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なし

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II. 研究成果の刊行に関する一覧表

<平成21年度>

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Chapter VI

Histological and Serological Tumor Markers of Gastric Cancer

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Abstract

Gastric cancer is one of the most common cancers worldwide. The prognosis of early gastric cancer patients is prolonged drastically by recent progress of diagnosis and treatment; however, the prognosis of patients with advanced disease remains poor. Therefore, the most important to conquer gastric cancer is the early detection and the effective treatment for advanced cancer. This chapter reviews classical and possible serological tumor markers and their usefulness in gastric cancer detection and histological tumor markers in relation with patient prognosis. Known tumor markers such as CEA and CA 72-4 are not satisfactory in their sensitivity for early detection although they may have prognostic impact. Several of possible tumor markers such as interleukins, matrix metalloproteinases, cell adhesion molecules, cell cycle regulators and methylated DNA are reported to be useful in clinical or histological diagnosis that must be confirmed by prospective study. Novel tumor markers and possible therapeutic targets such as Reg IV and GW112 identified by our global analysis of gene expression are also described. Further investigations are needed to identify new diagnostic targets, which are directory corrected to molecular target therapy.

Keywords: Serological tumor marker – Histological prognostic factor – Gastric cancer – CEA – CA 72-4 – Growth factor – Matrix metalloproteinase – Cell adhesion molecule – DNA methylation – Cell cycle regulator - Serial analysis of gene expression.

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Introduction

Gastric cancer is the fourth most common cancer and the second leading cause of cancer death only to lung cancer in the world [1]. Incidence of gastric cancer is declining worldwide. which is mainly due to changes in life style especially eating habits (decreased consumption of high-salt diet and availability of fresh fruit and vegetables throughout the year). Another point for decreasing incidence of gastric cancer is a rate of Helicobacter pylori (Hp) infection. It is known that worldwide gastric cancer has geographical variations in incidence, patient's outcome and molecular bases between the West and the East [2, 3]. The prognosis of early gastric cancer is prolonged drastically by recent progress of diagnosis and treatment. However, if patients are diagnosed with gastric cancer as advanced disease, the prognosis is extremely poor with survival rates rarely exceeding 15%. According to the world cancer report by World Health Organization, five-year survival rate of gastric cancer patients of all stages after diagnosis is around 50% in Japan and is 30% or less in other countries [4]. Therefore, the point, which should be conquered in gastric cancer, is the discovery in an early stage and the effective medical treatment for advanced cancer. Integrated research in molecular pathology has uncovered the genetic and epigenetic alterations in the course of development and progression of gastric cancer [5-8]. These include telomerase activation, genetic instability, and abnormalities in oncogenes, tumor suppressor genes, growth factors, matrix degradation enzymes, cell cycle regulators, cell adhesion molecules and DNA repair genes. Most of these can be used as tumor markers of gastric cancer, and if secreted, those serve as serological tumor markers. A better knowledge of the molecular bases of stomach carcinogenesis leads to new paradigms in diagnostics. Novel molecules participating in biological behavior of cancer must be useful targets for cancer therapy. This chapter describes classical, possible and novel tumor markers of gastric cancer and their clinical usefulness in diagnosis using serum samples and histology sections.

Known Serological Tumor Markers

Serological tumor markers have clinical value in screening high risk group, differentiating between normal and cancer patients, characterizing tumor behavior, and monitoring cancer growth and response to therapy [9]. While most of tumor markers are derived from cancer cells, some are produced by host cells in response to tumor growth and invasion. Known and possible serological tumor markers are listed in table 1.

Table 1. Serological tumor markers of gastric cancer

Known markers	Pepsinogen, CEA, CA19-9, CA 72-4
Possible markers	Interleukins
	IL-1beta, IL-6, IL-8, IL-18, IL-2 receptor
	Growth factor and angiogenic factor
	VEGF-A, VEGF-C, TGF-betal, HGF
	Matrix metalloproteinase
	MMP-9, MMP-10, MMP-11, TIMP-1

Known markers	Pepsinogen, CEA, CA19-9, CA 72-4
	Cell adhesion molecule
	E-cadherin, ICAM-1
	Oncogene / tumor suppressor gene
	HER-2/c-erbB2, p53, p53 autoantibody
	DNA methylation
	p16, p15, E-cadherin, DAP-kinase, RARbeta
	Novel markers identified by us
	Reg IV, GW112, MIA

Pepsinogen

Serum pepsinogen (PG) has been used as biomarkers of gastric inflammation and atrophic change. Serum pepsinogen I (PG I) and pepsinogen II (PG II) levels are known to increase in the presence of Helicobacter pylori (H. pylori)-related chronic gastritis which may be predisposed condition for developing gastric cancer [10]. Decreased ration of PG I to PG II is associated with atrophic gastritis. The serum PG test has been the first screening step for gastric cancer in Japan, although this test is used to screen high risk subjects with atrophic gastritis rather than as a test for cancer its self. Miki et al. reported that the percentage of cases screened by PG test, who need further examination was 24% and who required endoscopic examination was 52% [11]. Most gastric cancer cases detected by PG test are asymptomatic and at early stage which are well suited for endoscopic treatment. As H. pylori infection and gastric atrophy are both risk factors for gastric cancer, detection of H. pylori antibodies (IgA and IgG) is also useful for screening [12]. A case-control study demonstrated that the odds ratio of gastric cancer between infected and non-infected persons was 3.12 for elevated IgA and 2.88 for elevated IgG antibodies [13]. The highest gastric cancer risk was found among individuals with simultaneously elevated IgA and IgG antibodies and low PG I with an odds ratio of over 10 in comparison with those who were negative for both antibodies and had normal PG I.

CEA and CA19-9

Carcinoembryonic antigen (CEA), an oncodevelopmental tumor antigen, is a glycoprotein that was discovered in extracts of colorectal cancer in 1965 and is still the most useful and widely investigated tumor marker for colorectal cancer [9]. CA19-9 is a carbohydrate marker recognized by the monoclonal antibody which reacts with a sialylated derivative of the Le^a blood group antigen donated as Le^{xa} (sialylated lacto-N-fucopenteose II). CA19-9 represents the reference marker of pancreatic cancer and is elevated in about 80% of patients affected by this disease [9]. Elevated serum CEA and CA19-9 levels are observed in 15-25% of gastric cancer patients [14-17]. Elevated serum CEA and CA19-9 correlates well with depth of tumor invasion, various forms of metastases and stage grouping. Patients with elevated CEA and CA19-9 levels are at high risk of having metastases or recurrence. CEA or CA19-9 monitoring after surgery is useful to predict the recurrence of gastric cancer. The patients of gastric cancer with elevated CEA or CA19-9 level show