

ABSTRACT

Title of Thesis:

**PREDICTING CANCER PROGNOSIS AND
DRUG RESPONSE FROM THE TUMOR
MICROBIOME**

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Tumor gene expression is predictive of patient prognosis in some cancers. However, RNA-seq and whole genome sequencing data contain not only reads from host tumor and normal tissue, but also reads from the tumor microbiome, which can be used to infer the microbial abundances in each tumor. Here, we show that tumor microbial abundances, alone or in combination with tumor gene expression data, can predict cancer prognosis and drug response to some extent – microbial abundances are significantly less predictive of prognosis than gene expression, although remarkably, similarly as predictive of drug response, but in mostly different cancer-drug combinations. Thus, it appears possible to leverage existing sequencing technology, or develop new protocols, to obtain more non-redundant information about prognosis and drug response from RNA-seq and whole genome sequencing experiments than could be obtained from gene expression or mutation data alone.

**PREDICTING CANCER PROGNOSIS AND DRUG RESPONSE FROM
THE TUMOR MICROBIOME**

by

Leandro Cruz Hermida

Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
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Dedication

This thesis is dedicated first and foremost to my spouse, Aviel, and to my parents, for without their continual support, love, and help during difficult times none of this would have been possible.

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List of Abbreviations

<i>Abbreviation</i>	<i>Meaning</i>	<i>Page</i>
<i>16s-rRNA</i>	16S ribosomal ribonucleic acid	34
<i>ACC</i>	Adrenocortical carcinoma	17
<i>AUC^{C/D}(t)</i>	Time-dependent, cumulative/dynamic area under the curve	14
<i>AUROC</i>	Area under the receiver-operator characteristic curve	9
<i>AUPRC</i>	Area under the precision-recall curve	10
<i>BCR</i>	Balanced accuracy or balanced classification rate	10
<i>BH</i>	Benjamini-Hochberg	10
<i>BRCA</i>	Breast cancer	13
<i>CESC</i>	Cervical squamous cell carcinoma	13
<i>C-index</i>	Harrell's concordance index	8
<i>COAD</i>	Colon adenocarcinoma	32
<i>CPM</i>	Counts per million	7
<i>CR</i>	Complete drug response	4
<i>CV</i>	Cross validation	8
<i>EBV</i>	Epstein-Barr virus	34
<i>FDR</i>	False discovery rate	10
<i>GDC</i>	Genomic Data Commons	1
<i>LAML</i>	Acute myeloid leukemia	13
<i>LGR</i>	Logistic regression	5

<i>ML</i>	Machine learning	1
<i>NCI</i>	National Cancer Institute	1
<i>OS</i>	Overall survival	1
<i>PAAD</i>	Pancreatic adenocarcinoma	33
<i>PD</i>	Progressive disease (drug response)	4
<i>PFI</i>	Progression-free interval	1
<i>PR</i>	Partial drug response	4
<i>QL</i>	Quasi likelihood	6
<i>READ</i>	Rectum adenocarcinoma	32
<i>RFE</i>	Recursive feature elimination	5
<i>RNA-seq</i>	Ribonucleic acid sequencing	1
<i>SARC</i>	Sarcoma	13
<i>SD</i>	Stable disease (drug response)	4
<i>SNM</i>	Supervised normalization of microarrays	3
<i>STAD</i>	Stomach adenocarcinoma	5
<i>SVM</i>	Support vector machines	5
<i>TCGA</i>	The Cancer Genome Atlas	1
<i>THCA</i>	Thyroid carcinoma	17
<i>THYM</i>	Thymoma	28
<i>TMM</i>	Weighted trimmed mean of M-values	7
<i>UCEC</i>	Uterine corpus endometrial carcinoma	14
<i>UCSC</i>	University of California San Diego	4
<i>UUID</i>	Universally unique identifier	5

<i>WGS</i>	Whole genome sequencing	1
<i>WXS</i>	Whole exome sequencing	32

Chapter 1: Introduction

The Cancer Genome Atlas (TCGA), available from the NCI Genomic Data Commons (GDC)¹, provides RNA-seq and whole genomic sequencing (WGS) data for thousands of cases across dozens of cancer types. RNA-seq data is typically used to measure the expression of human genes, and there is a long history linking tumor gene expression to cancer outcomes²⁻⁸. Milanez-Almeida et al.⁹ recently showed that gene expression from TCGA RNA-seq data could predict overall survival (OS) or progression-free interval (PFI) better than classical clinical prognostic covariates – age at diagnosis, gender, and tumor stage. Importantly, Milanez-Almeida et al. used a data-driven machine learning (ML) based approach that selected features that were predictive of and correlated with prognosis, rather than approaches based on classical statistics or biological knowledge that chose features *a priori*.

While the human gut microbiome and its role in cancer initiation and progression has been studied extensively over the past decade¹⁰, only more recently has the scientific community focused on the potential importance of the intratumor microbiome. Research into the human tumor microbiome has been rapidly expanding, and multiple laboratories have attempted to utilize existing technologies and data to identify microbial species and quantify their abundance within human tumors compared to adjacent normal tissue. RNA-seq and WGS data not only contain human sequencing reads, but also reads from the local intratumor microbiome that are typically filtered out from the data when analyzing human gene expression or mutations. Poore et al.¹¹ recently developed a computational workflow, using two orthogonal microbial detection pipelines, to estimate, decontaminate, normalize, and batch effect correct microbial abundances from human high-throughput sequencing data. They applied this workflow to create a first-of-its-

kind comprehensive dataset of pan-cancer tumor microbial abundances derived from WGS or RNA-seq data for the entire TCGA cohort.

Our central research questions then were, 1) does a data-driven ML approach reveal that tumor microbial abundances in TCGA data, quantified from these reads, are predictive of cancer prognosis or drug response, 2) what microbial genera are potentially predictive biomarkers of prognosis or drug response, 3) how do these models compare to equivalent models based on tumor gene expression data, and 4) does combining both microbial abundance and gene expression features produce models and select combinations of gene and microbial genera features that are more predictive of prognosis or drug response than models from each individual data type? We used the processed microbial abundances directly from the Poore et al. dataset to build predictive models of prognosis and drug response for TCGA. We also used TCGA RNA-seq read counts to build equivalent predictive models for comparison. As a positive control, we also showed that our prognosis ML modeling methods, which differed somewhat from Milanez-Almeida et al.⁹, identified a similar set cancers and outcomes for which gene expression was predictive of prognosis.

Chapter 2: Results

Tumor microbial abundances are substantially less predictive of prognosis than gene expression

The analysis pipeline overview is outlined in **Fig. 1**. The pipeline has four major parts, 1) data download and preprocessing, 2) prognosis and drug response ML modeling, 3) model evaluation and scoring, and 4) feature analysis. A more detailed technical description of the analysis pipeline and computational methods is provided in the Methods chapter.

We built OS and PFI gene expression ML models of 32 TCGA tumor types (cohort information in **Supplementary Data 1**) using the Coxnet¹² algorithm, which jointly selects the most predictive subset of features via cross-validation (CV) while simultaneously being able to control for prognostic clinical covariates. In our models, we included and controlled for the clinical covariates age at diagnosis, gender, and tumor stage. For comparison, we also built standard Cox regression models based on the clinical covariates alone. We evaluated the predictive performance of our models using Harrell's concordance index (C-index), which is a metric of survival model predictive accuracy. Each model analysis generated 100 model instances and C-index scores from different randomly shuffled train-test CV splits on the data. We found 33 OS and PFI models for 21 tumor types that had a mean C-index score ≥ 0.6 and significantly outperformed their corresponding clinical covariate-only models (**Fig. 2a & c, 3a, 4a**). Our models were predictive of prognosis in 11 of the same 13 tumor types that were reported by Milanez-Almeida et al.⁹ (**Table 1**). We did not analyze one tumor type that Milanez-Almeida did, acute myeloid leukemia (LAML), because Poore et al. excluded it from their analysis. Among the cancers and outcomes that Milanez-Almeida et al. analyzed, our

methodology produced predictive models for four additional tumor types: breast cancer (BRCA), cervical squamous cell carcinoma (CESC), sarcoma (SARC), and uterine corpus endometrial carcinoma (UCEC), as well as quite a few predictive models for additional cancers and outcomes that were not analyzed in their study (**Table 1**). We also evaluated prognosis model performance by calculating the time-dependent, cumulative/dynamic area under the curve ($AUC^{C/D}(t)$)^{13,14}, which is an extension of the area under the receiver operating characteristic curve (AUROC) for continuous outcomes and can provide a more detailed resolution picture of predictive performance throughout the test outcome time range compared to the C-index score. Although 33 of our OS and PFI gene expression models had a statistically significant C-index score improvement compared to clinical covariates alone, only 22 of these models showed an improvement in $AUC^{C/D}(t)$, where the improvement in mean $AUC^{C/D}(t)$ over the entire test time range after diagnosis was ≥ 0.025 (**Fig. 3b, 4b**).

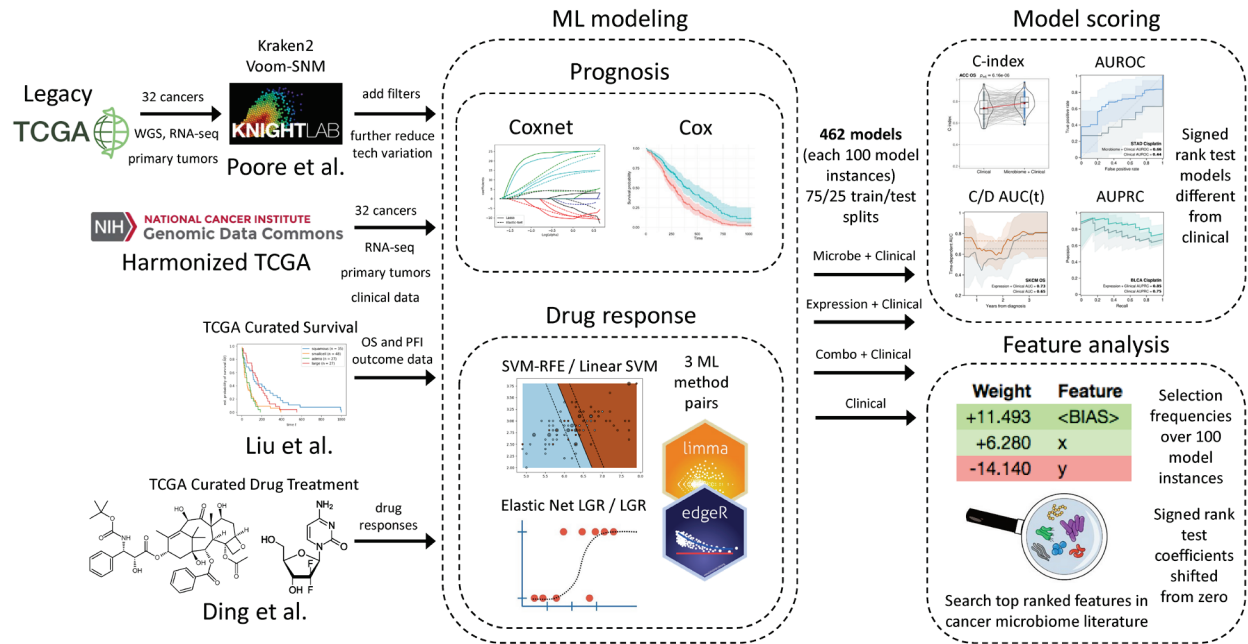


Figure 1. Analysis pipeline overview

Download and data preprocessing (**left**) of Poore et al. TCGA primary tumor Kraken2 Voom-SNM microbial abundances with additional filters to reduce technical variation, NCI Genomic Data Commons (GDC) harmonized TCGA primary tumor RNA-seq counts and clinical data, Liu et al. TCGA curated overall survival (OS) and progression-free interval (PFI) outcome data, and Ding et al. TCGA curated drug response clinical data. Prognosis machine learning (ML) modeling (**middle**) of microbial abundance, gene expression, and combined data types with clinical covariates for each cancer using penalized Cox with elastic net penalties (Coxnet) against matched clinical covariate-only models using standard Cox regression. Drug response classification ML modeling of same data types for each cancer using three ML approaches, 1) SVM-RFE, elastic net logistic regression (LGR), and limma-trend (microbial and combined data types) or edgeR (gene expression) differential analysis feature scoring and selection with L2-penalized LGR. Matched clinical covariate-only modeling performed with linear SVM and L2-penalized LGR, respectively. ML modeling generates 100 model instances for each model from 75/25 train/test randomly shuffled and stratified dataset splits. ML model instance scoring (**right top**) using concordance index (C-index) and time-dependent cumulative/dynamic AUC (C/D AUC(t)) for prognosis models and area under receiver-operating characteristic curve (AUROC) and area under the precision-recall curve (AUPRC) for drug response models. Significance of model performance improvement over matched clinical covariate-only model determined by signed rank test of C-index and AUROC scores between each matched model instance for prognosis and drug response models, respectively. Feature analysis (**right bottom**) performed using model instance coefficients and selection frequencies. Overall feature importance ranking and significance determined by signed rank test of model instance feature coefficients shifting from zero and top features filtered if selection frequency $\geq 20\%$.

Table 1. Prognosis model results comparison to Milanez-Almeida et al.

	Milanez-Almeida		Hermida & Gertz					
Cancer	Tested	Hit	Tested	Hit	Common Hit	New Hit	M-A Tested New Hit	Missing M-A Hit
ACC	OS	OS	OS, PFI	OS, PFI	OS	PFI		
BLCA	OS	OS	OS, PFI	OS, PFI	OS	PFI		
BRCA	PFI		OS, PFI	PFI		PFI	PFI	
CESC	OS		OS, PFI	OS, PFI		OS, PFI	OS	
CHOL	<i>EXCL</i>		OS, PFI					
COAD	OS		OS, PFI					
DLBC	<i>EXCL</i>		OS, PFI					
ESCA	OS		OS, PFI					
GBM	OS		OS, PFI					
HNSC	OS	OS	OS, PFI	OS	OS			
KICH	<i>EXCL</i>		OS, PFI					
KIRC	OS	OS	OS, PFI	OS, PFI	OS	PFI		
KIRP	OS	OS	OS, PFI	OS, PFI	OS	PFI		
LAML	OS	OS	<i>EXCL</i>					OS
LGG	PFI	PFI	OS, PFI	OS, PFI	PFI	OS		
LIHC	OS	OS	OS, PFI	OS, PFI	OS	PFI		
LUAD	OS	OS	OS, PFI	OS	OS			
LUSC	OS		OS, PFI	PFI		PFI		
MESO	OS	OS	OS, PFI	OS, PFI	OS	PFI		
OV	OS		OS, PFI					
PAAD	OS	OS	OS, PFI	PFI		PFI		OS
PCPG	<i>EXCL</i>		OS, PFI	OS		OS		
PRAD	PFI	PFI	OS, PFI	PFI	PFI			
READ	PFI		OS, PFI					
SARC	OS		OS, PFI	OS, PFI		OS, PFI	OS	
SKCM	<i>EXCL</i>		OS, PFI	OS, PFI		OS, PFI		

	Milanez-Almeida		Hermida & Gertz					
Cancer	Tested	Hit	Tested	Hit	Common Hit	New Hit	M-A Tested New Hit	Missing M-A Hit
STAD	OS		OS, PFI	PFI		PFI		
TGCT	OS		OS, PFI					
THCA	PFI		OS, PFI					
THYM	PFI		OS, PFI	OS		OS		
UCEC	OS		OS, PFI	OS, PFI		OS, PFI	OS	
UCS	OS		OS, PFI					
UVM	OS	OS	OS, PFI	OS, PFI	OS	PFI		

We applied Coxnet¹² using the same methodology to build prognosis models using the microbial abundance estimates provided by Poore et al.¹¹. We found six microbial abundance models that had a mean C-index score ≥ 0.6 and significantly outperformed their corresponding clinical covariate-only models (**Fig. 2b & c, 5a**). We found that in only two of the six models, microbial abundances outperformed clinical covariates alone in terms of $AUC^{C/D}(t)$, where the improvement in mean $AUC^{C/D}(t)$ over the entire test time range after diagnosis was ≥ 0.025 (**Fig. 5b**). In adrenocortical carcinoma (ACC), microbial features predicted OS significantly better than clinical prognostic covariates starting at approximately 6 years after diagnosis. In CESC, microbial abundances predicted OS better than clinical covariates from approximately 6 months to 10 years after diagnosis. Overall, we found that tumor microbial abundances from Poore et al. were only marginally predictive of prognosis across the TCGA cohort, and that gene expression was a significantly more powerful predictor of prognosis (**Figs. 2-5**).

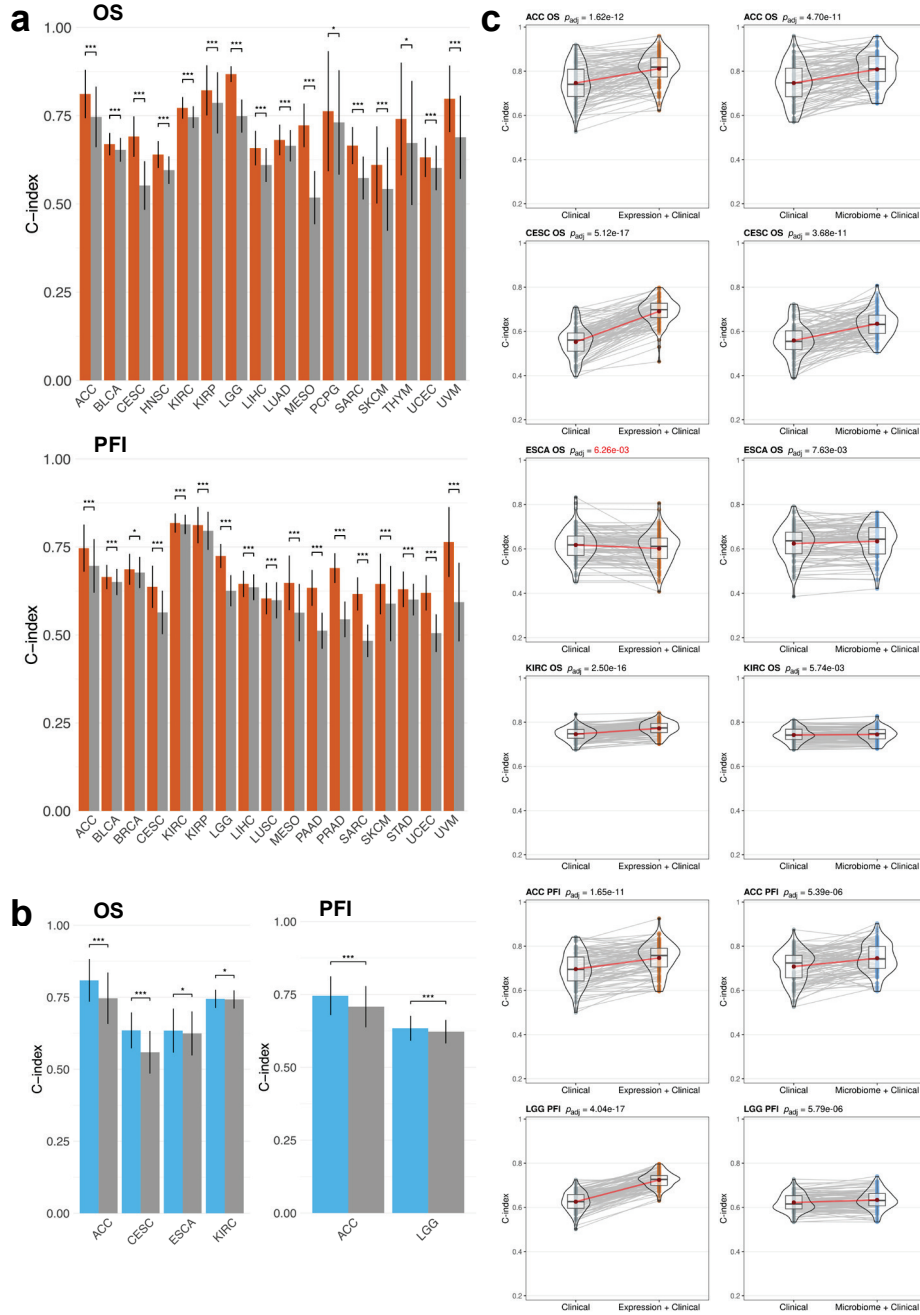


Figure 2. Performance of gene expression and microbial abundance prognosis prediction models where features add predictive power to clinical covariates

Mean C-index scores for **(a)** gene expression with clinical covariate models (orange) and **(b)** microbial abundance with clinical covariate models (blue) vs clinical covariate-only models (grey). Error bars denote standard deviations. Significance: * ≤ 0.01 , ** ≤ 0.001 , *** ≤ 0.0001 . **(c)** C-index score violin density plots for the six models where microbial abundance with clinical covariate features outperform clinical covariate-only models. Corresponding gene expression models shown for comparison. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean C-index scores shown as red dots with red lines connecting the means. Significance for the prediction improvement over clinical covariate-only models was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top. Adjusted p-values colored in red signify difference where clinical covariate-only model is better.

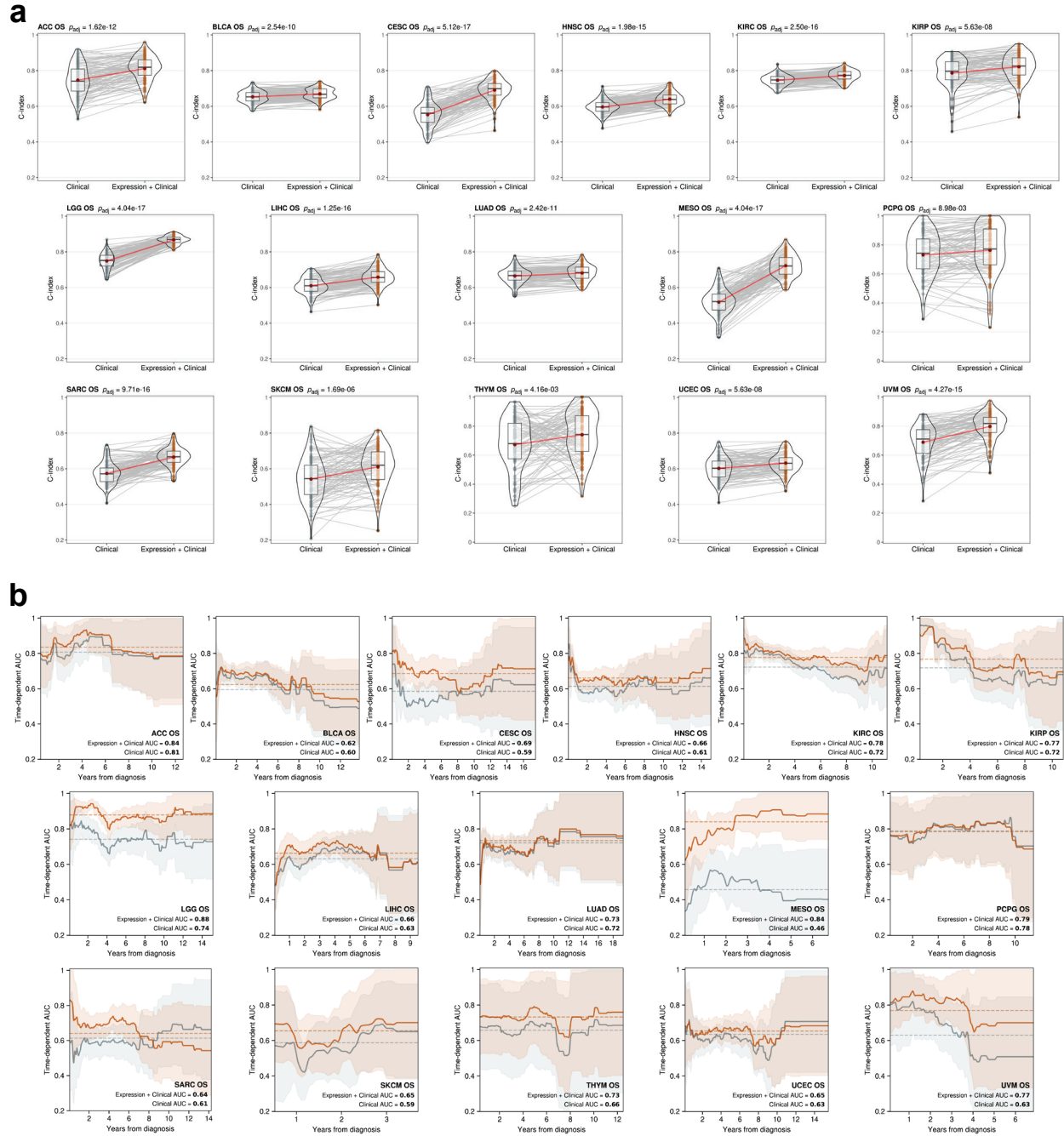


Figure 3. Performance of gene expression overall survival (OS) models in the 16 tumor types where gene expression adds predictive power to clinical covariates

(a) C-index score density distributions (top rows) for gene expression with clinical covariate models vs clinical covariate-only models. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean C-index scores and connecting lines shown in red. Significance for the prediction improvement over clinical covariate-only models was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top. **(b)** Time-dependent, cumulative/dynamic AUCs (bottom rows) for gene expression with clinical covariate models (orange) vs clinical covariate-only models (grey) following years after diagnosis. Mean AUCs across entire test time range after diagnosis shown as a horizontal dotted line and in legends and shaded areas denote standard deviations.

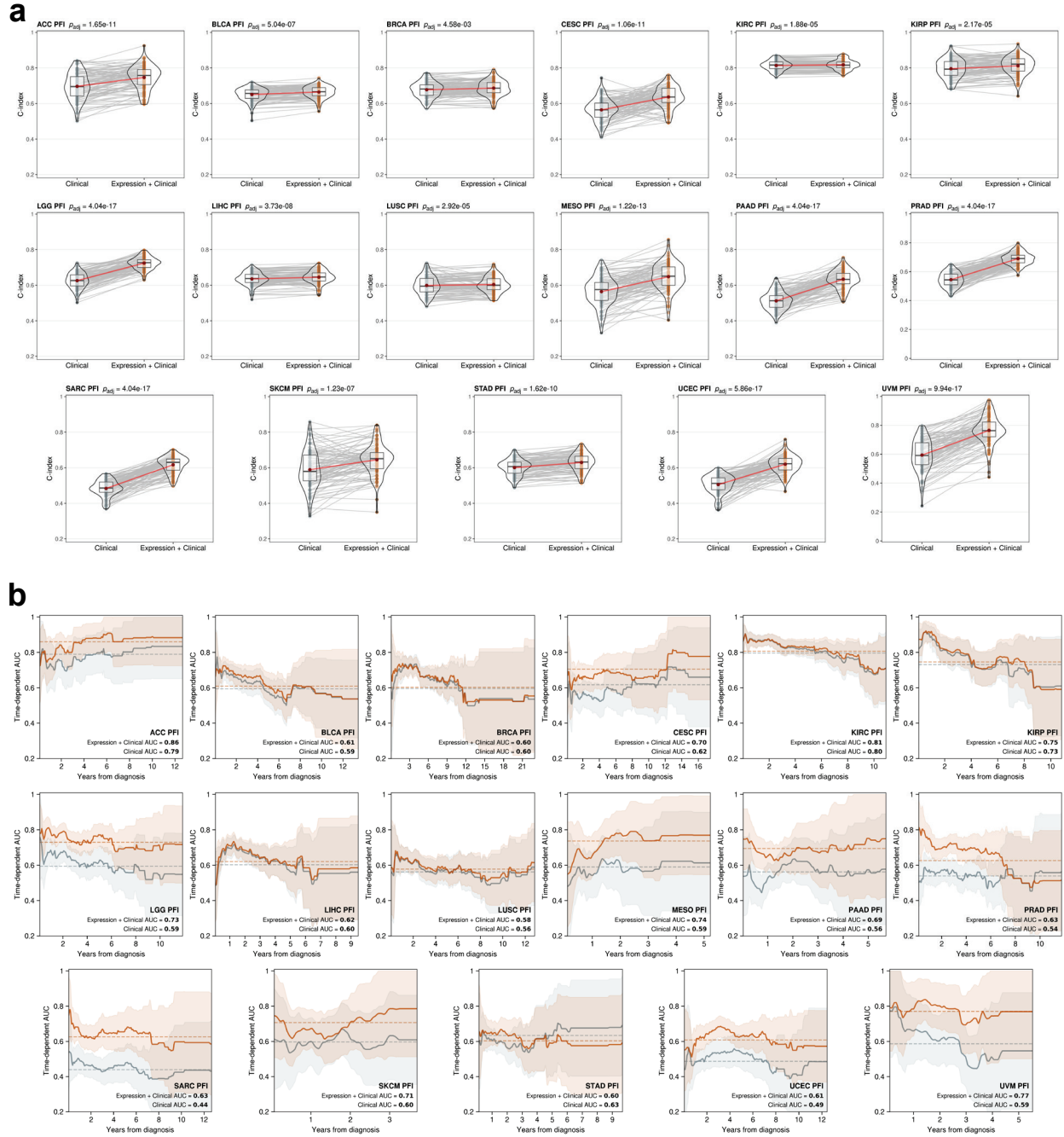


Figure 4. Performance of gene expression progression-free interval (PFI) models in the 17 tumor types where gene expression adds predictive power to clinical covariates

(a) C-index score density distributions (top rows) for gene expression with clinical covariate models vs clinical covariate-only models. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean C-index scores and connecting lines shown in red. Significance for the prediction improvement over clinical covariate-only models was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top. **(b)** Time-dependent, cumulative/dynamic AUCs (bottom rows) for gene expression with clinical covariate models (orange) vs clinical covariate-only models (grey) following years after diagnosis. Mean AUCs across entire test time range shown as a horizontal dotted line and in legends and shaded areas denote standard deviations.

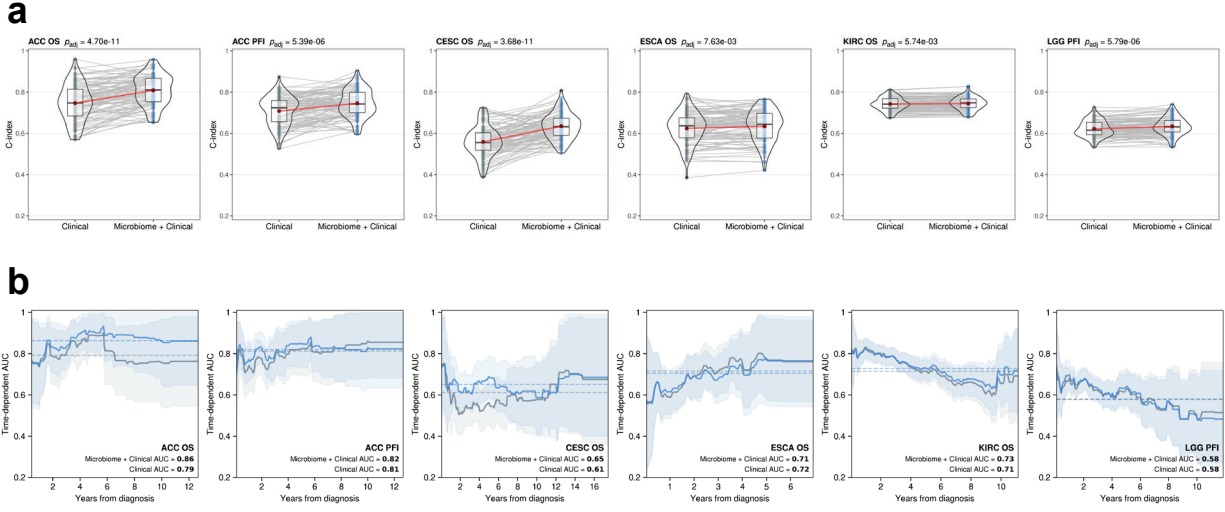


Figure 5. Performance of microbial abundance prognosis models in the five tumor types where microbial abundance features add predictive power to clinical covariates

(a) C-index score density distributions (top row) for microbial abundance with clinical covariate models vs clinical covariate-only models. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean C-index scores and connecting lines shown in red. (b) Time-dependent, cumulative/dynamic AUCs (bottom row) for microbial abundance with clinical covariate models (blue) vs clinical covariate-only models (grey) following years after diagnosis. Mean AUCs across entire test time range shown as a horizontal dotted line and in legends and shaded areas denote standard deviations. Significance was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top of violin plots in (a).

Tumor microbial abundances are predictive of chemotherapy drug response in some cancers and in mostly different cancer-drug combinations than gene expression

We next asked whether tumor microbial abundances from pre-treatment biopsies could predict drug response better than the clinical covariates age at diagnosis, gender and tumor stage alone. TCGA drug response clinical data were obtained from Ding et al.¹⁵ as described in Methods (cohorts shown in **Supplementary Data 1**). Cases with complete response (CR) or partial response (PR) were labeled as responders and those with stable disease (SD) or progressive disease (PD) as non-responders. Thirty TCGA cancer-drug combinations met our minimum dataset size thresholds. We built drug response models using three different ML methods: 1) a variant of the linear support vector machine recursive feature elimination (SVM-RFE) algorithm¹⁶ that we developed, 2) logistic regression (LGR) with elastic net¹⁷ (L1 + L2) penalties and embedded feature selection, and 3) logistic regression with an L2 penalty and limma¹⁸ (for tumor microbial and combination datasets) or edgeR^{19,20} (for RNA-seq count datasets) differential abundance/expression feature scoring and selection methods (see Methods for details). All three ML methods unconditionally included the clinical covariates – age at diagnosis, gender, and tumor stage – in the model (bypassing feature selection) while selecting the most predictive subset of microbial abundance or gene expression features. For comparison, we built standard linear SVM or LGR models using the clinical covariates alone. We evaluated the predictive performance of drug response models using AUROC. Each analysis generated 100 model instances, AUROC, and area under the precision-recall curve (AUPRC) scores from different random train-test CV splits.

We found five cancer-drug microbial abundance models had a mean AUROC score ≥ 0.6 and performed better than clinical covariates alone in at least two out of three ML methods (**Fig. 6**).

Three of these cancer-drug combinations involved stomach adenocarcinoma (STAD). We performed the same drug response modeling using TCGA gene expression data and here we found six cancer-drug combinations had a mean AUROC score ≥ 0.6 and significantly outperformed their corresponding clinical covariate-only models in at least two out of three ML methods (**Fig. 7**). Only one cancer-drug combination, SARC docetaxel, overlapped between the microbial abundance and gene expression drug response model results, suggesting that tumor microbial abundances have independent predictive power. Overall, our results support the notion that the tumor microbiome may contain information that is predictive of drug response in some cancers, consistent with recent reports^{21,22}. We also found there was considerable overlap in the selected microbial abundance and gene expression features reported by each ML method (**Fig. 8a & c**). We also frequently found a significant correlation between the feature importance rankings reported by each ML method when comparing the two most significant methods in each cancer-drug combination (**Fig. 8b & d**).

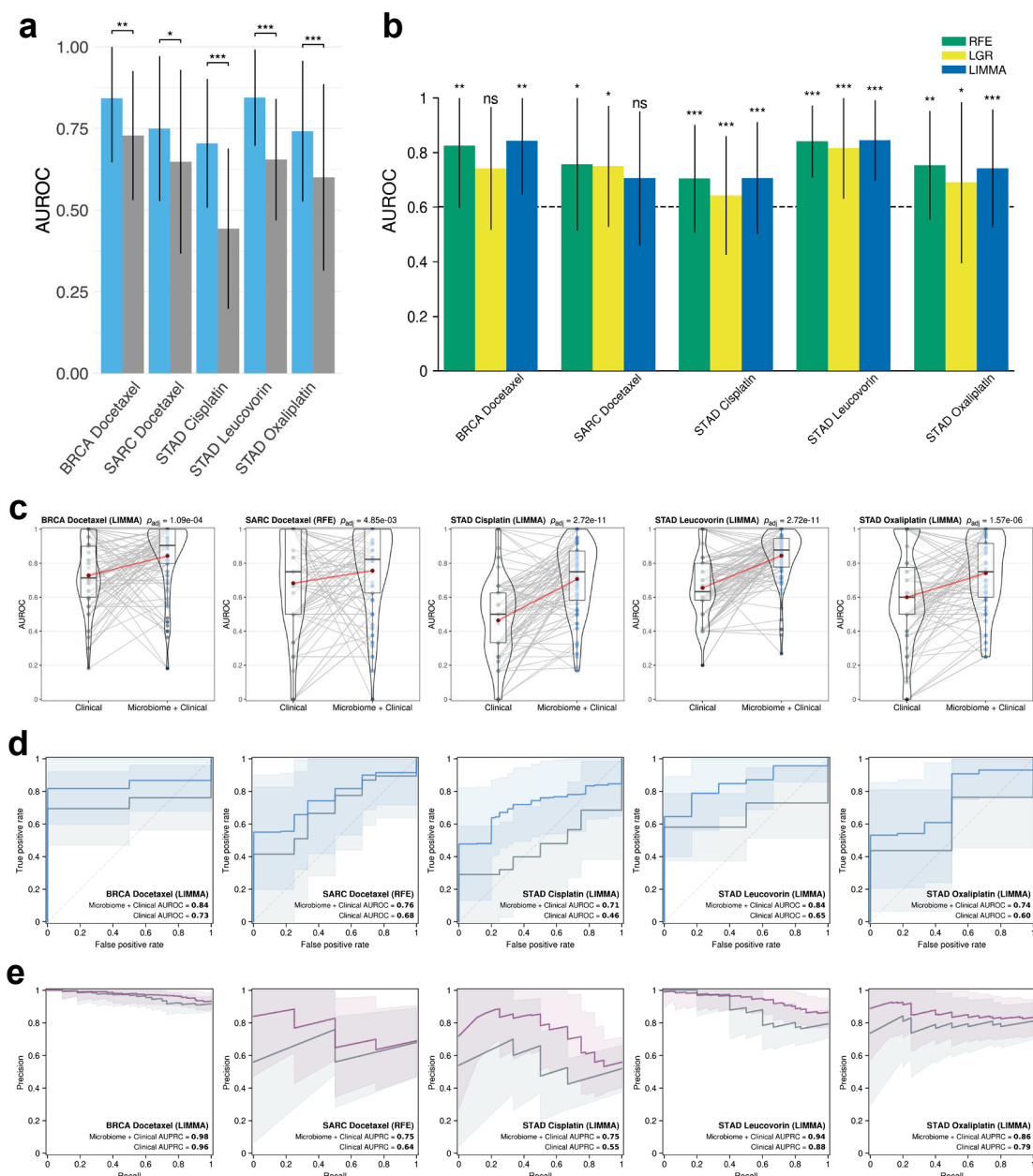


Figure 6. Performance of microbial abundance drug response prediction models in the five cancer-drug combinations where models performed better than clinical covariates alone

(a) Mean AUROC scores for microbial abundance with clinical covariate models (blue) vs clinical covariate-only models (grey) and (b) mean AUROC scores for each ML method. In both (a) and (b) error bars denote standard deviations. Significance: * ≤ 0.01 , ** ≤ 0.001 , *** ≤ 0.0001 . (c) Violin density plots of AUROC scores (top row) for microbial abundance with clinical covariate models vs clinical covariate-only models. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean AUROC scores are shown as red dots connected by red lines. (d) Mean ROC (middle row, blue) and (e) precision-recall (PR) curves (bottom row, purple) for microbial abundance with clinical covariate models vs clinical covariate-only models (grey). Mean AUROC and AUPRC scores shown in legends and shaded areas denote standard deviations. Significance for the prediction improvement over clinical covariate-only models was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top of violin plots in (c).

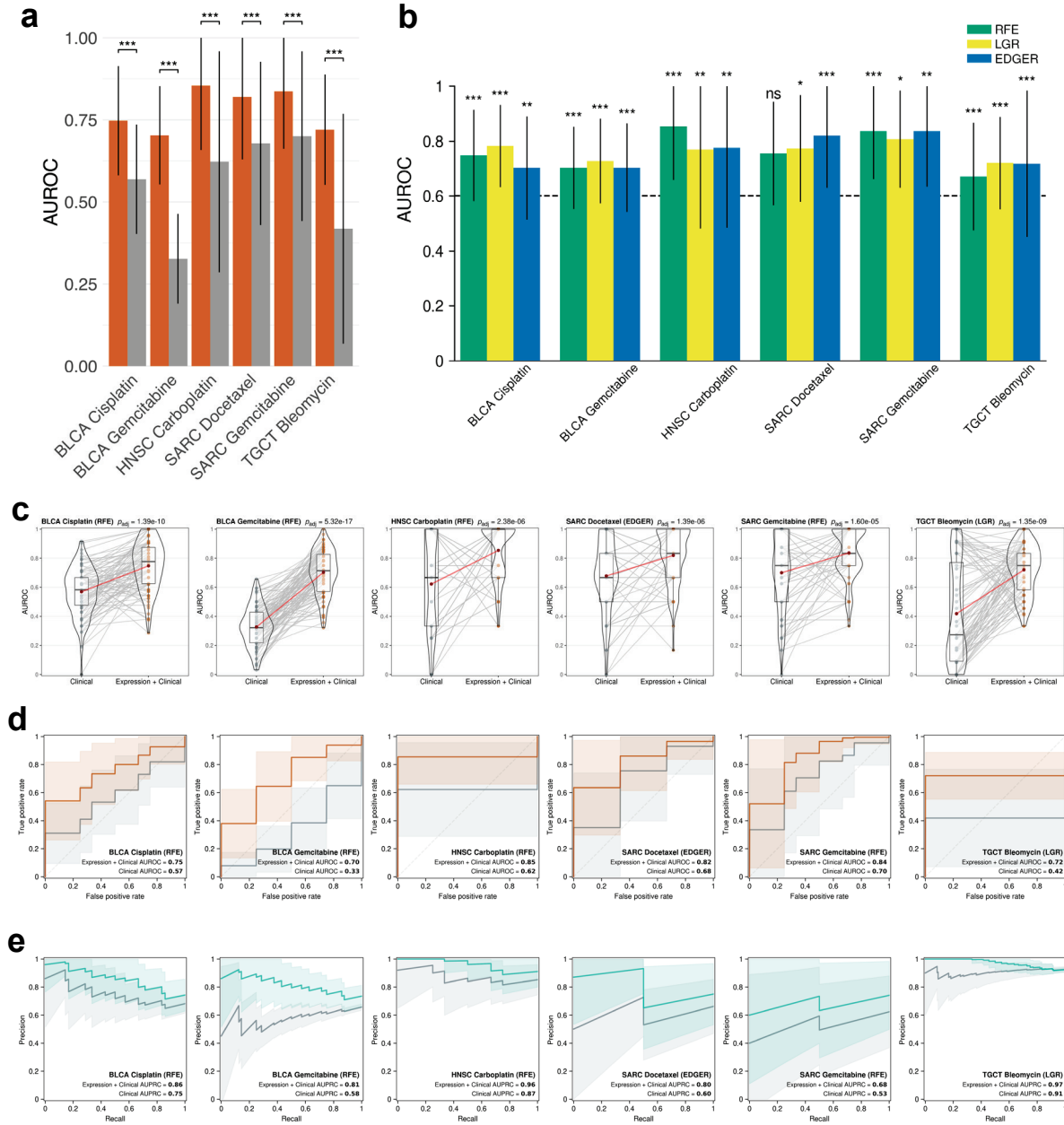


Figure 7. Performance of gene expression drug response prediction models in the six cancer-drug combinations where models performed better than clinical covariates alone

(a) Mean AUROC scores for gene expression with clinical covariate models (orange) vs clinical covariate-only models (grey) and (b) mean AUROC scores for each ML method. In both (a) and (b) error bars denote standard deviations. Significance: * ≤ 0.01 , ** ≤ 0.001 , *** ≤ 0.0001 . (c) Violin density plots of AUROC scores (top row) for gene expression with clinical covariate models vs clinical covariate-only models. Lines connecting points (light grey) represent score pairs from same train-test split on the data. Mean AUROC scores are shown as red dots connected by red lines. (d) Mean ROC (middle row, orange) and (e) precision-recall (PR) curves (bottom row, green) for gene expression with clinical covariate models vs clinical covariate-only models (grey). Mean AUROC and AUPRC scores shown in legends and shaded areas denote standard deviations. Significance for the prediction improvement over clinical covariate-only models was calculated using a two-sided Wilcoxon signed-rank test and adjusted for multiple testing using the Benjamini-Hochberg method with adjusted p-values shown at top of violin plots in (c).

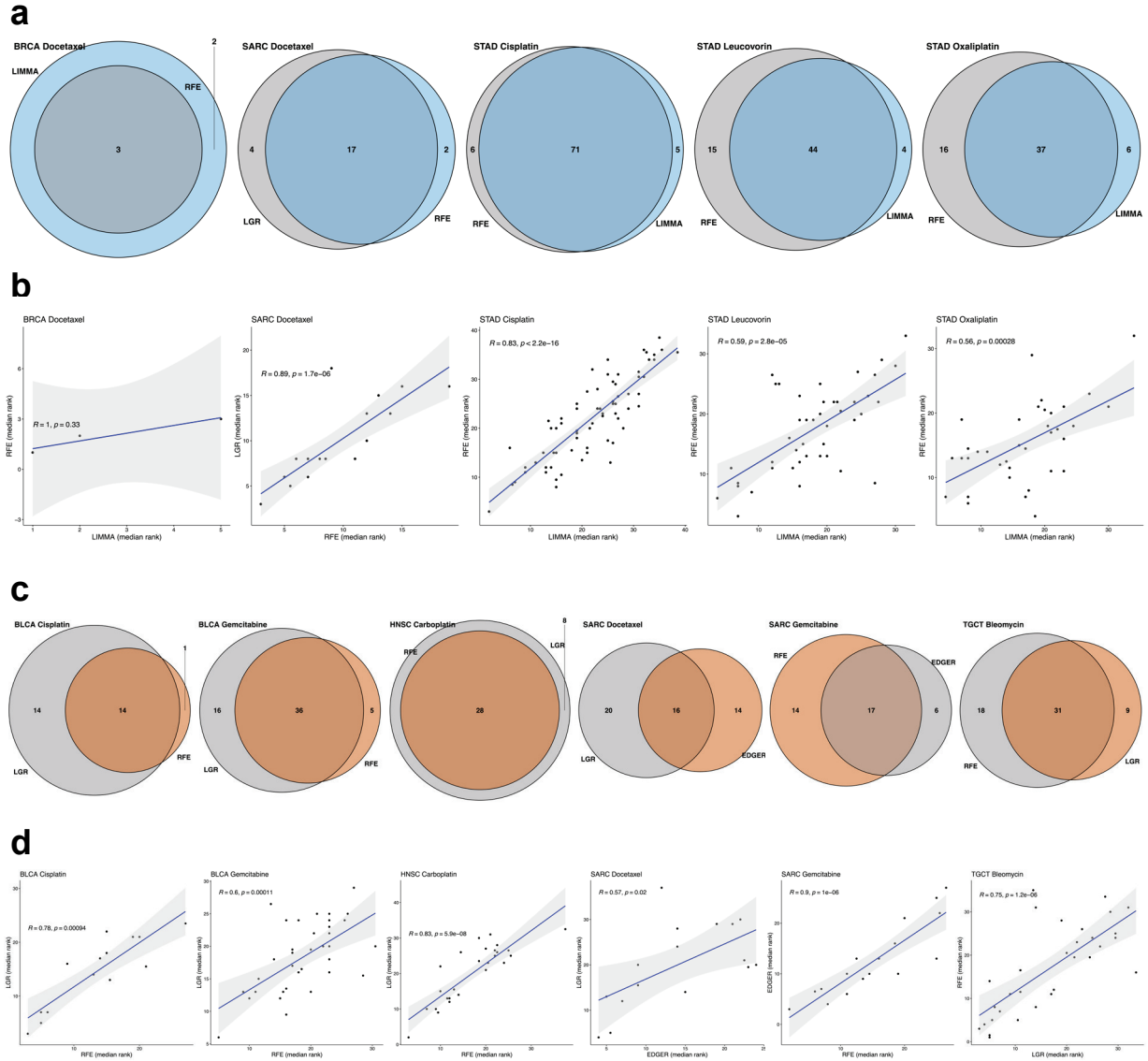


Figure 8. Comparison of top-ranked selected drug response model features by each ML method

For each drug response model, we selected the two best ML methods by significance for the prediction improvement over their respective clinical covariate-only model. **(a, c)** Venn diagrams for microbiome **(a)** or gene expression **(c)** models comparing the number of features individually selected by each ML method, and the intersection of the two ML methods. **(b, d)** Spearman rank correlation plots microbiome **(b)** or gene expression **(d)** models showing that the median rank of features (among the 100 model instances in which the feature was selected) often correlated between the two most significant ML methods. The best method is shown on the x-axis, the second best on the y-axis.

Combining tumor microbial abundance and gene expression features adds a modest predictive improvement in some cancers

Finally, we investigated if models built from combining microbial abundance and gene expression features would result in an improvement in predictive power over their corresponding single data type models. Combining data types resulted in a modest predictive improvement in only three prognosis models: SARC OS, STAD PFI, and thymoma (THYM) OS (**Fig. 9a**). Although this improvement was not statistically significant in terms of C-index score, the $AUC^{C/D}(t)$ metric showed a clear improvement in prognostic predictive power for the combined data type models, where the improvement in mean $AUC^{C/D}(t)$ over the entire time range after diagnosis was ≥ 0.025 compared to their respective single data type models. We also found five combined data type drug response models which performed significantly better than clinical covariates alone, although none of these models reached statistical significance when compared to their respective single data type model in terms of improvement in AUROC score, but one of these models, for BLCA cisplatin, did show an improvement in $AUROC \geq 0.025$ compared to its corresponding single data type models (**Fig. 9b-c**).

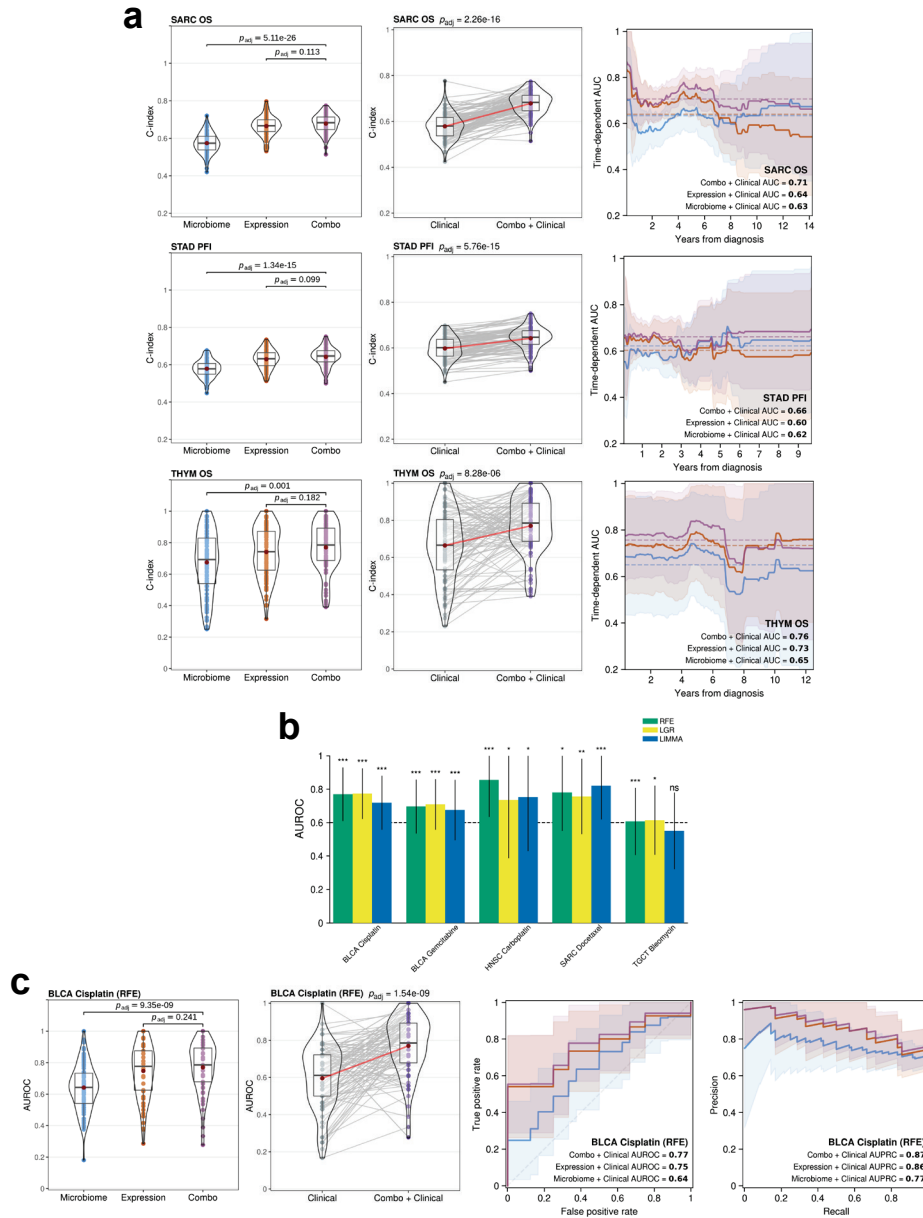


Figure 9. Performance of combined microbial abundance and gene expression models where combining both data types adds to predictive power

(a) Prognosis model C-index score violin density distributions (left) between microbial abundance, gene expression, and combined data type models. Mean scores shown in red. Significance was calculated using a two-sided Dunn test and p-values were adjusted for multiple testing using the Benjamini-Hochberg method. Model C-index score violin density distributions (middle) for combined data type with clinical covariate models vs clinical covariate-only models. Time-dependent, cumulative/dynamic AUCs (right) for combined data type (purple), microbial abundance (blue), and gene expression (orange) models following years after diagnosis. (b) ML method drug response model mean AUROC scores where combining data types performed better than clinical covariates alone. For the combined data type drug response model closest to reach significant improvement over respective single data type models (c) AUROC score violin density distributions (left) comparing each data type model, AUROC score violin density distributions (middle left) comparing combined data type and clinical covariate model to clinical covariate-only model, and mean ROC and PR curves (right) for each data type model. Mean AUROC and AUPRC scores shown in panel legends and shaded areas denote standard deviations.

Feature analysis reveals a wide range of predictive microbial genera

To learn more about the most predictive features, we determined the top microbial genera and top genes (**Supplementary Data 2**) selected by each of the significantly predictive microbial abundance and gene expression models, respectively, according to their selection frequency and model coefficients across the 100 model instances from each analysis. There were 428 distinct microbial genera appearing in at least one prognosis or drug response model. Of these 428 genera, 160 were individually significantly predictive of prognosis or drug response by a Wilcoxon test, indicating that the other genera were significantly predictive in combination. The median number of genera selected per model was 52, with a minimum of 3 (BRCA docetaxel) and a maximum of 78 (STAD cisplatin). Of the 428 genera, 95 were selected in more than one model and only 13 were selected in more than two models. This is consistent with the observation of Nejman et al.²³ that the tumor microbiome is tumor type specific. The predictive genera we found span all non-eukaryotic domains of life, in total encompassing 365 bacterial, 17 archaeal, and 46 viral genera (**Supplementary Data 2**).

Chapter 3: Discussion

In summary, we find that the microbial abundance estimates generated by Poore et al.¹¹ are predictive of cancer patient prognosis and response to chemotherapy in a subset of tumor types, survival outcomes, and treatments. Machine learning methods, such as those applied in this study, are not able to infer causality, but only inform on the positive or negative predictive associations covariates have with the response variable. The potential causal role that those may play in determining patient prognosis or drug response can only be ascertained via dedicated mechanistic studies. Overall, in terms of the number of significant models, based on their cross-validated C-index or AUROC scores and improvement over clinical covariates alone, the tumor microbiome is considerably less predictive than the tumor human transcriptome at predicting patient prognosis, but notably, performs similarly to gene expression at predicting chemotherapy response and in mostly different cancer-drug combinations. Our investigation motivates future studies investigating the role of the tumor microbiome in predicting the response to targeted therapies and immunotherapies.

There are also limitations to our current study. With respect to the drug response models, the relatively small cohort size of most TCGA cancers where drug response data were available and also the often small responder or non-responder case numbers within these cohorts do have an impact on the interpretability of the results (see **Supplementary Data 1** for cohort size information). We have attempted to overcome this limitation as best as possible by applying robust and advanced ML techniques at every level of model building and evaluation, including fitting and evaluating 100 randomly shuffled model instances, performing an exhaustive grid search for hyperparameter optimization and model selection, using a nested cross-validation (CV) strategy, utilizing advanced stratified and replicate grouping CV iterators, and applying

both sample and class weighting to the learning algorithm and scoring methods (see Methods for full details).

There are further limitations to this study inherited from limitations in the data, originally raised by Poore et al.¹¹ First, the study was retrospective, using existing data from the TCGA. As such, it did not involve any specific protocols to capture microbial reads or to control for contamination. Second, decontamination of such retrospective data is a highly involved and dataset-specific process, which they made great effort to validate. Poore et al. conclude from this validation that the retrospective study of TCGA was successful, and that similar retrospective studies would be valuable. A third point, which they touch on briefly, is that the protocols that were used have limitations with respect to capturing microbial reads and cannot distinguish if the source of microbial reads is intracellular or extracellular, or alive or dead when the sample was taken. Poore et al. suggest, correctly we believe, that additional protocols need to be developed for prospective studies.

Accepting the limitations of the study, we observed certain trends. Proteobacteria and Firmicutes were the most frequent phyla identified as predictive features (**Supplementary Data 2**), followed by Actinobacteria and Bacteroidetes. Among viruses, Herpesvirales were the most frequent. More microbial genera were negatively predictive of drug response or prognosis than those positively predictive (negative for 306/537 features; two-sided binomial test p-value = 0.0014). Firmicutes reversed this trend, being more often positively predictive (positive for 49/82 features, two-sided Fisher's exact test p-value = 0.0036; **Table 2**).

Table 2. Per cancer, the number of times genera from the phylum Firmicutes were found among the selected features, whether positively or negatively associated with drug response or prognosis.

Cancer	Selected Negatively	Selected Positively	Total
ACC	8	13	21
BRCA	1	0	1
CESC	4	7	11
ESCA	0	4	4
KIRC	4	7	11
LGG	1	6	7
SARC	2	2	4
STAD	13	10	23

Further examining the predictive features of our significant models and their cancer types, we noted that several genera of Firmicutes were predictive of OS in CESC, including genera of *Lactobacillales* were found to be negatively predictive of survival. We also found that the genus *Chlamydia* had an even stronger negatively predictive association with OS in CESC. Notably, though CESC is known to often arise from HPV infection, the presence of other microbial species, in particular the genera *Chlamydia* and *Lactobacillales*, have been reported in the literature to be positively associated with the risk of developing CESC^{24,25}.

Our prognosis analysis results were different than two recent reports^{26,27} which found some intratumor microbes that were potentially correlated with prognosis in three TCGA cancers. We did not find that Poore et al. tumor microbial abundances estimated from TCGA were predictive of OS or PFI in any of these cancers using our data-centric, regularized ML computational approach. A few important possible reasons for this difference in results are that different source

data and methods were used to perform prognosis analysis compared to these studies.

Gnanasekar et al. analyzed the THCA cohort by tumor subtype, they used harmonized and normalized GDC TCGA data instead of legacy TCGA followed by normalization and batch effect correction as in Poore et al., they only used RNA-seq data instead of WGS and RNA-seq data, they applied different methods for extraction of microbial reads and decontamination, and finally they did not perform any direct analysis of correlation of their derived microbial abundances with survival outcomes. Dohlman et al. analyzed colorectal cancers (colon (COAD) and rectum (READ) adenocarcinomas) also using harmonized and normalized GDC TCGA data, they used WGS and whole exome sequencing (WXS) data instead of WGS and RNA-seq, they also used different methods for extraction and decontamination of microbial reads, and finally they also applied classical univariate statistics on their entire data to infer correlation with overall survival (OS). While we believe the use of harmonized GDC TCGA data is superior to legacy TCGA, Poore et al. applied robust computational methods to remove technical variation from legacy TCGA data and validated that their approach was effective. We also applied additional filters of TCGA samples to further remove technical variation. We also believe that, in general, applying classical univariate statistics on the entire data to find correlations has the potential to overfit the specific dataset and it does not consider the multivariate nature of high-dimensional biological data like intratumor microbial abundances. A data-centric, multivariate, and regularized ML approach focused on fitting models on training data and evaluating on unseen test data has potential to generalize better and discover whether features are potentially predictive of and correlated with the response variable, such as survival outcomes or drug response.

Looking at our drug response model results, in STAD, tumor microbial abundances were predictive of response to three different drugs: cisplatin, leucovorin, and oxaliplatin. The genus *Helicobacter* was a quantified microbial abundance feature in the Poore et al. dataset although notably, even though it is well established that patients infected with *H. pylori* have an increased risk of developing gastric cancer²⁸, *Helicobacter* was not identified as a predictive feature of drug response in our STAD models. This finding is in line with recent research indicating reduced microbial diversity, decreased abundance of *H. pylori*, and enrichment of other mostly commensal bacterial genera in gastric carcinoma²⁹. Instead, in STAD we found that known opportunistic bacteria *Cedecea* and *Sphingobacterium* were both strongly negatively predictive of leucovorin response, *Sphingobacterium* was strongly negatively predictive of cisplatin response, and the opportunistic bacteria *Rouxiiella* was strongly negative predictive of oxaliplatin response. *Cedecea* and *Sphingobacterium* have been implicated in bacteremia in immunocompromised individuals in rare cases, including cancer^{30,31,31,33}. As dysbiosis is frequent in stomach cancer^{34,35}, and in light of the mechanism of action of leucovorin, it may be of interest to study whether organisms from these two genera may sequester or prevent the bacterial production of folinic acid³⁶.

We found three microbial genera whose abundances were strongly associated with breast cancer response to doxorubicin. Indeed, the involvement of the microbiome in breast cancer (BRCA)^{23,37} has recently received considerable attention. In BRCA, we found that the genus containing Epstein-Barr virus (EBV) was negatively associated with response to docetaxel, which is concordant with previous findings that EBV is associated with chemoresistance to docetaxel in gastric cancer³⁸. Interestingly, Cyanobacteria were predictive features in several cancers in our study and we identified a genus of Cyanobacteria as predictive of response to

docetaxel in BRCA. Notably, the presence of Cyanobacteria in BRCA was recently confirmed by Nejman et al.²³ by 16S-rRNA sequencing. While the genus we identified, *Raphidiopsis*, a planktonic Cyanobacteria that produces toxins harmful to human health and found in freshwater, is possibly a taxonomic identification error in the original microbial abundance estimates, our findings may point to a related genus under the recently discovered clade Melainabacteria of Cyanobacteria³⁹, which is present in humans. Though Melainabacteria are difficult to culture, we believe that confirmation of the relationship between BRCA to response to docetaxel and Melainabacteria should be tested, and a first step would be to confirm our computationally derived findings in a dedicated 16S-rRNA analysis.

Interestingly, in sarcoma (SARC), among the most predictive microbial features we found the genus *Lactococcus* to be positively associated with response to docetaxel. *Lactococcus* contains species that can sometimes cause opportunistic infections in humans, as *Lactococcus* are similar to *Streptococcus* and formerly belonged to that genus. The result that this genus was positively associated with response in our model initially appeared counterintuitive, although while the use of therapeutic bacteria as antitumor agents has not been an extensively studied field, there have been some limited findings in the literature that suggest the use of bacteriotherapy as anticancer agents⁴⁰. Historically, the intentional use of the toxins of various *Streptococcus* species showing significant antitumor activity in SARC has been documented^{41,42,43}. One possible testable explanation for some microbes being strongly positive predictive of docetaxel response in our model is that they might produce some extracellular products or toxins that could work as an adjuvant to the chemotherapy.

Our drug response analysis results were different than a recent report²¹ which found *Mycoplasma* to be correlated with chemoresistance to gemcitabine in pancreatic

adenocarcinoma. We did not find any intratumor microbes that were predictive of gemcitabine response or resistance in TCGA pancreatic adenocarcinoma (PAAD), or any drug we analyzed against PAAD. We also did not find *Fusobacterium* to be associated with chemoresistance or prognosis in TCGA COAD and READ, in contrast to several reports which found *Fusobacterium nucleatum* to be enriched in TCGA colorectal cancers⁴⁴ and associated with prognosis or chemoresistance in other cohorts^{45,46,47}.

In summary, while these findings and others reported in this study are computationally derived associations, we believe that they can serve as leads for further experimental studies of the role of microbial species in modulating patients survival and drug response, potentially by metabolizing drug levels in the tumor microenvironment as suggested above, or by altering the immune response, either by changing the levels of specific immunometabolites or by having the tumors present specific bacterial antigens⁴⁸.

Chapter 4: Methods

Data retrieval and processing

Normalized and batch effect corrected microbial abundance data for 32 TCGA tumor types were downloaded from the online data repository referenced in Poore et al.¹¹ (ftp://ftp.microbio.me/pub/cancer_microbiome_analysis). Specifically, the “Kraken-TCGA-Voom-SNM-Plate-Center-Filtering-Data.csv” microbial abundance data file and adjoining “Metadata-TCGA-Kraken-17625-Samples.csv” metadata file were used as the starting input for further data processing.

We first filtered the data for primary tumor samples (TCGA “Primary Tumor” or “Additional - New Primary” sample types). Poore et al. generated microbial abundances from all the available WGS and RNA-seq data in legacy TCGA (after some quality filters), which frequently contained replicate WGS and RNA-seq data for the same case and sample type. It was common in legacy TCGA to increase WGS sequencing coverage by performing an additional sequencing run from the same sample and these secondary runs typically had a much lower number of reads and coverage compared to their corresponding primary sequencing runs. When comparing the normalized and batch effect corrected read counts between these WGS runs, we found that microbial abundance data which came from lower coverage secondary runs could be substantially different from abundances derived from the larger primary sequencing runs. Therefore, we excluded microbial abundance data which came from secondary runs. In addition, legacy TCGA commonly contained data for the same samples analyzed using different computational pipeline versions. We excluded replicate microbial abundance data from older TCGA analysis pipeline versions if a replicate from a newer version existed. After the above

filters, the Poore et al. data went from 17,625 samples and 10,183 unique cases to 12,111 samples and 9,812 unique cases (comprising of 1,944 WGS samples from 1,904 unique cases and 10,167 RNA-seq samples from 9,745 unique cases).

TCGA gender, age at diagnosis, and tumor stage demographic and clinical data and as well as primary tumor RNA-seq read count data for the 32 TCGA tumor types included in our study were obtained from the NCI Genomic Data Commons (GDC Data Release v29.0) using the R Bioconductor package GenomicDataCommons. TCGA GENCODE v22 gene annotations were obtained from the GDC data portal and Ensembl Gene v98 using the R package rtracklayer and R Bioconductor packages AnnotationHub and ensemblDb. The downloaded GDC primary tumor cohort with RNA-seq read count data comprised of 9,735 samples from 9,680 unique cases. There were 68 cases at the GDC which had missing age of diagnosis but existing values in the Poore et al. data and we chose not to exclude these data and used the Poore et al. age of diagnosis values for these cases. TCGA curated survival phenotypic data⁴⁹ were obtained from UCSC Xena. Cases which had both missing overall survival (OS) and progressive-free interval (PFI) outcome data were excluded from survival modeling.

TCGA curated drug response clinical data were compiled from Ding et al.¹⁵ Our drug response models used the following binary classification targets: complete response (CR) and partial response (PR) were labeled as responders and stable disease (SD) and progressive disease (PD) as non-responders. All TCGA samples with drug response phenotypic data were from pre-treatment biopsies. Due to the limited cancer-drug combination cohort sizes in TCGA, we modeled each drug individually, even if a patient received multiple drugs concurrently. If the same drug was given at multiple timepoints to a patient, we only considered their first drug response. We considered cancer-drug combinations that contained a minimum of 18 cases and at

least 4 cases per response binary class, except for stomach adenocarcinoma (STAD) oxaliplatin, where we allowed a minimum of 14 cases so that the gene expression dataset could be included. In total, we analyzed 30 cancer-drug combinations which had paired microbial abundance and gene expression data that met the above thresholds. Combined feature microbial abundance and gene expression datasets were created by joining data from each individual dataset which had matching TCGA sample UUIDs. For some TCGA cases, data existed from multiple different aliquots per sample or multiple technical runs per aliquot, therefore in these cases all combinations were joined at the sample UUID level. Cross-validation sampling probability weights as well as model and scoring sample weights were applied to account and adjust for any imbalance caused by the process.

ML modeling

Machine learning (ML) models were built using the scikit-learn⁵⁰ and scikit-survival libraries^{51,52,53}. Custom extensions to scikit-learn and scikit-survival were developed to add new methods and functionalities required by this project. Survival models were built using Coxnet – regularized Cox regression with elastic net penalties¹². Coxnet models controlled for gender, age at diagnosis, and tumor stage clinical prognostic covariates by including them as unpenalized features in the model (Coxnet penalty factor = 0). Drug response classification models were built using three different ML methods: 1) a variant of the linear support vector machine recursive feature elimination (SVM-RFE) algorithm¹⁶ that we developed with a number of additional features and better performance than the scikit-learn built-in version, 2) logistic regression (LGR) with elastic net¹⁷ (L1 + L2) penalties and embedded feature selection, and 3) LGR with an L2 penalty and limma¹⁸ (for tumor microbial and combination datasets) or edgeR^{19,20} (for RNA-seq count datasets) differential abundance/expression feature scoring inside a k-best

wrapper feature selection method around the learning algorithm. limma differential abundance analysis was run inside the ML pipeline with default parameters except for fitting an intensity-dependent trend to the prior variances and running a robust empirical Bayes procedure (eBayes function parameters trend = TRUE and robust = TRUE). edgeR differential expression analysis was run inside the ML pipeline with default parameters except for enabling robust estimation of the negative binomial dispersion (calcDispersions function robust = TRUE) and robust estimation of the prior quasi-likelihood (QL) dispersion (glmQLFit function robust = TRUE). Both limma and edgeR methods scored and ranked features by differential abundance/expression p-value.

All three drug response ML methods unconditionally included the same three clinical covariates in the model as in the prognosis models by having them bypass feature selection in the ML pipeline, though in drug response models clinical covariates were modeled as L2 penalized features. In SVM-RFE, clinical covariate features bypassed recursive feature elimination but were always included at each RFE recursive feature elimination model fitting step as well as final model refitting. To the best of our knowledge, no available comprehensive ML library in python or R currently provides an elastic net LGR algorithm with the functionality to specify features that can bypass embedded feature selection and be modeled with an L2 penalty (setting the R glmnet penalty factor, for example, does not provide this functionality as it is not a penalty factor per regularization term but a factor applied to the sum of both L1 and L2 terms). In order to develop this functionality for our study, our elastic net LGR model pipeline was designed as a two-level LGR, 1) an elastic net LGR and embedded feature selection on only microbial abundance or gene expression features with clinical covariates bypassing this step, followed by 2) an L2 penalized LGR on features selected by the elastic net LGR step and the clinical

covariates. We know this design does not likely produce the exact same model settings and results of a single-level elastic net LGR algorithm with the functionality we needed, if such a implementation it existed, though we tested every drug response model through an ML pipeline with elastic net LGR and no clinical feature selection bypass and found that model predictive performance, feature coefficients and signs, and feature importance rankings were similar to our two-level ML pipeline setup.

Gender was one-hot encoded and tumor stage ordinal encoded by major stage. In the final cohort included in our prognosis and drug response models, 3363 out of 9708 tumor microbial abundance cases (34.64%) and 3244 out of 9484 gene expression cases (34.21%) had tumor stage “not reported” or BRCA stage “X”. Since missing tumor stage metadata is so prevalent in TCGA, we took the approach of including these in our study and modeled missing tumor stage with as neutral an ordinal encoding as possible. Looking at the distribution of reported major tumor stages in our cohort, we determined that encoding missing data as an ordinal between tumor stage II and III was as close to the middle of the distribution of stages in TCGA as we could possibly achieve with ordinal encoding.

All prognosis and drug response models included the previously described feature selection as well as normalization and transformation steps integrated into the ML modeling pipeline using an extended version of the scikit-learn Pipeline framework. Training data splits always underwent feature selection, normalization, and transformation through the ML pipeline independently from held-out test and validation data splits before learning. Models built using gene expression read count data included edgeR low count filtering, weighted trimmed mean of M-values (TMM) normalization, and log counts per million (CPM) transformation steps within the ML pipeline. These were developed and integrated into our scikit-learn-based framework via

R and rpy2. All models also included standardization of features within the ML pipeline just before learning. During prediction, held-out test or validation data were feature selected, normalized and transformed through the ML pipeline using the parameters learned from the training data at each pipeline step before model prediction and scoring. Each cancer, data type, and survival or drug response target type combination was modeled individually using a nested cross-validation (CV) strategy to perform model selection and evaluation on held-out test data. All cross-validation iterators kept replicate sample data per case grouped together such that data would only reside in either the train or test split during each CV iteration.

Survival models used a stratified, randomly shuffled outer CV with 75% train and 25% test split sizes that was repeated 100 times. The CV procedure stratified the splits on event status. Each training set from the outer CV was used to perform hyperparameter tuning and model selection by optimizing Harrell's concordance index (C-index) over a stratified, randomly shuffled, 4-fold inner CV on the training set, repeated 5 times. A few cancer datasets contained fewer than four uncensored cases which required reducing the number of inner CV folds for these models such that at least one case per fold was uncensored. The data derived from Poore et al. often included more than one sample per case, and an unequal number of samples between cases, therefore requiring either ML model sample weighting or CV random sampling per case. The Coxnet implementation in scikit-survival does not currently support sample weights, therefore our custom outer CV iterator randomly sampled one replicate sample per case during each iteration, using a sampling procedure with probability weights that balanced the probability that a replicate WGS- or RNA-seq-based sample was selected during each CV iteration. Model selection grid search was performed on the following hyperparameters: elastic net penalty L1 ratios 0.1, 0.3, 0.5, 0.7, 0.8, 0.9, 0.95, 0.99, and 1, and for each L1 ratio a default alpha path of

100 alphas using an alpha min ratio of 10^{-2} . Alpha is the constant multiplier of the penalty terms in the Coxnet objective function. Optimal alpha and L1 ratio settings were determined via inner CV and a model with these settings was then refit on the entire outer CV train data split. Model performance was evaluated in both inner and outer CV on the held-out validation or test data split, respectively, by generating model test predicted risk scores and using these scores to directly calculate C-index scores. We also evaluated and compared model predictive performance for each test data split survival time period by calculating time-dependent cumulative/dynamic AUCs^{13,14}.

Drug response models used a stratified, randomly shuffled, 4-fold outer CV that was repeated 25 times (i.e. 100 model instances). Each training set from the outer CV was used to perform hyperparameter tuning and model selection by optimizing the area under receiver-operator curve (AUROC) over a stratified, randomly shuffled, 3-fold inner CV repeated 5 times. Case replicate sample weights were provided to SVM-RFE and LGR learning algorithms and all model selection and evaluation scoring methods. Class weights were provided to SVM-RFE and LGR learning algorithms to adjust for any class imbalance. Model selection grid search was performed on the following hyperparameters: SVM and L2 penalized LGR C regularization parameter from a range of 10^{-5} to 10^3 , elastic net LGR L1 ratios of 0.1, 0.3, 0.5, 0.7, 0.8, 0.9, 0.95, 0.99 and 1, elastic net LGR C regularization parameter from a range of 10^{-2} to 10^3 (microbial abundance) or from 10^{-2} to 10^1 (gene expression), and finally RFE, elastic net LGR, and limma and edgeR feature scorer k-best feature selection search range from 1 to 400 top scoring microbial abundance or gene expression features. Optimized hyperparameter settings were determined via inner CV and a model with the optimized settings was then refit on the entire outer CV train data split. Model performance was evaluated in both inner and outer CV on the held-out validation or

test data split, respectively, by AUROC, area under precision-recall curve (AUPRC), and balanced accuracy (BCR). AUROC was used to evaluate and select the best model and optimized hyperparameter settings from the grid search. Average precision and BCR scores were also reported for each model instance.

Gender, age at diagnosis, and tumor stage clinical covariate-only survival models were built using standard unpenalized Cox regression. Clinical covariate-only drug response models were built using linear SVM or LGR. Models included standardization of features as part of the ML pipeline. Models were trained and tested using the same outer CV iterators and train/test data splits as their corresponding microbial abundance, gene expression, or combination data type models. To test whether a Coxnet, SVM-RFE, or LGR microbial abundance or gene expression model was significantly better than their corresponding Cox, linear SVM, or LGR clinical covariate-only model, respectively, a two-sided Wilcoxon signed-rank test was performed between the 100 pairs of C-index or AUROC scores between both models. All raw p-values generated from the signed-rank test across survival or drug response analyses from the same data type were adjusted for multiple testing using the Benjamini-Hochberg (BH) procedure to control the false discovery rate (FDR), and a threshold $FDR \leq 0.01$ was used to determine statistical significance. To test whether a combined data type model was significantly better than its corresponding microbial abundance or gene expression model, a two-sided Dunn test was performed between all three groups of data type model scores. Each Dunn test raw p-value was adjusted for multiple testing using the Benjamini-Hochberg (BH) procedure to control the false discovery rate (FDR), and a threshold $FDR \leq 0.05$ was used to determine statistical significance.

Microbial abundance model feature analysis

For each analysis, 100 prognosis or drug response model instances were generated from the outer CV procedure. Each model instance selected a subset of features that performed best during CV and the model algorithm learned coefficients (or weights) for each feature. To select microbial genera for downstream investigation from the feature results across all these model instances, we proceeded as follows. First, we applied a two-sided Wilcoxon signed-rank test that the mean feature coefficient rank generated by the model is shifted away from zero, and thus that the genus is identifiably positively or negatively associated with survival or drug response. For all Wilcoxon tests, we used the package *coin*⁵⁴, which allows exact calculation of p-values. Coefficients were ignored when a genus was assigned a zero coefficient or absent from a model. Second, within each model, all coefficients, ignoring the results of the Wilcoxon test, were ranked by absolute magnitude. We then kept genera that were among the top 50 features in at least 20% of the models and for which the Holm-adjusted, two-sided Wilcoxon signed-rank test p-value was ≤ 0.01 . Having a Coxnet feature coefficient equal to zero or feature being absent from an SVM-RFE or LGR model was not strong enough evidence that the genus has no effect, but rather that one or more features with stronger effect were chosen. Thus, we ignored genera with a zero coefficient or absent from a model when computing mean coefficient weight and Wilcoxon statistics on the means.

For the drug response models, where three ML methods were tested, we noted the features selected by individual models and the median rank the feature attained in the instances in which it appeared, but further filtered the features to account for the consensus between ML models. We kept features selected in any two ML model methods that individually met our criteria for

inclusion, ignoring features in ML models that did not meet these criteria. We then computed the Spearman correlation between the median ranks attained by the features.

For each selected microbial feature, we tested whether it was a significantly univariate feature of survival or drug response. This is a strictly different question than whether the coefficient of a feature has consistent sign – sign may be consistent when used in combination with other features, but the feature may not be individually predictive. For drug response models, we divided individuals into responders and non-responders, and for survival data we divided individuals whose survival time was greater or less than the censored median, ignoring those who were lost to follow up before median time. For each cancer-test type pair, we applied a two-sided Wilcoxon rank-sum test. We applied a Benjamini-Hochberg multiple hypothesis correction for each cancer-test type pair and report the false discovery rate in **Supplementary Data 2**.

We analyzed the distribution of features, selected by the rules described above, that had positive or negative signs for their mean coefficient. We used a two-sided binomial test to show that selected features had significantly more negative the positive mean coefficients. We used a two-sided Fisher's exact test to determine if selected genera belonging to Firmicutes had a statistically significant difference in the breakdown between positive and negative mean coefficients than selected features as a whole.

Code and data availability

All code and data used to produce this work are available under <https://github.com/ruppinlab/tcga-microbiome-prediction>. All results generated from this work are available under <https://doi.org/10.5281/zenodo.5221525>.

Appendices

Description of Supplementary Data Files

Supplementary Data 1.xlsx

Worksheet #1 Prognosis model cohort sizes: number of cases in each prognosis model dataset.

Worksheet #2 Drug response model cohort sizes: number of cases in each drug response model dataset, including the breakdown between responder (R) and non-responder (NR) cases.

Supplementary Data 2.xlsx

Worksheet #1 Microbial genera features: by cancer and by comparator, the genera selected as features by the criteria outline in Methods, and the ML methods that selected each genus.

Further we show the number of times each genus was seen with rank at most 50 over the number of times the genus could be seen: 100, 200 or 300 if one, two, or three ML methods chose the feature, respectively. The column conditional direction shows the direction assigned to the feature for each ML method; an asterisk indicates that there was more than one relevant ML method, but all methods chose the same direction. The conditional direction is the typical sign of the coefficient within a model, which is conditional on other features in the model. Also shown is the Univariate FDR, which is the FDR that the feature is univariately predictive (n.s. is not significant), and the direction in which the feature is univariately predicative, which may differ from the conditional direction.

Worksheet #2 Gene expression features: by cancer and by comparator, the genes selected as features by the criteria outline in Methods, and the ML methods that selected each gene. Further we show the number of times each gene was seen with rank at most 50 over the number of times

the gene could be seen: 100, 200 or 300 if one, two, or three ML methods chose the feature, respectively. The column conditional direction shows the direction assigned to the feature for each ML method; an asterisk indicates that there was more than one relevant ML method, but all methods chose the same direction. The conditional direction is the typical sign of the coefficient within a model.

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