



# LUND UNIVERSITY

## Associations of anthropometric factors with KRAS and BRAF mutation status of primary colorectal cancer in men and women a cohort study

Brändstedt, Jenny; Wangefjord, Sakarias; Nodin, Björn; Eberhard, Jakob; Sundström, Magnus; Manjer, Jonas; Jirström, Karin

Published in:  
PLoS ONE

DOI:  
[10.1371/journal.pone.0098964](https://doi.org/10.1371/journal.pone.0098964)

2014

[Link to publication](#)

### Citation for published version (APA):

Brändstedt, J., Wangefjord, S., Nodin, B., Eberhard, J., Sundström, M., Manjer, J., & Jirström, K. (2014). Associations of anthropometric factors with KRAS and BRAF mutation status of primary colorectal cancer in men and women: a cohort study. *PLoS ONE*, *9*(6), e98964. Article e98964. <https://doi.org/10.1371/journal.pone.0098964>

Total number of authors:  
7

### General rights

Unless other specific re-use rights are stated the following general rights apply:  
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Read more about Creative commons licenses: <https://creativecommons.org/licenses/>

### Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117  
221 00 Lund  
+46 46-222 00 00



# Associations of Anthropometric Factors with KRAS and BRAF Mutation Status of Primary Colorectal Cancer in Men and Women: A Cohort Study

Jenny Brändstedt<sup>1,2\*</sup>, Sakarias Wangefjord<sup>1,2</sup>, Björn Nodin<sup>1</sup>, Jakob Eberhard<sup>1</sup>, Magnus Sundström<sup>3</sup>, Jonas Manjer<sup>4,5</sup>, Karin Jirström<sup>1</sup>

**1** Department of Clinical Sciences, Division of Oncology and Pathology, Lund University, Skåne University Hospital, Lund, Sweden, **2** Department of Surgery, Skåne University Hospital, Malmö, Sweden, **3** Department of Immunology, Genetics and Pathology, Uppsala University, Uppsala, Sweden, **4** Department of Clinical Sciences, Malmö, Lund University, Skåne University Hospital, Malmö, Sweden, **5** Department of Plastic Surgery, Skåne University Hospital, Malmö, Sweden

## Abstract

Obesity is a well-established risk factor for colorectal cancer (CRC), and accumulating evidence suggests a differential influence of sex and anthropometric factors on the molecular carcinogenesis of the disease. The aim of the present study was to investigate the relationship between height, weight, bodyfat percentage, waist- and hip circumference, waist-hip ratio (WHR), body mass index (BMI) and CRC risk according to KRAS and BRAF mutation status of the tumours, with particular reference to potential sex differences. KRAS and BRAF mutations were analysed by pyrosequencing in tumours from 494 incident CRC cases in the Malmö Diet and Cancer Study. Hazard ratios of CRC risk according to anthropometric factors and mutation status were calculated using multivariate Cox regression models. While all anthropometric measures except height were associated with an increased risk of KRAS-mutated tumours, only BMI was associated with an increased risk of KRAS wild type tumours overall. High weight, hip, waist, WHR and BMI were associated with an increased risk of BRAF wild type tumours, but none of the anthropometric factors were associated with risk of BRAF-mutated CRC, neither in the overall nor in the sex-stratified analysis. In men, several anthropometric measures were associated with both KRAS-mutated and KRAS wild type tumours. In women, only a high WHR was significantly associated with an increased risk of KRAS-mutated CRC. A significant interaction was found between sex and BMI with respect to risk of KRAS-mutated tumours. In men, all anthropometric factors except height were associated with an increased risk of BRAF wild type tumours, whereas in women, only bodyfat percentage was associated with an increased risk of BRAF wild type tumours. The results from this prospective cohort study further support an influence of sex and lifestyle factors on different pathways of colorectal carcinogenesis, defined by KRAS and BRAF mutation status of the tumours.

**Citation:** Brändstedt J, Wangefjord S, Nodin B, Eberhard J, Sundström M, et al. (2014) Associations of Anthropometric Factors with KRAS and BRAF Mutation Status of Primary Colorectal Cancer in Men and Women: A Cohort Study. PLoS ONE 9(6): e98964. doi:10.1371/journal.pone.0098964

**Editor:** Antonio Moschetta, University of Bari & Consorzio Mario Negri Sud, Italy

**Received:** November 18, 2013; **Accepted:** May 9, 2014; **Published:** June 11, 2014

**Copyright:** © 2014 Brändstedt et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

**Funding:** This study was supported by grants from the Knut and Alice Wallenberg Foundation, the Swedish Cancer Society, the Gunnar Nilsson Cancer Foundation, Region Skåne and the Research Funds of Skåne University Hospital. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

**Competing Interests:** The authors have declared that no competing interests exist.

\* E-mail: Jenny.brandstedt@med.lu.se

## Introduction

It is well established that body size influences risk of colorectal cancer (CRC). It has however been less investigated whether this risk differs according to molecular subsets of the disease. Colorectal carcinogenesis is a multistep process driven by accumulation of several genetic alterations, including chromosomal abnormalities, gene mutations, and epigenetic modifications involving regulation of proliferation, differentiation, apoptosis, and angiogenesis [1,2]. At least three distinct pathogenetic pathways have been identified, i.e. the chromosomal instability (CIN), microsatellite instability (MSI), and CpG island methylator phenotype (CIMP) pathways [3,4].

Somatic mutations in the KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene homolog) oncogene are identified in 30–40% of sporadic CRC and these mutations occur early in the carcinogenic process [5,6]. While KRAS mutation predicts non-responsiveness to epidermal growth factor receptor (EGFR)-targeting

agents, the prognostic relevance of KRAS mutations still remains controversial [7–9].

Recent studies suggest that BRAF (v-Raf murine sarcoma viral oncogene homolog B1) mutations occur in 10–20% of sporadic CRC [10]. BRAF mutations are more frequent in women, in right-sided tumours and are more often associated with lower differentiation grade, mucinous histology and, subsequently, a poor prognosis [9,11–16].

KRAS and BRAF mutations are nearly always mutually exclusive, and BRAF mutations are relatively rare in conventional adenomas, but closely associated with the CIMP pathway, which is found in 70–80% of all dysplastic serrated lesions of the right colon, predominantly in women [6].

Body weight and BMI are the most commonly used anthropometric measurements in studies on the associations of obesity and CRC risk, the majority of which have shown a positive relationship between BMI and risk of CRC in men, but weak or

no associations in women [17,18]. The more precise mechanisms behind the discrepancy between men and women regarding the association of body size with CRC risk remain unclear, and may be related to differences in fat distribution between the sexes. It is also possible that evaluation of risk in relation to specific molecular tumour markers may help clarify these associations. Since KRAS and BRAF mutations are thought to occur early in colorectal carcinogenesis [5,6], it seems biologically plausible that exposures such as obesity might modulate CRC risk differentially according to KRAS and BRAF mutation status of the tumours [19,20].

Hence, the aim of this prospective cohort study was to investigate the associations of obesity, measured as several anthropometric factors, with CRC risk according to KRAS and BRAF mutation status of the tumours, overall, and with particular reference to potential sex differences.

## Methods

### Study group

Between 1991 and 1996, a total number of 28 098 individuals; 11 063 (39.4%) men and 17 035 (60.6%) women, between 44–74 years were enrolled in the prospective, population-based cohort study Malmö Diet and Cancer Study (MDCS), from a background population of 74 138 [21]. All participants completed the baseline examination, which included a questionnaire, anthropometric measurements and a dietary assessment. The questionnaire covered information on physical activity, use of tobacco and alcohol, heredity, socio-economic factors, education, occupation, previous and current disease and current medication. In addition, blood samples were collected and stored in  $-80^{\circ}\text{C}$ . Follow-up is performed annually by record-linkage to national registries for cancer and cause of death.

Cases were identified from the Swedish Cancer Registry up until 31 December 2007, and from The Southern Swedish Regional Tumour Registry for the period of 1 January to 31 December 2008.

Until end of follow-up 31 December 2008, 584 incident cases of CRC had been registered in the MDCS. Eight tumours were reclassified as intramucosal cancer, and these were not included as cases, but did, however, contribute with person-years in all analyses. A total number of 181 cases were diagnosed with CRC before baseline examination, i.e. prevalent colorectal cancers, and therefore excluded from the study.

All tumours with available slides or paraffin blocks were histopathologically re-evaluated by a senior pathologist (KJ) on haematoxylin and eosin-stained slides. Histopathological, clinical and treatment data were obtained from the clinical and/or pathology records. Information on vital status and cause of death was obtained from the Swedish Cause of Death Registry up until 31 December 2009. Patient and tumour characteristics of the cohort have been described in detail previously [22–24]. Ethical permissions for the MDCS (Ref. 51/90), and the present study (Ref. 530/2008), were obtained from the Ethics Committee at Lund University.

### Anthropometric measurements

At baseline examination, weight (multiples of 0.1 kg) and height (to the nearest 0.005 m) were measured and body mass index (BMI) was calculated as  $\text{kg}/\text{m}^2$ . Waist circumference was measured at the midpoint between the lower ribs and the iliac crest, and for hip circumference the level of greatest lateral extension was used. These measurements were estimated to the nearest 0.01 m. The waist and hip circumferences of each participant were used to calculate waist-hip ratio (WHR; cm/

cm) as an additional measure of fat distribution. All anthropometric measurements were performed by a trained nurse. Body composition was estimated using a single frequency bio-impedance methodology (BIA 103, RJJ-systems, Detroit, MI, USA) with tetra polar electrode placement and subjects in a supine position. Lean body mass and fat mass were determined and served to calculate body fat percentage. The BIA method has previously been validated in Swedish middle-aged and elderly adults [25].

### Pyrosequencing analysis of KRAS and BRAF mutations

The PyroMark Q24 system (Qiagen GmbH, Hilden, Germany) was used for pyrosequencing analysis of KRAS and BRAF mutations in DNA from 1 mm formalin-fixed paraffin-embedded tumour tissue cores taken from areas with  $>90\%$  tumour cells as previously described [16]. In brief, genomic DNA was extracted from tumour tissue using QIAamp MinElute spin columns (Qiagen) and DNA regions of interest were PCR amplified (Veriti 96 Well Fast Thermal Cycler, Applied Biosystems Inc., Foster City CA). KRAS codons 12 and 13 were analysed using the Therascreen KRAS Pyro Kit (Qiagen). Analysis of BRAF mutation hotspots in codons 600 and 601 was performed using previously published PCR primers [29] and a novel BRAF sequencing primer (5'-TGATTTTGGTCTAGCTACA-3') which was designed using the PyroMark Assay Design 2.0 software (Qiagen). All samples with a potential low-level mutation were re-analysed. In the analysis, KRAS is categorised into KRAS wild type (0) or KRAS mutated (1), and BRAF as wild type (0) or mutated (1).

### Statistical methods

Anthropometric measurements were divided into tertiles. Separate tertiles were also calculated for men and women. A Cox proportional hazards analysis was used in order to calculate relative risks of different anthropometric factors and subgroups of CRC defined by KRAS and BRAF mutation status, overall, and stratified for sex. This yielded hazard ratios (HR) with a 95% confidence interval. Follow-up time was defined as time from baseline to diagnosis, death or end of follow-up 31 December 2009. Median time from baseline until diagnosis was 8.6 (SD = 4.3) years in all cases; 8.9 (SD = 4.4) years in men and 8.4 (SD = 4.3) years in women. The proportional hazards assumption was confirmed by a log<sub>e</sub>-log plot [26]. Potential confounders were included in the multivariate analysis, i.e. age (years), educational level (not completed elementary school/elementary school (6–8 years)/“grundskola” (9–10 years)/“studentexamen” (10–12 years)/one year after “studentexamen”/university degree), smoking habits (yes regularly, yes occasionally, former smoker, never smoker), alcohol consumption (g/day), and sex (in the overall analysis). The confounders were chosen on the base of already established and potential risk factors of CRC [27–31]. Trend was calculated as linear trend over tertiles. Missing category was not included in the trend analysis.

A two-tailed p-value less than 0.05 was regarded as statistically significant. Chi square test was applied for assessment of the distribution of investigative factors according to baseline characteristics. A case-to-case analysis examined the heterogeneity between different tumour subgroups regarding their association to anthropometric factors using an unconditional logistic regression model. In order to assess any potential interaction between each anthropometric factor and sex, an interaction term was introduced in the logistic regression model. P-values  $<0.05$  were considered statistically significant.

All statistical analyses were conducted using IBM SPSS statistics 20.0 (SPSS Inc., Chicago, IL, USA).

**Table 1.** Distribution of risk factors in cases and rest of cohort

Characteristics	Rest of cohort	CRC cases	p	KRAS wild type	KRAS mutated	p	BRAF wild type	BRAF mutated	p
n (%)	27514	584	<0.001	314(63.6)	180(36.4)	0.985	423(85.6)	71(14.4)	0.048
<b>Sex (%)</b>									
male	39.2	47.9		148(47.1)	85(47.2)		208(88.9)	26(11.1)	
female	60.8	52.1		166(52.9)	95(52.8)		215(82.7)	45(17.3)	
<b>Age at baseline (years)</b>									
overall	58.0	61.8	<0.001	62.2	61.8	0.457	61.8	63.4	0.044
male	59.2	61.7	<0.001	62.2	61.0	0.183	61.6	63.3	0.209
female	57.3	62.1	<0.001	62.2	62.5	0.661	61.9	63.8	0.174
<b>Smoking (%)</b>			0.092			0.425			0.366
regularly	23.8	21.2		62(19.7)	39(21.7)		84(19.9)	17(23.9)	
occasionally	4.5	3.4		7(2.2)	7(3.8)		14(3.3)	0(0)	
former smoker	33.7	39.7		132(42.0)	64(35.6)		167(39.5)	30(42.3)	
never smoker	37.9	35.6		113(36.0)	70(38.9)		158(37.4)	24(33.8)	
<b>Smoking male (%)</b>			0.104			0.348			0.457
regularly	23.9	18.9		23(15.4)	19(10.6)		35(16.7)	7(26.9)	
occasionally	4.8	4.3		3(2.0)	4(2.2)		7(3.3)	0(0)	
former smoker	43.0	51.8		83(56.1)	42(23.3)		112(53.8)	14(53.8)	
never smoker	28.2	25.0		39(26.2)	20(11.1)		54(25.7)	5(19.2)	
<b>Smoking female (%)</b>			0.652			0.571			0.373
regularly	23.8	23.3		39(23.4)	20(11.1)		49(22.6)	10(22.2)	
occasionally	4.3	2.6		4(2.4)	3(1.7)		7(3.2)	0(0)	
former smoker	27.7	28.6		49(29.3)	22(12.2)		55(25.3)	16(35.6)	
never smoker	44.2	45.4		74(44.6)	50(27.8)		104(48.4)	19(42.2)	
<b>Level of education (%)</b>			0.023			0.429			0.409
not completed	0.8	0.9		3(1.0)	1(0.6)		2(0.4)	2(2.8)	
6–8 years	41.0	49.1		167(53.5)	85(47.5)		214(51.0)	39(54.9)	
9–10 years	26.2	22.4		71(22.8)	37(20.7)		93(22.1)	15(21.1)	
10–12 years	8.9	8.7		25(8.0)	18(10.1)		37(8.8)	5(7.0)	
1 year university	8.7	7.7		22(7.1)	16(8.9)		33(7.9)	5(7.0)	
university degree	14.3	10.8		24(7.7)	22(12.3)		41(9.8)	5(7.0)	
<b>Level of education male (%)</b>			0.912			0.793			0.042
not completed	0.8	0.7		1(0.7)	0(0)		0	1(3.8)	
6–8 years	45.1	48.9		78(52.7)	40(22.2)		109(52.4)	10(38.5)	
9–10 years	19.6	19.6		30(20.1)	16(8.9)		42(20.2)	4(15.4)	
10–12 years	11.9	10.4		15(10.1)	10(5.6)		20(9.5)	5(19.2)	

Table 1. Cont.

Characteristics	Rest of cohort	CRC cases	<i>p</i>	KRAS wild type	KRAS mutated	<i>p</i>	BRAF wild type	BRAF mutated	<i>p</i>
1 year university	9.3	6.7		9(6.0)	6(3.3)		13(6.2)	2(7.7)	
university degree	13.2	13.6		15(10.1)	13(7.2)		24(11.4)	4(15.4)	
<b>Level of education female (%)</b>			0.009			0.688			0.167
not completed	0.8	1.0		2(1.2)	1(0.6)		2(0.9)	1(2.2)	
6–8 years	38.5	49.8		89(53.9)	45(0.25)		105(49.5)	29(64.4)	
9–10 years	30.5	24.9		41(24.8)	21(11.7)		51(23.8)	11(24.4)	
10–12 years	7.0	7.3		10(6.1)	8(4.4)		17(7.9)	0(0)	
1 year university	8.4	8.6		13(7.9)	10(5.6)		20(9.4)	3(6.7)	
university degree	15.1	8.3		9(5.5)	9(5.0)		17(7.9)	1(2.2)	
<b>Alcohol (g/day)</b>									
overall	10.7	10.8	0.404	10.4	11.2	0.286	11.2	7.8	0.052
male	15.5	15.7	0.793	16.3	15.6	0.925	16.3	14.2	0.842
female	7.7	6.2	0.001	5.1	7.3	0.134	6.3	4.0	0.112
<b>Height (cm)</b>									
overall	168.6	169.5	0.020	169.4	169.6	0.792	169.8	167.5	0.052
male	176.4	176.3	0.400	176.3	177.2	0.108	176.7	175.9	0.443
female	163.6	163.3	0.220	163.2	162.8	0.632	163.2	162.6	0.432
<b>Weight (kg)</b>									
overall	73.4	76.6	<0.001	76.4	77.6	0.481	77.4	73.8	0.075
male	81.7	83.8	0.014	83.3	86.0	0.173	84.7	81.2	0.181
female	68.0	70.0	0.008	70.3	70.0	0.725	70.3	69.6	0.913
<b>Bodyfat %</b>									
overall	26.8	26.9	0.974	27.0	27.3	0.607	26.9	27.7	0.372
male	20.8	21.6	0.019	21.2	21.7	0.676	21.6	20.0	0.199
female	30.2	31.9	<0.001	32.0	32.3	0.595	32.1	32.1	0.955
<b>Hip (cm)</b>									
overall	98.4	100.7	<0.001	100.8	101.1	0.617	101.0	99.9	0.353
male	99.4	101.2	<0.001	101.2	101.9	0.517	101.8	99.5	0.162
female	98.0	100.2	<0.001	100.4	100.3	0.984	100.4	100.2	0.958
<b>Waist (cm)</b>									
overall	84.1	87.9	<0.001	87.4	88.9	0.224	88.5	84.8	0.038
male	94.0	96.3	<0.001	96.0	97.6	0.334	97.0	93.6	0.107
female	78.2	80.1	0.001	79.8	81.0	0.341	80.3	79.7	0.898
<b>WHR (cm/cm)</b>									
overall	0.85	0.87	<0.001	0.87	0.88	0.184	0.87	0.85	0.036

Table 1. Cont.

Characteristics	Rest of cohort	CRC cases	<i>p</i>	KRAS wild type	KRAS mutated	<i>p</i>	BRAF wild type	BRAF mutated	<i>p</i>
male	0.94	0.95	0.027	0.95	0.96	0.323	0.95	0.94	0.349
female	0.80	0.80	0.525	0.79	0.81	0.062	0.80	0.80	0.808
<b>BMI (kg/m<sup>2</sup>)</b>									
overall	25.7	26.6	<0.001	26.6	26.9	0.374	26.7	26.3	0.286
male	26.2	26.9	<0.001	26.8	27.4	0.185	27.1	26.3	0.204
female	25.4	26.3	0.001	26.4	26.4	0.946	26.4	26.3	0.935

doi:10.1371/journal.pone.0098964.t001

## Results

### Distribution of risk factors in cases and controls, and in strata according to KRAS and BRAF mutation status

Distribution of well-established risk factors in CRC cases and rest of cohort, as well as distribution of KRAS and BRAF mutations in cases, are shown in Table 1. Compared to rest of cohort, CRC cases were slightly older ( $p < 0.001$  for both men and women), of higher weight ( $p = 0.014$  for men and  $p = 0.008$  for women), had a higher bodyfat percentage ( $p = 0.019$  for men and  $p < 0.001$  for women), a higher waist circumference ( $p < 0.001$  for men and  $p = 0.001$  for women), a higher hip circumference ( $p < 0.001$  for both sexes), a higher WHR for men ( $p = 0.021$ ), and a higher BMI ( $p = < 0.001$  for men and  $p = 0.001$  for women). Among women, cases had a higher level of education ( $p = 0.009$ ) and a lower intake of alcohol ( $p = 0.001$ ) than rest of cohort. Smoking status did not differ between cases and rest of cohort. Of note, while the proportion of current smokers was similar in both sexes, the proportion of former smokers was higher (51.8%) in men than in women.

KRAS and BRAF mutations were successfully evaluated in 494 (84.6%) cases. A total number of 314 (63.7%) tumours were KRAS wild type and 180 (36.4%) were KRAS-mutated. Further, 423 (85.6%) of the tumours were BRAF wild type, and 71 (14.4%) were BRAF-mutated. KRAS and BRAF mutations were mutually exclusive. BRAF mutation was significantly associated with female sex and with higher age overall.

### CRC risk according to KRAS and BRAF mutation status in the entire cohort

Associations of anthropometric factors with KRAS and BRAF mutation status of the tumours in the entire cohort are shown in Table 2. High weight, bodyfat percentage, hip, waist, WHR and BMI were associated with an increased risk of KRAS-mutated CRC ( $p_{\text{trend}} = 0.006$ ,  $p_{\text{trend}} = 0.007$ ,  $p_{\text{trend}} = 0.004$ ,  $p_{\text{trend}} = 0.004$ ,  $p_{\text{trend}} = 0.041$ ,  $p_{\text{trend}} = < 0.001$ ), and BMI was also associated with an increased risk of KRAS wild type tumours ( $p_{\text{trend}} = 0.046$ ). Interaction analysis revealed a significant difference between sexes for BMI and risk of KRAS-mutated tumours ( $p_{\text{interaction}} = 0.044$ ).

Increased weight, bodyfat percentage, hip, waist and BMI were associated with risk of BRAF wild type tumours ( $p_{\text{trend}} = 0.007$ ,  $p_{\text{trend}} = 0.002$ ,  $p_{\text{trend}} = 0.002$ ,  $p_{\text{trend}} = 0.001$ ,  $p_{\text{trend}} = < 0.001$ ). None of the anthropometric factors were associated with BRAF-mutated CRC.

### CRC risk according to KRAS and BRAF mutation status in men

Associations of anthropometric factors with KRAS and BRAF mutation status of CRC tumours in men are shown in Table 3. While elevated height was not associated with CRC risk according to KRAS or BRAF mutation status, high weight was significantly associated with KRAS-mutated and BRAF wild type CRC ( $p_{\text{trend}} = 0.004$  and  $p_{\text{trend}} = 0.001$ ). Moreover, bodyfat percentage was significantly associated with BRAF wild type CRC. High waist- and hip measures were associated with an increased risk of KRAS wild type tumours ( $p_{\text{trend}} = 0.045$  and  $p_{\text{trend}} = 0.043$ ), KRAS-mutated tumours ( $p_{\text{trend}} = 0.007$  and  $p_{\text{trend}} = < 0.001$ ), as well as BRAF wild type tumours ( $p_{\text{trend}} = < 0.001$  and  $p_{\text{trend}} = < 0.001$ ). Moreover, high WHR and BMI were positively associated with an increased risk of KRAS-mutated and BRAF wild type CRC ( $p_{\text{trend}} = < 0.001$  and  $p_{\text{trend}} = 0.001$ ).

Due to the comparatively small subgroup of male subjects with BRAF-mutated tumours, all analyses were also performed with

**Table 2.** Hazard ratio of overall CRC risk defined by KRAS and BRAF mutation status

Anthropometric factor	tertile	KRAS wild-type		KRAS mutated		BRAF wild-type		BRAF mutated	
		n = 314	HR	n = 180	HR	n = 422	HR	n = 71	HR
Height (kg)	1 (<164)	90	1.00	55	1.00	117	1.00	27	1.00
	2 ( $\geq 164 < 172$ )	98	1.10(0.81–1.50)	50	0.94(0.60–1.48)	127	1.06(0.81–1.39)	21	0.94(0.52–1.72)
	3 ( $\geq 172$ )	126	1.25(0.84–1.87)	74	0.95(0.53–1.71)	178	1.21(0.85–1.71)	23	1.19(0.52–2.76)
	p trend		0.274		0.846		0.295		0.763
Weight (kg)	1 (<67)	84	1.00	46	1.00	107	1.00	23	1.00
	2 ( $\geq 67 < 79$ )	104	1.11(0.82–1.49)	53	1.21(0.76–1.92)	133	1.10(0.85–1.44)	24	1.09(0.60–1.98)
	3 ( $\geq 79$ )	126	1.30(0.95–1.79)	80	1.87(1.17–2.99)	182	1.44(1.09–1.90)	24	1.17(0.61–2.23)
	p trend		0.099		0.006		0.007		0.640
Bodyfat%	1 (<23)	95	1.00	54	1.00	131	1.00	19	1.00
	2 ( $\geq 23 < 31$ )	106	1.26(0.92–1.74)	55	1.42(0.89–2.26)	137	1.31(0.99–1.71)	24	1.06(0.51–2.21)
	3 ( $\geq 31$ )	111	1.43(0.96–2.13)	70	2.20(1.23–3.91)	152	1.73(1.23–2.43)	28	1.00(0.42–2.37)
	p trend		0.087		0.007		0.002		0.966
Hip (cm)	1 (<77)	84	1.00	35	1.00	98	1.00	21	1.00
	2 ( $\geq 77 < 90$ )	143	0.90(0.66–1.22)	87	1.48(0.92–2.38)	126	1.13(0.87–1.48)	18	0.81(0.43–1.54)
	3 ( $\geq 90$ )	87	1.20(0.91–1.59)	58	1.89(1.21–2.95)	198	1.46(1.14–1.87)	32	1.09(0.62–1.91)
	p trend		0.123		0.004		0.002		0.695
Waist (cm)	1 (<95)	79	1.00	38	1.00	97	1.00	20	1.00
	2 ( $\geq 95 < 101$ )	98	1.01(0.74–1.39)	54	1.06(0.67–1.71)	124	1.07(0.80–1.41)	28	1.18(0.65–2.16)
	3 ( $\geq 101$ )	137	1.29(0.91–1.83)	87	1.98(1.20–3.28)	201	1.60(1.18–2.16)	23	0.99(0.48–2.02)
	p trend		0.120		0.004		0.001		0.962
WHR (cm/cm)	1 (<0.80)	100	1.00	44	1.00	118	1.00	26	1.00
	2 ( $\geq 0.80 < 0.90$ )	91	0.85(0.62–1.15)	62	1.29(0.82–2.01)	128	1.04(0.78–1.37)	24	0.88(0.48–1.58)
	3 ( $\geq 0.90$ )	123	0.93(0.60–1.45)	73	1.98(1.04–3.74)	176	1.24(0.85–1.82)	21	0.80(0.32–2.01)
	p trend		0.647		0.041		0.291		0.609
BMI (kg/m <sup>2</sup> )	1 (<23.8)	81	1.00	42	1.00	103	1.00	20	1.00
	2 ( $\geq 23.8 < 27.1$ )	106	1.05(0.78–1.40)	54	1.04(0.65–1.66)	136	1.07(0.82–1.39)	24	1.01(0.55–1.85)
	3 ( $\geq 27.1$ )	127	1.32(0.99–1.76)	83	2.11(1.38–3.22)	183	1.53(1.20–1.97)	21	1.15(0.64–2.08)
	p trend		0.046		<0.001*		<0.001		0.627

Adjusted for age, sex, level of education, smoking habits and alcohol consumption. \* significant interaction with sex.  
doi:10.1371/journal.pone.0098964.t002

**Table 3.** Hazard ratio of CRC risk defined by KRAS and BRAF mutation status in men

Anthropometric factor	KRAS wild-type		KRAS mutated		BRAF wild-type		BRAF mutated	
	n = 148	HR	n = 85	HR	n = 208	HR	n = 26	HR
Height (cm)								
1(<173)	37	1.00	21	1.00	52	1.00	6	1.00
2( $\geq$ 173-<179)	63	1.50(1.00-2.26)	26	1.06(0.59-1.89)	76	1.26(0.89-1.80)	14	2.18(0.83-5.72)
3( $\geq$ 179)	48	1.18(0.76-1.83)	38	1.50(0.87-2.59)	80	1.35(0.94-1.93)	6	0.92(0.29-2.93)
p trend		0.513		0.126		0.110		0.875
Weight (kg)								
1(<76)	43	1.00	18	1.00	53	1.00	8	1.00
2( $\geq$ 76-<86)	41	0.80(0.52-1.24)	27	1.30(0.72-2.29)	59	0.95(0.65-1.37)	9	1.02(0.39-2.67)
3( $\geq$ 86)	64	1.37(0.93-2.03)	40	2.10(1.25-3.87)	96	1.69(1.20-2.38)	10	1.18(0.44-3.11)
p trend		0.083		0.004		0.001		0.742
Bodyfat%								
1(<18)	31	1.00	16	1.00	39	1.00	8	1.00
2( $\geq$ 18-<22)	45	1.07(0.68-1.69)	28	1.30(0.71-2.41)	66	1.24(0.84-1.85)	8	0.79(0.30-2.12)
3( $\geq$ 22)	70	1.39(0.91-2.12)	41	1.66(0.93-2.97)	101	1.60(1.11-2.33)	10	0.87(0.34-2.23)
p trend		0.101		0.078		0.009		0.797
Hip (cm)								
1(<96)	31	1.00	12	1.00	35	1.00	8	1.00
2( $\geq$ 96-<102)	53	1.23(0.79-1.92)	35	2.22(1.15-4.29)	79	1.65(1.11-2.47)	9	0.84(0.32-2.20)
3( $\geq$ 102)	64	1.54(1.00-2.38)	38	2.55(1.32-4.92)	94	2.06(1.39-3.05)	9	0.87(0.33-2.31)
p trend		0.045		0.007		<0.001		0.795
Waist (cm)								
1(<89)	38	1.00	14	1.00	42	1.00	10	1.00
2( $\geq$ 89-<97)	40	0.90(0.57-1.40)	23	1.45(0.74-2.82)	58	1.18(0.80-1.76)	5	0.45(0.15-1.32)
3( $\geq$ 97)	70	1.45(0.97-2.16)	48	2.92(1.60-5.33)	108	2.06(1.44-2.95)	11	0.96(0.40-2.30)
p trend		0.043		<0.001		<0.001		0.972
WHR (cm/cm)								
1(<0.80)	44	1.00	23	1.00	59	1.00	8	1.00
2( $\geq$ 0.80-<0.90)	51	1.15(0.77-1.72)	24	1.06(0.60-1.89)	64	1.08(0.76-1.54)	11	1.44(0.78-3.59)
3( $\geq$ 0.90)	53	1.45(0.97-2.17)	38	2.13(1.26-3.61)	85	1.76(1.25-2.46)	7	1.20(0.43-3.34)
p trend		0.073		0.004		0.001		0.697
BMI (kg/m <sup>2</sup> )								
1(<24.7)	46	1.00	19	1.00	55	1.00	10	1.00
2( $\geq$ 24.7-<27.5)	43	0.81(0.53-1.23)	24	1.18(0.64-2.16)	60	0.96(0.67-1.39)	7	0.66(0.25-1.74)
3( $\geq$ 27.5)	59	1.21(0.82-1.80)	42	2.44(1.41-4.23)	93	1.67(1.19-2.35)	9	0.97(0.39-2.44)
p trend		0.287		0.001		0.001		0.939

Adjusted for age, level of education, smoking habits and alcohol consumption.  
doi:10.1371/journal.pone.0098964.t003



continuous anthropometric variables, which did not alter the significant associations (data not shown).

### CRC risk according to KRAS and BRAF mutation status in women

As shown in Table 4, a high WHR was significantly associated with an increased risk of KRAS-mutated CRC ( $p_{\text{trend}} = 0.046$ ) as compared to KRAS wild type tumours in women, with a significant heterogeneity in the highest tertile ( $p = 0.032$ ). Moreover, high bodyfat percentage was significantly associated with an increased risk of BRAF wild type tumours ( $p_{\text{trend}} = 0.032$ ).

### Discussion

In this prospective cohort study, we have investigated the relationship between obesity, measured as several anthropometric factors, and risk of CRC according to KRAS and BRAF mutation status of the tumours, with particular reference to potential sex differences. In the overall analysis, significant associations were found between most anthropometric factors and risk of KRAS-mutated and BRAF wild type tumours, whereas only BMI was associated with KRAS wild type tumours, and none of the anthropometric factors were associated with risk of BRAF-mutated CRC. Further analyses stratified for sex revealed that these associations were similar in the male but not in the female subcohort. Of note, a significant interaction was only found between sex and BMI with respect to risk of KRAS-mutated tumours, and heterogeneity analysis was only significant for the highest tertile of WHR in relation to risk of KRAS-mutated compared to KRAS wild type tumours among women.

Despite a growing awareness of the molecular heterogeneity of CRC, comparatively few studies have evaluated CRC risk in relation to its various molecular phenotypes [32–35]. To our knowledge, the relationship between obesity, KRAS mutation status and CRC risk has only been investigated in a few previous studies. Slattery et al have studied the associations between diet, physical activity, KRAS mutation status and risk of rectal cancer, demonstrating a reduced risk of KRAS-mutated rectal cancer with a high intake of vegetables, fibre and a high level of physical activity. Moreover, BMI was not associated with overall risk of rectal cancer, nor with specific molecular subtypes thereof [19]. In another study, Slattery et al have shown that men, but not women, with low levels of physical activity were more likely to have KRAS-mutated colon cancer, and that KRAS-mutated tumours were more common in women with a higher BMI [36]. The results from the present study appear to be somewhat different in that a high BMI was found to be associated with risk of KRAS-mutated tumours in men but not in women, with a significant interaction of sex with BMI regarding this risk.

The prognostic role of KRAS mutation has been more extensively investigated, with diverging results [7,8,37].

Of note, in the here examined cohort, it has recently been shown that mutation in KRAS codon 13, but not in codon 12, was associated with a significantly reduced cancer specific survival which is in line with other previous publications [16,38,39] [40], and most previous studies have not considered the prognostic value of specific mutations [7–9,37,41]. Furthermore, KRAS codon 13 mutation was found to be significantly associated with metastatic disease, and codon 12 mutation with mucinous tumour type, indicating that specific KRAS mutations have different impact on protein functionality, and hence influence clinical outcome in CRC patients differently [16]. Moreover, KRAS codon 13 mutation was also found to be associated with poor prognosis in women, but not in men [16]. In light of these findings,

it will also be relevant to study whether the associations of anthropometric factors with risk of CRC defined by specific KRAS mutations may differ between sexes. This will however require a larger sample size, as KRAS codon 13 mutations are less frequent than KRAS codon 12 mutations.

In the here studied cohort, BRAF mutation has previously been demonstrated to be an independent factor of poor prognosis in men, but not in women, in particular in MSS tumours [24]. It is well established that BRAF mutation, in contrast to KRAS mutation, is associated with MSI [9,15,41] and female sex [41,42]. MSI has generally been associated with good prognosis in most, but not all, studies [43,44]. On the other hand, BRAF mutation is generally associated with an inferior patient survival [9,14,45]. We have recently presented data showing that obesity was not associated with MSI tumours in any of the sexes, but that high weight, hip circumference and BMI was significantly associated with MSS CRC in women, and that high waist and hip circumference was significantly associated with MSS CRC in men [46]. The findings from the present study demonstrate a significant association of obesity with BRAF wild type tumours, being particularly evident in men. This suggests that obesity is more related to MSS tumours, and to tumours lacking BRAF mutation. Two previous studies have investigated the association between BMI and BRAF status in CRC tumours. In a case-control study, Slattery et al. reported that obesity was not associated with BRAF-mutated tumours, but associations with BRAF wild type tumours were not reported [47]. Further, Hughes et al presented data showing that BMI and waist measurements were strong risk factors for BRAF wild type tumours, which is consistent with our findings [20].

While it is well documented that body size influences CRC risk, also with differences regarding sex, location, and tumour stage [48], the exact biologic mechanisms underlying the association between obesity and increased risk of CRC are not fully understood. A large number of studies have shown an increased risk of CRC in men, but not in women, and the reason for this sex difference remains unclear, but is most probable due to hormonal factors [49,50]. BMI has been the most commonly used measurement of obesity, which may not be ideal because of the changes in physiologic functions that may depend on differences in adipose tissue distribution. A few prospective studies have examined the association of body fat distribution, reflected as waist- and hip circumference, and CRC risk [51–53], and available epidemiologic evidence suggests that abdominal obesity (high waist circumference and waist-hip-ratio) may be more predictive of CRC risk than overall obesity [52–54]. Increased bodyweight has been suggested to be more closely related to abdominal obesity in men, and to gluteofemoral obesity in women [55] and central adiposity is thought to be a better predictor of CRC risk than BMI [54].

General strengths of this study are the relatively large number of CRC cases, and the prospective design. However, a statistical issue to be addressed is the rather small numbers emerging in the subgroup analyses and, subsequently, limited statistical power with a potential risk of true associations not being detected, i.e. a type II error. Risk estimates in small groups often result in wide confidence intervals and, consequently, poor precision. Therefore, such risk estimates will need careful interpretation and validation in additional patient cohorts. Moreover, it should also be pointed out that a relatively large number of comparisons have been performed, which may result in a type I error, i.e. the null hypothesis being rejected when it is actually true.

The validity of the anthropometric measurements is another methodological aspect, as there may be a potential inter-observer

**Table 4.** Hazard ratio of CRC risk defined by KRAS and BRAF mutation status in women.

Anthropometric factor	tertile	KRAS wild-type		KRAS mutated		BRAF wild-type		BRAF mutated	
		n = 166	HR	n = 94	HR	n = 214	HR	n = 45	HR
Height (kg)	1(<161)	60	1.00	28	1.00	68	1.00	19	1.00
	2(≥161-<166)	47	0.88(0.60–1.29)	38	1.44(0.88–2.36)	73	1.15(0.83–1.61)	12	0.76(0.37–1.57)
	3(≥166)	59	1.17(0.80–1.70)	28	1.12(0.65–1.93)	73	1.19(0.84–1.68)	14	1.07(0.52–2.18)
	p trend		0.443		0.658		0.318		0.926
Weight (kg)	1(<62)	36	1.00	23	1.00	48	1.00	11	1.00
	2(≥62-<71)	62	1.47(0.97–2.22)	36	1.36(0.80–2.29)	81	1.44(1.01–2.07)	17	1.33(0.62–2.86)
	3(≥71)	68	1.51(1.00–2.27)	35	1.22(0.72–2.08)	85		17	1.13(0.53–2.44)
	p trend		0.061		0.508		0.057		0.806
Bodyfat%	1(<29)	32	1.00	22	1.00	43	1.00	11	1.00
	2(≥29-<33)	56	1.38(0.89–2.15)	23	0.90(0.50–1.62)	68	1.31(0.89–1.93)	11	0.75(0.32–1.73)
	3(≥33)	78	1.41(0.92–2.15)	49	1.42(0.84–2.38)	103	1.50(1.04–2.16)	21	1.01(0.49–2.12)
	p trend		0.144		0.125		0.032		0.834
Hip (cm)	1(<93)	37	1.00	22	1.00	47	1.00	12	1.00
	2(≥93-<101)	59	1.10(0.72–1.67)	30	0.97(0.56–1.69)	77	1.15(0.80–1.67)	12	0.66(0.30–1.48)
	3(≥101)	70	1.21(0.81–1.83)	42	1.28(0.75–2.17)	90	1.30(0.90–1.86)	21	0.95(0.46–1.97)
	p trend		0.343		0.309		0.159		0.951
Waist (cm)	1(<72)	39	1.00	22	1.00	50	1.00	11	1.00
	2(≥72-<81)	62	1.09(0.73–1.63)	31	1.02(0.59–1.76)	80	1.13(0.79–1.61)	13	0.77(0.35–1.73)
	3(≥81)	65	1.11(0.74–1.66)	41	1.32(0.77–2.24)	84	1.17(0.83–1.70)	21	1.06(0.51–2.24)
	p trend		0.645		0.268		0.361		0.745
WHR (cm/cm)	1(<0.77)	61	1.00	25	1.00	75	1.00	11	1.00
	2(≥0.77-<0.81)	61	0.93(0.65–1.34)	33	1.19(0.71–2.01)	72	0.90(0.65–1.24)	22	1.74(0.84–3.59)
	3(≥0.81)	44	0.80(0.54(1.19)	36	1.68(1.00–2.81)*	67	1.05(0.75–1.46)	12	1.06(0.46–2.41)
	p trend		0.270		0.046		0.822		0.920
BMI (kg/m <sup>2</sup> )	1(<23.2)	35	1.00	25	1.00	52	1.00	8	1.00
	2(≥23.2-<26.6)	67	1.54(1.02(2.33)	30	1.04(0.61–1.77)	75	1.21(0.84–1.73)	22	2.07(0.92–4.68)
	3(≥26.6)	64	1.40(0.92–2.14)	39	1.28(0.76–2.15)	87	1.38(0.97–1.96)	15	1.20(0.50–2.87)
	p trend		0.162		0.329		0.077		0.939

Adjusted for age, sex, level of education, smoking habits and alcohol consumption. \* significant p for heterogeneity.  
doi:10.1371/journal.pone.0098964.t004

variation. Recommendations for the nurses performing baseline examinations described how participants should be dressed, in which position the participants should be examined, and location for the estimation of waist- and hip measurements. We therefore consider the risk of misclassification of anthropometric measurements to be low. In contrast, most previous studies have used self-reported anthropometric measures. As anthropometric data was assessed only at baseline, it is further possible that some individuals have gained and some have lost weight. Such a misclassification is likely to lead to an attenuation of risks and, if anything, observed risks may be underestimated.

It is also possible that participation in the MDCS was associated with body constitution, which may have led to a potential selection bias. In a previous paper, Manjer et al compared BMI in the MDCS population in relation to the background population, and found an equal distribution of overweight and obesity [56].

Screening for CRC will most probably increase rapidly in westernized countries, and it is therefore a great challenge to identify individuals at risk of developing CRC. Detection and removal of adenomas are feasible by endoscopic techniques, but the majority of adenomas will not progress to cancer. Thus, defining the “adenoma at risk”, and consequently, the “patient at

risk”, in relation to specific molecular subgroups of CRC, is a major research challenge. Moreover, given that the global prevalence of overweight and obesity continues to rise, it is of great importance to invest in primary prevention.

## Conclusions

In conclusion, the results from this prospective study provide further support to the accumulating evidence of the influence of lifestyle factors and sex on different pathways of colorectal carcinogenesis, defined by KRAS and BRAF mutation status of the tumours. These findings need to be confirmed in additional molecular pathological epidemiology studies, in order to gain further insight into the interplay between lifestyle and colorectal carcinogenesis, with the ultimate goal to develop improved strategies for individualized prevention of the disease.

## Author Contributions

Conceived and designed the experiments: KJ. Performed the experiments: JB BN SW MS. Analyzed the data: JB SW JE JM KJ. Contributed reagents/materials/analysis tools: JB JE KJ JM. Wrote the paper: JB.

## References

- Vogelstein B, Fearon ER, Hamilton SR, Kern SE, Preisinger AC, et al. (1988) Genetic alterations during colorectal-tumor development. *N Engl J Med* 319: 525–532.
- Russo A, Rizzo S, Bronte G, Silvestris N, Colucci G, et al. (2009) The long and winding road to useful predictive factors for anti-EGFR therapy in metastatic colorectal carcinoma: the KRAS/BRAF pathway. *Oncology* 77 Suppl 1: 57–68.
- Armaghany T, Wilson JD, Chu Q, Mills G (2012) Genetic alterations in colorectal cancer. *Gastrointest Cancer Res* 5: 19–27.
- Pancione M, Remo A, Colantuoni V (2012) Genetic and epigenetic events generate multiple pathways in colorectal cancer progression. *Pathol Res Int* 2012: 509348.
- Rosenberg DW, Yang S, Pleau DC, Greenspan EJ, Stevens RG, et al. (2007) Mutations in BRAF and KRAS differentially distinguish serrated versus non-serrated hyperplastic aberrant crypt foci in humans. *Cancer Res* 67: 3551–3554.
- O'Brien MJ, Yang S, Mack C, Xu H, Huang CS, et al. (2006) Comparison of microsatellite instability, CpG island methylation phenotype, BRAF and KRAS status in serrated polyps and traditional adenomas indicates separate pathways to distinct colorectal carcinoma end points. *Am J Surg Pathol* 30: 1491–1501.
- Nash GM, Gimbel M, Cohen AM, Zeng ZS, Ndubuisi MI, et al. (2010) KRAS mutation and microsatellite instability: two genetic markers of early tumor development that influence the prognosis of colorectal cancer. *Ann Surg Oncol* 17: 416–424.
- Phipps AI, Buchanan DD, Makar KW, Win AK, Baron JA, et al. (2013) KRAS-mutation status in relation to colorectal cancer survival: the joint impact of correlated tumour markers. *Br J Cancer* 108: 1757–1764.
- Ogino S, Noshi K, Kirkner GJ, Kawasaki T, Meyerhardt JA, et al. (2009) CpG island methylator phenotype, microsatellite instability, BRAF mutation and clinical outcome in colon cancer. *Gut* 58: 90–96.
- Benvenuti S, Sartore-Bianchi A, Di Nicolantonio F, Zanon C, Moroni M, et al. (2007) Oncogenic activation of the RAS/RAF signaling pathway impairs the response of metastatic colorectal cancers to anti-epidermal growth factor receptor antibody therapies. *Cancer Res* 67: 2643–2648.
- Kim IJ, Kang HC, Jang SG, Kim K, Ahn SA, et al. (2006) Oligonucleotide microarray analysis of distinct gene expression patterns in colorectal cancer tissues harboring BRAF and K-ras mutations. *Carcinogenesis* 27: 392–404.
- Deng G, Kakar S, Tanaka H, Matsuzaki K, Miura S, et al. (2008) Proximal and distal colorectal cancers show distinct gene-specific methylation profiles and clinical and molecular characteristics. *Eur J Cancer* 44: 1290–1301.
- Yokota T, Ura T, Shibata H, Takahara D, Shitara K, et al. (2011) BRAF mutation is a powerful prognostic factor in advanced and recurrent colorectal cancer. *Br J Cancer* 104: 856–862.
- Samowitz WS, Sweeney C, Herrick J, Albertsen H, Levin TR, et al. (2005) Poor survival associated with the BRAF V600E mutation in microsatellite-stable colon cancers. *Cancer Res* 65: 6063–6069.
- Farina-Sarasqueta A, van Lijnschoten G, Moerland E, Creemers GJ, Lemmens VE, et al. (2010) The BRAF V600E mutation is an independent prognostic factor for survival in stage II and stage III colon cancer patients. *Ann Oncol* 21: 2396–2402.
- Wangefjord S, Sundstrom M, Zendeherokh N, Lindquist KE, Nodin B, et al. (2013) Sex differences in the prognostic significance of KRAS codons 12 and 13, and BRAF mutations in colorectal cancer: a cohort study. *Biol Sex Differ* 4: 17.
- Larsson SC, Wolk A (2007) Obesity and colon and rectal cancer risk: a meta-analysis of prospective studies. *Am J Clin Nutr* 86: 556–565.
- Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M (2008) Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. *Lancet* 371: 569–578.
- Slattery ML, Curtin K, Wolff RK, Herrick JS, Caan BJ, et al. (2010) Diet, physical activity, and body size associations with rectal tumor mutations and epigenetic changes. *Cancer Causes Control* 21: 1237–1245.
- Hughes LA, Williamson EJ, van Engeland M, Jenkins MA, Giles GG, et al. (2012) Body size and risk for colorectal cancers showing BRAF mutations or microsatellite instability: a pooled analysis. *Int J Epidemiol* 41: 1060–1072.
- Berglund G, Elmstahl S, Janzon L, Larsson SA (1993) The Malmö Diet and Cancer Study. Design and feasibility. *J Intern Med* 233: 45–51.
- Wangefjord S, Manjer J, Gaber A, Nodin B, Eberhardt J, et al. (2011) Cyclin D1 expression in colorectal cancer is a favorable prognostic factor in men but not in women in a prospective, population-based cohort study. *Biol Sex Differ* 2: 10.
- Larsson A, Johansson ME, Wangefjord S, Gaber A, Nodin B, et al. (2011) Overexpression of podocalyxin-like protein is an independent factor of poor prognosis in colorectal cancer. *Br J Cancer* 105: 666–672.
- Wangefjord S, Brandstedt J, Lindquist KE, Nodin B, Jirstrom K, et al. (2013) Associations of beta-catenin alterations and MSI screening status with expression of key cell cycle regulating proteins and survival from colorectal cancer. *Diagn Pathol* 8: 10.
- Steen B, Bosaeus I, Elmstahl S, Galvard H, Isaksson B, et al. (1987) Body composition in the elderly estimated with an electrical impedance method. *Compr Gerontol A* 1: 102–105.
- Katz MH, Hauck WW (1993) Proportional hazards (Cox) regression. *J Gen Intern Med* 8: 702–711.
- Giovannucci E, Colditz GA, Stampfer MJ, Hunter D, Rosner BA, et al. (1994) A prospective study of cigarette smoking and risk of colorectal adenoma and colorectal cancer in U.S. women. *J Natl Cancer Inst* 86: 192–199.
- Giovannucci E, Rimm EB, Stampfer MJ, Colditz GA, Ascherio A, et al. (1994) Intake of fat, meat, and fiber in relation to risk of colon cancer in men. *Cancer Res* 54: 2390–2397.
- Cho E, Smith-Warner SA, Ritz J, van den Brandt PA, Colditz GA, et al. (2004) Alcohol intake and colorectal cancer: a pooled analysis of 8 cohort studies. *Ann Intern Med* 140: 603–613.
- Chen K, Jiang Q, Ma X, Li Q, Yao K, et al. (2005) Alcohol drinking and colorectal cancer: a population-based prospective cohort study in China. *Eur J Epidemiol* 20: 149–154.
- Palmer RC, Schneider EC (2005) Social disparities across the continuum of colorectal cancer: a systematic review. *Cancer Causes Control* 16: 55–61.
- Pritchard CC, Grady WM (2011) Colorectal cancer molecular biology moves into clinical practice. *Gut* 60: 116–129.
- Slattery ML, Curtin K, Anderson K, Ma KN, Ballard L, et al. (2000) Associations between cigarette smoking, lifestyle factors, and microsatellite instability in colon tumors. *J Natl Cancer Inst* 92: 1831–1836.
- Morikawa T, Kuchiba A, Yamauchi M, Meyerhardt JA, Shima K, et al. (2011) Association of CTNNB1 (beta-catenin) alterations, body mass index, and physical activity with survival in patients with colorectal cancer. *JAMA* 305: 1685–1694.

35. Hughes LA, Simons CC, van den Brandt PA, Goldbohm RA, de Goeij AF, et al. (2011) Body size, physical activity and risk of colorectal cancer with or without the CpG island methylator phenotype (CIMP). *PLoS One* 6: e18571.
36. Slattery ML, Anderson K, Curtin K, Ma K, Schaffer D, et al. (2001) Lifestyle factors and Ki-ras mutations in colon cancer tumors. *Mutat Res* 483: 73–81.
37. Hutchins G, Southward K, Handley K, Magill L, Beaumont C, et al. (2011) Value of mismatch repair, KRAS, and BRAF mutations in predicting recurrence and benefits from chemotherapy in colorectal cancer. *J Clin Oncol* 29: 1261–1270.
38. Samowitz WS, Curtin K, Schaffer D, Robertson M, Leppert M, et al. (2000) Relationship of Ki-ras mutations in colon cancers to tumor location, stage, and survival: a population-based study. *Cancer Epidemiol Biomarkers Prev* 9: 1193–1197.
39. Bazan V, Migliavacca M, Zanna I, Tubiolo C, Grassi N, et al. (2002) Specific codon 13 K-ras mutations are predictive of clinical outcome in colorectal cancer patients, whereas codon 12 K-ras mutations are associated with mucinous histotype. *Ann Oncol* 13: 1438–1446.
40. Zlobec I, Kovac M, Erzberger P, Molinari F, Bihl MP, et al. (2010) Combined analysis of specific KRAS mutation, BRAF and microsatellite instability identifies prognostic subgroups of sporadic and hereditary colorectal cancer. *Int J Cancer* 127: 2569–2575.
41. Roth AD, Tejpar S, Delorenzi M, Yan P, Fiocca R, et al. (2010) Prognostic role of KRAS and BRAF in stage II and III resected colon cancer: results of the translational study on the PETACC-3, EORTC 40993, SAKK 60-00 trial. *J Clin Oncol* 28: 466–474.
42. Kalady MF, DeJulius KL, Sanchez JA, Jarrar A, Liu X, et al. (2012) BRAF mutations in colorectal cancer are associated with distinct clinical characteristics and worse prognosis. *Dis Colon Rectum* 55: 128–133.
43. Popat S, Hubner R, Houlston RS (2005) Systematic review of microsatellite instability and colorectal cancer prognosis. *J Clin Oncol* 23: 609–618.
44. Kim GP, Colangelo LH, Wieand HS, Paik S, Kirsch IR, et al. (2007) Prognostic and predictive roles of high-degree microsatellite instability in colon cancer: a National Cancer Institute-National Surgical Adjuvant Breast and Bowel Project Collaborative Study. *J Clin Oncol* 25: 767–772.
45. Bond CE, Umopathy A, Buttenshaw RL, Wockner L, Leggett BA, et al. (2012) Chromosomal instability in BRAF mutant, microsatellite stable colorectal cancers. *PLoS One* 7: e47483.
46. Brandstedt J, Wangejford S, Borgquist S, Nodin B, Eberhard J, et al. (2013) Influence of anthropometric factors on tumour biological characteristics of colorectal cancer in men and women: a cohort study. *J Transl Med* 11: 293.
47. Slattery ML, Curtin K, Sweeney C, Levin TR, Potter J, et al. (2007) Diet and lifestyle factor associations with CpG island methylator phenotype and BRAF mutations in colon cancer. *Int J Cancer* 120: 656–663.
48. Brandstedt J, Wangejford S, Nodin B, Gaber A, Manjer J, et al. (2012) Gender, anthropometric factors and risk of colorectal cancer with particular reference to tumour location and TNM stage: a cohort study. *Biol Sex Differ* 3: 23.
49. Slattery ML, Ballard-Barbash R, Edwards S, Caan BJ, Potter JD (2003) Body mass index and colon cancer: an evaluation of the modifying effects of estrogen (United States). *Cancer Causes Control* 14: 75–84.
50. Reeves GK, Pirie K, Beral V, Green J, Spencer E, et al. (2007) Cancer incidence and mortality in relation to body mass index in the Million Women Study: cohort study. *BMJ* 335: 1134.
51. Giovannucci E, Ascherio A, Rimm EB, Colditz GA, Stampfer MJ, et al. (1995) Physical activity, obesity, and risk for colon cancer and adenoma in men. *Ann Intern Med* 122: 327–334.
52. MacInnis RJ, English DR, Hopper JL, Haydon AM, Gertig DM, et al. (2004) Body size and composition and colon cancer risk in men. *Cancer Epidemiol Biomarkers Prev* 13: 553–559.
53. MacInnis RJ, English DR, Hopper JL, Gertig DM, Haydon AM, et al. (2006) Body size and composition and colon cancer risk in women. *Int J Cancer* 118: 1496–1500.
54. Pischon T, Lahmann PH, Boeing H, Friedenreich C, Norat T, et al. (2006) Body size and risk of colon and rectal cancer in the European Prospective Investigation Into Cancer and Nutrition (EPIC). *J Natl Cancer Inst* 98: 920–931.
55. Krotkiewski M, Bjorntorp P, Sjostrom L, Smith U (1983) Impact of obesity on metabolism in men and women. Importance of regional adipose tissue distribution. *J Clin Invest* 72: 1150–1162.
56. Manjer J, Carlsson S, Elmstahl S, Gullberg B, Janzon L, et al. (2001) The Malmo Diet and Cancer Study: representativity, cancer incidence and mortality in participants and non-participants. *Eur J Cancer Prev* 10: 489–499.