The Association between Epstein-Barr virus (EBV) Past Infection with the Risk of Oral Squamous Cell Carcinoma (OSCC)

JESINDA P KERISHNAN, MING-KIT MAH, NURUL AIN BINTI MOHD FAWZI, ANAND RAMANATHAN, GHEE-SEONG LIM, AZWATEE ABDUL AZIZ, USHARANI BALASINGAM & YENG CHEN

ABSTRACT

The association of Epstein-Barr virus (EBV) with oral cancer has been widely reported in the past. However, previous studies mainly focused on the current infection of EBV without acknowledging the possibility of past infection in patients which may lead to oral cancer development. The present study aims to investigate the correlation between past EBV infections with Oral Squamous Cell Carcinoma (OSCC). Both Immunoglobulin M (IgM) and Immunoglobulin G (IgG) antibodies against EBV were screened to detect the presence of EBV in sera of OSCC patients using Enzyme-Linked Immunosorbent Assay (ELISA). The use of IgM antibody against EBV confirms current infection in patients, whereas IgG antibody would predict past infection throughout patients’ lifetime. Through the present study, we would be able to confirm whether patients with past EBV infection have a significant risk in developing oral cancer. ELISA tests were carried out to detect the presence of EBV IgG and IgM in 206 OSCC and control serum samples. Statistical analysis was performed using SPSS 12.0.1. Our results had shown that 96.6% (n = 199) of OSCC samples and 97.2% (n = 130) control were positive with EBV VCA IgG, however, none of the OSCC and control samples was positive for EBV VCA IgG. The presence of EBV VCA IgG in both OSCC and control suggest that past EBV infection does not play a significant role as a risk indicator for OSCC. Therefore, the association between EBV and OSCC was not well demonstrated in this study.

Keywords: Enzyme-linked immunosorbent assay; Epstein-Barr virus; immunoglobulin G (IgG); immunoglobulin M (IgM); oral squamous cell carcinoma

INTRODUCTION

Oral cancer is classified under the Head and Neck cancer. It was reported as the sixth most prevalent cancer worldwide (Tang et al. 2015). Oral cancer has been ranked as the 17th most common cancer worldwide and 16th most common cancer with a high mortality rate (Ferlay et al. 2018). Consequently, the mortality rate of oral cancer remains high, which is at approximately 50% of the overall mortality rate (Le Campion et al. 2017). Oral squamous cell carcinoma (OSCC) which originates from
the mucosal lining represents 90% of oral cancer and remains as a major health problem in many parts of the world (Sand & Jaloulı 2014; Syrjänen et al. 2011). The development of OSCC has been widely associated with several known risk factors such as tobacco and betel quid chewing, alcohol consumption and smoking (Acharya et al. 2015; Rosnah et al. 1999). However, there are several other risk factors that have been identified in association with the development of OSCC such as ionising radiation, genetic predisposition, Human Papilloma Virus (HPV) and Epstein Barr Virus (EBV) infection (Kumar et al. 2016; Scully & Bagan 2009).

One of the prominent viruses associated with oral cancer is EBV. EBV is a member of the herpes virus family which infects approximately 90% of the world’s adult population (Danielsson et al. 2018; Sand et al. 2002). EBV is also well known to be associated with infectious mononucleosis, Burkitt’s lymphoma, B-cell lymphoma, Hodgkin’s disease, peripheral T-cell lymphoma, nasopharyngeal carcinoma, oral hairy leukoplasia, gastric carcinoma and OSCC (Macsween & Johannessen 2014; Patel 2014; Prabhu & Wilson 2016; Yen et al. 2009). EBV primary infection occurs within the early years of life with no symptoms, and the virus persists throughout the life in the B-lymphocytes and leads to the shedding of the virus particles from the oral epithelium when re-activated (Jayasooriya et al. 2015; Purushothaman & Verma 2014; Shimakage et al. 2002). In primary infection, EBV infects and replicates in the oropharynx epithelial cells and expresses proteins causing cell proliferation (Cohen 2015; Thompson & Kurzrock 2004). In this phase, antibodies IgG, IgM and IgA are produced in response to EBV Viral Capsid Antigen (VCA) (Hanlon et al. 2014; Thompson & Kurzrock 2004). EBV infected individuals carry EBV throughout their whole life without presenting any illness and this individual usually show an elevated IgG, IgM and IgA in response to EBV VCA antigen by passive absorption. All sera samples were diluted to obtain a uniform concentration using the provided sample diluents. The sample diluents for EBV VCA IgM ELISA contains anti-human IgG. This anti-human IgG precipitated and removed IgG and rheumatoid factor leaving only IgM in the samples to react with the immobilized antigen. The diluted sera samples were then added to the strips and incubated for 25 min at 25°C. After thorough washing, Peroxidase Conjugates goat anti-human IgG (γ chain specific)/IgM (μ chain specific) was added in and the strips were further incubated for 25 min at 25°C. The wells were subsequently washed and 3,3',5,5'-Tetramethylbenzidine (TMB) substrate solution was pipetted into each well and incubated for 15 min at 25°C. The peroxidase substrate solution was added to terminate the enzyme-substrate reaction. These changes were then measured using 450 nm using a microplate reader (Tecan Infinite m200 Pro, Tecan Group Ltd., Mannedorf) spectrophotometrically. EBV antibody’s (IgG or IgM) valence in the samples was detected through optical density (OD) according to the manufacturer’s protocol and was further correlated to the Calibrator. The cut-off level for seropositivity was determined according to the manufacturer’s guidelines. The positive and negative controls were provided with the kit.

**STATISTICAL ANALYSIS**

All statistical analyses in this study were conducted using the Statistical Package for the Social Sciences (SPSS) software version 12.0.1. In addition, to determine whether variables such as EBV IgG/IgM, gender, race and age were predictors of OSCC, logistic regression analysis was conducted. The assumption on independent errors, normality, multicollinearity, nonsoscedasticity, and outliers were examined (Kerishnan et al. 2016).
EBV belongs to the herpes virus family which infects approximately 90% of the world’s adult population (Danielsson et al. 2018; Sand et al. 2002). EBV infection is associated with various cancers such as infectious mononucleosis, Burkitt’s lymphoma, nasopharyngeal carcinoma, oral hairy leucoplaikia and OSCC (Macsween & Johannessen 2014; Patel 2014).

EBV infection was reported to be correspondent to the increased risk of OSCC (She et al. 2017). Studies have shown that EBV infected individuals usually carry the virus throughout their whole life without any symptoms and present elevated EBV VCA-IgG (Hanlon et al. 2014; Jenson 2011). Therefore, it had been suggested that the past or the long-term exposure to viruses may contribute to the onset of OSCC (Gupta & Metgud 2013). Similarly, in our previous association study on Human Papillomavirus (HPV) 16 in OSCC, HPV16 IgG antibodies were identified as a significant indicator of OSCC risk factor and further supporting that past exposure to HPV could increase the risk of OSCC (Kerishnan et al. 2016).

To identify the presence of EBV in patients, many of the previous studies applied methods such as in situ hybridization and polymerase chain reaction (PCR) to detect viral deoxyribonucleic acid (DNA) and ribonucleic acid (RNA) transcripts (Syrränen et al. 2011; Yen et al. 2009). However, these methods are expensive, time-consuming and unable to determine past exposure of EBV (Petter et al. 2000; Salehi et al. 2016). Therefore, in the present study, the presence of both IgG and IgM antibodies against EBV were determined using ELISA. Through IgG and IgM screening, the patients’ past and current exposure status against EBV were confirmed. The presence of IgM antibodies against the virus directly shows acute or current exposure, whereas, IgG antibodies against virus indicate past exposure to the virus.

RESULTS AND DISCUSSION

A total of 206 OSCC patients (cases) and 134 non-OSCC patients (control) representing a mean age of 58.8±14.2 and 33.5±8.6, respectively, were included in this investigation. Based on the socio-demographic profiles of OSCC patient recruited in this study, female (67.0%) Indians (49.5%) were found to be the highest number of patients diagnosed with OSCC (Table 1).

Although the high incidence of oral cancer is generally associated with tobacco smoking, betel quid chewing and alcohol consumption, viruses are also known to play a role in OSCC development (Kumar et al. 2016; Polz-Gruszka et al. 2014). The general causative virus for OSCC includes EBV (Jalouli et al. 2010; Sand & Jalouli 2014).

EBV VCA SEROLOGICAL ANALYSIS

To evaluate the seropositivity of EBV VCA in OSCC (n=206) and control (n=134) patients, EBV VCA ELISA assays were used to detect both EBV VCA IgG and EBV VCA IgM. Based on the analysis, 96.6% of OSCC patients and 97.2% of control were seen positive for EBV VCA IgG, whereas EBV VCA IgM was not detected in both OSCC patients and control (Table 2).

EBV was reported as the most common and widespread human virus with lifelong latent infection (Evans 2013). Most of the normal adults carry EBV throughout their life with no ill effects and these patients usually showed an elevated EBV VCA IgG (Odumad et al. 2011; Riordan et al. 1996). Studies have shown that EBV is able to form a latent infection, of which it remains dormant with low viral expression and minimal cytopathic effects for infection (Sand & Jalouli 2014). Furthermore, since it takes years for cancer to develop, long persistence of EBV infection may likely to contribute to the occurrence of cancer (Farrell 2019). Therefore, our results further support previous studies on the association between EBV and OSCC.

TABLE 1. Socio-demographic profile of OSCC patients and control

<table>
<thead>
<tr>
<th></th>
<th>OSCC samples (n=206)</th>
<th>Control samples (n=134)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of patients</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>33.0</td>
</tr>
<tr>
<td>Female</td>
<td>138</td>
<td>67.0</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malay</td>
<td>47</td>
<td>22.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>35</td>
<td>17.0</td>
</tr>
<tr>
<td>Indian</td>
<td>102</td>
<td>49.5</td>
</tr>
<tr>
<td>Others</td>
<td>22</td>
<td>10.7</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>206</td>
<td>58.8±14.2</td>
</tr>
</tbody>
</table>
On the contrary, none of the OSCC and control was found to be positive for EBV VCA IgM. These results demonstrate that both OSCC patient and control exhibit past EBV infection in early life and therefore seropositivity was only observed in EBV VCA IgG antibodies and not in EBV VCA IgM. The association between viral IgM and OSCC was not well-defined due to the fact that the onset of carcinogenesis by viral infection is influenced by the past infection or the latency of a virus (de Oliveira et al. 2016; Sand & Jalouli 2014).

RISK INDICATOR OF OSCC

To assess whether a certain variable could significantly predict the risk of OSCC, a logistic regression analysis was used. Based on these analyses, independent variables such as gender (female), and race (Indian) and age were identified as a significant contributor in predicting the risk of OSCC (Table 3). However, EBV was not found significant compared with the other variables further suggesting that past EBV infection may not play a significant role as a risk indicator for OSCC.

CONCLUSION

The association of EBV with the development of OSCC has been extensively studied in the past. Even though this association has been widely reported previously (Sand et al. 2014), no safe conclusion was drawn from this (Sand & Jalouli 2014). Similarly, based on our current EBV IgG and IgM results, seropositivity was found in both OSCC and control sample. Therefore, the association between EBV and OSCC was not well demonstrated in this study, further suggesting that past EBV infection does not play a significant role as a risk indicator for OSCC.

ACKNOWLEDGEMENTS

This project was supported by the High Impact Research MoE Grant UM.C/625/1/HIR/MOE/DENT/09 from the Ministry of Education, Malaysia. Samples used in the study were provided by the Oral Cancer Research Coordinating Center (University of Malaya).

REFERENCES


Jesinda P Kerishnan, Ming-Kit Mah, Nurul Ain binti Mohd Fawzi & Yeng Chen* Department of Oral & Craniofacial Sciences Faculty of Dentistry University of Malaya 50603 Kuala Lumpur, Federal Territory Malaysia

Anand Ramanathan Department of Oral & Maxillofacial Clinical Sciences Faculty of Dentistry University of Malaya 50603 Kuala Lumpur, Federal Territory Malaysia

Ghee-Seong Lim & Azwatee Abdul Aziz Department of Restorative Dentistry Faculty of Dentistry University of Malaya 50603 Kuala Lumpur, Federal Territory Malaysia

Usharani Balasingam Faculty of Law University of Malaya 50603, Kuala Lumpur, Federal Territory Malaysia

*Corresponding author; email: chenyeng@um.edu.my

Received: 9 February 2019
Accepted: 11 June 2019