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Repurposing metformin for the treatment of gastrointestinal cancer

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Abstract

Diabetes mellitus type 2 and cancer share many risk factors. The pleiotropic insulin-dependent and insulin-independent effects of metformin might inhibit pathways that are frequently amplified in neoplastic tissue. Particularly, modulation of inflammation, metabolism, and cell cycle arrest are potential therapeutic cancer targets utilized by metformin to boost the anti-cancer effects of chemotherapy. Studies in vitro and in vivo models have demonstrated the potential of metformin as a chemo- and radiosensitizer, besides its chemopreventive and direct therapeutic activity in digestive system (DS) tumors. Hence, these aspects have been considered in many cancer clinical trials. Case-control and cohort studies and associated meta-analyses have evaluated DS cancer risk and metformin usage, especially in colorectal cancer, pancreatic cancer, and hepatocellular carcinoma. Most clinical studies have demonstrated the protective role of metformin in the risk for DS cancers and survival rates. On the other hand, the ability of metformin to enhance the actions of chemotherapy for gastric and biliary cancers is yet to be investigated. This article reviews the current findings on the anti-cancer mechanisms of metformin and its apparatus from pre-clinical and ongoing studies in DS malignancies.

Key Words: Antidiabetic treatments; Gastrointestinal tumors; Therapeutic target

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Core Tip: Modulation of cell function into the neoplastic and around the microenvironment tissue are possible cancer targets utilized by metformin to raise

INTRODUCTION

Diabetes mellitus type 2 (DM2) and cancer share several risk factors[1]. Notably, obesity and metabolic syndrome, with their inherent biological connections, such as hyperinsulinemia[2] and chronic inflammation[3]. Furthermore, some antihyperglycemic medications (e.g., sulfonylureas and insulin) used for the treatment of DM2 may increase cancer risk[4]. Particularly, central obesity, physical inactivity, and perhaps a low dietetic polyunsaturated fat to saturated fat ratio are major risk factors for insulin resistance and hyperinsulinemia and seem to be related to cancer risk[5]. All of them have been recognized as proposed gears holding those relationships[6-9]. Epidemiologic studies and meta-analyses have suggested that patients with DM2 have a higher incidence and mortality from malignancies[10,11], including digestive system (DS) cancers[12-15].

Metformin is a well-known oral hypoglycemic drug that belongs to the biguanide class and has been used to treat DM2 for almost a century[16]. Importantly, those patients with DM2 with long-term use of metformin have a decreased tumor incidence and lower cancer-associated mortality[17-21]. Furthermore, recent research indicates that metformin can have direct anti-cancer activity against many tumor cells, including tumor stem cells[22,23], therefore, carrying out pleiotropic effects in both the cancer cell and the neoplastic microenvironment[24]. Their potential mechanisms are insulin-dependent [via insulin growth factor (IGF) receptor, phosphatidyl inositol 3 kinase (PI3K), and Akt/mammalian target of rapamycin (mTOR)] and insulin-independent [via adenosine kinase monophosphate (AMPK), tuberous sclerosis complex (TSC), and mTOR][27,28]. Moreover, it promotes antitumor immunity-related metabolic checkpoints in T-cells, cancer cells, as well as associated with immunosuppressive cells of the tumor milieu[29]. Furthermore, it might interfere with the gut microbiota and have systemic impacts on body metabolism[30,31]. This article aims to review the rationale of metformin as a drug that might be repurposed for DS cancer treatment.

MECHANISM OF ACTION OF METFORMIN AS AN ANTI-CANCER AGENT

Two potential mechanisms for the antineoplastic action of metformin have been suggested (Figure 1). First, metformin can directly activate AMPK, resulting in inhibition of downstream Akt/mTOR signaling and consequent suppression of cell proliferation[32,33]. Second, metformin-induced reductions in circulating insulin and IGF concentrations may reduce activation of the IGF receptor signaling axis, resulting in decreased growth promotion and mitogenesis[2,24]. Hence, the anti-cancer effects of metformin are mediated through a systemic improvement in the metabolic milieu or directly on tumor cells[35].

The noticeable intracellular metabolic change caused by metformin is the decreased accumulation of glycolytic intermediates and a coordinated decrease in tricarboxylic acid (TCA) cycle intermediates[36,37]. Moreover, the activation of AMPK reduces fatty acid synthase (FAS) gene expression in the synthesis of fatty acids[32]. Furthermore, metformin offers other direct anti-tumor effects by (1) decreasing specific protein (Sp) transcription factors and Sp-related oncogenic proteins[38,39]; (2) decreasing AMPK-dependent c-Myc oncogene; (3) increasing other miRNAs, such as mir33a[40]; (4) increasing other miRNAs, such as miR-26a[41]; (5) reducing endogenous reactive oxygen species and associated DNA damage[42]; (6) reducing Sonic hedgehog...
Insulin-dependent or indirect effects

A central signal transduction pathway involved in cancer is the PI3K/Akt/mTOR pathway, which, when hyperactivated, leads to deregulation of survival and cell growth[28,46,47]. IGF-1 is a more potent mitogen than insulin and, like insulin, binds to its particular growth factor receptor and stimulates cell growth and anti-apoptotic activity via MAPK/ERK or Ras/Raf/MEK/ERK and PI3K/Akt/mTOR signaling [2,24]. In addition, IGF-1 inhibits PTEN, a phosphatase that deactivates PI3K/Akt/mTOR [2]. The indirect mechanisms of metformin action include inhibition of hepatic gluconeogenesis and stimulation of peripheral glucose absorption, which ultimately lead to decreased blood glucose and insulin levels. Thus, the most apparent mechanism of insulin-dependent metformin involves decreasing insulin levels, which reduces insulin binding to the insulin receptor (IR), inhibiting tumor growth[48]. A reduction of insulin/IGF-1 levels is, at least in part, involved in the antiproliferative activity of metformin[49]. Additionally, metformin downregulates IGF-R and IR by decreasing the promoter activity of receptor genes with subsequent Akt/mTOR and MAPK/ERK signaling inhibition[30,51].

Insulin-independent or direct effects

Metformin activates AMPK by inhibiting mitochondrial complex I, which leads to impaired mitochondrial function, decreased adenosine triphosphate synthesis, increased adenosine monophosphate, and subsequent phosphorylation and activation by LKB1[52]. Activated AMPK then phosphorylates TSC2, which negatively regulates mTOR activity[53]. Activation of LKB1 and AMPK, AMPK-induced stabilization of TSC1-TSC2 (inhibitor of Rheb, an mTORC1 activator), and activation of the tumor suppressor p53[54]. Moreover, independent of AMPK, metformin impedes mTORC1 by raising p53-dependent expression of REDD1 and repressing Rags[55]. Metformin

expression[43]; (7) reducing expression of angiogenic factor CCN1, which inhibits invasion induced by the stromal cell-derived factor-1 and reducing levels of type 4 chemokine receptor[44]; and (8) inhibiting Rac1 GTPase activity[45]. Finally, metformin might interfere with the gut microbiota[30,31], as well as interfere with the balance between T-cells and associated immunosuppressive cells in the tumor milieu[29].
also retards transformation by inhibiting mediators of the inflammatory response, including transcription factors (nuclear factor kappa, Signal transducer and activator of transcription 3, and Forkhead box O signaling), and downregulating Lin28B, most Let-7 miRNA family members, and inflammatory molecules [interleukin (IL)-1α, IL-1β, IL-6, and vascular endothelial growth factor (VEGF)][56].

Metformin has other AMPK-mediated actions that may be implicated in cancer. Through the activation of AMPK, metformin causes the suppression of FAS gene expression, which is involved in the synthesis of fatty acids, resulting in reduced lipogenesis, increased fatty acid oxidation, and decreased cell proliferation[32,57]. The activation of AMPK also modulates cyclin D1 (cell cycle protein), p21 and p27 (cyclin-dependent protein kinase), which further contribute to its anti-cancer effects[35,58]. Interestingly, metformin may act as a chemosensitizer, for example, increasing the 5-fluorouracil (5-FU) and paclitaxel sensitivities of cancer cell lines[59,60]. The ability of metformin to disconnect the electron transport chain by inhibiting complex I (NADH dehydrogenase) strongly induces cell death when glucose is limited. Metformin also reduces the hypoxic activation of hypoxia inducing factor (HIF-1), suggesting that the effects of metformin are increased in hypoglycemic and hypoxic conditions[61].

**Other mechanisms**

As a drug that controls metabolism, metformin promotes a coordinated decrease of TCA cycle intermediates, including succinate, fumarate, malate, citrate, and α-ketoglutarate[36,37]. The dependency of neoplastic cells on glucose metabolism has been shown to be reprogrammed by the Kras oncogenic pathway through a single pathway involving serum glutamic-oxaloacetic transaminase, which maintains the cellular redox states essential to mitochondria and offers innovative therapeutic targets in combination with metformin[62].

Metformin can exert antitumor activity by increasing CD8+ T-cells[63,64]. It might inhibit apoptosis of CD8+ tumor infiltrating lymphocytes and prevent immune exhaustion[63,65]. Furthermore, metformin might adjust the expression profile of immune checkpoints[66], such as programmed death ligand 1, in the context of the neoplasm[37], thereby suggesting that a combination of metformin might have the potential to enhance the strength of cancer immunotherapy[63].

There is evidence that epigenomic modifications by metformin may contribute to its anti-cancer properties[67]. Metformin might regulate the activity of numerous epigenetic modifying enzymes, principally by modulating the activation of AMPK. Activated AMPK can phosphorylate several substrates, comprising epigenetic enzymes, such as histone acetyltransferases (HATs), class II histone deacetylases (HDACs) and DNA methyltransferases (DNMTs), usually resulting in their inhibition; however, HAT1 activity may be increased. Metformin has also been related to the diminished expression of various histone methyltransferases[68], enhancing the activity of the class III HDAC SIRT1 and minimizing the influence of DNMT inhibitors[69,70].

**METFORMIN STUDIES IN DIGESTIVE SYSTEM MALIGNANCIES**

**Metformin in colorectal cancer**

**Cell lines and animal models:** Metformin promotes cell cycle arrest in the G0/G1 phase in colorectal cancer (CRC) cell lines. It also decreases the expression of c-Myc and causes down-regulation of IGF-1R[71]. Consequently, up-regulation of the adenosine A1 receptor induces apoptosis[72]. Additionally, it was shown that metformin enhances the activity of the Sprouty2 gene, which suppresses colon cancer growth[73].

The combination of metformin with 5-FU was investigated on the SW620 CRC cell line and on patients with DM2. The study showed that metformin plus 5-FU treatment significantly inhibited the proliferation of SW620 cells compared with that in monotherapy. Additionally, the examination of 86 CRC tissue samples obtained from patients with DM2 revealed that treatment with metformin decreased the proportion of poorly differentiated tumors[74]. Moreover, a synergistic effect of 5-FU and metformin was observed in a 5-FU resistant cell line[74] and metformin radiosensitizer CRC cells, with reduced survival of ionization-resistant cells[75]. Consistently, the association of oxaliplatin, 5-FU and metformin also demonstrated a superior antitumor activity in chemoresistant HT-29, and HCT-116 cells compared to that with the drugs separately[76].
In 1977, it was firstly reported that phenformin inhibits metabolic immuno-suppression in rats[77]. Since then, several reports have demonstrated that metformin has both chemopreventive and therapeutic activities in animal models of CRC. For instance, metformin treated ApcMin/+ mice showed significantly smaller polyps[78], and carcinogen-induced animal models that received metformin had a reduction of aberrant crypt foci[79], indicating the chemopreventive effect of metformin. Moreover, the association of metformin with D3 vitamin demonstrated a chemopreventive effect against 1,2-dimethylhydrazine (DMH)-induced CRC in rats and DMH-dextran sodium sulfate-induced colitis-associated CRC in mice[80]. On the other hand, treatment with metformin, 5-FU and oxaliplatin demonstrated superior antiproliferative effects in SCID mice bearing CRC[76]. In avatar models, metformin suppressed the tumor growth in the patient-derived xenografts by 50%-81%. In the same study, when metformin was combined with 5-FU, the tumor growth was inhibited up to 85%-81%.

Clinical use of metformin

Metformin and CRC risk: As shown in Table 1 many case-control and cohort studies and associated meta-analyses have evaluated DS cancer risk and metformin use. Specifically, a decreased risk of CRC was found in the majority of studies[82-86], but no association or an increased risk of CRC was found in some of them[87-91]. Although these different results may be related to biases, a large cohort study that used adequate methods to minimize biases also concluded that metformin use decreased the risk of CRC[92].

Saliently, Cardel et al[82] demonstrated, in a case-control study, that the risk of CRC was decreased by 17% (OR: 0.83, 95%CI: 0.74-0.92) among patients treated with metformin compared to that among patients not using metformin[82], while Liu et al[93] showed a 22% risk reduction for the development of CRC[93]. Importantly, the role of metformin for CRC prophylaxis was addressed in a prospective Japanese phase III trial that demonstrated that low metformin doses for 1-year reduced polyp formation and colorectal adenomas in non-diabetic patients at high risk for new polyps[94]. However, further studies are necessary to draw a definitive conclusion.

Metformin and CRC treatment

Table 2 summarizes the clinical studies of metformin on DS cancers treatment. Specifically related to CRC, a Korean study of 595 patients with diabetes who had CRC with clinical stages I to IV showed that patients using metformin had higher overall survival (OS) and specific cancer survival compared to patients who did not use it[95]. In accordance, metformin use in 424 diabetic patients with CRC was associated with an OS of 76.9 mo vs 56.9 mo in patients not using metformin (P = 0.048)[95]. After adjusting for possible confounding factors, the study showed that patients with DM2 treated with metformin had a 30% increase in OS when compared to patients with DM2 treated with other antidiabetic drugs[95]. Recent meta-analyses demonstrated that metformin increases the OS of patients with CRC, as well as a 10% reduction in the incidence of the disease[96,97]. The ASAMET trial, an ongoing randomized, phase II, double-blind, placebo-controlled trial aims to determine the effect of low-dose aspirin and metformin in patients with stage I-III CRC in reducing CRC mortality rates and adenoma recurrence[98]. The 160 patients with CRC were divided in four arms: aspirin, metformin, aspirin plus metformin and placebo for a duration of 1 year.

The radiotherapy-induced tumor response was improved with metformin in a Korean retrospective study that evaluated patients with localized rectal cancer. The diabetic patients receiving metformin had significantly more tumor regression grade 3-4 (P = 0.029) and higher lymph node downstaging (P = 0.006) as compared to patients not receiving the medication. However, the disease-free survival (DFS) and OS was not affected[99]. Consistently, a study with 482 patients examined the effect of metformin use on pathologic complete response (pCR) rates and outcomes in patients submitted to neoadjuvant chemoradiotherapy for rectal cancer. The pCR rates were higher in patients with DM2 taking metformin (35%) compared with those in nondiabetic patients (16.6%) and patients with DM2 not using metformin (7.5%). Additionally, significantly increased DFS and OS was found in patients taking metformin[100].

A phase II clinical trial addressed the combination of metformin with 5-FU in patients with refractory CRC. It demonstrated a disease control rate in 8 wk of 22%, with a median OS of 7.9 mo and progression-free survival (PFS) of 1.8 mo[101]. A trial of our group with a similar design that analyzed the combination of irinotecan with metformin found 41% disease control rate and OS of 8.2 mo[102]. Further randomized prospective studies are needed to establish metformin as a modern drug for the treatment of refractory CRC.
## Table 1 Selected clinical studies of metformin on digestive system cancers chemoprevention

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<td></td>
<td>History of GC or gastrectomy</td>
</tr>
</tbody>
</table>

### Pancreatic ductal adenocarcinoma

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study Type</th>
<th>Participants</th>
<th>Intervention</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shuai et al</td>
<td>2020</td>
<td>Meta-analysis. 11 cohort studies</td>
<td>Studies conducted in humans that</td>
<td>Metformin user vs nonuser</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>evaluate metformin and GC risk</td>
<td></td>
<td>HR: 0.79 (0.62-1.00)</td>
</tr>
</tbody>
</table>

### Hepatocellular carcinoma

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study Type</th>
<th>Participants</th>
<th>Intervention</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donadon et al</td>
<td>2010</td>
<td>Clinic-hospital based case control. Cases-controls: 190:359</td>
<td>Cases: HCC patients. Controls: Liver cirrhosis patients and healthy controls</td>
<td>Metformin vs sulfonylurea, Metformin vs insulin</td>
<td>OR: 0.39 (0.22-0.73). OR: 0.21 (0.11-0.42)</td>
</tr>
</tbody>
</table>

### Intrahepatic cholangiocarcinoma

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study Type</th>
<th>Participants</th>
<th>Intervention</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaiterakij et al</td>
<td>2013</td>
<td>Clinic-hospital based case-control. Cases-controls: 612:594</td>
<td>Cases: ICC patients. Controls: Non-cancer patients</td>
<td>Metformin user vs nonuser</td>
<td>OR: 0.40 (0.20-0.90)</td>
</tr>
</tbody>
</table>

PDAC: Pancreatic ductal adenocarcinoma; HR: Hazard ratio; OHA: Oxidized hyaluronate; RCT: Randomized clinical trial; HCC: Hepatocellular carcinoma; ICC: Intrahepatic cholangiocarcinoma; CRC: Colorectal cancer.

Interestingly, a randomized trial that included 40 patients with stage III CRC evaluated the use of metformin in preventing oxaliplatin-induced neuropathy. After the 12th cycle of the FOLFOX-4 regimen, in the metformin group, there were fewer patients with grade 2 and 3 neuropathy as compared to the control arm (60% vs 95%, P = 0.009). Moreover, significantly higher total scores on the Ntx-12 questionnaire and pain score were found in the metformin arm. The serum levels of neurotensin and malondialdehyde were also significantly lower in the metformin arm after 6 and 12 cycles[103].

Furthermore, there are ongoing trials evaluating the role of metformin in CRC. We highlight, in adjuvant setting, a phase 3 trial (NCT02614339) with high-risk stage II and stage III CRC that aims to evaluate the impact of metformin for 48 mo on disease-free survival. In refractory CRC setting, there is an interesting phase 2 trial is recruiting patients to explore the combination of the immune checkpoint inhibitors, such as nivolumab and metformin (NCT03800602).

**Metformin and gastric cancer**

The effect of metformin alone or in combination with cisplatin or rapamycin was studied in a tumor xenograft model[104]. It demonstrated that metformin alone decreased tumor volume. The combination of metformin with cisplatin, rapamycin or both increase the effect of each drug alone and inhibited the peritoneal dissemination of gastric cancer (GC)[104]. In accordance, Wu performed an in vitro study with AGS cell lines that analyzed how the association of metformin with cisplatin or adriamycin or paclitaxel enhanced the effects of each drug alone[105]. In striking contrast, Lesan...
### Table 2 Selected clinical studies of metformin on digestive system cancers treatment

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Study design and population</th>
<th>Inclusion criteria</th>
<th>Combined interventions /drugs</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colorectal cancer</strong></td>
<td></td>
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<tr>
<td>Ramjiessingh et al[99], 2016</td>
<td>Retrospective cohort. 1394 all stages CRC patients</td>
<td>Patients with CRC</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.81 (0.60-1.08)</td>
</tr>
<tr>
<td>Skinner et al[100], 2013</td>
<td>Retrospective cohort. 482 locally rectal cancer patients</td>
<td>Locally advanced rectal adenocarcinoma treated with chemoradiation and surgery</td>
<td>Metformin user vs nonuser</td>
<td>pCR: OR: 16.8 (1.6-181.1). OS at 5 and 10 years (metformin vs non): 81% and 79% vs 56% and 39% (P = 0.022)</td>
</tr>
<tr>
<td>Miranda et al[101], 2016</td>
<td>Phase 2 Clinical trial. 50 refractory CRC patients</td>
<td>Refractory CRC patients</td>
<td>Metformin 850 mg twice a day + 5-FU 425 mg/m² weekly</td>
<td>DFS: 18.0 mo. OS: 7.9 mo. Obese vs lean: 12.4 vs 5.8 mo</td>
</tr>
<tr>
<td>Bragagnoli et al[102], 2021</td>
<td>Phase 2 Clinical trial, 41 refractory CRC patients</td>
<td>Refractory CRC patients</td>
<td>Metformin 2500 mg a day + Irinotecan 125 mg/m² D1, D8, every 21 d</td>
<td>DFS: 2.4 mo, CI 95%, 2.0-4.5 mo. OS: 8.4 mo, CI 95%, 5.9-10.8 mo</td>
</tr>
<tr>
<td>El-Fatatry et al[103], 2018</td>
<td>Clinical Trial, 40 Stage III CRC patients</td>
<td>Stage III CRC patients</td>
<td>FOLFOX 4 12 cycles + metformin 500 mg 3 times a day</td>
<td>Neuropathy grade 2-3 (metformin vs non): 60% vs 95% (P = 0.009)</td>
</tr>
<tr>
<td><strong>Gastric cancer</strong></td>
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<tr>
<td>Lee et al[118], 2016</td>
<td>Retrospective Cohort, single center in Korea. 1974 GC resected patients: - 132 DM2 with metformin; -192 DM2 without metformin; -1648 non-diabetic</td>
<td>GC patients who underwent curative gastrectomy</td>
<td>Metformin user vs nonuser</td>
<td>OS-HR: 0.58 (0.37-0.93). RFS-HR: 0.63 (0.41-0.98)</td>
</tr>
<tr>
<td>Lacroix et al[120], 2018</td>
<td>Retrospective Cohort. 371 Patients</td>
<td>Stage I to III GC patients</td>
<td>Metformin user vs nonuser</td>
<td>OS-HR: 0.73 (0.52-1.01); cancer specific mortality-HR: 0.86 (0.56-1.33)</td>
</tr>
<tr>
<td>Baglia et al[121], 2019</td>
<td>Prospective cohort study in Shanghai. 543 GC patients</td>
<td>Breast, CRC, Lung and GC patients</td>
<td>Metformin user vs nonuser</td>
<td>OS-HR: 1.11 (0.81-1.53). Disease-specific survival-HR: 1.03 (0.73-1.43)</td>
</tr>
<tr>
<td>Seo et al[119], 2019</td>
<td>Retrospective cohort study. 2187 GC resected patients: - 103 DM2 with metformin; -139 DM2 without metformin; -1945 non-diabetic</td>
<td>GC patients who underwent curative gastrectomy</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.45 (0.30-0.66)</td>
</tr>
<tr>
<td><strong>PDAC</strong></td>
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<tr>
<td>Sadeghi et al[128], 2012</td>
<td>Retrospective cohort. n = 302</td>
<td>DM2 patients. All stages. United States single center</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.64 (0.48-0.86)</td>
</tr>
<tr>
<td>Chaiterakij et al[129], 2016</td>
<td>Retrospective cohort. n = 980</td>
<td>DM2 patients. All stages. United States single center</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.93 (0.81-1.07)</td>
</tr>
<tr>
<td>Lee et al[130], 2016</td>
<td>Retrospective cohort. n = 237</td>
<td>DM2 patients. All stages. Korean single center</td>
<td>Use of metformin ≥ 1-mo post-diagnosis vs nonuser</td>
<td>HR: 0.61 (0.46-0.81)</td>
</tr>
<tr>
<td>Ambe et al[130], 2016</td>
<td>Prospective cohort study n = 44</td>
<td>DM2 patients. Resected PDAC, stage I-II. United States single center</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.54 (0.16-1.86)</td>
</tr>
<tr>
<td>Cerullo et al[131], 2016</td>
<td>Retrospective cohort. n = 3393</td>
<td>Resected PDAC United States population based</td>
<td>Metformin use after surgery vs nonuser</td>
<td>HR: 0.79 (0.67-0.93)</td>
</tr>
<tr>
<td>Jang et al[132], 2017</td>
<td>Prospective cohort. n = 764</td>
<td>DM2, OHA user. Resected Korean population based</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.73 (0.61-0.87)</td>
</tr>
<tr>
<td>Hwang et al[133], 2013</td>
<td>Retrospective cohort. n = 516</td>
<td>DM2 patients. Locally advanced and metastatic. United Kingdom population based</td>
<td>Use of metformin peridiasnosis vs nonuser</td>
<td>HR: 1.11 (0.89-1.38)</td>
</tr>
<tr>
<td>Choi et al[134], 2016</td>
<td>Retrospective cohort. n = 183</td>
<td>DM2 patients. Locally advanced and metastatic. Korean single center</td>
<td>Metformin user vs nonuser</td>
<td>HR: 0.69 (0.49-0.97)</td>
</tr>
<tr>
<td>Kordes et al[137], 2015</td>
<td>RCT, n ≤ 121</td>
<td>Locally advanced and metastatic. Multicentric. Netherlands</td>
<td>Gemcitabine-everolimus (1000 mg/m² D1, 8, 15-every 28 d-1.000 mg/d) +/- metformin (2000 mg/d)</td>
<td>HR: 1.05 (0.72-1.55)</td>
</tr>
<tr>
<td>Reni et al[138], 2016</td>
<td>RCT, n = 60</td>
<td>Metastatic. Single center. Italian</td>
<td>PEG (cisplatin-epirubicin-cap cetabine-gemcitabine: 30 mg/m²</td>
<td>HR: 1.56 (0.87-2.80)</td>
</tr>
<tr>
<td>Name</td>
<td>Methodology</td>
<td>Stages</td>
<td>Treatment Details</td>
<td>HR (95% CI)</td>
</tr>
<tr>
<td>-----------------</td>
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</tr>
<tr>
<td>Zhou et al[136], 2017</td>
<td>Meta-analysis12 cohort studies and 2 RCT.</td>
<td>n = 94778</td>
<td>Studies that investigated metformin exposition. All stages PDAC.</td>
<td>Metformin user vs nonuser</td>
</tr>
<tr>
<td>Li et al[139], 2017</td>
<td>Meta-analysis. 9 cohort study and 2 RCT.</td>
<td>n = 8089</td>
<td>Studies that investigated metformin exposition. All stages PDAC.</td>
<td>Metformin user vs nonuser</td>
</tr>
<tr>
<td>Wan et al[140], 2018</td>
<td>Meta-analysis 15 cohort studies and 2 RCT.</td>
<td>n = 36791</td>
<td>Studies that investigated metformin exposition. All stages PDAC.</td>
<td>Metformin user vs nonuser</td>
</tr>
<tr>
<td>Braghin et al[141], 2015</td>
<td>Single-arm phase II.</td>
<td>n = 20</td>
<td>Locally advanced or metastatic. 2nd line treatment. Single center. Brazilian</td>
<td>Paclitaxel (80 mg/m² D1, 8, 15 every 28 d) + metformin 1750 mg/d</td>
</tr>
<tr>
<td>Pancreatic neuroendocrine tumor</td>
<td>Retrospective cohort.</td>
<td>n = 445</td>
<td>Locally advanced or metastatic. Multicentric. Italian</td>
<td>No DM2 vs DM2. Metformin user vs nonuser</td>
</tr>
<tr>
<td>Hepatocellular carcinoma</td>
<td>Retrospective cohort.</td>
<td>n = 53</td>
<td>DM2. Early-stage HCC. RFA treated. Single center. Taiwanese</td>
<td>Metformin user vs nonuser</td>
</tr>
<tr>
<td>Ma et al[164], 2016</td>
<td>Meta-analysis. 11 cohort studies.</td>
<td>n = 3452</td>
<td>Studies that investigated metformin exposition. HCC patients</td>
<td>Metformin user vs nonuser</td>
</tr>
<tr>
<td>Intrahepatic cholangiocarcinoma</td>
<td>Retrospective cohort.</td>
<td>n = 250</td>
<td>DM2. Newly diagnosed ICC. United States single center</td>
<td>Metformin user vs nonuser</td>
</tr>
</tbody>
</table>

PDAC: Pancreatic ductal adenocarcinoma; ORC: Origin recognition complex; HR: Hazard ratio; PCR: Polymerase chain reaction; OS: Overall survival; PFS: Progression-free survival; RFS: Regarding refeeding syndrome; OHA: Oxidized hyaluronate; RCT: Randomized clinical trial; PEXG: Pseudoexfoliative glaucoma; DCR: Dacryocystorhinostomy; HCC: Hepatocellular carcinoma; RAF: Rapidly accelerated fibrosarcoma; ICC: Intrahepatic cholangiocarcinoma; CRC: Colorectal cancer; DM2: Diabetes mellitus type 2; GC: Gastric cancer.

et al[106] showed in vitro that metformin and cisplatin in combination decreased the effects of cisplatin alone[106].

In recent years, several observational studies have shown that metformin reduces the risk of GC[107-112]. The study of Tseng et al[107] demonstrated that GC risk was reduced using metformin, especially when the cumulative duration was more than 2 years[107]. In addition, metformin reduced the risk of GC, while opposite results were observed with sulfonylureas[108].

On the other hand, a study conducted in United Kingdom did not show a difference in GC incidence in patients receiving metformin compared to sulfonylureas[113]. Other reports also could not find any reduction in GC risk associated with metformin use[83,114,115]. Despite that, a meta-analysis showed a 21% reduction in the risk of GC with the use of metformin, in Asians the benefit was more prominent than in Westerners[116]. Another meta-analysis of cohort studies that included 591077 patients found a significantly lower incidence of GC with metformin therapy than other types of therapy (HR: 0.763; 95%CI: 0.642-0.905)[117].

Two retrospective studies conducted by Lee et al[118] and Seo et al[119] concluded that metformin reduced GC recurrence in patients undergoing gastrectomy[118,119]. Lacroix et al[120] showed that metformin improved OS but not cancer specific survival, in contrast, Baglia et al[121] observed that metformin use did not impact patient’s survival[120,121].

More studies are needed to confirm the effect of metformin in GC treatment and chemoprevention. Unfortunately, there are few clinical trials that are ongoing to analyze this question. An interesting phase 2 randomized trial (NCT04114136) are ongoing to evaluate the synergistic effect of metformin, rosiglitazone and anti-PD-1 on
the treatment of refractory solid tumors including GC. Metformin could reduce tumor oxygen consumption creating a less hypoxic T cell environment leading to restore its anti-tumor cell function. The trial NCT04033107 analyze the combination of metformin and vitamin C in DS tumors including GC.

Metformin and pancreatic cancer

Pancreatic cancer is the fourth leading cause of cancer death in the United States and its prognosis remains dismal, encouraging research to discover innovative agents active in its treatment is an urgent unmet need[122]. Pancreatic ductal adenocarcinoma (PDAC) is its most common histologic type. An association between metformin use and decreased PDAC incidence in patients with DM2 was first recognized by two large clinical studies. In a large general practice retrospective cohort, Currie et al[123] reported risk reduction in metformin users related to sulfonylurea users (HR: 0.20; 95%CI: 0.11-0.36) and to insulin-based-treatment users (HR: 0.22; 95%CI: 0.12-0.38). Likewise, in a hospital-based case-control study, Li et al[124] encountered risk reduction in metformin users compared to those who did not use metformin (OR: 0.38; 95%CI: 0.21-0.67). Several meta-analyses have strongly reinforced PDAC risk reduction with metformin use in patients with DM2[18,125-127]. However, this effect should prospectively be confirmed in large prospective clinical trials.

Regarding survival, in a retrospective study, Sadeghi et al[128] reported a 36% lower risk of death (HR: 0.64; 95%CI: 0.48-0.86), OS benefit of 4 mo (15.2 mo vs 11.1 mo) and approximately 2-fold increase in 2-year survival rate (30.1% vs 15.4%) in patients who took metformin compared to those inpatients who did not take metformin. Interestingly, longer survival was only observed in non-metastatic disease, when stratified by disease stage[128]. Further evidence also encountered survival improvement in the subgroups of resected or locally advanced but not in patients with metastatic disease[129]. Specifically, among resected patients with PDAC, metformin use seemed to improve OS after 18 mo[130-132]. Related to locally advanced or metastatic disease, further evidence was contradictory on survival gains in patients with PDAC exposed to metformin with benefit being reported only in an Asian cohort[133-135]. A large meta-analysis analyzed data from 12 retrospective cohorts demonstrating OS improvement in metformin users at various stages (HR: 0.77; 95%CI: 0.68-0.87)[136].

Stimulated by this retrospective evidence, two European groups explored, in randomized clinical trials (RCTs), the association of metformin with gemcitabine-based chemotherapy as first-line treatment of advanced PDAC with negative results on OS improvement[137,138]. Recently, a meta-analysis, with inclusion of two RCTs, re-analyzed the improvement in OS and confirmed benefit in the whole population of diabetic patients with PDAC (HR: 0.86; 95%CI: 0.76-0.97)[139]. Analysis of subgroups in this study demonstrated improved survival in patients with resected or locally advanced tumors but not in the metastatic group. Similar results were observed in another group with a benefit in OS at various stages, which was more evident in the subgroups of less advanced stages and Asian patients[140]. Considering second-line treatment, a single arm prospective study did not reach survival gain of metformin associated to paclitaxel[141]. Results of ongoing clinical trials recently completed are expected with substantial interest. NCT01666730 explores overall survival improvement of metformin associated with modified FOLFOX6 in metastatic patients, NCT02005419 evaluates DFS at 1 year with the combination of metformin and gemcitabine in resected subjects and NCT02048384 analyses safety of metformin with or without rapamycin after disease stabilization on first line chemotherapy in metastatic individuals.

This clinical evidence is associated with the pre-clinical data that pancreatic cancer cells are sensitive to inhibition of oxidative phosphorylation, decreases in insulin-IGF signaling and inhibition of the mTOR pathway through AMPK activation, which are some of the major antineoplastic effects of metformin[39,142-145]. Identifying predictive or prognostic factors of response to metformin should be of relevance to select patients most likely to benefit from the effects of metformin[39]. Recent advances in molecular characterization might distinguish different biology and response to therapy in patients with morphologically similar PDAC and may be incorporated into clinical trials[146-148]. Moreover, the recently experienced challenge of standard of care in advanced pancreatic cancer treatment with polychemotherapy also brings new perspectives, as patients experience longer survival with the need to combine other active agents[149,150]. Future trials would include disease stage, identification of biomarkers and concentrations of metformin in neoplastic tissue to powerfully evaluate the benefit of metformin in the treatment of PDAC.
Another pancreatic neoplasm with rising incidence is pancreatic neuroendocrine tumors (panNETs)[151]. Few studies have evaluated the clinical benefit of metformin in the treatment of panNETs[152]. Pusceddu et al[153], in a multicentric retrospective cohort of patients receiving everolimus with or without somatostatin analogues, reported increased PFS in diabetic patients exposed to metformin compared to diabetic patients not exposed to metformin or non-diabetic patients [44.2 vs 20.8 mo (HR: 0.49; 95%CI: 0.34-0.69) or 15.1 mo (HR: 0.45; 95%CI: 0.32-0.62), respectively][153]. This result correlates with in vitro evidence that metformin decreases proliferation in human panNET cell lines[154,155]. A recent study demonstrated that the combination of metformin and everolimus strongly inhibited human panNET cell proliferation through mTOR suppression, compared to each agent used alone[156]. Results of the ongoing NCT02294006 prospective trial are expected to better evaluate the effects of this experimental treatment on PFS at 12 mo.

**Metformin and hepatocellular carcinoma**

The incidence of hepatocellular carcinoma (HCC) has strongly increased in last two decades, as well as the prevalence of its metabolic risk factors[156,157]. Hassan et al[158] and Donadon et al[159], in hospital-based case-control studies, first observed the strong association of metformin use and reduced risk of HCC in subjects with DM2 (HR: 0.15; 95%CI: 0.04-0.50) (HR: 0.30; 95%CI: 0.20-0.60)[156,158,159]. This protective effect was validated by accumulated evidence of observational studies including more than 0.5 million subjects (OR: 0.52; 95%CI: 0.40-0.68), being more evident in case-control than in cohort studies and without significance in the post hoc analysis of RCTs[160-162]. These data suggest an association between metformin use and reduced HCC incidence that needs to be confirmed in prospective clinical trials.

Improvement in HCC survival was first reported by Chen et al[163] in an early-stage cohort of patients treated with radiofrequency ablation with longer OS in metformin users compared to non-users (HR: 0.24; 95%CI: 0.07-0.90)[163]. A meta-analysis of 11 cohort studies was in accordance with better prognosis related to metformin use in patients with HCC related to their counterparts (HR: 0.59; 95%CI: 0.42-0.83)[164].

Although the antineoplastic effects of metformin in liver cancer are not completely understood, pre-clinical evidence observed inhibition of proliferation and induction of cell cycle arrest and apoptosis in HCC cells through AMPK activation[165,166]. Future prospective trials should explore the potential benefit of metformin in prevention and treatment of HCC.

**Metformin and intrahepatic cholangiocarcinoma and gallbladder cancer**

Intrahepatic cholangiocarcinoma (ICC) is the second most common hepatic cancer, and its incidence has markedly increased in the last decades[167]. Chaiteerakij et al[168], in a clinic-hospital-based retrospective cohort, reported 60% reduced risk of ICC in patients with DM2 who used metformin related to non-users (OR: 0.4; 95%CI: 0.2-0.9)[168]. The same group, however, did not encounter better prognosis in patients with DM2 with ICC taking metformin (HR: 0.8; 95%CI: 0.6-1.2)[169]. Although gallbladder cancer (GBC) is the most common biliary tract cancer[170], no clinical data and scarce basic evidence have explored the antineoplastic effects of metformin and its potential mechanisms of action in GBC.

Regarding comprehension of the possible mechanistic effects of metformin on ICC and GBC there are some in vitro and in vivo evidence. Overall, the studies observed the induction of apoptosis and cell cycle arrest mediated by activation of the AMPK-mTOR axis[171-173]. The association of metformin in combination with gemcitabine and cisplatin (the standard of care for advanced ICC) enhanced the antiproliferative effects of treatment in a cell model through their effects on AMPK, cyclin D1 and caspase-3[174]. Furthermore, Liu et al[175] first observed the decreased survival of GBC cells via inhibition of phosphorylated Akt (p-Akt) and Bcl-2 signaling[175]. Likewise, metformin inhibited GBC cell proliferation via downregulation of HIF-1α and VEGF and promoted cell cycle arrest by reduction of cyclin D1 expression in different animal experiments[176,177]. The association of metformin with cisplatin also promoted reduced expression of p-Akt and cyclin D1 downregulation, resulting in a synergistic antiproliferative effect in GBC cells[178].

These pre-clinical and preliminary clinical evidence highlights the need for metformin to be more deeply explored in clinical studies of ICC and GBC prevention and treatment. Considering the rationale that metformin may be active in the prevention and treatment of ICC and limited clinical data, exploratory studies should address this issue for a better understanding of its benefit in these clinical settings.
PERSPECTIVES

DS tumors are often associated with high morbidity and mortality and their incidence has increased over recent decades[179]. Recognition of its main risk factors and conditions of worse prognosis as well as development of strategies for prevention and treatment urges. In this context, projection of a worldwide burden of cancer attributable to diabetes and excess weight for the near future is an alarming public health concern[180]. Association of several cancers, including many DS tumors to diabetes and obesity have already been recognized (IARC, WCRF). Further strategies of prevention and treatment urge to be known. The large amount of evidence presented herein supports the idea of an important effect of metformin in decreasing risk and improving prognosis of several DS tumors.

Although most clinical studies presented here are retrospective that are often limited by immortal time and selection bias, recent discoveries of pre-clinical research on antineoplastic effects of metformin establish biological plausibility for the clinical data and reinforce the interest on its effects in carcinogenesis and cancer progression. These preclinical and clinical evidence supports running of adequately powered trials to investigate clinical use of metformin on DS tumors treatment. This should consider diabetic status, predictive biomarkers, disease stage and treatment setting. Concerning chemoprevention, safety, low cost, and widespread access are key to its feasibility. Therefore, repurposing metformin for DS cancer treatment is a scientific field of remarkable interest as it focuses on a global public health problem.

Currently, clinical research is considered a job with its inherent needed professional skills[181]. Taking in consideration that the low metformin cost does not impact the expensive process of drug repurposing, the development of this potential anti-cancer drug has been hampered. Moreover, the current stage of metformin clinical development needs testing in large, randomized, genome-guided, multicenter trials. These aspects explain, at least in part, the shortage of current studies on metformin in cancer prevention and treatment despite the large number of pre-clinical and clinical evidence indicating its potential benefit. We hope that this comprehensive review integrating the potential mechanisms, pre-clinical and clinical studies of metformin as anticancer agent alert the DS cancer community for the need of studying metformin effects in more specific clinical scenarios.

CONCLUSION

The remarkable intracellular pathway change caused by oncogenesis and the potential mechanisms of the antitumoral action of metformin have been supported. They have revealed novel target molecules and newly discovered treatment possibilities. In connection with epidemiological, pre-clinical, and clinical research, data support that metformin benefits some patients with DS tumors, requiring strict clinical trials to identify those who might obtain advantage from metformin combinations. Given that the survival outcomes are affected by a multitude of factors, such as cancer type, differentiation, staging and treatment, for adequately repurposing the use of metformin in DS cancers it is essential to take into consideration patient characteristics that may serve as predictive biomarkers of metformin antitumoral effects, such as insulin resistance, diabetes, body composition, and chronic diseases related to inflammation, as well as the specific tumor driven oncogenic pathway, which may interfere with the direct and indirect antitumoral effects of metformin.

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Metformin effects on GI cancers


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identify molecular subtypes of pancreatic cancer.


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