Genetic Alterations Detected in Cell-free DNA are Associated with Enzalutamide and Abiraterone Resistance in Castration-resistant Prostate Cancer

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# SUPPLEMENTAL MATERIALS AND METHODS

### Patients

This prospectively collected biomarker study was approved by the Johns Hopkins Medicine Institutional Review Board (IRB). All patients provided written informed consent prior to enrollment. Patients had histologically confirmed prostate adenocarcinoma, progressive disease despite ADT, and documented metastatic disease by computed tomography (CT) or bone scan with technetium-99mm-labeled methylene diphosphonate. Eligibility criteria included patients diagnosed with mCRPC who were about to begin either abiraterone or enzalutamide therapy. 70 patients were prospectively enrolled between September 2014 and June 2017 at the Johns Hopkins Hospital (Baltimore, MD) and Sibley Memorial Hospital (Washington, D.C.) and followed through April 2018. Of the 70 enrolled patients with mCRPC who were about to begin either abiraterone or enzalutamide therapy, three patients were excluded due to concurrent treatment with other therapies (Veliparib or Docetaxel). Five eligible patients were excluded due to the absence of clinical follow-up data. Blood and clinical follow-up data were obtained for the remaining 62 patients. Blood was collected prior to initiation of therapy for all patients with most pre-therapy samples collected within one week prior to start of therapy (median collection day was on the day of therapy initiation). Patients were treated with enzalutamide (n=25), abiraterone + prednisone (n=35), or concurrent enzalutamide plus abiraterone + prednisone (n=2).

## **Study Endpoints**

Study endpoints were PSA response, PFS, and OS. PSA response was defined by a  $\geq$ 50% decline in PSA from pre-therapy baseline PSA. A  $\geq$ 30% decline in PSA from pre-therapy baseline PSA

was also evaluated. Progression was defined by an increase in PSA by  $\geq 25\%$  above the baseline or nadir PSA, radiographic progression, or death from prostate cancer. PSA increase by  $\geq 25\%$ above the baseline or nadir PSA was confirmed by a subsequent PSA increase, radiographic progression, death from prostate cancer, or physician-determine change of therapy. PFS was defined by the time to the first of the following events: an increase in PSA by  $\geq 25\%$  compared to baseline or nadir PSA, radiographic progression, or death from prostate cancer. Blood was also collected following PSA increase from nadir prior to change in therapy for 26 of the 35 patients who had a decrease in PSA following therapy and then progressed as determined by an increase in PSA by  $\geq 25\%$  above the baseline or nadir PSA, radiographic progression, or death from prostate cancer.

#### **Sample Collection**

Three, 10mL blood samples were collected in Streck BCT tubes prior to therapy initiation and if applicable, at progression. Blood was stored at room temperature and then processed for plasma isolation within 24 hours. To optimize patient sample integrity and to limit DNA contamination, plasma was extracted in a bleach- and ultraviolet (UV)-cleaned hood specifically for plasma extraction in a room dedicated for blood processing, storage, and cfDNA isolation. Plasma was extracted from blood by centrifugation for 10 minutes at 1,500 x g followed by a second centrifugation for 10 minutes at 3,000 x g as previously described<sup>1-4</sup>. Plasma was stored at -80°C in 1.5mL aliquots. In a dedicated bleach- and UV-cleaned hood, cfDNA was extracted from 3mL plasma using the QIAamp Circulating Nucleic Acid Kit (Qiagen) per the manufacturer's protocol. To limit cross-contamination, samples were processed individually.

#### Deep NGS

GeneRead<sup>™</sup> DNAseq Custom Mix and Match Targeted Panel V2 (Qiagen) (46 genes; 352,096 bases; Data Supplement) was used to prepare libraries from cfDNA for NGS as per the manufacturer's protocol. NGS libraries were prepared in a dedicated bleach- and UV-cleaned hood. cfDNA was quantified using Qiagen's QIAseq<sup>™</sup> DNA QuantiMIZE Assay (DNQC-100Y-F) as per the manufacturer's protocol. Between 0.5 and 40.0ng of cfDNA was used for library generation. Samples were PCR-amplified using Qiagen's GeneRead<sup>™</sup> DNAseq Panel PCR Reagent V2 (Cat. #181942) for 18-22 cycles depending on input concentration as per the manufacturer's protocol. PCR panel amplicons were purified using AMPure XP beads (Beckman Coulter, Cat. #A63880) and then quantified by the Agilent 2100 Bioanalyzer, Qiagen's GeneRead<sup>™</sup> DNA Library Prep I Kit (Cat. #180435) and GeneRead<sup>™</sup> Adapter I Set A 12-plex (Cat. #180985) were used to construct all libraries according to the manufacturer's instructions. Purified libraries were amplified using Qiagen HiFi PCR Master Mix for 5 cycles according to the manufacturer's instructions. Prepared libraries were quantified using QIAseq<sup>TM</sup> Library Quant Assay (Qiagen; QSTF-ILZ-F or NGTF-ILZ-R). NGS was performed on the Illumina Hi-Seq with a median on-target coverage of 6,631x.

#### **Sequence Alignment and Analysis of Variants**

Raw sequencing data was aligned to Human Genome (build GRCH37.p13/hg19) reference<sup>5</sup> using BWA aligner (v0.7.10)<sup>6</sup>. Post-alignment data was passed through Picard Tools (V1.125]<sup>7</sup> to assess the alignment quality. Quality-controlled alignment data was employed to call the variants using an in-house variant caller, MDLVC, which scans through the alignment data for raw variants. Resulting raw variant calls were further applied with various filters including

minimum base quality of q25, minimum base depth of 25, strand bias threshold, and allele frequency of  $\geq 1\%$  with the exception of AR which had an allele frequency threshold of  $\geq 0.5\%$  as validated previously<sup>3</sup>. In addition to the above filters, false positive variant calls arising due to the given sequencing run were assessed, tracked, and filtered out using 11 negative controls sequenced in this study. Variant calls that were coding silent or that were designated as common in populations by dbSNP<sup>8</sup>, EXaC<sup>9</sup>, TCGA<sup>10</sup>, and ClinVar<sup>11</sup> reference databases were excluded from analyses. ClinVar was used to determine pathogenicity of missense mutations<sup>11</sup>. Missense mutations that were pathogenic or likely pathogenic by ClinVar were used for analyses. Highconfidence somatic variants were further annotated with information from COSMIC<sup>12</sup>, Mutation Assessor, and cBioPortal<sup>13</sup>. Final variant calls were visualized and assessed further for validity using Integrated Genome Viewer (IGV)<sup>14</sup>. For patients with allelic fractions of ClinVar pathogenic or likely pathogenic *BRCA1* or BRCA2 mutations that were  $\geq 20\%$ , germline information was obtained through clinical records or by sequencing germline leukocyte DNA obtained from isolated buffy coat. Finally, samples with low input for NGS, the lack of genetic alteration detection was considered indeterminate as opposed to negative.

#### **CN Variation**

NGS-based CN detection was performed using an in-house developed algorithm, TMM-CNV and third-party tool, CNVKit<sup>15</sup>. TMM-CNV calculates trimmed mean and corresponding two standard deviations from mean relative coverage depths obtained for the sample and a mean of multiple references including sequence of 9 healthy controls (pool of controls). Data distribution at the gene level was used to apply a trimmed mean of 0.2, 0.1 and corresponding standard deviation to calculate and set the lower and upper thresholds for calling focal deletions and focal amplifications respectively. For autosomes a  $\log_2$  value of mean relative coverage depth between sample and pool of controls was used, whereas for chromosome X, a logarithmic value of mean relative coverage depth between sample and pool of controls was used. Final copy number calls between TMM-CNV and CNVKit were compared for consensus. Final copy number calls were visualized and assessed further for validity using the in-house MDLVC. Conservative thresholds based on heterozygous SNP fractions of control cfDNA were used to call CN gain and deletion. Given that it is targeted, gene panel sequencing and tumor cellularity varies in cfDNA sequencing, two thresholds were applied to detect copy gains and losses. CN gain for autosomes was defined by a  $\log_2$  ratio of mean relative sequencing coverage at the gene level  $\geq 0.4$  and  $\geq$ 1.2. CN loss for autosomes was defined by a  $\log_2$  ratio of mean relative sequencing coverage at the gene level  $\leq -0.4$  and  $\leq -1.0$ . For chromosome X, CN gain was defined by a logarithmic ratio of mean relative sequencing coverage at the gene level  $\geq 0.4$  and  $\geq -1.0$ .

#### **Estimation of ctDNA Fraction**

Estimation of high verse low ctDNA fraction was based upon both mutant allele fraction (MAF) and CN alterations. The fraction of ctDNA (% ctDNA) was estimated based upon the highest autosomal variant allele fraction. ctDNA burden was dichotomized into high and low for statistical analyses. Patients with low ctDNA burden had a ClinVar-annotated pathogenic or likely pathogenic missense mutation or truncating mutation MAF < 7%. Conversely, patients with a high ctDNA burden had a ClinVar-annotated pathogenic missense mutation or truncated pathogenic or likely pathogenic missense mutation MAF  $\geq$  7% and/or a CN loss  $\leq$  -0.55 and/or a CN gain  $\geq$  1.0.

#### **Statistical Analyses**

Sample size estimate of 60 informative patients was calculated prior to study initiation. Power and confidence bounds were calculated using PASS 11 (NCSS Software). Chi-squared tests and logistic regression were used to determine associations between genomic status and PSA response. Kaplan-Meier methods and log-rank tests were used to estimate survival functions. Cox proportional-hazard modeling was used to estimate PFS and OS. Due to small sample size, clinical variables were dichotomized. PSA was dichotomized at 20ng/mL based on the median PSA of 19.3ng/mL. Age was dichotomized at 72 years based on the median age of 71.5 years. Prior abiteraterone and enzalutamide was dichotomized as yes or no, visceral metastasis was dichotomized as yes or no, and ctDNA burden was dichotomized as low or high. Multivariable models included only two variables to reduce the likelihood of overfitting. Statistical analyses were performed using STATA SE/15.1, and GraphPad Prism 5 was used for figure generation.

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#### SUPPLEMENTAL FIGURE LEGENDS

**Supplemental Figure S1.** PSA response and PFS were similar between patients on abiraterone + prednisone and patients on enzalutamide. A, Waterfall plot of best PSA response for patients receiving abiraterone + prednisone therapy (n=35) as determined by best percentage fold change in PSA. B, Waterfall plot of best PSA response for patients receiving enzalutamide therapy (n=25) as determined by best percentage fold change in PSA. Chi-squared analysis of PSA response in patients receiving abiraterone + prednisone compared to patients on enzalutamide (P=0.583). C, Kaplan-Meier method and log-rank test to determine median time to progression for patients who were treated with abiraterone + prednisone (n=35) compared to patients who were treated with enzalutamide (n=25) therapy (26.1 weeks vs. 24.7 weeks; P=0.645). D, Kaplan-Meier method and log-rank test to determine to progression for patients who had prior abiraterone + prednisone or enzalutamide therapy (n=15) compared to patients who were abiraterone + prednisone and enzalutamide therapy (n=47) (17.9 weeks vs. 26.0 weeks; P=0.660).

**Supplemental Figure S2**. Genetic alterations detected in cfDNA following progression. Genetic alterations (CN status, ClinVar pathogenic/likely pathogenic missense and germline mutations, and truncating mutations) in 46 genes detected by NGS of cfDNA from 26 patients following progression on abiraterone + prednisone or enzalutamide therapy.

**Supplemental Figure S3.** A, Pre-therapy PSA is associated with cfDNA concentration prior to therapy as determined using Pearson correlation (r=0.40; *P*=0.002). Pre-therapy PSA was

compared with the amount of cfDNA isolated per 1.0mL plasma prior to therapy. B, PSA for a patient progressing on abiraterone + prednisone with a detectable AR L702H mutation and then switched to abiraterone + dexamethasone.

**Supplemental Figure S4:** Mutations detected in *BRCA1*, *BRCA2*, and *ATM* prior to therapy and at progression. A-C, Gene schematics illustrating deleterious germline and somatic mutations in (A) BRCA2 (B=BRC repeats, Helical=helical domain, Oligo=oligonucleotide binding domain, T=tower domain), (B) BRCA1 (R=Ring finger domain, Serine=Serine rich domain associated with BRCT, BRCT=BRCA1 C terminus domain) and (C) ATM (TAN=Telomere length maintenance and DNA damage repair, FAT=FAT domain, PI3,4K=Phosphatidylinositol 3- and 4-kinase, FC=FATC domain) and as detected by deep, targeted NGS of cfDNA prior to abiraterone + prednisone and enzalutamide therapies and at progression while on therapy.

Supplemental Table S1: Qiagen Mix and Match Panel					
AR	BRCA1	POLH	CDH1		
NCOA2	BRCA2	POLE	MET		
TP53	ATM	POLD1	SPOP		
RB1	ATR	MLH1	POU6F2		
MYC	CHEK2	MLH3	SCN11A		
CDKN1B	PALB2	MSH2	GNAS		
PTEN	NBN	MSH3	MED12		
PIK3CA	CDK12	PMS2	ZFHX3		
AKT1	FANCG	KDM6A	IDH1		
AKT2	FANCM	KMT2C	IDH2		
APC	ERCC3	KMT2D			
CTNNB1	ERCC5	GLI1			

Supplemental Table S2. Patient Samples with AR Genetic Alterations							
			Pre-therapy (n=62)		Progression (n=26)		
AR Genetic Alteration, n (%) 34 (54.8		34 (54.8)		15 (57.7)			
AR Copy N	umber Gain, n (%)		32 (51.6)		15 (57.7)		
AR Mutation	n, n (%)		8 (12.9)			4 (15.4)	
≥2 AR Muta	itions, n (%)		0 (0)		1 (3.8)		
AR Copy N	umber Gain and Mutat	ion, n (%)	6 (9.7)			4 (15.4)	
		Pre-therapy				Progression	
Patient	AR LBD Mutation	Allelic Fraction (%)	ctDNA Low vs. High	Therapy	AR LBD Mutation	Allelic Fraction (%)	ctDNA Low vs. High
26	W742C	1.4	Low	ENZA	No Response		
38	-	-		ABI	L702H T878A	1.5 9.4	High
52	-	-		ABI	L702H	18.5	High
54	T878I	0.8	Low	ABI	No Response		
63	H875Y	0.6	Low	ABI	No Sample		
70	L702H	74.6	High	ENZA	No Response		
82	T878A	1.3	High	ABI	No Response		
83	L702H	27.3	High	ENZA	No Response		
86	-	-		ENZA	H875Y	1.3	Low
91	-	-		ABI	T878A	1.7	Low
97	V731M	1.5	High	ABI	No Response		
105	H875Y	5.3	Low	ABI	No Sample		
AR: androg	gen receptor; LBD: liga	and binding domain.					

#### Supplemental Table S3. Response to Therapy: Univariate Logistic Regression Analyses (n=62)

			Univariate	
		≥30% Decrease in PSA from Baseline		
	Patients (n)	0R	95% CI	Р
Prior Abiraterone or Enzalutamide	15	1.54	0.48-5.01	0.469
PSA ≥20 ng/mL	30	1.46	0.52-4.07	0.470
Age ≥72 years	32	1.18	0.42-3.29	0.749
Visceral Metastasis	6	0.77	0.13-4.58	0.776
ctDNA High	27	3.61	1.24-10.56	0.019
AR CN Gain and/or LBD Mutation	34	1.67	0.59-4.73	0.337
AR LBD Mutation	8	6.00	1.10-32.76	0.039
AR CN Gain	32	2.06	0.72-5.85	0.176
TP53 Mutation and/or CN Loss	23	1.37	0.48-3.94	0.554
RB1 Mutation and/or CN Loss	17	2.25	0.72-7.01	0.162
TP53 and RB1 Mutation and/or CN Loss	6	9.74	1.06-89.40	0.044
PI3K Pathway Defect	15	7.19	1.94-26.68	0.003
WNT Pathway Defect	9	3.89	0.87-17.39	0.076
BRCA1/BRCA2/ATM Mutation and/or CN Loss	24	1.63	0.57-4.63	0.362
BRCA1/BRCA2/ATM Truncating Mutations	14	1.25	0.37-4.19	0.718

Significant *P* values in bold. OR: odds ratio; CI: confidence interval; PSA: prostate-specific antigen; ctDNA: cellfree tumor DNA; AR: androgen receptor; CN: copy number; LBD: ligand binding domain; TP53: tumor protein 53; RB1: retinoblastoma-associated protein 1; PI3K: phosphoinositide 3-kinase; WNT: wingless-type MMTV integration site; BRCA1/2: breast cancer gene 1/2; ATM: ataxia-telangiectasia mutated gene.

#### Supplemental Table S4. Response to Therapy: Multivariable Logistic Regression Analyses (n=62)

		Multivariable		
		≥30% Decrease in PSA from Baseline		
	Patients (n)	0R	95% CI	Р
AR LBD Mutation	8	6.52	1.10-38.67	0.039
ctDNA High	27	3.81	1.23-11.78	0.020
AR LBD Mutation	8	5.76	1.02-32.60	0.048
Prior Abiraterone or Enzalutamide	15	1.15	0.32-4.12	0.827
AR LBD Mutation	8	6.28	1.13-34.79	0.036
Prior Abiraterone, Enzalutamide, and/or Chemotherapy	25	0.73	0.24-2.21	0.578
AR LBD Mutation	8	5.78	1.05-31.79	0.044
PSA ≥ 20 ng/mL	30	1.32	0.45-3.84	0.616

Significant *P* values in bold. PSA: prostate-specific antigen; OR: odds ratio; CI: confidence interval; AR: androgen receptor; ctDNA: cell-free tumor DNA; LBD: ligand binding domain.

#### Supplemental Table S5. Progression-free Survival: Multivariable Logistic Regression Analyses (n=62)

			Multivariable	
	Patients (n)	HR	95% CI	Р
AR LBD Mutation	8	2.51	1.15-5.45	0.020
ctDNA High	27	1.81	1.05-3.10	0.032
AR LBD Mutation	8	2.40	1.11-5.17	0.025
Prior Abiraterone or Enzalutamide	15	1.18	0.64-2.17	0.600
AR LBD Mutation	8	2.45	1.13-5.31	0.024
Prior Abiraterone, Enzalutamide, and/or Chemotherapy	25	1.13	0.65-1.95	0.674
AR LBD Mutation	8	2.42	1.12-5.23	0.024
PSA ≥ 20 ng/mL	30	1.00	0.999-1.001	0.666

Significant *P* values in bold. PSA: prostate-specific antigen; HR: hazards ratio; CI: confidence interval; AR: androgen receptor; ctDNA: cell-free tumor DNA; LBD: ligand binding domain.

Supplemental Table S6. Overall Survival: Multivariable Logistic Regression Analyses (n=62)						
		Overall Survival				
	Patients (n)	HR	95% CI	Р		
TP53 Mutation and/or CN Loss	23	2.70	1.27-5.72	0.009		
ctDNA High	27	2.42	1.13-5.18	0.022		
TP53 Mutation and/or CN Loss	23	3.19	1.53-6.65	0.002		
Prior Abiraterone or Enzalutamide	15	1.52	0.71-3.25	0.283		
TP53 Mutation and/or CN Loss	23	3.05	1.44-6.46	0.003		
Prior Abiraterone, Enzalutamide, and/or Chemotherapy	25	1.24	0.59-2.59	0.592		
TP53 Mutation and/or CN Loss	23	3.10	1.49-6.48	0.003		
PSA ≥ 20 ng/mL	30	1.29	0.62-2.67	0.497		
TP53 and RB1 Mutation and/or CN Loss	6	4.56	1.78-11.71	0.002		
ctDNA High	27	2.99	1.40-6.36	0.005		
TP53 and RB1 Mutation and/or CN Loss	6	4.41	1.57-12.41	0.005		
Prior Abiraterone or Enzalutamide	15	1.04	0.44-2.46	0.935		
TP53 and RB1 Mutation and/or CN Loss	6	4.14	1.55-11.04	0.004		
Prior Abiraterone, Enzalutamide, and/or Chemotherapy	25	1.20	0.56-2.58	0.643		
TP53 and RB1 Mutation and/or CN Loss	6	4.24	1.64-11.00	0.003		
PSA ≥ 20 ng/mL	30	1.19	0.56-2.51	0.656		

Supplemental Table S7. Overall Survival: Multivariable Logistic Regression Analyses (n=62)					
		Overall Survival			
	Patients (n)	HR	95% CI	Р	
PI3K Pathway Defect	15	2.62	1.12-6.10	0.026	
ctDNA High	27	2.17	0.96-4.92	0.063	
PI3K Pathway Defect	15	3.50	1.59-7.71	0.002	
Prior Abiraterone or Enzalutamide	15	1.89	0.54-2.62	0.669	
PI3K Pathway Defect	15	3.45	1.58-7.54	0.002	
Prior Abiraterone, Enzalutamide, and/or Chemotherapy	25	1.29	0.62-2.68	0.502	
PI3K Pathway Defect	15	3.51	1.61-7.64	0.002	
PSA ≥ 20 ng/mL	30	1.23	0.59-2.57	0.579	

Significant P values in bold.

HR: hazards ratio; CI: confidence interval; PSA: prostate-specific antigen; ctDNA: cell-free tumor DNA; CN: copy number; PI3K: phosphoinositide 3-kinase.

Significant P values in bold.

HR: hazards ratio; CI: confidence interval; PSA: prostate-specific antigen; ctDNA: cell-free tumor DNA; CN: copy number; TP53: tumor protein 53.



# Progression



Supplemental Figure S2



# Supplemental Figure S3

