



EDITORIAL

Endocrinologist and oncologist, a friendship under construction about obesity[☆]



Endocrinólogo y oncólogo, una amistad en construcción a propósito de la obesidad

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The professional cooperation of endocrinologists and oncologists has traditionally been focused on nutritional support to patients with advanced cancer and in multidisciplinary management of patients with some types of endocrine neoplasms. However, in addition to these areas of interest, an increasing evidence accumulated in recent years suggests the need for a coordinated approach to the care of patients with obesity and cancer.¹

People with obesity have a greater risk of cancer.² The types of cancer most commonly related to obesity are those of colon, kidney, endometrium, breast in postmenopausal women, pancreas, liver, and esophageal adenocarcinoma. Obesity has also been related to an increased risk of other types of neoplasms such as those of the thyroid gland, gallbladder, cardia, lymphoma, prostate, and meningioma.³ Moreover, some studies have shown a relationship between

cancer and abdominal obesity, and also with weight gain.¹ Because of this close relation, in the complete work-up of subjects with obesity, in addition to early detection of diseases classically associated to excess weight, type 2 diabetes mellitus, dyslipidemia, high blood pressure, non-alcoholic fatty liver disease, or sleep apnea–hypopnea syndrome, we should maintain a high index of suspicion for the most common cancers.⁴ In fact, “incidental” detection of cancer in obese patients is increasingly common.

Also because of this close association, endocrinologists and oncologists should cooperate in the campaigns for early detection of some of the most common cancers in the general population. The objective should be to screen people with obesity for certain types of cancer, and endocrinologists may play a key role in this area.

In basic research, and in basic-clinical research, many of the mechanisms involved in the pathophysiology of obesity and oncology are common.⁵ Some examples include hyperinsulinism, low grade inflammation, hyperestrogenism, or activation of pathways such as mTOR (intermediate mammalian target of rapamycin).⁶ Thus, in basic-clinical research, obesity and oncology researchers are bound to cooperate to promote synergies and greater scientific efficiency. Such synergies may undoubtedly contribute to advances in understanding of those diseases.

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In the clinical activity area, the most important challenge we face in obesity and cancer is treatment of obesity in cancer patients with long survival.⁷ Because of the extraordinary advances in early detection, diagnosis, and treatment of cancer, there is an increasing number of “long cancer survivors”. In these subjects, obesity causes a poorer quality of life⁸ and greater risks of suffering cardiovascular diseases and a relapse of the initial cancer, or developing a second neoplasm.⁹ Thus, treatment of obesity should be a priority in long cancer survivors, and requires optimum collaboration of oncologists and endocrinologists. On the one hand, oncologists should be made aware of the importance of detecting obesity in patients with cancer either in the active treatment or long survival phases. In the treatment phase, obesity may require adaptation of the different treatment modalities.¹⁰ The long survival phase, in which the patient has overcome cancer and can hope to have a good quality of life, provides a very good opportunity to address treatment of obesity. At this stage, advice from oncologists, as key physicians in cure of the disease, will be highly credible and convincing.⁷ Oncologists will be essential to make patients aware of the need to lose weight in order to decrease the risk of relapse or second malignancies. Advice in this regard should however be accompanied by adequate care, and this is the sense of the title of this editorial: “a friendship under construction about obesity”. We should design and implement recommendations, protocols, and clinical procedures to treat obesity in cancer patients, adapted to the different types of cancer, to the degree of obesity, and to other clinical characteristics.¹¹ Treatment of obesity in clinical practice is often difficult, but even more under these circumstances, in which it is badly needed.

Oncologists should therefore inform patients on the relationship between obesity and different types of cancer, and remind them that it is important to lose weight, because obesity is also associated to a high risk of recurrence and mortality related to cancer.⁷ In addition, obesity interferes with the effectiveness of systemic therapies, contributes to morbidity of treatments, and increases the risk of second neoplasms.³ Obesity is one of the comorbidities with greater impact on prognosis. Obese patients have greater rates of complications related to surgery.¹² In the most common types of cancer, obesity is associated to a higher rate of biochemical recurrence and to greater specific mortality.¹² In patients with long-term survival after cancer remission, control of various health problems, such as obesity, becomes very important. Dietary intervention and physical activity are very important in cancer survivors because they will have a substantial impact on reduction of recurrence, second neoplasms, and deaths from cancer. The transition of cancer patients to a survivor status is an adequate time for educating them on the lifestyle changes that may help decrease the risk of recurrence and associated diseases, and improve their quality of life.³

Readers may be thinking that this new area of competence cannot be assumed because of the permanent care overload. In obesity care, this new area will be added to those of severe obesity requiring bariatric surgery, obesity related to other diseases, or the strong social demand for specialized management of simple obesity. In hospital nutrition, it will be added to nutritional support in cancer with malnutrition. The potential care overload should not make

us panic, because rationalization of this care area, including all possible agents involved, may be very useful. Oncologists play a key role, as they detect obesity and advise patients on the need for treatment.⁷ Depending on the complexity of the case, the sequelae of cancer treatment, and the diseases associated to obesity, treatment prescription may be stratified into different care levels, from primary care teams, through oncology nurses and psychologists providing support to the oncology and endocrinology departments, to endocrinologists and dietitians.¹³ Availability of specific programs for management of obesity in different types of cancer, prepared and agreed by all the above mentioned health care professionals, would be very important.^{14,15}

Luckily, the “friendship under construction” is already underway. The Spanish Society for the Study of Obesity and the Spanish Society of Medical Oncology have implemented the collaborative program OBEyCAN. The first result of OBEyCAN has been the publication of two consensus documents that represent a significant contribution in this field.^{3,13} These documents report the research made on the epidemiological and pathophysiological relations between obesity and cancer³ and lay the foundations for medical care in the different clinical settings.¹³ There is still a long way to go, but we have already started, with enthusiasm and rigor, to construct this friendship between endocrinologists and oncologists.

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