Requests for Tumor Marker Tests in Turkey Without Indications and Frequency of Elevation in Benign Conditions

Medine Cumhur Cure¹*, Erkan Cure², Aynur Kirbas¹, Tarkan Yazici¹, Suleyman Yuce²

Abstract

Aims: To investigate the incidence of ordering tests for tumor markers which are used in cancer diagnosis, follow-up treatment and detection of recurrence, the rate of elevation in benign diseases and which clinics order them frequently. Materials and Method: Data for the tumor markers carbohydrate antigen 19-9 (CA 19-9), carcinoembryonic antigen (CEA), cancer antigen 125 (CA 125), cancer antigen 15-3 (CA 15-3) and alphafetoprotein (AFP) that were ordered by all the clinics in our Hospital between 2010 and 2011 were screened. When excluding repeated orders the results of 3,416 patients were available. It has been determined that in which benign diseases were the tumor markers frequently ordered and which of these conditions had high levels of them. Results: CA 19-9 was ordered for 1,858 patients 191 (10.3%) were malignant while 1667 (89.7%) were ordered in benign diseases. For CEA the total was 1,710, 226 (13.2%) malignant and 1484 (86.8%) benign, and for CA 125 1267, 111 (8.8%) malignant and 1156 (91.2%) benign. AFP was ordered for 1687 cases, 80 (4.7%) malignant but 1607 (95.3%) benign. CA 15-3 was ordered 1449 times, 174 (12%) for malignant and 1275 (88%) for benign diseases. In all cases, considerable proportions were positive. Conclusions: It was shown that clinicians frequently order tumor markers for benign conditions. The findings of this study has shown that tumor markers are used widely without indications as cancer screening tests.

Keywords: CA 19-9 - CEA - CA 125 - CA 15-3 - AFP - benign disease -Turkey

Introduction

Although there are no specific tumor markers used in cancer screening, some markers can be used to assist in making a diagnosis and determining a prognosis. They can be used to follow up in cases where the diagnosis is cancer through monitoring the recurrence of the disease and/or evaluating the response to therapy (Duffy, 2001; Perkins et al., 2003). These markers are not specific as the number increases in multiple cases of cancer. In addition, they can act as false negatives, so their utilization in the diagnosis of cancer could be misleading. Clinicians often use these markers as a guideline. The markers can also be high in benign disease. Finding levels higher than normal through use of these markers in patients without cancer could lead to difficult situations and even cause psychological trauma and expensive research costs.

Carbohydrate antigen 19-9 (CA 19-9) is a marker that increases in pancreatic, biliary, hepatocellular and gastrointestinal malignancy. This marker is related to the Lewis blood group antigens and only patients who belong to the Le (α-β+) or Le (α+β-) blood groups will express the CA 19-9 antigen (Kannagi, 2007). The application of CA 19-9 as a universal biomarker is limited as Le (α-β-) phenotypes occurring in 5–10% of the population which lack enzyme 1, 4-fucosyl transferase that is required for antigen epitope production (Goonetilleke and Siriwardena, 2007).

Carcinoembryonic antigen (CEA) is a glycoprotein with a molecular weight of 180-200 kDa (Kruepey et al., 1975). CEA is expressed in adenocarcinomas of the colon and other organs including the pancreas, lungs, prostate, urinary bladder, ovaries, and breasts; so it is commonly used as a marker of malignancy (Locke et al., 2006; Amayo and Kuria, 2009). Screening of this marker for adenocancer is very low sensitivity and specificity (Lim et al., 2009). It is also not recommended for use as a screening test for colorectal cancer (Locke et al., 2006). Cancer antigen 125 (CA 125) is a cell surface glycoprotein with 220-kDa expressed in more than 80% of non-mucinous epithelial ovarian cancers (Bast et al., 2005). Cancer antigen 15-3 (Ca 15-3) is a mucinous glycoprotein with a high molecular weight. It is used to track patients with breast cancer (Cheung et al., 2000). Alpha-fetoprotein (AFP) is an oncofetal glycoprotein consisting of a single chain and has a molecular weight of 70,000. It is released from liver cancer and germ cell tumors. However, this marker is low sensitivity for screening of hepatocellular cancer (Malaguarneta et al., 2010). Since tumor markers can increase in benign conditions, our aim is to determine

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the frequency and the purpose of ordering tumor markers in such cases.

Materials and Methods

The data of the tumor markers CA19-9, CEA, CA 125, AFP and CA 15-3 that were ordered by all the clinics in our Hospital between 2010 and 2011 were screened. The files of the patients where there was an incompatibility between the diagnosis and the ordered tumor markers were checked again by the clinician.

Incompatible results and incorrect records were excluded from the study. Repeated results in the same patient were excluded from the study, leaving 3,416 patients’ records to be included in the study. Tumor markers were recorded if they were ordered singly or in groups. It was then determined for which diseases and from which clinics they were mostly ordered. In our laboratory, tumor markers were studied by the Chemiluminescent Microparticle Immunoassay (CMIA) method via the ARCHITECT i2000 device. The reference values were Ca 19-9 0-37 U/ml, CEA 0-5 U/ml, CA125 0-35 U/ml, CA15-3 0-33.3 U/ml and AFP 0-8 ng/ml.

Statistical analysis and Ethic issue

The results were evaluated using SPSS 13 software with simple statistical tests (mean±standard deviation, frequency). It was determined in which benign diseases tumor markers were ordered and in which of them they were high. The study was approved by the local ethics committees, and informed consent from each participant was obtained (Approval number: 2012/73).

Results

CA 19-9 was ordered for 1,858 patients and in 191 (10.3%) tumors were malignant, while in 1,667 (89.7%) they were benign. The benign occurrences were mostly for ovarian cysts (10.2%), anemia (7.3%) and abdominal pain (5.8%). CEA was ordered for 1,710 patients and in 226 of them (13.2%) malignant results occurred, whereas in 1,484 (86.8%) results were benign. It was mostly ordered in anemia (17.6%), abdominal pain (6.2%), and ovarian cysts (5.1%).

CA 125 was ordered for 1,267 patients and in 111 (8.8%) results were malignant, while in 1,156 (91.2%) results were benign. Benign cases were mostly for ovarian cysts (14.5%), anemia (11.6%) and ovarian cysts (18.6%).

Table 1. The Incidences of Ordering Tumor Markers in Benign and Malign Diseases

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>CA 19-9</th>
<th>CEA</th>
<th>CA 125</th>
<th>AFP</th>
<th>CA 15-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>57±17</td>
<td>58±16</td>
<td>54±18</td>
<td>51±18</td>
<td>57±17</td>
</tr>
<tr>
<td>Gender (M/F)</td>
<td>679/1179</td>
<td>708/1002</td>
<td>248/1019</td>
<td>996/691</td>
<td>435/1014</td>
</tr>
<tr>
<td>The number of ordering</td>
<td>1858</td>
<td>1710</td>
<td>1267</td>
<td>1687</td>
<td>1449</td>
</tr>
<tr>
<td>Frequency of ordering in benign diseases (%)</td>
<td>191 (10.3%)</td>
<td>226 (13.2%)</td>
<td>111 (8.8%)</td>
<td>80 (4.7%)</td>
<td>174 (12%)</td>
</tr>
<tr>
<td>1. Ordered in BD (%)</td>
<td>Ovary cyst (10.2%)</td>
<td>Anemia (17.6%)</td>
<td>Ovary cyst (17%)</td>
<td>Chronic hepatitis B (33.8%)</td>
<td>Ovary cyst (9.9%)</td>
</tr>
<tr>
<td>2. Ordered in BD (%)</td>
<td>Anemia (7.3%)</td>
<td>Abdominal pain (6.2%)</td>
<td>Anemia (7.3%)</td>
<td>Chronic hepatitis C (6.8%)</td>
<td>Anemia (9%)</td>
</tr>
<tr>
<td>3. Ordered in BD (%)</td>
<td>Abdominal pain (5.8%)</td>
<td>Ovary cyst (5.1%)</td>
<td>Menstrual disorder (6.7%)</td>
<td>Anemia (4.7%)</td>
<td>Abdominal pain (4.2%)</td>
</tr>
</tbody>
</table>

Table 3. Frequency of Tumor Markers Levels in Benign and Malign Diseases

<table>
<thead>
<tr>
<th>Found to be elevated in BD (%)</th>
<th>Level of Tumor Markers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ovary cyst</td>
<td>Anemia (11.6%)</td>
</tr>
<tr>
<td>2. Pneumonia</td>
<td>Anemia (9.3%)</td>
</tr>
<tr>
<td>3. Dyspepsia</td>
<td>Anemia (6.2%)</td>
</tr>
</tbody>
</table>

*BD: benign disease
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to be used as screening tests. Not only can they be increased in benign cases (false positive), but they may also be low in malignant cases (false negative). For example, CA 19-9 is known to be elevated in gastrointestinal tumors and has a sensitivity of 79-81% and a specificity of 82-90% in patients with asymptomatic pancreatic cancer (Ballehaninna and Chamberlain, 2011). It may be increased in benign cases such as acute cholecystitis, biliary obstruction and liver disease as well (Dogan et al., 2011; Yue et al., 2011). Even heavy tea consumption can lead to elevated serum CA19-9 levels (Howazi et al., 2003). In our study, this marker was ordered mostly for ovarian cysts, anemia, and abdominal pain, and it was found to be high in benign conditions as ovarian cysts, pneumonia, and anemia. Previous studies showed that the level of CA 19-9 was found to be elevated in menstrual disorders, endometriosis, dermoid ovarian cysts, and ovarian chocolate cysts (Harada et al., 2002). Increased CA 19-9 levels in benign pulmonary events have also been reported (Pavai and Yap, 2003). In a previous study, the level of CA 19-9 was found to be elevated in 13 (3%) of patients with pneumonia (Marechal et al., 1988). It has been reported that in megaloblastic anemia the levels of CA 19-9 were not increased (Symeonidis et al., 2004). This marker was found to be sporadically high in patients with beta thalassemia (Christoforidis et al., 2007). Current literature does not confirm whether levels are elevated for this marker or not in patients with other types of anemia. On the other hand, this marker is ordered frequently in anemic patients, even though it may be sporadically elevated in this study. Also, CA 19-9 has been reported to be high in chronic renal failure and diabetes mellitus (Pavai and Yap, 2003; Yu et al., 2012). In current study show that the marker is increased these diseases.

CEA may increase in colorectal, lung, and ovarian cancers. CEA may rise in benign cases, especially in cigarette smokers (Sajid et al., 2008). It is also known to be elevated in chronic renal failure, senility, hypothyroidism, and other inflammatory conditions (Amino et al., 1981; Witherspoon et al., 1983). In current study, it has been found that doctors order CEA mostly in anemia, abdominal pain, and ovarian cysts. Additionally, it is found to be high in benign cases such as anemia, pneumonia, and dyspepsia. CEA was frequently indicating a false positive high in benign cases such as anemia, pneumonia, and dyspepsia. CEA may rise in colorectal, lung, and ovarian cancers. CEA may increase in many benign cases. It may be elevated during menstruation, pregnancy, in endometriosis, pelvic inflammatory disease, liver disease, and lung disease (Escudero et al., 2011). In this study, it was found that this marker was ordered mostly in ovarian cysts, anemia, and menstrual disorders, and it was elevated mostly in ovarian cysts.
cysts, menstrual disorders, and anemia. CA 125 was high in cases of endometriosis and was recommended as a biomarker for the diagnosis of endometriosis (Szubert et al., 2012). It has also been reported to be elevated in cases of benign ovarian cysts. In a study of postmenopausal women with ovarian cysts, CA 125 (levels<35 IU/ml) was found to be a useful marker that is significantly related to benign cysts (Dikensoy et al., 2007). In follow-up treatment for ovarian cysts, in cases where levels are <5 cm or CA 125 is high, the decision to operate may be taken with regard to the patient’s age and menstrual status (Knudsen et al., 2004). As a result of being retrospective, our study has revealed no information about the incidence of malignancy in ovarian cyst patients with high CA 125 levels or whether or not they underwent operations. This marker does not increase in megaloblastic anemia (Symeonidis et al., 2004). Literature does not confirm whether CA 125 levels are elevated or not in patients with other types of anemia. It is known to be increased in heart failure and renal failure (Xiaofang et al., 2007; Topatan and Basaran, 2011). Our study show that is similar results of previously studies.

CA 15-3 is used frequently in follow-up treatment of breast cancer and in showing metastasis. In this study, it was ordered mostly in cases of ovarian cysts, anemia, and abdominal pain. It has been found to be high in benign conditions, especially in cases of anemia, pneumonia, and pleural effusions. CA 15-3 was found to be high in megaloblastic anemia (Triantafillidis et al., 2002; Symeonidis et al., 2004). This marker was found to be elevated in patients with beta thalassemia (Symeonidis et al., 2006). There was no information about the relation among this marker, iron deficiency, and chronic anemia. CA 15-3 indicated a false positive in 5% of pneumonia cases (Marechal et al., 1988). The level of CA 15-3 was high in malignant pleural effusions, but it was normal in benign pleural effusions (Topolcan et al., 2007; Wagner et al., 2007). In this study, the level of CA 15-3 was found to be higher than normal in 82 cases with benign pleural effusion. In 13 of these cases, it was more than three times higher, and in 17 of these cases was more than 50 U/ml higher. However, most of them were between normal range and 50 U/ml. Excessive increases may be reported in sporadic cases. On the other hand, the etiology of these was not researched in this study. High results may be found regarding the etiology.

AFP is a marker that increases in liver cancer and germ cell tumors. AFP was found to be high in benign liver diseases such as hepatitis and cirrhosis (Kobeisy et al., 2012). The levels between 15-100 ng/ml were found to be significant in acute hepatitis cases, levels >100 ng/ml were found in 4.9% of chronic liver disease (Forones et al., 1995). In another study, AFP levels were found to be high in patients with or without cirrhosis (Collazos et al., 1992). In this study, it was ordered mostly in cases of chronic hepatitis B, hepatitis C, and anemia. Among benign conditions it was found to be high mostly in hepatitis B, hepatitis C and cirrhosis. AFP is used frequently as a screening test for hepatocellular cancer, in cirrhosis, hepatitis B, and hepatitis C infections.

Current study has revealed that tumor markers were clearly ordered without indications. Recommendations include using CA 125 in discriminating between benign and malignant ovarian cysts, CA 15-3 in discriminating between benign and malignant pleural effusions, and AFP to screen hepatocellular cancer in chronic hepatitis B, hepatitis C, and cirrhosis. However, in our study, tumor markers were ordered in non-specific cases, mostly for anemia, dyspepsia, abdominal pain, ovarian cysts, chronic renal failure, and menstrual disorders. Tumor markers were ordered in cases with abdominal pain mostly without researching the etiology. Similarly they were ordered to patients with anemia without considering the etiologic factors. Particularly in the elderly population, the rate of ordering these markers was found to be high. It is thought that doctors are more likely to order these markers not to miss underlying cancer and to detect and treat it early.

The distribution of the types of clinics according to the ordering of tumor markers was found to be mostly obstetrics and gynecology, internal medicine, gastroenterology, and general surgery clinics. This may be due to these clinics frequently encountering cancer cases, such as breast cancer, ovarian cancer, and gastrointestinal system cancers. Unlike other markers, AFP was frequently ordered by infectious diseases clinics and often by urology clinics. It was observed that infectious diseases clinics ordered this marker for following up cases of chronic viral hepatitis, whereas urology clinics used this marker in cases of disease in the male urogenital system and in cases of infertility. All markers were ordered for 288 patients, while they were ordered separately in single, double or triple. It has been concluded that clinicians use these markers as screening tests without considering the diagnoses.

In conclusion, the results of the study have shown that tumor markers may often be high, even in benign cases. This is time-consuming for doctors and can cause severe trauma in patients who are misdiagnosed with or unnecessarily tested for cancer. Furthermore, the radiation that is given off during computerized tomography scans may lead to cancer in healthy subjects in the future. Even a single shot of radiation during computerized tomography may be enough to cause cancer. Strict malpractice laws, patients fear of cancer, and the establishment of healthcare organizations such as cancer screening centers may lead to the unnecessary ordering of tumor marker tests. Ordering tumor marker tests without a clear indication of need is not only high in cost, but it can also lead to anxiety for patients.

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References
