44
Fig. (10)	Mucinous adenocarcinoma	46
<b>Fig.</b> (11)	Signet ring cell carcinoma	47
Fig. (12)	Medullary carcinoma of the colon.	48
Fig. (13)	Histopathological views reveal adenosquamous carcinoma of the sigmoid colon.	49
Fig. (14)	Rectal squamous cell carcinoma.	50
Fig. (15)	The morphology of SAC. (A)	52
Fig. (16)	Primary colorectal adenocarcinoma with micropapillary features.	54
Fig. (17)	<ul><li>(A) an example of tumor with pushing border</li><li>(B) an example of tumor with infiltrating border</li></ul>	66
<b>Fig.</b> (18)	Tumor budding cells at the invasive front of CRC in a standard H&E stain.	68
Fig. (19)	Peritonelaized and non-peritonealized(radial) surfaces of the colon	71
Fig. (20)	colon crypt showing the positon of stem cells and different cell types	73
Fig. (21)	The organization of the colon crypt and the small intestinal crypt–villus.	74
Fig. (22)	Model of the epithelial-mesenchymal signaling that defines SC niche in normal or cancer intestine	77
<b>Fig.</b> (23)	Cancer stem cell model.	80

Fig. No.	Subject	Page
Fig. (24)	Systemic chemotherapy and loco-regional	83
Fig. (24)	radiation therapy effect on tumor cells.	
Fig. (25)	some strategies for sensitizing colon CSCs	85
Fig. (26)	A diagram of Notch signaling pathway.	89
Fig. (27)	Mechanism of action of RNA binding protein	89
Fig. (21)	and stem cell regulator Msi1.	
Fig. (28)	sex distribution of the studied cases	107
Fig. (29)	Tumor site distribution in the studied cases	108
Fig. (30)	histologic type of the studied cases	109
<b>Fig.</b> (31)	histologic grade of the studied cases	110
Fig. (32)	depth of tumor invasion in studied cases	112
E:- (22)	Distribution of studied cases as regards the	113
Fig. (33)	lymph node metastasis	
E:~ (24)	Distribution of studied cases as regards distant	115
Fig. (34)	metastasis.	
Fig. (35)	Stage grouping in studied cases	116
Fig. (36)	Modified Dukes' classification in studied	118
116. (50)	cases	
<b>Fig.</b> (37)	perineural invasion in studied cases	119
<b>Fig.</b> (38)	lympho-vascular emboli in studied cases	120
Fig. (39)	recurrence in studied cases	121
Fig. (40)	Response of metastasis to chemotherapy	122
E!- (41)	Msi-1 intensity of staining in the studied	124
Fig. (41)	cases	
Fig. (42)	Msi-1 additive score in the studied cases	127
Fig. (43)	Well differentiated adenocarcinoma (grade I),	137
Fig. (44)	Well differentiated adenocarcinoma (grade I),	137
rig. (44)	Negative Msi-1 IHC stain	
	Well differentiated adenocarcinoma (grade I),	138
<b>Fig.</b> (45)	Positive cytoplasmic and nuclear Msi-1 IHC	
	stain (x100), intensity=+1	
	Well differentiated adenocarcinoma (grade I),	138
<b>Fig.</b> (46)	Positive cytoplasmic and nuclear Msi-1 IHC	
	stain (x100), intensity= $+2$	

Fig. No.	Subject	Page
Fig. (47)	Well differentiated adenocarcinoma (grade I), Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity=+3	139
Fig. (48)	Well differentiated adenocarcinoma (grade I), Positive cytoplasmic and nuclear Msi-1 IHC stain (x200), intensity=+3	139
Fig. (49)	Moderately differentiated adenocarcinoma (grade II), H&E x40.	140
Fig. (50)	Moderately differentiated adenocarcinoma (grade II), H&E x100.	140
Fig. (51)	Moderately differentiated adenocarcinoma (grade II), Negative Msi-1 IHC stain (x 100)	141
Fig. (52)	Moderately differentiated adenocarcinoma (grade II), Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity= +2	141
Fig. (53)	Moderately differentiated adenocarcinoma (grade II), Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity= +2	142
Fig. (54)	Moderately differentiated adenocarcinoma (grade II), with cribriform pattern. Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity=+3.	142
Fig. (55)	Moderately differentiated adenocarcinoma (grade II), Positive cytoplasmic and nuclear Msi-1 IHC stain (x200), intensity= +3	143
Fig. (56)	Poorly differentiated adenocarcinoma (grade III), H&E	143
Fig. (57)	Poorly differentiated adenocarcinoma (grade III), H&E X200.	144
Fig. (58)	Poorly differentiated adenocarcinoma (grade III), Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity=+2.	144
Fig. (59)	Poorly differentiated adenocarcinoma (grade III), Positive cytoplasmic and nuclear Msi-1 IHC stain (x200), intensity= +2	145
Fig. (60)	Poorly differentiated adenocarcinoma (grade III), Positive cytoplasmic and nuclear Msi-1 IHC stain (x200), intensity=+3	145

Fig. No.	Subject	Page
Fig. (61)	Poorly differentiated adenocarcinoma (grade III) , Positive cytoplasmic and nuclear Msi-1 IHC stain (x200), intensity=+3	146
Fig. (62)	Mucinous adenocarcinoma, H&E x200	146
Fig. (63)	Mucinous adenocarcinoma, Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity=+2	147
Fig. (64)	Mucinous adenocarcinoma, Positive cytoplasmic and nuclear Msi-1 IHC stain (x100), intensity=+3	147

#### Introduction

Colorectal carcinoma (CRC) is a multifactorial disease with many documented genetic and non-genetic risk factors (*Sharafeldin et al.*,2015).

CRC is a commonly diagnosed and a highly lethal malignancy in both men and women (*Murat et al.*, 2016). It is considered the  $3^{rd}$  most common cancer in men and the  $2^{nd}$  in women (*Ferlay et al.*, 2015).

Since 1998, colorectal carcinoma (CRC) incidence increased at a rate of 1.6 % per year (*American cancer society, 2011*). Nowadays, the estimated new cases per year are 746,000 cases in men and about 614,000 cases in women. This represents 10% of total cancers in men and 9.2 % of total cancers in women (*Ferlay et al., 2015*).

In Egypt, The incidence is estimated to be around 2.5 per 100,000 ( *Ibrahim et al.*,2014 ) with male to female ratio 3: 1 (*Mahfouz et al.*,2014). Moreover, patients under age of 40 reported relatively higher rates than those in the United States for the same age group (*Gado et al.*, 2014).

Despite the progress made in the last few years in its management, it still remains a major health problem (*Yan et al., 2016*). And a leading cause of cancer-related morbidity and mortality worldwide(*Ho MY et al., 2016*).