Supplemental Information

Clinical Impact of TP53 Disruption in Chronic Lymphocytic Leukemia Patients Treated with Ibrutinib. A Campus CLL Study

Riccardo Bomben¹, Francesca Maria Rossi¹, Filippo Vit¹, Tamara Bittolo¹, Antonella Zucchetto¹, Robel Papotti², Erika Tissino¹, Federico Pozzo¹, Massimo Degan¹, Jerry Polesel³, Pietro Bulian¹, Roberto Marasca^{4,5}, Gianluigi Reda⁶, Luca Laurenti⁷, Jacopo Olivieri⁸, Annalisa Chiarenza⁹, Roberta Laureana¹⁰, Massimiliano Postorino¹⁰, Maria Ilaria Del Principe¹⁰, Antonio Cuneo¹¹, Massimo Gentile^{12,13}, Fortunato Morabito^{12,14}, Gilberto Fronza¹⁵, Agostino Tafuri¹⁶, Francesco Zaja¹⁷, Robin Foà¹⁸, Francesco Di Raimondo⁹, Giovanni Del Poeta¹⁰, and Valter Gattei¹

¹Clinical and Experimental Onco-Haematology Unit, Centro di Riferimento Oncologico di Aviano (CRO) IRCCS, Italy;

²International PhD School in Clinical and Experimental Medicine, University of Modena and Reggio Emilia, Modena, Italy;

³Unit of Cancer Epidemiology, Centro di Riferimento Oncologico di Aviano (CRO) IRCCS, Aviano, Italy;

⁴Hematology Unit, Department of Oncology and Hematology, Azienda-Ospedaliero Universitaria (AOU) of Modena, Policlinico, Modena, Italy;

 5 Department of Medical and Surgical Sciences, University of Modena e Reggio Emilia;

⁶Division of Ematologia, Fondazione IRCCS Ca'Granda Ospedale Maggiore Policlinico di Milano, Milano, Italy;

⁷ Fondazione Universitaria Policlinico A Gemelli di Roma, Roma, Italy;

⁸Clinica Ematologica, Centro Trapianti e Terapie Cellulari "Carlo Melzi" DISM, Azienda Ospedaliera Universitaria S. Maria Misericordia, Udine, Italy;

⁹Division of Hematology, Policlinico, Department of Surgery and Medical Specialties, University of Catania, Catania, Italy;

 10 Division of Haematology, University of Tor Vergata, Rome, Italy;

¹¹Hematology Section, Department of Medical Sciences, University of Ferrara, Ferrara, Italy;

¹²Hematology Unit AO of Cosenza, Cosenza, Italy;

¹³Biothecnology Research Unit, AO of Cosenza, Cosenza, Italy

¹⁴Hematology Oncology Department, Augusta Victoria Hospital, East Jerusalem, Israel;

¹⁵Mutagenesis and Cancer Prevention Unit, IRCCS Ospedale Policlinico San Martino, Genoa, Italy;

¹⁶Department of Clinical and Molecular Medicine and Hematology, Sant'Andrea - University Hospital - Sapienza, University of Rome, Rome, Italy;

 17 Department of Medical, Surgical and Health Sciences, University of Trieste, Italy;

¹⁸Hematology, Department of Translational and Precision Medicine, 'Sapienza' University, Rome, Italy.

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TP53 **mutations and bioinformatics pipeline of analysis**

All the samples enrolled in this study were sequenced and analyzed with the same pipeline at the Clinical and Experimental Onco-Hematology Unit (Aviano, Italy).

For a more detailed description of the procedures for *TP53* mutational status determination, including functional evaluation and the applied bioinformatics pipeline, please refer to a recent publication of ours [1]. In addition, a custom script of the bioinformatics pipeline, as described herein and in [1]. is available at the website address [https://github.com/gamabunta313/TP_SNP-calling/.](https://github.com/gamabunta313/TP_SNP-calling/)

Briefly, analysis of *TP53* mutations was performed by next generation sequencing (NGS) with an amplicon-based strategy, covering exons 2-11, in keeping with the ERIC recommendations [2]. Specific primers were designed with the Primer3 program, and modified according to the Illumina (San Diego, CA) protocol [1]. Amplicon libraries were generated using a modified Illumina protocol starting from 40 ng of DNA (~6,000 diploid genomes), a quantity capable to successfully detect mutations below the 1% variant allele frequency (VAF) in the context of our procedures [1]. Multiplex PCR products were generated using Phusion High-Fidelity DNA Polymerase (Thermo Scientific, Milan, Italy) and subsequently tagged with specific index according to modified procedures for NexteraXT (DNALibrary Preparation kit, Illumina), as previously reported [3, 4]. Purified libraries were pooled, and paired-end sequenced in a MiSeq instrument (Illumina).

FASTQ files were aligned to the Hg19 reference with Burrows-Wheeler Aligner (BWA)-MEM algorithm, and allele variants were called by FreeBayes with non-stringent parameters [5–8]. A coverage $\geq 2,000X$ was obtained for each sample in 100% of the analyzed sequences. To calculate random/systematic errors, a database of 362 *TP53* wild-type (wt) cases was utilized [1]. As in Bomben et al [1], *TP53* mutations were accepted if both of the following conditions were fulfilled: i) with a VAF that outdistanced for at least 2.75 standard deviations the mean of the transformed VAF distribution related to any single nucleotide position of the *TP53* sequence; ii) validated by Fisher's exact test after Bonferroni correction (*P<0.01*). The minimal allelic fraction for *TP53* mutation calling was 0.3% [1].

The IARC TP53 Database [\(https://tp53.isb-cgc.org/\)](https://tp53.isb-cgc.org/) [9] was used to annotate *TP53* mutations, and to functionally evaluate *TP53* missense mutations for their capability to transcribe the *CDKN1A* gene [9, 10]. *TP53* mutated cases with less than 2% VAF were all confirmed by a second independent NGS run starting from DNA.

FISH analysis

Interphase FISH was performed on nuclei preparations of PB mononuclear cells, to detect 17p13.1 deletion (del17p) and 11q22.3 deletion (del11q) using the following locus specific probes, respectively: LSI-TP53 SpectrumOrange (17p13, 167 kb, *TP53* gene), LSI-ATM SpectrumGreen (11q22.3, 338 kb, ATM gene) (MetaSystems, Italy). Analyses were performed on a Eclipse 90i Nikon fluorescent microscope equipped with a 100x planApo objective. In all cases, at least 200 interphase nuclei with well delineated fluorescent spots were examined and a threshold of ≥5% of nuclei (\geq 10% of nuclei for del 17p) was applied to discriminate between normal cases and cases bearing a specific chromosomal abnormality, in agreement with internal technical laboratory cut-offs, and as reported previously [11, 12].

Digital Droplet PCR

The detection of *TP53* mutations presented at very low frequencies was confirmed by Digital Droplet PCR (ddPCR) using specific Mutation Detection Assays according to manufacturer's instructions. A set of specific molecular probes were used to detect in the same assay the wild-type form of *TP53* and the specific mutations R248Q, R273H and Y234C (dHsaMDV2010127, dHsaMDV2010109, dHsaMDV2516900; Biorad), as born with low-VAF abundance in 22 CLL cases. The ddPCR experiments were performed on a QX200 system (BioRad). The reaction mixture was prepared in a final volume of 20 μ L and comprised 10 μ L of 2X ddPCR Super Mix for Probe (no dUTP), 1 μ L of 20X target (FAM) and wild-type (HEX) primers/probe, $4 \mu L$ of water and $5 \mu L$ of template DNA with a concentration of 30 ng/ μ L. All samples, including negative controls (WT) were prepared in two replicates. After droplet generation with QX200 Droplet Generator, the PCR reaction was performed under the following conditions: 95 °C for 10 min; 40 cycles of 94 °C for 30 s and 57.5 °C for 60 s; 98 °C for 10 min, and in the end at 4°C (Veriti, Applied Biosystems). The droplets were read with QX200 Droplet Reader and QuantaSoft software was used to analyze the fractional abundance of each sample. The threshold was selected based on the WT controls, allowing a good separation between positive and negative events. Only fractional abundance percentage >0.1 and that outdistanced for at least 4 times respect to that calculated for WT samples were considered as truly mutated. ddPCR confirmed the presence of all the three *TP53* mutations investigated with similar fraction abundance (r=0.96; *P<0.0001*) in all the 22 CLL cases (Table S4 and Figure S2).

Other CLL characterizations

CLL patients were also characterized for gender, age, Rai staging, previous lines of therapy, anemia, β 2-microglobulin (β 2M), lactate-dehydrogenase (LDH) [3, 13–16]. Immunoglobulin-heavy-variable (IGHV) gene mutational status were analyzed by using the LymphoTrack IGHV Leader Somatic Hypermutation Assay MiSeq kit (Invivoscribe, San Diego, CA), according to the manufacturer's protocols [17]. Analysis of *BTK*, and *PLCG2* mutations was performed by NGS with an amplicon-based strategy, covering exons 11, 15, and 16, exons 12, 19, 20, 24, 27, and 30, respectively. Specific primers were designed with the Primer3 program, and modified according to the Illumina (San Diego, CA) protocol [1]. Amplicon libraries were generated using a modified Illumina protocol starting from 40 ng of DNA [1]. Multiplex PCR products were generated using Phusion High-Fidelity DNA Polymerase (Thermo Scientific, Milan, Italy) and subsequently tagged with specific index according to modified procedures for NexteraXT (DNALibrary Preparation kit, Illumina), as previously reported [3, 4]. Purified libraries were pooled, and paired-end sequenced in a

MiSeq instrument (Illumina). Figure S1 summarizes the clinical impact (OS) for all these variables in the cohort. In multivariable analyses, the variables "Rai staging" and "previous lines of therapy", were dichotomized according to OS results, i.e. stage I-II vs III-IV and lines 0-1 vs >1, respectively.

Statistical analysis

All statistical analyses were performed by using standard methods [18–20]. OS was computed from date of ibrutinib start to death (events) or last follow-up (censoring). Progression-free survival (PFS) was calculated from the date of ibrutinib treatment initiation to progression (event) or last follow-up (censoring). The Cox proportional hazards regression models was chosen to assess the independent effect of covariates, treated as dichotomous, on OS or PFS, with stepwise procedure for selecting significant variables. Molecular studies were blinded to the study end points. Internal bootstrapping validations were as reported [18], by performing at least 500 replications.

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Figure legends

Figure S1. Clinical impact of sex, age, b2 microglobulin, hemoglobin, anemia, LDH, IGHV gene status, Rai stage, number of previous lines of therapy. Kaplan-Meier curves comparing OS of patients from the ibrutinib treated cohort split in groups according to different prognostic markers. The number of patients in each group is reported; P values refer to the log-rank test.

Figure S2. Variant specific ddPCR analysis of 3 different *TP53* **mutations.** A) ddPCR for c.743G>A,p.R248Q. Fractional abundance percentage for 10 mutated cases and wild-type (WT) cases. B) ddPCR for c.701A>G,p.Y234C. Fractional abundance percentage for 3 mutated cases and WT cases. C) ddPCR for c.818G>A,p.R273H. Fractional abundance percentage for 9 mutated cases and WT cases. QuantaSoft software was used to calculate fractional abundance percentage. For WT cases fractional abundance percentage was calculated as the median value of 4 WT cases (R248Q), 4 WT cases (Y234C), and 7 WT cases (R273H). D) Correlation plot between variant allele frequency (VAF) % calculated by NGS and fractional abundance percentage calculated by ddPCR. P value refers to Rank correlation.

Figure S3. Clinical impact of *TP53* **aberrations in ibrutinib-treated CLL.** Kaplan-Meier curves comparing OS probabilities of 103 *TP53* wt (green line), 126 cases with *TP53* mutations irrespectively of VAF (red line). Cases with more than one mutation are classified according to the mutation with the highest VAF (see Table S3). The number of patients in each group is reported; P values refer to the log-rank test.

Figure S1

Figure S1. Clinical impact of sex, age, β2 microglobulin, hemoglobin, anemia, LDH, IGHV gene status, Rai stage, number of previous lines of therapy. Kaplan-Meier curves comparing OS of patients from the ibrutinib treated cohort split in groups according to different prognostic markers. The number of patients in each group is reported; P values refer to the log-rank test.

Figure S2

Figure S2. Variant specific ddPCR analysis of 3 different *TP53* mutations. A) ddPCR for c.743G>A,p.R248Q. Fractional abundance percentage for 10 mutated cases and wild-type (WT) cases. B) ddPCR for c.701A>G,p.Y234C. Fractional abundance percentage for 3 mutated cases and WT cases. C) ddPCR for c.818G>A,p.R273H. Fractional abundance percentage for 9 mutated cases and WT cases. QuantaSoft software was used to calculate fractional abundance percentage. For WT cases fractional abundance percentage was calculated as the median value of 4 WT cases (R248Q), 4 WT cases (Y234C), and 7 WT cases (R273H). D) Correlation plot between variant allele frequency (VAF) % calculated by NGS and fractional abundance percentage calculated by ddPCR. P value refers to Rank correlation.

Figure S3

Figure S3. Clinical impact of *TP53* aberrations in ibrutinib-treated CLL. Kaplan-Meier curves comparing OS probabilities of 103 *TP53* wt (green line), 126 cases with *TP53* mutations irrespectively of VAF (red line). Cases with more than one mutation are classified according to the mutation with the highest VAF (see Table S3). The number of patients in each group is reported; P values refer to the log-rank test.

Table S1. Clinical features of the retrospective CLL cohort

Abbreviations: IGHV unmutated, > 98% identity with germ line;

^a number of previous lines respect to ibrutinib treatment;
^b high-VAF, <u>></u>10.0% VAF; low-VAF, <10.0% VAF.

Table S2. Univariable and multivariable analyses of OS and PFS (n=219)

Notes and abbreviations: Anemia, <110 g/L for women or <120 g/L for men; IGHV unmutated (UM), ≥98% identity with germ line; β2 microglobulin and LDH high, > upper normal level according to the different laboratories; OS, overall survival from ibrutinib start; PFS, progression free survival; UVA, univariable analysis; MVA, multivariable analysis; HR, Hazard Ratio; CI, confidence interval; LCI, 95% lower CI; UCI, 95% Upper CI; -: not used in the final model; ni: not included in the final model.

^a Multivariable analysis was carried out using the following variables (n=219): Rai stage, previous lines of therapies, anemia, LDH, del17p (Model 1) or *TP53* mutations (Model 2)

Notes and abbreviations: Anemia, <110 g/L for women or <120 g/L for men; IGHV unmutated (UM), ≥98% identity with germ line; β2 microglobulin and LDH high, > upper normal level according to the different laboratories; OS, overall survival from ibrutinib start; PFS, progression free survival; UVA, univariable analysis; MVA, multivariable analysis; HR, Hazard Ratio; CI, confidence interval; LCI, 95% lower CI; UCI, 95% Upper CI; -: not used in the final model; ni: not included in the final model.

^a Multivariable analysis was carried out using the following variables (n=219): gender, Rai stage, previous lines of therapies, anemia, LDH, IGHV, del17p (Model 1) or *TP53* mutations (Model

2)

† high-VAF, >10.0% VAF; low-VAF, <10.0% VAF;

‡ According to Human Genome Variation Society (HGVS) nomenclature. https://www.mutalyzer.nl/;

For cases with multiple mutations the mutation with the highest VAF is highlighted (grey cell fill color). § Cases with very high VAF percentage (>81%) in absence of concomitant del17p indicative of duplication of the mutated allele i.e. copy neutral loss of heterozygosity; copy neutral loss of heterozygosity was also consistent with what observed for the P72R polymorphysm: in all 4 cases the VAF of one of the

Table S4. NGS and ddPCR

* Fractional abundance percentage of the WT was calculated as the median value of 4 WT cases;

† Fractional abundance percentage of the WT was calculated as the median value of 7 WT cases;

ddPCR Fractional Abundance and positive droplets according to ddCPR software.

Table S5. Clonal evolution of *TP53* **mutations in** *TP53* **mutated cases**

* According to Human Genome Variation Society (HGVS) nomenclature. https://www.mutalyzer.nl/

† Collected before ibrutinib treatment

‡ Collected at ibrutinib end for relapsed cases, or during ibrutinib treatment for non-relapsed cases

Mutation coding refferring to *PLCG2* are highlighted in grey.