Susceptibility and Prevention

High Innate Production Capacity of Proinflammatory Cytokines Increases Risk for Death from Cancer: Results of the PROSPER Study

Stella Trompet,1,2 Anton J.M. de Craen,1 Simon Mooijaart,1 David J. Stott,4 Ian Ford,5 Naveed Sattar,6 Wouter Jukema,2,3 and Rudi G.J. Westendorp1,7

Abstract Purpose: Various lines of evidence suggest that proinflammatory factors may play a role in tumor growth and metastasis, the leading cause of cancer-related mortality. However, most evidence originates from animal models, only few human studies reported an association between proinflammatory cytokines and death from cancer. Here, we investigated the association between circulating levels and innate production capacity of proinflammatory cytokines and cancer incidence and mortality in the prospective Study on Pravastatin in the Elderly at Risk (PROSPER).

Experimental Design: Circulating levels of interleukin 6 (IL-6) and C-reactive protein were measured in all 5,804 participants of the PROSPER study. The innate production capacity of IL-6, IL-1β, and tumor necrosis factor α (TNF-α) were measured in a random sample of 403 subjects.

Results: We showed that high circulating inflammatory markers were associated with an increased risk for cancer incidence and death from cancer during follow-up (all \( P < 0.05 \)). Moreover, high innate proinflammatory cytokine production capacity is associated with an increased risk for death from cancer (all \( P < 0.04 \)) but not with higher cancer incidence during follow-up (all \( P > 0.6 \)).

Conclusions: High innate production capacity of proinflammatory cytokines is associated with an increased risk for death from cancer, probably because of increased tumor growth and metastasis. Because there was no association between innate production capacity and cancer incidence, the association between circulating levels and cancer incidence at least partially reflects reversed causality. (Clin Cancer Res 2009;15(24):7744–8)

Inflammation plays an important role in the development of various age-related diseases such as atherosclerosis, stroke, cognitive decline, and dementia (1). Various studies support the hypothesis that inflammatory stimuli, such as the proinflammatory cytokines interleukin 6 (IL-6), IL-1β, and tumor necrosis factor α (TNF-α), are involved in cancer pathogenesis (2–5). Moreover, elevated levels of various cytokines, such as IL-1, IL-6, TNF, fibroblast growth factor, and transforming growth factor, have been found in blood, urine, and ascites of cancer patients, suggesting that these cytokines are involved in incidence and growth and spread of cancer (6).

Inflammatory responses are thought to be critical in many aspects of promoting the growth and spread of cancers. A recent study on Kim et al. (7) showed that cell lines of Lewis lung carcinoma had an increased production of the proinflammatory cytokines IL-6 and TNF-α through activation of the Toll-like receptor family members TLR2 and TLR6. Moreover, proinflammatory cytokines are also involved in promoting tumor cell adhesion in metastatic sites, which then activate local normal cells to produce tumor growth factors (6). Distinct-site metastases are the leading cause of cancer-associated mortality. Furthermore, animal studies have suggested a role for proinflammatory cytokines in the generation of cancer-associated cachexia, which

Authors’ Affiliations: Departments of 1Gerontology and Geriatrics, and 2Cardiology, Leiden University Medical Center, Leiden, the Netherlands; 3Durrer Center for Cardiogenetic Research, Amsterdam, the Netherlands; 4Department of Geriatric Medicine, 5Robertson Centre for Biostatistics, and 6British Heart Foundation Glasgow Cardiovascular Research Centre, Faculty of Medicine, University of Glasgow, Glasgow, Scotland; and 7Netherlands Consortium of Healthy Ageing, Leiden, the Netherlands

Received 8/10/09; accepted 9/22/09; published OnlineFirst 12/8/09.

Grant support: This work was partly supported by an investigator initiated grant from Bristol-Myers Squibb; an unrestricted grant from the Netherlands Genomics Initiative (NGI 050-060-810); R.G.J. Westendorp, and funding from the Chest Heart Stroke Associations for the interleukin 6 and C-reactive protein arrays.

The costs of publication of this article were defrayed in part by the payment of page charges. This article must therefore be hereby marked advertisement in accordance with 18 U.S.C. Section 1734 solely to indicate this fact.

Note: J.W. Jukema is an established clinical investigator of the Netherlands Heart Foundation (2001 D 032).

Requests for reprints: Stella Trompet, Department of Gerontology and Geriatrics, C-2-R, Leiden University Medical Center, P.O. Box 9600, 2300 RC, Leiden, the Netherlands. Phone: 31-71-526-6640; Fax: 31-71-524-8159; E-mail: s.trompet@lumc.nl.


© 2009 American Association for Cancer Research.
is the most important cause of morbidity among cancer patients (3, 8–10).

These various lines of evidence suggest that proinflammatory factors may play a role in cancer metastasis eventually leading to death. However, most evidence originates from animal models; only a few human studies have reported an association between proinflammatory cytokines and death from cancer (11, 12). Here, we investigated the association between circulating levels and innate production capacity of proinflammatory cytokines and cancer incidence and mortality in the PROspective Study on Pravastatin in the Elderly at Risk (PROSPER).

Materials and Methods

A detailed description of the protocol of the PROSPER study has been published elsewhere (13, 14). A short summary is provided here.

Participants. PROSPER was a prospective multicenter randomized placebo-controlled trial to assess whether treatment with pravastatin diminishes the risk for major vascular events in the elderly. Between December 1997 and May 1999, we screened and enrolled subjects in Scotland (Glasgow), Ireland (Cork), and the Netherlands (Leiden). Men and women with ages 70 to 82 y were recruited if they had pre-existing vascular disease or increased risk for such disease because of smoking, hypertension, or diabetes. A total number of 5,804 subjects were randomly assigned to pravastatin or placebo.

Inflammatory markers. In all subjects, C-reactive protein (CRP) was measured after 3 y of follow-up.

Translational Relevance

We assessed the association between circulating levels and innate production capacity of proinflammatory cytokines in whole blood samples and cancer incidence and mortality. High innate production capacity of proinflammatory cytokines is associated with an increased risk for cancer mortality, probably because of increased tumor growth and metastasis. No association was found between innate production capacity and cancer incidence, which indicates that the association between circulating levels and cancer incidence is probably disturbed by reversed causality. Anticytokine therapy for the interleukin 1β, interleukin 6, and tumor necrosis factor α cytokines might be of therapeutic interest for advanced cancer. Blocking the proinflammatory cytokines by anticytokine based therapies might reduce tumor growth and metastasis, the leading cause of cancer-associated mortality. Moreover, it might reverse cachexia-induced weight loss. Hence, when tumor growth and progression and cancer-related cachexia can be delayed or reversed by administering antibodies against proinflammatory cytokines, the survival time for cancer patients might be extended.

Results

Baseline characteristics of the 5,804 subjects of the PROSPER study are presented in Table 1. The mean age of the subjects was 75.3 years, and about half of them were female. The baseline characteristics of the random sample of the 403 subjects with additionally obtained innate cytokine production capacities are also shown in Table 1. Both groups were similar in baseline characteristics. Cancer incidence and mortality were measured...
for the total group for a mean follow-up period of 3.2 years; for the random sample, we extended the initial follow-up period with 3.5 to 6.7 years. The percentages of cancer incidence and cancer mortality are therefore higher in the random sample.

The association between circulating inflammatory markers and cancer risk is shown in Table 2. The hazard ratio for cancer incidence for subjects with high levels of CRP was 1.20 \((P = 0.063)\) compared with subjects with low CRP levels. Moreover, the hazard ratio for cancer incidence for subjects with high levels of IL-6 was 1.35 \((P = 0.003)\) compared with subjects with low IL-6 levels. High levels of both inflammatory markers were also significantly associated with an increased risk for death from cancer compared with low levels \([\text{hazard ratio, } 1.42 (P = 0.01) \text{ and } 1.55 (P = 0.003), \text{ respectively}]\).

In Table 3, the association is shown between the innate production capacity and cancer risk in a random sample of 403 subjects. No associations were found for innate cytokine production capacity and cancer incidence. However, innate production capacity levels of the proinflammatory cytokines IL-1β, IL-6, and TNF-α were significantly associated with death from cancer \(\text{(all } P < 0.04)\). Participants with high production capacity levels of these cytokines had a higher risk for death from cancer compared with participants with low cytokine production levels.

### Table 2. Association between circulating levels of inflammatory markers and cancer risk

<table>
<thead>
<tr>
<th>Inflammatory marker</th>
<th>Hazard ratio (95% CI)</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRP</td>
<td>1.20 (0.99-1.45)</td>
<td>0.063</td>
</tr>
<tr>
<td>IL-6</td>
<td>1.35 (1.11-1.64)</td>
<td>0.003</td>
</tr>
<tr>
<td>Cancer mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRP</td>
<td>1.42 (1.07-1.89)</td>
<td>0.014</td>
</tr>
<tr>
<td>IL-6</td>
<td>1.55 (1.16-2.07)</td>
<td>0.003</td>
</tr>
</tbody>
</table>

**NOTE:** Hazard ratios are assessed with the Cox proportional hazard model adjusted for sex, age, country, current smokers, and use of pravastatin.

### Table 3. Association between innate inflammatory cytokine production capacity and cancer risk

<table>
<thead>
<tr>
<th>Cytokine level</th>
<th>Hazard ratio (95% CI)</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL-1β</td>
<td>0.85 (0.47-1.55)</td>
<td>0.60</td>
</tr>
<tr>
<td>IL-6</td>
<td>1.11 (0.61-2.02)</td>
<td>0.74</td>
</tr>
<tr>
<td>TNF-α</td>
<td>0.92 (0.51-1.67)</td>
<td>0.78</td>
</tr>
<tr>
<td>Cancer mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL-1β</td>
<td>2.67 (1.15-6.20)</td>
<td>0.02</td>
</tr>
<tr>
<td>IL-6</td>
<td>2.51 (1.09-5.81)</td>
<td>0.03</td>
</tr>
<tr>
<td>TNF-α</td>
<td>3.14 (1.31-7.54)</td>
<td>0.01</td>
</tr>
</tbody>
</table>

**NOTE:** Hazard ratios are assessed with the Cox proportional hazard model adjusted for sex, age, current smokers, and use of pravastatin.

---

**Fig. 1.** Kaplan-Meier curves. Dotted line, high innate cytokine production capacity; straight line, low innate cytokine production capacity.

---

cancer compared with participants with low cytokine production levels. There was no association between high IL-1β and TNF-α cytokine production levels and other causes of death, whereas high IL-6 production capacity was also associated with an increased risk for all other deaths except cancer \(\text{(hazard ratio, } 1.92; P = 0.04)\).

The Kaplan-Meier curves of the association between the innate production capacity and mortality from cancer are graphically
depicted in Fig. 1. Subjects with high levels of IL-1β, IL-6, and TNF-α production capacity had a higher cumulative mortality compared with subjects with low production capacity.

**Discussion**

We assessed the association between circulating levels and innate production capacity of proinflammatory cytokines in whole blood samples and cancer incidence and mortality. High levels of the circulating inflammatory markers were associated with an increased risk for cancer incidence and death from cancer. Furthermore, we showed that high innate proinflammatory cytokine production capacity was associated with an increased risk for death from cancer during follow-up, whereas high innate production capacity of proinflammatory cytokines was not associated with incident cancer.

We found that a high innate proinflammatory cytokine production capacity is a risk factor for cancer mortality but not for cancer incidence and also not for any other causes of death. This indicates that circulating markers of inflammation are increased in cancer patients, probably by autocrine production of the cancer cells themselves. There are two ways to explain the association between the innate production capacity of IL-1β, IL-6, and TNF-α, and death from cancer. First, proinflammatory cytokines play an important role in promoting the growth and spread of cancers. There are some examples of solid tumors proliferating in response to IL-1, IL-2, and IL-6 (6). Cytokines are also involved in promoting tumor cell adhesion in metastatic sites and then activate local normal cells to produce tumor growth factors (6). Furthermore, TNF-α receptors have been associated with tumor cells, suggesting that TNF-α could play a role in cancer growth (15–17). The most convincing evidence comes from the recent study on Kim et al. (7) who reported that cell lines of Lewis lung carcinoma had an increased production of the proinflammatory cytokines IL-6 and TNF-α through activation of the Toll-like receptor family members TLR2 and TLR6. Moreover, TNF-α and TLR2 were found to be required for Lewis lung carcinoma metastases in mice (7).

Second, animal studies have suggested that proinflammatory cytokines may have a role in cancer related cachexia, which is an important cause of morbidity and mortality in cancer patients (3, 8–10). In a tumor model used by Strassmann et al. (18, 19), it was suggested that IL-1 and IL-6 are involved in mediating cachexia. Administering IL-6 antibodies in a similar model partially reversed the weight loss. Mice with TNF-α producing tumors also developed cachexia, and administration of TNF neutralizing antibodies reversed the weight loss related to cachexia (16).

Although we found an association between circulating inflammatory markers and cancer incidence, we found no association between innate production capacity and incident cancer. This might indicate that the association between circulating inflammatory markers and cancer incidence might be disturbed by reverse causality because it has been shown in various studies that tumor cells have autocrine production of proinflammatory cytokines (6). Although all participants of the PROSPER study had to be free of cancer in the 5 years before the study, underlying cancer that had not been diagnosed yet could have resulted in higher levels of circulating inflammatory markers. Alternatively, strong cancer risk factors may have contributed to an altered inflammatory milieu. By investigating the association between innate cytokine production capacity and cancer incidence, we do not have the problem of reverse causality because innate production capacity reflects the maximum response to lipopolysaccharide in an individual independent of cytokine production by tumor cells. Therefore, we suggest that subjects with cancer a strong proinflammatory profile are associated with an increased risk for dying, but the increased innate production capacity does not lead to an increased risk for developing cancer.

A possible limitation to use the PROSPER study cohort for this research question is that subjects were selected to have a history of vascular disease or have an increased risk for such a disease, and the results can only be extrapolated with this in mind to the general population. One of the strengths of our study is our population size. We had prospective data of >5,000 subjects on various outcomes in three different countries. Because of the large population size, we had sufficient cases of incident cancer to reach a high power for statistical analyses. Furthermore, all subjects were included into the study when they did not have a history of malignancy within the 5 years before the start of the trial. Cancer incidence and mortality were main outcomes of our study and were accurately monitored. In addition, the fact that we had a follow-up of 3.2 years for all subjects with little lost to follow-up is a strong element of our study.

In conclusion, high innate production capacity of proinflammatory cytokines is associated with an increased risk for cancer mortality, probably because of increased tumor growth and metastasis. No association was found between innate production capacity and cancer incidence, which indicates that the association between circulating levels and cancer incidence is probably disturbed by reversed causality. Anticytokine therapy for the IL-1β, IL-6, and TNF-α cytokines might be of therapeutic interest for advanced cancer (20, 21). Blocking the proinflammatory cytokines by anticytokine based therapies might reduce tumor growth and metastasis, the leading cause of cancer-associated mortality. Moreover, it might reverse cachexia-induced weight loss (22). Hence, when tumor growth and progression and cancer-related cachexia can be delayed or reversed by administering antibodies against proinflammatory cytokines, the survival time for cancer patients might be extended.

**Disclosure of Potential Conflicts of Interest**

All authors declare that they have no conflicts of interest.

**References**


High Innate Production Capacity of Proinflammatory Cytokines Increases Risk for Death from Cancer: Results of the PROSPER Study


Access the most recent version of this article at: doi:10.1158/1078-0432.CCR-09-2152

This article cites 22 articles, 2 of which you can access for free at:
http://clincancerres.aacrjournals.org/content/15/24/7744.full.html#ref-list-1

This article has been cited by 1 HighWire-hosted articles. Access the articles at:
/content/15/24/7744.full.html#related-urls

Sign up to receive free email-alerts related to this article or journal.
To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.
To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.