8-HYDROXY-DEOXYGUANOSINE AS AN INDEPENDENT PROGNOSTIC FACTOR IN PATIENTS WITH METASTATIC COLORECTAL CANCER

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ABSTRACT

Introduction. Surgical injury can stimulate tumor growth in metastatic colorectal cancer (mCRC), due to mitochondrial dysfunction. The objective of the study was to analyze the clinical significance of the molecular marker of 8-hydroxydeoxyguanosine and the oncological influence of the liver parenchyma warm ischemia on the prognosis of mCRC.

Materials and methods. The study involved 89 CRC patients with metachronous metastatic liver disease treated in The National Cancer Institute of the Ministry of Health, Kyiv, Ukraine, from 2015 till 2018, and 19 conditionally healthy donors. 8-Hydroxy-deoxyguanosine (8-OHdG) level in the urine of patients with mCRC was determined. Urine sampling was done 24-hours before and on day 3 after surgery. Measurements of the marker of oxidative DNA damage were repeated three times. The state of the hepatocyte detoxification energy system, the levels of superoxide radicals (O2-) in the tumour tissue were determined by electron

RÉSUMÉ

Introduction. Un traumatisme chirurgical peut stimuler la croissance de la tumeur pendant le cancer colorectal métastatique à la suite de la formation d’un dysfonctionnement mitochondrial.

But. Nous avons analysé l’importance clinique du marqueur moléculaire de 8-hydroxydeoxyguanosine (8-OHdG) et l’influence oncologique d’ischémie chaude de parenchyme hépatique.

Matériaux et méthodes. L’étude portait sur 89 patients atteints de cancer colorectal atteints de métastase hépatique métastatique traités à l’Institut National du Cancer du Ministère de la Santé, Kiev, Ukraine, de 2015 à 2018, et 19 donneurs sous condition. Le taux de 8-hydroxydeoxyguanosine (8-OHdGu) dans l’urine des patients atteints de mCRC a été déterminé. La collecte d’urine a été effectuée un jour avant l’opération.

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paramagnetic resonance (EPR) and Spin Trapping Technology.

**Results.** The urinary 8-OHdG level of donors was within 0.24±0.063 nM/kg · day, whereas before the resection and on day 3 after the R₀-resection of liver in mCRC patients it was 3.42±0.18 nM/kg-day and 2.12±0.08 nM/kg-day (p < 0.05), respectively. On day 1 after the liver resection with a total duration of warm ischemia period < 30 min and > 30 min have had marker at level 2.108 ± 0.13 nM/kg-day and 2.9883 ± 0.159 nM/kg-day (p < 0.0001), respectively. The volume of metastatic tissue (V_{mts}) significantly and directly increased the level of urine 8-OHdG. The duration of surgical intervention (resection time) and duration of warm liver ischemia (t ischemia) significantly increased urine level of 8-OHdG.

**Conclusions.** R₀-resection of liver metastases in mCRC patients decreases urine 8-OHdG level after surgery. Warm liver ischemia during the Pringle maneuver (≥ 40 min), surgical intervention duration (≥ 300 min) and metastatic tissue volume (≥ 12 cm³) in liver parenchyma in mCRC patients significantly increase urine 8-OHdG levels. The level of 8-OHdG correlates with the extent of organ resection, duration of ischemia, volume of post-resection liver tissue, volume of metastases and rate of superoxide radicals' generation.

**Keywords:** colorectal cancer, 8-hydroxy-deoxyguanosine, superoxide radicals, liver metastases, liver resection.

**Abbreviations list**
- mCRC – metastatic colorectal cancer
- DNA – Deoxyribonucleic acid
- O₂ - superoxide radicals
- 8-OHdG – 8-Hydroxydeoxyguanosine
- EPR – electron paramagnetic resonance
- V_{mts} – volume of metastatic tissue
- resection time – time of resection
- t ischemia – duration of warm liver ischemia
- I/R – ischemia-reperfusion
- PM – Pringle maneuver
- CTX – chemotherapy
- CT – computed tomography
- CRC – colorectal cancer
- ALF – acute liver failure
- ISGLS – International Study Group of Liver Surgery
- BMI – body mass index
- ETC – electron transport chain
- ATP – adenosine triphosphate

et trois jours après. Les mesures du marqueur des dommages oxydatifs à l’ADN ont été répétées trois fois. On déterminait l’état énergique et celui du système de détoxication des hépatocytes, les niveaux des ions superoxydes dans le tissu tumoral par la méthode de résonance paramagnétique électronique (RPE) et par les technologies des capteurs de spin (Spin Traps).

**Résultats.** Le niveau de 8-OHdGu dans l’urine des donneurs était dans les limites de 0,24±0,063 nM/kg · jour, alors que avant et le troisième jour après la R₀ résection hépatique le niveau de 8-OHdGu dans l’urine était égal à 3,42±0,18 nM/kg · 24 heures et 2,12±0,08 nM/kg · 24 heures (p<0,05). Les patients atteints de cancer colorectal métastatique, le 1-er jour après la résection hépatique, avec la durée totale d’ischémie chaude < 30 minutes et ≥ 30 minutes avaient le niveau de 8-OHdGu de 2,108 ± 0,13 nM/kg · 24 heures et 2,9883 ± 0,159 nM/kg · 24 heures (p<0,0001), respectivement. Les patients atteints de cancer colorectal métastatique, le 1-er jour après la résection hépatique, avec la durée totale d’ischémie chaude < 30 minutes et ≥ 30 minutes avaient le niveau de 8-OHdGu de 2,108±0,13 nM/kg · 24 heures et 2,983±0,159 nM/kg · 24 heures (p<0,0001). Le volume de tissu métastatique (V_{mts}) augmentait véritablement le niveau de 8-OHdGu dans l’urine des patients opérés. La durée de l’opération (t \_ resection) et le temps de l’ischémie chaude (t \_ ischemia) augmentaient le niveau de 8-OHdGu des patients.

**Conclusions.** R₀-resection de métastases hépatiques provoque la baisse du niveau de 8-OHdGu dans l’urine des malades après l’opération. La durée de l’ischémie durant la manoeuvre de Pringle (≥ 40 minutes), le temps de l’opération (≥ 300 minutes) et le volume de tissu métastatique (≥ 12 cm³) dans le parenchyme de foie des patients atteints de cancer colorectal métastatique augmentent véritablement les niveaux de 8-OHdGu dans l’urine des malades. Le niveau de 8-OHdGu est en corrélation avec la durée de l’opération, la vitesse de génération des ions superoxydes.

**Mots-clés:** le cancer colorectal, 8-hydroxy-déoxyguanosine, les ions superoxydes, les métastases dans le foie, la résection hépatique.
INTRODUCTION

In 30% of patients with colorectal cancer with metastatic lesion of liver (mCRC), during the first year after the liver resection, repeated metastatic lesions are diagnosed, and the recurrent metastatic lesion occurs since the time of first resection in 50–60% of patients\(^1\). Local and systemic control of the disease course in metastatic colorectal cancer (mCRC) patients is a key point of modern oncology and individualized prediction of the disease course in mCRC patients is the subject of active research. Recently, prognosis of such patients depended predominantly on clinical, radiological, pathological, and molecular criteria, but this approach did not demonstrate sufficient clinical efficacy\(^2\).

Ischemia-reperfusion (I/R) effect in liver is usually recorded in case of large as well as advanced liver resections using Pringle maneuver (PM) and/or total blood supply blockage in organ\(^3\). It’s proven that liver oxygenation is significantly reduced during the organ mobilization/retraction and its preparation for the latter transection of parenchyma, which leads to additional hepatocytes damage and death\(^4\). Liver with signs of fibrosis, steatosis due to toxic effect of chemotherapy (CTX) is much more susceptible to damage caused by I/R\(^5\). It was shown that damage by PM and I/R during the liver resection leads to hepatocytes dysfunction, increases the anti-inflammatory cytokines levels and enhances metastatic metalloproteinases activity in animal experiments\(^6\). That may stimulate the progression of micro metastases of mCRC carcinoma further\(^6\). Surgical trauma creates favourable conditions for the growth of uncontrolled concentrations of superoxide radicals (O2-) which in turn creates a new redox state in surgery-treated organ and organism in general, which is a key factor in local relapse and distant metastases after the tumour resection performed\(^7\).

Despite the fact that this is considered to be the main factor in the pathogenesis of an increasing list of clinical conditions, the role of oxidative-induced DNA damage in ischemia in the operated liver remains undetermined. In particular, in the study by Yamashita et al, an independent predictor of oncological prognosis for patients with mCRC the degree of ischemia that arose as a result of a blood supply violation in liver parenchyma during the first 30 days after the resection (liver stroke) was assumed\(^3\). The authors observed a direct-proportional dependence between non-recurrent survival rate and stroke severity in resection area according to CT data. This approach and scale of ischemia described by these authors as an evidence proving that level of liver ischemia after the surgery can be a significant predictive factor of mCRC patients survival rate since the time of surgical intervention. These findings were confirmed by our results, as well.

It is known that O2- causes DNA oxidation leading to formation of a number of oxidative bases and nucleotides in DNA. Such lesions become a cause of mutations and carcinogenesis initiation in healthy people or in malignant neoplasms progression, including those with CRC. 8-oxo-2’-deoxyguanosine (8-oxodGu) is the most frequently reported form of oxidative bases in DNA or in a nuclear pool. It has dangerous effects because of capacity to form pairs with adenine and/or cytosine in DNA molecule.

8-oxoguanine (8-oxoG) is able to accumulate in both nuclear and mitochondrial DNA. That is why the latter considered a highly informative marker of malignant neoplasms formation.

The aim of our study is to evaluate the clinical significance of 8-oxodGu marker, to assess the oncological effects of warm ischemia of liver parenchyma on disease prognosis in patients with mCRC and to determine the correlation relationship between the latter and the marker under study.

### Table 1. Characteristics of participating patients.

| Characteristics                              | Value                      |
|---------------------------------------------|----------------------------|
| Age                                         | 61.4 ± 2.3                 |
| Body mass index                             | 26.5 ± 5.3                 |
| Sex (male/female)                           | 36/33                      |
| Metastatic liver injury (synchronous/metachronous) | 14/55                     |
| Primary tumour location (rectum/colon)      | 35/54                      |
| Metastatic injury of other sites at the moment of liver resection (lungs/abdomen cavity) | 4/5                        |
| Number of resected metastases               | 3.41 ± 1.3 (4 – 7)         |
| Volume of metastatic tissue in liver, cm\(^3\) | 9.2 ± 7.3 (1.0 – 43.2)     |
| Type of liver resection (major/minor)        | 55/34                      |
| Neoadjuvant CTX (yes/no)                    | 27/62                      |
| Patient condition (ASA scale):              |                            |
| \(G_1\) tumors                              | 56                         |
| \(G_2\) tumors                              | 33                         |
| Warm ischemia duration in time of the PM, min | 19.7 ± 20.5               |
| Liver parenchyma transection duration, min   | 228.9 ± 118.2              |
| Pringle maneuver applied (yes/no)           | 61/28                      |
The study involved 89 CRC patients with metachronous metastatic liver disease (pT1N0M0 colon cancer and pT4N0M1 rectal cancer) treated in National Cancer Institute of the Ministry of Health, Kyiv, Ukraine, from 2015 till 2018, and 19 conditionally healthy donors. 46 men and 43 women were included in the study. The average age of patients was 61.4±2.3 years. 38 patients were diagnosed with rectal cancer, while 51 — with colon cancer. Based on the degree of tumour differentiation, the patients were classified as follows: G1 — healthy donors, G2 — rectal cancer, G3 – 4 tumors — in 35 patients, G4 tumors — in 56 patients.

In each clinical case, a multidisciplinary approach was used, where surgeons, oncologists, chemotherapists and radiologists took part. In all cases, the diagnosis of metastatic liver damage was confirmed using cytology/histology techniques and fine-focal biopsy of the pathological liver sites. Routine computed tomography (CT) scan with intravenous contrast of thoracic, abdominal and pelvic cavity was applied; in complicated cases (suspicion of canceromatosis or bilobate lesions), the examination was supplemented by magnetic resonance imaging with intravenous contrast. Positron-emission tomography was used only in case of metastatic involvement of other organs/sites.

The surgical technique included the implementation of radical resection with the maximum possible preservation of parenchyma and ensuring adequate retreat from the tumour edge (4–10 mm). Each operation was accompanied by intraoperative ultrasound examination in order to mark sites in relation to major hepatic veins and Glissonian pedicles and also to detect small metastases. Major liver resections referred to removal of 3 or more liver segments (class Couinaud). The technique of ischemia assumed the use of classic and selective PM (15 min — ischemia, and 5 min — reperfusion)³. The parenchyma transection was performed using the „crash-clamp” method. Resected parenchyma haemostasis was performed by prolene 4.0, 5.0 flashing, bipolar forceps, clipping of LT200, LT300.

The patients received adjuvant CTX according to international standards, FOLFOX-6/FOLFIRI/XELOX (4–6 courses). Patients treated with CTX and with signs of disease progression did not undergo liver resection. The liver functional capacity was assessed using Child – Turcotte – Pugh score and MELD score. The manifestations of CTX toxicity were documented according to STCAE 5.0 criteria. The degree of acute liver failure (ALF) in the postoperative period was determined by the International Study Group of Liver Surgery (ISGLS) classification.

Urine sampling was done 24-hours before and on day 3 after the surgery. Then, 20 mL of 24-hour volume test urine filtered through a solid-phase extraction column. Measurement of 8-OHdG level in eluate was carried out using spectrophotometric method⁶. The energy system and hepatocyte detoxification system state, O2- generation speed in tumour tissue, hepatocyte mitochondria and tissue-associated neutrophils was determined using method of electron paramagnetic resonance (EPR) and technology of spin traps (SpinTraps) at room temperature. Measurements were carried out on a computerized EPR spectrometer RE-1307. EPR spectra were recorded at liquid nitrogen temperature (−196 °C) in a paramagnetically pure quartz dewar on a computerized spectrometer PE-1307 with resonator H011. Following parameters were used: power of microwave source level 40 mW, modulation frequency 100 kHz, amplitude 10 Gaussian, the receiver’s constant time τ = 0.3 s. As a standard of intensity a specially oriented sample of a single crystal Al2O3 with specific concentration of Cr³⁺ ions were used. Method of double integration evaluated the concentration of molecules by comparing the signals intensity in EPR spectra to standard intensity. The error of spectrum integration method and spread of spectrum reproduction of one sample was within 3%.

Generation by mitochondria in surgical tissue samples of tumors was determined by electron paramagnetic resonance (EPR) method with computerized spectrometer RE-1307 using a spin trap TEMPO-H (2,2,6,6-tetramethyl-4oxypiperidine) (Sigma, USA) at the room temperature in a special paramagnetic pure quartz cuvette³⁰.

Statistical Methods. Statistical analysis of the results was performed using IBM SPSS Statistics (Version 20.0, Armonk, NY, USA). T-test was used to evaluate the difference of urine 8-OHdG between donors and mCRC patients. Concentration on urine 8-OHdG at different disease stages was compared using One-way ANOVA test. Logistic regression model designed to determine the relation between the urine 8-OHdG concentrations in patients with CRC and other factors i.e. body mass index, presence of ischemic liver tissue, presence of distant metastases, volume of metastatic tissue in liver, stage of process, age, sex, degree of tumour differentiation. Statistical tests were two-sided and statistical significance was assumed when p < 0.05. Patient’s survival was analysed by the Kaplan–Meier estimating method. Results are presented as M±m.
RESULTS AND DISCUSSION

The main reason for the development of mCRC in the intestinal mucosa is considered to be the mutation process in the genes controlling the cell cycle (proliferation, differentiation, adhesion and apoptosis). Oxidative damage of nuclear and mitochondrial DNA, hypermethylation of gene promoters are major events in all stages of carcinogenesis. The prolonged exposure of intestinal mucosa to O2− initiates chronic inflammation and dysplasia. Disorders caused by O2− include oxidative-induced mutations in genome, its functional instability and consequently cell proliferation dysregulation. The integral quantitative analysis of urine 8-OHdG provides an opportunity to non-invasive evaluation of degree of DNA oxidation and redox condition of tissue after surgery.

We have studied a number of factors that could negatively affect the level of oxidative DNA damage and subsequently the oncologic prognosis in surgically operated patients. A statistically significant effect was registered only with volume of metastatic tissue in liver (p=0.037), duration of warm ischemia duration during parenchyma transection. Thus, the mean value of urine 8-OHdG in healthy donors is 0.244±0.063 nM/kg · day. In patients with mCRC on 1 day after the liver resection due to its metastatic lesion with a total duration of warm ischemia < 30 min was 2.10±0.13 nM/kg · day and 2.98±0.159 nM/kg · day (p < 0.0001), respectively.

Fig. 1 shows the results of urine 8-OHdG levels in healthy donors and mCRC patients depending on the warm liver ischemia duration during parenchyma transection. Thus, the mean value of urine 8-OHdG in healthy donors is 0.244±0.063 nM/kg · day. In patients with mCRC on 1 day after the liver resection due to its metastatic lesion with a total duration of warm ischemia < 30 min was 2.10±0.13 nM/kg · day and 2.98±0.159 nM/kg · day (p < 0.0001), respectively. Obviously, the urine level of 8-OHdG is significantly increased in patients with mCRC and depends on warm ischemia duration caused by PM (Fig. 2).

We have analysed the urine 8-OHdG levels in mCRC patients before and after removal of liver metachronous metastases (Fig. 1). The obtained data and their analysis showed that metastatic tissue removal leads to normalization of oxidative DNA damage. Thus, the average level of the marker in donors’ urine is 0.244±0.063 nM/kg · day, whereas on day 3 after the R-resection of liver due to its metastatic lesion, it was 3.42±0.18 and 2.12±0.08 nM/kg-day (p < 0.05).
ischemia during the liver parenchyma transection (p = 0.001) and duration of surgery (p = 0.006).

Statistical analysis of studied factor dependence on oxidative DNA damage (8-oxodGu) level showed that duration of liver parenchyma transection, warm ischemia duration using the Pringle maneuver and volume of metastatic tissue in liver are independent factors that negatively affect the level of studied marker (Fig. 3). In particular, the volume of metastatic tissue (V mts) significantly and proportionally increases the level of urine 8-oxodGu in surgery-treated patients (R² = 0.54; 95% CI 0.037–0.091 at p < 0.000) (Fig. 3a). Surgery time (t resection) and duration of warm ischemia during the surgical manipulations (t ischemia) significantly increased the level of urine 8-oxodGu in surgery-treated patients (R² = 0.54; 95% CI 0.001–0.004 at p < 0.001).

**Linear regression model equation**

We have created a linear regression equation for 8-oxodGu marker levels = 1.253 + 0.483 • V mts + 0.342 • t resection + 0.352 • t ischemia

Using EPR method under conditions of low temperature stabilization (T 77 K) the study of ischemic liver tissue samples and liver tissue samples dissected at a distance of 5 cm from the tumour node (postoperative material) was done. In EPR spectra of healthy liver tissue following spectra were detected: EPR signals g = 1.94, which characterize the state of mitochondrial electron transport chain (ETC) (iron-sulphur proteins of Complex I, NADN-dehydrogenase 1a); EPR signal g = 2.00 – level of flavo-, ubisemiquinone, a main electron transfer in ETC; EPR signal g = 2.03 – level of NOFeS-protein complexes; EPR signal g = 2.25 and g = 2.42 – activity level of cytochrome P450 (CYP) in redox cycle of hepatocyte detoxification system;
Table 2. Results of the linear logistic regression analysis of the studied factors in mCRC patients.

| Model  | Non-standard coefficients | Standard coefficients | t     | Significance | 95.0% CI lower limit |
|--------|---------------------------|-----------------------|-------|--------------|---------------------|
|        | B | Standard error | Beta |          |                    |
| Constant | 1.235 | 0.172 | 7.167 | 0.000 | 0.891 |
| $V_{mts}$ | 0.064 | 0.013 | 0.486 | 4.738 | 0.037 |
| $t_{resection}$ | 0.003 | 0.001 | 0.345 | 3.369 | 0.001 |
| Age | 0.023 | -0.034 | 0.071 | 0.042 | 1.076 |
| T | 0.443 | 0.300 | 0.150 | 0.089 | 0.659 |
| N | 0.638 | 0.414 | 0.111 | 0.066 | 2.170 |
| G | -0.071 | -0.373 | -0.323 | -0.201 | 1.199 |
| PM | 0.786 | 0.453 | 0.308 | 0.190 | 1.387 |
| BMI | 0.016 | -0.020 | -0.121 | -0.072 | 1.111 |
| $t_{ischemia}$ | 0.017 | 0.005 | 0.352 | 3.277 | 0.002 |

BMI – body mass index; Pringle maneuver (PM) – yes/no; G – degree of tumour differentiation; N – status of regional lymph nodes; T – status of primary tumour; $t_{ischemia}$ – duration of warm ischemia during the transection of liver parenchyma (min); $t_{resection}$ – duration of the surgery on the liver, min; $V_{mts}$ – volume of metastatic tissue based on CT-volumetry data, cm$^3$.

Fig. 3. Linear regression model of the effect on urine 8-oxodGu levels in mCRC patients of:
- volume of metastatic liver tissue ($V_{mts}$);
- duration of liver parenchyma transection ($t_{resection}$);
- duration of warm ischemia during PM ($t_{ischemia}$).
ERPR signal \(g=2.65\) — free iron level; EPR signal with \(g=4.25\) — level of lactoferrin, transferrin functioning in oxidative metabolism in mitochondria (Fig. 4).

Qualitative and quantitative changes in energy and detoxification systems of ischemic liver tissue mitochondria were detected. In conditionally healthy liver tissue at a distance of 5 cm from the metastasis, the value of cytochrome P.450 activity was detected at level 0.44±0.08 a.u. while in healthy tissue — 1.48±0.13 a.u. In ischemic tissue activity of cytochrome P.450 was detected at level 0.11±0.07 a.u., which is an evidence of significant decrease of detoxification system effectiveness (Fig. 4). In mitochondria of these cells reduced activity of Complex 1 (NADH-ubiquinone oxidoreductase) to value 0.31±0.06 a.u. was detected, while in control group 1.51±0.10 a.u. and 0.59±0.09 a.u. in conditionally healthy liver tissue. Decreased activity of the electron transport complexes in ETC occurs due to NO complexes with FeS proteins (\(g=2.03\)) formation, which levels are increased; and this refers to formation of triplet structure in EPR, which is typical for mitochondria of malignant tumors (Fig. 4, ESR spectrum 2). In liver tissue at a distance of 5 cm from the metastatic node, complexes NO-FeS-proteins in ETC detected at level 0.25±0.07 a.u. These changes in hepatocytes ETC functioning in ischemic liver tissue cause an increase in mitochondrial \(O_2^-\) generation rate up to 0.81±0.09 nM/g tissue ∙ min. Mitochondria of conditionally healthy liver tissue generate \(O_2^-\) at level 0.73±0.07 nM/g tissue ∙ min. Ischemic liver cells generate \(O_2^-\) at level 1.42±0.15 nM/g tissue ∙ min, conditionally healthy tissue cells produce \(O_2^-\) at level 0.96±0.12 nM/g tissue ∙ min (Fig. 4). These results show the contribution of other producers of oxygen radicals, in particular NOX neutrophils, which infiltrate affected tissues. In liver tissue, under ischemia, a decrease of molybdenum-containing enzymes activity — xanthine and aldehyde oxidase (\(g=1.97\)) was found, which leads to toxic products of purines and aldehydes destruction accumulation.

Detected changes in ischemic tissue mitochondria functioning cause a violation of energy...
metabolism (decrease ATP levels), enhanced anaerobic glucose metabolism, lactate accumulation. An ATP synthesis reduction leads to acute cellular swelling (edema) — one of the earliest manifestations of ischemic injury, decreased intracellular levels of Na" and increased intracellular Ca" concentration, which facilitates the activation of proapoptotic pathways8.9. Restoration the oxygen tissues supply as a result of reperfusion causes unregulated O2- generation in hepatocyte mitochondria and NOX of leukocytes and platelets, inducing the opening of mitochondrial pores and cell apoptosis10-12.

Liver ischemia is a risk factor in case of its transplantation and resection13-15, and the growth of O2- levels in hepatocyte and tissue mitochondria is a specific feature not only of ischemic tissue, but also of many diseases (neurodegenerative, cardiovascular, chronic inflammation)16-21, those associated with enhanced O2- generation22. However, O2- is known to be a key factor in cell apoptosis induction, in particular in hepatocytes, which in turn plays an important role in ALF development after resection24,25. In addition, persistent oxidative stress contributes to pathological progression of liver fibrosis and increases the risk of surgery-treated organ functional failure.

Our results and also the results of other authors determine that human mCRC tumors, experimental tumor strains, tumor cell lines have significantly higher levels of 8-OHdG than normal tissues or normal cell lines10,26-27. The key point is that the growth and development of malignant neoplasms is accompanied with steadily increase of O2- generation level produced as a result of mitochondrial ETC dysfunction28-31. Oxidative modification of DNA can lead to cytotoxic effects that are fundamental in the pathogenesis of many diseases12,31, including neurodegenerative, cardiovascular, chronic inflammatory diseases and cancer34-37. 8-OHdG formation leads to transcription violations due to switch G:C to T:A. Moreover, formation of 8-OHdG may cause decreased microsatellites formation and accelerate the telomere reduction10. The obtained results indicate a significant increase of urine 8-OHdG levels in mCRC patients, which can be an informative biomarker for evaluation of metastatic organ damage in mCRC patients.

Conclusions

Thermal ischemia of liver during the PM (≥ 40 min), long-term surgery (≥ 300 min), and metastatic tissue volume (≥ 12 cm³) in liver parenchyma in patients with mCRC cause damage of mitochondrial ETC (formation of NO-FeS-proteins), resulting in an increase of O2-generation rate in mitochondria and tissue in these patients. Unregulated levels of O2- oxidize guanine in DNA with 8-OHdG formation. Re-resection of metastases in liver in mCRC patients leads to decrease of urine 8-OHdG already at day 3 after the surgery. The level of urine 8-OHdG in mCRC patients correlates with the volume of resection, duration of ischemia, volume of post-ischemic liver tissue, volume of tumour tissue in liver and the rate of O2- generation in tumour tissue and degree of tumour differentiation. Urine 8-OHdG levels are significantly higher in patients with long-term metastases as compared to those in patients who did not have metastases. Levels of urine 8-OHdG, level of intraoperative and postoperative ischemia of liver parenchyma are new factors of oncological prognosis in patients with rectal forms of mCRC that affect the liver.

Compliance with ethic requirements:

„The authors declare no conflict of interest regarding this article“.

„The authors declare that all the procedures and experiments of this study comply with the ethical standards of the Declaration of Helsinki 1975, revised in 2008, as well as national legislation“.

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