Absence of MMP2 Expression Correlates with Poor Clinical Outcomes in Rectal Cancer, and Is Distinct from MMP1-Related Outcomes in Colon Cancer

John C.T. Wong¹, Simon K. Chan³, David F. Schaeffer², Xavier Sagaert⁵, Howard J. Lim⁴, Hagen Kennecke⁶, David A. Owen², Kwang W. Suh⁶, Young-Bae Kim⁶, and Isabella T. Tai¹,³

Abstract

**Purpose:** Treatments for colorectal cancer (CRC) are primarily disease stage based. However, heterogeneity in outcome within even a single stage highlights its limitations in predicting disease behavior. Recently, the role of gene expression as predictive and prognostic markers has been explored. Our objectives were to identify consistently differentially expressed genes through meta-analysis of high-throughput gene-expression studies, and evaluate their predictive and prognostic significance in colon (CC) and rectal (RC) cancers.

**Experimental Design:** Publications applying high-throughput gene-expression technologies to specific CRC stages were identified. A vote counting strategy was used to identify the most significant differentially expressed genes. Their predictive and prognostic values were independently assessed in a tissue microarray of 191 cases of stage II-IV CC/RC from two tertiary care centers. Their biological effects were also examined in vitro.

**Results:** MMP1 and MMP2 were identified as consistently underexpressed in liver metastasis compared with primary CRC. Shorter time to distant metastasis and overall survival occurred in stage III CC lacking MMP1 expression, and in stage III RC lacking MMP2. MMP1 levels in stage II and III CC were associated with increased likelihood of distant metastasis, whereas the risk of local recurrence in stage III RC could be stratified by MMP2. Promotion of cell invasion of CRC cell lines exposed to MMP1/2 inhibitors were confirmed in vitro.

**Conclusions:** MMP1 and MMP2 may be useful biomarkers that can help stratify patients at higher risk of developing recurrence in colorectal cancer, and guide individualized treatment decisions to achieve better outcomes. *Clin Cancer Res; 17(12); 4167–76. ©2011 AACR.*

Introduction

Recurrence of colon and rectal cancers, either locally or regionally at the site of original disease or distantly as metastases, after "curative" surgical resection represents a significant cause of morbidity and mortality. Risk reduction interventions have centered on the use of neoadjuvant and/or adjuvant chemotherapy and/or radiotherapy. In stage III colon cancers, whereas resection alone leaves a 50% to 60% risk of disease recurrence, the addition of adjuvant chemotherapy could improve the five year overall survival by greater than 10% (1). As a result, surgical tumor resection followed by adjuvant 5-fluorouracil (5-FU)-based chemotherapy represents the standard of care for stage III colon cancers (2). In stage II disease, however, the role of adjuvant chemotherapy is more controversial due to its minimal efficacy (maximal 5% improvement in five year overall survival) in exchange for potentially serious lifelong toxicities, and is therefore not recommended according to the most recent practice guidelines (3). However, it is recognized that 25% to 30% of stage II disease will experience recurrence after resection (3). This heterogeneity in disease behavior, even within a single stage, highlights the limitations of staging as the sole determinant of treatment strategies. This has led to searches for better predictive markers that could complement staging, ensuring those at the highest risk for recurrence are identified and receiving appropriate and timely treatment. Whereas stage II disease would seem to benefit most from such markers, their application to stage III disease may conversely identify those at lower risk of recurrence. Although the majority of stage III disease receive adjuvant chemotherapy, it is...
In the last several years, the role of gene expression as possible predictive and prognostic markers in multiple types of malignancies including colorectal cancers (CRC) has been explored. Some studies have identified differences in gene expression between normal-colon mucosa, adenomas and CRCs, suggesting their potential role as diagnostic markers (14). Others have correlated gene expression with response to chemotherapy or overall survival, identifying them as putative predictive or prognostic biomarkers, respectively (14–15). Unfortunately, the biological significance and clinical application of such findings are often unclear due to the small sample sizes of the studies, and the lack of independent replicated studies. As a way of highlighting genes of greater clinical significance in the setting of CRC, Chan and colleagues recently completed a meta-analysis, reviewing 25 independently published cancer profiling studies comparing gene expression between CRC and normal colon, resulting in the successful identification of numerous genes that were consistently up or downregulated in CRC across multiple published studies (16).

The objectives of our study were to complete a similar meta-analysis, but of gene expression studies comparing expression profiles of liver metastases versus the primary CRC. These consistently identified differentially expressed genes would be considered as high-yield markers of metastatic disease. Because metastatic disease is associated with worse overall survival, the validity of these putative genes as predictive markers of disease recurrence and prognostic markers for survival in a much earlier stage of disease were evaluated by immunohistochemistry using a tissue microarray of stage II, III, and IV colon and rectal cancers. Their effects on CRC cell lines were also assessed in vitro by invasion assay.

**Materials and Methods**

**Identifying high-throughput gene expression studies**

We utilized PubMed to identify publications that applied transcript-based high-throughput gene expression technologies to the following comparisons: liver metastases versus corresponding primary CRCs (type one); primary CRCs that underwent liver metastasis versus those that did not (type two); primary CRCs that underwent lymph node metastasis versus those that did not (type three). We limited our search to studies published between 2001 and 2007, and utilized the key words “colorectal,” “metastatic,” “liver,” and “lymph node.” When possible, the given gene identifiers were mapped to the NCBI Entrez Gene ID using the Clone/Gene ID Converter tool (17).

**Ranking differentially expressed genes and assessing significance**

The meta-analysis method was previously developed by our group (16, 18). Briefly, the method involved a vote-counting strategy whereby differentially expressed genes reported in independently published studies were ranked according to 3 criteria in the following order of importance:
CRCs Lacking MMP1 and MMP2 Have Earlier Metastasis and Death

(i) the number of studies reporting the differential expression of a gene (i.e., a gene’s overlap), (ii) the number of tissue samples utilized in these studies, and (iii) the average fold change. To assess the statistical significance of the number of genes reported in at least two or more studies (i.e., multistudy genes), we developed Perl scripts that carried out Monte-Carlo simulations. This assessment for statistical significance was carried out to determine if the observed number of multistudy genes could be observed by chance alone. One can imagine randomly choosing genes from each expression-profiling platform of each study, randomly labeling them as up or downregulated, and observing some level of overlap due to chance alone. For each study in each comparison type, the same number of mapped up and downregulated genes was randomly chosen from the corresponding list of genes that were represented on each of the expression profiling platforms. Note that these genes represent those that could potentially be reported as differentially expressed by each study. Next, the number of genes with an overlap of two, three, four, etc., would be calculated. Ten thousand such permutations were executed. At the conclusion of the permutations, a distribution of overlap results from the simulations was determined and a P-value was estimated by comparing the overlap from the simulations to the level of overlap in the actual data. Statistical significance was defined at P < 0.05.

Note that for 10 microarray studies, we were unable to obtain the genes represented on the corresponding expression profiling platform (Supplementary References 2, 4, 5, 8–11, 14, 16, 18). Thus, an approximation approach was used in which the appropriate number of genes was randomly chosen from the combined gene lists from the other platforms. For the lone serial analysis of gene-expression (SAGE) study, the genes listed in the tag to gene-mapping data from SAGE Genie were used as genes that SAGE can potentially identify as differentially expressed (19).

Characteristics of patients represented in tissue microarray

191 patients with colon and rectal cancers distributed across stages II, III, and IV, diagnosed at Ajou University School of Medicine (Korea) from 1994 to 2002 and the British Columbia Cancer Agency (BCCA) from 2000 to 2008, consented to study participation and inclusion of their tissue in the tissue microarray (TMA). Ninety-seven patients had colon cancer with 23 at stage II, 37 at stage III, and 37 at stage IV. The stage distribution of the 94 rectal cancers were 29, 51, and 14 for stage II, III, and IV, respectively. One hundred were men and 84 were women, with the remaining 7 unknown due to lack of registry information. The median age at diagnosis was 60 years (range: 30 to 91) (Table 1). In the Korean cohort, stage II colorectal cancers underwent surgical resection followed by 12 months of adjuvant oral 5-FU based chemotherapy (doxifluridine, 900 mg/day). Stage III colorectal cancers postresection received the modified Mayo regimen (six cycles of continuous infusion of 5-FU 1000 mg/m²) plus bolus injection of 30 mg of leucovorin for 5 consecutive days. For the BCCA cohort, first-line therapy for colon cancers was irinotecan alone or in combination with 5-FU for 50% of patients, oxaliplatin and 5-FU based therapy in 37%, and capecitabine alone among 7% (8%). The remaining 5% received second-line treatment. Among the 24 patients with rectal cancer, 4 received no radiation to the primary tumor, 16 received preoperative radiation, and 4 postoperative radiation. Local recurrence, distant metastasis, and death occurring during a 60-month follow up period were documented for each patient. Ethics approval was obtained from the institutional review boards.

Table 1. Characteristics of patients represented in the tissue microarray

<table>
<thead>
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<th>Colon cancer (n = 97)</th>
<th>Rectal cancer (n = 94)</th>
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<tr>
<td>Median age at diagnosis (Range)</td>
<td>60 (30–85)</td>
<td>61 (35–91)</td>
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Tissue microarray construction and immunohistochemistry

Two-formalin-fixed, paraffin-embedded cores were taken from representative areas of primary tumors from each patient and mounted onto the TMA block. 4 μm–thick sections were made from the TMA block and subsequently deparaffinized in xylene and rehydrated. Sections were heat in citrate buffer for 15 minutes in a cooker for antigen retrieval. Endogenous peroxidase activity was blocked using 0.3% H₂O₂ and washed with PBS for 10 minutes. Immunohistochemical staining with all primary antibodies was carried out using Ultravision LP detection kit (Thermo Fisher Scientific). Sections were treated with Ultra V Block for 5 minutes to prevent nonspecific reaction with primary antibodies, then incubated at 4°C for 24 hours with primary antibodies, followed by incubation with a primary antibody enhancer for 10 minutes at room temperature. Subsequently, sections were treated with horseradish peroxidase (HRP) polymer for 15 minutes and the reaction product was developed using 3,3-di-aminobenzidine tetrahydrochloride (Zymed). The sections were counterstained with hematoxylin and mounted with Tissue–Tek Glas 6419 (Sakura Finetek). Negative controls consisted of omission of the primary antibodies. Primary antibodies used in this study were directed against MMP1 (Thermo Fisher Scientific, rabbit polyclonal, diluted 1:30), and MMP2 (Epitomics, rabbit polyclonal, diluted 1:50). Staining expression scores were based on the number of tumor cells with positive staining in the cytoplasm, and were categorized as follows: 0 or none (expression < 10%), 1+ or weak (10% to 50%), 2+ or strong (50% to 80%), and 3+ or intense (>80%), by two independent pathologists at each center (DFS, X.S, KWS, YK) who were blinded to...
the same medium as above with the addition of 5-FU (50 μmol/L) and CPT-11 (5 μmol/L). Cells were starved overnight in serum-free medium (containing 0.1% FBS), in the presence/absence of MMP1 inhibitor (MMP1-I: 0.5 μmol/L, Cat# 444250, Calbiochem) or MMP2 inhibitor (MMP2-I: 5 μmol/L, Cat# 444244, Calbiochem). Six-hundred microliter medium was added to the lower well (+/− MMP1-I or MMP2-I). After 3 days of incubation at 37°C and 5% CO2, cells remaining in the upper surface of the membrane were completely removed with cotton swabs. The medium in the lower chamber was removed to collect any cells that had invaded through the membrane. In addition, fresh medium (100 μl) was added to the lower well and the attached cells at the bottom of the well were counted under microscope. To collect the cells that had migrated to the undersurface of the membrane, the membranes were washed with PBS three times (all PBS washes were collected), and then trypsinized with 0.25% trypsin. All cells were collected following centrifugation at 500 g for 15 minutes. The cell pellet was resuspended and stained with trypan blue, and counted under the microscope. Data collected from triplicate experiments were analyzed by two-sample test of means using Smith’s statistical package.

Results

Identification of consistently differentially expressed genes by meta-analysis

In total, 18 independent metastasis studies were included in the meta-analysis (Supplementary Table SI). These studies reported 1,341 differentially expressed genes (528 up and 813 downregulated), of which 1,232 (91.9%) were mapped successfully to an NCBI Entrez Gene ID (506 up and 726 downregulated). Supplementary Table SII summarizes the results of the analysis for gene overlap for each comparison. For each comparison type, the number of (a) independent studies included, (b) differentially expressed genes identified, and (c) multistudy genes identified (that is, genes reported in at least two independent studies with the same direction of differential expression) are detailed. Of note, five studies were included in comparison type one (liver metastases versus corresponding primary CRCs), which yielded six multistudy genes, which was significantly greater than the average of 1.264 (95% CI: 1.255 to 1.273) genes expected by Monte-Carlo simulations to have an overlap of two by chance alone (P = 0.001). The number of multistudy genes observed in all remaining comparisons (types two, three, combined liver studies, and combined all studies) was not statistically significant (Supplementary Tables SIII and SIV). Of the six multistudy genes identified in comparison type one, MMP1 and MMP2 were significantly underexpressed by an average 1.96 and 1.64 fold in liver metastasis, respectively (Table 2). Due to their role as putative markers of metastasis, their predictive and prognostic significance were independently assessed by a tissue microarray consisting of stage II–IV colon and rectal cancers, and by in vitro cell invasion studies.

Low MMP1 expression is associated with poor outcomes in Stage III colon cancer

Correlation with disease stage. MMP1 expression was downregulated with advancing disease stage for both colon and rectal cancers. However, the progressive effect was more pronounced in rectal cancers (P = 0.002) (Fig. 1A and B). Whereas less than 25% of stage II rectal cancers had no MMP1 expression and more than 70% had strong expression, by stage IV metastatic disease, the proportion with no MMP1 staining increased to almost 60%, with a remaining 20% having strong MMP1 expression. A representative staining pattern for MMP1 expression is shown in Fig. 2.

Correlation with disease recurrence, disease-free, and overall survivals. For both colon and rectal cancers, MMP1 expression in neither stage II nor III disease was associated with local recurrence. However, development of distant metastasis in stage II (P = 0.008) and stage III (P = 0.01) colon cancers during a five-year follow-up period
correlated to lower MMP1 staining in the primary malignancy (Figs. 1C and D). Of the 23 stage II–colon cancers represented in the TMA, 10 did not experience distant metastasis and within this group, 70% had strong MMP1 expression. In contrast, of the remaining 13 patients that did have distant metastasis, almost 70% had no MMP1 expression. Among the 37 stage III–colon cancers, 16 patients had distant metastasis during follow-up and almost 70% of this group had no MMP1 expression. Only one third of the remaining 21 patients that did not have recurrence had no MMP1 staining. MMP1 did not correlate to distant metastasis in rectal cancer. Interestingly, among stage II, III, and IV colon and rectal cancers, stage III colon cancer without MMP1 experienced both shorter time to distant metastasis (P = 0.001) and overall survival (P = 0.007) (Figs. 1E and F).

**Low MMP2 expression is associated with poor outcomes in rectal cancer**

**Correlation with disease stage.** Similar for MMP1, downregulation of MMP2 occurred with more advanced stages of colon and rectal cancers. Among stage II rectal cancers, 21% did not express any MMP2, whereas 31% showed strong expression. The proportion of stage IV disease without MMP2 expression and strong expression increased to 50%, and decreased to 7%, respectively (Figs. 3A and B).

**Correlation with disease recurrence, disease-free, and overall survivals.** The only association noted between MMP2 expression and recurrent disease was found in stage III rectal cancers where downregulation of MMP2 was correlated to local recurrence (P = 0.002) (Fig. 3C). Of interest, all 7 of the 51 stage III rectal cancers that experienced local recurrence did not have any MMP2 expression. This is compared with the group with local recurrence, of which only 30% had no MMP2 staining. Therefore, a MMP2 of 0 (if considered as the positive test result) had a negative predictive value of 100% and a positive predictive value of 35% for local recurrence in stage III rectal cancer. Finally, absent MMP2 was associated with a shorter time to local recurrence (P = 0.001), distant metastasis (P = 0.02), and death (P = 0.008) in stage III rectal cancers (Figs. 3D, E, and F). At the end of the five years follow-up, 80% of stage III rectal cancers with any expression of MMP2 survived compared with only 40% of no expressors. No correlations to disease-free or overall survivals were noted in stage II or IV rectal disease.

**In vitro studies: inhibition of MMP1 and MMP2 promotes cell invasion.** The effect of MMP1 and MMP2 inhibition on cell invasion was examined in vitro. Following incubation with either MMP1-I or MMP2-I, all cell lines examined (chemotherapy sensitive CRC cell lines RKO and HCT 116, as well as CPT-resistant RKO/CPT, and 5-FU-resistant RKO/5-FU colorectal cells) showed an increased number of cells that had invaded through the matrigel membrane compared with control cells not exposed to either MMP1-I or MMP2-I (Fig. 4). For sensitive cells, cell invasion increased from 27.0 ± 7.1 cells to 51 ± 5.6 cells (P = 0.03) and 58.0 ± 1.4 cells (P = 0.013) following inhibition with MMP1-I or MMP2-I, respectively in RKO cells; and similarly, from 177.0 ± 4.2 cells to 223.0 ± 12.7 cells (P = 0.0166, MMP1-I) and 284.0 ± 32.5 cells (P = 0.028, MMP2-I) in HCT116 cells. The most dramatic increase was observed in resistant RKO/CPT and RKO/5FU cells: incubation with inhibitors resulted in a 1.6- to 4-fold increase in cell invasion in RKO/CPT and RKO/5FU cells, respectively following incubation with MMP1-I, whereas MMP2-I induced a 0.5- to 2.9-fold increases in cell invasion in the same cell lines, respectively.

**Discussion.**

In 2010, there were an estimated 142,570 new diagnoses of and 51,370 deaths in the United States due to colon and rectal cancers, the third most common cause of death among malignancies (20). Unfortunately, disease
recurrence after “curative” surgical resection contributes to many of these mortalities. Neoadjuvant and/or adjuvant chemotherapy with/without radiation is frequently offered to select patients for risk reduction. For example, in stage II colon cancer, the presence of poor prognostic features such as a clinical presentation of bowel obstruction or perforation, a T4 primary, lymphovascular invasion, poorly differentiated histology, and a small number of lymph nodes sampled are used at some centers to justify adjuvant chemotherapy (21). Identifying biomarkers predictive of local recurrence or distant metastasis and their complementary applications to patients may permit more individually tailored treatments. Further, understanding their molecular roles may help to clarify the pathogenesis underlying tumor growth, local invasion, and distant metastasis.

Through our meta-analysis of high throughput expression studies comparing gene profiles of liver metastases versus primary CRC, six genes were identified as consistently differentially expressed across multiple published studies. Specifically, MMP1 and MMP2 were significantly underexpressed by 1.96- and 1.64-fold in liver metastasis, respectively. This downregulation was further confirmed in a recent reverse transcriptase PCR–based study not included in our meta-analysis (22). Briefly, MMP1 and MMP2 are two of more than 20 members of zinc-dependant matrix metalloproteinases that collectively function as the main extracellular matrix remodelling enzymes. They can be further subgrouped by their substrate specificity, with MMP1 classified as a collagenase and MMP2 as a gelatinase. There is however redundancy, with...
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where adjuvant chemotherapy may be most beneficial. In

possible predictive marker in identifying high-risk patients

in stage II and III colon cancers, suggesting its role as a

promoting properties, and together with low MMP2

expression, may be potentiating the growth and metastatic

potential of colon and rectal cancers, as observed in this

study. Evaluation of TIMP1 in future studies would help
test this hypothesis.

To understand how low expressions of MMP1 and

MMP2 could be associated with shorter time to metastasis

in both colon and rectal cancers, in vitro studies were

conducted. Interestingly, the results showed that inhibition

of MMP1 and MMP2 promoted cell invasion and in partic-

ular, that induction of cell invasion was most dramatic in

chemoresistant cells. Our in vitro observations can help

explain the clinical outcomes observed in this study. How-

ever, that low MMP1 expression may predict distant metas-

tasis and poor survival in cases of colon cancers only,

whereas MMP2’s prognostic value is limited to rectal can-

cers, suggest differences in biologic behavior of cancers at

these two distinct anatomic sites.

Another interesting observation from our TMA was that

low MMP2 expression in stage III rectal cancers correlated

with local recurrence, the first such finding to our knowl-

dge. Within our TMA, absence of MMP2 expression in

stage III rectal cancer had a negative predictive value of

100% and a positive predictive value of 35% for local

recurrence. These findings highlight the predictive and

prognostic value of MMP2 expression in rectal cancers

and suggest that it could complement existing modalities,

each metalloproteinase able to breakdown more than one extracellular matrix component (23). Their activity is
tightly controlled (i) at the gene transcription level both

positively and negatively by various oncogenes, cytokines

and growth factors; (ii) via proteolytic activation of pro-

MMPs; (iii) by endogenous tissue inhibitor of matrixpro-
teinases (TIMPs) at varying affinity (24).

In this study, we identified stage specific MMP1 differ-

ces by noting downregulation of MMP1 with advancing

colon and rectal cancer stages. Weaker MMP1 expression

was also associated with development of distant metastasis

in stage II and III colon cancers, suggesting its role as a

possible predictive marker in identifying high-risk patients

where adjuvant chemotherapy may be most beneficial. In

earlier studies, it was stronger MMP1 expression that cor-

related to distant metastasis development, but those

cohorts were mixtures of colon and rectal cancers of all

stages (25–26). Because disease recurrence in colon cancer

occurs more commonly via distant metastasis than local

recurrence, the absence of any correlations to the local

recurrence endpoint was not unexpected. Differences in

dividing patient subgroups for analysis, and cohort com-

positions, may also explain inconsistent results in survival
correlations. Whereas we report stage III colon cancer

without MMP1 had earlier time to distant metastasis and
death, making it a putative prognostic marker, Hilska and

colleagues noted no such associations, whereas Murray

and colleagues found it was stronger MMP1 which had

worse prognosis (27–28). That correlations were noted in

colon, but not rectal cancers, could be attributed to differ-

ent pathogenesis and clinical behaviors of malignancies

from the two sites.

We also noted downregulation of MMP2 with advancing

stages in both colon and rectal cancers. Given that MMP2’s

upregulation is often associated with loss of the basement

membrane type IV collagen (29), reflecting its role in
degrading components of the extracellular matrix to facili-
tate local invasion and disease progression, and that

cleavage of laminin-5 by MMP2 may expose a putative

cryptic promigratory site on Ln-5, triggering cell motility

(30), it was expected that MMP2 would be progressively

upregulated with advancing disease stage, as shown by Li

and colleagues (31). However, in support of our observa-

tions, and in keeping with the results of our meta-analysis,

Waas and colleagues similarly showed that low stage (I and

II) disease showed higher MMP2 expression than more

advanced stages (III and IV) (32). Interestingly, mRNA

levels of MMP2’s inhibitor, TIMP1, have been reported
to be significantly upregulated in stage IV compared with

stages I and II disease (33). At the time, it was postulated

this was in response to high levels of MMP2 in the more

advanced stages. Our results raise the possibility that pro-

gressively higher levels of TIMP1 may be responsible for,
rather than a consequence of, progressively downregulated

MMP2. In addition, TIMP1 has been shown to have growth

promoting properties, and together with low MMP2

expression, may be potentiating the growth and metastatic

potential of colon and rectal cancers, as observed in this

study. Evaluation of TIMP1 in future studies would help
test this hypothesis.

Figure 2. Representative images of (A) MMP1 expression in CRC scored as 1+ expression; and (B) MMP2 expression scored as 2+ expression. 40× magnification.
such as EUS or MRI, in stratifying a stage III rectal cancer's risk of local recurrence, and therefore, influence treatment strategies for this disease. Stage III rectal cancers expressing no MMP2, not only had earlier local recurrence, but also shorter time to distant metastasis, and death, compared with higher MMP2 expressors. This is in contrast to findings that higher MMP2 was associated with shorter cumulative survival in colon cancers, in a recent study involving all stages, but predominantly stage III disease (27).

Tumor MMP2 was not associated with local recurrence or distant metastasis in either stage II colon or rectal cancers, suggesting its limited role as a predictive marker at this earlier disease stage. This was in agreement with a recent study involving only stage II colon cancers, which interestingly showed it was stromal MMP2 expression that was an independent risk factor for recurrence and associated with shorter disease-free survival (34).

Of note, the current study was primarily limited by the absence of typical clinico-pathologic prognosticators such as differentiation, and lympho/vascular invasion, preventing multivariate analysis.

In summary, we completed a large meta-analysis of CRC high-throughput gene-expression studies, identifying six genes as differentially expressed in liver metastasis compared with primary CRC. Using an independent TMA, the expressions of two such genes, MMP1 and MMP2, were separately analyzed in stages II-IV colon and rectal cancers. We noted decreased MMP1 and MMP2 expressions correlated with advancing colon and rectal cancer stages. Interestingly, for stage III colon cancer, development of distant metastasis, and shorter

**Figure 3.** Downregulation of MMP2 expression correlated to (A) more advanced colon cancer stage ($P = 0.01$); (B) more advanced rectal cancer stage ($P = 0.05$); (C) development of local recurrence in stage III rectal cancer ($P = 0.002$); (D) shorter time to local recurrence (LR), (E) distant metastasis (DM) and (F) overall survival in stage III rectal cancer (● = no MMP2 expression, ■ = weak MMP2 expression, □ = strong MMP2 expression).

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Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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References


Figure 4. Effect of MMP1 and MMP2 inhibitors on cell invasion of RKO and its drug-resistant cell lines (RKO/CPT, RKO/5FU), and HCT116 CRC cells.
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