Colorectal cancer in South Africa: A heritable cause suspected in many young black patients

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Background. Colorectal carcinoma (CRC) has a low incidence among the black African population. Largely unrecognised in the scientific literature is the fact that a disproportionately large number of young black patients (<50 years old) present with CRC.

Objectives. To analyse those tumours, which we propose may link them to morphological features associated with known genetic pathways.

Methods. A retrospective review of South African patients histologically diagnosed as having CRC by the Division of Anatomical Pathology, National Health Laboratory Service (NHLS) and the University of the Witwatersrand (1 732 patients from 1990 to 2003). The histology was fully reviewed in 609 patients (1997 - 2002), and all specimens from patients <50 years of age were subjected to immunohistochemistry tests for mismatch repair proteins, as well as APC and p53 proteins.

Results. Most young patients (<50 years) were black (41% v. 10% white; p≤0.001). Blacks had predominantly proximal tumours and significantly more poorly differentiated and/or mucinous tumours (p=0.006), and loss of mismatch repair protein expression was more evident than in whites.

Conclusions. It seems likely that CRC in young blacks develops through the accumulation of mutations, most probably via mismatch repair deficiency or promoter methylation, which in turn is linked to poor differentiation and a mucinous architecture.

Colorectal carcinoma (CRC) is uncommon in developing countries, typically in Africa and Asia.1 It is generally a disease of older people, and is associated with a Western-style diet and a sedentary lifestyle. However, the age at which patients present with CRC may be a marker for the involvement of hereditary factors which often have specific pathological features.

Over the past decade, the overall incidence of CRC in South Africa has increased markedly. In 1989, CRC was the 10th most common cancer diagnosed in males and females in South Africa but was more recently ranked among the foremost 5 cancers (5th among males and 3rd among females).2 The epidemiology of CRC in white South Africans appears to follow the classic Western trend, although the molecular pathology has not been comprehensively investigated. CRC among black South Africans is far less common, but there is evidence that numbers have been increasing in some centres.3 Furthermore, disproportionately large numbers of young black patients seem to be presenting with CRC,4 a trend which appears to be common among countries throughout the African continent.

Classically, CRC is associated with chromosomal instability and mutations of multiple tumour suppressor genes and oncogenes, including APC, K-ras and p53. Alternatively, the tumour may develop through microsatellite instability (MSI), which may be sporadic (10% of cases) or hereditary, as evident in hereditary non-polyposis colorectal cancer (HNPPC) (in 90% of cases).5 MSI is associated with mutations in the DNA mismatch repair genes hMLH1 and hMSH2, and less frequently hMSH6 and PMS2, leading to the rapid development of neoplasms through the accumulation of mutations.6 Both of these pathways follow the adenoma-carcinoma sequence.

Recently, an alternative ‘serrated adenoma’ pathway was proposed, involving the formation of a tumour from hyperplastic polyps and adenomas through intermediate serrated adenomas.7 These tumours show a low level of MSI (MSI-L) together with a methylation phenotype characterised by the methylation of CpG islands within the promoter regions of genes such as hMLH1 and O-6-methylguanine DNA-methyltransferase (MGMT).8 Serrated neoplasia is less common and could possibly explain the occurrence of CRC among some young patients. This is frequently referred to as the ‘methylator pathway’.

This study evaluates the occurrence and morphological features of CRC in South African patients over a 13-year period. Many younger patients (<50 years) were black South Africans and presented with proximal tumours that were often poorly differentiated or mucinous and with significant risk of loss of hMSH2 protein expression. These are features associated with a heritable cause of colon cancer and would aid in its early diagnosis and improved prognosis.
Methods

Patients/tumour specimens

The data were retrospective, comprising all biopsy and resection specimens that fulfilled the histological criteria for adenocarcinoma of the colon or rectum from 1990 to 2003 from the records of the Division of Anatomical Pathology, NHLS and the University of the Witwatersrand, which comprised cases seen at academic and public sector hospitals in the Gauteng, Mpumalanga and North-West provinces of South Africa. All cases were stratified by age (<50 years of age or ≥50 years of age at diagnosis), gender, ethnicity and tumour location (identified from histology reports). The study was approved by the Ethics Committee of the University of the Witwatersrand (clearance number 9/11/88).

From 1990 to 2003, 1 732 black and white South African patients (961 and 771 respectively) with colorectal cancer were identified. Because the study was retrospective, colorectal cancer was not obtained. The reports of all cases were examined, and formal pathological review of cases was limited to 609 cases reported between 1998 and 2002. The original histological details were reviewed in consultation with a single pathologist (ACP), without knowledge of patient demographics and tumour sites. Each site was recorded as distal (descending colon, sigmoid, rectum) or proximal (caecum, ascending colon, transverse colon to the splenic flexure). Tumours were graded as well, moderately (low grade) or poorly differentiated (high grade) according to accepted morphological features.1 Mucinous and signet-ring tumours were considered to be of high grade. A subset of more recently diagnosed cases (1998 - 2002) identified in patients <50 years, regardless of race, and an equivalent number of patients ≥50 years, were then subjected to immunohistochemical analysis.

Immunohistochemistry

Table I summarises the antibody specifications. Immunohistochemical staining was performed on formalin-fixed, paraffin-embedded tissue sections by means of routine techniques using a DakoCytomation Autostainer (DakoCytomation, Denmark). Briefly, heat-induced antigen retrieval was performed using a combination of microwave heating and pressure cooking, endogenous peroxidase was blocked in 3% H2O2 in dH2O for 15 minutes, and nonspecific antigen activity was blocked by immersion of sections in 5% normal goat sera. Sections were then exposed to the monoclonal antibodies in a humidified atmosphere, rinsed and treated with a peroxidase-conjugated polymer, and secondary antibody directed against rabbit and mouse immunoglobulin (ChemMate Dako EnVision Detection kit, DakoCytomation, Denmark). Slides were again washed and incubated with 3,3’-diaminobenzidine (DAB) chromogen, washed with H2O2 and counterstained with haematoxylin, dehydrated and mounted. Appropriate positive and negative controls were used for each run. Slides were considered unsuitable for analysis when there was complete absence of signal in both mucosa and tissue lymphocytes. In some cases, there was insufficient tissue for full immunohistochemical analysis.

Statistical analysis

Statistical comparisons between groups were completed using the two-sided Fisher’s exact test. Patients were analysed on the basis of ethnicity (black v. white), age (<50 years v. ≥50 years), gender (male v. female) and tumour site. Multinomial logistical regression analysis was performed to calculate odds ratios. All statistical analyses were compiled by Stata Intercooled 7.0 (Stata, College Station, Tex, USA). At p<0.05 the differences were considered statistically significant.

Results

Patient demographics

A total of 1 732 patients (961 blacks and 771 whites) with histologically diagnosed CRC were identified; 73% (1 259/1 731) were ≥50 years of age and 27% (472/1 731) were ≤50 years of age (age range 14 - 100 years, mean 59). Distinct differences were noted between black and white cohorts. Black patients diagnosed with CRC were predominantly male (55%), while 53% of white patients were female (p=0.001). Similarly, 83% of black patients were ≤50 years of age compared with only 10% of younger whites (p=0.001). Tumour location showed no correlation with race (p=1.000; 95% confidence interval (CI)).

Pathological characteristics

All young patients (<50 years, N=69) presented predominantly with low-grade tumours (65%: 109/169), with 19% (32/169) being poorly differentiated; of these, 9% (16/169) were mucinous (p=0.001). In contrast, 82% (372/452) of tumours in older patients (>50 years, N=452) were of low grade, while 10% (44/452) were poorly differentiated and, of these, 4% were mucinous (18/452) (p=0.001). Young patients also presented more commonly with high-grade tumours showing a signet ring cell morphology (11%; 14/125) compared with older patients (3%; 12/382) (p=0.001).

When compared with white patients, 15% of black patients (N=367) had poorly differentiated tumours (p=0.001), of which 7% (27/367) were exclusively mucinous. In contrast, whites

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(N=245) showed fewer poorly differentiated (8%; 21/245) and purely mucinous tumours (3%; 7/245) (p=0.001).

Immunohistochemistry

Black patients more frequently showed loss of expression of the mismatch repair gene proteins hMLH1 (23%; 29/128) (p=0.121), hMSH2 (12%; 16/129) (p=0.013) and hMSH6 (43%; 54/126) (p=0.210) (Table II) (Fig. 1, A). In contrast, white patients more frequently showed loss of APC protein expression (15%; 9/62) (p=0.648) and the accumulation of mutant p53 protein within cancer cells (58%; 37/64) (p=0.047) (Fig. 1, B). Loss of MGMT protein expression was observed in similar percentages in both ethnic groups, i.e. 27% blacks (33/123) and 26% whites (16/62) (p=1.000).

In summary, there was a significant risk (odds ratio (OR) 1.9) for young black male patients to present with poorly differentiated tumours with a degree of mucin expression, as calculated through multinomial regression analysis. In addition, young black patients have a further additional risk of developing a tumour with an exclusively mucinous appearance and with a loss of hMSH2 protein expression (OR 6.5) while they were less likely to show accumulation of mutant p53 protein in cancer cells (OR 0.6).

Discussion

We investigated the pathological features of CRC among patients presenting to academic and public sector hospitals in South Africa’s most densely populated regions. Among the 961 black patients, 41% were aged ≤50 years, compared with the equivalent of only 10% among white patients. Of black patients, 29% were <40 years and 11.6% <30 years old, supporting studies that have identified disproportionate numbers of young South African black patients presenting with CRC.14

An increased incidence of colon cancer among young black patients has also been identified outside Africa. A higher proportion of African-American and Hispanic patients between 20 and 40 years of age has been reported, compared with older patients (60 - 80 years) of the same ethnicity.15 The tumours in the younger patients were poorly differentiated and/or mucinous, which is similar to the finding of our study.

An association between MSI-H CRC genotype and phenotype in African-American patients has been identified.11 These microsatellite-unstable tumours showed distinct clinical and pathological features including proximal location, high-grade and/or mucinous histology, the presence of tumour-infiltrating lymphocytes and mismatch repair gene deficiency, most frequently in the hMLH1 and hMSH2 genes.12 Young black males in our series presented with a similar morphology as well as a risk of absent hMLH1 protein expression and an increased possibility of loss of hMSH2 protein expression.

Hereditary non-polyposis colorectal cancer (HNPCC) shows similar features, including presentation at average age ≤50 years.13 However, diagnosis of HNPCC relies on fulfilling the Amsterdam and Bethesda criteria, and this was unavailable in our series. The strict Amsterdam criteria may lead to under-diagnosis of HNPCC, and it is suggested in the 1997 Bethesda guidelines that CRC diagnosed at a young age, even without a family history, may indeed have a genetic element leading to cancer development and that such patients should be tested for HNPCC.14 Early screening for HNPCC15 failed to identify new HNPCC cases and concurred with the revised Bethesda guidelines16 that excluded microsatellite instability testing in all adenomas from patients <40 years of age. However, Velayos and co-workers commented on the possibility of using direct germline testing as an alternative, as this shows increased sensitivity.17 As such, confirming the CRC cases in our young patients as being HNPCC by germline detection of microsatellite instability may be appropriate.

Microsatellite-unstable tumours also occur within 10 - 15% of sporadic CRCs.17 The difference in the development of sporadic versus hereditary CRC is thought to invoke the ‘methylator

| Table II. Differences between blacks and whites in the loss of protein expression, as assessed by immunohistochemistry* |
|---------------------------------|-----------------|-----------------|-----------------|
|                                  | Blacks          | Whites          | p-value         |
| hMLH1                           | 23% (29/128)    | 13% (8/63)      | 0.121           |
| hMSH2                           | 12% (16/129)    | 2% (1/65)       | 0.013           |
| hMSH6                           | 43% (54/126)    | 33% (21/64)     | 0.210           |
| APC                             | 12% (15/124)    | 15% (9/62)      | 0.648           |
| p53                             | 42% (54/126)    | 58% (37/64)     | 0.047           |
| MGMT                            | 27% (33/123)    | 26% (16/62)     | 1.000           |

*Values are given as a percentage of the overall distribution between the different variables.
promoter region and increase the risk of colorectal cancer. This is consistent with the observation that genetic changes in colorectal cancer can be due to the accumulation of mutations in the MLH1 gene.

References

7. Fisman HJ. Heterogeneity of colorectal adenomas, the serrated adenoma, and implications for screening and surveillance. World J Gastroenterol 2008; 14: 3865–3868.

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