

A Novel Non-Immunoglobulin (*non-Ig*)/*BCL6* Translocation in Diffuse Large B-Cell Lymphoma Involving Chromosome 10q11.21 Loci and Review on Clinical Consequences of *BCL6* Rearrangements

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Abstract *BCL6* rearrangements (3q27) are the most common chromosomal abnormalities in diffuse large B-cell lymphoma (DLBCL), with numerous immunoglobulin (*Ig*) and *non-Ig* genes as partners. In DLBCL, the translocations occur predominantly in the “major breakpoint region” encompassing the first noncoding exon and a part of the first intron of *BCL6*; few cases with “alternative breakpoint cluster” located 245–285 kb 5′ *BCL6* were also described. The regulatory sequences of known *Ig* and *non-Ig* partners replace the 5′ untranslated region of the *BCL6* in the same transcriptional orientation. Contrary to *Ig/BCL6* fusions typical by high *BCL6* gene expression, in *non-Ig/BCL6* translocations were observed unexpectedly low *BCL6* mRNA levels. From the clinical point of view, the survival rate of DLBCL patients with *non-Ig* partners is inferior to those with *Ig/BCL6* translocations, suggesting that *non-Ig/BCL6* fusion is a poor prognostic indicator. Hereby we provide comprehensive information about known *non-Ig* translocation partners and clinical consequences of *BCL6* rearrangements in DLBCL. Moreover, we

describe a novel reciprocal translocation t(3;10) in refractory patient with DLBCL with the breaking points at 5′ untranslated region of *BCL6* and 5′ untranslated region of the *RASGEF1A* gene on chromosome 10q11.21 loci; this rearrangement was associated with low *BCL6* and *RASGEF1A* gene expressions. Our patient harbouring dual chromosomal rearrangement involving *BCL2* and *BCL6* genes relapsed three-times and died soon; thus, further supporting the notion that *non-Ig/BCL6* fusion is a poor prognostic indicator of DLBCL. There is evidence of prognostic value of *BCL6* rearrangements also in rituximab era.

Keywords Diffuse large B-cell lymphoma · *BCL6* rearrangements · *BCL2* rearrangements · Non-immunoglobulin gene translocations · Complex chromosomal changes

Introduction

Diffuse large B-cell lymphoma (DLBCL) is the most common subtype of non-Hodgkin’s lymphomas. This malignancy is characterized by wide variability in clinical outcome and high genetic heterogeneity [1, 2]. The most common chromosomal abnormality in DLBCL is a 3q27 translocation affecting *BCL6* gene, occurring in up to 45 % of patients [3–6].

The *BCL6* gene (3q27) is a proto-oncogene expressed in the course of B-cell differentiation in the germinal centre (GC) [7]. This zinc-finger transcription factor functions as a sequence-specific transcriptional repressor [8–10]. *BCL6* is commonly translocated in DLBCL with diverse partners, including one of three immunoglobulin gene (*IGH*, *IGK*, *IGL*) loci [11–13] or diverse *non-Ig* chromosomal loci [3, 5, 6, 14]. The translocations affecting the *BCL6* gene occur in DLBCL

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predominantly in the major breakpoint region (MBR) encompassing the first noncoding exon and a part of the first intron of *BCL6* [3, 12]; few cases with alternative breakpoint cluster (ABR) located 245–285 kb 5' *BCL6* were also described [15]. As a result, many types of regulatory sequences of known *Ig* as well as *non-Ig* genes replace the 5' untranslated region of the *BCL6* in the same transcriptional orientation and the rearranged *BCL6* is presumed to be under the control of the replaced promoter activity [3]. From the clinical point of view, there is evidence about the influence of 3q27 translocation on the etiopathogenesis of DLBCL. Moreover, the survival rate of DLBCL patients with *non-Ig* partners is inferior to that of those with *Ig/BCL6* translocation, suggesting that *non-Ig/BCL6* fusion is a poor prognostic indicator of DLBCL [16–18].

Here, we review current knowledge about the *BCL6* rearrangements in DLBCL and spectrum of known *non-Ig* fusion partners involved in *non-Ig/BCL6* rearrangements and clinical consequences of *BCL6* translocations in DLBCL. Additionally, we describe of a novel *non-Ig/BCL6* translocation involving chromosome 10q11.21 loci found in refractory posttransplant patient with DLBCL.

Case Description

A 52-year old male was referred to the Department of Haemato-Oncology, University Hospital in Olomouc, with severe B-symptoms including weight loss of 20 kg and abdominal pain caused by a large abdominal tumour mass in June 2006. Laparoscopic biopsy of the small mesenteric lymph node revealed anaplastic subtype DLBCL with a fraction of Hodgkin- and Reed-Sternberg-like neoplastic cells and neoplastic lymphoid cells bearing CD20 and CD30 positivity and Bcl2 positivity. Trepine biopsy and flow cytometry of the bone marrow did not show lymphoma infiltration. Staging was done using a whole-body FDG-PET/CT fusion camera (Siemens Biograph 16); PET-positive enlarged lymph nodes were detected in the mediastinal, retroperitoneal and mesenteric areas. Finally, the Ann Arbor clinical stage was IIIB; the International Prognostic Index (IPI) and age-adjusted IPI were intermediate-high and high, respectively.

Our patient was treated with intensive rituximab (R) - anthracycline-containing sequential protocol [19], followed by up-front autologous stem cell transplantation (ASCT) after BEAM 200 conditioning in February 2007. Treatment response was assessed on day +100 (May 2007) after ASCT using PET/CT and classified as PET-negative complete remission (CR).

At first relapse in September 2010, FDG-PET/CT revealed PET-positive generalized peripheral, mediastinal, retroperitoneal, mesenteric and inguinal lymphadenopathy with maximum lymph node size of 38 mm, PET-positive splenomegaly and FDG bone marrow uptake. Biopsy of the PET-positive

inguinal lymph node confirmed tumour cells expressing CD20, *BCL2* and CD10 (Fig. 1). Based on *BCL6* gene rearrangement and the presence of complex karyotypic changes, the patient was classified as being in the ABC DLBCL prognostic subgroup.

The patient was treated with one cycle of platinum-based salvage therapy (EDHAP), with accompanying severe sepsis. Subsequent therapy with one CHOP-like and one R-Dexa regimen was accompanied by prolonged neutropenia despite the application of pegylated G-CSF. Bone marrow examination excluded therapy-related myelodysplastic syndrome. Lymphoma infiltration was not detectable. PET-positive enlarged lymph nodes were detected in all previously involved areas and response to therapy was reported as stable.

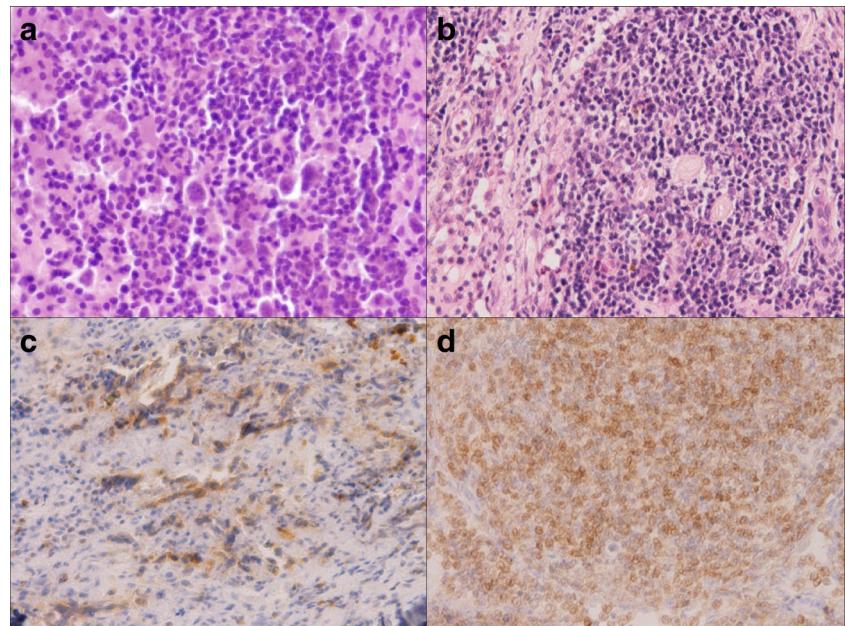
The patient was followed up until subsequent progression of lymphoma in August 2012. The neoplastic cells bore Bcl2 positivity, CD19, CD20, CD22, FMC7 antigens, but were CD10 negative. Due to severe allergic reaction to rituximab, the patient was treated with six cycles of the CHOP regimen (from August 2012 to January 2013). The applied chemotherapy brought about short-term lymphoma control and after 3 months, lymphoma progressed again. Therefore, the patient was shifted to palliative care. In February 2015, after 96-months after ASCT and after three relapses/progressions, the patient died.

Cytogenetic Analysis

At the time of diagnosis, standard cytogenetic analysis was performed on the lymph node and bone marrow samples. In the lymph node, karyotype 79–88, XXY,-Y,-1,-3,-6,-7,-9,-14,-15,-22[cp5]/46,XY [5] was confirmed. In the bone marrow, only normal karyotypes were found (46,XY [10]). Due to the limited amount and quality of lymph node material, only PCR-examination of *BCL2* rearrangement and FISH with LSI IGH/BCL2 DC DF probe (Abbott Molecular, Illinois, USA) were performed with positive result for *BCL2/IgH* rearrangement in the minor cluster region.

At the time of first relapse in September 2010, conventional cytogenetic analysis of the lymph node showed complex karyotype with 49–50 chromosomes in the 9 metaphases karyotyped. In the bone marrow, only normal karyotypes (46,XY [27]) were found. To determine chromosomal and gene rearrangements, FISH was used with the following set of probes: LSI BCL6 DC, LSI IGH/BCL2 DC DF, LSI TP53, CEP 17 (Abbott Molecular), ON 1q21/SRD (1p36), ON 6q23/CEP6 and ON RET (10p11) Break probe (Kreatech, Amsterdam, Netherlands), RET probe (Agilent, Santa Clara, USA) and BAC probes (RP11-124O11, RP11-168L22) (BlueGnome, Cambridge, UK); at least 200 interphase cells were evaluated. Other techniques applied included multicolor FISH (mFISH) with the 24XCyte Human Multicolor probe set

Fig. 1 The histological features of formalin-fixed paraffin-embedded lymph nodes taken at the time of (a) diagnosis and (b) relapse stained with H&E. Immunohistochemistry confirmed Bcl-2 positive expression in neoplastic cells (clone 100, Biogenex (Dako) at (c) the time of diagnosis and as well at (d) the time of 1. relapse. Magnification 200×



(MetaSystems, Altussheim, Germany) and array comparative genomic hybridization (arrayCGH) with 4x44K microarray (BlueGnome) in accordance with the manufacturer's instructions. The arrayCGH result was evaluated with BlueFuse Multi software (BlueGnome).

The arrayCGH method confirmed gains in the region 1q21.1qter and on chromosomes 5, 12 and 17, and loss of 6q12q27. Based on the cytogenetic, FISH, mFISH and arrayCGH analyses, the following complex karyotype in three pathological clones were determined:

48, XY, +X, t(3; 10)(q27; q11.21), der(6)t(1; 6)(q21.1; q12), +12, t(14; 18)(q32; q21)[4]/50, XY, +X, t(3; 10)(q27; q11.21), +5, der(6)t(1; 6)(q21.1; q12), +12, t(14; 18)(q32; q21), +17[3]/53, XY, +X, +Y, t(3; 10)(q27; q11.21), +5, der(6)t(1; 6)(q21.1; q12), +11, +12, t(14; 18)(q32; q21), +17, +22[2].

These findings showed clonal evolution of the clone with 48 chromosomes. This clonal evolution was represented by the required gains of chromosomes 5 and 17 in one and 5, 17, 11, 22 and chromosome Y in the last clone. In all these clones, FISH and mFISH showed two reciprocal translocations: t(14;18)(q32;q21) and t(3;10) with *BCL2* and *BCL6* gene rearrangements, respectively (Fig. 2). As the red signal of *BCL6* probe covering 5' *BCL6* region was detected on chromosome 10, we started mapping the breakpoint on chromosome 10 with RET probes. Whereas the RET probe (Agilent) was located on both chromosomes 10, the RET break-part probe (Kreatech) shows normal fusion signal on chromosome 10 and smaller green/red fusion signal on derivative chromosome 10, and the larger green signal being located on the derivative chromosome 3 (Fig. 2e). The FISH results with BAC probes confirmed the breakpoint located in the 5' non-coding region of *RASGEF1A* gene (Fig. 3). Finally, the breakpoint on chromosome 10 was mapped to the 10q11.21 region. This breakpoint as well as the gene candidate represent the first observation in a DLBCL case, as shown in Table 1, where

the spectrum of known *non-Ig*/*BCL6* translocations reported in DLBCL is summarized.

Gene Expression Profiling of *BCL2*, *BCL6*, *RASGEF1A*

To assess the gene expression level of *BCL2*, *BCL6*, *RASGEF1A* in the lymph node from our DLBCL patients with t(3;10), we performed quantitative RT-PCR and compared the mRNA expression of *BCL2*, *BCL6*, *RASGEF1A* in our patient with lymph nodes of 1) two DLBCL cases with *BCL6* rearrangements such as t(3;14) and t(3;22), and 2) patients with DLBCL without *BCL6* rearrangements (DLBCL, $n=11$); and with peripheral blood from 3) healthy control subjects (C, $n=18$).

Total RNA from the lymph nodes and peripheral mononuclear cells was isolated with mirVana miRNA kit (Ambion, Austin, USA) and reverse transcription was performed with anchored dT primers (Roche Applied Science, Indianapolis, USA) according to the manufacturer's recommendation.

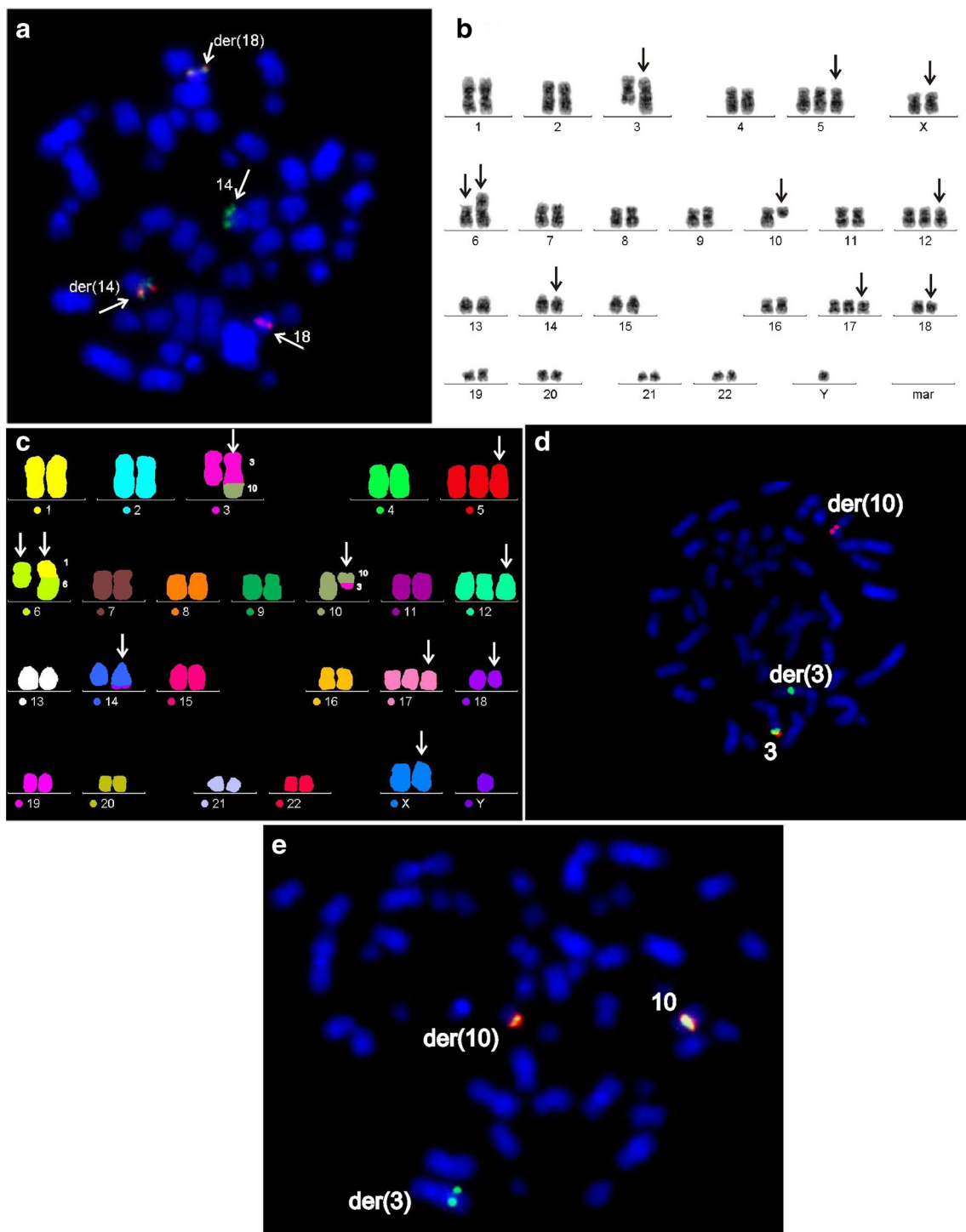


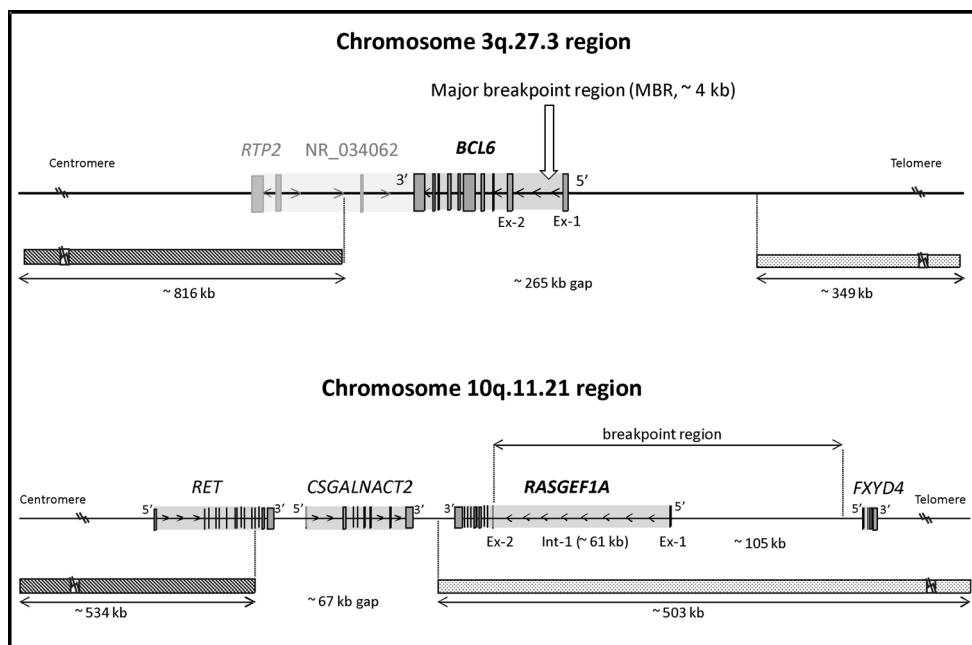
Fig. 2 Cytogenetic and molecular cytogenetic analyses of tumour tissue of our DLBCL patient. **a** FISH result with LSI *BCL2*/*IgH* Dual Colour, Dual Fusion Translocation probe (Abbott Molecular) confirming *t*(14;18) with fusions on *der*(14) and *der*(18). **b** Karyogram (G-banding technique) documenting complex chromosome aberrations detected in one of the three malignant clones (changes are indicated by *arrows*). **c** mFISH complex karyotype (changes are indicated by *arrows*). **d** FISH with LSI *BCL6*

Dual Colour Break Apart probe (Abbott Molecular) confirming a break of *BCL6* gene and location the 5' untranslated region of *BCL6* gene (*red* signal) on derivative chromosome 10. **e** FISH with the *RET* (10q11) Dual Colour Break Apart Probe (Kreatech) confirming the break and location of a green/red signal *RET* on derivative chromosome 10 and larger green signal of probe on derivative chromosome 3

Quantitative PCR was performed using TaqMan probes (*BCL2*: Hs00608023_m1, *BCL6*: Hs00153368_m1, Life

Technologies; *RASGEF1A*: Hs.PT.58.3776983, *PGK1*: Hs.PT.39a.1406561, Integrated DNA Technologies) on

Fig. 3 Diagram of positions of FISH break-apart probes for *BCL6* rearrangements at chromosome 3q27 and those for chromosome 10q11.21 loci



Rotor-GeneQ (QIAGEN Inc., Valencia, CA) as described elsewhere [62]; a second-derivative method was used for calculations (RotorGene Software 6.1.81, QIAGEN Inc.); *PGK1* as a reference gene [63]. Data analysis was performed using GraphPad Prism 5.01 (GraphPad Software, La Jolla, CA, USA).

Our qRT-PCR analysis revealed that novel *non-Ig/BCL6* translocation involving chromosome 10q11.21 loci in our DLBCL patient was associated with low mRNA expression of *BCL6* and *RASGEF1A* genes comparing to i) DLBCL patient with t(3;22), ii) patients with DLBCL without *BCL6* rearrangements and iii) healthy control subjects (Fig. 4). Additionally, we confirmed upregulated gene expression of *BCL6* in our DLBCL patient carrying also *BCL2/IgH* rearrangement.

Role of *BCL6* in Normal Cells and in B-Cell Lymphomagenesis

To gain deeper knowledge about the consequences of *BCL6* gene rearrangements, we need to clarify the role of *BCL6* in normal cells and in B-cell lymphomagenesis. A direct target of *BCL6* in germinal centre (GC) B-cells is the anti-apoptotic proto-oncogene *BCL2*, thus an important function of *BCL6* in facilitating apoptosis of GC B-cells is the suppression of *BCL2* [64]. Further, *BCL6* controls BCR signalling through repression of the SYK phosphatase, PTPROT; thus, being involved in a *BCL6*-dependent pro-survival pathway in B-cell lymphomagenesis [65]. *BCL6* is also required for GC B-cells to proliferate and tolerate the DNA damage that occurs as a by-product during *Ig* affinity maturation [66]. *BCL6* mediates these effects by direct binding and repressing the replication checkpoint and DNA damage sensor encoding gene *ATR*, as well as the key

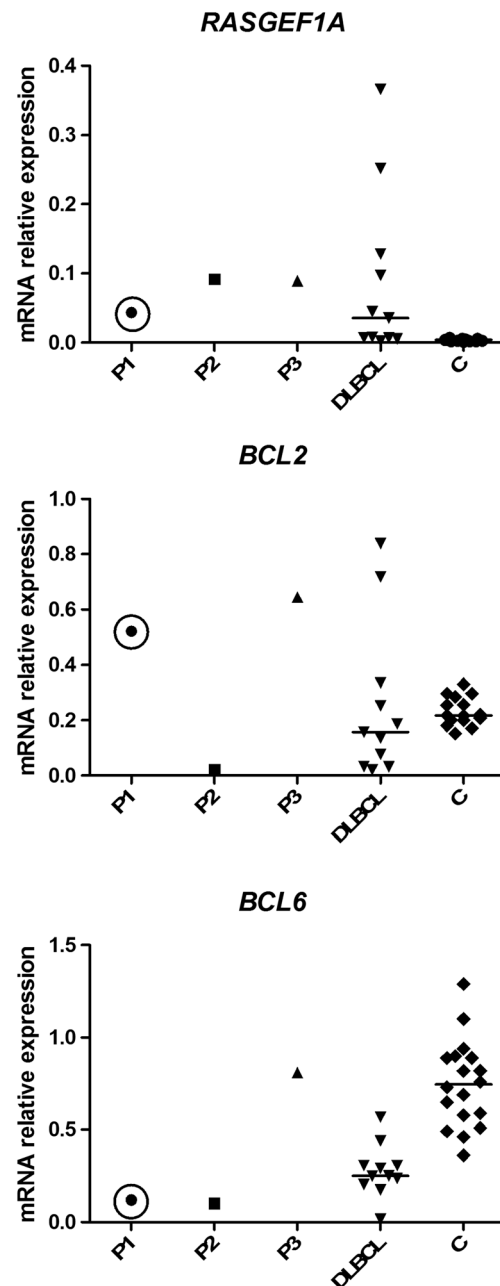
checkpoint genes *CHEK1*, *TP53*, *CDKN1A*, *CDKN2A* and *p14ARF* [67–70]. Next, downregulation of *BCL6* is a prerequisite for GC B-cells to mature toward plasma cells, because *BCL6* is a repressor of *PRDM1*, a master regulator of plasma cell differentiation [67, 71]. Nevertheless, *BCL6* contains the negative regulatory regions within the first exon and intron of the *BCL6* gene and can, therefore, autoregulate its own expression [72]. However, the exact role of *BCL6* in DLBCL pathogenesis is still limited because only few genes have been functionally characterized as direct targets of *BCL6* transrepression activity.

BCL6 Gene Rearrangements in DLBCL

BCL6 gene rearrangements belong to the most common aberrations observed in DLBCL [3–7, 73]. Most frequently, the *BCL6* gene is frequently involved in reciprocal translocations with *IgH* gene and rarely also with *IgL* and *IgK* genes [11–13]. Additionally, more than 20 *non-Ig* fusion partners have been identified in *non-Ig/BCL6* fusions to date. According to the published data, the most frequent partner chromosomes involved in *non-Ig/BCL6* translocations in DLBCL are chromosomes 6 and 12; however, almost all chromosomes were identified in *non-Ig/BCL6* fusions, except chromosomes 5, 15, 17, 20, 21, X and Y. Regarding the involved genes, the majority of *non-Ig* fusion genes are involved in cell cycle control and genome stability [3]. In all yet reported *BCL6* translocations, normal regulatory sequences of *BCL6* are replaced with those of the partner gene, because the translocated gene partners are in the same transcriptional direction [18]. This process, termed “promoter substitution”, is hypothesized to deregulate *BCL6* expression; thus, the changes in *BCL6* together with fusion partner gene

Table 1 Fusion partners in *non-Ig/BCL6* rearrangements reported in DLBCL

Translocation	Chromosomal locus partners	Gene partner	References
t(1;3)	(p34;q27)		[20, 21]
	(q32;q27)		[22]
	(q25;q27)	<i>GAS5</i>	[21, 23]
t(2;3)	(q21;q27)		[24]
	(p12;q27)		[25, 26]
	(q33;q27)		[27]
	(p11;q27)		[18, 28]
	(p23;q27)	<i>ALK</i>	[29]
t(3;3)	(q11;q27)		[30]
	(q25;q27)	<i>MBNL1</i>	[31]
	(q29;q27)	<i>TFRC</i>	[13]
	(q27-q28;q27)	<i>ST6GAL1</i>	[31]
t(3;4)	(q28;q27)	<i>EIF4A2</i>	[12]
	(q27;q25)		[32]
	(q27;q32)		[33]
t(3;6)	(q27;p13)	<i>RHOH</i>	[34, 35]
	(q27;p25)		[36]
	(q27;p21.2)	<i>PIMI1</i>	[18]
	(q27;p12)	<i>HSPCB</i>	[37]
	(q27;q15)	<i>SNHG5</i>	[38]
	(q27;q21)	<i>SFRS3</i>	[39]
	(q27;p21.33)	<i>HIST1H4I</i>	[40, 41]
	(q27;p12)	<i>IKZF1</i>	[42, 43]
t(3;7)	(q27;q13)	<i>ZNFN1A1</i>	[13, 44]
	(q27;q21)		[45]
t(3;8)	(q27;q32)	<i>FRA7H</i>	[46]
	(q27;q24)	<i>MYC</i>	[47–50]
t(3;9)	(q27;p13)		[33]
	(q27;q12)	<i>GRHPR</i>	[31]
t(3;10)	(q27;q22)		[51]
	(q27;q11.21)	<i>RASGEF1A</i>	this study
t(3;11)	(q27;p14)		[52]
	(q27;q23.1)	<i>POU2AF1</i>	[53]
t(3;12)	(q27;q24)		[54]
	(q27;q13)		[28]
	(q27;p11)		[28]
	(q27;p13.31)	<i>GAPDH</i>	[55]
	(q27;q23)	<i>NACA</i>	[13]
	(q27;p12.1)	<i>LRMP</i>	[31]
	(q27;q14.3)	<i>LCP1</i>	[56]
	(q27;q32.33)	<i>HSPCA</i>	[13]
	(q27;p13)	<i>CIITA</i>	[28, 57, 58]
	(q27;p11)	<i>IL21R</i>	[59]
t(3;18)	(q27;q21)		[50, 60]
t(3;19)	(q27;q13)	<i>NAPA</i>	[61]

**Fig. 4** Relative mRNA expression of *BCL2*, *BCL6*, and *RASGEF1A* (ration target gene expression/reference gene *PGKI*) in lymph node from DLBCL patients 1) with *BCL6* rearrangements (reported case P1 with t(3;10); P2 with t(3;14); P3 with t(3;22)) and 2) without *BCL6* rearrangements (DLBCL, $n=11$); and in the peripheral blood from 3) healthy control subjects (C, $n=18$)

expression may influence the biology of DLBCL [15]. Nevertheless, although the *BCL6* rearrangements are predominantly associated with DLBCL, this genetic aberration may be present also in other types of lymphoma such as follicular [74] and mantle cell lymphomas [75].

In this study we included also a description of a novel *non-Ig/BCL6* translocation involving chromosome 10q11.21 loci in a refractory posttransplant DLBCL patient. According to the FISH results, the 5' region of *BCL6* on chromosome 3 was

replaced by 5' non-coding region of the *RASGEF1A* gene from the chromosome loci 10q11.21, both fusion genes oriented in the same transcriptional direction. *RASGEF1A* (RasGEF domain family, member 1A) encodes a putative Ras guanine nucleotide exchange factor domain-containing protein [76]. The animal studies showed that *RASGEF1A*, an evolutionary conserved gene, is paternally imprinted in mice and regulates longevity as well as embryogenesis [77]. Besides delays in aging, *RASGEF1A* deficient mice possessed enhanced tumor free survival, and protection against oxidative stress [78]. In humans is *RASGEF1A* probably not imprinted and serves as an *in vivo* activator for *H-RAS* and members of the *R-RAS* and *RAC* sub-families [79], regulator of glucose metabolism and insulin - insulin like growth factor signaling [80] and/or is involved in cell-cell adhesion [76, 81]. Moreover, *RASGEF1A* regulates proliferation and metastatic behavior of human alveolar rhabdomyosarcomas [82]. In our DLBCL cohort, we observed high interindividual variability in gene expression of *RASGEF1A*, whereas our case with t(3;10) belonged to those with lower *RASGEF1A* expression. The exact role of this gene in DLBCL should be further explored in future studies. This is the first observation of t(3;10)(q27;q11.21) in DLBCL, the only single case of t(3;10) reported in DLBCL involved other loci (q27;q22) [51]. Reciprocal translocation t(3;10)(q27;q11.21) was already reported in follicular lymphoma; however, no link to patient outcome and break-point region was given [18].

To obtain more insights into the break-point region in *BCL6* rearrangements, Lu et al. [83] analyzed a large set of *BCL6* chromosomal translocations to *Ig* as well as non-*Ig* partners and showed that *BCL6* breaks occur at different regions depending on the fusion partner. The *BCL6* breaks in non-*Ig* rearrangements occur at CpG/CGC sites in addition to WGCW and the *Ig/BCL6* translocations prefer known activation-induced cytosine deaminase (AID) hotspots, such as WGCW and WRC (W=A/T, R=A/G) [83]. Interestingly, there are many similarities between *BCL6* and *IGVH* somatic mutations, suggesting that the *Ig*-somatic mutation machinery also targets *BCL6*, thereby predisposing to chromosomal breaks and subsequent translocations [1]. Similar mechanism is reported also in *BCL2*, where *BCL2* mutations commonly occur in DLBCL patients with *BCL2/IgH* rearrangements as a result of somatic hypermutation normally occurring at the *IgH* locus [84]. The theory of the driving role of somatic mutations in non-*Ig* genes for non-*Ig/BCL6* fusions is supported by common observation of these translocations in treated patients, as was shown also in our case. Further research in this direction is needed.

Clinical Consequences of *BCL6* Translocations in DLBCL

Although there is no consensus on the effect of *BCL6* translocation on the clinical outcome, studies on *Ig/BCL6*

rearrangements commonly point to the fact that high *BCL6* expression at mRNA and/or protein levels is a favourable prognostic indicator of DLBCL [3, 85, 86]. One may suggest that this may be through the repressory control of anti-apoptotic *BCL2* and other known *BCL6* pro-survival target genes. On the other hand, enhanced *BCL6* levels may perturb the molecular network that controls the differentiation of GC B-cells to *Ig*-secreting plasma cells, thereby predisposing B-cells to neoplastic transformation [67]. Contrary, in non-*Ig/BCL6* translocations were *BCL6* mRNA levels unexpectedly low and inferior survival in DLBCL patients with non-*Ig/BCL6* translocations comparing to those with *Ig/BCL6* fusions was reported [3, 7, 87]. In line with observations in other non-*Ig/BCL6* translocations, the t(3;10) translocation in our case was associated with low mRNA expression of the *BCL6* as well as its fusion partner *RASGEF1A*.

Lymphomas with recurrent chromosomal breakpoints activating multiple oncogenes, including *BCL6* and/or *BCL2* and/or *MYC* are often referred as "Dual Hit" lymphomas (DHL). DHL are highly aggressive lymphomas with generally poor response to first line and salvage treatment. Limited data is available to guide therapeutic decisions, and despite aggressive measures including high dose chemotherapy followed by ASCT, outcome is sadly poor [17, 20, 88]. Similarly, our patient with non-*Ig/BCL6* fusion with low gene expression of *BCL6* and combination with rearrangement of *BCL2*, a repressional target of *BCL6*, belonged to the high-risk category with poor prognosis. He relapsed several times after aggressive treatment; thus, further supporting the suggestion that non-*Ig/BCL6* fusion and its combination with high expression of *BCL2* are poor prognostic indicators of DLBCL. In line with the observation of others [4], we suggest that there is potential value for *BCL6* rearrangement and together with the activation of *BCL2* as adverse predictive biomarkers in DLBCL also in the rituximab era.

Conclusions

Reports on genetic variability and rearrangements involving *BCL6*, a gene most commonly affected in DLBCL, and the clinical consequence of these genetic changes may contribute to the understanding of the role of *BCL6* in etiopathogenesis of DLBCL and also open new therapeutic options for DLBCL patients.

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Compliance with Ethical Standards The authors declare that they have no conflict of interest. Written informed consent was duly obtained from the patient for the publication of this report and its accompanying images. All examinations were performed in accordance with the current

version of the Helsinki Declaration and the study was approved by the Ethics Committee of the University Hospital in Olomouc.

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in the study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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