Postmenopausal Hormone Therapy and Colorectal Cancer Risk by Molecularly Defined Subtypes and Tumor Location

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Abstract

Background: Postmenopausal hormone therapy (HT) is associated with a decreased colorectal cancer (CRC) risk. As CRC is a heterogeneous disease, we evaluated whether the association of HT and CRC differs across etiologically relevant, molecularly defined tumor subtypes and tumor location. Methods: We pooled data on tumor subtypes (microsatellite instability status, CpG island methylator phenotype status, BRAF and KRAS mutations, pathway: adenoma-carcinoma, alternate, serrated), tumor location (proximal colon, distal colon, rectum), and HT use among 8220 postmenopausal women (3898 CRC cases and 4322 controls) from 8 observational studies. We used multinomial logistic regression to estimate odds ratios (OR) and 95% confidence intervals (CIs) for the association of ever vs never HT use with each tumor subtype compared with controls.

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Colorectal cancer (CRC) is a heterogeneous disease that evolves through multiple pathways defined by genetic and epigenetic events (1, 2). Four tumor markers have been commonly used to better characterize this heterogeneity: microsatellite instability (MSI), CpG island methylator phenotype (CIMP), somatic mutations in BRAF, and somatic mutations in KRAS. Together, these tumor markers approximate 3 distinct molecular pathways of colorectal carcinogenesis: adenoma-carcinoma (traditional), alternate, and serrated (1, 3, 4). These pathways are established early in disease pathogenesis and can be identified within pre-cancerous lesions by microscopy (3, 5–8). Research has shown that these tumor types have distinct appearances, predilections for locations within the colon, and biologic behaviors (8–10). As such, it is plausible that the epidemiologic factors underlying their etiologies could also differ.

Multiple lines of evidence, including randomized controlled trials, show that postmenopausal hormone therapy (HT) is associated with a decreased risk of CRC (11–20). The reduction in risk, about 20%–40% in recent analyses, has been observed in users of estrogen alone as well as combined estrogen plus progestin. Few studies have evaluated whether the association of HT use and CRC risk differs by molecularly defined CRC subtypes; however, such information might increase the understanding of the mechanisms for this beneficial effect. Current literature suggests that HT use is associated with a lower risk of MSI-low or microsatellite stable tumors (MSI-L/MSS) and possibly with a lower risk of CIMP-negative and BRAF wild-type tumors (21, 22). HT use has only been associated with KRAS wild-type tumors in the distal colon in 1 previous study (23). Regarding tumor location, the association of HT use and CRC is reportedly stronger among tumors of the distal colon compared with the proximal colon (22, 24). To our knowledge, no study has evaluated both tumor markers and location in relation to HT use to provide a comprehensive understanding of subtype-specific CRC risk.

In this study, we examined HT use in relation to molecularly defined CRC subtypes using available data from the Colon Cancer Family Registry (CCFR) (21, 25, 26) and 7 studies contributing to the Genetics of Epidemiology of Colorectal Cancer Consortium (27, 28). Specifically, we evaluated each of the 4 common tumor markers (MSI, CIMP, BRAF, and KRAS) separately, as well as 3 pathways of carcinogenesis defined by combinations of those markers and tumor location.

Methods

Study Populations

Data from 8 observational studies of CRC were pooled: the Cancer Prevention Study II (CPS-II) (29), the German Darmkrebs: Chancen der Verhutung durch Screening Study (DACHS) (30, 31), the Diet Activity and Lifestyle Study (DALS) (32), the Swedish population of the European Prospective Investigation into Cancer (EPIC) (33), the Melbourne Collaborative Cohort Study (MCACS) (34), the Nurses’ Health Study (NHS) (35, 36), the Northern Sweden Health and Disease Study (NSHDS) (37), and 3 population-based sites from the Colon Cancer Family Registry (21, 25, 26). Each study included women diagnosed with incident invasive CRC and contemporaneous unaffected controls. Only women with tumor marker data were eligible for inclusion in this analysis. Study-specific details are described in the Supplementary Methods (available online). All participants provided informed consent for participating in this research, and studies were approved by their respective Institutional Review Boards.

Data Collection and Harmonization

The harmonization procedure and ascertainment of HT use are described in more detail in the Supplementary Methods (available online). Information on demographics and environmental risk factors was collected via telephone or in-person interviews and/or structured self-completed questionnaires (24, 38, 39). HT use was generally ascertained as any self-reported use at baseline survey. Additionally, ever use of formulation-specific (estrogen-only or estrogen plus progestin) HT use was derived from 3 studies (CCFR, CPSII, and NHS). HT nonusers at reference time were used as the comparison group. Postmenopausal status was harmonized as either 1) study-derived menopausal status, if available; 2) self-reported menopausal status, if study-derived data were not available; or 3) age 55 years and older, if study-derived and self-reported data were not available (40).

Tumor Characteristics and Molecular Subtyping

Tumor marker testing was conducted using DNA extracted from formalin-fixed, paraffin-embedded tumor tissue specimens. Individual study protocols varied, as outlined below and further detailed in the Supplementary Methods (available online).

MSI testing was primarily conducted using polymerase chain reaction (PCR) following the National Cancer Institute Bethesda Consensus Panel (CCFR, CPS-II, MCCS, NHS) (41). Typically, 4 or more interpretable markers were required to classify tumors, with some variation across studies outlined in Supplementary Table 1 (available online). Additional methods used include immunohistochemistry (NSHDS, EPIC, and a subset of CCFR and MCCS) and mononucleotide marker panels (DACHS, DALS) (Supplementary Methods, available online). Tumors were classified as MSI-high (MSI-H) if at least 30% of the markers showed...
instability and MSI-L/MSS if less than 30% of the makers showed instability. MSI status could be determined for 3639 CRC cases (93.4%).

Most studies used Methylight (42) methylation analysis to determine CIMP status, classified as positive or negative based on either an 8-(CPS-II, EPI, NHS, NSHDS) (43, 44) or 5-gene (CCFR, MCCS) (45–47) panel. The percent of methylated reference value was calculated to determine whether each gene was positive for methylation (generally percent of methylated reference > 10). DACHS used a different 5-gene panel (48, 49) to determine CIMP status and based methylation on the presence or absence of the methylation-specific PCR product. DALS (50) determined CIMP status using a classic panel of CpG islands (51, 52). Specific genes included in each panel, details of calling methylation status, and number of methylated genes present to classify a tumor as CIMP-positive are outlined in Supplementary Table 2 (available online). CIMP status could be determined for 3453 CRC cases (88.6%).

Studies used PCR, sequencing, and immunohistochemistry techniques to assess BRAF and KRAS mutations, as detailed in the Supplementary Methods (available online). The majority of studies evaluated BRAF via V600E mutations in exon 15 and KRAS via mutations in codons 12 and 13, although a few evaluated additional loci. BRAF and KRAS status could be determined for 3564 (91.4%) and 3435 (88.1%) CRC cases, respectively.

Tumor pathways were defined as follows, consistent with previously suggested classifications (3, 8): 1) adenoma-carcinoma (traditional) pathway (MSS/MSI-L, CIMP-negative, BRAF wild-type, KRAS wild-type), 2) alternate pathway (MSS/MSI-L, CIMP-negative, BRAF wild-type, KRAS-mutated), and 3) serrated pathway (CIMP-positive, BRAF-mutated, KRAS wild-type). Tumor pathway could be classified for 2401 CRC cases (61.6%).

Tumor location was obtained from registry and pathology reports. Location was grouped based on the International Classification of Diseases (ICD-9) codes as follows: 1) proximal (153.0/Hepatic flexure, 153.1/Transverse colon, 153.4/Cecum, 153.6/Ascending colon), 2) distal (153.2/Descending colon, 152.3/Sigmoid colon, 153.7/Splenic flexure), and 3) rectal (154.0/Rectosigmoid junction, 154.1/Rectum). Tumor location could be classified for 3808 CRC cases (97.7%).

**Statistical Analysis**

We excluded women who were pre- or perimenopausal at study baseline (934 cases, 760 controls) and those with missing data on HT use (208 cases, 209 controls). After exclusions, 3898 CRC cases and 4322 controls were included in our analyses (Figure 1).

Odds ratios (ORs) and 95% confidence intervals (CIs) from logistic regression models were used to approximate the relative risks for the association of HT use and CRC. Separate models were evaluated for each tumor-specific outcome using multinomial logistic regression with tumor marker status vs control as the outcome (eg, BRAF-mutated or BRAF wild-type vs control). All models included study site as well as covariates selected a priori based on known associations with both HT and CRC.
These included age in years, body mass index (BMI; normal or underweight [BMI <25], overweight [BMI 25–30], obese [BMI >30], unknown), smoking status (current, former, never, unknown), and first-degree relative with CRC (yes, no, unknown). Secondary analyses were conducted for estrogen-only therapy and combined estrogen plus progestin therapy. For multinomial logistic regression models, Wald $\chi^2$ tests were used to evaluate heterogeneity in odds ratios by tumor marker status (53). Additionally, sensitivity analyses were conducted excluding 1) women aged 45 years and younger ($n = 131$) and 2) women with probable Lynch syndrome based on 4 tumor markers (defined as MSI-H, CIMP-negative, BRAF wild-type, KRAS wild-type; $n = 89$), because both populations may have unique factors altering their CRC risk. We also performed a meta-analysis of the association of any HT use and CRC risk to evaluate heterogeneity by study site.

Results

Baseline population characteristics of the 8220 postmenopausal women in our study are shown in Table 1. Compared with...
controls, cases were more likely to have a family history of CRC and be current or former smokers. Cases were less likely to be HT users than controls (32.4% vs 42.8%). Among those with formulation-specific data, cases were less likely than controls to use both estrogen-only (22.2% vs 29.7%) and estrogen plus progestin formulations (14.3% vs 17.8%).

Multivariable-adjusted associations between HT use, HT formulation, and overall- and tumor marker–specific CRC risk are presented in Figure 2 and Supplementary Table 3 (available online). Ever use of HT was associated with a 38% reduction in CRC risk (OR = 0.62, 95% CI = 0.56 to 0.69). Both use of estrogen-only (OR = 0.71, 95% CI = 0.62 to 0.83) and estrogen plus progestin (OR = 0.76, 95% CI = 0.64 to 0.91) formulations were associated with reduced CRC risk, although the effect estimates were attenuated compared with any HT use in this subsample of the study population. Few differences in baseline characteristics were noted between women with and without formulation-specific data (Supplementary Table 4, available online).

Among cases with respective tumor marker data, 19.8% were MSI-H (n = 719), 24.3% were CIMP-positive (n = 841), 18.4% were BRAF-mutated (n = 654), and 32.0% were KRAS-mutated (n = 1098). Ever use of HT was associated with reduced risk of almost all tumor marker subtypes of CRC, with some variation across subtypes (Figure 2; Supplementary Table 3, available online). The association of ever HT use and CRC was attenuated among CIMP-positive cases (OR = 0.74, 95% CI = 0.63 to 0.87) compared with CIMP-negative cases (OR = 0.62, 95% CI = 0.55 to 0.69) (P_or < 0.05). This trend was consistent across HT formulations, although the difference in odds ratios was not statistically significant. HT use was inversely associated with both KRAS-mutated and wild-type individuals. This association was consistent for estrogen-only use; however, estrogen plus progestin formulations were not statistically significantly associated with KRAS-mutated individuals (OR = 0.90, 95% CI = 0.70 to 1.14; P_or = 0.09). No differences were observed for MSI or BRAF mutation status.

Of 2401 tumors (61.6%) that were able to be classified by pathway, the majority were classified as adenoma-carcinoma pathway tumors (48.4%; n = 1162), with 32.9% classified as alternate pathway (n = 790) and 18.7% as the serrated pathway (n = 449). No major differences in baseline characteristics were noted between women who were and were not able to be classified by pathway (Supplementary Table 4, available online). The effect estimates for HT use in both the adenoma-carcinoma and alternate pathways were similar to that seen for HT overall (adenoma-carcinoma OR = 0.63, 95% CI = 0.55 to 0.73; alternate OR = 0.61, 95% CI = 0.51 to 0.72). However, the effect estimate was attenuated and no longer statistically significant for tumors that arose via the serrated pathway (OR = 0.81, 95% CI = 0.66 to 1.01; P_or vs adenoma-carcinoma = .04). This difference was not consistent across HT formulation: for estrogen-only formulations, ever use was statistically significantly inversely associated with all 3 pathways (adenoma-carcinoma OR = 0.71, 95% CI = 0.57 to 0.88; alternate OR = 0.60, 95% CI = 0.47 to 0.77;
Our results indicate that both estrogen-only and estrogen plus progestin formulations reduce CRC risk. In general, effect estimates were attenuated for estrogen plus progestin formulations compared with estrogen-only formulations, perhaps reflecting smaller exposure frequencies. However, overall trends were similar. Two main exceptions were present. First, whereas estrogen-only and any HT use were associated with about a 40% reduction in tumors arising via the alternate pathway, estrogen plus progestin use was not statistically significantly associated with these tumors. This may indicate that alternate pathway tumorigenesis is specifically modified by estrogen and not progestin. Likewise, there was a null association between estrogen plus progestin use and proximal colon tumors despite a 24%–29% reduction in risk with estrogen-only or any HT, respectively.

To our knowledge, this is the largest study to assess whether the association of HT use and CRC differs by individual tumor markers and location. In addition, it is one of few investigations that combines multiple tumor markers to evaluate tumor pathway–specific associations. Some limitations should be considered in interpreting our results. First, all exposure and epidemiologic covariate information included in this analysis was based on self-report, which could lead to exposure misclassification. Second, HT use was assessed only during the reference period, and detailed information on dose, frequency, and duration of use was not routinely available. Third, we were not able to assess endogenous hormones that may reflect age at menarche, parity, or breast feeding, which may also influence CRC risk. Fourth, there is some evidence that HT users may be more likely to undergo CRC screening (72, 73). It is unclear how this may impact our results because this relationship may be complicated by differences in sensitivity of screening detection
for specific CRC subtypes. Temporal trends and regional differences in screening and HT use may also influence observed associations. Finally, although this study includes populations in many locales, the participants were predominantly white, and therefore, these findings may not be generalizable to other racial and ethnic groups.

In this large, multisite study we observed a strong inverse association between HT use and CRC risk, regardless of individual tumor markers and HT formulation. The decreased risk may predominantly reflect tumors of the distal colon or rectum and those arising via the adenoma-carcinoma (traditional) pathway, because the association was relatively weaker among proximal colon tumors and those arising via the serrated pathway. Further investigation into the mechanisms underlying these differences may add to our understanding of subtype-specific CRC risk and pathways of tumorigenesis.

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