Thyroid hormones (THs) may play a role in diseases other than hyper- and hypothyroidism. Several lines of evidence suggest tumor-promoting effects of TH and TH receptors. They are possibly mediated by phosphatidylinositol-3-kinase and MAPK and involve among others stimulation of angiogenesis via $\alpha v \beta 3$. Thus, an increased risk for colon, lung, prostate, and breast cancer with lower TSH has been demonstrated in epidemiological studies, even suggesting a TH dose effect on cancer occurrence. Furthermore, higher TH levels were associated with an advanced clinical stage of breast and prostate cancer. In rodent models, TH stimulated growth and metastasis of tumor transplants, whereas hypothyroidism had opposite effects. In clinical studies of glioblastoma and head and neck cancer, hypothyroid patients showed longer survival than euthyroid patients. Also, patients with renal cell cancer that were treated with the tyrosine kinase inhibitor sunitinib and developed hypothyroidism in due course showed significantly longer survival than patients that remained euthyroid. Development of hypothyroidism was an independent predictor for survival in two studies. Yet, it is still possible that hypothyroidism is only a surrogate marker for treatment efficacy and does not positively influence treatment outcome by itself. Future cancer treatment studies, especially with substances that can induce hypothyroidism, should therefore be designed in a way that allows for an analysis of thyroid function status and its contribution on treatment outcome.

Key Words
- thyroxine
- PI3K
- $\alpha v \beta 3$
- tyrosine kinase inhibitor

Introduction

The thyroid hormones (THs) thyroxine ($T_4$) and triiodothyronine ($T_3$) are mostly recognized for their roles in normal growth, development, and metabolism, especially during fetal development and early childhood. In adults, the diseases usually associated with TH are excess and lack of TH and hyper- and hypothyroidism, with their distinct clinical symptoms. But TH may play a greater role in the development and course of diseases. This perspective focuses on evidence for tumor-promoting or suppressing effects of TH and their receptors and potential clinical consequences.

TH receptors and actions

TH action is mainly understood as modification of gene expression, mediated by the nuclear TH receptors (TRs). Two different genes, THRA on chromosome 17 and THRB on chromosome 3, encode TR$\alpha$ and TR$\beta$ respectively (Yen 2001). They share a highly homologous protein structure including a central DNA binding domain (DBD) and a C-terminal ligand binding domain (LBD). A short amino acid sequence within the DBD mediates TR binding to...
DNA and dictates sequence specificity. With the DBD, the TRs recognize TH response elements (TREs) in the promoter of their target genes that act as enhancers for genes positively regulated by TH. The LBD binds TH, T₃ with 10- to 15-fold higher affinity than T₄. Due to alternative splicing and promoter usage, various TR isoforms exist. The most studied isoforms are TRβ1 and TRβ2, which differ in the amino terminal domain, and TRα1 and TRα2, which differ in the C-terminal region in length and amino sequence. As a consequence, TRα2 lacks T₃ binding activity and acts as a weak antagonist in vitro. The TRα1, -β1, and -β2 isoforms bind DNA and T₃ and act as functional apo- and liganded TRs. In addition, truncated TR isoforms exist that lack amino terminal domains and DNA binding (Cheng et al. 2010).

Classical TH and TR action

In the classical model of gene induction by TH, the TRs bind to TREs in the promoter of their target genes. Without T₃, co-repressors with histone deacetylase activity are bound to the TR complex, preventing transcription. Upon T₃ binding, co-repressors are released and replaced by co-activators, which ultimately engages the RNA polymerase II in transcription of the target gene. The TRs are therefore seen as ligand-dependent transcription factors. Studies from TR knockout mice and stably transformed HepG2 cells showed largely overlapping gene expression patterns of positively regulated genes for TRα and TRβ, suggesting that TR amount, rather than isoform type, is important (Yen et al. 2003). Yet, the TR isoforms show differential DNA binding affinity to promoters and the transcriptional response of a gene on a given tissue may depend on the predominant TR isoform (Chan & Privalsky 2009, Chiamolera et al. 2012). The clinical differences between patients with resistance to TH (RTH) due to TRβ and TRα mutations further demonstrate that distinct physiological roles for the TR isoforms exist (Refetoff & Dumitrescu 2007, Bochukova et al. 2012, Ferrara et al. 2012, van Mullem et al. 2012).

Nonclassical TH and TR action

A few years ago, it became evident that TH and TRβ could also act through a different mechanism: the ligand-bound TRβ could activate the phosphatidylinositol-3-kinase (PI3K) pathway via phosphorylation of Akt/PKB within minutes, which subsequently affected gene expression (Simoncini et al. 2000, Lei et al. 2004, Cao et al. 2005). This mechanism is independent of TRβ binding to DNA and TREs. Ultimately, this nonclassical action of TH results in induction of gene expression. For example, ZAKI-4z had previously been described as a TH-responsive gene. ZAKI-4z induction by T₃ is dependent on TRβ and could be blocked by PI3K inhibitors, such as LY294002 (Cao et al. 2005, Moeller et al. 2005b). Similar results as for TRβ were obtained for TRα. Cao et al. (2009) could demonstrate PI3K activation in TRα overexpressing neuronal cells and Hiroi et al. (2006) found TRα association with p85α followed by phosphorylation of Akt/PKB, a downstream target of PI3K, and activation of endothelial nitric oxide synthase.

αvβ3 as TR

Bergh et al. (2005) demonstrated that T₄ and T₃ could bind to a purified plasma membrane protein, the integrin αvβ3. αvβ3 contains two TH binding sites, denoted as S1 and S2, which translate the TH signal differently (Davis et al. 2011, Freindorf et al. 2012). S1 exclusively binds T₃ at physiological concentrations and leads to PI3K activation. S2 binds T₄, and to a lesser extent T₃, and ultimately activates the ERK1/2 pathway (Lin et al. 2009). As the integrin αvβ3 binds TH and transmits TH the signal into the cell, it clearly qualifies as a cell surface TR.

These various ways of action of TH and their receptors harbor potential to promote tumor growth. For example, the most highly induced genes in a microarray study of T₃-induced gene expression in human skin fibroblasts were the aldo-keto reductases 1–3 (AKR1C1–3; Moeller et al. 2005b), which are associated with aggressiveness of prostate cancer due to increased conversion of adrenal androgens to testosterone (Fung 2006, Penning & Byrns 2009). And the oncogenic PI3K pathway, activated by TH via TRα/β and the S1 site of αvβ3, facilitates cell growth and survival and inhibits apoptosis (Chalhoub & Baker 2009). Via PI3K, T₃ induces expression of the α subunit of the transcription factor hypoxia-inducible factor 1 (HIF1; Moeller et al. 2005a). HIF1 target genes play key roles in cancer biology, from angiogenesis to adaptation to hypoxia, prevalent in rapidly growing tumors, and invasion and metastasis (Semenza 2009). HIF1α expression is a prognostic marker in renal cell carcinoma (RCC) and breast and prostate cancer, among others (Kimbro & Simons 2006). TH can, via αvβ3/S2, activate ERK1/2 and induce fibroblast growth factor 2 and promote angiogenesis, as crucial for rapid tumor growth (Davis 2004).

From a clinical perspective, the following important questions regarding TH and cancer arise: can TH influence tumor incidence, tumor progress and metastasis, and, ultimately, success of tumor treatment?
Epidemiology suggests tumor-promoting effects of TH

A population-based case–control study of risk factors for ovarian cancer with 767 cancer patients and 1367 controls found a higher rate of patients with a history of hyperthyroidism in the cancer patients than in the controls. The odds ratio (OR) for ovarian cancer was almost doubled in participants with a history of hyperthyroidism (OR 1.8, adjusted for age, pregnancies, race, oral contraceptive use, hysterectomy, and familial history of ovarian cancer) (Ness et al. 2000). In a similar study on risks for pancreatic cancer, a history of hyperthyroidism was associated with a twofold increased risk (OR 2.1, adjusted for race, education, BMI, smoking, and history of diabetes) (Ko et al. 2007). While these retrospective studies indicated an increased cancer risk with higher TH levels, their results depended on self-reported thyroid disorders and thyroid function tests were not analyzed.

A relationship also appears to exist between TH and prostate cancer: T3 levels were measured and compared in 161 men with localized prostate cancer, 20 men with benign prostate hyperplasia (BPH), and 27 age-matched controls with no history of cancer, BPH, or thyroid disease (Lehrer et al. 2002). Patients with prostate cancer and BPH had significantly higher T3 levels than controls. Furthermore, T3 levels were associated with higher clinical stage and risk of recurrence of prostate cancer (Lehrer et al. 2001). At diagnosis, 68 prostate cancer patients were divided into three risk groups for recurrence, low risk (serum PSA <10, stage ≤T2a, or Gleason grade ≤6), moderate risk (serum PSA 10–15, stage ≤T2b, or Gleason grade 7), and high risk (serum PSA >15, stage T2c or T3, or Gleason grade >7). While all patients had T3 levels within the reference range, T3 levels were highest in the high-risk group and significantly different from the low- and moderate-risk groups. More recently, a prospective, randomized, and control-matched study on THs and prostate cancer risk in smokers showed that hypothyroid men had a lower risk of prostate cancer than euthyroid men (OR=0.48, P=0.006) (Mondul et al. 2012).

Cristofanilli et al. (2005) retrospectively studied the prevalence of hypothyroidism in patients with breast cancer. They identified 74 hypothyroid women in 884 breast cancer patients. Compared with euthyroid patients, the hypothyroid patients were older at diagnosis (58.8 vs 51.1 years, P<0.001) and were more likely to be diagnosed at an earlier stage of breast cancer (pathologic stage I/II: 95 vs 85.9%, P=0.025), with a smaller tumor (T1 (≤2 cm): 72.5 vs 55%, P=0.002) and without pathologic lymph node involvement (63.9 vs 55.9%, not significant). These results seem to indicate that invasive breast cancer progression may be slower in hypothyroidism. In interpreting these results, it must be considered that hypothyroidism was determined by the use of thyroid supplements as TSH and free T4 levels were not available. TH levels have probably been normal since start of T4. Hypothyroidism in this study therefore refers to a period of assumedly low TH levels of unknown duration in the patients’ past.

Also for breast cancer, a prospective study of 2696 women showed an association between T3 levels at baseline and cancer risk during a mean follow-up of 19.3 years (Tosovic et al. 2010). The overall risk of breast cancer was statistically significantly higher for women with T3 in the highest vs lowest quartile. This association was due to findings in the 1322 peri-/postmenopausal women because the association was even stronger in these participants, but absent in pre-menopausal women. There were three cases of breast cancer in the 196 women with a T3 in the lowest quartile and 38 cases in the 408 women with a T3 in the highest quartile. From lowest to highest T3 quartile, the adjusted relative risk continuously increased from 1.00 to 3.26, 5.53, and 6.87 respectively. This increase was preserved when taking into account only tumors diagnosed 3 years after baseline. These results indicate a positive correlation and a dose response for T3 and risk of breast cancer development in peri-/postmenopausal women.

Another prospective study assessed a connection of thyroid function with cancer risk: participants of the Nord-Trøndelag Health Study were studied for TH and TSH levels and cancer incidence (Hellevik et al. 2009). After exclusion of participants with a history of thyroid disease, a history of cancer or missing information, almost 30,000 participants, could be analyzed for cancer risk (29,691 people, 19,710 women, and 9,981 men) in a median follow-up of 9 years using the Cancer Registry of Norway. According to their TSH, the participants were placed in five categories: each one below and above the TSH reference ranges, indicating hyper- and hypothyroidism respectively and three groups within the TSH reference range. Participants with a TSH in the lower normal third probably been normal since start of T4. Hypothyroidism in this study therefore refers to a period of assumedly low TH levels of unknown duration in the patients’ past.

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cancer (HR 1.38), prostate cancer (HR 1.97), lung cancer (HR 2.34), and breast cancer (HR 1.20). When HRs were calculated only for cancers diagnosed 2 years and later after baseline, to exclude effects of yet undiscovered cancer on TH and TSH levels, these results were only strengthened. Interestingly, a subanalysis of the participants with a TSH below the reference range revealed that during follow-up starting 2 years after baseline, the HR for total cancer for participants with suppressed TSH and elevated free T4 or total T3 was higher (HR 2.35) than for those with either suppressed TSH and normal free T4 and total T3 levels or TSH between 0.2 and 0.49 mU/l (HR 1.42), again suggesting a dose effect for TH on cancer occurrence.

Different results were obtained in a case–control study for hepatocellular carcinoma (HCC). Women, but not men, with a history of hypothyroidism had a 2.8-fold higher risk of HCC than participants without a history of hypothyroidism (after adjustment for age, race, diabetes, smoking, alcohol consumption, family history of cancer, and HBV/HCV status) (Hassan et al. 2009). This calculation was based on self-reported absence or presence of hypothyroidism because TH levels and data regarding substitution were not available. In this context, it is interesting that hypothyroidism was significantly more prevalent in patients with HCC of unknown etiology than in HCC patients with alcoholic liver disease or HCV in another case–control study (Reddy et al. 2007), suggesting that hypothyroidism may be a permissive factor in the development of HCC.

**TH, TRs, and tumor progress in animal models**

An experimental method for demonstrating that TH are involved in tumor growth has been the xenograft assay, which involves s.c. implantation of tumor cells into immunodeficient mice with subsequent treatment, e.g. TH treatment or induction of hypothyroidism, and measurements of tumor growth rates and extent of metastasis.

**TH effects in rodent tumor implant models**

Evidence for tumor-promoting effects of TH stems from mouse models of cancer cell lines (Table 1). Shoemaker et al. (1976) reported a connection between survival and induced hypothyroidism in mice after implantation of murine mammary adenocarcinoma cells. Half of the mice were treated with propylthiouracil (PTU) for 21 days, starting on day 14 postimplant through day 35. Tumors had grown in all mice until day 13 and from day 16 on the tumor size was different between the PTU-treated group and the untreated control group with 0.22 $G_0.2$ and 0.63 $G_0.45$ cm$^3$ respectively. This difference was maintained throughout the rest of the experiment with mean tumor sizes in the surviving animals of 8.3 $G_5.1$ vs 17.6 $G_8.2$ cm$^3$.

<table>
<thead>
<tr>
<th>Tumor implant (cell line)</th>
<th>Tumor origin</th>
<th>Comparison</th>
<th>Observation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammary adenocarcinoma  (C3HBA)</td>
<td>Murine</td>
<td>No treatment vs PTU</td>
<td>Reduced tumor size and prolonged survival in the PTU group</td>
<td>Shoemaker et al. (1976)</td>
</tr>
<tr>
<td>Sarcoma (S1), fibrosarcoma  (T241)</td>
<td>Murine</td>
<td>No treatment vs T4 treatment vs $^{131}$I-induced hypothyroidism</td>
<td>Tumor weight and metastatic index increased in the T4 group and reduced in the hypothyroid group</td>
<td>Kumar et al. (1979)</td>
</tr>
<tr>
<td>Morris hepatoma 44</td>
<td>Rat</td>
<td>No treatment vs hypothyroidism</td>
<td>Reduced tumor size, lung metastasis, and prolonged survival in the hypothyroid group</td>
<td>Mishkin et al. (1981)</td>
</tr>
<tr>
<td>Prostate adenocarcinoma  (PC3)</td>
<td>Human</td>
<td>No treatment vs PTU</td>
<td>Reduced tumor growth in the PTU group</td>
<td>Theodossiou &amp; Schwarzenberger (2000)</td>
</tr>
<tr>
<td>Prostate adenocarcinoma  (PC3), lung adenocarcinoma (201T)</td>
<td>Human</td>
<td>No treatment vs PTU-induced hypothyroidism</td>
<td>Reduced tumor growth in the PTU group</td>
<td>Theodossiou et al. (1999)</td>
</tr>
<tr>
<td>Hepatocarcinoma (SK-hep1), breast cancer (MDA)</td>
<td>Human</td>
<td>No treatment vs methimazole-induced hypothyroidism</td>
<td>Reduced tumor growth and proliferation, but enhanced invasiveness and metastasis in hypothyroid mice</td>
<td>Martinez-Iglesias et al. (2009)</td>
</tr>
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</table>

PTU, propylthiouracil.
(PTU treated vs control) on day 48. The delay in tumor growth seemed to be reflected in survival time with the PTU-treated animals surviving 58.9±24.7 vs 42.7 ±10.4 days of the control mice. However, the extent of hypothyroidism achieving this effect is unknown as hormone values are not available for this experiment.

In rats, hypothyroidism inhibited both local and metastatic growth of hepatomas and prolonged host survival. Rats, in which hypothyroidism was induced by either PTU or 131I treatment or thyroidecmy 2 weeks after hepatoma implantation (Morris hepatoma 44) into the hind limbs, survived longer and developed smaller tumors than untreated controls (Mishkin et al. 1981). The time of induction of hypothyroidism by 131I treatment influenced the outcome significantly: while early treatment 2 weeks after implantation led to 78% longer survival compared with untreated controls, the survival benefit was reduced to 35% at 6 weeks and 17% at 11 weeks postimplantation. Similarly, incidence of pulmonary metastasis was reduced from 80% in untreated controls to 30 and 40% with 131I treatment after 2 and 6 weeks respectively and unchanged with 88% after 11 weeks.

The effect of T4 treatment and 131I-induced hypothyroidism on tumor growth and metastasis formation was compared to that in control mice for two murine thyroid carcinoma, follicular thyroid carcinoma, and RCC (Yalcin et al. 2012). The antitumor effect of Tetrac has also been shown in other xenograft models, e.g. medullary thyroid carcinoma, follicular thyroid carcinoma, and RCC (Yalcin et al. 2009, 2010a,b). These observations are very promising because they go beyond merely describing an effect of TH and provide a potential treatment. As the stimulatory effect of TH on cell proliferation and angiogenesis could clearly be inhibited by Tetrac in vitro, it seems logical to assume that the same mechanisms apply in vivo. But a demonstration that a tumor-stimulating effect of TH observed in vivo, as described earlier, can be blocked by Tetrac treatment has yet to be provided. In a live tumor environment, more signals other than TH (e.g. various growth factors, hypoxia) influence tumor progress, which may in part also be mediated by Tetrac and consequently blocked by Tetrac.

The TRβIPV mouse model

TRβ mutations that prevent T3 binding or disturb interaction with corepressors and coactivators lead to
RTH. In RTH, patients have raised serum TH and raised or inappropriately normal TSH levels. Common clinical features of RTH include goiter, tachycardia, and delayed bone growth with a variable phenotype (Weiss & Refetoff 2000). The TRβPV mouse, a TRβ knock-in mouse model initially generated as a mouse model of RTH, surprisingly provided more evidence for the involvement of the TRs in carcinogenesis and tumor progression. The TRβPV mutation, introduced by homologous recombination, was derived from a patient with severe RTH. A C-insertion at codon 448 (exon 10) produces a frameshift of the carboxyterminal 14 amino acids of TRβ1. This mutant completely lost T3 binding ability, showed no transactivation activity, and exerted a strong dominant negative effect (Kaneshige et al. 2000). But, interestingly, not all modes of action of TRβ WT were lost in the TRβPV mutant. The TRβPV mutant bound significantly stronger to the regulating subunit of PI3K than WT TRβ, leading to stronger activation of PI3K and downstream kinases (mTOR, AKT, and p70S6K) (Furuya et al. 2006). Other than the WT TRβ, the TRβPV was not able to bind T3. The degree of PI3K activation therefore cannot be modified by T3 levels. Rather, PI3K is constitutively activated by TRβPV.

The heterozygous mice, TRβPV+/+, reproduced the classical phenotype of RTH with elevated T3 and TSH levels, enlargement of the thyroid gland, and delayed bone development (Kaneshige et al. 2000). The homozygous TRβPV/PV mice showed more severe RTH and the size of their thyroid gland was several fold increased. The enlargement of the thyroid in the homozygous TRβPV/PV mice began at 3 weeks and reached 19- and 36-fold the weight of WT mice at ages 5–7 and >12 months respectively (Suzuki et al. 2002). Furthermore, the homozygous mice showed poor survival compared with WT and heterozygous TRβPV+/+ mice: median survival was only 12.9 months and at age 14 months only 20% of the TRβPV/PV mice were alive, whereas almost all WT and heterozygous mice survived. Histopathological examination of the thyroid glands showed a neoplastic progression in these TRβPV/PV mice, from invasion of the thyroid capsule to development of focal anaplasia and distant metastasis, predominantly to the lung. The TRβPV/PV mouse spontaneously developed follicular thyroid cancer. Because the TRβPV mutant constitutively activates PI3K and subsequently Akt, phosphorylation status of these kinases was tested in the TRβPV/ PV mice (Kim et al. 2005). pAKT was markedly increased in both the thyroid tumors and metastases. The importance of PI3K-Akt overactivation in the TRβPV/ PV mice is highlighted by the fact that treatment with LY294002, a potent PI3K inhibitor, significantly decreased vascular invasion and prevented lung metastases. This led to significantly longer median survival of the LY-treated compared with untreated TRβPV/ PV mice with 329±65 vs 244±63 days respectively (Furuya et al. 2007). PI3K is counteracted against by PTEN, which dephosphorylates PIP3. To test whether reducing PTEN further increased tumor growth, mice haplodeficient for PTEN were crossed with the PV mice (TRβPV/ PV Pten+/- mice) (Guigon et al. 2009). Indeed, the TRβPV/ PV Pten+/- mice had a significantly shorter median survival time with 5.5 months than either TRβPV/ PV Pten+/-/ K mice (10.0 months) or TRβPV/ PV Pten+/-/ K mice (14.1 months). Capsular invasion was detectable at earlier age in the TRβPV/ PV Pten+/-/ K mice compared with TRβPV/ PV Pten+/- mice and anaplasia, vascular invasion and lung metastasis occurred earlier and more frequently in the TRβPV/ PV Pten+/-/ K mice, which was associated with an increased activation of PI3K.

TR mutants in human cancers

TRα and β mutants have been described in HCC, RCC, and papillary thyroid carcinoma (Lin et al. 1999, Kamiya et al. 2002, Puzianowska-Kuznicka et al. 2002). These mutants arise de novo in carcinomas and often harbor more than one mutation. The main consequences appear to be impaired T3 binding and altered recognition of promoter sequences, leading to regulation of a set of genes distinct from that regulated by the wild-type receptors (Rosen & Privalsky 2011). This mechanism may contribute to tumor progress, but the clinical relevance is still unclear.

TH and success of tumor therapy

As TH appear to promote tumor growth, metastasis, and survival in animal models, it seems possible that thyroid function could influence the outcome of tumor therapy, which is defined by exactly these parameters. For example, an association between TH levels and survival was found for patients with astrocytoma grades III and IV. Twenty-two patients with recurrence after initial surgery and chemo- and/or radiation therapy were treated with tamoxifen (Hercbergs et al. 2003). With the idea that IGF1 inhibits the efficiency of tamoxifen and IGF1 levels are reduced in hypothyroidism, the patients were co-treated with a fixed PTU dose to induce hypothyroidism. Eleven of the 22 patients became hypothyroid. Surprisingly, median survival was significantly longer in
the hypothyroid patients (10.1 months) than in the euthyroid patients (3.6 months).

Nelson et al. (2006) analyzed retrospectively whether thyroid function is associated with treatment outcome in head and neck squamous cell cancer. One hundred and fifty-five patients with head and neck cancer were treated with radiation therapy alone or in combination with chemotherapy and/or surgery. Fifty-nine patients developed hypothyroidism with increased TSH levels. Hypothyroidism was most likely a consequence of radiation, but the radiation dose was not different for hypothyroid and euthyroid patients (70 vs 69 Gy, NS). Of the 59 patients who became hypothyroid during the course of treatment and follow-up, 16 had a recurrence (ten before or with diagnosis of hypothyroidism and six after), whereas recurrence was detected in 41 of 96 euthyroid patients. The risk for death or recurrence was significantly lower in hypothyroid patients (HR 0.37, \( P < 0.001 \)). In contrast to the intended induction of hypothyroidism in the glioblastoma patients, the hypothyroid head and neck cancer patients were started on \( T_4 \), but data on efficacy of \( T_4 \) supplementation were not available.

Hypothyroidism as a side effect of treatment and treatment outcome

Development of autoimmune thyroid disease, mostly thyroiditis with hypothyroidism and more seldom autoimmune hyperthyroidism, is a known side effect of interleukin-2 (IL2) treatment. A potential correlation between treatment outcome and thyroid function was noted in the 1990s, when in a small series of 13 patients with RCC or malignant melanoma 6 of 7 euthyroid patients died from progressive disease, but only one of five patients who developed hypothyroidism. Four hypothyroid patients were placed on \( T_4 \) supplementation (Reid et al. 1991). Similarly, of 15 cancer patients (RCC, malignant melanoma) treated with IL2 and lymphokine-activated killer cells, five of seven hypothyroid patients responded with partial or complete remission, but none of the euthyroid patients (Weijl et al. 1993). Three of the seven hypothyroid patients received \( T_4 \) substitution.

In the context of thyroid function and cancer treatment outcome, studies with tyrosine kinase inhibitors (TKIs) such as sunitinib are extremely interesting because hypothyroidism is a common side effect of TKIs. Sunitinib is an oral multitargeted TKI with activity against vascular endothelial growth factor receptor, platelet-derived growth factor receptor, KIT, and RET. Sunitinib is also the TKI most frequently associated with hypothyroidism with roughly one-third (range 14–85%) of patients on sunitinib treatment developing hypothyroidism (Lodish & Stratakis 2010, Brown 2011). In a recent study using a German pharmacy prescription claims database, 178 of 1295 patients (13.7%) on sunitinib treatment later received a first prescription for \( T_4 \) (Feldt et al. 2012). How TKI induce hypothyroidism is not fully understood and several mechanisms have been proposed, for example, reduction of thyroid volume due to atrophy of follicles, degeneration of follicular epithelial cells (Shinohara et al. 2011), and capillary rarefaction (Kappers et al. 2007). Extrathyroidal mechanisms affecting TH metabolism must also be involved because patients with medullary thyroid cancer treated with imatinib, who underwent thyroidectomy and were on \( T_4 \) replacement therapy, also developed hypothyroidism (de Groot et al. 2007). As one possible explanation, sunitinib appears to increase deiodinase 3 activity (Kappers et al. 2011).

A positive correlation between sunitinib-induced hypothyroidism and progression-free (PFS) or overall survival (OS) of RCC patients was first reported in 2008 (Wolter et al. 2008). Twenty-eight of 40 sunitinib-treated RCC patients became hypothyroid (70%) and their median PFS was significantly longer than that of euthyroid patients (10.3 vs 3.6 months) as was their OS (18.2 vs 6.6 months). Thirteen hypothyroid patients were supplemented with \( T_4 \).

In a prospective Italian study, 13 of 22 sunitinib-treated RCC patients (59.1%) developed hypothyroidism as defined by at least one elevated TSH level (Baldazzi et al. 2012). Two patients required \( T_4 \) substitution. Again, the hypothyroid patients experienced a longer median PFS (8.55 months) compared with euthyroid patients (7.03 months, \( P < 0.05 \)). In an Austrian study, RCC patients were treated with either sunitinib or sorafenib and subclinical hypothyroidism occurred in 30 patients (36.1%) (Schmidinger et al. 2011). The rate of objective remission (RECIST criteria) was significantly higher in the hypothyroid patients than in euthyroid patients (28.3 vs 3.3%) and median survival was longer (not reached vs 13.9 months). \( T_4 \) replacement was started in 16 patients but normalized TSH in only four, while the other 12 remained hypothyroid. On multivariate analysis, only elevated TSH was an independent predictor of survival.

Development of hypothyroidism was again an independent prognostic parameter in another study of 66 patients with metastatic RCC and sunitinib or sorafenib...
treatment. Twenty-one patients developed hypothyroidism (31.8%), which was associated with a longer median PFS (16.0 vs 6.0 months) (Riesenbeck et al. 2011). Patients with overt hypothyroidism were placed on T4 and the association of hypothyroidism with PFS was not diminished by T4 replacement. Interestingly, a prospective study, for which the investigators chose to supplement all hypothyroid patients, overt and subclinical, found no association between survival and thyroid dysfunction (Sabatier et al. 2012): of 69 patients with RCC, euthyroid at initiation of standard treatment with sunitinib and without disease progression at a 6-month landmark, 45 (65%) developed hypothyroidism. Patients with elevated TSH were placed on T4 replacement. Mean PFS was not significantly different with 15.9 months for euthyroid patients and 18.9 months for patients with thyroid dysfunction (P=0.94).

Similar effects as for sunitinib were observed for another TKI, cediranib: Speranza et al. (2011) reviewed NCI-sponsored single-agent clinical trials of cediranib and analyzed the response rate for patients with and without hypothyroidism. Hypothyroidism was reported in 168 of 504 (33.3%) cediranib-treated patients and these had a response rate of 25%, while only 8.6% of the patients without hypothyroidism showed a response to treatment (P<0.001).

**Conclusion and outlook**

Epidemiological data suggest a tumor-promoting effect of TH as the incidence of some tumors (colon, breast, prostate, and lung cancer) was found to be increased with increasing TH whereas other tumors, e.g. breast cancer, occur later and are diagnosed in a less advanced stage in patients with hypothyroidism. In tumor transplant rodent models, TH appear to stimulate tumor growth and metastasis, whereas hypothyroidism has opposite effects. Therefore, the results of clinical studies showing that treatment-induced hypothyroidism is associated with a favorable outcome in several cancer types, most prominently in RCC, are immediately comprehensible. In two prospective studies of RCC treated with sunitinib, development of hypothyroidism was an independent predictor of treatment success. Furthermore, in the only study replacing T4 in every RCC patient with elevated TSH and including only patients with normal TSH in the final analysis, no difference in treatment outcome between the patients that developed hypothyroidism and those that remained euthyroid was observed (Sabatier et al. 2012). It is tempting to assume that induction of hypothyroidism is one of the mechanisms through which TKIs slow tumor growth and that correction of hypothyroidism eliminates the survival advantage. There is reasonable concern that substituting these cancer patients with T4 could deprive them of the potential beneficial effects of hypothyroidism (Garfield et al. 2007, 2008).

Yet, one must be cautious because it cannot be ruled out that hypothyroidism is only a surrogate marker of antitumor treatment efficacy due to higher drug levels or different drug metabolism or susceptibility of the immune system in a subset of patients and does not influence tumor growth on its own. There may also be a bias because cancer patients on successful, and therefore continued, treatment are exposed to higher cumulative doses and have more time to develop hypothyroidism than rapidly deteriorating patients. Additionally, a tumor-promoting effect of TH may only be found in certain types of cancer, such as glioblastoma and RCC, but not for others, e.g. HCC.

Given the results of the tumor implant animal models and the TKI trials in cancer patients, it is of great clinical importance to determine whether and in which types of cancer hypothyroidism can contribute to prolonged survival and should be tolerated or, more provocative, should even be induced. To address these questions, future cancer treatment studies, especially with substances that can induce hypothyroidism, should be designed in a way that allows for an analysis of thyroid function status and its contribution on treatment outcome.

**Declaration of interest**
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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