Omega-3 polyunsaturated fatty acids for the treatment and prevention of colorectal cancer
A J Cockbain, G J Toogood, M A Hull

ABSTRACT
Omega-3 polyunsaturated fatty acids (PUFAs) are naturally occurring substances that are well tolerated and have been used extensively for the prevention of cardiovascular disease. More recently, omega-3 PUFAs have been recognised to have anticancer activity. There is also evidence suggesting improved efficacy and/or tolerability of conventional cancer chemotherapy when administered with omega-3 PUFAs. The purpose of this review is to (i) describe the mechanisms by which omega-3 PUFAs are thought to have antineoplastic activity, (ii) review published preclinical and clinical studies that support anti-colorectal cancer activity and (iii) summarise current clinical trials investigating the potential therapeutic role(s) of omega-3 PUFAs at different stages of colorectal carcinogenesis, from adenoma (polyp) prevention to treatment of established malignant disease and prevention of cancer recurrence.

INTRODUCTION
There is growing epidemiological, experimental and clinical evidence that omega-3 polyunsaturated fatty acids (PUFAs) have anti-colorectal cancer (CRC) activity. Omega-3 PUFAs may possibly play a role in several stages of CRC management, from the primary CRC prevention, through to ‘tertiary’ prevention after treatment of CRC and advanced metastatic disease.

In this article, we summarise current knowledge of the mechanistic basis by which omega-3 PUFAs are thought to attenuate CRC, before reviewing the experimental data supporting omega-3 PUFA supplementation for prevention and treatment of CRC. Finally, we review recent clinical data, which now support anti-CRC activity in humans, and summarise current clinical trials of the potential therapeutic roles of omega-3 PUFAs at different stages of colorectal carcinogenesis.

POLYUNSATURATED FATTY ACIDS
Fatty acids are carbon chains with a methyl group at one end and a carboxyl group at the other. Saturated fatty acids contain only carbon—carbon single bonds, whereas unsaturated fatty acids contain one (monounsaturated) or more (polyunsaturated) carbon—carbon double bonds. Dietary PUFAs of interest are the omega-3 and omega-6 PUFAs, so named by the position of the first double bond at the third and sixth carbon from the methyl (omega) end respectively (figure 1).
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Figure 1 Structure and nomenclature of polyunsaturated fatty acids (PUFAs). Cx:y ω-z refers to the chemical structure where x is the number of carbon atoms, y is the number of carbon—carbon double bonds and z is the position of the first carbon—carbon double bond away from the methyl (ω) end of the hydrocarbon chain. Note that all double bonds are in the cis configuration. Small quantities of conjugated ω-3 PUFAs (which contain alternating single and double carbon—carbon bonds) also exist naturally.

are both found in vegetable oils. Humans can easily metabolise linoleic acid to form the ω-6 PUFA arachidonic acid (AA). However, endogenous production of the ω-3 PUFAs eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) from ω-6-linolenic acid by humans is so small as to be insignificant. Therefore, the main ω-3 PUFAs EPA and DHA are also considered ‘essential’ and are obtained predominantly from cold water, oily fish such as mackerel and salmon.

PUFAs are biologically important, with roles in phospholipid membrane structure and function, as well as cellular signalling and lipid metabolism. PUFAs can be liberated from phospholipid membranes by the phospholipase A2 family of enzymes and are metabolised by three main pathways: (i) the cyclo-oxygenase (COX) pathway, (ii) the lipoxygenase (LOX) pathway and (iii) the cytochrome P450 monooxygenase pathway. Metabolites derived from the ω-6 PUFA AA, such as prostaglandin (PG) E2, are typically proinflammatory and have been linked with initiation and progression of colorectal carcinogenesis, whereas those derived from ω-3 PUFAs (eg, PGE3) are less proinflammatory, and may even have anticancer properties. Excellent reviews are already available on the metabolism of ω-3 PUFAs, the implications of inhibition of AA metabolism on cell proliferation2 and the effects of ω-6 and ω-3 PUFA metabolites on colorectal carcinogenesis.4

In addition to their potential role in the treatment and prevention of CRC, ω-3 PUFAs are believed to have a number of other health benefits. ω-3 PUFAs (usually a mix of EPA and DHA as fish oil) are widely available in a ‘nutraceutical’ formulation. Evidence is strongest for cardiovascular benefits of the ω-3 PUFAs.5 6 There is some evidence of benefit in patients who have had a myocardial infarction5 6 but also uncertainty about whether ω-3 PUFAs have anti- or pro-arrhythmogenic properties.5 6 ω-3 PUFAs have also been variously implicated in treatment of inflammatory bowel disease, rheumatoid arthritis, age-related maculopathy and neurodegenerative diseases.7

ω-3 PUFAs
► are ‘essential’ nutrients
► are found in large quantities in oily fish
► are also widely available as ‘over-the-counter’ nutraceuticals
► have broad health benefits, including cardiovascular prophylaxis
► may have anticancer properties.

MECHANISMS OF THE ANTINEOPLASTIC ACTIVITY OF ω-3 PUFAS

Current knowledge of the antineoplastic activity of ω-3 PUFAs has been comprehensively reviewed elsewhere.5 4 8 A brief summary concentrating on more recent findings is provided here. The three main antineoplastic activities of ω-3 PUFAs that have been proposed are (i) modulation of COX activity; (ii) alteration of membrane dynamics and cell surface receptor function and (iii) increased cellular oxidative stress. Recently described novel anti-inflammatory lipid mediators derived from EPA and DHA, including resolvins, protectins and maresins, represent a fourth potential antineoplastic mechanism of action of ω-3 PUFAs.

Modulation of COX activity

COX-2-dependent synthesis of PGs in colorectal mucosa, in particular PGE2, is believed to play a critical role in the early stages of colorectal carcinogenesis.9 EPA can act as an alternative substrate for COX-2, instead of AA, leading to a reduction in formation of pro-tumorigenic ‘2-series’ PGs (eg, PGE2) in favour of ‘three-series’ PGs (eg, PGE3) in several cell types including CRC cells (figure 2).2 10 11 PGE3 has anti-tumorigenic activity against human lung cancer cells in vitro11 and inhibits pro-tumorigenic PGE2-EP4 receptor signalling in human CRC cells.10 Recently, a ‘PGE2 to PGE3 switch’ has been demonstrated in colorectal mucosa of rats treated with fish oil.12 However, reduction of PGE2 synthesis and/or generation of PGE3 following EPA treatment remains to be demonstrated in human CRC tissue. It is known that DHA also binds the substrate channel of COX-2 and inhibits COX-2 activity,13 although the biochemistry of DHA metabolism by the COX isoforms and the subsequent production of downstream lipid mediators is poorly understood compared with EPA.2

Alteration of membrane dynamics and cell surface receptor function

There is some evidence that the incorporation of ω-3 PUFAs into cell phospholipid membranes alters the fluidity, structure and/or function of lipid rafts or calveolae.14 These are sphingolipid- and cholesterol-rich microdomains that float freely in the cell membrane. The localisation of cell surface receptors, such as epidermal growth factor receptor...
Figure 2 The effect of eicosapentaenoic acid (EPA) without or with concurrent aspirin treatment on cyclo-oxygenase (COX) activity. (A) When arachidonic acid (AA), derived mainly from dietary Ω-6 polyunsaturated fatty acid (PUFA) linoleic acid in ‘westernised’ diets, is the main substrate for COX-1 and COX-2, the predominant prostaglandin (PG) species in colorectal tissue is PGE2. COX-2 is the predominant COX isoform in dysplastic and malignant colorectal tissue.28 (B) EPA can act as an alternative substrate for both COX enzymes. It effectively inhibits COX-1 activity but modulates the enzymatic activity of COX-2 so that PGH3 is the major product.2 PGH3 is then converted to other three-series PGs such as PGE3 by downstream PG synthases. Although the Km for EPA is similar to AA, the enzymatic turnover for EPA is approximately threefold less than that of AA so that the overall outcome is reduction in COX-2-dependent PGE2 synthesis and simultaneous appearance of smaller quantities of PGE3.2 (C) Aspirin irreversibly acetylates COX-1 and COX-2. This leads to effective inhibition of COX-1 activity. However, acetylated COX-2 can metabolise EPA producing 18R-hydroxyeicosapentaenoic acid (HEPE) and 18S-HEPE instead of PGH2. In turn, HEPEs can be metabolised by 5-lipoxygenase (5-LOX) generating E-series resolvins, in combination with a reduction in tissue PGE2 levels.23,24 D-series resolvins are generated via docosahexaenoic acid metabolism by lipoxigenase-dependent pathways.

The relative contributions of, and interactions between, these three activities to the anticancer properties of Ω-3 PUFAs are unclear. For example, Ω-3 PUFAs might alter EGFR function by changing receptor behaviour in lipid rafts but EPA might also decrease trans-activation of EGFR by reduction in PGE2 synthesis.25 Activation of peroxisome proliferator-activated receptors by Ω-3 PUFAs is also recognised but it is not known whether this occurs directly or via changes in COX metabolism, thereby altering levels of PGD2 or 15-deoxy PGJ2.26

Novel anti-inflammatory lipid mediators

In the presence of aspirin, which irreversibly acetylates the COX enzyme, EPA drives COX-2-dependent production of resolvin (Rv) E1 (5S,12R,18R-trihydroxyeicosapentaenoic acid) via metabolism of 18R-hydroxyeicosapentaenoic acid by 5-LOX (figure 2).27 18R-RvE1 has been detected in plasma of healthy volunteers in ng/ml quantities after aspirin and EPA ingestion.28 More recently, synthesis of the 18S enantiomer of RvE1 has been demonstrated after EPA and aspirin treatment in healthy volunteers.29 The precursors of E-series resolvins may also be produced independently of COX by direct cytochrome P450 metabolism of EPA.30 Metabolism of DHA can produce D-series resolvins via a LOX-dependent pathway to produce 17S-resolvins, or via acetylated-COX-2 leading to 17R-resolvin synthesis.31 DHA can also be metabolised by leucocyte-mediated pathways to produce 17S-docosatrienes termed protectins31 or by macrophage-mediated pathways to produce 14-LOX-derived products termed maresins.32 These newly described families of EPA- and DHA-derived lipid mediators all share anti-inflammatory and inflammation resolution activity in animal models of acute inflammation.33

Cell signalling via these novel lipid mediator families is best characterised for RvE1. Both 18R and 18S enantiomers of RvE1 are ligands for ChemR23 and BLT1 G protein-coupled receptors.29 RvE1 has been shown to induce expression of intestinal alkaline phosphatase in human CRC cells in a ChemR23-dependent manner and abrogate chemically induced colitis in mice.34 It is currently not known whether Ω-3 PUFA-derived resolvins exhibit antineoplastic activity. However, it is known that ChemR23-dependent RvE1 signalling inhibits nuclear factor κB activation, which is a critical regulator of early-stage colorectal carcinogenesis.35

Although Ω-3 PUFAs have recognised immunomodulatory activity, including alteration of T-cell activation and cytokine production,36 the contribution of any effect on host antitumour immune surveillance to the anticancer activity of Ω-3 PUFAs has received relatively little attention, to date. In vitro studies have suggested that both EPA and DHA may suppress angiogenesis.37 Whether negative regulation of stromal-epithelial cell signalling and/or the angiogenic response contributes to the antineoplastic activity of Ω-3 PUFAs in vivo requires further investigation.

(EGR),15 in lipid rafts is believed to be crucial for downstream receptor signalling, controlling proliferation and apoptosis.16,17

Increased oxidative stress

Ω-3 PUFAs may have an antineoplastic effect through alteration in the cellular redox state and increased oxidative stress. PUFAs are highly peroxidizable, which generates reactive oxygen species (ROS) such as the superoxide radical. Many tumour cells display altered cellular pathways for the handling of ROS, including depletion of the major intracellular antioxidant, glutathione. A subsequent elevation of intracellular ROS levels by Ω-3 PUFAs has been hypothesised to induce cancer cell apoptosis.18 A potential beneficial interaction between Ω-3 PUFAs and dietary fibre leading to induction of colonocyte apoptosis has been elegantly studied by Chapkin and colleagues.19–21 DHA has been shown to potentiate oxidative stress and colonocyte apoptosis induced by the fermentation product short-chain fatty acid butyrate via both intrinsic and extrinsic apoptosis pathways.22–24

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ω-3 PUFAS FOR THE PREVENTION OF CRC

Epidemiological observations

A link between dietary ω-3:ω-6 PUFA balance and CRC risk originated from epidemiological studies that observed reduced rates of CRC in Greenland and the Far East compared with Western populations.9 While the results of epidemiological studies have been variable, they have tended, in general, to report a small reduction in CRC risk with increasing dietary fish intake, a view supported by the second expert report into food, nutrition and the prevention of cancer by the World Cancer Research Fund and the American Institute for Cancer Research in 2007.40

Interpretation of epidemiological studies has been hampered by heterogeneity in study design. The use of food questionnaires to record dietary intake is subjective, and does not always discriminate between oily fish such as sardines (high in ω-3 PUFAs) and lean fish such as cod (lower ω-3 PUFA content). Moreover, studies do not always discriminate between processed (smoked or salted) and non-processed fish, which may confound observational data on CRC risk.40 A meta-analysis of 19 prospective cohort studies was limited by study heterogeneity and wide variability in both carcinogen and non-processed fish consumption between the study populations.

As mentioned above, the difference in fish consumption between the highest and lowest categories was at least seven portions of fish a month.

Since this meta-analysis, two large observational studies have demonstrated significant inverse relationships between ω-3 PUFA intake/levels and risk of colorectal neoplasia. The first, a case–control study of 1872 patients (929 cases of distal CRC and 943 controls), estimated ω-3 and ω-6 PUFA intake from dietary questionnaires.41 The study showed a significant dose-dependent reduction in CRC risk for total ω-3 PUFA intake (OR=0.61 for the highest vs lowest quartile), as well as for EPA and DHA intake individually. In the second study, serum PUFA levels were measured in 861 patients undergoing endoscopy.43 Three hundred and sixty-three patients were diagnosed with a colorectal adenoma(s) and 498 polyp-free patients served as controls. When comparing serum ω-3 PUFA levels (as a percentage of overall PUFA levels), there was a significant reduction in colorectal adenoma risk (OR=0.67) between the first tertile (<1.8% ω-3 PUFA) and the third tertile (>2.3% ω-3 PUFA). By contrast, there was a significant increase in colorectal adenoma risk (OR=1.68) between the first tertile (<58.9%) and third tertile (>62.8%) of serum ω-6 PUFA content.

Animal studies

The differential effect of ω-3 and ω-6 PUFAs has been demonstrated in a number of animal models of early-stage colorectal carcinogenesis. The studies are summarised in table 1. Injection of the carcinogens azoxymethane or 1,2-dimethylhydrazine drives development of colorectal aberrant crypt foci (ACF) after 6–8 weeks, before development of colorectal adenomas and adenocarcinomas from 8 months onwards. These lesions have all been widely used as end points for comparison of the effects of ω-3 and ω-6 PUFA supplementation on ‘sporadic’ colorectal carcinogenesis. Alternatively, the effects of ω-3 and ω-6 PUFAs on adenoma number in the ApcMin/+ mouse model of familial adenomatous polyposis (FAP) has been investigated.

Studies of rodents fed an ω-3 PUFA-supplemented diet versus an equivalent ω-6 PUFA-supplemented diet or low-fat control diet controls (table 1) have consistently reported a 20–50% reduction in chemically induced tumour incidence.19 45 47 48 50 52 53 55 56 61 64 together with a 30–70% reduction in tumour multiplicity, in both carcinogen and ApcMin/+ mouse studies.44 45 50 53 58 59 61 64 Studies using the number of ACFs as the primary end point (table 1) have reported an effect of similar magnitude with ω-3 PUFA supplementation.24–26 67 Reddy and Sugie demonstrated that ω-3 PUFA supplementation reduced chemically induced colon tumour incidence when given in either the pre- or post-initiation phase compared with ω-6 PUFA supplementation.46 When given in both phases, tumour incidence was further reduced to half that seen in low-fat control animals. Further studies have demonstrated that these effects are directly related to ω-3 PUFA supplementation rather than simply a reduction in ω-6 PUFA intake.53 65 66 While most in vivo studies have compared a mixture of EPA and DHA, attention is drawn to the few studies either directly comparing EPA and DHA,60 or using EPA45 61 64 or DHA59 51 58 as single agents. In general, similar results have been demonstrated with each of the two main ω-3 PUFAs. The effect of fish oil administration on azoxymethane-induced ACF multiplicity in rats has also been tested in combination with the fibre fermentation product butyrate. Crim and colleagues have demonstrated that butyrate decreases ACF number in rats administered fish oil, but not corn oil (rich in ω-6 PUFAs).20

One recent study demonstrated that dietary supplementation with a large amount (6%) of DHA exacerbated colonic inflammation and dysplasia in a mouse model of infection-induced colitis-associated cancer.57 The dose–response relationship between ω-3 PUFA intake and intestinal tumorigenesis in animal models of colitis-associated cancer requires further investigation.

Analysis of mucosal PUFA content has consistently demonstrated incorporation of ω-3 PUFA, at the expense of AA content, in rodents

Recent advances in basic science
Table 1  In vivo pre-clinical studies of ω-3 PUFA supplementation for the prevention of CRC

<table>
<thead>
<tr>
<th>Study</th>
<th>Model</th>
<th>N</th>
<th>Treatment groups</th>
<th>Timing/duration</th>
<th>Outcome measure(s)</th>
<th>Results (maximal changes ω-3 PUFA group vs Ctrl unless stated)</th>
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</thead>
<tbody>
<tr>
<td>Nelson et al&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Sprague-Dawley rat DMH</td>
<td>50</td>
<td>17% MO&lt;sub&gt;2&lt;/sub&gt; vs 17% CO vs Ctrl</td>
<td>7 wk pre- and 17 wk post-DMH</td>
<td>Tumour incidence and multiplicity</td>
<td>← Tumour incidence, 35% ↓ tumour multiplicity, ← incidence of metastases</td>
</tr>
<tr>
<td>Minoura et al&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Danyu rat AOM</td>
<td>100</td>
<td>4.7% EPA vs 5% LA</td>
<td>15 wk pre- and 20 wk post-AOM</td>
<td>Tumour incidence</td>
<td>50% ↑ Tumour incidence, 75% ↓ multiplicity, ↑ EPA &amp; ↓ AA in tumour and mucosa, 80% ↑ tumoral PGE₂</td>
</tr>
<tr>
<td>Reddy&lt;sup&gt;16&lt;/sup&gt;</td>
<td>F344 rat AOM</td>
<td>234</td>
<td>4%–12% MO&lt;sub&gt;2&lt;/sub&gt; vs 24% &amp; 5% CO</td>
<td>38 wk post-AOM</td>
<td>Tumour incidence and colonic mucosal PUFA + PGE₂ content</td>
<td>50% ↑ Tumour incidence + multiplicity in 24% CO vs all other grps, ↑ tumoral EPA + DHA with MO diets</td>
</tr>
<tr>
<td>Deschner et al&lt;sup&gt;17&lt;/sup&gt;</td>
<td>CF1 mouse AOM</td>
<td>300</td>
<td>4–16% Max EPA vs 4% and 20% CO</td>
<td>2 wks pre- &amp; 1–45 wk post-AOM</td>
<td>Colonic mucosa PI &amp; FAD 1 wk Tumour incidence 45 wk</td>
<td>Tumour incidence, 35% ↓ tumour multiplicity, 5% ↑ tumoral PGE₂ content</td>
</tr>
<tr>
<td>Reddy&lt;sup&gt;18&lt;/sup&gt;</td>
<td>F344 rat AOM</td>
<td>273</td>
<td>18% MO&lt;sub&gt;2&lt;/sub&gt; vs 23.5% and 5% CO</td>
<td>2 wk pre- &amp; 36 wk post-AOM</td>
<td>Tumour incidence</td>
<td>Tumour incidence and multiplicity when MO vs 23.5% CO given in either initiation or post-initiation phases</td>
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<tr>
<td>Nelson et al&lt;sup&gt;19&lt;/sup&gt;</td>
<td>Sprague-Dawley rat DMH</td>
<td>97</td>
<td>0.7 ml DHA vs 0.7 ml H₂O ig daily</td>
<td>1 day pre- and 4/8/12 wk post-DMH</td>
<td>No. of colonic ACFs Serum chol and PUFA content</td>
<td>60% ↓ ACFs (↓ ACFs seen when DHA given in either initiation or post-initiation phase), 50% ↑ AA, 50% ↑ DHA and EPA, 20% ↓ chol</td>
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<tr>
<td>Hendrickse&lt;sup&gt;20&lt;/sup&gt;</td>
<td>Wistar rat + colon anastomosis vs sham AOM</td>
<td>160</td>
<td>20% FO&lt;sub&gt;3&lt;/sub&gt; vs 20% CO</td>
<td>3 wk pre- and 15/23 wk post-AOM</td>
<td>Colonic mucosal PI Tumour incidence, size, no. Mucosal PUFA content</td>
<td>40% ↑ Tumour incidence, 50% ↓ multiplicity, 60% ↓ pre-anastomotic tumours. ↑ PI [TEPA/ DHA ≥ 90%] AA in tumour/mucosa</td>
</tr>
<tr>
<td>Chang&lt;sup&gt;21&lt;/sup&gt;</td>
<td>Sprague-Dawley rat AOM</td>
<td>260</td>
<td>11.5% FO&lt;sub&gt;3&lt;/sub&gt; vs 15% CO ± 6% cellulose vs 6% pectin</td>
<td>1 week pre- &amp; 16/32 wk post-AOM</td>
<td>Colonic tumour incidence</td>
<td>20% ↑ Tumour incidence, ↓ PI, 20% ↑A1L ↓ cell differentiation, ↑ A1L F0-pectin grp vs all other fat-fibre grps</td>
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<tr>
<td>Takahashi et al&lt;sup&gt;22&lt;/sup&gt;</td>
<td>F344 rat AOM</td>
<td>96</td>
<td>1 ml DHA vs 1 ml water ig daily</td>
<td>4/12/36 wk</td>
<td>No. of ACFs and tumours Plasma PUFAs and PGE₂</td>
<td>25% ↑ ACF (wk 4/12) &amp; 35% ↑ tumour multiplicity, 50% ↓ plasma PGE₂, 75% ↓ plasma AA, 30% ↓ EPA, 6×↑ DHA (wk 36)</td>
</tr>
<tr>
<td>Good et al&lt;sup&gt;23&lt;/sup&gt;</td>
<td>F344 rats AOM</td>
<td>161</td>
<td>18% MO&lt;sub&gt;2&lt;/sub&gt; vs 5% and 23% CO</td>
<td>5% CO 12 wk post-injection then 6–12 wk experimental diet</td>
<td>No. ACF</td>
<td>15–20% ↑ ACFs vs both CO grps, 25% ↓ tumour incidence but 50% ↓ tumour size MO vs CO grps (both NS)</td>
</tr>
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<td>Singh&lt;sup&gt;24&lt;/sup&gt;</td>
<td>F344 rat AOM</td>
<td>144</td>
<td>21% FO&lt;sub&gt;3&lt;/sub&gt; vs 24% CO vs Ctrl</td>
<td>1/12/36 wk post-AOM</td>
<td>No. + size colonic tumours</td>
<td>Tumour incidence and multiplicity F0 grp 30% ↓ tumour incidence and multiplicity, 23.5% CO grp 33% ↓ tumour incidence and 90% ↓ multiplicity</td>
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<tr>
<td>Latham&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Wistar rat DMH</td>
<td>68</td>
<td>8% FO&lt;sub&gt;3&lt;/sub&gt; vs 8% CO</td>
<td>FO vs CO 24/48hrs post-DMH then 18 wk CO</td>
<td>Tumour cell AI &amp; PI (24/48 h)</td>
<td>↑ AI and ↓ PI at 24/48 h, 50% ↓ ACF at 18 wk</td>
</tr>
<tr>
<td>Rao et al&lt;sup&gt;26&lt;/sup&gt;</td>
<td>F344 rat AOM</td>
<td>360</td>
<td>17% FO&lt;sub&gt;3&lt;/sub&gt; vs 5% CO vs 20% mixed lipids</td>
<td>CO 2 wk pre-AOM Experimental diets for 8–38 wk post-AOM</td>
<td>No. ACF, tumour incidence Colonic mucosa AI</td>
<td>44% ↓ ACFs, 30% ↓ tumour incidence, 60% ↓ tumour multiplicity 2× ↑ A1L vs 20% mixed lipid diet</td>
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<td>Crim et al&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Sprague-Dawley rat AOM</td>
<td>80</td>
<td>11.5% FO&lt;sub&gt;3&lt;/sub&gt; vs 15% CO ± 5% butyrate</td>
<td>3 wk pre- and 8 wk post-AOM</td>
<td>No. ACF, colonic mucosa AI &amp; →</td>
<td>↑ ACF + CO + butyrate vs all grps, ↓ large ACFs and ↓ A1L in FO + butyrate grp vs FO alone or control</td>
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<tr>
<td>Vanamala et al&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Sprague-Dawley rat AOM</td>
<td>20</td>
<td>15% FO&lt;sub&gt;3&lt;/sub&gt; + pectin vs 15% CO + cellulose</td>
<td>32 days pre- and 31 wk post-AOM</td>
<td>Colonic mucosa AI Colonic mucosa PGE₂/PGE₃ β-catenin and PPARδ expression</td>
<td>2×↑ A1L and 78% ↓ mucosal PGE₂, ↑ PGE₂ (PGE₂ not detected in CO group), ↓ β-catenin and PPARδ expression</td>
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<tr>
<td>Momina et al&lt;sup&gt;29&lt;/sup&gt;</td>
<td>Wistar rat DMH</td>
<td>20</td>
<td>18% FO&lt;sub&gt;3&lt;/sub&gt; vs 18% SOYO</td>
<td>2 wk pre- &amp; 36 wk post-DMH</td>
<td>No. ACFs, adenoma incidence Colonic/liver PUFA content</td>
<td>47% ↓ ACF, 80% ↓ adenoma incidence, 5 × ↑ ω-3 PUFA in colon + liver, 60–75% ↓ 6-PUFA in colon + liver</td>
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</table>
### Table 1 continued

<table>
<thead>
<tr>
<th>Study</th>
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<tr>
<td>Woodworth et al[^7]</td>
<td>SMAD3−/− mouse H. pylori induced gastritis</td>
<td>122</td>
<td>0.75%−6% DHA vs 8% SAFO vs 7% CO vs Ctrl</td>
<td>1. 9 wk pre-infection</td>
<td>Colonic inflammation/dysplasia, Hepatic PUFAs content, Body wt</td>
<td>1 Inflammation/dysplasia 2.25−6% DHA vs Ctrl. 5×1 hepatic PUFAs content, 85% less wt gain and 10−18%; 4 wk survival in 6% DHA grp vs CO/SAFO/Ctrl</td>
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<td>Oshima et al[^8]</td>
<td>ApC[0,16]</td>
<td>20</td>
<td>3% DHA vs Ctrl</td>
<td>7 wk</td>
<td>Colonic polyp no. and size</td>
<td>69%; Polyp no. in female mice only. [poly, size]</td>
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<td>Paulsen et al[^9]</td>
<td>ApC[^6]−/−</td>
<td>51</td>
<td>0.4−2.5% FO vs 12% CO</td>
<td>17 wk</td>
<td>No. ACFs and adenomas</td>
<td>48−56%; no. and 26−38%; size of tumours, ACFs in female mice on 2.5% diet only</td>
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<tr>
<td>Petrick et al[^10]</td>
<td>ApC[^10]−/−</td>
<td>77</td>
<td>3.1% EPA vs 3.1% DHA vs Ctrl</td>
<td>7 wk</td>
<td>Tumour size + no. Mucosal PUFA + PGE2</td>
<td>30%−50%; Tumour no. DHA/PFA vs Ctrl. 15%; tumour size EPA/DHA grp vs Ctrl. 50%; PGE2 in EPA/DHA grp vs Ctrl</td>
</tr>
<tr>
<td>Base et al[^12]</td>
<td>ApC[^12]−/−</td>
<td>95</td>
<td>12% MO4 vs 20% mixed lipid diet</td>
<td>9 wk</td>
<td>Tumour no. + size Mucosal PUFA + COX-2</td>
<td>[poly, size; 50% no. tumors &gt;2 cm. 3.7 ×3 AL, PGE2, β-catenin 72%−79%; Polyp size (2.5%/5% EPA grp) &amp; COX-2 and EPA 1 &amp; EPA in EPA grps. Weight Ctrl grp</td>
</tr>
<tr>
<td>Fini et al[^13]</td>
<td>ApC[^13]−/−</td>
<td>48</td>
<td>2.5% and 5% EPA vs Ctrl</td>
<td>12 wk</td>
<td>Mucosal PUFA + COX-2, Polyp no. + size, body weight</td>
<td>[poly, size; 50% no. tumors &gt;2 cm. 3.7 ×3 AL, PGE2, β-catenin 72%−79%; Polyp size (2.5%/5% EPA grp) &amp; COX-2 and EPA 1 &amp; EPA in EPA grps. Weight Ctrl grp</td>
</tr>
</tbody>
</table>

[^14]: no significant difference; ↓: decrease; ↑: increase.  
AA, arachidonic acid; AF, aberrant crypt foci; AI, apoptosis index; AOM, azoxymethane; chol, cholesterol; CO, corn oil; Ctrl, control; CRC, colorectal cancer; DHA, docosahexaenoic acid; DMN, 1,2-dimethylhydrazine; EPA, eicosapentaenoic acid; FAD, focal area of dysplasia; FO, fish oil (FO1 18% EPA/15% DHA; FO2 unspec. ω-3 PUFA content; FO3 18% EPA/16% DHA; FO4 13% EPA/12% DHA; FO5 unspecified ω-3 PUFA content; FO6 1% EPA/20% EPA; FO7 18% EPA/8% DHA; FO8 54% EPA/30% DHA); ig, intragastric; LA, linoleic acid; MaxEPA, 18% EPA + 12% DHA; MCO, menhaden oil (MO1 16% EPA + 11% DHA; MO2 2.4% EPA + 11% DHA; MO3 unspecified ω-3 PUFA content; MO4 13% EPA/12% DHA); PG, prostaglandin; PI, proliferation index; PPAR, peroxisome proliferator-activated receptor; PUFA, polyunsaturated fatty acid; SAFO, safflower oil; SOYO, soybean oil; wk, weeks; wt, weight.
Table 2. In vivo pre-clinical studies of ω-3 PUFA group vs control group unless stated

<table>
<thead>
<tr>
<th>Study</th>
<th>Model</th>
<th>N</th>
<th>Treatment groups</th>
<th>Timing/harvest</th>
<th>Outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannizzo et al</td>
<td>BALB/c mouse, C57BL6 CRC</td>
<td>300</td>
<td>5% and 25% MO vs 20% SAFO</td>
<td>30 days post-injection</td>
<td>Tumour size and % of mice with metastasis</td>
</tr>
<tr>
<td>Calder et al</td>
<td>HT-29 CRC cells subcut</td>
<td>102</td>
<td>10% EPA vs 20% SAFO</td>
<td>3 wk post-injection</td>
<td>Tumour size and COX-2 expression</td>
</tr>
<tr>
<td>Mund et al</td>
<td>Walker 256 tumour cells</td>
<td>50</td>
<td>50% EPA vs 100% SAFO</td>
<td>70 days post-injection</td>
<td>Tumour weight and COX-2 expression</td>
</tr>
</tbody>
</table>

PHARMACOLOGY, SAFETY AND TOLERABILITY OF ω-3 PUFA IN HUMANS

Bioavailability of ω-3 PUFA preparations

The bioavailability of ω-3 PUFA is highly variable and dependent on the form of the ω-3 PUFA, the mode of administration and the timing of administration—for example, with food. Dietary PUFA are absorbed primarily in the small intestine. ω-3 PUFA in the fishy fatty acid (FFA) form are absorbed more efficiently than those in the triglyceride or ethyl ester form. Lawson and Hughes demonstrated >95% absorption of an oral dose of EPA and DHA (as measured by plasma PUFA content) when given to healthy volunteers in the FFA form, whereas absorption in the triglyceride and ethyl ester forms was approximately 65%.
Table 3  Clinical studies of ω-3 PUFA treatment on colorectal mucosal biomarkers and polyp number

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Mucosal biomarker studies</th>
<th>Tissue PUFA content</th>
<th>Side effects</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
<td>Tissue ω-3 PUFA dose</td>
<td>Treatment duration</td>
<td>Primary outcome</td>
<td>Tissue ω-3 PUFA treatment on colorectal mucosa biomarkers and polyp number</td>
</tr>
<tr>
<td>1</td>
<td>40</td>
<td>7.7 g FO daily</td>
<td>24</td>
<td>AA</td>
<td>2/15 Dropout, 5/15 fish odour, 1/7 diarrhea</td>
</tr>
<tr>
<td>2</td>
<td>80</td>
<td>2.5–7 g FO daily</td>
<td>4 wk to 6 wk</td>
<td>PI</td>
<td>No effect on PI at surgery or 12 wk post-op</td>
</tr>
<tr>
<td>3</td>
<td>51</td>
<td>7.2 g FO daily</td>
<td>30 days</td>
<td>PI</td>
<td>No effects or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
<tr>
<td>4</td>
<td>41</td>
<td>2.4 g FO daily</td>
<td>7–21 days pre and 8–12 wk post surgery</td>
<td>PI</td>
<td>Dropout due to capsule intolerance</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
<td>Dietary advice and 500 mg FO daily</td>
<td>2 years</td>
<td>PVA</td>
<td>No effect or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
<tr>
<td>6</td>
<td>48</td>
<td>EPA/DHA as capsule</td>
<td>3 months</td>
<td>PVA</td>
<td>No effect or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
<tr>
<td>7</td>
<td>30</td>
<td>EPA 1.2 g daily as free fatty acid</td>
<td>3 months</td>
<td>PVA</td>
<td>No effect or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
<tr>
<td>8</td>
<td>152</td>
<td>EPA 1.2 g daily as free fatty acid</td>
<td>6 months</td>
<td>PVA</td>
<td>No effect or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
<tr>
<td>9</td>
<td>58</td>
<td>EPA 2 g as fatty acid</td>
<td>6 months</td>
<td>PVA</td>
<td>No effect or PI at highest dose of 12 wk in patients with high baseline PI</td>
</tr>
</tbody>
</table>

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Duration of ω-3 PUFA supplementation

There is considerable variation in the duration of ω-3 PUFA supplementation in clinical studies, ranging from 4 weeks to 6 months. These are summarised in Table 3. Studies have demonstrated that maximal incorporation of orally administered ω-3 PUFA into plasma and colorectal mucosa occurs within 5 weeks. Hillier et al. gave fish oil (5.2 g EPA+2.2 g DHA daily) to 11 patients with active inflammatory bowel disease and took colonic biopsy specimens at 3, 6 and 12 weeks. After 3 weeks, mucosal EPA content had increased sevenfold and DHA content had doubled. These levels were maintained but did not increase further throughout the 12 weeks’ study period. By contrast, AA content did not fall significantly until after 6 weeks of treatment. Colonic mucosal PGE2 content fell to 45% of baseline values after 3 weeks of fish oil supplementation, and fell only slightly further to 45% of the baseline value at 12 weeks. Similarly, in eight healthy volunteers taking 1.4–4.2 g daily EPA for 12 weeks, a significant, maximal increase in EPA content of plasma, platelets, neutrophils, monocytes and lymphocytes was observed at 2 weeks, whereas AA content fell significantly only by week 12.

These results support the hypothesis that the increased mucosal EPA and DHA content, rather than the reduction in ω-6 PUFA content, contributes to the reduction in PGE2 levels. Tissue ω-3 PUFA incorporation in humans plateaus after a few weeks. The optimal duration of ω-3 PUFA treatment required to produce maximal antineoplastic effects remains to be established.

Adverse effects

ω-3 PUFA formulations are generally very well tolerated. Table 3 summarises the adverse effects reported in human studies of the effect of ω-3 PUFA supplementation on colorectal mucosal parameters and colorectal polyps. Study withdrawal due to EPA intolerance in a recent phase III trial of EPA-FFA 2 g daily was only 3.4%. In a previous phase II trial with the same preparation,
the most common gastrointestinal adverse event, diarrhea, was associated with the EPA 2 g daily dose of EPA (14.0%), but not the 1 g dose (2%, cf. placebo 7.8%), suggesting dose de-escalation as a potential strategy for maintaining ω-3 PUFA treatment if diarrhea occurs.64

The excellent safety and tolerability profile of ω-3 PUFA supplementation is supported in large studies of the effects of ω-3 PUFA in cardiovascular disease. In the GISSI prevention study, 2856 patients were given 0.85 g ω-3 PUFA for 3.5 years.105 The commonest side effects were gastrointestinal disturbance (4.9%) and nausea (1.4%). Only 3.8% of patients discontinued the drug. Gastrointestinal symptoms are typically mild diarrhea, indigestion, belching or a ‘fishy’ taste.106 107 In a study using a higher dose of 6.9 g EPA+DHA daily for 6 months, gastrointestinal disturbance was reported by 7% of 275 patients, but also by 8% of patients taking placebo (corn-oil) capsules.108

For more detail, the reader is recommended to review concise overviews of the safety and toxicology of EPA and DHA by Kim et al92 and Lien.109

Risk of bleeding

ω-3 PUFAs have antiplatelet activity, thought to be due to a reduction in COX-1-dependent production of thromboxane A2 from AA in platelets, leading to reduced platelet activation and aggregation.110 However, the concern that ω-3 PUFA may increase bleeding has not been realised clinically, even when co-administered with aspirin. A recent review highlighted that in over 4000 patients taking ω-3 PUFAs undergoing carotid endarterectomy, percutaneous transluminal coronary angioplasty or coronary artery bypass grafting, excess bleeding was virtually non-existent.106 111

Environmental contaminants

While it has been suggested that fish oils may contain potentially toxic levels of heavy metals (eg, mercury), environmental toxins and fat-soluble vitamins, all of which can accumulate in fish, there is no evidence to support this in practice.106 111 The extraction and purification methods used in the production of fish oil supplements result in negligible or undetectable levels of such toxins,106 112 and so fish oil preparations given in daily doses up to 2 g/day are classified by the US Food and Drug Administration (FDA) as ‘generally regarded as safe.’

TRANSLATIONAL STUDIES OF HUMAN COLORECTAL BIOMARKERS AND ω-3 PUFA CONTENT

Mucosal biomarker studies

The long natural history of colorectal carcinogenesis in humans precludes the use of CRC incidence as a primary end point in clinical intervention studies and a 3–5 year intervention period is generally required for adenoma (polyph) prevention trials. Therefore many investigators have measured the effect of ω-3 PUFA administration on putative mucosal biomarkers of future CRC risk, such as epithelial cell mitosis frequency in microdissected whole crypts or immunohistochemistry for the Ki-67 ‘proliferation’ antigen. The design of such studies and their main findings are summarised in table 3.

We identified eight studies of oral ω-3 PUFA supplementation in patients with previous ‘sporadic’ colorectal adenomas (table 3), in which colorectal mucosal biopsy specimens were obtained at endoscopy before and after ω-3 PUFA supplementation. Two studies used EPA-FFA, whereas the others used a fish oil mixture containing EPA and DHA in varying proportions in either the ethyl ester or triglyceride form. In six of eight studies a 13–70% reduction in mucosal epithelial cell proliferation index was observed compared with the respective placebo group.34 93 94 96 97 100 In those studies comparing different doses of ω-3 PUFA, a dose-dependent reduction in the PI was observed.44 96

By contrast, two studies demonstrated no change in PI following administration of 2.4 g ω-3 PUFA daily for 12 weeks90 or low-dose ω-3 PUFA (400 mg DHA+100 mg EPA/day) for 1–2 years.99 The latter study did demonstrate a 50% increase in AI and increased expression of the pro-apoptotic protein BAX. Although in vivo preclinical work suggests that ω-3 PUFAs may have anti-CRC activity via an increase in apoptosis, AI has been measured in only two other studies, which demonstrated a significant increase in AI after 3–6 months’ treatment with EPA 2 g daily.64 100 One further study noted a more modest 16% reduction in PI after 28 days supplementation in healthy volunteers.95 In those studies measuring mucosal PUFA content, significant increases in mucosal DHA and EPA, together with a reduction in mucosal AA, were observed in all but one study (table 3).

Polyp prevention studies

Patients with FAP have a heterozygous germline mutation in the Adenomatous Polyposis Coli (APC) gene. Following somatic loss of the second APC allele, multiple colorectal adenomas develop, and prophylactic colectomy is advised in order to prevent CRC. Patients who undergo total colectomy and ileorectal anastomosis are at risk of further polyposis. Studies of potential chemopreventative agents in these patients allow polyph size and number to be used as end points over a relatively short (6–12 months) period of time.

A recent phase III randomised, double-blind, placebo-controlled trial investigated treatment with EPA-FFA 2 g daily for 6 months in patients with FAP who had previously undergone colectomy and ileorectal anastomosis.102 Rectal polyp multiplicity and size were measured by blinded video-endoscopic assessment of a tattooed area at baseline and at 6 months. There was a 22.4% reduction in polyph number in the EPA
group compared with placebo (p=0.01), a similar magnitude of reduction to that seen with the selective COX-2 inhibitor celecoxib. In keeping with previous studies, a significant increase in mucosal EPA levels was seen. The demonstration of chemopreventative efficacy of EPA-FFA in patients with FAP has led to funding of a randomised, placebo-controlled trial of EPA-FFA in patients who have had ‘sporadic’ colorectal adenomas removed and who require further colonoscopic surveillance (http://www.eme.ac.uk/funded_projects/).

Only one further polyplyp prevention study was identified. In this small study, five patients who had previously undergone colectomy for FAP or had >30 colorectal polyps removed endoscopically were given 2.2 g DHA+0.6 g EPA daily for 1–2 years. No significant change in polyp number was seen.

One patient developed proximal CRC, a second patient developed lung cancer and a third patient developed endometrial cancer before termination of the study. The published report does not make it clear whether this study was stopped prematurely and gives no indication of the planned sample size for the trial.

CLINICAL TRIALS OF ω-3 PUFAS IN PATIENTS WITH CRC

Single agent treatment

Despite strong in vitro and animal model evidence for direct anti-CRC activity of ω-3 PUFAs, no published studies have yet investigated the anti-neoplastic effect of ω-3 PUFAs in patients with primary or metastatic CRC. The authors are currently recruiting patients into a phase II trial of the safety and efficacy of oral EPA-FFA 2 g daily in patients awaiting surgery for colorectal liver metastases (CRCLM) (NCT01070555). Primary tissue biomarker end points (tumour cell proliferation, apoptosis and angiogenesis) are supported by mechanistic analyses investigating whether a PGE2→PGE3 switch occurs in CRC tissue. The authors are aware of only one further trial, registered on http://clinicaltrials.org/ (NCT00942292), investigating the effects of a parenteral fish oil preparation on tumour angiogenesis in CRCLM. ω-3 fish oils are also being investigated for the treatment of advanced prostatic cancer (NCT00996749), and in the prevention and treatment of breast cancer (NCT01282580, NCT00627276).

Adjuvant therapy with traditional chemoradiotherapy

DHA has been shown to potentiate the pro-apoptotic properties of 5-fluorouracil against several CRC cell lines, with a reduction in the expression of the antiapoptotic proteins BCL-2 and BCL-X1. Moreover, the addition of a fish oil mixture (55% EPA, 45% DHA) to 5-fluorouracil synergistically reduces CRC cell proliferation. Similar results have been demonstrated in rodent CRC models. These findings complement those of combination fish oil treatment with other chemotherapeutic drugs in vitro and in vivo for other solid tumour and haematological malignancies.

We identified only one published human study of the anticancer effects of combining ω-3 PUFAs with chemotherapy. A phase II study evaluated addition of 1.8 g DHA daily to an anthracycline-based chemotherapy regimen for metastatic breast cancer. Patients were dichotomised into two groups based on high or low DHA incorporation into plasma phospholipids. The high DHA-incorporation group had a significantly longer time to disease progression (median 8.7 months vs 3.5 months) and overall survival (median 34 months vs 18 months).

There are a small number of in vitro studies demonstrating that both EPA and DHA potentiate the cytotoxicity of ionising radiation in various cell lines, including CRC cells. A retrospective review of 143 patients, who had been prescribed ω-3 fish oil (0.9 g EPA, 1.5 g DHA daily) for 18 weeks following radiotherapy for brain metastases, found reduced radionecrosis (3.5% vs 14.1%) and improved overall survival (median survival 93.8 weeks vs 54.1 weeks) compared with the 262 patients who had not been prescribed fish oil. While un-blinded and non-randomised, this study nevertheless demonstrated a clear survival advantage linked to ω-3 PUFAs supplementation.

One further study demonstrated improved tolerability of chemoradiation for oesophageal cancer in patients taking ω-3 PUFAs supplements, with a reduction in the incidence of grade 2–4 neutropenia, diarrhoea and pharyngitis compared with those not taking supplements. There is a clear need for further human studies to evaluate the role of ω-3 PUFAs in improving the efficacy and/or tolerability of chemoradiotherapy and radiotherapy. Two ongoing studies are investigating the combination of fish oil (either enteral or parenteral) and gemcitabine in patients with advanced pancreatic cancer (study identifiers NCT01019382 and JPRN-UMIN000003658). A DHA-paclitaxel compound is also being investigated for the treatment of metastatic prostate (NCT00024414), pancreatic (NCT00024375) and CRC (NCT00024401).

ω-3 PUFAs as nutritional treatment

While the potential anti-CRC benefits of ω-3 PUFAs as either single agent or combination treatment are yet to be established in human studies, the role of ω-3 PUFAs for preventing cancer-related cachexia has been more widely investigated.

There have been two systematic reviews of the effects of ω-3 PUFAs on cancer cachexia and outcome. A Cochrane review of the benefit of EPA for treating cancer cachexia identified 59 potential trials, of which only five were randomised controlled trials (RCTs). Patients in these studies generally had pancreatic, gastrointestinal or lung cancers. No trial has studied CRC patients exclusively. The Cochrane review concluded that there were insufficient data to determine whether EPA supplementation was beneficial in the treatment of cancer cachexia, and identified a clear need for
a large well conducted RCT. Four of the five trials demonstrated either stabilisation of weight loss, or weight gain, following EPA supplementation, but this was no greater than the weight changes associated with the isocaloric control diet. However, one study did demonstrate a significant dose-dependent association between EPA supplementation and weight gain when taking into consideration the poor tolerance of up to 18 capsules/day by some patients.123 Of the studies reporting survival data, one demonstrated improved survival in the EPA-supplemented group versus placebo (median 590 days vs 165 days),124 but neither of the two studies comparing EPA supplementation with an isocaloric control intervention demonstrated a survival benefit of EPA.125

Colomer et al published a systematic review including the above RCTs and an additional 12 prospective observational studies.126 Many of these studies were in patients with advanced pancreatic cancer. They concluded that there was fair evidence (grade B) to recommend ω-3 PUFA supplementation in patients with solid upper gastrointestinal and pancreatic tumours, with the benefits of increased weight, appetite and quality of life, as well as lower postoperative morbidity.

We have identified only one published (uncontrolled) study in patients with CRC. Treatment of 23 patients with advanced CRC awaiting chemotherapy was started with oral supplement drinks containing a total of 2.18 g EPA+0.92 g DHA per day for 4 weeks before and 5 weeks after irinotecan-based chemotherapy (FOLFIRI). There was a significant improvement in weight (mean increase 2.5 kg) during the period of ω-3 PUFA supplementation before chemotherapy, despite a fall in total protein and energy intake in this time, with weight gain persisting after the start of chemotherapy.127

More recently, a RCT demonstrated that patients undergoing oesophagectomy for cancer who received EPA-enriched enteral nutrition for 5 days pre- and 21 days postoperatively conserved fat-free mass compared with patients receiving standard enteral nutrition. Total weight loss was 1.2 kg in the EPA group versus 1.9 kg in the control group (p=0.05). The EPA group also demonstrated an attenuated stress response (measured by serum tumour necrosis factor α, interleukin 8 (interleukin 10 levels) compared with controls, although there was no difference in postoperative complications.128

Animal studies have shown that ω-3 PUFA supplementation impairs the host response to mycobacterial infection.129 130 This raises the question whether the anti-inflammatory and immunoregulatory effects of ω-3 PUFA supplementation might increase susceptibility to infection in immunocompromised patients. This complex topic was comprehensively examined in a review in 2002.131 Subsequent preclinical data have been conflicting.129 130 132–155 Moreover, results from limited human observational studies investigating fatty acid intake and risk of community-acquired pneumonia are inconclusive.156 157

Long-term observational studies of ω-3 PUFA intake have not revealed an increase in infectious adverse events.156 157 Further trials of ω-3 PUFAs for CRC treatment and/or prevention should examine whether ω-3 PUFAs alter host susceptibility to infection, particularly in immunocompromised patients with cancer who may require surgery.

IS THERE A DIFFERENCE IN ANTI-CRC EFFICACY BETWEEN EPA AND DHA?

It is clear from the preclinical ‘prevention’ studies that combination EPA and DHA treatment has anti-CRC activity. There is only one ‘head-to-head’ comparison, which demonstrated that EPA had greater efficacy than DHA.60 However, the two preclinical ‘treatment’ studies that have been published did not show any difference between EPA and DHA.71 79 As far as we are aware, there is no published report comparing EPA and DHA in patients with, or at-risk for, CRC. It is also unclear whether an EPA/DHA mixture would give additional benefits over and above equivalent doses of either ω-3 PUFA alone.

In addition, a note of caution should be made of the two studies that demonstrated negative effects of high-dose fish oil in a model of CRC.132 133 A recent study has compared the effects of high-dose ω-3 PUFA alone is not clear and warrants further investigation with particular emphasis on the safe maximal dose of either EPA or DHA as single agents, or in combination with other chemotherapeutic agents.

Any comparison between the efficacy of EPA and DHA may also be confounded by interconversion between these two ω-3 PUFAs in vivo. EPA to DHA conversion can occur, via docosapentaenoic acid, in a two-stage process involving elongase and desaturase activity (with docosapentaenoic acid—EPA conversion being the limiting step). However, limited evidence from clinical trials suggests that there is no significant EPA—DHA conversion in human colorectal mucosa.100 102 By contrast, administration of DHA in humans has been shown to result in an increase in EPA content in plasma phospholipids.136 This may be as high as 12% during chronic dosing with DHA and is thought to occur via β-oxidation of the fatty acid.138 The possibility that DHA treatment could result in an eventual increase in EPA content of normal and/or neoplastic colorectal mucosa requires investigation.

CONCLUSION

ω-3 PUFAs are likely to have multifaceted roles in both prevention and treatment of CRC. The excellent tolerability and safety profile of ω-3 PUFAs combined with other health benefits, particularly cardiovascular, make ω-3 PUFAs an attractive candidate for prevention and treatment of CRC (and other cancers).
There is a wealth of evidence to support the antineoplastic effects of ω-3 PUFAs, with both in vivo models and human biomarker studies demonstrating a clear reduction in mucosal proliferation and an increase in mucosal apoptosis, as well as mucosal ω-3 PUFA incorporation at the expense of ω-6 PUFA. The role of ω-3 PUFAs in prevention of CRC is further supported by the recent demonstration of chemopreventative efficacy of EPA-FFA in patients with FAP.102

Strong in vivo evidence also supports a role for ω-3 PUFAs in the treatment of CRC, with studies consistently demonstrating tumour ω-3 PUFA incorporation and a reduction in tumour size. Phase II and phase III evaluations of ω-3 PUFAs are justified to establish their safety, tolerability and antineoplastic activity in patients with established CRC. Ongoing studies are investigating the effect of ω-3 PUFAs on tumour growth and vascularity in CRC/CLM. These studies should eventually inform the design of large, multicentre phase III evaluation of ω-3 PUFAs in patients with CRC, both as neoadjuvant/adjuvant treatment in patients undergoing surgery with curative intent and in the management of incurable disease. ω-3 PUFA treatment should be investigated, as a single agent and in combination with other chemotherapeutic agents, for treatment of CRC. Evaluation of combination therapy with ω-3 PUFAs is already underway in other cancers, including breast and pancreatic cancer.

A third potential role of ω-3 PUFAs as nutritional treatment in patients with CRC has also been identified, with reported improvements in cancer-related cachexia and perioperative outcomes in other cancers. Improved understanding of the mechanisms of anti-CRC activity of EPA and DHA will lead to identification and validation of predictive therapeutic response biomarkers for use in future clinical trials and help to determine the best anticancer agents to use in combination with ω-3 PUFAs for prevention and/or treatment of CRC.

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Provenance and peer review Commissioned; externally peer reviewed.

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