CpG Island Methylator Phenotype–Positive Tumors in the Absence of MLH1 Methylation Constitute a Distinct Subset of Duodenal Adenocarcinomas and Are Associated with Poor Prognosis

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Abstract

Purpose: Little information is available on genetic and epigenetic changes in duodenal adenocarcinomas. The purpose was to identify possible subsets of duodenal adenocarcinomas based on microsatellite instability (MSI), DNA methylation, mutations in the KRAS and BRAF genes, clinicopathologic features, and prognosis.

Experimental Design: Demographics, tumor characteristics, and survival were available for 99 duodenal adenocarcinoma patients. Testing for KRAS and BRAF mutations, MSI, MLH1 methylation, and CpG island methylator phenotype (CIMP) status was conducted. A Cox proportional hazard model was built to predict survival.

Results: CIMP+ was detected in 27 of 99 (27.3%) duodenal adenocarcinomas and was associated with MSI (P = 0.011) and MLH1 methylation (P < 0.001), but not with KRAS mutations (P = 0.114), as compared with CIMP-/C0 tumors. No BRAF V600E mutation was detected. Among the CIMP+ tumors, 15 (55.6%) were CIMP+/MLH1-unmethylated (MLH1-U). Kaplan–Meier analysis showed that tumors classified by CIMP, CIMP/MLH1 methylation status, or CIMP/MSI status could predict overall survival (OS; P = 0.047, 0.002, and 0.002, respectively), whereas CIMP/MLH1 methylation status could also predict time-to-recurrence (TTR; P = 0.016). In multivariate analysis, CIMP/MLH1 methylation status showed a significant prognostic value in both OS (P < 0.001) and TTR (P = 0.023). Patients with CIMP+/MLH1-U tumors had the worst OS and TTR.

Conclusions: Our results showed existence of CIMP in duodenal adenocarcinomas. The combination of CIMP+/MLH1-U seems to be independently associated with poor prognosis in patients with duodenal adenocarcinomas. This study also suggests that BRAF mutations are not involved in duodenal tumorigenesis, MSI, or CIMP development.

Introduction

Primary adenocarcinoma of the duodenum was initially described by Hamburger in 1746 and represents about 0.3% of all malignant neoplasms of the gastrointestinal tract (1). During recent years, duodenal cancer incidence rates have increased more markedly than those for other subsites of small intestine (2). Integrated genetic and epigenetic analysis of duodenal adenocarcinoma is needed to better understand the pathways involved in its carcinogenic process, establish markers of resistance to traditional therapies, and contribute to the development of targeted therapies.

Much of our understanding of intestinal malignancies has developed from studies of colorectal cancers (CRC). Two mechanisms of tumorigenesis in CRC have recently drawn a great deal of attention: microsatellite instability (MSI) and CpG island methylator phenotype (CIMP). MSI, the abnormal shortening or lengthening of DNA by 1 to 6 repeating base pair units, develops from defects in the mismatch repair (MMR) genes MLH1, MSH2, MSH6, and PMS2 (3). Patients with Lynch Syndrome have an inherited defect in MMR genes and have an increased risk of around...
CpG island methylator phenotype (CIMP) has been found in multiple malignancies, including duodenal adenocarcinoma, but has not been further characterized because of the rarity of this disease. Using a large cohort of duodenal adenocarcinomas, we prove that CIMP exists in duodenal adenocarcinomas and is associated with microsatellite instability (MSI) and MLH1 methylation. No BRAF V600E mutation has been detected in this study, indicating that BRAF mutations are not critically involved in duodenal tumorigenesis. MSI, or CIMP development. CIMP+ is a prognostic marker for poor overall survival (OS) in patients with duodenal adenocarcinomas. CIMP+ in the absence of MLH1 methylation is a marker for poor OS and time-to-recurrence in duodenal cancers. Our findings highlight the usefulness of CIMP classification for prognosis prediction. Patients with CIMP+ duodenal adenocarcinomas, especially those with CIMP+/MLH1- tumors, may need more intensive surveillance and novel subtype-specific adjuvant therapy strategies after surgery.

Materials and Methods

Study population

This retrospective cohort study included patients with pathologically confirmed duodenal adenocarcinoma who had surgical resections. Patients were identified from the Johns Hopkins Hospital Oncology Clinical Information System from January 1997 to December 2009, and 155 duodenal adenocarcinomas patients who underwent surgical resection at our institution were identified. Patients who underwent preoperative chemotherapy/radiotherapy, lacked follow-up information or had missing archival primary tumors or corresponding matched normal samples were excluded. Formalin-fixed, paraffin-embedded (FFPE) tissue blocks of primary tumors and corresponding matched normal samples were collected from 107 patients. Tissue sections from the blocks were then reviewed by an expert gastrointestinal pathologist. After excluding ampullary tumors and low tumor cellularity sections, the remaining 99 cases formed the final study cohort (Table 1). Ascertainment of survival was carried out by using the Johns Hopkins electronic health records, the Cancer Registry, and mortality was confirmed also within the Social Security Death Index. The Johns Hopkins Hospital Institutional Review Board approved this research protocol.

Analyses of KRAS and BRAF mutations, and MSI

Genomic DNA was extracted from FFPE tissues. PCR and sequencing targeted for KRAS codons 12 and 13, BRAF codon 600 were conducted (16). MSI status was determined using D2S123, DSS346, D17S250, BAT25, and BAT26 (17). Microsatellite sizes were compared with those of normal adjacent tissue, and tumors with 2 or more of the markers exhibiting instability were classified as high MSI (MSI-H). Tumors with only one marker exhibiting instability or no markers with instability were classified as low MSI (MSI-L) or microsatellite stable (MSS), respectively.

Bisulfite modification and methylation analysis

Purified DNA (2 μg) was bisulfite treated and purified using the EZ DNA methylation kit (Zymo Research) according to the manufacturer’s instructions.

A 5-gene signature was used to assess the CIMP methylation status of the primary tumor tissue: CACNA1G, IGF2, NEUROG1, RUNX3, and SOCS1 (6). Methylation was quantified by Methylight, a methylation-specific, probe-based, real-time PCR technique (6, 18). Alu was used as a normalization control reaction. All CIMP probes used a 5’ FAM fluorophore, a 3’ IBFQ quencher, and an internal ZEN normalization control. DNA methylation was reported as the percent of methylated reference (PMR) = 100 × [(methylated reaction/Alu)sample/(methylated reaction/Alu)reference; ref. 6]. We classified each marker as methylated when PMR ≥ 4. The PMR cut-off

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levels were set at plus 2 SDs of the average methylation levels observed in normal duodenal mucosa controls. Samples were considered CIMP$^+$ if at least 3 of the 5 studied genes were methylated (6).

Conventional methylation-specific PCR (MSP; ref. 19) was carried out to validate the CIMP status by using a panel of 20 cancer-specific genes/loci (6, 7, 9, 20–27), as well as the 5 genes used for MethyLight. Gene and locus names and primers are shown in Supplementary Table S1. Methylation index was calculated as total number of genes and loci methylated/total number of genes and loci analyzed (28).

Immunohistochemistry

Immunohistochemical analysis for MLH1 expression was carried out. In brief, FFPE tissues were sectioned at 6 μm and stained with antibody to MLH1 (BD PharMingen). Tumor cells with absent nuclear staining were interpreted to have an absence of protein expression. Intact nuclear staining of adjacent nonneoplastic epithelium served as an internal positive control.

Statistical methods

Differences in categorical variables between study groups were analyzed using $\chi^2$ test for homogeneity of Fisher exact test. To compare continuous variables, the Student $t$ test was used when variances were equal. The Mann–Whitney $U$ test was used when variances were unequal. Correlation between MethyLight and MSP results were analyzed by Fisher exact test. All hypotheses tests were 2-sided, and results were considered statistically significant for $P$ values less than 0.05.

The main outcome of this study was overall survival (OS), which was defined as the time from surgery to death resulting from any cause. In addition, time-to-recurrence (TTR) was defined as the time from surgery to recurrence, in
which patients without evidence of recurrence were censored for TTR at last follow-up. Survival was estimated by using the Kaplan–Meier method and log-rank statistics computed to test for differences between survival curves for various prognostic factors. Cox proportional hazard models were used to calculate HR with corresponding 95% confidence interval (CI) of recurrence or death according to molecular features (i.e., CIMP/MLH1 methylation, CIMP, MLH1 methylation, or MSI status), adjusted for age, sex, stage, tumor differentiation, chemotherapy and/or radiotherapy, and KRAS mutation status. All calculations were done using SPSS 16.0 software (SPSS Inc.).

Results

Clinicopathologic characteristics by CIMP

DNA extraction and CIMP testing by MethyLight were successful in all 99 patients. Twenty-seven patients (27.3%) of the 99 patients tested were CIMP<sup>+</sup> (Fig. 1, Table 1).

To further determine whether the 5-gene signature accurately classifies patients as CIMP<sup>+</sup> and validate the CIMP status as characterized by MethyLight, we determined the methylation of an additional panel of 20 genes/loci using conventional MSP in a group of samples. These genes were selected because they have either been previously used to identify CIMP or showed frequent methylation in various cancers, including duodenal cancers (6, 7, 9, 20–27). Aberrant methylation was significantly more frequent in tumors characterized as CIMP<sup>+</sup>, using the 5-gene signature, with a methylation index of 0.67 (average 13.4 genes methylated of 20 genes examined) compared with a methylation index of 0.14 (average 2.8 genes methylated of 20 genes examined) in tumors characterized as CIMP<sup>−</sup>, showing a marked difference (P < 0.001; Supplementary Fig. S1). In addition, comparison between the 5-gene methylation status using MethyLight technology and MSP analysis revealed significant correlations (k = 0.583–0.813). These results suggested that the 5-gene signature was successful in identifying a CIMP<sup>+</sup> subset of tumors.

Median age at diagnosis of duodenal cancer was 66.0 years (65.4 ± 13.4; mean ± SD). Comparison of the CIMP<sup>+</sup> and CIMP<sup>−</sup> subgroups showed that there were no differences in gender, age, tumor differentiation, extent of resection, and undergoing chemotherapy/radiotherapy between the 2 groups (Table 1). Although not statistically significant, a trend toward association between stage and CIMP status was observed (P = 0.067). The CIMP<sup>+</sup> group had more stage I tumors than the CIMP<sup>−</sup> group (18.5% vs. 4.2%).

MSI, CIMP, and MLH1 methylation

Among the 99 duodenal cancer patients, 20 (20.2%) displayed MSI-H, 14 (14.1%) MSI-L, and 65 (65.7%) MSS status. In this study, MSI-L and MSS tumors were grouped together and henceforth are referred to as MSS. Among the 27 (27.3%) patients showing CIMP<sup>+</sup> (10 (37.0%) were MSI as well (Fig. 1, Table 1). A statistically significant correlation between MSI and CIMP status was observed (P = 0.011, Table 1).

MLH1 methylation was detected in 14 (14.1%) patients and 12 (85.7%) were also CIMP<sup>+</sup>. Further associations showed that 8 (57.1%) of these were CIMP<sup>+</sup>/MSI, 4 (28.6%) were CIMP<sup>+</sup>/MSS, 2 (14.3%) were CIMP<sup>−</sup>/MSI, and none showed CIMP<sup>−</sup>/MSS (Fig. 1). There were strong associations between MLH1 methylation and both MSI and CIMP<sup>+</sup> (P < 0.001, all). Distributions of MSI, CIMP, and MLH1 methylation in all patients are shown in Supplementary Fig. S2.

Immunohistochemical analysis of MLH1 in tumors

Immunohistochemical analysis of MLH1 expression was carried out on selected MLH1 unmethylated (MLH1-U) and MLH1 methylated (MLH1-M) tumors. All tested MLH1-M tumors (including 4 MSS/MLH1-M tumors) had negative or low protein expression level (Fig. 2).

Frequency and associations of tumor mutations

Mutation analysis was successfully conducted in all 99 tumors and matched normal duodenal tissue specimens for KRAS and BRAF. KRAS mutations were prevalent in 32.3% (32 of 99) of patients and the characteristics of patients with KRAS mutations are shown in Supplementary Table S2. The most prevalent KRAS mutations were GGT > GAT (G12D) and GGT > G7T (G12V) within codon 12, and GCC > GAC (G13D) within codon 13. All mutations seem to be somatic because the same alterations were not detected in the corresponding normal tissues. Twenty-five of 32 cases (78.1%) with KRAS mutations occurred in
tumors exhibiting methylation in at least 1 of the 6 study genes (OR, 3.08, 1.17 to 8.08; \( P = 0.020 \)). However, KRAS mutations were not associated with CIMP (\( P = 0.114 \), Table 1), as compared with wild-type tumors. No BRAF V600E mutation was found in any tumor or corresponding normal duodenal tissue.

**Survival analysis by CIMP and MSI**

Median follow-up of patients was 36.9 months for OS analysis and 30.5 months for TTR analysis. Kaplan–Meier survival curves were generated according to clinicopathologic and molecular characteristics. The median OS for the entire group was 53.7 months, with 5- and 10-year OS of 49% and 35%, respectively. Age, stage, and MSI status were the 3 important predictors of OS with older age and late stage conferring worse OS, whereas MSI was associated with improved OS, as expected (log-rank \( P < 0.05 \), all; Supplementary Fig. S3). CIMP\(^+\) was significantly associated with shorter OS (log-rank \( P = 0.047 \); Fig. 3A). The median OS time was 33.9 months in patients with CIMP\(^+\) tumors (5- and 10-year OS of 36% and 27%, respectively) compared with 90.8 months in patients with CIMP\(^-\) tumors (5- and 10-year OS of 53% and 47%; Supplementary Table S3). CIMP alone was, however, not a predictor for TTR (log-rank \( P = 0.608 \); Fig. 3B). The median TTR time for the CIMP\(^-\) group was 123.4 months and had not been reached for the CIMP\(^+\) group. Age, stage, differentiation, and chemotherapy and/or radiotherapy were predictors of TTR with young age, late stage, poor differentiation, and undergoing chemotherapy and/or radiotherapy conferring worse TTR (log-rank \( P < 0.05 \), all; Supplementary Fig. S4).

Tumors were further classified by CIMP and MLH1 methylation status into CIMP\(^-\)/MLH1\(-U\) (\( n = 70 \)), CIMP\(^-\)/MLH1\(-M\) (\( n = 2 \)), CIMP\(^+\)/MLH1\(-U\) (\( n = 15 \)), and CIMP\(^+\)/MLH1\(-M\) (\( n = 12 \)) groups. There were significant differences both in OS (log-rank \( P = 0.002 \); Fig. 4A) and TTR (log-rank \( P = 0.016 \); Fig. 4B) in the groups classified by CIMP/MLH1 methylation status. CIMP\(^+\)/MLH1\(-U\) group had the shortest OS and TTR, whereas CIMP\(^+\)/MLH1\(-M\) group had the longest OS and TTR. CIMP\(^+\)/MLH1\(-U\) group consisted of 2 patients with a remarkable recurrence-free follow-up of 85.8 and 144.9 months at the conclusion of the study, respectively.

Tumors were also categorized by CIMP and MSI status into CIMP\(^-\)/MSS (\( n = 62 \)), CIMP\(^+\)/MSS (\( n = 10 \), CIMP\(^+\)/MSI (\( n = 17 \) and CIMP\(^+\)/MSI (\( n = 10 \) groups. In the groups classified by CIMP/MSI status, there was significant difference in OS (log-rank \( P = 0.002 \); Fig. 4C), but not in TTR (log-rank \( P = 0.196 \); Fig. 4D) with CIMP\(^+\)/MSS group having the worst OS.
Multivariate analysis of outcome predictors

A Cox proportional hazards model for multivariate analysis, including CIMP/MLH1 methylation status, age, sex, stage, tumor differentiation, chemotherapy and/or radiotherapy, and KRAS mutation status in relation to OS and TTR was conducted (Table 2). Only CIMP/MLH1 methylation status ($P < 0.001$), age ($P = 0.002$), and stage ($P < 0.001$) remained statistically significant as predictors of OS. CIMP/MLH1 methylation status ($P = 0.023$), stage ($P = 0.020$), along with tumor differentiation ($P = 0.034$) were also associated with risk of recurrence and independently predicted TTR.

The influence of CIMP, MLH1 methylation, or MSI on OS and TTR, independent of the clinicopathologic and molecular variables were separately assessed (Supplementary Table S4). In multivariate analyses, CIMP by itself only showed a trend toward correlation with both OS ($P = 0.081$) and TTR ($P = 0.176$). MLH1 methylation status

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**Figure 3.** Kaplan–Meier survival estimates of OS and TTR in patients with CIMP$^+$ and CIMP$^{-}$duodenal adenocarcinomas. A, OS; B, TTR.

**Figure 4.** Kaplan–Meier survival estimates of OS and TTR in patients with duodenal adenocarcinomas. OS in (A) groups classified by CIMP/MLH1 methylation status, (C) groups classified by CIMP/MSI status. TTR in (B) groups classified by CIMP/MLH1 methylation status, (D) groups classified by CIMP/MSI status. The $P$ values shown have been pooled over strata.
was independently associated with OS ($P = 0.021$), but not TTR ($P = 0.070$). MSI independently correlated with both OS ($P = 0.003$) and TTR ($P = 0.018$).

### Discussion

The CIMP was first characterized in human CRC by our group as cancer-specific CpG island hypermethylation of a subset of genes in a subset of tumors (7). Weisenberger and colleagues confirmed and further characterized CRC CIMP using MethyLight technology (6). Since then CIMP has been shown in multiple other malignancies, including gastric (29), pancreatic (20), lung (21), oral (22), breast (30), and small intestinal cancers (31), as well as neuroblastoma (32), malignant melanoma (23), and glioma (33). In this study, we analyzed a large cohort of patients with duodenal adenocarcinomas and showed that CIMP existed in 27.3% of the tumors.

There is no consensus with regard to the best markers for defining CIMP in duodenal cancer. Fang and colleagues compared the CIMP-associated loci from breast cancer, colon cancer, and glioma, and found that the CIMP signature was shared by multiple human malignancies (30). By using CIMP-associated loci in CRC, previous studies have successfully identified CIMP tumors in duodenal cancers (9, 31). In this study, CIMP was defined by a panel of 5 markers proposed and validated by Weisenberger and colleagues (6). This 5-gene signature has been shown to be highly accurate and the most cost-effective screening method for CIMP status in CRC (6). The question therefore arises as to whether this panel of markers would also be applicable in duodenal cancers. Ideally, it would be helpful to use a whole epigenomic approach to define CIMP in cancers. However, this is not feasible given the rarity of duodenal adenocarcinomas and lack of appropriate fresh tissue samples to conduct this analysis. To confirm whether the 5-gene signature truly differentiates a CIMP$^+$ group, we screened a panel of 20 commonly used markers for CIMP. Importantly, duodenal tumors that were identified as CIMP$^+$ by the 5-gene signature were concordant with those positive on the large-scale screen. Our results showed that this 5-gene signature correlated with CIMP and accurately define CIMP in duodenal adenocarcinomas.

It has been established that KRAS and BRAF mutations have a number of downstream effectors that can activate or repress genes, and which may then contribute to patterning the epigenome (34). In our data, KRAS gene mutation was associated with tumors that had at least one gene methylated, and this is in accordance with the evidence of

### Table 2. Univariate and multivariate Cox proportional hazard analysis of OS and TTR

<table>
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<tr>
<th>Characteristic</th>
<th>Total n</th>
<th>HR (95% CI)</th>
<th>$P$</th>
<th>HR (95% CI)</th>
<th>$P$</th>
<th>HR (95% CI)</th>
<th>$P$</th>
<th>HR (95% CI)</th>
<th>$P$</th>
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<td>CIMP$^–$/MLH1$^–$</td>
<td>70</td>
<td>1.00 (Referent)</td>
<td>0.011</td>
<td>1.00 (Referent)</td>
<td>&lt;0.001</td>
<td>1.00 (Referent)</td>
<td>0.062</td>
<td>1.00 (Referent)</td>
<td>0.023</td>
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<td>CIMP$^–$/MLH1$^+$/</td>
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<td>2.76 (1.46–5.19)</td>
<td>0.002</td>
<td>4.73 (2.34–9.54)</td>
<td>&lt;0.001</td>
<td>2.26 (1.04–4.88)</td>
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<td>3.33 (1.39–8.00)</td>
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<td>CIMP$^+$/MLH1$^+$/</td>
<td>12</td>
<td>0.80 (0.31–2.07)</td>
<td>0.649</td>
<td>0.43 (0.15–1.24)</td>
<td>0.117</td>
<td>0.21 (0.03–1.57)</td>
<td>0.212</td>
<td>0.26 (0.03–2.10)</td>
<td>0.204</td>
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<td>CIMP$^+$/MLH1$^+$</td>
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<td>2.56 (0, –)</td>
<td>0.971</td>
<td>0 (0, –)</td>
<td>0.973</td>
<td>0 (0, –)</td>
<td>0.977</td>
<td>0 (0, –)</td>
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<td>Age &lt;70</td>
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<td>1.00 (Referent)</td>
<td>0.0002</td>
<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
<td>0.177</td>
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<tr>
<td>Age ≥70</td>
<td>35</td>
<td>1.73 (0.99–3.00)</td>
<td>0.053</td>
<td>2.65 (1.42–4.92)</td>
<td>0.002</td>
<td>1.00 (Referent)</td>
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<td>Sex Male</td>
<td>55</td>
<td>1.00 (Referent)</td>
<td>0.0002</td>
<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
<td>0.177</td>
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<tr>
<td>Sex Female</td>
<td>44</td>
<td>0.96 (0.55–1.67)</td>
<td>0.887</td>
<td>1.45 (0.80–2.65)</td>
<td>0.221</td>
<td>0.50 (0.24–1.03)</td>
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<td>0.90 (0.42–1.94)</td>
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<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
<td>0.177</td>
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<tr>
<td>Stage III and IV</td>
<td>70</td>
<td>2.72 (1.35–5.45)</td>
<td>0.005</td>
<td>5.27 (2.25–12.38)</td>
<td>&lt;0.001</td>
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<td>Differentiation Well/moderately</td>
<td>55</td>
<td>1.00 (Referent)</td>
<td>0.0002</td>
<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
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<td>Differentiation Poorly</td>
<td>44</td>
<td>1.65 (0.95–2.87)</td>
<td>0.078</td>
<td>1.42 (0.78–2.56)</td>
<td>0.252</td>
<td>3.01 (1.48–6.12)</td>
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<td>2.27 (1.06–4.84)</td>
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<td>Chemotherapy/radiotherapy No</td>
<td>38</td>
<td>1.00 (Referent)</td>
<td>0.0002</td>
<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
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<td>61</td>
<td>1.42 (0.79–2.57)</td>
<td>0.246</td>
<td>1.10 (0.55–2.20)</td>
<td>0.778</td>
<td>3.67 (1.49–9.03)</td>
<td>0.005</td>
<td>1.87 (0.71–4.92)</td>
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<td>KRAS mutations Absent</td>
<td>67</td>
<td>1.00 (Referent)</td>
<td>0.0002</td>
<td>1.00 (Referent)</td>
<td>0.27 (0.09–0.75)</td>
<td>0.013</td>
<td>0.47 (0.15–1.41)</td>
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<td>KRAS mutations Present</td>
<td>32</td>
<td>1.09 (0.61–1.95)</td>
<td>0.772</td>
<td>0.64 (0.34–1.20)</td>
<td>0.160</td>
<td>1.02 (0.50–2.09)</td>
<td>0.960</td>
<td>0.51 (0.22–1.17)</td>
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Abbreviations: MLH1-M, MLH1-methylated; MLH1-U, MLH1-unmethylated.
induction of the ras oncogenic pathway may result in DNA methylation (35). Yet it seems that KRAS mutations alone do not dictate duodenal cancer CIMP status because KRAS mutations were not associated with CIMP as compared with wild-type tumors.

Moreover in CRC, CIMP status has been associated with mutations of the BRAF gene and has been felt to be mutually exclusive to KRAS mutations (6). In fact, we did not detect any mutations in codon 600 of the BRAF gene. This is in keeping with Blaker and colleagues who described only one mutation [a 3 bp (GAT) deletion at codon 603/604] in a panel of 21 adenocarcinomas of the small intestine (36). It is possible that other mutations exist outside codon 600 of the BRAF gene and would have been detected if we had screened the whole of the BRAF gene; however, most BRAF mutations in human cancers are within codon 600 (10, 37). These data lead us to conclude that BRAF mutations are not critically involved in duodenal tumorigenesis, MSI, or CIMP development.

It was reported that CIMP+ CRCs have a distinct clinicopathologic and molecular features, such as associations with proximal tumor location, female sex, poor differentiation, MSI, and MUC1 expression (38). On the basis of a limited number of cases, we found that CIMP+ duodenal cancers had a relatively earlier stage when compared with CIMP tumors, though this was not statistically significant. The result indicates that CIMP development is an early event in some cases of duodenal cancer.

Several studies have investigated the relationship between CIMP status and survival in various malignancies. However, these results are inconsistent (30, 39–46). The association of better clinical outcome with CIMP+ tumors has been reported in CRC, gliomas, and breast cancer. Poor prognosis with CIMP+ tumors has also been reported across CRC (44), esophageal cancer (45), gastric cancer (46), myelodysplastic syndromes (43), neuroblastomas (41), and leukemia (42). The discrepancy of these observations might be because of different methylation markers of CIMP panels, methodologies for methylation detection, patient populations, distribution of tumor stages and differentiation, terms of follow-up, and other factors associated with prognosis being included (such as chemotherapy and/or radiotherapy).

The prognostic significance of CIMP status in duodenal cancer has not previously been described. We identified a patient population that was CIMP+ and found that this inversely correlated with survival. Stratification of CIMP by MSI status was predictive of OS but not TTR. However, stratification of CIMP by MLH1 methylation status further enhances the ability to predict OS as well as predict TTR in CIMP+ patients on multivariate analysis. CIMP+/MLH1-U patients had a poorer outcome than individuals with CIMP+/MLH1-U tumors and indeed compared with all other individuals in the study. Interestingly, there were only 2 patients with CIMP+ but MLH1-methylated tumors, both of them did extremely well with long-term follow-up. This is particularly surprising because one of the tumors was poorly differentiated, the other was moderately differentiated, and both were advanced stage (stage III). Most importantly, in 27 CIMP+ tumors, there were 17 MSS and 10 MSI tumors. Even though multivariate analysis showed that MSI was an independent predictor of OS and TTR, stratification of CIMP+ tumors by MSI could not clearly define 2 subtypes. On the contrary, MLH1 methylation status segregated the CIMP+ tumors into 15 MLH1-U tumors and 12 MLH1-M tumors. Both subtypes behave differently with significantly different OS and TTR, which indicate that CIMP+ tumors may follow 2 different pathways. The significant survival difference between the groups classified by CIMP/MLH1 methylation status might imply a clue to the complexity of CIMP development. It suggests that not only oncogenic pathways but also epigenetic pathways themselves jointly affect CIMP in a pattern of reciprocal causation.

An important limitation of our study is the lack of statistical power because of a low number of patients in some subgroups might obscure more subtle relations. The analysis in a larger cohort of duodenal adenocarcinomas is needed to validate our findings.

In conclusion, our data suggests that CIMP does exist in duodenal adenocarcinomas and it may assist in the prognostic classification of these patients. Stratification of CIMP by MLH1 methylation status enhances the ability to predict OS as well as predict TTR. Patients with CIMP+ duodenal adenocarcinomas, especially those with CIMP+ tumors in absence of MLH1 methylation, may need more intensive surveillance and subtype-specific adjuvant therapy strategies. We did not detect any BRAF V600E mutation, which suggests that BRAF mutations are not critically involved in duodenal tumorigenesis, MSI, or CIMP development. These results give new insight into the genetic and epigenetic pathways of duodenal adenocarcinoma and show the need for further understanding of these unique tumors.

Disclosure of Potential Conflicts of Interest
S.B. Baylin has commercial grant funding and serves on the advisory board for MDx Health Inc. and BioNumerik Pharmaceuticals Inc. No potential conflicts of interest were disclosed by the other authors.

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References

CpG Island Methylator Phenotype–Positive Tumors in the Absence of MLH1 Methylation Constitute a Distinct Subset of Duodenal Adenocarcinomas and Are Associated with Poor Prognosis

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