Obesity Is an Independent Prognostic Variable in Colon Cancer Survivors

Frank A. Sinicrope 1,2, Nathan R. Foster 2, Daniel J. Sargent 2, Michael J. O’Connell 1, and Cathryn Rankin 3

Abstract

Purpose: Obesity is associated with an increased risk of colon cancer. However, the influence of body mass index (BMI) on the prognosis of colon cancer survivors and its relationship to gender remains unknown.

Experimental Design: BMI (kg/m²) was categorized in patients with tumor-node-metastasis stage II and III colon carcinomas (n = 4,381) enrolled in seven randomized trials of 5-fluorouracil–based adjuvant chemotherapy. Cox proportional hazards models were used to determine the association of BMI with disease-free survival (DFS) and overall survival (OS).

Results: Among colon cancer patients, 868 (20%) were obese (BMI, ≥30 kg/m²), of which 606 were class 1 (BMI, 30-34 kg/m²) and 262 were class 2,3 (BMI, ≥35 kg/m²). Obese versus normal-weight patients were more likely to be younger, have distal tumors, show intact DNA mismatch repair, and have more lymph node metastases (P < 0.017). In a multivariate analysis, BMI was significantly associated with both DFS (P = 0.030) and OS (P = 0.0017). Men with class 2,3 obesity showed reduced OS compared with normal-weight men [hazard ratio, 1.35; 95% confidence interval, 1.02-1.79; P = 0.039]. Women with class I obesity had reduced OS [hazard ratio, 1.24; 95% confidence interval, 1.01-1.53; P = 0.045] compared with normal-weight women. Overweight status was associated with improved OS in men (P = 0.006), and underweight women had significantly worse OS (P = 0.019). BMI was not predictive of therapeutic benefit.

Conclusions: Obesity is an independent prognostic variable in colon cancer survivors and shows gender-related differences. These data suggest that obesity-related biological factors can influence clinical outcome. Clin Cancer Res; 16(6): 1884–93. ©2010 AACR.
chemotherapy and the remaining 1,155 patients received – sected with curative intent. Of these 4,381 patients, or III colon carcinomas (24) that had been surgically re-

All patients had tumor-node-metastasis (TNM) stage II –

Materials and Methods

Study population. The study population (n = 4,381) consisted of participants in seven colon cancer adjuvant therapy trials sponsored by the U.S. National Cancer Institute and conducted by Mayo Clinic/North Central Cancer Treatment Group (NCCTG) and the Southwest Oncology Group. The details and findings of the individual studies have been previously reported (20–23). All patients had tumor-node-metastasis (TNM) stage II or III colon carcinomas (24) that had been surgically re-

Statistical analyses. χ² and Wilcoxon rank-sum tests were used to test for an association between the categorical BMI and other clinicopathologic variables. The Cochran-Armitage test was used to test for a trend across the BMI ordered categories for the two-level clinicopathologic variables. Overall survival (OS; censored at 8 y) was calculated as the number of years from random assignment to the date of death or last contact. Disease-free survival (DFS; censored at 5 y) was calculated as the number of years from random assignment to the first of either disease recurrence or death. The distributions of OS and DFS were estimated using Kaplan-Meier methodology. Univariate and multivariate Cox proportional hazards models were used to explore the association of BMI with other clinicopathologic variables and with DFS and OS. The score and likelihood ratio test P values were used to test the significance of each covariate in the univariate and multivariate models, respectively, after stratifying by the patient’s original treatment study. Interaction effects between BMI and other variables of interest were tested in multivariate Cox models with the use of the likelihood ratio test. Statistical tests were two-sided, with P ≤ 0.05 considered signifi

www.aacrjournals.org
Results

**BMI baseline characteristics.** The study population included 4,381 participants from seven randomized trials of 5-fluorouracil–based adjuvant chemotherapy for tumor-node-metastasis stage II and III colon cancer. Using our predetermined BMI categories (see Materials and Methods), 868 (20%) were obese, 1,605 (37%) patients were overweight, 281 (6%) were underweight, and 1,627 (37%) were of normal weight (Table 1). Obese patients were further classified into class 1 (BMI 30–34.9 kg/m²) and class 2,3 (BMI ≥ 35 kg/m²) obesity, where 606 (70%) of the 868 obese patients were class 1 and the remaining 262 (30%) were class 2,3. Median BMI in the entire cohort was 25.7 (range, 14.0–70.3). Obese and normal-weight patients both received a median of six cycles of adjuvant chemotherapy from our NCCTG cohort (\(P = 0.9436\)).

**Association of BMI with clinicopathologic variables.** We examined the association of the categorical BMI with demographic and clinicopathologic variables (Table 1). Across BMI categories, we found significant associations between BMI and tumor stage and site, where obese patients had the highest rate of stage III tumors and were more likely to have distal colon cancers (Table 1). Distal tumors were defined relative to the splenic flexure with those at the flexure included in the distal category. Obesity was associated with a higher number of metastatic lymph nodes in that obese patients were more likely to have greater than three metastatic lymph nodes (N2 disease; ref. 24) compared with normal-weight patients (28% versus 22%; \(P = 0.017\); Table 1). Age was also associated with BMI (\(P = 0.0005\)) in that obese and underweight patients were younger than were normal and overweight patients (Table 1). Similarly, gender was

<table>
<thead>
<tr>
<th>Table 1. Clinical characteristics by BMI categories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Histologic grade ²</td>
</tr>
<tr>
<td>1/2</td>
</tr>
<tr>
<td>3/4</td>
</tr>
<tr>
<td>Stage</td>
</tr>
<tr>
<td>III</td>
</tr>
<tr>
<td>II</td>
</tr>
<tr>
<td>Tumor site</td>
</tr>
<tr>
<td>Distal</td>
</tr>
<tr>
<td>Proximal</td>
</tr>
<tr>
<td>MMR</td>
</tr>
<tr>
<td>Intact</td>
</tr>
<tr>
<td>Defective</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Range</td>
</tr>
<tr>
<td>Treatment status</td>
</tr>
<tr>
<td>Ineffective</td>
</tr>
<tr>
<td>Effective</td>
</tr>
<tr>
<td>Lymph nodes</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1-3</td>
</tr>
<tr>
<td>&gt;3</td>
</tr>
<tr>
<td>T stage</td>
</tr>
<tr>
<td>T1,T2</td>
</tr>
<tr>
<td>T3,T4</td>
</tr>
</tbody>
</table>

*Kruskal-Wallis test for continuous data; \(\chi^2\) test for variables with 3+ categories; Cochran-Armitage test for trend \(P\) value for variables with only 2 categories.

\(1\) \(\chi^2\) test for categorical data and Wilcoxon rank-sum test for continuous data.

\(2\) Grade 1/2: well/moderate differentiation; grade 3/4: poor/undifferentiated.
associated with BMI ($P < 0.0001$), where underweight patients were more likely female, overweight patients were more likely male, and normal-weight and obese patients were evenly split by gender. No relationship between BMI and patient performance status was found.

The prevalence of defective MMR colon cancers was 14.5% (Table 1), and the frequency was higher in women than in men (18% versus 11%; $P = 0.001$). Defective MMR was associated with older age in women ($P = 0.0005$) but not in men ($P = 0.5818$; $P_{\text{interaction}} = 0.0009$). Obese patients had a lower rate of defective MMR compared with normal-weight patients (9.5% versus 15.5%; $P = 0.0347$; Table 1), and this association was stronger in patients younger ($P = 0.0037$) compared with those older than 60 years of age ($P_{\text{interaction}} = 0.0310$; adjusted for covariates).

Impact of BMI on cancer recurrences or death. After a median follow-up of 8 years, 1,585 (36%) of the 4,381 eligible patients experienced cancer recurrence, and 1,833 (42%) had died. In a univariate analysis, the categorical BMI was significantly associated with both DFS and OS (Table 2). Specifically, patients who were obese (BMI $\geq 30$ kg/m²) had worse DFS and OS rates compared with normal-weight patients that were of borderline statistical significance. When obesity was further categorized, those with class 2,3 obesity (BMI $\geq 35$ kg/m²) had worse DFS [hazard ratio (HR), 1.23; 95% confidence interval (95% CI), 1.01-1.49] and OS (HR, 1.18; 95% CI, 0.98-1.44; $P = 0.0879$) rates compared with normal-weight patients (Table 2). Underweight patients had a significantly worse OS ($P = 0.0500$) after adjusting for these same covariates (Table 3). The HRs and 95% CIs for both DFS and OS by the individual

<table>
<thead>
<tr>
<th>Variable</th>
<th>DFS, HR (95% CI)</th>
<th>$P^*$</th>
<th>OS, HR (95% CI)</th>
<th>$P^*$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorical BMI (overall)</td>
<td>1.08 (0.89-1.31)</td>
<td>0.0477</td>
<td>1.13 (0.93-1.36)</td>
<td>0.2209</td>
</tr>
<tr>
<td>Underweight vs normal</td>
<td>0.94 (0.84-1.05)</td>
<td>0.2880</td>
<td>0.93 (0.83-1.03)</td>
<td>0.1623</td>
</tr>
<tr>
<td>Overweight vs normal</td>
<td>1.13 (0.99-1.28)</td>
<td>0.0670</td>
<td>1.13 (0.99-1.28)</td>
<td>0.0622</td>
</tr>
<tr>
<td>Obese vs normal</td>
<td>1.08 (0.94-1.25)</td>
<td>0.2768</td>
<td>1.10 (0.96-1.27)</td>
<td>0.1785</td>
</tr>
<tr>
<td>Class 1 obese</td>
<td>1.23 (1.01-1.49)</td>
<td>0.0370</td>
<td>1.18 (0.98-1.44)</td>
<td>0.0879</td>
</tr>
<tr>
<td>Class 2,3 obese</td>
<td>0.45 (0.39-0.52)</td>
<td>&lt;0.0001</td>
<td>0.47 (0.41-0.53)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Stage</td>
<td>1.05 (0.95-1.15)</td>
<td>0.3348</td>
<td>1.10 (1.00-1.20)</td>
<td>0.0490</td>
</tr>
<tr>
<td>Gender</td>
<td>1.41 (1.24-1.61)</td>
<td>&lt;0.0001</td>
<td>1.43 (1.26-1.63)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Histologic grade‡</td>
<td>0.90 (0.80-1.01)</td>
<td>0.0836</td>
<td>1.02 (0.91-1.15)</td>
<td>0.6984</td>
</tr>
<tr>
<td>Tumor site</td>
<td>0.68 (0.49-0.94)</td>
<td>0.0174</td>
<td>0.71 (0.53-0.96)</td>
<td>0.0252</td>
</tr>
<tr>
<td>MMR status</td>
<td>1.00 (0.996-1.004)</td>
<td>0.9007</td>
<td>1.01 (1.005-1.014)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Defective vs intact</td>
<td>1.75 (1.50-2.04)</td>
<td>&lt;0.0001</td>
<td>(1.51-2.04)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Number of lymph nodes</td>
<td>3.57 (3.04-4.20)</td>
<td>3.58 (3.05-4.19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment status</td>
<td>0.61 (0.52-0.72)</td>
<td>&lt;0.0001</td>
<td>0.69 (0.59-0.81)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*Score test $P$ value from a Cox regression model after stratifying by study.
†Wald $\chi^2$ $P$ value for the individual categories shown.
‡Grade1/2: well/moderate differentiation; grade 3/4: poor/undifferentiated.
BMI categories are shown in Fig. 2A. As shown by the HRs, an adverse prognostic effect of BMI is seen for both underweight and class 2,3 obese patients. When the data were analyzed by patient gender (Table 3), we found that BMI was significantly associated with OS in men (overall \( P = 0.0021 \)) and was of borderline significance in women (OS; overall \( P = 0.0674 \); adjusted \( P_{\text{interaction}} = 0.081 \) for categorical BMI and gender for OS). Specifically, men with class 2,3 obesity had a significantly worse OS (HR, 1.35; 95% CI, 1.02-1.79; \( P = 0.0391 \)) compared with normal-weight men (Table 3; Fig. 1A). In women, class 1 obesity was associated with worse OS compared with normal-weight women (HR, 1.24; 95% CI, 1.01-1.53; \( P = 0.0447 \); Fig. 1B), whereas this same effect was not observed in men (Table 3; Fig. 1A). Overweight men had a significantly improved OS (\( P = 0.0063 \)) compared with normal-weight men after adjustment for covariates (Table 3). The poor prognosis of underweight patients was more evident in women (OS; \( P = 0.019 \); Table 3). A comparison of the OS HRs (95% CI) by BMI category and gender is shown graphically in Fig. 2B to illustrate the gender-related differences. Age, tumor stage, and treatment were at least of borderline significance for OS among all patients and in both genders (Table 3).

Because normal-weight and overweight patients had the best prognoses, we combined these groups and

### Table 3. Multivariate analysis of BMI and OS

<table>
<thead>
<tr>
<th>Variable</th>
<th>All patients ((n = 4,366))</th>
<th>Women ((n = 2,098))</th>
<th>Men ((n = 2,268))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorical BMI (overall)</td>
<td>HR (95% CI)</td>
<td>( P^* )</td>
<td>( P^* )</td>
</tr>
<tr>
<td>Underweight vs normal</td>
<td>1.24 (1.03-1.50)</td>
<td>1.32 (1.05-1.67)</td>
<td>1.14 (0.81-1.61)</td>
</tr>
<tr>
<td>Overweight vs normal</td>
<td>0.90 (0.80-1.00)</td>
<td>1.01 (0.85-1.19)</td>
<td>0.82 (0.71-0.95)</td>
</tr>
<tr>
<td>Class 1 obese vs normal</td>
<td>1.07 (0.93-1.23)</td>
<td>1.24 (1.01-1.53)</td>
<td>0.94 (0.78-1.15)</td>
</tr>
<tr>
<td>Class 2,3 obese vs normal</td>
<td>1.19 (0.98-1.45)</td>
<td>1.35 (1.02-1.79)</td>
<td>1.35 (1.02-1.79)</td>
</tr>
<tr>
<td>Age</td>
<td>1.01 (1.01-1.02)</td>
<td>1.01 (1.01-1.02)</td>
<td>1.01 (1.01-1.02)</td>
</tr>
<tr>
<td>Stage (II vs III)</td>
<td>0.47 (0.41-0.53)</td>
<td>0.51 (0.43-0.61)</td>
<td>1.04 (1.04-1.26)</td>
</tr>
<tr>
<td>Treatment (effective vs control/ineffective)</td>
<td>0.72 (0.62-0.85)</td>
<td>0.64 (0.51-0.80)</td>
<td>0.64 (0.51-0.80)</td>
</tr>
<tr>
<td>Gender (men vs women)</td>
<td>1.15 (1.04-1.26)</td>
<td>1.15 (1.04-1.26)</td>
<td>1.15 (1.04-1.26)</td>
</tr>
</tbody>
</table>

*Likelihood ratio \( P \) value after stratifying by study.
†Wald \( \chi^2 \) \( P \) value.
conducted a secondary analysis. Using these combined
groups as the reference (BMI, 20-30), we found that
obesity (class 1-3; BMI, >30) was associated with a signif-
ically worse DFS ($P = 0.0254$) and OS ($P = 0.0093$) after
adjusting for age, stage, treatment, and gender. Given the
findings for individual BMI categories and patient out-
come, we determined whether a curvilinear or quadratic
relationship could also describe the results observed. We
found that continuous BMI displayed a significant curvi-
linear relationship with OS ($P = 0.0071$) after adjustment
for age, stage, treatment, and gender.

**Predictive analysis.** We determined whether BMI was
predictive for 5-fluorouracil–based chemotherapy out-
come among all patients and within stage III patients.
In the multivariate models, there was no significant re-
relationship between BMI and treatment efficacy (adjusted
$P > 0.15$) for any of the BMI categories tested.

**Discussion**

Although obesity and a sedentary lifestyle are known
to increase the risk of developing colon cancer (2–7), on-
ly recently have studies examined whether obesity can in-
fluence the outcome of survivors of this disease. To
determine whether obesity is associated with differences
in colon cancer recurrence and/or survival, we studied
stage II and III colon cancer patients from completed ad-
juvant chemotherapy trials. Using study baseline BMI
measurements, we observed that obesity (BMI, ≥30 kg/m²)
was significantly associated with an increased number of
metastatic regional lymph nodes compared with normal-
weight patients. The number of lymph node metastases is
an accepted adverse prognostic variable in colon cancer pa-
tients (24). Obese patients were more likely to have distal
versus proximal colon cancers, and distal tumors have been
shown to have higher rates of chromosomal instability, p53
mutation, and DNA aneuploidy that may confer a worse
prognosis (32, 33).

We found that obese patients showed higher rates of
cancer recurrence and mortality compared with normal-
weight patients that was most evident overall for class
2,3 (BMI, ≥35 kg/m²) obesity. In a multivariate analysis,
class 2,3 obesity was associated with a 19% increase in
the risk of death (i.e., OS) compared with normal-
weight patients. It is important to note that unlike the
NSABP colon cancer adjuvant trials (13), our studies did

Fig. 1. Relationship between obesity and
clinical outcome for stage II and III colon
cancer patients participating in adjuvant
chemotherapy trials. A, OS in men only.
B, OS in women only.
not limit chemotherapy dosing based on body surface area, and therefore, the less favorable outcomes among obese patients are not related to differences in the amount of chemotherapy received. In support of the prognostic effect of obesity, we found that chemotherapy dosing and the number of cycles of adjuvant chemotherapy received were similar in obese versus normal-weight subjects. Although we did not have data on the total number of lymph nodes removed at surgical resection, we further addressed the adequacy of surgical resection by examining local recurrence rates in patients where such data were available (n = 243). Across all BMI categories studied, local recurrence rates were similar (P = 0.67) and did not differ significantly among obese versus normal-weight patients (n = 130; P = 0.20). Therefore, our data suggest that obesity did not adversely affect the adequacy of surgical resection when local recurrence is used as a surrogate. Regrettably, we did not have colon cancer–specific survival data; however, DFS is a useful surrogate for such information and results for DFS and OS were similar.

We determined whether the prognostic effect of obesity was related to patient gender. Data about BMI, gender, and prognosis have been conflicting in patients with established colon cancer. In an adjuvant chemotherapy trial, obese women (BMI, ≥30.0 kg/m²) but not men experienced significantly worse overall mortality (12). In an analysis of pooled adjuvant colon cancer studies conducted by a single cooperative group (NSABP), no differences between obesity and colon cancer outcome by gender were found (13). However, we found a stronger relationship between BMI and clinical outcome in

---

**Fig. 2.** A, HRs and 95% CIs for DFS and OS in relation to BMI category in all patients. B, HRs and 95% CIs for OS by BMI category in men versus women. HRs were adjusted for age, stage, treatment, and gender.
men compared with women. Men who were very obese (BMI, ≥35 kg/m²) had a 35% increased risk of death that was statistically significant, whereas very obese women had only an 11% increased risk of death that was not significant compared with normal-weight patients after adjustment for covariates. Women with class 1 (BMI, 30-34 kg/m²) obesity, however, had worse OS (P = 0.045) compared with normal-weight women, whereas this same effect was not observed in men. These data are consistent with the finding that the association of BMI and colon cancer incidence and mortality is stronger and more linear in men than in women (9, 10, 34–39). Stronger associations for BMI and prognosis in men compared with women may be explained, in part, by the observation that BMI is more closely related to the amount of abdominal or central adiposity in men than in women (40, 41). In this regard, a 20% increase in the risk of colon cancer recurrence or death was observed for every 10-cm increase in waist circumference (42). Another potential explanation for gender differences in colon cancer prognosis is an effect modification by menopausal status and/or hormone replacement therapy in that a protective effect of hormone replacement therapy has been associated with a significant reduction in colon cancer mortality (3, 43, 44).

Patient gender was related to the molecular pathway of colon tumorigenesis in that colon cancers with defective MMR were more prevalent in older women but not in men (19, 45). In this regard, we found that defective MMR was associated with older age in women but not in men (P_{interaction} = 0.0009). An excess of colon cancers with defective MMR found in older women as shown here may be related to a withdrawal of estrogens (45, 46). Interestingly, we found that obese patients had significantly fewer colon cancers with defective MMR compared with normal-weight patients. Similarly, obesity and lack of physical activity were associated with a lower prevalence of colon cancers with defective MMR in women but not in men in a population-based, case-controlled study (45). Obesity is associated with increased levels of circulating estrogen (47), and estrogen may protect against the development of colon cancers with defective MMR in women (45).

We found that colon cancer mortality was increased among underweight (BMI, <20.0 kg/m²²) patients in a multivariate analysis. A worse outcome for underweight patients has been a consistent finding among studies, and underweight may reflect underlying comorbidities that increase mortality risk (48). Mortality in underweight CRC patients was more often due to noncancer-related causes than was mortality in normal-weight patients (13). We also observed that overweight patients had significantly better OS rates in a multivariate analysis. This effect was limited to men, whereby overweight men showed significantly improved OS (P = 0.006) after adjusting for age, stage, and treatment. Some longitudinal studies have shown that overweight subjects without a cancer history have the lowest mortality among BMI categories when examining BMI and risk of death (49, 50). This finding may reflect a limitation of BMI in that it makes no distinction between body weight from muscle versus fat, and therefore, muscular individuals can be categorized as overweight or obese when they are not. Together, our data show the complex relationship of BMI and clinical outcome whereby the prognostic effect of BMI varies by category. Based on WHO guidelines and prior studies (13, 26), we analyzed BMI as a categorical variable. The results of this analysis suggested that BMI has a curvilinear or quadratic relationship with OS. We also modeled BMI as a continuous curvilinear variable and found that it was associated with OS (P = 0.0071). Therefore, our data show consistent results when modeling BMI as a categorical variable or as a continuous curvilinear variable.

The mechanism underlying the effect of obesity on the clinical behavior of colon cancers remains poorly understood but may involve interactions among insulin, IGFs, and IGF-binding proteins (16, 17, 51–54) that have all been implicated in colon cancer development. Increased circulating levels of insulin and free IGF-I have been associated with obesity and physical inactivity (18, 55, 56). Furthermore, both insulin and IGF-I promote cell proliferation and inhibit apoptosis in colon cancer cells (57, 58), suggesting that they may promote the growth of micrometastases. In a prospective case-control study nested within the Physicians’ Health Study, men in the highest quintile for IGF-I had 2.5 times the risk of CRC as did men in the lowest quintile (51). An analysis of the Nurses’ Health Study cohort found a comparable risk increase among women, with a relative risk of 2.17 for those in the highest quartile of IGF-I compared with those in the lowest (15). Studies have also shown (16, 52) an increase in CRC risk with increasing levels of C-peptide, a marker of insulin production, and in men with the high levels of the hormone leptin (59, 60). Another mechanism that may contribute to differences in colon cancer survival based on BMI is suggested by data for fatty acid synthase (FASN) expression (61). Among normal-weight and minimally overweight patients (BMI, <27.5 kg/m²), FASN positivity was associated with a reduction in mortality, whereas among moderately overweight and obese patients (BMI, ≥27.5 kg/m²), FASN overexpression conferred a significant increase in mortality (61). FASN plays an important role in de novo lipogenesis and is physiologically regulated by energy balance in that exercise and energy restriction downregulate FASN (62).

Important strengths of our study include its large size, accuracy of BMI measurements done at study entry by trained staff rather than self-reporting of height and weight, and rigorous collection of recurrence and survival data during an extended follow-up period. Limitations include the retrospective design and measurement of obesity by BMI versus measures of central obesity such as waist-to-hip ratio or waist circumference that may be more predictive of the risk of developing colon cancer than BMI (3, 42, 63). We were also unable to analyze factors such as diet, physical activity, or menopausal status and hormone
replacement therapy use that may have independent associations with colon cancer outcomes as well as risk of death from other causes. Importantly, Meyerhardt et al. (14) reported that changes in weight (either gain or loss) during the period of adjuvant chemotherapy in colon cancer patients were not associated with clinical outcome.

Our findings extend the effect of obesity beyond its known association with colon cancer risk by showing that obesity is an independent prognostic variable in colon cancer survivors that shows differences by gender. Obesity was a poor prognostic factor despite adjuvant chemotherapy. Such information has the potential to influence patient management decisions and surveillance strategies. Further study is needed to determine the mechanism of the adverse effect of obesity on survivors of colon cancer. Lastly, our findings suggest the potential for evaluating interventions among obese survivors of colon cancer with the goal of improving patient outcomes.

**Disclosure of Potential Conflicts of Interest**

No potential conflicts of interest were disclosed.

**Grant Support**

Supported in part by National Cancer Institute grant CA 104683 (F.A. Sinicrope).

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.


---

**References**

Obesity Is an Independent Prognostic Variable in Colon Cancer Survivors

Frank A. Sinicrope, Nathan R. Foster, Daniel J. Sargent, et al.


Updated version  Access the most recent version of this article at:
doi:10.1158/1078-0432.CCR-09-2636

Cited articles  This article cites 60 articles, 27 of which you can access for free at:
http://clincancerres.aacrjournals.org/content/16/6/1884.full.html#ref-list-1

Citing articles  This article has been cited by 25 HighWire-hosted articles. Access the articles at:
/content/16/6/1884.full.html#related-urls

E-mail alerts  Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions  To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions  To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.