DNA methylation–based immune response signature improves patient diagnosis in multiple cancers

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**BACKGROUND.** The tumor immune response is increasingly associated with better clinical outcomes in breast and other cancers. However, the evaluation of tumor-infiltrating lymphocytes (TILs) relies on histopathological measurements with limited accuracy and reproducibility. Here, we profiled DNA methylation markers to identify a methylation of TIL (MeTIL) signature that recapitulates TIL evaluations and their prognostic value for long-term outcomes in breast cancer (BC).

**METHODS.** MeTIL signature scores were correlated with clinical endpoints reflecting overall or disease-free survival and a pathologic complete response to preoperative anthracycline therapy in 3 BC cohorts from the Jules Bordet Institute in Brussels and in other cancer types from The Cancer Genome Atlas.

**RESULTS.** The MeTIL signature measured TIL distributions in a sensitive manner and predicted survival and response to chemotherapy in BC better than did histopathological assessment of TILs or gene expression–based immune markers, respectively. The MeTIL signature also improved the prediction of survival in other malignancies, including melanoma and lung cancer. Furthermore, the MeTIL signature predicted differences in survival for malignancies in which TILs were not known to have a prognostic value. Finally, we showed that MeTIL markers can be determined by bisulfite pyrosequencing of […]

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Introduction

Breast cancer (BC) remains challenging to treat because of its vast heterogeneous nature. Even within BC subtypes, patients experience different rates of survival and responses to anticancer therapies. This diversity needs to be further explored to improve prognosis and optimize therapeutic approaches in the future. In this respect, the tumor immune response is increasingly recognized to predict clinical outcomes in breast and other cancers (1). In particular, tumor-infiltrating lymphocytes (TILs) have been shown to provide prognostic and predictive information. High numbers of TILs have been associated with increased survival and response rates to preoperative chemotherapy in triple-negative (TN) (2–5) as well as human EGFR 2–positive (HER2) BCs treated with chemotherapy and trastuzumab (2, 4–6). Among TILs, T cell subsets are most abundant (7) and are associated with clinical outcomes (8–11) that suggest they play a major role in the antitumor immune response.

The evaluation of tumor immune responses by measuring TILs remains suboptimal, since pathologists base their quantification on subjective measurements. Microscopic counting of TILs using H&E- or IHC-stained tumor sections suffers from bias and variability and is only of a semiquantitative nature (12, 13). Recently, guidelines were published for a more consistent and reproducible morphological measurement of TILs, with the overall aim of establishing an “immunological grade” for clinical practice (14). Gene expression–based immune markers and signatures have been associated with TILs, and they also predict better clinical outcomes and response to therapy in TN and HER2 tumors (2, 5, 15).

DNA methylation plays a critical role in cell lineage specification and may therefore serve as a specific molecular marker for immune cell typing. Upon differentiation, cell lineage–specific
changes occur in methylation, influencing the expression of key transcription factors and regulatory genes that lock the identity of cells (16–18). Although cell identity is determined by both DNA methylation and gene expression, DNA methylation may reflect distributions of cell subtypes more adequately, given that the relationship of only 2 DNA molecules per cell is of a more linear nature than are thousands of mRNA copies exposed to mRNA degradation (13, 19). Indeed, several studies have identified DNA methylation signatures that accurately evaluate the distribution of cell subpopulations in blood (19–21). However, within complex tissues such as tumors, DNA methylation has barely been explored in terms of evaluating immune cell subtypes, particularly TILs, and the diagnostic value of such a marker is unknown.

DNA methylation landscapes in BC are highly abnormal, and numerous studies have shown differences in BC methylomes according to clinical and pathological parameters such as the expression of hormone receptors, tumor grade and stage, and survival (22–25). Interestingly, differences captured through whole-tumor DNA methylation profiling not only originate from tumor cells but also from TILs, suggesting the potential of DNA methylation for the evaluation of tumor immune responses (26).

In this study, we applied genome-wide DNA methylation profiling to identify markers (methylation of TIL [MeTIL] signature) for evaluation of the local tumor immune response and their potential to improve the prognostic accuracy for BC patients. Our results showed that the MeTIL signature score measured TILs in a sensitive manner, resulting in a better prediction of survival for BC subtypes. We further showed that the MeTIL score might predict the response to anthracycline-based chemotherapy. This signature further stratifies patients with different clinical outcomes in other cancers including types for which TILs were not known to have a prognostic value. Finally, we demonstrated the clinical merit of applying this methodology in the clinic, since the MeTIL score can be determined by bisulfite pyrosequencing of low amounts of DNA from formalin-fixed, paraffin-embedded (FFPE) tumor tissue.

Results
Evaluation of TIL distributions in breast tumors with the MeTIL signature. The MeTIL signature was developed in 2 steps and subsequently tested for its prognostic and predictive value in various cohorts, as outlined in Figure 1. Given that among TILs, T cells are the most abundant (7) and are associated with clinical outcomes (8–11), we identified, in a first step, CpGs that are highly differentially methylated between normal or cancerous breast epithelial cells and T lymphocytes (Supplemental Figure 1 and Supplemental Table 1; supplemental material available online with this article; https://doi.org/10.1172/JCI91095DS1). In a second step, we used DNA methylation profiles from breast primary tumors in cohort 1. Cohort 1 (n = 118) is an in-house retrospective cohort of BC patients who received adjuvant therapies according to institutional recommendations and were assessed by histopathological methods for the percentage of TILs, tumor cells, and other cell types of the tumor microenvironment (Supplemental Table 2). Pathological assessment of TILs (PaTILs) was performed on H&E-stained tumor sections by defining the percentage of mononuclear cells within the epithelium of the invasive tumor cell nests (Supplemental Table 3). We applied a random forest machine learning approach to DNA methylation profiles of cohort 1 to select markers from our list of 29 T cell–associated CpGs that most accurately predict the quantity of PaTILs in patients’ samples (Supplemental Figures 1 and 2). The final signature, named MeTIL, included 5 CpGs located within the promoter of 5 individual genes, namely protein tyrosine phosphatase, receptor type C–associated protein (PTPRC), internexin neuronal intermediate filament protein α (INN), semaphorin 3B (SEMA3B), Kelch-like family member 6 (KLHL6), and Ras association domain family member 1 (RASSFL) (Supplemental Table 4). As expected, their biological functions comprised immunity-related mechanisms (Supplemental Figure 1). The development of the MeTIL signature is described in detail in the Supplemental Methods.

The ability of the MeTIL signature to evaluate TILs is based on highly differential methylation values of MeTIL markers in T
Figure 2. Measurement of TIL distributions with DNA methylation (MeTIL signature). (A) Markers of the MeTIL signature showed highly differential methylation values in normal and cancerous breast epithelial cells (MCF10A, MCF-7, T47D, SKBR3, BT20, MDA-MB-231, MDA-MB-361, ZR-75-1) versus T lymphocytes (WEI35E5, R129, and ex vivo T cells). (B) Unsupervised hierarchical clustering analysis of MeTIL marker β values in CD45+ Epcam− (lymphocytes) and CD45−Epcam+ (epithelial) cells sorted from whole breast tumor samples. (C) Unsupervised hierarchical clustering analysis of cohort 1 based on β values of MeTIL markers. Note, a hypomethylated, an intermediate methylated, and a hypermethylated cluster appeared, all of which are associated with differences in BC subtypes, PaTILs, and MeTIL scores. Differences between methylation clusters were assessed with a 1-way ANOVA or χ² test, and P values are shown in the upper right corner of the heatmap. (D) The MeTIL signature was transformed into a score, and MeTIL scores were computed for T cells, Tregs, B cells, NK cells, granulocytes, monocytes, and DCs. Infinium DNA methylation profiles for these sorted blood cell populations are publicly available in the NCBI’s GEO database (GEO GSE35069, GSE39981, GSE49667, and GSE59796), per the Methods section. The MeTIL score values are plotted on the y axis and blood cell subpopulations on the x axis. Differences in the MeTIL score between the groups including T cells, Tregs, B cells, and NK cells and the group of granulocytes, monocytes, and DCs were assessed with a Student’s t test (P < 0.05). (E) MeTIL scores were computed in tumors enriched for CTLs with high expression of GZMB and PRF1-GZMB/PRF1-high and in tumors enriched for CTLs with low expression of GZMB and PRF1-GZMB/PRF1-low. The difference in MeTIL scores between the 2 groups was assessed with a Student’s t test, and the P value is shown. (F) MeTIL scores were correlated with the percentage of adipocytes, fibroblasts, and endothelial cells or PaTILs for 62 samples from cohort 1. MeTIL score values are plotted on the y axis and the percentage of cells on the x axis. The correlation was assessed with a Spearman’s rank correlation test. The Spearman’s rank correlation coefficient (rho) and its P value are shown for each plot. Note, because of methodological limitations, fibroblasts and endothelial cells were assessed as 1 cell type. (G) Color map showing the MeTIL score performance for simulations across noise (y axis) and the presence of additional cell type(s) (x axis) (randomly selected methylation values). With a SD of noise of 1, the performance (assessed using the Spearman’s correlation metric R) stayed higher than 0.7, even if the tissue consisted of more than 70% non–BC cells and non–T cells (yellow border). (H) Cohort 1 (105 samples) and cohort 2 (100 samples) were grouped by PaTILs, and MeTIL score values are shown by PaTIL group. MeTIL score values are plotted on the y axis and PaTIL groups on the x axis. Differences in the MeTIL score between groups were assessed with a 1-way ANOVA, and the P value is shown in each plot. (I) TIL distributions in BC subtypes based on MeTIL score (left panel) or PaTILs (right panel) in cohort 1 and cohort 2. Note that the MeTIL score showed greater differences within (especially in LumA and LumB) and between subtypes than did PaTILs. BC subtypes were defined on the basis of IHC results for the hormone receptors and HER2.

Next, we sought to test whether the MeTIL score is specific to TILs or whether it also reflects other cell types of the tumor microenvironment that have been shown to impact tumor progression and patient outcomes (31–33). Using Infinium DNA methylation data from the Encyclopedia of DNA Elements (ENCODE), we found the highest MeTIL scores for lymphocytes as compared with those for epithelial cells, fibroblasts, muscle cells, and other microenvironmental components such as adipocytes and endothelial cells (Supplemental Figure 6). We further correlated MeTIL scores with pathological assessments of adipocytes or fibroblasts and endothelial cells in 62 samples from cohort 1 and observed no significant correlation between MeTIL scores and adipocytes (rho = 0.083; P = 0.521) or between MeTIL scores and fibroblasts and endothelial cells (rho = −0.239; P = 0.061) (Figure 2F). In contrast,
MeTIL scores strongly correlated with the PaTILs (rho = 0.696; P < 0.001) in these samples. Additionally, we estimated the MeTIL score performance in simulation models reflecting biological admixtures of breast tumors (34). The MeTIL score accurately resolved known mixture proportions with an unknown cell content of up to approximately 70% and a noise up to approximately 70% of the SD (Figure 2G). Together, these data suggest that the MeTIL score is specific to TILs and does not measure other cell types typically found in the breast tumor microenvironment.

After we confirmed that the MeTIL score specifically measures TILs, we tested this score for the evaluation of TIL distributions within breast tumors. When MeTIL scores were grouped by PaTILs, we observed a significant increase in median MeTIL scores, with increasing levels of PaTILs in cohort 1 (P < 0.001) and cohort 2 (P < 0.001) (Figure 2H), suggesting that MeTIL scores may be suitable for quantifying TILs. Cohort 2 (n = 119) is an in-house retrospective BC cohort that received adjuvant therapies according to institutional recommendations and was assessed for PaTILs (Supplemental Tables 3 and 5). We then applied the MeTIL score to measure TIL distributions according to BC subtypes, namely TN, HER2, luminal A (LumA), and luminal B (LumB). In cohorts 1 and 2, the MeTIL scores had the highest values in TN and HER2 tumors, corresponding to previous findings of the highest TIL abundance in these subtypes (Figure 2I). Interestingly, the MeTIL score showed wider distributions within and greater differences between subtypes than did PaTILs.

**Improved prediction of survival and response to chemotherapy with the MeTIL score.** Recent studies have shown that TILs carry prognostic information mainly in TN breast tumors (3, 4). We tested whether the MeTIL score and PaTILs predict survival within BC subtypes in cohort 1 and cohort 2. Additionally, we used 38 TN tumors from a previously published prospective clinical
Table 1. Correlation between the MeTIL score or PaTILs and median survival of BC patients in the context of other prognostic clinical and pathological variables by BC subtype in various cohorts (multivariate Cox proportional hazards regression)

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Cohort</th>
<th>Patients (events)</th>
<th>Variable</th>
<th>MeTIL</th>
<th>HR</th>
<th>95% CI</th>
<th>P value</th>
<th>PaTILs</th>
<th>Variable</th>
<th>PaTILs</th>
<th>HR</th>
<th>95% CI</th>
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<td>TN</td>
<td>Cohort 1</td>
<td>28 (14)</td>
<td>MeTIL</td>
<td>1.10</td>
<td>0.8–1.52</td>
<td>0.564</td>
<td>2 (14)</td>
<td>PaTILs</td>
<td>1.01</td>
<td>0.9–1.04</td>
<td>0.214</td>
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<tr>
<td></td>
<td>Nodal status</td>
<td>0.52</td>
<td>0.34–1.97</td>
<td>0.336</td>
<td>Nodal status</td>
<td>0.58</td>
<td>0.16–2.08</td>
<td>0.404</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Cohort 2</td>
<td>32 (6)</td>
<td>MeTIL</td>
<td>0.55</td>
<td>0.25–1.19</td>
<td>0.130</td>
<td>32 (6)</td>
<td>PaTILs</td>
<td>0.96</td>
<td>0.78–1.18</td>
<td>0.692</td>
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<tr>
<td></td>
<td>Nodal status</td>
<td>3.59</td>
<td>0.33–38.9</td>
<td>0.293</td>
<td>Nodal status</td>
<td>5.94</td>
<td>0.65–54.1</td>
<td>0.114</td>
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<td>TOP</td>
<td>38 (8)</td>
<td>MeTIL</td>
<td>0.43</td>
<td>0.25–0.74</td>
<td>0.003</td>
<td>Nodal status</td>
<td>8.74</td>
<td>1.12–68.4</td>
<td>0.039</td>
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<td>LUM</td>
<td>Cohort 1</td>
<td>52 (18)</td>
<td>MeTIL</td>
<td>0.69</td>
<td>0.47–1.01</td>
<td>0.055</td>
<td>52 (18)</td>
<td>PaTILs</td>
<td>0.99</td>
<td>0.93–1.06</td>
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<td>Grade</td>
<td>4.16</td>
<td>1.24–13.9</td>
<td>0.021</td>
<td>Grade</td>
<td>2.91</td>
<td>0.82–10.3</td>
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<td>Nodal status</td>
<td>3.09</td>
<td>1.14–8.40</td>
<td>0.028</td>
<td>Tumor size</td>
<td>3.00</td>
<td>0.77–11.6</td>
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<td>Cohort 2</td>
<td>47 (3)</td>
<td>MeTIL</td>
<td>0.17</td>
<td>0.03–1.05</td>
<td>0.056</td>
<td>47 (3)</td>
<td>PaTILs</td>
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<td>0.44–2.28</td>
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<td>0.340</td>
<td>Grade</td>
<td>0.20</td>
<td>0.01–10.4</td>
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<tr>
<td></td>
<td>Nodal status</td>
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<td>0.26–650</td>
<td>0.198</td>
<td>Tumor size</td>
<td>10.4</td>
<td>0.40–269</td>
<td>0.159</td>
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<td></td>
<td>HER2</td>
<td>Cohort 1</td>
<td>25 (13)</td>
<td>MeTIL</td>
<td>0.69</td>
<td>0.46–1.03</td>
<td>0.067</td>
<td>25 (13)</td>
<td>PaTILs</td>
<td>0.98</td>
<td>0.93–1.03</td>
<td>0.351</td>
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<td>Age</td>
<td>4.45</td>
<td>1.02–19.3</td>
<td>0.046</td>
<td>Age</td>
<td>2.45</td>
<td>0.71–8.53</td>
<td>0.159</td>
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<tr>
<td></td>
<td>Cohort 2</td>
<td>21 (3)</td>
<td>MeTIL</td>
<td>0.81</td>
<td>0.27–2.46</td>
<td>0.713</td>
<td>21 (3)</td>
<td>PaTILs</td>
<td>0.90</td>
<td>0.43–1.86</td>
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<td></td>
<td>Age</td>
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<td>0.04–18.9</td>
<td>0.919</td>
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<td>0.85</td>
<td>0.05–14.8</td>
<td>0.913</td>
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</table>

BC subtypes were defined on the basis of the status of ER, progesterone receptor, and HER2 status evaluated by IHC or FISH, respectively. Optimal multivariate models for each subtype were determined in the discovery cohort (cohort 1) by applying a forward and backward variable selection based on the AIC. PaTILs, pathological assessment of TILs in H&E-stained tumor sections; HER2, HER2 subtype; LUM, luminal subtype. Bold indicates test results that were significant or close to significant.

TILs have been associated with higher response rates to preoperative chemotherapy in hormone receptor-negative and HER2-positive BCs (5). We assessed the potential of the MeTIL score to predict the response to preoperative chemotherapy in 58 hormone receptor-negative breast tumors from the TOP trial. An AUC of 0.73 (95% CI, 0.54–0.92) suggested a predictive value for the MeTIL score (Figure 3B). Logistic regression modeling demonstrated that the MeTIL score predicts for response to preoperative chemotherapy independently of other clinical and pathological variables, with an odds ratio (OR) of 4.38 (CI, 1.62–21.5; P = 0.02) (Figure 3C and Supplemental Table 9). Of interest, the MeTIL score showed the highest AUC and a significant OR (Supplemental Figure 7, A and B, and Supplemental Table 10) for response when compared with several gene expression–based immune markers (CD3D, CXCL9, CD247) (15) and signatures such as the STAT1 metagene (36). These results suggest, if further validated, that the MeTIL score may be a potential marker of response to chemotherapy in the future.

Evaluation of TILs in low amounts of DNA from FFPE tumor tissue through bisulfite pyrosequencing of MeTIL markers. The MeTIL score measures TILs in a sensitive manner and results in an improved prediction of survival and response to therapy. It would therefore be an attractive tool in clinical practice. To make its application easy, fast, and feasible in the clinic, we optimized bisulfite pyrosequencing for MeTIL score measurement in FFPE tumor tissue. We sequenced 21 FFPE tumor samples from cohort 1,
for which Infinium array–based MeTIL scores from frozen tissue were available, and observed significant correlations between the methylation values of MeTIL markers obtained by bisulfite pyrosequencing (y axis, Figure 4A) and Infinium arrays (x axis, Figure 4A). MeTIL scores obtained through bisulfite pyrosequencing of individual markers strongly correlated (\(\rho = 0.79, P < 0.01\)) with Infinium-based MeTIL scores (Figure 4B). Of note, bisulfite pyrosequencing–based MeTIL scores stratified breast tumors according to PaTILs (Figure 4B) and subtypes, since these are associated with different levels of TILs (Figure 4C).

**Prediction of survival outcomes in other cancer types with the MeTIL score.** Acknowledging that the MeTIL signature was developed for the evaluation of TILs in BC, we assessed whether it could predict survival differences in other cancer types available in TCGA (Supplemental Table 11). In 5 of 20 tested cancer types (head and neck squamous cell carcinoma [HNSC], pheochromocytoma and paraganglioma [PCPG], skin cutaneous melanoma [SKCM], thyroid carcinoma [THCA], and thymoma [THYM]), high MeTIL scores, but not PaTILs, were associated with a better outcome (Figure 5A and Supplemental Table 12). MeTIL scores

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**Figure 4. Determination of the MeTIL score in FFPE tumor tissue by bisulfite pyrosequencing.** (A) Scatter plots showing for each MeTIL marker the correlation between methylation values (percentage), determined by pyrosequencing in FFPE tumor tissue (y axis), and methylation values (percentage), determined by Infinium arrays in fresh-frozen tumor tissue (x axis). The correlation was established on the basis of 21 samples from cohort 1, for which fresh-frozen and FFPE tissue was available. Spearman’s rank correlation coefficient (\(\rho\)) and its \(P\) value for each marker are shown. Different colors of the dots reflect the PaTIL group to which each sample was assigned. PaTIL groups were defined on the basis of TIL percentages as follows: no PaTILs (PaTILs <1%), low PaTILs (PaTILs ≥1% and <20%); and high PaTILs (PaTILs ≥21% and ≤100%). (B and C) Scatter plots showing the correlation between the MeTIL score, determined by pyrosequencing in FFPE tumor tissue (y axis), and the MeTIL score, determined by Infinium arrays in fresh-frozen tumor tissue (x axis), with respect to the PaTIL group (B) or BC subtype (C).
predicted survival differences independently of other prognostic variables in HNSC, PCPG, SKCM, and THYM, but also in lung squamous cell carcinoma (LUSC) (Figure 5B and Supplemental Table 13). As with BC (Figure 2C), MeTIL scores clustered SKCM samples into 3 groups that were associated with variable levels of PaTILs (P = 0.049), distinct molecular subtypes (37) (P < 0.001), and MeTIL scores (P < 0.001) (Figure 5C) as well as differences in survival (P = 0.018) (Figure 5D). MeTIL scores varied for melanoma subtypes, with the “immune” subtype showing the highest median MeTIL score (P < 0.001) (Figure 5E). Together, these data suggest that the MeTIL score may predict survival outcomes in other cancer types. It is noteworthy that we did not observe significant differences in BC survival with the MeTIL score in TCGA data. This was not unexpected, as TILs have been shown to be more abundant and associated with clinical outcomes in TN and HER2 breast tumors. We therefore correlated MeTIL scores with survival endpoints in BC subtypes and observed differences in survival with HER2 tumors (HR, 0.57; 95% CI, 0.16–0.85; P = 0.02). In luminal (HR, 0.82; 95% CI, 0.67–1.02; P = 0.069) and TN (HR, 0.67; 95% CI, 0.44–1.03; P = 0.066) tumors, the association between MeTIL score and survival was borderline significant. PaTILs, on the other hand, predicted no survival differences between luminal (HR, 0.98; 95% CI, 0.93–1.02; P = 0.324), HER2 (HR, 0.56; 95% CI, 0.2–1.58; P = 0.273), or TN (HR, 0.99; 95% CI, 0.96–1.03; P = 0.733) tumors. These results are in line with our earlier findings that suggested a prognostic value for the MeTIL score in luminal and TN tumors and further show a prognostic value for HER2 tumors. Importantly, as in BC, the MeTIL score may have a prognostic value in other cancer types if these are grouped into subtypes.

Discussion

The tumor immune response is increasingly recognized to be associated with better clinical outcomes in breast and other cancers. However, quantitative evaluation of the tumor immune response based on TILs remains suboptimal, since histopathological measurements are semiquantitative and limited in their accuracy and reproducibility (12, 13). This has prompted an international TIL working group to publish guidelines for the harmonization of this method (14). DNA methylation plays a critical role in cell lineage specification and may therefore sustain a specific molecular marker for typing of immune cell subtypes (16–18). Indeed, several studies have identified DNA methylation signatures that accurately evaluate the distribution of cell subpopulations in blood (19–21). However, within complex tissues such as tumors, DNA methylation has barely been explored for the evaluation of immune cell subtypes, particularly TILs, and the diagnostic value of such a marker is unknown.

In this study, we identified DNA methylation markers (MeTIL signature) for the evaluation of TIL-based tumor immune responses and their impact on clinical outcomes in BC. Interestingly, the functions of all MeTIL markers were related to TILs or other components of the antitumor immune response. PTPRCAP is a phosphoprotein that is specifically associated with CD45, a surface marker on lymphocytes, and has been shown to function as a key regulator of T and B cell activation (38). KLHL6 is a member of the Kelch-like protein family and is important for antigen receptor signaling on B cells and germinal center formation (39). INA and SEMA3B are best known for their role in neuronal development, but studies also linked them to immune-related functions (40, 41). INA encodes for the neurofilament protein internexin neuronal intermediate filament protein α, and neurofilaments have been linked to T cell activation (40). SEMA3B belongs to the family of semaphorins, which regulate immune functions by controlling activation, differentiation, and trafficking of immune cells, including T cells and B cells (41). RASSF1 is a well-established tumor suppressor that is frequently inactivated in several cancers, including breast and lung cancer, by aberrant promoter methylation. RASSF1 controls genome stability in response to replication stress through activation of the Hippo pathway, which regulates phosphorylation of breast cancer 2 (BRCA2) and recruitment of RAD51 recombinase (RAD51) (42). The absence of RASSF1A led to chromosomal aberrations and increased genomic instability such as that seen in BRCA-mutant cells (42). Concordantly, a positive correlation between RASSF1A promoter methylation and increased copy number alteration has been shown in breast and lung cancer (43). These findings, together with those of other studies, which linked genomic instability to more TILs and a better antitumor immune response, suggest that methylation of RASSF1 may be an indirect measure of TILs and the antitumor immune response (44, 45).

A thorough characterization of the MeTIL signature showed that the signature score measures predominantly mononuclear immune cells including T cells, B cells, and NK cells. Among these cell subtypes, T cells had the highest MeTIL scores, suggesting a bias of the MeTIL score toward T cells. Moreover, MeTIL scores were markedly higher in tumors enriched for functional CTLs than in those enriched for nonfunctional CTLs, suggesting that the MeTIL score may reflect the functionality of tumor immune responses. Intriguingly, MeTIL scores were also high in Tregs, which have an immunosuppressive role in tumors. This is interesting in light of previous studies that showed a positive correlation between immunosuppressive markers, including the Treg marker FOXP3, and TILs and suggested a feedback activation of immunosuppressive pathways as part of the immune reaction (5, 46). Hence, Tregs and other immunosuppressive markers can be a surrogate for an immune reaction in tumors, and their contribution to the MeTIL score further facilitates the quantification of tumor immune responses. Other immune cells, e.g., granulocytes, monocytes, and DCs, showed markedly lower MeTIL scores and hence contributed only minorly to the MeTIL score. Importantly, the frequencies of nonimmune cells (adipocytes, fibroblasts, endothelial cells), which are typically found in the tumor microenvironment, did not correlate with MeTIL scores. Together, these results suggest that the MeTIL score measures predominantly TILs. This is substantiated by the strong correlation we observed between the MeTIL score and PaTILs in vivo. Next, we used the MeTIL score to measure TIL distributions within breast tumors of different subtypes in 2 independent cohorts. We consistently observed differences between subtypes with the MeTIL score, but not with PaTILs. In line with other studies, the MeTIL score showed the highest TIL levels in TN and HER2 tumors (3, 4). Interestingly, also within BC subtypes, especially in luminal tumors with low infiltration, the MeTIL score showed wider TIL distributions than did PaTILs. Together, these results may suggest a greater sensitiv-
Figure 5. The MeTIL score predicts differences in survival in other types of cancer. Forest plot showing the log2 value of the HR and CI for the prediction of survival outcomes in univariate (A) or multivariate (B) Cox models for the MeTIL score (orange) or PaTILs (black) in different TCGA cancer types. Red asterisks indicate statistical significance (P < 0.05 by a likelihood ratio test). BLCA, bladder urothelial carcinoma; BRCA, breast invasive carcinoma; CESC, cervical squamous cell carcinoma and endocervical adenocarcinoma; COAD, colon and rectum adenocarcinoma; ESCA, esophageal carcinoma; KIRP, kidney renal papillary cell carcinoma; LIHC, liver hepatocellular carcinoma; LUAD, lung adenocarcinoma; OV, ovarian serous cystadenocarcinoma; PAAD, pancreatic adenocarcinoma; PRAD, prostate adenocarcinoma; SARC, sarcoma; STAD, stomach adenocarcinoma; TGCT, testicular germ cell tumors; UCEC, uterine corpus endometrial carcinoma. (C) Heatmap displaying the results of an unsupervised hierarchical clustering analysis of TCGA skin cutaneous melanomas based on β values for the MeTIL markers. Note, a hypomethylated, an intermediate methylated, and a hypermethylated cluster appeared, all of which are associated with differences in subtypes, PaTILs, and MeTIL scores. Differences between methylation clusters were assessed by 1-way ANOVA (MeTILs) or χ² test (PaTILs and subtypes), and P values are shown. (D) Kaplan-Meier survival curves for the 3 methylation clusters defined in the heatmap. (E) MeTIL scores grouped according to 3 melanoma subtypes. Differences in MeTIL scores between melanoma subtypes were assessed by 1-way ANOVA, and the P value is shown. MITF, melanogenesis-associated transcription factor.
pathologist cannot distinguish between, for example, 11% of TILs and 14% of TILs and thus will score this example as either 10% or 15% (14). This categorical assessment is suboptimal, as relevant information, which is important for the prognostic TIL effect that has been shown to be linear in various studies, is lost (51). The guidelines therefore suggest that TILs be scored as a continuous variable and as accurately as possible, which means that TIL categories should be kept as small as possible to avoid the loss of prognostic and potentially predictive information. Nevertheless, in contrast to the MetTIL score, which is a real continuous parameter, PaTILs is, strictly speaking, rarely scored as a continuous variable in daily clinical practice (14). This probably caused some loss of relevant prognostic information with regard to PaTILs and might further explain discrepancies with MetTIL scores and with studies that have assessed TILs as a continuous variable. Last, we demonstrated that the MetTIL score predominantly reflects T cells and functional CTLs. This bias further adds to the discrepancy in prognostic performance between MetTIL scores and PaTILs.

In this study, we highlighted the power of DNA methylation to evaluate local and functional TIL-based tumor immune responses and the ability of this approach to improve prognosis in breast and other cancers. The MetTIL signature, if further validated, holds potential for the future to refine the stratification of cancer patients for clinical trials and the choice of therapeutic approaches, including immunotherapy.

**Methods**

**Patient cohorts.** Cohort 1 and cohort 2 consists of 118 and 119 retrospectively selected fresh-frozen tumor samples from patients treated with adjuvant therapies according to institutional recommendations and diagnosed at the Jules Bordet Institute from 1995 to 2003 and 2004 to 2009, respectively. The preoperative TOP cohort consisted of 149 patients with estrogen receptor-negative (ER-negative) disease who were treated at the Jules Bordet Institute from 2003 to 2008 with neoadjuvant epirubicin monotherapy (100 mg/m²) (35). Patients with operable BC were treated every 3 weeks for 4 cycles, and patients with inflammatory or locally advanced BC were treated every 2 weeks for 6 cycles. Pretreatment biopsies were obtained from the primary lesion. A pathologic complete response (pCR) was the primary endpoint of this trial. A pCR was defined as the absence of residual invasive breast carcinoma in the breast and in the axillary nodes after completion of chemotherapy. Persistence of in situ carcinoma without an invasive component was also considered a pCR. Fifteen minutes, 72°C for 10 minutes. Amplification was confirmed on agarose gel, and pyrosequencing of successfully amplified PCR products was performed with the PyroMark Q24 System (Qiagen). Primer sequences are listed in Supplemental Table 14. Biostatistical analysis. Infinium HumanMethylation450K raw data were submitted to the NCBI’s Gene Expression Omnibus (GEO) database (GEO GSE72308; http://www.ncbi.nlm.nih.gov/geo/query/acc.cgi?acc=GSE72308).

**Bisulfite pyrosequencing.** Genomic DNA (275 ng) was bisulfite converted with the EZ DNA Methylation Kit, and 3–6 μl converted DNA (corresponding to approximately 45 to 95 ng DNA) served as the input for PCR. PCR assays were performed with HotStarTaq DNA Polymerase (Qiagen) under the following cycle conditions: 95°C for 15 minutes, 50–60 cycles at 95°C for 1 minute, 50 cycles at 55°C for 1 minute, 72°C for 1 minute, and 72°C for 10 minutes. Amplification was confirmed on agarose gel, and pyrosequencing of successfully amplified PCR products was performed with the PyroMark Q24 System (Qiagen). Primer sequences are listed in Supplemental Table 14. Bioinformatics. Infinium HumanMethylation450K raw data (uncorrected probe intensity values) were preprocessed and β values computed and corrected as described in the supplemental material. T lymphocyte-associated markers (Supplemental Table 1) were identified through an approach using previously published DNA methylation profiles from normal or cancerous breast epithelial cell lines and T lymphocyte samples (26) (Supplemental Figure 1). From these, MeTIL markers (Supplemental Table 4) were selected by applying
machine learning to cohort 1 (Supplemental Figures 1 and 2). Individual methylation values of MeTIL signature markers were transformed into a score (MeTIL score) using a normalized PCA (NPCA) approach (Supplemental Table 15). To estimate the performance of the MeTIL score, various biological admixtures of solid tumors were simulated as reported by Newman et al. (34). A detailed description of the bioinformatic methods is provided in the supplemental material.

Statistics. Statistical analyses were conducted with RStudio, version 0.94.110. Differences between more than 2 groups were assessed with a 1-way ANOVA or χ² test. Cox proportional hazard regression analyses and Kaplan-Meier survival curves with log-rank tests, recording patients at the time of death or disease recurrence or last follow-up visit, were used to compare overall survival or disease-free survival rates. Multivariate Cox regression models were established on the basis of Akaike’s information criterion (AIC). ORs were used to compare pCR rates. The AUC was used to assess prediction performance. All P values were 2 sided, and P values of less than 0.05 were considered statistically significant. Statistical methods are further explained in the Supplemental Methods.

Study approval. This study was approved by the Medical Ethics Committee of Institute Jules Bordet, Brussels, Belgium, and all patients gave written informed consent before their participation in the study.

Author contributions

JF and MB designed experiments, performed research, and interpreted data. SD and EC processed Infinium methylation arrays. JF and EC performed bisulphite pyrosequencing. JJ, MB, AK, and MD conducted bioinformatic and statistical analyses. CD, DL, RS, and GVE collected, prepared, and characterized clinical samples. FF, CS, MD, and CD designed experiments, interpreted data, and directed the study. JJ, CD, FF, and CS wrote the manuscript. SG, KGW, and GB critically revised the manuscript. JJ, MB, and FF had full access to all data for this study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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