Human Cancer Biology

Detection of Tumor DNA at the Margins of Colorectal Cancer Liver Metastasis

Matthias Holdhoff1, Kerstin Schmidt1, Frank Diehl5, Nishant Aggrawal1, Philipp Angenendt5, Katharine Romans1, Daniel L. Edelstein1, Michael Torbenson2, Kenneth W. Kinzler1, Bert Vogelstein1, Michael A. Choti3, and Luis A. Diaz, Jr.1,4

Abstract

**Purpose:** Defining an adequate resection margin of colorectal cancer liver metastases is essential for optimizing surgical technique. We have attempted to evaluate the resection margin through a combination of histopathologic and genetic analyses.

**Experimental Design:** We evaluated 88 samples of tumor margins from 12 patients with metastatic colon cancer who each underwent partial hepatectomy of one to six liver metastases. Punch biopsies of surrounding liver tissue were obtained at 4, 8, 12, and 16 mm from the tumor border. DNA from these biopsies was analyzed by a sensitive PCR-based technique, called BEAMing, for mutations of KRAS, PIK3CA, APC, or TP53 identified in the corresponding tumor.

**Results:** Mutations were identified in each patient’s resected tumor and used to analyze the 88 samples circumscribing the tumor-normal border. Tumor-specific mutant DNA was detectable in surrounding liver tissue in 5 of these 88 samples, all within 4 mm of the tumor border. Biopsies that were 8, 12, and 16 mm from the macroscopic visible margin were devoid of detectable mutant tumor DNA and of microscopically visible cancer cells. Tumors with a significant radiologic response to chemotherapy were not associated with any increase in mutant tumor DNA in beyond 4 mm of the main tumor.

**Conclusions:** Mutant tumor-specific DNA can be detected beyond the visible tumor margin, but never beyond 4 mm, even in patients whose tumors were larger prior to chemotherapy. These data provide a rational basis for determining the extent of surgical excision required in patients undergoing resection of liver metastases. Clin Cancer Res; 17(11); 3551–7. ©2011 AACR.

Introduction

Margin status is one of the most important factors in determining the success of a solid tumor resection. Surgical margins that show the presence of cancer cells have an increased risk of local recurrence, aggressive biology, and a decreased overall survival (1–4). As a result, a margin of normal tissue surrounding the perimeter of the resected tumor is always included as part of the resected tumor specimen when possible. Historically, a circumferential rim of at least 1 cm around the macroscopically visible metastatic lesion is removed. While more recently, the width of surgical margin has been challenged, achievement of negative margins remains important to optimize long-term outcome in these patients (3).

Despite gross and microscopic review of the margins of a surgical resection, some patients will have local recurrence of their tumors at the site of surgery, thereby suggesting that standard microscopic evaluation of the surgical margins may not be sufficient in many cases (2). Moreover, the extent of the necessary surgical margin in patients following response to preoperative chemotherapy is less clear.

An analytic approach could provide evidence that would help determine the width of the surgical margin required in resection of hepatic colorectal metastases, whether untreated or following response to preoperative chemotherapy. Careful histopathologic assessment can in principle be used for assessing the presence of tumor cells outside the tumor-liver border. However, histopathologic analysis can miss small numbers of cancer cells. We therefore supplemented histopathologic analysis with a molecular genetic approach, using patient-specific somatic mutations as exquisitely specific indicators of the presence of tumor cells in clinical samples.

Traditional mutation detection methods cannot readily detect mutations when they are present at less than 1% of...
Translational Relevance

How much normal tissue should be excised around a liver metastasis from a colorectal cancer? Determination of the margin status after surgical resection has major prognostic and therapeutic implications in patients with solid tumors. Assessment of the exact margin becomes more complex in the setting of preoperative chemotherapy that aims to decrease tumor size prior to resection. In this report, we utilize a digital PCR–based technique, termed BEAMing, which enumerates rare mutant DNA events in a pool of wild-type DNA. We applied this technique to measure rare mutant events in the tumor margins of liver metastases from colorectal cancer at varying distances from the tumor. The information obtained provides a scientific basis for determining the proper excisional margins and the approach we used can be generally applied to other tumor types and locations.

the DNA templates under study. This fraction of tumor involvement in a sample would be visible by microscopy and we were interested in detecting smaller quantities of tumor cells. We therefore turned to a highly sensitive digital PCR–based assay, termed BEAMing (5), for this study. The method is named after its components (Beads, Emulsification, Amplification, and Magnetics) and can detect mutations in samples that contain as few as 1 in 100,000 mutant DNA fragments (6). In this study, we applied this approach to evaluate the ostensibly normal liver closely circumscribing surgically resected metastatic lesions.

Materials and Methods

Patient selection

Patients with colorectal cancer undergoing planned resection of liver metastases and who underwent partial hepatectomy were eligible for this study. Those patients with multiple tumors undergoing major hepatic resection with more than 1-cm resection margins were included to optimize the analysis, including chemo naive, chemoresponders, and nonresponders. The study was approved by the Johns Hopkins Institutional Review Board and written consent was obtained from all patients prior to their enrollment in the protocol.

Sample collection

Freshly resected liver tissue was cut into 0.5 to 1.0 cm slices and processed immediately following surgical resection. Punch biopsies of 4 mm in diameter were obtained radially from surrounding liver tissue at 4, 8, 12, and 16 mm distances from the macroscopically visible tumor border. The number of biopsies in each direction (away from the macroscopically visible tumor border) varied between 1 and 4, depending on the individual geometry of each tissue specimen (see Supplementary Fig. S1). The samples were immediately cryopreserved and the ends of the punch biopsies were preserved in formalin. One punch biopsy was taken from the tumor itself for mutation analysis and 1 sample was obtained from normal liver tissue far removed from any metastasis as a negative control.

DNA purification of frozen tumor tissue

Frozen tumor tissue sections were mounted on slides and microdissected with the PALM microscope. The dissected tissue was digested overnight at 60°C in 15 µL ATL buffer (Qiagen) and 10 µL Proteinase K (20 mg/mL; Invitrogen). DNA was isolated using the QIAamp DNA Micro Kit (Qiagen) following the manufacturer’s protocol.

DNA purification of frozen liver tissue

Frozen punch biopsies (~50 mg) were mixed with 1 mL of Cell Lysis Solution CLS-TC and homogenized in the FASTPrep (Q Biogene, Inc.) instrument for 40 seconds at a speed setting of 6.0. Tissue debris was removed by centrifugation and the supernatant was transferred to a new microcentrifuge tube. Binding, washing, and elution steps were carried out according to the FASTPrep protocol supplied by the manufacturer.

DNA quantification

DNA isolated from tissue samples was quantified using a modified version of a human LINE-1 real-time PCR assay (7). The primer set was designed to amplify the most abundant consensus region of the human LINE-1 family (amplicon 97 bp; forward primer TGGCCCATATAAAACCATGGA; reverse primer TGAGAATGATGGTTTCCAATT). PCR was carried out in a 25 µL reaction volume consisting of 4 µL of various dilutions of template DNA, 0.5 µL of Platinum Taq DNA Polymerase, 1x PCR buffer, 6% (v/v) dimethyl sulfoxide (DMSO), 1 mmol/L of each dNTP, 1:100,000 dilution of SYBR Green I (Invitrogen), and 0.2 µmol/L of each primer. Amplification was carried out in an iCycler (Bio-Rad) using the following cycling conditions: 94°C for 1 minute; 3 cycles of 94°C for 30 seconds, 67°C for 30 seconds, 70°C for 1 minute; 3 cycles of 94°C for 30 seconds, 64°C for 35 seconds, 70°C for 1 minute, 3 cycles of 94°C for 30 seconds, 61°C for 30 seconds, 70°C for 1 minute; and 35 cycles of 94°C for 30 seconds, 59°C for 30 seconds, 70°C for 1 minute. Various dilutions of normal human lymphocyte DNA were incorporated in each plate setup to serve as standards. The threshold cycle number was determined using Bio-Rad analysis software with the PCR baseline subtracted.

Sequencing of tissue DNA for mutations

All DNA samples isolated from tumor tissue were analyzed for mutations in 26 regions of APC, 1 region of KRAS, 2 regions of PIK3CA, and 4 regions of TP53 using direct Sanger sequencing. The first PCR was carried out in a 10 µL reaction volume containing 50 to 100 genome equivalents (GE) of template DNA (1 GE equals 3.3 pg of human genomic DNA), 0.5 U of Platinum Taq DNA Polymerase (Invitrogen), 1x PCR buffer...
[67 mmol/L of Tris-HCl, pH 8.8, 67 mmol/L of MgCl₂, 16.6 mmol/L of (NH₄)₂SO₄, and 10 mmol/L of 2-mercaptoethanol], 2 mmol/L ATP, 6% (v/v) DMSO, 1 mmol/L of each dNTP, and 0.2 μmol/L of each primer. The sequences of the primer sets were described previously in the work of Diehl and colleagues (8). The amplification was carried out under the following conditions: 94°C for 2 minutes; 3 cycles of 94°C for 15 seconds, 68°C for 30 seconds, 70°C for 15 seconds; 3 cycles of 94°C for 15 seconds, 65°C for 30 seconds, 70°C for 15 seconds, 3 cycles of 94°C for 15 seconds, 62°C for 30 seconds, 70°C for 15 seconds; 40 cycles of 94°C for 15 seconds, 59°C for 30 seconds, and 70°C for 15 seconds. One microliter of the first amplification was then added to a second 10-μl PCR reaction mixture of the same makeup as the one described above, except that different primers were used. The second (nested) PCR reaction was temperature cycled using the following conditions: 2 minutes at 94°C; 15 cycles of 94°C for 15 seconds, 58°C for 30 seconds, and 70°C for 15 seconds. The PCR products were purified and sequenced as described in Jones and colleagues (9) with primers containing a 30-bp polyT tag attached to the 5′ end to improve the sequence quality for the first 30 bases.

BEAMing of Tumor Margin DNA for Mutations

A total of 150,000 GEs were used for each BEAMing assay. An initial amplification with a high fidelity DNA polymerase was carried out in 5 separate 50-μl PCR reactions each containing template DNA, 5× Phusion High Fidelity PCR buffer (NEB), 1.5 U of Hotstart Phusion polymerase (NEB), 0.2 μmol/L of each primer, 0.25 mmol/L of each dNTP, and 0.5 mmol/L of MgCl₂. Preamplification primers and temperature cycling conditions are listed in Supplementary Table S1, a second PCR (nested) was carried out by adding 2 μl of the first amplification to a 10-μl PCR mixture of the same makeup as the one described above, except different primers were used. The second (nested) PCR reaction was temperature cycled using the following conditions: 2 minutes at 94°C; 15 cycles of 94°C for 15 seconds, 58°C for 30 seconds, and 70°C for 15 seconds. The PCR products were purified and sequenced as described in Jones and colleagues (9) with primers containing a 30-bp polyT tag attached to the 5′ end to improve the sequence quality for the first 30 bases. [Tag1 primer: 5′- (dT)₃₀-tcccgcgaaattaatacgac; M13 primer: 5′- (dT)₃₀-tcccgcgaaattaatacgac]. Data analysis were carried out using Mutation Explorer (SoftGenetics).

Emulsion PCR was carried out as described previously (3). Briefly, a 150 μl PCR mixture was prepared containing 20 pg template DNA, 42.5 U of Platinum Taq DNA polymerase (Invitrogen), 1× PCR buffer (see above), 0.2 mmol/L dNTPs, 5 mmol/L of MgCl₂, 0.05 μmol/L Tag1 (5′-tcccggaattaatacgac-3′), 8 μmol/L of Tag2 (5′-gtctgagcttcgaca-3′), and approximately, 6 × 10⁷ magnetic streptavidin beads (MyOne; Invitrogen) coated with Tag1 oligonucleotide (MyOne; Invitrogen, dual biotin-T-Spacer18, 5′-tcccggaattaatacgac-3′ MyOne, Invitrogen). The 150 μl PCR reaction, 600 μl oil/emulsifier mix (7% ABI, WE09, 20% mineral oil, 73% Tegosoft DEC, Evonik Goldschmidt Cooperation), and one 5-mm steel bead (Qiagen) were added to a 96 deep well plate 1.2 mL (Abgene). Emulsions were prepared by shaking the plate in a TissueLyser (Qiagen) for 10 seconds at 15 Hz and then 7 seconds at 17 Hz.

Emulsions were dispersed into 8 PCR wells and temperature cycled at 94°C for 2 minutes; 3 cycles of 94°C for 10 seconds, 68°C for 45 seconds, 70°C for 75 seconds; 3 cycles of 94°C for 10 seconds, 65°C for 45 seconds, 70°C for 75 seconds, 3 cycles of 94°C for 10 seconds, 62°C for 45 seconds, 70°C for 75 seconds; 50 cycles of 94°C for 10 seconds, 59°C for 45 seconds, and 70°C for 75 seconds.

To break the emulsions, 150 μl breaking buffer (10 mmol/L Tris-HCl, pH 7.5, 1% Triton-X 100, 1% SDS, 100 mmol/L NaCl, 1 mmol/L EDTA) was added to each well and mixed with a TissueLyser at 20 Hz for 20 seconds. Beads were recovered by centrifuging the suspension at 3,200 × g for 2 minutes and by removing the oil phase. This breaking step was repeated twice. All beads from 8 wells were consolidated and washed with 150 μl wash buffer (20 mmol/L Tris-HCl, pH 8.4, 50 mmol/L KCl). The DNA on the beads was denatured for 5 minutes with 0.1 mol/L NaOH. Finally, beads were washed with 150 μl wash buffer and resuspended in 150 μL of the same buffer. The mutation status of DNA bound to beads was determined by allele-specific hybridization. Fluorescently labeled probes complementary to the mutant and wild-type DNA sequences, designed for the different mutations were used. The size of the probes ranged from 15 to 18 nucleotides, depending on the GC content of the target region. All mutant probes were coupled to a Cy5STM fluorophore and all wild-type probes were coupled to a Cy3STM fluorophore at their 5′ ends (Integrated DNA Technologies or Biomers). In addition, oligonucleotides that bound to a separate location within the amplicon ("universal probes") were used to label every extended PCR product as a positive control. These amplexon-specific probes were synthesized with a ROXTM fluorophore attached to their 5′ ends. Probe sequences are listed in Supplementary Table S2. Each allele-specific hybridization reaction contained about 1 × 10⁷ beads in 30 μl wash buffer (see above), 66 μl of 1.5× hybridization buffer (1.5 × = 4.5 mol/L tetramethylammonium chloride, 75 mmol/L Tris-HCl, pH 7.5, 6 mmol/L EDTA), and 4 μl of a mixture of mutant, wild-type, and gene-specific fluorescent probes, each at 5 μmol/L in TE buffer. The hybridization mixture was heated to 70°C for 10 seconds and slowly (0.1°C/s) cooled to 35°C. After incubating at 35°C for 2 minutes, the mixture was cooled (0.1°C/sec) to room temperature. The beads were collected with a magnet and the supernatant containing the unbound probes was removed using a pipette. The beads were resuspended in 100 μl of 1× hybridization buffer and heated to 48°C for 5 minutes to remove unbound probes. After the heating step, the beads were again separated magnetically and washed once with 100 μl wash buffer. In the final step, the supernatant was removed and beads resuspended in 200 μl TE buffer for flow cytometric analysis.
An LSR II flow cytometry system (BD Biosciences) equipped with a high throughput autosampler was used for the analysis of each bead population. Beads with no extension product were excluded from the analysis.

**Results**

Twelve patients with resected metastatic colorectal cancer were enrolled in this study, accounting for a total of 12 resected tumors. All patients underwent major hepatic resection (>3 segments) and had negative histologic margins (R0 resection). Ten patients had received chemotherapy at some point in their treatment prior to surgery, 3 of which had a measurable radiologic tumor response (minor response by RECIST criteria), and 2 were chemotherapy naive. On standard histologic assessment, all patients had evidence of some residual tumor within the macroscopically evident metastasis.

The tumors within the liver were interrogated for a subset of mutations in APC, KRAS, PIK3CA, and p53 by Sanger sequencing. Six tumors were found to have mutations of APC, 4 of KRAS, 1 of PIK3CA, and 1 of TP53 as shown in Table 1. These tumor-specific oncogenic mutations were used as markers to create probes (Supplementary Table S2) to detect the presence of tumor-specific mutant DNA in the liver tissue surrounding the tumor.

A total of 88 samples from the tumor periphery were probed for mutations present in the corresponding tumor using BEAMing. Punch biopsies of 4 mm in diameter were obtained in circumferential fashion around the macroscopically visible tumor-liver border as shown in Figure 1 and Supplementary Figure S1.

Mutations identical with those identified in the tumor were detected outside of the visible tumor margin in only 5 of the 88 punch biopsies analyzed. All biopsies containing a mutation were detected only at the closest (4 mm) distance from the macroscopic tumor border, accounting for 20% (5/25) at the 4 mm distance. None of the 63 samples at 8, 12, or 16 mm from the visible tumor margin contained tumor-specific mutant DNA (Table 1).

The biopsies with detectable tumor DNA beyond the histologic margin were only in patients who had received chemotherapy prior to surgery. Three of these 4 patients had an objective radiographic response to chemotherapy prior to surgery. The biopsies from the 2 chemotherapy naive patients did not have detectable DNA outside the tumor-normal border.

Margin status was confirmed independently in a blinded fashion by a pathologist who reviewed tissue from both ends of the punch biopsy cylinder using microscopic analysis. Malignant cells were noted in biopsies from 4 of the 5 punch biopsies with detectable mutant DNA (all at 4 mm). In these cases, nests of cancer cells could be observed in sections of tissue immediately adjacent to those used for genetic analyses. A representative case, where clusters of tumor cells were present, is shown in Supplementary Figure S2. In the fifth case with detectable mutant DNA, no tumor cells could be identified in such sections, even after extensive searching. Importantly, no tumor cells could be identified histopathologically in any of the 83 biopsies that did not contain mutant DNA.

**Discussion**

Although mutations provide ideal tumor biomarkers, their use as a measure of minimal residual disease in pathologic specimens from solid tumor patients has been limited. One reason has been the much greater concentration of normal DNA at histologically normal tumor margins, making mutant DNA fragments difficult to detect with conventional technologies. In this study, we were able to overcome this limitation through the use of BEAMing.

There were 2 particularly notable results emanating from this study. First, 33% of tumors had evidence of tumor DNA beyond the macroscopically visible tumor-normal border but none had evidence of neoplastic cells or tumor DNA beyond 4 mm. These results support the clinical evidence that a negative (R0) margin may be sufficient. Second, we did not find evidence of residual tumor DNA in the region in which the tumor likely existed prior to chemotherapy, suggesting that tumors which respond to chemotherapy likely do so in a concentric fashion. In previous studies which have histologically investigated chemotherapy responses in patients with metastatic colorectal cancer to the liver, viable tumor was mostly found within the central region (10, 11). Similarly, Ng and colleagues reported, using standard histologic assessment, that most colorectal metastases contract centripetally when responding to chemotherapy (12).

Some qualification must be considered when interpreting these findings. One limitation is that our technical sensitivity is, conservatively, 1 tumor cell among 10,000 normal cells (6). We therefore would not be able to reliably detect tumor cell populations that were smaller than this. In addition, although the sampling was extensive, specimens of the peripheral tissue were still selective, allowing for the possibility of missed tumor extension, even using this highly sensitive methodology. Moreover, the overall number of patients in this study and number of patients with positive margins who received neoadjuvant chemotherapy is comparatively small; further studies will be necessary to validate these findings. Finally, BEAMing cannot distinguish whether the mutant DNA arose from live tumor cells versus dead ones left after chemotherapy. The accompanying histopathologic analysis overcame this limitation in most cases, as nests of cancer cells were detected in 4 of the 5 biopsies with mutant DNA. On the basis of morphologic criteria, these nests were very likely to be live cancer cells capable of progressive tumor growth.

In summary, our study provides additional evidence that normal negative histologic margin seems to be sufficient when resecting hepatic colorectal metastases, even following chemotherapy response. It will be informative to apply
<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age, y</th>
<th>Gender</th>
<th>Chemotherapy</th>
<th>Response</th>
<th>Gene</th>
<th>Exon</th>
<th>Mutation</th>
<th>Ray Fraction mutated: wild-type DNA; distance from tumor, mm</th>
<th>Histopathology; distance from tumor, mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>51</td>
<td>M</td>
<td>Yes (neo)</td>
<td>Yes</td>
<td>APC</td>
<td>5</td>
<td>C637T</td>
<td>A 1.09 ND ND ND Pos Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>47</td>
<td>M</td>
<td>Yes (neo)</td>
<td>Yes</td>
<td>APC</td>
<td>C4012T</td>
<td>A 0.22 ND ND ND Pos Neg Neg Neg Neg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
<td>B ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>55</td>
<td>M</td>
<td>Yes (neo)</td>
<td>Yes</td>
<td>KRAS</td>
<td>1</td>
<td>G35A</td>
<td>A 0.97 ND ND Pos Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>59</td>
<td>F</td>
<td>Yes (neo)</td>
<td>Yes</td>
<td>TP53</td>
<td>8</td>
<td>C844T</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>52</td>
<td>F</td>
<td>Yes (neo)</td>
<td>Yes</td>
<td>KRAS</td>
<td>1</td>
<td>G35T</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>41</td>
<td>F</td>
<td>Yes (neo)</td>
<td>Stable</td>
<td>APC</td>
<td>6</td>
<td>C646T</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>63</td>
<td>M</td>
<td>Yes (adj)</td>
<td>N/A</td>
<td>PIK3CA</td>
<td>20</td>
<td>A3140G</td>
<td>B 0.92 ND ND Pos Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>69</td>
<td>M</td>
<td>Yes (adj)</td>
<td>N/A</td>
<td>KRAS</td>
<td>1</td>
<td>G35A</td>
<td>B ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>64</td>
<td>F</td>
<td>Yes (adj)</td>
<td>N/A</td>
<td>KRAS</td>
<td>1</td>
<td>G35C</td>
<td>B ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>53</td>
<td>M</td>
<td>Yes (neo)</td>
<td>Stable</td>
<td>APC</td>
<td>15</td>
<td>4165del TC</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>74</td>
<td>M</td>
<td>No</td>
<td>N/A</td>
<td>APC</td>
<td>15</td>
<td>4241–4242 Ins T</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>74</td>
<td>M</td>
<td>No</td>
<td>N/A</td>
<td>APC</td>
<td>15</td>
<td>3927del AAAGA</td>
<td>A ND ND ND ND Neg Neg Neg Neg Neg</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Samples positive for mutation are outlined.
Abbreviations: neo, neoadjuvant chemotherapy; adj, prior adjuvant chemotherapy; ND, no mutant DNA detected; Neg, negative; Pos, positive.
this same type of combined histopathologic molecular analysis to other tumor types and locations.

**Disclosure of Potential Conflicts of Interest**

B. Vogelstein, L.A. Diaz, and K.W. Kinzler are members of the Scientific Advisory Board of Inostics, a company that is developing technologies for the molecular diagnosis of cancer. B. Vogelstein, L.A. Diaz, and K.W. Kinzler also own stock in Inostics. B. Vogelstein, K.W. Kinzler, and L.A. Diaz, Jr. are members of the Scientific Advisory Board of PDGx and own stock in the company. The authors are entitled to a share of the royalties received by the University on sales of products related to genes described in this article. The terms of these arrangements are being managed by the University in accordance with their conflict of interest policies. B. Vogelstein and K.W. Kinzler, and Johns Hopkins University, also own stock in Exact Sciences, which is managed under similar arrangements.

**References**

4. Winter JM, Cameron JL, Campbell KA, Arnold MA, Chang DC, Coleman J, et al. 1423 pancreaticoduodenectomies for pancreatic cancer:

**Acknowledgements**

The authors thank Lilian Dasko-Vincent in the microscopy core facility for technical assistance.

**Grant Support**

This work was supported by The Virginia and D. K. Ludwig Fund for Cancer Research, the Maryland Cigarette Restitution Fund, and by the NIH CA129825 (L.A. Diaz, Jr.).

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.

Received January 5, 2011; revised March 23, 2011; accepted March 27, 2011; published OnlineFirst April 29, 2011.


Detection of Tumor DNA at the Margins of Colorectal Cancer Liver Metastasis

Matthias Holdhoff, Kerstin Schmidt, Frank Diehl, et al.

Clin Cancer Res 2011;17:3551-3557. Published OnlineFirst April 29, 2011.

Updated version

Access the most recent version of this article at:
doi:10.1158/1078-0432.CCR-10-3087

Supplementary Material

Access the most recent supplemental material at:
http://clincancerres.aacrjournals.org/content/suppl/2011/06/03/1078-0432.CCR-10-3087.DC1

Cited articles

This article cites 12 articles, 4 of which you can access for free at:
http://clincancerres.aacrjournals.org/content/17/11/3551.full#ref-list-1

Citing articles

This article has been cited by 2 HighWire-hosted articles. Access the articles at:
http://clincancerres.aacrjournals.org/content/17/11/3551.full#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, use this link:
http://clincancerres.aacrjournals.org/content/17/11/3551.
Click on "Request Permissions" which will take you to the Copyright Clearance Center's (CCC) Rightslink site.