Bidirectional Association of Anogenital and Oral Cavity/Pharyngeal Carcinomas in Men

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Objective: To test the hypothesis of a bidirectional association of anogenital and oral cavity/pharyngeal human papillomavirus (HPV)-associated cancers in men.

Design: Population-based epidemiological study using the Surveillance, Epidemiology, and End Results cancer database.


Participants: The study included 47,308 men 20 years and older with an index oral cavity/pharyngeal or anogenital cancer.

Main Outcome Measure: Second primary HPV-associated cancers (anogenital or oral cavity/pharyngeal) or HPV-unrelated cancers (prostate, bladder, or colon).

Results: The standardized incidence ratio (SIR) was elevated for both anogenital cancer following oral cavity/pharyngeal cancer (SIR, 1.9; 95% confidence interval [CI], 1.2-2.7) and oral cavity/pharyngeal cancer following anogenital cancer (SIR, 3.0; 95% CI, 2.1-4.2). The increase in SIR was most pronounced for tonsillar cancer following anal cancer (SIR, 8.4; 95% CI, 2.7-19.6). The risk of second primary HPV-associated cancers did not vary significantly by age, race, year of diagnosis, or geographic location but was greater among never-married men, particularly for anal cancer following oral cavity/pharyngeal cancer (SIR, 6.5; 95% CI, 1.8-16.7 in never-married men, but SIR, 1.6; 95% CI, 0.7-3.1 in ever-married men) and for tonsillar cancer following anogenital cancer (SIR, 13.0; 95% CI, 3.5-33.2 in never-married men, but SIR, 3.8; 95% CI, 1.0-9.7 in ever-married men). Other than a slightly increased risk of tongue cancer following colon cancer (SIR, 1.3; 95% CI, 1.1-1.6), there was no increased risk of oral cavity/pharyngeal or anogenital cancer following HPV-unrelated cancers or vice versa.

Conclusion: The association between index and second primary anogenital and oral cavity/pharyngeal cancers, strongest in never-married men, supports the influence of sexual behavior on the risk of HPV-associated head and neck cancers.


ONCOGENIC HUMAN PAPILLOMAVIRUS (HPV) is responsible for a subset of head and neck cancers, particularly oropharyngeal (chiefly tonsillar and tongue base) carcinomas,1,2 and is a well-described cause of carcinomas of the cervix,3 vulva,4 anus,5,6 and penis.7 These cancers are also associated with certain sexual behaviors, including multiple partners, earlier age at first intercourse, and oral sex.8,9 Furthermore, patients with an index anogenital cancer appear to have an increased risk of second primary oropharyngeal cancers, an association that is best described in women with cervical cancer.10,11 While anal cancer is a rare disease, its incidence has increased markedly in the past 3 decades, particularly in men.12,13 Few studies have emphasized the possible association of anogenital cancers with carcinomas of the oropharynx and oral cavity in men. We used the Surveillance, Epidemiology, and End Results (SEER) cancer database to test the hypothesis of bidirectional association of anogenital and oral cavity/pharyngeal cancers in men and to explore possible modifiers, including marital status.

METHODS

Using SEER*Stat MP-SIR software (http://seer.cancer.gov/seerstat; version 6.3.6), we searched the original 9 SEER registries, November 2006 submission (1973-2004). We identified a cohort of male patients, 20 years and older, with initial tumors diagnosed during the calendar years 1973 through 2004. We included patients with initial cancers of the oral cavity and pharynx (International Classification of Dis-

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Among men with index anogenital cancers, there was a significantly elevated SIR for second primary oral cavity/pharyngeal cancers, especially of the tonsil or tongue (Table 1). Men with index cancers of the anus, there was an 8-fold elevated SIR for second primary cancers of the tonsil, and among men with index cancers of the penis, there was a 5-fold elevated SIR for second primary cancers of the tongue (Table 1). Analysis of second primary tumors in women did not reveal an elevated risk of oral cavity/pharyngeal cancers following anal cancer or an elevated risk of anal cancer following oral cavity/pharyngeal cancers (data not shown). However, the much smaller number of index primary anogenital or oral cavity/pharyngeal cancers in men with index cancers at HPV-unrelated sites (prostate, bladder, or colon) were not elevated over what was expected (Table 1), except for tongue cancer following colon cancer.

The SIRs for second primary anogenital and oral cavity/pharyngeal cancers in men did not vary significantly by age, race, year of diagnosis, or geographic location (data not shown). However, the SIR for second primary anogenital cancers following oral cavity/pharyngeal cancers varied significantly by marital status (Figure): the SIR for second primary anogenital cancers was 6.5 (95% CI, 1.8-16.7) in never-married men but only 1.6 (95% CI, 0.7-3.1) in ever-married men. Also, the age at diagnosis of these second primary anogenital cancers was younger among never-married men than among ever-married men (61.0 years vs 69.6 years, P = .03).

Similarly, the SIR for second primary oral cavity/pharyngeal cancers following anogenital cancers also varied significantly by marital status (Figure): the SIR for second primary tonsillar cancers was 13.0 (95% CI, 3.5-33.2) in never-married men but only 3.8 (95% CI, 1.0-9.7) in ever-married men. Even more striking, the SIR for second pri-
significantly younger among never-married men than these second primary oral cavity/pharyngeal cancers was in 0 of 15 ever-married men. When we examined the sub-
tonsillar cancer in 2 of 5 never-married men (40%) but
primary oral cavity/pharyngeal cancers following index oral cavity/pharyngeal cancers or following index anogenital cancers. Asterisks indicate that the difference between standardized incidence ratios for ever- and never-married men is statistically significant (P < .05). Error bars represent 95% confidence intervals.

Figure. Effect of marital status on risk of second cancers of the anogenital region (anus and penis), oral cavity/pharynx (including tonsil and tongue), tobacco-related sites (lung, larynx, and esophagus), or non–human papillomavirus–related sites (prostate, bladder, and colon) following index oral cavity/pharyngeal cancers or following index anogenital cancers. The mean latency (time elapsed between diagnosis of the index tumor and second primary tumor) was 4.2 years for oral cavity/pharyngeal index tumors and 5.6 years for anogenital index tumors. There was no increased risk of HPV-related sites (prostate, bladder, and colon) following index oral cavity/pharyngeal or anogenital cancers, and these findings were not modified by marital status (Figure).

The elevated and reciprocal risk of second primary anogenital and oral cavity/pharyngeal cancers in men supports HPV as a link between these cancers. The dramatically elevated risk among never-married men compared with ever-married men suggests that never-married status may be a surrogate for sexual practices associated with HPV transmission. The earlier age at diagnosis of these second primary cancers in never-married men is consistent with observations that HPV-associated oral cavity/pharyngeal cancers present earlier than cancers caused by smoking and/or use of alcohol.

A significant limitation of our study relates to the lack of tobacco use information in SEER: smoking may be more common among never-married men than among ever-married men, potentially causing spurious differences in the risk of second primary tumors. Such confounding may have been present in the analysis of men with index oral cavity/pharyngeal cancers in whom second primary tobacco-related cancers (of the lung, larynx, and esophagus) are common and among whom we found that elevated SIRs for second primary tobacco-related cancers occurred more often in the never-married men (Figure). However, in men with index anogenital cancers, the SIRs for second primary tobacco-related cancers were not dramatically elevated, nor were there differences by marital status. Also, analysis of oral cavity/pharynx second pri-
mary cancer by subsite suggests that tobacco use may have actually been more prevalent in ever-married men with index anogenital cancer. Carcinomas of the floor of the mouth and hypopharynx (subsites with the strongest link to smoking) were more common second primary cancers following index anogenital cancers in ever-married men (Table 2) and were more common index cancers in ever-married men as well (Table 3). Furthermore, the disproportionate representation of second primary tonsillar cancers among never-married men in our study is more consistent with HPV than smoking as a common etiologic agent. Another limitation is the inability to extract HIV status (which is strongly associated with risk of anal carcinoma) from the SEER registry, making it impossible to control for different rates of HIV positivity among ever- and never-married men.

Understanding risk factors for additional primary tumors in patients with HPV-related head and neck carcinomas is essential for proper patient counseling and risk reduction. While the attention of both the medical community and the lay population are understandably focused on the dramatic impact of oncogenic HPV on women's health, physicians who treat HPV-associated cancers must be mindful that sexual transmission of HPV also places men at risk for HPV-related cancers at other body sites. The present data identify a patient population (never-married men) that may be at increased risk for additional HPV-related cancers after an index diagnosis of oral cavity/pharyngeal or anogenital carcinoma. Population-based databases that address behavioral risk factors, including smoking and sexual practices, are needed to further define the interaction between marital status and reciprocal increased risk of second primary anogenital and oral cavity/pharyngeal cancers.

Submitted for Publication: July 24, 2008; final revision received September 25, 2008; accepted October 29, 2008.

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Author Contributions: Dr Sikora had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Sikora and Sturgis. Acquisition of data: Sikora and Morris. Analysis and interpretation of data: Sikora and Sturgis. Drafting of the manuscript: Sikora, Morris, and Sturgis. Critical revision of the manuscript for important intellectual content: Sikora and Sturgis. Statistical analysis: Sikora and Morris. Administrative, technical, and material support: Sturgis. Study supervision: Sikora and Sturgis.

Financial Disclosure: None reported.

Previous Presentation: This study was presented at the Seventh International Conference on Head and Neck Cancer of the American Head and Neck Society; July 23, 2008; San Francisco, California.

Additional Contributions: Rosalind Gary assisted with manuscript preparation, and Stephanie P. Deming edited the manuscript.

REFERENCES